Project 3D: Chronic Disease Prevention and Control

Project Objective: Integrate health system and community approaches to improve chronic disease management and control.

Target Population: Medicaid beneficiaries (adults and children) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke, with a focus on those populations experiencing the greatest burden of chronic disease(s) in the region.

Evidence-based Approach:

1. Chronic Care Model (www.improvingchroniccare.org)

Regions are encouraged to focus on more than one chronic condition under the Chronic Care Model approach.
Examples of Specific Strategies to Consider within Chronic Care Model Approach:

- The Community Guide (https://www.thecommunityguide.org/)
- Million Hearts Campaign (http://millionhearts.hhs.gov)
- Stanford Chronic Disease Self-Management Program (http://patienteducation.stanford.edu/programs/cdsmp.html)
- CDC-recognized National Diabetes Prevention Programs (NDPP) (http://www.cdc.gov/diabetes/prevention/index.html)
- Community Paramedicine models, (http://www.emsa.ca.gov/Media/Default/PDF/CPReport.pdf and https://www.ruralhealthinfo.org/topics/community-paramedicine), locally designed, community-based, collaborative model of care that leverages the skills of paramedics and EMS systems to address care gaps identified through a community specific health care needs assessment.

Reference the "Project Implementation Guidelines" for additional details on the project's core components, including Domain 1 strategies and evidence-based approaches, to guide the development of project implementation plans and quality improvement plans.

Project Stages

Stage 1 – Planning

Milestone	**Proof of Completion**	**Timeline** ***(complete no later than)***

• Assess current state capacity to effectively impact chronic disease	Completed current state assessment	DY 2, Q2
• Identify how strategies for Domain I focus areas – Systems for Population Health Management, Workforce, Value-based Payment – will support project	Completed Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 2C efforts	DY 2, Q2
• Select specific target population(s), guided by disease burden and overall community needs, ACH will identify the population demographic and disease area(s) of focus, ensuring focus on population(s) experiencing the highest level of disease burden. • Select evidence-based guidelines and best practices for chronic disease care and management using the Chronic Care Model approach to improve asthma, diabetes, and/or heart disease control, and address obesity in their region. ○ Region may pursue multiple target chronic conditions and/or population-specific strategies in their overall approach.	Definition of target population(s) and evidence based approach (es)	DY 2, Q2
• Identify, recruit, and secure formal commitments for participation from all implementation partners, including health care providers (must include primary care providers) and relevant community-based service organizations. • Form partnerships with community organizations to support and develop interventions that fill gaps in needed services (www.improvingchroniccare.org).	List of implementation partners, inclusive of primary care providers and community-based service providers, with formal written commitment to participate.	DY 2, Q2

• Develop Implementation Plan that includes, at minimum:
  ○ Implementation timelines.
  ○ Description of the mode of service delivery, which may include home-based and/or telehealth options.
  ○ Roles and responsibilities of key organizational and provider participants, including community-based organizations.
	Completed Chronic Care implementation plan, including identification of specific change strategies.	DY 2, Q3

○ Description of how project aligns with related initiatives and avoids duplication of efforts. ○ Specific change strategies to be implemented across elements of the Chronic Care Model: ▪ Self-Management Support ▪ Delivery System Design ▪ Decision Support ▪ Clinical Information Systems ▪ Community-based Resources and Policy ▪ Health Care Organization ○ Justification demonstrating that the selected strategies and the committed partner/providers are culturally relevant and responsive to the specific population health needs in the region. ○ Strategies to identify and focus efforts in high risk neighborhoods or geographic locations within the region, with attention to addressing health care disparities related to selected diseases. ○ Describe strategies for ensuring long-term project sustainability		
Stage 2 – Implementation		
Milestone	**Proof of Completion**	**Timeline *(complete no later than)***
• Develop guidelines, policies, procedures and protocols	Adopted guidelines, policies, procedures and/or procedures	DY 3, Q1
• Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected model / approach	Completed and approved QIP, reporting on QIP measures	DY 3, Q2
• Implement disease/population-specific Chronic Care Implementation Plan for identified populations within identified geographic areas, inclusive of identified change strategies to develop and/or improve: ○ Self-Management Support ○ Delivery System Design ○ Decision Support	Number and list engaged Implementation Team sites, members, and roles.	DY 3, Q4

