Case Management and Care Coordination: Two Successful Models

Asthma Educator Sharing Day

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Genesee County Asthma Network
Overview

- Asthma case management program components
  - The role of the health plan
  - The role of the asthma coalition
- Two successful collaborative models:
  - Asthma Network of West Michigan
  - Genesee County Asthma Network
- Replication of a model: Where do you begin?
Health Plan: Population Management

- Identify members with asthma through registries & patient profiles
- Stratify the population based on risk and care opportunities
- Develop clinical programs & provider partnerships to provide the highest quality asthma care
- Individualize member interventions, referrals, and education to meet specific health needs
Health Plan: Outpatient Case & Disease Management

- Member Identification
- Member Stratification
- Case Management Process
  - Assessment
  - Plan of Care
  - Intervention
  - Evaluation
Health Plan: Member Stratification

- Missed services
  - PCP visits
- Utilization
  - ER, Inpatient
- Co-morbidities
- Medication Adherence
  - Rescue/control for asthma
Health Plan: Member Education

- Disease process
- Evidenced-based standards of care
- Community resources
- Treatment options
- Plan benefits
- Self-management techniques
Health Plan: Provider Partnerships

- Tools & Data
  - Interactive web portals
  - Registries
- Incentives for Quality Performance
Community Partnership: A Model for Collaboration

- First introduced in West Michigan
  - Asthma Network of West Michigan (ANWM) and Priority Health
- First partnership between a managed care organization and an asthma coalition in the nation
Collaborative Asthma Program Goals

- Improve the health status, quality of life and the clinical outcomes for all members with asthma by engaging them in the disease management program.
- Increase physician awareness of current asthma treatment modalities and available covered services.
- Improve the rate of inhaled anti-inflammatory prescriptions.
- Decrease ER visits and inpatient admissions for exacerbations of asthma.
Partnership: Identifying Roles

**Health Plan**
- Identify the asthma population and stratify those that will benefit from program
- Commitment to provide coverage for asthma education in benefit design
- Commitment to partner with asthma coalition to provide those services

**Asthma Coalition**
- Ability to contract with plan and bill for services
- Adequate staff; all certified as asthma educators
- Internal processes and program components
Partnership: Collaboratively Defined:

- Goals, responsibilities, billing processes
- Education of members and providers about program

Established outcome evaluation:

- Clinical Outcomes – Medication compliance
- Cost Outcomes – Decreased Utilization (ER & Inpatient)
- Quality of Life - Survey
Partnership: Outcome Goals

- Evidence-based standards of care promoted to all asthmatic members
- Effective case management services
- Reimbursement for home-based program
- Physician driven education and incentives
- Increased use of asthma action plans
- Community collaboratives
- Data driven, evidenced-based outcomes
Impact: Health Plan Case Management

- Additional expertise available for education/home-based services
- Evidence-based interventions for members at highest risk
- Additional opportunity to coordinate care with PCP
- Foundation for providing high quality asthma care
A Model that Works: Asthma Network of West Michigan

- Established in 1994 as the grass-roots asthma coalition serving West Michigan
- Began providing home-based asthma case management services in 1996
- Obtained 501(c)(3) status in 1997
- Contracted with area’s largest payer in 1999
- The first asthma coalition in Michigan; one of the first in the nation
The Asthma Network’s Two Overall Goals

- Community educational resource for professional and lay public
- Case management of children and adults with moderate to severe asthma from predominantly low-income families
Home-Based Case Management

- Services are unique
  - Home visits
    - AE-Cs, LMSWs and CHWs
  - School/daycare visits
  - Physician care conferences to elicit a written asthma action plan
  - Licensed masters social worker (LMSW) to assist with psychosocial barriers
  - First asthma coalition in the nation to partner with third-party payers
Asthma Network of West Michigan Staff

- Asthma Educators/Case Managers
  - 2.8 FTEs
  - RN or RRT with interest/experience in asthma management
  - Sit for exam within within 12 months of employment (ANWM covers the cost)
Asthma Network of West Michigan

Staff

• Asthma Network of West Michigan Manager (1.0 FTE)

