

USING DATA TO IMPROVE ASTHMA CONTROL: ASTHMA QUALITY MEASURES

11/21/2019

Chris Talbot:

Thank you for your patience as we dealt with the technical issues. As we start out, I wanted to let you know that I'll be your technical lead for today's event. My name is Chris Talbot.

And before we get started, I wanted to cover a couple of housekeeping issues for you. I wanted to let you know that as everybody joined the event center today, your phones were muted, so please keep your phones muted throughout today's event to prevent background noise from impacting others on the call. We do have the opportunity for you to submit questions for our presenters today using the Q&A widget over on the right-hand side. You can type in your question to the Q&A pod and your questions will be shared with the presenters throughout today's event. If you should experience any technical issues during today's event, please reach out to me using the chat pod over on the right-hand side. When you use the chat pod, please select my name as the host, Chris Talbot, and I will work to resolve any issues that you have along the way.

At this point, I'd like to turn things over to Deirdra Stockmann who's going to give us a welcome for today's event.

Deirdra Stockmann:

Thank you so much, Chris. It is my pleasure to welcome you all to the second webinar in our series on improving asthma control in Medicaid and CHIP. The Improving Asthma Control Learning Collaborative is one of a new series of activities to support Medicaid and CHIP agencies and their partners to drive improvement on Medicaid and CHIP Core Set measures. As a reminder, as you may know, we have three measures in the Adult and Child Core Sets that's focus on asthma, including Asthma Medication Ratio for both children and adults, Asthma Admissions in Younger Adults, and Asthma and COPD Admissions in Older Adults.

So, here's our agenda for today. After a brief introduction, I'll hand the floor to Natasha Reese-McLaughlin from Mathematica to give an overview of the use of data in asthma quality improvement projects and to give you some things to think about as you listen to the following panel discussion.

Then we have an esteemed panel of state presenters today who will give you a wide range of real-world state experiences using data to drive asthma improvement. We are absolutely thrilled to have such a strong panel to share a variety of different experiences and responses to questions like what data do you use to decide how to target an asthma quality improvement project? What kinds of data speak to Medicaid directors? What kinds of data speak to Medicaid health plan leaders? What kind of data speak to beneficiaries and other stakeholders? So, stay tuned for that.

Moving on to the next slide, as I mentioned in the first webinar in October, we're thrilled to see such great interest in this topic, and we think that indicates your commitment to improving the quality of care and outcomes for people with asthma in our programs. Our objectives for this learning collaborative are to support you in taking action on that interest and commitment and in particular, we aim to support state Medicaid and CHIP agencies, and your partners, to reduce the impact of asthma among Medicaid and CHIP beneficiaries.

And the focus of our October webinar was really on the second bullet, to expand state Medicaid and CHIP agency's knowledge of evidence-based asthma interventions. Today's webinar focuses on the importance of using data-driven approaches to focus asthma improvement efforts and to track your progress. And both today and next month you'll have the opportunity to learn from states experiences implementing asthma interventions. After this webinar series, all of these objectives will continue to be the focus of an affinity group. The affinity group is designed for state Medicaid agencies that want to take action on the information discussed throughout this webinar series and are at or very near the point of implementing quality improvement projects on asthma in their Medicaid and/or CHIP programs. One-on-one technical assistance, quality improvement coaching, and additional state-to-state learning will be available through the affinity group. And there will be many more details to come on the affinity group in January and in the January webinar.

I want to note that all of the webinars in this series will be recorded and posted on Medicaid.gov for your reference and for those who are unable to join at this time. The slides for webinar one have been posted, and that link has been provided to you and will be after the webinar as well. So again, the slides will be made available. And I apologize I skipped over a few of the agenda items. After our great panel discussion, there will be time for questions and answers, but you're also encouraged to submit questions and answers during the presentations. That will help us kind of keep abreast of them and be ready to share your questions when that time comes.

And with that I will hand it over to Natasha Reese-McLaughlin who will give a great overview and get us started today. Thank you.

Natasha Reese-McLaughlin:

Great. Thank you so much, Deirdra. As Deirdra mentioned, my name is Natasha Reese-McLaughlin and I'm a Health Researcher at Mathematica. Before we begin, let's learn about who you, our webinar participants, are. Next slide.

First, please let us know which type of organization you represent. You can select one of the answers from the following list, which includes Medicaid agency, department of public health, other state or local agency, health plan, health care provider, community asthma program, or other. We will keep the poll open for about 45 seconds.

In responding to the poll, please click submit once you've submitted your answer.

Thank you. The results of the poll indicate that today we're joined largely by staff from Medicaid agencies, department of public health, health plans, and other, so very good mix and we're happy to have you.

Next, please let us know how you are currently using asthma data. You can select as many options as you'd like from the list, which includes using data to target high risk individuals, or identify areas of needs, using data to monitor health outcomes, using data to assess return on investment, collect data but do not track results, other. Again, we'll keep the poll open for about 30 seconds.

