NACCHO
National Association of County & City Health Officials

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2020 Model Practices

Applicant Information

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Size

Select a size: *

- ☐ Small (0-50,000)
- ☐ Medium (50,000-499,999)
- ☑ Large (500,000+)

Application Information

Local Health Department/Organization Name: *

Florida Department of Health in Broward County

Title of Practice: *

PROACT Program Collaborates to Improve HIV Retention in Care

Submitter Name: *

Yvette A. Gonzalez, MPH, CCHW

Submitter Title: *

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Practice Categories

Model and Promising Practices are stored in an online searchable database. Applications may align with more than one practice category. Please select the most relevant category that applies most to your practice: : *

- [ ] 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
- [x] HIV/STI
- [ ] Immunization
- [ ] Infectious Disease
- [ ] Information Technology
- [ ] Injury and Violence Prevention
- [ ] Marketing and Promotion
- [ ] Maternal-Child and Adolescent Health
- [ ] Organizational Practices
- [ ] Other
- [ ] Primary Care
- [ ] Quality Improvement
- [ ] Research and Evaluation
- [ ] Tobacco
- [ ] Vector Control
- [ ] Water Quality
- [ ] Workforce

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- [ ] Access to Care
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- [ ] Research and Evaluation
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- [ ] Vector Control
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- [ ] Workforce

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.

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

Brief description of LHD

Broward County is the second most populous county in Florida, 17th most populous in the United States with almost 1.9 million people and 10% of Florida's residents. Broward County is home to an international airport that is ranked 19th in the U.S. in total passenger traffic and a sea port which is the cruise ship capital of the world. 15.4 million tourists visit our beautiful beaches each year. However, there is more to Broward County. We are a majority/minority community with a population of 37% White, 30% Black, and 30% Hispanic of any race (U.S. Census) with one-third residents being foreign born. Nearly 15% of the residents are living below the poverty level and 20 % of children under age 18 are living in poverty. South Florida continues to be the most cost-burdened metro region in the nation with over half of Broward residents spending more than 30% of their monthly income on housing expenses. The county-seat, Fort Lauderdale, ranks 10th nationwide as one of the most cost-burden communities. Broward County Public Schools (BCPS) is the sixth largest public-school system in the United States. Students are from 204 different countries and speak 191 different languages.

Broward County is widely known as “collaboration county” due to the multitude of coalitions and task forces that work together in a non-competitive way to improve the health and quality of life of residents. In 2018, the Florida Department of Health in Broward County (DOH-Broward) Community Health Assessment (CHA), priorities identified for the Community Health Improvement Plan (CHIP) include: 1) Increase Access to Health Services, 2) Reduce the Incidence of Communicable and Infectious Diseases, 3) Improve Maternal, Infant and Child Health, and 4) Enhance Preventive Care Activities. Understanding the role of Social Determinants of Health from the HHS Healthy People 2020 initiative and the role of institutional racism in creating and perpetuating health disparities has allowed DOH-Broward to develop a more comprehensive approach to building a culture of health. DOH-Broward implements, evaluates and refines our actions to address the social determinants of health through a more inclusive health equity approach with the goal to ultimately eliminate health disparities in Broward County.

Public Health Issue

In 2018, Broward County had 21,048 people living with HIV (PLHIV) of which 661 were newly diagnosed with HIV and 261 diagnosed with AIDS. In 2017, Broward County had the second highest number of new HIV cases out of Florida’s 67 counties. Furthermore, Broward County currently has the second highest rate of HIV infection in the U.S. The five top priority populations for primary HIV prevention is Black Heterosexuals, Hispanic/Latino men that have sex with men (MSM), Black MSM, White MSM, and Hispanic/Latino Heterosexuals. The public health issue is high rates of HIV infection in Broward County and ensuring HIV/AIDS clients receive continued care and treatment.

Goals and Objectives

The goal and objective of this practice is to ensure HIV positive clients remain in care and on antiretroviral medication to increase HIV medication adherence, reduce the number of clients that fall out of care and ultimately reduce HIV transmission. Increasing the number of clients in care will decrease community viral load and the number of new HIV cases in Broward County.

How practice was implemented

Dedicated HIV Disease Intervention (DIS) staff who are trained in HIV linkage and retention, identified pharmacy HIV clients whose medications had not been picked up in a timely manner and located clients lost to care and re-linked them back to care and treatment.

Specific Factors Leading to Success

The specific factors that led to the success of this practice were the re-tasking of DOH-Broward HIV DIS workers to focus on medication adherence and re-linking clients lost to care.

