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Promoting Asthma Self-Management Program Implementation Toolkit

Suffolk Care Collaborative

PROGRAM TOOL FOR PARTICIPANTS OF DSRIP PROJECT 3DII
DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM
SUFFOLK CARE COLLABORATIVE

Promoting Asthma Self-Management Program

Implementation Toolkit

April, 2018

PROGRAM TOOL FOR PARTICIPANTS OF DSRIP PROJECT 3DII
DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM

For more information, please contact us at DSRIP@stonybrookmedicine.edu

SUFFOLK CARE COLLABORATIVE
1383 Veterans Memorial Highway, Suite 8, Hauppauge, NY 11778

www.suffolkcare.org

Acknowledgements

We would like to acknowledge members of our program who support our ongoing efforts in health care delivery system reform.

Promoting Asthma Self-Management Program Committee

A composition of key internal and external project stakeholders, including representation from key community and public service and governmental agencies engaged to support the conclusions, deliverables and monitor system impacts of the DSRIP Program.

Special thanks to our key contributors for their work on the 1st Edition Toolkit:

- **Susmita Pati, MD, Chief, Division of Primary Care Pediatrics/Associate Professor of Pediatrics, Stony Brook Medicine, PASP Program Clinical Lead**
- **Ellen Miller, MBA, Associate Director of Operations, Children's Hospital & Women's Health, Stony Brook Medicine, PASP Program Lead**
- Linda Efferen, MD, SCC Medical Director/VP
- Katharine Kevill, MD, Attending Pulmonologist, Stony Brook Medicine
- Catherine Kier, MD, Division Chief Pediatric Pulmonologist, Stony Brook Medicine
- Giuseppina Caravella, Program Coordinator, Keeping Families Healthy, Stony Brook Medicine
- Lisa Romard, Nurse Practitioner & Asthma Educator, Department of Pediatrics, Division Of Pulmonary/Allergy/Immunology/Cystic Fibrosis & Sleep Disorders, Stony Brook Medicine
- Hua Wang, Project Staff Associate, Dept. of Pediatrics, Stony Brook Medicine
- Jessica Wyman, Associate Director, DSRIP, Catholic Health Services
- Barbara Rowe, Director of Specialty Services, Catholic Health Services
- Andrew Tucci, DSRIP Project Manager, Northwell Health
- Marie Frazzitta, DNP, FNP, Northwell Health
- Amanda Brown, MHA, Senior Associate, Veralon
- Teresa Cichosz, RN, MSN, CCRN, GCN, CDE, Nurse Educator, Northwell Health

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Overview

Background

In response to rising healthcare costs, Medicaid spending and concerns of health care quality, Governor Andrew M. Cuomo created the Medicaid Redesign Team (MRT). The MRT initiatives accounted for approximately $17.1 billion in federal savings. On April 14, 2014, Governor Andrew M. Cuomo announced New York finalized terms and conditions with the federal government for a groundbreaking waiver that will allow the state to reinvest $8 billion of federal savings generated by the MRT reforms. The MRT waiver amendment goal is to transform the state's health care system, bend the Medicaid cost curve, and ensure access to quality care for all Medicaid members. NYS Department of Health's charter under this waiver is to fully implement an action plan to allow for comprehensive reform through a Delivery System Reform Incentive Payment (DSRIP) Program.

State-wide Effort: Delivery System Reform Incentive Payment Program

Through the Delivery System Reform Incentive Payment Program, a federal grant waiver administered by the NYS Department of Health (NYS DOH), $6.42 billion Medicaid dollars were allocated to fundamentally restructure the health care delivery system to transition care delivery from a largely inpatient-focused system to a community-facing system that addresses both medical needs and social determinants of health. DSRIP is a 5-year, performance payment-based program with primary goal of reducing avoidable hospital use by 25% over 5 years. At the end of the program life, the aim is for the newly-transformed system to be sustainable. Project efforts are focused on achieving improved overall health through integration of behavioral health and primary care, provision of appropriate levels of care management, and care delivery models designed to improve chronic disease prevention and outcomes.

