

# Hypertension

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**Patricia Charvat,**  
Senior Vice President, Marketing and Strategy

**Lisa Volo,**  
Senior Director, Behavioral Health and Community Services

**Tracy Lebert, RN, BSN,**  
Lead Community Health Nurse

*Mohawk Valley Health System*

# Agenda

Introductions

Our partners

Session 2: Hypertension

Upcoming sessions



# HANYS Care Connections Team



**Kathleen Rauch, RN, MSHQS, BSN, CPHQ**

Vice President, Quality Advocacy, Research and Innovation and Post-acute and Continuing Care



**Christina Miller-Foster, MPA**

Senior Director, Quality Advocacy, Research and Innovation



**Morgan Black, MPA**

Director, Care Connections



**Maria Baum, MS, RN, CPHQ**

Project Manager, Western New York



**Kira Cramer, MBA**

Project Manager, New York City



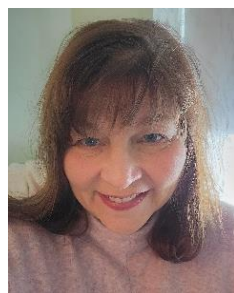
**Rachael Brust, MBA**

Project Manager, North Country



**Jonathan Serrano**

Communications Coordinator



**Theresa Green, PhD, MBA**

Associate Director, Associate Professor, Center for Community Health & Prevention Public Health Sciences URM, SON

# Our partners



## OUR FUNDER

Funding from the [Mother Cabrini Health Foundation](#) allows HANY to expand its capacity to provide education, direct support, tools and data to our members. With Care Connections, we strive to build hospital-community partnerships and share evidence-based chronic disease prevention and management strategies to address healthcare access barriers at the local level.



## OUR PARTNER

DataGen®, Inc. develops custom analytics for participants to help them understand healthcare access barriers and the chronic disease burden in their communities so they can develop tailored interventions.

# Today's presenters



**Patricia Charvat**

Senior Vice President of Marketing and Strategy  
Mohawk Valley Health System



**Lisa Volo**

Senior Director, Behavior Health and Community Services  
Mohawk Valley Health System



**Tracy Lebert, RN, BSN**

Lead Community Health Nurse  
Mohawk Valley Health System

THE MOHAWK VALLEY PARTNERSHIP FOR

# Healthy Lifestyles



*Focused approach to hypertension*



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# Overview

- Welcome and introductions
- About MVHS and our community
- Health needs of our community
- Evolution of the Mohawk Valley Healthy Lifestyles Partnership
- Our approach
- Our accomplishments
- Impact stories
- What's next



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# The MVHS Team

**Patty Charvat**

Senior Vice President, Marketing & Strategy

**Lisa Volo**

Senior Director, Behavioral Health & Community Services

**Tracy Lebert**

Lead Community Health Nurse



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# The Mohawk Valley Health System



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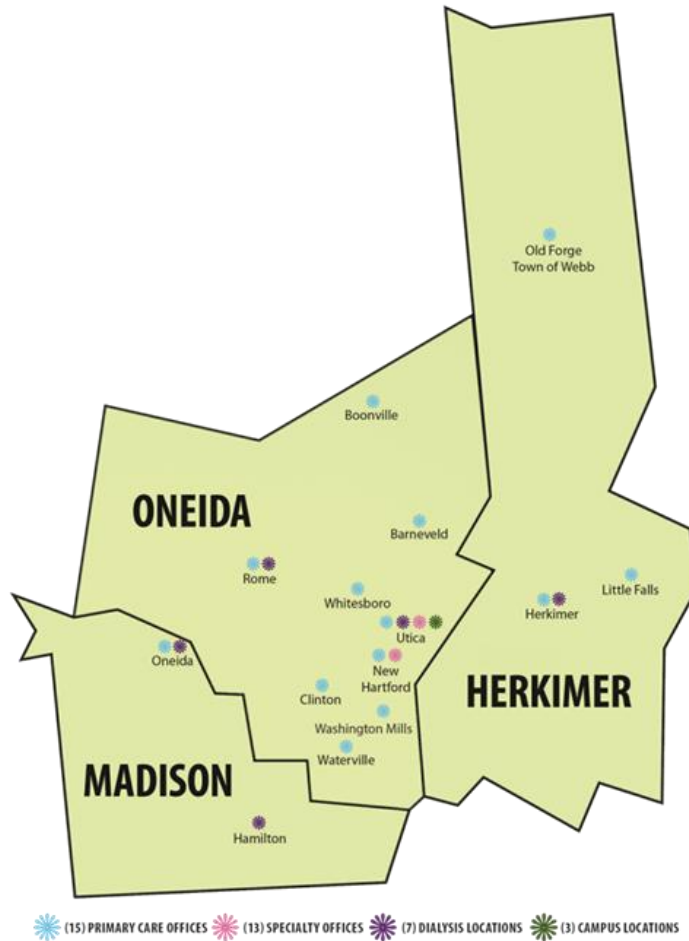
# MVHS Today

