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

Project Objective: 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.

Project Description: 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.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the attachment: **Domain 1 DSRIP Project Requirements Milestones and Metrics,** which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.
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 such as pests, mold, and second hand smoke.
3. Develop and implement evidence based asthma management guidelines.
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.
5. Ensure coordinated care for asthma patients includes social services and support.
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.
7. Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.
8. Use EHRs or other technical platforms to track all patients engaged in this project.

Project Response & Evaluation (Total Possible Points – 100):

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

The CNA revealed an average Medicaid pediatric asthma rate of 412.3 cases per 100,000. The Observed/Risk Adjusted Expected ratio ("risk-adjusted O/E") of pediatric asthma across NYC is 1.23 and 1.24 in our service area. Fifteen neighborhoods exceeded 1.23: Brooklyn (Bedford/Stuy/Crown Hts, Flatbush/E. Flatbush, Canarsie/Flatlands, E. New York); Manhattan (Central Harlem/Morningside Heights, E. Harlem, Upper W. Side); Bronx (NE Bronx, Highbridge/Morrisania, Hunts Point/Mott Haven, Crotona/Tremont, Fordham/Bronx Park); and, Queens (Rockaway, SE Queens, Jamaica).

For asthma among younger adults (18-39 years), the risk-adjusted O/E in NYC is 1.20 and 1.22 in our service area. Seventeen neighborhoods exceeded 1.20: the Bronx (Highbridge/Morrisania, Hunts Point/Mott Haven, Crotona/Tremont, NE Bronx, Fordham/Bronx Park, Kingsbridge/Riverdale, Pelham/Throgs Neck); Manhattan (Central Harlem/Morningside Hts, Washington Hts/Inwood, E. Harlem, Chelsea/Clinton); Brooklyn (Canarsie/Flatlands, Bedford/Stuy/Crown Hts, Flatbush/E. Flatbush, E. New York, Williamsburg/Bushwick); and, Queens (Rockaway).

For COPD or asthma in adults ages 40 and older, risk-adjusted O/E for NYS is 1.04, 1.05 for NYC and 1.06 in our service area. Twenty neighborhoods exceeded 1.05: Manhattan (Central Harlem/Morningside Hts, Washington Hts/Inwood, Upper W. Side, E. Harlem, Chelsea/Clinton); Brooklyn (Flatbush/E. Flatbush, Bedford/Stuy/Crown Hts, Canarsie/Flatlands, E. New York, Williamsburg/Bushwick, Downtown/Heights/Slope, Greenpoint); the Bronx (NE Bronx, Highbridge/Morrisania, Crotona/Tremont, Hunts Point/Mott Haven, Fordham/Bronx Park, Pelham/Throgs Neck, Kingsbridge/Riverdale); and, Queens (Rockaway).

The CNA links asthma prevalence and associated utilization to poor environmental conditions (e.g., housing, pollution) and other social determinants of health. The CNA notes that areas with high rates of serious housing violations and rat sightings overlap with high respiratory PQI hospitalizations and asthma-related utilization. In the Bronx, for example, asthma is among the most significant health concerns commonly attributed to indoor and outdoor environmental conditions. Similarly, 35% of CNA survey respondents from Upper Manhattan selected asthma as one of the biggest health concerns. Poverty is also an important factor in asthma prevalence; poor households are more likely to have potential triggers (e.g., pest infestation, mold).

Our PPS selected 3.d.ii because of the opportunities to improve health outcomes (see CNA need 5). The initiative will include: development of a uniform, evidence-based approach to ensure that the target population is provided with a range of home-based services (e.g., self-management education, home environmental evaluation and strategies for remediation, linkages to social services); procedures to provide, coordinate and link patients to resources for evidence-based trigger reduction interventions (e.g., changing indoor environment to reduce exposure to asthma triggers); development of evidence-based curricula for providers and staff; and, bidirectional care pathways supported by a range of health IT functionality.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

Our PPS intends to engage the following population: patients with new or existing diagnoses of asthma who reside in our service area (see CNA need 5). The initial implementation will focus on engaging patients ages 0 – 18 with asthma (and their families) in the following neighborhoods: South Bronx, Northern Manhattan and North Central Brooklyn. As part of the intervention, we will identify patients with two or more ED visits in the last six months and will conduct enhanced outreach to this population (see CNA need 1).

