National Models for Asthma Care:
Best Practices From the 2019 Asthma Award Winners
Welcome to the Webinar

National Models for Asthma Care: Best Practices From the 2019 Asthma Award Winners

Moderator
• Tracey Mitchell, RRT, AE-C, U.S. Environmental Protection Agency (EPA)

Presenters
• Matt Siemer and Amy Bain, MSN, APN, CPNP, Mobile Care Chicago
• Ian Sheets, Omaha Healthy Kids Alliance
• Ashley Fogarty, MPH, Rhode Island Department of Health

Thursday, May 23, 2019
Webinar: 2:00 p.m. – 3:00 p.m. EDT
Live Online Q&A: 3:00 p.m. – 3:30 p.m. EDT on AsthmaCommunityNetwork.org

Operator-Assisted Toll-Free Dial-In Number: 866-527-8921
Conference ID: 2096399
2019 Award Winners

Mobile C.A.R.E. Foundation
(Mobile Care Chicago) Asthma Vans

Omaha Healthy Kids Alliance (OHKA)
Asthma In-Home Response (AIR)
Program

Rhode Island Department of Health
Asthma Control Program Home
Asthma Response Program (HARP)
Polling Question 1

What type of organization do you represent?

1. Government agency
2. Health care provider
3. Health plan
4. Community-based program
5. Other
Learning Objectives

Participants will share—

• Successful strategies for effective in-home interventions and critical asthma education.

• Innovative and diverse community-based partnerships that can further your program's impact.

• Methods to use data to measure key program outcomes and improve return on investment.

• Models for providing the full continuum of asthma care.
About the Award

• Nation’s highest honor for exceptional asthma management programs
• Showcases best practices in asthma care and management
• Eligible applicants use the National Institutes of Health’s (NIH) Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma
• Join the Hall of Fame: Apply in 2020!
  www.AsthmaCommunityNetwork.org/Awards
Awards Hall of Fame

Since 2005, 46 health plans, health care providers and communities in action have been inducted into the Awards Hall of Fame.
Asthma Is a Public Health Challenge Characterized by Disparities

MORE THAN 6 MILLION children ages 0 to 17 in the United States have asthma.

15.7% of black, non-Hispanic children have asthma compared to 7.1% of white, non-Hispanic children.

That's 8.3% or 1 in 12 children.

Poorest and minority children are disproportionately affected.

10.5% of children living in poverty suffer from asthma.

Children below the poverty level have more ED visits, missed school days, and hospitalizations.

^Defined as living at or below 100% of the federal poverty level
Environment Plays a Critical Role in Asthma Control

- Federal asthma guidelines recognize environmental trigger reduction as a critical component of comprehensive asthma care.*
- The evidence base demonstrates that in-home environmental interventions are effective at improving asthma control in children and adolescents.†

EPA is a federal lead for integration of environmental risk reduction into standards of care.

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The System for Delivering High-Quality Asthma Care

Key Drivers of Program Effectiveness

- Committed Leaders & Champions
- Strong Community Ties
- High-Performing Collaborations
- Integrated Health Care Services
- Tailored Environmental Interventions
Polling Question 2

Which of the following best practices are you currently employing in your work?

1. Strong community ties
2. Integrated health care services
3. Tailored environmental interventions
4. High-performing collaborations
5. Committed leaders and champions
Founded in 1999 by Dr. Philip Sheridan, Sr.

Inspired by the Breathmobile program in Los Angeles and the knowledge that cost and transportation were the two most cited barriers to asthma care.
Now we have two vans with 2,700 patient visits per year and 47 partner school sites.
2013: Our home assessment program piloted in the Roseland neighborhood and reduced pediatric asthma emergency department visits by 84% in that local hospital.
Programs

Asthma Vans
Dental Van
Portable Dental Clinic
Home Assessments
25% of low-income children have asthma

#1 cause of pediatric emergency room use

#1 cause of school absenteeism
#2 in asthma fatalities in the nation
Limited Asthma Specialist Access Necessitates Need for Mobile Intervention

CHWs Oversee Relationships with Partner Schools and Patient Families, Offer Home Assessments

