15th Annual ACCP Community Asthma Coalitions Symposium
Welcome

W. Brendle Glombe, MD, FCCP
Welcome From EPA
Tracey Mitchell, US EPA, Indoor Environments Division
Welcome
Stacy Ignoffo, Chicago Asthma Consortium
Coalitions and Innovations in Asthma Control

Tracy Washington Enger, US EPA
EPA’s Asthma Education and Outreach Program

GOALS and OBJECTIVES

By 2012, 6.5 million people with asthma will have reduced exposure to environmental asthma triggers, leading to 90,000 ER visits avoided annually.

EPA’s PLAN TO REACH the GOAL

• Work with stakeholders to integrate environmental management into program approaches
• Continue to identify and share best practices information and provide tools to facilitate the adoption of effective interventions
• Mobilize community level action to address asthma
• Recognize leaders in asthma care
EPA’s Calling

Mobilizing 1,000 Communities to Lead the Nation in the Delivery of Quality Asthma Care
What Defines a “Community in Action”

• Committed to driving toward the best possible delivery of asthma care

• Aimed at bold stretch goals in parallel with Healthy People 2010 and Network

• Tracking progress toward those goals
Total Members in Action
2,571
The System for Delivering High Quality Asthma Care
**What:** Delivering Comprehensive High-Quality Asthma Care

**Integrated Health Care Services**
- Physician champions
- Guidelines-based care
- Robust patient-clinician interactions
- Asthma education and action plans
- Community-wide coordination of care

**Tailored Environmental Interventions**
- Clinical assessment of triggers
- Individually tailored counseling & education
- Environmental management support
- Trigger control at home, school, and work
How: Through an Integrated, Collaborative, Community-Based System

Integrated Health Care Services

Tailored Environmental Interventions
Who: Champions and Leaders of Community Asthma Assets

- Non-Profits
- Service Providers
- Coalitions
- Health Plans
- Funders

Integrated Health Care Services
Tailored Environmental Interventions

TARGET POPULATION
COMMUNITY ASSETS
COLLABORATIONS
PARTNERSHIPS
COMMUNITY ASSETS
TARGET POPULATION

Schools
Public Housing
State Agencies
Public Officials
Local Environmental
**How:** Through an Integrated, Collaborative, Community-Based System
How: Through an Integrated, Collaborative, Community-Based System

Build

Evaluate

Sustain

Community Assets

Collaborations

Integrated Health Care Services

Tailored Environmental Interventions

Partnerships

Target Population

Schools
Public Housing
State Agencies
Public Officials
Local Environmental

Non-Profits
Service Providers
Coalitions
Health Plans
Funders
What is Your Domain of Influence?

• *What is it you are called to do?*

• *Whom are you called to serve?*
Empowering Through Influence

• Framework for delivering high quality asthma care
  – Behaviors and Practices

• Value Proposition and Business Case
  – Partners, Funders and Payers

• Asthma Disparities Action Plan
  – Reducing disparities at the community level

• National Community-based Network
  – Scale out by recruiting and enrolling others
The “What” of the Symposium

• Experience a Successful Framework and Proven System for Delivering Effective Asthma Care
• Witness how community programs are using national resources to address diversity.
• Develop a Value Proposition and Business Case to help resource your Results-Driven, Outcomes-Focused Programs
The “What” of the Symposium

• Construct Management Tools that Build, Sustain and Spread Your Unique Program Assets
• Connect to a Resource Rich Campaign and Network
• Develop and Practice a Leadership Narrative to Convene Partners and Stakeholders
The “Who” of the National Asthma Forum

- National Award Winners
- Community-Based Programs
- Health Care Providers
- Community Assets from across the Nation
The “How” of the Symposium

• Dynamic Presentations
• Powerful Leadership Discussions
• Direct Mentorship
• Break-Ins
• Conversations of Opportunities
• Generate Requests and Offers that Get Results
How to “Be”

• A Powerful Community Together
• Assuming a National Leadership Role in Asthma Control
• Willing to Set Ambitious and Strategic Goals
• Focused on Committing to Actions You and Your Organization Can Take
• Leaders in Service to One Another
• PRESENT!
What does it mean to be “Present”? 

- Present- I am here 
- Present- In the moment 
- Present – A gift 
- Presence – I am here, in the moment as a gift.
Net Forward Energy: More Positives Than Negatives

Reasons Why We Cannot Do It

What We Can Do to Reach The Goal

Source: Enlightened Leadership Institute
“People are much more likely to act their way into a new way of thinking than to think their way into a new way of acting”

“People change what they do less because they are given analysis that shifts their thinking than because they are shown a truth that influences their feelings”

The Heart of Change, John Kotter & Dan Cohen, 2002
What we do matters

“Guinea worm is poised to become the second human disease to be eradicated – and the first to be eliminated without the aid of a vaccine.”

