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Thank you for joining today's webinar. We will begin promptly at 1:00 p.m. Central.

Introducing the Rural Chronic Disease Management Toolkit

1

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Your *First* **STOP** for *Rural Health* **INFORMATION**

Introducing the Rural Chronic Disease Management Toolkit

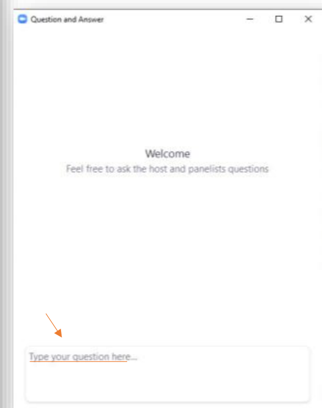
2

Housekeeping

- Slides are available at https://www.ruralhealthinfo.org/webinars/chronic-disease-toolkit
- Technical difficulties please visit the Zoom Help Center at support.zoom.us

3

If you have questions…



4

Featured Speakers

Amy Rosenfeld, Senior Research Director, NORC Walsh Center for Rural Health Analysis

Doris Boeckman, Project Director, Mobile Integrated Healthcare (MIH) Initiative at the Great Mines Health Center in Farmington, Missouri

Gilbert Rangel, HRSA Programs Coordinator at Lake County Tribal Health Consortium in Lakeport, California

5

NORC WalshCenter FOR RURAL HEALTH ANALYSIS

Rural Chronic Disease Management Toolkit

November 7, 2024

Amy Rosenfeld, MPH

6

Who We Are

NORC Walsh Center for Rural Health Analysis

- Established in 1996 and now part of the Public Health Research department at NORC at the University of Chicago. NORC is an independent and nonpartisan research organization that provides expertise in public health and other areas.
- The NORC Walsh Center conducts timely policy analysis, research, and evaluation to address the needs of policymakers, the healthcare workforce, and the public on issues that affect healthcare and public health in rural America.

Toolkit Development

Partnership between RHIhub, NORC Walsh Center, and Federal Office of Rural Health Policy (FORHP)

- The development of this toolkit was supported by FORHP and was produced by the NORC Walsh Center and RHIhub
- First published on June 14, 2024

Contributors from the NORC Walsh Center

- Amy Rosenfeld, Sierra Arnold, Rachel Van Vleet, Izzy Mandema, Luciana Rocha, Alexa Siegfried

Toolkits are a key step in disseminating successful rural programs and strategies

Toolkit methods and development

1.

Literature and resource review

Extensive review of existing literature, resources, and materials

2.

Rural program interviews

Interviews with grantees and other community programs that shared real-world experiences and lessons learned from implementation

3.

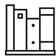
Expert interviews

Interviews with individuals with subject matter expertise in rural chronic disease management

4.

Toolkit development

Developed toolkit with information, resources, and feedback from interviews to support chronic disease management efforts



IN THIS TOOLKIT

Modules

1: Introduction

2: Program Models

3: Program Clearinghouse

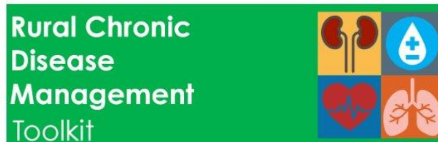
4: Implementation

5: Evaluation

6: Funding & Sustainability

7: Dissemination

About This Toolkit



Welcome to the Rural Chronic Disease Management Toolkit. The toolkit compiles evidence-based and promising models and resources to support the implementation of chronic disease management programs in rural communities across the United States.

The modules in this toolkit contain resources and information focused on developing, implementing, evaluating, and sustaining rural programs for the *management* of chronic disease. For information about rural programs for the *prevention* of chronic disease, see our Health Promotion and Disease Prevention Toolkit.

This toolkit highlights evidence-based and promising approaches for managing a wide range of chronic diseases. Several leading chronic diseases that affect rural populations may benefit from these approaches, including diabetes, chronic obstructive pulmonary disease (COPD), heart disease, arthritis, chronic kidney disease, cancer, obesity, and chronic pain. The strategies included in this toolkit do not specifically address all chronic diseases.

