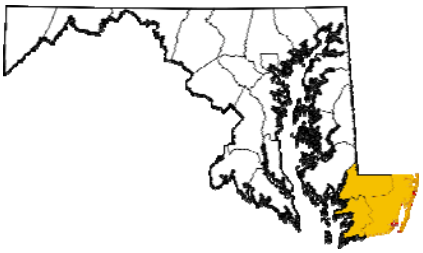
Tri-County Health Planning Board of Worcester, Wicomico and Somerset Counties

Reduction in Rate of Diabetes Related ER visits and

Racial disparity in ED visit rates

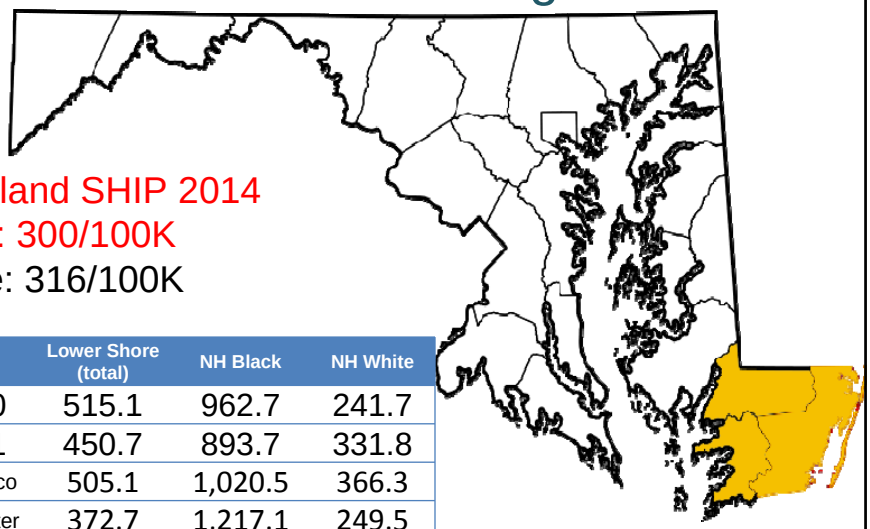
Through Evidence-Based Care Management



Maryland SHIP Objective 27

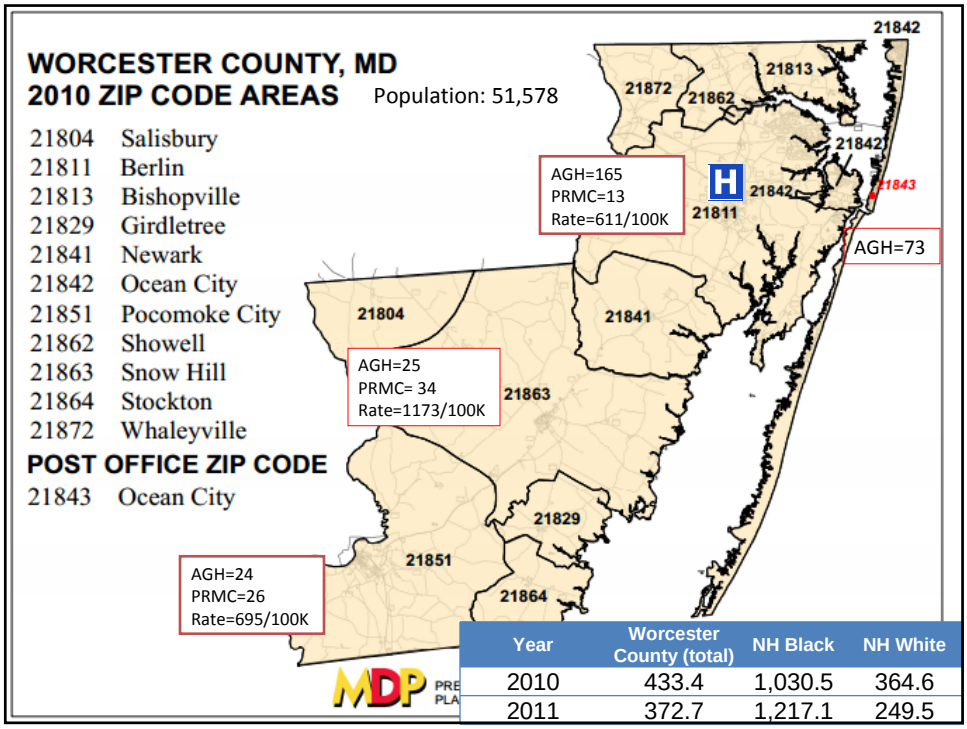
