

MODELS OF ASTHMA CARE: SUCCESSFUL STATE CASE STUDIES

12/19/2019

Chris Talbot:

Hello everyone and thank you for attending today's third webinar in the series for the Center for Medicaid and CHIP Services' (CMCS) Improving Asthma Control Learning Collaborative. Today's topic is Models of Asthma Care: Successful State Case Studies. My name is Chris Talbot, and I'll be your technical host for today's session. Before we begin, I wanted to cover a couple housekeeping items. As people sign in today to our WebEx meeting, your phone lines have been muted. We do ask that you please keep your phones muted throughout today's presentation to prevent background noise from impacting others on the call. Today we will be utilizing our Q&A pod over on the right-hand side of your screen for submitting any questions that you have for any of our presenters. Please feel free to use that throughout today's session, although, we may delay having questions and responses given by our presenters until there are breaks within their presentation. But we will do our best to address all questions that are submitted using this Q&A tool.

Also, I want to let you know that if you experience any technical difficulties with today's call, you can reach out to me personally for technical help using the chat feature over on the right-hand side of your screen. To activate the chat feature, you can click the cartoon balloon in the bottom of your screen to have it appear over on the right-hand side. Then, when connecting to the chat, please make sure to select my name as the host. Again, my name is Chris Talbot, and I'll do my best to handle any issues that you have along the way. Finally, I do want to let you know that today's session is being recorded for those attendees that cannot join us today. At this point, I'm going to turn things over to Natasha Reese-McLaughlin who's going to start us off today. So, Natasha, please take it away.

Natasha Reese-McLaughlin:

Thank you so much, Chris. It's my pleasure to welcome all of you to the third webinar in our series on improving asthma control in Medicaid and CHIP. The Improving Asthma Control Learning Collaborative is one component of a new series of activities to support Medicaid and CHIP agencies and their partners to drive quality improvement on Medicaid and CHIP Core Set measures. To quickly review our agenda for today, after a brief introduction, I'll hand the floor over to our incredible panel of state presenters from Missouri, Maryland, and California who will share a wide range of real-world state experiences with asthma quality improvement initiatives. We are thrilled to have such a strong panel to share with you today, who will walk through a variety of strategies aimed at helping beneficiaries improve asthma medication management and mitigate and manage asthma triggers.

After each presentation, we will open the floor for one to two audience questions. We encourage you to submit questions during the presentations, as that will help us be ready to raise questions when the time comes. We will also have a longer Q&A period after the final presentation. So, again, please feel free to submit questions over the course of the presentation. Moving to the next

slide, as I mentioned, this webinar is part of a series of activities aimed at improving asthma control. To date, we've had a wonderful response to the webinar series, and I think that reflects not only great interest on this topic but also a commitment to improving the quality of care and outcomes for Medicaid and CHIP beneficiaries with asthma. Our objective for this learning collaborative is to support you in acting on this interest and commitment.

The focus of today's webinar is on the last bullet, to learn from state experiences implementing asthma interventions. Today's webinar highlights three exemplar state case studies, each with a different approach to improving asthma control. After the webinar series, we'll be hosting an affinity group designed for states that want to act on the information discussed throughout the webinar series and are very near or at the point of implementing asthma quality improvement projects. Through the affinity group, we will provide one-on-one technical assistance, quality improvement coaching, and additional state-to-state learning opportunities. We will be hosting our final webinar on January 23rd, where we'll provide more details on the affinity group.

One final note, all the asthma webinars are recorded and posted on Medicaid.gov for your reference. The slides, transcripts, and recordings from Webinars #1 and #2 have already been posted. We will send out the link after this webinar. The slides from today will be posted in a few weeks. So, we thank you in advance for your patience. With that, I will hand the floor over to Eric Armbrecht from Missouri.

Eric Armbrecht:

Hello, it's Eric. I join you today from St. Louis, Missouri, the "Show Me" state. Thrilled to be here – thank you for the opportunity to be part of this. If there are any audio problems, please let me know through the chat box, but I hope my voice is coming through nice and clear. So, next slide, please. I'm representing the work today from the entire team of collaborators at the Missouri Asthma Prevention and Control Program – a group that's been funded by the Centers for Disease Control and Prevention (CDC) for 15 or so years. What's interesting is that many of my colleagues and I have been part of that team and have been involved with that work almost since the beginning in 2002. Just a little bit of context in terms of the Asthma Prevention and Control Program in Missouri – we focus on children, especially those enrolled in Medicaid, or those living in minority communities.

Today, our work maps to four major goals for the program, (1) prescription choice and adherence; (2) control of lung function and symptoms; (3) triggers; and (4) cost of care. We find our work taking place in three different settings: schools, homes, and healthcare systems, and we think about our work as being "enviro-clinical" – that is, recognizing that there's interplay between the environment and the clinic, and the clinic is really where children with asthma and their parents are best supported.

