2008 Annual Report

Celebrating 40 Years of Excellence

FROM THE EXECUTIVE DIRECTOR

TO THE COMMUNITIES WE SERVE…

Never has meeting our Mission seemed more critical: ***To improve and promote the health of our communities by providing quality health care services that are affordable and accessible.***

Our communities are living through unprecedented times. The downturn in our economy has placed many of those we serve in a health care crisis due to loss of health coverage through their employer or as a result of narrowing of eligibility for our state's public coverage programs. Many have been forced to forego treatment for acute illnesses—ignoring medical symptoms due to the economic realities in their lives. Some are also foregoing critical monitoring and treatment services for chronic medical conditions. Everyday, patients must decide between using their diminished resources to pay for needed medications versus paying for housing, food or transportation.

Fremont is here, ready with a variety of health services and programs to lend a hand to our communities. Our three primary care clinics, located in North & Northeast Minneapolis, have served over 9,000 patients in 2008. We have had a ten percent increase in patient visits during the last year. Our pharmacy service has provided a viable alternative for over 5,000 patients to receive the vital medications need to control their chronic conditions. Our Community Outreach Programs have directly touched the lives of over 3,000 community members in 2008. Our Patient Eligibility staff have assisted more than 800 individuals with the process of qualifying and applying for public program coverage.

During this same time, the quality of care demonstrated by our providers continues to be among the best in the Twin Cities—as measured by payers, Federal & State government and by *Minnesota Community Measurement.* Our Patient Satisfaction ratings continue to demonstrate the culturally-competent care delivery that our patients value.

All these accomplishments start with dedicated board leadership, staff, and donors who share a commitment to this vital Mission. Our organization is very grateful to those in our communities who have stepped forward to help fund these accomplishments. We sincerely thank you, and recognize you for your efforts.
Our 2010 *Annual Gala* event, celebrating our 40th year, will be held this coming spring. Please look for an event announcement soon. The *Gala* will offer a chance to celebrate our many accomplishments, as well as to renew our collective commitment to our Mission.

On behalf of Sharon and myself, we welcome the opportunity to lead this fine organization as it looks forward to expanding the reach of our Mission.

Steven J. Knutson
Executive Director

Sharon Ruibal-Bolling
Chair, Board of Directors

Fremont Community Clinics

Key Accomplishments

Key accomplishments for the 2008 health care plan include:

Perinatal: We provided 1,665 visits to 333 women during this 12 month period and: 94% received post-partum f/up within 8 weeks of delivery, 98% received newborn f/up within 4 weeks of delivery and 88% of users received prenatal services in their 1st trimester.

Pediatric: 96% of 18-24 month olds were current on primary immunizations on an annual basis and, 98% of 9-30 month olds had at least one blood lead level (BLL) screening. 1% of births were less than 2500 grams.

Adolescent: 96% of teens were queried about tobacco use, and 100% of males were screened at their annual screening for Gonorrhea and Chlamydia and 87% of teens were compliant with their birth control at one year.

Adult and Geriatric-Cardiovascular Disease: 98% of CVD patients had a blood pressure twice per year, 94% of patients with known CVD or Diabetes had a BP <140/90 at last visit, and 93% of patients with CVD/DM had a self-management goal at their last visit.

Adult and Geriatric Diabetes Mellitus: 86% of patients with DM received a lipid test, and 75% had an HbA1c < 7.0.

Adult and Geriatric Immunizations: 100% of patients 65 or older received a pneumonia vaccine and 67% received an influenza vaccine. 66% of adults 20 and older had received tetanus boosters.

Oral Health: BBTD education was given to all caregivers of patients under 24 months of age.

Mental Health: We provided Mental Health Services to 837 patients at 1,827 visits. 91% of patients continued depression Rx at 5-8 months. 92% of adolescents with mental health issues were managed.

