Evolving Concept of Asthma Care: The patient centered medical home

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and

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No disclosures

We have associations or memberships with the following organizations

Stony Brook University Hospital

Association of Asthma Educators

Asthma Coalition of Long Island

American Thoracic Society

American Academy of Pediatrics

American College of Chest Physicians

National Association of Pediatric Nurse Practitioners

Objectives

After attending this presentation the learner should be able to:

1 define **patient centered medical home** as an evolving concept of asthma care

2 recognize the role of **community health workers** as the link between families and health care providers

3 demonstrate a process whereby a **multifaceted approach** will address confounders and challenges of asthma care

What is ***patient centered medical home (PCMH)***

- a model of care
  - emphasizes care coordination and communication
  - transform primary care into "what patients want it to be"
- empowers the patient to be an active part of his/her health care team
  - physician-led team approach
  - staff works to the highest capability of license/skills

National Committee for Quality Assurance (NCQA)
Healthcare Association of New York State

Standards

patient centered medical home (PCMH)

1. Patient-Centered Access:

- Accommodate patients' needs during and after hours, provide medical home information, offer team-based care

2. Team-Based Care:

- Engage all practice team members meet cultural and linguistic needs of patients

3. Population Health Management:

- Collect and use data for population management

Standards

patient centered medical home (PCMH) -continued

4. Care Management and Support:

- Use evidence-based guidelines for preventive, acute and chronic care management

5. Care Coordination and Care Transitions:

- Track and coordinate tests, referrals and care transitions

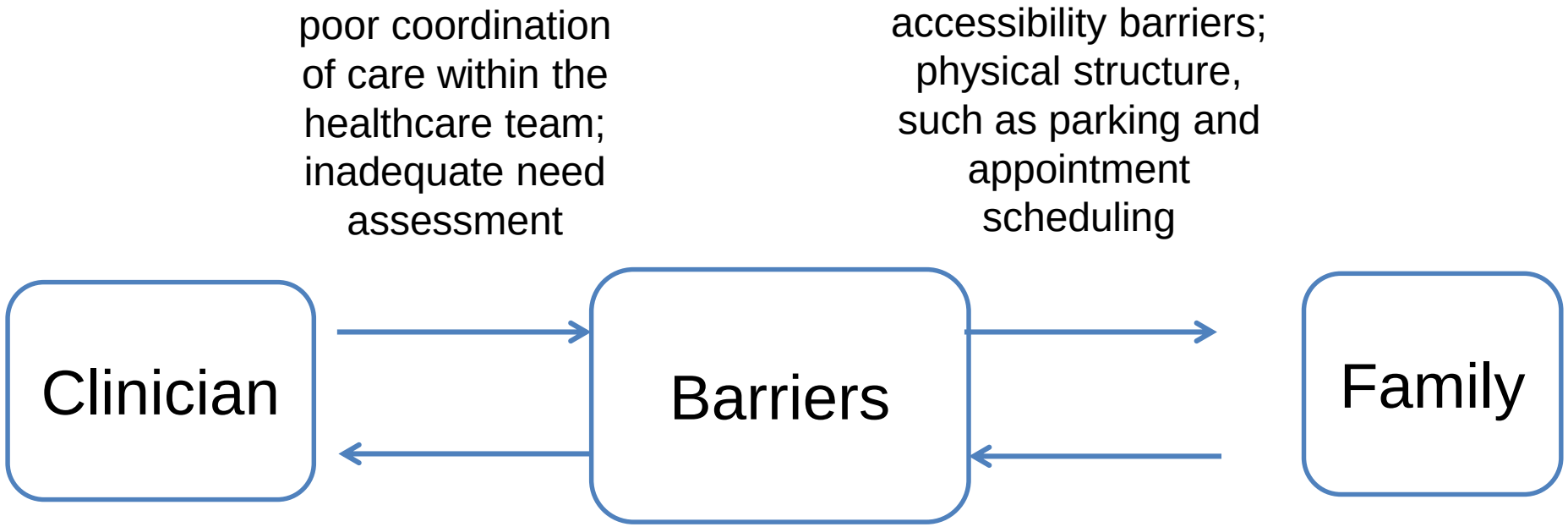
6. Performance Measurement and Quality Improvement:

- Use performance and experience data for continuous improvement

Why **asthma** as the model chronic disease for ***PCMH***

- Asthma is intertwined with **issues on health literacy, cultural barriers and poverty**
- **Partnership with patient and families** is a significant emphasis in asthma care
- The changing face of healthcare is geared towards **preventative care and the community**