*Washington Post*

“For Guinea worm, the only thing you can do is persuade people - many who are very isolated and tradition-bound – to change their behavior”

*Guinea worm expert, Donald Hopkins attributing progress to the strength of local volunteer programs and a “unique grassroots effort”*
A Comprehensive Approach to Asthma Management: Policy and Reimbursement Issues-The Changing Climate

W. Brendle Glombe, MD, FCCP
Coalitions and Innovations in Asthma Control: Comprehensive Approach to the Management of Asthma

Noreen Clark, PhD
Programs in Action for Results
EPA Asthma Award Winners
Purpose of Session

1. Learn about three exemplary asthma management programs and how they accelerate improvements in asthma care and address asthma disparities.

2. Hear about a key achievement of each program that contributed to positive health outcomes.

3. Learn about a challenge each program faced and their lessons learned in addressing the challenge.

4. Learn how to improve your asthma management program.
1. Introduce EPA’s National Environmental Leadership Award in Asthma Management and the *System for Delivering High-Quality Asthma Care*

2. Highlights of Award Winning Programs
   - Connie Kerrigan, Parkview Health System
   - Cheryl Kimble, Greenville Health System’s Children’s Hospital Center for Pediatric Medicine
   - Diane Rhodes, North East Independent School District

3. Key Challenge and Lessons Learned from Each Program

4. Open Forum Discussion
EPA’s National Environmental Leadership Award in Asthma Management

“We would urge applicants for this Award to use this opportunity to share their expertise with others. By sharing their successes and challenges, we all learn, and help each other move closer to our goals in asthma care, education and partnership. We have learned so much from the other Award winners, and from other resources and programs on www.AsthmaCommunityNetwork.org!”

John Dowling, 2012 Award Winner, Michigan Department of Community Health Asthma Prevention and Control Program

Since 2005, 26 health plans, health care providers and communities in action have been inducted into the Hall of Fame.

Learn more at www.asthmaawards.info
The System for Delivering High Quality Asthma Care
Integrated Health Care Services

• Strategies for Action:
  – Educate and support clinical care teams to facilitate consistent, high-quality care
  – Support continuous clinical improvement
  – Promote robust patient/provider interaction
  – Facilitate communication across the care team
Tailored Environmental Interventions

• Strategies for Action:
  – Educate care teams to deliver environmental trigger assessment and management
  – Assess trigger sensitivity and exposure in clinical interviews
  – Provide tailored education and counseling during clinical visits
  – Make environmental management a reality at home, school and work
High Performing Collaborations

• Strategies for Action:
  – Build on what works: partner with collaborators active in your target community
  – Collaborate to build credibility
Committed Leaders and Champions

• Strategies for Action:
  – Use outcomes data to promote change
  – Institutionalize the focus on outcomes
  – Create program champions
Strong Community Ties

• Strategies for Action:
  – Include your community in program planning
  – Engage your community ‘where it lives’
  – Make it easy to accept services
How to Listen

• What elements of this System are emerging in this program’s story?
• What am I hearing that resonates with me?
• What can I take away to use in my work?
Programs in Action for Results

- Parkview Hospital Foundation
  - Panelist: Connie Kerrigan
- Greenville Health System
  - Panelist: Cheryl Kimble
- Northeast Independent School District
  - Panelist: Diana Rhodes
Parkview Health
Comprehensive Asthma Education and Care Navigation

Connie Kerrigan, RN, BSN
Community Nursing and Women’s Services Manager
Parkview Health Comprehensive Asthma Education and Care Navigation

- **Location:** Fort Wayne, Indiana
- **Type:** Not-for-profit Health System
- **Service Area:** Eleven counties in Northeast Indiana and Northwest Ohio
- **Population Served:** 875,000 people from urban, suburban and rural communities
- **Key Players:** East Allen, Northwest Allen and Fort Wayne Community School Districts; Central, West and East Noble County School Districts; Fort Wayne-Allen County Department of Health; Indiana State Department of Health
Asthma Action Team’s Key Components

• **Community and School-Based Asthma Education**
  - A is for Asthma/Open Airways/Kickin’ Asthma
  - 1:1 asthma education
  - Universities
    - Allen County Board of Health Healthy Homes

• **Asthma Care Navigation**
  - Initiated July 2009 in the ED
  - Expanded in 2013 to include all hospitals within system
  - Currently enhancing continuity to include Primary Care
Key Achievement: Addressing Barriers to Care

- ED Asthma Call-Back Program
- 90 people enrolled monthly
- Medication Assistance Program
- Home visits
- ED recidivism: 21.95% at baseline to 15.04% in the intervention yr
Home Visits