Once you've chosen your responses to the poll, please click submit to submit your answer.

Great. So, I see here that the results here indicate that many of you are using data to target high risk individuals, to monitor health outcomes, and a few of you are also using it to assess return on investment. So, starting with our presentation, next slide.

Given the results from our second poll, it's clear that many of you know that data is an essential component of quality improvement. Data can help answer key questions in preparation for an asthma project, such as how are we performing on asthma care and what should the goal and aim of the quality improvement initiatives be? Data not only enables us to accurately identify problems, but also to prioritize quality improvement initiatives and enables objective assessment of whether change and improvement has indeed occurred.

Next slide. Not only can data be used to answer key questions for a quality improvement project, but data is also used in diverse ways throughout each phase of a project life cycle. Shown here is the Plan, Do, Study, Act cycle, also known as the PDSA cycle. PDSA cycles are framework you can use to test, develop, and implement changes that lead to asthma quality improvement.

Step one is the Plan stage, shown here on the top right. During this stage, data can be used to identify the problem and target population. For example, you might identify that asthma-related ED visits have been increasing in your state, and to address this problem you decide to implement a project that trains providers on asthma self-care management support.

During the Plan stage you might analyze data to identify the target population. For example, is it adults or children? Are there certain geographic areas within your state that need to be targeted?

Step two is the Do stage, shown here on the bottom right. This is the stage where your program launches the asthma initiative. During the Do stage, data can be used to monitor output measures to ensure proper implementation. Continuing with our example asthma project, during this stage you might monitor the number of providers who have participated in self-management training.

Step three is a Study stage, where data can be used to evaluate the asthma initiative you have implemented. In our example during the Study stage, you would look to see if the number of

asthma-related ED visits have in fact declined since the implementation of the asthma project.

Finally, step four is the Act stage, which can be used to refine a project based on the results of the initial implementation. During this stage, data can be used to further analyze findings. As you see from this example, some measures are tailored to fit with specific stages of a project life cycle, while other measures can be used in multiple stages of the cycle. For the purposes of today's webinar and of the Asthma Learning Collaborative, we will be focusing primarily on the Plan and Do stages of this cycle.

Next slide please. One of the challenges of using data is ensuring that you are using the right measure to support your project. On this slide, we've highlighted some of the key considerations you have when selecting asthma measures. Starting at the top and moving clockwise, one key consideration is data accessibility. It's important to understand the availability of data and what, if anything, you must do to ensure you have access to the data you need to calculate a measure.

Continuing, you might also want to consider the source of the data. Some asthma measures can be calculated using administrative data while others require other data sources such as medical records or surveillance data. Another consideration is the level of measurement. For example, whether the measure is calculated at the state-level or at the provider-level.

The frequency that a measure can be calculated is another consideration. Some measures can be calculated annually, while others can be calculated more frequently, such as monthly. As discussed on the previous slide, measures that can be calculated more frequently may be more suitable for the Do stage of a project. There are also different types of asthma measures including quality measures, utilization and cost measures, prevalence and patient experience. Some measure types may better align with your program's needs and priorities.

Finally, it can be beneficial to consider whether or not you can stratify a measure. Some measures can be stratified by age, race and ethnicity, or region, and can help you identify a target population or analyze performance for different groups of beneficiaries. Defining your needs for some of these dimensions can be incredibly useful as you work to isolate and select measures from the landscape of available asthma measures.

Next slide. That was a very brief introduction to the use of data and quality improvement initiatives, and now we will turn to our state panel discussion. We are very excited to have representatives today from four states: California, New York, Rhode Island, and Utah.

Next slide please. To start, each panelist will give a brief introduction about themselves, their agency, and their Medicaid asthma project, starting with Ashley Kissinger from California.

Ashley Kissinger:

Hello everyone and thank you for the opportunity to speak with you all today. My name is Ashley Kissinger and I am with the California Department of Public Health State Asthma Program. We are a state of about 40 million people with nearly 5 million being diagnosed

with asthma. For the past 20 years, CDPH has been the recipient of CDC asthma-related grant funding, and we are a current grantee of a comprehensive public health approach to asthma control through evidence-based interventions grant.

Through CDC funding, CDPH provides robust asthma surveillance and a program we call the Asthma Management Academy, which is a no cost, bilingual training for community health workers and other health educators to learn how to deliver asthma self-management education. The curriculum is from the Association of Asthma Educators. It's based on the EPR-3 guidelines and is co-delivered by a community health worker and a certified asthma educator.

Since June of 2017, we have trained approximately 400 community health workers across 48 organizations including Medi-Cal managed care plans, Federally Qualified Health Centers, community clinics, community-based organizations, and hospitals. And I look forward to sharing more information with you today.

Natasha Reese-McLaughlin:

Wonderful. Thank you so much, Ashley. Next, we have Ryan Ashe and Stephanie Mack from New York.

