Building Effective Partnerships in Asthma Care, What are Your Targets?

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Asthma Ready® Communities
asthmaready.org
Disclosure

• Dr. Francisco has intellectual property rights and a financial interest in IMPACT Asthma Kids© (Curators of the University of Missouri)

• Dr. Francisco will not discuss experimental or off-label use of medications or devices

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2016
Objectives

1) Describe the process of forming active partnerships to accomplish desired change
2) Identify various types of partners that help accomplish asthma improvement goals
3) Cite examples of unexpected benefits of engaging asthma partners
Partnerships are essential.

We don’t have to like all our partners, but we must respect them & realize we need them.
We don’t work together on the same projects anymore.

We do respect each other and share the common cause of supporting children who are struggling with asthma – we are mission-level partners.
Why we need and respect partners

- Inspire, motivate (agitate) and guide us
- Bring creative solutions, new workforces
- Money to innovate, network, be accountable
- Technological capacity to change work flow
Partners as High Performing Teams
Money is the Honey

• Worker bees are focused on the money
• Fiscal accountability drives innovation
• In-kind contributions mean skin-in-the-game
• Business models are critical
Sparks and Flames

• Grants are sparks
• Partnerships are the tender (fuel)
• Policy and practice change are the flames
• Without sustaining revenue the fire dies
People & relationships win the day

- Engagement in small projects builds capacity
- People move around, “cross lines”, roles/agencies
- Friendships and respect translate into power
- Power is not a dirty word, powerless IS
- We seek to emPOWER people who have asthma
- **The story of Steve** (Peggy, Tammy, Sherri, Paul... )
From Problem to Practice Change

Practice → Problem → Policy → Partner → Power → Practice
Steve’s Story

• Respected local pharmacist/friend
• Reluctant “Asthma educator”, POS Rx
• Asthma Encounter Management Application
• House Bill 1188, change of pharmacy practice
• Medicaid Pharmacy Director
• Asthma formulary change crisis
Resonating with Change Themes

• Better care, better health, lower cost mandate
• Population health, clinical plus public health
• Value-based reimbursement, claims data analysis
• Learning collaboratives, best practices, MOC
• Shared decision-making, data integration
• Standardized, effective asthma care & education
Are you ready for population health?

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<tr>
<td>Collects family, social, and behavioral history</td>
<td>Identifies the roles of behavior, social determinants or health, and genetics as factors in health promotion and disease prevention</td>
<td>Explains the basis of health promotion and disease prevention recommendations to patients with the goal of shared decision making</td>
<td>Tracks and monitors disease prevention and health promotion for the practice population</td>
<td>Integrates practice and community data to improve population health</td>
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<td>Demonstrates awareness of recommendations for health maintenance and screening guidelines developed by various organizations</td>
<td>Incorporates disease prevention and health promotion into practice</td>
<td>Describes risks, benefits, costs, and alternatives related to health promotion and disease prevention activities</td>
<td>Integrates disease prevention and health promotion seamlessly in the ongoing care of all patients</td>
<td>Partners with the community to improve population health</td>
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<tr>
<td>Recombines recommendations for health maintenance and screening guidelines developed by various organizations</td>
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<td>Mobilizes team members and links patients with community resources to achieve health promotion and disease prevention goals</td>
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Changing Landscape of Medical Training

- Integrates practice and community data to improve population health
- Partners with the community to improve population health
LOCAL STRATEGY EXAMPLE

Framework for Community-based Approaches to Improving Asthma Care for Children
- Simple, to-the-point, one-page summary
- Sets goals and interventions for integrating efforts in five areas: schools, home environment assessments, primary care providers, hospitals/emergency rooms, and child care

KEY CONCEPTS
1. Demonstrate success at local level
   - Kennett Public Schools (Dunklin County)
   - Springfield (Greene County)
2. Experience, testimonials and data drive expansion of successful ideas
3. Identify statewide policy change opportunities through community-based work (e.g., spacers)
4. Statewide workforce development produces system-level change (e.g., LPHA staff, school nurses)
5. Cultivate local leadership
Population Level Improvement

• Fewer asthma acute care days (ACD)
• More appropriate care (OP and preventive)
• Fewer systemic/oral steroids (SOS)
• Fewer short-acting beta agonists refills (SABA)
• Better inhaled corticosteroid adherence (ICS)
  – It doesn’t have to be perfect to have an effect
ICS Use and Risk of Death

