

Prediabetes/Hypertension Panel

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State of CVD Risk Factor Control at CPC

- * Two community programs funded by CDPHE
 - * CHARLAR (Latino-metro area)
 - * Colorado Heart Healthy Solutions (rural-state wide program)
- * Why we chose our interventions
 - * CHW/promotora model - augments existing health care delivery services
 - * Tailored to local community
 - * Focus on underserved populations
 - * Community-based with strong clinical linkages

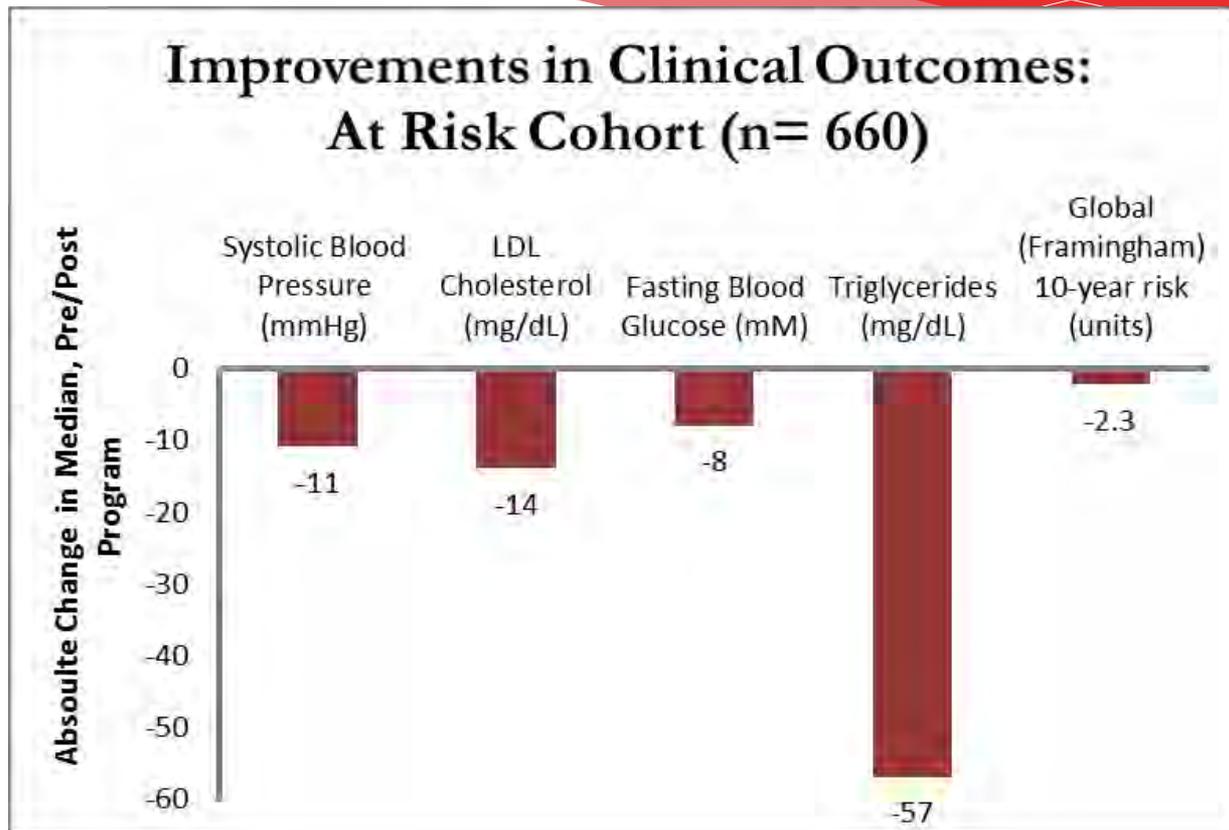
CHARLAR

- * CHARLAR = Community Heart Healthy Actions for Latinos At Risk
- * CREA Results: primary community partner
- * 12-week community based pre-diabetes and CVD prevention curriculum
- * Includes medical intervention & integration into healthcare delivery system