○ Clinical Information Systems ○ Community-based Resources and Policy ○ Health Care Organization • Implementation should ensure integration of clinical and community-based strategies through communication, referral, and data sharing strategies.		
Stage 3 – Scale & Sustain		
Milestone	**Proof of Completion**	**Timeline** ***(complete no later than)***
• Increase scale of approach, expand to serve additional high-risk populations, include additional providers and/or cover additional high needs geographic areas, to disseminate and increase adoption of change strategies that result in improved care processes and health outcomes	Document Stage 3 activities in Semi-Annual Reports.	DY 4, Q4
• Continue to employ continuous rapid cycle improvement processes/continuous quality improvement methods to refine change strategies and scale up implementation.		DY 4, Q4
• Provide or support ongoing training, technical assistance, learning collaborative platforms, to support shared learning, spread and continuation, and expansion of successful change strategies.		DY 4, Q4
• Engage and encourage Managed Care Plans to develop/refine model benefits aligned with evidence-based clinical guideline-concordant care and best practice recommendations.		DY 4, Q4
• Identify and document the adoption by partnering providers of payment models that support Chronic Care Model approach and the transition to value based payment for services.		DY 4, Q4

Project Metrics

Year	Metric Type	Metric	Report Timing
DY 3 – 2019	**P4R – ACH Reported**	• Report against QIP metrics • Number of partners trained by selected model / approach: projected vs. actual and cumulative	Semi-Annual

		• Number of partners participating and number implementing each selected model / approach • Identify number of new or expanded nationally recognized self-managed support programs, such as CDSMP and NDPP. • Identify number of home visits for asthma services, hypertension. • Identify percent of documented, up to date Asthma Action Plans. • Identify number of health care providers trained in appropriate blood pressure assessment practices. • Identify percent of patients provided with automated blood pressure monitoring equipment.	
	P4P – State Reported	• Child and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Medication Management for People with Asthma (5 – 64 Years) • Outpatient Emergency Department Visits per 1000 Member Months	Annual
DY 4 – 2020	**P4R – ACH Reported**	• Report against QIP metrics • Number of partners trained by selected model / approach: projected vs. actual and cumulative • Number of partners participating and number implementing each selected model / approach • Identify number of new or expanded nationally recognized self-managed support programs, such as CDSMP and NDPP. • Identify number of home visits for asthma services, hypertension. • Identify percent of documented, up to date Asthma Action Plans. • Identify number of health care providers trained in appropriate blood pressure assessment practices. • Identify percent of patients provided with automated blood pressure monitoring equipment	Semi-Annual

	P4P – State Reported	• Child and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Inpatient Hospital Utilization • Medication Management for People with Asthma (5 – 64 Years) • Outpatient Emergency Department Visits per 1000 Member Months • Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	Annual
DY 5 – 2021	**P4R – ACH Reported**	• Report against QIP metrics • Number of partners trained by selected model / approach: projected vs. actual and cumulative • Number of partners participating and number implementing each selected model / approach • Identify number of new or expanded nationally recognized self-managed support programs, such as CDSMP and NDPP. • Identify number of home visits for asthma services, hypertension. • Identify percent of documented, up to date Asthma Action Plans. • Identify number of health care providers trained in appropriate blood pressure assessment practices. • Identify percent of patients provided with automated blood pressure monitoring equipment.	Semi-Annual
	P4P – State Reported	• Child and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Inpatient Hospital Utilization • Medication Management for People with Asthma (5 – 64 Years) • Outpatient Emergency Department Visits per 1000 Member Months • Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	Annual

***Project Implementation Guidelines*:** This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and quality improvement plans.

