Chronic Disease Management
Resources & Services

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Where are we?

County Health Rankings
(1 being the best, 241 being the worst)

<table>
<thead>
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<th>2016 County Health Rankings</th>
<th>Wichita County</th>
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<td>Health Outcomes</td>
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<td>LENGTH OF LIFE</td>
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<td>QUALITY OF LIFE</td>
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Note: Green represents the best ranking for the county, and red represents the worst ranking.
Where are we?

Diabetes Prevalence Rates, Adults (18+), 2014

- Wichita County: 11.8%
- Texas: 9.2%
- Nation: 9.2%

Source: URHCS CHNA, 2016

Where are we?

Uninsured population, all ages, 2015

- Wichita County: 15.0%
- Texas: 16.0%
- Nation: 10.7%

Source: URHCS CHNA, 2016
Barriers to Care

1. Lack of available primary care resources for patients to access may lead to increased preventative hospitalizations
2. Cost of health care may delay or inhibit patients from seeking preventative care

Todays Agenda

1. Development of community networks to share ideas, learn, and improve processes across the continuum of care
2. Increase access to chronic disease management resources for the chronically ill and link uninsured and underinsured with community resources
3. Connecting Community Resources
4. Improve post-acute care coordination
Community Partners

Community Partners is a multidisciplinary group to which organizations are invited to send clinical and administrative representatives to collaborate on improving communication, team work, and overall care transition process.
Community Partners

This venue provides a platform to disseminate information, outcomes, process improvements, and educational initiatives from the activities of internal and external work teams to facilitate coordinated care transitions and improve outcomes.

Community Partners

Community Partner members form small focus groups or work teams that focus on process improvements based on needs identified.
Annual Needs Assessment

How would you describe your position or role in healthcare?

[Bar chart]
I typically attend Community Partners for

Do you access or utilize the Community Partner webpage?
The Community Partners web-site can be accessed by visiting United Regional Health Care System on the web. Community Partners is featured as a tab on the homepage that offers:

- Educational Materials
- Presentations from Past Meetings
- Forms, References & Resources
- Information on Special Events
- And More!

Find us at www.unitedregional.org

Contact Zach Kast @ zkast@unitedregional or 940.764.6719 for more information

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The tabs to left offer multiple resources for clinical staff:

- More Information
  - Member Organizations
  - Minutes Request
  - New Member/Update Member
  - General Question
- Support Groups & Events
- Presentations
- Forms
  - Referral Forms
  - Process Improvements
- References & Resources
  - Community Resources
  - Clinical Guidelines

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In your opinion, are the Chronic Disease Summits beneficial to you or your organization?

![Yes and No Chart]

What topics do you feel are most important for this group to explore as a community?

1. Chronic Disease Management
2. Care Transitions
3. Community Assistance
4. QA/QI
5. Population & Public Health
Do you feel that focus groups would be beneficial?

Focus Group of Interest
1. Diabetes & Diabetes Education
2. Home Health
3. Chronic Disease Management
4. Palliative Care
5. Community/Public Health

Chronic Disease Management

Increase access to chronic disease management resources for the chronically ill and link uninsured/underinsured with community resources.
Chronic Disease Management

Chronic Disease Management consists of multidisciplinary team members and programs focused on managing disease processes and symptoms of the chronically ill including:

- Diabetes Education and Management
- Heart Failure Clinic
- Palliative Care
- Transition Clinic

Increase access to chronic disease management resources for the chronically ill and link uninsured/underinsured with community resources.

Diabetes Education and Management

United Regional offers an Outpatient Diabetes Self-Management Education Program - series of comprehensive educational classes teach the patient and family self-management skills to reduce the risk of complications. Inpatient consults and education provided 7 days a week.

The team consists of:
- Advanced Practice Nurses
- Certified Diabetic Educator (CDE) RNs
- RNs
- PCP, Specialists, Registered Dietitian, Chronic Care Professionals etc.

Increase access to chronic disease management resources for the chronically ill and link uninsured/underinsured with community resources.
Diabetes Survival Skills

- Provides patients with diabetes the **necessary skills** and **equipment** to help control blood sugars and maintain health and safety at home

Provided at several locations

- United Regional Physicians Group Clinics
- United Regional Diabetes Education
- Community Health Care Center

To register for the complimentary class, please call 764-8190.

Classes are held in United Regional's Education Building at 1800 Tenth Street, Wichita Falls.

A Spanish-speaking diabetes educator is available. Please let us know if you prefer to enroll in a class in which she teaches.
Diabetes Supply Kits

- Provided at no-cost to 100% uninsured patients and includes:
  - Monitor
  - Single-use Insulin Syringes
  - Test Strips
  - Lancets
  - Insulin

Increase access to chronic disease management resources for the chronically ill and link uninsured/underinsured with community resources.
Diabetes 30 Day Readmissions

- URHCS has decreased diabetes readmission rates from 16.5% in 2015 to 8.7% in 2016

Heart Failure Clinic

United Regional offers an Outpatient Heart Failure Clinic specializing in symptom management and education. Services include:

- Monitor and manage heart failure symptoms
- Medication, diet and behavioral counseling/education
- Medication titration
- IV diuretic therapy
- Advanced Care Planning

The team consists of:

- Advanced Practice Nurse
- RNs
**Palliative Care**

Palliative Care provides patients with comprehensive services to help those with chronic conditions live more comfortably and productively.

