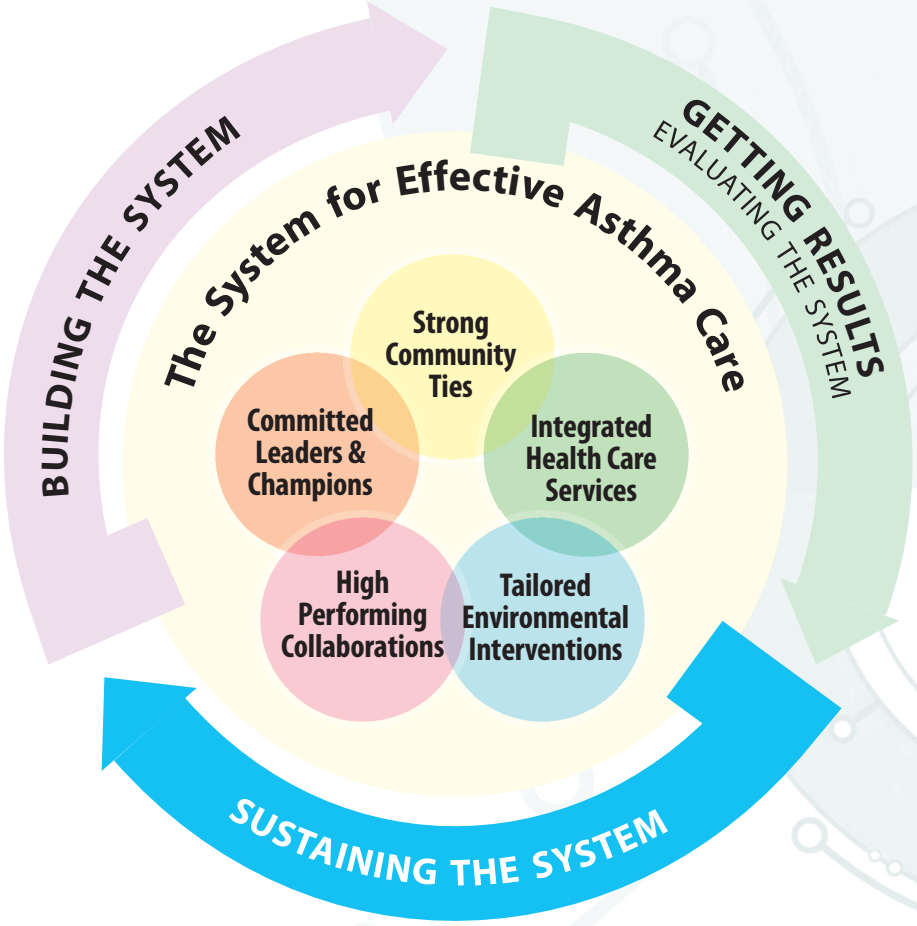
Communities in Action for Asthma-Friendly Environments

