



K. Hovnanian
Children's Hospital

AT JERSEY SHORE UNIVERSITY MEDICAL CENTER

Member of the **Meridian Health** Family



PEDIATRIC ASTHMA PROJECT

Improving outcomes through Partnership, Communication & Education

DSRIP LEARNING COLLABORATIVE PRESENTATION

Barbara Cirella, RN, MS, CPNP

Clinical Program Manager

August 14, 2014

WHERE WE ARE GOING?

PROBLEM RECOGNITION:

1. Pediatric Patients present to the Emergency Department at increased rates
2. Admission and readmission rates are high
3. Repeat patients tend to be those with inadequate follow-up
4. Controllers are being used for rescue
5. Identification and/or remediation of triggers is poor

WHERE WE ARE GOING?

OUR DSRIP PROJECT GOAL IS TO PROVIDE COMPREHENSIVE COORDINATED CARE WHICH WILL:

1. Address the underlying causes of noncompliance/under treatment
2. Establish protocols for treatment and communication to improved treatment standards, compliance and control.
3. Developed model will be comprehensive and evidence based. The program will serve as a model for other hospitals on partnering with patients/families, community medical providers, schools , local health departments and community organizations to improve pediatric asthma care.

WHERE WE ARE GOING?

4. Increase number of children with up to date asthma actions plans, increase number of children with accurate classification of their asthma, increase use of controllers for children with persistent asthma, increased identification and remediation of triggers.
5. Decrease ED visits, decrease admissions, decrease missed school days, decrease missed work for parents.

HOW ARE WE GETTING THERE? *THROUGH PARTNERSHIP AND COMMUNICATION*

STEP # 1:

RE-ENGAGE THE TEAM MEMBERS WHO IDENTIFIED PEDIATRIC ASTHMA AS A MAJOR PROBLEM IN THE PEDIATRIC LOW INCOME POPULATION SERVED BY THE K.HOVNANIAN CHILDREN'S AT JSUMC

- ❖ Spring 2014 project approved
- ❖ Hiring process for key personnel began (Clinical Program Manager and Community Case Manager/Asthma Educator)

- ❖ June 30th Clinical Program Manager started. Allowing the program to begin moving forward. Projected start date for Case Manager/Asthma Educator Aug. 18, 2014

HOW ARE WE GETTING THERE?

THROUGH PARTNERSHIP AND COMMUNICATION

- ❖ July 1st meeting to introduce Clinical Program Manager and begin discussion on identifying where and how to focus our efforts.
- ❖ July 15th existing team meets with Hospital's Quality Improvement Manager, group defines 4 areas where Quality Improvement needs to happen in order to meet our goal, as support by current literature.
- ❖ These areas will be the points of entry to our comprehensive program for the patients and families
 1. Inpatient Asthma treatment and education
 2. Emergency Department Asthma treatment and education
 3. Community Primary Care Settings: PCP offices/ Community Clinic
 4. Community Agencies including but not limited to: Schools, Monmouth County Department of Health, Community Organizations.

HOW ARE WE GETTING THERE?

THROUGH PARTNERSHIP AND COMMUNICATION

Step #2: Engage individual stakeholders/partners, other than patients/families, who were identified and contacted during the grant writing process. Together we will identify what is in place and working, where support from our program is needed and barriers to providing comprehensive evidence based care. Given the large scope of the overall project, initially unique rapid cycle quality improvement projects will be developed in each of the 4 areas.

HOW ARE WE GETTING THERE?

THROUGH PARTNERSHIP AND COMMUNICATION

Clinical Program Manager began process with:

1. Meeting with Quality Improvement Manager who will mentor the team through the PDSA process.
2. Engaging new partners within K. Hovnanian Children's Hospital has begun. (i.e. staff nurses on inpatient service, Emergency Department Medical Director and staff, outcomes staff)
3. Meetings with School Based Clinic Team and Community Based Clinic Team have occurred
4. Inviting PCP's to an educational/informational breakfast meeting.
5. Contacting the Director of Monmouth County Board of Health

HOW ARE WE GETTING THERE?

THROUGH PARTNERSHIP AND COMMUNICATION

STEP # 3 Quantify when possible the efforts each partner has made to improve pediatric asthma care in their particular setting or identify quantifiable & evidenced based interventions, that can be implemented in their setting and result in improved outcomes. Develop rapid cycle quality improvement pilots for each of these initiatives.

Examples to date:

1. Inpatient nursing staff has identified their teach back asthma education program - increase the rates of execution and documentation.
2. Inpatient medical staff has identified increasing rates of documenting proper classification of asthma diagnosis by residents and attending physicians.
3. Pediatric ED has identified updating discharge instructions.

