THE ROLE OF MEDICAID AND CHIP IN IMPROVING ASTHMA CONTROL

10/22/2019

Chris Talbot:

Hello, and welcome to the Center for Medicaid and CHIP Services Improving Asthma Control Learning Collaborative. Today's topic is the role of Medicaid and CHIP in Improving Asthma Control. Today's event will feature three speakers, including Deirdra Stockmann from the Center for Medicaid and CHIP Services, Natasha Reese-McLaughlin from Mathematica, as well as Joy Hsu from the Centers for Disease Control and Prevention.

Before we get started, I want to cover a couple of housekeeping items just so that we are all starting out with a good start with the technology. If you called in for today's session, you may have noticed that your phone line is muted, and we do ask that you please keep your phone muted to prevent background noise from impacting others on the call. Please keep your phone on mute throughout today's presentation unless you are speaking.

On the right side of your screen, you'll see the audience console, which includes multiple features. If you have questions during the webcast, you can click on the Q&A pod to submit your question in the text box provided. Please select "All panelists" in the ask field when submitting your question or comment. We'll do our best to answer your questions during today's webinar, but we may defer some questions until after the webinar if there are more than what we can fit into our one hour today.

If you have any difficulties at all with the webinar platform today, please reach out to me directly using the chat function. You can send me a direct message by selecting my name, Chris Talbot, in the "to" field. My name will also be marked as being the host for the event, and I'll work to resolve any issues that you might have.

At this point, I'd like to turn things over to Deirdra Stockmann, who will lead us off into today's session and let us know about our topics for today. Deirdra, the floor is yours.

Deirdra Stockmann:

Great. Thank you so much, Chris. It is my great pleasure to welcome all of you to the first webinar in our series on Improving Asthma Control in Medicaid and CHIP. The Improving Asthma Control Learning Collaborative is one of a new series of activities to support state Medicaid and CHIP agencies and their partners to drive improvement on Medicaid and CHIP Core Set measures. So, here is our agenda for today. I'll give an overview of the Improving Asthma Control Learning Collaborative, then Dr. Joy Hsu from the Centers for Disease Control and Prevention will make the case for improving asthma control and share about what works to improve outcomes for people with asthma.

Next, Natasha Reese-McLaughlin from Mathematica will focus in further on Medicaid and CHIP's role in improving asthma outcomes by looking at the drivers of improvement that

Medicaid and CHIP programs can most directly influence, and we'll be sure to allow times for questions and answers at the end. Our goal for this, and all the webinars, in the series is to give you news you can use, information that is directly applicable to your work and your programs as possible, and your questions help us do a better job of honing in on that kind of information.

On this slide I'll talk a little bit about the goals for our learning collaborative. But I wanted to start out to say that we've had a really wonderful response to this webinar series so far, and I think that that reflects a few things; one, I think you already have an understanding that asthma is a common condition among Medicaid and CHIP beneficiaries, and it's one where we have room for improvement; and, two, I will dare to say that you may also have an interest in and commitment to improving the quality of care in the outcomes for people with asthma in our program. Our objectives for this learning collaborative are to support you in taking action on that interest in that commitment.

In particular, our objectives are to support state Medicaid and CHIP agency efforts to reduce the impact of asthma among Medicaid and CHIP beneficiaries, to expand your agency's knowledge of evidence-based asthma interventions; to discuss the importance of using data-driven approaches to focus asthma improvement efforts; and to learn from other states' experiences implementing asthma interventions.

On the next slide I'll give an overview of the webinar series and the rest of the learning collaborative. So, in order to support you in your asthma quality improvement journey, we'll start this webinar series today with what we know works to improve asthma control. We have collaborated deeply with the CDC in the development of this learning collaborative, and today we're very thrilled to have Lieutenant Commander Dr. Joy Hsu from the CDC kick us off with the science and public health practice of what works.

In our next webinar, we'll dive deep into using data to improve asthma control. We want to help you be as data-driven as possible so that you can make efficient use of your limited resources and be able to show the impact of your efforts. So, we'll focus on CMS Medicaid and CHIP core measures related to asthma care, as well as other data sources that you can use to identify where improvement is needed to target efforts and to track the impact of your quality improvement activities. On that webinar, we'll hear from a panel of states about how they've used data on their asthma quality improvement work.

