

WMC DSRIP PPS Project Plans

Application Section 4

Submitted December 22 2014

3.c.i. Implementation of Evidence-Based Strategies in the Community to Address Chronic Disease – Primary and Secondary Prevention Projects - Diabetes

Project Response & Evaluation:

1. Project Description and Justification

1a. 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.

Diabetes is a prevalent diagnosis and comorbidity among Medicaid beneficiaries in our region. Hospitalization rates for short-term diabetes complications per 10,000 are higher than the regional rate (4.3) in Delaware (4.9), Orange (5.9) and Sullivan (6.2). Large numbers of Medicaid beneficiaries with diabetes are found in areas of population density served by our PPS associated with higher levels of poverty, including Yonkers, Mount Vernon, New Rochelle and Peekskill in Westchester County; Spring Valley and Monsey in Rockland County; Newburgh and Middletown/Port Jervis in Orange County; Poughkeepsie in Dutchess County; the Kingston area in Ulster County; and Liberty and Monticello in Sullivan County.

In a survey of our region's residents conducted as part of our CNA development, 43% of Medicaid respondents considered diabetes to be one of the top five health issues in their community; more than 50% of these same respondents had not had a diabetes test in the past 12 months and close to 25% did not know where to go within their county of residence to access diabetes testing, nutrition education or weight loss programs.

High prevalence, noted prioritization among surveyed residents, and the failure to meet quality standards make diabetes an important target for PPS intervention. Our PPS will implement four strategies to improve outcomes: (1) promote systematic incorporation of evidence-based treatment guidelines for diabetes management into primary care; (2) establish a PPS-wide registry to track diabetes patients; (3) coordinate efforts to close gaps in care by care teams including Health Homes, pharmacists, behavioral health providers, primary care based care coordinators; and (4) promote patient self-efficacy and expand the availability of evidence-based, self-management training for patients in the community setting.

Our PPS Quality Committee will review performance measures associated with the project and consult with participating primary care providers (PCPs) to focus on overcoming barriers to better performance. Our PPS is evaluating analytics and population health management platforms; in DSRIP DY1, we will implement a system to identify and track patients with diabetes. The PPS will expand care coordination resources region-wide, working with existing

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Health Homes to the extent possible to train care coordinators which will be integrated into primary care sites to support DSRIP project goals. Our PPS will share information with PCPs about existing community based self-management and education resources and work with community-based organizations offering self-management to develop cost effective expansion of such programs. We are also evaluating patient-facing tools that connect patients with community-based resources critical to self-management (such as support groups, food banks, nutrition counseling, etc.) and that allow patients to report their experience with services received.

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.

This project will target attributed adult Medicaid beneficiaries who have Type 1 or Type 2 diabetes as identified either by the beneficiary's PCP, by medical claims or by EHR data available to our PPS. Our PPS will establish a central registry to track beneficiaries with diabetes and will engage with Medicaid MCOs to coordinate diabetes outreach to beneficiaries and their PCPs. We will also identify patients with pre-diabetes or are at risk for diabetes based on increased BMI index consistent with overweight status or obesity and/or hemoglobin A1C blood test that is above normal but below the threshold for diabetes. Patients with pre-diabetes will be tracked separately and offered access to programs such as the Diabetes Prevention Program, which is available in the community from many of the same groups offering the Stanford Chronic Disease Self-Management Program.

The PPS will initially work with PCPs who have achieved NCQA PCMH Level 3 accreditation to put in place the four strategies. During DY 1-3 the PPS will ensure all affiliated PCPs achieve PCMH accreditation and implement a Meaningful Use-certified EHR. As part of our efforts to support PCMH accreditation, we will work with practices to extend the diabetes management project to 80%-100% of PCPs who treat adult patients.

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.

For over a decade, diabetes care has been a focus for quality improvement in our region. The New York Diabetes Coalition (NYDC), founded in Westchester County in 1999, has involved a broad group of stakeholders including health professional societies, health plans, patient advocacy groups and State, city and county departments of health and continues to be a State-wide source for diabetes management tools. Though still below goal, scores on diabetes quality of care measures have improved across the region. Our PPS will adopt appropriate NYDC tools,

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help to standardize, streamline and centralize patient outreach and build on existing collaborations to help primary care practices more consistently deliver excellent diabetes care.

Our region has existing resources for patient self-management training. Several PPS Participants offer the Stanford Chronic Disease Self-Management Program - The Greater Hudson Valley Family Health Center, Open Door Family Medical Centers, and Visiting Nurse Association of Hudson Valley offer the Stanford program for diabetes. Web-based cross-training is available from Stanford that will allow PPS partners who current use the Stanford model for other chronic diseases to develop diabetes-focused offerings.

HealthAlliance of the Hudson Valley's Diabetes Education Center offers a Support Group, financial and insurance assistance, and training to children and adults with Type 1, Type 2, Gestational, and pre-diabetes. The Institute for Family Health and Mount Vernon Neighborhood Health Center offer diabetes education programs. The Rockland County Department of Health implemented an electronic diabetes registry in partnership with NYDC and Steps program and offers a Diabetes Prevention Program to individuals at risk for Type 2 diabetes. A proposal from the Primary Care Development Corporation, Hudson Information Technology for Community Health (HITCH), and FQHCs participating in our PPS was selected as one of four finalists in a State-sponsored pay-for-success project that, if selected, will administer the National Diabetes Prevention Program to approximately 3,570 patients over five years. The National Diabetes Prevention Program is led by the Centers for Disease Control and takes an evidence-based approach to lifestyle change and prevention of Type 2 diabetes. (This work would complement, not duplicate, our PPS program efforts.)

