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- **Christina Busse**, Registered Dietitian, Foothills Health and Wellness Center
- **Gena Byrd**, Nurse Supervisor, Farmworker Services, Greene County Health Care, Inc.
- **Susan Kunz**, Chief of Program Development, Mariposa Community Health Center
- **Matt Jewett**, Associate Director of Grants and **Valentina Hernandez**, Director of Integrated Nutrition Services, Mountain Park Health Center
- **Kelly McCue**, Diabetes Program Coordinator, North Country HealthCare
- **Alyssa Palmer**, Director of Quality, Southside Community Health Services

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INTRODUCTION

Diabetes affects more than 30 million people in the United States. More than fourteen percent (14.3%) of patients served by Health Resources and Services Administration-funded health centers have diagnosed diabetes.\(^1\) Multi-tiered efforts to prevent, treat and manage diabetes are critical in reducing the burden of diabetes, particularly for medically underserved communities, including racial and ethnic minority populations.

Agricultural workers are particularly vulnerable to developing diabetes due to a variety of social and environmental factors, including work and living conditions, stress, poverty, and migratory patterns.\(^2\) Uniform Data System (UDS) data show that in 2016, 8% of migrant health center patients had a diabetes diagnosis.\(^3\) This number has been steadily increasing in the past decade. Health center representatives who responded to the 2015 Farmworker Health Network (FHN) needs assessment expressed concerns about this increase, as well as the increasing rates of obesity, which is linked to diabetes.\(^4\)

Diabetes is manageable through physical activity, diet, and appropriate use of insulin and oral medications to lower blood sugar (glucose) levels. Outreach can play a critical role in facilitating patient access to health care and social services that support pre-diabetic and diabetic patients, and their families, in understanding and managing their chronic illness.

ABOUT INNOVATIVE OUTREACH PRACTICES (IOPs)

Health Outreach Partners (HOP) defines outreach as the process of improving people’s quality of life by: facilitating access to quality health care and social services, providing health education, bringing linguistically and culturally responsive health care directly to communities, helping people to become equal partners in their health care, and increasing the community’s awareness of the presence of underserved populations.

Since 2002, HOP has published Innovative Outreach Practices (IOP) Reports. Drawn from outreach programs throughout the country, these reports provide a platform for health centers and other community-based organizations to showcase effective, field-tested strategies for improving access to care. HOP considers outreach practices to be innovative when they accomplish one or more of the following criteria in a unique way:

- Engage and empower low-income and underserved populations,
- Support low-income and underserved populations in overcoming barriers to care,
- Maximize organizational resources in order to extend services,
- Partner with others in the community,
- Collect and use data,
- Connect with an emerging population, or
- Address an emerging issue among low-income and underserved populations.

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\(^3\) Health Resources and Services Administration (HRSA). 2016 National Health Center Program Grantee Data. 71,966 total patients with diabetes diagnoses with a total of 862,552 patients served (8.3%)


Addressing Diabetes Through Outreach: Innovative Outreach Practices from the Field Health Outreach Partners
METHODOLOGY

Addressing Diabetes Through Outreach: Innovative Outreach Practices from the Field features the innovative diabetes-focused outreach practices of eight HRSA-funded health centers. HOP recruited health centers for the profiles through three channels: (1) targeted invitations to health centers that had previously participated in diabetes-focused training and technical assistance services offered by HOP; (2) a call for participants released in HOP’s quarterly e-newsletter (March 2018); and (3) two marketing messages released in the Bureau of Primary Health Care’s (BPHC) Primary Health Care Digest (March and April 2018). Health centers that indicated an interest in being featured in the 2018 IOP Report were invited to either contribute a written summary of their innovative outreach practice or to participate in an in-depth interview. HOP received written summaries from three health centers and conducted in-depth interviews with five additional health centers.

HOP conducted the five in-depth interviews with health centers between March and May 2018. Interviews were conducted via phone and lasted approximately 45 minutes. HOP developed a detailed interview guide (Appendix A) to ensure consistency in the content solicited from each participating health center. Health centers were asked to describe why the organization started the innovative outreach practice, to share the experience of implementing the practice on a day-to-day basis, and to explain the funding sources for the outreach practice, as well as any evaluation processes that the health center uses to assess the practice. Upon completing the five interviews, HOP developed a detailed profile for each health center as featured in the resource. Health centers that completed the in-depth interview were invited to share photos to accompany the profile of their innovative outreach practice.

ABOUT THE RESOURCE

Health Outreach Partners developed Addressing Diabetes Through Outreach, Innovative Outreach Practices from the Field as a resource for Health Resources and Services Administration-funded health centers, including existing and potential health centers, Primary Care Associations, and other community-based organizations that are interested in using outreach to address diabetes among their patient populations.

The profiles included in this resource offer background information about the featured organization, a description of the innovative outreach practice, and key lessons learned, as shared by the featured health center. Readers seeking more detailed information about the innovative outreach practices can contact the health center point of contact listed within each profile.
ARcare is a Federally Qualified Health Center that serves thirteen counties throughout Arkansas. Founded in 1986, the health center has grown to include 41 primary care clinics, four pharmacies, and three wellness centers.

