Approved Care Model for Project 3dii:

Expansion of the Home Environmental Asthma Management Program

OneCity Health Webinar
January 6, 2016
Overview of presentation

- Approach to care model development
  - Project overview
  - Project requirements and metrics
  - Target population
  - Roles of partners in implementation
    - Clinical sites
    - Community health workers
    - Home remediation services
- Questions/ Discussion
What is a care model?

- “A standard set of roles, responsibilities, resources, and relationships for organizations within the PPS, designed to accomplish a specific project.”
- Examples of more detailed implementation can be helpful in understanding how a care model will work.
- However, detailed implementation plans require an understanding of the local environment, and will be developed in conjunction with partners.
- Our discussion today will focus on the care model for this project. We recognize that implementation is the fundamental work to achieve a successful initiative, and we welcome discussion with sites as we work on phasing implementation of this project across the OneCity Health PPS.
October-December 2014
- Asthma workgroup was created under leadership of subject matter experts to complete the NYS DOH DSRIP application. The application included description of the intervention that responded to the NYS DOH’s project requirements.

January-June 2015
- Clinical expertise group with broad range of backgrounds met in February and in April 2015 to review application, submit updates required by the NYS DOH, and determine implementation steps for basic implementation planning.

July-December 2015
- OneCity Health finalized details for the State Implementation Plan (SIP).
- Asthma Care Model developed based on national guidelines, literature review of evidence-based standards, and input from clinical expertise group and subject experts.
- Asthma Care Model was completed and presented to the OneCity Health Care Models Committee on October 26, 2015. The Care Models Committee represents a range of partner types and professional backgrounds, and members were nominated through a formal application process. The care model was recommended by the Care Models Committee and subsequently approved by the OneCity Health Executive Committee.
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Objective: To reduce avoidable emergency room (ER) use and hospitalizations related to asthma, by means of implementing or expanding home-based services.

The intervention is being built on principles from the National Asthma Education and Prevention Program (NAEPP) based on the EPR-3 Clinical Guidelines for Asthma Management and other evidence-based best practices, to provide a comprehensive, multidisciplinary approach that complements traditional delivery of care.

Home-based services will address home environmental trigger management, self-monitoring, medication use, medical follow-up, and coordination with social services.

The success of this project also requires support for strong clinical asthma management programs.

Special focus on children.
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Asthma Home-Based Self-Management Program (3.d.ii):
NYSDOH Project Requirements (Milestones)

1. Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow up. (due 3/31/18)

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. (due 3/31/17)

3. Develop and implement evidence-based asthma management guidelines. (due 3/31/17)

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. (due 3/31/17)

5. Ensure coordinated care for asthma patients including social services and support. (due 3/31/18)

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. (due 3/31/17)

7. Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers. (due 3/31/18)

8. Use EHRs or other technical platforms to track all patients engaged in this project. (due 3/31/17)
## State-defined metrics for asthma project

<table>
<thead>
<tr>
<th>Type of metric</th>
<th>Measurement</th>
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<tbody>
<tr>
<td><strong>Patient engagement commitment</strong></td>
<td>“The number of participating patients based on home assessment log, patient registry, or other IT platform.”</td>
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<td>• 584 by 3/31/16</td>
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<td></td>
<td>• Annual commitments: 4,674 (DSRIP year 2) 9,348 (DSRIP year 3) 11,695 (DSRIP years 4 and 5)</td>
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</table>
| **Asthma-specific clinical improvement metrics**   | • Admissions with principal diagnosis of asthma (ages 2-17; ages 18-39)  
• People ages 5-64 with persistent asthma who received at least one controller medication who filled controller prescription (during at least 50%, at least 75% of treatment period)  
• Asthma medication ratio in people ages 5-64 with persistent asthma (controller: total asthma meds ≥0.50) |
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**Target population**

- Roles of partners in implementation
  - Clinical sites
  - Community health workers
  - Home remediation services

- Questions/ Discussion
Focus on patients with poor asthma control

- This initiative will focus on patients with poor asthma control, which can include any of the following:
  - Admitted to the inpatient unit for asthma exacerbation within the last 12 months
  - Seen in the emergency department with asthma exacerbation two or more times within the last 6 months
  - Received a prescription for systemic corticosteroids two or more times within the last 6 months
  - Have prescription patterns indicating overuse of short acting beta agonists (e.g. albuterol)

- Year 1 and 2 recruitment will focus on ages 0-18
  - We will also accept referrals from older patients, but will not actively recruit them until year 3
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Roles in implementation of asthma model

- Both partners and CSO will have obligations in success of implementation

- Each partner type will have specific roles and responsibilities

- Contract structure and processes will be developed to support the work required for implementation for each partner type

Clinical services
Active partnership with primary care (including school-based clinics), inpatient, and ER; also will accept referrals from other clinical settings

Community health workers (CHWs)
Trained personnel with understanding of local communities who will provide home visits

Home remediation services
Remove sources of allergens from the home such as mold and vermin
The care model describes functional roles, which will be integrated into partners’ staffing and workflows according to local implementation planning.

