

### 3.d.iii. Implementation of Evidence Based Medicine Guidelines for Asthma Management

#### Project Response & Evaluation:

##### 1. Project Description and Justification

**1a. 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 feeling of being unable to breathe is understandably frightening. Accordingly, an exacerbation of respiratory disease, particularly asthma, often results in visits to the emergency department (ED). In a survey of residents in our region conducted as part of our PPS CNA development, 17.4% of respondents considered asthma to be one of the top five health issues in their community. Asthma clusters appear in Middletown, Newburgh, Poughkeepsie, Haverstraw, and southern Westchester. According to data analyzed for Medicaid beneficiaries in our region, there were over 13,000 total inpatient admissions and more than 39,000 total ED visits in 2012.

Respiratory illnesses, including asthma, chronic obstructive pulmonary disease (COPD), and bronchiectasis are found among Medicaid beneficiaries in our region in areas associated with higher levels of poverty, including Yonkers, Peekskill, Spring Valley, Newburgh, and Monticello. Our PPS CNA found hot spots of elevated risk for asthma hospitalization around Middletown, Newburgh, Poughkeepsie, Haverstraw, and southern Westchester. People with behavioral health conditions have a high rate of asthma; according to the Medicaid Institute, 24% of Medicaid mental health beneficiaries have asthma/COPD (at least 30% higher than among non-mental health beneficiaries), and 26% of substance abuse beneficiaries have asthma/COPD (at least 50% higher than non-substance abuse beneficiaries). Furthermore, because some asthma medicines cause patients' heart rates to increase, they can trigger anxiety attacks, leading to ED visits.

Our PPS will utilize four strategies to engage and address attributed Medicaid patients with asthma: (1) specialists in our PPS will review and adopt national and state evidence-based guidelines for asthma management, including protocols for appropriate spirometry, a common office test used to assess how a patient's lungs work, specialty referrals, and an Asthma Action Plan; (2) we will establish a PPS-wide registry to track asthma patients informed by work the PPS is doing now to evaluate analytics and population health management platforms (during DY 1 we will implement a system to identify and track patients with chronic disease, including asthma, and monitor patient and provider adherence to treatment guidelines); (3) we will implement health information exchange (HIE) protocols for creating, updating and sharing

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patient-centered asthma action plans among treating providers, Health Homes, patients and their families (to do so, a region-wide, all-PPS asthma workgroup will engage with HealthlinkNY, the local RHIO, to facilitate HIE); and (4) we will expand training for primary care providers (PCPs) on asthma management and use of spirometry and expand the availability of evidence-based asthma education for patients and parents of patients who are minors.

**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 will target attributed Medicaid beneficiaries aged 5 and older who have persistent asthma identified either by the beneficiary's PCP, medical claims, or EHR data available to the PPS. We will also incorporate the Area Deprivation Index (ADI) as we identify and stratify patients according to risk. The ADI is a well-accepted measure of neighborhood socioeconomic disadvantage which links a patient's zip code to an index of broader social and environmental risk factors to inform patient care decisions. Asthma is often exacerbated by environmental triggers, such as living conditions, that are reflected in the ADI. Patients with higher ADI scores may be stratified to a higher level of risk.

The PPS will engage Medicaid MCOs and Health Homes to coordinate asthma outreach to attributed Medicaid beneficiaries and their PCPs. The PPS will initially work with PCPs who have achieved PCMH accreditation to put in place the four strategies referenced above. As more affiliated PCPs connect to the RHIO, the asthma project will be extended broadly among the PPS primary care network. We estimate that a minority of patients in our region currently have an Asthma Action Plan, and our goal is to raise the proportion of patients with an Asthma Action Plan to 75% of asthma patients treated within our PPS.

**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.**

The Hudson Valley Asthma Coalition, a major asset to our PPS, is currently assisting organizations in two of the identified high need areas in our region, Yonkers and Newburgh. The Coalition assists health care providers to incorporate national evidence-based guidelines from the National Heart Lung and Blood Institute into their EHRs to prompt guideline-compliant asthma care and track asthmatic patients and their outcomes. Our PPS will work closely with the Coalition in supporting and expanding the reach of its programs across the region.

HealthlinkNY, a RHIO formed recently from the merger of Taconic Health Information Network and Community (THINC) and Southern Tier HealthLink (STHL), will span 11 counties across the Hudson Valley, Catskills, and Southern Tier, offering secure electronic access to statewide

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health information for both providers and patients in our region as well as information and tools to aid in health transformation. HealthlinkNY will maintain and consolidate patients' health information from participating health care organizations and provider practices across the region. Access to patient health information through HealthlinkNY's single, central, secure platform will allow a health care provider to view a patient's complete medical record. This expanded network will enable more efficient care coordination, reduce duplication of medical testing, and substantially cut health care costs.

The PPS will work with the Hudson Valley Asthma Coalition and HealthlinkNY to establish a regional asthma guidelines workgroup including PCPs, asthma specialists, asthma educators and representatives of all PPSs in the region working on asthma to standardize elements of an AAP that can be created, updated and shared among providers and with patients and families using the HealthlinkNY platform.

WMC, our PPS lead organization, is in the process of expanding its telemedicine capabilities that may support specialty asthma consultations across the region. The PPS will use rapid-cycle evaluation techniques to evaluate the efficacy of telemedicine to improve asthma care by making specialty asthma consultations more widely available and accessible to our attributed Medicaid patients.

Our PPS also has exceptional educational assets that we will build upon. We will leverage the experience of a local asthma specialist in our PPS who offers two highly regarded physician training programs: (1) a curriculum designed to train PCPs who currently do not perform spirometry to achieve proficiency; and (2) a program for PCPs to shadow an experienced pediatric pulmonologist to boost PCPs' comfort with asthma management. Our PPS will make these training programs more widely available to PPS Participants.