• Pre/Post Test
• Education provided
• Environmental assessment
• Establish goals to reduce triggers
• Provide mitigation supplies
• Link to other community agencies
If Home Visit is Provided

- Follow-up calls 3 months after visit
  - Discuss how things are going
  - Assess progress towards established goals determined at home visit
  - Ascertain use of mitigation supplies provided
  - Offer 2nd home visit, if desired
Results: Year to Year Total Cost Reductions

- Ratio was created for each type of visit (ER, Observation, Inpatient) by payor and by program year.
- Average cost per discharge ÷ Average charge per discharge = Average cost to charge ratio (for the program year by type and payor)
  - Average cost to charge ratio × Patient charge = Cost per patient visit
- The total costs per program year were calculated by adding up all of the costs of the patient visits during each program year.
Thank you.

For more information:

Connie Kerrigan, RN, BSN
Community Nursing and Women’s Services Manager
Parkview Health
www.AsthmaCommunityNetwork.org
Greenville Health System’s Children’s Hospital Center for Pediatric Medicine
Asthma Action Team

Cheryl Kimble, RRT-NPS,AE-C
Greenville Health System’s Children’s Hospital Center for Pediatric Medicine

- **Location:** Greenville, South Carolina
- **Type:** Public, Not-for-profit Hospital Program
- **Service Area:** Greenville County and surrounding areas
- **Population Served:** Largely Medicaid, multi-ethnic population from urban, suburban and rural communities
- **Key Players:** Family Connection of South Carolina’s Project Breathe Easy, South Carolina Asthma Alliance, Greenville Pediatric Asthma Community Collaborative, Greenville County School District, United Way of Greenville County Child Care Resource and Referral UnitedWay, SCORxE (South Carolina Offering Prescribing Excellence), Decision Dynamic Inc.’s Disease Management Coordination Network (DMCN)
Asthma Action Team Key Components

**IDENTIFICATION**
- Over 4,388 patients in Registry
- Stratification
- Identify barriers to adherence
- Track asthma control tests over time, flu vaccination, impact of home visits

**EDUCATION**
- Medical residents
- Consistent education throughout continuum of care
- Customized pictorial asthma action plans on SharePoint
- Assessment of home triggers

**AWARENESS**
- Trained parent educators visit homes, schools, child care, health fairs, Laundromats, neighborhoods
- Collaborations/Partner Expectations

**SUPPORT**
- Parent-to-Parent
- Intensive case management
- Provide access to a medical home
- Extended hours for clinic
- Address barriers to health literacy
GREEN ZONE: EVERYDAY PLAN

When to use?
- EVERYDAY plan.
- Take whether you are sick or well.

YELLOW ZONE: SICK PLAN

When to use?
Use in addition to everyday meds when you have:
- Daytime or nighttime cough
- Wheezing
- Chest tightness or shortness of breath
- Waking at night due to asthma

IDENTIFIED ASTHMA TRIGGERS CIRCLED: colds smoke pollen dust animals exercise reflux weather strong odors emotions food cockroaches

RED ZONE: MEDICAL ALERT PLAN

When to use?
- When you are getting worse and the YELLOW ZONE SICK PLAN medications DID NOT help within 15-20 minutes or
- Breathing is very hard and fast or
- You cannot walk or talk or do usual activities or
- Lips or fingernails are BLUE

EVERYDAY PLAN

<table>
<thead>
<tr>
<th>Medication</th>
<th>How much?</th>
<th>How Often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flovent 110 mcg</td>
<td>1 puff twice a day</td>
<td>Morning and Night</td>
</tr>
<tr>
<td>Zyrtec 5 mg</td>
<td>1 tablet</td>
<td>night</td>
</tr>
<tr>
<td>Singulair 5 mg</td>
<td>1 tablet</td>
<td>night</td>
</tr>
</tbody>
</table>

Rinse mouth after Flovent

SICK PLAN: for asthma symptoms
Continue giving your EVERYDAY medications

<table>
<thead>
<tr>
<th>Rescue Medication</th>
<th>How Much?</th>
<th>How Often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>GIVE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albuterol inh OR</td>
<td>4-6 puffs or 1 vial</td>
<td>give Albuterol treatments every 4-6 hours as needed.</td>
</tr>
<tr>
<td>Albuterol neb</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If your asthma symptoms are NOT relieved after taking 1 breathing treatment, you may administer another treatment in 20 minutes. If treatments are not relieved after this treatment - administer a third treatment in 20 minutes. If this happens you are now in the RED ZONE and will need to go to the Emergency Room immediately.

AND:
- If you stay in the YELLOW ZONE for more than 2 days or if you have a cough; wheeze or Albuterol use more than 2 days a week, CALL YOUR DOCTOR.

