Health is impacted by factors outside of the health care delivery system, including housing, education, poverty, employment, food availability, transportation, and safety. Recognizing that addressing these socioeconomic determinants of health is needed to meaningfully impact health inequities, a national policy shift is taking place. Government agencies, payers, and providers are all adopting a social determinants perspective. To effectively address these nonclinical needs, partners must work across sectors. Now, the question is how — what are the best practices for effectively aligning systems?

Aligning Systems for Health: Health Care + Public Health + Social Services, sponsored by the Robert Wood Johnson Foundation (RWJF) and managed by the Georgia Health Policy Center (GHPC), is focused on learning from stakeholders across the nation about effective ways to align these three sectors to better meet people’s goals and needs.

Given variance in the local context, there is no single model or formula to align systems. However, Aligning Systems for Health seeks to understand commonalities that drive successful efforts to align sectors. This series examines how communities that describe their work as aligning systems are doing it around four core components of a Framework for Aligning Sector that RWJF and GHPC are testing: purpose, governance, data, and sustainable financing mechanisms.

The Utah Asthma Program and partners from the Asthma Task Force developed the Utah Asthma Home Visiting Program. The program serves individuals and families with uncontrolled asthma and includes a combination of education, assessment, and — if needed — referrals and remediation.

**Local Context**

In 2001, the Utah Asthma Task Force formed as part of a Centers for Disease Control and Prevention (CDC) grant that required a coalition of partners to develop an asthma state plan. For 20 years, health professionals, educators, and members of housing programs, the community, and community-based organizations have continued to meet, and subgroups work together on projects of interest — both from the state plans and emerging opportunities.

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those who achieved asthma control through the program sustained control 12 months after program completion. Other 12-month benefits include an 80% decline in average missed workdays and a 51% decline in missed school days.

The home visiting program, housed within the Asthma Program at the Utah Department of Health, continues to adapt strategies, grow cross-sector partnerships, and find financial resources for program expansion and sustainability.

**PURPOSE**

The Utah Asthma Task Force and the CDC’s National Asthma Control Program have the goal of helping people with asthma achieve better health and improved quality of life. The CDC developed EXHALE, a set of six strategies that each contributes to better asthma control, one of which is home visits for trigger reduction and asthma self-management. This was the impetus for Utah’s home visiting asthma program.

The CDC grant set specific performance measures, but the format of program delivery and educational curriculum design was left to local partners, which included university researchers, the American Lung Association (Utah chapter), University of Utah Health Plans, Green and Healthy Homes Initiative–Salt Lake, the state health department, as well as the two local health departments (Utah County and Salt Lake County) selected for the pilot. Partners also reviewed the literature and best practices from other states.

Asthma is a high-burden health condition with evidence-based interventions recognized by the CDC’s 6|18 Initiative. The home visiting program used the opportunity to gain insights and blend resources from the 6|18 Initiative with EXHALE strategies and program activities. This led to the creation of the Utah Department of Health 6|18 Initiative workgroup, which has since expanded beyond asthma control and continues to collaborate across 6|18 public health programs, Medicaid, and accountable care organizations (ACOs) in Utah. Utah’s 6|18 work led to a second technical assistance opportunity led by the National Center for Healthy Housing. The technical assistance provided Utah with useful feedback and guidance on materials developed to seek reimbursement for Utah’s home-based asthma services.

**DATA**

The Utah Asthma Home Visiting Program collects self-reported data from participants and has data forms completed for each visit by the home visiting asthma health educators. Data is used to track progress and outcomes (up to 12 months post program completion) for all participants. However, this is a manual process with data entered into spreadsheets, as Utah does not currently have an interoperable referral and tracking system.

As partnerships with Utah’s Medicaid program and ACOs develop, the home visiting program will have access to actual claims data for beneficiaries participating in the program. Additionally, data informs recruitment and expansion planning for the home visiting program. The Utah Department of Health developed the Utah Health Improvement Index, which looks at small areas in Utah and specific geographic areas that are disproportionately burdened with health issues and unmet social determinants of health needs. The home visiting program uses this data, as well as asthma-related emergency department visit rates, to target recruitment for referring clinics in high-burden areas.

**FINANCING**

The fact that home visiting originated as a CDC-funded grant made getting initial health department leadership approval easier. However, the Utah Asthma Home Visiting Program immediately saw the need to plan for financial sustainability and developed a return-on-investment analysis for asthma home visiting services. Initial analysis showed that for each dollar spent through the program, Medicaid could save up to $1.31.

The Utah Asthma Program presented the return-on-investment results to Utah’s Medicaid advisory board and leadership to gain support for the business case for reimbursement of asthma home visiting services, enabling the expansion of the home visiting program to two additional local health departments in rural areas that maintain fee-for-service Medicaid (TriCounty Health Department and Southeast Utah Health Department). The Utah legislature approved allocating $160,000 of Utah’s Medicaid administrative funds to implement the program. Funding has been used to hire asthma coordinators employed in each of the health departments. Utah is currently monitoring the program outcomes and exploring partnerships with ACOs to expand and sustain home visiting services in non–fee-for-service areas. (There are four ACOs in urban areas of Utah.)
“A local health department can’t just donate staff to us, so until we find outside funding to pay them either through a payer or other grant funding, we don’t have a lot of opportunity to expand,” acknowledges Kellie Baxter, health program specialist at the Utah Asthma Program.

