



Asthma CarePartners

An Innovative Care Management Collaboration

Family Health Network
and Sinai Urban Health Institute

June 9, 2016

Agenda

1. FHN and SUHI Introductions
2. Sinai Asthma Initiatives
3. Asthma CarePartners Program
 - Components
 - Outcomes
4. FHN/Payer's Perspective
5. Recommendations



Family Health Network

- Founded in 1995, FHN is the only not-for-profit health plan in Illinois.
- All operations are directed by local “safety net” hospitals.
- Awarded HFS contract to serve Family Health Plan & Affordable Care Act beneficiaries (FHP/ACA).
 - Seniors and Adults with Disabilities (SPD)
 - Medicare Advantage (MA) and Dual Special Needs Plan (D-SNP)
 - Health Exchange expanding our market from Cook County to surrounding counties of Northern Illinois.
- Received HMO license July 1, 2015 with application for NCQA accreditation in progress.
- FHN’s mission is to *“provide access to cost effective quality health care for people who could not otherwise afford it.”* We do so through enrollment in our health plan and also through the support we provide to Safety Net Providers.
- Our Vision is *“To be the health plan of choice in our market and the leader in improving health outcomes.”*
- Founding partner with Sinai Urban Health Institute for Asthma CarePartners program.

Sinai Urban Health Institute

- 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 and depth of health status and health services access disparities in our communities
 - Led us to design, implement and refine high impact, cost saving community-based intervention strategies for a number of chronic health conditions, including asthma and diabetes

Sinai Asthma Initiatives

- SUHI has implemented a series of nine comprehensive interventions; four are currently underway
- Goals:
 - Decrease asthma-related morbidity and mortality
 - Improve quality of life for people living with asthma
 - Decrease costs
- Each program has built on the successes and shortcomings of its predecessors
- Partner extensively with other organizations
- Mostly grant funded

Sinai Asthma Initiatives: CHW Model

- APHA defines a Community Health Worker (CHW) as:
 "...a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served."
- CHWs are the agent of change
- CHWs are hired from the target community
- No prior medical or asthma experience required
- Knowledge of the community and passion to help others
- Host a pre-hire training course prior to interviewing potential CHWs

Sinai Asthma Initiatives

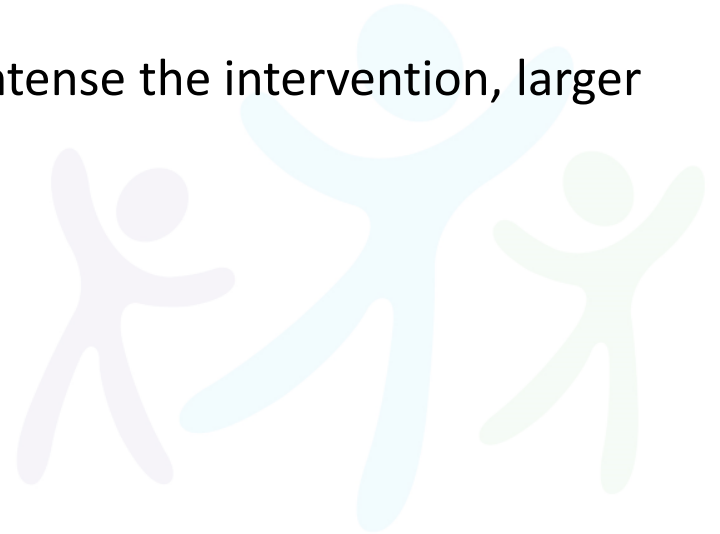
- Four of the interventions paved way for creation of Asthma CarePartners program
- Grant funded
- All were rigorously evaluated
- Consistent and powerful outcomes



Pediatric Asthma Initiative 1

2000-2002

- Compared three pediatric asthma interventions with increasing intensities of asthma education
- CHWs educated in clinic setting
- Any intervention made a difference; more intense the intervention, larger the impact



Pediatric Asthma Initiative 2

2004 - 2006

- African American children (2-16 yrs) with severe asthma living in Westside Chicago communities
- Pilot intervention based in the community
- CHWs delivered case-specific asthma education in the home environment
- CHWs visited homes of clients three or four times over a six month period
- Significant improvement in all outcomes assessed

