Calvert County Community Health Improvement Roundtable Narrative Report

Before beginning to form the Community Coordination Care Team, emergency room utilization report were developed for diabetes and hypertension related visits by African American population to address disparity target area in Calvert County SHIP action plan. Based upon the analysis we found that most of the patients had some type of insurance as well as listed a primary care physician. We met with hospital ER case manager, Patient Center Medical Home Care Coordinators, Diabetes Educators, Endocrinologist, Inpatient Nurse Educators, Transitions Care Coordinators as well as individual patients to get a perspective of what was actually causing the high number of repeat cases and sheer number of ER visits. We found that ER case managers were working with patients who did not have insurance or primary care physician and making the appropriate referrals, we also found that patients who had primary care physician were being referred back and with one CPA practice they actually already had a protocol where daily report were sent to Care Coordinators to address ER visit by patients of that practice.

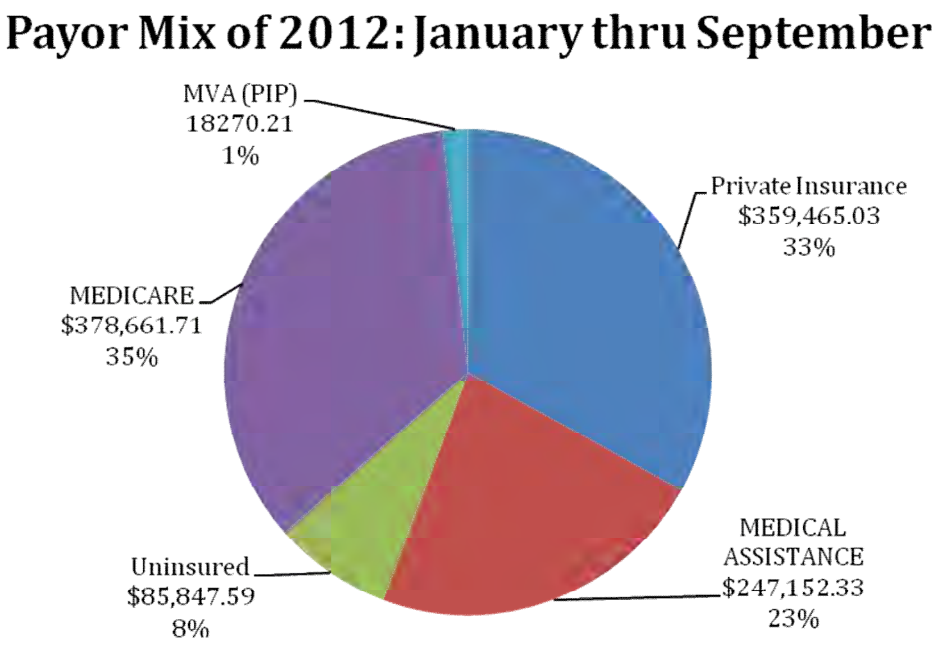
What we found was a gap in transitioning patients from the ER to the appropriate next level of care. Although the patients were directed to see their physician or appropriate care provider many times either the appointment was not made, the patient did not understand, they did not have access to transportation or funding to see provider. We also evaluated how patients were educated within our health care system around Diabetes. We found that many different educational materials were be using by the inpatient education, doctor offices, ER discharge, diabetes educators and community programs. We also found that many of the patients had already taken the Diabetes Self – Management program and insurance would only cover it once in a lifetime.

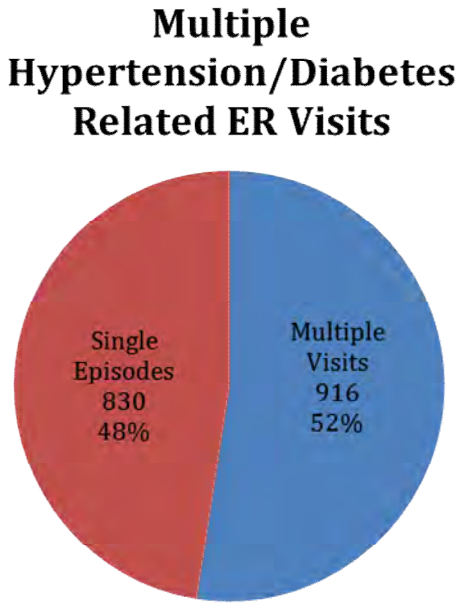
We brought these issues before out Diabetes Care Team and decided to look at our overall diabetes protocol and order sets. The team decided it would be beneficial to work collaboratively with the LHIC grant and implement a system wide "Diabetes Survival Guide" education books to complement our Diabetes Self-Management program as well as develop a Diabetes Boot Camp. The camp would teach patient how to monitor their blood sugar level as well as give them a refresher course on the important of maintain normal blood sugar level to avoid having to complications. Upon further discussion we discovered that when teaching patient how to monitor blood sugar level they are asked to check their blood four time per day (once in the AM, two hours after they eat, mid-day and before they go to bed), however Medicare/Medicaid will only cover one testing strip per day. We realized this was a barrier to the patients learning how to monitor their blood sugar levels and may be part of the problem. We would like to ask that some of the grant funding monies be reallocated to pay for testing strip for participants in the Boot Camp program. These patients will be referred from the ER to our program.