More resources for addressing the social determinants of health and their impact on chronic disease management in rural areas are available in our Social Determinants of Health in Rural Communities Toolkit. Additional resources on general community health strategies are available in our Rural Community Health Toolkit.

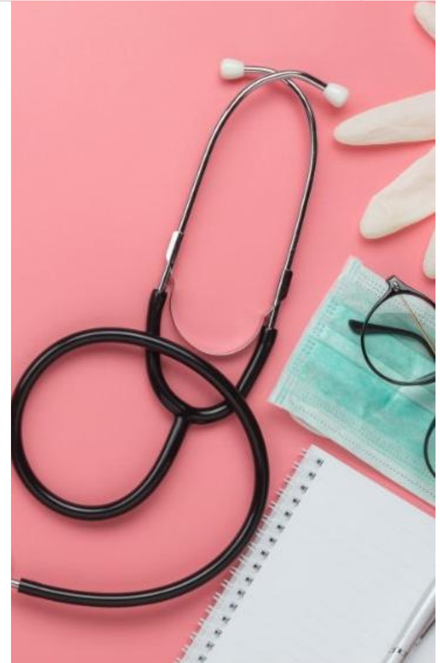
Module 1: Introduction to Rural Chronic Disease Management

In this module:

- Overview of Rural Chronic Disease Management
- Need for Addressing Chronic Disease in Rural Areas
- Facilitators and Barriers to Chronic Disease Management in Rural Areas

Overview of Chronic Disease Management

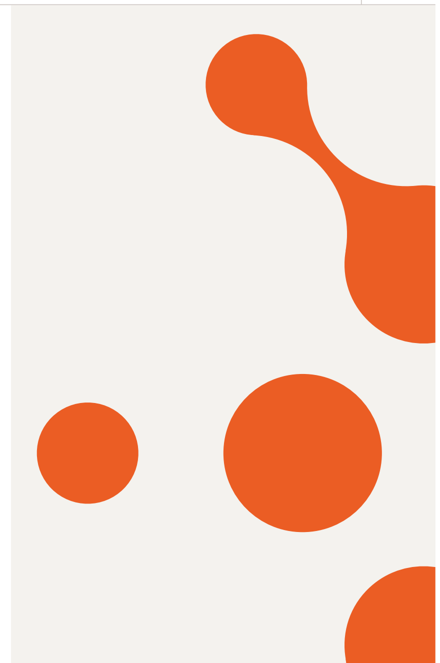
- Rural areas face higher rates of many of the most prevalent chronic diseases. Depending on the disease, different types of management activities and strategies may be appropriate.
- **Chronic disease management** focuses on improving the quality of care and well-being for people living with chronic diseases by improving access and coordination of healthcare services to facilitate self-management.
- Managing chronic diseases can involve various strategies and care approaches. Common management activities include:
  - Regular screenings
  - Medical visits
  - Monitoring
  - Care coordination
  - Managing medications
  - Education to improve the ability to self-manage chronic conditions



13

Module 2: Evidence-Based and Promising Chronic Disease Management Program Models

In this module:
- Chronic Disease Self-Management
- Behavior Change
- Medication Management
- Care Coordination
- Community Health Workers (CHWs) and Community Paramedics
- Chronic Care Model (CCM)
- Care Transitions
- Palliative Care



14

Chronic Disease Self-Management Programs

Self-management

- Refers to the activities and behaviors an individual undertakes to control and treat a chronic condition.
- The goal of self-management programs is to improve physical and emotional health and quality of life and minimize disease-related impairments.

The Chronic Disease Self-Management Program (CDSMP)

- CDSMP from the Self-Management Resource Center is an evidence-based chronic disease self-management program.
- Designed to increase self-efficacy among participants and improve the skills required to manage chronic conditions. CDSMP has been adapted for various chronic conditions.

15

Medication Management Models for Chronic Disease

- **Medication management** involves helping patients manage use of prescription medications, with the goal of helping ease symptoms and disease progression.
  - Medication adherence, or taking medications as prescribed, is important for managing and treating many chronic diseases.
- **Medication management models include:**
  - Medication therapy management (MTM)
  - Comprehensive medication management (CMM)

16

Behavior Change & Care Coordination Models for Chronic Disease Management

Behavior Change Models

- Behavior change models aim to help individuals adjust behaviors to promote and improve health.
- The Rural Health Promotion and Disease Prevention Toolkit describes theories and models for health promotion and disease prevention.

