Funding Opportunity

For Diabetes Prevention and Blood Pressure Management

Healthcare Education Foundation of West Virginia
Health Promotion Chronic Disease/ State Office of Rural Health
Lunch and Learn
2/10/21

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

Agenda

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- **Introduction- 5 min**
- **Program Overview- 7 min**
- **Partners- 2 min**
- **Success Story- 15 min**
- **Closing Remarks- 1 min**
- **Questions- 15 min**

Introduction

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Introduction

Health Promotion and Chronic Disease (HPCD)

The Division of Health Promotion and Chronic Disease takes a comprehensive approach to chronic disease management and prevention. We work with communities, health systems, and decision-makers to make it easier for people to be healthy in the places they live, learn, work, eat, play and pray.

State Office of Rural Health (SORH)

The West Virginia State Office of Rural Health's mission is to implement programs and promote best practice models through collaboration with stakeholders to address rural health care. SORH coordinates the SHIP and FLEX federal grants and loan repayment programs.

Healthcare Education Foundation of West Virginia

The Healthcare Education Foundation of West Virginia of the Critical Access Hospital Network has a mission to help the membership meet their needs for quality, operational and financial benchmarks through collaboration and partnering.

Program Overview

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Program Overview

The Self Monitored Rural Health Expansion Program

Integrated Health Goals

Planning Funding

Implementation Funding (Proposed)

How to apply

What Is required

Program Overview

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The Self Monitored Rural Health Expansion (SMRHE) Program

- This round of funding is to **PLAN** for the Implementation and/or Expansion of a National Diabetes Prevention Program and Self Monitored Blood Pressure Program.
- This is a **COMBINED** program that includes both the National Diabetes Prevention Program and the Self Monitored Blood Pressure Program within the same cohort.
- We are funding up to 10 Small Rural Hospitals for the Planning Phase with follow up funding being proposed for the Implementation Phase.

Integrated Health Goals

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How does this integrate with what you are already doing.

Potential for:

- Reduced number of new diabetes diagnoses.
- Reduced chronic disease burden.
- Improved quality performance measures.
- Improved quality of life measures.

Program Overview

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The Self Monitored Rural Health Expansion Program- Planning Funding

- $5,000 to access virtual training, individualized technical assistance, and the development of an implementation plan.
- $10,000 to plan for the implementation and/or expansion of a National Diabetes Prevention Program.
- $5,000 to plan for the implementation and/or expansion of a Self Monitored Blood Pressure Program.
- Initial Funding is expected to be issued via simple invoicing approximately one month after selection of participants.

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The Self Monitored Rural Health Expansion Program-Implementation Funding (Proposed)

- In order to qualify for additional funding for the implementation of the program, awardees are required to enroll their first cohort of at least 15 participants, within one calendar year of receiving initial funding. (Proposed)
- Apply for CDC recognition.
- $15,000 (Proposed) for the implementation and/or expansion of a National Diabetes Prevention Program.
- $5,000 (Proposed) for the implementation and/or expansion of a Self Monitored Blood Pressure Program.

How to Apply

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- All applicants are required to complete the SMRHE Readiness Survey.
- The survey is designed to give us an understanding of your current capacity and readiness for the program.
- The survey should take no more than 10-15 min.
- **Current Capacity is Not a Guarantee or Requirement of Funding.**
- **Surveys must be completed by February 26, 2021.**
    - https://is.gd/SMRHE_Readiness_Survey

Requirements

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The Self Monitored Rural Health Expansion Program- What is Required?

- All Awardees must plan to implement/expand programs that combine the National Diabetes Prevention Program with a Self Monitored Blood Pressure Program.
- All Awardees must provide a written plan, no later than May 28, 2021, to enroll their first cohort of 15 individuals within 12 calendar months of receiving funding.
- All Awardees will be required to enroll and use Health Connection for cohort monitoring.

Partners

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West Virginia University: Office of Health Services Research

- Works to assist groups who are supporting the health and well-being of their community through listening to the needs of our partners, finding common ground, and working collaboratively.

The Department of Family & Community Health at the Marshall University Joan C. Edwards School of Medicine

- Works to improve the health of the people of West Virginia and the Appalachian region through education, patient care, research and community outreach.