**Mobile Care Chicago**
- Non-profit organization in Chicago, IL
- In response to the high volume of asthma-related ED visits and deaths in Chicago, offer free medical and preventive care, education and support to low-income children in partnership with local schools
- Community Health Workers (CHWs) distribute surveys to identify patients with asthma symptoms and conduct home visits when necessary
- Van staff (three Nurse Practitioners, two Medical Assistants, one Clinic Technician) travel to 47 partner schools approximately once per month to conduct allergy assessments and provide education and ongoing treatment
- The percentage of children who had to visit the hospital or ED for asthma symptoms dropped from 36% to 3% within 1 year of treatment, which saved the local health care system an estimated $6.7 million

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**Interdisciplinary Team Offers Ongoing Specialty Asthma Care**

1. **Survey**
   - CHWs distribute yearly surveys to partner schools to identify children with asthma symptoms
   - Connect with families to schedule appointments at school where adult can be present

2. **Patient Visit**
   - Van staff diagnose patients, perform diagnostic tests, conduct allergy assessments, and provide medication
   - Educate patients and families about asthma treatment and common triggers

3. **Ongoing Treatment**
   - Van staff provide care to patients once per season on average
   - Patient education reinforced by each staff member

4. **Home Assessments**
   - CHWs conduct home assessments for approximately one-third of patients to address asthma triggers
   - Target patients who follow treatment plan but are not improving

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“Exemplary Programs: Making Services Easier to Use” National Center for Ease of Use of Community-Based Services, http://www.communitybasedservices.org/sites/communitybasedservices.org/files/Exemplary_Protocols_Evidence_Based_Paper.pdf; Population Health Advisor research and analysis

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Obtaining Patients

- Survey all enrolled students at participating school sites
- Form relationships with 47 volunteer staff, “point person”—one per school site
- Referrals from community
- Siblings of patients
Initial Patient Visit

- Parent/guardian is required to be present
- 45-minute appointment
- Bilingual staff
- No copays or costs to the family
Initial Patient Visit

- Diagnostic tests performed on children 5 years and older
  - Spirometry
  - Fractional exhaled nitric oxide (FeNO)
- Administer Asthma Control Test (ACT) (> 4 years old)
- Full medical history and physical obtained
- Asthma 101/Asthma Action Plan
- Correct spacer/device technique
- Individualized treatment plan discussed
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"Exemplary Programs Making Services Easier to Use," National Center for Ease of Use of Community-Based Services, http://www.communitybasedservices.org/sites/communitybasedservices.org/files/File/Mobility200_A_E_E-2704.pdf; National Center for Population Health Advisor research and analysis.
Ongoing Treatment

- 30- to 45-minute appointment
- Virtual visit capability
- Treat asthma exacerbations/sick visits
Ongoing Treatment

- Repeat diagnostic tests and ACT at each visit
- Allergy skin test typically performed at 2nd visit
  - Discuss individualized triggers and allergens
- Review medications and correct spacer/device technique at every visit
- Review asthma action plan
- Recommend home assessment
Potential Opportunities

Marketing & Community Relations

Cross Referrals to Meet HEDIS Metrics

Community-Based Research

Data-Sharing to Lower ED Utilization

Screening for Other Chronic Diseases
Telemedicine

- Follow-up phone calls
  - 1–2 weeks after initial visit
  - After missed appointments, cancellations, no-shows
  - 2–3 days after sick visit or as needed
  - Frequent albuterol refills
Home Assessments

- Performed in combination with the American Lung Association
- Recommended for the following patients:
  - Uncontrolled asthmatics (Mild–Moderate Persistent Asthma)
  - Asthmatics with multiple allergies and risk for flares
  - Severe Persistent Asthma diagnosis
- Community health worker assesses home and allergen risks and provides remediation and supplies to families
Prior to the home assessment, these boys were sleeping on an air mattress on the living room floor.

They were ecstatic to receive their new beds!
Community Partnerships

- American Lung Association
- University of Illinois at Chicago
- Partnering schools and sites
- Chicago Asthma Consortium
Perfect Aire donated 60 air conditioners and dehumidifiers to Mobile Care Chicago.