The program consists of:
- RNs including Chronic Care Professionals (CCP)
- APNs
- Interdisciplinary team includes: Physicians, Pastoral Care, Respiratory Therapy, Social Workers, Pharmacists, Nutritionists, and Physical Therapists
Palliative Care

Palliative Care also assists in care transitions and making appropriate referrals to post-acute settings. On average, 63% of Palliative Care patients are discharged to post-acute facilities.

Patients Transitioned

- 1900
- 1950
- 2000
- 2050
- 2100
- 2150
- 2200
- 2250

Increase access to chronic disease management resources for the chronically ill and link uninsured/underinsured with community resources

Connecting with Community Resources and providing for uninsured/underinsured
Food Insecurity Screenings

In 2013, compared to state and national data, Wichita County had a higher incidence of food insecurity.

- Wichita County: 19.90%
- Texas: 17.60%
- Nation: 15.20%

Source: URHCS CHNA, 2016

Food Insecurity Screenings

- The majority of census tract populations in Wichita County have at least 5.1%-20.0% of their populations facing limited food access, or classified as living within a food desert.
- Several census tracts in the county have over 50% of residents with limited food access.
- Food insecurity significantly increased likelihood of adult chronic disease.

Source: URHCS CHNA, 2016
Food Insecurity Screenings

• United Regional implemented Food Insecurity Screenings in several outpatient settings:
  – Diabetes Education
  – Heart Failure Clinic
  – Chemo/Infusion Therapy

Increase access to chronic disease management resources for the chronically ill and link uninsured/underinsured with community resources.

Food Insecurity Screenings

• Screening tool developed using best-practice recommendations to assess food security and socioeconomic factors such as transportation

Increase access to chronic disease management resources for the chronically ill and link uninsured/underinsured with community resources.
**Food Insecurity Screenings**

- Interventions provided for patients identified as being food insecure including:
  - Referrals for SNAP, WIC, CHIP, TANF Assistance
  - Meals on Wheels Referrals
  - Community Pantry Lists
  - Additional referrals to Community Organizations as needed

**Food Secure**
- 183
- 72%

**Food Insecure**
- 70
- 27%
Food Insecurity Screenings

Food Boxes: 149
MLIU: 90

Interventions

Increase access to chronic disease management resources for the chronically ill and link uninsured/underinsured with community resources.

Oncology Treatment Assistance

- Dedicated LVN focused on finding drug replacement and grant programs for patients needing chemotherapy and biotherapy drug treatments.

- Community providers would refer the unfunded or underinsured patients to the outpatient infusion center to avoid paying for expensive treatments they would not get reimbursed for.
Oncology Treatment Assistance

2015
– 60 Patients assisted
– $1,619,731.34 credited toward patient accounts

2016
– 33 Patients assisted
– $2,002,627.34 credited toward patient accounts

Increase access to chronic disease management resources for the chronically ill and link uninsured/underinsured with community resources

Improving Post-Acute Care Coordination
Transition Clinic

The Transition Clinic is an outpatient clinic originally utilized to manage diabetic patients prior to elective surgery in an effort to reduce SSIs.

In 2016, expanded the Discharge Navigation program to refer at risk patients to the Transition Clinic for interim care until they can be seen or established with a PCP. 2017 initiatives include possibly expanding the Transition Clinic to additional patient populations including Sepsis & Pulmonary patients.

The team consists of:
• Medical Director
• Advanced Practice Nurse
• Registered Nurses

Who does the Transition Clinic benefit?
• Patients without a PCP or waiting to be established with a PCP
• Patients experiencing a delay in seeing their PCP or accessing community resources
• Patients requiring complex post-discharge navigation
• Patients who are unable to self manage
• Patients with multiple chronic conditions
Post Discharge Navigation

The Discharge Navigation Program exists to help guide patients with chronic conditions through a complicated discharge. A dedicated Discharge Care Navigator follows patients from the discharge process to the community setting by phone.

Staff

- Nurse Navigator

Patient populations include:

- Heart Failure
- Diabetes
- Respiratory Disease (COPD, PNE)

Discharge Navigation Calls

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<td>Heart Failure</td>
<td>81</td>
<td>514</td>
<td>510</td>
<td>838</td>
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<tr>
<td>Diabetes</td>
<td>67</td>
<td>488</td>
<td>449</td>
<td>957</td>
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<tr>
<td>COPD</td>
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<td>35</td>
<td>364</td>
<td>447</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>N/A</td>
<td>N/A</td>
<td>92</td>
<td>518</td>
</tr>
</tbody>
</table>
Facility Discharge Navigation Calls

The intention of discharge calls made to facilities or home health agencies is to ensure proper transitions of care and follow up on:

• Referrals
• Medications
• Discharge instructions

Discharge Navigation Calls

• The Chronic Disease Management Team is looking to collaborate with facilities to up-date this process & improve care transitions for patients with chronic conditions
• Staff have developed a new assessment to streamline the process
LACE Score

Utilized to identify and notify post-acute facilities/services of patients with a greater risk for readmission and complex discharge planning/navigation needs.

Patients with a LACE score of 10+ may be at a greater risk for mortality and readmissions.

Score Factors
- Length Of Stay
- Acuity of Admission
- Comorbidities
- Emergency Department visits during the previous six months

In closing

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Questions?
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United Regional Health Care System

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