2009 National Asthma Forum

2009 CHANGE PACKAGE

The System for Delivering High Quality Asthma Care



2009 National Asthma Forum Change Package
The System for Delivering High Quality Asthma Care

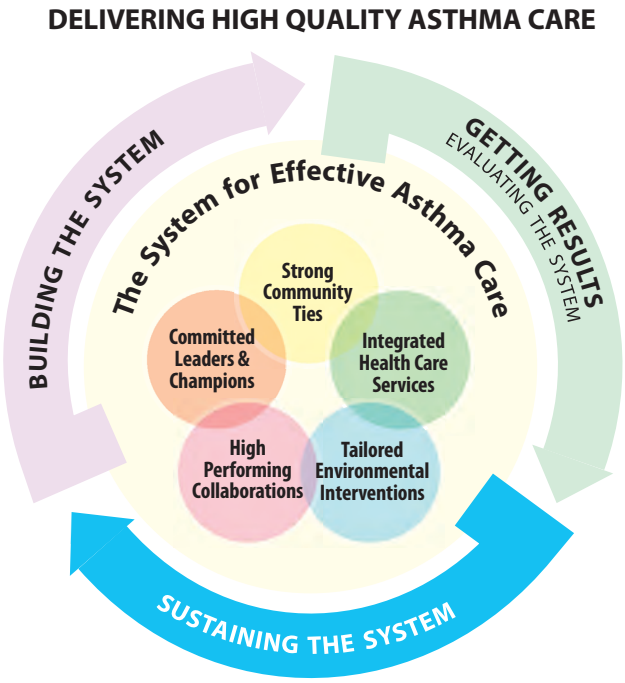
This change package is a guide for achieving breakthrough improvements in community asthma care. It provides quick access to a tremendous knowledge base on program strategies and approaches that drive improved health outcomes and program sustainability. It is built on strong evidence: the University of Michigan Asthma Health Outcomes Project (AHOP); the chronic care, program improvement, and social change literatures; in-depth analysis of highly effective asthma programs; and lessons from the more than 250 members of the *Communities in Action for Asthma-Friendly Environments* Network. Synthesis of this research base reveals a dynamic system—the *System for Delivering High Quality Asthma Care*—that drives successful asthma program design, delivery, outcomes, growth, and longevity.

Asthma Change Materials

Access a broad suite of materials and tools designed to help programs apply the *System for Delivering High Quality Asthma Care* at **www.asthmacommunitynetwork.org**, where you will find in-depth profiles of the exemplary asthma programs described here, tools for benchmarking your program, and more.

What is the *System for Delivering High Quality Asthma Care*?

The *System for Delivering High Quality Asthma Care* is a conceptual framework that identifies the core elements of successful asthma programs and the processes that drive their implementation, continuous improvement, and endurance. The *System* is flexible and any asthma program, regardless of its size, institutional home (e.g., health plan, health care provider, community program), budget, target community, or level of development, can use the *System* to guide its work. How you apply the *System* will depend on where your program is in its evolution. As programs mature, the *System* evolves with them. The applicability to your program and your understanding of different elements of the *System* is likely to change over time. Early on, you may focus on using the *System* as a guide for getting started. After several years, you may focus more on using it to make your program last.



How Can I Use the Change Package?

The table below presents the change concepts and strategies that successful asthma programs have applied to incorporate the *System for Delivering High Quality Asthma Care* into their programs. 'First Things First' and 'Making It Last' headings appear in the table to help programs at different stages of development focus in on the *System* components and strategies that may be most relevant to their situations. It is important to recognize, however, that this *System* is dynamic. Its effectiveness results from the ongoing interaction between its components. The most successful and enduring asthma programs continually pursue all of the System components, deepening, refining, and enriching these components as their programs mature. Community asthma programs that achieve breakthrough results are works in progress and most put the components of success in place over time. High-quality asthma care is a marathon and not a sprint.

This Change Package is designed to capture the current knowledge base. The *Communities in Action for Asthma-Friendly Environments* Network updates this document as real-time learning and information exchange drive the ongoing improvement of asthma care. This release is version 4.

KEY to ABBREVIATIONS:

AH! Program – MaineHealth Asthma Health Program
ANWM – Asthma Network of West Michigan
BPHC – Boston Public Health Commission's Asthma Program
CAPP – The Children's Hospital of Philadelphia's Community Asthma Prevention Program
CHA – Cambridge Health Alliance's Planned Care Program
CMFHP – Children's Mercy Family Health Partners Asthma Management Program
IMPACT DC – Improving Pediatric Asthma Care in the District of Columbia
Monroe –Monroe Plan's Improving Asthma Care for Children Program
NYCAI – The New York City Asthma Initiative
Optima – Optima Health
Priority – Priority Health Asthma Management Program
UHP – Urban Health Plan

