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Program Overview:
Wellness & Chronic Disease Management

Presenters:

+ **Brielle Ruth, MPH,** Wellness Project Manager
+ **Tatiana Oakes, RN,** Wellness Nurse Manager

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Disclosure to Participants

Notice of Requirements for Successful Completion:

Learners must participate in the full activity and complete the evaluation in order to claim continuing education credit/hours.

Presenter Conflicts of Interest/Financial Relationships Disclosures:

Brielle Ruth, MPH – None

Tatiana Oakes, RN BSN – None

Disclosure of Relevant Financial Relationships and Mechanism to Identify and Mitigate Conflicts of Interest: No conflicts of interest

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Agenda

- Caring Health Center
- Wellness & Chronic Disease Management Programming
- Wellness Center
- Diabetes Services
- Questions & Discussion

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Caring Health Center

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Caring Health Center

Section 330 Federally Qualified Health Center (FQHC) in Springfield, Massachusetts; 6 sites + 2 regional jail-based dental sites.

Founded in 1995 in response to a community health disparity: disproportionate rates of low-birth-weight babies among African Americans in Springfield.

51% consumer-led Board of Directors; accessible, quality healthcare, provision of healthcare regardless of ability to pay.



Mission Statement

We are committed to eliminating health disparities and achieving health equity through providing accessible, value-driven healthcare for diverse, multi-ethnic communities in Western Massachusetts.

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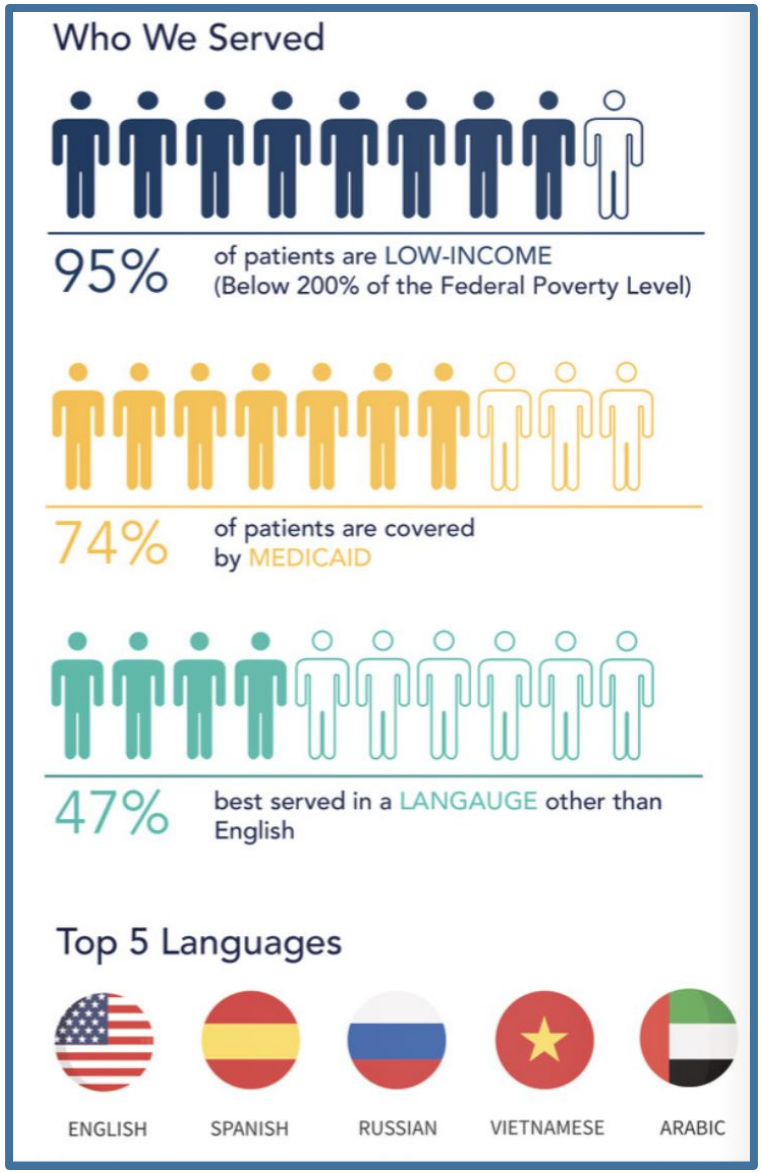
Caring Health Center