Clinical partners
- Primary care sites
- Medical centers including ambulatory, inpatient, and emergency services
- Other clinical partners e.g. school based clinics, urgent care centers

Community health workers
- This care model defines community health workers as people who are carrying out the functions of home-based self-management support and home assessment
- In this definition, community health workers may be from a variety of backgrounds and employed by a range of different partner organizations

Home remediation
- A technical service to achieve allergen removal from the home
Roles in implementation of asthma model

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### Clinical partners: Roles and PPS support for primary care team (1)

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<th>Partner responsibilities</th>
<th>Examples of activities</th>
<th>CSO support</th>
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<tbody>
<tr>
<td>Provide clinical care consistent with national standards</td>
<td>• Implement processes to: -- consistently and accurately document asthma classification in medical record -- assess control during follow-up visits -- follow guidelines for medication prescription -- use Asthma Action Plan -- provide asthma education -- provide follow-up visits available within 7 days after asthma-related ER or hospital visit</td>
<td>• Support for certification in asthma education for PCMH staff member • Education/ training on: -- clinical guidelines for asthma classification and management -- spirometry use -- billing for reimbursable services related to asthma (spirometry, asthma education) • Spirometer</td>
</tr>
<tr>
<td>Identify patients with poor asthma control</td>
<td>• Implement processes to identify patients during clinic visit who meet inclusion criteria • Leverage population data to identify poorly controlled asthmatics for intervention</td>
<td>• Tools and sample workflows • As feasible, IT support for EHR development, registry development, and leveraging of population-level data (e.g. EHR data, billing data)</td>
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## Clinical partners: Roles and PPS support for primary care team (2)

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| Screen patients for home assessment needs, and track number screened (*engagement metric*) | • Screening questionnaire incorporated into visit workflow  
• Report number of screened patients | • Training in use of screening tool  
• As feasible, support incorporation of tool into EHR |
| Refer patients to CHW to assist in self-management, if indicated | • Create process for referrals | • Linkage to CHW program  
• Training in motivational interviewing and techniques to encourage program acceptance |
| For patients who decline CHW, administer detailed home assessment tool in clinic setting | • Standardized tool for assessment of home environment through patient interview conducted in clinic  
• Refer directly to home remediation services, if indicated (for patients who decline CHW) | • Standard assessment tool provided; training as needed  
• Linkage to home remediation services |
| Create and track a registry of patients with persistent asthma | • Use IT platform to track patients with persistent asthma, including those meeting inclusion criteria and those referred to CHW program | • Provide template of log or registry for clinical use; promote incorporation into EHR |
| Root cause analysis for patients who went to ER or hospital for asthma exacerbation | • Identify potentially modifiable factors leading to acute event | • Training/or tool for root cause analysis |
### Clinical partners: roles and CSO support for inpatient and ER settings

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<tr>
<td>Identification of patients</td>
<td>• Process in place to identify patients who meet inclusion criteria</td>
<td>• Education, sample workflows, support from facility leads</td>
</tr>
<tr>
<td>Linkage to primary care (and/or pulmonologist)</td>
<td>• Ensure follow-up appointment made</td>
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<tr>
<td>Referral to CHW program</td>
<td>• Referral to CHW program with warm hand-off if available</td>
<td>• Education and linkage support for CHW referrals</td>
</tr>
<tr>
<td>Contribute to root cause analysis</td>
<td>• Communicate important aspects of root cause analysis in discharge paperwork</td>
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Active partnership with primary care (including school-based clinics), inpatient, and ER; also will accept referrals from other clinical settings

Community health workers (CHWs)
Trained personnel with understanding of local communities who will provide home visits

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Removes sources of allergens from the home such as mold and vermin
# Community health workers: Roles and PPS support

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| Reinforce education in asthma self-management with patient and family | • Reinforce and support self-monitoring skills  
  • Reinforce and support appropriate medication use | • Training or retraining of CHW staff to PPS standards  
  • Ongoing educational opportunities to increase and update knowledge |
| Assess home environment | • Provide materials to assist in trigger reduction in the home environment  
  • Teach home cleaning strategies  
  • Refer to home remediation services, if indicated | • Provision of materials to assist in trigger reduction (e.g. pillowcases, cleaning products) |
| Coordinate care | • Communicate with primary care team, specialty providers, and care managers (including Health Home and managed care plans) as needed  
  • Refer to care management or social work for complex needs  
  • Coordinate clinical follow-up for root cause analysis after any ER or hospital visits | • Care management platform |
| Tracking and reporting | • Track and report process and outcomes measures to CSO | • Care management platform |
Training for CHWs

- OneCity Health partners providing CHW services will be required to demonstrate that CHWs have completed standard training courses, or equivalent training activities that cover the core competencies included in these courses.
- CHWs will have to refer to the appropriate provider for any clinical, social, or other issue that is beyond their role.
- Training in Community Health Worker role
  - Community Health Worker Network of NYC
- Training in asthma-specific knowledge and skills
- Training in home environmental assessment
  - National Healthy Homes Training Center and Network
Roles in implementation of asthma model

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Home remediation services: Roles and CSO support

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<td>Remediation of home environment to address factors that exacerbate asthma symptoms</td>
<td>• Remove triggers such as mold and vermin, through advocacy or direct intervention</td>
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Two Examples of Organizational Configurations

**Configuration 1: Hospital-Based Program**
- Internally hired Community-Based Workers

**Configuration 2: Community-based Workers**
- Clinical Sites
  - External Community Health Worker Programs via CBOs

Home Remediation Services
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