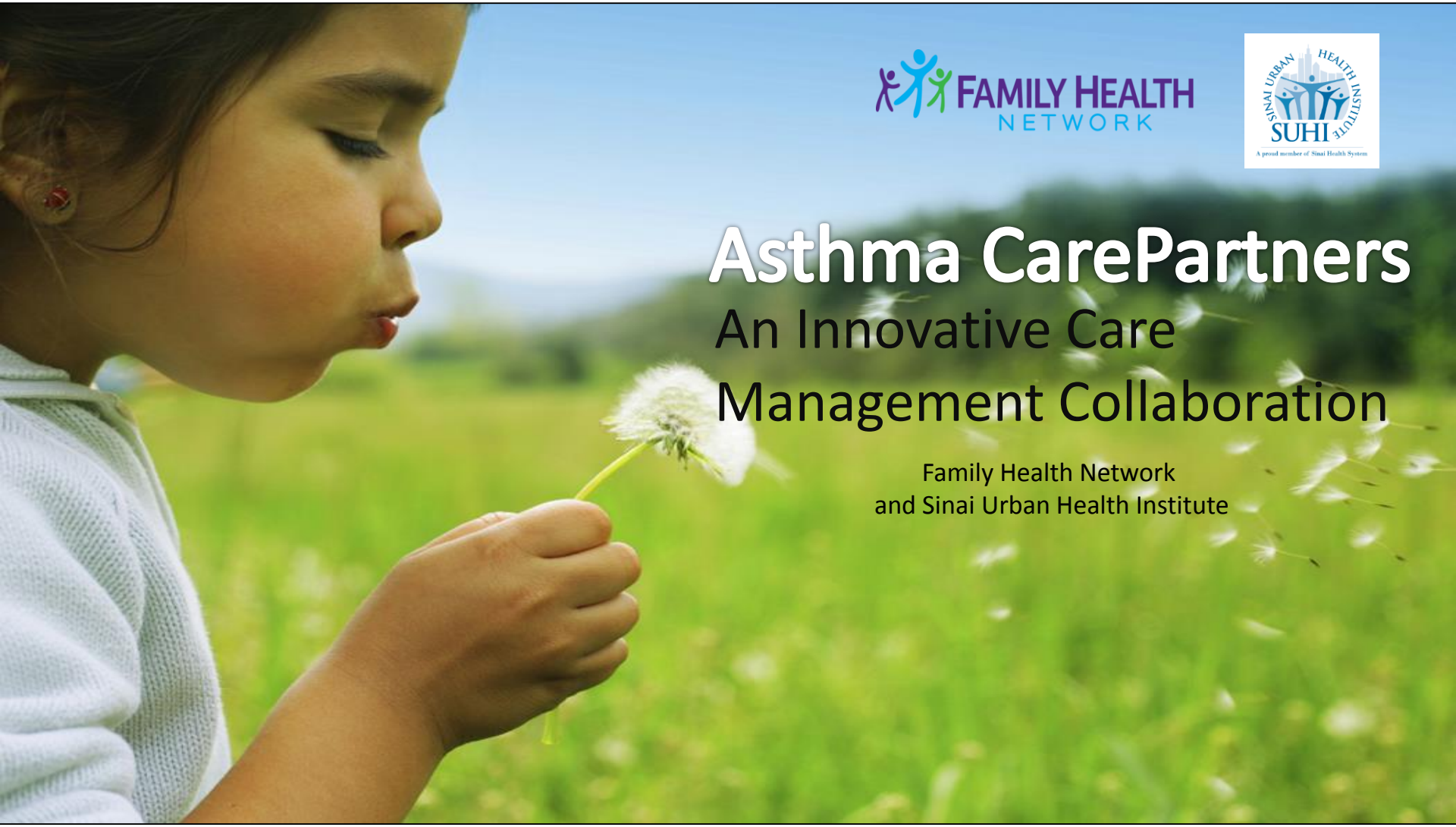
Payer's Perspective Panel

Barbara Hay
Internal Consultant and Former COO
Family Health Network



Asthma CarePartners

An Innovative Care Management Collaboration

Family Health Network
and Sinai Urban Health Institute

FAMILY HEALTH NETWORK

Provider Sponsored Health Plan, Managed Care Community Network (MCCN).

Illinois participants covered under the Medicaid Program, recently expanded from the Cook County to the Collar Counties.

Our Values

- Respect
- Integrity
- Teamwork
- Service
- Stewardship

SUHI was founded in 2000 and is part of Sinai Health System on the west side of Chicago.

SUHI conducts award winning research that has:

Defined the scope of health status and health service access disparities in our communities.

Led us to design and implement high impact, cost saving community-based intervention strategies for a number of chronic health conditions, including asthma and diabetes.

