Suffolk Care Collaborative
Diabetes Wellness & Self-Management Program (DWSP)

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

Project Charter

Executive Summary:
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.

Objective Statement:
The Suffolk Care Collaborative (SCC) will support the implementation of evidence-based best practices for disease management in primary care medical practice related to diabetes.

Target Population:
The target patient population is:

1) Suffolk County residents,
2) Medicaid patients,
3) Diagnosed with Type 1 or Type 2 diabetes mellitus (T1DM/T2DM)

The project seeks to target areas with greatest potential for impact.
Specifically, 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.

For more information on the target population of our project, please refer to page 63, Section 1b, of the attached DOH Project Plan Application found at the following web address:
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/stony_brook_university_hospital/stony_brook_project_plan.pdf

High Level Deliverables:

- Implement evidence based best practices for disease management, specific to diabetes, in community and ambulatory care settings
- Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices
- 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
- Develop strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods

Project Description & Benefits:

Diabetes prevalence among Medicaid beneficiaries in Suffolk County is 19.3%, and significantly exceeds the County as a whole (11%). While short-term complications of diabetes 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 in 2013. In 2014 a Community Needs Assessment survey was issued to 51 PPS partners to assess the health status and clinical care needs of the population to be served, and an assessment of the health care and community wide systems available to address those needs. 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 barrier 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, etc.). 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.

This project will attempt to close the above identified gaps by engaging at least 80% of primary care practices to focus on the development of a care coordination/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. 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.

Constraints:

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

Success Criteria:

- Successful completion of all Domain 1 requirements, including meeting patient engagement and project engagement commitments
- Improvement throughout DSRIP Measurement Years across all Domain 2-3 outcome measurers (achievement of 10-20% gap to goal)
- Engagement of 80% of PCPs
- Overall achievement of project objectives (they are listed on our PMO directory)
- Sources that influenced the development of the program is accepted by public, community and key project stakeholders

Stakeholder Analysis:

- The current educational assets and resources to be enhanced and expanded are located at the 8 Hospitals, 6 Suffolk County Health Centers currently run by the Suffolk County DOH 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 the Integrated Delivery System project 2.a.iA1 will be leveraged for this project.

- **Hospitals:** 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.

- **Community Based Organizations:** There are several 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.

  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 engaged for early implementation of CM and practice redesign efforts around diabetes care with the Medicaid population that they currently serve.

- **Health Homes:** 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.

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:

Show value to PCPs by improving access to comprehensive diabetes education and point-of-care testing (POC-HbA1c). Provide effective care management support.

- 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.

- Provide practice support teams to engage PPS primary care practices to redesign their care delivery processes to achieve to Level 3 Patient Centered Medical Home recognition.
- 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).
- Deployment of POC- testing will improve patients' access to testing, enhancing compliance with national guidelines for regular testing/monitoring.
- Align PCPs through pay for performance incentives.