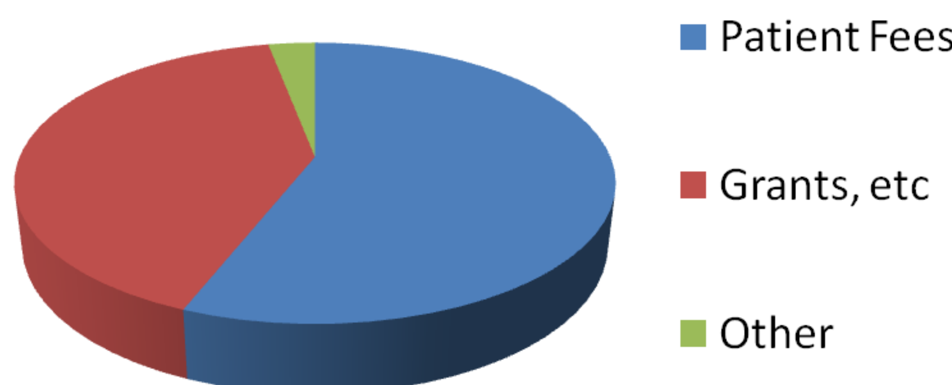
Improved Quality through Lab and Referral Tracking: 100% of lab orders and summaries were complete, and 99% were initiated and followed-up. 97% of consults are initiated by the provider and 100% are followed-up. 89% of all referrals are tracked.

Drug Allergies: 99% of drug allergies are documented.

FINANCIAL SUMMARY

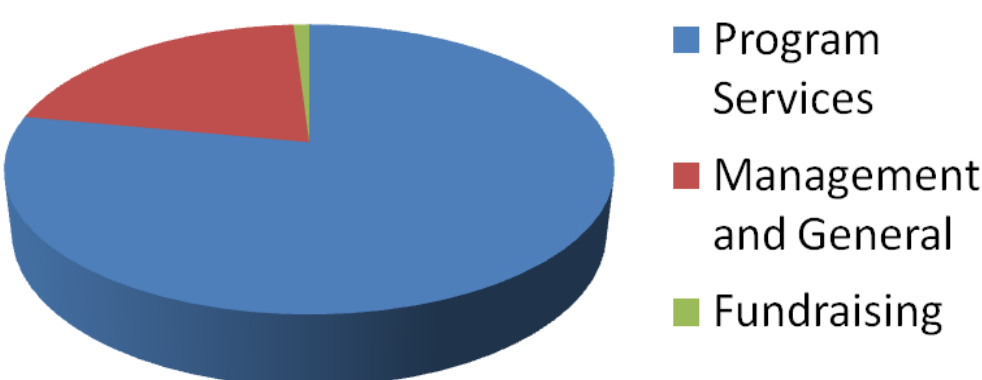
January 1, 2008 - December 31, 2008

REVENUE		
Grants, Contracts and Contributions	$1,936,170	41%
Patient Fees	$2,593,568	56%
Other Revenue	$125,873	3%
TOTAL REVENUE	**$4,655,611**	**100%**



EXPENSES		
Program Services	$3,671,214	78%
Management & General	$955,146	21%
Fundraising	$27,141	1%
TOTAL EXPENSES	**$4,653,501**	**100%**

NET REVENUE **$2,110**



Medical Services 2008

2008 SERVICES SNAPSHOT	VISITS	PATIENTS
Medical Services – All Clinics	24,889	9,093
Fremont	10,077	
Central	8,632	
Sheridan	6,180	
Mental Health/Substance Abuse	554	389
Health Education & Support	3,011	
Health Supervision of Infants & Children (0-11)	2,193	1,511
Contraceptive Management	1,463	797
Prenatal Care	1,500	256
Care for Selected Chronic Diseases		
Asthma	359	325
Diabetes	1,348	456
Hypertension	2,034	878
Heart Disease	333	135

LEADERSHIP AND VOLUNTEERS

Board of Directors

Bruce Adams
Deb Anderson
Robert Carson
Sinouane Chanthraphone
John Clawson
Julie Colby
James Cunningham
Bonita Gowan
Kelly Maynard
Sharon Ruibal-Bollig
Sheila Scott
Dawn Stanton
Ken Tyra
Marge Vanderburg

Current in bold

Management Staff

Name	Title
Steven Knutson	Executive Director
Ron Jankowski, MD	Medical Director
James Ricketts	Finance Director
Cheryl Giblin, RN	Director of Clinical Operations
Donna Budde	Fundraising/QI/Compliance Manager
Rahshana Price-Isuk, MD	Associate Medical Director
Wendy Rider	HR/Business Office Manager
Kenya Dalton	Business Operations Manager
Bridgette Shepherd Anderson	Clinical Operations Manager

Thanks to all of our employees and their family members who provided volunteer services in 2008!

