

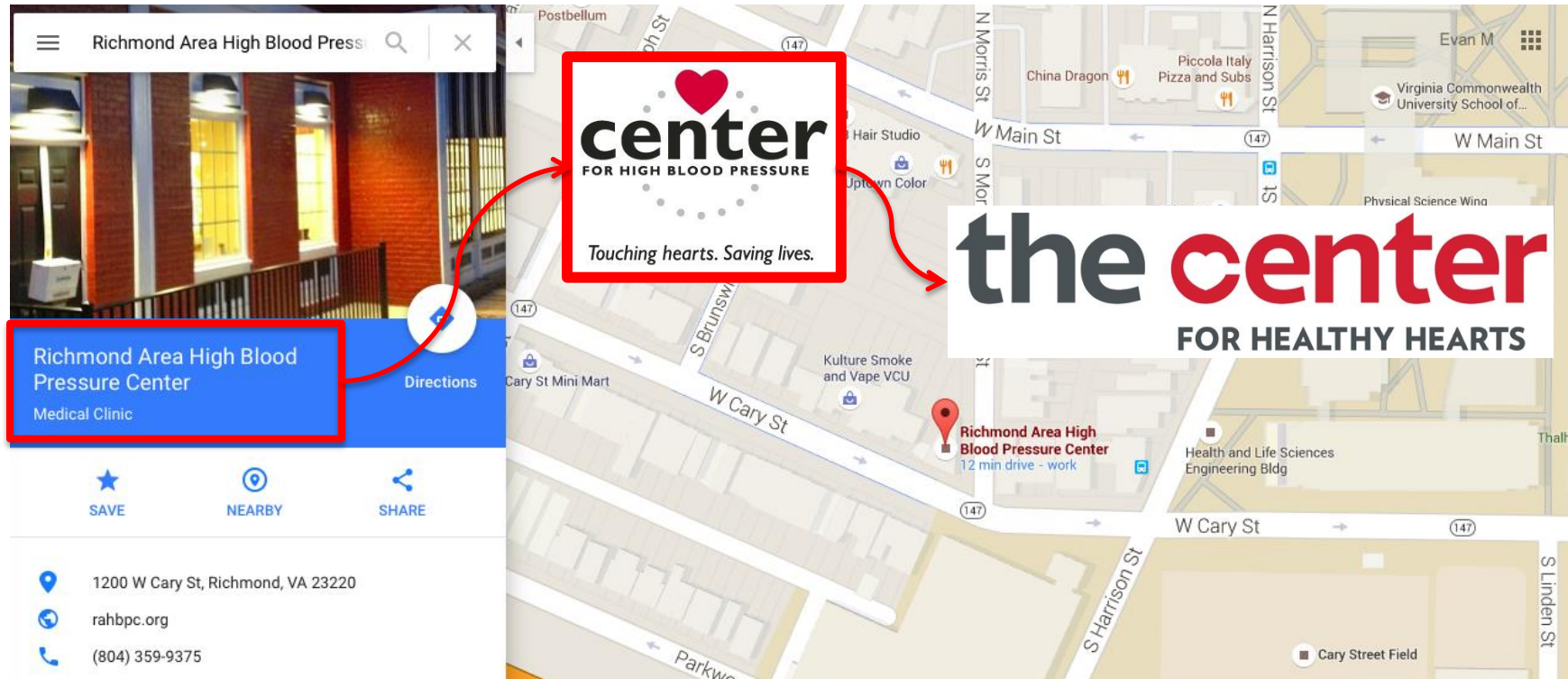
the center

FOR HEALTHY HEARTS

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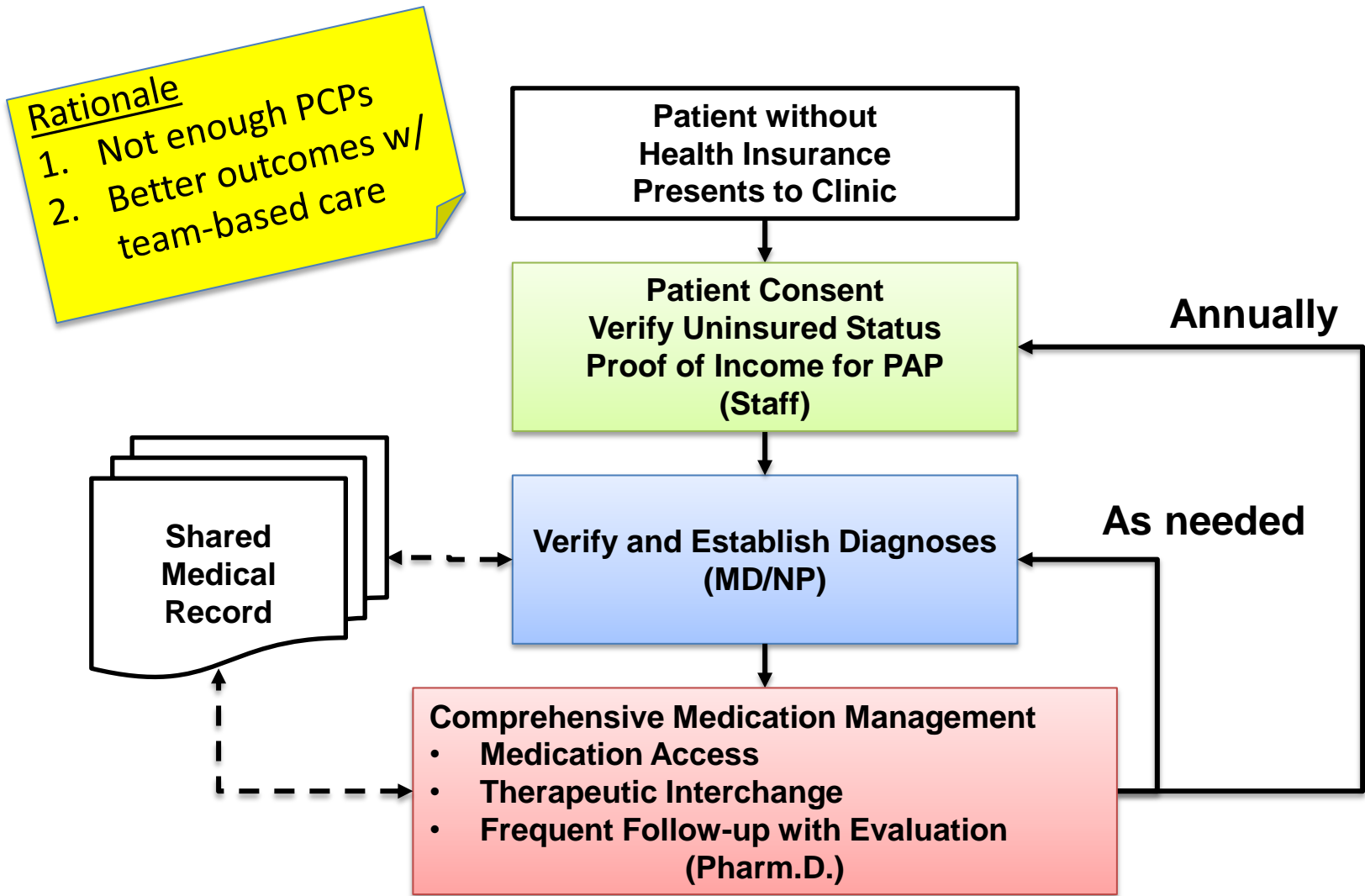
Evolution of Chronic Disease Management for Uninsured Patients at the Center



- 1983 – Established to address hypertension in the urban African American population
- 2008 – Mission revised to include diabetes and chronic disease
- 2016 – Rebranded to emphasize medication management and stabilization of patients with chronic disease