Asthma CarePartners

- Collaborative effort that supports the mission and goals of both organizations
- SUHI past experiences demonstrated success working with FHN members
- Partnership and specific program elements were implemented in August 2011
- 706 referred to program, 424 participants
- Program model uses Community Health Worker (CHWs)
  - Culturally competent service of evaluation and peer education
  - Social support and sensitivity to community issues

Best Practices Guidelines

- Community Health Worker model at heart of Asthma CarePartners
- SUHI has conducted extensive research on the CHW model and in 2014 released a report entitled *Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings.*[1]

1. Gutierrez Kapheim M and Campbell J. *Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings.* Chicago, IL: Sinai Urban Health Institute, January 2014.

Referrals to Asthma CarePartners

- FHN Care Managers identify members who could benefit from the program and obtain permission from the member to make the referral
  - Hospitalizations
  - ER visits
  - Medication utilization or non-compliance
  - Expressed need from member, parent or care manager

Home Visits

- Home environment is more conducive to open communications
- CHWs are able to observe the home environment and help to identify and address triggers such as mold, rodents, cockroaches, dust, smoke etc.
- CHWs observe the use of devices and can demonstrate devices, to insure correct utilization
- CHWs have the time to dispel myths and misinformation about medications, such as steroids

Program Components

CHWs make approximately six visits to each enrolled household over the course of a 12-month intensive intervention period.

CHWs complete comprehensive Home Environmental Assessments at the 1 month, 6 month and 12 month visits to identify asthma triggers and to create plans to minimize their presence and affect.

The supervising case manager coordinates referrals to agencies with expertise in resolving housing, environmental and social issues for most complex cases.

Program Components

CHWs work with clients and their physicians to strengthen their relationship – ensuring that each client sees their primary care physician regularly and has an Asthma Action Plan that he/she understands and can follow.

CHWs insure the member understands how to obtain and use asthma medications and devices, thereby enhancing member compliance with physician directed Asthma Action Plans.

Program provides “Healthy Home” resources such as asthma-friendly cleaning kits and/or supplies to control pests, dust mites, mold, etc.

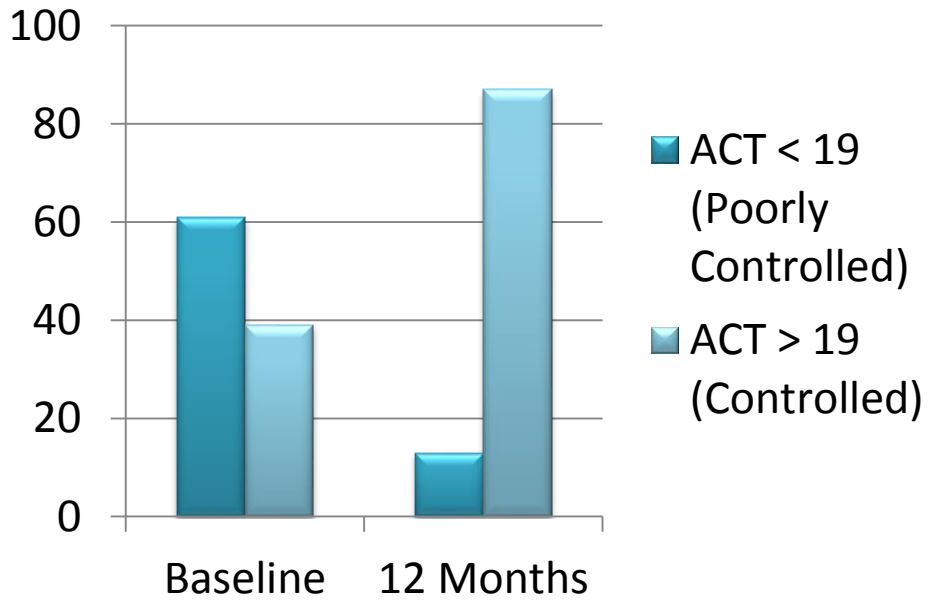
Barriers to Managing Asthma

- Lack of understanding medication usage
- Incorrect medical device usage
- Home environment
  - Substandard housing issues
  - Toxic cleaning products, such as bleach
  - Tobacco use by family member or person with asthma
- Numerous and complex issues at home (poverty, mental health issues, employment challenges, etc.)

