

2017 Model Practices

Applicant Information

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Model Practice Title

Please provide the name or title of your practice: *

Oakland County Health Division

Practice Categories

Model and Promising Practices are stored in an online searchable database. Applications may align with more than one practice category. Please select all the practice areas that apply.: *

- | | | | | |
|---|--|---|--|---|
| ☐ Access to Care | ☒ Advocacy and Policy Making | ☐ Animal Control | ☐ Coalitions and Partnerships | ☐ Communications/Public Relations |
| ☐ Community Involvement | ☐ Cultural Competence | ☐ Emergency Preparedness | ☐ Environmental Health | ☐ Food Safety |
| ☐ Global Climate Change | ☐ Health Equity | ☐ HIV/STI | ☐ Immunization | ☒ Infectious Disease |
| ☐ Informatics | ☐ Information Technology | ☐ Injury and Violence Prevention | ☐ Marketing and Promotion | ☐ Maternal-Child and Adolescent Health |
| ☐ Organizational Practices | ☐ Other Infrastructure and Systems | ☐ Organizational Practices | ☐ Primary Care | ☐ Quality Improvement |
| ☒ Research and Evaluation | ☐ Tobacco | ☐ Vector Control | ☐ Water Quality | ☐ Workforce |
| ☐ Conference Theme: Bridging Clinical Medicine and Population Health | | | | |

Other::

Is this practice evidence based, if so please explain. :

Yes. Researchers have demonstrated a bidirectional association between TB and diabetes mellitus (DM). For persons with latent TB infection (LTBI), the risk of converting to active TB disease increases three fold among DM. It is estimated that one third of the world's population has tuberculosis infection. It is much lower in the United States; yet still approximately 13 million people in the US have LTBI. Of these, about 5-10% will go on to develop TB disease if untreated. It is known that certain health conditions increase the risk of conversion from latent infection to active disease. Among diabetics, it has been found that this risk is increased threefold. Often people are reluctant to take LTBI treatment at the early stage of infection, knowing that their lifetime risk of progression to active disease is only about 5-10%. That risk increases to about 30% with diabetes.

Winnable Battles

To keep pace with emerging public health challenges and to address the leading causes of death and disability, CDC initiated an effort called Winnable Battles to achieve measurable impact quickly. Winnable Battles are public health priorities with large-scale impact on health and known effective strategies to address them. Does this practice address any CDC's seven Winnable Battles? If so, please choose from the following: *

- | | | | | |
|---|--|--|----------------------------------|---|
| ☐ Food Safety | ☐ HIV in the U.S. | ☐ Nutrition, Physical Activity, and Obesity | ☐ Tobacco | ☐ Healthcare-associated Infections |
| ☐ Motor Vehicle Injuries | ☐ Teen Pregnancy | ☒ None | | |

Overview: Provide a brief summary of the practice in this section (750 Word Maximum)

Your summary must address all the questions below:

- Brief description of LHD- location, demographics of population served in your community
- Describe public health issue
- Goals and objectives of the proposed practice
- How was the practice implemented/activities
- Results/Outcomes (list process milestones and intended/actual outcomes and impacts.
 - Were all of the objectives met?
 - What specific factors led to the success of this practice?
- Public Health impact of practice
- Website for your program, or LHD.

750 Word Maximum

Demographics: Oakland County, Michigan, located in southeast Michigan, covers approximately 900 square miles and has a population of over 1.2 million (<https://www.oakgov.com/advantageoakland/business/Pages/county-profile-default.aspx>). The demographic make-up is 76.2% white; 14.4% black/African American; 0.3% American Indian/Alaskan Native; 6.8% Asian; 3.9% Hispanic/Latino. 10% of Oakland County's population is at or below poverty level (<http://www.census.gov/quickfacts/table/PST045215/26125#headnote-js-b>). Oakland County is home to many immigrants and international employees. The Oakland County Health Division (OCHD) has two locations, one in the south end of the county bordering Detroit, and one in the county seat, Pontiac, which is in the north part of the county.

Description of Public Health Issue It is estimated that one third of the world's population has tuberculosis infection. It is much lower in the United States; yet still approximately 13 million people in the US have LTBI. Of these, about 5-10% will go on to develop TB disease if untreated. Because of this, identification and treatment LTBI is critical to our goal of TB elimination in the United States. Certain health conditions increase the risk of conversion from latent infection to active disease. Among diabetics, this risk is increased threefold. Often people are reluctant to take LTBI treatment at the early stage of infection, knowing that their lifetime risk of progression to active disease is only about 5-10%. That risk increases to about 30% with diabetes. Particularly in low incidence states, physicians may delay diagnosing tuberculosis, leading to potentially broader community exposure. This can be a vicious circle because the latent infection is in a broader population not normally identified as high risk.

