Great Lakes Regional Asthma Summit: Sustainable Funding for In-Home Asthma Interventions

Making Your Case and the Value of In-Home Asthma Management

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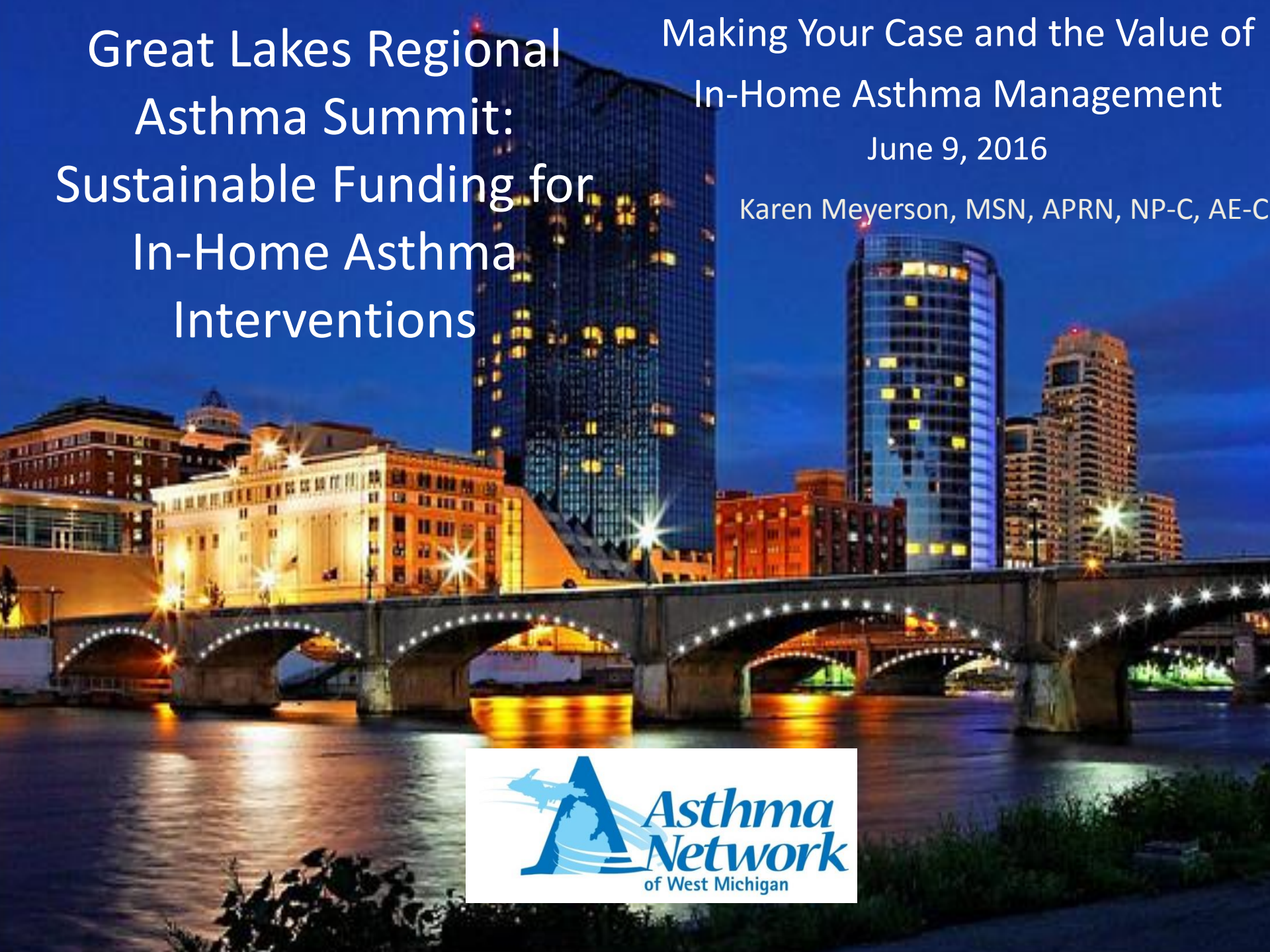


Despite the development of more effective treatments for asthma, we have not seen a corresponding decrease in asthma morbidity.

