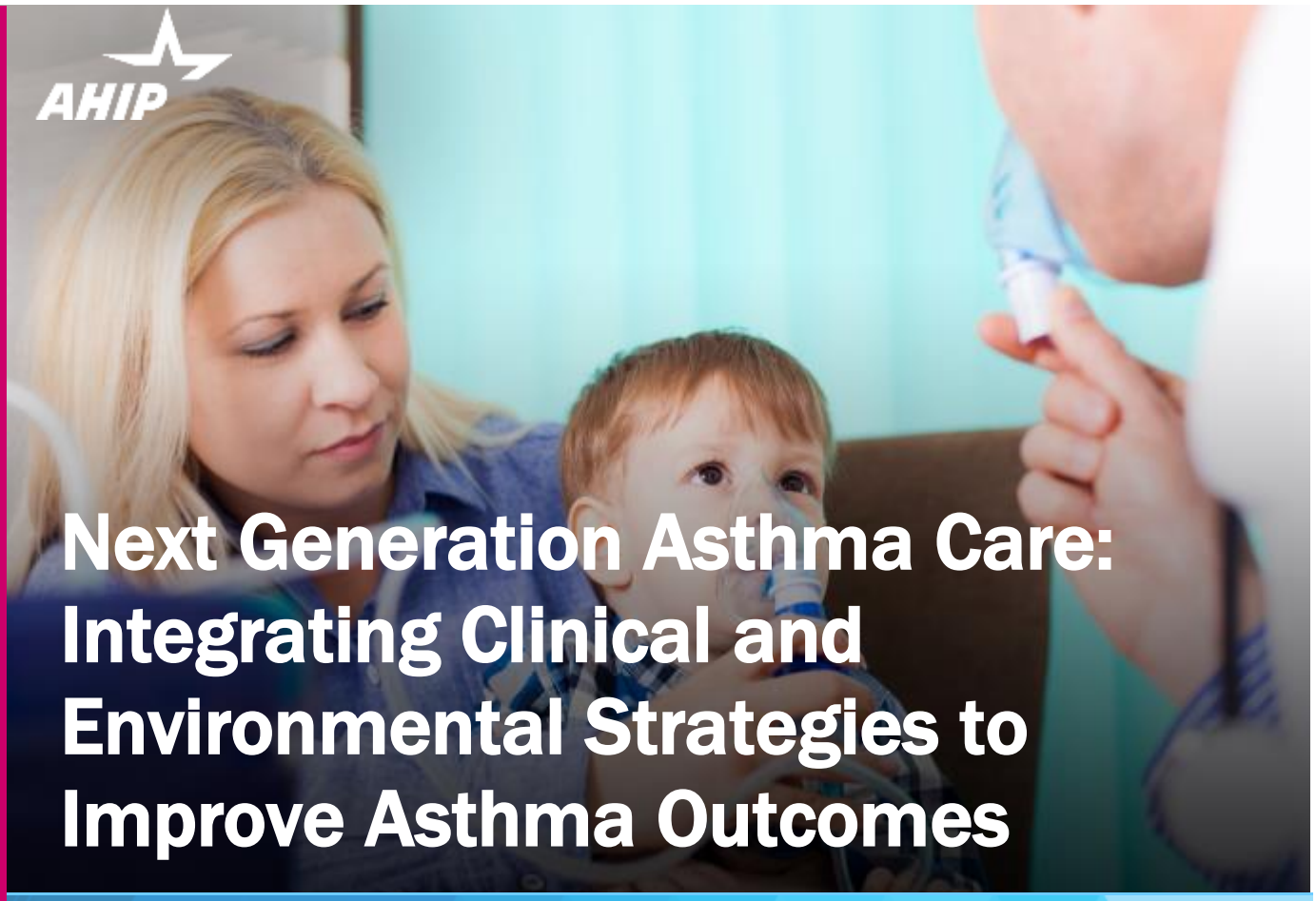


Next Generation Asthma Care: Integrating Clinical and Environmental Strategies to Improve Asthma Outcomes

Report from the AHIP National Asthma Leadership Roundtable

NOVEMBER 2016

KEY TAKEAWAYS

Effective asthma care includes both clinical treatment and environmental management.

Home visits may help health plans improve quality of life for those with asthma and reduce asthma disparities.

Home-based assessments that reduce exposure to triggers are important elements of quality care.

Health Plan Strategies to Expand Home-Based Asthma Assessments

Improving Access to Comprehensive Care: Educate providers on the need to link clinical services with environmental management, particularly for members with uncontrolled asthma.

Member Engagement: Use culturally and linguistically appropriate educational materials and providers; collaborate with partners to enhance member engagement; link members to trusted health care providers; meet members' non-asthma needs to improve their asthma care.

Staffing and Training: Utilize community health workers to expand reach, effectiveness, and add community expertise; utilize care managers to assist with home-based interventions; engage provider practices.

Partnerships: Leverage partnerships to improve member engagement, expand reach, augment expertise and capabilities, improve community ties, and activate credible and neutral messengers.

Ensuring Cost-Effectiveness: Target high-risk members for greater impact. These include members with uncontrolled asthma, high use of rescue medications, emergency visits, or hospital admissions.

Reach and Scalability: Maximize partnerships to increase reach, scale up programs once they show return on investment (ROI) in pilot testing; address local characteristics when scaling up.

Executive Summary

Asthma is one of the most common chronic diseases of children and adults, impacting 25 million Americans. Poor and minority children have the greatest burden of disease. Adults with asthma lose an average of five days of work each year and children miss four days of school due to asthma. Asthma exacts an enormous financial toll in health care and productivity costs and results in millions of emergency visits and hospitalizations.[1,2]

This report offers findings from a national assessment of health plan asthma care activities and a summary of a 2016 National Asthma Leadership Roundtable. The Roundtable, convened by America's Health Insurance Plans (AHIP) in collaboration with the Environmental Protection Agency (EPA), included leaders from Housing and Urban Development Agency (HUD) and the Centers for Disease Control and Prevention (CDC), and featured discussions with health plan representatives on developing sustainable environmental asthma management programs for culturally diverse populations.

Roundtable participants explored health plan strategies and models for developing and scaling asthma management programs that incorporate both clinical care and home-based assessments and remediation. Health plan representatives described their programs to integrate clinical and home-based care for asthma, along with their approaches to overcome implementation challenges. Health plan case examples presented at the Roundtable are featured throughout this report.

Roundtable discussions focused on ways to expand health plan asthma services to home-based environmental assessments. Asthma program expansions are often carried out through community partnerships. In addition, many plans have expanded their relationships with public health organizations to increase assistance available to their members with asthma.

The models described in this report are pioneering the next generation of comprehensive asthma care, integrating effective clinical care with home-based environmental management. Health plans are developing innovative approaches to overcoming challenges in:

- Member engagement
- Staffing and training
- Partnerships
- Cost and return on investment
- Reach and scalability

By implementing integrated programs and partnerships, health plans are working to enhance access to culturally competent, linguistically appropriate asthma care services for members, and to help reduce disparities in asthma care and outcomes.

This publication was developed under Assistance Agreement XA - 83576401 awarded by the U.S. Environmental Protection Agency. It has not been formally reviewed by EPA. The views expressed in this document are solely those of American's Health Insurance Plans and EPA does not endorse any products or commercial services mentioned in this publication.

Part 1: The Landscape

About Asthma

Asthma is one of the most common chronic diseases of children and adults, impacting 25 million Americans. Asthma is an inflammation and narrowing of the airways that causes shortness of breath, coughing, and wheezing.[1] Certain triggers can cause acute attacks requiring emergency care or hospitalization. Effective control of asthma symptoms requires both prevention and treatment. Prevention includes identifying, avoiding, and removing allergens and other triggers of asthma episodes.

Asthma is extraordinarily burdensome, especially to people with the least resilience and resources. Poor and minority children have the greatest burden of disease: 13 percent of African-American children have asthma compared to 8 percent of non-Hispanic white children. Similarly, 11 percent of poor children and 8 percent of non-poor children have asthma.[2] Asthma is also costly to individuals and society:

- Asthma costs over $50 billion annually in medical expense and lost productivity;[3]
- There are 10.5 million physician office visits annually with asthma as the primary diagnosis;[4]
- Over 1.8 million visits annually to emergency departments have asthma as the primary diagnosis;[4]
- On average, adults with asthma lose five days of work and children miss four days of school each year due to asthma.[5]

In May 2016, AHIP convened the National Asthma Leadership Roundtable to bring together health insurance plans, government agencies, and other stakeholders to share experiences and perspectives about sustainable environmental asthma management programs for culturally diverse populations. Roundtable participants explored health plan strategies and models for developing and scaling such programs. They discussed challenges along with potential solutions. In addition, participants explored best practices for using data analytics and technology to identify and engage both health plan members and health care professionals.

