Suffolk Care Collaborative

Consolidated Project Information

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

Contents

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

3.b.i Project Objective & Requirements

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.

The project must clearly demonstrate the following 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.

3.b.i Requirements Matrix by Provider Type

	Primary Care Physicians	Non PCP	Clinics	Health Home/ Care Management	Behavioral Health	Substance Abuse	Pharmacy	Community Based Orgs (CBOs)	All Other	PPS Project Level
1) Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										X
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 DY 3.	X*	X*			X*					X*
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 3.	X									X

	Primary Care Physicians	Non PCP	Clinics	Health Home/ Care Management	Behavioral Health	Substance Abuse	Pharmacy	Community Based Orgs (CBOs)	All Other	PPS Project Level
4) Use EHRs or other technical platforms to track all patients engaged in this project.										X
5) Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).										X
6) Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.										X
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.										X
8) Provide opportunities for follow-up blood pressure checks without a copayment or advanced	X									

	Primary Care Physicians	Non PCP	Clinics	Health Home/ Care Management	Behavioral Health	Substance Abuse	Pharmacy	Community Based Orgs (CBOs)	All Other	PPS Project Level
appointment.										
9) Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.										X
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.										X
11) Prescribe once-daily regimens or fixed-dose combination pills when appropriate.										X
12) Document patient driven self-management goals in the medical record and review with patients at each visit.										X

	Primary Care Physicians	Non PCP	Clinics	Health Home/ Care Management	Behavioral Health	Substance Abuse	Pharmacy	Community Based Orgs (CBOs)	All Other	PPS Project Level
13) Follow up with referrals to community based programs to document participation and behavioral and health status changes.										X
14) Develop and implement protocols for home blood pressure monitoring with follow up support.										X
15) Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.										X
16) Facilitate referrals to NYS Smoker's Quitline.										X
17) Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group										X

	Primary Care Physicians	Non PCP	Clinics	Health Home/ Care Management	Behavioral Health	Substance Abuse	Pharmacy	Community Based Orgs (CBOs)	All Other	PPS Project Level
visits, and implementation of the Stanford Model for chronic diseases.										
18) Adopt strategies from the Million Lives Campaign.	X	X			X					
19) Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.										X
20) Engage a majority (at least 80%) of primary care providers in this project.	X									

X* indicates safety net providers only

3.b.i Milestones & Metrics

Color Legend
Project System Changes
Project Requirements with Specific Time Periods
Project Requirements tied to PPS Speed and Scale Commitments

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
1	Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Quarterly reports demonstrating successful implementation of project requirements	Project
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 DY 3.	EHR meets connectivity to RHIO's HIE and SHINNY requirements.	QE participant agreements; sample of transactions to public health registries; use of DIRECT secure email transactions	Provider (SN: PCP, Non-PCP, BH)
		PPS uses alerts and secure messaging functionality.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging	Project
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 3.	EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Meaningful Use certification from CMS or NYS Medicaid	Project
		PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	List of participating NCQA-certified practices; Certification documentation	Provider (PCP)
4	Use EHRs or other technical platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
5	Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	PPS has implemented an automated or work driver scheduling system to facilitate tobacco control protocols.	Vendor System Documentation, if applicable; Other Sources demonstrating implementation of the system; Periodic self-audit reports and recommendations	Project
		PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.	List of training dates along with number of staff trained; Written training materials	Project
6	Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).	Policies and procedures related to standardized treatment protocols for hypertension and elevated cholesterol; List of training dates along with number of staff trained; Written training materials; signed agreement with PPS organizations to implement consistent standardized treatment protocols	Project
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.	Clinically Interoperable System is in place for all participating providers.	Contract; Report; Vendor System Documentation, if applicable; Other Sources demonstrating implementation of the system	Project
		Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.	Care coordination team rosters; Care coordination policies and procedures; Standard clinical protocol and treatment plans	Project
		Care coordination processes are in place.	Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained	Project
8	Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	Policies and procedures related to blood pressure checks; Roster of patients, by PCP practice, who have received follow-up blood pressure checks	Provider (PCP Practice)

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
9	Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.	Policies and procedures; List of training dates along with number of staff trained, if applicable	Project
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.	PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.	Risk assessment tool documentation; Risk assessment screenshots: Patient stratification report; Documented protocols for patient follow-up	Project
		PPS has implemented an automated or work driver scheduling system to facilitate scheduling of targeted hypertension patients.	Vendor System Documentation, if applicable; Other Sources demonstrating implementation of the system	Project
		PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.	List of training dates along with number of staff trained; Written training materials	Project
Improve Medication Adherence:				
11	Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.	Policies and procedures	Project
Optimize Patient Reminders and Supports:				
12	Document patient driven self-management goals in the medical record and review with patients at each visit.	Self-management goals are documented in the clinical record.	Documentation of self-audit of de-identified medical records over project timeframe demonstrating self-management goals documented in the clinical record	Project
		PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.	List of training dates along with number of staff trained; Written training materials	Project
13	Follow up with referrals to community based programs to document participation and	PPS has developed referral and follow-up process and adheres to process.	Policies and Procedures including warm transfer protocols	Project

