CHRONIC DISEASE MANAGEMENT

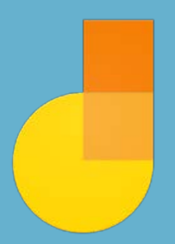
WHAT’S YOUR FAVORITE FOOD?!

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Identify some of the most common chronic diseases in the United States and discuss health inequalities in rates of chronic disease among populations.
- Apply the ecological model to analyze the causes and consequences of chronic conditions.
- Analyze and discuss the limitations of traditional medical models for the treatment of chronic conditions, and ways to integrate medical and public health approaches.
- Discuss team-based approaches to the delivery of primary health care, and the role and scope of practice of CHWs within these teams.
- Analyze and explain the concept of patient empowerment and the self-management of chronic conditions.
- Discuss the application of client-centered concepts and skills to supporting patients in learning how to effectively manage their own chronic conditions.

WORDS TO KNOW

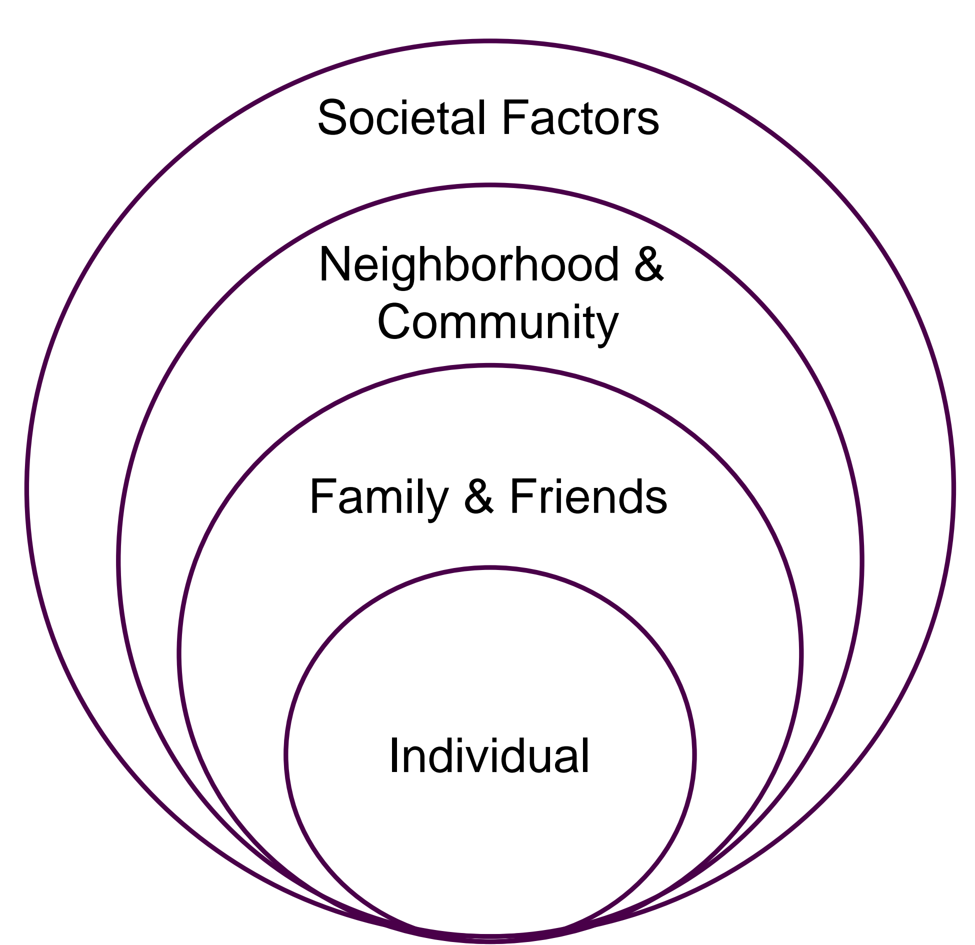


- Adherence
- Chronic condition
- Concordance
- Discordance
- Medication management
- Panel management

