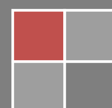
2018

Breathe Alabama:
An ACHIA Asthma Learning Collaborative
January 2018 – February 2019

Final Report
April 2019



University of Alabama at Birmingham
School of Public Health

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Breathe Alabama: An ACHIA Asthma Learning Collaborative

January-September 2018

About the Alabama Child Health Improvement Alliance

A member of the National Improvement Partnership Network (NIPN) since 2013, the Alabama Child Health Improvement Alliance (ACHIA) is a statewide collaboration of public and private partners that uses measurement-based efforts and a systems approach to improve the quality of children's healthcare. Our partners include the Alabama Chapter American Academy of Pediatrics, Children's of Alabama, the University of Alabama at Birmingham Department of Pediatrics, the University of South Alabama Department of Pediatrics, the Alabama Medicaid Agency, the Alabama Department of Public Health – Title V, ALL Kids, Blue Cross and Blue Shield of Alabama, The Children's Rehabilitation Services and others. ACHIA's administrative home is in the University of Alabama at Birmingham Department of Pediatrics, a state agency, with staffing comprised of a Director and administrative/support staffing. A cornerstone of ACHIA's project-level work is working with practices and health systems to improve care on the front-line, using meaningful data to gauge these efforts, and identifying policy-level implications and improvements. A key component of our staffing structure and work is the use of practice-/system-level facilitators to guide improvement efforts at the ground-level and ensure that evidence-based strategies are implemented and sustained.

Vision and Mission Statements

Vision: Alabama's children achieve optimal health.

Mission: To improve health outcomes by fostering a culture of quality improvement through partnerships with practitioners, payers, families and organizations that deliver care to Alabama children.

Values Guiding ACHIA Work

We will:

- Be committed to conducting high value, high quality project work.
- Be measurement driven.
- Focus our work on improving the use of interventions with a solid evidence base of effectiveness in practice-based settings.
- Select projects that address priority health/healthcare issues for Alabama children.
- Conduct our work in a multi-disciplinary fashion as improving pediatric care requires the involvement of many different sectors and systems.
- Operate in a spirit of collaboration not competition. We will not address a pediatric health or healthcare priority that is already being comprehensively addressed by another organization unless there is a mutually identified role the ACHIA can play to support that organization's efforts.
- Adhere to principles of health data confidentiality.
- Share knowledge and information learned through our quality improvement work with Alabama public agencies interested in child health and National Improvement Network Partnership stakeholders in the interest of child betterment.

Asthma in Alabama: Background

Asthma is the most prevalent chronic disease among children affecting more than 120,000 of Alabama's children. Symptoms can be controlled with appropriate medical treatment, self-management, and by avoiding exposure to environmental allergens and irritants that can trigger an attack. Implementation by clinicians of the 2007 National Health Lung and Blood Institute (NHLBI) *Guidelines for the Management and Treatment of Asthma Expert Panel Report* can significantly reduce asthma exacerbations, related hospitalizations and emergency department visits. Home-based multi-trigger, multi-component interventions with an environmental focus for children with asthma are proven to reduce exposure to multiple indoor asthma triggers.

Participants, Faculty Experts, Community Partners

Collaborative Format

Practices voluntarily participated in the 9 month collaborative. Each practice created a Core Team responsible for testing change ideas using the Model for Improvement and QI tools such as Plan-Do-Study-Act cycles and process mapping. Content education was available online for all practice members. QI coaching and the sharing of ideas occurred through monthly practice webinars. Integrating parent and patient insights into practice approaches was emphasized. Continuing Medical Education and American Board of Pediatrics Maintenance of Certification Part IV credits were available.

For home visiting interventions, patients with Medicaid were identified from practice referrals of those with poor asthma control and/or from data-mining of patients with two Emergency Department visits, one hospitalization and/or two or more courses of oral corticosteroids in the previous 12 months. ACHIA developed online home-visiting modules for training current and future health home staff. Funding for supplies to address environmental triggers was provided. Monthly Health Home Webinars allowed for dissemination of best ideas among home-visiting teams. Home visit reports back to practices offered findings related to medication adherence to the Asthma Action Plan, understanding of asthma, and any other barriers to care. Reports back to ACHIA documented the number of visits completed, medication adherence, patient ability to use inhaler devices appropriately and environmental mediation supplies provided.
Practice barriers to achieving well controlled status exist:

- Lack of practice application of asthma guidelines
- Failure of patient/guardian/patient to be engaged in adherence and self-management
- Patient disparities (e.g. lack of transportation, inability to mediate environmental triggers)

Participants	Project Partners	Project Support
14 practices from all regions of Alabama, 39 pediatricians, 64 support staff	Alabama Medicaid Health Homes	Children's of Alabama University of Alabama at Birmingham
Practices have 11,236 children (ages 2 – 21) with a diagnosis of asthma (approximately 10% of children in Alabama with asthma). Practices have 230,000 annual visits.	Alabama Children's Rehabilitation Services – Family Voices of Alabama	University of Alabama – Department of Pediatrics
55.6% of participating practice patients have Medicaid.	Alabama Chapter-American Academy of Pediatrics	The Caring Foundation
	Children's of Alabama Asthma Clinic	Alabama Medicaid Agency

Participating Practices

Participating Practices: Charles Henderson Child Medical Center, Enterprise Pediatric Clinic (Dothan Pediatric Healthcare Network), Fairhope Pediatrics, Fort Payne Pediatrics , Greenvale Brook Highland, HAPPI , Jefferson Country Western Health Department, Metro Pediatrics P.C., Preferred Medical Group, Primary Care Pediatrics and Family Medicine, Purohit Pediatric Clinic, Southeastern Pediatrics, University Medical Center, University of South Alabama Pediatrics

Expert Faculty

- Isabel Virella-Lowell MD, FAAP, Associate Professor of Pediatrics, Division of Pulmonary and Sleep Medicine, UAB, Content Expert
- Katrina Roberson-Trammell, MD, FAAP, Physician Lead
- E. Cason Benton, MD, FAAP, Associate Professor, Department of Pediatrics, UAB Principal Investigator
- Susan Walley, MD, FAAP, Associate Professor, UAB, Hospital Medicine, Content Expert
- Amy CaJacob, MD, FAAP, Assistant Professor, Associate Program Director, UAB/Children's of Alabama, Division of Pediatric Allergy and Clinical Immunology, Content Expert
- LaCrecia Thomas, RN, MSN, CPNP-AC/PC, CF Coordinator and Nurse Practitioner, UAB/COA Cystic Fibrosis Center, QI Coach
- Susan Colburn, Family Advisor, Family Voices of Alabama, CRS Family Engagement Advisor
- Linda Champion, MPA, ACHIA Project Manager
- Terri Magruder, MD, FAAP, MPH, Associate Professor of Pediatrics, Division of Pulmonary and Sleep Medicine, UAB, Content Expert
- Katy McMullen, MSW, LICSW , AE-C, Medical Social Worker, COA, Content Expert

Community Partners

Alabama Medicaid Health Homes were a central Breathe Alabama community partner. Health Homes coordinate care for patients with asthma and certain other chronic conditions in all 67 Alabama counties. Homes connect patients with needed resources, teach self-management skills, provide transitional care, and bridge medical and behavioral health services. The American Academy of Pediatrics made funds available to the Health Homes for supplies to mitigate environmental triggers.

