Integrated Health Care Services

Integrated Health Care Services

Programs with integrated health care services achieve the strongest results. Strategies for creating integrated care systems include:

- Educating and supporting providers on national guidelines
- Using data to drive clinical improvement
- Promoting strong provider-patient relationships
- Facilitating communication across team

Integrated Health Care Services

MaineHealth AH!
Asthma Health Program

Rhonda Vosmus, RRT, AE-C
Barbara Chilmonczyk, MD

The AH! Program: *What We Believe In*

Our Philosophy: *Knowledge is Power*

- **4 Key components**:

  1) Public policy 2) Public Awareness 3) Outreach 4) Education

- **We have become essential to the delivery of quality asthma care in our community:**
  - Involve and become involved in the work of physicians, hospitals, schools, community, regional and state organizations
  - Assess and prioritize community needs for asthma care and the patient/family's perceived needs around education and self-management
  - Plan program based on community feedback, guidelines, research, and expert opinion
  - Continuous quality improvement

The AH! Program

Who We Are

- **Nonprofit, Integrated Health Care Delivery System**
- **Located:** Portland, Maine
- **Program Established:** 1998
- **Growing diverse populations including Somali and Latino (**52 languages in Portland, ME)
- **Serve:** 975,000 adults, 90,675 children with asthma
- **Key Partners:** MaineHealth, Maine Medical Center, Southern Maine Medical Center, Medicaid, ALA of ME, Maine Asthma Council, Maine CDC, 3rd party payers and recently the Maine AAP

Our Integrated Health Care Services:

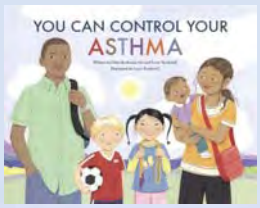
Knowledge is Power

- **For Patient's and Families One:One**
  - Prepare patients so they are active partners and advocates; emphasize the family's role in supporting the patient's well being and illness
    - Deliver consistent, focused messages about healthy lifestyles
    - Address environmental/economic issues and access supporting services
    - Assess readiness to change & self-efficacy, and provide advice for behavior change consistent with patient / family's readiness to change
    - Use collaborative approach to setting goals
    - Promote self-management skills
- **We ask for and use feedback**

Our Integrated Health Care Services:
Knowledge is Power

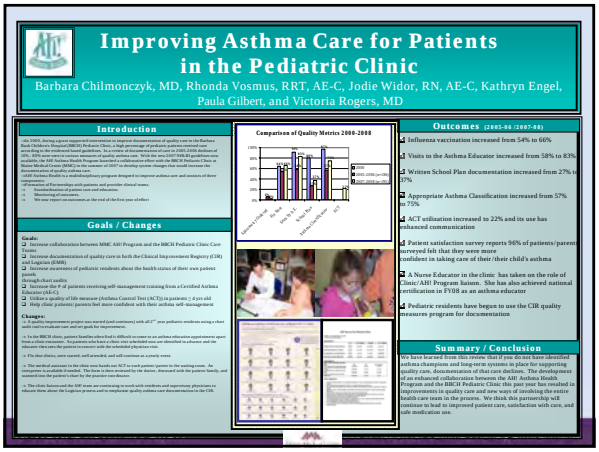
- **For providers:**
  - Hands-on tools and education sessions
  - Initiation of an automatic referral process—Emergency Department, inpatient and office
  - Availability of a Clinical Improvement Registry
  - Physician Incentive Quality Reward Program
  - We are available as a resource for provider and staff questions and problems

Knowledge is Power: AH! Asthma Health tools



Asthma Tools

NATIONAL ASTHMA FORUM Communities in Action for Asthma-Friendly Environments



Improving Asthma Care for Patients in the Pediatric Clinic

Barbara Chilmonczyk, MD, Rhonda Vosmus, RRT, AE-C, Jodie Widor, RN, AE-C, Kathryn Engel, Paula Gilbert, and Victoria Rogers, MD

Introduction

Goals / Changes

Outcomes (2005-06 /2007-08)

- Influenza vaccination increased from 54% to 66%
- Visits to the Asthma Educator increased from 58% to 83%
- Written School Plan documentation increased from 27% to 57%
- Appropriate Asthma Classification increased from 57% to 75%
- ACT utilization increased to 22% and its use has enhanced communication
- Patient satisfaction survey reports 96% of patients/parents surveyed felt that they were more confident in taking care of their /their child's asthma
- A Nurse Educator in the clinic has taken on the role of Clinic/AH! Program liaison. She has also achieved national certification in FY08 as an asthma educator
- Pediatric residents have begun to use the CIR quality measures program for documentation

