



Change Process

- Integrating nonclinical Patient Health Navigators (PHNs) into community clinics
- Implementing standardized best practices of care across the Network
- Outcomes linked to adopted evidenced based clinical guidelines by Providers around the treatment of patients with CVD/DM/COPD

What led us here?

- Geographically isolated/workforce shortage
- Proactive vs reactive medicine
- Enhance access and care coordination
- Improve fragmented care for high risk chronic disease patients
- Population Health Management





Our Strengths

- Obtain buy-in from the clinic and the community members by hiring local, passionate people
- Registry data helping drive care decisions/outreach
- Bi-directional referrals from PHNs to CHWs
- 10 evidence-based/best practices and workflows implemented across the network



Essential Partners

- CDPHE – funding
- Partner clinics
- Beacon Program
- Clinical Champion, Sharon Grundy, MD - *leads by example, respected by Providers, involved with CPCi pilot*

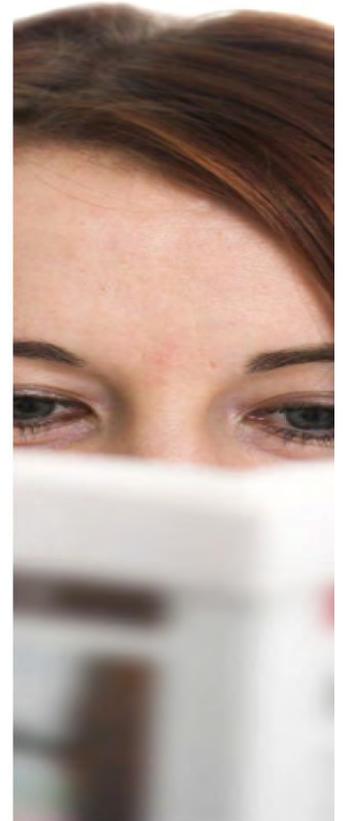
How do we get referrals?

- “warm hand-offs”
- Disease registries
- Daily huddles
- Part of a Network



How do they know about us?

- Word of mouth
- Quarterly Clinical Subcommittee Meetings
- Statewide awareness
- Monthly case management meetings
- Collaboration with other similar coalitions





Resources

- Disease registries
- Trainings offered at State level for PNs
- Health Team Works algorithms
- Beacon Program
- Team trainings – MI, AI
- Community support groups - CDSMP, Cooking Matters



Thank you

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TRI-COUNTY HEALTH NETWORK

