

Building Your Workforce – Panel Discussion

Kevin Kennedy, Director, Environmental Health, Children’s Mercy Hospital and Clinics

Mr. Kennedy is an environmental hygienist for Children’s Mercy Hospital and clinics, which serve areas in Kansas and Missouri within 150 miles of the hospital. The hospital has 24 specialty clinics.

In 1996, an audit of a community managed by Children’s Mercy found there was little follow-up with patients and ineffective management. Facility staff were aware of environment effects on patients but had no way to address the problem. A disease management program did not lead to improvements in patient health. After the program hired a hygienist to conduct home visits and identified community resources to support the visits, it saw an improvement in patient health. The hospital needed a comprehensive asthma management program.

Fifteen years later, the program includes full-time hygienists, environmental health coordinators and an office coordinator who is a community health specialist. The program:

- Used three Healthy Homes HUD and other grants to fund an assessment and characterization of risk and home interventions and track them.
- Has hygienists who are certified healthy homes specialists.
- Offers training on healthy homes and assessments to its ~100 community partners.
- Partners with Paul Haan and the Healthy Homes Coalition.
- Began in asthma immunology and now reports to pediatrics; the program receives referrals from any location served by the hospital or a clinic. Families can also contact the program to be connected to a provider.
- Initially received insurance reimbursement for asthma intervention services; later, PPO and network payments for the services declined. Eventually, they were denied.
- Identifies corporate support when available.
- Had a managed care subsidiary at one point but sold it because adult care management was not the focus. The program agreed to manage the pediatric population.

Karen Meyerson, Manager, Asthma Network of West Michigan

The Network is an asthma coalition based in Grand Rapids, Michigan. It provides services for children and adults with asthma in three counties. After three years of grant funding, the coalition approached Priority Health (the largest payer in western Michigan) about affiliation with Medicaid. It signed a contract with Priority Health for Medicaid. It was the first contract of its kind in the country.

The coalition also works with three other Medicaid managed care organizations for home-based case management. The coalition:

- Has a staff of certified asthma educators.
- Works with another organization that has community health workers (CHWs) that co-manage and make home visits.

- Meets with primary care providers for reimbursable meetings. The rest of the budget is covered by grant dollars and community benefits dollars from other hospitals.
- Receives referrals from emergency departments and health plans. Health plans send at-risk member lists and authorize home visits, which provides flexibility for more visits.
- Receives referrals from Great Lakes Health Connect, which is Health Insurance Portability and Accountability Act (HIPAA) compliant.

The coalition has seen outcomes in the reduction of school days missed, spirometry rates, flu shots rates and environmental tobacco smoke exposures. The coalition asks case managers to send patient referrals, focusing on children and adults with uncontrolled asthma as well as newly diagnosed asthma cases. The coalition makes home visits as often as possible. When working with the Healthy Homes (HH) Coalition, it is also possible to address integrated pest management.

Gloria Seals, Senior Supervisor of Asthma Education, Sinai Urban Health Institute

Gloria Seals has been at the Institute for 16 years, working across a variety of programs.

After noting the number and significance of residential risks, the Institute awarded funding to send CHWs into homes. The Institute has had various funders, as well as grants and money provided by the Family Health Network Insurance Program. Its team has grown. Patient education once took place in the clinic. Now it takes place in homes.

The Institute:

- Works with social services, has a HUD program and an asthma care program with a certified asthma educator as well as a respiratory therapist on staff.
- Has staff visit homes and build relationships with patients.
- Receives funding based on the outcomes seen from data collected in the homes. Home visits in conjunction with doctor and nurse visits have been successful.
- Is funded partially by grants as well as referrals from community-based organizations (CBOs), the Family Health Network, institutions, clinics and outpatient referrals from other programs.

One challenge is locating transient patients. A team goes into homes to bring patients back into services. Building patient relationships by speaking with them directly helps ensure quality care. Home environmental assessments provide vital information for the doctors.

