

Asthma Disease Management Program

A: Program Content

GHC-SCW is committed to helping members, and their practitioners, manage chronic illness by providing tools and resources to empower members to self-manage their asthma and stay healthy. Asthma is a major concern for GHC-SCW due to the number of members being diagnosed and the health risks and costs associated with poor control. Proactive practitioner intervention and support, in collaboration with health education and clinical outreach, helps members manage their condition. Through this program, routine asthma evaluations are performed and education is given to help members gain control of their asthma and keep it controlled throughout their life.

GHC-SCW has designed the Asthma Program to educate members about asthma, teach members how to self-manage their disease, emphasize the importance of regular care, and provide support tools and screenings. The content of the asthma program includes condition monitoring, patient adherence to treatment plans, consideration of other health conditions, lifestyle issues and ongoing screening for behavioral health concerns. The organizations adopted clinical practice guidelines for asthma diagnosis and management listed in Appendix A are the clinical basis for the program. Current guidelines are posted on ghcscw.com

Along with performing disease-specific clinical activities, GHC-SCW's Asthma Educator and Clinical Pharmacists also have a significant impact on the development, implementation and improvement of the program. Examples of how they impact disease management at GHC include:

- Provide education to patients about the disease
- Conduct periodic review of the patient's inhaler technique
- Target high-risk and high-utilizing patients for education and/or intervention,
- Conduct outcomes research to form the basis for treatment guidelines
- Educate other pharmacists and physicians about treatment guidelines
- Involve the pharmacy and therapeutics committee in disease management processes
- Influence prescribing patterns
- Provide expert information on medications and pharmacotherapy
- Use health system databases to track drug expenditure patterns and health care professionals' adherence to regimens

Condition monitoring

GHC monitors condition for all asthmatic members in the program and uses either outreach calls, MyChart messages or postal letters as reminders if assessments are indicated or overdue.

Items monitored include:

- Assessment of Lung Function (spirometry, peak flow monitoring)
- Symptom Assessment & History of Exacerbations
- Functional Status in adults and children: Asthma Control Test (ACT)
- Functional Status in kids 5 years or less: (TRACK)

- Annual Flu Vaccination needs
- Tobacco Use/Exposure
- Asthma Triggers

Adherence to treatment plans

Members work with an Asthma Educator, Clinical Pharmacists, Tobacco Cessation Counselor, nursing staff and/or their primary care practitioner who monitor patient adherence in the following areas:

- Modification of risk factors
- Self-Administration of Inhalants
- Medication compliance and appropriateness
- Tobacco cessation
- An individualized Asthma Action Plan
- Symptom or peak flow based on asthma plans
- Scheduling of regular practitioner appointments
- Physical Activity Level
- Tobacco Cessation
- Clinical Practice Guidelines (See Appendix A)

Members may check future appointments, outstanding orders, medication lists, lab and diagnostic test results through GHCMYChartSM-a secure interactive online patient health portal. All encounters and treatment plans are documented in the EMR.

Medical and behavioral health comorbidities and other health conditions

GHC-SCW is committed to a collaborative approach to disease management, especially for those members with multiple co-morbidities. The asthma registry includes prescription refill information and other risk factor data. GHC-SCW identifies members with asthma who also have hypertension, cardiovascular disease, hyperlipidemia and/or depression.

Prior to creating the treatment plan, consideration is given to the members learning style preferences, cognitive abilities, socio-economic factors, and/or physical limitations. A team approach ensures members requiring more intensive care get the right care at the right time.

- Clinic staff (CMA's, LPN's, RN's, Practitioners, lab, radiology) have access to the electronic medical record and can see the problem list for each member.
- Practitioners refer patients to Clinical Specialists, Health Educators or Behavioral Health to support the needs of the patient.
- Registered Dietitians document their encounters with members contributing to the plan of care.
- Case Managers may also ensure appropriate care for those with more complex needs that meet criteria

Health Behaviors

Behavior modification is an essential component of asthma management. GHC-SCW Health Educators (Asthma Educator, Tobacco Cessation Counselors, Registered Dietitians) work with members to provide personalized support and to promote healthy lifestyle options. Members may receive individual counseling as needed or are provided information regarding alternative resources.

