Priority Health

Asthma Management Program
Controlling Asthma in Michigan

Priority Health

Scale

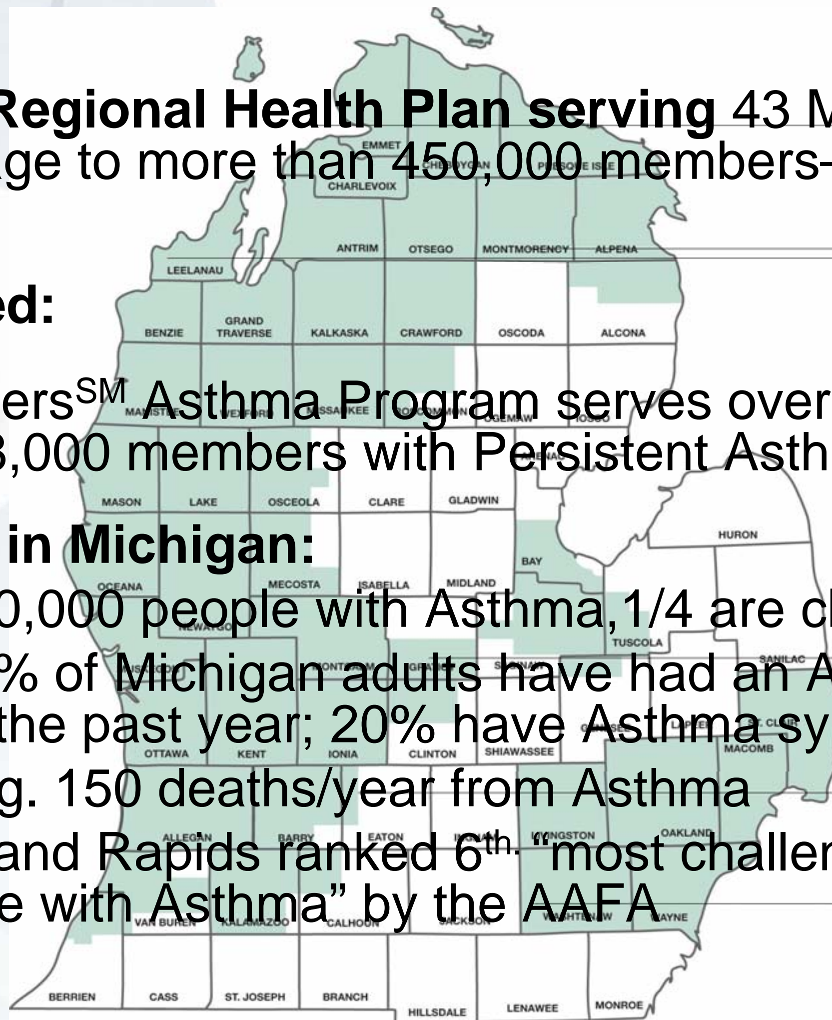
Service Area: Regional Health Plan serving 43 Michigan counties providing coverage to more than 450,000 members—established in 1986

Members Served:

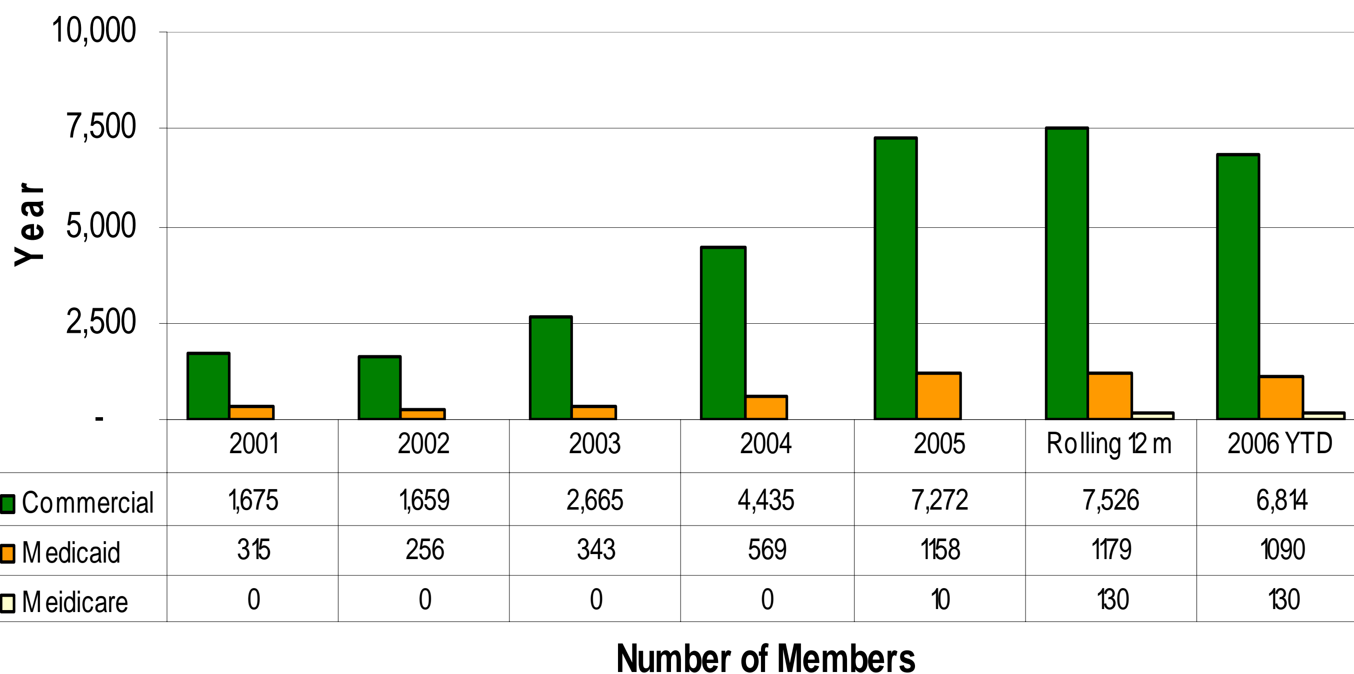
HealthyEncounters^{SM} Asthma Program serves over 19,010 members with Asthma; > 8,000 members with Persistent Asthma

Burden in Michigan:

- 930,000 people with Asthma,1/4 are children
- 50% of Michigan adults have had an Asthma attack in the past year; 20% have Asthma symptoms every day
- Avg. 150 deaths/year from Asthma
- Grand Rapids ranked 6th "most challenging place to live with Asthma" by the AAFA

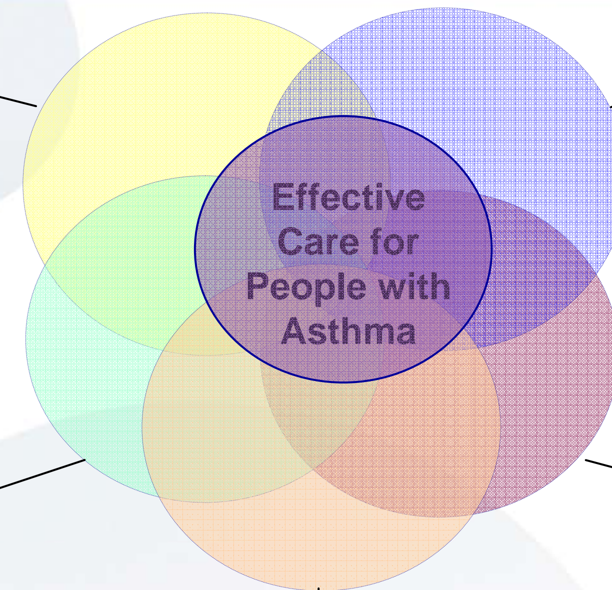


Priority Health



	2001	2002	2003	2004	2005	Rolling 12 m	2006 YTD
Commercial	1,675	1,659	2,665	4,435	7,272	7,526	6,814
Medicaid	315	256	343	569	1158	1179	1090
Meidicare	0	0	0	0	10	130	130