Health Promotion and Disease Prevention Toolkit

Learn about strategies and models for rural health promotion and disease prevention in the community, clinic, and workplace.

Care Coordination Models

- Care coordination models seek to streamline care strategies and coordinate communication among providers to minimize disease progression and improve quality of life.
- The Rural Care Coordination Toolkit provides detailed information about implementing care coordination models in rural communities.

Care Coordination Toolkit

Find models and program examples for delivering high-quality care across different rural healthcare settings.

Community Health Worker & Community Paramedic Models

Community health workers (CHWs)

- Provide chronic disease management by helping address individual- and community-level factors affecting chronic disease care and outcomes.
- Can mitigate barriers to accessing chronic disease care in rural areas by providing services within the patient's community, like at the local library, YMCA, community center, or home.

Community paramedics

- Like CHWs, paramedics and emergency medical technicians (EMTs) can serve as a bridge between the patient and provider.
- Community paramedics can provide medical services in the patient's home, facilitate telehealth visits in areas with limited internet access, and connect patients to CHWs for additional support.

Chronic Care Model

•The **Chronic Care Model (CCM)** is a framework for improving the quality of chronic disease management delivered to patients.

•CCM provides evidence-based guidelines that can be implemented to improve chronic disease care within different components of a healthcare system.

Care Transitions

- **Care transitions** models can help patients with chronic diseases who are transitioning between healthcare settings.
- The main goal of all care transitions models is to build a personalized patient care plan that addresses the patients' needs while providing a continuum of care.
- Three models that are commonly implemented in rural communities are:
  - Transitional Care Model (TCM)
  - Community-Based Transition Model (CBTM)
  - Coleman Care Transition Intervention (CTI)

Palliative Care Models for Chronic Disease Management

- **Palliative care** is a type of specialized care that eases the symptoms and stress of managing disease and focuses on improving quality of life.
  - Palliative care may include hospice care, but a terminal diagnosis is not necessary for receiving palliative care services.
- In rural areas, palliative care can be community-based, hospital-based, or delivered through home health services.

The Program Clearinghouse provides real-world examples of rural chronic disease management programs

- Access East
Synopsis: Helps improve health outcomes and quality of life for qualifying uninsured and underinsured residents in eastern North Carolina with chronic diseases. HealthAssist has developed three different programs to help patients access needed medications to manage their illnesses, acquire supplies for diabetes treatment, and meet other healthcare needs.

- Avera Health
Synopsis: Offers a care transitions program in rural South Dakota that uses remote patient monitoring to support patients with congestive heart failure after hospital discharge

- Delta Health Alliance
Synopsis: Provides chronic disease management through telehealth endocrine counseling and mobile primary care services to patients with diabetes in rural Mississippi.

- Great Mines Health Center: Mobile Integrated Healthcare
Synopsis: Uses a community paramedicine model to deliver care. MIH takes highly skilled emergency medical services staff into the homes of people living with chronic diseases, allowing them to receive quality medical care in their home and avoid expensive hospital visits.

- Lake County Tribal Health Consortium, Inc.
Synopsis: Offers chronic disease and diabetes self-management programs for Native American and Latino populations in rural Lakeport, California.

- Mainline Health Systems
Synopsis: Uses a patient-centered medical home model to provide intensive chronic disease case management, medication management, and other chronic disease programs to improve the health of residents of rural Southeast Arkansas.

- South Carolina Center for Rural and Primary Healthcare
Synopsis: Partnership between the University of South Carolina School of Medicine and the state's Department of Health and Human Services. The center funds programs to expand access to healthcare services, including chronic disease management, for rural communities in South Carolina.

- Sullivan 180
Synopsis: Nonprofit organization dedicated to building a healthy community through people, places, and policy. The Hands4Health Network was created to bring together county partners to review and select a community health worker program for Sullivan County residents living with a chronic disease.