What are best practices for asthma management?

Implementing Best Practices

- "Abundant scientific evidence that asthma self-management programs reduce urgent care visits and hospitalizations and improve overall health status," (EPR-3).
- **Five key elements** of a successful asthma program (U.S. EPA):

1. Committed Leaders and Champions
2. Strong Community Ties
3. High-Performing Collaborations & Partnerships
4. Integrated Health Care Services
5. Tailored Environmental Interventions

Asthma Network of West Michigan

- **Date established:** January 1994, as the grassroots asthma coalition serving West Michigan
- **Location:** Grand Rapids, Michigan
- **Population:** 121,764 people with asthma - 3 counties
- **Target population:** children (<18 years) with uncontrolled asthma from low-income families (we also serve adults)
- **Population served:**
  - 33% African American, 32% Hispanic/Latino, 15% Caucasian
  - 82% children; 78% covered by Medicaid; 20% uninsured/under-insured
- **Original funding:** Local foundations & hospital systems
  - Created direct service arm in 1996 (**20 year anniversary!**); obtained non-profit status in 1997

Building a Better Program: Committed Leaders and Champions (#1)

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 for any organizational advantage
  - Tried to ensure mission/program alignment and didn'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

Building a Better Program: Strong Community Ties (#2)

- Included our community in program planning
- Engaged our community "Where it Lives"
- Recruited asthma champions
- Collaborated with:
  - Hospital systems
  - School districts
  - Health care providers/clinics
  - Local universities
  - Foundations
  - Corporations
- Engaged health plans

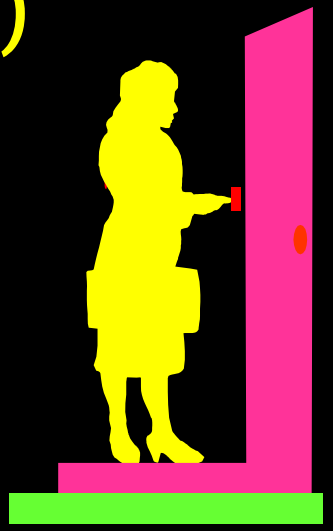
Building a Better Program: High Performing Collaborations (#3)

- Collaborated to build credibility – we wanted to become indispensable to our community
  - Medical home pilot
  - Research studies
- Engaged health plans
  - Offered a trial period
  - "Payer Summit" for sister communities replicating our model
  - Responsive and flexible – Muskegon, COPD

Integrated Health Care Services Goals (#4)

- Identify and **address systems barriers** that prevent patients from optimally managing asthma
- **Increase access** to, availability, and coordination of asthma services for children on Medicaid
- **Standardize asthma management** in Kent County
- **Reduce emergency department use and hospitalizations** related to asthma among target population

Tailored Environmental Interventions (#5)



- Home-Based Case Management:
  - Home visits conducted by:
    - AE-Cs, LMSW and CHWs
  - School/daycare visits
  - Physician care conferences
  - Licensed masters social worker (LMSW who is also AE-C) assists with psychosocial barriers
- Health professional education / technical assistance
  - In-services for providers and office staff
    - Spirometry, asthma medications & devices, asthma guidelines, Asthma Action Plans, etc.

Referral Sources

- Health Net
- Inpatient population/ED
- Physician practices/clinics
- School nurse
- Public Health Nurse
- Self-referral
- Managed Care Organizations
- “No wrong door” for referrals!

Case Management Model

- 5 AE-C Home Visits in 3 months
- 3 monthly visits thereafter
- 1 visit to medical home
- 1 visit to school or daycare
- 2 LMSW visits
- Target: 6 - 12 visits over 6 - 12 months
- CHW enroll patients and conduct follow-up visits after discharge

Staffing – Case Managers

- Nurse (RN) or Respiratory Therapist (RRT)
- Must be AE-C when hired or become a certified asthma educator within one year of employment
- Expertise in asthma & home care desirable
- ANWM covers cost of review course, Self-Assessment Exam (SAE), as well as cost of the exam and then re-certification by exam or CEUs