Summary / Conclusion

Our Integrated Health Care Services:
How We Make It Work

- Automatic referral process-#'
- Partnering with tobacco cessation and obesity programs
- Using registry data to motivate providers and to drive continuous improvement-pilot sites, QI resident project
- Annual report to administrative and opinion leaders highlighting successes, how much it costs (little), how much it saves, and how our work can improve provider efficiency
- Provide summary reports to providers

NATIONAL ASTHMA FORUM Communities in Action for Asthma-Friendly Environments

Our Impact

- **Key indicators for measuring success:**
  - Decreased healthcare utilization, ED and Hospital
  - Decreased missed days from work and school
  - Increased number of patients with persistent disease on controller medications
  - Increased # of asthma plans written
  - Increased referrals for asthma self management education
  - Improved care and quality measures for providers
  - Increased outreach opportunities
  - Positive patient satisfaction surveys

Our Impact

- **The results we're most proud of:**
  - After integrating asthma education awareness we saw a reduction in ER visits from 22% to 5% and hospitalizations from 24% to 0% at 6 months post intervention
  - This resulted in health care cost savings of $473,105

Process & Outcome Measures
Baseline & 6 Months
AH! Asthma Pediatric, Cohort 8
(Total N=193)

Measure	Baseline	6 Month
Responded at follow-up (%)		130 (67.3%)
Controller medication for persistent asthma	115 (76.7%)	78 (62.9%)
ED Visit	43 (22.2%)	6 (4.6%)
Hospital stay	46(23.8%)	0 (0.0%)
Patient/caregiver missed school/work	78 (49.4%)	12 (9.8%)

* FY'08 MMC AH! Asthma Health Program data (October'07 – Sept '08)

Sharing Our Value—Sustaining Our Success

- **We demonstrate our value by:**
  - Sharing our data – keeping our stakeholders informed
  - Patient satisfaction surveys
  - Reduced overall health care utilization
  - AARC Certification
- **Our number of patients seen has grown by 30%**
- **We help to fund that growth by:**
  - Hospitals and collaborators
  - 3rd party payer receipts
  - Grants

Integrated Health Care Services

Urban Health Plan
Asthma Relief Street Program

Acklema Mohammad MD, CAE

Urban Health Plan

Who We Are

- Federally Qualified Community Health Center
- Joint Commission accredited
- Founded in 1974 by local physician
- Largest employer in our zip code
- 2008 served; 31,000 patients through 171,000 visits
- **Key Partners:** NYCDOHMH , Affinity Health Plan, and Bureau of Primary Health Care's Health Disparities Collaborative

Urban Health Plan

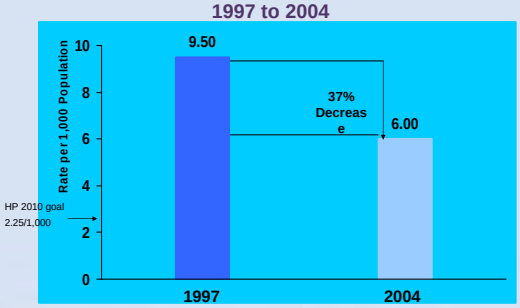
What We Believe In

Our Philosophy:

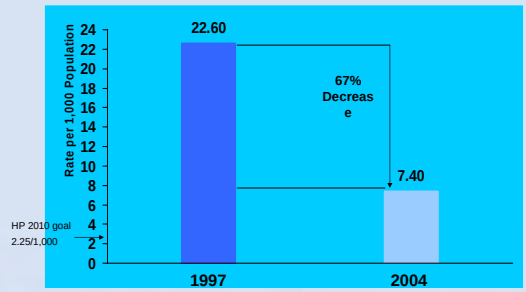
Using Outcomes Data to Promote Change

- **Why we are essential to the delivery of quality asthma care in our community:**
  - 27% of children in the South Bronx have asthma
  - Urban Health Plan is the largest provider of health care in the community and has a responsibility to improve outcomes for our patient population with asthma

New York City
Comparison of Asthma Hospitalization Rates in Children Aged 0-14
1997 to 2004



Hunts Point-Mott Haven NYC
Comparison of Asthma Hospitalization Rates in Children Aged 0-14
1997 to 2004



Our Integrated Health Care Services:
Using Outcomes Data to Promote Change

- **Apply Chronic Care Model**
- **Infrastructure supports spread of data-driven interventions:**
  - Provider Champion Monitors Program Outcomes & Provides Continuous Training and Reinforcement
  - Evidence Based Guidelines are Embedded in the Electronic Health Record
  - Monthly Outcomes Data Shared with Providers
  - Asthma Educators at Point of Care
  - Asthma Educator Tool Kit is continuously updated & used