Roundtable participants included representatives from the EPA, HUD, CDC, health plans, and community-based organizations.

This report draws on data and information presented at the Roundtable along with other information created as part of this project. The report provides details on health plan strategies to integrate clinical and environmental asthma care. Through discussion and case examples, it identifies innovations for the foundation of the next generation of integrated asthma care.

What is Good Asthma Care?

High-quality asthma care helps individuals prevent and manage symptoms, thereby avoiding unnecessary hospitalizations and emergency care. Environmental management involves reducing exposure to indoor air triggers that can make asthma worse. Table 1 lists a number of triggers and EPA-recommended remediation strategies.

Standards of care for asthma treatment are defined by the National Institutes of Health National Heart, Lung, and Blood Institute in the Guidelines for the Diagnosis and Management of

Table 1: Taking Action Against Asthma Triggers[6]

Cigarette Smoke	Don't smoke, avoid secondhand smoke
Dust Mites	Use HEPA vacuum, use dust-proof covers on beds and pillows
Mold	Eliminate sources of moisture, use exhaust fans in kitchen and bath
Cockroaches and Pests	Keep areas clean, seal cracks in walls and cabinets, use pesticides cautiously
Pets	Preferably avoid having pets with fur, keep pets out of bedrooms and off furniture, vacuum frequently

Asthma (EPR-3).[7] Critical components of care include:

- Routine use of 'controller' medicines
- Appropriate use of 'rescue' medicines to open the airways immediately
- Avoidance of asthma triggers, such as cigarette smoke, mold, pet allergens, cockroaches, and other pests
- Implementation of clean air management strategies to prevent exposure to triggers
- Continuation of other healthy behaviors, particularly exercise

An Asthma Action Plan that outlines individualized, comprehensive recommendations for medical care and trigger management is recommended for all individuals diagnosed with asthma.[8] The plan defines how the individual will control asthma through medications and prevention, and what to do in case of an acute asthma attack. The Asthma Action Plan is an important tool to educate the individual as well as to communicate treatment and prevention strategies with parents, caregivers, and schools.

Key Partners in Improving Asthma Outcomes

Diverse organizations in the health, environmental health, and housing systems have adopted proactive roles in preventing and managing asthma. Organizations participating in the AHIP Roundtable are identified below, while key stakeholders are identified in the sidebar on page 7. Other important organizations are not listed, including research, advocacy, and support groups that work to reduce the burden and disparities in asthma care.

> "Everything EPA does is ultimately about public health. Asthma is manageable, and we should help people manage it. Innovation abounds in asthma management, with solutions encompassing medical care, housing, the environment, and more. We need to make systemic changes as much as possible to achieve the greatest improvements in people's lives."
>
> — Janet McCabe, Acting Assistant Administrator, EPA Office of Air and Radiation

Federal Organizations

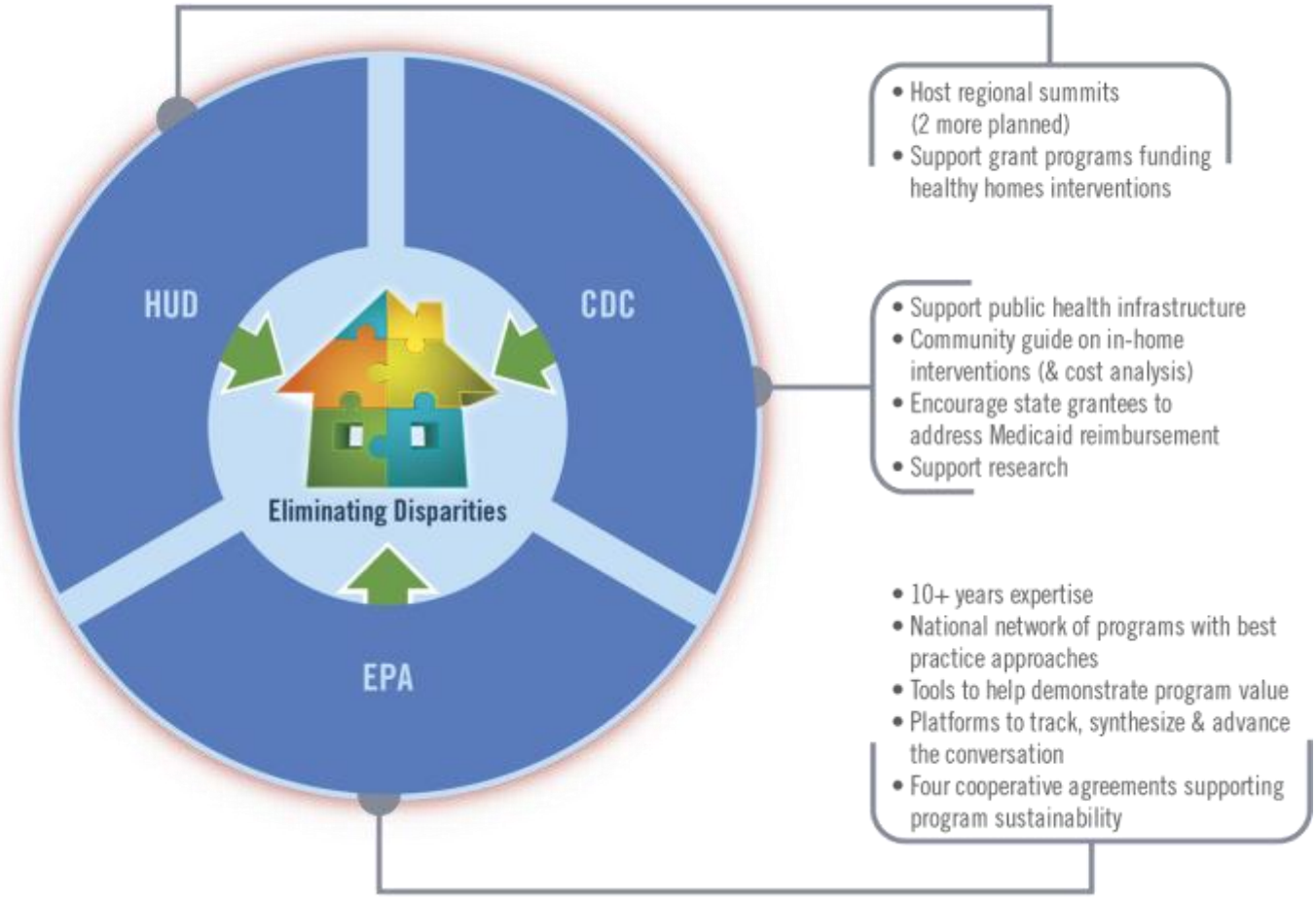
In addition to the National Institutes of Health, which develops guidelines for treatment, three federal agencies have leadership roles in coordinating clinical and environmental care and reducing disparities. Figure 1 illustrates strategies adopted by these agencies to reduce asthma disparities.

EPA: The EPA's coordinated approach to asthma promotes scientific understanding of environmental asthma triggers and ways to manage asthma in community settings through research, education, and outreach.[9]

CDC: The CDC's National Asthma Control Program helps Americans with asthma achieve better health and improved quality of life. The program funds states, school programs, and non-government organizations to help them improve surveillance of asthma, train health professionals, educate individuals with asthma and their families, and explain asthma to the public.[10]

HUD: HUD works with federal partners to highlight the value of residential interventions for pediatric asthma and to encourage the initiation of pilot programs that include reimbursement by health insurers. With local partners, HUD is holding a series of meetings that provide information on the efficacy and cost-effectiveness of in-home interventions and highlight local and national programs that deliver effective in-home asthma interventions.[11]

Figure 1: Federal Strategies to Reduce Asthma Disparities



Health Insurers

Health insurance plans have long been committed to improving the lives of individuals with asthma through comprehensive asthma management strategies. Their approaches involve:

- Promoting evidence-based asthma interventions to improve quality of care and lower health care costs;
- Adopting data analytics and outreach programs to identify and engage members in patient-centered asthma care programs;
- Partnering with regional, state and community-based organizations to augment their capabilities; and
- Developing culturally and linguistically appropriate care for their members.[12]

Health Plan Industry Trends

Health Plan Asthma Performance

For many years, health plans have taken active steps to improve the quality of clinical care for asthma. Many of these strategies rely on data analysis and information sharing to drive improvements. The following are examples of how health plans leverage data to collaborate with providers, engage members, and improve clinical programs:

- Analyze claims data to identify members with asthma who may need additional support or intervention;
- Analyze pharmacy data to flag members who have not refilled prescriptions for 'controller' medications, or to identify members who use a lot of 'rescue' medications, indicating the member may need a stronger controller medication;
- Alert members' physicians about the need for additional education and management so that physicians can contact members with treatment improvements; and

Partners in Asthma Care

Clinicians:
Physicians, nurse practitioners, and other health care professionals diagnose, treat, and educate patients with asthma and can initiate a comprehensive Asthma Care Plan. Clinical practices may include care coordinators, respiratory therapists, or asthma educators to provide patient education. Provider organizations designated as patient-centered medical homes (PCMHs) organize and coordinate care to maintain health and control chronic disease, including asthma.