After initial implementation, our PPS will leverage our experience and expand engagement activities to other geographical areas, focusing first on other neighborhoods in Brooklyn and the Bronx with higher ED and inpatient rates and also on other age groups. As with the pediatric population, the PPS will conduct enhanced outreach to patients with two or more ED visits in the last six months.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

Our PPS has a range of assets and resources to support this project. Woodhull Medical and Mental Health Center, a hospital in our PPS, is one of 13 organizations in the country selected by the National Asthma Control Initiative – National Institute of Health as a demonstration project for the effectiveness of the most recent national guidelines for asthma management. As part of this project, Woodhull will develop and expand its Physician Asthma Care Education Reinforcement (PACER) program to serve as a model to overcome barriers to guideline-based medical care. Woodhull was also identified as the "Provider Spotlight" for NY State in a recent national publication by the Centers for Disease Control and Prevention (CDC): Asthma Self-Management, Education and Environmental Self-Management: Approaching to Enhance Reimbursement. In addition to Woodhull's exemplar program, it has an asthma registry to help identify and track patients with asthma.

HHC also has long-standing relationships with DOHMH, developing and implementing programs like Asthma Friendly School Guidelines, Managing Asthma in Daycares, Use of Community Health Workers for Asthma Self-Management Education, and leveraging their "Healthy Homes" program which is anticipated to play a key role in identifying home environmental triggers and developing mitigation strategies. HHC is also an active participant in regional asthma coalitions (e.g., North Brooklyn Asthma Action Alliance, R.E.S.P.I.R.A.R.) and will leverage this involvement to support ongoing work to learn promising practices and improve coordination.

Our PPS also intends to enhance existing and develop new collaborations with entities such as the NYC Departments of Education, Aging and Housing Violations, the NYC Office of School Health, public schools, the YMCA, pharmacies, day care organizations, senior centers, and other CBOs. These relationships will help to promote education and training around asthma, awareness, and allow for other areas of collaboration. For each type of organization, our PPS will set standards for communication by including information tailored to specific exchanges (i.e., discharge communication to PCPs will have a set of required data elements, referral/coordination with Health Homes will have required set of information).

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

Based on previous work, our PPS anticipates a number of challenges. First, we will require additional staffing and infrastructure to scale up existing asthma home-based activities within the PPS. To address this challenge, we intend to develop a strategy to recruit and train community health workers. We may also seek to leverage the workforce of other CBOs to augment existing capacity.

We also anticipate that patient retention in home-based programs may be challenging. To address this concern we will consider patient incentives related to trigger remediation (e.g., pillow cases, shower curtains, etc.) in order to improve retention.

Language and cultural barriers could impact our ability to identify and engage patients (see CNA need 3). We will address this concern by ensuring that training provided to community health workers emphasize the importance of meeting the culture and language needs of the population.

We will work closely with CBOs to implement this initiative and we know there are varying health IT capabilities. As such, we expect to identify core health IT capabilities (i.e., using an electronic asthma action plan) and work with partners to develop these capabilities.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve overlapping service areas. If there are no other PPSs within the same service area, then no response is required.

As part of planning activities to date, our PPS has collaborated with Bronx Partners for Healthy Communities (BPHC) and Community Care of Brooklyn (CCB). We have achieved a number of important goals, including aligning project selection for this and other projects, and identifying areas for collaborate during implementation and operations. We have also jointly reached out to CBOs with expertise providing asthma home-based management services to discuss augmenting capabilities in order to meet the needs of our population.

During implementation planning, we intend to continue our collaboration with BPHC and CCB. We expect this collaboration to focus on: ensuring alignment and coordination of standardized protocols; developing common risk assessment methodologies; adopting common core partner contracting vehicles; developing workforce strategy, including common job descriptions and functional capabilities; coordinating workforce training efforts; identifying data sharing issues; and, selection of culturally competent patient education resources to support this project.

