3.c.i. – Evidence-Based Strategies for Disease Management in High Risk Adult Diabetes Patient Populations (Adults Only)

Summary	Resources in Place	Challenges	Resource Needs
• PPS will undertake evidence-based strategies to address diabetes. • All patients will be assigned a PCMH and enrolled in patient registries. • Care management software will be utilized to categorize patients by risk level. • Care management teams of nurses, navigators, care managers and pharmacists will closely follow patients. • Highest risk patients will be managed in home or in nursing homes.	• CHSLI has outpatient diabetes education centers • NS-LIJ has numerous programs to address diabetes, including community outreach programs focusing on diabetes wellness. • NuHealth's Zoki Hossain Center for Hypertension, Diabetes and Cardiovascular Disease employs a multidisciplinary approach. • Bariatric Surgery programs and hyperbaric therapy are available throughout the PPS. • High intensity home-based programs	• Insufficient outpatient providers, including diabetes educators. • Ineffective weight loss programs • Food Deserts/lack of healthy food in many communities.	• Develop a larger outpatient workforce. • Regulatory relief that will allow home health aides to administer medication. • IT infrastructure for seamless interoperability. • Remote monitoring devices for patients. • Telehealth to enable specialists to assist primary care providers.

3.c.i Evidence based strategies for disease management in high risk/affected populations. (Adult only)

Project Objective: Support implementation of evidence-based best practices for disease management in medical practice related to diabetes.

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 diabetes. Specifically, this includes improving practitioner population management, increasing patient self-efficacy and confidence in self-management, and implementing diabetes management evidence based guidelines.

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 and Metrics,** which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Implement evidence based best practices for disease management, specific to diabetes, in community and ambulatory care settings.
2. Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.
3. 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.
4. Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.
5. Ensure coordination with the Medicaid Managed Care organizations serving the target population.
6. Use EHRs or other technical platforms to track all patients engaged in this project.
7. Meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3 for EHR systems used by participating safety net providers.

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.

The rate of diabetes in the Nassau County is 5.9%, below the prevalence for NYS of 10.4%, but above the NYS Prevalence Agenda Objective of 5.7%; in Queens, the prevalence rate is 11%, above both NYS and NYSPAO. Diabetes prevalence is higher among the Medicaid population, at 9% of Nassau beneficiaries and 12% of Queens'. Medicaid avoidable hospitalization for adult uncontrolled diabetes in Nassau, at 63 admissions per 100,000, is above the state average of 46 per 100,000. The Queens rate of 36/100,000 belies rates of illness in specific areas. The communities of Bellerose, Freeport, Glen Cove, Jamaica, Far Rockaway and Westbury are "hot spots" for adult diabetes. The rates of avoidable hospitalizations for adult diabetes short term complications follows a similar pattern with areas in eastern Queens exhibiting high rates compared to the rest of the county. Nine low-income communities identified by Nassau County as high-risk for health disparities evidence twice the hospitalization rate for type 2 diabetes when compared with the rest of the county. Lifestyle factors, nutrition and physical activity, impact diabetes management. In Nassau County, 28% of the population gets the recommended amount of fruits and vegetables, compared to 10% in Queens. 1 in 4 Nassau and Queens residents are inactive. Stakeholders identified a lack of culturally sensitive effective care coordination, evidence-based chronic disease treatment protocols and self-management programs.

These findings demonstrate opportunities to redesign the care of diabetic patients so that they receive appropriate care at the right time and in the right setting.

NQP partners will manage diabetes patients through the use of evidence-based care, with the goal of reducing avoidable hospitalizations. Patients will be risk stratified, preferably using uniform care management software among clinical partners to categorize patients by risk level. Patients will receive customized levels of care management based upon their risk level once protocols are established for the initiative. Care coordination teams including diabetes educators, nursing staff, behavioral health providers, pharmacists, community health workers, and home healthcare managers will follow high risk patients closely with higher intensity engagement for patients with more advanced disease. Those teams will work to address health literacy, and support patient self-efficacy and patient self-management. NQP will facilitate patients seeing their PCPs, preferably in a PCMH, and enroll them in patient registries. Highest risk patients will be managed with intensive care in home or in nursing homes.

