Priority Health (Health Plan)
National Exemplary Award – 2007

Background: Founded in 1986, Priority Health (PH) is a nationally recognized health insurance company based in Michigan. PH insures more than 450,000 people. PH has strong relationships with over 6900 employers and more than 4000 providers and serves these members in 43 Michigan counties. The PH network includes 38 acute-care hospitals and nine facilities for in-patient mental health care and substance abuse. In October 2006, ***U.S. News & World Report*** magazine rated PH one of the nation's top health plans. In August 2006, PH was rated first in Michigan and second in the nation by the National Business Coalition on Health, which rates health plans on performance using the eValu8 process.

PH developed a formal Asthma Disease Management program in 1995, and has continued to sustain and drive best practices for Asthma management for its members. The Asthma Management Program envelops a population health management program which involves strategies focused on disease and referral management, provider collaboration and incentives, as well as regular evaluation of outcomes in conjunction with refining of PH multifaceted interventions that promote consistent evidenced based care. Asthma Disease management supports the provider/patient relationship, emphasizes the prevention of exacerbations and complications, and evaluates clinical and economic outcomes on an ongoing basis, with the goal of improving overall health. The goal setting process is a collaborative process within the work group between key staff members of the Health Management Dept., including Case and Disease management, Utilization Management, Quality and Outcomes Management and Behavioral Health, as well as other key Department leaders.

The objectives of the Workgroup, for 2006: (1) Improve the percent of members. with optimal ratios of long term control medications to quick relief inhalers; (2) Reduce ER visits and hospitalizations related to Asthma; (3) Support improvements in clinical outcomes through various initiatives: PIP targets, individualized performance improvement plans,online registries, and taking a leadership position in a community wide improvement (Impact) project on chronic disease management; (4) Expand penetration and value on investment of disease management programs; more efficiently deploy resources and use of technology, all contributing to the development of a customer centric program.

Partners: Asthma Network of West Michigan (ANWM)

Key Drivers and Program Areas:

Committed Leaders and Champions: Community partners are involved in developing and sustaining the program's tenets. Utilization measures and Pharmacy measures, as well as quality-of-life measures are considered and reflected in their goals; all goals are measurable and monthly statistical progress toward goals are discussed at the Workgroup meetings. There is a strong emphasis in educating and empowering the member toward self-management, and PH's resources and benefits are aligned to optimally support this goal. Additionally, there is a strong emphasis in educating and driving best practice for the physician community. Workgroup leaders are charged with taking the Program goals and outcomes back to their teams, to educate and empower staff at all levels to further best practices in Asthma management, and to be active participants in our community-based initiatives. The Case and Disease Management program has standardized goals for the (case) management of Asthma members, and these goals are populated in the Clinical case management software that the Case Managers (CM) use to document their work. This way, they are well assured that all members receive the same evidence driven approach (plan) of care.

The Asthma Workgroup work plan is evaluated and updated annually, with workgroup participants committed to driving change and best practice in evidenced-based Asthma management. One the most compelling examples of PH's commitment to promoting evidenced-based practice to our physician community is through its' Physician Incentive Program (PIP). Asthma Disease management is a part of the PIP measure in which various parameters related to optimal asthma outcomes are measured and interpreted, such as examining the percent of members with optimal ratios of long term control medications to quick relief (2:1) —physicians receive an incentive (per member per month) if this measure is met. Furthermore, Asthma Disease management is reflected in Patient profiles, an on-line tool whereby physician's can look at specific individual Asthma members' experience, or sort for care opportunities on all their PH asthmatic members.

Strong Community Ties: PH is involved in promoting and fostering asthma education and management in the communities it serves; our most significant relationship is with the ANWM. While PH stratifies the Asthmatic

members according to risk and has tailored interventions to address all levels of risk, it was realized that there was a need to provide home-based, case management services to their members with moderate to severe Asthma. A partnership between ANWM and PH was formed in the late 1990s between health plans and an asthma network – the first in the nation. This underscores the value of ANWM's services and PH's commitment to its members. Although PH's CMs communicate telephonically with members and providers to assess and educate on Asthma care management strategies, they realized that PH was not able to independently and effectively assess and educate on all elements in the management of this illness telephonically. ANWM's CMs and social workers provide home-based education which reveals vast information on the physical and psychosocial aspects of the management of this illness, while permitting an environmental assessment of the home. Additionally, PH provides reimbursement to ANWM whose CMs meet with the providers to develop customized asthma management plans, and educate school and day care personnel on the asthma management plan so that the entire care continuum for the member is educated about Asthma in general. All members who hit high risk via PH's stratification rules, and who reside in the ANWM service area receive a referral to ANWM's services. Additionally, any member who the PH case management team identifies as a candidate for ANWM's services is referred to this service. For members residing outside of ANWM's service area and who reside in Northern Michigan and are able to travel to Munson Memorial Hospital, they receive Asthma education from a Doctoral candidate Respiratory therapist who is a Certified Asthma educator. It is important to note here that all these community partners communicate frequently with PH's internal case management team, and with the physician providers, so that all educators are driving the same evidenced-based goals, and the member is receiving case management support collaboratively and cohesively. When home-based education is vital to the success of the case management plan and the member resides outside of ANWM's service area or is not able to access Munson's services, community-based home care is implemented. Again, PH's CM works with the Home Care nurse to articulate the goals of care and communicate openly and frequently on the progress toward goal attainment.

