NEBRASKA PRIMARY CARE PROVIDERS CHRONIC DISEASE MANAGEMENT CARE AND USE OF COMMUNITY-CLINICAL LINKAGES

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INTRODUCTION

Overall health outcomes improve when chronic disease management is optimized through use of community-clinical linkage strategies locally by primary care providers. While much is known about various strategies, little is known about the extent to which various strategies are adopted in practice.

PURPOSE

Explore disease management and community-clinical linkage strategies employed locally by primary care providers with chronic disease patients across the state of Nebraska.

METHODS

Study Design: An exploratory state-wide survey of all primary care providers was developed, pilot tested and disseminated via U.S. mail following the Dillman technique. A comprehensive database identifying the primary care providers within their primary practice sites and health system affiliation was developed. Analysis was performed at the:

1) individual provider level to determine the singular care and treatment procedures;
2) practice level to determine what services are accessible within a primary care practice site; and
3) health system level to determine what is occurring across health systems with multiple practice sites.

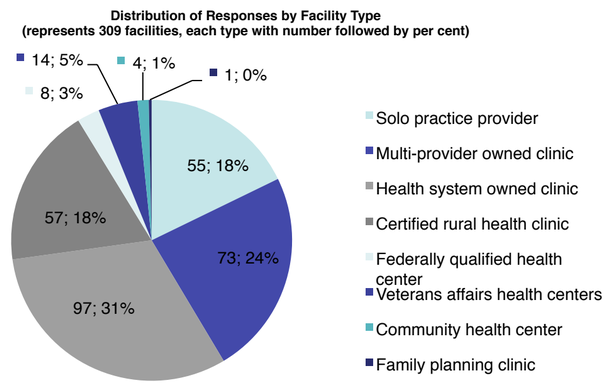
Population Studied: 906 primary care providers serving persons who reside in Nebraska (645 physicians and 261 nurse practitioners with independent practice authority). Of the 309 practice sites, 125 are independent, and 184 part of a health system. A total of 97 health systems were identified in the state. 87 of the 97 health systems had providers respond.

FUNDING & REFERENCES

This project is being completed under Contract from the Nebraska Department of Health and Human Services Division of Public Health Chronic Disease Prevention and Control Program.

RESULTS

Principal Findings: Overall response rate was 60%.



Chronic Disease Management

98% manage pre-hypertension, hypertension, pre-diabetes and diabetes; 87% engage patients in self-management with a goal-setting plan and 80% document this in the medical chart.

Strategies Promoting Self Management

Strategies for promoting self-management heavily involve community linkages:

- 51% refer patients to others (e.g. pharmacists) in the community for blood pressure "drop in" measurements and monitoring,
- 26% refer to others for blood glucose "drop in" measurements, and
- 26% refer to others for medication therapy management services.

Community Health Workers and Community Linkages

Only 39% report being familiar with community health workers (CHW) and 18% report a CHW being involved in their practices for the purpose of linking patients to social service resources or health care system navigation.

- 50% - CHWs to link to social service resources
- 46% - help navigate the health care system
- 48% - help with coordination of care
- 48% - informal counseling, support, follow up
- 41% - help with health coaching
- 37% - home visits
- 47% - assist with chronic disease self-management education

Electronic Health Record Uses

60% report using an electronic health record (EHR) to make referrals within their own practice and 52% also use it to make referrals outside their practice. While one-third use the EHR for registry purposes, a full third report needing a separate registry for chronic disease tracking. There remain a large variety of EHRs in use:

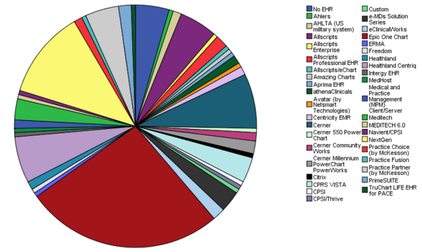


Figure 11. EHR Product Used By Practices Affiliated with a Larger Health System.

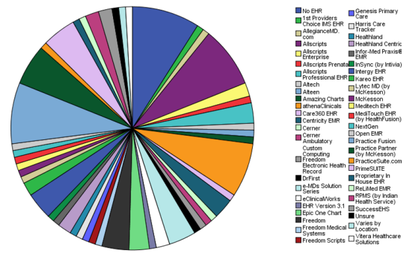


Figure 12. EHR Product Used By Practices Unaffiliated with a Larger Health System.

Health System Affiliation and Community Linkages

Practices affiliated with a health system had higher rates of reporting community linking and referral across all areas. Nearly all practice sites offer same day appointments, timely clinical advice by telephone, and routinely planned visits for chronic disease management. Independent practices report less sophisticated EHR integration, resulting in less than half of these practices reporting dashboard data use in daily practice and panel management for chronic diseases.

CONCLUSION

Conclusions: Primary care practitioners in Nebraska are highly active in managing chronic diseases including a strong focus on engaging patients in self-management approaches. The value of community linkages to support and extend care to persons with chronic disease is clear to primary care providers. Those providers who are in practices affiliated with larger health systems have greater activity related to referrals and linkages than those in independent practice.

IMPLICATIONS FOR POLICY OR PRACTICE

Increased opportunity for community linkage use in chronic disease management, particularly with primary care providers in independent practices, exists.