

Highlights from the Improving Asthma Control Affinity Group

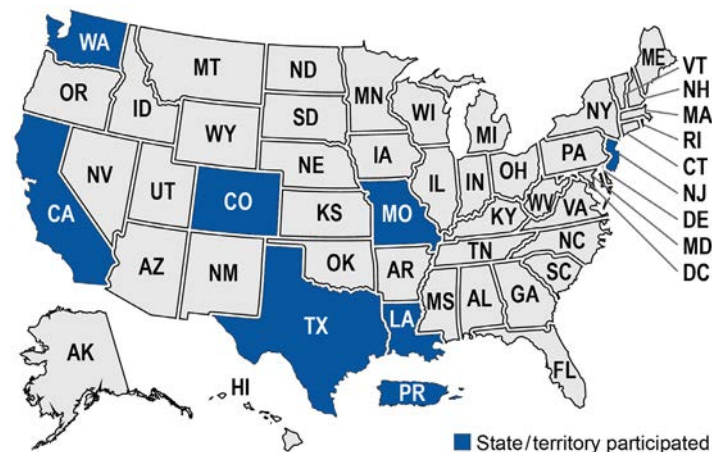
Background

Asthma is among the most common chronic illnesses in the United States, especially among children enrolled in Medicaid and the Children’s Health Insurance Program (CHIP).¹ While there is no cure for asthma, it can be effectively managed to prevent exacerbation.

Despite an array of efficient treatments, poorly controlled asthma accounts for \$50 billion in national healthcare costs annually and is one of the leading causes of school absenteeism among children.^{2,3} State Medicaid and CHIP programs are the most common primary payer for asthma-related hospitalizations and emergency department (ED) visits.⁴

Due to asthma’s impact on Medicaid and CHIP programs and populations, the Centers for Medicare & Medicaid Services (CMS) convened the Improving Asthma Control Affinity Group. From June 2020 through June 2022, eight states⁵ participated in the asthma affinity group (Figure 1). A principal objective of the affinity group was to improve asthma control among Medicaid and CHIP beneficiaries by improving beneficiary self-management, reducing their exposure to asthma triggers, and improving adherence to asthma medications.

Figure 1. State Participation in the Improving Asthma Control Affinity Group



The asthma affinity group began as the COVID-19 public health emergency (PHE) was shifting state priorities and often limiting the capacity of Medicaid and CHIP programs, health care providers, and public health partners to participate in voluntary activities. During the two years of the affinity group, all states adapted and persevered through the challenges posed by the PHE. Although the state teams ended up at different phases of project implementation, all contributed to the lessons learned for driving improvement in asthma control.

¹ <https://www.lung.org/research/trends-in-lung-disease/asthma-trends-brief/current-demographics>.

² https://www.cdc.gov/asthma/pdfs/EXHALE_technical_package-508.pdf.

³ https://www.cdc.gov/asthma/asthma_stats/missing_days.htm.

⁴ <https://www.cdc.gov/asthma/national-surveillance-data/healthcare-use.htm#NEDS>.

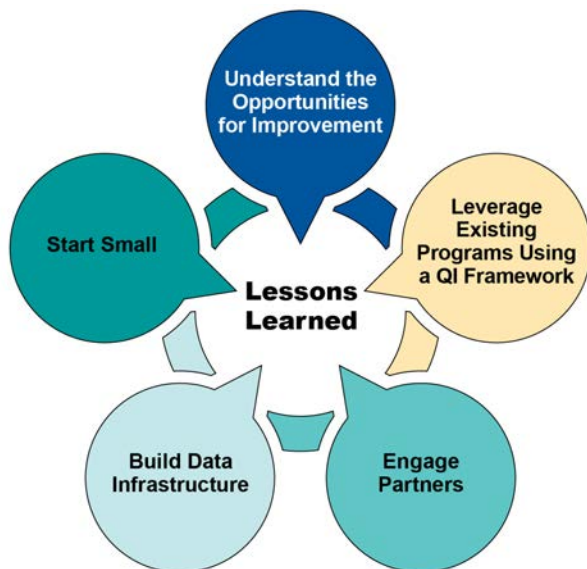
⁵ The term “states” includes the 50 states, the District of Columbia, and U.S. territories.

