December 21, 2015

California Department of Health Care Services (DHCS)
Via email: hhp@dhcs.ca.gov

Re: Comments on Health Homes Concept Paper Version 3.0 – support for inclusion of asthma

Dear DHCS staff:

Thank you for the opportunity to comment on the recently released Concept Paper Version 3.0 for California's Health Homes for Patients with Complex Needs program (HHP). The undersigned organizations and individuals are in strong support of the promise of the Health Home model, and have specific recommendations for making it as effective as possible for the high-need members within the Medi-Cal system.

Maintain inclusion of asthma as a qualifying condition but loosen overall eligibility requirements.
We are very pleased that asthma is included as one of the chronic conditions eligible for services under the HHP. Addressing asthma within the HHP can help achieve the state's triple aim goal of better health, better care, and lower costs. Consistent with the Health Home approach, there is a strong evidence base of effective asthma interventions leading to improved health outcomes and costs savings, both of which are realized in a very short amount of time. Additionally, as you undoubtedly know 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. According to the California Department of Public Health, "Medi-Cal beneficiaries represent a high-risk population for asthma,"[i] while 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%).[ii]

However, we are concerned that the new concept paper effectively limits the member eligibility pool by requiring, in most cases, that members have two chronic conditions, e.g., asthma and another condition such as diabetes, chronic liver disease, or congestive heart failure. Previous concept papers suggested that a greater number of Medi-Cal members would be eligible based on having one chronic condition while being at-risk for another. While the concept paper does note that "the HHP is intended to be an intensive set of services for a small subset of members who require coordination at the highest levels," evidence indicates that individuals with severe asthma would benefit from HHP services even if they're not diagnosed with another condition. For example, 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."[iii] Such qualities can also be extended to treating adult asthma per the HHP requirement that all services be made available to all categorically needy Medi-Cal beneficiaries. Below are several examples showcasing the clear link between asthma and the core health home services outlined in the Concept Paper.[iv]

Comprehensive care management

- "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

- "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."

Comprehensive transitional care

- Various asthma programs have long recognized the need for and demonstrated the ability to conduct prompt engagement of patients admitted to or discharged from an emergency department, hospital, etc., in order to provide increased levels of coordinated care in part to avoid readmissions. For example, the renowned Boston Children's Hospital Community Asthma Initiative specifically targeted program services to patients admitted to the emergency department with asthma, noting "Meeting the family in-person in the hospital…and having a personal hand-off from a known care provider, whenever possible, helps with acceptance of the program by the parent/guardian. Also, the asthma hospitalization or ED visit is a teachable moment when families seem receptive to additional services."[v] Such interventions contributed to program successes like reduced hospitalizations and medical expenditure savings, and can be replicated as part of DHCS's Health Home Program.

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."
- "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."

Referral to community and social supports

- Many asthma programs throughout California have demonstrated the value of community-based linkages to address the whole-person needs of the patient. Staff and "well-trained community health workers effectively …connect families with community and medical resources, and the formal health care system." Such connections are often to housing resources which in turn can help patients better address their asthma (e.g., tenant legal assistance organizations to speed up asthma trigger-related code violations like moisture intrusion), but also include other social services needed by the patient.

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."
- The 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.

Support for use of Community Health Workers within the HHP

We were pleased to see the latest concept paper include Community Health Workers (CHWs) as a key part of the HHP's multi-disciplinary care team, with roles such as engaging eligible HHP members, health promotion and self-management training, distributing health promotion materials, and assisting with linkages to social supports (Concept Paper pg24). There is extensive evidence showing that CHWs play a key role in helping patients manage their asthma in a culturally competent manner, improving health outcomes, and reducing health care expenditures by avoiding more costly hospitalizations and emergency room visits.[vi] As California continues to expand and explore the use of CHWs and other front-line providers in order to improve delivery of better and cost-effective care, the HHP will hopefully be a useful source of information and lessons that can be applied to other programs.

In closing, 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 appreciate that asthma is included within the HHP. We look forward to working with you to implement an effective Health Home Program that serves the needs of Medi-Cal members.

Regards,

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[i] *Ibid*
[ii] California Health Interview Survey data. 2011. UCLA Center for Health Policy Research. http://ask.chis.ucla.edu/main/default.asp
[iii] 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

[iv] Unless otherwise noted by additional footnotes, the additional quotations under each Health Home Service are from The Affordable Care Act, Medical Homes, and Childhood Asthma: A Key Opportunity for Progress, cited above.

[v] A Case Study in Payment Reform to Support Optimal Pediatric Asthma Care. 2015. Center for Health Policy at Brookings. http://www.brookings.edu/research/papers/2015/04/27-case-study-pediatric-asthma-farmer

[vi] For a variety of resources on the effectiveness of CHWs, see the U.S. Environmental Protection Agency's Asthma Community Network website: http://www.asthmacommunitynetwork.org/search/node/community%20health%20workers.