How to Top Angie's list, or : the Asthma-friendly Office

Asthma Coalition of Texas

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Disclosure Statement

John Jay Shannon, MD

The following relationships with commercial interests related to this presentation existed during the past 12 months:

none.

Disclosure Statement-II

John Jay Shannon, MD

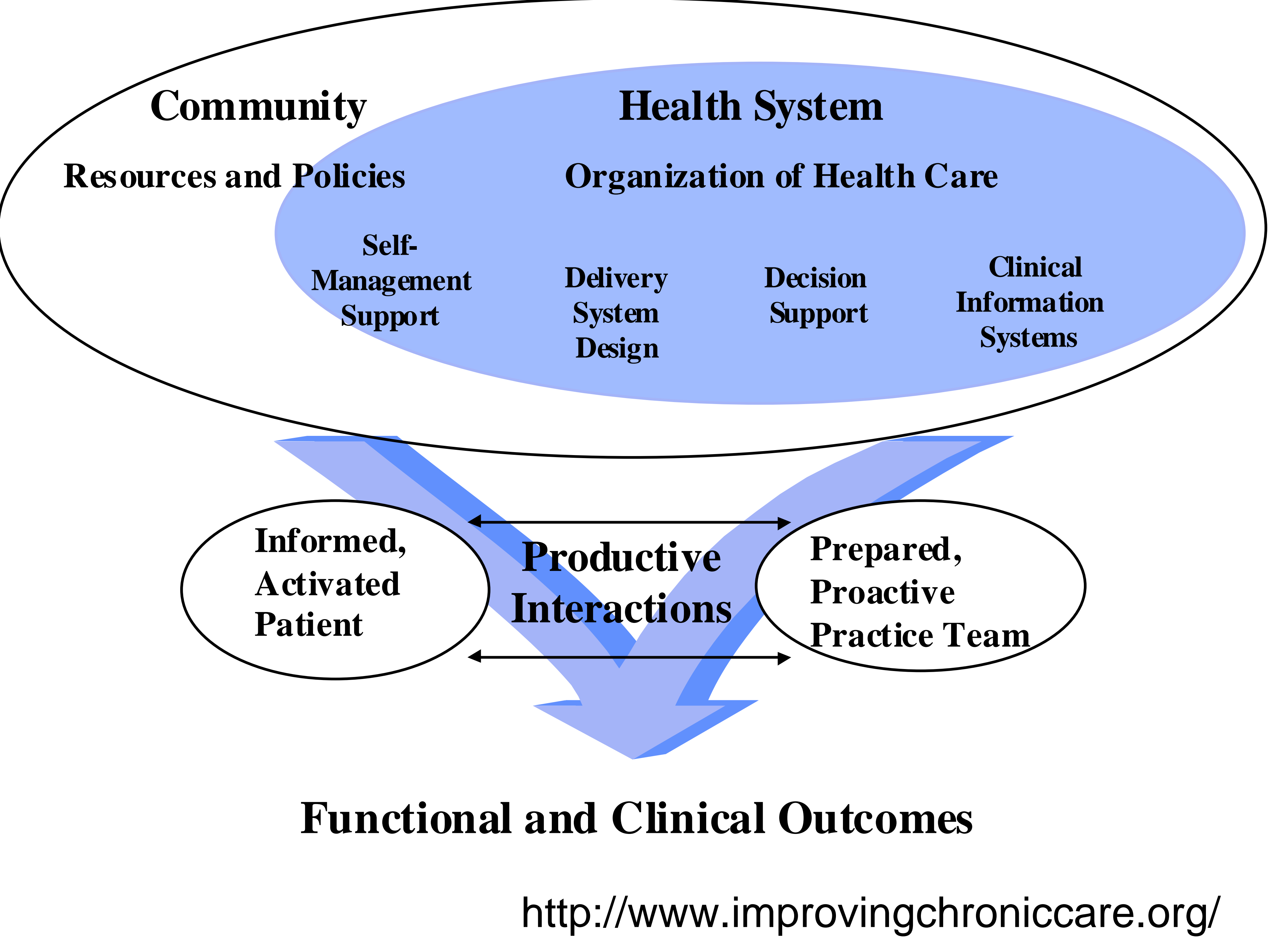
Is a card-carrying adult pulmonary and critical care physician who exclusively cares for adults, although he likes children. These remarks are adult-oriented, though no violence or nudity will be shown.

