Asthma Change Package for Practice Sites

Family and Self-Management Support	*Decision Support*	*Clinical Information System*	*Delivery System Design*	*Health Care Organization*	*Community Resources*
1. ***Collaborate with patient and family to set and document shared management goals**. 2. Emphasize and educate the patient and family about their role in management of asthma. 3. Create care plan with patients and families that provides strategies for optimal asthma management in all zones.	1. *** Use NHBLI guidelines to establish a clear diagnosis for all people with asthma.** **2. * Employ severity classification at planned visit intervals based on symptom frequency and pulmonary function.** 3. Use structured encounter form with embedded guideline elements to guide decision making among known asthma patients. 4. Develop a refill protocol to identify patients who are overusing beta agonists 5. Identify and manage predisposing factors (environmental triggers, co-morbidities). 6. Maintain practice-wide guidelines for specialty referral for poorly controlled, complicated, or confusing patients.	1. *** Maintain registry of asthma patients updated with encounter form, including patients' race, ethnicity and language preference.** 2. Conduct monthly identification of poorly controlled asthma patients via billing data (hospitalizations, ED visits, and if available, medication use). 3. Track asthma care quality measures and generate planned visit prompting list via registry and encounter data *including proactive care*. 4. Use a registry or billing data to monitor for patients who do not show for asthma planned visits and assign staff to follow-up.	**1. * Use planned care visits determined by severity of illness. Frequency and content of planned visits discussed and agreed upon by care team and patient/family.** 2. Define roles and delegate tasks to optimize staff efficiency (i.e. office staff assist clinicians in maintaining written management plan, providing education, etc.). 3. Create a system to identify and vaccinate all patients with asthma for influenza. 4. Asthma provider champion, nurse champion, and care team identified and well organized.	1. Organizational leadership establishes and monitors goals of asthma program. 2. Maintain practice infrastructure for systematic improvement with measurement embedded in work flow and actively monitored 3. Provide culturally and linguistically appropriate care at all points of contact. 4. Assess organizational and individual understanding of culturally and linguistically effective care and implement appropriate strategies for making and sustaining improvements. 5. Maintain a well-functioning linkage to Health Plan leadership	**1. * Partner with schools, workplaces and other community organizations to encourage optimal management in all settings** 2. Identify and utilize community resources, i.e. smoking cessation programs and providers

NICHQ
National Initiative for Children's Healthcare Quality

Bolded items with a * indicate changes that should be a priority for the practice site

Developed by NICHQ based on the Chronic Care Model.[1]

[1] *Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? Effective Clinical Practice. 1998;1:2-4.*

Health Plan Activities to Support Practice Site Changes

Family and Self-Management Support

1. Provide self-management training courses for practice site teams.
2. Provide self-management education directly to members with asthma.
3. Provide health education classes to teach members with asthma how to figure out their own severity classification. Educate on the importance of knowing that information.
4. Provide resources and incentives for patients, parents, household members of patients who smoke to help them quit.
5. Work with practice sites to incent members with asthma that participate in health promotion/physical activity programs.
6. Identify age/cultural/literacy gaps in patient education tools and develop/purchase and disseminate through network physicians.
7. Work with other plans in a region to standardize provider and member educational documents.

Decision Support

1. Distribute asthma guidelines to your provider network and educate providers about standards of care.
2. Create/purchase an asthma flow chart that corresponds with the asthma guidelines that have been distributed and provide free to practice sites.
3. Incent providers to perform self assessment of their care using standardized tool (like American Academy of Pediatrics).
4. Provide pharmacy-profiling information to network physicians (filled prescriptions – rescue to controller data etc.).
5. Establish a relationship in which specific asthma specialist is 'assigned' to a set of providers (or patients) for consultation, review of medication use, utilization of acute care, random chart review, academic detailing.

Clinical Information System

1. Provide software or build registry functionality into existing software at practice sites.
2. Provide practice sites with training to integrate clinical information systems into everyday practice.
3. Provide IT support to build measures and reporting capability into software
4. Assist practice sites in identifying their patients with asthma
5. Facilitate downloading of any automated clinical data to the software
6. Provide chart audit assistance for non-automated data needed in software
7. Work with practices to send reminders to enrollees for asthma preventive, well visits.
8. Monitor group practice specific indicators for quality chronic illness care (moving beyond administrative data):
   - Severity assessment.
   - Treatment with anti-inflammatory meds
   - Patients exposed to ETS or other triggers.
9. Establish policies and programs to provide information system infrastructure among providers especially in smaller ambulatory community and rural settings.

Delivery System Design

1. Provide patient scheduling for planned visits and follow-up calling assistance to practice site.
2. Design and reimburse for group education visits by doctor, nurse or asthma educator.
3. Reimburse practice sites for peak flow meters, spacers, nebulizers kits, compressors, etc.
4. Provide clinicians with a list of vendors they can work with to obtain an inventory of asthma equipment for their practice site.
5. Send Technical Assistance team from health plan that specializes in information management, clinical management and patient education, to individual practice sites to assist in development of assessment, quality improvement and monitoring documentation tools, patient registry, reminder systems, etc.
6. Reward primary care/specialist clinicians that provide extended hours, evening and weekend appointments for urgent visits process/organization/redesign.
7. Provide an "asthma coordinator" to a struggling practice site.

Health Care Organization

1. Create performance incentives for providers who provide outstanding asthma care as defined by HEDIS, chart review, office redesign for chronic care and patient satisfaction.
2. Adopt the Chronic Care model as a framework for improving chronic illness care among members, as evidenced by mission statement and QI Policies & Procedures.
3. Be proactive in providing case mgmt/disease mgt to high risk patients with asthma to facilitate better self management and access to care.
4. Build internal competency at the health plan around improving chronic illness care and quality improvement via staff development.
5. Become a clearinghouse for decision support tools, e.g. asthma flowcharts, asthma guidelines, asthma specialist referral form, etc. Provide consultant support on how to integrate into practice.

Community Resources

1. Provide equipment for school asthma management program implementation, e.g. peak flow meters, spacers, disposable nebulizer kits, compressors.
2. Review with hospitals what training/education/information members with asthma receive when they receive services in the hospital.
3. Work with local emergency departments to develop a means by which the health plan/provider is notified when a patient is seen in the ED
4. Pilot a program which partners with pharmacists to provide education, assesses patient technique, evaluates for spacer use, etc.
5. Support/promote and participate in local and regional clinical and community collaboratives.
6. Employ/incent training of Certified Asthma Educators to provide group asthma education classes at the primary care site /schools / daycare centers

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Developed by the New York State Department of Health based on the Chronic Care Model and modified, with permission, by the Center for Health Care Strategies.