State Spotlights in Asthma Control

Centers for Medicare & Medicaid Services (CMS) Improving Asthma Control Learning Collaborative

February 22, 2023

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Housekeeping

Welcome to the CMS State Spotlights in Asthma Control Webinar!

- All participants are muted upon entry.
- There will be a Q&A session at the end of the webinar.
  - Please submit questions using the Q&A panel throughout the presentation.
- Please contact Derek Mitchell (Event Producer) through the Q&A panel with any technical issues you may encounter.
- There will be a survey pop-up at the end of the webinar.
  - Please complete this survey before leaving the meeting.
- A recording of the meeting and slides will be available after the webinar on Medicaid.gov.
  - We will send an email when these materials are posted.

Agenda

- Overview of the CMS Quality Improvement (QI) Technical Assistance (TA) Program
- Improving Asthma Control Affinity Group
- State Spotlights
  - California: Asthma Control Among Black/African American Medi-Cal Beneficiaries in Alameda County
  - Texas: Asthma Control for STAR Children in the Nueces and Harris Service Areas
- Questions & Discussion
- Upcoming CMS QI TA Opportunities

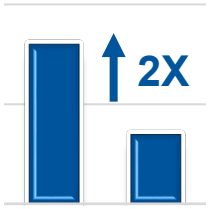
CMS Quality Improvement Affinity Groups

- The CMS QI TA program supports state Medicaid and Children's Health Insurance Program (CHIP) programs and their QI partners with information, tools, and expert knowledge to improve care and outcomes for Medicaid and CHIP beneficiaries.
- As part of the QI TA program, CMS convenes action-oriented affinity groups (AG) to help states build QI knowledge and skills; develop QI projects; and scale up, implement, and spread QI initiatives.
- Each AG is preceded by a webinar series that includes topical information and state QI success stories.

Why Focus on Asthma?

Asthma places a significant economic burden on the U.S. with medical costs surpassing $50 billion annually.[1]

Adults with asthma miss an average of five days of work each year due to their condition, and it is the leading cause of school absenteeism among children.[2]



Black children are two times more likely to be diagnosed with asthma than White and Hispanic children.[3]

Medicaid is the most common primary payer for asthma-related hospital and emergency department (ED) visits.[4]

Roughly 10% of Medicaid and CHIP populations have asthma.[5]

While there is no cure for asthma, it can be effectively managed to prevent exacerbation.[6]

Sources:
1 https://www.cdc.gov/asthma/pdfs/EXHALE_technical_package-508.pdf
2 https://www.cdc.gov/asthma/asthma_stats/missing_days.htm
3 www.cdc.gov/asthma/most_recent_national_asthma_data.htm
4 https://www.cdc.gov/asthma/national-surveillance-data/healthcare-use.htm#NEDS
5 https://www.lung.org/research/trends-in-lung-disease/asthma-trends-brief/current-demographics
6 https://pubmed.ncbi.nlm.nih.gov/17983880/

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Goals and Objectives of the Improving Asthma Control Affinity Group

Goal: Support state Medicaid and CHIP QI teams to drive measurable improvement on asthma control

Objectives:

- Expand state Medicaid and CHIP agencies' knowledge of evidence-based asthma interventions and best practices for implementation.
- Learn from states' experiences implementing asthma interventions.
- Use data-driven approaches to identify, test, implement, and evaluate an asthma-related QI project.
- Support state strategies to work with providers and communities to improve asthma control.
- Improve states' QI skills.

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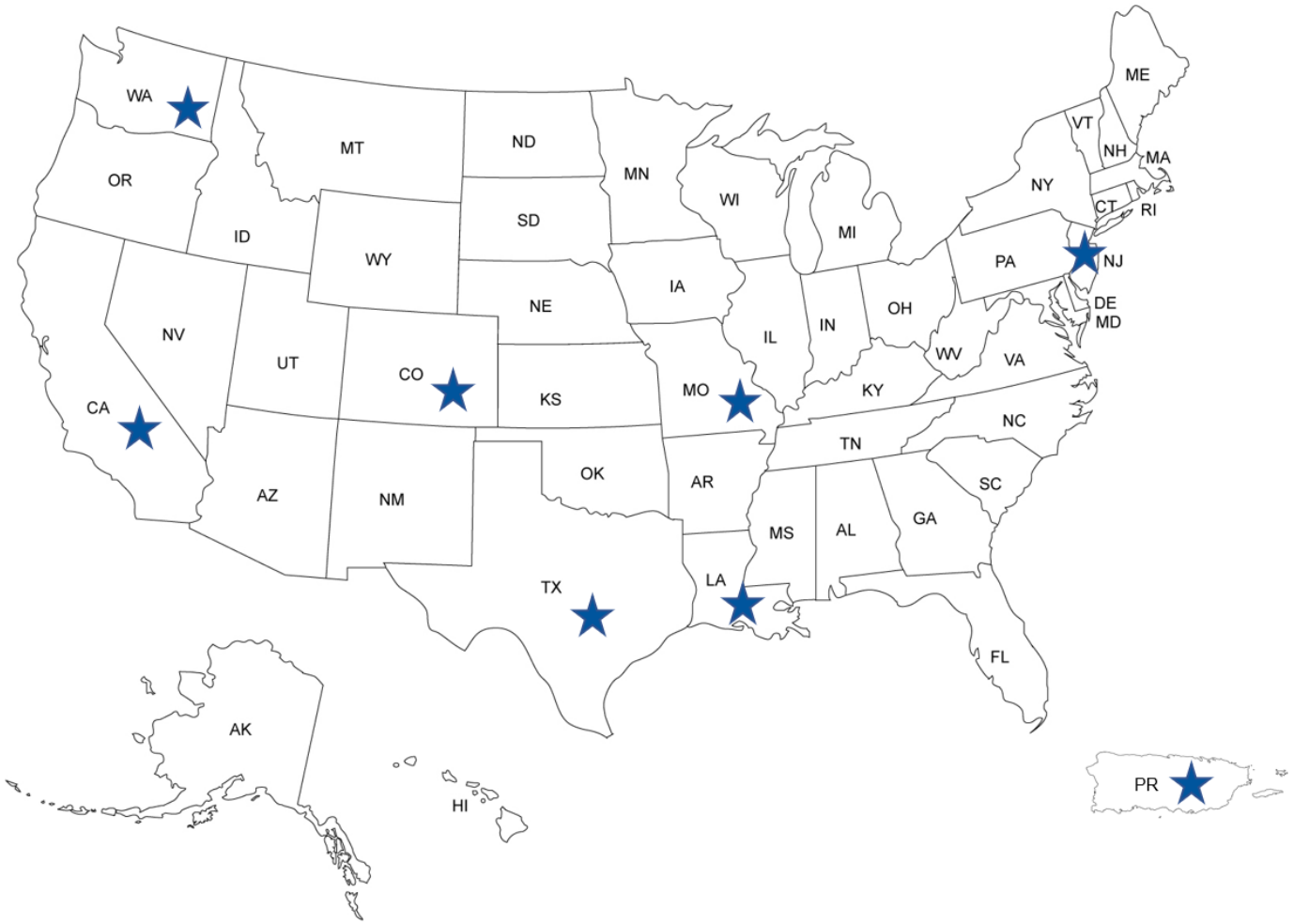
Improving Asthma Control Affinity Group States



- April 2020 – June 2022
- 8 participating states

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Affinity Group State Highlights

Puerto Rico

Sought to increase access to home visits for children with uncontrolled asthma.

Trained case managers from all managed care organizations (MCOs) to link beneficiaries with asthma home visiting services.

Louisiana

Sought to increase the number of children with an asthma diagnosis who received a nonclinical intervention, such as a home visit, for asthma management.

Engaged a large provider and MCO in the home visiting program. Received 180 referrals for the program.

California

Sought to improve health equity among Black adults with asthma.

Conducted member and provider outreach to improve asthma self-management among Black adult members with low Asthma Medication Ratio (AMR) scores.

Washington

Sought to address health disparities in asthma outcomes.

The team conducted listening sessions to understand providers' perspectives on regional disparities and how to identify patients with poorly controlled asthma.

Affinity Group State Highlights (continued)

Missouri

Sought to improve asthma management among children enrolled in health homes.

Fostered strong connections between MCOs and health homes by developing novel communication channels and data reports to identify frequent ED utilizers.

Texas

Sought to improve asthma management for children in two priority service areas.

Built a condition-specific dashboard that aggregated asthma data and worked with managed care organizations (MCOs) to implement asthma projects.

New Jersey

Sought to decrease asthma-related hospitalizations and ED visits.

Create a partnership between the state Medicaid agency and the state's Department of Public Health to expand community health worker training on asthma self-management.

Colorado

Sought to reduce asthma-related ED visits.

Partnered with a regional accountability entity and a provider organization to conduct outreach to patients with poorly controlled asthma to better understand the barriers they faced.

Asthma Control Among Black/African American Medi-Cal Beneficiaries in Alameda County

Arlene Silva, California Department of Health Care Services, Medi-Cal

Helen Lee, Rahel Negash, and Rosa Reyes, Alameda Alliance For Health

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Alameda Alliance for Health

- Alameda Alliance for Health is a Medi-Cal Managed Care Health Plan.
- Provides health care coverage for over 320,000 children and adults in Alameda County (San Francisco Bay Area).
- Our team was comprised of members from the Pharmacy Services, Quality Improvement, Health Programs, Complex Case Management, Analytics, Provider Relations, and Senior Leadership (SLT).

