Illinois CHIPRA Patient-Centered Medical Home

Asthma Learning Collaborative

Final Report

February 2016

ILLINOIS CHIPRA Quality Demonstration Project
Improving Child Health and Medical Homes for Illinois AllKids

ILLINOIS DEPARTMENT OF Healthcare and Family Services

Contents

Executive Summary

In 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) was signed into law. The law required the Center for Medicare and Medicaid Services (CMS) to award grants to states to experiment with and evaluate promising ideas for improving the quality of children's health care under Medicaid and the Children's Health Care Insurance Program (CHIP). Illinois, in partnership with Florida, was awarded one of ten grants. The CHIPRA Quality Demonstration Grant contains five categories of work: A) quality measurement, B) health information exchange/technology, C) enhancing provider-based models to improve primary care, D) pediatric electronic health record, and E) creating a model targeting health care delivery, coordination, quality or access. Illinois participated in four of the five categories – Illinois did not participate in Category D, testing the pediatric electronic health record. Illinois' focus for Category E was to improve birth outcomes.

To enhance provider-based models to improve primary care under Category C, Illinois implemented a number of activities to promote primary care transformation through adoption of patient-centered medical home (PCMH) concepts. One activity was a PCMH Learning Collaborative with a clinical focus on asthma. Fifteen practices across the State of Illinois participated in a 10-month medical home Learning Collaborative from May 2014 through February 2015. The practices were diverse in setting, size, patient population, organizational structure, use of health information technology, and level of patient-centered medical homeness.

The stated goal of the collaborative was: To assess the effectiveness of systems of care and implement tools, strategies and measures designed to improve medical homeness, including enhancing access to care; providing family-centered care; providing and documenting planned, proactive, comprehensive care; and coordination care across all settings. The collaborative included both pediatric and family practices. Focusing on asthma allowed practices to improve asthma care using PCMH concepts; building and spreading those concepts to create an infrastructure for sustainability. The rationale was to integrate PCMH concepts into practices specific to their pediatric patients with a diagnosis of asthma, and then spread them to other chronic conditions and patient populations, including adults.

Practices signed a Memorandum of Understanding committing to actively participate through the following activities during the course of the Learning Collaborative:

- Form a core team consisting of at least 3 practice members; engage a parent partner on the core team
- Complete the Medical Home Index (MHI) as a team pre- and post-participation
- Attend three 1.5 –day learning sessions (team members and parent partner)
- Participate in site visits and conference calls with assigned practice facilitator
- Participate in monthly data sharing webinars
- Learn the *Model for Improvement* and test and implement Plan-Do-Study-Act (PDSA) cycles
- Champion transformation within the practice
- Submit requested data and reports in a timely manner
- Share lessons learned and problem-solve with other participating practices
- Spread lessons learned and best practices within practice/system
- Use the Illinois Health Information Exchange (ILHIE) Direct Secure Messaging product to coordinate patient care
- Use the Statewide Provider Database (SPD) to locate and make patient referrals for community and social services

Practices received resources and support for their transformation work, including a change packet, a SharePoint website, experts in PCMH, asthma care, quality improvement (QI), and patient/family engagement, assigned

facilitator/coach, data analysis and run charts, monthly data sharing calls, three on-site learning sessions, a 15-month subscription to ILHIE Direct, access to the SPD, and opportunities to collaborate with and learn from other practices.

All teams were asked to provide monthly data reports, via Survey Monkey, for clinical process measures for asthma patients and practice implementation of core concepts of a medical home. Practice teams completed the Medical Home Index three times during the collaborative. On average, the overall scores improved for all measurable indicators. There were six clinical measures reported during the collaborative. The collaborative achieved goal for 17% of the clinical indicators and achieved a positive percentage change of at least 50% for 83% of indicators from April 2014-January 2015. Practice teams reported on 20 medical home indicators and achieved goal for 40% of those. A positive percentage change greater than 50% was achieved for 60% of the medical home indicators during the measurement period. Practice teams were asked monthly to rank the change in workload as a result of the collaborative; the mode response was 3, no change. This indicates that although practices took on additional work related to transformation, they did not perceive an increased workload. This may be due to increased efficiencies resulting from transformation. For example, incorporating team huddles was initially seen as increasing workload, and practices shared that setting aside a few minutes each day to plan for asthma patients actually improved productivity and care provided. The MHI scores showed improvement from level 2 (reactive) to level 3 (proactive) from pre-assessment to post-assessment.

Practice teams experienced major successes during the collaborative. Practice teams created significant changes within their practices, as well as at the community and state levels. Many practice teams worked with their local school districts to further compliance with Illinois Public Act 92-0402, a law allowing students to care and self-administer rescue (quick-acting) asthma medications. As a result of increased provider awareness of this law, outreach and education was provided to the Illinois High School Association (IHSA), a statewide organization out of compliance with the law, and as of fall 2015 their policy is now in compliance.

Over the course of the collaborative many practices mentioned provider and/or leadership buy-in was an obstacle to transformation. While some practices initially resisted facilitation assistance, by the end of the collaborative all the practice teams saw the added value in having individual facilitators to motivate, find creative solutions, and coach them in transformation. Several practices struggled early on to understand how data is used in quality improvement and questioned the need for reporting of monthly indicators. Electronic Medical Records (EMR) provided many challenges for practice teams. Issues related to functionality, education/training, and lack of technical support, resulted in manual workarounds and practices not utilizing their EMRs for transformation. This collaborative demonstrated with appropriate support and resources practices can transform. The collaborative also demonstrated that strengthening a practice's medical homeness and using evidence-based practices correlates with improved quality of care for asthma patients.

About the Project

In 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) was signed into law. The law required the Centers for Medicare and Medicaid Services (CMS) to award grants to states to experiment with and evaluate promising ideas for improving the quality of children's health care under Medicaid and the Children's Health Insurance Program (CHIP). Ten five-year grants (2010-2015) were awarded, involving 18 states. Illinois received one of the grants in partnership with Florida. Late in 2014, CMS offered grantee states the opportunity to extend the grant for up to one year. The majority of grantees took advantage of the opportunity to continue and finalize various projects, and Illinois received a one-year extension through February 2016.

The CHIPRA Quality Demonstration Grant contains five categories: A) quality measurement, B) health information exchange/technology (HIE/HIT), C) enhancing provider-based models to improve primary care, D) pediatric electronic health record, and E) creating a model targeting health care delivery, coordination, quality or access. Illinois participated in four of the five categories – Illinois did not participate in Category D, testing the pediatric electronic health record. Illinois' focus for Category E was to improve birth outcomes. In Category C, Illinois partnered with Illinois Chapter of American Academy of Pediatrics (ICAAP), Health Management Associates (HMA), and others to implement a number of activities to promote practice adoption of patient-centered medical home (PCMH) concepts. One of these activities was the PCMH-Asthma Learning Collaborative, the topic of this report.

Health Management Associates (HMA) and the Illinois Department of Healthcare and Family Services (HFS) convened the PCMH-Asthma Collaborative. Twenty practices initially agreed to participate; five practices subsequently withdrew from participating, citing time and resource commitments, prior to the start of the learning collaborative. Fifteen practices from across the state attended the kick-off webinar in April 2014, with all practices remaining engaged through the last learning session, in February 2015.

A unique feature to this collaborative is the clinical focus of asthma. Utilizing a chronic condition to focus on medical home transformation allowed practices to improve asthma care using evidence-based practices and tools and work on medical home transformation simultaneously. Focusing on asthma allowed practices to integrate evidence-based care and best practices in their pediatric population for a specific condition and to spread those concepts to other chronic conditions, and other patient populations, including adults for family practice sites.

Collaborative Participants

Fifteen primary care practices participated in the PCMH-Asthma Learning Collaborative. One organization enrolled five clinic sites, including a school-based health clinic.

The collaborative's practices were diverse in setting, size, patient populations, organizational structure, and staffing. The table below summarizes the characteristics of the practices.

Summary of Clinic Participant Characteristics

Practice Setting			
Rural	Suburban	Urban, not inner city	Urban, inner city
2	4	2	7

Number of Providers in Practice		
5 or fewer	6-20	21+
2	8	5

Total Number of Patients at Practice Sites		
Total Patients Served	Children (0-21 years) Served	Pediatric asthma patients (5-18 years) served
175,144*	136,537*	12,313

Number of Practices Sorted by Percentage of Medicaid Patients			
0-25% of Total Patients	26-50% of Total Patients	51-75% of Total Patients	76-100% of Total Patients
1 Practice	8 Practices	3 Practices	3 Practices

Types of Organization (duplicated count as practice may fit under more than one type)							
Academic Practice	Family Medicine	Federally Qualified Health Center	Hospital-Based Primary Care Practice	Hospital-Based Residency Clinic	Pediatric Practice	Rural Health Center	School- Based Health Clinic
2	7	4	1	2	5	1	1

Number of Providers and Ancillary Clinical Professionals by Credential at Enrolled Practices																					
Physician		**Nurse Practitioner**		**Nursing Staff**		**Physician Assistant**		**Medical Assistant**		**Care Coordinator**		**Social Worker**		**Mental Health Provider**		**Case Manager**		**Clinical Pharmacist**		**Healthy Steps Specialist**	
FT	PT	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT
46	57	8	6	42	13	5	6	66	1	2	3	3	1	1	3	0	2	1	0	1	0

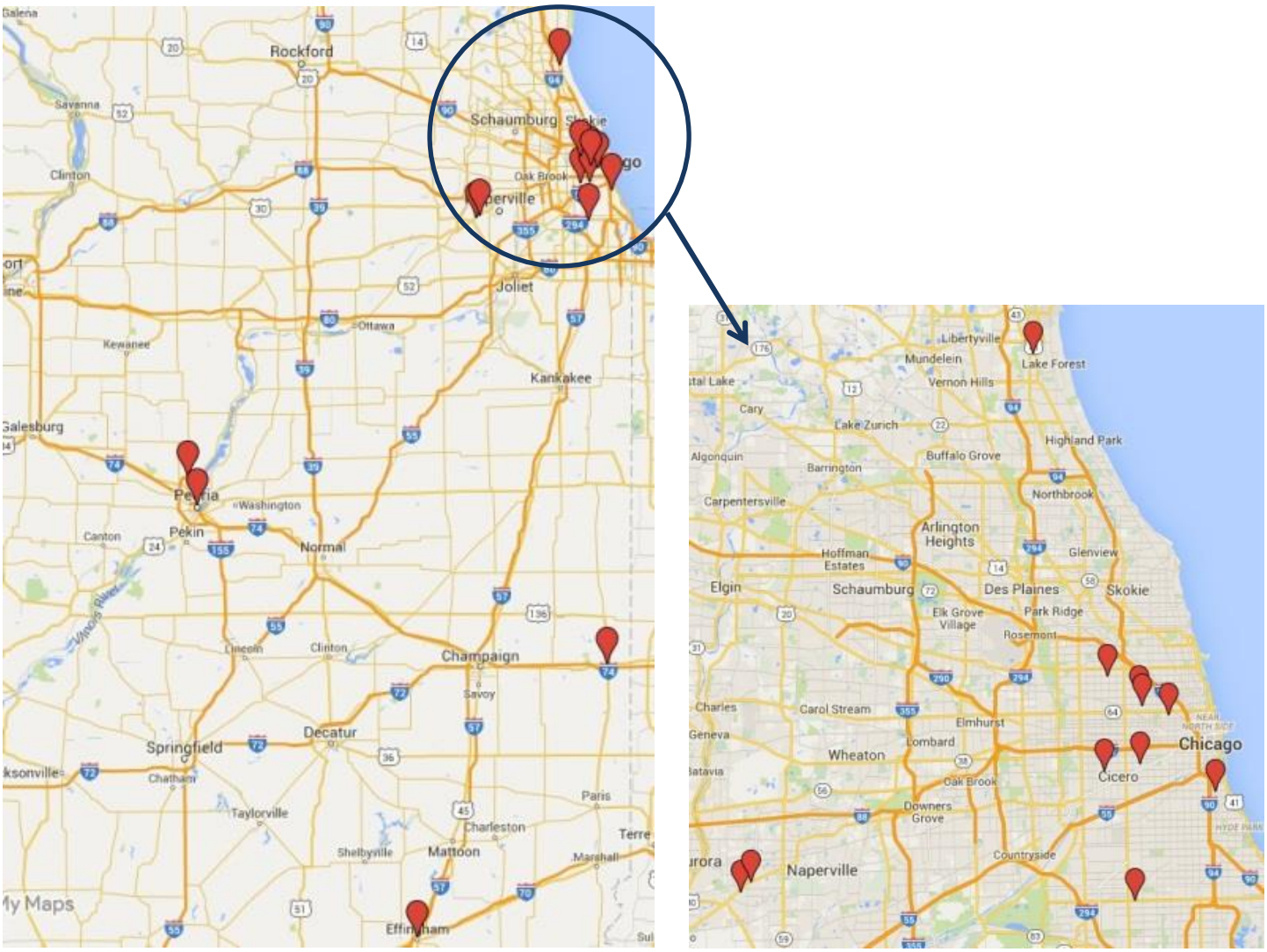
*Data unavailable from one practice site

Table 1: Summary of Clinical Participant Characteristics

Each practice team consisted minimally of three members, including a lead physician; the remaining members could be clinical or administrative staff. One team was led by a pharmacist rather than a physician. Teams were highly encouraged to include a parent partner on the team, and by the end of the collaborative six practices were able to engage a parent partner. Teams ranged in size from three to nine, with most teams having four members.

In order to be eligible for selection, practice teams had to accept patients enrolled in the Medicaid or CHIP program. Further selection included diversity of geographic location, practice settings (urban, rural, suburban), practice size, and type of organization (e.g., private practice, FQHC, hospital outpatient departments).

The map below shows the location of the participant practices.



Collaborative Governance

Expert Advisory Group

The Expert Advisory Group was formed to oversee the design and implementation of the PCMH-Asthma Learning Collaborative, including providing input into the curriculum and identifying speakers, tools, and resources. The membership evolved as the need for specific expertise changed. The Expert Advisory Group consisted of representatives from pediatric primary care practices, the Chicago Asthma Consortium, the Chicago Health IT Regional Extension Center, a PCMH/QI expert, a parent partner and asthma advocate, an asthma expert, and the medical director from the Illinois Department of Healthcare and Family Services. The group has expertise in quality improvement, medical home, asthma care, evaluation, IT, and working with diverse healthcare settings and practices. The full advisory group met four times over the course of three months. A subgroup of the Expert Advisory Workgroup met once over that timeframe, to develop the evaluation framework and identify measures and develop the data collection plan.

Leadership Group

The PCMH-Asthma Leadership Group was responsible for the planning and implementation of the collaborative and met on a regular basis during the course of the collaborative. The leadership group constructed themes and agendas for the

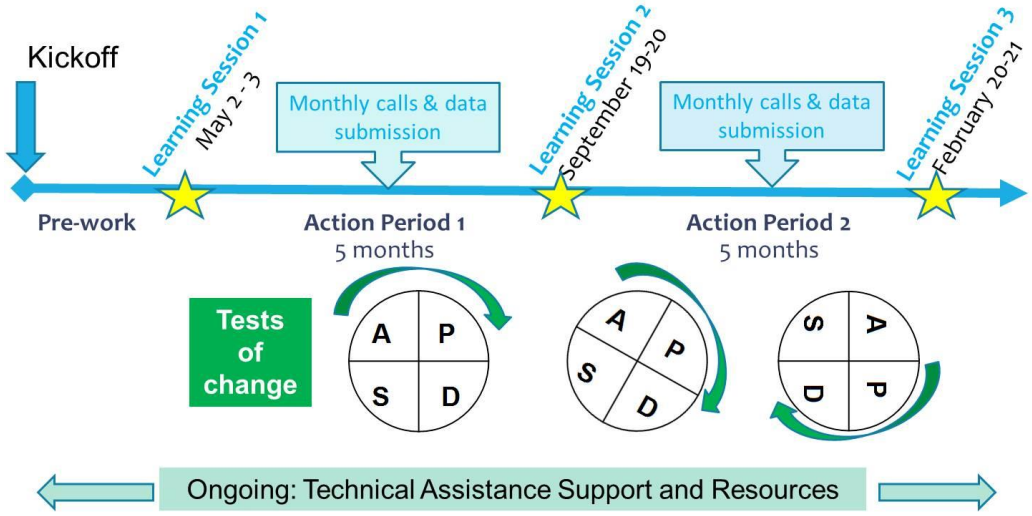
learning sessions which were reviewed and approved by the Expert Workgroup. Additionally, the PCMH-Asthma Leadership Group generated topics and speakers for the monthly data calls and provided support to the facilitation team.

Collaborative Structure

Curriculum

The curriculum highlighted medical home concepts through the provision of evidence-based and best practices around pediatric asthma care. Highlights include:

- The Expert Advisory Group was convened to advise curriculum development and identify speakers, tools, and resources. The Expert Advisory Group allowed the collaborative to offer Continuing Medical Education (CME) credits to participating eligible clinicians.
- Focus on both clinical and operational improvements. Topics and speakers were selected with focus on evidence-based clinical practices (e.g. immunologist perspective of care) as well as process and operational improvements making care more patient- and family-centered (e.g., appointment access, patient experience, partnering with the community, engagement of parents).
- Focus on the parent and patient perspective. The collaborative's Parent Expert provided a parent and advocacy perspective, which is prominently featured in medical home, to pediatric asthma care. The Parent Expert, a state and national asthma advocate, has two children with severe asthma and has successfully advocated for changes in laws to support children with asthma. The Parent Expert developed content for the collaborative to engage practices' parent partners, as well as educated providers regarding the experience of care, including barriers and challenges.
- Focus on use of health information technology to support clinical care and medical home concepts. In addition to facilitating discussion regarding how practices EHRs can support asthma care and medical home (e.g. registry function), the collaborative encouraged the integration and use of two state resources:
    - Illinois Health Information Exchange Direct (ILHIE Direct). ILHIE Direct is a direct secure messaging (DSM) platform that can be used by providers to securely transmit health information between providers, especially those that do not have EHRs. The collaborative promoted its use between participating practices and schools and/or specialists that do not otherwise have data exchange capabilities.
    - Illinois Statewide Provider Database (IL SPD). The IL SPD is a resource developed and maintained by the Illinois Department of Children and Family Services (DCFS) in partnership with Northwestern University, mapping medical and social support resources by zip code across the state. The collaborative focused on its use as a tool to support the care coordination for patients.



