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

Glynnis Hunt Schenectady County Public Health Services

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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



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SCHOOLTAN COUNTY PERSONNEL SEPARTISENT

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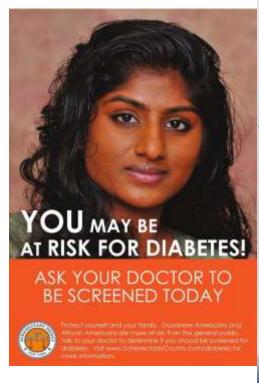
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Policy, Systems and Environmental Changes

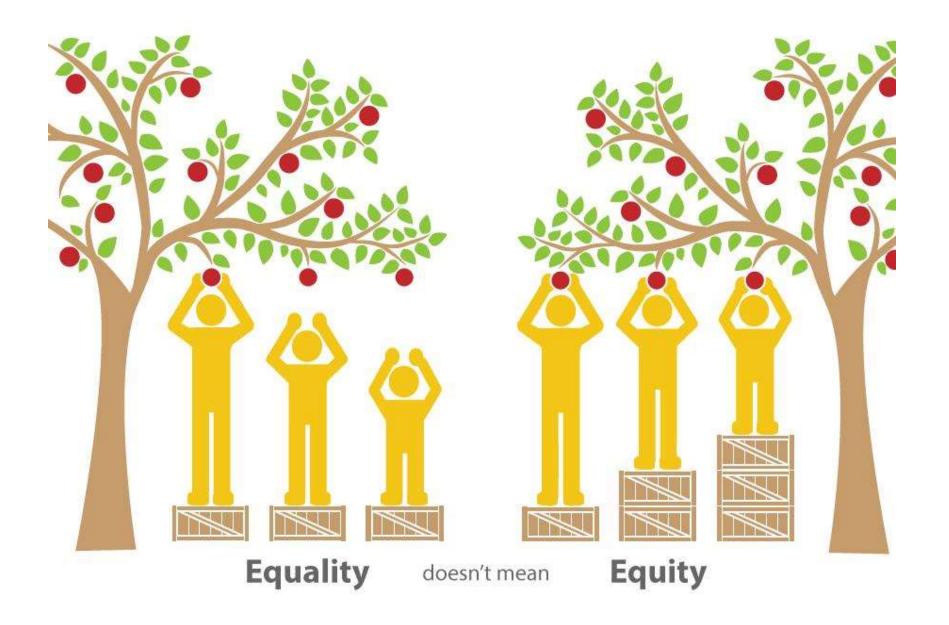
Partnerships to Improve Community Health Grant

Community and Clinical Linkages

Partnerships to Improve Community Health

Racial and Ethnic Disparities:

Guyanese – Type 2 Diabetes



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, Communitywide 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
- Ellio Hongistal (d/h/a Ellio Medicine): Community Health Neeth Appenment (CHNA) and Implementation Strategy as required to be flect with the Internal Revenue Service by the Fatient Protection and Affordable Care Act of 2010 (2013-2015)
 Filed November 15, 2012