Tools to Evaluate Asthma CarePartners

- ✓ **Asthma Control Test** – measures the degree to which a person's asthma is controlled monthly
- ✓ **Pediatric Asthma Caregivers Quality of Life Questionnaire** – measures the quality of life of the child's primary caregiver (baseline, 6, and 12 months)
- ✓ **Asthma Quality of Life Questionnaire** – measures the quality of life of adult asthma patients (baseline, 6, and 12 months)
- ✓ **Home Environmental Assessment** – evaluates the participant's home environment and identifies triggers in the home (1, 6, and 12 months)

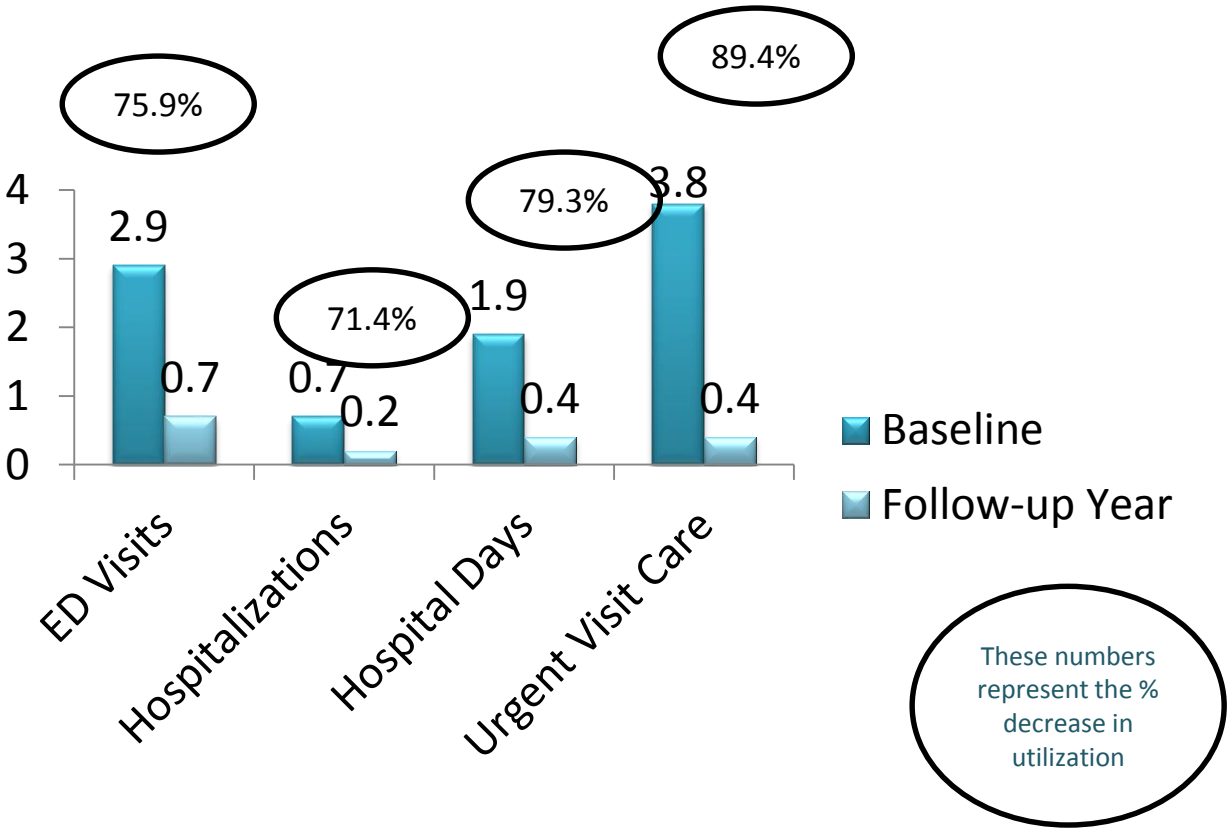
Baseline and Follow-up ACT Scores for Child Asthma CarePartners
Participants with Follow-up ACT Score at 12 Months



Result Comparison at Baseline and 12 Months

- Caregiver quality of life score 27% improvement
- Symptom frequency 64% reduction
- Missed school days 59% reduction
- Identified home triggers (6) 41 – 100% reduction

ACP Outcomes: Health Resource Utilization



Result Comparison at Baseline and 12 Months

	# Baseline Year	Illinois Medicaid	Follow –Up Year	Illinois Medicaid
ED Visits	3	$543	0.8	$145
Hospital Days	2	$3498	0.4	$699
Urgent Care	3.8	$254	0.4	$27
		$4295		$871

Implementation year savings	**$2260**
Follow-up year	**$3424**
	$5684

Cost of Asthma CarePartners - Under $2000

Asthma CarePartners Summary

Program data demonstrates dramatic and life-changing improvement in asthma management resulting in:

- ↑ Improved quality of life scores
- ↓ Reduction in asthma symptom frequency
- ↓ Reduced number of missed school/work days
- ↓ Reduction in health resource utilization
  - 75.9% Reduction in ED visits
  - 71.4% Reduction in hospitalizations
  - 79.4% Reduction in hospital days
  - 53.4% Reduction in “rescue medications”
- ↓ Reduction in cost of care

The Asthma CarePartners program won the 2013 URAC Gold Best Practices Award in health care consumer engagement and protection.

