

ASTHMA TRAINING PROJECT FINAL REPORT

INTRODUCTION

This report describes the Asthma Training Project undertaken by the North Carolina Division of Medical Assistance (DMA) Managed Care Section and the Center for Children's Healthcare Improvement (CCHI) from June 2003-June 2004. The primary purpose of the project was to develop a training approach to build the capacity of DMA Managed Care Program Operations and Quality Management staff to effectively assist practices in improving asthma care delivery. The project used specific quality improvement training strategies that emphasize: 1) the use of focused site visit consultations; 2) data collection and feedback; and 3) the application of tools to improve asthma care quality. The project also sought to assess practices' readiness to participate in asthma care quality improvement activities.

Practices targeted for inclusion in this project were those who had an unusually high number of patients with severe disease (as determined by emergency department visits and hospitalizations) and practices who were not involved in the Community Care North Carolina (CCNC) network. CCNC is North Carolina's largest managed care program for Medicaid recipients with established quality improvement projects in place for asthma management.

The approach developed and implemented in this project included the following elements described in detail in the Methods section of this report:

1. Training of DMA Managed Care Section Staff
2. Development of a systematic process for focused site visits with selected practices which included:
 - the assessment of current asthma clinical processes,
 - the provision of feedback to practices about their systems of asthma care and
 - the dissemination of tools and resources.
3. Establishment of follow-up activities

During the course of this project, a number of tools and materials were developed or refined. Each of these is attached as an appendix and described in the Methods section of this report:

1. Chart Review
2. Chart Review Instructions - Question by Question
3. Asthma Care Questionnaire
4. Asthma Care Questionnaire Instructions – Question by Question
5. Debrief Tool
6. Debrief Tool Instructions – Question by Question
7. Asthma Toolkit
8. Feedback Letter to Practices

BACKGROUND

In June 2003, approximately half of North Carolina's Medicaid enrollees were assigned to practices that were part of the CCNC network's asthma disease management program.

These practices received training and case management support for asthma care through CCNC. At the time of this project's inception, plans were underway to expand greatly CCNC network capacity across the state.

This project targeted practices that contracted with Medicaid but were not yet part of the CCNC network. The DMA Managed Care Section wanted to build on the results of the 2002 NC DMA Asthma Learning Collaborative by providing opportunities for quality improvement activities with these non-CCNC practices. The Division would provide content similar to that offered through the Learning Collaborative but would not require the level of participation a Learning Collaborative demands (e.g. several one-day workshops, monthly conference calls, data collection). With the assistance of CCHI, the DMA Managed Care Section initiated the Asthma Training Project to help these practices improve their care of patients with asthma and also prepare for involvement in CCNC quality improvement activities.

As of June 2003, the targeted practices were already involved in routine chart audits conducted by the Section's Quality Management Nurses and Managed Care Consultants as part of periodic site visits to assess compliance with Medicaid regulations and Carolina ACCESS program requirements. With this activity, the Managed Care Section's leadership saw an opportunity to enhance the existing site visits to help practices learn about ways to improve asthma care and prepare for quality improvement activities that would occur as they became involved in CCNC.

Asthma was selected as the clinical focus for the enhanced site visits for several reasons. First, CCNC had identified asthma as a top priority for disease management as it is the most common and costly disease among children (ages 0 – 18). Second, focusing on asthma made it possible to utilize and build on materials and strategies that had been developed and proven effective in previous asthma projects conducted by the DMA Managed Care Section and CCHI.

METHODS

The Asthma Training Project piloted 3 strategies to increase the capacity of DMA staff members to improve asthma care delivery for "high risk" practices. These strategies included: 1) targeted training of DMA Managed Care Staff; 2) development of a systematic process for focused site visits with "high risk" practices; and 3) establishment of follow-up activities.

The following section describes the implementation activities of these three strategies.

I. DMA Managed Care Section Staff Training

During the course of the project, CCHI conducted three half-day training sessions with eleven DMA Managed Care Section staff including both quality management nurse consultants and program operations managed care consultants. The training sessions were designed to prepare DMA staff to conduct enhanced asthma and quality-improvement-focused site visits and establish follow-up activities. Members of the CCHI project team conducted the training using adult learning techniques that actively engaged participants in the pilot training curriculum. Training objectives for each session are listed below. (See Appendix A for training agendas).

Training 1: November 2003

Objectives

1. Discuss the purpose of the asthma-focused site visits, the proper use of the site visit materials, and the intended use of the results within the context of the Model for Improvement.
2. Understand the recommended site visit approach and the data collection instruments.
3. Identify new strategies to improve the site visit approach and accelerate improvement in asthma care.
4. Identify available resources/support for sustaining the site visit effort and promoting improvement.

Training 2: February 2004

Objectives

1. Describe the purpose and activities of the site visit to practice physicians and staff.
2. Explain the purpose of the tools in the asthma toolkit for practices.
3. Identify strategies to support practices in improving asthma care

Training 3: June 2004

Objectives

1. Discuss project accomplishments/progress to date and lessons learned.
2. Conduct chart reviews and deliver toolkit with confidence.
3. Identify follow-up strategies to support practices in improving asthma care.

II. Development of a Systematic Process for Focused Site Visits

The site visits were conducted by DMA Managed Care QM Nurses and Managed Care Consultants operating in teams of two (one nurse and one managed care consultant). The implementation of a systematic process for focused site visits provided the opportunity for these trained DMA staff to offer each practice an assessment of its asthma care delivery system through a structured interview and feedback from chart reviews. Division staff identified training, tools and support for improvement for the practice.

A. Identification of “high risk” practices

Prior to the site visit, training participants reviewed claims data as determined by ED visits and hospitalizations to identify practices that would likely benefit from a site visit focused on assessing and improving asthma processes. Practices selected to receive focused site visits met the following criteria:

1. Claims data showed patients in the practice population identified as having chronic asthma per HEDIS criteria with two or more emergency department visits or two or more hospitalizations with primary diagnosis of asthma during the two timeframes (10/01/02-09/30/03 and 01/01/03-12/31/03)
2. Higher Carolina ACCESS enrollment (100 enrollees or more)
3. Largest percentage of asthma patients per population (at least 30 asthma enrollees)
4. Relatively high rates for hospitalizations or emergency department visits (3 or more)

If no practices within the six geographic regions met these criteria, then a large practice in the region was randomly selected by the Managed Care consultant to receive the enhanced site visit. The goal was two site visits per region per quarter. For regions with more than two practices identified, the largest practices were selected.

Conducting the Site Visit

During these visits, DMA staff applied strategies for assessing the practices' clinic processes for managing asthma care and their readiness to participate in quality improvement activities. They also raised awareness in the practice of their patients' use of emergency department and hospital care and assessed practice compliance with Medicaid regulations as a means of providing feedback and engaging the practice in quality improvement. As noted earlier, the Managed Care Section staff offered assessment and resources for education, tools and support to improve asthma care.

