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

Lesson 5:
Connecting patients/families with appropriate supports and services

PCPCC Support and Alignment Network
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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 an innovative collaboration testing/using PFE strategies
• Identify partners in your community who can help engage patients with asthma and their families in care management
• Discuss strategies to communicate/coordinate with family supports and services in your community to help engage patients with asthma and their families
• Wrap up and review of several strategies and resources related to achieving PFE metrics shared during previous PLN webinars
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. July: Engaging the Patient and Family at the Point of Care (Part 2 - shared decision-making)
4. August: Engaging the Patient and Family at the Point of Care (Part 3 – e-tools)
5. Today: Connecting patients/families with appropriate supports and services

Plus! Action steps between each call
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: Does the practice use an e-tool (patient portal or other E-Connectivity technology) that is accessible to both patients and clinicians and that shares information such as test results, medication list, vitals and other information and patient record data?

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

1. Diagnose asthma
2. Assess asthma severity
3. Initiate medication and demonstrate use
4. Develop written asthma action plan
5. 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 understand 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)
Norah Bertschy, APRN, MSN, PPCNP-BC
Nurse Practitioner
Cincinnati Health Department
Cincinnati, OH
Vision

City of Cincinnati to become the healthiest city in the nation.

Mission

To achieve health equity & improve the health and wellness of all who live, work and play in Cincinnati.
Interprofessional Collaborative Practice Team
- NPs
- RNs
- MAs
- Case Work Associates
- Pharmacist
- Health Educators
Asthma CHAMPIONS!!!!

- How Asthma Friendly Is Your School?
- Teacher/coach asthma education
- School Staff education
- Building air quality
Polling Question...
Who do you currently **partner** with in your community, to help connect and engage your patients with asthma and their families with support and services? (Choose all that apply)

- Specialists who are co-managing my patients with asthma and their families
- Emergency Department(s)
- Schools
- Local public health department(s)
- Community-based organizations
- None of the above, as of yet
Coordinated Care
Partnerships and Collaboration

Medical Neighborhood
Specialists
Emergency Departments
Inpatient service
Schools
Community organizations

It takes a Village …………..

Source: Adapted with permission from Faye Holder-Niles, MD, MPH, “Medical Home Neighborhood : A Primer for Primary Care and Subspeciality Pediatrics.” Presented at the American Academy of Pediatrics Medical Home Chapter Champions Program on Asthma, Allergy and Anaphylaxis Learning Session, Elk Grove Village, IL, January 29-30, 2016
Medical Home Coordination

How can we facilitate increased partnership and communication across the medical neighborhood...

How do we facilitate seamless and timely transitions of care...
Co-Management: Specialists

Enhanced communications
- Reasons for referral (PCP)
- Treatment plans (Specialist)
- Sharing information in timely way

Specialists lunch talks
- Meet the specialist
- Evidence-based guidelines
- Medical management support

Closing loops
- Facilitating seamless transition of care
- Patient experiences and perception of the care continuum

qsen-interdisciplinaryteams.wikispaces.com
Medical Neighborhood
Building Bridges— ED

Enhanced communications
- Identify Care Manager/ Point of contact
- Treatment plan (patient care plan card)
- Changes to plan

Coordinated care
- Patient f/u post ED/Hospital
  - Symptoms check
  - Have medications
  - Review treatment plan
  - In office follow-up

Closing loops- care management
School Partnerships

• Families rely on schools to keep kids safe
• Families rely on medical providers to provide the needed information to schools to keep kids safe
• Safe and effective management require prompt symptom recognition, trained personnel and access to medication
• Strong collaborative partnerships are key
School Partnerships Require:

- Open communications
  - Schools, family, physician office
- Shared goals
- Shared responsibility
- Opportunities for ongoing family participation in decision making and care plans
Community Partnerships

- Food Insecurity
  - WIC, Farmers market, food banks
- Housing
  - Inspectional services
  - Pest management
- Utility assistance programs
  - Local utility companies, heating and fuel assistance
- Parent partners
- Community Health Workers
- Public Health Department
Strategies For Good Partnership
Talk among yourselves...

• What current communication pathways have been developed in the practice to improve asthma management?
  • What opportunities for partnership with...