GHC-SCW requests members complete a General Medical History Form every time they schedule a

physical. Practitioners can counsel on at risk behaviors noted in the history information such as alcohol consumption, drug use, tobacco use/smoking or other hazards. Members with documented tobacco use receive outreach about access to a cessation counselor and are provided information about community resources such as the Wisconsin Quit Line. GHC-SCW covers tobacco cessation medications on its formulary for many plan members if they have a pharmacy benefit. Substance use and addition services are primarily provided by our partner, UW Behavioral Health and Recovery. A referral is not required to initiate this service.

Psychosocial issues

GHC-SCW's Primary Care providers collaborate with Clinical Health Educators, Nursing, Case Management and Behavioral Health staff to identify possible psychosocial issues that may be significant to the conditions being managed and strive to identify interventions or resources to overcome the issues. Psychosocial issues which have potential to affect adherence to a treatment plan may include but not be limited to:

- Beliefs and concerns about the condition and treatment
- Perceived barriers to meeting treatment requirements
- Access, transportation or financial barriers to obtaining treatment
- Cultural, religious and ethnic considerations

Assessment tools play a key role in evaluating some members general level of anxiety upon learning about their asthma diagnosis or any perceived barriers to managing their disease. GHC-SCW has incorporated the GAD-7 anxiety screening tool into its electronic health record. This patient self-assessment tool has been developed and validated in a primary care setting. It can be completed independently and reviewed at a follow-up appointment or in conjunction with the practitioner or another member of the care team. The evaluation is documented in the members EMR under "Screening Tools".

Depression screening

GHC-SCW has incorporated the PHQ-9 for monitoring symptoms of depression into its electronic health record. Primary Care and/or Behavioral Health practitioners are encouraged to obtain screenings on asthmatics in the program and make recommendations for treatment if screening is positive. The Patient Health Questionnaire-9 is standardized and has been extensively studied in primary care settings. This patient self-assessment tool can be completed in the office jointly with the practitioner or independently and reviewed at a follow-up appointment. The assessment is documented within the members EMR under "Screening Tools".

Information about the patient's condition provided to caregivers who have the patients consent

Family members and/or caregivers who want or need access to the patient's medical record are required to file a patient signed "Release of Information" consent form, indicating they may have access to their records. Patients may choose to share electronic access to their medical record by sharing password information to their GHCMYChartSM account with family members and/or caregivers. The asthma action plan created by the Practitioner, Asthma Educator or Clinical Pharmacist can be shared with family, and is available to other health care professionals for continuity of care.

Encouraging patients to communicate with their practitioners about their health conditions and treatment.

GHC-SCW's asthma program outreach letter delivered to all members in the registry encourages contact with their practitioner and stresses the importance of communication. Members have the option to utilize GHCMYChartSM a secure patient portal within the electronic medical record. All members are encouraged to sign up for an account so they can send messages directly to their care team (practitioners, nursing, asthma educator) or staff of the insurance plan (member services, pharmacy). Members registered, automatically get care and/or appointment reminders via their account. The MyChart App is available for both Apple and Android smart devices making it convenient for members to access.

Additional resources external to the organization

Members have access to *Healthwise*, a health topics database & shared decision making resource within GHCMYChartSM and are encouraged to complete a Health Risk Assessment (HRA) available free of charge via the WebMD® Portal, also within MyChart. *Healthwise* topic information may be printed during clinic visits for members.

B. Identifying Members for DM Programs

GHC-SCW uses the following data sources to identify members for the program:

- Claims or encounter data
- Prescription data
- Problem list in the electronic medical record
- Health risk assessments
- Data collected through the utilization management or care management process
- Member referral
- Practitioner referral

GHC-SCW does not use continuous enrollment criteria for identifying members

C: Frequency of Member Identification

GHC-SCW's BI asthma registry updates weekly to identify new members with asthma based on established criteria and the above data sources. The registry is evaluated monthly to look for members who have outstanding asthma identifiers such as increased use of short acting beta agonist medication, decreased ACT or TRACK scores, or increased emergency department admissions or rising oral steroid use. The asthma educator uses the registry to stratify outreach.

D: Providing Members with Information

How members become eligible and how to use services:

All members on the BI Asthma registry are automatically included in the program to receive outreach materials to help them learn to live well with asthma unless they choose to Opt out. New and existing members receive a program letter about the services available on a quarterly

basis. Communications explain the importance of managing asthma and highlight both internal and external resources and important contact information at GHC-SCW. Mailings may also include an educational newsletter with tips & stories and the brochure titled *Asthma Zone* with more resources.

