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. Project Justification, Assets, Challenges, and Needed Resources (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.

The prevalence of cardiovascular disease (CVD) among Medicaid beneficiaries in NYC far exceeds that of other chronic diseases. In NYC, 30% of Medicaid beneficiaries have been diagnosed with a cardiovascular related condition, while only 10% have been diagnosed with a respiratory related condition, 11% with a diabetes related condition, and 20% with a mental health related condition.

Heart disease is the leading cause of death and the second leading cause of premature death in the four boroughs that comprise our service area. In 2011, the age-adjusted CVD mortality rate per 100,000 was 249.3 in NYC and 242.3 in NYS.

The age-adjusted CVD hospitalization rate per 10,000 was 173.6 in NYC compared to 159.9 in NYS. Each borough has hot spots for CVD. Twenty-four UHF neighborhoods have risk-adjusted O/E ratios greater than one (indicating a gap in care) for three Prevention Quality Indicator (PQI) measures related to CVD and risk factors (Circulatory Composite, Hypertension, Diabetes). Given that these neighborhoods encompass a large proportion (66%) of the Medicaid adult population, our PPS will enhance engagement efforts in these areas.

CNA focus groups identified concerns related to chronic conditions, including lack of sufficient information on health and health services. Other concerns included minimal knowledge, interest, and engagement in prevention services, and "a gap in primary care provider's ability to find specialists who are accepting Medicaid or different kinds of insurance."

Major CVD risk factors include hypertension (HTN), diabetes, hyperlipidemia, and smoking. Neighborhoods across NYC had a risk-adjusted O/E ratio for the HTN PQI measure greater than one: Manhattan (9 neighborhoods), Brooklyn (6 neighborhoods), the Bronx (7 neighborhoods) and Queens (3 neighborhoods). Similarly high risk-adjusted O/E ratios (i.e., greater than one) were identified across NYC: Manhattan (8 neighborhoods), Brooklyn (6 neighborhoods), the Bronx (7 neighborhoods) and Queens (2 neighborhoods). The CNA noted that diabetes is considered by many residents and key informants to be the most significant health issue in Brooklyn.

To address these gaps, our PPS will pursue a multi-pronged approach, with a focus on the ABCs of the Million Hearts Campaign. This includes improving prescribing and adherence to aspirin prophylaxis among eligible patients, improving blood pressure control by updating and strengthening implementation of HTN guidelines, improving cholesterol control by updating current cholesterol management and treatment guidelines, and increasing smoking cessation by enabling PCPs to distribute nicotine replacement therapy at the point-of-care (see CNA needs 1, 5). Our PPS will also focus on improving diabetes control using the Collaborative Care Model, currently used for depression (see CNA need 5).

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.

Our PPS expects to engage the following patient population: all uniquely attributed adult patients (ages 18+ years) with cardiovascular conditions based on a defined set of ICD-9 diagnosis codes. The project will intensify efforts in medical and professional shortage areas, and the 24 UHF neighborhoods where three risk-adjusted O/E ratios for PQI measures related to CVD and risk factors (Circulatory Composite, Hypertension, Diabetes) are greater than one. This includes the following neighborhoods: Bedford/Stuy/Crown Heights, Fordham/Bronx Park, Crotona/Tremont, Highbridge/Morrisana, Washington Heights/Inwood, Pelham/Throgs Neck, Flatbush/E. Flatbush, Jamaica, Williamsburg/Bushwick, East New York, Hunts Point/Mott Haven, Central Harlem/Morningside Heights, NE Bronx, Canarsie/Flatlands, East Harlem, Downtown/Heights/Slope, Rockaway, Stapleton/St. George, Chelsea/Clinton, Upper West Side, Kingsbridge/Riverdale, Upper East Side, Lower Manhattan, and Gramercy Park/Murray Hill. Project efforts will coordinate with 2.d.i activities to engage low- and non-utilizers.

The PPS will leverage and enhance use of clinical patient registries and care coordination/management platform to identify patients to engage based on health risk and

socio-economic factors (see CNA needs 3, 5). Among the 24 targeted neighborhoods, the 10 poorest have 26-43% of the population below 100% FPL. These 10 neighborhoods also have 13%-26% who are non-U.S. citizens, 7%-38% who speak English "less well," 20%-44% of adults with less than a high school education, and 9%-17% who live with a disability.

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.

