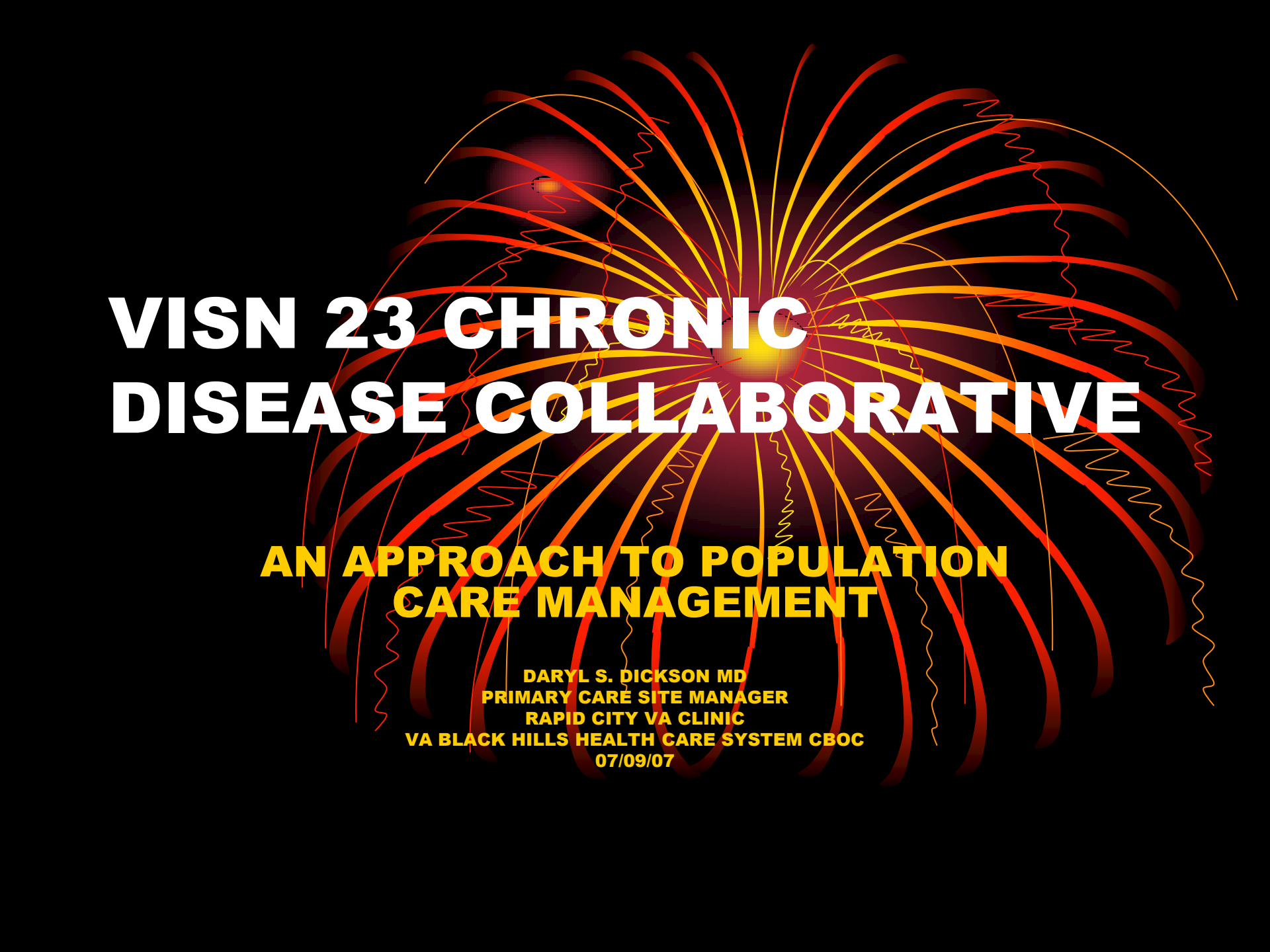

VISN 23 CHRONIC DISEASE COLLABORATIVE

AN APPROACH TO POPULATION CARE MANAGEMENT

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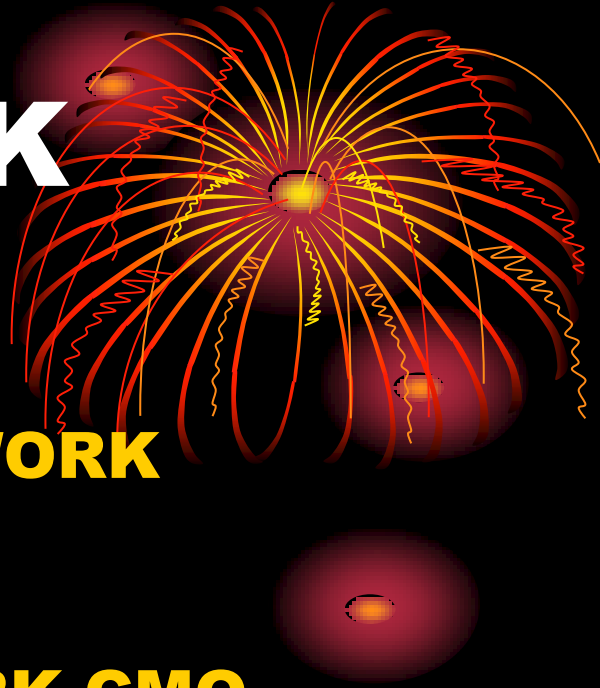
VA BLACK HILLS HEALTH CARE SYSTEM CBOC
07/09/07

VISN 23 NETWORK LEADERSHIP