Rate Ratio for Death from Asthma

Low-Dose ICS and the Prevention of Death from Asthma in Canada

Number of Canisters of ICS per Year

Clinical Asthma Improvement

• Improving self-care behaviors (ICS use, technique)
• Decreasing environmental triggers (ETS)
• Better ICS adherence, decreasing need for SOS
• Well controlled co-morbid conditions (AR, GERD)
• Better lung function (FEV1, FEV1/FVC)
• Less asthma-related impairment (ACT, TRACK)
Insurer Asthma Improvement

- ????
- Is cost the only factor
- No, but plan must be at least cost neutral
## Total Cost Children with Asthma

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Table : Average Medicaid Costs Per Asthma Children (less than 19 years old)
Can Asthma Improvement Impact “all of the above”?

• Better care
• Better health
• Lower costs
Asthma Trained School Nurses Serving Students with Uncontrolled Asthma

- Identified at risk students (guided judgement)
- Delivered 3 standardized “check-ups”
- ICS adherence improved
- Inhalation technique improved
- FEV1% predicted increased (83 to 95)
- Impairment decreased (AAP-CHSA-C)
- MC cost fell by 30% ($1400), ROI – 8:1
What are some “accelerators” for asthma improvement?

- Network of champions/partners (ECHO)
- Insurer policy reform (CMS, Mo HealthNet)
- Learning communities (ECHO®)
- Monitoring risk and impairment through data sharing – claims, community & person
- Standardized, effective self-care education
Evidence for Practice Improvement

- Academic detailing (EPR3 guidelines)
- Local learning collaboratives
- Performance feedback (panel reports)
- Practice facilitation ("embedded" mentors)

THE TRANSFORMATIVE MODEL IN MEDICAL EDUCATION AND CARE DELIVERY

Project ECHO® (Extension for Community Healthcare Outcomes) helps democratize medical knowledge and develops specialty care capacity in underserved communities.

Using a revolutionary model of telementoring, collaborative medical education and care management, Project ECHO empowers front-line primary care professionals to provide the right care, in the right place, at the right time.

https://www.youtube.com/watch?v=VAMaHP-tEwk

“One to Many” – Leveraging a proven model to significantly increase access to specialty care for common complex conditions

Hubs & Spokes - ECHO provides front-line providers with the knowledge and support they need to care for complicated patients they would otherwise refer out. ECHO links expert specialist teams at an academic ‘hub’ with primary care providers in local communities – the ‘spokes’ of the model.

Together, they participate in weekly teleECHO™ clinics, which are like virtual grand rounds, combining patient case presentations with didactic learning and mentoring.
WHY ECHO?

THE UNSERERVED PATIENTS

PROBLEM:
Underserved patients have limited access to quality specialist care for common complex conditions.

SOLUTION:
A model that expands access to care by leveraging telementoring and guided practice to build system capacity by empowering primary care providers to care for complex conditions at their local clinic.

In 2003:
Only 5% of New Mexicans infected with hepatitis C were able to access treatment.

In 2015:
80% of New Mexicans infected with hepatitis C have access to the right treatment, at the right time, at the right place.
WHY ECHO?

THE PROVIDER

PROBLEM:
- Want to advance their skills, career and professional relationships.
- Lack access to knowledge and training to provide specialty care for their patients.
- Providers often feel socially and professionally isolated.

SOLUTION:
- Providers engage in a community with like-minded fellow providers and specialists from academic centers.
- Develop specialized knowledge.
- Provide specialty care for common complex conditions.
- Receive free CME/CE credits.

In New Mexico:
More than 76k free CME/CE credits issued.


Providers participating in ECHO in New Mexico: felt their professional isolation diminish, professional satisfaction and self-efficacy for treating hepatitis C increase.
WHY ECHO?

THE FQHCs

PROBLEM:
• Limited ability to provide specialty care for common complex conditions.
• Difficulties recruiting and retaining community providers.

SOLUTION:
Primary care providers acquire new skills and competencies, expanding access to care. They become part of a community of learners, increasing their professional satisfaction while their feelings of professional isolation decrease.

Through ECHO, FQHCs have a way to expand access to care for complex chronic conditions and serve more patients, while keeping treatment dollars in the community. They also acquire a new tool for recruiting and retaining providers.

