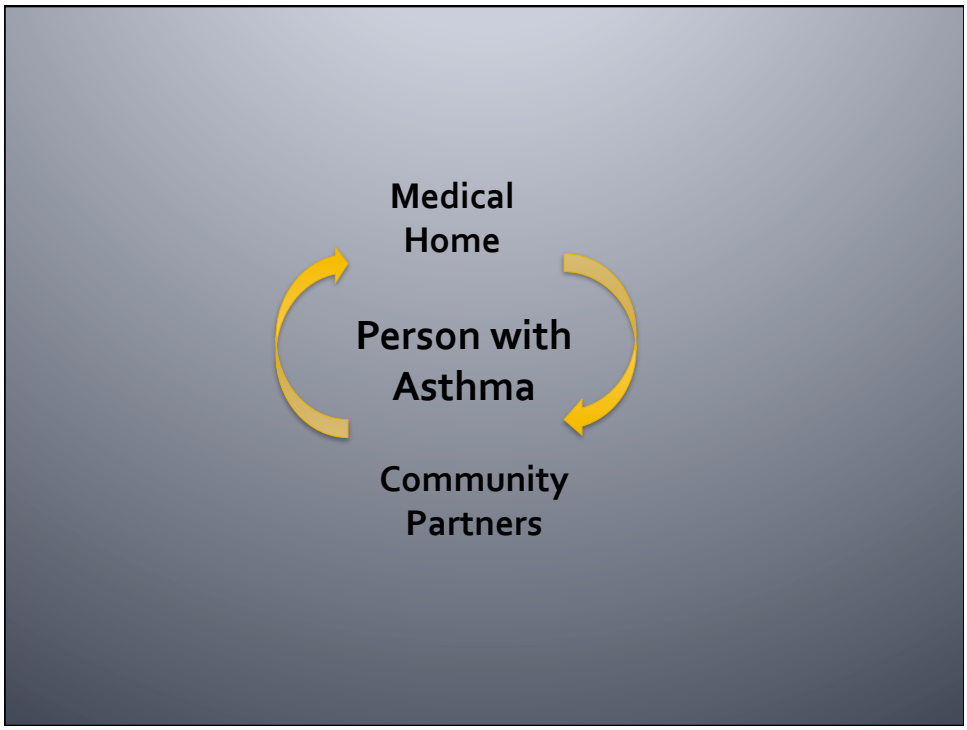
Asthma Ready® Communities
University of Missouri Health Care

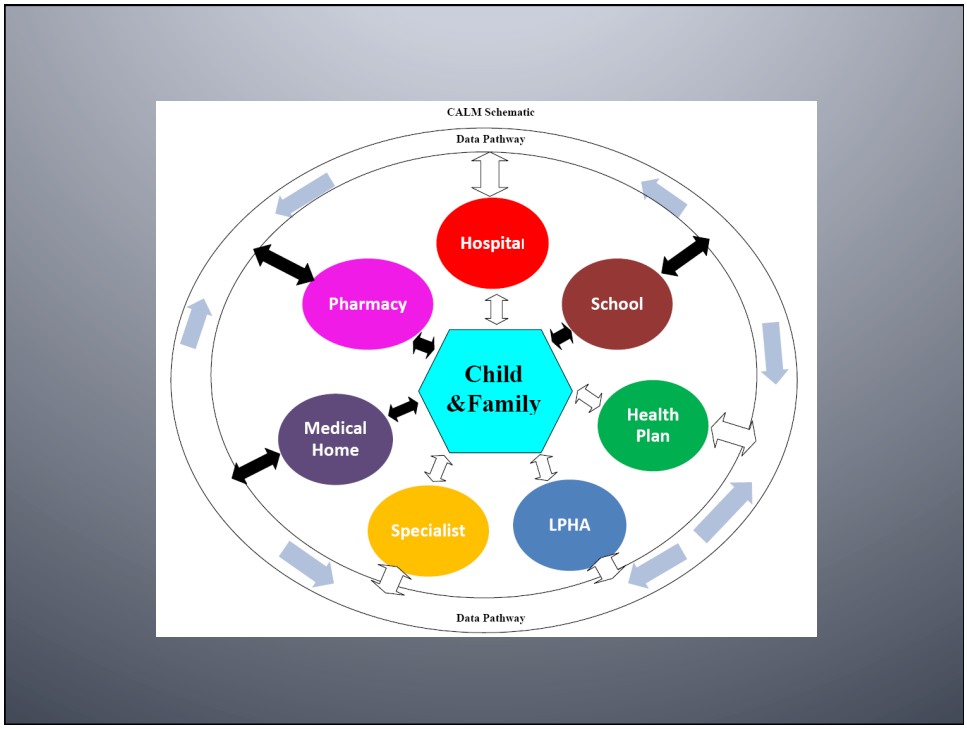
Reimbursement for "Asthma Education"

