



TARGETING THE ATOPIC MARCH: MANAGING ATOPIC DERMATITIS

OUTCOMES ASSESSMENT

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NATIONAL JEWISH HEALTH



EXECUTIVE SUMMARY

In 2012 and 2013, National Jewish Health (NJH), in partnership with Rocky Mountain Youth Clinics (RMYC), conducted a performance improvement continuing medical education (PI CME) program titled, *Targeting the Atopic March: Managing Atopic Dermatitis* (AD). The initiative was funded by an unrestricted educational grant from GlaxoSmithKline.

The RMYC provides comprehensive primary care and related services to thousands of medically underserved children and adolescents in the Denver metropolitan region. Healthcare providers (HCPs) at RMYC had identified practice gaps in diagnosing and treating pediatric patients with AD, a chronic, relapsing skin disorder that is thought by many experts to be a precursor of other allergic diseases, namely asthma, allergic rhinitis, and food allergy.

The purpose of the AD initiative was to improve the assessment and treatment of RMYC patients with AD. The goals of the program were to provide evidence-based AD diagnosis and treatment education to clinicians, as well as to educate and activate patients toward effective self-management of AD.

The AD initiative included several interventions:

- A live, multidisciplinary training led by NJH faculty
- In-clinic training visits by NJH health educators
- Clinician support tools, including new EHR care prompts for AD
- Bilingual patient AD education materials, including some for the iPad
- Custom patient AD resource website (www.theADZone.org)

Sixty-three (63) health care personnel participated in the live, multidisciplinary training (14 MD/DO, 21 MA, 8 PA, 2 NP, 6 RN and 12 administrative staff). Eleven physician CME certificates were awarded, as well as six PA certificates, one NP certificate, and four RN certificates. In addition, physicians were eligible to receive American Board of Pediatrics (ABP) Part 2 and Part 4 Maintenance of Certification (MOC) credit for participation. In discussions with the ABP early in the application process, they communicated their

enthusiasm around establishing a PI CME initiative that also has approval for ABP MOC Parts 2 and 4.

The success of this program was evident throughout, over time and across multiple intervention components. Performance improvement consisted of better AD care as reflected in results from self-assessment AD care checklists (chart audits) and use of newly implemented EHR prompts.

On the self-assessment checklists, HCPs evaluated their performance of key components of AD care before (Stage 1) and over the course of the initiative (Stages 2-4). Checklist data showed immediate improvement on care indicators following the live, multidisciplinary training and sustained performance throughout the program. Table 4 shows all indicators assessed, broken down into outcomes goals identified at the onset of the initiative:

Table 4. Percentage of Self-Assessment AD Care Checklists Documenting Elements of AD Care						
Indicator of AD Care	Phase 1 n=238	Phase 2 n=108	<i>Point Increase Phase 1 to 2</i>	Phase 3 n=143	Phase 4 n=154	<i>Point Increase Phase 1 to 4</i>
Outcomes Goal: Assess AD Severity						
AD severity assessed and documented	39%	78%	+39	76%	77%	+38
Itch scale used	1%	67%	+66	57%	51%	+50
Outcomes Goal: Incorporate Team-based Care						
Document visit to ED for AD in last 6 months	4%	8%	+4	5%	1%	-3
Referral made to specialist for AD	8%	4%	-4	12%	6%	-2
Outcomes Goal: Provide Patient Education						
Home management plan provided	52%	81%	+29	69%	66%	+14
Skin care reviewed	89%	97%	+8	94%	90%	+1

Home moisturizing plan reviewed	61%	93%	+32	85%	87%	+26
Chronic nature of AD reviewed	45%	80%	+35	83%	82%	+37
Potential AD triggers discussed	32%	66%	+34	62%	69%	+37
Outcomes Goal: Prescribe Medications for AD						
Received a topical corticosteroid	83%	85%	+2	86%	78%	-5
Non-steroidal topical drug recommended/prescribed	76%	73%	-3	34%	31%	-45
Oral anti-itch drug prescribed	16%	26%	+10	15%	25%	+9
Outcomes Goal: Arrange for Follow-up Care						
Follow-up plan discussed	52%	80%	+28	81%	80%	+28

TABLE 4 NOTE:

Phase 1: prior to the live, multidisciplinary training on Sept. 20, 2012 (providers were asked to “audit” 10 AD patients seen prior to the training by applying the checklist to those patients)

Phase 2: September 20, 2012 and November 2012

Phase 3: November 2012 and February 2013

Phase 4: February 2013 and April 2013

One measure that was planned and implemented initially was the CDLQI quality of life index. The goal for the CDLQI was to have the patient complete the questionnaire in the office visit, and then repeat the answers to the questionnaire during a follow-up phone call two weeks after their visit. Due to systems barriers at RMYC, CDLQIs were administered in some initial AD patient visits, but it was not a sustainable tool. We learned that healthcare providers at RMYC modified their use of the CDLQI by actually incorporating the questions into the conversation with AD patients, rather than utilizing scarce resources such as time per office visit and ancillary staff to score the instrument and conduct follow-up calls.

Parallel to the completion of checklists, EHR usage of new AD care prompts remained modest throughout the program; however, 10 percent or more of patient visits had information recorded in the EHR through completely new prompts, a notable achievement. Going forward, the new EHR prompts will support evidence-based AD care and allow continuous monitoring of quality indicators for AD at the provider and organizational levels.

Participant survey data collected during and at the end of the initiative demonstrated that HCPs were successfully engaged and motivated to make changes in how they managed AD patients in their practices. Significantly, in a self-reflection survey at the end of the initiative, all (100%, n=15) said they were now better able to treat AD patients as a result of the program. All of these HCPs reported they were either “extremely skilled” or “somewhat skilled” in 6 out of 7 skills recognized as key elements of quality AD care. Most (60-93%) of these 15 HCPs reported that they had made either “some change” or “significant change” in specific behaviors related to optimal management of AD patients as a result of the initiative. The majority (80-93%) of HCPs thought that the practice changes would be sustainable going forward.

To improve HCP knowledge about and competence in AD care beyond RMYC, NJH has partnered with Medscape CME to produce and disseminate an enduring, online CME activity on AD and the outcomes of this initiative. The format will be a roundtable discussion featuring NJH faculty and health educators, as well as physician leaders from RMYC who were involved in the design and execution of the AD initiative. This CME activity is expected to be available online at Medscape.com in October 2013.