Objectives

1. Describe an office team approach to care of patients with asthma
2. Describe current best practice around office management of asthma
3. Describe quality improvement activity around asthma disease management in the office

Rocket science:
Asthma friendly doctor AND staff

- Competent
- Available
- Incorporates elements of the Chronic Care model


Community
Health System
Resources and Policies
Organization of Health Care
Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems
Informed, Activated Patient
Productive Interactions
Prepared, Proactive Practice Team
Functional and Clinical Outcomes
http://www.improvingchroniccare.org/

Aussies know what’s what

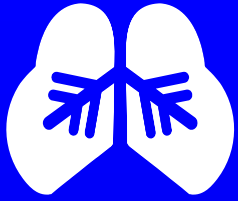
- How are you treated on the phone and in the office?
- Does the doctor offer and encourage longer appointments?
- Are they willing to listen and take time to talk and explain things?
- Do they believe in prevention?
- Do they treat you as a partner in health care?
- Have they chosen tests and procedures carefully, and prescribed medication carefully?
- What is the waiting time for appointments? Will they see emergencies immediately?
- Can they be contacted by phone?
- Do they have office hours or after work hours?
- Can you have the same doctor in a multi-doctor practice for on-going care?

Asthma Foundation of Queensland (AU)

Aussies know what's what

- Do they have a particular interest in asthma?
- Would they refer you to a respiratory specialist if there were any difficulties in identifying causes and in treating them?
- Do they suggest twice yearly reviews if you remain well?
- Do they have a machine to test your breathing capacity, called a spirometer, in the office and do they regularly use it?
- Are they more likely to suggest a puffer and spacer rather than a nebulizer?
- Do they routinely use an Asthma Action Plan?

Asthma Foundation of Queensland (AU)



Working Within Time Constraints of Office Visits

- Have patients complete questionnaire in waiting room
- Schedule more frequent visits initially
- Delegate some tasks to nurses or office staff:
  - Spirometry
  - Review MDI technique
  - Review daily peak flow

Major barriers to physician-patient partnership in asthma

- literacy, numeracy
- depression, anxiety
- substance use
- domestic violence
- language discordance
- MD/clinic philosophy on availability

From years of practice

- Consistent message from staff
  - “no cough syrup”
- Interest in patient’s concerns (actively elicited)
- Communication styles
  - Active listening
  - Closing the loop
  - Motivational interviewing
  - Shared goal-setting

Other basics

- Support materials
- Encourage independence
  - Action plans
  - Education
  - Sharing of experiences (shared medical visits)

Materiel

- Placebos for common drug delivery devices and spacers
- Peak flow meters
- Action plans
- Materiel for schools (e.g. certificates to carry Rx)
- Literature (appropriate) with info on where to learn more (e.g., http://www.texasasthma.org/)

Semi-acute care in the office

- Ability triage and handle sub-acute exacerbations
- Medicines
- Protocols for assessment and care
  - Over phone
  - In office
- Used as an opportunity to learn

Assessment at follow-up

- Activity/control of asthma:
  - since last visit: ER visits, hospitalizations, bursts of prednisone
  - in past two weeks:
    - #nights w/symptoms
    - #days w/ >3 doses albuterol
- problems with medication
- competence

Assessment at follow-up

- Activity of asthma since last visit
- problems with medication
- competence

Assessment at follow-up

- Activity of asthma since last visit
- problems with medication
- competence
  - Uses MDI appropriately
  - Monitors PEFR appropriately
  - Knows Sx of worsening airflow
  - Understands steroid/bronchodilator
  - Knows when to start prednisone

Predictors of ED visits for asthma

- awakened from sleep with asthma in past month
- admitted to hospital in past year
- seen by more than one MD for asthma in past year
- higher self-reported severity in past month
- oral steroid use in past month

Wakefield, Chest 1997;112:1527

Anticipation

- Use of data and simple algorithms to predict risk
  - ACT
  - ATAQ
- Simple, can be done by patient in waiting room

Factors associated with successful education

- group education probably as effective as one-on-one
- written vs. verbal vs. video
- mutual participation in goal-setting
- patient/provider language concordance
- availability of physician when patient needs support in activating an action plan

Principles of asthma education

- individualize therapy to each patient's:
  - best PEFR
  - triggers
  - particular symptoms
- monitor disease regularly, modifying Rx to *current* circumstances
- emphasize *chronicity* of illness

Fish and Peters, 1997

Action plans: key elements

- Understandable
- concrete
- reviewed/reinforced/modified
- prednisone Rx
- actions if failing (phone numbers, local hospital, etc)

Review of action plan activation

- How long were you sick before you noticed?
- What made you decide to act?
- What actions did you take?
- How did you know they were working?
- What made you decide to stop prednisone?
- What would you have done if it did not work?
- What did you learn?
- Did the plan we made help? Why/why not?