MEDICAL ALERT PLAN

<table>
<thead>
<tr>
<th>Medication</th>
<th>How much?</th>
<th>How Often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuterol neb OR</td>
<td>1 vial</td>
<td>Take medications AND call your doctor NOW.</td>
</tr>
<tr>
<td>Albuterol inhaler</td>
<td>8 puffs</td>
<td></td>
</tr>
</tbody>
</table>

GO to the EMERGENCY ROOM or CALL 911
**ZONA VERDE: PLAN DIARIO**

**Cuando usarla?**
- Plan para todos los días.
- Tomarlo si está enfermo o sano.

**PLAN para TODOS los DIAS**

<table>
<thead>
<tr>
<th>Medicamento</th>
<th>Que cantidad?</th>
<th>Cuando?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flovent 110 mcg</td>
<td>1 inhalacion 2 veces al día</td>
<td>Manana y en la noche</td>
</tr>
<tr>
<td>Singulair 5 mg</td>
<td>1 tableta</td>
<td>noche</td>
</tr>
</tbody>
</table>

Enjuage la boca después Flovent

**ZONA AMARILLA: PLAN PARA CUANDO ESTÁ ENFERMO**

**Cuando usarla?**
- Usese cuando tiene:
  - Tos de día o de noche.
  - Silbido en el pecho
  - Pecho apretado o falta de aire
  - Si se despierta en la noche por el asma.

**PLAN para CUANDO ESTÁ ENFERMO: Síntomas de asma**
Continue dándole los medicamentos de uso diario

<table>
<thead>
<tr>
<th>Medicamento de Rescate</th>
<th>Que cantidad?</th>
<th>Cuando?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuterol inhaler</td>
<td>4-6 inhalaciones</td>
<td>Cada 20 minutos durante 1 hora si es necesario</td>
</tr>
</tbody>
</table>

Si los síntomas de asma no mejoran luego de 3 tratamientos de respiración en 1 hora **LLAME A SU MEDICO** Ya se encuentra en la ZONA ROJA.

**Y:**
- **LLAME A SU MEDICO SI TIENE:**
  1) Ya está mejor, dele el tratamiento de Albuterol cada 4-6 horas según sea necesario por 2 días o
  2) Se mantiene en la ZONA AMARILLA mas de 2 días o
  3) Tiene tos, silbido en el pecho, o usa Albuterol mas de 2 veces por semana.

**ZONA ROJA: ALERTA MÉDICA**

**Cuando usarla?**
- Cuando se está poniendo peor y el plan de la ZONA AMARILLA no logra mejorarle entre 15-20min
- Si su respiración es muy difícil y rápida
- Si no puede caminar, hablar, o hacer lo que hace siempre
- Si sus labios o unas están morados o azulosos.

**PLAN de ALERTA MÉDICA**

<table>
<thead>
<tr>
<th>Medicamento</th>
<th>Que cantidad?</th>
<th>Cuando?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuterol inhaler</td>
<td>8 inhalaciones</td>
<td>Tome la medicina Y llame al medico AHORA.</td>
</tr>
</tbody>
</table>

**VAYA al CUARTO DE URGENCIA** o **LLAME al 911**

Si después de tomar esta medicina los síntomas se mantienen **Y** no puede localizar a su medico.  
**Physician Signature**  
**Caretaker Signature**
Key Achievement: Effective Collaboration with Family Connection of South Carolina Project Breathe Easy

- Parent-to-parent support
- Home visits and environmental assessments
- Resource assistance to families
- Asthma management education
- School and childcare training
- Community awareness and education
CPM Asthma Action Team

Years 2007 – 2012 are reflected by Measures 1-6. Y12: partial

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma Pts</td>
<td>908</td>
<td>817</td>
<td>907</td>
<td>1518</td>
<td>2388</td>
<td>3376</td>
</tr>
<tr>
<td>ED Visits Related to Asthma</td>
<td>777</td>
<td>498</td>
<td>443</td>
<td>371</td>
<td>638</td>
<td>902</td>
</tr>
<tr>
<td>Asthma Pts that went to ED</td>
<td>505</td>
<td>362</td>
<td>315</td>
<td>291</td>
<td>462</td>
<td>616</td>
</tr>
</tbody>
</table>
Thank you.