Goals and Objectives of the Proposed Practice

1. Screen all LTBI patients in our clinics for hyperglycemia via HbA1c test, in order to ascertain the magnitude of hyperglycemia in our LTBI population.
2. Use diabetes screening as an opportunity to improve management of LTBI patients, such that patients who are reluctant to undergo recommended treatment may accept medication if they understand their increased risk of conversion.
3. To help us achieve these goals, we plan to perform a 4 year study which includes:
 - Recruit Michigan public health departments to screen LTBI patients with HbA1c and pool their data with ours to study prevalence of hyperglycemia in LTBI patients
 - After 2 years, analyze data and create enhanced tuberculosis educational materials for patients with hyperglycemia
 - Have public health nurses use the DM/TB specific educational materials to achieve an increase in LTBI treatment completion rates.
 - Analyze data after 2 more years to determine if the nursing education intervention was successful in increasing LTBI treatment completion rates.

How Was the Practice Implemented/Activities

- 03/2016: Developed protocol and procedures for screening LTBI patients for hyperglycemia
- 03/2016: Provided education and training to OCHD Public Health Nurses on relationship between DM and TB, following up with patients regarding results, and providing education and resources for patients with HbA1c > 5.7%
- 04/2016: Began HbA1c testing on untreated LTBI patients, providing education to LTBI patients on the relationship of DM & TB, and encouraging treatment.
- 06/2016: Student epidemiology intern began data collection and analysis
- 12/2016: Invited other Michigan health departments to join in implementation of the practice and data collection.
- 01/2017: Data collection for the study to begin

Outcomes

- 100% of new and existing untreated patients with LTBI were screened for diabetes via HbA1c test.
 - o Of those screened, 55% had an HbA1c level of >5.7% indicating pre-diabetes or diabetes
 - o Of those with high HbA1c, only 13% were already aware of their DM status.
- 100% of those tested were informed of their results and the reason for the test.
- 100% of those with high HbA1c levels received teaching by nurses regarding the elevated risk of conversion to active TB.
- 100% of those with high HbA1c levels were referred to either their private provider or an FQHC for follow up of their hyperglycemia.

Outcomes for the study will be evaluated at 2 points, in December 2018 and December 2020

Public Health Impact Low incidence TB states struggle with having sporadic outbreaks of active disease in persons not otherwise considered high risk, which puts the community at risk. This practice and related study will raise awareness among public health and primary care providers about the important relationship between DM and TB. While diabetes screening is the standard of care for LTBI patients, it has not been implemented in low incidence states. Showing that screening can be an inexpensive way to increase the acceptance of treatment among LTBI patients, will contribute to goal of elimination of TB elimination.

Oakland County Health Division - www.oakgov.com/health

Responsiveness and Innovation

A Model Practice must be responsive to a particular local public health problem or concern. An innovative practice must be (1) **new to the field of public health (and not just new to your health department)** OR (2) **a creative use of an existing tool or practice**, including but not limited to use of an Advanced Practice Centers (APC) development tool, The Guide to Community Preventive Services, Healthy People 2020 (HP 2020), Mobilizing for Action through Planning and Partnerships (MAPP), Protocol for Assessing Community Excellence in Environmental Health (PACE EH). Examples of an inventive use of an existing tool or practice are: tailoring to meet the needs of a specific population, adapting from a different discipline, or improving the content.

- Statement of the problem/public health issue
- What target population is affected by problem (please include relevant demographics)
 - What is the target population size?
 - What percentage did you reach?
- What has been done in the past to address the problem?
- Why is the current/proposed practice better?
- Is current practice innovative? How so/explain?
 - Is it new to the field of public health

OR

 - Is it a creative use of existing tool or practice:
 - What tool or practice did you use in an original way to create your practice? (e.g., APC development tool, The Guide to Community Preventive Services, HP 2020, MAPP, PACE EH, a tool from NACCHO's Toolbox etc.)
- Is the current practice evidence-based? If yes, provide references (Examples of evidence-based guidelines include the Guide to

