Health Resources in Action
Advancing Public Health and Medical Research

Asthma Regional Council
of NEW ENGLAND

Promoting Payer Policy Change

The Business Case for Home Asthma Interventions

Regional Summit on Pediatric Home Asthma Interventions

University of Maryland School of Nursing
January 17, 2014

ASTHMA REGIONAL COUNCIL

Working for 13 years, across New England, to improve pediatric asthma outcomes and reduce disparities through partnerships and policy

Promoting Policy Change - Payers

Regional Goal: Improve health and quality of life for asthmatics and reduce disparities by promoting sustainable coverage and reimbursement for comprehensive asthma management

Focus: Promote policies for voluntary coverage of in-home environmental assessments and interventions, and self-management education and interventions.

Why Insurance Coverage?

What's not paid for doesn't get done!

- Asthma is a costly disease that remains out of control
- Clear evidence on link to environmental contributors in homes, schools, work.
- Less costly to prevent than to treat
- Opportunity with health care reform
- Medicaid payers -low hanging fruit

Making the Case: Cost of Asthma & Savings

1 in 12

11.5 Million

Medical visits

56 Billion

Example: Home based asthma education & environmental interventions shown to be cost effective ($2-$28 per symptom free-day gained)

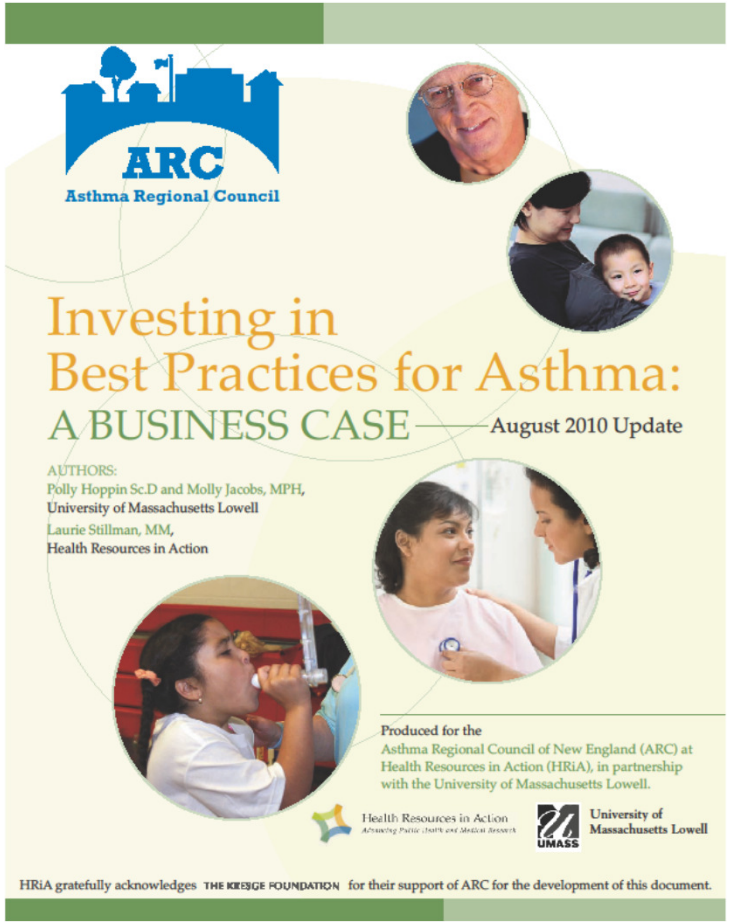
Building the Case to Insurers

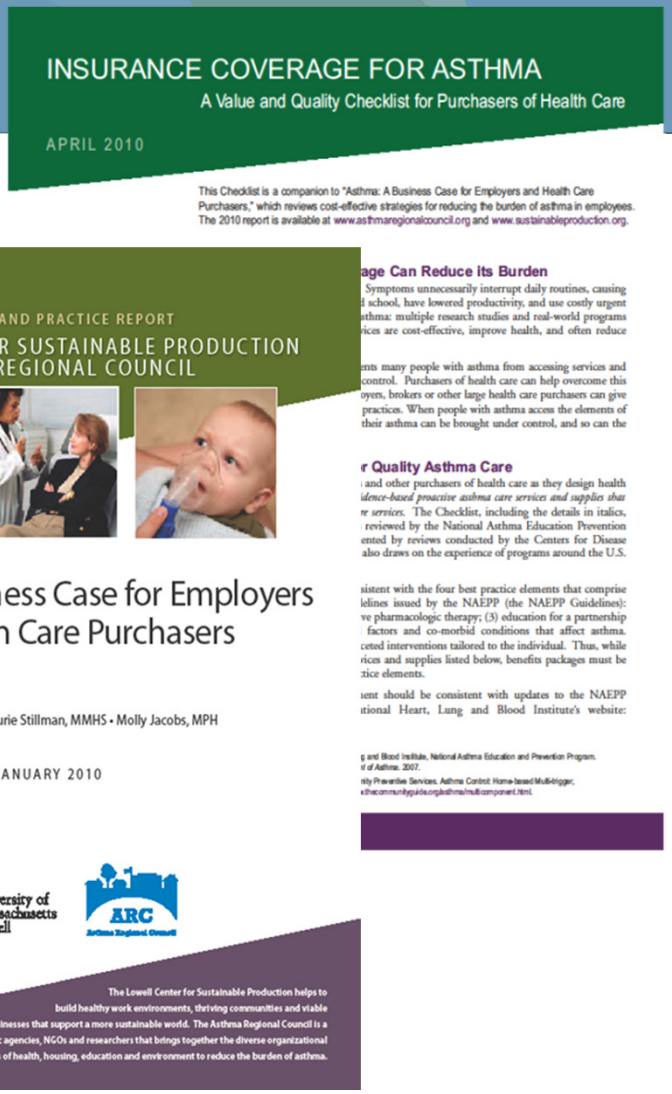
- Interviews with Medical Directors.
- Payer Symposium in 2004 & 2010
- "Business Case for Payers"- 2007 & 2010.
- Pilots with two payers -- payment & policy change.
- Collaboration with CDC-funded NE State Asthma Programs to promote financing.
- Insurance coverage survey – Gap Analysis
- New England Asthma Innovations Collaborative

Payers Want to Know

- Evidence-base for best practices
- Standard practice and models of care
- What providers and purchasers want
- How interventions fit into QI efforts
- Payment models
- **Health outcomes**
- **Benefit-cost ratio**
- **Anticipated costs**

