NACCHO
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2017 Model Practices

Applicant Information

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Model Practice Title

Please provide the name or title of your practice: *

ASTHO Million Hearts Initiative

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.: *

- [x] 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
- [x] Health Equity
- [ ] HIV/STI
- [ ] Immunization
- [ ] Infectious Disease
- [ ] Informatics
- [ ] Information Technology
- [ ] Injury and Violence Prevention
- [ ] Marketing and Promotion
- [ ] Maternal-Child and Adolescent Health
- [x] Organizational Practices
- [ ] Other Infrastructure and Systems
- [x] Organizational Practices
- [ ] Primary Care
- [x] 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. :

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

Please use this portion to respond to the questions in the overview section. : *

The Las Animas- Huerfano Counties District Health Department (LAHCDHD) was established in September 1941. Our mission is to promote preventative healthcare, education, and to provide healthcare services that will enhance the quality of life for citizens of Las Animas and Huerfano Counties. A five member is elected to serve on the Board of Health (two representatives from Huerfano County and three representatives from Las Animas County). The health department has two offices within the bi-county region, one in Trinidad and Walsenburg. According to the US Census Bureau the 2016 population for Las Animas County is 14,058, per 2016 Colorado Children's Campaign, Kids Count Data, the population living in poverty under the age of 18 is 19.4% and in Huerfano County the population is 6,492 and 16.2% of the population under 18 live below poverty. The LAHCDHD is an advocate, partner, coordinator of support systems for citizens across two rural/frontier geographical counties, approximately 6,364 square miles. Per the 2016 Robert Woods Foundation County Health Rankings, Las Animas County Health outcome is rated 53 and Huerfano County is rated 60 out of 60. The public health issue that we are currently working on in the bi-county is Hypertension. According to Centers for Disease Control and Prevention High Blood Pressure Facts Las Animas County has 81.8% Hypertension Death Rate per 100,000, All Ages, All Race, All Gender, 2012-2014 and in Huerfano County 71.7%. The percent of adults in Las Animas and Huerfano Counties with high blood pressure and selected risk factors for high blood pressure, 2003-2013 are in the highest quartile (28.0-31.7%). In August of 2015, Colorado Department of Public Health and Environment (CDPHE) asked LAHCDHD, Mt San Rafael Hospital (MSRH), Mt Carmel Health and Wellness Center, Spanish Peaks Regional Medical Center/Outreach Clinic if they would like to be part of a pilot project through Association of State and Territorial Health Officials (ASTHO) for hypertension in Las Animas and Huerfano Counties. This project will serve the health care needs of the local population, increase efficiency among the agencies, and create measurable improvements in population health. The two counties are known for high hypertensive rates but are also know for strong collaboration among each other. The goals and objectives of the ASTHO Million Hearts Initiative project are community clinical linkages and bi-directional referral between community resources and health systems that include lifestyle change programs. Develop and test a collaborative model of bi-directional data exchange between community screenings and service sites with clinical practices, ensuring accuracy, timeliness, and HIPAA compliance that may be replicated by other clinic systems and LPHA partnerships. Health system interventions to improve the quality of care delivery will include implementing systems to facilitate identification of patients with undiagnosed hypertension. This will happen by improving community health through evidence-based interventions to increase access to hypertension diagnosis, treatment, management and improving identification of patients who are undiagnosed or at risk for developing hypertension. Increase electronic health records adoption and the use of health information technology to improve performance, manage patient panels, and identify higher risk patients by increasing collaboration and linkages to develop strong referral relationships between the clinic and LPHA, as well as other community health systems through the health information exchange and electronic health records. Prioritize resources in the counties by creating a resource referral list using local data. Multi-Sector Partnerships is key, they will include State Health Agency Lead: Health Systems Quality Improvement Specialist, Kelly Means, and Health Systems Specialist, Local health department/Community Partner: LAHCDHD, Clinical Provider: MSRH, Clinical Provider: Spanish Peak Regional Medical, Health IT expertise: CDPHE Health Informatics Program, CORHIO, Health Equity/Diversity Expert: Rich Marquez, CDPHE. Learning Collaborative Participants will include Senior Deputy: Larry Wolk, Public or Private Health Plans: Medicaid, Colorado Access and Regional Partners: Colorado Rural Health Center. Goals and objectives have been met and have exceeded expectations. Going into year two we have included new partners that include Behavior Health, Mountain Creek Home Health, and Otero Crowley Public Health. The health department has also been granted access into MSRH Electronic Health Records in addition to Mt Carmel Health and Wellness Center's EHR System. This access will allow public health nurses to input real time data into a patient's medical record during in between blood pressure checks or business screenings. Specific factors that lead to the success of this practice are Plan Do Study Act (PDSA) cycles to ensure we can meet goals and expectations and a very strong collaboration between all of our partners. Web address: www.la-h-helath.org.