Care Coordinators and Educators:
Community health workers, nurses, asthma educators, respiratory therapists, and other individuals educate individuals, assess needs, and help implement remediation in the home. This workforce can be deployed by physician groups, community-based organizations, health departments, or health insurers to improve comprehensive asthma care.

Community-Based Organizations, State and Local Health Departments:
Health departments and community-based organizations help to disseminate population-based health improvement programs. They promote health of individuals, as well as environmental and community-based improvements that create a healthier community. State and local health agencies work with the CDC to implement chronic disease prevention and management programs and to promote health at the community level.

Individuals:
Effective asthma management takes a lot of work for individuals and families. People with asthma need to take preventive medications and avoid triggers, as well as take active steps to control environmental allergens. Education and engagement are critical to good outcomes.

- Monitor data on emergency department use and admissions for asthma, and use this information to connect members to better chronic care services.

Many of the Case in Point examples illustrate how health plans use data to develop, target, and evaluate the impact of their asthma improvement interventions.

Health plans are required to report quality data to states, customers, and the Centers for Medicaid and Medicaid Services (CMS). Clinical indicators for health plans are most commonly measured through the HEDIS© data set. Asthma-specific HEDIS© measures assess effectiveness of medication management for adults and children with asthma, the use of controller versus rescue drugs, and overall 'resource use,' which captures the use of preventable emergency care and readmissions.[13] Health plans perform well on HEDIS© asthma care measures, consistently scoring around 90 percent on the 'asthma medication rate' for members in commercial plans and around 84 percent for Medicaid members.[14] However, that difference in performance rates of plans serving commercially insured members versus Medicaid members and a plateauing of performance indicates there is still opportunity for improvement. Adding home-based assessments to asthma care is another strategy to close quality gaps, and possibly to reduce disparities in asthma care for low-income and racial and ethnic minority populations.

> "Health plans offer credible voices for getting the message out about the linkages between housing and asthma. HUD is making systemic changes in public housing to improve indoor environmental quality and safety, which in turn should benefit the heath of residents. For example, HUD is moving to create smoke-free housing and offers training on pest management, in addition to hosting asthma summits."
>
> — Peter Ashley, Director, Policy and Standards Division, HUD Office of Lead Hazard Control and Healthy Homes

2015 Assessment of Health Plan Strategies for Managing Asthma

In 2015, as part of its cooperative agreement with the EPA, AHIP conducted a study of health plan strategies for managing asthma and incorporating environmental asthma management into comprehensive asthma care programs. The study included an assessment of health plan practices, followed by individual leadership interviews. A total of 59 health plans serving commercial and/or Medicaid members responded. There were 31 responses that pertained to commercial and 28 responses that pertained to Medicaid. The assessment examined health plans' overall asthma management strategies, including efforts to improve asthma care through both clinical and environmental quality improvement. It also identified key challenges to adopting home-based programs. Follow-up interviews examined barriers to effective asthma management strategies, resources, partnerships, member engagement strategies, payment and delivery methods, and sustainability.

Health Plan Asthma Services

As Table 2 shows, the large majority of both Medicaid and commercial plans offer asthma self-management education, asthma education, and disease management. In addition, 79 percent of Medicaid plans and 77 percent of commercial plans offer non-home-based social services. Digital/telephonic assessments are conducted by 93 percent of Medicaid plans and 68 percent of commercial plans.

Table 2: Health Plan Services to Improve Asthma Care		
Non-Home-Based Services Offered	**Medicaid**	**Commercial**
Self-Management Education	93%	100%
Asthma Education	93%	100%
Disease Management	96%	100%
Social Services	79%	77%
Digital/Telephonic Assessment	93%	68%

Health plans have adopted a variety of techniques to engage members in their asthma care. Some health plans offer asthma-specific case management, while others address asthma in the context of members' health and psychosocial issues that impact health improvement. Table 3 depicts engagement strategies most frequently reported. Both Medicaid and commercial plans are near or above 90 percent for many of these strategies.

Home-Based Assessments

Home-based asthma management services are not yet ubiquitous, although many Medicaid health plans – which serve high needs, low-income families - have adopted home-based programs. More Medicaid plans than commercial plans provide home visits and remediation services for members with asthma than do commercial plans. This is consistent with the

Table 3: Member Engagement Strategies		
	Medicaid	**Commercial**
Providing asthma information based on principles of clear health communication	93%	90%
Tailoring care management plans	93%	90%
Using an asthma action plan	93%	90%
Increasing member confidence to perform asthma self-management behaviors	93%	87%
Offering vouchers for asthma products	50%	32%
Mapping technologies to track triggers by geography	46%	29%
Transportation to appointments	93%	42%
Offering assessments at members' preferred hours	79%	35%

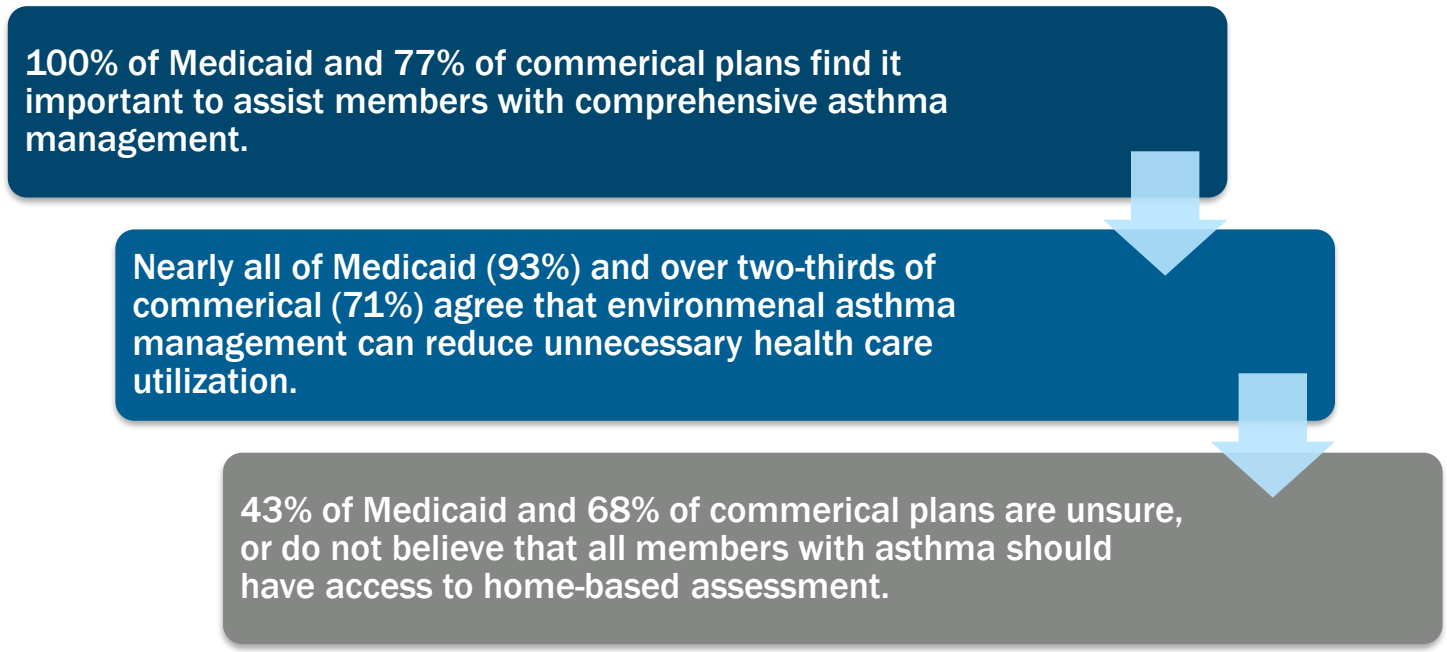
Table 4: Health Plans' Home-Based Services to Improve Asthma Care		
Home-Based Services Offered	**Medicaid**	**Commercial**
Home-Based Environmental Education	57%	29%
Home-Based Environmental Assessments	61%	23%
Home-Based Environmental Remediation	39%	13%

benefit structure of Medicaid, which offers plans more flexibility to deliver services for low-income members that support health and health care engagement.