Center Patient Care Model

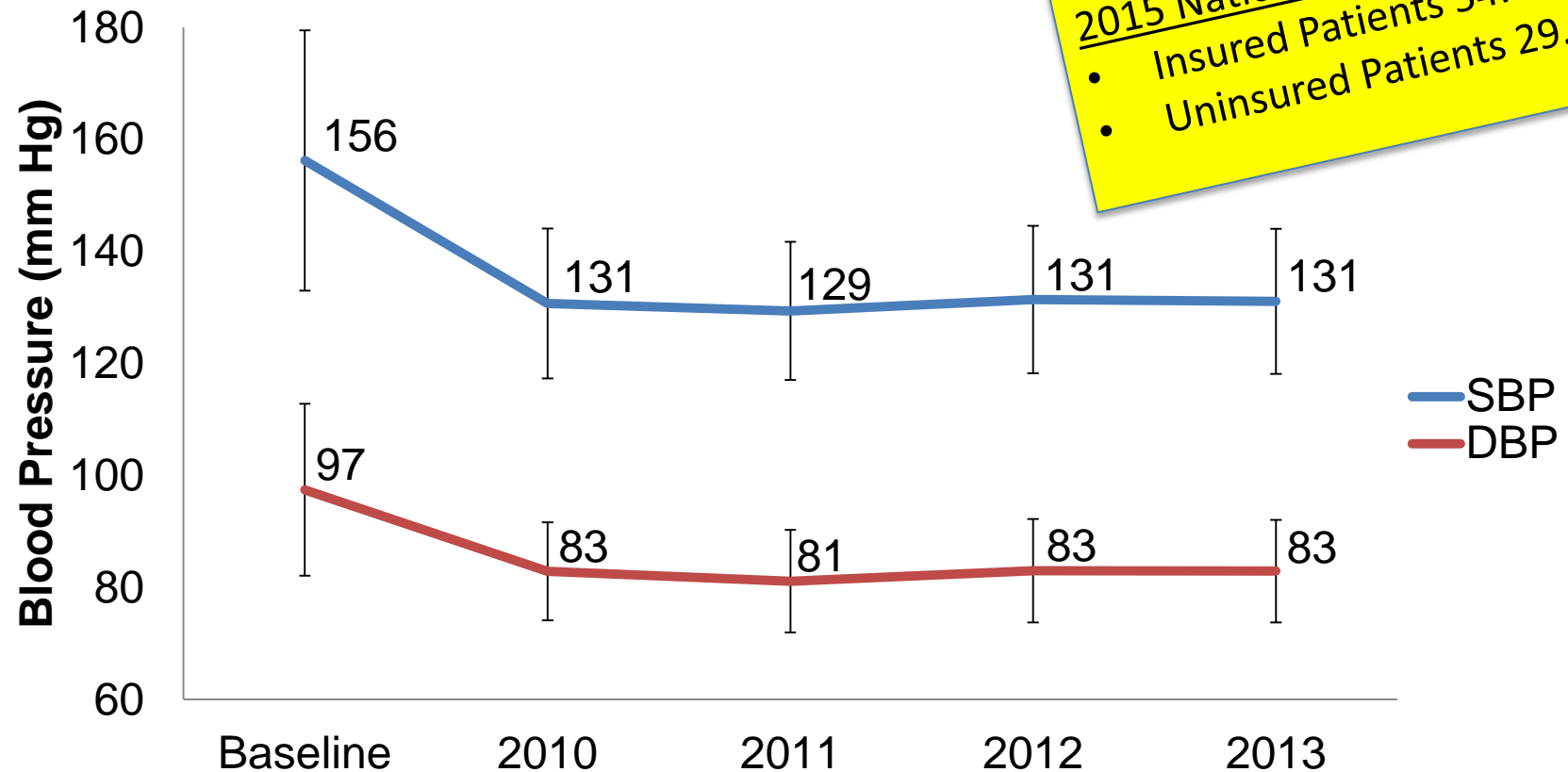


Center Patient Characteristics

Characteristics (n=172)*	n (%)
*Patients with ≥ 2 pharmacist visits during 2009	
Age mean \pm SD, years	51.3 \pm 9.9 (32-81)
Gender	
Female	106 (61.63)
Male	66 (38.37)
Ethnicity	
African American	131 (76.16)
White	31 (18.02)
Asian	4 (2.33)
Hispanic	3 (1.74)
Other	3 (1.74)
Past Medical History	
Hypertension	172 (100.00)
Hyperlipidemia	56 (32.56)
Diabetes	32 (18.60)
CVA/TIA	7 (4.07)
Coronary Artery Disease	6 (3.49)
Smoker	67 (38.9)
Body Mass Index (BMI) mean, kg/m ²	33.5 \pm 8.2



Mean Blood Pressure Baseline through 2013 (n=172)



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Secrets of Center Success

- Optimization of distinct interprofessional roles
 - Diagnoses established by **physicians**
 - Medication management by **pharmacists**
 - Urgent care by **nurse practitioners**
 - Case management by **nurses**
 - Education and coaching by **student lay health workers**
 - Nutrition education by **dietitians**
- Access to a common medical record
- Frequent follow-up with evaluation
- Collaborative practice agreement with sufficient scope of practice to implement medication changes at the time of the visit
- Specialized services – focus on chronic disease challenges
 - Certified Diabetes Educators
 - Cardiology, Nephrology
 - Clinical pharmacy specialists