We gave 8 air conditioning units to one of our partner schools, Visitation, a Catholic school that does not have air conditioning.
Before Enrollment

- Fewer than 5 school absences: 75%
- No emergency department visits: 45%
- No asthma hospitalizations: 81%
- ACT score 19 or above: 42%
## After Enrollment

<table>
<thead>
<tr>
<th></th>
<th>After Enrollment</th>
<th>Before Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer than 5 school absences</td>
<td>97%</td>
<td>75%</td>
</tr>
<tr>
<td>No emergency department visits</td>
<td>94%</td>
<td>45%</td>
</tr>
<tr>
<td>No asthma hospitalizations</td>
<td>98%</td>
<td>81%</td>
</tr>
<tr>
<td>ACT score 19 or above</td>
<td>75%</td>
<td>42%</td>
</tr>
</tbody>
</table>

Asthma vans prevent $3.00 in emergency room and hospital costs for every dollar spent.
Summary

20,000 families reached annually
100+ school partners each year
$100 per family reached

Comprehensive care to alleviate the number 1 driver of health care costs for children and the number 1 cause of school absenteeism
ASTHMA IN-HOME RESPONSE
(PROJECT AIR)

Presented by Ian Sheets, Grants Manager
Omaha Healthy Kids Alliance
INTRODUCTION

- Ian Sheets, Grants Manager at Omaha Healthy Kids Alliance (OHKA)
- OHKA is a children’s environmental health nonprofit
- Started out of Omaha’s Superfund Site in 2006
- Lead poisoning prevention efforts until 2010—pivot to Healthy Housing
- Focus on in-home education and supply provision
- Provide community-wide education through public service announcements, video games, outreach
ASTHMA IN-HOME RESPONSE (AIR)

- Started in 2015
- Multi-layer, multi-trigger in-home interventions
  - Behavior
  - Education
  - Supplies
  - Construction
  - Triage/referrals
- Serve ~50 kids a year
AIR—INTERVENTION BREAKDOWN

- Referral to program
- Intake
- Initial visit
  - Education
  - Environmental evaluation
  - Question-AIR
- Supply drop-off
- Construction
- Follow-ups
VISIT

- Full-scale environmental assessment
  - Start outside, work inside
  - Look at everything, but focus on indoor air quality hazards in AIR homes

- Meanwhile, education and Question-AIR
  - Collect baseline info on child’s asthma
  - Educate client on asthma best practices
  - Build rapport with client
  - Start establishing potential referrals

- Both staff meet at end with client and go over findings
SUPPLIES

- Personalized, free supply kit based on:
  - Client’s triggers
  - Family’s needs
  - Home’s health and safety
- Additional round of education based on supplies
- Specific cost tracking to help establish return on investment
EVALUATING THE PROGRAM

- Asthma severity
  - Symptomatic days
  - Medication usage
  - Emergency room visits
  - Hospitalizations
  - Asthma attacks

- Behavior
  - Vacuuming
  - Dusting
  - Furnace filter
  - Smoking in home
  - Asthma Action Plan

- Quality of life
  - General fear/helplessness
  - Fear of medication side effects
  - Concern with asthma’s effects on grades
  - Concern with asthma’s effects on day-to-day life

- Home’s health/safety hazards
  - Moisture
  - Maintenance
  - Safety
  - Contaminants
    - Cleanliness
    - Pests
    - Energy efficiency
    - Ventilation
INTERNAL MEASURES

- Dual enrollment rates
- Cost per intervention
- Cost of supplies
- Follow-up rate
- Time spent in program
- Time of construction projects
- Referrals made
- Referral sources
HEALTH/ QUALITY OF LIFE OUTCOMES (STUDY OF 55 CLIENTS)

<table>
<thead>
<tr>
<th>Metric</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptomatic Days</td>
<td>131</td>
<td>11</td>
</tr>
<tr>
<td>Missed School Days</td>
<td>171</td>
<td>51</td>
</tr>
<tr>
<td>Missed Work Days</td>
<td>52</td>
<td>17</td>
</tr>
<tr>
<td>Collective Emergency Room Visits</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>Collective Hospitalizations</td>
<td>7</td>
<td>2</td>
</tr>
</tbody>
</table>

Return on investment: $1.83 for every $1 invested
BEHAVIORAL OUTCOMES

Significant increases in:
- Dusting frequency
- Vacuuming frequency
- Furnace filter changing frequency

Significant decreases in:
- Smoking indoors
- Using harsh cleaning chemicals
- Using candles and air fresheners
PHOTOS OF WORK
PHOTOS OF WORK
PARTNERSHIPS

