Diabetes and Cardiovascular Clinical Improvement Programs Implementation Toolkit

Suffolk Care Collaborative
Implementation Toolkit for Clinical Improvement Programs

10th Edition: February 27, 2017

“Healthy people, healthy communities, healthy society.”

PROGRAM TOOL FOR PARTICIPANTS OF DSRIP PROJECTS 3BI & 3CI
DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM

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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.

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Cardiovascular Wellness and Self-Management Committee
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- Brookhaven Memorial Hospital Medical Center
- Bureau of Community Chronic Disease Prevention
- Catholic Health Services of Long Island
- Catholic Health Solutions - Home Care
- Cerner Corporation
- Dolan Family Health Center
- Good Samaritan Hospital Medical Center
- Hudson River HealthCare
- Interim HealthCare of Greater NY
- John T. Mather Memorial Hospital
- King Kullen Pharmacies Corporation
- Long Island Pharmacists Society
- Mercy Medical Center
- Northwell Health
- Northwell Health Solutions
- Peconic Bay Medical Center
- Premier Home Health Care
- Purti Drugs Corporation
- St. Catherine of Siena
- Stony Brook University Hospital
- Stony Brook Medicine
- Suffolk County Department Health Services
- Suffolk Independent Living Organization (SILO) Inc.
- Visiting Nurse Service of New York

Diabetes Wellness and Self-Management Committee
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- Brookhaven Memorial Hospital Medical Center
- Care Connection Home Care, LLC.
- Catholic Health Services of Long Island
- Catholic Health Solutions - Home Care
- Cornell Cooperative Extension of Suffolk County
- Dolan Family Health Center
- Eastern Long Island Hospital
- Fairview Pharmacy & Homecare Supply
- Freeport Medical Supply Inc. Xtra Care Pharmacy
- Good Shephard Hospice
- Harborview Medical Services
- Hudson River HealthCare
- Interim HealthCare of Greater NY
- John T. Mather Memorial Hospital
- Long Island Pharmacists Society
- Northwell Health
- Northwell Health Solutions
- Options for Community Living
- Peconic Bay Medical Center
- Planetree Training Institute
- Purti Drugs Corp.
- Retired Senior Volunteer Program of Suffolk (RSVP)
- Stony Brook University Hospital
- Stony Brook Medicine
- Suffolk County Department of Health Services
- Suffolk Independent Living Organization (SILO)
- Visiting Nurse Service of New York
- The Way Back, Inc.
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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 is 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 Cross-walk 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.

<table>
<thead>
<tr>
<th>DSRIP Protocols</th>
<th>PCMH Standards</th>
</tr>
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<tbody>
<tr>
<td>Implement the Million Hearts Campaign (01) Aspirin Usage, BP Control, Cholesterol mgmt., &amp; Smoking cessation</td>
<td>2D (Must Pass), 3C, 3E, 4E</td>
</tr>
<tr>
<td>Communication Plan (02)</td>
<td>2D (Must Pass), 4E2</td>
</tr>
<tr>
<td>BP Administration, Monitoring, Measurement and F/U (03) Technique; Home BP Monitoring; &amp; ASTHO MH Home BP Intervention; &amp; Follow up BP w/o copayment or advanced appointment</td>
<td>2D (Must Pass), 3C, 3D (Must Pass), 3E, 4A, 4B (Must Pass), 4E</td>
</tr>
<tr>
<td>Pt Identification &amp; Standard Treatment Protocols for HTN, Elevated Cholesterol &amp; Prescribing Guidelines (04)</td>
<td>2D (Must Pass), 3E, 4B (Must Pass), 4C, 4D</td>
</tr>
<tr>
<td>Risk assessment &amp; Prescribing guidelines</td>
<td></td>
</tr>
<tr>
<td>Implementing 5As (05) EHR integration of tobacco intervention ( Ask, Advice, Assess, Assist, Arrange) &amp; Referral to NY Smokers’ Quitline</td>
<td>2D (Must Pass), 3B, 3C, 3D (Must Pass), 4A5, 4B (Must Pass), 4E3</td>
</tr>
<tr>
<td>Implementing NY Smokers’ Quitline (06)</td>
<td>2D (Must Pass), 4A, 4E5</td>
</tr>
<tr>
<td>Documenting Patient Driven Self-Management Goals (07)</td>
<td>2D (Must Pass), 3C, 3D (Must Pass) 4B (Must Pass), 4E</td>
</tr>
<tr>
<td>DSRIP Protocols</td>
<td>PCMH Standards</td>
</tr>
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</tr>
<tr>
<td>Disease Management &amp; Treatment Protocols (01)</td>
<td>2D (Must Pass)</td>
</tr>
<tr>
<td>Medical history; Physical exam; Laboratory evaluation; Testing criteria;</td>
<td>3A, 3B, 3C, 3D (Must Pass)</td>
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<tr>
<td>and Referral to self-management &amp; diabetes education opportunities (01)</td>
<td>4A, 4E, 5B (Must Pass)</td>
</tr>
<tr>
<td>Guidelines for Patient Referral to Self-Management Education (02)</td>
<td>2D (Must Pass)</td>
</tr>
<tr>
<td>(Stanford University DSMP; AADE or ADA recognized education programs;</td>
<td>4A, 4B (Must Pass)</td>
</tr>
<tr>
<td>Diabetes Prevention Program; and Referral process)</td>
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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
Suffolk Care Collaborative Program Contacts

