Communities in Action – Assets for Delivering High Quality Asthma Care
A System Mindset

- **TARGET POPULATION**
- **COMMUNITY ASSETS**
  - Integrated Health Care Services
  - Tailored Environmental Interventions
  - Partnerships

- **COLLABORATIONS**
  - Non-Profits
  - Service Providers
  - Coalitions
  - Health Plans
  - Funders

- **TARGET POPULATION**
Changing pO_2olicy: The Elements for Improving Childhood Asthma Outcomes

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THE GEORGE WASHINGTON UNIVERSITY
SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES

SUPPORTED BY
Merck
Childhood Asthma Network
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Key Findings

Focus on Controllable Factors
Inadequate access to insurance coverage that pays for appropriate, high quality comprehensive health care and case management

Children with asthma more likely to have insurance but 9% still uninsured

1.17 million children with asthma and without coverage

Nearly 600,000 uninsured children with asthma are eligible for MA/CHIP at current eligibility levels but not enrolled

Extending eligibility to 300% FPL – as in 7 states now – covers an additional 1 million, including 180,000 with asthma

These two steps would cut the total # uninsured children with asthma by 75%
QUALITY: Factor #2

Suboptimal quality of clinical care, case management, asthma education for many children, including those ineligible for insurance coverage

Source: Kim et al. (2009). Health Care Utilization by Children with Asthma, Preventing Chronic Disease Vo. 6:No. 1
ENVIRONMENT: Factor #3

Failure to address the indoor air environment and other indoor asthma triggers as well as outdoor environmental triggers that affect communities in which children live and grow

- Approximately 64% of children live in counties where the 8 hour ozone standard is violated at least 1 day annually

- Over 60% live in communities where 1 or more federal air quality standards are not met
DATA: Factors #4 and 5

Absence of systematic means for monitoring asthma prevalence and treatment effectiveness at the local level and for deploying targeted resources to most burdened communities

- Prevalence of over 43% in West Brookfield in Massachusetts, compared to over 20% in 4 other communities and 5-15% in the remaining areas of the state

Lack of a coordinated research strategy

- NIH funding for asthma research decreased by 25% between 2005-2009 ($252 million in ’09)
Identified Priority Elements for Improvement

- Asthma trigger reduction in homes and communities
- Research to learn more about what works
- Continuous information exchange and progress monitoring
- High quality clinical and case management
- Stable and continuous health insurance
Improving Coverage: Specific Recommendations

- Encourage all states to expand MA/CHIP up to at least 300% FPL

- Increase and target outreach, enrollment and retention efforts in MA/CHIP
  - FQHC outstationing
  - Schools and other community–based locations

- Encourage providers to make MA/CHIP enrollment a part of the individual asthma treatment plan for every child with asthma who is eligible for coverage
Improving Quality: Specific Recommendations

- Develop an HHS-led, cross-agency, Administration-wide guidance on how to comprehensively address quality asthma care.

- Make all recommended care a focus of quality performance improvement for MA/CHIP, health centers, and IHS:
  - MA/CHIP cover 30 million children and 1 in 6 has asthma.
  - CHCs serve 7 million children and 1 in 5 has asthma.
  - IHS serves approximately 660,000 children and roughly 80,000 or 1 in 8 have asthma.
Improving Information Exchange & Progress Monitoring: Specific Recommendations

- Enhance asthma monitoring at the community level through linkages of existing data sources (e.g., vital statistics, hospital discharge data, Medicaid claims), local and regional model registries, uniform datasets.

- Encourage meaningful use of HIT among providers and link providers to public health agencies to facilitate continuous information exchange and communication of up-to-date data.
Improving Environmental, School and Housing Air Quality: Specific Recommendations

- Encourage public health agencies, education authorities, housing authorities, and environmental agencies to promote evidence-based interventions and services that fall outside of the traditional health care interventions to reduce exposure to asthma triggers.
Improving Research Agendas: Specific Recommendations

- Promote a strengthened and diversified Administration-wide research agenda to include basic, clinical, and translational/implementation investigations to learn more about what works and what can be translated into policy change.
State & Local Roles

- **Set Medicaid/CHIP eligibility** at least at 300% FPL
- **Eliminate waiting periods under CHIP** for any child with a clinical diagnosis of persistent or uncontrolled asthma
- **Guarantee 12-month continuous enrollment in Medicaid/CHIP**
- **Train and educate** clinical and non-clinical personnel about asthma
  - Assure that all children with asthma have an asthma management plan
  - Verify Medicaid and CHIP enrollment as part of every child’s asthma management plan
  - Assure that all children with asthma have an asthma action plan as well as ongoing case management
- **Recognize payment of patient home visits** in cases where severity/control warrant trigger reduction
- **Include NAEPP guidelines** in managed care contracts
- **Require asthma management reporting** as a measure of clinical quality
State & Local Roles (Cont.)

• Make asthma ED visit or hospital admission a reportable incident to enable measurement of community-level severity
• Use reported data (1) to identify communities with highest pediatric asthma burdens for home, community/environmental and school health interventions and (2) to determine zoning and highway construction parameters
• Deploy resources related to the reduction of asthma triggers in home and community environments, including schools
• Study
  – Effects of medical home on ED visits, hospital admissions, treatment adherence for children with asthma
  – Enablers/ barriers to implementing science-based asthma guidelines and interventions in state-based health care systems; cost-effectiveness/savings associated with such implementations
• Consider asthma as condition for pilot testing pediatric Accountable Care Organizations (ACO), medical homes, bundled payment arrangements
Collaboration & Coordination are Key in More Effectively Addressing the Burden of Asthma

- Primary Care
- Specialty Care
- Acute Care

- Private Insurers
- Public Payers

- Childhood Asthma
- Prevention
- Diagnosis & Treatment
- Management

- Environment
- Housing

- Education
- School Health Services

- Public Health Surveillance
- Public Health Programs
- Public Health Research
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