PriorityHealth

Attacking Chronic Disease via Community Partnerships

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A Healthier Approach to Healthcare

PriorityHealth

priorityhealth.com

Asthma Management

High Performing Collaboration and Partnerships

ANWM Infrastructure

- Ability to contract with plan and bill for services
- Adequate staff; all certified as asthma/COPD educators
- Internal processes and program components
- Share best practices and programmatic structure with other stakeholders

Health Plan

- Ability to identify the asthma population and stratify those that will benefit from program
- Commitment to provide coverage for asthma/COPD education in benefit design
- Commitment to partner with asthma coalition to provide those services

Expansion to COPD

- Expansion of MAPD
- Burden of illness
- Need for self management support to fulfill complex plan of care
- Oftentimes unable to access appropriate services

There are no mistakes, no coincidences. All events are blessings given to us to learn from."
– Dr. Kubler Ross

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“

Outcomes

- Quantitative
- Member success stories

“The secret of the care of the patient is caring for the patient.”
~Francis W. Peabody

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NHP Asthma Program

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nhp.org

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About Neighborhood Health Plan

- 264,000 members
- 70 % Medicaid
- 30 Commercial and CCHIP
- Multi-faceted, mature asthma program

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EPA
Asthma Leadership Award

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NHP Asthma Disease Management Program

Background & Program Overview

- NHP's program founded on the National Heart, Lung, Blood Institute (NHLBI) guidelines
- NHP's inception of the Asthma Disease Management program in 1999

Prevalence and Incidence

- Prevalence of Asthma is higher in Massachusetts than in most states in the U.S.
- Approximately 10.4% of NHP members meet NHP's criteria for Asthma
- Disproportionate prevalence in:
  - Latinos, Hispanics, and blacks
  - Impoverished, urban environments

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REDUCE ← → INCREASE

TREATMENT STEPS

	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5
	asthma education				
	environmental control				
	as needed rapid-acting β_2-agonist	as needed rapid-acting β_2-agonist			
CONTROLLER OPTIONS		SELECT ONE	SELECT ONE	ADD ONE OR MORE	ADD ONE OR BOTH
		low-dose ICS*	low-dose ICS *plus* long-acting β_2-agonist	medium- *or* high-dose ICS *plus* long-acting β_2-agonist	oral glucocorticosteroid (lowest dose)
		leukotriene modifier**	medium- *or* high-dose ICS	leukotriene modifier	anti-IgE treatment
			low-dose ICS *plus* leukotriene modifier	sustained-release theophylline	
			low-dose ICS *plus* sustained-release theophylline		

*inhaled glucocorticosteroids

** receptor antagonist or synthesis inhibitors

NHP Asthma Home Visiting Program

Asthma Home Visit Program 2001

- Home visit by a trained health care professional/health educator
- Environmental Assessment
- Asthma education to avoid triggers
- 3 Home Visits

Enhanced Home Visit Program 2005

- DME products to decrease exposure to environmental triggers; allergy encasings for bedding, air purifier, and a vacuum with a HEPA filter

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From Research to Managed Care

- Medicaid members do not have the resources to make home environmental modifications as in ICAS
- Primary asthma care does not include comprehensive environmental assessment, teaching, or intervention
- Asthma specialty services underutilized
- Anti-IgE therapy (Xolair) offers specialists an intervention for uncontrolled atopic asthma patients

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NHP Enhanced Asthma Home Visit Program (EAHVP)

- 2005 NHP translated environmental components of ICAS as covered health plan benefit
- Asthma home visitor; social care management, tobacco treatment specialist enhancements
- Available to asthma population of all ages

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Member Identification

- Self Referral
- Provider referral: increased in 2011
- Members screened in Asthma Care Management
- Majority of members are identified internally for CM
- In patient referrals for post discharge outreach

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Implementation Challenges

- No vendor with whom to contract for full range of services or that covers our entire service area
- VNA skill set not inclusive of home environmental assessment and teaching
- Equipment delivery not coordinated with home visits
- Timely, appropriate referrals from clinicians versus recruiting research subjects

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If You Build It Will They Come?

