



Learning Session #3
**Cross Sector Strategies for Improving Patient and
Person-Centered Care**

**January 15, 2025
1pm – 2pm**

Call Agenda

- Welcome

- Housekeeping

- Presentation

- Close-Out & Next Steps

Housekeeping



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- Dr. Phillip Levy, MD, MPH, FACEP, FAHA, FACC
 - Professor of Emergency Medicine and Associate Vice President for Translational Science - Wayne State University
 - Director, Wayne Mobile Health Unit Program

Cross Sector Strategies for Improving Patient and Person-Centered Care

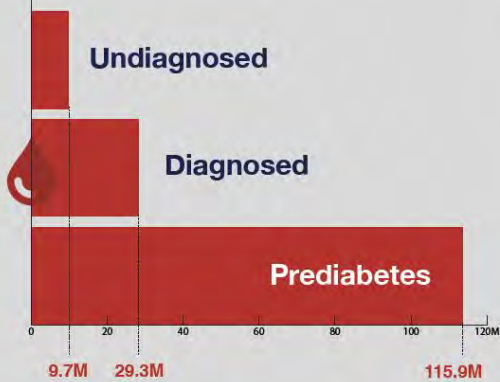
Phillip D. Levy, MD MPH, FACEP, FAHA, FACC

Professor of Emergency Medicine and Associate Vice President for Translational Science - Wayne State University

Director, Wayne Mobile Health Unit Program

Issues We Need to Confront

- Motivation and messaging
- Multilevel care delivery models
- Payment and payment reform
- Skill sets, trainings, and pathways



Heart Disease & Stroke Statistics

2024 Update

The American Heart Association (AHA) **2024 Statistical Update** is a major source for monitoring cardiovascular health, risk factors, and disease in the US and global population. It is published annually in *Circulation* and can be accessed for free at [AHAjournals.org/StatUpdate](https://www.ahajournals.org/statupdate)

9.7 million

adults have undiagnosed diabetes

29.3 million

adults have diagnosed diabetes

115.9 million

adults have prediabetes

(based on 2017-2020 data)

25.5%

of US adults have high LDL-C (≥ 130 mg/dL)

(based on 2017-2020 data)



3.72 million

deaths globally were attributed to high LDL-C in 2021



224.0
per 100,000

The age-adjusted US death rate attributable to CVD (based on 2021 data)



On average, someone in the US dies of CVD every **34 seconds**

2562 US deaths from CVD each day (based on 2021 data)



On average, someone in the US dies of a stroke every **3 minutes and 14 seconds**

446 US deaths from stroke each day (based on 2021 data)



237.9
per 100,000

The age-adjusted global death rate attributable to CVD (based on 2021 data)



122.4 million, or 47%,
of US adults are estimated to have
hypertension.

(based on 2017-2020 data)



On average,
1 in 4 adults

in the United States reported achieving adequate
leisure-time aerobic and muscle-strengthening
activities to meet the physical activity guidelines.

(based on 2020 data)



1 in 8
male adults
in the United States
are current smokers.

(based on 2021 data)



1 in 10
female adults
in the United States
are current smokers.

(based on 2021 data)



1 in 7
high school students
in the United States used
e-cigarettes in the past 30 days.

(based on 2022 data)



Every **1 h/night**
decrease in sleep
below the 7-8 h/night
recommended duration
is associated with
6% higher risk
of total CVD.

Every **1 h/night**
increase in sleep
duration above
7-8 h/night is
associated with
12% higher risk
of total CVD.

In 2021, Alzheimer disease and
other dementias affected

57 million
people globally.



Less than 10%



of US adults met the guidelines for whole grain,
whole fruit, and nonstarchy vegetable consumption
each day in 2017-2018.

Forecasting the Burden of Cardiovascular Disease and Stroke in the United States Through 2050—Prevalence of Risk Factors and Disease: A Presidential Advisory From the American Heart Association

Karen E. Joynt Maddox, MD, MPH, FAHA, Chair; Mitchell S.V. Elkind, MD, MS, FAHA; Hugo J. Aparicio, MD, MPH; Yvonne Commodore-Mensah, PhD, MHS, BSN, RN, FAHA; Sarah D. de Ferranti, MD, MPH, FAHA; William N. Dowd, BA; Adrian F. Hernandez, MD, MHS, FAHA; Olga Khavjou, MA; Erin D. Michos, MD, MHS, FAHA; Latha Palaniappan, MD, MS, FAHA; Joanne Penko, MS, MPH; Remy Poudel, MS, MPH, CPH; Véronique L. Roger, MD, MPH; Dhruv S. Kazi, MD, MSc, MS, FAHA, Vice Chair; on behalf of the American Heart Association

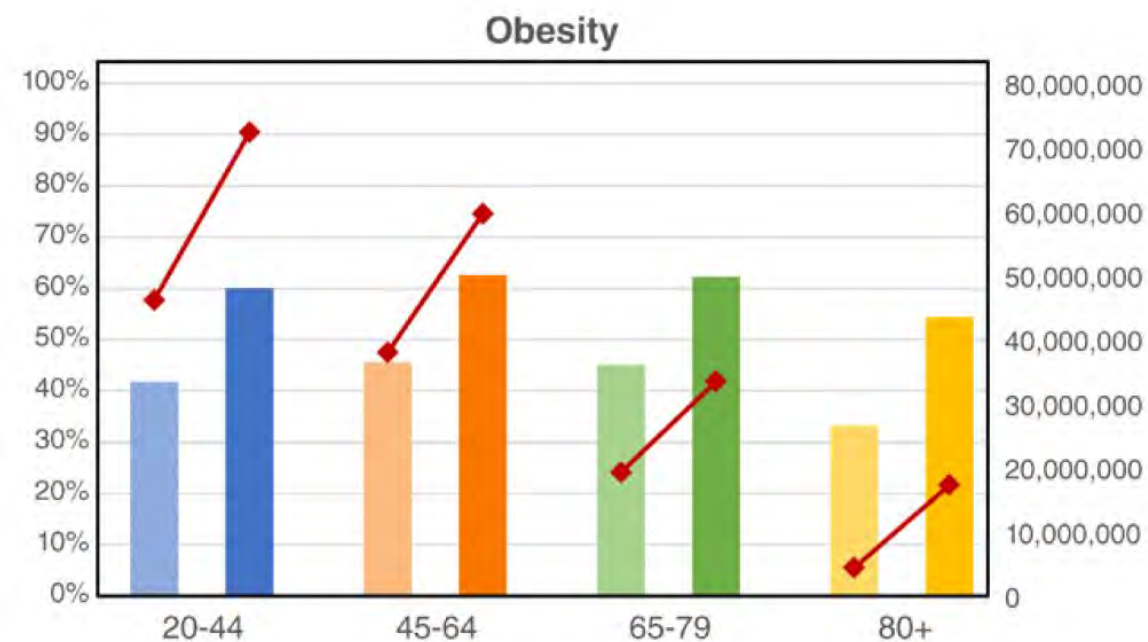
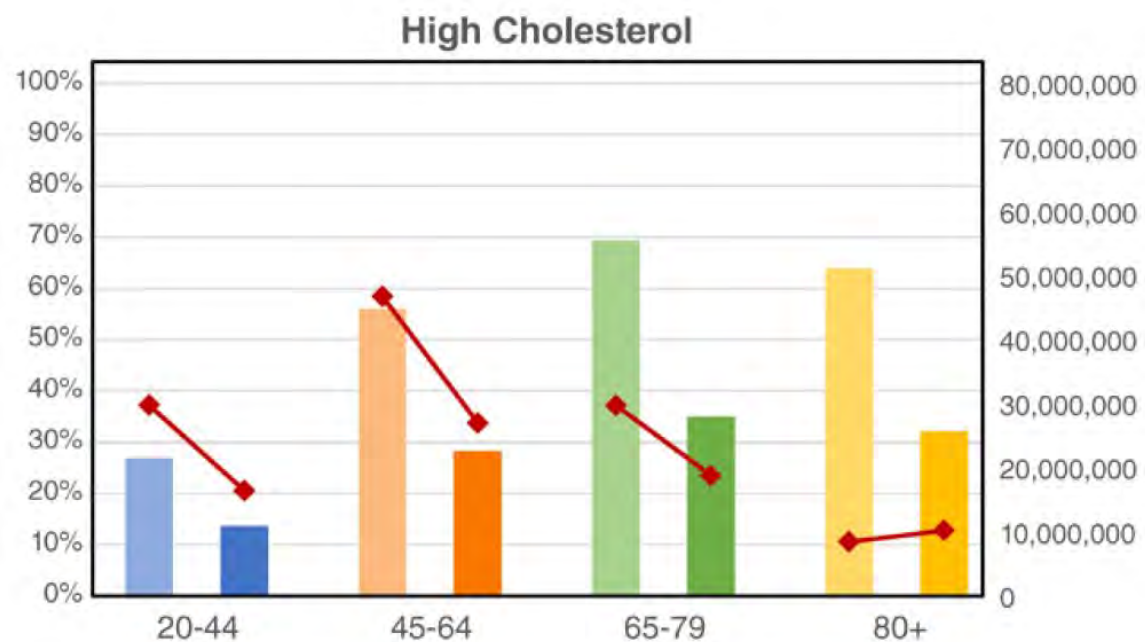
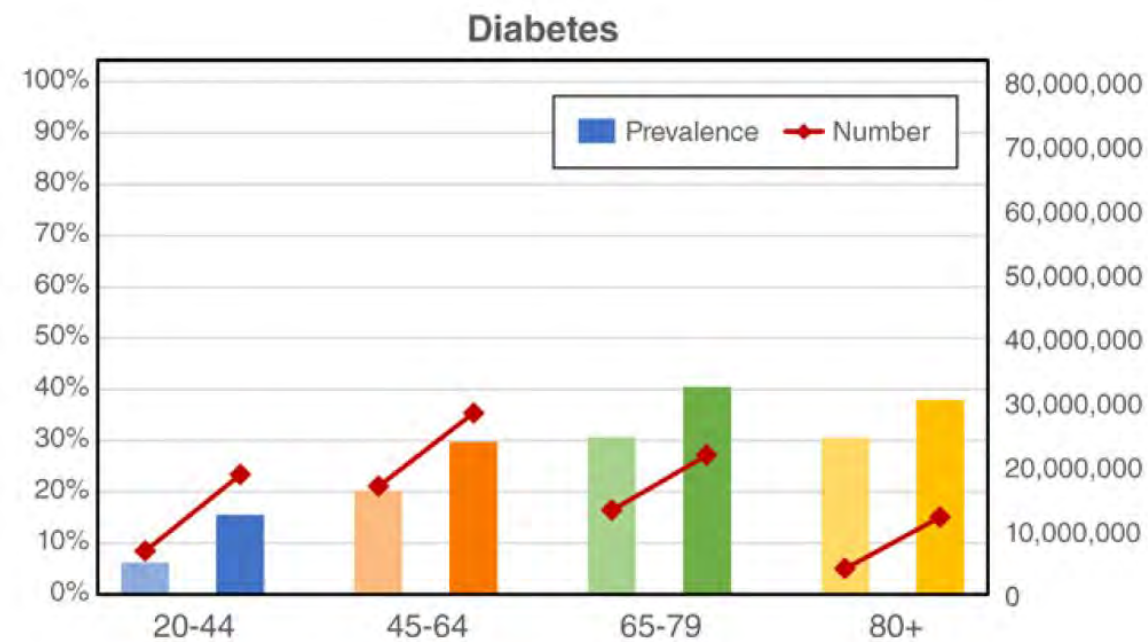
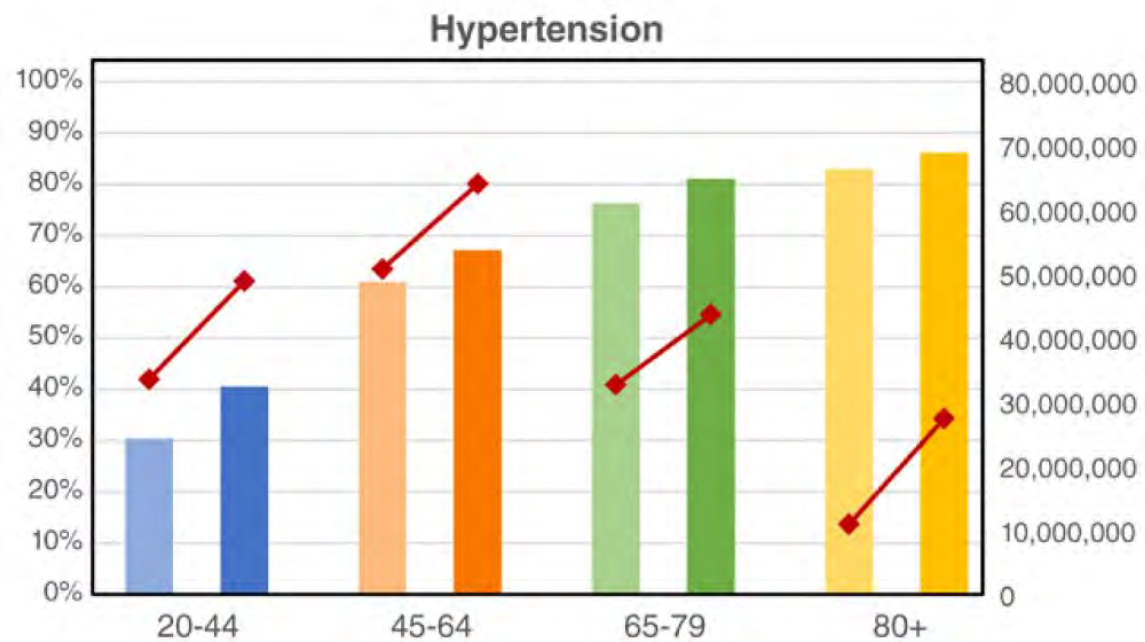


BACKGROUND: Cardiovascular disease and stroke are common and costly, and their prevalence is rising. Forecasts on the prevalence of risk factors and clinical events are crucial.

