LA CLÍNICA DEL PUEBLO

Partnering for Health Equity to Address Disparities in Diabetes Care, Management, and Prevention for Low-Income Latinx Immigrants.

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Introduction

Our organization: La Clínica is a nonprofit, community-based organization and Federally Qualified Health Center (FQHC) committed to delivering high-quality, culturally and linguistically appropriate health services and education to the low-income Latinx immigrant community.

Target population/zip codes: Low-income, uninsured, underinsured, and Limited English Proficient (LEP) Latinxs in La Clínica's Hyattsville Primary Care Center's Service Area, primarily in Prince George's County. Our top patient zip codes include 20783, 20782,20737, 20784, 20786.

History serving the target population and community:

- Founded in 1983 in Washington, DC in response to the healthcare needs of a growing Latinx population displaced by civil wars.
- Focus on a culturally-competent, holistic approach to healthcare.
- Provide comprehensive health services in a co-located setting (primary, behavioral, and reproductive/sexual health) reducing barriers.
- Expanded physical presence in Prince George's County from 2015 onwards:
    - School-based mental health program in Northwestern High School
    - Primary care clinic in Hyattsville
    - Expanded community outreach across Prince George's County and with local partners, including Doctors Community Hospital (now Luminis Health)
- Providing diabetes prevention and self-management programs for 10+ years including CDC certification in DPP and Chronic Disease Self-Management certification (SMRC).

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Specific Health Disparities

- **Specific health disparities the proposal will address:**
  - Disproportionate rates of diabetes and risk for diabetes among Latinx community:
    - 50% of Latinxs will develop Type 2 diabetes in their lifetime (CDC)
    - 16% of La Clínica's patients have diabetes.
    - 13.8% of adults in Prince George's County have been clinically diagnosed with diabetes
    - 66.3% of Latinxs in Prince George's County were overweight or obese in 2019, a risk factor for developing Type 2 diabetes.
  - Immigration Status
  - Lack of Health Insurance & Understanding of the US Healthcare System
  - Poverty and Food Insecurity
  - Language Barriers
  - Health Literacy

- **Key partners :**

Luminis Health	Health care provider
ayuda	Legal services provider
Crossroads Community Food Network	Food access provider

