STATE OF MARYLAND
Community Health Resources Commission
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Martin O'Malley, Governor - Anthony G. Brown, Lt. Governor
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LHIC Grant Application Cover Sheet FY 2013-FY 2014

State Health Improvement Process: Supporting Local Health Improvement Coalitions (LHICs) to Fuel Local Action and Improve Community Health

LHIC Designated Applicant Organization:

Name of Organization: Worcester County Health Department

Federal Identification Number (EIN): 52-1835864

Street Address: 6040 Public Landing Road

City: Snow Hill State: MD Zip Code: 21863 County: Worcester

LHIC Official Authorized to Execute Grants/Contracts:

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Phone: 410-632-1100 Fax: 410-632-1119

Signature: Deborah Goeller Date: 5/3/2013

LHIC Project Director (if different than the official authorized to execute contracts)

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Phone: 410-632-1100 x1004 Fax: 410-632-1119

Overall LHIC Grant Funding Request: $250,000

(Range of $150,000 to $250,000 may be provided by CHRC on a competitive basis; funding requests below $150,000 will also be received and considered).

Tri-County Health Improvement Plan (T-CHIP)

With Linkages to MD SHIP, February 29, 2012

	SHIP Objectives	Disease Continuum	Evidence-based Model	Lead Agencies & Partners	Strategies	Action Steps	Milestones& Outcomes
Chronic Disease	Reduce Diabetes Complications as measured by **SHIP 27. Reduce diabetes-related emergency department visits** **Tri-County SHIP: rate/100,000 Black 1110.8; White 257.5**(HSCRC- 2010)	Diabetes Risk Assessment	American Diabetes Association (ADA) Diabetes Risk Test	**Lead**: Somerset, Wicomico, and Worcester County Local Health Departments (LHDs) **Partners**: Local Hospitals, TCDA members	Tri County Diabetes Alliance (TCDA) continues screening and referral for diagnostic testing and follow-up, on-going, targeting Low SES, Underserved By December 31, 2012, diabetes risk test administration will become standard practice in clinical programs provided by the local health departments , such as WIC, Family Planning, Smoking Cessation, Dental, Cancer Screening, and Behavioral Health Programs.	1. Develop a policy for integration of Diabetes Risk Test administration in -to clinical programs offered through the Local Health Departments. 2. Provide follow up calls, emails or letters to individuals found to be 'at risk' to encourage further diagnostic screening. (i.e. primary care, Diabetes Clinics in Somerset/-Worcester) Individuals will also be referred to Diabetes Education, National Diabetes Prevention Program and Self-Directed Physical Activity Programs. 3. Refer individuals diagnosed with diabetes to the Outpatient Diabetes Self Management Programs provided by the local hospitals. (AGH, PRMC, McCready)	Copies of policies #screened #referred #diagnosed by race/ethnicity
		Primary Prevention	National Diabetes Prevention Program (NDPP)	**Lead**: Somerset, Wicomico, and Worcester County LHDs **Partners:** Worksites, faith-based organizations, recreation departments, community sites, and local YMCAs	TCDA to apply to MCHRC for funding to provide program in all 3 Counties, targeting Low SES, Underserved By December 31, 2012, local health department staff will be trained in the National Diabetes Prevention Program.	1. Coordinate NDPP "Lifestyle Change Coach" training for local health department staff. 2. Initiate, promote, and provide NDPP in Somerset, Wicomico, and Worcester Counties as resources allow. 3. Evaluate NDPP program outcomes and conduct follow up (one year). 4. Enroll NDPP participants and family members in free, self-directed, self-reported, incentive-based physical activity programs sponsored by the LHDs (such as the Just Walk Program in Worcester County)	# Staff trained, copies of certificates # participants # pounds lost by race/ethnicity

SHIP Objectives	Disease Continuum	Evidence-based Model	Lead Agencies & Partners	Strategies	Action Steps	Milestones& Outcomes
	Diabetes Self-Management for Control	Certified Diabetes Self-Management Education Programs	**Lead**: Atlantic General Hospital, McCready Foundation, and Peninsula Regional Medical Center **Partners:** LHDs, TCDA	TCDA promotes diabetes self management education for newly diagnosed and problematic diabetes patients by certified program and educators. By December 31, 2012, develop and implement a Social marketing Campaign highlighting the importance of Diabetes Self Management Education, targeting Low SES, Underserved	1. Develop and implement a community outreach and education campaign (Social Marketing Campaign) highlighting the importance of Diabetes Self-Management Education (DSME) provided by certified educators in outpatient programs (AGH, McCready, PRMC). Outreach may include billboards, advertisements, news releases, flyers, postings on the TCDA website, and TCDA Resource Guide. 2. Link/enroll participants that completed DSME with self-directed, self-reported, incentive-based physical activity programs sponsored by the LHDs (such as the Just Walk program in Worcester County). 3. Promote Diabetes Self Management Support Groups offered in the counties and establish a monthly Diabetes Support Group in Somerset County.	# patients by race/ethnicity # visits %improved A1C blood test Date of start up Copies of press releases, advertisements, flyers, and ancillaries
	System Infrastructure	Coalition Development Model: Tri-County Diabetes Alliance (TCDA)	**Lead**: Tri County Diabetes Alliance **Partners:** Atlantic General Hospital, McCready Foundation, and Peninsula Regional Medical Center	TCDA to review Emergency Department data for baseline in all 3 hospitals; explore other data for long and short term indicators; and recommend appropriate interventions. By December 31, 2012, establish a routine procedure for reviewing diabetes-related ER visits to recommend appropriate interventions, targeting Low SES, Underserved	1. Educate emergency department (ED) staff at all 3 hospitals about the Tri County Diabetes Alliance, Outpatient Diabetes Self-Management Programs, Diabetes Support groups, and the National Diabetes Prevention Program. 2. Establish a protocol that will ensure that patients presenting with diabetes related symptoms receive a TCDA Resource Guide upon discharge from ED.	Dates of Report on key indicators; adoption of new and monitoring reports on all indicators, new recommendations

SHIP Objectives	Disease Continuum	Evidence-based Model	Lead Agencies & Partners	Strategies	Action Steps	Milestones& Outcomes
SHIP 31. Reduce the proportion of children and adolescents who are considered obese. **Tri-County from SHIP: percent Total 15%; Black 20%; White 12%; Hispanic 18%**(MYTS 2010)	System Infrastructure	Coalition Develop-ment Model	**Lead:** Wicomico County Health Department **Partners:** Somerset and Worcester County Health Depts, Atlantic General Hosp., Peninsula Regional Medical Center, Deer's Head, Board of Education, Recreation Dept, University of Maryland Extension Service, Lower Shore Family YMCA, Consumer	By April 1, 2012 establish a Tri-County Healthy Weight Coalition.	1. Determine Coalition name and leadership. 2. Develop mission, goals, and objectives. 3. Recruit members. 4. Set regular meeting dates and locations.	Copies of Meeting Minutes Copy of Mission, goals, objectives, and membership list.

	SHIP Objectives	Disease Continuum	Evidence-based Model	Lead Agencies & Partners	Strategies	Action Steps	Milestones& Outcomes
Chronic Disease		Planning		**Lead:** Wicomico County Health Department **Partners:** Somerset and Worcester County Health Departments, Atlantic General Hospital, Peninsula Regional Medical Center, Deer's Head, Board of Education, Recreation Department, University of Maryland Extension Service, Lower Shore Family YMCA, Consumer	By December 31, 2012 collect and review local data to establish baseline measures related to children and adolescents weight in order to establish coalition priorities, esp. low SES and Underserved.	1. Review data sources related to collecting BMI for-age- percentiles (i.e. B.O. E., WIC, MYTS) 2. Establish baseline for each county. 3. Determine if disparities exist. 4. Develop a plan to address problems identified. 5. Share findings and recommendations to School Health Council. 6. Assist in updating School Wellness Policy.	Report in committee minutes Copy of findings and recommendations.
		Healthy Eating		**Lead:** Tri County Healthy Weight Coalition **Partners:** Board of Education, Recreation Department,	By December 31, 2012, establish policies or practices to increase awareness of healthy food options, esp. low SES and Underserved. .	1. Develop a resource guide of local farmers markets, grocery stores, co-ops. 2. Promote "MyPlate" resources 3. Educate the public about healthy eating on a budget. 4. Promote healthy food options and policies at gatherings (i.e. Schools, workplaces)using promising practices.	Report in committee minutes

SHIP Objectives	Disease Continuum	Evidence-based Model	Lead Agencies & Partners	Strategies	Action Steps	Milestones& Outcomes
			faith-based community, worksites.			
	Physical Activity		**Lead:** Tri County Healthy Weight Coalition **Partners:** Board of Education, Recreation Department, faith-based community, worksites	By December 31, 2012, establish policies or practices to promote and integrate physical activity for all children and families.	1. Develop policies that increase physical activity for children in school and during after school hours. (example- Instant Recess, Take 10, Self-directed, self-reported, incentive-based physical activity programs) 2. Promote Healthy Lifestyle choices for families esp. low SES and Underserved.	Report in committee minutes

1. Abbreviations: **MYTS** – Maryland Youth Tobacco Survey; **TCDA** – Tri-county Diabetes Alliance; **SHIP** – State Health Improvement Process
2. SHIP 25. Reduce deaths from heart disease and other SHIP objectives may be improved as both priorities are risk factors for other health conditions.
3. T-CHIP activities will include monitoring Years of Potential Life Lost to age 75 rather than SHIP 25 as we want to reduce premature deaths from heart disease – Note: Death data is always 3 years behind.
4. Each committee will have primary responsibility for their own objectives and activities and report to the Tri-County Health Planning Board for advice and oversight.

Tri-County Health Improvement Plan (T-CHIP) Grant Application for Diabetes Chronic Care Management to Reduce t Diabetes Related ED visits and Health Disparities
Project Narrative

The Tri-County (Somerset, Wicomico, and Worcester Counties) community of the Lower Eastern Shore of Maryland through the Tri-County Health Planning Board (Local Health Improvement Coalition) developed the Tri-County Health Improvement Plan (T-CHIP). The Tri-county Health Improvement Plan focuses on a limited number of initiatives that may reasonably be accomplished across the three-county region. Each county has its own CHIP which reflects the county-specific SHIP, Healthy People and County Health Rankings priorities. The T-CHIP includes only those goals which are shared as SHIP priorities among all three counties. Certain goals, specifically Cardiovascular Diseases, hypertension, tobacco use, and physical activity, are addressed in the county-specific CHIPs. The T-CHIP as attached is approved by Maryland *State Health Improvement Process (SHIP),* and has linkages to Maryland's *SHIP.* (Attachment 1)

Since 2010, the Tri-County Health Improvement Coalition has implemented several projects to focus on primary diabetes prevention, early screening, diagnosis, and diabetes education, and self- management. All three counties have implemented the National Diabetes Prevention Program (NDPP) which promotes healthy lifestyle practices to prevent and delay diabetes. The NDPP is a labor intensive case management program that uses "Lifestyle Coaches" as instructors. Target populations have included individuals at risk for type 2 diabetes due to family history, overweight, lack of physical activity, and age. Significant improvements in program participants have been documented. The combined goals of weight loss and increased physical activity help reduce the risk for diabetes, improve diabetes blood glucose control, reduce high blood pressure, improve cholesterol levels, and reduce overall risk for heart disease. However, the T-CHIP strategic action plan identified as of February 2012 to specifically reduce diabetes related ED visits in the region has not yet been fully implemented. Specifically, the strategies related to improving Health System Infrastructure have not been implemented.

The **overall goal** for this project is to reduce Diabetes related Emergency Department (ED) visit rates (Maryland SHIP Objective 27) and associated racial disparities among residents of Somerset, Wicomico, and Worcester Counties. As the designated lead and applicant organization, Worcester County Health Department requests funding from the Maryland Community Health Resources Commission to support a new project of the LHIC, aimed at expanding efforts beyond activities currently implemented by the LHIC. Funding of $250,000 is requested to implement an evidence based program of Diabetes Chronic Care Management during the period of July 1, 2012 through September 30, 2013 (15 months) in the three Lower Shore counties.

