December 2025

Concept Report

This report outlines scope of services and duties for potential contractors for the
Bronx Case Management Initiative

Purpose of the Proposed Request for Proposal (RFP)

In accordance with Section 3-16(j) of the New York City Procurement Policy Board (PPB) Rules, the New York City Department of Health and Mental Hygiene ("NYC Health" or "the agency") is issuing this Concept Report in advance of issuing a Request for Proposals. The New York City Department of Health and Mental Hygiene, Bureau of Bronx Neighborhood Health – Asthma Initiative, seeks qualified contractors to provide **asthma case management services** in the South Bronx as part of the newly formed Bronx Asthma Program. Through this initiative, the NYC Health Department aims to reduce asthma-related health disparities by contracting with approximately two providers to deliver culturally competent, family-centered case management services that strengthen care coordination and promote asthma self-management among residents in the South Bronx.

Background

Asthma remains a significant public health concern in the Bronx, particularly among children, where it is a leading cause of preventable emergency department (ED) visits and hospitalizations. According to 2023 Statewide Planning and Research Cooperative System (SPARCS) Data, available on the NYC Health Department's Environment and Health Data Portal, asthma-related ED visits and hospitalizations among children in the Bronx occur at rates substantially higher than the citywide average, which has persisted for more than a decade.

For example, in 2023, the rate of asthma-related ED visits for children ages 5-17 was 239.8 per 10,000 children living in the Bronx, compared to 143.7 per 10,000 children in this age group citywide. For children ages 0-4, the ED visit rates were also 1.7 times greater for Bronx children in 2023, at 343.1 per 10,000 compared to 200.9 per 10,000 for all NYC children. Asthma-related hospitalization rates follow a similar pattern, with rates for Bronx children in each age group 1.9 times higher than the rates for all NYC children (92.9 per 10,000 for Bronx children vs 42.9 for all NYC children ages 0-4, and 41.6 per 10,000 for Bronx children vs 21.8 per 10,000 for all NYC children ages 5-17. Within the Bronx, rates are generally higher among children living in the South Bronx for both age groups, compared to other parts of the borough and city. Furthermore, data from 2017–2019 highlight that neighborhoods in the South Bronx experience elevated rates of asthma-related ED visits linked to environmental factors such as ozone and fine particulate matter (PM 2.5), compared to other areas of New York City.

Several contributing factors exacerbate the burden of pediatric asthma in the Bronx, including poor housing conditions, exposure to environmental triggers, barriers to accessing medications, and limited connections to consistent primary care services. Addressing these challenges requires a comprehensive approach to case management that supports children and their families in managing asthma effectively and reducing preventable healthcare utilization.

Service Model and Parameters

Services should be delivered using a comprehensive case management model, designed to provide personalized, coordinated care to enrolled pediatric asthma patients and their families. The selected contractor will be responsible for delivering case management services that address the unique needs of each patient and their family. Case management services should be provided in a way that emphasizes a holistic approach, focusing on the following key parameters: assessment, care coordination, education and support, monitoring and follow-up and advocacy. By implementing a comprehensive case management model, the contractor will aim to improve health outcomes, enhance the quality of life for pediatric asthma patients, and empower families to manage asthma effectively.

Rationale for Providing Case Management Services

Asthma is a complex disease that involves an interplay of physiological, environmental, and psychosocial factors. Evidence suggests that the common factor for successful childhood asthma case management entails case managers spending time contacting and patiently and persistently working with the family, thus building a trusting relationship. Case management programs teach children and families basic facts about asthma, the role of medications, the correct way of using asthma medications, how to respond when asthma symptoms get worse, and how to reduce exposure to asthma triggers, in addition to coordinating care and resources to help the client reach their goals. Although case management time is an expense for a health care payer, provider, and the child and family, the positive outcomes achieved can demonstrate the benefit of these interventions to all parties involved.

Program Goals/Outcomes

Selected contractors will be responsible for providing asthma case management services in partnership with healthcare facilities, schools, and community organizations in the Bronx.

