Rio Grande Valley Chronic Care Management Coalition

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Implemented Across the RGV
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Upper Valley Project

Lower Valley Project
Salud y Vida Serves Participants with Uncontrolled Diabetes each Demonstration Year

![Bar chart showing individuals receiving chronic care management services over three demonstration years (DY 3, DY 4, and DY 5). The chart displays the number of new enrollments and total served for each year.]

 DY 3 | DY 4 | DY 5
--- | --- | ---
1205 | 1755 | 1204
1205 | 2670 | 2626

Legend:
- New Enrollment
- Total Served
Majority of Salud y Vida participants are improving control of diabetes

Comparison of Baseline and Quarterly HbA1c Results

- 73% Success
- 69% Success
- 68% Success
- 69% Success
- 62% Success

Includes data from October 1, 2013 - February 1, 2016
Average HbA1c values improve during the time frame where program services are most concentrated

Includes data from October 1, 2013 - February 1, 2016
Salud y Vida Program Services Time Line

Day 1 for participants
- Enroll in program
- Receive evaluation
- Enroll in Diabetes Self-Management Education (DSME) course

Months 1 – 2 for participants
- Attend DSME classes
- Assigned community health worker (CHW)
- If no PCP, connected to a Medical Home by CHW
- Receive home visit and assessments by CHW
- Receive motivational text-messages

Months 3 – 12 for participants
- Receive HbA1c test every 3 months
- Receive support via phone & home visits from CHWs
- Attend Participant Advocate Leader Board meetings
- For participants with HbA1c results increasing 1.5% or greater, receive case review with action plan
- Obtain care coordination between program and medical home

Receive referral to other resources e.g. behavioral health, exercise and cooking classes, Compassion Funds, transportation assistance, social worker services, support groups
Coordinated Care Across Partner Organizations

Improved HbA1c Control

Community Health Worker (CHW) home visits

Nurses relaying important health information to clinics

CBOs Providing Diabetes Self-Management Education in clinic and community

Behavioral health screening and services provided by mental health authority

Social Services provided by clinics, CBOs, hospitals

CHWs and nurses coordinating visits with medical home at clinics
Meet a Salud y Vida Participant  * Name changed

Before Salud y Vida Ms. Cruz* was at high risk

- 53-year old with Type 2 diabetes
- HbA1c > 10.4% at time of enrollment

Salud y Vida Team

- Enrolled the participant in Diabetes Self-Management Classes (DSME) and completed all classes prior to the 3-month time point
- Worked together to improve eating habits
- Provided glucometer for daily monitoring
- Provided 7 home visits and multiple phone calls

Better Health!

- Stabilized glucose levels
- Changed eating and exercise habits
- HbA1c decreased after 12 months
- Volunteered as peer facilitator with support groups

“I always thought that visiting your physician and taking your medications was all you needed to do. In Salud y Vida I have learned a lot... I was the kind of person that by eleven in the morning, I was sleepy again. No strength, didn’t want to do anything. Now I have lots of energy. I believe it’s never too late to start. I’m 53 years old and I feel great, something I could have said in those 12 years I lost.”

HbA1c Results
Salud y Vida, a program delivered through a coalition model will serve by end of DY 5 at least 4,164 individuals with uncontrolled diabetes in the Rio Grande Valley over 3 years.

Projected Final Outcomes

- 77% will attend at least 1 Diabetes Self-Management Education class and 68% will complete all classes.
- 68% of those that receive an HbA1c test will reduce their HbA1c within 3-months.
- 66% will have reduced their HbA1c at 12-months. 41% will reduce their HbA1c below 9 at 12-months.