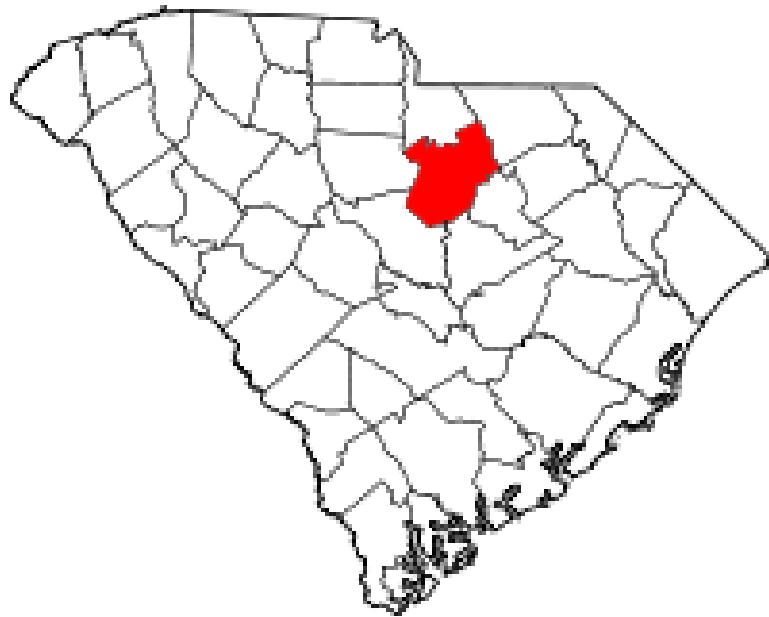



Improving Outcomes with Chronic Disease Management in Rural Communities

Kelly Warnock, APRN
Director, Access Kershaw

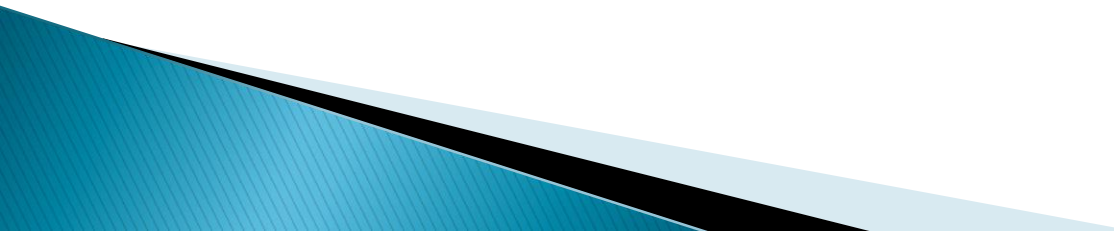
Kershaw County, South Carolina: A River Runs Through It



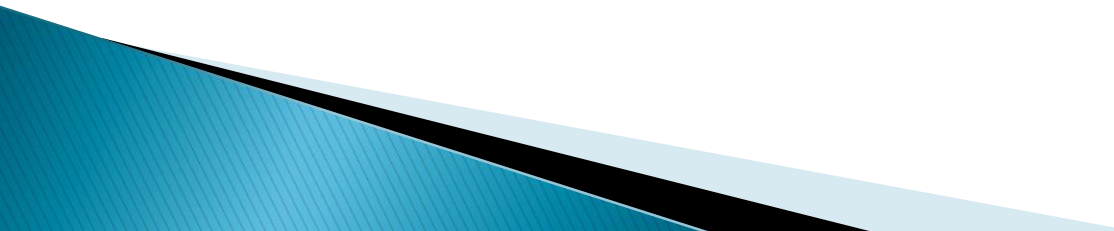
Kershaw County Statistics:

- ▶ 13,820 residents lack health insurance---18% of population (State average is 23%)
 - ▶ Limited availability of health care providers and appropriate entry points into system
 - ▶ Unmanaged chronic diseases most common preventable admission to hospitals
 - ▶ Most common avoidable emergency room visits—sinus infections, strep throat, urinary tract infections for the uninsured
 - ▶ Lack of transportation to primary care visits
- 

