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.c.i

Evidence-Based Strategies for Disease Management in High Risk/Affected Populations. (Adult Only) - *Diabetes*

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.

Patient Population:

Adult Medicaid patients being treated for diabetes

Identified Community Need:

Diabetes can be effectively treated in the outpatient setting. Over 40% of Medicaid beneficiaries indicated diabetes as a concern. Diabetes is the fourth highest driver of inpatient and emergency department use for the target population. The region performs below state average on the adult diabetes composite and short-term complications of diabetes and adult uncontrolled diabetes are of particular concern. Primary care implementation of evidence based strategies in the treatment of diabetes will result in less emergency department and inpatient utilization and improved quality of life for beneficiaries.

3.c.i

Evidence Based Strategies for Disease Management in High Risk/Affected Populations. (Adult Only) - *Diabetes*

Project Milestones	
1	Implement evidence based best practices for disease management, specific to diabetes, in community and ambulatory care setting
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 & health home care managers) to improve health literacy, patient self-efficacy & patient self-management
4	Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Standard Model for chronic diseases in high risk neighborhoods.
5	Ensure coordination with Medicaid Managed Care organization serving the target population.
6	Use EHRs or other technical platforms to track all patient engagement 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.