Attacking Chronic Disease via Community Partnerships

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A Healthier Approach to Healthcare
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
Outcomes

- Quantitative
- Member success stories

“The secret of the care of the patient is caring for the patient.”

~Francis W. Peabody
NHP Asthma Program

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About Neighborhood Health Plan

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

[Image of group of people holding an award, with a background promoting asthma awareness]
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
**TREATMENT STEPS**

**STEP 1**
- asthma education
- as needed rapid-acting β₂-agonist

**STEP 2**
- environmental control
- as needed rapid-acting β₂-agonist

**STEP 3**
- low-dose ICS
- low-dose ICS plus long-acting β₂-agonist
- medium- or high-dose ICS
- medium- or high-dose ICS plus long-acting β₂-agonist
- medium- or high-dose ICS
- medium- or high-dose ICS plus long-acting β₂-agonist

**STEP 4**
- low-dose ICS
- low-dose ICS plus leukotriene modifier
- sustained-release theophylline
- oral glucocorticosteroid (lowest dose)
- anti-IgE treatment

**STEP 5**
- leukotriene modifier
- high-dose ICS
- medium- or high-dose ICS
- anti-IgE treatment

*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
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
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
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
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
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
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
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
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
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
Appropriate Medications for Asthma – By Race and Ethnicity

- Only medication measure without disparity
- Asthma program may be reason for equity in treatment
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
Asthma Goal
Enhancements to the Asthma Home Program

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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
Questions