<u>Somerset, Wicomico and Worcester Counties Data Analysis</u>

Tri-County citizens are being diagnosed with diabetes at an alarming rate of 14.3 percent versus Maryland's rate of 8.3 percent as noted in the *2009 Community Health Assessment* by Professional Research Consultants, Inc. The high prevalence poses a burden to both patients and the health care system, especially emergency department use. According to data analysis of 2010 MD HSCRC data provided by the Maryland SHIP, the three Lower Shore counties fall within the worst 8 counties in Maryland for Diabetes Related ED visit rates. The collective rate for the three Lower Shore counties for Diabetes related ED visits due to diabetes was 515.1 per 100,000 which was significantly higher than the state rate (316.0 per 100,000). The combined ED visit rate for blacks was four times higher than the rate for whites (962.7 vs. 251.7 per 100,000

respectively). Disparities are particularly notable in Worcester and Wicomico County, in which the ED visit rate for blacks was 3.6 to 4 times the rate for whites in 2010. While there have been modest improvements in the overall rate of ED visits between 2010 and 2011, the racial disparity actually worsened in Worcester County, rising from 2.8 to 4.8 times the rate for blacks compared to whites in 2011.

Table 1: Diabetes ED Visits by age and race/ethnicity, Worcester County, 2011

	Total		20-44 years old		45-64 years old		65+ years old	
Worcester County Race/ethnicity	Count	Rate	Count	Rate	Count	Rate	Count	Rate
	192	372.7	50	387.4	75	462.9	62	510.1
NH black	85	1,202.9	23	1,119.8	28	1,405.6	30	2,742.2
NH white	103	249.5	25	257.4	47	344.3	31	285.7

Note: Prepared by E. Erdem and C. Bell, State Health Improvement Process (SHIP), Office of Population Health Improvement. ED visits from Health Services Cost Review Commission (HSCRC). Population counts from Maryland Department of Planning. NH=Non-Hispanic.

Recently updated analysis of HSCRC ED data from the Maryland SHIP shows modest reduction of diabetes-related emergency department visit rates and disparities for the Tri-County area in 2012. (Attachment 2) However, the rates of Diabetes related ED visits in all three Lower Shore Counties are still significantly worse than the Maryland SHIP 2014 Target rate of 300.2/100,000 population.

The 2012 T-CHIP strategy aimed at reducing Diabetes related ED visits called for a partnership between the Tri-County Diabetes Alliance and the three community hospitals to review Emergency Department data for baseline in all 3 hospitals, explore other data for long and short term indicators; and recommend appropriate interventions to reduce diabetes-related ED visits.

In response to this RFP, an evaluation of ED data was undertaken to assist in designing the proposed intervention. With the cooperation of Atlantic General Hospital (AGH) and Peninsula Regional Hospital (PRMC), the Worcester County Health Department obtained the Diabetes Related ED visit data for visits which occurred from July 1, 2012 through the present. This information included the age, race, zip code, county of residence, payer source and ICD-9 codes for episodes of ED care, but did not include the name or street address of patients. Dr. Andrea Mathias, Deputy Health Officer for Worcester County, reviewed this data for demographic determinants, payer mix, patterns of use, and geographic distribution or "hot spots". This information will be used to focus a targeted intervention to prevent Diabetes-related ED visits. If funded, this program will be able to obtain patient specific information in a HIPAA compliant manner for the purpose of care management and coordination.

An analysis of ED visit data from Atlantic General Hospital in Worcester County revealed:

- Approximately 50% of patients were primarily covered by Medicare, and an additional 20% were covered by Medicaid payers, or self-pay.
- 39% of patients seen are over the age of 65.
- 76% of patients are identified as "white", while 22% are identified as "black".
- 88% of the visits to AGH ED from residents of the Tri-County area occurred from residents within Worcester County, and

- 48% of the visits from Worcester County residents occurred from patients who live in the single zip code 21811. Based on census population, the rate of ED visits for this zip code area is over 611/100,000. (Attachment 3)
- Approximately 60 patients had 2 or more visits related to diabetes in the period, and 10 patients had 3 or more visits in the period evaluated. Five of the 10 highest utilizers reside in a single zip code within Worcester County- 21811.
- From Worcester residents in the Zip Code 21863 there were 25 visits to AGH and 34 to PRMC, giving this Zip code an ED visit rate of 1173/100,000K. One of the 10 high ED utilizers reside in this community. Interestingly, 76% of the patients in this Zip with ED visits to either AGH or PRMC are younger than age 65
- From Worcester residents in Zip Code 21851 there were 24 ER visits to AGH and 28 visits to PRMC, giving this Zip code an ED visit rate of 695/100,000. Two of the high ED utilizers live in this community, and they are uninsured.

An analysis of PRMC ED data in Wicomico County showed the following:
(Attachment 4,5)

- 42% of patients were covered by Medicare and an additional 25% are covered by Medicaid or self pay.
- 37% of patients are over the age of 65.
- 47% of patients are identified as "white" and 49% of patients are identified as "black".
- 72% of the visits to PRMC from residents of the Tri-County area occurred from residents of Wicomico County.
- 73% of visits from Wicomico County residents occurred from patients residing in 3 zip codes in Wicomico county (21801, 21804 and 21875)
- In Wicomico County residents, 14 patients had 3 or more visits, with some having 6 to 10 visits in the period evaluated. 10 of the 14 patients live in the 3 zip codes identified as 'hot spots" for high utilizers in Wicomico County.

For Somerset County, the Zip Code 21853 appears to be a hot spot of frequent ED utilizers for Diabetes related illness. (See Attachment 6)

- From Somerset residents of Zip code 21853 there were 59 visits to PRMC and 3 visits to AGH. The rate of ED visits for this area is at least 557/100,000, and this does not include zip code level data for visits to McCready
- Black residents in this Zip code contributed 43 visits to PRMC for a rate of 672/100,000 of the black population. White residents contributed 15 visits to PRMC, plus 3 to AGH, for a rate of 395/100,000 white population. While HSCRC data for the entire county did not demonstrate as significant a racial disparity, when broken down further geographically, there are clearly "hot spot" areas of racial disparity in Somerset County.
- 58% of the ED visits from this Zip Code were covered by Medicare or Medicaid.
- 4 patients contributed 19 visits to PRMC and 3 visits to AGH from the 21853 Zip code.
- Further analysis is needed of zip code level data for McCready ED visits, but will be undertaken as a part of the next action steps of the program if funded.

The Proposed Evidence Based Intervention: (Attachment 7- Summary slide)
This Lower Shore Tri-County Health Improvement initiative proposes innovative partnerships across three counties, to implement a regional Diabetes Care Management (CM) program,

serving those at high risk for ED overutilization, as well as other targeted groups to reduce racial disparities. The Diabetes Case Management Program will address the medical and social determinants of diabetes related ED visits in the Lower Shore Region.

This Diabetes Care Management program design is based on several evidence based models of chronic disease care management. The core team of professionals will be an RN, a Social Worker, and Health Outreach Worker, who work in collaboration with primary care providers. The primary interventions include home visits, medication reconciliation, and facilitated referrals into primary care, diabetes care and social support resources. Additionally, patients will be referred to the Lower Shore Connector Entity to obtain or optimize insurance coverage, as appropriate. Multiple studies support the proposed model of chronic care management.

An important resource of information about designing the Lower Shore Care Management Program is the Robert Wood Johnson Foundation Research Synthesis Report No.19 [*"Keys to Successful CM Programs ; Care Management of Patients with Complex Health Care Needs" (Bodenheimer, T, and R. Berry-Millett. 2009 Princeton, NJ)* www.rwjf.org/files/research/021710.policysynthesis.caremanagement.rpt.revised.pdf] This publication identifies the essential components of a chronic disease care management program which will achieve both improved quality of care and cost savings. These components are:

- Appropriate Patient selection and Case Load size
- Person-to-person encounters including home visits
- Multidisciplinary teams including physicians
- Use of Coaching for patient and family or caregivers

Specifically, this meta-analysis found that person-to-person encounters, including home visits, are more effective than telephone based contacts in achieving significant changes in complex patients. Care management must be provided by teams of professionals capable of addressing medical and social determinants of health, in collaboration with primary care providers. While CM consistently improves quality of care, reduction in costs is only achieved in programs which focus CM interventions to certain high cost, high complexity patients. Without these elements, care management programs have not been proven to reduce costs.

Studies involving Medicare beneficiaries show that the Care Management (CM) elements identified in the RWJ Synthesis report are successful in reducing costs in this population. *["Follow the Money: Factors Associated with the Cost of Treating High-Cost Medicare Beneficiaries" Feb. 11, 2011 Health Services Research, published online before print James D. Reschovsky, Jack Hadley, Cynthia B. Saiontz-Martinez, Ellyn R. Boukus]*

Studies in patients covered by Medicaid show similar success when Care Management is focused on high cost enrollees. [T*he Priority Partners Addictions and Chronic Disease CM Study, Medicaid Plan-Sponsored Support of Case Managers Serving High-Cost Enrollees With Substance Abuse Disorders Enhances Access to Services Without Increasing Costs.* http://www.innovations.ahrq.gov/content] In this Payer-sponsored case management program, services were provided by an RN case manager and focused on high cost enrollees. Those patients receiving care management experienced increased access to necessary disease management resources compared to a control group. Pharmacy costs rose among participants but fell in the control group, suggesting that the program enhanced access to appropriate medication therapy. The program achieved reduction in inpatient and emergency department (ED) use. Generated savings on medical care equaled roughly 94 percent of program operating expenses, meaning that the quality improvement gains came at a very modest expense.

Based on review of these resources, the Staffing Allocation and Duties of the Diabetes Care Management Team are as follows:
Registered Nurse (1.0 FTE) carries a Case Load of up to 50-60 patients with at least one chronic condition, in this instance, diabetes. The Nurse confirms patient eligibility and provides specific services (Guided Care Chapter 2, pg. 16)

- Assesses the patient at home, Approximately 2 hour interview
- Monitors the patient proactively, At least monthly by phone
- Empowers the patient; encouraging self-management
- Refers to chronic disease self management courses
- Coordinates information for providers of care, including medication reconciliation between providers, pharmacies and patient medication lists
- Educates and supports caregivers

Clinical Social Worker (0.5 FTE) assists with patient transitions, especially involving ED care, and aids in accessing the need and eligibility for community resources

- Communicates to providers about the patient's unique home circumstances.
- Visits the patient at home, especially after hospital or ED discharge, to ensure patient and caregiver know what they should be doing whom to call for advice
- Ensure the patient sees the primary care physician as indicated.
- Educates and Supports Caregivers
- Provides facilitated referral to community-based resources, including the Lower Shore Navigator or Connector Entity

Community Health Outreach Worker (0.5 FTE) Peer educator, trained to provide basic health improvement information in a culturally sensitive and relatable manner.

- Communicates with rest of team about issues which may be specific overt or underlying cultural contributors to health outcomes.
- Facilitates access to community resources after referral is made

The proposal includes strategies that will assist in building a collaborative, interconnected, and efficient health care system at the local/regional level;

The Lead Agency is the Tri-County Health Improvement Coalition with Worcester County Health Department as administrative lead and applicant. Partners which are existing members of the TriCounty Health Planning Board (LHIC) include: Worcester County Health Department, Wicomico County Health Department, Somerset County Health Department, Atlantic General Hospital, McCready Foundation, Peninsula Regional Medical Center, and the Three Lower Counties (TLC) Federally Qualified Health Center. New partners in this project, not previously members of the LHIC include; the Lower Shore Connector Entity, Emergency Services Associates (Emergency Physicians who staffs all three ED's), various PCMH pilot practices and primary care providers, and Apple Drug Pharmacy.