Staffing – Licensed Masters Level Social Worker

- Dually certified as an AE-C so can function as a case manager as well as LMSW
- Conducts psychosocial screening with each family enrolled to assess for needs
- Provides psychosocial support for families
- Refers to community agencies/resources as indicated
- Can engage in short-term counseling
- Resident expert in CPS cases

Home Visit

- Asthma education lessons
- Review medication adherence
- Review medication technique
- Environmental assessment
- Basic needs/psychosocial assessment
- Connect to community resources
- Connect to medical home
- Address barriers to asthma control
- Reimbursable visit –either AE-C or LMSW

Care Conference

- Conducted with PCP (and possibly specialist as well) with or without family present
- Goals:
  - Elicit a written asthma action plan
  - Discuss adherence issues, including psychosocial barriers to asthma management
  - Discuss access to care issues - PCP visits, devices, medication refills, etc.
- Reimbursable visit

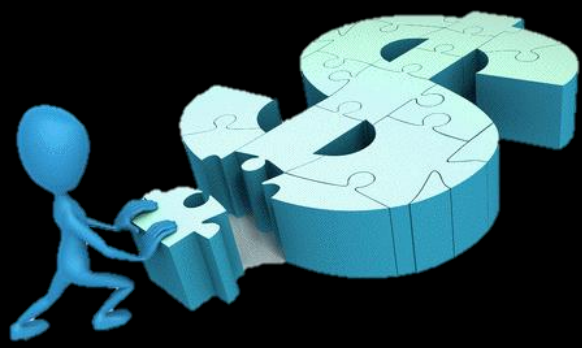
School/Daycare Visit

- Scheduled with key school personnel:
  - principal, school nurse, classroom teacher, phys. ed. teacher, and/or school secretary
- May provide in-service for entire staff if requested
- Discuss key issues concerning child's asthma and psychosocial or learning barriers identified by school
- Provide with copy of AAP - ensure school staff understands how to implement
- Reimbursable visit

Partnerships with Health Plans

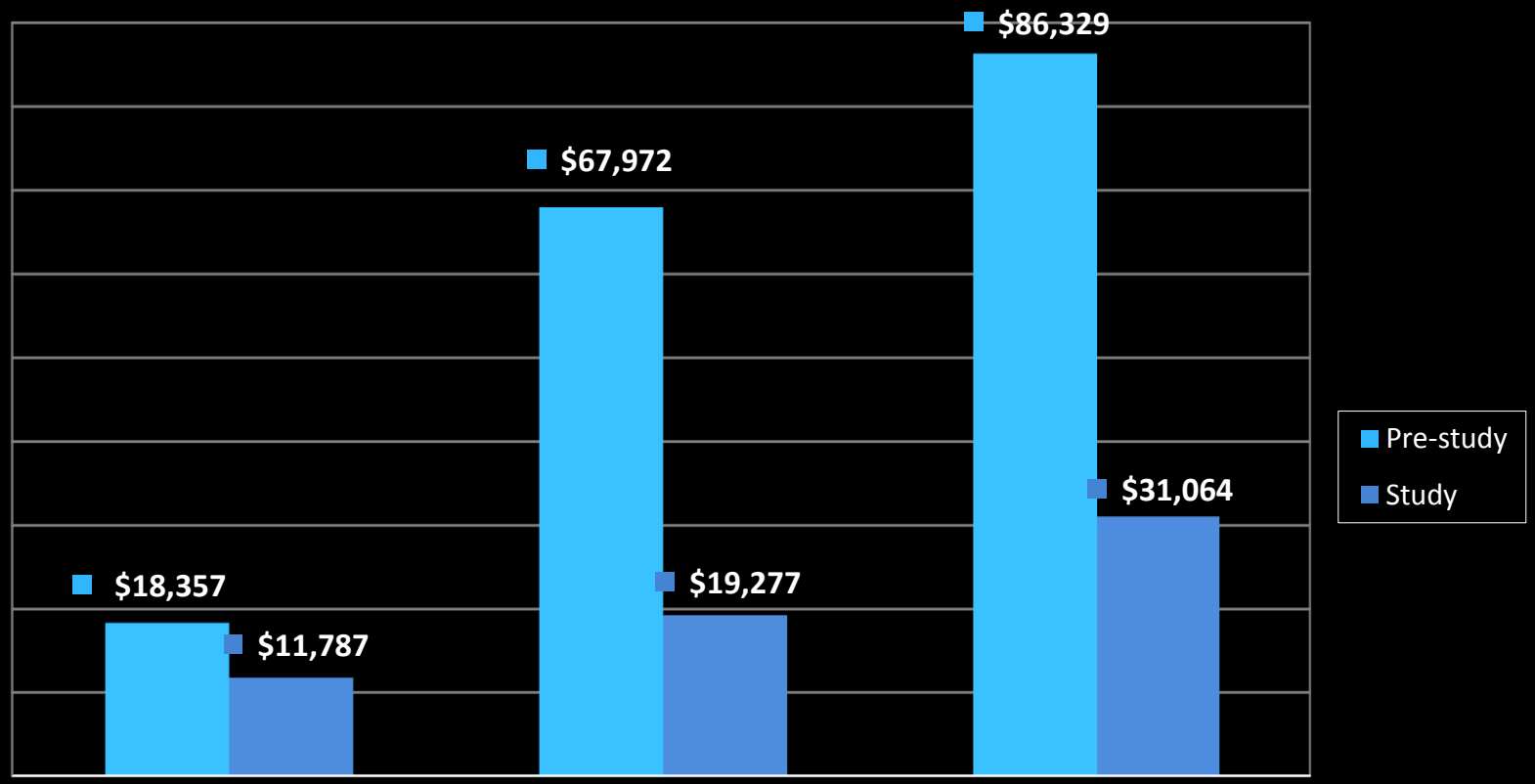
- First asthma coalition in the nation to contract with health plans for home-based asthma case management
- Some health plans authorize 18 visits, others authorize fewer and AE-C must call and justify the need for more visits
- Target members with uncontrolled asthma
- Signed contracts with 4 health plans
- Reimbursement (~$100,000) covers ~1/4 of our operating budget ($400,000)

