Background

Traditional healthcare systems focus on episodic care rather than proactive, preventative disease management for chronic conditions.

Resources are fragmented and under utilized internally and within the community.

As part of the IHI Triple Aim, population health programs help create coordinated networks to improve outcomes.

Asthma is the most common chronic condition in children 2-17 years of age, affecting over six million children nationwide. It is the third leading cause of hospitalization and leading cause of missed school days for children under 18. National annual cost of providing care for children with asthma is $3.2 billion.

Project Aim

Over the period of a year to be completed by July 2015, we aimed to create a reproducible model focused on interdependent collaboration within the community and our healthcare system to thrive in an environment which emphasizes value over volume.

Project Design

Applying IHI’s High Impact Leadership Framework and lessons from the I-CAN experience we were able to develop our pediatric population health model.

Using asthma as our initial population, we aimed to create a blueprint that could be spread to other disease processes.

Key strategies incorporated included:
- Motivating Vision
- Relational Strategizing
- Asset Mapping
- Snowflake Model
- Interprofessional Teaming
- Mobilizing Collective Action

Actions Taken

Asthma was identified as the pilot population for developing our framework.

An initial gap analysis served to recognize the need for collaboration and increased efficiency between all members of the healthcare team and other stakeholders to ensure that our populations are appropriately identified, our definitions are standardized and care delivery is consistent across the continuum.

Multidisciplinary teams were formed to work on education, information technology and medical management standardization. Another focus for the collaborative team was to improve patient access to primary care physicians, specialists and medications.

External resources were identified and we established relationships to create a network of community stakeholders.

Utilizing this network we were able to influence patient well-being through increased awareness, improved access and standardized education.

Outcomes

- LOS decreased by 12%
- Readmit rate decreased from 2.1% to 1.5%
- Discharges (admits) decreased by 29%
- ER touch points per MRN (testing) decreased by 3%
- ER cost per touch point increased by 6% from CY 2013-2014 but then a 4% decrease from 2014 to 2015

Lessons Learned

- Importance of early engagement of all stakeholders
- Time and resources greater than anticipated
- Be innovative and leverage current resources
- Employ multiple mechanisms of communication

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