Ryan Ashe:

Hi there. This is Ryan Ashe. I'm Director of Value-Based Payment and Health Care Innovation at the New York State Department of Health. Specifically, I work in the Office of Health Insurance Programs where we oversee our state's Medicaid program. Over the course of the last few years, we've been engaged with a number of stakeholders throughout the Medicaid program, managed care organizations, providers, community-based organizations, and others to transition a significant portion of our Medicaid expenditure into value-based payment.

And, in doing that, we've designed our asthma intervention program within the construct of that VBP model. So what we're really trying to do is quite literally link what a lot of us have been talking about, the social determinants of health with more health-focused services, and deliver those together within one intervention in a way where providers and payers can leverage that asthma program to meet their cost and quality measures within their value-based payment program. And I'll stop there and turn it over to Stephanie.

Stephanie Mack:

Hi, my name is Stephanie Mack and I'm the population health data manager here at the New York State Department of Health. I'm in the Public Health Information Group in the Office of Public Health Practice, where we do surveillance and evaluation for a number of DOH initiatives. We maintain surveillance and dashboards for a number of programs including opioids, maternal child health, county health indicators, and asthma is one of them.

I work very closely with the New York State Asthma Control Program, which has been funded by the CDC for a number of years and worked across the health department to build

infrastructure and partner with initiatives like the value-based payment initiatives and within the Office of Health Insurance Program. We work in a number of areas and coordinate regional contractors throughout the state to deliver home-based services as well as QI initiatives and quality improvement collaboratives to focus QI on applying the NAPP guidelines.

And so, there are a number of projects that we have underway funded through the CDC and aligned with the state health improvement plan to conduct our asthma surveillance efforts and our asthma evaluation efforts and the VBP project that Ryan mentioned. This healthy homes initiative is a combination and a culmination of a lot of efforts to develop a comprehensive program embedded within the state's VBP initiative to really drive a coordinated effort to deliver home-based guidelines-based services for our patients with persistent asthma.

Natasha Reese-McLaughlin:

Wonderful. Thank you, Ryan and Stephanie. We're also joined today by Dr. Jerry Fingerut and Julian Rodriguez-Drix from Rhode Island. Jerry or Julian, would you like to introduce your team and asthma program?

Jerry Fingerut:

Sure. This Jerry. Our team is spearheaded by Julian Drix, the Asthma Program manager at the Rhode Island Department of Health. I'm the Medical Director at the Rhode Island Executive Office of Health and Human Services with a primary focus on Medicaid. Our collaboration goes back about four years, perhaps a little longer. I think as we get into the meat of the presentation, we can comment a lot more on our use of data and the cooperation and support we initially were seeking on the Medicaid side.

We had the advantage, I think, in a small state, that Julian's program was already achieving some success and our hope was that we could expand the number of beneficiaries that we'll reach and also include the MCOs. We're about a 90% MCO state, and particularly in the early phases, I believe it may have been the second convening three or four years ago now, that we were able to also have a Medicaid Medical Director participate from one of the MCOs, but it was the MCO that had the majority of children and has about 160,000 of our 300,000 beneficiaries. We benefited, I think, because I was already aware of Julian's program and its successes, and we were able to work together in trying to expand it in a more general way into Medicaid. As we comment throughout this program, because this is 95% based at Department of Health and under Julian's direction, I think he will lead specific questions and I'll add Medicaid comments as needed.

Natasha Reese-McLaughlin:

Great. Thank you, Jerry. Rounding out this wonderful panel, we have Holly Uphold from Utah.

Holly Uphold:

Hi. Yes, this is Holly Uphold from Utah. I'm the Epidemiologist and Evaluator for the Utah Department of Health Asthma Program. I've been working with the program for seven years, and I worked on the asthma home visiting program since its inception in 2015. I'll talk a little bit more about that in just a second. With the home visiting program, I helped create the data collection tools and develop the asthma quality improvement measures. I've also created and implemented several process and outcome evaluations using our home visiting data, and today, I'll be speaking about data from our home visiting program. Just to give you a little background, our home visiting program is made up of three home visits, two to three weeks apart, and two follow-up calls, one at six months post-program and one at 12 months post-program.

We currently fund two local health departments in our two most urban counties of the state, and we have spent the last two years trying to get coverage and reimbursement for the home visiting program through Medicaid and other payers to expand past those to local health departments. This process has included presenting to the Medicaid Medical Care Advisory or MCAC committee. What we ended up with this last year were Medicaid administrative funds to fund two additional local health departments in their fee-for-service areas that were in our rural and high-need areas, and we're currently in the process of finalizing contracts with those two local health departments.

Natasha Reese-McLaughlin:

All right, well, thank you, Holly. Next slide please. Now, to kick off the discussion, we would first like to know which asthma measures you are using to drive and demonstrate improvement. We'll start with Ashley.