Tools for Advocacy



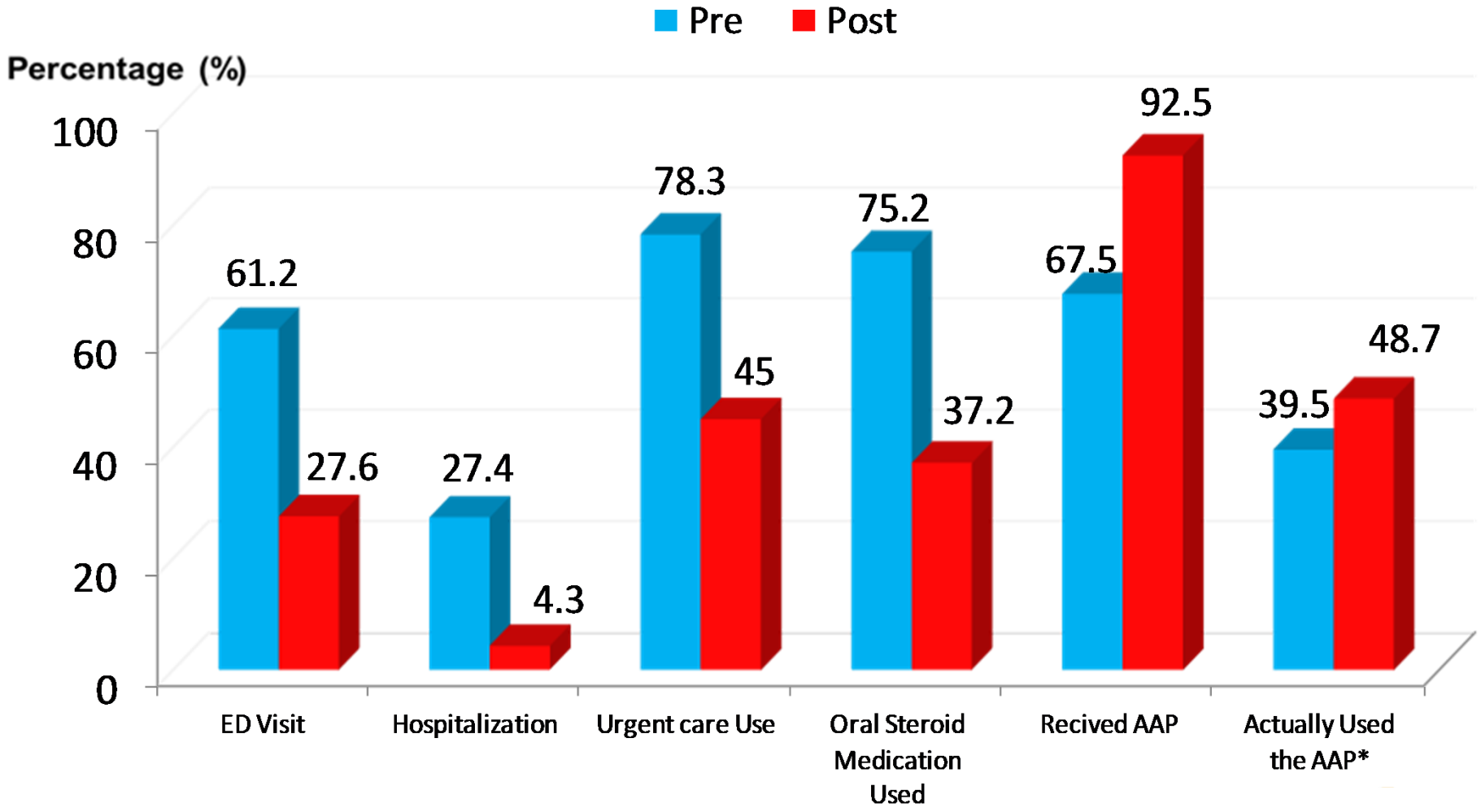


In February 2011, HHS Secretary Sebelius cited "Investing in Best Practices for Asthma" in a guidance letter to all Governors regarding Medicaid cost-saving opportunities.

Reducing Ethnic/Racial Disparity in Youth Study (MA DPH, Boston and Baystate Medical Centers)

Pediatric Asthma Home Visiting Intervention

Preliminary Results – Health Outcomes Pre vs Post (N = 119)



Funded by HUD Healthy Homes Technical Studies and AARA R01 grants

Sinai Urban Health Institute – Chicago
Pediatric Asthma Home Visiting Intervention - Outcomes

	PAI-1	PAI-2	CPATCE (Sinai)	HHHC	HCBT	ACP
N	56	50	160	151	59	68
Asthma Emergency Dept. Visits	74% decline*	74% decline*	48% decline*	69% decline*	83% decline*	74% decline*
Asthma Hospitalizations	86% decline*	71% decline*	50% decline*	63% decline*	50% decline*	96% decline*
Urgent Health Care Resource Utilization^	80% decline*	69% decline*	50% decline*	55% decline*	76% decline*	74% decline*
Nighttime Asthma Symptoms	-	52% decline*	64% decline*	44% decline*	73% decline*	62% decline*
Pediatric Asthma Caregiver's Quality of Life	-	Increased by 0.8* ¥	Increased by 0.4*	Increased by 1.2* ¥	Increased by 0.7*¥£	Increased by 1.0*¥£
Cost-savings per Participant^^	$4,503.44	$2,561.60	$1,402.87	$2,119.81	$813.03	$3,200.05
Cost-savings/$ spent on the program€	$7.79	$5.58	$3.38	$4.54	$2.33	$5.79

*Statistically significant p<0.05

^ Sum of ED visits, hospitalizations, and urgent clinic visits

¥An increase of 0.5 is clinically significant

£ Ns vary because parent is unit of analysis not child. HCBT N=42 ACP N=50

^^ Cost-savings after accounting for program costs

€Cost Savings per $ spent = Healthcare Cost Savings/Cost of Program

New England Asthma Innovations Collaborative

Controlling Asthma. Controlling Costs.

Goal: Create *New England Asthma Marketplace – to Control Asthma and Control Costs*