Secrets

1. High touch – right provider skill mix
2. High intensity – right visit frequency

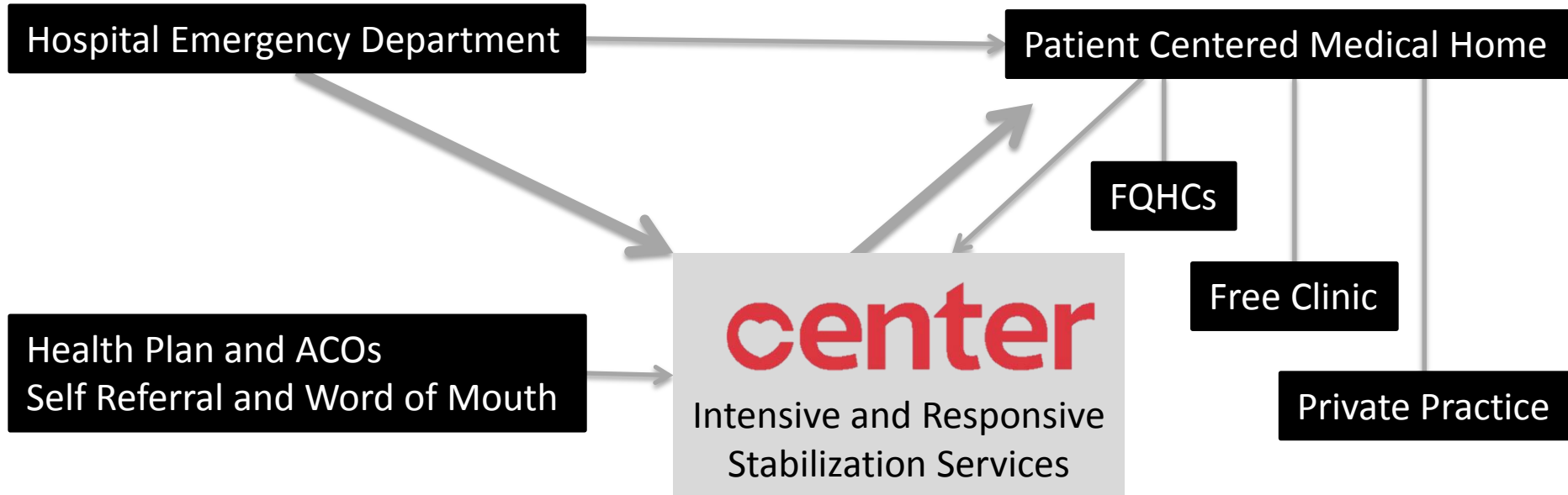


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Center for Health Hearts

a specialty medical home and free clinic for uninsured patients with chronic disease



Our Services

Appointments within 72 hours
Medication Management and Access
Pharmacy, Cardiology, and Nephrology Specialists

Patients We Serve

Diabetes

High BP

High Chol



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Diabetes Prevention Program



October 2014
AmeriCares Grant
for DPP in
Uninsured Patients

February 2016
2 DPP Study
Cohorts started

July 2015
2 DPP Study
Cohorts started

Integration of health professional students with trained lifestyle coaches



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<https://www.americares.org>

Data and Results

Cohort Number	Number of Participants	Avg. Number of Sessions Attended*	Avg. Weight Loss (in lbs.)
1	8	12 (out of 22)	4.8
2	7	12 (out of 22)	3.4
3	7	9 (out of 18)	3.2
4	5	11 (out of 18)	4.5



Program Strengths

Student Guides

Grocery &
Kitchen Demos

Discovering the
“Ah-ah”
Moment

Nonjudgmental
attitude

Intimate,
Trusted Setting

Accountability



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Patient Stories



“Becoming
Ambassadors”



“All steps are not
created equal” Joe

“Losing weight is a
mental battle” Jozet



“Sweating isn’t
too bad!” Karen



“I know I can lose
more” Lisa



“It’s a family
affair!” Janet



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Looking Back...

- **Recruitment**

- Key Start dates
- Time of classes

- **Retention**

- Monthly Meetings
- Use of Incentives

- **Curriculum Content**

- Used DPP 2012 for all 4 classes
- Recently introduced to T2 in July 2016



Moving Forward!



- Interprofessional collaboration
 - Nursing, pharmacy, medicine, physical therapy and health education
- Participant-Coach-Student Teams

- Community Partnerships
 - VCU Office of Sustainability Garden
 - Local YMCA



Thank you!!

the center

FOR HEALTHY HEARTS