We'll hear from more states and Medicaid health plans in our December webinar, which will highlight a few state stories about how they've approached improving access to evidence-based asthma care and improving outcomes. And finally, in January, we'll conclude the webinar series with an orientation to the action-focused Affinity Group that is the second component of this learning collaborative. The Affinity Group is designed for states that want to take action on the information discussed throughout the webinar series and are at or very near the point of implementing quality improvement projects on asthma in their programs. So, we'll provide one-on-one technical assistance, quality improvement coaching, and additional state-to-state learning opportunities through the Affinity Group. Many more details will come in that January webinar. I don't want to get too far ahead of myself today.

All of the webinars will be recorded and posted on Medicaid.gov for your reference, and for those who are unable to join at this time. So, in answer to the most common webinar question, yes, the slides will be made available, but please note, it takes us a little time to prepare for posting on the web, and we appreciate your patience. We'll get them up as soon as we can. So, now that I've given in the lay of the land, I'm very pleased to hand the floor over to Joy to delve into the topic at hand today.

Joy Hsu:

Thank you, Deirdra. So, as mentioned, I'm the medical officer in CDC's Asthma and Community Health Branch, and I'm a physician trained in internal medicine and allergy immunology. I'm going to set the stage for today's webinar by giving you a brief introduction to asthma and asthma control.

In the United States, asthma is common and disparities exist. About 1 in 13 Americans have asthma. This bar graph shows some known disparities in asthma prevalence; that is, how common asthma is among a certain population. Going from left to right, asthma is more common among children than adults. Asthma is more common in people who report household incomes below the federal poverty line, and asthma is more common among black non-Hispanic Americans. Not only is asthma more common among this population, but asthma attacks, which can lead to emergency department visits, hospitalizations, and deaths, are more common among these groups as well.

Healthcare costs for asthma place an economic burden on our country, as well as each state. As you can see, asthma costs the nation over $50 billion per year in medical costs alone. If you factor in other costs like missed work or school days, the national annual cost of asthma exceeds $80 billion. Asthma-related healthcare costs are higher among low income populations. The per-person medical cost of asthma is higher for people living below the poverty line compared to the overall population of people with asthma.

Medical costs from asthma-related hospitalizations and emergency department visits, or ED visits, can be reduced by improving asthma control. Now, what do I mean when I say "asthma control?" Asthma control includes clinical, environmental, and community-based strategies or interventions that help people with asthma achieve better health. By controlling asthma, you can help people avoid ED visits and hospitalizations for asthma, avoid missing school or work because of asthma, and lead the lives they want to live without having to worry about their asthma. Controlling asthma can also control health care costs. Next slide.

So, regarding the burden of asthma, it's also worth noting that asthma prevalence varies by state and by payer. This variation suggests there are opportunities for improvement. State-by-state analyses of all 50 states show the burden of asthma in each state is different among people who receive Medicaid coverage compared to people who receive commercial or private insurance. This table highlights some differences in asthma prevalence by payer. For example, looking at the first row, asthma affects 6 to 9.6% of Medicaid member with any given state, compared to 4.2 to 5.9% of commercial insurance recipients. These data come from a publication I'll highlight at the end of my talk. This publication provides state-specific

estimates the cost of asthma for 50 states, from Alabama to Wyoming, as well as the District of Columbia. Next slide.

So, what I've shared so far about the burden and cost of asthma has long been known. Why is now the right time for this Asthma Learning Collaborative? Over the past few decades, and accelerating over the past few years, we've improved understanding of how various state agencies, including Medicaid and public health agencies, can improve asthma control. Because of this progress, we now have an increased number of tools available and designed for state agencies. I'll highlight a public repository for many of these tools at the end of my talk.

Also, these past few years have seen an accelerated alignment of federal, state, and local public health activities regarding asthma. I'll mention a few examples from CDC. The graphic on the left describes CDC's 6|18 initiative, a national initiative some of you might have heard of, which is targeting, six, common, and costly health conditions to improve asthma. Since it began, the 6|18 initiative has helped many states, territories, and local jurisdictions strengthen partnerships between Medicaid and public health to improve health and control healthcare costs.

The graphic on the right represents CDC's new pediatric initiative called the CCARE Initiative, which just launched last month. CCARE stands for Controlling Childhood Asthma and Reducing Emergencies. The goal of CCARE is to prevent half-a-million pediatric hospitalizations and ED visits due to asthma over the next five years. If any of you are familiar with the Million Hearts initiative to address cardiovascular disease, with a focus on adults, the intent of CCARE is to be the pediatric equivalent that is focused on asthma. Next slide.

