**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.**

# 4.b.ii

## Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings *(Focus Area 3)*

***(This project targets chronic diseases that are not included in Domain 3, such as cancer)***

## Project Objective:

This project will help to increase access to high quality chronic disease preventative care and management in both clinical and community settings for chronic diseases that are not included in Domain 3 projects, such as cancer.

## Project Description:

The delivery of high-quality chronic disease preventive care and management can prevent much of the burden of chronic disease or avoid many related complications. Many of these services have been shown to be cost-effective or even cost-saving. However, many New Yorkers do not receive the recommended preventive care and management that include screening tests, counseling, immunizations or medications used to prevent disease, detect health problems early, and prevent disease progression and complications. This project is targeted on increasing the numbers of New Yorkers who receive evidence-based preventative care and management for chronic diseases.

## Patient Population:

All Medicaid patients or recipients

## Identified Community Need:

Throughout the needs assessment it was clear that respiratory disease and in particular COPD needed a concentrated prevention strategy as did colorectal cancer. COPD is the third leading cause of hospitalization and emergency room visits for the target population. More than 20% of the region's population smokes and prevention efforts need to be stepped up. Colorectal cancer mortality rates exceed NYS rates and Colorectal cancer screening rates are significantly lower than NYS. A concerted effort to advance respiratory disease prevention and incorporate smoking prevention and cessation is needed.

## 4.b.ii

# Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings *(Focus Area 3)*

***(This project targets chronic diseases that are not included in Domain 3, such as cancer)***

| Project Milestones | |
|---|---|
| **1** | Establish or enhance reimbursement and incentive models to increase delivery of high-quality chronic disease prevention and management services. |
| **2** | Offer recommended clinical preventive services. |
| **3** | Incorporate Prevention Agenda goals and objectives into hospital Community Service Plans, and coordinate implementation with local health departments and other community partners. |
| **4** | Adopt and use certified electronic health records, especially those with clinical decision supports and registry functionality. Send reminders to patients for preventive and follow-up care, and identify community resources available to patients to support disease self- management. |
| **5** | Adopt medical home or team-based care models. |
| **6** | Create linkages with and connect patients to community preventive resources. |
| **7** | Provide feedback to clinicians around clinical benchmarks and incentivize quality improvement efforts. |
| **8** | Reduce or eliminate out-of-pocket costs for clinical and community preventive services. |