- **Non-profit, independent, integrated healthcare system**
  - Serves Oneida, Herkimer and Madison Counties
  - Second largest employer in the Utica-Rome region
- **MVHS campuses include:**
  - **Wynn Hospital**, 373-bed hospital in downtown Utica (opened 10/29/23)
  - **Faxton Outpatient Campus**
    - Cancer Center
    - Women's Health Services
    - Rehabilitation Services
    - Bariatric Surgery Group
  - **Center for Rehabilitation and Continuing Care Services**
    - MVHS Rehabilitation and Nursing Center, 202-bed long-term care facility
    - Home care/visiting nurse service
  - **St. Elizabeth College of Nursing**
  - **Medical Group/Community Sites**
    - 16 primary care sites
    - 18 physician specialty offices



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# Counties Served and Locations



- ▶ Oneida County – 75.7%
- ▶ Herkimer County – 15.6 %
- ▶ Madison County – 2.7%



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# About the Mohawk Valley Region

*Focus on Oneida County*



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# Profile of Oneida County – Age

| Population Age – Oneida County |                |       |                |       |                  |       |                    |       |                          |
|--------------------------------|----------------|-------|----------------|-------|------------------|-------|--------------------|-------|--------------------------|
| Age                            | 2000<br>Census |       | 2010<br>Census |       | 2021<br>Estimate |       | 2026<br>Projection |       | 2021 to 2026<br>Variance |
| 0 to 4                         | 13,427         | 5.7%  | 13,281         | 5.7%  | 12,969           | 5.6%  | 12,893             | 5.6%  | -0.6%                    |
| 5 to 14                        | 32,589         | 13.8% | 28,296         | 12.0% | 27,667           | 12.0% | 27,011             | 11.7% | -2.4%                    |
| 15 to 19                       | 30,501         | 13.0% | 33,252         | 14.2% | 29,954           | 13.0% | 29,771             | 12.9% | -0.6%                    |
| 20 to 24                       | 29,094         | 12.4% | 26,692         | 11.4% | 28,778           | 12.5% | 28,196             | 12.2% | -2.0%                    |
| 25 to 34                       | 37,373         | 15.9% | 29,171         | 12.4% | 25,824           | 11.2% | 26,371             | 11.4% | 2.1%                     |
| 35 to 44                       | 31,889         | 13.5% | 35,912         | 15.3% | 28,756           | 12.5% | 26,853             | 11.6% | -6.6%                    |
| 45 to 54                       | 21,684         | 9.2%  | 30,106         | 12.8% | 32,315           | 14.0% | 30,621             | 13.3% | -5.2%                    |
| 55 to 64                       | 18,429         | 7.8%  | 18,495         | 7.9%  | 24,192           | 10.5% | 26,281             | 11.4% | 8.6%                     |
| 65 to 74                       | 15,081         | 6.4%  | 12,879         | 5.5%  | 13,043           | 5.7%  | 15,409             | 6.7%  | 18.1%                    |
| 75 to 84                       | 5,449          | 2.3%  | 6,794          | 2.9%  | 6,861            | 3.0%  | 7,317              | 3.2%  | 6.6%                     |
| 85+                            | 13,427         | 5.7%  | 13,281         | 5.7%  | 12,969           | 5.6%  | 12,893             | 5.6%  | -0.6%                    |

\*Data collected from eSite Analytics



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# Profile of Oneida County – Poverty

| Population  | Percent Below Poverty Level |
|---|-----------------------------|
| <i>All Families</i>   | 10.3%                       |
| <i>With related children under 18 years</i>                 | 16.7%                       |
| <i>With related children under 5 years only</i>             | 16.5%                       |
| <i>Married couple families</i>                              | 4.3%                        |
| <i>With related children under 18 years</i>                 | 5.5%                        |
| <i>With related children under 5 years only</i>             | 3.3%                        |
| <i>Families with female householder, no husband present</i> | 31.4%                       |
| <i>With related children under 18 years</i>                 | 39.6%                       |
| <i>With related children under 5 years only</i>             | 36.9%                       |
| <i>All People</i>   | 14.2%                       |
| <i>Under 18 Years</i>                                       | 20.7%                       |
| <i>Related children under 18 years</i>                      | 20.4%                       |
| <i>Related children under 5 years</i>                       | 22.8%                       |
| <i>Related children 5 to 17 years</i>                       | 20.0%                       |
| <i>18 years and over</i>                                    | 9.7%                        |
| <i>18 to 64 years</i>                                       | 13.8%                       |
| <i>65 years and over</i>                                    | 8.0%                        |