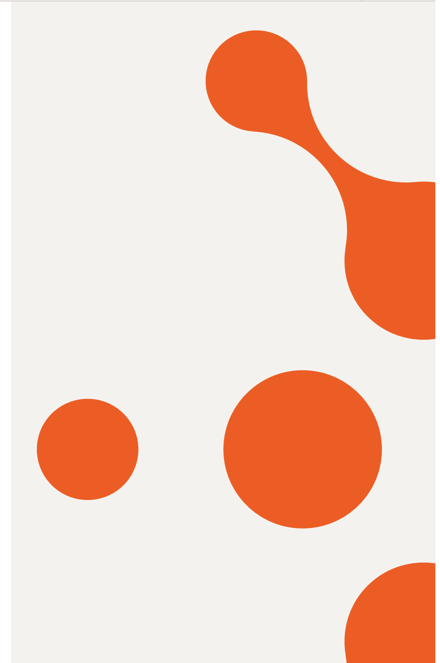
- West Virginia School of Osteopathic Medicine Center for Rural and Community Health (WVSOM CRCH)
Synopsis: Empowers communities to reach their highest level of health and wellness through education, research, and evidence-based programs. The center offers training services to become a Community Health Education Resource Person (CHERP) and conducts workshops across West Virginia in chronic disease self-management, chronic pain self-management, and diabetes self-management.

Module 4: Implementation Strategies for Rural Chronic Disease Management Programs

Implementation

In this module:

- Staffing and Resource Considerations
- Community Partners and Outreach
- Transportation Considerations
- Population Considerations



23

Thank you.

Amy Rosenfeld
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24

How the Mobile Integrated Healthcare (MIH) model aligns with the Rural Chronic Disease Management Toolkit
November 7, 2024

DIVERSE | INCLUSIVE | WHOLE PERSON CARE

25

Mobile Integrated Healthcare From The 10,000 Ft. View

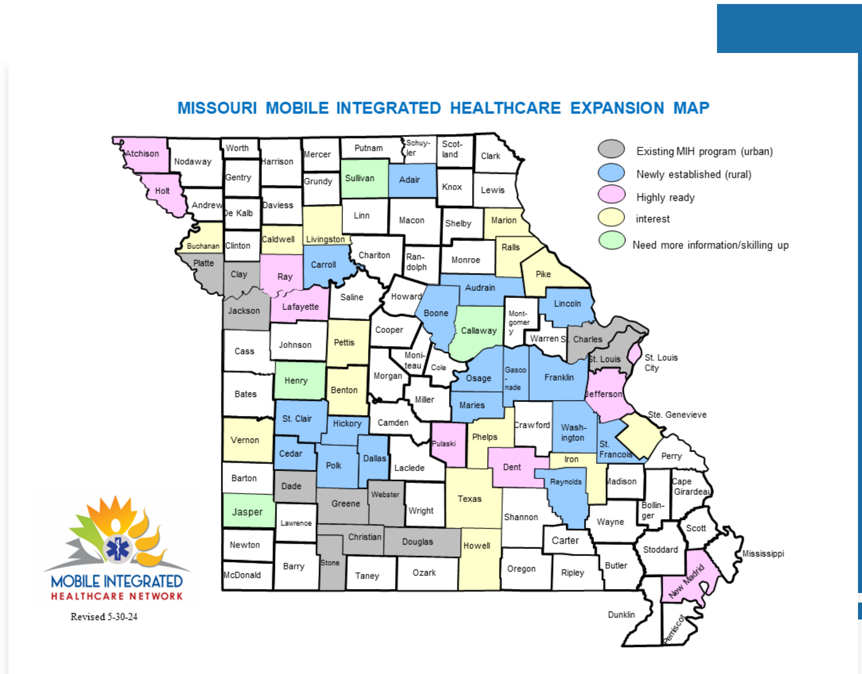
MISSION
Diverse | Inclusive | Whole Person Care

SYSTEM DESIGN
Community Paramedic / Community Health Workers serve as the bridge between the patient and the provider outside brick and mortar.