- Children’s Hospital — Direct reimbursement for interventions on their patients
- WellCare of Nebraska — Partial reimbursement for interventions on their patients and sharing of claims-data
- Nebraska Asthma Coalition — Network of Nebraska-based asthma stakeholders
- Awair — Corporation piloting in-home IAQ monitors with OHKA
- City of Omaha — Healthy Homes construction partnership
- Children’s Hospital of Missouri — Equipment and training trading
- Boys Town Pediatrics — Referrals and case management
- University of Nebraska Medical Center — Peer-reviewed research
NEXT STEPS FOR AIR

- Duplication of model in other locales
- Continued expansion of reimbursement model
- Continued formalization of claims-sharing data
- Scaling up individual services
- Establishing an automated, community-wide referral system
Rhode Island Department of Health: Asthma Control Program

2019 National Environmental Leadership Award in Asthma Management Webinar
Thursday, May 23, 2019
Ashley Fogarty, MPH
# Asthma Data: Health Inequities

## Children with Asthma

### Asthma* Emergency Department and Hospitalization Rates, by Age and Race/Ethnicity, Rhode Island Children, 2013-2017

**Emergency Department Visit Rates**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Black</th>
<th>White</th>
<th>Hispanic*</th>
<th>All Races</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 0-4</td>
<td>20.5</td>
<td>16.5</td>
<td>9.7</td>
<td>14.3</td>
</tr>
<tr>
<td>Ages 5-17</td>
<td>3.5</td>
<td>10.8</td>
<td>5.8</td>
<td>3.5</td>
</tr>
</tbody>
</table>

**Hospitalization Rates**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Black</th>
<th>White</th>
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<tbody>
<tr>
<td>Ages 0-4</td>
<td>3.5</td>
<td>1.4</td>
<td>2.7</td>
<td>1.9</td>
</tr>
<tr>
<td>Ages 5-17</td>
<td>2.3</td>
<td>0.6</td>
<td>1.5</td>
<td>0.9</td>
</tr>
</tbody>
</table>

### Estimated # of Children Under Age 18

<table>
<thead>
<tr>
<th>City/Town</th>
<th># of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Four Core Cities</td>
<td>73,741</td>
</tr>
<tr>
<td>Remainder State</td>
<td>150,215</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>223,956</td>
</tr>
</tbody>
</table>

### # of Child Emergency Dept. Visits with Primary Asthma Diagnosis

<table>
<thead>
<tr>
<th>City/Town</th>
<th># of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Four Core Cities</td>
<td>4,438</td>
</tr>
<tr>
<td>Remainder State</td>
<td>3,205</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>7,643</td>
</tr>
</tbody>
</table>

### Rate of Child Emergency Dept. Visits with Primary Asthma Diagnosis, per 1,000 Children

<table>
<thead>
<tr>
<th>City/Town</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Four Core Cities</td>
<td>12.0</td>
</tr>
<tr>
<td>Remainder State</td>
<td>4.3</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>6.8</td>
</tr>
</tbody>
</table>
Key points:

- Asthma is the most common chronic condition in children.
- Nationally, 8.5% of children have asthma.
- In Rhode Island, 9.8% of children have asthma.
- Black children and Hispanic children are more likely to visit the emergency room or be hospitalized due to asthma.
- Over 70% of pediatric asthma emergency department (ED) visits in Rhode Island are children on Medicaid.

RI asthma emergency department rates (per 1,000):
1. Providence: 13.3
2. Central Falls: 12.3
3. Newport: 10.0
4. Woonsocket: 10.9
5. Pawtucket: 9.3
Claims Data: Children With Asthma

Any Asthma Claims Among Children on Medicaid, 2013–2017 (asthma prevalence)
Children With Asthma: ED Visits

Asthma Emergency Department Visits Among Children on Medicaid with Asthma, 2013–2017

Rate of ED asthma claims per 100 asthmatic Medicaid enrollees

- Lowest Quintile (0.0 - 4.0)
- Second Quintile (4.1 - 5.6)
- Middle Quintile (5.7 - 6.6)
- Fourth Quintile (6.7 - 8.4)
- Highest Quintile (8.5 - 11.5)

- Unstable
- Suppress
Asthma, Poverty and Housing
RIDOH Asthma Control Program

RHODE ISLAND STATEWIDE INTEGRATED POPULATION HEALTH LEADING PRIORITIES, STRATEGIES, AND GOALS

Three Leading Priorities Guide Our Work

Address the Socioeconomic and Environmental Determinants of Health in Rhode Island

Eliminate the Disparities of Health in Rhode Island and Promote Health Equity

Ensure Access to Quality Health Services for Rhode Islanders, Including Our Vulnerable Populations

• Housed in Division of Community Health & Equity

• Serves children 0–17 living in high-poverty, urban areas of the state

• Well-known for long-term partnerships with researchers, hospitals, public health, housing, social justice and environmental organizations

• Efforts focused around collaborative approach with linkages between healthy housing, health care and other regional collaborations
Asthma Program Services

Asthma Action Plan

An Asthma Action Plan is a written plan. It lists a person’s asthma triggers, medicines, and doses. It also tells what to do in an asthma emergency.

