C.O.A.C.H

Community Outreach for Asthma Care & Healthy lifestyles

"Improving Outcomes through education and partnership"

Barbara Cirella, RN, MS, CPNP

DSRIP Learning Collaborative

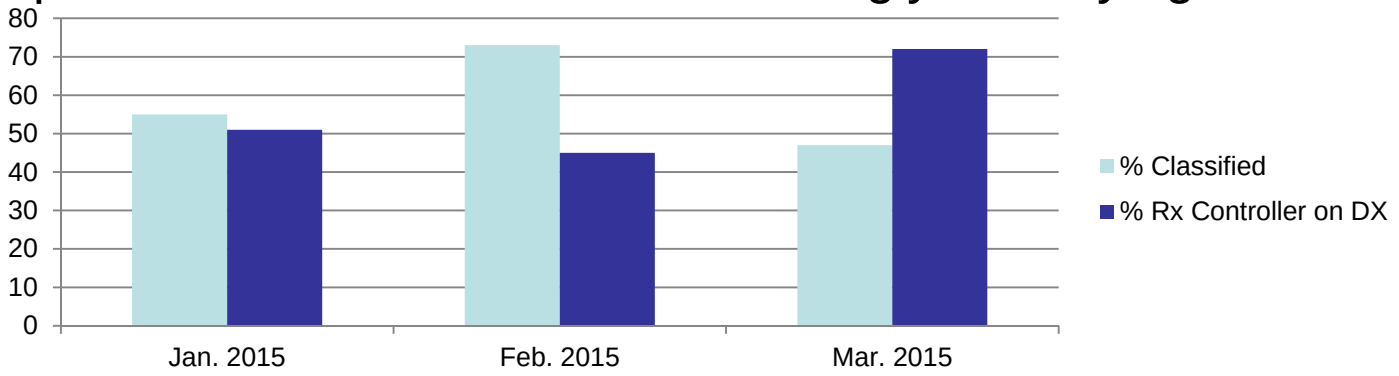
May 14, 2015

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

Moving Forward Inpatient Service

- Through March 31, 2015, 110 families have received asthma education through the COACH program

- Hospitalists and residents are increasingly classifying asthma



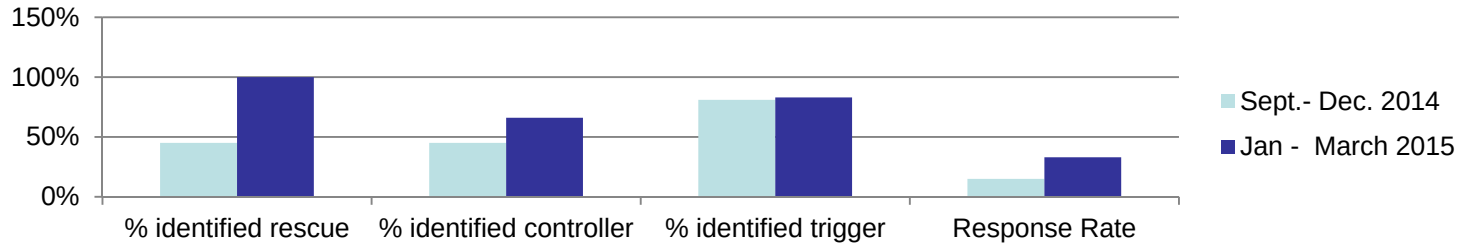
- Patients are being discharged with controller medications and spacer

- Patients are being evaluated on barriers to compliance – spacers with masks are being used for younger patients

Moving Forward Inpatient Service

- COACH Nurse Educator/Case Manager sees over 90% of the asthma patients admitted to the Pediatric Service.

- On last quarter's follow-up calls 100% of the parents knew the name of their child's rescue medication, 66% knew the name of the controller medication, 83% could identify at least 1 trigger



- On week 4 follow-up calls it was interesting to note that 9/10 parents reported their child's asthma to be in control however when a ACT/TRACK was completed it revealed that only 6/10 were in control

Moving Forward Inpatient Service

- Of the 110 families who received COACH interventions we were able to identify 7 readmission to the hospital and 5 who were seen in the ED.

Challenges

- Work still needs to be done to ensure consistent patient/family education when COACH Team is unavailable.

- Having the actual medications the patients will be taking home available at discharge.

- Increase of home visits. Especially for those we identify with exacerbations within 30 days.