Operating Health Home Programs by Region

Region	Organization	Contact Name	Phone #
A	• Alabama Community Care – Region A	• Dana Garrard Stout	• (256) 382 - 2366
	• My Care Alabama	• Stacey Copeland	• (855) 494 - 6335
B	• Alabama Care Plan	• Michael Battle	• (205) 558 - 7645
C	• Alabama Community Care – Region C	• Lashaunda Lark-Darien	• (205) 553 - 4661
D	• Care Network of Alabama	• Jan Carlock	• (334) 528 -5804
E	• Gulf Coast Regional Care Organization	• Sylvia Brown	• (251) 476 - 5656

Goals, Aims, Key Drivers and Measures

Project Goals

- Improve primary care infrastructure to build a sustainable, evidence-based, patient-centered, quality improvement infrastructure within the practice so patient's asthma is well controlled.
- Improve the opportunities for a child to maintain well controlled status by referrals to the Alabama Medicaid's Health Home for Asthma Home Visiting and feedback to physician offices.

Project Aims

- Practices will implement the National Asthma Education and Prevention Program- Expert Panel Report 3 at 80% of asthma visits to achieve optimal asthma care for their patients by determining and documenting:
    - Asthma Severity
    - Asthma Level of Control
    - NHLBI Stepwise approach is used to identify treatment options or adjust therapy
    - Written Asthma Action Plan updated and reviewed
- Practices will make appropriate referrals for asthma home visiting to the Alabama Health Homes

Practices were encouraged to select optional measures:

- Using a Validated Tool to assess asthma control
- Prescribing Inhaled Corticosteroids for patients with persistent asthma
- Flu Shot Received
- Patients with Asthma Receive Education
- Smoke Exposure Accessed
- Spirometry Completed

Key Drivers

Engage CQI Team and Practice

- The CQI Team and practice is active and engaged in improving practice processes and patient outcomes

Manage Population

- Identify asthma patients at every visit
- Identify needed services for each patient
- Recall patients for follow-up
- Incorporate Home Visiting

Use Planned Care Approach to Ensure Reliable Asthma Care in the Office

- Standardize asthma visit to provide optimal asthma care
- Care Team is aware of patient needs and works together to ensure all needs are completed

Develop Protocols

- Standardized practice-wide process for Optimal Asthma Care
- Practice/site-wide asthma guidelines implemented for sustainability

Provide Self-Management Support (SMS)

- Realized patient/family and care team relationship support parent's awareness of asthma care

Core Measures:

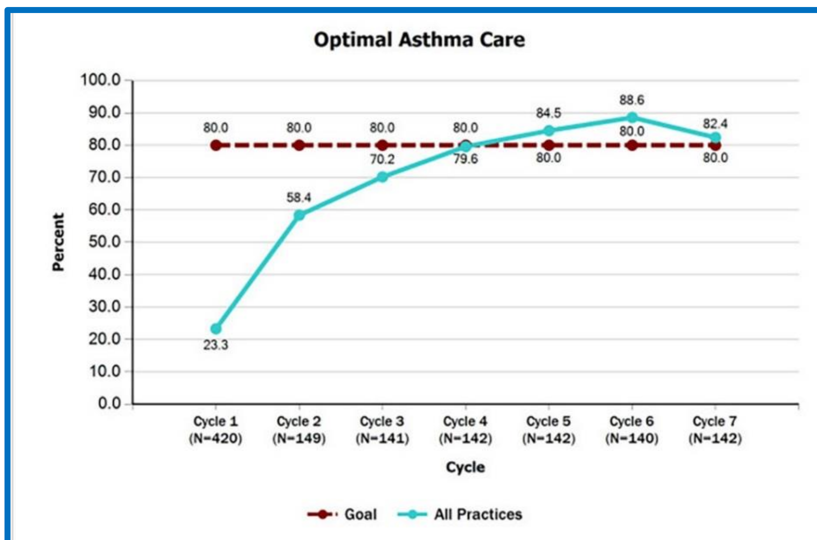
Name of Measure	Type	Numerator	Denominator	Goal
Fig 1: Optimal Asthma Care (Wrap up)	Process	Patients ages 2-21 years: 1. asthma severity classified 2. level of control assessed 3. treatment appropriately stepped up/down/maintained 4. proper dose of mediation prescribed	# of patients between the ages of 2 - 21 years who had a visit to the participating practice during any visit related to asthma and have a documented diagnosis of asthma	80%
Fig 2: Provide/Review Asthma Action Plan	Process	# of patients between the ages of 2 - 21 years with a diagnosis of asthma whose asthma action plan was updated at any asthma visit	# of patients between 2 - 21 years who had a visit to the participating practice during any asthma visit and have a documented diagnosis of asthma.	80%

Practice Data Highlights

Over the course of the collaborative, optimal asthma care delivery increased from one in five patients to more than four out of five patients.

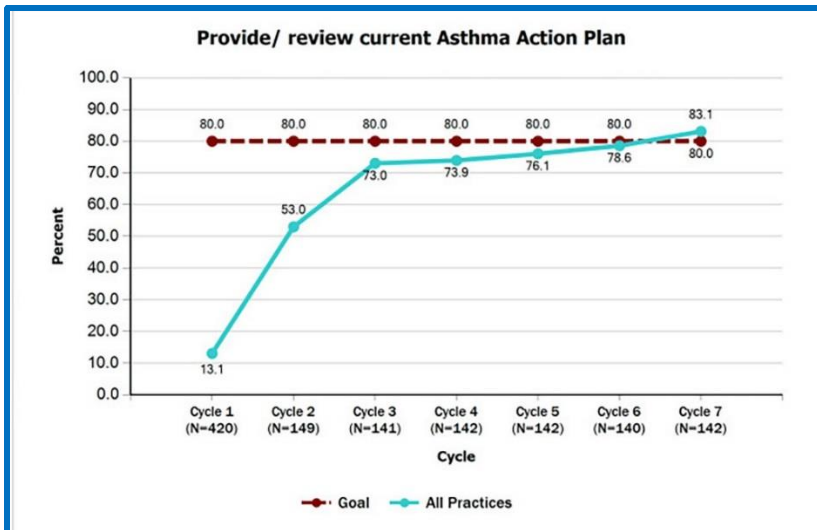
The greatest area of improvement involved implementing better systems to reliably assess the level of control with either a validated tool or by asking the impairment and risk questions regarding frequency of symptoms, nighttime awakenings, use of short acting medicines for symptom control, interference with normal activity and frequency of steroid use for asthma control over the previous year.

Engaging patients in self-management by providing and reviewing an asthma action plan jumped from 10% to over 80%.