Questions?

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Payer's Perspective Panel

Patricia Guerra-Garcia, M.D., F.A.C.P.
Chief Medical Officer
Aetna Better Health

AETNA BETTER HEALTH®

Philadelphia Summit on Pediatric Home Asthma Interventions

Patricia Guerra-Garcia, M.D., F.A.C.P.

June 26, 2015

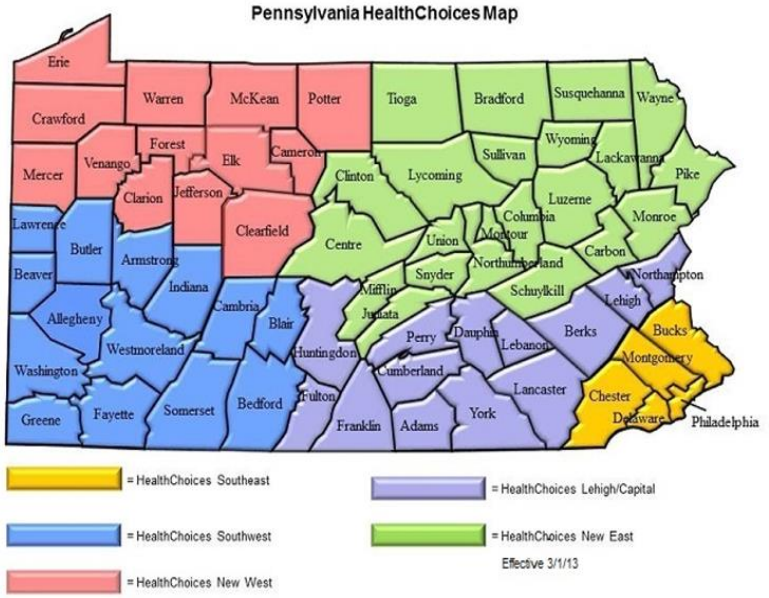
AETNA BETTER HEALTH®

Doing the right thing for the right reason

Who and where we serve

Aetna Better Health (ABH) serves:

- **More than 170,000 members**
- **In all PA zones**
- **Over 100 network hospitals**

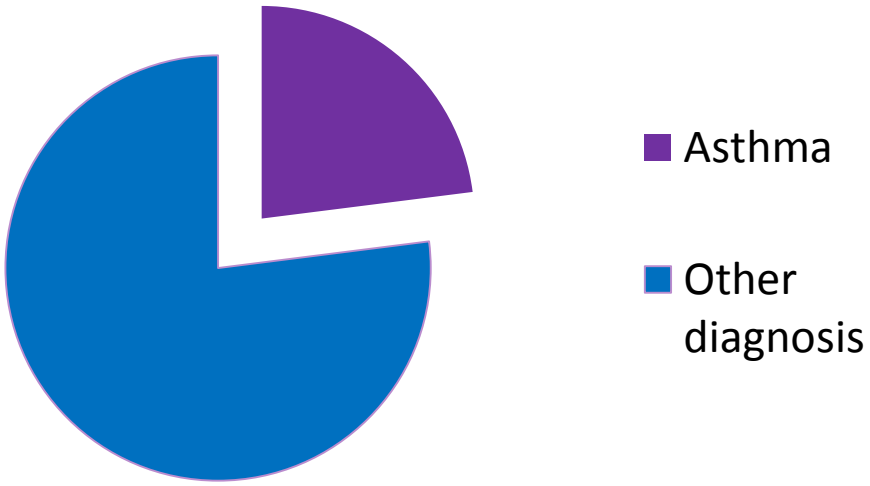


Aetna Better Health asthma statistics

Aetna Better Health	Number of members with asthma	ED visits	Hospitalizations
Adults	3,447	23.4%	4%
Children	7,100	21.4%	4%
Total	10,547	22%	4%

Incidence of asthma versus other diagnoses in high-risk members

- **23% of ABH's Medicaid high-risk members have asthma**



High-risk intensive case management

Members with asthma	ED visits	Hospitalizations
1492	↓ 32%	↓ 52%

Asthma interventions

- Disease Management
- Case Management
- Community Health Worker Programs
  - CHOP
  - Esperanza FQHC
- Other Community-Based Programs

Results and next steps

- 15% of ER visits have an asthma diagnosis
- ABH in alignment with regulatory State leadership and providers
- Research shows positive outcomes using community health workers

Strategic planning

- Evaluate pilot data and outcomes for our membership
- Analyze geographic distribution for strategic planning
- Reimbursement issues
- Legal/Regulatory/Labor issues