2008-'09 Volunteers

Owen Anderson
Trisha Becker
Carolyn Belle
Carolyn Engeldinger
Chuck Engeldinger
Camille Evans
Jeanne Fish
Saibeth Garay Villagomez
Kelly Harrington
Vivian Jeffrey
Sarah Klawitter
Sarah Larson
Amanda Larson-Mekler
Travis Lee
Anne Linde
Eleanor Monroe
Jennifer Monroe
Lizzie Nelson
David Orbuch
Elizabeth Paulson
Mandi Proue
Melody Shepherd
Maricela Velazquez
Amy Velenchenko
Kristina Vicks
Lauren Zurek

INDIVIDUAL & CORPORATE GIVING

Corporate/Organizational

Ameriprise Financial
Certified Quality Consultants
Dyste Williams Agency
David Martin Agency
Eastside Food Co-op
Flannery Construction
Garden & Associates
McKesson Medical-Surgical
Minnesota Chapter of NAPNAP
Mutual of America
Netrix Information Technologies
Transcend Comunications
Valley Community Presbyterian Church

Foundations/Grants

General Mills Foundation
Greater Twin Cities United Way
Healthier Minnesota Community Clinic Fund
Medica Foundation
Phillips Family Foundation
Pohlad Family Foundation
UCare Minnesota
Walter C. Rasmussen-Northeast Bank Foundation

Government

Bureau of Primary Health Care/HRSA
Hennepin County
Minneapolis Department of Health and Family Support
Minnesota Department of Health

In-kind $500+

AirTran Airways
Best Buy - Eagan
Blue Fin Bay Resorts
Fishson Graphics/Jeanne Fish
G.E. Miamen/ Eric Miamen
Minuteman Press Central/Dave Forster
Northwestern Mutual Financial Network/Tim Bohannon

Individual

$1-$99

Cynthia Arnold
Kaye Baum
Carolyn Belle
Ken Bence
Mark Bixby
Thomas Blankenship
James Cain
James Cassidy
Inesta Dorofeeva
Sandy Faris
Jeanne Fish
Brian Fujito
Paul Henry
David Johnson
David Johnston
Harold Kaiser
Daniel Kinsella
Sarah LeCorq
Greg & Mina Leierwood
Laura Lipkin
Tina Lorsung
Alvin McFarlane
Kelly Maynard
Barbara Milon
Patricia Murphy
Lynne Ogawa
Steve Onken
Betty Ragan
Margaret Scherbing
Jane Seeley
Suzanne Sjoselius
Jane Steinhagen
Kristen & Leif Stennes
Mark Stesin
Ken Tyra
Kelly Wheeler
Derek Wong

$100-$499

Diane & Vic Anderson
Cathy Anson
Michelle Ansorge
Emily & James Benzie
Crystal Boe
Linda & Mark Brakke
Patti Breen
Yvonne Brutger
Al Bunnett
Paul Busch
Mark Byrnes
Robert Carson
Mary Colbert
Julie Colby
Nora Collins
Michelle Combs
Shirley Conn
Walt Cooney
Alison Coulter
Daniel Day
Howard & Linda Dickman
Sam Economou
Frank & Randi Grovenstein
Linda Hart
Jude Heinecke
Dorothy Huesers
John Hull
J.M. Janiga
Cindy Kallstrom & Will Merrill
Pat Keenan
Peter Kramer
Patty Krieger
Sandra Levine
Patrick Lilja
Brenda Lindner
Krista Loop
Carol McCarter