As shown in Table 4, AHIP found that 57 percent of Medicaid plans and 29 percent of commercial plans offer home-based environmental education to members with asthma; 61 percent of Medicaid plans and 23 percent of commercial plans offer home-based environmental assessments. A smaller percentage, 39 percent of Medicaid plans and 13 percent of commercial plans, offer home-based environmental remediation.

Health plan leaders agree that assisting members with comprehensive asthma management is important. Indeed, 100 percent of Medicaid and 77 percent of commercial plans find it important to assist members with comprehensive asthma management. Nearly all of Medicaid (93 percent) and 71 percent of commercial health plans agree that environmental asthma management can reduce unnecessary health care utilization, but, as Figure 2 illustrates, 43 percent of Medicaid plans and 68 percent of commercial plans are unsure or do not believe that all members with asthma should have access to home-based assessments. These

Figure 2: Health Plan Perspectives on Comprehensive Asthma Management



findings suggest that health plans recognize the importance of home-based environmental assessment as a strategy to improve quality and reduce unneeded utilization; but, they may believe that targeting high needs members is the most effective approach.

Sharing of best practices among health plans may lead to both increased awareness of the need to integrate home-based services with comprehensive asthma management programs and a better understanding of the most effective strategies to do so.

Challenges to Implementing Home-Based Assessments for Asthma Care

Health plans face challenges implementing home-based asthma management programs, including:

- Member Engagement: Health plans are often challenged to contact or locate members, who may move frequently or change phone numbers. In addition, many plans find it challenging to provide health education in ways that promote healthy behaviors and are meaningful to members with diverse backgrounds and complex lives.

- Staff and Training: Health plans may be challenged to find the right clinical and non-clinical staff to meet the needs of members. Staff need knowledge and skills as well as capabilities in cultural competence and members' languages. When new skills are required, such as home-based assessments, plans must find effective ways to recruit and train staff.

- Partners: Plans may need to augment their capabilities through partnerships. There is a need to find effective partners and foster collaborative long-term relationships.

- Cost and Return on Investment (ROI): The high cost of home-based assessments is a barrier. Health plans must justify financial commitments in health care promotion by showing a return measured by reduced costs or health improvements.

- Reach and Scalability: As health plans develop environmental management programs, they are challenged to meet the needs of members throughout their service areas. They need metrics to demonstrate effectiveness and capacity to expand programs that are successful.

Figure 3 provides details on some of these challenges.

Health plans cite specific challenges relating to delivery of home-based asthma assessments. These include:

- Members' hesitance to allow health care workers into the home;
- Members' social/economic burdens may take priority over the need for environmental asthma management;
- Members cancelling home visits;
- Inability to improve the immediate environment if landlords do not address building-wide issues; and
- Medication adherence.

The 2016 National Asthma Leadership Roundtable was convened to examine challenges identified in the 2015 AHIP Assessment and to share strategies for overcoming these challenges. Health plans discussed incorporating home-based assessments with clinical asthma quality improvement initiatives. The Roundtable discussion is featured in Part 2 of this report.

Figure 3: Health Plan Challenges Implementing Comprehensive Asthma Care Programs

Cost

- Determing how to fund services; best payment structure (e.g., claims based, PMPM).
- Identifying the necessary resources to develop, implement, and sustain a program.
- Incorporating home-based services and the use of non-clinical providers.

Return on Investment

- Lack of health plan specific information on the value of home assessments.
- Clinical considerations — do health outcomes outweigh programmatic costs?
- Financial considerations – can a health plan break even?

Staffing

- Home assessments require full time staff and after hours availability (not a 9-5 job).
- Identification of triggers, multiple follow-up visits and coaching are resource intensive.
- Large caseloads can lead to staff shortages. How to staff such a program?

Member Engagement

- Identifying and stratifying eligible members with asthma.
- Working with transient members and members in geographically hard-to-reach areas.
- Engaging members reluctant to have people in their home even after scheduling visit.
- Addressing more than triggers (SES concerns, culturally-relevant and tailored materials).

Partnerships

- Identifying community partners to work with across states and regions.
- Building a network of trained professionals to help implement program/reduce health plan staff burden.
- Learning from partnership models used by other plans.

Reach and Scalability

- Scaling across multiple states and/or regions.
- Reaching diverse populations (geographically, ethnically and racially diverse).
- Managing competition with vendors; inability to reach/work with landlords.
- Demonstrating ROI to support scaling.

Part 2: Next Generation Asthma Care — Leadership Roundtable

AHIP's Asthma Leadership Roundtable was convened in collaboration with the EPA to understand the challenges to implementing home-based assessments for asthma management, and to identify health plan strategies to overcome those challenges. This section highlights pioneering approaches for implementing home-based, environmental asthma management programs. Each sub-section delves into key issues and presents brief Case in Point examples from plans participating in the Roundtable. Selected highlights from these case examples are summarized in Table 5.

Common themes from the Roundtable were the need for partnerships with federal, regional, and community stakeholders; strategies and tools to engage consumers in their care; and approaches to scale and sustain asthma programs that include home-based assessments.

Table 5: Health Plan Innovations to Integrate Home-Based Asthma Care*

Challenge	Organization	Innovation
Member Engagement	BMC HealthNet	Includes services to meet members' behavioral health needs and link with social services such as housing
	Molina Healthcare	
	Anthem	Develops programs that are culturally and linguistically appropriate to increase trust, engage, and educate members
	Affinity Health Plan	Supports development of medical homes to improve asthma care, and provides wrap-around services (e.g., referrals for behavioral health, social services)
	Neighborhood Health Plan	Uses health workers who provide asthma-related products at each visit, such as a vacuum cleaner, mattress cover, or air purifier
Staffing and Training	AmeriHealth Caritas	Hosts an annual community health fair and encourages staff to get to know community partners to build relationships and improve engagement
	BMC HealthNet	Employs community health workers to do home assessments and partners with the Massachusetts Department of Health to provide training
	Health Care Service Corporation	Supports intensive clinic-level provider training to improve quality and asthma management at the provider-level through a community partner

Next Generation Asthma Care

Challenge	Organization	Innovation
Partnerships	Anthem	Partners with a.i.r. nyc, a community-based organization that delivers culturally competent asthma care
	AmeriHealth Caritas	Partners with a pharmacy service supplier to provide onsite inhaler dispensing at provider offices and improve medication refill rates
	Health Care Service Corporation	Partners with the regional American Lung Association affiliate to deploy consistent standards of care and targeted education, in addition to tracking outcomes through key metrics
Cost and ROI	Priority Health	Provides incentive payment to providers that become medical homes and incorporate asthma quality measures
	Health Care Service Corporation	Uses data to prioritize interventions for members where they will have the most impact, such as reducing readmissions or where there is high asthma incidence
	Anthem	
	Neighborhood Health Plan	Uses an asthma home visit code and reimbursement rate for home visits, and a cost predictor tool
	Anthem	Conducts test to assess cost and effectiveness before rolling out interventions on a wider scale
	Molina Healthcare	
Reach and Scalability	Molina Healthcare	Trains non-clinical community health workers to educate members and conduct home assessments
	BMC HealthNet	
	Health Care Service Corporation	Engages entire clinic staff to create sustainable change. Once changes are made to improve asthma care, the plan works to replicate the intervention model to improve care for other chronic conditions
	Molina Healthcare	Uses non-traditional provider partners such as Visiting Nurse Associations and pharmacy students to expand reach and effectiveness
	BMC HealthNet	
	Anthem	Uses data to identify communities with high prevalence of asthma to launch programs, and considers program expansions to other communities based on evidence of effectiveness

*The examples in this table illustrate some but not all strategies adopted by these plans

Member Engagement

People with asthma may have difficulties balancing their health care needs with other issues in their lives. Health plans have devised strategies to capture their members' attention in order to provide asthma education and an action plan. Home-based assessments themselves are an innovation that engages members. The personalized visits help members to identify and understand asthma triggers in their own homes. Other member engagement strategies adopted by plans include:

- Developing culturally and linguistically matched programs for the communities served;
- Engaging partner organizations to increase local presence and member trust;
- Offering asthma-related incentives for providers and members; and
- Helping to address barriers members may face due to other health or social issues.