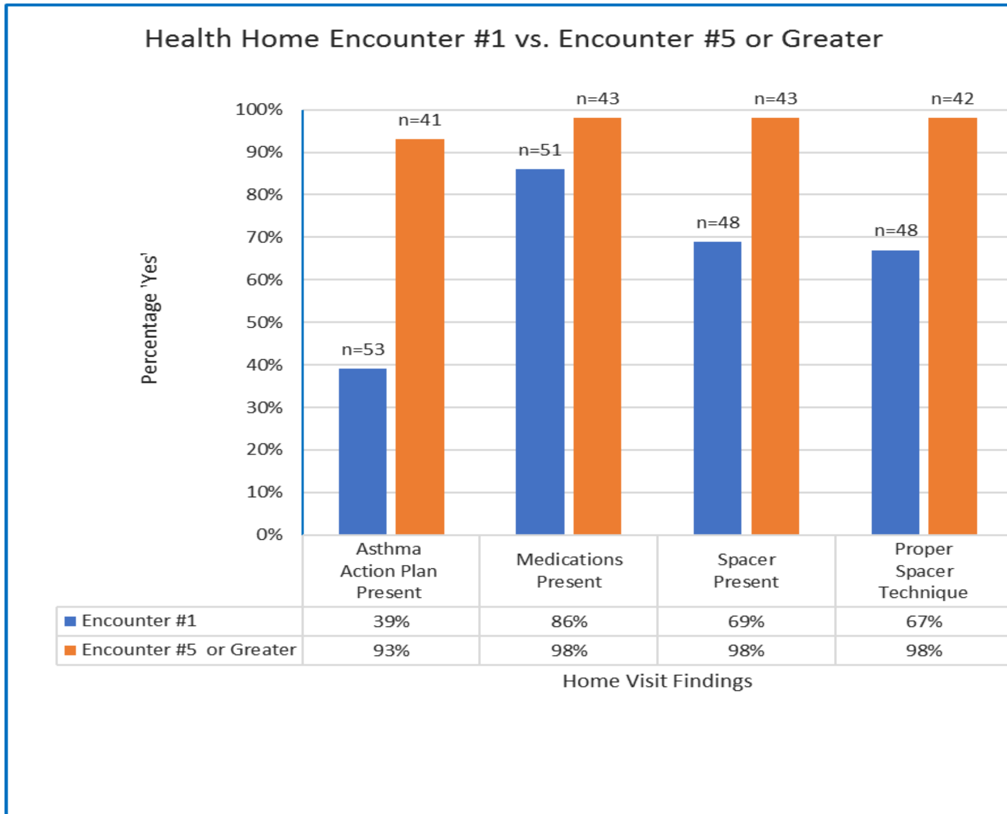
Optimal Care:
1. Classify Asthma Severity
2. Assess Level of Control
3. Step Treatment Up/Down as needed
4. Medication Dose appropriate for age.

Cycle 1= Baseline
Cycles 2- 7: Monthly Data



Health Home Data and Patient Survey Highlights

Health Home Teams working to close care gaps and support self-management had excellent results with key components such as having the proper medications and spacers present in the home reached over 90%. Patients with Asthma Action Plans present in the home more than doubled. Proper spacer technique, an essential step in medicine delivery, increased to well over 90%. Well controlled asthma increased 26% to over 80%



2019 Health Home Data Aggregate May 2018 – January 2019 Level of Control			
May – Nov 2018	**Encounter #1**	**Encounter #2**	**Encounter #3**
Well Controlled	28	25	26
Not Well Controlled	16	8	4
Very Poorly Controlled	5	2	1
Not Assessed	14	5	3
% Well Controlled of Assessed	57%		83%

Note: Use a validated tool such as the Asthma Control Test or TRACK (2-4 yo) to determine level of control

Health Home Patient Survey Results

At the conclusion of the home visiting intervention parents reported an increase in knowledge and confidence in managing asthma.

As a result of working with the Care Coordinator, I understand my child's asthma better.

Response	Number (N)	Percent (%)
Yes	12	100.0
No	0	0.0

As a result of the Health Home Care Coordinator visits, I feel more confident in helping my child follow his or her daily routine for asthma care as outlined in the Asthma Action Plan.

Response	Number (N)	Percent
Strongly Disagree	0	0.0
Disagree	0	0.0
Agree	1	9.0
Strongly Agree	10	91.0

Post Collaborative Practice Survey Highlights

In Winter 2018, the UAB SOPH conducted a post-survey of practices that participated in the 2018 ACHIA Breathe Alabama Asthma Collaborative. A survey was distributed to the 14 practices that participated in the spring 2018 ACHIA Breathe Alabama Asthma Learning Collaborative; all 14 participating practices responded. Highlights include:

- Half of providers viewed the asthma collaborative as positively impacting their ability to deliver quality care in other areas. Five noted mixed results while one suggested that the collaborative did not impact delivery of quality care in other areas (n=13).
- Nine of the practices plan to use this project as part of our Patient Centered Medical Home (PCMH) certification or re-certification process.
- Twelve practices consistently referred patients to their Health Home as a result participating in this project
- Practices identified the following benefits of referring patients to a Health Home:
    - Identifying triggers at home
    - Proactive approach to care
    - Feedback regarding medications and the home environment
- Practices also identified the following barriers to referring patients to a Health Home:
    - Patient reluctance/Lack of buy-in
    - Fear/Judging (assuming Health Home is DHR)
- Respondent comments regarding the most beneficial aspect of the learning collaborative include:
    - Improving our asthma care by examining what we were doing as opposed to what we know is recommended and making sure newer providers were meeting asthma optimal care goals. I think providers who participated in CQN knew what we were supposed to do but did not realize we were not doing it consistently and newer providers needed to learn all the layers of what to do and having an organized group activity is a great way to achieve this.
    - Our practice was able to identify asthma patients, streamline our asthma visits, update our Asthma Action Plans, and update any missing vaccines. This collaborative allowed us to improve in multiple areas not just asthma.
    - Coming together as a team to work on patient improvement. The collaborative was a great way to keep us working in sync and building a better team.
    - Able to see what other practices are doing, what works better for them, learning from their experience, having specialist talk about updates in asthma, getting formulary update and option, learning community resources.
    - For the practice: Working together as a team to come up with templates/innovative ideas and a work flow that was efficient For the patients: consistent management, education and counseling
    - Asthma Action Plan
- When looking at the overall asthma improvement effort of our practices based on the Institute for Healthcare Improvement Scale, eleven (11) noted outstanding and sustainable results or significant progress and real improvements vs. three (3) 3 identifying modest improvements.

Lessons Learned

Key take-away points from the Breath Alabama: An Alabama Asthma Collaborative include:

- Monitoring practice data is essential for improvement and sustainability
- Working as a team on a shared goal is highly valued by participants
- Collaborative work leads to improvements in other clinical areas
- Important for practices have a system to locate patients lost to follow up
- Asthma home visits close care gaps – especially around self-management skills
- Health Home ability to engage patient is strongly related to how well Health Home and practice connect
- Parents Agree and Strongly Agree that Health Home visits help the parent have more confidence in following daily routine for asthma care.

Appendices

ACHIA 360

Breathe Alabama: Asthma Continuous Quality Improvement Collaborative *January – September 2018*

Asthma is the most prevalent chronic disease among children affecting more than 120,000 of Alabama's children. Symptoms can be controlled with appropriate medical treatment, self-management, and by avoiding exposure to environmental allergens and irritants that can trigger an attack. Implementation by clinicians of the 2007 National Health Lung and Blood Institute (NHLBI) Guidelines for the Management and Treatment of Asthma Expert Panel Report can significantly reduce asthma exacerbations, related hospitalizations and emergency department visits. Home-based multi-trigger, multi-component interventions with an environmental focus for children with asthma are proven to reduce exposure to multiple indoor asthma triggers.

