



Asthma

Care Coordination

Introduction

eQHealth solutions utilizes the National Coalition on Care Coordination (N3C) definition of Care Coordination: “Care Coordination is a person-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which a Care Coordinator manages and monitors an individual’s needs, goals, and preferences based on a comprehensive plan.”

For the frail or elderly, children, those who suffer from multiple chronic conditions, and/or have limited support systems, finances, and resources to access the health care system, Care Coordination is important. This population requires both medical and social support to address these issues. To be successful, Care Coordination must focus on:

- Establishing an interdisciplinary team
- Developing and implementing individualized care plans
- Coaching and behavior modification to promote participant self-care
- Coordinating care across all health care settings
- Providing for the social support needs of this population
- Providing condition specific physician and clinical practice guidelines
- Providing education and assistance in meeting the recommended standards of care

These components support the Care Coordination philosophy of integration of clinical treatment guidelines, disease prevention strategies, participant self-care education, and social support services while demonstrating a quantifiable cost savings to the payer.

Clinical Practice Recommendations

Clinical Practice Guidelines are evidence based statements and recommendations written by clinicians and multidisciplinary panels. The Asthma Care Coordination program is designed around the National Asthma Education and Prevention Program Expert Panel Report 3 “Guidelines for the Diagnosis and Management of Asthma” and the Milliman Asthma Chronic Care Guidelines.

The Asthma Care Coordination Program includes: transitional care interventions after an acute, inpatient stay, program introduction, in-person and written disease specific education, general health reminders, telephonic/in person health coaching and behavior modification, telephonic and/or in person disease assessments with a Care Coordinator, including medication adherence, coordination assistance with social/community resources, and the development of individualized plans of care for each participant based on national guidelines and with participant input..

Asthma Background

More than 22 million Americans have Asthma. Asthma is one of the most common chronic diseases affecting children with over 6 million children diagnosed nationally. The burden of Asthma affects the participant, their quality of life, their family, and society in terms of lost productivity (school and work) and the financial strain on the public healthcare system.

Despite these statistics, Asthma is a manageable condition allowing individuals to maintain active, healthy lives.

Objectives

The objectives of this program are consistent with those set forth by the National Asthma Education Program sponsored by the U.S. Department of Health and Human Services.

The program is a comprehensive approach to addressing Asthma treatment options and self-management within high risk populations. It focuses on both the participant and family/caregiver's medical and social needs.

Objectives:

- Participant achievement of optimal health through the administration of an HRA and disease specific assessments, self-care education, coaching and behavior modification, wellness screenings, in person and telephonic on-going engagement and resolution of barriers to care
- Promote physician understanding and adherence of the NAEP practice guidelines
- Early identification of participants for earlier intervention by Care Coordination staff
- Develop a community resource network to work in conjunction with Care Coordinators and physicians to address participant socio-economic barriers
- Promote a multidisciplinary approach to care of high risk populations
- Create a strong participant-physician-Care Coordinator relationship
- Demonstrate cost savings related to the integrated Care Coordination program
- Improve participant quality of life

Program Inclusion and Exclusion Criteria

Inclusion Criteria

- One year of continuous eligibility enrollment
- Claims Data:
 1. At least two claims with a code of 493* based on Emergency Department, Inpatient and MD office claims
 2. Pharmacy claims for Asthma medications, at least one claim in a year

Exclusion criteria

- 020 Emergency Certification
- 021 Illegal alien
- 029 Family Planning
- 031 Qualified Medicare Beneficiary
- 041 PLAD < 100% FPL
- 042 PLAD < 120% FPL
- 043 PLAD < 135% FPL
- 046 PLAD – Cancer waiver
- 047 PLAD – Renal disease waiver
- 048 PLAD –Transplant waiver
- 061 Hospice
- 087 Pregnant Women – 133%
- 088 Pregnant Women – 185%
- KK K-Baby
- Lock-in type HSP (Hospice).
- Members Who Opt-Out of Program

Severity Stratification

Eligible Asthma participants will be initially stratified into four severity levels based on claims data. Stratification is re-evaluated each time new clinical information is received, each time there is a Care Coordinator-participant encounter, and/or at least every six months for the entire population.

