

ASTHMA AND COPD PROGRAM FOR PRIMARY CARE WITH CARE MANAGEMENT SUPPORT

Objectives:

By implementing EBM into your practice will promote consistency of treatment and optimal outcomes, helps establish national standards of patient care, and sets criteria to measure and reward performance-based medical practice.

Enhance care coordination and communication among clinical partners and community based organization that results in holistic approach to patient care.

Method: Practices will institute a QI team that support the GINA Guidelines for Asthma and GOLD Guidelines for COPD. Implement a standardized approach pre visit planning and at the patient point of contact.

Benefits to participating partners:

1. Improve patient experience
2. Improve the health of Asthma and COPD population
3. Reducing cost of health care
4. Improving provider satisfaction
5. Address Social Determinants of health barriers affecting patient outcomes
6. Decrease avoidable ED and Inpatient admissions
7. Increase impact of quality measures associated with Asthma and COPD

Asthma/COPD program requirements:

1. Participation in readiness assessment
 - a. Identify practice strengths and weakness and develop a plan for program implementation

Implementation Plan Month 1 and 2

1. Identify QI team participants and their role
2. Begin discussion for workflows related to utilizing Population Health Service-Care Management team
3. Development of Asthma/COPD Registries Gaps in Care (GIC)
 - a. Spirometry

- b. Pneumo vaccination
- c. Influenza vaccination
- d. Smoking and intervention
- e. Population segmentation H-M-L

4. ADT are in place
5. Begin to address Gaps in Care from patient registry
 - a. Establish workflows for working collaboratively with Population Health Services-Care
 - b. Management team (providing support for both practice and patients)
6. Monthly submission of patient registry (Name, DOB, CIN #) along with key process measures
7. Monthly meeting with MCC and QI team to review elements of program process, performance and outcomes measures

Implementation Plan Month 3 and 4

1. Continue to manage Asthma/COPD Registries GIC
2. Continue utilization of Population Health Service-Care Management -modify work flows as needed
3. Implement validated Asthma and COPD patient screening tools for:
 - a. Social Determinates of Health
 - b. Medication Adherence Tool
 - c. Symptom Assessment tool
4. Submission of monthly patient registries and key process measures
5. Participate in additional education opportunities offered by MCC
6. Monthly meeting with MCC and QI team to review elements of program process, performance and outcomes measures

Implementation Plan Month 5 and 6

1. Continue to manage Asthma/COPD Registries GIC
2. Continue to utilize Asthma patient validated screening tools
3. Continue utilizing Population Health Service-Care Management
4. Implement Post-Acute Exacerbation workflow(transitions of care)
 - a. Address screening and assessment findings
 - b. Medication reconciliation
 - c. Correct Medications
 - d. Teach Back
 - e. Initiation of Asthma/COPD Care Plans
 - f. Schedule case conference for high utilizers of ED and Inpatient admissions
5. Submission of patient registries along with key process measures
6. Monthly meeting with MCC and QI team to review elements of program process, performance and outcomes measures

Steps for participation in this project:

1. Agreement to participate in Asthma/COPD program
2. Submit QI team member roster to MCC
3. Agree to the program requirements.
4. If desirable, agreement to use the Population Health Services -Care Management services

Millennium will provide:

1. Education opportunities for your practice and patients
2. Care Management and additional support services are offered both onsite and/or remotely from Millennium's Population Health Service Team:

Additional Support Services:

- a. **SDOH support:** Assist the practice and patients in identifying gaps in care for the Social Determinants of Health and strength connection and linkage to resources and community based organizations.
- b. **Pharmacist support:** Assisting with medication questions, medication reconciliation, prescription cost savings, evidenced based therapeutic guideline recommendations,

medication adherence and education of your disease state .

- c. **Healthcare Coach:** Wellness coaching to promote a healthy lifestyle. Assist your patients with complex or chronic needs with behavioral and lifestyle changes
- d. **Intensive Care Management Service:** A direct patient care service, designed to enhance care coordination efforts. Providing patients with an evidence-based, home visiting-care management service connecting and linkage patients to needed resources and community services. A 2-3month opportunity to support patients in overcoming barriers that impact their health, support self-management skills and learning for the purpose of returning patients back to PCP.

Inclusion criteria for Intensive Care Management:

- Active Medicaid 18 years or older
 - 2 or more potentially avoidable ED visits in 6 months
 - 1 or more avoidable acute admissions in 6 months
 - COPD and /or Asthma diagnosis
 - No PCP visit in 12 months
3. Copies of guideline driven assessment tools and patient action plans
 4. Mentoring, coaching and addressing barriers identified within the practice

Partner Activities: Each partner will address the following components.

1. Ensure initial and ongoing education is provided to your practice team. i.e. Spirometry, medical skill (teach back)
2. Ensure pre-visit planning process is in place
3. Ensure timely access to spirometer
4. Incorporate patient specific care plans
5. Develop and implement work flows to address gap in care from registries
6. Develop and implement work flow for transitions of care from inpatient or ED.
7. Implement assessment tools as outlined in program deliverables
8. Implement workflows to support onsite or remote MCC population services

- a. Provide space for services to be offered onsite
 - b. Allow access to EMR
 - c. Assist with consent process
 - d. Refer patients
9. Establish key clinical and community based organization partners to support your Medical-N