Diabetes and Cardiovascular Clinical Improvement Programs Implementation Toolkit
Acknowledgements

We would like to acknowledge members of our program who support our ongoing efforts in health care delivery system reform.

Cardiovascular & Diabetes Wellness & Self-Management Workgroup
A composition of subject matter experts engaged to support the development, execution and monitoring of project milestones.

Cardiovascular & Diabetes Wellness & Self-Management Committees
A composition of key internal and external project stakeholders, including representation from key community and public service and governmental agencies engaged to support the conclusions, deliverables and monitor system impacts of the DSRIP Program.

Special thanks to our key contributors for their work on the 1st Edition Toolkit:

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- Cerner Corporation
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- Good Samaritan Hospital Medical Center
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- Long Island Pharmacists Society
- Mercy Medical Center
- Northwell Health
- Northwell Health Solutions
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- Purti Drugs Corporation
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- Stony Brook Medicine
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- Suffolk Independent Living Organization (SILO) Inc.
- Visiting Nurse Service of New York

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• Northwell Health
• Northwell Health Solutions
• Options for Community Living
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Overview

Background
In response to rising healthcare costs, Medicaid spending and concerns of health care quality, Governor Andrew M. Cuomo created the Medicaid Redesign Team (MRT). The MRT initiatives accounted for approximately $17.1 billion in federal savings. On April 14, 2014, Governor Andrew M. Cuomo announced New York finalized terms and conditions with the federal government for a groundbreaking waiver that will allow the state to reinvest $8 billion of federal savings generated by the MRT reforms. The MRT waiver amendment goal is to transform the state’s health care system, bend the Medicaid cost curve, and ensure access to quality care for all Medicaid members. NYS Department of Health’s charter under this waiver to fully implement an action plan to allow for comprehensive reform through a Delivery System Reform Incentive Payment (DSRIP) Program.

State-wide Effort: Delivery System Reform Incentive Payment Program
Through the Delivery System Reform Incentive Payment Program, a grant waiver administered by the NYS Department of Health (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 the 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.

Local Leadership: Suffolk Care Collaborative
New York State is broken into 25 regional organizations called Performing Provider Systems (PPS). Each PPS is responsible for engaging providers, designing programs, coordinating collaboration, reporting project outcomes and allocating funds to partners.

The Suffolk Care Collaborative (SCC) is the PPS for Suffolk County under the DSRIP Program. The goal of SCC is to meet the requirements of the Triple Aim Initiative – improving patient experience, improving health outcomes and reducing the per capita cost of healthcare. Our vision to become a highly effective, accountable, integrated, patient-centric delivery system has positioned us well to make an important contribution to the DSRIP program. Some of the many goals will include the capacity to make the most of patients’ self-care abilities, improve access to community-based resources, break down care silos, and reduce avoidable hospital admissions and emergency room visits.

The SCC has operationalized all DSRIP requirements through a portfolio of programs.

Cardiovascular and Diabetes Wellness and Self-Management Programs
The objective of the Cardiovascular program is to support the implementation and integration of evidence based strategies, clinical guidelines, and patient education material into clinical practice within the PPS.

The objective of the Diabetes program is to support the implementation of evidence-based best practices for disease management in primary care medical practice related to diabetes.
The projects specifically target 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 and diabetes are significant issues in Suffolk County, especially among the targeted Medicaid

Click here to access the Cardiovascular program webpage. Click here to access the Diabetes program webpage.

**Cardiovascular Program Goals**

- Decreasing the admission rate for patients with a principal diagnosis of hypertension (PQI 7) and heart failure (PQI 8).
- Prescription of statin therapy and medication adherence.
- 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).

**Diabetes Program Goals**

- 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

**Purpose of the Implementation Toolkit**

The purpose of this toolkit is to assist all internal and external program stakeholders during the implementation phase and throughout the life cycle of the program described herein. It provides an overview of the Cardiovascular and Diabetes and Wellness Self-Management Programs, including key directory of SCC project management office contacts, Program Charter, tools and resources for implementation, program protocols, patient engagement requirements, instructions on how to submit documents and maintain project documents and valuable program resources. It is meant to act as a guide and information source in which you can refer to for all your DSRIP needs.
Returning Required Documents
This toolkit includes several documents that will be needed to be completed and returned to the Suffolk Care Collaborative by participating providers. Electronic copies of these documents can be accessed via our Partner Portal or you can complete the hard copies provided here and return them to SCC. If you complete a document in hardcopy form, please scan the completed document and email or fax it to your Provider Relations Manager. We also recommend you keep a hardcopy of every document submitted to Suffolk Care Collaborative.

PCMH Certification Program Alignment
The SCC’s clinical improvement program’s implementation approach is closely aligned to our participating primary care practices participation in our Patient Centered Medical Home (PCMH) Practice Transformation Program.

Stakeholders have aligned all Domain 3 Clinical Improvement Program implementation protocols to PCMH standards, as described herein. Implementing DSRIP’s primary care practice protocols throughout the programs can help meet the requirements of many PCMH standards. An interactive crosswalk lists the DSRIP Domain 1 Project Requirements connected to primary care and aligns them with requirements for the 2014 Patient-Centered Medical Home (PCMH) standards, Advanced Primary Care (APC) model, and Transforming Clinical Practice Initiative (TCPI). Requirements for each model come directly from their respective sources.

Click here to access our Program Goal Crosswalk to the PCMH Standards. This cross-walked was leverage in the design of our SCC Clinical Improvement Program (Domain 3) Implementation Toolkits as well as our implementation approach in working with our primary care practice sites.

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Program Resources

Appended to this Implementation Toolkit is a set of Program Resources designed for our network participating providers. Click [here](#) to access. Program resources include the following:

- Implementation Resources
- Provider Resources
- Patient Education Resources
- Additional Reading Materials
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Clinical Improvement Programs: Cardiovascular Health Wellness & Self-Management Program (CWSP) and Diabetes Health Wellness & Self-Management Program (DWSP)

Clinical Program Summaries
Below are the Clinical Summary documents for each program. The documents contain information about DSRIP program goals, initiatives being implemented to meet these goals, clinical metrics, and important program reference documents.
Evidence-Based Strategies for Disease management in High Risk/Affected Populations: Cardiovascular

Project goal

**Immediate:** Integrate evidenced-based strategies and clinical guidelines and patient education material; document at least one self-management goal identified by the patient and review at each visit.

**Long-term:** 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 (PO7) and heart failure (PO8); adequately controlled blood pressure for patients with a diagnosis of hypertension. For high risk / affected population increase percentage of patients with discussion of 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 CAHPS –QHL 13, 14, 16).

Interventions

Cardiovascular disease is a significant issue and the 3rd leading cause of avoidable admissions in Suffolk County. 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 within or before appointments 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. Utilize S A’s of tobacco control, 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-manage practices and lifestyle change. This program will be utilized by PPS partners and offered in “hot-spot” areas with the highest burden of illness.

Patient Engagement Metric

The number of patients (age 18 and older) with a principal or secondary diagnosis of hypertension or hypercholesterolemia with documented self-management goals in the medical record reviewed at each visit.

Clinical Metrics

- Discussion of Risks and Benefits of Aspirin Use (CAHPS Survey) – The number of respondents who are men, age 46 to 79, and women, age 56 to 79, who discussed the risk and benefits of using aspirin with a doctor or health provider.
- Aspirin Use (CAHPS Survey) – The number of respondents who are men, age 46 to 65, with at least one cardiovascular risk factor; men, age 66 to 79, regardless of risk factors; and women, age 56 to 79, with at least two cardiovascular risk factors who are currently taking aspirin daily or every other day.
- Controlling High Blood Pressure – The number of people, who have hypertension, and whose blood pressure was adequately controlled as follows: below 140/90 if age 18-59; below 140/90 if age 60 to 85 with diabetes diagnosis; or below 150/90 if age 60 to 85 without a diagnosis of diabetes.
- Flu Shots for Adults Age 18-64 (CAHPS Survey) – The number of respondents, age 18 to 64, who have had a flu shot.
- Health Literacy (CAHPS Survey – QHL 13, 14, 16) – The number of respondents who answered that they saw their provider for an illness or condition and were given instructions that were “Usually” or “Always” easy to understand, described how the instruction would be followed and were told what to do if the illness/condition got worse or came back.