ALAMEDA Alliance FOR HEALTH

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Asthma Medication Ratio Measure

- Included in the Child and Adult Core Sets (AMR-CH and AMR-AD).
- Defined as: The percentage of beneficiaries identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
- In an ideal world, the patient's asthma would be managed so that no rescue medication would be needed. Thus, the ratio would be 1 - 1 unit of controller medication divided by 1 unit of controller medication.
- **Lower ratios indicate that the patient is using more rescue medications.**

$$\frac{\text{Units of Controller Medication}}{\text{Units of Controller Medication} + \text{Units of Rescue Medication}}$$

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The Alliance Asthma Affinity Group Project – At a Glance

The Challenge	Asthma Medication Ratio (AMR) health disparity identified in our Population Needs Assessment (PNA) for Black members between 21-44 years old.
Our Aim	To improve asthma self-management for approximately 200 or more Black adults ages 21-44 such that: (1) 63.6% or more of the target population have an AMR rate of 0.5 or higher and, (2) Asthma-related ED visits decrease.
Strategy	Contact AMR groups separated by score, conduct a survey and interventions. Interventions include coordinating PCP appointments and transportation, providing asthma education, mailing educational materials, and offering a live pharmacist consult.

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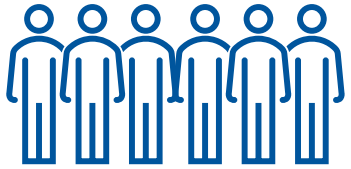
Outreach Groups

Group 1

AMR: 0.4-0.49

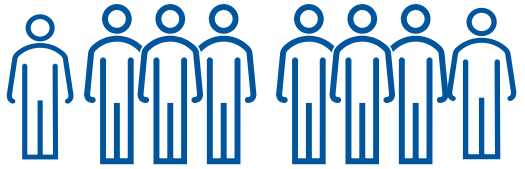
12 members



Group 2

AMR: 0.3-0.39

15 members

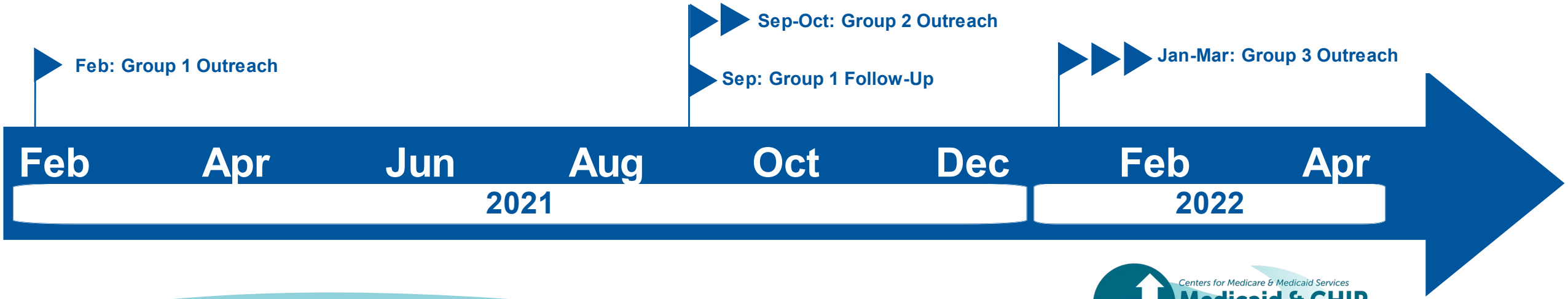


Group 3

AMR: 0.2 – 0.29

(poorest controlled asthma)

35 members



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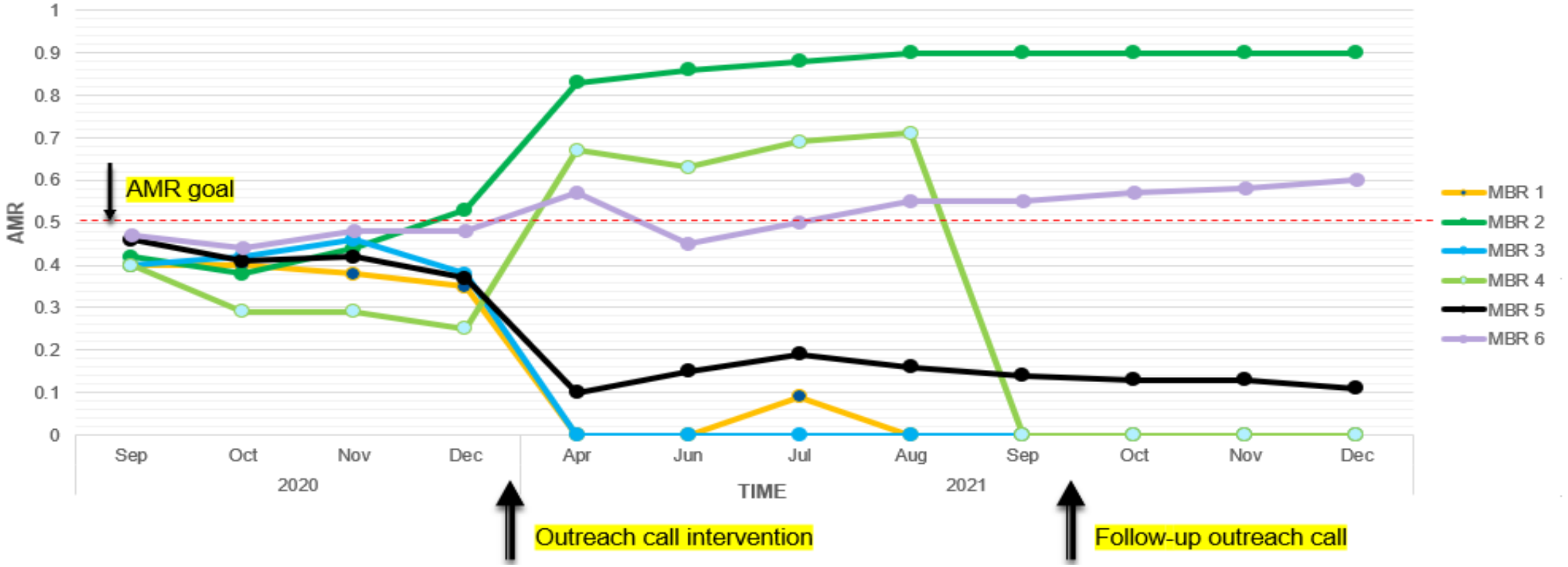
Outreach Group 1- AMR Score 0.4-0.49

- **February 2021, Initial Outreach**
  - Contacted 12 members.
  - Reached 6 members; all agreed to the survey and received at least 1 intervention.
  - Total of 9 interventions provided, including:
    - Transportation (2 members)
    - Asthma education (4 members)
    - PCP scheduling (2 members)
    - Pharmacist formulary assistance (1 member)
- **September 2021, Follow-up Outreach**
  - Contacted 12 members.
  - Reached 2 members, each received at least 1 intervention, including:
    - Asthma education (2 members)
    - Pharmacist consult (2 members)
    - Referral to case management (1 member)

Results – Group 1 Outreach Calls

Figure 1. Outreach Group 1: Monthly AMR by Member



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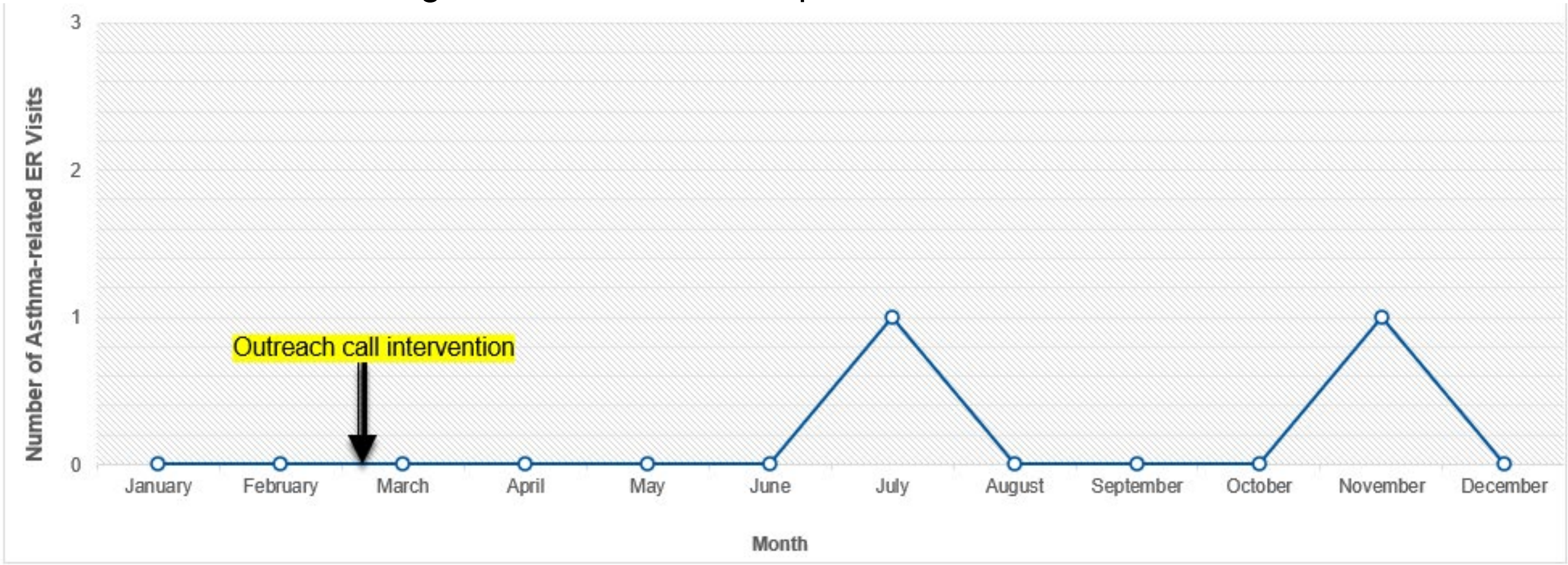
Results – Group 1 ED Visits