Guidance for Project-Specific Domain 1 Strategies

- **Population Health Management/HIT:** Current level of adoption of EHRs and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable chronic disease population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- **Workforce:** Capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs such as:
  - Shortage of Community Health Workers, Certified Asthma Educators, Certified Diabetes Educators, Home Health care Providers
  - Access to specialty care, opportunities for telehealth integration
  - Workflow changes to support Registered Nurses and other clinical staff to be working to the top of professional licensure. Training and technical assistance to ensure a "prepared, proactive practice team" and "prepared, proactive community partners;" (www.improvingchroniccare.org)
  - Cultural and linguistic competency, health literacy needs
- **Financial Sustainability:** Alignment between current payment structures and guideline-concordant care, inclusive of community-based services (such as home-based asthma visits, Diabetes Self-Management Education, and home-based blood pressure monitoring); incorporate current state and anticipated future state of VBP arrangements to support chronic disease control efforts into the regional VBP transition plan. Consider inclusion of the following within reimbursement models: bundled services, group visits, once-daily medication regimens, community-based self-management support services.

Guidance for Evidence-Based Approaches

Chronic Care Model

Regions are encouraged to focus on more than one chronic condition under the Chronic Care Model approach.

Examples of Specific Strategies to Consider within Chronic Care Model Approach:

- *The Community Guide (https://www.thecommunityguide.org/)*
- *Million Hearts Campaign (http://millionhearts.hhs.gov)*
- *Stanford Chronic Disease Self-Management Program (http://patienteducation.stanford.edu/programs/cdsmp.html)*
- *CDC-recognized National Diabetes Prevention Programs (NDPP) (http://www.cdc.gov/diabetes/prevention/index.html)*

- *Community Paramedicine models*, *(http://www.emsa.ca.gov/Media/Default/PDF/CPReport.pdf and https://www.ruralhealthinfo.org/topics/community-paramedicine)***,** locally designed, community-based, collaborative model of care that leverages the skills of paramedics and EMS systems to address care gaps identified through a community specific health care needs assessment.

Specific change strategies to be implemented across elements of the Chronic Care Model: *Self-management support, delivery system design, decision support, clinical information systems, community-based resources and policy, and health care organization.*

- **Self-Management Support** strategies and resources to "empower and prepare patients to manage their health and health care" (www.improvingchroniccare.org), such as: incorporate the 5As into regular care; complete and update Asthma Action Plans; provide access to Asthma Self-Management Education, Diabetes Self-Management Education, Stanford Chronic Disease Management Program; support home-based blood pressure monitoring; provide motivational interviewing; ensure cultural and linguistic appropriateness.
- **Delivery System Design** strategies to support effective, efficient care, such as: implementing and supporting team-based care strategies, increasing the presence and clinical role of non-physician members of the care team; increasing frequency and improving processes of planned care visits and follow-up; referral processes to care management and specialty care.
- **Decision Support** strategies to support clinical care that is consistent with scientific evidence and patient preference, such as: development and/or provision of decision support tools (guideline summaries, flow sheets, etc.); embed evidence-based guidelines and prompts into EHRs; provide education as needed on evidence-based guidelines via case-based learning, academic detailing or modeling by expert providers; establish collaborative management practices and communication with specialty providers; incorporate patient education and engagement strategies.
- **Clinical Information Systems** strategies to organize patient and population data to facilitate efficient and effective care, such as: utilization of patient registries; automated appointment reminder systems; bi-directional data sharing and encounter alert systems; provider performance reporting.
- **Community-based Resources and Policy** strategies to activate the community, increase community-based supports for disease management and prevention, and development of local collaborations to address structural barriers to care such as: Community Paramedicine, tobacco free policy expansion, tobacco cessation assistance, nutritional food access policies, National Diabetes Prevention Program, home-based and school-based asthma services, worksite nutritional and physical activity programs behavioral screen time interventions.
- **Health Care Organization** strategies that ensure high quality care, such as: engagement of executive and clinical leadership; support for quality improvement processes; shared learning structures; intersection with Care Coordination efforts; financial strategies to align payment with performance.