Miami Rescue Mission Clinic
Caring Place Clinic

FAFCC IMPACT SUMMIT

Leveraging Technology for Sustainable Funding and Growth

PRESENTATION - 2025

www.caringplaceclinic.org 305-572-2026

MEET OUR PRESENTERS

Gisela Bretones

Dr. Linda Brown

Mario Alvarez

OUR SITES

MIAMI

2015 NW 1st Avenue
Miami, FL. 33127

HOLLYWOOD

2056 Scott Street
Hollywood, FL. 33020

DORAL

9600 NW 38th Street,
Suite 100 Doral, FL 33178

MIAMI RESCUE MISSION CLINIC

MEDICAL CENTER

MR

MC

WELCOME TO OUR CLINIC

The Miami Rescue Mission Clinic (MRMC) is a Free Clinic that annually provides medical services to over 11,000 homeless and underserved populations. MRMC provides compassionate health care while enhancing the lives of diverse communities served. MRMC has had a consistent presence in the community since May 14, 2009, providing value-based services to the homeless and uninsured and training opportunities to crucial personnel working with high-risk, high-cost populations and requiring careful proactive management. MRMC opened its doors due to the need for medical care in our homeless community. Before the first clinic opened in 2009, our homeless population could only receive medical care at local emergency rooms or limited care provided by local colleges during yearly health fairs. To mitigate this problem, leaders from our community shelters and a local college created "The Mission Project" in 2000 to improve clinical skills, cultivate civic responsibility, expand awareness of health needs, and significantly enhance our community homeless. A long-term goal of The Mission Project had been to establish an on-site clinic at the shelters, which served the primary care needs of those experiencing homelessness in surrounding neighborhoods. MRMC is in an area designated as a "Medically Underserved Area/Population" and as a "Health Professional Shortage Area" by the Department of Health and Human Services. Most of these individuals have little or no access to health care. MRMC's Miami office opened in 2009, followed by our Hollywood office in 2012 and our Doral office in 2019; our services reach two counties.

MIAMI RESCUE MISSION CLINIC

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Technology Landscape for Non-Profits (At a Glance)

Nonprofit tech fits four zones – fundraising, operations, mission delivery, and compliance. Choosing one versatile cloud platform for each zone saves staff hours, grows revenue, and satisfies auditors..

Revenue & Relationships

Give Lively
Salesforce Nonprofit Cloud
Bloomerang
Salesforce Sales Cloud
HubSpot CRM
Insightly
Zoho
Network for Good

Operations & Automation

monday.com
WorkOS + Automations
Zapier
Power Automate
QuickBooks Online for Nonprofits
VolunteerHub

Clinical Care

AthenaHealth
athenaOne
Hikma Health
COVID Plus
Visiontree (Roadmap to Health)

Compliance & Impact

Microsoft Cloud for Nonprofit / Sustainability
Okta / Azure AD (Zero-Trust)
Vendor SOC-2 / HIPAA Attestation

Unified Tech Spine: Four Pillars That Turn Technology into Repeatable Revenue

Data Capture & Integrity

Definition: log each operational event once, in one authoritative system, guarded by SSO + MFA.

Example: A $250 Give Lively gift triggers a Zapier webhook that lands in Salesforce in five seconds; duplicate-rate audit shows 0.3 %—well below the 0.5 % threshold.

Orchestrated Workflows & Automations

Definition: “When → Then” automations that launch tasks, set SLAs, and log every step, so no human has to remember.

Example: When a grant status flips to “Due in 7 days,” monday.com instantly builds a Form 990 checklist, assigns the CFO, and starts a 48-hour timer —result: zero missed deadlines in 12 months.

Intelligence & Decision Layer

Definition: analytics / AI that converts raw logs into ranked action lists and live metrics.

Example: Einstein GPT scans all open grant records and surfaces 18 high-probability awards; a Looker panel auto-updates, letting staff tackle the most winnable grants first.

Outcome Reporting & Trust

Definition: the same data stream populates executive dashboards, sponsor ESG portals, and audit trails without manual effort.

Example: Nightly ETL pushes gifts, grants, and invoices into BigQuery; Looker refreshes a public “Operations Health” page before breakfast, giving sponsors real-time proof of spend efficiency.

Operations & Automation Pillars inside the Unified Tech Spine

Data Capture & Integrity

Definition Every gift, grant milestone, and volunteer hour is recorded once, travels by API, and is secured by single sign-on plus MFA.

Example A $250 Give Lively donation fires a webhook that lands in Salesforce NPSP within five seconds; Okta logs user + IP; the dedup report shows a 0.3 % duplicate rate—well under the 0.5 % target.

Orchestrated Workflows & Automations

Definition “No human babysitting”: monday.com, Zapier, or AWS Lambda run “When → Then” recipes, log every step, and flag failures.