- 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

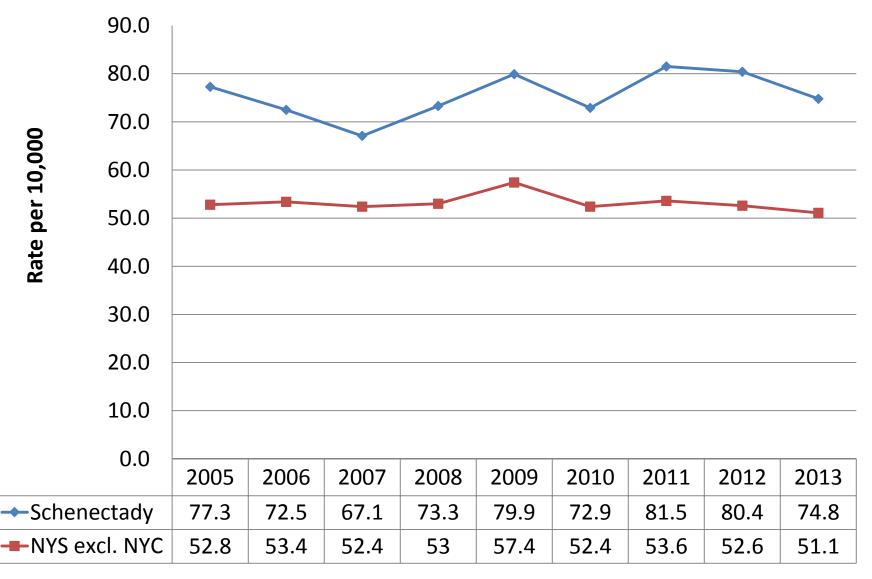
Total cost \$2 million

Smoking

52.8% smoked at least 100 cigarettes in lifetime

37% of adults are current smokers

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



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

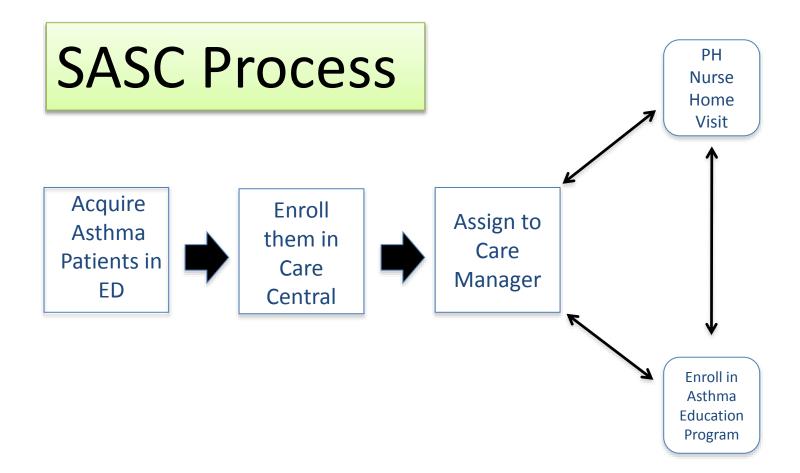


Three – Pronged Approach

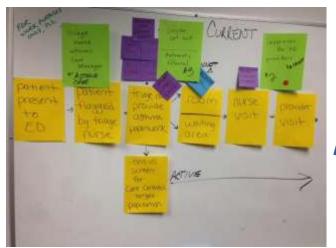
Care Central

Asthma Education

Healthy Neighborhoods



LEAN Process Improvement











Ellis Care Central

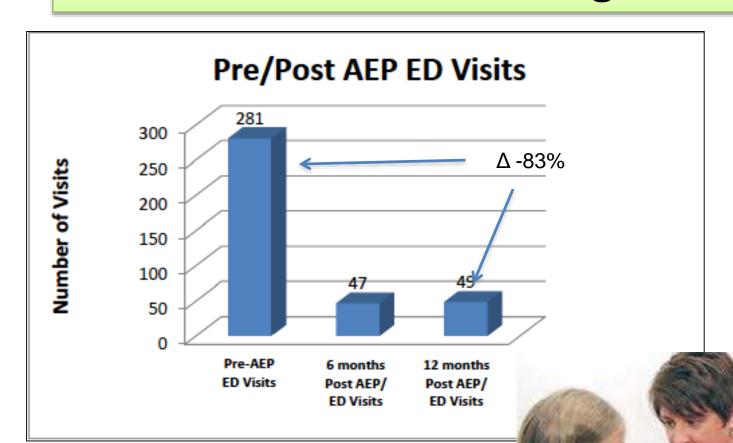
- Embedded Care
 Manager into ED
- Consent into program
- Dual referrals
- Address barriers

timesunion.com



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

Ellis Asthma Education Program



ED Visits and Hospital Admission by 83%

SCPHS Healthy Neighborhoods Program



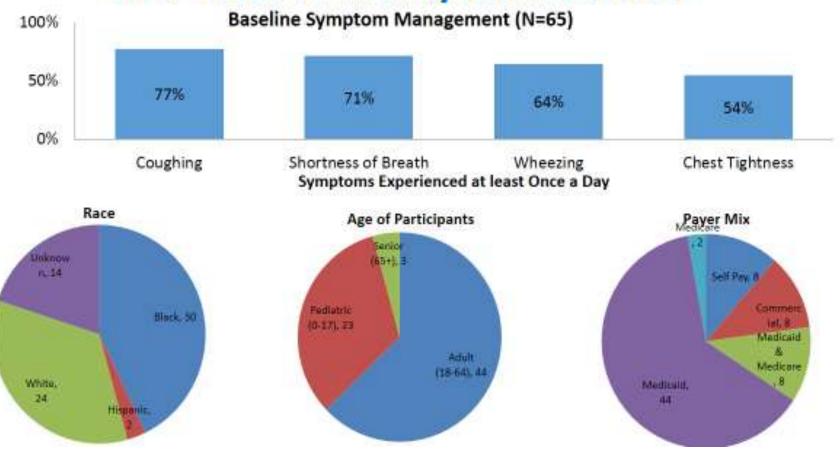
Home Visits, Re-visitsPublic Health Nurse
Reinforce education, skill mastery



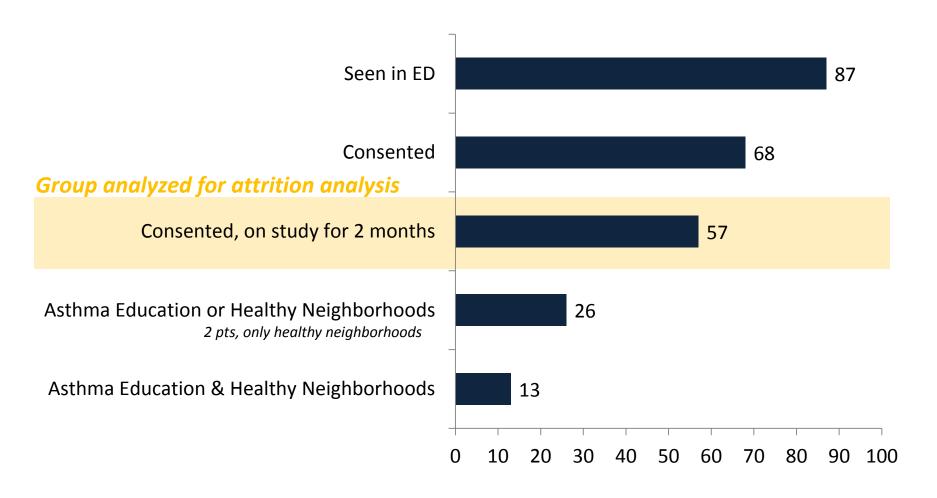
Working Together

- 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

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