The specific strategies to improve Health System Infrastructure on the 2012 T-CHIP will be updated to reflect several new partnerships and innovations recently forged by community health providers in the Lower Shore region.

In Worcester County, the majority of primary care services are delivered by employed physicians and providers of the Atlantic General Hospital Health System. In 2011, Atlantic General Hospital (AGH) began participating in the Maryland Patient Centered Medical Home pilot projects, and in July 2012, AGH received a CMS Health Care Innovation Challenge grant.

The primary goal was to expand AGH's Patient Centered Medical Home pilot services to the target population of Medicare enrollees, which were not included in the PCMH pilot projects. The target patient for the CMS grant are limited to residents of Worcester County, with CHF, COPD or Diabetes, who also receive primary care services through the AGH Outpatient Primary Care network of providers. This project does not serve all patients in the three Lower Shore Counties, or those who receive primary care services from providers outside of the AGH network.

An innovative partnership formed as AGH partnered with Worcester County Health Department (WCHD) in creating a Care Management workforce for this project, based on a modified Guided Care Model. The Care Management Teams includes four RN's, one LPN, and one half-time LCSW. They are co-located within AGH primary care offices as part of the AGH PCMH team. The team assists in educating patients/caregivers and health professionals within the community on PCMH, services available and appropriate use of the emergency department. One of the RN's and the Social worker are health department staff and bring specific experience in case management services to the aging/disabled population and patients with chronic disease, such as HIV. A selection of AGH's PCMH Medicare patients receive home visits, delivered by the public health staff; a service not routinely provided by the PCMH model. A limitation of this program is that the services are primarily office based for most patients, and the referrals for the program come from within a specified Patient Centered Medical Home. By definition, most of the enrollees already have an identified primary care provider. The target population is not specifically high users of ED services, nor selected to reduce health disparities.

The proposed program of Diabetes Care Management for the three Lower Counties plans to expand on the existing innovation and partnerships in several ways. Geographically, the program will serve a broader patient base, by establishing two Diabetes Care Management teams which will serve any patient in the three counties. One team of an RN, part time LCSW, and part time health outreach worker will serve Wicomico County residents. A second team of same staffing will serve both Worcester and Somerset residents.

Health Departments will employ the RN, Social Work and Health Outreach staff members, providing the public health expertise in home visiting models, case management, and accessing community based services. Health Departments in this region will also expand access to the National Diabetes Prevention Program called Lifestyle Balance, by offering this nutrition and exercise program to patients identified as high risk of poor diabetes control and ED use. The NDPP has demonstrated significant health outcomes among those who enroll, but unfortunately, this has not always included the patients at highest need.

The targeted patient population will be derived specifically from data on ED utilization, reflecting a focused effort to reach patients who are identified as needing significant improvements in care coordination and health system innovations which better serve their needs.

The hospitals in each county have agreed to collect and submit ED utilization data to the lead agency on a quarterly basis, so that patient referral lists and strategies may be refined as the program progresses. They will host medical staff education venues as a forum to orient providers to the Diabetes Care Management program and resources. The three regional hospitals also host the American Diabetes Association certified Diabetes Education programs, and agree to provide at least one session, including Medical Nutrition Therapy, to patients referred from the Diabetes Care Management program, regardless of ability to pay.

All three hospital Emergency Rooms are staffed by a single private Emergency Physician practice. The Emergency physicians are eager to refer high needs and 'frequent flyer" diabetic patients into the Care Management program. They will receive orientation to the program and

become familiar with a universal referral form designed to facilitate transfer of care from the Emergency Room. (Attachment 8) The Tri-County Diabetes Alliance recently created this form specifically for referral into diabetes self management resources in the Tri-County region. It has now been modified to include the Diabetes Case Management program, which will greatly simplify the referral process into multiple types of diabetes services.

Based on ED data and anecdotal reports of Emergency Room providers, it is likely that this population lacks primary care medical homes. Therefore, initiation of care management services will be patient focused, and primarily home-based, with referral to and coordination with any appropriate primary care provider. TLC- the regional FQHC, has committed in partnership to accept program referrals into primary care, and facilitate timely outpatient visits for high utilizing patients, especially if the Diabetes Care Management team identifies an urgent care need, to potentially avoid an ED visit. The AGH and PRMC Systems of outpatient providers, as well as various private primary care providers are agreeable to facilitated referrals into acute office visits as well. Common secondary diagnoses in diabetes related ED visits include various types of infections, or acute changes in blood glucose levels. A facilitated referral by the Nurse Care Manager into the primary care setting may be able to address early signs of infection or fluctuating blood glucose before an emergency room visit is needed.

This program will serve a client base which is established to be high risk for early death, have poor health indicators, has high utilization of health resources and great health disparities. This population would benefit from health information data sharing for population health management. The sharing of clinical data through CRISP augments the community level sharing of information, contributing to building of community based medical record or community medical home. AGH in Worcester County is an early participant in CRISP, contributing data on medical diagnoses and laboratory studies. Worcester County Health Department has executed a contract to begin CRISP participation, and the medical providers, including psychiatrists and a primary care Nurse Practitioner, will begin individual prescriber participation soon. Data sharing is an integral element of chronic disease care management. Therefore, the program will encourage all clinical care participants to enroll in CRISP as contributors to and consumers of information in the community health record.

Although this RFP indicates that funds are not allowable for major equipment, an alternative proposal for purchase of portable telemedicine equipment can be submitted if the CHRC considers this an acceptable innovative proposal. If approved, the Care Management team would facilitate a home-based telemedicine visit with a primary care office- making the potential to obtain acute outpatient treatment even more attainable.

The TriCounty Diabetes Care Management proposal will employ specific strategies to address unmet health needs of low-income, uninsured, and underinsured populations and helps reduce health disparities in the region.

Particular effort will be made to engage patients in the geographic regions identified as "hot spots' of high utilization, and racial disparities in ED use. Through home-based evaluation with medical and social work providers, the Care Management team will gain a more comprehensive understanding of the specific challenges and barriers to care for this population. It is already evident from the data analysis conducted thus far that 65-70% of the Diabetes related ED visits are by patients covered by Medicare, Medicaid or self pay. Many patients in these rural areas may benefit from transportation services, perhaps through Medicaid or with individualized transportation assistance. Some of the very highest utilizers of ED care in Worcester and Somerset Counties are in the areas most remote from the hospitals. However, this

may indicate that patients lack transportation and access to primary care, and fall back on ambulance transportation to the hospital as a last resort.

Medication reconciliation is a National Patient Safety goal, involving the cross checking of medication lists between the patient, prescribers and pharmacy records. This process often reveals that patients who are uninsured or underinsured take their medications less often or sparingly in an attempt to save on out of pocket expenses. Individualized medication teaching and financial assistance will be made available through partnership with Apple Drug, an independently owned pharmacy with branches in Worcester and Wicomico County. With this innovative health system partnership, the CEO of Apple Drug agrees to offer individualized medication assistance to patients referred from the Diabetes Care Program, especially when the care manager has identified that medication sparing may be a cause of poor diabetes control. Further health care innovations and strategies will be proposed as information is derived from ongoing quarterly data analyses and care management team meetings.

Wicomico County Health Department, in partnership with PRMC and community medical providers, has demonstrated success of a model in which a Community Health Outreach worker is hired from the target population as a peer educator. Specifically this pilot program provides services for asthma patients who need medication teaching, and an Asthma Action Plan to avoid asthma related emergency department visits. The Community Health Outreach worker on the Diabetes Care Management teams will be hired and trained under a similar model, to enhance efforts to reduce racial disparities and provide relatable disease management outreach from peer educators.

The proposal assists the state's overall implementation of the Affordable Care Act by expanding access for Marylanders who will become eligible for health insurance in 2014.

The Lower Shore Connector Entity has been established to improve access to care by connecting people to health care coverage, specifically by expanding access for Marylanders who will become eligible for health insurance in 2014. Worcester County Health Department has been awarded the grant to administer the regional program, Navigators will provide outreach, education, enrollment and eligibility services for Somerset, Wicomico and Worcester County residents seeking assistance with health plans offered through Maryland Health Connection. Navigators are deployed throughout the Tri-County region, with dedicated office space at Local Health Departments, and Local Departments of Social Services. There will also be Community/mobile locations for outreach and enrollment. Open enrollment will coincide with much of the implementation period of this Diabetes Care Management program, specifically October 1, 2013 – March 31, 2014. During this time, the Diabetes Care managers will be identifying uninsured individuals and may find populations or areas with low insurance participation rates. The Diabetes Care Management program will refer these individuals into the Navigator entity. In this way, the Program contributes to the regional Connector Entity goal to enroll 5,304 people in Year 1 of the Navigator Program.

Local Health Action Plan Goals, Objectives and Action Plans

GOAL 1: To reduce Diabetes related ED visit rates and disparities among residents of Somerset, Wicomico, and Worcester Counties during a period between July 1, 2013- September 30, 2013.

Objective 1: By September 30, 2013, establish a routine procedure for reviewing diabetes-related ER visits to recommend appropriate interventions, targeting high ED utilizers and geographic or racial disparities in ED use.

Action Steps :
1.TriCounty Health Improvement Coalition will obtain and review Emergency Department data for baseline in all 3 hospitals; explore data for long and short term indicators of ED visits, "hot spots" and "frequent flyers" and changes in visit rates.
2. Identify Patient lists and geographic regions for targeted outreach and case management

Outcome Measures:
For the period of implementation, the Program will produce Quarterly ED visit data analysis reports, and lists of ED visit indicators for targeted outreach. Dates of reports are October 15, 2013, January 15, 2014, April 15, 2014 July 15, 2014 and October 15, 2014.
2. Reduction in overall ED visit rate for the Lower Shore Counties, as calculated from HSCRC data by October 14, 2014
3. Reduction in racial disparities rate for Worcester, Wicomico and identified areas of Somerset as calculated by HSCRC by October 15, 2014

Objective 2: Implement a Nurse/Social Work/ Health outreach worker Diabetes Care management program to assist diabetes patients in obtaining resources aimed at reducing ED visits related to diabetes.
Action Steps:
1.Hire, train and deploy 2 FTE RN's, 1 FTE LCSW and 2 CHOW's to provide Diabetes Case management services for patients identified as high risk for avoidable Emergency Room visits.
2. Increase capacity within the Diabetes Prevention and Education programs with additional funding and targeted outreach to pre-identified patients.
3. Establish the Access to Pharmaceutical care program with Apple Drug- including referral process and covered services or products.
Optional: Purchase portable telemedicine unit for recording and transmitting Diabetes related biometrics in real time from patient home to primary care provider.

Outcome Measures:
1. Two CM teams hired, trained and accepting new patients by September 15, 2013 in all three counties.
2. At least 5 Diabetes Care Management patients in each county enrolled in NDPP- LifeStyle Balance and/or ADA Certified Diabetes education programs by November 1, 2013
3. At least 1 Diabetes Care Management Patient from each county begins utilizing Pharmacy assistance services by November 1, 2013.

Objective 3: Establish a protocol that will ensure patients presenting with diabetes related ED visits receive referral into Case Management services, or at a minimum, a TCDA Resource Guide upon discharge from ED.
Action Steps:
1.Implement the universal referral form for referral into Diabetes Case Management services as developed by the TriCounty Diabetes Alliance
2.Educate emergency department (ED) physicians and staff at all 3 hospitals about the Tri-County Diabetes Case Management services, and related Outpatient Diabetes Self- Management Programs, Diabetes Support groups, and the National Diabetes Prevention Program.

Outcome Measure:

1. 3 Provider/ Medical Staff orientation meetings will be held: 1 at AGH, 1 at PRMC and 1 for the Emergency Services Physicians, by January 15, 2014.