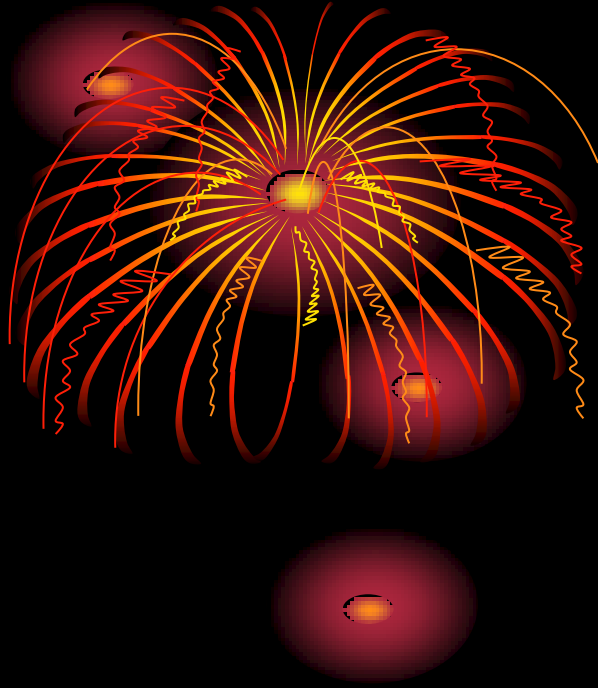


- ROBERT A. PETZEL MD—NETWORK DIRECTOR
- BARRY GRAHAM MD—NETWORK CMO
- JANET P. MURPHY MBA—NETWORK PRIMARY AND SPECIALTY MEDICINE SERVICE LINE CEO—COLLABORATIVE DIRECTOR
- TERRY WAHLS MD—PRIMARY AND SPECIALTY MEDICINE NETWORK MEDICAL DIRECTOR

