Community Health Team Cardiovascular Disease/Diabetes (CVD/DM) Expansion Program

Year 2 “Kick Off”

October 6, 2021

Agenda

1. Welcome and Introductions
2. Q2 Data Review
3. Self-Efficacy Data Review
4. Discussion

   Successes, challenges, or key takeaways from Year 1 of this pilot program

5. Year 2 Program Description
6. Questions and Next Steps

Introductions

Your name

Agency name

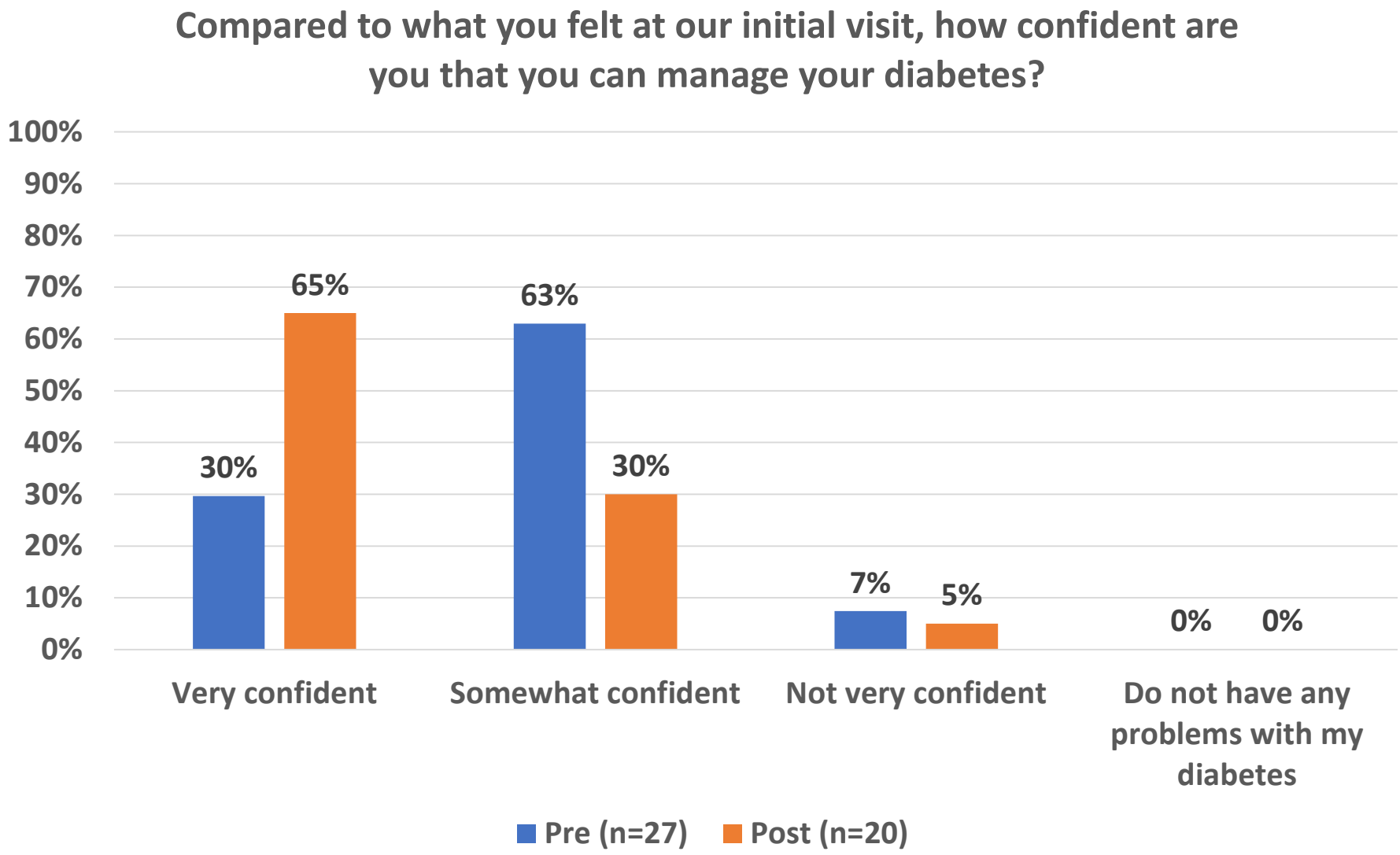
Your role within your agency

Your role within this program

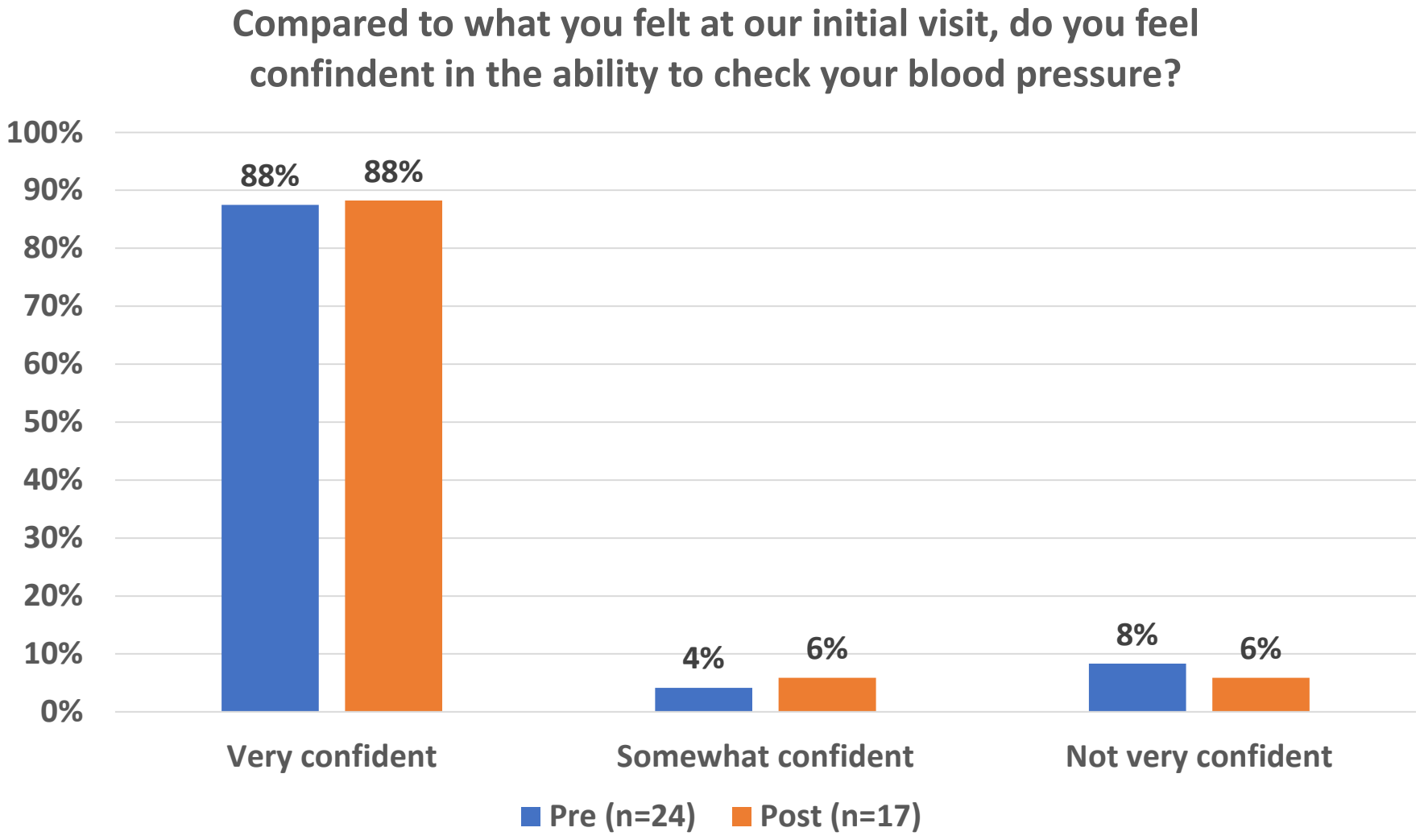
Combined Health Risk Assessment Results

(Baseline & Follow-up data)