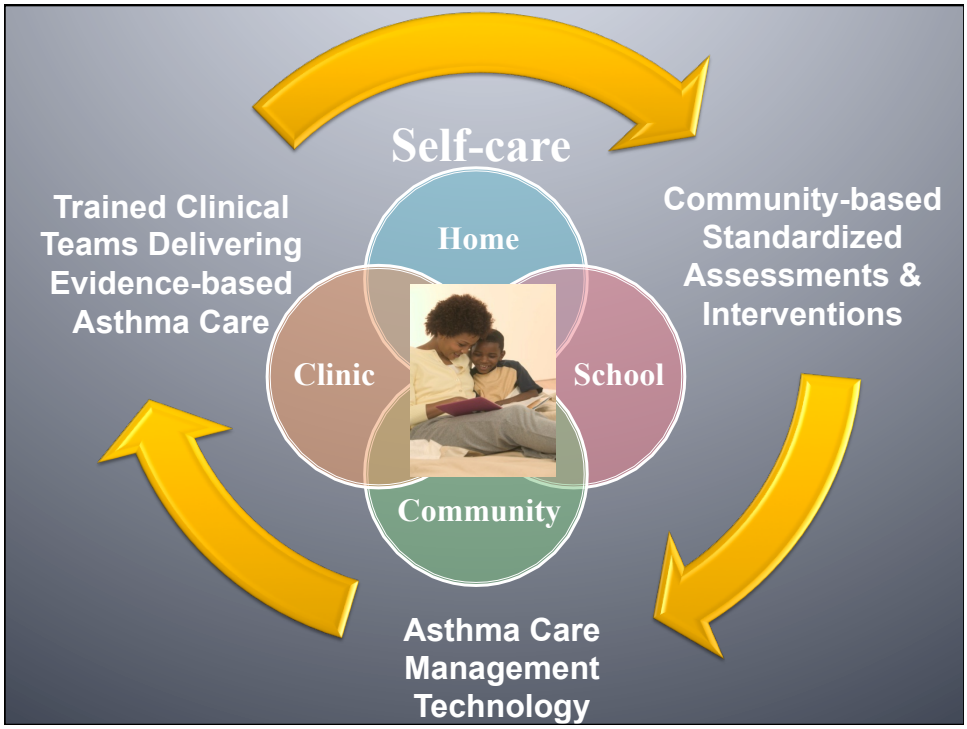
Children's Hospital
University of Missouri Health Care

Clinical and Community Care Collaboration

Ben Francisco, PhD, PNP, AE-C




CALM Schematic
Data Pathway
Hospital
Pharmacy
School
Child &Family
Medical Home
Health Plan
Specialist
LPHA
Data Pathway


Self-care
Trained Clinical Teams Delivering Evidence-based Asthma Care
Community-based Standardized Assessments & Interventions
Home
Clinic
School
Community
Asthma Care Management Technology