CHRONIC DISEASE COLLABORATIVE

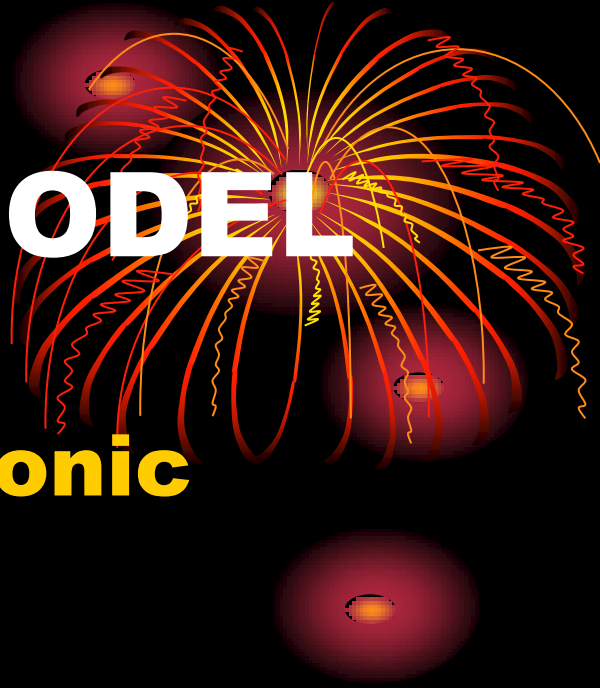
- 18 MONTH DURATION—STARTED IN APRIL 2006
- 4 FACE-TO-FACE LEARNING SESSIONS—MOST RECENT SESSION (L.S.#3) MAY 2007
- 3 ACTION PERIODS BETWEEN LEARNING SESSIONS

FOCUS OF COLLABORATIVE



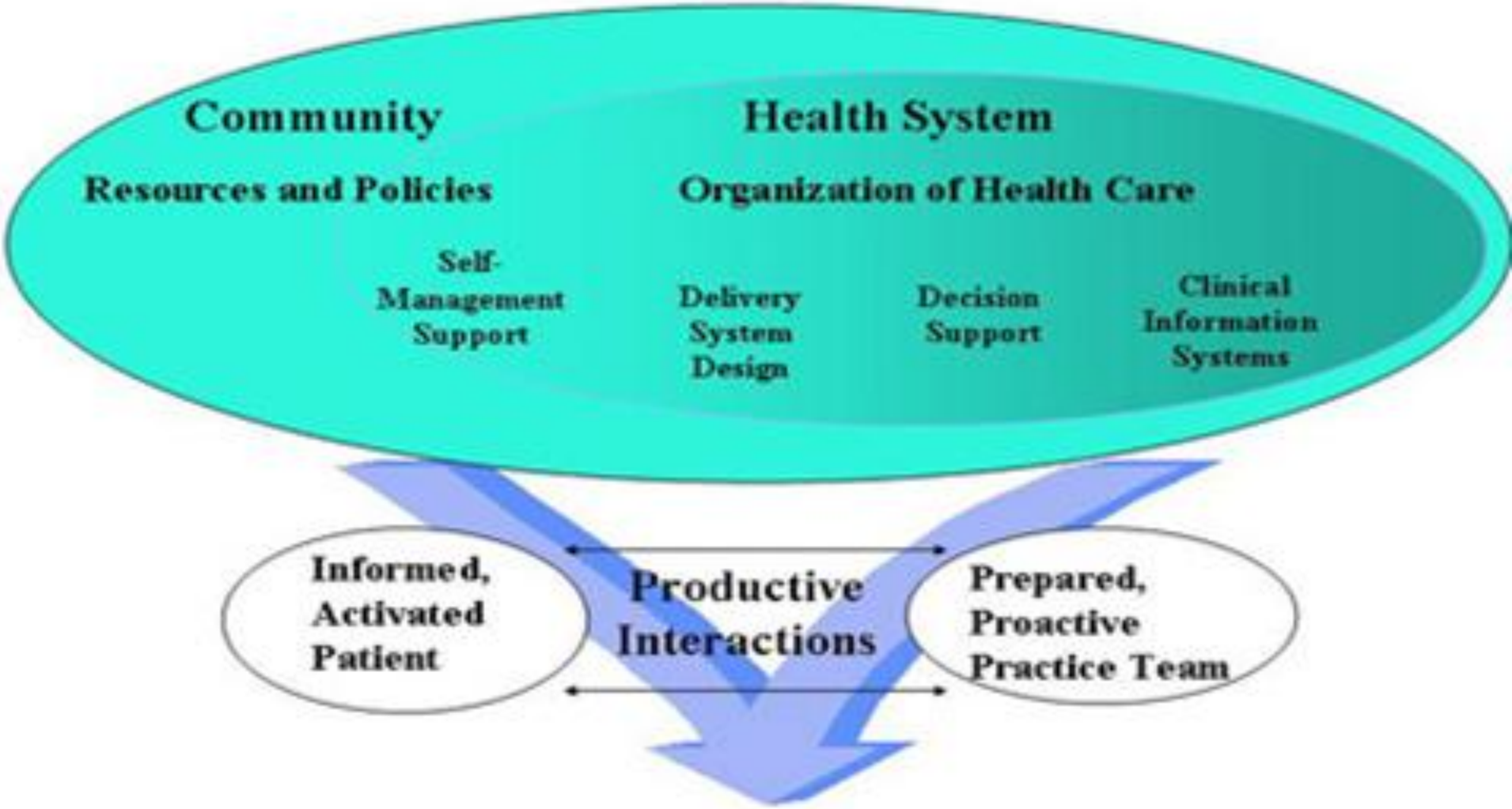
- Diabetes Mellitus
- COPD
- CHF—SUBJECT MATTER EXPERT DR. I. ANAND—MINNEAPOLIS VA CARDIOLOGY