Priority Health: Key Program Elements



Tailored Environmental Interventions

- Home based case management services through partnership with ANWM (Asthma Network of West Michigan)
- Implementation of Tobacco Cessation Quit Line

Strong Community Ties

- Local coalition
- F.L.A.R.E. (Emergency department discharge plans for asthma management)
- MARK (Michigan Asthma Resource Kit)
- Meijer collaborative
- Asthma camp

Integrated Health Care Services

- Internal asthma work group
- Scheduled and individualized mailings
- Patient profiles
- Local physician practices
- Local community resources
- Collecting and sharing outcome data

Committed Program Champions

- Organizational champions (Sr. Managers and Medical Directors)
- Internal asthma work group with wide-ranging expertise
- Committed providers

High-Performing Collaborations & Partnerships

- Asthma registry
- Patient profiles
- PIP (Physician Incentive Program)
- ANWM
- Northern coalition

High-Performing Collaborations & Partnerships:
Working Together to Deliver Quality Care

HealthyEncounters℠
Asthma

Tailored Environmental Interventions:
Personalized Care Through Home-Based Case Management

Building a Successful Program: Defining Moments

HealthyEncounters Asthma Program established in 1995 to improve the quality of life for people who suffer from Asthma.

Defining Moments:

- Priority Health Asthma Case Management Program
- Partnership with ANWM - 1999
- Implementation of the Asthma Workgroup
- Asthma PIP measure
- Outcome measures

Key Process and Health Outcome Goals

Process Outcome Goals

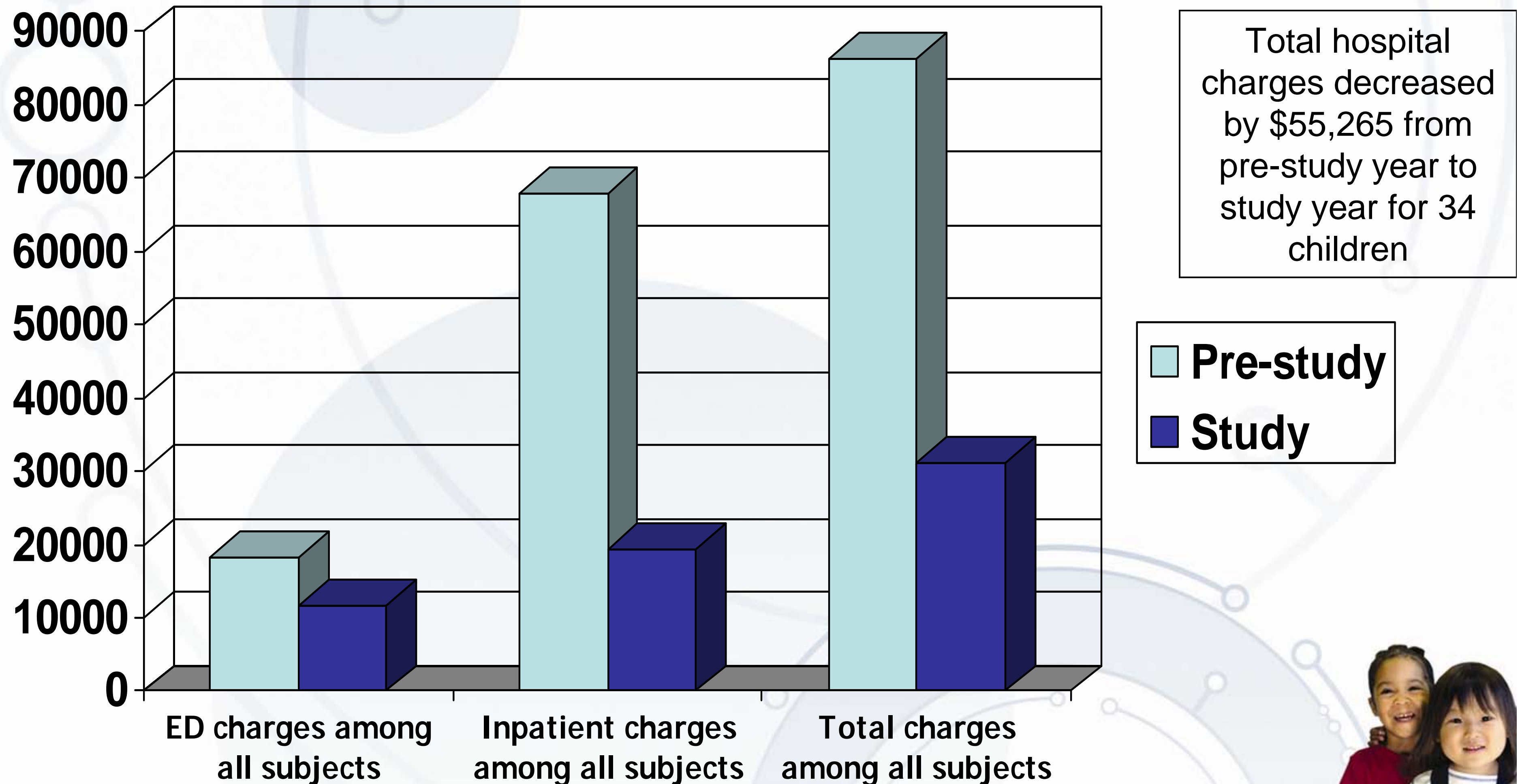
- Support improvements in clinical outcomes through various initiatives: Physician Incentive Program targets, individualized performance improvement plans, online registries, and taking a leadership position in community-wide Impact project on chronic disease management
- Expand penetration and value on investment of disease management programs; more efficiently deploy resources and use of technology
- Delivery of integrated services through case management and community partnerships