Insurer-Prompted Interventions

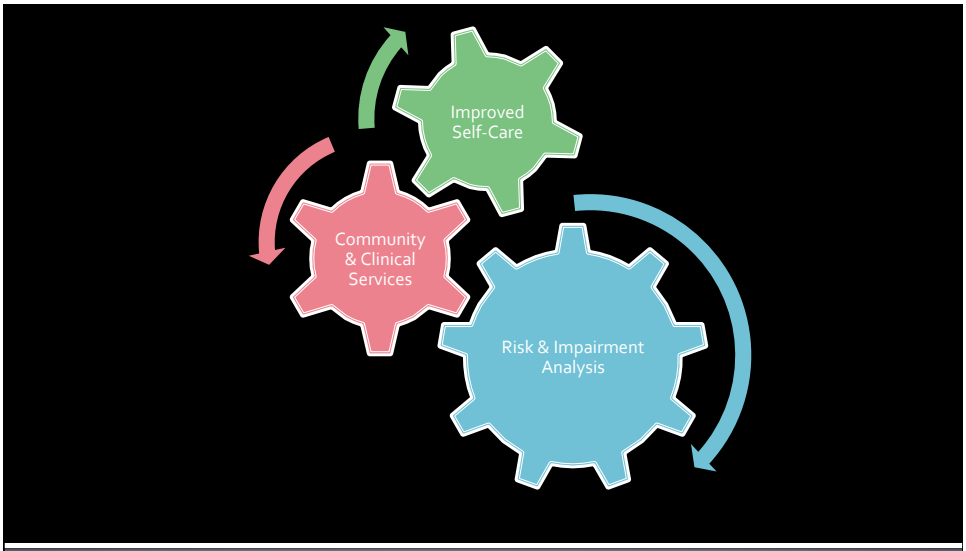
Array of Clinical & Preventive Services*

Service Type	Eligible Group	Service Cost
1) Asthma Literacy	Uncontrolled asthma	Low, S9441*
2) Key Messages	Everyone w/asthma	Bundled w/OP visit
3) Inhalation instruction	Everyone w/asthma	Low, 94664
4) PMC, risk reduction	Uncontrolled asthma	Medium, 99402,1
5) Medication Therapy Management	Claims alerts at point of dispensing Rx	Medium, 99605,6,7
6) Self-management	Very poor control-VPC	Moderate, 98960,1,2*
7) Home Trigger Reduction	VPC, good ICS adherence/technique	Moderate, T1028*
8) Coach/counselor	VPC, failed 1-7	High, CPT-?????

Asthma Ready® Communities 2014

MO Medicaid Reimbursement Plan

- Childhood asthma as a qualifying condition for health home services (PMPM allocation for patients receiving a "touch" that month)
- Community preventive asthma services – CPT codes approved for reimbursement: S9441, T1028, 98960.61, 62 (with Rx)
- Clinical asthma educational services – CPT codes approved for reimbursement: 99401, 99402, 98960 (61, 62), 94664

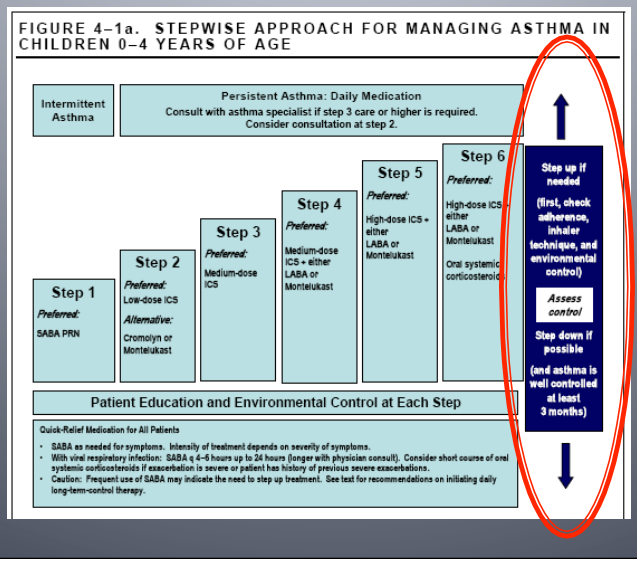


Data-driven Care & Evaluation

Service & Data Linkages

- All interventions are coupled with EPR3-complaint assessments (impairment and risk)
- All paid encounters (clinic or community) generate EPR3-compliant assessment data
- Claims and assessment data are merged to stratify risk, assess impairment and prompt a cost-effective intervention