PH is concerned about education to all people who care for their members with Asthma, as is evidenced by its reimbursement to ANWM for education at the school and day care centers, as well as to the members and providers. PH provides financial support for an Annual Asthma camp, a collaborative community effort including local health care professionals enthusiastic in optimizing asthma management of children 8-14 years of age while promoting 'normal' experiences in camping.

Additionally, PH was recently approached by representatives from Meijer Corporation, a large employer group in Western Michigan, to partner in the care management of their members with Asthma. PH is an active participant in the Asthma coalition work in Michigan and ANWM worked collaboratively to educate staff members on the MARK (Michigan Asthma Resource Kits) manuals so that they in turn could educate/distribute this Asthma toolkit to health care providers in the Western Michigan area. Additionally, a CM from PH is represented on the Northern Michigan Asthma coalition to bring best practices back to the organization. PH supports the annual Asthma camp, a week long camp for children with Asthma, with funding, staff, and marketing.

High-Performing Collaborations and Partnerships: These have been built upon PH's relationship with ANWM. Due to financial constraints, in particular the reimbursement from PH and the declining funding that ANWM was receiving from its' grant sources, ANWM made the decision that it needed to discontinue its' services from one of PH's (regional) markets, due to financial commitment in time/travel in servicing this area. As the particular area in reference is an area of high member need, this was discouraging to all committed to Asthma education for the members. Subsequently, PH ran utilization and cost data, on those members whose case was closed due to ANWM's departure from this service area. The results were stunning, with Asthma related costs for (the study) members requiring inpatient and/or ED services in excess of $70,000, representing 7 hospitalizations and 24 ED visits. Thus, with this utilization and cost data in hand, a proposal was made to senior management at PH, to increase the reimbursement to ANWM for providing services to members in this market. PH's senior. management considered the data driven proposal with the projected ROI had ANWM's services been employed and utilization would have been thwarted, and accepted the proposal for an increased reimbursement to ANWM to continue services to this market. Another new collaboration will be occurring between emergent/urgent care providers of members who access these services for an asthma exacerbation and PH. Recently, the Asthma Initiative of Michigan (A.I.M.), the state-based asthma program, developed and distributed a tool kit to these providers called the F.L.A.R.E. plan, which, among other things, allows for documentation of a temporary asthma management plan. CMs will be confirming receipt of this document with those members who are contacted following an emergency encounter and will assess comprehension and compliance.

Integrated Health Care Services: PH has a variety of member and provider interventions to improve clinical outcomes for members with asthma. Key activities employed to improve asthma care include: (1) Incentive payments for primary care physicians whose asthmatic members adhere to long-term controller medications (2:1

ratio of LTC to quick relief medications); (2) Monthly reports to primary care physicians detailing outcomes measures for asthma compared to benchmarks and targets; (3) On-line registry listing asthma patients. Physicians can identify patients who have care opportunities using established filters; (4) Directed member mailings sent to members needing to refill medications or who have had an ER visit or hospitalization for an asthma exacerbation; and, (5) Case management for high risk members with repeat hospitalizations.

One strategy that PH has developed to help Provider offices reach targeted goals is the Pacesetters initiative. The PaceSetter initiative aims to improve care in the primary care micro system via the implementation of the Planned Care Model (PCM). In this program, PH staff team with provider office staff to make evidence-based process and systems changes based on PCM elements. For example, PH also has worked with a Pediatric office to help them improve compliance on their Asthma measures. A Team met with the office representatives routinely to identify the status of progress to meeting goals and addressing barriers.

Meetings included a review of the office practice for managing an asthma patient, training in the Michigan Asthma Resource Kit (MARK, a guide book to help practioners treat asthma patients), and arranging and providing partial reimbursement for their office staff to attend an asthma education course. The CM assigned to this office became an integral part of the team, facilitating referral of their asthma patients to the PH case management program. This was felt to be a key part of the plan as it would provide sustainability for ongoing management of these patients.