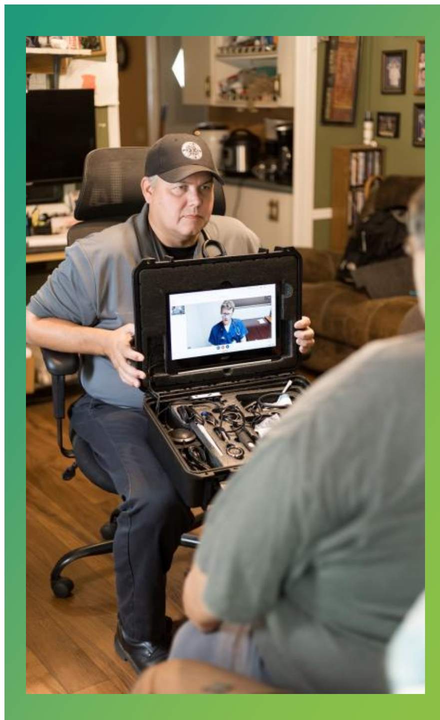
PROVIDE CARE
Initiate care in the home with Community Paramedics.

CORE VALUES
Right Care | Right Place | Right Time

26



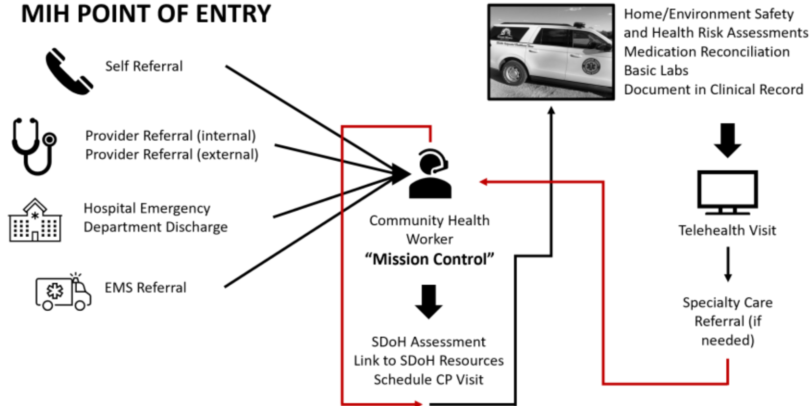
27



Our Model

Goal	Goal 1 •Take the healthcare to the patient
Goal	Goal 2 •Serve as the bridge and the glue
Goal	Goal 3 •Flow based / standing order-based care
Goal	Goal 4 •Have telehealth available 100% of the time
Goal	Goal 5 •Take the "provider centric" model to a "patient centric" model of care
Goal	Goal 6 •Engage and collaborate with all provider types inside & outside of the brick and mortar setting

28



EMS - REFERRAL AGNOSTIC

FQHC | CAH | RHC | Large Healthcare Systems | Private Physicians | Anyone & Everyone

29

30

MIH SERVICES

- Chronic Disease Management
- Telehealth Provider Appointments
- In-Home Diagnostics
- In-Home Point of Care Testing
- In-Home Infusions
- In-Home Vaccines
- Care Gap Closure
- Lab Collection
- Wound Care
- Wellness Checks
- SDOH Assessment, Navigation and Resource Support
- In-Home Safety Assessments
- Medication Reconciliation
- Care Coordination
- Non-Emergency Transportation
- Public Health Support
- Home Health Bridge Support
- Hospice Bridge Support
- No-Call, No-Show Follow Up
- Direct Hospice Support
- Direct Health Support

31

HRSA Primary Care Challenge
1st Place 2023

The Washington County MIH Network was awarded FIRST PLACE in the HRSA nationwide competition, "Building Bridges to Better Health: A Primary Health Care Challenge."

