Disease Management in the Under and Uninsured Population

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Healthy York Network

- Background and Rationale
- Role of Disease Management
- Enrollment
- Outcomes
- Future Plans

What is Healthy York Network?

Our Mission: Healthy York Network (HYN) is a consortium of private and public providers and agencies who work together to improve access to healthcare services to those in our region who lack the ability to pay.

Our Vision: All residents in the service area of our network will have timely access to providers who offer a coordinated program of services designed to efficiently and compassionately meet this population's essential healthcare needs.

What is HYN?

- HYN is not health insurance or assurance
- HYN is a coordinated program of discounted health care, pharmaceuticals and Disease and Case Management
- Funded through grants and charitable contributions by the not-for-profit health care sector

History of HYN

- Founded in January 2002 as WellSpan Community Network
  - Pharmacy program through York Hospital and the WellSpan Medical Group.
  - Decreased cost of “donated medications” from $1.5mil in 2001 to $800,000 plus $900,000 in pharmaceutical company donations in 2003.
  - Claims submitted and patients tracked through Health Plan as “Virtual” Health Plan

History of HYN

- Federal grant received in August 2003 to transition to Healthy York Network and implement a community wide program.
  - Funding through the Healthy Community Access Program (HCAP) through the Health Services and Resources Administration (HRSA)
  - $2.5 million over three years to establish processes and an infrastructure

Consortium Partners

- WellSpan Health
- Memorial Hospital
- York Health Corporation
- York City Bureau of Health
- York Spanish American Center
- Community Progress Council

How It Works

- A person/family comes in contact with one of the providers or agencies
- Application completed for financial eligibility
  - 200% of poverty = $38,700 family of 4
- If accepted, Medical Intake form is completed
- An HYN eligibility card is issued
- Medical home is provided
- Patient screened for chronic condition and enrolled in DM
- Medications provided through Healthy Community Pharmacy
- Care is given and discounts of 50% or 100% are applied to charges incurred at a consortium provider (eligibility six months to one year). Discounts vary by provider policy.

What does HYN coordinate?

- Disease Management for chronic conditions (asthma, diabetes, cardiovascular)
- Medications through Healthy Community Pharmacy
- Access to primary and specialty care
- Inpatient, emergency and urgent care
- Testing (lab, x-ray etc.)
- Assistance in applying for other forms of public health care

Healthy Community Pharmacy

- Single central location
- Pharmacy for HYN members only
- Formulary used, esp. generics
- Central repository for samples
- Each prescription at actual cost plus a $5 dispensing fee
  - If unable to afford, cost underwritten
- Staff assist patients in applying to drug manufacturer programs when possible

HealthCompanion - Improving Chronic Conditions

Healthy York Network

Objectives

- To enroll all HYN patients with chronic conditions in the HealthCcompanion program

- Goals:
  - help people with chronic conditions that are *under* or *uninsured*
  - create a program that will promote patient self-care
  - provide a system that will coordinate healthcare interventions and communications

The DM program focuses on 4 major Disease Diagnosis Groups

Asthma

Diabetes

Coronary Artery Disease (CAD)

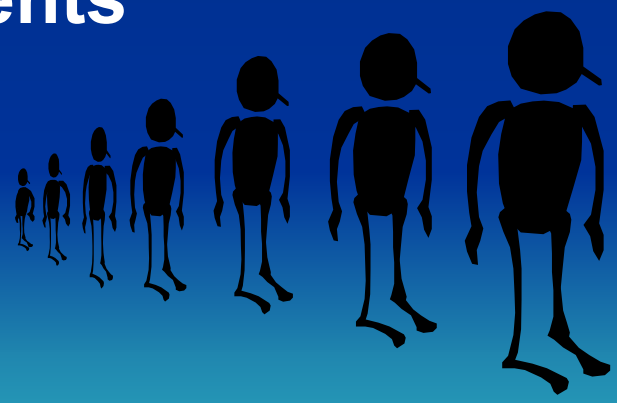
Congestive Heart Failure (CHF)

Diabetes, Asthma and CAD have been implemented with CHF to be implemented by end of 2005

Process

Members are identified thru the following methods:

- weekly screening of medical intake forms/health risk assessments
- review of claims data
- review of pharmacy data

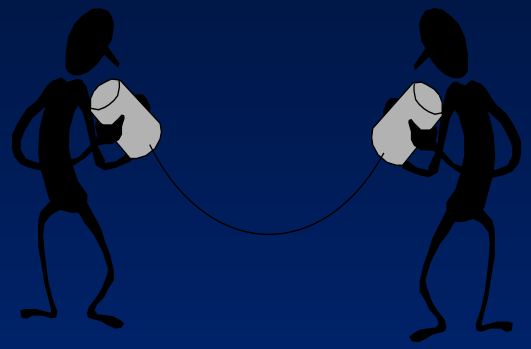


Members are identified and stratified into 3 groups: low, medium and high risk populations

