HRSA Expanded Services Proposal

Project Information

Need: Describe the need to expand or to begin providing the proposed service(s), and how this project will respond to the health care needs of the target population (with reference to any special populations, demographic characteristics, and/or access to care/health status indicators relevant to the proposed ES project). (3000)

Clinic (CLINIC) Community Clinic is a safety-net provider of prevention and treatment services in South Los Angeles, one of the most distressed communities in the nation. CLINIC’s patient population is 70% Latino, 25% African American, 3% Caucasian, and 2% other/unreported. In 2013, 75 percent of the patients CLINIC served were 100 percent and below the Federal Poverty Level and 99 percent were under- or uninsured, or enrolled in public insurance programs like Medi-Cal. CLINIC’s service area is both a Federally designated Medically Underserved Area (MUA) and a Primary Care Health Professional Shortage Area. South Los Angeles have very limited health care resources with one primary-care physician for every 35,536 residents—a ratio 10 times worse that the federal requirement for classification as a Health Professional Shortage Area. In addition, existing federally qualified health centers in our target area serve only 20 percent of the low-income population. The need for consistent and quality healthcare is exacerbated by the high rates of chronic diseases in South Los Angeles.

Prevalence of Chronic Conditions in South Los Angeles

Los Angeles County Service Planning Area (SPA) 6—South Los Angeles consistently has the worst health outcomes of all communities in Los Angeles County. Unfortunately this negative distinction translates into the unacceptable prevalence of chronic disease in our community.

Obesity, diabetes and hypertension are at near epidemic proportions in South Los Angeles, disproportionately affecting this African American and Latino population. Death rates from diabetes, coronary heart disease and stroke rank highest in South LA, when compared to countywide averages, for example. According to the LA County Dept. of Public Health, among adults in our service area, more than one in four (28.4%) have been diagnosed with hypertension; more than 1 in 10 have been diagnosed with diabetes (10.1%); and nearly one in three (31.1%) are obese.

In 2013 CLINIC, funded by the CDC REACH, participated in a pilot Enhanced Diabetes Management program with the goal of positively addressing diabetes and other chronic conditions in high-risk communities. CLINIC will use the Expanded Services funds to build upon this successful pilot program to implement a comprehensive strategy to decrease the prevalence of diabetes, obesity and hypertension in South Los Angeles and reduce the health disparities associated with these conditions. CLINIC propose implementing our Triple Threat Impact (TTI) program with the goal of improving access to specialty chronic care among underserved, high need patients through education on self-care and chronic disease management, screening & monitoring, care coordination, and treatment. CLINIC anticipates serving 300 diagnosed with one or more chronic conditions in the two-year grant term.

Response: Describe the following: (3000)

1. An appropriate timeline for project implementation that demonstrates operational readiness within 120 days of award for the provision of new and expanded existing services.
2. How all proposed services are or will be integrated into the existing service delivery model and incorporated into the QI/QA plan. Describe the process for:
   a. Ensuring all employed and contracted providers are appropriately licensed, credentialed, and privileged to perform the proposed services.
   b. Ensuring that appropriate risk management plans are in place for all proposed services.
3. The sliding fee discount that will be used to ensure that all proposed services are accessible without regard to ability to pay.
4. The health center’s plans to ensure that all patients will have reasonable access to any proposed new services, as appropriate.
5. If any services will be provided by a Formal Written Agreement

The long-term goal of CLINIC’s Triple Threat Impact (TTI) Program is to decrease the prevalence of diabetes, obesity and hypertension in our community and reduce health disparities associated with these conditions.

CLINIC seeks to expand and enhance our CDC supported Enhanced Diabetes Care Management Initiative, by including obesity and/or hypertension as co-morbidities, as well as strengthening the care coordination and referral to healthy activities. Triple Threat Impact—Diabetes, Obesity & Hypertension Care Management Initiative (Triple Threat) will build upon CLINIC’s existing Diabetes Care Management Initiative and will operate a 24-month program from a team care approach that will feature a dedicated Medical Provider/Clinician (Physician Assistant—PA), Medical Support (Medical Assistant—MA), Case Manager/Care Coordinator and Chronic Health Care Educator. The team will be supervised by the Chief Medical Director. Patients with co-morbidities will be especially targeted. The team will empanel at least 300 clinic patients diagnosed with the following:

- HbA1c ≥ 9; and/or
- Blood pressure reading ≥ 140/90; and/or
- BMI ≥ 30

Team Member Roles:

**Physician Assistant (0.5 FTE)** is the medical provider and will be responsible for diagnosis and creation of the treatment plan. Conduct group visits.