A provider in an FQHC in California saw an increase of 38 new HCV patients in one year as a result of participating in ECHO.
ECHO connects providers with specialists through ongoing, interactive, telementoring sessions.

ECHO creates ongoing knowledge networks by linking primary care providers at numerous locations with a team of expert inter-disciplinary specialists, to mentor them to treat their patient cases. These specialist teams use low-cost, multi-point videoconferencing technology to conduct weekly teleECHO clinics with community providers. Specialists serve as mentors, training community providers to provide care in clinical areas that previously were outside their expertise.
The Missouri Experience

- MD/legislator visited ECHO Albuquerque
- Sponsored a bill for 6 ECHO hubs: asthma, chronic pain, autism, dermatology, hepatitis C, and endocrinology (See Gwen Ratterman)
- Funded ($1.5 M) by projected savings from the Medicaid transportation budget (2015)
Treatment of chronic, common, and complex diseases, program authorized, purpose.

191.1140. 1. Subject to appropriations, the University of Missouri shall manage the "Show-Me Extension for Community Health Care Outcomes (ECHO) Program". The department of health and senior services shall collaborate with the University of Missouri in utilizing the program to expand the capacity to safely and effectively treat chronic, common, and complex diseases in rural and underserved areas of the state and to monitor outcomes of such treatment.

2. The program is designed to utilize current telehealth technology to disseminate knowledge of best practices for the treatment of chronic, common, and complex diseases from a multidisciplinary team of medical experts to local primary care providers who will deliver the treatment protocol to patients, which will alleviate the need of many patients to travel to see specialists and will allow patients to receive treatment more quickly.

3. The program shall utilize local community health care workers with knowledge of local social determinants as a force multiplier to obtain better patient compliance and improved health outcomes.
Key Purposes

• Safely & effectively treat common & complex conditions in rural & underserved areas
• Decrease treatment delays and the need for patients to travel to see specialists
• Utilize community health care workers to address social determinants, improve adherence and health outcomes
**SHOW-ME ECHO**

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**IMPACT ASTHMA ECHO**

**HELP KIDS BREATHE EASIER WITH EXPERT ASTHMA COLLABORATION**

Get expert support for your asthma patients in a virtual learning network with asthma specialists from across the state.

- Learn about best practices for diagnosing and managing asthma.
- Identifying environmental risks.
- Stepwise pharmacotherapy.
- Asthma self-management.

**INTERDISCIPLINARY PANEL INCLUDES PEDIATRICS, ALLERGY, ENVIRONMENTAL ASSESSMENT, NURSING AND ASTHMA EDUCATION SPECIALISTS**

**WHAT DOES IMPACT ASTHMA ECHO OFFER?**

- Free CME for health care professionals.
- Collaboration, support, and ongoing learning with experts and peers.
- Patients get better care in home community.

**HOW DOES IT WORK?**

- Join an online lunch hour video conference.
- Discuss and share:
  - Clinical case presentations.
  - A brief educational presentation by an expert in asthma.

*See website for CME information*

**READY TO JOIN?**

Visit showmeecho.com

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**WHY IMPACT ASTHMA ECHO?**

Asthma is a major cause of morbidity and disability among children, with 29,086 emergency room (ER) visits and 6,526 hospitalizations across Missouri in 2013 (asthma as principal diagnosis), resulting in $383,2 million in hospital charges. More than 80 percent of preschoolers and nearly 49 percent of school-age children with asthma missed one or more days of day care or school because of asthma. Connecting with the Impact Asthma ECHO team supports better quality care, lower asthma risk and reduced health care costs.

**TOPICS FOR CASE-BASED LEARNING AND DISCUSSION INCLUDE:**

- Applying EPR3 guidelines.
- Asthma risk panel reports.
- Measuring and interpreting airflow.
- Assessing and improving inhalation technique.
- Using validated impairment.
- Assessing and managing environmental triggers.
- Engaging community partners.
- Reimbursable preventive services.
- Environmental assessments.
- Managing asthma exacerbations.
- Assessing “exercise-induced asthma.”

