Clinical Committee Agenda
November 9th, 2021 from 9 – 10 am

I. Opening Remarks – Warria Esmond & Jose Canario

II. State & National Policy Update – Marie Mongeon

III. Emergency Management Update – Alex Lipovtsev

IV. Monthly Topic: Hypertension – Diane Ferran
   a. Data Review
   b. CHC Successful Strategies: Community Health Network & Jericho Road

VIII. Closing Remarks
Hypertension Data Review
# Social Determinants of Health: Race & Ethnicity

### HTN Controlling High Blood Pressure by Race

<table>
<thead>
<tr>
<th>RACES</th>
<th>RESULT</th>
<th>NUM</th>
<th>DENOM</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaska Native</td>
<td>●</td>
<td>63.2%</td>
<td>918</td>
</tr>
<tr>
<td>Asian</td>
<td>●</td>
<td>68.3%</td>
<td>3,385</td>
</tr>
<tr>
<td>Black/African American</td>
<td>●</td>
<td>57.6%</td>
<td>20,882</td>
</tr>
<tr>
<td>Hispanic</td>
<td>●</td>
<td>59.6%</td>
<td>872</td>
</tr>
<tr>
<td>More than One Race</td>
<td>●</td>
<td>61.3%</td>
<td>2,633</td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td>●</td>
<td>60.6%</td>
<td>129</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>●</td>
<td>63.3%</td>
<td>695</td>
</tr>
<tr>
<td>Unmapped</td>
<td>●</td>
<td>100.0%</td>
<td>4</td>
</tr>
<tr>
<td>Unreported/Refused to Report Race</td>
<td>●</td>
<td>62.0%</td>
<td>24,785</td>
</tr>
<tr>
<td>White</td>
<td>●</td>
<td>64.0%</td>
<td>58,832</td>
</tr>
</tbody>
</table>

### HTN Controlling High Blood Pressure by Ethnicity

<table>
<thead>
<tr>
<th>ETHNICITIES</th>
<th>RESULT</th>
<th>NUM</th>
<th>DENOM</th>
<th>TO TRGT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic/Latino</td>
<td>●</td>
<td>63.1%</td>
<td>33,542</td>
<td>53,138</td>
</tr>
<tr>
<td>Non-Hispanic/Latino</td>
<td>●</td>
<td>63.4%</td>
<td>77,433</td>
<td>125,596</td>
</tr>
<tr>
<td>Unreported/Refused to Report Ethnicity</td>
<td>●</td>
<td>59.4%</td>
<td>9,260</td>
<td>15,598</td>
</tr>
</tbody>
</table>
Social Needs Among HTN Patients

SDOH Count Distribution

<table>
<thead>
<tr>
<th>SDOH COUNTS</th>
<th>NUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>33,139</td>
</tr>
<tr>
<td>1</td>
<td>51,530</td>
</tr>
<tr>
<td>7</td>
<td>55,095</td>
</tr>
<tr>
<td>3</td>
<td>42,877</td>
</tr>
<tr>
<td>4</td>
<td>22,104</td>
</tr>
<tr>
<td>5</td>
<td>6,433</td>
</tr>
<tr>
<td>6</td>
<td>7,004</td>
</tr>
<tr>
<td>7</td>
<td>181</td>
</tr>
<tr>
<td>8</td>
<td>464</td>
</tr>
<tr>
<td>9</td>
<td>390</td>
</tr>
<tr>
<td>10</td>
<td>121</td>
</tr>
<tr>
<td>11</td>
<td>61</td>
</tr>
<tr>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>13</td>
<td>24</td>
</tr>
<tr>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>19</td>
<td>0</td>
</tr>
</tbody>
</table>

TY 7/21

37 # Pts w/ UOS Qualifying Enc
898 # Pts w/ UOS Qualifying Enc
31,402 # Pts w/ UOS Qualifying Enc
182,641 # Pts w/ UOS Qualifying Enc
Community Health Center
Successful Strategies
REMOTE PATIENT MONITORING:
Leveraging technology to improve hypertension in underserved communities

CORE GROUP
Jean Better Cazeau, DNP, RN
Rebecca Lee, MD
Sara Fernandez, PhD
RPM INITIATIVE BACKGROUND

- CHN serves medically underserved populations -- disproportionately impacted by chronic diseases including hypertension (HTN)
  - 28% Adults in NYC
  - 40% Adults in CHN communities

- >7700 CHN adult patients diagnosed with HTN
  - 50% controlled Hypertension
  - Declined since COVID pandemic

- CHN received grant from HHS/HRSA to improve HTN among racial and ethnic minorities
  - National Hypertension Control Initiative

Controlling High Blood Pressure (UDS 2021 Table 7)
PROJECT GOALS

PROMOTING PATIENT’S ENGAGEMENT IN THEIR CARE

ACHIEVING BP CONTROL (<140/90) FOR ENROLLED PATIENT OVER THE COURSE OF AT LEAST 1 MONTH

IMPROVEMENT IN BP OF 10% ENROLLED PTS/YR OVER 3 YR = 30% OF ENROLLED PATIENTS AT THE CONCLUSION OF THE PROJECT
PILOT LAUNCH - AUG 2021

• **4 pts** (2 participants of Health Homes (HH))

• **Enrollment Day**
  - Routine visit with PCP
  - Meet with Clinical staff (HH, Nursing) for training
    - Consent
    - Downloading platform app on smartphone
    - Navigating platform
    - Pairing BP monitor to platform
    - How to take BP
At a glance...

