NEW YORK STATE
Healthy
Neighborhoods
Program

New York State (NYS) Department of Health
Center for Environmental Health

Program Overview

NEW YORK STATE
Healthy
Neighborhoods
Program

- **Location:** High-risk neighborhoods across NYS
- **Type of Program:** Local and State Public Health Department Collaboration
- **Service Area:** Target neighborhoods within selected urban, suburban and rural communities
- **Population Served:** Between 10/2007 and 6/2011, the program provided services to 58,000 residents in more than 20,000 homes in high-risk areas:
  - Approximately 13% of the residents had asthma.
  - Half of the households were identified as non-white and roughly half receive public assistance.

Program Overview

- **We are a healthy homes program** that seeks to reduce the burden of housing related illness and injury, especially among vulnerable populations in NYS
- Our program is **centrally managed** at the state level, but **delivered through local programs**
- Homes in high-risk areas are **identified** through a combination of door to door canvassing and referrals
- Homes are **assessed** for a range of health and safety hazards and **interventions (education, referrals and products) are provided based on specific problems** identified during the home visit

Bold Goals (before we had the framework)

Our Asthma Program :

will provide healthy homes services to help improve the home environment, and specifically common asthma triggers

for:

people with asthma in communities that are disproportionately affected by asthma.

Bold Goals (emboldened by the framework)

Our Asthma Program:

will improve targeting of healthy homes services **for** people with poorly controlled asthma by collaborating with regional managed care plans to identify and provide services to 150 people with poorly controlled asthma and demonstrate that this approach yields a measurable impact on targeting and outcomes.

Bold Goals (even more emboldened)

Our Asthma Program:

will use our evaluation findings to seek additional funding and advocate for policies that will support the expansion of services to an additional five counties, serving an additional 1000 patients per year and demonstrating an improvement of up to 7 additional symptom free days per year for each patient with poorly controlled asthma who completes the intervention and preventing unnecessary hospitalizations for an estimated ?? patients per year.

The long-term impacts we are targeting include:

- Identify people with poorly controlled asthma living in environments that minimize their ability to effectively control their asthma
- Reduce the presence of triggers or conditions that promote triggers in the home
- Improve self-management strategies
- Decrease asthma morbidity
- Assess the impact of different approaches on targeting and outcomes
- Demonstrate the value of this program and seek sustainable funding sources

The outcomes we track include:

- **Reduction in the presence of asthma triggers or conditions that promote triggers**
  - Dust mites, cockroaches, mice, rats, mold, pets, tobacco smoke, chemical smells, scented products, leaks, housekeeping/sanitation, structural disrepair
- **Increase in self-management knowledge/actions**
  - Medication use, asthma action plans, peak flow meters, knowledge of early warning signs, knowledge of personal triggers and trigger avoidance, feels asthma is controlled
- **Decrease in short and long-term asthma morbidity**
  - # of days in previous three months with worsening asthma, missed days of school/work/daycare
  - # of times in previous 12 months visited ED, hospitalized

Activities and Outcomes

- The major activities my program pursues to drive toward my target outcomes include:
  - **Integrated clinical services:** strategic local partnerships with clinical organizations
  - **Tailored environmental interventions:** built upon existing successful healthy homes program that has a strong asthma component
  - **High performing collaborations:** the state health department is uniquely positioned to facilitate partnerships and to streamline communication and evaluation activities

Collaborations and Partnerships

STATE

Asthma Control Program
Healthy Neighborhoods Program
Tobacco Control Program
Center for Environmental Health
Center for Community Health
Office of Health Insurance Programs
Asthma Partnership of New York

LOCAL

NYS Healthy Neighborhoods Program
Providers and practices
Hospitals and urgent care centers
Managed care plans
School nurses
Community foundations and organizations and many others

