

Implementing a Chronic Disease Management Registry Program



Parkland





AIM

Implement a chronic care registry that provides support to providers in managing health care for patients enrolled in a medical home and who have chronic care conditions.

TARGET POPULATION

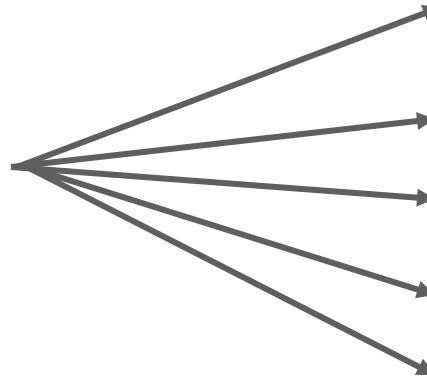
Patient's with chronic care conditions such as Diabetes, Congestive Heart Failure (CHF), Chronic Kidney Disease (CKD), Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Pediatric Asthma, and Adult/Pediatric Obesity.

NEED FOR PROJECT

Approximately 30,000 of Parkland's patient population have or are at high risk of being diabetic. Many other patients have one or multiple conditions or comorbidities. Implementing a registry will give providers the tools to monitor/track care of patients with specific needs. Such proactive management of patients will improve quality of care as well as decrease high cost utilization within the system.

Key Needs:

- Identify Target Populations
- Provide Detail per Disease
- Integrate Data into Clinical Workflows
- Provide Intervention Mechanics
- Measure Outcomes and Performance



Disease Specific Registries

Hx and Current Tables

EHR Tools

Self Service Reporting

Alignment with Category 3 Measures / Stratification

Parkland NUMBER OF UNIQUE PATIENTS IN THE REGISTRIES

Parkland UNIQUE REGISTRY PATIENTS BY VISIT MONTH

Diabetes Registry Patients by Visit Month

IT-1.2 Annual Monitoring for Patients on Persistent Medications - ACE/ARB's

Rate of Lab Components: FEV1/FVC (Result Value 80.0-90.0)

IT-1.2 Annual Monitoring for Patients on Persistent Medications - ACE/ARB's

Risk Category	Values	Icon Color
Low	0 through 5	Green
Medium	6 through 10	Yellow
High	11 through 15	Red

MRN Patient

MRN	Patient	DOB	Age	Sex	Patient Risk Score
			50 year old	Male	15
			54 year old	Male	15
			84 year old	Female	10
			77 year old	Female	5
			64 year old	Male	5
			69 year old	Female	5
			49 year old	Male	5
			63 year old	Female	5

A user can hover over the patient's risk score to get the following hover bubble summary:

Patient Risk Score	Risk Score (Testing)
2	7 points ED Visit Risk Score: Not on file
0	1 point Hospital Admission Risk Score: 1
0	1 point Readmissions Risk Score: 1
0	7 points Active TCU Patient?: Not on file
0	7 points Chronic Conditions Risk Score: Not on file
0	7 points Admission with Readmission Risk Score: Not on file



Impact:

Reduction in HbA1c poor control (>9.0%)

Improved Retinal Eye Screening for Diabetic Patients

Improved Annual Monitoring for Patients on Persistent Medications – ACE/ARBs

Reduction in All-Cause Readmissions

Patient Story:

Patient Doris Mondragon, 46, of Dallas developed gestational diabetes when pregnant 13 years ago. She appreciates the regular contact with nurse navigator Theresa Lira, RN.

“Theresa calls me every two weeks to check on how I’m feeling and remind me of my clinic appointments,” Mondragon said. “The staff taught me how to give myself insulin injections and helped me find a primary care provider at the Parkland clinic near where I live. I’m really, really happy with the care at Parkland and I’m feeling better than I did before.”