Each site visit included:

1. Review of the quality utilization report
2. Chart abstraction designed to assess asthma care processes
3. Assessment of regulations compliance
4. Structured interview with a physician or practice staff member in each practice to assess asthma care processes
5. Education about resources and tools to help practices better manage asthma in their population

These focused site visits were also intended to build a positive relationship between the practice and the managed care consultant so that the managed care consultant would be viewed as a resource that could be called upon for technical assistance. The systematic process developed for the focused site visit included the following activities:

1. Describe the reason for the visit and describe the role and function of the DMA Managed Care Section, the QM Nurse and the Managed Care Consultant. The Managed Care staff also reviewed the purpose of the Carolina ACCESS program with the office staff and answered program related questions.
2. Review Quarterly Utilization Report
3. Perform medical record reviews using the Asthma Chart Review forms
4. Complete the PCP Assessment Tool
5. Review and discuss the ER Report, Enrollment report and Referral Report data
6. Complete the Asthma Care Questionnaire
7. Discuss the Asthma Toolkit Materials with the physician or practice staff

B. Assessment of Current Clinical Processes

Chart Reviews

During each site visit, trained consultants conducted an assessment of nationally recommended asthma clinic processes by reviewing charts and interviewing physicians and practice staff. Systematic assessment of clinic processes for the management of asthma care was conducted by the Managed Care Section team to establish a baseline measurement of practice performance and reveal areas for improvement in asthma care. The clinical processes assessed included:

1. Clear diagnosis of asthma

2. Diagnostic criteria for asthma
3. Severity classification
4. Persistent asthmatics on anti-inflammatory agents
5. Use of asthma management plan
6. Environmental tobacco smoke exposure discussed
7. Allergies assessed
8. Flu shot offered
9. Scheduled follow-up visit

The target number of chart reviews per focused site visit was ten. Charts for review were chosen by DMA staff prior to the site visit. For each practice, a list was generated of patients that met the following criteria in the specified timeframe:

1. Linked with practice
2. Meet HEDIS criteria for chronic asthma
3. Meet continuous enrollment criteria
4. Two or more hospitalizations or emergency department visits
5. One or more office visits

Any deviation from the selection criteria was noted on the Asthma Chart Review Tool. (See Appendix B). DMA staff conducting the site visit abstracted information from the charts and recorded the results on the Asthma Chart Review Tool.

Practice Staff Interviews

In addition to the chart review, each practice was surveyed by the DMA staff about its asthma care processes using the Asthma Care Questionnaire (See Appendix C). This survey's purpose was two-fold: one, it provided a way to compare the practices' reported asthma care processes with actual asthma care processes as documented in reviewed charts; and two, it offered the DMA Nurse and Managed Care Consultant a tool to help structure interaction with the physician or other practice staff during the site visit.

Primary Care Provider (PCP) Assessment

As with current routine site visit protocol, during the focused site visit DMA Consultants utilized the PCP Assessment to assess each practice's adherence to contractual obligations.

The Quality Utilization Review (QUR)

As part of the assessment process, the Quality Utilization Review was also conducted to gather information about emergency department use and hospitalizations among the practice's patient population.

C. Provision of Feedback to Practices about their Systems of Asthma Care

In order to motivate practices to engage in quality improvement activities, the DMA staff consultants used information from the assessment process to provide feedback regarding the practice's systems of care. DMA staff supported and encouraged the practices' efforts to improve by providing relevant, useful, and practical information about how the practice might enhance asthma care based on the assessment results. Discussion of Quarterly Quality Utilization Review documents also provided DMA staff an opportunity to educate the practice about emergency department use and hospitalizations among its patient population.

D. Dissemination of a Mini-Asthma Toolkit

As part of the focused site visit, a draft mini Asthmas Toolkit was given to each practice. The purpose of the draft mini-Asthma Toolkit was to provide practical targeted tools that promote and support adoption of key elements of good asthma care, thereby making changes easier. The Asthma mini Toolkit included the following:

Materials for Providers

- Severity Assessment/ Medications Sheet
- Asthma Visit Form
- Management Plans
- Smoking Cessation Tool
- Asthma Websites for Patients

Resources for Providers

- Updated Resources List
- Asthma Websites for Providers
- AAP eQIPP Handout

At the end of the project a complete toolkit was developed for practices based on the Chronic Care model developed by Ed Wagner and the NHLBI guidelines. It was reviewed by Laura Gerald, MD of CCNC and includes several tools developed by the CCNC program networks. (See Appendix D for the table of contents for the toolkit and introductory letter).

III. Establishment of Follow-up Activities

Specific follow-up activities were conducted by trained DMA staff to: 1) assess readiness of practices to participate in additional quality improvement efforts; 2) analyze chart review data and asthma care questionnaire; 3) provide a summary of data results to individualized practices using a feedback letter signed by the Assistant Director of Managed Care; and 4) distribution of the final toolkit.

Assessment of Readiness for Quality Improvement

Each practice was assessed for its readiness to participate in quality improvement activities. Following each site visit, the QM Nurse and/or Managed Care Consultant completed the Debrief Tool (See Appendix E). Readiness to participate in quality improvement was measured as follows:

1. Physician's participation in enhanced site visit
2. Physician's attitude toward asthma care tools
3. Physician's attitude toward site visit
4. Barriers to quality improvement at the practice
5. Type of resources requested by practices of the QM Nurse or Managed Care Consultant
6. Number of requests for additional materials or consultation following site visit

Data Analysis and Feedback Reports

Following each site visit, DMA staff also entered data from the Asthma Chart Review Tool into WebFormKit, an online database available to the DMA. Reports reflecting each practice's performance of asthma-related clinic processes and readiness to participate in

quality improvement activity were generated by CCHI for DMA to include in a letter to each practice visited. A sample is included in Appendix F.

Other follow-up activities included dissemination of complete Asthma toolkit, visits to select practices, referrals to eQIPP, local asthma coalitions or programs, and CCNC.

RESULTS

The primary purpose of the Asthma Training Project was to develop and test a training approach to build the capacity of DMA Managed Care Section staff to effectively assist practices in improving asthma care delivery. The project piloted targeted quality improvement training strategies that emphasize: 1) the use of focused site visit consultations; 2) data collection and feedback; and 3) the application of tools to improve asthma care quality. The project also sought to assess practices' readiness to participate in asthma care quality improvement activities.

DMA Staff-level

As a result of the Asthma Training Project, 11 DMA staff members were trained in targeted quality improvement methods and gained competence and confidence in applying these methods in the area of asthma care delivery with "high risk" practices.