Figure 2. Outreach Group 1: ER Visits 2021

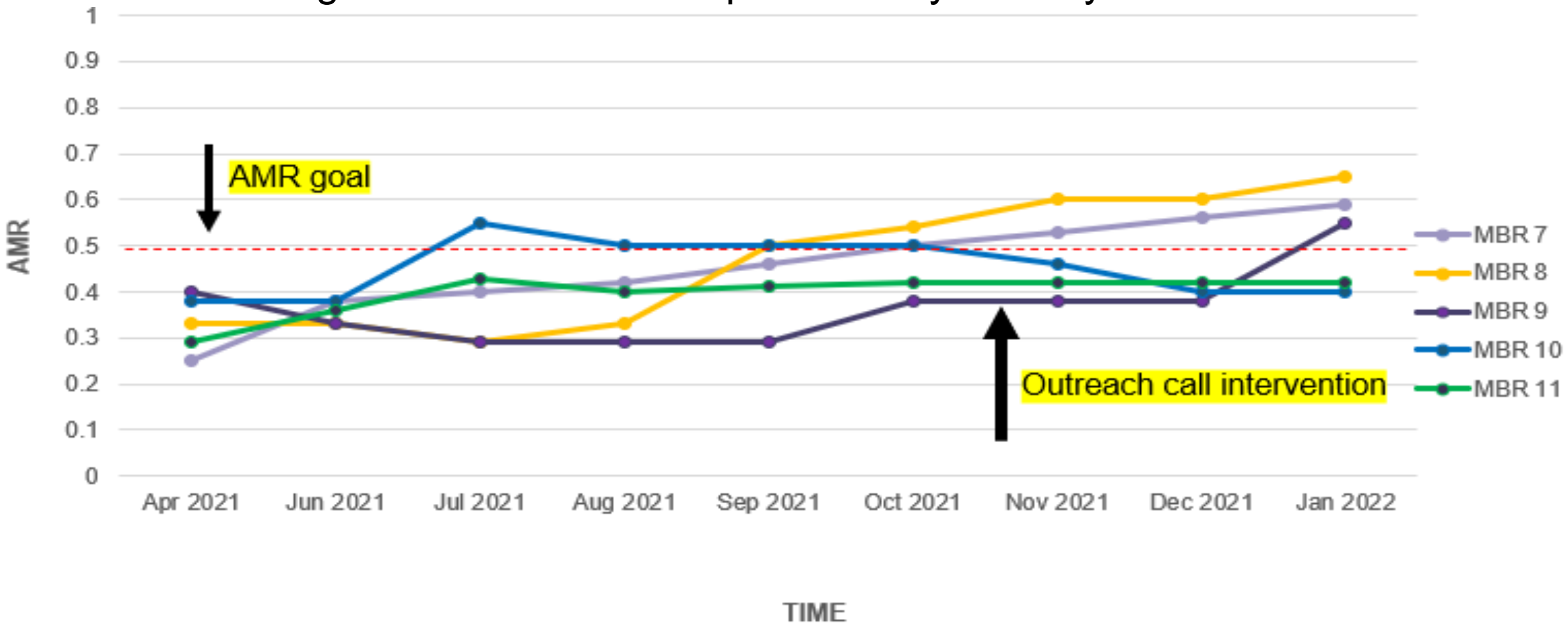


Outreach Group 2-AMR Score: 0.3-0.39

- **September-October 2021, Outreach**
  - Contacted 15 members.
  - Reached 5 members; all agreed to the survey.
  - Four members received at least 1 intervention.
  - Total of 7 interventions provided, including:
    - Transportation (3 members)
    - Asthma education (2 members)
    - Pharmacist consult (1 member)
    - Beacon referral offered (1 member)

