COMMUNITY HEALTH PROGRAM

UTMB Health

utmb Health
Community
Health Program

About the Program

The Community Health Program's Outpatient Care Management Program is an integrated care and disease management model that focuses on high-risk, uninsured, UTMB Health patients with chronic diseases. The program focuses on the following chronic diseases:

- *Congestive heart failure*
- *Diabetes*
- *Chronic obstructive pulmonary disease*
- *Renal disease*
- *Cellulitis*
- *Coronary artery disease*
- *High-risk hypertension*
- *Liver disease*
- *Asthma*
- *Other diseases as needed*

The goals of the Community Health Program are to improve disease management by supporting treatment compliance, reduce complications from chronic disease, establish patient with a primary care provider, and decrease utilization of acute care services related to chronic disease.

Patients enrolled in the program receive the benefit of a care manager who acts as a disease-state manager and helps the patient navigate the health care system. Care managers provide the following services over the telephone and during face-to-face sessions with the patient at their home or a primary care clinical visit:

- *Disease education*
- *Pharmaceutical assistance programs*
- *Goal-setting and monitoring for self-mgmt.*
- *Guidance in obtaining Medicare and other assistance*
- *Securing a medical home*
- *Referrals to disease education classes*
- *Referrals to social service organizations*
- *Care coordination/health system navigation*

Program Evaluation

The program evaluation was retrospective and included 83 patients enrolled in the program between April 1, 2007 and August 31, 2008. Evaluation highlights are as follows:

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Demographics and Disease Condition

- Demographic Characteristics
  - 60% female
  - 52% non-Hispanic white
  - 73% over the age of 50
- Chronic Diseases
  - Diabetes
  - Hypertension
  - Congestive Heart Failure
  - Coronary Artery Disease
- The patient population used for this evaluation was required to be enrolled in the program for a minimum of 6 months and have a minimum of 2 case management encounters. They were required to have 1 or more of the program diagnoses and at least 1 acute encounter at UTMB within the 12 months prior to enrollment in the Community Health Program.
- 70% of the study cohort was enrolled in the program for 12 months or more. The longest length of time on the program for this cohort was 17 months.
- Interventions were provided at home visits, over the telephone and at provider clinic visits.

Diagnoses and Co-Morbidities

- 88% with Hypertension
- 53% with Diabetes
- 42% with CAD
- 30% with CHF
- 84.3% of the patients were multi-morbid and of those, 28.9% had 4 or more program specific chronic diseases

Utilization

- 53% reduction in inpatient hospital admissions
- 62% reduction in acute encounters (not admitted)

Costs of Care

- 41% reduction in overall aggregate costs
- 62% decrease in acute encounter costs
- 53% decrease in inpatient hospital admission costs
- 143% increase in outpatient (primary & specialty care) costs
- The greatest overall cost reductions were seen in Hispanics (-59%) and those under age 50 (-51.3%)

For more information contact:
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