- Medical home to the largest Refugee Health Assessment Program in the state; serves patients in more than 30 languages.
- Comprehensive quality care:
  - Medical, Dental, Behavioral Health, Substance Use Disorder Treatment, Reproductive Health, Chronic Disease Management, Pharmacy, Outreach & Enrollment, and more.
- Approximately 19,000-20,000 patients served annually; 75,00 visits.
- Culturally, linguistically diverse patient population.
- Social Determinants of Health (SDOH):
  - 40% < high school education, 40% food insecure, 37% low health literacy, 52% low medication adherence.



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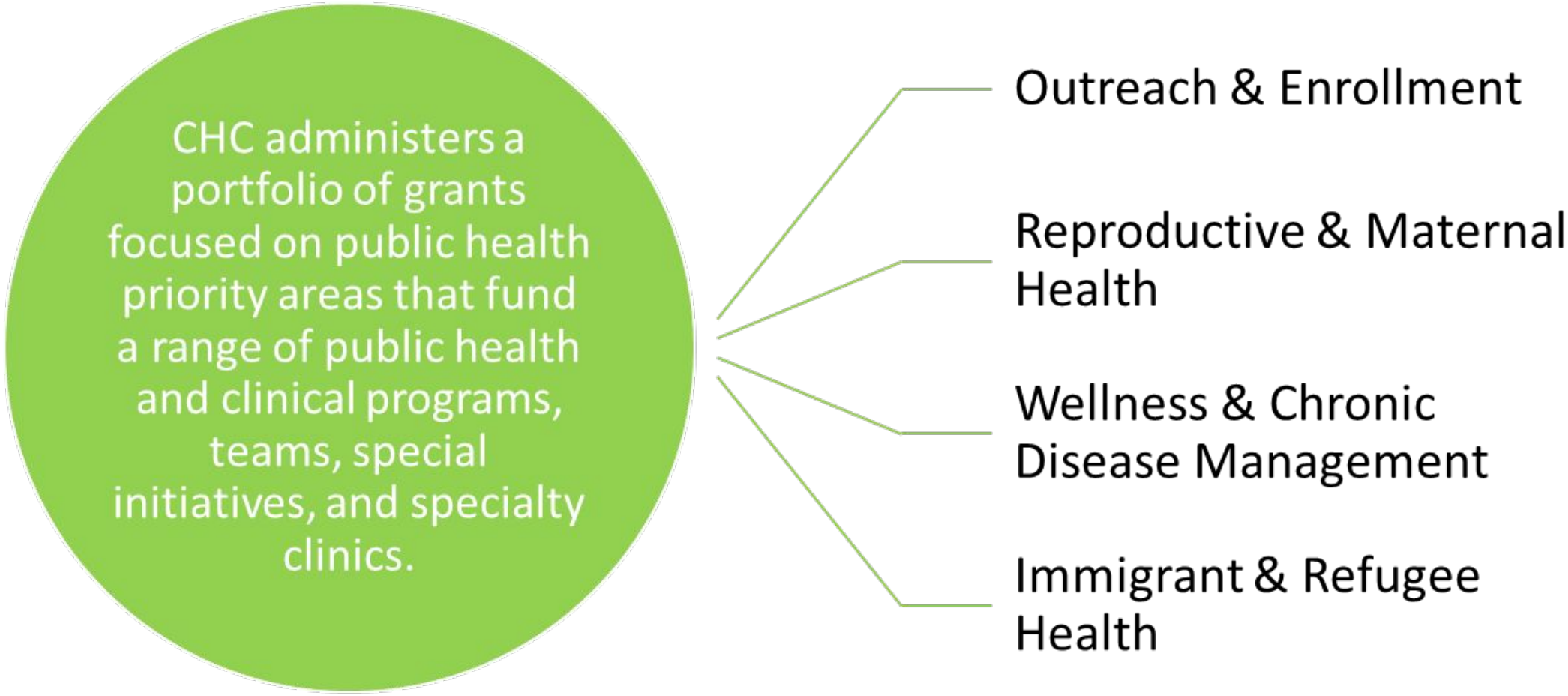
Public Health Programs & Specialty Clinics