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**MEET OUR TEAM**

- **Sam Fazio**, MD, MPH, AS-C, Associate Professor Pulmonary Medicine and Allergy, University of Missouri.
- **Berea Dodson**, MD, Pediatrician, University of Missouri.
- **Kelli Smith**, MD, Assistant Professor, Pulmonary Medicine and Allergy, University of Missouri.
- **Lyle Brinkman**, MD, Professor, Environmental Sciences, Missouri State University.
- **Paul Foreman**, PhD, Project Director, Asthma, Quality Communities.
- **Eric Arntzen**, PhD, Lead Director, Missouri Asthma Prevention and Control Program.
- **Melissa Pottlitz**, CNE, RN, FNP-C, Clinical Assistant Professor, Nursing, Missouri State University.
- **John Servoss**, MD, Pediatric Pulmonologist, St. Louis Children's Hospital.

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**TO LEARN MORE:**

Missouri Telehealth Network (877) 982-9933
showmeecho@health.missouri.edu
drj@health.missouri.edu

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Missouri Telehealth Network
University of Missouri Health
Challenges

1) Recruiting new practices, providers
2) Technology, video aversion
3) PCP selection of cases to present
4) Having time to abstract the case
5) Carving 90 minutes out of any day
6) >500,000 Missourians w/asthma, need to engage hundreds of clinics
Impact Asthma Show-Me ECHO
- Case Presentation Form -

Presenting Provider Name: Lance Robbins, DO
Clinic/Facility Name & City: University of Missouri Pediatric and Adolescent Specialty Clinic, Columbia, MO
Provider Phone Number: (573) 875-9000
Provider Fax Number:

ECHO ID: COM2016
Date of Submission: 02/03/2016

Presentation type: Follow Up
Biological Gender: Male
Patient Age: 15mo

Insurance Type: Medicare
Insurance Company: Missouri Care

Race: Hispanic/Latino
Ethnicity: Not Hispanic/Latino

Other:

When we receive your case, we will email you with a confidential patient ID number (ECHO ID) that must be utilized when identifying your patient during clinic.

Please Note: Project ECHO Case consultations do not create or otherwise establish a provider-patient relationship between any UMHC clinician and any patient whose case is being presented in a Project ECHO setting. The information in this email message is privileged and confidential. It is intended only for the use of the recipient at the location above. If you have received this in error, any dissemination, distribution or copying of this communication is strictly prohibited. If you receive this message in error, please notify the clinic coordinator, Candace Garle at (573) 884-5847.

Impact Asthma Show-Me ECHO
— Case Presentation Template —

PLEASE NOTE that Show-Me ECHO case consultations do not create or otherwise establish a provider-patient relationship between any UMHC clinician and any patient whose case is being presented in a Show-Me ECHO setting.

Data Sources Used: Clinical [ ] CyberAccess/Pharmacy [ ] School [ ] Other [ ]

I chose this case because
Illustrates a common pattern of medication use in asthma among toddlers with uncontrolled asthma - excess antibiotics and SABA with underuse of ICS.

Chief Complaint:
Persistently cough - follow up moderate persistent asthma, chronic rhinitis, GERD
Mother reports no asthma exacerbations since last visit (4mo prior). Reports using Flonase 110mcg 2PD, rare missed doses and using Albuterol/oralpidium 80mg regardless of symptoms. Feels overall that his asthma is well controlled/stable except when he returned from father's house with cough/clear rhinorrhea. Does have cough most days of the week and nocturnal cough which is treated with at-risk medication. No other medication prescribed.

Family History:
Mother - asthma, allergic rhinitis
Father - allergic rhinitis

Please list other medical, behavioral, social, or special problems:
Parents separated - mom reports concerns with cleanliness/handwashing at father's house, unsure of what treatment patient receives at father's house, does not know if he has a copy of asthma action plan. Father has patient approximately 50% of the time.

In the past 12 months, about how many days of school were missed? None
In the past 12 months, about how many days of school were missed due to asthma or breathing problems? None

Is there an asthma action plan at school? No [ ] Yes [ ]

Revised 10/2016
New Opportunities Afforded by ECHO®

1) Accelerate adoption of innovations
2) Communicate MC policy changes (Asthma HH, Community PAS)
3) Convene special asthma work groups
4) Workforce training: CHWs, care managers, AE-Cs, environ. Assessors
5) Support multispecialty MOC (2017)
Introduce/Integrate New Data Sources

1) Insurer (MC) administrative claims
2) Data from community assessments
3) EHR and clinic data, care patterns
4) Person, family, home (eHealth apps)
Will the “Accelerator” Work?

