REGIONAL SUMMIT ON SUSTAINABLE FUNDING FOR IN-HOME ASTHMA INTERVENTIONS

8:00-8:25	**REGISTRATION**
8:30-8:45	**Uniting Stakeholders to Shift the Focus to Asthma Preventive Care** • Opening remarks by Ameesha Mehta-Sampath (EPA Region 2), Tanya Pagan-Raggio Ashley (DHHS HRSA), and Maida Galvez (Mount Sinai) to set the stage for the day's presentations and contextualize this summit within the current broader landscape of asthma
8:50-10:00 Moderator: Ameesha Mehta-Sampath	**Federal, State, City Commitment to Reducing Asthma Disparities** Ameesha Mehta-Sampath, USEPA • 15 years ago, EPA held asthma summit to begin long journey of promoting in-house asthma interventions. • Now we are back again to find ways for sustainable funding for in-house asthma interventions. • Need Braided approach – more funding streams intertwined, instead of one. Philip Landrigan, Mount Sinai • Diverse group gathered here speaks to the impacts of asthma on many. • Asthma is an epidemic in our region • Research has identified a whole list of triggers • Science based intervention shows what works - go after outdoor air pollution, control sources, drive less and clean-up homes and indoor air. • So why does it continue if we know these facts? – lack of priority and sustainable funding • Prevention of childhood asthma has to be made a priority. Panel Discussion Catherine McCabe, USEPA • Outdoor source of air pollution is EPA's focus • But also indoor air issues • Today's focus is in-home asthma intervention Michelle Davis, USDHHS • Eliminate health disparities and inequalities. • 28% increase in asthma since 2001. • Relationship between obesity and asthma. No cure but can be managed and treated. • HHS – health in all policies addressed by coordination between agencies

	Ricardo Holligan, CMS • CMS operates Medicare program. • Financial part of states to implement programs. • Develop strategies for value-based payments. CMS tries to help pay for treatment but also prevention Cheryl Donald, HRSA • HRSA 279 grantees in R2. • Under US HHS – to increase access to health care. • Establish asthma collaborative programs. Susan Horowitz, USHUD • Healthy homes rep. HUD. • Connection between health and housing. • Grantees for healthy homes. • Guidance documents on smoke free housing. • Eliminate smoking in public housing proposed rule. • Pest management program. • Coordinate rehabilitation activities for healthy homes. Daniel Kass, NYCDOH • City health dept. progressive health code on pest control. • Enforce other codes on indoor environment. • Health tracking portal NYC website. • Air quality community air survey – data matters. Created new set of stakeholders. • Ideal moment to have conversation. • Need to look at cost for pest management and how those dollars are ill-spent. Doug Fish, NYSDOH • Asthma Medicaid members pay considerably more than other members. • State worked out agreement with CMS on reimbursement on Medicaid costs. • Reference made to http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/ Jesus Irizarry, PR Gov office • Developing asthma surveillance system. • High prevalence of asthma in PR. • Continue to look for partnerships on in-home asthma intervention. Q & A; comments: • Catherine McCabe– 2 themes from panel - Incredible knowledge and incredible commitment. • John Shaw – Next Wave – info on Ricardo website on grantees • Puerto Rico – home based projects. Tool kit on NYS website. • Support for legal aid – lawyers needed to assist with landlords – NYC has many non-profits like legal aid. Legal services – Newburgh coalition has some contacts. • Driver to reducing hospital stays means less funding for other patients – victim of our own