Public Health Impact

The Public Health impact of this practice was a reduction of the number of HIV clients lost to care and an 11% decrease in the number of new infections in Broward County.

Website www.broward.floridahealth.gov

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.

Please state the Responsiveness and Innovation of your practice : *

Responsiveness and Innovation

"PROACT" (Participate, Retain, Observe, Adhere, Communicate and Teamwork) is a DOH-Broward public health initiative and treatment adherence program designed to support the community-based provision of HIV primary care services in Broward County through the delivery of navigating a client, linkage to care, retention in care, and promoting adherence to ART for all Broward County residents living with HIV/AIDS. PROACT ensures that clients referred to DOH-Broward receive timely services to assist them in finding HIV-related medical care, staying in medical care, and taking medications prescribed by their medical provider. PROACT utilizes a client Referral Form that is completed by area HIV providers and faxed to a secure fax in the PROACT program. The Program Director distributes the forms to the HIV DIS for client follow-up. Outcomes of the follow-up are then provided to the referring agencies within 30 days or sooner.

Statement of the problem/public health issue.

In 2018, Broward County had 21,048 people living with HIV (PLHIV) of which 661 were newly diagnosed with HIV and 261 diagnosed with AIDS. In 2017, Broward County had the second highest number of new HIV cases out of Florida's 67 counties. Furthermore, Broward County currently has the second highest rate of HIV infection in the U.S. The five top priority populations for primary HIV prevention is Black Heterosexuals, Hispanic/Latino men that have sex with men (MSM), Black MSM, White MSM, and Hispanic/Latino Heterosexuals. The public health issue is high rates of HIV infection in Broward County and ensuring HIV/AIDS clients receive continued care and treatment.

What target population is affected by problem? (please include relevant demographics)

The target population is the 21,048 people living with HIV and AIDS in Broward County. There has been 9,517 referrals to the PROACT Program which consists of HIV DIS, Perinatal HIV DIS, Pharmacy HIV DIS and Dental HIV DIS to locate clients lost to care.

What percentage did you reach?

96% of HIV clients served by our DOH-Broward HIV DIS were found and 27% were already in care. Of the 9,517 referrals made from January 2015 to October 31, 2019, 4,566 referred to the HIV DIS, 1,216 referred to Linkage to care, 2,711 referred to the Pharmacy HIV DIS and 1,024 referred to the Perinatal HIV DIS.

Of the 4,566 referrals to the DOH-Broward PROACT Program HIV DIS, the outcomes are: 1,232 In Care (27%), 1,386 Linked to Care (75%), 557 Unable to locate (17%), 360 Out of Jurisdiction (11%), 328 inactive clients (10%), 50 deceased (1%), 64 Refused (2%) and 42 Incarcerated (1%).

Of the 1,216 referrals to Linkage to care, 841 of 1,216 (69%) were linked to care.

Of the 2,711 referrals to Pharmacy HIV DIS, 120 Unable to Locate (4%), 320 Out of Jurisdiction (12%), 654 Inactive clients (24%), 27 Deceased (1%), 196 Linked to Care (13%), 15 Refused our services (0.5%) and 48 Incarcerated (2%).

What has been done in the past to address the problem?

Prior to implementing this proactive integrated program, DOH-Broward's HIV clients received automated integrated voice responses (IVR) calls from the pharmacy to alert the client their prescriptions were ready for pickup. In a separate related process, the HIV eligibility program staff monitored clients' enrollment status. PROACT program staff were contacted by pharmacy and HIV eligibility staff as needed to evaluate, intervene and assist clients. Prior to the implementation of dedicated HIV DIS staff, DOH-Broward did not have a lost to care program where outside agencies could refer clients.

Why is current/proposed practice better?

The DOH-Broward practice is better because it coordinates and facilitates pharmacy and HIV Disease Intervention Specialist (DIS) staff, Dental HIV DIS and Perinatal HIV DIS to collaborate, identify and locate potentially non-adherent HIV clients to improve retention in care and potentially reduce new HIV rates. DOH-Broward PROACT Program has evolved from "prescription focused" to a "client focused" and is able to accurately monitor HIV clients' pharmacy participation on a monthly basis by calculating and evaluating the percentage of clients not returning to pharmacy due to a voided/cancelled/non-received prescription. Prior to this new approach, the number of AIDS Drug Assistance Program (ADAP) prescriptions filled each month was monitored and evaluated to determine the percentage that were picked up.