**Medical Assistant (0.5 FTE)** the MA’s responsibilities above traditional duties will include: managing the patient panel; identifying high risk patients and recommending them for the Triple Threat program; as well as, facilitating the communication between the PA and other team members to ensure appropriate patient care. Prepare patient charts and assist in conducting Group Visits.

**Case Manager/Care Coordinator (0.5 FTE)** is responsible for running wellness activities; ensuring that program patients complete health education and disease management classes. Care Coordinator will case manage the empaneled patients and assist patients to take medications appropriately. The Care Coordinator will facilitate scheduling and conducting Group Visits.

**Chronic Health Care Educator (0.5 FTE)** is responsible for conducting all chronic health care education.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeline</th>
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<tbody>
<tr>
<td>Recruit and hire PA, MA, Care Coordinator &amp; Health Educator</td>
<td>By Month 3</td>
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<tr>
<td>Create written program requirements, policies and procedures</td>
<td>By Month 3</td>
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</table>
Staff training        By Month 4
Conduct community in-reach and outreach    Months 3-24
Conduct patient orientations, education, case mgmt and treatment Months 3-24
Gather individual and aggregate reports Months 3-24

CLINIC Human Resource Director is responsible for ensuring that all employees are appropriately licensed and credentialed. The benefits and enrollment department will counsel patients of their healthcare options and will enroll them into the program that they are eligible for. CLINIC’s mission indicates that all patients will be provided with care, regardless of their ability to pay.

Impact: Describe the following: (3000)

1. The impact of the proposed project, including the number of 1) proposed new patients, 2) existing patients with increased access to services (if applicable), and 3) new providers (if applicable).
2. A detailed explanation of how the patient projections were calculated (including data sources)

The intermediate goals of CLINIC’s TTI Program are:

- Increase healthy behaviors related to the prevention of diabetes, obesity and hypertension in our target population.
- Improve chronic disease management among CLINIC patients and community members diagnosed with diabetes, obesity and hypertension.
- Fully integrate TTI Program into CLINIC’s EHR and practice management systems.
- Improve resource referral and case management/care coordination of participants to ensure maximum participation and benefit

Impact

CLINIC seeks to incorporate the better of two evidence-based chronic care models to implement the Triple Threat Impact program. The models include the CDC REACH Enhanced Diabetes Care Management Initiative and the Wellness Rx and Patient Navigator programs—both have been implemented in community-based and hospital settings. CLINIC has worked with both models and recognize the clinical strength of the REACH diabetes program that effectively utilizes our electronic records and practice management tools and the care coordination strength of the Patient Navigator program to successfully link patients to community resources will address impediments to patient participation (i.e. transportation, age-appropriate activities, etc.). CLINIC is confident that the combined programs will allow us to build upon the success of the REACH diabetes program, while effectively expanding the program to also address the needs of the significant number of CLINIC patients that also have obesity and hypertension as co-morbidities with their diabetes diagnosis.

Success will be measured as follows:

- Decrease the HbA1c levels of 25% of diabetic patients enrolled in the program to ≤9 by the end of the grant term.
- Decrease the blood pressure of 25% of hypertensive patients enrolled in the program to ≤ 140/90 by the end of the grant period
- Decrease of at least one point in the BMI of 25% of obese patients enrolled in the program by the end of the grant period.

Patient Impact

CLINIC’s proposes serving 300 new patients in the TTI program. The need for the program has been verified by the regional and clinic level data. The SPA 6 data and health indicators clearly define the need for a comprehensive strategy to address the pervasive chronic diseases in South Los Angeles. This data is confirmed through CLINIC’s UDS findings. In 2013, CLINIC had more than 3,500 visits from 931 patients diagnosed with diabetes; 4,345 visits from 1,407 patients diagnosed with hypertension; and 1,125 visits from more than 800 patients found to be obese. CLINIC will conduct in-reach and outreach to identify new patients for the TTI program. We arrived at the target number of 300 new patient based upon an 50% increase in the number of patients served under our Enhanced Diabetes Management pilot program implemented in 2013. This is a number that we believe that we can adequately serve.