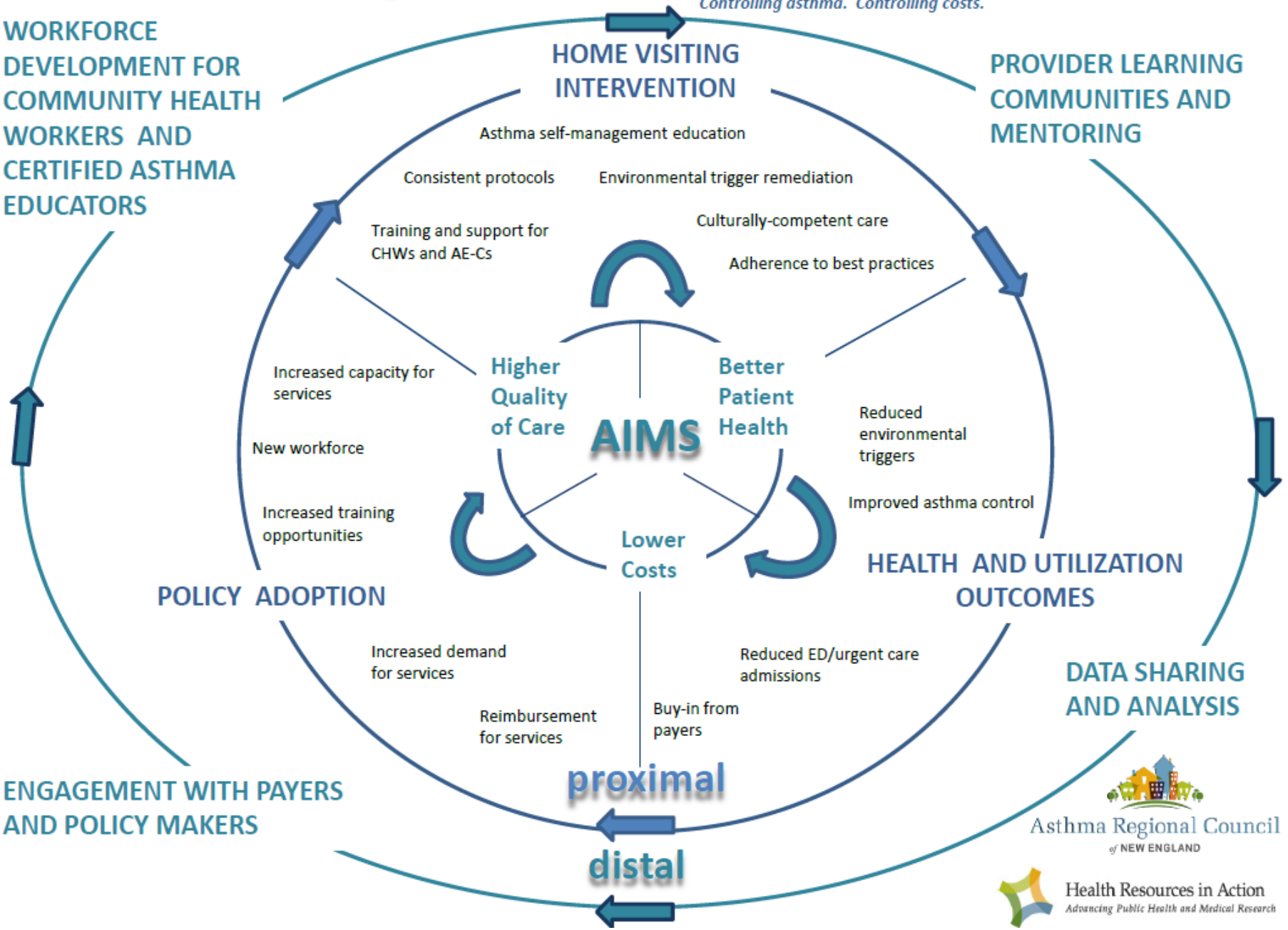
Outcomes:

- Better health and quality of life
- Reduced disparities
- Cost savings
- New workforce: CHWs
- Policy Change: sustainability

The project described is supported by Grant Number 1C1CMS331039 from the Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) The contents of this presentation are solely the responsibility of the authors and have not been approved by the DHHS, CMS.

New England Asthma Innovations Collaborative

Controlling asthma. Controlling costs.



Asthma Regional Council of NEW ENGLAND

Health Resources in Action
Advancing Public Health and Medical Research

NEAIC Intervention: Home Visiting – 1100 Children

- **Assess** patients' needs and home environment
- **Provide** asthma self-management education
- **Deliver** cost-effective environmental supplies
- **Improve** quality and experience of care:
  - Client-centered, use of motivational interviewing
  - Promote asthma action plans
  - Promote connections to primary care & preventic
  - Referrals for social services
  - Review of needs and progress

NEAIC Partners: 8 Health Care Providers

MA:

- Children's Hospital Boston
- Boston Medical Center
- Baystate Children's Hospital

RI:

- RI/Hasbro Hospital
- St. Joseph's Health Services

CT:

- Middlesex Hospital
- Children's Medical Group

VT:

- Rutland Regional Medical Center

NEAIC Partners: 6 Medicaid Payers

MA:

- Neighborhood Health Plan, MA
- BMC HealthNet
- Health New England

RI: Neighborhood Health Plan, RI

CT: CT Department of Social Services
\Children's Health Network (ASO) (Medicaid)

VT: Department of Vermont Health Access (VT Medicaid)