Combined Health Risk Assessment Results



Combined Health Risk Assessment Results



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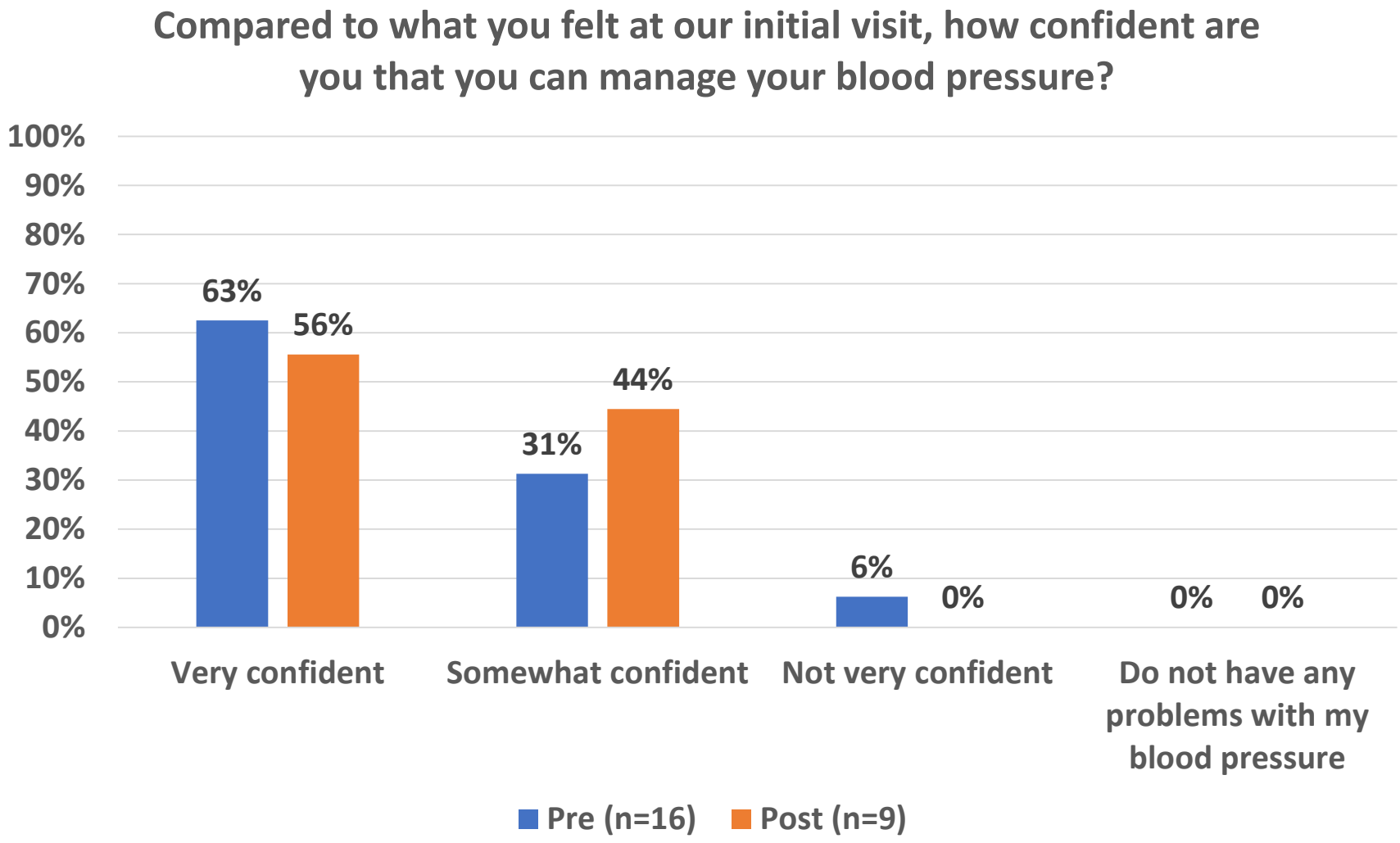
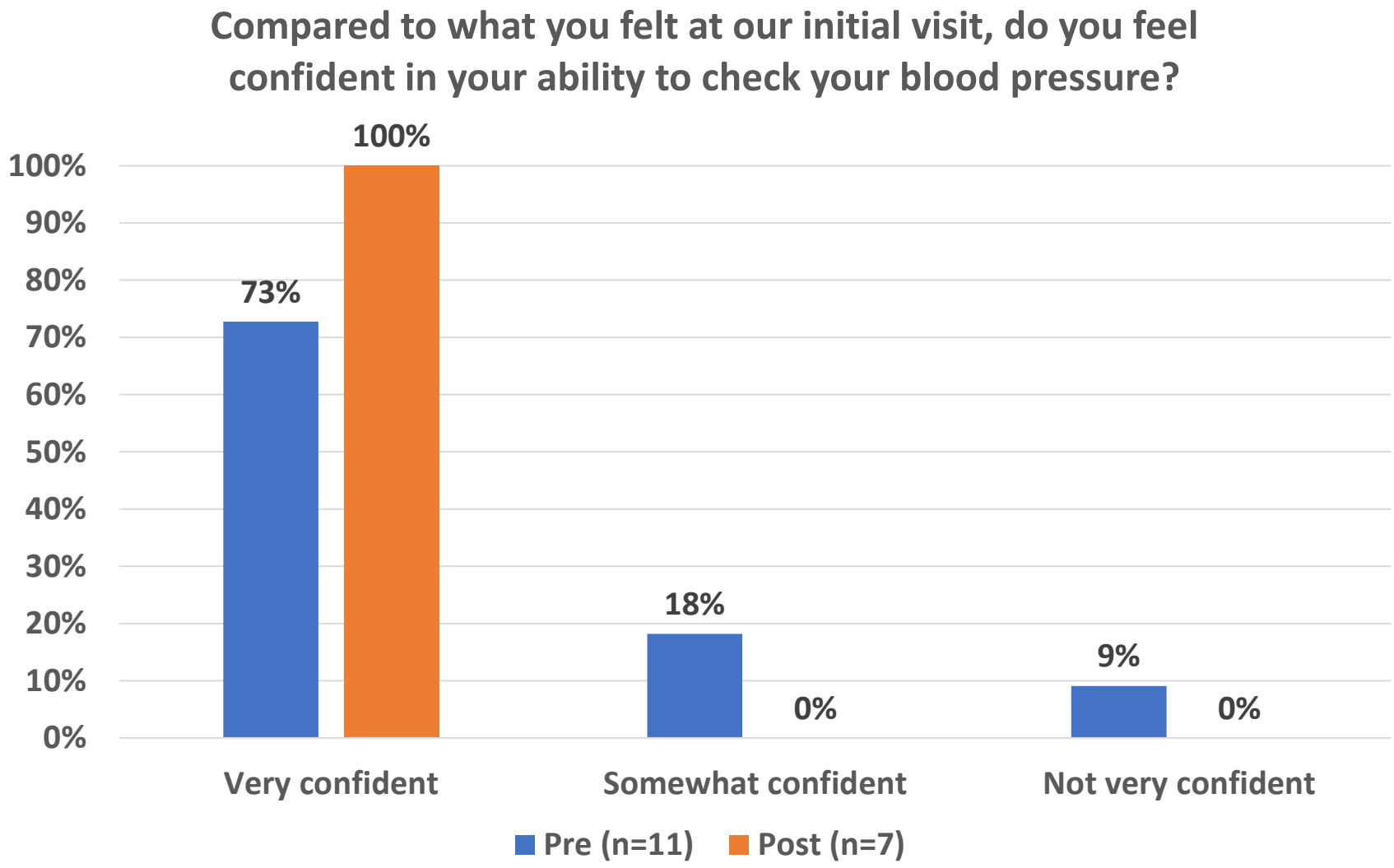
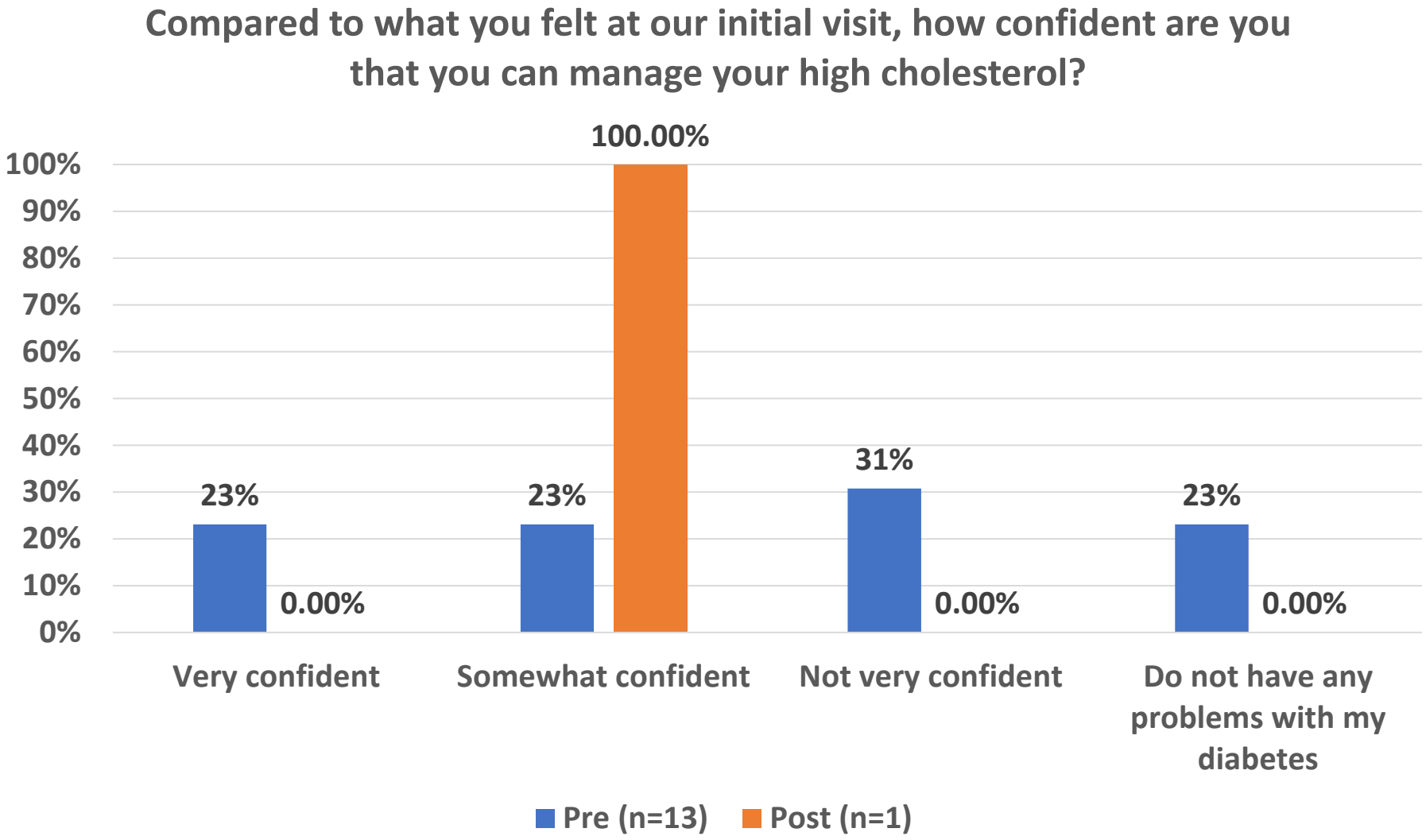