Barriers to optimal services experienced by patients with asthma



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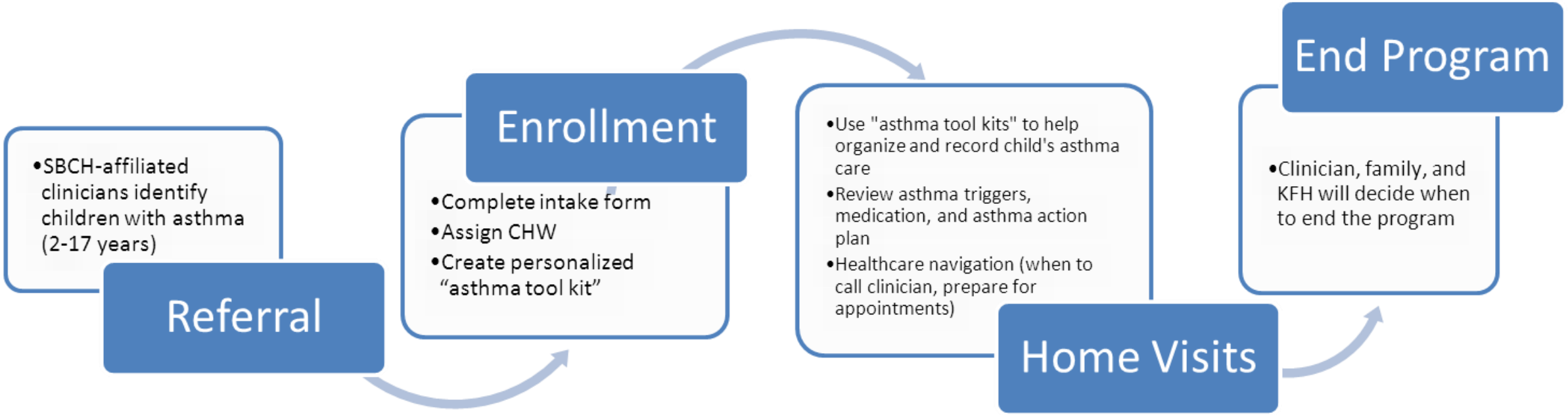
Stony Brook model for ***PCMH*** – Keeping Families Healthy



Keeping Families Healthy (KFH)

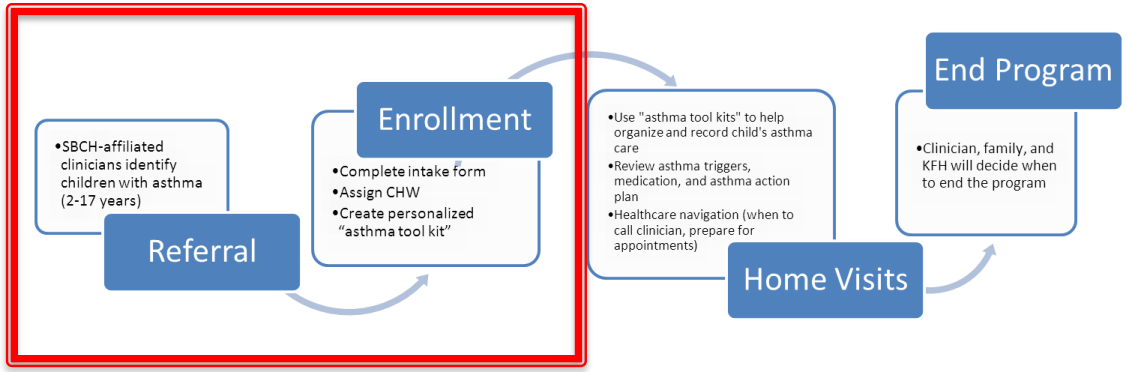
- Launched July 2011
- Pediatricians refer “at risk” patients
- Community Health Workers (CHWs):
  - Assist with healthcare navigation
  - Provide basic health education
  - Connect families to community resources
- Program is tailored to the needs of each family
- Over 2600 home visits for more than 730 children

Starting July 2012, Stony Brook Children's Pulmonary Division began collaborating with KFH to:

1. Train CHWs in asthma education and self-management techniques (By AE-C)
2. Enroll high risk patients
3. Review families' progress in self-management
4. Increase patient-provider communication via CHWs

Prior to Initial Visit

- Clinician identifies and refers high risk patients
- KFH contacts family to enroll
- Clinician reviews the patient's asthma management plan with KFH staff
- KFH creates a personalized asthma tool kit