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Wellness & Chronic Disease Management Programming

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Wellness & Chronic Disease Management

Wellness Team:

- **Brielle Ruth, MPH,** Wellness Project Manager
- **Tatiana Oakes, RN,** Wellness Nurse Manager
- **Jacqueline Martinez, LPN,** Wellness Nurse
- **Jeanette Rodriguez, C-CHW,** Senior Wellness Community Health Worker
- **Shams Thaher, C-CHW,** Senior Wellness Community Health Worker
- **Lamont Scott, GFI,** Wellness Specialist

Wellness Services:

- Wellness Center (Nutrition, Cooking, Physical Activity, & Self-Management Programs)
- Self-Monitored Blood Pressure (SMBP) Program
- Asthma Clinic, Spirometry Clinic, & Asthma Home Visiting Program
- Tobacco Cessation Program

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Wellness & Chronic Disease Management

Self-Monitored Blood Pressure (SMBP) & Hypertension Management Clinic

Diabetes Clinic

Asthma Clinic & Asthma Home Visiting Program

Tobacco Cessation Program

Medication Therapy Management (MTM) Clinic

Wellness Center

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Wellness Center

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Wellness Center 1.0 (2009-2013)

- Patient needs identified in research proved the practice observations and trends of patient barriers.
- "The Impact of Cultural Differences on Health Literacy and Chronic Disease Outcomes, 2006-2011" (4 year mixed-methods study).

Barriers to Exercise (n=278):

- **Top 3 Barriers:**
  - Too painful (38.1%).
  - Prefer doing other things (33.1%).
  - Not motivated (28.1%).
- **Other Barriers:**
  - Weather: Rain and cold.
  - Safety: Uneven pavement is a risk for falling and breaking a bone.
  - Limited Ability: Lack of being "sure-footed."
  - Cost: Exercise at a gym or classes.

High Rates of Food Insecurity

Barriers to Managing Chronic Disease

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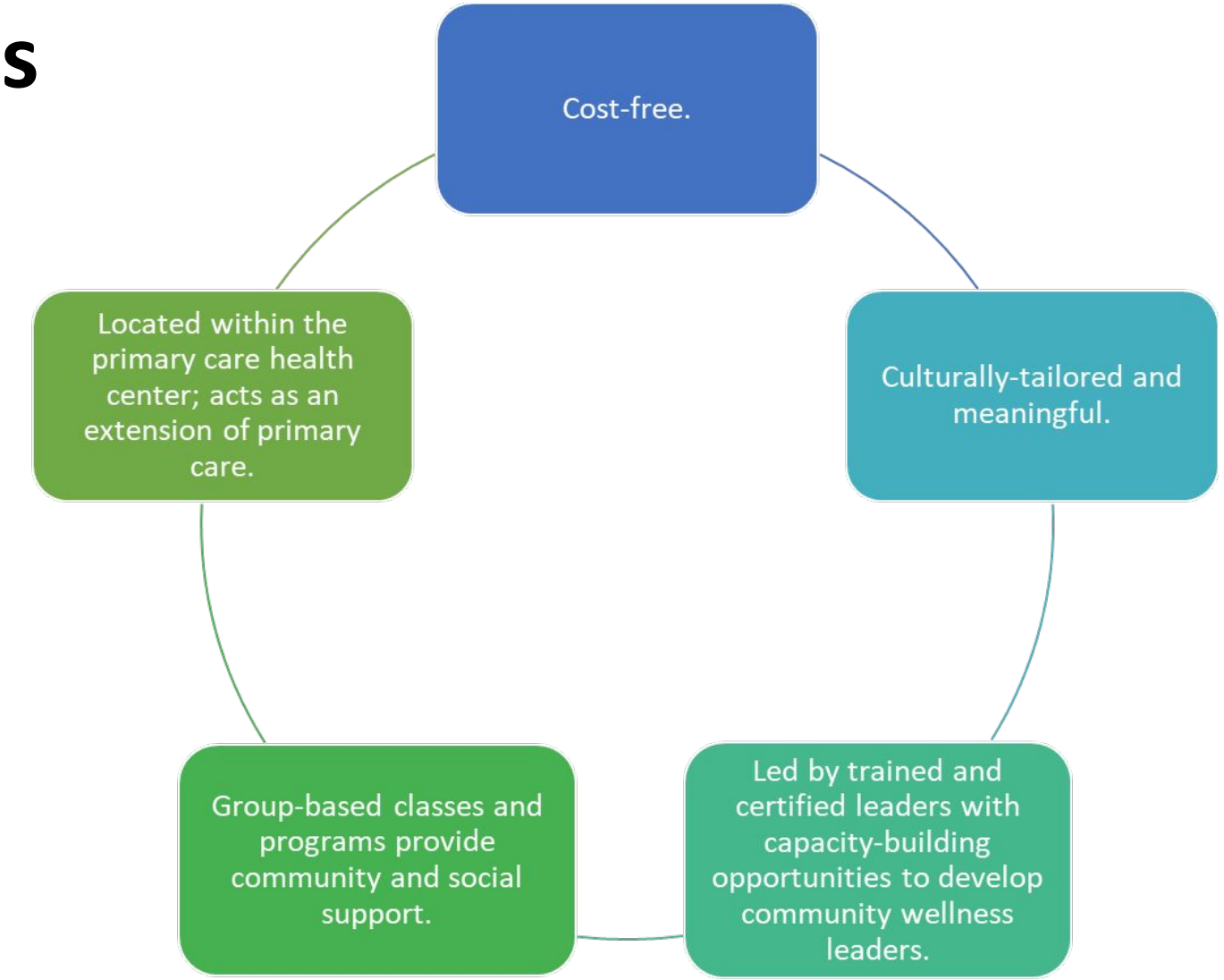
Five Guiding Principles