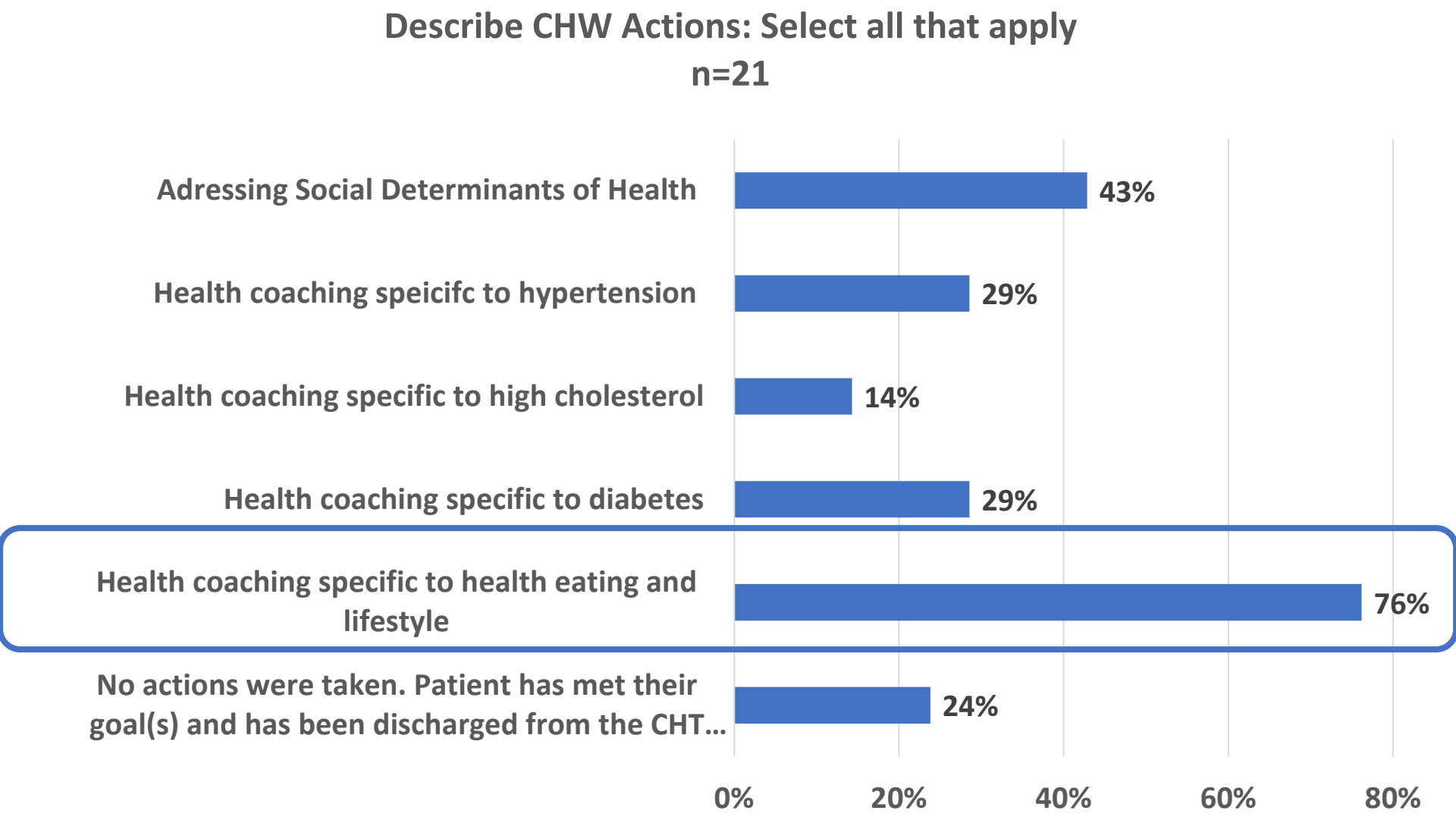
Combined Health Risk Assessment Results



Combined Health Risk Assessment Results



Combined Follow up Health Risk Assessment Results



Welcome Community Health Teams

Self-Efficacy Reflections

Focus of Presentation

CHT Final Self-Efficacy Comparison Data

- Aggregated Pre-& Post-Self-Efficacy Comparison
- Degree of Change

CHT Post-Pilot Gains

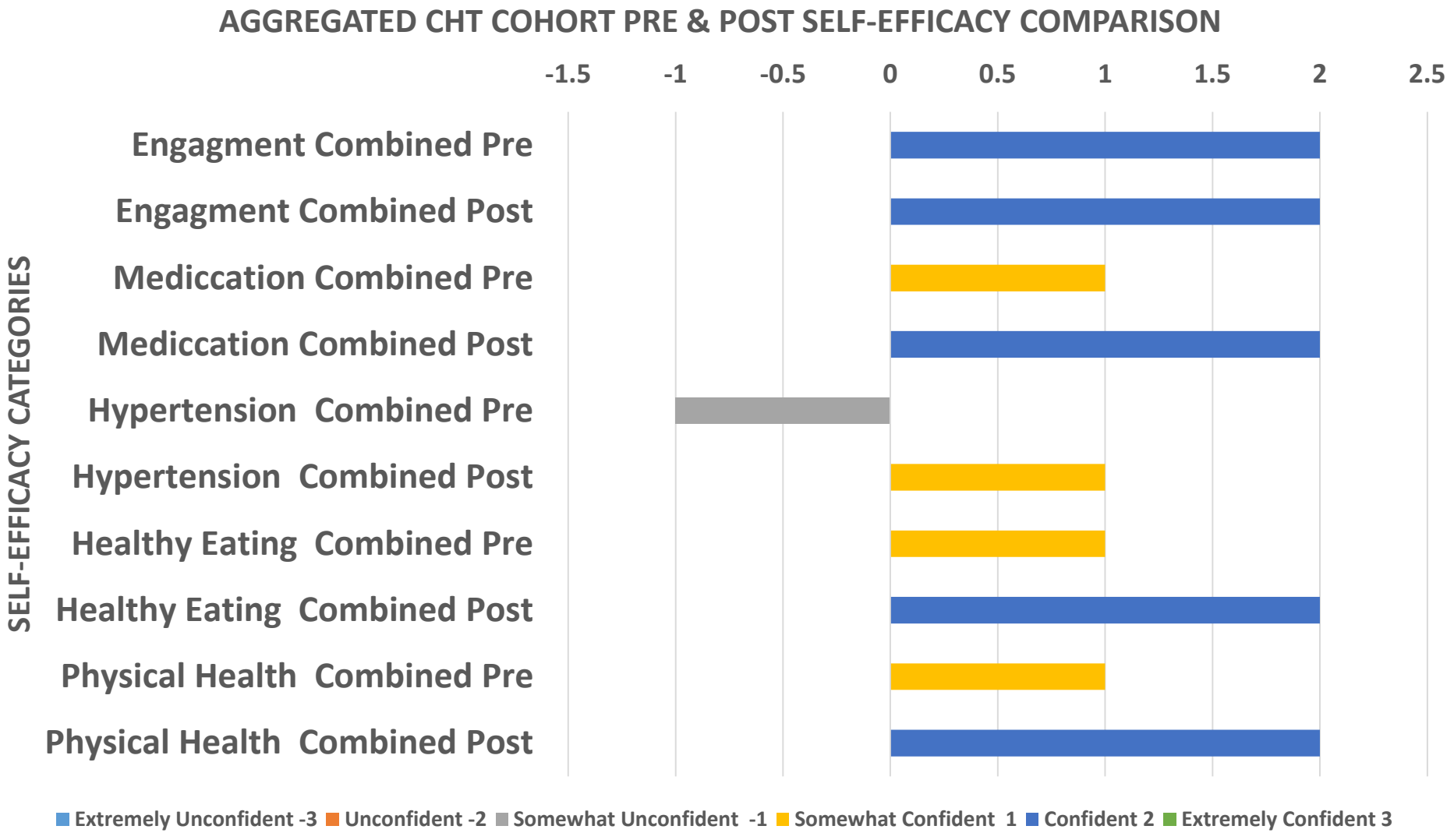
- Narrative Analysis
- Helpful Resources

Observations

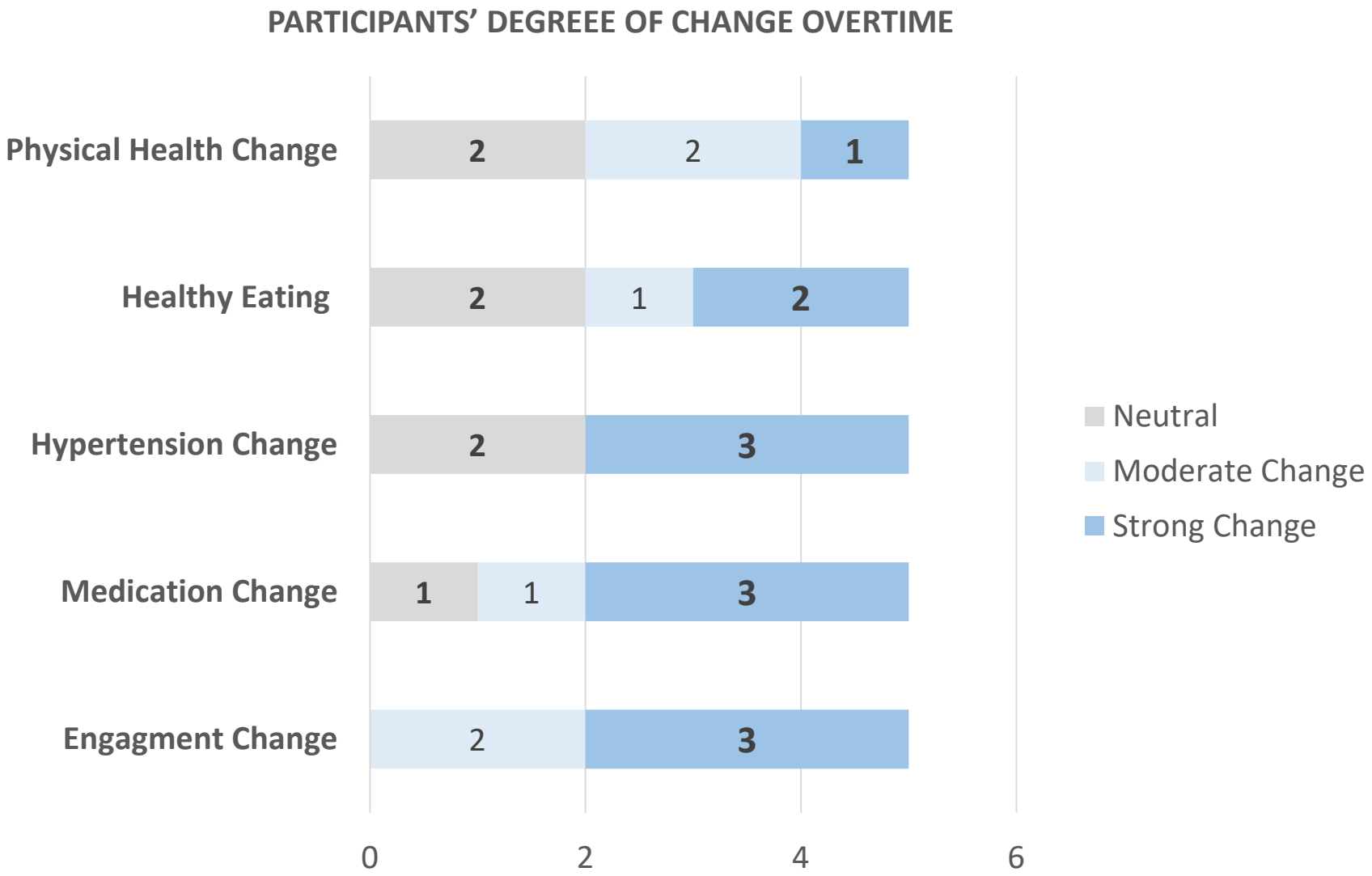
CVD-DM Final Comparison Data

- Aggregated Pre-& Post-Self-Efficacy Comparison
- Degree of Change

Retrospective Self-Efficacy Comparisons



Self-Efficacy Changes: Pilot vs Cohort



CHT Post-Pilot Gains

- Narrative Analysis

INCREASED KNOWLEDGE OF CHRONIC HEALTH CONDITIONS & THEIR CAUSES

I feel I have more knowledge

It has increased my confidence level.

I definitely feel more confident counseling patients on disease management now... I think it's important that I am now able to distinguish when a patient's questions are something that I can handle in my scope and when questions should be handled by a medical professional.

I have learned more about heart diseases and what causes them.

INCREASED AWARENESS OF STRATEGIES TO IMPROVE CHRONIC HEALTH CONDITIONS

Having materials ready to hand out and review with patient's has been very helpful.

I am thankful for the opportunity for additional training and education/ resources …

How closely related food is to disease

That a lot of times mental illness can be a contributing factor to the diseases

This training and project has absolutely made me a more well-rounded professional and given me knowledge and experience that I will continue to use in my career.

We still have multiple barriers with access to healthy food choices especially surrounding transportation because we serve such a rural population

BUILD SKILLS TO HELP PATIENTS UNDERSTAND & POSITIVELY IMPACT THEIR CHRONIC CONDITIONS

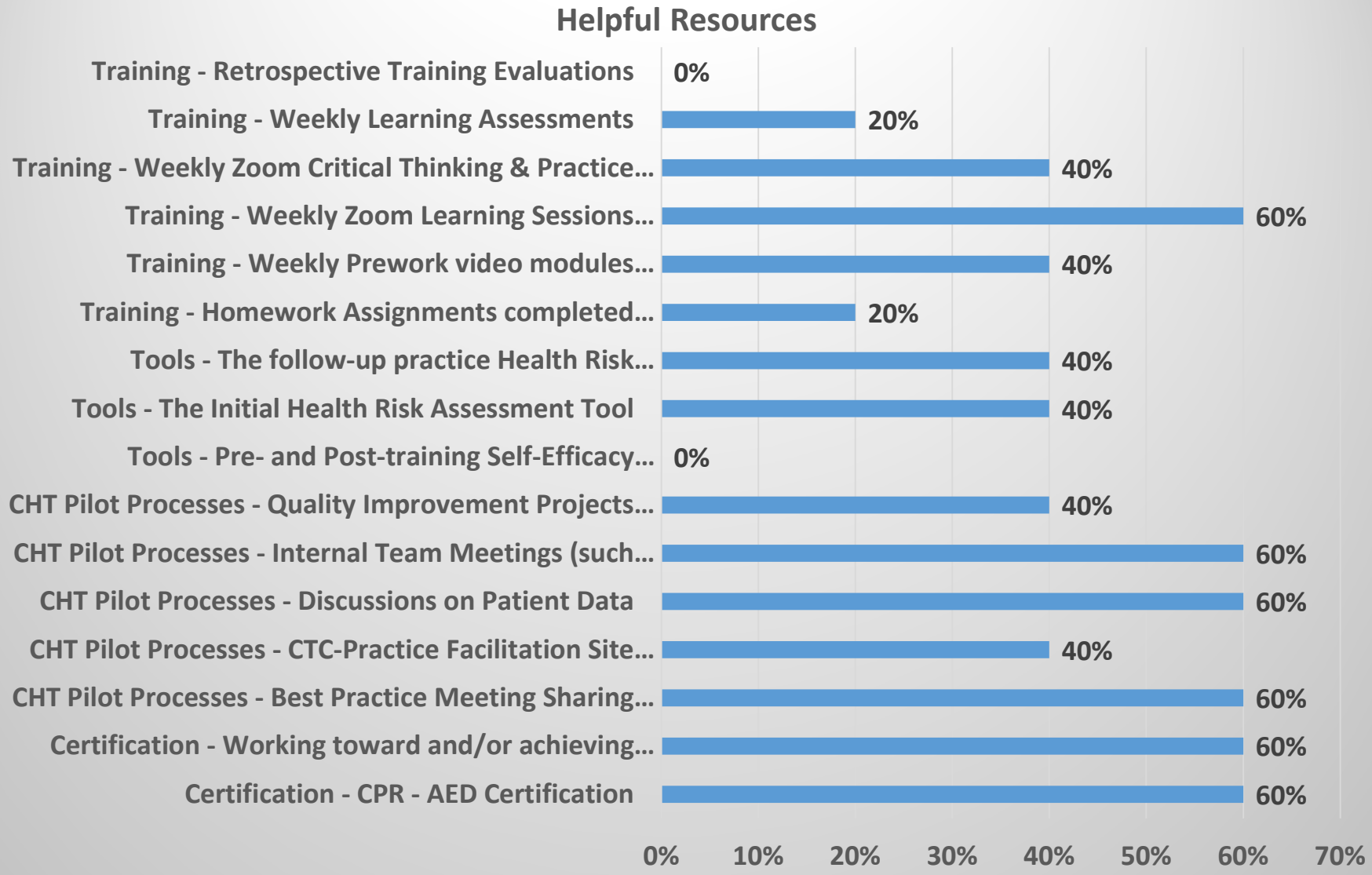
It has built my confidence in discussing disease management on a micro level with patients, where I previously felt more confident in the social work/macro public health level.