Controlling Pediatric Asthma Through Collaboration and Education 2006 - 2008

- Initiative of IDPH to improve asthma management among high risk children in IL
- Expanded Sinai's PAI-2 model to six target areas throughout IL
- Findings substantiated PAI-2 results and conclusions at Sinai and other areas
- Evidence that the model can be replicated in other communities

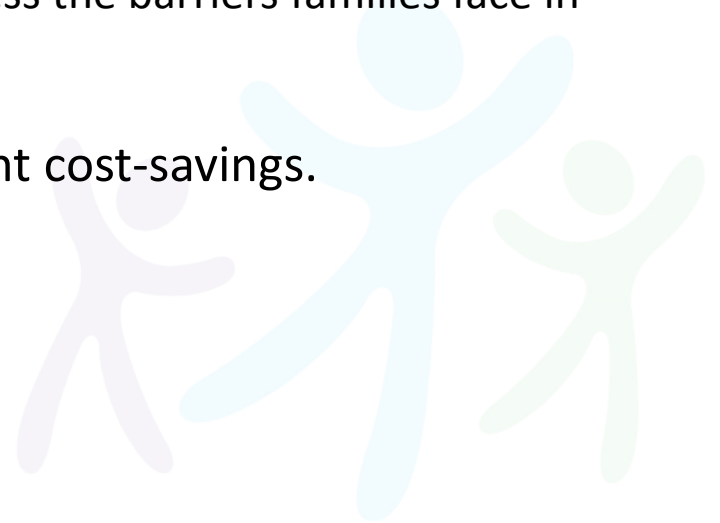
Healthy Home, Healthy Child: Westside Children's Asthma Partnership 2008-2011

- Most intensive intervention to date
- Funded by CDC; employed the Seattle-King County Healthy Homes model (Phase I) as a foundation (Krieger et al. 2005)
- CHWs made six home visits over the course of a 12-month intervention period
- Referrals to partner agencies for assistance with complicated environmental and legal situations that impede family's well being

Sinai Asthma Initiatives:

Key Lessons

- Issues that impede a family's ability to manage asthma are complex and often require varying areas of expertise.
- CHWs are immensely effective in establishing relationships of trust with the families they serve.
 - Consequently, in the best position to address the barriers families face in properly managing asthma
- CHW approach is associated with significant cost-savings.
 - PAI-1: \$7.79 per dollar spent (Group 3)
 - PAI-2: \$5.58 per dollar spent
 - CPATCE: \$3.38 per dollar spent (Sinai)
 - HHHC: \$4.54 per dollar spent



Asthma CarePartners (ACP)

- Strong evidence of effectiveness and potential for cost savings
 - TIME TO SCALE UP AND INTEGRATE INTO STANDARD HEALTHCARE DELIVERY!
- Sought out opportunities to present to health plans and providers
- Identified program champions – advocates for CHW model with critical relationships
- ACP champion set-up meeting with CEO and CFO of FHN
- Another ACP champion set-up meeting with the Chief Medical Officer of BCBSIL
- Meetings eventually resulted in opportunity to integrate into standard care coordination via Medicaid managed care (FHN) and private insurer (BCBSIL)

Asthma CarePartners - FHN

- Collaborative effort that supports the mission and goals of both FHN and SUHI
- Partnership and specific program elements were implemented in August 2011