<table>
<thead>
<tr>
<th>Contact Name</th>
<th>Title</th>
<th>Email Address</th>
<th>Phone Number</th>
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<td>631-638-1318</td>
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<td>516-465-1921</td>
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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.

<table>
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<th>Preview</th>
<th>Clinical Summary Link</th>
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<tr>
<td><img src="image" alt="Cardiovascular Preview" /></td>
<td>Evidence-Based Strategies for Disease Management in High Risk/Affected Populations: Cardiovascular</td>
</tr>
<tr>
<td><img src="image" alt="Diabetes Preview" /></td>
<td>Evidence-Based Strategies for Disease Management in High Risk/Affected Populations: Diabetes</td>
</tr>
</tbody>
</table>
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>
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<tbody>
<tr>
<td>3bi.01</td>
<td>Implementing the Million Hearts Campaign</td>
<td>SCC Cardio Program Procedure_</td>
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<tr>
<td>3bi.02</td>
<td>Communication Plan of the Million Hearts Campaign Strategies</td>
<td>SCC Cardio Program Procedure_</td>
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<tr>
<td>3bi.03</td>
<td>Blood Pressure Administration, Monitoring, Measurement &amp; Follow up</td>
<td>SCC Cardio Program Procedure_</td>
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<td>3bi.04</td>
<td>Patient Identification, Standard Treatment Protocols for Hypertension and Elevated</td>
<td>SCC Cardio Program Procedure_</td>
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<td>Cholesterol Protocol; and Preferential Drugs Prescribing Guidelines Protocol</td>
<td>SCC Cardio Program Procedure_</td>
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<td>3bi.05</td>
<td>Implementing the 5A's of Tobacco Control Protocol</td>
<td>SCC Cardio Program Procedure_</td>
</tr>
<tr>
<td>3bi.06</td>
<td>Implementing the NY Smokers Quitline Protocol &amp; Promotional Materials References</td>
<td>SCC Cardio Program Procedure_</td>
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<tr>
<td>3bi.07</td>
<td>Patient self-management goal guideline Protocol</td>
<td>SCC Cardio Program Procedure_</td>
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</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>
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<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>
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<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>
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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>
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<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 Screenshots</td>
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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>
<th>Clinical Workflow Name</th>
<th>Clinical Workflow Diagram</th>
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<tbody>
<tr>
<td>3bi.21</td>
<td>Cardiovascular Wellness &amp; Self-Management Program Flow Chart</td>
<td>3bi Cardio FLOW CHART FINAL DRAFT</td>
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<td>3bi.22</td>
<td>Follow-up blood pressure check appointment</td>
<td>[PDF](3bi BP Checks Workflow v1.pdf)</td>
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<tr>
<td>3bi.23</td>
<td>Identifying patients with hypertension</td>
<td>[PDF](3bi Identifying HTN Patients v3.pdf)</td>
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<td>3bi.24</td>
<td>Home blood pressure administration, warm referral, monitoring, measurement and follow-up</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>
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<td>3bi.26</td>
<td>Patient-driven self-management goals</td>
<td>[PDF](Collaborative Care_Cycle of Self-M.pdf)</td>
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<td>3bi.27</td>
<td>Identifying &amp; Treating Patients who use Tobacco (Tobacco Cessation)</td>
<td><a href="Tobacco-Cessation-Protocol.pdf">PDF</a></td>
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<tr>
<td>3ci.21</td>
<td>Diabetes Wellness &amp; Self-Management Program Flow Chart</td>
<td>[PDF](3ci Diabetes FLOW CHART FINAL DRAFT.pdf)</td>
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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>
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## Clinical Improvement Programs Toolkit