THE NEED
Located in Woodruff County, Arkansas, the City of McCrory is considered a food desert, and residents need assistance with accessing emergency food and preventive health screenings. A high volume of McCrory residents live more than 20 miles from a supermarket and lack transportation to a supermarket. Almost one fourth of the 1,650 residents are considered to be food insecure. The few stores that do sell healthy food items have much higher prices and lower variety than neighboring regions. According to the U.S. Census data, household incomes are lower in McCrory than neighboring counties. The increased price for food represents a disproportionate burden to residents.

THE WAREHOUSE
ARcare offers a Diabetes Self-Management Education Support Program to patients in multiple rural communities. The program provides patient assessments, education services, community resources information, and support groups to promote self-management of diabetes. During health assessments in the clinics, diabetes educators frequently identified participants who were unable to access affordable and healthy food. Out of this identified patient need, and through a collaborative effort with numerous community stakeholders, the Warehouse was born.

The Warehouse is a community partnership between ARcare, the University of Arkansas Division of Agriculture Research and Extension in Woodruff County, and the City of McCrory. The partners work collaboratively to promote a culture of health through education and community-based strategies. As a cohesive team, they have been able to provide access to healthy foods, promote wellness in the community, and involve community volunteers to foster a culture of health and wellbeing.

A COLLABORATIVE EFFORT
The McCrory City Council voted to allow monthly usage of the community civic center for The Warehouse food storage and distribution. The University of Arkansas Extension Service, coordinated by the Family and Consumer Sciences Agent, received community grant funds to provide tables, shelving, and a commercial refrigerator and freezer to the City of McCrory for use in The Warehouse.

As a member of the North East Arkansas Food Bank, ARcare uses grants and donations to obtain healthy foods for The Warehouse. ARcare is responsible for placing food orders, and is instrumental in the planning and management of the food distribution to the community. On monthly food distribution days, ARcare’s Coordinated Care Team also provides screenings such as blood pressure screenings, diabetes risk screenings, and diabetes foot screenings during food distribution days. A registered nurse or clinical pharmacist is available each month for counseling and education related to chronic diseases, smoking cessation, and the importance of immunization status. Flu shots are administered in the fall. Program information brochures are provided to educate the public about the preventative and wellness services offered at their local health care facilities.

The County Extension Agent conducts monthly food demonstrations and tastings using the products received that month from the food bank. Presentations include education on food safety, handling, and storage, as well as smart shopping topics. Local churches and other community
organizations have donated items to improve quality of life for The Warehouse participants, and have provided assistance as needed. For example, Supplemental Nutrition Assistance Program (SNAP) education representatives are available each month to provide much needed counseling and resources.

The Warehouse accepts everyone, regardless of their financial status or their place of residence. There have been 320 unduplicated people reached through the operation of the Warehouse. Each month the event draws 75-150 clients which represents approximately one fifth of the population of McCrory. Typically, 25-30 of these are first time participants. Approximately 40% of those clients (126) receive SNAP benefits. Almost 48% of those served have been 60 years of age or older and nearly 25% of the participants are minorities.

OPPORTUNITIES FOR PROGRAM EXPANSION

Due to the success of The Warehouse, the mayor of Parkin, Arkansas, another underserved area, requested services from The Warehouse. ARcare began providing The Warehouse services in the township of Parkin in January 2018. Between 60 and 90 community members participate each month. Additional grant funding is being sought to expand The Warehouse to include a mobile trailer. This will allow for food demonstrations, nutrition education, and access to healthy foods in more rural areas of the county.

The City of McCrory was recently selected as a finalist to receive technical assistance through the federal Local Foods, Local Places program. This will help guide the development of new programs and the sustainability of The Warehouse.

ABOUT ARcare

Location: Augusta, AR
Community Health Center Funding: 330(e), 330(g), and 330(i)
Contact: Leisa Watkins, DSME Program Manager
Email: leisa.watkins@arcare.net
Website: http://www.arcare.net
PROVIDING COORDINATED, RESPONSIVE CARE TO DIABETIC PATIENTS

Beaufort Jaser Hampton Comprehensive Health Services, Inc.
Method: In-Depth IOP Interview

“...

I love doing this work because I see people who make a difference in their life that affects them directly, not only then but their futures, in a really positive way, and it’s wonderful to be able to help that much.”

– Susan Mills Tucker, Registered Dietitian & Certified Diabetes Educator (RD/CDE)

Beaufort Jasper Hampton Comprehensive Health Services, Inc. (BJHCHS) provides quality, affordable health care and social services to the residents of the South Carolina Low Country Community. The Federally Qualified Health Center currently operates eight clinics and nine school-based programs that serve communities located in Beaufort, Jasper, and Hampton counties. BJHCHS specifically works to address barriers to care that are experienced by underserved communities, including the underinsured, the uninsured, and migrant and seasonal agricultural workers. BJHCHS’ services include family medicine, pediatric care, mental health services, behavioral counseling, dental care, home health services, a pharmacy, outreach, and social support services.

THE NEED

BJHCHS began using outreach services to address disparities in diabetes and hypertension among its patient populations in the early 2000s. Racial disparities persist: approximately 75% of BJHCHS’ diabetic patient population is African American and 10% speak only Spanish. To better address patient needs, BJHCHS provides medical nutrition therapy (MNT) and diabetes self-management education (DSME) sessions at each of the health center’s eight sites, as well as in eight of the nine school-based programs.