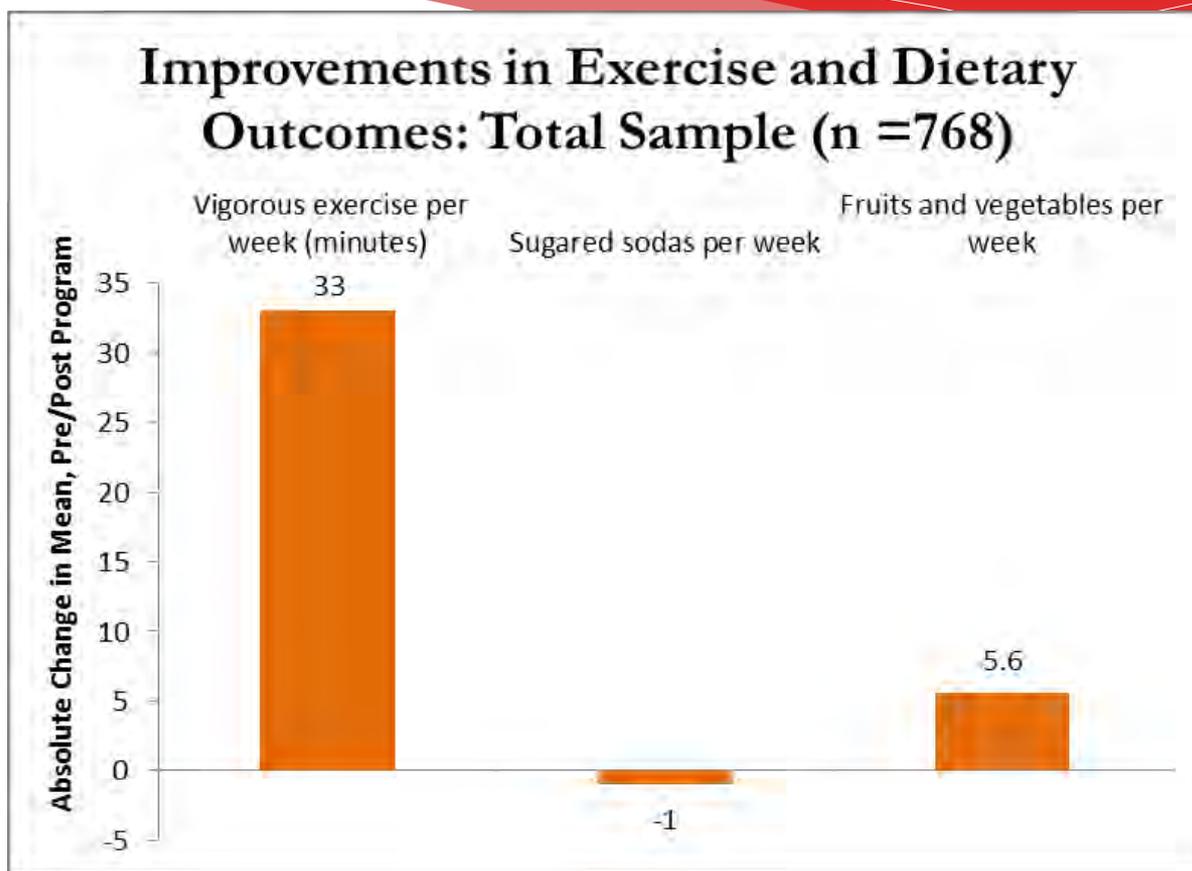
Community Heart
Health Actions for
Latinos at Risk