(continued on reverse)
Evidence-Based Strategies for Disease Management in High Risk/Affected Populations: Cardiovascular

**Clinical Metrics (continued)**

- Medical Assistance with Smoking and Tobacco Use Cessation – Advised to Quit (CAHPS Survey) – The number of respondents, aged 18 and older, who smoke or use tobacco some days or every day and were advised to quit.
- Medical Assistance with Smoking and Tobacco Use Cessation – Discussed Cessation Medication (CAHPS Survey) – The number of respondents, aged 18 years and older, who smoke or use tobacco and discussed or were recommended cessation medication.
- Medication Assistance with Smoking and Tobacco Use Cessation – Discussed Cessation Strategies (CAHPS Survey) – The number of respondents, aged 18 and older, who smoke or use tobacco some days or every day and discussed or were provided with cessation methods or strategies.
- Prevention Quality Indicator #6 (Heart Failure) – The number of people, aged 18 and older, with an admissions with a principal diagnosis of heart failure.
- Prevention Quality Indicator #7 (Hypertension) – The number of people, aged 18 and older, with an admissions with a principal diagnosis of hypertension.
- Statin Therapy for Patients with Cardiovascular Disease – Re-initiated Statin Therapy – The number of males age 21 to 75 or females age 40 to 75, who were dispensed at least one high or moderate intensity statin medication.
- Statin Therapy for Patients with Cardiovascular Disease – Statin Adherence 80% - The number of males age 21 to 75 or females age 40 to 75, who achieved a proportion of days covered of 80% for the treatment period.

**Tools to be employed:** 5 A’s of Tobacco Control; Stanford Chronic Disease Self-Management Program

**References/Guidelines**


Evidence-Based Strategies for Disease Management in High Risk/Affected Populations: Diabetes

**Project goal**

**Immediate**: Identification of eligible individuals with diabetes; risk stratification based on high-risk comorbidities/conditions (e.g., chronic kidney disease, coronary disease, insulin use, polypharmacy, etc.).

Verify medical home/PMD for each enrollee; assign high-risk patients to care coordinator. Interact with SCC clinicians to obtain diabetes-specific clinical data based on the American Diabetes Association (ADA) Standards of Medical Care in Diabetes (e.g., hemoglobin A1c (HbA1c), lipids, urine microalbumin, rates of secondary prevention screening, etc.). Inform SCC clinicians of the most recent ADA standards as well as tools from the National Diabetes Education Program to assist their practices in meeting clinical benchmarks for the disease.

**Long-term**: Improve utilization of HbA1c testing in patients with diabetes; increase rates of screening for diabetes-related complications and secondary prevention; Empower patients with diabetes to achieve successful self-management practices; Decrease rates of diabetes-related complications in those with the disease; Improve HbA1c and LDL-c measures.

**Interventions**

- Population identification and stratification: SCC clinicians will be asked to provide diabetes-related data through the HIU; this data will populate the diabetes registry in Cerner’s HealthIntelligence platform, providing the Project Management Office (PMO) with vital information about the population of patients with high-risk diabetes in Suffolk County. This data will help to drive resource allocation and educational efforts within the PPS to improve diabetes-related outcomes in the county.

- Care Management: High-risk patients with diabetes will be assigned to care managers (CM).

- Diabetes Education: The Stanford Chronic Disease Self-Management Program is a comprehensive educational program aimed at empowering patients with diabetes to achieve self-management practices and lifestyle change. The project will increase access to Stanford Diabetes Self-Management Training (DSMT) by working with PPS partners to expand existing DSMT resources in the county and offering the program in areas of highly prevalent high-risk disease. Certified Diabetes Educators (CDEs) offer individualized and group-education to patients with the disease and are credentialed by the National Certification Board of Diabetes Educators. The project will work with partners to improve access to the number of CDEs in the county to support primary care practices for individualized patient education. SCC clinicians, with the assistance of CMs, will be asked to identify and refer their high-risk patients with diabetes to DSMT and CDE resources.

- Primary Care Providers: Clinicians will be expected to adhere to the ADA Standards of Medical Care in Diabetes and obtain diabetes-specific clinical data and outcomes as noted in the Immediate and Long-term Goals.

**Patient Engagement Metric**

The number of patients (age 18 and older) who have diabetes or are “at-risk” for diabetes with at least one hemoglobin A1c test within the four most recent quarters.

**Clinical Metrics**

- Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) Poor Control (>9.0%) - The number of people age 18 to 75 with diabetes whose most recent A1c indicated poor control, was missing or did not have a HbA1c.

- Comprehensive Diabetes Screening - All three tests (HbA1c, dilated eye exam, retinopathy monitor) - The number of people, age 18 to 75, with diabetes who received at least one of each of the following tests during the measurement year; HbA1c test, diabetes eye exam and retinopathy monitor.

- Flu Shots for Adults Age 18-64 (CAHPS Survey) - The number of respondents, age 18 to 64, who have had a flu shot.

(continued on reverse)
Evidence-Based Strategies for Disease Management in High Risk/Affected Populations: Diabetes

Clinical Metrics (continued)

- Health Literacy (CAHPS Survey – QHL13, 14, and 15) – The number of respondents who answered that they saw their provider for an illness or condition and were given instructions that were “Usually” or “Always” easy to understand, described how the instruction would be followed and were told what to do if the illness/condition got worse or came back.

- Medication Adherence with Smoking and Tobacco Use Cessation (CAHPS Survey) – Advised to Quit – The number of respondents, age 18 and older, who smoke or use tobacco some days or every day and were advised to quit.

- Medical Assistance with Smoking and Tobacco Use Cessation (CAHPS Survey) – Discusses Cessation Medication – The number of respondents, age 18 and older, who smoke or use tobacco and discussed or were recommended cessation medication.

- Medication Assistance with Smoking and Tobacco Use Cessation (CAHPS Survey) – Discusses Cessation Strategies – The number of respondents, age 18 and older, who smoke or use tobacco some days or every day and discussed or were provided with cessation methods or strategies.

- Prevention Quality Indicator #1 (Diabetes Short Term complication) – The number of people, age 18 and older, with an admission with a principal diagnosis of diabetes with short term complications (ketoadosis, hyperosmolar, or coma).

Tools to be employed: Stanford Chronic Disease Self-Management Program

References/Guidelines


Clinical Program Protocols

CWSP Practice Site Program Protocols

Below are the listings of program protocols and program templates for the Cardiovascular Wellness and Self-Management Program. The protocols were developed to help guide clinicians through the implementation of DSRIP and correlate to specific DSRIP milestones. DSRIP partners are expected to review each protocol and attest that they understand them.

<table>
<thead>
<tr>
<th>Number</th>
<th>Program Protocol Name</th>
<th>Protocol Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>3bi.01</td>
<td>Implementing the Million Hearts Campaign</td>
<td>SCC Cardio Program Procedure_3bi.01_v1.pdf</td>
</tr>
<tr>
<td>3bi.02</td>
<td>Communication Plan of the Million Hearts Campaign Strategies</td>
<td>SCC Cardio Program Procedure_3bi.02_v1.pdf</td>
</tr>
<tr>
<td>3bi.03</td>
<td>Blood Pressure Administration, Monitoring, Measurement &amp; Follow up</td>
<td>SCC Cardio Program Procedure_3bi.03_v2.pdf</td>
</tr>
<tr>
<td>3bi.05</td>
<td>Implementing the 5A’s of Tobacco Control Protocol</td>
<td>SCC Cardio Program Procedure_3bi.05_v2.pdf</td>
</tr>
<tr>
<td>3bi.06</td>
<td>Implementing the NY Smokers Quitline Protocol &amp; Promotional Materials References</td>
<td>SCC Cardio Program Procedure_3bi.06_v2.pdf</td>
</tr>
<tr>
<td>3bi.07</td>
<td>Patient self-management goal guideline Protocol</td>
<td>SCC Cardio Program Procedure_3bi.07_v1.pdf</td>
</tr>
</tbody>
</table>
**DWSP and Self-Management Education Program Protocols**

Below are the listings of program protocols for the Diabetes Wellness and Self-Management Program and referring patients to self-management education resources. The protocols were developed to help guide clinicians through the implementation of DSRIP and correlate to specific DSRIP milestones. DSRIP partners are expected to review each protocol and attest that they understand them.