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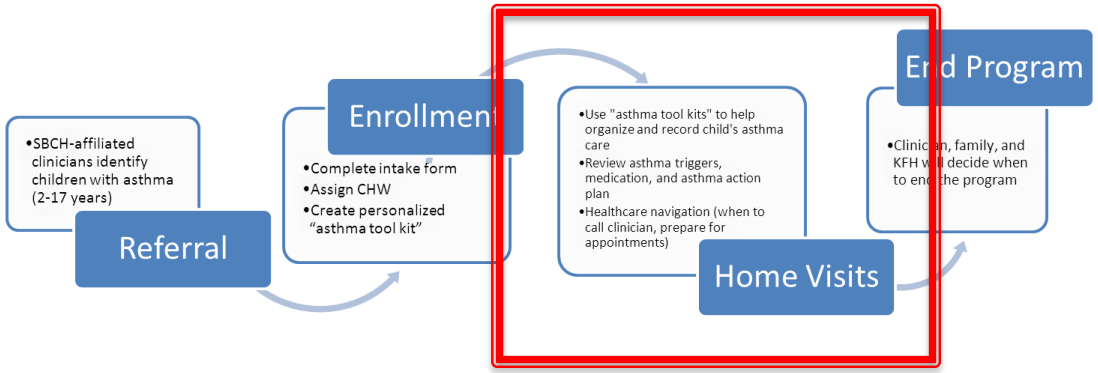
During the Visit

- CHW conducts home visits to:
  - Assist families in understanding the content of their Asthma Action Plan (AAP)
  - Address barriers to adhering to the AAP
  - Follow up with care coordination
  - Discuss techniques for triggers avoidance
  - Give referrals to community resources



Program Timeline of Home Visits

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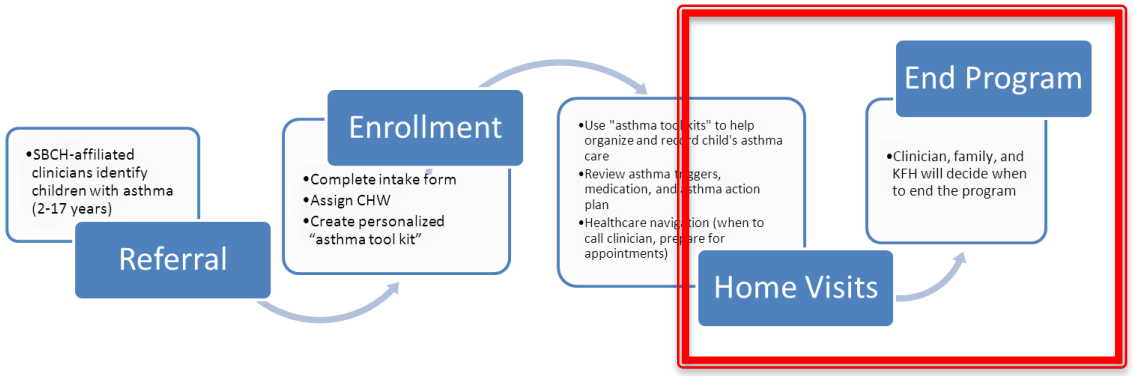
Between Home Visits

- CHW write summary of visit
- Summary sent to clinician through EMR
- Clinician reviews and gives feedback
- CHW checks in with family



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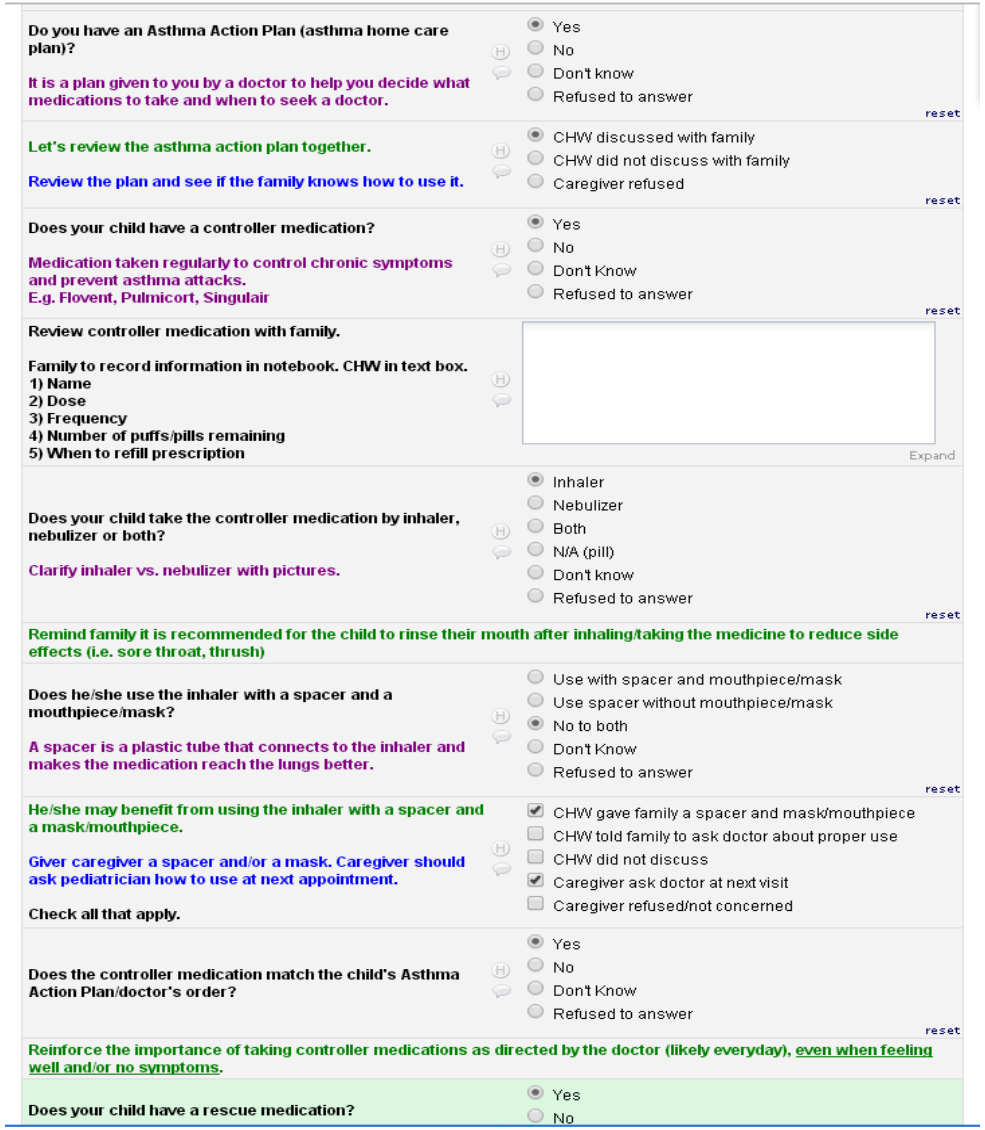
Research

