

Healthways, Inc.

Asthma Product

Product Need:

Every day in America:

- o 40,000 people miss school or work due to asthma
- o 30,000 people have an asthma attack
- o 5,000 people visit the emergency room due to asthma
- o 1,000 people are admitted to the hospital due to asthma
- o 11 people die from asthma

Product Goal:

To educate the asthma population regarding:

- o Self-management, in an attempt to reduce the number of unnecessary emergency room visits and hospital admissions related to Asthma
- o Effective use of medications
- o Knowledge and understanding of the causes and consequences of the disease, and...
- o Modifications of behaviors and environmental exposures that may negatively impact the disease

Target Population:

The target population includes all health plan members with an active asthma diagnosis. Members with an active COPD diagnosis in addition to an asthma diagnosis are excluded from the program.

Participant Identification:

Members can join the program through Healthways' claims identification process or through provider or health plan referrals.

- o **Claims Assessment:** Healthways identifies members through medical and pharmacy claims assessment.
- o **Provider/Health Plan Referral:** A member's provider or health plan can refer them.
- o There are no age restrictions in the identification of asthma members.
- o Members diagnosed with COPD are not eligible for the asthma program.

NOTE: If a member's primary disease program is Asthma, but he/she is later identified for a 'core' disease (i.e., diabetes, CAD, HF, COPD), then the member's primary disease program changes from Asthma to the core disease for reporting and fee purposes.

Value of the Program:

Promote clinical improvement through teaching self-care management skills:

- o Having and using a written asthma plan
- o Taking medications as prescribed
- o Using the tools for daily self-evaluation

Foster Risk Mitigation through identification of gaps in knowledge:

- o Knowledge deficits about condition and triggers, perceptions and beliefs
- o Medication adherence and persistence
- o Accurate self-assessment
- o Annual Flu vaccine

And by:

- o By screening for depression and offering referral for treatment when appropriate
- o By coaching to improve communication with the treating providers

**Program
Features for
Members:**

- o Members are stratified using a Healthways proprietary **Asthma Predictive Model**:
- o **Claims Algorithm Triggers**: a clinical algorithm is run on the total population of members and will initially stratify them based on their associated asthma risk
- o **Graduation**: members graduate from the program after remaining low risk for 1 year of continuous enrollment
- o **Re-entry**: a member can re-enter the program as appropriate through routine data mining
- o **Age**: Age-specific workbooks (child, teen and adult) are provided

Standard Product Features for Members:

- Introduction Letter and Asthma Workbook
- Engagement Calls
- Care Calls Based on Member Delivery Segment
- Flu and Pneumonia Vaccine Reminders
- Lifestyle Management Survey
- Asthma Specific Assessment/Intervention
- Depression Screening
- Quarterly Newsletter
- Educational Topic Sheets
- Customized Goal Development
- Toll-Free Telephone Service Website Access

**Clinical
and Risk
Mitigation**

Clinical Improvement:

- Action Plan in place
- Appropriate medication use: controller and rescue medications
- Inhaled corticosteroids for severe persistent asthma
- Daily self-evaluation
- Flu and pneumonia vaccinations

Risk mitigation: closing the gaps in care

Case Study:

Jackie, a 37-year old female was identified as having asthma and was engaged in the asthma program.

Intervention: Upon engaging the member telephonically, Jackie reported to Tracey, her care manager, that she smoked 1 to 1 ½ packs of cigarettes each day. With Tracey's help, Jackie set a goal to lessen the number of cigarettes smoked per day. Jackie now reports smoking 2 to 3 cigarettes daily, but plans to quit the habit entirely. Tracey will continue to work with Jackie to help her achieve this smoking cessation goal.

Tracey helped Jackie set a second goal to ask her provider for a Peak Flow Meter. This would enable Jackie to monitor her Asthma and seek medical assistance early in an exacerbation.

Outcome: Two months after setting the goal, Jackie reported that she was using her Peak Flow Meter every other day and recording her values for her doctor. She also reported that she recently noticed an abrupt change in her readings, immediately called her doctor, and started medical treatment for an infection.

Jackie told Tracey that she weighed 411 pounds prior to her engagement in the program. After 7 months of her program membership, she now weighs 352 pounds. She is walking every day and swims at a local pool once a week. Jackie attributes her weight loss to the motivation she receives from her care manager, Tracey.

Empowered to be more active in her own health care, Jackie began the discussion about her Asthma with her doctor. By learning how to use her Peak Flow Meter, Jackie's need for emergency service resulting from her asthma should decrease; thus, decreasing overall health care costs. The early management of Jackie's Asthma and her routine exercise program should improve her quality of life as well as decrease her health care utilization.

Source: All names are fictitious for confidentiality.