The severity assigned to a participant determines the type and intensity of interventions that the member will receive as part of Care Coordination.

**Note: Pregnant women are only excluded from predictive model referrals. Any referrals of pregnant women from Utilization Review, facilities or physicians will be accepted.*

Severity Levels

Educational Outreach

Asthma with ICD-9 code of 493* AND:

- **No hospitalizations in the last 12 months**
- **Less than 2 ER visits in the last 12 months**
- **Adherent with medications, based on pharmacy claims**

Low

Asthma AND AT LEAST ONE of the following:

- **At least two emergency department visits for 493* – Principal diagnosis ONLY.**
- **An Asthma medication index less than 0.5 (defined below)**

Medium

Asthma AND AT LEAST ONE of the following:

- **Any prescription for oral corticosteroids**
- **Any code for Status Asthmaticus (493.01 or 493.11) – Principal or secondary diagnosis, inparticipant and/or ED claims only.**

High

Asthma and at least one of the following:

- **2 or more inparticipant hospitalizations with LOS \geq 1 day for 493* - Principal diagnosis only.**
- **At least one co-morbidity**

Children 0-4

In addition to the above severity levels, children under 4 years old with identified claims for Asthma will be placed into a separate category for **Infant Asthma**.

Because of the special needs of this group, eQHealth Solutions has created a separate category with separate assessment for this population. The intent of this separate population is to identify those children who seemingly have a true diagnosis of Asthma and ensure they are getting the proper medications to prevent exacerbations and impairment.

Once an assessment is completed, the infant will be placed in one of the pre-defined severity levels.

Asthma Medication Index: The number of dispensed Asthma anti-inflammatory meds/ (number of dispensed Asthma anti-inflammatory meds + number of dispensed beta2 agonists).

Care Coordination staff will validate the participants' diagnosis of Asthma and their agreement to participate in the program at the time of initial contact. Any participant, or legal guardian/caregiver, who does not willing want to participate in the program, can opt out at any time.

Low, medium, and high-risk members who are unable to be contacted will receive educational outreach interventions and are reevaluated every six months for updated demographic information.

All enrolled participants are processed through a stratification algorithm and are re-assessed every six months for current severity. If the stratification level has changed, the Care Coordinator will be notified of the change and the participant will be reassessed. If there is no change in the stratification, the Care Coordinator proceeds with the current plan of care.

Participant Interventions

Participant Introductory Call/Visit

All participants will receive either an introductory phone call/visit or educational literature in addition to an informational welcome packet. The Care Coordinators will attempt to reach the participant within **60 days** of identification to perform an initial health risk assessment (HRA) and SF12. The program welcome kit will provide the participant with information about the program, how they can opt-out if they do not wish to participate, and general Asthma education.

If the Care Coordinator is unable to reach the participant by telephone or in person after four attempts (including at least one after normal business hours call), a written notification is sent to the participant. If the participant does not respond to any attempts at outreach within 30 days, the participant is transitioned to the educational outreach level of the program to receive mailed material.

Participant Follow Up Calls/Visits and Disease Specific Assessment

All participants enrolled in Low, Medium, or High severity levels of the program will receive at least one additional call/visit in addition to the HRA call/visit. Follow up will consist of a disease specific assessment to document if the participant understands the diagnosis and self-management of Asthma. Based on the assessment, the member may receive further Care Coordinator interactions at scheduled intervals.

Care Transition

If a Care Coordination participant is admitted to the hospital for an inpatient stay, regardless of diagnosis, the Care Coordinator will be notified of the admission. The Care Coordinator will then reach out to the participant or legal guardian/caregiver while they are still in the acute setting. These participants will also be re-assigned to a High Severity level of management for the next 1-2months for intensive education, coaching and behavior modification of self-care measures, medication use and adherence, and follow up.