In light of the progress we've made and the direction we are headed in population-level asthma control, I want to introduce you to the scientific framework we and partners are using to inform our asthma activities. We call this framework EXHALE, an acronym that summarizes six clinical and community-based strategies known to work. We know they help people with asthma. These strategies are not listed in order of importance or impact but are arranged this way to make a digestible acronym. I'll briefly walk you through this framework, but more information is available at the link listed at the bottom of the slide. Here are the six strategies.

The first E stands for education on asthma self-management, which includes providing education to people with asthma and their families on how to use asthma medications correctly and when; how to reduce exposure to asthma triggers, such as cockroaches or mold that might worsen their asthma, and what to do if asthma symptoms worsen. X stands for extinguishing smoking and secondhand smoke, as tobacco is known to worsen asthma symptoms and lead to asthma attacks. H stands for home visits for trigger reduction and asthma self-management education, which include environmental assessments for common triggers of asthma and intensive tailored education on asthma self-management described in the first E.

These home visit programs can serve as care management programs for people at high risk of asthma attacks; for example, those who have had multiple ED visits or hospitalizations for

asthma. I want to mention that not every person with asthma needs a home visit. Home visit programs tend to be more cost-efficient when focused on people at highest risk of asthma attacks. A stands for achievement of guidelines-based medical management. This strategy includes improving healthcare quality, as well as improving access to and adherence to asthma medications and their devices. L stands for linkages and coordination of care across settings. Examples of how to advance L includes Medicaid health homes and patient-centered medical homes. Also, partnerships and communication between health insurance plans, public health, healthcare providers, schools and others can advance this strategy. The last E stands for environmental policies or best practices to reduce asthma triggers from indoor, outdoor, and occupational sources. You will notice these strategies are complementary, and you might also wonder why we are using these set six of strategies. Well, we have learned from past CDC and World Health Organization efforts to address other health conditions that prioritizing a manageable number of strategies like those shown here can sharpen and focus what otherwise might be vague commitments to action, avoid a scattershot approach of a large number of interventions, many of which might only have a small impact, and achieve substantial synergistic improvement on health outcomes. Next slide.

I also want to emphasize that every strategy in this framework works. Every strategy in this framework has reduced asthma-related hospitalizations and ED visits, as well as shown a positive return on investment. Also, the first five strategies, that is, E X, H, A, and L, have improved asthma medication adherence by reducing rescue inhaler use, increasing asthma controller use, and improving asthma medication ratios. Next slide.

I'm going to take a few minutes to share some examples and parting thoughts about how EXHALE can be used. As I alluded to earlier, every person with asthma does not necessarily need every strategy in EXHALE. More resource intensive EXHALE-related activities can be focused on those at higher risk of asthma attacks. The table on the left is an example of how a Medicaid managed care plan in Missouri, Family Health Partners, used stratified interventions aligned with EXHALE. It was a funnel approach, so to speak, and you see that interventions at the top of the table were applied to all health plan members and the interventions at the bottom of the table are limited to what they refer to as ultra-frequent fliers.

Some highlights from this table include that for all health plan members for asthma in stratum two, asthma education was emphasized. And for those people who were at the highest risk of asthma attacks, stratum five, the health plan emphasized environmental assessment and counseling, as indicated. With this stratified approach, this health plan reported a net savings of $1.57 per member per month, and you can read more about this health plan's approach in the resource listed below.

The information on the right describes a home visit program, led by the State of Rhode Island Department of Health in partnership with healthcare organizations, and is called the Home Asthma Response Program. They analyzed data from all program participants. People had to have at least one or more ED visits or hospitalizations for asthma to be eligible. And they found that the program return on investment was $1.33 per every $1 invested. They also limited their data analysis to the sub-group to participants who had two or more ED visits for

asthma. And they found when they did that, their return on investment was higher at $2.26 per every $1 invested when they looked at that faction of people with higher healthcare utilization. Next slide.

So, as I mentioned, I'm going to leave you with some resources if you were interested in learning more, which I'll briefly walk through. The first line gives you the link to learn more about EXHALE, our scientific framework for population level asthma control, what we know works. The second link contains some contact information for public health asthma programs in state, local, or territorial health departments. These asthma programs might have activities that align with or can help your work, so I encourage you to explore opportunities to partner with a public health asthma program. The third link provides examples of what state Medicaid agencies have done in CDC's 6|18 Initiative, and the fourth link is a public repository of tools to help state agencies, including tools to improve asthma control. This website includes a webpage and tools specific for Medicaid agencies. The fifth link summarizes some best practices for Medicaid managed care, including the stratified approach that I just mentioned. And the last link is for the publication I mentioned that provides state-specific estimates with the burden and cost for asthma for each of the 50 states by payer by state, as well as the District of Columbia.