Learning Sessions

Over the course of the collaborative, the practice teams, leadership group, and facilitators gathered three times for one and a half day (5/2-3/14, 9/19-20/14, and 2/20-21/15) learning sessions in Naperville, Illinois. The CHIPRA Quality Demonstration Grant covered meals, lodging, and travel expenses for all participants. In addition, Parent Partners were given a $100 Visa gift card stipend. No other financial incentives were offered to participants. Upon completion of each learning session, continuing education units (CEUs) and continuing medical education (CME) credits were available, however, maintenance of certification (MOC) credit was not provided for this learning collaborative. Following the completion of the collaborative one physician separately submitted an application and received MOC credits, stating her involvement in this QI project benefited her patients more than other projects she had participated in that were approved for MOC.

Each learning session had a unique theme. Learning Session One introduced the basic concepts and components of PCMH, Learning Session Two focused on the clinical care of asthma, and Learning Session Three focused on sustainability. During these learning sessions, teams learned about concepts and evidence-based practices in asthma care and medical home transformation, and shared lessons learned from their own quality improvement efforts.

At the conclusion of each learning session all practice team participants were asked to complete an evaluation. All three learning sessions yielded positive results and provided insight on how to improve. One of the lessons learned related to the presentation topics; clinical participants were extremely interested in the clinical presentations and felt administration staff could break-off for the QI related presentations. While it is easy to understand the desire to listen to presentations appealing to one's personal interests, it is important for the transformation process for all team members to understand and participate in QI to assure sustainability, post Learning Collaborative. Participants also requested more time for Q & A and group activities during the learning sessions and based on this input the Leadership Group made adjustments to future learning sessions. Through the evaluations it was confirmed, participants valued the presentations from other practices, learning how they overcame obstacles, as well as celebrating in their successes.

Action Periods

Between the learning sessions, two five-month action periods took place providing the opportunity for practices to conduct QI/PDSA cycles. Both action periods involved a variety of small tests of change, some successful on the first attempt and others requiring a few times through the PDSA cycle.

During Action Period One, teams worked to transform their practices with the PCMH concepts of patient/family engagement and team-based care, while improving asthma care in the pediatric population. Many of the practices focused on identifying asthma patients using a registry, testing the use of evidence-based tools such as the Asthma Control Test and Asthma Action Plan, ensuring "asthma" was marked on the school physical form, engaging and communicating with schools, and transmitting the Asthma Action Plan to proper school personnel. Other activities included receiving regular notification of emergency department discharges and scheduling follow-up appointments with the patients. A major success through this action period was a private practice starting to work directly with the area pediatricians and the community school district (6,207 enrollment) to increase asthma education to parents and staff. These partnerships resulted in nebulizers in every school (11) in the district and establishing the "Asthma Task Force of Danville". The task force is a collaboration of local physicians, school administrators and nurses, and local emergency departments (ED) to improve the coordination between institutions to provide high quality of care for Danville's asthma population. In addition, the providers are regularly providing health education to parents and students through the school district's Parent University.

In Action Period Two, the focus shifted to spreading successful interventions and sustaining gains. Several of the practices began spreading their tests of change to other physicians in the practice. Some of these tests of change included incorporating a huddle into daily work flow, integrating the Asthma Control Test and Asthma Action Plan into workflow and the EMR. Hoping to increased provider buy-in and engagement, one team began sharing their monthly data reports with the entire practice, resulting in an increase of identified asthma patients throughout the practice.

Monthly Data Calls

Monthly data calls allowed for the teams to gather through a webinar, to share lessons learned and challenges faced. During the kickoff webinar, practices were polled to find the most convenient times. Two webinars were held monthly and practices were required to attend one of the two monthly sessions offered (8). One webinar each month was held at 8am and the other at 12pm, over the lunch hour. Having this flexibility resulted in most practices being available to participate each month. Monthly calls were not held during the months that learning sessions took place. Each one-hour webinar consisted of a 15-20 minute educational presentation with the remaining time spent on chart/data review, QI coaching, and sharing successes and challenges among the practices. The monthly data call education presentations covered various tools and resources available to the practices, asthma care and patient management, and topics on transforming into a patient centered medical home. The table below lists topics and presenters

Month	Topic	Presenter
March	Kick-off	PCMH Asthma Leadership Team
June	Engaging Parent Partners	Maureen Damitz, AE-C
July	Back to School with Asthma	Linda Follenweider, MS, CNP, PhDc, PCMH CCE
August	IHC Provider Portal and Quality Assurance Tools	Aliva Siddiqi, MD, FAAFP
October	Engage, Educate & Empower	Tonya Winders, President & CEO Allergy & Asthma Network
November	Patient Centered Care Collaboration (PCCC)-Health Empowerment & Lifestyle Program (HELP)	Tiana Kieso, M.B.Ch.B, MPH, PCCC Project Manager
December	Group Visit Tools and Tips	Linda Follenweider, MS, CNP, PhDc, PCMH CCE
January	Connecting your Medical Home to your Health Neighborhood	Michael Jampol MD, FAAP & Jeannine Warren

Resources and Support

Facilitation

Each team was assigned a practice facilitator, who did on-site visits and held monthly facilitation/coaching calls. Teams and the facilitator engaged in up to five site visits; monthly phone calls took place if a site visit did not occur. Facilitators provided knowledge and coaching on use of PDSA cycles and QI methods, PCMH transformation, and asthma care. Facilitators also met monthly via conference call with the PCMH-Asthma Leadership Group for updates on the practices, to share successes, and formulate strategies to overcome various practice obstacles.

Resources

Practice teams had a wide variety of resources available to them; some proved to be very useful, while others did not provide much value. The most valuable resources included a parent partner expert with a strong asthma advocacy background, a QI expert, and the grant partnership with the State of Florida. Not only did the parent partner expert provide information on how to engage and utilize parent partners in a PCMH setting, her advocacy and asthma knowledge spurred changes in individual practices, communities, and at the state level. The QI expert provided QI education at each learning session and led discussions during the data portion of the monthly data calls. Her involvement was key in engaging practices to share successes, lessons learned, and overcoming challenges; she also assisted the facilitators with QI. Illinois' CHIPRA partner, Florida, was finishing their PCMH collaborative as the Illinois collaborative was launching. Being able to directly communicate with Florida's leadership on lessons learned and adapt resources for development of the Illinois' collaborative proved beneficial. The QI Expert was also engaged in Florida's collaborative, bringing knowledge of Florida's successes and challenges to the Illinois practices, often citing the QI motto, "Steal shamelessly; share seamlessly." In addition, Florida faculty and practices participated in some monthly webinars to discuss their experiences and lessons learned, resulting in intra- and inter-state collaboration.

The collaborative was able to secure various tools (educational materials, inhalers, spacers, etc.) and make "swag bags" to hand out to each practice at Learning Session Two; practices were very appreciative of these resources, using them to improve patient education. The collaborative also provided a SharePoint website housing resources and tools for the practices. Team members could find sample Asthma Action Plans and Asthma Control Tests, asthma guidelines, patient engagement articles, the state asthma law, and much more. SharePoint was found to be a useful resource, with many practices incorporating a variety of these tools into patient care. In addition to providing resources for the practices, SharePoint was intended to facilitate sharing among the practices. While the practices made good use of the resources provided, they did not use SharePoint to post information/resources for sharing with other practices.

Practices did not see the value in some of the resources provided and, therefore, did not use them as envisioned. The Statewide Provider Database (SPD) was provided to facilitate identification and referral of patients to community and social service resources. SPD is an ever growing, comprehensive online database with information on service agencies and programs throughout Illinois. The SPD includes geomapping functionality and information that is not usually available, such as languages spoken, staff credentials and eligibility requirements. Almost 30% of the practices integrated SPD into their workflow, mainly accessing it for behavioral health services. A few practices cited they had case managers who maintained their own local resource list, as a reason for not using the service. Illinois Health Information Exchange Direct Messaging System (ILHIE Direct) is a nationally-certified, HIPAA compliant, encrypted messaging service, allowing patient care information to be exchanged across organizations with and without an Electronic Medical Record (EMR) system. The collaborative offered up to a 15 month paid subscription to all practices; five practices took advantage of this offer. However, by the end of the collaborative none of the practices had successfully incorporated it into their workflow. At Learning Session Two, a PDSA was developed to use ILHIE Direct to transmit Asthma Action Plans to school nurses, but practices opted to fax the plans rather than use the secure

messaging option. Some practices indicated secure email was available within their EMRs and for some of those practices, communication was limited to their respective network/health system with no capability to communicate with community partners. Some had direct secure messaging functionality reaching outside the practice/network and did not see a need for the service. Other practices declined to participate because they did not want to pick up the cost of the service after the collaborative. Still others were not able to obtain approval within their organizations to use the service, either because of administrative or legal hurdles. The practices that experimented with ILHIE Direct said it was too burdensome to use, since using ILHIE Direct required additional steps of leaving the EMR and opening a web browser, in order to send the email.

Evaluation and Results

The collaborative used three main sources of data to monitor progress and determine the effectiveness of the program. Sources of data include:

- Pre and post assessment using the Medical Home Index (MHI). Participants were asked to complete the MHI as part of pre-work (i.e. before the first learning session) and at the conclusion of the project to determine improvement in Medical Home-related functions.
- Monthly data reports. Participants were asked to submit monthly quantitative and qualitative data designed to measure the extent of improvement among practices. Aggregate data was shared and discussed monthly in group calls. Facilitators also highlighted best practices and challenges as reported by the practices for group discussion.
- Learning Session evaluations.

Medical Home Index

Practice teams completed the Medical Home Index (MHI) three times during the collaborative, once at the start of the collaborative and twice during Learning Session Three. The MHI is offered by the Center for Medical Home Improvement and is a validated self-assessment tool designed to translate broad defining medical home indicators into observable and measureable processes of care within a practice. It is based on the theory that medical home transformation is an evolutionary process, rather than fully realized status for most. Short and long versions of the assessment tool are available. The long version was used in the collaborative. Scores are based on a combined score of six domains, with 25 themes; points ranging from 1-8

Domains	
Organizational Capacity	Community Outreach
Chronic Condition Management	Data Management
Care Coordination	Quality Improvement

Level	Partial	Complete	Medical Homeness
1	1 point	2 points	Basic
2	3 points	4 points	Reactive
3	5 points	6 points	Proactive
4	7 points	8 points	Comprehensive

Practices were asked to complete the MHI as a team prior to the start of the collaborative as part of pre-work; however there was no way to assure this was completed as a team. During Learning Session Three the practice teams were asked to complete the MHI again. Incorporating the MHI into Learning Session Three accomplished two things -- provided an opportunity for completion as a team, and allowed all assessments to be gathered for immediate analysis and feedback at the learning session. In addition to completing the post-assessment, the practice teams were asked to complete a "retrospective pre-assessment." This retrospective assessment was an attempt to determine the difference in practice perceptions of where they started following their exposure to medical home principles in the learning

collaborative. The hypothesis was practices who complete a pre-assessment score themselves higher than they actually are because they may not fully understand medical home concepts/expectations. After learning more about medical home, practices realize they were not performing at the level they originally indicated. The retrospective assessment confirmed this hypothesis. The difference in the overall percent change between the pre- and post-assessment and the retrospective pre- and post-assessment was 29 percent compared to 46 percent. In the retrospective pre-assessment, practices scored themselves lower across every MHI domain. When looking at individual practices, only 4 of the 15 scored themselves slightly higher on the retrospective pre-assessment. After completing the retrospective pre-assessment and the post-assessment, the surveys were gathered, analyzed, and the results were presented to the practices the next day of the learning session.

The results are depicted on the charts below. Time period 1, pre-assessment completed in April 2014 is represented by T1. T1a represents the retrospective pre-assessment and T2 represents the post-assessment, both of which were completed in February 2015.

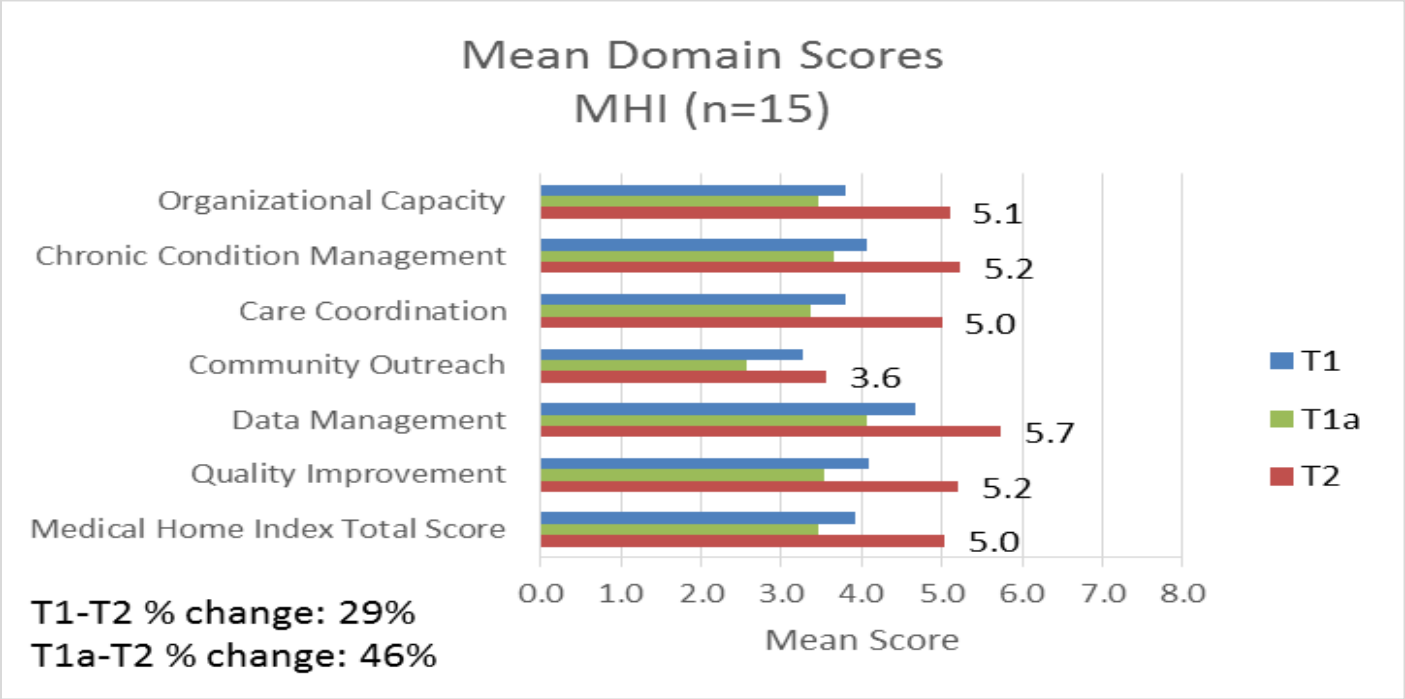


Figure 1: MHI Mean Domains Scores

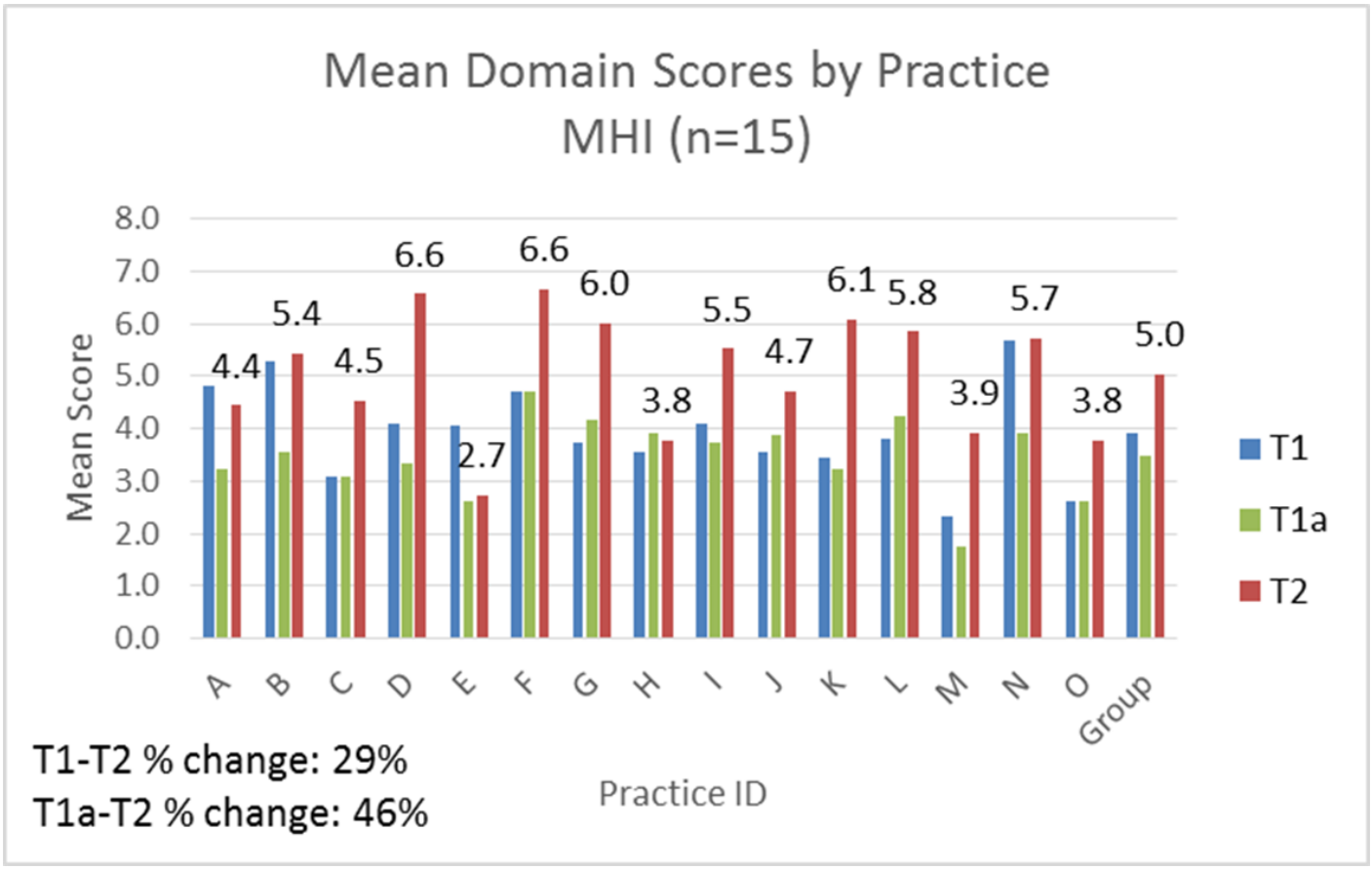


Figure 2: MHI Mean Domain Scores by Practice

Findings

During the collaborative, the overall average score of medical home indicators improved from a level 2 (reactive) to level 3 (proactive). At the end of the collaborative, the highest average score was in the data management domain (5.7) with the community outreach domain (3.6) being the lowest. All domains saw improvement over the course of the collaborative. Analyzing data for different time periods yields differing results.