Is current practice innovative? How so/explain?

The practice is innovative. To our knowledge, DOH-Broward is the only health department that utilizes this unique client focused practice model to improve HIV retention in care and medication adherence. The process of jointly utilizing pharmacy and HIV DIS staff to take a proactive approach to contact and/or locate potentially non-adherent HIV clients and lost to care clients is innovative and new to the field of public health by ensuring no opportunity is missed to identify a non-adherent, or potentially "lost to care" HIV client.

What tool or practice did you use in an original way to create your practice?

DOH-Broward utilized the Program Collaboration System Integration Model (PCSI). For this practice to be successful, internal stakeholders must be willing to collaborate daily. To measure the impact of the initiative, pharmacy prescription data is imported to an Excel spreadsheet to identify and calculate the total number of ADAP clients served, the total number of ADAP clients with a voided or non-received prescription, and the total number of clients with a voided or non-received prescription that picked up a prescription the

following month. This information is utilized to determine the percentage of pharmacy clients that are retained in care each month. The HIV DIS use a DOH program called HIV Prevention Care Coordination (HPCC) that monitors the number of referrals and outcomes monthly.

Is current practice evidence-based?

The practice is evidence-based in that it follows the CDC, AIDS.gov, the National ***HIV***/AIDS ***Strategy*** (NHAS) and utilizes actual DOH-Broward pharmacy and lost to care data.

Does practice address any CDC Winnable Battles? Select all that apply

- HIV in the US

LHD and Community Collaboration

The LHD should have a role in the practice's development and/or implementation. Additionally, the practice should demonstrate broadbased 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.

Enter the LHD and Community Collaboration related to your practice : *

LHD and Community Collaboration

Goal(s) and objectives of practice

The goal and objective of this practice is to increase adherence to HIV medication therapy and reduce the number of clients that fall out of care to improve health outcomes, reduce new HIV infections and reduce community viral load.

What did you do to achieve the goals and objectives?

According to the CDC, "Improving the health of persons with HIV and reducing the number of new infections in the United States will depend on increasing access to HIV medical care and eliminating disparities in the quality of care received." Steps taken to implement the program included a series of multidisciplinary staff meetings within DOH-Broward to create and deploy action plans. DOH-Broward endeavored to find a simple, easily deployable, and cost effective method to identify LHD clients who have not picked up their HIV medication, locate lost to care clients that are referred to the DOH-Broward PROACT Program, and either re-engage clients into care as appropriate and/or consult with the client's healthcare provider to provide timely feedback so as to provide optimal care and treatment. HIV related provider agencies, Federally Qualified Health Centers notify DOH-Broward of client's lost to care through a PROACT Referral form. A supervisor reviews the information and assigns a dedicated HIV DIS to locate and find the client.

DOH-Broward's pharmacy staff works with the HIV DIS to assure that HIV clients who are enrolled in ADAP and Ryan White Pharmacy Assistance program are receiving their HIV medications as prescribed. HIV medications are provided by DOH-Broward Pharmacy Department pursuant to prescriptions authorized from client's physicians/providers. Daily, pharmacy staff generate a "return to stock" report, which identifies all prescriptions that have not been picked up for 11 days (5 days early, plus a 6-day grace period) after the prescription's "date filled". Clients begin receiving automated prescription reminder refill calls before their prescription is due to ensure every opportunity is offered to pick up medications. This list is distributed to the PROACT Director for distribution to the Pharmacy DIS.

DOH-Broward Pharmacy HIV Disease Intervention Specialists (DIS) review the Excel file to identify which clients have not been successfully contacted by the pharmacy staff of the two centrally located DOH-Broward Pharmacies. DOH-Broward Pharmacy, Dental, Perinatal HIV DIS staff then utilize a variety of methods to locate HIV clients such as database searches to obtain the most current contact information. Some client search databases include:

- Lexus Nexus,
- Driver and Vehicle Information database (DAVE),

- STARS Surveillance Tools and Reporting System STD database,
- Provide Enterprise the Broward County Ryan White HIV clinical database
- Careware (HRSA database for HIV Clients),
- HMS, Florida DOH Health Management System,
- FMMIS, Florida Medicaid Management Information System,
- FLSHOTS, Florida Immunization database,
- WAGES, Wage database from Bureau of Labor eHARS,
- Enhanced HIV AIDS Reporting System, ADAP, AIDS Drug Assistance Program,
- FDLE type of database,
- Social Media and home visits as necessary.

