PROJECT OVERVIEW
ATTACHMENT B

Community-based Chronic Disease Management (CCDM)

HWPP PROJECT NUMBER 20071-06

PROJECT SUMMARY
Describe the major purpose of the project, the need and how it relates to the Health Improvement Model. Briefly describe the project's implementation plan, methods to be utilized and involvement of affected communities. Detail the community-academic partnership plan. Specify the evaluation method that will be used to measure feasible, quantifiable and significant outcomes and the impact the project will have on the health of Wisconsin residents. Do not exceed this one page.

To help prevent early deaths, heart attacks, strokes, renal failures, amputations and other health disparities, CCDM proposes to demonstrate the benefits of integrating screening and interventional services with low-cost and no cost interventions to increase adherence and thus prevent disease-related complications.

No shortage of both scholarly and lay press articles decry the epidemic of unchecked HTN, DM and obesity in US central cities. Impoverished African Americans are particularly at risk because of poor insurance coverage and high disease prevalence in this ethnic minority. CCDM seeks to eliminate health disparities related to chronic disease complications in Milwaukee's poor African American population by addressing "underlying causes of higher levels of disease and disability" as called for in the Health Improvement Model and described in Healthiest Wisconsin 2010.

To attract the poor, CCDM will establish its first Wellness Site at New Life Presbyterian Church Food Pantry, followed in six months by a Wellness Site at Divine Providence Food Pantry and a third in year two at the COA Goldin Center, with additional sites as deemed appropriate in year three.

A nurse, following a physician-supervised protocol, will manage preventive services, dispense prescribed medicine and teach clients to improve health through diet, exercise and medication—with more nurses trained as the program expands. MCW students will also play a vital role through service-learning experiences. A physician will oversee the protocol. Clerical staff will manage client flow and maintain records while a resource specialist will connect clients to community resources.

CCDM will invite participants to discuss program expansion using both qualitative and quantitative methods. Plans are to involve the larger community by encouraging members of churches and other groups to participate in wellness activities (e.g. ensure proper nutrition, monitor diseases and enroll in exercise clubs). CCDM especially values the input of the B.R.A.N.C.H Out nurses and the food pantry administrators as representative of their community.

The CCDM partnership joins the strengths of CSM's Bill Solberg, M.S.W., L.C.S.W., Director-Community Services with a background in managing community health programs, and MCW's James Sanders, M.D., M.P.H., Director-Community Medicine Track for residency training at CSM Family Health Center and a founder/Academic Partner for Healthier Wisconsin Partnership-funded Riverwest Health Initiative. Plans are to use the consulting expertise of Clarence Grim, B.S., M.S., M.D., and outreach skills of CSM's Julia Means, R.N., and Theresa Flaherty, R.N.

Additionally, the plans involve collaboration with the B.R.A.N.C.H Out churches (for pantry sites, referrals and client follow up), Saturday Clinic for the Uninsured, Columbia St. Mary's Family Health Center, MCW student groups, Riverwest Health Initiative and COA Goldin Center. Past accomplishments of all these demonstrate skills in and commitment to health care for the poor. Agreeing to shared principles, partners and collaborators communicate in meetings and informally to build strong relationships and attain measurable objectives, thus setting the standard for community-based, preventive health services.

CCDM contributes to two community outcomes: prevention of health disparities related to chronic disease complications in Milwaukee's poor African American population and demonstration of an evidence-based prevention model for reducing health disparities related to chronic disease complications in the urban poor—replicable in Milwaukee and other Wisconsin communities.

Evaluation will measure number of persons screened for DM, HTN and obesity (BMI); percent of previously uncontrolled DM and HTN people who are enrolled for preventive services, percent of those with blood pressure managed by low-cost medication; percent of those with HgA1c lowered by low-cost interventions, number of education sessions conducted for clients covering nutrition, weight control, smoking cessation and other chronic disease-related information; and patient knowledge, attitude, and perceptions around chronic disease topics, to impact Wisconsin residents by contributing to accomplishment of Healthiest Wisconsin 2010 objectives for access, prevention and health disparities.