# Profile of Oneida County – Disability

| Oneida County - Disability  |            |
|---|------------|
| Indicator   | Percentage |
| <i>Percentage of adults with an independent living disability</i> | 6.4%       |
| <i>Percentage of adults with an ambulatory disability</i>         | 7.7%       |
| <i>Percentage of adults with a self-care disability</i>           | 3.1%       |
| <i>Percentage of adults with a vision disability</i>              | 2.0%       |
| <i>Percentage of adults with a hearing disability</i>             | 3.9%       |
| <i>Percentage of adults with cognitive disability</i>             | 5.4%       |
| <i>Percentage of adults with a disability</i>                     | 13.7%      |

Data collected from 2020 American Community Survey (U.S. Census Bureau)

For the entire state of New York, the overall percentage of people with disabilities is 11.5%.

# Profile of Oneida County – Race/Ethnicity

| Race/Ethnicity – Oneida County         |                |       |                |       |                  |       |                    |       |                             |
|--|----------------|-------|----------------|-------|------------------|-------|--------------------|-------|-----------------------------|
|  | 2000<br>Census |       | 2010<br>Census |       | 2021<br>Estimate |       | 2026<br>Projection |       | 2020 to<br>2025<br>Variance |
| White                                  | 212,205        | 90.1% | 204,678        | 87.1% | 194,150          | 84.3% | 191,721            | 83.1% | -1.3%                       |
| Black or<br>African<br>American        | 13,369         | 5.7%  | 14,688         | 6.3%  | 15,452           | 6.7%  | 15,867             | 6.9%  | 2.7%                        |
| American<br>Indian or<br>Alaska native | 492            | 0.2%  | 605            | 0.3%  | 665              | 0.3%  | 676                | 0.3%  | 1.7%                        |
| Asian/native<br>Hawaiian/              | 2,783          | 1.2%  | 6,634          | 2.8%  | 9,473            | 4.1%  | 10,433             | 4.5%  | 10.1%                       |
| Some Other<br>Race                     | 2,528          | 1.1%  | 3,407          | 1.5%  | 4,374            | 1.9%  | 4,751              | 2.1%  | 8.6%                        |
| Two or More<br>Races                   | 4,138          | 1.8%  | 4,865          | 2.1%  | 6,244            | 2.7%  | 7,274              | 3.2%  | 16.5%                       |
| Hispanic                               | 7,419          | 3.2%  | 10,819         | 4.6%  | 14,187           | 6.2%  | 15,531             | 6.7%  | 9.5%                        |
| Non-Hispanic                           | 228,096        | 96.9% | 224,058        | 95.4% | 216,171          | 93.8% | 215,191            | 93.3% | -0.5%                       |

\*Data collected from eSite Analytics



## But, in Utica...

| Race and Hispanic Origin      | 2022 Estimate |
|-------------------------------|---------------|
| White (alone)                 | 60.8%         |
| Black/African American        | 15.6%         |
| Hispanic                      | 12.9%         |
| Asian                         | 11%           |
| Two or more races             | 8.1%          |
| American Indian/Alaska Native | 0.3%          |

19.4% of the population = refugees



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# Top refugee populations in Oneida County

| Country             | Total | New Arrivals - 2024 |
|---------------------|-------|---------------------|
| Bosnia/Herzegovina  | 4,449 |                     |
| Myan Mar/Burma      | 4,212 | 93                  |
| Former Soviet Union | 2,502 | 19                  |
| Vietnam/Amerasian   | 2,087 |                     |
| Somalia             | 477   | 8                   |
| Iraq                | 442   | 4                   |
| Cambodia            | 383   |                     |
| Sudan               | 371   | 17                  |
| Bhutan              | 366   |                     |
| Ukraine             | 349   | 21                  |
| Laos                | 266   |                     |
| Afghanistan         | 200   | 22                  |
| Congo/Zaire         | 163   | 47                  |
| Poland              | 146   |                     |

