3.b.i Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only)

Project Objective: To support implementation of evidence-based best practices for disease management in medical practice for adults with cardiovascular conditions. (Adults Only).

Project Description: The goal of this project is to ensure clinical practices in the community and ambulatory care setting use evidence based strategies to improve management of cardiovascular disease. These strategies are focused on improving practitioner population management, adherence to evidence-based clinical treatment guidelines, and the adoption of activities that will increase patient self-efficacy and confidence in self-management. Strategies from the Million Hearts Campaign (http://millionhearts.hhs.gov) are strongly recommended.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the attachment: **Domain 1 DSRIP Project Requirements Milestones & Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.
2. Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.
3. Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.
4. Use EHRs or other technical platforms to track all patients engaged in this project.
5. Use the EHR or other technical platform to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).
6. Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.
7. Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.
8. Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.
9. Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.
10. Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.

Improve Medication Adherence:

11. Prescribe once-daily regimens or fixed-dose combination pills when appropriate.

Actions to Optimize Patient Reminders and Supports:

12. Document patient driven self-management goals in the medical record and review with patients at each visit.
13. Follow up with referrals to community based programs to document participation and behavioral and health status changes
14. Develop and implement protocols for home blood pressure monitoring with follow up support.
15. Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.
16. Facilitate referrals to NYS Smoker's Quitline.
17. Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.
18. Adopt strategies from the Million Lives Campaign.
19. Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.
20. Engage a majority (at least 80%) of primary care providers in this project.

Project Response & Evaluation (Total Possible Points – 100):

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

Cardiovascular disease (CVD) is a significant issue in Suffolk County. Of all Medicaid beneficiaries with a cardiovascular condition, 25,403 were admitted to the hospital and 19,717 visited the ER for this condition in one year. Ten percent of Medicaid admissions are related to Cardiac Disorders or Hypertension, 49.3% of total admissions have either a primary or secondary diagnosis of CVD including Hypertension. CVD is the 3rd leading cause of avoidable admissions in Suffolk County. The areas with the highest number of Medicaid beneficiaries with CVD are: Brentwood, Bay Shore, Huntington Station, Patchogue, Riverhead and Lindenhurst according to Health Data NY. Community Health Survey Data revealed that almost three quarters of the Medicaid population in Suffolk County is overweight or obese, 15.6% report that they suffer from or have been diagnosed with heart disease (Total Suffolk County 6.2%), 36.4% of the Medicaid population has high cholesterol (Total Suffolk County 31.1%) and 31% of the Medicaid population are current smokers (Total Suffolk County 15.9%).

OVERVIEW: To help close these identified gaps, this project seeks to engage 80% of participating primary care practices to focus on the development of 1) a case management (CM) approach for patients with hypertension/CVD risk and 2) a PPS-developed practice support model to improve

and automate their office practices within the context of PCMH/Advanced Medical Home, targeted toward best-practice clinical care for CVD.

The CM approach will use designated Health Managers (commonly nurses), lay care associates, and existing care/education resources in the County. These resources, in conjunction with the embedded and regional CM resources developed within the PPS care management structure (see project 2A1) for all projects, will use evidence-based prevention and disease management techniques, like those used in the Million Hearts Campaign, to better manage the population of patients with Hypertension and CVD risk. The Stanford Chronic Disease Self-Management program will be implemented in a targeted population of high-risk individuals. CM staff will be responsible for developing linkages with Health Homes to identify and manage high-risk populations.

The primary care practice support model will leverage the Million Hearts physician recommended interventions. The practices will build new processes to manage hypertension and CVD risk factors with standard protocols and automation through the EHR for patient tracking, alerts for abnormal readings and for care gaps. Health literacy and self-efficacy will be addressed through targeted education and self-management techniques and a self-management plan for each patient will be created; documented in the EHR.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

The patient population expected to be engaged is 1) adult Suffolk County residents, 2) who are Medicaid and, 3) have a cardiovascular disorder, HTN and/or hypercholesterolemia. The population will be risk-stratified into high, medium and low risk with the high risk category targeted for more in-depth CM support and/or alignment with the Health Home as appropriate. In addition, key zip codes with high burden of illness and utilization will be the first targeted patient populations for implementation of this project (Brentwood, Bay Shore, Huntington Station, Patchogue, Riverhead and Lindenhurst). The primary care practice support model will be first rolled out in DY 1 and 2 to those practices serving these geographic locations with the highest burden of illness, then spread to other PCP sites moving them all to Level 3 PCMH by the end of DY 3. Particularly in Riverhead, the CNA showed a higher proportion of Spanish-speaking, immigrant population. This region will be targeted for initial focus on piloting culturally sensitive and translated educational materials for patients and educational sessions related to cultural sensitivity and health literacy for primary care practice staff.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

Hudson River Health (HRH) has implemented the Million Hearts Campaign in counties outside of

Suffolk with great success. HRH plans on rolling this campaign out to its Suffolk County sites and will be mobilized as a resource to mentor other participating providers.

