



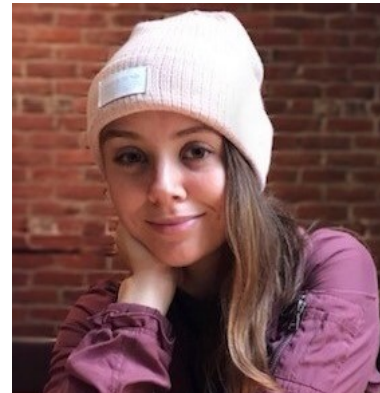
Reducing Hypertension in High-Risk Populations: Outreach to African-Americans before and during the COVID-19 Pandemic

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ACPM Preventive Medicine: Focusing Upstream

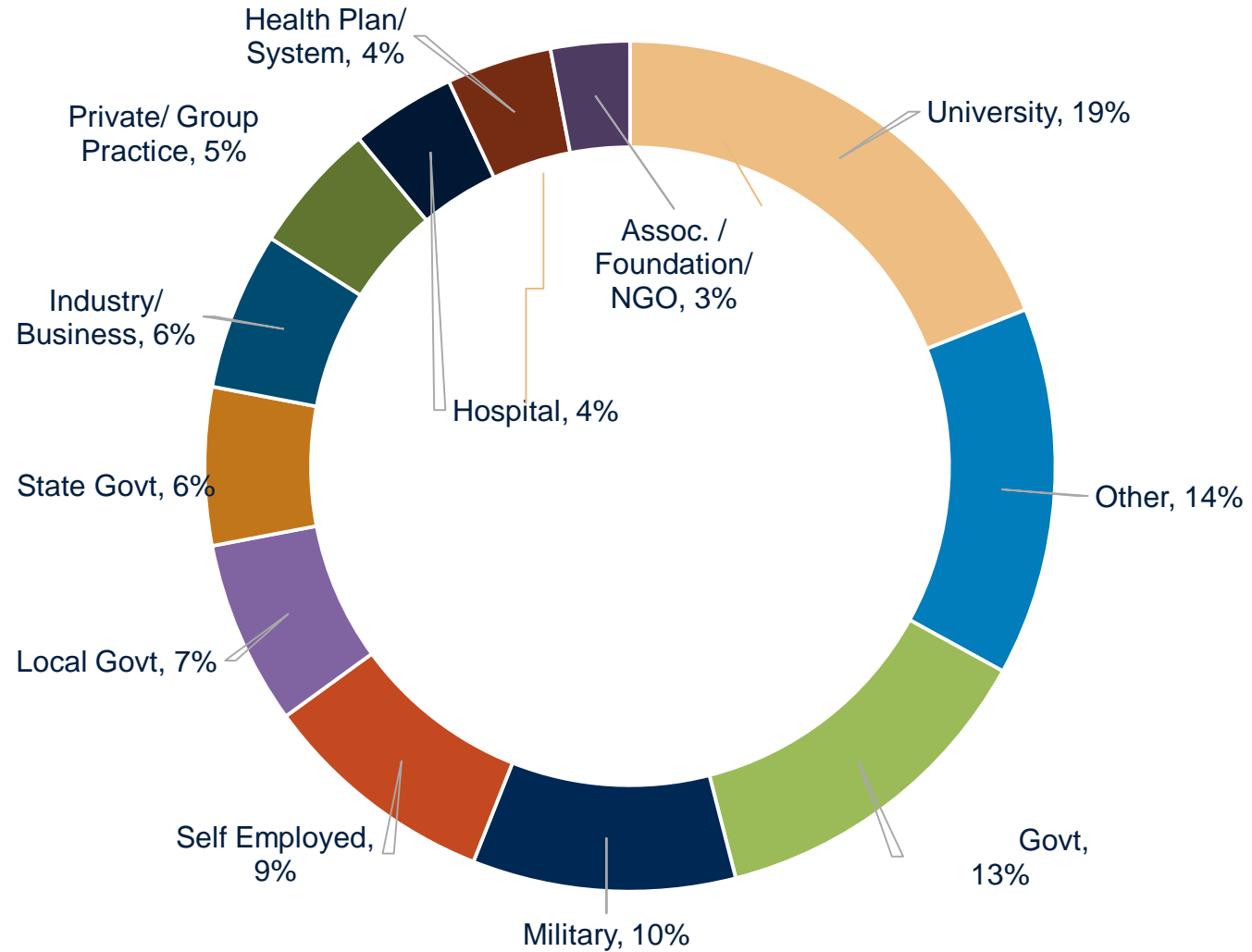
Our Impact

- ACPM is a national medical specialty society that represents physicians who work at the unique intersection of clinical care and population health.
- ACPM members have both an MD (or DO) and MPH and are trained to care for both individuals and populations.