Ashley Kissinger:

Hi. Yes. Through the Asthma Management Academy, we strive to collect a comprehensive list of de-identified patient-level asthma quality measures from patients who are seen by community health workers that received Asthma Management Academy education and deliver asthma self-management education. We believe that collecting these diverse indicators help paint a picture of asthma control over time. If we could pull up the California Department of Public Health slide. Thank you. Here's the list of our asthma quality indicators. You can see we collect these indicators over time, usually baseline on the top, a six-month follow-up, and then following up again at 12 months. We collect indicators like demographics, exposure to smoke or smoking, access to a primary care provider, asthma control medication use, whether a patient has an Asthma Action Plan and their healthcare utilization, ideally asthma-related hospitalizations or emergency department visits. At follow up, we collect these same indicators but also look at the number of asthma self-management education sessions received, and their referrals to additional asthma services, and also the patient's skills and knowledge. So, if they can successfully demonstrate basic asthma knowledge and skills after receiving asthma self-management education from a community health worker.

Natasha Reese-McLaughlin:

Wonderful. Thank you so much, Ashley. Stephanie and Ryan, can you tell us about the measures that you use for your asthma work?

Ryan Ashe:

Sure. This is Ryan Ashe. So, just at a high level, as part of our VBP effort, we've engaged a number of stakeholders to identify quality measures that we would then require plans and providers to include in those contractual arrangements that ultimately would be used to measure the quality in those plan and provider partnerships. So, more recently we required a broader set of metrics to make sure that we're really capturing the full spectrum of care that we want individuals to obtain. So, it would range from physical health, to substance use disorder, to mental health and children's measures, to name a few, but specific to asthma and within that VBP quality measure set, so we're leveraging that measure set so that there's alignment, but we're using measures, the asthma admission rate measure, medication management for asthma, but what I would stress is that, because this is within the construct of our value arrangements, that we've really tried to align them. Stephanie, I think, will go into a bit more detail there.

Stephanie Mack:

Right. When I look at the asthma measures that we're using to both drive and demonstrate improvement, I look at our data on a number of levels. We have asthma surveillance data, so we have our ED and inpatient discharge data that we use. We have our mortality data that we use, and we also have, on the surveillance-level, our asthma universe and persistent asthma population for the Medicaid managed care and the Child Health Plus population, as well as our asthma prevalence information and so on. The surveillance-level we really look at are those on a statewide, a regional, a county and drill down to the zip code to take a look at where we need to plan our initiatives and where initiatives should be conducted and where we are targeting our greatest need and we align these in strategic planning with our state health improvement plan, our prevention agenda, and with them, also, these VBP measures that we're trying to drive, that asthma admission rate, the asthma ED rates. We're looking at those measures and how we can have an impact on those measures.

So, we really look to where we should target our initiatives and then, once we have based our region on targeting, especially for this VBP, one of the ones that we really looked at then was plan-level data. Among those who have persistent asthma, we looked at the plans to see which plans and providers had the highest rates of persistent asthma that had an event, an ED event or a hospitalization event, because we could use that information to then really get plans on board and indicate to them what the burden of asthma was within their plan structure and within their plan and provider partnerships so that we could get them on board.

Then, once we are doing our quality initiatives and our interventions, we have more of the EHR data and the intervention-level data. So, when we're doing the quality improvement projects and trying to do advisement on utilizing the guidelines to drive improvements in asthma care, we're looking at what practice-specific measures we can use and we have a quality measures package that includes asthma control measures, documentation of asthma

severity, symptom-free days, and those types of things. Then, for the intervention, especially for the home-based intervention, we do collect a lot of the individual-level data and self-report data, self-report on triggers, self-report on number of visits to the ED, number of unscheduled or urgent care visits, exposure to smoke, self-report information about exposure to different triggers, and then also that dwelling-level environmental assessment that really then, on that intervention-level, takes a look at the home environment and what aspects of the home environment can we know and understand that might need remediation, so that we can then coordinate and partner with different community-based organizations to really address those social determinants of health. But when I look at the avenues-

Natasha Reese-McLaughlin:

I know you can talk about this for several hours, but I do want to make sure that we are able to get to audience questions.

Stephanie Mack:

Right. So those are the different levels that we look at.

Natasha Reese-McLaughlin:

Wonderful. Thank you so much, Stephanie and Ryan. Julian or Jerry, can you tell us a little bit about the measures you're using to drive asthma quality improvement in Rhode Island?

Julian Drix:

Sure. This is Julian with the Rhode Island Department of Health. I would definitely echo what Stephanie was just sharing in terms of those different levels of information and data that we look at. We also look at the very same surveillance-level information statewide at different geographic levels in terms of evaluation.

One of the first things that we did a few years ago in our partnership with Medicaid through the 6|18 initiative is work on discussing data sharing. In addition to all of the other normal surveillance systems that we have in place with [inaudible] and hospital discharge data, we worked with Medicaid to get access to the entire pediatric Medicaid claims data set at the individual- and address-level.

We've used that Medicaid data, and shared the results with Medicaid in multiple different ways, one of which was to work on a return on investment analysis for our home-based intervention, HARP, looking at one-year pre and one year post results, in terms of cost reductions from ED visits and utilization. We've also looked at the data in terms of looking at potential eligibility for the intervention, referrals, both statewide and plan-specifically, and have been able to look at, within each individual specific MCO, what the current costs, total costs of asthma care are, how many of their members would be eligible for our home-based intervention, and projected potential return on investment. So that's been a key piece for us.