Problem Solving

1. Identify the problem
2. List all possible solutions
3. Pick one
4. Try it for 2 weeks
5. If it doesn’t work, try another
6. If that doesn’t work, find a resource for ideas
7. If that doesn’t work, accept that the problem may not be solvable now

The IHI Model for Improvement

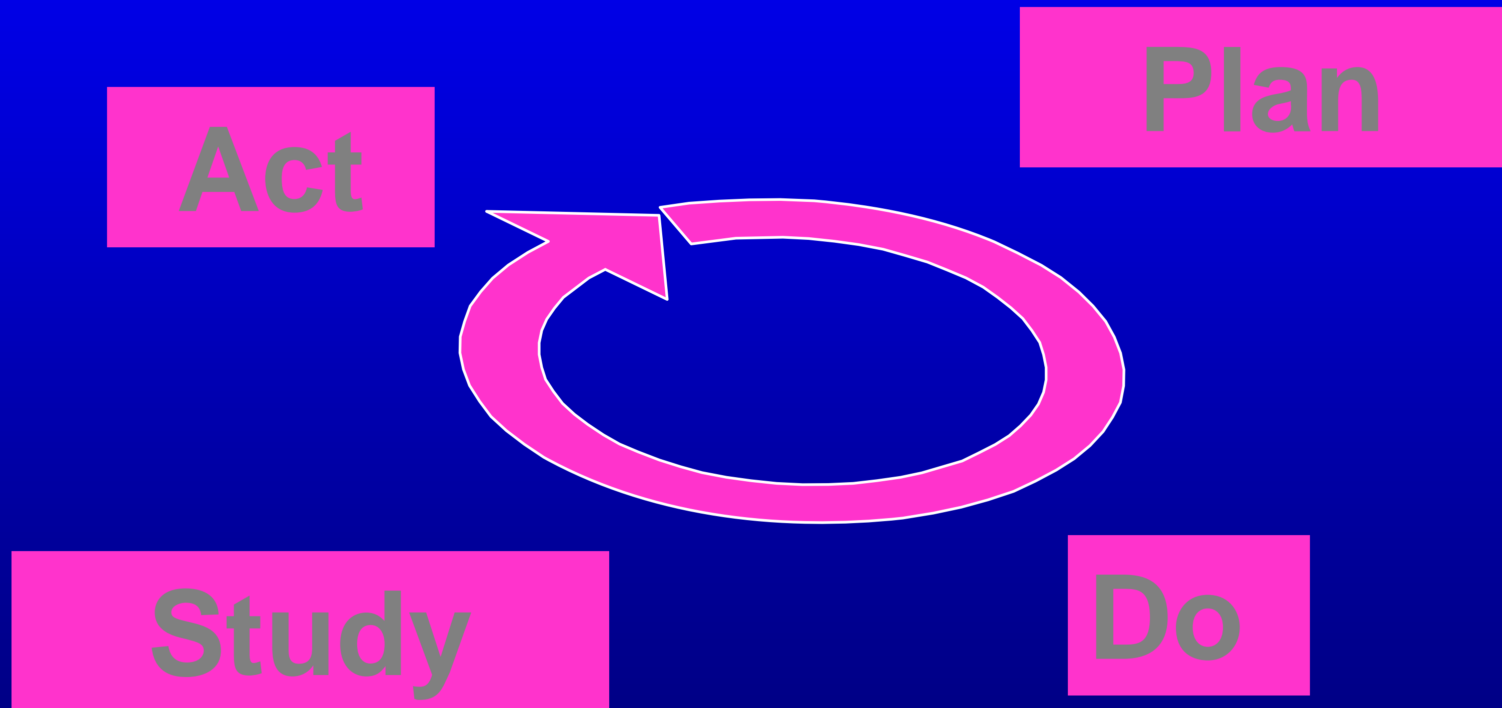
What are we trying to accomplish?

How will we know that a change is an improvement?