If a participant is admitted to the hospital with the diagnosis of Asthma and they are not currently part of the Care Coordination program, our Care Coordinators will make initial contact and enroll the participant into Care Coordination while the participant is still hospitalized.

Participant Education

All participants and their caregivers enrolled into Care Coordination will receive initial educational materials focused on an explanation of the Care Coordination program, program benefits, the opt out process and a general overview of Asthma.

As Care Coordinators interact with participants, it may be determined the participant could benefit from additional information. Care Coordinators will then either mail, email, or provide a copy of educational material in person to the participant. All educational material provided are reviewed with the participant by the Care Coordinator and is written on a 5th grade reading level. Any participant requiring additional information is assessed for any literacy issues prior to providing written materials. Other types of educational information, such as videos or items in a different language may be provided when deemed appropriate.

Educational wellness reminders will be sent to all program participants quarterly.

Multidisciplinary Team

A multidisciplinary team of healthcare professionals will collaborate to ensure the participants' needs are met. This is accomplished by addressing clinical, functional, financial, psychosocial, environmental, and support system needs. Team members include, but are not limited to, internal physician advisors, community physician advisors, treating physicians, registered nurses, pharmacists, community advocates and behavior health specialists. Any or all of these team members may participate in case conferences to coordinate care for individuals who require intense management.

Care Coordinators will be strategically placed within communities, physician practices and hospitals in order to reach more participants on a one to one basis and assist physicians with clinical support of the participants. With Care Coordinators and the participant as the focal point of the delivery model, they are able to provide clinical support so physicians can focus on administering clinical care then transitioning the participant to a Care Coordinator for disease education, medication education, etc. Care Coordinators will also identify social resources needed and make the appropriate referrals.

Individualized Plan of Care

Every participant enrolled in low, medium and high severity programs will work collaboratively with a Care Coordinator to develop an individualized plan of care consistent with national guidelines and the physician treatment plan.

James Prochaska noted that in order for behavior change to be successful a person must want to make the change and must be involved in how the change will occur. Care Coordinators will devise a list of participant problems based on the HRA and disease specific assessment responses. These problems will be reviewed with the participant and his/her family or caregivers when identified. The participant, with Care Coordinator guidance, will then be asked to provide input on methods to resolve the problems and which problems are most important to them at that particular time.

The Care Coordinator will supply the participant with any/all tools they may need to make informed decisions related to their problems and plan of care such as:

- Physician treatment plan
- Disease specific information
- Medication information
- Self-care education
- Referrals to community resources
- Referrals to specialty physician care
- Medical equipment

Low, Medium and High Level Interventions

- Care Coordinator access
- Welcome kit

- Nurse Calls/Visits providing health education, behavior modification and/or health coaching.
 - High level – At least 10 scheduled calls/visits
 - Call/Visit Schedule – Initial, then months 1, 2, 3, 4, 5, 6, 8, 10, and 12
 - Medium level – At least 6 scheduled calls/visits
 - Call/Visit Schedule – Initial, then months 2, 4, 7, 10, and 12
 - Low level- At least 2 scheduled calls/visits
 - Call/Visit schedule- initial and then month 2
- Assessment of the participant’s social and psychosocial support system
- Assessment of the participant’s physical environment (scheduled home visit or telephonic assessment)
- Access to community resources to assist with social, psychological, family, and/or financial needs
- Access to behavioral health resources to screen for depression/coping with chronic conditions
- Identifying and resolving gaps in care (wellness visits, physician follow up schedule, recommended follow up testing, medication adherence, etc.)
- Education materials tailored to the participant’s primary language and reading level
- Ongoing collaboration with the primary care physician
- Assessment of uncontrolled co-morbidities and development of an individualized plan to address them
- Evaluation of medications and medication adherence
- Quarterly general health reminders (such as annual flu vaccines)
- Ongoing reassessment and adjustment of the plan of care
- Evaluation and/or demonstration of self-care practices
- Annual participant satisfaction survey

Educational Outreach Interventions

- Access to a Care Coordinator if the participant chooses
- Welcome kit with HRA form for them to complete
- General Asthma literature
- Quarterly general health reminders
- Annual participant satisfaction survey

Physician Interventions

Local physician involvement is critical to a successful Care Coordination program. In order for participants to succeed in managing their chronic illnesses, they must be able to work with a primary care physician.

