A Coordinated Community-Based Approach to Reducing the Burden of Asthma

Glynnis Hunt

Schenectady County Public Health Services

Sabrina Halse

Ellis Medicine

Schenectady County, NY

Capital Region

Suburban, Rural and Urban areas

• Population	County - 155,000 City - 66,000 High population density
• Disparities	Guyanese – 8,000 city residents • 30% Type 2 diabetes
• Unemployment	7.4 %
• Poverty	18% of children under 18 Some zip codes as high as 40%
• Obesity	33% of county residents obese

Policy, System and Environmental Changes

TO:
FROM:
RE:
DATE:

Policy, Systems and Environmental Changes

Partnerships to Improve Community Health Grant

Community and Clinical Linkages

Partnerships to Improve Community Health

Racial and Ethnic Disparities:

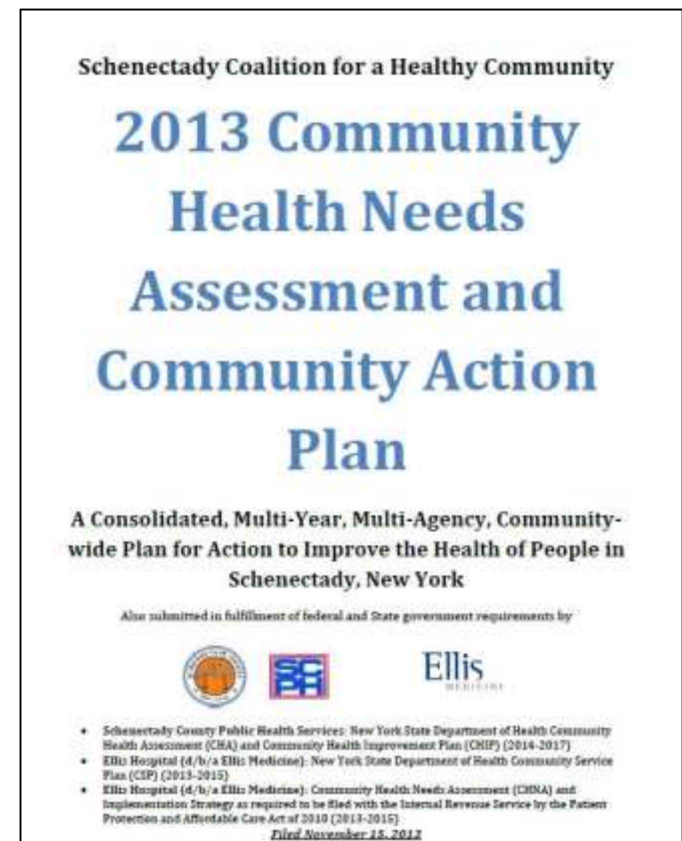
Guyanese – Type 2 Diabetes

Equality
doesn't mean
Equity

Partnership at its BEST

Community Health Improvement Plan

- Schenectady Coalition for a Healthy Community
- CHA/CHIP – 2013
- Prevention Agenda Priority
  - Asthma and Smoking



Schenectady Coalition for a Healthy Community

2013 Community Health Needs Assessment and Community Action Plan

A Consolidated, Multi-Year, Multi-Agency, Community-wide Plan for Action to Improve the Health of People in Schenectady, New York

Also submitted in fulfillment of federal and State government requirements by

- Schenectady County Public Health Services: New York State Department of Health Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) (2014-2017)
- Ellis Hospital (d/b/a Ellis Medicine): New York State Department of Health Community Service Plan (CSP) (2013-2015)
- Ellis Hospital (d/b/a Ellis Medicine): Community Health Needs Assessment (CHNA) and Implementation Strategy as required to be filed with the Internal Revenue Service by the Patient Protection and Affordable Care Act of 2010 (2013-2015)

Filed November 15, 2013

- Spring 2013
- Face to face - door to door Survey
- Trained Community Health Workers
- 2,200 surveys
- 283 questions
- Neighborhood,
  Street level data