With that, I will stop and turn it over to Natasha to talk more about Medicaid's role in improving asthma control.

Natasha Reese-McLaughlin:

Thank you. Great. Thanks so much, Joy. I just also want to let you know we will be sending out the links to these resources after the webinar. As Joy mentioned, my name is Natasha Reese-McLaughlin, and I'm a health researcher at Mathematica. Mathematica is supporting CMCS with the Asthma Learning Collaborative. We will focus the discussion on the role of Medicaid and CHIP agencies in improving asthma control.

In preparation for the Asthma Learning Collaborative, we conducted an environmental scan on asthma quality improvement and related initiatives. Our findings from the scan informed the asthma driver diagram shown here. For those of you who are new to driver diagram frameworks, the purpose of the diagram is to define a range of actions that states can undertake to drive progress towards a specific goal or aim. As you can see here on left, we have listed a few potential asthma-related aims your state may use. Aims could be broad, such as reducing the impact of asthma, or they can be more specific, such as reducing asthma related ED visits or improving performance and asthma medication ratio measures.

As your state finalizes your driver diagram, we recommend using an aim with a specific and measurable goal; for example, reducing asthma-related ED visits by 20%. You can hone in on an asthma statement based on priority populations in your state or by using data to determine the most appropriate goals for your state. Moving to the middle column, you can see six primary drivers. Primary drivers are the key factors that states can address in order to achieve the aim. Another way to think of them is as the focus areas states can target to improve asthma control.

Listed here alphabetically, are the six primary drivers the evidence supports as having the greatest impact on asthma control: air pollution, asthma management, asthma triggers, occupational irritants, respiratory infections, and smoking or second-hand smoke. While we've listed six primary drivers here, I'd like to quickly note that the evidence suggests that Medicaid and CHIP agencies can have the most impact on asthma control by focusing on four of these drivers, which we will highlight later the presentation.

Each primary driver is associated with at least one secondary driver, shown here on the right. Secondary drivers are the change concepts or actions that support progress on the primary driver. For example, air pollution is a common trigger for acute and sub-acute asthma events. To mitigate the impact of air pollution, one action might be to reduce vehicle exhaust pollutants. There's not always a one-to-one relationship between secondary and primary drivers. One secondary driver facilitates cross-sector collaboration shown here in grey, is, in fact, tied to multiple primary drivers.

As your state considers the primary and secondary drivers most relevant to your unique context, it's also important to identify the populations most at risk for each primary driver and tailor interventions to address these disparities. For states interested in developing their own driver diagram, we will be offering a driver diagram workshop as part of our improving asthma control Affinity Group.

Here, we've added the final component of the driver diagram, the change activities shown on the right. Change activities are the evidence-based interventions that states can implement to address a secondary driver and achieve the state's ultimate aim. For example, suppose your state chose to focus on improving asthma management, one secondary driver you might consider is increasing adherence to asthma medication and devices among beneficiaries. An evidence-based change activity you could implement to address adherence is to provide asthma self-management education to patients with frequent medication referrals, ED visits, or hospitalizations for asthma.

Alternatively, your state may choose to target asthma triggers by addressing the secondary driver of reducing exposure to home and school-based triggers, such as mold, dust mites, rodents, etc. One change activity you might consider implementing is providing home assessments for asthma trigger reduction and/or allergen elimination services.

For those of you interested in learning more about successful asthma-related initiatives that state Medicaid and CHIP agencies have implemented, please join us for our third webinar in our webinar series, which is scheduled for December 2019. That webinar will include a discussion of several commonly used change activities, as well as state case studies and lessons learned.

Earlier in the presentation, Joy reviewed the EXHALE framework from CDC. On this slide, we map the EXHALE framework, represented by bubbles with capital letters, to some of our change activities. Continuing with the previous examples providing asthma self-management education, maps to E, education on asthma self-management; X, extinguishing smoking and second-hand smoke; H, home visits for trigger reduction, and asthma self-management, and L, linkages in coordination of care across systems. Meanwhile, our other example, providing home assessments for asthma trigger reduction, also maps to H in EXHALE, home visits for

trigger reduction and asthma self-management. The EXHALE technical package includes various strategies states can use to implement a change activity. We encourage you all to review the technical package as you prepare to implement change activities.