Post-application, we also intend to broaden our collaboration efforts to include other PPSs in our service area. We believe this coordination will be crucial to reduce the burden on providers

and CBOs, address key capacity and workforce needs, and improve clinical outcomes and patient experience.

2. Scale of Implementation (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

3. Speed of Implementation/Patient Engagement (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

4. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☐	☒

If yes: Please describe why capital funding is necessary for the Project to be successful.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☒	☐

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
New York City Health & Hospitals Corporation (HHC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HHC is a NYS-designated Health Home.
Community Care Management Partners (CCMP) Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CCMP is a NYS-designated Health Home.
CBC Pathways to Wellness Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CBC Pathways to Wellness is a NYS-designated Health Home.
Community Health Care Network	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CHN is a NYS-designated Health Home.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	ASCNYC is a Health Home care management provider, providing culturally competent care management team services comprised of licensed social workers and trained Peer Health Coaches.
CAMBA	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CAMBA is a Health Home care management provider, serving over 2,200 members and conducting outreach to between 300 – 900 members per month.
FEGS Health & Human Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	FEGS is a NYS-designated Health Home in Nassau and Suffolk counties as well as a case management agency under subcontract with a number of NYC Health Homes.
Harlem United (HU)/ Upper Room AIDS Ministry, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Harlem United (HU) provides services under subcontract to the CCMP-led Health Home in the Bronx and Manhattan, CHN in Queens and Maimonides in Brooklyn. Currently, approximately 900 clients are enrolled in HU's Health Home program.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Health People	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Health People provides services to NYS Medicaid Health Homes under subcontract. The organization provides outreach, engagement, follow-up, care retention and relevant self-care education for Medicaid enrollees with chronic conditions.
HELP/PSI	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HELP/PSI is a Health Home care management entity under subcontract with 4 NYS Health Home providers.
Leake & Watts	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Leake & Watts provides a Health Home for children through the Children's Collaborative, a collation of children- and family-focused agencies that provides Health Home services for children.
MetroPlus	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	MetroPlus provides contracting and care coordination services under subcontract to multiple Health Homes, including HHC and VNSNY.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
PSCH	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	PSCH provides services to NYS Medicaid Health Homes under subcontract, including care coordination services to individuals with complex and/or multiple chronic conditions.
The Osborne Association/ Osborne Treatment Services, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2015	The Osborne Association provides services under subcontract to Health Homes in Bronx and Brooklyn.
Physician Affiliate Group of New York, PC (PAGNY)	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	PAGNY provides necessary staffing, such as physicians, allied health providers and other employees deemed necessary by HHC, to the HHC Health Homes as part of this initiative.
Arms Acres and Conifer Park	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	Arms Acres and Conifer Park provides services to NYS Medicaid Health Homes under subcontract. Services include coordination of behavioral health services for patients with chronic medical and behavioral conditions.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Coordinated Behavioral Care IPA/ Postgraduate Center for Mental Health	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	The Postgraduate Center for Mental Health provides services to NYS Medicaid Health Homes under subcontract. Services include care coordination following the transition of targeted case management services.
Coordinated Behavioral Care IPA/Brooklyn Bureau of Community Service d/b/a Brooklyn Community Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2013	2015	Brooklyn Community Service provides care coordination services under subcontract to participating agencies in the Brooklyn Health Home and CBC Pathways to Wellness Health Home.
Community Health Project, Inc. d/b/a Callen-Lorde Community Health Center	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Callen-Lorde participates in the Mount Sinai Health Homes network. Callen-Lorde has been assigned approximately 150 patients and 85 are actively enrolled. The program is growing, with two new Health Home positions are anticipated in the next two months. The program will scale up to 300+ patients by 2016.

c. Please describe how this proposed DSRIP project either differs from, or significantly expands

upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

Although this home-based asthma program intervention does not include a comprehensive care management component, the experience and capacity of our participating Health Homes and downstream care management and care coordination agencies will help ensure that this intervention is part of a broader patient-centered care management plan.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. Detailed Implementation Plan: By March 1, 2015 PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.