For more information:
Cheryl Kimble, RRT-NPS, AE-C
Greenville Health System’s
Children’s Hospital Center for Pediatric Medicine
Asthma Action Team
www.AsthmaCommunityNetwork.org
North East Independent School District
Asthma Awareness Education Program

Diane Rhodes, BBA, RRT, AE-C
Assistant Director
North East Independent School District
Asthma Awareness Education Program

• **Location**: San Antonio, TX

• **Type**: K-12 School-Based Program

• **Service Area**: School District-Wide
  (144 square mile area in San Antonio/Bexar County)

• **Population Served**: An urban community with more than 67,000 school-aged children and their families and 9,000 staff

• **Key Players**: School district’s medical director and five other local allergists and pediatric pulmonologists, faculty and students from the University of Texas Health Science Center’s (UTHSC) Department of Respiratory Care, Santa Rosa Health System, South Texas Asthma Coalition, Asthma Coalition of Texas, American Lung Association, U.S. EPA, and the Centers for Disease Control and Prevention
NEISD Four Components of Control: Planning and Action Implemented

Bring an understanding of prevalence and assess needs for improved processes district wide
- School District impact
- Quality of Life Surveys
- Parent/Staff expectations
- Recruit champions (custodial, nurses, PE staff, administrators)
- Data, data, data feedback

Assess Culture and reduce environmental risks
- Education and Removing Triggers from home/school environments
- Indoor Environment Quality Best Practices
- TFSSix Technical Solutions
- Tips for Healthy Learning Environment
- Facility Assessment
- Facility scores

Provide tools/educational resources to reduce healthcare barriers
- Emergency Nebulizer Policy
- Asthma Action Plans
- NIHLEPR 3 guidelines
- Health Check data
- EMS incidents
- Inhaler usage tracking
- Asthma Control Test

Identify gaps and provide disease management information to improve quality of life
- Coordinated Approach to Child Health
- Asthma Curriculum
- Environmental Curriculum
- Webinar/Podcasts to staff
- Staff Development/AFC
- Website
- Asthma Blow Outs

Stakeholders:
students, parents, staff, community
Asthma Blow Out!

What is Asthma?

Early Warning Signs

Triggers

Medication

Trigger Avoidance

Student Sessions

Living with Asthma & Exercise
Student Entrance:
Asthmatic vs non-asthmatic

Asthmatics:
Inhaler technique review

Staging area: All students
“Asthma is like the weather”

Awareness
What is Asthma?
Parts of airway, 3 changes
Inflammation, mucous production
Bronchoconstriction
Early Warning Signs:
Define, identify, classify

Medication
Use of medications
Controller
Inflammation
Reliever
Bronchoconstriction
Technique review
Compliance review

Environment
Triggers
Define, identify, effect to airway

Trigger Avoidance
Practical strategies to avoid most common triggers

Education
Living with Asthma
Peak Flows
Peak flow technique
Understanding zones
Exercise
Define & Importance
Self-assessment scenario

Asthma Control
Make it fun, make it relevant

Controlled Asthma

Uncontrolled Asthma
Asthma Blow Out!

Parent Sessions

Awareness - Allergist

Medication – Pedi Pulmonologist

Respiratory Therapist – Free ‘spacer’ Inhaler technique

Education - Pedi Pulmonologist

Environment- Allergist
**Asthma Control**

**Awareness**
- Allergist
  - 10 commandments of control
  - Asthma Control Test

**Medication**
- Pedi Pulmonologist
  - Controller inhaler
  - Inflammation
  - Reliever Inhaler
    - Symptoms

**Environment**
- Allergist
  - Trigger awareness and avoidance
    - Indoor
    - Outdoor

**Education**
- Pedi Pulmonologist
  - Exercise / nutrition
  - Asthma control
  - Communication and compliance

**Adult Entrance**
- Family of Asthmatics: inhaler/medication review
Reducing Communication Barriers

Any Questions?

Have your 'Awareness' component on your card stamped. Cards with all four components stamped are eligible for drawing at the end of the evening.

Please complete feedback at the end of the evening.

English to Spanish translation through headsets
Results

I know that I have to use my controller medicines, or my asthma can turn into an emergency.

-Student

I can’t tell you how much my daughter and I learned at the Asthma Blow-out...

we have always been reactive in dealing with [her asthma]...Even with regular checkups we’ve apparently missed a lot of information. Now I understand there are options for keeping asthma under control and avoiding problems altogether.

- Parent
Results after first year

Comparison of Inhalers/Nebulizers

Results of student Inhaler/Nebulizer Usage after initiating ‘Tips for a Healthy Classroom’ and ‘Asthma Trigger Education’ to staff and Awareness Information to parents. Data comes from the time period of first six weeks of school which is termed the ‘September Epidemic’ despite non-peak allergy season
Results After First Year

Nebulizer Protocol

Initial impact

<table>
<thead>
<tr>
<th>Year</th>
<th>No EMS Transport Required</th>
<th>EMS Transports to ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>80</td>
<td>40</td>
</tr>
<tr>
<td>2</td>
<td>32</td>
<td>55</td>
</tr>
<tr>
<td>3</td>
<td>24</td>
<td>70</td>
</tr>
</tbody>
</table>

In year 1 and 2 includes students who do not have the 'diagnosis' requirement to follow protocol.
Thank you.