- Will providers from high risk communities participate in ECHO®?
- Will providers and community health care workers gain confidence and implement asthma best practices?
- Can we document asthma improvement through claims analysis (ACD, SOS, SABA, ICS, $)?
Target Asthma Disparities with ECHO®


Legend
- ECHO Participants Jan-Feb 2016
- ECHO Participants Sep-Oct 2015
- Location of ECHO HUB

Program Type
- CALM2
- Planning

Panel Report Year
- 1
- 2

Asthma ER Rates
- Suppressed
- 0.1-4.0
- 4.1-10.1
- 10.2-18.4
- 18.5-38.4
- ECHO HUB

Sources: DHSS Missouri Information for Community Assessment (MICA), Missouri/Asthma Prevention and Control Program, and Asthma Ready Communities, University of Missouri
Notes: **ECHO A2 Participants**
**Seeds** = Black Dots are Actual Location of Participants
**Session 2 = Red Dots are Grouped Around Actual Locations**
Perception & Practice Gap

• Most providers believe they are doing a reasonably good job with asthma (self-efficacy) – grade of “B”
• When asked about specific EPR3-compliant practices, very few are “routine” (My Steps) – grade of “D”
• Lacking: clinical measures of lung function, formal assessment of impairment, verification of adherence, assessment of inhalation, AAP, documentation of severity, control & responsiveness
Peds Asthma Self-Efficacy Survey

Please complete the survey below.

Thank you!

Show-Me Asthma ECHO: Please rate your knowledge, skills or competencies TODAY:

1 = none or no skill  
2 = vague knowledge, skills or competence  
3 = slight knowledge, skills or competence  
4 = average among my peers  
5 = competent  
6 = very competent  
7 = expert, teach others

I rate my ability to:

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<td>1)</td>
<td>Diagnose asthma by severity (intermittent, mild persistent, moderate persistent or severe persistent)</td>
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<td>2)</td>
<td>Use objective measures of airflow to assess lung function impairment, response to treatment and level of control (well controlled, not well controlled or very poorly controlled)</td>
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</table>
The goal of this asthma care quick reference guide is to help clinicians provide quality care to people who have asthma.
Participants Select 1 or 2 Action Steps

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**My Action Steps for Improving Asthma Care**

*Asthma Ready® Clinics*

Please select two (2) of the following items as your “high priority actions” for the next 100 days. Mark your choices with a check. As part of our training, follow-up, and evaluation, our team will be contacting you a few times to ask about progress. Your responses are vital to our efforts to provide high quality training that is responsive to the needs of health care teams dedicated to high quality asthma care.

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**High Quality Medical Care**

1. **Assess Severity Initial Visit.** Assess and document asthma severity at initial visit and update severity when well controlled based on lowest therapy step required (intermittent or mild, moderate or severe persistent)

2. **Assess Asthma Control Always.** Assess and document asthma control at every visit (well controlled, not well controlled, or very poorly controlled)

3. **FEV1.** Assess, interpret and document FEV1 for all patients age 5 and older at each visit

4. **Spirometry.** Order and evaluate spirometry every 1-2 years for all patients 6 years and older (FVC, FEV1, and FEF25-75), determine lung growth pattern and evidence for lung function impairment

5. **Inhalation Technique.** Assess adequacy of inhalation technique for ICS and LABA inhalers (MDI and DPI, if using). Document inspiratory flow rate and time before and after coaching.
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(All calculations are for the preceding 12 months)

Sample FQHC

March 2014 - February 2015

N = randomized listing number
DCN = Medicaid number
ACD = Acute Care Days = ED visits + inpatient days
ED = # times in emergency room
SOS = Systemic or Oral Steroid = # times steroids taken
SABA = # of inhalers obtained Short-acting Beta Agonist
ICS = #/12 as a % of expected refills

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<tbody>
<tr>
<td>ACD</td>
<td>≤ 1</td>
<td>2 to 3</td>
</tr>
<tr>
<td>ED</td>
<td>≤ 1</td>
<td>2 to 3</td>
</tr>
<tr>
<td>SOS</td>
<td>≤ 1</td>
<td>2 to 3</td>
</tr>
<tr>
<td>SABA</td>
<td>0 to 4</td>
<td>5 to 7</td>
</tr>
<tr>
<td>ICS</td>
<td>&gt; 80%</td>
<td>80% to 40%</td>
</tr>
</tbody>
</table>