Others pending: MassHealth (Medicaid)

NEAIC Policy and Training Partners

- American Lung Association, New England
- Boston Public Health Commission's Community Health Education Center
- Central MA – Area Health Education Center's Outreach Worker Training Institute
- MA Association of Community Health Workers
- CDC funded - New England State Asthma Programs

NEAIC Evaluation Overview

Aim 1 – Improve quality of care for children with poorly controlled asthma

- Caregiver satisfaction (focus groups)
- Knowledge and use of asthma action plans (caregiver self-report)
- Received influenza vaccine (caregiver self-report)

NEAIC Evaluation Overview

Aim 2 – Improve health and quality of life for children with poorly controlled asthma and their families

- Asthma control (caregiver self-report)
- Pediatric Asthma Caregiver's Quality of Life Questionnaire (caregiver self-report)
- Missed school and work (caregiver self-report)
- Environmental triggers (CHW observations & caregiver self-report)

NEAIC Evaluation Overview

Aim 3 – Lower utilization costs for children with poorly controlled asthma

- Health care utilization
  (caregiver self-report & claims data)
- Health care utilization costs
  (claims data)

Comparing before and after for intervention population and comparison groups for health claims data.

NEAIC Payer Engagement

- Providing Claims and Encounter Data
- Attending Payer/Provider Meetings
- Participating in Payer Assessment – What payers want to know .
- Paying in Year Three for Patients
- Policy Change!

Acknowledgements

- ARC Funding:
  - 2009-2011 Kresge & Boston Foundations, EPA & DHHS (Region 1)
  - On-going – EPA (Region 1)

- ARC Business Cases authored by:
  - Polly Hoppin, ScD – U of MA, Lowell
  - Laurie Stillman, MMHS - HRiA
  - Molly Jacobs, MPH - U of MA, Lowell

- NEAIC is supported by Grant Number 1C1CMS331039 from the Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS). The contents of this presentation are solely the responsibility of the authors and have not been approved by the DHHS, CMS.

Questions?

Contact:

- *Laurie Stillman, Principal Investigator at lstillman@hria.org*
- *Stacey Chacker, ARC Director at schacker@hria.org*
- *Heather Nelson, Senior Research Scientist at hnelson@hria.org*
- *Christine Gordon, ARC Program Coordinator cgordon@hria.org*

Business Case for Home Asthma Interventions

Regional Summit on Pediatric Home Asthma Interventions

January 17, 2014

Baltimore, MD

Karen Meyerson, MSN, RN, FNP-C, AE-C

Asthma Network of West Michigan

First Things First: Building the System

- Established in 1994 as the grass-roots asthma coalition serving West Michigan – 20th Anniversary this month!
- Start Small to Get Big
  - The first asthma coalition in Michigan; one of the first in the nation
  - Began providing home-based asthma case management services in 1996
  - Obtained 501(c)(3) status in 1997
  - Contracted with area's largest payer in 1999
- **<u>Target Population</u>: children with uncontrolled asthma from low-income families in West Michigan**

First Things First: Building the System

- Let the data guide the program
  - Population Served – 3 West Michigan counties (Kent, Ottawa, Muskegon)
    - Total Population Served: 1,032,426
    - Total Medicaid Population: 134,194
    - Total with asthma: 82,933
    - Total adults: 57,568
    - Total children: 25,365

- Build evaluation in from the start
  - Began to measure outcomes on day one, national abstract presented one year later
  - Demonstrated quality outcomes, resulting in cost savings, which we took to the area's largest payer

Committed Leaders and Champions

- Institutionalize the focus on outcomes
  - Community collaborative guided by a physician champion and partners in key positions of leadership, able to parlay that partnership into action
  - "Leave your badges at the door" –
    - partnered to achieve a shared goal and not for any organizational advantage
    - Ensure mission-program alignment, don't just "follow the money"

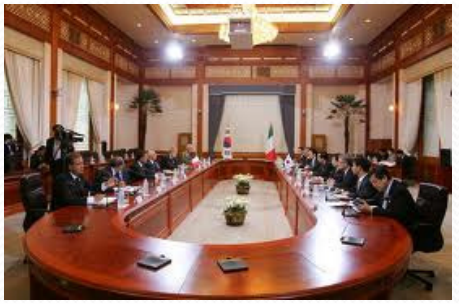
  - Designed a comprehensive program, which would provide direct service and would target the most at-risk children with asthma in our community