Registered Dietitians (RD) provide the MNT, and DSME is provided by Certified Diabetes Educators (CDE). BJHCHS employs three RDs, two of whom are also CDEs. These three staff members rotate between the clinics and school-based programs. For example, one of the two RD/CDEs visits five sites twice per month. The team has found the following strategies to be effective for improving health outcomes among diabetic patients.

PATIENT ASSESSMENT AND CUSTOMIZED EDUCATION COURSES

“...

Some programs will have people self-assess with a form that they fill out. We don’t do that. We do an individual one-hour assessment where we talk with them about their conditions and what is going on. So our program has made that decision, to do a more in-depth assessment.”

– Susan Mills Tucker, RD/CDE

Care providers refer both newly diagnosed diabetic patients and patients who have been previously diagnosed with diabetes who are not coping well to the RDs. When an RD receives a patient referral, they schedule an in-person, one-on-one initial assessment. During the consult, which typically lasts 30 - 60 minutes, the RD will assess what the patient is doing to manage their disease and, together, the RD and patient will set goals for behavior change. Depending upon the complexity of the patient case, as well as patient interest, the
RD will schedule a follow-up MNT session. These sessions typically last 25-45 minutes and are used to provide patients with customized information about lifestyle and behavioral interventions specific to their health conditions and related needs.

Diabetic patients have the option to participate in a diabetes self-management education class. Interested patients attend two-hour sessions every two weeks. Classes may be held one-on-one or in groups, and are taught by the two RDs with CDE training. If classes are offered to a group, the RD/CDEs present the content in a way that still supports patients in addressing their personal goals.

COMMUNICATION WITH CARE PROVIDERS

Electronic health record systems can be leveraged to facilitate dialogue between care providers and RDs. Increased communication can result in increased patient referrals to the RDs, better understanding of patient challenges with medication adherence, and improved coordination of treatment and management services.

Because I’m in the same electronic system that they [doctors] are, they can see every note that I do and every experience that the patient has with me, so they have access to everything that I’m doing which is kind of neat, and that also means that I can see their notes. Another thing that I’m going to do with the diabetes program is that I’m going to reinforce their specific plan of care...I’ll let them [doctors] know if the patient is having trouble with medicine use, and we’ll get those things refined… And we also have a communications system within this system where they [doctors] can express concerns directly to me and I can do the same.”

– Susan Mills Tucker, RD/CDE

CONNECTING TO COMMUNITY RESOURCES

Patients who complete the DSME classes work with the RD/CDEs to create a plan for self-management. To support patients with putting their personalized plan into action, the RD/CDEs provide referrals to locally available community resources. For example, an RD/CDE may share with the patient a list of local food banks or information about a local walking trail.

Another thing that I do as a Dietitian is if I’m going to be practicing in an area, I usually like to assess their grocery stores and see what kinds of products are available, and whether or not they’re in a food desert. And that will inform my counseling and how we address that.”

– Susan Mills Tucker, RD/CDE

ABOUT BEAUFORT JASPER HAMPTON COMPREHENSIVE HEALTH SERVICES

Location: Ridgeland, SC
Community Health Center Funding: 330(e) & 330(g)
Contact: Susan Mills Tucker, Registered Dietitian and Certified Diabetes Educator
Email: stucker@bjhchs.org
Website: www.bjhchs.org
A lot of our patients might not have access to a stove or might not have access to equipment to prepare healthy meals. You really have to question what they have access to. Over the last year or so I’ve learned what to tailor. What is affordable, what is practical, what can be stored. If you tell them actions that they are not going to be able to accomplish, number one, they are not going to want to come back, and number two, they are not going to be able to be successful.”

— Christina Busse, Registered Dietitian

Founded in 1962, Kentucky River Foothills Development Council, Inc. (KRFDC) is a community action agency based in Richmond, KY that began offering health care services to the residents of Powell and Estill counties in 2005 through mobile outreach services. In 2011, KRFDC opened the Foothills Health and Wellness Center, a Federally Qualified Health Center that serves uninsured and underinsured patients, with a particular focus on individuals and families experiencing homelessness. Their Healthcare for the Homeless Program serves approximately 2,000 patients across Powell and Estill counties in eastern Kentucky. Patients of Foothills Health and Wellness Center have access to comprehensive medical services, behavioral health services, a patient prescription program, substance abuse services, oral health and vision services through a voucher program, dietitian services, and a care coordination program.

DIABETES SERVICES
Foothills Health and Wellness Center provides outreach and supportive services, including care coordination and nutrition counseling for diabetes, cardiovascular disease, and weight management. Foothills Health and Wellness Center has found care coordination and community-based health education to be the most effective strategies for addressing diabetes among the patient populations served by the health center.