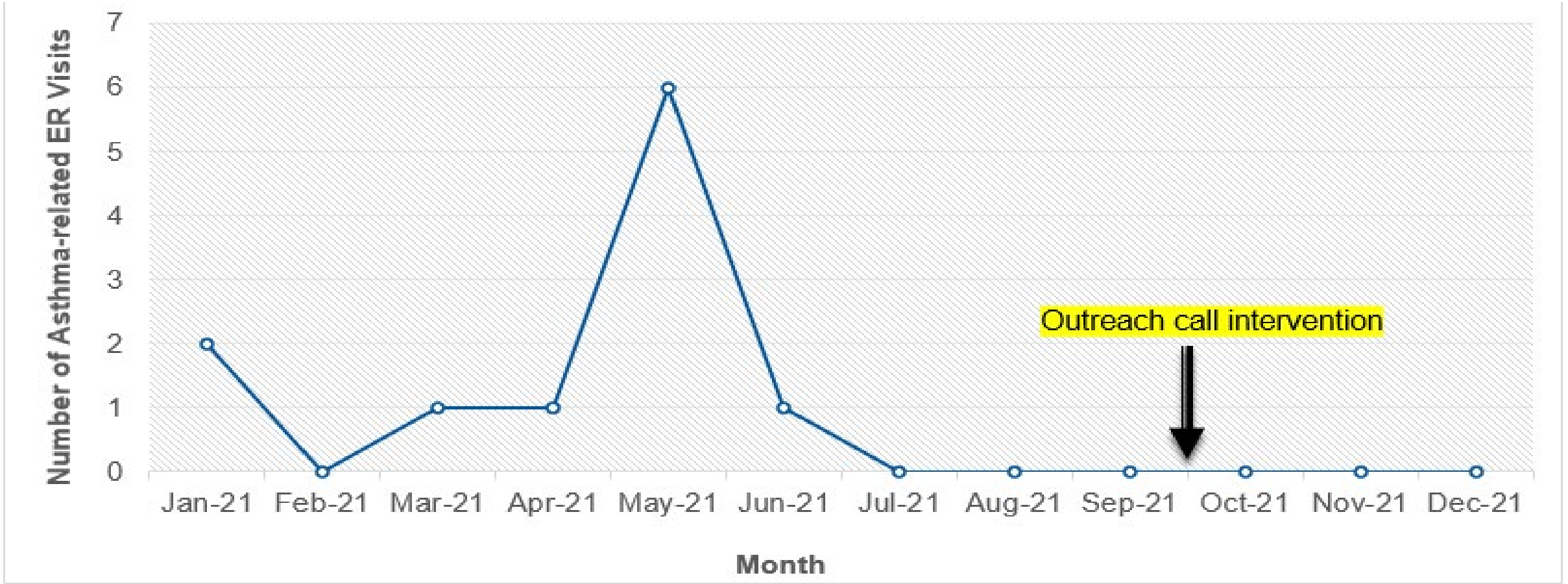
Results - Group 2 Outreach Calls

Figure 3. Outreach Group 2: Monthly AMR by Member



Results – Group 2 ED Visits

Figure 4. Outreach Group 2: Asthma-related ER Visits 2021

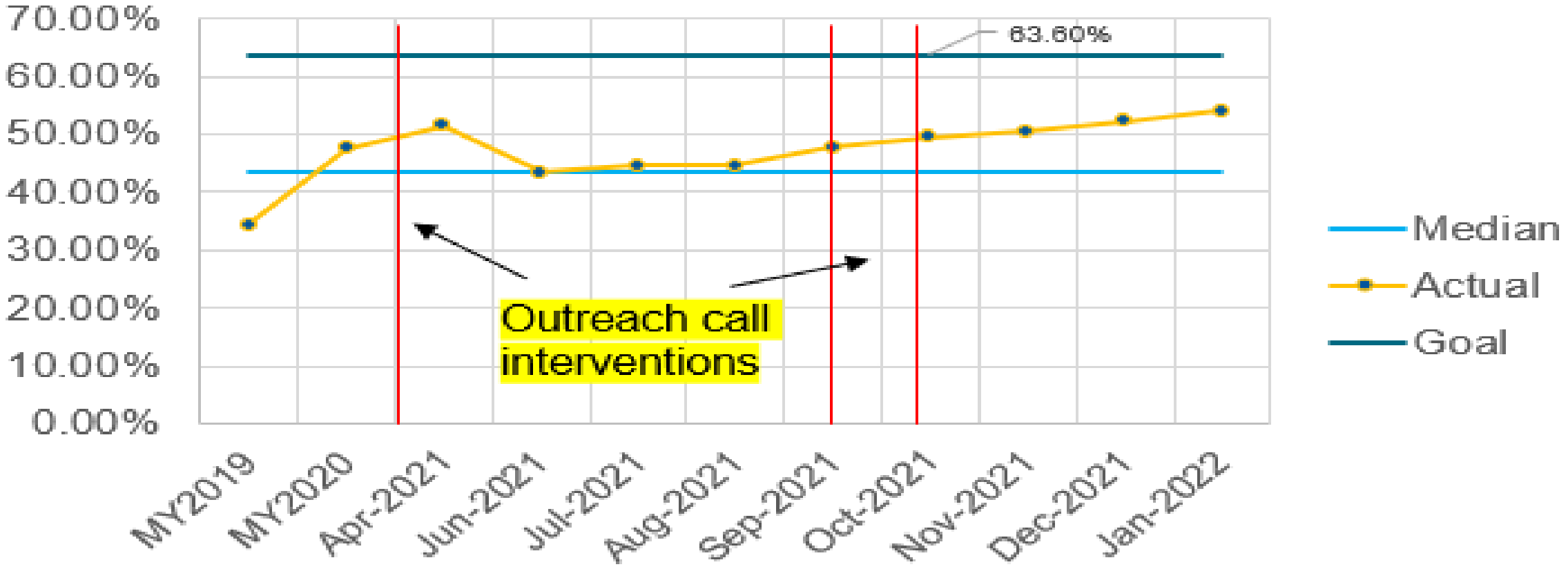


Outreach Group 3- AMR Score: 0.2 – 0.29

- **January-March 2022, Outreach**
  - Contacted 35 members.
    - These members had the lowest AMR scores of the three groups.
  - Reached 12 members; 7 agreed to the survey.
  - 7 members received at least 1 intervention.
  - Total of 14 interventions provided, including:
    - Transportation (5 members)
    - Asthma education (5 members)
    - Smoking cessation help offered (3 members)
    - Beacon referral offered (1 member)
- **Data pending.**

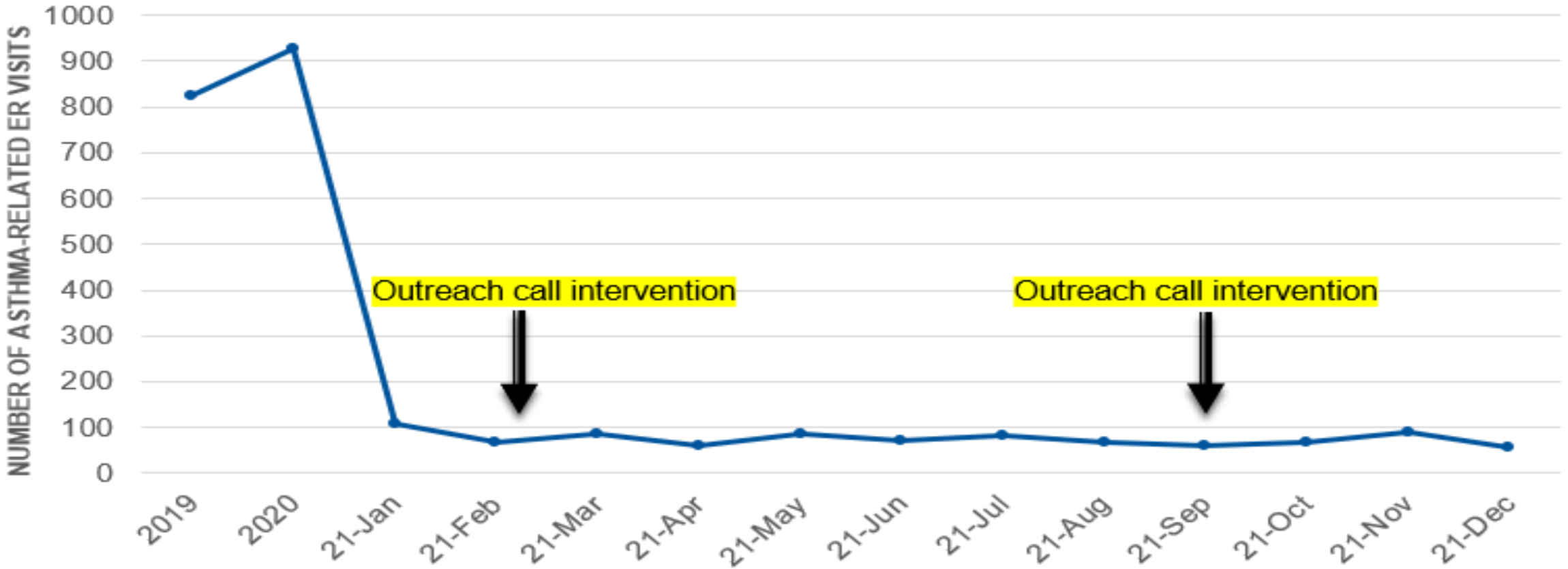
AMR Results – All Groups

Table 1. AMR Compliance Rate



ER Results – All Groups

Table 2. Asthma Related ER Visits



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Lessons Learned for Alameda County

- **Interest/openness to our asthma survey was high.**
  - All live calls in Groups 1 and 2 (n = 11) agreed to survey.
  - In Group 3 (n = 12), 58% agreed to survey.
- **Essential teams for project completion included: Pharmacy Services, Quality Improvement, Health Programs, and Complex Case Management.**
- **Access to active member phone numbers was a barrier.**
- **Data skewing should be considered when interpreting AMR scores.**
  - Limited NCQA-approved medications list can generate lower AMR scores than clinically appropriate.
  - For example, we had a member filling generic Advair Diskus every month, but their AMR score was below 0.5.
  - Member eligibility can generate false low AMR scores.

Reflections on the Affinity Group for Alameda County

- **TA group meetings helped us organize and summarize appropriate data, goals, and interventions** (e.g., Plan-Do-Study-Act (PDSA) cycles, study design).
- **TA resource tools** helped catalyze project movement and understanding with internal departments.
- **TA 1:1 state calls** with subject matter experts (SMEs) helped validate appropriate project approach (e.g., data interpretation and presentation strategy).

Next Steps for Alliance Asthma Team

- **Increase provider involvement to optimize improved outcomes.**
  - For example, California Department of Public Health (CDPH) collaborative provider videos and provider fax blasts.
- **Increase QI department-driven asthma initiatives for continued Medi-Cal Accountability Set (MCAS) for Health Care Delivery Systems AMR Healthcare Effectiveness Data and Information Set (HEDIS) measure projects.**
  - MCAS AMR HEDIS measure above benchmark.

Texas: Asthma Control for STAR Children in the Nueces and Harris Service Areas

Susana Peñate, Texas Health and Human Services, Medicaid & CHIP

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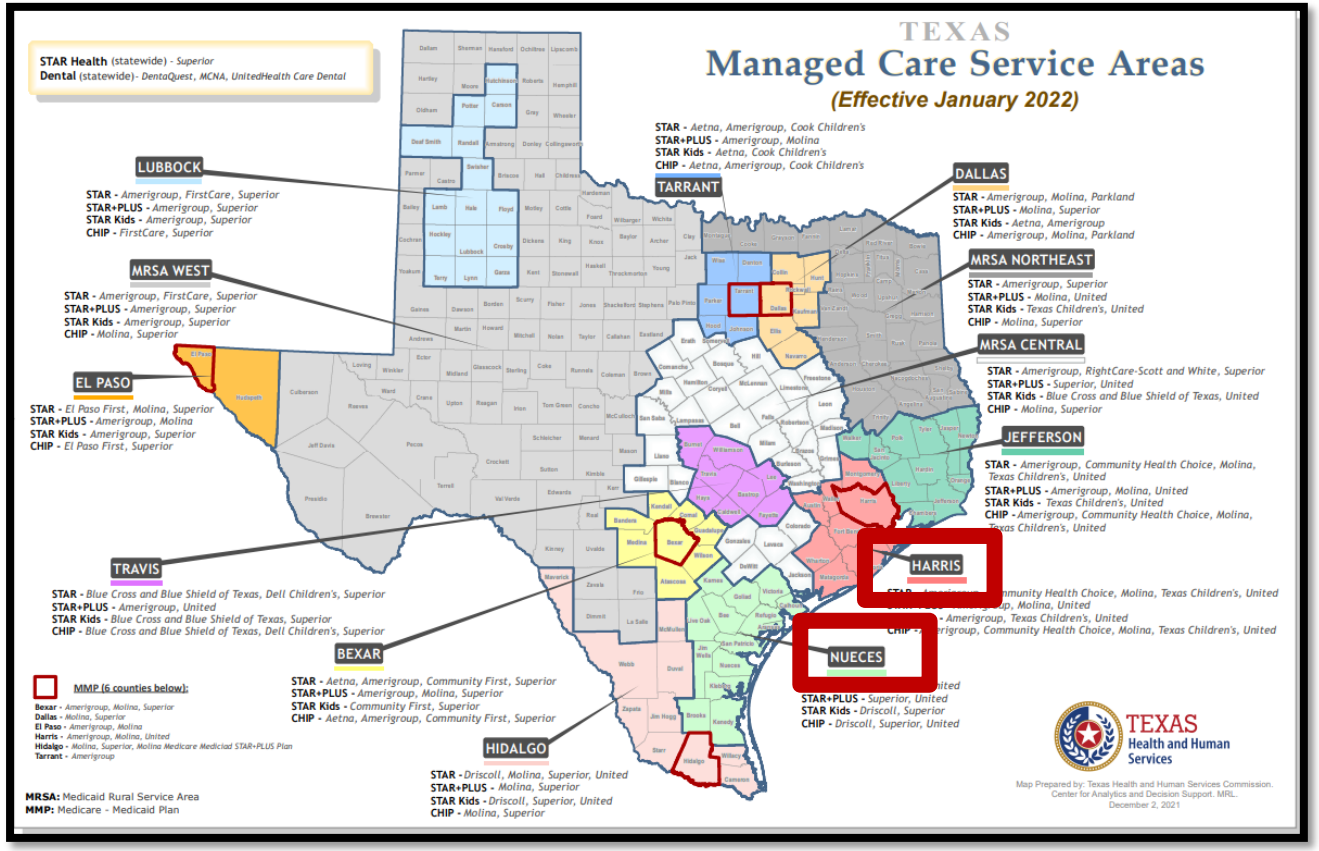
Texas Asthma Team

- Our team was comprised of Texas Health and Human Services Commission (HHSC) and its QI partners including:
  - Texas Medicaid and CHIP Services (Office of Policy, Office of the Medical Director, and Quality).
  - Department of State Health Services (Texas Asthma Control Program).
  - Medicaid managed care organizations (MCOs).