Local Leadership: Suffolk Care Collaborative

New York State is broken into 25 regional organizations called Performing Provider Systems (PPS). Each PPS is responsible for engaging providers, designing programs, coordinating collaboration, reporting project outcomes and allocating funds to partners.

The Suffolk Care Collaborative (SCC) is the PPS for Suffolk County under the DSRIP Program. The goal of SCC is to meet the requirements of the Triple Aim Initiative – improving patient experience, improving health outcomes and reducing the per capita cost of healthcare. Our vision to become a highly effective, accountable, integrated, patient-centric delivery system has positioned us well to make an important contribution to the DSRIP program. Some of the many goals will include the capacity to make the most of patients' self-care abilities, improve access to community-based resources, break down care silos, and reduce avoidable hospital admissions and emergency room visits.

The SCC has operationalized all DSRIP requirements through a portfolio of programs.

Promoting Asthma Self-Management Program

The objective of this program 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.

Click here to access our program webpage.

Program Goals

- 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.

Purpose of the Implementation Toolkit

The purpose of this toolkit is to assist all internal and external program stakeholders during the implementation phase and throughout the life cycle of the program described herein. It provides an overview of the Promoting Asthma Self-Management Program, including key directory of SCC project management office contacts, Program Charter, tools and resources for implementation, program protocols, patient engagement requirements, instructions on how to submit documents and maintain project documents and valuable program resources. It is meant to act as a guide and information source that you can refer to for all your DSRIP needs.

Returning Required Documents

This toolkit includes several documents that will need to be completed and returned to the Suffolk Care Collaborative by participating providers. Electronic copies of these documents can be accessed via our Partner Portal or you can complete the hard copies provided here and return them to SCC. If you complete a document in hardcopy form, please scan the completed document and email or fax it to your Provider Relations Manager. We also recommend you keep a hardcopy of every document submitted to Suffolk Care Collaborative.

PCMH Certification Program Alignment

The SCC's clinical improvement program's implementation approach is closely aligned to our participating primary care practices participation in our Patient Centered Medical Home (PCMH) Practice Transformation Program.

Stakeholders have aligned all Domain 3 Clinical Improvement Program implementation protocols to PCMH standards, as described herein. Implementing DSRIP's primary care practice protocols throughout the programs can help meet the requirements of many PCMH standards. An interactive crosswalk lists the DSRIP Domain 1 Project Requirements connected to primary care and aligns them with requirements for the 2014 Patient-Centered Medical Home (PCMH) standards, Advanced Primary Care

(APC) model, and Transforming Clinical Practice Initiative (TCPI). Requirements for each model come directly from their respective sources.

Program Resources

Appended to this Implementation Toolkit is a set of Program Resources designed for our network participating providers. Program resources include the following:

- Implementation Resources
- Provider Resources
- Patient Education Resources
  Additional Reading Materials

Suffolk Care Collaborative Program Contacts

Contact Name	Title	Email Address	Phone Number
Linda Efferen, MD	Medical Director, Suffolk Care Collaborative	Linda.efferen@stonybrookmedicine.edu	631-638-1318
William Bishop, MHA	Director of Clinical Program Innovations, Suffolk Care Collaborative	William.Bishop@stonybrookmedicine.edu	631-638-3183
Alexandra Kranidis, MPH	Project Manager, Suffolk Care Collaborative	Alexandra.kranidis1@stonybrookmedicine.edu	631-638-1772
Susmita Pati, MD, MPH	PASP Program Lead Chief, Division of Primary Care Pediatrics/Associate Professor of Pediatrics, Stony Brook Medicine	Susmita.Pati@stonybrookmedicine.edu	631-444-3094
Ellen Miller	PASP Program Co-lead Associate Director of Operations, Children's Hospital & Women's Health, Stony Brook Medicine	Ellen.Miller@stonybrookmedicine.edu	631-444-2205

General Contact Information:

Suffolk Care Collaborative

1383 Veterans Highway, Suite 8, Hauppauge, NY 11788

Phone: (631) 638-2227

Fax: (631) 638-1009

Email: DSRIP@stonybrookmedicine.edu

www.suffolkcare.org

Evidence-based Clinical Protocols & Guidelines

PASP Clinical Guidelines Summary

The long term goal is to 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 prescription 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.

