

Asthma Disease Management Program – 2008

The Asthma Disease Management Program is designed to assist HealthPlus Commercial and Medicaid members in making safe, appropriate, and informed health care choices for their chronic condition, and to assist the providers who care for them to improve member health status. This is achieved through the development of a multi-disciplinary, continuum-based approach which targets both health and utilization behaviors of members with asthma.

The Program creates and maintains key desired behaviors of an asthma population and the providers who care for them to improve member health status, thereby reducing health care costs. The Program incorporates all interventions necessary to optimize patient care. These interventions are based on the most up-to-date, evidence-based HealthPlus Diagnosis and Management of Asthma clinical practice guideline, developed and reviewed by physicians.

Objectives:

The primary objectives of the Asthma Disease Management Program are to:

- Prevent acute exacerbations of the disease
- Reduce risk of member acute exacerbations and death
- Educate and empower members toward self-management of asthma and co-morbidities
- Improve members' quality of life through lifestyle management support and goal setting
- Educate and support physicians through evidence-based medicine

Program content information and decision support activities are directed at improving/maintaining member health status and include condition monitoring, patient adherence to treatment plans, management of co-morbid conditions, management of lifestyle issues (such as goal setting, techniques, problem solving), and community resource support.

Eligibility: Members with asthma, ages 5-56, are identified through medical and pharmacy claims analysis and referrals using any one of the following claims criteria or referral sources without continuous enrollment requirements:

1. At least 4 asthma medication (as defined in the HEDIS[®]NDC list) dispensing events in the last 12 months; **or**
2. At least 1 Emergency Room visit with a primary diagnosis of asthma (ICD-9 493) in the last 12 months; **or**
3. At least 1 inpatient discharge with a primary diagnosis of asthma (ICD-9 493) in the last 12 months; **or**
4. At least 4 outpatient visits that include a diagnosis of asthma (ICD-9 493) and 2 asthma medication dispensing events in the last 12 months; **or**
5. Physician, UM, or Case Management referral based on symptoms and treatment plan; **or**
6. Health Risk Appraisal results; **or**
7. Member referral.

Enrollment and participation in the program is automatic once HealthPlus identifies the member's eligibility. The asthma registry is updated monthly. Newly identified members receive an introductory packet explaining how members become eligible to participate, how to use the program, and how to opt out. All inpatient admissions are evaluated for case management interventions. Members who meet eligibility criteria remain in the registry and are eligible for the program unless they choose to opt out of the program. Members can request to opt out of the program by calling 1-800-345-9956, ext. 1943, option 4, or by e-mailing dismgmt@healthplus.org.

Physicians can enroll a member in the program and/or receive additional information about the asthma program by calling HealthPlus at 800-345-9956, ext. 2186, to speak to a Disease Management Coordinator, or by e-mailing dismgmt@healthplus.org.

Interventions based on stratification:

Disease management programs are targeted to patients that will most likely benefit from the intervention. Identifying those patients and determining their level of risk (and the necessary level of intervention) requires sophisticated retrospective claims analysis tools.

Eligible members are stratified into one of three mutually exclusive risk levels (Low, Moderate, or High). Re-stratification of the members in the registry occurs at least annually.

High

The member is identified as having asthma and has met one or more criteria either through claims (including pharmacy) data or telephonic assessment and must meet one or more of the following criteria, with a primary diagnosis of asthma used for ER visits and/or inpatient admissions.

- ≥ 2 Emergency Room (ER) visits in last 6 months
- ≥ 1 inpatient admissions in last 6 months
- Oral steroid prescription filled in last 12 months
- Not on either a short-acting bronchodilator or anti-inflammatory in last 12 months

Moderate

The member is identified as having asthma, not previously identified as high risk, and has met one or more criteria listed:

- 1 ER visit in the last 6 months with a primary diagnosis of asthma
- Not on an anti-inflammatory agent, but on short-acting bronchodilator in last 12 months

Low

The member is identified as having asthma and does not meet criteria for the moderate or high-risk levels.

How the HealthPlus Asthma Program works with physicians and their Commercial and Medicaid patients:

Note: TPA members receive informational mailings, and their PCPs receive profile reports; but they do not receive phone calls or case management related services.

**Member Interventions
Commercial and Medicaid Members**

Risk Level → Intervention ↓	Low	Moderate	High
Introductory letter and program packet informing how member was identified, how to use the services and how to opt out	Once initially	Once initially	Once initially
Disease-specific newsletter	Twice a year	Twice a year	Twice a year
Standard of care service reminders in newsletter	Annually	Annually	Annually
Automated telephonic standards of care reminder	Annually	Annually	Annually
Satisfaction survey	Annually	Annually	Annually
Web-based personalized support and education	Ongoing	Ongoing	Ongoing
Missed services reminder letter with controller med information		At least once a year	At least once a year
Missed services automated telephonic standards of care reminder		At least once a year	At least once a year
Letter to members identified as high rescue medication users		Once a year	Once a year
Asthma special equipment		As needed	As needed
Telephonic assessment for standards of care compliance after ER visit twice within 90 days			Monthly
Case management discharge telephonic assessment for standards of care compliance after inpatient admission for asthma			Each discharge
Enrollment for case management (post hospitalization)			As needed
Referral to case management			As needed

