Pediatric Learning Network:
Adopting PFE Strategies to Improve Pediatric Asthma Care

Lesson 3:
Engaging the patient/family in asthma care visits (Part 2)

PCPCC Support and Alignment Network
Quality Improvement Leader:
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PCPCC SAN Facilitator
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Learning Network Goal

Goal: Reduce hospital admissions for asthma by improving quality of care, emphasizing person and family engagement (PFE) strategies.

Today:
• Discuss the goal of the learning network
• Highlight innovative pediatric practice/organization using PFE
• Offer concrete examples demonstrating adoption of the ‘shared decision making’ metric
• Share resources to help support testing shared decision-making strategies to engage patients/caregivers in asthma management
Learning Network Plan

1. May: Patient and Family Voices
2. June: Engaging the Patient and Family at the Point of Care (Part 1 - shared decision-making, patient activation, health literacy, and collaborative medication management)
3. Today: Engaging the Patient and Family at the Point of Care (Part 2 - shared decision-making)
4. Engaging the Patient and Family at the Point of Care (Part 3 – e-tools) - August 15, 2017 3:30 ET / 12:30 PT
5. Connecting patients/families with appropriate supports and services - Sept 19, 2017 3:30 ET / 12:30 PT

Plus! Action steps between each call
TCPI Person and Family Engagement Performance Metrics

- **PFE Metric 1: Support for Patient and Family Voices**
- **PFE Metric 2: Shared Decision-Making**: Does the practice support shared decision-making by training and ensuring that clinical teams integrate patient-identified goals, preferences, and concerns into the treatment plan (e.g. those based on the individual’s culture, language, spiritual, social determinants, etc.)?
- **PFE Metric 3: Patient Activation**: Does the practice utilize a tool to assess and measure patient activation?
- **PFE Metric 4: Active e-Tool**
- **PFE Metric 5: Health Literacy Survey**: Is a health literacy patient survey being used by the practice (e.g., CAHPS Health Literacy Item Set)?
- **PFE Metric 6: Medication Management**: Does the clinical team work with the patient and family to support their patient/caregiver management of medications?
QI Opportunities Connected to TCPI PFE Metrics

NHLBI Asthma Care Quick Reference: Diagnosing and Managing Asthma
Initial visit algorithm showing patient and family engagement opportunities

- **Initial Visit Algorithm**
  - Diagnose asthma
  - Assess asthma severity
  - Initiate medication and demonstrate use
  - Develop written asthma action plan
  - Schedule follow-up appointment

- **A patient and family advisory group** can help your practice be more welcoming to patients and families, improving word of mouth and patient experience survey scores — more patients and better retention

- **Health literacy assessment** — what is the right type of information (written, verbal, video and right level) that will be meaningful?
- **Assess patient and family activation** — what is the patient’s knowledge, skills, ability, and willingness to take action on asthma self-management? Use readiness information for goal setting, teaching and care planning
- **Your medication management teaching plan** will be based on patient activation and their knowledge and skills in self-management. Use teach-back and demonstration to ensure patient and family understands medication use

- **Shared decision-making** — identify patient and family goals for asthma management (fewer missed days at school, staying out of the ED, etc.), and their preferences for treatment plan options, and incorporate them into the plan

- **Use the patient portal for scheduling, answering patient questions, pushing out reminders** — to maintain a relationship with the patient and family and keep them engaged in care
Defining Patient and Family Engagement

An innovative approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families

Engaging patients and families
- In their own care
- In practice improvement
- In policy (practice, hospital, community)
Pediatric Practice Innovator

Lucy Morizio, DPM
Children’s Hospital of Orange County (CHOC)
Manager, Population Health Quality
Southwest Pediatric PTN
Orange, CA
Southwest Pediatric Practice Transformation Network
Appropriate ED Utilization for Asthma

- Claims data source
- All 234 practices
- Total PTN capitated population of 230,000 children
- 18,613 children with asthma
- 46% year over year reduction in ED use

- Full population projection:
  - 120,000 children impacted
  - $1.0 million potential savings