<table>
<thead>
<tr>
<th>Number</th>
<th>Program Protocol Name</th>
<th>Protocol Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>3ci.01</td>
<td>Standard Protocols for Disease Management &amp; Treatment Plans</td>
<td>3ci 01 Standard Protocols for Disease Management &amp; Treatment Plans.pdf</td>
</tr>
<tr>
<td>3bi.3ci.01</td>
<td>Guidelines for Patient Referral to Self-Management Education</td>
<td>3bi.3ci 01 Guidelines for Patient Referral to Self-Management Education v2.pdf</td>
</tr>
</tbody>
</table>

**CWSP Practice Site Program Templates**

The templates below provide supporting materials to help clinicians execute program expectations and supply required feedback to SCC. DSRIP partners are expected to complete each document and return them to SCC.

<table>
<thead>
<tr>
<th>Number</th>
<th>Program Template Name</th>
<th>Template Document</th>
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</thead>
<tbody>
<tr>
<td>3bi.11</td>
<td>Patient Self-Management Goal EHR Documentation Request Form</td>
<td>Patient Self-Management Goal EHR Documentation Request Form.pdf</td>
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<tr>
<td>3bi.12</td>
<td>5 A’s of Tobacco Control Screenshot Request Form</td>
<td>5 A’s of Tobacco Control Screenshot Request Form.pdf</td>
</tr>
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</table>

**DWSP and CWSP Practice Site Clinical Workflow Diagrams**

The documents below were created to assist clinicians and administrators with visualization of the workflow steps involved in executing the Cardiovascular Wellness and Self-Management Program and the Diabetes Wellness and Self-Management Program. The workflows were developed using evidence-based guidelines and information. The expectation is that clinicians will follow the workflows based on the needs of their patients.

<table>
<thead>
<tr>
<th>Number</th>
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<tr>
<td>3bi.21</td>
<td>Cardiovascular Wellness &amp; Self-Management Program Flow Chart</td>
<td>3bi Cardio FLOW CHART FINAL DRAFT.pdf</td>
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<td>3bi.22</td>
<td>Follow-up blood pressure check appointment</td>
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<td>3bi.23</td>
<td>Identifying patients with hypertension</td>
<td><a href="#">PDF</a></td>
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<tr>
<td>3bi.24</td>
<td>Home blood pressure administration, warm referral, monitoring, measurement and follow-up</td>
<td><a href="#">PDF</a></td>
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<td>3bi.25</td>
<td>Standard Treatment Protocols for Hypertension and Elevated Cholesterol Protocol; and Preferential Drugs Prescribing Guidelines</td>
<td><a href="#">PDF</a></td>
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<td>3bi.26</td>
<td>Patient-driven self-management goals</td>
<td><a href="#">PDF</a></td>
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<td>3bi.27</td>
<td>Identifying &amp; Treating Patients who use Tobacco (Tobacco Cessation)</td>
<td><a href="#">PDF</a></td>
</tr>
<tr>
<td>3ci.21</td>
<td>Diabetes Wellness &amp; Self-Management Program Flow Chart</td>
<td><a href="#">PDF</a></td>
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</table>
### Patient Education Materials

CWSP Patient Education Materials

The list below includes the resources endorsed by the Suffolk Care Collaborative for practice use.

<table>
<thead>
<tr>
<th>Name of Document</th>
<th>Organization</th>
<th>PDF</th>
<th>English Link</th>
<th>Spanish Link</th>
<th>Spanish PDF</th>
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</thead>
</table>
### High Blood Pressure: How to Make Control Your Goal

- **Name of Document:** High Blood Pressure: How to Make Control Your Goal
- **Organization:** Million Hearts Campaign by the Centers for Disease Control and Prevention
- **PDF Link:** TipSheet_How_to_MCYG_General.pdf
- **English Link:** http://millionhearts.hhs.gov/files/TipSheet_How_to_MCYG_General.pdf
- **Spanish Link:** http://millionhearts.hhs.gov/files/TipSheet_Empower_Spanish.pdf

### Supporting Your Loved One with High Blood Pressure

- **Name of Document:** Supporting Your Loved One with High Blood Pressure
- **Organization:** Million Hearts Campaign by the Centers for Disease Control and Prevention
- **PDF Link:** TipSheet_LovedOne_General.pdf
- **English Link:** https://millionhearts.hhs.gov/files/TipSheet_LovedOne_General.pdf
- **Spanish Link:** http://millionhearts.hhs.gov/files/TipSheet_LovedOne_Spanish.pdf

### Tobacco Control

#### Welcome to the New York State Smokers’ Quitline

- **Name of Document:** Welcome to the New York State Smokers’ Quitline
- **Organization:** New York State Smoker’s Quitline
- **PDF Link:** NYS Smokers’ Quitline Information sheet.4b2approved.pdf
- **Link:** http://www.nysmokefree.com/Specialpages/rViewpdf1.ashx?No=2056

#### Staying Tobacco Free

- **Name of Document:** Staying Tobacco Free
- **Organization:** The Tobacco Control Program of Roswell Park Cancer Institute
- **PDF Link:** StayingTobaccoFree_10-2010_4b2approved.pdf
- **Link:** https://rpcs.roswellpark.org/StayingTobaccoFree

#### You, Smoking and The Flu

- **Name of Document:** You, Smoking and The Flu
- **Organization:** New York State Department of Health
- **PDF Link:** You, Smoking, The Flu, NY Smoker’s Quitline.pdf
- **Link:** https://www.health.ny.gov/publications/2461.pdf

#### Break Loose: Facts and Tips to help you stop smoking

- **Name of Document:** Break Loose: Facts and Tips to help you stop smoking
- **Organization:** New York State Smokers’ Quitline
- **PDF Link:** BreakLoose2010_Tobac_4b2approved.pdf
- **Link:** https://www.health.ny.gov/prevention/tobacco_control/docs/break_loose.pdf
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<tr>
<td>10 Things You Didn’t Know About Smoking</td>
<td>New York State Smokers’ Quitline</td>
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<tr>
<td>Nicotine Patch Use Instructions</td>
<td>New York State Smoker’s Quitline</td>
<td><a href="https://www.nysmokefree.com/Factsheets/NicotinePatchInstructions.pdf">https://www.nysmokefree.com/Factsheets/NicotinePatchInstructions.pdf</a></td>
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<td>Smoking and Asthma</td>
<td>New York State Smoker’s Quitline</td>
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<tr>
<td>Smoking and COPD</td>
<td>New York State Smoker’s Quitline</td>
<td><a href="https://www.nysmokefree.com/Specialpages/rViewpdf1.ashx?No=2094">https://www.nysmokefree.com/Specialpages/rViewpdf1.ashx?No=2094</a></td>
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<tr>
<td>Smoking and Diabetes</td>
<td>New York State Smoker’s Quitline</td>
<td><a href="https://www.nysmokefree.com/Specialpages/rViewpdf1.ashx?No=2091">https://www.nysmokefree.com/Specialpages/rViewpdf1.ashx?No=2091</a></td>
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<tr>
<td>Smoking and Heart Disease</td>
<td>New York State Smoker’s Quitline</td>
<td><a href="https://www.nysmokefree.com/Specialpages/rViewpdf1.ashx?No=2092">https://www.nysmokefree.com/Specialpages/rViewpdf1.ashx?No=2092</a></td>
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</table>
DWSP Patient Education Materials

American Diabetes Association: Diabetes Pro™ Professional Resources Online

The list below includes the resources endorsed by the Suffolk Care Collaborative for practice use.

Important Topics:

<table>
<thead>
<tr>
<th>Name of Document</th>
<th>English PDF</th>
<th>English Link</th>
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<tr>
<td>Type 1 Diabetes</td>
<td>type_1.pdf</td>
<td><a href="http://professional.diabetes.org/sites/professional.diabetes.org/files/media/type_1.pdf">http://professional.diabetes.org/sites/professional.diabetes.org/files/media/type_1.pdf</a></td>
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### Additional Topics:

<table>
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<th>English PDF</th>
<th>English Link</th>
<th>Spanish Link</th>
<th>Spanish PDF</th>
</tr>
</thead>
</table>
Learning About Diabetes, Inc.: a non-profit charity providing easy-to-understand diabetes-care information in English and Spanish. The list below includes the resources endorsed by the Suffolk Care Collaborative for practice use. Coming soon!