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 Community Preventive Services, MMWR Recommendations and Reports, National Guideline Clearinghouses, and the USPSTF Recommendations.)

2000 Word Maximum

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

Responsiveness and Innovation The target population includes patients with uncontrolled hypertension, undiagnosed hypertension, and patients at risk for developing hypertension in both Las Animas and Huerfano counties. Both counties are identified as frontier, a subset of rural, meaning they have a population density of six or fewer people per square mile. These counties are also designated as Health Professional Shortage Areas and experience high rates of physician turnover, creating a lack of adequate and consistent primary care. According to the County Health Rankings report, Las Animas county ranked 56 out of 60 for Health Outcomes and Huerfano county ranked 60 out of 60 for Health Outcomes. Las Animas county has a diagnosed hypertensive population of 38% or 5,340 residents and Huerfano county has a diagnosed hypertensive population of 39% or 2,520 residents, compared to the statewide rate of diagnosed hypertension of 26% (BRFSS 2011, 2013). Additional risk factors contribute to the high need for hypertension control in these counties, including a high rate of obesity and diabetes in adults. Below in Table A are rates for additional risk factors for the populations of these counties: Table A Additional Risk Factors for Hypertension Huerfano County Las Animas County Statewide Adults over age 20 BMI>30 (obese) (BRFSS 2011) 31.10% 28.80% 20.30% Heart Disease Mortality (age adjusted rate per 100,000 population, NVSS 2007-2011) 204.06 170.56 151.4 Uninsured (ACS 2009-2013) 19.70% 18.16% 21.20% In order to assess the need for public health intervention concerning high blood pressure, CDPHE's Health Informatics Program utilized the 2011 and 2013 Colorado Behavioral Risk Factor Surveillance System (CO BRFSS) to conduct an analysis of the risk factors for high blood pressure and create a tier ranking by level of risk. The tier ranking was determined by summing each of six dichotomous risk factors in series, with high blood pressure measures to create a measure of each counties level of blood pressure risk and severity of hypertension. Counties were ranked first by percentile, then by composite risk factor, then by rate of high blood pressure as established by CO BRFSS. Both Las Animas and Huerfano counties were ranked in Tier 6, reflecting the highest need for public health intervention concerning high blood pressure. There has been no set practice to address Hypertension in the two counties. Each clinical site has had their way of diagnosing and treating Hypertension. Public health for example allows walk in visits for blood pressure checks and if they do have a high reading we ask that they come back an additional two visits before referring to their physician. If they have an extremely high pressure that is life threatening we do walk them over to the emergency room. This project will work in a collaborative approach, linking the public health departments with the healthcare sector in these counties to reduce these elevated risk levels. Expected outcomes of this project include: • Development of a referral system for alert blood pressure values from LAHCDHD program participants to primary care clinics (MSRH, SPRHC) • Development of a referral system for patients from MSRH and SPRHC to LAHCDHD for walk-in blood pressure checks, self-management education programs, and social services referrals • Completion of a feasibility study into the acquisition of an electronic health record for LAHCDHD • Creation of a map and resource list for the bi-county region for LAHCDHD, MSRH, SPRHC and other primary care clinics in the community to utilize when referring patients to social services. The ASTHO Million Hearts Project is innovative and unique to Colorado. This project has allowed partners such as Mt. San Rafael Hospital, Mt. Carmel Health and Wellness Center, Spanish Peaks Outreach Clinic, Mountain Creek Home Health and now Otero Crowley Public Health Department to all partners together on a well needed problem in Region 6. The primary focus was high blood pressure and community-clinical linkages relating to the condition. As a public health department serving the unique needs of two rural/frontier counties, we already viewed the creation and maintenance of these types of linkages as our duty in enhancing public health. Our mission statement starts with "In partnership with the community." This was a perfect fit. Since accepting the opportunity to work on a learning collaborative under the guidance of CDPHE, we have implemented a standardized blood pressure measurement guideline, a protocol for identification of hypertension and referral to primary care and a bi-directional referral process. This has all been in partnership with primary care clinics and other community agencies. Community members are identified with high blood pressure, and we are now asking their permission to send a referral to be seen at their primary care provider's office. Primary care clinics then make a phone call to schedule an appointment. Getting high blood pressure treated will go a long way towards achieving the Million Hearts goal of reducing heart attacks and strokes by 1 Million. The ASTHO Project has implemented a local health information exchange system not currently available for local clinical and community resources. Currently, there is not a similar method available for partnering agencies to electronically refer clients to one another and maintain constant communication regarding community members' health status. There is not currently a standardized and sustainable best-practice guideline being used for the self-monitoring of blood pressures outside of the clinical setting. This project has evidence-based guideline for this self-monitoring. The access to the clinics EHR Systems has enabled the collaborative partners to effectively work together to support and strengthen one another's programs through referrals to and from clinical and community programs. Providers will not duplicate services already available. Rather they will utilize existing programs more effectively through improved care coordination. In addition, the access of the EHR has enabled partnering agencies to identify clients who are defined as "high/super utilizers" who use the emergency room for primary care rather than a less expensive medical care facility. Identifying these "high/super utilizers" will enable the collaborative to coordinate their care in such a way that emergency room admissions will be reduced in both counties. By doing so we will be able to provide a more appropriate level care for patients, and make the rural health care agencies in our region more financially sustainable. Each collaborative partner has a role in this project. The Las Animas Huerfano Counties District Health Departments role in scheduling Worksite Wellness visit's in the Bi-County that allow us to go into the business and provide free blood pressure screenings to employees. During this time we offer employees resources and referrals if need to their primary care physician. The clinics are using public health as there in-between blood pressure screenings since we do not require appointments or payment. Mt San Rafael Hospital is a primary home for most patients. They have sent out calls to all of their patients that have had a high blood pressure to go to the health department for their free blood pressure screening with no appointment needed. MSRH has allowed the health department access into their EHR system to allow a public health nurse access to the patients file to input real time screening data into the patients chart. At that time the Public Health nurse can message the doctor or nurse that the patient came in and has a new reading. The EHR system can also allow us to send bi-directional referrals to each site if need for example Tobacco Cessations classes or Diabetes Self Management classes. Mt. Carmel Health and Wellness Center is another primary care home for patients. Mt. Carmel