Example A grant’s status flips to Due in 7 days—monday instantly spawns a Form 990 checklist, assigns the CFO, starts a 48-hour SLA timer, and posts the audit trail to BigQuery. Over 14 months the clinic misses zero grant deadlines, avoiding $5 k in late-submission penalties.

Intelligence & Decision Layer

Definition Machine-learning scores donors and grants in real time, while clean tables feed live dashboards.
Example Einstein GPT ranks a 1 000-donor file: 120 VIPs score > 80. Development calls 20 VIPs per day and closes 18 % of them, compared with 6 % before scoring. A Looker dashboard refreshes nightly to show LTV, CAC, and multigift rates.

Outcome Reporting & Trust

Definition The same data stream populates donor receipts, sponsor ESG dashboards, board KPI portals, and public impact pages, hands-free.

Example Athena and Hikma push nightly CSVs to BigQuery; Looker auto-publishes an “Impact Microsite” each quarter, while a JSON feed updates a corporate sponsor’s ESG portal at 00:05 ET. Sponsor renewals jump from 71 % to 93 %, and board members stop asking for PDFs.

monday.com Clinic “OS” what each piece is and why we need it

monday.com is a code-free workspace where clinics create boards, automations, and dashboards so prescriptions, surveys, and compliance tasks run themselves and update metrics instantly.

Pharmacy Program board

What it is A single board where every prescription lives from “Requested” to “Picked Up,” including refills and insurance-auth status.
Why we need it It replaces the phone-tag notebook and inbox searches, so techs know today’s workload at a glance can trace any script in seconds. No-show pickups trigger automatic text nudges instead of day-end detective work.

Patient Questionnaires board

Our patient questionnaires are fully iPad-ready, using responsive monday forms that auto-resize for any screen size and can be edited on the fly—so nurses can tweak a question in seconds and every kiosk or tablet shows the updated version immediately.

Sterilized Project-Management ecosystem

What it is A master board that tracks every initiative—flu-shot drive, mobile-unit upgrade, grant implementation, and links out to task boards in pharmacy, questionnaires, IT, and facilities.
Why we need it Execs finally get one Gantt view of everything in flight, each task inherits a phase, budget line and risk color, and finance sees overspend alerts before month-end close. It turns side-thread email chains into auditable workflow.

Clinical Care Inside a Unified Tech Spine

Data Capture & Integrity

One patient record lives in a single EHR and syncs everywhere, even offline.

Example: A vitals form entered in Hikma on a mobile tablet during a street-outreach visit stores locally, then uploads to AthenaHealth as soon as the device hits Wi-Fi—no double-charting, no lost data.

Orchestrated Workflows & Automations

Definition When → Then" rules automatically create follow-ups, labs, and reminder texts the moment a chart closes.

Example: Closing a chart with an uncontrolled-diabetes code triggers monday.com to ① book a tele-visit two weeks out, ② place a lab order, and ③ text the patient in English/Spanish—no manual clicks.

Intelligence & Decision Layer

AI scans fresh data and highlights who needs help first.

Example: Athena's note-assist spots a patient's A1c rise above 9.0, tags her "High-Risk Diabetes," and moves her into tomorrow's huddle queue before staff arrive.

Outcome Reporting & Trust

Definition The same data feeds live dashboards for clinicians, board, donors, and regulators—no Friday spreadsheets.

Example: Nightly ETL pushes de-identified outcomes into BigQuery; Looker refreshes a public "Impact" page showing no-show rates dropping from 18 % to 12 %, giving funders real-time proof of success.

HIKMA HEALTH

Hikma Health is an open-source, offline-first electronic health-record system designed for free and charitable clinics that work in bandwidth-starved environments. Staff enter vitals and SOAP notes on an Android tablet; the data are AES-encrypted locally and automatically sync to the cloud—then into Athena or a BigQuery lake—whenever the device finds any connection, eliminating double-entry and paper charts. The interface is multilingual (English, Spanish, Arabic, Haitian Creole, and more) and includes a built-in social-determinants dashboard that scores housing, food and transport risk; patients whose score or A1c crosses a red line are flagged for priority follow-up. Simple webhooks let clinics tie those flags to monday.com or Twilio so a high-risk diabetes visit can trigger a tele-appointment, lab order and bilingual reminder text without staff intervention. In a six-month a free pilot clinic, Hikma cut average charting time from 12 to seven minutes, doubled mobile-outreach visits, and trimmed 30-day CHF readmissions from 11 % to 8.3 %—all on a software license cost of zero

Bottom line: the alert framework turns Hikma from a passive chart into an active early-warning system, so clinicians intervene sooner, navigators act on social crises the same day, and IT never loses data in the field.