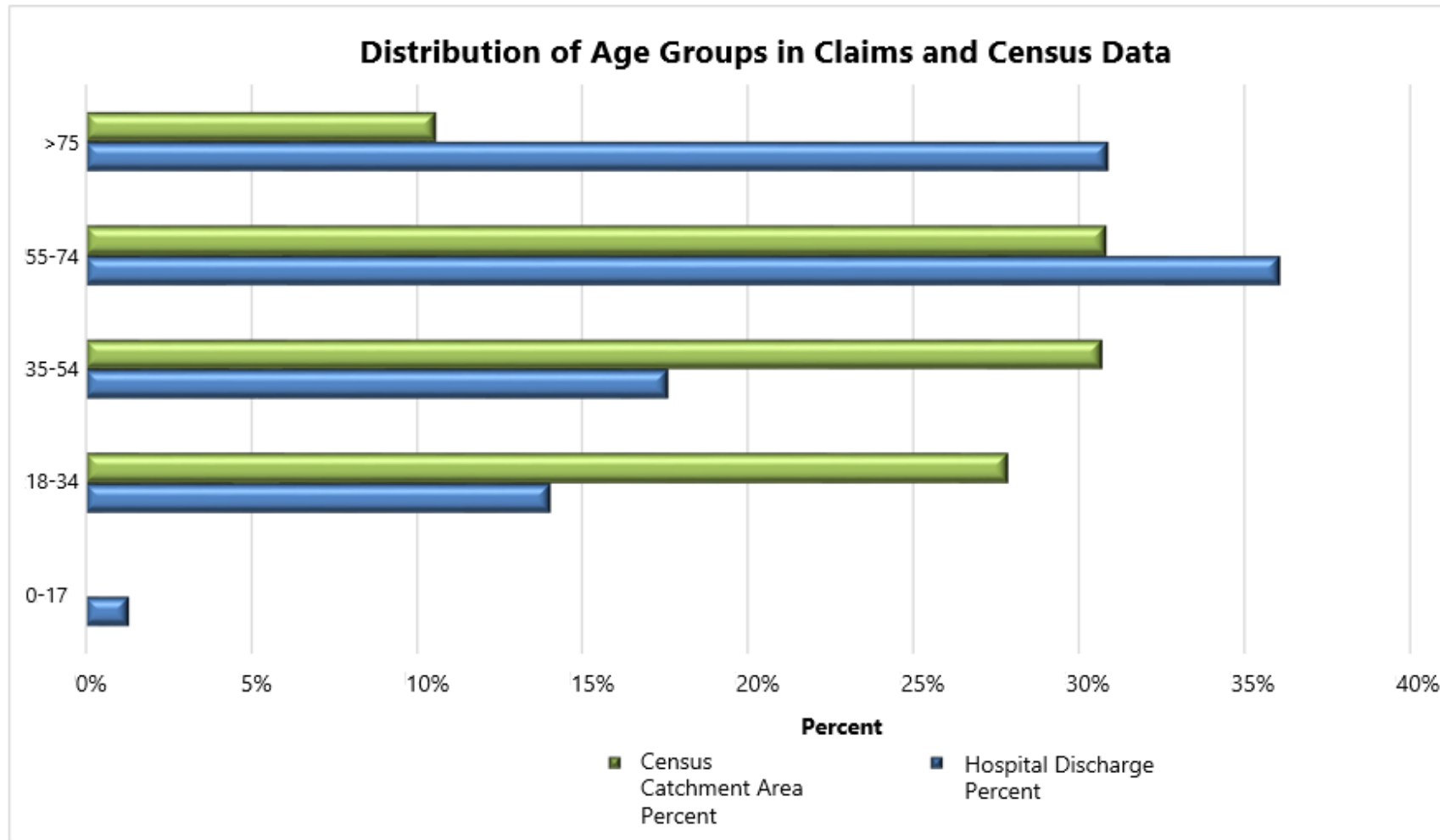
# About the MVHS Patient Population – Community Health Needs