Asthma

20% told by a health professional they have asthma

ED use 1,000 asthma visits - 2013

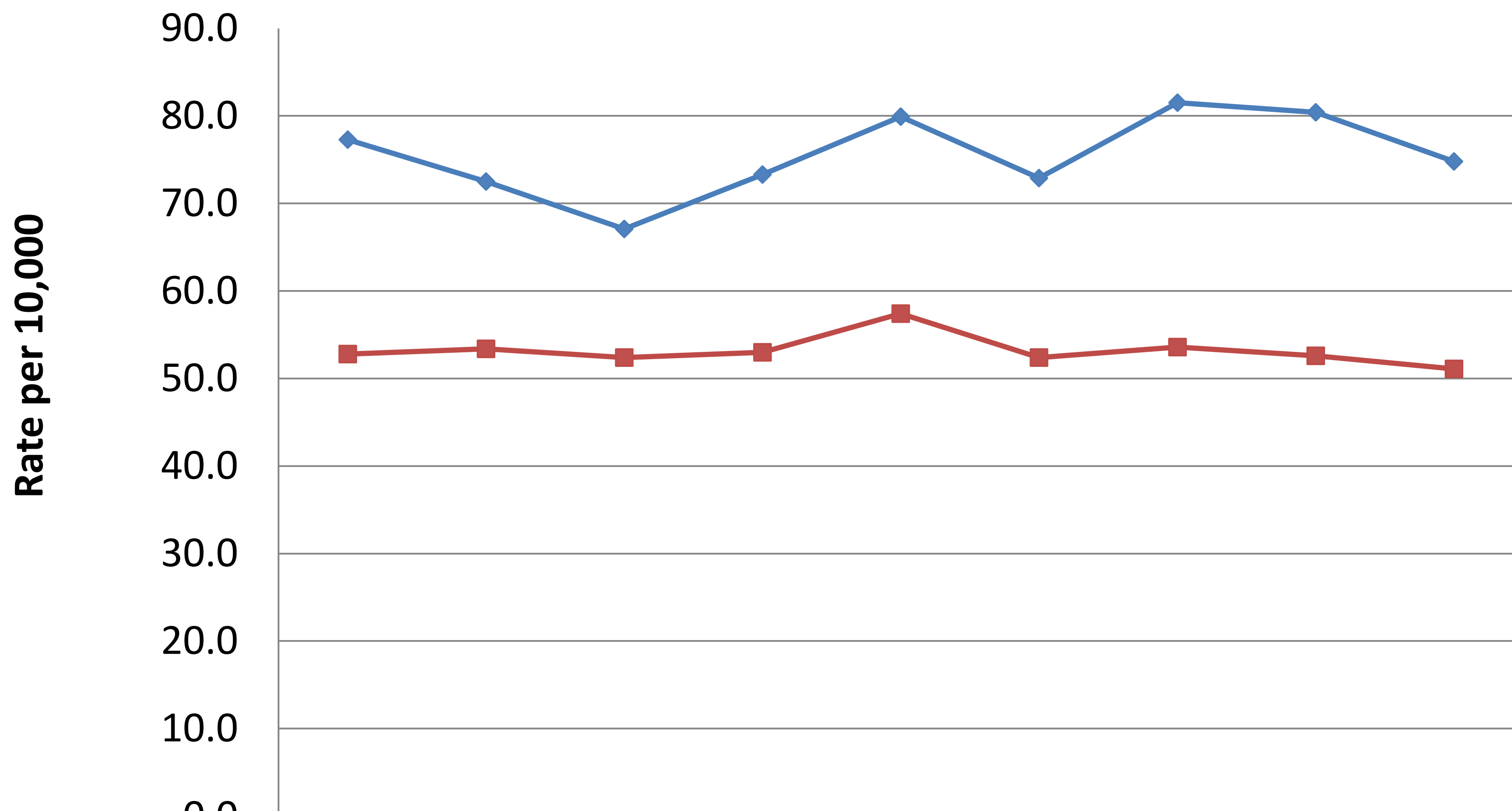
Total cost $2 million

Smoking

52.8% smoked at least 100 cigarettes in lifetime

37% of adults are current smokers

Age-adjusted Asthma ED Visit Rate per 10,000, NYS, excl. NYC, and Schenectady County, 2005-2013



	2005	2006	2007	2008	2009	2010	2011	2012	2013
Schenectady	77.3	72.5	67.1	73.3	79.9	72.9	81.5	80.4	74.8
NYS excl. NYC	52.8	53.4	52.4	53	57.4	52.4	53.6	52.6	51.1

County Health Rankings & Roadmaps

- Coaching –
  - Roadmaps to Health Action Awardee
- Community Engagement – Building Capacity
- Data supporting PH Focus
- Generates a Community Conversation

Clinical Community Linkages Addressing Asthma

- **Evidence Based Approach**

  Boston Children's Hospital

- **Capacity**

  Existing Programs at Ellis and SCPHS

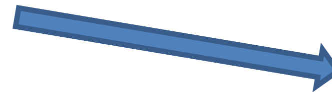
- **Funding** - Private Public Partnerships