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
	behavioral and health status changes.	PPS provides periodic training to staff on warm referral and follow-up process.	List of training dates along with number of staff trained; Written training materials	Project
		Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.	Written attestation or evidence of agreement; Documentation of process and workflow including responsible resources at each stage of the workflow	Project
14	Develop and implement protocols for home blood pressure monitoring with follow up support.	PPS has developed and implements protocols for home blood pressure monitoring.	Policies and procedures	Project
		PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.	Policies and procedures; Log of blood pressure follow-up contacts; Documentation of process and workflow including responsible resources at each stage of the workflow; Periodic self-audit reports and recommendations	Project
		PPS provides periodic training to staff on warm referral and follow-up process.	List of training dates along with number of staff trained; Written training materials	Project
15	Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	PPS has implemented an automated or work driver scheduling system to facilitate scheduling of targeted hypertension patients.	Vendor System Documentation, if applicable; Other Sources demonstrating implementation of the system; Roster of identified patients	Project
16	Facilitate referrals to NYS Smoker's Quitline.	PPS has developed referral and follow-up process and adheres to process.	Policies and Procedures including warm transfer protocols	Project
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	If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.	REAL dataset; Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained; Periodic self-audit reports and recommendations	Project

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
	diseases.	If applicable, PPS has established linkages to health homes for targeted patient populations.	Written attestation or evidence of agreement; Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained	Project
		If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.	Written attestation or evidence of agreement with community partners; List of training dates along with number of staff trained; Written training materials	Project
18	Adopt strategies from the Million Lives Campaign.	Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Lives Campaign.	Policies and procedures; Log of blood pressure follow-up contacts; Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials	Provider (PCP, Non PCP, BH)
19	Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.	Written attestation or evidence of agreement	Project
20	Engage a majority (at least 80%) of primary care providers in this project.	PPS has engaged at least 80% of their PCPs in this activity. (By Year One)	List of total PCPs in the PPS; List of PCPs engaged in this activity	Provider (PCP)

3.b.i Active Engagement Definition

The active engagement definition for project 3.b.i is defined as the number of participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.).

Project	# of Actively Engaged	Attributed Population	% of Attributed	Definition of Actively Engaged	Counting Method
3.b.i	14,556	148,118	10%	Documented Self-Management goals in Medical records	3

The purpose of counting methods is to estimate the number of patients that will be impacted by a particular project. This feeds the patient scale portion of the application.

Each counting method should be used in conjunction with the definition of "actively engaged" patients for that project.

Summary of counting method 3:

- Counted within a DSRIP year; resets each year
- Patients are to be counted only once
- So long as "at least" one encounter with the patient resulted in A.E. definition being met, it counts towards total

e.g., if a patient visits the PCP 5 times a year but get a1C tested just one of those 5 times, she is actively engaged

3.b.i Speed and Scale Submission

Scale is a measure of the magnitude of providers in the project and the volume of patients affected. Speed is a measure of how quickly project requirements are executed and how quickly patient impact occur. Speed and Scale represent 80% of the points for each project application – and therefore, most significantly impact initial valuation.

Project Implementation Speed for Project 3.b.i

Project	DY 0 (2014)		DY 1 (2015)		DY 2 (2016)		DY 3 (2017)		DY 4 (2018)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
3.b.i								X		

Patient Engagement Speed for Project 3.b.i

Patient Engagement Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
Number of *Actively Engaged* Patients	0	0	1453	3633	2907	7267	5814	11628	7267	14556
Expected # of Actively Engaged Patients	14556	14556	14556	14556	14556	14556	14556	14556	14556	14556

Rationale for Project 3.b.i

The rationale related to project 3.b.i implementation speed is as follows:

- PCMH Level 3 certification by DY3 is a project requirement so 100% is achieved at end of DY3 to give practices maximum amount of time to achieve

The rationale related to project 3.b.i patient engagement speed is as follows:

- For this project, Actively Engaged is defined as the number of participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.)
- Patients are counted as those who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years**.**

The patient scale rationale is calculated as detailed below.

Patient Scale Rationale			
	High-End Prevalence Approach		**Low- End Salient Approach**
Baseline # of Adults	100,988 Patients	**Baseline # of Patients**	12,872 Patients
35.3% prevalence rate of CVD	35,649 Patients	**60% Engagement Factor**	7,723 Patients
60% Engagement Factor	21,389 Patients	**Total**	7,723 Patients
Total	21, 389 Patients		
Expected # of Actively Engaged Patients =		**Midpoint of 2 approaches** =	**14,556 Patients**

References

Please see pages 55-62 in the Suffolk Care Collaborative DOH Application for additional project related information.

http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/stony_brook_university_hospital/stony_brook_project_plan.pdf