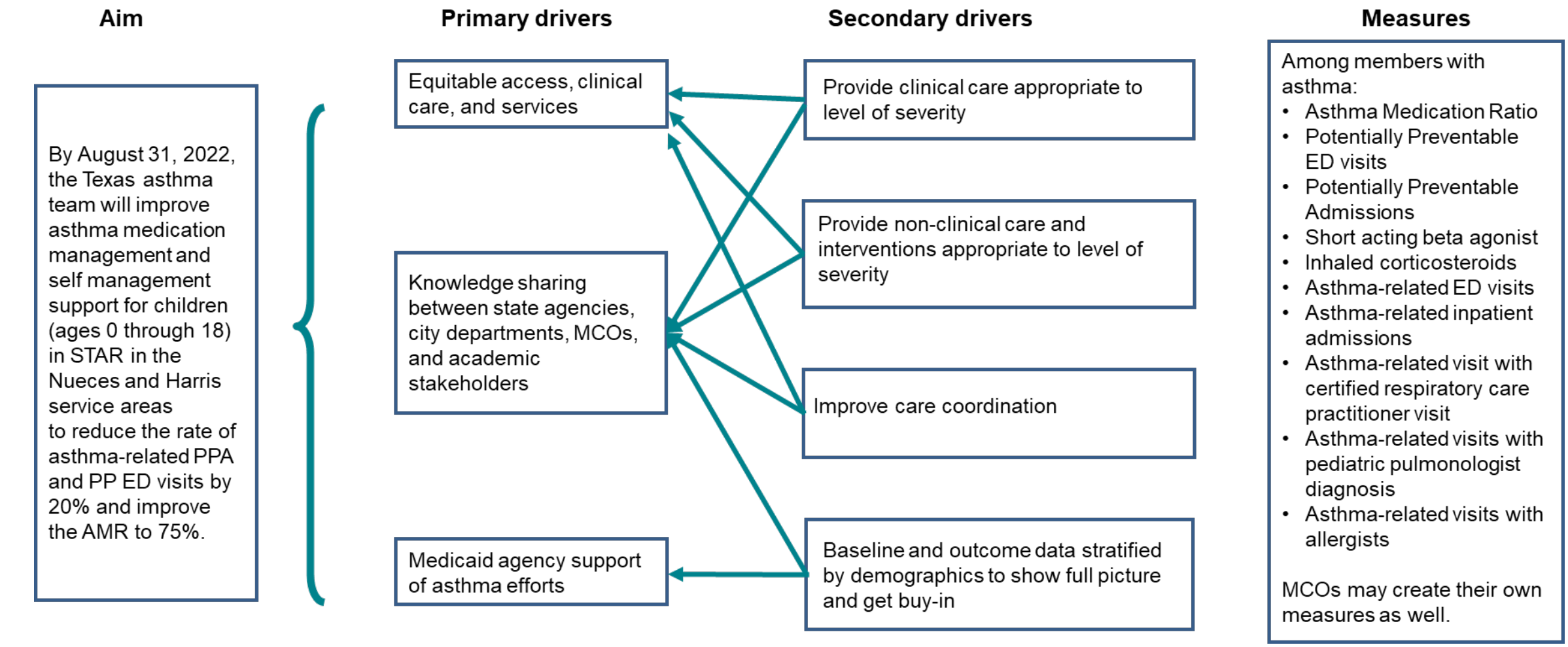
Texas Aim Statement

By August 31, 2022, the Texas asthma team will improve asthma medication management and self-management support for children (ages 0 through 18) in STAR (Medicaid managed care program) in the Nueces and Harris service areas to reduce the rate of asthma-related potentially preventable admissions (PPAs) and potentially preventable emergency visits (PPVs) by 20% and improve the AMR to 75%.



Note: Each MCO had specific targets for PPA and PPV.

Texas Driver Diagram



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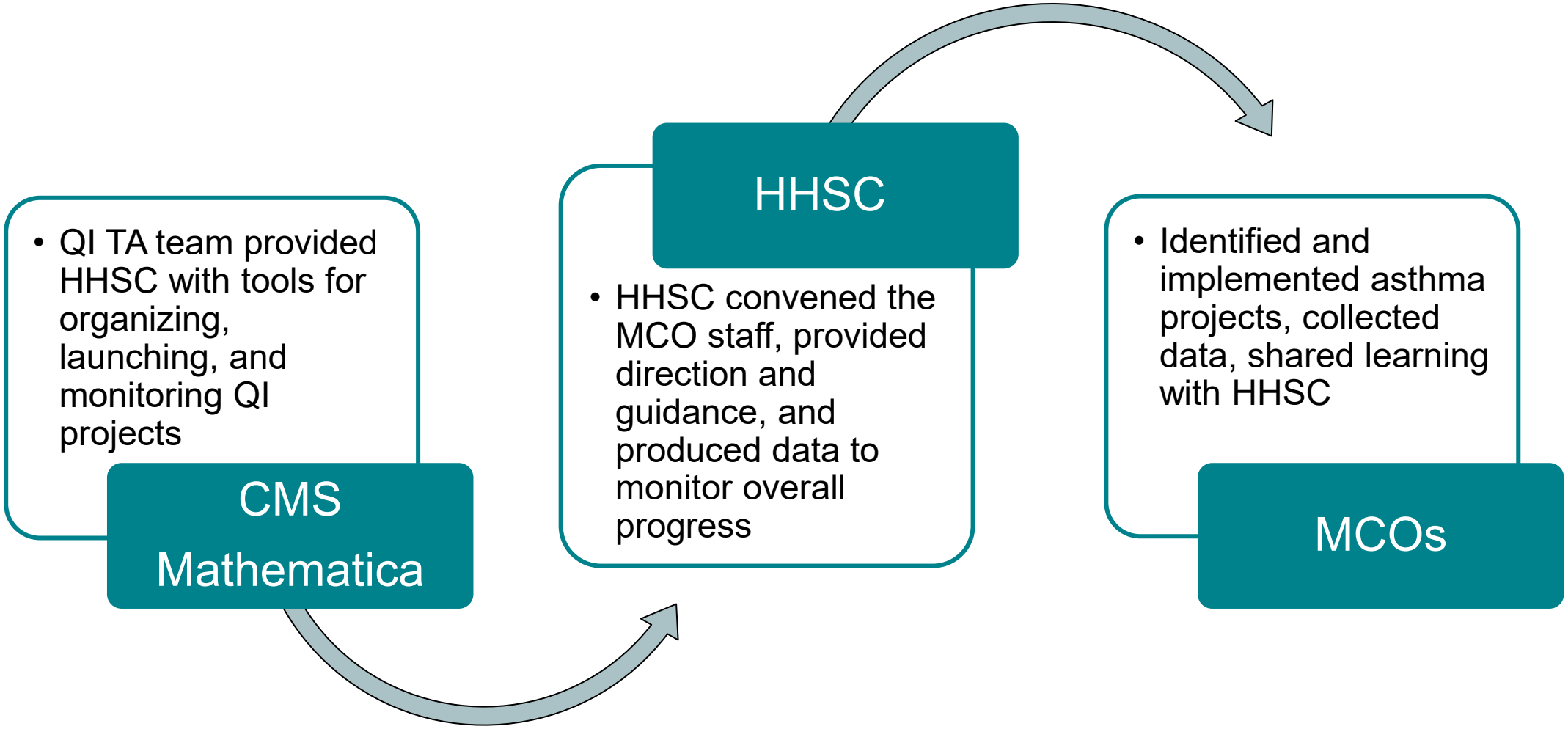
The “Texas” Model



Year 1 (June 2020-June 2021): Kicking Off the Affinity Group

- **HHSC sent a survey to all Medicaid and CHIP MCOs to learn about their disease management programs. We learned that**:
  - Several asthma-related programs were already available to Medicaid and CHIP members.
  - MCOs had varying definitions for “member with asthma.”
- **After the survey, we recruited six MCOs to participate in the AG.**
- **Asthma stakeholders participated in two workgroup series.**
  - Workgroup 1**:** Focused on creating standard definitions for “member with asthma” and “asthma-related ED visit” and delved deeper into risk stratification should be considered when interpreting AMR scores.
  - Workgroup 2: Focused on assessing existing asthma programs in the two service delivery areas (SDAs), shared learning, and compiling asthma education materials.