It has added knowledge that I can now share with my patient's.

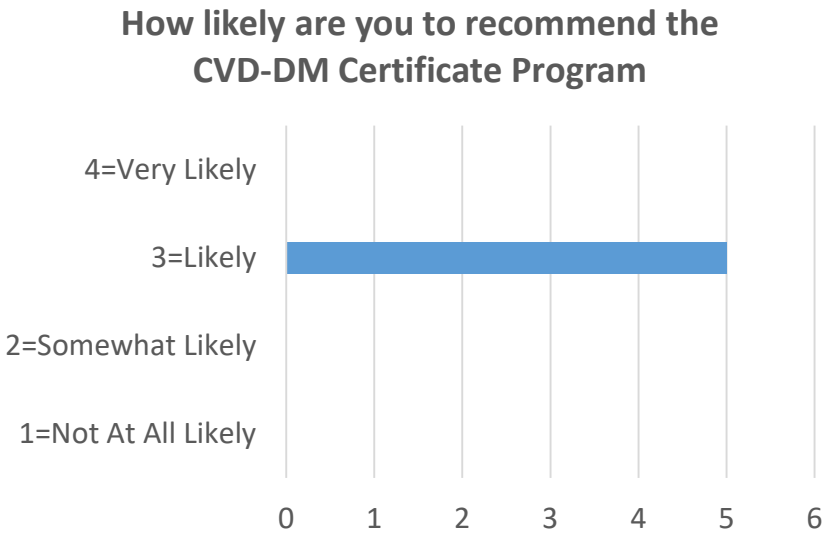
I can apply the training to all of the patients with whom I work

I have more prepared to walk into sessions with patients and talk about the health side of the Social Determinants of Health, not just the social part

Helpful Resources



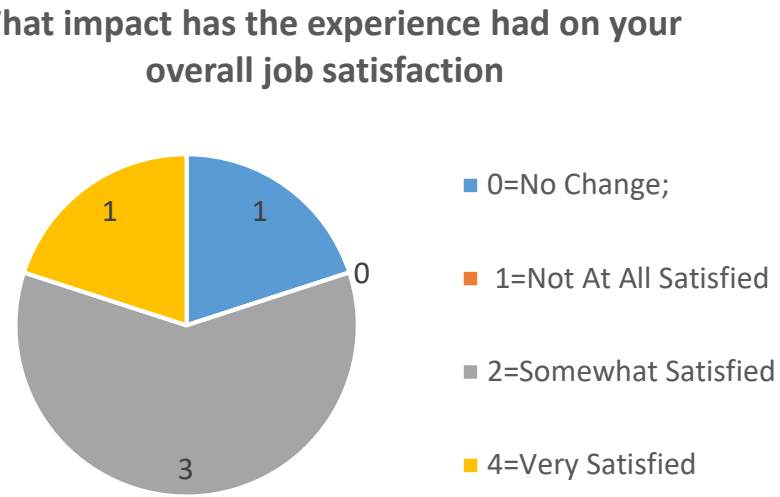
Reflections



I'm glad that goal setting and MI were part of this training so that the CHWs learned to apply this knowledge

I am thankful for the opportunity for additional training and education/ resources but it has not changed the overall job satisfaction.

This project has added a LOT of work to my role in addition to my regular job responsibilities. While I really enjoy participating in this project and think it is important for our patients, I think it is also important to consider how to work impacts front line staff in the decision making process for the next round



Discussion

Successes, challenges, or key takeaways from Year 1

Discussion Questions

EBCAP	
Successes	
Challenges	
Final Thoughts?	

South County Health CHT/Wood River	
Successes	
Challenges	
Final Thoughts?	

Thank you, Wood River Health Services!

Year 2 Program Description

Goals, structure, and deliverables

Centers for Disease Control and Prevention (CDC) Funding

"1815"	*Improving the Health of Americans Through Prevention and Management of Diabetes, Heart Disease, and Stroke*
"1817"	*Innovative State and Local Public Health Strategies to Prevent and Manage Diabetes, Heart Disease, and Stroke*
Category A	Diabetes Management and Type 2 Diabetes Prevention Strategies
Category B	Cardiovascular Disease Prevention and Management Strategies

Community Health Worker Strategies

Category A	Increase adoption and use of clinical systems and care practices to improve health outcomes for people with diabetes (e.g., HIT/EHRs, clinical decision support tools, learning collaboratives to improve quality of care)
Category B	Facilitate engagement of patient navigators/CHWS in high blood pressure and high cholesterol management in clinical and community settings

Pilot Aims

1. Improve clinical outcomes for patients with diabetes and CVD alongside meeting SDoH, behavioral health and substance use disorder needs

2. Enhance the skills of CHWs working in clinic and community settings
    - CVD/DM Specialty CHW training
    - Health Coaching for CVD/DM
    - Goal Setting for CVD/DM

Patient Selection

Uncontrolled Diabetes

Patients 18-75 years of age with diabetes, whose most recent HbA1c level is >9.0%

Uncontrolled Hypertension

Patients 18-85 years of age with hypertension, whose blood pressure at the most recent visit is uncontrolled (systolic blood pressure > 140 mmHg and diastolic blood pressure > 90 mmHg)

High Risk of Cardiovascular Events

Patients aged >= 21 years at the beginning of the measurement period with clinical ASCVD diagnosis

or

Patients aged >= 21 years at the beginning of the measurement period who have ever had a fasting or direct laboratory result of LDL-C >=190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia

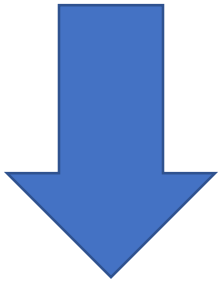
or

Patients aged 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes and with an LDL-C result of 70-189 mg/dL recorded as the highest fasting or direct laboratory test result in the measurement year or during the two years prior to the beginning of the measurement period

Referrals

1

Existing CHT Patients



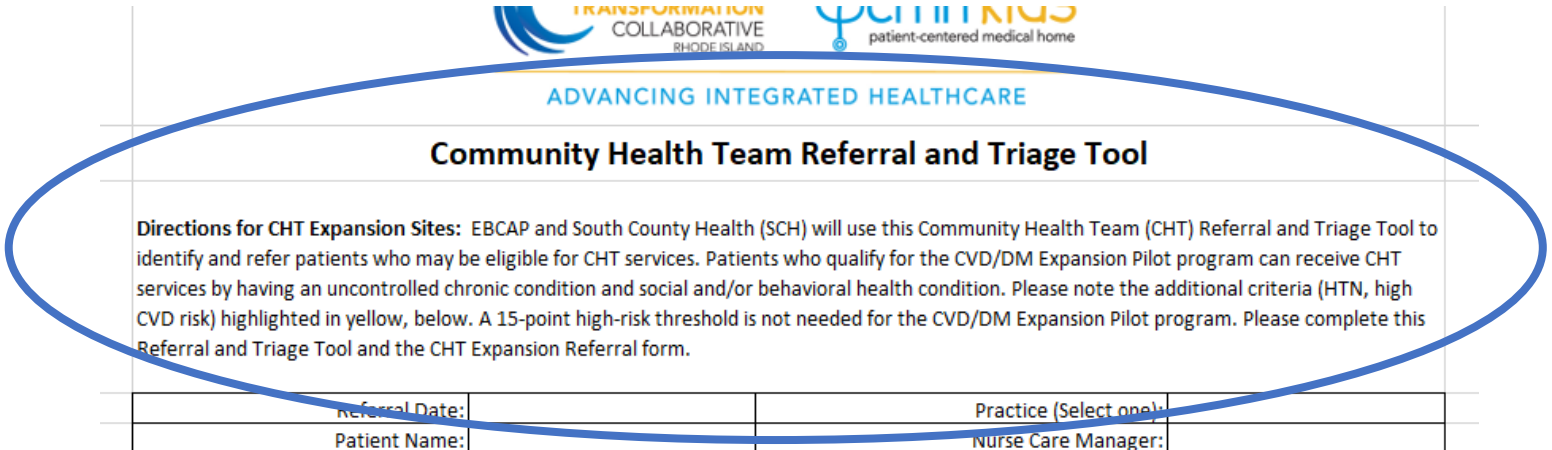
Complete the CVD/DM Referral Form

2

New CHT Patients

Complete the *updated* Referral and Triage Tool
&
Complete the CVD/DM Referral Form

Referral and Triage Tool



COLLABORATIVE RHODE ISLAND

patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Community Health Team Referral and Triage Tool

Directions for CHT Expansion Sites: EBCAP and South County Health (SCH) will use this Community Health Team (CHT) Referral and Triage Tool to identify and refer patients who may be eligible for CHT services. Patients who qualify for the CVD/DM Expansion Pilot program can receive CHT services by having an uncontrolled chronic condition and social and/or behavioral health condition. Please note the additional criteria (HTN, high CVD risk) highlighted in yellow, below. A 15-point high-risk threshold is not needed for the CVD/DM Expansion Pilot program. Please complete this Referral and Triage Tool and the CHT Expansion Referral form.

Referral Date:		Practice (Select one):	
Patient Name:		Nurse Care Manager:	
Patient DOB:		Primary Care Provider:	
Gender(select one):		Next Visit Date and Time:	
Address 1:		Health Insurance(Select one):	
Address 2:		Health Insurance ID:	
City:		Address of Health Insurance:	
State:		Other Insurance(please provide):	
Zip:		Secondary Health Insurance:	
Best Phone # to Reach Patient:		Secondary Health Insurance ID:	
Home/Cell(select one):		Pharmacy:	
Emergency Contact & Phone #:		Enrolled in Current Care:	
		Interpreter Needed:	
Is patient aware of referral?			