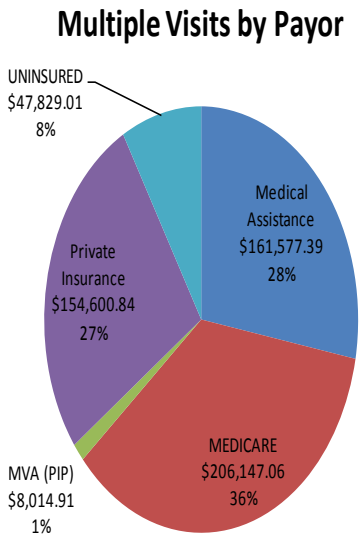
Listed below are the Stats for ER utilization from January through September, 2012:

Data shows that 1,746 ER visits were primarily related to diabetes or hypertension costing $ 1,089,396.87. Further analysis shows that 299 individuals had multiple visits within the nine month period, some having multiple visits within the same month. These

multiple ER visits resulted in 916 visits costing a total $578,169.21 with 36% attributed to Medicare, 28% Medial Assistance, 8% self-pay / uninsured and 27% to Private Insurance. This type of service utilization results in a financial loss for Calvert Memorial Hospital due its Total Patient Revenue (TPR) payment structure. This is also an area and opportunity for cost saving to the State Plan.



