

Asthma Data Workgroup Minutes

2/8/07, 2:00 to 4:00

Portland State Office Building, 800 NE Oregon Street, Portland, OR 97232

ATTENDEES: Cynthia Ackerman* (MRIPA), Susan Arbor* (DMAP), Susan Bricker (CareOregon), Jan Britt* (MRIPA), Amy Brittan (ODS), Donna Erbs* (Kaiser), Thuy Kisselman* (MPCHP), Prasad Ravi (Kaiser), Chris Coon* (DMAP), Mike Emerson (DHS), Tracy Scharn (Providence), Artie Veira (Providence), Yolanda Welch (FamilyCare)

* Attended by conference call.

ANNOUNCEMENTS:

- Several new Asthma Data Workgroup (ADWG) members were introduced, including:
 - Susan Bricker, a new analyst at CareOregon.
 - Amy Brittan, a new analyst at ODS Companies.
 - Yolanda Welch, a new analyst at FamilyCare.
 - Onie Greiling (in absentia), the new Health Systems Liaison for the Oregon Asthma Program.
- The presentation on pediatric asthma disparities was postponed until the next ADWG meeting on April 26, 2007.

PRESENTATION:

- Mike presented the asthma care indicators from the 2005 measurement year. Data was submitted through two mechanisms: the ADWG and the Division of Medical Assistance Programs-Quality and Performance Improvement (DMAP-QPI) Workgroup. The presentation included aggregate and individual plan data for indicators currently measured by ADWG. Please contact Mike (971-673-1121 or michael.j.emerson@state.or.us) for a copy of the PowerPoint presentation.
 - Note that, due to data sharing agreements previously agreed upon in the ADWG, individual plan data submitted through ADWG is presented in a blinded fashion and is only presented in the ADWG meetings. The individual plan data submitted through DMAP-QPI, on the other hand, may be presented outside the DMAP-QPI and ADWG meetings after the Medicaid plans have already seen the results of the analyses.
 - Mike and Susan A. noted that, for some measures, only 1-2 plans may have submitted data, so this is an important limitation to consider with respect to reliability and generalizability across all plans, commercial or Medicaid.

- Briefly, the presentation covered the following topics:
 - Background information on *The Guide to Improving Asthma Care in Oregon* (the *Guide*), the indicators in the Guide, and Oregon Asthma Program priorities.
 - Claims data for the measures and indicators in the Guide from Measurement Year 2005.
 - Discussion of data, the utility of this data for the health plans that submit it, and how the data are used to improve asthma care. These discussion focused on the following:
 - Standard vs. enhanced measures for short-acting beta₂-agonists. Prasad and Artie indicated that the enhanced measure is preferred and more accurate. They noted that mistakes can occur due to factors such as data entry errors (e.g., incorrect entry of a metric quantity or days supply), but that it is possible to identify such errors during analysis.
 - Room for improvement on performance measures. The three measures that appear to have the most room for improvement include follow-up to ED visits, over-use of short-acting beta₂-agonists, and the medication ratio. Donna and several other attendees noted that it is very difficult to improve follow-up to an ED visit due to the time and difficulty in getting records from the ED to the health plan or to the patient's physician. For this reason, several plans are choosing to focus on other measures such as the medication ratio for asthma care improvement projects.
 - Utility of analyzing asthma measures. When asked by Mike whether the asthma performance measures were useful for the health plans, several attendees indicated they are indeed useful and aid the plans in tracking asthma patients, particularly patients who are receiving sub-optimal care. Attendees from some plans indicated they would track measures such as those in the Guide whether or not the State collected them, but that it did not create an undue work burden to also share these measures with the State. Attendees from other plans indicated they use these measures or plan to use these measures, and they would not otherwise do so.
 - Including asthma HEDIS measure. Mike asked the plans about potentially collecting data for the asthma HEDIS measure as part of the submission process for the ADWG. Donna noted that this information may be available elsewhere, so Mike will do some research to find what is publicly available.
 - Performance Improvement Projects. Several plans have performance improvement projects that have been piloted or implemented to improve asthma care. The plans and their projects are summarized in the table below.

