Suffolk Care Collaborative
Cardiovascular Wellness & Self-Management Program

3.b.i Cardiovascular Disease: Evidence-based strategies for disease management in high risk/affected populations

Project Charter

Through the Delivery System Reform Incentive Payment (DSRIP) Program, 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. Project 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.

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 cardiovascular disease. These strategies include the adoption and adherence to evidence-based clinical treatment guidelines set forth by the Suffolk Care Collaborative and the adoption of project requirements that increase patient self-efficacy and confidence in self-management.

Objective Statement:
The Suffolk Care Collaborative will support the implementation and integration of evidence based strategies, clinical guidelines, and patient education material into clinical practice within the PPS. The project specifically targets all Suffolk County Medicaid recipients ages 18 years of age or older who receive care from a SCC provider at primary care practices, non-PCP practices and behavioral health sites. Cardiovascular disease is a significant issue in Suffolk County, especially among the targeted Medicaid population, and is the 3rd leading cause of avoidable admissions.

High Level Deliverables:
Improve access and management of hypertension and hypercholesterolemia in Suffolk County as demonstrated by:

- Decreasing the admission rate for patients with a principal diagnosis of hypertension (PQI 7) and angina without a cardiac procedure (PQI 13).

- Adequately controlled blood pressure for patients with a diagnosis of hypertension.
- For high risk / affected population increase percentage of patients:
    - Discuss risks / benefits of aspirin use
    - Use of aspirin
    - LDL-C testing
    - Management for patients with cardiovascular conditions and LDL-C > 100 mg/dl
    - Advised to quit smoking and were recommended cessation medications and cessation strategies
    - Received flu shots
    - Improve health literacy (measured by QHL13, 14, 16).

Benefits:

- Improvement in management of cardiovascular disease, hypertension and hypocholesteremia within the Medicaid population in Suffolk County
- Decrease in avoidable admissions and readmissions to an acute care facility
- Integration of providers, health systems, health homes, community based organizations, and care management organizations in the coordination of care

Assumptions:

- Evidence based strategies and clinical guidelines will be utilized to implement the project
- Stakeholder commitment and buy-in to the project is strong as there is an evident need in the community
- Patient's self-management of disease processes is imperative and will be supported through the Stanford Chronic Disease Model as well as support from providers

Constraints:

- Project Budget, available resources, and available support for the life of the project
- Content experts with experience implementing similar project requirements
- Lack of public transportation and limited transportation within Suffolk County

High-Level Risks:

- Engagement of 80% of primary care providers within the PPS
- Use of EHRs to track all patients engaged in the project
- Providing opportunities for follow-up blood pressure checks without copayment or advance appointment
- Communication and coordination at handoffs between multiple entities
- Prescribing once-daily regimens or fixed dose combination pills
- Documentation of patient driven self-management goals in the medical record and review of the goals at each appointment
- Adopting strategies from the Million Hearts Campaign by non-PCPs and Behavioral Health providers

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 and of PCPs, non-PCPs, and BH providers in implementation of the Million Hearts Campaign
- Overall achievement of project objective
- Sources that influenced the development of the program is accepted by public, community and key project stakeholders

Stakeholder Analysis:
The project focuses mostly on PCPs but also requires adoption of the policies and procedures by non-PCPs and behavioral health providers and a commitment to adhere to them in clinical practice. PCPs will be fully implementing the project while non-PCPs and behavioral health providers will be implementing principles from the Million Hearts Campaign.

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:
The Million Hearts Campaign is a national initiative to prevent one million heart attacks and strokes by 2017. The goal of the campaign is to enhance cardiovascular disease prevention by focusing on blood pressure control, cholesterol management, smoking cessation, and aspirin use for people at risk. The project focuses mostly on PCPs but also requires adoption of the policies and procedures by non-PCPs and behavioral health providers and a commitment to adhere to them in clinical practice.

Use of home blood pressure monitoring and support as appropriate and facilitating access to blood pressure checks without copayment or advanced appointment in the office. Patients who have repeated elevated blood pressure readings but no diagnosis of hypertension, should be identified and scheduled for a hypertension visit.

Care management will play an integral role in meeting project requirements through follow up and coordination of care. The 5 A's of tobacco control will be used, optimally

embedded in the EMR to support/prompt use of the screening tool, with referral to the NYS Quitline if indicated. At least one self-management goal identified by the patient must be documented in the medical record and reviewed at each visit. The Stanford Chronic Disease Self-Management Program is an educational program aimed at empowering patients with cardiovascular disease to achieve self-management practices and lifestyle change. This program will be utilized by PPS partners and offered in communities with the highest burden of illness.

Approved:

Alyssa Scully - Director PMO	**Date**
Joseph Lamantia - COO	**Date**
Linda Efferen, MD - Medical Director	**Date**