Each contractor must designate at least one full-time Asthma Care Coordinator (ACC) to implement the activities listed below. The ACC must meet the below requirements:

- **Asthma Care Coordinator (ACC):** Bachelor's degree in health, social work, or related field, with a minimum of two years' experience in health education, case management, or community health.
- **Preferred qualifications:** Staff with knowledge of asthma case management, certification as an Asthma Educator Specialist (AE-C) by the National Board for Respiratory Care, experience with motivational interviewing, and experience working with Bronx families.
- All staff must complete NYC Health Department-approved asthma management and case documentation training prior to service delivery. The NYC Health Department will schedule and coordinate trainings on behalf of all awardees.

Service expectations are as follows:

1. Identification and Enrollment

- Collaborate with hospitals, clinics, schools, and community partners to identify and enroll Bronx children (ages 0–17) with moderate to severe persistent asthma or frequent ED visits.
- Obtain appropriate consent and conduct initial outreach to families referred for case management.

2. Comprehensive Case Assessment

- Conduct an initial assessment that includes:
  - Asthma severity and control level
  - Medication usage and adherence
  - Environmental triggers (e.g., pests, mold, tobacco smoke)
  - Social determinants of health (housing, food access, transportation, etc.)
- Develop an individualized care plan in collaboration with the family and healthcare provider.

3. Ongoing Case Management and Follow-Up

- Provide continuous support for up to six months per family, including:
  - Ensuring prescriptions for long-term control medications are filled and used correctly
  - Confirming primary care and specialist appointments are scheduled and attended
  - Conducting regular follow-up calls or visits (minimum monthly contact)
  - Addressing barriers to care, including transportation, insurance, or pharmacy issues
- Refer families to additional resources such as home visiting, housing remediation, or social support programs (SNAP, WIC, etc.).

4. Asthma Education and Self-Management Support

- Deliver individualized asthma education covering:
  - Asthma basics and common triggers
  - Proper medication use and inhaler technique
  - Understanding and using the Asthma Action Plan
  - Recognizing warning signs and when to seek medical help
- Provide materials in the family's preferred language and at an appropriate literacy level.

5. Post-Hospitalization and ED Follow-Up

- Contact families within 72 hours of an asthma-related hospitalization or ED visit.

- Ensure the child received prescribed medications and has a follow-up appointment with a primary care provider.
- Reinforce education and update the family's care plan as needed.

6. Data Collection, Reporting, and Quality Assurance

- Maintain case files and electronic records documenting all services and contacts.
- Track indicators such as medication adherence, ED visits, follow-up attendance, and asthma control level.
- Submit monthly reports to The NYC Health Department summarizing caseload, progress, challenges, and outcomes.
- Participate in NYC Health Department-led evaluation and quality improvement activities.

Target Population & Geographic Service Area

Contractor will provide service delivery throughout the Bronx with a focus on South Bronx neighborhoods that have historically had the highest asthma rates in NYC. Services will be provided to eligible families who live in the Bronx, with outreach focused on Community Districts (CD) 201 through 206 (roughly zip codes 10451, 10452, 10453, 10454, 10455, 10456, 10457, 10459, 10460, and 10474).

Anticipated Program Evaluation and Reporting

The Contractor will collect data and report on the service components specified above. All staff, including, partners and subcontractors providing asthma case management services will operate and provide reports as defined by the NYC Health Department. Such reports would be submitted monthly and annually.

The contractor will provide monthly reports which would include but not limited to the following in data points:

- Deliverables will include detailed monthly reports on provided case management services and a yearly report summarizing progress on case management program goals and objectives. Monthly reports should include client demographics (e.g., number of families served, geographic location, age, and gender), service delivery metrics (e.g., total number of sessions conducted, types of services provided, and frequency of interactions), and referral and coordination data (e.g., number and type of referrals made, follow-up actions, and outcomes of referrals). Additionally, reports should highlight client outcomes (e.g., asthma control metrics, emergency room visits, and medication adherence), family engagement efforts (e.g., number of family members involved and types of support provided), and environmental assessments (e.g., identification and mitigation of asthma triggers). Contractors should also include a summary of challenges encountered, strategies implemented to address them, and recommendations for improving service delivery.

