

December 17, 2014
California Department of Health Care Services (DHCS)
hhp@dhcs.ca.gov

Re: Inclusion of asthma in the Health Homes for Patients with Complex Needs model

Dear DHCS staff:

The undersigned stakeholders appreciate the thoroughness reflected in the Department of Health Care Services' (DHCS) planning of the CalSIM Health Homes for Patients with Complex Needs model (HHPCN). We were extremely disappointed to hear that the state will not receive a State Innovation Model Testing Grant from the Center for Medicare and Medicaid Service's Center for Medicare and Medicaid Innovation (CMMI). Still, we are grateful that Secretary Diana Dooley, in sharing news about the award, wrote "California continues to stand out as an innovator in health care and we must proceed to implement elements of our Plan including the transparency agenda, *health homes*, and public reporting of Let's Get Healthy California Indicators [emphasis added]." Given the state's continued interest in the HHPCN model, we respectfully submit the following comments about the program's design.

Asthma was listed as one of the chronic conditions under consideration for inclusion in the HHPCN on the November 17th DHCS Webinar and HHPCN Concept Paper. Even without CMMI support, we strongly support the inclusion of asthma in any future promulgation of the HHPCN model. Targeting asthma will help the state achieve its overall triple aim goal of better health, better care, and lower costs.

Asthma is a chronic disease that is among the most common, costly, and preventable of all health problems in the United States. Rates of asthma have nearly doubled in the United States over the last few decades. Over 23 million people have asthma nationwide.ⁱ Over 5 million of those diagnosed with asthma live in California.ⁱⁱ In 2007, the U.S. spent an estimated \$19.7 billion on asthma in both direct and indirect costs. Among pediatric hospitalizations that could be prevented, asthma is responsible for the highest costs.ⁱⁱⁱ

In California, surveillance data show that there is much room for improvement in routine health care for people with asthma. According to the California Department of Public Health (CDPH), Environmental Health Investigations Branch, "More than half of adults with current asthma have not had a routine asthma checkup in the past year and only 40% of adults and children with asthma have received a written asthma action plan [such plans are a critical component of the national clinical guidelines for care] from their health care provider...[T]here are about 400 deaths, 35,000 hospital discharges, and 180,000 emergency department visits per year due to asthma. In addition, the costs of asthma hospitalizations are enormous—over \$1 billion in 2010. Proper prevention efforts could reduce many of these poor outcomes and costs. For example, [in California] 12% of people who were hospitalized for asthma in 2010 had at least one repeat visit during that same year. Intervening to prevent these repeat asthma hospitalizations could have saved \$156 million in medical costs."^{iv}

Asthma is of particular concern to California's Medi-Cal population. Low income is associated with higher asthma severity, poorer asthma control, and higher rates of asthma emergency department visits and hospitalizations. Again according to CDPH, "Medi-Cal beneficiaries represent a high-risk population for asthma."^v Additional data from the 2011-2012 California Health Interview Survey indicate 1,128,000 Medi-Cal beneficiaries have been diagnosed with asthma at some point in their lives. This prevalence (16.2%) is higher than those not covered by Medi-Cal (13.6%).^{vi} In 2010, there were 90,004 asthma emergency department visits and 14,514 asthma hospitalizations among continuously enrolled Medi-Cal beneficiaries. That translates to a rate of 145.4 asthma emergency department visits per 10,000 beneficiaries (compared to 46.1 per 10,000 statewide) and a rate of 26 asthma hospitalizations per 10,000 beneficiaries (compared to 9 per 10,000 statewide). Medicare and Medicaid covered 65% of asthma hospitalizations and 50% of asthma ED visits in California in 2010.^{vii}

Asthma is often associated with various comorbidities, a fact that fits HHPCN's requirement that eligible individuals have two or more chronic conditions or one chronic condition and at risk for another. The most frequently reported asthma comorbid conditions include rhinitis, sinusitis, gastroesophageal reflux disease, obstructive sleep apnea, hormonal disorders and psychopathologies. These conditions may share a common pathophysiological mechanism with asthma as well as influence asthma control, its phenotype and response to treatment.^{viii} In addition to these most common comorbidities, people with current asthma report worse general health than people without asthma, including the following:

- Adults with current asthma are 8-10 times more likely to have chronic obstructive pulmonary disease (COPD) than adults who do not have asthma.
- Almost one in three adults with current asthma is obese (31% vs. 21.7% among adults who do not have asthma), and one in seven teens (age 12–17) with current asthma is obese (14.4% vs. 10.9% among teens who do not have asthma).
- Among adults with current asthma, 11.6% also have diabetes, 37% also have high blood pressure, and 9.8% also have heart disease (compared to 8.2%, 25.5%, and 5.6%, respectively, among adults who do not have asthma).
- Over 40% of adults with current asthma are disabled (compared to 26.3% among adults who do not have asthma).
- About 6% of adults and teens with current asthma have psychological distress.^{ix}

Treating asthmatic patients in a health home model would allow for addressing comorbidities more effectively.