Next slide, please. I want to give you a little bit of information about what I call our "reimbursement pathways." When we were charged by the CDC to do this work, we saw a gap in reimbursement and coverage for two important services – (1) home environment assessments and (2) self-management education.

Both are known to be effective strategies as part of a comprehensive asthma care management program, including guideline-based medical care. I'm going to focus my conversation here today about our work on getting reimbursement for these two components. In home environment assessment services, the focuses are trigger management, trigger reduction plans, and self-management education, to support children and their families to better understand how to take care of their asthma.

There are three different things that we did here in Missouri that are important and noteworthy. First, we pursued and received a state plan amendment for reimbursement of home environment assessment services. I'll make a note here that getting the state plan amendment was just a starting point for us, it wasn't the finish line – it was an important and necessary step. There are other ways to do this, but we found that getting the state plan amendment in place has made some things we're doing easier, but it did not necessarily create demand for these critical services around home environment assessment and health management education. The second thing we did was have a home health program. Our home health program is a per member per month-funded care coordination by primary care sites. This allows us to increase provider demand for asthma care interventions and possibly, for home environment assessments. Please note, this program does not do direct fee-for-service reimbursement for home environment assessment services, but it does provide sizable contributions, or sizeable revenue streams, to primary care providers for care coordination, which is a critical component to effective asthma care management.

The third thing we did was work with our managed care health plans. When we started our work 30-40 percent of children on Medicaid were covered by managed Medicaid health plans, and we started this work intently. In the last couple years, we've gone to 90-95 percent of children with asthma being covered by managed Medicaid health plans. It turns out that these managed health plans can make changes happen with or without a state plan amendment, but we find that their motivation depends on alignment around key performance indicators or coverage requirements that are set in the RFP. And one of the things that Missouri did, and kudos to Peggy Gaddy and others across the state who worked on this, is encourage MO HealthNet, our Medicaid agency, to make sure that our RFPs or the bid documents which are used to solicit bids for contractors for managed Medicaid health plans, included items regarding coverage requirements for comprehensive asthma services. Next slide, please.

I make this film reference from the 80s - Kevin Costner, right? If you build it, they will come. It's not necessarily true. You can't just put a state plan amendment and then hope that the demand for home environment assessments and self-management education is just going to come, or that the capacity that you need to provide those is going to just happen on its own.

I'll share with you our current focus. Next slide, please. Where our plan is currently focusing gives you an idea of the challenges that we still face today and the ones that we are most attentive to right now. We think it's very important to make referrals easy, that is referrals for home environment assessments and self-management education. It has to be simple and convenient for healthcare providers, case managers who work at health plans, and school nurses.

We rely and invest considerably in school nurses and their capacity to do this. It's important to calibrate expectations regarding what percentage of referrals you are going to be able to close and deliver services. It doesn't matter – 100 percent of people that are referred to these types of services do not accept them, but we still believe it's very important to pursue those referrals vigorously, especially when they're coming from healthcare providers, case managers, and school nurses. Secondly, we are focusing on steady growth of the provider network. We need a capable, trained provider network across the state who can deliver the services that we've talked about today. What's important for us is that we must balance capacity with demand. One of the things we don't want to do is go out and build a statewide network that has broad capacity to deliver these types of services and have there be no demand for those services. It's about striking a balance between cultivating demand in certain parts of the state and then marrying it with a capacity to provide home environment assessments, or self-management education services, in this case.

My third point is around school nurses and our support for school nurses. We see many benefits to connecting school nurses and managed Medicaid health plans. It's one of our interesting connections or linkages that we're making right now. You know, because managed Medicaid health plans have a lot of resources that they can provide in terms of care coordination, transportation, enhanced benefits for medication adherence, etc. Our goal in our approach to school nurses has always been respecting their dedication to the children and their level of professionalism. For other states considering this, the orientation and value we've had in the school nurse partnership has been immense over the years.

The last point is clinical quality, and I know the other speakers will talk a lot about this, and we're doing a lot of work in this area. I'll highlight a couple things that are noteworthy for those that have a real quality improvement (QI) focus. Years ago, we did a lot of provider training face-to-face in the clinics and we're now using Project ECHO to engage healthcare providers to drive QI, and increase demand for in-home services, like self-management, education, or home environment assessment services. Project ECHO, if you're not familiar, is a kind of telehealth platform, which started out in New Mexico. We're using it here in Missouri to take cohorts of teams who work collaboratively on shared cases around asthma care management. This is a case-based learning method with providers from different parts of the state meeting at the same time via a live telehealth platform which uses Zoom technology. One of the things we use in clinical quality improvement is building our work around what the providers are willing to do and what their current focus is. There are many ways that they can provide QI. We use a 35-item tool called "Asthma Care," which is routine in my practice. It's an assessment form that measures what providers are currently doing and where they would like to make improvement. The work around Project ECHO is focused on driving quality improvement and is tailored to individually selected domains of improvement.