Phase 1: Planning & Research

- **Goals: Understand the grant requirements and outline the application.**
- Tools:
- Instrumentl or GrantStation – Identify funding opportunities.
- Notion / Trello / Asana – Task board for deadlines, roles, deliverables.
- Google Drive – Shared folders for guidelines, templates, references.

Goals: Write the narrative, budget, and attachments.

Tools:

ChatGPT or Jasper – Generate draft sections (mission, need statement, etc.).

Google Docs – Collaboratively write and track changes.

Grammarly – Improve grammar, tone, and clarity.

Canva – Design infographics, charts, visuals.

Excel / Google Sheets – Build the budget with templates.

Phase 2: Drafting the Proposal

Phase 3: Review & Edit

Goals: Ensure compliance, clarity, and compelling storytelling.

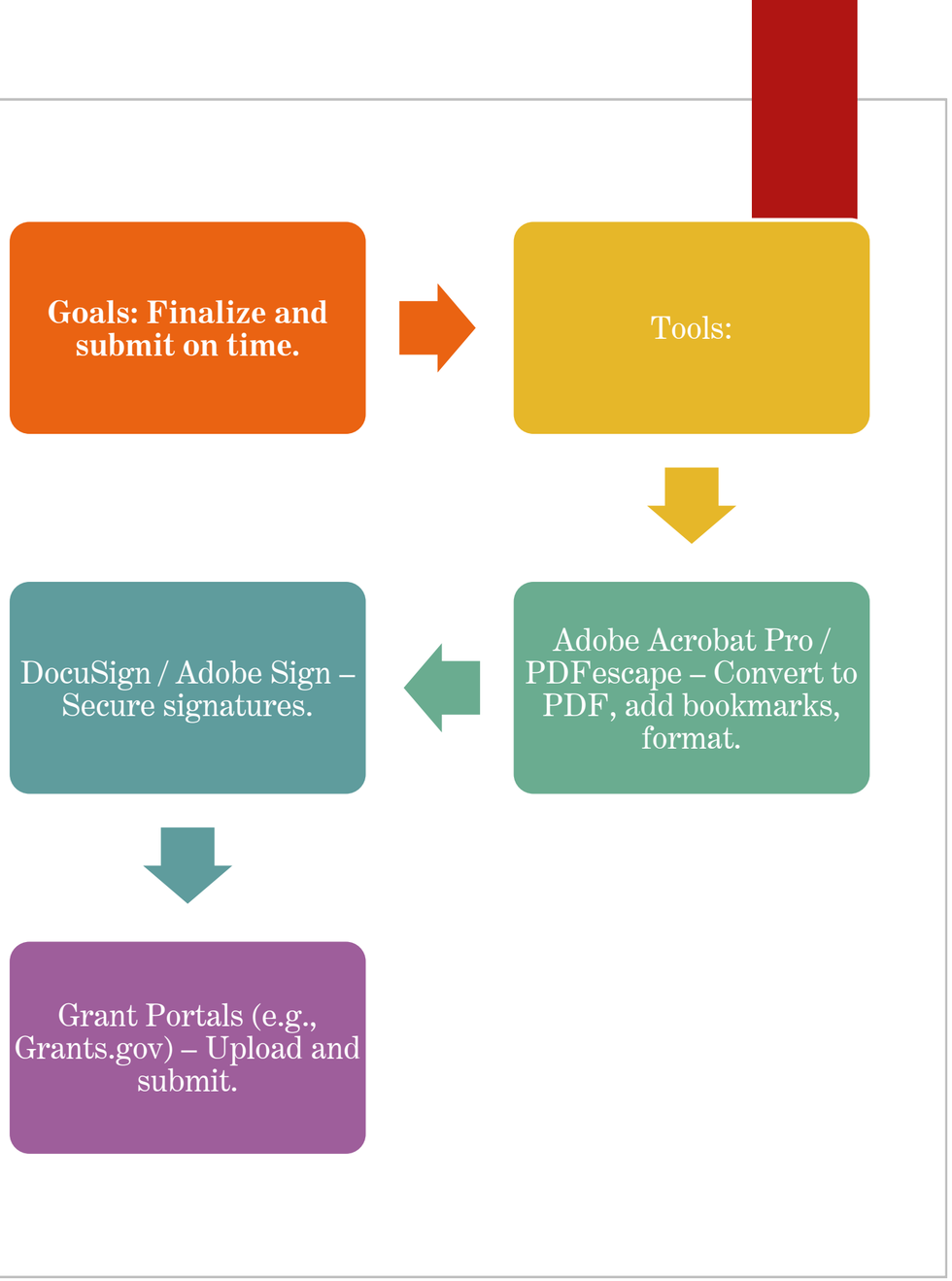
Tools:

Linguix or Hemingway Editor – Check readability, sentence length, passive voice.