- For T1-T2, pre-assessment (April 2014) to post-assessment (February 2015), the greatest improvement was in Domain 1, Organizational Capacity, with a percent change of 34%.
- For T1a-T2, retrospective pre-assessment (February 2015) to post-assessment (February 2015), the greatest improvement was in Domain 3, Care Coordination, with a percent change of 49%.
- When comparing T1 to T1a, all domains regressed with the T1a assessment, as a result of increased understanding of medical home concepts. Community Outreach, Domain 4, saw the greatest change between T1 and T1a. In T1, the average score was level 2 (reactive), but in the T1a assessment, the average was level 1 (basic).

Eight of the practice teams (53%) MHI scores saw a decrease from T1-T1a. Three showed no change and four showed slight increases. Two practice teams saw a drop from T1-T2, with both showing an increase from T1a-T2. One practice team saw no change from T1-T2, and had a decrease from T1-T1a. Further research is needed in this area; the findings helped the collaborative Leadership Group identify opportunities for improving the pre-assessment process in the future, such as:

- Review the assessment tool and definitions with the practices before the pre-assessment.

- Provide examples of how practices partially or fully meet each domain/theme so practices are better able to understand concepts and rate themselves.
- Use practice facilitators to guide the team's completion of the assessment tool.

Sustainability

During Learning Session Three's discussions of the MHI results and sustainability, the faculty asked the practices, if they would complete a six-month post MHI, which was not a requirement of their memorandum of understanding (MOU). Approximately six months after the collaborative (August 2015) practices were sent an email with a hard copy and survey link to complete the six-month post MHI. Practices could complete either version of the MHI and return via email, fax, or Survey Monkey. MHI surveys were collected through mid-December 2015, with 11 of the 15 (73%) practices reporting.

The six-month reassessment shows a slight improvement of medical homeness from the reporting practices. At the end of the learning collaborative (T2), practices' average score was 5.0, while the six-month post (T3) MHI score showed an increase to 5.2. Using the retroactive MHI (T1a) there was a percent change of 1% from collaborative conclusion (47%) to six-month post (48%). Although the MHI level (level 3, proactive) remained the same, the practices were able to continue and sustain their gains post collaborative.

The mean domain scores (Figure 3) of the 11 reporting practices show a slight decrease in Organization Capacity (Domain 1); all other domains stayed the same or slightly improved. Domain 1 saw the greatest improvement from T1 (Pre-collaborative)-T2. Data Management (Domain 5) saw the greatest improvement from T2-T3. One of the contributing factors could be increased familiarity with the EMR, as several practices received new EMRs right before or during the collaborative.

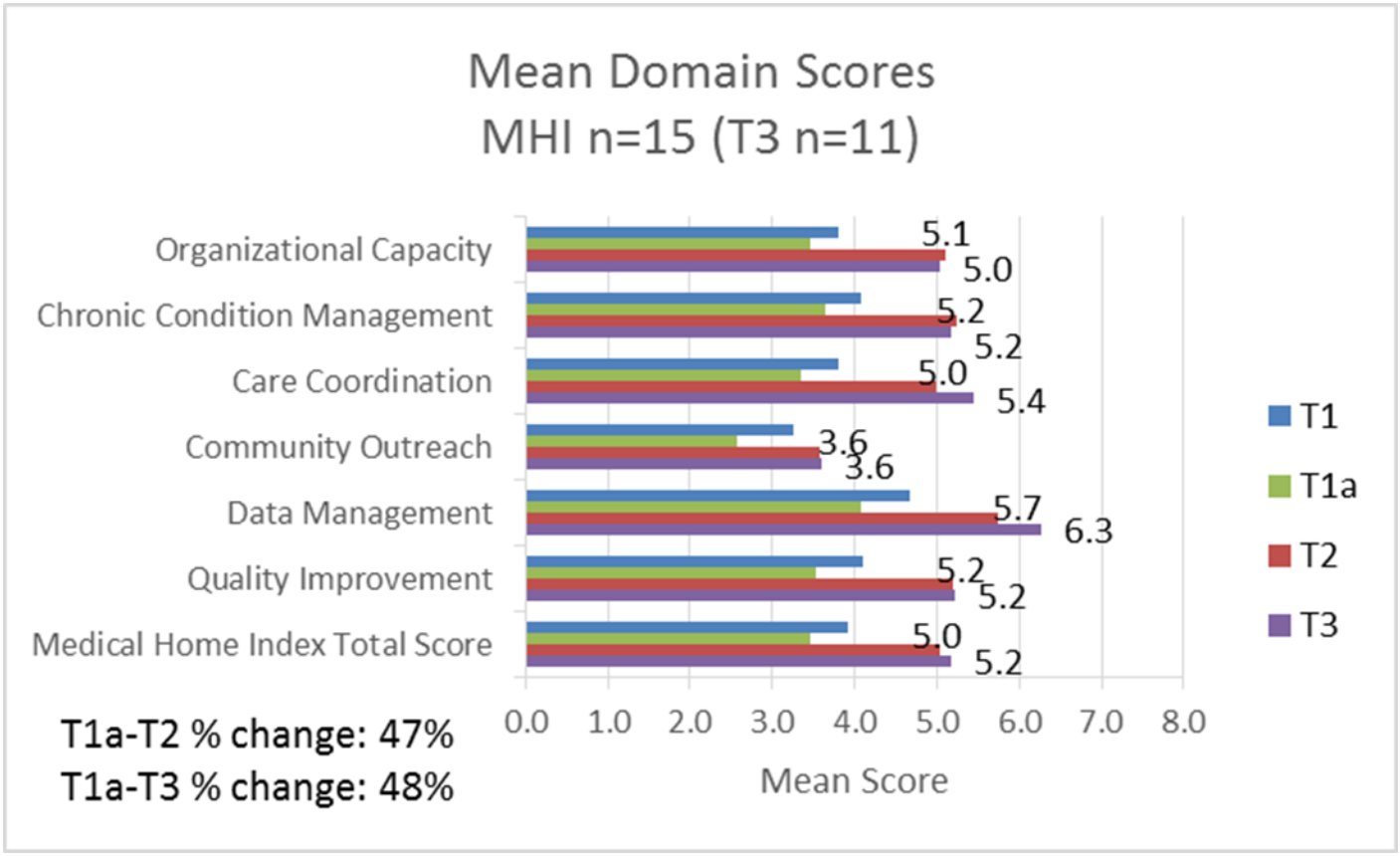


Figure 3: 6-month post MHI Mean Domain Scores

Figure 4 depicts the MHI scores of the 11 practices that submitted their six-month post MHI. Six of the practices saw an increase in their MHI score, four practices' scores decreased, and one remained the same.

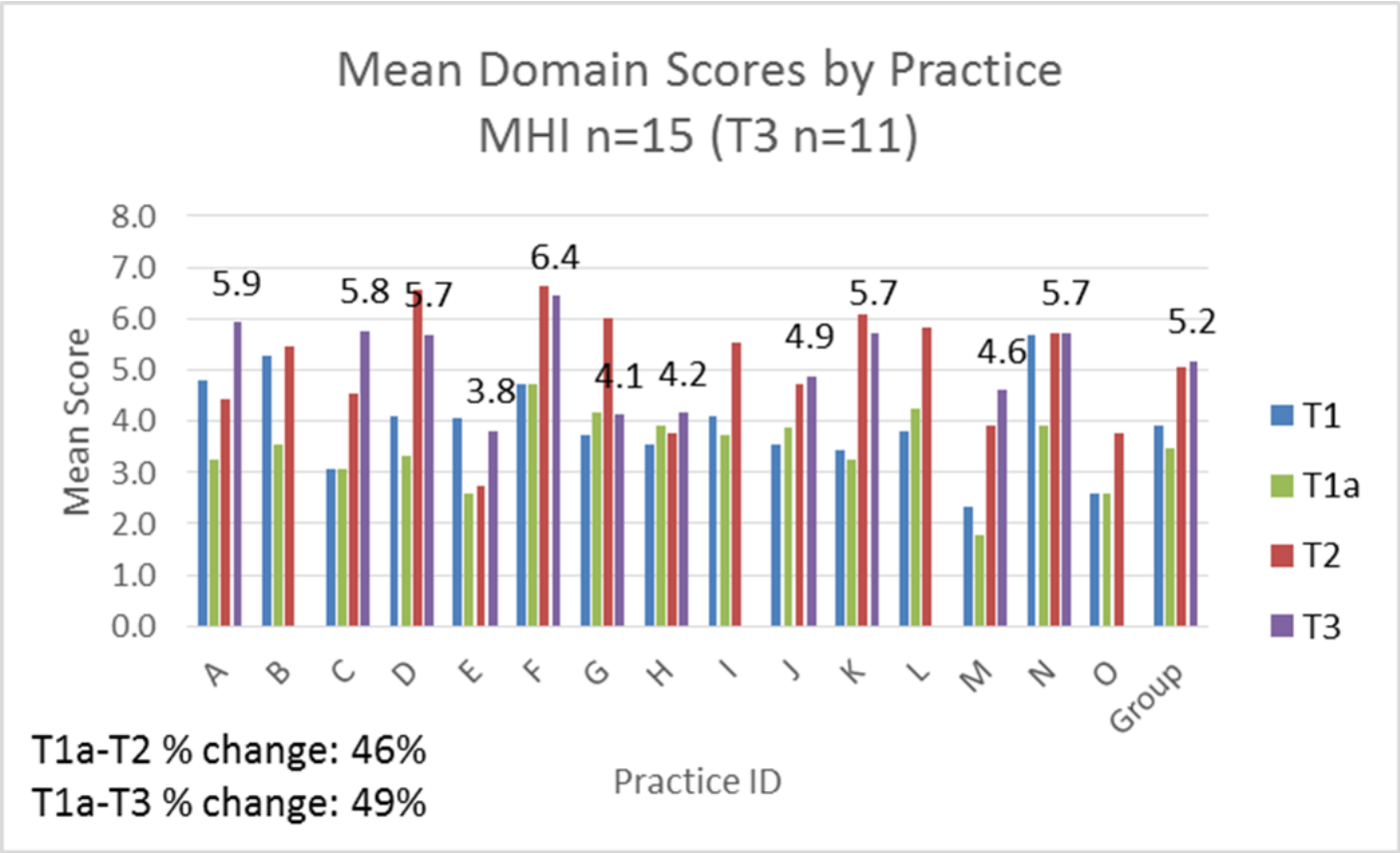


Figure 4: 6-month post MHI Mean Domain Scores by Practice

Monthly Data Reports

Practice teams were required to submit monthly (10) data (see Appendix D) via Survey Monkey. The report was broken into various sections including: clinic information, chart reviews, AIMS and tests of change, medical home policies, procedures and practices, and overall assessment and future topics. Teams were asked to review 10 charts each month (20 charts for baseline data); charts reviewed and reported were for patients aged 5-21 with an established asthma diagnosis. Asthma diagnosis was established through utilization of the National Heart, Lung, and Blood Institute (NHLBI) guidelines (EPR-3 2007).

Measures

Participating teams measured progress in clinical process measures for asthma patients and the degree to which clinics implemented core concepts of a medical home. Not all clinics contributed data to the combined results each month. Monthly reports were received from at least 14 of the 15 practice teams each month, with five months having a 100% reporting rate for clinical measures and one month for medical home measures

Clinical Process Measures

The practices conducted and reported monthly chart reviews for clinical process measures (Table 1). During the ten months of the collaborative, practices achieved the goal for one of 6 indicators (17%) and achieved a positive percentage change of at least 50% for 5 of 6 indicators (83%).

Summary of Clinical Measures

Measure	April 2014	January 2015	Goal	Percent Change
The percentage of patients that had their asthma severity, risk, and control assessed at the last visit	50%	76%	90%	+52.6%
The percentage of current Asthma Action Plans composed or reviewed and adjusted as necessary	26%	63%	90%	>+100%
The percentage of patients/families that were offered and reviewed a copy of the current Asthma Action Plan	30%	61%	90%	>+100%
The percentage of patients who received anticipatory guidance to obtain an influenza immunization (during flu season)	40%	75%	90%	>+100%
The percentage of most recent acute visits scheduled with the patient's assigned provider or care team	68%	82%	90%	+21.1%
The percentage of patients seen in the ED that were seen and/or given an appointment for follow-up within one week of discharge	61%	92%	90%	+50.0%

Table 2: Summary of Clinical Measures

Individual practice team improvements were monitored and analyzed on a monthly basis. Practice teams and their facilitators received monthly results. Many of the teams showed modest improvement (a difference of at least five percentage points) from baseline to the end of the collaborative (Figure 3), with a few showing significant changes in asthma clinical care. Danville Polyclinic achieved and/or maintained goal for all asthma clinical measures monitored during the collaborative. Associated Pediatrics of Fox Valley and UnityPoint Clinic Pediatrics North achieved and/or maintained goal for four out of six measures.

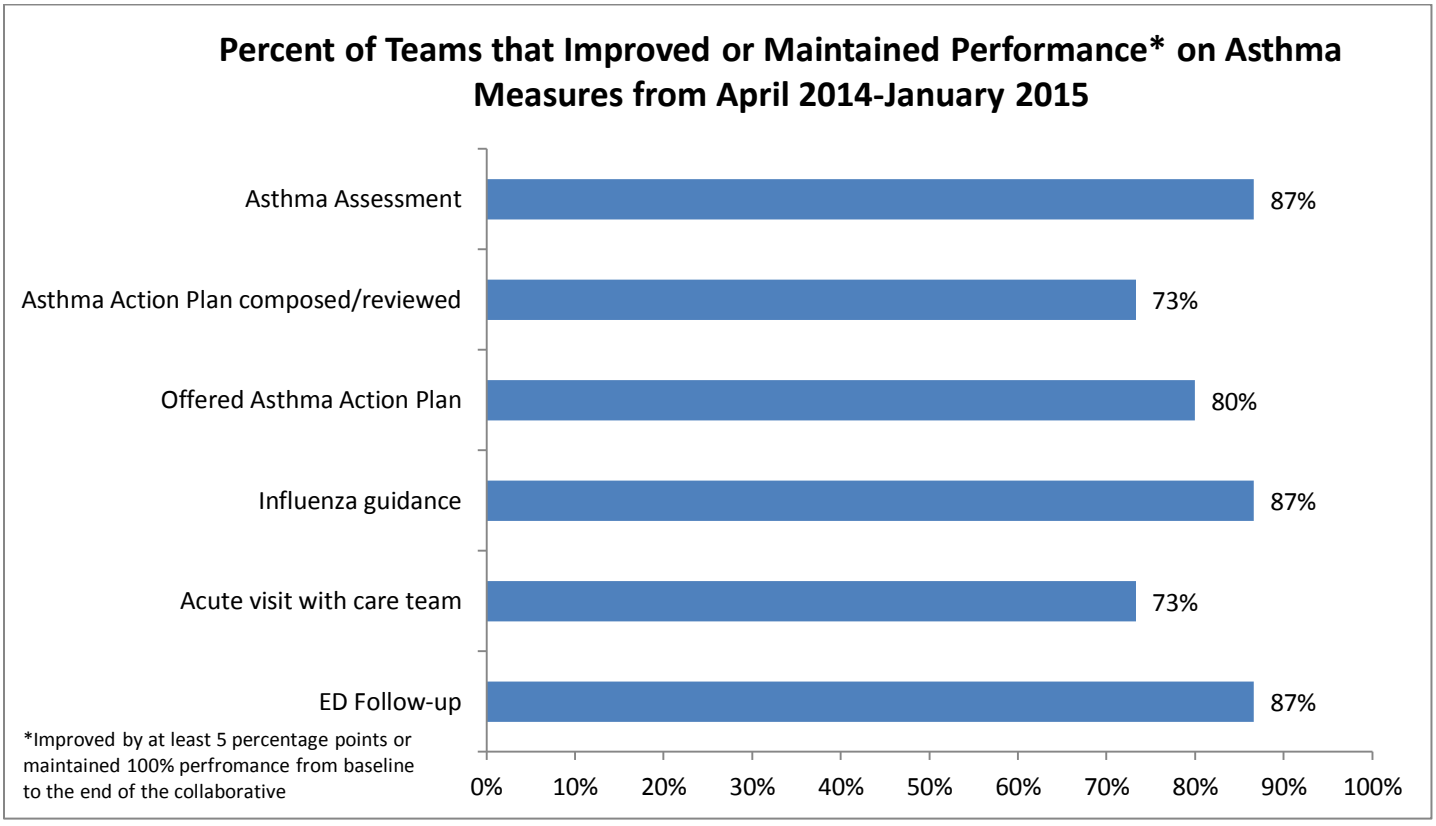


Figure 5: Practice Team improvement or maintance of performace

Medical Home Measures

Practices submitted monthly data to evaluate medical home transformation (Table 2). From April 2015 to January 2015, practices achieved the goal for 8 of 20 (40%) indicators and achieved a positive percentage change greater than 50% for 12 of 20 (60%) indicators. All teams met and/or maintained goal for at least 5 of the measures. UnityPoint North Pediatrics met and/or maintained goal for 16 of the 20 measures. None of the practices met the goal for all 20 measures.

