Bridging the Gap through the PTN

Learning Objectives

1. Participants will recognize that counties have infrastructure to support patient referrals to local self-management and lifestyle change programs.

2. Participants will identify specific programs offered locally to assist patients prevent or manage a chronic disease.
Connect to Community Supports and Tools
Thrive in Value-Based Care

Health Care Providers

Build Networks

Community Pharmacists
Local Health Departments
Payers
Worksites
Community Organizations

Chronic Care Model

Community Resources, Systems & Environments

Health System
Health Care Organization

Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems

Productive Interactions

Informed, Activated & Connected Patient
Prepared Proactive Practice Team

Population Health Outcomes / Clinical Outcomes

Kansas Healthcare Collaborative
Leverage Existing Resources & Networks

Kansas Healthcare Collaborative
Leverage Resources

Compass PTN Training Event

2016 Training and Kick-off Event

Prune, April 29

KNEH/CO Conference Center
433 NW 12th Ave.
Topeka, KS

This one-day event is offered at no cost to Compass PTN participants and will provide overviews of the initiatives that are focused on better health, better health care and lower costs through quality improvement. The goal is to achieve transformed practices that provide higher quality of care under a business model that is sustainable and value-based purchasing environment. For more information, contact Roseanne Makiwaski, Program Director at 785-235-1764 ext. 1124 or email PTN@kccin.org.

Board Handsouts
- Health redesign
- Compass PTN: Preparing Clinicians for the Future
- Using Evidence to Effect Change
- Community Collaboration & Resources Panel
- IDME development
- Worksite changes
- Integrating Clinical Practice Into Ambulatory Care: Engaging Patients, Families & Community as an Engaged Team

IDME community resources
- Summits
- Chronic Disease Self-Management Program
- Diabetes Prevention Program
- Diabetes Self-Management Program
- Early Detection Works Program
- Enhance Fitness Program
- Kansas Tobacco Quitline

Bridging the Gap through the PTN

Health Care Providers

Local Health Departments

Community Organizations

Community Pharmacists

Worksites

Payers
References:

Slide 3: Chronic Care Model
Created by: Community Care of North Carolina

Slide 5: KDHE Supported Programs with local networks to connect with health care providers
Chronic Disease Self-Management Program (CDSMP)
Diabetes Self-Management Program (DSMP)
Diabetes Prevention Program (DPP)
Accessed online at http://www.toolsforbetterhealthks.org/

Slide 6: KDHE Supported Programs with local networks to connect with health care providers
Walk With Ease
Enhance Fitness
Stepping On
Tobacco Quitline
Accessed online at http://www.toolsforbetterhealthks.org/

Slide 7: County map of KDHE Supported Programs
Notes:
- Counties in green receive Chronic Disease Risk Reduction (CDRR) funding.
- Counties with cross hatching are 1422 communities. Chronic Disease Self-Management Education Program (CDSME) are geocoded to the street address of the facility.

Source:

Created by: Cynthia Snyder, KDHE Bureau of Health Promotion, January 25, 2016