3.c.i Evidence based strategies for disease management in high risk/affected populations. (Adult only)

Project Objective: Support implementation of evidence-based best practices for disease management in medical practice related to diabetes.

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 diabetes. Specifically, this includes improving practitioner population management, increasing patient self-efficacy and confidence in self-management, and implementing diabetes management evidence based guidelines.

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 and Metrics,** which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Implement evidence based best practices for disease management, specific to diabetes, in community and ambulatory care settings.
2. Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.
3. Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.
4. Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.
5. Ensure coordination with the Medicaid Managed Care organizations serving the target population.
6. Use EHRs or other technical platforms to track all patients engaged in this project.
7. Meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3 for EHR systems used by participating safety net providers.

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.

Diabetes prevalence among Medicaid beneficiaries in Suffolk County (19.3%) significantly exceeds the County as a whole (11%). Suffolk exceeds statewide PDI and PQI rates in all but one category. While short-term complications of diabetes (PQI 01) were similar for both Suffolk and New York, rates of long-term complications and uncontrolled diabetes were demonstrably higher countywide. Diabetes drives more unnecessary admissions in Suffolk than NYS as a whole. Four zip codes drive diabetes admissions and ED visits: Brentwood, Bay Shore, East Patchogue, and Central Islip.

Suffolk is the second largest NYS County (geographically) and public transportation is limited. Among the Target Population, 20.5% report that lack of transportation hindered their medical care last year. Although transportation proves challenging, only 37.3% of 51 PPS partners surveyed offered point-of-care (POC) HbA1c testing to their patients. Low basic literacy, health literacy and limited English proficiency is also a problem for this population.

A survey of 51 PPS members revealed only 41.2% offered diabetes education based on nationally-recognized curricula (ADA, AADE, Stanford Model). Further, according to the AADE, there are currently only 122 Certified Diabetes Educators (CDE) living in Suffolk County with a lower than expected ratio of 0.7 CDEs per 1,000 people with diabetes.

OVERVIEW: This project will close the above identified gaps by engaging at least 80% of primary care practices to focus on the development of a care management (CM) approach for patients with diabetes utilizing designated Health Managers, lay care associates, and existing diabetes care/education resources in the county who will focus on providing culturally competent service support. These resources, with the embedded or regional CM resources developed as a component of the PPS care management structure to support all projects, will create a comprehensive strategy that incorporates Identification, Management, Education and Empowerment of target population's "high risk" patients with diabetes, as well as meet the needs of those at medium or low risk; consistent with DSRIP 3.c.i requirements.

The project will leverage population management registries and care management tools as well as expand on current under-resourced educational initiatives and community resources. Primary care practices in the PPS will be engaged to redesign care delivery processes in the context of moving toward Level 3 NCQA PCMH recognition and the Advanced Medical Home model. Redesign regarding diabetes care will include integration of best practice clinical guidelines and leveraging the EHR to effectively identify and close care gaps in the patient population with diabetes.

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 target patient population is: 1) Suffolk County residents, 2) Medicaid patients, 3) who have been diagnosed with Type 1 or Type 2 diabetes mellitus (T1DM/T2DM). The project seeks to

target areas with greatest potential for impact: areas with 1) highest prevalence of diabetes 2) highest utilization of ED and inpatient care and 3) where there is an overlap of patients with the highest level of comorbidity. Regions with high burden of illness and utilization will be the first targeted patient populations for implementation of this project (Brentwood, Bay Shore, East Patchogue, and Central Islip). The primary care practice support model will be first rolled out in DY 1 to those practices serving these geographic locations, then spread to other PCP sites moving them all to Level 3 PCMH by the end of DY 3.

The targeted "high-risk" patients include those with multiple co-morbidities (CHF, CKD, COPD, CAD), elevated HbA1c, polypharmacy and/or insulin use. Based on Stony Brook population data, prevalence of concurrent diabetes and comorbid cardiovascular disease, CKD and behavioral health disorders are markedly higher in the Medicaid/Uninsured population in Suffolk County. Presence of one or more comorbidities increases the risk of ED visit, hospitalization and readmission.

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.