Health Outcome Goals

- To improve the health status, quality of life, and the clinical outcomes for all Priority Health patients with asthma by engaging them into the HealthyEncounters-Asthma program
- Improve the percent of members with optimal ratios of long term control medications to quick relief inhalers
- Reduce emergency room visits and hospitalizations related to asthma

Evidence of Success:

Case Management Demonstrating Reduced Hospital Charges



Evidence of Success: Key Results

Key Metrics

Goals	2005		2006		
	Commercial	**Medicaid**	**Commercial**	**Medicaid**	**Goal**
Use of Appropriate Asthma Meds 5-9	81%	76%	98%	93%	**99%**
Use of Appropriate Asthma Meds 10-17	75%	80%	96%	96%	**96%**
Use of Appropriate Asthma Meds 18-56	80%	77%	93%	86%	**93%**
Optimal 2:1 Ratio	77%	NA	73%	NA	**100%**
APT (Asthma Prime)	26	62	18	36	**0**

Evidence of Success: Key Results

Asthma Outcomes

	ER Visits/1000	% of Members using proper medication
1999	262	69%
2005	196	98%

Maintaining a Successful Program: Financing & Sustainability

Asthma Program's Annual Budget (Costs) in 2005: $856,744

How It's Financed:

ROI in 2005:2.1 to 1

Cost savings of $1.7 million in 2005

Key Actions:

- Effective Case management services, including reimbursement for ANWM's home based program
- Physician driven education and incentives
- Community collaboratives
- Data driven, evidenced-based outcomes

PH's Envisioned future:

Lead the nation in measuring and improving health delivery and outcomes – 90th Percentile nationally

Summary

- **Assess your community's need and capacity for an asthma program**
  - Maintain/develop strong partnership with community agencies
  - Identify disparities and address cultural competencies
  - Be innovative in addressing needs/Removing barriers/Seeking solutions
- **Develop an evaluation plan before you begin.**
  - Track outcomes
  - Assure that all members with asthma are educated according to the most recent evidenced based standards of care

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