Where PM Doctors work



PM's Agenda: Design Upstream Interventions



OBJECTIVES

In our inaugural Learning Collaborative, Dr. Keith C. Ferdinand talked about the need to nurture the doctor-patient relationship if we are going to improve cardiovascular outcomes for African-Americans

If patients are not touched and talked to with cultural competency, we will not see some of the positive outcomes that we have in clinical trials.

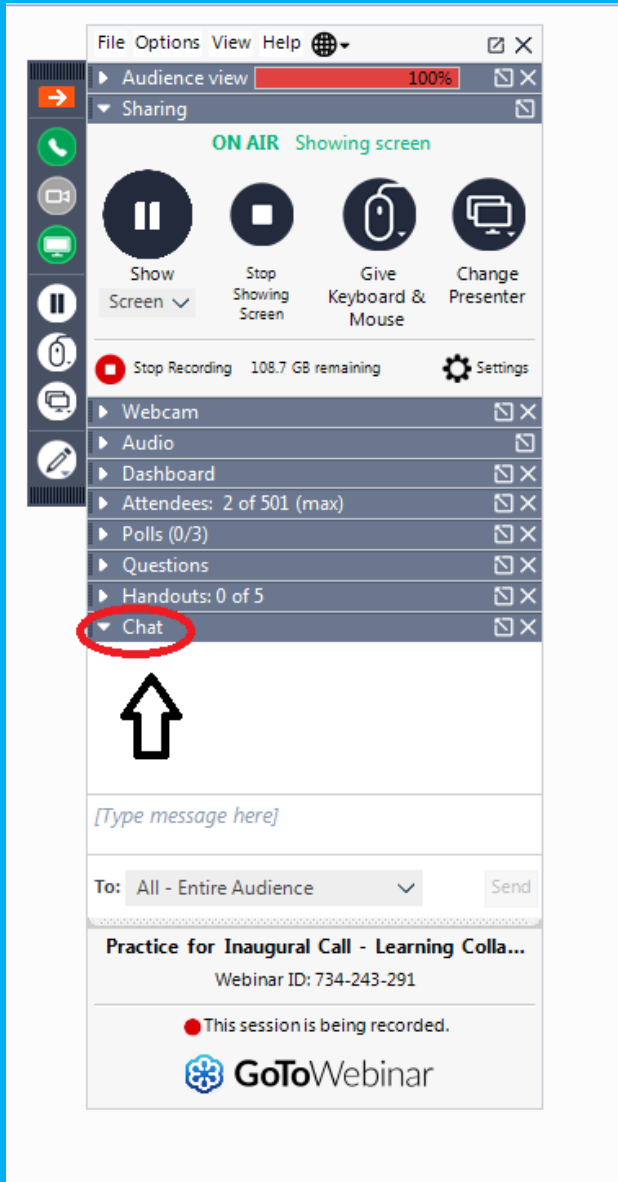
- How are we meeting this challenge?
- What can we do during the response to COVID-19?

Housekeeping



American College of Preventive Medicine
physicians dedicated to prevention

- Please stay in listen-only mode.
- The recording will be posted on the ACPM website.
- Please type questions in the Q&A box
- ACPM will email you a brief feedback survey after the webinar – please respond so that we can improve our offerings!