Summary of Medical Home Measures

Measure	April 2014	January 2015	Goal	Percent Change
Does the practice have same day appointment availability for sick visits?	100%	100%	90%	0%
Does the practice have same day appointment availability for well visits?	42.9%	78.6%	90%	+83.3%
Does the practice have a protocol/system regarding Short-Acting Beta Agonist refills that includes frequency of refills/follow-up appointment?	35.7%	71.4%	90%	+100%
Does the practice have a system to identify asthma patients that were seen in the ED/admitted to the hospital for asthma and document these occurrences?	57.1%	100%	90%	+75.0%
Does the practice have a system to follow-up within a specified timeframe with patients seen in the ED/admitted to the hospital for asthma?	50.0%	92.9%	90%	+85.7%
Is at least one practice team member competent to evaluate and teach/demonstrate the use of asthma devices and equipment?	100%	100%	90%	0%
Does the practice have a system established to identify, follow and provide care management to children with asthma (i.e. registry function)?	57.1%	92.9%	90%	+62.5%
Does the practice's system used for asthma condition management incorporate the NHLBI asthma care management guidelines?	64.3%	78.6%	90%	+22.2%
Is the practice's system for asthma condition management used to identify or proactively remind clinicians and patients/families of needed services?	28.6%	57.1%	90%	+100%
Does the practice team systematically plan for patient encounters?	50.0%	100%	90%	+100%
Does the practice complete a systematic assessment of the health center's cultural and linguistic, attitudes, practices, structures and policies?	28.6%	50%	90%	+75.0%
Does the practice have trained staff assigned to support pediatric asthma patients and their families in self-management, self-efficacy and behavior change?	64.3%	92.9%	90%	+44.4%
Do practice teams begin clinical sessions with a team "huddle"?	35.7%	92.9%	90%	>+100%
Does the practice have a system in place to obtain regular feedback from parents/families	64.3%	85.7%	90%	+33.3%
Does the practice include one or more family members on the improvement team?	42.9%	35.7%	90%	-16.7%
Did the improvement team meet this month for reflection, problem solving, and to plan for practice innovations/PDSA cycles?	50.0%	64.3%	90%	+28.6%
Did the practice invite at least one community organization to a quarterly practice team "lunch and learn"?	0%	14.3%	90%	>+100%
Does the practice have relationships with local schools and coordinate care of pediatric asthma patients (with poor asthma control) with the schools?	21.4%	50%	90%	>+100%
Does the practice team use ILHIE Direct Secure Messaging (DSM)?	0%	0%	90%	0%
Does the practice use the Statewide Provider Database?	7.1%	28.6%	90%	>+100%

Table 3: Summary of Medical Home Measures

Additionally, practice teams were asked to rate the medical home components in practice. They were asked to respond to, "On a scale of 1 to 5, with 1 being much more difficult and 5 much easier, because of the project, my clinical and operation work this month has been…". Throughout the entire duration of the project the mode response was 3, no

change. This indicates although practices took on additional work related to transformation, they did not perceive an increased workload. This may be due to increased efficiencies resulting from transformation. For example, incorporating team huddles was initially seen as increasing workload, and practices shared setting aside a few minutes each day to plan for asthma patients improved their productivity and care provided to their asthma patients.

Learning Session Evaluations

Evaluation forms were included in the curriculum packets provided to participants at each learning session. Participants were asked to complete the evaluations at the end of the learning session and turn them in before leaving. The first two evaluations included four questions addressing the learning session, including clarity, teaching style, content, and organization and pacing of content delivery. Twelve questions addressed the extent to which learning objectives were achieved for the respective learning session. Participants could choose from five possible responses: 1=Not at all; 2=Not really; 3=To some extent; 4=Yes; 5=Yes, definitely. Two open-ended questions were included to solicit input on facilitation needs during the action periods and suggestions for the next learning session. The evaluations were overwhelmingly positive, with all responses rated as a 4 (yes) or 5 (yes, definitely). In the first learning session, 19% of the responses were rated as 5 and 81% were rated as 4. The second learning session showed better results with 50% rated as 4 and 50% rated as 5. The evaluation for the third learning included questions to evaluate the learning collaborative as a whole. Again, the evaluations were positive, with all responses rated as 4 (100%), along with very positive feedback provided about the collaborative. Practices found the collaborative sharing of experiences among practices to be very helpful. The monthly data calls were well received and the practice facilitators valued. Other themes included praise for the parent partner expert, problems engaging parent partners, and appreciation of subject matter experts (QI, PCMH and asthma) and resources provided. Many positive comments were received about the sustainability tools and information provided in the final learning session. The evaluation results for each learning session are located in Appendix F.

Challenges

During the collaborative, practice teams and facilitators faced numerous challenges collecting data from EMRs. A major difficultly involved trying to utilize the EMR for functionality to support medical home concepts. A few practices either implemented or switched EHR vendors within one year prior to the start of the collaborative and one practice's EMR went live two days after the first learning session.

Some of the barriers encountered in using EMRs to their full potential include:

- Many EMRs lack PCMH functionality;
- Some EMRS have PCMH functionality, and staff are not aware it is available or simply have not been trained to use it;
- In health system environments, functionality may not have been deployed to practices;
- Also in health system environments, EMRs were purchased to address hospital needs or needs of adult patients and do not have needed functionality for pediatric primary care settings;
- There can be burdensome organizational requirements for requesting changes to the EMR;
- Simple changes or obtaining functionality that already exists but not included in the basic EMR package are costly;
- Most practices did not have direct or any access to programmers or technical support staff
- Practices did not have access to user manuals/guides;
- Frustration led to manual workarounds, creating more work, and delaying receipt of the change or functionality needed; and

- Providers also struggled with getting adequate support from their vendors to have needs addressed, which occurred regardless of which EMR systems the practices used. In this collaborative, more than half of the practices used the same EMR. Collaborative leadership was unsuccessful in engaging the EMR vendor to meet with these practices, as a group to discuss specific functionality needed for pediatric asthma care. The vendor indicated each practice should contact their sales representative to discuss needs individually.

Another issue faced during the collaborative related to staffing within the practices. One practice saw a major staffing turnover. The team lost one member in the middle of the collaborative, and experienced significant turnover a few months later resulting in two new team members. Integrating new staff into the practice made it challenging to focus on medical home transformation, PDSAs, and data collection for the collaborative. During the collaborative two of the sites, from the five site health system, were co-located into a single building for a few months, slowing down momentum for both practices.

Providers questioned the need for practices to gather and report data on a monthly basis. The QI expert and facilitators were enlisted to help providers understand the difference in using data for research versus QI, however, skepticism remained. As individual and aggregate data were shared and discussed during monthly webinars, the value of the data collection and reporting on PDSA cycles became evident.

Stories of Improvement

Community and Statewide Change

Illinois Public Act 92 0402, was originally passed in 2001 and has been amended many times since then. The Act allows all children in Illinois the right to self-carry and self-administer quick relief asthma medication and auto-injectable epinephrine pens. The law states that no schools are exempt from this law and park districts, camps and sports programs are covered in this legislation. Many of the practices were unaware of this law and their local school districts were out of compliance. A direct result of the collaborative practices worked with their local school districts to assure compliance. There were a few instances of resistance from school districts, and by the end of the collaborative all were in compliance.

The collaborative not only tackled compliance locally, but at a statewide level. The Illinois High School Association (IHSA) governs the equitable participation in interscholastic athletics and activities that enrich the educational experience of students in the State of Illinois. The IHSA requires a yearly sports physical on file for all student athletes. A team member from University Pediatrics has an asthmatic child participating in high school football and noticed the IHSA was not complying with the law. After months of phone calls and emails, the IHSA has changed their albuterol carry form to eliminate a physician's signature and to align with the law in Illinois. The physician signature was a barrier to children having albuterol on person for sporting events.

Teamwork and Staffing Changes

Practice teams acknowledged the importance of teamwork, and were able to successfully spread that concept within their practice sites. Almost all practice teams implemented team huddles during the collaborative and planned on maintaining team huddles post collaborative. Practice teams agreed patient care had improved as a result of their improved teamwork.

During the collaborative many practices worked to assure practice staff was working at the top level of their licensure. For example, Rush Copley, a residency clinic, began utilizing their PharmD and pharmacy students along with residency

and faculty physicians to create an interdisciplinary approach to care. The pharmacy students were engaged to assist in asthma education after the physician's visit with the patient. The students taught patients how to use devices and provided medication and general asthma education. They also assisted the provider in creating and reviewing the Asthma Action Plan with the patient. AMG Oak Lawn secured resources to hire a certified Asthma Educator to be part of the practice team. The Asthma Educator provides asthma education in the clinic and makes follow-up phone calls to patients.

Patient Education

University Pediatrics hosted an asthma clinic for their asthma patients towards the end of the collaborative. During the afternoon clinic, the team focused solely on asthma care and education. Setting aside a block of time for asthma patients, allowed providers to spend more time with patients and families to answer questions regarding the varying aspects of asthma. As a result of a successful first clinic, University Pediatrics decided to continue holding asthma clinics on a regular basis. University Pediatrics also created educational signs to hang on doors in exam rooms. The practice created asthma education kits used to educate patients during visits, with materials given to patients for later reference.

Danville Polyclinic partnered with community pediatricians and the local school district to educate parents, students, and school staff and faculty about asthma and their respective roles regarding asthma care. These partnerships led to the creation of an Asthma Task Force in the community, and ongoing health education being provided by pediatricians through the school district's Parent University. In addition, the school district now sends letters to all families of students with asthma encouraging them to get the flu vaccine.

A unique aspect to the collaborative was the participation of a school-based health clinic, PrimeCare Hamlin (Ames). Although the clinic was not the PCP, it took steps to improve asthma care for students. The clinic staff began to administer the Asthma Control Test and discuss asthma education with patients. In order to increase education, they collaborated with the Respiratory Health Association to offer asthma education classes for students, parents, school staff, and faculty.

Parent Partners

Many practices struggled with finding a parent partner. The teams that did have partner partners engaged them in reviewing various educational materials and providing feedback from a parent's perspective about the practice's operations. The resulting educational materials are being used in waiting rooms, on the back of exam room doors, and handed out to parents during the visit. Some practices changed their processes for education and follow-up with patients and their families based on parent input. The parent partners worked together to create a Parent Resource Booklet (Appendix G). This booklet was designed to help parents find answers they need to help control their child's asthma. The booklet contains internet resources, quick information on asthma gadgets, and tips for parents.

Moving Forward

The last learning session focused on sustainability and teams were encouraged to maintain their gains. Several of the teams were motivated by monthly performance data available through the collaborative. As a result, all practice teams received a customized Excel file, programmed to record and graph their progress, if they continued to enter record review data. The Excel file can be easily adapted to address issues beyond asthma. Additionally, a panel of representatives from the Illinois Department of Public Health's Asthma Program, the Illinois Chapter of the American Academy of Pediatrics and the Illinois Academy of Family Physicians provided information on asthma and PCMH resources and support available through their respective organizations. Business managers, Chief Financial Officers, and other practice leadership were invited to this Learning Session. Each team was recognized and celebrated for their

respective accomplishments allowing practice leadership in attendance to appreciate the strides made. A national PCMH expert presented on emerging financial incentives and payment models promoting improved quality and the PCMH model of care, and the direction of PCMH nationally. This presentation was targeted towards practice leadership, to encourage continued support and maintenance of the PCMH model of care. A state and national advocacy organization presented on various types of advocacy, including tips for advocating at the local, state and national levels. A team exercise included creating an elevator speech to support advocacy efforts. Finally, the QI Expert guided the teams in an exercise using a template to create a sustainability plan. The teams left the learning session with a clear plan for sustaining collaborative gains.

Many of the practice teams cited one of their biggest obstacles was buy-in from leadership and/or other providers. The practices acknowledged medical home transformation increases burden on the clinic, and they believe their transformation efforts resulted in improved patient care. Leadership support is essential for practice transformation. Dedicated time is required for PCMH/QI teams to meet on a regular basis and transformation can involve staffing changes and additional costs associated with EMR enhancements/functionality. Collaborative practices frequently used the word "overwhelming" to describe medical home transformation and valued the expertise, advice, technical assistance, and motivation received from the practice facilitators. Engaging this support to assist practices in transformation outside the collaborative can be costly.

External supports are needed for practice transformation, including reimbursement models reflecting the way care is provided in the medical home, funding currently non-reimbursable activities such as care coordination, and providing incentives for improved quality. In addition, non-financial support in the form of practice facilitation/coaching, QI education and resources, continuing education credits, and collaboration opportunities is needed to promote transformation.

At the conclusion of Learning Session Three, practices were committed and motivated to continue their transformation efforts and developed sustainability plans to identify the specific steps they would take. They vowed to use tools, education and resources provided during the learning session, to further PCMH and asthma care in their practices and communities. Practices committed to continuing transformation activities such as registries, data collection, quality improvement, and teamwork as well as spreading these concepts to other conditions and/or other providers in the practice. In addition, practices discussed bigger picture sustainability such as advocating for PCMH within their health systems and with payers.

Based on the results of the six-month MHI assessment, practices sustained their gains and continued their transformation towards medical homeness. Eleven of the 15 participating practices submitted a six-month post MHI survey. The MHI Medical Homeness Level remained the same (proactive) with a slight improvement in the total score (5.0 to 5.2). Only one theme (Organizational Capacity) saw a slight decrease. Care Coordination and Data Management saw improvements, while Chronic Condition Management, Community Outreach, and Quality Improvement remained the same.

Medical home transformation is an on-going process, requiring internal and external support. Practices are knowledgeable of the burden they will encounter; however knowing it will improve care provides some relief. Internal support for buy-in, adjustment of schedules and duties, among other things need to be taken into consideration when pursuing medical home transformation. The financial strain required to achieve recognition can be too costly for some practices to incur, leading practices to ask, "Does the cost justify the means?" This collaborative did not provide any financial support to the practices; it did provide support in other forms, practice facilitators, a QI expert, and parent partner expert. Practices saw great value in these resources during their time spent in the collaborative.

Appendices

Appendix A-Practice Information

Practice	Location	Type	Setting	Number of Providers	Medicaid/AllKids Pediatric Patients
AMG Pediatrics Oak Lawn	North Aurora	Hospital-Based Residency Clinic	Urban, not inner city	19	90%
Associated Pediatrics of Fox Valley	Aurora	Pediatric Practice	Suburban	16	60%
Cicero Health Center of Cook County	Cicero	Federally Qualified Health Center	Urban, not inner city	15	99%
Danville Polyclinic	Danville	Pediatric Practice	Rural	3	50%
Family Care Associates	Effingham	Pediatric Practice, Family Medicine, Rural Health Clinic	Rural	30	30%
Lake Forest Pediatric Associates	Lake Bluff	Pediatric Practice	Suburban	36	5%
Near South Health Center of Cook County	Chicago	Family Medicine	Urban, inner city	12	95%
PrimeCare Community Health-Hamlin (Formally Ames)	Chicago	School Based Health Clinic, Federally Qualified Health Center	Urban, inner city	4	47%
PrimeCare Community Health-Fullerton	Chicago	Family Medicine	Urban, inner city	11	47%
PrimeCare Community Health-Northwest Clinic	Chicago	Family Medicine, Federally Qualified Health Center	Urban, inner city	11	47%
PrimeCare Community Health-Portage Park	Chicago	Family Medicine, Federally Qualified Health Center	Urban, inner city	9	47%
PrimeCare Community Health-West Town	Chicago	Family Medicine	Urban, inner city	36	47%
Rush-Copley Family Medicine Center	Aurora	Family Medicine, Academic Practice, Hospital-Based Residency Clinic	Suburban	23	65%
UnityPoint Clinic Pediatrics North	Peoria	Hospital-Based Primary Care Practice	Suburban	27	35%
University of Illinois Pediatrics	Peoria	Pediatric Practice, Academic Practice	Urban, inner city	14	55%

Appendix B-Collaborative Governance

Expert Workgroup

Lisa Cosgrove, MD—Atlantic Coast Pediatrics, AAP Florida Chapter Immediate Past President/FL CHIPRA Project
Maureen Damitz, AE-C—Stroger Hospital of Cook County, Chicago Asthma Consortium Board Member and Parent Partner Expert
Linda Follenweider, MS, CNP, PhDc, PCMH CCE—Health Management Associates, IL CHIPRA Demonstration Grant
Arvind Goyal, MD—Medical Director, Illinois Department of Healthcare and Family Services
Ruth Gubernick, MPH, PhDc, PCMH CCE—QI Expert
Stacy Ignoffo, MSW—Chicago Asthma Consortium
Abel Kho, MD, MS—Co-Executive Director, CHITREC
Juanita Mora, MD—Associated Allergists and Asthma Specialists, Ltd
Dru O'Rourke, BA—Illinois Chapter, American Academy of Pediatrics, IL CHIPRA Demonstration Grant
Cari (VonderHaar) Outman, RN—Automated Health Systems/Illinois Health Connect PCCM
Lauren Seemeyer, MPH—Illinois Chapter, American Academy of Pediatrics, IL CHIPRA Demonstration Grant
Lois Wessel, RN, CFNP—Association of Clinicians for the Underserved (ACU)

PCMH-Asthma Leadership

Melissa Corrado, MBA, PCMH CCE
Maureen Damitz, AE-C
Linda Follenweider, MS, CNP, PhDc, PCMH CCE
Ruth Gubernick, MPH, PhDc, PCMH CCE
Alison Rhodes, MPH, MPA, PCMH CCE
Gwen Smith, PCMH CCE

Facilitators

Tiana Kieso
Mary Morissey
Alison Rhodes, MPH, MPA, PCMH CCE

Faculty

Scott Allen
Melissa Corrado, MBA, PCMH CCE
Jeff Damitz
Kyle Damitz
Maureen Damitz, AE-C
Eileen DeRoze
Linda Follenweider, MS, CNP, PhDc, PCMH CCE
Ruth Gubernick, MPH, PhDc, PCMH CCE
Lilah Handler
Janine Hill
Art Jones, MD
Vince Keenan
Margaret Kirkegaard, MD
Anissa Lambertino, PhD
Diane Ozog, MD
Erik Sandberg
Robin Shannon, RN MSN
Gwen Smith, PCMH CCE
Cory Verblen

Appendix C-Learning Session Agendas

- Learning Session 1

ILLINOIS CHIPRA Quality Demonstration Project
Improving Child Health and Medical Homes for Illinois AllKids

IHFS Illinois Department of Healthcare and Family Services

Illinois Patient-Centered Medical Home (PCMH) Learning Collaborative

Friday, May 2, 2014: 2:30pm to 8:30 pm
Saturday, May 3, 2014: 8:00 am to 4:00 pm

Program Moderators
Melissa Corrado, MBA, Learning Collaborative Project Manager
Linda Follenweider, MS, CNP, PhDc, Learning Collaborative Director

Learning Session 1 Agenda
- Friday, May 2, 2014 -

2:30 pm	**Registration and Storyboard Set-Up**
3:15 pm	**Welcome and Introductions** *Linda Follenweider, MS, CNP, PhDc*
3:35 pm	**Overview of the Day** *Melissa Corrado, MBA*
3:45 pm	**Illinois CHIPRA Patient-Centered Medical Home Learning Collaborative** *Gwen Smith and Melissa Corrado*
4:15 pm	**Components of the PCMH** *Melissa Corrado*
4:45 pm	**Assessing Progress toward PCMH** *Anissa Lambertino, PhD*
5:00 pm	**Patient and Family Engagement** *Maureen Damitz, AE-C*
5:30 pm	**Team-Based Care** *Linda Follenweider*
6:30 pm	**Dinner**
7:00 pm	**Practice Teams Present Storyboards** *Moderated by: Cari Outman, RN; Mary Morrissey, RN, MA; and Tiana Kieso, MBChB, MPH*
8:30 pm	**Closing Remarks, Adjourn**

Illinois Patient-Centered Medical Home (PCMH) Learning Collaborative

Learning Session 1 Agenda
- Saturday, May 3, 2014 -

8:00 am	**Breakfast**
8:30 am	**Welcome Back and Overview of the Day** *Melissa Corrado*
8:40 am	**Asthma Care in the PCMH** *Linda Follenweider*
10:00 am	**Break**
10:15 am	**Asthma Away from Home: Schools, Daycare and Sports** *Maureen Damitz*
10:45 am	**Overview of Quality Improvement Science: Accelerating Change Using Small Tests of Change** *Ruth Gubernick, MPH*
12:00 pm	**Lunch** [Parent Partner Break-Out Lunch: *Maureen Damitz and Ruth Gubernick*]
12:45 pm	**Measurement and Reporting** *Anissa Lambertino*
1:00 pm	**Team Exercise in Break-Out Groups: PDSA Development** *Ruth Gubernick*
2:00 pm	**Statewide Provider Database and ILHIE Direct Secure Messaging Demos** *Erik Sandberg and Cory Verblen*
2:30 pm	**Break**
2:45 pm	**Round Table Discussions** [Participants can choose two, 20-minute discussions.]
3:30 pm	**Review Plans for Action Period** *Melissa Corrado*
3:45 pm	**Question and Answer** *All Faculty*
4:00 pm	**Evaluation/Adjourn**

This learning session is funded under grant CFDA 93.767 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government.

