



NETWORK HEALTH

ASTHMA DISEASE MANAGEMENT PROGRAM DESCRIPTION

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1 Introduction

In 2007, the percentage of persons of all ages who experienced an Asthma episode in the past 12 months was 4.2%; and in 2007, 7.9% of persons of all ages currently had Asthma.¹ Millions of people in the United States are affected by Asthma, a chronic respiratory disease characterized by attacks of difficulty breathing. An Asthma attack is a distressing and potentially life-threatening experience. Scientific advances have greatly improved the understanding of the mechanisms that cause Asthma attacks and have led to effective medical interventions to prevent morbidity and improve quality of life. Yet, the burden in prevalence, health care use, and mortality remains high. Asthma remains a significant public health problem in the United States.²

2 Scope

In 2007, the Massachusetts Department of Public Health reported the rate of those currently with Asthma in the State to be 9.9% for adults (over 18 years of age) and 10.5% for children (under the age of 18).² Network Health reported for the same time period the rate of Enrollees currently with Asthma was 5.0%. Network Health's Asthma Disease Management program is a population-based approach to the clinical and quality management of this chronic condition. This approach identifies individuals with Asthma, and through the use of disease-specific interventions, attempts are made to alter the course of the disease. Referrals may be received from a number of sources: Network Health staff, practitioners, facility staff, vendors, health coaches, or self-referral by an Enrollee. The Disease Management team works collaboratively with other clinicians and licensed professionals at Network Health to improve disease state outcomes and maximize individual Enrollee functioning. Enrollees with complex issues or the need for more intense interventions are referred to Care Management. Program components include mailed educational materials, provider education on evidence-based clinical guidelines, telephonic Enrollee education (health coaching), and care coordination.

The clinical basis for our program was established by the U.S. Department of Health and Human Services Guidelines for the Diagnosis and Management of Asthma, and Network Health's Asthma care guidelines.

Midway through FY2010, Network Health launched a pilot care management program, Network Health Alliance (NHA). This launch occurred on January 4th 2010. The NHA program is the result of partnering with the parent company, Cambridge Health Alliance (CHA), and Commonwealth Care Alliance (CCA). A total of 1,500 members were selected and enrolled in this modified medical home program, and within that program Disease Management will be provided by nurse practitioners employed by Cambridge Health Alliance and serving as the primary care managers. Healthwise Knowledgebase

¹Early Release of Selected Estimates Based on Data From the 2007 National Health Interview Survey (released on 6/25/2008). National Center for Health Statistics, US Department of Health and Human Services, Centers for Disease Control. Accessed at the following Web address and page: <http://www.cdc.gov/nchs/about/major/nhis/released200806.htm#15> on 7/15/08.

² Massachusetts Department of Public Health, Health Survey Program Bureau of Health Information, Statistics, Research, and Evaluation. Profile of Health Among Massachusetts Adult, 2007, Results from the Behavioral Risk Factors Surveillance System. Published December 2008.

educational materials will be utilized on a regular and ad-hoc schedule for these enrollees. The identified population is excluded from the traditional Disease Management program with the vendor. Enrollees actively engaged with a health coach will be allowed transition time to the new program.

3 Program Structure

The components of Network Health's Asthma Disease Management program are described below. The program is depicted in flow-chart format in Attachment 1. A summary of program interventions are in Attachment 2.

3.1 General Educational Interventions

The goal of our general education campaign is to ensure that Enrollees, practitioners, and health plan staff are aware of the existence of the Asthma Disease Management program and how to access its services. Network Health targets two audiences in its general education campaigns: Enrollees and practitioners. Through distribution of disease-specific information, such as in member and practitioner newsletter articles and special mailings, Network Health attempts to raise awareness in Enrollee and practitioner populations about the signs and symptoms of Asthma and interventions to control this disease. Along with notifying an Enrollee who has Asthma and practitioners treating the disease about our program, these materials also provide support and encouragement for undiagnosed Enrollees to speak with their health care practitioners about possible symptoms, thereby reducing the rate of an Enrollee with Asthma who remains undiagnosed. Program information contains an option for Enrollees to "opt out" of the program or any parts of the program, and to "opt in" to portions of the program, such as health coaching.