2000 Word Maximum

Please state the Responsiveness and Innovation of your practice (2000 Word Maximum) : *

RESPONSIVENESS AND INNOVATION Statement of the Problem/Public Health Issue More than 13 million people living in the United States have latent TB infection; however most of these people are unaware of their infection . Identification and treatment at the early stage of tuberculosis infection is critical to TB elimination in the United States and is a cornerstone of the U.S. strategy for TB elimination. The major concern with LTBI is the potential for progression to TB disease. In fact, about 5-10 percent of those with latent TB infection in the United States will go on to develop TB disease if not treated. The risk of progression to active disease is considerably higher in infected individuals who belong to specific high risk populations, including the diabetic population. Among those with LTBI and diabetes, this conversion rate is tripled. . . In the United States, 29.1 million people or 9.3% of the population have diabetes. Among these people, it is estimated that 27.8% are undiagnosed. Thus, many patients at risk of diabetes are unaware of their status, at the same time, many are unaware that they have TB infection and an even greater risk of converting to active TB disease. Target Population The demographic makeup of Oakland county is 76.2% white; 14.4% black/African American; 0.3% American Indian/Alaskan Native; 6.8% Asian; 3.9% Hispanic/Latino with a total population of over 1.2 million. With 71,748 persons being foreign born and approximately 314,500 adults over the age of 21 being pre-diabetic (many unknowingly), the convergence of these two epidemics became our focal point. - To our knowledge, no other health departments in low incidence states are routinely screening all LTBI patients for diabetes. While HbA1c testing is recommended for persons with LTBI, this recommendation is poorly followed. The United States Preventative Services Task Force (USPSTF) guidelines recommend screening for type 2 diabetes in asymptomatic adults, ages 4—70 who are overweight or obese. However, we found in our study population, many patients with high HbA1c levels have normal BMI (mean 25), and are of an age where an HbA1c otherwise would not be recommended according to USPSTF guidelines. The potential benefits of screening in our LTBI population, are substantial. While it is recommended that patients with LTBI undergo treatment, most people are reluctant to do so, due to the length of treatment regimens and perceived low risk of converting to active disease. We propose that nursing education regarding the threefold increase in conversion risk, and an even greater subsequent increased morbidity and mortality in active disease, will increase treatment uptake and compliance, thereby decreasing potential spread of active TB disease among communities. After collecting data for two years regarding HbA1c, LTBI incidence, and treatment acceptance and completion rates, OCHD will develop health education material targeted at educating persons who have both LTBI and hyperglycemia about their increased risk of converting to active disease. Using this material, public health nurses in our clinics will implement an educational nursing intervention with all LTBI patients. Data will again be collected on a quarterly basis for a period of two years and analyzed to determine whether the increased knowledge leads to an increased acceptance of LTBI treatment. The effect of diabetes on the development and severity of tuberculosis, and the complex relationship between diabetes and tuberculosis remain provocative issues in public health and clinical medicine, and we believe that our innovative and evidence based practice of implementing HbA1c testing among the LTBI population will work in tandem with national goals to decrease the burden of TB.

LHD and Community Collaboration

The LHD should have a role in the practice's development and/or implementation. Additionally, the practice should demonstrate broad-based involvement and participation of community partners (e.g., government, local residents, business, healthcare, and academia). If the practice is internal to the LHD, it should demonstrate cooperation and participation within the agency (i.e., other LHD staff) and other outside entities, if relevant. An effective implementation strategy includes outlined, actionable steps that are taken to complete the goals and objectives and put the practice into action within the community.

- Goal(s) and objectives of practice
- What did you do to achieve the goals and objectives?
 - Steps taken to implement the program
- Any criteria for who was selected to receive the practice (if applicable)?
- What was the timeframe for the practice
- Were other stakeholders involved? What was their role in the planning and implementation process?
 - What does the LHD do to foster collaboration with community stakeholders? Describe the relationship(s) and how it furthers the practice goal(s)
- Any start up or in-kind costs and funding services associated with this practice? Please provide actual data, if possible. Otherwise, provide an estimate of start-up costs/ budget breakdown.