<table>
<thead>
<tr>
<th>Name of Document</th>
<th>English PDF</th>
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<tr>
<td>Diabetes Care Schedule: Take Good Care of Yourself</td>
<td>CareScheduleEN_SuffolkCare.pdf</td>
<td>CareScheduleSP_SuffolkCare.pdf</td>
</tr>
<tr>
<td>Healthy Plate Eating</td>
<td>HealthyPlateFishEN_SuffolkCare.pdf</td>
<td>HealthyPlateFishSP_SuffolkCare.pdf</td>
</tr>
<tr>
<td>Diabetes: Know the Signs</td>
<td>KnowTheSignsEN_SuffolkCare.pdf</td>
<td>KnowTheSignsSP_SuffolkCare.pdf</td>
</tr>
<tr>
<td>Type 1 Diabetes</td>
<td>Type1DiabetesEN_SuffolkCare.pdf</td>
<td>Type1DiabetesSP_SuffolkCare.pdf</td>
</tr>
<tr>
<td>Type 2 Diabetes</td>
<td>Type2DiabetesEN_SuffolkCare.pdf</td>
<td>Type2DiabetesSP_SuffolkCare.pdf</td>
</tr>
<tr>
<td>Name of Document</td>
<td>English PDF</td>
<td>Spanish PDF</td>
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<tr>
<td>---------------------------</td>
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<td>What's My A1C?</td>
<td><a href="WhatsMyA1CENSuffolkCare.pdf">PDF</a></td>
<td><a href="WhatsMyA1CSP_SuffolkCare.pdf">PDF</a></td>
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<tr>
<td>Why Do I Need Insulin?</td>
<td><a href="WhyNeedInsulinEN_SuffolkCare.pdf">PDF</a></td>
<td><a href="WhyNeedInsulinSP_SuffolkCare.pdf">PDF</a></td>
</tr>
</tbody>
</table>
CWSP and DWSP Practice Site Training Methodology & Curriculum

Module Overview: This module reviews the evidence-based resources and treatment strategies being implemented to support the Cardiovascular Wellness and Self-Management Program and the Diabetes Wellness and Self-Management Program. You will learn about the Million Hearts® campaign, tools available to identify patients in need of follow-up care, and how to successfully retrieve accurate blood pressure readings and teach self-monitoring blood pressure techniques. You will also learn about tools available to identify patients with diabetes or “at-risk” of developing diabetes, comprehensive diabetes testing methods and lifestyle recommendations. Finally, you will learn about documentation of patient self-management goals and how to refer patients to self-management education. DSRIP partners are expected to review each curriculum presentation and attest that they understand the training. Additional information can be found in the Resources section of this document.

<table>
<thead>
<tr>
<th>Training Topic</th>
<th>Learning Objectives</th>
<th>Curriculum</th>
</tr>
</thead>
</table>
| **The Cardiovascular Wellness & Self-Management Program**      | 1. Demonstrate the elements of the DSRIP Cardiovascular Wellness & Self-Management Program  
2. Recall major strategies, goals, and tools of the Million Hearts® campaign  
3. Recognize how a registry is used to identify and track hypertension patients  
4. Summarize key points from guideline recommendations | CWSP.pptx                                        |
| **Blood Pressure Measurement (practice-based or self-monitored)** | 1. Summarize proper techniques and equipment for measuring Blood Pressure  
2. Identify implications of performing blood pressure measurements incorrectly  
3. State the impact of self-monitored BP programs (SMBP) in reducing risk of disability or death due to uncontrolled hypertension  
4. Identify features to consider in guiding patient in selection of SMBP equipment  
5. Review the validation process for automatic blood pressure measurement devices | BP Measurement.pptx                               |
| **Diabetes Wellness & Self-Management Program**                | 1. Review the impact of diabetes  
2. Define the elements of the Diabetes Wellness & Self-Management Program  
3. Apply the screening and treatment recommendations for patients with diabetes | 3ci-Diabetes Project Training v4.pptx             |
| **Patient Self-Identified Goals and Diabetes and Chronic Disease Self-Management Education Programs** | 1. Formulate ‘smart goals’ in collaboration with patient  
2. Illustrate Motivational Interviewing techniques to assist patients in setting health goals  
### Training Topic | Learning Objectives | Curriculum
--- | --- | ---
Components of self-management programs, and the various programs to which a patient can be referred

**Module Overview:** This module is intended to support trainees in understanding interventions for tobacco cessation to support the SCC’s clinical improvement programs and population-wide wellness initiatives. You will learn about Tobacco Cessation control methods endorsed by the Million Hearts® campaign as well as understanding the services provided through the NYS Smokers’ Quitline.

<table>
<thead>
<tr>
<th>Training Topic</th>
<th>Learning Objectives</th>
<th>Core Curriculum</th>
</tr>
</thead>
</table>
| 5 A’s of Tobacco Cessation Control and Referring to the NYS Quitline | • Summarize the 5 A’s of tobacco cessation counseling  
• Describe the services of the NYS Smokers’ Quitline and the referral process  
• Illustrate how Progress Reports are obtained and the information included in the reports  
• Discuss the role of patient-center communication in providing effective tobacco counseling  
• Provide evidence-based brief interventions in counseling tobacco users | 5 A’s and NYS Quitline.pptx |

**Reference:** SCC Core Curriculum Guidelines for Practice Sites
Quarterly Reporting Requirements

Below are the Domain 1 Patient Engagement Data Request documents for the CWSP and the DWSP. The documents contain the patient engagement definitions and specifications for the data that are to be returned to SCC via BOX.

<table>
<thead>
<tr>
<th>Domain 1 Patient Engagement Data Request</th>
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<tbody>
<tr>
<td>3bi- Cardiovascular Wellness and Self-Management</td>
<td>SCC Project 3.b.i Cardio Data Request-no date.pdf</td>
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<tr>
<td>3ci- Diabetes Wellness and Self-Management</td>
<td>SCC Project 3.c.i Diabetes Data Request-no date.pdf</td>
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### Clinical Outcome Measures

