ADVANCING INTEGRATED HEALTHCARE

Asthma QI Learning Collaborative: Final Learning Collaborative Meeting

October 11, 2023

Agenda

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
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Item	Time
Welcome & Announcements ***Sue Dettling, BS, PCMH CCE, Program Manager & Practice Facilitator, CTC-RI***	5 min
Practice Quality Improvement Projects ***PRIMA Inc*** ***Dr. Concillio***	30 min
QI Baseline & Post-Assessment Data ***Michelle Mooney, MPA, Program Coordinator II, CTC-RI***	10 mi
Discussion & Feedback ***Susanne Campbell, RN MS PCMH CCE, Sr Program Administrator, CTC-RI***	10 min
KIDSNet Recommendations ***Sue Dettling, BS, PCMH CCE, Program Manager & Practice Facilitator, CTC-RI***	10 min
Discussion & Questions All	10 min

Announcements

CALL FOR APPLICATIONS: Pediatric/Adult Primary Care Health Care Transfer of Care Quality Improvement Initiative *DUE Oct 18th*

https://www.surveymonkey.com/r/2023TOCCallforApplications?name=%5bname_value%5d

FMEC Healthcare Innovators Network October 13-15, 2023 8:00am - 5:00pm Rhode Island Convention Center

The FMEC Annual Meeting, held every fall, attracts 800-1,000 attendees, with about 300 medical students who attend on scholarships, and hundreds of family medicine residents and faculty from the FMEC's 14 state + DC region in the northeast U.S. The meeting theme is "Family Medicine: Anchoring Patients and Communities" and will incorporate Rhode Island's official symbol, the anchor, and motto, "hope."

https://fmec.memberclicks.net/2023annual_meeting_preconf#!/

ADVANCING INTEGRATED HEALTHCARE

Asthma Quality Improvement Initiative

Final Learning Collaborative Meeting - Practice Updates

October 11, 2023

P.R.I.M.A Inc.,

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Asthma Action Plans (AAPs) given to patients

Asthma Care “Pop T” score*

a. **Baseline** (Oct 1, 2022-April 27, 2023): N = 39/ D = 46 (39+7); **39/46 = 85%**
b. **Midpoint** (5/29 – 6/28/23): N = 3/ D = (8+1); **8/9 = 89%**
c. **Final** (6/29 – 9/28/23): N= 4/D = (4+1); **4/5=80%**

Final data Reference:

Number of office visits related to asthma symptoms (June 29th -Sept. 28th 2023): 4
Number of ER/UC visits related to asthma symptoms (June 29th -Sept. 28th 2023): 1

Practice specific measure baseline data:

a. **Baseline** (5.1.2022 - 4.27.2023): percentage of patient w/ asthma who have AAP: **5/36=13.8%**
b. **Midpoint** (5/29 – 6/28/23)**:** percentage of patients w/ asthma seen who were given/reviewed AAP: **2/3= 67%**
c. **Final** (6/29 – 9/28/23)**:** percentage of patients with asthma seen who were given/reviewed AAP: **4/4= 100%**

Total AAP given April 28 – September 28th, 2023 = 103

Reference: *chart review/manual tracking for 20 patients with Asthma; Baseline data: manual review of 38 patients (codes J45.3, .4,.5), 2 inactive, 5 had AAPs;

P.R.I.M.A Inc.,

Asthma Action Plans (AAPs) given to patients

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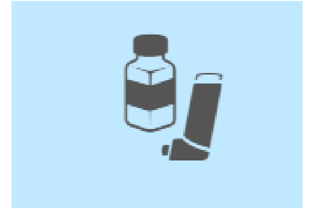
PDSA – Plan, Do, Study, Act - Quality Improvement:

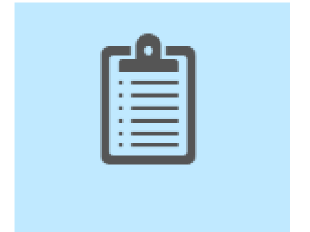
Describe the measured results and how they compared to the predictions

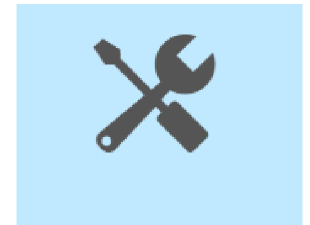
- The population T started off at 85% ending at 80% (however due to the short time and small sample this is not statistically significant).
- Provision or review of Asthma Action Plans started at 13.8%, midpoint at 67% and final at 100%. Due to the small numbers and season aspect of patients visits for asthma related projects further study is needed.

Act: Describe what modifications to the plan will be made for the next cycle from what you learned
Because of participation in the Asthma QI project, what changes to your workflow, if any will be sustained?

- P.R.I.M.A. will continue to give or review the AAP at every visit with patients with asthma; the practice will continue to make copies of the AAP;
- Use of the AAP is a routine part of workflow now.
- Practice looks forward to enhancements to KIDSNET for the AAP and referrals.
- Practice would consider using KIDSNET to print AAP (blank or filled out); would also consider use for referrals
- Funding for the asthma supplies was extremely helpful as well as the practice has these extra spacers and nebulizers on hand if patients need them.