- CHWs complete CITI and HIPAA trainings
- IRB approval for research activities
- Families are asked to participate in a research study (sign consent)
- CHWs use health technology (iPad) to collect data
- REDCap, secure online database, collects data in real time

Asthma Specific Questions:

- # ED visits and Hospitalizations
- Controller and Rescue Medications Reviewed
- Devices Used (Inhaler with Spacer, Nebulizer)
- Asthma Action Plan Reviewed
- Medication at school/daycare
- Triggers and how to reduce/avoid
- Known Allergies
- If Flu Vaccine Given



Data Collected During Initial KFH Visit

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Initial Barriers	Improvements
CHWs are not AE-C	-REDCap restructured to guide the CHW in data collection and to identify “teaching moments” in real time -Ongoing asthma education provided to the CHWs by AE-C -KFH given access to EMR clinician notes and medical treatment plan
Families are hesitant to agree to home visits	-“Warm Hand-off” from clinician to KFH introduced family to the benefits of the program -Asthma tool kits provided incentives for participation
KFH visit summaries were not easily accessible to clinicians	-Integration of EMR allowed instant messaging of visit summary to clinician for review and feedback
Families were not interested in logging medication and symptoms	-Personalized sticker logs created for young children -Parents and older children encouraged to download asthma phone apps -Clinician reviewed logs in office and reiterated importance of logging

Lessons Learned

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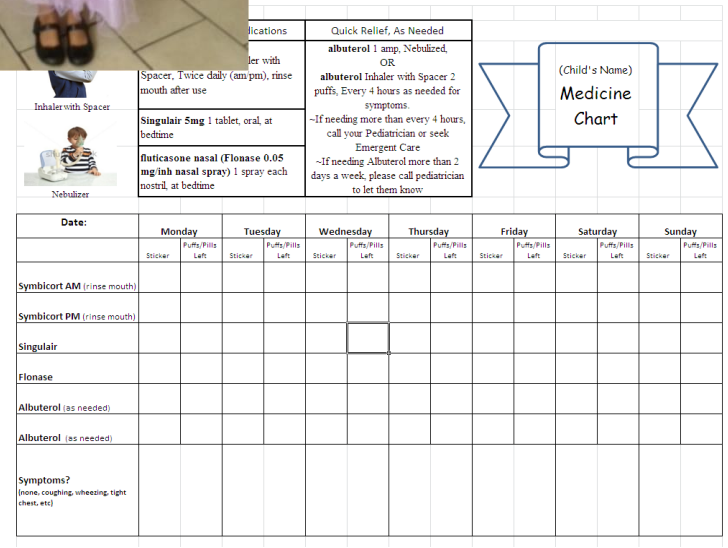
Personalized Tool Kits

- Stony Brook Children's Bag
- Asthma Care Notebook
- Personalized Health Information Sheets
- Asthma Education Handouts
- Spacers and Masks
- Pillow and Mattress Dust Mite Covers



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KFH evolved from few referrals to a more robust asthma medical home (after QI) to now a proposal medical home concept for DSRIP

Delivery System Reform Incentive Payment (DSRIP) Program

New York State will implement the Medicaid Redesign Team

fundamentally restructure the health care delivery system by reinvesting in the Medicaid program

primary goal of reducing avoidable hospital use by 25% over 5 years

Expansion of Asthma Home-Based Self-Management Program

Project Objective: Implement an asthma self-management program including home environmental trigger reduction, self-monitoring, medication use, and medical follow-up to reduce avoidable ED and hospital care.