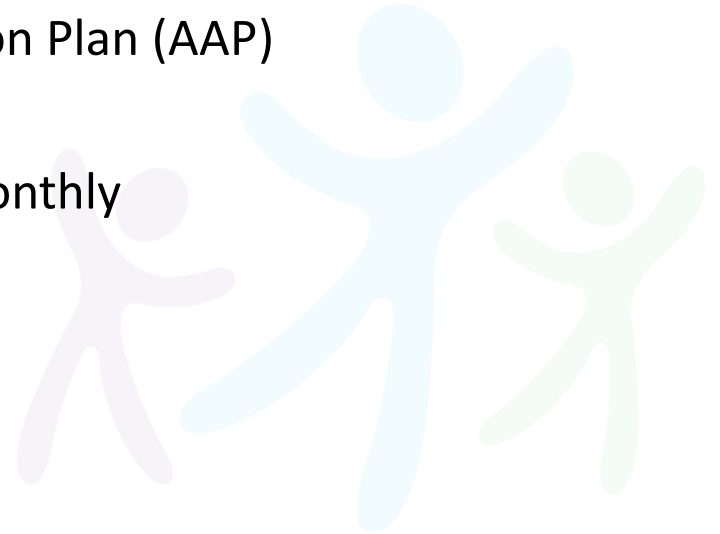
FHN Program Referrals

- FHN care managers identify members who could benefit from the program and obtain permission from the member to make the referral:
 - ACT > 19, high risk asthma profile
 - Asthma related hospitalizations, ER visits
 - Medication utilization or non-compliance
 - Expressed need from member, parent, care manager, practitioner



ACP Program Components

- CHWs make six visits during the 12 month intervention
- Asthma education, home environmental assessment, medical device training
- Development and teaching of Asthma Action Plan (AAP)
- ACT (Asthma Control Test) administered monthly
- Follow up phone calls on non-visit months



ACP Program Components

- Partnership with Metropolitan Tenants Organization, a tenants rights group
- Program provides “Healthy Home” resources such as asthma-friendly cleaning kits and/or supplies to control pests, dust mites, mold, etc.



Home Visits

- Home environment is more conducive to learning since participants are more comfortable and likely to ask questions
- CHWs are able to observe the home environment and help to identify and address triggers including:
 - Mold, rodents, cockroaches, dust
- CHWs deliver and demonstrate devices, making sure participants learn how to use them correctly
- CHWs have the time to dispel myths and misinformation about medications, such as steroids

ACP Outcomes

- As of 12/31/15, 958 referred to program, 509 enrolled
- Of those participating in the program, 125 had completed the 12-month intervention (90 children, 35 adults)
- Healthcare utilization decreased dramatically and symptoms have been reduced
- Reduction in missed work and school days
- Process measures evaluated



Payer Perspective

Program Goals:

1. Maximize participation of high risk members
 - Effective recruitment
 - Retention and completion

2. Achieve the Triple Aim:
 - Improved population health
 - Reduction in avoidable cost
 - Member experience and quality of life



Referrals and Recruitment

Barriers

- Referral Goal = 7 /week;
 - Avg = 4.5 / week
- Recruitment Goal = 5/week;
 - Avg = 3 / week

Interventions in Progress

- Careful assessment for program eligibility
- Immediate phone transfer from FHN care coordinator to program intake
- Direct community outreach for hard-to-connect
- Use of “doorhanger” notices to incent call back

