C.O.A.C.H. PROGRAM

"JSUMC 's DSRIP PROJECT – YEAR ONE"

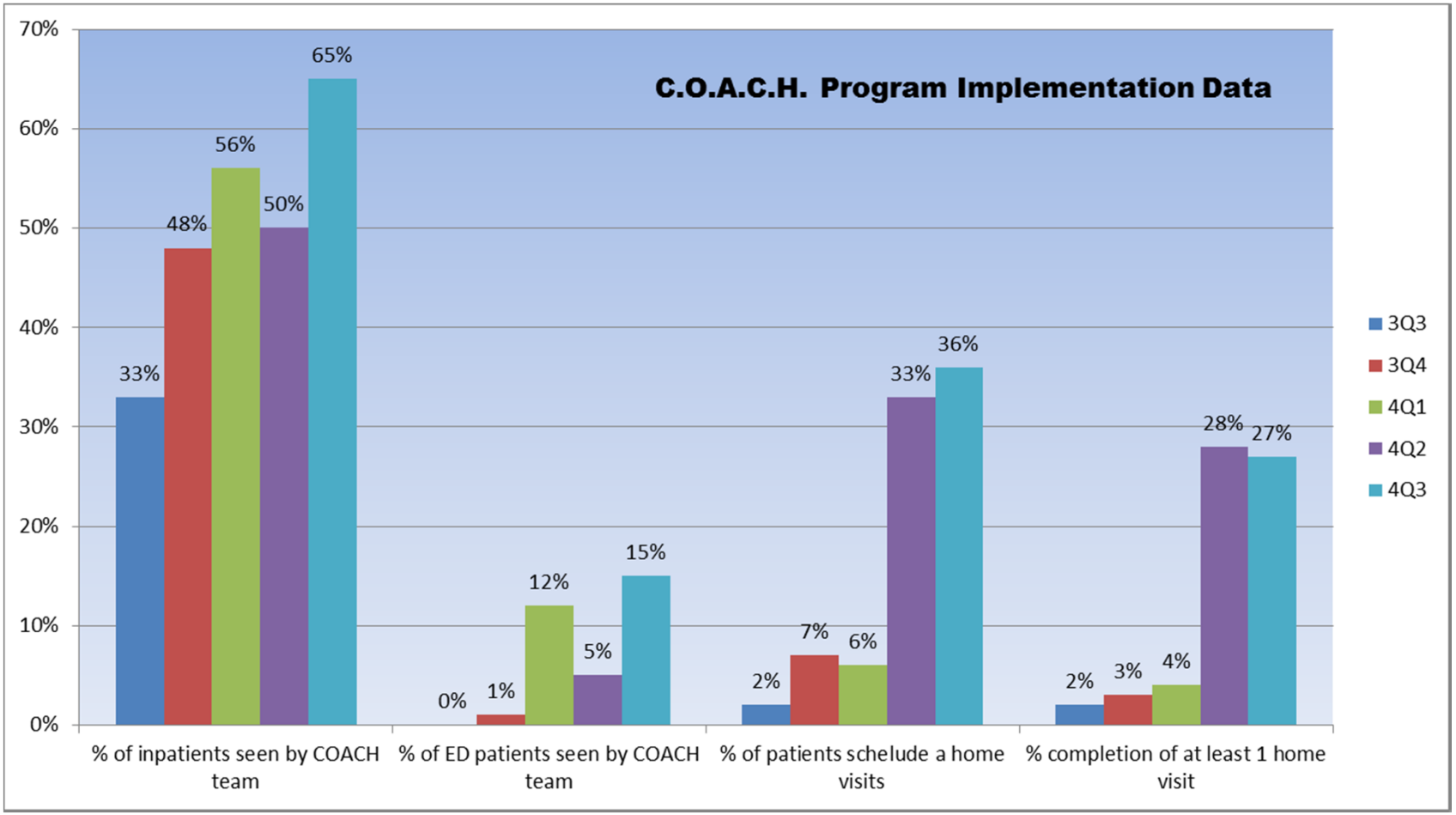
Barbara Birde Cirella, MS, CPNP, AE-C

Learning Collaborative One
Presentation
February 11, 2016

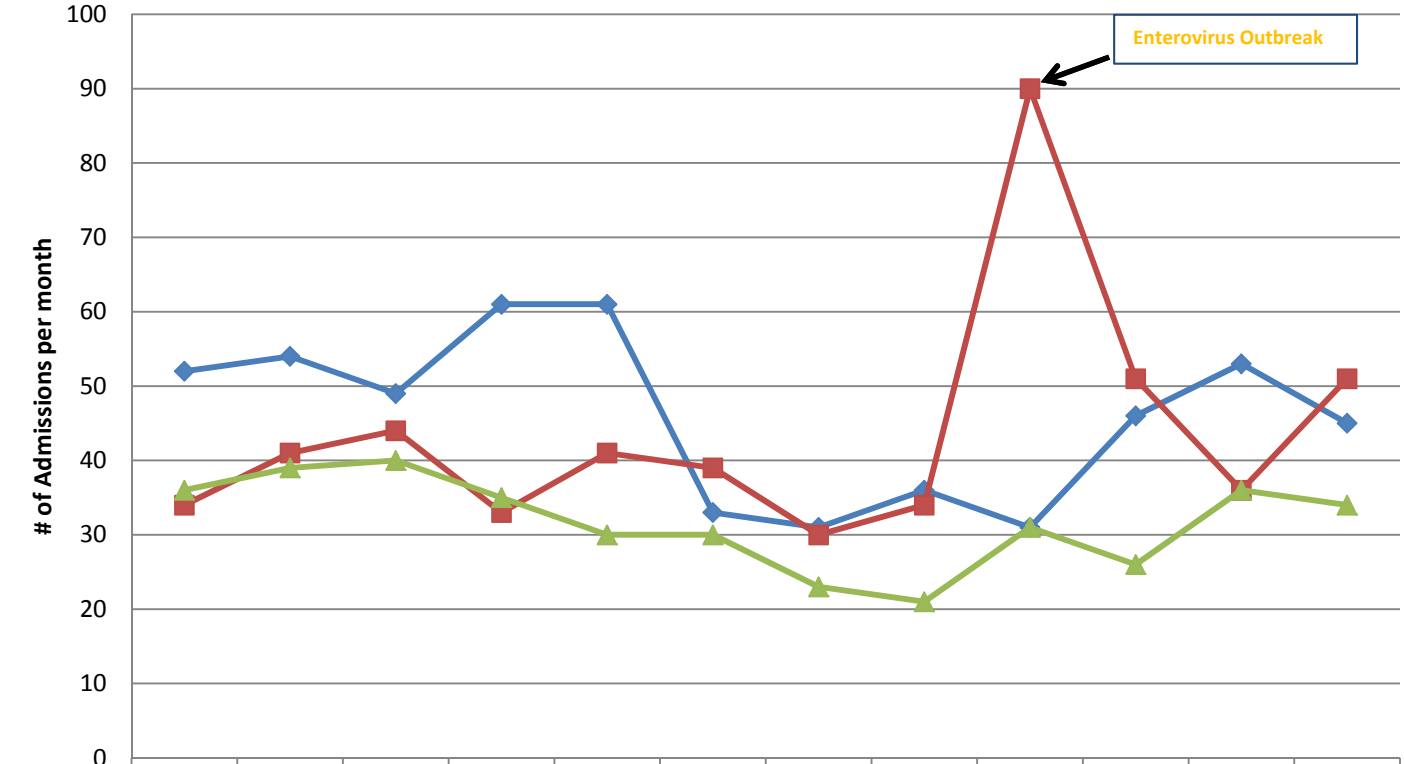
K. Hovnanian Children's Hospital
AT JERSEY SHORE UNIVERSITY MEDICAL CENTER
Member of the Meridian Health Family

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


C.O.A.C.H. Program Implementation Data
70%
60%
50%
40%
30%
20%
10%
0%
33%
48%
56%
50%
65%
0%
1%
12%
5%
15%
2%
7%
6%
33%
36%
2%
3%
4%
28%
27%
% of inpatients seen by COACH team
% of ED patients seen by COACH team
% of patients schelude a home visits
% completion of at least 1 home visit
3Q3
3Q4
4Q1
4Q2
4Q3