- Targeted roll-out to allergists and pulmonologists with follow-up letters
- <25% of ‘HEDIS’ persistent asthmatic members see an asthma specialist in prior year
- NHP is small plan and only payer offering this benefit
- Initially dependent upon active referrals

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Expand the Scope

- 2005 Contracted with Vendor :
  - Community Health Workers specialty trained as Asthma Home Visitors
  - Limited Geographic Area
  - NHP provided a reimbursement CPT code for services

- 2012 Contracted with Boston Public Health Commission

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Enhancements to the Asthma Home Program

- A NHP Social Care Manager has been trained as an Asthma Home Visitor
- Criteria:
  - Environmental Concerns ***and*** Social Care Needs
  - Poorly Controlled Asthma
  - Post Discharge from hospital or ER

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Educational Materials

- Low literacy and available in several languages
- Take Control of Your Asthma Booklet
- Take Everyday Control Medications
- Quick Relief Medications
- How to use your Medication Delivery Devices
- EPA Materials Gain Control of Your Asthma

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NHP Asthma Population Achievements

- The lowest hospitalization rate since the Asthma program's inception in 1999 1.9 %
- ER use in 2012 at lowest rate in the program's history at 8.8%
- Controller /Reliever medication Ratio .72

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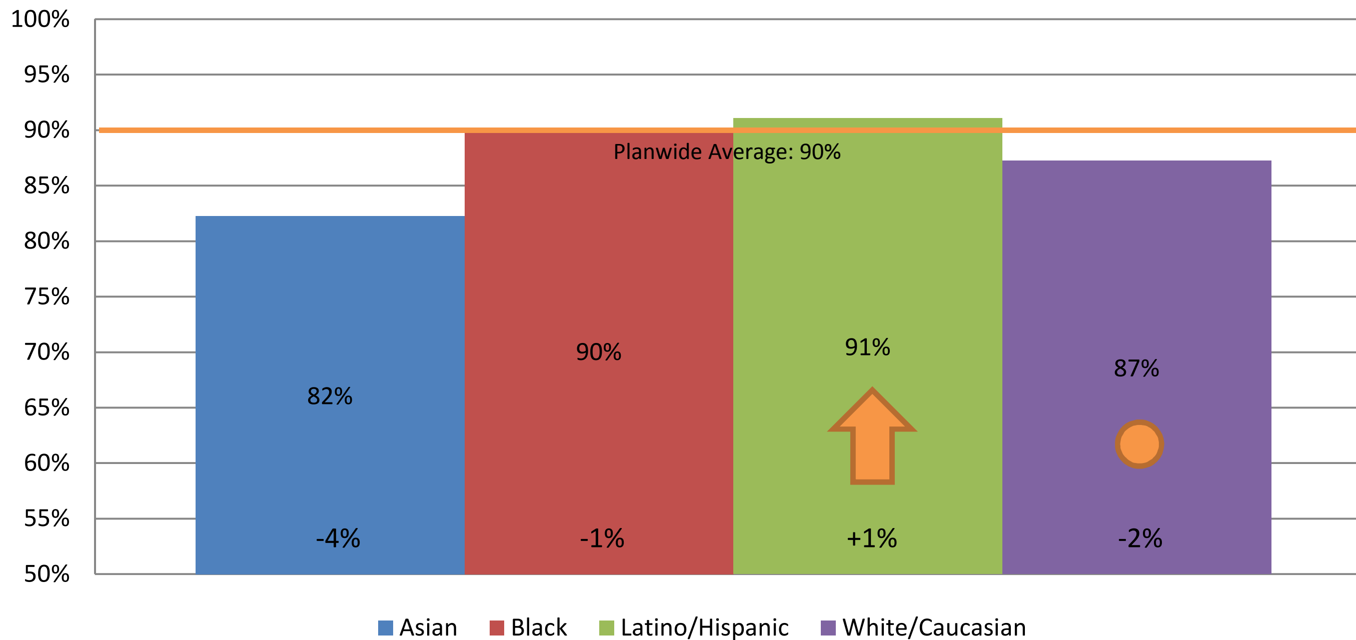
Appropriate Medications for Asthma – By Race and Ethnicity



- Only medication measure without disparity
- Asthma program may be reason for equity in treatment

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Asthma
Enhanced Home Visit Program

- Criteria for Enhanced home visit program:
  - Household must be non-smoking.
  - Member must be at least 80% adherent to control medications. (i.e. inhaled steroid)
  - Member must have a proven indoor allergy (i.e. dust) through skin or RAST allergy testing

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Asthma Goal
Enhancements to the Asthma Home Program

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- Criteria:
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Opportunities for Improvement

NEXT STEPS:

- Expansion of the Enhanced Asthma Home Visit Program (EHVP)
- Increase Improvement with Medication Adherence
- Ongoing collaboration with community-based initiatives
- Enhance Provider engagement

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Questions

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