Many plans recognize that offering care and education in a culturally and linguistically appropriate way makes a difference in both member engagement and impact. Anthem's partnership with a.i.r. nyc illustrates how working with a trusted community partner to provide culturally competent services can improve member engagement and improve their health.

Additionally, plans recognize the importance of understanding how members prioritize their needs (which may not always be asthma-related). Many have developed strategies to address other member needs while also offering asthma interventions. For example, BMC HealthNet and Molina Healthcare bolster member engagement by ensuring resources are in place to meet members' mental health and psychosocial needs, necessary precursors to health improvement.

Case in Point: Anthem

The Opportunity: As Anthem reviewed its data, asthma surfaced as preventable utilization. The plan decided to pilot test the asthma initiative in areas of high density of members with the condition. This provided the opportunity to create a scalable intervention and to have a large enough cohort to see if the program had an impact.

The Strategy: Anthem initially started with a celebrity spokesperson strategy, recruiting a former soccer star and a chef to be a part of their program. Program developers soon recognized they needed to go to members, rather than expect the members to come to them.

The Program: Anthem launched three unique asthma management programs in 2015, each tailored to ensure cultural and linguistic relevance to the target communities:

- One program is with a large pediatric pulmonology practice. The practice's certified asthma educators conduct home assessments and develop patients' asthma action plans with providers and families. By working with the group practice, the asthma intervention is part of an integrated care continuum for members.
- A second program is with a large medical center. Primary care physicians, community health workers and certified asthma educators deliver the asthma education. The medical center's community health workers conduct the outreach and home assessments. The community health workers and providers work together with the patients to implement care management plans.
- A third program is with a community-based asthma care management nonprofit, a.i.r. nyc. a.i.r nyc meets with families and conducts home assessments.

Results Thus Far: Developing effective asthma management programs is a 'journey' that requires investigation to figure out what works and what doesn't.

Presenter: Lauren Howard, Clinical Program Development Manager

The Drill Down on Community-Based Services: a.i.r. nyc

a.i.r. nyc operates a community-based care coordination program in which community health workers deliver evidence-based, multi-component asthma self-management services in the home. Their services include care planning, home assessment, and patient education. Drivers of success include rigorous staff training, using data and technology to establish metrics, supervision, and support. a.i.r. nyc reports back on performance to health plans and tracks its own measures of effectiveness.

Staffing and Training

Home-based environmental asthma management programs require different staff capabilities than traditional clinical or care management programs. For example, home-based assessments may need to be carried out after regular working hours and may require follow-up visits, which can be time consuming and labor intensive. Plans' asthma management staff, clinicians, or care coordinators may need additional training to conduct home assessments. Health plans may need staff that understand the culture and speak the language of members to build the trust needed for a successful home visit.

Plans work to determine the optimal staffing model for home-based assessments. Hiring staff enables the plan to provide training and integrate the assessments with other health plan programs, but may increase administrative costs. Contracting with another organization to provide the services enables the plan to access specific expertise and ties to the community. Innovative approaches include:

- Expanding the health plan care management program to include home-based assessments;
- Hiring community health workers that reflect the communities they serve;
- Contracting with trusted community-based organizations to conduct home visits;
- Training providers or enhancing PCMH services to include more comprehensive asthma management services;
- Partnering with a health department for staff training on environmental assessments; and
- Using expert-developed tools and resources such as the EPA home assessment guide.

Many health plans recognize that when they make home visits, the visitor may frequently find that the member has other issues that need to be addressed. Some issues, like the need for mental health services, can be handled through staff training and referral systems. A need for pest management services, for example, may require another set of community partnerships. Success of some home remediation services – such as smoke-free buildings or pest control - may depend on cooperation by building landlords, which remains challenging. This is an area where public health partnerships and HUD involvement plays an important role.

The Case in Point example from Boston Medical Center HealthNet illustrates both the plan's partnership for home-based assessment training, and its approach to helping members resolve issues identified during the visit.

Case in Point: Boston Medical Center HealthNet Plan/Well Sense Plan Health

The Opportunity: This asthma management program was initially implemented several years ago, relying solely on telephone calls to engage members. The organization quickly recognized that their members had more pressing concerns than simply managing one disease.

The Strategy: BMC HealthNet revised its original model to reach more members and better meet their needs, to reduce language barriers that impact health care, and to offer culturally appropriate services. The plan's philosophy is 'Meeting members where they are.' That means doing whatever the member needs to help them manage their health. Health plan care management staff will meet members at home, in provider offices, or in the community, including homeless shelters, coffee shops, etc. A staffer might call a member to talk about asthma and end up talking about another health or psychosocial challenge. The aim is to do what they need to for a member so their health can become a priority.

The goals of the program are:

- Engage members
- Improve medication adherence
- Help members better understand both asthma and asthma triggers
- Improve communication with providers
- Increase appropriate utilization of services

The Program: The health plan developed infrastructure, education, and partnerships to implement asthma interventions. The health plan*:*

- Provides asthma care management via telephone, in-person, and embedded in provider offices
- Includes social workers and behavioral health staff are on the care team, and a pharmacy team reviews medications and prescription fill patterns. Community health workers provide home environmental asthma assessments
- Offers real-time data access for providers to optimize holistic care management

Partners:

- Visiting Nurse Associations provide asthma visits and additional support outside the community health workers' territory
- Massachusetts Department of Public Health provides health worker training
- American Lung Association provides inhalers
- The police department provides staff safety training

Community Health Workers:

- Play an essential role in asthma home assessment and home care visits
- Complete an EPA home assessment tool for asthma triggers along with a "My Medication" list
- Identify the need for mattress covers and other support
- Provide members with an asthma action plan

Results Thus Far: The plan has staffed up to nine in-house community health workers. Although the plan is early in its asthma home-based management program, nurses and community health workers have been engaging with members. The plan will continue to collect asthma data to evaluate the results of this program.

Presenter: Jean-Marie Javorski, Manager of Care Management

Partnerships

Asthma cannot be resolved by medication alone – it is a public health issue that can be more effectively addressed by tackling multiple factors that can trigger attacks. Collaborating with communities and public health organizations serves to address many of these factors. Health plans also collaborate with physicians to improve quality and care coordination.

Innovative health plans recognize the need for partnerships to promote health. To maximize the value of partnerships, health plans bring in partners that offer the expertise and community ties that support asthma program goals and ensure coordination of partner programs and data.

Organizations that work effectively with partners know that each partner needs to understand their roles. Questions to consider when evaluating partners include:

- What core competency does the partner to bring to the table? (In the case of asthma home assessments, many plans seek partnerships to bring in expertise in home-based asthma assessments, expand the reach of the plan, and bring needed cultural/linguistic competence.)
- What method of compensation will work with the partners?
- How can data and information obtained by the partner be integrated in the plan system?
- How can partners contribute (by handoffs or referrals) to meeting other member needs that are identified?
- What can the plan do to maximize internal awareness about partner organizations?
- What metrics or indicators are used to hold partners accountable for their performance?

As shown in the next Case in Point, AmeriHealth Caritas has developed effective strategies to work with community-based partners to deliver culturally competent services to members. The Case in Point focusing on Priority Health demonstrates the plan's partnership with the Asthma Care Network of West Michigan (ANWM), as well as its work to promote development of medical homes to improve quality of care.

Case in Point: AmeriHealth Caritas Family of Companies

A 2016 Winner of EPA's Asthma Leadership Award

The Opportunity: AmeriHealth Caritas has about 1.8 million primarily Medicaid members. In some communities located in the company's Philadelphia plan, one in four children has asthma.

The Strategy: AmeriHealth Caritas uses an evidence-based, integrated, population health approach to providing access to asthma medication and supplies, asthma education, environmental assessments, and community-based interventions. In 2016, AmeriHealth Caritas was one of four organizations to receive the National Environmental Leadership Award in Asthma Management from the Environmental Protection Agency (EPA) to honor innovative asthma programs. The EPA recognized AmeriHealth Caritas for its comprehensive asthma management program that is helping Medicaid recipients and their families better control their asthma exacerbations.

The Program:

- Care Management: Care managers and community health workers provide face-to-face and telephone support for members and their families and mitigate social determinants of health. AmeriHealth Caritas hires community health workers in-house and provides safety and de-escalation training.
- Environmental Management: AmeriHealth Caritas supported the delivery of 875 asthma home kits from 2013 through 2015. The kits included hypoallergenic mattress and pillowcase covers, storage bins, trash bags, cockroach bait stations, and cleaning supplies to help reduce environmental asthma triggers in members' homes.
- Partnerships: AmeriHealth Caritas partners with multiple organizations.
  - The plan hosts an annual health fair to which they invite all their community health organizations to strengthen relationships between staff.
  - AmeriHealth Caritas partners with providers to support the role of care managers and community health workers in delivering community-based care.
  - AmeriHealth Caritas started the Breathe Easy. Start Today. ® (B.E.S.T.) program with a pharmacy services supplier to provide medication dispensing cabinets in clinicians' offices. Members can get their medication from the clinician along with instructions on how to use it during their visit. Participation in the dispensing program also triggers a refill reminder. Members may be called by the pharmacy services supplier to arrange delivery of the refill to the home.