3 year Comparison of Asthma Admissions K. Hovnanian Children's Hospital



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2013	52	54	49	61	61	33	31	36	31	46	53	45
2014	34	41	44	33	41	39	30	34	90	51	36	51
2015	36	39	40	35	30	30	23	21	31	26	36	34

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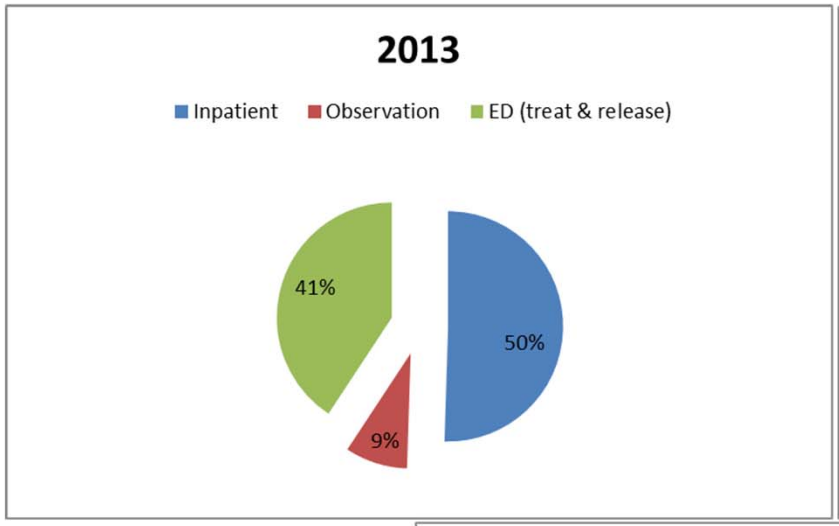