Now, implementing a change activity requires a fundamental understanding of what is happening in the delivery of asthma care, what factors affect care delivery and how states can implement these factors to drive improvement. Data plays a key role in answering these questions. Data on asthma care will help your state tackle the right problems, implement strategies that work, and monitor that a strategy is demonstrating initial success and impact.

This slide provides a very high-level overview of how data can be used at various stages of implementing a change activity. For example, your state may analyze claims data to identify patients with frequent medication refills, ED visits, or asthma-related hospitalizations. This analysis will identify the main target population of your intervention, which, in this case, might be providing asthma self-management education. The analysis can then be used to set a baseline that you will refer back to as you evaluate the effectiveness of the self-management education intervention.

Alternatively, suppose your state has chosen to provide home assessments for trigger reduction. For this intervention, you might also consider tracking the number of asthma patients referred for home assessments as an interim measure in monitoring how successfully the intervention is implemented. For those of you interested in learning more about asthma measures and using available data for quality improvement initiatives, please join us for our next webinar on November 21st.

Now, for the last two slides, we focused on a holistic driver diagram that shows an array of actions that states can use to reduce the impact of asthma. However, this slide highlights the four primary drivers that state Medicaid and CHIP agencies have the greatest ability to impact through quality improvement; asthma management, asthma triggers, respiratory infections, and smoking and second-hand smoke.

And here we present the secondary drivers tied to these four drivers. While Medicaid and CHIP agencies are certainly not limited to acting on these primary and secondary drivers, all of the Medicaid and CHIP agency-driven evidence-based strategies we reviewed fell within one of these categories. Again, we will review case studies in more depth during our third webinar, planned for December 2019.

Moving forward, the Asthma Learning Collaborative and the rest of the webinar series will focus on two of these drivers, asthma management and asthma triggers. These drivers were selected based on the strength of the available evidence and the range of opportunities available to Medicaid and CHIP agencies. Related to asthma management, the two strategies we will review during the Learning Collaborative are increasing medication and device adherence and promoting guideline-based care. Related to asthma triggers, we will focus on reducing exposure to home and school-based triggers.

Finally, research has found cross-sector collaboration to be an effective and innovative method to address asthma disparities through partnerships among diverse stakeholders. Recognizing that Medicaid and CHIP agencies are not the sole entities working on asthma

quality improvement, we will also discuss how Medicaid and CHIP agencies can facilitate cross-sector collaborations with other state agencies, including public health partners, non-governmental agencies, and healthcare providers to improve asthma control.

The learning collaborative aims to be as receptive as possible to state needs and interests. To that end, please respond to this live poll on the secondary driver or drivers of most interest to your state. You can select as many options as you would like from the list, which includes improve asthma self-management, increase adherence to asthma medications and devices, promote guideline-based care, reduce exposure to home and school-based triggers, and facilitate cross-sector collaboration. We will open the poll in a few seconds, and we will keep it open for about 15 seconds.

Wonderful. Thank you so much for that feedback. We will now open the floor for any questions or comments about the Asthma Learning Collaborative and materials we have collected today. Please submit your questions through the Q&A box.

Deirdra and Joy, is there anything else you'd like to add as people keep submitting their questions?

Deirdra Stockmann:

Thanks so much, Natasha. This is Deirdra at CMS. I know that we presented a lot of information quickly. Hopefully that means it was efficiently delivered to you all. But if there's anything that we moved through too quickly that would be helpful to go back, we're happy to flip back to an earlier slide if you want a little bit more information on it.

Natasha Reese-McLaughlin:

All right, there is one question we would like to turn to Joy for. That question is, which is the best approach for respiratory infections?

Joy Hsu:

Well, so, let's see, we're referring to your driver diagram, Natasha, I think, about reducing respiratory infection. So, I mean, guidelines recommend certain respiratory -- certain vaccines against respiratory infections, including for people with asthma. One example, for example, is flu shots are recommended for people with asthma, as well as other people with chronic conditions. Natasha, since you have developed this diagram, do you have more to add?

Natasha Reese-McLaughlin:

No. I think that was great. I would just like to add that we are considering doing additional work related to respiratory infections during the Asthma Learning Collaborative.

