Domain 4: Population-wide Projects

Problem Statement:
Individuals lack the knowledge and health literacy to effectively manage chronic diseases, and providers often lack the knowledge of resources in the community that can support these individuals in this effort, leading to poorer management of chronic diseases and ineffective behavior modification to reduce the risk of developing chronic disease.

Summary Statement:
This project will help to increase access to high quality chronic disease preventative care and management in both clinical and community settings. Interventions will be targeted toward high-risk patients who will be identified using a standardized tool and tracked using an integrated IT solution that will be implemented in both clinical and community settings.

Objective:
The objective of this project is the sustainable delivery of high-quality chronic disease and preventive care and management in clinical and community settings, which can be accessed, monitored and evaluated using IT solutions developed through the creation of an integrated delivery system.

Core Components and Deliverables:
- Identification of high-risk patients using a standardized risk assessment that includes an evaluation of health, socio-economic and psychological risk factors.
- Development of best practices and processes to ensure the appropriate referral and treatment of targeted patients, based on their level of risk and patient activation
- Establishment funding mechanisms that value the prevention and management of chronic disease for targeted high-risk patients.
- FLPPS PCMH-eligible clinical providers will adopt medical home or team-based care models. Medical Homes will function as the hub for tracking and improving outcomes for high risk patients.
- FLPPS partners will adopt and use certified electronic health records, especially those with clinical decision supports and registry functionality. They will send reminders to patients for preventive and follow-up care, and identify community resources available to patients to support disease self-management. Success will be determined by establishing innovative ways to connect with a highly mobile patient population and again, this can be facilitated by an integrated IT solution.
- FLPPS partners will deliver evidence-based preventive services in the clinical setting and connect patients to community-based preventive resources, including self-care management and support. Appropriate interventions will be determined based on a standardized assessment of risk and documented and monitored via an Individual Care Plan that is shared across clinical and community settings.
Through the provision of technical assistance and facilitation of best practices, FLPPS will deliver culturally, linguistically and ethnically appropriate chronic disease management programs that consider the needs of the patients and "where they are". There will be "No Wrong Door" to receiving a risk assessment, referral and chronic disease management support.

FLPPS will document available community-based resources. Using this information, the PPS will work across its partnership to define and fill gaps, as needed (where are individuals most likely to learn/feel supported in chronic disease self-management?). In addition, the PPS will create linkages between providers and CBOs to facilitate referrals to community-based preventive resources.

The PPS will incorporate Prevention Agenda goals and objectives into Hospital Community Service Plans, and coordinate implementation with local health departments and other community partners. To this end, implementation will include the growth of programming focused on high-risk patients.

The PPS will adopt and/or grow best practice paradigms for motivational interviewing/health coaching and self-care/self-management across clinical and community settings, and provide technical assistance for delivery of model programs across the organization.

The PPS will monitor and provide feedback to clinicians, care teams and community-based partners around clinical outcomes and benchmarks, incentivizing quality improvement efforts, as appropriate. Incentives will be targeted at improving the health status and facilitating chronic disease prevention and management among high-risk patients.

Through contracts with its partnership, the PPS will establish and/or enhance reimbursement and incentive models to increase delivery of high-quality chronic disease prevention and management services, including the expansion of reimbursement to community-based disease management and peer support programs targeting high-risk patients.

The PPS will reduce or eliminate out-of-pocket costs for clinical and community preventive services. This will ensure access to services for high-risk individuals, particularly those with Low SES.

**Target Population:**
Individuals identified as being “high-risk” for developing chronic illness and those who currently have a diagnosis of chronic illness and are at “high-risk” for further deterioration.

**Challenges:**

- Paradigm Shift
- Coordination across counties
- Sustainability
- Facilitation of Partnerships

**Milestones**

- Identify target population (DY1 Q1/2)
- Develop and test risk assessment (D1 Q3/4)
- Map existing resources throughout the PPS (DY1 Q3/4)
- Contract with CBO assets serving target population (DY1 Q3/4)
- Begin to monitor outcomes associated with interventions delivered to target population (DY2 Q1)
- Identify gaps in resources throughout the PPS and work to close the gaps (DY2 Q4)
• Update and distribute asset map to include newly developed resources (DY2 Q3/4, ongoing)
• Develop cost-benefit analysis to identify high value interventions (DY3 and beyond)
• Develop value-based payment methodology (DY5 Q3/Q4)
• Facilitate long-term partnerships (DY5 Q3/Q4)

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