PREVVY PLATFORM-PATIENTS

Hypertension (also known as high blood pressure) is when the blood pressure, the force of blood flowing through your vessels, is too high.

High blood pressure can be silent, which means you may not have any symptoms or warning signs. Many people may not know that they have high blood pressure.

Getting your blood pressure checked is the only way to know if you have high blood pressure.

- Your doctor will check your blood pressure at your visits and make
At a glance...

PREVVY PLATFORM - CLINICAL TEAM

[Image of Prevvy Platform interface showing patient data and observations]
PILOT SUCCESS CASE

46 year old Female with history of hypertension, obstructive sleep apnea, obesity, dyslipidemia

HTN has been uncontrolled since 2017.
- 09/01/2017: 152/103
- 06/05/2018: 123/94
- 07/08/2019: 151/93
- 07/10/2020: 144/102
- 07/26/2021: 146/110
- 08/16/2021: 128/100 (PILOT enrollment)
- 10/15/2021: 116/81

Current HTN medications: Amlodipine 10mg daily, Atenolol 50mg daily, lisinopril 40 mg daily.

Patient reports improved adherence to lifestyle changes due to daily reminders.
PILOT – LESSONS LEARNED

MEANINGFUL SURVEY

<table>
<thead>
<tr>
<th>THEME</th>
<th>FEEDBACK (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FREQUENCY OF ALARMS</td>
<td>+</td>
</tr>
<tr>
<td>Alarm encouraged me to exhibit the right behavior (taking BP, monitor sodium level)</td>
<td></td>
</tr>
<tr>
<td>TIME OF BP CHECK</td>
<td>+</td>
</tr>
<tr>
<td>As long as reminder is there, patient would still exhibit the right behavior.</td>
<td></td>
</tr>
<tr>
<td>EASE OF USE OF BP DEVICE AND NAVIGATION OF PLATFORM</td>
<td>+</td>
</tr>
<tr>
<td>ACCESSING SUPPORT</td>
<td>+</td>
</tr>
<tr>
<td>Patient can benefit from more guidance. A check in once a week would be helpful for the first two months, ideally with a phone call since it is more personable.</td>
<td></td>
</tr>
</tbody>
</table>

- COMPLIANCE-TRACKED DAYS/MONTH (SEP)

![Graph showing compliance tracked days/month for Pt 1, Pt 2, Pt 3 (HH), and Pt 4 (HH).]
RPM PROGRAM EXPANSION

PHASE 1:
HEALTH HOME PATIENTS OUTREACH
MARKETING BEGAN OUTREACH with 200+ PATIENTS OCT 2021

PHASE 2:
NON-HEALTH HOME PATIENTS OUTREACH
3100+ PATIENT RECEIVING MEDICAL CARE AT CHN

RPM PROGRAM EXPANSION

www.prevvy.co
THANK YOU!

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Founder and COO
PREVVY
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Objective: Health centers have until the end of the 3-year period to make SMBP devices available to a majority of patients 18 to 85 years old diagnosed with hypertension

Awarded: January 13th 2021

Measurable Outcomes:
- Disengaged patients with hypertension (decreased number)
- Blood pressure levels (decrease in both systolic and diastolic)
- Mortality Rates (decrease in ED visits and hospital discharge for hypertensive crisis)
- Med adherence
- % Controlled
- # patients screened for HTN
- SDOH lens: patient education and understanding
- Culture change: workflow, treatment protocols, SMBP based patient engagement
- Health and digital literacy
Hypertension Care Team Roles & Deliverables

**Community Health Workers**
- Engaged patients with hypertension
- SDOH lens: patient education and understanding
- Health and digital literacy

**Clinical Pharmacist**
- Med adherence
- # patients screened for HTN

**Clinical Team**
- Culture change: workflow, treatment protocols, SMBP based patient engagement
HRSA HTN Potential Candidate

Report Criteria:

Patients seen in Q1 of 2021 with 3 BPs greater than 140 or 90 for the past 3 BPs

(excluding those only seen for covid testing or vaccine administration)

Q1 Report total = 374 patients
Welch Allyn Home with SureBP Technology
  ● Bluetooth/Wifi enabled
  ● Data is stored in the Welch Allyn Home app

Challenges:
  ● Devices arrived June 30th due to back order
  ● Not all patients have wifi access or compatible devices

Billing:
  ● 99473- Self-measured blood pressure using a device calibrated for clinical accuracy; patient education/training and device calibration
  ● 99474- Self-measured blood pressure; two readings one minute apart twice daily over a 30-day period (minimum 12 readings)

Device Loaner Agreement:
  ● 3 month loaner agreement
# 6 Month Progress

## Outreach Efforts

<table>
<thead>
<tr>
<th></th>
<th>Quarter 3 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreached Total</td>
<td>157</td>
</tr>
<tr>
<td>Scheduled</td>
<td>78</td>
</tr>
<tr>
<td>Declined</td>
<td>35</td>
</tr>
<tr>
<td>Intake Completed</td>
<td>45</td>
</tr>
<tr>
<td>Devices Loaned</td>
<td>16</td>
</tr>
</tbody>
</table>

## UDS: Controlling High BP

<table>
<thead>
<tr>
<th></th>
<th>CY 2020</th>
<th>Jan - Aug 2021</th>
<th>2020 National Avg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Candidates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan - Oct 2021</td>
<td>936</td>
<td>30%</td>
<td></td>
</tr>
</tbody>
</table>

- US National Avg: 57.98%