Strong Community Ties

- Included our community in program planning
- Engaged our community "Where it Lives"
  - Situated our offices in target community
  - Demonstrated broad commitment to our target community by getting involved in community affairs
- Recruited asthma champions
- Reached out to local foundations and corporations
- Collaborated with competing hospital systems
- Supported school districts
- Focused on health care providers/clinics
- Partnered with local universities
- Engaged health plans

High Performing Collaborations and Partnerships: Build on What Works

- Collaborate to build credibility – become *indispensable* to your community
  - Patient-centered medical home model in Kent County
  - We Are For Children – largest pediatric practices in West Michigan – training/mentoring providers and staff to improve asthma care protocols across the board
  - Merck Childhood Asthma Network grant/GWU study
- Engage health plans
  - Identify key decision-makers, offer a period
  - "Payer Summit"
  - Be responsive and flexible (e.g., service to Muskegon and COPD program at the request of Priority Health)



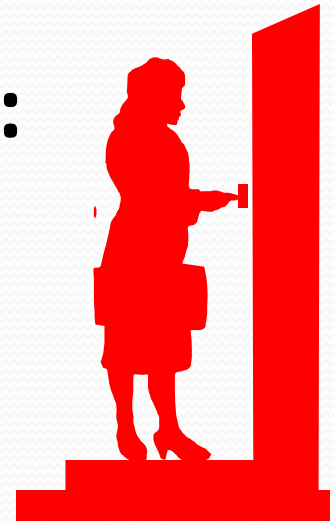
High Performing Collaborations and Partnerships: Health Plans

- First asthma coalition in the nation to contract with health plans
- Target members with uncontrolled asthma
- Signed contracts with 3 health plans – negotiating with a 4th
- Reimbursement ($130,000) covers ~ 1/3 of our operating budget ($390,000)
- Working towards reimbursement covering ½ of our budget by increasing our productivity/efficiency

High Performing Collaborations and Partnerships: Reimbursement

- Reimbursement for AE-C or MSW home visits, school visits and physician care conferences
- Rev Code 551 - Skilled Nursing Visit for RN, RRT or LMSW
- Some health plans authorize 18 visits, others authorize fewer and AE-C must call and justify the need for more visits
- Utilize health plan registries to enroll high risk patients with asthma

Tailored Environmental Interventions: Program Activities



- Home-Based Case Management:
  - Home visits: AE-Cs, LMSW, CHWs
  - School/daycare visits
  - Physician care conferences
  - Social work support to assist with psychosocial barriers
- Community outreach:
  - Speakers' Bureau

Case Management Team

- Clinical Manager
- 1.8 FTE Asthma Educator/Case Manager – must be a Certified Asthma Educator (AE-C) – RN, RRT or LMSW – or become certified within one year
- 1.0 FTE LMSW (Masters-prepared) to become dually trained as an AE-C
- 1.0 FTE Business Office Coordinator/Biller
- 2 Community Health Workers (CHW)
  - .75 FTE combined

Case Management Referral Sources

- Inpatient population
- PCP/clinic
- School nurse
- Public Health Nurse
- Self-referral
- Managed Care Organizations