NQP will work with health homes to coordinate care management of the target population. Health homes have multipronged approaches for diabetes and other chronic illnesses; they also have real-time notification and utilize texting with patients to improve diabetes management (remind patients to check their blood sugar and take their medications). NQP will coordinate with managed care plans to move to different payment incentives for caring for this population.

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.

Anyone who received a hemoglobin A1c in the last year, for either diagnosis of or management of diabetes, will be included in this project. This includes both Type 1 and Type 2 diabetes. Individuals with diabetes who become pregnant will have prenatal care coordinated with the on-going management of their diabetes. Providing care to this population could potentially prevent complications at birth for both mother and baby. In addition, any woman with gestational diabetes is at high risk for developing type 2 diabetes, so there is a prevention aspect to this as well with the proper diabetes education implemented during the gestational period. The patient population will be risk-stratified into four categories for management:

1 - Patients at high risk for developing diabetes (i.e. obesity, family history)
2 - Patients with newly diagnosed diabetes
3 - Patients with diabetes with complications
4 - Patients with diabetes and other chronic conditions in an advanced state.

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.

The 3 NQP hubs have extensive experience caring for patients with diabetes in both inpatient and outpatient settings. Combining those resources with those in the community into a single coherent strategy for coordinated, evidence-based care will require combining different approaches to care management, staff and public education into one; and disseminating the strategy to many partners in a way that gains cooperation and trust. Coordination between hubs will be facilitated by working on the project committee, a shared IT infrastructure and sharing of patient information as needed. The existing programs below will work together to manage care of the patients. Most programs will be expanded to meet patient demand.

-CHS has outpatient diabetes education centers throughout their 3 hospitals as well as at St. John's. CHS provides pre-diabetes education at all sites through a Diabetes Prevention Program, which uses ADA curriculum. Bishop McHugh Health Center in Hicksville runs a diabetes education program for uninsured individuals. CHS also has an inpatient diabetes champion program which educates nurses to identify, care for and manage patients with diabetes.

-LIJ and its affiliates have diabetes wellness programs in multiple sites across Queens and Nassau that deploy certified diabetes educators for patients with pre-diabetes and diabetes. NSUH operates a Center for Diabetes in Pregnancy.

-NuHealth's Zaki Hossain Center for Hypertension, Diabetes and Vascular Diseases has a multi-disciplinary approach to diabetes and vascular disease. A team manages these diseases, and provides access to other needed medical specialties (e.g., ophthalmology, cardiology, neurology, podiatry, bariatric surgery and wound management).

-LIFQHC sites run diabetes education groups that are multidisciplinary and include a nurse, a nutritionist and a social worker.

-There are number of other diabetes programs in Queens and Nassau including: Loving Care Diabetes Program at Albright Medical Office in St. Albans, East Coast Diabetes Education Program in Valley Stream, ProHEALTH Care Associates in Lake Success, Institute for Urban Family Health/Family Practice Center of New Hyde Park, Winthrop University Hospital Diabetes Education Center, Beacon IPA outpatient diabetes program at 4 locations in Freeport

-Bariatric surgery programs at LIJ, NUMC/ NuHealth and Winthrop can be an important resource for patients who are obese and have diabetes.

-LIJ has processes in place to enroll patients with severe and end stage disease into high intensity home based programs, such as home based primary care, intensive home care, and hospice.

-Advanced diabetes often requires wound care and hyperbaric therapy, available at Franklin Hospital, NUMC/NuHealth, St. Joseph Hospital, Mercy Medical Center and Winthrop University Hospital.

-LIJ has a cloud-based care management platform (Care Tool), claims-based risk stratification software suite (Optum), health information exchange with event notification (Intersystems), and will soon have a predictive analytics engine (Explorys). These investments will allow for a more efficient identification and management of high risk patients.

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.

- Resources in the health care delivery system have not kept up with the pandemic of diabetes, particularly around patient education and support. Winthrop offers a training program for diabetes educators that can be used as a replicable model. LIJ's corporate university and other vendors will help NQP address this training need.

- Home health aides are not permitted to administer insulin. Removing scope of practice limitations for home health aides is regulatory relief that NQP will seek.

