

EXPANSION OF THE ASTHMA HOME-BASED ENVIRONMENTAL PROGRAM

PROGRAM APPLICATION

April 1, 2019 through June 30, 2020

Background & Project Participation Opportunity

OneCity Health is issuing this Project Participation Opportunity (PPO) to select Partner(s) with demonstrated capacity and success to expand the Asthma Home-Based Environmental Program into multiple-care settings, as well as to serve adults, using an integrated care-coordinated model.

The Asthma Home-Based Environmental Program presents a significant opportunity to prevent Emergency Department (ED) visits and Inpatient (IP) admissions. Many elements potentially inhibit asthma self-management, including exposure to environmental triggers, gaps in proper medication adherence, language barriers, and the cost of home remediation services. These frequently lead to avoidable asthma-related hospital use.

To address these challenges and extend asthma services to the home, the OneCity Health Performing Provider System (PPS) implemented the Asthma Home-Based Environmental Program in 2017, augmented by an integrated Community Health Worker (CHW) and pest remediation services targeting outpatient pediatric and adolescent patients with asthma diagnoses.

A preliminary analysis using managed-care claims data of pediatric patients who received the Asthma Home-Based Environmental Program showed promising reductions in admissions and cost across all care settings. Building on the program's success, OneCity Health is seeking to refine the program elements and expand into various care settings, such as:

- Outpatient Primary Care
- Specialty Clinic
- Acute Inpatient
- Emergency Department
- School-based Health Clinic

In addition to expanding to these settings, the selected Partner(s) will ensure that they provide integrated services to both pediatric and adult patients with asthma diagnoses.

Program Goals and Requirements

The program's goals are to reduce avoidable ED and IP visits and admissions, and improve patient care and well-being by connecting patients to primary care and needed social services.

To achieve these goals, the selected Partner(s) must deliver the Asthma Home-Based Environmental Program in an integrated care-coordinated model working with facility care teams and community providers. The Partner must reach "high utilizer" asthma patients, i.e., those with repeated ED and/or IP admissions and/or those utilizing multiple facilities. Patients who are high utilizers of the ED and IP pose additional challenges to engage and will require proactive outreach to close the loop and reconnect to the primary care provider. Patients in outpatient primary care are usually engaged, and providers are able to complete the Asthma Action Plan (AAP) and refer them to the Asthma Home-Based Environmental Program. If desired, the Partner(s) will have the flexibility to refer appropriate patients from their own programs and/or community organizations, including school-based health clinics.

The Partner(s) must identify a CHW supervisor with sufficient professional skills, such as social work, law, care management, community nursing, or comparable experience to ensure the CHW, with the support of the care team, can effectively address patients with asthma and other complex illnesses, including needs related to the social determinants of health.

Partners will be expected to define a sustainable workflow to connect patients to the Asthma Home-Based Environmental Program, the facility care teams, and the community providers. At a minimum, the Partner(s) will be required to meet the following requirements and deliverables:

- Patient Outreach and Engagement
 - » Conduct outreach and engage patients from provider referrals and targeted lists
 - » Ensure patient consents to receive all services
 - » Ensure CHW staff are based on-site at the facility in close proximity to the care teams (providers, nurses, care managers) to participate in face-to-face, regular clinical huddles, and workgroup meetings
 - » Develop a strategy to engage with community providers and work cooperatively to address their patients' asthma and utilization of the ED
- Home Assessments
 - » Complete home assessments to identify and address environmental triggers, including provision of Integrated Pest Management (IPM) services
 - » Administer Asthma Control Test (ACT) and document pre-and post-test scores

- » Provide education on long-term controller medication use in patients with persistent asthma while discouraging overutilization of quick-relief medications like Albuterol for day-to-day asthma management
- » Follow-up with patients who have frequent admissions to ED and IP to ensure they keep outpatient appointments and comply with prescribed medication
- Community-based Connections
 - » Administer social determinants of health screening tool to connect patients to social, economic, and community resources
- Closed Loop Communication
 - » Ensure integration with the facility care teams and community providers
 - » Propose a communication strategy to ensure care continuity with the care teams

A. CHW Skills and Training Requirements

- » CHW staff must have the skills and competencies required to work with both pediatric and adult patients with dual-diagnoses in the ED and IP settings, including communication, care coordination, case management, and motivational interviewing, advocacy, and social services connections.
- » CHW staff must have clearly defined roles and responsibilities as they relate to engaging patients and acting as liaisons to the community, thereby providing invaluable support for patients and the care team.
- » The Partner(s) must deliver trainings that address social determinants of health screening.
- » The Partner(s) must participate in OneCity Health sponsored trainings, including Physician Asthma Care Education (PACE) and CHW.