has allowed the health department access into their EHR system as well to allow a public health nurse access to the patients file to input real time screening data into the patients chart. At that time the Public Health nurse can message the doctor or nurse that the patient came in and has a new reading. The EHR system can also allow us to send bi-directional referrals to each site if need for example Tai Chi classes. Spanish Peaks Regional Outreach clinic is another collaborative partner this is going to worksites to do health screenings and bi directional referrals. They also rent out blood pressure cuffs to patients that are hypertensive. At that time patients are educated on how to use the blood pressure cuffs how to log the vitals and offered resources and referral for lifestyle changes. Each agency can make same-day referrals for primary care, exercise classes at Mt. Carmel Health and Wellness Center, tobacco cessation classes at the health department. Diabetes workshops at Mt. San Rafael Hospital Clinic, or Chronic Disease Self-Management workshops at Spanish Peaks Outreach Clinic. As referrals are received and phone calls are made, each agency provides feedback regarding the referral status. Our communication has improved tenfold with the effort we've put into the Million Hearts Initiative. Our biggest success has been a newfound strength in collaboration. We never knew how much we had available until we worked together for a few months developing the referral system. We cannot go back to the way things were before joining the Million Hearts Initiative. The referral forms we've created are in use at various agencies across both counties, and awareness is increasing regarding available resources. Our counties are growing and changing. The Million Hearts Initiative and ASTHO learning collaborative have positioned us and our Million Hearts Partners to walk forward together into a new and hopeful future for the bicounty region; a future in which medical establishments are aware of what is available to their patients for them to lead healthy, productive, happy lives. One day it will be as simple as the click of a button. And all this was made possible through ASTHO's Learning collaborative and our participation in the Million Hearts Initiative.

