Advancing Asthma Care: A PHN Initiative

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Program Slides

Pediatric Health Network

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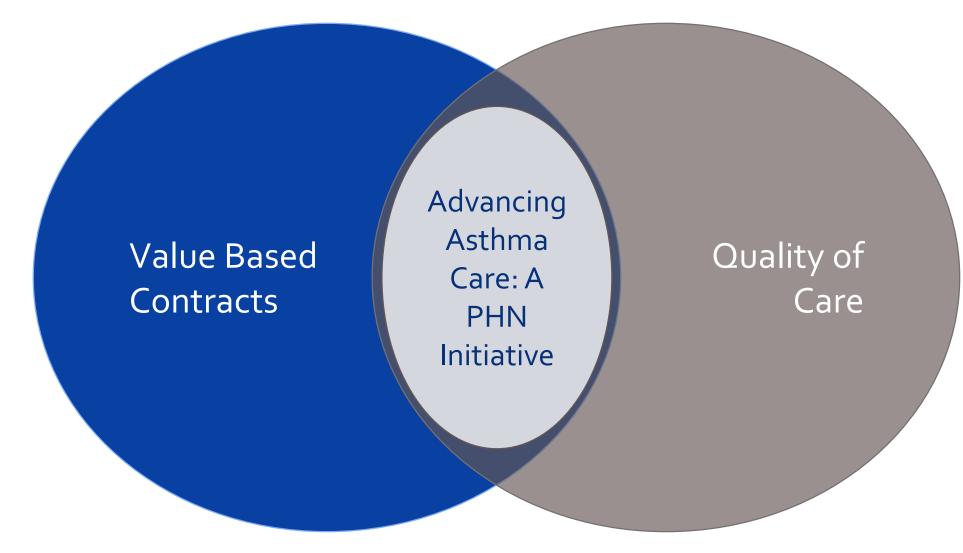
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#### **Global AIM**

Identify and optimally manage your population of patients with persistent asthma



### **Program Model**



# Objectives



Identify patients with asthma and stratify the population to identify those patients who may need more help managing their condition



Develop targeted education and interventions to help all patients achieve better health outcomes



Measure the impact of interventions using quality improvement methodology



Achieve improvement on asthma control measures

### This is a practice team initiative:

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Engage practice data champions to learn to retrieve data and report to practice team



Educate whole practice team on advancing care and promoting optimal health outcomes with educational sessions and focused, practice-specific quality improvement



Provide MOC Part 2, Part 4, and CME credit for providers

# Required Practice Participation

**Clinical integration**, by definition, requires all members to participate in data sharing and clinical quality improvement.

Practices must actively participate and engage in the initiative by:

- 1. Having practice members attend live or review recording of at least 75% of the educational sessions
- 2. Identifying a data champion
- 3. Having data champions attend live or review recording of at least 75% of the data champion meetings
- 4. Submitting all requested data elements

### MOC Part 2 Requirements

MOC Part 2 Credits will be awarded through Inova ICMES system. To gain MOC Part 2 credits:

- Complete pre-test for the educational session on the Inova ICMES site
- Attend the educational session live or watch the recording on the Inova ICMES site
- Complete post-test for the educational session on the Inova ICMES site

<u>Click Here</u> for information on how to complete the MOC Part 2 pre and post test.

### MOC Part 4 Requirements

| REQUIREMENT               | INDIVIDUAL REQUIREMENTS                              | TEAM REQUIREMENTS                                                                   |
|---------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------|
| QI Education              | Participate in at least 1 QI Learning Session        | N/A                                                                                 |
| Educational<br>Webinars   | Participate in at least 75% of educational webinars  | N/A                                                                                 |
| Practice Team<br>Meetings | Attend at least 50% of scheduled practice meetings   | Representative submits at least 80% of team meeting reports in Glasscubes           |
| Project Data              | Discuss and review data with team                    | Data champion submits all required data reports                                     |
| Metrics                   | N/A                                                  | Selected practice measures including consistent<br>use of Asthma Control Test (ACT) |
| Data Champion<br>Meetings | N/A                                                  | Attend at least 75% of scheduled data champion meetings                             |
| PDSA cycles               | Design, implement and review practice<br>PDSA cycles | Practice submits 3 PDSA cycle reports                                               |

### Quality Improvement Training – MOC Part 4

Complete your QI101 training today!