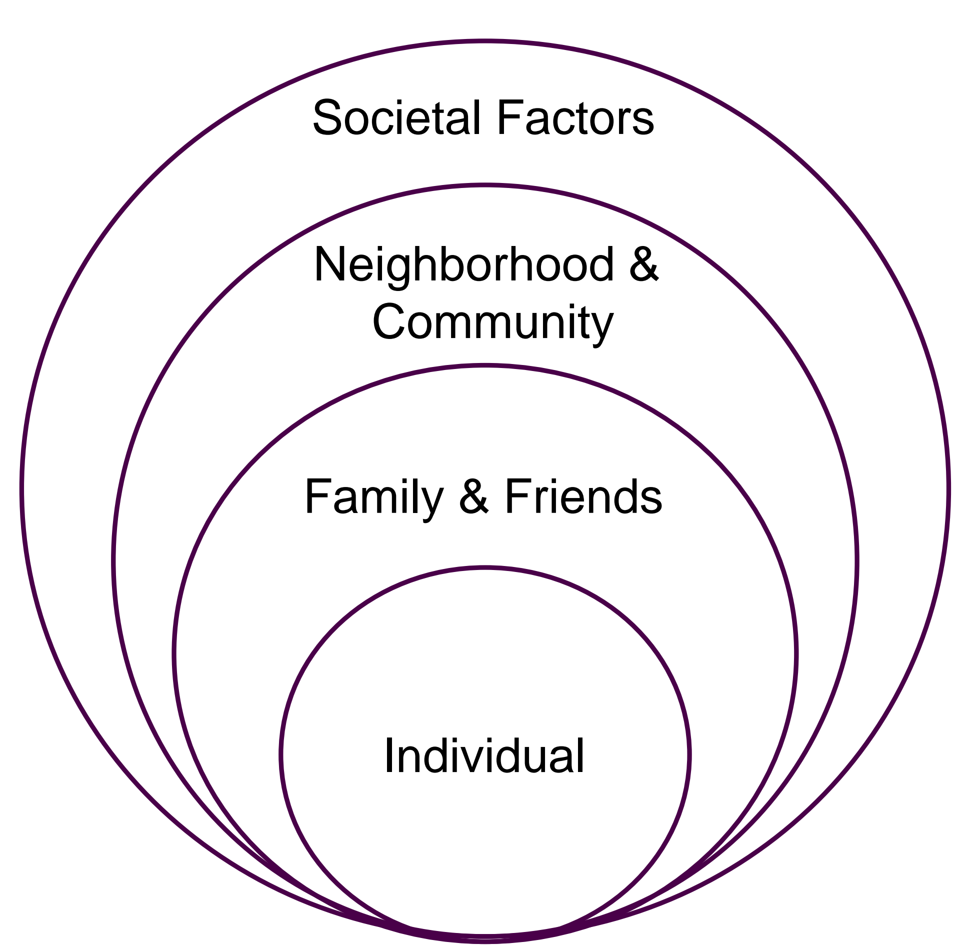
DEFINING CHRONIC CONDITIONS

Illness or health condition that lasts for **at least 3 months** and is slow to progress.

6 in 10 adults have a chronic disease



Social-Ecological Model



Social-Ecological Model

What are the contributions to chronic disease at each of these levels?

CAUSES AND CONTRIBUTIONS

Individual

- Level of physical activity.
- Diet and nutrition.
- Tobacco use.
- Alcohol consumption.
- Family history.

Family / Friends

- Influence.
- Social support.

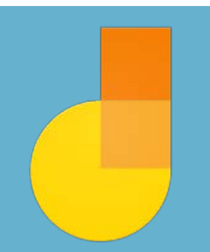
CAUSES AND CONTRIBUTIONS

Neighborhood and Community

- Access to health resources.
- Environmental conditions.
- Violence.
- Parks, schools, etc.