• Think of your current practice...
  • Is there 1 partnership or process that is working well?
  • Is there 1 partnership/process you would like to improve or make?
Circling back around and wrapping up...
How Could We Implement a Patient Registry?

- Identify a care coordinator as your Registry “Champion”
- Meet as a practice team
  - Flow charting/process mapping of current care coordination functions
- Define your registry population (asthma diagnosis)
  - MD recall
  - Diagnosis codes
    - Identify initial data fields
    - Identify available technology (e.g., Excel, Access or other software application; as a function within your EHR)
  - Use PDSA cycles to test “small” changes
Engaging Patients/Families in Conversation Related to Their/Child’s Care

- Pre-visit contact/forms (AAP Bright Futures)
- Family Strengths
- Asthma Control Test (ACT)
Engaging and Partnering with Parents/Caregivers

- In Their Child’s Care
- On Your Practice QI
- On Your PFAC
Teach-Back Strategy

- Evidence-based Health Literacy Intervention
- Communication approach for shared decision-making
- Ask your patients/parents to “Teach it Back”

What is teach-back?
Teach-back IS a way for you to make sure your patients understand what you tell them.

Teach-back IS NOT a test or a quiz for patients.

How do I use teach-back?
Just ask patients to explain what you have told them using their own words. For example, if you explain what they need to do to prepare for a procedure, ask them if they can teach back to you how they are going to prepare.

Why should I use teach-back?
As part of the care team, you have an important safety role in making sure your patients understand all the information they are given during their visit.

Did you know that patients forget up to 50% of what you tell them after a visit? If they do remember, only half of what they remember is correct?

When should I use teach-back?
Use teach-back whenever explaining important concepts to patients regarding their health care, including:
- Medicines
- Home care instructions
- Use of a new device
- Next steps in their care
- Anything else that is important for them to understand.

Health Literacy: Confirm Patient/ Family Understanding

• Ensuring agreement and understanding about the care plan is essential to achieving adherence. Examples:
  
  • “Tell me what you’ve understood.”
  • “I want to make sure I explained your medicine clearly. Can you tell/show me how you/your child will take this asthma medicine?”

• Schillinger, D. Archives of Internal Med, 2003
Patient Activation

MY HEALTH CONFIDENCE
What number best describes your:

Health confidence
How confident are you that you can control and manage most of your health problems?

Health information
How understandable and useful is the information your doctors or nurses have given you about your health problems or concerns?

If your rating is less than “7,” what would it take to increase your score?

Medication Management Strategy

• Develop a complete & accurate medication list
  ▶ Patients and family members bring all their medications – OTC and prescriptions

• Complete medication reconciliation using the accurate medication list
  ▶ Identify & correct safety issues

Asthma Support

Review medication device use with patients/families
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.

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

Personal Best Peak Flow

Peak flow from ___ to ___

Use these medicines every day

<table>
<thead>
<tr>
<th>MEDICINE/DOSAGE</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 ABD:

<table>
<thead>
<tr>
<th>MEDICINE/DOSAGE</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>

Albuterol: 2 Puffs every 4-6 hours as needed

COMMENTS:

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 ___

Emergency Medicine/Dosage

<table>
<thead>
<tr>
<th>MEDICINE/DOSAGE</th>
<th>HOW MUCH TO TAKE</th>
<th>WHEN TO TAKE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orapect</td>
<td>2 tsp</td>
<td>Morning and Night</td>
</tr>
<tr>
<td>Albuterol</td>
<td>2 Puffs</td>
<td>Every 3-4 hours as needed</td>
</tr>
</tbody>
</table>

COMMENTS: Use Orapect only if it’s 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.

Pay Attention to Symptoms:

- Check all items that trigger your asthma and things that could make your asthma worse:
  - Chalk Dust
  - Cigarette smoke & Second hand smoke
  - Cold/Flu
  - Dust mite, dust, mould, animals, carpet
  - Exercise
  - Mold
  - Oven alert days
  - Pets - rodent, cockroaches, cats, dogs
  - Plants - animal dander
  - Pollen, flowers, cat grass, pollen
  - Strong odors, perfumes, cleaning products, scented products
  - Sudden temperature change
  - Weed smoke
  - Foods:
  - Other:

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 Department of Health
Adapted from NHLBI

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Printed 2003

White - School/Child Care Copy
Pink - Family Copy
Yellow - Doctor Copy
Use of e-Tools (Patient Portals)

Patient Portal

Pediatrics provides personal access to your family’s medical records through our Patient Portal. You can access information such as Immunization records, visit summaries, lab results and dates for upcoming appointments.

