AHAP
Annual Report Summary

Lisa Crosby, DNP
Cincinnati Children's

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Cincinnati AHAP Goals

- Engage with families whose children have been admitted or seen in emergency department for asthma
- Provide home visit services to help address asthma triggers and other needs in coordination with existing asthma services to implement EXHALE guidelines
- Improve asthma control (measured by ACT scores)
- Reduce ED/hospital admissions for asthma

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Overall aim

This improvement project aims to align resources and will involve collaboration with community and institutional partners, including Medicaid managed care organizations

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Objectives

- To learn about home asthma triggers and needed mitigation for children with poorly controlled asthma.
- **Interventions will impact the 4 key drivers:**
  - patient's access to medications
  - patient's ability to use medication appropriately and adherence to medication regimens
  - reduction of environmental barriers to achieving optimal asthma care
  - continuous contact/relationship with the patient and family

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Milestones

- Multiple asthma interventions
- Pediatric Environmental Health Specialty Unit
- Large clinical network

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Activities

- Formal and informal CHW asthma trainings and meetings
- Review and discussions with CHW and CHW supervisor
- Home visits
- In-person visits during asthma admission

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Data

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Results

Program Year	Hospital/ED Pre-ASME	Hospital/ ED Post-ASME	ACT Score Pre-ASME	ACT Score Post-ASME	Average change in ACT Score*	% poorly controlled Pre-ASME	% poorly controlled post-ASME
1	1.6	0.4	17.8	18.4	0.6	72%	53%
2	3.9	0.5	17.1	20.3	3.1	62%	46%
3	1	0.1	13.6	20.1	6.5	71%	10%

* Minimum clinically important difference – 2 points

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EVALUATION

Program patient/family engagement summary

Program Year	Number enrolled	Contacted not enrolled	Age at enrollment (yrs)	Hospital/ED at enrollment	ACT at enrollment
1	18	TBD	7.9	1.6	17.8
2	13	TBD	5.9	3.9	17.2
3	31	20	7.3	TBD	13.5

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Partnerships

- Partnering with Primary Care Asthma RN
- Partnering with Health Equity Asthma team at CCHMC
- Alignment with Asthma Learning System at CCHMC
  - Partnering with local Health Dept and People Working Collaboratively

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Adjustments based on feedback

- Provided a “menu” for families to choose items
- CHW does ASME visit on porch
- Conversation about asthma – avoid jargon
- Discuss potential benefits for health beyond the actual items being dropped off
- Working to better connect with other services to address needs (food pantry, etc.)

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Strengths/Challenges

- Strengths
  - Long history of asthma interventions
  - Pediatric Environmental Health Specialty Unit
  - Large clinical network
- Challenges
  - Limited experience with home visitation for asthma
  - Paradigm shift
  - CHW staff turnover
  - Need to align/coordinate with other asthma initiatives at CCHMC
  - COVID-19 Pandemic

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Conclusions

- Observing steady improvement in ACT scores and ED/hospitalizations for children in program (year 3 was most promising)
- Difficulties in starting program during COVID-19
- New paradigm of care for hospital – learning curve

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Sustainability

- Continued partnership with primary care and Social Work/CHW team
- Will continue with Asthma CHWs in primary care and Healthvine
- Determine best methodology to determine which asthma patients the CHW will most significantly impact

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Future Direction

- Continue to develop expertise in CHW staff regarding asthma
- Improve internal educational materials regarding asthma
- Iteratively improve program based on family feedback and changing conditions
- Integrate this model into existing asthma programs at CCHMC
- Partnering with Healthvine Asthma Team

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