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

Enter the LHD and Community Collaboration related to your practice (5000 words maximum): *

Agency goals LAHCDHD is the local public health department for the City and Counties of Las Animas and Huerfano. Its focus is to improve the health of the residents of Las Animas and Huerfano Counties. As such, LAHCDHD provides public health services which includes recommendations for addressing disease control, provision of direct disease control services (e.g., tuberculosis, HIV, STD clinics, and immunizations), administration of vital records/vital statistics (such as births and deaths), Environmental Health (retail food inspections, child care inspections, onsite waste water treatment, etc), tobacco control, STD/HIV training programs, and health promotion/wellness programs. Our health promotion and wellness programs at LAHCDHD are community-based and encompass a number of important areas of health concerns. These include tobacco control, preconception health, immunization outreach activities, STD/HIV/TB prevention activities, and worksite wellness. All of our programs focus on underserved and low-income communities. Goals and Objectives Achieved The goals and objectives of the ASTHO Million Hearts project are community clinical linkages and bi-directional referral between community resources and health systems that include lifestyle change programs. Develop and test a collaborative model of bi-directional data exchange between community screening and service sites with clinical practices, ensuring accuracy, timeliness, and HIPAA compliance that may be replicated by other clinic systems and LPHA partnerships. Health system interventions to improve the quality of care delivery will include implementing systems to facilitate identification of patients with undiagnosed hypertension. This will happen by improving community health through evidence-based interventions to increase access to hypertension diagnosis, treatment, and management and improving identification of patients who are undiagnosed or at risk for developing hypertension. Increase electronic health records adoption and the use of health information technology to improve performance, manage patient panels, and identify higher risk patients by increasing collaboration and linkages to develop strong referral relationships between the clinic and LPHA, as well as other community health systems through the health information exchange and electronic health records. Prioritize resources in the county by creating a resource referral list using local data. Multi-Sector Partnerships are key, they will include State Health Agency Lead: Health Systems Quality Improvement Specialist, Kelly Means, and Health Systems Specialist, Brooke Bodart, Local health department/ Community Partner: Huerfano-Las Animas County Department of Public Health and Environment, Clinical Provider: Mount San Rafael Hospital Specialty Clinic ,Clinical Provider: Spanish Peak Regional Medical, Health IT expertise: CDPHE Health Informatics Program, CORHIO, Health Equity/Diversity Expert: Rich Marquez, CDPHE. Learning Collaborative Participants will

include Senior Deputy: Larry Wolk, Public or Private Health Plans: Medicaid, Colorado Access and Regional Partners: Colorado Rural Health Center. To achieve the goal for this project to improve health equity and reduce the burden of chronic disease in Las Animas and Huerfano Counties by increasing the capacity of the bi-directional communication system to create Community – Clinic Linkages between electronic health record systems (EHR). The first activity was to formalize partnerships between Las Animas-Huerfano Counties District Health Department (LAHCDHD), Mt. San Rafael Hospital (MSRH), Spanish Peaks Regional Health Center (SPRHC), and Mt. Carmel Health, Wellness, and Community Center (Mt. Carmel) through a Memorandum of Understanding. Second, a Business Agreement was finalized with MSRH and Mt. Carmel Health and Wellness to allow LAHCDHD access into their Electronic Health Record systems. The expected outcome is the enabling a seamless referral system between clinic and community resources. Public health nurses go to local business and organizations to do health screenings, referrals and education. From the health screenings if they see a patient that has a blood pressure of 140/90 they are asked to come into the health department for two more readings. If that patient is still high we then make a referral to their primary care physician through MSRH or Mt. Carmel's EHR. Public health nurses are also the in between doctor visit blood pressure checks. Patients can come in with no appointment for a free blood pressure check. Using the EHR systems, work on chronic disease prevention, diagnosis, and management in the region will reach a new level of efficiency and effectiveness. Patients visiting any of the primary care clinics can be easily referred through the EHR systems to evidence-based community programs already in place improving the level of care and quality of services currently available. The system will also work in reverse order allowing a community program to refer a client to a primary care provider. Data from this bi-directional system will be reviewed monthly amongst the collaborative team and patients will receive follow up consultation as necessary. This will result in patients receiving more appropriate and timely services related to their health care needs ultimately improving their health outcomes. Due to the large portion of local residents at-risk of developing chronic disease due to demographics, income, or education level, hypertension patients have become the program's focus. Hypertension patients will receive counseling and education plus home blood pressure monitors and community placed blood pressure monitors for self-monitoring purposes. The blood pressure monitoring kits will instruct them to report their blood pressure to their designated source for entry into care coordination platform. Focusing efforts on chronic diseases and using the EHR systems to track patients diagnosed with or at-risk of these diseases, will improve the health outcomes of these patients and thus a large percentage of the local population. This will improve health equity and reduce the local burden of chronic disease. Representatives from each organization will meet in person at least monthly to discuss and monitor referrals between clinical and community partners. Communication during these meetings can address any barriers to a successful project and identify gaps in services that could be eliminated. Las Animas-Huerfano Counties District Health Department (LAHCDHD) will be the lead agency for this project. They will be responsible for: • communicating with and collaborating efforts between the partners • referring and processing patients through the EHR's or Fax. • gathering, tracking, and reporting on evaluation measures • completing grant contract requirements • providing chronic disease services to patients including low cost blood glucose and A1C screenings, free blood pressure checks, and self-management education • establish interagency agreements for successful business partners Mt. San Rafael Hospital will be responsible for: • actively participating in assisting public health with their EHR and communicating with and participating in collaboration efforts with partners • referring patients and processing incoming referrals through fax or EHR • submitting evaluation information to the lead applicant agency and CDPHE Mt. Carmel Health, Wellness, and Community Center will be responsible for: • actively participating in assisting public health with their EHR and communicating with and participating in collaboration efforts with partners • referring patients and processing incoming referrals through fax or EHR • conducting, monitoring, and reporting data for the Stanford Chronic Disease Self-Management program and other wellness programs • submitting evaluation information to the lead applicant agency and CDPHE Spanish Peaks Regional Health Center will be responsible for: • actively participating in assisting public health with their EHR and communicating with and participating in collaboration efforts with partners • referring patients and processing incoming referrals through fax or EHR • completing certification for the Diabetes Prevention program • conducting, monitoring, and reporting data for the Stanford Chronic Disease Self-Management program and other wellness programs • conducting, monitoring, and reporting data for wellness programs • submitting evaluation information to the lead applicant agency and CDPHE During our monthly meetings success stories are shared that make this project so successful. This project has built and strengthened relationships in the bi-county area that we never expected to happen. It is amazing to see how well we share resources, ideas and work together to make this project be successful. CDPHE does play a large part in creating this project and helping us pilot this project for ASTHO as the Colorado team. There are currently 11 other states that are working on a project with ASTHO and Las Animas and Huerfano Counties were selected to pilot this project give our collaboration with each other on past projects as well as high hypertension rates. CDPHE received a grant from ASTHO in the amount of $125,000 for all of the partners to work toward this project and pay for a Care Coordination Platform. As we go into year two funding has decreased to around $50,000, but we will continue to look for grant to help support the sustainability of this project. The access to MSRH and Mt. Carmel's EHR Systems is no cost to public health which is a huge savings. All collaborative partners have been doing the work that is being done even before the project was formed. It was putting us all together to see how we can make it stronger and more effective for our communities. In year two we are adding new partners to our collaborative team that include Behavior Health, Mountain Creek Home Health and Otero Crowley Health Department.

