3.b.i Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only)

Project Objective: To support implementation of evidence-based best practices for disease management in medical practice for adults with cardiovascular conditions. (Adults Only).

Project Description: The goal of this project is to ensure clinical practices in the community and ambulatory care setting use evidence based strategies to improve management of cardiovascular disease. These strategies are focused on improving practitioner population management, adherence to evidence-based clinical treatment guidelines, and the adoption of activities that will increase patient self-efficacy and confidence in self-management. Strategies from the Million Hearts Campaign (http://millionhearts.hhs.gov) are strongly recommended.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the attachment: **Domain 1 DSRIP Project Requirements Milestones & Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.
2. Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.
3. Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.
4. Use EHRs or other technical platforms to track all patients engaged in this project.
5. Use the EHR or other technical platform to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).
6. Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.
7. Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.
8. Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.
9. Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.
10. Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.

Improve Medication Adherence:

11. Prescribe once-daily regimens or fixed-dose combination pills when appropriate.

Actions to Optimize Patient Reminders and Supports:

12. Document patient driven self-management goals in the medical record and review with patients at each visit.
13. Follow up with referrals to community based programs to document participation and behavioral and health status changes
14. Develop and implement protocols for home blood pressure monitoring with follow up support.
15. Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.
16. Facilitate referrals to NYS Smoker's Quitline.
17. Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.
18. Adopt strategies from the Million Lives Campaign.
19. Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.
20. Engage a majority (at least 80%) of primary care providers in this project.

Project Response & Evaluation (Total Possible Points – 100):

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

Overall, Western New York has a 24% higher incidence of cardiovascular disease than the rest of New York State. Some of the most significant concerns for cardiovascular health were seen in Niagara County, which was ranked in the bottom quartile for prevention metrics, and performed worse than the state on hospital admissions for all categories of cardiac-related chronic disease including angina and ischemic heart disease, congestive heart failure, coronary atherosclerosis, and hypertension. Western New York has higher rates of heart attack hospitalizations and obesity, particularly in Erie, Niagara, and Cattaraugus counties. Niagara was also ranked in the bottom third for prevalence of heart failure, and WNY as a whole was ranked last in the state for angina without procedure. According to the CNA the WNY region has 32.7% prevalence of high blood pressure compared to 26.8% state wide. Erie, Niagara and Chautauqua counties performed worse than the state on admissions for patients with hypertension, with Erie and Niagara showing rates of over 200 per 100,000. Erie County also showed higher rates of admission for congestive heart failure. Cardiovascular disease is the leading cause of hospitalization and death in every county of New York State The goal of this project is to slow the progression of cardiovascular disease, improve patient outcomes and reduce ER visit/hospital admissions. The project will utilize a cardiovascular care management program which includes provider and patient education,

implementation of care management processes and protocols, a care management team (pharmacists, dieticians, social workers, etc.), use of coordinators to provide patient assessments including risks and barriers, self-management techniques including assessing readiness to change, adherence to treatment plan, lifestyle modification, confidence and conviction. Also included is linkage to community based programs/resources with follow-up.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

The target population consists of Medicaid and uninsured patients >18 years attributed to the PPS in Erie, Niagara and Chautauqua counties with a cardiovascular disease diagnosis. The target population is estimated to be 12,707 individuals.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

In keeping with the Million Hearts Campaign, adopting a heart healthy lifestyle, receiving timely evidence based care and prescribing appropriate medications are included in the cardiovascular care management program developed by Sisters of Charity Hospital/CMP Project Management Team. The chronic disease self-management program of the Stanford Model will also be implemented throughout the PPS to promote patient engagement. The current assets and resources that can be mobilized to achieve the project goals include national evidence based clinical guidelines adopted by for the diagnosis and treatment of congestive heart failure, coronary artery disease and hypertension in ambulatory and community care setting. Another asset is office based electronic health records (EHRs) that enable the practice to create condition specific patient registries identifying patients with “Gaps in Care”. Existing resources (the Care Team) include: (a) the clinical transformation team, which supports EHR implementation, maximizes EHR use in the medical office by developing patient registries, and facilitates the use of RHIO, enhancing complete patient health information, (b) social work resources, (c) pharmacist resources, (d) registered dieticians and (e) office based nurse care coordinators. Care coordinators initiate a patient assessment including risks and barriers, self-management techniques including assessing readiness to change, adherence to treatment plan, lifestyle modification, confidence and conviction. The Care Team follows up on referrals to community based programs. Sisters of Charity Hospital/CMP Project Management Team has web based and in person training programs for care coordinators and materials to leverage across the PPS. Sisters of Charity Hospital/CMP Project Management Team developed a web based “tool kit” to perform an assessment, including health literacy, language/translation needs, and readiness to change. The tool kit provides self-management tools and shared decision making resources for patient engagement.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include

issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

Some of the challenges anticipated include reaching, engaging and motivating the adult Medicaid patient population in managing cardiovascular disease. Education level is an underlying factor with the lowest rates of high school completion in Buffalo, Niagara Falls and the Southern Tier. Transportation and housing issues exist and may negatively impact patient engagement in seeking healthcare. Community Outreach Workers along with social workers, will provide home visits with linkage to community resources such as legal aid, food banks, transportation, and provide blood pressure monitoring without charging copays. The Health Home will provide integrated services in one setting for patients needing home care services. PCMH practices will provide open appointment access. Tobacco Cessation services will be provided by the NYS Quitline using the 5 A's approach since 49% of Medicaid population are smokers. Patients will be referred to nutritionists at community settings for education and budget meal planning promoting hypertension and cholesterol control. Pharmacists can assist with promotion of once-dally regimens or fixed –dose combination pills. Patient reminder systems will be expanded and enhanced with secure text messages for blood pressure checks, lab work and office appointment reminders. The PPS will provide ongoing competency training for all staff and patients on proper BP monitoring techniques. The PPS will dedicate IT resources to drive improvement in the management of cardiovascular disease through data integration and system interoperability.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve overlapping service areas. If there are no other PPSs within the same service area, then no response is required.

The PPS will collaborate with regional health plans and other PPS in our service area through project leads, meetings and a toll free hotline.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

3. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application

will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

4. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

If yes: Please describe why capital funding is necessary for the Project to be successful.

Capital funding will be required to provide an electronic medical record to practices currently using paper charts, to upgrade existing office EHRs to ensure interoperability and/or consistent data capture for quarterly quality metrics, develop patient registries for cardiovascular disease in the practice, enable alerts and reminders to close gaps in care related to the management of coronary artery disease, hypertension and congestive heart failure.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☐	☒

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards scale of project implementation, completion of project requirements and patient engagement progress in the project.

a. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.