Chronic Care Management in Primary Care: A Needs Assessment

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Purpose

To conduct a needs' assessment of a primary care safety net clinic's capacity to address care of patients with chronic conditions.

Stakeholder

The stakeholders for this project are the clinic director, manager, physician and nurse practitioners of a new primary care clinic as well as the Nurse Navigator from the Internal Medicine Clinic who is the local subject expert.

Definition

Chronic condition:

Defined as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both. (Centers for Disease Control and Prevention, 2021)

Ethics

- IRB Number: 21-35
- The Colorado Mesa University Institutional Review Board (IRB) deemed this project to not be research involving human subjects as defined by 45 CFR 46.102(e).

Background & Methods

Data collection:

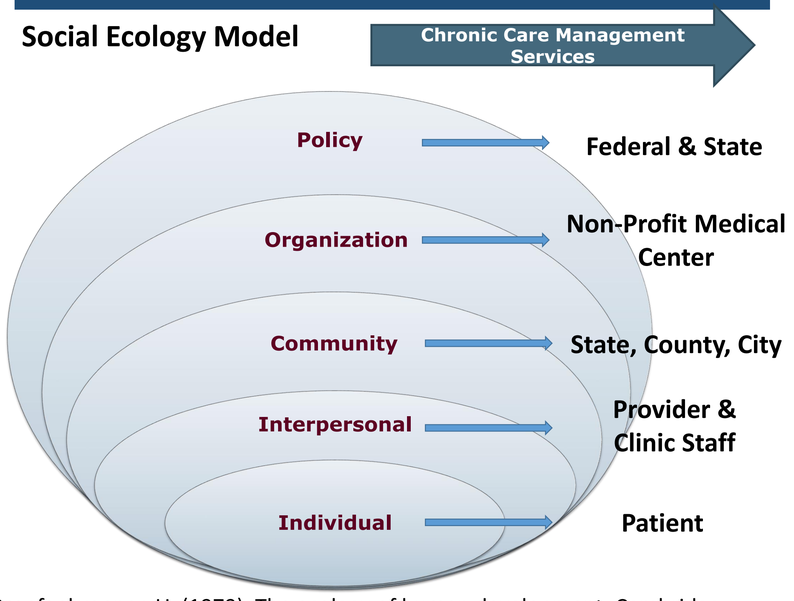
Direct observation of patient flow
Informal one-on-one Interviews
Chart review for representative sample
Letter of interest sent to qualifying patients
Internet search at community and policy level

Process:

Periodic meetings with stakeholder
Data recorded in field notebook
Written summaries posted in online classroom
Weekly feedback from faculty & peers
Weekly SMART goals developed

Methods

Social Ecology Model



- Bronfenbrenner, U. (1979). The ecology of human development. Cambridge, MA: Harvard University Press

The social ecology model as described by Bronfenbrenner and the CDC was used as the framework to organize the data for my needs' assessment inventory.

- Individual level if focused on the patient living with two or more chronic conditions.
- Interpersonal level is focused on the relationship between the patient and the provider and clinic staff.
- Community level includes the patient's social unit and where the interpersonal interactions take place on a day-to-day basis. For the purposes of this project, it includes the state, county, and city in which the patient lives.
- Organization level includes the non-profit medical center where the patient receives medical care.
- Policy level includes the federal and state policies that affect the quality and availability of the health care resources available to the patient.

Results

Individual Level

Gap	Need
Patients with complex chronic care needs & insufficient chronic care (by self or others)	Chronic care access

Interpersonal Level

Gap	Need
Lack of provider awareness and understanding of CCM services	Increase provider awareness and utilization of CCM services

Community Level

Gap	Need
Poorly organized community-based systems in place	Increase organization of community-based systems

Organizational Level

Gap	Need
No organized process for implementing CCM services	Organized process for implementing CCM services

Policy Level

Gap	Need
Selected populations with barriers to access chronic care services	Remove barriers to access chronic care services

Summary

Stakeholder's Identified Need

- Individual -> Chronic care access
- Interpersonal -> Increase provider awareness and utilization of CCM services
- Community -> Increase organization of community-based systems
- Organizational -> Organized process for implementing CCM services
- Policy -> Remove barriers to access chronic care services

Recommendation

Standardize the process for providing CCM services among providers, staff, patients, and the community.

*Further references available on request