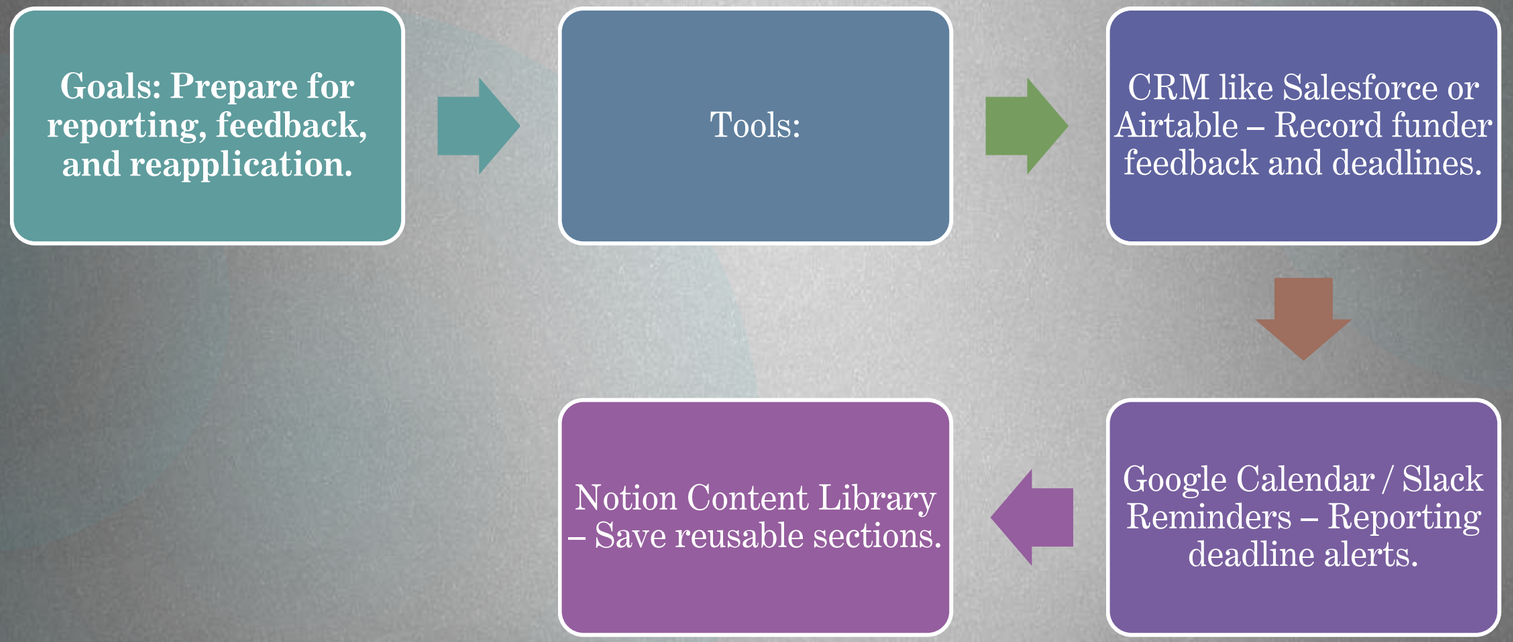
Google Docs Comments / Word Track Changes – Feedback and approval.

Version Control – Use OneDrive or Dropbox for draft management.

Phase 4: Submission



Phase 5: Post-Submission Tracking



🎯 Sample Tech Toolkit Summary

- Purpose | Tool(s)
- Research & Planning – Instrumentl, Notion, Trello
- Writing & Editing – ChatGPT, Google Docs, Grammarly
- Budgeting – Excel, Google Sheets
- Review & Collaboration – Hemingway, Google Docs Comments
- Submission – Adobe Acrobat, DocuSign
- Follow-up & Tracking – Airtable, Google Calendar

ADVANCING MENTAL HEALTH AND WELLNESS AMONG ADULT HOMELESS MEN

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OUM – Pre-clinical Student

This project was supported by a grant from the Florida Association of Free and Charitable Clinics (FAFCC)