Diabetes Related ED Visits

Lower Shore Region

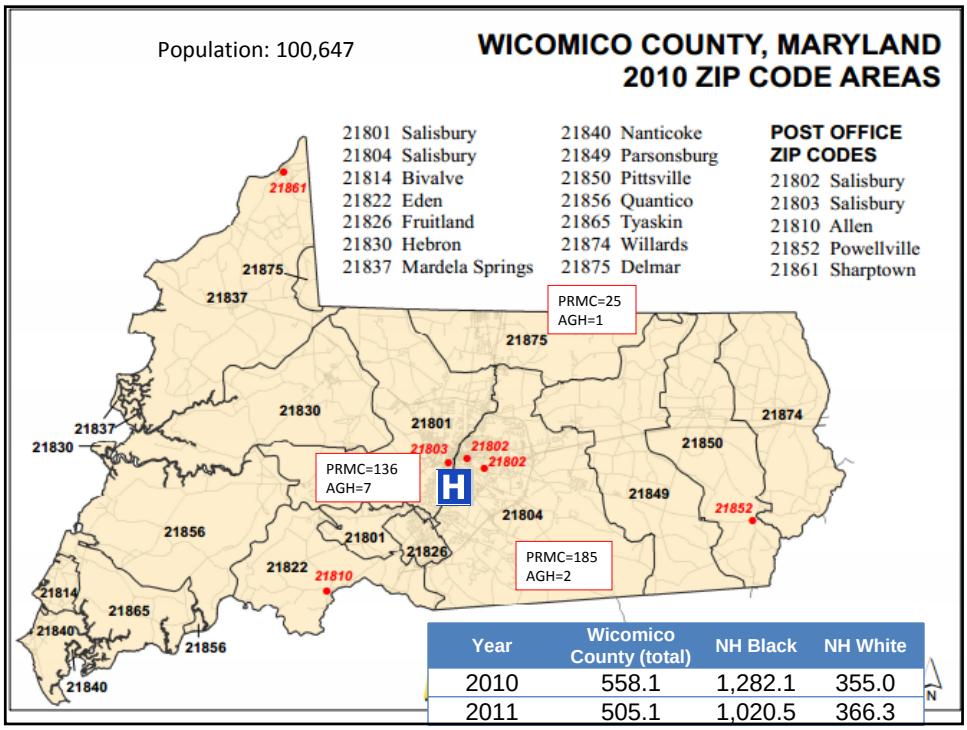


Maryland SHIP 2014
Goal: 300/100K
State: 316/100K

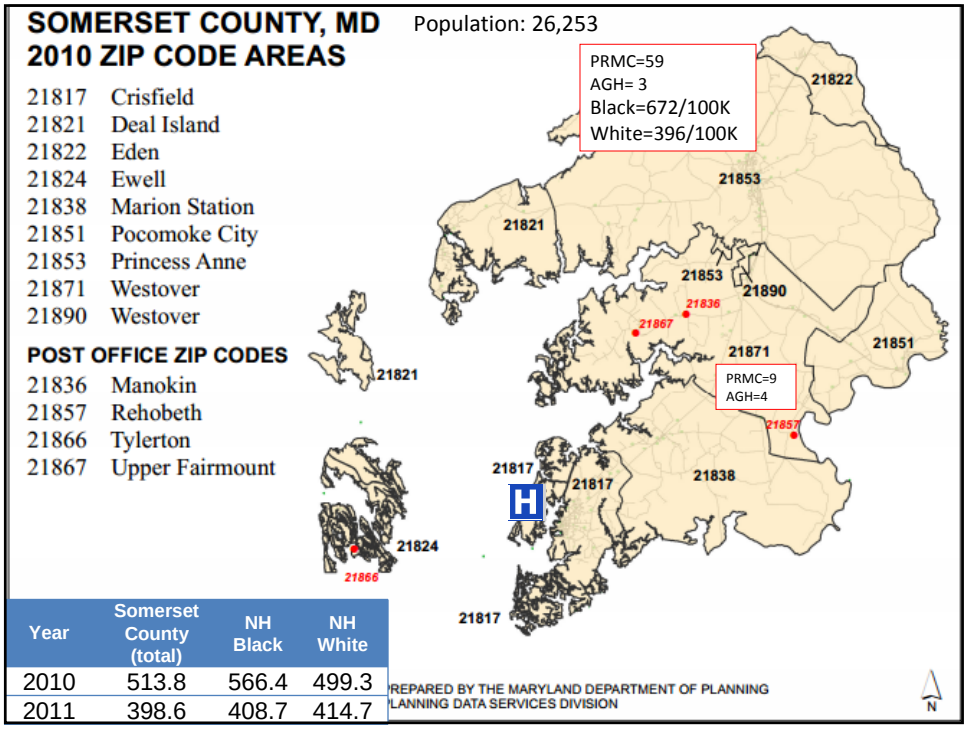
Year	Lower Shore (total)	NH Black	NH White
2010	515.1	962.7	241.7
2011	450.7	893.7	331.8
Wicomico	505.1	1,020.5	366.3
Worcester	372.7	1,217.1	249.5
Somerset	398.6	408.7	414.7