Log into Glasscubes:

- 1. Review the QI101 PowerPoint located in the "Files" section
- 2. Complete the QI 101 tracker form located in the "Forms" section.



## Advancing Asthma Care: A PHN Initiative

### **Phased Approach**

**Phase 1:** Improving Your Practice's Capacity to Identify and Manage Your Persistent Asthma Patient Population

• January 2021 – March 2021

**Phase 2:** Implementing Care Management and Addressing Social & Environmental Factors in Asthma Care

• April 2021 – June 2021

Phase 3: Measuring Asthma ControlJuly 2021 – Dec 2021 and beyond

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#### Phase 1: Setting the Stage

#### **Objective:**

Identify your practice's current population of asthma patients and, within that population, those with persistent asthma

#### Actions:

- 1. Practices will identify a practice data champion
- 2. Data champions will pull practice data with support from other data champions and PHN QI team
- 3. Select project asthma measures

PHN Support and Shared Resources:

- 1. Coaching cohorts of practices as needed
- 2. Data super users will share best practices



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#### Phase 2: Social, Environment & Care Mgmt

#### **Objectives:**

- Incorporate the environmental and social factors that impact asthma health outcomes and health equity
- Identify patients who would benefit from care management

#### Actions:

- 1. Develop a practice specific approach to documenting environmental and social factors
- 2. Use race and zip code to examine your population's asthma health outcomes
- 3. Implement a practice care management plan

#### PHN Support and Shared Resources:

- 1. Formatting your EMR to capture structured data
- 2. Care Management support and care plan template design

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#### Phase 3: Measurement & Improvement

#### **Objective:**

Demonstrate asthma control using selected measures

#### Actions:

- 1. Collect and submit data on selected asthma measures
- 2. Use quality improvement methodology to demonstrate improvement of asthma control

#### PHN Support and Shared Resources:

- 1. Coaching cohorts of practices as needed
- 2. Quality improvement support
- 3. Project data assimilation and reports

### Menu of Asthma Measures

Practices are requested to select at least **2 of the 6** measures

- 1. Consistent use of Asthma Control Test (ACT) to measure control (required for MOC)
- 2. Conduct PCP Asthma check-in visit at least every 4 months for patients with persistent asthma
- 3. Develop method to track ED/hospitalizations
- 4. Develop method to track persistent asthma population
- 5. Integrate care management referral process into office workflow
- 6. Patients in care management achieve goals in care plan





- Tools will include:
  - Tips on How to Conduct a Asthma Telehealth Visit
  - Red Flags for Referral
  - Patient Education Materials (AS-ME)
  - Coding and Billing Tips
  - MDI Dosing for In Office Administration in Place of Nebulizer Treatment
  - Tips on Partnering with Schools
  - Managing Asthma During the Pandemic





### Data Champion Meetings

- Review data with PHN QI Team
- Open forum for practices to:
  - Ask data questions
  - Share best practices

Month

February 2021

**April 2021** 

June 2021

## **Didactic Webinar Topics**

\*\*All webinars are CME eligible\*\*

| Month        | Торіс                                                                                                                                                                             |  |  |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| January 2021 | <ul> <li>Latest Recommendations on Medication Management</li> <li>New NHLBI Asthma Guidelines</li> <li>Coding and Billing to Optimize Data Retrieval and Reimbursement</li> </ul> |  |  |
| March 2021   | <ul> <li>Patient Education and Asthma Telehealth Visits</li> <li>When to Refer: The Role of Pulmonologists and Allergists in Asthma<br/>Diagnosis and Management</li> </ul>       |  |  |
| May 2021     | <ul> <li>Health Disparities Data for the DMV Region</li> <li>Social and Environmental Factors Affecting Asthma Outcomes: Tips for<br/>Screening and Intervention</li> </ul>       |  |  |
| June 2021    | <ul> <li>Family Panel</li> <li>Partnering with Schools</li> <li>PHN Practice Data: Current Status of our Initiative</li> </ul>                                                    |  |  |

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## Thank you! Please email any questions/comments to <u>PHN@childrensnational.org</u>

