Million Hearts State Learning Collaborative
State Snapshot

TRANSFORMING SYSTEMS SAVING LIVES

NORTH DAKOTA

State Health Agency: North Dakota Department of Health
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The North Dakota Department of Health is leading a team of partners including local public health units and clinical health systems. Partners are working to identify and refer adults living with undiagnosed or untreated hypertension through targeted screening events at worksites and in rural, medically-underserved areas. Partners are also working to prepare communities to prevent and quickly respond to cardiac events. Partners have increased connectivity of electronic health records to the North Dakota Health Information Network and engaged the dental care side of a community health center for hypertension diagnosis and referral.

AIM STATEMENT

By June 2017, through collaboration and use of data, the project will identify and treat hypertensive patients between the ages of 18-85 by linking public health and clinical systems, that include EMS and community paramedics, to improve standardized care.

Current Reach: *The local public health units, community paramedics and dental providers screened 4,449 individuals and identified 2,224 with high blood pressure (5%). Turtle Mountain Indian Health Services screened 245 Native Americans and identified 39 with high blood pressure (16%). Cardiac Ready Communities screened 323 individuals and identified 52 with high blood pressure (16%). Additionally, a total of 266 patients were referred to services.*

Potential Reach: *16,863 employees in target area worksites and 144,610 Cardiac Ready Community members.*

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BURDEN OF HYPERTENSION

- Approximately 29% of adults in North Dakota report being told by their doctor that they have hypertension (Behavioral Risk Factor Surveillance System, 2013).
- American Indians living in North Dakota experience death due to cardiovascular disease at twice the rate of the white population.
- At least 150,000 North Dakotans are being monitored or treated for hypertension, and 1 out of 4, or 25% of them do not have hypertension under control.

TARGET POPULATIONS

This project began in the counties encompassing Southwestern District Health Unit and Central Valley District Health Unit, and expanded to five local public health jurisdictions, one community health center dental clinic and one American Indian Reservation area. Target populations began with people at worksites and rural-living adults, and expanded to include people with low socio-economic status who are medically underserved. The project started and grew with the willing partners and their ability to tap into key channels that proved successful in previous state initiatives.

KEY PARTNERS

State

- North Dakota Department of Health
- Blue Cross Blue Shield of North Dakota
- Quality Health Associates
- Healthy North Dakota
- American Heart Association
- North Dakota Health Information Network
- University of North Dakota-Center for Rural Health

Local/Regional

- Southwestern District Health Unit
- Central Valley District Health Unit

Community/Clinical

- Sanford Health System
- Altru Health System

EVIDENCE-BASE/BEST PRACTICES USED

Best and promising practices used to identify those with undiagnosed or untreated hypertension and refer to clinical care include:

- Work to establish a secure electronic referral process to track and follow up with workers identified with hypertension.
- Connect electronic health records to the statewide North Dakota Health Information Network (NDHIN).
- Engage EMT's in hypertension diagnosis, referral, and treatment protocols and procedures (supported by North Dakota Legislature Concurrent Resolution, 2004).

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- Support and monitor individuals in their hypertension self-management through the use of an electronic portal.
- Work to prepare rural communities to prevent and quickly respond to a cardiac event through CPR instruction, public access to AEDs, hypertension screenings, and resuscitation protocols and transport plans for first responders and area hospitals.
- Work with a broad number of state partners and continue to engage new partners.

KEY PROJECT SUCCESSES

- The use of EMT's in rural areas improved access to preventive screening services.
- Worksites were determined to be an appropriate venue to identify individuals with undiagnosed or uncontrolled hypertension. Public Health nurses and EMT's provided screening services at worksites and reached employees who may have not have sought to measure blood pressure. Worksites were not found to support a coaching/mentoring system for those diagnosed with hypertension.
- Development of an algorithm to synthesize best practices for screening for high blood pressure and referring to clinical care that was shared statewide throughout the public health system. Sharing of best practices for taking blood pressure was also shared by third party payers through their quality networks.
- Engagement with state clinical quality organization and alignment with clinical quality measures.
- Active engagement of a minimum of 7 key statewide partners to work together and spread best practices for increasing awareness of the importance of screening and treatment.
- Determined the steps and software changes needed to connect local public health units to statewide NDHIN.
- Engagement of 11 communities in the Cardiac Ready Designation program.
- Development of a community paramedic visit module for efficient health care data collection and sharing with providers.
- Development and implementation of an electronic portal for patient's self-reporting of blood pressures.

PROJECT SCALABILITY AND SPREAD

North Dakota's systems are engaged and in place; partners include the North Dakota Association of City and County Health Officials (local public health system), North Dakota Worksite Wellness, North Dakota Cardiac System and North Dakota Stroke System of Care,

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Quality Health Associates and Blue Cross Blue Shield. Current partners are now better connected and have tools and experience to share with more public health, clinic-based and hospital systems partners through their respective systems.

The process of testing, Plan-Do-Study-Act, will be used in other chronic disease efforts. The systems changes that have occurred in the NDHIN will have a lasting impact in allowing clinical and public health systems to better connect and access data to better serve patients.

These Million Hearts projects, focused on hypertension identification and reduction, established channels, especially between clinical systems and worksites, through which other chronic disease management initiatives may expand.

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