	success? • Upstate NY – use of Spiegel act as a way to address housing discrimination issues. • Energy efficiency US Department of Energy – need to connect DOE programs with local work-in-home programs.
10:00-10:15	**BREAK**
10:20-10:50 Moderator: Ameesha Mehta-Sampath	**#MedicaidReform and #ProviderServices for #InHomeAsthmaInterventions** Sankaran Krishnan M.D. (NY Medical College) discussed a partnership with private payers for in-home asthma intervention. The rationale for in-home asthma intervention included: the limited amount of time for clinicians to provide patients/parents with information on allergens in the home; the dissemination of asthma education; and the belief that parents learn better in their homes. A one year pilot program re: in-home asthma intervention was described. One hundred children have been recruited into the program. Measures of effectiveness include tests for asthma control and an assessment of home and environmental risk factors. The pilot program was initiated in April, 2015. Data on cost/benefits are expected by the summer of 2016. Stacey Chacker (Health Resources in Action) Health Resources in Action is a Boston-based non-governmental organization that promotes sustainability for community health workers. A New England initiative for children on Medicaid with poorly controlled asthma was described. The intervention includes an assessment of patient needs in the home; provisions for asthma self-management; and the delivery of in-home services. Payers as partners are engaged through: recruitment; reaching out to key decision makers; and emphasizing benefits. A Payer/Provider Summit was held in 2015 generating preliminary findings on in-home asthma intervention. Challenges include: need to "braid" funding; turnover at payer organizations; and, obtaining adequate pay within fee-for-service schedules. Optimism was expressed over the possibility of numerous funding sources. Joy Krieger M.A., R.N. (Asthma and Allergy Foundation of St. Louis MO) This non-governmental organization provides a prescription assistance program for asthma patients and facilitated the passage of legislation for in-home asthma intervention services in Missouri. This was accomplished through building relationships, schmoozing legislators, and working closely with the Missouri Departments of Health and Social Services. The legislative effort was initiated in 2012 and stressed early successes from intervention. 2013 – Held legislative meetings, explained cost savings and submitted a white paper. Legislation was passed in 2014 with 400 K committed from State with a 1.2 million federal match. Implementation includes: weekly conference calls; development of provider credentials; and, structure for overseeing providers.
10:55-11:25 Moderator: Ameesha Mehta-Sampath	**Presenter: John Shaw, President, Next Wave** **"<u>Why Are Children Still Dying from Asthma in the U.S.?</u>"** • It is complicated. It is hard for a lay person to understand. There are many triggers, mechanisms, and controllers/rescue meds. • It is hard to manage. Fast progression which lead to Asthma "Attack". • Large difference in asthmatics: High risk/high $ use, chronic loss of control, well controlled. • Many stakeholders: Asthmatic, parent, school, employer, caregivers, CBOs, housing, and

	insurance plan. • Conflicting signals: cross-sector regulatory barriers, complex coordination, and different value cases. "**<u>Case Example: In-Home Asthma Services Through the Eyes of a Health Plan</u>**" • Some of the health plan costs includes: Doctors, medicines, ED, hospital, and in-home costs. • Some of the health plan revenue includes: Premiums, co-pays, cost savings • Plan concerns: Cost savings vary by risk, Trigger Mitigation $ • Value-Based "Braiding" for Best Outcomes: 1) Use Evidence: Match intervention Scope to Risk Level; 2) Higher Premium/Co Pays for those that Benefit; or, 3) Cost Shift Needed to those that Benefit. • Value - What is Value? Don't know how much it costs • Economics - Benefit outweighs the costs • Future State – we can plan together • Value Based Payment - have all of us sit on the table and bridge the gap. Redistribute the costs **Presenter: Joseph A. Stankaitis, MD, MPH; Monroe Plan for Medical Care** **"<u>Numerous Stakeholders</u>"**: • Dr. Stankaitis explained that there are numerous stakeholders: The Child; Parents/Guardians; Practitioners; Health Plans/MCOs; Schools; Employers; Community Based Organizations; Governmental Agencies: Federal, State and Local. • **Parents** may experience anxiety or depression; we should consider these symptoms when we do an evaluation. • **School** is important; the child misses school days. • **Employers** are paying health care and their interest is for them to get involved; they will lose money if their workers could not focus or misses work days. • **Governmental Agencies**: Local government agencies have different mandate and some experienced strapped budget. **"<u>Green & Healthy Homes Initiatives</u>":** • Utilize social impact bonds to fund asthma services; bonds can be paid back from "realized savings". This initiative also funds environmental mitigation in home, and working with community agencies to arrange improvements in home. • There are many challenges and all kind of programs. **<u>"The Three "Cs""</u>:** The three "Cs" are Collaboration, Cooperation and Coordination. We need to be working jointly with others in an intellectual endeavor, working together for a common purpose or benefit, and bringing the elements of a complex activity together to ensure efficiency (make sure I am not stepping on your toe and you are not stepping on my toe.) It is not insurmountable….so Let's Get to Work! **Presenter: Susan Beane, MD, Healthfirst** • Healthfirst works in partnership with providers to maximize outcomes. Large and diverse