Year 1: Selecting QI Project Ideas and Gathering Data

- **MCOs selected their QI project ideas.**
  - Change ideas included texting campaigns, a referral system to asthma-related sources, a telehealth program, and enhanced asthma case management programs.
  - MCOs also created or updated their asthma registry and risk stratification system.
- **After the HHSC published "Guidance on Asthma Education Coverage in Medicaid and CHIP"**
  - The Department of State Health Services (DSHS) Texas Asthma Control Program shared the guide with their statewide asthma network.
- **HHSC created a data dashboard for asthma-related utilization data (see the following two slides for an example).**

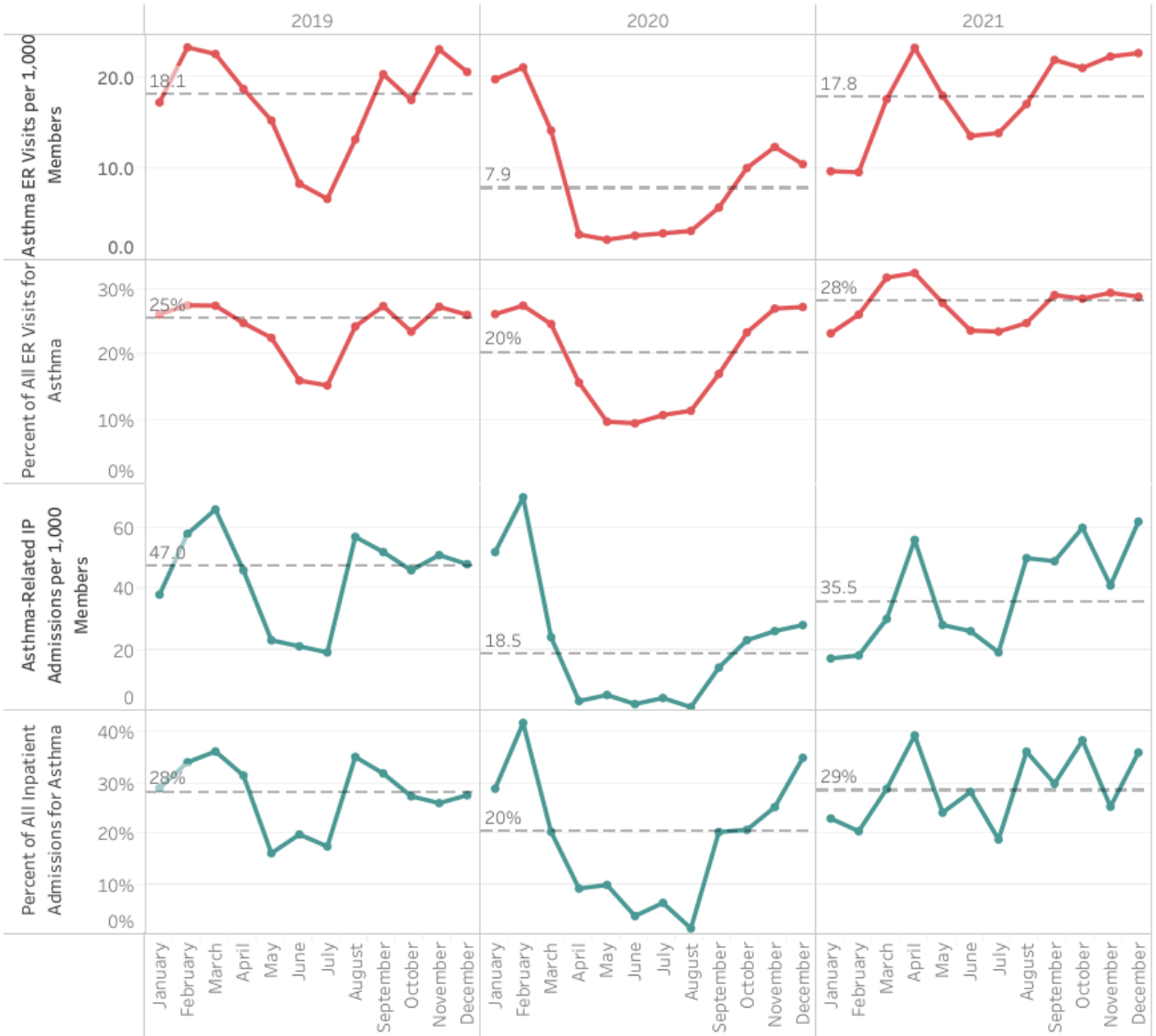
Asthma-Related Emergency Room (ER) Visits and Inpatient Hospitalizations

Among Members with Asthma Age 0-18

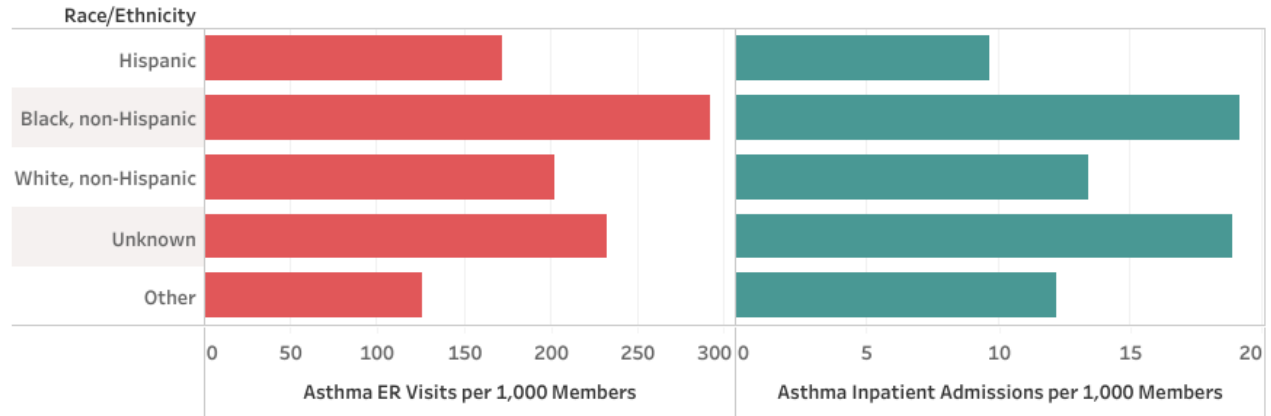
Calendar Year	Quarter	Choose a Service Delivery Area (SDA)	Choose a Managed Care Organization (MCO)	Choose an Age Group	Choose a Race/Ethnicity Group	Choose a Sex Category
All	All	All	All	All	All	All