- Learning Session 2

ILLINOIS CHIPRA Quality Demonstration Project
Improving Child Health and Medical Homes for Illinois AllKids

HFS Illinois Department of Healthcare and Family Services

Illinois Patient-Centered Medical Home (PCMH) Learning Collaborative

Friday, September 19, 2014: 2:30pm to 8:00 pm
Saturday, September 20, 2014: 8:00 am to 3:00 pm

Program Moderators
Melissa Corrado, MBA, Learning Collaborative Project Manager
Linda Follenweider, MS, CNP, PhDc, CHIPRA IL PCMH Project Director

Learning Session 2 Agenda
- Friday, September 19, 2014 -

2:30 pm	**Registration and Storyboard Set-Up**
3:15 pm	**Welcome and Introductions** *Linda Follenweider, MS, CNP, PhDc*
3:35 pm	**Overview of the Day** *Melissa Corrado, MBA*
3:45 pm	**Illinois CHIPRA Patient-Centered Medical Home Learning Collaborative—Where We've Been, Where We Are, Where We're Going** *Gwen Smith* *Anissa Lambertino, PhD, MPH* *Linda Follenweider*
4:15 pm	**Community Partnerships: Working with Schools** *Robin Shannon, RN, MSN*
5:00 pm	**Community Partnerships: Working with Groups to Promote Healthy Habits** *Gwen Smith* *Lilah Handler*
5:45 pm	**Practice Team Storyboard Presentations (Group 1)** *Facilitator: Melissa Corrado*
6:15 pm	**Dinner**
6:45 pm	**Diagnosing Asthma: Definitions and Case Studies** *Linda Follenweider*
7:30 pm	**Practice Team Storyboard Presentations (Group 2)** *Facilitator: Melissa Corrado*
8:00 pm	**Closing Remarks, Adjourn**

Illinois Patient-Centered Medical Home (PCMH) Learning Collaborative

Learning Session 2 Agenda
- Saturday, September 20, 2014 -

8:00 am	**Breakfast (at hotel)**
8:30 am	**Welcome Back and Overview of the Day** *Melissa Corrado*
8:40 am	**Living with Asthma: a Patient/Family's Perspective** *Maureen Damitz, Jeff Damitz, and Kyle Damitz*
9:40 pm	**Practice Team Storyboard Presentations (Group 3)** *Facilitator: Melissa Corrado*
10:00 am	**Break**
10:15 am	**Asthma and Allergy in Pediatric Practice: a Specialist's Perspective** *Diane Ozog, MD*
11:00 am	**Overview of Quality Improvement Science: Intermediate Topics (QI 201)** *Ruth Gubernick, MPH*
12:00 pm	**Lunch** [Parent Partner Break-Out Lunch: *Maureen Damitz and Ruth Gubernick]*
12:45 pm	**Team Exercise in Break-Out Groups: PDSA Development for Action Period 2—Using DSM and SPD for Care Coordination** *Ruth Gubernick, MPH*
1:45 pm	**Mobile C.A.R.E Asthma Van: presentation and tour** *Matt Siemer* **Round Table Discussions** [Participants can choose two, 20-minute discussions.]
2:40 pm	**Review Plans for Action Period** *Melissa Corrado*
2:45 pm	**Question and Answer** *All Faculty*
3:00 pm	**Evaluation/Adjourn**

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- Learning Session 3

ILLINOIS CHIPRA Quality Demonstration Project
Improving Child Health and Medical Homes for Illinois AllKids

IHFS Illinois Department of Healthcare and Family Services

Illinois Patient-Centered Medical Home (PCMH) Learning Collaborative

Friday, February 20, 2015: 2:30pm to 8:00 pm
Saturday, February 21, 2015: 8:00 am to 3:00 pm

Program Moderators
Melissa Corrado, MBA, Learning Collaborative Project Manager
Linda Follenweider, MS, CNP, PhDc, CHIPRA IL PCMH Project Director

Learning Session 3 Agenda
- Friday, February 20, 2015 -

2:30 pm	**Registration**
3:00 pm	**Welcome and Introductions** *Linda Follenweider, MS, CNP, PhDc*
3:15 pm	**Overview of the Day** *Melissa Corrado, MBA*
3:20 pm	**Medical Home Index: Team Completion** *Ruth Gubernick, MPH*
4:00 pm	**Parent Partner Toolkit Presentation** *Maureen Damitz, Parent Partners*
4:30 pm	***Practice Presentations***
4:45 pm	**PCMH: State and National Trends** *Margaret Kirkegaard, MD, HMA*
5:15 pm	**Ongoing Support for PCMH and Asthma Care: Panel Presentation** *Scott Allen, ICAAP* *Vince Keenan, IAFP* *Eileen DeRoze, IDPH* *Maureen Damitz, Chicago Asthma Consortium*
6:30 pm	**Dinner**
7:30 pm	**Celebration and Networking**
8:00 pm	**Closing Remarks, Adjourn**

Illinois Patient-Centered Medical Home (PCMH) Learning Collaborative

Learning Session 3 Agenda
- Saturday, February 21, 2015 -

8:00 am	**Breakfast (at hotel)**
8:30 am	**Welcome Back and Overview of the Day** *Melissa Corrado*
8:40 am	**Medical Home Index: Pre- and Post-assessment Results** *Anissa Lambertino, PhD*
9:15 am	***Practice Presentations***
9:30 am	**Aligning Financial Incentives with PCMH Model of Care** *Art Jones, MD, HMA*
10:15 am	**Break**
10:30 am	***Practice Presentations***
10:45 am	**How to Advocate for Changes** *Janine Lewis, EverThrive Illinois*
11:45 am	**Becoming PCMH Recognized** *Melissa Corrado*
12:15 pm	**Lunch**
1:00 pm	***Practice Presentations***
1:30 pm	**Sustainability Planning—How to Keep It Going** *Ruth Gubernick*
2:00 pm	**Sustainability Planning Activity**
2:40 pm	**Life after the Collaborative** *Linda Follenweider*
2:45 pm	**Question and Answer** *All Faculty*
3:00 pm	**Evaluation/Adjourn**

This learning session is funded under grant CFDA 93.767 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government.

Appendix D-Monthly Survey

Monthly Data Survey

Section 1: Clinic Information

Please complete this monthly report (using charts from August) no later than the following date: September 15, 2014 (10 charts only)

If you are having difficulty using Survey Monkey, please contact

*1. Practice Name

*2. Primary Care Provider Name

*3. Name of Individual(s) Completing this Survey

4. Phone number of individual(s) completing this survey

Section 2: Chart Review Questions

*Are you using an eligible chart? You must answer yes to question 1.

Chart Review Directions: Use this data collection tool to individually review the charts of the pediatric patients (aged 5-21 years) with established asthma seen in the office for either health supervision or sick visits during the 4-week data collection period. The number of patients to review is as follows:

For Baseline Data (initial data collection) =20 pediatric (5-21 years) asthma patients

Follow-Up Cycle/Data Collection Period (all subsequent data collection) =10 pediatric (5-21 years) asthma patients

If fewer than 20 (if baseline collection) or 10 (if follow-up collection) pediatric asthma patients are seen, a provider can select from other charts within the practice if they are not being used more than one time (i.e., as long as another provider is not using the same chart in his/her data reporting).

To establish a diagnosis of asthma, the clinician should utilize the NHLBI guidelines: (EPR– 3 2007):

•Episodic symptoms of airflow obstruction or airway hyper-responsiveness are present.

•Airflow obstruction is at least partially reversible.

•Alternative diagnoses are excluded.

Note: Actions must be documented in the patient chart in order to answer affirmatively to the chart review questions.

If you are having difficulty using Survey Monkey, please contact

*1. Are the patients reviewed and reported aged 5-21 with an established asthma diagnosis?

*2. How many patients had their asthma severity, risk and control assessed at the last visit (during visit or via phone prior to visit), as documented in chart?

Number

Total number of charts reviewed

*3. How many current Asthma Action Plans were composed or reviewed and adjusted, as necessary, at the last visit as documented in the chart?

Number

Total number of charts reviewed

*4. How many patients/families were offered and reviewed a copy of the current Asthma Action Plan?

Number

Total number of charts reviewed

*5. How many patients receive anticipatory guidance to obtain an influenza immunization (during flu season)?

Number or N/A

Total number of charts reviewed or N/A

*6. How many of the most recent acute visits were scheduled with the patient's assigned provider or care team?

Number

Total number of charts reviewed

If number=0, give reason

*7. How many patients with asthma were seen in the ED for asthma/respiratory symptoms during the review period?

Number

If number=0, give reason

*8. Of those patients seen in the ED from question 7, how many were seen and/or given an appointment for follow up within one week of discharge?

Section 3: AIMS and Tests of Change

The following are domains from the National Committee for Quality Assurance (NCQA) PCMH standards. Please indicate "yes" or "no" as to whether you have set an AIM and tested a change/used a related tool within these domains in the previous month. For that domain, please indicate the AIM and describe changes tested and tools used. We recognize that the practice team may not have something to report for each domain every month.

Poor AIM example: Our practice team will improve care for all of our patients diagnosed with asthma.

Good AIM example: By February 28, 2015, XYZ Pediatrics will aim to improve chronic care management in our practice. Our team will focus on testing the suggested strategies, tools and resources related to improving care for our patients diagnosed with asthma so that:

- 90% have their asthma severity, risk and control assessed at last visit (during visit or via phone prior to visit) documented in chart.

- 90% have an Asthma Action Plans composed or reviewed and adjusted, as necessary, at the last asthma visit documented in the chart.

If you are having difficulty using Survey Monkey, please contact

1. Have you set an AIM to Enhance Access and Continuity?

   If yes, indicate AIM/S and changes tested/tools used:

2. Have you set an AIM to Identify and Manage Patient Populations?

   If yes, indicate AIM/S and changes tested/tools used:

3. Have you set an AIM to Plan and Manage Care?

   If yes, indicate AIM/S and changes tested/tools used:

4. Have you set an AIM to Provide Self Care Support and Community Resources?

   If yes, indicate AIM/S and changes tested/tools used:

5. Have you set an AIM to Track and Coordinate Care?

   If yes, indicate AIM/S and changes tested/tools used:

6. Have you set an AIM to Measure and Improve Performance?

   If yes, indicate AIM/S and changes tested/tools used:

Section 4: Medical Home Policies, Procedures and Practices

If you are having difficulty using Survey Monkey, please contact

*1. Does the practice have same day appointment availability for sick visits?

*2. Does the practice have same day appointment availability for well visits?

*3. Does the practice have a protocol or system in place regarding Short-Acting Beta Agonist refills that includes frequency of refills and follow up appointment?

*4. Does the practice have a system in place to IDENTIFY pediatric asthma patients that have been seen in the ED/admitted to the hospital for asthma and document these occurrences in the patient chart?

*5. Does the practice have a system in place to FOLLOW UP WITHIN A SPECIFIED TIMEFRAME with pediatric asthma patients that have been seen in the ED/admitted to the hospital for asthma?

*6. Is at least one practice team member competent to evaluate and teach/demonstrate the use of asthma devices and equipment?

*7. Does the practice have a system established to identify, follow and provide care management to children with asthma (i.e. registry function)?

*8. Does the practice's system (registry or other) used for asthma condition management incorporate the NHLBI asthma care management guidelines?

*9. Is the practice's system (registry or other) for asthma condition management used to identify or proactively remind clinicians and patients/families of needed services?

*10. Does the practice team systematically plan for patient encounters (e.g., collects pre- visit data; reviews the patient chart; assembles consultation reports, lab tests, and emergency department records; identifies patient and parent concerns and ensures that adequate time is scheduled for the visit)?

*11. Does the practice complete a systematic assessment of the health center's cultural and linguistic, attitudes, practices, structures and policies using the "Promoting Cultural and Linguistic Competency Self-Assessment Checklist for Personnel Providing Primary Health Care Services?"

*12. Does the practice have trained staff assigned to support pediatric asthma patients and their families in self-management, self-efficacy and behavior change?

*13. Do practice teams begin clinical sessions with a team "huddle?"

*14. Does the practice have a system in place to obtain regular feedback from parents/families?

15. If yes, what does this system include? (Check all that apply.)

Parent/family focus groups

Parent/family surveys

Parent/family advisory committee

Ask families for informal feedback

Other (please specify)

*16. Does the practice include one or more family members on the improvement team?

*17. Did the improvement team meet this month for reflection, problem solving, and to plan for practice innovations/PDSA cycles?

*18. Did the practice team invite at least one community organization to a quarterly practice team "lunch and learn" during which information was shared and introductions/personal connections were made with staff?

*19. Does the practice have relationships with local schools and coordinate care of pediatric asthma patients (with poor asthma control) with the schools?

*20. Does the practice team use ILHIE Direct Secure Messaging (DSM)?

Other (please specify)

21. If yes, who is your practice communicating with via DSM? (Check all that apply.)

Hospital Specialists

Behavioral health providers Schools

Patient/family Community resources

Other (please specify)

*22. Does the practice team use the Statewide Provider Database?

Other (please specify)

23. If yes, who is your practice referring/communicating? (Check all that apply.)

Afterschool programs and tutoring

Nutrition and physical activity resources

Behavioral health providers

Social services (homelessness, domestic violence)

Parenting classes

Community resources

Other (please specify)

Section 5: Overall Assessment and Future Topics

If you are having difficulty using Survey Monkey, please contact

1. What was your biggest accomplishment this month?

2. What was the biggest barrier you encountered this month? Were you able to overcome it? If so, how?

3. What issues or topics would you like to discuss on a conference call or through the project e-mail list?

4. Do you have additional issues you would like to discuss with your facilitator this month?

Section 6: Medical Home Components in Practice

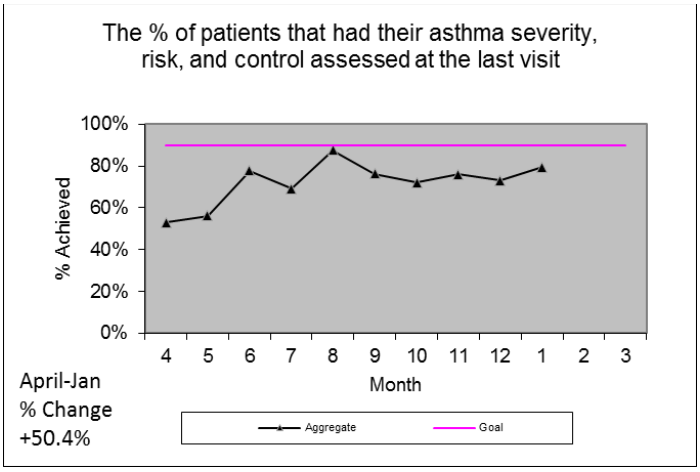
If you are having difficulty using Survey Monkey, please contact

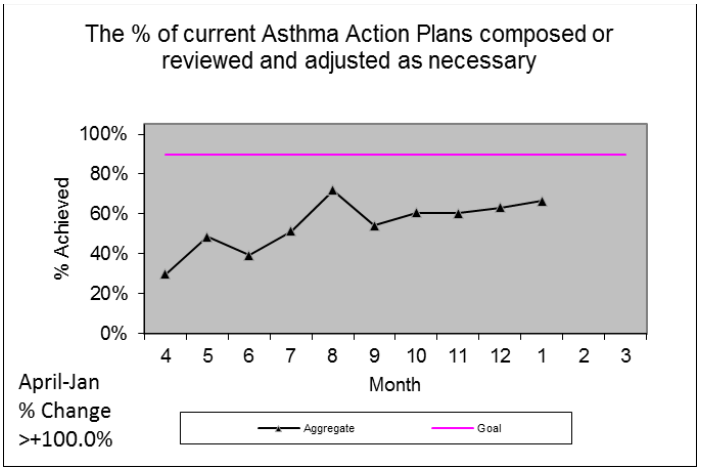
*1. Think about how your practice handles medical home processes and the impact of the IL Pediatric Medical Home Demonstration Project. On a scale of 1 to 5, please respond to this statement: because of the project, my clinical and operational work this month has been (see scale below)