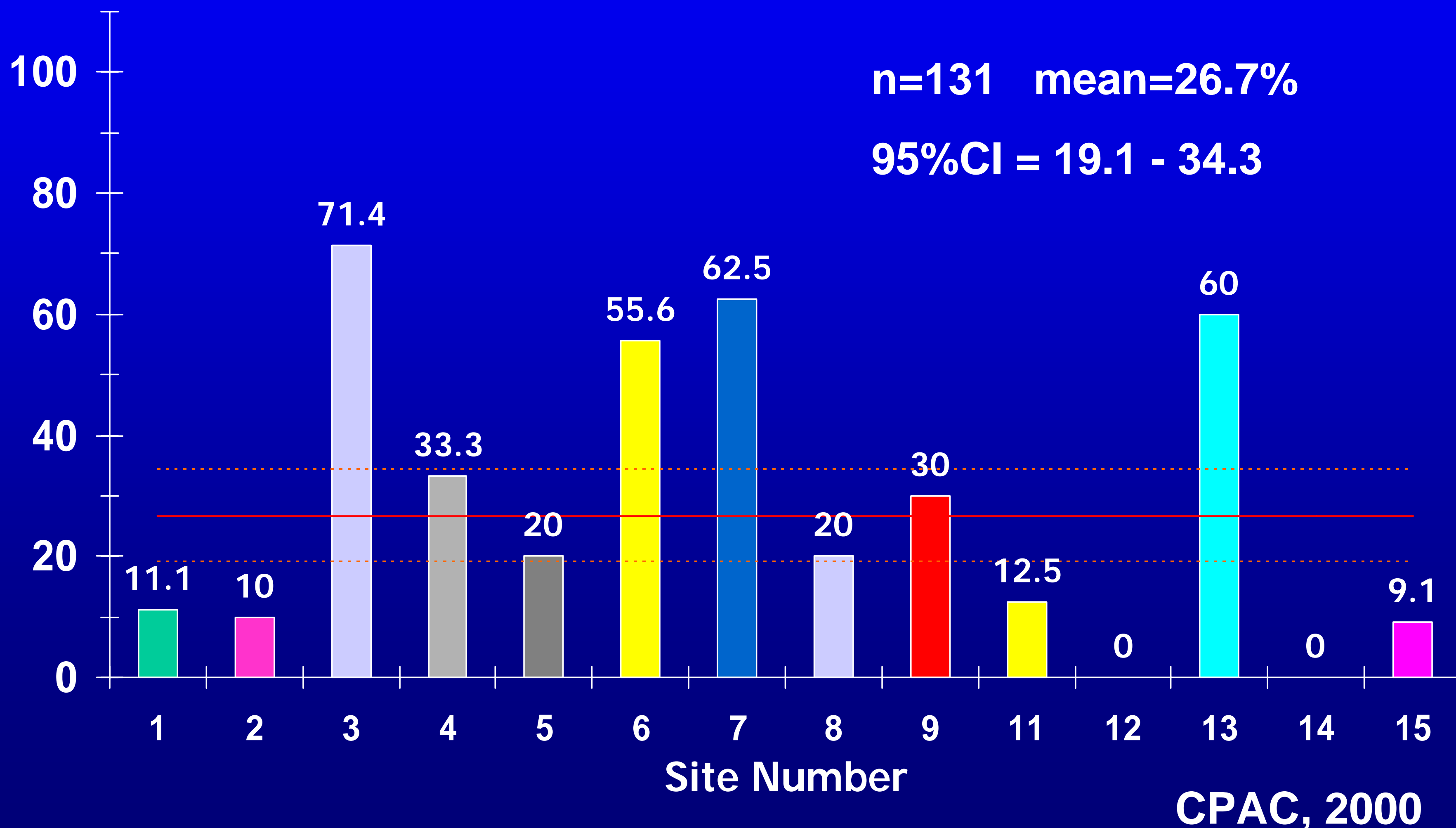
What changes can we make that will result in an improvement?