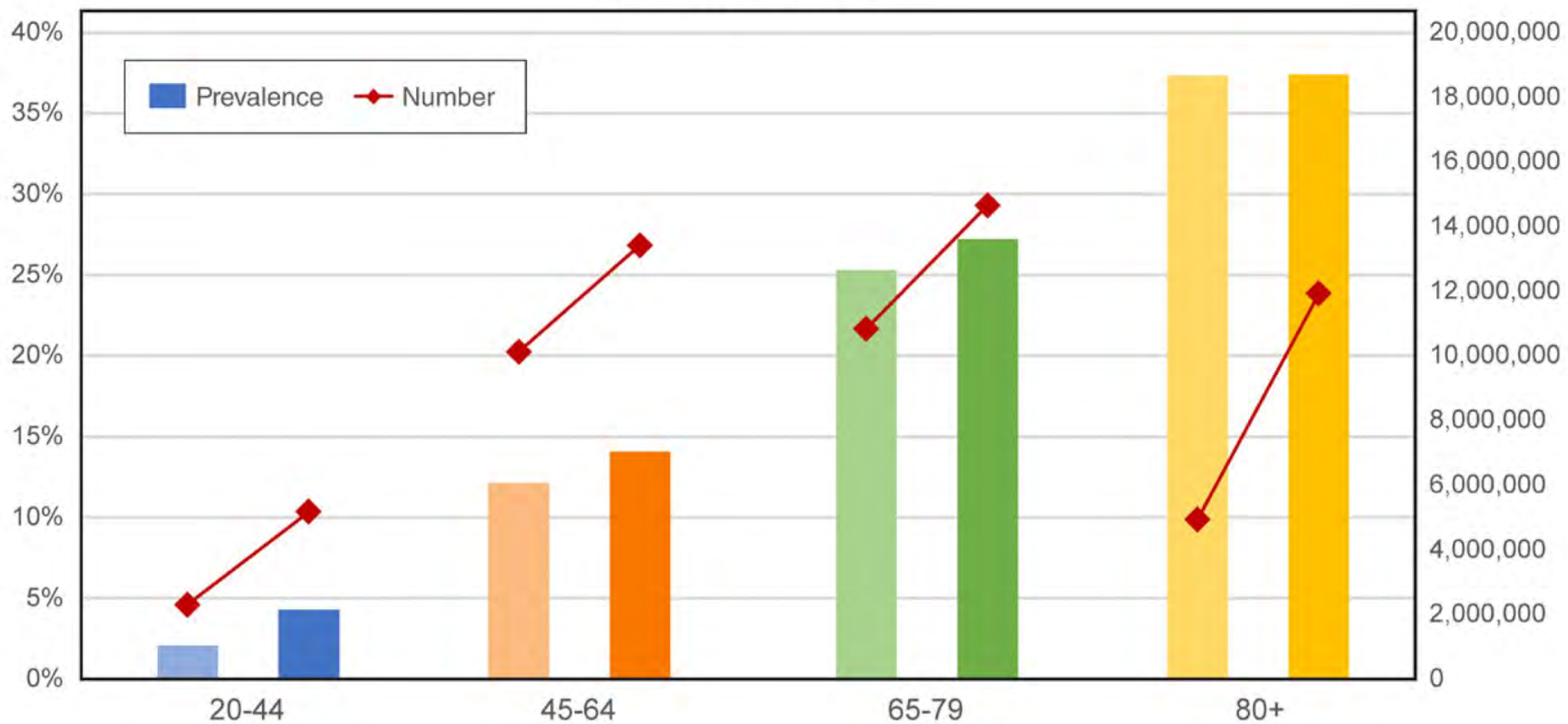
METHODS: Using the 2015 to March 2020 National Health and Nutrition Examination Survey and 2015 to 2019 Medical Expenditure Panel Survey, we estimated trends in prevalence for cardiovascular risk factors based on adverse levels of Life's Essential 8 and clinical cardiovascular disease and stroke. We projected through 2050, overall and by age and race and ethnicity, accounting for changes in disease prevalence and demographics.

RESULTS: We estimate that among adults, prevalence of hypertension will increase from 51.2% in 2020 to 61.0% in 2050. Diabetes (16.3% to 26.8%) and obesity (43.1% to 60.6%) will increase, whereas hypercholesterolemia will decline (45.8% to 24.0%). The prevalences of poor diet, inadequate physical activity, and smoking are estimated to improve over time, whereas inadequate sleep will worsen. Prevalences of coronary disease (7.8% to 9.2%), heart failure (2.7% to 3.8%), stroke (3.9% to 6.4%), atrial fibrillation (1.7% to 2.4%), and total cardiovascular disease (11.3% to 15.0%) will rise. Clinical CVD will affect 45 million adults, and CVD including hypertension will affect more than 184 million adults by 2050 (>61%). Similar trends are projected in children. Most adverse trends are projected to be worse among people identifying as American Indian/Alaska Native or multiracial, Black, or Hispanic.

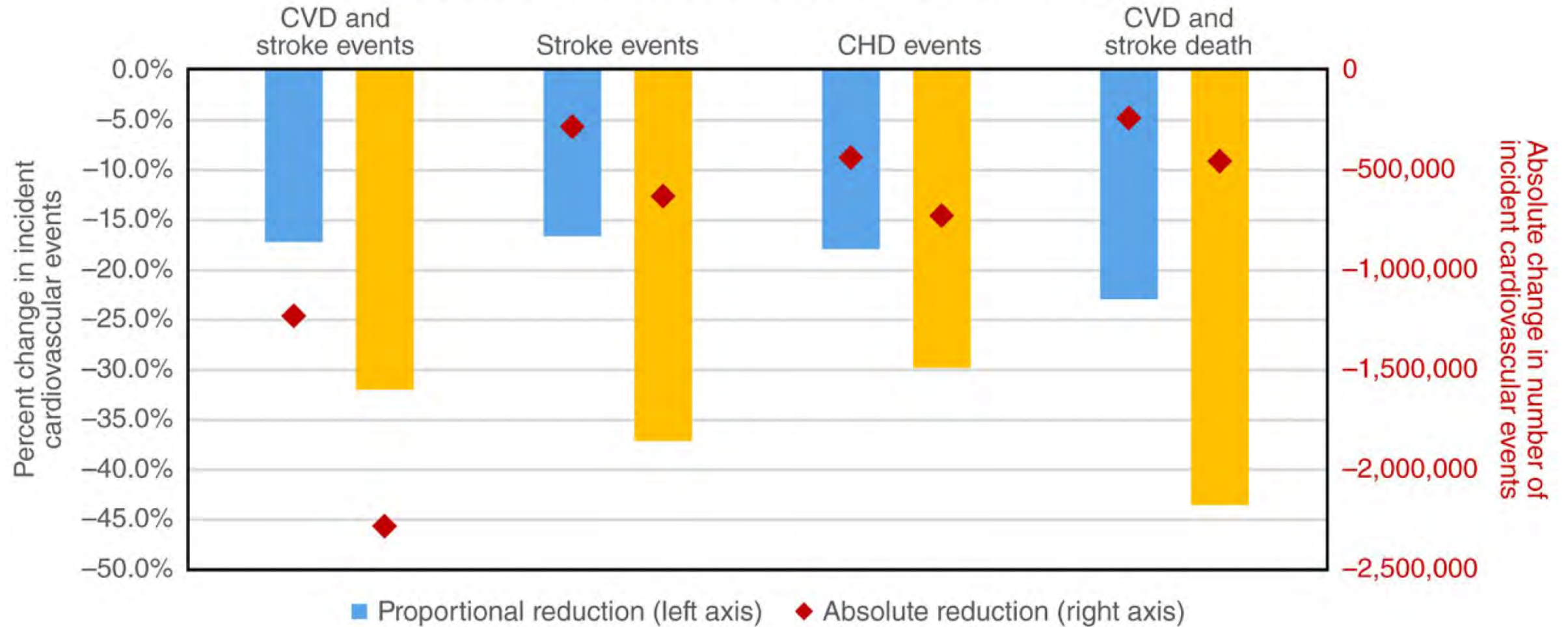
CONCLUSIONS: The prevalence of many cardiovascular risk factors and most established diseases will increase over the next 30 years. Clinical and public health interventions are needed to effectively manage, stem, and even reverse these adverse trends.



Total CVD and Stroke







Reduction in Incident Cardiovascular Events



ORIGINAL RESEARCH

Stage 1 Hypertension and the 10-Year and Lifetime Risk of Cardiovascular Disease: A Prospective Real-World Study

Xinyi Peng , MD;* Cheng Jin , MD;* Qirui Song, MD; Shouling Wu , MD, PhD; Jun Cai , MD, PhD

BACKGROUND: The 10-year and lifetime cardiovascular disease risk in the population with stage 1 hypertension and the effects of recovery from and progression of stage 1 hypertension remain undetermined.

METHODS AND RESULTS: This prospective cohort study included 96268 individuals with blood pressure measurements obtained in 2006 and again in 2010. The 10-year cardiovascular disease risk was estimated using the multivariable Cox proportional hazards model, and the lifetime risk was calculated using a modified survival analysis that accounted for the competing risk of death. Stage 1 hypertension was detected in 30.83% of the cohort. The 10-year cardiovascular disease risk was 2.80%, and the lifetime risk was 16.61%. Compared with the normal blood pressure group, the stage 1 hypertension group had a 35% higher 10-year risk (hazard ratio [HR], 1.35 [95% CI, 1.19–1.52]) and a 36% higher lifetime risk (HR, 1.36 [95% CI, 1.25–1.49]). By 2010, 12.57% of the participants with stage 1 hypertension had progressed to stage 2, with a significant 156% increase in 10-year risk (HR, 2.56 [95% CI, 2.11–3.11]) and an increased lifetime risk of 129% (HR, 2.29 [95% CI, 1.89–2.77]). There was no appreciable change in risk in those with stage 1 hypertension whose blood pressure returned to the normal-elevated range.

CONCLUSIONS: Stage 1 hypertension was associated with a significant increase in 10-year and lifetime cardiovascular disease risk. Progression to stage 2 hypertension was associated with a marked increase in lifetime risk. The current guidelines require revision to promote early detection and appropriate management of blood pressure.

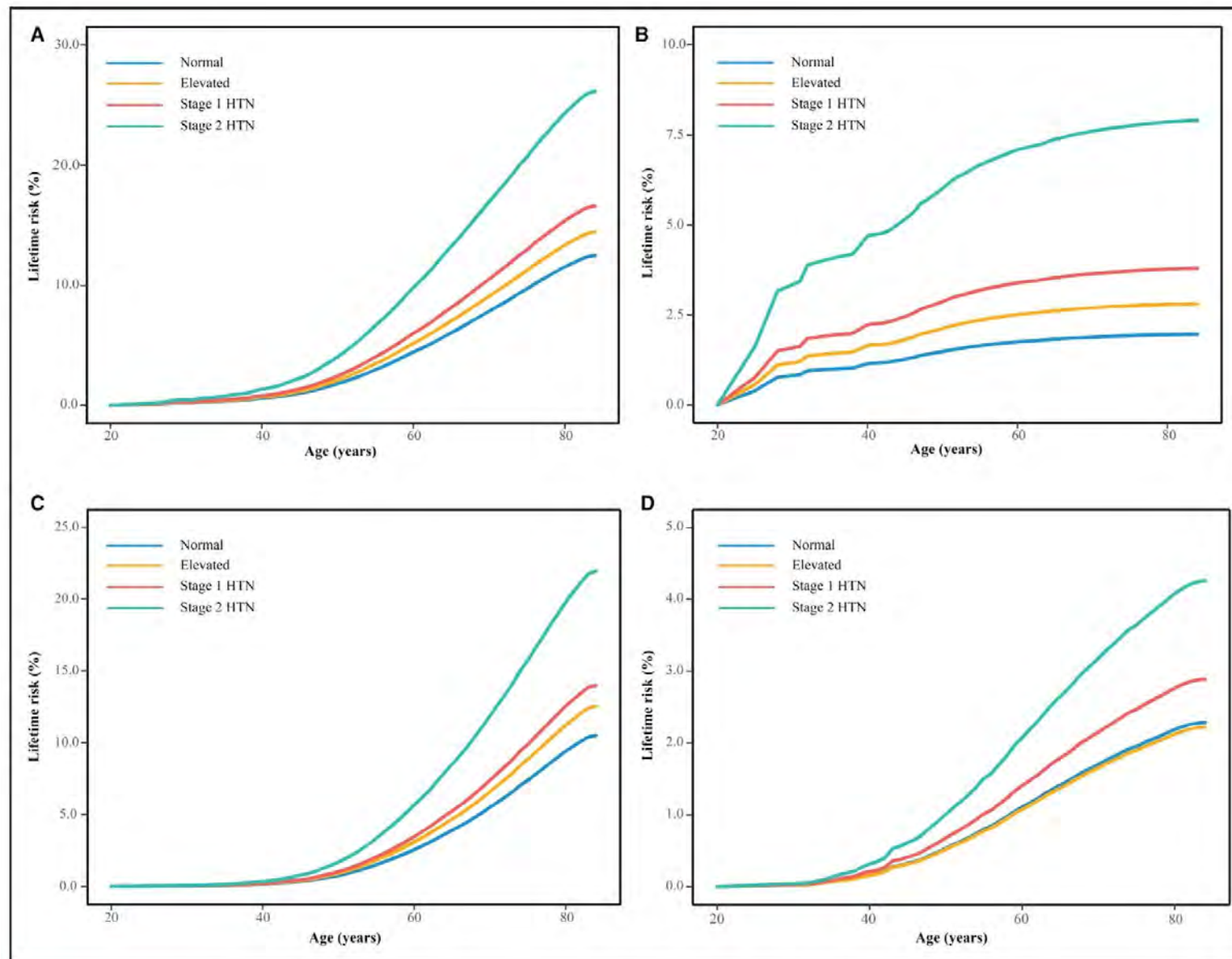


Figure 2. Lifetime risk of cardiovascular diseases, according to BP levels in 2006.

A, Cardiovascular disease; **B**, cerebral hemorrhage; **C**, cerebral infarction; and **D**, myocardial infarction. Participants were stratified by BP levels on the basis of the following criteria: (1) a normal BP group (SBP <120mmHg and DBP <80mmHg); (2) an elevated BP group (SBP 120–129mmHg and DBP <80mmHg); (3) a stage 1 hypertension group (SBP 130–139mmHg or DBP 80–89mmHg); and (4) a stage 2 hypertension group (SBP ≥140mmHg or DBP ≥90mmHg or currently taking antihypertensive agents). BP indicates blood pressure; DBP, diastolic blood pressure; HTN, hypertension; and SBP, systolic blood pressure.



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It's easy to understand risks to your health

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Healthy Life HRA



This report explains your health risks as a 52 year old male.

Current Age

52

Risk Age

58.0

Target Age

48.5

Your risk age compares you to other people your age and sex for all causes of death

Your target age is what your risk age could be if you made changes to your lifestyle.

Your answers point to lots of changes you can make to reduce your risks and live healthy. Making lifestyle changes can reduce your risk age by 9.4 years.