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Discussion:

- ❑ **Patient success story**
- ❑ **Connections with school nurses/AAP**
- ❑ **Referrals to HARP**

Concilio Pediatrics

Patient Education: Asthma Inhaler Use

Data:

1. **Asthma Care "Pop T" score**
   a. **Baseline (6.1.22 – 5.31.23)** : 108/129 = 84.4%
   b. **Midpoint* (June 2023)** : 4/5 = 80%
   c. **Final*(7.1.23 – 9.30.23) :** 13/14= 93%

2. **Practice specific measure*: Asthma Inhaler Use Education**
   a. **Baseline (May 2023) :** 7/16 = 43.7%
   b. **Midpoint (June 2023)**: 5/5 = 100%
   c. **Final (July – Sept 2023):** 12/12 = 100%

Reference:
Provided education regarding correct inhaler use - Yes/No

**chart review/manual tracking for 20 patients with Asthma*

Concilio Pediatrics

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Patient Education: Asthma Inhaler Use

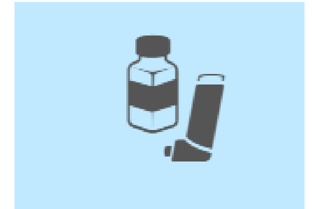
PDSA – Plan, Do, Study, Act - Quality Improvement:

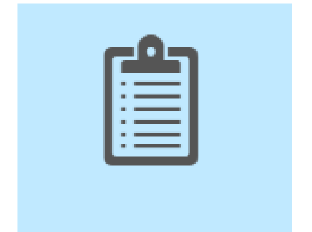
Describe the measured results and how they compared to the predictions

- The population T score improved by the end of this project; starting off at 84.4% ending at 93% (however due to the short time and small sample this is not statistically significant).
- Asthma inhaler education use went from 43.7% to 100% by the end of the project. This was expected as the practice made a commitment to including this education at every visit with patients with Asthma.

Act: Describe what modifications to the plan will be made for the next cycle from what you learned
Because of participation in the Asthma QI project, what changes to your workflow, if any will be sustained?

- Dr. Concilio will continue with the asthma inhaler education at every visit with patients with asthma; he will give out the colored posters that support this education; once supply runs out the practice will continue to make copies of this poster;
- Education is routine part of workflow now.
- Practice looks forward to enhancements to KIDSNET for the AAP and referrals.
- Practice would consider using KIDSNET at the time of the patient visit to populate the AAP.
- Funding for the asthma supplies was extremely helpful as well as the practice has these extra spacers and nebulizers on hand if patients need them.





Concilio Pediatrics

Discussion:

- ❑ **Patient success story**
- ❑ **Connections with school nurses/AAP**
- ❑ **Referrals to HARP**

ADVANCING INTEGRATED HEALTHCARE

Asthma Quality Improvement Initiative

Final Learning Collaborative Meeting - Discussion

October 11, 2023

Practice Pre & Post Survey Overview

- What are the biggest changes?
- What are practices doing now that they were not doing before?
- Where are there continued opportunities?

Practice Baseline Survey Overview

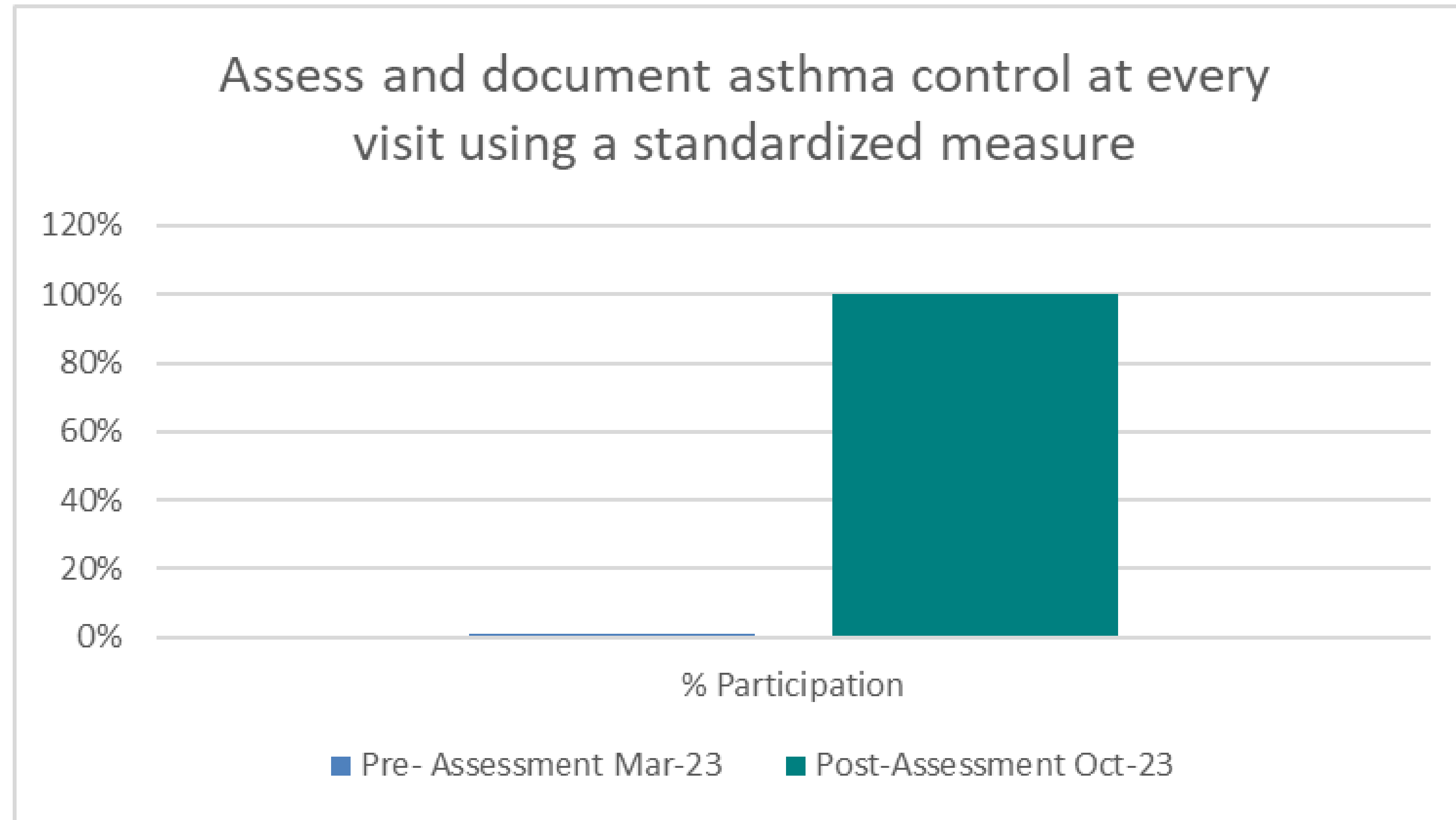
Opportunities:

- Ensure patients & families receive self-education at each encounter
- Assess and document asthma control at every visit using a standardized measure – i.e. Asthma Control Test (ACT)
- Use the “Stepwise approach for management of asthma” including prescribing controller therapy as referenced in the updated Asthma Guidelines recommendations for Single Maintenance and Reliever Therapy (SMART).
- All patients (or caregiver if child is less than 5 years old) can identify their asthma inhalers from a poster with color photographs & use “teach back” to confirm the patient and/or caregiver describe the purpose, actual use pattern and intended dosing regimen for each inhaler.
- All patients receive an asthma action plan
- Complete environmental screening questionnaire

Already happening:

- Reviewing medication adherence with patients
- Tracking patient's ED & urgent care use
- Follow-up visits are set at appropriate intervals matching patient’s level of control

Use the "Stepwise approach for management of asthma" including prescribing controller therapy as referenced in the updated Asthma Guidelines recommendations for Single Maintenance and Reliever Therapy (SMART) when appropriate.



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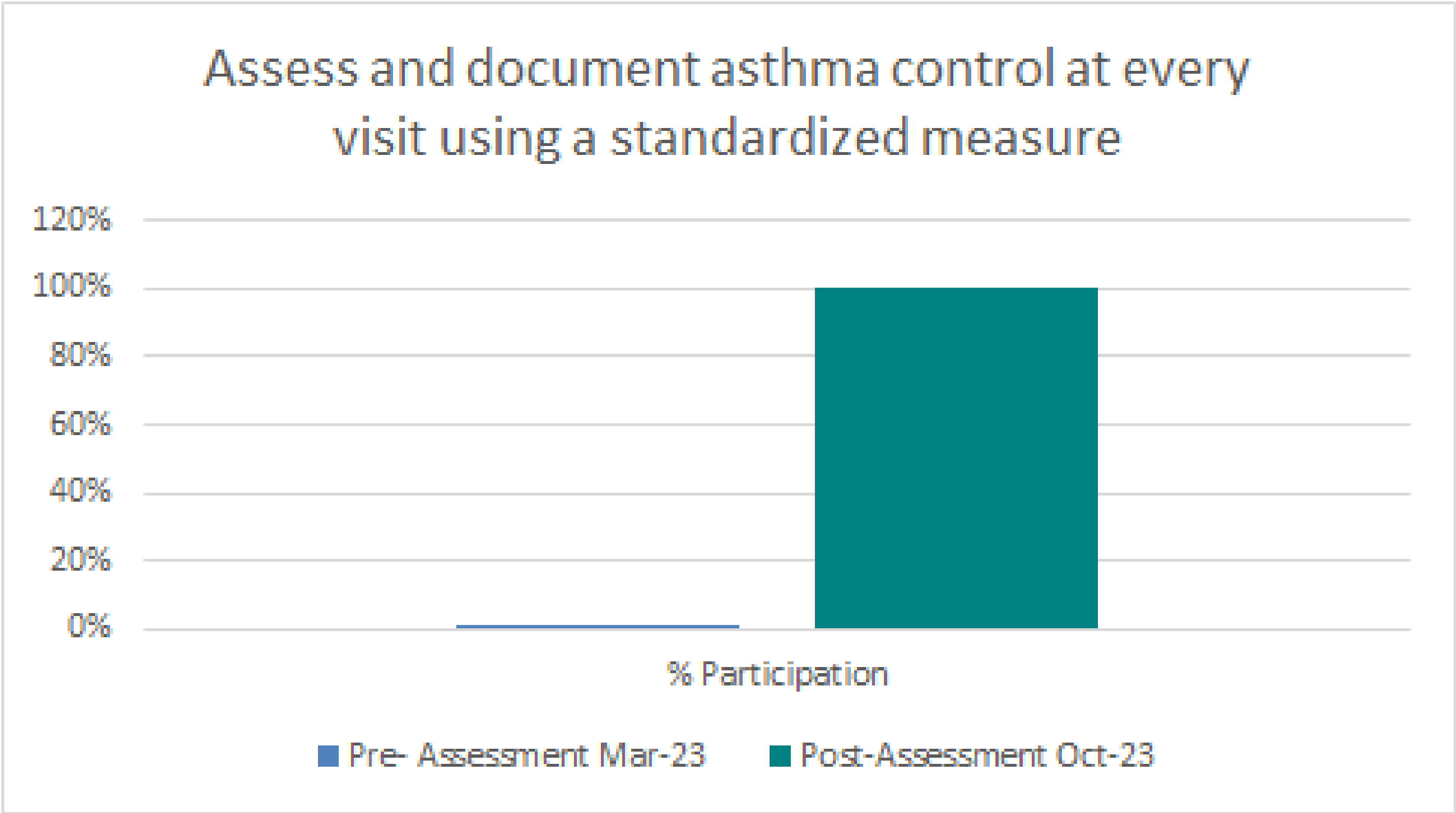
Assess and document asthma control at every visit using a standardized measure – i.e. Asthma Control Test (ACT) (well controlled, not well controlled, or very poorly controlled)