Societal Factors

- Food / water.
- Safe housing.
- Working conditions.
- Civil rights.



LET'S PUT THIS INTO ACTION…

- Ronald Lewis

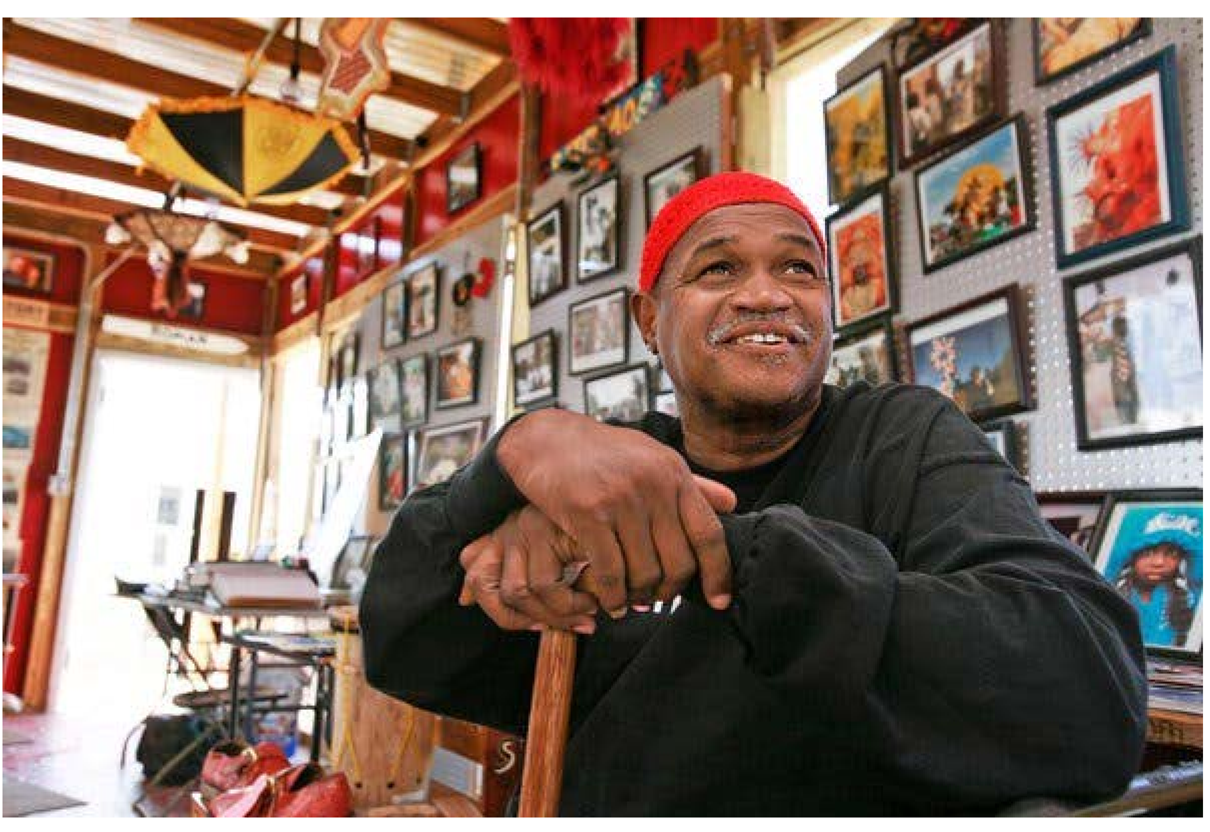
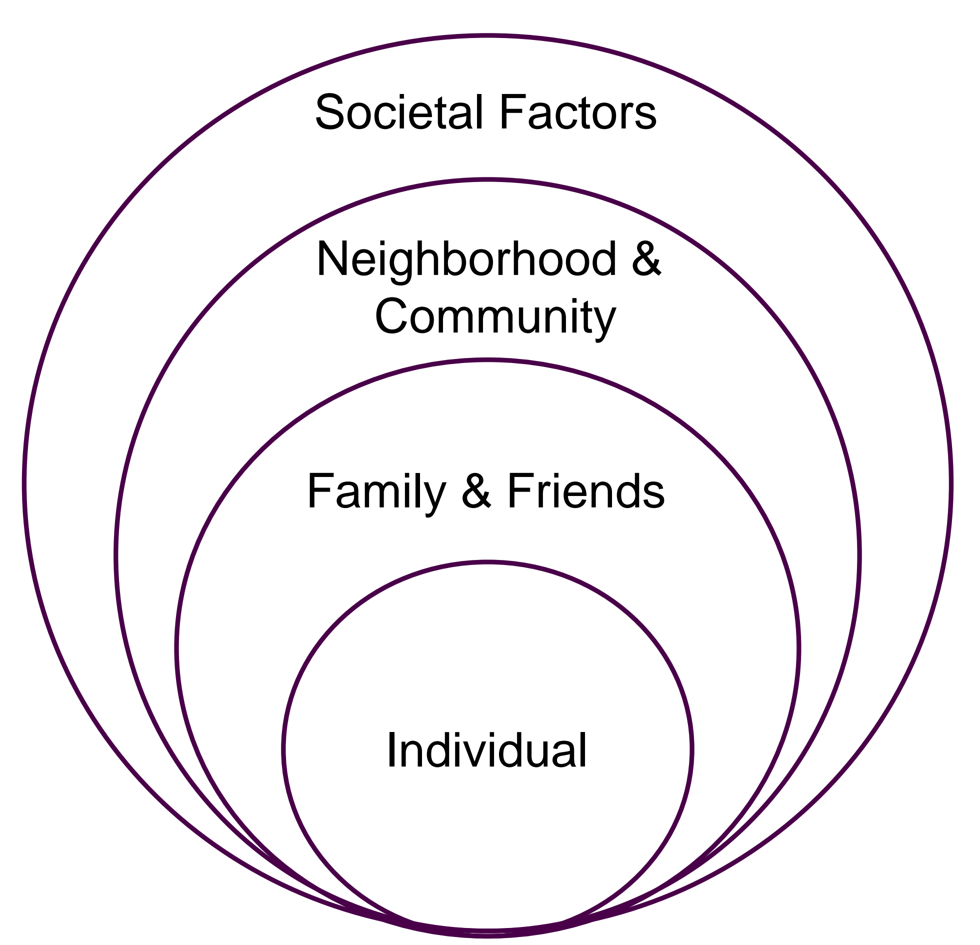