Objective 4: Contribute to the establishment of Community Health Record by promoting utilization and participation in CRISP among Lower Shore Health Care providers.
Action Items:
1.Enroll each Health Department which employs the care management team in CRISP participation agreements
Outcome Measures

1.Worcester, & Wicomico signed contracts for CRISP participation.
2.Each Care Manager Team will access, if available, pertinent medical information through CRISP- such as laboratory data, medication lists, ED visit data and discharge information on at least 2 patients from each county by April 15, 2014.

Goal 2: Assist the state's overall implementation of the Affordable Care Act by expanding access to coverage for residents of the Tri-County area who will become eligible for health insurance in 2014.
Action Items:
1.Obtain payer source coverage information from hospital ED records and care management referrals, direct patients to the Navigator entity, as indicated.
Outcome Measure:
Referral of at least 25 patients from each county to the Lower Shore Navigator Entity by January 15, 2014

Evaluation
The TriCounty Health Planning Board, as the LHIC will be the Program Oversight agency, and will receive all performance reports and monitor program milestones. The TriCounty Health Planning Board, through Worcester County Health Department, will submit reports to CHRC as required or requested. The progress toward each outcome will be assessed quarterly, for evidence of progress and potential need to modify strategies or action steps. The program will be evaluated by the following:

Outcome Measures:
1. For the period of implementation, the Program will produce Quarterly ED visit data analysis reports, and lists of ED visit indicators for targeted outreach. Dates of reports are October 15, 2013, January 15, 2014, April 15, 2014 July 15, 2014 and October 15, 2014.
2. Reduction in overall ED visit rate for the Lower Shore Counties, as calculated from HSCRC data by October 15, 2014
3. Reduction in racial disparities rate for Worcester, Wicomico and identified areas of Somerset as calculated by HSCRC by October 15, 2014
4. Two CM teams hired, trained and accepting new patients by September 15, 2013 in all three counties.
5. At least 5 Diabetes Care Management patients in each county enrolled in NDPP-LifeStyle Balance and/or ADA Certified Diabetes education programs by November 1, 2013. Total of 20 patients per county complete NDPP by October 15, 2013

6. At least 1 Diabetes Care Management Patient from each county begins utilizing Pharmacy assistance services by November 1, 2013. (need money in budget if here or value letter)
7. 3 Provider/ Medical Staff orientation meetings will be held: 1 at AGH, 1 at PRMC and 1 for the Emergency Services Physicians, by January 15, 2014.
8. Worcester and Wicomico Health Departments execute contracts for CRISP participation.
9. Each Diabetes Care Manager Team will access, if available, pertinent medical information through CRISP- such as laboratory data, medication lists, ED visit data and discharge information on at least 2 patients from each county by April 15, 2014.
10. Referral of at least 25 patients from each county to the Lower Shore Navigator Entity by January 15, 2014

Post-CHRC Funding Sustainability Plan

The Lower Shore Diabetes Care Management Plan may be sustained after CHRC funds are expended through several strategies.

Wicomico and Worcester Health Departments will employ the Care Management teams. The services provided will be billable and reimbursable by many plans once the Health Insurance Exchange is online, and the essential benefits defined. Financial sustainability will come, in part, by appropriate third party billing and reimbursement for these services.

Hospitals will benefit from the activities of the program by having fewer non-reimbursed or insufficiently reimbursed ED visits. This will be achieved through both a reduction in ED visit number and rate, as well as increased coverage by insurance, with fewer uninsured patients seeking ED care. If the model is successful, the value of the cost savings for hospitals may calculated and be re-invested into the program. The savings could perhaps be used toward team member salaries or other administrative and costs of the program, such as travel and IT/ computer equipment and support. At the present time, AGH has expressed interest in employing the Nurse Case manager team member, so transition to hospital or private entity employment may be an option for sustainability. Additionally, there may be viability to billing for telemedicine consultations if equipment is purchased to provide this service during home visits, if indicated. Billing for a physician telemedicine visit would add a source of income to the home visiting model, separate from the care management service.

If the model is successful, there will be savings to the publically funded payer system, as is demonstrated in various studies referenced here. Medicaid and Medicare cost savings are not currently shared with Care Management service providers unless those providers are also enrolled as Patient Centered Medical Homes. We would advocate for a shared savings model to be considered to invest in the longevity of the program.

Over time, and with the implementation of many aspects of the ACA in Maryland, the Care Management Program may produce a reduction in demand for certain services. Near universal insurance coverage may improve other access to care issues, although access to primary care remains a barrier in the Lower Shore Counties, due to health professions shortages. Through increasing participation in CRISP, and the building of a community health record, the program may make the available primary care services more efficient. Currently, a tremendous amount of time is spent gathering records from multiple hospitals or providers, before a primary care provider can make an informed decision on care. Private physician groups may become convinced of the value and benefits of chronic disease care management, Additionally, these physician groups may find that working with, and contributing to a community based chronic disease case management team meets the requirements for being a Patient Centered Medical Home. Primary care physicians could experience shared savings from payer sources and increased productivity, or improved health outcomes in Pay-for-Performance programs. It is the hope of the TriCounty Health Planning Board to invest in a community care management infrastructure, which will eventually be funded by contributions from the health provider community at large, including physician offices, hospitals, pharmacies, emergency responders, public health and safety net providers.

Project Budget Form for LHIC Grant Funding Request	
MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION	
State Health Improvement Process: ***Supporting Local Health Improvement Coalitions (LHICs) to Fuel Local Action and Improve Community Health***	
LHIC/Organization Name:	Tri-County Health Planning Board Worcester County Health Department
Project Name:	TriCounty Diabetes Care Management for the Reduction of Diabetes related ED visits and disparities
Budget Request for CHRC Grant Funding	**Amount of Request**
Personnel Salary	
NDPP 0.40 - Coordinator of Special Programs I-Somerset For 13 weeks	4,773.
NDPP .05-.07- Community Health Outreach Worker I-Somerset for 13 weeks	2,385.
NDPP 0.50 for 13 weeks – Dietician-Somerset	7,800.
CM 1.0-Community Health Nurse II Wicomico	42,719.
CM 0.5 - Social Worker I-15/B-Wicomico	20,070.
CM 0.5 -Community Health Outreach Worker- Wicomico	8,462
NDPP 0.18-Community Health Nurse II-Wicomico	13,320.
CM 1.0 – Community Health Nurse II-16/B-Worcester	42,719.
CM 0.5-Social Worker I-15/B - Worcester	20,070.
CM 0.5 Community Health Outreach Worker	8,462
NDPP 0.05-Community Health Nurse II - Worcester	3,160.
NDPP 0.10 - Coordinator of Special Programs HSII - Worcester	4,934.
NDPP 0.10- Consultant Dietician – Worcester	5,616.
Personnel Subtotal	184,490.

Personnel Fringe (15% - fringe county specific)	27,496
Advertising	
Data Collection and processing $2500 x 3 hospitals	7,500.
Educational Supplies	3,500.
Equipment/Furniture	
Office Supplies	77.
Telephone	1,500.
In-StateTravel/Mileage/Parking	2,750.
Staff Trainings/Development	
Contractual	
Subtotal	227,313
Indirect Costs (no more than 10% of direct costs)	22,687
Matching Funds – at least 10% of the overall CHRC grant request must be provided in matching funds	25,000
Total	275,000.

Local Health Improvement Coalition

Grant FY'14

Budget Justification-Somerset County

Personnel

Coordinator of Special Programs I- 0.40 FTE Grace Terrell **$4,773**

Justification: Projected 16 hours/week for 13 weeks to provide coordination, outreach and implementation of the National Diabetes Prevention Program (Lifestyle Balance).

Fringe **$1,355**

Justification: FICA , Retirement,Health Insurance, Retiree Health Insurance, and Unemployment Insurance

Special Payments-Community Health Outreach Worker I Vacant **$2,385**

Justification: Projected 4 hrs./wk for 20 weeks to provide outreach in community and physician offices

Fringe **$110**

Justification: FICA $ and Unemployment Ins. $

Contractual Services-Kathy Wool **$7,800**

Justification: Dietitian-20 hours/week for 13 weeks to conduct outreach and education for the National Diabetes Prevention Program (Lifestyle Balance).

Educational Supplies **$3,000**

Justification: To purchase incentives for 20 individuals who participate in the program. Incentives to include but not limited to: theraband, step counter, Calorie King Fat Tracker, cookbook, food scales, waterbottle, exercise dvds and exercise and healthy food posters for two sites.

Office Supplies **$77**

Justification: folders, clipboards, and pens

Data Collection **$2,500**

Justification: To support hospital reporting and data tracking.

Sub-Total Request-Somerset County: **$22,000**

Budget Justification-Wicomico County

Personnel

Diabetes Case Management Team

Community Health Nurse II-16/B 1.0 FTE Vacant **$ 42,719**

Justification: To provide program implementation of care coordination services for eligible clients.

Social Worker I-15/B 0.5 FTE Vacant **$ 20,070**

Justification: To provide program implementation of care coordination services for eligible clients.

Fringe **$ 4,980**

Justification: FICA and Unemployment Insurance

Lifestyle Balance Team

Community Health Educator III- Sharon Cooper **$8,462**
(in lieu of CHOW)
Justification: Projected 7 hours/week x 52 weeks to provide weekly group education, coaching, and follow up for participants enrolled in the Lifestyle Balance Program.

Community Health Nurse II, Brenda Williams **$13,320**

Justification: Projected 7 hours/week x 52 weeks to assist with program promotion and implementation and to serve as back up for weekly education.

Fringe (2 merited employees) **$11,200**

Data Collection **$2,500**

Justification: To support hospital reporting and data tracking.

Sub-Total Request-Wicomico County **$103,251**

Budget Justification-Worcester County

Personnel

Diabetes Case Management Team

Community Health Nurse II-16/B 1.0 FTE Vacant **$42,719**

Justification: To provide program implementation of care coordination services for eligible clients.

Social Worker I-15/B 0.5 FTE Vacant **$20,070**

Justification: To provide program implementation of care coordination services for eligible clients.

Community Health Outreach Worker .5 FTE Vacant **$8,462**

Justification: To provide peer counseling, outreach with Care management team

Fringe **$5,651**

Justification: FICA and Unemployment Insurance

Lifestyle Balance Team

Community Health Nurse II- 0.05 FTE Linda Green **$3,160**

Justification: To assist with NDPP program promotion and implementation and to serve as back up for weekly education.

Coordinator of Special Programs HSII- .10 FTE Kerri Daye **$4,934**

Justification: To provide weekly group education, coaching, and follow up for participants enrolled in the Lifestyle Balance Program.

Consultant Dietitian Kathy Wool, RD, LD **$5,616**

Justification: To provide weekly group education, coaching, and follow up for participants enrolled in the Lifestyle Balance Program. 4 hours/week x $27/hour x 52 weeks

Fringe **$4,200**

Calculated according to current plan cost and includes health insurance, workers compensation and state unemployment costs.

Data Collection **$2,500**

Justification: To support hospital reporting and data tracking.

Educational Materials **$500**

Justification: To purchase educational supplies and incentives including cook books, healthy eating journals, exercise DVDs, food scales @$25/per participants x 20 participants

Subtotal Worcester **$97,812**

Telephone **$1,500**

Justification: Cell lines for Home Visit CM team $50/month per phone line (3 phone lines) to cover maintenance, long distance costs

In-state Travel **$2,750**

Justification: Home visits, Lifestyle Balance Programs, required meetings throughout the Tri-County area. Calculated at .55 per mile x 5,000 miles

Total Direct Costs **$227,313**

Total Indirect Costs-10% of the Direct Costs **$ 22,687**

Administrative Support (Indirect), personnel, fiscal and procurement services.