<table>
<thead>
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<th>Name of Document</th>
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### Tobacco Control

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<td>Welcome to the New York State Smokers’ Quitline</td>
<td>New York State Smoker’s Quitline</td>
<td>NYS Smokers’ Quitline Information</td>
<td><a href="http://www.nysmokefree.com/Specialpages/rViewpdf1.ashx?No=2056">http://www.nysmokefree.com/Specialpages/rViewpdf1.ashx?No=2056</a></td>
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<tr>
<td>Staying Tobacco Free</td>
<td>The Tobacco Control Program of Roswell Park Cancer Institute</td>
<td>StayingTobaccoFree10-2010 4b2approved.pdf</td>
<td><a href="https://rpcs.roswellpark.org/StayingTobaccoFree">https://rpcs.roswellpark.org/StayingTobaccoFree</a></td>
</tr>
<tr>
<td>Topic</td>
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<tr>
<td>10 Things You Didn’t Know About Smoking</td>
<td><img src="http://www.nysmokefree.com/Specialpages/rViewpdf1.ashx?No=2052" alt="PDF" /></td>
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<tr>
<td>Nicotine Patch Use Instructions</td>
<td><img src="https://www.nysmokefree.com/Factsheets/NicotinePatchInstructions.pdf" alt="PDF" /></td>
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<tr>
<td>Tobacco: Leading Cause of Preventable Death</td>
<td><img src="https://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume8/n3_tobacco_leading_cause.pdf" alt="PDF" /></td>
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<tr>
<td>Medications Covered by Medicaid</td>
<td><img src="https://www.nysmokefree.com/subpage.aspx?pn=medications" alt="PDF" /></td>
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<td>7000 Chemicals in Cigarettes</td>
<td><img src="https://www.nysmokefree.com/Subpage.aspx?P=40&amp;P1=4020" alt="PDF" /></td>
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<tr>
<td>Smoking and Asthma</td>
<td><img src="https://www.nysmokefree.com/Specialpages/rViewpdf1.ashx?No=2093" alt="PDF" /></td>
<td></td>
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<tr>
<td>Smoking and COPD</td>
<td><img src="https://www.nysmokefree.com/Specialpages/rViewpdf1.ashx?No=2094" alt="PDF" /></td>
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<tr>
<td>Smoking and Diabetes</td>
<td><img src="https://www.nysmokefree.com/Specialpages/rViewpdf1.ashx?No=2091" alt="PDF" /></td>
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<tr>
<td>Smoking and Heart Disease</td>
<td><img src="https://www.nysmokefree.com/Specialpages/rViewpdf1.ashx?No=2092" alt="PDF" /></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>
<th>Spanish Link</th>
<th>Spanish PDF</th>
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<tbody>
<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>
<td><a href="http://professional2.diabetes.org/content/PML/Type_1_Spanish_1013c577-e105-417f-a13bc-d488b037d482/Type_1_Spanish.pdf">http://professional2.diabetes.org/content/PML/Type_1_Spanish_1013c577-e105-417f-a13bc-d488b037d482/Type_1_Spanish.pdf</a></td>
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<td>type_2.pdf</td>
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<td><a href="http://professional.diabetes.org/sites/professional.diabetes.org/files/media/Type_2_Spanish.pdf">http://professional.diabetes.org/sites/professional.diabetes.org/files/media/Type_2_Spanish.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>
<th>Spanish PDF</th>
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<tbody>
<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>Name of Document</td>
<td>English PDF</td>
<td>Spanish PDF</td>
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<tr>
<td>------------------------</td>
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</tr>
<tr>
<td>Type 1 Diabetes</td>
<td>Type1DiabetesEN_SuffolkCare.pdf</td>
<td>Type1DiabetesSP_SuffolkCare.pdf</td>
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<td>Type 2 Diabetes</td>
<td>Type2DiabetesEN_SuffolkCare.pdf</td>
<td>Type2DiabetesSP_SuffolkCare.pdf</td>
</tr>
<tr>
<td>Why Do I Need Insulin?</td>
<td>WhyNeedInsulinEN_SuffolkCare.pdf</td>
<td>WhyNeedInsulinSP_SuffolkCare.pdf</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 Attempt.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.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  
3. Identify benefits of diabetes and chronic disease self-management education,                                                                                                                                                                                                                                                                                                         | Self-ID Goals_Self-Manager                                               |

SUFFOLK CARE COLLABORATIVE | Project Management Office | www.suffolkcare.org | DSRIP@stonybrookmedicine.edu
**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.