Thank you

aetna®

Payer's Perspective Panel

Lily Higgins, M.D., M.B.A, M.S.
Network Medical Director
Keystone First

Asthma Initiatives

Y. Lily Higgins, MD, MS, MBA
Network Medical Director

Keystone First

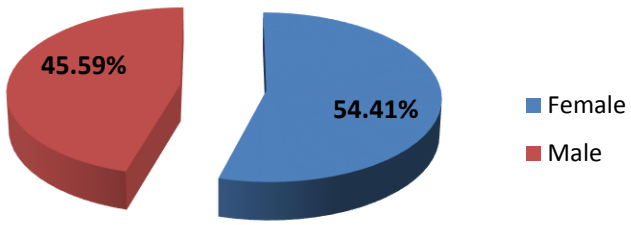
Medicaid Managed Care Organization

- Based in southeastern region of Pennsylvania.
- Counties of Philadelphia, Delaware, Bucks, Montgomery, and Chester.
- @ 313,000 members.

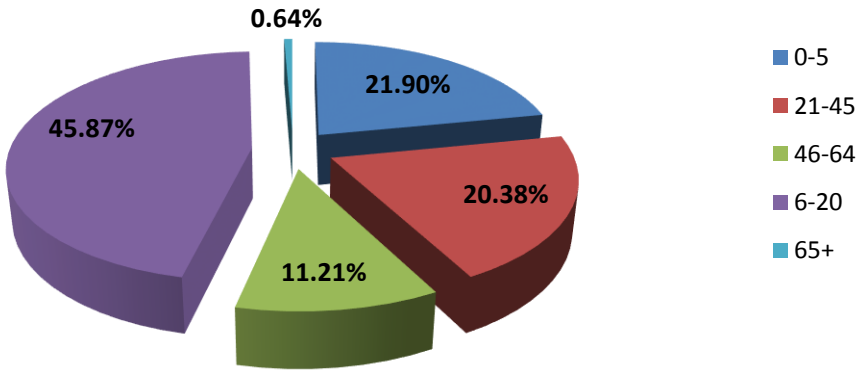
Keystone First

Keystone First Member Demographics

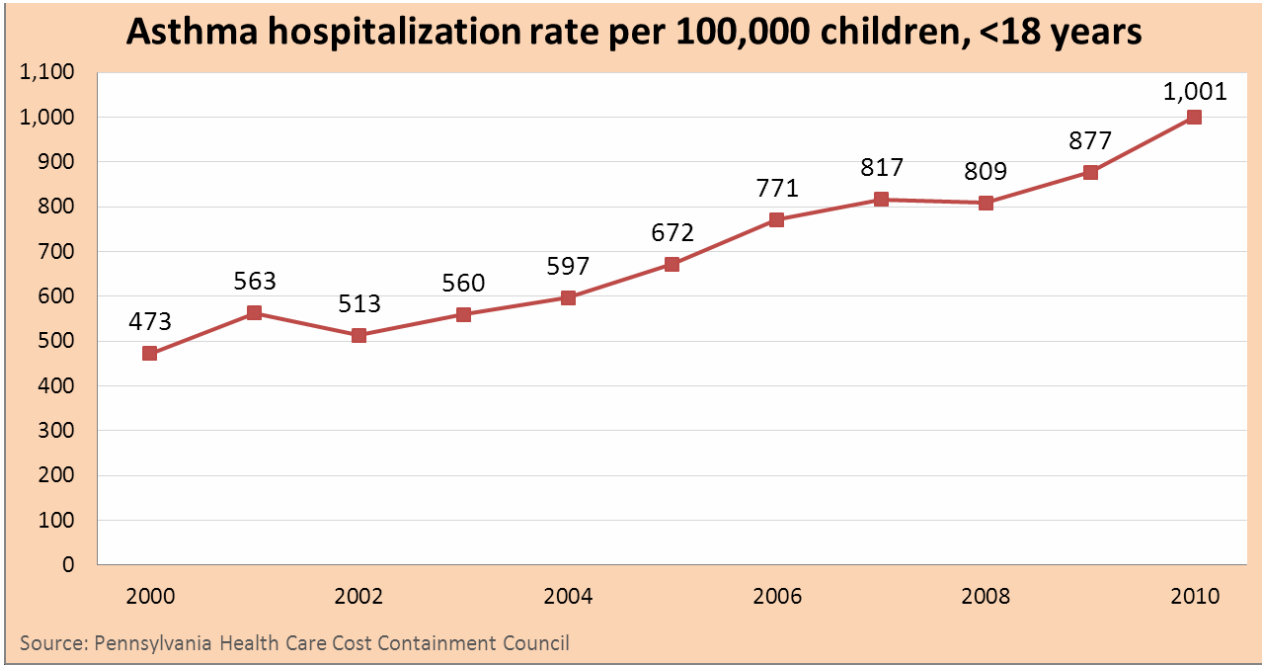
Keystone First Gender



Keystone First Age



Child Asthma Hospitalization Philadelphia



B.E.S.T is an award-winning collaboration between Keystone First and providers, members and pharmacists to enhance coordination, access and adherence to critical asthma medications.