Outcome:

0

HIGH RISK DRIVERS

Utilization (medical or psych): ***(15 Points Max; 3 points each)***

Select Yes for all that apply

	IP admit in past 30 days OR
	30-day Readmission in past year OR
	2+ IP admits in past 6 months OR
	2+ ED visits in past 6 months
	Health Plan High Risk Report – impactable costs actual or predictive > $25,000

Subtotal *0*

General Steps of the Program

1. Identify patients (new or existing)
2. Refer; schedule initial visit with CHW
3. Identify and compile baseline data (i.e., CHT intake data, blood pressures, A1c values)
4. Complete Baseline Health Risk Assessment at initial visit
   Schedule follow-up visit (6-8 weeks from initial visit)
5. Complete Follow-up Health Risk Assessment at follow-up visit
   Continue follow-up visits or discharge patient
6. Identify and compile follow up data (i.e., blood pressures, A1c values)

Participation

Year 1	Year 2
EBCAP	EBCAP
South County Hospital	South County Hospital
Wood River Health Services *(referring to SCH)*	South County Medical Group *(referring to SCH)*

EBCAP's Year at-a-Glance

Performance Period (12 months)							
Q1	October 2021*	Q2	January 2021*	Q3	April 2022*	Q4	July 2022*
	Novem[illegible]r 2021		Febru[illegible]y 2021		May 2022		August 2022
	Decem[illegible] 2021		Ma[illegible]022		June[illegible]22		Sept[illegible]er 2022*

* Anticipated di[illegible]tion dates for incentive [illegible]ments

Attend "Y2 Kick Off" Meeting

Identify and invoice for infrastructure needs (i.e., IT support)

CHW completes training

Submit quarterly data report

Submit CHW self-efficacy surveys

Attend Best Practice meeting

Submit quarterly data report

Attend Best Practice meeting

Submit quarterly data report (25 patients total)

Attend Best Practice meeting

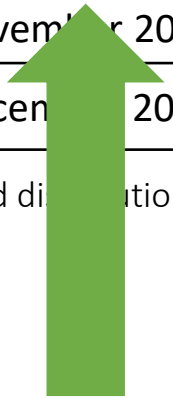
Present on Sustainability Plan

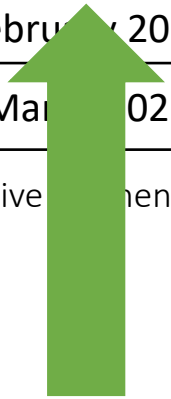
Complete CHW Self-Efficacy Survey

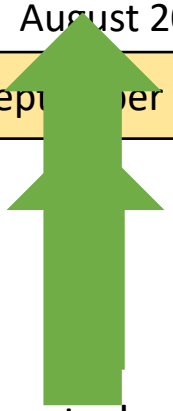
SCH's Year at-a-Glance

Performance Period (12 months)							
Q1	October 2021*	Q2	January 2021*	Q3	April 2022*	Q4	July 2022*
	November 2021		February 2021		May 2022		August 2022
	December 2021		March 2022		June 2022		September 2022*

* Anticipated distribution dates for incentive payments







Attend "Y2 Kick Off" Meeting

Identify and invoice for infrastructure needs (i.e., gift cards)

CHW completes training

Submit quarterly data report

Attend Best Practice meeting

Submit CHW self-efficacy surveys

Attend Best Practice meeting

Submit quarterly data report (25 patients total)

Attend Best Practice meeting

Present on Sustainability Plan

Complete CHW Self-Efficacy Survey

SCMG's Year at-a-Glance

Performance Period (12 months)							
Q1	October 2021*	Q2	January 2021*	Q3	April 2022*	Q4	July 2022*
	November 2021		February 2021		May 2022		August 2022
	December 2021		March 2022		June 2022		September 2022*

* Anticipated distribution dates for incentive payments

Attend "Y2 Kick Off" Meeting

Meet with PF to establish workflows

Identify patients for referral

Refer identified patients

Work collaboratively with SCLI to propose Sustainability Plan

Continue to meet with PFs

Assist in quarterly data reports

Attend Best Practice meeting

Assist with submission of quarterly data report

Attend Best Practice meeting

Assist with submission of quarterly data report (25 patients total)

Attend Best Practice meeting

Attend Best Practice meeting

Present on Sustainability Plan

Important Documents

1. Referral Triage Tool (for new CHT patients)
2. CVD/DM Referral Form (for new or existing CHT patients)
3. Project Plan
4. Data Collection Form
5. Health Risk Assessment (Baseline and Follow-up)
6. CHW Self-efficacy surveys

One Great Idea

In conjunction with your Practice Facilitator, identify and submit a sustainability plan – Due January 15, 2022

Submit and present a completed sustainability plan – Due September 1, 2022

- Practices will be asked to share key takeaways/findings from completed performance improvement plan at best practices sharing meetings throughout the year

Next Steps

1. If applicable, identify CHWs who will attend the Fall CVD/DM training (starts October 25th)
2. Schedule regular meetings with your practice facilitator
    - Review Project Plan that lists deliverables
    - Begin to think through relevant changes to existing workflows
3. Data due October 15th to conclude Y1
4. December Best Practice Sharing Meeting - date TBD
    - Report out on proposal for “One Great Idea” or Sustainability Plan

What questions do you have?

Thank you for your participation!

Thank you to the team at CTC-RI for their partnership in this Pilot!!

Carol Votta
carol.votta@health.ri.gov
401-222-3497

Megan Fallon-Sheridan
megan.fallon@health.ri.gov
401-222-3667

Appendix SLIDES

Data Reporting

Continue to collect…	Please also collect…
• Demographics • Risk scores (using existing algorithms)* • Social determinant of health needs* • Chronic disease underliers (e.g., depression, anxiety, smoking)* • Stage in CHT process (intake, follow-up, discharge)	• Blood pressure* • HgbA1c* • Statin Therapy/LDL-c if applicable*

* Capture at intake, follow-up, and discharge

Baseline Data Collection

CR	CS	CT	CU
Uncontrolled Diabetes			
Baseline HgbA1c% Date	Baseline HgbA1c%	Follow-up HgbA1c% Date	Follow-up HgbA1c%
mm/dd/yyyy	*12.1%*	*mm/dd/yyyy*	*11.3%*

CV	CW	CX	CY
Uncontrolled Hypertension			
Baseline BP Reading Date	Baseline BP Reading	Follow-up BP Reading Date	Follow-up BP Reading
mm/dd/yyyy	*145/97*	*mm/dd/yyyy*	*135/82*

CZ	DA	DB	DC	DD	DE
HIGH RISK OF CARDIOVASULAR EVENTS					
Date of Baseline LDL-c, if applicable	Baseline LDL-c, if applicable	Follow-up LDL-c, if applicable	Date of Follow-up LDL-c, if applicable	Statin therapy prescribed at baseline?	Statin therapy prescribed at follow-up?
mm/dd/yyyy	*102*	*mm/dd/yyyy*	*78*	*Yes, No, or N/A*	*Yes, No, or N/A*

Goal Setting

Complete the Health Assessment/Goal Setting tool by documenting:

- Scheduled follow-up visit
- CHW Actions taken

Current CHW Actions:

- Refer to NCM
- Refer to Pharmacist
- Refer to Dietitian
- Identified and addressed social needs; made referral
- Motivational Interviewing
- Tobacco Cessation – goal setting
- Other: _____

Goal Setting

Through participation and completion of the CVD/DM Training, we anticipate adding the following CHW actions:

- Teach patient how to self-measure blood pressure
- Educate patient on high blood pressure
- Educate patient on high cholesterol
- Educate patient on high blood sugar/diabetes
- Educate patient on signs/risks of heart disease
- Educate patient on self-care
- Discuss strategies for healthy eating
- Discuss strategies for increasing physical activity

Overview of CVD/DM Training

Established Cooperative Agreement with Rhode Island College

- Hired a Training and Evaluation Coordinator
- Coordinate and Implement Core CHW Trainings (Fall and Spring)
- Promote Cardiovascular Disease and Diabetes Specialty Training and Certification
- Coordinate and Implement Cardiovascular Disease and Diabetes Specialty Training (Fall and Spring)

Overview of CVD/DM Training

- 5-day, online training through Rhode Island College (October 25th -December 13th, 2021)

- 10 Modules
    1. Stroke
    2. Heart Attack
    3. Heart Failure
    4. Atrial Fibrillation
    5. High Blood Pressure
    6. High Blood Cholesterol
    7. Pre-Diabetes and Diabetes
    8. Healthy Eating and Weight Control
    9. Patient Driven Health Care
    10. Mental Health and Wellness

CVD/DM Specialty Certification

- ✓ Certified Community Health Worker
- ✓ Complete 30-hour training
- ✓ Complete three (3) months of full-time qualifying experience or 500 hours part-time qualifying experience
  - Qualifying experience = experience in the prevention and management of heart disease, stroke, HTN and DM

For more information, visit:
https://www.ricertboard.org/sites/default/files/applications/RICB_CCHW_Endorsement_CardioDiabetes_Application_19_0.pdf

Demographic Data Summary

April- June 2021

SCH CHT (n=28)

- All English speaking
- No Hispanic/Latino, 13 refused to answer
- 50% white patient panel
- 61% male patient panel
- Average Age: 56 Years

Note: Due to small population, difficult to draw any conclusions.

EBCAP CHT (n=13)

- All English speaking
- Two patients Hispanic/Latino
- 8% Hawaiian or Pacific Islander patient panel
- 31% Black or African American patient panel
- 57% white patient panel
- 46% male patient panel
- Average Age: 55 Years

South County Health/ Wood River Health

SCH CHT Clinical Data Summary (July 2021)

Baseline

Diabetes (HgbA1c)

- 18 Patients
- Average Reading: 9.48
- Age Range: 37– 74 years old

Blood Pressure

- 11 Patients
- Average Readings:
  - Systolic: 138.8
  - Diastolic: 83.9
- Age Range: 46 – 74 years old

Statin Therapy

- 16 Patients
- 5 patients with no Statin Prescribed
- Average Reading: 111.9
- Age Range: 39 – 78 years old

Follow Up

Diabetes (HgbA1c)

- None

Blood Pressure

- None

Statin Therapy

- None

Aggregated Diabetes (A1c) Clinical Data Review details

SCH CHT	March 2021	July 2021
Number of Patients	8	18
Gender Breakdown	2 Females; 6 Males	6 Females, 12 Males
Age Range	47 - 74 years old	37-74 years old
Race Breakdown	5 white; 3 refused	8 white, 10 refused
Highest Reading(s)	13.9	13.9
Lowest Reading(s)	5.8	5.8
Median Reading	8.8	9.4
Average Reading	9.22	9.48
Statin Prescription Breakdown	N/A	N/A