Asthma Disease Management Program levels and interventions

Program level	Stratification/Risk level	Intervention
I	Low Risk Grade 0-1	Participant will receive: * Introductory letter describing the program * Comprehensive educational packet * Quarterly newsletter * Telephonic access for questions & concerns
II	Moderate Risk Grade 2-4	Participant will receive: * Introductory letter describing the program * Comprehensive educational packet * Quarterly newsletter * Quarterly Disease Manager call for 1:1 education * Telephonic access for questions & concerns * Referral to quarterly educational session
III	High Risk Grade > 4	Participant will receive: * Introductory letter describing the program * Comprehensive educational packet * Quarterly newsletter * Telephonic access for questions & concerns * Monthly Disease Manager call for 1:1 education * Case management referral based on assessment and co-morbid conditions * Referral to quarterly educational session

Process



- Members receive a condition specific introductory educational packet
- Moderate and high risk groups receive phone calls quarterly/monthly from Disease Manager for 1:1 education
- Members are provided with a toll free phone number to call with questions and concerns
- Members are referred/encouraged to attend free diabetes and asthma classes

Date

Patient Name
Patient Address
City, State, Zip

Dear Mr/Mrs/Ms. Patient,

HealthCompanion is a new program offered through Healthy York Network. HealthCompanion is a free program designed to help people with chronic conditions live as healthy as possible. It provides information about your particular condition through easy to understand educational packets, helpful quarterly newsletters, and questions answered by your very own nurse.

I am a nurse with the HealthCompanion program and am here to help you. It is my hope that together working with your doctor, we can improve your health.

This program does not replace the good care already provided by your doctor. It is to support your doctor with your medical needs. The information we obtain from you is confidential and follows all Federal and State laws regarding medical information and confidentiality.

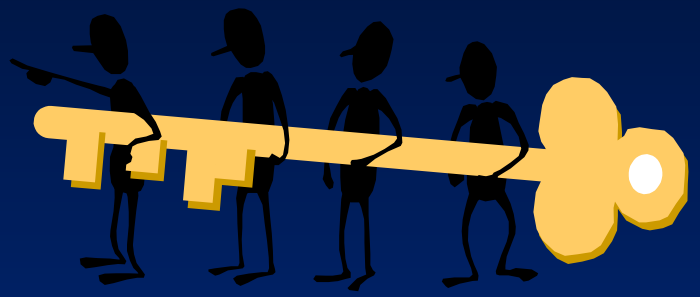
Please call me at **1-800-749-4194**, so that we can talk about your medical needs and begin to plan a healthier life for you. I have a private phone line with voicemail. If I am not available at the time of your call, please leave a message with a number where I can call you back. I will call you back as soon as possible. If you have a specific date and/or time that is best for me to return your call, please let me know. I look forward to working with you and your doctor.

Sincerely,

Houshang Babaie RN

Houshang Babaie, RN, BSN, CCM
Disease Manager
HealthCompanion Program

Outcomes



- Medical intake screening began 6/14/2004
  - As of 4/30/05 there are 4942 total members enrolled in the HYN network
- There has been an increase in re-enrollment rates for HYN diabetic and asthma populations
- There has been an increase in outpatient/office visits by HYN populations associated with members being encouraged to communicate and follow-up with their Primary Care Physician

Outcomes-Total Population

- ED visits decreased by 3 visits per 100 member per month from the benchmark period
- ED visits decreased by estimated 65.5 per month
- Average charge per claim for the measurement period after beginning disease management is $517.01
- Estimated savings per month for ED visits due to inception of Disease Management = $33,844.33

Outcomes/Statistics

June 14th – April 30, 2005

- Total medical intake forms screened = 3050
- Total diabetic patients identified = 570
- Total asthmatic patients identified = 321

Diabetes Outcomes

Total enrollment	161
Total Months	606
Total Months/Pt	3.8
# Pts.> 3 mos	99
# Pts.> 6 mos	31
Avg initial RI	4.6 (13 max)
#avg in RI>6	16

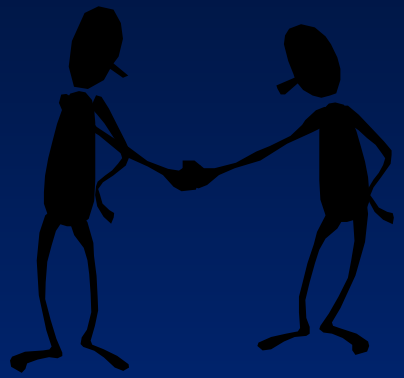
Diabetes Outcomes

	Base line	3 mos.	6 mos.
# patients	143	56	18
% with HbA1c	89	57	30
HbA1c mean	8.8	8.5	8.5
% with HbA1c <7%	26	27	17
% with HbA1c >9.5%	25	25	17
% < HbA1c		30	35
% >HbA1c		24	26

Diabetes Outcomes

	Base line	6 mos.
% Pts. microalb	42	17
% Pts on ACEI/ARBS		19
% Pts abn. Microalb on ACE/ARB		83
% Pts with LDLC	78	62
% Pts with LDL<100 mg/dl	48	36
% Pts with LDL>130 mg/dl	36	11

Follow Up



- Continue monthly monitoring of member's stratification levels
- Monitor patient satisfaction through communication and 1 year survey (to be done in June 2005)
- Continue monthly/quarterly phone calls to moderate and high risk populations for 1:1 education and follow up

Conclusions

- The under and uninsured population has a high prevalence of chronic conditions
- It is possible to establish collaborative community programs including disease management to provide care to this population
- DM in this population can be done in a cost effective manner to decrease utilization of high cost resources