32

Integration of Care & Gap Closure

Integrated Care

- Whole person care
- Co-location
- Shared talent

Care Gap Closure

- CHWs
- Telehealth
- Workforce training & education

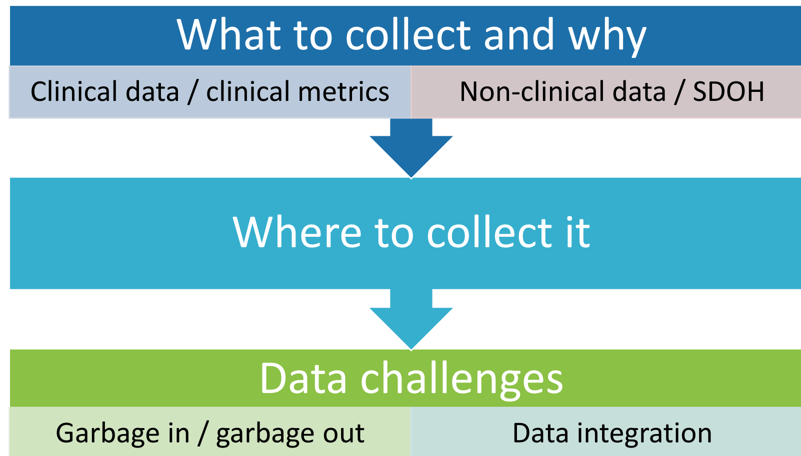
33

Why it works

- Integrated Care
- Licensed CP as the "eyes and ears" of the provider in clinic
- Think primary care / chronic disease but emphasize "whole person"
- Success Story
  - Trust built over 2 years
  - Poor living conditions
  - Several unmanaged diagnoses
  - Hopelessness

34

DATA & Compliance



35

Impact of Care Gap Closure

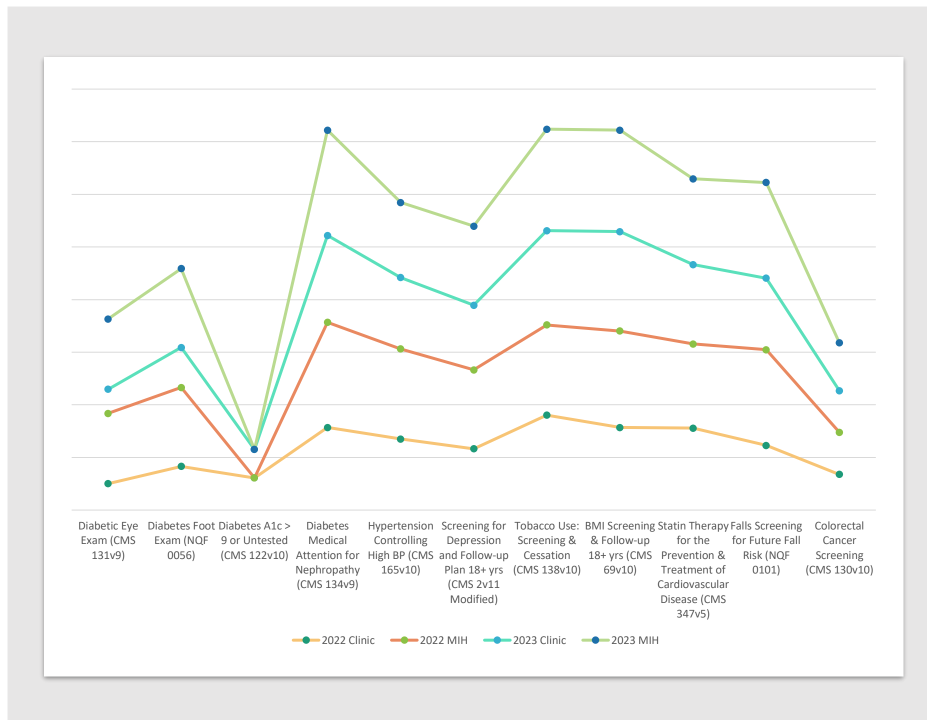
- Improved patient adherence to appointments
- Fewer ED visit
- Fewer EMS calls
- Improved medication compliance
- Improve patient quality of life