5000 words maximum

LHD AND COMMUNITY COLLABORATION Goals and Objectives of the Practice • Our goals and objectives for this practice are two-fold: 1. Considering the association between TB and DM, and the increased risk for conversion to active TB among those with DM, we decided to screen all LTBI patients in our clinics for hyperglycemia via HbA1c test, in order to ascertain the magnitude of hyperglycemia in our LTBI population. 2. Mirroring the US strategy for TB elimination, our practice aims to prevent the occurrence of active TB through the treatment of LTBI. Historically, rates of LTBI completion rates have been low, approximately 20-30%, or lower depending on the length of regimen used (Horsburgh, 2004). OCHD has similar completion rates among our LTBI patient population, with approximately 28% completion in 2015. Our objective is to use diabetes screening as an opportunity to improve management of LTBI patients, such that patients who are reluctant to undergo recommended treatment may accept medication if they understand their increased risk of conversion. **Steps Taken to Implement the Program** 1. Estimated cost of implementing the practice: a. Reviewed data from previous years to assess how many new LTBI cases we diagnose per year and how many untreated LTBI patients we provide clearance for annually. b. Contacted our contracted lab for HbA1c pricing. 2. Worked with our IT department to make sure our Electronic Health Record (EHR) had the means to order and document the new lab test. 3. Created clinical procedures: a. Assessing patients for meeting the testing criteria and drawing the lab test b. Processing the laboratory results c. Documentation in the EHR d. Follow up with patients regarding test results and providing resources for abnormal results 4. Created and presented a training PowerPoint for clinic nurses who would be providing the test, educating the patients and following up on results. 5. Ordered required medical equipment a. 4cc Lavender top blood collection tubes; clinic has other venipuncture equipment already in stock. 6. Continued follow up and consultation as needed with clinic supervisors to answer questions and clarify procedures. 7. Epidemiology intern created spreadsheet to track and analyze data. **Criteria for who was selected to receive the practice** • Oakland County resident • Positive TB Skin Test or IGRA – TB test performed at OCHD or documentation from an outside provider • Not previously diagnosed with DM • Not previously treated for LTBI • Age >18 years **Timeframe for the Practice** • The practice began April 1, 2016 and has been ongoing since. • Alteration of the study parameters was to include persons previously diagnosed with DM to have their HbA1c checked. This will potentially provide information to stratify the risk of conversion according to how well controlled is the patient's DM. • The study, which has received IRB approval per OCHD guidelines, will commence on 1/1/2017 and go through 12/31/2020 **Other Stakeholders Involved** • OCHD Staff: During the initial phase of this project, stakeholders included staff within OCHD who would be involved in the implementation and follow up of the practice. This includes nursing staff, nursing supervisors, clerical staff, clerical supervisors, epidemiologists, chief of medical services, and laboratory staff. • FQHC's: OCHD maintains relationships with several FQHC's in the community, so we had a resource list already in place to be given to uninsured patients requiring follow up and management for pre-diabetes or diabetes. • Other Michigan Health Departments: The second phase of this project which begins January, 2017, is a 4-year study with an educational intervention. This will involve the same OCHD staff as listed above, as well as those from other local health departments in Michigan. OCHD has invited the other local health departments in Michigan to take part in this practice implementation study by screening LTBI patients for hyperglycemia, pooling their data with ours, and using the nursing educational intervention developed by OCHD, to determine if LTBI completions rates increase. • Other Public Health Professionals: Health educators within OCHD will be involved in creating the educational tools that will be used by nursing staff. **Costs** • HbA1c = \$6.00 per test • Tests done 4/1/16 – 12/6/16 = 73 • HbA1c cost 4/1/16 – 12/6/16 = \$438 • Nursing cost is negligible, as the HbA1c is drawn simultaneously with HIV, a practice that has already been in place. **Reference** Horsburgh, C.R. (2004). Priorities for the treatment of latent tuberculosis infection in the United States. *New England Journal of Medicine*, 350, 2060-2067.

Evaluation

Evaluation assesses the value of the practice and the potential worth it has to other LHDs and the populations they serve. It is also an effective means to assess the credibility of the practice. Evaluation helps public health practice maintain standards and improve practice. Two types of evaluation are **process** and **outcome**. Process evaluation assesses the effectiveness of the steps taken to achieve the desired practice outcomes. Outcome evaluation summarizes the results of the practice efforts. Results may be long-term, such as an improvement in health status, or short-term, such as an improvement in knowledge/awareness, a policy change, an increase in numbers reached, etc. Results may be quantitative (empirical data such as percentages or numerical counts) and/or qualitative (e.g., focus group results, in-depth interviews, or anecdotal evidence).

