Suffolk Care
Collaborative

Consolidated Project Information

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

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

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

The project must clearly demonstrate the following 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.

3.c.i Requirements Matrix by Provider Type

	Primary Care Physicians	Non PCP	Clinics	Health Home/ Care Management	Behavioral Health	Substance Abuse	Pharmacy	Community Based Org s (CBOs)	All Other	PPS Project Level
1) Implement evidence based best practices for disease management, specific to diabetes, in community and ambulatory care settings.										X
2) Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.	X									
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.										X
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.										X
5) Ensure coordination with the Medicaid Managed Care organizations serving the target population.										X

	Primary Care Physicians	Non PCP	Clinics	Health Home/ Care Managem ent	Behavioral Health	Substance Abuse	Pharmacy	Comm unity Based Org s (CBOs)	All Other	PPS Project Level
6) Use EHRs or other technical platforms to track all patients engaged in this project.										X
7) Meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.	X*	X*			X*					X*

X* indicates safety net providers only

3.c.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 evidence based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	Evidence-based strategies for the management and control of diabetes in the PPS designated area are developed and implemented for all participating providers. Protocols for disease management are developed and training of staff is completed.	Disease management protocols; Documentation of process and workflow including responsible resources at each stage of the workflow; List of training dates along with number of staff trained; Written training materials; Periodic self-audit reports and recommendations	Project
2	Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.	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	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.	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 established and implemented.	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
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.	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
		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

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
		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
5	Ensure coordination with the Medicaid Managed Care organizations serving the target population.	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
6	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
		PPS uses a recall system that allows staff to report which patients are overdue for which preventive services and to track when and how patients were notified of needed services.	Recall report; Roster of identified patients; Screenshots of recall system	Project
7	Meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.	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)
		EHR meets connectivity to RHIO/SHIN-NY requirements.	QE participant agreements; Sample of transactions to public health registries; Use of DIRECT secure email transactions	Provider (SN: PCP, Non-PCP, BH)

3.c.i Active Engagement Definition

The active engagement definition for project 3.c.i is defined as the number of participating patients with at least one hemoglobin A1c test within previous Demonstration Year (DY).

Project	# of Actively Engaged	Attributed Population	% of Attributed	Definition of Actively Engaged	Counting Method
3.c.i	12,094	148,118	8%	Received a hemoglobin a1c test in previous DSRIP year	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.c.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.c.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.c.i								X		

Patient Engagement Speed for Project 3.c.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	1813	4230	3022	6044	4834	9669	6044	12094	6044	12094
Expected # of Actively Engaged Patients	12094	12094	12094	12094	12094	12094	12094	12094	12094	12094

Rationale for Project 3.c.i

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

- For this project, Actively Engaged is defined as the number of participating patients with at least one hemoglobin A1c test within previous Demonstration Year (DY).
- 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.

High-End Prevalence Approach		Low- End Salient Approach	
Baseline # of Adults	100,988 Patients	**Baseline # of Patients**	8,309 Patients
19.3% prevalence rate of Diabetes	19,491 Patients	**80% Engagement Factor**	6,647 Patients
90% Engagement Factor	17,542 Patients	**Total**	6,647 Patients
Total	17,542 Patients		

Expected # of Actively Engaged Patients = Midpoint of 2 approaches = 12,094 Patients

References

Please see pages 63-69 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