

2010 HEALTHY COMMUNITIES/HEALTHY AMERICA GRANT RECIPIENTS

Agape Clinic Dallas, Texas

Grant Amount: \$10,000

www.agapeclinic.org



The Agape Clinic provides medical care and social services to uninsured and medically indigent patients in the Dallas area. Many of their patients are immigrants or refugees from countries such as Mexico, Burma, and El Salvador. With 30 volunteers, 7 of whom are physicians, and 8 staff members, the clinic had 3,319 patient visits last year.

In order to effectively help their diabetes patients better manage their care, the clinic is focusing on improving patients' knowledge, attitude, and behavior. To address knowledge, a promotora will take patients through a curriculum that includes a pretest of their knowledge and goal setting, followed by discussions about complications and medications, diet and exercise, and posttests. With increased knowledge, the clinic believes that attitudes can be improved by helping patients see evidence of change,

as measured by weight and A1C, and then supporting and recognizing patient improvements through letters of congratulations and the teaching encounters. Lastly, to support healthier behaviors, the clinic plans to start holding specific diabetes clinic days. They will be encouraging patients that attend during those days to find mutual support and share resources that have worked for them. A select number of patients will also receive home visits to assess and reinforce healthy behaviors.

The clinic will track their success by examining these patients' A1C, blood pressure, and weight. Their goal is to see at least 20% reduction in of A1Cs in at least 60% of patients, at least 20% improvement in blood pressure in at least 60% of patients, and at least 1 pound weight loss per week in at least 60% of project patients who are obese.

Grant funds will be used to cover the promotora's salary, glucometers and test strips, A1C tests, and a dry erase board.

Bethesda Health Clinic Tyler, Texas

Grant Amount: \$10,000

www.bethesdaclinic.org

Opening in 2003, the Bethesda Health Clinic treats uninsured adults who live or work in Smith County. To qualify for services, patients must be ages 16-64 years, make less than 200% of the federal poverty level, and work at least 20 hours per week. Last year, the clinic saw 2,828 patients in 11,714 visits. They currently have a total of 543 volunteers, 243 of whom are physicians, and 10 staff members.

Despite some successes in controlling A1C levels through its Chronic Disease Management program, Bethesda Clinic continues to struggle in adequately addressing nutrition and obesity as key factors in overall diabetes management for their 425 diabetic patients. Although the clinic offers comprehensive

case management, a free monitored exercise program, health classes, and follow-up phone calls, their patients are still having difficulty committing to long-term lifestyle changes.



Recently launched, the Smith County Healthy Living Initiative targets obesity and will continue to offer case management and exercise programs, as well as an on-site demonstration kitchen for hands-on cooking and healthy eating programs. Classes held at the demonstration kitchen will combine nutrition education (such as appropriate portion sizes, understanding food labels, identifying food groups, and stocking pantries) with cooking skills and food tastings. The clinic has also designed an incentive program to further encourage patients to control their A1C, blood pressure, cholesterol, and weight. Throughout the process of completing the group of classes and surveys, setting long-term goals, and

checking in for the 3- and 6-month follow-ups, participants will receive various items such as measuring cups, cutting boards, cookbooks, and grocery store gift cards.

The clinic aims to evaluate the progress at least 100 patients who participate in the first year's classes. Their goals for the patients who actively participate in the program for at least 6 months and with 2 sets of lab tests are: 60% of patients will have an A1C of less than 7%, 30% of patients reaching their goals on the 3 major indicators of blood pressure, cholesterol, and A1C, and 50% of patients decrease their weight by at least 5% of their total weight.

Grant funds will cover cooking supplies, small appliances, and incentives.

Church Hill Free Medical Clinic Church Hill, Tenn.

Grant Amount: \$10,000

www.ofoneaccordministry.org/free_clinic.htm

The Church Hill Free Medical Clinic serves patients who are uninsured or underinsured and whose incomes fall within 185% of the federal poverty level. Their patients are primarily from Hawkins and Sullivan Counties in Tennessee and Scott County in Virginia. In 2008, they saw 538 patients in 1,947 visits.

In February 2008, the clinic established a Diabetes Management Program that was run by an all-volunteer staff who donated their time one day a week to treat the clinic's existing diabetes patients. As the community discovered the program and demand increased, the clinic expanded the program to three days a week. One day became a medication refill day, the second became the day for individualized patient education, and the third day was when the doctors saw and treated patients.



Realizing that volunteers cannot always keep commitments or “become weary in well-doing”, the clinic would like to fund the staff for part of their work. Each of their nursing staff agreed to increase their hours to 12 per week if they can get paid for 6.