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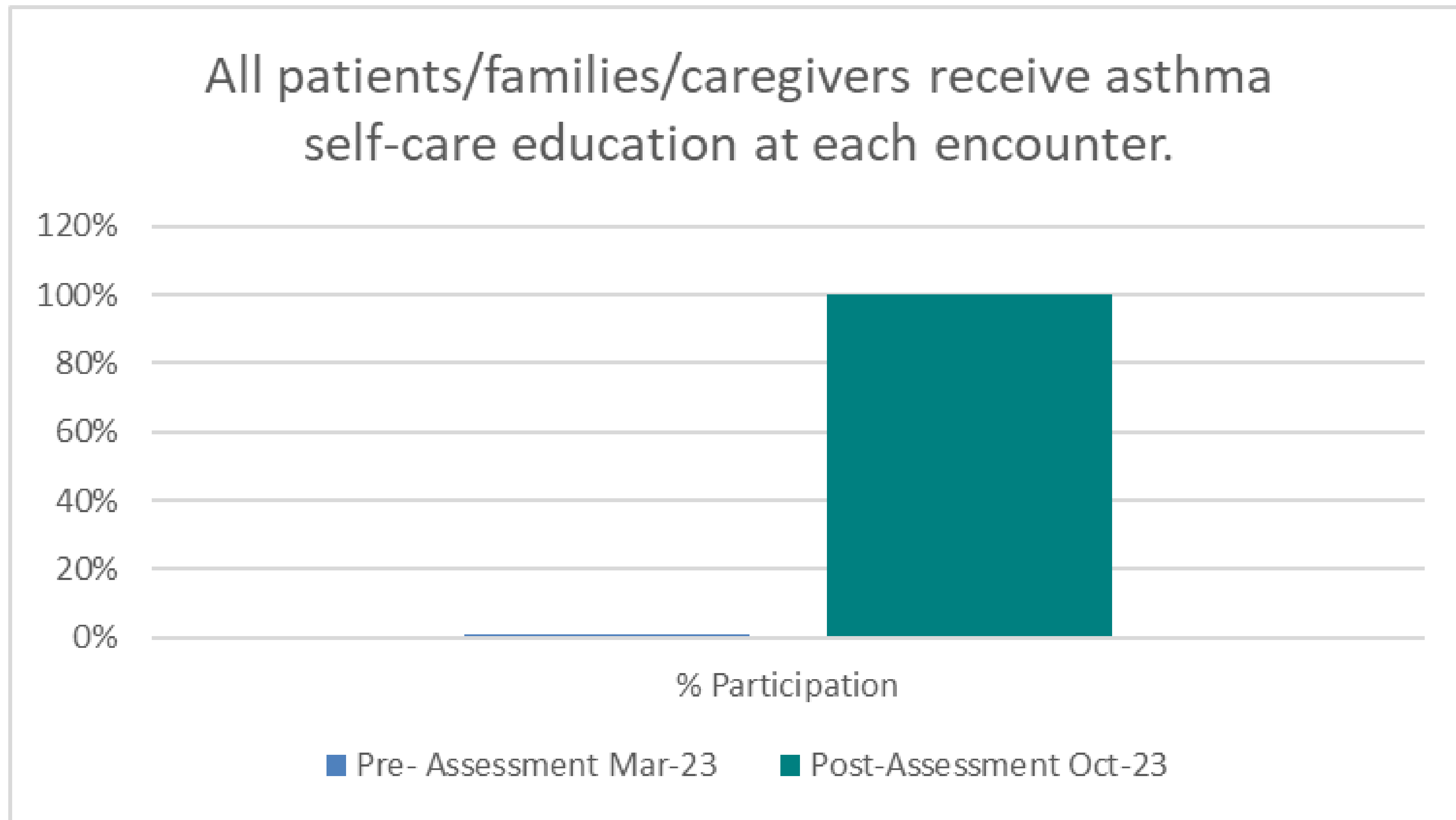
All patients/families/caregivers receive asthma self-care education at each encounter.



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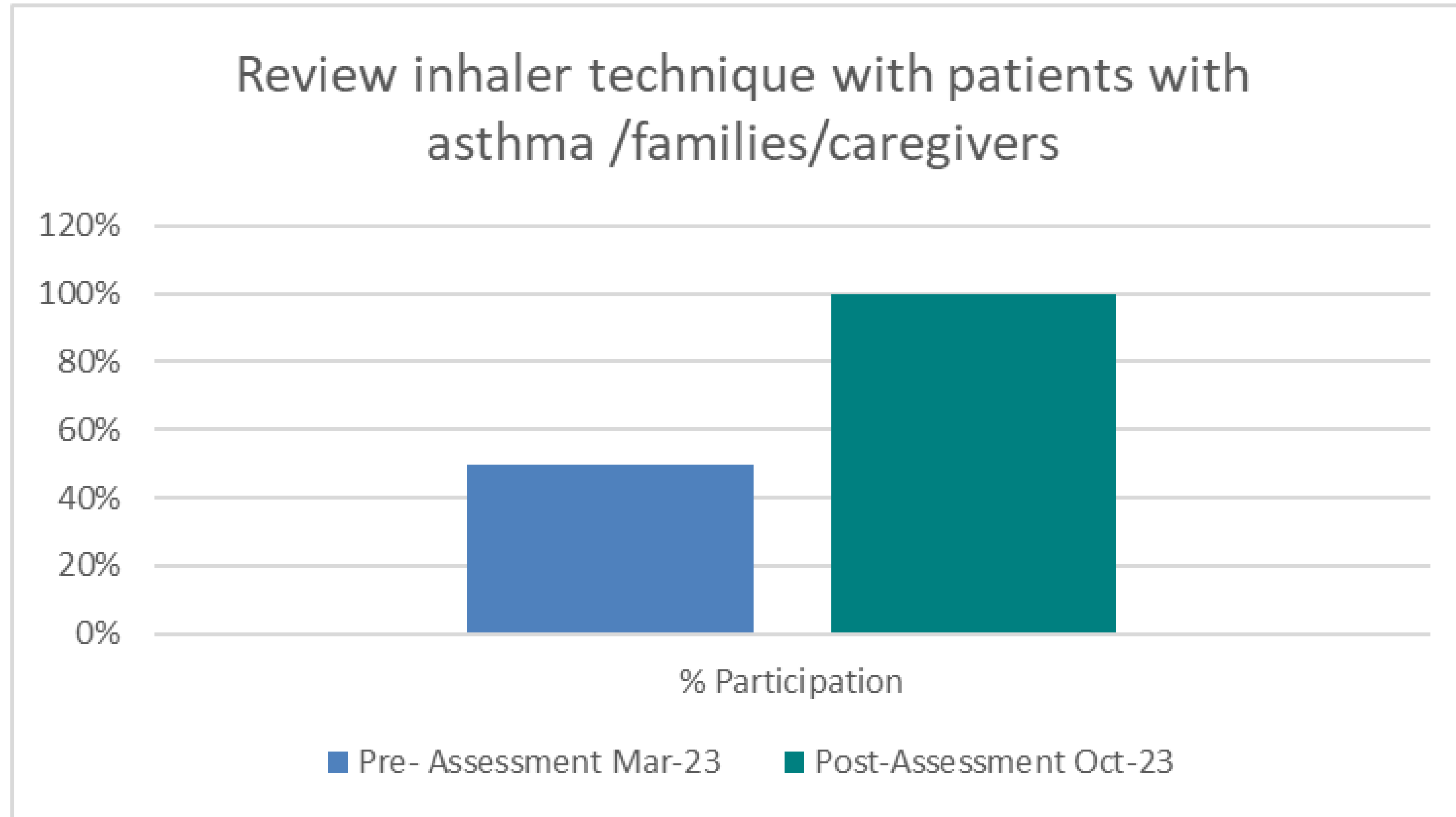
Review inhaler technique with patients with asthma /families/caregivers; reinforce technique by showing the appropriate CDC video. Patients demonstrate good device technique /use of medication.