Benefits of CHWs

- Home monitoring
- Ongoing asthma education
- Coordination of asthma care
- Identification of risk factors and barriers
- Assistance with referrals, transportation, communication and arranging medical appointments, insurance , pharmacy, community referrals such as : DOH, landlord assist with home environmental issues, CPS coordination of care and more
- Assist with provider communications

Community Health Workers

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Launch of the AAE's *Asthma Education for the Community Health Worker*: A National High Quality Curriculum

Traci Hardin, MPH, AE-C

Ellen A. Becker, PhD, RRT-NPS, RPFT, AE-C, FAARC

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AAE Educational Initiatives

Advanced Level
AAE's National Asthma Educator Certification/ Preparatory & Recertification Course

Intermediate Level
AAE's Becoming an Asthma Educator and Case Manager (BAECM)

Introductory Level
?

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AAE CHW Initiative

July 2012:

AAE Board initiated the CHW Task Force

Consistent national curriculum for asthma education

Reviewed existing resources

Utilized medical terminology

Assumed prior asthma education knowledge

Reached out to AAE members for feedback

August 2013:

Recruited additional AAE member (CHW Task Force) involvement

September 2013 – May 2015:

Curriculum development, pilot programs, editing based on pilot feedback

June 2015:

Video Shoot of Didactic Content

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Funding & Collaboration

The CHEST Foundation Community Service/Humanitarian Grant

Funding for video production

South Carolina Department of Health & Environmental Control

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Design of *Asthma Education for the Community Health Worker Program*

- Six modules
  - Didactic content & learning activities
  - 120 minutes each
  - Comprehensive Evaluation of mastery of information
- Video for didactic content
  - “Taught” by experienced CHW
  - Ensures continuity of content
  - Allows for additional review of information

Design of *Asthma Education for the Community Health Worker Program*

Trainer(s)

- AE-C
- Approved AAE Faculty

Materials:

- Participants: 5 workbooks, 1 DVD
- Trainers: Manual, 1 DVD

AAE Certificate of Completion

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Module 1: *The Scope*

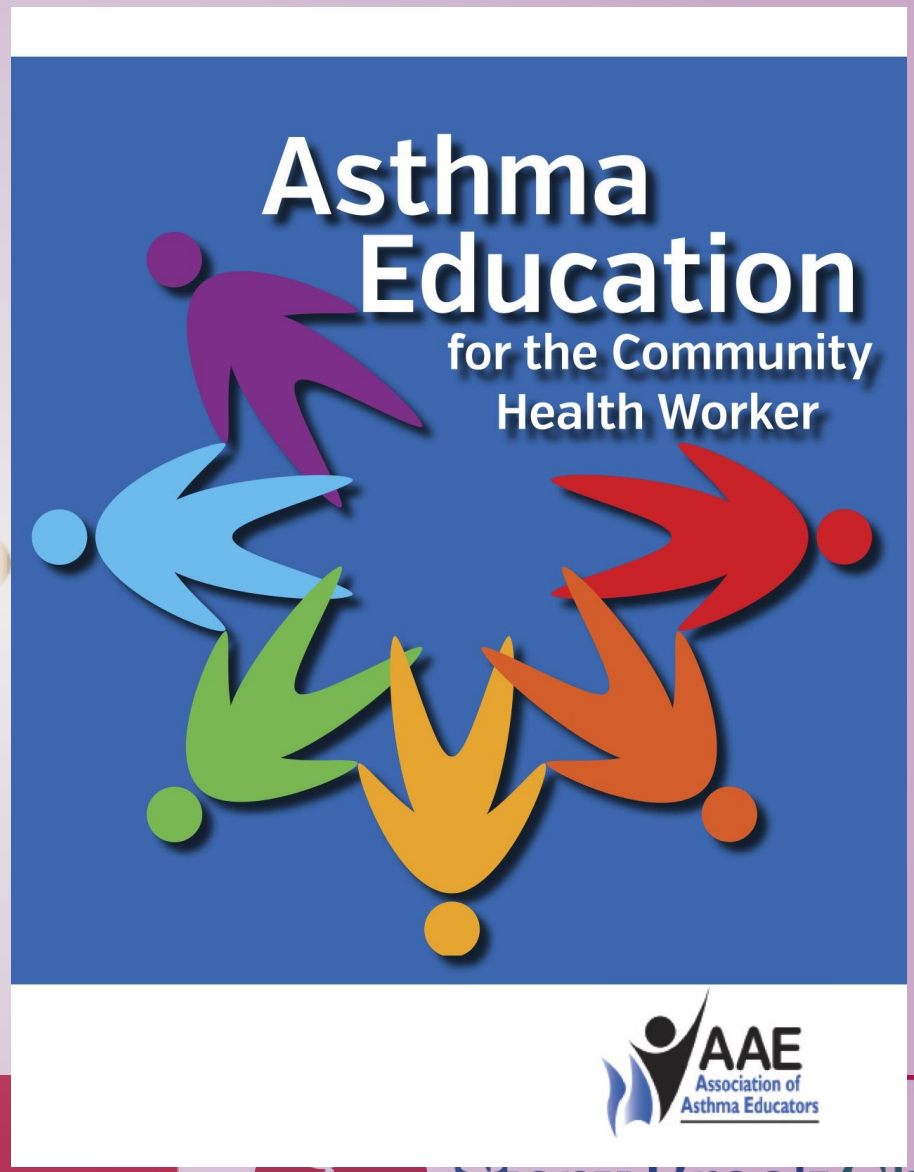
Module 2: *Triggers & Environmental Control*