We've also used that same claims data for mapping and being able to map down to the census track level, and looking at prevalence rates, emergency department rates, and hospitalization

rates within pediatric Medicaid. That fits well within our overall approach to data and measures within the Rhode Island Department of Health, which our strategic framework is focused on equity, social determinants, eliminating disparities, and ensuring access to quality health services for all Rhode Islanders, especially the state's vulnerable populations.

Within that, in addition to the asthma-specific measures, we've also adopted and are using the state's health equity indicators, which is a way of really looking at tracking progress and improvements, not just at the individual patient level, but looking at community-level improvements towards health equity, which we have 15 different indicators across five different domains such as community resiliency, the physical environment, socioeconomics, and community trauma. So, we very much look at asthma in the context of the broader social determinants and environmental determinants of health that have huge impacts on asthma.

Natasha Reese-McLaughlin:

Great. Thank you so much, Julian. Last, but certainly not least, Holly, can you speak a little bit about the measures that you are using to drive quality improvement in Utah?

Holly Uphold:

Absolutely. I, again, echo everything that's been said about, at a higher level, using surveillance measures like ED visits and hospitalizations to monitor asthma and look for improvement areas in Utah. But I'm going to speak specifically about our home visiting program and the data that we collect.

Depending on the evaluation we want to do, or what our outcome is that we're trying to share with our stakeholders, we use a lot of different types of data to demonstrate improvement. The most common ones we use are improved asthma control test scores, reduced asthma ED visits and hospitalizations, improvement in confidence managing asthma, and reduced missed work and school days.

The way we determine these measures was we did a literature review looking at other home visiting programs and what they've used to demonstrate success and improvement. We talked a lot with our stakeholders, asking them about what they value and what they would want to see in a home visiting program. Then, like I mentioned, we also looked at other home visiting programs and what their data collection tools were.

I do want to reiterate that all of our home visiting program data is self-reported. We use the data to evaluate program implementation and outcomes a lot. The asthma measures we use most to demonstrate improvement are probably the asthma-related ED visits and hospitalizations. We asked participants how many of these visits they've had in the 12 months prior to the program, and then we follow up with them 12 months post-program and ask them again how many ED visits and hospitalizations they've had. We also use these measures to ...[inaudible].

We use ED visits and hospitalization data because, in a lot of conversations with our stakeholders, they reported that these were good measures because we could do a return on investment of our program, and they are good measures because they seem to be related to the large immediate costs that come with asthma and going to the emergency room and hospital.

Some other considerations that we've had in using this data is wanting to know how accurate our self-report data is. We have worked with payers to look at our home visiting participants that have gone through our program that were clients of a payer and look at the difference between the self-report data and the claims data. What we found was that our participants that went through our home visiting program actually under-report slightly the number of ED visits and hospitalizations they've had related to their asthma.

We've also had conversations with payers about how we can get this information sooner than 12-month post follow-up. We've had these conversations because Medicaid especially has mentioned that, because they have members who move in and out of Medicaid coverage, it would be nicer to have this type of information sooner than 12 months so that they can ensure that, more likely than not, the client was still covered during the time of the post intervention.

So yeah, I think that's pretty much it.

Natasha Reese-McLaughlin:

Wonderful. Thank you so much, Holly. Moving to our next question. Can you tell us a little bit about some of the challenges your program faced with obtaining and using data, and how you overcame these challenges? Ashley, can you share some of the challenges you've faced obtaining and using data in California?

Ashley Kissinger:

Of course, thank you. Generally speaking, the size of California is a challenge, just being able to reach a number of organizations and providers, and also there are different needs and expectations between public health and clinical care. As a state health department, we approach asthma through a public health and health equity perspective as it's outside of our scope to provide medical care.

But through the Asthma Management Academy, we've learned that asthma control indicators are not collected consistently across organizations, if at all. So, we at CDPH help organizations develop and implement processes to collect or improve the collection of asthma control indicators, for example, implementing the asthma control test into their electronic health records for a more streamlined QI process.

At CDPH, we are able to provide some limited financial support to our partner organizations in order to collect asthma control indicators from a cohort of patients. We found that some financial assistance can help defray costs to follow a cohort of patients and collect asthma QI measures at different time points.

With partners that share data for QI purposes, we found that there is a significant time investment, so it takes multiple conversations with QI coordinators and programmatic staff to agree on asthma quality measures in general, and it takes even more conversations to try implementing new measures or tools to make changes at the systems-level.

Natasha Reese-McLaughlin:

Thank you, Ashley. Ryan and Stephanie, can you share some of the challenges you've faced and strategies you've used to overcome these challenges?

