

C.O.A.C.H

*Community Outreach for Asthma Care & Healthy
Lifestyles*

“Improving Outcomes through education and partnership”

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MOVING FORWARD

C.O.A.C.H Driver Diagram

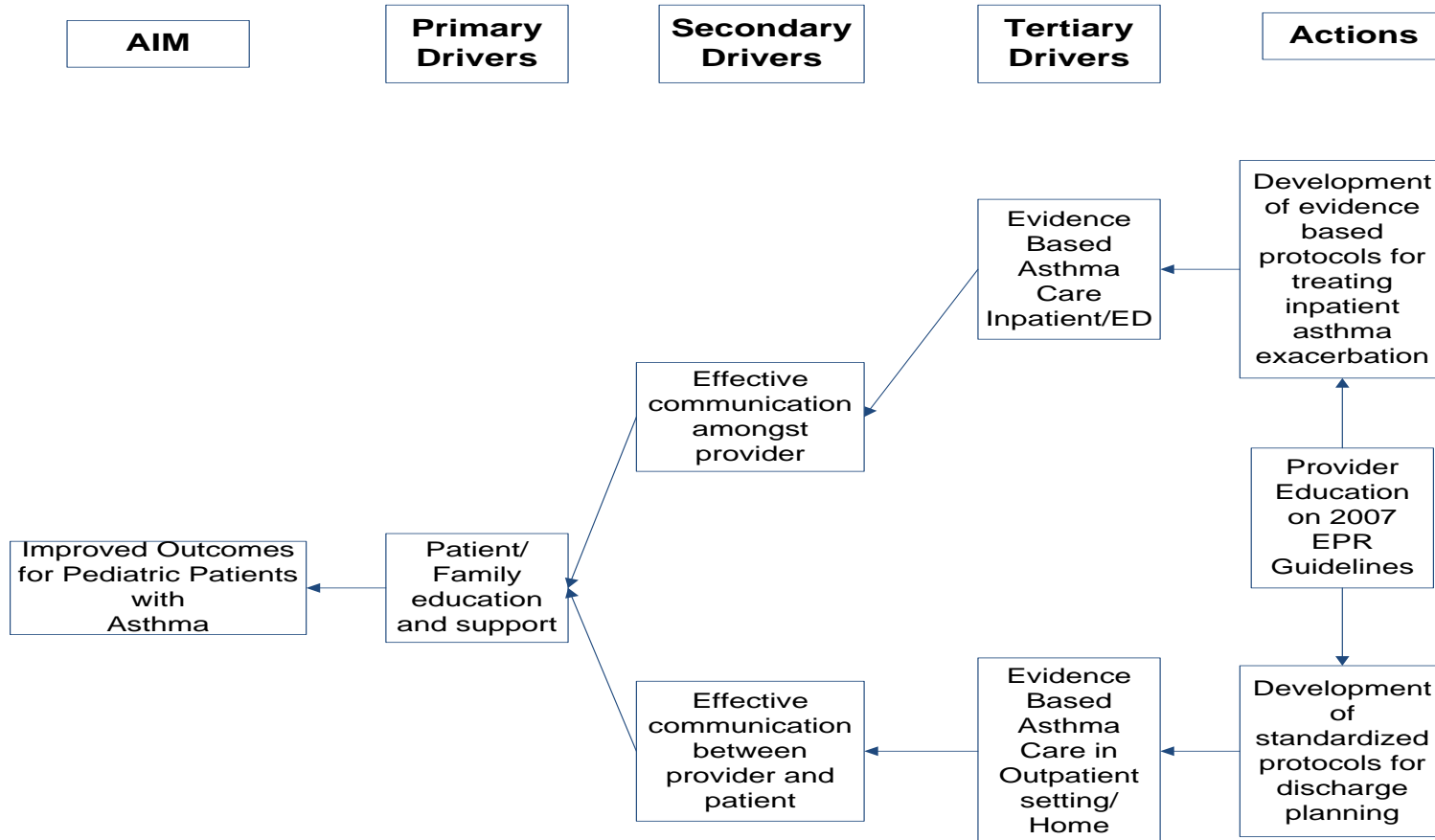


Figure 1

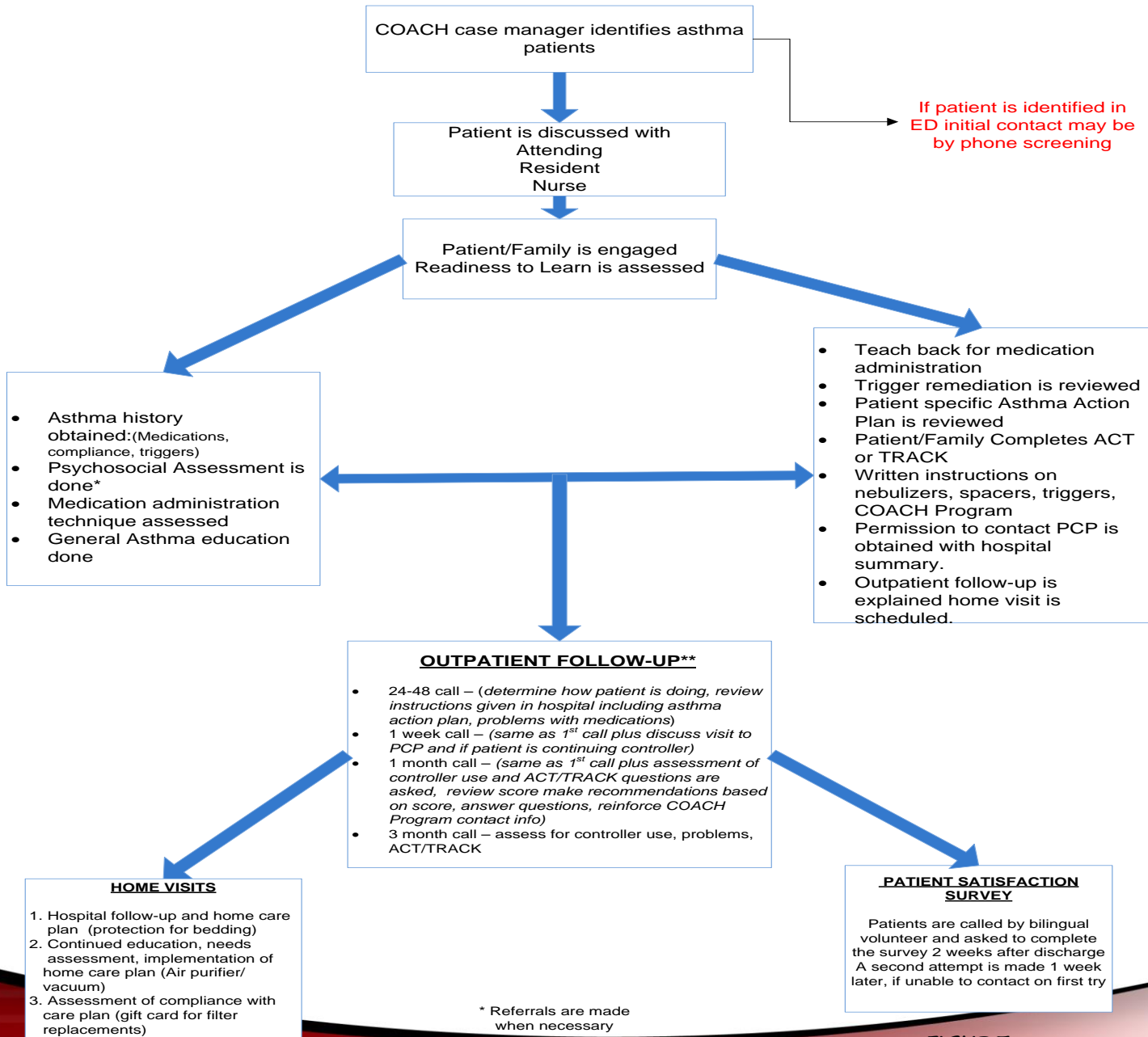
Inpatient/ED Setting

- ❖ Developed education programs for providers
- ❖ Developed teaching aides and checklist instructions - providers and patients/families
- ❖ In service training for Nurses, Residents & Hospitalist
- ❖ COACH case manager provides asthma education to all patients/families admitted to the Pediatric Service with a diagnosis of asthma
- ❖ Emergency Department refers patients who are poorly compliant to COACH Team

Inpatient/ED Setting Continued

- ❖ Home visits are offered to all patients with Medicaid, CHIPS or self-pay status and diagnosis of asthma, by COACH team
- ❖ Patients are contacted within 24-48 hours of discharge to assess status
- ❖ Telephone contact continues at 1,4 and 12 weeks
- ❖ Patient satisfaction surveys conducted within 2 weeks of discharge

C.O.A.C.H. PROGRAM INTERVENTION



* Referrals are made when necessary

FIGURE 3

Community Outreach

- ❖ Educational programs for school nurses on pathophysiology of asthma, asthma classification, medications and administration, asthma action plans and triggers