FIRST THINGS FIRST • FIRST THINGS FIRST • FIRST THINGS FIRST

BUILDING THE SYSTEM

Strategy I – Ensure Mission-Program Alignment	Strategies In Action – Ensure Mission-Program Alignment
• **Develop a program strategy that aligns your organization's mission and priorities with your community's asthma care needs** • **Respect the boundaries that your mission entails**	• BPHC's leaders asked, "What is our core function and where do we fit in the fight against asthma?" BPHC had capacity in environmental health, home-based services, and health education and saw an unmet need their program could address: in-home environmental interventions. • IMPACT DC's mission is to serve underserved children with the most poorly controlled asthma. The program's directors know that "our strength is our presence in the community and their trust in us. We can't afford to promise anything we aren't sure we can deliver and sustain."
Strategy 2 – Build Evaluation in From the Start	**Strategies in Action — Build Evaluation in From the Start**
• **Determine your program's data needs and incorporate a process for collecting the data into the program's design** • **Do what it takes to get the data you need—train staff to collect it, partner with local hospitals or public health departments, or provide incentives, if necessary**	• CHA's program seeks to reduce the number of ER visits and hospitalizations for children with asthma. One of CHA's first steps when establishing its program was to create an information technology (IT) system to support an asthma registry and electronic medical records for patients. This infrastructure provides the mechanism CHA needs to collect the data to validate the program. • CAPP trains their home visitors to collect reliable environmental and health outcomes data using a standard assessment form. "Each home visitor needs to respond the same way to the question, 'is the home carpeted' when they see a throw rug." CAPP reviewed the forms item-by-item with their home visitors to ensure consistent answers and CAPP now uses the data to assess the home visit program's impact. • CMFHP found it difficult to get quality of life (QOL) data from patients, so they began offering $10 gift certificates to patients who returned surveys.
Strategy 3 – Let the Data Guide the Program	**Strategies in Action — Let the Data Guide the Program**
• **Use surveillance, utilization, health outcomes, or other data that describes the burden of asthma in your community to guide strategic planning, program design, and implementation** • **Continuously monitor the data to optimize program delivery**	• CMFHP used surveillance and health care data to identify their pediatric asthma population and assess the systems in place to meet its needs. They saw a large primary care provider (PCP) network, so they designed a program to turn available PCPs into high-quality asthma care providers by educating, supporting, and paying them to deliver improved care. • CHA uses its asthma registry and electronic medical records to monitor outcomes—"The IT infrastructure and constant review of evaluation data has been critical…When there's slippage, we take immediate corrective action." For more than three years in a row, CHA has held hospitalizations to 2% per year and ER visits to 6%.

Strategy 4 – Conduct Needs-Based Planning	Strategies in Action — Conduct Needs-Based Planning
• **Ask patients, providers, partners, and other stakeholders what they need and act on what you hear** • **Seek ongoing feedback from your target community to refine your program delivery**	• CMFHP convened provider focus groups to discuss what it would take to improve pediatric asthma care. The answers were training, time, support for patient education, and regular feedback on the impact of their efforts. CMFHP hired asthma educators to provide intensive training for PCPs and developed codes that providers who completed the training could use to bill for patient education. • Based on feedback from families in the low-income communities they served, the BPHC began providing resources and materials as well as in-home environmental education to make it easier for families to act on the environmental management guidance they received.
Strategy 5 – Start Small to Get Big	**Strategies in Action – Start Small to Get Big**
• **Create a process for testing out new approaches and recognize that you cannot do everything at once. Building a high-quality asthma care system is a marathon, not a sprint**	• UHP's program leaders wanted to ensure that upgrades to care led to sustained improvements. One way they do this is to pilot-test potential improvements at single sites, refining interventions hundreds of times while carefully studying the data for evidence of improved outcomes. "When we see the slope in the line that we're looking for, we launch our spread strategy…we have an approach that works and data to prove it." • Optima staff noticed that, despite pharmacological advances in asthma therapy, hospital admissions for asthma were increasing. They designed a year-long pilot study with 50 high-risk children, during which clinicians made home visits to develop self-management practices. When they compared post-study to pre-study utilization, they saw a dramatic improvement. Based on these results, Optima expanded the program to all members with asthma.
Strategy 6 – Align Incentives With Goals	**Strategies in Action – Align Incentives With Goals**
• **Use institutional levers, such as pay for performance, awards for high-performers, and provider compensation for standards-based care, to drive progress toward program goals**	• Monroe's goal is to shift asthma care from ERs and hospitals to clinical settings by improving patient-provider interactions. Monroe incentivizes patients and providers to interact regularly by providing transportation subsidies for patients and CPT codes to reimburse providers for time spent on patient education. • Priority established the Physician Incentive Program (PIP) to offer incentives to providers to ensure that members use asthma medications appropriately and to implement the Planned Care Model. The goal is to encourage evidence-based practice, so the program offers a financial incentive (per member per month) to physicians whose asthma patients meet a specified ratio of long-term controller to short-acting medication.

