Breathe With Ease

Asthma
Disease Management
Program

MOLINA
Breathe With Ease
Pediatric and Adult Asthma Disease Management Program

Background

According to the National Asthma Education and Prevention Program (1997) asthma prevalence is increasing at an alarming rate nationally. It is the most common chronic disease of childhood. The disease accounts for approximately one in six pediatric emergency room visits and a 74% increase in hospital admissions for children under the age of 15. Asthma hospitalization rates have been the highest among blacks and children.

Molina Healthcare’s membership, as a largely managed Medicaid plan, is comprised predominantly of children (70% to 74%, depending upon the year under review.) Additionally, the membership in many of our health plans represents minority groups who suffer disproportionate asthma rates compared to the general population. Diseases of the respiratory system were found to be the second most frequent diagnosis following complications of pregnancy and childbirth (using AHRQ grouper third level) across all health plans within Molina Healthcare, Inc. This is not surprising as asthma prevalence is increasing in adult women, and this demographic comprises the second largest population group within Molina’s Medicaid membership.

Purpose

Given Molina Healthcare's membership composition (culturally diverse women and children), a health management system created around the chronic illness of asthma should improve clinical outcomes. Molina’s *Breathe With Ease* disease management program strives to improve outcomes through continual, rather than episodic, care. Providing a continuum of coordinated, comprehensive care reduces the incidence of acute episodes requiring inpatient or emergency room treatment.

Program Overview

Molina’s *Breathe With Ease* asthma disease management program is a collaborative team approach comprised of health education, clinical case management and provider education. The team works closely with contracted practitioners in the identification, assessment and implementation of appropriate interventions for adults and children with asthma.

Goals of Asthma Disease Management

The goals of asthma management are to:
- Maintain normal activity levels (including exercise and other physical activities).
- Maintain (near) normal pulmonary function rates.
- Prevent chronic and troublesome symptoms (e.g., cough or breathlessness at night, in the morning, or after exertion).

- Prevent recurrent episodes of asthma and minimize the need for emergency room visits or hospitalizations.
- Avoid adverse effects from asthma medications.
- Meet patients' and families' expectations and satisfaction with asthma care.
- Support practitioner network to improve the quality of care with children who have asthma.
- Ensure practitioner compliance with clinical practice guidelines for the treatment of asthma.

Asthma requires long-term, ongoing care to control symptoms, prevent acute asthma episodes, and reduce persistent airway inflammation caused by this chronic disease. The key components in controlling asthma are interventions focused on practitioner education emphasizing early diagnosis of asthma, early use of anti-inflammatory medications, proper use of inhalation devices, objective monitoring of patient status, and use of a written action plan. Additionally, education and assistance is provided to members and their families in the following aspects of the disease management process:

- Environmental controls (reduce and/or eliminate exposure to allergens and irritants.)
- Pharmacological therapy (prevent, reverse and control airway inflammation and obstruction.)
- Patient education (knowledge of the disease, compliance with medications, self-monitoring skills, communication with practitioners, and the adherence to a written action plan.)

Program Eligibility Criteria and Referral Source

Breathe with Ease asthma program is designed for children and adults who are active Molina members at least two years of age upon enrollment in the program, and their families. The member must have a confirmed diagnosis of asthma. The member/family shall participate in the program for the duration of his or her eligibility with the plan's coverage or until the member "opts out." The program model is an "opt-out" design with the member remaining in the program unless they request to be removed from the registry.

Multiple sources are used to monthly identify the total eligible population. These include the following:

- Pharmacy claims data for all classifications of asthma medications (two or more scripts required of a short-acting beta agonist due to its use with other conditions)
- Encounter data or paid claim with an CPT or ICD-9 code indicating a diagnosis of asthma (493.XX)
- Member Services – welcome calls made by staff to new member households and incoming calls have the potential to identify eligible members. Eligible members are referred to the program registry.
- Practitioner referral (asthma is a condition listed on the standard health education referral form utilized by the practitioner network)
- Case Management or Utilization Management review for an eligible member
- Member self-referral – general plan promotion of program through member newsletter and other member communications
- Nurse Advice Line services and other sources of member/practitioner contact whereby identification and referral is possible.

Program Components and Stratification

The *Breathe With Ease* asthma program will have two foci of intervention, member directed and practitioner directed. The components of member directed interventions are member education and high risk case management. Practitioner directed interventions include the development and dissemination of guidelines, promotion of the program to practitioners, identified member assignments and the dissemination of member profiles.

Member Education (Health Education and Clinical Case Management)

Once members are identified for the asthma registry all known member data will be added to the database registry to assist with the stratification process. Additionally, member responses to a quality of life assessment conducted during initial outreach to the member are also used to determine appropriate stratification, and thereby identify the most appropriate resources and interventions.

Risk stratification results in member assignment into one of three levels (low, medium, and high). The intensity of outreach efforts and education increase with each level. If at any time a member requires a higher level of care, a referral is made to Clinical/Medical Case Management.

The focus of the program interventions is to ensure the member and/or family understands key self-management concepts and has the resources to implement them. All education is consistent with the National Asthma Education Program and the National Heart, Lung, and Blood Institute (NHLBI) guidelines for the prevention and treatment of asthma. A standardized chart note is forwarded to the member's primary care physician (PCP) for inclusion in the member's medical record following each educational intervention.