What you can do lower your risk age:



lower blood pressure

increase hdl cholesterol

lower total cholesterol

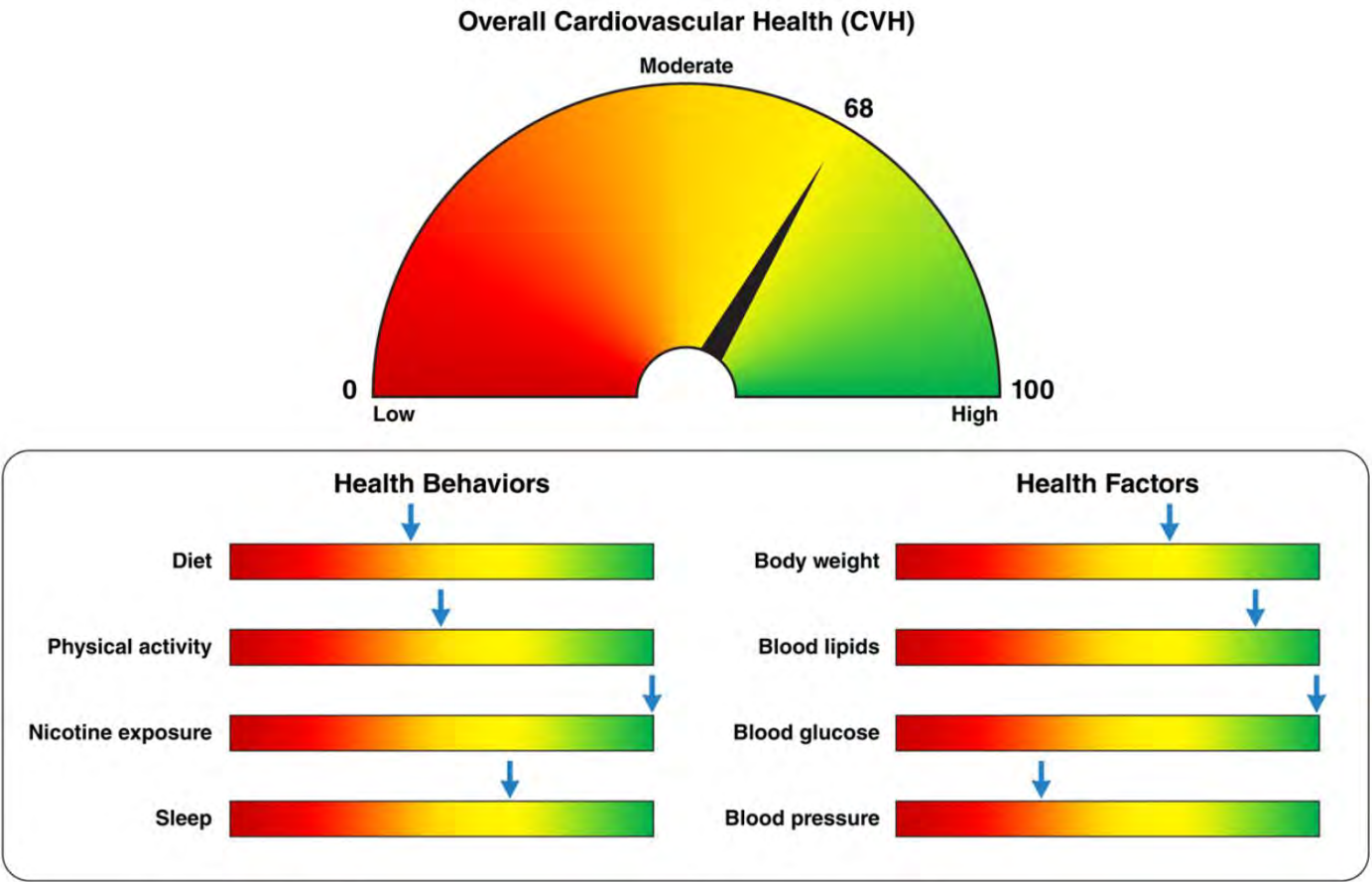
lose weight

reduce alcohol use

Issues We Need to Confront

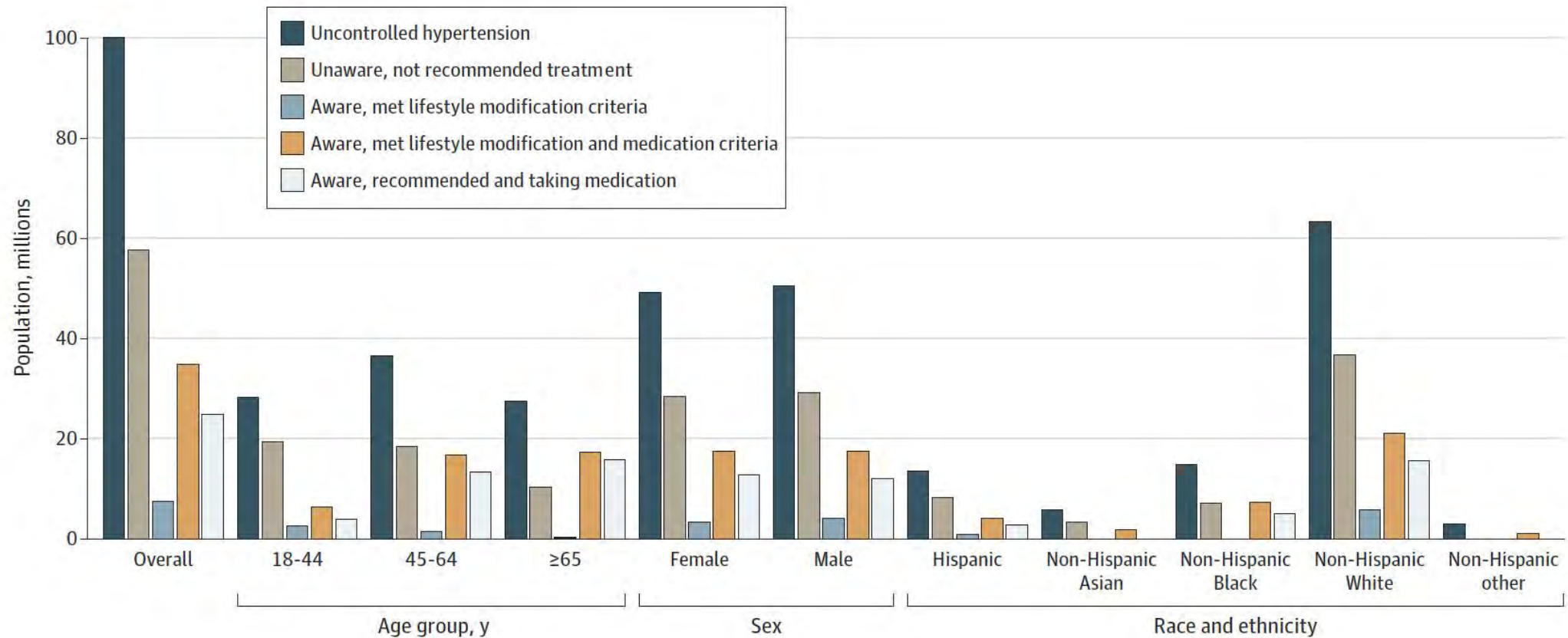
- Motivation and messaging
- Multilevel care delivery models
- Payment and payment reform
- Skill sets, trainings, and pathways

Life's Essential 8: Updating and Enhancing the American Heart Association's Construct of Cardiovascular Health: A Presidential Advisory From the American Heart Association



Examining the Hypertension Control Cascade in Adults With Uncontrolled Hypertension in the US

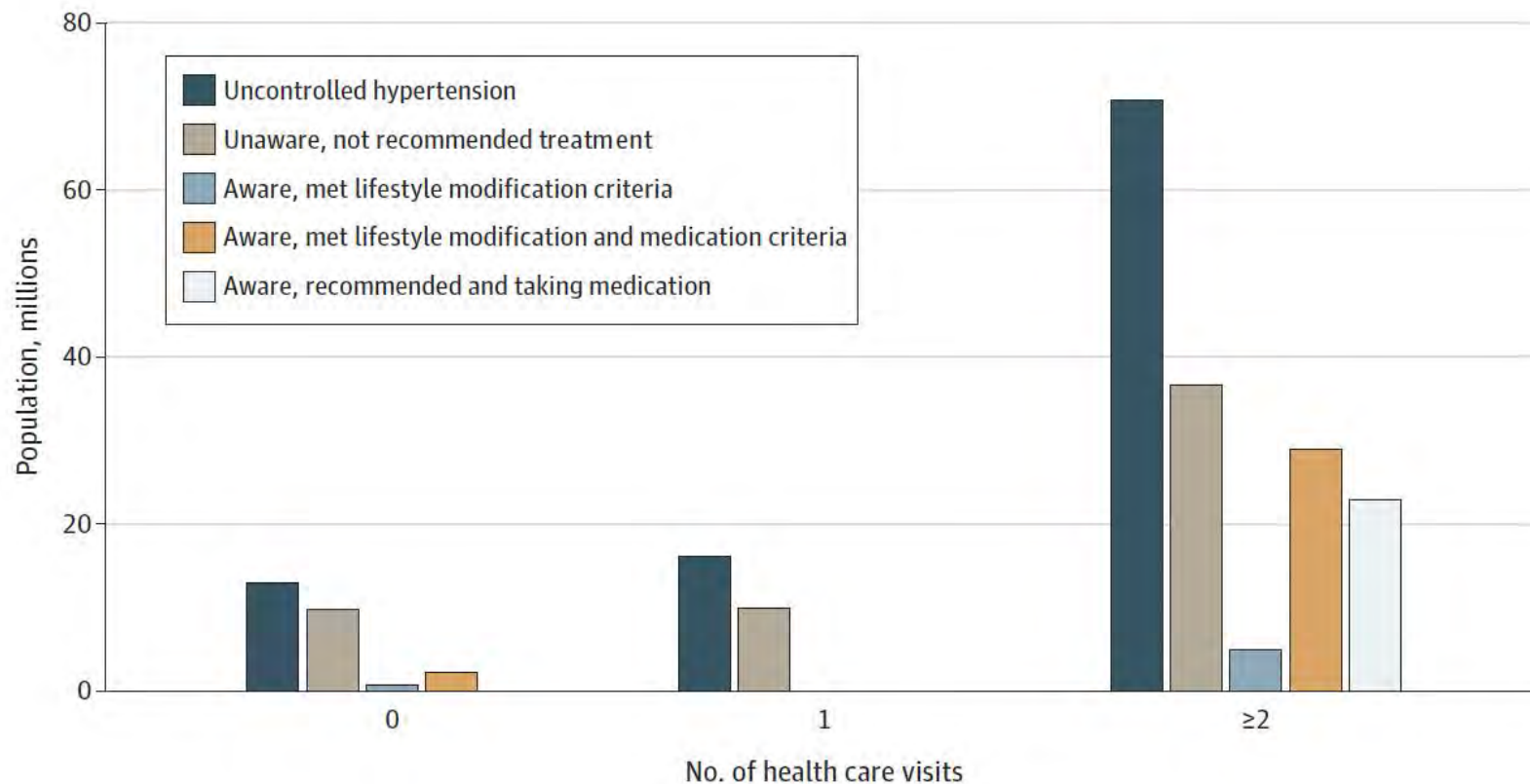
LaTonia C. Richardson, PhD; Adam S. Vaughan, PhD; Janet S. Wright, MD; Fátima Coronado, MD



Original Investigation | Cardiology

Examining the Hypertension Control Cascade in Adults With Uncontrolled Hypertension in the US

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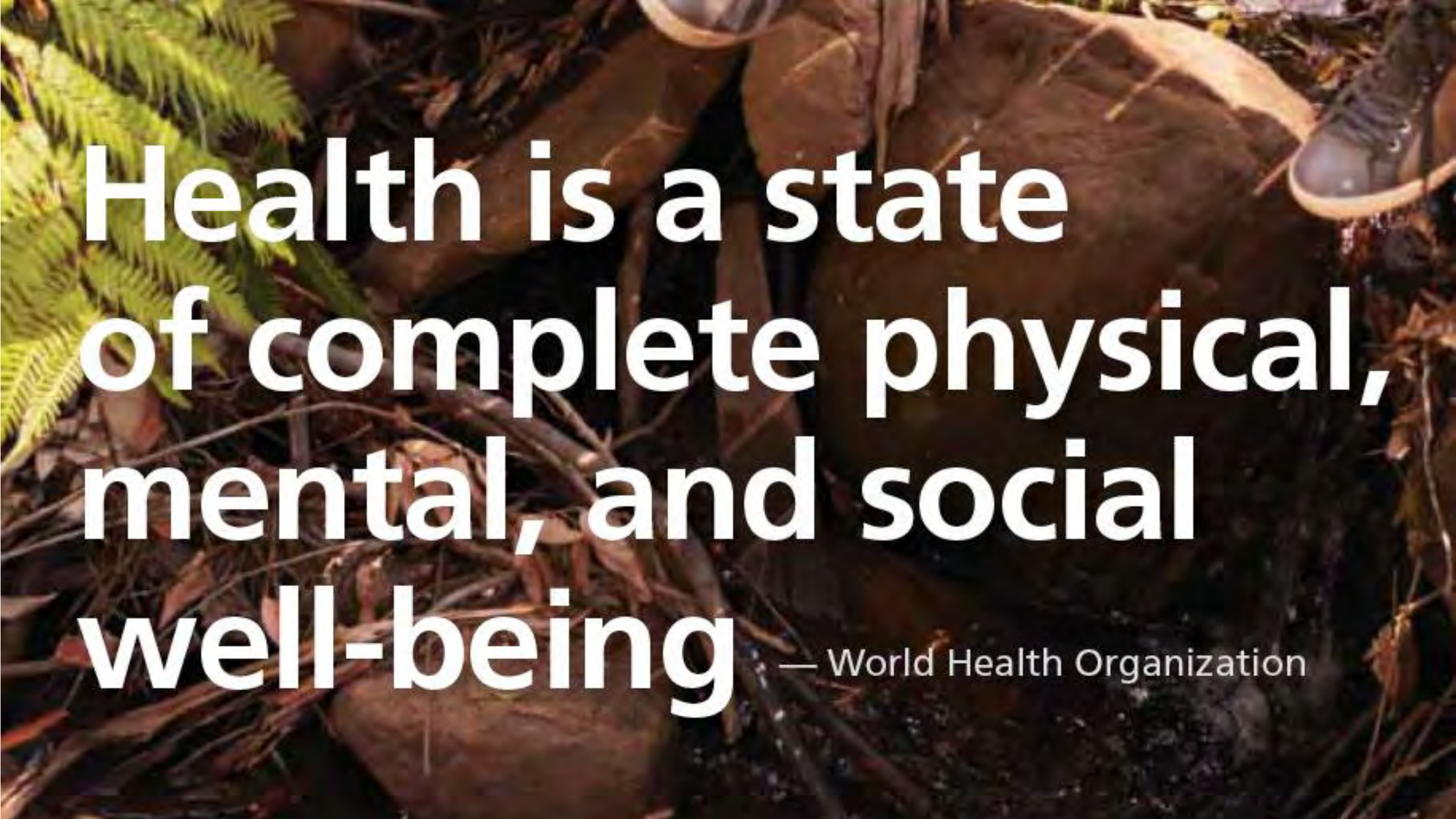
Stress and Achievement of Cardiovascular Health Metrics: The American Heart Association Life's Simple 7 in Blacks of the Jackson Heart Study

LaPrincess C. Brewer, MD, MPH; Nicole Redmond, MD, PhD, MPH; Joshua P. Slusser, BS; Christopher G. Scott, MS;
Alanna M. Chamberlain, PhD; Luc Djousse, MD, MPH, DSc; Christi A. Patten, PhD; Veronique L. Roger, MD; Mario Sims, PhD, MS

Background—Ideal cardiovascular health metrics (defined by the American Heart Association Life's Simple 7 [LS7]) are suboptimal among blacks, which results in high risk of cardiovascular disease. We examined the association of multiple stressors with LS7 components among blacks.