	network of health centers, community physicians, and hospital-based clinicians. They have 1.1 million members in NYC, Nassau, Suffolk and Westchester. • Shown an Asthma Driver Map – chart included: Rescue meds, exacerbations, Family/School/Sports/Hobbies; Controller Meds; Stress; Action Plan; ED; Inpatient; External Environmental Triggers; Home based triggers; **Asthma patient's experience** is: • Complicated, confusing that occur without warning and often without seeming remedy • More likely to lead to use of the ED and inefficient use of available benefits and services • Asthma is a scary and dangerous condition for children "**How can we impact the drivers**?" • Optimize clinical management and School Based Care – 20% of drivers • Community based interventions addresses the remaining 80% is important to make a difference. "**Asthma ED Visit Rates Reflect Magnitude of Burden on Children and Families" and what Healthfirst data found** • Significant burden • Medication possession and controller use is suboptimal • Variable management of acute asthma exacerbations • Asthma is seasonal. • Asthma drives ED visits and admissions; readmissions, less of an issue. Is Asthma admission preventable? An Admission issue more than a readmission problem. Prevention is critical. Challenge of variability in managing patients presenting to the Emergency Department "**Pediatric Asthma Initiatives**" • Partnership with AIR NYC for a long time. Beginning in 2015, outreached to over 1,500 Healthfirst members. Found a way to collaborate with AIR NYC. The reimbursement methodology is innovative. • Healthfirst is also collaborating with the American Lung Association for certified Asthma Educator training. The American Lung Association will pay for the training. Train staff that may not be certified for Asthma Educator. **"Challenges Ahead"** • Where does this all fit? The funding stream? Need to step out our comfort zone, need a champion, need to identify people to do it, and focus on prevention T • Presentism – Not economic for business. • Clinically license Provider can provide service – may need to change
11:30-12:10 Moderator: Tanya Pagán Raggio-Ashley	**Community Health Workers in Asthma Care** Summary: 1. CHW's have been defined by numerous federal and public health organizations as having a clear role in care

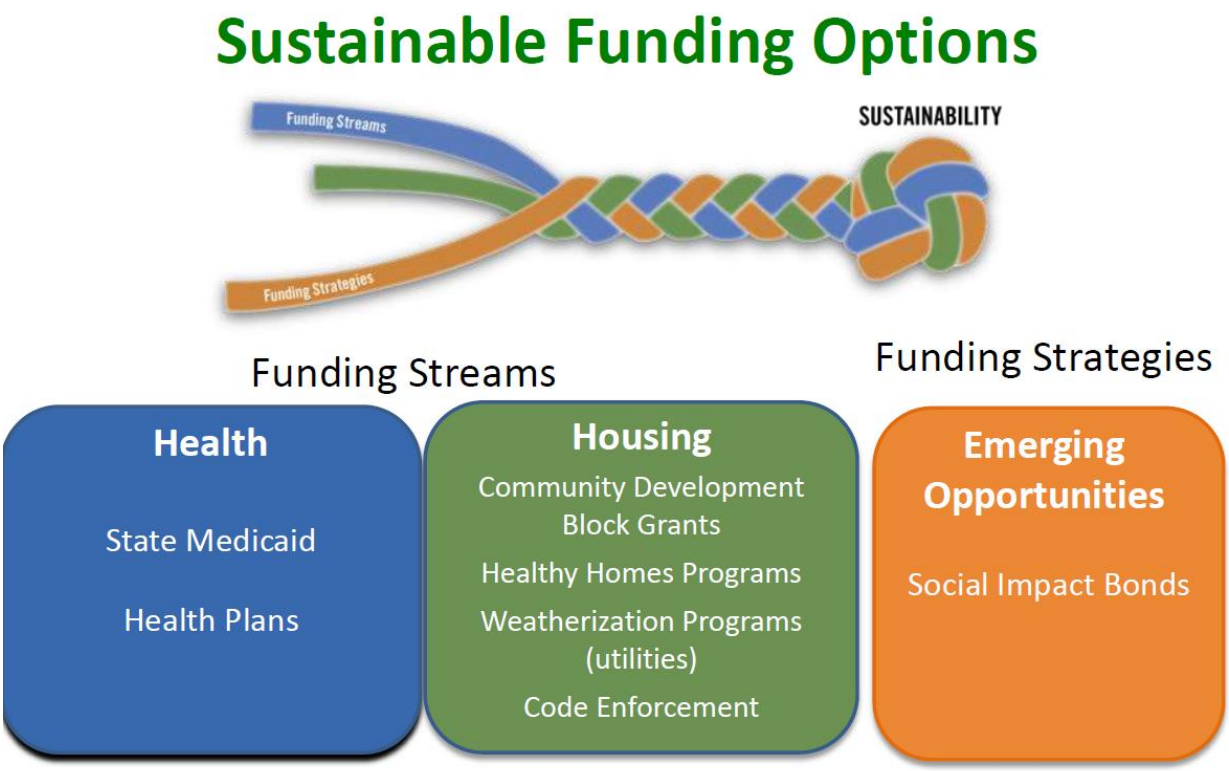
	2. There is data to support the cost effectiveness of the use of CHW 3. CHW's may focus on factors that families see as more important than clinical measures 4. Reimbursement for CHW's still seems to have some regulatory, logistical barriers for reimbursement Notes: · **Reimbursement issue under NYS regulations – appears that only licensed medical professionals can be reimbursed – even if they are certified asthma educators (this came up more than once, but clearly represents an issue for CHW's)** · NIH has core competencies for CHW's – also defined by national organizations – it's in the guidelines (la Tempa) · Asthma is like other chronic diseases, but Home Environment issues make it different (Jim Krieger) o Assess home & self-management § Coaching § Navigation § Asthma trigger supplies § Social support – trusted advisors – address social determinants of health as well so asthma can be controlled · For every $1 spent – save $1.90 o CDC community Guide has a meta-analysis on CHW o CHW in NE Journal – net cost savings across all illnesses o Less expensive than commonly prescribed medicines · APHA Definition - CHW maintain trust and engagement (Perez) o Clinical vs non-clinical o Builds independence and community capacity · Resources o Peer model Listening o CHW Exchange Spaces o CHW Worker Toolkit (this sounds quite intriguing) o Facilitating Strategic partnerships o Enhancing Workforce Vision and Value · Quality of Life measures important to families (Brown) o Inspire change o Asthma education o Refer to 3rd party services o Interfaith, multi-ethnic, respectful of all o Don't need asthma knowledge at first – can learn that
12:15–1:15	**NETWORKING LUNCH**