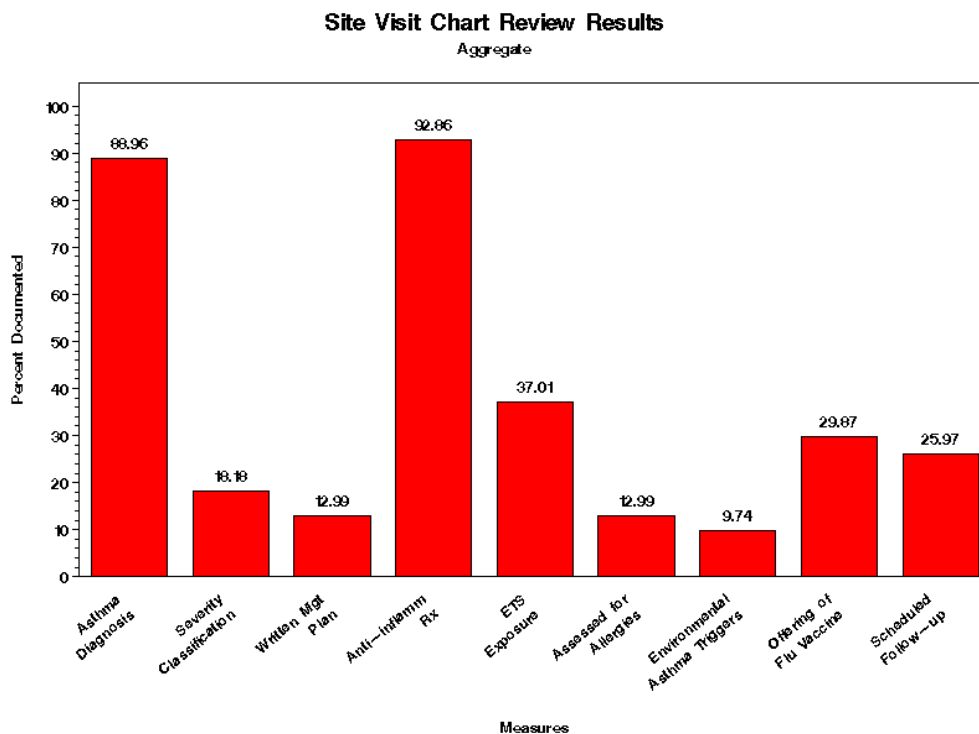
Results of these efforts also included the development of training curriculum and refinement of tools to: 1) support the DMA in supporting practices in implementing targeted improvement efforts; and 2) provide practices with much needed resources about how to improve care for children with asthma. Consequently, curriculum, tools and materials from the DMA Asthma Training Project have informed the implementation an asthma care dissemination project, NC AHEC's *A1R/1000* Initiative and strategic plans for the *Improving Performance in Practice* Initiative.

Practice-level

As a result of the Asthma Training project, the following practice-level activities occurred:

- 24 site visits were completed
- 159 chart reviews were conducted
- 24 Asthma care questionnaires were completed
- All 24 sites received follow-up contact

The following table includes a summary of practice-level results of chart reviews for all 24 site visits. The feedback letter (Appendix F) provided to each of the 24 practices included the same table as well as individual practice-level data on these same variables.



Comparison of DMA Chart Abstraction and Asthma Care Questionnaire

A total of 24 practices submitted chart review and data from the Asthma Care Questionnaire. Further analysis of this data was conducted to determine whether the Asthma Care Questionnaire could serve as an alternative to conducting chart reviews. Results showed that 1/3 of total practices routinely report classifying asthma severity. Furthermore, patients in these reporting practices are approximately three times as likely to be classified as those in practices that do not report classifying severity; however overall rates are low (34% vs. 12%). Additional investigation of the utility of chart abstraction versus the Asthma Care Questionnaire is needed to confirm and determine significance of these results. In addition, this analysis found that:

- Almost 1/3 of practices reported routinely using asthma management plans
- Patients in practices that reported using asthma management plans were nearly twice as likely to have a management plan documented as those in practices who do not report using management plans; however, overall rates are low (17% vs. 10%).
- Many practices mentioned patient non-compliance as a primary barrier to improving asthma care in their practice, although one might ask, “non-compliance with what?” since only 12% of charts overall contained a management plan.

DISCUSSION

The Asthma training project was designed to build capacity among the managed care staff to conduct targeted practice visits utilizing a method to identify and understand practices at ‘high risk’ relative to asthma care outcomes and test a systematic process for conducting office visits with consistency across practices, regions, and site visit teams. CCHI assisted the Division of Medical Assistance in the development and implementation of this systems approach to supporting practices in improving care by providing training to DMA staff in

quality improvement methods .As part of this process, trained consultants applied targeted improvement methods taught in the training sessions and provided tailored feedback and support to practices to regarding their systems of asthma care.

This type of training approach is an essential component of building capability and capacity for quality improvement. It involves applied learning of skills using a systematic process that includes 1) the identification of “high risk” practices; 2) the assessment of current clinical processes using nationally recommended standards; 3) the provision of targeted feedback; 4) the dissemination of resources and tools; and 5) the establishment of follow-up activities.

Additionally, designing methods for content similar to a Learning Collaborative in a manner that does not require the level of participation by practices is a valuable approach for advancing quality improvement efforts of the DMA and enhancing practice-based capabilities. These types of strategies can be a valuable component of spreading improvement through the CCNC practice network.

CCHI would like to acknowledgement the leadership of Anne Rogers & Betty West from DMA Managed Care Section, the tireless effort of the Quality Management RNs and Managed Care Consultant staff, and the practices who gave their time to participate in this project.

For further information please contact Anne Rogers at Anne.Rogers@ncmail.net or Divvie.Powell@unc.edu

List of Appendices

- A. Training Agendas
- B. Chart Review Tool and Instructions
- C. Asthma Care Questionnaire and Instructions
- D. Asthma Toolkit & Letter
- E. Debrief Tool and Instructions
- F. Feedback Letter to Practices

**North Carolina Asthma Spread
DMA Site Visit Training
Jordan Center – Raleigh, NC
November 19, 2003
*Agenda***

<u>TIME</u>	<u>CONTENT</u>	<u>FACILITATOR</u>
8:00 a.m. – 8:15 a.m.	Welcome to Training and Introductions Project Background	Betty West Anne Rogers
8:15 a.m. – 8:30 a.m.	Review of Objectives and Agenda	Liana Richardson Leah Gilbert
8:30 a.m. – 8:45 a.m.	Overview of the Model for Improvement	Divvie Powell
8:45 a.m. – 9:30 a.m.	Model for Improvement – Aims <i>What are we trying to accomplish?</i>	Divvie Powell
9:30 a.m. – 9:45 a.m.	Break	
9:45 a.m. – 10:30 a.m.	Model for Improvement – Measures <i>How will we know that a change is an improvement?</i>	Divvie Powell Liana Richardson
10:30 a.m. – 11:00 a.m.	Model for Improvement – Ideas <i>What changes can we make that will result in improvement?</i>	Divvie Powell
11:00 a.m. – 11:15 a.m.	Break	
11:15 a.m. – 12:00 p.m.	“Pulling It All Together”	Liana Richardson
12:00 p.m. – 12:30 p.m.	Next Steps	Liana Richardson Leah Gilbert
12:30 p.m. – 1:00 p.m.	Training Evaluation Lunch	Leah Gilbert