Strategy 7 – Focus on the Resource Strategy at Every Step	Strategies in Action – Focus on the Resource Strategy at Every Step
• **Build a strategy for resourcing and sustaining the program into your program design**	• When CAPP expanded to North Philadelphia, they first convened a group of local partners to discuss the program, and hear about local needs. They also established a long-term resource plan: in year 1, CAPP would deliver the program; in year 2, CAPP would manage a train-the-trainer program to prepare community members to take over; in year 3, CAPP would be available as a resource, if needed. "Our home visit and community education [has been] incorporated into existing programs and sustained by local providers."

FIRST THINGS FIRST • FIRST THINGS FIRST • FIRST THINGS FIRST

THE SYSTEM FOR EFFECTIVE ASTHMA CARE: INCORPORATING THE FIVE KEY DRIVERS

COMMITTED LEADERS AND CHAMPIONS

Strategy 1 – Use Outcomes Data to Promote Change	Strategies in Action – Use Outcomes Data to Promote Change
• **Lead program improvement by making sure staff and partners understand your vision, core goals, desired outcomes, and how progress will be measured** • **Share outcomes data regularly to drive program improvement**	• The Chief Medical Officer and Director of Medical Informatics at Monroe developed an evaluation program that includes QOL, care management process, medical claims, and qualitative interview data and regularly share their results with the Plan's Quality Management Committee, CEO and Board, and with program partners. • UHP developed an asthma-severity classification test for all providers. At first, providers used the classification scheme inconsistently and were reluctant to change their practices. To motivate clinical change, program champions showed clinicians the health outcomes achieved by the sites that used the classification scheme correctly.

Strategy 2 – Institutionalize the Focus on Outcomes	Strategies in Action – Institutionalize the Focus on Outcomess
• **Incentivize care teams to deliver evidenced-based care linked to the outcomes you seek**	• ANWM gives out a quarterly MVP award to employees for training providers on national guidelines. • CHA's pay-for-performance model encourages clinical attention to the elements in the asthma registry, including severity classification, home visit referrals, and individualized action plans. CHA runs monthly reports sorted by clinical care site that highlight gaps in performance. There is a limit to the number of times a site can show up on the "out of compliance" list before CHA docks the provider's pay.

Strategy 3 – Create Program Champions	Strategies in Action – Create Program Champions
• **Recruit champions to help spread improvement**	• When CAPP educators identify particularly motivated parents at asthma education classes, they ask the parents to become peer educators. When parents accept, they receive training and mentoring until they are ready to lead community classes on their own.

STRONG COMMUNITY TIES

Strategy 1 – Include Your Community in Program Planning	Strategies in Action – Include Your Community in Program Planning
• **Involve your target community, including local service delivery experts, in all stages of program planning** • **Institutionalize a feedback channel for ongoing communication: community needs change and the best programs change with them**	• Before CAPP began delivering services in North Philadelphia, they heard from local parents about the kinds of home visits, clinical support, and provider interaction that would work best for them. Over time, the parents helped CAPP refine the program. Parents made clear that it was sometimes hard to know if a child had asthma, so CAPP established a door-to-door asthma-screening program.
Strategy 2 – Engage Your Community 'Where It Lives'	**Strategies in Action – Engage Your Community 'Where It Lives'**
• **Situate offices and care sites in the target community** • **Promote cultural competence by meeting local needs with local people** • **Demonstrate broad commitment to your target community by getting involved in community affairs**	• UHP is the largest employer in their zip code with 13 sites in their service area. Most people in the South Bronx know about UHP's asthma program and many know someone who works there. • Monroe hired and trained local, culturally competent staff for asthma outreach, and promoted the program at local community events. • ANWM's manager serves on the local United Way's Investment Council, donating time to review proposals, conduct site visits, evaluate existing programs, and make funding decisions.
Strategy 3 – Make it Easy to Accept Services	**Strategies in Action – Make it Easy to Accept Services**
• **Understand and respond to your target community's needs by delivering convenient services**	• CAPP provides simultaneous asthma education classes for adults and children so parents can attend without worrying about childcare. CAPP's classes are offered in the evenings, several days per week, in English and Spanish, in multiple locations—schools, churches, etc.—and all locations are close to public transportation. • The AH! Program provides program materials in six languages and low-literacy materials that use pictograms to educate disadvantaged and multi-cultural audiences.