Deirdra Stockmann:

This is Deirdra. I'll also add that some of the key change activities are really improving delivery of vaccines that other, you know, quality improvement activities related to getting

vaccines to target populations, in this case, people with asthma, would be where we'd look, and happy to bring more information to you and others who are interested in that. But part of it would be looking at vaccine delivery and stratifies trying to look at who, with asthma in your health plan or in your program, depending on what level you're at, or in your practice, are giving the vaccines and dealing some targeted outreach to that population to make sure they understand the importance, given their condition.

Natasha Reese-McLaughlin:

Sure. Another question came in. Joy, I'm wondering if you can speak to any recommendations to increase medication adherence.

Joy Hsu:

Definitely. So, we have known that, through speaking to the audience, and kind of echoing messages that have been heard before, using data is very helpful. It works. Using data works. It helps. It's not only effective but also helps focus resources. So, we know that interventions that can improve medication adherence include what are called audit and feedback systems. These are interventions that can be implemented by health insurance plans through sort of, for example, their claims data, or healthcare organizations through their electronic health record data, and sort of define -- people can analyze medical records or claims data to identify people who might not be taking their medications as appropriately; for example, you know, if someone has been to the emergency department multiple times for asthma but is not taking any asthma medication. So, the audit part is the analyzing part, and the feedback part is sort of reaching out to either the healthcare provider or the person with asthma to try to see what additional interventions, health-related interventions, would be helpful to this person. We also know that asthma self-management education is proven to improve asthma medication adherence.

Deirdra Stockmann:

Thanks, Joy. This is Deirdra. I see another question about the cost of medications and care guidelines. I don't know if the questioner has anything more specific that you want to add, please feel free to do so. But, Joy, I don't know if you have any comments in general on medication costs or guidelines.

Joy Hsu:

Sure. I can say that there have been studies that have shown that all payment amounts for asthma medications and devices can influence whether people with asthma obtain what they are prescribed to take, and we can share this as the resource. The American Lung Association has performed a recent inventory of Medicaid coverage, as well as not only Medicaid, state Medicaid, but also Medicaid managed care organizations coverage of medications and other measures of guidelines-based asthma care, and also assess any barriers to accessing guidelines based asthma care, such as copayments, and so we can share the link to that. You can go to the website and look up any state you're interested in and have a better sense of

what barriers -- what may be covered through the guidelines-based care and what barriers exist.

I will also add, kind of related to this question, the previous question, another proven method to improve medication adherence for people with asthma and other health conditions is shared treatment decision-making. Now, this is really something that's -- this is sort of something that happens between healthcare provider and the patient. So, shared decision-making, in a nutshell, is when patients with asthma, or other health care conditions and their health care providers collaborate, work together to decide on treatment, and that this discussion provides opportunities to discuss patient goals, preferences, or concerns that are factored into the treatment plan that the healthcare provider will recommend.

Deirdra Stockmann:

Thanks, Joy. I see another question here about whether there's a mode of communication that we found to be most effective in contacting providers. And I'll start a little bit and then hand it over to Joy and Natasha. This is a great question. I think it comes up in many of our quality improvement activities with states that usually involve something about working with providers to either make sure they know about what's covered, how to bill for it, or are aware of changes in the field. And, of course, there are lots of different ways to contact and work with providers, and I will say with our past experience here at CMS that it's been important for states to reach out to their providers and provider groups directly and find out what is the best mode for them, because there hasn't been one -- it's not necessarily one-size-fits all. There seem to be some different kind of cultures within states and among providers about which are the best ways to reach them. A lot of times, there are existing networks of providers and communications that are kind of regular and they're used to referring to, and so some states have found it helpful, or some plans involved in quality improvement have had it helpful to partner with those modes of communication that they know that the providers that they're trying to reach usually look to, and integrating their content, you know, working together to integrate their content into those modes of communication.

So, this is absolutely something that if a state wanted to join the Affinity Group and implement some quality improvement activity, some of these change activities in their state, that the participating in the Affinity Group would be able to really support you in figuring out how to answer this question for the specific state context so that you can get the information to the people who need it, and, of course, encourage them to actually act on that. Joy or Natasha, anything else that you would add from your experience on communicating with providers?

Joy Hsu:

This is Joy. Yeah, I totally agree with what you just said. I agree. I think there is, it's not one-size-fits-all, and partnerships are key, partnerships at the state or local level. So, it's another reason to reach out to either your public health asthma programs or state medical professional societies; for example, the state chapter for the American Academy of Pediatrics or an organization of internists for example, to try to deliver a message. And I also would say, kind

of speaking from personal experience in a practice, is that sometimes repetition or receiving messages from different modes or audiences is helpful too, because in a busy practice, you may miss the first message for example, so hearing from multiple sources through multiple partners can help.

