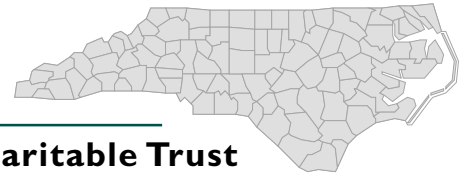


OutReach



A Publication of the Kate B. Reynolds Charitable Trust

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Visit our Website:
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consultations
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For more information
about the
Kate B. Reynolds
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about specific grant
programs, contact
the Trust office in
Winston-Salem.
Phone: (336) 723-1456 or
(800) 485-9080 -N.C. only

Project IDEAL: Improving Diabetes Education, Access to care, and Living*



1. Albemarle Regional Health Services
2. Better Health of Cumberland County, Inc.
3. Bladen County Hospital
4. Catawba Memorial Hospital
5. Columbus County Hospital, Inc.
6. Duke University
7. Edgecombe County Health Department
8. FirstHealth of the Carolinas, Inc.
9. Free Clinic of Reidsville and Vicinity, Inc.
10. Gaston Family Health Services, Inc.
11. North Carolina Foundation for Advanced Health Programs, Inc.
12. NorthEast Medical Center
13. Onslow County
14. Wake Health Services, Inc.

* A Kate B. Reynolds Charitable Trust initiative managed by the Wake Forest University School of Medicine.

Earlier this year, the Health Care Division of the Kate B. Reynolds Charitable Trust extended its support of Project IDEAL (Improving Diabetes Education, Access to care, and Living) for a third year. The Project IDEAL initiative was originally launched in May 1999 in response to the increasing rate of diabetes in North Carolina. Every year, diabetes is directly responsible for over 1,800 deaths and is a contributing factor to more than 5,100 other mortalities in North Carolina alone. Because diabetes is a major risk factor for cardiovascular disease, kidney failure, lower extremity amputation, and blindness, it greatly diminishes the quality of life for many who have the disease and for their caregivers. The cost of hospital-based care for diabetes patients statewide exceeds \$1.4 billion per year. (See related data on Page 4.)

Project IDEAL supports community programs throughout the state that are designed specifically to improve quality of life by improving quality of care for low-income and underserved adults who have diabetes or are at risk for diabetes and its complications.

When the initiative was announced, 57 letters of intent were received. Of those agencies, 26 submitted proposals and 14 were approved for funding in May 1999 (see list above). The funded programs include public and private, non-profit healthcare organizations that serve populations with a substantial burden of diabetes. They exhibit significant local commitment, and much of their strength is in the cooperative alliances among community organizations.

Each of the 14 funded programs addresses barriers commonly found in all areas of the state. The barriers may originate on the part of the provider or the patient. Physicians who provide a full range of services may not specifically focus on diabetes and the most recent American Diabetes Association guidelines. They also face time constraints that make self-management education ineffective.

Among underserved patients, limited knowledge of the disease and its complications is a

(Continued on Page 4)

Columbus County

Columbus County

- Qualifies as a Medically Underserved Rural Area and a Health Professional Shortage Area.
- Ranks 3rd in the state in the number of hospitalizations with diabetes as a principal diagnosis.
- Has state's highest level of amputations due to complications of diabetes.
- Annually records approximately 60 deaths caused by diabetes. Latest figures showed 268 deaths listing diabetes as a contributing factor.
- 40% of adult population did not graduate from high school.
- Has large elderly population.
- Is ethnically diverse.
- Is North Carolina's third largest county geographically but has a limited transportation system.

Columbus County IDEAL Group, Columbus County Hospital, Inc. Deborah L. Albritton, Director (910-642-1734)

When the Project IDEAL initiative was announced in 1998, Deborah Albritton, director of the Columbus County Healthy Carolinians, recognized and seized an opportunity to turn a very limited, existing diabetes program into one of the top intervention/education diabetes programs in the state. The Columbus County Healthy Carolinians Task Force had been in place since 1993 and had distinguished itself by receiving top state awards for its broad-based collaboration in addressing general health and safety issues. By expanding and enhancing the existing group, Albritton established a multi-disciplinary group to focus on diabetes.

The primary partners, Columbus County Hospital and Columbus County Health Department and their staffs, were already committed to the program. Other individuals and groups came on board — pharmacists, dieticians, diabetes nurse educators, and other allied health professionals were recruited, and civic, church, and community groups offered support and volunteered their resources for on-site screenings and education programs.