All 8 participating hospitals in Suffolk serve as core resources with some existing form of diabetes education and prevention classes (Eastern Long Island Hospital, NSLIJ, Stony Brook, Brookhaven and Southampton hospitals all offer free diabetes prevention classes to the community). These resources implement current best-practices in diabetes education (i.e. Stanford Model, AADE curricula), however access is extremely limited and resources are underutilized, due in part to limited availability in high prevalence areas. The current educational assets and resources to be enhanced and expanded are located at these Hospitals, 6 Suffolk County Health Centers currently run by the SCDOH and Hudson River Health, in addition to multiple privately/publicly offered programs (i.e. YMCA, Suffolk County Department of Aging, Diabetes Resource Coalition of Long Island and Suffolk County Department of Health Services in collaboration with Cornell Cooperative Extension of Suffolk County). We plan to expand and better resource current education initiatives in the county and redirect to highest-risk patients by geographic need. This will be accomplished by increasing the number of CDEs and Stanford Model-trained educators, along with disseminating nationally-recognized diabetes education materials and resources in multi-lingual, culturally-sensitive formats. Resources available through IDS project 2A1 will be leveraged for this project

There are several other organizations that currently provide health screenings and programs that support the aims of this project, which along with the entities noted above will be leveraged as part of a "resource catalogue" that will be created for an easy provider reference of available resources. These include Suffolk County government which offers free disease prevention classes at the Southampton Town Center, Southold Free library, Wyandanch Senior Nutrition Center and Southside Hospital, and the "Creating Healthy Places in Suffolk County" initiative aimed at improving access to healthier food choices and increasing physical activity.

Three Health Homes currently exist to serve the complex health needs of this population and

will be leveraged to continue their foundational support for the highest risk population as well as to learn from their current knowledge of the community and community based resources.

Hudson River Health (HRH), an organization managing Federally Qualified Heath Centers (FQHCs) across multiple NY counties, is a key asset in this diabetes management project with its current plans to assume management of all six former Suffolk County DOH clinics. They will be leveraged as high-volume sites for early implementation of CM and practice redesign efforts around diabetes care with the Medicaid population that they serve.

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.

CHALLENGES: 1)Engagement of 80% of primary care practices within the PPS. 2)Difficulty addressing issues with medication errors: omissions, duplications, dosing errors or drug interactions. 3)Ability to achieve PMCH Level 3 recognition by DY 03. 4) Address growing epidemic of Diabetes and Obesity. 5)Lack of available public transportation. 6)PCP participation

REMEDIES: 1)Show value to PCPs by improving access to comprehensive diabetes education and point-of-care testing (POC-HbA1c). Provide effective care management support. 2)Build medication reconciliation into diabetes care management program to occur at every transition of care: when new medications are ordered, existing orders are adjusted or patients report non-prescriptive medications. Medication adherence will be embedded in all case management protocols, pharmacist support, and will be part of the Stanford Chronic Care educational platform. 3)Provide practice support teams to engage PPS primary care practices to redesign their care delivery processes to move to Level 3 and Advanced Medical Home model. 4)Increase Stanford education resources and also increase CDE resources at a ratio of 2 CDEs to 1,000 people with diabetes in the target population (doubling current capacity in the county) 5)Deployment of POC-testing will prevent patients from extra traveling to physician's offices or clinical laboratories, enhancing compliance with national guidelines for regular testing/monitoring. 6) Align PCPs through pay for performance incentives.

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. <u>Scale of Implementation</u> (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 outreach campaign e.g., tobacco cessation programs and counseling, nutrition counselors.
Space Rentals – Rent space in community centers and other venues to outreach to the general population with key messages re: diabetes prevention and management.
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.
Additional Resources – There will also be a need for point-of-care HbA1c machines as well as associated supplies

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
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
Central Nassau Guidance & Counseling Service				3-year grant for on-site primary care; also received OMH funding for short-term crisis respite -hospital division - 2 years
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.

The programs listed above provide support to this PPS project through various means that primarily include the sharing of important information about their efforts. This includes such items as the sharing of comparative information about expected gaps in care, the type of community resources that have been found to be available, and sharing of information about individual patients that they may have been touched. However, in no case do these programs specifically duplicate what the PPS intends to accomplish with this project to be able to meet the specific project requirements. All staffing and resources that need to be applied to make this project successful do not duplicate the resources used by these existing community programs, they are complimentary. In particular all PPS efforts will be highly aligned with the

local Medicaid Health Homes, which are taken into account as an existing form of care support that will not be duplicated in this 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 completion of project requirements, scale of project implementation, 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.