High Performing Collaborations

HIGH PERFORMING COLLABORATIONS & PARTNERSHIPS

Strategy 1 – Build on What Works	Strategies in Action – Build on What Works
• **Partner with individuals and organizations with a strong presence in your target community—train them if necessary—to build your program's effectiveness and leverage resources**	• NYCAI recognized the risk of increased asthma in lower Manhattan after September 11, 2001. To reach at-risk pediatric populations, they developed a simple form to help local day care providers recognize asthma symptoms and refer children to local providers. • ANWM collaborated with local university faculty to evaluate utilization and hospitalization outcomes for case-managed patients.
Strategy 2 – Collaborate to Build Credibility	**Strategies in Action – Collaborate to Build Credibility**
• **Collaborate with well-known partners to garner the social capital and community infrastructure needed to deliver comprehensive community asthma care**	• CHA works with the Superintendent of area schools, providers outside of CHA's network, health and housing department officials, university representatives, and local politicians to implement the Planned Care Model for Asthma Management across the community.

Integrated Health Care Services

INTEGRATED HEALTH CARE SERVICES

Strategy 1 – Educate and Support Clinical Care Teams	Strategies in Action – Educate and Support Clinical Care Teams
• **Encourage providers to deliver care consistent with national guidelines by educating them, possibly through physician champions, and giving them tools to facilitate consistent, high quality care**	• CMFHP delivers asthma education to all staff at plan-affiliated clinics. Certified asthma educators provide eight weeks of on-site training in asthma diagnosis and assessment, environmental management of triggers, and guidelines for treatment. The training helps ensure consistency in care from practice to practice. • Monroe trains new medical residents on asthma care guidelines. • Providers receive at least four education sessions through CAPP's training program, and a clinical coordinator visits all sites every week for three to six months to conduct case reviews and asthma care education. Providers can also submit their cases for review by the CAPP Program Director.

Strategy 2 – Support Continuous Clinical Improvement	Strategies in Action – Support Continuous Clinical Improvement
• **Monitor the delivery of asthma care and use data to regularly update clinical teams on their performance and how they can improve their delivery of asthma care**	• UHP uses asthma-severity classification forms to promote care improvement. Program leaders train clinical teams on how and why to use the form (i.e., the health outcomes they can achieve). UHP tracks providers' use of the form, shares monthly outcomes data with each care site, and highlights results from sites that use the form consistently. • When providers over estimated the percentage of their patients classified for asthma severity, CHA's leaders conducted chart audits and put the actual percentages in front of providers. CHA shares monthly outcomes data with all providers and uses the data to demonstrate the difference in outcomes between those practices that engage fully in the Planned Care Model and those following outdated clinical strategies.
Strategy 3 – Promote Robust Patient/ Provider Interaction	**Strategies in Action – Promote Robust Patient/Provider Interaction**
• **Look for ways to create strong relationships between asthma patients and their care teams**	• UHP trains their asthma educators on the national guidelines for asthma care and motivational interviewing techniques and stations educators at the point of care. Sixty percent of UHP's asthma patients have self-management goals they developed in consultation with their providers, health educators, and medical assistants.
Strategy 4 – Facilitate Communication Across the Care Team	**Strategies in Action – Facilitate Communication Across the Care Team**
• **Forge connections between service providers to ensure communication and coordination of asthma care across the team**	• Monroe's asthma outreach staff attends clinical visits with families to coordinate home-based and clinical care, share the results of home assessments, and work with providers on environmental management. • Case managers, social workers, and asthma educators from ANWM regularly meet with providers to refine asthma management plans. Case managers also share information with schools and health plans. • CHA's asthma registry is an effective communication tool because schools, clinics, hospitals, outreach workers, and other members of the team can access it and be in a real-time conversation about patient care.