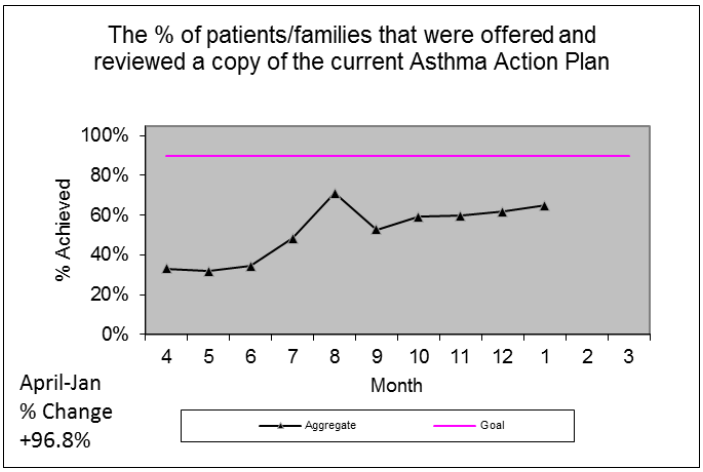
5 Much Easier 4 Easier 3 the Same/No Change 2 Difficult 1 Much more difficult

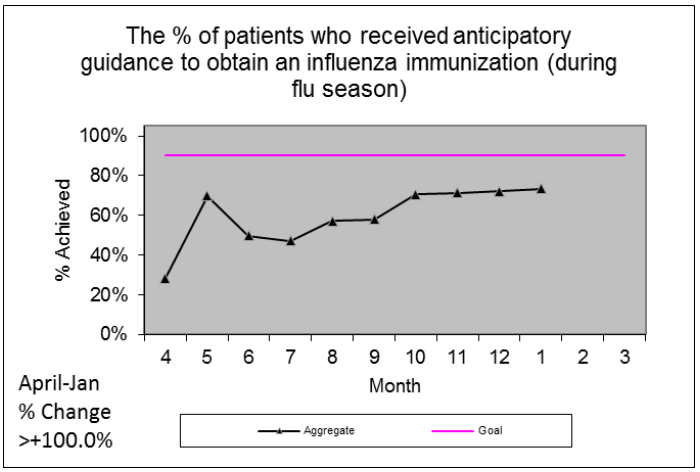
Appendix E-Run Charts

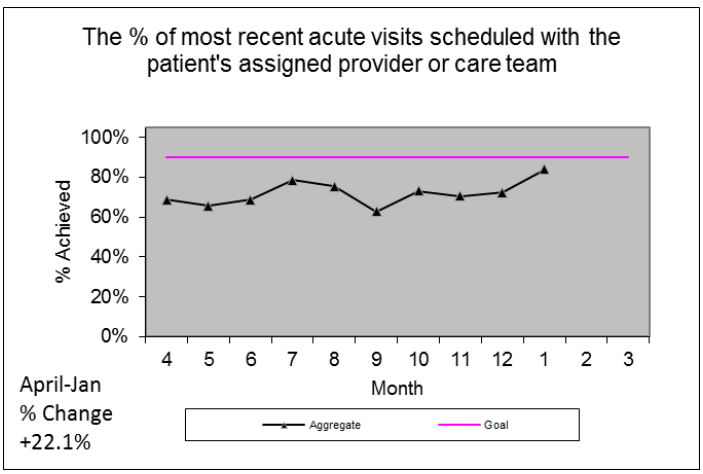
Chart Reviews

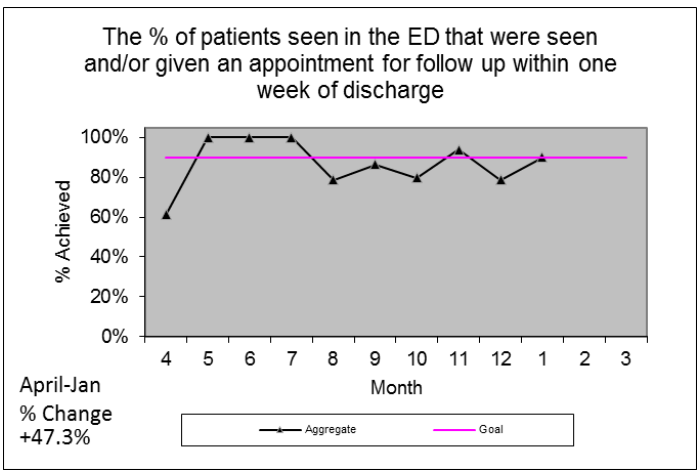




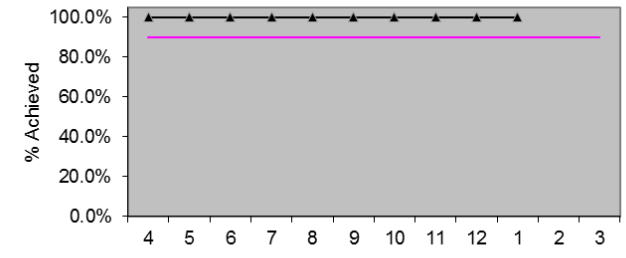






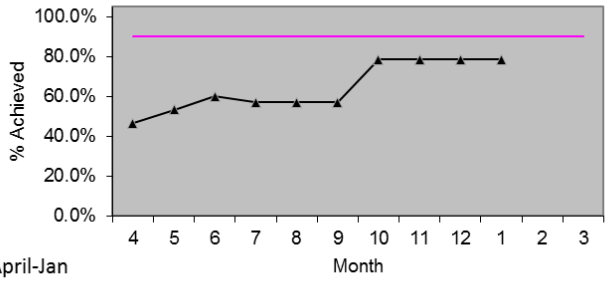


Does the practice have same day appointment availability for sick visits?



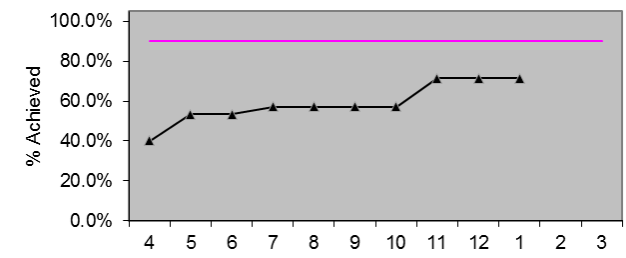
April-Jan
% Change
0%

Does the practice have same day appointment availability for well visits?



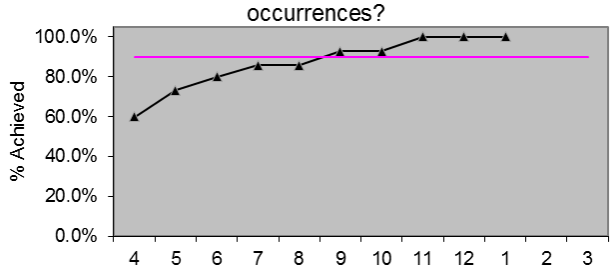
April-Jan
% Change
+68.4%

Does the practice have a protocol/system regarding Short-Acting Beta Agonist refills that includes frequency of refills/follow up appointment?



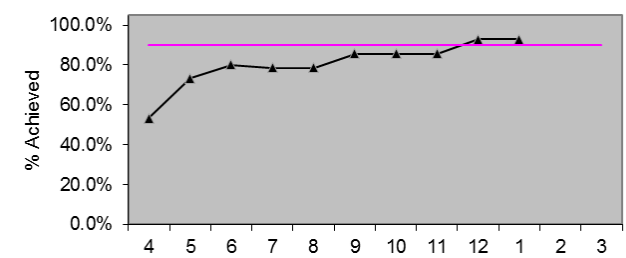
April-Jan
% Change
+78.6%

Does the practice have a system to IDENTIFY asthma patients that were seen in the ED/admitted to the hospital for asthma and document these occurrences?



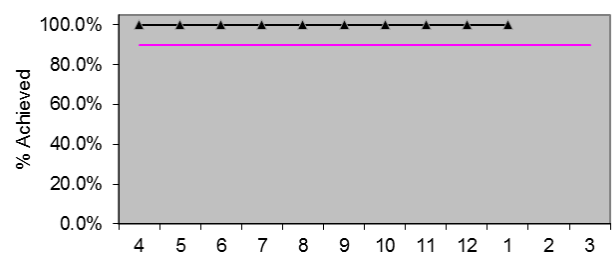
April-Jan
% Change
+66.7%

Does the practice have a system to FOLLOW UP WITHIN A SPECIFIED TIMEFRAME with patients seen in the ED/admitted to the hospital for asthma?



April-Jan
% Change
+74.1%

Is at least one practice team member competent to evaluate and teach/demonstrate the use of asthma devices and equipment?



April-Jan
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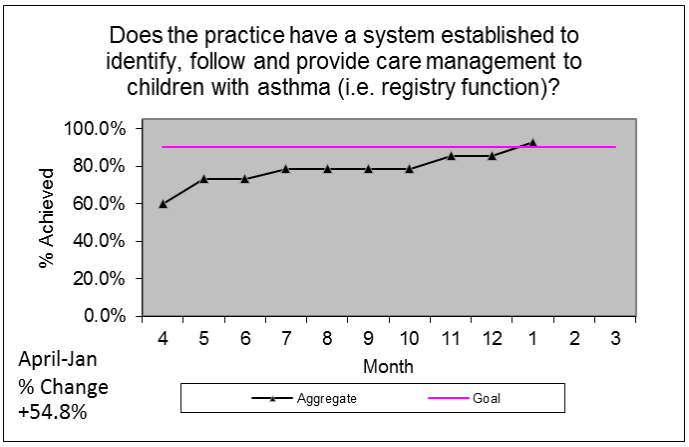
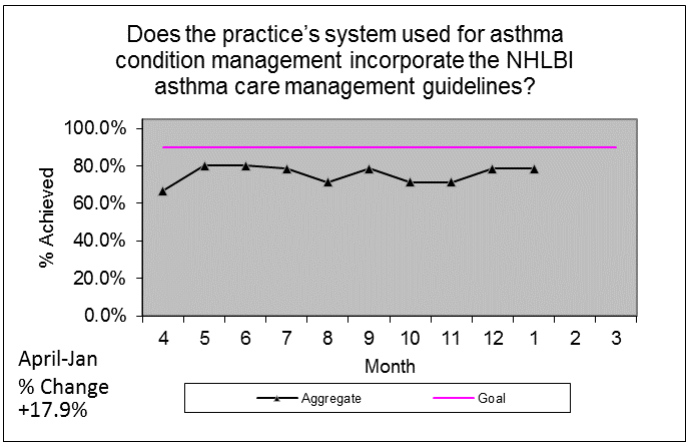
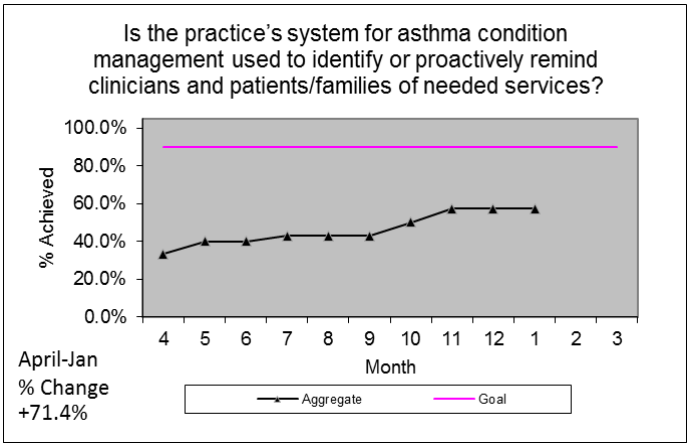
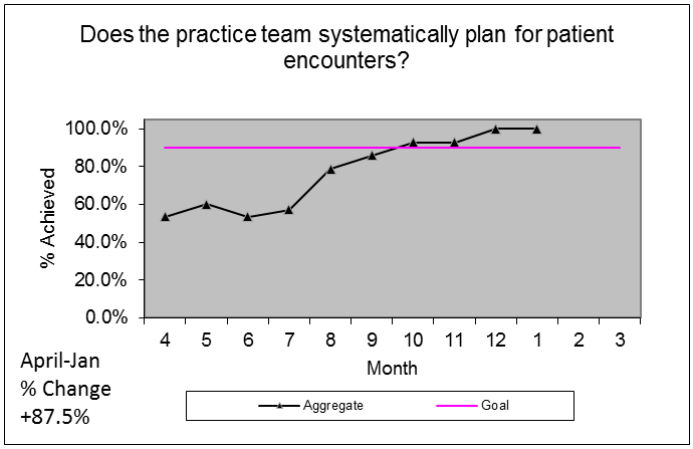
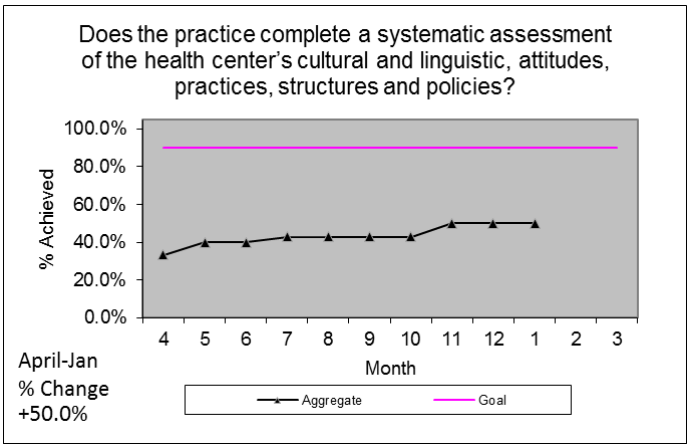
Medical Home Policies, Procedures, and Practices

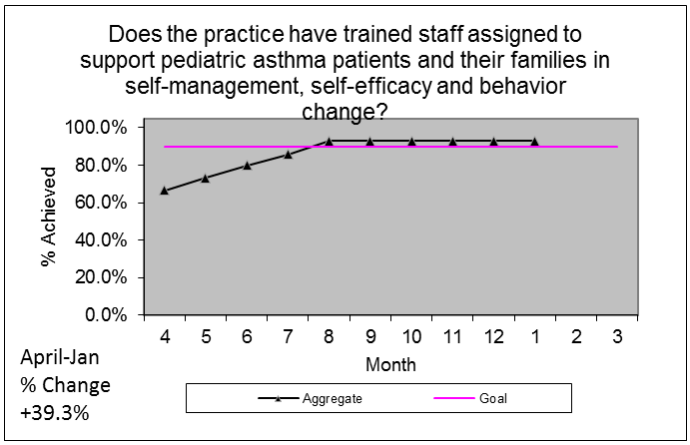




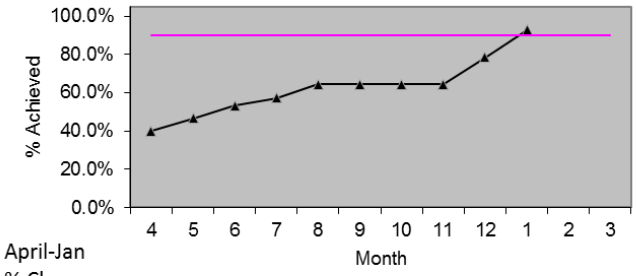






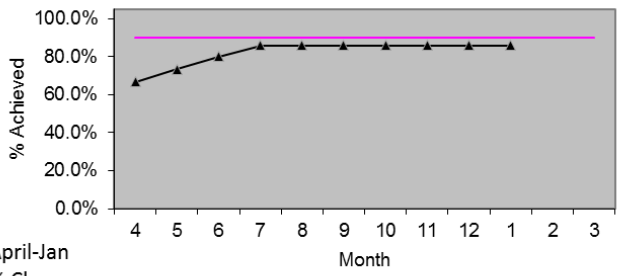


Do practice teams begin clinical sessions with a team "huddle"?



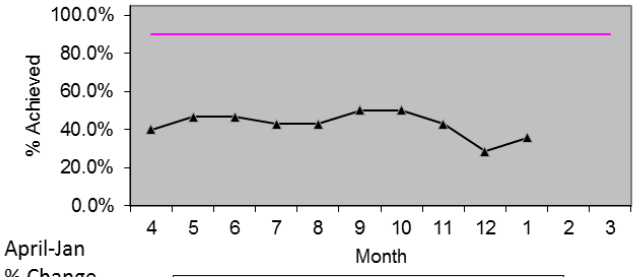
April-Jan
% Change
>+100.0%

Does the practice have a system in place to obtain regular feedback from parents/families?



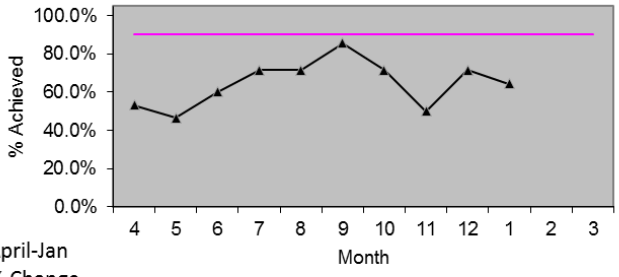
April-Jan
% Change
+28.6%

Does the practice include one or more family members on the improvement team?



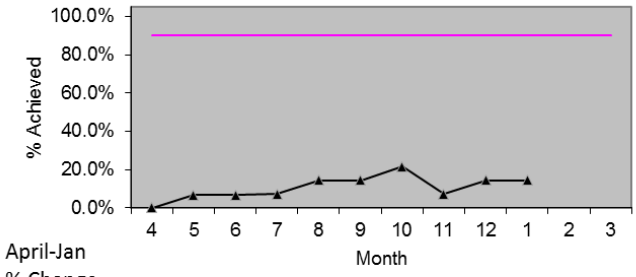
April-Jan
% Change
-10.7%

Did the improvement team meet this month for reflection, problem solving, and to plan for practice innovations/PDSA cycles?