With help from the AMA Foundation grant, the Church Hill Free Medical Clinic will continue its weekly Diabetes Management Program. The program consists of a physician-led diabetes mini-clinic on one day a week, a medication refill clinic on one day a week provided by advance practice nurses, and a telephone follow-up clinic on one afternoon a week. The Mini-Clinics will provide group and individual education, check-ups, medication refills, and lab testing. The Refill Clinics will allow the nursing staff to provide refills as prescribed by the doctors, check blood pressures, review glucose diaries, and answer questions between doctor’s appointments. The staff consults with the doctors if there are concerns regarding the patient’s care or if the patient is experiencing difficulties. Lastly, the Telephone Follow-Up Clinics allow patients to call in if they have questions for a diabetes educator, but do not necessarily need an appointment at the clinic.

The clinic’s project goals are to increase enrollment to 120 patients by Oct. 1, 2010, and increase the number of patients enrolled in the patient assistance programs for insulin and test strips to 80%, have 50% of patients conducting regular self glucose monitoring, and 75% of patients in compliance with the clinic’s interventions regarding A1C tests, foot exams, fundoscopic/retinal exams, and urinary microalbumin tests by June 1, 2010.

Coastal Medical Access Project Brunswick, Ga.

Grant Amount: \$10,000

www.cmapga.org



Established in 2002, the Coastal Medical Access Project (CMAP) is a nonprofit rural health network that provides health services for uninsured adults whose income is at or below 200% of the federal poverty level. Their clinics serve the residents of Camden, Glynn, and McIntosh Counties. In their last year, they saw 649 patients in 2,070 visits. They have 250 volunteers, 25 of whom are physicians.

Diabetes has been diagnosed in at least 24% of their clinics’ patients. In 2007, a volunteer endocrinologist began holding a regular diabetes clinic, and while some patients made progress, the clinic felt their efforts were not consistent or comprehensive enough. In the following year,

CMAP piloted a one-year program called Alive & Lively© for 28 uninsured patients. The majority of them showed improvements in the three clinical indicators of A1C, blood pressure, and cholesterol/LDL, and one patient was removed from insulin dependence.

Based on this success, CMAP began a three-year process to expand the Alive & Lively© program in 2009. They plan to add more uninsured diabetic patients from their clinics, as well as uninsured patients beyond the clinics by conducting outreach through the Coastal Health District and Southeast Georgia Health System.

The Alive & Lively© program involves monthly visits with an RN Case Manager and Patient Navigators who closely monitor patients’ symptoms, psychosocial indicators, and lifestyle behaviors.

They also help each participant develop individual goals and a customized plan of care. CMAP plans to track the participants' clinical indicators, health risks, and the local emergency departments' costs of caring for them. They are using Health Information Technology to track and evaluate chronic disease management information, Patient Navigator intervention data, and patient-centered data.

Their goals are to add 150 patients to the Alive & Lively© program in 2010, have 80% of participants improve their clinical indicators of A1C, blood pressure, and cholesterol, have 50% of participants demonstrate decreased health risk, and see a 30% decrease in the local emergency departments' costs of caring for program participants by February 2011.

The AMA Foundation grant will provide partial support for the Patient Navigators and Clinic Supervisor, and test strips and glucometers.

Hope Health Clinic, Inc. Griffin, Ga.

Grant Amount: \$10,000

www.hopehealthclinic.com

The Hope Health Clinic provides free exams, labs, diabetic monitors and strips, and access to free or low-cost prescription medications to the uninsured of Spalding County. They have 14 volunteers, 12 of whom are physicians, and 8 staff. Last year, they saw 2,034 patients in 6,848 visits. Approximately 25% of their patients have been diagnosed with diabetes. At least half of their 500 diabetic patients do not have their A1C levels in an acceptable range.



The clinic would like to specifically address the lack of coping and life skills that are essential to good diabetes management, and helping their patients manage a diabetic diet given their economic circumstances. In designing their Healthy Eating for Diabetes Course, a committee was formed and patients were consulted on their diabetes knowledge, and the challenges they encountered in managing their diabetes and eating the right foods.

The plan is to offer at least 150 patients the opportunity to take a 5-week course that first teaches the necessary skills to manage a diabetic diet, and second, menus and methods in diabetic food preparation that are affordable for this population. Each course will consist of 2 one-hour classes on life skills trainings, 2 one-hour classes on diabetes education and/or cooking, and 1 class that covers how to apply the life skills to managing diet. There will be five 5-week courses.

Goals for the project are that 50% of the diabetic patients who take the course improve their A1C and blood sugar levels, and 50% will improve their knowledge of healthy cooking/eating for diabetes and confidence in self-management.

The grant will cover test strips, A1C tests, staff salary, and materials.

Samaritan's Touch Care Center, Inc. Sebring, Fla.
Grant Amount: \$10,000

Established in 2007, the Samaritan's Touch Care Center provides free medical care to families in Highland County whose incomes are at or below 200% of the federal poverty level. In their last year, they saw 712 patients in 5,817 visits.