Captain Michael Wright, Milwaukee Fire Department

The Department's services have shifted over time to better meet community needs. At first, the focus was fires, then emergency medical services. Now, the department is addressing asthma management. The Department previously handled "red light" patients, assisting people in critical condition. Now they are learning about "yellow light" and "green light" cases from the College of Nursing in Milwaukee. Department staff are a natural choice for home visits because people are accustomed to seeing them in that capacity.

The Department:

- Interviews and carefully selects its paramedic staff.
- Conducts home assessments, including smoke detector checks.
- Has found home visits identify more and better information about patient situations.
- Has patient referrals from 911 management, which can be a drain on resources.
- Includes home visit and asthma management services.
- Is looking for funding.
- Collaborated with a local pharmacist who assisted with medical reconciliation.
- Received environmental assessment training from the American Lung Association.

The Department faces similar challenges in terms of finding and engaging patients and keeping them in the program. The Department's dispatch process gives them an advantage; so does the fact that people identify themselves when calling 911.

Questions

Question (for Gloria Seals): Can you tell us more about your training for CHWs?

Answer: We do extensive training with the CHWs. An information session lasts eight hours. If physicians are available, we interview them. Total training time is about 200 hours. The second half of the training consists of a three-level evaluation – identifying the CHW's current level of knowledge, then evaluating that knowledge and the triggers. The CHW must pass before they are allowed in the field, first with a supervisor for three to five visits. Then, they can go alone.

Question (for Captain Wright): Can you tell us how you pass your patients to other health care professionals that you work with?

Answer: We have a well-defined scope of practice. We have a four-visit plan. The first visit lasts two hours. Following visits are one hour each. We have a clear goal – if a patient has managed care, we want to identify it. By the third visit, we want the care manager to come with us to the home. Since we do not have the capacity to continue visiting patients, the care manager becomes the point of contact. Patients are also given a phone number where they can reach us.

Overview of the National Standards for Asthma Self-Management Education

Karen Myerson provided the overview. The standards are part of the Healthy People 2020 Initiative; goals include increasing appropriate asthma care and decreasing environmental exposure. A recent review noted positive changes as a result of self-management education. An adequate supply of educators is needed to increase education levels. The National Asthma Educators Certification Board (NAACB) is a good resource.

A task force came together to review and evaluate current asthma education standards and trends. The NAACB reviewed the findings and provided input. The National Standards are the result; they meet CPT code requirements and establish a standard reimbursement for corresponding services. There are 16 standards to cross check with individual programs. Three

standards to note in particular – #5: program coordinator; #6: instructor standards; and #7: standardized asthma education curriculum.

Questions

Question: How do the professionals on today's panel use the standards?

Answers:

- *Karen Myerson:* (#5) We pay for staff to take the exam and they maintain the certification. (#7) We make sure our work complies with the standards.
- *Kevin Kennedy:* (#5) We have an asthma coordinator/educator at the hospital. We go into homes and employ asthma educators as well. Respiratory therapists follow a standard curriculum. (#7) We have a curriculum. With the new standards, we are reviewing what needs to be added.
- *Gloria Seals:* We are working toward meeting the guidelines for certified respiratory therapist asthma educators.
- *Captain Wright:* To become a firefighter you need to be a paramedic, which requires 1,500 hours of training and a biannual certification. The majority of that is covered in our general curriculum. We partner with the American Lung Association for additional training on spirometry and asthma action plans. We are participating in grant-funded asthma outreach to see if we can affect change at the macro level.

Question: What unique benefits do service providers in your programs offer?