TAILORED ENVIRONMENTAL INTERVENTIONS

Strategy I – Educate Care Teams on Environmental Management	Strategies in Action – Educate Care Teams on Environmental Management
• **Provide education to clinical care teams on environmental triggers, diagnosis of sensitivities, techniques for minimizing trigger exposure, patient education, and ways to refer patients for environmental services**	• UHP trains providers, health educators, and medical assistants to improve patient self-management by helping patients follow their action plans. All plans include trigger diagnoses and customized environmental management strategies. • CAPP makes it easy for providers to refer patients for environmental education and home-visits and reports back to providers on the outcomes of in-home interventions.
Strategy 2 – Promote Assessment of Environmental Sensitivity and Exposures in Clinical Interviews	**Strategies in Action – Promote Assessment of Environmental Sensitivity and Exposures in Clinical Interviews**
• **Promote skin and blood tests to assess environmental sensitivities** • **Guide teams on how to assess exposures through effective interviews that inquire about exposure to tobacco smoke, seasonal worsening of symptoms, etc.**	• Monroe's Chief Medical Officer helped develop guidelines for asthma care that recommend clinical assessment of patients' exposure to irritants and allergens and counseling on avoiding secondhand smoke. The guidelines indicate that skin testing is preferred, but not necessary; effective interviewing can provide accurate exposure information.
Strategy 3 – Provide Tailored Education and Counseling During Clinical Visits	**Strategies in Action – Provide Tailored Education and Counseling During Clinical Visits**
• **Ensure care teams educate patients on how to identify, control, and avoid their environmental triggers, tailoring recommended interventions to individual sensitivities**	• NYCAI promotes the use of individualized asthma action plans across their provider and plan network. • UHP requires clinical care teams to deliver written plans that address environmental triggers—"writing it down for the patient makes the biggest difference…when it's written down, the families can't forget."

Strategy 4 – Promote Environmental Trigger Management at Home, School, and Work	Strategies in Action – Promote Environmental Trigger Management at Home, School, and Work
• **Partner with local service providers to provide home assessments and interventions, and to teach patients to manage home environments** • **Promote environmental asthma management in schools by educating school nurses, decision-makers, and parents about the risks of exposures at school** • **Partner with employers to educate adult patients and minimize exposures in the workplace**	• ANWM case managers work with families, schools, and health care providers to control environmental triggers. A medical social worker coordinates with housing officials, social service agencies, and property owners to address risks. • CHA clinicians can refer patients to the local Healthy Homes program for home visits and the Healthy Homes staff has access to CHA's asthma registry where they can report on home visit findings. • CAPP trained all school nurses in North and West Philadelphia on environmental asthma management techniques for schools. • The AH! Program partners with a large employer, Barber Foods, to provide on-site asthma education on minimizing workplace exposures.

MAKING IT LAST • MAKING IT LAST • MAKING IT LAST

GETTING RESULTS - EVALUATING THE SYSTEM

Strategy I – Evaluate Program Implementation	Strategies in Action – Evaluate Program Implementation
• **Analyze population data over time to assess whether your program is reaching its target audience** • **Analyze process and outcomes data on an ongoing basis to identify what works and how you can improve program design and delivery**	• BPHC tracks the communities from which clients are recruited, client retention, and participant satisfaction for their Healthy Homes program. The program's mission is to deliver care to the underserved, so when early data indicated that the number of clients from low-income communities was not as high as intended, BPHC changed its approach to allow for word-of-mouth referrals in addition to provider referrals. As clients started telling neighbors and friends about BPHC's services, requests from the target communities spiked. • To refine their training, CMFHP solicited feedback from providers and revised the standard asthma action plan to respond to the questions providers said their patients regularly asked. • Initially, Optima's case managers and life coaches focused patient education on taking prescribed medication. After two years, patient self-management data indicated that adherence to a treatment plan alone often did not lead to decreased asthma severity. The leaders determined that trigger avoidance was necessary and that modifications should be gradual. Now, the coaches suggest "small changes that patients can make quickly, without too much cost or effort."