Document Title	Link to Document
PASP Clinical Guidelines Summary	Click here

PASP Practice Site Program Protocols & Templates

Below are the listings of program protocols and program templates for the Promoting Asthma Self-Management Program. The protocols were developed to help guide providers through the implementation of the program and correlate to specific milestones.

Protocol Number	Program Protocol Name	Link to Document
3dii.01	Patient Identification & Standard Treatment Protocols for Asthma Care	Click here
3dii.02	Evidence Based Trigger Reduction Home Assessment Referral	Click here
3dii.03	Root Cause Analysis	Click here
3dii.04	PASP Reporting Procedure	Click here

Clinical Improvement Program Resources

Asthma Action Plans

According to the American Lung Association, an Asthma Action Plan (AAP) is a written, individualized worksheet that shows patients the steps to take in order to keep their asthma under control. Asthma Action Plans provide guidance on when to call one's healthcare provider or when to go to the emergency room. New York State Asthma Action Plans can be found in both English and Spanish.

Title	Description	Link to Document
New York State Asthma Action Plan	NYS Asthma Action Plan – English version	Click here
New York State Asthma Action Plan	NYS Asthma Action Plan – Spanish version	Click here

PASP Training Methodology & Curriculum

Asthma Training Curriculum

Module Overview: These modules review the evidence-based resources and treatment strategies being implemented to support the Promoting Asthma Self-Management Program. You will learn about tools available to assess and monitor patients with asthma, comprehensive education about asthma self-management, the importance of controlling environmental exposures that affect asthma patients, medication to treat asthma. DSRIP partners are expected to review each curriculum reference and attest that they understand the training.

Title	Learning Objectives	Core Curriculum
Asthma Home Environmental Trigger Assessment Services Overview	• Asthma Home Environmental Trigger Assessment Services Overview. • Values of promoting asthma self-management and learn about the tools and patient education resources available.	https://suffolkcare.org/forpartners/learning-center
The American Lung Association's Asthma Basics Course	• Recognize and manage triggers. • Understand the value of an asthma action plan. • Recognize and respond to breathing emergency. • View the What is Asthma? Animation that shows the three primary changes in the airways during an asthma episode. • Learn about comprehensive resources, including asthma medication devices and demonstration video downloads for patients.	Asthma Basics in English Asthma Basics in Spanish

PASP Root Cause Analysis

Root cause analysis (RCA) is a structured team process that assists in identifying underlying factors or causes of an event, such as an adverse event or near-miss. Understanding the contributing factors or causes of a system failure can help develop actions that sustain corrections. The purpose of an RCA is to find out what happened, why it happened, and determine what changes need to be made.

Document Title	Link to Document
Root Cause Analysis Procedure	Click here
Guidance for Performing Root Cause Analysis	Click here
Five Whys Tool for Performing RCA	Click here

Asthma Home Environmental Trigger Assessment Program

PASP Home Assessment Referral Process

Catholic Health Services

The documents included below outline the Catholic Health Services referral process to the Pediatric Asthma Home Visit Program. Once an eligible patient is identified, a referral is made the Catholic Health Services home visitation program provides intermittent skilled nursing visits to patients. Nurses use the attached checklist to structure their visits and record completed tasks.