Practice barriers to achieving well controlled status exist
- Lack of practice application of asthma guidelines
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- Patient disparities (e.g. lack of transportation, inability to mediate environmental triggers)

Practices encouraged to select optional measures
- Use a Validated Tool to assess asthma control
- Prescribe Inhaled Corticosteroids for patients with persistent asthma
- Administer Flu Shot
- Patients with Asthma Receive Education
- Assess Smoke Exposure
- Complete Spirometry

Project goals

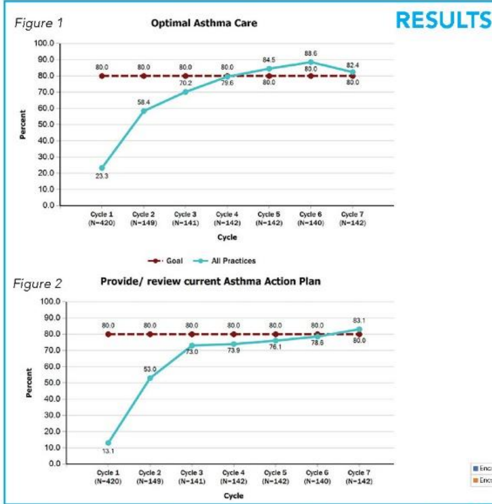
- Improve primary care infrastructure to build a sustainable, evidence-based, patient-centered, quality improvement infrastructure within the practice so patient's asthma is well controlled.
- Improve the opportunities for a child to maintain well controlled status by referrals to the Alabama Medicaid's Health Home for Asthma Home Visiting and feedback to physician offices.

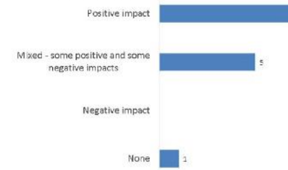
Project aims

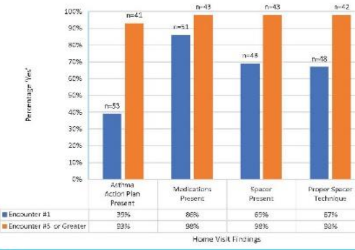
- Practices will implement the National Asthma Education and Prevention Program Expert Panel Report 3 at 80% of asthma visits to achieve optimal asthma care for their patients by determining and documenting:
  - Asthma Severity
  - Asthma Level of Control
  - NHLBI Stepwise approach is used to identify treatment options or adjust therapy
  - Written Asthma Action Plan updated and reviewed
- Practices will make appropriate referrals for asthma home visiting to the Alabama Health

Participating Practices: Charles Henderson Child Medical Clinic, Enterprise Pediatric Clinic, Fairhope Pediatrics, Fort Payne Pediatrics, Greenvale Pediatrics –Brook Highland, HAPPI, Inc., Jefferson County Health Department – Western Clinic, Metro Pediatrics, Preferred Medical Group, Primary Care Pediatrics and Family Medicine, Purohit Pediatrics Clinic, Southeastern Pediatric Associates, University Medical Center, USA Pediatrics

RESULTS







Name of Measure	Type	Numerator	Denominator	Goal
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Practices have 11,236 children (ages 2 - 21) with a diagnosis of asthma (approximately 10% of children in Alabama with asthma) Practices have 230,000 annual visits.	Alabama Children's Rehabilitation Services—Family Voices of Alabama	University of Alabama — Department of Pediatrics
55.6% of participating practice patients have Medicaid	Alabama Chapter — American Academy of Pediatrics	The Caring Foundation
Two practice teams lead by Nurse Practitioners	Children's of Alabama Asthma Clinic	Alabama Medicaid Agency

LESSONS LEARNED

- Patient driven asthma goals are essential for improved outcome
- Previous improvements in asthma care decline unless data continuously monitored
- Working as a team on a shared goal is highly valued by participants
- Practice data essential for improvement and sustainability
- Important to have a robust reminder/recall to identify patients lost to follow up
- Health Home ability to engage patient is strongly related to how well Health Home and practice connects
- Nurse practitioners are effective practice champions
- Parents agree and atrongly agree that health home visits help the parent have more confidence in following daily routine for asthma care.

Key Driver

BREATHE ALABAMA: AN ACHIA CQI COLLABORATIVE 2018

Global Aim

We will build a sustainable patient-centered quality improvement infrastructure within our practice so patient's asthma is well controlled.

Specific Aim

From January to September 2018 we will achieve measurable improvements in asthma outcomes in 80% of asthma visits by implementing the NHLBI guidelines and making key practice changes

Measures/Goals:

Optimal asthma care 80% of patient visits with all of the following:

- Asthma Severity Documented
- Asthma Level of Control Documented
- NHLBI Stepwise approach is used to identify treatment options or adjust therapy
- Written Asthma Action Plan updated and reviewed

Optional measures recommended at 80% of patient visits with the following:

- *ACT with Validated Tool*
- *Inhaled Corticosteroids Prescribed*
- *Flu Shot Received*
- *Asthma Patients Receive Education*
- *Smoke Exposure Accessed*
- *Spirometry Test Completed*

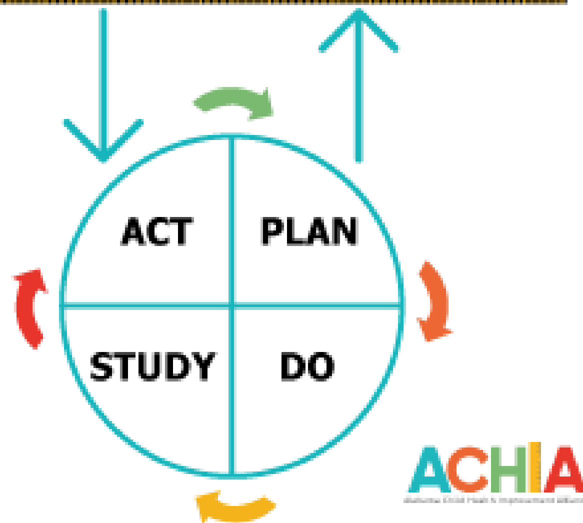
Key Drivers	Interventions
Engage CQI Team and Practice • The CQI Team and practice is active and engaged in improving practice processes and patient outcomes	Form 3 person interdisciplinary team and meet routinely Meet with CQI Coach at practice Communicate to practice importance and goals of asthma care Collect, enter, review baseline and monthly data with team and practice Use data to inform CQI tools such as aims statement, process maps, and PDSAs Involve Parents/Families in workflow design Complete monthly CQI assignments Participate in monthly webinars Ensure Knowledge of Evidence-based medicine (CME) modules
Manage Population • Identify asthma patients at every visit • identify needed services for each patient • Recall patients for follow-up • Incorporate Home Visiting	Select and populate a tracking/registry tool Use the tool to manage patient care & support population management Ensure visits are coded properly Create workflow to coordinate care with home visiting team
Use Planned Care Approach to Ensure Reliable Asthma Care in the Office • Standardize asthma visit to provide optimal asthma care • Care Team is aware of patient needs and works together to ensure all needs are	Determine workflow to support reliable completion of asthma components at each asthma visit Monitor use of the asthma components Monitor and address patient's needs
Develop Protocols • Standardized practice-wide process for Optimal Asthma Care • Practice/site-wide asthma guidelines implemented for sustainability	Select and customize evidence-based protocols for your office Determine staff workflow to support protocols, including standing orders Use protocols with all patients Maintain protocols and update as needed
Provide Self-Management Support (SMS) • Realized patient/family and care team relationship support parents awareness of asthma care	Obtain patient education materials Gauge caregiver's self-assessment of comfort in managing child's asthma Determine staff workflow to support SMS Provide training to staff in SMS Assess and set patient goals and degree of control collaboratively Document & monitor patient progress toward goals Link families with community resources