Module 3: *Medications*

Module 4: *Medication Delivery Devices*

Module 5: *Assessment & Monitoring*

Module 6: *Comprehensive Evaluation*



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Module Basic format

- Review Activity- previous Module Material
- Video of Didactic Content (10-20 minutes)
- 2 Learning Activities

Suggested Delivery Format

- (6) 2-hour sessions
- (3) 4-hour sessions
- Encourage continued review of material between sessions

To be determined

- Final competency test
  - Scoring Framework
  - AAE Certificate of Completion
- Completion date (Estimated October 2015)
- Costs

Pilot Sites-Acknowledgements

El Centro, CA * Dr. Saima Khan

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CHW Task Force -Acknowledgements

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CASE #1
Patient: J A-S
Age 7 yo
Diagnosis: moderate persistent asthma,
with a history of

- Severe exacerbation including intubation 1st year of life
- 2x/yr OCS & Ed visits

Other: chronic rhinitis & OSA
Other contributing factors affecting asthma control & home management:
Sibling newly diagnosed Type I DMM
Mother: depression with recent inpatient psych admission
Admittedly having problems with focus & memory
& is concerned about ability to carry out effectively & correctly a home management plan for this child

Question:

What kind of assistance with the medical home model can be offered?

1- Collaboration, communication with this child/families PCP & office staff

2-Home assessment by a PHN

3- Home visits by a CHW trained in asthma in home assessment & home management plans