Clinicians Adjust Rx Therapy Based on…



EPR3 Guide to Stepping Therapy Up or Down

- **Step up IF** needed
- FIRST, check adherence
- THEN, check inhaler technique
- AND, check environmental control
- **Step Down,** IF asthma is well controlled for 3 months or longer

Must base therapy step changes on assessment of adherence, inhalation technique and triggers

Recognizing Uncontrolled Asthma

Clinical

Ill child, short of breath, wheezing, coughing, fever?

Allergy season?

GERD flare?

(MD, NP, PA)

Lens 1

Clinicians Assess Impairment & Risk

FIGURE 4–3b. ASSESSING ASTHMA CONTROL AND ADJUSTING THERAPY IN CHILDREN 5–11 YEARS OF AGE

Components of Control		Classification of Asthma Control (5–11 years of age)		
		Well Controlled	Not Well Controlled	Very Poorly Controlled
Impairment	Symptoms	≤2 days/week but not more than once on each day	>2 days/week or multiple times on ≤2 days/week	Throughout the day
	Nighttime awakenings	≤1x/month	>2x/month	≥2x/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting beta$_2$-agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
	Lung function • FEV_1 or peak flow	>80% predicted/ personal best	60–80% predicted/ personal best	<60% predicted/ personal best
	• FEV_1/FVC	>80%	75–80%	<75%
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year	≥2/year (see note)	
		Consider severity and interval since last exacerbation		
	Reduction in lung growth	Evaluation requires long-term followup.		
	Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		
Recommended Action for Treatment (See figure 4–1b for treatment steps.)		• Maintain current step. • Regular followup every 1–6 months. • Consider step down if well controlled for at least 3 months.	• Step up at least 1 step and • Reevaluate in 2–6 weeks. • For side effects: consider alternative treatment options.	• Consider short course of oral systemic corticosteroids, • Step up 1–2 steps, and • Reevaluate in 2 weeks. • For side effects, consider alternative treatment options.

Recognizing Uncontrolled Asthma

Claims

↑ SOS (systemic oral steroids)

↑ SABA (quick relief inhaler)

↑ Acute care days (ER, hospital stays)

? ICS

(↑ antibiotics)

(Too many doctors)

Lens 2

Successful Strategies
& Promising Interventions

just do it.

Pharmacy Claims

MPR % Description

Service Date	Drug Name	Quantity	Days Supply	Refill	Therapeutic Class	MPR%	Alerts	Physician	Pharmacy
10/05/2011	FLUTICASONE PROP 50 MCG SPRAY	16	30	0	Eye, Ear, Nose & Throat Preparations	181%		C	A
10/05/2011	RANITIDINE 150 MG TABLET	60	30	0	Gastrointestinal Drugs	90%		C	A
10/05/2011	FLOVENT HFA 220 MCG INHALER	12	30	0	Hormones and Synthetic Substitutes	-	B	C	A
10/04/2011	IPRATROPIUM BR 0.02% SOLN	125	30	1	Autonomic Drugs	102%		A	A
10/04/2011	ADVAIR HFA 230-21 MCG INHALER	12	30	1	Hormones and Synthetic Substitutes	91%	B	C	A
09/28/2011	NAPROXEN 500 MG TABLET	60	30	0	Analgesics and Antipyretics	103%		A	A
09/24/2011	TRAZODONE 50 MG TABLET	30	30	1	Psychotherapeutic Agents	105%		O	A
09/22/2011	CEFUROXIME AXETIL 500 MG TAB	28	14	0	Antibiotics	-		C	A
09/20/2011	CEPHALEXIN 500 MG CAPSULE	30	10	0	Antibiotics	-		D	B
09/12/2011	CYCLOBENZAPRINE 5 MG TABLET	28	14	0	Autonomic Drugs	-	A	A	A
09/01/2011	IPRATROPIUM BR 0.02% SOLN	125	30	1	Autonomic Drugs	-		A	A