ER Visits and Inpatient (IP) Admissions

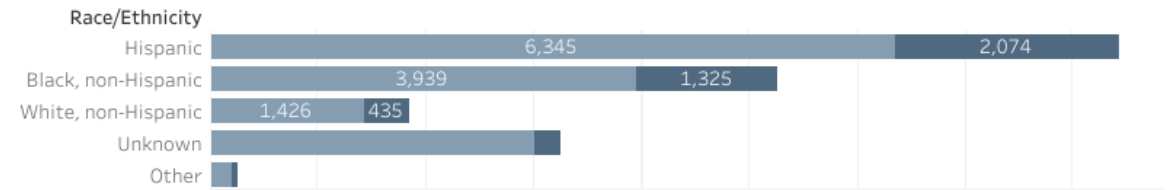
Dashed lines indicate median values



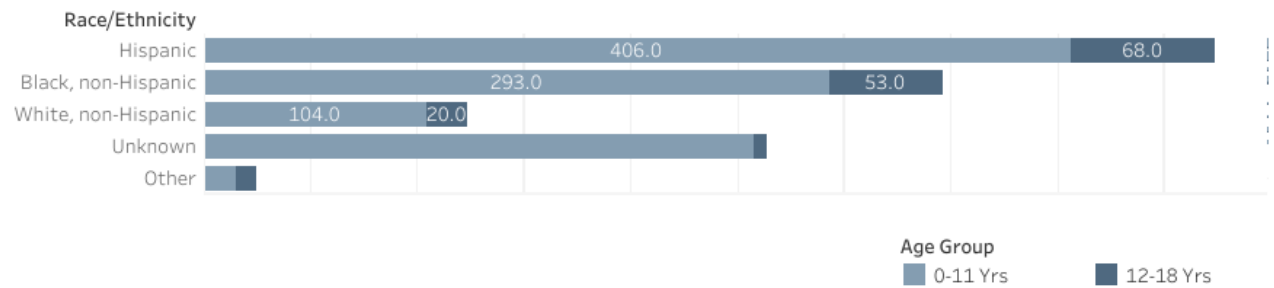
ER Visits and Inpatient (IP) Admissions



Asthma-related Emergency Room Visits - Demographics



Asthma-related Inpatient Admissions - Demographics



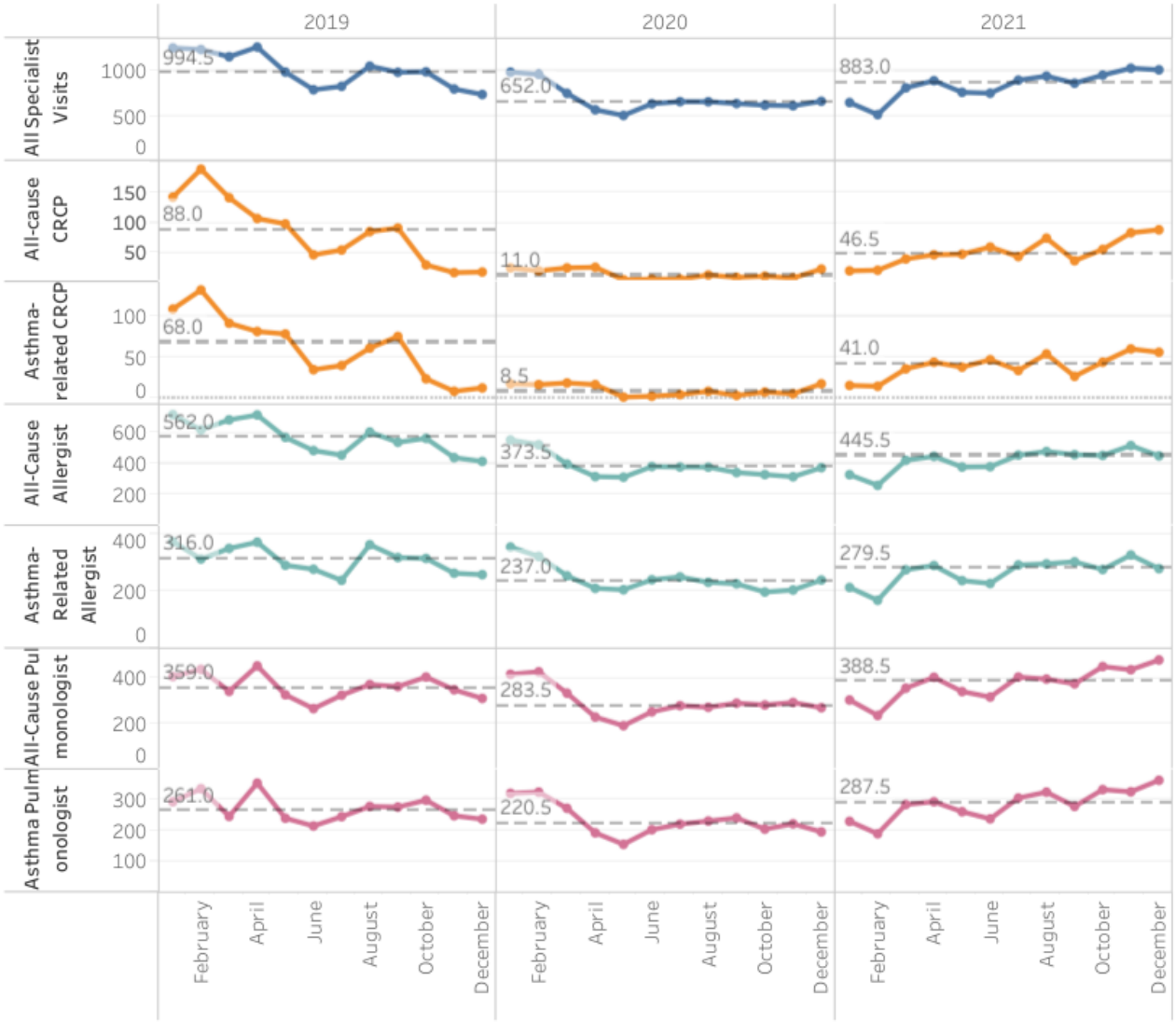
Utilization of Certified Respiratory Care Practitioners (CRCP), Allergists & Pulmonologists

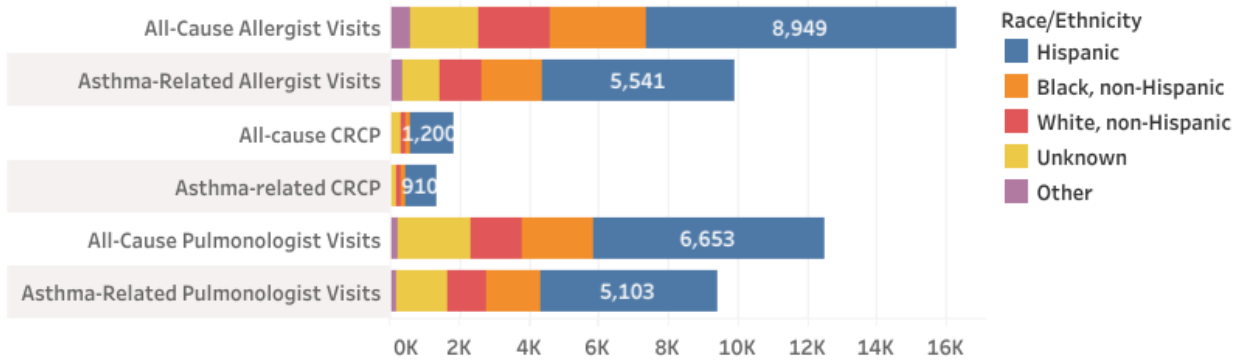
Among Members with Asthma Age 0-18

Calendar Year	Quarter	Choose a Service Delivery Area (SDA)	Choose a Managed Care Organization (MCO)	Choose an Age Group	Choose a Race/Ethnicity Group	Choose Sex of Members
All	All	All	All	All	All	All

Specialist Utilization

Dashed lines indicate median values

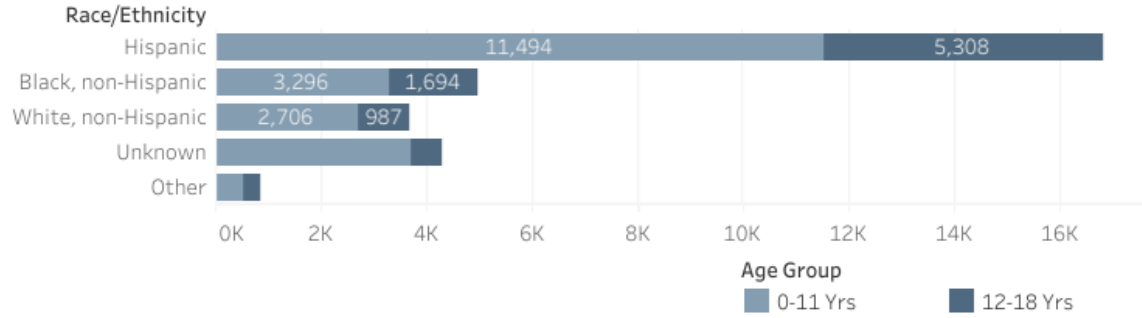




CRCP Visits by Code

Codes 98960 and S9441 are for asthma education.

All Specialist Visits - Demographics



Year 2 (June 2021-June 2022): Starting QI Projects

- **MCOs began implementing QI projects.**
  - Submitted Plan-Do-Act-Study (PDSA) cycles to HHSC for review.
  - Developed run charts for the first six months of pilot projects.
  - Shared data. Data included:
    - Asthma-related ED visits and inpatient admissions
    - AMR
  - Some MCOs expanded QI projects to other areas and populations.

Lessons Learned for Texas

- Having a consistent definition for “members with asthma” took longer than expected but was the foundation for developing the data dashboard.
- Starting with a small number of members (as recommended by the PDSA cycle method) required coaching MCOs, who are more accustomed to operating projects at a larger scale.
- Small-scale interventions will not always result in immediate improvement for the AMR for the selected population in the service area.
- Be flexible and open to pivoting when encountering barriers, such as staff changes.

Reflections on the Affinity Group for Texas

- The affinity group workshops provided insight into on barriers and successes of other state participants.
- The addition of a second year to the affinity group provided long-term support as the MCOs began implementing their QI projects.
- Both state and MCO staff used quality improvement courses (Open School) to learn more about QI methods.

Next Steps for Texas Team

- Add 2022 data to the Tableau dashboard and continue to monitor asthma-related data.
- Participate in forums with other asthma stakeholders across the state.
- Apply and improve upon the “Texas” model in other Texas affinity groups.