Answers:

- *Captain Wright:* We face some challenges because we are all-hazard mitigation. Everything from a cat in a tree to a terrorist event falls within our purview, and we do not want to step on anyone's toes. We provide unrivaled access in the community and are looking for an increased role. Right now, we are moving toward working with translators so we can better serve our diverse population. Working in homes makes a huge difference, and we work in conjunction with CHWs.
- *Gloria Seals:* We are different because we meet people where they are, and the CHWs have this benefit. We do things other practitioners are not able to do to build a lasting relationship with families. This can help prevent regular visits to the emergency department. Since we might not see transient patients for six months, we want to make sure we can continue to contact them.
- *Karen Myerson:* Being in the home environment is a privilege. We have a staff of nurses and respiratory therapists that observe family dynamics and identify patient needs. We try to locate patients and stay with them as long as possible.
- *Kevin Kennedy:* The most important thing is getting into homes and meeting people where they are. We use surveys to stratify patients by risk, then offer the corresponding level of service. We also work with community partners. A lack of visibility in the community is a challenge for us. When people see a car from Children's Hospital, it

helps establish trust. Once we build trust, people understand our role and want to work with us. Making the first contact is difficult.

Question: How has your workforce or discipline changed?

Answers:

- *Kevin Kennedy:* We started by doing everything ourselves and realized it was not feasible. The number of kids suffering from asthma showed us that we could not go it alone. We partnered with other groups and offered them training. In our model, others who go into homes can refer people to us and they can offer services as well. We would like to expand the network in that way.
- *Karen Myerson:* We have a licensed social worker and an intern who works with families. They visit families to assess their financial, housing, counseling and other service needs. Some families do not need follow-up assistance. We also have a resident HIPAA and child protective services expert.
- *Gloria Seals:* We have been expanding, employing more people, and are receiving extra funding because of our successes. We are working with a certified asthma educator and improving our in-home services for families.
- *Captain Wright:* Asthma is not our only issue; we can be confronted with any number of ailments. A major change for us is that our members are protocol driven. In an asthma home visit environment, you are not performing a procedure. We are helping our staff focus on “yellow light” work instead of “red light” work. Previously, if we delivered a patient to the hospital alive, our job was done. It is an adjustment. The toughest thing for us is that we have only a finite number of visits.

Question: Can you speak to your successes and challenges regarding structural housing issues, in terms of getting repairs done, pest infestations and other concerns?

Answers:

- *Gloria Seals:* We often have noncompliant landlords. Some families deal with things in their homes that are beyond belief. The Metropolitan Tenants Organization helps us in those situations.
- *Karen Myerson:* We work with the Healthy Homes Coalition. If we have a family that requires assistance, we refer them there. Our social worker has also been successful working with other organizations, such as churches, to assist.
- *Captain Wright:* The American Lung Association is our number one resource for mitigation. When we began our pilot program, I was not aware of their resources in the community. Our funding comes from United Health Care. Because we do not have a remediation budget for homes, working with the Association has been great.
- *Kevin Kennedy:* We have had HUD Healthy Homes and EPA grants, and partner with local organizations to pay for home repairs. We do an assessment and share it with our housing partners; they take over the work and we oversee the repairs. We go into rental

homes to look for code violations. We meet with landlords and tell them that we can take care of some repairs if they can complete others. Many landlords are receptive to the funding incentive. Sometimes, landlords can be helpful but tenants refuse to comply. Tenants have a responsibility too.

Question: In looking at areas with significant interaction with the Medicaid population, are there opportunities during home visits to identify a lead paint hazard? Is it possible to have a child with asthma who is referred to you for lead treatment?

Answers:

- *Kevin Kennedy:* We deal with lots of environmental hazards, including lead. We do work with lead-poisoned children, and we take over management at no cost. We have a one-touch philosophy for healthy homes. If I am in a home and know about other hazards, we address them.
- *Karen Myerson:* We do not typically assess for lead, as our staff are not trained for that, but we do receive referrals from the Healthy Homes Coalition.
- *Gloria Seals:* We have been in a home with lead paint on the windowsills where kids were eating it. I referred them to a physician.
- *Captain Wright:* We have the same experience in older homes.

Comment from Kevin Kennedy: Today, you have heard from people and organizations working in this field. Make the models work for you and you can help families. The Asthma Community Network (www.asthmacommunitynetwork.org) offers helpful resources. There are a lot of potential partners.

Karen Myerson: Nothing we do is proprietary. We are happy to share information.