Domain 3: *Clinical Improvement Projects*

Project ID: *3.c.i*

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

Objective:

Support implementation of evidence-based best practices for disease management in medical practice related to diabetes.

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.

Target Patient Population:

Adults with a diabetes diagnosis, with particular attention to residents of neighborhoods with the highest rates of diabetes.

Actively Engaged Patients for DSRIP Reporting Purposes:

The number of participating patients with at least one hemoglobin A1c test within previous Demonstration Year.

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 evidence based best practices for disease management, specific to diabetes, in community and ambulatory care settings.
Engage at least 80% of primary care practices within the PPS in the implementation of disease management evidence-based best practices.
Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy,
Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.
Ensure coordination with the Medicaid Managed Care organizations serving the target population.
Use EHRs or other technical platforms to track all patients engaged in this project.
Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.