- ❖ Educational program for non medical school personnel (teachers, administrators, teaching assistants) that addresses similar topics plus what to do when the school nurse is unavailable.
- ❖ Asthma Self-Management Lunch and Learn program underway for sixth grade students identified by the school nurse as having asthma.
- ❖ Reviewed existing Meridian Outreach Programs and their effectiveness with the Outreach Team and developed plan for collaboration on reaching parents as well as students, to broaden our reach.

Primary Care Providers

- ❖ COACH case manager provides a detailed summary of inpatient stay and discharge medications to primary care provider within 24 hours of discharge so the information will be available at the initial follow-up visit
- ❖ COACH case manager/asthma educator goes to the regularly scheduled asthma clinic at the Booker Family Health Center.
- ❖ Developing an AAP maintenance of certification quality improvement project for the establishment of asthma medical homes in pediatric practices and Family Health Center. Project will include standardization of asthma treatment according to the NHLBI 2007 EPR-3 Asthma Guidelines.

Observations

Provider education has resulted in:

- ❖ Establishment of the COACH program as a resource for the inpatient service and community schools
- ❖ Heightened awareness of proper administration of inhaled asthma medications by staff
- ❖ Increased number of children being prescribed controller medications on discharge
- ❖ Presentations to school nurses were well received and lead to the development of the Asthma Lunch and Learn Program

Barriers exist to Evidence-base Asthma Care

- ❖ Healthcare providers charged with educating patients on self-management have varying levels of competency
- ❖ Methods of administration of inhaled medications vary amongst providers
- ❖ Asthma classification is inconsistent
- ❖ Discharging patients with controllers is inconsistent
- ❖ Health care providers in general are slow to adopt change
- ❖ Patients/families are reluctant to allow home visits

COACH Patient/Family Intervention

- ❖ COACH Nurse educator/case manager provided asthma education to 67 patients/families (Sept. 2014 – Jan. 2015)
- ❖ Follow-up has occurred at least once with 73% of these families.
- ❖ Contact at 4 weeks occurred with 36% - we are now doing ACT/TRACK's at 4 weeks to assess symptom control - approx. 60% scored in the controlled range.
- ❖ On follow-up patient report controller medications being stopped by PCP.
- ❖ At home visits we find patients frequently have not filled prescriptions.

DSRIP

- ❖ Abstraction tools have been developed for hospital measures
- ❖ Working with outside abstraction vendor to run the current attribution model against our hospital measure data
- ❖ Plan and tools are developed for chart abstraction at the Family Health Center
- ❖ Tracking and Trending dashboards are developed for COACH interventions

QUESTIONS ?