Domain 3*: Clinical Improvement Projects*
Project ID*: 3.d.ii*
Project Title*: Expansion of asthma home-based self-management program*

Objective:

Implement an asthma self-management program including home environmental trigger reduction, self-monitoring, medication use, and medical follow-up to reduce avoidable ED and hospital care.

Description:

Despite best efforts of practitioners to implement evidence based practices, patients continue to have difficulty controlling their symptoms. The goal of this project is to develop home-based services to address asthma exacerbation factors. Special focus will be emphasized on children, where asthma is a major driver of avoidable hospital use.

Target Patient Population:

Adult and pediatric patients with an asthma diagnosis. The patient population will include adults and children with newly diagnosed or preexisting asthma, with a special emphasis on children and patients who have had either three or more PCP visits or an ED visit or hospital discharge with asthma as the primary diagnosis in the past year.

Actively Engaged Patients for DSRIP Reporting Purposes:

The number of participating patients who completed a new or updated comprehensive care management plan.

Providers Expected to Participate:

Primary care physicians, non-PCP practitioners, clinics, health homes / care management organizations, pharmacies, community based organizations, and others.

Project Milestones
Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.
Establish procedures to provide, coordinate, or link the client to resources for evidence based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.
Develop and implement evidence-based asthma management guidelines.
Implement training and asthma self- management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.
Ensure coordinated care for asthma patients includes social services and support.
Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.
Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.
Use EHRs or other technical platforms to track all patients engaged in this project.