The purpose of the New York State Department of Health's Delivery System Reform Incentive Payment (DSRIP) Program is to restructure the healthcare delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years. In partnership with hospitals, public health agencies, physicians and community-based organizations, the North Country Initiative is advancing state-wide projects to transform the healthcare system, coordinate care, and improve the health and wellness for our population.

3.b.i

Evidence Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only) - *Cardiovascular Conditions*

Evidence-based medicine allows physicians to utilize the most up to date, solid, reliable, scientific evidence when healthcare decisions are made for their patients. Ensuring high-quality care reflecting the interests, values, needs to effectively manage their patients. The onus to effectively manage a patient's cardiovascular care does not lie solely on their clinical care. It is also necessary to create realistic opportunities for patient self-management through healthy lifestyle choices and prescription management. All of these components are essential to guarantee long term success in cardiovascular care in the North Country. To successfully achieve the goals identified for this project, we will take a three-way approach; Clinical Care for Disease Control, Medication Adherence and Patient Supports.

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.

Patient Population:

Adult Medicaid patients with cardiovascular conditions

Identified Community Need:

Cardiovascular disease can be effectively treated in the outpatient setting. Cardiovascular disease is the second highest driver of inpatient hospitalizations and emergency department use for the target population. This region performs below both NYS and upstate in these two categories. Primary care implementation of evidence-based strategies in the treatment of cardiovascular will result in less emergency department and inpatient utilization and improved quality of life for beneficiaries.

NORTHCOUNTRY INITIATIVE

3.b.i

Evidence Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only) - *Cardiovascular Conditions*

Project Requirements Milestones and Metrics	
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 and/or APCM 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 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.
11	**Improve Medication Adherence:** Prescribe once-daily regimens or fixed-dose combination pills when appropriate.
12-20	**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.