Abstract

- **Background**: The Miami Rescue Mission Clinic (MRMC)، a free and charitable clinic، is affiliated with the Miami Rescue Mission (MRM) Caring Place Center that provides annually over ٦٠٠،٠٠٠ free meals and ١٤٠،٠٠٠ nights of safe shelter to the homeless.
- **Problem**: Two-thirds of homeless adults' report substance use، mental health problems، and about one in four meets the criteria for a severe mental illness، compared to one in ١٧ adults in the general U.S. population. The incidence of these disorders is vastly higher among people who have been homeless long-term.
- **Methods**: Descriptive correlational design using a non-random convenience sample of sheltered homeless men، to evaluate the impact of weekly health literacy sessions on anxiety، depression، blood pressure (BP)، blood glucose (BG)، and weight over a ٣-month period.
- **Interventions**: Weekly patient education، **meditation**، exercises، BP، BG، and weight measurements were conducted at each session to ٢٠ at-risk homeless men diagnosed with diabetes (DM)، hypertension (HTN)، and obesity who resided at the MRM Caring Place Center from January ٢٠٢٤ to April ٢٠٢٤.
- **Results**: The mean age of the participants was ٥٨.٥٧ years. The mean recorded Systolic BP of the participants was ١٣٣.٥٥، mean Diastolic BP ٧٩.٣٠، mean heart rate (HR) ٧٧.٨٩، and mean BG ١٦٩.٩٤mg /dl. The past family history of DM and HTN was prevalent among participants، with ٤٤٪ reporting previous family history of DM and ٥٥٪ with a family history of HTN. Only ١٧٪ of the participants reported that they did not understand or manage their current diagnosis of DM or HTN، while the majority (٨٣٪) believed that they understood and managed their current diagnoses.
- **Conclusions**: There was improvement in knowledge and disease management، increased involvement in diet and exercise، and minimal changes in blood pressure، weight gain or loss، and depression or anxiety.

Research Purpose and aim

The purpose of this study was to:

١. **identify and screen twenty** (٢٠) adult sheltered homeless men between ٢٥ – ٧٥ years of age experiencing anxiety، depression، using the PDQ-٩ Depression Questionnaire and GAD-٧ Anxiety Scale، diabetes mellitus (DM) and diabetes-related complications، hypertension (HTN)، obesity using blood glucose (BG)، anthropometric monitoring، **and knowledge of chronic diseases**.

٢. promote health education through scheduled lectures، exercise، meditation، and peer mentoring referred to as “the buddy system” during a ٣-month intervention program aimed at helping them manage and improve their health through culturally competent patient education and training.

Aim:

This study aims to examine the feasibility، acceptability، and effectiveness of a hybrid health education and wellness program among residential homeless men by conducting a descriptive correlational research design using a non-random convenience sample.

Background

- Homelessness is a crisis and presents unique barriers to holistic healthcare and measurable gaps that affect thousands of Floridians at any point in time, bringing with it multifaceted mental and physical health disorders.

- Research has established that individuals who are experiencing homelessness are more likely to experience symptoms of depression and anxiety than the public.

- Due to a lack of access to health services, homeless individuals can also suffer from multiple diseases such as HTN, DM, coronary artery disease, and poor nutrition. In many homeless patients, these illnesses can occur simultaneously and not taking care of one's existing illness can be a tell-tale sign of undiagnosed depression.

Instruments

Anxiety

- **General Anxiety Disorder-7 (GAD-7)**
- The GAD-7 Scale is an easy-to-score, self-report measure of core generalized anxiety disorder symptoms.
- The GAD-7 Scale has good internal consistency and convergent validity with depression, anxiety, stress and worry, and is sensitive to change.

Depression

- **The Patient Health Questionnaire-9 (PHQ-9)**
- The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression.
- The tool rates the frequency of the symptoms which factors into the scoring severity index.
- Established validity of the PHQ-9
- PHQ scores ≥10 had a sensitivity of 88% and a specificity of 88% for major depression

Research Questions

1. Among residents with moderate to severe depression or anxiety, is the pattern of change to mild or minimal depression or anxiety attributed to the health education and training interventions on meditation, diet, exercise, and monitoring drug therapy?

2. Among residents with body mass indexes (BMIs) greater than or equal to 26, stage I or higher blood pressure BP), and blood glucose (BG) greater than or equal to 110 g/dL, is the pattern of change in BMIs to less than 26, BP normal, and BG less than 110 g/dL attributed to the weekly anthropometric measurements, health education and training interventions on meditation, diet, exercise, and monitoring drug therapy?

Research Design and Hypotheses

Research Design: Descriptive correlational design using a non-random convenience sample.

Hypotheses:

Hypothesis 1: Homeless men participating in the Advanced Mental Health and Wellness Initiative will demonstrate a reduction in feelings of depression or anxiety across two measures in time (baseline and twelve weeks).

Hypothesis 2: Homeless men participating in the Advanced Mental Health and Wellness Initiative will demonstrate normalization of blood glucose, blood pressure and weight across two measures in time (baseline and twelve weeks).