How to opt in or out:

The program letter explains how members can opt out of future program outreach materials associated with being on the BI asthma registry by contacting GHC-SCW Quality Management staff.

E: Interventions based on Assessment

GHC-SCW provides interventions for asthma members based on stratification. Different interventions are based on severity of illness, completion of diagnostics and the results of those tests or examinations.

Tier 1: All new and existing registry members

Tier 1 Interventions:

- Program letter mailed to all new and existing registry members quarterly (unless they opted out)
- Access to asthma educator and/or PCP to help develop a comprehensive plan of care
- Annual flu shot reminder
- Wellness activities reimbursable by the insurance plan
- Practitioners notified of outreach activities

Tier 2: Members with recent visits to Urgent Care, Emergency Rooms, and/or Hospitalizations

Tier 2 Interventions: same as Tier 1 plus

- Contact via secure messaging, phone calls or mailings
- Scheduled appointment with asthma educator and/or primary care within 14 days of the event

Tier 3: Subset of members referred to Case Managers

Tier 3 Interventions: same as Tier 2 plus CM involvement

F: Eligible Member Active Participation

GHC-SCW annually reports the active participation rate to the Clinical and Service Quality Committee. The data represents the number of members with at least one interactive contact in the year analyzed. An interactive contact is defined as a two –way interaction in which the member receives self-management support and includes anyone who utilized a health educator or specialist, a health coach or had a phone or MyChart consultation related to asthma. Disease management survey participation is also considered an interactive contact.

G: Informing and Educating Practitioners

Instructions on how to use DM services

GHC-SCW provides practitioners with information about program services via the following:

- Provider resources page on **ghcscw.com** maintains a current version of all DM program descriptions
- New practitioner on-boarding letter and/or at orientation
- Updates in organizational newsletters
- Health Maintenance Modifiers for labs and screening
- Best Practice Alerts

How the organization works with practitioner's patients

Practitioners have EMR access to an encounter in Chart Review for all contacts the member has with nursing, health educators, clinical pharmacists, behavioral health or case managers. Communications include secure electronic messaging, telephone and/or in person contact.

H: Integrating Member Information

GHC-SCW utilizes a common electronic medical record system (Epic[®]) which allows for integration of member information for continuity of care. This information can be extracted into a variety of reporting tools utilized by the organization that focus on the asthma population to ensure relevant interventions and allow for comprehensive coverage by the health information line, case management program, utilization management program, quality management outreach program and health/wellness education. Epic Link and Care Everywhere functionality within the system allow staff to see the patients' medical record if they have been seen by a partnering facility utilizing the Epic system and ensures access to patient information while they are out of the service area.

I: Experience with Disease Management

GHC-SCW surveys a sample of registry members who participated in the program (did not opt out) annually for feedback on their experiences with services and the usefulness of disseminated materials/information. GHC-SCW clinics also utilize Press Ganey to administer CG-CAHPS to patients who had a practitioner or health education encounter to gather experience information related to these visits. Complaints are managed through Member Services per protocol.

J: Measuring Effectiveness

HEDIS results are analyzed monthly to look for trends or changes in compliance. GHC-SCW's Quality team, along with other stakeholders in the organization, pursue opportunities to impact measure performance. These typically target areas where a measure is below the 50th percentile as well as ensuring measures stay near or above the 75th percentile. Measures include the entire relevant population of asthma members. Each measure:

- 1) Address a relevant process or outcome
- 2) Produces a quantitative result
- 3) Is population based
- 4) Uses valid data and methodology
- 5) Is compared to a benchmark or goal

GHC-SCW selects and tracks one performance measure for each DM program. An annual quantitative and qualitative analysis is conducted to identify cause and areas of opportunity if goals are not achieved on the measure selected.

Appendix A
Asthma Disease Management
Clinical Practice Guidelines

GHC-SCW has a representative of the organization participate in a city-wide guideline working group to improve the consistency of care across the Madison area. Guidelines undergo periodic review within the UW Health Center for Clinical Knowledge Management and GHC-SCW formally adopts the guidelines recommended by this working group. UW Health has endorsed the Global Initiative for Asthma (GINA) Global Strategy for Asthma Management & Prevention Guideline with key recommendations summarized from GINA (<http://www.ginasthma.org>)

1. Diagnosis and Management of Asthma: Adult/Pediatric – Inpatient/Ambulatory Last revised* 09/2016

*Periodic Review scheduled; Target Completion 08-24 2017