Lessons Learned from Asthma QI Projects

CMS helped state teams use a data-driven approach to identify, test, implement, and evaluate an asthma-related QI project. The state QI projects yielded five lessons on driving improvement in asthma control in Medicaid and CHIP (Figure 2).

The five lessons are highly interrelated, and most state projects yielded more than one lesson. The state examples in the following sections are illustrative and not exhaustive.

Figure 2. Lessons Learned for Improving Asthma Control in Medicaid and CHIP



Understand the Opportunities for Improvement

Identifying the populations facing the greatest burden of disease is an important step toward understanding opportunities to improve outcomes and reduce disparities. Two commonly measured outcomes are asthma-related ED visits and the Asthma Medication Ratio (AMR) (Box 1).

Two state teams identified disparities in asthma control by stratifying available data on asthma outcomes by race, ethnicity, and age, and used this information to inform the focus of their asthma QI projects.

Box 1. Asthma Medication Ratio (AMR)

The AMR quality measure assesses children and adults ages 5–64 years who were 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. AMR is part of the Healthcare Effectiveness Data and Information Set (HEDIS), the Medicaid and CHIP Child and Adult Core Sets, and the Medicaid and CHIP Scorecard. Higher rates are better and indicate that a person’s asthma is better controlled.

Louisiana stratified data on asthma-related ED visits by age and found that children had a higher median number of ED visits for asthma than adults during a two-year period before the start of the affinity group. The state team sought to increase the number of children with asthma who received a home visit for asthma management.

California stratified data on the AMR quality measure by race, ethnicity, sex, and age within one managed care organization (MCO). After reviewing the data, the state team decided to focus on reducing disparities between Black and White adult members of the MCO by conducting member and provider outreach to improve asthma self-management and reduce disparities.

Washington stratified AMR data by demographic characteristics and learned that rural areas had the lowest AMR rates. Following the affinity group, the state team planned to conduct outreach to health care providers in rural counties to understand their needs related to improving performance on the AMR measure among their patients.

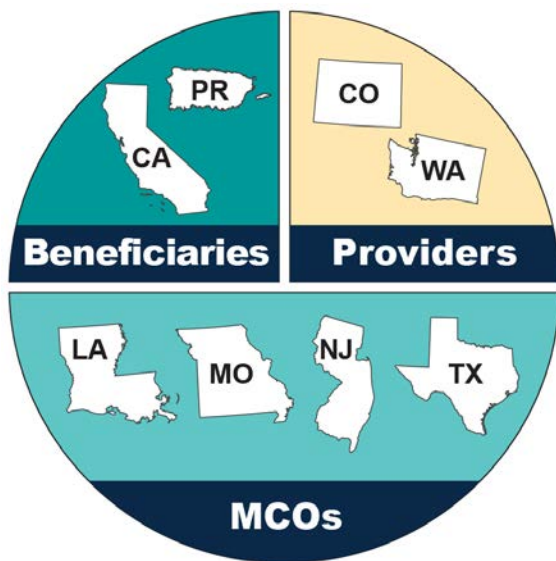
Another important step toward understanding opportunities for improvement is to obtain input from QI partners about potential needs and interventions.

Missouri reviewed asthma data and learned that beneficiaries with health homes had better asthma outcomes than those without health homes. The state team then worked with MCOs to develop a method for identifying beneficiaries without a health home who had poorly controlled asthma and a process for connecting them to resources and support services.

State team experiences showed that gathering information about opportunities for improvement is important for focusing interventions and selecting change ideas. The state teams tailored their interventions to focus on

beneficiaries (two states), providers (two states), and MCOs (four states) (Figure 3).