Asthma Related ED Utilization Rates

- 2015 Q1: 3.80%
- 2016 Q1: 2.10%

→ ED Visit Rate/Qtr
Aim

To Decrease Asthma ED Visits

Primary Drivers

- Practice use of the Asthma Clinical Care Guidelines
- Practice use of the Asthma Action Plans
- Patient Education
- Risk Stratification

Secondary Drivers

- Provide the practice with research based clinical Practice guidelines.
- Categorize the patients based on asthma control.
- Categorize patients based on Asthma Severity
- Provide the practice with Asthma Plans
- Practice Use of the Asthma registries
- Patient Care Guidelines
- Patient Asthma Care/Educational Classes
- Patient Engagement before during and after the visit.
- Referral to a specialist (Breathmobile)
- Review the patient specific asthma ED utilization lists
Action Item for Learning Network Participants

Review Teach-Back Method tool and...

Plan/Test using Teach-Back with the next patient with an asthma diagnosis and his/her parent or caregiver

HOW DID IT GO??
What is Shared Decision-Making?

- Shared decision-making occurs when a health care provider and a patient work together to make a health care decision that is best for the patient.
- The optimal decision takes into account evidence-based information about available options, the provider’s knowledge and experience, and the patient’s values and preferences.

Source: The SHARE Approach, developed by the Agency for Healthcare Research and Quality (AHRQ)
The SHARE Approach: A Model for Shared Decision Making

The SHARE Approach is a five-step process for shared decision making that includes exploring and comparing the benefits, harms, and risks of each option through meaningful dialogue about what matters most to the patient.

**STEP 1**
Seek your patient’s participation.

**STEP 2**
Help your patient explore & compare treatment options.

**STEP 3**
Assess your patient’s values and preferences.

**STEP 4**
Reach a decision with your patient.

**STEP 5**
Evaluate your patient’s decision.

Shared Decision-Making in Clinical Care of Children

Factors to consider when attempting shared decision-making with children
(Dixon-Woods, Young, & Heney, 1999)

1. Competence of children at different ages and abilities
2. A family oriented perspective as not to undermine the parent-child relationship.
3. Motivation of child to make decisions for his/her health management
4. Parental attitudes and beliefs about child’s involvement in health care decisions

Goal: To change dyadic interactions between provider and parent into triadic interactions that include provider, parent and child to improve the child’s asthma management.

• May enhance their self-confidence, as well as improve self-management skills

• Requires assessing the child’s competence at different ages and abilities

• Use of specific communication techniques (visual aids, turn-taking, clarifying communication and role modeling)

• Offer strategies to parents on how to provide general information about asthma and treatments, based on child’s questions and interest

A reminder about communicating with patients...

- Acknowledge the complexity of the patient’s medical condition.
- Speak slowly and avoid using medical jargon.
- Listen actively and provide information in small segments.
- Pause to allow patient participation.
- Periodically check with your patient for understanding.
- Use the teach-back technique to assess comprehension of key points.
- Use decision aids and other resources to help comprehension.
- Offer interpreter services for people with language or hearing barriers.
- Invite family members and caregivers to participate when appropriate.

Source: The SHARE Approach. Essential Steps of Shared Decision Making
Care Plan Goals

- Understand where patients are in managing their health
- Understand patients’ priorities for their health (what matters to you?)
- Create shared goals
- Develop an action plan WITH the patient
- Customize care interventions
- Identify and address strength and challenges
- Build skills needed to reach the goal
- Leverage team-based care model

All teams work from the same care plan, for care coordination, shared goals, and communication between teams. Plan is printed and given to patient.

Living a Happy, Healthy Life

My Goals... My Plan

**My Goals:**
1. 
2. 

**My Strengths:** (For example: kind, helpful, hard-working)

**Challenges:** Things that could get in the way of me reaching my goals (for example: decreased energy, lack of family support, money)

**My Team / Supports:** Who can help me reach my goals?
(For example: my doctor, family, friends, therapist)

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Which of these things may help me feel better?