Free Asthma Services

Families who have children with asthma and live in Providence, Pawtucket, Central Falls, or Woonsocket may qualify for:

- Up to three classes to learn how to manage their child’s asthma
- Home visits by a Certified Asthma Educator to help find and fix asthma triggers (things that cause asthma attacks)
- Help coordinating asthma care with primary care providers, school nurses, teachers, and caregivers
- Help getting support for healthy housing, tenant rights, and social services

To see if you qualify, call the Health Information Line: 401-222-5960 / RI Relay 711

Asthma at Home

Clean and healthy homes help reduce asthma. Asthma triggers in the home include dust mites, mold, pets, pests, smoke, and chemical cleaners. The Asthma Control Program offers:

- **Breathe Easy at Home (BEAH)** If a landlord will not fix a suspected housing code violation that triggers asthma, BEAH helps doctors contact building code officials. BEAH can also help tenants get legal support.
- **Asthma Home Visits** Families can have up to three visits by a Certified Asthma Educator. The Certified Asthma Educator teaches how to get rid of asthma triggers and better manage asthma.

Asthma at School

Asthma causes children to miss school, so schools need to be asthma-friendly. Schools in cities with more childhood asthma need this most. Healthy schools are good for all students and staff.

**Project CASE** (Controlling Asthma in Schools Effectively) works with elementary schools to:

- Offer Hasbro’s Draw a Breath classes for students with asthma
- Give training for school staff about asthma needs at school
- Improve the school’s indoor and outdoor spaces, asthma-friendly policies, and indoor air quality
- Promote the use of Asthma Action Plans
- Improve asthma care coordination between school nurses, teachers, healthcare providers, and families

Asthma and Healthcare

The Asthma Control Program works with healthcare providers, community health centers, and patient-centered medical homes. It helps them offer better asthma care by:

- Encouraging the use of Certified Asthma Educators
- Providing a current Asthma Action Plan for patients
- Teaching families how to use the Asthma Action Plan to manage asthma
- Partnering with community-based public health programs
- Sharing national guidelines that help providers diagnose, monitor, and treat asthma

Health Information Line: 401-222-5960 / RI Relay 711 | www.health.ri.gov/asthma
Launched in 2011 in collaboration with Hasbro Children’s Hospital, St. Joseph Health Center, HARP is an evidence-based intervention with well-defined and tested partnerships, roles and responsibilities, curriculum, service delivery infrastructure, eligibility criteria, and evaluation framework.
HARP Screening Tool

Screening: Health Care Use and Asthma Control

If 2+ ED visits or 1 inpatient, and/or very poorly controlled symptoms (daily)

- 2–3 sessions with Certified Asthma Educator (AE-C) and CHW

If symptoms > 2x/week but less than daily (i.e., not well controlled)

- Environmental supplies and instruction for remediation

Single session with AE-C
CDC’s 6|18 Initiative

The “6|18” Initiative

Promote adoption of evidence-based interventions in collaboration with health care purchasers, payers, and providers

High-burden health conditions 6|18 Evidence-based interventions that can improve health and save money
PROPOSED PAYER INTERVENTION

Expand access to home visits by licensed professionals or qualified lay health workers to improve self-management education and reduce home asthma triggers for individuals whose asthma is not well-controlled with the 2007 National Asthma Education and Prevention Program (NAEPP Guidelines) based medical management and intensive self-management education.

OPPORTUNITIES FOR PAYERS AND PROVIDERS

Payers can consider expanding patient access to home visits by licensed professionals or qualified lay health workers to improve patients’ ability to self-manage their asthma and reduce home asthma triggers.