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Steward and Specification Version</th>
<th>NQF #</th>
<th>Projects Associated with Measure</th>
<th>Numerator Description</th>
<th>Denominator Description</th>
<th>Performance Goal</th>
<th>Achievement Value</th>
<th>Reporting Responsibility</th>
<th>Payment: DY 2 and 3</th>
<th>Payment: DY 4 and 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention Quality Indicator # 7 (Hypertension) ±</td>
<td>AHRQ 5.0.3</td>
<td>0276</td>
<td>3.b.i</td>
<td>Number of admissions with a principal diagnosis of hypertension</td>
<td>Number of people 18 years and older as of June 30 of measurement year</td>
<td>12.32 per 100,000 Medicaid Enrollees</td>
<td>1 if annual improvement target or performance goal met or exceeded</td>
<td>NYS DOH</td>
<td>P4P</td>
<td>P4P</td>
</tr>
<tr>
<td>Prevention Quality Indicator # 8 (Heart Failure) ±</td>
<td>AHRQ 5.0.3</td>
<td>0277</td>
<td>3.b.i</td>
<td>Number of admissions with a principal diagnosis of heart failure</td>
<td>Number of people 18 years and older as of June 30 of measurement year</td>
<td>TBD per 100,000 Medicaid Enrollees</td>
<td>1 if annual improvement target or performance goal met or exceeded</td>
<td>NYS DOH</td>
<td>P4P</td>
<td>P4P</td>
</tr>
<tr>
<td>Statin Therapy for Patients with Cardiovascular Disease –Received Statin Therapy</td>
<td>HEDIS® 2016</td>
<td></td>
<td>3.b.i</td>
<td>Number of people who were dispensed at least one high or moderate-intensity statin medication</td>
<td>Number of males age 21 to 75 or females age 40 to 75 who have had an MI, CABG or PCI in the year prior or a diagnosis of ischemic vascular</td>
<td>100%^</td>
<td>0.5 if annual improvement target or performance goal met or exceeded</td>
<td>NYS DOH</td>
<td>P4R</td>
<td>P4P</td>
</tr>
<tr>
<td>Measure Name</td>
<td>Steward and Specification Version</td>
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<td>Projects Associated with Measure</td>
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<td>Payment: DY 4 and 5</td>
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<td>Statin Therapy for Patients with Cardiovascular Disease – Statin Adherence 80%</td>
<td>HEDIS® 2016</td>
<td>3.b.i</td>
<td></td>
<td>Number of people who achieved a proportion of days covered of 80% for the treatment period</td>
<td>Number of males age 21 to 75 or females age 40 to 75 who have had an MI, CABG or PCI in the year prior or a diagnosis of ischemic vascular disease in both the measurement year and year prior</td>
<td>100%^</td>
<td>0.5 if annual improvement target or performance goal met or exceeded</td>
<td>NYS DOH</td>
<td>P4R</td>
<td>P4P</td>
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<tr>
<td>Measure Name</td>
<td>Steward and Specification Version</td>
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<td>Projects Associated with Measure</td>
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<td>Denominator Description</td>
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<td>Reporting Responsibility</td>
<td>Payment: DY 2 and 3</td>
<td>Payment: DY 4 and 5</td>
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</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>HEDIS® 2016</td>
<td>0018</td>
<td>3.b.i</td>
<td>adequately controlled as follows:</td>
<td>Number of people, ages 18 to 85 years, who have hypertension</td>
<td>73.3% (2012 Data) *High Perf Elig</td>
<td>1 if annual improvement target or performance goal met or exceeded</td>
<td>PPS and NYS DOH</td>
<td>P4R</td>
<td>P4P</td>
</tr>
<tr>
<td>Aspirin Use</td>
<td>HEDIS® 2016 (Volume 3 using CAHPS data)</td>
<td>NA</td>
<td>3.b.i</td>
<td>Number of respondents who are men, ages 46 to 65 years, with at least one cardiovascular risk factor; men, ages 66 to 79 years, regardless of</td>
<td></td>
<td>62.9%</td>
<td>0.5 if annual improvement target or performance goal met or exceeded</td>
<td>NYS DOH</td>
<td>P4R</td>
<td>P4P</td>
</tr>
<tr>
<td>Measure Name</td>
<td>Steward and Specification Version</td>
<td>NQF #</td>
<td>Projects Associated with Measure</td>
<td>Numerator Description</td>
<td>Denominator Description</td>
<td>Performance Goal</td>
<td>High Performance eligible <strong>#</strong></td>
<td>Statewide measure</td>
<td>Achievement Value</td>
<td>Reporting Responsibility</td>
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</tr>
<tr>
<td>Discussion of Risks and Benefits of Aspirin Use</td>
<td>HEDIS® 2016 (Volume 3 using CAHPS data)</td>
<td>NA</td>
<td>3.b.i</td>
<td>Number of respondents who discussed the risks and benefits of using aspirin with a doctor or health provider</td>
<td>Number of respondents who are men, ages 46 to 79 years, and women, ages 56 to 79 years</td>
<td>67.3%</td>
<td>NYS DOH</td>
<td>P4R</td>
<td>0.5 if annual improvement target or performance goal met or exceeded</td>
<td>P4P</td>
</tr>
<tr>
<td>Medical Assistance with Smoking and Tobacco Use Cessation – Advised to Quit</td>
<td>HEDIS® 2016 (Volume 3 using CAHPS data)</td>
<td>0027</td>
<td>3.b.i, 3.c.i</td>
<td>Number of responses ‘Sometimes’, ‘Usually’ or ‘Always’ were advised to quit</td>
<td>Number of respondents, ages 18 years and older, who smoke or use tobacco some days or every day</td>
<td>95.6%</td>
<td>NYS DOH</td>
<td>P4R</td>
<td>0.33 if annual improvement target or performance goal met or exceeded</td>
<td>P4P</td>
</tr>
<tr>
<td>Measure Name</td>
<td>Steward and Specification Version</td>
<td>NQF #</td>
<td>Projects Associated with Measure</td>
<td>Numerator Description</td>
<td>Denominator Description</td>
<td>Performance Goal</td>
<td>High Performance eligible #</td>
<td>Statewide measure</td>
<td>Achievement Value</td>
<td>Reporting Responsibility</td>
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</tr>
<tr>
<td>Medical Assistance with Smoking and Tobacco Use Cessation – Discussed Cessation Medication</td>
<td>HEDIS® 2016 (Volume 3 using CAHPS data)</td>
<td>0027</td>
<td>3.b.i, 3.c.i</td>
<td>Number of responses ‘Sometimes’, ‘Usually’ or ‘Always’ discussed cessation medications</td>
<td>ages 18 years and older, who smoke or use tobacco some days or every day</td>
<td>83.9%</td>
<td>performance goal met or exceeded</td>
<td>NYS DOH</td>
<td>P4R</td>
<td>P4P</td>
</tr>
<tr>
<td>Medical Assistance with Smoking and Tobacco Use Cessation – Discussed Cessation Strategies</td>
<td>HEDIS® 2016 (Volume 3 using CAHPS data)</td>
<td>0027</td>
<td>3.b.i, 3.c.i</td>
<td>Number of responses ‘Sometimes’, ‘Usually’ or ‘Always’ discussed cessation methods or strategies</td>
<td>Number of respondents, ages 18 years and older, who smoke or use tobacco some days or every day</td>
<td>75.3%</td>
<td>*High Perf Elig</td>
<td>NYS DOH</td>
<td>P4R</td>
<td>P4P</td>
</tr>
<tr>
<td>Flu Shots for Adults Ages 18 – 64</td>
<td>HEDIS® 2016 (Volume 3 using CAHPS data)</td>
<td>0039</td>
<td>3.b.i, 3.c.i</td>
<td>Number of respondents who have had a flu shot</td>
<td>Number of respondents, ages 18 to 64 years</td>
<td>63.4%</td>
<td>performance goal met or exceeded</td>
<td>NYS DOH</td>
<td>P4R</td>
<td>P4P</td>
</tr>
<tr>
<td>Health Literacy – Instructions Easy to Understand</td>
<td>2357a_ C&amp;G CAHPS Adult</td>
<td>NA</td>
<td>3.b.i, 3.c.i</td>
<td>Number of responses ‘Usually’ or ‘Always’ that</td>
<td>Number of respondents who answered they</td>
<td>98.8%</td>
<td>1 if annual improvement target or performance goal met or exceeded</td>
<td>NYS DOH</td>
<td>P4R</td>
<td>P4P</td>
</tr>
<tr>
<td>Measure Name</td>
<td>Steward and Specification Version</td>
<td>NQF #</td>
<td>Projects Associated with Measure</td>
<td>Numerator Description</td>
<td>Denominator Description</td>
<td>Performance Goal</td>
<td>Reporting Responsibility</td>
<td>Payment: DY 2 and 3</td>
<td>Payment: DY 4 and 5</td>
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<td></td>
</tr>
<tr>
<td>Health Literacy – Describing How to Follow Instructions</td>
<td>Supplement (QHL13)</td>
<td>NA</td>
<td>3.b.i, 3.c.i</td>
<td>instructions for caring for condition were easy to understand</td>
<td>saw provider for an illness or condition and were given instructions</td>
<td>goal met or exceeded</td>
<td>NYS DOH</td>
<td>P4R</td>
<td>P4P</td>
<td></td>
</tr>
<tr>
<td>Health Literacy – Explained What to do if Illness Got Worse</td>
<td>2357a_C&amp;G CAHPS Adult Supplement (QHL14)</td>
<td>NA</td>
<td>3.b.i, 3.c.i</td>
<td>Number of responses ‘Usually’ or ‘Always’ that provider asked patient to describe how the instruction would be followed</td>
<td>Number of respondents who answered they saw provider for an illness or condition and were given instructions</td>
<td>89.7%</td>
<td>NYS DOH</td>
<td>P4R</td>
<td>P4P</td>
<td></td>
</tr>
<tr>
<td>Prevention Quality Indicator</td>
<td>AHRQ 5.0.3</td>
<td>0272</td>
<td>3.c.i</td>
<td>Number of admissions</td>
<td>Number of people 18</td>
<td>8.23 per 100,000</td>
<td>NYS DOH</td>
<td>P4P</td>
<td>P4P</td>
<td></td>
</tr>
<tr>
<td>Measure Name</td>
<td>Steward and Specification Version</td>
<td>NQF #</td>
<td>Projects Associated with Measure</td>
<td>Numerator Description</td>
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<td>Performance Goal #</td>
<td>High Performance eligible #</td>
<td>Statewide measure</td>
<td>Achievement Value</td>
<td>Reporting Responsibility</td>
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<tr>
<td># 1 (DM Short term complication) ±</td>
<td></td>
<td></td>
<td></td>
<td>with a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma)</td>
<td>years and older as of June 30 of measurement year</td>
<td>Medicaid Enrollees</td>
<td>target or performance goal met or exceeded</td>
<td>NYS DOH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes screening – All Three Tests (HbA1c, dilated eye exam, and medical attention for nephropathy)</td>
<td>HEDIS® 2016</td>
<td>0055, 0062, 0057</td>
<td>3.c.i</td>
<td>Number of people who received at least one of each of the following tests: HbA1c test, diabetes eye exam, and medical attention for nephropathy</td>
<td>Number of people ages 18 to 75 with diabetes</td>
<td>64.6%</td>
<td>1 if annual improvement target or performance goal met or exceeded</td>
<td>PPS and NYS DOH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%) ±</td>
<td>HEDIS® 2016</td>
<td>0059</td>
<td>3.c.i</td>
<td>Number of people whose most recent HbA1c level indicated poor control (&gt;9.0 percent), was missing or did not have a HbA1c test</td>
<td>Number of people ages 18 to 75 with diabetes</td>
<td>23.2%</td>
<td>1 if annual improvement target or performance goal met or exceeded</td>
<td>PPS and NYS DOH</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SCC CWSP & DWSP Support Services
Community-Based Programs Engagement
Purpose: SCC supports facilitating follow up referrals to community-based programs to document participation and behavioral and health status changes for CWSP and DWSP practice sites.