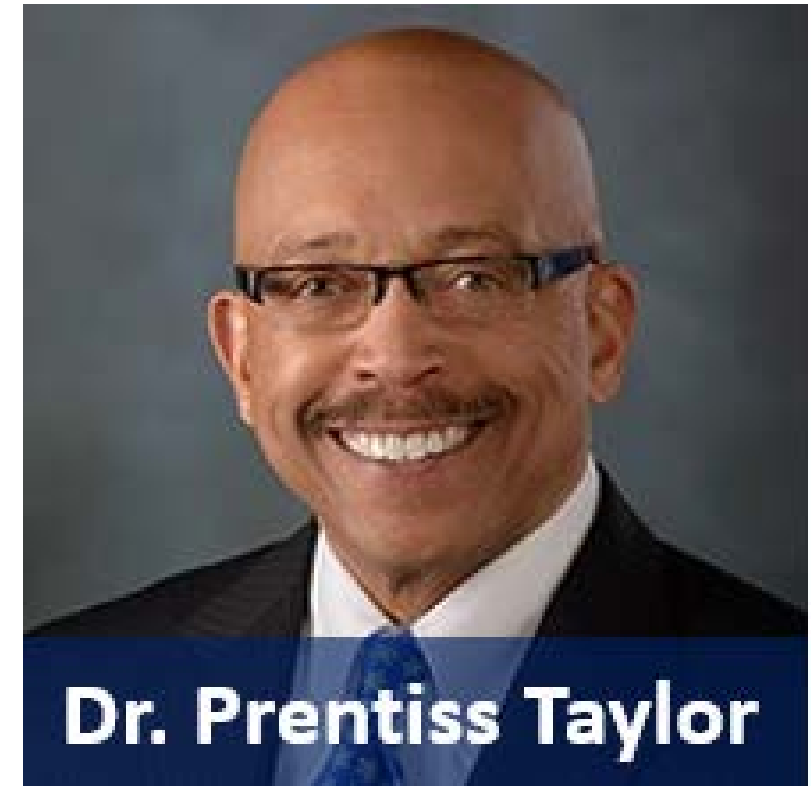




Reducing Hypertension Among African-Americans

Session Moderator

Prentiss Taylor, MD, FACP,
ACPM National Faculty Member,
Attending Physician, Advocate Christ
Medical Center, Oak Lawn, Illinois, and
Vice President for Medical Affairs at
Doctor On Demand Telemedicine



Starting with a short story: My Uncle Maurice



Lifestyle intervention	Drop in systolic BP
Low sodium diet	5 mm Hg
Enhanced potassium diet	4 mm Hg
DASH dietary pattern	11 mm Hg
Smoking cessation	4 mm Hg
Limit alcohol men 1-2 drinks per day women one drink per day	4 mm Hg
Weight loss	1 mm Hg/2lbs weight loss
Exercise	4 mm Hg



Four Key Goals of our Reducing Hypertension in High-Risk Populations Program

- **Screen, Test, and Refer to evidence-based lifestyle change programs**
- **Engage pts to enroll in evidence-based lifestyle change programs**
- **Address a SDOH that is a barrier to screening, enrollment, care management, and retention in lifestyle change or SMBP programs**
- **Collect data on Process Measures and Outcome Measures and report impact on these measures.**

The Centers for Disease Control and Prevention funded the grants

Focus is on African-American men in the target age group of ages 35- 64 years old.

Grantees applied from across the country, and 6 grantee sites were selected for funding.

Grantees mainly focused their budgets on funding support staff (for example a nurse or certified medical assistant) and on purchasing automatic blood pressure monitors for clinics.

Grantee sites are also supported by 3 national faculty physicians as mentors giving monthly technical assistance.

Examples of common questions from the faculty to grantee site staff

- How are you engaging patients for SMBP?
- How are you using team-based care?
- How are you engaging all members of your clinic staff with effective workflows focused on the 4 Key Goals?
- Do you use your EMR and Patient Registry to full effect?
- How are you partnering for community outreach? For example, with barber shops or YMCAs, etc.
- How have you developed patient education materials?
- What Social Determinant of Health is most critical there?