- ✓ Medication and supplies are put onsite at the physician's office:
  - Therapy can start immediately at point-of-service.
  - Provider-conducted demonstration and/or evaluation of the patient's ability to properly use equipment.
- ✓ Ongoing coordination and monitoring of medication adherence.
- ✓ Member education and delivery of the refill to patient's home.

Asthma Navigators

- Collaboration with CHOP
- Home visit occurs after ER/Inpatient admission
- Home visit after non-compliance with controller medicine refill from B.E.S.T. program
- Claims payment

Keystone First collaborates with the Center for the Urban Child at St. Christopher's Hospital for Children to support practice-based population health management for members with asthma.

Belinda, Keystone First CHW Assigned to St. Chris

Success to date attributed to:

- ✓ Committed leadership of St. Chris, supportive environment.
- ✓ Data and enhanced information sharing.
  - Targeting.
  - Outcomes.
- ✓ Keystone First-funded embedded community health worker (CHW).
- ✓ Coordination of care management services.
  - Within/between Keystone First and St. Chris teams.
  - Member transitions post-discharge.
  - Collaboration with community services, e.g., Healthy Homes.
- ✓ Model includes home visits, enhancing capacity to identify and support member/family goals.
- ✓ B.E.S.T. Asthma Program – Breathe Easy. Start Today.®
- ✓ Ongoing: regular meetings between Keystone First and St. Chris for process and communication improvement cycles.

Population Profile: Health Plan Data

Population of Interest:
6905 Keystone First members attributed to the practice

Children with asthma coded claim (N = 814)	**Children without asthma coded claim (N = 6091)**
• 12% of the total population	• 88% of the total population
• 54% of children with asthma claim had 1 inpatient admission and/or 2 ED visits in the last year (N = 438) • Total of 184 admissions and 1506 ED visits	• 18% of children with no asthma claims had 1 admission and/or 2 ED visits in the last year
• Average non-Rx medical costs were 3X higher for children with asthma-coded claim	

Outcomes: Descriptive, Process and Impact

Member engagement summary	
Targeted, not engaged	**14**
Declined	5
Unable to establish visit	9
Active	**30**
Asthma-only	21
Asthma-plus	9
Discharged	**8**

Reason for Engagement	N	%
Gaps in PCP appts	8	21%
Gaps in Rx	4	11%
Peds superutilizer combo	4	11%
Peds superutilizer ED	6	16%
Peds superutilizer IP	6	16%
Provider Recommended	10	26%

Pre/post analysis of cost and utilization pending sufficient numbers

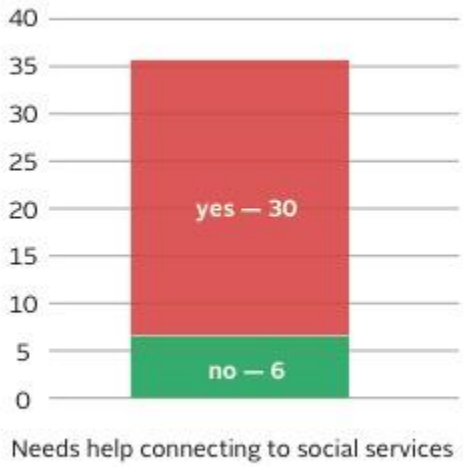
Asthma history, N=36*	N	%
Times per week child has asthma symptoms		
<1 time per week	1	3%
1-2 times per week	5	14%
3-6 times per week	16	44%
every day	10	28%
n/a	4	11%
Nights per week child coughs		
<1 time per week	4	11%
1-2 times per week	4	11%
3-6 times per week	10	28%
every day	14	39%
n/a	4	11%
Times per week child uses Albuterol		
<1 time per week	2	6%
3-5 times per week	4	11%
7 days a week	10	28%
PRN	12	14%
n/a	3	8%
Misses school due to asthma		
No	5	14%
Yes	22	61%
n/a	9	25%
Restricted physical activity due to asthma		
No	14	39%
Yes	20	56%
n/a	2	6%