The HIV DIS staff ascertain/determine the reasons for which clients' have not picked up their HIV medications and clients that are lost to care. Every attempt to re-engage clients into care is made including calling case managers, clinicians, and/or other individuals connected with the client's care. The HIV DIS provide client contact outcome results to the PROACT/Perinatal Director such as, returned to care, unable to locate, out of jurisdiction, incarcerated, refused services, in care, and has medical insurance. The PROACT Director then ensures that the referring agency is provided with the outcomes of the referrals.

To evaluate the outcomes of the DOH-Broward HIV DIS initiative, data is exported to an Excel report to determine the number and percentage of unique HIV clients that had a prescription returned to stock (voided and/or not picked up) in a given month and whether that same client had a prescription filled during the following month. This indicates whether the client was lost to pharmacy care.

On a monthly basis, the Director of PROACT reports to the DOH-Broward Health Officer the total number of clients referred to PROACT, the total number of clients successfully contacted by HIV DIS, and the percentage of clients who did not pick-up their prescriptions that returned to the pharmacy (retained in care). Metrics were created in the department's performance management system, Active Strategy, to monitor this information monthly, to track trends and historical information. This information is shared and discussed at monthly business review meetings.

Any criteria for who was selected to receive the practice (if applicable)?

The criteria for those selected to receive the practice was any DOH-Broward client that was referred to PROACT from DOH Pharmacy and/or HIV Agencies that are lost to care over six months or non-adherent to medication.

What was the timeframe for the practice?

The timeframe for the practice implementation was January 2015 and is now a routine part of the DOH-Broward client care process.

Were other stakeholders involved? What was their role in the planning and implementation process?

Other stakeholders involved with this program were the DOH-Broward HIV/AIDS program's ADAP staff, community HIV/AIDS providers and the HIV DIS staff. Their role in planning and implementation was nominal.

What does the LHD do to foster collaboration with community stakeholders? Describe the relationship(s) and how it furthers the practice goal(s).

DOH-Broward has developed strong partnerships with our stakeholders that are involved in the system of care in Broward County. These include but are not limited to the grantees for Ryan White (RW) Part A, RW Part B, RW Part C, RW Part D, Community Based Organizations, Case Management agencies, Food Banks, Substance Abuse Facilities and Federally Qualified Health Centers. DOH-Broward Pharmacy and HIV DIS work closely with staff from these agencies to assure retention in care as well as appropriate care and treatment of HIV/AIDS clients.

Any start up or in-kind costs and funding services associated with this practice? Please provide actual data, if possible. Else, provide an estimate of start-up costs/ budget breakdown.

Specific factors that led to the success of this practice included hiring and training of 4.0 FTE HIV DIS staff ($31,500 salary per employee), 2.0 FTE Pharmacy HIV DIS, one FTE Perinatal HIV DIS and one FTE Dental HIV to closely monitor prescription pickups, missed medical appointments and find lost to care clients. They educate clients daily to increase adherence and retention in care. Information Technology programming cost was approximately $1,000. All the information that is gathered about these clients are entered in a local database called HIV Prevention Care Coordination (HPCC) database. This database allows us to review the staff client load and discuss outcomes.

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?

Please enter the evaluation results of your practice : *

Evaluation

What did you find out? To what extent were your objectives achieved? Please re-state your objectives from the methodology section.

The objective is to increase medication adherence and retention in care for HIVAIDS clients in order to reduce new HIV infections and improve health outcomes.

In 2017, the average number of DOH-Broward pharmacy clients who did not pick-up their prescriptions that responded to pharmacy staff's phone calls, was 39%. The remaining 61% of clients were evaluated by HIV DIS staff. As of October 31, 2019, 2,711 clients were referred to the Pharmacy HIV DIS. The outcomes are: Inactive clients 24%, 85% picked up medications, 4% unable to locate, 12% moved out of this jurisdiction, 7% had insurance, 1% deceased, 7% linked to care ,5% refused, 2% incarcerated and approximately 766 field visits were performed. This is an increase from 70% in 2016 and 81% in 2017 for a 20% increase in referrals. By increasing the percentage of PLHIV on antiretroviral and in care, community viral load will decrease as well as the number of new HIV infections. DOH-Broward learned that, of the clients evaluated by HIV DIS staff, an average of 61% of clients returned to the pharmacy the following month to pick-up their prescriptions.

