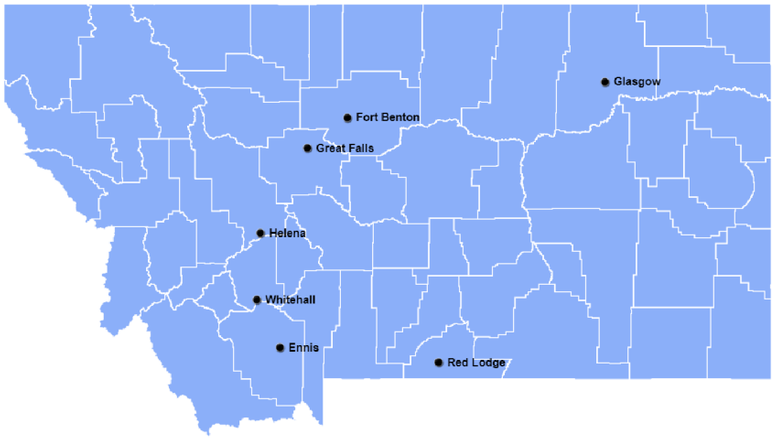
Community Integrated Health (CIH) Final Report Summary, Year 5, October 2022 to September 2023, P1

CIH sites work with patients according to **community need** but also **recruit** patients with diabetes, hypertension, hyperlipidemia, and asthma in a **regular assessment and education process** to help them improve their personal control of their chronic diseases (CD).



7
CIH Pilot Sites

24 (38 total in MT)
Endorsed CIH Staff at Pilot Sites

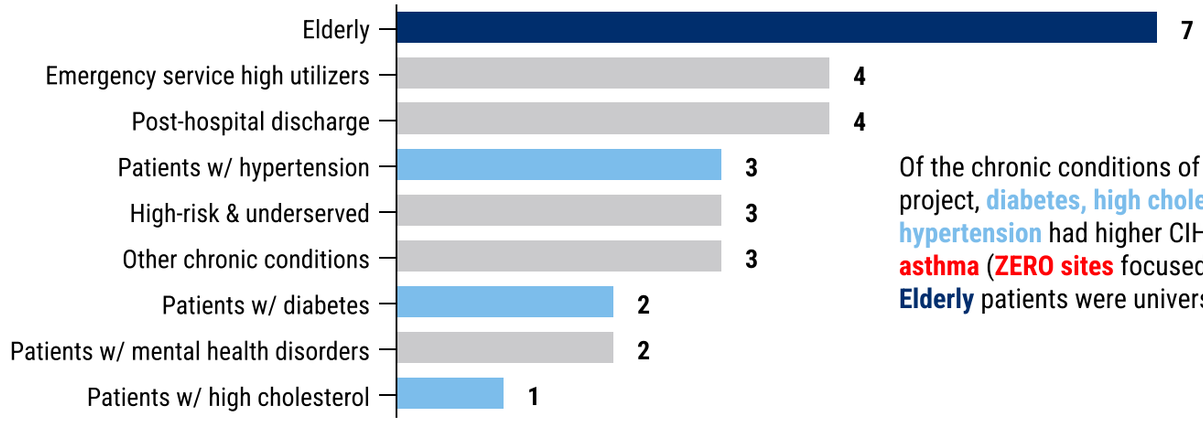
510
Unique Patients Seen (All Reasons)

1,942
Total Patient Visits (All Reasons)

46%
Patient Visits Associated with Cardiovascular Health, Diabetes, or Asthma

360
Follow-Up Visits (Patients Receive More Than One Visit)

Number of CIH Sites Prioritizing High-Needs Populations of Concern Throughout the Project



Of the chronic conditions of concern for this project, **diabetes, high cholesterol, and hypertension** had higher CIH engagement than **asthma** (**ZERO sites** focused on these conditions). **Elderly** patients were universally served.