Individual

$100-$499

Amy McNeil
Maddie & Toby Muse
Gretchen Musicant
Kurt Nisi
Pam & Paul Norman
William Omlie
Bev Price
Tony Pulver & Lucy Swift
Daniel & Marva Randa
Anne Ricketts
Wendy Rider
Sharon Ruibal-Bollig
Sheila Scott
Kevin Shore & Kevin Winge
Jay Simonson
Todd Sorenson
Margaret Storm
David Treftz
Richard & Tara Varco
Charlotte Vick
David Weinberg
Mary Welke
Marianne Wheelock
Mary Yoshida
Mary & Paul Youngquist

$500-$999

Donna & Ward Budde
Sinouane Chanthraphone
James Cunningham
Ron & Louise Jankowski
Steve Knutson
JoAnn & Pat Kraft
Don Masler
Jennifer Monroe
Lisa & Steve Schroeder
Barb & John Zurek

$1,000+

Bruce Adams
Andrew & Nellie Bauer
R. Scott Dyer
Meg Friese

Fremont Community Clinics

Community &Clinic-Based Initiatives

OBESITY AND DIABETES PREVENTION – *F.I.T. Force*

This family-oriented healthy lifestyles program is targeted to youth 10-18 and their caregivers to prevent and decrease the prevalence of obesity in North and Northeast Minneapolis. In the community, we use six to twelve week curriculum, the program coordinates with schools, park recreation centers, and libraries to engage youth in hands-on, fun interactive nutrition and physical activity education. In the clinic, we counsel all patients on a healthy lifestyle and offer one on one appointments with a dietitian and/or health educator for those at risk or affected by obesity and diabetes.

Since July of 2008, the program has reached hundreds of youth and family members throughout North and Northeast Minneapolis helping them to increase their healthy eating habits and level of activity. The program also offers in-clinic obesity-prevention support with the help of a registered dietician and care coordinators. Funding is provided by the *General Mills Foundation*, *UCARE* and Great*er Twin Cities United Way*.

"This program is extremely beneficial providing a unique and proactive emphasis on wellness, while establishing a great rapport with students at our school [Northeast Middle School]. The program is very well facilitated – giving youth the experience to choose a healthier lifestyle." –Barbara Kapala, Northeast Middle School Beacons Director

Melanie Richie, Community Health Coordinator, mrichie@fremonthealth.org, 612-277-3195

Community &Clinic-Based Initiatives

STROKE PREVENTION

The Stroke Prevention Project seeks to increase understanding of cardiovascular disease — including, stroke, peripheral vascular disease (PVD) and diabetes. The project has focused on the uninsured and underinsured African-American and African-born adult communities in North and Northeast Minneapolis and the Northwest corridor; in 2010, the project will expand to reach the Northeast neighborhood as well.

The project seeks to increase education, outreach and screening toward early detection and treatment of diabetes, hypertension, and high cholesterol. Community Health Workers (CHWs) provide a critical link to adult community members who are not connected to a health provider, who may not be aware that they have risk factors for stroke, and are not getting treatment for a undiagnosed and/or under diagnosed condition. Of the geographic and ethnic communities they serve, CHWs have access to and rapport with the target population which disproportionately experiences cardiovascular disease and diabetes.

CHWs receive ongoing culturally-appropriate training and support and are equipped with electronic blood pressure equipment to provide education, and blood pressure readings at community sites including churches, beauty & barbershops, workplaces, public housing, and other locations and health events. They conduct exercise classes and oversee other self-management activities. Since 2002, this project has educated and screened thousands of community members. Funding is provided by *the Minnesota Department of Health, Office of Minority & Multicultural Health, Eliminating Health Disparities Initiative.*

Carol Brown, RN, Project Coordinator, cbrown@fremonthealth.org, 612-287-2433

COMMUNITY & CLINIC-BASED INITIATIVES

ADOLESCENT AND YOUNG ADULT HEALTH – *Seen on Da Streets*

This project targets young people in North Minneapolis who are high-risk for sexually-transmitted infections (STIs). It will expand to reach the Northeast community in 2010. This community has a disproportionately high rate of STIs among African Americans in the 15-24 age group. *Fremont Community Clinics* is partnering with the *Minneapolis Department of Health and Family Support and Teenage Medical Services (TAMS)* to reach disaffiliated and high-risk males on the streets. The *Minnesota Department of Health* has helped fund our weekly walk-in clinic for males and females. This award-winning street outreach initiative addresses clinic environments, community norms and individual behavior toward increased awareness and use of STI prevention, testing and treatment options. It increases the skills of the targeted population to negotiate the use of contraception and discuss reproductive health with sexual partners, increased use of condoms and the willingness and motivation to make use of community health services.