Project Goals and objectives

- **The main goal** of this study was to increase access to comprehensive quality healthcare services and education (Healthy People ﷺHP ، ٢٠٣٠) for homeless individuals with limited access to health education ، health literacy ، mental health services ، and wellness programs .
- **Sub Goal I** : Provide DM ، HTN ، Obesity ، and Mental health education to ٢٠ homeless individuals weekly x ١٢ weeks
- **Objectives** :

i . Identify and enroll a maximum of ٢٠ MRMC patients diagnosed with DM ، HTN ، obesity ، anxiety or depression in weekly educational sessions by month ٠١ .

ii . Educate and train participants on the use and interpretation of blood glucose monitoring devises and digital blood pressure machines by month ٠٢ .

iii . Educate and provide therapeutic management to project participants in Months ٠١ to ٠٣

Population

- Beginning project population: 20 males (enrolled at the onset of project)
- Ending project population: 19 males
  - African Americans: 8; White: 5; Hispanic: 3; Haitian: 2
  - Mean age: 58.57 years
  - Tri-modal: 62 years
  - Age range: 29 to 74 years
- Meeting Project Criteria:
  - HTN = 15 (75 %)
  - DM = 12 (50%)
  - HTN and DM: 10 (50%)
  - Obesity [BMI> 26] + HTN or DM: 15 (75%)

Methods

The Advancing Mental Health and Wellness Initiative provided direct and indirect services to ٢٠ homeless men experiencing substance abuse، behavioral health disorders، and comorbid conditions that included DM، HTN، and obesity in an outpatient setting over ١٢-weeks (١/١٧/٢٠٢٣ to ٣/٣٠/٢٠٢٤).

- All residents admitted to the residential facility were screened for anxiety، using the GAD-٧، and depression، using the PDQ-٩، during their intake physical at the MRMC. A follow-up GAD-٧ and PDQ-٩ was completed by participants at the end of the project.

  The project activities included:

- Agency approval
- Identification of target audience ﷺmales between ٢٥ to ٧٥ years of age رضي الله عنه
- Participant signed consent
- Pre-post testing
  - Knowledge of DM، HTN، Obesity، Anxiety، Depression
- Weekly ١.٥ hours sessions
  - Meditation، BP، BG، weights، health education، health literacy، and wellness رضي الله عنهdiet and exercise ﷺprograms.

Methodology

- Following MRMC BOD approval, authorization was granted by both the MRM Center and Clinic to conduct the project.
- All residents meeting the criteria wishing to participate in the project were invited to attend the first on-campus introductory session.
- Once persons agreed to participate by signing a consent to participate, a review of their electronic medical records was conducted to confirm their medical diagnoses.
- A pre-test identifying knowledge of DM and HTN was administered.
- Baseline BP, BG, weight was obtained by researchers; initial GAD 7 and PDQ 9 scores were obtained from the EMR (if available).
- Project equipment was purchased through grant funds and delivered by the MRM clinic staff to the MRM Center's Case Managers' office.

Methodology continued

- The case manager's office staff issued the equipment to identified participants under the direction and supervision of the project director.
- Weekly sessions were scheduled through the case manager's office and announcements were made to participants to join the session located in a large recreation room adjacent to the offices of three onsite case managers for constant supervision.
- Sessions included:
  - BP, BG, and weight was measured at the beginning of each session.
  - Lectures were presented on DM, HTN, heart disease, stroke, obesity, diet/exercise, depression, anxiety, and substance use / recovery.
  - Brochures were provided along with step-by-step instructions on the use of all equipment provided with opportunities for return demonstration.
  - Live interactive exercises with movement to music culminated the 1.5-hour weekly project sessions.

Methodology continued

- A sign-in sheet was provided at each session and collected by the case manager and emailed to the project director.
- The project director reviewed the weekly recordation of participants' weight, BP, and plasma glucose, if taken.
- The project director reviewed and referred participants to the MRM clinic for management of elevated BP or blood glucose ranges, if indicated.
- At the end of the project, participants were assigned an accountability partner (Case Manager) who served as the "buddy" to reinforce the teachings and to provide support when needed.
- A 5-day Challenge booklet was also provided to participants wishing to have a buddy following the end of the project. The 5-day challenge booklet allowed participants to record their activities, challenges, and reflections for a 5-day week. Weekends were not cluded to allow residents time off for rest and relaxation.

