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Evaluation of a Chronic CareManagement Model for Improving Efficiency and Fiscal Sustainability

Chronic care management is effective. Barriers to program durability include dependence on the provider–nurse duo to carry out labor-intensive services and the lack of a fiscally sustainable model. Between January and October 2022, an expanded chronic care management team—consisting of a provider, nurse, community health worker, and pharmacist—conducted a four-month intervention in an ambulatory setting. This intervention, using a convenience sample of 134 Medicare patients with uncontrolled type 2 diabetes or hypertension, demonstrated statistically significant improvements in controlling type 2 diabetes ($P < .01$) and blood pressure ($P < .001$). Direct provider workload decreased, and the Medicare reimbursement rate was 85.5%.

Keywords: care management team, Community health worker

Biography

board-certified-Internist, Clinical Specialist at the Virginia Department of Health; 40 years of broad-based experience in academia, managed care and ambulatory care; Founder of the Clinical Research Center at Morehouse School of Medicine; have sat on numerous committee/panels addressing issues such as Ethics and Health Care Management, Hospice care, Medical Treatment Effectiveness and Education of Health Care Providers; formerly grant reviewer for Health Resources Services Administration and NIH; have worked very closely with Federal, State and local governmental bodies on critical health care issues. Have received over 25 awards.

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