Network Health informs practitioners about services offered to Enrollees with Asthma and how to use the Disease Management program through the *Provider Manual*, the Network Health Web site, provider updates, and new provider orientation.

3.2 Identification of At-Risk Enrollees

Identification of Enrollees with Asthma occurs monthly based on medical and pharmacy claims data using HEDIS® criteria (without continuous enrollment criteria). Additional identification includes Enrollee Health Risk Assessment (HRA), self, family, or practitioner referral.

3.2.1. Network Health uses the following mechanisms to identify Enrollees who might benefit from Asthma Disease Management program:

- Claims data
- Pharmacy data
- HRA results
- Referrals from UM and Care Management
- Referrals from Enrollees and practitioners
- Other Disease Management programs, as applicable

- 3.2.2.** Claims-based data sources are analyzed on a monthly basis to identify individuals newly diagnosed with Asthma by health coaching. Referrals from UM processes/data, care managers, practitioners and self-referral from Enrollees (including via HRA) occur on an ongoing basis. All Enrollees diagnosed with Asthma and all those who may benefit from the Asthma Disease Management program are eligible.

3.3. Program Steps

- 3.3.1.** Distribution of Network Health Asthma Disease Management program information starts with the Enrollee being sent a general awareness welcome letter that introduces some of the components of the program and the concept of health coaching. The mailing also notifies Enrollees of their access to an RN information line. Starting in January 2010, all Network Health members are made aware of the Asthma Disease Management program and the RN information line when they are sent “Welcome!,” a booklet which explains the Disease Management program that is part of their initial mailing from the plan. In addition, all Enrollees may receive Visiting Nurse Association home visits with environmental assessment after an emergency department or inpatient event for Asthma.
- 3.3.2.** A disease-specific mailing follows either the introduction letter (before January 2010) or the “Welcome!” booklet (after January 2010). It includes:
- Information about health coaching and condition monitoring including self-management of chronic disease
 - How an Enrollee is identified eligible for our program, a description of services included, and how to “opt out” (an Enrollee is presumed to be in the program unless they choose to “opt out”)
 - Information discussing Asthma Trigger identification, encouraging goal setting and appropriate lifestyle modification around exercise and smoking
 - Encouragement to work with their practitioner to develop and adhere to an Asthma Action Plan
 - Encouragement to call a health coach with a focus on behavioral modification, overall assessment of other health conditions as they relate to Asthma and overall health, goal setting, problem solving, etc.
- 3.3.3.** Condition monitoring occurs on an ongoing basis. Analysis of clinical gaps is performed and notification of any care gaps is provided to Enrollees and the Enrollee’s PCP through the following mechanisms:

Enrollee Notification

- Controller inhaler medications – claims within the past 5 months are analyzed for gaps in controller inhaler medications for Asthma.
 - If a gap is identified for a controller inhaler medication, a specific mailing is forwarded to the Enrollee identifying the gap, educating him/her about the importance of filling their prescription, and encouraging him/her to seek additional care to ameliorate the gap. The vendor utilizes a 180-day look back quarterly to select those members who require a mailing.

Practitioner Notification

- Trigger Reports to PCP for Enrollees meeting HEDIS® criteria (without continuous enrollment criteria) with Asthma needing controller medication with fax-back forms for PCP to provide feedback on individual Enrollees.
- Controller inhaler medications – claims within the previous 9-12 months are analyzed for gaps in controller inhaler medication for Asthma.
 - If a gap is identified, a mailing is forwarded to the Enrollee’s PCP identifying the gap. Gaps flagged in *yellow* are for the prescription that should be provided within the 9-12 month period and has not been filled; gaps flagged in *red* are for the prescription that was not filled within the 12-month period, which puts the Enrollee in a non-compliant category based on our clinical guidelines.