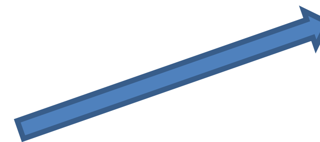
  NYS Health Foundation

  The Schenectady Foundation, GE, MVP

Schenectady Asthma Support Collaborative

- Established team
- Roles
  - **Public Health**
    - Facilitator / Convener
    - Grant writer
    - Community Linkages
    - Home visiting programs
    - Public Health lens
  - **Healthcare Organization**
    - Clinical expertise
    - LEAN process improvement
    - Care Management
    - Asthma Care Management Program

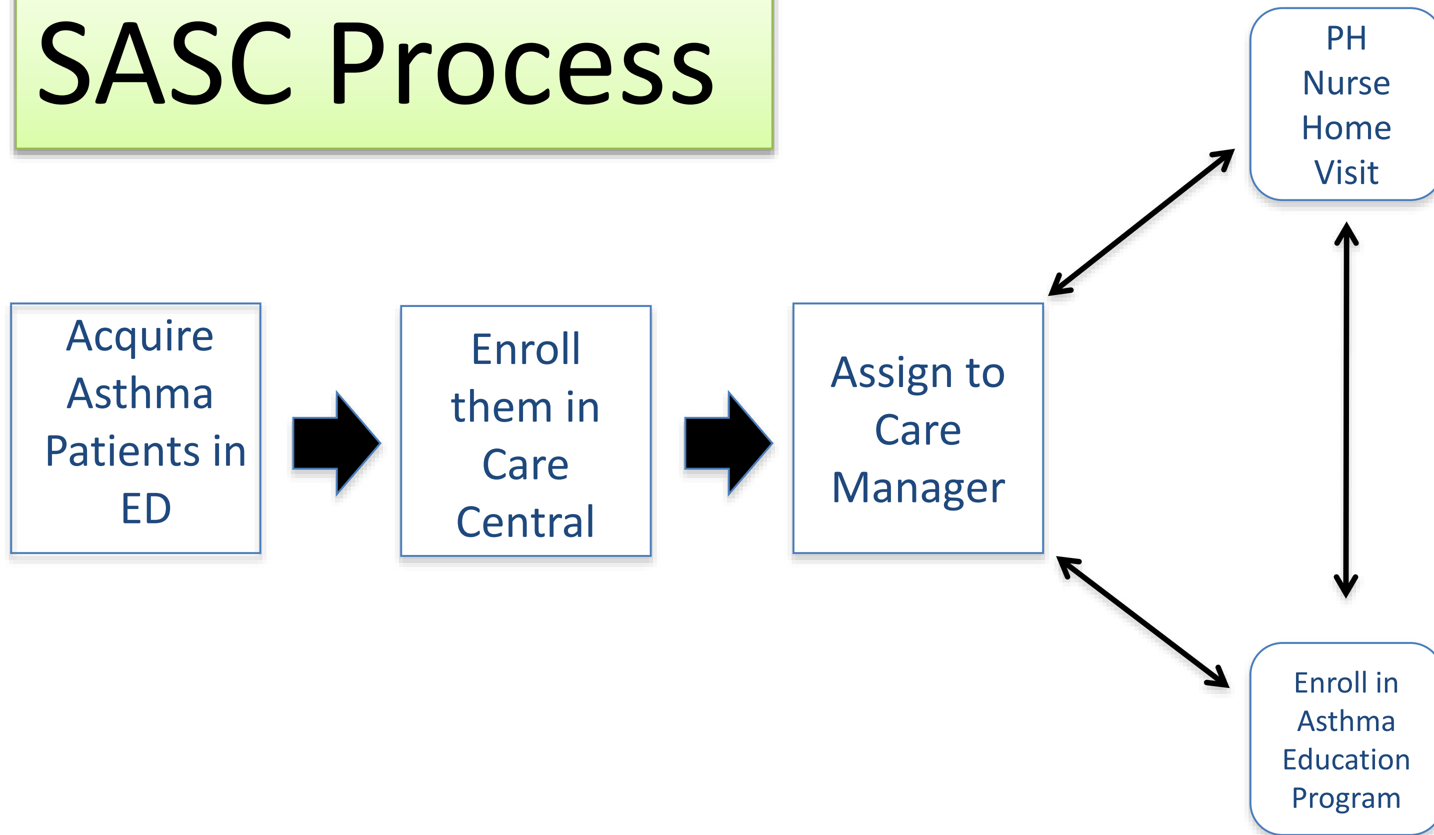




SHARED GOALS

Three – Pronged Approach

- **Care Central**
- **Asthma Education**
- **Healthy Neighborhoods**



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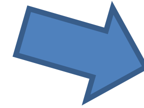