Results Thus Far: AmeriHealth Caritas has gotten very positive responses from providers about the community health programs. For example, providers like that they get medication adherence data, including medication adherence data from the plan. Over three years, the asthma quality improvement program led to statistically significant improvements in asthma controller medication adherence rates, acute hospitalizations, and hospital readmissions.

Presenter: Karen Michael, Vice President, Corporate Medical Management

Case in Point: Priority Health

A 2007 Winner of EPA's Asthma Leadership Award

The Opportunity: Priority Health is a non-profit health plan that serves more than 19,000 people with asthma in 43 Michigan counties. In the late 1990s, Priority Health recognized the need for home-based asthma care that includes environmental trigger management. It became the first health plan in the U.S. to fund community-based asthma care management in the home.

The Strategy: Priority Health formed first-of-its-kind partnership with the Asthma Care Network of West Michigan (ANWM) using their case managers and social workers (all certified asthma educators) to increase its ability to assess and educate its members. ANWM provides home-based asthma education, home environmental assessments, and resources to reduce exposures to environmental asthma triggers.

The Program:

- Inspired by EPA's call to action on asthma and to improve member engagement, Priority Health implemented a patient-centered medical home (PCMH) model to improve access to care for children with Medicaid. The plan providers develop services aligned with the Children's Health Access Project (CHAP), a patient-centered home model for children with Medicaid designed to improve access to health care.
- Priority Health incorporated care managers, armed with health plan data, into pediatricians' offices to scale the program. The plan also collaborates with ANWM to deliver full range of services for members with asthma, including in the home.
- Priority Health's members with moderate or high risk asthma within ANWM's service area receive intensive case management that integrates patient education, home-based environmental interventions, and evidence-based clinical care.
- Priority Health reimburses ANWM for meeting with providers to develop individualized care plans, as well as meeting with school staff to review asthma management in schools.
- Priority Health also provides incentives to their providers to implement a PCMH and ensure that members use asthma medications appropriately.

Results Thus Far: All 20-plus pediatric practices, serving about 80 percent of Priority Health's Medicaid members, are CHAP medical homes. Outcomes include double-digit percentage reductions in ER visits and hospitilizations. Engagement is up to 85 percent under the CHAP model because of close collaboration with providers, patients, and the Asthma Network. Missed school days have been reduced by 50 percent. The cost savings and return on investment from the program have been strong as has member satisfaction.

Presenter: Mary Cooley, Associate Vice President, Care Management and Operations

Cost and Return on Investment

Health plans are wrestling with both how to fund home-based assessments and what the payment structure might look like. Typically, plans analyze data to capture quality improvements that directly benefit members and to assess changes in cost and return on investment (ROI). Adding home-based environmental assessments adds cost and complexity. Plans must ensure that investments in these types of programs have a 'return' in either cost reductions or health improvements.

Health plans are adopting cost and quality measures to evaluate the impact of home-based assessment programs. Identifying the right metrics is an important element in assessing cost and ROI. Changes in utilization such as reducing emergency care or reducing hospital admissions are easily quantified. Home-based assessments may have an incremental impact, and thus may be more difficult to measure.

Administrative issues are also a concern. Health plans are under pressure in commercial and Medicaid markets to keep administrative costs low. Some plans are concerned that home-based services delivered by community health workers might not be considered "medically related." Lack of billing codes for home-based assessments can make it difficult to reimburse and track these services.

To mitigate the challenge, Neighborhood Health Plan, described in the Case in Point below, developed a billing code for asthma home health visits. Affinity Health uses data driven asthma management coordination and evaluates changes in utilization to asses cost and ROI. Several other plans at the Roundtable also developed billing approaches, and use community health workers to deliver home assessments cost effectively.

> "Comprehensive asthma control programs can have quick (1-2 year) return on investment, including reducing emergency department visits by as much as 68% and hospitalizations by as much 85%. CDC's National Asthma Control Program has summarized the evidence supporting comprehensive services and is identifying the most effective strategies and models to put those services on a fast track to implementation."
>
> — Elizabeth Herman, MD, MPH, Senior Scientist, CDC's National Asthma Control

Plans participating in the Roundtable use parallel strategies of managing cost and measuring return to justify their investment in home-based assessments. They use public health partnerships to share costs, manage costs carefully, and measure the impact on health care utilization. Many innovative health plans also note that it takes time to show ROI for new programs, and that it is important to allow enough time to implement, adjust the program, and measure results.

In the future, a shift to value-based care and accountable care organizations may change provider views on investments in prevention. With new financial incentives to keep people healthy, health care providers may consider home-based care – including asthma assessments – more within their scope of services.

Case in Point: Neighborhood Health Plan

A 2010 Winner of EPA's Asthma Leadership Award

The Opportunity: Neighborhood Health Plan (NHP), an organization serving 450,000 members (70% Medicaid, 30% commercial), has an active community-based asthma initiative.

The Program:

- Registry and Data: NHP uses registry information along with other systems to review data and identify high-risk members. NHP's asthma registry now lists 22,000 members. The plan makes data available for providers to see which patients had hospitalizations, emergency department visits, and more. If a patient is hospitalized with asthma, the system is triggered to send a letter informing the provider.
- Home Visits: Staff may make up to three home visits to find asthma triggers. When appropriate, the plan offers air purifiers, bed and pillow encasements, and a vacuum cleaner with a HEPA filter.
- Linkages: Staff commonly find that members are worried about far more than just asthma, so the program is coordinated with other member support services. Asthma home visitors are very skilled at navigating the broader system.
- Incentives: To encourage members to allow plan staff to visit, the asthma home visitor typically brings something each time to encourage the member to let them in (e.g., pillow encasements, vacuum cleaners, air purifiers).
- Partnerships: The plan partners with the local public health department and the Boston Asthma Home Visit Collaborative.
- Provider and Community Education: Educational materials can be ordered for free from NHP's website. The plan has also used the materials in the Boston schools. Parents love the DVD, which features kids and young adults talking about having an inhaler and how to use it properly.

Results Thus Far: NHP developed a cost predictor tool as one approach to evaluating cost and impact. It is difficult to assess the program's impact long term, however, since members enroll and dis-enroll frequently based on eligibility. Although ROI is difficult to quantify, the plan has impacted quality measures: the plan's hospitalization rate for asthma is below two percent versus a reported nationwide rate of 10%.

Presenters: John Pruett, Asthma Care Manager
Ellen Whitney Sharpe, Clinical Manager, Disease and Conditions

Case in Point: Affinity Health Plan

The Opportunity: This plan started by using asthma data to stratify its population. The plan started by identifying members with at least two emergency room visits for asthma, and expanded the asthma program to include people admitted to the hospital with a primary diagnosis of asthma.

The Strategy: Affinity's model is a patient-centered care model that incorporates community resources, clinical decision support, and patient self-management and support. The asthma intervention is focused on improving access to resources for patients. The program works to augment trusting relationships between patients and providers.

The Program:

- Home Visits: Patients are invited to have a home intervention where a clinical environmental action plan assessment and patient education are completed. Assessments are done by respiratory therapists. Information collected during the home evaluation is communicated back to the primary care physician and to Affinity's case managers.
- Medication Adherence: Affinity's asthma managers show members how to use their inhalers, keep an eye on their medication adherence, and educate members.
- Practice Improvement: Affinity works with a provider 'champion' who can spearhead changes at the practice level. Champions help providers to prioritize asthma care and to enable conversations with patients about asthma management.
- Referral Resources: Providers are also encouraged to leverage plan resources. Where patients have complex health or social service needs, providers can refer patients back to Affinity. The plan may bring in behavioral health professionals or other resources as needed.

When asthma managers identify the need for external remediation of environmental problems in the home, the only intervention currently available is to provide advice and simple solutions like mattress covers. The organization does not yet have a system in place to refer for pest management, but anticipates collaborating with public health organizations for this capability.

Results Thus Far: Affinity has seen important improvements in outcomes including a 60% decrease in hospital admissions and a 13% decrease in emergency room visits. Critical success factors include:

- Engaged leadership
- Engaged patients
- Home assessments
- Patient education (in-person and home-based)
- The health plan as a resource (and linking to providers and other community and clinical resources)
- Actionable and manageable data

All the pieces have to be in place to achieve results.