1:20-1:55 Moderator: Tanya Pagán Raggio-Ashley	**Advancing Sustainable Funding for Asthma In-Home Interventions in Region 2: Open Forum** State Updates · PRDOH – Asthma Program does not include home visits; capacity building; Proyecto AIRE-PRDOH; Asmarlin cartoon project from UPR · NYS/NYC – defining professional roles is crucial, awareness of reimbursement opportunities needs to be strengthened across the board; · Consider breaking out into urban/rural for different states/areas?
2:00-2:30 Moderator: Tanya Pagán Raggio-Ashley	**Region 2 Call to Action: Sustainable Health Care Payment for Asthma In-Home Interventions** Keynote – Amanda Reddy, NCHH · Call to Action · Costs of asthma are high and it affects blacks and minorities more than whites · There is momentum for states to expand home-based asthma service reimbursement through Medicaid · We have enough demonstration projects, it's time to connect and put into place the services and systems to implement them. · Home energy efficiency solutions can also be very effective in addressing asthma triggers, look for ways to combine funding streams. · Reimbursement piece is important, but housing quality is another big piece that needs to be addressed in a parallel track. What other coalition-type work can move on healthy housing in addition to getting in-home interventions addressed? · Asthma is weather/seasonal-related, are warmer/wetter states moving faster? NCHH looked at this, and no not really. State activity on reimbursement is not necessarily divided by politics or weather.
2:30-2:45	**BREAK**
2:50-3:40 Moderator: Maida P. Galvez	**Ins and Outs of Asthma Business Plans and Insurance Reimbursement** • Mary Beth Malcarney (GW) led the session • Michael McNight (Green Healthy Homes Initiative) o Baltimore, MD organization doing in home interventions since 1999 o Funding: HUD, weatherization resources, etc…"braided approach" ▪ More challenging to get the funding from Healthcare; have made very deliberate plan o NAEPP Guideline based care calls for environmental interventions for asthma o Their model was explained (many facets including the environmental interventions) o Studied their results; found good improvements on ED visits, hospitalizations, etc ▪ Currently doing a study with HUD to compare medical utilization/outcomes with matched group of asthmatics o Important to think about the COST ▪ How much would the prevention of an asthma hospitalization save? ▪ Pay for success model • Private sources of funding to invest in home interventions…want a "return on investment"; i.e. show that frequently admitted