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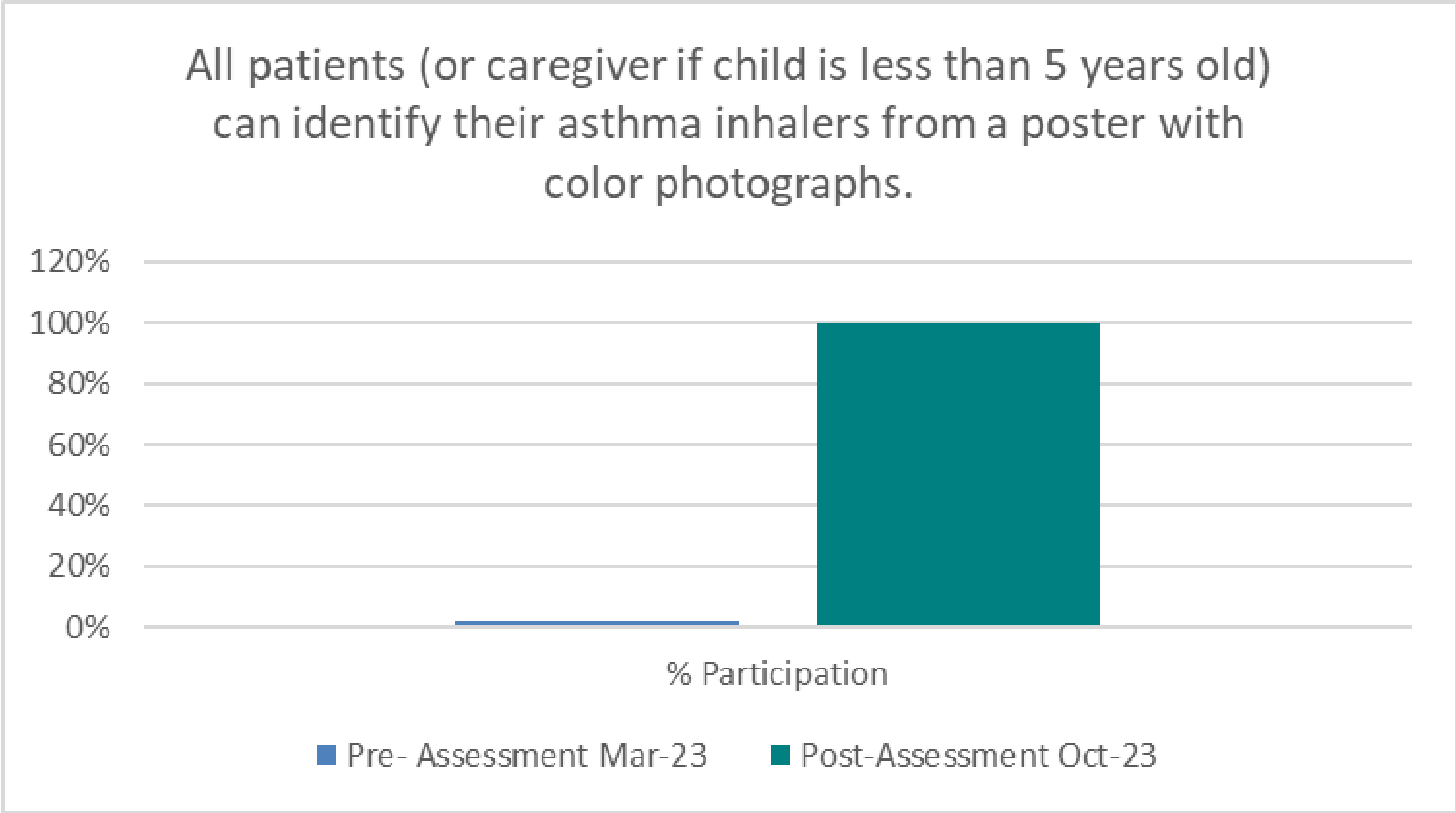
All patients (or caregiver if child is less than 5 years old) can identify their asthma inhalers from a poster with color photographs. “Teach back” is used to confirm the patient and/or child/caregiver describe the purpose, actual use pattern and intended dosing regimen for each inhaler.