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

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

CDPHE will engage members of the learning collaborative in all phases of the evaluation. They will be an integral part of the entire evaluation process from the initial design phase to interpreting data, disseminating findings, and ensuring use. The project team will partner with CDPHE's Public Health Informatics Program (PHIP) to collect data on performance measures and to plan and implement the evaluation of the proposed strategies. The evaluation will assess the degree to which the project accomplished its goal of implementing system-level changes that improve the use and sharing of data to better identify individuals with undiagnosed hypertension and improve management of diagnosed hypertensive individuals. To gain insight into the challenges facing this work and the outcomes from the project, data collection and analysis at population health and individual patient levels will be measured as described below. At this time, each collaborative partner keeps track of their own data. Every two months, all partners send a data report to the Colorado Department of Public Health and Environment (CDPHE). Results are analyzed by looking at: 1. The number of newly diagnosed Hypertension patients identified 2. Number of diagnosed but uncontrolled Hypertension patients 3. Outcome of the above identified patients Performance measures used include: 1. Developing a referral process with each collaborating partner. 2. Ensuring that referrals are received and addressed through adequate communication with collaborating partners. 3. All collaborating partners participated in the Standardization of Blood Pressure check training through the Million Hearts Initiative. Changes or modifications are made per result of data findings.

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): *

Sustainability: This ASTHO project will serve as the model for improving community-clinical linkages and health system interventions funded by various other partners. Through the promotion of community-clinical linkages, CDPHE will be able to model the bi-directional referral system for other counties across the state to engage local public health and community clinics. The successes and lessons learned will serve as a guidance tool on how to strengthen community relationships to best serve its population. Whether the entities share an EHR or utilize the health information exchange, building the systems and capacity to identify, treat, and manage hypertensive populations will be disseminated. Sustainability is established through the community –clinical linkages and partnerships that are developed locally. Partnerships and sharing of information needed to adequately treat our hypertensive population has been a successful collaboration with local partners.

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