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Project Title	*Asthma Healthy Homes Home Visit*

Rationale for the Project

- Washington State has one of the highest rates of asthma among adults in the country, 9.8 percent. Additionally, 6.7% of children have asthma in Washington State. Whatcom County, the largest county in our service territory ranks higher with an asthma rate of between 8.8 and 9.6 percent for children. Asthma also disproportionately affects low-income individuals, with those in the lowest income percentile twice as likely to report asthma than in the top percentile. Additionally, American Indian/Alaska Natives in Washington State have a lifetime asthma prevalence twice that of the general population.
- 57,000 Washington adults, typically with very poorly controlled asthma, visited the emergency room in 2010 at least once due to asthma. 60 percent of asthma hospitalization costs are paid for by public funds, such as Medicaid. In a small study completed by Oak Ridge National Laboratory and Opportunity Council, 35% participants were considered Medicaid super-utilizers.
- Washington State Department of Health's report Asthma and Socioeconomic Status in Washington State recommends improving the indoor living environments for low-income asthma patients. It is widely accepted that reducing exposure to indoor asthma triggers is an effective intervention to reduce asthma episodes and to improve quality of life.
- Healthy Homes home visits improve the health outcomes for Medicaid and low-income population, a key objective of Medicaid. Medicaid beneficiaries often live in sub-standard housing with compromised indoor air quality. By addressing the indoor air environment and occupant behavior through home visits, Medicaid beneficiaries experience an improved quality of life and better asthma outcomes.

Project Description

Which Medicaid Transformation Goals are supported by this project/intervention?

☑ Reduce avoidable use of intensive services
☑ Improve population health, focused on prevention

Which Transformation Project Domain(s) are involved?

☑ Population Health Improvement – prevention activities

Describe:

- The Northwest Washington region of Washington State, which includes Whatcom, Island and San Juan Counties, will be the initial area benefiting, with a long-term goal of expanding into Skagit and Snohomish Counties through partnership with the North Sound Accountable Community of Health (ACH). Medicaid beneficiaries in the mainstream population and tribal communities in our region who have poorly controlled asthma or other respiratory ailments that may be controlled through improving the indoor air quality and/or behavioral changes will be the primary targets of this project. As a Community Action Agency, Opportunity Council's mission is to serve low-income individuals. 38% of respondents to the triennial Island, Whatcom and San Juan County Needs Assessment report they are Medicaid beneficiaries. The agency reaches thousands of households a year through energy assistance, employment, housing, and early learning programs. Partnerships with the Lummi Nation, Nooksack Tribe and Whatcom Alliance for Health Advancement will bring additional Medicaid beneficiaries into the project.
- This project is directly linked to the Transformation Project goals of reducing intensive services, especially

avoidable emergency room visits, as well has improving population health through prevention activities.

- The goals of the project are to reduce Medicaid costs associated with emergency/urgent care usage, hospitalizations, medication and overall health system usage for asthma and respiratory illnesses; to improve quality of life for asthma sufferers by reducing the number of days asthma affects daily activity; to improve indoor air quality of homes through behavior change and low cost interventions (when available), such as dust mite covers and walk mats, and to enroll households in Weatherization programs that address additional indoor air quality issues, such as ventilation issues and replacing carpet with solid surface flooring.
- This project links directly to WA State Department of Commerce's Weatherization plus Health Basic Matchmakers program, which as of December 2015 allows Weatherization agencies, like Opportunity Council, to direct funds to improve the indoor air environment in low-income households. In addition to the basic program, Matchmakers has also awarded Opportunity Council additional funding through a competitive Matchmakers Weatherization plus Health Enhanced Innovations grant that will expand capacity in the initial three-county service area, as well as Snohomish County through Snohomish County Weatherization.
- Initial partner Whatcom Alliance for Health Advancement, in their work with us through the Matchmaker Innovation grant, will position the agency to accept referrals from the medical community and to monitor the health outcomes of the Matchmaker Innovation project. This project and the Matchmaker project will connect with local tribal health clinics, community health centers, area hospitals, asthma and allergy clinics, public health and family care clinics, with most groundwork being established through the Matchmaker project. Partners in Skagit and Snohomish County will be established based on protocols determined in the start up phase and will include Community Action Agencies and local medical providers.
- The Executive Director of Opportunity Council is on the board and steering committee of the North Sound ACH. We will be submitting this proposal for endorsement by the North Sound ACH on January 19th. In 2015, the board considered it as an ACH pilot project given its focus on upstream prevention and potential to reduce Medicaid expenditures.

Core Investment Components

Describe:

- The proposed activities for this project include receiving a referral from a physician or other authorized agent, a first home visit and follow up. The first home visit is a two-hour visit conducted by credentialed Healthy Homes Specialist (NEHA credential). The visit focuses on assessing the asthma patient, assessing the home for asthma triggers, surveying the family/household, behavior change through collaborative action planning, and proposing a treatment plan for the home that connects to other available programs. A follow up visit will occur at 6 months, with follow up phone calls occurring at the 1 month, 3 month, and 1 year mark. Follow ups will include the Asthma Control Test, quality of life survey and problem solving around barriers to implementation of action plan and home treatment plan.
  - 300 households served annually (home visits)
  - Reimbursement rate of $175 per visit
- Additional leveraged funding through WA State Department of Commerce Enhanced Weatherization Plus Health programming will round out the costs associated with the full home intervention and follow up.
- Oak Ridge National Laboratory recently completed a quasi-experimental, small subject study of our previous Weatherization plus Healthy Homes program and found promising trends, despite the small study size. The return on investment compared Medicaid data for the asthma patient one year pre intervention to up to three years post intervention, depending on the subject, with the costs of the Weatherization plus Healthy Homes program, which included home visit, low cost inventory and enhance mitigation measures (i.e. ventilation, solid surface flooring). The study found that nearly 83% of all cases observed some decrease in the number of Medicaid claims per month, and nearly 64% observed some decrease in cost of those claims per month. Nearly 82% saw a decrease in annualized Medicaid cost post intervention. These preliminary results along with the

ongoing evaluation of the Matchmaker Innovation program will help inform realistic ROI opportunities. We anticipate having benchmark ROI metrics available in the third quarter of 2016.

- With much of the groundwork being laid for physician referrals and medical provider partnerships during the Matchmakers Innovation start up phase, full implementation in the initial three-county area could occur quite rapidly after that. Expanding into the additional two-county area would be a longer implementation, approximately another six months after full implementation in the initial three-county area.

Project Metrics

- First six months:
  Establish physician referral system and Medicaid reimbursement system. Establish ROI benchmark using existing data. Finalize home visit tools and tracking system.
  Year 1:
  Begin receiving referrals and conducting home visits and first 6-month follow up visit. Begin analyzing Medicaid data between first and follow up visit and revise ROI benchmarks as appropriate. Begin planning for establishment of program in Skagit and Snohomish county.
  Year 2:
  Roll out direct program or partner program in Skagit and Snohomish County. Analyze Medicaid data from patients who have been enrolled for full year and revise program and/or ROI benchmarks as needed.
- Benchmark performance will be established using data from Oak Ridge study, other current studies, Medicaid Transformation Waiver goals and consultation with Whatcom Alliance for Health Advancement and ThreeCubed, an evaluation firm contracted through Matchmakers Innovation project.
- Our project will fit best under the future inclusion of Home and Community-Based Service Utilization or Reduction in avoidable use of institutions (hospital, nursing home) performance measure in the MCO, BHO and AAA contracts to help ensure additional cross system coordination.