Program Metrics

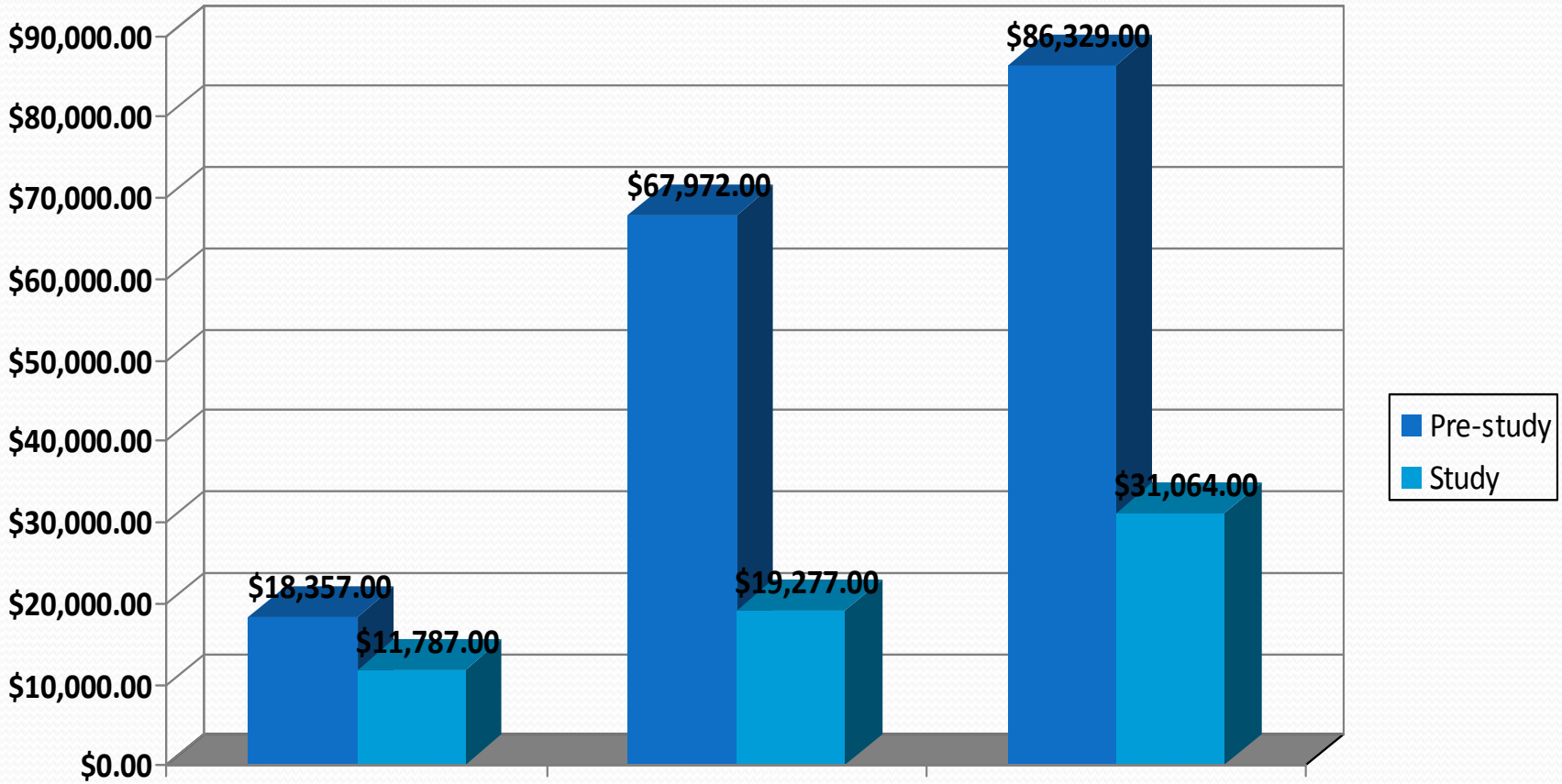
Dashboards

- Patient level:
  - Reductions in ER visits, hospital admissions, school days missed, exposure to ETS
  - Spirometry rates
  - Flu shot rates
  - Juniper QOL
  - ACT scores
  - # Asthma Action Plans

- Staff level
  - # of families served per year
  - # of home visits accomplished monthly (% target)
  - # of community members educated about asthma
  - # of visits/AE-C, no-show rates, time-to-open cases

Health Outcomes:

Reduced Facility Charges



Total hospital charges decreased by **$55,265** from pre-study year to study year

