Implementing a Chronic Disease Management Registry Program
AIM
Implement a chronic care registry that provides support to providers in managing health care for patients enrolled in a medical home and who have chronic care conditions.

TARGET POPULATION
Patient’s with chronic care conditions such as Diabetes, Congestive Heart Failure (CHF), Chronic Kidney Disease (CKD), Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Pediatric Asthma, and Adult/Pediatric Obesity.

NEED FOR PROJECT
Approximately 30,000 of Parkland’s patient population have or are at high risk of being diabetic. Many other patients have one or multiple conditions or comorbidities. Implementing a registry will give providers the tools to monitor/track care of patients with specific needs. Such proactive management of patients will improve quality of care as well as decrease high cost utilization within the system.
Key Needs:
Identify Target Populations
Provide Detail per Disease
Integrate Data into Clinical Workflows
Provide Intervention Mechanics
Measure Outcomes and Performance

Disease Specific Registries
Hx and Current Tables
EHR Tools
Self Service Reporting
Alignment with Category 3 Measures / Stratification
Impact:

- Reduction in HbA1c poor control (>9.0%)
- Improved Retinal Eye Screening for Diabetic Patients
- Improved Annual Monitoring for Patients on Persistent Medications – ACE/ARBs
- Reduction in All-Cause Readmissions

Patient Story:

Patient Doris Mondragon, 46, of Dallas developed gestational diabetes when pregnant 13 years ago. She appreciates the regular contact with nurse navigator Theresa Lira, RN.

“Theresa calls me every two weeks to check on how I’m feeling and remind me of my clinic appointments,” Mondragon said. “The staff taught me how to give myself insulin injections and helped me find a primary care provider at the Parkland clinic near where I live. I’m really, really happy with the care at Parkland and I’m feeling better than I did before.”