Total:
498 140 358 108 595 20%
## Asthma Risk Panel Report

<table>
<thead>
<tr>
<th>Mean</th>
<th>ACD rate</th>
<th>SOS rate</th>
<th>ICS rate</th>
<th>SABA rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.1</td>
<td>0.5</td>
<td>2.4</td>
<td>2.5</td>
</tr>
</tbody>
</table>

**Risk Profile (Zero equals No Risk)**

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOS/ICS ratio</td>
<td>0.19</td>
</tr>
<tr>
<td>ACD/ICS ratio</td>
<td>0.90</td>
</tr>
<tr>
<td>SABA/ICS ratio</td>
<td>1.07</td>
</tr>
</tbody>
</table>

Benjamin Francisco, PhD, PNP, AE-C
Asthma Ready®, University of Missouri
Asthma Risk Panel Report Analysis

• Sample analysis – Medical vs Dental patients
• FQHC (521 children w/asthma) only 145 had clinical visits for asthma (1st or 2nd diagnosis)
• FQHC – 376 children w/asthma received dental services, but had no clinical visits for asthma
• Behavioral health – similar problem, some children with uncontrolled asthma are only receiving BH services
The ARPR Spreadsheet

- Sort [Dental<19] by asthma acute care days
- Find all (27) with >1 day in ED or hospital
- Look at the number of **SOS**, **SABA** and **ICS** prescriptions, outpatient asthma visits
- Compare these children to those receiving asthma care in the clinic
Community Care

“Asthma Check-up App”

Community Health Care Workers
(school nurse, CHW, home visitor, educators)
Asthma Check-Up Application
“Spirometry Light”

- After standardized training school nurses and clinic staff received an electronic flow meter capable of selecting best FEV1 and PEF after a series of 3 or more efforts.
- Prescribers also received a more costly meter capable of measuring FEV1/FVC ratio and calculating % predicted FVC.
In-Check Dial™ Device

- Only device currently marketed in the US
- Set resistance for common inhaler types
- Use disposable, one-way mouth piece, surface wipe
- Train for optimal IFR and IFT
- Coach to a “target” IFT
- Formula for MDI IFT = 2 seconds/L x (FEV1 in L) = target inhalation time
  (Example: 2 seconds/L X 3.5 L = 7 seconds)
Community Care
"Asthma Check-up App"
(school nurse, CHW, home visitor, educators)

OSEDA
MO HealthNet Claims Repository

S.H.A.R.E
Daily Alerts
Patient Profiles
Panel Reports

MPCA DRVSS
Care Manager Alerts
Daily Visit Summary
Asthma Registry

Health Center
Timely care
Population management
Quality improvement
Reimbursement Opportunities

• Childhood Asthma As a Qualifying Condition for Health Home (July 1, CMS approval)
• Preventive Asthma Services (August 1, Proposed Rules, Missouri Register)
• SB 579 – School as an Originating Site for Telemedicine
Education for self-care based on Real Need, Right Service, Reasonable Cost...

<table>
<thead>
<tr>
<th>Message Type</th>
<th>Eligible Group</th>
<th>CPT/Service Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Asthma Literacy</td>
<td>Everyone w/asthma</td>
<td>S9441/Low</td>
</tr>
<tr>
<td>2) Key Messages</td>
<td>Everyone w/asthma</td>
<td>Bundled w/OP visit</td>
</tr>
<tr>
<td>3) Inhal. instruction</td>
<td>Everyone w/asthma</td>
<td>94664/low</td>
</tr>
<tr>
<td>4) PMC, risk reduction</td>
<td>Not well controlled</td>
<td>99402,1/low</td>
</tr>
<tr>
<td>5) Rx Therapy Manag.</td>
<td>Claims alerts – POD</td>
<td>99605/low</td>
</tr>
<tr>
<td>6) Self-management</td>
<td>Very poorly controlled</td>
<td>98960/moderate</td>
</tr>
<tr>
<td>7) Home Trigger Red.</td>
<td>VPC, step 5, good IHT</td>
<td>T1028/moderate</td>
</tr>
<tr>
<td>8) Coach/counselor</td>
<td>VPC, VH$, refractory</td>
<td>Health Home/high</td>
</tr>
</tbody>
</table>

Stratified= intensity (cost) of care is appropriate for burden of disease (not just the $ spent on health care)

Asthma Ready® Communities 2016
Childhood Asthma As a Sole Qualifying Condition for Health Home (HH)

