

In order to meet some of the Health care needs addressed in the Community Needs Assessments from 2012 and 2016:

Parmer Medical Center proposes to expand management of Chronic Care diseases in order to address some of the healthcare issues introduced in the community needs assessment (CNA). Chronic diseases such as Diabetes, Chronic Obstructive Pulmonary Disease and Heart Disease affect a large number of our population. The implementation of a Chronic Disease Management program will assist in meeting the needs of those who struggle with their disease, compliance with treatment, and complications of the disease process.

The project will improve effective management of chronic conditions and ultimately improve patient clinical indicators, health outcomes and quality as well as reduce unnecessary acute and emergency care utilization. The Chronic Care Management Program will provide for a collaborative, multi-disciplinary team that may include but not be limited to Providers, Licensed Nurses, Dietician, Physical Therapist (PT) and other Rehab personnel as needed, a Case Manager (CM), Pharmacist and Social Worker trained in the Chronic Care Model.

Chronic disease management initiatives use population-based approaches to create practical, supportive, evidence-based interactions between patients and providers to improve the management of chronic conditions and identify symptoms earlier, with the goal of preventing complications and managing utilization of acute and emergency care. Program elements may include the ability to identify one or more chronic health conditions or co-occurring chronic health conditions that merit intervention across a patient population, based on an assessment of patients' risk of developing complications, comorbidities or utilizing acute or emergency services. These chronic health conditions may include diabetes, congestive heart failure, chronic obstructive pulmonary disease, among others, all of which are prone to co-occurring health conditions and risks.

Chronic Care Management (CCM) is needed in rural areas such as Parmer County - specifically models which take a community-wide problem-solving focus. The CCM team will ensure proper access to care, appointment scheduling, and will use targeted outreach strategies and health education to reach patients early in the disease process and when they are risk of leaving the care of Parmer Medical Center. Once recruited, patients will receive follow up phone calls, communication, education and support from team members to ensure that patients continue treatment, medication management, and follow-ups.

The goal of this project is to develop and implement chronic disease management interventions that are geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization. Program elements may include the ability to identify one or more chronic health conditions or co-occurring chronic health conditions that merit intervention across a patient population, based on an assessment of patients' risk of developing complications, comorbidities or utilizing acute or emergency services.

Project Goals:

- Increase the number of patients participating in a chronic care management program.
- Decrease hospital admissions related to chronic disease
- Decrease unnecessary ED visits
- Improves health care outcomes and patient satisfaction.

Chronic disease management initiatives use evidence-based approaches to create practical, supportive, evidence-based interactions between patients and providers to improve the management of chronic conditions and identify symptoms earlier, with the goal of preventing complications and managing utilization of acute and emergency care. The program leverages the existing Parmer Medical Center infrastructure to meet the need for enrollment in the Chronic Care Management Program with the goal of improving the poor outcomes currently exhibited in Parmer County.

Challenges:

The primary challenge for this project will be to engage and build trust with patients. Creating and implementing a Chronic Care Management Model is a new initiative for Parmer County. Historically, patients with chronic disease are seen in the general clinic population and are monitored by our physicians or do not seek medical care at all until in a crisis situation. No special team focus or outside resources have been utilized in the past to manage the disease process or to emphasize a change in lifestyle. Wellness measures are not usually the focus of our treatment plans and prevention measures are secondary to treatment. Introducing a new concept and style of disease management, cultural competency training and the involvement of a variety of innovative provider types within the care team that can address the full spectrum of the participants' needs will facilitate patient engagement and ensure program success.

5-Year Expected Outcome for Provider and Patients:

The implementation of a Chronic Care Management Model will lead to the reduction in reactive rescue care including ED and inpatient care and improve disease specific metrics. Introducing a new concept and style of disease management, cultural competency training and the involvement of a variety of innovative provider types within the care team that can address the full spectrum of the participants' needs will facilitate patient engagement and ensure program success.

Project Components:

A) *Design and implement care teams that are tailored to the patient's health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; nutritionists offering culturally and linguistically appropriate education; and health coaches helping patients to navigate the health care system -*

This will be accomplished by providing training to a multi-disciplinary team that may include but not be limited to Providers, Nurses, Dietician, Physical Therapist, Certified Health Coach, Case Manager, Pharmacist and Social Worker trained in the Chronic Care Model as well as invited expert speakers to support these patients navigating through the project. These providers can navigate the patient through the health care system, education process and build patients who are better informed and able to assist the providers in managing their chronic diseases.

B) *Ensure that patients can access their care teams in person or by phone or email-*
Patients that are enrolled in chronic care management will be given access to contact their health care team. This contact will be in the form of phone numbers and email.

C) *Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources-*

Implementing this project will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will initiate active follow-up to ensure positive outcomes, and will enhance patients' abilities to manage their own illnesses. The multi-disciplinary team will initiate patient education as well as group and self-management support while utilizing available community resources.

D) *Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions-*

Community and individual education, health and lifestyle coaches and other healthcare team members can assist in chronic disease management and encouraging compliance with treatment and preventative plans.

E) *Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations-*

To achieve this component we have reviewed chronic care management best practices and conduct an assessment of the hospital/health system to guide quality improvement efforts and evaluate changes in chronic illness care. Chronic disease management initiatives use population-based approaches to create practical, supportive, evidence-based interactions

The Chronic Care Management program began in mid- 2015 and has been ongoing for two years. The first phase of the program has been focused on Diabetes. 2017 - 2018 will focus on adding COPD and/or Congestive Heart Failure management components to the CCM program.