On the next slide are three of the key members of our team: Peggy Gaddy, the program manager, Ben Francisco, a Professor at the University of Missouri, our Asthma Ready Communities partner, and then me. We'll answer any questions you might have now or later in the session. Thank you.

Natasha Reese-McLaughlin:

Wonderful, thank you so much, Eric. One question we have received is what sort of items are part of the asthma care routine practice tool that is used for assessment and quality improvement, and can webinar attendees review a copy of this tool?

Eric Armbrecht:

Yes, we'll provide a copy of this tool so you can see how we approach this particular problem. The tool has 34 items. It asks questions around four domains, one around high-quality care, another around clinical operations, the third is around administration, and then the fourth is around their role in the community. For example, with regards to high quality care, we ask the question, "Do you assess the severity at the initial visit and update severity to well-controlled based on the lowest therapy step required?" Then, we ask the question, "Is this routine practice or not, and is this an area that you want to improve?" There are other areas we can talk about, such as FEV1 and spirometry inhalation technique. This is very clinically oriented.

We also do things we think are important in the domain of administration. For example, monitoring asthma billing codes and communicating with payers to clarify reasons for rejected charges. There's also a domain around community. For example, "Are you reporting the health status of children with asthma to schools and/or other community-based organizations who take care of the child?" and "How is that clinical operation connecting or linking with community resources that are not in their clinic?" We built this kind of list of what we might consider best practices based on our work in clinical QI over the last decade or so. I am happy to share if that gives you a sense, maybe, of what's included there. Thanks for that question.

Natasha Reese-McLaughlin:

Great, thank you again, Eric. Next up we have the fabulous team from Maryland. Alyssa and Cliff, I'll turn the presentation over to you.

Alyssa Brown:

Great, thanks so much. My name is Alyssa Brown and I'm the Deputy Director of our Office of Innovation, Research, and Development for the Maryland Medicaid program, which is located within the Office of Healthcare Financing in the Maryland Department of Health. Cliff, did you want to take a moment to introduce yourself as well?

Clifford Mitchell:

Sure. I'm Clifford Mitchell and I'm the Director of the Environmental Health Bureau, also located in the Department of Health under a different Deputy Secretary. I'm working very much in partnership with Medicaid on this project.

Alyssa Brown:

Great. Next slide, please. We're here to talk to the group about a couple of different programs that Maryland's Medicaid program has been operating since 2017. Both programs are supported with CHIP administrative funds. These programs are both operated under the Health Services

Initiative State Plan Amendment authority, and we operate these in collaboration with a couple of other state agencies, which I think is a really key component of the success of our programs. We work very closely in partnership with Cliff and his team in the Environmental Health Bureau, which, as he noted, is located within the Maryland Department of Health. But we also work with two other departments within our state, the Department of Housing and Community Development, DHCD, and not mentioned on this slide, but a frequent partner for us, is the Maryland Department of Environment.

I think a lot of the folks on the call today are probably familiar with the Health Services Initiative (HSI) authority. Under that authority, we're permitted to use up to ten percent of our CHIP administrative funds towards health services initiatives. We sought authority to run these two programs in January 2017, and CMS approved our HSI SPA in June 2017. We operate two programs, which we call for short, program one and program two. The first is Healthy Homes for Healthy Kids, which is a program focused on lead abatement in homes for children with elevated blood lead levels. Program two is our Childhood Lead Poisoning Prevention and Environmental Case Management program, which focuses on children with elevated blood lead levels and those with moderate to severe asthma. We'll talk a little bit in detail about those programs as we go through.

The state was interested in leveraging these funding sources in part because of the enhanced CHIP match that was in place over the last few years and is now declining. We also saw an opportunity because we had existing HSI authority to help pay for some poison control services within the state. But we hadn't fully leveraged all the available administrative funds, so, it seemed like a good opportunity to expand some of our programs using that funding stream, and today, total funding for these two programs exceeds approximately five million dollars a year.

Next slide, please. As I mentioned, one of the keys to the success of these programs is our partnership across agencies and within the Maryland Department of Health itself. Again, all these different units bring different types of expertise to the table. I will echo what the previous presenter Eric from Missouri said, which is getting a state plan amendment in place is only the first step in implementing these programs.

There were months of planning involved with all the partners listed on the slide here, and we continue to meet on a bi-weekly basis even today in 2019, a couple of years into the program. A lot of initial challenges with implementing these programs really dealt with coordination between the agencies, figuring out funding streams, and entering into all the appropriate agreements to operate the programs on a day-to-day basis, both contracts and data use agreements. And then working out really the "meat and potato" aspects of the program, which is working on eligibility, referrals, the services that will be offered – all those things that we'll address in detail today.