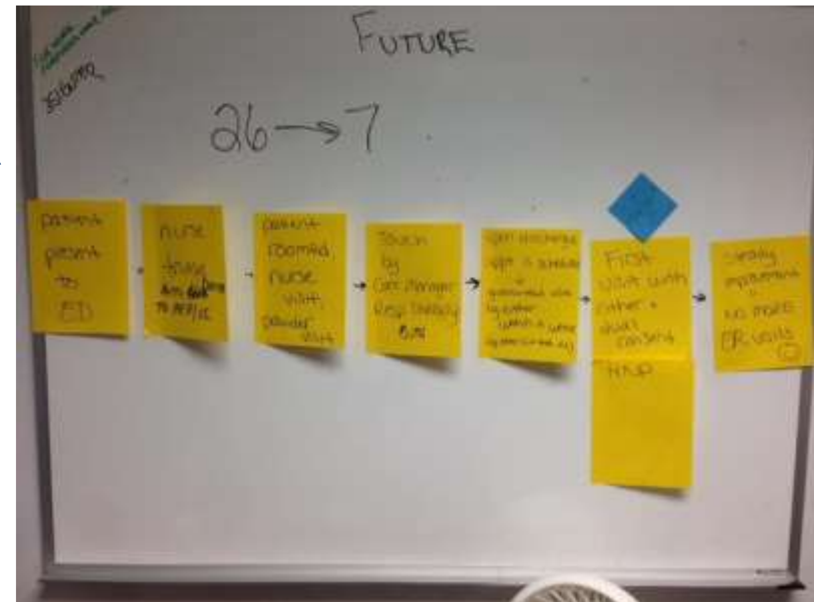
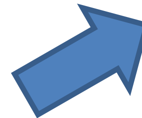
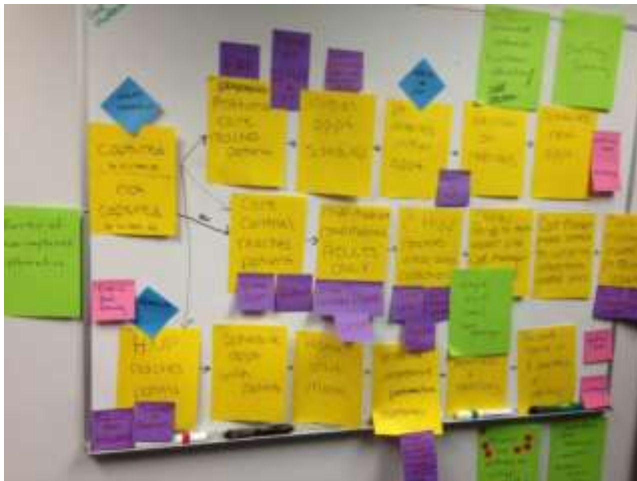
LEAN Process Improvement









Ellis Care Central

- Embedded Care Manager into ED
- Consent into program
- Dual referrals
- Address barriers

timesunion.com

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Schenectady program helps people manage asthma

Schenectady program helps asthma sufferers control their conditions

By Claire Hughes

Updated 6:56 am, Tuesday, May 26, 2015

NEXT ▶ ◀ PREV 1 of 2

Maria Delacruz reviews her asthma medication with JoAnn Vergine, a community health worker from Ellis Medicine. (Claire Hughes / Times Union)