For more information:
Diane Rhodes, BBA, RRT, AE-C
Assistant Director
North East Independent School District
www.AsthmaCommunityNetwork.org
Challenges and Lessons Learned
North East Independent School District

Asthma Awareness Education Program

Diane Rhodes, BBA, RRT, AE-C, Assistant Director
Our Challenge

Changing School Culture
Lessons Learned

• **Conduct an assessment:** identify needs and recruit champions

• **Create partnerships and buy-in**
  – Custodians: cluttered classrooms are a challenge to effectively clean
  – PE Teachers: lack of asthma control limits students’ PE
  – School Nurses: want to eliminate frequent repeat visits
  – Administrators: classroom triggers lead to more in-clinic time/ less classroom time, impacts student performance

• **Acknowledge this BIG challenge:** teachers feel classroom environment is their domain
Parkview Health
Comprehensive Asthma Education and Care Navigation

Connie Kerrigan, RN, BSN
Community Nursing and Women’s Services Manager
Our Challenge
Addressing the needs we encounter during care navigation and home visits.
Lessons Learned

• Have a good understanding of community resources
  – Food Banks
  – Transportation
  – FQHCs

• Know who to ask when you don’t have an answer
  – Medication needs for numerous chronic health conditions

• Leverage organizational and community resources to maximize impact
  – Community Collaboration Burmese Care Navigation
Greenville Health System’s Children’s Hospital
Center for Pediatric Medicine
Asthma Action Team

Cheryl Kimble, RRT-NPS, AE-C
Our Challenge

Getting patients to follow their prescribed plan.
Lessons Learned

• Non-adherence may be non-intentional – life gets in the way
• Non-adherence may be intentional – biases, myths
• Cost of medication can be a burden – lapse of insurance; co-pays with other insurance; self-pay
• Many patients and caregivers – and health care professionals – cannot visually identify asthma medications
• Use a consistent educational message throughout the continuum of care
Open Forum

• What did you hear?
• What was your reaction?
• What do you want to understand better to get into action?
Interventions to Improve Health Care Providers’ Adherence to Guidelines: AHRQ Report

Sande Okelo, MD, PhD
The System for Effective Asthma Care

- Committed Leaders & Champions
- Strong Community Ties
- High Performing Collaborations
- Tailored Environmental Interventions

BUILDING THE SYSTEM

GETTING RESULTS

EVALUATING THE SYSTEM

SUSTAINING THE SYSTEM

Integrated Health Care Services
Coalitions and Innovations in Asthma Management: Healthy Homes/Environmental Interventions

Catherine Baker, AIA
Connecting to the System
Asthma in 2013- Clinical Highlights and Controversies

Jay Peters, MD, FCCP,
Committed Leaders and Champions
Convening Committed Leaders and Champions
Connecting to the System
Coalitions and Innovations in Asthma Management: Community Health Workers

James Krieger, MD
Connecting to the System

- Strong Community Ties
- High Performing Collaborations
- Community Assets
Coalitions and Innovations in Asthma Management: Evaluation from the Illinois Asthma Partnership

Nancy Amerson
15th Annual ACCP Community Asthma Coalitions Symposium

Poster Session
Welcome to Day 2
The “What” of the Symposium

• Construct Management Tools that Build, Sustain and Spread Your Unique Program Assets
• Connect to a Resource Rich Campaign and Network
• Develop and Practice a Leadership Narrative to Convene Partners and Stakeholders
Questions to Run On

• Who does my Program Serve/What is my Population of Service?
• What does my program do really well?
• What do I need to keep my program going?
• Who else in my community delivers really good asthma care?
My Program’s Strategic Plan

- Mission
- Goals
- Objectives
- Tasks
“Community is a locus of healing, not the hospital or the clinic.”

“Patients cannot see outside their pain, we cannot see in, relationship is the only bridge between”

15th Annual ACCP Community Asthma Coalitions Symposium

Coalitions Then and Now
Constructing Coalitions
Coalitions Then and Now

• Chicago Asthma Consortium
  – Stacy Ignoffo, Chicago, IL CAC
• Regional Asthma Management Program
  – Anne Kelsey, MPH, San Francisco, CA
• New York Citywide Asthma Initiative
  – Jean Sale-Shaw, MSN, MPH, BSN, AE-C, New York, NY
Then and Now Panel Discussion

• What do you offer your target population now that is different than when you started?

• How have your evaluation methods evolved throughout the lifetime of your program?