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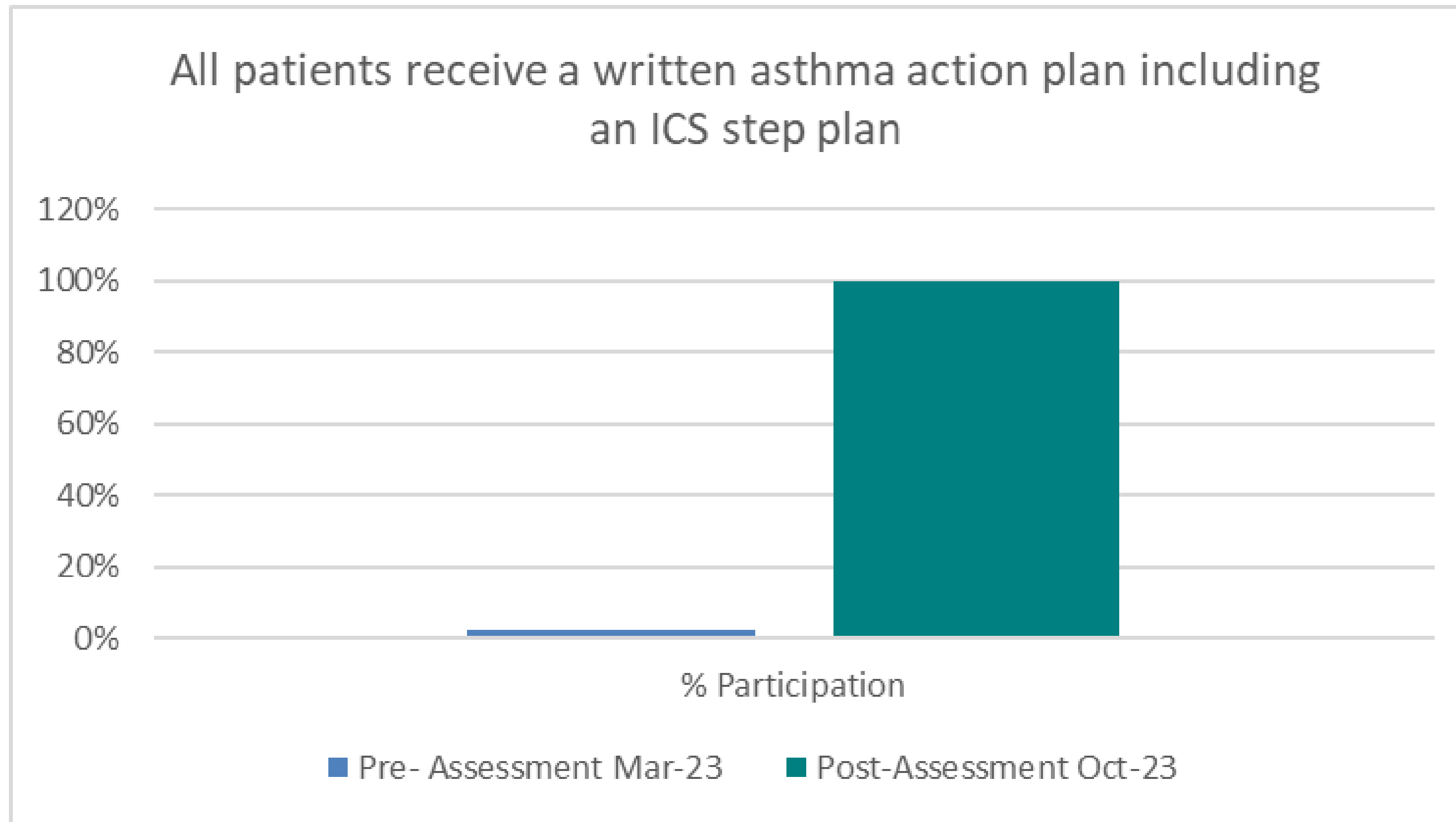
All patients receive a written asthma action plan including an ICS step plan and other yellow zone actions to manage co-morbidities, as well as indications for a 911 call and use of albuterol by valved holding chamber for life-threatening asthma. Use "teach back" to confirm green, yellow and red zone actions are understood. Review details with patient and caregiver, giving the family time to ask questions.



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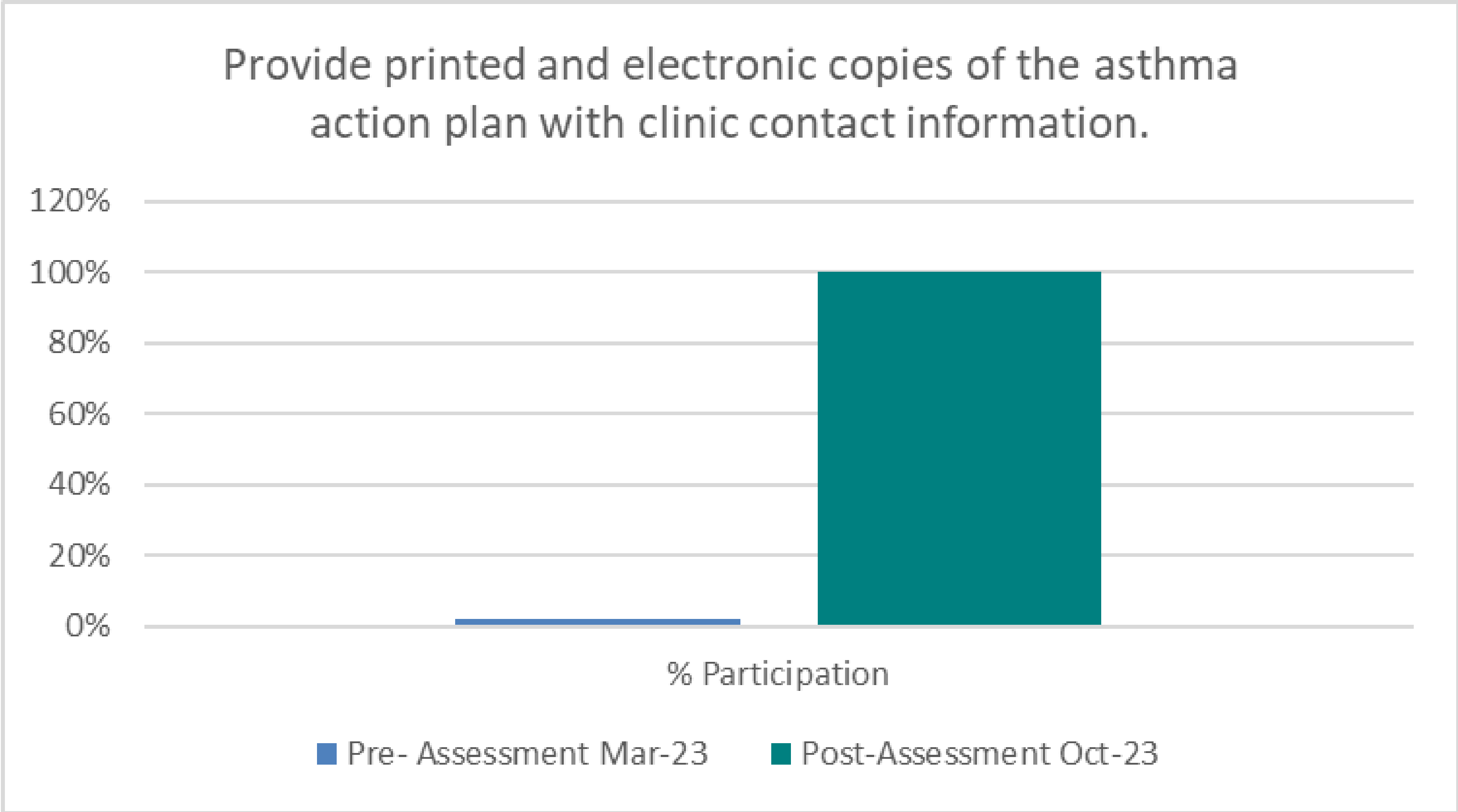
Provide printed and electronic copies of the asthma action plan with clinic contact information. With consent, assure asthma action plans are available to school nurses, teachers, coaches, childcare workers.