HOW ARE WE GETTING THERE? *THROUGH PARTNERSHIP AND COMMUNICATION*

STEP # 4 K. Hovnanian Children's Hospital Asthma Program will be utilized as a pediatric asthma management resource, by all the stakeholders identified.

Support will be provided to *patients/family* through:

- ❖ Comprehensive assessment in all settings including the home
- ❖ Family/patient education
- ❖ Concrete assistance with implementing interventions improved control including help with medication, housing ,medication, navigation of the health care system

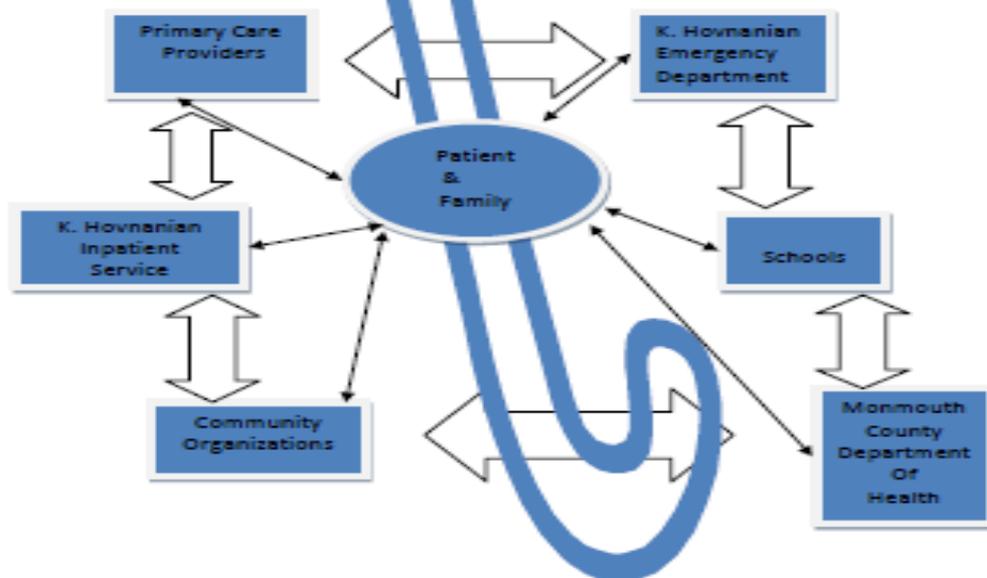
HOW ARE WE GETTING THERE? *THROUGH PARTNERSHIP AND COMMUNICATION*

Support for providers:

- ❖ Provider education on evidence base practice and compliance with State and Federal guidelines
- ❖ Communication regarding patients hospital encounters
- ❖ Providing social support services for there pediatric asthma patients

KHOVNIANIAN CHILDREN'S HOSPITAL
PEDIATRIC ASTHMA PROJECT

"Improving outcomes through education and partnership"



The program will ensure communication between all providers and patients/families

HOW ARE WE GETTING THERE?

THROUGH PARTNERSHIP AND COMMUNICATION

What's been learned?

1. Like the patients we serve each project partner/setting has different needs and priorities.
2. Each partner/setting is wary of over commitment to a new project.
3. Each partner/setting identifies site specific problems when caring for patient/families with asthma
4. Each partner/setting has different educational needs. Needs may vary within a particular setting.
5. Each partner recognizes the need for a coordination of pediatric asthma care in order to improve outcomes.
6. A project with such a large scope needs to be broken into smaller projects.
7. Team members and partners must be engaged at a level that see as relevant to their individual practice.

Successes

- ❖ New key team member has started
- ❖ Education needs within our own institution have been identified and QI projects are beginning to be developed
- ❖ Awareness of the project has increased throughout K.Hovnanian Children's Hospital
- ❖ Re-engagement of our community partners has begun
- ❖ Identification of types of support partners feel they need to assist in comprehensive care.

What are the challenges?

Administrative:

1. Delayed project approval
2. Not having key personnel on board.
3. Integrating new personnel into the team
4. Delayed attribution model
5. Multiple documentation methods across our institution
6. Multiple documentation methods across settings
7. Establishing effective lines of communication among team members and partners

What are the challenges?

Development:

1. Efficient utilization of team members time – everyone is busy and often wears many hats
2. Engaging outside providers to participate and implement evidence base changes in their practice –what's in it for them
3. Helping providers identify all factors that determine patient family compliance
4. Developing trust between program providers and community