Each one of the partners listed here really brings a special area of expertise to the table, which I think strengthens the overall quality of these programs. On the Medicaid side, obviously, we have a lot of expertise in terms of financing different types of interventions and navigating some of the challenges and benefits of partnering with CMS and seeking appropriate authority for getting funding. Our partners at the Environmental Health Bureau bring a lot of clinical expertise to the table, which Cliff will expand on in just a few minutes, as well as some familiarity with

different opportunities for structuring financing to our local health departments, who are a key partner for these programs. The Department of Housing and Community Development has several existing programs in place already focused on lead abatement work, as well as a process for working with contractors to perform those types of services. One aspect of our program that is a little bit unique compared to how other states are implementing these is that it's not a service that is covered directly by our managed care organizations, even though about 85 percent of our population is enrolled in managed care. We chose to really leverage some of the existing infrastructure in our state to implement this program.

Next slide, please. I won't go into too much detail about program one, since the focus today is really on interventions for asthma, but I did want to mention it briefly. Again, this is an expansion of existing lead identification and abatement programs that are in place through the Maryland Department of Housing and Community Development. The target population for this is statewide. We have issues in our state with children with elevated blood levels, and specifically the focus is on enrolling children who are either already enrolled in Medicaid or CHIP or would be eligible for those programs and have elevated blood lead levels. I mention this because this segues nicely into some of the information, we'll share with you about program two. This program serves as a natural complement to that program, where we're doing some in-home assessments that may also discover issues in the home that may require abatement due to lead contamination. And so, this provides the natural referral place for dealing with some of those issues on a statewide basis.

Next slide, please. At a high level, the goal of program two is an intervention for children with moderate to severe asthma, or elevated blood lead levels. This is really an example of how the state was trying to leverage existing infrastructure, rather than reinventing the wheel. Program two expanded existing county-level programs that were already providing environmental case management and in-home education programs, with the end goal of improving the quality of life for our two target populations. The program is managed by our local health department on a day-to-day basis, with oversight from Environmental Health Bureau, rather than living within our MCO program or being a required benefit for them. But MCOs, providers out in the fields, and many others are natural partners for referrals to this program. I'm going to turn it over to Cliff now. He can talk a little bit more about the target population for this program, the service delivery model, as well as covered services, some of the durable goods we cover under this program, and some of our very preliminary outcomes which we're excited to share with the group today.

Clifford Mitchell:

Thanks, Alyssa. As Alyssa said, there were a couple of things that motivated us to do this. One is we wanted to take an integrated healthy home approach where if we were in the home for one thing, like lead, we would also be looking at opportunities to affect other childhood chronic conditions, particularly asthma, because it is such an important chronic condition affecting school proficiency and a lot of other outcomes. I agree with Alyssa – this has been an incredibly strong partnership which has been helpful to both public health services and Medicaid in its approach to important childhood conditions.

As Alyssa mentioned, we have a funding mechanism where, for each of the nine counties that are participating in this health services initiative, we determine their population of expected children with asthma and/or lead who would qualify. We provide them with enough funding to hire one environmental case manager who is typically a nurse as well as one to three community health workers, depending on the size of our population. When we do that, we train those folks with a standardized protocol that includes both recognizing lead hazards such as peeling, chipping/flaking paint, as well as asthma triggers and asthma case management or self-management using the NAEPP Guidelines provided by a certified asthma educator. And then, we send them in each of the nine jurisdictions to children who are eligible where they do an initial home visit which consists of an intensive discussion with the parent or guardian, a discussion around home hazards, and an inventory of those home hazards. Based on goals that are set mutually by the family and the home visiting team, we do two to five subsequent visits for a total of three to six home visits depending on the severity and several other factors.

Next slide. This slide shows the nine jurisdictions that are in the program. In order to be eligible, the child must be under the age of 19 years, so 0 to 18 years, and must be enrolled in or eligible for Medicaid and CHIP. This allows us to serve children who may not currently be enrolled in Medicaid/CHIP but are eligible. The children must also reside in one of the nine specific counties and have a diagnosis of moderate to severe asthma, as defined by a clinician, and/or a blood lead level of greater than or equal to five micrograms per deciliter. I should add that parenthetically, if you look at these nine jurisdictions, they represent a majority of the children, up to eighty percent of the children, who had blood lead levels of five deciliters or more who are enrolled in Medicaid/CHIP. These jurisdictions were selected to reach a maximum population for the funds and resources that we had, as well as to represent a diversity of urban, rural, and geographic spread.

Next slide. The home visits focus on triggers for asthma and/or lead. They're aligned with the comprehensive healthy home assessment criteria, and we take the referrals from a number of different agencies. We're getting referrals from hospital emergency departments, primary care providers, and a wide variety of other agencies. We also started the program by getting children who were in the Medicaid program to be billed administratively for these conditions so that the local health departments could ramp up.