Sample FQHC — March 2014 - February 2015

	N =	randomized listing number
	DCN =	Medicaid number
	ACD =	Acute Care Days = ED visits + inpatient days
	ED =	# times in emergency room
	SOS =	Systemic or Oral Steroid = # times steroids taken
	SABA =	# of inhalers obtained Short-acting Beta Agonist
	ICS =	# / 12 as a % of expected refills

(all calculations are for the preceding 12 months)

	White	Yellow	Red
ACD	≤ 1	2 to 3	≥ 4
ED	≤ 1	2 to 3	≥ 4
SOS	≤ 1	2 to 3	≥ 4
SABA	0 to 4	5 to 7	≥ 8
ICS	> 80%	80% to 40%	< 40%

N	DCN	ACD	Hospital	ED	SOS	SABA	ICS
217	###	0	0	0	1	0	0%
218	###	8	0	8	2	4	33%
219	###	4	0	4	10	9	42%
220	###	4	0	4	0	5	25%
221	###	0	0	0	0	0	0%
222	###	1	0	1	0	1	0%
223	###	2	0	2	1	11	58%
224	###	2	0	2	0	3	33%
225	###	2	0	2	1	1	17%
226	###	6	0	6	2	14	17%
227	###	0	0	0	0	3	25%
228	###	0	0	0	0	3	33%
229	###	1	0	1	0	5	58%
230	###	0	0	0	0	2	17%
231	###	6	0	6	3	3	50%
232	###	0	0	0	1	3	8%
233	###	6	0	6	1	3	0%
234	###	0	0	0	0	1	17%
		498	140	358	108	595	20%

Mean

ACD rate	2.1
SOS rate	0.5
ICS rate	2.4
SABA rate	2.5

Risk Profile (Zero equals No Risk)

SOS/ICS ratio	0.19
ACD/ICS ratio	0.90
SABA/ICS ratio	1.07

Recognizing Uncontrolled Asthma

https://www.youtube.com/user/AligningForces

Community

Impaired student

↑ Absence from school

"Sick House"

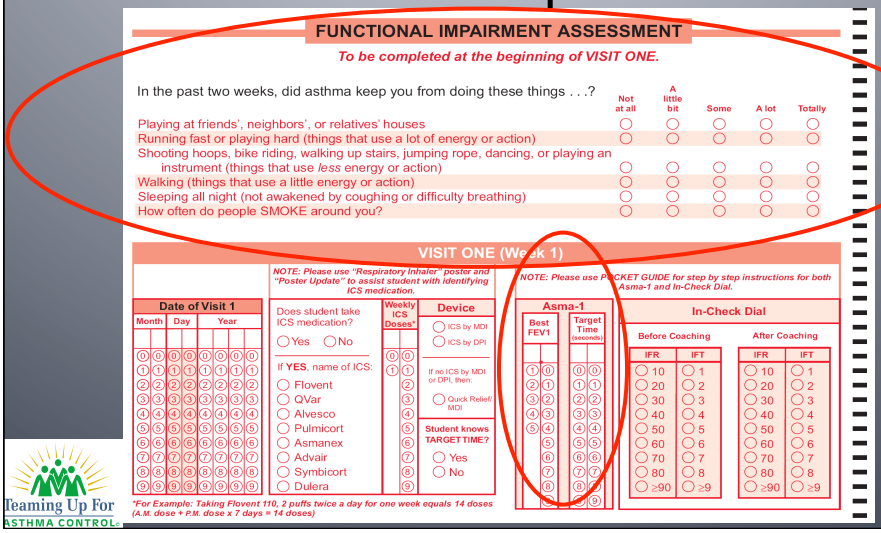
"Sick Building"

Lens 3

Successful Strategies & Promising Interventions

just do it.