Total Grant Request: **$250,000**

Letters of Commitment for Matching funds

Atlantic General Hospital	**$ 2,500**
Worcester County Health Department	**$ 5,000**
Peninsula Regional Medical Center	**$ 5,000**
Wicomico County Health Department	**$12,000**
McCready Foundation	**$ 500**
	$25,000

Key Staff

The Project Director is Andrea Mathias MD, MPH- Deputy Health Officer of Worcester County Health Department. For this project, she will oversee the clinical care aspects of the Care Management program, assisting in the development of associated policies and procedures. Her time will be an in-kind contribution.

Rebecca Jones RN, MSN is Program Manager for Worcester County Health Department's Community Health Services to Adult and Aging, and manages the RN, and Social Worker Care Management team in The CMS Innovations partnership with AGH. She will oversee the hiring and direction of the Diabetes Care Management team, including an RN, LCSW and Community Health Outreach Worker for Worcester and Somerset Counties. Her contribution will be in-kind.

Mimi Dean, MS is Chronic Disease Prevention and Tobacco Program Coordinator at Worcester County Health Department and an American College of Sports Medicine Certified Clinical Exercise Specialist. She oversees Worcester County Health Department's LifeStyle Balance Program. She will lead the expansion of the NDPP program at Worcester Health to accommodate patients referred from the Diabetes Care Management Program, aid is customizing the program to accommodate the specific cultural and social needs of the identified population and monitor the established outcomes specific to the program.

Kathy Wool, RD, LD is the registered dietician who offers diabetes education to patients in Worcester and Somerset County free of charge as a part of the NDPP- Lifestyle Balance. Her services will be expanded through this program to address the needs of the referrals from the Diabetes Care Management Program.

Mary (Matey) Barker MSW, MPA is Behavioral Health Director at Somerset County Health Department. She will provide oversight and consultation to the Care Managers when on site in Somerset County. She will also direct the hiring and training of the vacant position in the NDPP program- a Community Health Outreach Worker. The Health Department recently lost staffing in the Chronic Disease Prevention program.

Brenda Williams RN is Planning Coordinator at Wicomico County Health Department She will oversee the hiring and direction of the Diabetes Care Management team, including an RN, LCSW and Community Health Outreach Worker for Wicomico County. Additionally, she will assist with NDPP- Lifestyle program promotion and implementation and to serves as back up for weekly education.

Sharon Cooper is Community Health Educator III at Wicomico County Health Department. She will provide weekly group education, coaching, and follow up for participants enrolled in the Lifestyle Balance Program. She will expand and adapt the program to accommodate the needs related health disparities for minorities referred from the Diabetes Case Management Program.

Snow Hill (Main Office)
410-632-1100
Fax 410-632-0906
TTY 410-632-1100

Worcester County
HEALTH DEPARTMENT

P.O. Box 249 • Snow Hill, Maryland 21863-0249
www.worcesterhealth.org

Deborah Goeller, R.N., M.S.
Health Officer

May 31, 2013

Mr. Marc Luckner
Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

RE: Letter of Commitment for Regional Reduction of Diabetes ER Visits by Care Management

Dear Mr. Luckner:

The Worcester County Health Department supports the Tri-County Health Planning Board application for Reduction of Diabetes ER Visits by Case Management. As a partner we are already working closely on the Tri-County Diabetes Alliance and Tri-County Health Planning Board (Local Health Improvement Coalition).

We are making a commitment to:

- Continue active membership on the Tri-County Diabetes Alliance and the Tri-County Health Planning Board
- Hire and train the Diabetes Care coordination team for Worcester and Somerset Counties
- Provide office space, utilities and support for the care coordination team, as needed
- Have staff provide linkages with the care coordination team for shared clients

We estimate the value of this commitment to be valued at $ 5,000.

Sincerely,

Debbie Goeller

Health Officer

cc: Andrea Mathias, MD, Deputy Health Officer, Worcester County

ATLANTIC
GENERAL HOSPITAL
care.givers

May 31, 2013

Mr. Mark Luckner, Executive Director
Maryland Community Health Resources Commission
45 Calvert Sstreet, Room 336
Annapolis, MD 21401

RE: Letter of Commitment for Regional Reduction of Diabetes ER Visits through Case Management Tri-County Health Planning Board; LHIC for Somerset, Wicomico and Worcester Counties

Dear Mr. Luckner,

Atlantic General Hospital supports the application for Reduction of Diabetes ER visits and related disparities, submitted by Worcester County Health Department, on behalf of the Tri-County Health Planning Board (LHIC). The implementation will involve the collaboration of three local health departments, two community hospitals, one regional medical center, the Lower Shore Connector Entity, physician practices and groups participating in the PCMH initiatives, the private practice of Emergency physicians which staff the three hospital ED's, as well as other local health resources.

For the proposed project, Atlantic General Hospital agrees to:

1. Participate in the collection and analysis of data for Diabetes related ER visits by collecting and reporting requested data to the LHIC, via Worcester County Health Department, on a quarterly basis for 16 months, starting July 1, 2013 through November 30, 2014

2. Host one medical staff training venue to allow introduction and orientation of medical staff to the Tri-County Diabetes Case Management Team, project resources, as well as referral process.

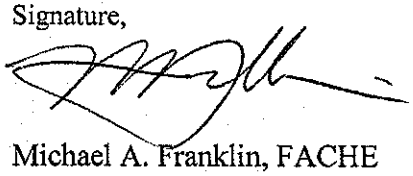
3. During the period of the grant implementation, accept diabetes patients into hospital sponsored Diabetes Self-Management programs, and offer one Medical Nutrition Therapy visit to referred patients, regardless of ability to pay or insurance coverage of the service (MNT).

4. Facilitate ED staff to make referrals from the ED into the Diabetes Case Management team covering the patients' county of residence, using the Universal Referral Form created by the Tri-County Diabetes Alliance.

In doing so, Atlantic General Hospital anticipates offering a value of $2,500 in matching funds or contributions on in-kind services to this project.

Please consider this letter of commitment as a statement of support in consideration of the application for CHRC funding of the TriCounty Diabetes ER visit and disparity reduction project.

Signature,



Michael A. Franklin, FACHE
President/CEO

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.

PENINSULA REGIONAL MEDICAL CENTER

May 31, 2013

Mr. Mark Luckner
Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

Re: Letter of Commitment for Regional Reduction of Diabetes ER Visits through Case Management

Dear Mr. Luckner:

The Peninsula Regional Medical Center supports the application for Reduction of Diabetes ER visits and related disparities, submitted by Worcester County Health Department, on behalf of the Tri-County Health Planning Board (LHIC).

This project aims to reduce diabetes-related ED visit rates in the three lower shore counties of Worcester, Wicomico and Somerset counties. Diabetes specific Nurse/Social Worker teams will assist patients to:

- obtain insurance coverage when needed,
- connect with primary care and patient centered medical homes,
- utilize diabetes self management and nutrition services,
- avoid unnecessary ER visits through screening and triage, with facilitated referrals to alternative care settings.

The implementation will involve the collaboration of 3 local health departments, 2 community hospitals, 1 regional medical center, the Lower Shore Connector Entity, physician practices and groups participating in the PCMH initiatives, the private practice of Emergency physicians which staff the three hospital ED(s), as well as other local health resources.

For the proposed project, this agency agrees to:

1. Participate in the collection and analysis of data for Diabetes related ER visits by collecting and reporting requested data to the LHIC, via Worcester County Health Department, on a quarterly basis for 16 months, starting July 1, 2013 through November 30, 2014.
2. Host 1 medical staff training venue to allow introduction and orientation of medical staff to the Tri-County Diabetes Case Management Team, project resources, as well as referral process.
3. During the period of the grant implementation, accept Diabetes patients into hospital sponsored Diabetes Self-Management programs, and offer 1 Medical Nutrition Therapy visit to referred patients, regardless of ability to pay or insurance coverage of the service (MNT).
4. Facilitate ED staff to make referrals from the ED into the Diabetes Case Management team covering the patients' county of residence, using the Universal Referral Form created by the Tri-County Diabetes Alliance.

In doing so, the Peninsula Regional Medical Center (hospital) anticipates offering a value of $5,000.00 in matching funds to this project.

Please consider this letter of commitment as a statement of support in consideration of the application for CHRC funding of the Tri-County Diabetes ER visit and disparity reduction project.

Sincerely,

Timothy Feist
Vice President, Ambulatory Services
Peninsula Regional Medical Center

Public Health
Prevent. Promote. Protect.
Wicomico County
Health Department

Wicomico County Health Department

108 East Main Street • Salisbury, Maryland 21801

Lori Brewster, MS, APRN/BC, LCADC • Health Officer

May 31, 2013

Mr. Marc Luckner
Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

RE: Letter of Commitment for Regional Reduction of Diabetes ER Visits by Case Management

Dear Mr. Luckner:

The Wicomico County Health Department supports the Worcester County Health Department's application for Reduction of Diabetes ER Visits by Case Management. As a partner, we are already working closely on the Tri-County Diabetes Alliance and Tri-County Health Planning Board (Local Health Improvement Coalition).

We are making a commitment to:

- Continue active membership on the Tri-County Diabetes Alliance and the Tri-County Health Planning Board
- Hire and train the Care Coordination Team for Wicomico County
- Provide office space, utilities and support for the Care Coordination Team, as needed
- Have staff provide linkages with the Care Coordination Team for shared clients

We estimate the value of this commitment to be valued at $12,000.

Sincerely,

Lori Brewster, MS, APRN-BC, LCADC
Health Officer

cc: Andrea Mathias, MD, Deputy Health Officer, Worcester County

Building a Healthy Community One Person at a Time

McCREADY FOUNDATION

Edward W. McCready Memorial Hospital

Alice B. Tawes Nursing & Rehabilitation Center

McCready Outpatient Center

Chesapeake Cove Assisted Living

201 HALL HIGHWAY
CRISFIELD, MD 21817

410-968-1200
FAX 410-968-3005

1-800-735-2258
TDD for Disabled
(Maryland Relay Services)

Mr. Mark Luckner
Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

May 29, 2013

RE: Letter of Commitment for Regional Reduction of Diabetes ER Visits through Case Management

Dear Mr. Luckner:

The E.W. McCready Hospital supports the application for Reduction of Diabetes ER visits and related disparities, submitted by Worcester County Health Department, on behalf of the Tri-County Health Planning Board (LHIC).

This project aims to reduce diabetes-related ED visit rates in the three lower shore counties of Worcester, Wicomico and Somerset counties. Diabetes specific Nurse/Social Worker teams will assist patients to:

-obtain insurance coverage when needed,
-connect with primary care and patient centered medical homes,
-utilize diabetes self management and nutrition services,
-avoid unnecessary ER visits through screening and triage, with facilitated referrals to alternative care settings.

The implementation will involve the collaboration of 3 local health departments, 2 community hospitals, 1 regional medical center, the Lower Shore Connector Entity, physician practices and groups participating in the PCMH initiatives, the private practice of Emergency physicians which staff the three hospital ED(s), as well as other local health resources.

For the proposed project, this agency agrees to:

1. Participate in the collection and analysis of data for Diabetes related ER visits by collecting and reporting requested data to the LHIC, via Worcester County Health Department, on a quarterly basis for 16 months, starting July 1, 2013 through November 30, 2014.

2. Host 1 medical staff training venue to allow introduction and orientation of medical staff to the Tri-County Diabetes Case Management Team, project resources, as well as referral process.

3. During the period of the grant implementation, accept Diabetes patients into hospital sponsored Diabetes Self-Management programs, and offer 1 Medical Nutrition Therapy visit to referred patients, regardless of ability to pay or insurance coverage of the service (MNT).

4. Facilitate ED staff to make referrals from the ED into the Diabetes Case Management team covering the patients' county of residence, using the Universal Referral Form created by the Tri-County Diabetes Alliance.

In doing so, the E.W. McCready Hospital anticipates offering a value of $500.00 in matching funds to this project.

Please consider this letter of commitment as a statement of support in consideration of the application for CHRC funding of the Tri-County Diabetes ER visit and disparity reduction project.