KEY HEALTH AND COST EVIDENCE MESSAGES FOR PAYERS AND PROVIDERS

Home-based educational and environmental intervention delivered by non-physician teams (nurses, certified asthma educators, community health workers) can improve asthma symptom control, particularly in inner-city children with asthma, and may have cost savings for payers.
Insurance Claims Data:

- With signed consent from participants, negotiated to receive claims data from Medicaid MCOs
- Examined costs for asthma-related hospitalizations, ED visits
- Compared 1 year pre-intervention to 1 year post-intervention
- Subset analysis for higher utilizers
Communicating Outcomes

HARP has a positive return on investment. This means that every dollar invested into reducing preventable ED/hospital visits gets returned, with additional savings earned. Overall, HARP participants had a 33% ROI on ED/hospital costs ($1 investment returned with extra 30 cents saved). The subset of high utilizers had an ROI of 126%. Including overall asthma costs which showed increased medication costs, HARP was still cost effective (i.e., investment equal to savings) and the high utilizer subgroup still had an overall ROI of 65%.

DEMONSTRATED OUTCOMES:

Quality Improvement: The asthma medication ratio HEDIS score for participants increased from 32% to 46%.

Improved Asthma Control: Patient population went from 20% well controlled to 51.5% well controlled.

Improved Quality of Life: Caregiver quality of life improved 17% on validated surveys.

Reduction of Environmental Triggers: Observed reductions in the presence of mold, dust, pests, pets, tobacco smoke, and chemicals.

Reduction in Missed School/Work Days: Caregivers report reducing missed work work days due to asthma by 62%. Patients cut missed school days almost in half.

Increased Asthma Action Plans: Availability and patient use of asthma action plans created by providers increased from 20% to 80% of participants.
Asthma Costs in Medicaid

Median Cost of Care by Population

<table>
<thead>
<tr>
<th>Year</th>
<th>HARP eligible</th>
<th>Asthma, non-HARP</th>
<th>Total Pediatric Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$3,956</td>
<td>$967</td>
<td>$4,553</td>
</tr>
<tr>
<td>2015</td>
<td>$1,948</td>
<td>$456</td>
<td>$2,404</td>
</tr>
<tr>
<td>2016</td>
<td>$2,101</td>
<td>$793</td>
<td>$2,894</td>
</tr>
</tbody>
</table>

Average Cost of Care by Population

<table>
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<th>Asthma, non-HARP</th>
<th>Total Pediatric Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$14,790</td>
<td>$3,372</td>
<td>$18,162</td>
</tr>
<tr>
<td>2015</td>
<td>$8,166</td>
<td>$2,411</td>
<td>$10,577</td>
</tr>
<tr>
<td>2016</td>
<td>$9,489</td>
<td>$2,652</td>
<td>$12,141</td>
</tr>
</tbody>
</table>

\( N = 365 \text{ } 6,265 \text{ } 98,725 \text{ } 377 \text{ } 5,888 \text{ } 101,377 \text{ } 345 \text{ } 5,667 \text{ } 102,674 \)
Ashley Fogarty, MPH
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Rhode Island Department of Health
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Nancy Sutton, MS, RD
Asthma Program PI

Julian Drix, MPH Candidate
Asthma Program Manager

Deborah Pearlman, PhD
Asthma Program Consultant/Epidemiologist
Polling Question 3

Based on what you have learned today, what next steps will you take?

1. Begin investigating potential partnerships with community organizations, schools and other stakeholder groups
2. Collect and analyze data to track key program outcomes and return on investment
3. Consider ways to add services to my program that move toward providing the full continuum of care
4. Develop strategies for effective in-home interventions and critical asthma education.
5. Visit the AsthmaCommunityNetwork.org Hall of Fame to learn more about past winners.
Thank You to Our Winners

Post your questions now on www.AsthmaCommunityNetwork.org
Question & Answer Session on AsthmaCommunityNetwork.org Discussion Forum

Please join us in the AsthmaCommunityNetwork.org Discussion Forum for a live online Q&A Session.
3:00 p.m. – 3:30 p.m. EDT

To post a question in the Discussion Forum, follow these directions:
1. If you are a Network member, log in to your AsthmaCommunityNetwork.org account.

   Not a member? Create an account at AsthmaCommunityNetwork.org by clicking the “Join Now” link at the top of the page. Your account will be approved momentarily, and you can begin posting questions.

2. Click on the “Discussion Forum” button on the home page.
3. Click on the “Live Online Q&A for 5/23/19 Webinar” link.
4. Click on the “Add new Forum topic” link to post your question.
5. Enter your question and click the “Save” button at the bottom of the page.