Next slide. And let me just share with you some of the characteristics of the homes. If you look at the orange bars, which represent the children in the program who are enrolled because of asthma, what you'll see is that up to 90 percent of those homes have asthma triggers identified in the home visits. Specifically, other air quality issues and other non-specific air quality issues were identified in half of those homes, and then second-hand smoke was identified in almost half of those homes. By contrast you'll see that in using the healthy homes approach, we also see chipping and peeling paint in up to 20 percent of the homes that have children with asthma. So, we can use this comprehensive approach.

Next slide. This graph shows some of the preliminary outcomes for children who have been enrolled due to asthma. We're seeing significantly fewer nights awakened, fewer days with shortness of breath or wheezing, fewer days with rescue inhaler use, and more of them with an up-to-date asthma action plan. All of these are measures that we are looking at in our

comprehensive evaluation, which is still ongoing. As Alyssa mentioned, we started the program effectively at the beginning of last year. We're now in our second year of operation and we're continuing to collect these data.

Next slide. This is our contact information and Alyssa and I are happy to take questions at this point.

Natasha Reese-McLaughlin:

Thank you so much, Alyssa and Cliff. One question that came in was about the financial structure of program two. Can you share a little bit about the state-level financial structure and how the local health departments are reimbursed?

Clifford Mitchell:

Alyssa, do you want to start and then I can talk a little bit about the reimbursement process?

Alyssa Brown:

Sure, I'll take the first half of that. One of the challenges for the state was determining if we were going to be able to determine our state matching funds. The state funds for program two originated from the Environmental Health Bureau's budget. We have a general transfer process where those can be brought into the Medicaid budget, and then we submit our reporting to CMS from billing that we receive from our local health departments. It's an opportunity to really leverage aspects of the budget that might not have otherwise been available to the Medicaid program and also enhance the amount of funding that we can draw down that used to be 100 percent state funds for programming on the Environmental Health Bureau side. The structure of this program overall in terms of distribution of funding to the local health departments is grant-oriented rather than being based on a billing code or something like that. Cliff can talk a little bit about that side as well.

Clifford Mitchell:

Right, what happens is that at the beginning of the state budget year cycle, each of the nine local health departments is given a global budget which includes components for personnel, Veblen goods, and indirect costs. They then develop their maximum budget based on that. Then, at the end of each month, they submit to us an invoice based on their actual activities for personnel costs and Veblen goods expenses. We then accumulate those on a quarterly basis and submit those back to Medicaid. What this allows the local health departments to do is plan – they can hire people, but they also have to justify the work that is done by accounting for activities that are done under the program. That in turn is submitted on a quarterly basis to Medicaid – Medicaid then processes it and does the federal draw. Those funds are then received by the department and then redistributed to the local health departments.

Natasha Reese-McLaughlin:

Great. Thank you again, Alyssa and Cliff. Before we turn to the next presentation, I wanted to quickly remind our attendees to submit questions through the Q&A box at any time during the

presentation. With that, I'd like to introduce Leslie Stucky from California. Leslie, please take it away.

Leslie Stucky:

Thank you, Natasha. Hi, my name is Leslie Stucky. I'm a quality improvement nurse at the Central California Alliance for Health. Next slide, please. The Alliance is a regional non-profit Medi-Cal managed care health plan. We serve approximately 330,000 members across three counties and we work with over 7,900 providers. All Medi-Cal managed care plans are required to conduct two performance improvement projects per each contract with the Department of Healthcare services. We were required to select the first topics from one of four priority focus areas in the Medi-Cal quality strategy. Our first topic, improving health outcomes for children with asthma in Merced County, aligned with the state quality strategy by aiming to increase self-management of asthma and improve quality of life for those affected by asthma. Throughout the project, we worked with the California Managed Care Quality and Monitoring Division and an external quality review organization.

Next slide. In deciding to focus on asthma outcomes in Merced, we started looking at ED visits. Those can reveal the frequency of poorly controlled or severe cases of asthma in a population. You can see from the heat map on the right that our counties in Santa Cruz and Monterey had ED visit rates in the 60 to 80 per 10,000 range. This matches the average rate in California, which was about 79.4. Merced was in the 120 to 140 per 10,000 range. This data is from California Breathing, based in the California Department of Public Health Environmental Health Investigation branch. We also looked at our HEDIS rates, specifically the measure Medication Management for People with Asthma (MMA). This gives us insight to asthma control and medication compliance. The dark blue line in the graph to the left shows that Merced's compliance rates were declining and significantly below our counties of Monterey and Santa Cruz – those are combined in the light blue line.