**North Carolina Asthma Spread
DMA Site Visit Training #2
February 18, 2004
9:00 a.m. – 2:00 p.m.
*Agenda***

<u>TIME</u>	<u>CONTENT</u>	<u>FACILITATOR</u>
9:00 a.m. – 9:15 a.m.	Welcome and Introductions Review of DMA Vision	Betty West Anne Rogers
9:15 a.m. – 9:30 a.m.	Review of Training Objectives, Agenda, and Materials	Liana Richardson
9:30 a.m. – 10:00 a.m.	Care Model for Child Health, Diffusion of Innovations, and Model for Improvement: Aims <i>What are we trying to accomplish?</i>	Divvie Powell
10:00 a.m. – 10:45 a.m.	Asthma 101	Jim Stout
10:45 a.m. – 11:00 a.m.	Break	
11:00 a.m. – 11:45 a.m.	Model for Improvement: Measures <i>How will we know that a change is an improvement?</i>	Helen Powell
11:45 a.m. – 12:00 p.m.	Break (<i>Lunch Served</i>)	
12:00 p.m. – 12:30 p.m.	Model for Improvement: Ideas <i>What changes can we make that will result in improvement?</i>	Liana Richardson
12:30 p.m. – 1:15 p.m.	Instant Messaging 101	Liana Richardson Dave Goff
1:15 p.m. – 1:45 p.m.	Post-Visit Follow-up Activities	Divvie Powell
1:45 p.m. – 2:00 p.m.	Wrap-Up	Leah Gilbert Bonnie Rains

**North Carolina Asthma Spread
DMA Site Visit Training #3
Kirby Building Room 297
June 2, 2004
12:30 p.m. – 5:00 p.m.
*Agenda***

<u>TIME</u>	<u>CONTENT</u>	<u>FACILITATOR</u>
12:30 p.m. – until	Lunch Served	
12:30 p.m. – 12:40 p.m.	Welcome and Introductions Overview of Objectives	Betty West Leah Gilbert
12:40 p.m. – 12:50 p.m.	DMA Vision - Revisited	Betty West Anne Rogers
12:50 p.m. – 1:45 p.m.	Project Debrief	Divvie Powell
1:45 p.m. – 2:00 p.m.	Break	
2:00 p.m. – 2:45 p.m.	Chart Reviewing 101	Liana Richardson
2:45 p.m. – 3:00 p.m.	The New and Improved Toolkit	Liana Richardson
3:00 p.m. – 3:15 p.m.	Break	
3:15 p.m. – 4:45 p.m.	Post-Visit Follow-Up Activities	Divvie Powell
4:45 p.m. – 5:00 p.m.	Wrap-Up and Evaluation	Leah Gilbert

ASTHMA CHART REVIEW TOOL

Criteria for choosing chart to review: Chronic asthma per HEDIS criteria

Reviewer's Name _____

DMA Clinic ID# _____

Date of Asthma Chart Review for this patient ____/____/_____

DMA Patient ID# _____ Patient Date of Birth ____/____/_____

Number of Asthma ED visits for this patient in last twelve months _____

Number of Asthma hospitalizations for this patient in last twelve months _____

Date of first patient visit to this practice ____/____/_____

Date of last patient visit to this practice ____/____/_____

1. Is patient diagnosed with asthma or RAD (Reactive Airway Disease)?
 1. No (If No, Stop Here.)
 2. Yes, asthma (If asthma and RAD, then check asthma)
 3. Yes, RAD

2. What information was used to diagnose asthma or RAD? Check all that apply.
 1. Past Medical History of Asthma/Wheezing
 2. Symptoms (reported wheezing, cough, etc.)
 3. Physical Exam Findings (current wheezing, breath sounds, etc.)
 4. Peak Flow
 5. Spirometry/FEV₁/Pulmonary Function Testing
 6. Other, please specify: _____

3. Is Asthma Severity classified anywhere in the chart in the last 12 months?
 1. Severity Not Documented in chart
 2. Mild Intermittent
 3. Mild Persistent
 4. Moderate Persistent
 5. Severe Persistent
 6. Other, please specify: _____

4. Was a written Asthma Management Plan in the patient's chart?
 1. No or not documented
 2. Yes

5. Is the patient currently prescribed any of the following medications? Please circle all that apply. Use information from the last three clinic visits or the last twelve months whichever is the shorter time interval.

1. No asthma medications (Go to Question 6)
2. Accolate (Zafirlukast)
3. Advair (Fluticasone/Salmeterol)
4. Aerobid, Aerobid-M (Flunisolide)
5. Alupent (Metaproterenol)
6. Azmacort (Triamcinolone)
7. Beclovent, Vanceril, Vanceril-DS (beclomethasone dipropionate)
8. Flovent (Fluticasone propionate)
9. Intal (Cromolyn)
10. Primatene (Epinephrine)
11. Pulmicort Turbohaler or Respules (Budesonide)
12. QVAR (beclomethasone dipropionate HFA)
13. Serevent (Salmeterol)
14. Singulair (Montelukast)
15. Slo-phyllin, Slo-bid, Theodur, Uniphyl (Theophylline)
16. Tilade (Nedocromil sodium)
17. Ventolin, Proventil (Albuterol)
18. Xopenex (Levalbuterol)
19. Other, please specify: _____

6. Was exposure to environmental tobacco smoke addressed in the last year?

1. No or not documented
2. Yes

7. Has this patient been assessed for allergies in the last year?

1. No, patient was never assessed or assessment is not documented (Skip to Question 9)
2. Yes, patient was assessed more than 12 months ago (may include referral to allergist)
3. Yes, patient was assessed in last 12 months (may include referral to allergist)

8. If yes, what type of allergy assessment was done (includes testing done elsewhere)?

1. Skin testing
2. RAST or CAP (serum IgE) done
3. Not documented

9. Are there any environmental asthma triggers documented such as cold weather, exercise, dust, fumes?

1. No or not documented
2. Yes

10. Has this patient been offered a flu vaccine in the last year?

1. No or not documented
2. Yes

11. At the last visit, was a follow-up appointment for asthma scheduled for this patient?

1. No, not documented, or follow-up as needed
2. Yes

ASTHMA CHART REVIEW TOOL – Q x Q's

Criteria for choosing each chart to review: Chronic asthma per HEDIS criteria

Reviewer's Name – Full name, first and last, of the person completing this asthma chart review.