Title	Description	Link to Document
Intervention Workflow Diagram	CHS pediatric referral process workflow diagram	Click here
CHS PASP Referral Form	Provider referral line for home services. To contact Catholic Home Care visit: http://catholichomecare.chsli.org/contact-us	Click here
Pediatric Asthma Checklist	Home care visit task checklist	Click here
CHS Asthma Community Flier	Pediatric asthma home care program, patient facing flier	Click here
Re-hospitalization Tool	5 W Question tool for visiting nurses to use during home visit	Click here

Northwell Health System

Northwell Health offers a tailored home visit asthma self-management program which includes a home environmental trigger reduction assessment, self-monitoring training, review of medication use and medication follow-up to reduce avoidable ED and hospital care. Once eligible patients are referred to the program, they are assigned a visiting nurse. The structure of the nurses' visits can be found in the workflow diagram. Nurses provide patients with a variety of asthma related materials.

Title	Description	Link to Document
Program Overview	Overview of Northwell's asthma home visiting program	Click here
Intervention Workflow Diagram	Pediatric visiting RN asthma home visit assessment workflow	Click here
Northwell PASP Referral Form	Form to be completed by referring provider	Click here

Stony Brook University Hospital

Below are general program documents for the Keeping Families Healthy Asthma Home Visitation Program. They include the general referral process, referral form to be completed by the patient's provider, as well as various workflow charts.

Title	Description	Link to Document
PASP Referral Process	Document which contains program eligibility requirements and procedures for referrals	Click here
PASP Patient Referral Form:	Tracking tool for individual patient referrals	Click here
Program Clinical Workflow Diagram:	Flow chart which includes how a patient is notified and referred to PASP program	Click here
Home Assessment & Trigger Reduction Resource Referral Flow Chart	Detailed flow chart of patient visits and communication flow between patients, CHWs and physicians	Click here

Promotional Materials

Catholic Health Services

The flyer included below is distributed to patients by Catholic Health Services to promote their Asthma Home Visitation Program. More information about pediatric services provided by Catholic Health Services can be found on their online at: http://catholichomecare.chsli.org/pediatric-care.

Title	Description	Link to Document
CHS Asthma Community Flyer	Pediatric asthma home care program, patient facing flyer	Click here

Northwell Health System

The materials below include the flyers distributed to patients by Northwell Health Services about the Asthma Home Visitation Program. Promotional materials can be found in both English and Spanish.

Title	Description	Link to Document
Families Nurse Visits Program Asthma Flyer	Patient facing nurse visit program flyer in English	Click here
Nurse Visits Program Asthma Flyer Spanish	Patient facing nurse visit program flyer in Spanish	Click here
Referral and Visit Workflow	Northwell referral and visit workflow diagram	Click here

Stony Brook University Hospital

The materials below are flyers distributed by the Stony Brook Hub about the PASP Home Visitation Program. Patient promotional materials can be found in both English and Spanish.

Title	Description	Link to Document
Provider Facing Brochure	Brochure written to educate Primary Care Providers on the PASP program	Click here
Patient Facing Brochure	Brochure written to educate patients on the PASP program and related services.	Click here
Patient Facing Brochure – Spanish	Brochure written to educate patients on the PASP program and related services in Spanish.	Click here

Patient Education Materials

Catholic Health Services

Included below are the patient education materials distributed to PASP program participants by Catholic Health Services program staff. Materials were adapted from the Environmental Protection Agency and Asthma Coalitions of Queens and Long Island.

Title	Link to Document
Dusty the Goldfish (English)	Click here
Asthma Trigger Patient Educational Materials (Eng. & Sp.)	Click here

Northwell Health System

Patients in the Northwell Health Asthma Home Visit Program are provided with asthma education materials that are designed to help them identify asthma triggers, eliminate triggers and treat their asthma symptoms accordingly. Included in the patient's education information is the patient's Asthma Action Plan, which is reviewed by the nurse in the patient's home.

Stony Brook University Hospital

Asthma Education Patient Tools

Below are asthma education handouts distributed by CHWs to patients in the PASP Program. These documents are compiled into an Asthma Toolkit binder that is presented to the patient and their family on their initial visit. Documents include but are not limited to community resources, online asthma information, medication information, logs for doctor's visits and how to use different asthma related equipment. After initial environmental home assessment, the CHW will provide patients with the relevant trigger reduction information sheet(s). Trigger information sheets can be found in both English and Spanish and are written at a 3-5th grade reading level.