Low Level Interventions

- *Asthma and You* educational brochure and welcome letter mailed to members
- Asthma quality of life survey (AQLS) mailed to members to complete and return via prepaid envelope
- Educational newsletters/mailings several times per year
- Telephonic counseling available at member's request

Medium Level Interventions
Initial contact assessment includes:

- Outbound call from Care Manager to members to complete the AQLS telephonically
- Evaluation of member health status, medication compliance and general quality of life
- Assessment of member learning preferences and needs and to determine the most appropriate interventions (hospital based group program, telephonic education, or individual appointments)
- Individualized care plans are developed for each member
- Members with identified co-morbid medical conditions are referred for screening by clinical or medical case management. Case management coordinates care for these members once referred to medical case management

- Upon completion of the AQLS, the member is mailed a welcome letter and an enhanced asthma education kit. Additional resources that may be provided include: peak flow diary, asthma action plan, allergen-proof pillow-cover, spacer, and peak flow meter.

- Ongoing contact includes:
  - Periodic telephonic outreach to assess member health status and continued learning/resource needs; frequency of outreach determined by member status
  - Adjustments to individualized care plan as necessary
  - Referral to medical case management as necessary
  - Educational newsletters/mailings several times per year

- 6-Month assessment includes:
  - Care manager reevaluates member's health status and general needs utilizing a subset of questions from the initial AQLS
  - Revisions to care plan as necessary

High Level Intervention

- Members will be triaged and screened by clinical staff or complex case management for case acceptance. If the member is eligible for complex case management their needs are coordinated by the complex case manager (refer to PP #). Once the member is discharged from complex case management they are referred back to Disease Management and stratified as low or medium and managed accordingly.

All interventions are tracked in the organization's health management data platform. Two primary goals for all enrolled members with "presumed" persistent asthma are a written asthma action plan and adherence to medication plan with consistent spacer use as indicated.

The goal for all levels of member education is increased member self-efficacy related asthma management and adherence to the medical treatment plan. The outcome desired for members "actively managed" is the completion of a peak flow diary (at least one week, preferably two weeks) and the establishment of preliminary zones on a written action plan. Members are encouraged to report all changes in symptoms to their PCP and maintain ongoing communication with the PCP so that the treatment plan can be optimized. At all times program participants are referred back to their respective PCP as the coordinator of their medical care and the "prescribing physician" of an optimal treatment plan.

Clinical Case Management

The clinical case management of asthma incorporates an intensive process of case assessment, planning, implementation, coordination and evaluation of services required to facilitate an individual with asthma through the health care continuum. The program consists of a comprehensive approach toward evaluating the member's overall care plan through an assessment and treatment planning process. The case management team, in conjunction with the treating physician, coordinates the all health care services including the following:

- facilitation of appropriate specialty care referrals

- coordination of home health and DME services
- referral to support groups/social services within the member’s community

Through the use of a secure data platform, Molina Healthcare’s clinical case managers efficiently and effectively assess individual member needs and learning preferences, conduct interventions, including medication therapy management and member mailings, and track all encounters. The data platform also houses all disease-associated inpatient, outpatient and pharmacy claims incurred by the member during the preceding twelve months. Case managers track member progress in health management programs and share this information with primary care physicians and other internal departments as appropriate to ensure continuity and coordination of member needs. The data platform creates a single integrated system that provides users with timely access to member information so that interventions match the severity of the member’s condition.

Provider Education

To ensure consistency in the approach of treating asthma and with the participation of practicing physicians, Molina developed clinical guidelines and pathways for asthma management. These guidelines originate from national guidelines established by NHLBI in the 1997 Expert Panel Report 2: Guidelines for the Diagnosis and Management of Asthma; revised again 2002, and Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma 2007. Their purpose is to serve as a basis for the medical treatment of asthma by contracting practitioners. Guidelines are distributed to contracting practitioners at least annually and are posted on Molina's web-page.

Practitioners are informed about the program via routine health plan communications such as *Just the Fax* weekly electronic publication, the *Partners in Care* physician newsletter, CMEs, and Joint Operation Meetings. A program promotional flyer, focused at physicians, is utilized for this purpose.

Annually member profiles are mailed to PCPs that include program enrollment, stratification level, member known encounter information relating to the asthma diagnosis and member assessment responses as appropriate. For all members stratified to high risk, PCPs are also sent copies of the member completed asthma assessment for inclusion in the member’s medical record and physician consideration in the member’s overall treatment plan.

The disease management program supports the practitioner practice by providing education and other resources to members to assist them in achieving optimal self-management knowledge and skill. All participants are referred back to their PCP regarding clinical care issues. The role of disease management is to support and assist the primary care physician in achieving quality health outcomes around asthma care.

Program Evaluation

To evaluate effectiveness of the program, the following measures are used:

1. Emergency Room visit rate for asthma among children and adults (ages 2 and over) by product line.
2. Hospitalization Rate for asthma among children and adults (ages 2 and over) by product line.
3. HEDIS asthma medication measures by product line.
4. Member/family satisfaction with the program for those members receiving active care management.

An annual program evaluation is completed and reviewed by the appropriate internal committee for improvement and/or enhancements. Additionally, annual reports are discussed at the Quality Improvement Committee and Clinical Quality Management Committee for comment and ongoing recommendations or changes to the program.