MODEL FOR IMPROVEMENT

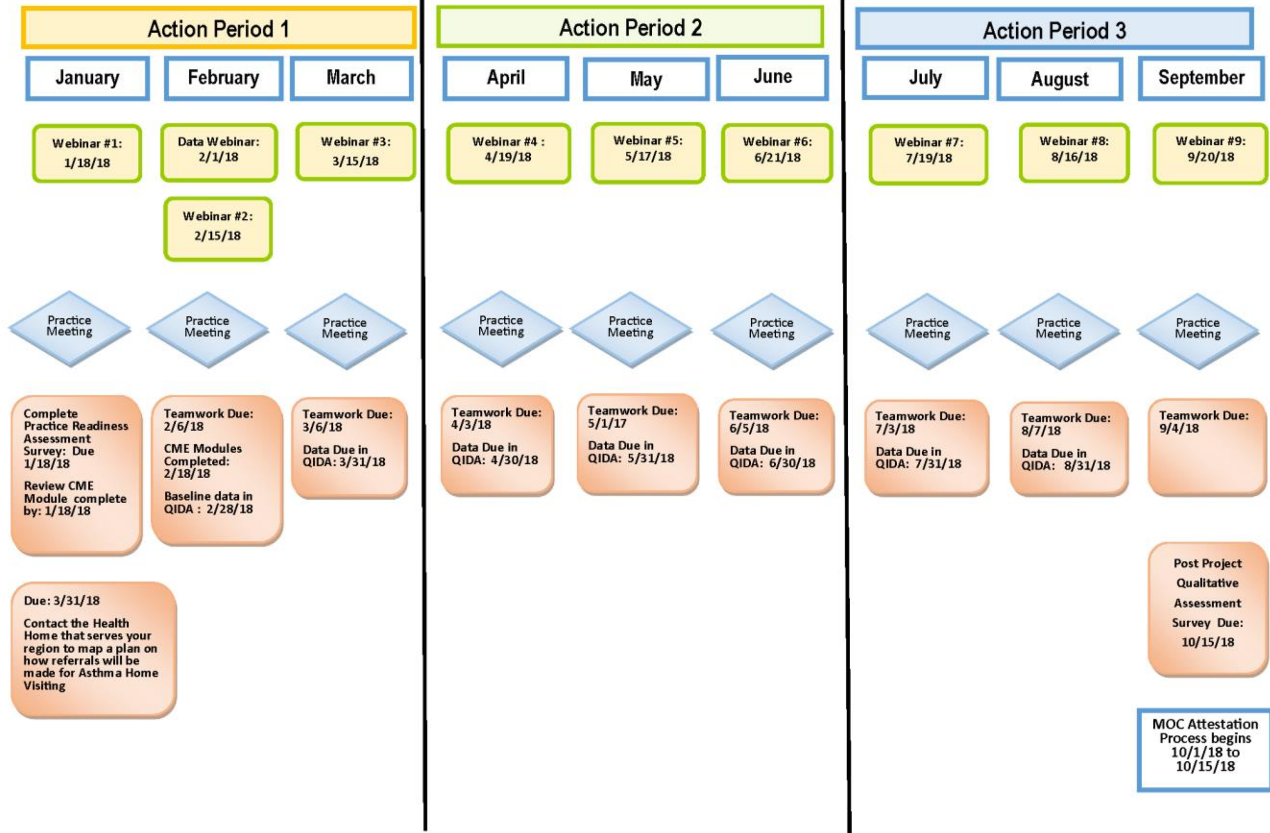
What are we trying
to accomplish?

How will we know that a change is an
improvement?

What change can we make that
will result in improvement?



Timeline



Post-Collaborative Survey Results

In Winter 2018, the UAB SOPH conducted a post-survey of practices that participated in the 2018 ACHIA Breathe Alabama Asthma Collaborative. The following report represents a composite of responses across practices.

Respondents

A survey was distributed to the 14 practices that participated in the spring 2018 ACHIA Breathe Alabama Asthma Learning Collaborative; all 14 participating practices responded including:

- Enterprise Pediatric Clinic
- Charles Henderson Child Medical Center
- Fairhope Pediatric Center
- Fort Payne Pediatrics
- Greenvale Brook Highland
- HAPPI
- Preferred Medical
- Primary Care Pediatrics and Family Medicine
- Purohit Pediatric Clinic
- Southeastern Pediatrics
- University Medical Center
- University of South Alabama Pediatrics
- Jefferson County Western Health Department
- Metro Pediatrics PC

Diagnosis and Management of Asthma

Q. How has the practice's knowledge and confidence related to the diagnosis and management of asthma changed because of participation in the Breathe Alabama Asthma CQI Collaborative?

Knowledge = understanding of the concept
Confidence = ability to apply the concept

1 = No improvement
2 = Somewhat improved
3 = Significantly improved
4 = Already had high Knowledge/Confidence

Practices expressed achieving high levels of improvement or maintaining knowledge and confidence related to the diagnosis and management of asthma.

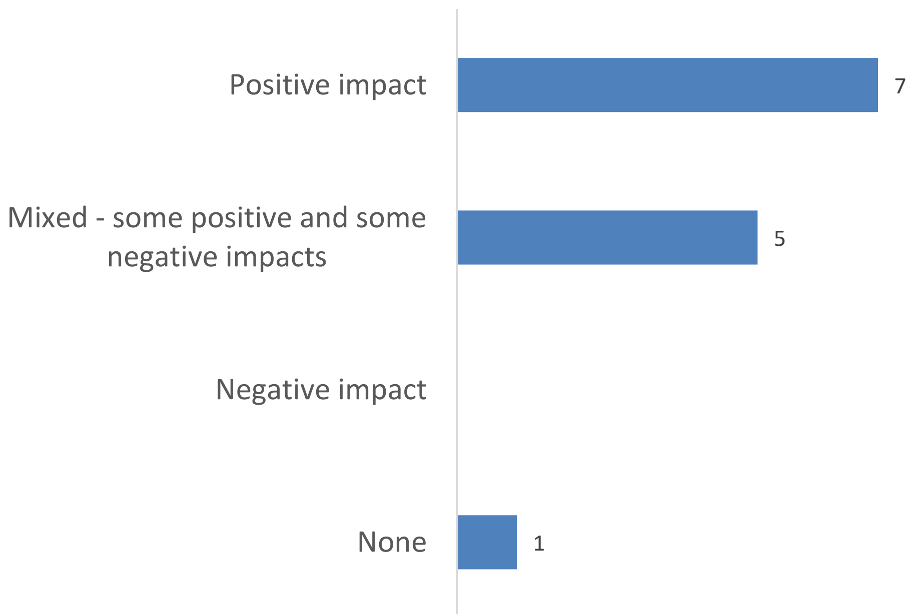
Knowledge	1	2	3	4
Optimal Asthma Care	0	1	6	7
Using the Asthma Action Plan	0	0	8	6
Assessing device and spacer technique	0	3	5	6

Confidence	1	2	3	4
Optimal Asthma Care	0	2	7	5
Using the Asthma Action Plan	0	2	8	4
Assessing device and spacer technique	0	3	6	5

Balancing Measure

Q. To what extent do efforts required to improve the diagnosis and management of asthma impact practice or provider ability to deliver quality care in other areas?

Half of providers viewed the asthma collaborative as positively impacting their ability to deliver quality care in other areas. Five noted mixed results while one suggested that the collaborative did not impact delivery of quality care in other areas (n=13).