- What did you find out? To what extent were your objectives achieved? Please re-state your objectives.
- Did you evaluate your practice?
 - List any primary data sources, who collected the data, and how (if applicable)
 - List any secondary data sources used (if applicable)
 - List performance measures used. Include process and outcome measures as appropriate.
 - Describe how results were analyzed
 - Were any modifications made to the practice as a result of the data findings?

2000 Words Maximum

Were Objectives Achieved? Restate Objectives 1. To implement a practice to test HbA1c for every new and existing LTBI patient, in order to ascertain the magnitude of hyperglycemia in our LTBI population. ? This objective has been achieved, with 100% of new and existing untreated LTBI patients receiving an HbA1c test. Results of this testing has revealed that 55% of those tested had an HbA1c of >5.7%, but only 13% of this group were aware of their DM status. ? This new practice was easily incorporated into the evaluation process of LTBI patients, particularly since nurses were already drawing blood for HIV testing. 2. Prevent the occurrence of active TB through the treatment of LTBI. We aim to use diabetes screening as an opportunity to improve management of LTBI patients, such that patients who are reluctant to undergo recommended treatment may accept medication if they understand their increased risk of conversion. ? This is ongoing. Data collection and analysis is ongoing to determine how this affects rates of LTBI treatment completion among Oakland County patients. IRB approval was recently obtained and other Michigan health departments will be recruited to join our efforts to screen LTBI patients with HbA1c, pool their data with ours, and use DM/TB specific educational materials (which will be developed) to achieve an increase in LTBI treatment completion rates. Informally, there has been high interest in participation by other health departments. Evaluation of the Practice • The primary data source for this project is OHCD's EHR, Insight. As all charting in our clinics is done via Insight, a student epidemiology intern was able to export data from Insight to an Excel spreadsheet. We worked with our IT professionals to create reports within Insight which allowed our intern to easily pull the necessary data. • Secondary data sources included aggregate data related to TB, LTBI, and DM incidence and prevalence. This data was retrieved from CDC. • Performance measures used for the initial phase of the practice program included measuring the percentage of patients meeting the criteria who received the HbA1c test, and the percentage of those who were tested who were counseled about their results and the implications for LTBI, and referred for follow up as indicated. • Data analysis was performed by our student epidemiology intern and is ongoing. All data is entered into an Excel spreadsheet, including date of T-spot, T-spot results, Date of HbA1c if drawn, HbA1c result, whether patient received counseling by the nurse, and whether they were referred out. Data was analyzed by calculating percentages/proportions for each variable. Going forward, data regarding start date of treatment, medication regimen used, treatment completion date will be collected and analyzed along with the data already mentioned. • The only modification that had to be made based on the data findings was a process issue related to the timing of the HbA1c blood test. In a few instances, we found that the HbA1c was drawn simultaneously with the T-spot, before a diagnosis of LTBI was made. Reinforcement was provided to the nurses that the HbA1c should only be drawn after T-spot results is returned indicating TB. Their practice was changed to draw the HbA1c when the client with a positive T-Spot or TST returned for a chest x-ray to rule out active TB disease. • Overall, the practice was implemented fairly easily with little disruption or change in the nurses' workflow. The nurses appreciated the increased knowledge about LTBI conversion to active TB, and were comfortable providing more comprehensive teaching regarding the risk of conversion to active TB for LTBI patients with high HbA1c levels, as well as those with normal lab values. Additionally, we have assigned LTBI "specialist" nurses in each clinic to follow all LTBI clients, so that more consistent and thorough education and follow up can be done for LTBI patients with high HbA1c levels (in terms of referring to outside providers for care), and LTBI care will be improved, more streamlined and comprehensive, with higher completion rates.

Sustainability

Sustainability is determined by the availability of adequate resources. In addition, the practice should be designed so that the stakeholders are invested in its maintenance and to ensure it is sustained after initial development (*NACCHO acknowledges that fiscal challenges may limit the feasibility of a practice's continuation.*)

- Lessons learned in relation to practice
- Lessons learned in relation to partner collaboration (if applicable)
- Did you do a cost/benefit analysis? If so, describe.
- Is there sufficient stakeholder commitment to sustain the practice?
 - Describe sustainability plans