B. Integrated Pest Management Services

- » The Partner(s) may propose direct contracting or subcontracting for IPM or other treatment services, e.g., mold and building repairs. In either case, the Partner(s) will be responsible for ensuring timely assessment, treatment, and follow-up on mold and structural issues with New York City Housing Authority and/or private landlords, including training, tracking, reporting, and communication to the care team.
- » The Partner(s) should specify how the relationship between the Partner(s) and the IPM vendor(s) will ensure timely and successful service outcomes for family well-being. The Partner(s) who directly contract(s) with the IPM vendor will be solely responsible for management and providing cleaning supplies and household items, including pillow and mattress covers.

C. Data and Infrastructure Requirements

- » Partner(s) must work with OneCity Health to demonstrate the efficacy and impact of the Asthma Home-Based Environmental Program based on the program's process and outcome data-collection efforts.
- » To minimize system data entry duplication, Partner(s) will be required to use the GSI Health Management platform for tracking referrals, enrollment, and IPM services, augmented with its own case-management database when appropriate. Partner(s) will also be required to work closely with OneCity Health Team to transition the data collection from GSI to the referring provider's Electronic Medical Record (EMR) system.
- » To monitor the Partner(s) performance, at a minimum, the Partner(s) will be required to collect the following process data on a monthly report:

Process Metrics

- » Number of outreach contacts, visits, and completed home assessments
- » Number of patients enrolled in the Asthma Home-Based Environmental Program
- » Number of meetings with care team to facilitate communication
- » Number of patients referred to IPM and social need services
- » Number of IPM assessments and treatments completed
- » Number of patients enrolled in CHW in-house programs, e.g., training program, housing, legal advocacy, insurance enrollment
- » Number of ACT administered

The following outcomes/impact measures will be evaluated by OneCity Health:

- » Reduced avoidable hospitalization rates
- » Improved Asthma Medication Ratio (AMR)*
- » Improved Medication Management for People with Asthma (MMA)**

^{*}AMR: The goal is to have an asthma patient have a ratio of 50 percent asthma controllers filled compared to the patient's total asthma medications (relievers + controllers)

^{**}MMA: The goal is to have the total dispensed days of a patient's asthma controller medication cover more than 50%-75% of the total number of days in the timeframe (i.e., the date of the year when the patient with persistent asthma obtains the first controller medication prescription from the pharmacy until the end of the same year).

Application Information

ELIGIBILITY AND CRITERIA

Organizations must have an executed Phase IV Comprehensive Schedule B with OneCity Health and fully meet these minimum criteria for participation:

- Extensively documented, successful, evidence-based practice and experience in implementing services under a care-coordinated model to improve patient care and well-being
- Ability to scale-up and independently implement an integrated Asthma Home-Based Environmental Program at each facility and community provider setting
- Capacity to directly contract with IPM vendors, including internal structure to manage, track, report, and communicate timely outcomes of services
- Ability to demonstrate that current CHW workforce is culturally competent with expertise and skill-sets to manage and support patients with dual diagnoses
- Internal infrastructure capacity to screen patients for social determinants of health and connect patients to in-house and external resources
- Internal infrastructure to collect data for reporting and evaluation in a timely manner

AWARD INFORMATION

Awards will be commensurate with the proposed scope of work and discussed with each awardee separately. See application process.

Selection Criteria and Weighting

Selection Criteria	Weight
Experience : Demonstrated experience, capability, and evidence-based practice implementing the Asthma Home-Based Environmental Program and other programs for high-risk population.	25%
Proposed Approach : Proposed plan is feasible to gain buy-in for short- and long-term sustainability, including care-coordination and integration at each facility and community provider setting	35%
Organizational Capacity: Demonstrated personnel and management to scale-up by beginning of the contract period	20%
Data : Adequate IT infrastructure and use of data, including connectivity, collection, and reporting to meet contractual requirements	10%
Cost : Budget is reasonable and aligns with the proposed approach, staff, and patient caseload	10%

Application Process and Timeline

APPLICATION COMPONENTS

- Partners interested in applying to "The Asthma Home-Based Environmental Program" should submit a proposal, not to exceed 7 pages (exclusive of any desired and applicable appendices), that includes the following:
 - » Documentation of experience and capability as described under "Selection Criteria";
 - » A proposed program budget for the 15-month contract period, inclusive of personnel, patient caseload, and other program delivery costs, that is responsive to the requirements and deliverables of the Asthma Home-Based Environmental Program model, as outlined in this PPO; and
 - » Documentation of required organizational data capacity and experience with reporting on operational process measures and longitudinal patient tracking.

APPLICATION SUBMISSION

- Applications must be submitted by close of business on Wednesday, March 20, 2019, to the OneCity Health Support Desk (ochsupportdesk@nychhc.org), with the subject line "Asthma Home-Based Environmental Program."
- This initiative will begin upon execution of a Schedule B and run for a 15-month period, from April 1, 2019, through June 30, 2020.

ONECITY HEALTH CONTACT INFORMATION

Please submit any questions to the OneCity Health Support Desk (ochsupportdesk@nychhc.org), with the subject line "Asthma Home-Based Environmental Program." We will respond to your inquiries promptly.