There are eight members of the Foothills Health and Wellness Center who are directly involved in providing diabetes-related prevention and management services to patients. This team includes two care coordinators, two Licensed Practical Nurses (LPN), one Registered Nurse (RN), a Registered Dietitian (RD), one Advanced Practice Registered Nurse (APRN) and the Medical Director. Community outreach and in-office visits for all high risk patients are primarily provided by the two full-time care coordinators; however, the RD will participate in warm hand-offs and referrals from all providers to offer medical nutrition therapy and nutrition education.
When the care coordinators are involved in the patient care of those that I am following they are more likely to come back to their appointments. Definitely a lot more than just somebody that was coming through the clinic.”

–Christina Busse, Registered Dietitian

**CARE COORDINATION**

Foothills Health and Wellness Center uses care coordination to address the needs of diabetic patients with hemoglobin A1C levels that are greater than 9%. During initial one-on-one visits, the care coordinators will evaluate for social determinants of health that influence patient access to care, set individual goals, discuss self-management skills, and link patients with community resources or provider services through referrals based upon the identified patient’s needs. Patients with elevated blood sugar levels are referred to the RD by the health center care providers or care coordinators. The RD will conduct a comprehensive patient assessment to assess for medical nutrition needs and identify barriers that would prevent behavior change. During these meetings, the RD will also provide a tailored health education session to the patient and may review how to use self-management tools, such as a blood sugar log.

Traditionally, care coordinators completed home visits, along with the dietitian, if the patient had been identified as high risk. Following the medical nutrition therapy session, the care coordinator would support the patient in developing actionable, small goals that align with the material covered by the Registered Dietitian and the treatment prescribed by the primary care provider. Between patient follow-up visits to the clinic, the care coordinator would either conduct a home visit or provide follow-up calls to assess patient adherence to their care plan and to support the patient in making necessary adjustments to their goals. Currently, the clinic has implemented a different model in which all patients are screened for risk as well as need for community support services or in-office referrals to available health center programs. This model has been successful in reaching more patients. It allows the care coordinators and providers to perform warm handoffs to support patients in accessing services offered on-site, as well as to follow up with patients via telephone.

**COMMUNITY-BASED NUTRITION EDUCATION SESSIONS**

Through the Healthcare for the Homeless Program, Foothills Health and Wellness Center provides nutrition education to the broader community served by the health center. For example, the RD conducts classes at the local senior citizen center that address nutrition needs and healthy living solutions for elderly individuals. In addition, the RD works with the Powell County Health Department to conduct community-wide nutrition education courses specific to diabetes prevention and management. These courses include information about monitoring for symptoms of diabetes, how to monitor blood sugar levels at home, and nutrition education specific to diabetes, such as how to use the USDA Center for Nutrition Policy and Promotion MyPlate logo to understand and implement portion control at home.

1 [https://www.choosemyplate.gov/](https://www.choosemyplate.gov/)

**ABOUT FOOTHILLS HEALTH AND WELLNESS CENTER**

*Kentucky River Foothills Development Council, Inc.*

**Location:** Clay City, KY

**Community Health Center Funding:** 330(h)

**Contact:** Christina Busse, Registered Dietitian

**Email:** cbusse@foothillscap.org

**Website:** [http://www.foothillscap.org](http://www.foothillscap.org)
TAKING DIABETES SELF-MANAGEMENT EDUCATION BEYOND THE CLINIC

Greene County Health Care, Inc.
Method: In-Depth IOP Interview

Greene County Health Care, Inc., is a Federally Qualified Health Center located in the community of Snow Hill, North Carolina. Over the past 45 years, Greene County Health Care has expanded from one community health center to include six sites that serve Greene, Pitt, and Pamlico counties and mobile services throughout the majority of eastern North Carolina. Greene County Health Care provides integrative and affordable primary health care services to underserved, uninsured, and underinsured communities, with a particular focus on agricultural workers.

THE NEED
Approximately twenty years ago, Greene County Health Care established Farmworker Services, a division of the health center that is dedicated to providing medical care, health education, and enabling services to agricultural workers. The primary population served by Farmworker Services is agricultural workers who are residing in camps, including H2A workers and other seasonal agricultural workers. During the off-season, Farmworker Services invests more heavily in providing health care and enabling services to rural populations other than agricultural workers. Rather than conduct outreach at camps, services are provided at a variety of other community sites including ministry programs, sporting events, homeless shelters, food banks, and schools.

Farmworker Services continues to expand its operations, and now provides services to agricultural workers and rural communities in twenty-five counties throughout eastern North Carolina. The team consists of twenty staff; however, outreach is primarily conducted by a team of ten full-time case managers, two Licensed Practical Nurses (LPN), and one Registered Nurse (RN). All but two of the team members are bilingual in English and Spanish. Farmworker Services is sustained through the Greene County Health Care funding sources, namely the Health Resources and Services Administration (HRSA).

At its inception, the Director of Farmworker Services identified diabetes as a health concern that needed to be addressed in the agricultural worker community. The division continues to use outreach to provide diabetes-related health education and to monitor patient health. The following are examples of effective strategies used by Farmworker Services to address diabetes among agricultural workers.
ROUTINE PATIENT ASSESSMENTS

The ten Farmworker Services case managers are assigned annually to various agricultural worker camps, and the RN and two LPNs rotate in coordination with the case managers. The Farmworker Services staff conduct site visits to camps at a minimum in the evening every Monday through Thursday; however, schedules are kept flexible to ensure that site visits can be made on a patient-by-patient basis, as needed.

