Rural Health Network

Support Connect Improve

MEETING MINUTES
AUGUST 15,2014

Members Present: Kerry Dunlavey Dr. Seidel Guest: Sharon Mora Dr. Shahady Marianna Mora Jamie Mora	**Staff:** **Monifa Charles** **Bernadette Overstreet** **Tatiana Ramirez** **Nikole Helvey**
	The St. Johns Rural Health Network and Project Turning Point wanted to recognize the community partners and Health Departments for their continuous partnership and support to the network. An award recognition and training was scheduled for all to attend on Friday August 15, 2015. Attendees were able to review the program purpose, objectives, and goals. Additionally receive an award for their years of participation. The Project Turning Point team was able to present details on "TEAMCare Approach", specifically on "Behavioral Interventions". This information was presented in PowerPoint, handouts were distributed to attendees. *This in-service training included success stories from two patients in the Project Turning Point Program. By having the clients share their stories members can see the perceptive from the patient's viewpoint and see the impact of their services and having the program in place within their Health Departments.*
	Speech from the Director of Rural Health: **The theme for the event- "How does our services fit in, in order to provide the best care for our patient". The American Diabetes Association reports that individuals living with diabetes, on average, have medical cost expense approximately 2.3 times higher than those in the absence of diabetes. Typically, it can run from $350 to $900 for individuals who do not have insurance. The mission of the ADA is "to prevent and cure diabetes and to improve the lives of all people affected by diabetes". Our mission is to provide practical, step by step assistance, care coordination, and service to our needed clients/patients. I know this is a goal we all share.** **With that being said a little background about Project Turning Point. Project Turning Point clients are those receiving primary care service, at one of our five partnering county health departments (Baker, Bradford,**

	Clay, Nassau, & Union), and who the medical staff have identified to be at low, medium, high or very high risk for complications from diabetes, as a result of inability to access needed medications/ supplies or to effectively self-manage their medical condition on an ongoing basis (between medical appointments). **Project Turning Point ensures a comprehensive approach to chronic disease management through identification and outreach;** **(a) screening and eligibility determination with linkage to other available resources ;** **(b) the program allows an increased access to diagnostic services (i.e. labs) and immunizations;** **(c) increased access to needed medications and medical supplies (such as home blood glucose testing supplies);** **(d) increased access to disease-related specialty care and screenings; and both individual and group level disease self-management education (DSME),** **(f) in conjunction providing evidences-based support through the Florida Academic Family Physicians with the collaboration of Dr. Edward Shahady for group sessions. The Diabetes Master Clinician Registry, which is a web-based tool where we are able to guide patient education, help them to understand their care coordination, and provide communication between our providers and health educators, this enhances services and makes it more of a patient- centered care.** **Since its inception and with combination with 5 CHDs (Baker, Bradford, Clay, Nassau, Union), with whom we have a very strong partnership and support, the Disease management program and our team has provided an impressive number of services over the years.** **For instance, over 4000 primary care visits to clients in need, over 10,000 direct encounters between clients and disease management team, being able to filled over 3000 prescriptions at the area pharmacies and covered over 2000 diagnostic laboratory tests, and over 500 visits to area specialists (private podiatry and vision/eye care providers), and performed over 1000 additional instances of care coordination for enrolled clients.** **Additionally benefits, avoid hospital and emergency room utilization. Combined, these cost savings and cost avoidance measures calculates to a total of $3.37 Return on Investment for every program dollars received and the project delivered a $4.98 ROI for every state/federal dollar received. However, the true success of the program is the initial encounter with a patient and to see the improvement of their health and for them to be able to self-management their diabetes.** **Despite the capacity of limits on the number of clients who can enroll in the program, there are small group classes for patients or anyone who has an interest in diabetes prevention/management, it is offered in a community-based settings. Our Team also assists the client with primary care information, coordinating and authorizing needs, specialty and pharmaceutical services.** **Essentially, experts have found out through extensive research and case studies being a successful program and to be able to provide the "top**

	notch" service(s) you need to leverage your community partnerships and resources, and to provide a team care approach. I strongly believe we have done so and will continue to do so. **Last but not the least, among the many positive outcomes from this program, just to list a few: Primary Care Service, Disease Management, Care Coordination, Labs, Specialty care, and Prescriptions, we value each and everyone's, time, dedication, and support for the 260 patients, within the program.** **Over the last few months I have an opportunity to meet a few of you, work collaboratively, attend meetings at your perceptive locations, and to be a part of this wonderful network of services. As we prepare for the upcoming months, we may face challenges, and have gainful, meaningful opportunities, that can enhance our services and care for our patients, for the most part, I want us to be excited and inspired to overcome all unforeseen obstacles or challenges that we may face, in essence to provide the best healthcare services.** **The goal in mind is to achieve long-term and ongoing services, opium level of access to care to our areas and most importantly for our patients. Additionally, our team provides interventions, education and support, across the counties to develop and coordinate systematic approaches.** **Thank you again for your support, hard work, and assistance, and please let us know if you have any questions, suggestions, or concerns.**