Next slide. We chose to focus on children rather than adults since children have lower rates of asthma control and medication compliance than adults, as seen in the graph to the left. This is data pulled from the Alliance's quality reporting database back in 2016. Children also have disproportionally higher asthma ED visit rates as seen in the heat map on the right from the California Department of Public Health.

Next slide. We chose to partner with one of our contracted providers, Livingston Community Health. There was room for improvement in their asthma action plan completion rates, which were at seven percent, and their MMA rates, which were at 38 percent. You can see them listed in the graph to the right as Clinic E, fifth from the top.

We knew Livingston Community Health had a strong quality improvement program, engaged leadership, and a newly open school-based clinic, which aligned with their focus on children. We expected our initiative would have a greater impact on that population. Our assessment of the other sites with lower compliance rates revealed shifting leadership, infrastructure rebuilding, or existing engagement in other quality improvement projects with the Alliance.

Next slide. Livingston Community Health assembled a multidisciplinary team and together we looked at the current state of a focused asthma visit. There were gaps identified and we decided to start with addressing the limited time the providers have to create and explain that asthma action plan, with little or no assistance from support staff. Evidence shows that increasing the perceived value of asthma action plans to professionals and patients is essential for implementation. When asthma action plans are incorporated by providers in the discussion with patients, the tool becomes more meaningful and patients are more likely to be engaged in the collaboration and implementation of the plan. The intervention would include a “Train the Trainer” program for the health coaches that focuses on medication adherence. The training was facilitated by a certified asthma educator.

Next slide. We created a self-confidence questionnaire which would measure the health coach’s confidence to cover topics chosen from the National Heart, Lung, and Blood Institute’s Guidelines Implementation Panel. The scale ranged from one to five, indicating not confident as one to highly confident as five. We administered this questionnaire to the health coaches at the beginning and the conclusion of the training. Livingston Community Health monitored the asthma action plan completion rate and they extracted their own data through i2i track software that pulled asthma action plan completion from extractable fields in their electronic health record, Next Gen, via an electronic interface. This allowed them to keep track of their progress even beyond the project period.

Next slide. During the first Plan-Do-See-Act (PDSA) cycle, we collaborated with the certified asthma educator to train health coaches in a four-hour didactic style training. The qualitative feedback from the questionnaire helped to drive the content focus and model the second training. In the second PDSA cycle, we revised the trainings so it would be a two-hour interactive training that included multifaceted methods and supportive learning materials. Research shows that the best way to effectively disseminate and implement guidelines is to use this blended approach.

Next slide. The learning materials we provided included the asthma control test and the asthma action plan. These are both recommended by the National Heart, Lung and Blood Institute as part of the priority Guidelines Implementation Panel (GIP) message. The job aid we chose also doubled as a patient handout – it’s the National Heart, Lung and Blood Institute Asthma Tip Sheet. It includes identification of asthma triggers, how to reduce exposure, and several easy-to-read step-by-step instructions for nebulizers, peak flow, metered dose inhaler, and dry powered inhalers, including the Diskus, Flexhaler, and Twisthaler. The Motivational Interviewing Tip Sheet had prompts and reminders on the foundational elements of this method.

Next slide. Here you can see some of the ways we made the training interactive, with different methods of learning. We watched a step-by-step instructional video from the CDC on how to use a metered dose inhaler. We provided an array of demo inhalers to each coach for hands-on practice and to keep for future patient education. They were each given a metered dose inhaler and the different styles of dry powdered inhalers, and we had a few different spacers and a few peak flow meters. The participants assisted one another with the proper peak flow meter technique and measured their personal best. They added this into the asthma action plan to be interactive with the plan. They each took a turn to read the tip sheets while I demonstrated each technique, and then we utilized the teach-back method of roleplay. The one health coach acted as

a patient and followed the instructions of their partner health coach who acted in the role of health coach. This gave each person the opportunity to teach and to receive the teaching, and to give peer feedback. We encouraged group discussion and worked some examples of motivational interviewing into a presentation as well.

Next slide. This is a summary of all 12 self-perceived confidence criteria, and you can see that prior to the intervention, in light blue, health coaches ranged from very little confidence, one, to highly confident at five. After the training, in the dark blue, all health coaches were either confident or highly confident. We could drill down into the data to see which elements were more often rated as confident versus highly confident, and that could raise modification of the training going forward, with the goal of seeing all scores move to highly confident.