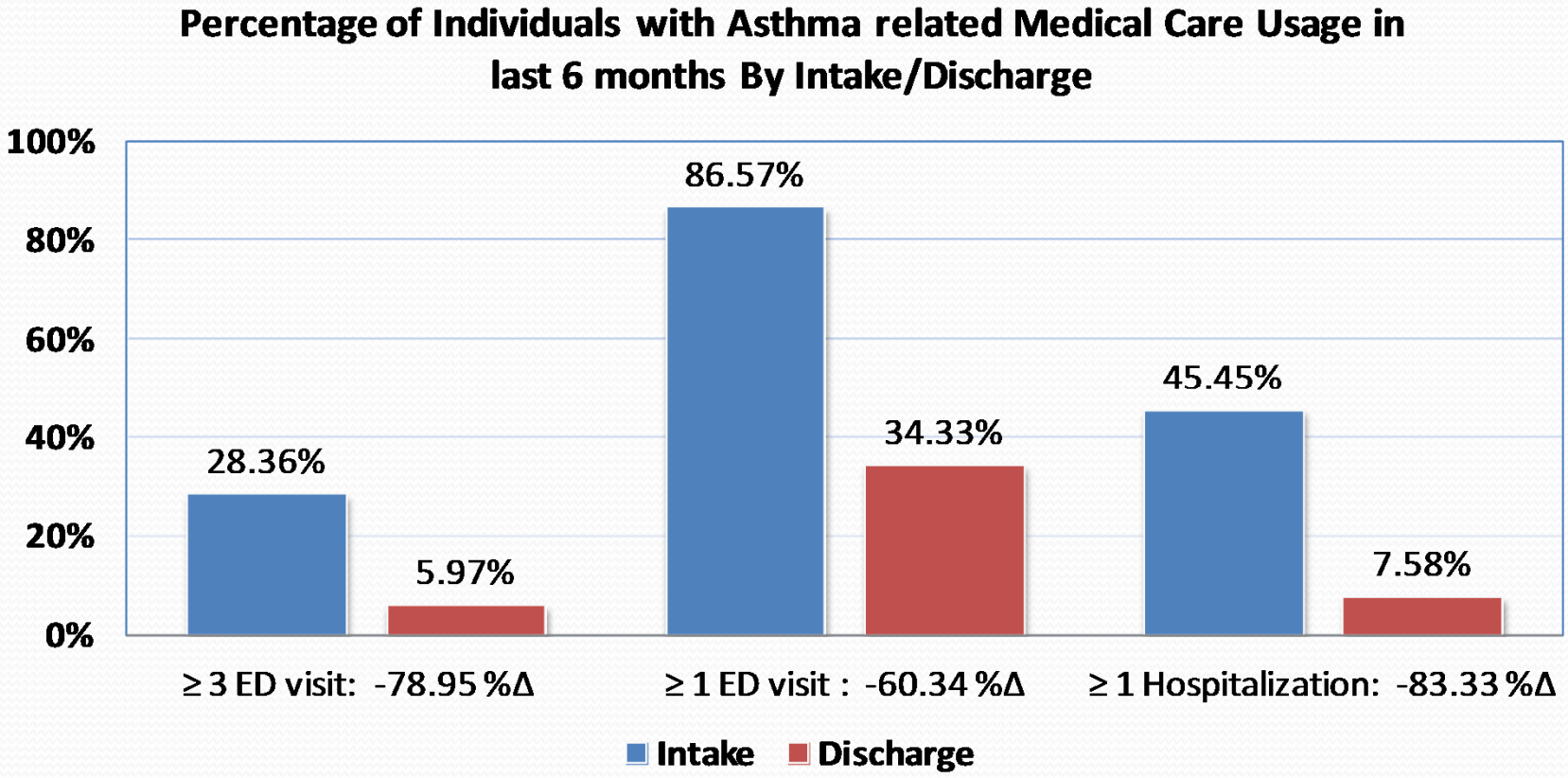
Health Outcomes

- Fewer emergency department visits
- Fewer hospitalizations
- Lower overall costs for asthma

Clinical Outcomes	Cohort Group N=45			Control Group N=39			Cohort vs. Control
	Pre	Study	P-value	Yr 1	Yr2	P-value	P-value
ED Visits	80	61	0.047	28	43	0.0211	0.0040
Hospitalizations	41	13	<0.0001	23	28	0.1457	<0.0001
Days Hospitalized	114	25	<0.0001	55	67	0.0779	<0.0001

Kirk GM, et al. Abstract presented to the American Thoracic Society International Conference in San Francisco - May 2001

Health Outcomes



Management Costs

- Major costs are staff salaries, mileage, and supplies
- Resource planning:
  - Leveraged funds from local foundations for a national grant we did not receive, but the local foundations provided the $ anyway
  - Secured in-kind and other support from a local hospital who houses our program for free
  - Secured long-term sustainable funding from the local United Way and a local hospital's Community Benefits program
  - Created a technical assistance package for replicating our model in other communities

Reflections

- What is your target population/community need?
- How many of your target population will you serve?
- What are your resources/capacity and what services will you offer?
- What are your staffing requirements to in order to implement your program? (FTEs, qualifications, etc.)
- What health outcomes are you committed to achieving (short-term/long-term)?
- What are your anticipated costs?
- What data will you need to refine my value proposition statement and how can you get it?
- Who in my community needs to hear my value proposition statement?

My Value Proposition Statement: Elevator Pitch

For $400,000, the Asthma Network will improve asthma outcomes for 400 at-risk children with poorly controlled asthma by achieving reductions in ER visits and hospital admissions, through our in-home asthma case management program.

We estimate that our work will deliver $640,000* per year in cost savings to the healthcare system through 40% fewer hospital admissions and 25% fewer ER visits.

* $1,600 savings per patient/year x 400 patients/year

For more information...

Karen Meyerson, MSN, APRN, NP-C, AE-C

- e-mail: meyersok@mercyhealth.org
- Phone: 616-685-1432
- websites: www.asthmanetworkwm.org
  www.naecb.com