SMRHE: Partners

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Technical Assistance from the WVU Office of Health Services Research

☐ Building your program

- ☐ Logistics to set up program implementation
- ☐ Connecting partners in a community
- ☐ Brainstorming and setting up virtual sessions
- ☐ Recruiting participants and promoting your program

☐ Obtaining/keeping recognition

- ☐ Providing National DPP lifestyle coach formal training and ongoing training through virtual platform
- ☐ Registering your organization with the CDC/applying to become a recognized program
- ☐ Implementation based on the standards
- ☐ Ongoing reporting to CDC or other agencies

SMRHE: Partners

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Technical Assistance from the WVU Office of Health Services Research

- ☐ **Data tracking, reporting & billing**
  - ☐ Tools to track data among program participants (i.e., attendance, weight, physical activity, blood pressure)
  - ☐ Use of electronic health record data to identify and enroll target patients
  - ☐ Monitoring program outcomes/reach over time
  - ☐ Information on Medicare DPP billing and other potential payment models

- ☐ **Referrals**
  - ☐ Development of referral model between clinics and community organizations
  - ☐ Connecting patients with healthcare providers (and receiving feedback about this process)
  - ☐ Sharing participant outcomes back with referring healthcare providers
  - ☐ Tracking referrals/interest for the program
  - ☐ Guidance/facilitation in collaborating with other organizations on data-sharing

SMRHE: Partners

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Ways to learn more

Visit our website at wvhealthconnection.com

Email us at wvhealthconnection@gmail.com

Follow us on Facebook (@WVHealthConnection)

The WVU Office of Health Services Research team

(From left to right) Cecil Pollard, Adam Baus, Audrey Semel, Mary Swim, Samantha Shawley-Brzoska, Andrea Calkins, and Divya Gadde

SMRHE: Partners

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MARSHALL UNIVERSITY JOAN C. EDWARDS SCHOOL OF MEDICINE

Division of Community Health

- Oral Health
- School Based Health
- Chronic Disease
  - Diabetes/Health Coalitions
- Community Health Worker (CHW)
- Addiction Science

SMRHE: Partners

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Technical Assistance Opportunities

- **Community Evidence-Based Programs 101**: Evidence-Based and Best Practice Chronic Disease Prevention and Self-Management Programs available at the **Community level.**
- **Community Health Workers 101:** Community health workers (CHWs) are lay members of the community who work either for pay or as volunteers in association with the local health care system in both urban and rural environments.
- **Community-Clinical Linkages 101:** Community-clinical linkages are connections between community and clinical sectors to improve population health. Our work focuses on building the capacity of diabetes/health coalitions.

Success Story: Boone Memorial Hospital

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CDC National Diabetes Prevention Program
Boone Memorial Hospital Healthy Lifestyle Program

Kathy J. Hill, APRN-BC
Director of Employee Health, Education & Wellness

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Grant Assistance

WV Bureau for Public Health

Division of Health Promotion and Chronic Disease

Success Story: Boone Memorial Hospital

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Get the Word Out

- Facebook
- Local Newspaper
- Local Radio Station
- Hospital Website
- Flyers
- Postcards
- Informational Seminar

FREE

Weight Loss & Diabetes Prevention Program

Classes begin Mid-February 2018

INFORMATIONAL SEMINAR
Thursday, Feb. 8th at 6pm
BMH Private Dining Room (1st floor)

THURSDAY WEEKLY MEETINGS
Morning, Afternoon, or Evening

TOPICS: Nutrition, Stress Reduction, Healthy Living Education, and Diabetes Prevention

THE BMH FITNESS CENTER
Open to all participants free of charge (extended & weekend hours will be available)

WEIGH-INS HELD WEEKLY

YEAR-LONG PROGRAM
Researched and certified by the CDC (Centers for Disease Control)

LIMIT OF 20 PER CLASS

JOIN US!
Simply complete a short screening tool at the Informational Seminar on February 8th or get a referral from your PCP (Primary Care Provider)

Call Kathy Hill, APRN, FNP-BC at 304-369-8826 to learn more

Bringing Medicine Home **bmh.org**

Success Story: Boone Memorial Hospital

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Results of Marketing

- **Attendance 205**

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Program Design

- Weekly meetings 1st 6 months
- Twice a month 2nd 6 months
- Make-up classes available
- Exercise room utilized

Success Story: Boone Memorial Hospital

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1 of 5 classes

Success Story: Boone Memorial Hospital

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First Graduating Class

Success Story: Boone Memorial Hospital

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2019 CHANGES

- ADDED TV ADVERTISING “MOMS EVERYDAY”
- CLASSES HELD ***TWO DAYS A WEEK***
  - TUESDAY & THURSDAYS
  - 9:30 AM, 11:00 AM, 2:00 PM, 4:30 PM & 6:00 PM
- CLASS SIZE 15-20
- Billboards: 5% and above
- Exercise class July / Aug