• Licensed Master Social Workers – LMSW (2.0 FTE)
  • LMSW prepared with experience in medical social work and extensive knowledge of community resources
  • Responds to psychosocial needs of patients

• Clerical (1.0 FTE)
  • Office assistant/biller with billing, database experience
  • Assists with scheduling appointments, correspondence
Goals of Case Management

- Target behavior modification to promote prevention rather than crisis care
- Access to medications and primary care physician (obtain “medical home” if necessary)
- Improved asthma knowledge/quality of life
- Resolving psychosocial issues allows AE to focus on asthma management issues
- Enhanced communication with school and medical personnel
- Ensure asthma management in accordance with National Asthma Education and Prevention Program (NAEPP) guidelines
Caseload Size

- Average 75 patients/AE-C
- 210 cases, with 185 reimbursable slots
- 25 non-reimbursable slots (waiting list) – supported by grant $
- Provided service to over 400 families in past 12 months
- Accomplished ~ 2,000 home visits in past year (70% rate of accomplished visits)
Referral Sources

- Inpatient population
- PCP/clinic
- School nurse
- Public Health Nurse
- Self-referral
- Managed Care Organizations
Care Conference

- Conducted with PCP (and possibly specialist as well), usually accompanying family
- Elicit a written asthma action plan
- Discuss compliance issues - psychosocial barriers to asthma management
- Discuss access to care issues - PCP visits, devices, medications, etc.
- Reimbursable visit
School/Daycare In-service

- Scheduled with key school personnel:
  - principal, school nurse, classroom teacher, phys. ed. teacher, and school secretary
- May provide in-service for entire staff
- Discuss (in private) key issues concerning child’s asthma and psychosocial barriers/learning problems identified by school
- Provide with copy of AAP - ensure school staff understands
- Reimbursable visit
ANWM and Managed Care Organizations

- Receive authorization prior to enrollment
- Some authorize 18 visits, others authorize fewer and AE must call and justify the need for more visits
- Target members with uncontrolled asthma
- Will often authorize after an encounter (ED visit or hospitalization)
- Signed contracts with 5 MCOs – negotiating with a 6th
- Reimbursement ($160,000) covers ~1/3 of our operating budget ($500,000)
ANWM Outcomes

- Fewer emergency department visits
- Fewer hospitalizations
- Lower overall costs for asthma

<table>
<thead>
<tr>
<th>Clinical Outcomes</th>
<th>Cohort Group N=45</th>
<th>Control Group N=39</th>
<th>Cohort vs. Control</th>
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<tbody>
<tr>
<td></td>
<td>Pre       Study</td>
<td>P-value</td>
<td>Yr 1    Yr2</td>
</tr>
<tr>
<td>ED Visits</td>
<td>80        61</td>
<td>0.047</td>
<td>28      43</td>
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<tr>
<td>Hospitalizations</td>
<td>41        13</td>
<td>&lt;0.0001</td>
<td>23      28</td>
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<td>Days Hospitalized</td>
<td>114       25</td>
<td>&lt;0.0001</td>
<td>55      67</td>
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</tbody>
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ANWM Outcomes
Patient-Centered Medical Home

73 children served between 2007 and 2009 through home-based case management

- 63% reduction in admissions
- 30% reduction in ED visits
Future Projects

- Establish more service agreements with area providers
- Achieve long-term financial sustainability
- Support asthma educator certification
- Expand comprehensive case management services to other counties
- Replicate our model around the state – respond to the needs of our payers
- Replicate our model nationally
Asthma Network Selected as Model Program by U.S. EPA

The *National Exemplary Award* recognizes community-based asthma programs that meet certain requirements:

1. Committed Program Champions
2. Strong Community Ties
3. High Performing Collaborations
4. Integrated Health Care Services
5. Tailored Environmental Interventions
6. Monitored Health Outcomes
ANWM – EPA Award Winner
A Model That Works: Genesee County Asthma Network

- **Scope of Program**
  - **Location:** Flint, MI
  - **Type:** Community Coalition
  - **Service Area:** Genesee County and surrounding areas; City of Flint
  - **Population Served:** 10,854 children and 30,156 adults with asthma
A Model That Works: Genesee County Asthma Network

- **Scope of Program:**
  - **Key Players:** American Lung Association (ALA), a network of 81 churches focused on community health, several local universities, Genesee County Medical Society Environmental Committee, Public Health Department and the local tobacco coalition.