Sincerely,

James Sexton, LFACHE

Interim Chief Executive Officer

County	#	SHIP Objective	Measure Description (Source)	SHIP 2011 County Baseline	SHIP 2012 County Update	SHIP 2012 Maryland Update	SHIP 2012 County Update (Race/Ethnicity)	SHIP 2012 Maryland Update (Race/Ethnicity)	Maryland SHIP 2014 Target	% Difference (Maryland vs. County)
Worcester	16	Reduce Salmonella infections transmitted through food	Rate of Salmonella infections per 100,000 population (OIDEOR 2008-2010) (OIDEOR 2009-2011)	***, 17 (Count only)	***, 18 (Count only)	16.7	N/A	N/A	12.7	
Worcester	17	Reduce hospital emergency department visits from asthma	Rate of ED visits for asthma per 10,000 population (HSCRC 2010) (HSCRC 2011)	62.8	56.7	59.1	NH black--172.7 NH white--38.8	NH Asian--12.1 NH black--116.3 Hispanic--32.0 NH white--35.9	49.5	-4.10%
Worcester	19	Reduce the number of days the Air Quality Index (AQI) exceeds 100	Number of days the air quality index (AQI) exceeded 100 (EPA 2010) (EPA 2011)	3	N/A	8.9	N/A	N/A	8.8	
Worcester	20	Reduce new HIV infections among adults and adolescents	Rate of new (incident) cases of HIV in persons age 13 and older per 100,000 population (CHSE 2009) (CHSE 2010)	***, 3 (Count only)	***, 3 (Count only)	29.8	***	NH black--82.6 Hispanic--20.1 NH white--6.6	30.4	
Worcester	21	Reduce Chlamydia trachomatis infections	Rate of Chlamydia infections per 100,000 population (CSTIP 2010) (CSTIP 2011)	388.7	423.2	466.9	N/A	N/A	431.0	-9.36%
Worcester	25	Reduce deaths from heart disease	Rate of heart disease deaths per 100,000 population (age-adjusted) (VSA 2007-2009) (VSA 2008-2010)	197.5	212.6	182.0	Black--320.4 White--200.0	Black--216.8 White--174.2	173.4	16.81%
Worcester	26	Reduce the overall cancer death rate	Rate of cancer deaths per 100,000 population (age-adjusted) (VSA 2007-2009) (VSA 2008-2010)	196.4	204.7	170.9	Black--236.2 White--203.2	Black--197.0 White--166.1	169.2	19.78%
Worcester	27	Reduce diabetes-related emergency department visits	Rate of ED visits for diabetes per 100,000 population (HSCRC 2010) (HSCRC 2011)	433.4	372.7	314.6	NH black--1,217.1 NH white--249.5	NH Asian--46.7 NH black--593.3 Hispanic--94.6 NH white--229.2	300.2	18.49%

Attachment 2

WORCESTER COUNTY, MD
2010 ZIP CODE AREAS

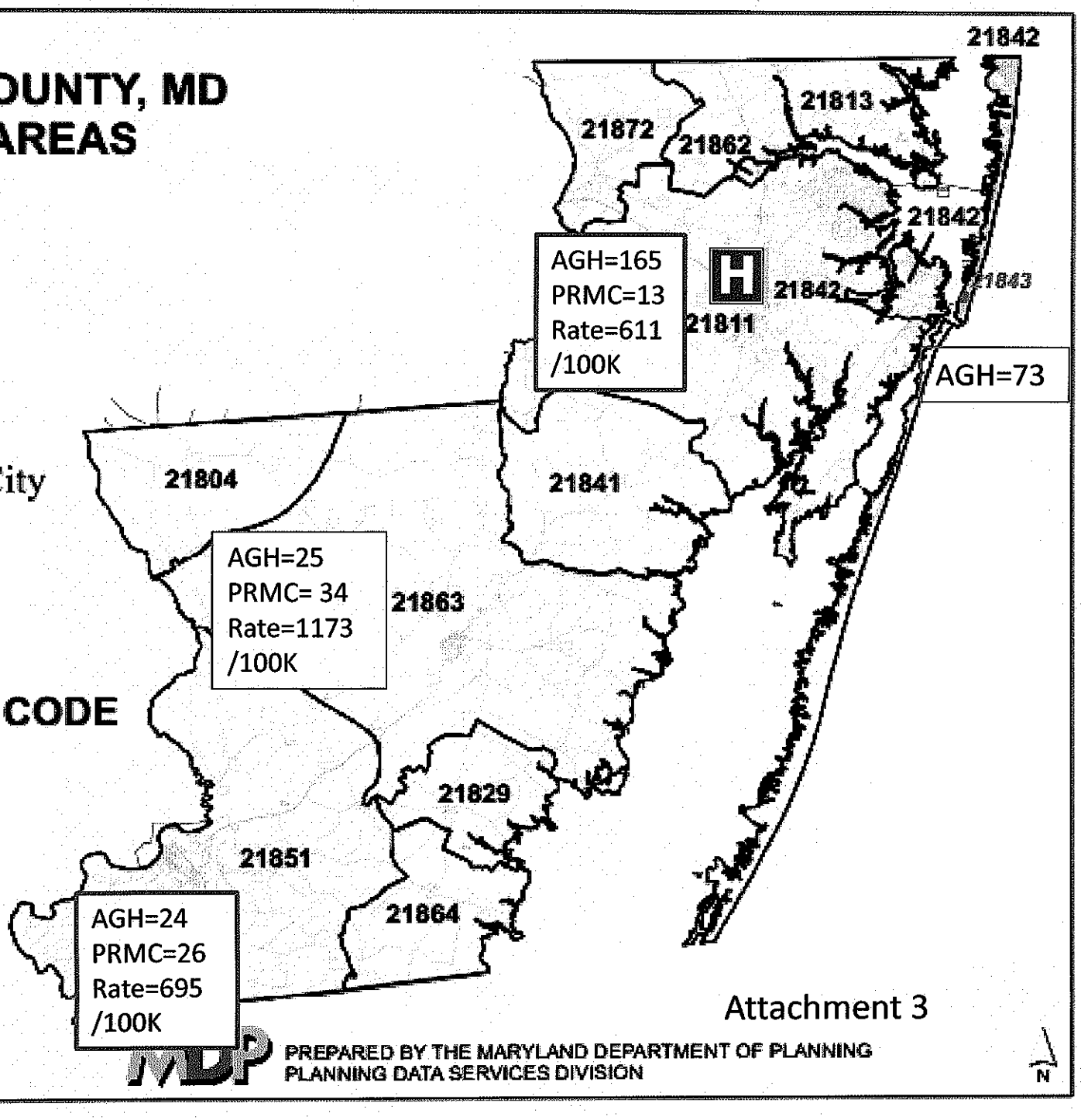
21804 Salisbury
21811 Berlin
21813 Bishopville
21829 Girdletree
21841 Newark
21842 Ocean City
21851 Pocomoke City
21862 Showell
21863 Snow Hill
21864 Stockton
21872 Whaleyville

POST OFFICE ZIP CODE

21843 Ocean City

Population: 51,578

Diabetes ED visits
AGH= 339
PRMC= 94



Attachment 3

PRMC Diabetes ER Visit Data July 2012- April 2013

Payer Source PRMC Visits	#	% of Total visits	Age Groups	#	%
Aetna	3	<1	>=84	50	7.6
BCBS	55	8	74-83	76	11.6
HealthSmart	6	1	64-73	116	18
HMO (?)	30	4.5	54-63	101	15.5
HMO-MCaid	131	20	44-53	102	15.6
Medicaid	18	3	34-43	78	12
Medicare	276	42	24-33	51	7.8
Patient	80	12	14-23	58	8.8
VA Maryland Health	6	1	<13	20	3
			Hispani	10	1.5
UHC Choice+ PPO or EPO	23	3.5	White	312	47.8
			Black	320	49
Other	24	3.5	Other	7	1
Total	652			652	

Attachment 4

Population: 100,647

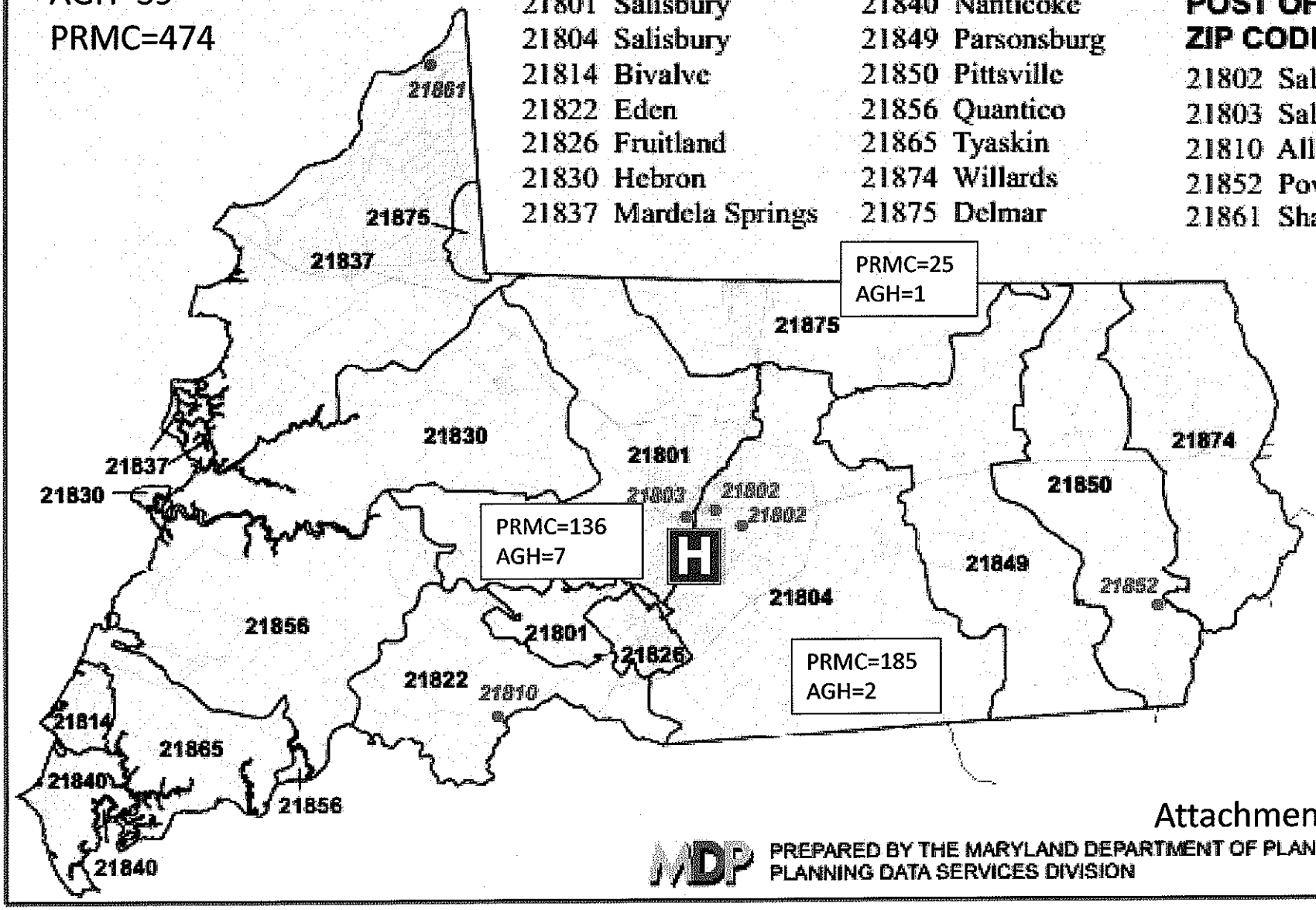
Diabetes ED visits
AGH=39
PRMC=474

WICOMICO COUNTY, MARYLAND
2010 ZIP CODE AREAS

21801	Salisbury	21840	Nanticoke
21804	Salisbury	21849	Parsonsburg
21814	Bivalve	21850	Pittsville
21822	Eden	21856	Quantico
21826	Fruitland	21865	Tyaskin
21830	Hebron	21874	Willards
21837	Mardela Springs	21875	Delmar