Tile	Description	Link to Document
Community Resources Guide	Packet of community resources for family referrals. This includes but is not limited to insurance information, nutrition assistance, transportation services, and family services	Click here
Online Asthma Resources	Document containing websites with information about asthma, asthma care, home assessment and trigger reduction	Click here
General Asthma Education	Document containing asthma informational handouts. These include general information about asthma, quick relief and rescue medications, how to use an inhaler, etc. Spanish versions of each handout are also included.	Click here

Trigger Specific Education	Link to English Document	Link to Spanish Document
Cockroaches	Click here	Click here
Pets & Animals	Click here	Click here
Mold	Click here	Click here
Dust Mites	Click here	Click here
Outdoor Air Pollution	Click here	Click here
Cigarette Smoke	Click here	Click here
Evidence-based Trigger Reduction Interventions	Click here	

PPS Wide Patient Education

Title	Description	Link to Document
Home Care Asthma Training Materials for Visiting Healthcare Workers	Asthma guidelines for home care (Asthma Coalition of Long Island training)	Click here
Asthma Family Education Flipbook English	Digital version of asthma family education flipbook in English	Click here
Asthma Family Education Flipbook Spanish	Digital version of asthma family education flipbook in Spanish	Click here
Environmental Trigger Assessment	Home environmental trigger assessment checklist from the National Environmental Education Foundation in English	Click here
Environmental Trigger Assessment	Home environmental trigger assessment checklist from the National Environmental Education Foundation in Spanish	Click here

Community Health Worker Training

Stony Brook University Hospital

Community Health Workers complete a comprehensive class-room-based training and orientation followed by field training and ongoing quality assurance monitoring, provided by Stony Brook pediatricians, pulmonary sub-specialists, nurses and KFH program staff. In addition, training is conducted by certified Asthma Educators from the Asthma Coalition of Long Island. Training materials are supplemented with materials from the Association of Asthma Educators.

Title	Description	Link to Document
CHW Home Safety Training	Training material about in home safety for Community Health Workers	Click here

PASP Trainers

Catholic Health Services

Name	Title	Organization
Anne Little	Director	Asthma Coalition of Long Island

Northwell Health System

Name	Title	Organization
Claudia Guglielimo	Director	Asthma Coalition of Long Island

Stony Brook University Hospital

Name	Title	Organization
Anne Little	Director	Asthma Coalition of Long Island
Lisa Romard	Nurse Practitioner & Asthma Educator, Department of Pediatrics	Stony Brook Medicine
Claudia Guglielmo	Director	Asthma Coalition of Queens
Giuseppina Caravella	Program Coordinator, Keeping Families Healthy	Stony Brook Medicine

Program Documents

Catholic Health Services

The documents included below outline the Catholic Health Services referral process to the Pediatric Asthma Home Visit Program. Once an eligible patient is identified, a referral is made the Catholic Health Services home visitation program provides intermittent skilled nursing visits to patients. Nurses use the attached checklist to structure their visits and record completed tasks. More information about pediatric services provided by Catholic Health Services can be found on their online at: http://catholichomecare.chsli.org/pediatric-care .

Title	Description	Link to Document
CHS PASP Referral Form	Provider referral line for home services. To contact Catholic Home Care visit: http://catholichomecare.chsli.org/contact-us	Click here
Pediatric Asthma Checklist	Home care visit task checklist	Click here
CHS Asthma Community Flier	Pediatric asthma home care program, patient facing flier	Click here

Northwell Health System

A description of the visiting nurses responsibilities and qualifications as well as a checklist of action items conducted during home visits can be found below.

Title	Description	Link to Document
Visiting RN Job Description	Outline of visiting nurse responsibilities and qualifications	Click here
Pediatric Home Care Asthma Checklist	Asthma related checklist to be conducted in home of patient	Click here

Stony Brook University Hospital

The documents below outline the roles and responsibilities of the various staff members as they relate to Stony Brook University Hospital's Keeping Families Healthy-PASP program.