King Kullen Pharmacies has been involved in Medication Therapy Management for Medicare Part D patients since the program's inception. King Kullen has agreed to become a partner in developing a program to coordinate and integrate care outcomes. Many of the participating King Kullen Pharmacies are located in the top locations of Medicaid CV discharges.

The Medication Adherence Project is an existing collaborative team of providers that utilizes technology to ensure medication adherence. Project members include: retail and hospital based pharmacists, clinicians representing hospital, skilled nursing, rehabilitation, and community organizations, patient care providers, behavioral and cognitive psychologists, as well as bioinformatics and IT infrastructure specialists. This team will be leveraged by the PPS project team to help implement both patient and provider interventions designed to create more effective use of medication to treat hypertension and hypercholesterolemia.

The Suffolk County Department on Aging sponsors two central locations that provide resources for the integration of the Stanford Chronic Disease Self-Management Program into the community. This will be leveraged as a resource for patient interventions and will be expanded to include additional trainers and sites.

There are several other participating organizations that currently provide health screenings and programs that support the aims of this project and will be leveraged as part of a "resource catalog" that will be created for easy reference of available resources for use by participating providers. The Ed & Phyllis Davis Wellness Institute at Southampton Hospital, runs several applicable programs for weight loss and smoking cessation. The NYS Quitline "Opt-to-Quit" program, currently being piloted at Stony Brook will be leveraged as one method to provide support to those seeking to quit. The Suffolk DOH and Association for Mental Health and Wellness have partnered in the past to train staff and pilot smoke free policies in OMH programs. The NYS funded smoking cessation center operating out of NSLIJ will provide an additional source of training and resources. Stony Brook's web-based self-management platform will also include smoking cessation components.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

PATIENT CHALLENGES: 1)Large disparities in race, ethnicity, language and other cultural factors results in the need for diverse health literacy and patient education materials. 2)Lack of public transportation and limited transportation provided by community organizations results in missed follow-up appointments. REMEDIES: 1)Patient education materials at a 5th grade reading level. Translation services at health screenings and workshops. Use available resources such as

Dr. Harold Fernandez, co-director of Stony Brook University Heart Institute, who can provide assistance in partnering with community leaders regarding solutions to address disparities. 2)Expansion of Suffolk County Accessible Transportation (SCAT), streamline process to make it more accessible. Outreach and educational efforts will be held in the community where these patients live.

PROVIDER CHALLENGES: 1)Communication and coordination at handoffs between multiple entities who will touch the patient. 2) Providers have difficulty impacting smoking; other attempts to address blood pressure are likely to be unsuccessful without addressing smoking first. 3)Getting PCPs to participate REMEDIES: 1)Develop a more effective OP CM structure and documentation platform with a dedicated practice support team to ensure accurate tracking, care coordination and follow-up of all targeted patients across the continuum of PPS providers. 2)Partner with community organizations that currently have successful smoking cessation programs. 3)Use financial incentives through flow of funds to increase PCP participation.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve overlapping service areas. If there are no other PPSs within the same service area, then no response is required.

2. **Scale of Implementation (Total Possible Points - 40):**
DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

3. **Speed of Implementation/Patient Engagement (Total Possible Points - 40):**
DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

4. **Project Resource Needs and Other Initiatives (Not Scored)**

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

If yes: Please describe why capital funding is necessary for the Project to be successful.

Technology: Licenses costs associated with helping practices achieve PCMH Level 3 certification, including EMR-upgrade investments to meet EMR MU standards.
Physical PC facilities: Space considerations for implementing aspects of the 'Million Hearts' campaign e.g., tobacco cessation programs and counseling, nutrition counselors.
Care Management – The major capital resources for care management (tele-health, space, technology, equipment etc.) are included in the IDS project but will be allocated to this project on a proportional basis.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☒	☐

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
PROHEALTH Care Associates, LLP	Medicare Shared Savings			In addition to Medicare Shared Savings program, PROHEALTH also has several value-based incentive programs that focus on their Managed Medicaid population
St. James Rehabilitation and Healthcare Center	Cardio Rehab program with North Suffolk Cardiology			Telemonitored rehab/discharge follow-up
Long Island Association for AIDS Care	Health Homes			Case management/ care coordination

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards scale of project implementation, completion of project requirements and patient engagement progress in the project.

a. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of

project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.