Suffolk Care
Collaborative

Consolidated Project Information

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

Contents

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

3.d.ii Project Objective & Requirements

The Project Objective is to 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.

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.

Please note this project is inclusive of patients up to age 25.

The project must clearly demonstrate the following 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.

3.d.ii Requirements Matrix by Provider Type

	Primary Care Physicians	Non PCP	Clinics	Health Home/ Care Management	Pharmacy	Community Based Orgs (CBOs)	All Other	PPS Project Level
1) Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.								X
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.								X
3) Develop and implement evidence based asthma management guidelines.								X

	Primary Care Physicians	Non PCP	Clinics	Health Home/ Care Management	Pharmacy	Community Based Orgs (CBOs)	All Other	PPS Project Level
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.								X
5) Ensure coordinated care for asthma patients includes social services and support.								X
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.								X

	Primary Care Physicians	Non PCP	Clinics	Health Home/ Care Management	Pharmacy	Community Based Orgs (CBOs)	All Other	PPS Project Level
7) Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.								X
8) Use EHRs or other technical platforms to track all patients engaged in this project.								X

3.d.ii Milestones & Metrics

Color Legend
Project System Changes
Project Requirements with Specific Time Periods
Project Requirements tied to PPS Speed and Scale Commitments

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
1	Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	PPS has developed a strategy for the collaboration of community medical and social services providers to assess a patient's home and provide self- management education for the appropriate control of asthma.	Documented agreements with partners to provide patient home assessment services; Patient educational materials; Rosters demonstrating that patient has received home based interventions	Project
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.	PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence based trigger reduction interventions.	Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained; Patient educational materials	Project
3	Develop and implement evidence based asthma management guidelines.	PPS incorporates evidence based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.	Standard Clinical Protocol and Treatment Plan; Evidence that guidelines are reviewed and revised	Project
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.	PPS has developed training and comprehensive asthma self-management education, to include 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.	Patient educational materials; Rosters demonstrating patient training	Project

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
5	Ensure coordinated care for asthma patients includes social services and support.	PPS has developed and conducted training of all providers, including social services and support.	Care coordination team rosters; Written training materials; List of training dates along with number of staff trained	Project
		All practices in PPS have a Clinical Interoperability System in place for all participating providers.	Contract; Report; Vendor System Documentation, if applicable; Other Sources demonstrating implementation of the system	Project
		PPS has assembled a care coordination team that includes 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.	Documentation of process and workflow including responsible resources at each stage of the workflow	Project
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.	Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family.	Rosters demonstrating follow-up is conducted; Materials supporting that root cause analysis was conducted, and shared with family	Project
7	Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers.	Written agreements	Project
8	Use EHRs or other technical platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

3.d.ii Active Engagement Definition

The active engagement definition for project 3.d.ii

Project	# of Actively Engaged	Attributed Population	% of Attributed	Definition of Actively Engaged	Counting Method
3.d.ii	6,751	148,118	4.5%	Registered in home assessment log, patient registry, or other IT platform.	3

The purpose of counting methods is to estimate the number of patients that will be impacted by a particular project. This feeds the patient scale portion of the application.

Each counting method should be used in conjunction with the definition of "actively engaged" patients for that project.

Summary of counting method 3:

- Counted within a DSRIP year; resets each year
- Patients are to be counted only once
- So long as "at least" one encounter with the patient resulted in A.E. definition being met, it counts towards total

e.g., if a patient visits the PCP 5 times a year but get a1C tested just one of those 5 times, she is actively engaged

3.d.ii Speed and Scale Submission

Scale is a measure of the magnitude of providers in the project and the volume of patients affected. Speed is a measure of how quickly project requirements are executed and how quickly patient impact occur. Speed and Scale represent 80% of the points for each project application – and therefore, most significantly impact initial valuation.

Project Implementation Speed for Project 3.d.ii

Project	DY 0 (2014)		DY 1 (2015)		DY 2 (2016)		DY 3 (2017)		DY 4 (2018)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
3.d.ii						X				

Patient Engagement Speed for Project 3.d.ii

Patient Engagement Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
Number of *Actively Engaged* Patients	0	337	674	2697	3371	5057	3371	6751	3371	6751
Expected # of Actively Engaged Patients	6751	6751	6751	6751	6751	6751	6751	6751	6751	6751

Rationale for Project 3.d.ii

The rationale related to project 3.d.ii implementation speed is as follows:

- Accelerated project implementation possible because "Keeping Families Healthy" program is already in place.
- Smaller patient population and strong existing resources allows for much faster project implementation

The rationale related to project 3.d.ii patient engagement speed is as follows:

- For this project, Actively Engaged is defined as the number of participating patients based on home assessment log, patient registry, or other IT platform.
- Patients are counted as those who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years**.**

The patient scale rationale is calculated as detailed below.

Patient Scale Rationale

	High-End Prevalence Approach		Low- End Salient Approach
Baseline # of population aged 0-25	56,824 Patients	**Baseline # of Patients**	5,945 Patients
13.3% prevalence rate of Asthma	7,558 Patients	**100% Engagement Factor**	5,945 Patients
100% Engagement Factor	7,558 Patients	**Total**	5,945 Patients
Total	7,558 Patients		
Expected # of Actively Engaged Patients =		**Midpoint of 2 approaches** =	**6,751 Patients**

References

Please see pages 70-77 in the Suffolk Care Collaborative DOH Application for additional project related information.

http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/stony_brook_university_hospital/stony_brook_project_plan.pdf