School nurses assess impairment & risk



FUNCTIONAL IMPAIRMENT ASSESSMENT

To be completed at the beginning of VISIT ONE.

In the past two weeks, did asthma keep you from doing these things . . .?

	Not at all	A little bit	Some	A lot	Totally
Playing at friends', neighbors', or relatives' houses	○	○	○	○	○
Running fast or playing hard (things that use a lot of energy or action)	○	○	○	○	○
Shooting hoops, bike riding, walking up stairs, jumping rope, dancing, or playing an instrument (things that use *less* energy or action)	○	○	○	○	○
Walking (things that use a little energy or action)	○	○	○	○	○
Sleeping all night (not awakened by coughing or difficulty breathing)	○	○	○	○	○
How often do people SMOKE around you?	○	○	○	○	○

VISIT ONE (Week 1)

NOTE: Please use "Respiratory Inhaler" poster and "Poster Update" to assist student with identifying ICS medication.

NOTE: Please use POCKET GUIDE for step by step instructions for both Asma-1 and In-Check Dial.

Date of Visit 1: Month / Day / Year

Does student take ICS medication? ○ Yes ○ No

If YES, name of ICS:
○ Flovent ○ QVar ○ Alvesco ○ Pulmicort ○ Asmanex ○ Advair ○ Symbicort ○ Dulera

Weekly ICS Doses*

Device: ○ ICS by MDI ○ ICS by DPI

If no ICS by MDI or DPI, then: ○ Quick Relief/ MDI

Student knows TARGET TIME? ○ Yes ○ No

Asma-1: Best FEV1 / Target Time (seconds)

In-Check Dial

Before Coaching IFR	Before Coaching IFT	After Coaching IFR	After Coaching IFT
○ 10	○ 1	○ 10	○ 1
○ 20	○ 2	○ 20	○ 2
○ 30	○ 3	○ 30	○ 3
○ 40	○ 4	○ 40	○ 4
○ 50	○ 5	○ 50	○ 5
○ 60	○ 6	○ 60	○ 6
○ 70	○ 7	○ 70	○ 7
○ 80	○ 8	○ 80	○ 8
○ ≥90	○ ≥9	○ ≥90	○ ≥9

*For Example: Taking Flovent 110, 2 puffs twice a day for one week equals 14 doses (A.M. dose + P.M. dose x 7 days = 14 doses)

Teaming Up For ASTHMA CONTROL

Recognizing Uncontrolled Asthma

3 Lens View

Progress to date in Missouri

- 3 year, CDC-funded study demonstrated ROI 8:1 for school based intervention for Medicaid
- AAFA and local legislator advanced a preventive asthma services proposal (2014)
- Governor signed Budget Bill 2011 (2015)
- Missouri Medicaid (MO MC) convened statewide group to determine rules & process
- MO MC added Childhood Asthma as a qualifying condition for Health Home

Progress to date in Missouri (2)

- IMPACT Asthma© ECHO® was funded by the Missouri legislature, PCP expert support & CME (**E**xtension for **C**ommunity **H**ealthcare **O**utcomes)
- Asthma Risk Panel reports were approved by MO MC, clinics serving >5000 children have received reports, many more waiting
- FQHC network has approved work plan to deliver claims and community risk reports as "Patient Visits Summaries" at point of care
- Pending CMS approval PAS, HH amendment

Thank you to the

Centers for Disease Control & Prevention

Missouri Foundation for Health

Health Care Foundation of Greater Kansas City

Project ECHO
(hub-and-spoke knowledge-sharing network)
https://www.youtube.com/watch?v=VAMaHP-tEwk

www.asthmaready.org

Thank you!