• What kinds of partnerships have you formed to advance your program goals?
Communities of Practice: Practicing Community to Address Asthma Disparities
Asthma Disparities Action Plan Launches!
Reducing Asthma Disparities is a Priority

- Childhood asthma is a large public health burden
  - 7.1 million children have asthma
  - Annually, there are:
    - 154,615 hospitalizations among children
    - 12.8 million school days lost
    - $57 billion costs (direct and lost productivity) across all ages
Reducing Asthma Disparities is a Priority

Minority children have a greater asthma burden than white children

Current Asthma Prevalence among Children by demographic characteristics: 2006-2008

Disparities in outcomes among children with asthma, by race/ethnicity, 2003-2004

**Note:** Two-sided significance test significant at the 0.05 level compared to first category in group.

Data Source: CDC/NCHS, National Health Interview Survey (NHIS)
Reducing Asthma Disparities is a Priority

• Federal research, clinical guidelines, and public health education programs have improved asthma control among all children

• But Federal Programs alone are not sufficient:
  – Racial and ethnic disparities persist
  – The causes of disparities are multi-factorial
  – A system wide approach is needed, with interagency coordination and collaboration with community partners
Coordinated Federal Action Plan to Reduce Racial and Ethnic Asthma Disparities

1. Reduce barriers to implementation of guidelines based asthma care
2. Enhance local capacity to deliver integrated, comprehensive asthma care
3. Improve capacity to identify the children most in need
4. Accelerate efforts to prevent the onset of asthma
The System for Delivering High Quality Asthma Care

Key Drivers of Program Effectiveness:
- Committed Leaders & Champions
- Strong Community Ties
- High Performing Collaborations
- Integrated Health Care Services
- Tailored Environmental Interventions

Building the System
Sustaining the System
Getting Results
Evaluating the System
Federal Action Plan to Reduce Asthma Disparities: Strategy One

Strategy 1: Reduce barriers to the implementation of Guidelines-based asthma management.

- Explore strategies to expand access to asthma care services
- Coordinate existing federal health care programs in underserved communities
- Reduce environmental exposures in homes
- Implement asthma care services and reduce environmental exposures in schools and childcare settings
Federal Action Plan to Reduce Asthma Disparities: Strategy One

Reduce Barriers to the Implementation of Guidelines-Based Care

Immediate Priority Actions:

• Improve health care purchasers understanding/coverage of quality asthma care
  – Prepare and disseminate publication “Key Clinical Activities” through NAEPP and CDC
• Integrate patient education and support services with medical care
  – CMS Health Care Innovation Awards include:
    • care teams w/respiratory therapists/asthma educators, social workers, home assessments
    • school health services and tele-health
    • pharmacist collaboration to improve adherence
  – HRSA Patient Safety and Clinical Pharmacy Collaborative:
    • team based medication management for patients with multiple chronic diseases
• Surface and spread sustainable strategies for reimbursement
  – HUD Regional Summits
Federal Action Plan to Reduce Asthma Disparities: Strategy One (cont.)

Reduce Barriers to the Implementation of Guidelines-Based Care

• Disseminate tools from NAEPP National Asthma Control Initiative programs targeting primary care
  – On-line CME and Board Certification tool kits for Family Physicians
  – 1-Hour presentations on practice change for physicians who serve minority patients
  – “Virtual Learning” training programs on spirometry

• Develop and disseminate Administration for Children and Families/EPA Asthma Resource Starter Kit for Early Childhood Care (parents, providers, children)
  http://eclkc.ohs.acf.hhs.gov/hsic/tta-system/health/
Federal Action Plan to Reduce Asthma Disparities: Stakeholder Participation

How might Stakeholders advance this effort?

- Example 1: **Help clinicians serving minority patients increase use of evidence based care**
  - Inhaled corticosteroids achieve asthma control; even children with mild persistent asthma need (*Martinez et al. Lancet 2011*).
  - Yet minority children are less likely to receive them (*Crocker D Chest 2009*).
  - Physician education on guidelines AND patient communication improves adherence; does not require more visit time (*Clark et al. Eur Respir J 2000 Jul*).
- Stakeholders can examine local medical care coverage issues and **target** educational messages/tools to key clinicians.
Reducing Barriers to Guidelines-Based Care

• Reflections:
  – What excites you about this work?
  – What opportunities do you see for accelerating the adoption of guidelines-based care in community settings?
  – What policy level actions might advance this work?
Tell Us About Your Program or Areas of Influence

– How can you/your organization help reduce the barriers to guidelines-based care?
– What tools and resources do you have to share?
– What tools or resources do you need?
Federal Action Plan to Reduce Asthma Disparities

- Strategy 2: Enhance capacity to deliver integrated, comprehensive asthma care to children in communities with racial and ethnic asthma disparities
  - Promote cross-sector partnerships among community based programs
  - Protect children from exposure to air pollution
  - Evaluate models of “empowerment zones”
    - Examine the relative contribution and cost effectiveness of different components of a community asthma care system.
Federal Action Plan to Reduce Asthma Disparities: Strategy Two

Enhance Capacity to Deliver Integrated, Comprehensive Asthma Care

• Integrate asthma with other home visit programs
  – Community Guide recommendation for asthma home visits (http://www.thecommunityguide.org/asthma/multicomponent.html)
  – HUD/ALA programs on smoke free policies for federally assisted subsidized and multi-family housing (“pilots” in Los Angeles, Cleveland, Portland)

• Leverage Weatherization Plus health.org for cross-sector coordination

• Conduct research on models for community partnerships to provide integrated care to children most in need
Federal Action Plan to Reduce Asthma Disparities: Strategy Two (cont.)

