

Suffolk Care Collaborative
Promoting Asthma Self-Management Program (PASP)

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

Project Charter

Executive Summary:

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.

Objective Statement:

The Suffolk Care Collaborative will 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.

Target Population:

1. Suffolk County (SC) residents,
2. diagnosed with asthma
3. aged ≤ 25 , and
4. Medicaid participant

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 communities with a high prevalence of asthma” (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.

High Level Deliverables:

- Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.
- 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.

- Identify and disseminate evidence based asthma management guidelines.
- 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.
- Ensure coordinated care for asthma patients includes social services and support.
- 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.
- Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.

Project Description & Benefits:

The project will implement a medical home program enriched with home visits by trained community health workers (CHWs) leveraging the strengths and model of the existing Pediatrics Keeping Family Healthy (KFH) program at Stony Brook Medicine 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 reduction interventions, 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.

The CHWs act as a direct extension of the primary care provider's office/medical home to support patients / 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 patients / families with appropriate community resources based on need, including additional healthcare services, food assistance, transportation services, childcare services, family services, and counseling.

Low/medium-risk patients will receive education and support from care managers / PCP offices and benefit from PPS-wide care management platforms whereby pertinent disease- management information, such as the individualized patient Asthma Action Plan, is accessible to all care team members. Initial implementation will occur in communities with high asthma prevalence (i.e. Islip, Patchogue, Brentwood, Bayshore, and Mastic) followed by expansion throughout SC.

Assumptions:

It is generally thought that emergency department visits and hospitalizations for exacerbations should be considered avoidable events with good asthma management. Often, despite the best efforts of practitioners to implement evidence based practices, patients continue to have difficulty controlling their symptoms. Home-based services can address the factors that contribute to these exacerbations.

The Community Needs Assessment (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 from 2013 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.

Constraints:

Patients / 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.

- Some PPS providers will experience barriers in implementing the National Heart, Lung, and Blood Institute asthma guidelines.
- Some PPS providers may not have resources to address the cultural/linguistic needs of the diverse Suffolk County population
- Provider participation
- Consistency in hiring, training, and supervision of CHWs.
- Building relationships with a diverse group of community partners.

Success Criteria:

- Successful completion of all Domain 1 requirements, including meeting patient engagement and project engagement commitments
- Improvement throughout DSRIP Measurement Years across all Domain 2-3 outcome measurers (achievement of 10-20% gap to goal)
- Overall achievement of project objective
- Sources that influenced the development of the program is accepted by public, community and key project stakeholders

Closeout Criteria:

- Closeout will be managed during the monitoring phase of the project lifecycle and is tentatively scheduled for period ending March of 2020
- Evaluate and ensure all Archive Data and final project records/documents are filed in a secure location and appropriate to demonstrate achievement of DSRIP metric/project commitments within Domain 1 – 4
- Archive all project data in a central repository. Include best practices, lessons learned, and any other relevant project documentation.
- Verifying acceptance of final project deliverables/ data sources by the NYS DOH
- Completion of the post-project assessment and lessons learned
- Completion of post-project review and evaluation

Project Strategy:

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 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.

Approved:

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Date