Natasha Reese-McLaughlin:

We've also just received a really interesting question about how the driver diagram shown here relates back to the social determinants of health and social determinants of health efforts in Medicaid and CHIP. One of the reasons why we selected asthma as a focus for our quality improvement initiative is that the condition is not limited to clinical environments alone, and in order to really drive improvement on asthma, it almost necessitates a look at the social determinants of health. As you can see from the drive diagram, many of the change activities here leave the clinical environment and address those social risk factors. Deirdra, is there anything you would like to add?

Deirdra Stockmann:

I don't think so. I think it's a very interesting and important question, and there are certainly a lot of opportunities in the home-visit context in particular and in targeted case management for people with asthma, which is another Medicaid option and service to help connect people to resources to address social determinants that may be affecting this condition, among other things in their lives. So, a good question, and there are a lot of connections, I think, to this condition.

Joy Hsu:

Yeah. This is Joy. If you don't mind, I'll jump in. I agree with everything that's been said. You know, as we saw, there's sort of a lot of connections between EXHALE and the driver diagram. And sort of some things that come to mind with respect to social determinants of health, how do you -- things that can improve conditions and the places where people live, learn, work, and play, include home visits that address conditions in the home when people talk about or assess homes for potential asthma triggers and provide people education and, potentially, methods to reduce asthma triggers in the homes or improving health conditions, for example, like if a home has a pest problem or a mold problem, for example, environmental policies or best practices to reduce asthma triggers are designed to address social determinants of health, and CDC has done a lot of thinking about public health policies to address social determinants of health, and I'd be happy to send links about that as well, something called the High-5 Initiative, which nests well with EXHALE.

And like Deirdra mentioned, connecting people with asthma, and others, who needed social and medical services, if they need help with housing, for example, or if they need help with paying for their medications, that is also -- the linkages are a way to address social determinants of health as well.

Natasha Reese-McLaughlin:

Another question came in about what role pharmacists can play in looking at medication management and medication alternatives. Joy, I'm wondering if you had any input on that one.

Joy Hsu:

Yes. I would be happy to start. So, pharmacists can play an important role. Asthma self-management education delivered by pharmacists in the places that pharmacists work, or if pharmacists go out to the community, can be very important, and has been -- I know at least a few states have sort of worked pharmacists into -- have had agreement or relationships with pharmacist organizations to help deliver asthma self-management education. And pharmacists might also be sort of -- this is unexplored territory that we're less familiar with, but pharmacy data could also be a potential place to try to analyze data from pharmacies, outside of claims data, and be able to identify people who could benefit from outreach and engagement for more outside interventions or support.

Deirdra Stockmann:

Thanks, Joy. I see a question. How long does it take to implement change activities by each state Department of Health and/or Medicaid and CHIP agencies? Great question. I think it depends on the change activity, so I don't know that there's one answer to that question. It will depend on what it is that you want to do and who the partners are, and what the reach is. So, we have designed the Affinity Group that will follow this webinar series, to start off with about a nine-month time period to support states in designing or kind of finishing the design and getting quality improvement project implemented, and we think first states are kind of at the point of implementing something. That's enough time. And then we plan to offer, depending on state needs, state team needs, additional kind of less intensive support for projects ongoing after that initial nine-month period, knowing that usually it takes several months to get something up and going.

And depending on what the desired reach is and what the outcomes that you're trying to get to, usually at least or more than a year to implement to then be able to track the impact of. So, it's a little bit of a roundabout answer to say it depends, and we want to work with states to figure out how to support you in designing and implementing improvement projects that fit within your time and resources, but can also improve care for people, which is part of why what we presented in this first webinar today, which is trying to gather and focus your attention on some of the things that have been shown to work most effectively and be, really, within the purview of state Medicaid and CHIP agencies to help at least do a little bit of the homework to get you started on some quality improvement work. So, thank you for that question.

Natasha Reese-McLaughlin:

We're also seeing a lot of questions about retail pharmacists, about community health workers, and we just wanted to note that, through the Affinity Group, we'll be exploring the

role of how various healthcare providers and partners can tackle quality improvement initiatives.

Deirdra Stockmann:

Thank you, Natasha. Yes, I am very interested, as I said at the top, your questions help us know what kind of information is most useful to you, and it's helpful to know that there are a number of questions around drugs and costs and pharmacies, and so that's something that we'll delve more into, and also make sure to bring in some of the other experts here at CMS, and other partners that can help those questions around asthma drugs and coverage if they are needed.