3.3.4. Stratification of Enrollees into low-, medium-, and high-risk scores is based on prescription patterns, ED and inpatient utilization patterns, co-morbid conditions and medical and pharmacy claims data. Risk scores are generated for all Network Health Enrollees which are predictive of increased severity of disease and a likely need of higher intensity of medical care.

- Enrollees identified as having the chronic condition and who are determined to have a high-risk score fall into the 85th-100th percentile.
- Enrollees identified as having the chronic condition and who are determined to have a moderate-risk score fall into the 60th-84th percentile.
- Enrollees identified as having the chronic condition and who are determined to have a low-risk score fall into the 0-59th percentile.

3.3.5 Additional interventions for moderate risk Enrollees:

- Enrollees receive automated outreach calls that notify them that they have access to a health coach, if desired. An automated transfer to a health coach is available during the call and a call-back option is provided.

- If the Enrollee chooses to speak with a health coach, s/he may provide one or all of the six dimensions of assistance (refer to section 3.3.7) which can be tailored to the Enrollees needs.

3.3.6 Additional Interventions for High-Risk Enrollees With:

- Persistent Asthma as identified by Network Health Disease Monitor Identification Criteria*
- A high-risk score (85 or higher), and
- Enrollees in Care Management for post acute stabilization receive:
 - Outbound calls from health coaches to encourage their participation in the health coaching program are made to chronic enrollees with risk rank of 90 and up. Refer to section 3.3.7 for a description of health coaching services.
 - Enrollees with a risk rank of 85-99 receive automated outreach calls that notify them that they have access to a health coach, if desired. An automated transfer to a health coach is available during the call and a call-back option is provided. Reaching the enrollees with the highest risk rank is enhanced by using both outreach methods.
 - A vendor is used to improve quality of the phone list for Enrollees with incorrect or inactive phone numbers, an attempt is made to correct demographic information to encourage participation in the health coaching program.
 - Intensive outreach to Enrollees who are identified by pharmacy data to have refilled 6 or more times a rescue inhaler medication in a 12-month period of time through a series of home visits by the Visiting Nurse Association for Asthma care self-management.
 - Care Management services for complex Enrollees with severe Asthma and significant comorbidities.

*(Similar to HEDIS ® Current Year Criteria for persistent Asthma, and expanded by eliminating requirement for:

- Continuous enrollment, and
- Duplicate identification in 2 consecutive years)

3.3.7 Health Coaching Services

- Health coaches provide support to individuals to facilitate improved behavior, motivation, confidence, decision-making skills, and knowledge and awareness of their disease and self-management.
- Six dimensions of assistance to facilitate moving the Enrollee through the disease self-management continuum are provided to high-risk Enrollees:
 - *Chronic condition support:* health coaches transfer skills to an Enrollee living with Asthma by providing awareness and an understanding of the condition, addressing gaps in care,

addressing lifestyle changes, and overcoming barriers related to treatment adherence.

- *Decision support:* health coaches apply shared decision-making methodologies to help transfer decision-making skills by using tools and models along with current medical information to discuss a decision regarding tests and treatment.
- *Decision support for symptom support:* health coaches and Enrollees used shared decision making tools and models along with current medical information to discuss a decision regarding an Enrollee's symptom(s).
- *Information support:* health coaches provide medical information, not directly associated with a decision, to an Enrollee.
- *Prevention support:* health coaches provide support to an Enrollee to help prevent complications, exacerbations, or development of health problems not associated with a chronic condition.
- *Provider communication support:* health coaches educate and support an Enrollee having general communication difficulties with his/her practitioner/s.

Any gaps in care or educational needs are reassessed and addressed during health coaching encounters; need-specific written materials are forwarded to the Enrollee as needs are identified.

If the health coach determines that more intensive Care Management is necessary s/he refers the Enrollee to Network Health's Care Management program.

