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# Clinical Summary
# Chronic Disease Management: Asthma and COPD

## Goal

**Immediate**: Identify individuals with asthma and chronic obstructive pulmonary disease (COPD), stratify risk level, and improve care coordination for highest risk individuals. Increase home-based services to manage the conditions.

**Long-term:** Decrease rates of asthma- and COPD-related complications in those with the diseases. Empower individuals to achieve successful self-management practices. Sustain home-based services to manage the conditions and reduce avoidable asthma- and COPD-related emergency department (ED) visits and hospital admissions.

## Focus Population

Medicaid members age 5 and older with uncontrolled asthma or COPD, defined as having one or more ED visit or hospitalization for the condition(s) in the past 12 months.

## Key Project Elements

*The following interventions are recommended for participating provider organizations. Pursuing the recommended strategies as appropriate for specific focus populations is likely to help Practice Partners achieve their goals related to HealthierHere's 2019 pay for progress incentives.*

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g., Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based upon the Chronic Care Model, NHLBI & NAEPP recommendations, and Global Initiatives for Asthma & COPD recommendations, implementing organizations are encouraged to utilize the following key strategies.

**Utilize Population Health Management Tools:**

- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers (PCPs), behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.
- Ensure that registry is in place to allow for identification of target population, and establish a process for adding appropriate individuals to registry (e.g., individuals who have asthma and/or COPD without a corresponding ICD-10 code on the problem list).
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

**Assess Whole Person Care Needs:**

- Whole person care needs include the following: physical health, substance use, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Identify individuals with asthma and COPD, and assess and monitor their severity levels using spirometry.
- Control conditions with appropriate treatment (e.g., medication, pulmonary rehabilitation).

- Make referrals to asthma specialists for individuals with uncontrolled asthma and/or individuals in need of Step 4 or higher treatment.

**Implement Team-based Care:**

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include a social worker, community support specialist, or other appropriate provider.
- Assign individuals at high risk for complications to a member of the team who can provide care coordination.
- Refer individual to community support specialist (e.g., community health worker, patient navigator), as appropriate.

**Develop Integrated Care Planning:**

- Create individually tailored, culturally appropriate treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all team members serving the individual's needs.
- For individuals with asthma, create an Asthma Action Plan and support individuals in self-monitoring of asthma symptoms.

**Provide Self-Management Support:**

- Provide all individuals with asthma or COPD should with self-management support from a member of the health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- A community support specialist should assess the home environment and work with individuals on remediation (e.g., allergen and irritant exposure control).
- Refer individuals at highest risk for complications from asthma and/or COPD to a community support specialist (e.g., community health worker, peer educator, or health coach) who will conduct in-person meeting(s) such as home visits and follow-up by phone and/or telehealth options in service of the following goals:
    a. Increase self-management skills
    b. Ensure personal goals are congruent with individual's self-efficacy
    c. Improve continuity of care with primary care follow-up
    d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
    e. Practice advocacy by identifying key questions for PCPs/specialists
    f. Educate on health system navigation
    g. Ensure individual can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why.

**Link to Community Resources:**

- As needed or desired, the care team will refer individuals to community resources, including culturally and linguistically appropriate services and/or chronic disease self-management programs.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies, and community based organizations depending on the individual's needs (e.g., transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and a community support specialist to support selected activities. In such cases, the community support specialist will communicate with PCP and/or specialist(s) regarding the individual's treatment and progress.

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# Pay for Performance Metrics

*Incentive payments for ACHs and partnering provider organizations are dependent on improvement in project-specific Pay for Performance metrics selected by the Health Care Authority. Partnering provider organizations participating in the Chronic Disease Management – Asthma and COPD project will be held accountable to the following set of metrics.*

| Metric | Definition |
|---|---|
| Medication Management for People with Asthma (5 – 64 Years) | The percentage of members 5-64 years of age who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period. |

## References/Guidelines


The Chronic Care Model
http://www.improvingchroniccare.org/

NHLBI Asthma Care Quick Reference
https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf

Global Initiative for Asthma Pocket Guide for Asthma Management and Prevention
https://ginasthma.org/2018-pocket-guide-for-asthma-management-and-prevention/

Global Initiative for Chronic Obstructive Lung Disease Pocket Guide to COPD Diagnosis, Management, and Prevention
https://goldcopd.org/wp-content/uploads/2018/02/WMS-GOLD-2018-Feb-Final-to-print-v2.pdf

Global Initiative for Chronic Obstructive Lung Disease Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease Report
https://goldcopd.org/wp-content/uploads/2017/11/GOLD-2018-v6.0-FINAL-revised-20-Nov_WMS.pdf

NAEPP Guidelines Implementation Panel Report
https://www.nhlbi.nih.gov/files/docs/guidelines/gip_rpt.pdf

NHLBI & NAEPP Guidelines for the Diagnosis and Management of Asthma Report
https://www.nhlbi.nih.gov/files/docs/guidelines/asthgdln.pdf