<table>
<thead>
<tr>
<th>Number</th>
<th>Program Document Name</th>
<th>Program Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>2ai.01</td>
<td>Warm Referral &amp; Follow up Protocol</td>
<td>2ai.01 SCC Cardio Program Procedure_v2.pdf</td>
</tr>
</tbody>
</table>

Care Coordination
Purpose: SCC provides support to CWSP and DWSP practice sites with care coordination policies and procedures, a guide to care coordination team roles and responsibilities, and a template for recording team rosters.

<table>
<thead>
<tr>
<th>Number</th>
<th>Program Document Name</th>
<th>Program Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>2ai.02</td>
<td>Clinical Improvement Program Clinical Team Roles &amp; Responsibilities Guide</td>
<td>2ai.02 Clinical Team Roles and Responsibilities-v2.pdf</td>
</tr>
<tr>
<td>2ai.03</td>
<td>Care Coordination Core Principles</td>
<td>2ai.03 Care Coordination Core f</td>
</tr>
<tr>
<td>2ai.04</td>
<td>Care Coordination Services</td>
<td>2ai.04 Care Coordination Services_v-02.pdf</td>
</tr>
<tr>
<td>2ai.05</td>
<td>Care Coordination Team Roster Request Template</td>
<td>Care Coordination Team Rosters.xlsx</td>
</tr>
</tbody>
</table>

*See the Core Curriculum Guidelines for Practice Sites: Care Coordination Methodology, Protocol & Treatment Plans

Home Blood Pressure Monitoring Support Services
Purpose: SCC provides services to CWSP practice sites with home blood pressure monitoring follow support to patients with ongoing blood pressure monitoring including equipment evaluation and follow up if blood pressure results are abnormal.

<table>
<thead>
<tr>
<th>Number</th>
<th>Program Document Name</th>
<th>Program Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>3bi.31</td>
<td>Home Blood Pressure Monitoring Services Plan</td>
<td>Home Blood Pressure Monitoring</td>
</tr>
</tbody>
</table>

* See 3bi.03 protocol, 3bi.24, and Blood Pressure Measurement (practice-based or self-monitored) training

SUFFOLK CARE COLLABORATIVE | Project Management Office | www.suffolkcare.org | DSRIP@stonybrookmedicine.edu
Stanford Chronic Disease & Diabetes Self-Management Program

Purpose: SCC provides Stanford University self-management education model workshop opportunities to CWSP and DWSP practice sites through partnerships with community-based organizations. The goal of this initiative is to support, leverage and supplement existing resources to increase the capacity of chronic disease self-management education services available to people with a principle diagnosis of hypertension or hypercholesterolemia and diabetes self-management education services available to people diagnosed with diabetes or who are “at-risk” of developing diabetes in high-need Suffolk County communities. CWSP and DWSP practice sites can identify locally available Stanford Chronic Disease Self-Management Programs (CDSMP) and Diabetes Self-Management Programs (DSMP) using the SCC provided resources listed below.

   a. SCC Community Webpage (coming soon)
      i. Community resources
      ii. Community calendar
         1. Long Island Population Health Improvement Program
      iii. Patient educational materials
   b. HITE- Health Information Tool for Empowerment website
      https://www.hitesite.org/
   c. SCC’s DSRIP in Action newsletter
   d. The Quality and Technical Assistance Center of NY (QTAC-NY)
      https://compass.qtacny.org/find-a-workshop
   e. Stanford workshop series flyers

*See the 3bi.3ci.01 protocol and the Patient Self-Identified Goals and Diabetes and Chronic Disease Self-Management Education Programs training

Health Home Navigation Services

Purpose: SCC establishes linkages to health homes for targeted patient populations (CWSP & DWSP).

<table>
<thead>
<tr>
<th>Program Document Name</th>
<th>Program Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffolk County Health Home Directory</td>
<td>Care Management Service Grid.pdf</td>
</tr>
</tbody>
</table>
## General Program Documents

### CWSP and DWSP Project Charters

Below are the project charters for the CWSP and the DWSP.

<table>
<thead>
<tr>
<th>Domain 1 Patient Engagement Data Request</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3bi- Cardiovascular Wellness and Self-Management</strong></td>
<td>[SCC Project 3bi Project Charter - FIN](SCC Project 3bi Project Charter - FINAL DRAFT_11.2015.pdf)</td>
</tr>
<tr>
<td><strong>3ci- Diabetes Wellness and Self-Management</strong></td>
<td>[SCC DWSP Project Charter - FINAL DRAFT.pdf](SCC DWSP Project Charter - FINAL DRAFT.pdf)</td>
</tr>
</tbody>
</table>
Project Milestone Timelines

DWSP Milestone Timeline

DSRIP Project 3ci: Diabetes Wellness & Self-Management Program (DWSP)
CWSP Milestone Timeline

- PCP Schedule Created for Implementation Plan: 8/31/2015
- Clinical Guideline Summary Presented to Clinical Committee for Endorsement: 8/31/2015
- Strategy for PCP engagement is complete: 1/31/2016
- CV Wellness & Self-Mgmt Training Program Development Completed: 3/31/2016
- Initiate Ongoing Cardio Stanford Model Education Classes (Chronic Disease Self-Mgmt program): 3/31/2016
- Initiate Implementation Plan with Engaged PCPs: 5/31/2016
- Health Home Participation Agreements Completed: 12/31/2016
- 80% of PCPs are Engaged with the CV Wellness & Self-Mgmt Program: 3/31/2017
- Engaged Partners to Use EHR or Other Tech Platforms to Track all Patients Engaged in Project: 3/31/2017
- Engaged Partners to All Sites Met: 3/31/2018

DSRIP Project 3bi: Cardiovascular Wellness & Self-Management Program (CWSP)
Clinical Improvement Program Resources

General

Suffolk Care Collaborative (SCC) Performing Provider System (PPS)

The Suffolk Care Collaborative (SCC) is the Performing Provider System (PPS) for Suffolk County under the Delivery System Reform Incentive Payment (DSRIP) program. The SCC has resulted from the recent partnership of thousands of healthcare delivery partners across Suffolk County, NY.

http://www.suffolkcare.org/

Patient Education

Agency for Healthcare Research & Quality (AHRQ): Health Literacy Universal Precautions Toolkit

The AHRQ Health Literacy Universal Precautions Toolkit can help primary care practices reduce the complexity of health care, increase patient understanding of health information, and enhance support for patients of all health literacy levels


Alliance for Health Reform – Health Literacy and Health Insurance Literacy Toolkit

The Alliance for Health Reform is a non-profit organization seeking to help policy makers and others move toward an improved health care system that can deliver affordable, quality care for all. This toolkit addresses the extent and significance of both health literacy and health insurance literacy for Americans buying and using health insurance.