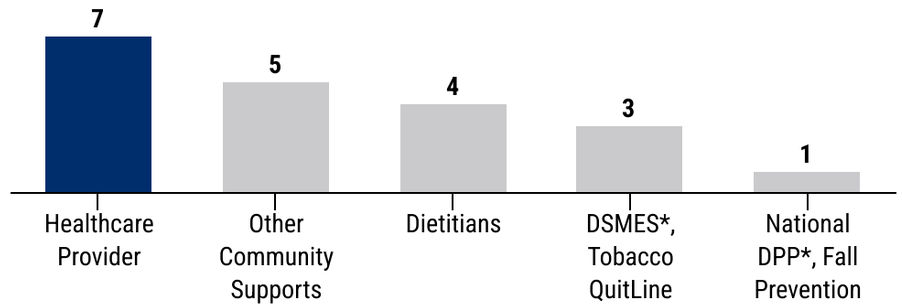
Patient Demographics

74
Average Patient Age

59%/40%
Female/Male

94%/3%/2%
White/Other/American Indian

Number of Sites Making Patient Referrals to Healthcare, Prevention and Self-Management Services for Chronic Disease, and Community Supports



ZERO sites referred to asthma supportive services, Health Coaches for Hypertension Control, Walk with Ease (arthritis). *DSMES: Diabetes Self-Management Education and Support. National DPP: National Diabetes Prevention Program

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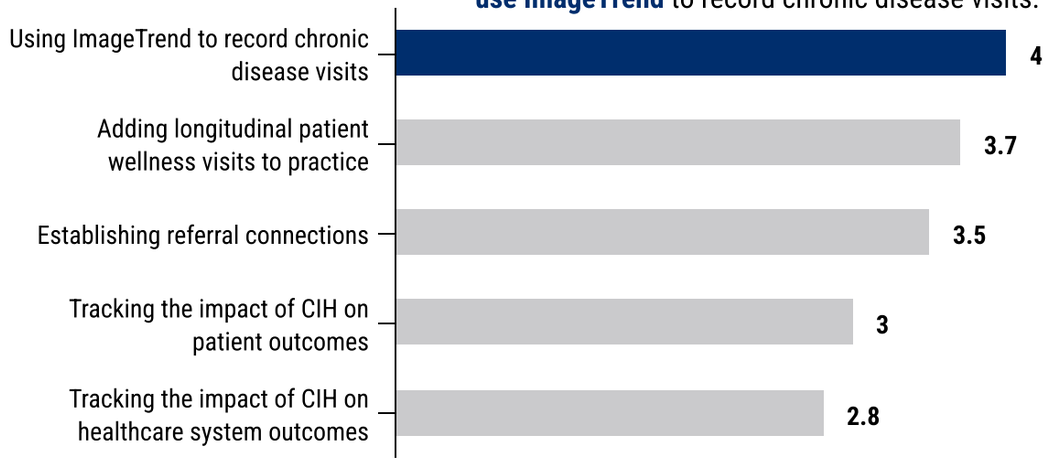
Average Self-Ratings (scale of 1 to 5) by CIH Sites on How Well They Achieved Five Project Goals

On average, sites felt they **best met the goal to use ImageTrend** to record chronic disease visits.



Y5 Barriers

- Maintaining consistent communication with relevant stakeholders about CIH benefits, purpose and capabilities (3).
- Concisely defining an expansive and locally malleable program (3).
- Provider and staff turnover and the need to re-educate re: CIH (2).
- Lack of consistent referrals from partners.

Y5 Facilitators

- Strong and supportive medical direction providing program guidance, administrative advocacy, and primary care provider communication (2)
- Strong personal relationships with referral partners (2).
- Data available through ImageTrend (2).
- Attending class with other CIH staff for peer-to-peer connection.

All sites have plans for sustaining community support and referral relationships. Only a few sites have financial sustainability plans.

	Financial Sustainability	Maintaining CIH Staffing	Maintaining Administrator Support	Sustaining Referral Relationships	Maintaining Community Support
Site 1	✓	✓	✓	✓	✓
Site 2	✓	✓	✓	✓	✓
Site 3	✓	✓	✓	✓	✓
Site 4		✓	✓	✓	✓
Site 5		✓	✓	✓	✓
Site 6				✓	✓
Site 7				✓	✓

"**This project is vital** for our EMS agency."

"I have time and time again heard this statement from our CIH patients, '**I do not know what I would do without you and this service**, you have to keep it going.' Thank you!"

Healthcare systems were the most commonly identified CIH stakeholders, but all sites identified at least one other key partner invested in CIH in their communities.

	Healthcare system	Community partner	EMS/ CIH program	Public health org.	Community based org.
Site 1	3			1	1
Site 2	3	1	1		
Site 3	1	1	1	1	
Site 4	2		3		
Site 5	2	1			
Site 6	2	1	1		
Site 7	2	1			