Columbus County's need for the program and its eligibility for Project IDEAL support were well documented. The county is very rural with a diverse population that has limited access to health care services and to public transportation. According to 1998 data, diabetic encounters at Columbus County Hospital alone numbered 3,071. These patients included 66% Medicare and 12% Medicaid patients. The overall poverty rate for Columbus County seniors over 65 is more than 37%.

From its Project IDEAL funding of \$200,000, the Columbus County IDEAL group has achieved all of the objectives established initially:

- It has enhanced the quality of life and quality of care by increasing educational opportunities, screenings, and referrals in the county.
- Its interdisciplinary team is in place and includes Cooperative Extension, pharmacists, Columbus County Health Department, Columbus County Hospital, churches, industries, and physician offices. Together, they provide an effective, integrated system of care.
- It has established and maintains a diabetes support group.
- It offers continuing education for members of the IDEAL team.
- It has applied for and received American Diabetes Association (ADA) recognition.

ADA recognition status is awarded only after a rigorous review process by experts in the field of diabetes to assure that the services provided by the site meet national standards. Becoming ADA-certified gives the overall program greater sustainability by making it eligible to receive Medicaid and Medicare reimbursement for services provided to uninsured, low-income individuals. Deborah Duchesneau, CDE, is coordinator of the newly ADA-certified site.

The Columbus County education and self-management programs have succeeded in reaching beyond traditional health care systems. The education staff includes a Health Education Coordinator and a Clinical Nurse/Outreach Worker who hold educational programs and self-management support groups in churches and industries. Vans run expanded routes to provide easily accessible transportation to the sites.

Future plans include the continuation of outreach programs and the introduction of additional strategies to improve quality of life for individuals with or at risk for diabetes.



Among the Columbus County Project IDEAL diabetes educators are (left to right) Bev Owens, Meleah Stanley, and Deborah Albritton.



The Columbus County Project IDEAL team includes (left to right) Shannon Fries, Pat Smith, Betty Thompson, Brian Jenkins, Meleah Stanley, Debby Duchesneau, Phillip Tarte, Donna Murray, Deborah Albritton, and Keith Murray. (Not pictured: Hilda Memory, Lisa Hooks, Brianne DiBartolo, Anne Wrenn, Dianne Cichero, and Pam Soles.)

Gaston Diabetes Center, Gaston Family Health Services, Inc.
Teresa Morris, Coordinator (704-853-5261)

The Gaston Diabetes Center of Gaston Family Health Services (GFHS) is dedicated to reducing the long- and short-term complications of diabetes by helping patients with the disease improve their self management skills and by facilitating improvement in their overall health status.

When Project IDEAL was announced in 1998, GFHS seized the opportunity to establish Gaston Diabetes Center as an enhancement to its existing, comprehensive program of services to adults with diabetes and other chronic diseases.

Since receiving Project IDEAL funding, the center has applied for and received certification from the American Diabetes Association. A staff of nurses and registered dietitians — all Certified Diabetes Educators — have been recruited and have implemented the Center's Self-Management Program, which serves 1,500 low-income adults living with diabetes.

The individuals enrolled in the Self-Management Program are adults who are most susceptible to serious diabetes-related complications. Most are at least 35 years old, have limited education, and work in or are retired from low-income jobs. They have not had access to primary medical care because they are uninsured, publicly insured, or underinsured. These individuals typically have relied on Emergency Department care, which provides diagnoses and treatments but does not promote self-management education. Without self-care skills, these patients are at high risk of incurring life-threatening and costly diabetes complications.

The Self-Management Program offers a series of courses that focus on practical strategies for improving quality of life by dealing more effectively with the disease and its complications: Diabetes 101, All About Insulin, and



The Gaston IDEAL team includes (left to right): Patricia Cherry, RD, CDE; Teresa Morris, R.N., CDE, Coordinator; Beth Brittain, RD, CDE; Rita Yeltan, Office Manager.

Basic Nutrition for Diabetes. Courses are offered during the day and in the evenings at GFHS and at satellite locations, such as churches and libraries. Courses are offered in Spanish at designated sites.

Since recruiting clients who have previously been without care is critical to the success of the program, the staff at the center has established a comprehensive network of referral sources that include local physicians, community screenings, the Emergency Department and hospital discharge planners, parish nurses, home health agencies, pharmacies, and members of the Community Health Partners and Diabetes Coalition.

After two years, the program has met or exceeded its original objectives: (1) 1,500 persons served by the center have attended at least one introductory diabetes class; (2) 270 persons have enrolled in the self-management program; and (3) graduates of the self management program have exhibited improvement in their post-program assessment of skills and knowledge.