Ellis Asthma Education Program

Pre/Post AEP ED Visits

Number of Visits

300
250
200
150
100
50
0

281
47
49

Δ -83%

Pre-AEP ED Visits
6 months Post AEP/ ED Visits
12 months Post AEP/ ED Visits

ED Visits and Hospital Admission by 83%

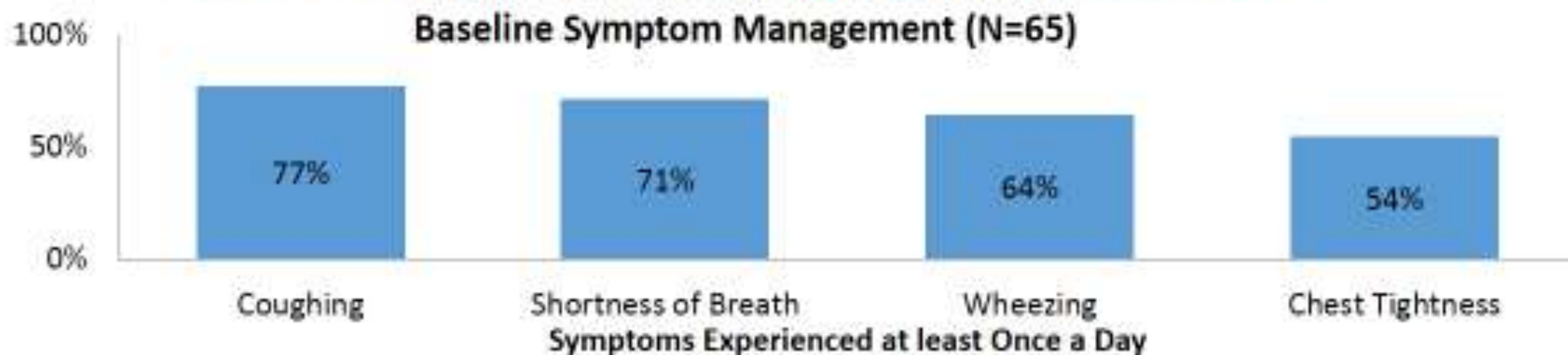
SCPHS Healthy Neighborhoods Program

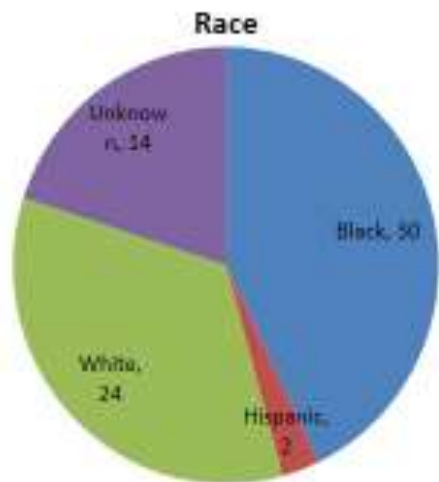
Home Visits, Re-visits
Public Health Nurse
Reinforce education, skill mastery

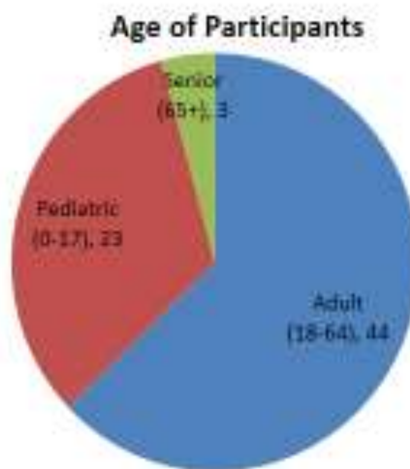
Working Together

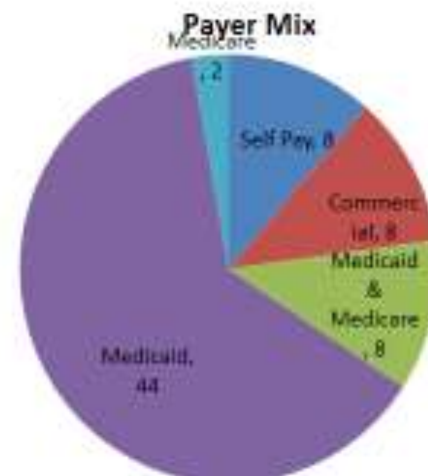
- Bi-directional referrals
- **Case conferencing**
- Refer out to other CBO’s
- Care Management – other issues – mental health, insurance, PCP, transportation, literacy, language
- **Course corrections as needed**

