National Standards for Asthma Self-Management Education

Conflict of Interest:

- Speaker Bureau for AAE: Ben Francisco, Wendy Brown
- No conflicts to declare: Sarah McBane
Objective:

- *This session will detail the newly published National Standards for Asthma Self-Management Education (SAS-ME) and describe how standards can be implemented in a pediatric and adult asthma practice.*

What is your current practice setting:

- Clinic
- Hospital
- Pharmacy
- College
- School
- Home Health
- Other
What is your primary profession:

• Physician
• Nurse
• Physician assistant
• Nurse practitioner
• Pharmacist
• Respiratory therapist
• Health educator
• Other

Do you have a standardized process for delivering asthma education?

• Yes
• No
• I’m working on it…
History

- 1991 EPR-1
- 1997 EPR-2
- 2000 NAECB
- 2002 AE-C Certification Update Select Topics
- 2006 Self Education CPT Codes
- 2015 SAS-ME

Non-physician Health Care Codes

- 98960—Education and training for patient self-management by a qualified, nonphysician healthcare professional using a standardized curriculum (ASA-ME), face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
- 98961—.... 2-4 patients
- 98962—.... 5-8 patients

http://medicalnewswire.com/artman/publish/article_8156.shtml
Reason for the Standards:

- “Establishes the minimum standard of asthma self-management education when teaching patients or caregivers how to effectively manage asthma in conjunction with the professional health care team.”


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<tr>
<th>Standard</th>
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| **Standard 1.** The Asthma Self-Management Education (ASME) entity, whether a healthcare provider or other agency, shall have a **written policy:**  
1) that emphasizes education as an integral component of asthma care, and  
2) that accepts responsibility for ensuring integration of the two – clinical care and education | ☐ Yes | ☐ No |
### Standard 2

**The ASME entity should have written policies, approved by an advisory committee, concerning the operation of the program. The program shall be conveniently and regularly available and shall be responsive to requests for information and referrals from consumers, health care professionals, health care agencies and other potential referral sources.**

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### Standard 3

**The service area shall be assessed in order to define the target population(s) (including its access to medical care providers) and determine appropriate allocation of personnel and resources to serve the educational needs of the target population(s).**

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<td><strong>Standard 4.</strong> An established system (i.e., committee, advisory group) consisting, minimally, of a nurse, clinician (experienced in asthma care), health educator, respiratory therapist, pharmacist, an individual with behavioral science expertise, an individual with asthma or a caretaker, (representation needs to include both an adult with asthma and a caregiver of a child with asthma), and a community representative, will participate annually in a planning and review process that includes data analysis and outcome measures, and addresses community concerns.</td>
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<td><strong>Standard 5.</strong> A coordinator shall be designated who is a certified asthma educator, certified by the National Asthma Educator Certification Board (NAECB). The coordinator is responsible for program planning, implementation, and evaluation.</td>
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<td><strong>Standard 6. The Asthma Self-Management Education (ASME) instructors for the entity will obtain regular continuing education in the areas of asthma management, behavioral intervention, teaching and learning skills, evaluation and follow-up and counseling skills.</strong></td>
<td>□ Yes □ No</td>
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<td><strong>Standard 7. A written curriculum, with criteria for successful learning outcomes, shall be available.</strong></td>
<td>□ Yes □ No</td>
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| **Standard 8. The program shall provide appropriate mechanisms to link patients to ongoing medical care, including medical management.** | □ Yes  
        □ No | |

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| **Standard 9. Comprehensive asthma education recognizes the need for continuing self-management education. The program shall reassess patient self-management behavior and provide continuing education based on that reassessment.** | □ Yes  
        □ No | |
Standard 10. Every patient requires a comprehensive assessment that includes a baseline assessment of the need for education, readiness to engage in self-management and an educational assessment of the level of asthma knowledge and skills. This assessment shall include relevant health and environmental history, present health status, health service or resource utilization, risk factors, asthma knowledge and skills, cultural influences, health beliefs and attitudes, health behaviors and goals, support systems, barriers, and socioeconomic factors. From this assessment, an evaluation of the readiness to learn is made.

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<tr>
<td>Standard 10</td>
<td>Yes</td>
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Asthma Patient Education Flow Sheet

Patient Education Assessment:

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<td><strong>Standard 11.</strong> An <em>individualized education plan</em>, based on the assessment, shall be developed in collaboration with each participant.</td>
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### Standard 12

The participant’s educational experience, including assessment, intervention, and follow-up, shall be documented in the permanent medical record. There shall be documentation of collaboration and coordination among all providers.