DMA Clinic ID# - The NC DMA provider identification code for this practice.

Date of Asthma Chart Review for this patient – Date that chart review was done in MM/DD/YYYY format.

DMA Patient ID# - Identification number according to DMA records for this patient.

Patient Date of Birth – Birth date of patient whose chart is being reviewed in MM/DD/YYYY format

Number of Asthma ED visits for this patient in last twelve months – From DMA utilization review data, the number of emergency department visits for asthma within the last twelve months or the four quarter period preceding this site visit.

Number of Asthma hospitalizations for this patient in last twelve months – From DMA utilization review data, the number of inpatient hospitalizations for asthma within the last twelve months or the four quarter period preceding this site visit.

Date of first patient visit to this practice – In the chart that is being reviewed, what is the date of the first utilization of any type at this clinic. Do not limit this to asthma visits.

Date of last visit to this practice - In the chart that is being reviewed, what is the date of the last utilization, the most recent visit? Do not limit this to asthma visits.

1. Is patient diagnosed with asthma or RAD (Reactive Airways Disease)? Look for asthma or RAD diagnosis anywhere in the chart. If there is both a RAD and an asthma diagnosis, document the asthma diagnosis. RAD stands for Reactive Airways Disease. It is sometimes used before an asthma diagnosis is used. Some practices use RAD rather than asthma in their charts. If there is no asthma or RAD diagnosis, check “No or not documented” and do not answer the remaining questions.

Where to look? Patient Visit Office notes, Physical Exam notes, Problem List

2. What information was used to diagnose asthma or RAD? Check all that apply – Note all information that is documented in the chart that was used for the asthma or RAD diagnosis. If “other” is used, please be as specific as possible.

Where to look? Patient Visit Office notes, Physical Exam notes, Consultation report, ER visit record sheet, Inpatient Hospital records, copies of records from previous physician

3. Is Asthma Severity classified anywhere in the chart in the last 12 months? According to the NAEPP guidelines, asthma severity should be classified as mild intermittent, mild persistent, moderate persistent, or severe persistent. These classifications drive the treatment options and monitoring of symptoms and lung function. If some other descriptor is used such as “bad asthma”,

“chronic asthma”, etc. please note this under Other. If it only states that the patient has asthma, note this as “Severity Not Documented in Chart.”

Where to look? Patient Visit Office notes, Physical Exam notes, Problem List, Asthma Management Plan, Consultation Report

- 4. Was a written Asthma Management Plan in the patient’s chart?** An Asthma Management Plan is a formal plan that helps the patient and their family monitor symptoms and lung function and determine what medications to take and what actions to take at home/school/daycare. If one has been developed and given to the patient, a copy will be in the chart or a note will be in the chart documenting this action.

Where to look? Patient Visit Office notes, Asthma Management Plan, copies of records from previous physician.

- 5. Is the patient currently prescribed any of the following medications?** Look for information about what prescription medications are being prescribed for this patient by this clinic. Current medications can be any prescriptions or refills made, or current medications noted as continued, in the last three clinic visits or the last twelve months, whichever is the shorter time interval. Evidence of actual prescription fills can be researched on the DMA patient database.

Where to look? Patient Visit Office notes, Physical Exam notes, Medication List, Prescription Refill sheets, Consultation report, ER Visit Record sheet, Inpatient Hospital records.

- 6. Was exposure to environmental tobacco smoke addressed in the last year?** Is there documentation in the chart over the last year that exposure to smoking has been assessed for this patient. The parent or patient may have been asked about their smoking habits or a more exhaustive inquiry may have been made. Any type of reference to smoke exposure is acceptable.

Where to look? Patient Visit Office notes, Physical Exam notes, especially under “Social History”, Consultation report, Initial History Questionnaire completed by the patient/parent.

- 7. Has this patient been assessed for allergies?** Is there documentation in the chart over the last year that allergens have been assessed. If not, answer “no or not documented” and skip to Question #9. Look for skin testing or RAST or CAP testing or a referral to an allergist for testing. If yes, please note if the testing or assessment was done in the last 12 months.

Where to look? Patient visit Office notes, Physical exam notes, especially under “health history”, Consultation report, copies of records from previous physician.

- 8. If yes, what type of allergy assessment was done?** Please note if the allergy assessment was done by skin testing, RAST or CAP, or if the type was not documented in the chart.

Where to look? Patient visit Office notes, Physical exam notes, especially under “health history”, Consultation report, copies of records from previous physician.

- 9. Are there any environmental asthma triggers documented such as cold weather, exercise, dust, fumes?** Look for evidence of asthma triggers documented in the chart. If the asthma is referred to as exercise-induced asthma, this qualifies as a Yes for this question.

Where to look? Patient visit Office notes, Physical exam notes, especially under “health history”, Consultation report, copies of records from previous physician.

10. Has this patient been offered a flu vaccine in the last year? Is there documentation in the chart over the last year that the patient has had a flu vaccine or that the patient was offered a flu vaccine? If the patient has been offered a flu vaccine but did not receive a flu vaccine, use “yes”. If the patient received a flu vaccine, use “yes”. If you can not that a flu vaccine was given or offered to the patient, use “No or not documented.”

Where to look? Patient Visit Office notes, Physical Exam notes under “Plan”, Consent Form for the flu shot signed by the patient.

NOTE: Many people receive flu vaccines from the Health Dept or at community locations; it is not necessary that the vaccine be given to the patient, but that it be offered to the patient.

11. At the last visit, was a follow-up appointment for asthma scheduled for this patient? Is there documentation in the chart at the last visit that a future appointment was scheduled for this patient to check on their asthma? Non-scheduled follow-up as needed does not qualify as a scheduled appointment for an asthma check-up.

Where to look? Patient Visit Office notes, Physical Exam notes under “Follow-Up Plan”, Consultation Report.

ASTHMA CARE QUESTIONNAIRE

The Asthma Care Questionnaire serves two purposes

- 1) *To facilitate a conversation around current asthma care services at the clinic*
- 2) *To collect practice-specific information about current asthma care services, policies, and resources.*

Please feel free to ask further questions while administering this tool and engage the interviewee in meaningful conversation around asthma care.

Date of Site Visit ____/____/_____

Name of Interviewer _____

Who answered these questions and what was their role at the clinic?