- Provider engagement - Aligning incentives through pay-for-performance programs for many providers, who have little experience with P4P, will be a challenge. NQP will have to model the approach and communicate what to expect among the various partners.

- While not considered food deserts, a number of communities have low access to food, as defined by the USDA. The communities of East Meadow, Far Rockaway, Freeport, Glen Cove, Hempstead, Roosevelt, and Westbury have a significant share of residents living more than ½ mile from the nearest supermarket. One strategy for addressing this is to offer on-site education at local supermarkets, providing community members opportunity to receive hands-on education regarding healthy food choices and portion control.

- The lack of a public transportation infrastructure further limits access to food. Addressing county-wide transportation is a necessary strategy.

- Behavior change can be hard. NQP will use culturally appropriate tools to encourage healthier food options among food stores in the community and to label healthier food choices in the store.

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.

In Nassau, NQP does not overlap with other PPSs. Advocate Community Partners (ACP) has eastern Queens in its service area; however, it has not included the Rockaway Peninsula. NY Hospital Queens and NYC HHC, and Mt. Sinai PPSs also serve Queens. Due to their geographic proximity, particularly eastern Queens, overlap will occur. It appears that Mt. Sinai is pursuing this project.

LIJ's affiliate has ACP Board representation. Leveraging the LIJ role in the NQP and in the ACP PPS, LIJ will be able to rapidly communicate and share information and best practices with the NQP. ACP plans to pursue project 3.c.i.

For evidence-based strategies for diabetes, NQP partners will coordinate efforts for patients identified with diabetes across levels of care. All partners will be linked to the RHIO, sharing patient information appropriately. Other PPSs will also be utilizing the RHIO. This common HIT platform will become a vehicle to share patients effectively and understand their clinical history and care plans. Regular meetings can also be held to discuss difficulties in implementation and how to garner the shared resources to meet the community's needs and the objectives of the DSRIP program.

This project, in particular, is a population-based project in that all individuals with diabetes, particularly with multiple chronic conditions, are the target population. As such, it requires cooperation and coordination across geographic boundaries. NQP will meet regularly with the other PPSs pursuing this project and with the health home about diabetes care and education efforts.

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. 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.

Capital budget funding is necessary for this project for the following items:

IT for interoperability among providers and for patient registries to manage patients. Care management software. Software is also needed to capture Diabetes prevention data to send to NYC.

Remote monitoring devices for patients such as glucose monitoring. Telephonic care management is a significant component of both PCMH and care transitions.

Telehealth to enable specialists to assist primary care providers in managing patients. Telehealth is particularly beneficial for homebound individuals.

Costs for PCMH Initiative – assuring that all safety net providers achieve PCMH. Costs associated with education of PCMH staff (care managers, navigators and physicians) so they can develop the skills to assist those at high-risk to meet diabetes-related outcomes and metrics.

Cost for developing patient education materials. There are very limited patient education materials that meet literacy guidelines. There are costs associated with the development or

purchase of plain-language material. In addition, materials must be available in multiple languages.

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
North Shore University Health Home (participating partner and LIJ affiliate) ; FEGS Health and Human Services System	Health Homes for Medicaid Enrollees with Chronic Conditions	9/1/12		A Health Home is a care coordination program whereby all of an individual's caregivers communicate with one another so that a patient's needs are comprehensively addressed. It is the health home's responsibility to develop a longitudinal care plan to address these needs. Information is shared notifications are sent in real time, care plans are updated and community partners are engaged all in an effort to keep the patient out of the emergency room and hospital

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.

These initiatives differ from this DSRIP initiative because they are for distinct services and populations, not the entire Medicaid and uninsured population. These initiatives do not involve the entire delivery system in accomplishing their goals either – they are largely about care management. They require managing the care of subpopulations, particularly those with chronic illnesses to improve outcomes and reduce costs. These initial population health programs, however, have given members of the PPS substantial experience in managing high risk patients.
The infrastructure underlying these program and the expertise gained will serve as the foundational building blocks for the PPS. These programs will accelerate the success of the PPS. They are good opportunities to learn from and to guide the development of the IDS.

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 completion of project requirements, scale of project implementation, 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.