Table of Asthma Care Improvement Projects by Health Plan

Health Plan	Asthma Care Improvement Project(s)
<p>FamilyCare</p>	<p>FamilyCare keeps current list of eligible members with persistent asthma, and this list is printed out monthly. The information in the printout includes ED visits, outpatient visits, inpatient visits, inhaled corticosteroid canisters, and short-acting inhaled beta₂-agonists. FamilyCare then contacts members and obtains additional information through a health history. Some of the information obtained includes the following:</p> <ul style="list-style-type: none"> • has the patient ever been taught how to use their inhalers • does the patient have a treatment plan with their primary care provider • does the patient miss work due to asthma • does the patient have a chronic cough, especially at night • what medications are they taking • what does the patient do if they experience an asthma attack • does the patient smoke • additional health history information on topics such as depression and diabetes <p>Based on the answers to these questions, a FamilyCare representative will determine if the member has special needs or needs more care, and then provide education over the phone and encourage patients to be seen regularly by their primary care provider.</p>
<p>Kaiser Permanente</p>	<p>1. The Panel Support Tool is part of a primary care panel management strategy that uses an online listing of a provider's panel to check for and address care gaps for patients. The asthma care gap is displayed as a colored prompt, and can be noted in either red, yellow, or green, based on the magnitude of the gap:</p> <ul style="list-style-type: none"> • Red means one of the following: <ul style="list-style-type: none"> ○ In the Asthma HEDIS cohort and no controller meds in last 12 months ○ 4 or more beta-agonist canisters in last 12 months and ratio of controller meds to beta-agonists is less than 0.3 ○ Emergency Department visit for asthma in last 3 months ○ Inpatient discharge in last 3 months with principal diagnosis of asthma • Yellow means one of the following: <ul style="list-style-type: none"> ○ 4 or more beta-agonist canisters in last 12 months and ratio of controller meds to beta-agonists is between 0.3 and 0.5 ○ Emergency Department visit for asthma in last 4-6 months ○ Inpatient discharge in last 4-6 months with principal diagnosis of asthma • Green means one of the following: <ul style="list-style-type: none"> ○ 4 or more beta-agonist canisters in last 12 months and ratio of controller meds to beta-agonists is greater than 0.5 ○ Less than 4 beta-agonist canisters in the last 12 months

Health Plan	Asthma Care Improvement Project(s)
	<p>2. In addition to the Panel Support Tool, which is relatively new, and still used only by adult medicine, Kaiser also make available online (and distribute to clinicians 3 X per year on paper) asthma rosters with the following data elements:</p> <ul style="list-style-type: none"> • demographics • medication ratio • beta-agonist dispenses in past 12 months • anti-inflammatory (ICS) dispenses in past 12 months • last visit to PCP, Allergy, or Pulmonology • ER, UC, Inpatient visits • smoking status • new to roster <p>Both of these tools are incorporated in various ways into the primary care workflow, either by clinicians, nurses, or MAs, or some combination of both.</p> <p>3. Kaiser also compiles quarterly team/provider level statistics for their HEDIS asthma measure, and posts them online.</p>
MRIPA	<p>Cynthia said during the ADWG meeting that she had conducted a pilot project with a pediatrician in their plan to examine asthma prescriptions. The pilot project was revealing in the following ways:</p> <ul style="list-style-type: none"> • Reports of the number of pediatric patients with asthma served by this provider varied widely, from a high of 19 (provider report) to a low of 7 (actual patients with asthma based on chart review). This finding highlighted the importance of identifying patients with asthma who are served by a plan. • Of the 7 pediatric patients with asthma identified, all 7 had received inhaled corticosteroid prescriptions from the provider. Only 2 patients, however, had filled the prescriptions, indicating that patient compliance with controller medications may be a very important issue.
ODS	<p>Asthma Care Disease Management Program Semi-annually, an invitation is sent out to all eligible ODS members with a diagnosis of asthma, asking them to participate in the Asthma Care Disease Management Program. Upon enrollment, patients are encouraged to identify personal health goals and the Health Promotion RN provides tools to help the member achieve their goals. Through telephonic interventions, the Health Promotion RN works with the member to assess individual healthcare needs and track progress in reaching goals. Telephone sessions include asthma education, self-monitoring skills, identifying triggers, and various assessment tools to evaluate both the member's mindset and the state of their disease. Members remain in the program until they have demonstrated appropriate understanding of their disease and have attained their goals, or they no longer wish to participate.</p> <p>Asthma Care Quality Improvement Project</p>

Health Plan	Asthma Care Improvement Project(s)
	<p>Semi-annually, a mailing is sent to all eligible ODS members with an asthma diagnosis and all eligible members that have refilled an asthma-related medication in a certain time period. In 2006, members received a newsletter that provided educational information on asthma triggers, medication, warnings signs of problems with asthma, and what to do in the event of an asthma attack. A second mailing included information on helping children to live with asthma, managing asthma triggers, and the possible side effects of certain asthma medications. This project also includes a provider intervention where physicians receive letters informing them of their patients with asthma and the percentage of them who refill asthma controller medications at the optimal level.</p>
<p>Providence</p>	<ol style="list-style-type: none"> 1. A new member letter is sent to Providence Health Plan members in our Commercial, Medicare, and Medicaid asthma registries. These letters introduce the member to the asthma resources available through Providence, including our "advice nurse line", ProvRN, our audio health library phone number, and our website. Included with the letter is a booklet on living with asthma and an Asthma Action Plan that the member can fill out regarding medications. The intent is for the member to take this action plan to their next appointment and discuss it with their doctor. 2. Provider Reports. A report goes out to Providence Medical Group providers listing our members (their patients) who have a medication ratio < 0.50 or who have had an ED or inpatient admission with a diagnosis of asthma. In the provider cover letter, the ratio is defined and we explain that the document is designed to give them patient-specific information about pharmacy-dispensed asthma medications and visits with an asthma diagnosis. 3. Member direct-mailings. Three direct-mailers go to members with asthma. Each mailer focuses on a different aspect of asthma (e.g., zones or triggers). This year there will also be a targeted mailer to those who have a medication ratio < 0.50. The topic of the mailer will be asthma medications, emphasizing increasing controller meds and decreasing rescue med use. 4. Additional information is sent through our case and disease management program.