1500 Words Maximum

Please enter the sustainability of your practice (2000 Words Maximum): *

Lessons Learned in Relation to Practice and Partner Collaboration • Staff nurse buy-in: The nurses who staff OCHD's clinics are the professionals who perform the test, provide patient education, provide LTBI treatment, and follow up on all test results. It is recognized that their support is of the utmost importance to make change happen in increasing LTBI acceptance. The nurses received training on the importance of the practice and the reasons for its implementation. They also had input on the clinical procedures, from the drawing of the blood sample, to the follow up on results. It was important to ensure that procedures were very clear and easy to follow, as we have 2 busy clinics with many public health nurses providing multiple services. It is critical that procedures be revisited and evaluated periodically to ensure that they are still being followed and make any necessary adjustments. • The biggest challenge was the additional workload created for the nurses following up with clients regarding high HbA1c results. Additional training on the interpretation of lab values, the extent of follow up required by our nursing staff and a reliable list of local providers to refer patients to has helped nursing staff incorporate this into their daily work duties. An easy to follow algorithm was created for nurses to reference when interpreting lab results and making referrals to community providers. • We were reminded of how important it is to have collaborative partnerships with Federally Qualified Health Centers (FQHC) so that our uninsured patients requiring follow up for hyperglycemia have a medical home where they can receive comprehensive health care without going into debt. We will continue efforts to partner with our local FQHC's to ensure that our uninsured clients have access to comprehensive health care and can achieve the best possible health outcomes. • Reaching out to known free/low-cost community health care providers/FQHC's that we have established relationships with allowed us to refer patients with confidence they would receive the care required for pre-diabetes and diabetes. It is important to make sure that the organizations where we are referring our patients are able to provide the service we refer for; this helps to ensure our patients keep trust and confidence in OCHD as a supporter of their overall health. Going forward, we will check in regularly with these providers to make sure they continue to be available to provide the service. • It is vital to have regular update meetings with clinical staff to check in to see how the practice is going, answer questions, and provide feedback on the success of the program will help to increase confidence, decrease confusion, and gain nurse support during the next study phase of the project. Cost/Benefit Analysis • In terms of a cost/benefit analysis, we were able to estimate the cost of the project, with the price of the HbA1c test at \$6, and the number of positive TB tests in previous years. However, it is difficult to quantify the benefit in a monetary sense. If our goal of increasing completion rates for LTBI treatment is met, costs will increase in the short term – the costs of medications and nursing time will increase. However, reaching this goal will contribute toward the larger goal of eliminating TB in the US, thereby decreasing the much more extensive costs associated with treating active TB and providing follow up for contacts. • An additional benefit that was identified during our initial study is that a high percentage of our LTBI population was unaware of their pre-diabetic status and were identified at a time in disease progression when lifestyle changes can be made with great success for diabetes prevention. Is there Sufficient Stakeholder Commitment to Sustain the Practice? Sustainability Plans? • The simplicity and ease of incorporating this new practice into the evaluation of our LTBI patients has been realized by all stakeholders involved, which supports the sustainability of the practice. Additionally, seeing the results of the HbA1c testing highlights the importance of screening this population for diabetes, which also contributes to the sustainability. We have learned that continuous process evaluation and feedback involving the nursing staff will maintain their support of the practice and increase the likelihood of the practice's continuation. The low cost of the practice makes continuing to fund it feasible. The benefits and potential impact of this practice have been seen at the staff, administrative, and state levels, and our hope is to have other health departments join us in implementing HbA1c testing routinely for LTBI patients, and make this the standard of care in Michigan. • Sustainability plans include: o Maintaining our Standing Orders to make HbA1c testing standard for all LTBI patients. o Continuing training of nursing staff on both clinical and follow up procedures, and the importance of the practice in terms of the relationship between TB and DM. o Data collection and analysis performed by our TB epidemiologist, with regular feedback to stakeholders on results of testing, patient acceptance of LTBI treatment, and treatment completion rates. o Monitoring of budget to make sure there is money available to perform the testing. o Regular contact with community FQHC's to raise awareness of the practice, maintain a collaborative relationship, and ensure our patients have reliable and affordable care available to manage hyperglycemia.

Additional Information

How did you hear about the Model Practices Program?: *

- | | | | | |
|---|---|--|--|---|
| ☒ I am a previous Model Practices applicant | ☐ At a Conference | ☒ NACCHO Website | ☐ Public Health Dispatch | ☒ Colleague in my LHD |
| ☐ Model Practices brochure | ☐ NACCHO Exhibit Booth | ☐ NACCHO Connect | ☐ Colleague from another public health agency | ☒ E-Mail from NACCHO |
| ☐ NACCHO Exchange | | | | |