Disrupting the Public Health Norm

Las Animas Huerfano Counties District Health Department

Kim Gonzales, Executive Director
Million Hearts Learning Collaborative
Learning Collaborative States, Territories, and Freely Associated States

KEY
- **Blue** = Year 1 states
- **Yellow** = Year 2 states
- **Green** = Year 3 states
Las Animas-Huerfano Counties
Million Hearts Learning Collaborative

In Colorado, about 1 in 4 ADULTS have been told they HAVE HYPERTENSION*

THE RISK IS HIGHER for:
- Low-income
- Elderly
- Overweight/Obese
- African-Americans

Barrier:
Access to care in rural and frontier counties
“Rural” - a non metropolitan county with no cities over 50,000 residents
“Frontier” - a county that has a population density of 6 or fewer residents per square mile
Community-Clinical Linkages

- **Learn** about community and clinical sectors.
- **Identify** and engage key stakeholders from community and clinical sectors.
- **Negotiate** and agree on goals and objectives of the linkage.
- **Know** which operational structure to implement.
- **Aim** to coordinate and manage the linkage.
- **Grow** the linkage with sustainability in mind.
- **Evaluate** the linkage.
Key Partners 2015

- Colorado Department of Public Health and Env.
- Association of State and Territorial Health Officials
- Million Hearts
- Mt San Rafael Hospital and Clinic
- Spanish Peaks Regional Medical Center and Outreach Clinic
- Health Solutions
- Mt Carmel Health and Wellness Center
- Mountain Creek Home Health
The Model

Clinical Medicine

Population Health

Community Health

Public Health
Learning Collaborative Goals

• **Implement evidence based interventions** to improve hypertension control

• Identify and **build networks and cross-sector partnerships** to control hypertension

• **Test models for collaboration** between public health and community partners

• Experience a **quality improvement** process to affect practice and **policy at all levels of the system**.
Aim Statement
- By June 30, 2017, Las Animas and Huerfano counties will reduce by 10% the number of individuals with the most recent blood pressure greater than 140/90 by key stakeholders through a community-clinical linkage referral system for medical care and healthy lifestyle interventions.

Burden of Hypertension
- Approximately 26.3 percent of adults in Colorado have hypertension, compared to the national rate of 31.4 percent (CO BRFSS 2013 & 2015). However, in Las Animas County, 38 percent of residents have been diagnosed with hypertension, and 31 percent of Huerfano County residents have been diagnosed with hypertension. In addition, both counties have higher rates than the statewide average for adult obesity, uninsured residents, and heart disease mortality, which are all risk factors for hypertension (CO BRFSS 2013).

Target Populations
- The Colorado Million Hearts Learning Collaborative focused on low-income and geographically isolated residents of Las Animas and Huerfano Counties. Both counties are identified as frontier (meaning they have population density of six or fewer people per square mile) and are designated Health Professional Shortage Areas.
• Implemented a standardized blood pressure measurement guideline

• Protocol for identification of hypertension and referral to primary care

• Bi-directional referral process

• Wellness Screening
Million Hearts Learning Collaborative

How

• Public Health:
  The Wellness Screenings include:
  Blood Pressure, A1C, Lipid Panel, BMI
  In between BP Checks

• Hospitals/Clinics
  Increase Self-Measured Blood Pressure (SMBP)
  Monitor pre-hypertensive & hypertensive
  Control BP and uncontrolled BP

• Home Health
  Increase Self-Measured Blood Pressure (SMBP)

• Bi-Directional Referrals
• Blood Pressure Monitor check out at all partner sites
• Monthly meetings
Evidence-based/Best-Practices Used

- AHA’s *Check. Change. Control. Self-monitoring blood pressure program*

- Million Hearts Undiagnosed Hypertension Prevalence Estimator

- Standardized blood pressure measurement protocol

- Standardized referral workflow to clinical care or lifestyle change programs

- Patient reminders through automated calls to get free blood pressure checks at Local Public Health Department

- Team based care through the development and use of a centralized community hypertension registry
Flow Chart Mt San Rafael and Health Department

Flowchart
Mt. San Rafael Hospital Clinic and Las Animas Huerfano Counties District Health Department

- Community Screenings
- Hypertension Registry
- Provider Visits
- Hypertensive Community Members
- Local Public Health Department
- BP < 140/90
  - Prevention Education
  - Offer Community Resources
  - Fax BP sheet to Clinic’s EHR
- BP > 140/90
  - Clinic Case Manager
  - Primary Care Provider
  - Clinic Case Manager
  - Local Public Health Department
Example of Patient Flow
Community Resource Quick Referral

Community Resources Referral

The following resources are available to help you. Read through this list and put a check mark next to the resources you would like to learn more about. Then, ask a staff member for help in making sure you are not missing out on resources that you could benefit from.

By sharing your name, date of birth, address, phone number and e-mail at the end of the form and signing, you are giving your permission for us to share your information with the specified agency and giving them permission to have a trusted contact person reach out to you to discuss the resources you are interested in.

By signing, you also confirm that you understand that you can revoke this consent at any time you wish to have your information withdrawn.

Spanish Peaks Outreach and Women’s Clinic

- **Zumba Classes**

- **Family Planning** – Programs for women and men of childbearing age. Staff can counsel you to determine if the time is right for you to begin a family and if not, what birth control method is right for you! **ALSO FREE CONDOMS.**

- **Women’s Wellness Connection (WWC)** – Free or low cost annual exams for women 40 to 64 screenings to identify breast and cervical cancer.