**Training Topic** | **Learning Objectives** | **Core Curriculum**
--- | --- | ---
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 |  

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>
<th></th>
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</thead>
<tbody>
<tr>
<td>3bi- Cardiovascular Wellness and Self-Management</td>
<td>SCC Project 3.b.i Cardio Data Request.pdf</td>
</tr>
<tr>
<td>3ci- Diabetes Wellness and Self-Management</td>
<td>SCC Project 3.c.i Diabetes Data Request.pdf</td>
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</tbody>
</table>
### Clinical Outcome Measures

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Steward and Specification Version</th>
<th>NJF #</th>
<th>Projects Linked with Measure</th>
<th>Numerator Description</th>
<th>Denominator Description</th>
<th>Goal *High Performanc e eligible #Statewide measure</th>
<th>Achievement Value</th>
<th>Reporting Duty</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></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 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>
</tr>
<tr>
<td>Statin Therapy for Patients with Cardiovascular Disease –Statin Adherence 80%</td>
<td>HEDIS® 2016</td>
<td></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>Controlling High Blood Pressure</td>
<td>HEDIS® 2016</td>
<td>0018</td>
<td>3.b.i</td>
<td>Number of people whose blood pressure was adequately controlled as follows: ♦ below 140/90 if ages 18-59;</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></td>
<td>P4R</td>
</tr>
<tr>
<td>Measure Name</td>
<td>Steward and Specification Version</td>
<td>NQF #</td>
<td>Projects Linked with Measure</td>
<td>Numerator Description</td>
<td>Denominator Description</td>
<td>Goal *High Performanc e eligible #Statewide measure</td>
<td>Achievement Value</td>
<td>Reporting Duty</td>
<td>Payment: DY 2 and 3</td>
<td>Payment: DY 4 and 5</td>
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<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 currently taking aspirin daily or every other day</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 risk factors; and women, ages 56 to 79 years, with at least two cardiovascular risk factors</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>
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<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>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>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>0.33 if annual improvement target or 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 –</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>Number of respondents, ages 18 years and older, who smoke or use tobacco some days or every day</td>
<td>83.9%</td>
<td>0.33 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>
<td>NQF #</td>
<td>Projects Linked with Measure</td>
<td>Numerator Description</td>
<td>Denominator Description</td>
<td>Goal *High Performance eligible #Statewide measure</td>
<td>Achievement Value</td>
<td>Reporting Duty</td>
<td>Payment: DY 2</td>
<td>Payment: DY 4</td>
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<tr>
<td>Discussed Cessation Medication</td>
<td>CAHPS data)</td>
<td></td>
<td></td>
<td>Number of respondents, ages 18 years and older, who smoke or use tobacco some days or every day</td>
<td>75.3% *High Perf Elig</td>
<td>0.33 if annual improvement target or performance goal met or exceeded</td>
<td>NYS DOH</td>
<td>P4R</td>
<td>P4P</td>
<td></td>
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<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% *High Perf Elig</td>
<td>0.33 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>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>1 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>Health Literacy – Instructions Easy to Understand</td>
<td>2357a_ C&amp;G CAHPS Adult Supplement (QHL13)</td>
<td>NA</td>
<td>3.b.i, 3.c.i</td>
<td>Number of responses ‘Usually’ or ‘Always’ that instructions for caring for condition were easy to understand</td>
<td>Number of respondents who answered they saw provider for an illness or condition and were given instructions</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>
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<tr>
<td>Health Literacy – Describing How to Follow Instructions</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>0.33 if annual improvement target or performance goal met or exceeded</td>
<td>NYS DOH</td>
<td>P4R</td>
<td>P4P</td>
</tr>
<tr>
<td>Health Literacy – Explained What to</td>
<td>2357a_ C&amp;G CAHPS</td>
<td>NA</td>
<td>3.b.i, 3.c.i</td>
<td>Number of responses ‘Usually’ or ‘Always’ that provider explained what to</td>
<td>Number of respondents who answered they saw provider for an illness or condition</td>
<td>94.1%</td>
<td>0.33 if annual improvement target</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>
<td>NQF #</td>
<td>Projects Linked with Measure</td>
<td>Numerator Description</td>
<td>Denominator Description</td>
<td>Goal *High Performanc e eligible #Statewide measure</td>
<td>Achievement Value</td>
<td>Reporting Duty</td>
<td>Payment: DY 2</td>
<td>Payment: DY 3</td>
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<tr>
<td>do if Illness Got Worse</td>
<td>Adult Supplement (QHL16)</td>
<td>0272</td>
<td>3.c.i</td>
<td>do if illness/condition got worse or came back</td>
<td>Number of people 18 years and older as of June 30 of measurement year</td>
<td>8.23 per 100,000 Medicaid Enrollees</td>
<td>or performance goal met or exceeded</td>
<td>NYS DOH</td>
<td>P4P</td>
<td>P4P</td>
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<tr>
<td>Prevention Quality Indicator # 1 (DM Short term complication) ±</td>
<td>AHRQ 5.0.3</td>
<td>0272</td>
<td>3.c.i</td>
<td>Number of admissions with a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma)</td>
<td>Number of people 18 years and older as of June 30 of measurement year</td>
<td>8.23 per 100,000 Medicaid Enrollees</td>
<td>or performance goal met or exceeded</td>
<td>NYS DOH</td>
<td>P4P</td>
<td>P4P</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</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>P4P</td>
<td>P4P</td>
</tr>
<tr>
<td>Comprehensive Diabetes: 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>P4P</td>
<td>P4P</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 Warm</td>
</tr>
<tr>
<td></td>
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<td>Referral &amp; Follow</td>
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<td>up.pdf</td>
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</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</td>
<td>2ai.02 Clinical</td>
</tr>
<tr>
<td></td>
<td>Team Roles &amp; Responsibilities Guide</td>
<td>Team Roles and</td>
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<td></td>
<td></td>
<td>Responsibilities</td>
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<td></td>
<td></td>
<td>Guide</td>
</tr>
<tr>
<td>2ai.03</td>
<td>Care Coordination Core Principles</td>
<td>2ai.03 Care</td>
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<td></td>
<td></td>
<td>Coordination Core</td>
</tr>
<tr>
<td>2ai.04</td>
<td>Care Coordination Services</td>
<td>2ai.04 Care</td>
</tr>
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<td>Coordination Serv</td>
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</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>
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</thead>
<tbody>
<tr>
<td>3bi.31</td>
<td>Home Blood Pressure Monitoring Services</td>
<td>Home Blood</td>
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<td></td>
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<td>Monitoring</td>
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<td>Services</td>
</tr>
</tbody>
</table>