CHRONIC CARE MODEL



- **Based on Wagner's Chronic Care Model**
- **Incorporates VA care, Community care, and encourages patients to take a more active role in their daily disease management.**

Wagner Chronic Care Model



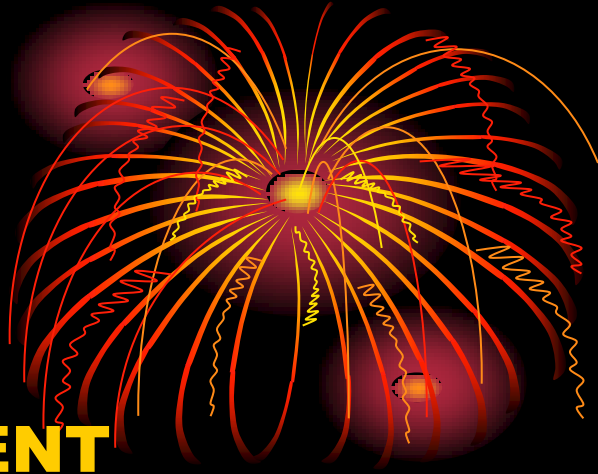
OVERALL CHF GOAL OF COLLABORATIVE

- IDENTIFY PATIENTS WHO QUALIFY FOR THE COLLABORATIVE
- ASSURE CORRECT DIAGNOSIS BASED UPON SET CRITERIA
- CHF CRITERIA BASED UPON NYHA CHF CRITERIA AND ACC STAGING WITH EJECTION FRACTION CONFIRMATION

OVERALL CHF GOAL OF COLLABORATIVE

- DECREASE HOSPITAL ADMISSIONS FOR CONGESTIVE HEART FAILURE
- DECREASE EMERGENCY ROOM AND URGENT CARE VISITS OF PATIENTS FOR CONGESTIVE HEART FAILURE SYMPTOMS
- IMPROVE QUALITY OF LIFE FOR PATIENTS WITH CONGESTIVE HEART FAILURE