• What will the “monthly touches” entail?
• Can we use standardized, effective approaches
• Will HH costs be offset by cost reductions?
  – Total Rx cost - Acute care burden
• Will referrals for preventive asthma services and special family care be integral?
Child Asthma Risk Assessment Tool
Google “AHRQ and CARAT”

Risk Factors

Medical Risk
Environmental
Smoking
Adherence
Responsibility
Child Behavior
Adult Well Being
Attitudes
Allergies

Risk Scores

0 1 2 3 4 5 6 7 8 9 10

04 April 2011
CHAMPS INTRODUCTION

You are here: Asthma Community Network Home » Tools » CHAMPS Introduction

Community Healthcare for Asthma Management and Prevention of Symptoms (CHAMPS) is a family-centered, patient-tailored, evidence-based, pediatric asthma intervention. The CHAMPS intervention combines asthma counseling and in-home mitigation of environmental triggers for children with poorly-controlled or moderate-to-severe asthma in primary care settings.

The CHAMPS intervention began as a research study conducted in three Federally-Qualified Health Centers to assess whether evidence-based interventions for asthma could be successfully replicated in the health center setting. The CHAMPS intervention demonstrated marked improvement in the control of patient’s asthma; an increase in patient and caregiver’s awareness and understanding of asthma; and, a reduction in asthma-related visits to urgent care and emergency departments.
AN ACT

To repeal sections 192.020, 192.667, 208.670, 334.108, and 335.175, RSMo, and to enact in lieu thereof twelve new sections relating to health care, with existing penalty provisions.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Sections 192.020, 192.667, 208.670, 334.108, and 335.175, RSMo, are repealed and twelve new sections enacted in lieu thereof, to be known
Partner Schools as an Originating Site for Telehealth – Data Argument

• Facilitated, billable visits for children at school
• Logical pairing with preventive asthma services and health home touches
• HB 1188 – “Asthma Rescue Medications for Life-threatening Asthma”
• 875 kids w/uncontrolled asthma in one district
Partners for Asthma QI

• Enroll providers for ECHO Asthma Essentials (4)
• Identify your asthma champions, enroll in ECHO Asthma Centers of Excellence (bi-monthly)
• Identify your care team, enroll in “Becoming an Asthma Educator and Care Manager” and ECHO Asthma Care and Education (8 annually)
• Request your quarterly Asthma Risk Panel Report
Becoming an Asthma Educator & Care Manager

- November 3, 2016 – Jefferson City (FQHC)
- November 7, 2016 – Springfield (FQHC)
- November 16, 2016 – St. Louis (FQHC)
- November 21, 2016 – Kansas City (FQHC)
- July 17, 2017 – KC, MO Community Action Network
- July 24, 2017 - StL, MO Community Action Network
Asthma Ready Communities

Asthma Ready® Communities (ARC) is an overarching endeavor to provide standardized, evidence-based educational programs for children with asthma, families and health professionals. These programs enhance the readiness of health care professionals and facilities to provide cost-efficient care that is compliant with the Guidelines for the Diagnosis and Management of Asthma: Expert Panel Report 3. For parents and caregivers, these programs provide comprehensive steps to improve asthma control in infants and children. For facilities, Asthma Ready® is a designation indicating that the facility has participated in asthma training, has the resources and is committed to delivering appropriate services, maintaining communication standards, and conducting quality improvement efforts to ensure best practices for the care of children with asthma. Asthma Ready® is a registered federal trademark owned by the University of Missouri.

The ARC team is located in the division of Pulmonary Medicine & Allergy, Department of Child Health, University of Missouri (MU), School of Medicine. Dr. Francisco and the clinical staff are members of University Physicians practice group, providing specialty care at MU Women’s and Children Hospital, Pediatric Specialty Clinic. Other staff represents disciplines ranging from social health science to epidemiology. The central office is located in Columbia, MO 65212.
Thank you to our funders and partners!
Thank you!

- Peggy Gaddy, Coordinator
  Missouri Asthma Prevention and Control Program
- Paul Garbe, Director
  CDC National Asthma Control Program
- Terry Plain, Program Officer,
  Missouri Foundation for Health
- Graciela Couchonnal, Program Officer, Health Care
  Foundation of Greater Kansas City
- MPCA (Susan & Angela), Dr. Stinson and Dr. Ross
Thank you!

Visit: http://echo.unm.edu