The Asthma Care Coordination program involves physicians/providers in the program by:

- Providing current NAEP Asthma guidelines through a provider web portal
- Providing written and/or verbal notification of participant involvement in the Care Coordination
- Ongoing communications between the participant’s Care Coordinator and the physician to assist with participant adherence and notification of emergent and non-emergent situations
- Access to real time participant profiles highlighting Care Coordination activities and how the provider ranks in standards compliance
- The Physician Asthma Care Education (PACE) Program provided by internal eQHealth staff
- Physician practice profiles
- Annual provider satisfaction survey

Program Evaluation

Program Outcomes will be measured at least semi-annually. Participant outcome measures will be compared to pre-enrollment baseline data. In addition, participants will be measured against those eligible participants who elected to opt-out of the program.

Population Reports

- Total eligible population (after exclusionary criteria applied)
- Distribution of eligible population by:
 - Age
 - Gender
 - Ethnicity
 - Geography
 - Severity Level

Program Reports

- Total # of program referrals
 - By Severity Level
 - By Referral Source
- # of Opt Out
 - Total
 - By Opt Out Reason
- # Participants engaged
 - Passive Engagement
 - Active Engagement
- Unable to Contact
 - Total % of enrolled unable to contact
 - # of unable to contact by severity level
 - # for each unable to contact reason
- Total # active participants by severity level
- Case Closure
 - Total # cases closed
 - # and % closed for each closure reason
- % of enrollees with severity level changes
 - # by change reason
 - # with severity increase
 - # with severity decrease
 - % of initial stratification changed after initial Care Coordinator assessment

Clinical Measures

- % of Asthma program enrollees taking controller medications
- % of Asthma program enrollees using rescue medications
- Asthma Medication Index (AMI)
- % enrollees with 2 or more MD office visits within the last 12 months
- % of enrollees getting an annual flu shot
- % of enrollees receiving a pneumovac within the last 5 years

Quality of Life Measure

- SF 12

Financial Measures (enrollees compared over time to eligible program participants who chose not to participate)

- Admits/thousand (program enrolled participants)

- Days/thousand (program enrolled participants)
- ALOS (program enrolled participants)
- % of total admissions for Asthma diagnosis (program enrolled participants)
- Admits/thousand for Asthma (program participants)
- # Asthma enrollees with ER visits
- # of total ER visits for Asthma (for Asthma enrollees)
- Pharmacy cost relation to overall cost

Provider Reports

- Annual satisfaction survey
- Individual provider profile related to adherence with national guidelines
- Participant report
- Peer comparison profile

Participant Reports

- Disease Specific and General HRA scores every 6 months
- Plan of Care
 - # problems resolved
 - # problems open
 - % goals met
 - # goals open
- Severity level change progression
- Behavior Change
 - Documented Asthma action plan
 - Documented controller medication adherence
 - Documented rescue medication adherence
 - Documented participant awareness of Asthma triggers
 - Documented use of peak flow meter

Program Quality Measures

- Annual enrollee satisfaction
- Annual provider satisfaction

Care Coordinator Productivity

- Total # participants referred
- Total # participants enrolled
- Total # participants unable to contact
 - Related to no valid phone #
 - Related to unable to reach the participant either in person or telephonically
- Total # Care Coordinator encounters
 - # Admission Encounters
 - # Participant Follow UP Encounters

Case Closure

Care Coordination cases will be closed when one of the following occurs:

- All program goals have been met and the participant is able to demonstrate and adhere to self care measures
- The participant requests to opt out
- Participant is no longer eligible for Care Coordination related to termination of benefits
- Participant expires
- Participant has no available contact information for Care Coordination to access them
- Participant's potential in the program has been met