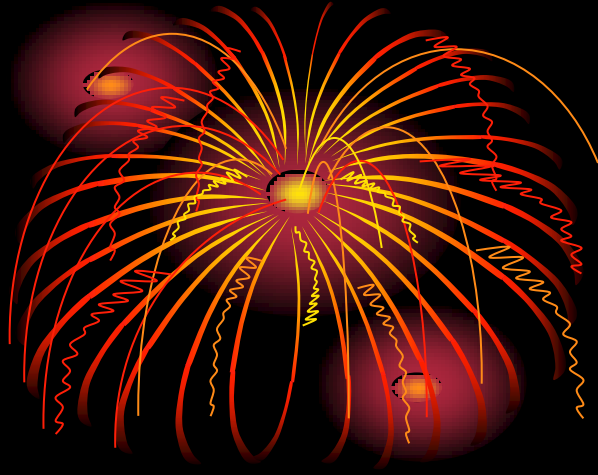
TOOLS PROVIDED



1. CHRONIC DISEASE MANAGEMENT PATIENT REGISTRIES

   - CREATED BY DSS FOR TRACKING PURPOSES—PATIENT IDENTIFICATION
   - EACH CHRONIC DISEASE HAS ITS OWN REGISTRY
   - CHF REGISTRY BASED UPON PROBLEM LIST AND DISCHARGE DIAGNOSIS
   - REGISTRIES ARE FACILITY (DIVISION SPECIFIC) AND CAN BE BROKEN DOWN TO PRIMARY CARE PROVIDER

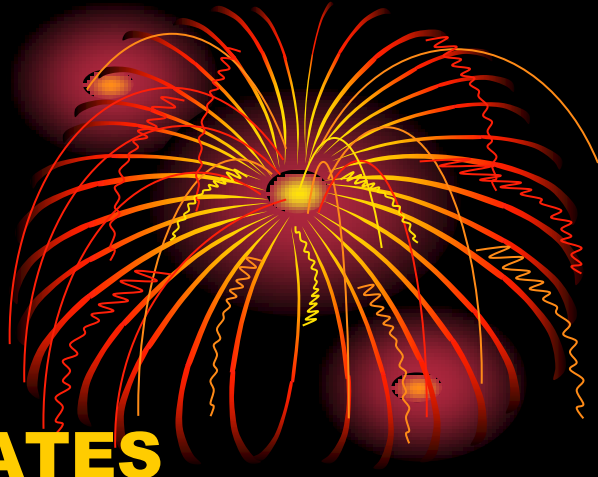
TOOLS PROVIDED



2. CHRONIC DISEASE CASE MANAGERS

- EACH FACILITY PROVIDED FTEE THROUGH NETWORK RESOURCES
- CASE MANAGERS ARE MAINLY RNs BUT SOMETIMES DISEASE SPECIFIC INDIVIDUALS (RT) FOR COPD AND OR CDE FOR DIABETES
- HOW TO USE CASE MANAGERS WAS DETERMINED BY FACILITIES
- CASE MANAGERS BECAME PRIMARY CARE CCHT(CHRONIC CARE HOME TELEHEALTH) “EXPERTS”

TOOLS PROVIDED



3. CDM HEALTH FACTOR TEMPLATES

- TEMPLATED PROGRESS NOTE TO HELP OPTIMIZE CHRONIC DISEASE CARE BY PROVIDERS FOR EACH COLLABORATIVE DISEASE STATE
- HELPS TO TRACK IMPROVEMENT OF PATIENT CARE WITH ESTABISHED STANDARDS OF CARE AS RECOMMENDED BY ACC AND AHA
- ACTS AS A REMINDERS TO PROVIDERS OF HOW TO OPTIMIZE CARE FOR PATIENTS WITH CHF AND OTHER DISEASE STATES

LESSIONS LEARNED

- GREATEST AMOUNT OF IMPROVEMENT IN PATIENT CARE OCCURS WHEN STAFF CAN FOCUS ON IMPROVEMENT GOALS (CASE MANAGERS ARE INVOLVED IN PATIENTS' CARE)
- PROVIDERS ARE REMINDED REGULARLY OF COLLABORATIVE EFFORTS (STAFF MEETINGS)
- STAFF REMAIN "ENGAGED" IN COLLABORATIVE EFFORTS (STAFF MEETING DISCUSSIONS)
- PATIENTS TAKE AN ACTIVE ROLL IN THEIR HEALTH CARE/DISEASE MANAGEMENT


QUESTIONS?
THANK YOU!