Finally, asthma fits strongly with many of the core health home services that will likely be provided as part of HHPCN, including comprehensive case management, care coordination and health promotion, individual and family support services, and use of health information technology. According to "The Affordable Care Act, Medical Homes, and Childhood Asthma: A Key Opportunity for Progress," "the very qualities that make a health care model a medical home are the qualities that are essential to high quality pediatric asthma care. Thus, pediatric asthma emerges as an extremely important diagnosis on which the medical home model can be built."^x Below are several examples showcasing the strong link between asthma and the health home model.^{xi}

Comprehensive care management, including screenings and assessments with standardized tools as well as health action plan assessment and reassessments:

- “Accurate symptom evaluation is a critical component of successful asthma management. This is especially so in children and families who face extra challenges because of illness severity, sociodemographics, or health care system characteristics. It has been shown that minority and poor children with asthma benefit from utilization of symptom-time peak expiratory flow rate (PEFR) as a symptom measurement tool. Children in this population who used peak expiratory flow meters when symptomatic had a lower asthma severity score, fewer symptom days, and lower health care utilization than children who did not utilize this measurement, indicating the positive impact of accurate and objective symptom evaluations.”
- “A continuous quality improvement component, incorporating a technical assistance team and community health workers, in an intervention for children with asthma improved asthma outcomes and processes of care measures, including a reduction in emergency department visits and asthma severity assessments, and improved family-reported psychological measures.”

Care coordination and health promotion, including developing a person-centered plan and managing referrals:

- “Written asthma action plans are an important tool for asthma management for children and families and have been found to be most effective when they are symptom-based and include tools for self-monitoring and self-management. They have been shown to be most effective with more severe asthma and have been associated with reduced utilization of health care services such as emergency department visits.”
- “Referrals to specialty care as needed are important for proper asthma management. Among a survey of Medicaid-insured children, having seen a specialty provider and having had follow - up visits with a primary care provider were associated with less underuse of controller medications.”

Individual and family support services:

- “Community health workers can be of great value for reaching and working with families where children have asthma. Well-trained community health workers effectively deliver health education and case management services, and connect families with community and medical resources, and the formal health care system.”
- “A dose response seems to exist between the intensity of asthma education intervention delivered and the reduction in health care utilization such as emergency department and acute care visits, with those children and families receiving more intensive education and increased time with a health educator or counselor having fewer unscheduled health care visits.”
- “Educational programs for the self-management of asthma in children and adolescents were associated with improvements in many outcome measures, including lung function, self-efficacy, absenteeism from school, number of days of restricted activity, number of visits to an emergency department, and nights disturbed by asthma, with the strongest effects seen among children with more severe asthma.”

Use of health information technology

- “Using a web-based monitoring system for children with asthma to report symptoms, asthma management, and quality of life to their health care provider resulted in improved health outcomes including a decrease in peak flow readings and fewer reports of limitations in their daily activity, when compared to a control.”
- “Tracking program Fight Asthma Milwaukee, where Children’s Hospital and Health System collaborated with five hospitals in the Milwaukee, WI region, developed a web-based registry that monitors emergency department care for children with asthma and wheeze, and identifies asthma burden and opportunities for intervention. Key elements of the registry include reporting functions and help screens for the user.”
- “Patient registries based on claims data have been shown to be useful in helping integrated delivery systems identify patients not receiving appropriate preventive asthma care (such as using a controller medication, per HEDIS® measurements) and to then conduct follow-up and outreach for the patient.”

While these recommendations are specific to childhood asthma, adult populations can also benefit from similar health home opportunities.

Based on the urgent need to address this prevalent and costly disease, combined with robust evidence about how to improve outcomes and reduce costs, we strongly recommend that the HHPCN include asthma as a targeted chronic disease. We look forward to hearing from you and to working with you to implement an effective Health Home program that serves the needs of Medi-Cal members.