CHARLAR Results: Clinical Outcomes



All p-values < 0.05

CHARLAR Results: Lifestyle Outcomes

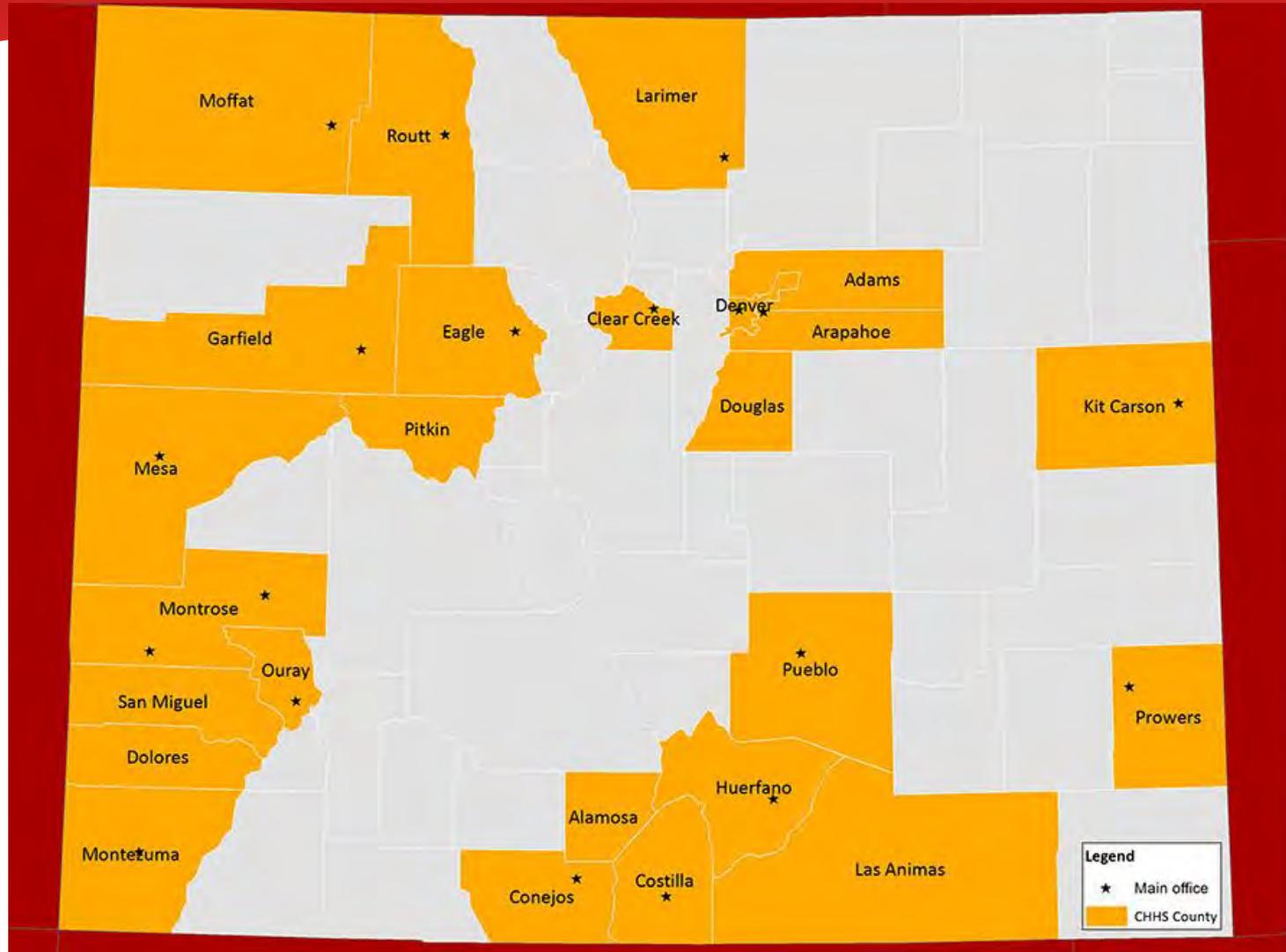


All p-values < 0.05

Element of Success - Community Engagement Outside Health Care System but with Community Clinical Linkages



CHHS Statewide Communities





Colorado
Heart Healthy Solutions
Keep the Beat 

RESEARCH AND PRACTICE

Effectiveness of a Community Health Worker Cardiovascular Risk Reduction Program in Public Health and Health Care Settings

Mori J. Krantz, MD, Stephanie M. Coronel, MPH, Elizabeth M. Whitley, PhD, Rita Dale, PhD

The US Affordable Care Act specifies implementation of a national partnership for disease prevention and health promotion, with a focus on reducing health disparities. Although the Affordable

Objectives. We evaluated cardiovascular disease (CHD) with community health workers in public health and health care settings.

American Journal of Public Health
2013;103(1): e19–e27.

CHHS Websites

www.hearthealthysolutions.org or
www.cpccommunityhealth.org

SCIENCE-IN-BRIEF

TURNING SCIENCE INTO ACTION

The Impact of Community Health Workers on Cardiovascular Risk Reduction

The following is a synopsis of “Effectiveness of a Community Health Worker Cardiovascular Risk Reduction Program in Public Health and Health Care Settings,” published in the January 2013 issue of the *American Journal of Public Health*.



www.cdc.gov/dhdsp/pubs/docs/sib_january2013.pdf



Field Notes



Colorado Heart Healthy Solutions

Problem:

To address growing rates of high blood pressure, elevated cholesterol, and other risk factors related to cardiovascular diseases in Colorado, there is a need to help people effectively navigate community health systems in order to support behavior change strategies and medication adherence.

Program:

Colorado Heart Healthy Solutions (CHHS) is a community-based program in which community health

Overview

The CHHS program started as a partnership between Denver Health's Community Voices and Colorado Prevention Center's (CPC) Community Health. CPC Community Health previously used unmanned kiosks to provide personalized cardiovascular health information in community settings as part of the Health-e-Solutions program. In July 2009, CPC Community Health's kiosk program merged with Denver Health's Community Voices' CHW Program to enhance participant interaction and care coordination through face-to-face intervention. As a result, the program emphasis shifted from raising awareness of the need for screening to providing community navigation and ongoing follow-up services intended to reinforce behavior change and medication adherence. The CHWs are supported by program staff and a data collection and decision support system known as the Outreach, Screening, and Referral system (OSCAR) which was launched in November 2009. The decision support component of the OSCAR system generates evidence-based health recommendations and referral cues to provide consistent, evidence-based messaging. OSCAR's data collection component is used to track client risk factors and outcomes, manage an inventory of local medical and healthy living resources, and monitor CHW productivity.