Q: … If you could do any kind of exercise and have access to it … what would be your ideal exercise?

P1: "… If they open up something over there at the clinic or something, you know for more people, you know to go in exercise together and stuff. Everybody going for the same thing…" (FG MA AA 12.12.08).



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Wellness Center 2.0 (2014-2019)





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Sustainability Model

2018: Began to refine strategy for a sustainable and interdisciplinary Wellness & Chronic Disease Management model.



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Group Programming





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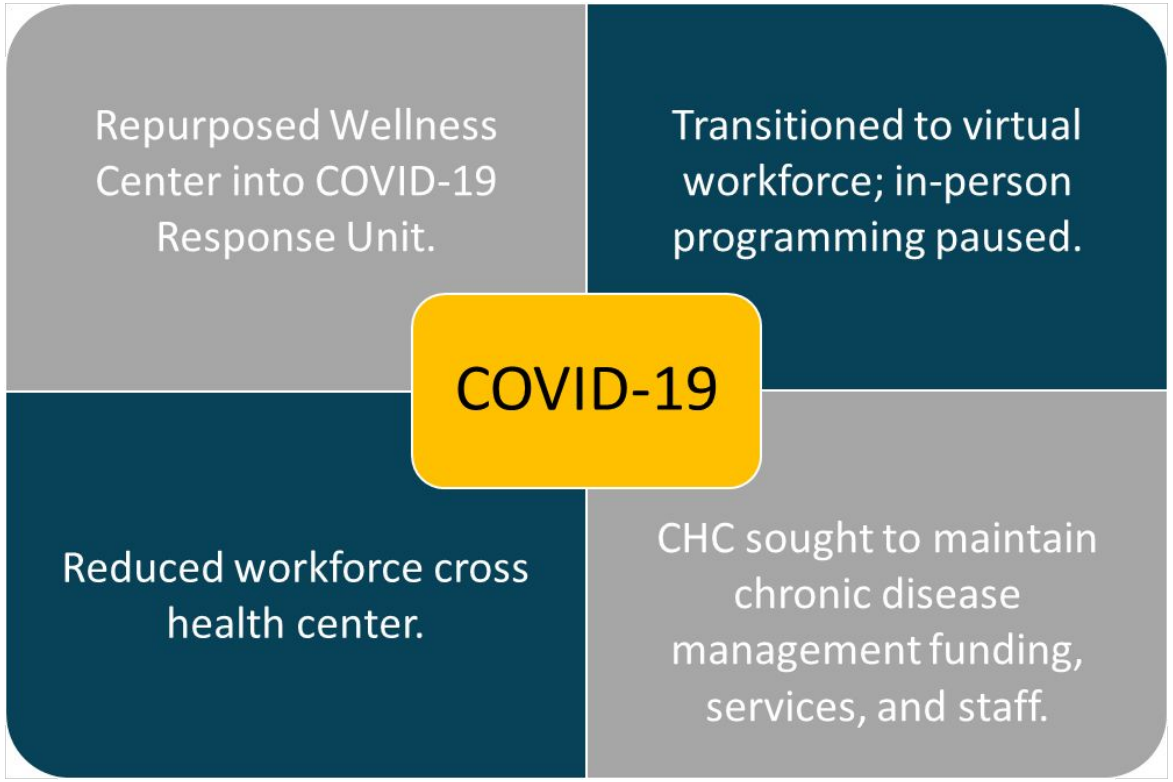
Wellness Center 3.0 (2020-Present)



