Suffolk Care Collaborative
Access to Chronic Disease Preventive Care Initiative

4b2. Increase Access to High Quality Chronic Disease Preventive Care & Management in both Clinical and Community Settings

Project Charter

Through DSRIP, a grant waiver administered by the NYS DOH, $6.42 Billion Medicaid dollars were allocated to fundamentally restructure the health care delivery system to transition care delivery from a largely inpatient-focused system to a community-facing system that addresses both medical needs and social determinants of health. DSRIP is a 5-year, performance payment-based program with primary goal of reducing avoidable hospital use by 25% over 5 years. At the end of program life, the aim is for the newly-transformed system to be sustainable. Program efforts are focused on achieving improved overall health through integration of behavioral health and primary care, provision of appropriate levels of care management, and care delivery models designed to improve chronic disease prevention and outcomes.

Objective Statement:

This project will help to increase access to high quality chronic disease preventative care and management in both clinical and community settings for chronic diseases by identifying those at risk and connecting them with local screening resources and supports.

The delivery of high-quality chronic disease preventive care and management can prevent much of the burden of chronic disease or avoid many related complications. Many of these services have been shown to be cost-effective or even cost-saving. However, many New Yorkers do not receive the recommended preventive care and management that include screening tests, counseling, immunizations or medications used to prevent disease, detect health problems early, and prevent disease progression and complications. This project is targeted on increasing the numbers of New Yorkers who receive evidence based preventative care and management for chronic diseases.

High Level Deliverables:

This project addresses 3 disease categories:

Cancer
Focusing on Breast Cancer, Lung Cancer and Colorectal Cancer, this project will educate providers on the current recommended criteria for screening within each disease category and provider resource guide for patient education materials and local screening services.

Obesity
Recognizing the many under-utilized Obesity Prevention resources in the region, the project seeks to educate medical and support service providers on such programs so as to connect high risk patients to the existing community resources.

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Tobacco
The project seeks to implement the 5 A's of Tobacco Dependence protocol in primary care offices and connect those who are interested in quitting with the NYS Quit-line via automatic referral.
The 5 A's:

Ask - Identify and document tobacco use status for every patient.
Advise - Urge every tobacco user to quit.
Assess - Is the tobacco user willing to make a quit attempt at this time?
Assist - For the patient willing to make a quit attempt, use counseling and pharmacotherapy to help him or her quit. Arrange - Schedule follow-up contact, in person or by telephone, preferably within the first week after the quit date.

Benefits:

Through this project, care team including primary care providers, care managers and community based organizations, will have access to resources which are specific to the disease categories in this project. This will create linkages between CBOs, local health departments and primary care providers, offering a vehicle for awareness and access to services.

Target Population: All Suffolk County Residents, especially those at high risk for Chronic Disease

Constraints:

- Tracking identified individuals who are referred for screenings/interventions
- Limited transportation is barrier to care, particularly in rural areas for patients to access services
- Significant linguistic and cultural variations across PPS, will require multiple strategies to engage various groups of patients

Success Criteria:

- Resource guides and patient education materials are complete and posted to PPS website and available to PPS partners
- PPS partners are educated about available materials for their use and implementation

Stakeholder Analysis:

- **Community Based Organizations**: PPS CBOs have demonstrated experience in successful outreach to the target population, and provide their services in a culturally competent manner. The project will feature resources guides specific to each chronic disease, connecting patients with both medical and support services.
- **Managed Care Organizations**: With the IDS project initiative developing a centralized case management function, the PPS will have the opportunity to enhance and coordinate existing community-based and MCO case management efforts to address the needs of the target population.

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- **Primary Care Providers**: PCPs will help to identify those at risk and be able to utilize the resources guides developed out of this project to navigate patients to necessary screening and support services.

Closeout Criteria:

- Close out will be managed during the monitoring phase of the project lifecycle and is tentatively scheduled for period ending March of 2020
- Evaluate and ensure all Archive Data and final project records/documents are filed in a secure location and appropriate to demonstrate achievement of DSRIP metric/project commitments within Domain 1 - 4
- Archive all project data in a central repository. Include best practices, lessons learned, and any other relevant project documentation.
- Verifying acceptance of final project deliverables/ data sources by the NYS DOH
- Completion of the post-project assessment and lessons learned
- Completion of post-project review and evaluation

Project Strategy:

- Engage key stakeholders from hospitals, local health department, provider community, and CBOs to assist in planning project
- Develop resource guide
- Project stakeholders endorse or create patient education materials for each disease category to be implemented by care team
- Provide education to providers on available materials for their use and implementation

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