Welcome Community Health Teams

Please type Your Name and Name of Organization in the chat

April 21, 2022

Agenda

RIDOH Staff Changes

Update on Quarterly Data Submission/Recruitment

Practice Updates and Sustainability Plans

Upcoming Deliverables

Reference Slides:

Update on CVD Training Curriculum - Outcomes of Spring CVD/DM training

New Faces!

RI Department of Health
Diabetes, Heart Disease, and Stroke Program

Randi Belhumeur
Program Administrator

Megan Fallon
Health Systems Intervention Manager

Carol Votta
Health Systems Intervention Coordinator

New Faces!

RI Department of Health
Diabetes, Heart Disease, and Stroke Program

Megan Fallon
Program Administrator

Breanne DeWolf
Health Systems Transformation Manager

CHT

Jayne Daylor
Quality Improvement Consultant

CCE

Data Overview
December 2021-April 2022

Demographic Data Summary

December 2021-April 2022

SCH CHT (n=7)

- All English speaking
- No Hispanic/Latino
- 100% white patient panel
- 86% male patient panel
- Average Age: 64 Years

EBCAP CHT (n=15)

- 2 patients enrolled after October 2021
- All English Speaking
- 1 patient Hispanic/Latino
- 40% Black or African American patient panel
- 60% white patient panel
- 53% female patient panel
- Average Age: 56 Years

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

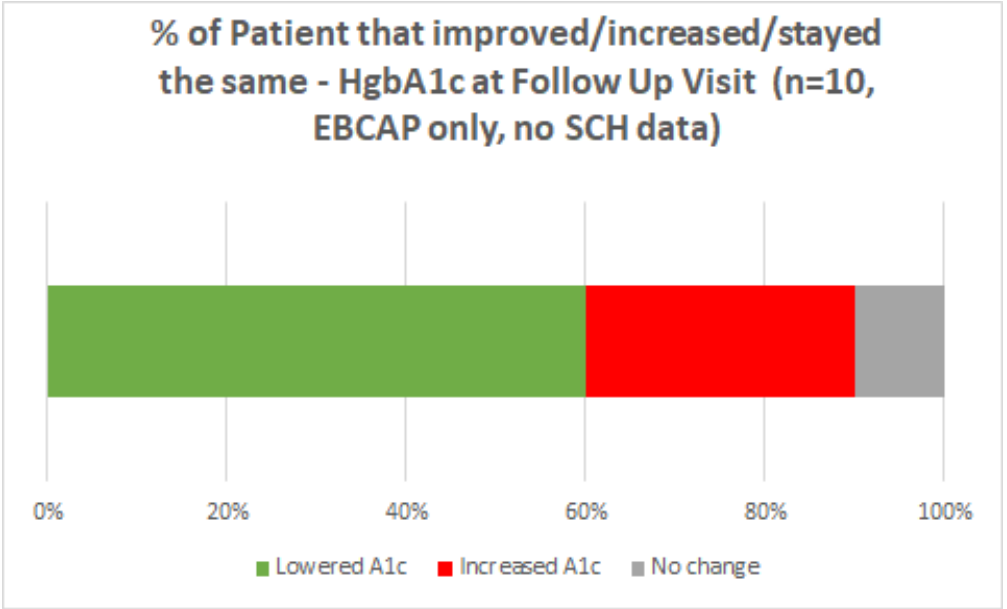
Diabetes Summary (SCH & EBCAP CHTs)

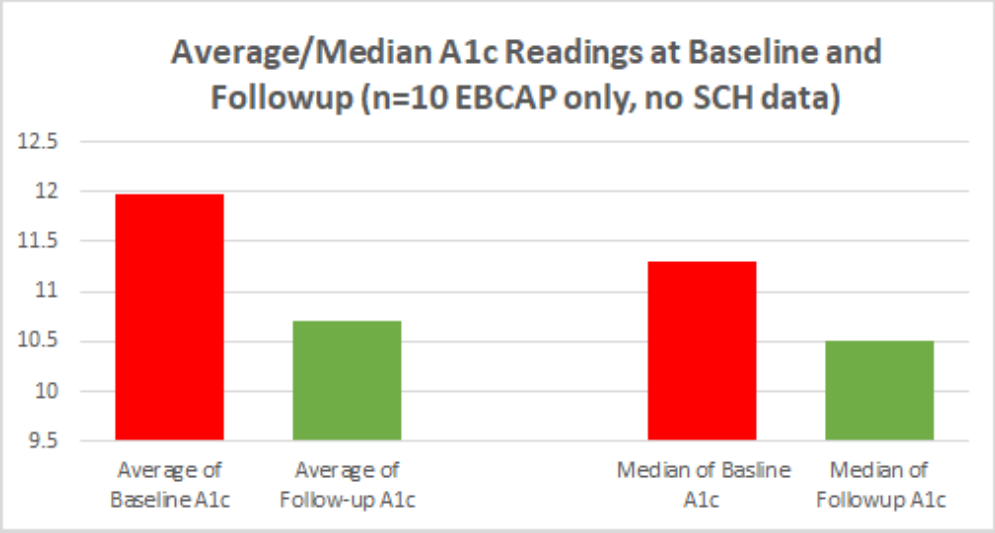
of patients in **baseline group**

Total	SCH CHT	EBCAP CHT
19	6	13

# of patients in **follow up group**

Total	SCH CHT	EBCAP CHT
10	0	10





SCH CHT Clinical Data Summary

Baseline

Diabetes (HgbA1c)