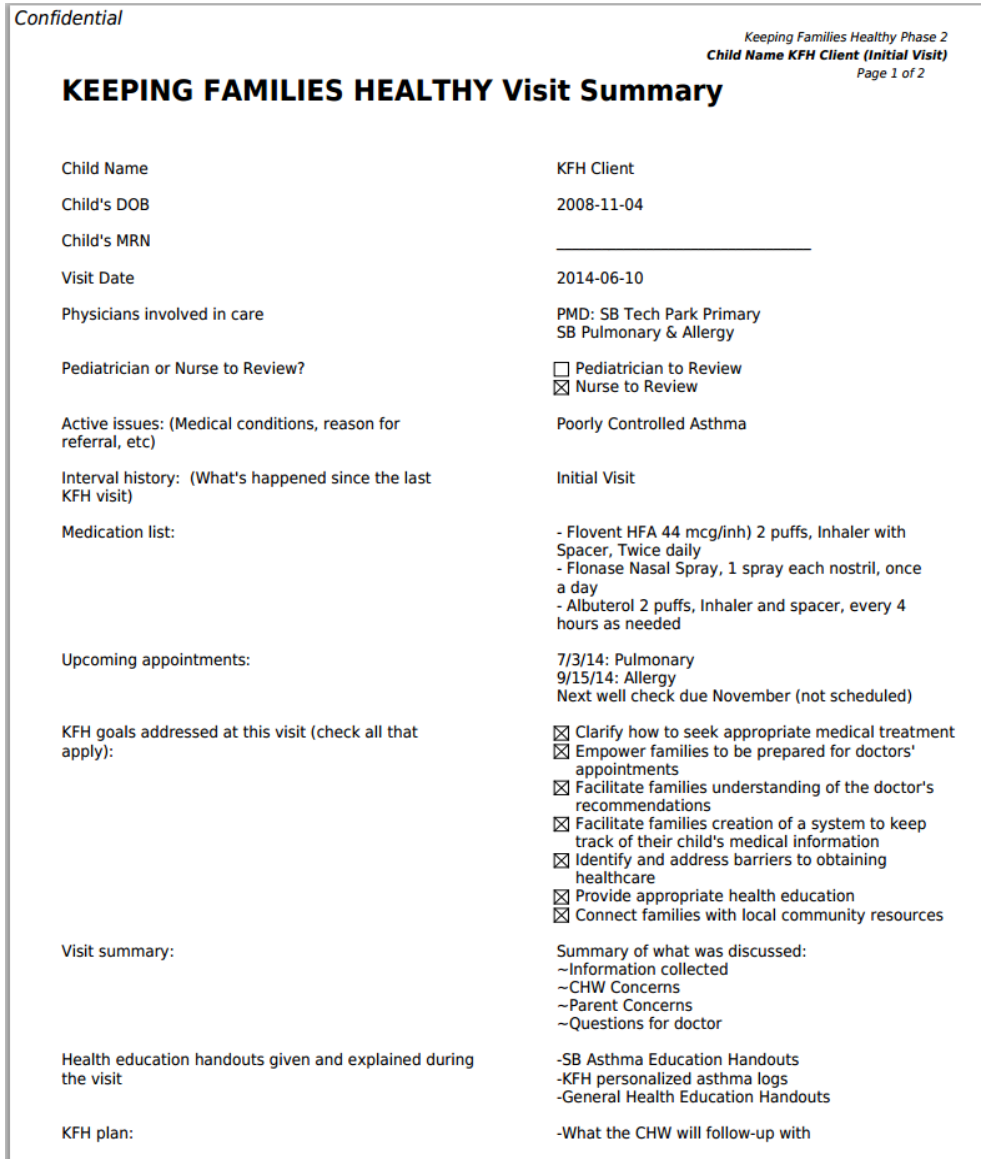
4- Home social work visit/assessment

5- Possible need for CPS preventative services

Nurturing a Partnership

KFH Visit summaries are sent to the clinician and uploaded into electronic medical records (EMR) for review

- Opening the lines of communication
- Identifies issues between doctor's appointments
- More frequent communications between patient/family and caregiver



Confidential

Keeping Families Healthy Phase 2
Child Name KFH Client (Initial Visit)
Page 1 of 2

KEEPING FAMILIES HEALTHY Visit Summary

Child Name	KFH Client
Child's DOB	2008-11-04
Child's MRN	_____
Visit Date	2014-06-10
Physicians involved in care	PMD: SB Tech Park Primary SB Pulmonary & Allergy
Pediatrician or Nurse to Review?	☐ Pediatrician to Review ☒ Nurse to Review
Active issues: (Medical conditions, reason for referral, etc)	Poorly Controlled Asthma
Interval history: (What's happened since the last KFH visit)	Initial Visit
Medication list:	- Flovent HFA 44 mcg/inh) 2 puffs, Inhaler with Spacer, Twice daily - Flonase Nasal Spray, 1 spray each nostril, once a day - Albuterol 2 puffs, Inhaler and spacer, every 4 hours as needed
Upcoming appointments:	7/3/14: Pulmonary 9/15/14: Allergy Next well check due November (not scheduled)
KFH goals addressed at this visit (check all that apply):	☒ Clarify how to seek appropriate medical treatment ☒ Empower families to be prepared for doctors' appointments ☒ Facilitate families understanding of the doctor's recommendations ☒ Facilitate families creation of a system to keep track of their child's medical information ☒ Identify and address barriers to obtaining healthcare ☒ Provide appropriate health education ☒ Connect families with local community resources
Visit summary:	Summary of what was discussed: ~Information collected ~CHW Concerns ~Parent Concerns ~Questions for doctor
Health education handouts given and explained during the visit	-SB Asthma Education Handouts -KFH personalized asthma logs -General Health Education Handouts
KFH plan:	-What the CHW will follow-up with