Our Integrated Health Care Services:
How We Make It Work

- **Trainer-champions teach proven interventions to all office staff (peer to peer model)**
- **Participants leave with:**
  - Understanding of why change is important
  - Data demonstrating effectiveness of changes
  - Tools to implement new approach
  - Monitoring, data sharing and training is continuous
  - Areas of weakness are caught early and resolved

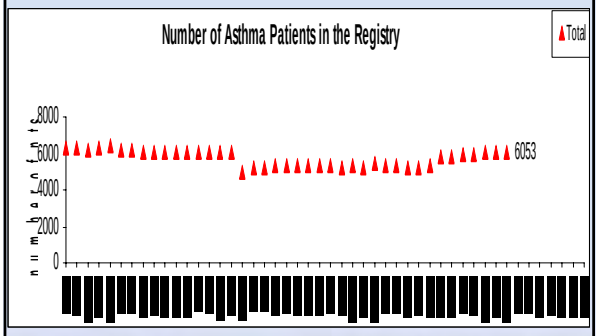
Our Impact

- **The results we're most proud of:**
  - 100% of providers use standard classification system
  - 95% of patients on anti-inflammatory meds
  - Sustained average of 10.4 symptom free days
  - Patients educated at point of care

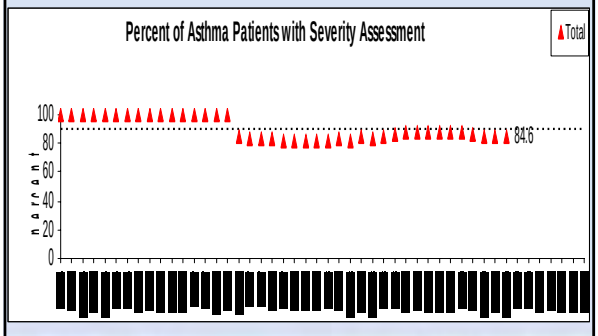
Our Impact (continued)

- **Key indicators for measuring success:**
  - Monthly Data Graphs
  - Cost savings of our program
    - Large local managed care plan showed a cost savings of 22% to 39% when UHP manage their asthmatics
    - Partnership with Affinity

Asthma Graphs



Asthma Graphs



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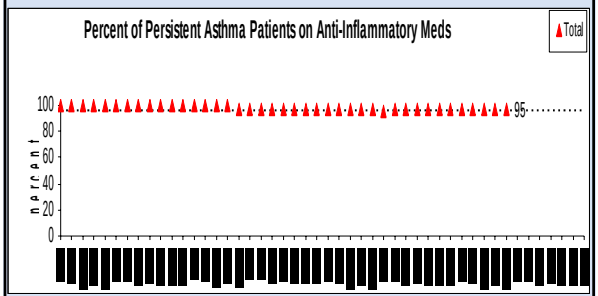

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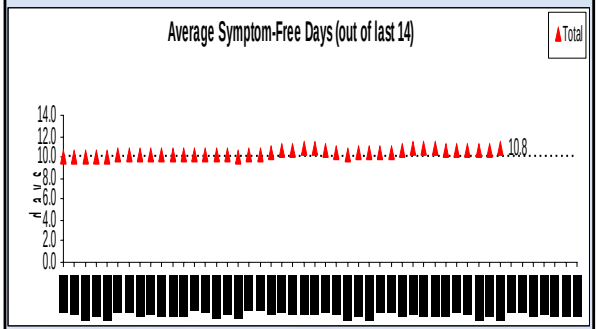

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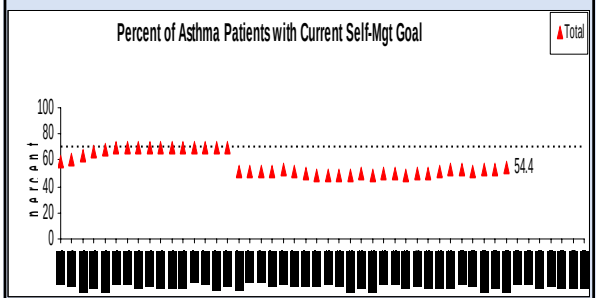

Tool Kit

Sharing Our Value—Sustaining Our Success

- **We demonstrate our value by:**
  - Sustaining our outcomes
  - Staying current with National Guidelines
  - Sharing what we know inside and outside of UHP
- **Our asthma program has grown from 2,100 patients to 6,095 patients**
- **We help to fund that growth by word of mouth**
  - Our patient volume grew by 190% over the past 7 years
  - Partnership with Affinity and other HMOs

"To know that even one life has breathed easier because you have lived. That is to have succeeded!"

-Ralph Waldo Emerson