*Focus on Oneida County*



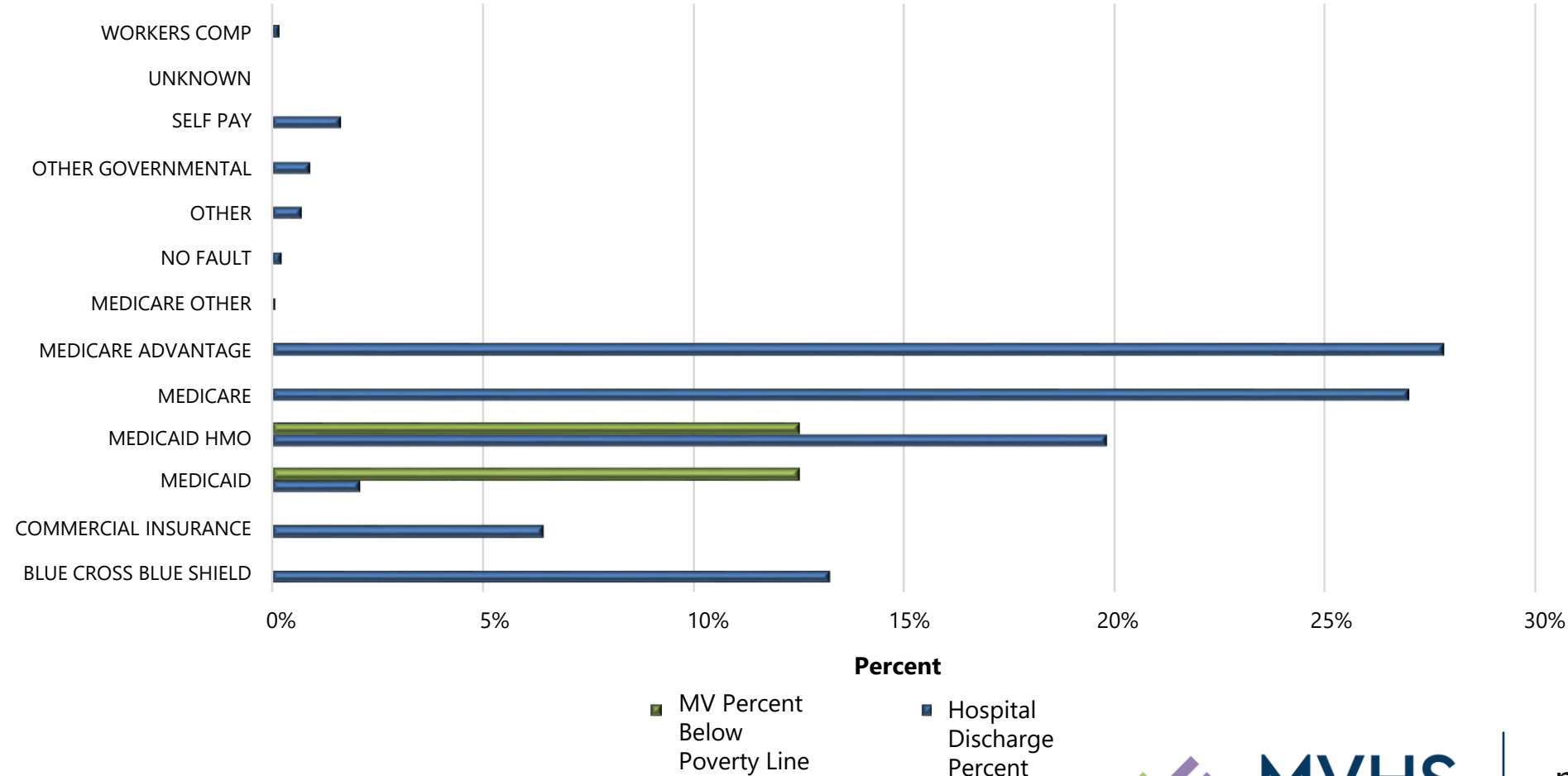
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# Our patient population