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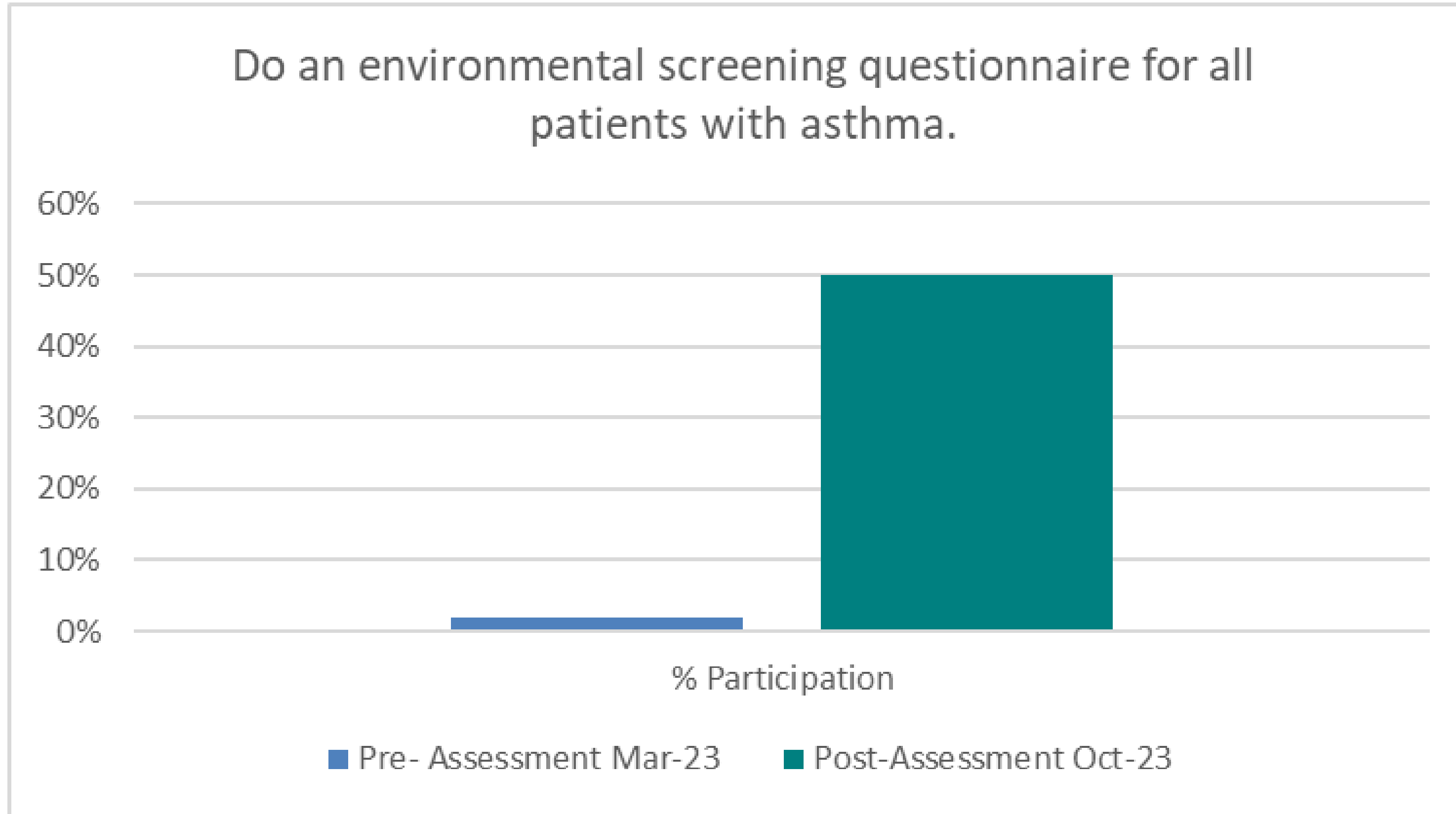
Do an environmental screening questionnaire for all patients with asthma.



