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.ii

Implementation of Evidence-Based Strategies in Community to Address Chronic Disease-Primary and Secondary Prevention Projects. (Adults Only)

Project Objective:

Engage at-risk populations in primary and secondary disease prevention strategies to improve patient self-efficacy and self-management.

Project Description:

While Project 3.c.i is focused on diabetes care practice improvement, this project focuses on developing community resources to assist patients with primary and secondary preventive strategies to reduce risk factors for diabetes, and ameliorate the long-term consequences of diabetes and other co-occurring chronic diseases.

Patient Population:

Adult Medicaid patients at risk of developing diabetes and other co-occurring diseases

Identified Community Need:

This 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.

Because Diabetes is significantly impacted by lifestyle and access to nutrition and exercise, it is critical that community based resources be leveraged to impact choices and decisions outside the physician's office walls. Activities like the Diabetes Prevention Program and lifestyle modification programs are critical to patient success and can be life-changing. Resulting in not only fewer avoidable hospitalizations and emergency department use to achieve DSRIP goals but improved quality of life for both patients and families.

NORTHCOUNTRY INITIATIVE

3.c.ii

Implementation of Evidence-Based Strategies in Community to Address Chronic Disease-Primary and Secondary Prevention Projects. (Adults Only)

Project Milestones	
1	Implement Center for Disease Control (CDC)-recognized National Diabetes Prevention Programs (NDPP) and/or create partnerships with community sites to refer patients to CDC-recognized programs.
2	Use EHRs or other technical platforms to track all patients engaged in this project.
3	Identify high-risk patients (including those at risk for onset of diabetes or with pre-diabetes) and establish referral process to institutional or community NDPP delivery sites.
4	Ensure collaboration with PCPs and program sites to monitor progress and provide ongoing recommendations.
5	Establish lifestyle modification programs including diet, tobacco use, and exercise and medication compliance.
6	Ensure coordination with Medicaid Managed Care organizations and Health Homes for eligible/involved patients.