Equipment and Supplies Provided

- Glucometers with strips (lancets were not issued but made available to participants in the 24-hour Case Manager’s office).
- Digital BP machines with size appropriate cuffs.
- Pedometers with digital read-outs.
- Exercise (yoga) mats
- Upright balanced scale
- BP, glucose, and weight recording charts
- Medical identification cards
- Lap top computer with SIM card for virtual meetings with personal trainer.
- Hand sanitizers, alcohol preps, and cleaning wipes
- Bottled water

Completed Activities

- Completed and signed participant agreements.
- Completed medical record reviews including medications and lab results.
- Completed attendance rosters at each education session.
- Provided weekly live interactive educational sessions.
- Completed pre-test and final posttest.
- Completed trend reports on vital signs (BP), weight, and plasma glucose.
- Follow up Post-GAD 7 and Post-PDQ 9.
- 5-Day Challenge Book distribution and collection

Hypothesis I

Hypothesis 1: Reduction in Depression or Anxiety

- Paired Sample Statistics: Pre-GAD vs. Post-GAD
- **Pre-GAD** (General Anxiety Disorder scale):
  Mean: 6.71 (SD = 6.525, SE = 2.466)
  Confidence Interval (CI): [2.57, 11.43]
- **Post-GAD**:
  Mean: 5.43 (SD = 5.287, SE = 1.998)
  CI: [2.15, 9.29]

Interpretation:

- **Reduction in GAD scores**: A decrease from 6.71 to 5.43 indicates a moderate reduction in anxiety levels, although the confidence intervals overlap. This suggests that the decrease may not be statistically significant without further tests or larger sample size.
- Variation: Standard deviations are relatively high (Pre-GAD: 6.525, Post-GAD: 5.287), indicating variability among participants. Small sample size (N = 7) further limits generalizability.

Paired Sample Statistics: Pre-PDQ vs. Post-PDQ

- Pre-PDQ (Patient Depression Questionnaire):
- Mean: 7.00 (SD = 8.185, SE = 3.094)
- CI: [2.00, 13.28]
- Post-PDQ:
- Mean: 5.00 (SD = 3.215, SE = 1.215)
- CI: [2.86, 7.14]

Interpretation:

- **Reduction in PDQ scores**: A decrease from 7.00 to 5.00 indicates a modest reduction in depressive symptoms. However, overlapping confidence intervals again raise concerns about statistical significance.
- **Variation:** High standard deviation for Pre-PDQ (8.185) reflects diverse responses among participants. Improvements are less variable post-intervention.

Hypothesis 2

- **Hypothesis 2: Normalization of Physiological Metrics**
- While the data above does not directly report on blood glucose, blood pressure, and weight, additional analysis is required to interpret any meaningful changes in these parameters. For now:
- Sample Demographics:
- Hypertension (HTN) affects 61% (33 participants).
- Diabetes mellitus (DM) affects 0.5% (3 participants), while 20% (11 participants) have both HTN and DM.
- Obesity combined with HTN or DM affects 74% (40 participants).

Interpretation:

- The high prevalence of HTN and obesity suggests these are critical areas of focus for normalization.
- Blood glucose, blood pressure, and weight outcomes across time would provide further insight into the program's success in meeting this hypothesis.

Conclusions

- Hypothesis 1 (Reduction in Depression/Anxiety):
  - Modest improvements in both anxiety (GAD) and depression (PDQ) scores suggest potential benefits of the intervention, though the small sample size and overlapping confidence intervals warrant caution in concluding effectiveness.
- Hypothesis 2 (Normalization of Physiological Metrics):
  - Specific results on physiological outcomes (e.g., glucose, BP) are not included but would require separate analysis to determine success.
- Demographic Considerations:
  - The sample's heterogeneity (age, race, health conditions) and prevalence of HTN/obesity highlight diverse participant needs, which might have influenced the outcomes.

Paired Sample Correlation

Hypothesis 1: Reduction in Feelings of Depression or Anxiety

- Paired Sample Correlation: Pre-GAD vs. Post-GAD
- Correlation Coefficient (r): 0.772
- One-Sided p: 0.021 (significant at the 0.05 level)
- Two-Sided p: 0.042 (significant at the 0.05 level)
- 95% CI for Correlation: [0.437, 0.997]

Interpretation:

- A strong positive correlation (r = 0.772) between baseline (Pre-GAD) and follow-up (Post-GAD) scores indicates a consistent pattern of reduction in anxiety.
- The significant p-values (both one- and two-sided) suggest that the observed changes in GAD scores are unlikely to be due to random chance.
- The confidence interval is relatively tight, further reinforcing the reliability of the correlation.

Paired Sample Correlation: Pre-PDQ vs. Post-PDQ

- Correlation Coefficient (r): 0.608
- One-Sided p: 0.074 (not significant at the 0.05 level)
- Two-Sided p: 0.147 (not significant at the 0.05 level)
- 95% CI for Correlation: [-0.241, 0.947]

Interpretation:

- A moderate positive correlation (r = 0.608) suggests some consistency in the pattern of reduction in depression. However, the p-values are not statistically significant, indicating the changes in PDQ scores may not be robust or consistent across participants.
- The wide confidence interval includes 0 and negative values, indicating high variability and less certainty about the relationship.