I did want to make clear, I know our webinar in January is going to be an information session about the Affinity Group, but for those of you who are already thinking about it, which is great, which is something we want you to do, I do want to make sure folks know that the Affinity Group is for state Medicaid agencies to apply to, with a very strong encouragement that they bring in other partners, other states departments, such as public health, as well as health plans, any kind of other stakeholders and partners who will be key to implementing, you know, improvement in these change activities, focused on Medicaid and CHIP populations. We did want to make sure folks knew that as you're thinking about who you need to build relationships with or call and reconnect with, if you haven't talked in a while, to get a state team together.

Natasha Reese-McLaughlin:

We're also hearing a lot of folks letting us know that they tried to respond to the polls but weren't able to. We're sorry to hear that. If you would like to submit your poll responses via the Q&A, we will collect the information that way as well.

Another question we just saw come through is how to make a choice between several activities that implement the same asthma strategy. I would invite you to come back to our second webinar, where the focus will be how to use data to sort of think through various options. We'll also be having a group of state panelists who will also show how they use different data sources to sort of make choices between various implementation approaches.

Deirdra Stockmann:

I see another question about whether there are differences in kind of management of asthma overall across different states. Not to, again, plug webinar number two, but that is also something we'll be discussing to get a little bit ahead to answer the question now. One way to look at differences in care for asthma across states is look at the Medicaid and CHIP Core Sets of quality measures. Among other measures, those, we have four measures on the Core Sets that are related to asthma care, including one on asthma medication ratio, which is one type of proxy for asthma management. Of course, there are many different ways to measure asthma management, and I recognize that. But a measure that we have in the Core Set is asthma medication ratio, and we did publicly post, not quite about a month ago, the most recent data that states submitted to us on performance on that measure, so you can see where

there is variation across states. You can also see how your state is performing compared to other states and start to think about where you might make some improvements.

But as Natasha mentioned, our next webinar, we'll talk a little bit about those Core Set measures, but also talk with states about how they dove in, jumped right into their data more deeply to better understand the variation, not only across, you know, how they compare to other states, but also within their states and think about how they can target and work with health plans in certain regions or certain cities or certain areas within their state where asthma management is not as good or more kids or young adults are showing up in the emergency room or in the hospital with uncontrolled asthma. So, there are lots of opportunities to use quality measures and other asthma data to help better understand what's happening in your state and across states, and identify target efforts to improve.

So, I see another good question about how you tackle the issue of rescue inhaler medications over inappropriate prescribing or refills without patient follow up. So, it sounds like kind of a big question about how you work with providers and families to improve and make the best use of the asthma medications available. Joy, I wonder if you can speak to that.

Joy Hsu:

Well, I think one of the speakers we have in mind for the upcoming webinar will include a discussion of those projects that have tackled this issue of rescue inhaler, over-repeated filling, for example. I think that will be the most relevant hands-on perspective that you can get. I think, again, -- sorry. I mean, it sounds repetitive. But it's, again, going back to using your data, you know, I think, often it's not easy to -- I think it takes time to develop a system that will flag when someone can tell you when somebody is sort of having too many refills without patient follow up. But once a system that can analyze data and give that information, give that feedback to you is developed, it can be very helpful in conducting the appropriate outreach to the healthcare provider or the patient to try to tackle this problem.

Deirdra Stockmann:

All right. Have we addressed, folks in Cambridge, are there additional questions that we haven't addressed that we can address here today? I have a feeling like I have a little bit of a delay on seeing the questions.

Natasha Reese-McLaughlin:

We have a number of very specific questions, and we will be following up with the person who asked them offline.

Deirdra Stockmann:

Okay, great, Natasha. I see one last question that I'll answer and then hand it back to you to close this out. But if did someone miss part of the meeting, will be recorded for review? So, as I said at the beginning, we are recording this session. We'll be posting it on Medicaid.gov on the Asthma Collaborative Learning page. Please note, it does take us a little bit of time to

process recordings and get them posted, so we appreciate your patience. But there will be a recording posted within a few weeks.

Natasha Reese-McLaughlin:

Great. Thank you so much, Deirdra, and thank you, everybody, for participating in the webinar. We hope you'll join us again on November 21st, when we dive into that discussion about data and asthma quality measures. As you exit, we ask for you to please complete the webinar evaluation. Hope you all have a wonderful rest of your afternoon.