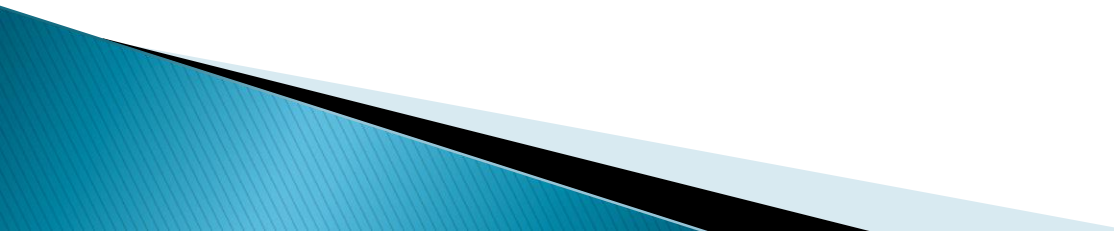
Perceptions from Health Study

- The system is incentivized to treat symptoms rather than causes
 - People in financial crisis place priority on food and shelter, rather than health
 - Providers may perceive the uninsured as unreliable and difficult
 - Many uninsured believe they are perceived by the system as being uninsured by choice and taking advantage of it.
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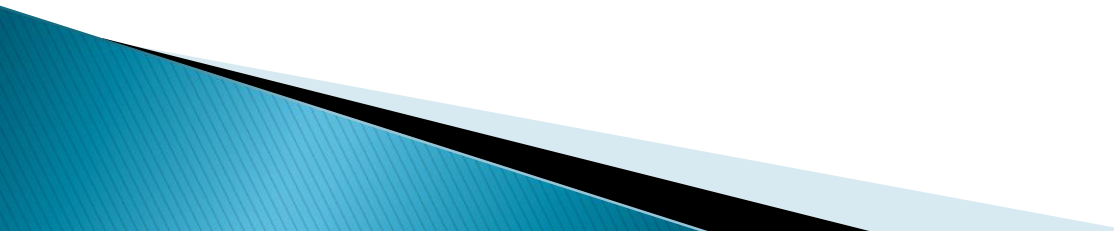
Creation of Access Kershaw

- ▶ Duke Endowment Grant
 - ▶ Development of Community Partnerships
 - ▶ Creation of Core Products
 - ▶ Development of Measurement Tools
 - ▶ Staffing
 - Director
 - 2 RN Case Managers
 - Office Manager
- 

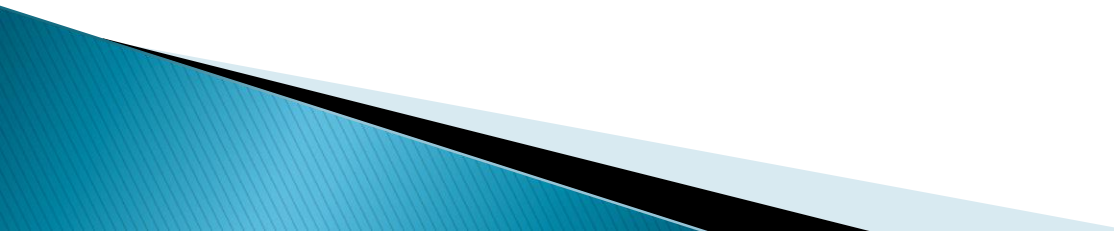
Access Kershaw Services

- Arrange for Primary Care Services
 - Arrange for Behavior Health Services
 - Provide for Case Management Services of chronic illnesses
 - Provide Pharmacy Assistance Programs and the application process
 - Assist with finding affordable specialty care
- 

Access Kershaw Services

- Screen for and completing applications for food stamps, Medicaid, and other benefits through The Benefit Bank
 - Assist with the disability process paperwork
 - Life Coaching
 - Navigation through the healthcare system
 - There is NO charge for the services of Access Kershaw
- 

Special Needs–The forgotten

- ▶ Highest county disease burden for
 - Diabetes
 - Congestive Heart Failure
 - End Stage Renal Disease
 - ▶ 1 Rural Health Clinic
 - 1 Full-time FNP
 - 4 hours a week MD coverage
 - ▶ Nearest pharmacy: 15 miles
 - ▶ Nearest grocery store: 17 miles
- 