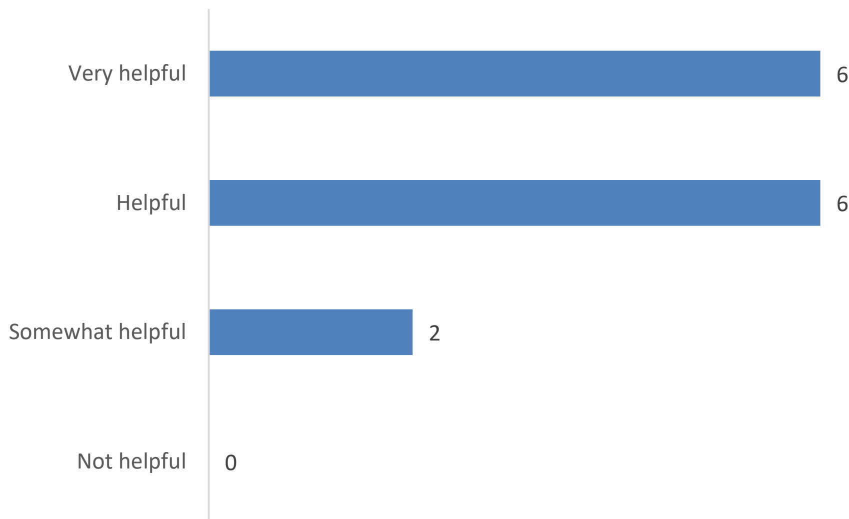
Other comments regarding QI and/or Asthma Collaborative:

- Time consuming
- Improved other processes/systems (i.e., vaccines, flu shots)
- Value of team work
- Reinforced best practices

Q. What type of visit did the practice receive?

Q. Please rate the value of the coaching visit

The vast majority found the coaching visit to be either “Helpful” (n=6) or “Very Helpful” (n=6). Two practices described the coaching visit as “Somewhat Helpful.”

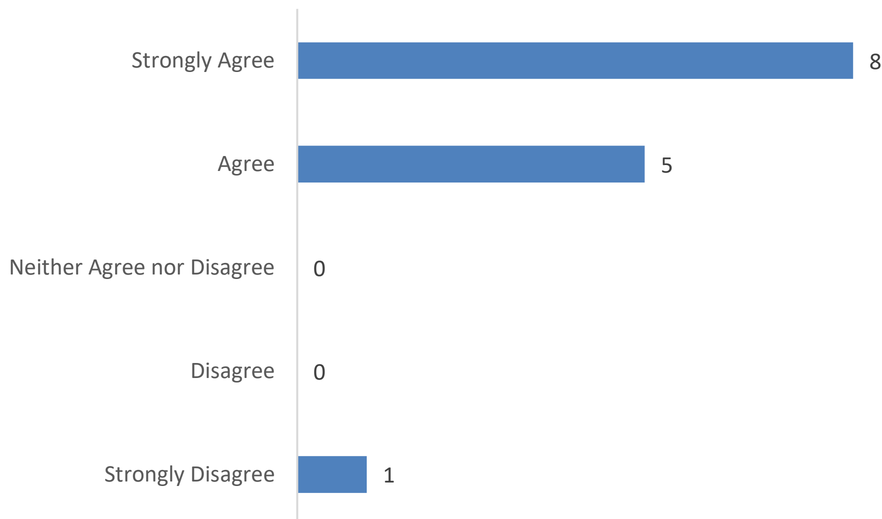


Comments:

- Office visit “energized the staff”
- Great sounding board
- Office reinforced ideas regarding “checks and balances” of quality patient care
- May have been better to do towards the middle of the practicum rather than beginning
- Hands-on work got to be “a little too much”
- Nice to meet in person and ask questions/brainstorm together
- Coach was “very detailed, positive and used behavioral questionnaire”

Q. The QI coach communicated content effectively during monthly webinars and one-on-one calls.

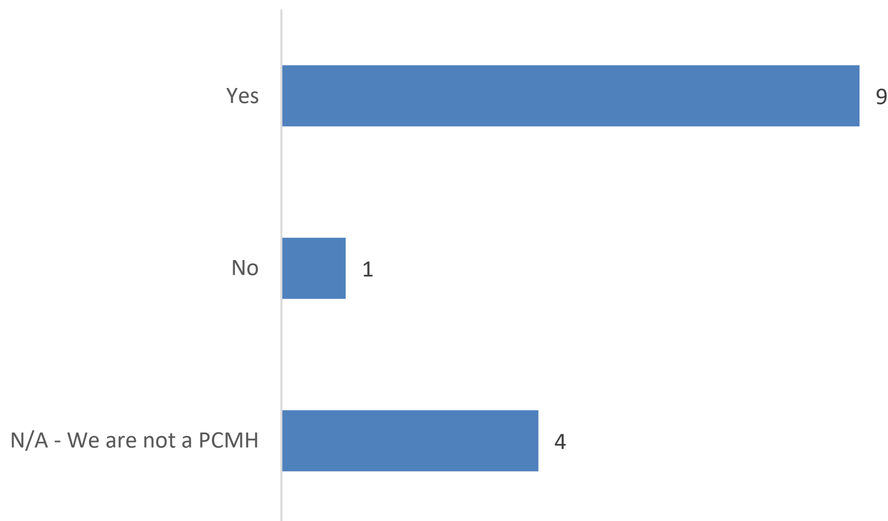
All but one practice either “Agreed” (n=5) or “Strongly Agreed” (n=8) that the QI coach communicated content effectively.



Q. QI Tools: Application

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	N
Using the Plan-Do-Study-Act activity was an effective tool in determining practice workflow to fully implement optimal asthma care	0	1	0	8	5	14
Our practice identified new strategies for increasing family engagement in optimal asthma care	0	1	1	6	6	14
Our practice team meetings effectively	0	0	0	4	10	14
Our practice intends to collect one or two measures after the collaborative concludes	0	2	3	7	2	14

Q. We plan to use this project as part of our Patient Centered Medical Home (PCMH) certification or re-certification process.

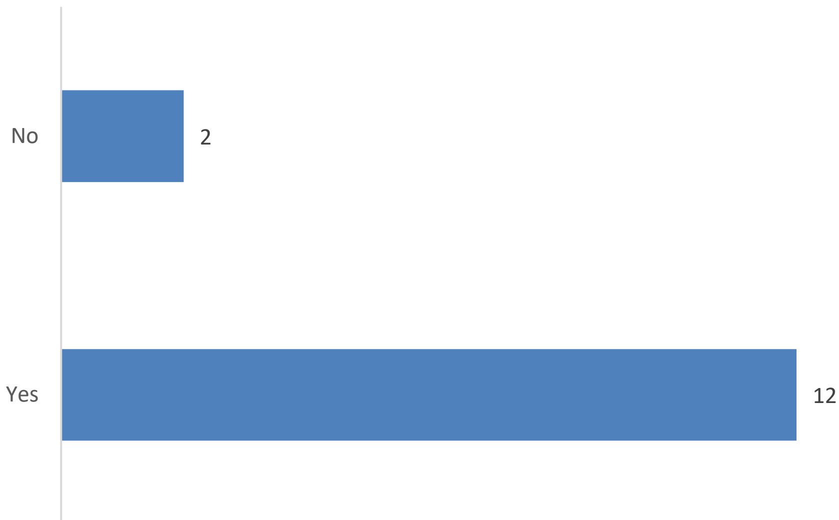


Community Partners

Q. Did the practice work with a Health Home?

Yes (n=14)

Q. Have you been referring patients to your Health Home as a result of your participation in Breathe AL?



Q. How many patients have you referred to your Health Home during your participation in Breathe AL?

Range: 0 to 20
Mode: 10

Q. What are the benefits of referring patients to your Health Home?

- Ability to address individual needs in the home
- More time
- Identify triggers in the home
- Proactive approach to care
- Better compliance
- Provide specific education and in-depth care
- New resources
- Improvement in using Asthma Plan
- Feedback regarding medications and home environment

