## 3.d.ii Expansion of Asthma Home-Based Self-Management Program

**Project Objective:** Implement an asthma self-management program including home environmental trigger reduction, self-monitoring, medication use, and medical follow-up to reduce avoidable ED and hospital care.

**Project Description:** Despite best efforts of practitioners to implement evidence based practices, patients continue to have difficulty controlling their symptoms. The goal of this project is to develop home-based services to address asthma exacerbation factors. Special focus will be emphasized on children, where asthma is a major driver of avoidable hospital use.

**Project Requirements:** The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the attachment: **Domain 1 DSRIP Project Requirements Milestones and Metrics,** which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.
2. Establish procedures to provide, coordinate, or link the client to resources for evidence based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.
3. Develop and implement evidence based asthma management guidelines.
4. Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.
5. Ensure coordinated care for asthma patients includes social services and support.
6. Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.
7. Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.
8. Use EHRs or other technical platforms to track all patients engaged in this project.

### Project Response & Evaluation (Total Possible Points – 100):

**1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 20)**

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

The CNA reveals some of the greatest health disparities affecting Medicaid populations are in respiratory disease. Childhood asthma prevalence in Suffolk County (SC) is 13.3% among the Medicaid vs. 4.5% among the total population. 72% of key informants in the CNA characterized asthma as a major or moderate problem. Reasons cited include factors such as increased exposure to environmental triggers, poor adherence to treatment, and housing conditions. Medicaid claims show that asthma is one of the eight most prevalent chronic conditions in SC. SPARCS data indicate that asthma is one of the top ten drivers of SC hospital admissions, readmissions and ED visits. 2012 Health Data NY document 13457 SC Medicaid members with asthma ; 6879 Medicaid members with asthma generated 18786 ED visits in one year; 3704 individuals were hospitalized with asthma generating 6796 admissions. These data demonstrate that some individuals have multiple hospitalizations for asthma. Total PDI annual admissions data show asthma in young adults and children is a significant cause of avoidable admissions, especially in comparison to other conditions.

We propose a medical home program enriched with home visits by trained community health workers (CHWs) leveraging the strengths of the existing Pediatrics Keeping Family Healthy (KFH) program at a current Level 3 PCMH site. Patients will be stratified into three risk categories: high, moderate and low. All high-risk patients will be referred for home visits. Families will receive ~4-5 CHW home visits over 6 months, with calls/text reminders as needed between visits, especially after ED/hospital visits, to provide patients with root cause analysis and avoid future incidents. CHWs will follow a protocol to guide visit content focused on home environmental trigger reduction, self-monitoring and self-management of asthma symptoms, asthma medication use, and medical follow-up. CHWs will link patients to resources for trigger reductioni nterventions, especially to change the indoor environment. A visit summary will be sent to all care team members (e.g., clinicians, Medicaid Managed Care plans, Health Home care managers, school nurses, etc.) via interoperable EHR and PPS-wide care management platforms created to support integrated care delivery.

Low/medium-risk patients will receive education and support from case managers at the medical home and benefit from PPS-wide care management platforms whereby pertinent disease-management information, such as Asthma Action Plan, is accessible to all care team members. Initial implementation will occur in known asthma “hot-spots” (i.e. Islip, Patchogue, Brentwood, Bayshore, and Mastic) followed by expansion throughout SC.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

We expect to engage patients with the following criteria for this project: 1) SC residents, 2) diagnosed with asthma 3) aged ≤25, and 4) Medicaid. 2012 Medicaid Data show the total SC Medicaid population is 266,450; 13,596 of those have asthma and are ≤25 years old. We include patients through age 25 because this project will support care transition for children with asthma from pediatricians to adult providers. Targeted patients will be stratified into three risk

categories: high, moderate and low; with each group receiving a specific set of interventions designed to improve their care- such that home visits provide the more intense support required for the high risk group. The project will first be implemented for patients and providers in known asthma "hot-spots" (Islip, Patchogue, Brentwood, Bayshore, and Mastic) followed by expansion throughout SC. Patients from all racial/ethnic groups will be engaged in this project, with special attention paid to making services more accessible for linguistically isolated groups. Groups with high smoking prevalence will be targeted for additional support due to the causal link between tobacco use and COPD, cancer, and asthma.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

Since July 2011, the KFH program at Stony Brook Children's has provided over 2800 home visits to more than 750 children broadly deemed by clinicians to be "at-risk" for poor health outcomes; of these, 64% have Medicaid and the majority reside in known asthma "hot-spots". Currently KFH has 2 Full-time CHWs and 8 Part-time CHWs(including 3 Spanish-speaking CHWs), with clinicians providing asthma health education training to all CHWs in the following areas: basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and use of written asthma action plans. The program sends trained CHWs into the home for scheduled visits to focus on improving communication between health care providers and child's caregiver(s). The CHWs act as a direct extension of the pediatrician's office/medical home to support families in adhering to recommended care following the National Heart, Lung, and Blood Institute (NHLBI) guidelines by building healthcare navigation and health literacy skills. In addition, the program links families with appropriate community resources based on need, including additional healthcare services, food assistance, transportation services, childcare services, family services, and counseling.

The main new resource that will need to be expanded and developed for the PPS's strategy for this project is to hire and train the necessary CHW workforce from the communities in which they live and work in order to ensure cultural competency and accessibility in asthma care and management for the target population. The CHWs will need to be equipped with Wi-Fi enabled secure tablet devices and cellular telephones to assist them in providing appropriate services to the patients and families. These devices will allow CHWs to quickly and securely communicate remotely with primary care providers and the entire care team involved in providing patient care.