Peer Health Educators provide education and screening for young people through on-street and community-based education and testing, walk-in clinics, sexuality groups and one-on-one. Since 2005, they've reached thousands of young men and women on the street, conducted on-street screenings of hundreds of young people (ages 15-24) and carried out hundreds of in-clinic screening visits.

Fred Evans, Community Health Coordinator, evansf@fremonthealth.org, 612-287-2423

FAMILY PLANNING - *What's Your Plan?*

Fremont Community Clinics offers a comprehensive family planning program with services for men, women, couples, teens, parents, and families. Our team of health professionals provides public information, community outreach, education and counseling, assistance with accessing birth control methods, referrals, and follow-up care. We offer health education at any of our three clinic sites and in the community. Men and women may be seen by appointment and/or on a walk-in basis. Additionally, health educators are available to provide one-on-one and group educational sessions. Funding for this project is provided by the *Minnesota Department of Health* and *Hennepin County*.

Terra Carey, Family Planning Coordinator, careyt@fremonthealth.org, 612-287-2420

Community & Clinic-Based Initiatives

PATIENT SERVICES COORDINATION

Patient Intake Coordinators provide information on access, education on health insurance options, eligibility, basic health education and health care navigation to enhance individual and community health. Through outreach and marketing initiatives aimed at organizations and the general public—particularly children, families and the elderly—we seek to increase awareness of *Fremont Community Clinic's* programs and services. The Coordinators meet one-on-one with uninsured patients to assess and advocate for insurance eligibility and conduct *Medical Assistance* and other public health insurance enrollment activities to facilitate access to care and improve health outcomes. They also provide assistance with sliding fee access both to our services and to other affordable and sliding fee health services in the community. Current funding is provided by the *Greater Twin Cities United Way* and the *Health Resources and Services Administration.* In 2008, we received support from the *Minneapolis, Department of Health and Family Support.*

Wendy Rider, Business Office Manager, wrider@fremonthealth.org, 612-287-2451

Community & Clinic-Based Initiatives

ACCESS TO MEDICATION

Treatment through medication is a foundation of patient self-management, reducing complications, mortality and morbidity when diseases are treated early and aggressively. Unfortunately, many of our patients lack prescription drug coverage—even those who may be otherwise insured. We increase our patients' access to needed medications in a variety of ways:

- As a PHS 330-funded health center (Federal funding), we are able to purchase select drugs at great discount through the federal *340B Drug Pricing Program*. We share this cost-savings with our eligible (uninsured) patients through a partnership with Snyder Drug.
- We receive select sample medications from pharmaceutical companies to help some of our poorest patients who must take expensive drugs for chronic conditions.
- Fremont nurses assist hundreds of uninsured, low-income patients in accessing free medications through drug companies' *Indigent Care* programs.
- Our staff lends a hand to our patients who are 65+ and other eligible patients with disabilities to navigate the complex bureaucracy of *Medicare Part D* enrollment.
- Our Physicians, Nurse Practitioners, Physician Assistant and other nursing staff provide counseling, health education and support to our patients to help them understand the purpose and limitations of medication, to increase compliance, and to make medication affordable.

Cheryl Giblin, RN, cgiblin@fremonthealth.org, 612-287-2496

Community & Clinic-Based Initiatives

ASTHMA INITIATIVE

Fremont is collaborating with the *American Lung Association* and a cohort of Twin Cities clinics to devise and implement new systems to improve delivery of care for patients with asthma, supporting and sustaining adherence to the *National Heart, Lung, and Blood Institute (NHLBI)* asthma guidelines. Goals include: assign an asthma severity rating to all patients with asthma; increase asthma control among patients; prescribe a controller medication for all patients with persistent asthma; make sure all patients have an asthma action plan; use spirometry in the diagnosis and management of asthma; provide better asthma education to all patients with asthma, and; improve documentation for asthma visits. Providers have received training in implementation and interpretation of spirometry, using the guidelines, inhaler techniques, and other areas.