Research Instruments Developed, Adapted or Used by the Stanford Patient Education Research Center

The Stanford Patient Education Research Center has about 20 years of experience developing, adapting, and testing self-administered scales in English and Spanish for research subjects with chronic diseases. These scales are here for you to use in your own research at no cost, thanks to funding from the National Institute of Nursing Research (NINR).

http://patienteducation.stanford.edu/research/
Patient-Centeredness

Agency for Healthcare Research & Quality (AHRQ): Shared Decision Making Toolkit

The AHRQ Shared Decision Making Toolkit provides access to a collection of new tools and accredited trainings to support health care professionals' implementation of patient-centered outcomes research in shared decision making. These tools include guides to AHRQ's patient-centered outreach research materials, shared decision making, and enhanced patient-provider communication.


CAHPS: Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys

Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

https://www.cahps.ahrq.gov/

National Committee for Quality Assurance (NCQA) Patient Centered Medical Home

The NCQA is a non-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda.

http://www.ncqa.org/Programs/Recognition/RecognitionProgramsResearchResources/MedicalSocietiesOrganizations.aspx

Qualis - Safety Net Medical Home Initiative

Qualis is a population healthcare consulting organization that partnered with the MacColl Institute for Healthcare Innovation to lead the Safety Net Medical Home Initiative (SNMHI). This Commonwealth Fund initiative sought to accelerate patient-centered medical home (PCMH) transformation in 65 practices around the country. The Initiative developed a framework for PCMH transformation and published a library of resources and tools to help practices understand and implement the PCMH Model of Care.

http://www.qualishealth.org/
Creating Patient-centered Team-based Primary Care

This paper from the Agency of Healthcare Research and Quality outlines a conceptual framework for the integration of team-based care and patient-centered care in primary care settings and provides practical strategies to support the implementation of patient-centered team-based primary care.


Cardiovascular Program Resources
Implementing the Million Hearts® Campaign

Million Hearts® Campaign

Million Hearts® is a national initiative with an ambitious goal to prevention 1 million heart attacks and strokes by 2017. The Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services co-lead the initiative on behalf of the U.S. Department of Health and Human Services. Million Hearts® aims to prevent heart attacks and strokes by: Improving access to effective care; improving quality of care for the ABCS of heart health (Aspirin, Blood Pressure, Cholesterol Management, Smoking Cessation); focusing clinical attention on the prevention of heart attack and stroke; activating the public to lead a heart-healthy lifestyle; and improving the prescription and adherence to appropriate medications for the ABCS.

http://millionhearts.hhs.gov/about_mh.html


Million Hearts Campaign: Hypertension Protocol

National Association of County & City Health Officials: Million Hearts Local Engagement Guide

Association of State and Territorial Health Officials (ASTHO) Million Hearts Campaign
http://www.astho.org/Million-Hearts/

Standard treatment protocols for hypertension and elevated Blood Pressure

HHC Adult Hypertension Clinical Practice Guidelines

Centers for Disease Control and Prevention National Cholesterol Education Program (NCEP) Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults

US Preventive Services Task Force (USPSTF) Screen for Dyslipidemia to Improve Cardiovascular Outcomes

2014 Evidence Based Guideline for the Management of High Blood Pressure in Adults: Report from the Panel Members Appointed to the Eighth Join National Committee (JNC 8). JAMA 2014; 311 (5); 507-520.
http://jamanetwork.com/journals/jama/fullarticle/1791497

Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC)

Medication Management

Improving Medication Adherence Among Patients with Hypertension

Medication adherence is critical to successful hypertension control for most patients. Find out how you can help.


NYC Medication Adherence Toolkit:

https://www1.nyc.gov/site/doh/providers/resources/public-health-action-kits-medication-adherence.page

NYC DOH City Health Information: Improving Medication Adherence


Pocket Blood Pressure Discussion Tool

Quick tips and conversation starters—in a convenient pocket size—helps you maximize time spent with patients on the topic of blood pressure.


Medicines to Help You: High Blood Pressure

Use this guide to help you talk to your doctor, pharmacist, or nurse about your blood pressure medicines. The guide lists all of the FDA-approved products now available to treat this condition. You will also find some general information to help you use your medicines wisely.

http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM282311.pdf

Blood Pressure Monitoring

Do you Measure Blood Pressure? Assess Your Clinic Checklist

https://healthinsight.org/tools-and-resources/send/90-tools/72-blood-pressure-assessment
Patient Visit Checklist: Supporting Your Patients with High Blood Pressure

Effective provider-patient communication improves health outcomes and saves time. Use this checklist with sample questions to communicate better with your patients during every visit.


American Heart Association: Home Blood Pressure Monitoring

http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/SymptomsDiagnosisMonitoringofHighBloodPressure/Home-Blood-Pressure-Monitoring_UCM_301874_Article.jsp#WAUS5qbrv4Y

American Heart Association: How to Monitor & Record Your Blood Pressure

http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/SymptomsDiagnosisMonitoringofHighBloodPressure/How-to-Monitor-and-Record-Your-Blood-Pressure_UCM_303323_Article.jsp#.WAUTUqbrv4Y

American Heart Association & American Stroke Association: My Blood Pressure Log

http://www.heart.org/idc/groups/heart-public/@wcm/@hcm/documents/downloadable/ucm_305157.pdf

Self-Measured Blood Pressure Monitoring: Action Steps for Clinicians

SMBP plus additional clinical support is one strategy that can reduce the risk of disability or death from high blood pressure. The purpose of this CDC guide is to help clinicians implement SMBP in their practices by providing evidence-based action steps and resources.


This program, from the American Medical Association and Johns Hopkins Medicine, is designed for use by physician offices and health centers to engage patients in SMBP. This program describes various ways that the patient can obtain blood pressure measurements outside of the clinical office either through the purchase of a device or a physician-led blood pressure monitor loaner program.

Self-Measured Blood Pressure Monitoring Interactive Infographic for Clinicians

This interactive infographic, from the Office of the National Coordinator for Health Information Technology, can be used to inform health care providers about SMBP, the burden of high blood pressure, and the medical and financial advantages of an SMBP monitoring program.

https://www.healthit.gov/sites/default/files/final_smbp_sector_508_tested_no_watermark.pdf

dabl Educational Trust Blood Pressure Monitors – Validations, Papers and Reviews
Recommended Devices by Category

http://www.dableducational.org/sphygmomanometers/recommended_cat.html

Video: Self-Measured Blood Pressure Monitoring to Control Hypertension

This Medscape video highlights ways health care clinicians can help patients manage hypertension. (To view the video, you may have to register with Medscape.)


How to Monitor and Record Your Blood Pressure - Blood Pressure Measurement Instructions

http://www.heart.org/hcm/groups/heart-public/@wcm/@hcm/documents/downloadable/ucm_445846.pdf

Instructional Video from the American Heart Association - Monitoring Blood Pressure at Home

Watch this video to learn how to monitor your blood pressure at home and how to work with your doctor on the results.

http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/SymptomsDiagnosisMonitoringofHighBloodPressure/Instructional-Video---Monitoring-Blood-Pressure-at-Home_UCM_303324_Article.jsp#WbtQkKbrv4Y

My Blood Pressure Log

American Heart Association/American Stroke Association Printable blood pressure tracker
Download and print this tracker to record and monitor your blood pressure levels.
Stroke

NINDS Know Stroke, Know the Signs Toolkits & Posters (English & Spanish)

This boxed kit of materials has everything needed for planning and conducting a stroke education event. Included is a facilitator's guide with step-by-step training on how to host a stroke awareness event; Know Stroke brochures in Spanish and English; What you Need to Know about Stroke brochures in Spanish and English; posters; and an award-winning 8 minute videotape featuring interviews with medical experts and stroke patients.

https://stroke.nih.gov/materials/toolkits.htm

Patient Registries

The American Medical Group Foundation- Measure Up, Pressure Down Toolkit

In this free toolkit, you'll find useful tools, tips, and resources to help you jump-start your hypertension quality improvement initiative and get you on the road to achieving better control rates.


Health Center Network of New York. Undiagnosed Hypertension Registry.

http://bit.ly/1sUmOPG
5 A’s of Tobacco Control

Million Hearts Campaign (MHC) Identifying & Treating Patients who use Tobacco; Centers for Disease Control and Prevention. *Protocol for Identifying and Treating Patients Who Use Tobacco*. Atlanta, Georgia. 2016. This protocol is reference throughout the Clinical Objective, Core Population, Narrative, Workflow, Roles and Responsibilities, it includes description of the core population, workflow of the tobacco screening intervention using the 5 A’s, includes billing and HER considerations as well as coding details for billing tips.