- **Results:** In first year, hospital savings of $660,000, 45% decrease in emergency department (ED) visits over two years, 25% decrease in hospitalizations and decreased missed school days.
GCAN – Scope of Program

- Serves both adult and children with focus on inter-city children in Genesee county and surrounding areas

- Number of Patients Served
  - 150-200 patients served per year through the disease management
  - Approx. 2000 people served through health fairs, school and church education and presentations/year
GCAN – Asthma Camp
GCAN – Key Process & Health Outcome Goals

- Process Outcome Goals
  - Complete home assessments including all rooms of the house
  - Telephone coaching
  - Emergency Department interventions
GCAN – Key Process & Health Outcome Goals

- Health Outcome Goals
  - Decrease Emergency Department visits
  - Decrease asthma hospitalizations
  - Improved quality of life factors (eg. Missed school days)
GCAN – Key Health Outcomes

- In 1st year had $660,000 in cost savings
  - ED visits 45%
  - Hospitalizations 25%
  - Intensive Care 18%

- For 2006 – 2008
  - ED visits from 516 --> 61
  - Hospital stays from 283 --> 42
  - IHAT - 55% in second hand smoke for those who received in home asthma education
GCAN – Financing

- Hurley Medical Center is our primary funding source with in-kind funds
- Secondary funding sources are Federal, State and Local Grants
GCAN – Financing

• Funding Issues:
  • Working with Hurley Medical Center as a fiduciary has enabled us to develop our programs goals and initiatives
  • Currently in the process of obtaining contracts with local managed care companies for reimbursement

• Proposed Solution:
  • Continue seeking grant money and other sources of funding
GCAN – On the Horizon

- The impacts of asthma are identified and managed in our community.
- To continue to improve the quality of life with asthma and their families through research, education, advocacy and community partnership.
GCAN – 5 Key Elements

Tailored Environmental Interventions
- IHAT – In Home Assessment tool (developed with U of M Flint)
- Habitat for Humanities (trigger free home for patient)
- EPA home assessment checklist

Integrated Health Care Services
- Local Physician Education
- Hospital based – closely associated with Asthma Clinic

Effective Care for People with Asthma

Strong Community Ties
- Faith Based Community – FAC ED
- Local Health Department
- SMART Coalition (tobacco)
- Local Intermediate School Districts

High-Performing Collaboration & Partnerships
- Asthma Camp (In collaboration with U of M Flint)
- Health Department (home screening for mold)

Committed Program Champions
- Hurley Medical Center
- American Lung Association
- Local Universities
- Local Health Program
- Pharmaceutical Companies
- Mott Children’s Health Center
Asthma management is effectively facilitated with expertise from diversified community partners.
GCAN – EPA Award Winner
Where Do You Begin?

- Assess your community’s need and capacity for an asthma program
  - Maintain/develop strong partnership with community agencies
  - Identify disparities and address cultural competencies
  - Be innovative in addressing needs/Removing barriers/Seeking solutions
- Develop an evaluation plan before you begin
  - Track outcomes
  - Assure that all members with asthma are educated according to the most recent evidenced based standards of care
Building the System

- Be true to your mission
- Identify your goals and plan for action
  - Know the impact of asthma on your community
  - Be data driven
  - Align your goals with your mission
  - Build upon your strengths
- Conduct needs-based planning
  - Seek input from the community
  - Be responsive to community needs
  - Meet your community where it is
- Collaborate to build a system that will last
Getting Results: Evaluating the System

- Collaborate to get the data you need
  - Train staff to collect program data
- Let the data guide program design/modification
- Use data to measure effectiveness
- Use evaluation data to build the Business Case
Resourcing the System

- Focus on your resource strategy at every step
- Use your data to demonstrate your value – funders will respond
- Drive institutional change to sustain your program
- Collaborate to resource the system
  - Recruit the target community
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www.asthmanetworkwm.org
www.GetAsthmaHelp.org
www.asthmacommunitynetwork.org