Asthma home assessment, N=36*	N	%
Housing		
Own	1	3%
Rent	33	92%
Other	2	6%
Smoking allowed in the home		
No	22	61%
Yes	14	39%
Supplemental heating source present		
No	28	78%
Yes	8	22%
Air conditioning units present		
No	5	14%
Yes	31	86%
Child sleeps in:		
Own bed	15	42%
Shared bed	21	58%
Floor covering type		
Carpet	14	390%
Wood	18	50%
Other	4	11%
Window covering type		
Blinds	16	44%
Curtains	16	44%
Other	4	11%
Water damage evident		
No	15	42%
Yes	20	56%
Mold evident		
No	23	64%
Yes	12	33%
n/a	1	3%
Plastic covers on pillows and mattresses		
No	27	75%
Yes	8	22%
n/a	1	3%
Evidence of pests, such as mice or roaches		
No	10	28%
Yes	25	69%
n/a	1	3%

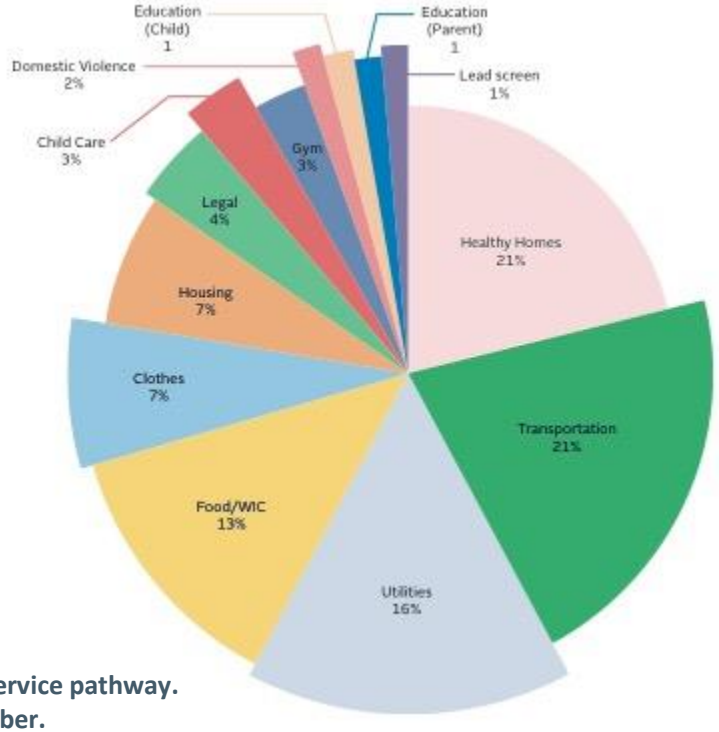
* Data not available for 2 members.

Interventions: Social Service Pathways

Social Connection Needs
(N=36 Members)



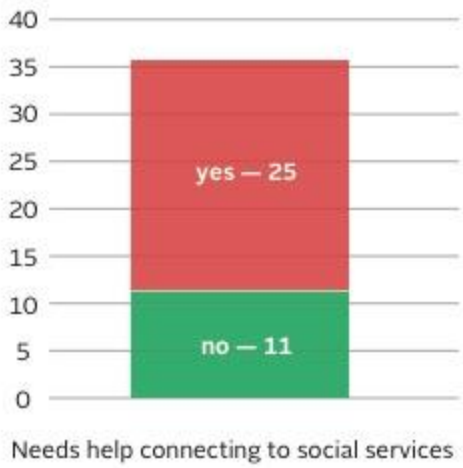
Social Services Pathways (N=71)



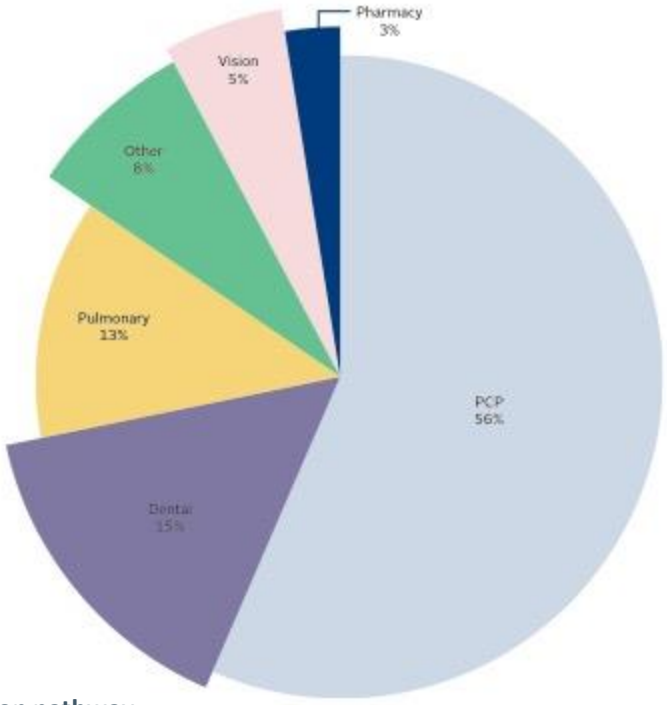
- **30/36 members (83%) have at least one social service pathway.**
- **Average of 2.4 social service pathways per member.**

Interventions: Medical Connection Pathways

Medical Connection Needs
(N=36 Members)



Medical Connection Pathways (N=39)



- **25 members (69%) have at least one medical connection pathway.**
- **Average of 1.6 medical connection pathways per member.**

Success Story

CHW Belinda holding thank-you notes from the family

It took new windows…

In a home assessment, Belinda recognized that broken windows were a huge barrier to asthma management for 12 y.o. "Billy" and his family. Thanks to the team, they now have brand-new windows…

"Billy" has had no ED visits since January!