Figure 3. State Team Asthma Project Focus Areas



Leverage Existing Programs Using a QI Framework

Drawing on an existing program can increase efficiency in the implementation of a project, given the established structures and resources. Coordinating with a well-known program can also increase buy-in among partners and beneficiaries. For example, two state teams worked with existing, evidence-based asthma home visiting programs to test methods of screening and enrolling Medicaid and CHIP beneficiaries into the program.⁶

Puerto Rico focused on expanding access to home visitors trained in asthma self-management for children with poorly controlled asthma. The state team hosted two trainings for case managers from all MCOs on conducting home visits. Participation in the trainings exceeded the team's initial expectations, both in the number of participants and the high level of engagement. Outreach to

⁶ According to the U.S. Environmental Protection Agency, home visiting programs are effective for improving overall quality of life and asthma symptoms and for reducing the number of school days missed due to asthma. For more information, please see <https://www.epa.gov/asthma/asthma-home-visit-programs>.

beneficiaries for home visiting services started at the end of Puerto Rico's participation in the affinity group.

Louisiana focused on expanding an existing Department of Public Health program that provides virtual home visits for children living with poorly controlled asthma. The state team engaged various partners to enroll Medicaid and CHIP beneficiaries into the asthma home visiting program. During the first year of the affinity group, the state team partnered with a large provider and identified 30 Medicaid and CHIP beneficiaries to contact for program enrollment. In the second year, the state team partnered with an MCO and received 90 beneficiary referrals for the program. By the end of the affinity group, 20 beneficiaries who qualified for the program were identified and began receiving home visits.⁷

Engage Partners

Four state teams successfully built collaborations with and among partners outside of the Medicaid and CHIP program. These partnerships enabled data sharing, beneficiary outreach, and case management, in addition to building a foundation for future endeavors.

New Jersey sought to expand community health worker training to include asthma self-management. The state's participation in the affinity group brought together Medicaid and the state's Department of Public Health, which had not worked together on an asthma-related project before. **Louisiana** also effectively engaged public health and MCO partners in their asthma QI project.

Missouri worked to create stronger connections with partners by building new communication channels between MCOs and health homes.

Texas engaged its MCO partners through a structured approach. The state team served as a convener, providing technical assistance to each MCO as they implemented

⁷ To meet the eligibility criteria for virtual home visits, individuals must have at least three indications of poor asthma control and at least two environmental concerns related to asthma in the home. Those who do not meet these criteria receive information via email. For more information, please see https://ldh.la.gov/assets/oph/Centers-EH/drywall/PreScreen_BREATHE_1.pdf.

their own QI projects and sharing lessons learned across the MCOs (Box 2).

Box 2. Spotlight on Texas: Developing a Proactive Approach for Engaging MCO Partners

Texas convened a QI affinity group with five of their MCOs to select and implement plan-specific interventions aimed at improving asthma medication management and self-management support for children in two service areas. In addition to group meetings, the state met monthly with each MCO one-on-one to develop a measurement strategy, review progress, and communicate best practices across the MCOs.

The MCOs completed one intervention testing cycle and were planning a second when the affinity group ended. Most MCOs had submitted baseline and six-month post-intervention data to the state team at the end of the affinity group. The state planned to add the data the MCOs shared to its state asthma dashboard by fall 2022.

Build Data Infrastructure

Tracking and monitoring outcomes are essential to determining the effectiveness of QI interventions. Three state teams created reports or dashboards to track the measures related to their asthma QI projects.

Texas created a condition-specific dashboard to monitor monthly trends in asthma-related, potentially preventable inpatient admissions, potentially preventable ED visits, and performance on the AMR measure. The dashboard enabled monitoring at the local level, which was important because the team's asthma QI project focused on two local service areas. The state team also created a template and shared it with the participating MCOs, so each could evaluate its own data every month.