The Pediatric office was able to increase their asthma PIP score from 67% in 2004 to 82% in 2005. It is believed that the three primary factors that lead to this positive outcome were: (1) Application of what they learned and tools through attending the M.A.R.K. presentation; (2) Attending the asthma educator's course; and, (3) Increasing utilization of case management services through awareness

Tailored Environmental Interventions: PH's out-patient CMs telephonically assess and educate members on Asthma management, in addition to the fact that they incorporated into their clinical case management software numerous questions about asthma trigger awareness. Next to this question is a "paperclip" for the CM to click on, that provides a ready reference for the discussion topics of trigger basics, environmental triggers, non-environmental triggers, immunizations, and FAQ's. The CM establishes this Asthma management goal, related to Asthma triggers: They determine if a member can state triggers and need for avoidance of triggers; CM then provides (and member verbalizes understanding of) verbal and written education and reinforces importance of trigger identification and exposure reduction. If member uses tobacco, CM advises to quit and educates them on available resources/benefits for assistance with tobacco cessation. Additionally, a new member mailing is sent to the member the first time that a claim for Asthma is received - within this packet of Asthma information is information regarding Asthma triggers.

Furthermore, the CM may recognize the need for additional education regarding triggers, based on the CM's assessment that the member may not fully grasp the importance of trigger avoidance-additional customized information on triggers is available for distribution. Also, the member can log in to the member center at www.priorityhealth.com, and click on the Asthma condition center for additional information and complete a personnel health file. In addition, PH has provided periodic educational sessions, called Wellness classes, for member with asthma, free of charge. PH partnered with an outside firm to provide around the clock, professional counseling and follow up (Quit Line) for members who are struggling with tobacco addiction and are ready to change. To date, 179 members have enrolled in this Program. The most significant approach to identifying Asthma triggers for our members. is our partnership with ANWM, as their home based assessment of asthma triggers and education regarding environmental modification yields landmark results. Most noteworthy of their actions are their efforts at reducing Tobacco use and environmental tobacco smoke, in the homes and vehicles of Asthmatic members, their assessment of the bedroom, as well as the resources and tools they share with the member and family to decrease the allergens in the bedroom.

Positive Health Outcomes: PH's goal is to achieve the national 90th percentile ranking for HEDIS asthma measures. PH monitors these outcomes annually and compares them available benchmarks. In the last measurement cycle (HEDIS 2006) PH achieved the national 90th percentile performance for use of long-term control medication for adolescents in both the commercial and Medicaid populations. (This target was not achieved for aggregate scores.)

Percent of members with persistent asthma using long-term relief medication	Commercial HEDIS 2004	Commercial HEDIS 2005	Commercial HEDIS 2006*	90th Percentile Goal
Aggregate (c)	79%	78%	94%	96%
Aggregate (m)	79%	78%	91%	93%

PH monitors the percent of members with a 2:1 ratio of LTC medications to short-acing beta agonists as part of the Physician Incentive Program. Physicians receive monthly Key Indicator reports listing outcomes for their patients and/or practice site. Provider can access the online registry to identity patients who have not reached the 2:1 threshold that require follow-up. Physicians who reach the goal (75% for 2006) receive an end-of-year payout of $100 per patient.

Percent of members with asthma with a 2:1 ratio of LTC medications to short- acting beta agonists (PIP Measurement)	2005	2006
Commercial	77%	76%
Medicaid	53%	51%
Medicare	na	60%

Program Sustainability and Financing: PH envisioned its' Asthma Disease Management Program in 1995, with 2 RN's committed to Program design and member education. By 1998, the program staff had quadrupled, and today there are 25 CMs working with PH members, providers and community partners toward the identification, assessment, education and evaluation of our members with Asthma. Four of the case managers have taken formal graduate level classes in Asthma management, and 1 CM has earned her AE-C. The relationship with ANWM was formed in 1999 and has grown from serving primarily Medicaid Pediatric members to serving all members, Pediatric as well as Adult, in all products. The Asthma Workgroup was founded in 2002, and has provided oversight for all of PH's Asthma initiatives, as well as evaluating the outcomes of those initiatives and coordinating, planning and implementing the revised interventions for unmet targets.

Lessons Learned:

- Asthma is a chronic disease that is oftentimes treated only in a period of acute exacerbation; therefore, education to members and providers is critical to reduce the burden of this disease.
- Be passionate about deriving solid outcome data---cost, clinical outcomes and quality of life---so that you can prove your value on investment, and publish your results.
- Continue incentivizing(rewarding) providers to practice evidenced based Asthma care.
- Relationship matters—partner to promote best practices.
- Disparities exist in the treatment/management of Asthma and health care professionals must strive to become culturally competent.

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