**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 barrier to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.**

The time needed to achieve agreement on standard Asthma Action Plan components will be a challenge. In addition, it may be difficult to engage some patient populations to follow their Action Plan. Asthma medications can cause feelings similar to an anxiety attack, which is a barrier to use for patients dually diagnosed with asthma and behavioral health conditions. An especially promising approach may be to involve trusted Health Home care coordinators in educating behavioral health patients on Action Plans, medications, and other treatment protocols.

Patients treated in the ED also present particular challenges. ED physicians are trained to treat acute problems and refer patients back to their usual source of care. However, because many

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patients do not actually follow up with their PCP after an ED visit, a meaningful plan for long term maintenance or self-management remains neglected. Training ED physicians to prescribe medicine to control inflammation and incorporating guidelines into EHRs may improve both prescribing and patient compliance rates because patients (and parents) in the ED are very attuned to the severity of their (or their child's) illness and particularly receptive to strategies for avoiding future attacks. We expect that other PPS projects, specifically 3.a.i "Integration of Primary and Behavioral Health Care" and 2.a.i. "Create an Integrated Delivery System" will also contribute to a streamlined, comprehensive approach to asthma management.

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

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieve DSRIP goals across. The three PPSs serving our region, led by Montefiore Medical Center, Refuah Health Center, and WMC, will establish a provider-led Regional Clinical Council to support development of a regional system of efficient and effective care, patient safety, and quality improvement.

The Council will review DSRIP project and implementation plans and make recommendations to align overlapping projects. Region-wide coordination, common requirements, and expectations will minimize providers' implementation burdens and create consistent, high quality patient experiences. The Council will identify region-wide care improvement goals and serve as a forum for sharing and evaluating clinical strategies and practices. The Council will support the rapid and widespread adoption of agreed-upon clinical protocols and evidence-based practices across the region and payers.

The PPSs in our region have embraced collaboration throughout the selection, design, and development phases of their respective DSRIP projects. To date, the PPSs have committed to coordinate implementation in three critical areas: behavioral health crisis intervention and coordination with local County Departments of Health and Mental Health; protocols for patient consent and physician connectivity to HealthlinkNY; and a tobacco cessation public health campaign.

## **2. Scale of Implementation**

*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*

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*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:*

**2a. Please indicate the total number of sites, programs and/or providers the PPS intends to include in the project by the end of Demonstration Year (DY), or sooner as applicable. These numbers should be entered in the table as Total Committed.**

***See accompanying Speed & Scale Excel document***

**b. Please indicate the total expected volume of patients the PPS intends to engage throughout this project by the end of Demonstration Year (DY) 4. This will become the Expected # of Actively Engaged Patients. Patient scale is measured by the total number of patients that are expected to be actively engaged by the end of Demonstration Year 4.**

***See accompanying Speed & Scale Excel document***

### **3. Speed of Implementation/Patient Engagement**

*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:*

**3a. Please indicate the Demonstration Year (DY) and Quarter by which all participating prescribing providers will achieve project requirements. Project speed is measured by how fast all the project requirements for all chosen locations are met.**

**PPSs will be expected to meet these requirements for all of the providers, sites, or other categories of entities included in the PPS “total committed” scale metric, unless otherwise specified in the Domain 1 DSRIP Project Requirements Milestones and Metrics.**

***See accompanying Speed & Scale Excel document***

**b. Please indicate the expected timeline for achieving 100% engagement of total expected number of actively engaged patients identified. For example, the PPS may indicate that 25%**

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of targeted patients will be actively engaged by the end of Demonstration year 1, 50% by the end of Demonstration year 2, etc.

**See accompanying Speed & Scale Excel document**

**4. Project Resource Needs and Other Initiatives (750 word limit, Not Scored)**

**4a. Will this project require Capital Budget funding? (Please mark the appropriate box below)**

Yes	No
X	

**Please describe why capital funding is necessary for the Project to be successful.**

The WMC-led PPS will seek capital funds to develop a shared, health IT infrastructure that supports region-wide population health management efforts. The population health management system will include: (1) a centralized care management platform; (2) a patient registry; (3) equipment and software for telehealth and remote monitoring; (4) enhancement of partners' EHR and HIE capabilities; and (5) analytic tools and reporting systems for network management. Collectively, these tools support critical communication and coordination among our PPS partner organizations for improved asthma management. The capability will be shared across all 11 DSRIP projects and are central to our IDS development.

**4b. 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
X	

**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.**

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
The Greater Hudson Valley Family Health Center, Inc.	Health Center Program (Section 330) Grant Program (HRSA)	6/1/12	5/31/17	Supports the provision of care to medically underserved areas and populations in the service area.

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Haverstraw Pediatrics	Health Homes for Medicaid Enrollees with chronic conditions	2011	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Open Door Family Medical Center, Inc.	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
The Institute for Family Health	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Mount Vernon Neighborhood Health	Health Homes for Medicaid Enrollees and	2013	ongoing	New York's Health Home program provides a suite

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Center Network	Chronic Conditions			of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
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**4c. 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.**

This project will seek to ensure patients are adequately informed of their asthma plan to minimize potential negative health outcomes from an asthma related event. The care management experiences of the Medicaid initiatives identified above will be valuable in informing this process. However this project differs from these initiatives because it expands the population targeted. For example, the Community based Care Transitions program targets Medicare patients. Our PPS will build on the experience of these Participants to establish a customized standard care transitions models across the region and will expand the model to support to a broader population of Medicaid patients. The PPS will also expand health center services for the attributed population.