Physician Support

Intervention	Frequency
Program update mailing (including clinical guidelines) to PCPs and appropriate specialists	Annually
Provider Manual introduction to program	Once initially
Asthma Care Profiles identifying potential missed services to PCPs	At least annually
Report of high albuterol use members with date of last office visit	Annually
Notification of disease management program information	Annually
Compliance reports (with comparative analysis) to PCPs	Annually
Educational presentation on pharmacy utilization to high volume providers	As needed
Office Staff Forum on HEDIS®	Annually
Educational tools provided to offices through website with mail option (e.g., inhaler instruction sheets, asthma care flow sheet, peak flow meter instruction sheets) and asthma management tools (e.g. action plans, peak flow meters)	As needed

Explanation of Member and Physician Interventions:

- **Standards of care service reminders:** Included annually in the asthma newsletter are asthma-related standards of care service reminders. Reminders urge members/parents/guardians to talk with their doctor about updating the asthma action plan and how to use anti-inflammatory medicines for long-term control, monitor peak flow, use “rescue” medicines, get a flu shot every year, get a lung exam every year, and respond to an emergency.
- **Asthma Educational Materials:** The newsletter members receive twice a year also contains information useful in the self-management of asthma. The newsletter highlights other sources of information including the HealthPlus website, www.healthplus.org (select “Providers,” then “Patient Education” and Asthma Educational Materials). The newsletters also include information about how to use asthma program services, how members become eligible to participate, and how to opt out of the asthma program.
- **Asthma missed services reminder letters:** At least annually, reminder letters are mailed to members, who have been identified as not using at least one anti-inflammatory controller prescription in the prior 12 months. The letter is mailed under the PCP’s name (with permission) or under Plan medical director’s name if the PCP does not give permission.
- **HealthPlus website information:** Information about asthma includes materials and links to the websites for the Asthma Initiative of Michigan; Asthma and Allergy Foundation; National Heart, Lung and Blood Institute; the American Lung Association; and StayWell-supported asthma disease management information.
- **Asthma special equipment:** Members can obtain nebulizers, as medically indicated, and spacers. Peak flow meters are available to members under their DME benefit.
- **Members receiving emergency room services for asthma** are called and assessed for education and self-care needs, using a scripted approach. Selected self-care information is sent.
- **Case management:** Members with asthma and complex care needs qualify for evaluation to enroll in HealthPlus case management.
- **Co-morbidity evaluation:** Members in the Asthma Program who are discharged from the hospital with a primary diagnosis of asthma are evaluated for case management. The assessment process includes a thorough evaluation of the patient’s medical conditions and psychosocial issues. The case management program involves ongoing management of the patient’s conditions. Members called for telephonic assessment due to evidence of poor control are provided information about depression assessment and care available.
- **Member surveys** are mailed annually to a sample of members with asthma to measure satisfaction with the disease management program as well as productivity, absenteeism, and perceived health status.
- **Coordination with Tobacco Cessation and Depression Screening Services** is available to members receiving Asthma Disease Management Services.
- **Asthma Care Profiles:** Member-specific reports are sent to PCPs of recent asthma-related services, including spirometry testing and medication fills, as well as ER visits, inpatient admissions, and medication management. This report is produced at least annually.
- **Asthma medications dosage review and analysis** is conducted at least once a year and reported to physicians as a component of the Asthma Care Profile for their patients identified with persistent asthma. The reports identify if the member claims indicate low use of oral or inhaled corticosteroids (HEDIS® qualifying controller medications) and high use of rescue medications. Also reported is last office visit date and ER/hospital inpatient visits for asthma-related illnesses.

Participation Rate:

HealthPlus measures the participation rate for the asthma program annually. The participation rate for this opt-out program in the years 2006 and 2007 is reported below.

			2006 Commercial	2006 Medicaid	2007 Commercial	2007 Medicaid
Participants (numerator)			1,716*	2412*	1,745	3,175
Asthma population (denominator)			1,778*	2490*	1,846	3,339
Participation rate			96.5%	96.9%	94.5%	95.1%

*NCQA redefined HEDIS® specifications for persistent asthma identification. HealthPlus incorporates these specifications into the identification methodology used for the Asthma Disease Management Program.

Measures of Effectiveness:

HealthPlus employs and tracks at least one performance measure for each disease management program. Each measurement:

- Addresses a relevant process or outcome
- Produces a quantitative result
- Is population based
- Uses data and methodology that are valid for the process or outcome measured
- Has been analyzed in comparison to a benchmark or goal

Current measures include:

HEDIS®:

- Use of appropriate medications for people with asthma
 - 5-9 year olds
 - 10-17 year olds
 - 18-56 year olds
 - Total (combined rate)

Non-HEDIS® Measures methodology descriptions for 2007 Asthma QI Program description:

- High Use of Albuterol (ten or more canisters of albuterol dispensed within a twelve-month period)
- High Risk with High Use of Albuterol (see above) with either no oral inhaled steroids in the prior twelve months or a medication possession ratio of less than 70% for the time within the prior twelve months on the medication. (Days Supply from MedImpact divided by days on the medication)
- ER Visit with Asthma Diagnosis (CPT of 99281-99285 with a primary diagnosis of 493 within the prior twelve months)
- **Office visit at least annually**

Denominator: HEDIS® specifications for Use of Appropriate Medications for People with Asthma including age and continuous enrollment criteria. Members without a pharmacy benefit are excluded.

Numerator: The count of unique members from the eligible population with at least one (1) preventive/ambulatory health services visit with a PCP (internal medicine, family practice, general practice or pediatrics), pulmonologist or allergist within the reporting year, using HEDIS® specifications for Children's and Adult's Access to Preventive/Ambulatory Health Services for the codes to identify Preventive/Ambulatory Health Services.

Member Satisfaction:

HealthPlus annually evaluates satisfaction by evaluating member survey results and member complaints.