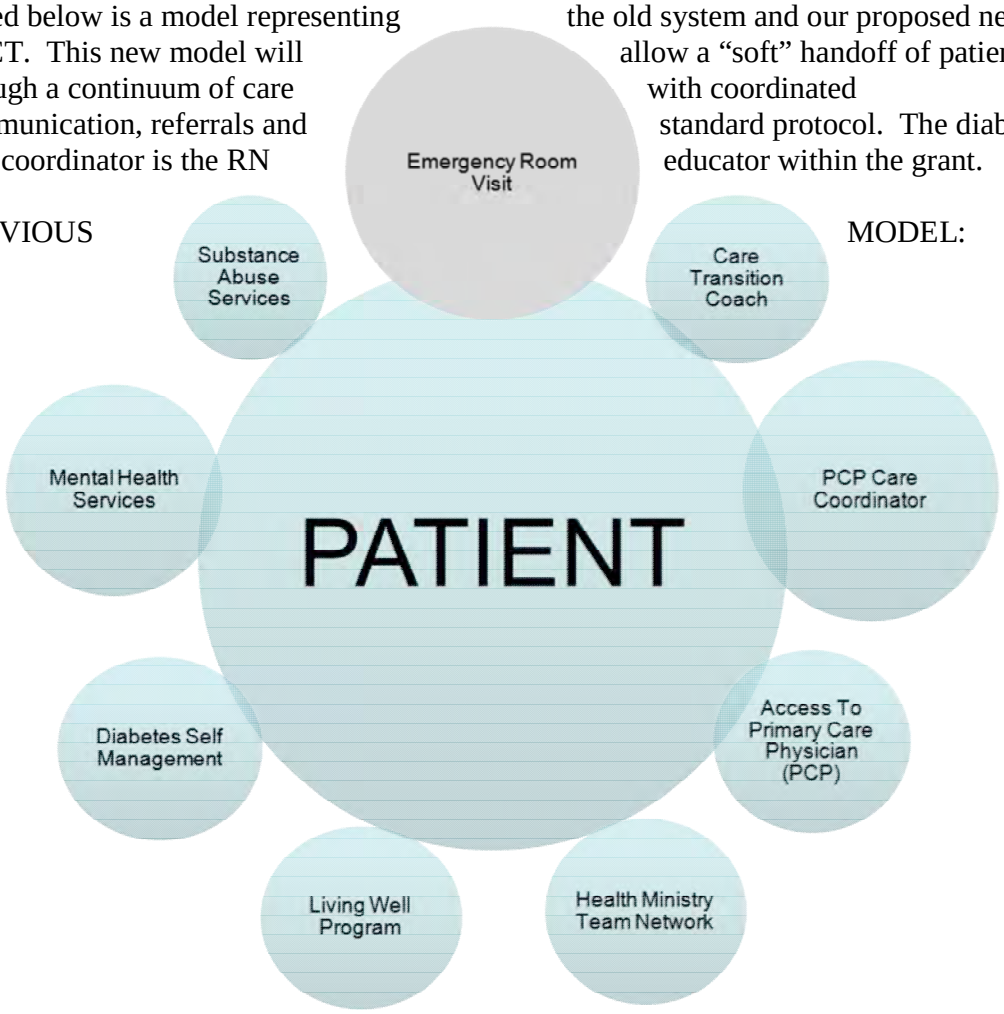




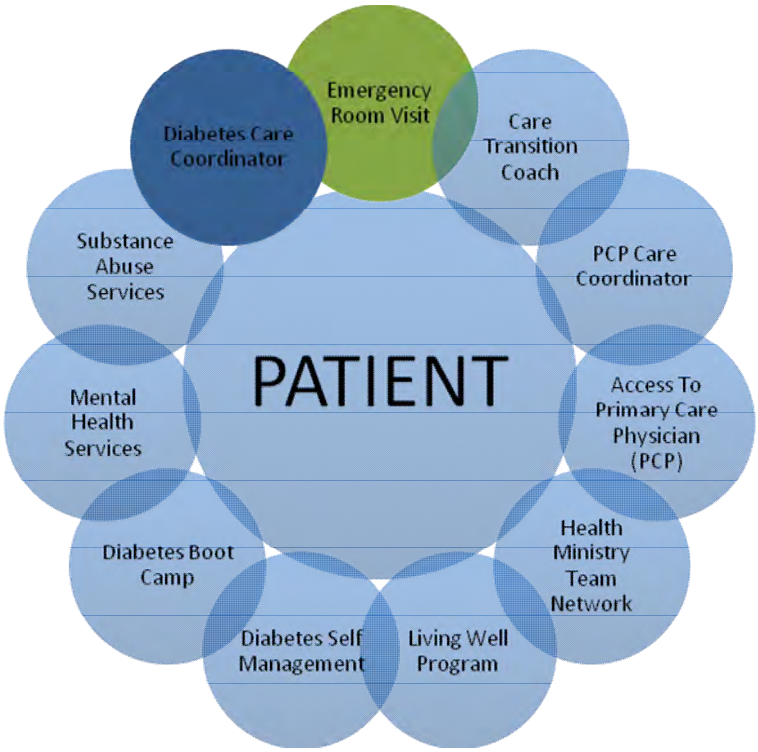
While most of our time has building the foundation to create the CCCT, creating new partnership with additional African American faith based organizations, developing measuring and tracking systems, new education programs and services as well as building a new screening tools with the finger stick A1c and cholesterol we have created a model that we feel will be very successful not only for sustainability, but continuity of care for the patient.

Listed below is a model representing the old system and our proposed new CCCT. This new model will allow a "soft" handoff of patients through a continuum of care with coordinated communication, referrals and standard protocol. The diabetes care coordinator is the RN educator within the grant.

PREVIOUS MODEL:



NEW MODEL


Emergency Room Visit
Diabetes Care Coordinator
Care Transition Coach
Substance Abuse Services
PCP Care Coordinator
PATIENT
Mental Health Services
Access To Primary Care Physician (PCP)
Diabetes Boot Camp
Health Ministry Team Network
Diabetes Self Management
Living Well Program

We feel this model will better serve the community it will create a wider area where patients can get the support they need to better understand how to take care of their health and help them navigate the healthcare system. It will give more support to patients who may need the extra care or special needs. In analysis of the ER data we also found that many patients who had diabetes or hypertension also suffered from a mental health condition or substance abuse. While diabetes and hypertension are medical conditions and based upon HSCRC data they are visiting the ER for those disease types, the main problem is due to a substance abuse or mental health condition that does not allow them to take appropriate care of their disease. With the integration of the mental health and substance abuse services we can better serve these patients.

The one major component we have identified is the need for one platform to communicate with each other since the CCCT involves state agencies, health system, faith based organizations and community programs. We will use conventional emails, telephone call and Next Gen for now, but will be looking into a new modality of Next Gen called Next Pen which allows limited access to Next Gen for coordinating care.

We also hosted a Dining with the Doctor which featured Lung Cancer Screening Awareness program where two of our Oncologist discussed causes of lung cancer, stages of cancer, as well as the new screening guideline for lung cancer to improve survival rates. We had 24 participants attend the program and provide education about the new screening guidelines, smoking cessation programs, stats for Calvert County Cancer rate based upon SHIP data and our action plan to help reduce cancer rates. We also had information around nutrition and fitness program available in the county.

Since we do not have access to the spectrum of physician needed to implement a full lung cancer screening program, we will continue to educate the community about these new guidelines and direct them to their primary care physician offices. We will also provide education to the primary care physician about the new lung cancer screening guidelines and provide referrals form. We did not utilize the grant funding for providing 10 low dose CT scans and would like to ask if we can reallocate this funding toward testing strip to be used by patients referred to the Diabetes Boot Camp who cannot afford the testing strips since insurances only cover one testing strip per day.

We are excited about the opportunities to roll out these new programs and services to the community and measure the impact on our community's health. I hope you will grant us permission to extend our grant period to June 30, 2013.

Thank you again for this grant opportunity.