HEALTH CARE HOME

An interdisciplinary team comprised of *Fremont Community Clinics'* staff, the *Neighborhood Health Care Network*, and patient members has developed and is piloting a "medical home" model for the provision of comprehensive primary care in our clinics. This model incorporates a patient-centered approach to health care delivery for chronically ill patients in which patients play a pivotal part in their health care team and are encouraged to have ownership of medical decisions, co-create action plans, and actively participate in disease self-management.

Patients currently eligible to enroll in the pilot phase of Health Care Home include those who have unmanaged cardiovascular disease and/or diabetes as well as other chronic diseases and psychosocial conditions. Each team, consisting of a Patient, his/her Family, Provider, Care Manager, Patient Advocate, Medical Assistant and designated others, meets regularly to develop individualized care plans and to assess progress and incorporate changes as needed to keep the plan viable. This model aims to improve health care outcomes, access to care and patient satisfaction.

COMMUNITY & CLINIC-BASED INITIATIVES

MAMMOGRAPHY PROJECT

We are committed to quality improvement in all our clinical endeavors. In order to improve follow-up rates for mammography referrals, we are continuously contacting all patients who were referred to mammography in order to encourage and assist them with follow-through. Many of our low-income patients are eligible for free or reduced cost services through the *Minnesota Department of Health's SAGE program*.

OTHER COMMUNITY PARTICIPATION

Fremont has always advocated for the health of our community by joining forces with other community, governmental and grassroots initiatives serving our geographic and cultural communities. Our programs focus on prevention, an integral part of our health care delivery model. We actively participate in local community networks, e.g., to improve services to youth, to expand access to mental health and other needed services and to advocate to maintain and expand the "safety net." Some of these initiatives include:

Minnesota Health Department's SAGE Program (Breast and Cervical Cancer Control Program) that provides free or reduced cost mammography and pap smears for uninsured women. *SAGE* also provides some financial help for treating abnormalities.

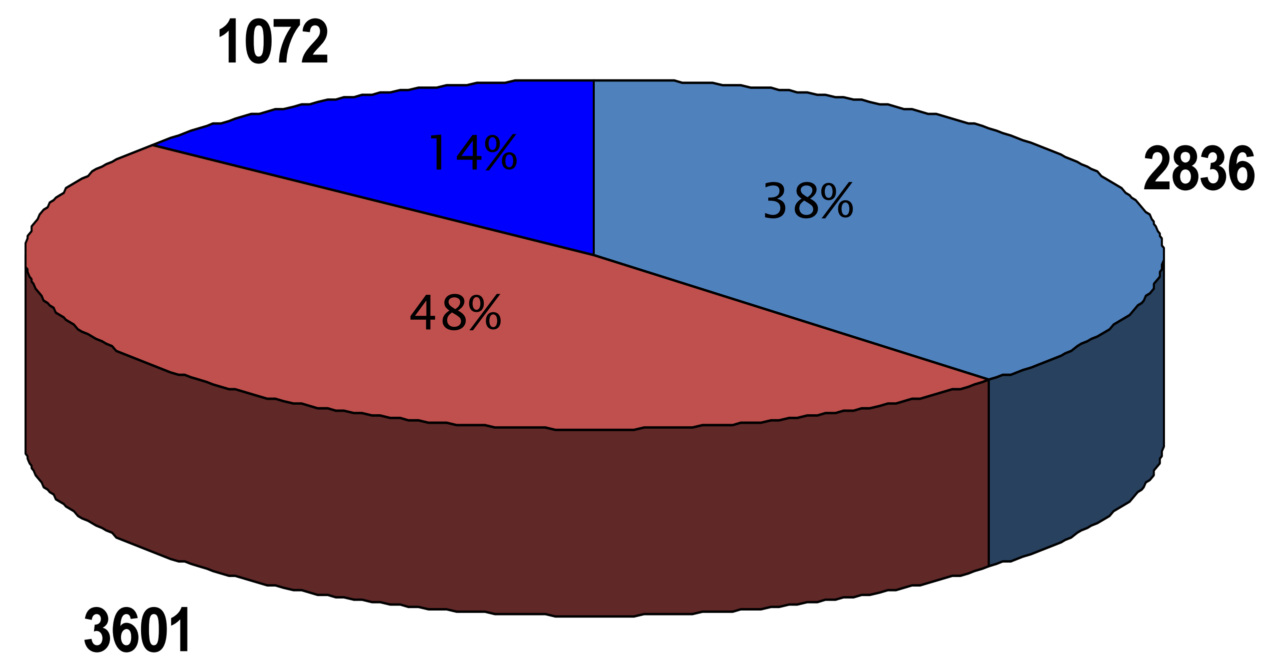
Our physicians serve as preceptors for *University of Minnesot*a doctors in residency training, advanced practice nurses and medical students via the Family Practice Residency Program (*North Memorial/UFP*) for hospitalized patients.