* See 3bi.03 protocol, 3bi.24, and Blood Pressure Measurement (practice-based or self-monitored) training
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>
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</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>
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</thead>
<tbody>
<tr>
<td><strong>3bi- Cardiovascular Wellness and Self-Management</strong></td>
<td>[PDF](SCC Project 3bi Project Charter - FIN)</td>
</tr>
<tr>
<td><strong>3ci- Diabetes Wellness and Self-Management</strong></td>
<td>[PDF](SCC DWSP Project Charter - FINAL DRAFT)</td>
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</tbody>
</table>
Project Milestone Timelines

DWSP Milestone Timeline

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

**Suffolk Care Collaborative**

**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 prevent 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_sect_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/IDC/groups/heart-public/@wcm/@hc/docs/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=PFN0cj4KMDExMC8xNjE3My9wZGYKPC9TdHI%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/CCNJSDownsloads/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

Smoking Cessation Leadership Center webinar
A Team Approach: Integrating Tobacco Dependence Treatment into Routine Clinical Practice

https://smokingcessationleadership.ucsf.edu/webinar/team-approach-integrating-tobacco-dependence-treatment-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://mmcdruгинformation.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>
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<tbody>
<tr>
<td>Self-Management</td>
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<td>SMART Goals</td>
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<tr>
<td>SMART Goals Worksheet</td>
<td>SMART Goals Worksheet.docx</td>
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</table>

The Joint 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