New windows

- **And a village…**
- St. Chris team.
- Keystone First community health worker.
- Keystone First telephonic care manager.
- Gifts of Mercy.
- Healthy Homes (Philadelphia Dept. of Public Health).

KF Telephonic Care Managers Loretta and Deanna

Keystone First

Payer's Perspective Panel

Indira Mahidhara, M.D., M.P.H.
Medical Director
Health Partners Plans

Health Partners Plans

Asthma Summit 2015

Health Partners Plans

Health Partners Plans

Background information:

- Medicaid, Medicare, and CHIP plan
- Total membership 227,398 with 193,409 Medicaid members
- 30,256 (13%) of our entire membership is diagnosed with Asthma
- 29,157 (15.08%) of our Medicaid population is diagnosed with Asthma
- 92.44% of the newly diagnosed asthmatics (since January 2013) are part of our Medicaid population.

Health Partners Plans

Available Participating Medicaid Providers

Provider Type	Total Medicaid Sites
PCPs	569
Hospitals	43
Urgent Care Centers/Walk-In Clinics	43

Health Partners Plans

HPP Asthmatic Members' Geographic Distributions

Region	Medicaid Asthmatics by region	% of Medicaid Asthmatics
North	19,077	65.43%
Northeast	3,406	11.68%
Northwest	2,127	7.29%
West	1,971	6.76%
Other Region	1,609	5.52%
South	581	1.99%
Center City	386	1.32%
Total Asthmatics	29,157	

Health Partners Plans

Gender Distribution-Medicaid

Gender	Members	Percent of Total
Female	103,522	56.70%
Male	79,017	43.30%
Total	182,539	100.00%

Health Partners Plans

Age Groups-Medicaid

Age Group	All Medicaid Members	Percent of Total	Asthma Disease Prevalence
Adult (21 and older)	79,414	43.51%	14.05%
Child (0-12)	69,944	38.32%	14.15%
Adolescent (13-20)	33,181	18.18%	18.13%
Total	182,539	100.00%	14.83%

Health Partners Plans

Race Ethnicity, Language-Medicaid

Race/Ethnicity	Members	Percent of Total
BLACK	84,131	46.09%
Hispanic	56,059	30.71%
WHITE	28,383	15.55%
Not Provided	8,358	4.58%
ASIAN OR PACIFIC ISLANDER	5,449	2.99%
AMERICAN INDIAN	159	0.09%
Total	**182,539**	**100.00%**

Group Of Language	Members	Percent of Total
ENGLISH	166,493	91.21%
SPANISH	13,098	7.18%
Other	1,395	0.76%
RUSSIAN	838	0.46%
VIETNAMESE	392	0.21%
CAMBODIAN	323	0.18%
Total	**182,539**	**100.00%**

Health Partners Plans

Race, Ethnicity- Medicaid Asthma

Race/Ethnicity	Total Members	Disease Prevalence
African American/Black	84,131	14.46%
Hispanic/Latino	56,059	20.04%
Caucasian	28,383	8.84%
Not Provided	8,358	8.22%
Asian or Pacific Islander	5,449	8.35%
Native American or Alaskan	159	11.95%
Total	182,539	14.83%

Health Partners Plans

Language – Medicaid Asthma

Language	Total Members	Disease Prevalence
English	166,493	14.64%
Spanish	13,098	19.00%
Other	1,395	5.38%
Russian	838	3.58%
Vietnamese	392	16.07%
Cambodian	323	12.07%
Total	182,539	14.83%

Health Partners Plans

Current Asthma Programs

- Care Coordination/Disease Management
  - Inpatient hospitalization
  - Newly diagnosed or new to plan
  - Seasonal
- Pilot Project with a high volume pediatric asthma site
  - On site procurement of medication
  - CHW

Health Partners Plans

Health Partners Plans

- Part of our mission is “to continually improve the health outcomes of our members.”
- Acknowledge the need for a holistic approach to management of illness.

Health Partners Plans

Q&A Discussion
Payer's Perspective Panel

Moderated by:

Corey Coleman

Chief of Staff

Pennsylvania Department of Health