36

Clinical Quality Data | CY 2023

Clinical Quality Measure	All Clinic Patients	MIH Cohort
Diabetic Eye Exam (CMS 131v9)	**23%**	**66.7%**
Diabetes Foot Exam (NQF 0056)	**38%**	**75.0%**
Diabetes A1c > 9 or Untested (CMS 122v10)	**27%**	**0.0%**
Diabetes Medical Attention for Nephropathy (CMS 134v9)	**82.6%**	**100.0%**
Hypertension Controlling High BP (CMS 165v10)	**67.8%**	**71.2%**
Screening for Depression and Follow-up Plan 18+ yrs (CMS 2v11 Modified)	**61.5%**	**75.0%**
Tobacco Use: Screening & Cessation (CMS 138v10)	**89.6%**	**96.4**
BMI Screening & Follow-up 18+ yrs (CMS 69v10)	**94.5%**	**96.4%**
Statin Therapy for the Prevention & Treatment of Cardiovascular Disease (CMS 347v5)	**75.4%**	**81.4%**
Falls Screening for Future Fall Risk (NQF 0101)	**68%**	**90.9%**
Colorectal Cancer Screening (CMS 130v10)	**39.5%**	**45.6%**

37



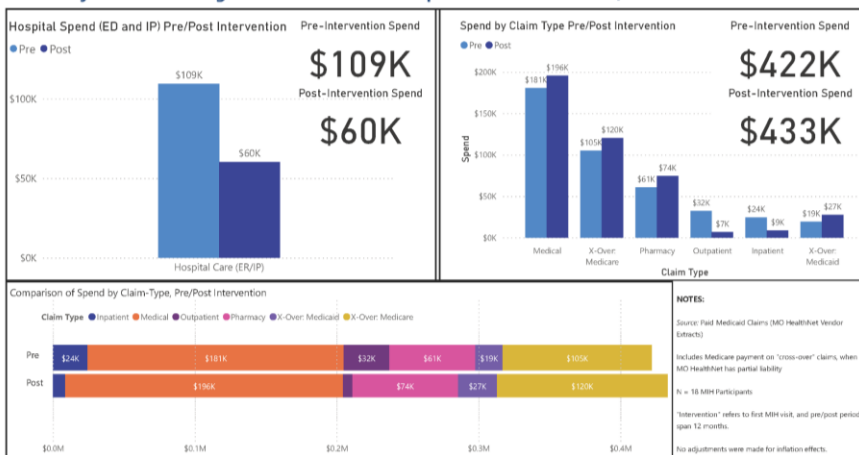
38

Documenting | Analysis

- Drives quality
- Ensures sustainability
- Enlist help of others with knowledge and resources
  - Funders
  - MoHealthNet
  - Medicaid MCOs
  - Missouri Primary Care Association

39

HRHI Heart Disease Project
Preliminary Data



40

Rural Chronic Disease Management Toolkit Alignment

- MIH networks/programs address key elements of chronic disease management best practices:
  - Chronic Disease Self-Management
  - Behavior Change
  - Medication Management
  - Care Coordination
  - Community Health Workers (CHWs) and Community Paramedics
  - Chronic Care Model (CCM)
  - Care Transitions
- The toolkit is a great resource for addressing SDOH, health equity and health literacy – all of which are encountered with populations served through mobile integrated healthcare networks/programs.

41

Cardiovascular Disease Intervention Project

- Contract between Missouri Department of Health & Senior Services and Missouri EMS Association
- Funded through Centers for Disease Control & Prevention
- Purpose:
  - Educate clients on risk of elevated blood pressure and hypertension
  - Risk of elevated cholesterol levels
  - Screen clients for SDOH
  - Collaborate with CHWs to refer clients for assistance to address barriers to completing lifestyle change programs
- In Year 2 – working with two MIH Networks
  - Citizen's Memorial Hospital
  - CoxHealth
- Goal is to engage with a total of six MIH networks over the five-year grant period
- Trained Community Paramedics provide the services in the home and can link patients to Self-Measure Blood Pressure kits for remote monitoring.

42

Data Collection

- Number of clients with hypertension or pre-hypertension identified
- Number of clients with high cholesterol identified
- Number of SDOH screenings conducted
- Number of referrals to lifestyle change programs or services
- Ideally, we hope sites will also monitor patient outcomes