Stephanie Mack:

I think one of the key challenges, even though we, as a control program, and the Office of Health Insurance Program, are both located within the Department of Health, there is some siloing. We did initially have some difficulty making sure that we could access the Medicaid claims data set, and also just understanding what's in that data set. It's a huge data set. It has lots of information. So, a lot of it was developing relationships so that we have a good understanding of what's entailed in that Medicaid claims data set, and how we can best use it, and use it to drive improvement.

A couple of other issues that we have in terms of data and obtaining data is patient-level data. Over and over again, we hear from our faculty advisors, our asthma champions, and our Asthma Partnership of New York, that having a consistent asthma control measure that's easily polled is something that's really important. If we look within the VBP context, we have pay-for-performance measures and pay-for-reporting measures, and there really isn't ...[inaudible].

There is a pay-for-reporting measure of assessment of asthma control, but it's hard to get that picked up because of the feasibility of providers being able to pull and collect that information consistently.

And then as we go forward in driving quality improvement, one of the biggest needs, at this point in time, is having good quality data available to do cost effectiveness or ROI analysis. And so, a lot of that has just been a lot of literature reviews, a lot of reviews of the different methodology, a lot of coming together with different experts, in having an evaluation guidance team that has these types of experts on that guidance team, so that we can understand what types of data might be available for doing that type of ROI and cost effectiveness, and how we can most effectively use that.

And the last thing, in terms of this type of initiative where we are getting patient-level data and the Medicaid level data, but the intervention affects the community and the household as well and has all this other spillover effect to other people. How to best capture that quality improvement when most of our data is patient-centered data.

Natasha Reese-McLaughlin:

Thank you, Stephanie. And finally, Julian or Jerry, can you share some of the challenges and strategies that you've faced in Rhode Island?

Julian Drix:

Sure. This is Julian again. I would definitely reiterate what was just shared by Ashley and Stephanie and won't repeat that. To kind of reemphasize the issues that were brought up earlier around the patient-centered quality measure of asthma control, I think the lack of having a national measure for this is a major barrier.

We definitely do use and will refer to the HEDIS scores, the standard asthma medication ratio types of measures, but really look at asthma control as being a really important measure and one that's a gap. For those who haven't seen it, I would refer everyone to the recent article by Elizabeth Herman, Suzanne Beavers, Ben Hamlin and Kaitlin Thaker called, "Is It Time for a Patient-Centered Quality Measure of Asthma Control?" It does a really excellent job of laying out these issues, and I think there's much work that needs to be done in terms of EHRs embedding asthma control tests or other validated tools into EHRs, but also having it become standard practice and something that can be shareable.

One thing in addition to that, we did have some challenges and took a while to get claims-level data from Medicaid, but I think that was a big success and it has been very great overall.

It's also been great to begin having health insurance plans provide asthma home visits in Rhode Island and so that's been a big success of using our claims data and information to make that case and then seeing it be successful.

One of the challenges that we have now is that we, in the past, have been able to collect a lot of information and a lot of details on those patients who are being provided asthma care when we are directly funding and supporting the intervention. Now that it's being moved into the healthcare system in a more integrated way, which is a victory and a success to celebrate, one of the challenges we're facing now is around coordination of services and being able to have systems in place to be able to know who is being provided home-based asthma services, by which provider, is covered by which plans, and where, so that we can avoid duplication of services, coordinate the services, evaluate them effectively while knowing that we're not going to have the same level of individual evaluation information that we do, and we are directly funding it and able to collect that kind of information. So that's another challenge that we are currently working on.

Deirdra Stockmann:

Natasha, you may be on mute.

Natasha Reese-McLaughlin:

Oh, I am so very sorry. Before we move to our next question, I just wanted to remind the audience to please submit questions to the Q&A box at any time during the presentation.

Moving to our next question, in some respects, we live in a data-rich era, but not all data is useful or effective for targeting and tracking quality improvement efforts. We would like each of the panelists to please share their best tip for identifying, selecting, and using asthma measures. Starting with Holly.

Holly Uphold:

Hi. Okay, so I think my tip for collecting and using asthma measures would be to think about the long-term goals of the program and talk to stakeholders about their timelines and what they see as valid information. Also, do some research on what other data collection tools are out there and how people are using them. Ask stakeholders what's going to be compelling information for them.

Do they want to see a return on investment and how can they help with this analysis? Can they provide claims data? Can they help you calculate the cost saving? Like I mentioned, I think ED visits and hospitalization data has been the most impactful. I think our return on investment numbers and analysis have really opened the door and started a lot of conversations with movers and shakers.

One important success that we had was with a payer. It was born out of a vision from our program coordinator at the time who wanted to start collecting insurance names from our home visiting program participants. And what this allowed us to do was to run our outcomes and our ROI data from our database, looking specifically at the payer's clients, and then we were able to show them that our home visiting program was potentially saving them money.

This caught the eye of an important person and opened the door for a meeting that started conversations about a pilot program with us and we're really hopeful that that will end in some sort of reimbursement.