Our PPS will work with the three regional Health Homes to identify additional "hot spots" where diabetes self-management programs are needed or are under-resourced. We will provide training to Health Home care coordinators on closing "gaps in care" for management of diabetes and other medical conditions and will provide training to affiliated PCPs on how better to link patients with Health Home resources and community based self-management training.

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

We will primarily concentrate our strategies for regional diabetes care improvement in the delivery of services to patients with diabetes through our enhanced primary care model network (comprised of PCMH Level 3-accredited practices). It will be challenging to deliver these enhanced services to beneficiaries attributed to our PPS who receive their primary care outside our PPS. Our cross-PPS Regional Clinical Council will be charged with addressing this and other region-wide issues. The Council will adopt a consolidated set of DSRIP performance metrics that will include best practices for diabetes.

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Our PPS anticipates providers and patients may not be aware of diabetes self-management programs, patients may be reluctant to attend, and the time or the location may be inconvenient. In an effort to engage patients, the PPS will coordinate with Health Homes, care coordinators, and peers to elevate awareness and ensure services and materials are widely available and in patients' native languages. All PPS providers will participate in annual cultural competency training throughout the life of the DSRIP initiative.

Young adults (ages 18 – 21) with diabetes may receive care from pediatric specialists who are less familiar with adult measures of diabetes care. Our PPS will use data to identify young adults with diabetes and consult with pediatricians and pediatric endocrinologists to modify the program to meet the particular needs of these beneficiaries.

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

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across our region and state. The three PPSs serving our region, led by Montefiore Medical Center, Refuah Health Center, and WMC, will establish a provider-led Regional Clinical Council to support development of a regional system of efficient and effective care, patient safety, and quality improvement.

The Council, with input from providers, payers, government agencies, and others, will review DSRIP project and implementation plans and make recommendations to align overlapping approaches. Region-wide coordination, common requirements, and expectations will minimize providers' implementation burdens and create consistent, high quality patient experiences. The Council will identify region-wide care improvement goals and serve as a forum for sharing and evaluating clinical strategies and practices. The Council will support the rapid and widespread adoption of agreed-upon clinical protocols and evidence-based practices across the region and payers.

Continuing the cooperation that resulted in the creation of a common CNA, the PPSs in our region have committed to coordinate in critical areas and will consider a comprehensive set of quality performance standards including evidence-based practices for diabetes and pre-diabetes across the region and its payers.

2. Scale of Implementation

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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:

2a. Please indicate the total number of sites, programs and/or providers the PPS intends to include in the project by the end of Demonstration Year (DY), or sooner as applicable. These numbers should be entered in the table as Total Committed.

See accompanying Speed & Scale Excel document

b. Please indicate the total expected volume of patients the PPS intends to engage throughout this project by the end of Demonstration Year (DY) 4. This will become the Expected # of Actively Engaged Patients. Patient scale is measured by the total number of patients that are expected to be actively engaged by the end of Demonstration Year 4.

See accompanying Speed & Scale Excel document

3. Speed of Implementation/Patient Engagement

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:

3a. Please indicate the Demonstration Year (DY) and Quarter by which all participating primary care providers will achieve project requirements. Project speed is measured by how fast all the project requirements for all chosen locations are met.

PPSs will be expected to meet these requirements for all of the providers, sites, or other categories of entities included in the PPS “total committed” scale metric, unless otherwise specified in the Domain 1 DSRIP Project Requirements Milestones and Metrics.

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b. Please indicate the expected timeline for achieving 100% engagement of total expected number of actively engaged patients identified. For example, the PPS may indicate that 25% of targeted patients will be actively engaged by the end of Demonstration year 1, 50% by the end of Demonstration year 2, etc.

See accompanying Speed & Scale Excel document

4. Project Resource Needs and Other Initiatives (750 word limit, Not Scored)

4a. Will this project require Capital Budget funding? (Please mark the appropriate box below)

Yes	No
X	

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

The WMC-led PPS will seek capital funds to develop a shared, health IT infrastructure that supports region-wide population health management efforts. The population health management system will include: (1) a centralized care management platform; (2) a patient registry; (3) equipment and software for telehealth and remote monitoring; (4) enhancement of partners' EHR and HIE capabilities; and (5) analytic tools and reporting systems for network management. Collectively, these tools support critical communication and coordination among our PPS partner organizations for improved asthma management. The capability will be shared across all 11 DSRIP projects and are central to our IDS development.

4b. 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
X	

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.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
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Dominican Sisters Family Health Service, Inc.	Community-based Care Transitions Program (CCTP)	2013	2017	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
The Greater Hudson Valley Family Health Center, Inc.	Health Center Program (Section 330) Grant Program (HRSA)	6/1/12	5/31/17	Supports the provision of care to medically underserved areas and populations in the service area.
Open Door Family Medical Center, Inc.	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
The Institute for Family Health	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Mount Vernon Neighborhood Health	Health Homes for Medicaid Enrollees and	2013	ongoing	New York's Health Home program provides a suite

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Center Network	Chronic Conditions			of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
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4c. 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.

This project will seek to equip patients with the right tools to effectively manage their diabetes. The care management experiences of the Medicaid initiatives identified above will be valuable in informing this process. However this project differs from these initiatives because it expands the population targeted. For example, The Community based Care Transitions program targets Medicare patients. Our PPS will build on the experience of these Participants to establish a customized standard care transitions models across the region and will expand the model to support to a broader population of Medicaid patients. The PPS will also expand health center services for the attributed population.

The Health Home program, particularly the experience and capacity of our participating Health Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects. This project will build on this work, but will serve a larger group of Medicaid patients, including those who are not currently eligible for Health Home services, and will expand the reach of the care management knowledge, techniques and experiences to populations not served by Health Homes.