“Tougher than Blood Pressure” Peer Education & Outreach Project

**Made possible through Grant Funding from the American College of Preventive
Medicine (ACPM)**



Agenda

1. Overview of Man with a Plan Peer Educator program
2. How it changed with onset of COVID-19
3. Peer Educator Program
4. Program Evaluation
5. COVID Impacts
6. Considerations specific to African-American patients - particular strengths, resources, challenges
7. Lessons learned

Overarching Goals

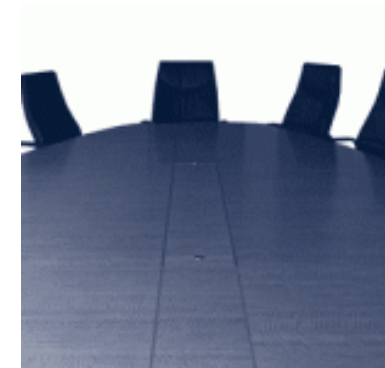
1. **Screen and test patients** from the targeted population at high-risk for hypertension
2. **Engage patients** to enroll in the evidence-based SMBP programs with clinical support and other related evidence-based lifestyle change programs
3. **Address a social determinant of health** that is an identified barrier to screening, care management, and enrollment and retention in an evidence-based lifestyle change or evidence-based SMBP program with clinical support
4. **Collect and report data** on process and outcome measures and assess the impact of interventions taken

Project Goals /Activities

- Develop a **hypertension registry** to identify patients in the target group with blood pressures out of range and will refer them to resources within our system.
 - Refer to a targeted nutritional education
 - Provide a tool kit of resources & skills
 - Surround them with the care team & peer educators
- **Recruit/Train Peer Educators** will provide targeted outreach and assist patients with goal setting
- **Year 1 Project Clinic Sites:** Asa Yancey, Camp Creek, East Point, & Primary Care Center

Our Team

- **Co PI/PI:** Drs. Wilhelmina Prinssen, Linda Toomer
- **Project Coordinator:** Darby Ford
- **7 Physician Champions**
- **2 Clinical PharmD**
- **3 Nutritionists**
- **Data Support/Population Health**
- **Public Relations**
- **Patient Education Specialist**



Overview of Peer Educator Program



- Cohort 1 (pre-COVID)
 - In person orientation and training held for 6 peer educators
 - Monthly check in sessions
 - Peers are connected to African American patients for bi-weekly phone calls



Cohort 1



Cohort 2

Patient Matching Process

- ✓ Patients are identified by using the hypertension registry, which identifies African American male patients aged 35-64 with hypertension
- ✓ Providers in the program hand-pick patients from the list and call them to invite to participate in the program
- ✓ Once the patient agrees, they are matched with one of our peer educators. If none are currently available, they are placed on a waiting list.
- ✓ Peer educators use a script and a list of guided questions to obtain information from their patient. This is reported to the program coordinator and shared with providers and other team members as necessary.

Tool: Peer Educator Script

- Outlines first 3 phone calls with patients
- Includes questions to ask and what to report to program coordinator

Patient Matching: Week One

<i>First Call</i>	
<i>Timeline</i>	By Friday, April 10 th
<i>Expectations</i>	<ul style="list-style-type: none">• Make contact & establish a relationship• Establish best times to talk• Ask baseline questions• Answer any questions
<i>What to send in</i>	<ul style="list-style-type: none">• Pre-test questionnaire

Call Script

My name is ____, and I'm a volunteer Hypertension Peer Educator. I was given your name by your primary care provider, who thought you might benefit from having someone help you move toward your hypertension goals. I'm hoping I can help you set some realistic goals, answer questions, and encourage you. If I don't know the answer, I'll reach out to our team to find out. I will be contacting you every 2 week(s) over the next 3 months to check and see how you're doing. How would you feel about that?

First off, is now a good time to talk?

- If not, when is the best time for us to talk? Day _____ Time _____


I would like to ask you a few questions to use as a starting point and see what you'd like to get out of this program. Is that okay?

- Ask questions from baseline questionnaire and document their answers

Are there any questions I can help you answer?/

Tool: Taking Care Of Yourself: Body, Mind, & Spirit

- Flyer developed for patients on how to manage their chronic disease during COVID
- Included with mail-order refill medications (approximately 500 per month)
- Available in English and Spanish




**TAKING CARE OF YOURSELF:
MIND, BODY, AND SPIRIT**

We know this is a difficult time for you and your family as we all struggle to stay safe and socially distant during the COVID-19 outbreak. This is especially true when you have high blood pressure, diabetes, or lung disease. That's why we want to share some tips to keep you healthy.