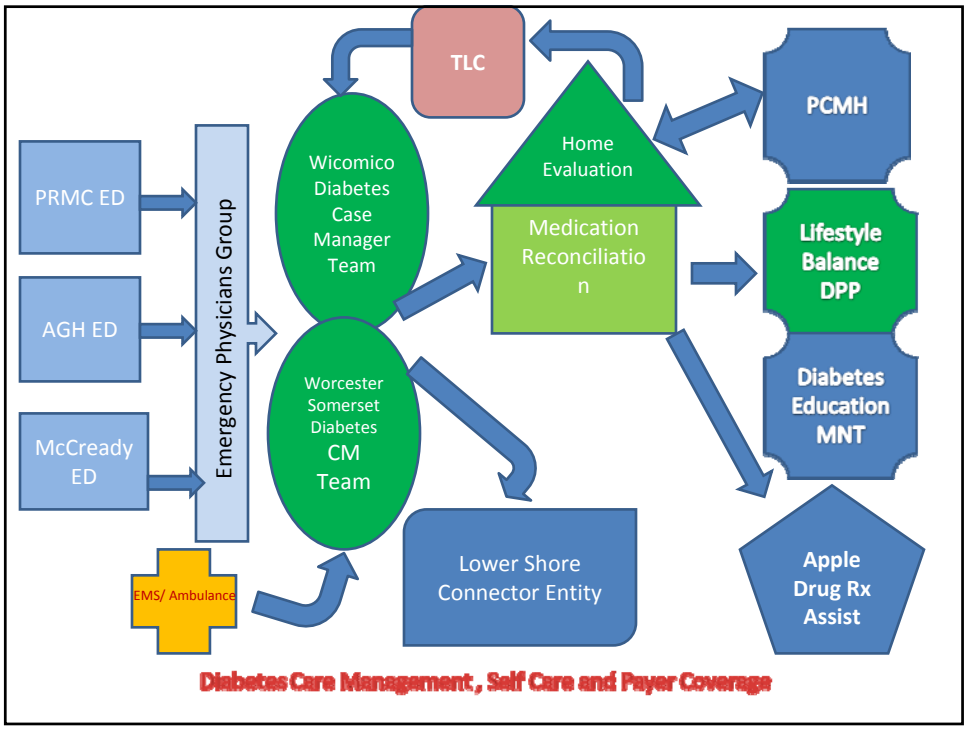
Year	Worcester County (total)	NH Black	NH White
2010	433.4	1,030.5	364.6
2011	372.7	1,217.1	249.5



Year	Wicomico County (total)	NH Black	NH White
2010	558.1	1,282.1	355.0
2011	505.1	1,020.5	366.3



Year	Somerset County (total)	NH Black	NH White
2010	513.8	566.4	499.3
2011	398.6	408.7	414.7



Fund Utilization

July 1, 2012 through September 30, 2013

	Somerset	Worcester	Wicomico	Total
Community Health Nurse II (RN)	0.5 FTE	0.5 FTE	1 FTE	2 FTE
LCSW –Social Worker	0.25 FTE	0.25 FTE	0.5 FTE	1 FTE
Health Outreach worker	0.25 FTE	0.25 FTE	0.5 FTE	1 FTE
Diabetes Management Program Staff	1 FTE	0.25 FTE	0.2 FTE	1.45 FTE
Total Staff				**5.45 FTE**
Data Map/Tracking				$7500
Home Visiting costs	Travel	Supplies	Phone, IT	$7827
TOTAL CHRC				**$250,000**
Matching funds				$25,000

Sustainability

- Diabetes Care Management evolution to billable service
- Calculate savings to ED- reinvest into program
- Primary Care partnerships- CM builds efficiency, savings to contract for CM services
- Public Payer shared savings programs- PCMH or like models
- Privatization of model- evolve to ACO or CHO
- Community Foundation or NPO funding

Partnerships

- TriCounty LHIC
- 3 Hospitals
  - ✓ AGH, PRMC, McCready
- Emergency Physicians Group
- 3 Local Health Depts
- Lower Shore Connector Entity
- Patient Medical Homes
- TLC- FQHC
- Diabetes Educators/ MNT
- Apple Drug Pharmacy

- TriCounty Diabetes Alliance
- Community Foundation
- Urgent Care Centers
- Emergency Services Responders

- Other resources/referrals
  - ✓ Behavioral Health
  - ✓ MA Transportation
  - ✓ MAP, AERS Nurse Managers
  - ✓ Go Getters

Evaluation

1. Quarterly Analysis of 3 ED data- "Hot spots"
2. Universal referral process into Diabetes Care Management
3. 2 Care Management Teams provide home evals, medication reviews
4. Patients complete Diabetes Education programs
5. Patients receive other services to avoid ED visits

6. CRISP enrollment for CM teams to promote Community Medical Record
7. Referral for insurer status to MD Connector Entity

Reduced Diabetes Related ED visit rate by October 15, 2014

Reduced racial disparities in ED visit rates by October 15, 2014

Questions?