Full Name	Title

1. As a group, do the providers at this practice classify asthma severity according to the classification system: mild intermittent, mild persistent, moderate persistent, and severe persistent?
 1. Yes
 2. No
 3. Don't know

2. Do you use spirometry?
 1. Yes, at the clinic
 2. Yes, refer out
 3. No
 4. Don't know

3. Who in your practice provides patient or parent education on delivery devices, medications, triggers? Where is the patient or parent education provided?

	In Clinic	Off-site
1. Physician		
2. Nurse		
3. Medical Assistant		
4. Pharmacist		
5. Other, please specify		

4. Do providers at your practice use Asthma Management Plans?

If yes, how often?

a. Often	c. Never
b. Sometimes	d. Don't know

5. Do providers in your practice assess their patients with asthma for exposure to environmental tobacco smoke?

If yes, how often?

a. Often

b.

Sometimes

c. Never

d. Don't know

6. As a practice, do you actively assist parents and teens in their smoking cessation efforts?

1. Yes. If yes, how? _____

2. No

7. What percentage of patients with asthma ALSO have clinical allergy?

1. _____% 2. Don't know

8. What percentage of patients with asthma AND clinical allergy have received formal allergy testing?

1. _____% 2. Don't know

9. What type of formal allergy testing is utilized by most of the providers in your practice? Choose one.

- 1. No formal allergy testing is utilized
- 2. Skin testing (In clinic or referred out)
- 3. RAST or CAP (In clinic or referred out)
- 4. Don't know
- 5. Other _____

10. What percentage of your asthma patients have regular asthma check-ups (3-6 months)?

1. _____% 2. Don't know

11. Do you use an asthma registry to facilitate recalling patients who need regular follow-up asthma care? (Registry does not need to be computerized.)

- 1. Yes
- 2. No
- 3. Don't know

12. What percentage of your patients with asthma use the following for acute asthma episodes after office hours or on weekends?

1. After hours office care	_____%
2. Urgent care facility	_____%
3. Emergency department	_____%
4. Managed at home	_____%
5. Other	_____%

13. Does your practice have a mechanism in place to avoid emergency room care for acute asthma?

1. No
2. Yes
 1. If yes, what?

14. Do you have internet access at your practice?

1. Yes
2. No

15. From our data, your practice has a high percentage of patients with asthma. Do you have any insights for why that is the case?

1. Yes
2. No
3. Don't know

If yes, please explain:

Additional Notes:

ASTHMA CARE QUESTIONNAIRE – Q x Q's

Clinic ID # - DMA Clinic ID Number

Date of Site Visit – Date in MM/DD/YYYY format of the actual visit or the date that the questionnaire was completed.

Name of Interviewer – Who was conducting this interview and asking these questions? Please indicate first and last name.

Did one of the physicians working on this project have an opportunity to contact one of the physicians at this practice prior to your visit to discuss your visit? Was one of the physicians at the clinic contacted by one of the physicians on the project before this visit? If so, please note which of the project physicians initiated the contact and the name of the physician they were able to contact.

Who answered these questions? – Who was the primary person at the practice who gave the site visitor the answers to the questions in the Asthma Care Questionnaire? Give first and last names and degrees if applicable (for example: John Smith, RN). If more than one person answered these questions, identify each, and give their initials. Initial each of the questions that were answered by that person (for example: John Smith, RN, would be identified at each question he answered by JS).

What was their role in the clinic? – What was the role in the clinic of the person answering the questions? For example, if Dr. Doctor answered the questions, is Dr. Doctor the medical director, an intern, etc.?

16. As a group, do the providers at this practice classify asthma severity according to the classification system: mild intermittent, mild persistent, moderate persistent, and severe persistent?

NAEPP guidelines classify asthma into these four categories. The point of this question is to determine to what extent this classification system is being utilized in this practice in the opinion of the person to whom you are speaking. Many of the recommendations in the guidelines are based on this classification system.

17. What tools does your practice use to assess asthma severity?

NAEPP guidelines classify asthma according to symptom frequency and/or lung function (peak flow variability or FEV₁ as determined by spirometry). Mark all that are mentioned.

18. Do you use spirometry?

Does the clinic ever use spirometry in the clinic or does it ever refer the patient to get spirometry done?

19. Who in your practice provides patient and parent education on delivery devices, medications, triggers?

Is someone at the clinic doing asthma education such as showing parents and patients how to use a nebulizer, an inhaler, a spacer, how to avoid asthma triggers, etc? Does the clinic utilize the pharmacist to give this information to the patient or parent? This information will be helpful in determining the audience for improved educational efforts.

20. What percentage of providers at your practice use Asthma Management Plans?

Is there a clinic policy to give asthma management plans to patients with asthma? Are asthma management plans given sporadically or dependent on the physician?

21. May I have a copy of one of your Asthma Management Plans?

Request a copy of a typical Asthma Management Plan used by the practice. How difficult was it to find one? Does the practice use a standard format?

22. What percentage of providers in your practice assess their patients with asthma for exposure to environmental tobacco smoke?

Is assessment of exposure to environmental tobacco smoke a routine procedure in this clinic? Do physicians routinely ask the patient or parent about smoking in the home, daycare, car, and other locations where the patient might be exposed?

23. As a clinic, do you actively assist parents and teens in their smoking cessation efforts?

Does the clinic have a goal to assist patients and parents in their smoking cessation efforts?

If yes, how? How is this goal implemented? Is the patch prescribed? Are referrals made to smoking cessation classes or support groups? Are flyers or booklets given out?

24. What percentage of patients with asthma ALSO have clinical allergy?

Do many of the patients with asthma at this practice have clinical allergy? Has this been assessed?

25. What percentage of patients with asthma AND clinical allergy have received formal allergy testing?

In the opinion of the person with whom you are speaking, what percentage of the patients with asthma who also have symptoms of clinical allergy have gotten formal allergy testing?

26. What type of formal allergy testing is utilized by most of the providers in your practice?

Is formal allergy testing routinely done (in the clinic or as a referral) for those asthmatics who are presumed to have allergy-mediated asthma. What type of testing is used most often by this practice? Allergy-mediated asthma is asthma that is made worse by exposure to allergens (dust mites, cockroaches, grass, pollen, etc.)

27. What percentage of your asthma patients have regular asthma check-ups (3-6 months)?

Routine asthma care can have a dramatic impact on reducing asthma ED visits and hospitalizations, and asthma symptoms in general. Does this practice routinely schedule follow-up appointments for their patients with asthma?

28. Do you use an asthma registry to facilitate recalling patients who need regular follow-up asthma care?

Does this clinic have a paper or computerized system to track their patients with asthma?

29. What percentage of your patients with asthma use the following for acute asthma episodes after office hours?

In the opinion of the person with whom you are speaking, when patients with asthma have an acute asthma episode after hours or on weekends, do these patients go to after-hours office care at the practice, an urgent care facility, an emergency department, have the knowledge, equipment, and skills to manage at home, or have another option?