Figure 3

Percent of Total Population that has Received a COVID-19 Vaccine Dose by Race/Ethnicity, Selected States, June 7, 2021

	White	Black			Hispanic			Asian		
	Percent Vaccinated	Percent Vaccinated	White to Black Ratio	Percentage Points from White	Percent Vaccinated	White to Hispanic Ratio	Percentage Points from White	Percent Vaccinated	White to Asian Ratio	Percentage Points from White
Total (41 states)	44%	31%	1.4	−13	35%	1.3	−9	56%	0.8	11
Kansas	37%	28%	1.3	−9	32%	1.2	−5	45%	0.8	8
Missouri	36%	28%	1.3	−8	42%	0.9	6	54%	0.7	18



Social-Ecological Model

What are the consequences of chronic disease at each of these levels?

CONSEQUENCES FOR INDIVIDUALS

- Fatigue or extreme tiredness.
- Chronic pain.
- Daily living challenges.
- Nausea, bowel, bladder problems.
- Loss of mobility, eyesight, hearing.
- Nerve damage.
- Increased levels of stress.
- Stigma.
- Shame and isolation.
- Symptoms worsen.
- Invisible illness.

CONSEQUENCES FOR SOCIETY

Families

- Stress.
- Economic.
- Educational.
- Medical costs.
- Transportation.
- Housing.
- Food.