Methods and Results—Using a community-based cohort of blacks (N=4383), we examined associations of chronic stress, minor stressors, major life events, and a cumulative stress score with LS7 components (smoking, diet, physical activity, body mass index, blood pressure, total cholesterol, and fasting plasma glucose) and an LS7 composite score. Multivariable logistic regression assessed the odds of achieving intermediate/ideal levels of cardiovascular health adjusted for demographic, socioeconomic, behavioral, and biomedical factors. The LS7 components with the lowest percentages of intermediate/ideal cardiovascular health levels were diet (39%), body mass index (47%), and physical activity (51%). Higher chronic, minor, and cumulative stress scores were associated with decreased odds (odds ratio [OR]) of achieving intermediate/ideal levels for smoking (OR [95% confidence interval], 0.80 [0.73–0.88], 0.84 [0.75–0.94], and 0.81 [0.74–0.90], respectively). Participants with more major life events had decreased odds of achieving intermediate/ideal levels for smoking (OR, 0.84; 95% confidence interval, 0.76–0.92) and fasting plasma glucose (OR, 0.90; 95% confidence interval, 0.82–0.98). Those with higher scores for minor stressors and major life events were less likely to achieve intermediate or ideal LS7 composite scores (OR [95% confidence interval], 0.89 [0.81–0.97] and 0.91 [0.84–0.98], respectively).

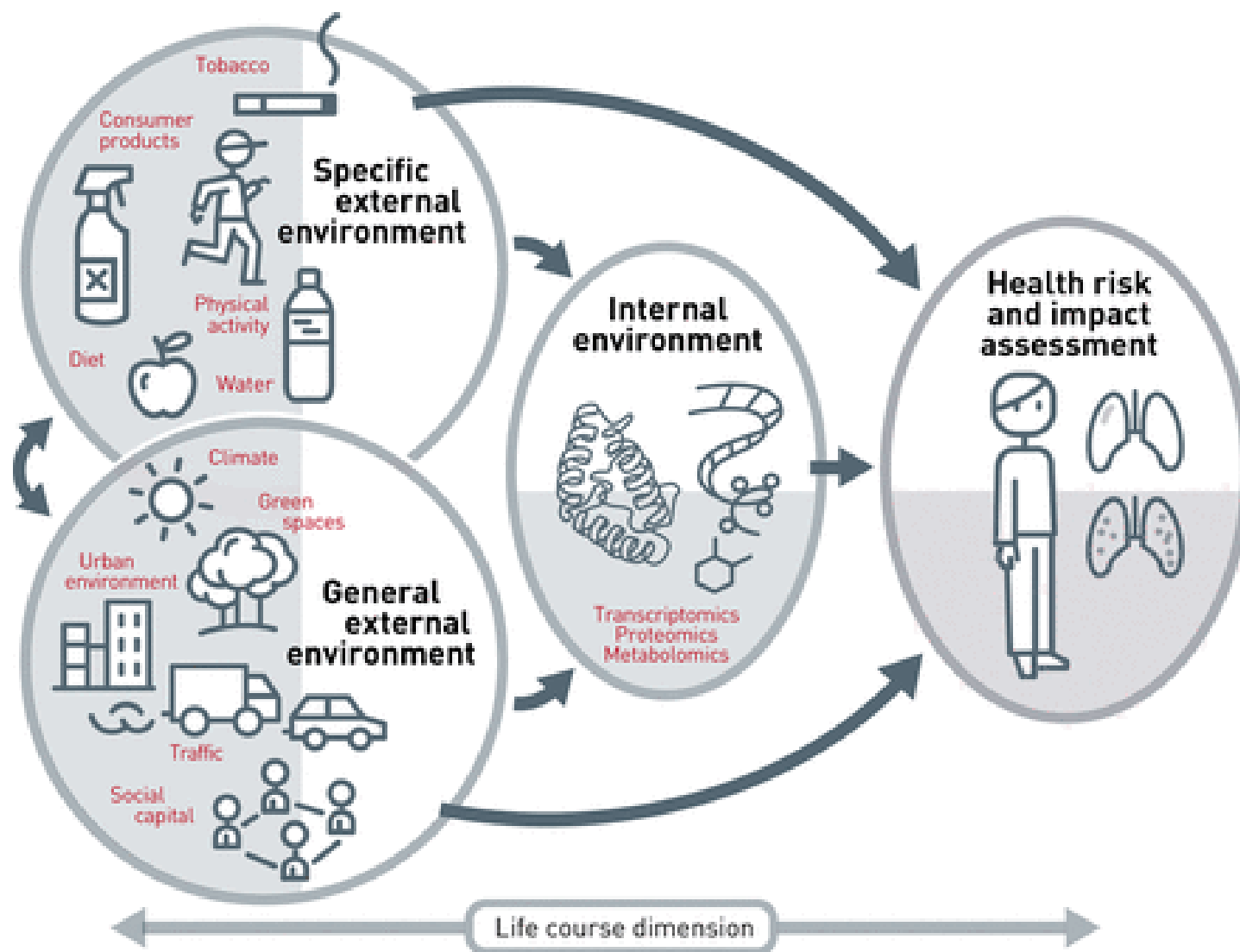
Conclusions—Blacks with higher levels of multiple stress measures are less likely to achieve intermediate or ideal levels of overall cardiovascular health (LS7 composite score), specific behaviors (smoking), and biological factors (fasting plasma glucose). (*J Am Heart Assoc.* 2018;7:e008855. DOI: 10.1161/JAHA.118.008855.)



**Health is a state
of complete physical,
mental, and social
well-being**

— World Health Organization

We Are a Product of Our Environments...



The Urban Environment and Cardiometabolic Health

Sanjay Rajagopalan^{ID}, MD; Armando Vergara-Martel, MS; Jeffrey Zhong^{ID}, BS; Haitham Khraishah^{ID}, MD; Mikhail Kosiborod^{ID}, MD; Ian J. Neeland^{ID}, MD; Jean-Eudes Dazard, PhD; Zhuo Chen, PhD; Thomas Munzel^{ID}, MD; Robert D. Brook^{ID}, MD; Mark Nieuwenhuijsen, PhD; Peter Hovmand, PhD; Sadeer Al-Kindi^{ID}, MD

ABSTRACT: Urban environments contribute substantially to the rising burden of cardiometabolic diseases worldwide. Cities are complex adaptive systems that continually exchange resources, shaping exposures relevant to human health such as air pollution, noise, and chemical exposures. In addition, urban infrastructure and provisioning systems influence multiple domains of health risk, including behaviors, psychological stress, pollution, and nutrition through various pathways (eg, physical inactivity, air pollution, noise, heat stress, food systems, the availability of green space, and contaminant exposures). Beyond cardiometabolic health, city design may also affect climate change through energy and material consumption that share many of the same drivers with cardiometabolic diseases. Integrated spatial planning focusing on developing sustainable compact cities could simultaneously create heart-healthy and environmentally healthy city designs. This article reviews current evidence on the associations between the urban exposome (totality of exposures a person experiences, including environmental, occupational, lifestyle, social, and psychological factors) and cardiometabolic diseases within a systems science framework, and examines urban planning principles (eg, connectivity, density, diversity of land use, destination accessibility, and distance to transit). We highlight critical knowledge gaps regarding built-environment feature thresholds for optimizing cardiometabolic health outcomes. Last, we discuss emerging models and metrics to align urban development with the dual goals of mitigating cardiometabolic diseases while reducing climate change through cross-sector collaboration, governance, and community engagement. This review demonstrates that cities represent crucial settings for implementing policies and interventions to simultaneously tackle the global epidemics of cardiovascular disease and climate change.

Ecosystems

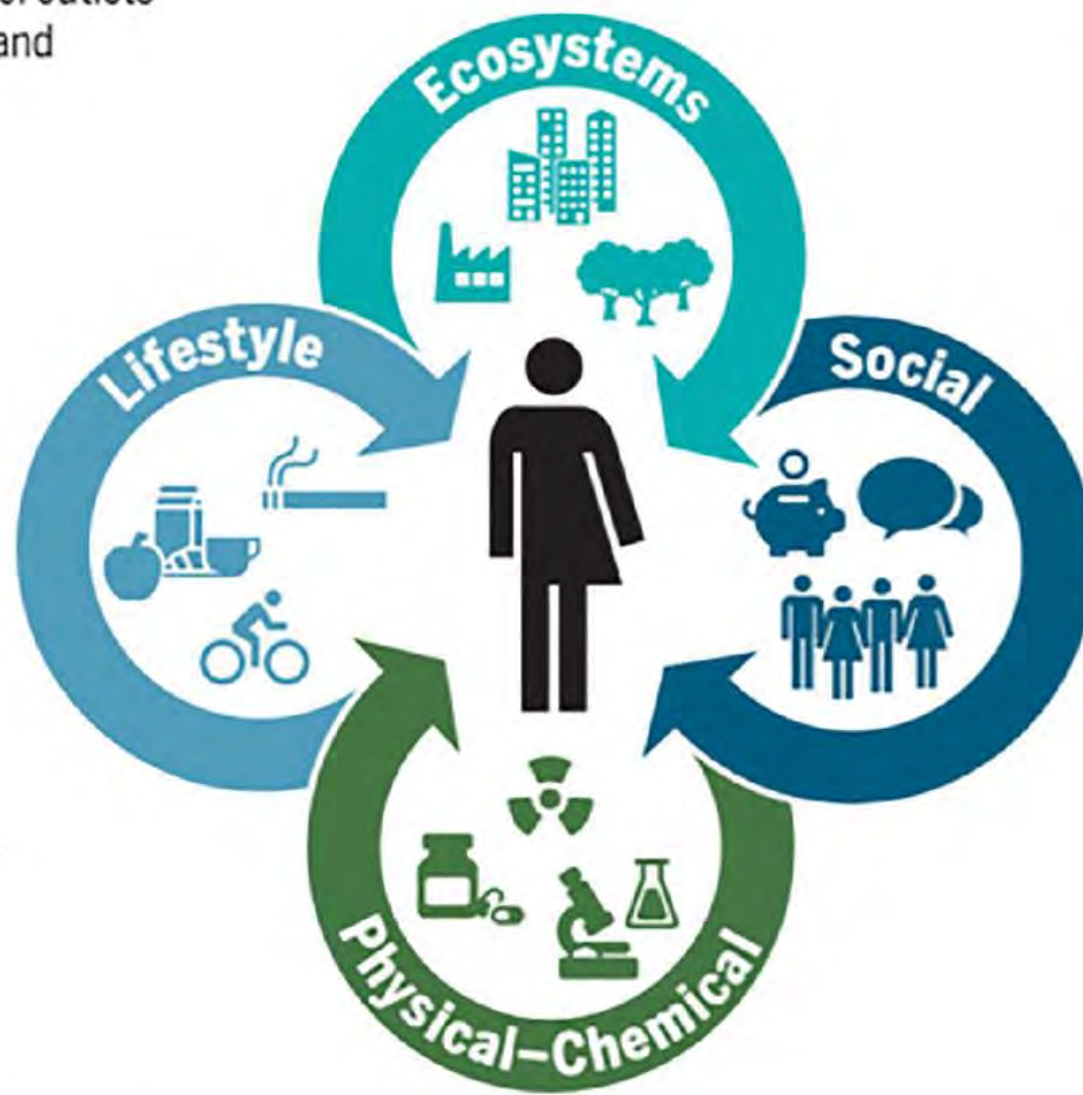
Food outlets, alcohol outlets
Built environment and
urban land uses
Population density
Walkability
Green/blue space

Lifestyle

Physical activity
Sleep behavior
Diet
Drug use
Smoking
Alcohol use

Social

Household income
Inequality
Social capital
Social networks
Cultural norms
Cultural capital
Psychological and mental stress



Physical-Chemical

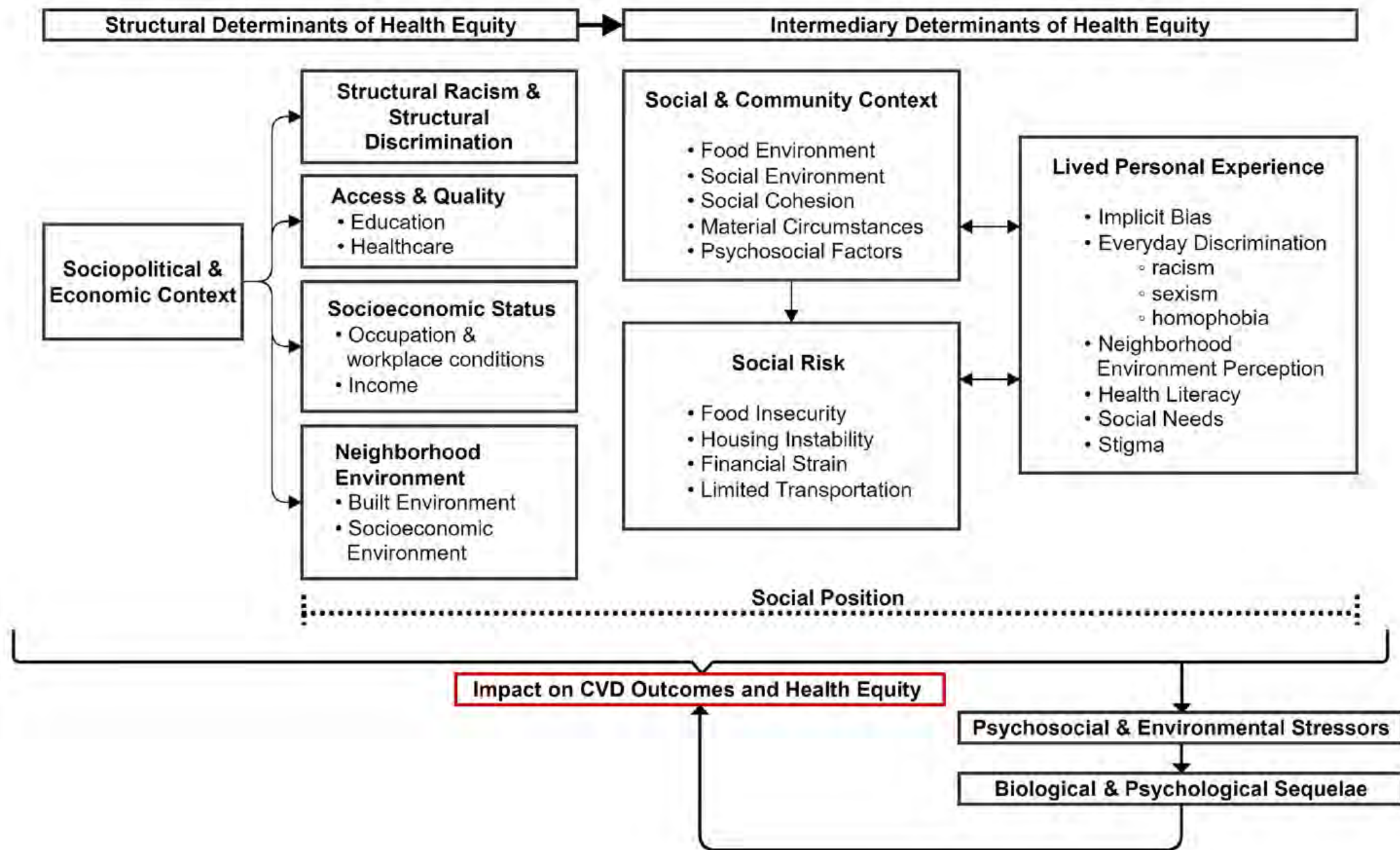
Temperature/humidity
Electromagnetic fields
Ambient light
Odor and noise
Point, line sources, e.g.,
factories, ports
Outdoor and indoor air
pollution
Agricultural activities,
livestock
Pollen/mold/fungus
Pesticides
Fragrance products
Flame retardants (PBDEs)
Persistent organic pollutants
Plastic and plasticizers
Food contaminants
Soil contaminants
Drinking water contamination
Groundwater contamination
Surface water contamination
Occupational exposures