- 6 Patients
- Average Reading: 9.2
- Age Range: 55– 72 years old

Blood Pressure

- 0 Patients

Statin Therapy

- 2 Patients, both prescribed statin
- Age Range: 60-66 years old

Follow Up—no data yet

EBCAP CHT Clinical Data Summary

Baseline

Diabetes (HgbA1c)

10 Patients with follow up visit completed

- Average Reading: 11.97
- Age Range: 30 – 67 years old

Blood Pressure

- 2 Patient
- Readings:
  - Systolic: 149
  - Diastolic: 94
- Age Range: early 60s

Cholesterol

- No patients

Follow Up

Diabetes (HgbA1c)

- 10 patients
- Average Reading: 10.71

Blood Pressure

- 2 patients
- Readings:
  - Systolic: 155
  - Diastolic: 94

Cholesterol

- None

Discussion Questions

Updates to data submission process….

1. Added question around internet access to health assessment Survey Monkey
2. In light of changing CTC-RI requirements for the CHTs, do you suggest any changes to the requirements of the CVD/DM Expansion Pilot that could make data submissions easier?
3. Other thoughts? Comments?

Practice Updates

CHT Name: EBCAP

Successes since we last met

Barriers since we last met

Sustainability Plan- EBCAP

Healthy Diet Shopping Guide

Increase awareness and use of “Healthy Diet Shopping and Meal Planning Guide” through existing health center staff and patient education.

Work with Brown University students to develop a smartphone app with the “Healthy Diet Shopping and Meal Planning Guide”

Takeaways? Updates?

CHT Name: South County Health

Successes since we last met

Barriers since we last met

Sustainability Plan- SCH

Targeted Education for health improvement of clients

Improve warm handoff through dedicated scheduled appointments.

Enhance wellness packet.

Collaborative nutrition project with Jonnycake Center to develop a take home meal kit.

Takeaways? Updates?

Upcoming Deliverables

CHT Expansion Pilot Program Year 3

Suggestions for Year 3 deliverables might include:

- CHW Reimbursement
- SDOH Needs
- Incentives/other

Next data submission due July 15th

Next Best Practice Sharing meeting: TBD in July

Upcoming Payments

- April 2022
- July 2022
- October 2022

CVD Training Curriculum

Tonya Glantz

Overview of the CVD-DM Training

Ten Modules

- Stroke
- Heart Attack
- Heart Failure
- Atrial Fibrillation (Afib)
- High Blood Pressure
- High Blood Cholesterol
- Pre-Diabetes and Diabetes
- Healthy Eating and Weight Control
- Patient Driven Health Care
- Mental Health and Wellness

LEARNING OBJECTIVES

1. **Increase their knowledge of chronic health conditions (**Stroke, Heart Attack, Heart Failure, Atrial Fibrillation (Afib), High Blood Pressure, High Blood Cholesterol, Pre-Diabetes and Diabetes, Healthy Eating and Weight Control, Patient Driven Health Care, and Mental Health and Wellness.)
2. **Develop awareness of strategies for prevention, diagnosis, and treatment for chronic health conditions.**
3. **Understand Community Health Worker's unique ways of helping clients manage these conditions.**
4. **Build comfort in Health Risk Assessment and Self-Efficacy tools to assess and support patient-driven care.**