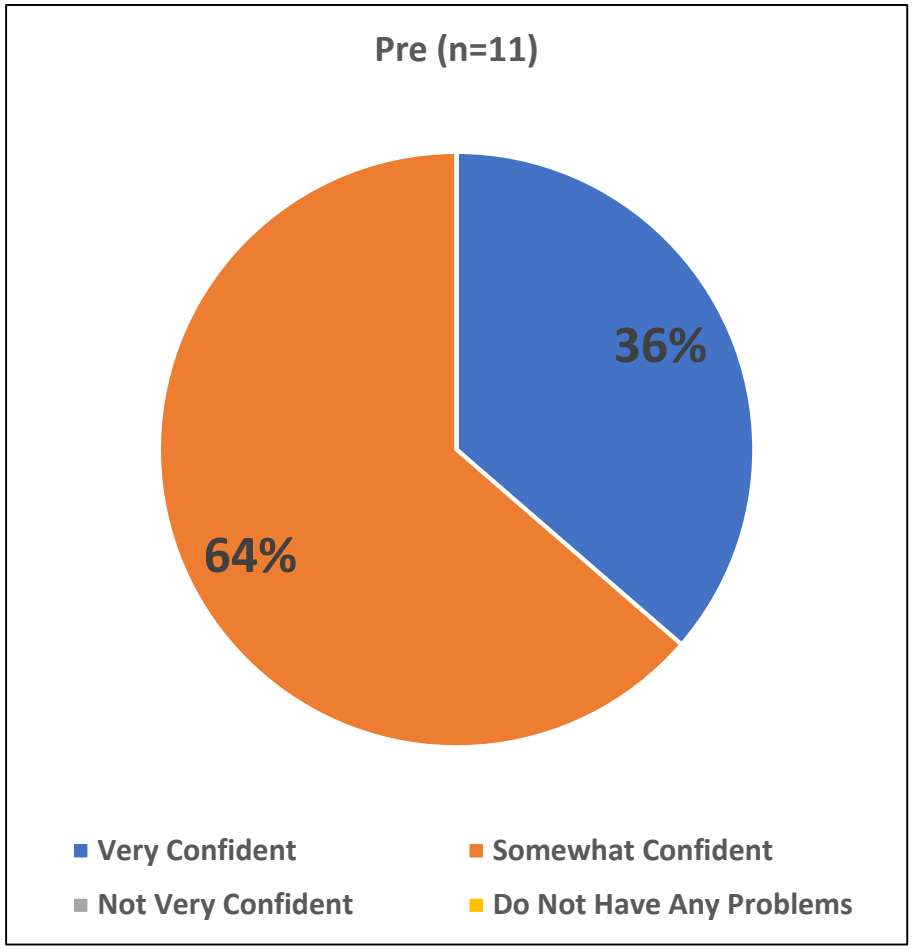
Aggregated Blood Pressure Clinical Data Review details

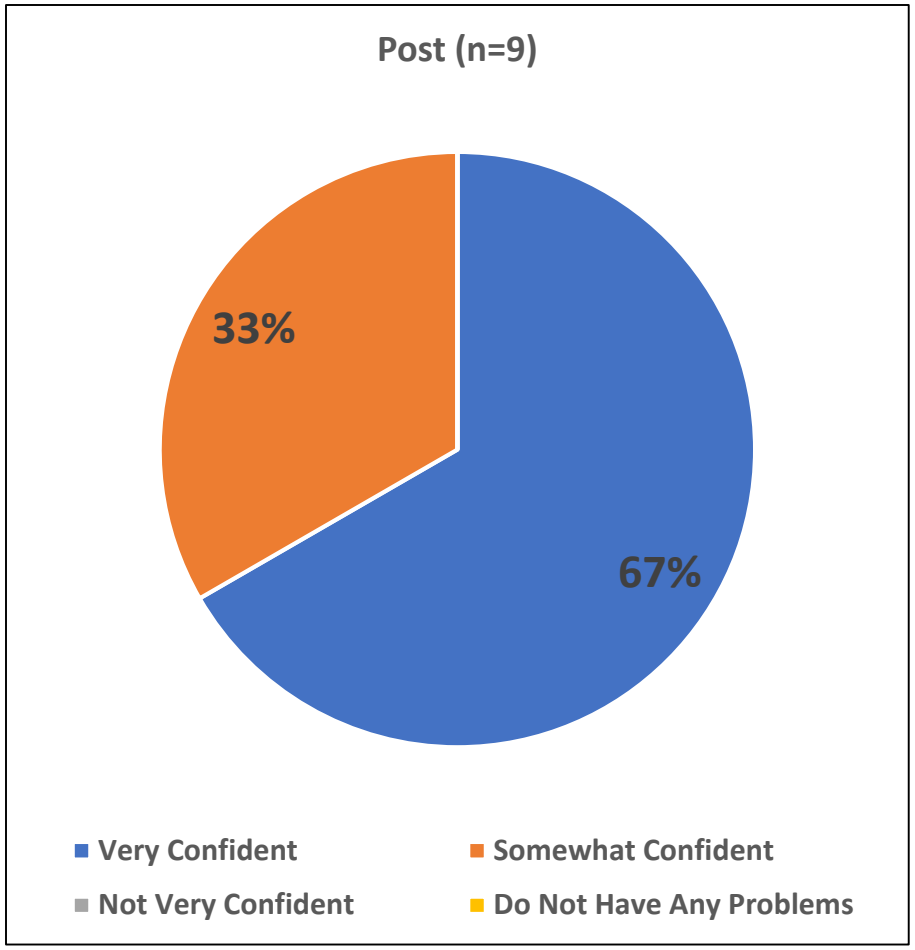
SCH CHT	March 2021	July 2021
Number of Patients	5	11
Gender Breakdown	2 Females; 3 Males	4 Females, 7 Males
Age Range	53 - 74 years old	46-74 years old
Race Breakdown	3 white, 2 refused	4 white, 7 refused
Highest Reading(s)	Systolic: 165; Diastolic: 94	Systolic: 165; Diastolic:94
Lowest Reading(s)	Systolic: 121; Diastolic: 77	Systolic: 121; Diastolic: 77
Median Reading	Systolic: 137; Diastolic: 80	Systolic: 137; Diastolic: 80
Average Reading	Systolic: 138.8; Diastolic: 82.8	Systolic: 138.8; Diastolic: 83.9
Statin Prescription Breakdown	N/A	N/A

Aggregated Statin Therapy Clinical Data Review details

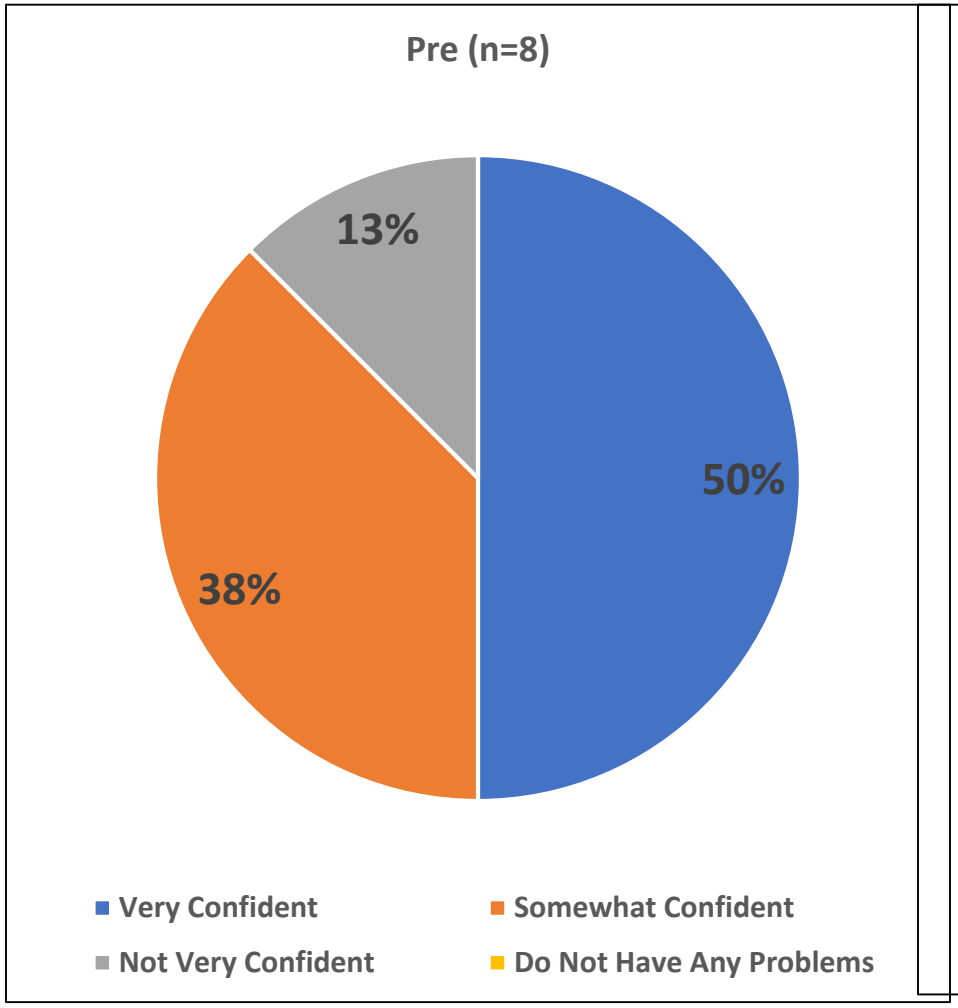
SCH CHT	March 2021	July 2021
Number of Patients	9 patients	16 patients
Gender Breakdown	5 Females; 4 Males	9 Females, 7 Males
Age Range	47 - 74	39-78
Race Breakdown	5 white; 4 refused	7 white, 9 refused
Highest Reading(s)	212	212
Lowest Reading(s)	50	50
Median Reading	130	106
Average Reading	125.2	113.6
Statin Prescription Breakdown	6 Yes; 1 No; 2 No answer	11 Yes; 2 No; 4 No answer

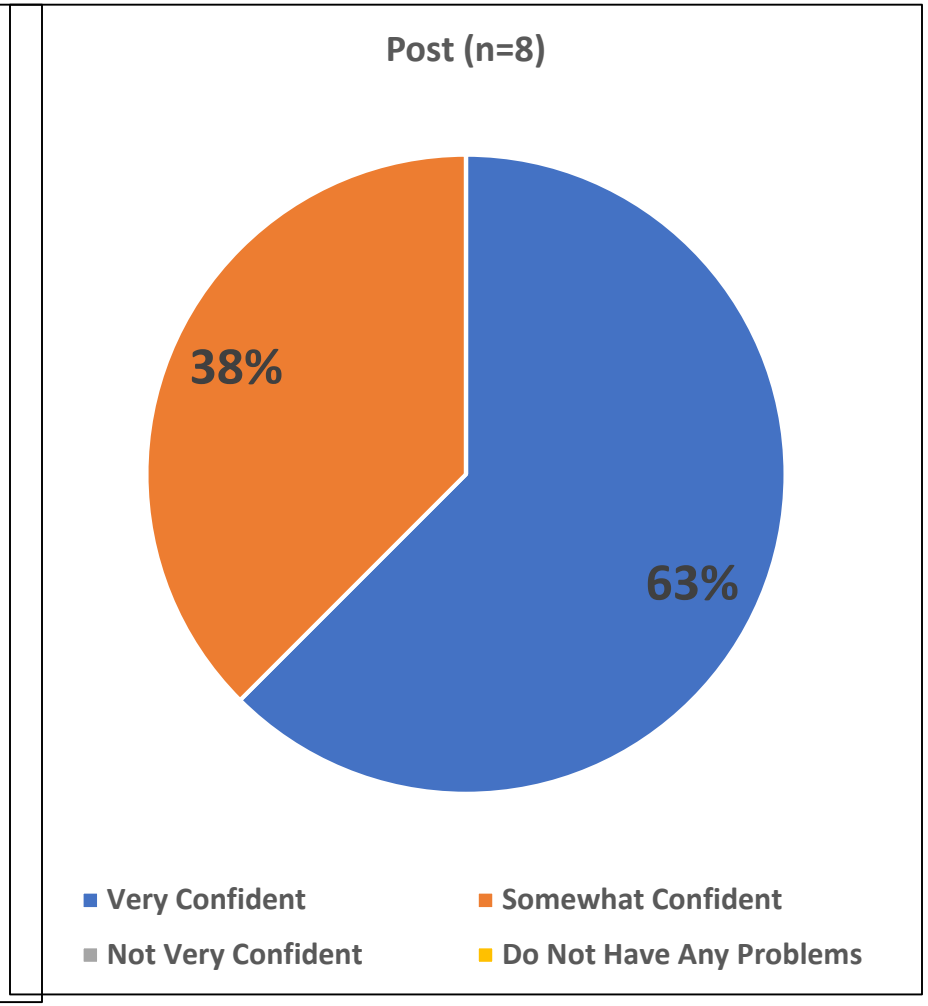
SCH: Compared to what you felt at our initial visit, how confident are you that you can manage your diabetes?