The contractor will provide an annual report which would include but not limited to the following in data points:

- The annual report should provide a comprehensive summary of the contractor's activities, outcomes, and progress toward program goals over the year. It should include key metrics such as the total number of patients served, demographic breakdowns, and service delivery data (e.g., sessions conducted, types of services provided, and referrals made). The report should highlight patient outcomes, including asthma control improvements, medication adherence, and reductions in emergency room visits or hospitalizations, as well as family engagement efforts and environmental assessments conducted to mitigate asthma triggers.
- Additionally, the report should summarize program impact, including progress toward goals, success stories, and data trends compared to previous years. It should address challenges encountered, strategies implemented to overcome them, and lessons learned. Financial and administrative data, such as expenditures and staffing levels, should also be included, along with compliance and quality assurance activities. Finally, the report should provide recommendations for improving service delivery and outline plans for the upcoming year, supported by aggregated data, charts, and any relevant documentation.

Performance Metrics

It is anticipated that contractors will be evaluated on their ability to meet the following annual benchmarks:

- Maintain an active caseload of **30–40 families per full-time coordinator**.
- Complete **initial contact within 72 hours** of referral.
- Achieve **at least 70% follow-up completion rate** for enrolled families.
- Demonstrate measurable reductions in asthma-related ED utilization among enrolled participants.

Partnership and Coordination

Contractors must establish and maintain partnerships with:

- Bronx hospitals and health centers (for referrals and coordination)
- NYC Health Department community programs and home visiting services
- Schools and other community stakeholders

Contractors will also be expected to participate in Bronx Asthma Program meetings, data review sessions, and other collaborative activities facilitated by the NYC Health Department.

Deliverables

- Case management services for Bronx families with asthma
- Monthly data and narrative reports to the NYC Health Department
- Participation in required trainings and evaluation activities
- Documentation of community partnerships and referral systems
- Procurement, secure storage, and delivery of program incentives and support items to help families in the treatment and management of asthma.

Proposed Term of the Contract(s)

The NYC Health Department anticipates that the term of each contract resulting from this RFP will be 4 years in duration, contingent on the availability of funding. As of the release date of this Concept Report, the anticipated contract start date is 7/01/2027.

Proposed Procurement Timeline

The proposed RFP would be issued through the PASSPort system, and proposals will only be accepted through PASSPort. It is anticipated that the RFP issuance date will be in late Summer 2026, with proposals due 45-60 after the RFP issuance date, and anticipated award decisions in Fall 2026.

Planned Method of Evaluating Proposals

The NYC Health Department anticipates that proposals will be evaluated based on the extent to which proposers demonstrate relevant organizational experience; the proposed approach to the scope of services; the proposed approach to data management, monitoring and reporting; demonstration of organizational capacity and qualifications; and the proposed approach to budget management.

Funding Information

The NYC Health Department anticipates awarding approximately 2 contracts from the RFP. The NYC Health Department estimates that the annual value of each contract will be $128,500 subject to funding availability.

Use of PASSPort and Prequalification

To respond to this future RFP and all other Human/Client Services RFPs, organizations must have an account and an Approved PASSPort HHS Accelerator PQL qualification status in PASSPort. Prequalification applications and proposals in response to RFPs will ONLY be accepted through PASSPort. If you do not have a PASSPort account or Approved PASSPort HHS Accelerator PQL Application, please visit nyc.gov/passport to get started. If you have any questions about your PASSPort HHS Accelerator PQL status or for assistance with creating a PASSPort account, please go to https://www.nyc.gov/site/mocs/about/help.page.

Provider Conference

The NYC Health Department will hold a virtual meeting for interested providers on January 7, 2026, at 2:00 PM. The purpose of this meeting is for the NYC Health Department to obtain feedback and input from the provider community relating to the content of this Concept Report.

If you plan to attend this meeting, please email RFP@health.nyc.gov with the attendee(s) name and email address(es); include **Bronx Case Management Provider Meeting RSVP** in the subject line.

Contact Information /Deadline for Questions/Comments

Written comments on this Concept Report are invited by **February 12, 2026**. Please email RFP@health.nyc.gov and indicate **Bronx Case Management Concept Report Comments** in the subject line of the email.