C.O.A.C.H. PROGRAM
“JSUMC’s DSRIP PROJECT—YEAR ONE”

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Learning Collaborative One
Presentation
February 11, 2016
Overview

• COACH interventions by the numbers
• Hospital Admissions
• Hospital Encounters (inpatient, observation, ED treat and release)
• How these numbers shape our interventions going forward
• What’s happening with our quality improvement PDSA project with our reporting partner (Booker Family Health Center)
• What’s happening with the community
• What were learning from home visit
• Where we want to go in DY5
3 year Comparison of Asthma Admissions K. Hovnanian Children's Hospital

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Enterovirus Outbreak
70 fewer total hospital encounters
2015 compared with 2014
FHC Asthma Guidelines Compliance
What’s happening with the community

• Summer Programs at the Boys & Girls Club
• Attended Community Health Fairs
• Worked with local pediatrician to educate staff and patients
• Back to School nights at local public schools
• Middle School Lunch and Learn Program
• Strengthened collaboration with local school nurses
• Meet with various organization such as Central Jersey Family Health Consortium, Monmouth County Council for Young Children
Lessons Learned from Home Visits

• Teaching a family about asthma is not enough
• Minimizing asthma triggers is only the beginning
• In order to effectively implement self management, the provider/educator needs to start with Maslow’s Hierarchy of Needs. Without basic needs being met asthma treatment won’t be a parents priority
• Finding the right resources to assist families is not easy for providers. They need to work in a team with community agencies.
• Schools can be a vital resource in managing a care
Case Studies

- LR – first encounter inpatient Fall 2014
- Next hospitalization Spring 2015
- Follow-up a challenge, unable to do home visit
- Collaboration with Child Protective Services ineffective
- August 2015 – admitted to PICU – 19 days on a vent followed by a week on the inpatient unit, then to rehab for 6 weeks.
- Once discharged it took the “whole” community to get LR into school – November 2015
- Readmit Dec. 2015 – PICU as a precaution home in 5 days
- Family engagement through collaboration with school
- Success first to weeks of January only missed 1 day of school
- Last exacerbation handled at home by mom without steroids.
Case Study # 2

- AL family – 3 children < 2 years all history of wheezing and allergy
- Referred by PCP
- Initial encounter home visit
- 2nd encounter home visit new apartment
- Interventions: controllers started, education, air conditioner, emotional support
- Success: none of the children have been hospitalized and they have had fewer sick visits for wheezing this winter.
- Mother still moving for home to home, continues to stay in touch with COACH case manager.
What’s next?

• Collaboration with Neptune school nurses has lead to plans for a monthly asthma clinic held at the districts Wellness Center.
• Staffed by Pulmonologist, NP, Asthma Educator
• Services will include: spirometry w/ interpretation, education, treatment plan, follow-up home visits when indicated, follow-up with school based NP
• Projected start date March 2016
• New PDSA program for the Pediatric ED.
• Recruitment of PCP for our asthma MOC QI project.