Program Retention

Barriers

- Goal = 75% at 12 months
 - Avg = 25%

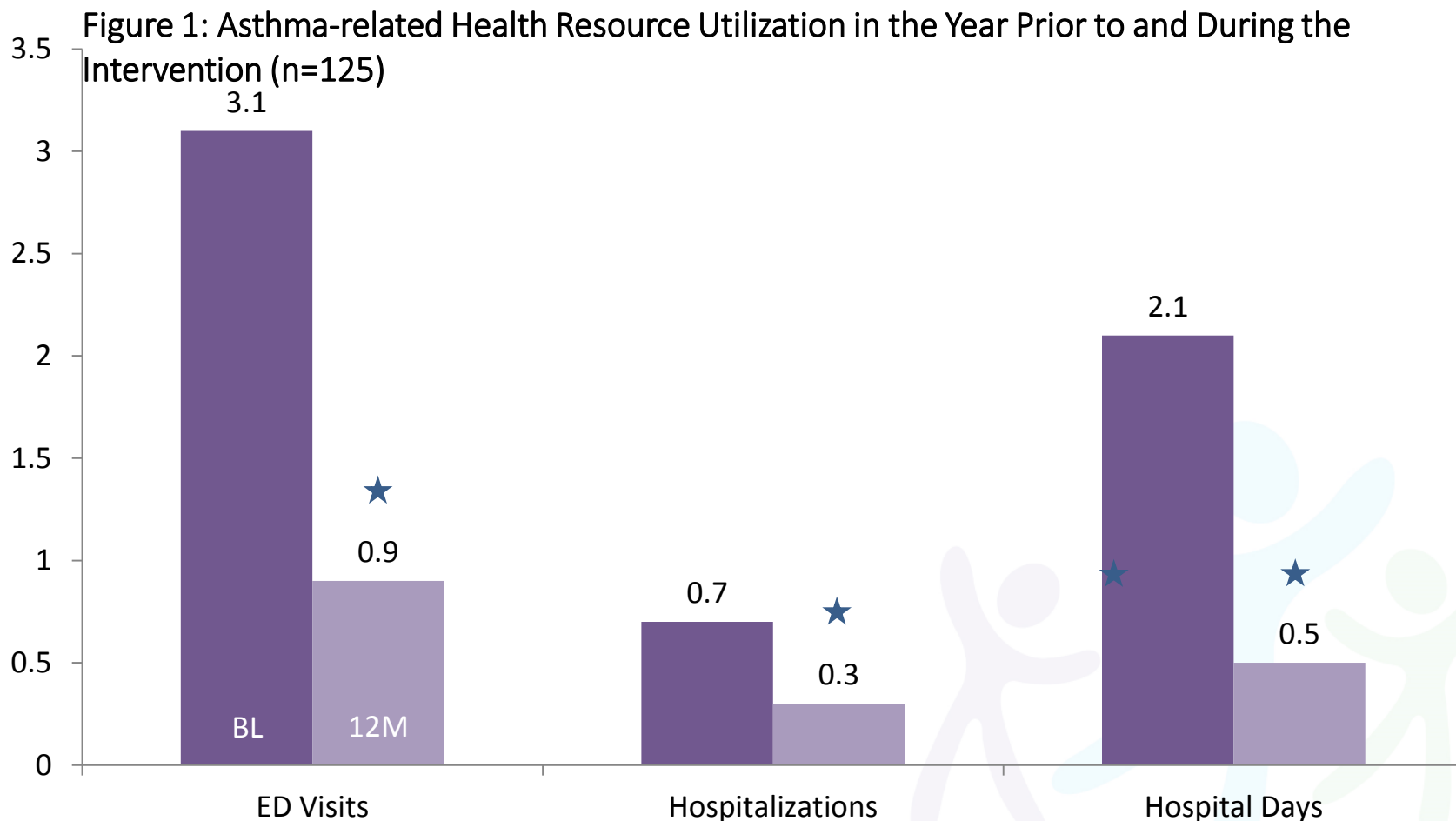
Interventions in Progress

- Close collaboration between SUHI and FHN care teams
- Weekly rounds for case review and barrier analysis
- Systems integration (health plan record)
- SUHI team facilitates redetermination education for member retention at health plan