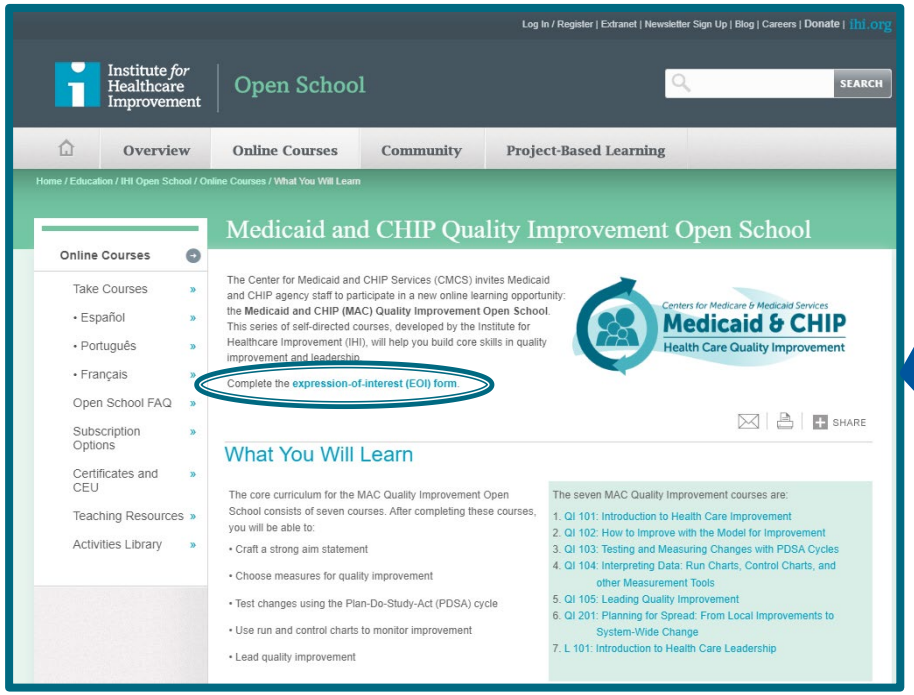
Questions & Discussion

Upcoming CMS QI TA Opportunities

Medicaid and CHIP QI Open School

- MAC QI Open School courses will help QI staff develop, strengthen, and use QI skills.
  - Understanding and applying the Model for Improvement (e.g., crafting an effective aim statement, choosing and using measures for QI, using PDSA cycles to develop strong programs and policies).
  - Access to the Institute for Healthcare Improvement's extensive resource library.
- To learn more, please contact:

MACQualityImprovement@mathematica-mpr.com



To get started, fill out an Expression of Interest (EOI) form at www.ihi.org/MACQuality

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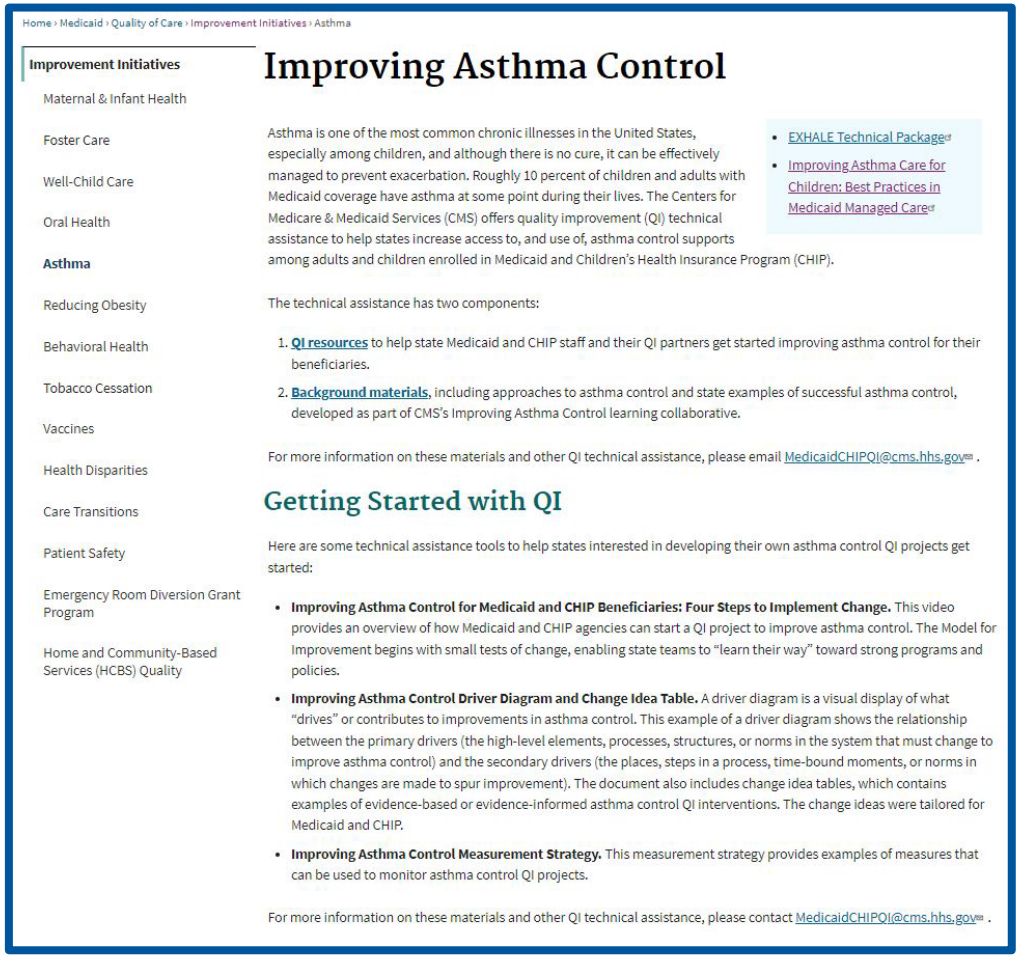
MAC QI Office Hours

- MAC QI Office Hours are offered weekly.
  - Three times a month with an Improvement Advisor.
  - Once a month with Division of Quality and Health Outcomes, Center for Medicaid and CHIP Service staff.
- There is no need to sign-up in advance, just bring your QI questions.
- To learn about upcoming Office Hours, join the Office Hours distribution list by emailing:

  MACQualityImprovement@mathematica-mpr.com

On-Demand Improving Asthma Control QI TA

- **QI TA resources include:**
  - A video on how to get started with QI.
  - Driver diagrams with evidence-based QI change ideas.
  - Example measurement strategies.
  - State highlights from CMS' AG projects.
- **Additional 1:1 QI TA support is available.**
  - Please contact: MedicaidCHIPQI@cms.hhs.gov



Home › Medicaid › Quality of Care › Improvement Initiatives › Asthma

Improvement Initiatives

- Maternal & Infant Health
- Foster Care
- Well-Child Care
- Oral Health
- **Asthma**
- Reducing Obesity
- Behavioral Health
- Tobacco Cessation
- Vaccines
- Health Disparities
- Care Transitions
- Patient Safety
- Emergency Room Diversion Grant Program
- Home and Community-Based Services (HCBS) Quality

Improving Asthma Control

- EXHALE Technical Package
- Improving Asthma Care for Children: Best Practices in Medicaid Managed Care

Asthma is one of the most common chronic illnesses in the United States, especially among children, and although there is no cure, it can be effectively managed to prevent exacerbation. Roughly 10 percent of children and adults with Medicaid coverage have asthma at some point during their lives. The Centers for Medicare & Medicaid Services (CMS) offers quality improvement (QI) technical assistance to help states increase access to, and use of, asthma control supports among adults and children enrolled in Medicaid and Children's Health Insurance Program (CHIP).

The technical assistance has two components:

1. **QI resources** to help state Medicaid and CHIP staff and their QI partners get started improving asthma control for their beneficiaries.
2. **Background materials**, including approaches to asthma control and state examples of successful asthma control, developed as part of CMS's Improving Asthma Control learning collaborative.

For more information on these materials and other QI technical assistance, please email MedicaidCHIPQI@cms.hhs.gov .

Getting Started with QI

Here are some technical assistance tools to help states interested in developing their own asthma control QI projects get started:

- **Improving Asthma Control for Medicaid and CHIP Beneficiaries: Four Steps to Implement Change.** This video provides an overview of how Medicaid and CHIP agencies can start a QI project to improve asthma control. The Model for Improvement begins with small tests of change, enabling state teams to "learn their way" toward strong programs and policies.
- **Improving Asthma Control Driver Diagram and Change Idea Table.** A driver diagram is a visual display of what "drives" or contributes to improvements in asthma control. This example of a driver diagram shows the relationship between the primary drivers (the high-level elements, processes, structures, or norms in the system that must change to improve asthma control) and the secondary drivers (the places, steps in a process, time-bound moments, or norms in which changes are made to spur improvement). The document also includes change idea tables, which contains examples of evidence-based or evidence-informed asthma control QI interventions. The change ideas were tailored for Medicaid and CHIP.
- **Improving Asthma Control Measurement Strategy.** This measurement strategy provides examples of measures that can be used to monitor asthma control QI projects.

For more information on these materials and other QI technical assistance, please contact MedicaidCHIPQI@cms.hhs.gov .

Centers for Medicare & Medicaid Services
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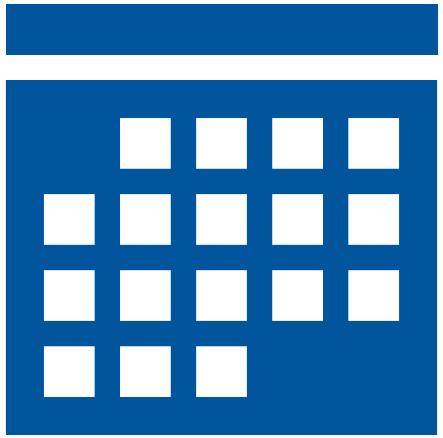
On-Demand QI TA Topics



- Asthma – **Available Now!**
- Tobacco Cessation – Coming Spring 2023
- Oral Health (Childhood caries) – Coming Spring 2023
- Maternal and Infant Health (Postpartum care) – Coming Spring 2023
- Children with Special Health Care Needs (Foster care) – Coming Summer 2023
- Behavioral Health (Follow-up care) – Coming Summer 2023
- Managed Care Quality Improvement – Coming Fall 2023
- Maternal and Infant Health (Well-child visits) – Coming Winter 2023
- Maternal and Infant Health (Low-risk cesarean deliveries) – TBD

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To learn more, contact CMS at
MedicaidCHIPQI@cms.hhs.gov

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Measurement & Improvement

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