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Standard 13. An educational strategy appropriate to the individual and the setting (individual or group or combined approach) is documented in the medical record. Minimally, follow-up arrangements for medical care and asthma education will be documented in the medical record.

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<td><strong>Standard 14.</strong> All asthma education will use active learning methods within a partnership based on modern concepts of teaching.</td>
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<td><strong>Standard 15.</strong> Periodic reassessments of health status, knowledge, skills, attitudes, goals, and self-care behaviors must be completed by either the clinician or the educator. Frequency of follow-up will be based on asthma severity and level of asthma control. Appropriate and timely educational intervention will be provided based on this reassessment.</td>
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Standard 16. The ASME entity shall review program performance annually, including all components of the annual program plan and curriculum, and use the information in subsequent planning and program modification.

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<tr>
<td>Standard 16</td>
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Pediatric Asthma Practice

Ben Francisco
Is there really a need for ASME?

- Where should ASME be available?
- Will just any program do? Must it be proven to be effective?
- Must it reduce asthma burden AND health care costs?
- Who needs ASME? How much? At what cost? Neutral or +ROI?
- Should ASME be matched to risk, cost and population?

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**Costs of School and Work Days Lost, By Children’s Asthma Type**

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<thead>
<tr>
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<th>Very poorly controlled</th>
<th>Not well controlled</th>
<th>Well controlled</th>
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<tr>
<td><strong>Baseline</strong></td>
<td>$369</td>
<td>$0</td>
<td>$3,087</td>
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<tr>
<td><strong>12 Months</strong></td>
<td>$251</td>
<td>$166</td>
<td>$3,139</td>
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<tr>
<td><strong>24 Months</strong></td>
<td>$478</td>
<td>$0</td>
<td>$4,277</td>
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Source: Dr. Szeffer

*Chest Physician, vol. 5:12, p. 21, December 2010*
Medication costs at 24 months

- Very poorly controlled ($2298)
- Not well controlled ($1995)
- Well controlled ($1606)

Chest Physician, vol. 5:12, p. 21, December 2010

Assessment-Driven Care & Education

- Improved Self-Care
- Clinical & Community Services
- Risk & Impairment Analysis
Recognizing Uncontrolled Asthma

Clinic

Ill child, short of breath, wheezing, coughing, fever?
Allergy season?
GERD flare?

(MD, NP, PA)

Claims

↑ SOS (systemic oral steroids)
↑ SABA (quick relief inhaler)
↑ Acute care days (ER, hospital stays)

? ICS

(↑ antibiotics)
(Too many doctors)
Recognizing Uncontrolled Asthma

Community

Impaired student
↑ Absence from school
“Sick House”
“Sick Building”

Lens 3

Recognizing Uncontrolled Asthma

Clinic

Community

Claims

3 Lens View
**Medicaid (MoHealth Net Data Project)**
**Persistent asthma ages 6-18**

- 36.4% Missouri Medicaid recipients received inhaled corticosteroids while national average is 79.8% (Arellano, et al, 2011)

- 24.0% ICS medication possession ratio (MPR) adherence for all ages (SFY 2010)

- Children are seen less than once per year by provider on average and 1.2 per year in FQHCs (Foreman & Francisco, 2012)

- Poor ICS medication delivery and adherence contributes to acute care

*Missouri Department of Social Services, Mo Health Net*
Applying SASME In Missouri

- Medicaid taking action to lower the burden of childhood asthma
  - SPA1 – Childhood Asthma to be a qualifying health home condition
  - SPA2 – Preventive Asthma Services reimbursable (S9441 & T1028)
  - The Asthma Clause – MCO must provide 99401,2,3 and 98960, 61, 62
- Higher education budget funds “IMPACT Asthma ECHO” telehealth to transfer knowledge to community-based providers
- (Search “Project ECHO”)

Missouri Medicaid Invites Workgroup

- Credentials for asthma educators, AE-C or “state certificate”
  - CE requirement for asthma educators – 7 hours annually
  - Declare ASME program as a condition of becoming a provider
  - Document assessment findings
- Credentials for environmental assessors
  - CE requirement for asthma educators – 7 hours annually
  - Document assessment findings
Adult Asthma Practice
Sarah McBane

Adult Asthma Patients

• Adults need asthma education too…
Consider the population

• Family Medicine
• Adult/ internal medicine
• Geriatric
  • Independent v. assisted living
• Other factors

Comprehensive Assessment

• When?
  • Initial visit
  • Scheduled follow up
• Where?
Asthma Education

- Develop in collaboration
  - Usually the patient
  - Sometimes the caregiver
Adult Education