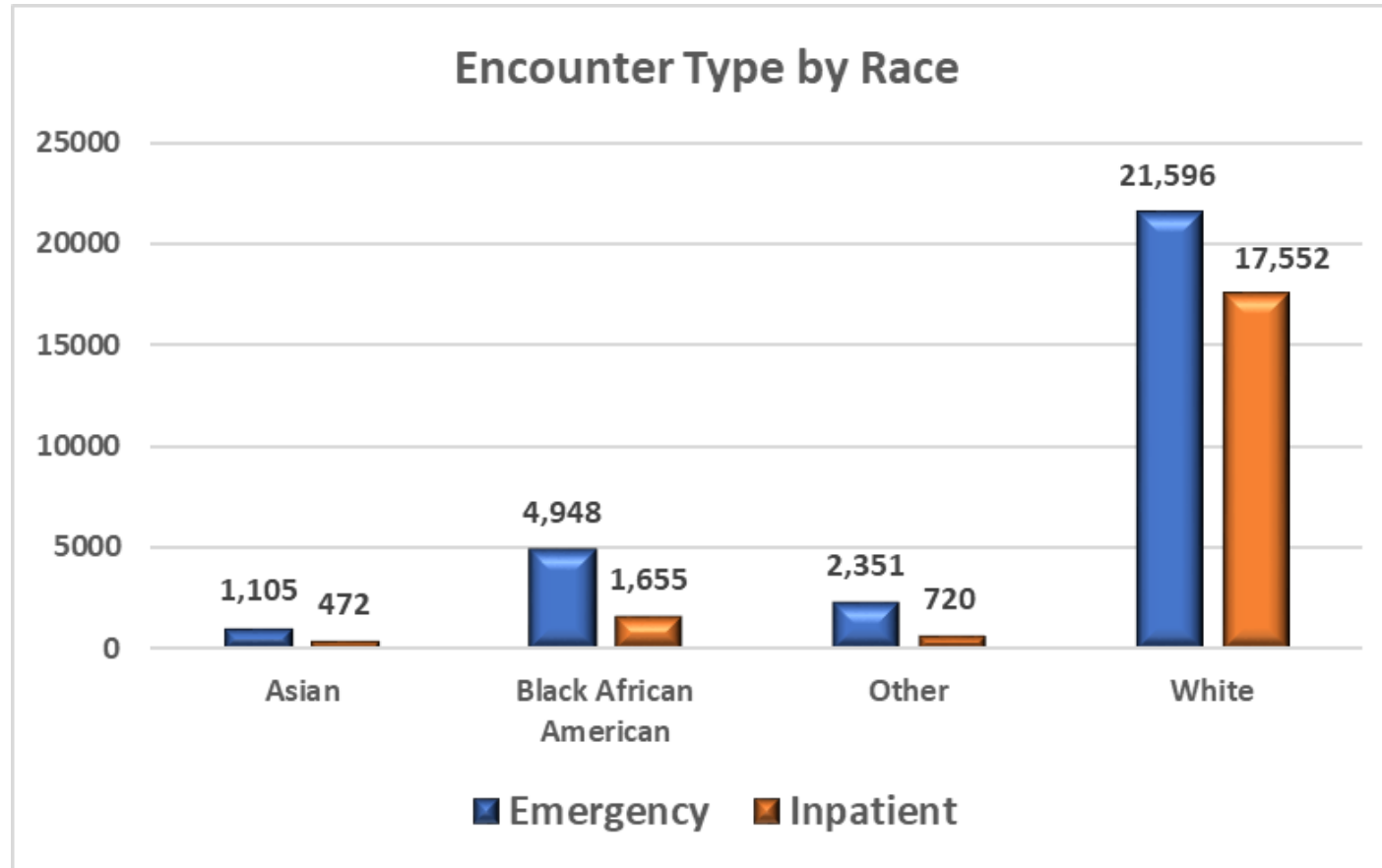


# Our patient population

Distribution of Payor Data in Claims and in Poverty Status in Census Data



# Our patient population



# Our patient population – top diagnoses

Virtually all the populations have the following diseases:

- ▶ Hypertension (Higher in Black and Hispanic patients)
- ▶ Diabetes (Higher in Black and Asian patients)
- ▶ Gastrointestinal (Higher in Black and Asian patients)
- ▶ Respiratory disease (Higher in Hispanic patients)
- ▶ Mental health (Higher in Black and Hispanic patients)
- ▶ Substance abuse (Higher in Black and Hispanic patients)
- ▶ Maternity



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# Language Services

| On Average 48 Different Languages Provided Monthly             |                          |  |
|--|--------------------------|--|
|  | 12 month Total by Number |  |
| Spanish  | 15092                    |  |
| Burmese  | 11188                    |  |
| Karen  | 10801                    |  |
| Bosnian  | 5801                     |  |
| Russian  | 4877                     |  |
| Arabic   | 3558                     |  |
| Bantu Group languages*   | 2544                     |  |
| ASL  | 567                      |  |
| All Others   | 7232                     |  |
| * Bantu Group Languages: MaayMaay, Kizgowa, Somali and Swahili |                          |  |



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THE MOHAWK VALLEY PARTNERSHIP FOR

# Healthy Lifestyles



*Focus on Oneida & Herkimer Counties*



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# How we began

- Evolved from the Mohawk Valley COVID-19 Vaccine Health Equity Task Force, facilitated by MVHS
- Commitment to focus on health needs and disparities
- Heart disease and stroke first priorities - recently added diabetes, women's health and mental health
- Three-year grant funding awarded from the Mother Cabrini Foundation in 2022



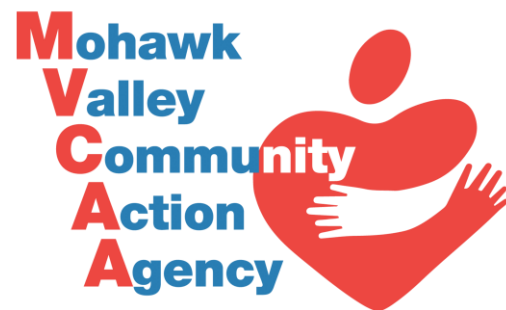
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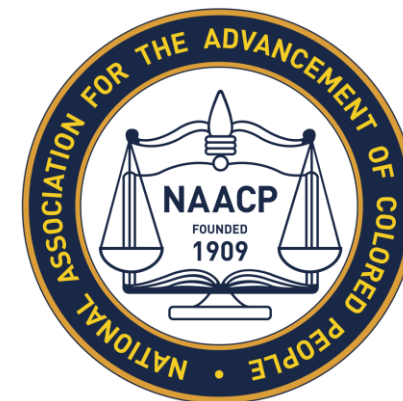
# Partners



Oneida County  
NEW YORK



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# Our approach

- Community health nurses
- Community navigators and navigator coordinator – ***unique feature***
- Nurse/navigator teams provide education and screening
- Data-driven
- Excellus Blue Cross partners to help with health benefits enrollment
- Cultural competency training



# Our approach

- **Events**

- Partner-led, e.g., Healthy Heart Tours with faith-based organizations and NAACP Health Fairs
- Community-based, e.g., Juneteenth celebrations

- **“Static sites”**

- Bargain Grocer
- The Center
- Feed Our Vets
- Old Forge Market and Ambulance
- Mother Marianne’s West Side Kitchen
- ....and it keeps growing!