Next slide. We also tracked Livingston Community Health's measure of the percentage of eligible members of the current asthma action plan on file. You can see the baseline was at seven percent, and in May, the Medical Director introduced the project to the care team early on to get buy-in and ensure the diagnosis of asthma would be coded correctly. This inadvertently caused a little boost in the number of AAPs in the next measurement, in June, prior to any other intervention. This really speaks to the engagement and enthusiasm of the Livingston Community Health team. The first training of health coaches completed in July 2016, led by the certified asthma educator, showed a five-percentage point increase in AAP completion through the following two months. In September 2016, the second workshop occurred, which led by the registered nurse and our registered respiratory therapist, resulted in a nine-percentage point increase of AAPs completed within one month. While there were additional interventions identified after this training, such as increasing provider referrals to the asthma health coaches and an outreach program aimed at those members who did not have an AAP on file, the Train the Trainer intervention created infrastructure and a foundation for these continued efforts. We checked back in with them one year after the intervention and they are showing evidence of sustained improvement.

Next slide. Thank you. If there are any questions, I can take them now.

Natasha Reese-McLaughlin:

Great, thank you so much, Leslie. We have received two questions for you. The first was were there incentives for this program? And the second was how can this program be scaled?

Leslie Stucky:

Okay, thank you. There were incentives for this program. We integrated it into our case-based incentive program. Providers received \$35 per asthma action plan completed. This was the model for CBI at the time. One of the things we found there was that there was no billing code for asthma action plans, so the providers would fax in the asthma action plans. We just needed to prepare for that, determining who receives them and then to be able to give them feedback based on completion, and all those things. But providers did receive \$35 if an action plan was completed and then also the members were also entered a monthly raffle. We found this to have a good impact. As for the other question, can it be scaled up? So, we did expand to two other sites in Merced, and in replicating the same trainings, we found that one site had similar results

where everyone had moved to confident and highly confident. This was a group of 14 people. The original group was five people, so it was a small group. So, we scaled to a larger clinic. The third expansion was a group of 20 people, and we found that this group was too large. When you get to 20 people and you have two trainers overseeing the program, we saw that there were some that remained in at the level 3 on the scale - neutral, uncertain. We recommend keeping it to smaller groups.

Natasha Reese-McLaughlin:

Wonderful, thank you so much, Leslie. We're going to go ahead and open the webinar to questions for any of the presenters. The first one that we received is for Eric in Missouri. The question is, how do you make referrals easier between providers, especially school nurses?

Eric Armbrecht:

Great question, thank you very much. One of the things that we have done is we have built a very simple website. It allows for school nurses or healthcare providers to make referrals for home environment assessment services to a central broker, so to speak, who then allocates out that request to a regional provider of that service. It's most in use right now in one or two regions of the state, although it has statewide scalability. We keep the requested information at the upfront request very, very basic. When you're doing a home environment assessment, the work really is on the agency or organization or individual that's doing the home environment assessment work to figure out a time, to confirm location, those types of things. So, we keep the level of information that we need at the entry point very, very basic to trigger a response from a home environment assessment provider to do the outreach to that family and then schedule the appointment. We've had some good traction on this – I think after three or four months, we've seen this scale up. We're not seeing the volume right now from the school nurses that is probably a function of promotion, not necessarily that of need, but uptake from managed Medicaid health plans. These case managers are using this tool regularly. Thank you for the question, that's great.

Natasha Reese-McLaughlin:

Thank you, Eric. Our next question is for Alyssa from Maryland. Can you speak to how this program is staffed? And, who in the Medicaid agency is working on this program?

Alyssa Brown:

Sure. I can talk a little bit about the behind the scenes staffing, and then Cliff, maybe if you can talk a little bit about what the staffing looks like on-site at the local health departments. In terms of day-to-day operations of program two, the Environmental Health Bureau (EHB) is responsible for oversight of the agreements with the local health departments to actually operate the program, but the Medicaid program has bi-weekly meetings with EHB to address any issues that come up in the local health department. You'd be surprised at how many different issues can still arise a couple of years into a program. The Medicaid program is also responsible for the review of all financial documentation submitted and approved by the EHB from the local health departments and submission of that information to CMS.

One of the responsibilities of the Medicaid program also is submitting quarterly reports to CMS regarding both program one and program two, the children being served, and the types of outcomes we're seeing. Hopefully that's some helpful insight and Cliff, maybe you want to talk a little bit more about the staffing model at the local health department level?

Clifford Mitchell:

Sure, Alyssa. First, here in the Environmental Health Bureau we have one person who serves as the fiscal and program person who collects and reviews all the invoices. I play an active role both clinically and looking at some of the management issues. At the local health departments, we have the nurse, the environmental case manager, and then one to three community health workers. I will say that we have had active engagement in the local health departments as well by their fiscal folks because this is a somewhat novel fiscal mechanism, rather than being a straight grant with the invoicing process. It's been a very close collaboration between the program team, the fiscal team, and local health departments, and then our team here, the Environmental Health Bureau, and the Medicaid team.

This goes back to Eric and Alyssa's point, when you do something like this, oftentimes with local health departments the state plan is the very beginning of a process that's quite intensive. There's a lot of work that comes into play afterwards.