Strategy 2 – Evaluate Program Impact	Strategies in Action – Evaluate Program Impact
• **Collect health outcomes data to see if your program is improving the asthma outcomes you are pursuing**	• Early in the program's development, CMFHP observed a decline in the proportion of patients classified as having severe asthma. CMFHP leaders quickly realized that the new provider training was leading to better and more frequent diagnoses of mild asthma. As the size of the population with mild asthma increased, severity data for the asthmatic population was diluted. To determine if the program was truly improving asthma health outcomes, CMFHP began comparing utilization data over time against the total number of health plan members rather than the total number of members with asthma; a better constant according to the Director of Health Management. • Monroe tracks hospital admissions and ER visits for asthma to measure the impact of their clinical outreach worker and home visit components. Monroe saw utilization, hospitalization, and ER visits fall as the number of patients seeing PCPs and specialists and the frequency of clinical visits increased. This confirmed that the strategy to promote richer patient-provider interaction was improving asthma health outcomes.
Strategy 3 – Use Evaluation Data to Demonstrate the Business Case	**Strategies in Action – Use Evaluation Data to Demonstrate the Business Case**
• **Assign costs to the program's elements and its outcomes**	• In the program's first year, ANWM tracked 34 children receiving home-based case management. Researchers pulled patient charts, collected cost information on ER visits and hospitalizations, and compared the costs of care from the year before to the first year of the program. ANWM demonstrated that case management cost $2,500 per person for up to 18 home visits per year leading to a 70% decrease in hospitalizations, a 46% decrease in the length of stay, a 60% decrease in ER visits, and improved medication usage. ANWM demonstrated that investments in the program resulted in a net savings of $800 per child per year.

SUSTAINING THE SYSTEM

Strategy 1 – Use Data to Demonstrate Your Program's Value	Strategies in Action – Use Data to Demonstrate Your Program's Value
• **Put data that matters to potential funders and payers in front of them to demonstrate the need for your program and your impact**	• When IMPACT DC's directors present to funders, they use quantitative data that describes the need, emphasizing the City's disproportionate asthma burden (10.3% of children aged 0-17 years in DC have asthma); and qualitative data that follows one child through the program to demonstrate the health and QOL improvements the program delivers. • ANWM visits corporations and describes the burden of asthma in terms that are relevant to employers. There are many children with severe asthma in the community and when they suffer acute attacks, their parents—the corporation's employees—are more likely to miss work.

Strategy 2 – Be Visible: Funders Support What They Know	Strategies in Action – Be Visible: Funders Support What They Know
• **Publicize your program's activities and results as broadly as possible**	• ANWM once received an unsolicited $30,000 grant because its leaders always made time to speak publicly about the program's results. The program manager regularly appears at local health fairs, community events, United Way meetings, etc. When a newly formed investors' circle was looking to support a significant social issue through an organization with demonstrated results, ANWM was the obvious choice.
Strategy 3 – Make it Easy to Support Your Program	**Strategies in Action – Make it Easy to Support Your Program**
• **Identify discrete program elements and their costs so that funders and payers can support individual elements if they are not ready to support the program in its entirety**	• After meeting with limited success in their attempts to sell their asthma program to payers in the Kansas City area, CMFHP established a model that allows it to sell pieces of its program to outside insurers (i.e., payers other than Family Health Partners). For example, plans can buy the disease management training component without the social worker support for high utilizers, or consulting services for help replicating CMFHP's program.
Strategy 4 – Promote Institutional Change for Sustainability	**Strategies in Action – Promote Institutional Change for Sustainability**
• **Embed your asthma management program in your organization**	• CHA built their Planned Care Program "not by creating new jobs, but by showing the staff [they] already had how to do their jobs better." CHA redesigned their workflows and developed the resources and systems, such as an electronic registry, to make it easy for staff to deliver the quality of care the program was designed to achieve.