

The Arizona Department of Health Services (ADHS) Bureau of Tobacco and Chronic Disease (BTCD) houses the Centers for Disease Control and Prevention (CDC) state-based heart disease and stroke prevention program. The Arizona Heart Disease and Stroke Program (Arizona HDSP) is committed to improving prevention and management of heart disease and stroke and their risk factors.

With direction from the CDC, the Arizona HDSP developed strategies:

- To leverage resources and coordinate interventions with community partners;
- To address program priorities by applying public health methods; and
- To produce policy and system change.

Arizona HDSP developed a program, *Hypertension System of Care*, to address hypertension (HTN) and cholesterol management by enhancing the continuum of care within a community health care system in collaboration with the Yuma County Health Department and the University of Arizona Mel and Enid Zuckerman College of Public Health (MEZCOPH).

Hypertension System of Care: Program Objectives

1. Identify patients at risk or already diagnosed with hypertension or high cholesterol;
2. Refer identified patients into an education program provided by community health workers (CHW) or promotoras;
3. CHW follow-up with the patient to increase success of self-management of hypertension and high cholesterol by the patient; and
4. CHW feedback to the primary care provider regarding the patient self-management of their condition.

Current Program Activities and Outcomes

- Baseline clinical systems assessments of two local clinics, San Luis Walk-in Clinic, Inc. (a subsidiary non-profit corporation of the Regional Center for Border Health, Inc.) and Sunset Community Health Center, Inc., were conducted to evaluate current clinical policies and systems for hypertension and cardiovascular disease (CVD) management .
- Outcome: Both clinics have an organizational policy or system (or plan, protocol, standard, program) addressing hypertension and CVD management.
- MEZCOPH trained promotoras using the CDC’s evidence-based curriculum, *Community Healthworker’s Sourcebook*.
- Outcome: 12 promotoras were trained in total. Six at both San Luis Walk-in Clinic, Inc. and at Sunset Community Health Center, Inc.
- Monthly Progress Reports of promotora-facilitated HTN educational program are submitted to assess promotora activity.
- Outcome: 96 patients were identified to attend the promotora-facilitated HTN educational program. Of these, 87 were enrolled into the program, and 31 completed the 4 educational sessions. The percent of patients that completed the educational program in June was greater at Sunset Health Center, Inc. (75%) than San Luis Walk-in Clinic, Inc. (7%).
- Quarterly Evaluation Progress Reports assessed each health care system for organizational support, promotora integration and feedback.
- Outcome: Each clinic showed extensive organizational support for both promotora integration and feedback.

Impact of this Health System Change

The Hypertension System of Care Program in Yuma County is a pilot project that is intended to address key priorities of Arizona’s HDSP Program. With CDC guidance, this project facilitates collaboration among public and private sector partners and identifies culturally appropriate approaches to promote heart disease and stroke prevention among racial, ethnic, and other priority populations. Other intended long-term outcomes of this project are to:

- Enhance community linkages
- Improve self-management support
- Improve healthcare delivery systems
- Improve decision support