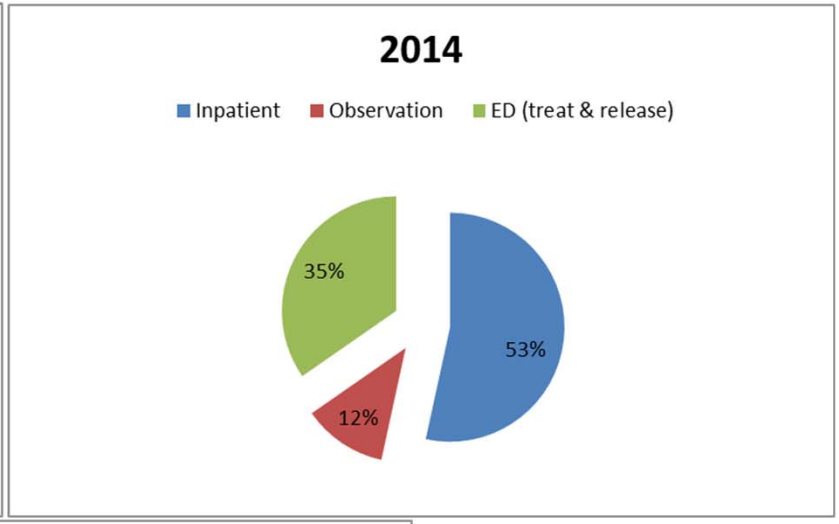

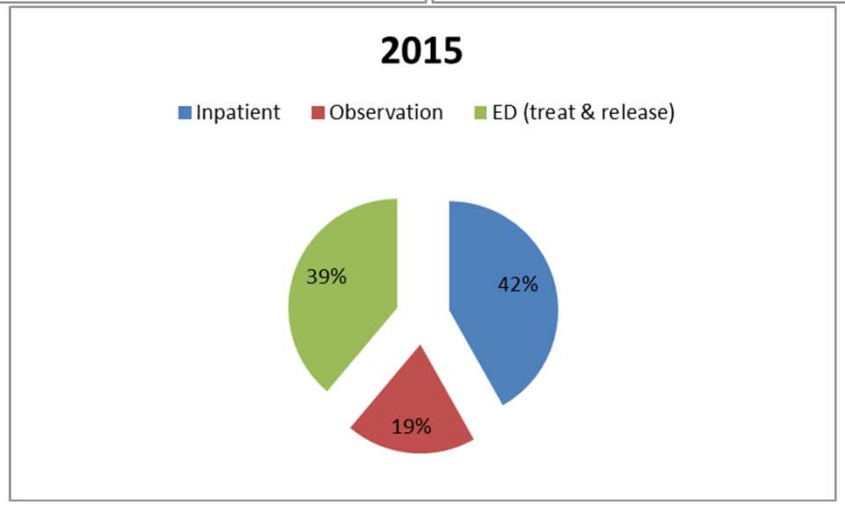

70 fewer total hospital encounters
2015 compared with 2014

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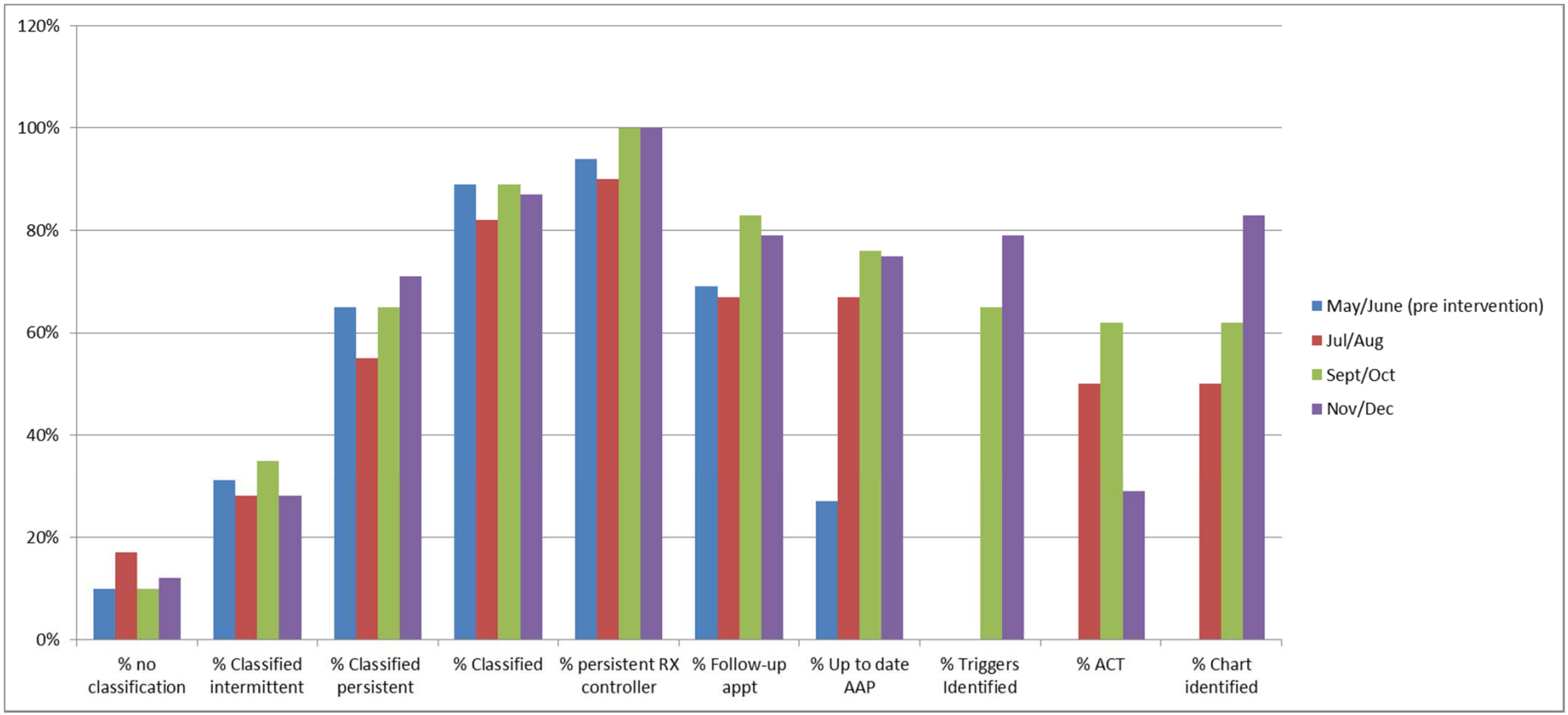

FHC Asthma Guidelines Compliance

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.