



Breathing

Health plan programs that take a more aggressive approach to asthma care show promise.

BY AILEEN KANTOR

EASIER

FOR MANY INDIVIDUALS, THE SIMPLE ACT OF BREATHING IN AND OUT is more complicated than it sounds. While asthma is more treatable than other chronic conditions, health providers face unusual circumstances when trying to manage it. Its unpredictable nature—wind, smog, allergens, or even a cockroach can, without warning, trigger an adverse effect—is as challenging as the condition’s disproportionate effect on children, racial and ethnic minorities, low-income populations, and inner-city groups.

As the most common chronic condition in childhood, asthma affects 6.2 million children under 18 years old and is the third-greatest cause of hospitalization among children under 15, according to the Centers for Disease Control and Prevention (CDC). African-Americans have more emergency room visits, are hospitalized more often, and die due to asthma at rates three times higher than white Americans. And with a 74 percent increase in self-reported asthma over the past two decades and the total number of children dying from asthma increasing almost 300 percent in the last decades of the 20th century, some experts now consider asthma a national epidemic.

With this high incidence comes high costs. In 2004, asthma affected nearly 20.5 million Americans, costing \$11.5 billion, which includes hospital and emergency room visits. When the cost of drugs and lost productivity are factored in, asthma’s national price tag was more than \$16 billion in 2004, according to the American Lung Association. Indirectly, the cost of asthma affects not only the individual but also the family, through lost time at work and school. The CDC reports that asthma is the No. 1 cause for school absence for a chronic disease. Racial and ethnic populations, smokers, and low-income populations were more likely to have asthma-related school absences.

TAKING THE PROGRAM'S PULSE

IN 2001, AMERICA'S HEALTH INSURANCE PLANS along with the American Academy of Allergy, Asthma and Immunology launched "Taking on Asthma," an initiative to support health plans in the design and management of health care for individuals with asthma. With later support from the U.S. Environmental Protection Agency (EPA), the goal of the expanded initiative, "Taking on Asthma: Communication, Education, and Outreach," was to develop and share approaches about the importance of integrating information about key environmental risk factors, such as allergens or secondhand smoke, into asthma management programs. Its primary goals include encouraging plans to:

- use nationally established asthma guidelines such as the NIH's National Heart Lung and Blood Institute clinical practice guidelines;
- implement evidence-based asthma self-management programs to increase control of asthma symptoms and reduce life-threatening acute episodes;
- increase attention on comprehensive asthma care management, including indoor asthma triggers; and
- identify and promote best practices for improving health outcomes in asthma care management.

To evaluate its progress, AHIP conducted a baseline assessment in 2004 with a follow-up in 2006. It wanted to examine whether plans were implementing evidence-based interventions or environmental management programs and if so, how these programs were working. Using the 2006 sample population of 136 plans and a 58 percent response rate—representing 51 million covered lives—AHIP found some interesting trends.

"When it came to the program's impact, plans reported improvements in outcomes of care and in cost savings from reduction of emergency room visits," says Rita Carreón, AHIP's senior manager, clinical strategies. "Programmatically, we noticed more targeted efforts to reduce disparities in health among individuals with asthma and we have seen an abundance of intense enrollee outreach and provider incentives from health plans."

The other big finding, Carreón notes, was the increase in the number of plans now using multiple asthma strategies. Highlights (using weighted data) of the growth from 2004 to 2006 follow.

COMMERCIAL PLANS:

- Expanding access to enrollee participation in asthma management plans (from 69 percent to 84 percent).

- Incorporating information on environmental asthma triggers through home visits (from 67 percent to 94 percent); follow-up contact after hospitalizations/ER visits (from 58 percent to 91 percent); and tailored mailings (from 47 percent to 90 percent).

- Incorporating information on environmental asthma management in *all* asthma disease management interventions (from 26 percent to 48 percent).

- Increasing financial support from health plans for environmental asthma management tools (from 19 percent to 27 percent) (unweighted data).

- Improving culturally and linguistically appropriate interventions by offering Web site information in multiple languages (from 13 percent to 64 percent) and printed information in multiple languages (from 61 percent to 77 percent).

MEDICAID PLANS:

- Strengthening outreach and integrating environmental health by offering a nurse advice line (from 57 percent to 85 percent); making proactive calls to enrollees with asthma (from 48 percent to 80 percent); initiating follow-up contact after hospitalization/ER visits (from 45 percent to 77 percent); and using asthma monitoring/management tools (from 45 percent to 67 percent).