30. Does your practice have a mechanism in place to avoid emergency room care for acute asthma?

Does this practice try to reduce emergency room care by providing alternatives to its patients with asthma?

31. Do you have internet access at your practice?

Does the practice have routine access to the internet at the clinic itself? Answer “NO” if internet access is not currently available on a routine basis at the clinic.

32. From our data, your practice has a high percentage of patients with asthma. Do you have any insights for why that is the case?

Please word this one carefully to avoid defensiveness. This question seeks an explanation from the clinic for its unusually high utilization among patients with asthma. If the person with whom you are speaking has an opinion as to why their utilization is high, please note their comments. Remember, this clinic may have a high utilization because it gives good care and attracts patients with asthma or it may be affected by factors such as the closure of a nearby practice or hospital.

Additional Notes – This is an area where more specific information can be noted about the conversation, the person with who you were speaking, or the practice.

Remember, if you spoke to more than one person, please be sure to put their initials next to each question that they answered. Each person in the practice will have a unique and valuable perspective.



North Carolina
Department of Health and Human Services
Division of Medical Assistance
Managed Care

1985 Umstead Drive – 2501 Mail Service Center - Raleigh, N.C. 27699-2501
Courier Number 56-20-06

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Gary Fuquay, Director

Dear Provider:

It gives me great pleasure to introduce you to “Key Components of Asthma Care: A Practical Toolkit for Clinicians”. This toolkit was prepared during one of the many initiatives that the NC Division of Medical Assistance has supported to reduce the burden of asthma throughout the state during the past 5 years. It is intended to provide support to primary care physicians (PCPs) who serve the Medicaid population in the optimal management of asthma – the most common and costly chronic illness among children. Inside this toolkit, you will find information, materials, and tools that will help busy practices like yours provide the best care to asthma patients.

The toolkit was developed by staff from the National Initiative for Children’s Healthcare Quality, the Child Health Institute at the University of Washington, and the North Carolina Center for Children’s Healthcare Improvement at the University of North Carolina – Chapel Hill. It is based on the National Guidelines for the Diagnosis and Management of Asthma¹ and has been reviewed by numerous local and national asthma experts and clinicians. The Chronic Illness Care Model developed by Ed Wagner et al. (described on page v of the toolkit) also serves as the organizing framework for much of the toolkit. Taken together, this means there is clinical, theoretical, and practical evidence for the validity and utility of the toolkit. We trust, therefore, that you will find it helpful to you in providing the highest quality of care to your asthma patients.

As you are aware, it is our goal that all Carolina ACCESS practices will participate in the Community Care of North Carolina (CCNC) network in the near future. Thus, the toolkit also includes examples of some of the materials from the various administrative entities within the CCNC. Please be assured that when you join an entity within CCNC, the entity-specific materials will be distributed to you free of charge. In the meantime, we invite you to use and copy the materials and information in this toolkit as you wish.

We know how busy you are, so we would like to thank you for your time and willingness to review and use this toolkit. We believe that it is a useful tool to support your individual efforts to improving asthma care for Medicaid recipients in North Carolina. If you have questions or would like to learn more about quality improvement, please do not hesitate to call your regional DMA Managed Care Consultant. His/her business card has been inserted into the inside front cover of this binder.

Sincerely,

A handwritten signature in black ink, appearing to read "Jeffrey Simms", with a long horizontal line extending to the right.

Jeffrey Simms
Assistant Director
Division of Medical Assistance

¹ We invite you to visit the following website <http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf> to view these guidelines.

Table of Contents

	Page
Key Components of Asthma Care	ii
List of Tools	iii
Chronic Illness Care Model	v
Assessing Your Practice’s Office System for Asthma Care	vi
I. Clear Diagnosis	
A. Diagnosis.....	I-1
B. Co-Morbidities	I-2
II. Accurate Classification of Severity	
A. Severity Classification	II-1
B. Spirometry.....	II-7
C. Medications	II-8
D. Managing Bronchodilator Therapy.....	II-10
E. Referrals	II-11
III. Planned Care	
A. Planned Encounters Based on Severity.....	III-1
B. Asthma Management Plans.....	III-6
IV. Self-Management Support and Trigger Identification	
A. Self-Management Support	IV-1
B. Environmental Triggers: Tobacco Smoke.....	IV-4
C. Environmental Triggers: Airborne Allergens	IV-6
D. Equipment	IV-9
V. Appendices: Tools and Resources	
Appendix A: Tools.....	V-1
Appendix B: Resources.....	V-3
Appendix C: Bibliography.....	V-5

To be completed after the site visit

DMA Clinic ID # _____

Date of site visit _____

Person completing this form _____

1. Length of time at the practice _____
2. Length of time at the practice devoted to asthma activities _____
3. Please indicate if a practice physician was contacted prior to visit
 1. No contact was made with a physician
 2. Phone contact made by DMA
 3. Letter was sent by DMA
 4. Other, please specify _____
4. Number of Asthma Chart Reviews Completed _____
5. Was the Asthma Care Questionnaire used during this visit?
 1. Yes
 2. No
6. Did you meet with a physician during your visit?
 1. Yes
 2. No
7. What other types of staff did you meet with during your visit? Please circle all that apply.
 1. None (Go to Question 8)
 2. Nurse
 3. Physician Assistant
 4. Nurse Practitioner
 5. Medical Assistant
 6. Practice Manager
 7. Laboratory personnel
 8. Pharmacist
 9. Other, please specify _____
8. Were you able to discuss the asthma tools with the physician?
 1. No
 2. Yes, briefly
 3. Yes, thoroughly
9. What was the physician's attitude toward the tools and focus of the visit?
 1. Very interested
 2. Interested but skeptical
 3. Skeptical
 4. Resistant
 5. Did not meet with physician

10. Were you able to review the UR data with the physician?

1. No
2. Yes, briefly
3. Yes, thoroughly

11. What factors do you believe contribute to this clinic's outlier status?

12. Did the practice request anything else to help them improve care?

1. Practice made no requests		6. Consultation	
2. Management Plans		7. Conference Calls	
3. Severity/Meds Sheets		8. Distance Learning Opportunities	
4. Resource Sheets for NC		9. Collaborative	
5. Resource Sheets for internet		10. Other	

13. In your opinion, what barriers might this practice face in implementing quality improvement activities? Indicate the level of barrier using a check in one box to the left of the barrier with