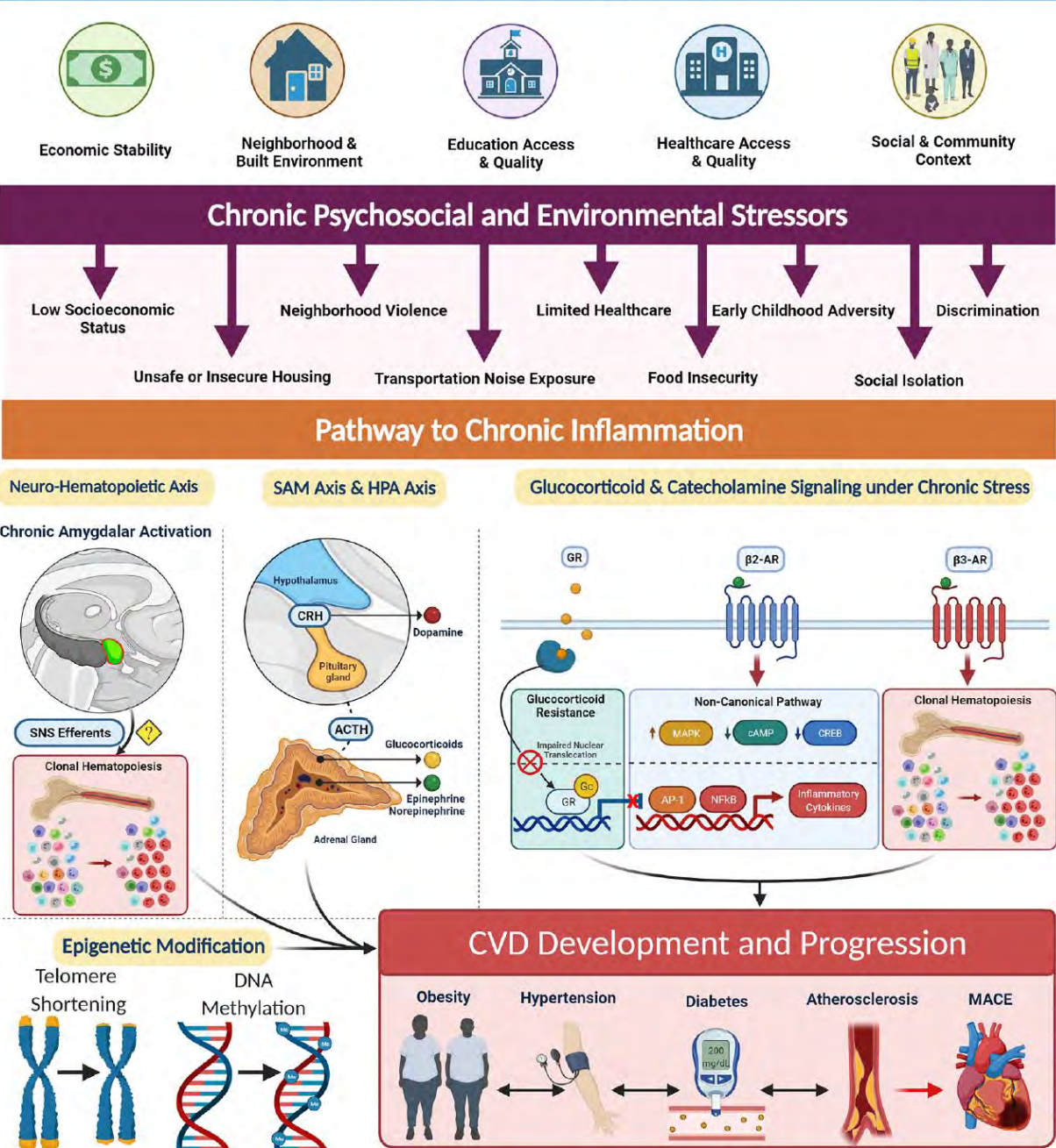
Social Determinants of Cardiovascular Disease

Tiffany M. Powell-Wiley^{ID}, Yvonne Baumer^{ID}, Foster Osei Baah, Andrew S. Baez^{ID}, Nicole Farmer, Christa T. Mahlobo^{ID}, Mario A. Pita, Kameswari A. Potharaju, Kosuke Tamura^{ID}, Gwentyth R. Wallen

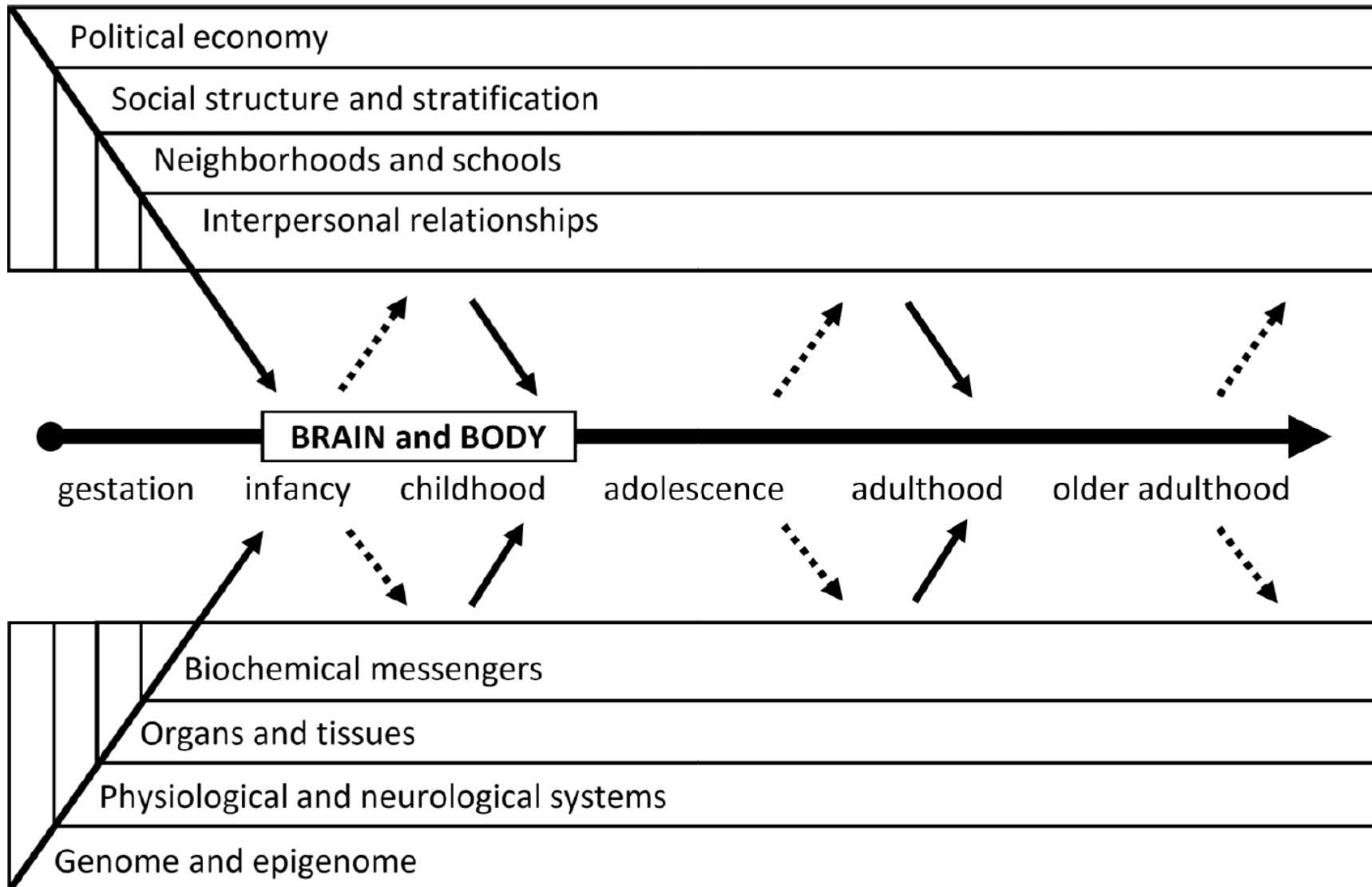
ABSTRACT: Social determinants of health (SDoH), which encompass the economic, social, environmental, and psychosocial factors that influence health, play a significant role in the development of cardiovascular disease (CVD) risk factors as well as CVD morbidity and mortality. The COVID-19 pandemic and the current social justice movement sparked by the death of George Floyd have laid bare long-existing health inequities in our society driven by SDoH. Despite a recent focus on these structural drivers of health disparities, the impact of SDoH on cardiovascular health and CVD outcomes remains understudied and incompletely understood. To further investigate the mechanisms connecting SDoH and CVD, and ultimately design targeted and effective interventions, it is important to foster interdisciplinary efforts that incorporate translational, epidemiological, and clinical research in examining SDoH-CVD relationships. This review aims to facilitate research coordination and intervention development by providing an evidence-based framework for SDoH rooted in the lived experiences of marginalized populations. Our framework highlights critical structural/socioeconomic, environmental, and psychosocial factors most strongly associated with CVD and explores several of the underlying biologic mechanisms connecting SDoH to CVD pathogenesis, including excess stress hormones, inflammation, immune cell function, and cellular aging. We present landmark studies and recent findings about SDoH in our framework, with careful consideration of the constructs and measures utilized. Finally, we provide a roadmap for future SDoH research focused on individual, clinical, and policy approaches directed towards developing multilevel community-engaged interventions to promote cardiovascular health.

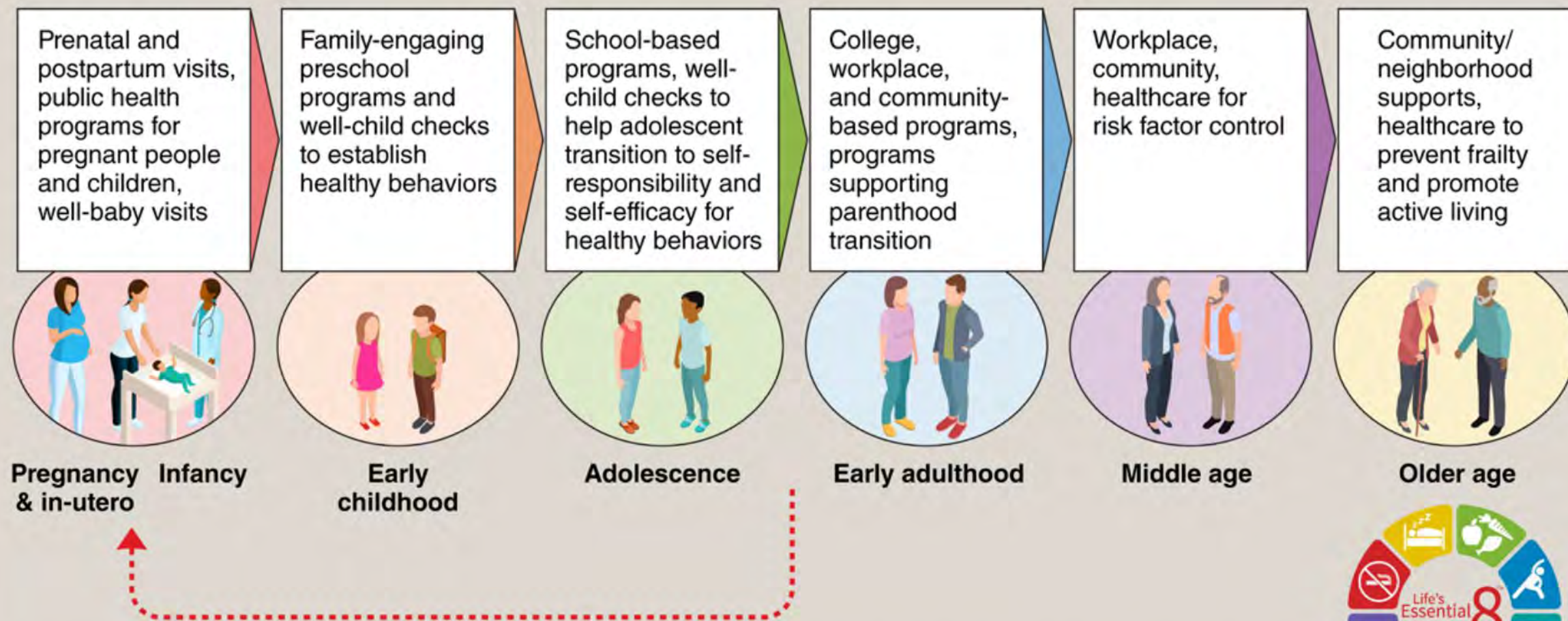


Social Determinants of Health



Biosocial Model of Health





CRITICAL TIME WINDOWS IN THE LIFE COURSE OF CARDIOVASCULAR HEALTH



Issues We Need to Confront

- Motivation and messaging
- Multilevel care delivery models
- Payment and payment reform
- Skill sets, trainings, and pathways

Wayne State wins \$18 million from National Institutes of Health to intercept chronic disease in Black communities

Center: [ACHIEVE GREATER](#)

The National Institute on Minority Health and Health Disparities has awarded Wayne State University \$18.15 million over five years to establish a Center for Multiple Chronic Diseases Associated with Health Disparities: Prevention, Treatment, and Management that will use community-based interventions deployed from three research institutions to fight hypertension, heart failure and coronary heart disease in the Black population.

The Addressing Cardiometabolic Health Inequities by Early PreVENTion in the GREAT LakEs Region, or ACHIEVE GREATER, Center is a proactive versus reactive approach to reducing overwhelming cardiometabolic health disparities and downstream Black-White lifespan inequality in Detroit and Cleveland, two uniquely comparable cities.