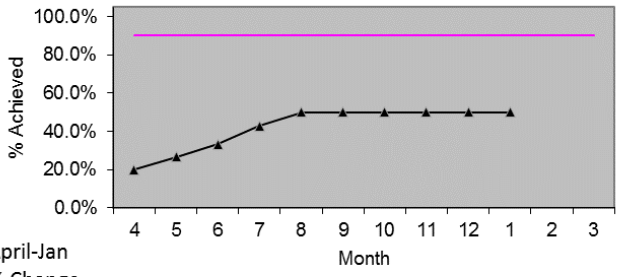
April-Jan
% Change
+20.5%

Did the practice invite at least one community organization to a quarterly practice team "lunch and learn"?



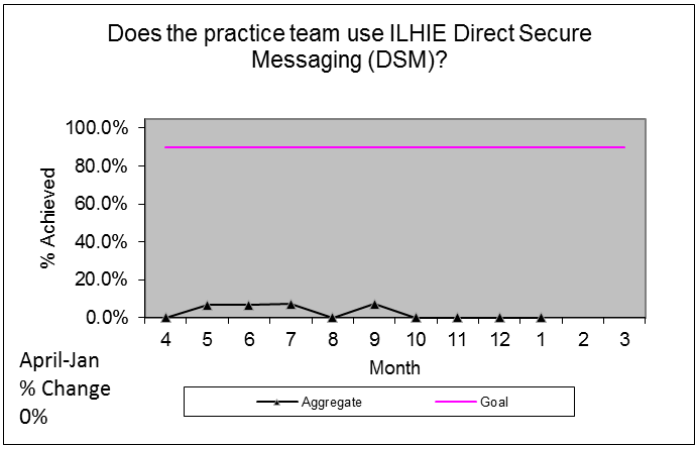
April-Jan
% Change
>+100.0%

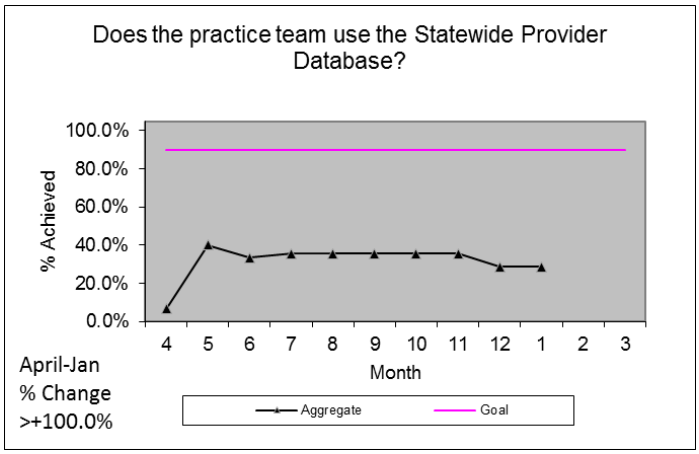
Does the practice have relationships with local schools and coordinate care of pediatric asthma patients (with poor asthma control) with the schools?



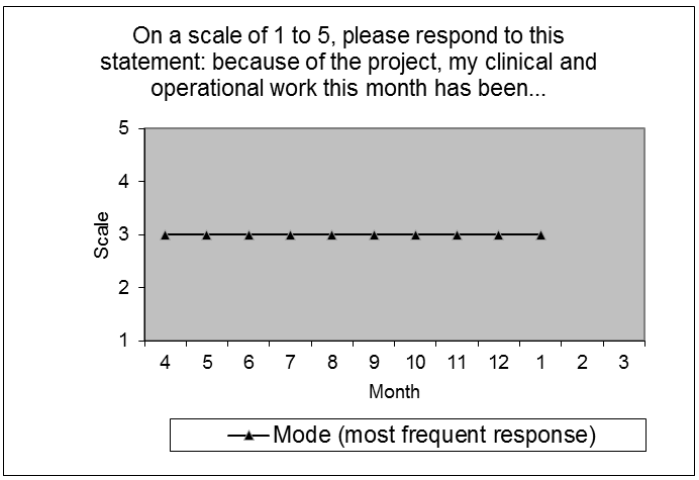
April-Jan
% Change
>+100.0%

Medical Home Policies, Procedures, and Practices





Medical Home Components in Practice



Scale
5=Much Easier
4= Easier
3= No Change
2=Difficult
1= Much More Difficult

n=14, Range= 2-5

Appendix F-Learning Session Evaluations

- Learning Session 1

ID	1.1	1.2	1.3	1.4	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10	2.11	2.12
1	4	4	5	4	4	4	4	4	4	4	4	4	4	4	4	4
2	5	5	5	4	4	3	4	4	4	4	4	4			4	4
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28	4	4	4	4	4	4	4	4	4	4	4	4	5	3	4	4
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30	5	5	5	5	5	5	5	5	4	5	5	5	4	4	4	5
31	4	4	5	4	4	2	4	4	3	4	4	3	4	3	4	3
32	4	4	4	4	4	4	4	4	5	4	5	5	5	5	5	5
33	5	5	5	5	5	5	5	5	5	5	4	5	5	5	5	5
34	5	5	5	5	5	4	5	4	5	5	4	5	4	5	4	5
Mode (most frequent response)	**5**	**5**	**5**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**

Key
5=Yes,definitely
4=Yes
3=To some extent
2=Not really
1=Not at all

Question number	
	Please indicate your experience of the learning session as a whole.
1.1	The content was presented clearly.
1.2	The faculty's teaching style met my needs.
1.3	The course content was relevant to my work.
1.4	The organization and pacing of the course was effective.
	Please indicate the extent to which you achieved the learning objectives for the course.
2.1	Describe the purpose of the CHIPRA learning collaborative, define roles and expectations of CHIPRA staff and health center team members including parent partners.
2.2	Describe key delivery/finance system reforms in Illinois and the role of the Patient-Centered Medical Home.
2.3	Identify key components of the PCMH as presented in the change package.
2.4	Use a rapid cycle improvement approach to test changes.
2.5	Define team-based care including roles of each team member.
2.6	Identify key components of evidence-based, pediatric asthma care including decision-support tools.
2.7	Identify PCMH process of care measures for the collaborative and method to establish baseline and track improvements.
2.8	Create opportunities for patients/parents to expand their role in decision-making, health-related behaviors and self-management, e.g., collaborative action plan development, advocacy in the school setting.
2.9	Assist patients in obtaining community resources as needed using Statewide Provider Database and other resources.
2.10	Develop care coordination protocols between health center and schools/day care.
2.11	Network with participating health centers.
2.12	Develop and report on plans for the action period.
3	**Is there anything else you need to make this a successful action period?**
	Not at this time
	Contact information for other practices
	No
	The team did a great job presenting and gave us great tips to get started
	Very good speakers, resources and tools!!
	Can't think of anything yet but after get baseline may have other questions
4.0	**What can we learn from Session 1 to make sure Session 2 better meets your needs?**
A	Could we update storyboard with successes/barriers
B	Nothing comes to mind at this time
C	Great job!
D	This was very overwhelming. Almost too much information for a weekend.
E	More group projects
F	The room was a little cramped; Food great; The venue was great; Great interaction between the team and practices; We got some great resources
G	This was great. It started out a little slowly, but gave great information. In general, I think less lecture-style and more group work/interactive stuff to keep us engaged. Faculty members did an excellent job of ? Questions and keeping it relevant for everyone.
H	More time built in for Q and A between intensive presentations
I	Plug ins for laptops; water on tables, book on jump drive; name and email addresses of participants and type of EMR participants use
J	Need planned breaks (i.e. 1st day unrealistic to sit for 3 hours without scheduled break). Would end up missing some portions if need to get up and break not scheduled.

- Learning Session 2

ID	1.1	1.2	1.3	1.4	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10	2.11	2.12
1	5	4	3	3		4	4	4	5	3	4	4	4	4	4	4
2	5	5	5	4	5	5	5	5	5	5	5	5	4	5	5	5
3	5	5	5	5	5	5	5	5	5	5	5	4	4	4	4	5
4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
5	4	4	4	3	4	4	4	3	4	4	5	3	4	4	4	4
6	5	5	5	4	5	4	4	4	5	4	5	4	4	5	4	4
7	5	5	5	5	4	4	4	4	5	5	5	2	3	5	4	4
8	5	5	5	5	4	4	4	4	5	5	5	5	5	5	5	5
9	5	5	5	5	4	4	4	4	4	4	4	4	4	4	4	4
10	5	5	5	5	4	5	4	5	5	5	5	5	4	5	4	5
11	5	5	5	5	5	3	4	5	4	3	5	5	4	4	4	4
12	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
13	4	4	4	4	4	4	4	4	3	3	4	3	4	4	4	4
14	5	5	5	4	4	3	3	5	4	4	5	4				
15	5	4	4	5	5	4	4	4	3	3	4	3	4	4	4	4
16	5	5	5	3	4	4	4	4	4	4	4	4	4	4	4	4
17	4	4	4	4	4	4	4	4	4	4	4	3	4	4	4	4
18	5	5	5	5	5	5	5	5	5	2	5	5	4	5	5	5
19	4	4	4	4	4	3	4	3	5	4	3	3	4	3	3	3
20	5	5	5	5	4	4	4	4	4	4		5	5	5	5	5
21	4	4	5	3	4	4	4	4	4	4	3	4	4	4	4	4
22	5	5	5	5	5	5	4	5	5	5	5	5		5	5	5
23	4	3	3	3	3	4	4	4	4	3	4	4	3	3	3	3
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25	4	4	5	4	4	3	4	5	4	4	5	3	4	4	5	5
26	4	4	5		5	5	4	5	4	4	5	5	4	4	5	4
27	4	4	5	4	5	4	4	5	5	5	5	3	2	4	4	4
28	5	5	5	5	5	5	5	5	5	5	5	4	4	4	5	4
29	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
30	5	5	5	5	5	5	5	5	5	5	5	3	3	4	4	4
31	5	5	4	5	5	4	5	5	5	5	5	5	4	5	5	5
32	4	4	4	4	4	4	3	4	4	4	4	4				
33	5	4	5	4	5	4	4	5	4	4	5	5	4	4	4	4
34	5	5	5	5	5	5	5	5	5	5	5	4	4	4	5	5
Mode (most frequent response)	**5**	**5**	**5**	**5**	**5**	**4**	**4**	**5**	**5**	**4**	**5**	**4**	**4**	**4**	**4**	**4**

Key	Mode
5=Yes, definitely	50%
4=Yes	50%
3=To some extent	
2=Not really	
1=Not at all	

Question number	Question
	Please indicate your experience of the learning session as a whole.
1.1	The content was presented clearly
1.2	The faculty's teaching style met my needs
1.3	The course content was relevant to my work
1.4	The organization and pacing of the course was effective
	Please indicate the extent to which you achieved the learning objectives for the course.
2.1	Describe the past, present and future work of the CHIPRA demonstration project
2.2	Describe Community partnership strategies with schools
2.3	Identify other community partners and strategies for partnering
2.4	Describe challenges and strategies for diagnosing asthma in pediatric populations
2.5	Identify learning opportunities from the work of other practices within the collaborative
2.6	Describe strategies for patient engagement as highlighted by the parent partner and patient presentation
2.7	Identify the role of allergy in asthma control and management
2.8	Identify care coordination strategies for working with specialists
2.9	Develop an action plan for secure messaging/statewide provider database that uses a rapid cycle improvement approach to test changes
2.10	Develop additional skills in PDSA development and quality improvement science
2.11	Network with participating health centers and potential community partners
2.12	Develop and report on plans for the action period
3	**Is there anything else you need to make this a successful action period?**
	5/34 or 15% answered this question (abbreviated answers below)
	ID 5. More information on medical home: How to accomplish, application help, how other teams are accomplishing
	ID 6. Mary's site visit helpful; another visit
	ID 7. Keep us on task
	ID 8. Information to get best handouts
	ID 9. Using information online
4	**What can we learn from Session 2 to make sure Session 3 better meets your needs?**
	12/34 or 35% answered this question (abbreviated answers below)
	ID 12. Review of national guidelines, enterovirus, flu, RSV; session 2 more informative
	ID 11. Follow up on suggestions
	ID 10. Additional medical information (asthma diagnosis, allergies, etc.); community/organization presentations relevant to our work
	ID 9. Finalizing PDSA; making this a foundation that will last
	ID 7. Interaction with other practices/speakers was helpful; continued communication with practices/speakers after session 3 to share ideas/improve office care
	ID 6. End session on time
	ID 5. More informative than first session; nice hotel room was comfortable
	ID 4. Session in same hotel is more convenient
	ID 3. Separate lectures on asthma care and QI projects
	ID 2. Separate admin and providers; longer sessions with time for questions
	ID 1. Separate session for QI and clinical information
	ID 34. Separate sessions for clinical and quality measures
	Additional Notes:
	ID 34. Government should regulate vendors who add additional costs for some EMR reports

- Learning Session 3

ID	1.1	1.2	1.3	1.4	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10	3.1	3.7	3.8	3.9	3.10	3.11	3.12
1	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	-9	5	5	5
2	4	4	4	4	4	4	4	4	4	4	2	3	-9	-9	4	4	5	3	-9	4	4
3	5	5	5	5	4	5	4	5	5	4	5	5	4	4	5	4	4	5	4	4	5
4	5	5	5	5	5	5	5	5	5	5	4	4	4	4	4	4	4	4	3	4	4
5	5	5	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	-9	4	4
6	4	3	3	3	4	5	4	3	3	2	4	4	4	3	3	2	2	1	1	3	3
7	4	4	4	4	4	4	4	4	4	1	3	4	4	4	5	4	4	4	3	4	4
8	4	4	5	4	3	4	4	4	4	4	3	4	4	3	5	4	4	3	3	4	3
9	4	4	3	4	-9	4	5	5	4	4	4	4	-9	4	4	4	5	5	-9	-9	5
10	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	4	4	5	4	5
11	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
12	4	4	5	4	4	4	4	4	4	4	3	4	4	4	5	2	3	-9	5	4	4
13	4	4	4	4	4	4	4	4	4	4	4	3	4	4	-9	4	3	5	5	5	5
14	4	4	4	4	3	4	5	4	4	4	4	3	4	4	4	4	3	-9	5	4	4
15	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	3	4	3	4	4	4
16	4	4	4	4	5	3	4	4	5	4	3	4	3	4	5	-9	-9	-9	4	5	5
17	5	4	5	4	3	5	3	4	5	4	3	4	-9	-9	5	3	2	2	2	5	5
18	4	5	5	3	4	5	4	4	4	5	4	3	4	5	5	5	5	4	3	5	4
19	4	4	4	4	5	4	4	4	4	5	4	4	5	4	5	4	4	3	-9	-9	-9
20	4	3	4	4	3	4	3	3	3	3	3	3	3	3	4	3	2	4	3	3	4
21	5	5	5	5	5	5	3	5	5	5	5	5	5	5	4	4	5	4	4	5	5
22	3	5	5	5	5	5	5	5	5	5	-9	5	5	5	5	5	5	5	5	5	5
23	4	4	3	3	4	4	4	4	4	3	3	3	4	4	4	4	3	4	1	3	4
24	4	4	4	3	4	4	3	4	4	4	4	4	4	4	4	3	4	4	-9	5	4
25	4	4	3	3	4	4	3	4	3	4	4	4	4	4	5	4	5	3	-9	-9	-9
26	4	4	4	4	4	4	4	4	4	3	-9	-9	4	4	4	4	4	4	3	4	4
27	5	5	5	5	5	4	4	3	3	4	3	4	3	4	2	3	4	2	-9	5	5
28	5	4	-9	4	4	4	5	4	4	-9	4	4	5	4	4	4	4	4	5	5	5
29	5	5	5	4	4	4	5	4	4	4	4	4	4	5	5	4	5	5	5	5	5
30	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	4	4	5	5
31	5	4	4	4	5	5	4	5	5	5	4	3	5	5	5	3	5	3	2	4	5
32	5	5	5	5	5	5	5	5	4	4	4	4	4	4	4	3	4	4	4	4	4
33	4	4	4	4	4	4	-9	4	4	4	3	3	3	4	4	4	5	4	3	4	4
34	4	4	4	4	3	4	3	3	3	2	3	4	4	4	4	4	3	2	5	4	4
35	5	5	5	4	4	5	3	4	3	3	3	3	4	4	-9	-9	-9	-9	-9	-9	-9
36	5	5	5	5	4	5	4	4	4	4	4	4	-9	-9	5	4	4	3	5	5	5
37	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	3	4	4	4
38	4	4	4	4	4	5	4	4	4	4	4	4	4	4	4	4	5	3	4	5	4
39	4	4	3	3	4	5	4	4	4	4	4	4	4	4	4	4	3	3	5	4	-9
40	4	4	4	4	5	5	5	5	4	4	3	4	3	4	5	4	5	4	4	4	5
41	4	3	2	3	4	4	4	4	4	4	4	4	4	4	4	3	3	3	3	4	4
42	5	5	5	5	4	4	4	4	4	-9	4	4	4	4	5	4	4	4	4	4	5
Mode (most frequent response)	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**TIE 4,5**	**4**	**4**
Number	**42**	**42**	**41**	**42**	**41**	**42**	**41**	**42**	**42**	**40**	**40**	**41**	**38**	**39**	**40**	**40**	**40**	**37**	**34**	**38**	**38**

Key

5=Yes, definitely

4=Yes

3=To some extent

2=Not really

1=Not at all

Question number		Question
		Please indicate your experience of the learning session as a whole.
1.1		The content was presented clearly
1.2		The faculty's teaching style met my needs
1.3		The course content was relevant to my work
1.4		The organization and pacing of the course was effective
		Please indicate the extent to which you achieved the learning objectives for the course. Learners will be able to:
2.1		Use the medical home index as a tool to help assess practice movement towards the PCMH model of care
2.2		Wo k as a team to complete an assessment tool
2.3		Identify components and opportunities for use of a parent toolkit
2.4		Describe current state and national trends in PCMH model of care
2.5		Identify the role of professional organizations as resources for ongoing support of PCMH and asthma care
2.6		Use Medical Home Index results to help to plan for future work in PCMH practice transformation
2.7		Identify how financial incentives align with the PCMH model of care
2.8		Identify the role of practices in advocacy for changes at a state and local level
2.9		Identify how to become PCMH recognized by one of the certifying bodies
2.10		Identify how to plan for sustaining the model and changes achieved
		Across this learning collaborative what parts have been <u>helpful to you as a practice?</u>
3.1		**Learning session 1, 2 and 3 (meeting together as a team with other practices)**
	ID 4	I enjoyed hearing about all the other practices transition to PCMH and the asthma collaborative. It was nice to learn about EMR work-arounds as well as successful PDSA cycles and ideas for change.
	ID 8	Learning from the experiences of other practices.
	ID 10	Strive to be a complete medical home.
	ID 14	Good to hear about other people/group struggles and how they worked on it as well as what they worked on.
	ID 24	The group worked very well together but to make changes as a whole practice were difficult.
	ID 28	I missed session 1 but 2 and 3 were great.
	ID 42	Made some great improvements.
3.7		**The data calls and receiving the data reports**
	ID 1	Great source for information. Extremely helpful.
	ID 4	The data was very useful to present to our practice.
	ID 8	Real time information on our progress.
	ID 10	Very effective and informing.
	ID 12	Data calls were helpful when interesting topic presented. Perhaps doing data calls at certain times only.
	ID 16	NA
	ID 17	Really did not participate as much as other team members.
	ID 20	Not all data levels are applied to practice.
	ID 23	Always very responsive and ready to help.
	ID 42	But need to change questions. Very repetitive.
3.8		**The facilitator visits**
	ID 1	Tiana is such an amazing person. She motivated us at all times. Very organized. We will miss her.
	ID 8	Gathering of ideas and direction.
	ID 10	Always came when needed.
	ID 12	Tiana was very nice and knowledgeable but can sometimes be too scattered in her discussions.
	ID 16	NA
	ID 17	Again, I did not meet with our facilitator but I believe other team members thought the visits were helpful and provided creative solutions to problems.
	ID 31	Alison, Gwen, and Linda have been very helpful.
	ID 39	Could be done via email or phone.
	ID 40	Tiana was excellent in helping our practice identify our strengths and weaknesses.
	ID 42	Great motivator.
3.9		**The documents on SharePoint**
	ID 1	NA
	ID 4	Useful documents. Hope to use them more.
	ID 8	Increasing resources available.
	ID 16	NA
	ID 39	A lot of info. Hard to read thru all of it for relative information.