"The biggest thing is just listen to the patient. Listen to what's going on when you're out talking to people."

– Gena Byrd, RN

Patient blood pressure and blood sugar levels are checked at every site visit to the camp, and results are entered in the patient’s health record. If a patient’s blood pressure or blood sugar levels are elevated Farmworker Services staff will conduct an informal assessment to try to understand the underlying causes. For example, they may inquire about the patient’s family history, their eating habits, and what medications they are taking. Patients with very elevated levels are advised to go to the hospital, whereas patients with moderately elevated levels may be referred for a same day or next day appointment at the local Greene County Health Care clinical site. Patients with slightly elevated levels may continue to be monitored weekly by Farmworker Services staff. Transportation is provided by the caseworker, as needed.

HEALTH EDUCATION SERVICES

Health education is a critical component of the diabetes-related outreach provided by Farmworker Services. The types of health education services offered are customized to address the specific identified concerns of the agricultural workers and, in some cases, the farm owner.

Farmworker Services uses visuals in health education sessions to engage participants. For example, when the RN provides a session on sugary beverages, she fills zip lock bags with the amount of sugar that corresponds to the beverage and places these bags in front of each bottle for participants to see. In addition, the print materials that Farmworker Services distributes that describe the symptoms and effects of untreated diabetes include images, and are available in both English and Spanish.

ABOUT GREENE COUNTY HEALTH CARE, INC.

Location: Snow Hill, NC
Community Health Center Funding: 330(e) & 330(g)
Contact: Gena Byrd, Nurse Supervisor, Farmworker Services
Email: gbyrd@greenecountyhealthcare.com
Website: http://greenecountyhealthcare.com/
Mariposa Community Health Center, a Federally Qualified Health Center (FQHC) based in Nogales, Arizona, is the lead organization for the Vivir Mejor! (Live Better!) Consortium for Diabetes Prevention and Care. Vivir Mejor! is a multi-sector partnership started in 2012 by five organizations: an FQHC, a Critical Access Hospital, a Community Food Bank, an Area Health Education Center, and a Community Development Corporation. A College of Public Health partner has documented and evaluated outcomes of the partnership for public dissemination and replication.

A MULTIPRONGED APPROACH

The Vivir Mejor! Consortium implements various strategies within the community to promote healthy eating and active living for diabetes prevention and treatment. Examples of effective strategies used by Vivir Mejor! partners include: (1) the use of Community Health Workers (Promotores de Salud) to provide group education and one-on-one home visitation for diabetes self-management, (2) incorporation of a dietitian or diabetes educator in patient care to improve dietary compliance, (3) diabetes-appropriate food boxes provided by the food bank, (4) motivational interviewing continuing education for medical provider teams, and (5) training on family budgeting to support the purchase of healthy foods. Patients who participate in the Vivir Mejor! program are recruited and trained to teach peer-led diet and exercise classes for their neighbors and friends.

The various approaches taken by the Vivir Mejor! Consortium have resulted in statistically significant improved patient outcomes. For example, program participants have reported increased fruit and vegetable consumption and increased physical activity. In addition, participants exhibit reduced hemoglobin A1C levels. Results of the Vivir Mejor! program were published in The Journal of Health Care for the Underserved and Health Promotion Practice. The National Rural Health Association recognized Vivir Mejor! as the Outstanding Rural Health Program in the country in 2014.

FUNDING AND OPPORTUNITIES BEYOND DIABETES SERVICES

Vivir Mejor! has received funding from the Health Resources and Services Administration (HRSA) Federal Office of Rural Health Policy and the CDC Racial and Ethnic Approaches to Community Health (REACH) Program. The cross-sector partnership created by Vivir Mejor! is key to the sustainability of services and creation of new services to meet the gaps that exist in our Hispanic/Latino community. For example, Vivir Mejor! is adding strategies to help adults with risk factors prevent development of cardiovascular disease. Additional funds were obtained from the RCHN Foundation to address access to healthy food as a social determinant of health. Vivir Mejor! is also the umbrella for an Office of Minority Health Childhood Obesity Prevention Research Project, La Vida Buena (The Good Life).

ABOUT MARIPOSA COMMUNITY HEALTH CENTER

Location: Nogales, AZ
Community Health Center Funding: 330(e)
Contact: Susan Kunz, Chief of Program Development
Email: skunz@mariposachc.net
Website: mariposachc.net

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1 www.aachc.org/vivir-mejor-consortium
2 https://doi.org/10.1353/hpu.2016.0188

Addressing Diabetes Through Outreach: Innovative Outreach Practices from the Field Health Outreach Partners
EMPOWERING DIABETIC PATIENTS TO USE FARMERS’ MARKETS

Mountain Park Health Center
Method: In-Depth IOP Interview

"Some of our patients live in the community but they didn’t know what the field was behind their house. Now they have the opportunity to go there and help grow produce or they can have a plot of land where they can grow their own produce.”