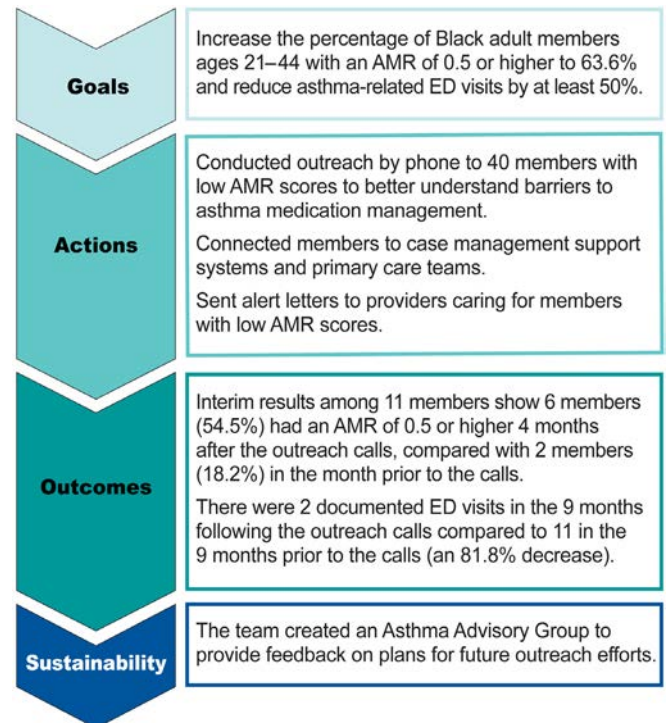
Tracking and monitoring outcomes are also important for effectively engaging with partners around a QI project.

Missouri generated data reports to help MCOs identify people with frequent ED visits who were not connected to a health home or referred to case management.

California tracked AMR scores, and interim results showed that 10 of the 11 members contacted by case

managers had improved AMR scores four months after contact. ED visits also declined after the outreach calls (Figure 4).

Figure 4. Spotlight on California: Asthma QI Project Goals, Actions, Outcomes, and Sustainability



Start Small

Starting with small Plan-Do-Study-Act (PDSA) tests allows for rapid feedback on outcomes and iteration on interventions within a QI framework.⁸ Most QI projects involve several iterative PDSA cycles to test and refine a change idea before implementing, spreading, and scaling it.

California conducted several PDSAs to test their outreach intervention on beneficiaries with lower AMR scores. The state team established clear goals and took specific actions to achieve the goals, which led to measurable outcomes. The state team also fostered collaboration between different departments in the MCO, including complex case management, health education,

⁸ To learn more about PDSA cycles, visit the Institute for Healthcare Improvement at <https://www.ihl.org/resources/Pages/HowtoImprove/default.aspx>.

communications and outreach, and provider relations. This collaboration helped ensure the project team had access to data to evaluate the progress of their QI activities. They generated data almost every month and were able to monitor progress over the course of their participation in the affinity group. They also built infrastructure to support the sustainability of the project.

For More Information

More information about Improving Asthma Control is available at <https://www.medicare.gov/medicaid/quality-of-care/quality-improvement-initiatives/improving-asthma-control/index.html>. Technical assistance resources are available to help states develop their own asthma control QI projects, including background materials, a driver diagram and change idea table, and a measurement strategy.

More information about other Medicaid and CHIP QI initiatives is available at

<https://www.medicare.gov/medicaid/quality-of-care/quality-improvement-initiatives/index.html>.

To obtain technical assistance, please email MedicaidCHIPQI@cms.hhs.gov.

About the CMS Medicaid and CHIP Quality Improvement (QI) Program

The CMS Medicaid and CHIP QI program provides state Medicaid and CHIP programs and their QI partners with the information, tools, and expert support they need to improve access, care, and outcomes for Medicaid and CHIP beneficiaries. Technical assistance is available to help states build QI knowledge and skills; develop QI projects; and implement, spread, and scale up QI initiatives. Participation is voluntary and involves collaboration between Medicaid and CHIP program leaders and other partners, including MCOs and public health agencies.