POST OFFICE ZIP CODES

21802	Salisbury
21803	Salisbury
21810	Allen
21852	Powellville
21861	Sharptown



Attachment 5

MDP PREPARED BY THE MARYLAND DEPARTMENT OF PLANNING
PLANNING DATA SERVICES DIVISION

N

SOMERSET COUNTY, MD
2010 ZIP CODE AREAS

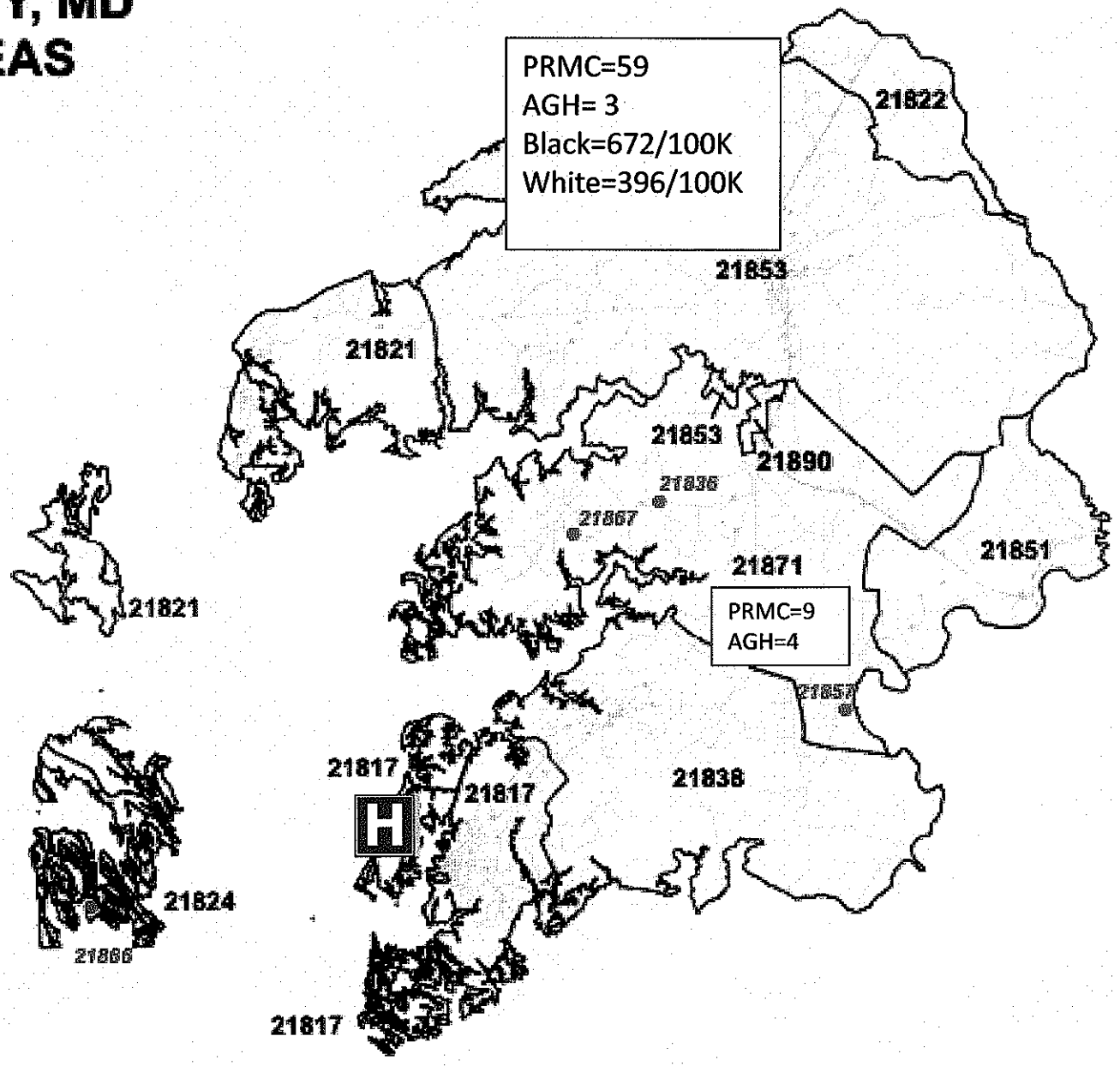
21817 Crisfield
21821 Deal Island
21822 Eden
21824 Ewell
21838 Marion Station
21851 Pocomoke City
21853 Princess Anne
21871 Westover
21890 Westover

POST OFFICE ZIP CODES

21836 Manokin
21857 Rehobeth
21866 Tylerton
21867 Upper Fairmount

Population: 26,253

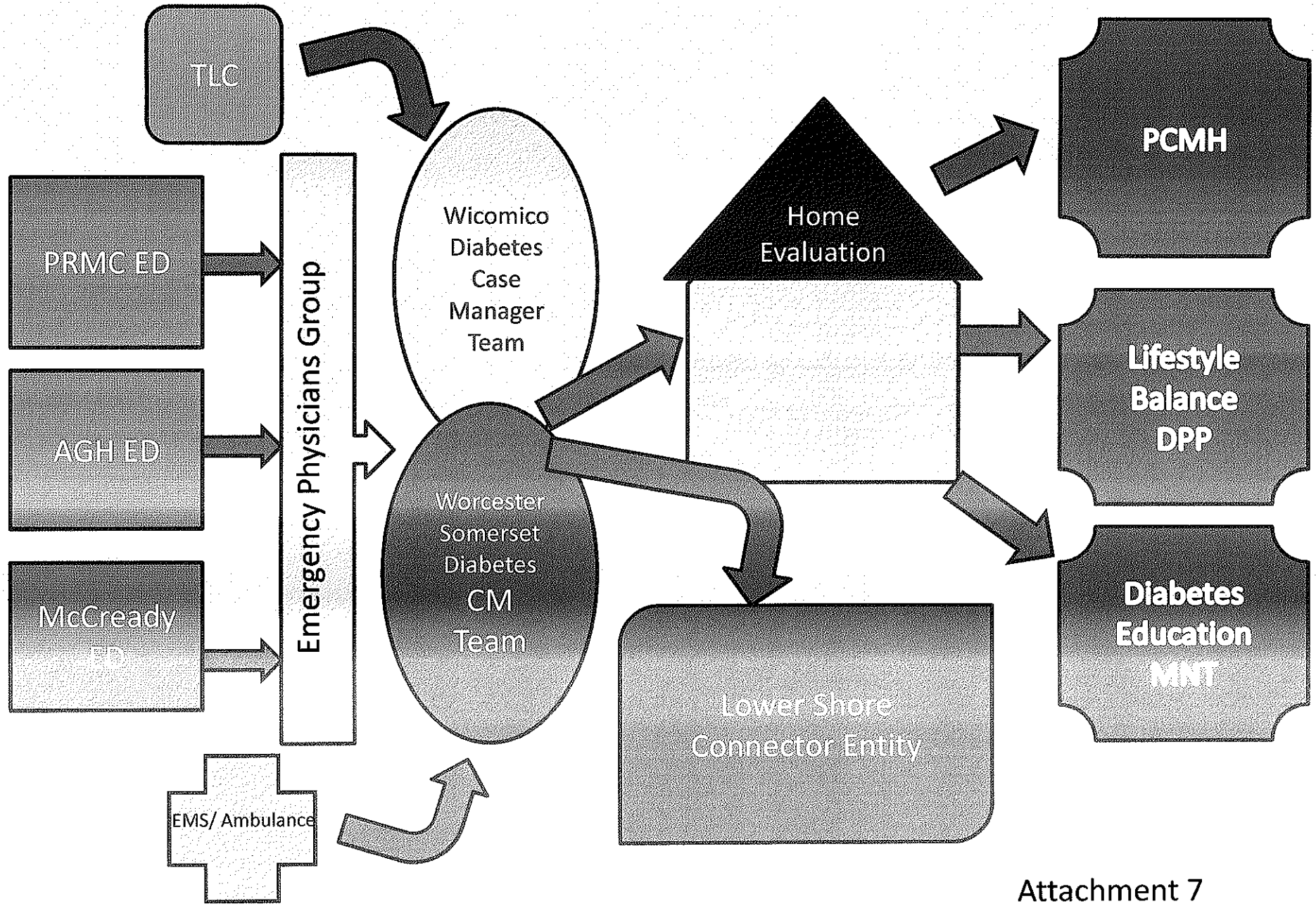
Diabetes ED visits
PRMC=82
AGH=7



Attachment 6

MDP PREPARED BY THE MARYLAND DEPARTMENT OF PLANNING
PLANNING DATA SERVICES DIVISION

N



Attachment 7

Diabetes Related ED visits: Access to Diabetes Care Management and Payer Coverage

Tri-County Diabetes Alliance

Referral for Diabetes Prevention, Self-Management Education, and Support

Patient Name:_____
Address:_____
Telephone:_____

- ☐ Somerset County Diabetes Case Management Team, Fax # XXX-XXX-XXXX
- ☐ Wicomico County Diabetes Case Management Team, Fax # XXX-XXX-XXXX
- ☐ Worcester County Diabetes Case Management Team, Fax # XXX-XXX-XXXX

Referred By:
- ☐ Atlantic General Hospital ER
- ☐ McCready ER
- ☐ Peninsula Regional Medical Center ER
- ☐ EMS/Ambulance Service

Telephone:_____
Date of Referral:_____
☐ Reply Requested

Diabetes Prevention/ Pre-Diabetes

- ☐ **Lifestyle Balance**-16-week, evidence-based program – **Somerset County Health Department**, Fax # 410-651-4083
- ☐ **Lifestyle Balance**-16-week, evidence-based program– **Wicomico County Health Department**, Fax # 410-548-5184
- ☐ **Lifestyle Balance**-16-week, evidence-based program– **Worcester County Health Department**, Fax # 410-632-0080
- ☐ **Pre-Diabetes/Weight Management Classes** 3-week program (Jan., May, Sept.) **Peninsula Regional Medical Center** Fax # 410-912-4936

Diabetes Self-Management Education

- ☐ **American Association of Diabetes Educators Accredited Program** Apple Drugs Diabetes and Education Center Fax # 410-860-1155
- ☐ **American Diabetes Association Recognized Diabetes Self-Management Education Program**-Atlantic General Hospital , Fax # 410-641-3341
- ☐ **American Diabetes Association Recognized Diabetes Self-Management Education Program**—Peninsula Regional Medical Center, Fax # 410-912-4936
- ☐ **Diabetes Education Programs– Senior Achieving Independent Living (SAIL)** Program seniors that have diabetes and have lost their vision– Blind Industries Fax # 1-888-548-5085
- ☐ **Stanford Diabetes Self-Management Education Program**– Education Programs for Adults age 50+, MAC INC Fax # 410-742-0525
- ☐ **Stanford Diabetes Self-Management Education Program**– University of Maryland Eastern Shore, Fax # 410-621-3550

Diabetes Support Groups

- ☐ **Monthly Support Group**– Berlin, Atlantic General Hospital Fax # 410-641-3341
- ☐ **Monthly Support Group**– Ocean Pines, Atlantic General Hospital Fax # 410-641-3341
- ☐ **Monthly Support Group**– Adults, Peninsula Regional Medical Center, 2nd Monday of the month May-Sept, Fax # 410-912-4936
- ☐ **Monthly Support Group**– Pocomoke Library, Worcester County Health Department Fax # 410-632-0080
- ☐ **Monthly Support Group**– Pump Club Every 3 months, Peninsula Regional Medical Center, Fax # 410-912-4936
- ☐ **Monthly Support Group**– Snow Hill Library, Worcester County Health Department Fax # 410-632-0080
- ☐ **Monthly Support Group**– Teens & Kids, Every other month, Peninsula Regional Medical Center, Fax # 410-912-4936

Medical Nutrition Therapy (MNT)- Individual nutrition counseling provided by a registered dietitian.