3.10	**Having access to a parent partner expert**	
	ID 1	Unfortunately we were never able to obtain a parent partner
	ID 5	NA
	ID 10	She's always very informative and knowledgeable.
	ID 12	Learned a lot from Maureen.
	ID 24	We lost our parent partner and did not have one.
	ID 27	Not successful.
	ID 31	We did not have luck with a parent partner.
3.11	**Having access to subject matter experts in QI, PCMH and asthma**	
3.12	**Handouts and resources**	
	ID 1	All the resources were great throughout the collaborative.
	ID 3	Able to incorporate some handouts into our practice.
	ID 10	Very informative and precise.
	ID 16	Unsure what speakers were trying to tell me. Could not hear everything some speakers said.
	ID 22	Plenty of resources useful for future questions.
	ID 39	Every power point printed on one sided paper is a compete waste of money.
4	**What did you learn from Session 3 to make sure your work moves forward with practice transformation? Comments by :**	
	ID 1	Just where we are currently at throughout this process. Continue data collecting to move forward with all chronic issues.
	ID 2	Awareness of evolving financial changes.
	ID 4	To continue creating a registry and collecting data to emphasize better quality of care.
	ID 8	Listening about current state of PCMH, funding, impact on our practice and on our patients. Repeating the Medical Home Index, self reflection on changes made in the last 9 months.
	ID 10	Continue to move forward to strive for excellence for patient welfare. Staying informed to help patients become knowledgeable on their medical plans and care.
	ID 12	Ongoing support for PCMH.
	ID 16	We need to work more as a team. Practices that seem more team oriented are more dedicated to continue the process. Looking forward to moving forward. Our office needs to decide where focus will be. Cost is an issue. I think this was started to help financially, but all these changes will help patients and also make office run smoother.
	ID 18	To continue monitoring our improvement and find ways to improve our shortfalls.
	ID 20	Continue to stay in contact to be able to provide same or better care to patients.
	ID 21	The Dr. Art Jones presentation was very helpful. The discussion of how we need to transform medical care was extremely important and relevant.
	ID 23	Continuation is key.
	ID 28	I love the parent information you have given.
	ID 32	Connect to speakers.
	ID 36	Advocacy.
	ID 38	Tips on how to sustain change.
	ID 39	Good information regarding PCMH.
	ID 42	Keep site of the goals made so far and continue to work toward PCMH if it is going to happen.
5	**Final thoughts?**	
	ID 1	Thank you for including our practice in this collaborative. We appreciate all your knowledge and hard work and passion.
	ID 2	Excellent. [Unintelligible].
	ID 4	Thank you for allowing us to be a part of this.
	ID 6	I think as a practice, we weren't at a point to truly engage in the process of becoming a PCMH. I was impressed by the smaller practices ability to embrace and make changes in their practices.
	ID 8	Thank you for your guidance.
	ID 9	My favorite parts of the session 3 were the practice presentations. I also liked Ms. Gubernick's presentation and visuals. Parent toolkit has a lot of useful information. I'll be sharing with other parents with asthmatic children. Thank you.
	ID 10	I hope there will be more learning sessions to attend. I appreciate the opportunity to become aware of the needs of medical care.
	ID 12	Thank you. It was wonderful to be a part of this collaboration. It really helped to keep us on track during our medical home journey.
	ID 16	Parent partner not completely included in team. Not completely sure of role as parent partner. Is parent partner only to as their thoughts? Being employed at office and parent partner might have confused my role. Maybe I should push more for parents.
	ID 18	We will continue to do our monthly chart reviews to see how we can improve. Thank you PCMH CHIPRA for your help and for giving us the tools to improve the quality of care of asthma patients and other participants with chronic illnesses.
	ID 20	NA
	ID 21	Advocacy lecture was an excellent resource, great info provided and very useful. Sustaining change lecture very helpful. This was a great final lecture.
	ID 22	Since we started to implement huddles it would be easier to do it with the provider a day before and have our supplies ready if we have a procedure. Work presentations gave me pointers on how to train our residents.
	ID 31	Great project.
	ID 32	Worth while. Better care to our patients.
	ID 33	Enjoyed the programs.
	ID 36	This collaborative has really helped our office streamline our asthma care and made us take a good look at what we were doing and make the necessary changes.
	ID 39	The best speaker was Maureen. She was very insightful and full of useful information. Loved when her boys spoke about their experiences. Most speakers were monotone and boring. I think this could have been done in a day seminar. Not 2 days overnight. Again waste of money.

Parent Resource Booklet

Created by the Parent Partners of the

Illinois CHIPRA Patient-Centered Medical Home (PCMH) Learning Collaborative

Asthma can be a difficult disease to manage. When you are told your child has asthma you are not sure where to turn for help, advice or answers. This booklet is meant to get you started on the right path to finding some of the answers you seek.

The internet has a wealth of information about asthma, if you know where to look. Below is a list of websites of community organizations and medical organizations that can provide assistance and guidance to you.

Organization Name	Website	Information Available
Asthma Initiative of Michigan	www.getasthmahelp.org	Educational information for patients and caregivers, resources, kids and teens sections and school information.
American Lung Association	www.lungusa.org	Educational information, online club for children, educational programming and links to other resources.
American Academy of Asthma Allergy and Immunology	www.aaaai.org	Reproducible asthma books for children in English and Spanish, asthma brochures for parents and providers and an interactive back to school game. Links to latest research articles.
Asthma and Allergy Foundation of America	www.aafa.org	Patient organization with education programs and asthma information. Brochures and information for parents. Links to clinical trials. Strong focus on advocacy and policy.
Asthma and Allergy Network Mother of Asthmatics	http://www.aanma.org/	National nonprofit organization of families living with asthma. Comprehensive information on asthma, easy to navigate website. Membership available for added benefits including quarterly magazines. **Link to question and answer section overseen by a medical advisory board**.
Chicago Asthma Consortium	www.chicagoasthma.org	Educational information, school section with specific 504 forms and posters to assist in an asthma emergency.
Clearbreathing	www.clearbreathing.com	This site is pharmaceutical sponsored and provides an animation of the pathophysiology of asthma. High quality information for parents and teens.
Free Breather	www.freebreather.com	Interactive website includes a kids' corner, videos, and links to the health related articles about asthma.
National Jewish Health	http://www.nationaljewish.org 800.222.5864	Provides basic asthma information and call the expert question line.
National Education Association Health Information Network	http://neahealthyfutures.org/	Information on asthma for parents and educators, including information on managing asthma episodes in school. Website includes resources, educational information and links to valuable information.
Respiratory Health Association	www.lungchicago.org	Educational information, asthma programs

Gadgets*

Spacer/Holding Chamber

A spacer or holding chamber is a device used to help you get the most out of your medicine. A spacer or valve-holding chamber attaches to the meter dose inhaler (MDI) and holds the medicine long enough for it to be inhaled. These devices assist with better medication delivery in the lungs and assist in timing. Making sure you have the correct tools will help to ensure the most medication gets delivered to the airways where it is needed.

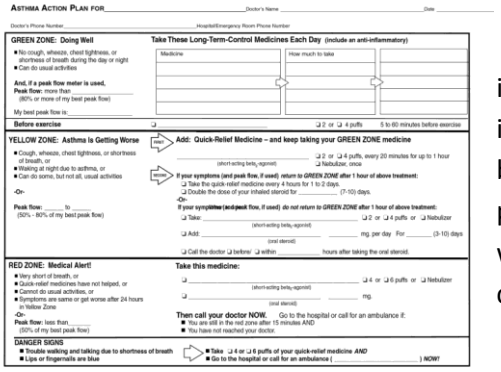
There is a wide variety of holding chambers to choose from. Finding the one that works the best for your child is important. It is important to remember to clean your device at least once a week according to the manufacturer's directions.

Peak Flow Meters

Peak flow meters are a tool used to determine how well your asthma is controlled. Peak flow meters are most helpful for people with moderate or severe asthma and are best once you know what your personal best number is.

To find your personal best peak flow number, take your peak flow every day for two to three weeks. Your asthma should be under good control during this time. Prior to taking any of your daily medications, take your peak flow as close to the same time each day as you can. Record your numbers each day. The highest number you had during this period is your personal best. Your medical provider will provide you a written asthma action plan that helps you know how to take care of asthma before you get into trouble.

Written Asthma Action Plan (AAP)



ASTHMA ACTION PLAN FOR_____ Doctor's Name _____ Date _____

Doctor's Phone Number_____ Hospital/Emergency Room Phone Number

GREEN ZONE: Doing Well
- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,
Peak flow: more than _____
(80% or more of my best peak flow)
My best peak flow is: _____

Take These Long-Term-Control Medicines Each Day (include an anti-inflammatory)

Medicine	How much to take	

Before exercise ❑ _____ ❑ 2 or ❑ 4 puffs 5 to 60 minutes before exercise

YELLOW ZONE: Asthma is Getting Worse
- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-

Peak flow: _____ to _____
(50% - 80% of my best peak flow)

Add: **Quick-Relief Medicine – and keep taking your GREEN ZONE medicine**

(short-acting beta$_2$-agonist) ❑ 2 or ❑ 4 puffs, every 20 minutes for up to 1 hour ❑ Nebulizer, once

If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:
❑ Take the quick-relief medicine every 4 hours for 1 to 2 days.
❑ Double the dose of your inhaled steroid for _____ (7-10) days.

-Or-

If your symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:
❑ Take: _____ (short-acting beta$_2$-agonist) ❑ 2 or ❑ 4 puffs or ❑ Nebulizer
❑ Add: _____ (oral steroid) _____ mg. per day For _____ (3-10) days
❑ Call the doctor ❑ before/ ❑ within _____ hours after taking the oral steroid.

RED ZONE: Medical Alert!
- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone

-Or-

Peak flow: less than _____
(50% of my best peak flow)

Take this medicine:
❑ _____ (short-acting beta$_2$-agonist) ❑ 4 or ❑ 6 puffs or ❑ Nebulizer
❑ _____ (oral steroid) _____ mg.

Then call your doctor NOW. Go to the hospital or call for an ambulance if:
- You are still in the red zone after 15 minutes AND
- You have not reached your doctor.

DANGER SIGNS
- **Trouble walking and talking due to shortness of breath**
- **Lips or fingernails are blue**

Take ❑ 4 or ❑ 6 puffs of your quick-relief medicine *AND*
Go to the hospital or call for an ambulance (_____) NOW!

Written asthma action plan (AAP) provides guidance and information on how to self-manage your child's asthma. The plan will include when to take medications, when to increase your medications based on your symptoms and how to avoid asthma triggers. The AAP provides information on how to recognize and handle worsening asthma, when, how and who to contact in an emergency. If appropriate, it will coordinate with your peak flow meter readings.

Metered Dose Inhaler (MDI)

A metered dose inhaler (MDI) is an aerosol delivery devise, which is one of the most commonly used types of inhalers. Many types of asthma quick relief medications and long term controller medications are delivered using an MDI. To be sure your child is getting the most medication, it is important they use their medication correctly. It is important to take your medication to your medical appointments and review the technique with your medical provider.

Dry Powder Inhaler (DPI)

A dry powdered inhaler (DPI) delivers medication in a dry powder form. There are many designs of DPIs in the market. Each one is slightly different in design and technique. DPIs are most often long term control medications and must be used even when you feel well. Since the DPI is reliant on patient effort for delivery it is important to take the medication to your medical visits and review technique and dosage instructions with your medical provider.

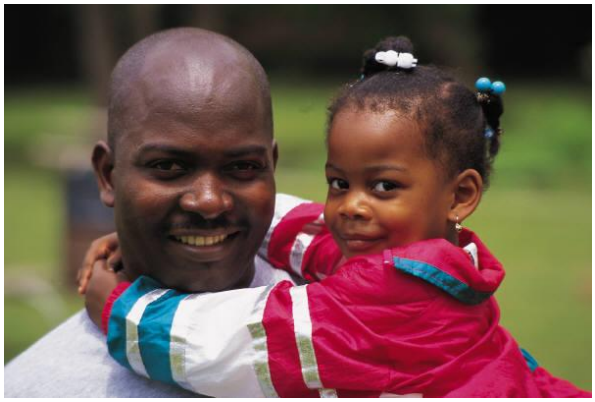
Nebulizer

A nebulizer is a small medication cup connected to a small air compressor and tubing. Once turned on the compressor forces air through the tube to the nebulizer cup causing a mist (aerosol) of the medication. The medication mist is inhaled through a mouthpiece or mask.

*More information on each of the above topics can be found at any of the websites listed

Parent Tips

Learning to live with asthma can be challenging. Others have already walked down the road you are about to travel and have shared their best tips for living with asthma.



- Take a partner (friend, parent or spouse) to specialist or doctor's appointments. There is a lot of information being given. It is best to have someone else there to listen and take notes for you.
- Write all of your questions down before going to the doctor's visit. That way you will be sure to leave with all of the answers you want.
- Be your child's advocate! Be their voice, at childcare, at school and with their health care provider.
- Just because asthma can't be seen does not mean it is not happening. If you feel something is not right trust your instincts.
- Be honest with your medical provider about how often you miss medication doses, how often your child has asthma symptoms, and any alternative treatments you are using.
- The earlier you can teach your child to swallow pills the easier life becomes. Mini M&Ms are a great to practice with for children not allergic to peanuts.
- Children need to know taking medications are non-negotiable as early as possible. This gets tougher with age.
- It is easier for young children doing a spirometry test to put the computer screen on the floor, where they can easily see the screen and the progress of the image they are aiming for.
- Children with chronic disease need to feel in control of small things because so much control is taken away by their disease. Find small ways to give them control. Let them choose their clothes, their hair styles or other things in their life that will give them control.
- Don't settle on medical care, make sure the provider you choose is present when it is your time with them. Medical care is a partnership.
- When you are working with schools never settle, if you are turned down on a request, move to the next level.
- Be honest with your children, they will take their disease more seriously if they understand it more fully.

Interesting Gadgets to Make Life Easier

Life with a chronic disease can be difficult for a child. Carrying an inhaler, a holding chamber, epinephrine pen can be challenging. Especially for an active child. Below are a few gadgets that parents have found helpful for either themselves or their child.

Active Inhaler – Puffer Sports Pouch average price $15.95

Easy pouch that Velcro's around arm or leg. Holds any size inhaler or other medications during sporting activity for easy use.
Available at http://www.activeaide.com/us/active-inhaler-puffer-sports-pouch.html

Auto-Injector Totes – average price $22.00-$38.00. Assortment of totes designed to make it easy and fun to carry your auto-injectors. Available from http://www.allergyhaven.com/c/epipen-tote

InhalerMate – average price $34.95. Water resistant case, protects your inhaler from dust, dirt, moisture and damage. Easy to open and close will clip to backpack, belt loops, and purses. Perfect for sports and people on the go. Available from http://www.starallergyalerts.com.au/shop/cart.php?target=product&product_id=16319&category_id=262

InhalerWear - average price $7.99**.** Make a line of neoprene inhaler covers that clip to backpacks, pants, buckles, sports bags or key chains. Creative patterns make carrying inhalers trendy.
Available from http://www.inhalerwear.com/shop/

My Medibag / Medpac– available in multiple sizes. Range in price from $16.95-$29.95
Convenient medication bags that allow one place for all of your child's medication to be stored in one bag for easy travel to school, childcare or overnight stays at Grandma's house. Provides a picture label and emergency medical information cards. Available at http://www.allergyapparel.com/medpac/

PuffMinder Inhaler Carrying Case - $16.88-$24.95 Small neoprene inhaler carrying case with carabineer. Makes it easy to keep your inhaler accessible when you need it.
Available from http://www.amazon.com/PuffMinder-MEDREADY-Carabiner-Children-backpack/dp/B002YFSSWG

Rescue Kits prices begin at $25.99
Each Kit is designed to contain a photo of the at-risk individual, details about their medical condition, their medications and instructions for administering them, and consent forms signed by the person at-risk (or their parent). Kit is designed to roll up to fit in a desk or back pack or can be ordered in a three ring binder option. Ideal school kit. Available from http://www.atriskrescue.com/kit.html

WaistPal prices range from $39.95-$42.00
A unique way to carry your auto-injector. Perfect for people on the go. The leg or waist pal allow your child to carry their epi-pens in a convenient way that does not interfere with daily activities.
Available from http://omaxcare.com/WaistPal.html