Protect Yourself and Others

- Wash your hands for 20 seconds when you get home, before you touch your face, and before you touch food.
- Practice social distancing by standing at least 6 feet away from others.
- Cover coughs and sneezes in your elbow or a tissue.
- Clean and disinfect frequently touched surfaces daily.
- Limit being around others who are not a part of your household.
- Cover your mouth and nose with a mask or scarf if you go out where you will be in contact with others like the grocery store.



Manage Your Chronic Disease

- Take medicines as directed by your doctor and make sure you have enough medications.
 - If you currently use a Grady pharmacy, please call (404) 616-5500 to learn about having your medicines mailed to you.
 - Some medicines may be available as 90-day supplies.
- Check your blood pressure, blood sugar, and weight daily. Write them down in a notebook to share with your doctor later. Tell your doctor about any changes in your health.
 - If you do not have a blood pressure cuff, talk to your provider about what options might be available.



Evaluation Points

- Data Warehouse – Registry
- Process
 - Peer Educator Training – Pre/Post
 - Patient & PE Evaluation of Process
- Outcome
 - Hypertension control in target

How COVID Changed Our Program

- Impact on Patients
- All meetings were moved to virtual (Webex)
- Added individual TA calls
- Online version of the training in development (go live June 19th)
- Phone call check ins for patients became even more important as patients may be unable to see their provider
 - 2 calls to patients identified potential situations. Both patients were linked to their provider for a virtual visit.

Challenges due to COVID

- Delays implementing training
 - We had to move the in-person training for cohort 2 online and are still in the process of recording the training. This has caused delays in matching cohort 2 with their patients.
- Peer Educator Conflicts
 - Some peer educators have been unable to continue at present due to personal circumstances
- Patient Challenges
 - Depression
 - Being disconnected from resources
 - Food insecurity
 - Difficulty reaching patient (disconnected phone numbers)

Considerations Specific to African American patients

- Our peer educators represent our target community and can offer real world questions and suggestions to dealing with African American men in the community
- Patients report their main source of support is often a woman
 - Should we be including female influencers?
- Anxiety, mistrust, and cultural unrest are stressors for our peers and our patients

Lessons Learned

- Feedback from peer educators was essential
 - Adapted training to address questions and myths from our peer educators (many have HTN)
 - Created a newsletter and monthly check in calls in order to make more touch points for peers
- Be flexible!
 - Moving the training online resulted in more flexibility
 - Several Hispanic men asked to become peer educators
- Telephone outreach results in timely intervention and may save lives!

Questions?



Slides and handouts
will be emailed to all
registrants and
posted on
[ACPM.org/initiatives/
Hypertension](https://www.acpm.org/initiatives/Hypertension)

Please enter your questions in the Q&A box

Lincoln Community Health Center Durham, NC

Caitlin Eckert, MSW, LCSW-A, LCAS-A

[My pronouns: she|her|hers]