1 = Not a barrier for this practice

2 = A small barrier for this practice

3 = A moderate barrier for this practice

4 = A significant barrier for this practice

BARRIERS	No	Small	Mod	Sig
	1	2	3	4
1. Practice too busy or understaffed				
2. Insufficient asthma training				
3. Competing needs/priorities				
4. Data system weaknesses				
5. Lack of organization				
6. Lack of practice consensus				
7. Large practice				
8. Do not recognize need				
9. Perceive tools as too much additional work				
10. Resistance to change				
11. Low income population				
12. Transient population				
13. Patients resistant to follow-up or education				
14. External factors				
15. Other, please specify				

Other comments and feedback:

ASTHMA SITE VISIT DEBRIEF TOOL – QxQ'S

To be completed by the site visitor(s) after the site visit

DMA Clinic ID # - Clinic identification number according to DMA records

Date of site visit – Date that site visit was completed

Person completing this form – Full name, first and last, of person completing this form

- 1. Length of time at the practice** – How many hours were you at the practice? Partial hours can be accounted for with decimals to the nearest quarter hour. For example, if you were at the practice for three hours and forty minutes, use 3.75 hours. If you were at the practice for five and a half hours, use 5.5 hours.
- 2. Length of time at the practice devoted to asthma activities** – Time in hours and quarter hours that were spent at the practice devoted to asthma activities, such as talking to the staff about the tools, completing the Asthma Care Questionnaire, doing the Asthma Chart Review, etc. Do not include significant time spent completing other tasks or discussing other clinical topics.
- 3. Please indicate if a practice physician was contacted prior to visit** – If no contact was made to a practice physician, answer “No”. If a phone call was completed with a practice physician, answer “Phone contact made by DMA.” If a letter was sent addressed to a practice physician, answer “Letter was sent by DMA.” If phone contact was made in response to a letter, answer both “Phone contact made by DMA” and “Letter was sent by DMA.” If email or fax was used to send the letter, please indicate that if known. If some other type of communication was made, please indicate under “Other, please specify.”
- 4. Number of Asthma Chart Reviews Completed** – How many asthma chart reviews were you able to complete during the site visit?
- 5. Was the Asthma Care Questionnaire used during this visit?** – Were you able to complete the Asthma Care Questionnaire for this visit?
- 6. Did you meet with a physician during your visit?** Were you able to meet with a physician from the practice and discuss the topic of the site visit?
- 7. What other types of staff did you meet with during your visit?** Indicate other types of staff you were able to meet with during your visit. Do not include staff that were simply introduced.
- 8. Were you able to discuss the asthma tools with the physician?** Were you able to discuss the asthma tools with a physician at the practice? If so, would you rate your discussion as brief or thorough?
- 9. What was the physician’s attitude toward the tools and focus of the visit?** Rate the physician’s response toward the tools and the visit in general.
- 10. Were you able to review the UR data with the physician?** Were you able to discuss the UR data with the physician. If so, would you rate your discussion as brief or thorough?

11. What factors do you believe contribute to the clinic's outlier status? After visiting the clinic, talking to the staff, and reviewing the charts, what factors do you believe contributed to the clinic's outlier status, particularly if you have different thoughts about this than the clinic?

12. Did the practice request anything else to help them improve care? There may be tools or assistance that the clinic would like to receive from DMA that we have not considered. If they have requested anything from DMA during your visit, this is your opportunity to let us know. Not all resources listed are currently available. Answers to this question will be helpful in determining which resources are being requested by the practices.

13. In your opinion, what barriers might this practice face in implementing quality improvement activities? A number of issues can be present at a clinic that can reduce its ability to engage in clinical improvement activities. Now that you have visited the clinic, talked with staff members, and done chart reviews, in your opinion, what barriers might be present at the clinic and to what degree?

Other comments and feedback: This is an area where you can add comments or feedback that have not been addressed adequately in the Asthma Care Questionnaire, the Asthma Chart Review, or the Debrief Tool.

Appendix F

[Date]

[Practice Name]

[Address]

Dear Dr. [Name of Provider],

Thank you for allowing staff from our Quality Management and Managed Care teams to visit your office on March 25, 2004. These site visits are among the many initiatives that DMA has supported to reduce the burden of asthma throughout the state during the past 5 years. The purpose of the visits is to learn how Carolina ACCESS Primary Care Providers (PCPs) are delivering care to Medicaid recipients with asthma and to provide PCPs with materials that promote optimal management of asthma – the most common and costly chronic illness among children. During the visit, we reviewed 10 patient charts selected from a list of chronic asthma patients (per HEDIS criteria²) linked to your practice. Your practice's results are provided in the graph on Page 2.

The data collected during our chart reviews are designed to reflect key elements of best practice treatment for asthma as established in the National Guidelines for the Diagnosis and Management of Asthma³. Please be assured that the data collected from your practice will not be used to judge you or evaluate your compliance to these guidelines. However, it will be used to assist us in identifying strategies to help practices improve the quality of asthma care throughout North Carolina. Although we only reviewed a small sample of your medical records, we hope the graph provided below will also inform you about current asthma care in your practice and potential areas for improvement.

Finally, we encourage you to review and use the toolkit materials that were provided to you during the visit, such as the community care card, asthma management plans, and smoking cessation tool. These materials have been tested with a number of practices and we trust that you will find them helpful in providing the highest quality of care to your asthma patients. Most importantly, we believe the materials will help providers keep in mind that:

- (1) All people with asthma need a clear diagnosis;**
- (2) Proper treatment of asthma depends on accurate classification of severity;**
- (3) Planned asthma care requires periodic preventive visits; and,**
- (4) Asthma management also requires both self-management support and an understanding of patients' triggers.**

² According to HEDIS (Health Plan Employer Data and Information Set) criteria, members are identified as having persistent asthma by having ANY of the following in the year prior to the measurement year: (1) at least 4 asthma medication dispensing events, (2) at least one Emergency Department (ED) visit with asthma (ICD-9 code 493) as the principal diagnosis, (3) at least one hospitalization with asthma (ICD-9 code 493) as the principal diagnosis, OR (4) at least four outpatient asthma visits with asthma (ICD-9 code 493) as one of the listed diagnoses AND at least two asthma medication dispensing events.

³ We invite you to visit the following website <http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf> to view these guidelines.

[Insert Date]

Page Two

We know how busy you are so we would like to thank you again for your time and willingness to help us with this effort. Your participation and assistance, along with that of other providers like you, are vital to improving asthma care for Medicaid recipients in North Carolina. If you have questions or would like to learn more about quality improvement, please do not hesitate to call Rosemary Long, the Managed Care Consultant who visited your practice, at [insert phone number]. She is prepared to answer any questions you may have about this project and to inform you of a number of quality improvement efforts and resources, such as an online interactive educational activity called eQIPP that is designed to help PCPs improve the care they provide to patients.

Sincerely,

Jeffrey Simms
Assistant Director
Division of Medical Assistance

cc: Managed Care Consultant
Quality Management Nurse Consultant