SASC Participants Poorly Managed Asthma, and Were Primarily on Medicaid

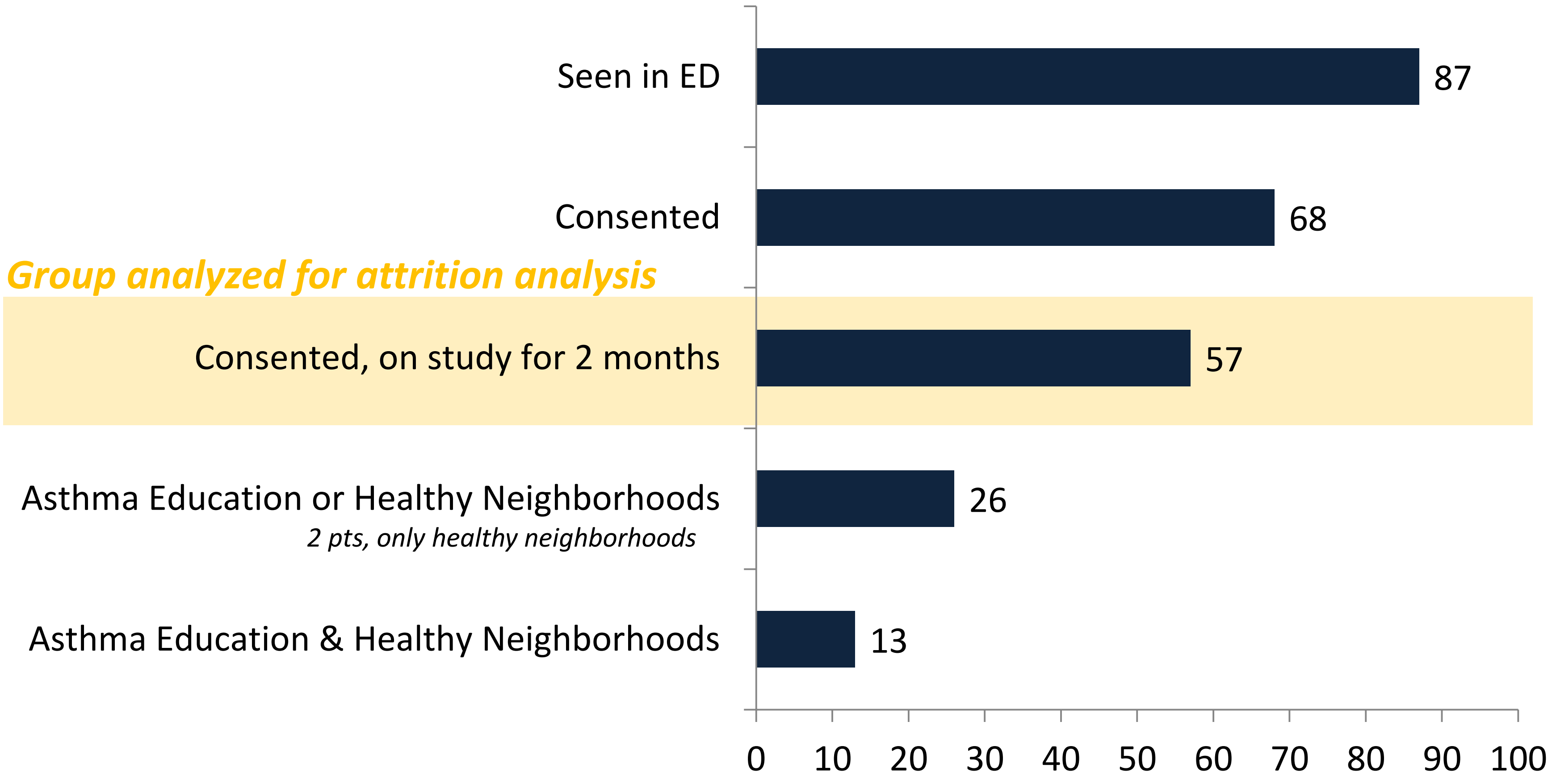








Program Utilization Within Two Months of Consent



Comorbidities

- A single comorbidity increased the likelihood of completing the program.
- Those diagnosed with asthma as a child (<18 years old) were less likely to participate.

Systemic Problems Identified

- Medication upon leaving ED
- Significant delay in obtaining PCP appointment
- Patient engagement
- Transportation
- Reliance upon ED

Opportunities to Improve

- IT system to share data – EMR improvements
- Asthma Care – EMR access
- Incorporate IT mechanism feedback to PCP
- Workforce – More CAE's needed
- PCP Care Managers trained

Moving Forward ***Together***

Gaining momentum: Community and Clinical Linkages

- Asthma, Diabetes, Hypertension

Sustainability - DSRIP goal alignment

Health Equity, Reducing Disparities, Community Engagement

Contact Information

Sabrina Halse

Ellis Medicine

518-347-5670

halses@ellismedicine.org

Glynnis Hunt

Schenectady County Public Health Services

518-386-2810

glynnis.hunt@schenectadycounty.com