Presenter: Loredana Ladogana, Medical Director

Reach and Scalability

To test expansion strategies and scalability, many plans start out with a pilot program to incorporate home-based environmental assessments into existing asthma programs. They may use outside partners such as community-based organizations to expand capacity or scale up quickly. For example, Health Care Service Corporation partnered with the American Lung Association of the Upper Midwest and targeted high volume clinics to reach the most acute patients. That plan intends to expand their partnership and training program after showing results. Anthem is testing multiple approaches in one high prevalence area, to determine how best to scale efforts and reach members.

Not all plans develop one approach and then scale it up. For example, Molina Healthcare plans to develop different models in different states, aligned with community-specific needs and resources. While scaling up is important, scalability does not mean 'one size fits all.'

Case in Point: Health Care Service Corporation (HCSC)

The Opportunity: HCSC operates through Blue Cross Blue Shield ® Plans in Illinois, Montana, New Mexico, Oklahoma, and Texas. The company's asthma improvement program was established as a 'community investment program' in response to startling trends of higher hospitalizations and emergency department visits related to asthma across the company's five states.

The Strategy: The objectives of the program are to implement sustainable and focused interventions to improve health outcomes for patients with asthma and reduce inappropriate health care utilization.

The Program: The asthma improvement program is operated as a partnership with the American Lung Association (ALA) of the Upper Midwest.

Provider-level Improvement: The program enables the ALA to work directly with clinicians to improve the quality of care delivered to patients with asthma. Utilizing the ALA's evidence-based framework, clinics are equipped to enhance the standard of care for children with asthma—along with parent/caregiver education to better manage asthma on a daily basis.

- Identifies clinics serving large populations of high-risk asthma patients
- Recruits clinics for a year-long training program to improve quality of care
- Utilizes a quality improvement framework
- Measures both self-reported data from clinics and claims analysis outcomes from HCSC

Health Plan Initiatives:

- Expand partnership to include home environmental improvement visits targeting individuals experiencing hospitalizations despite the participating in the program
- Support environmental improvements by providing pillowcases, mattress covers, furnace filters, and eliminating triggers such as mold, candles, and air fresheners
- Create a large-scale awareness campaign, Taking on Asthma, to leverage the program's best practices and share with the provider and caregiver communities.

Results Thus Far: ALA uses about six different quality indicators to measure program success. Case studies from clinics show overall improvements across each metric at both 12 and 18 months after intervention, demonstrating improved quality of care in addition to creating sustainable change within the clinic. HCSC claims analysis shows significant decreases in both hospitalizations and emergency department visits for members receiving services through a participating clinic. Some clinics experience as much as an 80 percent reduction in hospitalizations and emergency department visits for these high risk patients. In addition, patients are better managing their condition. The company has seen cost savings for members in the program due to a decline in unnecessary health care utilization. Preliminary results show a return on investment, with cost savings exceeding the cost of the partnership. Based on these positive results, the company has provided additional funding to the program and plans to replicate the approach. As the program progresses, HCSC expects new data on patient care and home assessments will inform systemic needs and intervention strategies.

Presenter: Bridget Burke, Director of Public Affairs

Case in Point: Molina Healthcare

The Opportunity: Molina Healthcare plans provide quality health care to people receiving government assistance. Molina has developed locally-based pilot asthma management programs with the goal of improving health outcomes while saving on costs.

The Strategy: The plan's strategy is to test pilot programs based on local needs, using local resources wherever possible.

Programs:

- In California, where the challenge is getting people into the program, Molina works with the Long Beach Alliance for Children with Asthma to engage community members.
- In Illinois, Molina collaborates with the state's department of public health and the Southern Illinois University Edwardsville through a CDC grant to identify members eligible for their *Asthma Home Assessment Referral Program*. The program focuses on high-risk asthmatics, children and adults, in the East St. Louis area, primarily addressing environmental triggers at home as well as providing some basic asthma education around the disease state and inhaler therapy.
- In Florida, Molina hired community health workers (e.g., Community Connectors) to educate members in their homes. In addition, the Community Connectors can go to the pharmacy to pick up the member's medication once the physician has faxed the prescription to the pharmacy, and can deliver the medication to the member's home. (A New Mexico study demonstrating the effectiveness and value of community health workers prompted Molina Healthcare to expand its use of community connectors.)
- In Michigan, Molina Healthcare is partnering with ClearCorps Detroit and Wayne Healthcare Access Program to address asthma-related behaviors, medical regimens, and home-based asthma triggers. Work is being done with the most vulnerable children with asthma in Detroit. A ClearCorps representative and Molina Community Connectors review home-based asthma triggers after the family agrees to participate. Home modifications are then made based on community-based funding from a local non-profit foundation.

Moving Forward with Community-Based Interventions: Molina recognizes the importance of implementing community-based interventions that combine asthma education with needed home modifications to address asthma triggers. The plan has identified key lessons learned that will complement future interventions:

- Community- and home-based visits are vital for adults and parents of children with asthma who may be non-adherent.
- Locating people is an important first step. Using a data-driven and interactive tool to identify appropriate member contacts has increased Molina's ability to reach members more quickly than traditional outreach methods.

Presenter: Deborah Wheeler, Assistant Vice President for Quality

Conclusion

AHIP's cooperative agreement with the EPA has helped to increase awareness of the need to integrate home-based assessments as part of next generation comprehensive asthma management programs. Data from the AHIP assessment shows that many health plans – particularly those with significant Medicaid membership – are offering home-based assessments. During the May 2016 National Asthma Leadership Roundtable, health plans and other stakeholders had an in-depth discussion about their programs, including implementation and growth strategies, key challenges, and solutions to those challenges. Their lessons learned may help other health plans to implement asthma innovations, including home-based assessment programs.

Some top tactics from plans leading the way to expand asthma programs to incorporate home-based assessments and remediation are:

- Identify asthma hot spots for initial roll out of home-based assessments;
- Consider pilot testing home-based assessment programs before widespread roll out;
- Use community health workers to expand reach;
- Use EPA tools to jump-start assessments;
- Link members to PCMHs for ongoing management; and
- Prepare to provide mental health, social service, and chronic care resources as part of the asthma program.

As the next generation of asthma care continues to gather momentum, health plans are likely to increasingly incorporate in-home assessments to complement clinically focused asthma programs. To be successful, health plans will need innovative approaches to staffing and evaluating the impact of home-based assessments and remediation. Many health plans are collaborating with public health and community-based organizations to expand their asthma capabilities and enhance culturally competent, linguistically appropriate asthma care. Health plan members will benefit from greater attention to proactively controlling asthma and reducing exposure to asthma triggers. Ultimately, home-based assessments may be a key tool to improve quality and reduce disparities in asthma care.

Endnotes

1 National Heart, Lung and Blood Institute. "What is Asthma?" http://www.nhlbi.nih.gov/health/health- topics/topics/asthma Accessed August 31, 2016.
2 Centers for Disease Control and Prevention. Summary Health Statistics: National Health Interview Survey, 2014. Available at: http://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2014_SHS_Table_C-1.pdf Accessed August 31, 2016.
3 CDC "Asthma in the US" Vital Signs, May, 2011 http://www.cdc.gov/vitalsigns/asthma/ accessed 09/02/16
4 CDC National Center for Health Statistics. Asthma FasStats. http://www.cdc.gov/nchs/fastats/asthma.htm Accessed 09/02/16
5 CDC "Asthma in the US" Vital Signs, May, 2011 http://www.cdc.gov/vitalsigns/asthma/ accessed 09/02/16
6 EPA Manage Environmental Triggers. https://www.epa.gov/asthma/manage-environmental-asthma- triggers Accessed 09/01/16
7 National Heart, Lung and Blood Institute. Guidelines for the Diagnosis and Management of Asthma (EPR-3) http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines. Accessed August 31, 2016.
8 Centers for Disease Control and Prevention. Asthma Action Plan. http://www.cdc.gov/asthma/actionplan.html Accessed August 31, 2016.
9 https://www.epa.gov/asthma
10 https://www.cdc.gov/asthma/
11 http://portal.hud.gov/hudportal/HUD?src=/program_offices/healthy_homes/HousingHealthAsthma 12 https://ahip.org/8705-2/
13 National Committee for Quality Assurance. [HEDIS] Summary Table of Measures, Product Lines, and Changes. http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2016/HEDIS%202016%20List%20of%20Measures.p df Accessed 09/01/16
14 National Committee for Quality Assurance. Use of Appropriate Medications for People with Asthma and Medication Management for People with Asthma - http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2015-table-of-contents/asthma. Accessed 09/01/16

Appendix A:

Many resources are available to inform stakeholders about how to improve asthma care at the federal, state, and local levels to assist health plans in developing home-based asthma management programs.