# Expanded focus each year

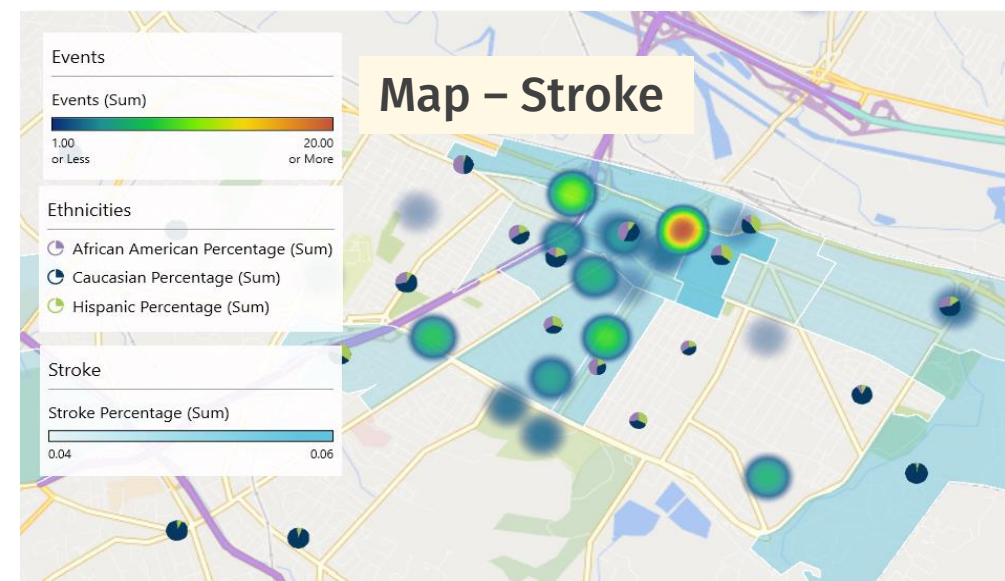
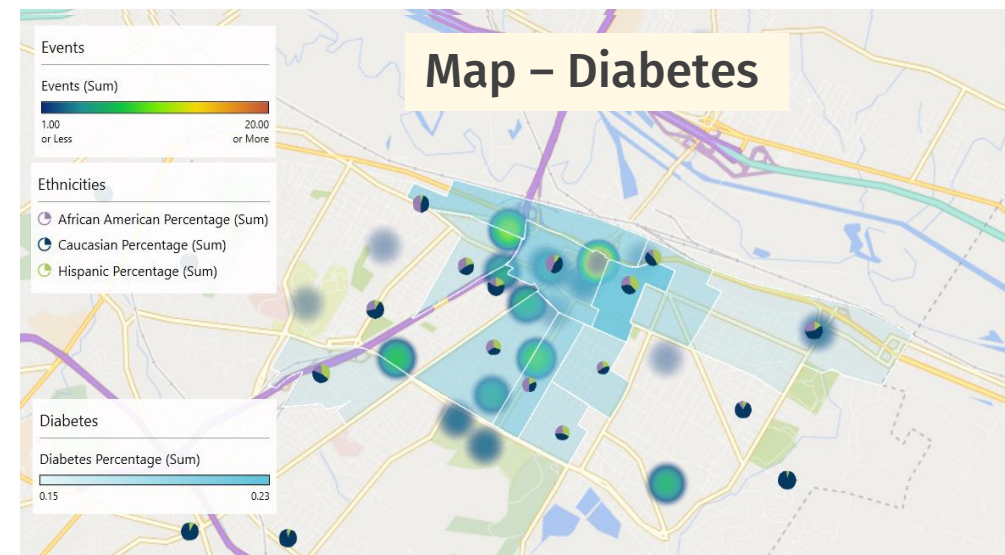
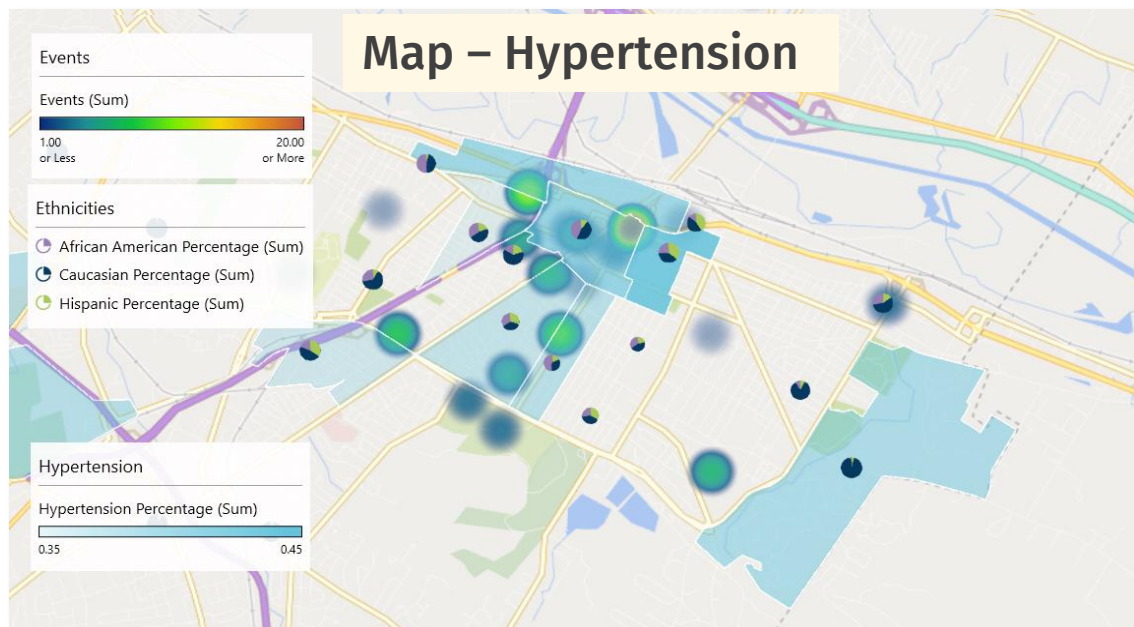
**2022** – Heart disease and stroke