The last thing I will say about tips for identifying and using measures is to constantly be evaluating the usefulness of the data. It's a lot of work for our home visitors to collect the data, so we always want to be mindful of their time and energy and only collect data that are useful. There have been many times where we have stopped collecting something or added something to our data collection tools because we're always asking the question of is this data useful? How are we using it?

Natasha Reese-McLaughlin:

Great. Thank you so much Holly. Jerry or Julian, can you share your best tip?

Julian Drix:

I don't have too much to add. This is Julian, again. I would reemphasize the need for an asthma control measure, but in terms of selecting from available ones, I know that in the healthcare setting and primary care providers in our state, utility and a lack of not having it be a burdensome measure is really important, and going with nationally recognized, existing measures rather than creating your own.

And then I think outside of that and in the public health setting and for program planning and evaluation, really focusing on an end goal in utility and working backwards from there. I'll stop there in the interest of time.

Natasha Reese-McLaughlin:

Thank you so much, Julian. Turning to Stephanie or Ryan, what tip would you like to share with our audience today?

Ryan Ashe:

Sure, this is Ryan and really quickly, three key lessons. Feasible, appropriate, credible. So, making sure that providers and plans and other stakeholders have a way to report that measure, that the measure is appropriate, meaning that it's truly an indication of value or rather of quality of care delivered or moreover, quality of outcomes of the Medicaid member. And that it's credible, that it's been tested in other environments and then leaving that window open for whether it's plans or providers or both to explore other measures that they think might be a better indication of quality.

And then finally, to align the measures across multiple programs so that you're making it easier for your partners to not only adopt the program but the measures within it. And then to have a plan to move those measures, whatever they might be, into your payment model. Because once you start paying on those measures, certainly that's where I think you'll see an uptick in their use. And Stephanie, any last bits to add?

Stephanie Mack:

I echo all of that and the aspect of collaborating with stakeholders for the information that they need to really drive, and for the interventions that they want to do.

Natasha Reese-McLaughlin:

Great. Thank you so much Stephanie and Ryan. And Ashley, what tips would you like to share with the audience today?

Ashley Kissinger:

Yes, thank you. We utilize the CDC's list of comprehensive asthma control measures that I pointed to earlier, but we do try and look at, or be flexible around, organizational capacity to provide and share those data. We found that the easiest measures to collect are encounter data, asthma control test scores, skills and knowledge and self-reported health care

utilization, but we'd have to also say the most effective measures that we can look at would be asthma control test, medication use, and health care utilization like ED visits and hospitalizations.

I do think it's important when you're looking at asthma measures to understand and know that some organizations may be proprietary with their data, but also may need guidance on understanding what are EPR-3 Guidelines and how to implement guidelines-based care. So, it's really important to develop relationships and see how best you can move forward to improve asthma quality overall.

Natasha Reese-McLaughlin:

Wonderful. Thank you, Ashley. Turning to our final question, stratifying data can be a critical component of developing a goal for an asthma program and ensuring your initiative has the desired effect on specific populations.

Turning back to Ashley, can you share how your program uses stratification?

Ashley Kissinger:

Yes. So, as I mentioned before, California is a state of 40 million people, five million who have been diagnosed with asthma at some point in their lives, but nearly three million who have current asthma. And of those people with current asthma, nearly one in five have poorly controlled asthma. And because of this, we use data to help us target interventions to the most impacted or burdened communities. As part of the state asthma program, we provide asthma surveillance at the state- and county-level on asthma indicators, like asthma-related ED visits and hospitalizations, and stratify based on race, ethnicity, and age.

In our programmatic work, we stratify asthma control indicators to target our interventions. So, for example, with the Asthma Management Academy, we utilized a population-based approach to decrease asthma burden in the most impacted communities. And we target partners who serve communities and census tracts that are above the 75th percentile in asthma-related ED visits or hospitalizations. In addition, we also examine social determinants of health for these communities using the Healthy Places Index. The Healthy Places Index was developed by the Public Health Alliance of Southern California and shows census tracts that scored using a composite of 25 social determinants of health indicators, with some areas indicating healthier conditions and others less healthy conditions.

To target specific populations, we've worked with managed care plans, or Medi-Cal Managed Care Plans, on their asthma-related performance improvement projects or health disparities projects. And for example, we helped Medi-Cal Managed Care Plan develop a Department of Healthcare Services mandated performance improvement or health disparity project, which would focus on addressing asthma control, specifically among their black or African-American members.

And for time purposes, I'll stop there.

Natasha Reese-McLaughlin:

Wonderful. Thank you so much, Ashley. And finally turning to Holly, can you share how your program stratifies data to target your intervention?

Holly Uphold:

Yes, so we stratify our data by geography, and we use this information to target our home visiting program and our clinical quality improvement activities. The way that we do that is by trying to recruit referral partners from those areas to send participants into our home visiting program. And we also stratify by race and ethnicity, and we try to bring partners to the table in helping with our program planning effort. And for that, we do use some of our higher-level surveillance data. Again, we're using emergency department visits and hospitalizations, and looking at what areas and what groups have a higher rate of those asthma-related ED visits or hospitalizations.