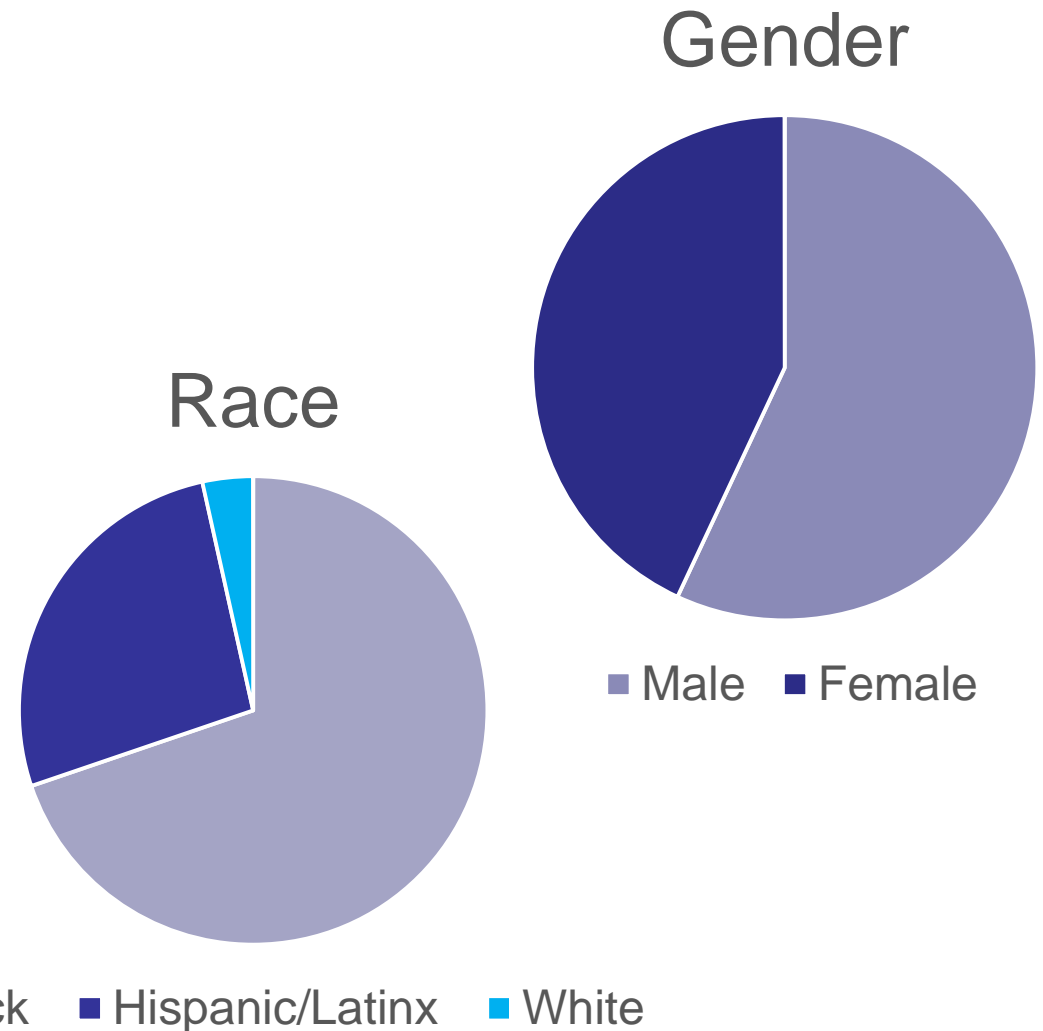


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"Your link to quality health care"

Whom Are We Serving?

- Hypertension project efforts at LCHC are led by Dr. Holly Biola, Chief of Family Medicine
 - I am a social worker at LCHC, and the project director for our HIV/HCV SAMHSA grant
- We have 86 participants who are involved in hypertension projects at LCHC



Engagement Efforts During COVID-19

- Calling all participants in the hypertension project to remind them that our program is on a “pause”, but still remaining actively engaged with them
 - Do you have a current health goal? If yes, what is it and who is helping encourage you? If no, would you like to set one with me?
 - When is the last time you checked your blood pressure, and what was it?
 - Do you have access to your medications?
 - Do you have access to enough food?
 - Have you been experiencing any COVID-19 symptoms?



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Engagement Efforts During COVID-19

How can LCHC further assist you?

“I need a refill of my medication.”

“I’ve been feeling depressed lately.”

“I’ve been smoking more than before and would like to stop.”

“Can you contact my provider?”

“Can you remind me when my next appointment is?”

“Can I make an appointment?”

“I’m experiencing some pain.”



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“Your link to quality health care”

Tools, Tracking, and Scripts

- Excel spreadsheet of all hypertension participants
- Enter information into spreadsheet as well as our medical record system (Epic)
- Created a template for documenting information from calls
- Patient-centered and tailored care
 - While some questions are uniform amongst patients, we strive to create experiences that are individualized to the person's healthcare needs, which includes patient-directed conversations

Integrated Care Model

- Providing supportive case management
- Using Motivational Interviewing to encourage patients to stay on track with blood pressure monitoring
- Supporting 8 participants with weekly therapeutic check-in calls due to disclosure of anxiety and depressive symptoms
- Contacting providers on behalf of patients to streamline healthcare efforts
- Reminding patients of upcoming appointments and options (video, telephone, in-person)



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Please enter your questions in the Q&A box



Reducing Hypertension Among African-Americans

Thank You!

www.acpm.org/initiatives/hypertension

This project funded by Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion/Division for Heart Disease and Stroke Prevention, Program Development and Services Branch NU38OT000289