– Valentina Hernandez, Director of Integrated Nutrition Services

Mountain Park Health Center, a Federally Qualified Health Center, has served the residents of Arizona’s Valley of the Sun for more than thirty years. The health center operates eight clinics: five clinics serving all ages situated in the communities of Goodyear, Phoenix, and Tempe, and three pediatric clinics located in Phoenix. Collectively, the clinics offer women’s health services, family medicine, a pharmacy, dental health, nutrition services, and health education classes.

EXISTING DIABETES PROGRAMS

Mountain Park Health Center has a well-established diabetes self-management education program that is available to both pre-diabetic and diabetic patients. Classes are delivered at the health center once per week for one month. Two Registered Dietitians and two Promotoras de Salud share responsibility for delivering the education program. The Registered Dietitians teach the classes and the Promotoras de Salud provide support such as offering encouragement to patients, providing reminder calls, and inviting new patients to the classes.

The majority of the people who participate in the diabetes self-management education program are monolingual, Spanish-speaking patients who are originally from Mexico. To address cultural differences and literacy challenges, Mountain Park Health Center developed a custom curriculum tailored to the needs of the classes. Classes are offered in both English and Spanish, and include the use of engaging props, such as food models, plates, and mixing cups.

Mountain Park Health Center provides other health education programs that are not specific to their diabetic patient population, but that support these patients as well. Specifically, the health center operates the All Kids Can program, a weight management program for pediatric patients and their families, and the Act Now program for adults who need support with weight management.

PRESCRIPTION FOR PRODUCE PILOT PROGRAM

For the past four years, Mountain Park Health Center has collaborated with local farmers to hold weekly farmers’ markets at its two largest clinics in Phoenix, AZ and to operate a Fresh Express bus that delivers produce to an additional clinic. Although the weekly farmers’ markets are primarily intended for use by the health center patients and staff, they are open to the public. The produce is sourced largely from local community gardens.

In Summer 2017, the Maricopa County Department of Public Health contacted Mountain Park Health...
The farm that we work with—the community garden—it’s called Tiger Mountain Foundation. Their revenue has almost tripled since we started the program because now they have all of these new customers who are consuming their products. So they’ve had to hire on new people for the community gardens. Which I think is a community benefit because it’s creating a job for somebody else in the community to grow healthy produce for the patient. So I see it as a really powerful cycle for the community.

- Valentina Hernandez, Director of Integrated Nutrition Service

Mountain Park Health Center initiated the pilot program at one of its sites in March 2018. Through the pilot program, pre-diabetic and diabetic patients, as well as patients with high BMIs, are eligible to receive a prescription from their primary care provider for fresh produce from the health center’s farmers’ market. This prescription entitles them to a $15 monthly voucher. To simplify the process for patients, Mountain Park made the decision to distribute prescriptions and vouchers at the weekly diabetes self-management education program, along with recipe cards that correspond to the produce available at the farmers’ market.

A local farmer helps run the farmers’ market at the health center and attends the diabetes self-management education classes in order to explain the produce that is available for the week. The Registered Dietitian and Promotoras de Salud work with the farmer to prepare bags of produce worth $5. Patients who attend the class can either use their vouchers to redeem the $5 pre-packaged produce bag or they can use their vouchers at the farmers’ market outside of the health center.

Since Mountain Park Health Center began the Prescriptions for Produce pilot program, attendance at the diabetes self-management classes has doubled. Due to increased demand for produce, the health center is now holding a farmers’ market twice per week. Mountain Park Health Center collected patient clinical measures (blood pressure, BMI, and weight) and a patient self-assessment at the start of the pilot program and will administer the same evaluation process upon completing the six-month pilot period.
North Country HealthCare (NCHC) is a 501(c)3 Federally Qualified Health Center located in Flagstaff, AZ. NCHC is the primary health center serving fourteen communities across five northern Arizona counties. NCHC’s mission is to provide accessible, affordable, comprehensive, quality primary healthcare in an atmosphere of respect, dignity, and cultural sensitivity. The health and well-being of patients and the community alike are promoted through direct services, training, education, outreach, and advocacy.

THE DIABETES PROGRAM
NCHC offers a Diabetes Self-Management Education and Support Program (Diabetes Program) to address the growing prevalence of diabetes and obesity, two conditions that drastically and disproportionately affect the community served by the health center. The NCHC Diabetes Program aims to prevent diabetes, reduce the risk of comorbidities among people living with diabetes, and provide a supportive network for people impacted by the condition. The Diabetes Program provides low-cost diabetic retinopathy screenings, free diabetes education classes, and billable shared medical appointments for gestational diabetes.

DIABETIC RETINOPIAHY SCREENING
The Diabetic Retinopathy Screening and Education Project originated in NCHC’s main clinic in Flagstaff, Arizona ten years ago. The project seeks to identify and treat retinopathy to prevent permanent vision loss and improve quality of life among underserved diabetic patient populations.

Currently, the project is the only low-cost retinopathy screening and diabetes education opportunity in northern Arizona. Screenings are administered in all fourteen of NCHC’s rural clinic locations on a monthly basis. Trained Care Managers administer retinopathy screenings then send the retina images via encrypted email to ophthalmologists at Barnet Dulaney Perkins Eye Center (BDPEC) for evaluation and diagnosis. The BDPEC ophthalmologists forward their assessment to primary care providers at NCHC to inform patients of recommended care plans.