DOH-Broward's objective was achieved. We continue to see a high percentage of clients retained in pharmacy care and a low percentage of HIV clients that did not pick up their HIV medication which is a measure of increased overall adherence and retention in medical care.

Did you evaluate your practice?

Yes

List any primary data sources, who collected the data and how (if applicable)

Primary data sources include: internal secure database, electronic HIV/AIDS reporting system (eHARS), Surveillance Tools and Reporting Systems (STARS), electronic lab reporting. Data was collected by the DOH-Broward Pharmacy, ADAP, and perinatal staff.

List any secondary data sources used (if applicable)

List performance measures used. Include process and outcome measures as appropriate.

Performance measures were created and tracked in the DOH-Broward performance management system, Active Strategy. These include prescriptions picked up, number of medications returned to stock, number of clients who did not pick up medications, number of client's reached by HIV DIS, pick up rates, and treatment adherence. A pharmacy metric includes the "pick up rate of ARV's from DOH pharmacies". Metric results, variance reports and corresponding action plans are discussed at monthly business reviews to revise process as necessary.

Describe how results were analyzed.

Due to the success of this objective, the process will continue and is supported by DOH-Broward's Director. Every LHD that interacts and/or serves HIV clients may have the potential benefit of this program by reducing HIV transmission through ensuring the highest possible rate of medication adherence. DOH-Broward analyzed the process and determined there is an improvement in knowledge and awareness by DOH-Broward Pharmacy and ADAP staff regarding the importance of clients understanding the importance of medication adherence to reduce or eliminate the risk of transmission of HIV thus improving health outcomes.

Were any modifications made to the practice as a result of the data findings?

No

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.

Please enter the sustainability of your practice : *

Sustainability

Lessons learned in relation to practice

Lessons learned were such that there was an improvement in knowledge and awareness by DOH-Broward Pharmacy and HIV DIS staff regarding the importance of retaining HIV clients in care.

Lessons learned in relation to partner collaboration (if applicable)

As a result of this practice, DOH-Broward's relations with its community partners improved through interagency collaboration. DOH-Broward is able to refer and link clients into care very effectively. Community partners are extremely appreciative of the efforts by DOH-Broward to retain HIV clients in care and alert clinicians to clients with possible adherence issues.

Did you do a cost/benefit analysis? If so, describe.

N/A

Is there sufficient stakeholder commitment to sustain the practice?

Measuring the effectiveness of return to care programs for people living with HIV (PLWH) presents a serious issue to public health evaluation. Categorizing those who leave, and re-enter HIV care is difficult as this cycle may occur before they would traditionally be considered not retained in care (6-month minimum). The PROACT program offers may strengths not available in other return to care programs. The most common return to care program is the Data2Care program. The Data2Care program utilizes surveillance data to identify those considered out of care, however these identifications often occur long after the PLWH has left care. There is literature that states that the longer an induvial is out of care, the more difficult locating and re-engaging the individual in care was. Thus, locating and re-engaging PLWH who are considered out of care is more effective shortly after a pattern of missed visits has been demonstrated. This is the methodology PROACT program uses. The Stakeholders (all the HIV agencies that refer to PROACT) are very satisfied with the work that we do because we are able to provide outcomes to them so they can decided what to do with this lost to care client.

Overall, the PROACT program re-engaged 73% of the clients that were found and eligible into HIV care. This number likely underestimates the true impact of the program. Many referred individuals considered unable to locate or refuse services often re-engage in care without health department assistance. These individuals are not counted as re-engaged in care per this evaluation.

Describe sustainability plans.

The HIV DIS in this program are paid thorough Ryan White Part A care and treatment dollars and the CDC HIV Prevention grants that are provided to the Health departments depending on the number of HIV individuals we serve in the county. Since, we are a high incident county in Florida we will continue to sustain the HIV DIS to do the work that they do of re-engaging lost to care clients throughout the county which then will decrease community viral load and reduce new HIV infections.

Additional Information

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

- [x] I am a previous Model Practices applicant
- [ ] At a NACCHO conference
- [ ] Colleague in my LHD
- [ ] Colleague from another public health agency
- [ ] E-Mail from NACCHO
- [ ] NACCHO Publication (Connect, Exchange, Public Health Dispatch)
- [ ] NACCHO Website

Have you applied for Model Practices before?: *

- [ ] No, this is my first time applying.
- [x] Yes, I have applied in the past.

If you answered yes to the question above, please let us know the year and award type. :

2019 Sealing and Educating All Little Smiles Model, Practice