Program Services

Core elements of CHHS include the use of evidence-based guidelines to inform CHWs' counseling and referral decisions and standardized electronic tracking requirements for CVD screening; however, the program encourages CHWs to leverage community resources to meet the needs of the priority population. CHHS features a blended approach of standardized and flexible implementation.

The sequence of activities performed by CHWs is described below.

- Each CHW provides CVD screening (including cholesterol, glucose,

CHHS by the Numbers

	Baseline Levels for At-risk Population	Change in Risk Factor	Baseline Levels for those with Abnormal Risk Factor	Change in Risk Factor
Total Cholesterol	215 mg/dL	↓ 15	240 mg/dL	↓ 24
LDL Cholesterol	139 mg/dL	↓ 18	164 mg/dL	↓ 30
Systolic Blood Pressure	131 mmHg	↓ 4	155 mmHg	↓ 18
Framingham Risk	11.3	↓ 0.8	20.8	↓ 2.4

Implementation

- * Bidirectional referral system: into care and from care to aid with lifestyle, adherence, motivation
- * How we increase awareness & program impact
 - * Local dissemination & recruitment
 - * Collaboration with trusted community partners
 - * Physician peer-to-peer education at clinics that either house our community health worker or receive patients in referral

Program Tools/Resources

- * Point of service data collection and decision support tools/resources that support our programs:
 - * Outreach Screening and Referral [OSCAR] system (CHHS)
 - * CVD Risk Calculator & Counseling Tool (CHARLAR)

CHARLAR Risk Calculator & Counseling Tool

- * Standardizes messaging
- * Uses current EBM guidelines

CHARLAR Risk Calculator and Counseling Tool*

Enter client info here (fasting)

Participant ID		
Gender (M or F)		
Age (years)		
Race (AA or WH)	wh	
Diabetes? (Y or N)		
Treatment for High BP? (Y or N)		
Heart Disease or Stroke? (Y or N)		
Smoker? (Y or N)		
Total Cholesterol (mg/dL)		<200
HDL-Cholesterol (mg/dL)		?
Triglycerides (mg/dL)		<150
LDL-Cholesterol (mg/dL)		<160
Glucose (mg/dL)		?
Systolic Blood Pressure (mmHg)		<140
Diastolic Blood Pressure (mmHg)		<90

Referrals

Blood pressure: _____

Glucose: _____

LDL Cholesterol: _____

Statin therapy: _____

Triglycerides : _____

Aspirin therapy: _____

Provide counseling on...

Blood pressure: _____

Glucose: _____

LDL Cholesterol: _____

Triglycerides : _____

10-Year ASCVD Risk (%)

This represents the client's chance of having a heart attack or stroke in the next 10 years of 100 people with this score will have a heart attack or stroke in the next 10 years

Save Data

Clear Data

*Based upon the 2013 ATP4 and JNC8 Guidelines
 Abbreviations: AA - African American; ASCVD - Atherosclerotic cardiovascular disease, defined as CHD death, nonfatal myocardial infarction, or fatal or nonfatal stroke; F - Female; M - Male; N - No; WH - White; Y - Yes.

CHHS OSCAR system

Maria L Jorge
9/30/2010 at CPC

LOW 0% 10% 20% HIGH

3%

Comments
Lifestyle Goals
Targets

Save Cancel

71% Complete

Submit

PREVIOUS INTERVIEW

Summary and Results

29 BMI LOW 0% 10% 20% HIGH

3%

Your Customized Health Prescription

- ♥ Congratulations! You are at LOW risk of having a heart attack or stroke in the next 10 years.
- ♥ 3 of 100 people with your score will have a heart attack or stroke in the next 10 years.
- ♥ Even though you are at low risk today, your high blood pressure is/are increasing your chance of having a heart attack or stroke in the more distant future.
- ♥ Because you are at low risk, we do not recommend aspirin for your heart
- ♥ Congratulations! Your LDL (bad) cholesterol is 101; goal is less than 130
- ♥ Attention! Your systolic blood pressure (top number) is 140; goal is less than 140

General Health Lifestyle Guidance