Role	Link to Responsibilities Document
Primary Care Provider Role	Click here
Community Health Worker Role	Click here
Program Coordinator Role	Click here
Vendor Role	Click here

PASP Quarterly Reporting Requirements and Clinical Metrics

Domain 1 Patient Engagement Definition & Data Request

Patient Engagement Definition: As per the definition of actively engaged, patient engagement refers to the number of participating patients based on home assessment log, patient registry, or other IT platform. A count of patients 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 evidence-based medicine guidelines for asthma management that will count for this program are the New York State Guidelines.

Title	Description	Link to Document
SCC Project 3dii Data Request Outline	Outline of elements to be included in SCC data reports	Click here
Patient Engagement Data Request	Template used to gather patient engagement information	Click here

PASP reporting procedures and performance metrics are established by the New York State Department of Health and the Suffolk Care Collaborative. Speed and scale reports as they relate to PASP program patient engagement and visits are required by the Department of Health on a quarterly basis.

Title	Description	Link to Document
PASP Reporting Procedures	Suffolk Care Collaborative PASP reporting requirements	Click here
Performance Metrics	Table of performance metric definitions, goals and achievements. PASP performance metric definitions and goals can be found in lines 65-69 of the Performance Metric excel document included below.	Click here

General Program Documents

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 visits and hospital care.

Title	Description	Link to Document
PASP Project Charter	Official PASP project charter including project summary, target population and deliverables	Click here
PASP Milestone Timeline	The milestone timeline outlines the PASP program's activities as broken down by quarter over the life course of the DSRIP project. A copy of the Suffolk Care Collaborative's PASP project charter and timeline can be found online at suffolkcare.org	Click here

Care Coordination Methodology

The care coordination team includes the 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. The PASP program aims to ensure coordinated care for asthma patients which includes social services and support.

Title	Description	Link to Document
SCC Care Coordination Core Principles Protocol	Outline of care coordination principals and basic elements	Click here
Clinical Improvement Program Roles & Responsibilities Protocol	Outline of roles and responsibilities at each stage of the workflow	Click here
SCC Care Coordination Services Protocol	Procedure for evaluation of patient needs and barriers in order to ensure required services are utilized as agreed upon by patient and family.	Click here
Care Management and Care Coordination in Suffolk County	A compilation of various care organizations available to patients in Suffolk County	Click here

Resources

1) Achieving Guidelines-Based Care for People Living with Asthma, Fact Sheet, American Lung Association
2) Asthma Coalition of Long Island
3) Crocker, D. D., Kinyota, S., Dumitru, G. G., Ligon, C. B., Herman, E. J., Ferdinands, J. M., Sipe, T. A. (2011). Effectiveness of Home-Based, Multi-Trigger, Multicomponent Interventions with an Environmental Focus for Reducing Asthma Morbidity. *American Journal of Preventive Medicine, 41*(2). doi:10.1016/j.amepre.2011.05.012
4) Environmental History Form: National Environmental Education Foundation Checklist
5) Kattan, M., Stearns, S. C., Crain, E. F., Stout, J. W., Gergen, P. J., Evans, R., Mitchell, H. E. (2005). Cost-effectiveness of a home-based environmental intervention for inner-city children with asthma. *Journal of Allergy and Clinical Immunology*, *116*(5), 1058–1063. doi:10.1016/j.jaci.2005.07.032
6) NHLBI Guidelines 2007: http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines/full-report
7) New York State Department of Health Services Asthma Information
8) New York State Department of Health Services Asthma Action Plan and Information Materials
9) Schottenfeld L, Petersen D, Peikes D, Ricciardi R, Burak H, McNellis R, Genevro J. Creating Patient-Centered Team-Based Primary Care. AHRQ Pub. No. 16-0002-EF. Rockville, MD: Agency for Healthcare Research and Quality. March 2016.