Our PPS will pursue a multi-pronged approach to help achieve the goals of this DSRIP project, with a focus on the ABCs of the Million Hearts Campaign and diabetes control. Existing assets and resources include: HHC's successful Treat to Target program; the NYS Quitline and NYC Treats Tobacco to support smoking cessation activities; health IT components, such as clinical registries, to track patients across a number of indicators; Stanford's evidence-based Chronic Disease Self-Management Program which educates patients regarding self-management activities; and, community-based partners with expertise addressing socio-economic risk factors (e.g., housing, education, transportation).

Using these assets and resources as a foundation, our PPS will first improve the prescribing of and adherence to aspirin prophylaxis among eligible patients. We will disseminate guidelines and leverage clinical registries to identify eligible patients not taking aspirin.

Second, we will improve blood pressure control by using and expanding existing clinical registries to identify patients needing follow-up care, to monitor blood pressure and strengthen implementation of HTN guidelines. Blood pressure checks will be available on a drop-in basis without a co-pay. Additional clinic personnel will be trained to take blood pressure measurements.

Third, the PPS will update current cholesterol management and treatment guidelines with recent changes in recommendations, and followed by wide dissemination and implementation. Further the PPS will use assets such as clinical registries to identify patients needing follow up and track cholesterol control rates over time.

Fourth, we will improve diabetes control. Existing assets include diabetic group classes and experience implementing the Collaborative Care Model for depression, which we intend to expand to include controlling A1c, blood pressure, and LDL.

Fifth, we will increase smoking cessation efforts by enabling PCPs to distribute nicotine replacement therapy at the point-of-care, which removes a co-pay and a pharmacy trip. We are also redesigning smoking-specific EHR measures to meet Meaningful Use standards and to be more provider-friendly. This will facilitate follow-up and referrals to the NYS Quitline, and will connect patients with additional resources. We will strengthen its partnership with New York City Treats Tobacco to obtain technical assistance and provide trainings on best practices to multi-disciplinary teams that provide smoking cessation services in PPS facilities.

To support the project, the PPS will train staff in guidelines and new roles. A newly developed CSO will house the PPS's care management services. The CSO will develop common job

descriptions, clinical protocols, metrics and other services, as needed.

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.

We anticipate a number of challenges in implementing this initiative. First, PCPs may find it difficult to reach clinical targets. To address this challenge we will provide clinical protocols, continually assess fidelity to standards, and institute corrective actions. Our extensive capacity in cardiac specialty care will be available to high-risk or complicated patients who need more intensive management.

We also expect difficulties with effective engagement of chronically ill patients over the long term, particularly with regard to behavior change. To address this challenge we will deploy peer educators and care managers to support patients, with heavy reliance on the recommended evidence-based Stanford Model.

MCO policies that are contrary to project goals (e.g., prohibition on 90-day refills and fixed dose combination pills) will present challenges. To address this challenge, we will work with MCOs to encourage policy changes that promote medication adherence. Care managers and pharmacists can also help with medication adherence.

Finally, we expect to face challenges associated with recruiting and training sufficient care management staff. To address these challenges we will work with community colleges and local partners to develop a pipeline of care management staff. We will train nurses and other members of the care team, as appropriate, to help patients with self-management.

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.

We are collaborating with Bronx Partners for Healthy Communities (BPHC) and Community Care of Brooklyn (CCB) to align project selection and begin joint project planning. During the January-February 2015 implementation planning period, we intend to collaborate further with our PPS colleagues to ensure alignment and coordination of standardized protocols, development of workforce strategy, workforce training efforts, and selection of culturally competent patient education resources to support this project.

Additionally, a critical component of the CVD project is the ability to share data not only across each individual PPS but also between PPSs in order to quickly receive information on PPS patients who may visit a clinical setting outside of the PPS' network. We plan to discuss IT implementation as part of our PPS collaboration and expand these discussions with other PPSs in the service area. Areas for additional collaboration include, but are not limited to, issues such

as selection and adoption of common screening tools across PPSs, common risk stratification models, adoption of common core partner contracting vehicles, and coordinated HIE initiatives.

2. Scale of Implementation (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. Speed of Implementation/Patient Engagement (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.

The PPS will enhance IT systems with needed capabilities. This will require establishing enhanced data connectivity through the RHIO and other HIE capabilities. Funding will support: functionality for secure notifications/messaging; work with PCPs to meet Meaningful Use and PCMH Level 3 standards; enhancing care coordination/management platforms that include functionalities to target patients with CVD or significant risk factors and that capture social determinants of health; and, establishing electronic communications with patients and CBOs to support coordination of clinical and social

services.