Leveraging Assets and Resources



- Primary expenses are staff salaries, mileage, and supplies
- Current Funding Sources
  - Secured sustainable funding from Community Benefits or operating funds from 2 largest hospital systems
  - Reimbursement from contracts with 4 health plans
  - Foundation /grant funding, including Amway Corp. and United Way
  - Expanded services to members with COPD at the request of our largest payer
  - Technical assistance revenue for replication of model

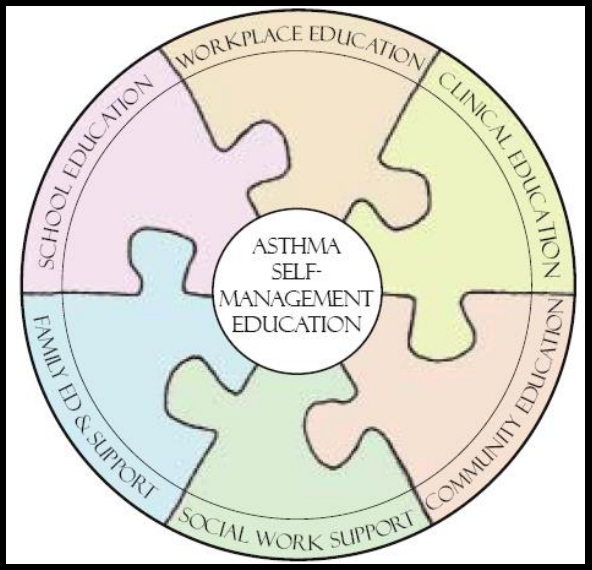
Outcomes:
Reduced Hospital Charges



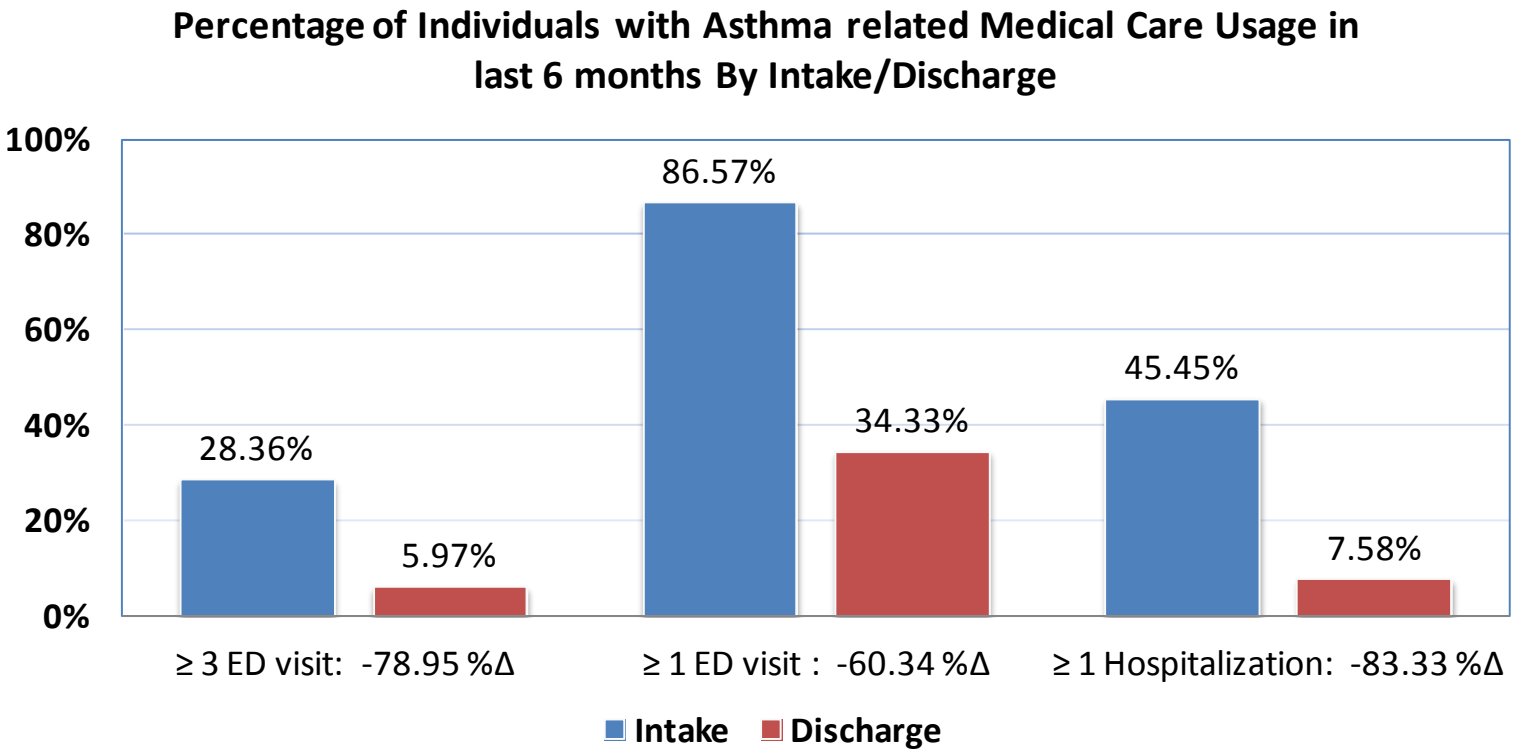
Total hospital charges decreased by **$55,265** from pre-study year to study year

Managing Asthma Through Case Management in Homes (MATCH)