RCC RD MCD



UC END DISPARITIES

SCCLH

C2DREAM

ACHIEVE GREATER

COMMUNITY

CAHPE

MACCHE

Wayne State University



Wayne State University

Case Western Reserve University

Henry Ford Health

University Hospitals

RESEARCH LETTER

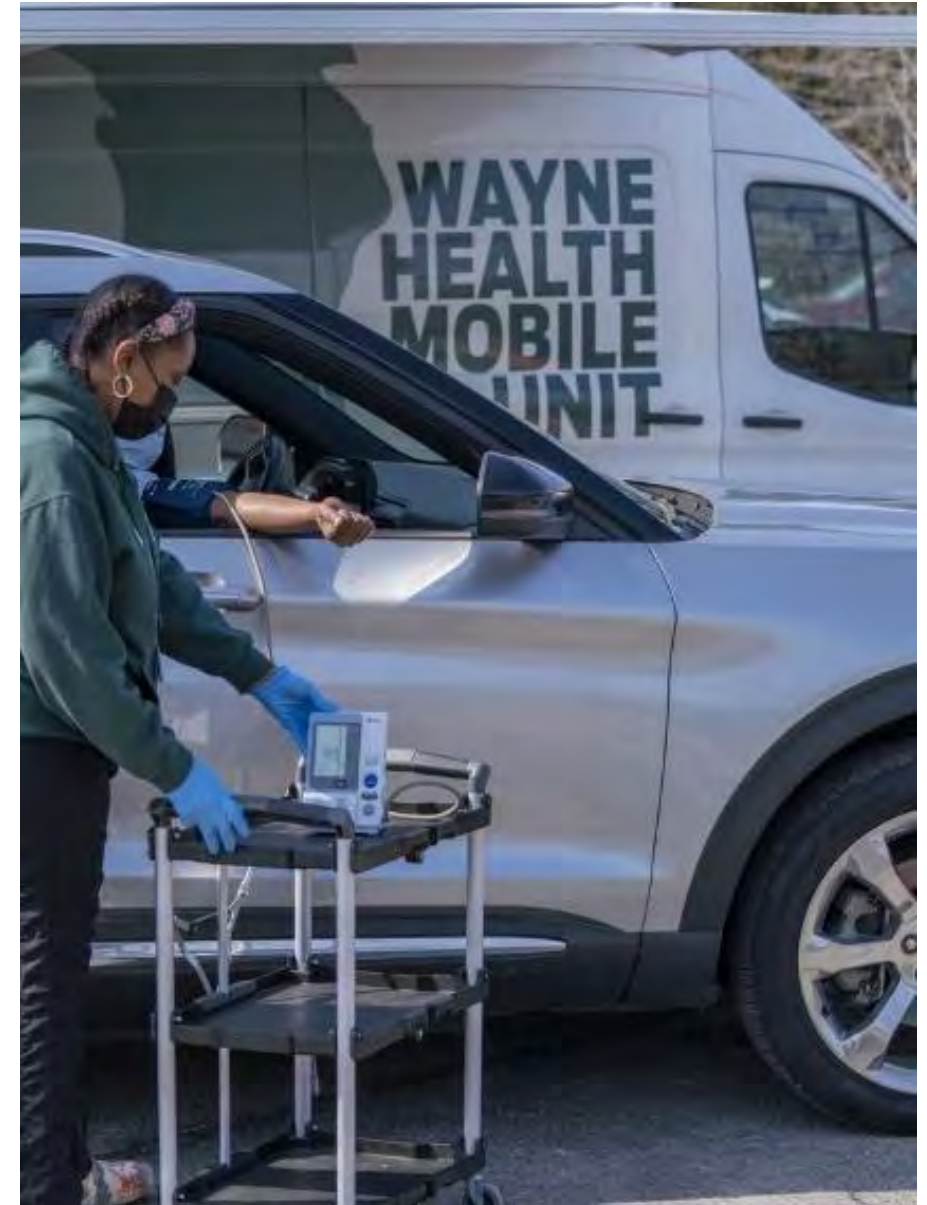
Utilizing Mobile Health Units for Mass Hypertension Screening in Socially Vulnerable Communities Across Detroit

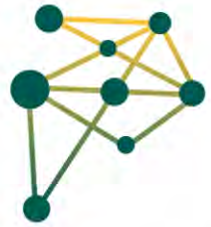
Robert D. Brook¹, Katee Dawood, Bethany Foster, Randi M. Foust, Catherine Gaughan, Paul Kurian, Brian Reed, Andrea L. Jones, Barbara Vernon², Phillip D. Levy³

Nearly half of all adults in the United States have hypertension, defined as a blood pressure (BP) $\geq 130/80$ mmHg. However, both the prevalence (56%) and control rates (18%) are worse in Black patients.¹ Numerous social determinants of health in socially vulnerable populations further exacerbate these disparities while reducing hypertension awareness and access to health care.² Few places exemplify this crisis like the city of Detroit (78% Black race) where hypertension rates are the highest in Michigan (<https://www.cdc.gov/places>) and all census tracts are in health professional shortage areas (<https://data.hrsa.gov/tools/shortage-area/>). As such, the public health importance of large-scale screening efforts to identify the enormous number of individuals with hypertension cannot be overstated.³ We here describe the first-year results using our novel Wayne Health Mobile Unit program developed in

Given the large population serviced (while also ensuring resiliency of the program during cold weather and COVID restrictions), we developed a high-throughput method to offer screening for high BP (defined as $\geq 120/80$ mmHg) beginning in November 2020. Those driving to a site ($\approx 90\%$) rested inside their parked car for ≥ 5 minutes. BP was then measured using an Omron 907XL monitor following a guideline-consistent protocol—up to an average of triplicate upper arm readings (1-minute intervals) using a correct cuff size with the arm supported at heart level (door armrest) and feet resting on the car floor. A minority ($<10\%$) of walk-up patients had seated BP measured in MHU canopy rooms. As privacy was limited, BP measurements were attended and cuffs were placed over long-sleeves when relevant.

All patients are provided follow-up care in the Wayne Health system per individual needs/wishes. Health information, including prior hypertension status, is collected but not currently available for the entire cohort. Individuals with a



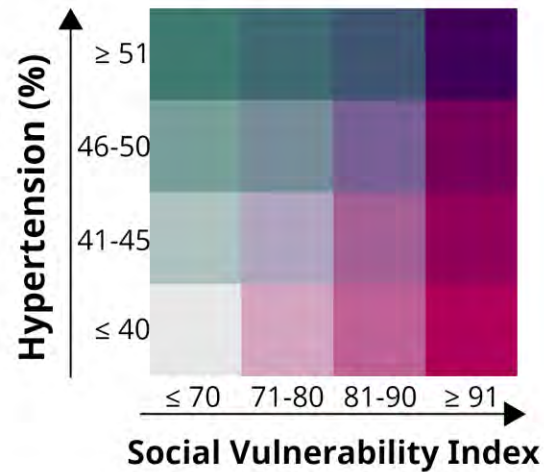


PHOENIX

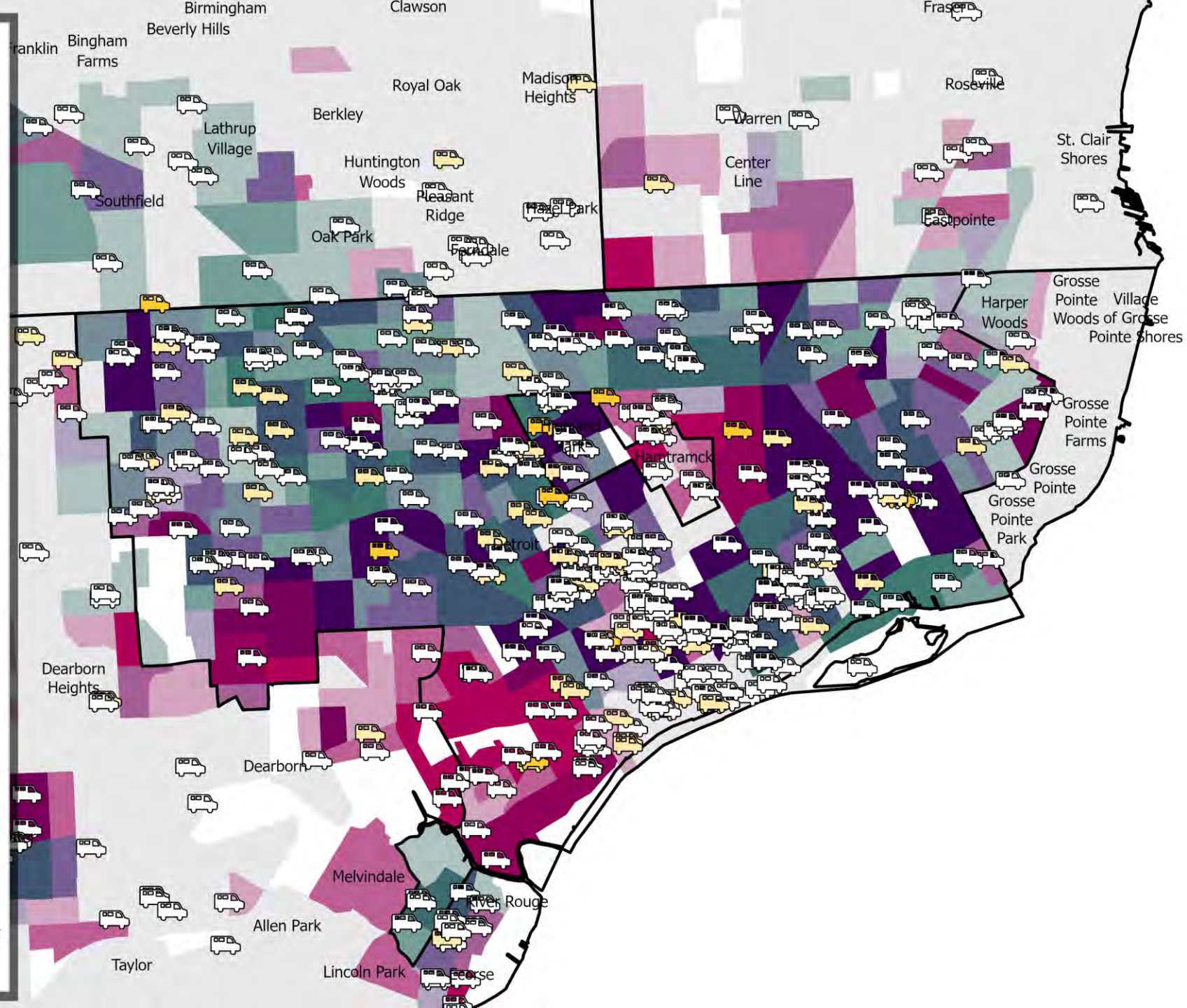
Hypertension Prevalence, Social Vulnerability Index, & Mobile Health Unit Outreach

Created by: Mallory A. Lund & Samantha J. Bauer, PhD
November 7, 2024

Individuals Screened for Hypertension (n=10,340)



Note: Mobile health unit data on screening for hypertension ranges from November 2020 to November 2024. Hypertension data from CDC PLACES, 2024 release. Social Vulnerability Index data from CDC, 2022.





AMELORATE NEGATIVE SDOH

Assessment of individual needs
Assist/link to social services
Education on high BP/lifestyle

Food Assistance
Public Benefits Assistance
Unemployment Assistance
Navigator Services (Health Insurance Navigation)
Utility Assistance
Voter Registration
PCP Referral *
Transportation Assistance

PAL²
Intervention

Education

Healthy Lifestyle

Exercise

Eating pattern

Removes

Life Obstacles

Lowers BP

RAISES BP

Improves

Reduces



Poor access and linkage to care



Negative SDOH



**LIFE CIRCUMSTANCES
STRESS/ALLOSTATIC LOAD**

HTN



**BARRIERS TO
HTN CONTROL**

“The Doctor Is Out”: New Tactics and Soldiers for Our Losing Battle Against Hypertension

Robert D. Brook¹, MD; Benjamin M. Scirica², MD, MPH; Phillip D. Levy³, MD, MPH

Nearly half of all adults in the United States (at least 116 million) have hypertension, defined as a blood pressure (BP) $\geq 130/80$ mm Hg.¹ Despite wide-scale efforts, the prevalence has remained stable at best, with improvements in BP control (currently at 19%) during the early 2000s having been partially erased by recent trends.¹ Serious health disparities also persist whereby communities of color and rural populations remain more adversely affected. These statistics, coupled with a growing population and a lower diagnostic threshold, explain why the number of adult Americans with uncontrolled hypertension has increased to 92 million (in 2015–2018).¹ It is likely that these rates worsened because of the COVID-19 pandemic. As such, a business-as-usual approach does not represent a cogent plan for future success. Numerous culprits contribute to poor BP control² but the fossilized structure of our health care delivery model is an underappreciated accomplice. Hypertension remains a leading risk factor for mortality in the United States partly because control efforts are hindered by the status quo. Viewed in this context, high BP is a public health threat of major importance and needs innovative approaches to care. We offer a vision with the potential to engineer some inroads that may help reverse this crisis. The crux of our perspective is that physicians (and other highly trained providers) are no longer always needed for the safe and effective treatment of hypertension.

A number of efforts (eg, Target: BP) aim to improve BP control.² We are concerned that conventional strategies will likely prove inadequate because they remain tethered to weaknesses of the existing system, in particular reliance on highly trained providers at nearly every step of management. We call for the adoption, expansion, and validation of novel vehicles of care that are less, or not at all, reliant on the active involvement of highly trained

providers. Although not a panacea, this strategy may help overcome obstinate barriers to BP control in physician-centric models. Foremost is inadequate and inequitable access to an overstrained health care system.^{2,3} Roughly 84 million Americans live in areas with a shortage of primary care physicians.³ This shortfall is projected to grow despite ongoing efforts, including expanding the pool of advanced practice providers (APPs), reaching a deficit of 17 800 to 48 000 primary care providers by 2034. New models of care, less (or not) reliant on highly trained providers, will be needed to meet the demands of millions of adults with hypertension and address persistent health disparities.¹ Beyond improving access to care, this strategy has the potential to mitigate additional shortcomings of the existing system (Table).

One novel care pathway is algorithm-driven disease management delivered by nonphysicians.^{4,5} Such a program incorporated into the Mass General Brigham health system proved to reduce home BP safely ($-14/6$ mm Hg) in 1437 patients with hypertension over several weeks.⁵ Community health workers conducted the interventions remotely and pharmacists oversaw prescriptions through collaborative practice agreements with physicians. Favorable BP changes were recently confirmed in a larger cohort and underserved populations. Although nearly a third of patients withdrew or required physician referral, these data provide compelling evidence that hypertension can be managed safely and effectively by programs without active physician involvement in a substantial proportion of patients. However, to realize their full potential, greater national investments in community health workers and remote care platforms to overcome the digital divide will be needed. Insurance reforms (eg, capitated payment models) will also be pivotal for economic viability.

