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Patient Centered Medical Home (PCMH)
Asthma Learning Collaborative

Background:

In February 2013, Family Care Associates was selected to participate in the Patient Centered Medical Home-Asthma Learning Collaborative. This national initiative is authorized and funded by the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant awarded jointly to the Illinois Department of Healthcare and Family Services (IHFS) and the Florida Agency for Health Care Administration (AHCA). The Collaborative began in May 2014 and will conclude in February 2015.

The goal of the collaborative, as well as our own, is to improve health outcomes for children with asthma, emphasize and support the family's central role in care, and coordinate care with community resources.

Collaboration

In Illinois, Family Care collaborates with 15 other child-serving practices working towards PCMH recognition and who have identified asthma as an "important condition." By participating in the collaborative, we have direct access to resources, education, and one-on-one expert advice to improve care by focusing on proactive, planned care; the foundation of the Patient-Centered Medical Home.

To keep each practice engaged and accountable, we submit monthly status reports and convene via conference call to discuss results as a group. Additionally, weekend conferences are offered periodically as a chance to meet with each other face-to-face, share our individual experiences, and learn from a panel of experts.

Quality Improvements at Family Care:

Since the beginning of the collaborative, Family Care has made many positive changes to provide better care to our asthmatic patients. Some of these include:

- **Identifying our asthmatic patients and applying an alert to their chart within our Electronic Medical Record**. This valuable tool immediately alerts the staff member answering the phone that the patient has asthma. Often times, a call to the office with a "cough" can be the first sign of an asthma exacerbation. Our goal by doing this is to make sure the patient is evaluated before their symptoms become too severe.
- **Asthma Control Tests**. We now provide each patient/parent over the age of 5 years with an Asthma Control Test that is filled out at each visit, regardless of the reason for the visit. This informs the provider of how well or not-well controlled the patient's asthma symptoms are. Medications can then be adjusted early to prevent a potential exacerbation.
- **Asthma Action Plans**. In addition to the Asthma Control Test, each patient is also given an Asthma Action Plan. We have found this to be a very helpful tool for our parents. It separates the patient's symptoms into three zones, green (well-controlled), yellow (somewhat symptomatic, but manageable), red (need to be seen immediately). For the older children, this has given them some autonomy by allowing them to manage their own asthma symptoms.

We are confident in the changes we've implemented and are already seeing improvements in how asthma is managed in the office and at home.

Current Outcomes:

As part of our participation in the Collaborative, each month we review, or audit, medical charts related to our asthma visits to ensure compliance with the goals, or objectives, we've set. These are:

1. Patient being reviewed has an established asthma diagnosis.
2. Patient had his or her severity, risk, and control (**Asthma Control Test**) assessed at last visit.
3. Patient had his or her **Asthma Action Plan** composed, reviewed, or adjusted, as necessary, at the last asthma-related visit.
4. The **Asthma Action Plan** was reviewed and a copy offered to the patient.

5. Patient received anticipatory guidance to obtain an influenza immunization (during the flu season).
6. Patient's most recent acute (sick) visit was scheduled with his or her primary care provider.
7. Identify whether the patient was seen in the Emergency Department for asthma or respiratory related symptoms during the review period
8. Of the patients identified in #7, how many were seen and/or given a follow-up appointment at Family Care within one week of discharge.

RESULTS TO DATE:

After eight months of chart review, we have seen an **overall increase of 68.8%** in Goals 1-6. Emergency Department visits have **decreased by 2%** and ED follow-up visits continue to be scheduled as necessary based on symptom control.

Looking Ahead:

As we continue to develop into a PCMH-model clinic, our focus on asthma education and self-management skills will continue to evolve. Based on the early success we've experienced, we fully expect improved outcomes for those with asthma and hope to translate these successes into improved outcomes for patients with other chronic conditions as well.