- Aim
- Measures
- Ideas

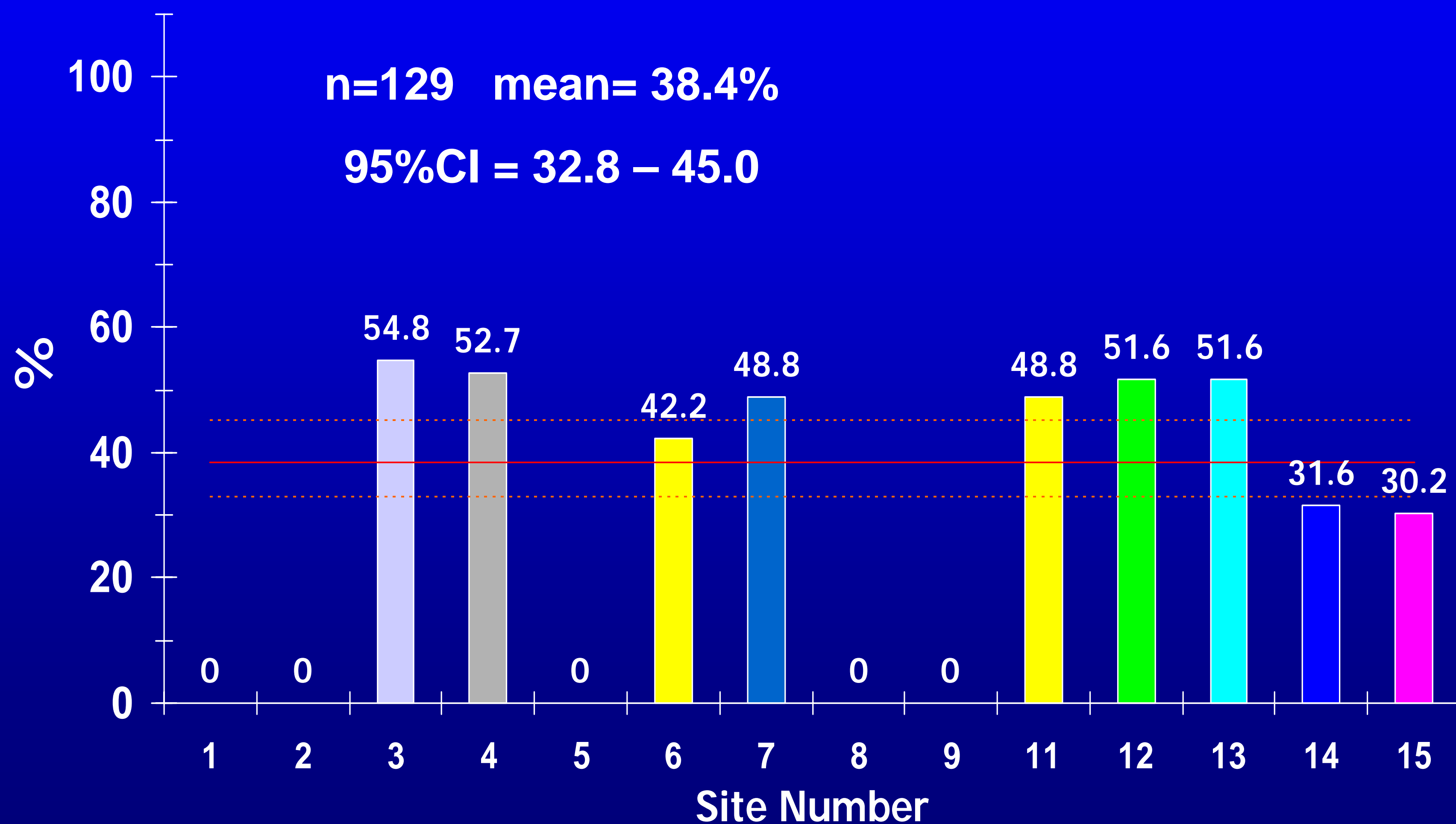
CYCLE for Learning and Improvement



Documentation of rescue albuterol use
Cycle 1: Baseline Data



Documentation of urgent office visit, ED visit, hospitalization
Cycle 1: Baseline Data



CPAC, 2000

Asthma Follow-Up Visit

Today's PEFR:___ Best:___Pred:___

Tobacco: current/former/never/scndhnd

Since last visit (date):

#Hosp. admits:__ #ER visits:__

#Days work/school missed:___

In last 2 weeks:

Symptoms: #days___#nights___

Can albuterol lasts: #days ___

Severity: mild int/mild/mod/sev perst

Actions:

Observed peak flow tech.	Y/N
Observed MDI/spacer tech.	Y/N
Created/reviewed action plan	Y/N
Added/adjusted inhaled steroids	Y/N
Counseled - inhaled steroids	Y/N
Counseled - smoking cessation	Y/N
Discussed trigger avoidance	Y/N

Decision support does not need to be high-tech to work:

"Asthma Stamp"