- Addressing the needs of culturally diverse populations by increasing an enrollee's access to translation services (from 73 percent to 100 percent) and case managers/disease management staff, with cultural competent and multilingual skills (from 69 percent to 86 percent).

Despite resource and measurement challenges, health plans have made significant strides in designing programs to assist enrollees and their providers to better control asthma by integrating environmental management into comprehensive asthma management programs. In addition, AHIP and the EPA are committed to highlighting health plan practices that work and to providing valuable resources for health care organizations. For example, EPA's annual National Environmental Leadership Award in Asthma Management recognizes one health plan and one provider for leadership in addressing management of environmental asthma triggers. The 2007 winners will be announced at the Communities in Action for Asthma-Friendly Environments National Asthma Forum in late May. To access additional resources and tools, visit AHIP's *Taking on Asthma* Web site (www.takingonasthma.org) and EPA's Web site (www.epa.gov/asthma).

And while these complicated issues continue to tax even the most ardent health care provider, one positive fact remains: Asthma is treatable. With new ways to target the disease and proactively manage its symptoms, health plans are finding that if they take the right approach to supporting physician-prescribed therapy and patient education, outcomes can improve. New medications, comprehensive asthma disease management programs, attention to environmental triggers, and enhanced patient and provider education are helping to reduce asthma-related deaths and hospitalizations for the population in general. The American Lung Association notes that the number of hospital discharges for asthma decreased 3 percent between 1995 and 2004 while the hospital discharge rate from asthma declined 13 percent between 2003 and 2004.

America's Health Insurance Plans has targeted asthma as one major condition that remains uncontrolled and for which improvement is possible. In 2001, AHIP launched the "Taking on Asthma" initiative with the American Academy of Allergy, Asthma and Immunology to support health plan members to design and offer comprehensive care for asthma management. Subsequent activities, now supported through a cooperative agreement with the United States Environmental Protection Agency, offer plans many resources and tools to integrate environmental risk factors into comprehensive asthma management programs. A recent assessment of AHIP's plan involvement in 2004 and again in 2006 reveals that more plans are taking aggressive steps to foster change and are seeing results (see sidebar, "Taking the Program's Pulse").

Going After Environmental Triggers

Asthma is a top priority for Neighborhood Health Plan of Rhode Island (NHPRI), a health plan based on partnerships with community health centers, given that the condition afflicts 7 percent of its population.

In 2005, more than 300 of its 75,000 members participated in its comprehensive asthma disease care management program. Members receive up to three contacts per month from case managers who help members manage their asthma care. NHPRI also routinely focuses on one area that members sometimes overlook: environmental triggers in their homes.

"Because some of our members do not know that environmental triggers such as dust, pet dander, and pollen can hurt their asthma, what these triggers are, or where they lurk, we go an extra step to do environmental assessments in members'

homes," explains Nancy Harrison, NHPRI's health and wellness team lead. "Once we find the triggers, we work to eliminate them and help our members keep their homes trigger free. Overall, we are finding the program is a key component to help our members breathe easier."

Consider Susan Allard, of Manville, Rhode Island, a 36-year-old mother raising three children. When a rather severe respiratory illness struck Allard and she was admitted to the hospital for close to two weeks, she learned she had asthma. In addition to understanding some basic facts about the disease and its implications for her health and lifestyle, Allard discovered

she would have to make many changes, including immediately quitting smoking. She was somewhat unsure about what her diagnosis meant or how it would affect her life.

However, within one day of her discharge, her worries dissipated. She received a phone call from Katie King, an asthma case manager from NHPRI, who explained to Allard that she would help her manage her asthma care.

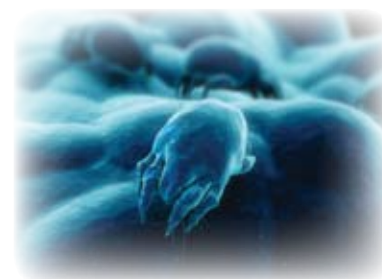
Besides teaching Allard important facts about asthma, King conducted an environmental assessment of Allard's home to help her identify environmental triggers. After an initial assessment, Allard learned that her home was filled with many well-known environmental

triggers, such as dust mites and mold. King not only helped to identify these triggers, but she also developed a specific action plan to remove them. The first step was to request that Allard's husband, also a smoker, smoke outside. Within a week, King contacted Allard's landlord and then managed all steps

necessary to have mold in the bathroom removed. Half of the carpet (a prime spot for dust mites) was removed and replaced. The identification and removal of environmental triggers continued until Allard's home was nearly trigger free.

