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## Expansion of Asthma Home-Based Self-Management Program

### Project goal

**Immediate:** Identify eligible individuals, stratify risk level for each patient, verify medical home/PMD for each enrollee, and enter patients' information to registry; assign patients to care coordinator and high risk patients to Community Health Workers (CHW).

**Long-term:** Provide patients with asthma care consistent with NHLBI guidelines including: regular asthma visits; classification of severity, risk and control of asthma at each visit; appropriate Rx of asthma control meds; provide an Asthma Action Plan (AAP) at each visit carrying a primary diagnosis of asthma. Sustain home-based services to address asthma triggers and reduce avoidable asthma-related ED and hospital visits.

### Interventions

In Suffolk County, the percentage of pediatric Medicaid patients with asthma is 13.3% compared to 4.5% in the general population. This project provides support for asthma patients to improve self-management with services tailored to meet the needs of those patients at highest risk for poor outcomes. Specifically, home visits for high-risk asthma patients, defined as any patient with an asthma-related ED or hospital visit, are provided by trained community health workers (CHWs) functioning as a direct extension of the medical home. This program component leverages infrastructure and lessons learned from an existing Keeping Families Healthy (KFH) program at a current Level 3 Patient-Centered Medical Home (PCMH) pediatric primary care site. The CHWs will be equipped with secure tablet devices and mobile phones to enable remote communication with all members of the health care team and perform environmental assessments to identify potential asthma triggers and recommendations for trigger reduction. Patients at low and medium risk for poor outcomes will be supported with tailored educational materials and/or care coordination support, as indicated.

Providers will be responsible for: 1) determining if patients have the diagnosis of asthma; 2) treating asthma per NHLBI guidelines, including classifying severity, risk and control, and dispensing an Asthma Action Plan for each visit with a primary diagnosis of asthma; 3) referring patients diagnosed with asthma to an asthma specialist if the diagnosis is not straightforward or if referral is

merited per the NHLBI guidelines; 4) screening asthma patients in the practice to identify those at high-risk and refer them to the designated care coordinator; 5) review information provided by care coordinators and CHWs regarding individual patients.

### Patient Engagement Metric

The number of participating patients age 26 years or younger based on home assessment log, patient registry or other IT platform.

### Clinical Metrics

- Asthma Medication Ratio (5 - 64 Years) - Ratio of controller medications to total asthma medications of 0.50 or greater
- Medication Management for People with Asthma (5 - 64 Years) - 50% of Treatment Days Covered - Patients with persistent asthma filled prescription for asthma controller medications during at least 50% of their treatment period
- Medication Management for People with Asthma (5 - 64 Years) - 75% of Treatment Days Covered - Patients with persistent asthma filled prescription for asthma controller medications during at least 75% of their treatment period
- Pediatric Quality Indicator (PQI) # 14 Pediatric Asthma - Inpatient admission age 2 to 17 with a principal diagnosis of asthma
- Prevention Quality Indicator (PQI) # 15 Younger Adult Asthma - Inpatient admission age 18 to 39 with a principal diagnosis of asthma

**Tools to be employed:** Electronic database for entry of enrollee data; Asthma Action Plan (AAP); Asthma Toolkit (ATK); National Environmental Education Foundation (NEEF) checklist

### References/Guidelines

1. NHLBI Guidelines 2007:  
<https://www.nhlbi.nih.gov/files/docs/guidelines/asthgdln.pdf>
2. Global Initiative for Asthma- Pocket Guide for Asthma Management and Prevention 2018:  
[https://ginasthma.org/wp-content/uploads/2018/03/wms-GINA-main-pocket-guide\\_2018-v1.0.pdf](https://ginasthma.org/wp-content/uploads/2018/03/wms-GINA-main-pocket-guide_2018-v1.0.pdf)