Success Story: Boone Memorial Hospital

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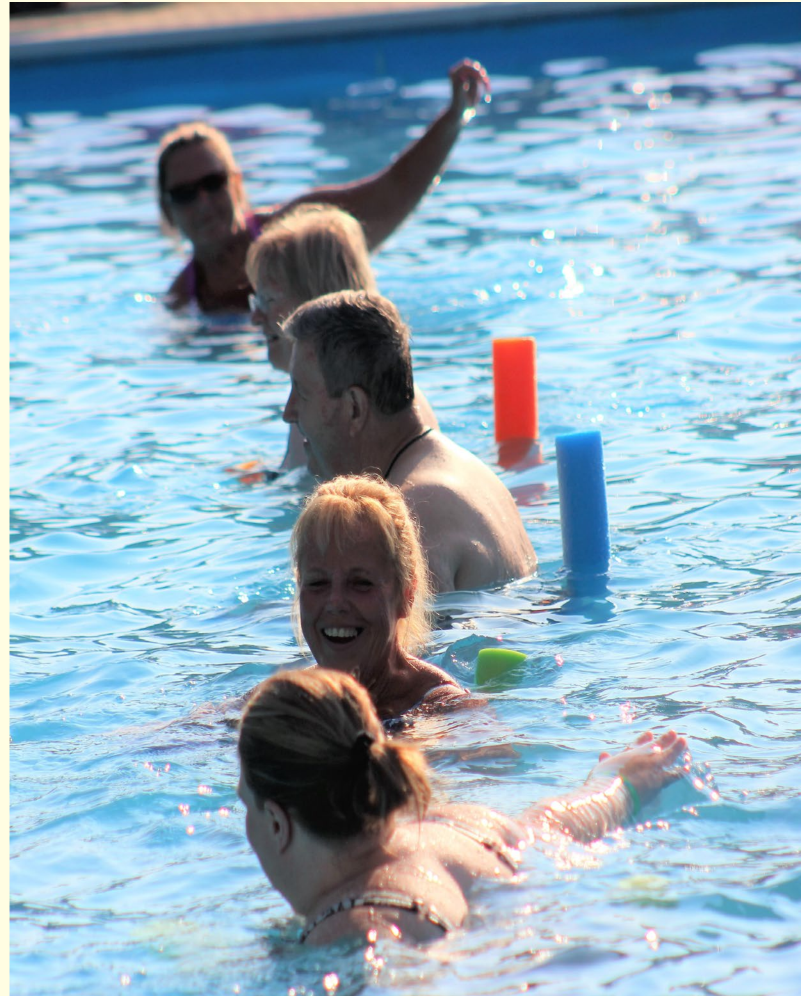


Success Story: Boone Memorial Hospital

BMH HEALTHY
Lifestyle
PROGRAM

bmh.org

Success Story: Boone Memorial Hospital

15%

Success Story: Boone Memorial Hospital

Jan. 14, 2020…..180 Participants

TUESDAY

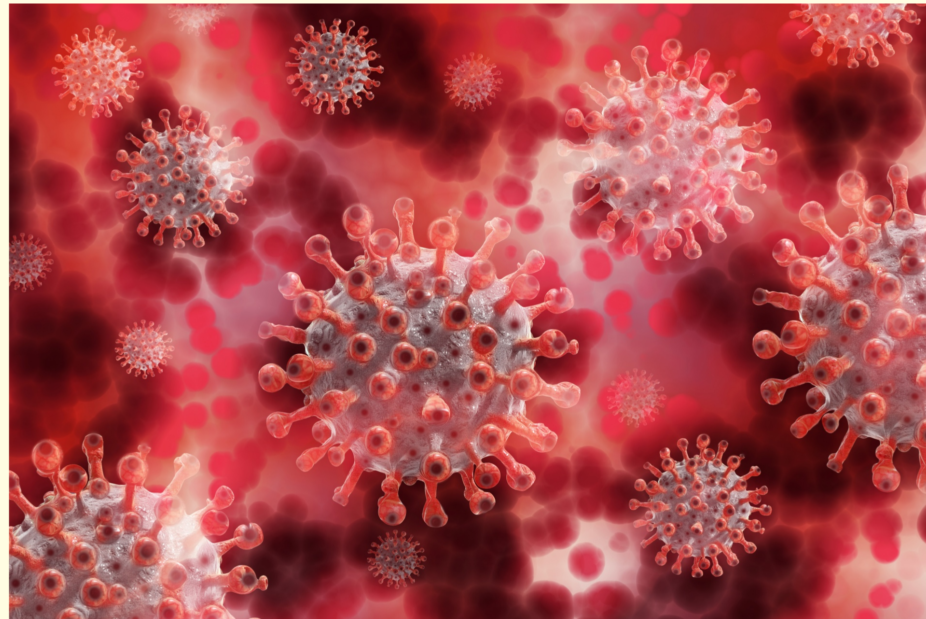
**Time options include:*

•9:30am
•11:00am
•4:30pm
•6:00pm

THURSDAY

**Time options include:*

•9:30am
•11:00am
•2:00pm
•4:30pm
•6:00pm



Success Story: Boone Memorial Hospital

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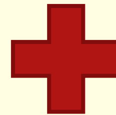
CDC National Diabetes Prevention



Program Accountability

Support

Success

Closing Remarks

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This is the end of our presentation we will be available for the next 15 minutes to answer any questions that you may have.

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Questions?