Q. What are the barriers to referring patients to your Health Home?

- Patient reluctance/Lack of buy-in
- Fear/Judging (assuming Health Home is DHR)
- Lack of trust
- Provider remembering to make referral
- Time consuming
- Confusion regarding Medicaid coding

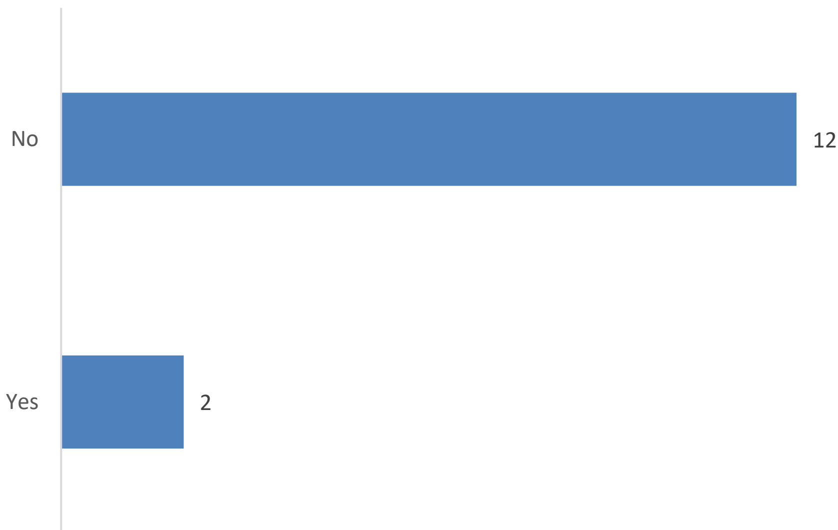
Q. Please share a story about a patient's success with a referral to a Health Home.

- Continued asthma control with the assistance of the Health Home
- Provide allergen air filters, vacuum cleaner, mattress, and pillow case covers
- Ability to identify transportation
- Identification of triggers (smoking and pets) and misuse of inhalers
- Helping guardians (grandparents) understand daily regime of medications for two children
- Better understanding of child's condition; better equipped with knowledge to handle condition
- Fewer patient visits
- Health home advisor helped family organize medications and color coded them to make it easier
- Stronger relationships between asthma clinic providers and families

Collaborative Format

	Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	N
We are satisfied with our experience in this learning collaborative	0	0	0	0	8	6	14
The online CME/CEU modules were effective for the core team, practice staff, and providers to learn about asthma, quality improvement, COPD, and smoking cessation	0	0	0	0	8	6	14
The email communication was at the appropriate level to keep the practice on track with the QI project	0	0	0	0	5	9	14
The monthly webinar calls were an effective format to learn from other practices and from the content experts	0	0	0	1	7	6	14
The ACHIA website (www.achia.org/breathealabama) was useful for accessing CME modules and obtaining project resources	0	0	1	0	2	11	14
The Quality Improvement Data Aggregator (QIDA) was easy to navigate and an effective way to track our practice's improvement	0	0	1	1	5	7	14
The 9-month collaborative is an appropriate length of time to implement optimal asthma care processes in our practice	0	0	1	1	8	4	14
Having Maintenance of Certification available was highly valued by our practice	0	0	0	1	3	10	14
Having CME/CEU available was highly valued by our practice	0	0	0	1	4	9	14
We plan to use this project as part of our Patient Centered Medical Home certification or re-certification process	0	0	0	3	3	8	14
After this collaborative concludes we plan to work with optional measures that have not previously been tracked (ACT with Validated Tool, Inhaled Corticosteroids Prescribed, Flu Shot Received, Asthma Patients Receive Education, Smoke Exposure Accessed, Spirometry Test Complete) to further our sustainability of quality gains in our practice	0	1	1	0	7	5	14

Q. Did your practice participate in the CQN/HAL collaborative format?



Q. Does the Breathe AL format provide advantages compared to the CQN format for your practice to improve?

CQN/HAL Collaborative Format: 12 month collaborative, 2 face-to-face learning sessions over 1 ½ days for the practice QI Core Team, Provider level data (all charts), EQIPP/RMEDE database.

Breathe AL Collaborative Format: 9 month, CME online modules for Core team and other providers, No travel for practice QI Core Team, practice level data (30 charts for baseline, 10 charts for 6 months of intervention), QIDA Database.

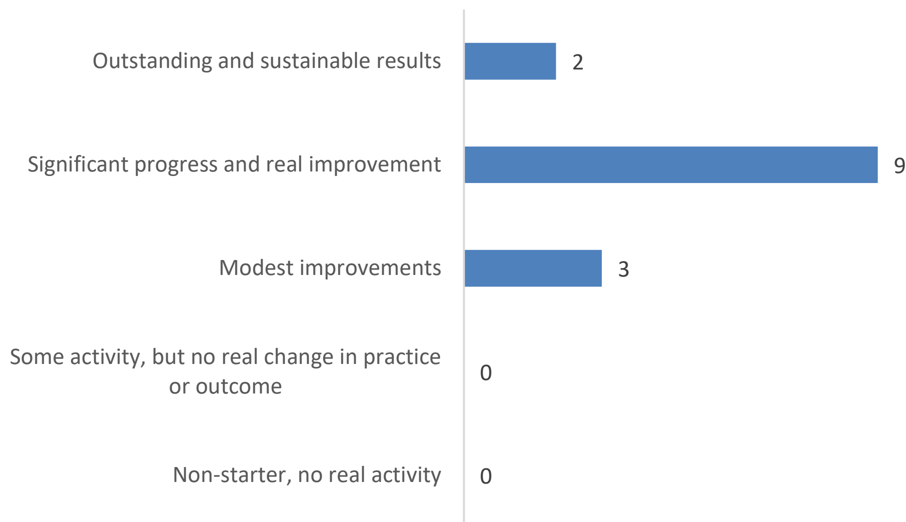
Yes (N=2)

Respondent comments regarding the most beneficial aspect of the learning collaborative
Used bell icon to identify patient which improved our asthma plan. Improved team work in office.
The most beneficial aspect was having a dedicated time to think about asthma and how to provide better care.
Improving our asthma care by examining what we were doing as opposed to what we know is recommended and making sure newer providers were meeting asthma optimal care goals. I think providers who participated in CQN knew what we were supposed to do but did not realize we were not doing it consistently and newer providers needed to learn all the layers of what to do and having an organized group activity is a great way to achieve this.
Our practice was able to identify asthma patients, streamline our asthma visits, update our Asthma Action Plans, and update any missing vaccines. This collaborative allowed us to improve in multiple areas not just asthma.
Coming together as a team to work on patient improvement. The collaborative was a great way to keep us working in sync and building a better team.
Improved our confidence in the stepwise approach to asthma management
Able to see what other practices are doing, what works better for them, learning from their experience, having specialist talk about updates in asthma, getting formulary update and option, learning community resources.
By being a part of this collaborative we realized our lack of documentation
The collaborative efforts of our entire practice to effectively serve our community.
For the practice: Working together as a team to come up with templates/innovative ideas and a work flow that was efficient For the patients: consistent management, education and counseling
Asthma Action Plan
Pushing us to take a comprehensive look at our asthma management and provide a framework for quality improvement that allowed us to update our asthma care.
Encouraging the brainstorming to come up with ways to improve and maintain the standard of care for asthma in our practice.