Technology needs include: (1) hardware to improve access to enhanced software systems (e.g., second computer monitors to compare information from different systems) and large computer screens to review EHR, registry and other data during quality improvement, population health management and patient case meetings; (2) equipment to enhance communication with patients (e.g., secure smartphones phones for staff to call and email patients, laptops/tablets for staff or community health workers visiting patients); (3) hardware for video conferencing with patients as needed; and, (4) telemonitoring capacity for patients and providers. Telemonitoring will include electronic activity monitoring devices (e.g., blood pressure cuffs, glucometers, scales, fitbits, medication dispensers) and connectivity to PPS health IT systems.

Construction or renovation of existing space for patient friendly and accessible wellness centers (e.g., purchase of health kiosks to offer culturally competent education on disease management, blood pressure checks, and patient navigator support to access a PCP during and after hours, and availability of specialized programs; clinic space with room for a nurse manager to conduct patient visits and to follow-up with patients via phone or electronically; to add rooms and needed equipment for nurse manager visits and community health worker counseling; and, clinic space for community health worker and peer coaching/counseling sessions).

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
New York City Health & Hospitals Corporation (HHC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HHC is a NYS-designated Health Home.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Community Care Management Partners (CCMP) Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CCMP is a NYS-designated Health Home.
CBC Pathways to Wellness Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CBC Pathways to Wellness is a NYS-designated Health Home.
Community Health Care Network	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CHN is a NYS-designated Health Home.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	ASCNYC is a Health Home care management provider, providing culturally competent care management team services comprised of licensed social workers and trained Peer Health Coaches.
CAMBA	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CAMBA is a Health Home care management provider, serving over 2,200 members and conducting outreach to between 300 – 900 members per month.
FEGS Health & Human Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	FEGS is a NYS-designated Health Home in Nassau and Suffolk counties as well as a case management agency under subcontract with a number of NYC Health Homes.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
HELP/PSI	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HELP/PSI is a Health Home care management entity under subcontract with 4 NYS Health Home providers.
Leake & Watts	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Leake & Watts provides a Health Home for children through the Children's Collaborative, a collation of children-and family-focused agencies that provides Health Home services for children.
PSCH	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	PSCH provides services to NYS Medicaid Health Homes under subcontract, including care coordination services to individuals with complex and/or multiple chronic conditions.
The Osborne Association /Osborne Treatment Services, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2015	The Osborne Association provides services under subcontract to Health Homes in Bronx and Brooklyn.
MetroPlus	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	MetroPlus provides contracting and care coordination services under subcontract to multiple Health Homes, including HHC and VNSNY.
Arms Acres and Conifer Park	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	Arms Acres and Conifer Park provides services to NYS Medicaid Health Homes under subcontract. Services include coordination of behavioral health services for patients with chronic medical and behavioral conditions.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Coordinated Behavioral Care IPA/ Postgraduate Center for Mental Health	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	The Postgraduate Center for Mental Health provides services to NYS Medicaid Health Homes under subcontract. Services include care coordination following the transition of targeted case management services.
Coordinated Behavioral Care IPA/ Brooklyn Bureau of Community Service d/b/a Brooklyn Community Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2013	2015	Brooklyn Community Service provides care coordination services under subcontract to participating agencies in the Brooklyn Health Home and CBC Pathways to Wellness Health Home.
Community Health Project, Inc. d/b/a Callen-Lorde Community Health Center	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Callen-Lorde participates in the Mount Sinai Health Homes network. Callen-Lorde has been assigned approximately 150 patients and 85 are actively enrolled. The program is growing, with two new Health Home positions are anticipated in the next two months. The program will scale up to 300+ patients by 2016.
CAMBA	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CAMBA is a Health Home care management provider, serving over 2200 members and conducting outreach to between 300 – 900 members per month.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Harlem United (HU)/ Upper Room AIDS Ministry, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Harlem United is a member of the CCMP-led Health Home in the Bronx and Manhattan, CHN in Queens and Maimonides in Brooklyn. Currently, approximately 900 clients are enrolled in HU's Health Home program.
Health People	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Health People provides services to NYS Medicaid Health Homes under subcontract. The organization provides outreach, engagement, follow-up, care retention and relevant self-care education for Medicaid enrollees with chronic conditions.
See additional entities at end of document	See additional initiatives at end of document			See additional descriptions at end of document

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. <u>Domain 1 DSRIP Project Requirements Milestones & Metrics:</u>

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.