**2023** – Heart disease, stroke and diabetes

**2024** – Heart disease, stroke, diabetes,  
women's health and youth



# Evolved to targeted, data-driven





# Our accomplishments – 2024

- 450 community events
- 18,663 community members reached with education
- 8,363 community members screened
- 605 nursing follow up calls
- 329 vaccinations (The Center, Rite Aid & Oneida County Health Department)
- 177 individuals linked to primary care
- 4,833 individuals received assistance with health insurance
- 3,490 heart healthy meals were provided
- 1,689 individuals received assistance with other services such as legal, elder services, etc.
- 11 different language translations of program materials (Arabic, Bosnian, Burmese, English, Karen, Nepali, Russian, Somali, Spanish, Swahili, Ukrainian)



# Impact stories



From the Outreach Coordinator for the SSG Fox Veteran Suicide Prevention Grant Program at the Utica Center for Development/Central New York Veterans Outreach Center:

*I never realized how serious high blood pressure was until I met this incredible team of nurses, Tracy and Alex from MVHS. They spoke to me with genuine care and concern about high blood pressure and the dangers of high blood pressure if it went untreated. Their encouragement made all the difference, and I finally put aside my stubbornness and was seen by my PCP where I was able to be placed on medication to lower my blood pressure to a healthy range. Thanks to Tracy and Alex's support, I now monitor my blood pressure regularly and feel more in control of my health.*

*Tracy and Alex are not just doing a job, they are changing lives. I know they have changed mine.*



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## Impact stories

Our Community Navigator from Sudan would get his blood pressure checked at our static sites, and every time it was extremely elevated with no other signs and symptoms. As the nurses we recommended going to the ER, but he refused and was trying to manage on his own. After many elevated readings and our teaching of high blood pressure and risk factors, he re-established with a provider and agreed to medications. His blood pressure came down, but not enough, and the provider changed his medications numerous times until his pressure became more regulated.



# Impact stories



A teacher from The Center wasn't feeling well, had a headache and some chest pain. She was even more worried after finding out her blood pressure was elevated. After recommendations of being seen in ER, she was given anti-hypertensive medications. Her blood pressure came down and has been within normal range since. She was extremely grateful for our community outreach education and nursing for being there and also for doing a follow up call with her.

# Lessons learned

What we learned in the last five years:

- Be open to all community organizations
  - Everyone is welcome at the table and has something to contribute
- Meeting cadence is important to maintain engagement
  - Once a week touch base – even if it's for 15 minutes
- “Taking turns” as the lead is critical to reduce drama
- “Static sites” build trust in vulnerable populations
- Doing what's right for your community is invaluable (and, yes, you can convince your CFO!)

# What's next

- Expanding into behavioral health and youth
- Identifying programs for the homeless – integrated primary and behavioral health
- Partnership continues to expand

# Upcoming sessions

Tuesday, May 27 | 11 a.m. – noon

## *Diabetes*

**Robert Rock, MD, MHS**

Clinical Director, Borough of Bronx Neighborhood Health  
Center for Health Equity and Community Wellness  
NYC Department of Health and Mental Hygiene

**Abbie Gellman, MS, RD, CDN**

Chef and Registered Dietitian  
St. Barnabas Hospital

## Remaining sessions in this series:

- June 3 | Asthma
- June 10 | COPD
- June 17 | Breast Cancer
- June 24 | Mental health and substance use disorders
- July 1 | Building Community Partnerships



# Care Connections

## Questions?

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