

**Broward Regional Health Planning Council, Inc.**

# **Disease Management**

**Community Access Program (CAP)**

**2001-2002**



Michael De Lucca, Master of Health Management

Deputy Director

Broward Regional Health Planning Council



# Presentation Overview

Introduction

Broward County's Community CAP Grant

Diabetes Outcomes



# Award

Broward Regional Health Planning Council  
received a CAP grant in the amount of \$922,500  
in March 2001 to enhance existing disease  
management programs for the uninsured and  
underinsured in Broward County.



# Program Focus

- Continuum of care and health care costs for **asthma, diabetes and HIV/AIDS,**
- Management of episodic clinical events, and
- High utilization patterns and health care costs



# Program Description

- **Case management** provided by **Broward County's two tax assisted hospital districts.**
- Disease-specific clinical case managers facilitate quality care by coordinating services, using clinical pathways and verifying patient progress according to individual care plans.



# Partnership Members

- [North Broward Hospital District](#)
- [South Broward Hospital District](#)
- [Broward County Health Department](#)
- [Broward County Human Services Department](#)
- [Broward Regional Health Planning Council, Inc.](#)
- [First Call For Help of Broward, Inc.](#)
- [Community Foundation of Broward County](#)
- [The Coordinating Council of Broward](#)
- [Broward Community and Family Health Centers](#)



# Program Goals

- **Improved access to health care** services through promotion of a pre-eligibility system;
- **Improved information and referral system**
- Increased awareness of existing resources;
- **Improved data management** and case tracking thorough an enhanced information management system; and
- **Improved care** through better case management for diabetes, asthma, and HIV/AIDS.



# 24 Hour Help lines:

Help-lines answered by trained counselors assess callers' needs, perform **preliminary eligibility screenings**, and make referrals to appropriate health and community services.



# Software Development

- **Standardization of data**, pre-eligibility screening criteria, and eligibility processes to standardize the process for the uninsured to obtain health care and other needed human services
- Consistent and appropriate adherence to **confidentiality** standards



# A critical role in ensuring enrollment was played by First Call For Help, which

- implemented a 24-Hour Health Hotline, whose counselors handled over 6,000 calls during the 12-month period, and provided **7,620 referrals** on health-related needs;
- developed and implemented a **marketing plan**; and
- distributed wallet cards and flyers in English and Spanish to make its availability known.



# Summary of Enrollments 2001-02

At the end of February 2002, **1,193 clients were enrolled** in the disease management program at the two hospital districts. Most of those patients had **diabetes (910, 76%)**, while another **214 had asthma** and the remaining **69 had HIV/AIDS**.



# Evaluation Methodology

## Diabetes



# Program Goals

- Improved patient health-related Quality of Life,
- Reduced patient HgbA1c levels,
- Decrease diabetes related emergency room visits and in-patient length of stay, and
- Reduce associated costs.



# Measures

- Quality of Life and glycemic levels were assessed upon patient enrollment and tracked over time.
- Patient hospitalizations and emergency room visits were analyzed for a one-year period prior to the program and compared to the same information following one year of enrollment.



# Quality of Life

Results from the initial and six month follow-up SF-12 health status survey data exhibited an **increase in quality of life** for clients in the disease management program.



# Emergency Room Visits and Hospital Admissions

- Reduction of **in-patient admissions** (80%) and associated costs (83%)
- Reduction of **emergency room visits** (51%) and associated costs (50%)
- Reductions totaled almost **\$3 million** and an **82% overall decrease**



## DIABETES RELATED IN-PATIENT AND ER ADMISSIONS

	Baseline	One-Year	# Change	Actual Change
In-Patient Admissions	497	96	-401	-80.7
ER Admissions	363	176	-187	-51.5
In-Patient Costs	\$3,476,871	\$588,712	-\$2,888,159	-83.1
Emergency Room Costs	\$91,319	\$45,021	-\$46,298	-50.7
Total Admissions Costs	\$3,568,190	\$633,733	-\$2,934,457	-82.2



# Clinical Measures

The mean baseline Hba1C level in this group was 8.45 and **decreased** to 7.72 over a 6 month enrollment, decreasing the mean severity one clinical level from moderate to borderline.



# CLINICAL OUTCOME: CHANGE IN Hba1C

Stratified Groups		At Baseline	At 6 Months
Mean		8.45	7.72
In Control	<7	31.7%	42.1%
Borderline	7.0-8.0	19.5%	20.7%
Moderate	8.1-10.0	27.4%	26.5%
Severe	>10.0	21.3%	10.7%

N=(328) # of Enrollees with at least a baseline and six month test



# Patient & Provider Satisfaction

The client and provider surveys both revealed **significant levels of satisfaction** with the program.



# SATISFACTION SURVEY RESULTS (n=28)

% Stating they Strongly Agree or Agree

I felt that my privacy was not invaded when contacted by the Disease Manager	82%
I was treated with dignity and respect by the Disease Manager	89%
The Disease Manager was sensitive to my feelings	89%
The explanation of the Disease Management Program and the benefits of me being a part of the program were clear to me	86%
The Disease Manager was helpful in clearing up any confusion I felt regarding my medical treatment	89%
I was treated with dignity and respect by the physician	89%
The physician was sensitive to my feelings	89%
The explanation of my medical condition was clearly explained by my physician	86%
I was satisfied with the plan of care offered by my physician	86%
My physician encouraged me to ask questions about my treatment plan	86%
I feel as though I have benefited from the Disease Management Program	86%



# Outcomes

Findings imply that disease management for the uninsured and underinsured populations create significant improvements in glycemic control, health related quality of life, and patient and provider satisfaction as well as substantial financial savings.



# Barriers

- This program was instituted as a clinically based program as opposed to a research study that resulted in limited data collection capabilities.
- Alternative stand-alone databases were created to analyze patient clinical status not maintained on the mainframe system.



# Data Collection Revisions

- At the end of year one, data collection systems were analyzed for effectiveness.
- Data collection revisions needed to be made in multiple areas including **collecting additional information** and **standardizing testing timeframes for comparison purposes.**



# Questions?

**MDELUCCA @BRHPC.ORG**

Additional Information:

[www.brhpc.org/cap/](http://www.brhpc.org/cap/)