REGISTER FOR THE HEALTHCARE SERVICES INVESTMENT CONFERENCE

PARTNERSHIPS

DEALS

Molina Healthcare of Michigan Partners with Wayne Health to Provide Mobile Health Unit

APRIL 27, 2023



RECENT POSTS

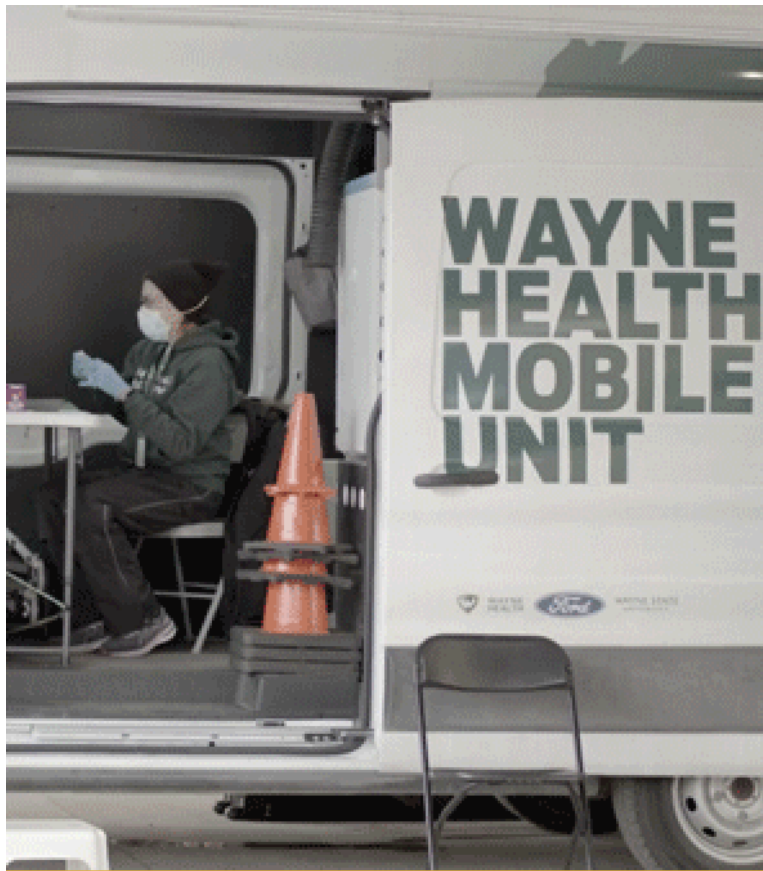
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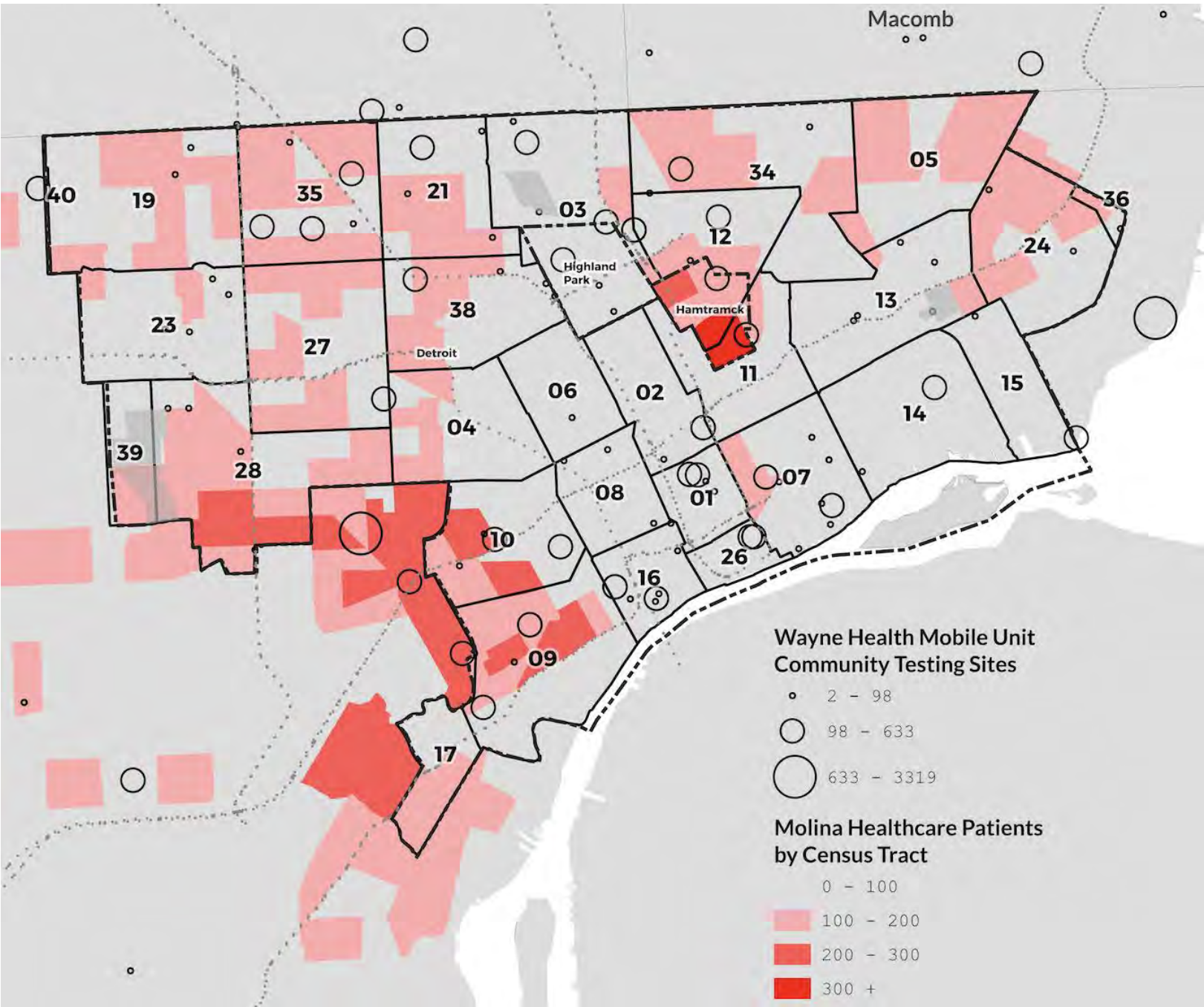
X-Caliber Rural Capital Refis Tennessee Medical Property With \$21M Loan

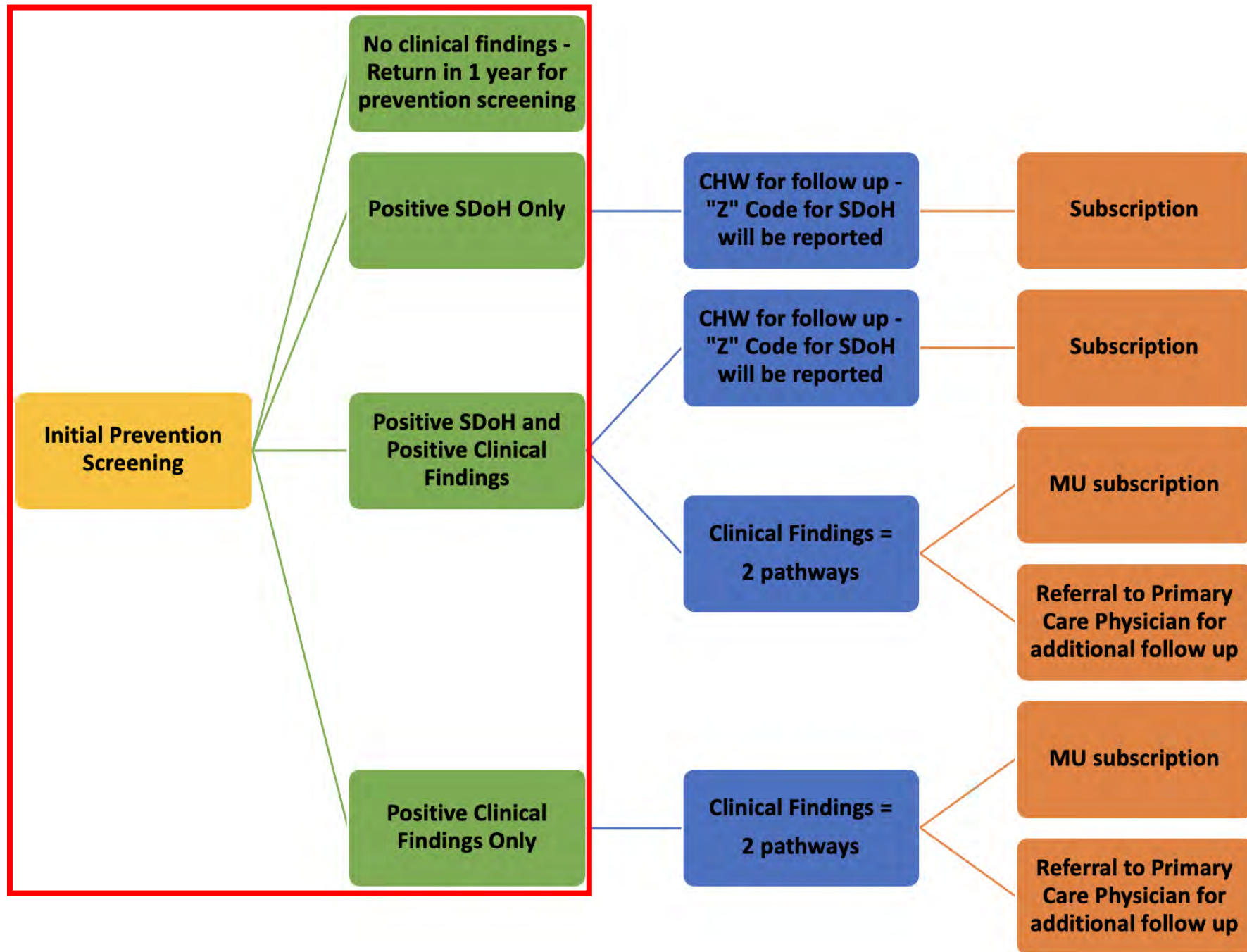
US Digestive Health Expands with New Practice Location in York, PA



MolinaCares partners with the Wayne Health Mobile Unit

Providing health screenings for the Detroit community.







Attachment D-1
Mobile Unit Compensation, Requirements and Statement of Work

Compensation for Medicaid – Mobile Unit. Health Plan agrees to compensate Provider in accordance to Table 1 for initial prevention screenings. Case rates noted in Table 1 are inclusive of all services performed at the visit. Provider will include all services on CMS 1500 claim form. Community workers, pharmacists and nurses may assist with some or all of the service under general supervision of the physician, NP or PA

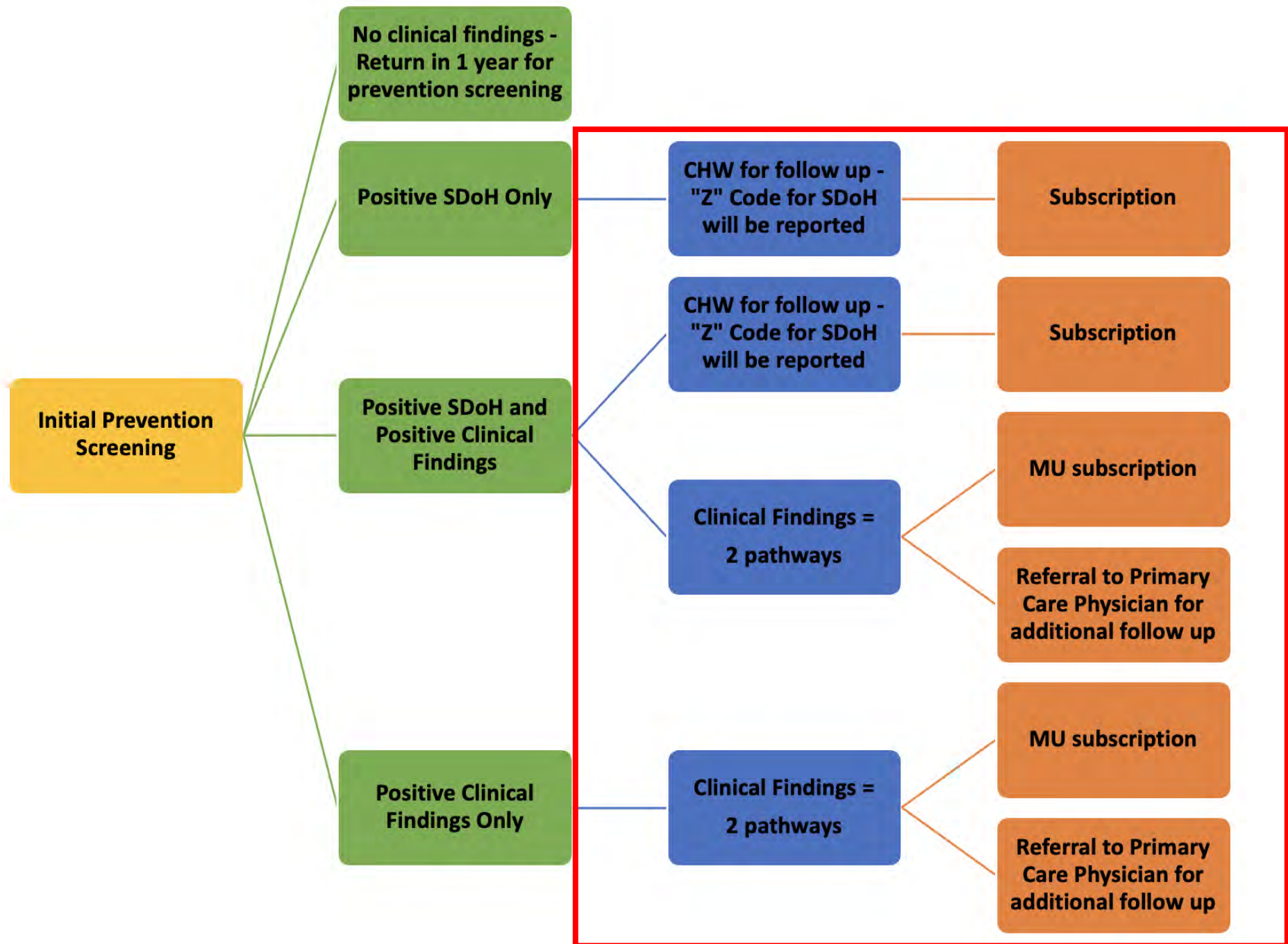
Table 1

Initial Prevention Screening		
CPT Code	Short Description	Case Rate Per Initial Visit
99385	Prev Visit New Age 18-39	\$350
99386	Prev Visit New Age 40-64	
99387	Init Pm E/M New Pat 65+ Yrs	



Initial prevention screening using the baseline diagnosis **“At Risk” (Review Z91 diagnosis codes)** OR ***Exam with Z00.01/without Z00.00 abnormal findings**

- New patient preventive exam based on **age (18 years and older _____)** = \$168.29
- Depression Screening = \$5.29
- Testing = \$59.17
 - Initial Remote imaging for detection of retinal disease (92227) = \$20.12
 - Venipuncture fee (36415) = \$15.00
 - Cardiovascular disease screening (Lipid panel - 80061) = \$16.58
 - Complete Metabolic Panel (80053) = \$15.19
 - Hemoglobin A1C (83037) = \$7.28
- CHW services (1-hour interview and documentation time) = \$29.50
- Use Code Z00.00 for initial SDoH screening if normal (only used for adult exams)
- Use Code Z00.01 for initial SDoH screening if abnormal (only used for adult exams) ***Report SDoH diagnosis Z code as secondary**
- Wayne Health admin = 30% of total
 - Revenue cycle
 - Corporate OH (Includes Qure4U)
 - Admin. Asst. for Event Scheduling
 - Fee to support remote mobile unit onsite screenings







[illegible]

Issues We Need to Confront

- Motivation and messaging
- Multilevel care delivery models
- Payment and payment reform
- Skill sets, trainings, and pathways

ORIGINAL ARTICLE

Role of Health Care Professionals in the Success of Blood Pressure Control Interventions in Patients With Hypertension: A Meta-Analysis

Katherine T. Mills , PhD; Samantha S. O'Connell , MS; Meng Pan , MS; Katherine M. Obst, MS; Hua He, PhD; Jiang He , MD, PhD

BACKGROUND: Globally, only 13.8% of patients with hypertension have their blood pressure (BP) controlled. Trials testing interventions to overcome barriers to BP control have produced mixed results. Type of health care professional delivering the intervention may play an important role in intervention success. The goal of this meta-analysis is to determine which health care professionals are most effective at delivering BP reduction interventions.