But King's efforts did not stop there. King remains in regular contact with Allard and calls her every two to three weeks to make sure she takes her medications. King also makes referrals to the health plan's asthma clinic and updates her with new information about asthma.

"Before the medication, I was always out of breath and had a hard time even getting out of bed," Allard recalls. "Now, I go bike riding and play ball with my son, and I'm doing things I could never imagine possible, such as quitting smoking or just breathing easier."



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Plan managers believe NHPRI’s focus on environmental trigger reduction contributed significantly to overall cost reductions. Since deploying the asthma care management program for the 300 members, NHPRI reports the following cost reductions: a drop in cost for inpatient utilization from \$534,755 (before intervention) to \$148,925 (after intervention), representing a savings of \$1,286 per member, and a decrease in cost for emergency room visits from \$62,075 (before intervention) to \$24,908 (after intervention), a savings of \$37,167 (an average of \$123 per member).

“We provide high touch case management for targeted members with chronic illnesses,” notes Harrison. “While intensive, the quality, cost, and satisfaction results clearly support this model.”

Taking Action Through Progressive Outreach

When telephonic outreach to asthma members did not work, Community Health Plan, a Seattle-based nonprofit health plan serving members in 33 state counties, tried a more direct approach: using physicians to directly manage change.

As a first step, the plan armed its physicians with clinical information about their asthma patients, such as recent hospital and ER visits, and asthma medication use. It concurrently used the plan’s e-prescribing system to provide specific reminders to physicians to use appropriate evidence-based guidelines to support clinical decisions at the point of care. The plan also forwarded them new medical research, clinical guidelines, and best practices, and offered to pay for physicians and other staff to attend asthma-related classes and education. And it gave its physicians feedback about members’ care, forwarding quality improvement surveys and outcomes data.

Community Health Plan knew that to see change for its members, many of whom were hard to reach, it would need to engage two other important populations: the members themselves and the community that served them. The plan launched an Asthma Initiative in 2000, hoping to target the 6 percent of its active population identified as having asthma as well as those who had not yet been diagnosed.

“We realized that to forge change, we needed a three-pronged approach,” says Melissa Mercurief, clinical quality project manager. “Our data about patient care was impressive and enabled us to pinpoint exactly which members had asthma, the physicians who treated them, or even exactly how care was billed or coded. But our real-life experience taught us we needed providers with innovative tools, incentives for patients,

and community involvement to actually see change.”

To sustain this process, the plan sent out educational information, such as tips on how to identify asthma symptoms, and advice on when patients should see their doctors. It supported this effort through the plan’s disease management program, which includes regular educational mailings, newsletters, asthma support groups, and routine outreach by disease managers for high-risk patients.

Finally, to help spread the program’s benefits throughout the state, Community Health Plan developed relationships with community agencies such as the American Lung Association of Washington, the Seattle-King County Public Health Department, the King County Asthma Forum and Washington State Asthma Initiative, and other programs. This allowed the plan to maximize its resources and combat asthma in a more integrated and transparent manner.

“We’ve established a true example of how a program works to manage aspects of chronic illness care—community awareness and partnerships, physician engagement and use of evidence-based medicine, empowerment of patient self-management skills, and plan-level support,” Mercurief says.

Physician Peer Program Results Spur Change

Banking on physicians’ competitive spirit, Blue Cross Blue Shield of Florida (BCBSFL), Jacksonville, puts great faith in its Peer-to-Peer Physician Profile, which uses comparative physician-specific information to foster change. At the heart of the program is data; each quarter the plan amasses individual provider performance, comparable data from peers, and comparable national standards and sends this information to each physician. The data enable physicians to review their performance, evaluate it against others, and then respond.

“Of all of the interventions we routinely use for asthma care, the provider peer profile is the most powerful and has the greatest effect on asthma care for our patients,” says Mary Margaret Serfilippi, director, medical management/care coordination, Blue Cross and Blue Shield of Florida Senior Solutions. “It is not a complicated process, but it delivers a dramatic impact.”