Tools to Evaluate ACP Outcomes

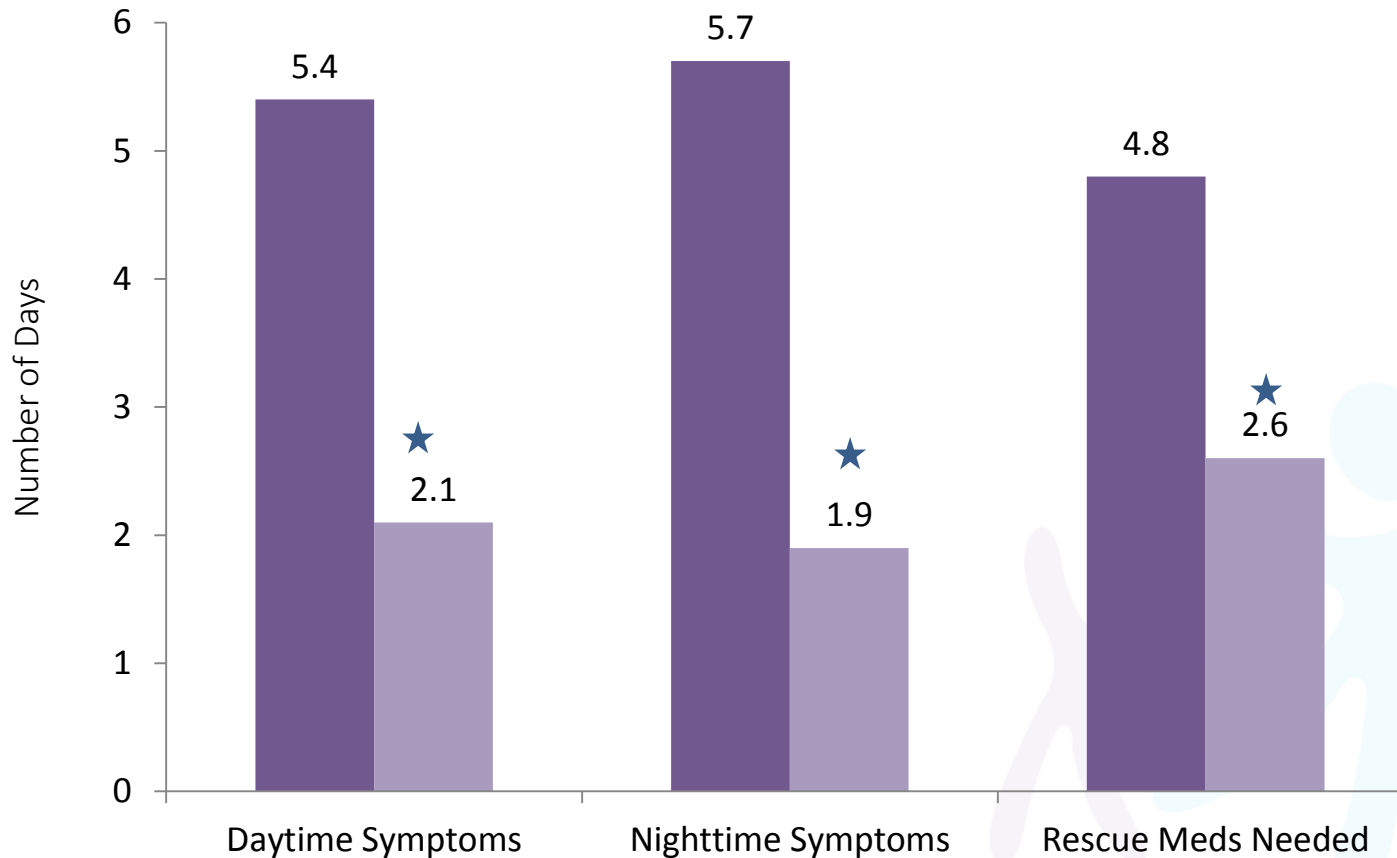
- ✓ **Asthma Control Test** – measures the degree to which a person's asthma is controlled monthly
- ✓ **Pediatric Asthma Caregivers Quality of Life Questionnaire** – measures the quality of life of the child's primary caregiver (baseline, 6, and 12 months)
- ✓ **Asthma Quality of Life Questionnaire** – 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)