The PPS project team will also need to mobilize existing asthma educators, including nursing staff in pulmonary and allergy/immunology offices, primary care or Federally Qualified Health Centers (FQHC) certified staff, hospital-based asthma educators, existing Medicaid Managed Care Organizations (MCOs) staff, and Health Homes (HH); all can help with expansion of the model. Notably, grant funding for the existing KFH program will end in April 2015 such that DSRIP funding will allow for continuation of the program.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

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| PATIENT CHALLENGES: Families eligible for Medicaid/uninsured are more likely to have challenges (e.g., low health literacy, difficulty obtaining medications, transportation problems, etc.) that contribute to increased risk for poor asthma-related health outcomes. PATIENT REMEDIES: Our multi-disciplinary teams will provide consistent asthma education at each encounter within the PPS (i.e. hospital/ED, office, home visit) and tailor interventions to address the unique challenges faced by each patient.<br><br>PROVIDER CHALLENGES: 1)Some PPS providers will experience barriers in implementing NHLBI asthma guidelines. 2) Some PPS providers may not have resources to address the cultural/linguistic needs of the diverse Suffolk County population. 3) Provider participation PROVIDER REMEDIES: 1) The project team will offer all PPS providers education and care redesign support required to meet project goals. 2)The PCP practice support teams will offer cultural competency training, including interpretation services use, for all practice staff. 3)Align providers through pay for performance incentives.<br><br>INFRASTRUCTURE CHALLENGES: 1)Consistency in hiring, training, and supervision of CHWs. 2) Building relationships with a diverse group of community partners. INFRASTRUCTURE REMEDIES: 1)Building upon our existing program, we will hire and train additional management personnel to provide consistent workforce training and supervision. 2)The project team will hold monthly meetings with all project participants, including community partners, to monitor progress and implement shared governance. |

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve overlapping service areas. If there are no other PPSs within the same service area, then no response is required.

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**2. <u>Scale of Implementation</u> (Total Possible Points - 40):**

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

***Please use the accompanying Speed & Scale Excel document to complete this section.***

**3. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40):**

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

***Please use the accompanying Speed & Scale Excel document to complete this section.***

**4. <u>Project Resource Needs and Other Initiatives</u> (Not Scored)**

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

| Yes | No |
|---|---|
| ☒ | ☐ |

**If yes:** Please describe why capital funding is necessary for the Project to be successful.

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| The project will require 1) equipment and hardware including computers for all workforce members and asthma "tool kits" for patients/families (includes spacers, dust mite covers for pillows and mattress, binders for families to keep medical information, and tote bags); 2) space rental at the Federation of Organizations, Inc. for CHW meetings & storing supplies, and 3) health information system configuration and connections for all relevant care team members, including specific purchase of software licenses necessary for project operations. |

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

| Yes | No |
|---|---|
| ☒ | ☐ |

**If yes:** Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

***Please note:*** *if you require more rows in order to list all relevant initiatives, please make a note*

*of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

| Name of Entity | Medicaid/Other Initiative | Project Start Date | Project End Date | Description of Initiatives |
|---|---|---|---|---|
| Asthma Coalition of Long Island (ACLI) | ACLI is one of eight regional asthma coalitions funded by a grant called "A Systems Approach to Redu | 2012 | 2016 | ACLI aims to reduce the burden of asthma in Long Island by bringing together regional stakeholders to apply a population-based systems change approach that translates the NHLBI guidelines into practice. ACLI does not directly provide any clinical care. |

| Name of Entity | Medicaid/Other Initiative | Project Start Date | Project End Date | Description of Initiatives |
|---|---|---|---|---|
| Hospital Medical Home (H-MH) Demonstration Program | The HMH Demonstration Program is a health care quality and safety improvement program for Medicaid m | 10/2012 | 04/2015 | The focus of the Hospital-Medical Home Demonstration is to improve health care provided to Medicaid members in sites that train residents to become primary care physicians. Those sites are required to become recognized as Patient Centered Medical Homes by the National Committee on Quality Assurance. Hospitals are required to work on specific projects related to improving resident training, measuring |

| Name of Entity | Medicaid/Other Initiative | Project Start Date | Project End Date | Description of Initiatives |
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| | | | | health outcomes, care coordination and improving the quality and safety of inpatient health care. |
| Long Island Association for AIDS Care | Health Homes | | | Case management / care coordination |
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| Name of Entity | Medicaid/Other Initiative | Project Start Date | Project End Date | Description of Initiatives |
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c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

The funding for the Hospital Medical Home Demonstration Program will end in April of 2015, which will eliminate any potential duplication of services to PPS members through funding of this project. In addition, the programs listed above provide support to this PPS project through various means that primarily include the sharing of important information about their efforts. This includes such items as the sharing of comparative information about expected gaps in care, the type of community resources that have been found to be available, and sharing of information about individual patients that they may have been touched. However, in no case do these programs specifically duplicate what the PPS intends to accomplish with this project to be able to meet the specific project requirements. All staffing and resources that need to be applied to make this project successful do not duplicate the resources used by these existing community programs, they are complimentary. In particular all PPS efforts will be highly aligned with the local Medicaid Health Homes, which are taken into account as an existing form of care support that will not be duplicated in this project.

**5. Domain 1 DSRIP Project Requirements Milestones & Metrics:**

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. **Detailed Implementation Plan:** By March 1, 2015 PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.