

Field Notes



Colorado Heart Smart Navigation Program

Problem:

High blood pressure and related cardiovascular diseases contribute to increased rates of morbidity and mortality in the community.

Project:

The Colorado Heart Smart Navigation Program (HSNP) employs patient navigators who work with patients and community organizations to offer assistance with managing blood pressure and other related conditions.

For more information please contact

Centers for Disease Control and Prevention

1600 Clifton Road NE
Atlanta, GA 30333

Telephone: 1-800-CDC-INFO
(232-4636)/TTY: 1-888-232-6348

Email: cdcinfo@cdc.gov

Web: <http://www.cdc.gov>

Overview

The Heart Smart Navigation Program (HSNP) is a network of eight community health centers (CHCs) located in rural and urban areas across the state of Colorado. The program integrates patient navigators into the health care team to help patients control their high blood pressure. Patient navigators and their chronic disease management teams develop self-management plans to overcome barriers to caring for high blood pressure and other coexisting disorders. HSNP patient navigators work individually and collaboratively, participating in monthly conference calls, communicating online via a listserv and Web site, and completing in-person activities, including trainings through the University of Colorado Health Sciences Center.

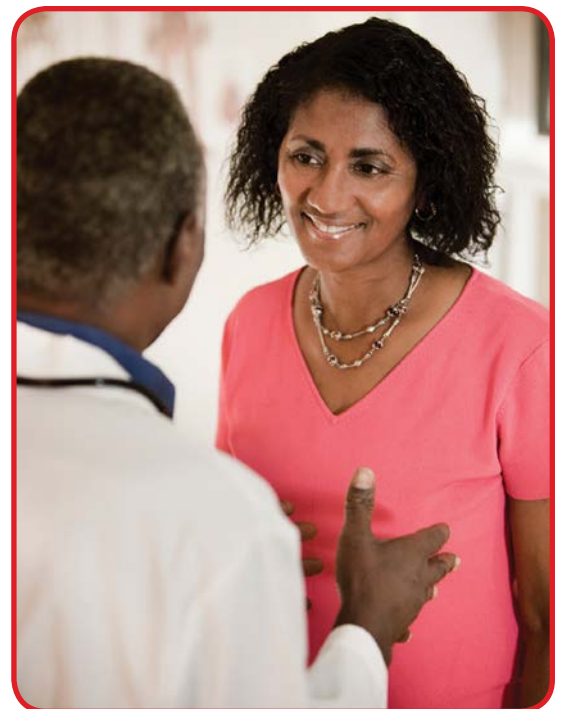
Another training opportunity is the Healthier Living Training program, which is a program for both patient navigators and patients, based on three decades of research on effective self-management programs for patients with chronic disease. Colorado's Consortium for Older Adult Wellness offers the chronic disease self-management component of the Healthier Living Training to patient navigators, and the Colorado Community Health Network (CCHN) receives funds from the state to oversee, coordinate, and implement the program. The Network's partnership with the Consortium for Older Adult Wellness allows CHCs to refer patients with chronic diseases to Healthier Living classes sponsored by the Consortium, and allows certified co-teachers, including HSNP patient navigators, to teach throughout Colorado.

Goals and Expected Outcomes

The ultimate goal of HSNP is to help reduce mortality and morbidity caused by high blood pressure and related cardiovascular disease as well as improve health outcomes in other disease areas.

Intended Audience

The intended audience of HSNP is patients aged 18 years and older who have been diagnosed with high blood pressure. CHCs typically serve low-income populations, many of whom have Medicaid or are uninsured. CHCs are located in both urban and rural, mountainous areas of Colorado.



Field Notes (cont.)

Progress Toward Implementation

The program is fully implemented at eight CHCs in rural and urban areas across Colorado and includes nine full-time employees serving as patient navigators. The program originally began as a pilot at two CHCs; after one year, the state deemed HSNP successful and provided additional funds for expansion. In 2010, when the Centers for Disease Control and Prevention, Division for Heart Disease and Stroke Prevention Evaluability Assessment site visits were completed, the program was in the third year of a 5-year grant.

HSNP has expanded from a pilot at two sites to implementation at eight CHCs across the state. All patient navigators and stakeholders interviewed reported that CCHN continues to do an excellent job in training and coordinating the patient navigators and making them more visible at CHCs.

Community Involvement

Patient navigators often partner with community organizations (e.g., social services, transportation authorities) to enhance patient access to services. In addition, navigators participate in local coalitions or workgroups that aim to lower rates of high blood pressure and chronic disease. CCHN partners with statewide and regional organizations to identify training opportunities and share resources.

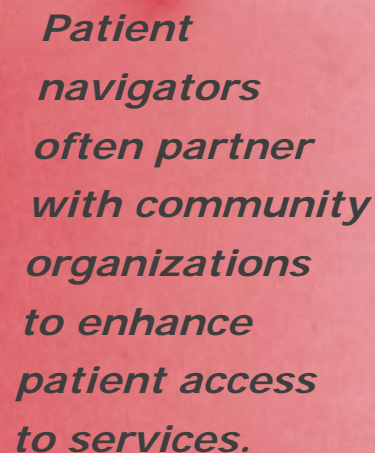
Reach and Impact

The pilot year of HSNP yielded measureable positive results—59% of patients with high blood pressure receiving navigation services had their blood pressure under control. This rate exceeds the Health Resources and Services Administration's Cardiovascular Disease Collaborative goal (40% of patients at CHCs with blood pressure under control) and the Colorado Heart Healthy and Stroke Free 2010 goal (50%).

In 2009, CCHN reported that about 489 participating patients had their blood pressure under control (about 59% of all patients with high blood pressure). In addition, patient navigators had assisted 1,127 patients with high blood pressure, and 1,166 patients had a documented self-management plan.

CCHN also reported community support for the intervention. Patients are receptive to the navigators, with whom they develop relationships through office visits and follow-up. Patients describe the navigators as less intimidating than providers.

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