Pre- and Post-Intervention Mental Health Measures (GAD, PDQ)

- **Pre-GAD** (Generalized Anxiety Disorder) Mean: 5.36, Std. Dev: 5.71, N: 11
- Indicates a moderate average level of anxiety at baseline with substantial variability among participants (high standard deviation).
- **Post-GAD** Mean: 7.09, Std. Dev: 5.94, N: 11
- The increase in mean anxiety scores from baseline suggests that anxiety may not have reduced after the intervention. The variability remains high.
- **Pre-PDQ** (Patient Health Questionnaire - Depression) Mean: 5.91, Std. Dev: 6.79, N: 11
- Reflects moderate levels of depression at baseline with high variability.
- **Post-PDQ** Mean: 5.82, Std. Dev: 4.64, N: 11
- A slight decrease in depression scores is observed, but the change is minimal. The variability is reduced post-intervention.

Physiological Measures

- SBP (Systolic Blood Pressure) Mean: 133.55, Std. Dev: 15.89, N: 20
- Indicates average blood pressure in the hypertensive range (Stage 1 Hypertension). High variability suggests that some participants had blood pressure in the normal range, while others were higher.
- DBP (Diastolic Blood Pressure) Mean: 79.30, Std. Dev: 8.37, N: 20
- Within the high-normal range for diastolic pressure, with moderate variability.
- HR (Heart Rate) Mean: 77.89, Std. Dev: 12.79, N: 18
- Averages in the normal range (60-100 bpm), with some participants exhibiting higher or lower values.
- BG (Blood Glucose) Mean: 169.94, Std. Dev: 115.27, N: 17
- The mean blood glucose level is well above the normal range (<110 mg/dL), suggesting that many participants may have poorly controlled glucose. The extremely high standard deviation indicates substantial variability, with some participants possibly closer to the normal range.
- WT (Weight) Mean: 193.95 lbs, Std. Dev: 42.13, N: 20
- Average weight suggests most participants were overweight or obese, consistent with BMI values above 26.

GAD-7 SCORING and CLASSIFICATION
0 to 4 Minimal anxiety symptoms
5 to 10 Mild anxiety symptoms
10 to 14 Moderate anxiety symptoms
15 to 21 Severe anxiety symptoms

PHQ-9 SCORING and CLASSIFICATION
5 to 9 Minimal symptoms
10 to 14 Minor depression
15 to 19 Major depression, moderately severe
> 201 Major depression, severe

CorrelationS

	Pearson R	Sig (2-tailed)	Lower	Upper
Pre-GAD-Post-GAD	0.772	0.042	0.046	0.964
Pre-GAD-Pre-PDQ	0.924	0.000	0.726	0.980
Pre-GAD-Post-PDQ	0.683			
Pre-PDQ-Post-PDQ	0.608			
Pre-GAD-SBP,HR,WT	<0.1			
Pre-GAD-BG	0.526	0.118	-0.155	0.868

Evaluation of Results

- A Pretest was given at the beginning of the project followed by a Posttest given at the end of the 3-month period to assess residents increase in health knowledge regarding hypertension, diabetes, obesity/ nutrition, exercise, managing anxiety and depression.
- The residents received a pre- and posttest GAD-7 and PDQ-9
- An Aggregate Analysis of all the questions was performed and showed an increase in knowledge by 10% correctly answering the questions.
    - The residents demonstrated an increase in knowledge of the disease processes (hypertension, diabetes, and obesity [including sustained exercise regimens]) and the appropriate measures to reduce the negative consequences of the disease.
    - Evaluation of interim results and how knowledge of healthy lifestyle habits impacted a change leading to improvement in biometrics is ongoing.

Conclusion

Due to a lack of access and follow up, many homeless persons experience preventable or treatable illnesses that can provide a healthier quality of life. Unless timely interventions are provided, even in the face of a pandemic, there are actionable measures that can be taken to provide education and disease management to the homeless population.

This project provided one method that worked and benefitted the participants by educating them on their disease processes, how to manage their disease, and what equipment is necessary for monitoring and timely interventions. The death of the four homeless persons prior to the start of this project provided the impetus to initiate a virtual platform for measurable interventions to persons experiencing HTN, DM, and obesity.

Individuals participating in the project were empowered to take charge of their health, understand the signs and symptoms (warnings) that may require immediate interventions, as well as have available the necessary medical equipment to provide information to health care providers managing their care.

Onsite BP and Plasma Glucose Checks

The Caring Place

No One is Homeless

The **Least** – Not the least in worth, but those who have the greatest need and for whom we must care.

The **Last** – Who shall be first, if they are cared for with compassion and love.

The **Lost** – Who will be found, if there are those who would seek them

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The End

Q and A

MRMC

THANK YOU FOR YOUR ATTENTION

ANY QUESTIONS?

PRESENTATION - 2025

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