One additional challenge of building financial sustainability is stabilizing referral channels. COVID-19 greatly impacted the capacity of some hospitals and clinics to refer to the home visiting program, as does staff turnover.

“Should we lose CDC funding today, the program isn’t ready to stand on its own yet, but we keep striving for that,” stated Nichole Shepard, program manager for the Utah Asthma Program.

**GOVERNANCE**

The Utah Asthma Task Force, which is a key partner to the home visiting program, has an informal governance structure with no formal bylaws. It has both an advisory board and subgroups, which are largely based on individuals’ capacity to and interest in participating. The leadership within the state and local health departments is required to buy in to the program, both initially and to scale up.

Relationships are governed on an individual basis, with no overarching agreement. For example, contracts are needed between the Utah Department of Health and each participating health department. The local health departments employ the asthma coordinators or health educators who provide the home visits. There are also arrangements in each county with a community-based organization or government agency that can provide any necessary remediation efforts and referrals. These arrangements and available services vary by locality.

**INSIGHTS FROM THE COLLABORATIVE**

Sustainability extends beyond financial considerations.

The Utah Asthma Home Visiting Program considers partnerships a key part of its sustainability planning. This includes partners that provide environmental support and external program evaluation. Shepard credits staffing personality and staffing capacity as key to sustaining partnerships, along with a willingness to include partners and give them voice.

“Success is not because the Utah Asthma Program did this,” Shepard says. “It is not the health department just needing things or making the decisions. It is our partners and highlighting their involvement and contributions to the success.”

Sometimes things just fall into place.

As chance would have it, the Utah Asthma Home Visiting Program was moved from the second floor, where the Bureau of Health Promotions sits, to the fourth floor, where executive directors sit. The proximity allowed for conversations between leadership and program staff, which develop relationships.

“It matters where you sit in a building,” says Shepard. This seemingly haphazard relocation “elevated our request, and we were able to meet with Medicaid’s division director to modify and submit our expansion proposal.”

Learn from others. The Utah Asthma Home Visiting Program has a small but mighty staff of four that has worked hard to educate themselves. This includes extensive learning from other states’ home visiting programs and participating in the 6|18 Initiative. But the learnings have allowed them to in turn invest and involve themselves in others’ local work.

“We have asked other home-visiting programs how we can elevate our business case and use the right language,” explains Shepard. “How do we talk to Medicaid appropriately? How do we talk to our providers? What is the right language to use? By involving ourselves with what others do and caring about what they do, when it’s our turn, they care about us.”

Evaluate and be willing to adapt.

The Utah Asthma Home Visiting Program takes evaluation seriously and brings in external support to ensure a nonbiased assessment.

“We want to get to problem-solving solutions through evaluation,” says Shepard. “Nothing is set in stone. We are not offended. When partners come and tell us, ‘Hey, you should be doing this differently,’ we really look at it.”
Currently, the home visiting program is evaluating its curriculum, and one important component of this is examining if it is culturally competent.

“A big focus of the evaluation of the home visiting curriculum is are we inclusive, especially because Black, Hispanic, and indigenous individuals that face the highest burden of asthma,” says Savannah Smith, program coordinator from the Utah Asthma Program. “We want to ensure we are always improving and collaborating and addressing the cultural stigmas, including our minority populations, to help continue to build that trust and ensure that we are getting the voices from the community so that the program can help them and their family.”

**Aligning in Action**

Each local health department is responsible for building its referral channels and partners. Then, an asthma coordinator at the local health department will call to do a 10- to 20-minute intake that introduces the program, collects some basic information, and consents individuals willing to allow the program in their home.

Over three in-person visits and several follow-up calls, the home visiting program provides education on asthma symptoms, triggers, medications, and inhaler technique; assesses the home environment to identify and reduce asthma triggers; and follows up on participants’ goals to improve asthma control and reduce asthma triggers.

Remediation efforts vary by county, with some having income requirements to qualify for home rehabilitation. For example, in Salt Lake County, Green and Healthy Homes conducts the assessment and drops off a basic kit that includes mattress covers, an air purifier, a vacuum with a HEPA filter, and cleaning supplies. The most commonly needed remediation services include carpet removal and replacement with hardwood flooring, mold removal, and weatherization, including new windows.

Typically, those who have uncontrolled asthma have other unmet socioeconomic needs. The Utah Department of Health Asthma Program is trying to ensure the root causes of uncontrolled asthma are being addressed. Asthma coordinators screen for social determinants of health at the first or second in-person visit. If participants are willing to complete the screening, referrals are made either to government agencies or community-based organizations to help connect them to needed resources, even if they are not directly asthma related (e.g., transportation, work, or food).

**Insights for Aligning**

- The program’s focus on sustainability highlights the importance of collecting data that can be used to demonstrate return on investment.
- The program is on an appropriate path in seeking stable financing that outlasts individual grants. Transitioning to a reimbursed service is one viable option.
- The program’s informal governance structure highlights the complexity involved in different departments and branches of government collaborating with private enterprise.

**Aligning Systems for Health**

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