Natasha Reese-McLaughlin:

Wonderful, thank you. Our next question, again, is for the Maryland team. How does Maryland determine when a child is Medicaid eligible so that they can participate in the program? Can you speak a little to that process?

Clifford Mitchell:

I can talk a little bit about that. For CMS purposes, we wanted to focus on the children who were the most severe. So, we defined our criteria as moderate to severe persistent asthma. In many cases, clinically, they may not have a diagnosis specifically of moderate to severe persistent asthma, so we essentially established a criterion. Medicaid did a review of its administrative records, Alyssa can talk a little bit about how that works, looking for children who have either been hospitalized or seen multiple times in the emergency department. We also, for functional purposes with the local health departments, have recommended that their screening includes if the child is on a controller medication, or if the child has persistent symptoms, frequent symptoms, or multiple attacks necessitating use of their rescue inhaler. That's allowed us to establish both our criteria administratively as well as functionally for the team.

Natasha Reese-McLaughlin:

Wonderful, thank you so much for that. Our next question is directed to Leslie in California. First, the participant would like to let you know that they really liked your heat maps and would like to know where the data came from? Was it just for Medicaid children or for all children? And if it was for all children, how many children are covered by Medicaid or CHIP in your counties?

Leslie Stucky:

Thank you for that question. That's a really good question, and my understanding is that it was for Medi-Cal or Medicaid members. And I'm just logging on to double check that for you.

Natasha Reese-McLaughlin:

Great. Well, as you double check that, maybe we can turn quickly to the next question and then we'll loop back with you. The next question is for Eric. Did you have to work with your Department of Education, and if so, how did you approach them as they've been hard to engage in Medicaid programs in my state?

Eric Armbrecht:

Right, it's a great question. We consider our Department of Elementary and Secondary Education as a fine partner for the state's asthma program. Keep in mind that the asthma program is located in our Department of Health, and our Medicaid agency is actually in another department. So, you have three departments in play in Missouri, you have an Education Department, a Health Department, and then the MO HealthNet is a Medicaid agency. We're all three different bureaucracies. We've not tried to broker or seen much direct engagement between the Department of Education and the Medicaid agency that pertains to the work that we're doing. In part because I think we haven't necessarily pursued that.

The value that we have seen has come from the State School Nurse Association and our state school nurse consultant, which is a leadership position that's located in the Department of Health, closely affiliated with the asthma program. Because we are in effect a rural state, the local school district has the rights and responsibilities to make decisions, at least in our state at the local level. Our approach has not necessarily been to engage our Department of Education in policy making or programmatic decisions in this area. We've worked really with individual school nurses, individual school districts, the state School Nurse Association, and the state school nurse consultant. They've been our solution to this.

I would say that if we pursued partnering with the Department of Education, I think we could've yielded some additional value. It's a good idea, we should probably pursue some aspects of that in future.

Natasha Reese-McLaughlin:

Great, thank you so much, Eric. So, moving back to Leslie, were you able to confirm?

Leslie Stucky:

Yes, thank you for your patience on that. The emergency department rates were pulled by the hospital discharge databases provided by the California Office of Statewide Health Planning and Development. This is not limited to Medi-Cal patients.

Natasha Reese-McLaughlin:

Got you. Do you know roughly how many children are covered by Medicaid or CHIP in your counties?

Leslie Stucky:

That's another good question that I can get back to you on.

Natasha Reese-McLaughlin:

Our next and final question is also directed at you, Leslie. Given excellent improvement in asthma action plans, has California seen any improvement in the Medication Management for People with Asthma measure?

Leslie Stucky:

We have seen some improvement and we've seen some decline as well. There's a lot of variables that we're looking into evaluating. One of them has been the wildfires in California which have had a big impact. Also, we've seen an increase in picking up rescue inhalers, rather than controller medications, so that's affected our rates. And then, new formularies being on the market has affected the data analysis. We're seeing an increase in controller rates because the rescue inhalers are not being identified in our data. So, that is a complicated question and we are still following it.

Natasha Reese-McLaughlin:

Great, thank you for that, and thank you to everyone for joining the webinar today, especially to our panelists for sharing their incredible work.

Next slide. As a reminder, the final webinar in this series will take place on January 23rd. This webinar will serve as an introduction to the upcoming Improving Asthma Control affinity group. Webinar attendees will have the opportunity to learn more about the goals and structure of the affinity group and to raise questions. We also want to remind you that all materials from webinar one and two are now available on [Medicaid.gov](https://www.Medicaid.gov), including the slides and audio from the webinar. The materials from today's webinar will be posted in a similar fashion once available.

Next slide. Finally, please reach out to the quality improvement technical assistance mailbox email shown here with any questions or feedback related to the asthma learning collaborative.

Thank you again for joining us today, have a great rest of your day. Happy holidays, and we look forward to seeing you at the next webinar in January.