Still have folks reporting that they are "unsure" if they do this

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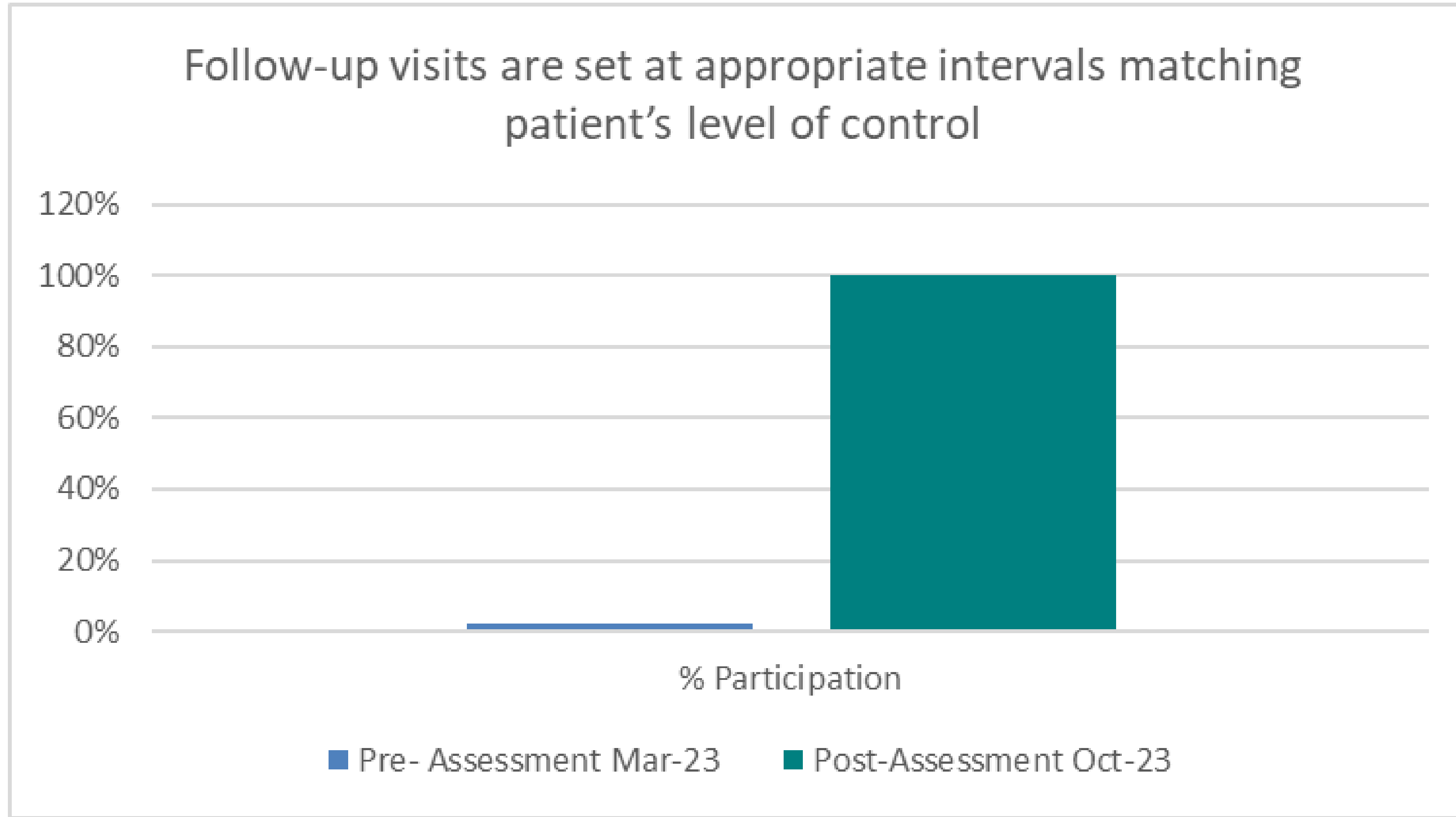
Follow-up visits are set at appropriate intervals matching patient's level of control (1-2 weeks for very poorly controlled, 2-6 weeks for not well controlled and 1-6 months for well controlled); Cancellations/"no shows" are contacted within 3 days.



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Practice Post-Assessment Survey Overview

Changes:

- Significant changes in patient and caregiver education
    - Patients are getting education at each visit
    - Getting more touch points regarding inhaler usage
    - Receiving copies of updated asthma action plans – key for self-management
- Better tracking of visits for uncontrolled to controlled asthma

Opportunity:

- Leverage environmental screening questionnaire & help patients manage triggers in their home environments

Discussion & Feedback

- Practice recommendations for our next Asthma learning collaborative
- Was the core measure - looking at number of visits in primary care practice vs. ED/IP - helpful?
- Goals of project was to:
  - 1) improve communication/coordination with school nurses around asthma action plans
  - 2) improve identification of patients who might benefit from HARP referral
    - Were these useful strategies?
- What did the practices find most helpful in the management of patients with asthma?

P.R.I.M.A., Inc. & Dr. Concilio

Recommendations for KIDSNET improvements

Each practice reviewed "KIDSNET demo" in Sept/Oct.; here are comments:

1. Demo of the Asthma Action Plan (AAP) was limited, so difficult to assess full functionality
2. Referral part was difficult for them to comment on since it seemed complicated

Wish list:

1. Ability to print a blank AAP
2. Ability to complete AAP online, print completed AAP for patient/family, send to school nurse
3. Ability to upload a completed AAP to KIDSNET and send to school nurse
4. Have date & demographics (Pt. name, DOB) auto-populated on AAP
5. Will KIDSNET AAP look just like the AAP Tri copies they use now?
6. Just fill out area "to be completed by Physician/Healthcare Provider"?
7. Will school nurse be notified by KIDSNET each time a new or updated AAP has been entered?
8. Can just AAP be opened (with no additional questions to be answered) to use the AAP /or need to do a referral have a prompt "Refer yes or no" …if yes, the referral screen would be displayed
9. Biggest barrier with filling out several "mandatory" questions – takes too much time
10. Referral process in KIDSENT – all the screens for 3 programs seem to have all the same questions – consider one referral screen and checkbox for which program/or programs the referral is for

THANK YOU

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