NYS BOH Bureau of Tobacco Control: Blueprint Questions for 5 A’s EHR Configuration

This blueprint will support electronic-health record configuration of the 5 A’s.

http://scc.perflogic.com/document?s=PFN0cj4KMDEXMC8xNjE3Mi81My9wZGYKPC9TdHl%2bCg%3d%3d

American Academy of Family Physicians: Integrating Tobacco Cessation into EHRs

This white-paper will further describe strategies to integrate tobacco cessation into EHRs.

https://www.nysmokefree.com/ConfCalls/CCNYSDownloads/EHR_Template.PDF

American Academy of Family Physicians: Treating Tobacco Dependence Practice Manual

This practice manual provides solutions and suggestions for implementing a systems-change approach for evidence-based tobacco cessation treatment.


NYC Department of Health & Mental Hygiene: Treating Tobacco Use Training Module

This Treating Tobacco use training module’s program objective includes helping trainees describe the “5 A’s” model of treating tobacco dependence treatment, identify indications and contraindications for tobacco dependence treatment medications.

http://www.nyc.gov/html/doh/media/flash/tobacco/player.html
CDC Office on Smoking and Health: Tips From Former Smokers Campaign
This campaign provides resources for health care clinicians to get their patients to quit smoking.
http://www.cdc.gov/tobacco/campaign/tips/

National Cancer Institute: Smokefree.gov
The information and professional assistance available on this website can help to support your patients’ immediate and long-term needs as they become, and remain, nonsmokers. Smokefree.gov allows patients to choose the help that best fits their needs.
https://www.smokefree.gov/

University of California, San Francisco: Rx for Change—Clinician-Assisted Tobacco Cessation
This comprehensive, turn-key, tobacco cessation training program equips health professional students and licensed clinicians with state-of-the-art knowledge and skills for assisting patients with quitting.
http://rxforchange.ucsf.edu/

University of Wisconsin Center for Tobacco Research and Intervention: Videos for Health Care Providers
This resource includes videos about tobacco dependence treatment for health care clinicians.
http://www.ctri.wisc.edu/providers-videos.htm

Smoking Cessation Leadership University of California, San Francisco
This six hour training will teach the comprehensive smoking cessation counseling training, Rx for Change. This program is divided into a series of three 2-hour recorded webinars, and will allow faculty to add this training to the curriculum at their respective schools. As well, this will equip students to be able to expertly counsel smokers once they enter practice.
http://smokingcessationleadership.ucsf.edu/webinars/tobacco-cessation-education

New York City Department of Health and Mental Hygiene: Tobacco Quit Kit
The Tobacco Quit Kit contains clinical tools, resources for clinicians, and patient education materials, which promote evidence-based practices for tobacco cessation.
https://www1.nyc.gov/site/doh/providers/resources/public-health-action-kits-smoking-cessation.page

[http://tobaccocontrol.bmj.com/content/18/1/34.full](http://tobaccocontrol.bmj.com/content/18/1/34.full)

Smoking Cessation Leadership Center webinar

A Team Approach: Integrating Tobacco Dependence Treatment into Routine Clinical Practice


Treating Tobacco Dependence Practice Manual: Build a Better Office System

This guide, produced by the American Academy of Family Physicians, addresses the U.S. Public Health Service’s (USPHS) Clinical Practice Guideline; Treating Tobacco Use and Dependence 2008 Update, recommendation for clinicians to change the clinical culture and practice patterns in their offices to ensure that every patient who uses tobacco is identified, advised to quit, and offered evidence-based treatments.


NYS Quit-line

For Participating Practice Implementation:

Refer-To-Quit Program: Online and Fax-To-Quit referral program

The New York State Smokers’ Quitline offers its Refer-to-Quit program for health care providers to help their patients stop smoking. As a confidential service, we offer coaching and cessation-related services to patients who use tobacco products.

NYS Smokers’ Quit-line: Fax-to-Quit Forms

Fax-to-Quit Program

http://www.nysmokefree.com/Specialpages/rViewpdf1.ashx?No=2112

Fax Referral Form

https://www.nysmokefree.com/Fax/Refer-to-QuitReferralForm2-11.pdf

Opt-To-Quit™

The Opt-to-Quit™ program is designed to support a hospital, clinic, office practice or program to provide tobacco using patients with help to stop smoking. The Opt-to-Quit™ program is a policy-driven system-wide solution for ensuring stop smoking support is offered and accessible to patients once they leave the health care setting.

https://www.nysmokefree.com/download/OptToQuitPrintable.pdf

NYS Smokers’ Quit-line: General Flyer

https://www.nysmokefree.com/SpecialPages/rViewpdf1.ashx?No=2056

NYS Smokers’ Quit-line: Office Poster


Order Quit-line Materials Web-Form


NYS Department of Health, Tobacco Control Webpage

https://www.health.ny.gov/prevention/tobacco_control/
For Patients:

Free Nicotine Replacement Request Web Form
https://www.nysmokefree.com/register/Intro.aspx

NYS Medicaid Managed Care (MMC) Pharmacy Benefit Information Center – Tobacco Cessation Medication Insurance Coverage Search
http://mmcdruginformation.nysdoh.suny.edu/search/

NYS Smokers’ Quit-line: Local Support Groups Search

NYS Smokers’ Quit-line: QuNiTY Community
https://qunity.nysmokefree.com/

Diabetes Program Resources


http://clinical.diabetesjournals.org/content/34/1/3

National Diabetes Education Program – Practice transformation for physicians and healthcare teams


http://clinical.diabetesjournals.org/content/34/1/3

National Diabetes Education Program – Practice transformation for physicians and healthcare teams


AHRQ offers several curriculum tools that health care professionals can use to make care safer and improve their communication and teamwork skills. Information on these tools is provided here.

Patient Identified Self-Management Goals

Documents and templates to assist with setting and recording patient identified self-management goals

<table>
<thead>
<tr>
<th>Document Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Management Evaluation Form</td>
<td>Self-Management Evaluation Form.docx</td>
</tr>
<tr>
<td>SMART Goals</td>
<td>SMART Goals.docx</td>
</tr>
<tr>
<td>SMART Goals Worksheet</td>
<td>SMART Goals Worksheet.docx</td>
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</tbody>
</table>

The Join Commission: Presentation slides from the 2014 Primary Care Medical Home Preconference - Self-Management Goals Made Simple


AAFP Video: Improve Care with Patient Self-Management Support

http://www.aafp.org/multimedia/performanceassessment/selfman112409.swf

Institute for Health Care Improvement: Set & Document Self-Management Goals Collaboratively with Patient who have Chronic Conditions

http://www.ihi.org/resources/Pages/Changes/SetandDocumentSelfManagementGoalsCollaborativelywithPatients.aspx

California Health Care Foundation: Video with Techniques for Effective Patient Self-Mgmt


**Referral to Patient Self-Management Education**

**Health Information Tool for Empowerment**

FREE online resource directory for social workers, caseworkers, discharge planners, and other information and referral professionals
http://www.hitesite.org/

**Stanford Chronic Disease Self-Management Program**

The Chronic Disease Self-Management Program is a workshop given two and a half hours, once a week, for six weeks, in community settings such as senior centers, churches, libraries and hospitals. People with different chronic health problems attend together. Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with chronic diseases themselves.
http://patienteducation.stanford.edu/programs/cdsmp.html

**Stanford Diabetes Self-Management Education Program**

The Diabetes Self-Management workshop is given 2½ hours once a week for six weeks, in community settings such as churches, community centers, libraries and hospitals. People with type 2 diabetes attend the workshop in groups of 12-16. Workshops are facilitated from a highly detailed manual by two trained Leaders, one or both of whom are peer leaders with diabetes themselves.
http://patienteducation.stanford.edu/programs/diabeteseng.html
The Quality and Technical Assistance Center of NY (QTAC-NY) is a part of the Center for Excellence in Aging & Community Wellness at the University at Albany School of Social Welfare. This website provides listings of local Stanford Chronic Disease and Diabetes Self-Management Education Programs.

Find a Workshop: https://compass.qtacny.org/find-a-workshop