Following completion of the program, graduates continue regular medical visits and glucose testing and work toward achieving ongoing nutrition, medication, exercise, or other risk-reduction goals.

Gaston County

Gaston County

- Qualifies as a Medically Underserved Rural Area.
- Has a low-income population of approximately 65,000 residents, including adults who are uninsured, Medicaid-enrolled and eligible, Medicare recipients, and underinsured.
- Has 14% of residents living below the poverty level.
- Estimates that more than 5,600 low-income county residents with diabetes are at-risk for preventable complications because they have limited access to primary medical and and diabetes self-care education.

Important Dates:

Satellite Offices:

Fayetteville satellite office will be open December 3-7, 2001.

Greenville satellite office will be open January 14-18, 2002.

Deadlines for Applications:

Health Care Division
September 17, 2001
March 15, 2002

Poor and Needy Division
January 2, 2002
May 1, 2002
August 1, 2002

Just A Reminder:

Advance Consultations Required In 2002

Beginning January 1, 2002, advance consultations will be a prerequisite to submitting an application to the Trust. This preliminary step has always been recommended; however, 2002 applications will not be accepted if the consultation has not been completed.

Many benefits may be derived from the consultation. It ensures that the program or project being proposed fits within Trust guidelines. For those that do fall within the guidelines, it jumpstarts the process by clarifying terms, specifying supporting documents, and reviewing general instructions.

Focus on Diabetes

According to the Third National Health and Nutrition Examination Survey ...

- More than 15 million Americans (approximately 5.9% of the total population) have diabetes.
- About one-third of persons with diabetes are undiagnosed.
- Approximately 798,000 new cases are diagnosed each year.
- In North Carolina, approximately 6.4% have been diagnosed. This is the seventh highest prevalence among all the states.
- Including undiagnosed cases, the number of North Carolina adults with diabetes is approximately 500,000.

(Continued from Page 1)

common barrier. Other frequent obstacles include inadequate insurance coverage, language and cultural differences, limited access to primary and specialty health care providers, distrust of providers, and a lack of knowledge of the “process” of seeking assistance.

After two years of operation, each of the programs funded through Project IDEAL has developed and begun implementing plans that address these barriers. Though the programs face common barriers and share common objectives, each relies on strategies designed specifically for the local community.

Many programs are expansions or outgrowths of agencies and services that are already in place. Administrators have planned carefully to ensure the best use of existing resources and to increase accessibility of care without duplicating services. In several counties, existing physical facilities and other resources that were previously underutilized have become an integral part of the program’s service delivery system.

Because transportation is a primary barrier among low-income populations in all regions of the state, outreach is a critical element of each program. Some agencies have purchased mobile units and staffed them with nutritionists, diabetes nurses, pharmacists, and other allied health professionals; others have set up systems of free van transportation to health system locations as well as non-traditional health care sites. Services are being offered at a variety of satellite locations, including community pharmacies, physicians’ offices, schools, Head Start centers, churches, and local companies.

In North Carolina, African-American women have the highest prevalence of diabetes among all

groups. Both African-American men and women experience high rates of complications related to diabetes, and they are more than twice as likely to die from diabetes as non-Hispanic Whites.

The national impact of diabetes among Native Americans has been a concern since the mid 1960s. In North Carolina, data on prevalence of diabetes among Native Americans is incomplete. However, a 1999 study by the Indian Health Service facility that serves the Eastern Band of Cherokee Indians reported a prevalence rate of 11% among Native Americans as compared with the state average of 6.4%. Other statistics show that Native Americans in the state are three times more likely to die from diabetes than are non-Hispanic Whites.

Data on Hispanics in North Carolina is also incomplete. On the national level, however, data shows a prevalence rate of 11% — almost twice the national average — and related studies indicate that prevalence is particularly high among Puerto Rican and Mexican Americans.

As the community-based collaborations shift health care delivery from a hospital base to neighborhood settings, services are becoming more accessible to all racial and ethnic groups.

Although the results of the Project IDEAL initiative will not be available until late 2002, early indications are encouraging: (1) each of the programs is reaching its targeted population; (2) barriers to accessibility are being substantially reduced; (3) the delivery of appropriate services to people with diabetes is being enhanced; and (4) more than 25,000 North Carolinians already have been touched by services through Project IDEAL programs — either for screening, one-to-one consultation, education, self-management support, ongoing care, or treatment.

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