Every other month, BCBSFL sends all primary care physicians with asthma members on their panel a report with an analysis of their asthma-related and non-related utilization data. Patient emergency room or hospital admissions, medication prescriptions, and their fill rates are also profiled. If a physician’s performance falls out of the national practice standards for asthma, if his or her patients have an emergency

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room visit or asthma-related hospital admit, or if patients had two or fewer prescriptions filled, the provider is flagged as an “outlier.” Outlier profiles include planwide utilization data of their peers and a copy of National Institutes of Health (NIH) standards for clinical care in asthma. Each physician profile is sent with a letter explaining that the package and its contents are for information purposes only. The health plan also includes articles on asthma care; its physician newsletter, the *Blueline*; and information on continuing medical education (CME) programs on asthma, which focus on the NIH guidelines.

“Upon receipt of this information, the physicians are generally receptive, regardless of whether they are an outlier or not,” says Serfilippi. “Few become stymied by the information and most physicians rise to the challenge to use the data to help change their patterns, become more aggressive with their patients, or simply try to understand why their data is aberrant. Then they take positive steps to manage change: They use the data to follow up with patients, contact health plan case managers to get the patients more involved, or take other steps to help their patients have lower health care utilization from asthma.”

In a two-year period, the plan’s comprehensive approach has dramatically improved components of patient care. Its successes include increasing use of long-term controller medications among members with asthma from 60.8 percent to 64.2 percent from 2002 to 2004, and reducing asthma-related emergency room visits among members enrolled in the program from 18.6 visits per 10,000 in 2003 to 14.0 visits per 10,000 in 2004. Serfilippi attributes some of this success to the comprehensive nature of the plan efforts, but she believes the physician peer-to-peer program has brought about the most significant change.

California Plan Targets Pharmacies

Like other health plans, Blue Cross of California State Sponsored Business (BCCSSB), which provides coverage to about one third of California’s Medicaid and Healthy Families, including 45,000 members with asthma, offers a comprehensive asthma intervention program. Nearly 75 percent of its members with asthma are children and adolescents from culturally and linguistically diverse low-income homes, and asthma is one of plan members’ 10 most prevalent conditions.

To help manage its members’ asthma, the health plan relies on an innovative program that counts on the pharmacy as a vital link between the plan and its members. As part of its Pharmacy Asthma Consultation Program, BCCSSB offers several resources to its pharmacists, including real-time point-of-service prompting

for pharmacy asthma consultation, eligible member name pop-up on pharmacists’ monitor screens when asthma prescriptions are filled, and an extra \$10 to each pharmacist for an extended asthma medication consultation with a member.

In 2003, BCCSSB did a baseline evaluation of this program to determine its effectiveness. The results revealed that 43.8 percent of all eligible members received a consultation and that members who had a consultation with their pharmacist used more asthma controller medications. Other data indicated a disparity in consultation rates among racial and ethnic groups.

To boost the program’s effectiveness, BCCSSB improved mailings to pharmacists, which included information about consultations and cultural competence; conducted outreach to pharmacists to reduce missed opportunities for pharmacy asthma consults; and identified and focused special efforts on African-American members, who had missed many consultation opportunities. During the fourth quarter of 2004, the plan learned that for non-chain pharmacies, 51 percent of missed opportunities to consult to African-Americans occurred in eight pharmacies. It also learned that 29 percent of its eligible African-American members received a consultation in this period, and less than 1 percent of this population refused this service.

To prevent future missed opportunities, BCCSSB field staff targeted the eight non-chain pharmacies to encourage them to implement the asthma consultation program. It also sent out an additional 4,000 pieces of educational materials to African-American members planwide with moderate to severe asthma. Re-measurement some months later revealed that the eight targeted pharmacies increased their rates of pharmacy asthma consultation to African-American members from 0 percent to 15 percent. The plan also observed significant improvements in the rates of pharmacy asthma consultations between 2003 and 2005 for all members and all racial and ethnic groups.

“By promoting this opportunity, offering incentives to our pharmacists, and placing more emphasis on asthma medication education, our program supports improved asthma maintenance for our members,” says Dawn Wood, M.D., vice president and medical director, BCCSSB. “We have also seen a decrease in asthma-related emergency room visits and hospitalizations. We believe this program contributes to an overall positive trend in asthma care.”



Aileen Kantor is the founder of PR Healthcare, Bethesda, Maryland.