- Healthy Eating
- Exercise Plan
- Email My Team
- Stress Reduction Group
- Medicine / Pill Box
- Talking
- Journaling
- Other

1. Choose ONE of the things below to work on. Set simple goals and take small steps.

- Make time for activities I enjoy
- Reach out to people who can help me
- Do something kind for someone else each day
- Eat Healthier
- Exercise
- Other

2. Choose your confidence level:
How sure are you that you can stick to your plan? (If less than 7, consider changing plan)

- 10 VERY SURE
- 7 SURE
- 6 SOMEWHAT SURE
- 0 NOT SURE AT ALL

3. Fill in the details of your activity:
   What: ____________________________
   How Much: _______________________
   When: ___________________________
   Where: __________________________
   With whom: ______________________
   Start Date: ______________________
   Follow-Up Date: __________________
   Best Way to Follow-Up: ___________
Care Plan, meet EMR

1. My goals to improve my health: ***
2. My healthcare team’s goals: ***
3. My strengths and supports to meet my goals: ***
4. Challenges to meeting my goals: dropdown.
   Need more support
   Housing problems
   Transportation problems
   Insurance problems
   Healthcare providers don’t speak my language
   Legal problems
   Financial problems
   Other
5. My healthcare team: ***
   keep my appointments
   if I feel worse, I will ***
   take my medicines every day
   Keep track of progress using ***
   Other
1. My confidence that I can follow my Action Plan: 1-10

Asthma Action Plan

Go (Green)

You have all of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

Peak flow from ___ to ___

CAUTION (Yellow)

You have any of these:
- First sign of cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

Peak flow from ___ to ___

DANGER (Red)

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Lips blue
- Fingernails blue
- Trouble walking and talking

Peak flow from ___ to ___

Use these medicines every day

<table>
<thead>
<tr>
<th>MEDICINE/DOSEAGE</th>
<th>HOW MUCH TO TAKE</th>
<th>WHEN TO TAKE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 40</td>
<td>2 Puffs</td>
<td>Morning and Night</td>
</tr>
</tbody>
</table>

COMMENTS: Don’t forget to use your spacer!

For asthma with exercise, take:
- Albuterol 2 Puffs 30 minutes before exercise

Continue with green zone medicine and ADR:

<table>
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<th>WHEN TO TAKE</th>
</tr>
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</tr>
<tr>
<td>Albuterol</td>
<td>2 Puffs</td>
<td>Every 4-6 hours as needed</td>
</tr>
</tbody>
</table>

COMMENTS:

IF QUICK RELIEVER/YELLOW ZONE MEDICINE IS NEEDED MORE THAN 2-3 TIMES A WEEK THEN CALL YOUR DOCTOR.

Take these medicines and call your doctor

<table>
<thead>
<tr>
<th>MEDICINE/DOSEAGE</th>
<th>HOW MUCH TO TAKE</th>
<th>WHEN TO TAKE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orapred</td>
<td>2 tsp</td>
<td>Morning and Night for five days only</td>
</tr>
<tr>
<td>Albuterol</td>
<td>2 Puffs</td>
<td>Every 3-4 hours as needed</td>
</tr>
</tbody>
</table>

COMMENTS: Use Orapred only if ok by office.

Get help from a doctor now! It’s important!

Asthma is a potentially life-threatening illness. If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT. Make an appointment with your primary care provider within two days of an ER visit or hospitalization.

This student is capable and has been instructed in the proper method of self-administering the medications named above (or attached prescription).

This student is not approved to self-medicate.

Check asthma severity: [ ] Mild Intermittent [ ] Mild Persistent [ ] Moderate Persistent [ ] Severe Persistent

PHYSICIAN SIGNATURE

PHYSICIAN STAMP

Produced by the Iowa Department of Public Health
Adapted from the NYC Children's Asthma Initiative
Adapted from MURH

Funding provided through a cooperative agreement with the Centers for Disease Control and Prevention

October 2010
Asthma Treatment Plan – Student

This asthma action plan meets NJ Law (N.J.S.A. 18A:40-12.8) (Physician’s Orders)

(Name) (Print)

Date of Birth

Effective Date

Doctor

Parent/Guardian (if applicable)

Emergency Contact

Phone

Phone

Phone

HEALTHY (Green Zone)

Take daily control medicine(s). Some inhalers may be more effective with a “spacer” – use if directed.