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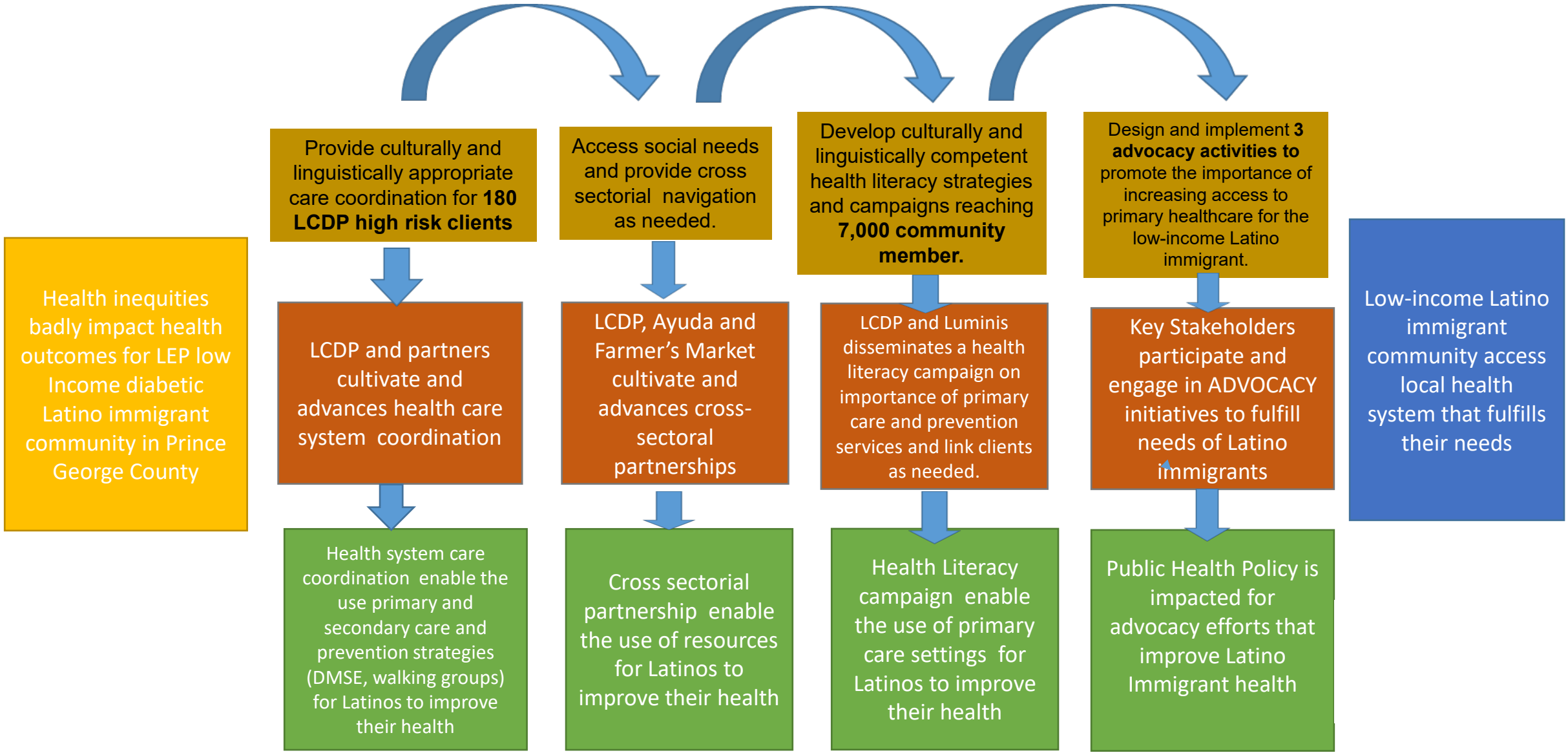
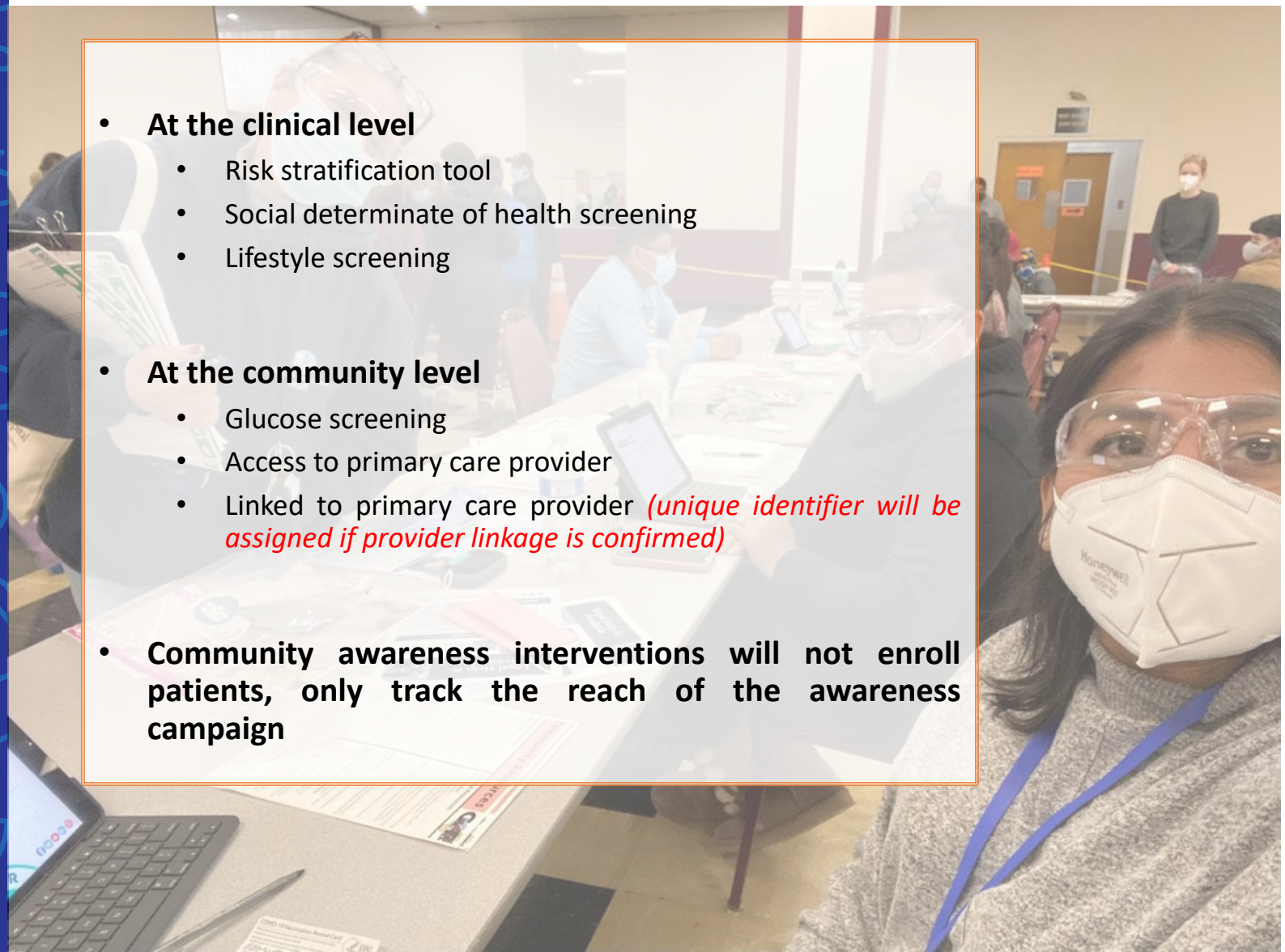
Interventions



Patient Enrollment Process



- **At the clinical level**
  - Risk stratification tool
  - Social determinate of health screening
  - Lifestyle screening
- **At the community level**
  - Glucose screening
  - Access to primary care provider
  - Linked to primary care provider *(unique identifier will be assigned if provider linkage is confirmed)*
- **Community awareness interventions will not enroll patients, only track the reach of the awareness campaign**

Unique identifier:

- Added to the EMR tracking care coordination, health education and referrals to specialty care, legal services and food access.

Luminis Health

ayuda

Crossroads Community Food Network

- Added to the internal data base tracking screening events and linkage to primary care providers.

Luminis Health

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