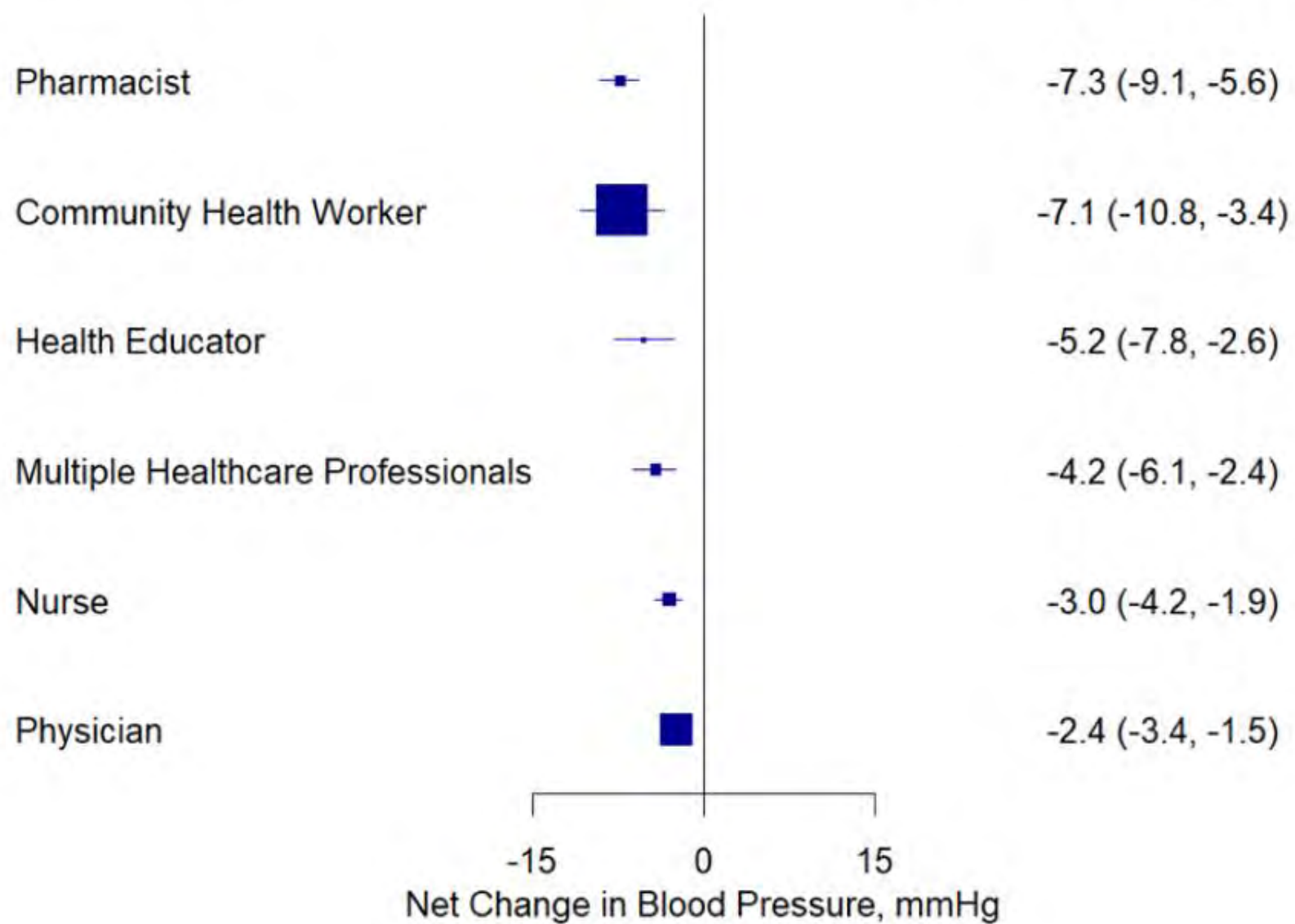
METHODS: We searched Medline and Embase (until December 2023) for randomized controlled trials of interventions targeting barriers to hypertension control reporting who led intervention delivery. One hundred articles worldwide with 116 comparisons and 90 474 participants with hypertension were included. Trials were grouped by health care professional, and the effects of the intervention on systolic and diastolic BP were combined using random effects models and generalized estimating equations.

RESULTS: Pharmacist-led interventions, community health worker-led interventions, and health educator-led interventions resulted in the greatest systolic BP reductions of -7.3 (95% CI, -9.1 to -5.6), -7.1 (95% CI, -10.8 to -3.4), and -5.2 (95% CI, -7.8 to -2.6) mm Hg, respectively. Interventions led by multiple health care professionals, nurses, and physicians also resulted in significant systolic BP reductions of -4.2 (95% CI, -6.1 to -2.4), -3.0 (95% CI, -4.2 to -1.9), and -2.4 (95% CI, -3.4 to -1.5) mm Hg, respectively. Similarly, the greatest diastolic BP reductions were -3.9 (95% CI, -5.2 to -2.5) mm Hg for pharmacist-led and -3.7 (95% CI, -6.6 to -0.8) mm Hg for community health worker-led interventions. In pairwise comparisons, pharmacist were significantly more effective than multiple health care professionals, nurses, and physicians at delivering interventions.

CONCLUSIONS: Pharmacists and community health workers are most effective at leading BP intervention implementation and should be prioritized in future hypertension control efforts.

Intervention Leader

Net Change in BP (95% CI), mmHg



A Cluster-Randomized Trial of Blood-Pressure Reduction in Black Barbershops

Ronald G. Victor, M.D., Kathleen Lynch, Pharm.D., Ning Li, Ph.D.,
Ciantel Blyler, Pharm.D., Eric Muhammad, B.A., Joel Handler, M.D.,
Jeffrey Brettler, M.D., Mohamad Rashid, M.B., Ch.B., Brent Hsu, B.S.,
Davontae Foxx-Drew, B.A., Norma Moy, B.A., Anthony E. Reid, M.D.,*
and Robert M. Elashoff, Ph.D.

ABSTRACT

BACKGROUND

Uncontrolled hypertension is a major problem among non-Hispanic black men, who are underrepresented in pharmacist intervention trials in traditional health care settings.

METHODS

We enrolled a cohort of 319 black male patrons with systolic blood pressure of 140 mm Hg or more from 52 black-owned barbershops (nontraditional health care setting) in a cluster-randomized trial in which barbershops were assigned to a pharmacist-led intervention (in which barbers encouraged meetings in barbershops with specialty-trained pharmacists who prescribed drug therapy under a collaborative practice agreement with the participants' doctors) or to an active control approach (in which barbers encouraged lifestyle modification and doctor appointments). The primary outcome was reduction in systolic blood pressure at 6 months.

From the Smidt Heart Institute at Cedars-Sinai Medical Center (R.G.V., K.L., C.B., E.M., M.R., B.H., D.F.-D., N.M., A.E.R.), the Department of Biomathematics, David Geffen School of Medicine, University of California, Los Angeles (N.L., R.M.E.), and Kaiser Permanente (J.H., J.B.) — all in Los Angeles. Address reprint requests to Dr. Victor at ronald.victor@cshs.org.

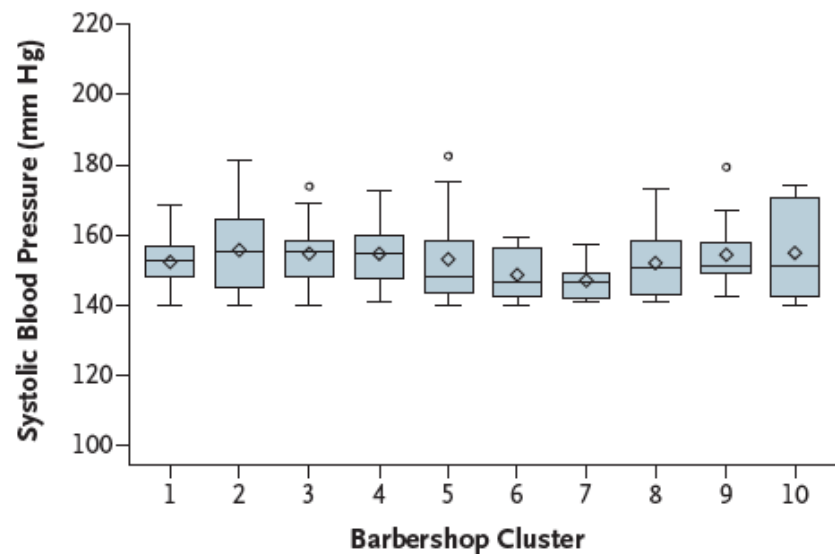
*Deceased.

This article was published on March 12, 2018, at [NEJM.org](https://www.nejm.org).

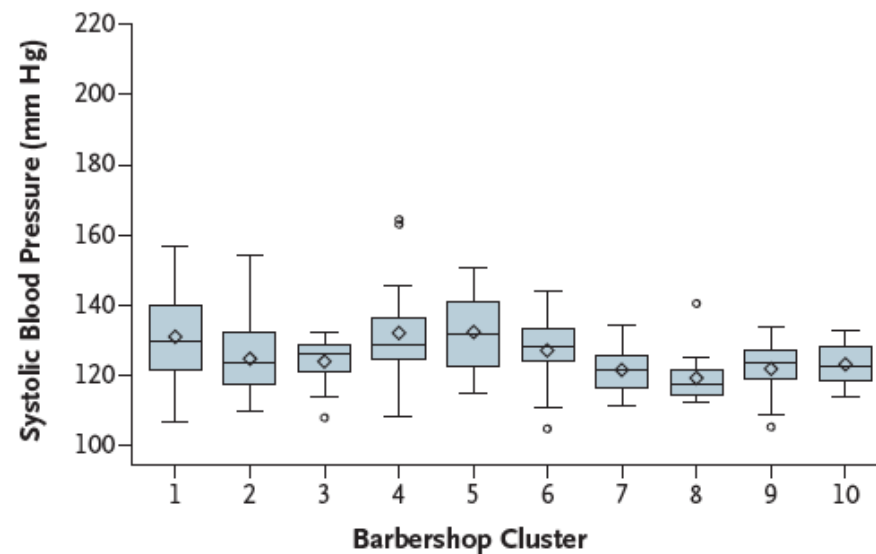
DOI: [10.1056/NEJMoa1717250](https://doi.org/10.1056/NEJMoa1717250)

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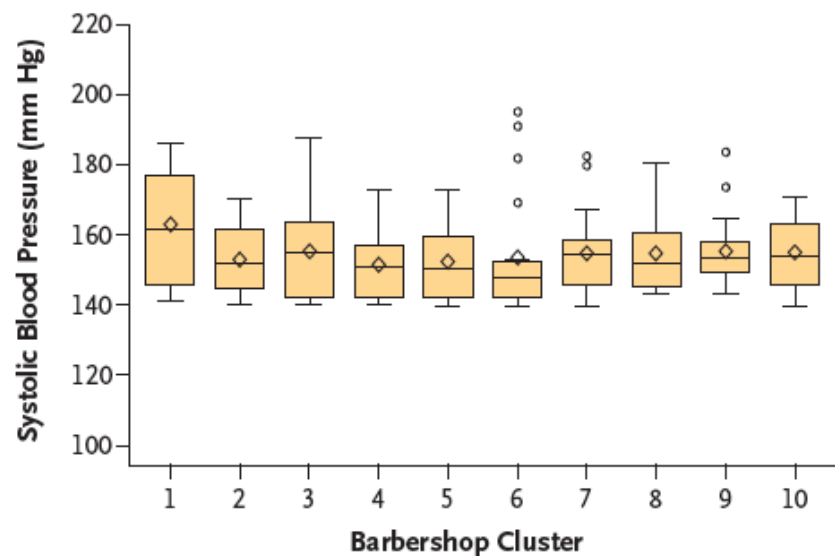
A Intervention Group at Baseline



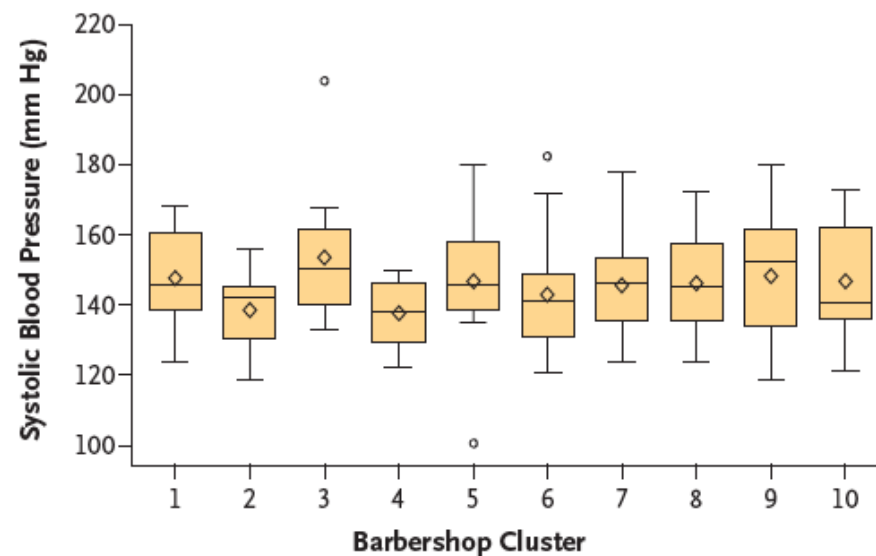
B Intervention Group at 6 Months



C Control Group at Baseline



D Control Group at 6 Months



A photograph of a modern building at night. The building features a large glass facade that is illuminated from within, showing interior spaces. A prominent section of the building is clad in horizontal wooden slats, which are also lit from within, creating a warm glow. The building is set against a dark blue sky with scattered clouds. In the foreground, there is a paved area and some landscaping with small trees and bushes. The overall scene is a high-quality architectural photograph.

plevy@med.wayne.edu

Questions?

Close-Out & Next Steps

- Learning Session #4 will be held in April 2025.
 - Topic: Best Practices for Assessing and Addressing Social Needs
 - Registration link will be provided in a follow-up email
- Let us know what you thought about today's session!





For additional questions about MICH Learning Sessions, contact:

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MDHHS-MICHLearningCollab@michigan.gov

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