Click here to learn how to use and navigate the portal with our User Guide!

Sign up is quick and easy by clicking on the link below to send an email with your name, DOB and email address, your children's name(s) and date(s) of birth.

Click here to sign up for the Patient Portal now or directly email wpportal@wpediatrics.com with the subject heading "I want to sign up for the Patient Portal"

If you are already enrolled in the Patient Portal, click here to log in.

Join Our Email List

Click here to sign up to receive important news and updates about the practice!
Use of e-Tools (Patient Portals)

Click here to access the Pediatrics P.C.'s Patient Portal

As always, for urgent medical matters, please contact us.

If your child is experiencing a medical emergency, please call 911 or go to the nearest emergency room. Requests made through the patient portal may take up to 48 hours to be processed.

The Patient Portal gives us a secure and efficient method of providing you with answers and access to your child's personal health information. Our providers and staff will be able to easily access, organize and respond to patient questions and feedback.

Best of all, you will be able to resolve issues online - improving the efficiency of our staff in the office. Of course, the Patient Portal is available to you 24 hours a day, 7 days a week, 365 days per year.

Click here for a short video about the features and benefits of our patient portal.

- NEW! Check-in or your appointment from home using our self check-in feature
- Exchange Secure and Compliant Messages with your physician or nurse practitioner, as well as the office staff
- View Past and Future Appointments
- Request New Appointments
- View and Update Personal Demographics
- View and Print Patient Forms
- Request insurance referrals
- View your patient Statements and make secure on-line payments
- Receive Lab Results
- Request Prescription Refills

We encourage you to sign up for the portal and use it often. We welcome your feedback about the Patient Portal.
Use of e-Tools (Patient Portals)

Patient Benefits:

- Contact the Office With Questions
- Request Appointment Cancellations
- Request Medication Refills
- View Statements and Pay Bills Online
- Receive Office Visit Summaries
- Review Lab and Test Results
- View Vaccine Records
- Print Medical Forms
- Obtain Educational Information
- Update Your Profile and Contact Info
- And More!

Registration is Simple:

All we need from you is a personal email address that you check regularly. Pediatric Care Group will then supply you with a temporary password and instructions.

You can access the Patient Portal Here so you can login from your home, office, or anywhere else you choose.

*Use of the Pediatric Care Group Patient Portal is Limited to*

*Non-Urgent Communications and Requests*

*For Urgent Matters, Please Call Our Office at*
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?

AIMS

MEASURES

IDEAS

Act

Plan

Study

Do

From: Associates in Process Improvement
Planning Tests of Change to Reduce Asthma-related ED Utilization

Determine current asthma-related ED Utilization Rate
Measure it, graphically display it and share it on a monthly basis!

Examples of planned tests of change (the “P” of a PDSA)

- Adding sick visit slots on Mondays and Fridays
- Having more practitioners available to see patients on Friday afternoons
- One practitioner who is “on call” each day to stay and make sure all walk-ins are seen
- Initiating or expanding evening and weekend hours for your practice
- Surveying a sample of patients in your practice to determine their satisfaction with your practice’s ability answer questions after hours (e.g., nurse triage)
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
Tips for Sustaining Gains:

• Keep leaders informed
• Systems must be independent of the people involved
• Constantly adapt and create new tools
• Continuously monitor results
• Celebrate successes with staff
• Communicate improvements with patients
• Use data as evidence that change is improvement!
Polling Question...
As a result of your participation in this Pediatric Learning Network, how confident do you feel about being able to keep your patients with asthma out of the ED?

- Very confident
- Somewhat confident
- No change
- Less confident
- Not at all confident
Please share Action Steps Taken:

• Engaging Patients/Families in Conversation Related to Their/Child’s Care
• 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
• Use of e-Tools (patient portals)
• Partnering with your community
Thank you for your hard work to transform and improve person and family engagement for children with asthma and their families!

Contact information:
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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

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