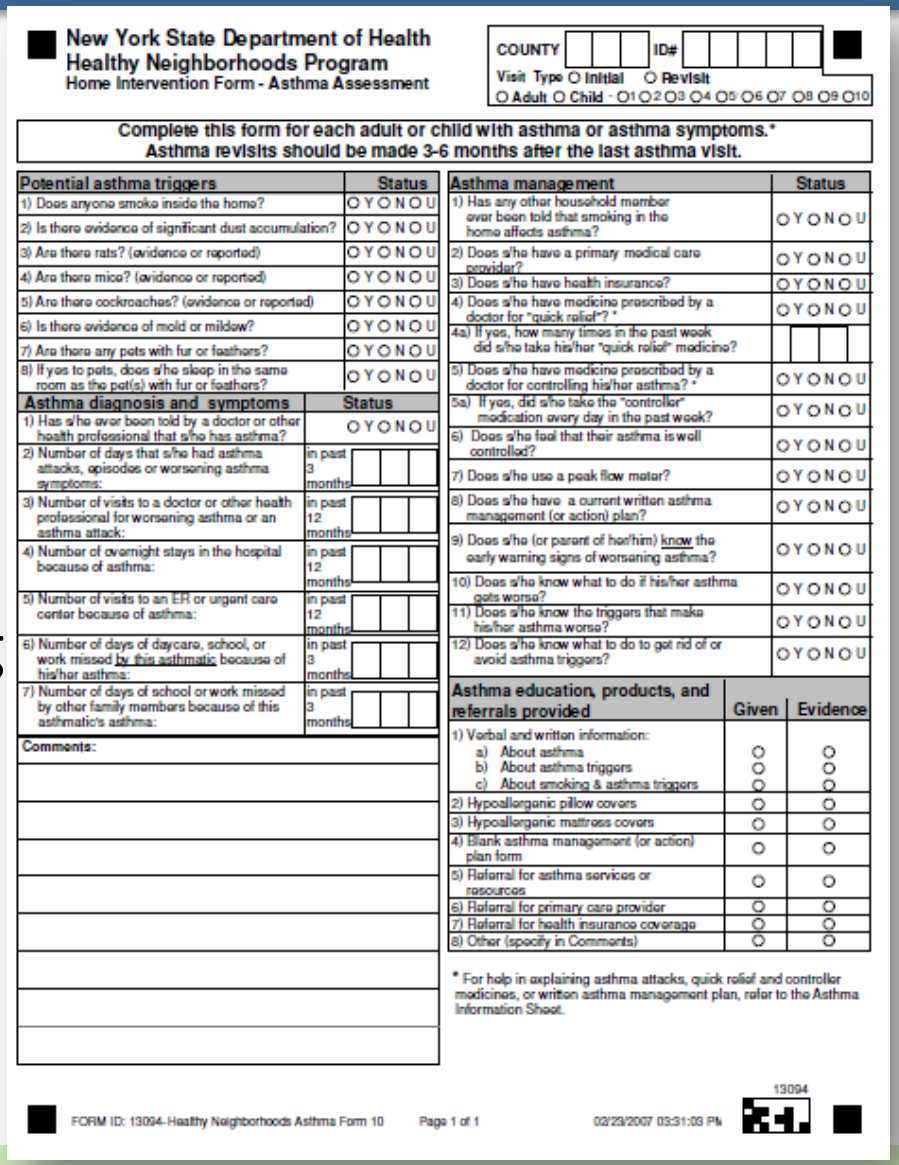
CLINICAL/ REGIONAL

Regional asthma coalitions
Managed care plans
Hospitals and urgent care centers
Providers and practices
School nurses
Office of Health Insurance Programs
Bureau of Chronic Disease Prevention

Evaluation and Results

Defining features:

- Data used dynamically to monitor progress and refine the approach
- State-led evaluation streamlines resources, allows for comparisons and spreading of best practices
- Scannable form and automated reports
- Use of supplemental data collection as appropriate



New York State Department of Health
Healthy Neighborhoods Program
Home Intervention Form - Asthma Assessment

COUNTY ___ ID# ___
Visit Type ○ Initial ○ Revisit
○ Adult ○ Child - ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

Complete this form for each adult or child with asthma or asthma symptoms.*
Asthma revisits should be made 3-6 months after the last asthma visit.

Potential asthma triggers	Status
1) Does anyone smoke inside the home?	○Y ○N ○U
2) Is there evidence of significant dust accumulation?	○Y ○N ○U
3) Are there rats? (evidence or reported)	○Y ○N ○U
4) Are there mice? (evidence or reported)	○Y ○N ○U
5) Are there cockroaches? (evidence or reported)	○Y ○N ○U
6) Is there evidence of mold or mildew?	○Y ○N ○U
7) Are there any pets with fur or feathers?	○Y ○N ○U
8) If yes to pets, does s/he sleep in the same room as the pet(s) with fur or feathers?	○Y ○N ○U

Asthma diagnosis and symptoms	Status
1) Has s/he ever been told by a doctor or other health professional that s/he has asthma?	○Y ○N ○U
2) Number of days that s/he had asthma attacks, episodes or worsening asthma symptoms:	in past 3 months ___
3) Number of visits to a doctor or other health professional for worsening asthma or an asthma attack:	in past 12 months ___
4) Number of overnight stays in the hospital because of asthma:	in past 12 months ___
5) Number of visits to an ER or urgent care center because of asthma:	in past 12 months ___
6) Number of days of daycare, school, or work missed by this asthmatic because of his/her asthma:	in past 3 months ___
7) Number of days of school or work missed by other family members because of this asthmatic's asthma:	in past 3 months ___

Comments:

Asthma management	Status
1) Has any other household member ever been told that smoking in the home affects asthma?	○Y ○N ○U
2) Does s/he have a primary medical care provider?	○Y ○N ○U
3) Does s/he have health insurance?	○Y ○N ○U
4) Does s/he have medicine prescribed by a doctor for "quick relief"? *	○Y ○N ○U
4a) If yes, how many times in the past week did s/he take his/her "quick relief" medicine?	___
5) Does s/he have medicine prescribed by a doctor for controlling his/her asthma? *	○Y ○N ○U
5a) If yes, did s/he take the "controller" medication every day in the past week?	○Y ○N ○U
6) Does s/he feel that their asthma is well controlled?	○Y ○N ○U
7) Does s/he use a peak flow meter?	○Y ○N ○U
8) Does s/he have a current written asthma management (or action) plan?	○Y ○N ○U
9) Does s/he (or parent of her/him) know the early warning signs of worsening asthma?	○Y ○N ○U
10) Does s/he know what to do if his/her asthma gets worse?	○Y ○N ○U
11) Does s/he know the triggers that make his/her asthma worse?	○Y ○N ○U
12) Does s/he know what to do to get rid of or avoid asthma triggers?	○Y ○N ○U

Asthma education, products, and referrals provided	Given	Evidence
1) Verbal and written information:		
a) About asthma	○	○
b) About asthma triggers	○	○
c) About smoking & asthma triggers	○	○
2) Hypoallergenic pillow covers	○	○
3) Hypoallergenic mattress covers	○	○
4) Blank asthma management (or action) plan form	○	○
5) Referral for asthma services or resources	○	○
6) Referral for primary care provider	○	○
7) Referral for health insurance coverage	○	○
8) Other (specify in Comments)	○	○

* For help in explaining asthma attacks, quick relief and controller medicines, or written asthma management plan, refer to the Asthma Information Sheet.

13094

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We have seen improvements in:

- **Presence of triggers in homes:**
  - 11-16% improvement in homes with ETS
  - 42-56% improvement in homes with cockroaches
  - 45-59% improvement in homes with mold
- **Self-management knowledge and strategies:**
  - 39-63% improvement in feeling asthma is well controlled
  - 40-100% improvement in using controller medication every day; 21-30% in using quick-relief medication < 2 times/week
  - 39-100% improvement in knowledge of personal triggers and trigger avoidance strategies
- **Short-term asthma morbidity:**
  - Up to 3.5 fewer days of worsening asthma in previous three months and up to 2 fewer days of missed work/school/daycare

www.health.ny.gov/health_care/medicaid/redesign/docs/health_disparities_report.pdf

Redesigni
THE MEDICAID PROG

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Health Disparitie

FINAL RECO

The Health Disparities Workgroup recommends the following changes/enhancement to ensure Medicaid coverage of primary and secondary chronic disease prevention and treatment:

1. Diabetes. Currently New York State does not cover pre-diabetes treatment, a condition that affects 1 in 3 adults in the nation, 40% of whom will go to develop diabetes. In New York State, diabetes disproportionately impacts people of color and low income persons. Individual and group lifestyle counseling has been demonstrated to lead to a 58% success rate in delaying or preventing onset of diabetes. The Workgroup proposes that Medicaid (fee-for-services and managed care) cover pre-diabetes group and individual counseling services.

2. Asthma. Extending Medicaid coverage for home-based assessments is expected to reduce asthma hospitalization and ED visits for children and adults with poorly controlled asthma by reducing exposure to common asthma triggers that contribute to preventable exacerbations, by helping parents and children learn self-management skills such as using medication properly and what to do when asthma symptoms worsen, and by assisting individuals with accessing medical care. These actions will both improve health and reduce overall costs. Medicaid accounts for 43% of the total asthma hospitalizations and incurs 37% of the total asthma hospitalization costs in NYS, but current funding and infrastructure to provide environmental services to this population are limited. This funding constraint means that individuals who may benefit from environmental services (in terms of both improved quality of life and reduced healthcare utilization) may currently lack access to these services. New Yorkers with asthma often live in environments that can exacerbate their symptoms and lead to preventable hospitalizations and ED visits. Compared to the nation, New York has higher asthma, ED and hospital discharge rates for all age groups and New York State's rates are roughly two times higher than the levels targeted in Healthy People 2010. The financial impact of New York's higher burden of asthma is significant. In 2007, the total annual cost of asthma hospitalizations in NYS was estimated to be $535 million[3]. For 2005-2007, Medicaid accounted for 43% of the total asthma hospitalizations and incurred 37% of the total asthma hospitalization costs in NYS (Medicare accounted for 23% of the total asthma hospitalizations and 34% of the costs) [3].