- **WISEWOMAN** – Must be in WWC program. Early detection for Heart Risk Disease and Type II Diabetes.

- **CCGP** – A patient navigation program for women between the ages of 40 and 64, with and without insurance.

- **Heart Healthy Solutions** – Free screenings that include a lipid panel (cholesterol, triglycerides and glucose levels) and heart risk assessment. The information is sent to your Primary Care Provider.

- **Chronic Disease Self-Management Education** – Six week workshop for people dealing with ongoing health conditions to learn skills to manage health conditions.

- **Diabetes Education** – Learn to manage your diabetes through diet and lifestyle changes. Participate in our Diabetes Prevention Program.

- **CHP+ and Medicaid** – CHP+ and Medicaid – We are a PEAK eligibility site and can help you with your paperwork to determine what type of insurance you might be eligible for.
Systems Change Diagram
Disrupting Public Health Norm

Leadership & Vision
- Partners committed to continuing and expanding collaborative work, leveraging financial and staffing resources

Policy change
- Provide services to all community members regardless of medical home

State health department
- Convene partners, support implementation of interventions, collect/aggregate data, provide funding

Health Systems, Local Health Department, Home and Behavioral Health Agencies
- Identify individuals with BP > 140/90
- Implement evidence-based interventions using a team-based care model
- Refer individuals
- Document and share data, close feedback loop

Evidence-based programs
- Use of a protocol for measurement of BP
- Use of HIT: patient registries, automated calls, patient portal
- Engage patients in home blood pressure monitoring

Community Resources
- Establish primary care, offer self-management support (e.g. home blood pressure monitoring), enroll in lifestyle change programs: CDSMP, tobacco cessation, DSME, DPP, etc.

Data Capture & Sharing
- Update status of referrals
- Report data: # of screenings, # of referrals, reduction in BP, etc.

Worksites
- Access to chronic disease screenings on-site

Access to electronic health records through a MOU

Use of OSCAR (community health data platform) - provided by the Colorado Prevention Center
Key Project Successes as of August 2017

**Clinical**
- 10,125 total patients identified with hypertension through registries from all clinic partners.
- 778 referrals made to primary care and community resources.
- 44 patients enrolled in Home Blood Pressure Monitoring Program.
- 405 patients with uncontrolled hypertension with improved blood pressure values.
- 178 patients identified with high blood pressure in the community at worksite wellness events.

**Data**
- Implemented system-level changes that improve the use and sharing of clinical data to better identify individuals with undiagnosed or uncontrolled hypertension and to improve management of diagnosed patients with hypertension.
- The average hypertension control rate across clinic partners and home healthcare increased from 68.1% in June 2016 to 75.8% by June 2017.

**Community-Clinical Linkages**
- Engaged stakeholders to update the Las Animas-Huerfano Counties Million Hearts Partnership Agreement.
- Developed a model that engages local public health, home health, and primary care clinics to improve hypertension diagnosis and control.
- Identified community members with undiagnosed hypertension in clinical and community settings making subsequent referrals to primary care and community resources.
Project Sustainability and Spread

Next steps include:

• Continue to engage multi-sector partnerships; including Local Public Health Agencies, health systems and practices, community based organizations and quality improvement organizations to implement system changes to facilitate the integration of public health and primary care.

• Continue to develop tools, guidance, and resources for this model of care with key partners, including identifying lessons learned challenges, successes and evidence.
Las Animas-Huerfano Counties
Million Hearts Learning Collaborative

2017 Model Practice Award
Otero & Crowley Counties
Million Hearts Learning Collaborative

Kick Off Meeting
February 10, 2017
Future Funding after ASTHO

• Clinical Quality Improvement (CQI)

• The Colorado Health Foundation:

• Cancer, Cardiovascular and Pulmonary Disease Grants Program
Partnerships now include:

- Mt. San Rafael Hospital Clinic
- Spanish Peaks Regional Health Center and Outreach Clinic
- Mount Carmel Health Wellness and Community Center
- Mountain Creek Home Health
- Salud Family Health Center
- Sangre de Cristo Community Care
- One Health Insights
- OSCAR
- Otero/Crowley Public Health Department
Cancer, Cardiovascular and Pulmonary Disease Grants Program (CCPD)

How

• Public Health:
  The Wellness Screenings include:
  Blood Pressure, A1C, Lipid Panel, Pre-Diabetes
  In between BP Checks
• Hospitals/Clinics
  Increase Self-Measured Blood Pressure (SMBP)
  Monitor pre-hypertensive & hypertensive
  Control BP and uncontrolled BP
  DSME (Diabetes Self Management Education)
  NDPP (National Diabetes Prevention Program)
• Home Health
  Increase Self-Measured Blood Pressure (SMBP)
  Bi-Directional Referrals
• Blood Pressure Monitor check out at all partner sites
• Monthly meetings
Quotes from partners

Once you trust each other...anything is possible as long as you have the right people at the table. Even if it had no effect on hypertension, the fact that we have the framework for future projects and initiatives is worth the effort.
When we first started, it was new and we were just creating the program. It was kind of hard. Once we got our partners and a plan together, it has been really awesome. Our collaboration and sharing EHRs has turned into a really awesome thing for this community, and I don’t see it going back.
Communication

Leadership and Vision

Policy Change

Evidence-based Programs

Data-driven Action

Financing

Complementary Sectors & Partners

Community-level Resources

Engaged Individuals
Thank you

Kim Gonzales, Executive Director
719-846-2213 Ext. 37
kgonzales@la-h-health.org