- ☐ **Atlantic General Hospital**– Fax # 410-641-3341
- ☐ **Three Lower Counties**—Fax # 410-546-2656
- ☐ **Peninsula Regional Medical Center**– Fax # 410- 4912-4936
- ☐ **Worcester County Health Department**– Fax # 410-632-0080

Referral Follow-up:
Referral received on:_____
Date

Check all completed:

Office Use Only

- ☐ Appointment made for program/service
- ☐ Patient refused service
- ☐ Patient ineligible for program
- ☐ Patient did not keep appointment
- ☐ Other action:_____

_____
Date/Signature

Return a copy of this form to Health Provider with Follow-up information

Attachment 8

Tri-COUNTY HEALTH PLANNING BOARD

The Local Health Improvement Coalition for Somerset, Wicomico and Worcester Counties on Maryland's Lower Shore

Craig Stofko, M.Ed., LCADC
Health Officer
Somerset County Health Dept
443 523-1700

Brenda Williams, R.N.
Coordinator
Wicomico County Health Dept
410 543-6943

Jane Apson, M.S.P.H., Ph.D.
Coordinator
Worcester County Health Dept
410 632-1100

Mr. Marc Luchner
Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

RE: Letter of Support for Regional Reduction of Diabetes ER Visits by Case Management

Dear Mr. Luckner:

The Tri-County (Lower Eastern Shore) Health Planning Board enthusiastically supports the Worcester County Health Department application for Reduction of Diabetes ER Visits by Case Management. This Board is the Local Health Improvement Coalition for Somerset, Wicomico and Worcester Counties on the Lower Eastern Shore. The Board is committed to monitoring the community health needs and facilitating local programs to improve health status. One mechanism is by keeping the majority of its membership community organizations, stakeholders, and non-healthcare agencies. Additionally, the Board developed a *Tri-County Health Improvement Plan* (T-CHIP) which includes the SHIP goal to reduce ER visit rates for Diabetes.

Somerset and Worcester Counties in the Tri-County region have been Medically Underserved Areas since the early 1970's. They continue to be re-designated as Health Professional Shortage Areas for primary care. The region is economically depressed. The Tri-County region has a prevalence of Diabetes approaching double the state rate. The risks for other chronic health conditions associated with Diabetes are also high; as are the Rates of ER visits by Diabetes diagnoses. The region has been implementing the National Diabetes Prevention Program for a year and the Tri-County Diabetes Alliance has been concentrating on early screening and diagnosis since 2005.

For the proposed project the three local health departments and all three acute care hospitals in the region, one of which is the tertiary hospital for the region, are:

- developing a coalition and subsequently a network for program implementation
- analyzing the local ER visit data to isolate the ER use rates for regional residents (objective on original T-CHIP)

- buying a portable telemedicine unit for recording and transmitting Diabetes related biometrics in real time
- implementing a case management program to get Diabetes patients in better compliance with primary care appointments and treatment
- project evaluation, for both process and outcome

The Tri-County Health Planning Board urges you to seriously consider this project.

Sincerely,

Jane R. Apson, MSPH, PhD
Coordinator

CC: Craig Stofko, Health Officer, Somerset County
Lori Brewster, Health Officer, Wicomico County
Deborah Goeller, Health Officer, Worcester County

P. O. Box 1978
Salisbury, MD 21802-1978
410-749-1015 (Fax) 410-749-1020

May 30, 2013

Mr. Mark Luckner
Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

RE: Letter of Commitment for Regional Reduction of Diabetes ER Visits through Case Management

Dear Mr. Luckner:

Three Lower Counties Community Services, Inc. supports the application for Reduction of Diabetes ER visits and related disparities, submitted by Worcester County Health Department, on behalf of the Tri-County Health Planning Board (LHIC).

This project aims to reduce diabetes-related ED visit rates in the three lower shore counties of Worcester, Wicomico and Somerset counties. Diabetes specific Nurse/Social Worker teams will assist patients to:

- obtain insurance coverage when needed,
- connect with primary care and patient centered medical homes,
- utilize diabetes self-management and nutrition services,
- avoid unnecessary ER visits through screening and triage, with facilitated referrals to alternative care settings.

The implementation will involve the collaboration of 3 local health departments, 2 community hospitals, 1 regional medical center, the Lower Shore Connector Entity, physician practices and groups participating in the PCMH initiatives, Three Lower Counties- the regional FQHC, the private practice of Emergency physicians which staff the three hospital ED(s), Apple Drug Pharmacy, as well as other local health resources.

For the proposed project, this agency agrees to:

1. Host 1 medical staff training venue to allow introduction and orientation of medical staff to the Tri-County Diabetes Case Management Team, project resources, as well as referral process.

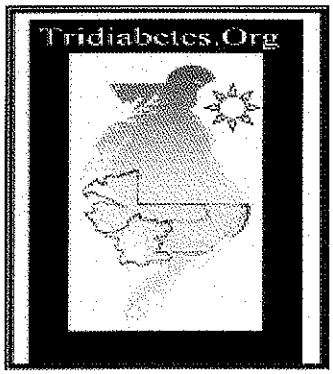
3. During the period of the grant implementation, TLC will accept new referred diabetes patients who are in need of a primary care medical home at TLC, regardless of ability to pay or insurance coverage for the service. This commitment is made acknowledging that all patients will be referred to the Navigator Entity to obtain insurance coverage within the period of the program.

4. Facilitate TLC providers and staff to make referrals into the Diabetes Case Management team covering the patients' county of residence, using the Universal Referral Form created by the Tri-County Diabetes Alliance.

Please consider this letter of support in consideration of the application for CHRC funding of the Tri-County Diabetes ED Visit and Disparity reduction project.

Sincerely,

Daniel R. Eisemann, M.D.
Vice President of Medical Affairs/CMO
Three Lower Counties Community Services, Inc.



Tri-County Diabetes Alliance

Prevention / Resources / Guidance / Education

May 30, 2013

Mr. Mark Luckner
Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

RE: Letter of Support for Regional Reduction of Diabetes ER Visits by Case Management

Dear Mr. Luckner:

The Tri-County Diabetes Alliance strongly supports the Worcester County Health Department's application for **Reduction of Diabetes ER Visits by Case Management**. The Alliance is committed, as a member of the Tri County Health Planning Board, to monitoring the community health needs related to diabetes prevention and management. The mission of the Tri County Diabetes Alliance is prevention and management of diabetes in Somerset, Wicomico, and Worcester Counties. Currently, the three Lower Eastern Shore health departments have partnered to implement the National Diabetes Prevention Program that promotes healthy eating, physical activity, and weight loss to prevent and delay diabetes.

Somerset and Worcester Counties in the Tri-County region have been Medically Underserved Areas since the early 1970's. They continue to be re-designated as Health Professional Shortage Areas for primary care. The region is economically depressed. The Tri-County region has a prevalence of Diabetes approaching double the state rate. The risks for other chronic health conditions associated with Diabetes are also high; as are the Rates of ER visits by Diabetes diagnoses. The region has been implementing the National Diabetes Prevention Program for a year and the Tri-County Diabetes Alliance has been concentrating on early screening and diagnosis since 2005.

For the proposed project the three local health departments and all three acute care hospitals in the region, one of which is the tertiary hospital for the region, are:

- developing a coalition and subsequently a network for program implementation
- analyzing the local ER visit data to isolate the ER use rates for regional residents (objective on original T-CHIP)

- implementing a Nurse/Social Work case management program to assist individuals with diabetes to:
    - Obtain payer source coverage as needed through use of the Navigator entity.
    - Achieve better adherence with primary care appointments through connection with Patience Centered Medical Homes or primary care services.
    - Achieve improved health outcomes through diabetes treatment and self management education.
    - Avoid unnecessary Emergency Room visits through pre-screening and facilitated urgent visits in alternative care settings (home visits or urgent care settings).
- purchasing a portable telemedicine unit for recording and transmitting Diabetes related biometrics in real time
- engaging in project evaluation, for both process and outcome

The Tri County Diabetes Alliance supports this collaborative proposal. We are excited about the potential for this project to improve both the quality and quantity of life for the residents of Somerset, Wicomico, and Worcester counties.

Thank you for your consideration.

Sincerely,

Mimi Dean

Mimi F. Dean, MS
Chair, Tri County Diabetes Alliance

Mr. Mark Luckner
Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

May 29, 2013

RE: Letter of Commitment for Regional Reduction of Diabetes ER Visits through Case Management

Dear Mr. Luckner:

Apple Discount Drugs (pharmacy provider) supports the application for Reduction of Diabetes ER visits and related disparities, submitted by Worcester County Health Department, on behalf of the Tri-County Health Planning Board (LHIC).

This project aims to reduce diabetes-related ED visit rates in the three lower shore counties of Worcester, Wicomico and Somerset counties. Diabetes specific Nurse/Social Worker teams will assist patients to:

1. obtain insurance coverage when needed,
2. connect with primary care and patient centered medical homes,
3. utilize diabetes self management and nutrition services,
4. avoid unnecessary ER visits through screening and triage, with facilitated referrals to alternative care settings.

The implementation will involve the collaboration of 3 local health departments, 2 community hospitals, 1 regional medical center, the Lower Shore Connector Entity, physician practices and groups participating in the PCMH initiatives, the private practice of Emergency physicians which staff the three hospital ED(s), as well as other local health resources.

For the proposed project, this agency agrees to:

1. Provide pharmaceutical assistance for clients who do not have insurance and require insulin until they can be linked to an insurance program.

Please consider this letter of support in consideration of the application for CHRC funding of the Tri-County Diabetes ED visit and Disparity Reduction project.

Sincerely,

Signature Jeffrey B Sherr RPh President

Name Jeffrey B Sherr RPh

Title President

Affiliation Apple Discount Drugs

ESA
Emergency Service Associates

Mr. Mark Luckner
Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

May 29, 2013

RE: Letter of Commitment for Regional Reduction of Diabetes ER Visits through Case Management

Dear Mr. Luckner:

The Emergency Services Associates supports the application for Reduction of Diabetes ER visits and related disparities, submitted by Worcester County Health Department, on behalf of the Tri-County Health Planning Board (LHIC).

This project aims to reduce diabetes-related ED visit rates in the three lower shore counties of Worcester, Wicomico and Somerset counties. Diabetes specific Nurse/Social Worker teams will assist patients to:

1. obtain insurance coverage when needed,
2. connect with primary care and patient centered medical homes,
3. utilize diabetes self management and nutrition services,
4. avoid unnecessary ER visits through screening and triage, with facilitated referrals to alternative care settings.

The implementation will involve the collaboration of 3 local health departments, 2 community hospitals, 1 regional medical center, the Lower Shore Connector Entity,

100 E. Carroll Street, Salisbury, MD 21801
410.543.7742

ESA
Emergency Service Associates

physician practices and groups participating in the PCMH initiatives, the private practice of Emergency physicians which staff the three hospital ED(s), as well as other local health resources.

For the proposed project, this agency agrees to:

1. Participate in a medical staff training to allow introduction and orientation of medical staff to the Tri-County Diabetes Case Management Team, project resources, and referral process.

2. Facilitate ED staff to make referrals from the ED into the Diabetes Case Management team covering the patients' county of residence, using the Universal Referral Form created by the Tri-County Diabetes Alliance.

Please consider this letter of support in consideration of the application for CHRC funding of the Tri-County Diabetes ED visit and Disparity Reduction project.

Sincerely,

Signature
JG

Name
Title
Affiliation

100 E. Carroll Street, Salisbury, MD 21801
410.543.7742