Communities

- High rates of disease.
- Higher rates of disabilities.
- Higher medical costs.
- Economic.
- Social.
- Loss of culture.

TREATMENT

- Medications.
- Increased activity.
- Diet.
- Therapy.
- Mental health.
- Medical equipment.
- Assistance.
- Holistic and integrative medicine.
- Access to treatments.

INTEGRATING CHWS, MEDICINE AND PUBLIC HEALTH

CHWs contribute to chronic disease management by:

- Sharing knowledge and raising awareness about health issues.
- Identifying community health priorities.
- Identifying community health risks.
- Assisting the community to identify local resources.
- Coordinating care though team-based care and panel management.
- Promoting empowerment and patient self-management.
- Assisting in the development of health goals.
- Upstream medicine.

UPSTREAM APPROACHES

BREAKOUT ROOMS

- What are two upstream approaches that CHWs can use to PREVENT chronic disease?
- What are two upstream approaches that CHWs can use to help MANAGE/IMPROVE chronic disease?

PANEL MANAGEMENT

- Panel manager identifies highest risk patients using data.
  - Team proactively contacts patient to schedule care.

- Panel management is:
  - Organized and coordinated.
  - Population based.
  - Data driven.
  - Evidence based.
  - Focused on patient outcomes.
  - Committed to prevention.

What is panel management?

Panel management, or population health management, is a proactive approach to ensuring that all patients whom a physician or practice is responsible for receive preventive care, not just those who come in for appointments. For example, your practice may use panel management to ask, *“Have all of our patients between 50 and 75 years of age received colorectal cancer screenings at the appropriate time intervals?”* or, *“Have all of our patients with diabetes had laboratory tests for HbA1c, cholesterol, and renal function at the appropriate times?”* This approach leads to better health outcomes for your patient population.

Six STEPS to implement panel management:

1. Develop a registry.
2. Use a health maintenance template.
3. Adopt clinical practice guidelines.
4. Select and train staff to serve as panel managers.
5. Identify care gaps.
6. Close care gaps through in-reach and out-reach.

SELF MANAGEMENT

- Rapidly becoming new standard of care.
- Recognizes that patients are in charge of day-to-day care.
- Focuses on supporting patients to successfully control their condition.
  - Develops skills.
  - Builds confidence.
  - Increases motivation.

SELF-MANAGEMENT

CHW SCOPE IN CHRONIC DISEASE MANAGEMENT

- Outreach to local agencies.
- Outreach to patients.
- Home visits.
- Panel management.
- Health education.
- Behavior change support.
- Developing action plans.
- Case management.
- Attending appointments.
- Medication management.
- Health exams / status checks.
- Facilitation support groups.
- Referrals to social services.
- Health system navigation.

KS Community Health Worker Coalition

CLIENT-CENTERED CONCEPTS AND SKILLS

- Cultural humility.
- Ecological model.
- Big eyes, big ears, and a small mouth.
- Harm reduction.
- Motivational interviewing (MI).
- Honoring self-determination.

ACTION PLANNING

Establishing Health Goals:

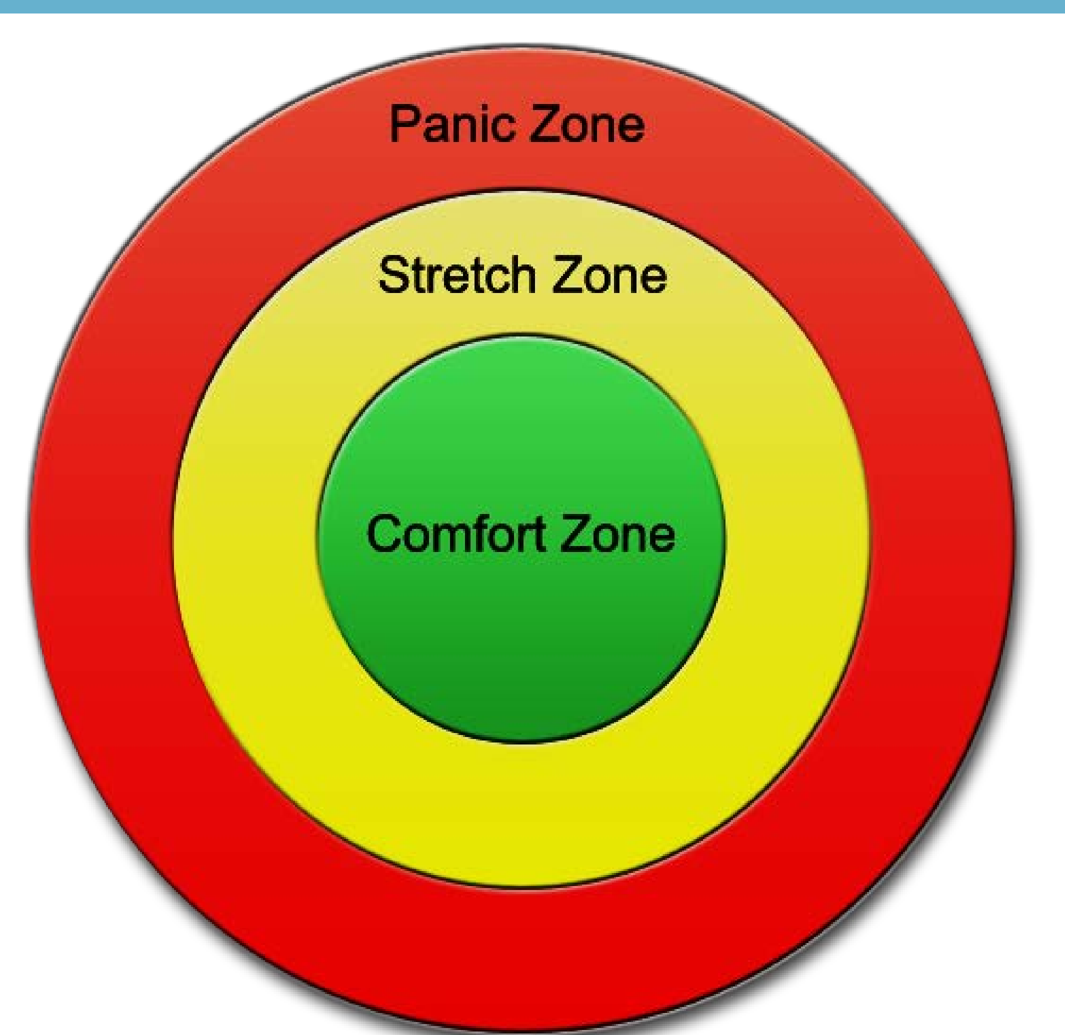
- Reduce symptoms or indicators.
- Slow progression of disease.
- Sustainable self-management.
- Increased ability to engage in activities.
- Enhanced autonomy.
- Improved economic and social circumstances.
- Stress reduction.
- Mental / spiritual health.
- Medication management.
- Family acceptance / support.
- Belonging.
- Social change / social justice.

KS Community Health Worker Coalition

BUBBLE CHARTS

What's the first step we need to take to accomplish this goal?

Second...Third...


Panic Zone
Stretch Zone
Comfort Zone

FOLLOW-UP SERVICES

- Reminding clients of appointments.
- New medications.
- New social service need.
- No longer using health services.
- Client visited an ER or urgent care.
- Client is discharged from a hospital or inpatient center.
- Reestablishing care.

RESPONDING TO AMBIVALENCE, RESISTANCE AND RELAPSE

- Listen without judgement.
- Demonstrate unconditional positive regard.
- Use client-centered skills.
- Roll with it — don’t argue or lecture.
- Reflect on your own reaction.

REVIEW – WHAT HAVE WE LEARNED TODAY?