We have partnered with the *Minnesota International Health Volunteers* and others to advance community health worker education and employment.

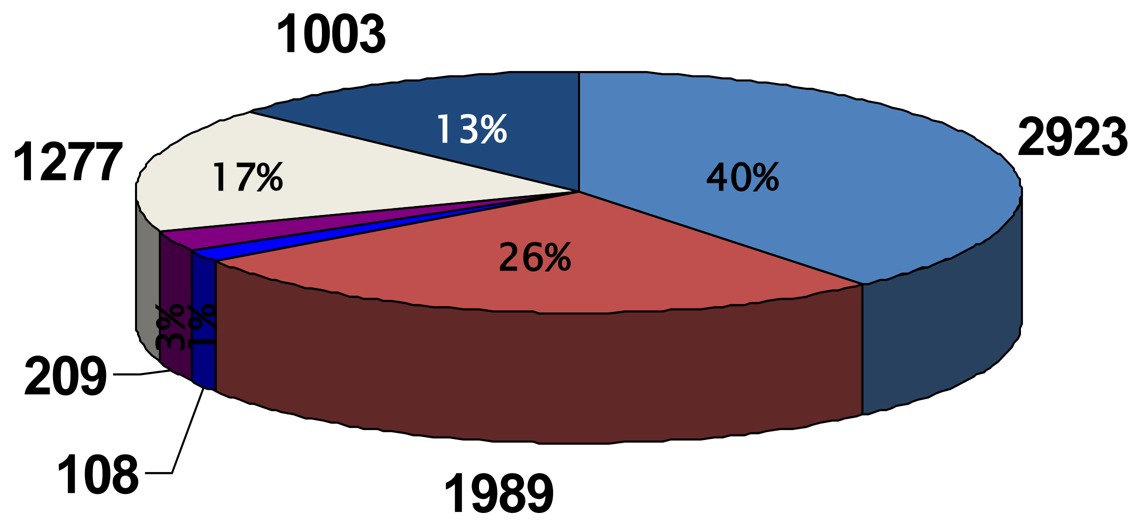
We are an active member of the *Neighborhood Health Care Network*, a shared management services collaborative that advocates for community health clinics serving economically and ethnically diverse populations in the Minneapolis-St. Paul metropolitan area. By working together, member clinics have access to more of financial resources, services and technology needed to provide high-quality care to more people. We are also part of the *Minnesota Association of Community Health Centers*, a non-profit organization that promotes the cost-effective delivery of affordable, quality primary health care services, with a special emphasis on meeting the needs of low-income and medically underserved populations.