	asthmatics decrease healthcare utilization (portion of those savings would be paid back to investors) • Projections of savings from healthcare utilization important (need the right experts to do this) o Rolling out this plan with 5 centers across the US o Preparing for engaging healthcare ▪ Documenting services ▪ Evidence base ▪ Outputs, outcomes, metrics ▪ Defining population served (demographics, etc) ▪ Capacity • Deborah Nagin and Carolyn Olson (NYC DOHMH) o Goal: Doctors be able to write prescription for safe pest control for affected asthmatics→ DOH can refer to appropriate resource/company that will be paid for by the insurance provider o IPM is one important piece of in-home asthma intervention o Data link between ED visits for asthma and cockroaches ▪ See other data like this from NYC DOH Environmental Health Tracking Portal o Home environmental problems lead to healthcare costs o Previously validated IPM interventions explained o Effective pest intervention could greatly reduce health care costs o Study: Return on Investment for IPM ▪ NYC DOH and Montefiore; partnering with Healthfirst and Affinity ▪ Age 5-12 asthmatics in home with pests ▪ To demonstrate feasibility of basic IPM intervention ▪ Prospective RCT with 386 children- study design described • Intervention: 2 visits-assessment/evaluation and treatments • Currently doing baseline analysis; results of study due in August 2016 • Joy Hsu (CDC) o CDC National Asthma Control Program o Business case is important for asthma programs o Main components ▪ Problem/opportunity- burden of asthma to the payer ▪ Solution ▪ Evidence base- what has been done? What works? • Evidence showing reduced ED visits, hospitalizations, short term positive return on investment • In NY, Affinity Health Plan program in Bronx. Many other examples mentioned. ▪ Local capacity- resources, infrastructure ▪ Impact – financial (cost/savings), quality (delivery of care) o How to estimate the burden of asthma to payers? ▪ Prevalence, hospitalizations, ED, missed school/work, quality of life, cost of asthma ▪ Chronic disease cost calculator from the CDC –good tool for this

	○ CDC products to help with this—access on their website www.cdc.gov/policy/hst/statestrategies ▪ State Strategies to improve health and control cost within 5 years ▪ NGA paper: Health investments that pay-off: Strategies for addressing asthma in children ▪ White paper on developing a business case for payers ▪ *In process:* Database of evidence for asthma control strategies ▪ CDC Chronic disease cost calculator ▪ AHRQ Asthma return on investment calculator ▪ Center for Health Care Strategies ROI calculator ▪ Asthma Community Network, Value proposition • Comments during the Q&A: ○ Need to quantity the program well for investors and transparent reporting. ○ ROI: wide range of #'s due to varying costs (CHW visit versus roof repair). ○ GHHI studying different levels of intervention and their changes in healthcare utilization. ○ Heterogeneity in the data and how ROIs calculated overall. To move forward, need to collaborate and talk about specifics (how, what, why). ○ Reach out to stakeholders early on. ○ CDC "sixeighteen" program
3:45-4:15 Moderator: Maida P. Galvez	**Q & A with the Experts: Best Practices in Asthma In-Home Interventions** Felesia Bowen ○ Research project funded by RWJ; working with a medical center to bring asthma specialty care into the community ▪ 3 groups of children in study: Regular care, asthma specialty care (after hours and weekends) in the community – part of this group randomized to a home visit to identify asthma triggers in the home Ray Lopez ○ CHW team does in home asthma interventions; they do the IPM and other work themselves (such as mold interim controls) Theresa Soriano ○ Home based primary care for elderly adults (Visiting Doctors); importance of community partnerships to address her patient's needs; working on how to get those other services reimbursable/sustainable What is biggest barrier? ○ Bowen: Cost, especially at her FQHC; hope to prove a benefit (ROI) in the end that will lead to next steps; they are monitoring health outcomes (missed days, etc) ○ Soriano: Cost; as system moves to move fee-for-value model, programs will change (higher up front cost but long-term benefits from reduced ED visits/admissions/etc) ○ Lopez: Cost/funding; his organization gets grant funding but always looking for other more sustainable sources How have obstacles impacted families served? Speakers provided anecdotes of families, their challenges, and how their organization helped them. What are the opportunities?

	○ Soriano: Holistic and multi-component approaches to chronic diseases like asthma; raising awareness and bringing people together ○ Lopez: making connections; working together for policy change ○ Bowen: putting resources together to make it happen—finding partnerships to get projects done What stakeholders? ○ Healthcare, payers, community, patients, community leaders ○ Bowen: patients/families need to be at the table
4:20-4:30	**NEXT STEPS: Advancing Sustainable Funding for In-Home Asthma Interventions** People are motivated and energized. Let's make it happen. How can we best get the payers on board? Let's continue the conversation. EPA committed to seeing this work through. Subcommittees will continue to work. A big thank you to everyone involved in this conference!



BRAIDED FUNDING

www.asthmacommunitynetwork.org

- In-home asthma care programs often braid separate funding streams together
- Pay for more services than any one stream can support on its own
- Carefully track expenditures to report back on how money was spent

www.asthmacommunitynetwork.org/financing