Enhance Capacity to Deliver Integrated, Comprehensive Asthma Care

• Provide exchange forums and technical assistance to community asthma coalitions
  
  – Symposium at American College of Chest Physician annual meeting: 100 + attendees
  
  – EPA’s website www.asthmacommunitynetwork.org “real time” exchange of resources, ideas, and sample materials
  
  – CDC State Asthma Control Programs surveillance, partnerships and interventions www.cdc.gov/asthma
Federal Action Plan to Reduce Asthma Disparities: Stakeholder Participation

How might Stakeholders advance this effort?

- Example 2: **Expand medical care teams to include educators/counselors/, home visits, community health workers (CHW)**
  
  - Home visits address environmental triggers and patient skills/barriers to adherence (*Crocker D, Amer J Preventive Med 2011*)
  
  - Lay CHWs -home visits are effective (as effective as nurses: *Partridge MR Thorax 2008 Sep*) (*integrated into team: Krieger J Amer J Preventive Med 2011*)

- Stakeholders can **target** clinics to assist with building business case for home visits, training and technical assistance for CHWs
  
  - Seton Family of Hospitals in Texas (*Conti S*)
  
  - NHLBI training program for Latino lay health workers
Enhance Community Capacity to Deliver Integrated, Comprehensive Asthma Care

• Reflections:
  – What excites you about this work?
  – What near term actions would you suggest that community programs take in order to develop or strengthen a system-wide approach to asthma care?
  – What policy level actions might accelerate this work?
Tell Us About Your Program or Areas of Influence

– What near term actions can you take to support integrated, comprehensive asthma care in the community you serve?
– What tools, resources, strategies for success can you share?
– What tools or resources do you need to expand and strengthen your community care system?
Leaving in Action
Value Proposition Script

**EXERCISE 25: My Value Proposition Statement**

For S: ____________________________ (MY COST)

MY PROGRAM will improve asthma outcomes for _______________________ (MY POPULATION OF FOCUS):

by achieving: _________________________ (MY IMPACTS & OUTCOMES).

and: ______________________________ (MY IMPACTS & OUTCOMES).

My community will benefit from my work in terms of (MY UNIQUE VALUE FOR THIS AUDIENCE): ____________________

**EXAMPLE**

For $250,000, Asthma Care In Action will improve the quality of life for the 3,200 pediatric asthma patients we serve by reducing adverse asthma events by 50%, doubling the number of families capable of effectively self-managing their asthma, and reducing children’s exposure to environmental asthma triggers in their homes. We estimate our work will deliver $550,000 per year in savings to the health care system through 50% fewer ER visits.

**Reflections:**

- What data do I need to refine my value proposition statement and how can I get it?

- Who in my community needs to hear my value proposition statement?

<table>
<thead>
<tr>
<th>Audience</th>
<th>Likely Value Preferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program:</td>
<td>Program, Data, Program Sustainability</td>
</tr>
<tr>
<td>City Council, Mayor:</td>
<td>Reimbursement, Budget Control</td>
</tr>
<tr>
<td>Medicaid, State legislators, Governors:</td>
<td>Lower Costs</td>
</tr>
<tr>
<td>Insurance Companies:</td>
<td>Cost Savings, Medicaid Expenditures</td>
</tr>
<tr>
<td>Care Providers:</td>
<td>Pay for Performance</td>
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<tr>
<td>Hospitals:</td>
<td>Reduced ED Costs, Lower readmissions, Improved Patient Satisfaction</td>
</tr>
<tr>
<td>Local Corporations:</td>
<td>Lower employee absence, Improved productivity</td>
</tr>
<tr>
<td>Program Partners:</td>
<td>Lower community asthma rates</td>
</tr>
</tbody>
</table>
Completing Our Work

- Write Your Value Proposition
- Leadership Story
- Say It Out Loud
- Be Showered with Encouragement!
Making the Pitch

“For $_____________________________ per year (MY COSTS) we will dramatically improve asthma outcomes for _______________ (MY POPULATION OF FOCUS) by achieving _______________________________, _______________, and _______________________________, and _______________ (MY HIGH VALUE OUTCOMES).”
Gratitude