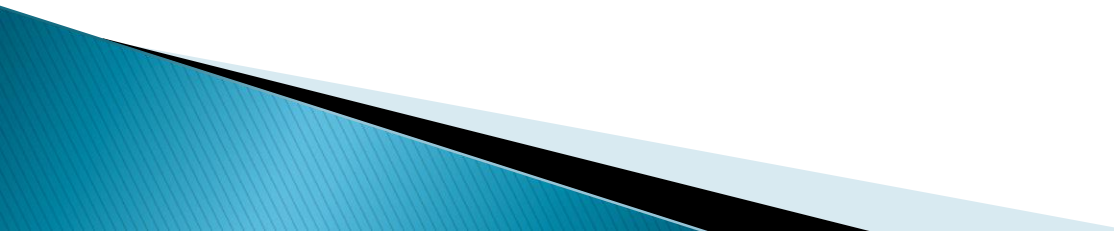
Does this look familiar?



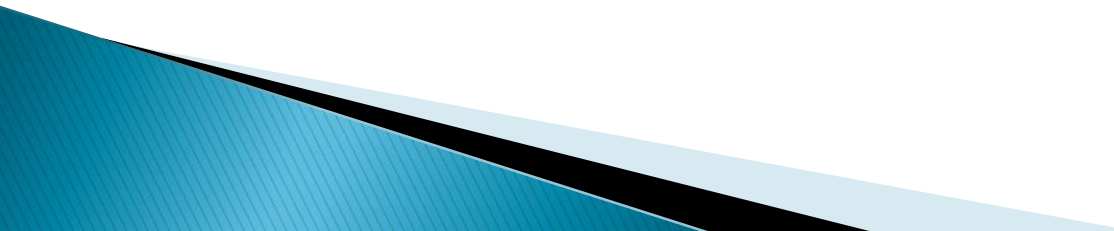
Rural Health Case Management

- ▶ Things we quickly discovered
 - Barriers are different in rural communities
 - Primary Care practitioners have limited time
 - Access to affordable medications is a problem
 - Social Service organizations are 20 miles away
 - Insulin is a Tier 3 drug for most Part D plans
- The under-insured are just as much “At Risk” as the uninsured.

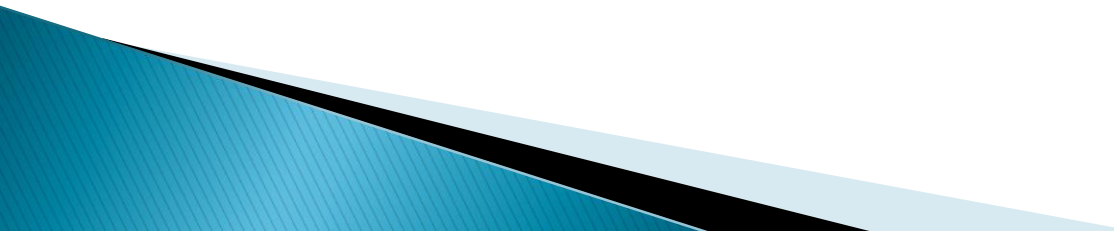
How do we eliminate barriers?

- ▶ Listen
 - ▶ Develop relationships with providers
 - ▶ Evaluate barriers on an individual basis
 - ▶ Be a part of the community
 - ▶ Gain trust
 - ▶ Offer on-site classes and access to healthy choice living
 - ▶ Place a nurse case manager into primary care
- 

Our Definition of Case Management

- Systematic approach to improving health status for chronic disease
 - Education
 - Accountability
 - A voice on the other end of the phone
Tracking the numbers that count
 - Follow up to primary care visits and specialty visits
- 

Our outcomes

- ▶ 60 client case managed in the rural health clinic
 - Hemoglobin A1C levels down 26% in 3 months
 - Systolic and Diastolic Blood Pressure down 30%
 - Increased medication compliance
 - Less missed visits/no show rate
 - Less ER visits
 - Decreased hospital admissions with decreased length of stay and costs
- 

How to be successful?

- ▶ Coordination of Care
 - ▶ Navigation through the variables
 - ▶ Address the barriers
 - ▶ Coordinate program eligibility efforts
 - ▶ Work in partnership
-
- ▶ Find something that is working well and JOIN them!!

Questions?

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