Respondent comments regarding the least beneficial aspect of the learning collaborative
It felt like there was a bit of a disconnect between the data we were measuring (correct documentation, correct selection of medications, etc.) and the learning points (improved compliance, medical home, etc.).
Because our patients for this collaborative were pediatric patients, the provider did not use the smoking cessation very often.
There is not one thing that could be identified as least beneficial
the guest speakers on the webinars did not always convey useful information, most likely because of the unstructured format of their portion of the webinars
Time crunch, trying to find time to attend webinar, put in data.
It was beneficial but time consuming.
A couple of the webinars got lengthy.
For us the number of team building projects at the beginning That may be specific to our group because we already spend a lot of time working together

Overall Impact

Q. Please rate the asthma improvement effort of your practice based on the Institute for Healthcare Improvement Scale. Break out 11 noted outstanding and sustainable results or significant progress and real improvements vs 3 identifying modest improvements



Q. Please describe what the practice will now do differently for asthma diagnosis and management because of participation in the collaborative by indicating the core team's level of agreement with the following statements:

	Strongly Disagree	Disagree	Agree	Strongly Agree	N
We believe our practice successfully applied our minds and hearts into this project and made significant improvements in patient outcomes in our populations	0	0	4	10	14
We believe this project influenced how the members of this practice perform	0	0	6	8	14
Our staff will use this information to train others in the future	0	0	9	5	14
Our staff has a clear vision for the future of asthma care for this practice	0	0	8	6	14

Q. Please identify any additional topics or skill areas for ACHIA to address in future learning collaboratives.

- Screening for mental health issues
- Screening for Adverse Childhood experiences
- Preventing child abuse
- Decrease of future opioid abuse in pediatrics
- Weight management/Obesity management
- Managing anxiety
- Depression at Primary Care office setting
- Dental care
- Compliance with optional vaccines: HPV, Flu screening for depression/anxiety

Summaries of Key Informant Interviews

LaCrecia Thomas: RN, MSN, CPNP-AC/PC CF Coordinator and Nurse Practitioner, UAB/COA Cystic Fibrosis Center, QI Coach

What went well?

- Since many of the sites are known to ACHIA and LaCrecia, they could be responsive to clinic needs/know how they operate
- Many of the sites tested optional measures in addition to required measures (e.g., tobacco cessation – which sites had initially expressed reluctance)
    - Increase from 30% to 70% of sites asking about tobacco use in the home
- Large number of practices enrolled (which was a success based on previous involvement in three, back-to-back asthma collaboratives through AAP
- Several areas of innovation
    - One of the academic practices shared with others the idea of the "asthma sandwich" 1. Assess asthma, 2. "meat" is the asthma action plan, 3. Appropriate and intentional follow-up
    - At least two sites were implementing EMR systems during the collaborative, but used the learning collaborative as an opportunity to see how other practices successfully integrated asthma into their EMR
    - More than previous collaboratives, NPs assumed leadership or co-leadership roles in guiding the collaborative
- Providers involved more non-providers in QI work than in previous collaboratives
    - Staff members flagged charts
    - NPs took lead roles in assessing asthma
- Positive peer learning – gained from previous developmental screening collaborative
- "Once we get a practice into a collaborative, they want to come back, they're 'hooked' on testing new areas and sustaining learning"

What was different this time?

- LaCrecia provided a great number of hands-on teaching tools, printouts
- Practices had more "fun"
    - Practices decorated the Styrofoam heads they use to demonstrate best use of the asthma spacer
    - One site did a "super hero" theme

Areas for Improvement

- Confusion between expectations of ACHIA vs. AAP collaborative
    - Sites were relieved that they did not have to register all patients, but more clarity needed up front
- Looking at Zoom communication platform to create more breakout rooms so that practices can get to know each other better in smaller groups

- Possibly expand coaching presence in South Alabama through second coach to provide more proactive than reactive coaching calls

- Would like to strengthen relationships between families and practices
    - Progress beyond family “advisors” to true collaborative “partners”

Opportunities

- Lots of interest in ACHIA learning collaborative from joint AAP/NAPNAP meeting
    - More academic posters and less formal presentations of “products” of collaborative
    - Making QI “mean and gentle”
- Pediatricians and NPs have realized that not every area of the state will have a physician to serve the state – empower NPs to assume greater roles in coverage

Dr. Katrina Roberson-Trammell, MD, FAAP, Physician Lead

Strengths:

- Supervision of the collaborative by ACHIA
- Webinars and training materials
- QI coach
- Standardization of asthma education to different levels of learners (seasoned providers, NPs, PAs, residents)
- Collaborative approach to topic – inclusion of health homes, providers and provider teams, QI coach
- Self-paced trainings and access to resources

Areas for improvement.

- How do we meet the needs of the rural areas better?
    - Possibly conduct a pilot in which case manager visits less frequently (1/month)
    - Use of technology (Skype)
    - Float case manager to lesser served areas
- ACHIA did a good job of rotating assignments, but how do we engage providers in more dialogue?

Future training topics:

- ADD/ADHD
    - More structured platform for addressing growing needs
- Medically complex patients
    - Referrals
    - Care coordination

Stacy Copeland and LaTria King-Mason, My Care Alabama Health Home

How did Health Homes interact with the practices participating in this collaborative?

My Care Alabama worked with one practice that had the largest number of asthma patients and was closest to the Health Home provider. Target age 4-12, number of patients/families (6-8)

Services: With funding, My Care Alabama was able to provide bed covers, dust covers, Swiffer, mopping, pest control, and some gas cards (transportation), with a goal of mitigating asthma triggers.

What worked well?

Funding through ACHIA allowed Health Home to purchase items that they normally could not provide (see above). Patients and families, they see tend to be on low income or fixed income. While My Care Alabama can make recommendations, cannot always provide resources

Participation in collaborative promoted patient/family engagement

Collaborative allowed Health Homes and providers to build rapport and share items (e.g., laminated asthma action form" – which providers could share with all of their patients "spill-over effect" to non-ACHIA patients

Participation in collaborative cleared barriers to access in the schools

Timeframe for collaborative was good: it aligned with beginning of school and cold and flu season

Areas for improvement.

9 month timeframe was "just right"

Opportunities.

My Care Alabama would like to repeat the collaborative and possible work with more than one provider

Future collaborative topics:

Reducing ED visits (among teens)
Childhood obesity (classes, strategic approach)

Felicia Pike, Region B Health Home

How did Health Homes interact with the practices participating in this collaborative?

Alabama Care Plan had embedded care coordinators in three metro practices (Greenvale, Metro, and Western) and received referrals from two rural clinics (Ft. Payne and Purohit)

Rural clinics far less engaged than metro clinics – embedded care coordinators made a big difference in terms of patient engagement

What worked well?

Collaborative helped Health Home streamline asthma education process and provide materials consistently to patients

Collaborative reinforced the team approach of provider, care coordinator, and patient working together towards the same goals.

Helped clarify roles, and with care coordinators – receive “warm handoff” from physician

Collaborative helped Health Home focus on overall management of care including engagement of environmental triggers

Collaborative was well-organized; consistent monthly meetings with Health Homes was a program strength

Areas for improvement.

More staff preparation for the collaborative. The Health Home used online education, but an in-person/process evaluation would be helpful

It may be worthwhile to have a midpoint check-in/refresher to maintain engagement. Towards the 9 month mark, Health Homes received significantly fewer referrals

Timelines did not seem to match up. Practices were engaged for 9 months but the last 2-3 months the referrals slowed significantly

Opportunities.

Recommendations for future collaborative topics:

Obesity/BMI
Overweight – preventative collaborative for children at risk for obesity

- May involve more partnerships with local community agencies such as YMCA, Boys/Girls Club, nutritional programs