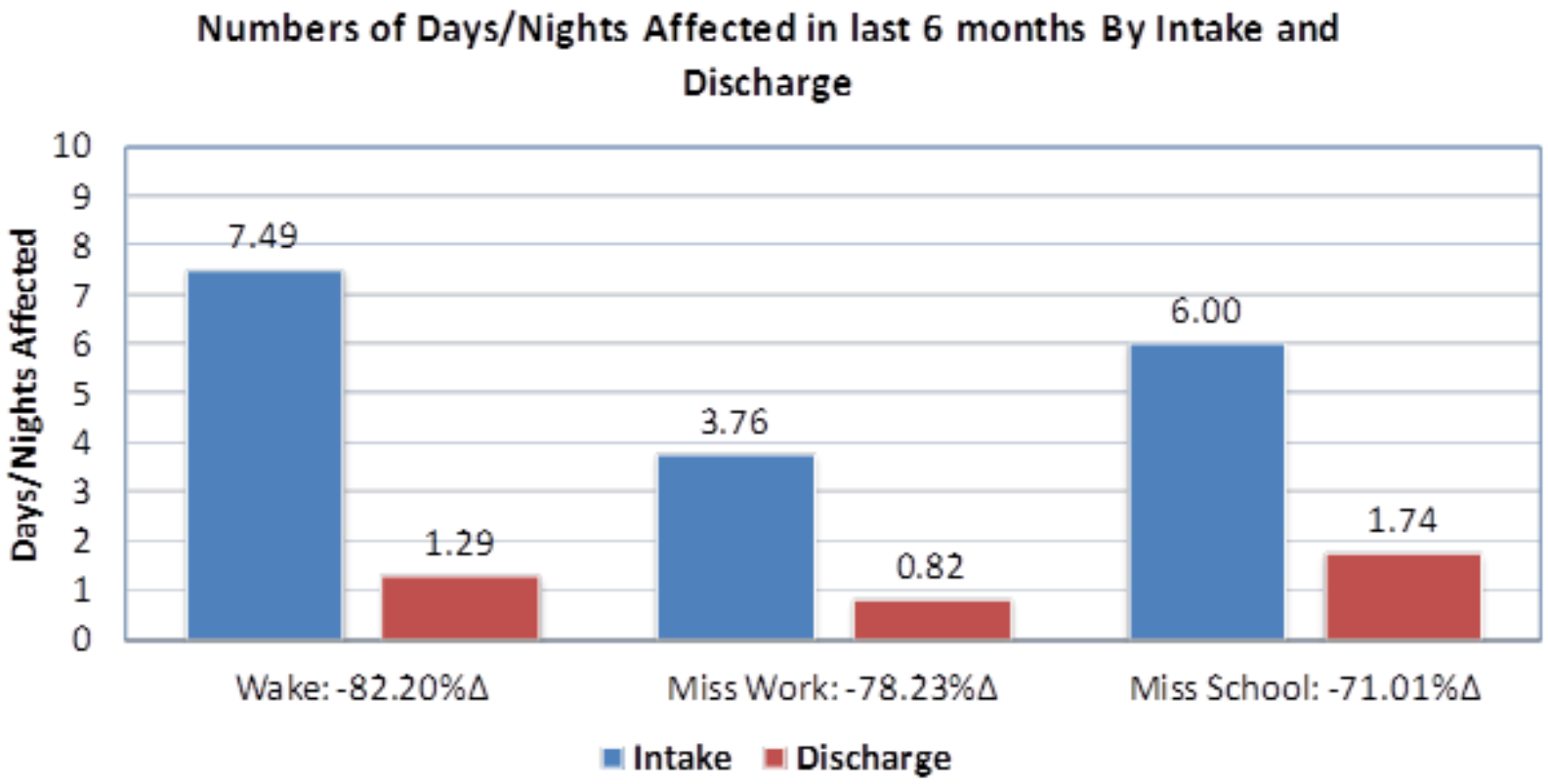
- Three established Michigan MATCH programs
  - Asthma Network of West Michigan
  - Hurley Medical Center
  - St. Joseph Mercy Health System
- Children and adults with asthma
- MATCH model
  - ≥ 6 visits
  - ≥ 5 months between Intake and Discharge visits



MATCH Outcomes: Utilization



MATCH Outcomes: Quality of Life



Major Achievements & Results

The results we're most proud of:

- Designed and implemented a comprehensive home-based asthma case management model
- First asthma coalition in the nation to partner with a health plan and obtain reimbursement for services
- Long-term partnership with health plans who report cost savings and positive return on investment (ROI)
- 40% decrease in hospitalizations (Priority Health, 2014)
- 25% decrease in ED visits
- Two national U.S. EPA awards:
  - "National Model Asthma Program" (2006)
  - National Environmental Leadership Award in Asthma Management (2008)

Our Value Proposition: The Business Case for an Asthma Program

For $400,000, the Asthma Network will improve asthma outcomes for 300 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 $212,000* per year in net cost savings to the healthcare system through 40% fewer hospital admissions and 25% fewer ER visits.

* $1.53 return for every $1 invested (2012) so $612,000 - $400,000 = $212,000 net savings

Thank You!

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