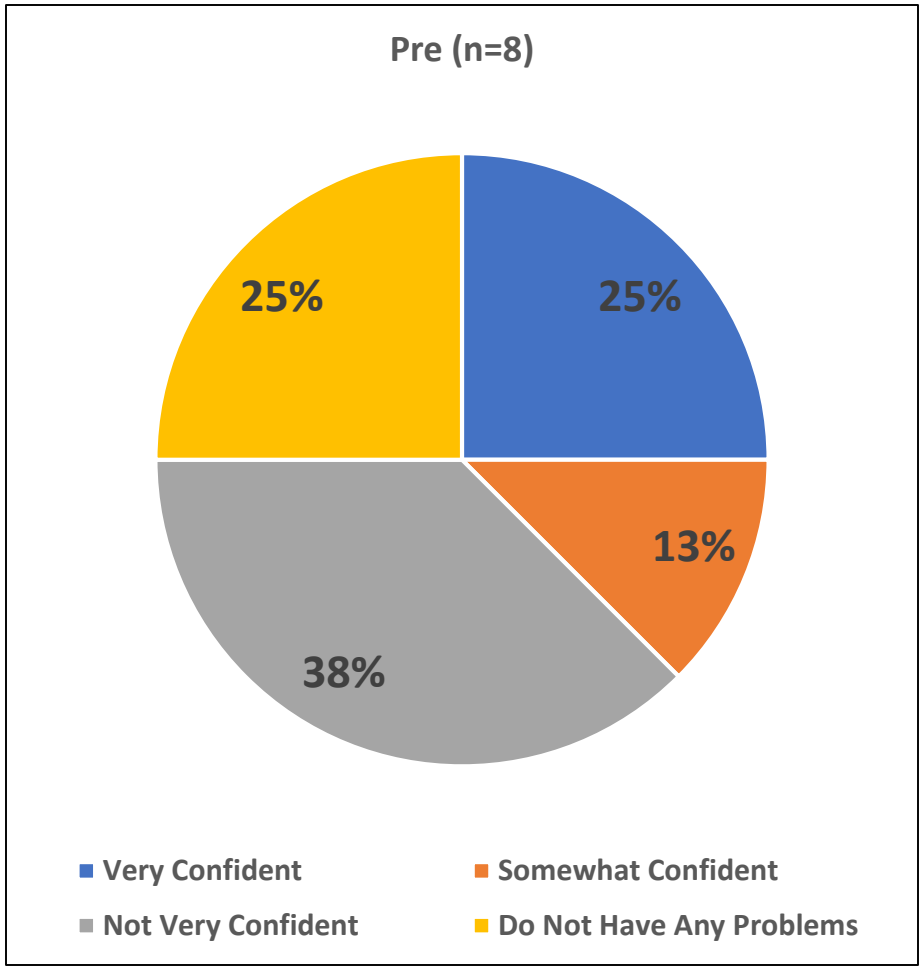


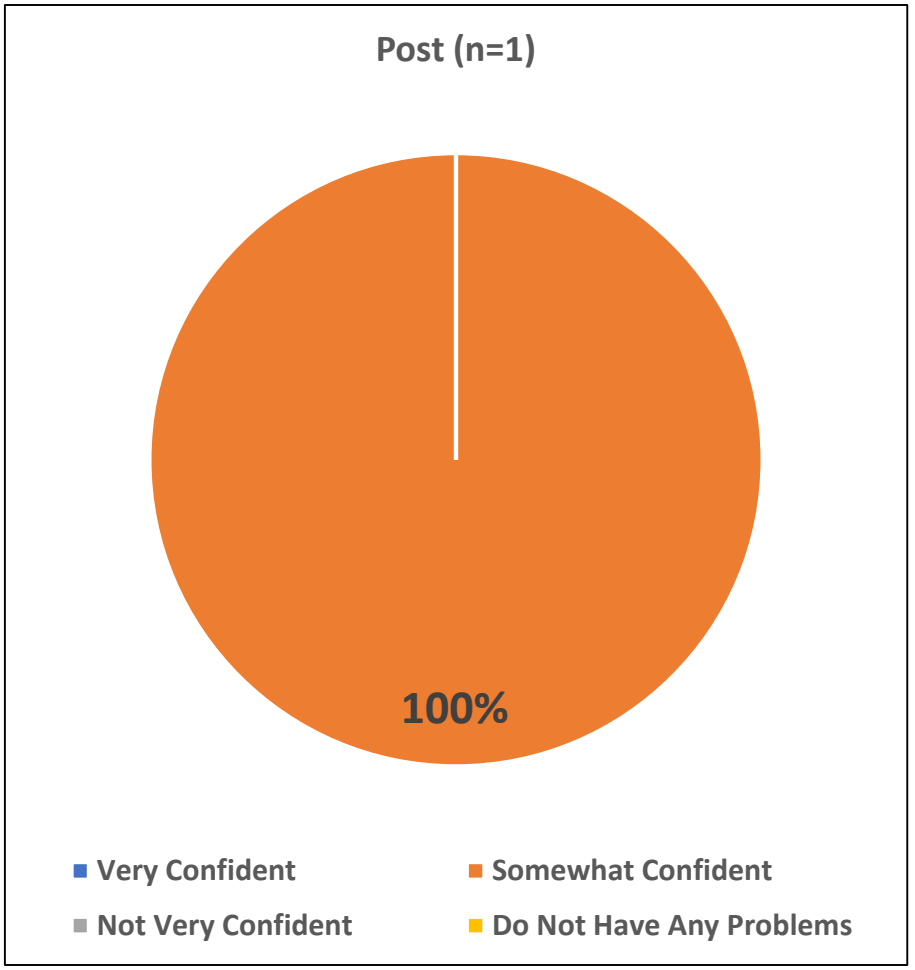
SCH: Compared to what you felt at our initial visit, how confident are you that you can manage your blood pressure?





SCH: Compared to what you felt at our initial visit, how confident are you that you can manage your high cholesterol?





East Bay Community Action Program

EBCAP CHT Clinical Data Summary (July 2021)

Baseline

Diabetes (HgbA1c)

- 12 Patients
- Average Reading: 11
- Age Range: 32 – 66 years old

Blood Pressure

- 1 Patient
- Readings:
  - Systolic: 151
  - Diastolic: 98
- Age: 60

Cholesterol

- No patients

Follow Up

Diabetes (HgbA1c)

- 5 patients
- Average Reading: 11
- Age Range: 55 – 63 years old

Blood Pressure

- 1 patient
- Readings:
  - Systolic: 147
  - Diastolic: 89
- Age: 60

Cholesterol

- None

Aggregated Diabetes (A1c) Clinical Data Review details…

EBCAP CHT	March 2021	July 2021
Number of Patients	3	12
Gender Breakdown	1 Females; 2 Males	6 females; 5 males; 1 refused
Age Range	63 - 66 years old	32-66 years old
Race Breakdown	2 white; 1 black	1 Hawaiian/Pacific Islander; 3 African American/Black, 8 white
Highest Reading(s)	>14	>14
Lowest Reading(s)	10.0	9
Median Reading	10.8	12
Average Reading	11.4	11
Statin Prescription Breakdown	N/A	N/A

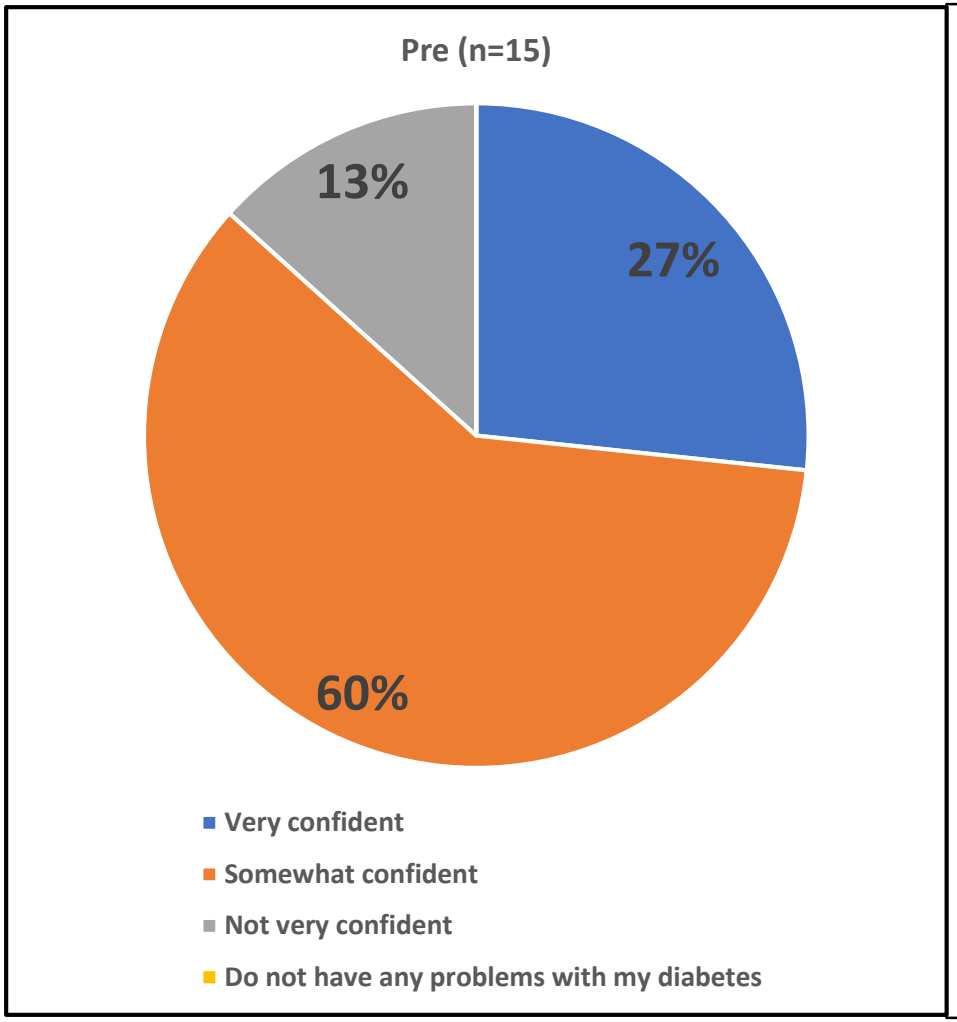
Aggregated Blood Pressure Clinical Data Review details