4 Program Evaluation

4.1. Participation rates are measured annually. Network Health's Asthma Disease Management program is a passive participation program. Outreach success is monitored quarterly with a focus on successful outreach for high-risk Enrollees.

4.2. Program effectiveness is measured by:

- HEDIS® criteria for Asthma controller medication use
- Trending of ED and inpatient utilization.
- Percent of Enrollees with a high-risk score (85 or higher) engaged in coaching
- Predicted versus actual medical costs for Network Health Enrollees with targeted chronic diseases
- Complaints and inquiries about the program
- Enrollee satisfaction with the program

4.3 Excluded Network Health Members:

- Network Health members who are enrollees in the NHA program will be excluded from any reporting provided by Network Health’s vendor. General reporting related to Disease Management will include data on these enrollees. Network Health will also report separately on enrollees in the HNA program.

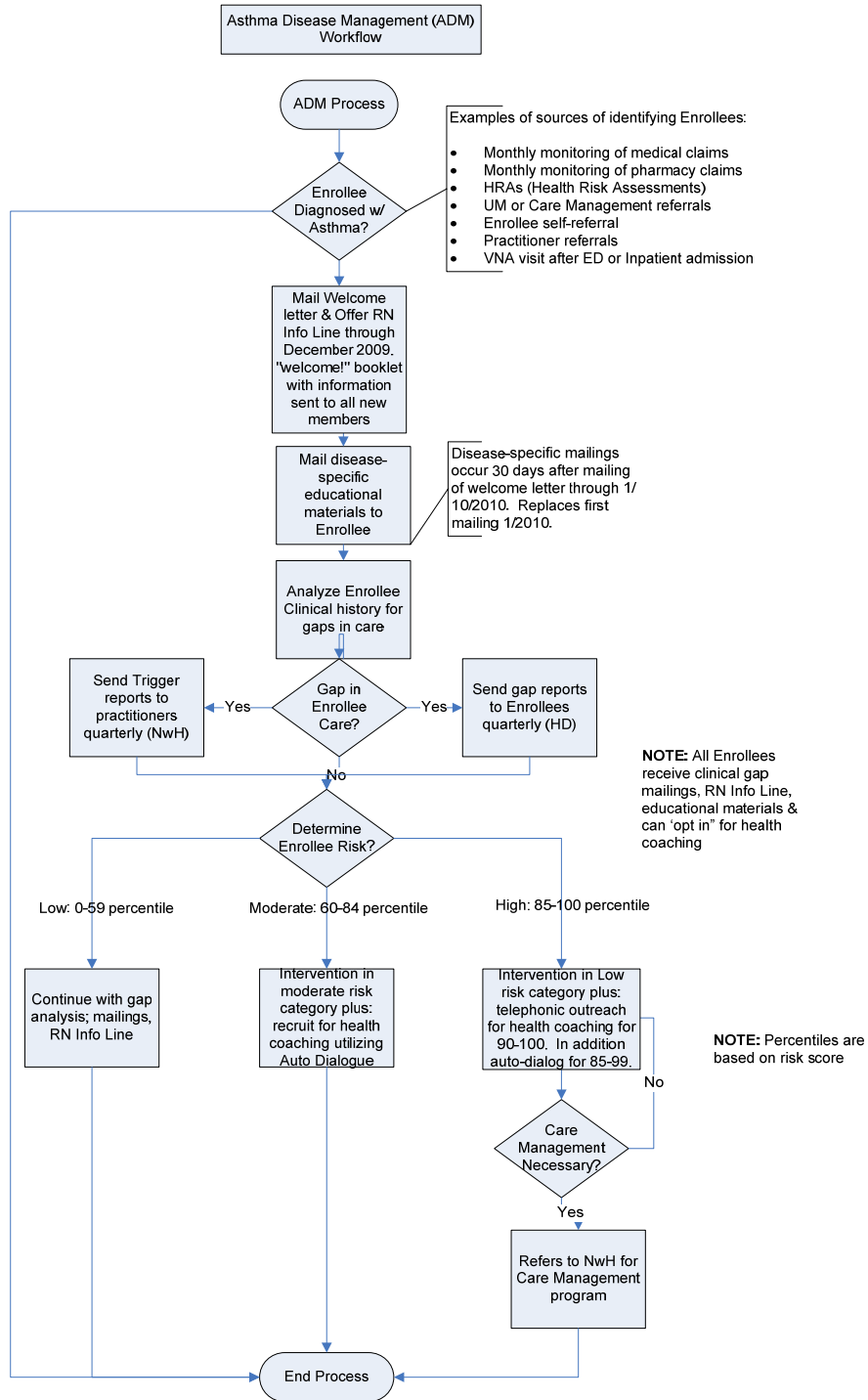
4.4. Asthma Disease Management Program Metrics:

The Asthma Disease Management program (ADMP) is evaluated annually using the following metrics.

Measure	Numerator/Denominator	Data Source/ Frequency of Analysis
Participation Rate		
Percent of Enrollees who participated in each intervention of the Asthma Disease Management program	Number of Enrollees who received each intervention/ Number of Enrollees who were identified for participation in the ADMP	ADMP/ annually
Enrollee Satisfaction Measures		
Asthma Disease Management program complaints & inquiry rate	Number of complaints received/Enrollees enrolled in the ADMP x 1000	Network Health Enrollee complaint logs/ annually
Results of Network Health’s Disease Management Enrollee satisfaction survey	N/A	Enrollee self-report/ annually
Clinical Effectiveness Measures		
Percentage of Enrollees compliant with use of appropriate medications for people with Asthma, per HEDIS®ASM specifications	Number of Enrollees compliant with use of appropriate Asthma medication/Number of Enrollees eligible, per HEDIS® specifications	Claims data/ annually
ED Discharges rate (among Enrollees with primary diagnosis of persistent Asthma, per HEDIS®ASM specifications)	Total number of ED discharges (primary diagnosis Asthma), among Enrollees with persistent Asthma/Enrollee with persistent Asthma as defined by HEDIS®ASM specifications per 1,000	Claims data/ annually
Acute inpatient hospital discharges rate among Enrollees with primary diagnosis of persistent Asthma, per HEDIS®ASM specifications	Total number of acute inpatient hospital discharges (primary diagnosis of Asthma) among Enrollees with persistent Asthma/ Enrollee with persistent Asthma as defined by HEDIS® ASM specifications per 1,000	Claims data/ annually

Measure	Numerator/Denominator	Data Source/ Frequency of Analysis
Percentage of Enrollees receiving environmental assessment performed by VNA	Total number of identified Enrollees that had home assessments/Total number of Enrollees as defined by HEDIS® ASM specifications and had an ED or inpatient admission	Claims data/ annually
Cost Savings Measures		
Cost savings per Health Dialog	Various measures of cost savings	Health Dialog predictive modeling/ annually

Attachment 1



Attachment 2

**Network Health’s Asthma Disease Management Program:
Summary of Program Interventions**

Network Health’s Asthma Disease Management Program Interventions	Low Risk	Medium Risk	High Risk
1. Welcome letter and disease-specific educational materials	✓	✓	✓
2. VNA visit after ED or inpatient admission	✓	✓	✓
3. Notification to Enrollee of clinical gaps	✓	✓	✓
4. Notification to Enrollees’ PCPs of impending clinical gaps	✓	✓	✓
5. Notification to PCPs of Enrollees’ actual clinical gaps	✓	✓	✓
6. Telephonic nurse support	✓	✓	✓
7. Automated calls to recruit for health coaching		✓	✓
8. Health coaching:			✓
• Chronic condition support			✓
• Decision support			✓
• Decision support for symptom support			✓
• Information support			✓
• Prevention support			✓
• Practitioner communication support			✓
9. Care Management program			✓