Results: Health Resource Utilization



Results: Symptom Frequency

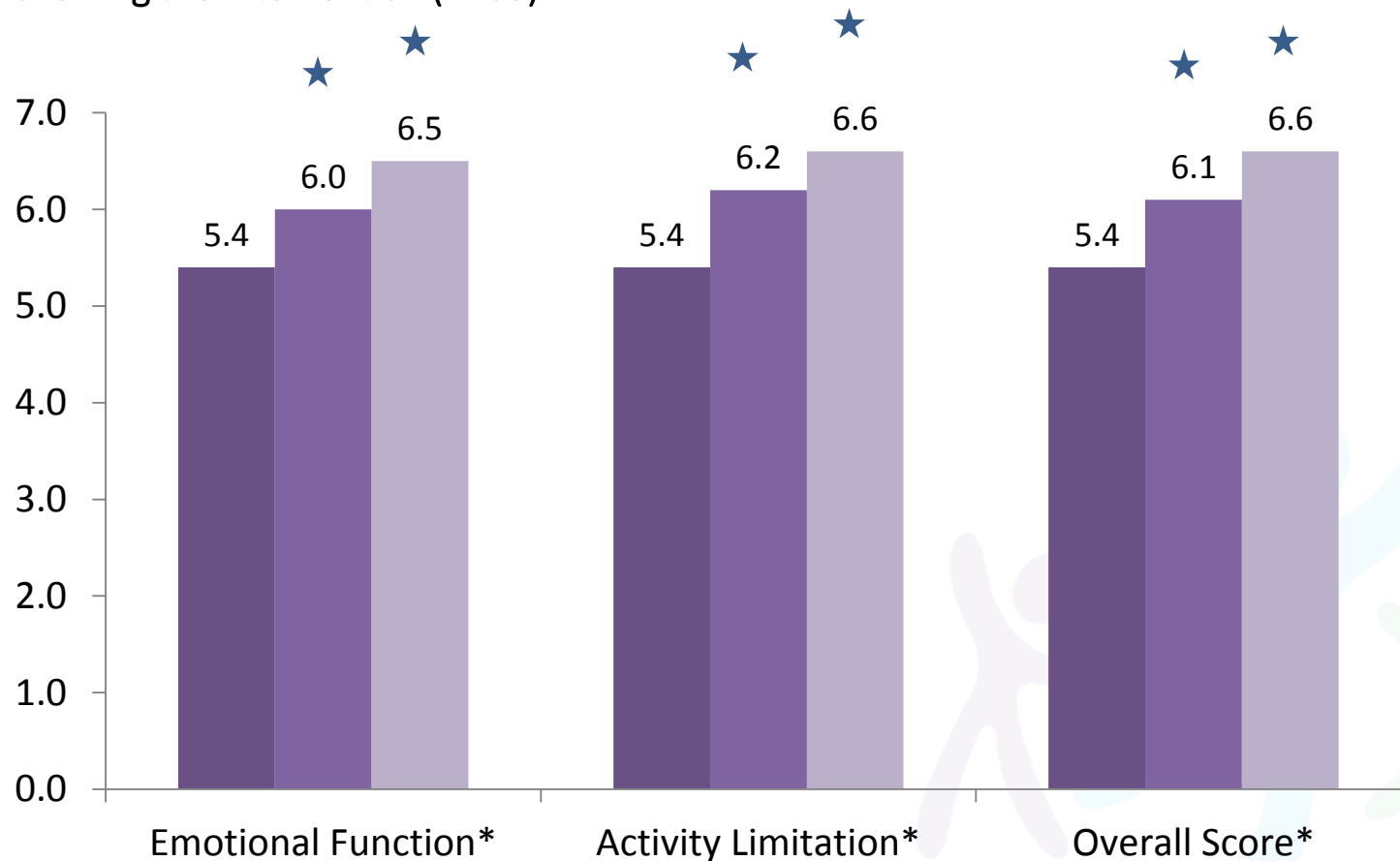
Figure 2: Symptom Frequency in the past 2 weeks at Baseline vs. Average During Follow-up Year (n=125)



★ Statistically significant difference found ($p < 0.05$) using Wilcoxon signed-rank non-parametric test

