Domain 3: *Clinical Improvement Projects*

Project ID: *3.b.i*

Project Title: *Evidence-based strategies for disease management in high risk/affected populations (adult only) – Cardiovascular Disease*

Objective:

To support implementation of evidence-based best practices for disease management in medical practice for adults with cardiovascular conditions

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.

Target Patient Population:

Adults with a CVD-related diagnosis, including hypertension (HTN), congestive heart failure (CHF), angina, and high cholesterol.

Actively Engaged Patients for DSRIP Reporting Purposes:

The number of participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.)

Providers Expected to Participate:

Primary care physicians, non-PCP practitioners, clinics, health homes / care management organizations, behavioral health providers, substance abuse treatment providers, pharmacies, community based organizations, and others.

Project Milestones
Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.
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 DY 3.
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or PPCM by the end of Demonstration Year 3.
Use EHRs or other technical platforms to track all patients engaged in this project.
Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).
Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.
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.
Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.
Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.
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.

Improve Medication Adherence: Prescribe once-daily regimens or fixed-dose combination pills when appropriate.
Optimize Patient Reminders and Supports: Document patient driven self-management goals in the medical record and review with patients at each visit.
Follow up with referrals to community based programs to document participation and behavioral and health status changes.
Develop and implement protocols for home blood pressure monitoring with follow up support.
Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.
Facilitate referrals to NYS Smoker's Quitline.
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.
Adopt strategies from the Million Hearts Campaign.
Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.
Engage a majority (at least 80%) of primary care practices in this project.