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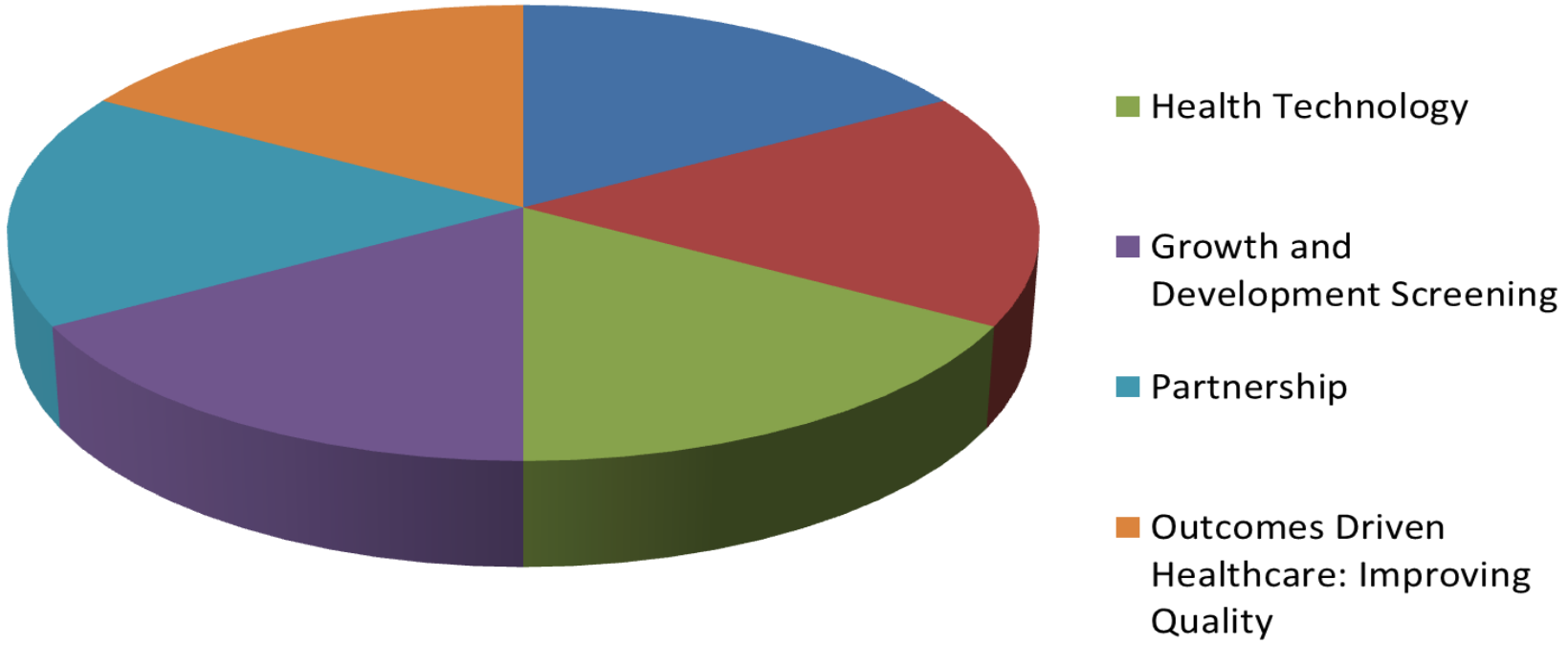
A Multi-Faceted Approach to Pediatric Preventive Care



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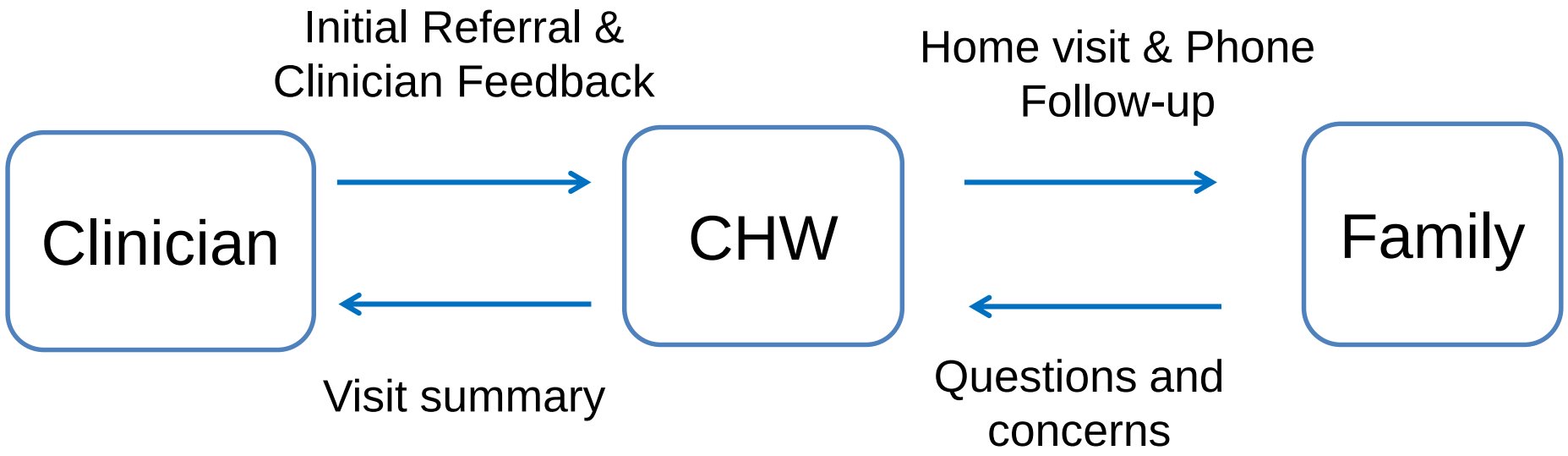
CHW acts as a BRIDGE between clinicians and families



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THANK YOU

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Questions?

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