Regards,

Anne Kelsey Lamb and Joel Ervice
Regional Asthma Management and Prevention (RAMP)

Robert Vinetz
Pediatric Asthma Disease Management Program
QueensCare Health Centers*
Past Co-chair, Asthma Coalition of Los Angeles County*

Karen Cohn
San Francisco Asthma Task Force

Patti V. Burton
Respiratory Care Consultant
Certified Asthma Educator

Kimberly Amazeen
Vice President, Public Policy & Advocacy
American Lung Association in California

Barbara Langham RN BSN
Pediatric Asthma Care Manager

St. John's Well Child and Family Center

Linda Ayala, MPH
Health Educator
Alameda Alliance for Health

Farhat Hanifi
Central California Asthma Collaborative

MariaElena Avila-Toledo, MPH
Asthma Advocate and Concerned Parent of a Child with Asthma

Betsy Campbell, MPH, CEHRS
Senior Health Educator
Solano Asthma Coalition

Mary Frazier, RN, MSN AE-C
Project Director
Breathmobile

Francisco Covarrubias
Chair
Asthma Coalition of Los Angeles County

Aide Fulton
Imperial Valley Child Asthma Program Director

Meredith Barrett, PhD
VP, Science & Research
Propeller Health

Scott H. Takahashi, Pharm.D., FCSHP , FASHP
Pediatric Ambulatory Care Pharmacist
California Asthma Partners Member
Asthma Coalition of Los Angeles County Clinical Wrokgroup Co-Chair

Robin Cox, MPH, CPH, Health Education Manager
Health Promotion & Community Wellness Bureau Chief
Solano County Public Health Services
Health & Social Services Department

Jean Farmer, RN
Certified Asthma Educator
Sonoma County Indian Health Project

Terry Kirkindoll
Asthma Advocate

Jessica Stahler
Asthma Advocate

Maria Jaime-Romero
Asthma Advocate

Dr. Washington Burns
Asthma Coalition of Alameda County
West Oakland Asthma Coalition
Prescott Joseph Center for Community Enhancement

Maisie Crookes, RN. BSc AE-C
Asthma Case Manager
Certified Asthma Educator

Jane Stewart, R.N.
Pediatric Asthma Care Manager
Supporting the children of Napa and Solano Counties who have asthma

Krysta Titel, MPH
Coalition Coordinator
San Joaquin County Asthma & COPD Coalition

Celeste Ramos
Chair
Merced/Mariposa County Asthma Coalition

Shan Magnuson
Chair
Sonoma County Asthma Coalition

Sylvia Betancourt
Long Beach Alliance for Children with Asthma

Karen Licavoli, MPH
Breathe California/Golden Gate Public Health Partnership

*Institutional affiliation listed for identification purposes only

ⁱ Investing in Best Practices for Asthma: A Business Case. 2010. Health Resources in Action.
<http://hria.org/resources/reports/asthma/best-practices-for-asthma-2010.html#sthash.ofHv4aDq.dpuf>

ⁱⁱ California Health Interview Survey data. 2011. UCLA Center for Health Policy Research.
<http://ask.chis.ucla.edu/main/default.asp>

ⁱⁱⁱ Investing in Best Practices for Asthma: A Business Case. 2010. Health Resources in Action.
<http://hria.org/resources/reports/asthma/best-practices-for-asthma-2010.html#sthash.ofHv4aDq.dpuf>

^{iv} Milet M, Lutzker L, Flattery J. *Asthma in California: A Surveillance Report*. Richmond, CA: California Department of Public Health, Environmental Health Investigations Brand, May 2013.
<http://www.californiabreathing.org/asthma-data/cal-asthma-report>

^v *Ibid*

^{vi} California Health Interview Survey data. 2011. UCLA Center for Health Policy Research.
<http://ask.chis.ucla.edu/main/default.asp>

^{vii} Milet M, Lutzker L, Flattery J. *Asthma in California: A Surveillance Report*. Richmond, CA: California Department of Public Health, Environmental Health Investigations Brand, May 2013.
<http://www.californiabreathing.org/asthma-data/cal-asthma-report>

^{viii} [Expert Rev Respir Med](#). 2011 Jun;5(3):377-93. doi: 10.1586/ers.11.34. Asthma-related comorbidities. [Boulet LP, Boulay MÈ](#).

^{ix} Milet M, Lutzker L, Flattery J. *Asthma in California: A Surveillance Report*. Richmond, CA: California Department of Public Health, Environmental Health Investigations Brand, May 2013.
<http://www.californiabreathing.org/asthma-data/cal-asthma-report>

^x The Affordable Care Act, Medical Homes, and Childhood Asthma: A Key Opportunity for Progress. The George Washington University, School of Public Health and Health Services; Merck Childhood Asthma Network; and RCHN: Community Health Foundation.
http://www.mcanonline.org/static/images/files_AffordableCareActMedicalHomesAndChildhoodAsthmaBrief.pdf

^{xi} *Ibid*.