Natasha Reese-McLaughlin:

Thank you so much, Holly. Now we would like to open the floor for questions from the audience. A reminder to please submit your questions through the Q&A box. We have received our first question and it's directed to the team from Rhode Island. The question is, what were the first steps you took to form the partnership between Department of Public Health and Medicaid?

Jerry Fingerut:

This is Jerry. I can start with that. On the Medicaid side, I had knowledge of the program that Julian was managing before. There were 618 conversations before we were approached, so when that started, it was fairly easy. The things that we had to stress, and we were also, on the Medicaid side in a leadership transition, which I think made it a little more difficult, but because Julian had data already relative to ROI and because we had opportunities to share additional data, the case was really made to Medicaid based on initial and expanded ROI information. And I think because of some budget issues and because of available data, we were able to make that happen, at least initially. I would say if the same thing happened today, four years later, that under different leadership, there is a much greater focus on data and it would probably be easier to capture the information that is needed, as opposed to four years ago. I'll let Julian comment further.

Julian Drix:

Sure, yeah. I think there is the asthma-specific level of this and then it's very much embedded in a larger context. And I think one of the lucky things about being in Rhode Island, as a smaller state, is that there are a lot of overlapping relationships and there's some really great work that's been happening in the state around healthcare integration and coordination, and just the transformation of the healthcare sector. So, in one of the [inaudible]... the piece around asthma fits within broader conversations of patients in their medical homes, community health workers, care transformation teams, and the SIM grant.

And so, I think we were able to make the case that asthma home visiting with certified asthma educators and community health workers was this very specific initiative with some very specific, good quality data to show the effectiveness of it, but that it also helped move these broader conversations forward around providing home-based services, around the value of community health workers in the healthcare system. And those were already happening around chronic disease more broadly, and the opportunity to be involved in the first round of the CDC 6|18 Initiative really came around at the perfect opportunity and kind of created a structure and technical assistance to support the relationship, but that there were existing relationships that made it possible to begin with.

Jerry Fingerut:

I think we had one additional factor, that the people that we had to go to present the program also had a fairly broad view of community services and public health services. And the fact that if the child was not in the ER or having an exacerbation, that the parents could still go to work, that they didn't have to take off, or the child wasn't missing school, and some of these other implications that are fairly hard to quantify sometimes, but do get into the picture in the real world.

Natasha Reese-McLaughlin:

Great. Thank you so much, Julian and Jerry. Our next question relates to stakeholders. You all work with a diverse set of stakeholders. Do you have any go-to measures you use to highlight the importance of your program to different sets of stakeholders, such as Medicaid, Medicaid Medical Directors, health department partners, or Medicaid managed care plans?

Stephanie or Ryan, would you like to speak to how you use any go-to measures with your stakeholders?

Ryan Ashe:

Sure, I can chime in briefly, and I'll turn it over to Stephanie. Certainly, with respect to our managed care organizations that we work with, the Core Set are the measures that they're familiar with for our quality improvement program, they're used to that measure set, that's the asthma admission rate and asthma medication management. So, they're used to those measures. They're able to obtain those measures, or the outcomes, from the providers, and the providers are able to track against those measures. But beyond that, there's a lot of interest in other more SDH-related metrics, and Stephanie touched on some of those around the home or the dwelling, the safety of the dwelling. So, there's a lot of energy there to want to use those measures.

But again, going back to, is it a feasible measure, is it an appropriate measure, has it been tested, that's where I think folks and other stakeholders tend to struggle with a little bit. But it's helpful, like I said earlier, to, I think, leave open that option for payers or providers to pursue those options. And, if they have more progressive measures that can get us to a more consolidated measure set that really measures health, that's helpful to just move our overall measure sets forward, especially in the context of the alternative payment models that I think we're all dabbling in. Stephanie, anything to add really quick?

Stephanie Mack:

Yeah, definitely, is the measure familiar, and does it have a data steward? But then for a lot of our providers, utilization measures are really key, especially the unexpected or urgent visits in the ED. Those are really key in driving what they need to do to convince others to come on board and make changes in their workflow or their practices. And asthma control, asthma control is used so heavily to drive where we target things, especially for our home-based services. We get a baseline of asthma control, and because revisits can be so challenging, focusing on those who are poorly controlled and making sure that the visits get back, the revisits get back, and the follow-up gets back to the poorly controlled really drives a lot of that effort.

Natasha Reese-McLaughlin:

Thank you so much, Ryan and Stephanie, and thank you to everybody who's joined us today, especially to our panelists for engaging in such an exciting and productive discussion. As you all digest the wonderful information shared during today's webinar, here are a few additional asthma quality measure resources. We will provide these links via email at the conclusion of our webinar. Please also reach out to the quality improvement TA mailbox shown here with any questions or feedback related to the Asthma Learning Collaborative. Thank you again for joining us. Have a great rest of your day and we look forward to seeing you at our next webinar on December 19th.