43

CONTACT INFORMATION

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Co-founder & Partner

Washington County Mobile Integrated Healthcare Network

www.mihnetwork.org

44

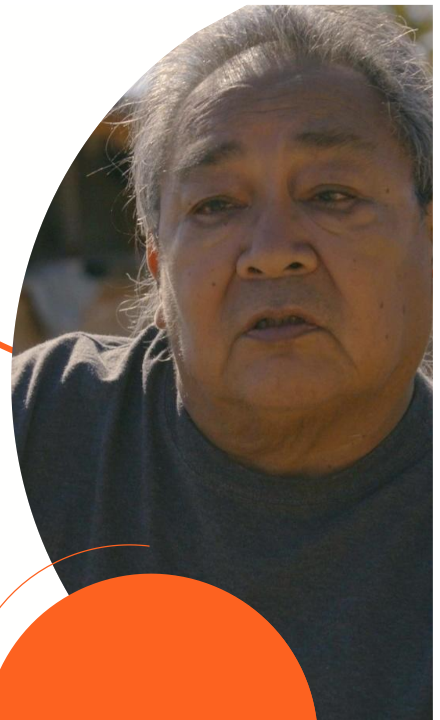
EMPOWERING HEALTH THROUGH CULTURE

Integrating Tradition to Combat Chronic Illness

45

What’s Holding Us Back

- **Limited Medical Resources**
- **Poverty & Culture of Poverty**
- **Language**
- **Cultural Understanding & Connection**
- **Poor Self-Management**
- **Negative Views on of Healthcare System**



46

Adverse Impact

When healthcare resources are limited, cultural and language barriers persist, and the lack of confidence in the healthcare system is existent, patients face **significant challenges** in managing their health. Without culturally relevant education, they **often adopt unhealthy habits**—such as consuming sugary drinks—leading to poorly managed conditions that compound over time. As patients continue developing additional chronic issues, their **quality of life declines**, and children grow up modeling habits that lead to chronic health issues, **continuing a cycle of poor health management**

47

Why Cultural Integration

Cultural integration **builds trust** by addressing historical mistrust, especially among Native American and Latino communities affected by systemic inequities. By respecting traditional practices, family dynamics, and cultural beliefs, healthcare providers foster open engagement and adherence to treatment. Patients who feel culturally understood are **more likely to participate** in regular care and self-management, leading to **improved health outcomes**. This partnership approach not only enhances immediate care but also lays the groundwork for healthier generations, helping to **break the cycle** of health disparities.

48

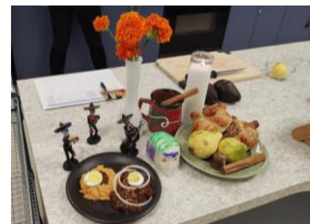
Cultural Integration Strategy

Building Relationships

Culturally Relevant Materials

49

Cultural Integration Strategy



Foster Culture in Programs

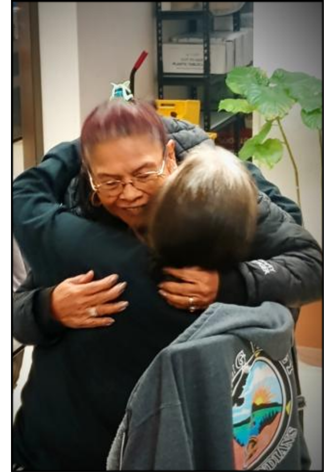
Continuity

50

Promising Results

Safe Spaces Rooted in Cultural Understanding: By creating culturally familiar environments, patients feel safe to open up about health challenges, making it easier to address behaviors and emotions that impact their wellness.

Empowering Self-Advocacy with Cultural Relevance: When care aligns with patients' language and cultural values, they feel seen and supported, motivating them to actively advocate for their health.



51

Promising Results

Promoting Health Improvements through Cultural Relevance: Integrating cultural knowledge into CDSME and DSME programs has led to specific behavior changes—like improved stamina, healthier food choices, and clinical improvements in A1c and blood pressure—showing that culturally relevant support makes a tangible difference.

Rekindling Trust with Culturally Sensitive Care: When patients see that providers respect their culture, trust grows. This has led to fewer missed appointments and better compliance with labs and check-ups, underscoring the power of cultural connection in healthcare.

52

Questions?

53

Thank you!

- Contact us at ruralhealthinfo.org with any questions
- Health Promotion and Disease Prevention Webinar 11/19 https://www.ruralhealthinfo.org/webinars/health-promotion-toolkit
- Please complete webinar survey
- Recording and transcript will be available on RHIhub website

54