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advair HFA</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Aerohaler</td>
<td>1 puffs twice a day</td>
</tr>
<tr>
<td>Flovent</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Symbicort</td>
<td>1 puffs twice a day</td>
</tr>
<tr>
<td>Advair Diskus</td>
<td>1 inhalation every 12 hours</td>
</tr>
<tr>
<td>Flovent Diskus</td>
<td>1 inhalation every 12 hours</td>
</tr>
<tr>
<td>Pulmicort Floxter</td>
<td>1 inhalation every 12 hours</td>
</tr>
<tr>
<td>Singulair</td>
<td>1 tablet daily</td>
</tr>
</tbody>
</table>

And/or Peak flow below ___

If exercise triggers your asthma, take ___ puffs ___ minutes before exercise.

Remember to rinse your mouth after taking inhaled medicine.

CAUTION (Yellow Zone)

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from ___

Continue daily control medicine(s) and ADD quick-relief medicine(s).

<table>
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<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
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<tbody>
<tr>
<td>Albuterol MDI</td>
<td>2 puffs every 4 hours as needed</td>
</tr>
<tr>
<td>Xopenex</td>
<td>4 puffs every 20 minutes</td>
</tr>
<tr>
<td>Duanastar</td>
<td>1 puffs every 4 hours as needed</td>
</tr>
<tr>
<td>Combivent Respihal</td>
<td>1 inhalation every 12 hours</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.

EMERGENCY (Red Zone)

Your asthma is getting worse fast:

And/or Peak flow below ___

Take these medicines NOW and CALL 911. Asthma can be a life-threatening illness. Do not wait!

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<tr>
<td>Xopenex</td>
<td>4 puffs every 20 minutes</td>
</tr>
<tr>
<td>Duanastar</td>
<td>1 unit nebulized every 30 minutes</td>
</tr>
<tr>
<td>Combivent Respihal</td>
<td>1 inhalation every 4 times a day</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

Permission to Self-administer Medications:

☐ This student is capable and has been instructed in the proper method of self-administration of the non-nebulized inhaled medications named above in accordance with NJ Law.

☐ This student is still approved to self-medicate.

PHYSICIAN/PAPA SIGNATURE

PHYSICIAN’S ORDERS

PARENT/GUARDIAN SIGNATURE

PHYSICIAN STAMP

DATE

Print Medicines Only

Make a copy for parent and for physician file, send original to school nurse or child care provider.
Asthma Support

Review medication device use with patients/families
Action Item for Learning Network Participants

Plan/Test the creation/update of an asthma action plan, by using shared decision-making tools/techniques, with the next school-aged patient with an asthma diagnosis and caregiver that you see in your practice.
Using QI Methodology (Model for Improvement) to test changes

- 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?

From: Associates in Process Improvement
Remember...
It Takes an Effective Team to Do QI Work!

- Members representing different kinds of expertise in the practice/organization
  - Clinical Leader
  - Technical Expertise
  - Day-to-Day Leadership
  - Administrative Staff
  - Parent/Caregiver Partner(s)
  - Practice Facilitator/QI Coach
Please share Action Steps Taken:

• Engaging Patients/Families in Conversation Related to Their/Child’s Care (e.g., Pre-visit contact/forms, Family Strengths, Asthma Control Test (ACT)
• Planning/Testing an Asthma Support Group
• Creation/maintenance of a Asthma Registry
• Assessment of Patient/Caregiver Activation
• Assessment of Health Literacy
• Use of Teach Back Method
• Additional PFE-related successes during the previous month(s)?
• Issues/challenges?
• Surprises or something important that you and your practice teams learned about PFE?
Reminders

• **Assignment:** Plan/Test the creation/update of an asthma action plan, by using shared decision-making tools/techniques, with the next school-aged patient with an asthma diagnosis and caregiver that you see in your practice.

• Engaging the Patient and Family at the Point of Care (*Part 3 – e-tools*) – **August 15, 2017 3:30 ET / 12:30 PT**

Contact information:
Ruth Gubernick
856-477-2177
gubernrs@hln.com
Technical Support Available from PCPPC SAN and Partners

PCPCC SAN website and PFE Resource Center

https://www.pcpcc.org/tcpi

Pediatric Asthma and PFE

https://www.pcpcc.org/tcpi/learning

Contact

• Liza Greenberg, Program Director
  liza@pcpcc.net