NCHC Care Managers coordinate timely follow-up eye care with BDPEC when necessary, and the NCHC Program Coordinator oversees the billing for the retinopathy screening and any follow-up treatment that patients require. NCHC bills the insurance provider for insured patients of the Diabetes Program. The insurance reimbursements received by NCHC for these screenings are allocated to assist with covering the costs of screenings for uninsured patients. The project’s collaboration is strategic and patient-centered, as BDPEC accepts affordable repayment plan options and is currently the only ophthalmologist group in the area that accepts Medicaid (through the Arizona Health Care Cost Containment System). Grants support these screenings and help uninsured patients receive screenings and other diabetes-related services regardless of their ability to pay.

IN-PERSON AND TELEHEALTH DIABETES EDUCATION
To further support patients, NCHC offers two types of diabetes education classes. NCHC hosts monthly two-hour classes at the Flagstaff health center. These classes are facilitated in both Spanish and English. Patients from the thirteen satellite clinics can stream the classes through a telehealth system. In addition, the Diabetes Program hosts quarterly comprehensive six-hour classes.
These sessions are facilitated by pharmacists, a registered dietitian, and Care Managers, and include breakfast and lunch. Topics covered during the classes include diabetes pathology, potential complications, self-management techniques, and medication therapies. In addition to the diabetes education classes, patients of NCHC have access to a weekly diabetes support group for ongoing education, support, and resources.

Offering these opportunities in a primary care setting has improved diabetes self-management and detection of diabetes complications for many NCHC patients. NCHC has seen a positive impact on patients’ disease management. Participants who experience a one to two percent (1-2%) decrease in hemoglobin A1C levels within three months are more likely to complete annual retinopathy screenings, diabetic foot exams, and regular blood glucose monitoring.

**DIABETES IN PREGNANCY PROGRAM**

In January 2015, NCHC received a grant from March of Dimes to implement the Sweet Success Education Program. The goal of Sweet Success is to improve pregnancy outcomes and life-course health for women with diabetes and their children through a series of three one-on-one patient education sessions. After two years of using the individual-based model of care, NCHC modified the program to better suit patient needs by creating a Diabetes in Pregnancy shared medical appointment. The Diabetes in Pregnancy group model is integrated into the OB/GYN department at NCHC’s Flagstaff location. Women who are at risk of gestational diabetes mellitus or who have diabetes prior to pregnancy are referred to the group appointment. These group education sessions are facilitated by an obstetrics Family Nurse Practitioner (FNP) and trained Community Health Worker. The sessions cover topics such as nutrition, exercise, complications of diabetes in pregnancy, and self-management goals. The shared medical appointments include a brief prenatal check by the FNP before or after the education component, which allows the clinic to bill for the encounter. NCHC found that the opportunity to meet other women with a similar condition and encouragement from providers boosts patient participation.

**ABOUT NORTH COUNTRY HEALTHCARE**

**Location:** Flagstaff, AZ  
**Community Health Center Funding:** 330(e)  
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Building Health Through the Cultivation of a Community Garden

Southside Community Health Services, Inc.

Method: In-Depth IOP Interview

“Working in an FQ [Federally Qualified Health Center] where you have a specialized population, it is important for staff – all staff – no matter what department they are in, to stay connected to that mission, to stay connected to that community, so that they are as inspired by what they are doing as they were the first day that they walked in.”

– Alyssa Palmer, Director of Quality

Southside Community Health Services, Inc. (Southside) is a Federally Qualified Health Center that operates two sites in South Minneapolis, MN. Founded in 1971 as a primary care clinic, Southside has since expanded its service provision to include behavioral health care, dental care, and vision services. To remove patient barriers to care, Southside maintains same day appointments at both clinics for all provider types.

The need

Hispanic patients represent approximately half of the general patient population served by Southside; however, they account for a disproportionately larger portion of the diabetic patients served at the health center (62%). Many of the Hispanic patients do not speak English or speak limited English.

Between June and December 2017, Southside participated in a diabetes focus group for a collaborative of ten Minnesota-based Federally Qualified Health Centers (FQHCs). The purpose of the focus group was to design and pilot a program for optimal diabetes care. During the pilot, Southside found that increased touch points between the patient and the health center correlated with lower hemoglobin A1C levels. This finding was consistent with the findings of the other ten FQHCs that participate in the pilot. Southside continues to use this experience to inform the development of diabetes-related programs for patients.

Southside patients who are newly diagnosed with diabetes or who experience challenges adhering to their care are referred to one of the health centers’ Registered Nurses (RNs) for one-on-one nutrition counseling. During the one-on-one nutrition counseling session, an RN will assess the patient’s socio-economic status and help the patient to set realistic health goals for themselves. Diabetic patients may schedule nurse-only visits to receive additional support as often as they need.

“That one-on-one time too is super beneficial. Where they can really hit home about the severity of the chronic illness and the importance of taking care of yourself, and what could happen if you don’t monitor it or control it.”

– Alyssa Palmer, Director of Quality
Pre-diabetic, diabetic, hypertensive, and overweight patients are encouraged to attend Southside’s weekly nutrition education group classes. The classes are taught by RNs and are offered three times per week. Two sessions are taught in Spanish and one is taught in English. To further address the diabetes-related needs of their patient population, Southside implemented the following strategies.