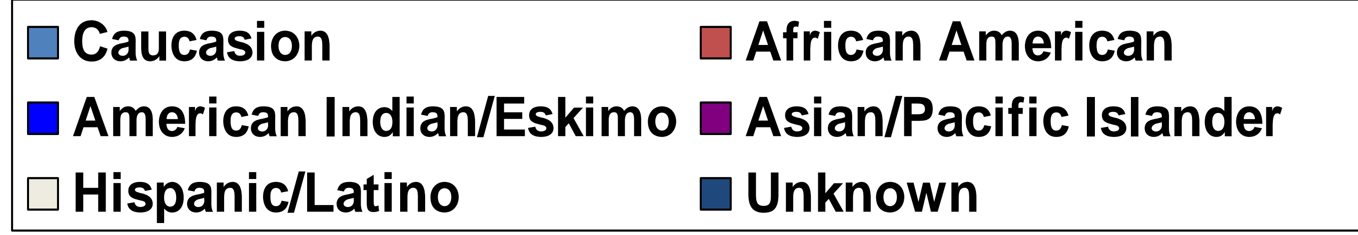
Donna Budde, budded@fremonthealth.org, 612-287-2427

Health Insurance Coverage

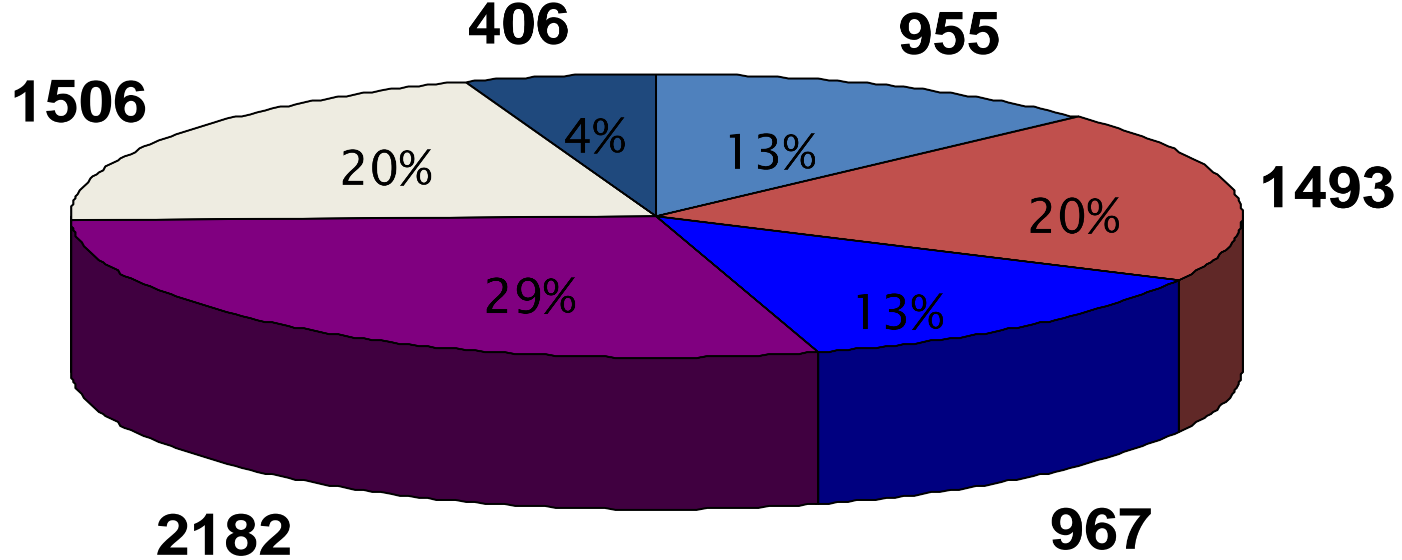


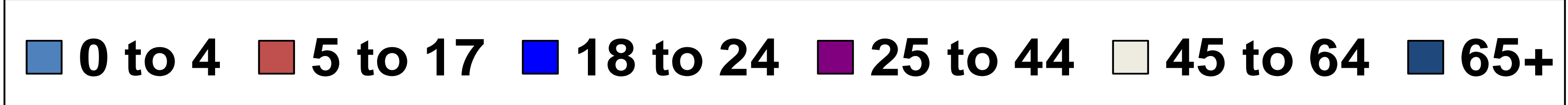
RACE / ETHNICITY





AGE





GENDER