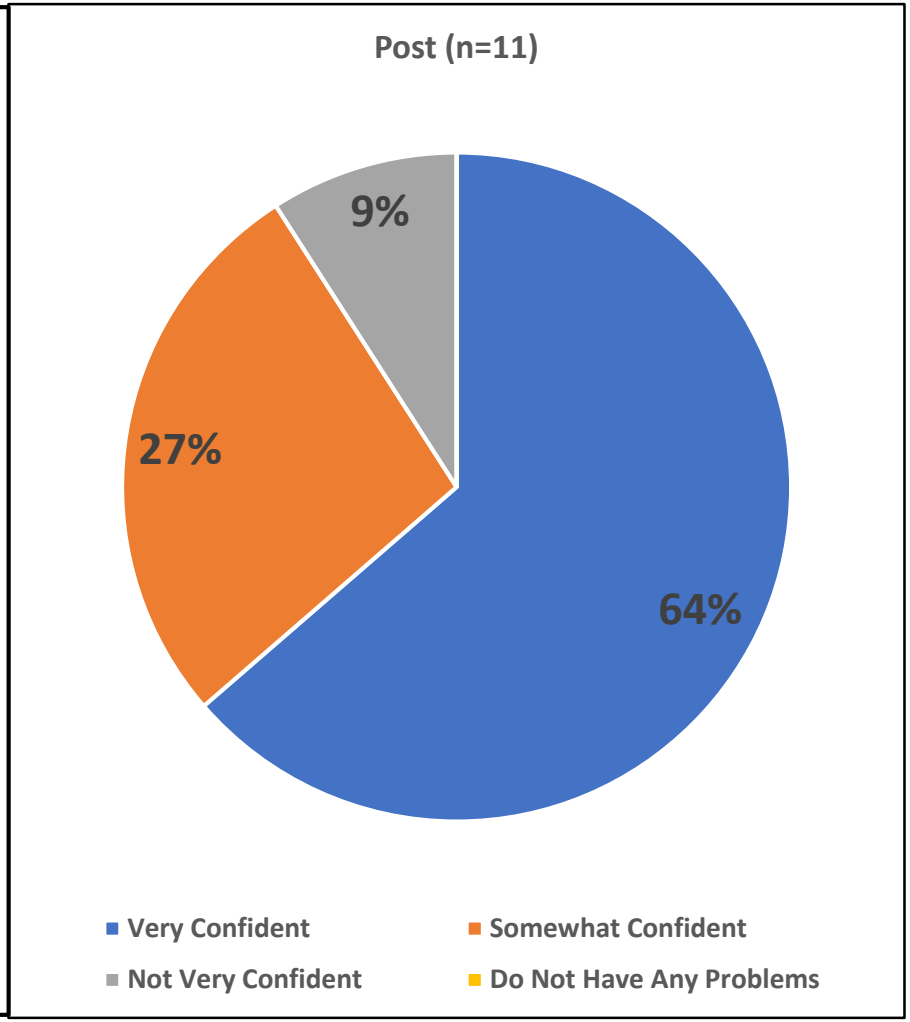
EBCAP CHT	March 2021	July 2021
Number of Patients	NONE	1
Gender Breakdown		Male
Age Range		60
Race Breakdown		African American/Black
Highest Reading(s)		151/98
Lowest Reading(s)		147/89
Median Reading		N/A
Average Reading		N/A
Statin Prescription Breakdown		N/A
Do you know what numbers indicate a high or a low reading for your condition?		N/A

Aggregated Statin Therapy Clinical Data Review details

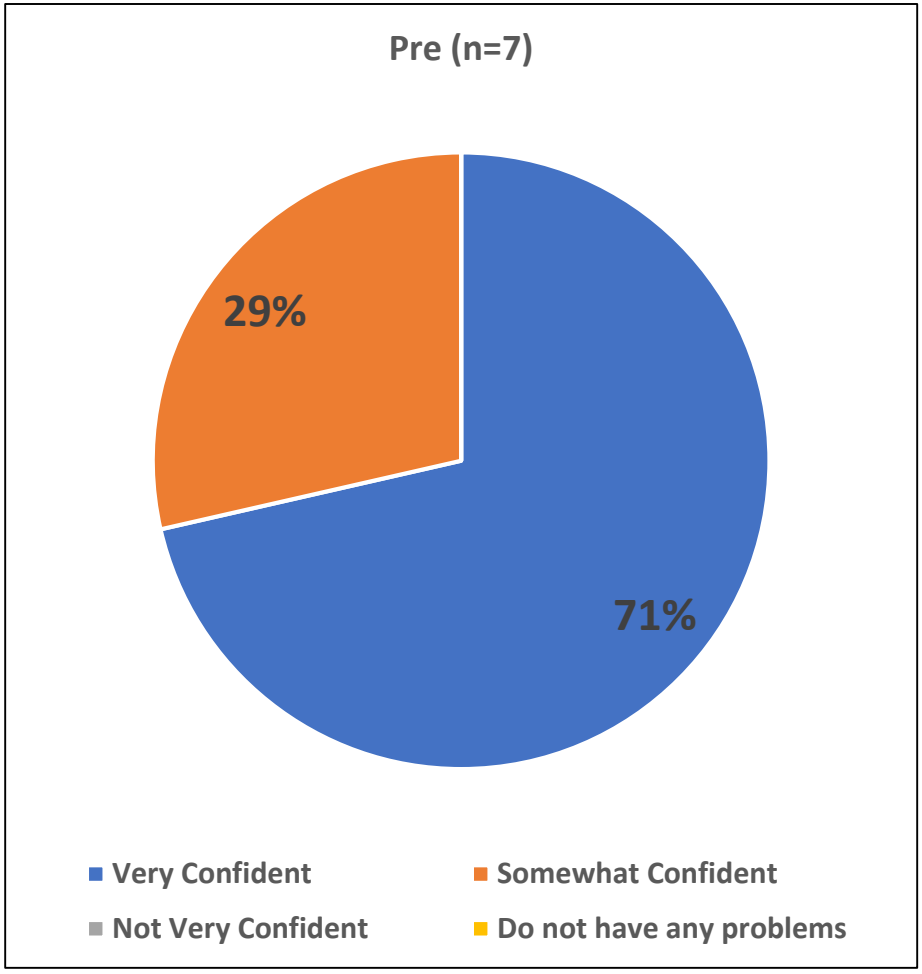
EBCAP CHT	March 2021	July 2021
Number of Patients	NONE	NONE
Gender Breakdown		
Age Range		
Race Breakdown		
Highest Reading(s)		
Lowest Reading(s)		
Median Reading		
Average Reading		
Statin Prescription Breakdown		
Do you know what numbers indicate a high or a low reading for your condition?		

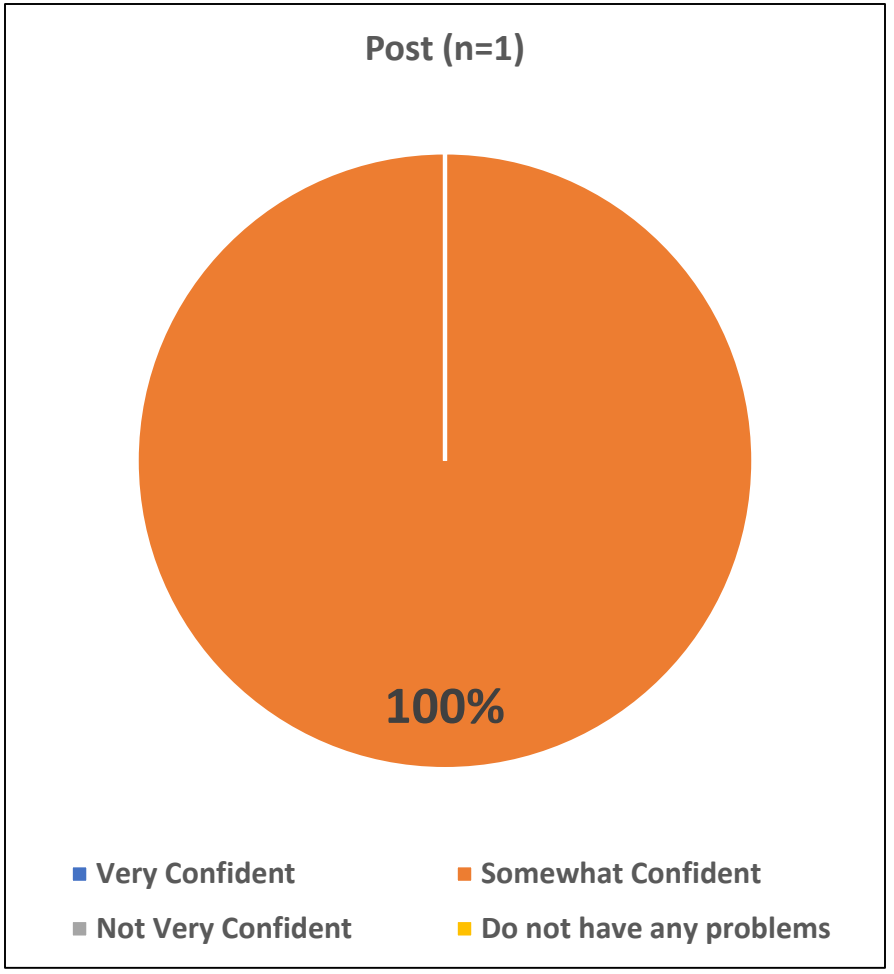
EBCAP: Compared to what you felt at our initial visit, how confident are you that you can manage your diabetes?



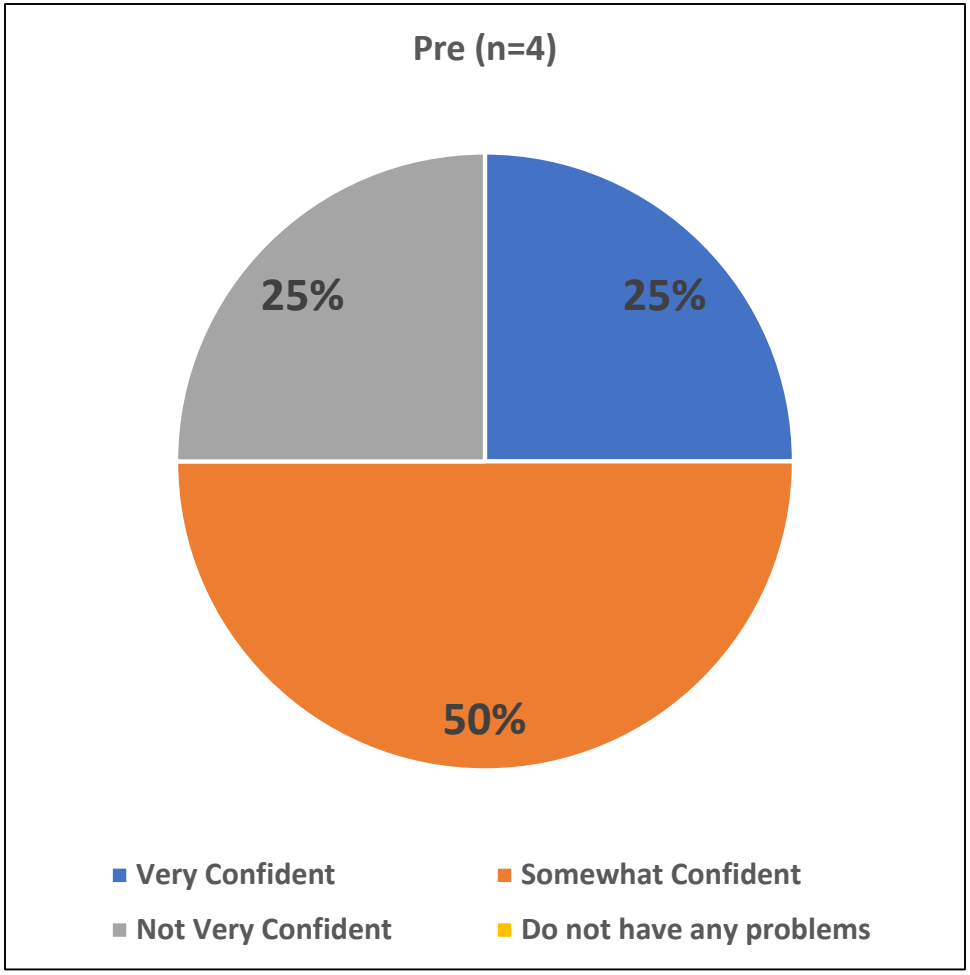


EBCAP: Compared to what you felt at our initial visit, how confident are you that you can manage your blood pressure?





EBCAP: Compared to what you felt at our initial visit, how confident are you that you can manage your high cholesterol?



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