Results: Caregiver Quality of Life

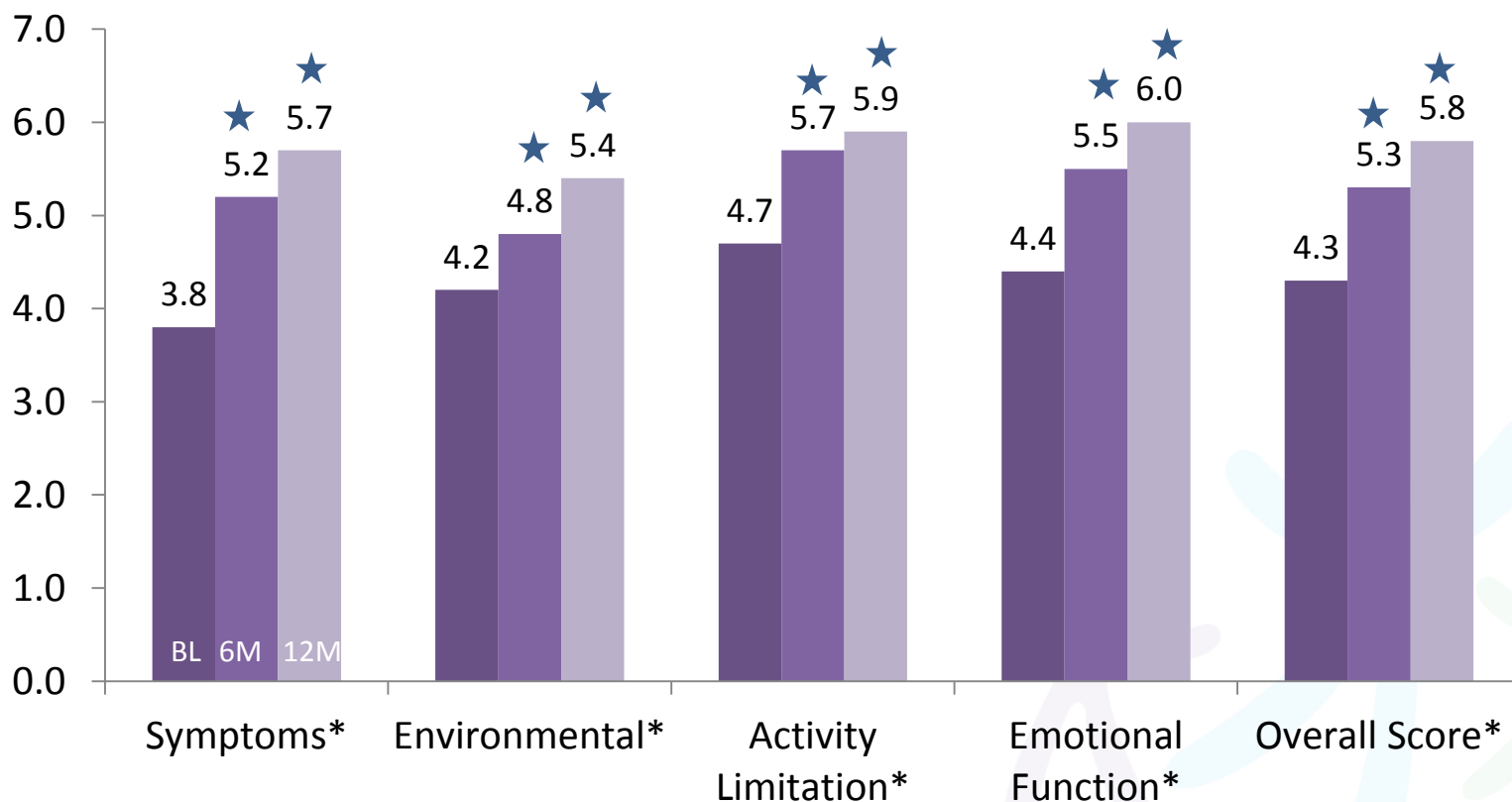
Figure 3: Caregiver Asthma-Related Quality of Life Scores at Baseline and at Twelve Months Following the Intervention (n=68)



★ Statistically significant difference found ($p < 0.05$) using Wilcoxon signed-rank non-parametric test

Results: Adult Quality of Life

Figure 4: Adult Asthma-Related Quality of Life Scores at Baseline and at Twelve Months Following the Intervention (n=30)



★ Statistically significant difference found ($p < 0.05$) using Wilcoxon signed-rank non-parametric test

Summary

- Statistical improvements for current enrollees in:
 - Health resource utilization
 - Symptom frequency
 - Quality of Life indicators at 6M and 12M (adults and caregivers)
- Cost savings
- Value proposition:
 - Significant opportunity to improve process measures around recruitment and retention through increased collaboration and navigating barriers.

Recommendations

- Build and maintain relationships with potential payers and partners
- Find a program champion
- Provide compelling data that makes the case for your program
- Build in process measures and methods to evaluate barriers to goal
- Leverage the interdisciplinary team and power of CHW relationships
- Don't give up!

Contact Information

Julie Kuhn

Supervisor of Program Initiatives

Sinai Urban Health Institute

julie.kuhn@sinai.org

773-257-2621

Sally Szumlas

Vice President, Care Management & Quality

Family Health Network

sszumlas@myfhn.com

312-995-1899