Self-Efficacy Data

Final Presentation

Training Evaluation Data

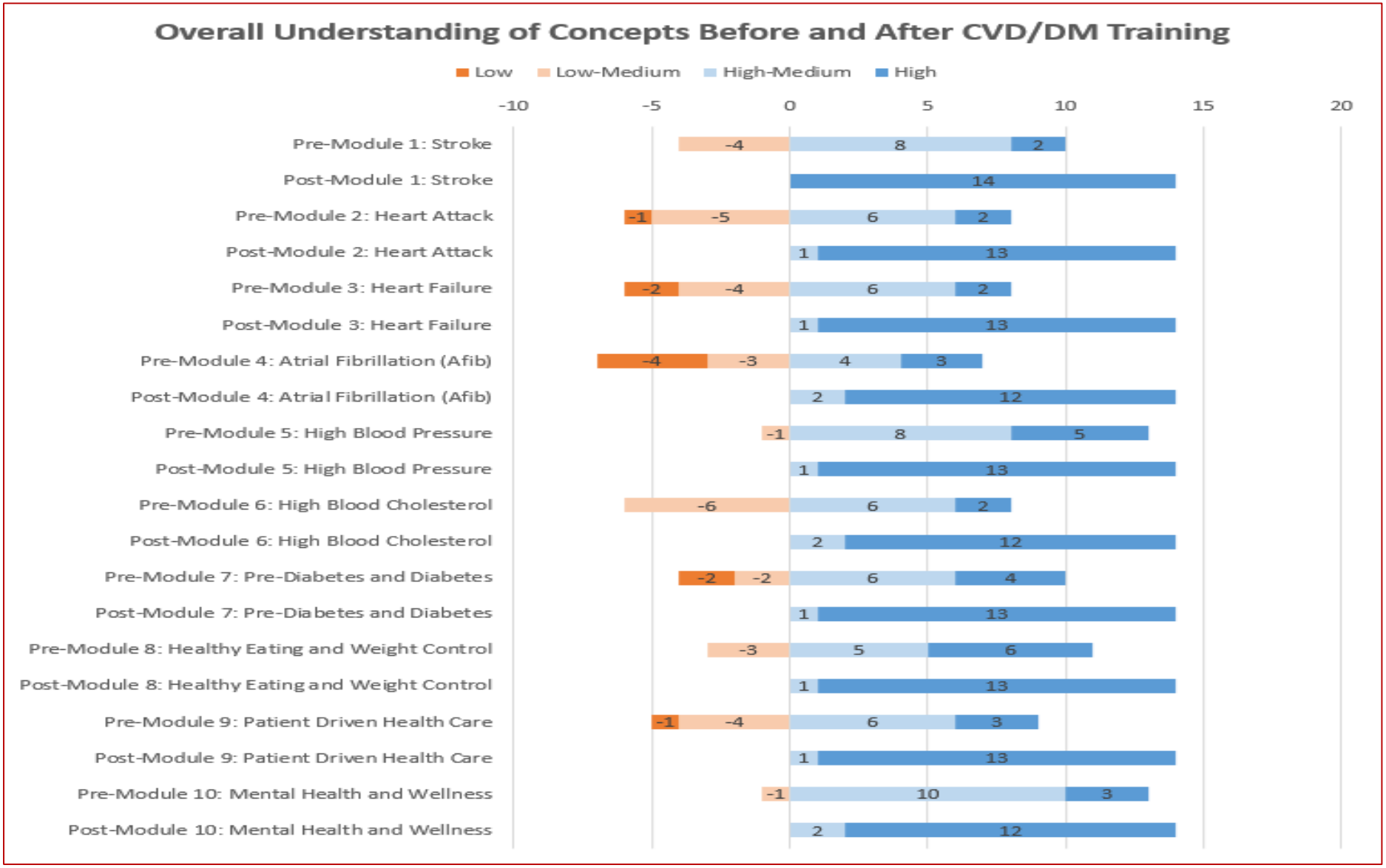
Outcome Data (*All Participants; **Only CHT

- Participant Information
  - Demographic data*
  - Reasons and expectations for participating in the training*
- Self-Efficacy Measure
  - Pre- & Post-Self-Efficacy *
  - Retrospective Self-Efficacy**
- CVD Presentation/Competency Demonstration*
  - typically conducted in groups and always held the final day of class
- Retrospective Training Evaluation*

Certificate Process (*All Participants; **Only CHT

- Full Disclosure of CVD Certification Requirements
  - CHW Certification
  - 500 hours of CVD-DM related work/volunteer hours
  - Certified in CPR-AED
- Assistance with & monitoring of requirements (see above)
- Support with RICB Application and Funding

CVD-DM Outcomes: Training



CVD-DM Outcomes: Training

CVD-DM Outcomes: Training

What was the most Important thing you Learned in the Training?
CVD/DM Key Concepts
"Chronic Diseases Level of Care."
"The interplay between high-blood pressure and diabetes as the two leading co-morbidities leading to heart attack and stroke."
"Mental Health and Diabetes Management information."
"The knowledge I gained learning about diseases and how it impacts [a] members overall well-being. Models [and] create tools."
"The most important thing I learned was that the CVD health risks are all related and that lifestyle changes are the most significant way to reduce unhealthy outcomes; that means that I have a constant job if I know how to show someone how to read food labels, cook healthy meals, and exercise."
"To become more aware with some health symptoms."
CVD/DM Practice, Knowledge, and Skills
"Ways to address conditions with patients."
"To help my community with health issues and to be able to find a job as a CHW."
"That the CHW is as important as any other health worker."
"How to build my confidence in dealing with my clients."
"How to engage clients, tips, and resources to use to educate clients; example [is the] readiness ruler."
"Make myself more sure of myself by addressing different people to obtain knowledge regarding the nutritional content of each product we consume. To be more aware that a sedentary lifestyle is the worst decision we can make."
"The importance of mental health and how much stress affects your daily life. It forced me to take a look at my life and start making decisions about my well-being such as working less hours which will help me slow down a bit and hopefully lower my stress."

CVD-DM Outcomes: Training

In what ways, if any, could the Training be Improved?
“In my case, it could be improved by implementing [more] trainings like this in the same format.”
“None, I thought it was a great training.”
“The instructor was very clear in the teaching of this training.”
“Doing it in person.”
“Have classes in the evening”
“It was great but as all things, there is always room for new improvements.”