- In 2020-2022, built SMBP Program, Asthma Clinic, Tobacco Cessation Program, and Virtual Wellness Center in response to patient, provider, and funder feedback.
- Today, Wellness staff deliver a range of virtual wellness and self-management programs, and collaborate with a network of partners to refer to community-based programs.

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Virtual Wellness Center Model

INTERNAL WELLNESS PROGRAMS

+ Chronic Disease Self-Management Program (CDSMP)
+ Diabetes Self-Management Program (DSMP)
+ Nutrition Workshops
+ Personal Training



COMMUNITY WELLNESS PARTNERSHIPS



+ Diabetes Prevention Program (DPP)
+ Cooking Workshops (SNAP-Ed)
+ Matter of Balance (MoB) Program (LifePath)
+ MIGHTY Pediatric Weight Management Program (YMCA)
+ Physical Therapy (Springfield College)
+ Stay Active and Independent for Life (SAIL) Fall Prevention Program (Springfield College)
+ Walk With Ease Walking Program (Springfield College)

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Social Determinants of Health (SDOH)

- The Wellness Team manages a comprehensive directory of community-based resources and utilizes platforms (e.g., 413Cares, FindHelp) to connect patients to resources that address SDOH barriers:
  - Transportation
  - Food
  - DTA Programs
  - Housing
  - Legal Advocacy
  - Pharmacy Concerns

- Patients participating in Wellness Programs receive free loaner tablets, grocery gift cards, and bus passes; and are connected to all other CHC services such as medication home delivery.

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Diabetes Services

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Wellness & Chronic Disease Management

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Wellness Center

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Diabetes Services

- **Diabetes Clinic Team:**
  - **Bonnie Paddleford, MS, PA-C,** Diabetes Specialty Care Director
  - **Vanessa Washington, RN, BSN, CDCES,CFCS,** Diabetes Health Coordinator
  - **Vela Nicasio, RDN, CDCES,** Registered Dietician
  - **Maxime Langlois, PharmD, BCACP,** Lead Clinical Pharmacist
  - **Carlos Echevarria-Maldonado, PharmD,** Clinical Pharmacist

- **Diabetes Clinic Services:**
  - Diabetes Management and Education
  - Insulin Pump Program
  - Foot and Body Mechanics Program
  - Targeted A1c Outreach and Engagement
  - Linkages to Wellness Center Programming

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Diabetes Services

- Patients are initially referred to the Diabetes Clinic by their PCP.
  - Depending on their medication needs, patients are scheduled with the Insulin Pump Clinic or with a PharmD for Medication Therapy Management.
  - The Diabetes Team has instituted a "Diabetes Clinic Triad" in which patients seen in the Diabetes Clinic for therapeutics/medication management are also referred to the Diabetes RN for self-management education and Registered Dietician for nutrition counseling.

- The Diabetes Clinic has a dedicated phone extension so patients can address their diabetes-related concerns directly.

- The Diabetes Clinic staff refers patients to the Wellness Team for SDOH assessments, connections to community resources, and enrollment in Wellness programming.

- The Diabetes Nurse and Registered Dietician co-facilitate Wellness programs, including DSMP and Virtual Nutrition Workshops.

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Thank You!

- For more information, please contact:
  - **Brielle Ruth:** bruth@caringhealth.org
  - **Tatiana Oakes:** toakes@caringhealth.org

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Questions & Discussion