**COOKING CLASSES**

To provide patients with additional strategies for managing diabetes, Southside partners with the University of Minnesota to host cooking classes at the health center. A representative from the university delivers the cooking course over a six-week period. An RN is present at each session to support as needed. The content of the six-week course includes general nutrition education, label reading, meal preparation, and a short exercise component. Participants are given the produce that they need to re-create the meal prepared during class at home. For one of the sessions, the class attendees go together to a grocery store to practice label reading and distinguishing between products. Patients who complete the full six-week course are gifted the individual hot plate that they used throughout the course. The cooking classes offered at Southside are sustained through seed money and grants.

**COMMUNITY GARDEN**

Since 2016, Southside has cultivated a community garden to facilitate patient access to healthy, fresh produce. The health center now maintains two community gardens during the summer months, one at each of its sites. The garden located at the Medical Clinic is maintained by the health center staff, and the garden situated in a lot next to the Dental and Vision Clinic is tended to by members of an urban youth program. The produce from the two gardens is provided to diabetic patients. Patients who attend the nutrition or cooking classes offered at Southside are invited to visit the community garden and take the produce home.

To further promote consumption of healthy produce, Southside partners with a local food co-op to provide “prescription Community-Supported Agriculture (CSA)” boxes to patients. The CSA program runs for sixteen weeks and is made available for up to thirty families at a time. Program candidates are identified by the RNs who lead the nutrition education classes and by providers at Southside’s Medical Clinic. Families who agree to participate are responsible for picking up their produce from the local co-op. Southside covers the cost of each CSA box using grant funding. Patients undergo a health screening before and after the CSA program. RNs track patient cholesterol levels (Lipids panel), glucose (HgbA1c levels), BMI, and blood pressure.

**ABOUT SOUTHSIDE COMMUNITY HEALTH SERVICES, INC.**

**Location:** Minneapolis, MN  
**Community Health Center Funding:** 330(e)  
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CONCLUSION

Outreach can play a critical role in facilitating patient access to health care and social services that support pre-diabetic and diabetic patients, and their families, in understanding and managing their chronic illness. Health Outreach Partners’ resource, *Addressing Diabetes Through Outreach: Innovative Outreach Practices from the Field*, is intended to support health centers in developing and implementing innovative outreach practices to address diabetes in their patient populations and improve community health outcomes.
ABOUT HEALTH OUTREACH PARTNERS

Health Outreach Partners (HOP) is a national organization providing training and technical assistance (T/TA) and key resources to health centers and other community-based organizations striving to improve the quality of life of low-income, vulnerable, and underserved populations. HOP has over 48 years of experience in the field of outreach, and offers support to organizations interested in exploring a more customized application of these ideas. Learn more at HOP’s website: www.outreach-partners.org

ADDITIONAL RESOURCES

Diabetes in Special and Vulnerable Populations Webinar Series

Link: www.aapcho.org/resources_db/diabetes-in-special-and-vulnerable-populations-a-national-learning-series-webinar-resources/

Health Outreach Partners collaborated with 15 National Cooperative Agreements (NCAs) to develop and deliver a four-part training series aimed at sharing strategies for diabetes prevention and control in special and vulnerable populations. Recordings of the four webinars are available via the link.

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APPENDIX: INNOVATIVE OUTREACH PRACTICE
IN-DEPTH INTERVIEW GUIDE

INTERVIEW QUESTIONS

1. Why did your organization begin using outreach to address diabetes among your patient population(s)?

   **Optional Probes:**
   - How did you identify the need for this practice?
   - What or who instigated the outreach practice?

2. Can you please tell me what specific diabetes prevention and management issues are addressed through the outreach services that your organization provides?

3. Please describe how the outreach practice works.

   **Required Probes:**
   - What is the target population(s) for your outreach practice?
   - What specifically is done?
   - Do you conduct your outreach within the health center, in the community, or both?
   - If in the community, where are services provided? (i.e., at home, at community centers, etc.)
   - How often do you provide outreach?
   - What material resources, if any, are needed? (i.e., health education materials, clinical supplies, an outreach vehicle, etc.)

4. I would now like to talk about who is involved in the outreach practice.

   **Required Probes:**
   - How many of your staff participate in carrying out the outreach practice?
   - What are the roles of the staff that do this outreach? (i.e., clinicians, CHWs, other health center staff)
   - How are your staff trained to carry out this work?

5. Do you currently have a formal evaluation process for the practice?

   **Required Probes:**
   - If yes, please describe your process.
   - If no, how do you assess the impact of the practice?

   **Optional Probes:**
   - How frequently do you look at evaluation results?
   - Do you collect and review patient feedback?
   - Do you assess changes in health outcomes of participating patients? If so, how?
6. **Please describe how the outreach practice is funded.**

*Optional Probes:*
- Does your organization receive diabetes-specific grants?
- Is the outreach practice budget part of your overall organizational budget?

7. **What would you recommend to others interested in implementing this practice at their organization?**

*Optional Probes:*
- What are some of your lessons learned?
- What else do you want others to know about this practice?
- (If needed) Please describe the history of your organization and the populations that it serves.