In collaboration with the Heartland Rural Health Network, the clinic plans to implement the Diabetes Master Clinician Program. Started in 2003, this program is an evidence-based model that provides clinicians with the tools they need to recognize and address treatment barriers and understand the rewards of chronic disease care. The program currently has over 80 participating providers, their 270 office staff members, and 15,000 patients in Florida.

There are three components of the program: the web-based Diabetes Data Registry, the Community Health Navigator, and the proposed Diabetes Patient Advocate. The registry compiles information that is frequently fragmented in rural counties and allows both providers and patients a complete view of patients' information, current status, and progress over time. Clinical Reports generated from the registry allow clinicians to quickly identify patients who need additional assistance managing their diabetes or who have not yet had their annual checks. The registry also generates Patient Report Cards that use patient-centered language to enable them to understand the reasons for certain tests, exams, and medications, to work toward their goals, and to improve their personal results.



The second program component is the Community Health Navigators. The Heartland Rural Health Network has made two Community Health Navigators available to the clinic; they are people who have diabetes or whose family members have diabetes. With patients' permission, they will conduct home visits to those participants who are having trouble meeting their goals, have the opportunity to assess the home environment, and review with the patient and their family members the Patient Report Card information.

About one-third of the patients in the registry are meeting their set health goals, another one-third find that the Patient Report Cards are adequate to help them keep their diabetes in check, and the final one-third need additional population-based strategies such as the Community Health Navigator. However, to maximize the effectiveness of the program, the clinic believes there needs to be a dedicated and ongoing focus on the program – a Diabetes Patient Advocate. This person will ensure that appointments are scheduled as necessary with local eye professionals, notify program patients of scheduled Diabetes Self-Management Education Classes, provide comprehensive foot exams, alert clinical staff when annual tests are indicated, and arrange lab appointments for patients to accomplish physician-ordered tests.

The clinic's goal is to see at least a 90% increase in the number of diabetic patients who receive timely assessments according to the standards of care, and at least a 10% improvement in one year of the patients currently not meeting the appropriate ranges for A1C, blood pressure, and LDL.

Volunteers in Medicine Clinic Eugene, Ore.

Grant Amount: \$10,000

www.vim-clinic.org

Incorporated in 1999, the Volunteers in Medicine Clinic provides free health services to the working uninsured of Lane County whose income falls between 85% and 200% of the federal poverty level. In their last year, they saw 1,719 patients in 11,770 visits. More than 450 community and medical volunteers donated over 30,000 hours of their time, resulting in an in-kind value of \$800,000.



The clinic established its Diabetes Management and Education Program in 2005; diabetes is the top diagnosis that their primary care physicians make the most. Over the last year, the clinic has been developing a plan to modify the Diabetes Management and Education Program to a three-tiered system which will expand the number of diabetic patients who can access classes. They will also begin offering a bilingual support group class since more than half of their diabetic patients are Latino.

When the program was originally established, patients were assigned to a support group but there was no “graduation”. Patients continued

in the program indefinitely without an evaluation of continued need, leaving fewer spots open for new patients. The clinic is developing an 8-week course for all new patients that covers food preparation, carbohydrate counting, foot care, physical fitness, lifestyle changes, and self glucose monitoring.

In the new proposed model, after the 8-week course, patients can return to the primary care setting and will be placed in one of three different tiers. Tier 1 will consist of patients who are consistently managing their diabetes. They are participating in the clinic’s group sessions and are seen every 3-6 months by a volunteer physician. Tier 2 will consist of patients who have one or more measurements that are not in control. These patients will be directed to one-on-one meetings with a diabetic educator who will determine the frequency of the meetings. Patients will still be seen by a general practitioner. Lastly, Tier 3 will consist of patients who have an A1C greater than 9% and require more support. They not only will receive the one-on-one sessions with a diabetic educator, but will also have their patient care handled by one of the clinic’s doctors who specializes in diabetes.

This doctor has already agreed to specialize her practice to see the Tier 3 diabetic patients. These patient visits will be longer, 40-minute visits, thereby allowing repeated visits with the same doctor who has expertise in diabetes and is trained in assessing and adjusting insulin levels.

Project goals are to assess topics to cover in informational packets given to diabetic patients during the one-on-one sessions, develop a checklist of information for patients that covers specific medications they receive from the clinic dispensary, standardize the use of their Diabetic Patient Profile form in all applicable charts and train all providers on how to use the form by the end of 2010, begin evening classes in Spanish, and recruit a volunteer to input patient chart data for the Diabetes Wellness Panels database which is processed through their regional hospital, PeaceHealth Oregon Region.

Grant funds will be used to support the diabetic dietician, medicine, and diabetic supplies such as test strips and lancets.