Environmental Protection Agency
EPA Asthma Home Page
https://www.epa.gov/asthma

EPA National Environmental Leadership Award in Asthma Management
https://www.epa.gov/asthma/national-environmental-leadership-award-asthma-management

Climate and Health Assessment: Indoor Air Quality
https://health2016.globalchange.gov/air-quality-impacts

EPA Home Environment Checklist (8 pages)
https://www.epa.gov/sites/production/files/2013-08/documents/home_environment_checklist.pdf

Implementing an Asthma Home Visit Program: 10 Steps To Help Health Plans Get Started (2005)
https://www.epa.gov/sites/production/files/2013-08/documents/implementing_an_asthma_home_visit_program.pdf

Centers for Disease Control and Prevention
CDC Asthma Home Page
https://www.cdc.gov/asthma/

CDC 6 | 18 Initiative - Accelerating Evidence into Action
www.cdc.gov/sixeighteen/

CDC Asthma Data, Statistics and Surveillance
http://www.cdc.gov/asthma/asthmadata.htm

Department of Housing and Urban Development
HUD Asthma Portal
portal.hud.gov/hudportal/HUD?src=/program_offices/healthy_homes/HousingHealth Asthma

HUD StopPests in Housing Program
www.StopPests.org

National Institutes of Health
National Heart, Lung and Blood Institute (NHLBI)
http://www.nhlbi.nih.gov/health/health-topics/topics/asthma/livingwith

National Institute for Allergy and Infectious Disease – Asthma page
https://www.niaid.nih.gov/topics/asthma/Pages/default.aspx

Community-based Organizations
a.i.r nyc (community-based organization that delivers culturally competent home-based asthma care)
http://www.air-nyc.org/

American Lung Association
http://www.lung.org/lung-health-and-diseases/lung-disease-lookup/asthma

Asthma Community Network (includes resources for partners and best practice information, along with a micro-site on financing home-based interventions)
http://www.asthmacommunitynetwork.org/

Regional Asthma Management and Prevention (regional resources for asthma partnerships)
http://www.rampasthma.org/

America's Health Insurance Plans
America's Health Insurance Plans Asthma Resources
https://ahip.org/asthma/

Appendix B:

AHIP National Asthma Leadership Roundtable
May 4, 2016 | 8:30 am — 3:30 pm ET
601 Pennsylvania Avenue NW Suite 500 Washington, DC 20004

Time	Session and Description	Presenter(s)
8:30 – 8:50 am	**Welcome & Introductions, Anti-Trust Policy**	Kate Berry, Senior Vice President Clinical Affairs and Strategic Partnerships, AHIP Michael Spector, Senior Counsel
8:50 – 9:00 am	**Overview of the Day & Planned Activities**	Tracy Enger, Program Manager, U.S. Environmental Protection Agency (moderator) Kevin Fahey, MA, Executive Director, Special Projects, AHIP (moderator)
9:00 – 9:20 am	**Keynote Address and Q&A**	Janet McCabe, JD, Acting Assistant Administrator for the Office of Air and Radiation (OAR), EPA David Rowson, MS, Director of Indoor Environments Division, OAR, EPA
9:20 – 9:50 am	**Industry Trends** *Findings from AHIP's 2015 Assessment on Health Plan Strategies for Managing Asthma & Trends from Health Plan Interviews will be presented.*	Nicole Brainard, PhD, MPH, Deputy Director, Survey and Qualitative Research, AHIP
9:50 – 10:00 am	**Break**	
10:00 – 11:30 am	**Session 1: Essential Resources and Partnerships for Delivering Home-based Environmental Asthma Services.** *Health plans will present and discuss cost-effective strategies and resources needed to develop and implement a home-based environmental asthma management program, including the importance of partnerships and establishing networks with federal, regional, and community stakeholders.* **Recap & Questions:** Nicole Brainard Discussion: Tracy Enger & Kevin Fahey	Bridget Burke, Director, Public Affairs, Health Care Service Corporation Jean-Marie Javorski, RN, CCM, Manager of Care Management, BMC HealthNet Plan / Well Sense Health Plan Deborah Wheeler, Assistant Vice President, Quality, Molina Healthcare **Lauren Howard, RN, BSN, MBA, Clinical Development Program Manager, Multicultural Health Programs, Anthem Shoshanah Brown, MS, MBA, Executive Director, a.i.r. NYC
11:30 – 12:30 pm	**Lunch**	

12:30 – 2:00 pm	**Session 2: Maximizing Member Engagement and Ensuring Program Sustainability** *Health plans will present and discuss models for maximizing member engagement and reach, including use of culturally- and linguistically-appropriate resources, and will provide strategies for ensuring a sustainable program, including identifying return on investment and available tools for health plans.* **Recap & Questions:** Nicole Brainard Discussion: Tracy Enger & Kevin Fahey	Mary Cooley, MS, RN, Associate Vice President, Care Management and Operations, PriorityHealth Loredana Ladogana, MD, Medical Director, Affinity Health Plan Karen Michael, VP, Corporate Medical Management, AmeriHealth Caritas Family of Companies John Pruett RN, BSN, CRT, Asthma Care Manager, Neighborhood Health Plan Ellen Whitney Sharpe, RN, MS, CCM Clinical Manager, Disease and Conditions Programs, Neighborhood Health Plan
2:00 – 2:15 pm	**Break**	
2:15 – 3:00 pm	**National and Regional Resources and Opportunities for Health Plans** *The EPA will explore resources at the federal, state, and local levels available to assist health plans with developing home-based asthma management programs. This session will highlight various Federal programs and activities, online communities, mentoring opportunities, and information on sustainability.*	Tracey Mitchell, Project Officer, EPA
3:00 – 3:30 pm	**Meeting Wrap-up & End**	

AHIP National Asthma Leadership Roundtable Participant List

Health Plans:

Kristin Beck
Director, Community Health Programs
Health Partners Plan

Bridget Burke
Director, Public Affairs
Health Care Service Corporation

Mary Cooley, MS, RN
Associate Vice President, Care Management and Operations
Priority Health

Roseann Degrazia, MNEd, RN
AVP Clinical Affairs and Clinical Business Operations
University of Pittsburgh Medical Center (UPMC) Health Plan

Rebecca Fitch, MD
Physician Director, Population Care Management
Kaiser Permanente Mid Atlantic

Lauren Howard, RN, BSN, MBA
Clinical Development Program Manager, Multicultural Health Programs,
Anthem, Inc.

Jean-Marie Javorski, RN, CCM
Manager of Care Management
BMC HealthNet Plan / Well Sense Health Plan

Loredana Ladogana, MD
Medical Director
Affinity Health Plan

Karen Michael
Vice President, Corporate Medical Management
AmeriHealth Caritas Family of Companies

John Pruett RN, BSN, CRT
Asthma Care Manager
Neighborhood Health Plan

Diana Quinn
Manager, Care Management
Amerigroup

Ellen Whitney Sharpe, RN, MS, CCM
Clinical Manager, Disease and Conditions
Neighborhood Health Plan

Pritpal Singh, DO, CPE
Medical Director
Cigna Healthcare

Celeste Smith, RN, MSN, CPHQ
Program Manager, Care Management
Healthfirst

Deborah Wheeler, MSPH
Assistant Vice President, Quality
Molina Healthcare

U.S. EPA:

Tracy Enger, MS
Program Manager

Janet McCabe, JD
Acting Assistant Administrator
Office of Air and Radiation (OAR)

Tracey Mitchell
Project Officer

David Rowson, MS
Director of Indoor Environments Division
Office of Radiation and Indoor Air

America's Health Insurance Plans (AHIP):

Kate Berry, MA
Sr. Vice President, Clinical Affairs

Nicole Brainard, PhD
Deputy Director, Survey & Qualitative Research

Kevin Fahey, MA
Executive Director, Special Projects

Michael Spector, JD
Senior Counsel

Other Organizations:

Peter Ashley, DrPH
Director, Policy and Standards Division Office of Lead Hazard Control and Healthy Homes
U.S. Department of Housing and Urban Development

Shoshanah Brown, MS, MBA
Executive Director
a.i.r. NYC

Elizabeth Herman, MD, MPH
Senior Scientist
U.S. Centers for Disease Control and Prevention (CDC) National Asthma Control Program