Moving Forward Emergency Department

- Data shows that 100% of patients received steroids and albuterol during ED visits
- Spacers and nebulizers are available in the ED for discharge

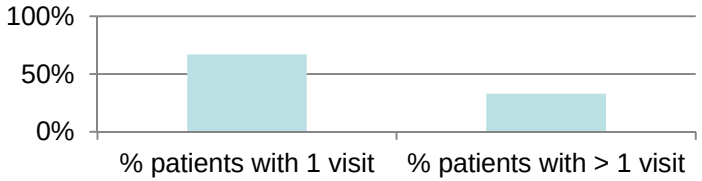
Challenges

- Lack of referrals to the COACH Program
- Asthma is not classified nor are controller medications ordered on a regular basis
- Triggers are not documented

Moving Forward Emergency Department

- Discharge instructions on the use of albuterol varies

New PDSA for ED



16% of a patients had 33% of the ED visits in 2014

Discharge Medications/Instructions
26 charts reviewed

	Rx oral Steriods	Albuterol Q 3 h	Albuterol Q 4 h	Albuterol Q 6 h	Albuterol Q 8 h	Controller Rx given	Triggers Identified
%	100%	3%	34%	11%	3%	7%	15%
Raw #'s	26	1	9	3	1	2	4

Moving Forward Emergency Department

- **Scope:** In 2014, 233 at risk patients between the ages of 2 & 18 years were seen in the Emergency Department for asthma exacerbations. 16% of these patients accounted for 33% of the total visits. Factors that contribute to this revisit rate include disease severity, repeat exposure to triggers and noncompliance. Chart review showed infrequent documentation of triggers, exacerbation frequency, prescribing of controller medications on discharge and asthma education. (Not documented not done?)

- **Goal:** To decrease revisit rates through implementation of a plan to facilitate evidence based care and improves compliance with prescribed therapies.

Moving Forward Emergency Department

Plan

- Document triggers, revisits & systemic steroid use
- Standard Discharge Instructions
- Increase referrals to COACH Program

Strategy

- Have the triage nurse responsible for these items on intake
- Implement use of a short checklist and patient education packet
- Awareness campaign targeting nurses in both EDs

Moving forward Community Partners

Family Health Center

- Nurse educator/case manager attends their asthma clinic 2x/month
- Working to implement a discharge checklist to be used for all asthma patients to improve symptom documentation, trigger identification classification, controller use and review of asthma action plans
- Quality improvement project for MOC credit will be implemented in the FHC once approved

Moving forward Community Partners

Primary Care Practices

- Have engaged PCP's and introduce Quality Improvement Project to implement Asthma Medical Homes in their offices
- Awaiting approval from the American Board of Pediatrics
- Approval will allow each participating physician to receive 24 QI MOC credits

AIM

tablish Pediatric Asthma Medical Homes in mmunity Primary Care Practices to improve asthma outcomes through a Quality Improvement Project

GOALS

- Increase compliance
- Increase number of asthma follow-up visits for assessment of control
- Decrease use of systemic steroids
- Decrease ED/urgent visits for exacerbations
- Decrease missed school/work days

PRIMARY DRIVERS

SECONDARY DRIVERS

- Proper classification of asthma
- Proper prescribing of controller medications
  - Provider Education on evidence based asthma care
- Comprehensive asthma education for patients and families
- Comprehensive case management – home visits by COACH Team
- Implement use of TRACK and ACT validated control assessment during visits.
- Implement of checklists to assure proper assessments and referrals, patient education done and appointments scheduled. (These will be site specific)
  - Provide practice staff (Nurses/PCA) with asthma education and checklists for patient asthma education (See attached for examples)
  - Implementation of regularly scheduled asthma follow-up
  - Assessment of medical and social needs
  - Develop community support for asthma patients
  - Asthma care plans

Moving forward Community Partners

Collaborative Efforts

- Asbury Park Boys & Girls Club working to bring an asthma education program to the summer camp for children and parents. Will be working students from COPC on this project. July 2015
- American Lung Association/PACNJ will Open Airways training for the Meridian Community Outreach nurses. July 2015
- Working with Monmouth Board of Health and American Lung Association to connect with Hispanic Families in the Asbury area
- Planning a “Back to School with Asthma” Day at the Meridian Health Education Center in the Freehold Mall. This is in collaboration with Monmouth Public Health Nurses “Healthy Homes” initiative, the American Lung Association and Meridian Community Outreach. August 2015

Moving forward Community Partners

- Ocean County Head Start Health Conference to develop relationships with Centers to provide staff and parent education.

- Monmouth County School Nurses Association meeting to expand our Staff Education and Lunch and Learn Programs to other schools.