Care Coordination for Patients with Asthma

Stephen de Waal Malefyt, MD

Commissioner’s Medical Grand Rounds, March 3, 2020
Financial Disclosure

I have no relevant financial relationships to disclose.
Objective

• Explain how to organize and implement a care coordination team in a primary care practice
Are Guidelines Enough?

• You can provide perfect, guideline-aligned care in the office...
• …but what’s really happening to your patient when they leave...
• …how are all your patients with asthma doing as a group?
Effective Asthma Control

- Is as dependent on patient behavior as it is on guideline-based asthma therapies
- Requires patients to be actively engaged
  - Self-monitoring of symptoms
  - Use of Asthma Action Plan
  - Environmental control
  - Adherence to prescribed medications
  - Appropriate device technique
Challenges Facing Providers

• Successful long-term asthma management is challenging

• Minority groups have hospitalization and ED visit rates 3x greater than white children (Kercsmar et al, 2017)

• Up to 20-40% of controller prescriptions are NEVER filled (Bollinger et al, 2013)
Challenges Facing Providers

• Poor adherence with asthma self-management is common
  – 30-70% adherence to prescribed controller medications (Bender et al, 1997)
  – <50% of patients successfully complete environmental control measures (Gergen et al, 1999)
  – More than half of children with asthma (54%) are exposed to secondhand smoke in the home. (Quinto et al, 2013)
Challenges Facing Providers

• Adequate time for patient education
• Access to data on patient medication adherence.
• Value-based programs
• Formulary changes/medication coverage
• Protected administrative time to address health care system-related issues
System-Induced Distress

HOW THE HEALTH CARE SYSTEM CAUSES PHYSICIAN DISTRESS

- High volume expectations
- System inefficiencies
- Lack of resources to deliver high-quality, equitable care

Physicians overworked
Moral injury

Physician distress

Source: Winner and Knight 2019
Care Coordination for Asthma

- Changing healthcare system mindset
- Passive ➔ Proactive
- “The health outcomes of a group of individuals, including the distribution of such outcomes within the group.” (Kindig and Stoddart 2003)
Care Coordination: It Works!

- Kercsmar et al. 2017
- Multifaceted approach
- Improved outcomes through 3 phases
  - Hospital-based inpatient care redesign
  - Outpatient-based care enhancements
  - Community-based supports and partnerships
Kercsmar et al. 2017

- Inpatient interventions:
  - Medication-in-hand (30-day supply)
  - Home Health Pathway
    - Social worker
    - Environmental assessment
    - Home nurse visits
Kercsmar et al. 2017

- Outpatient interventions:
  - Care coordination
    - 1 or more asthma-related hospitalizations
    - 2 or more ED visits
  - Linking inpatient home health pathway to accept outpatient referrals
  - EMR enhancements
    - Standard visit template
    - Pre-visit screening
Kercsmar et al. 2017

• Community interventions:
  – Partnership with Cincinnati public schools
  – Partnership with DOH School Asthma Program
  – Building QI capacity in schools
  – Read-only access to EMR
Kercsmar et al. 2017

• Reduced asthma-related hospitalizations
  – 8.1 to 4.7 per 10,000 Medicaid patients/mo.

• Reduced asthma-related ED visits
  – 21.5 to 12.4 per 10,000 Medicaid patients/mo.
Kercsmar et al. 2017
Kercsmar et al. 2017
How Do We Measure Success in Pediatric Asthma Care?

- PCMH
- School
- Patient
- Government
- MCO
Identify Your Asthma Measures

- Health-Delivery System (PPS)
- MCO
- State
- Organization
- Measure Steward
  - AHRQ
  - HEDIS
Where Do Measures Come From?

• National Committee for Quality Assurance (NCQA)
  – Healthcare Effectiveness Data and Information Set (HEDIS)
  – 90+ measures

• Agency for Healthcare Research and Quality (AHRQ)
  – U.S. Dept. of Health and Human Services
<table>
<thead>
<tr>
<th>MEASURE</th>
<th>CATEGORY</th>
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<tbody>
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<td>Asthma Admission Rate</td>
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Asthma Medication Ratio (AMR)

- Ratio of controller to controller + rescue medication fills for asthma
- Generally calculated over 12 months
- Ranges from 0 (no controller) to 1 (ideal)
- Ratios <0.5 associated with increased utilization (ED visits or hospitalization) and lower quality of life
Asthma Medication Ratio (AMR)

Low AMR (<0.50)  High AMR (>0.50)


### AMR Predicts Future Utilization

#### Exhibit 4. Logistic Regression Models Predicting Asthma Emergent Care Visits if Asthma Medication Ratio is <0.5

<table>
<thead>
<tr>
<th></th>
<th>Hospitalizations</th>
<th>ED Visits</th>
<th>Hospitalization or ED Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR (95% CI)</td>
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<tr>
<td><strong>2007–2008</strong></td>
<td></td>
<td></td>
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<tr>
<td>3 month</td>
<td>1.9 (1.1–3.4)</td>
<td>1.6 (1.2–2.0)</td>
<td>1.6 (1.3–2.0)</td>
</tr>
<tr>
<td>6 month</td>
<td>2.0 (1.3–3.0)</td>
<td>1.5 (1.3–1.8)</td>
<td>1.6 (1.3–1.9)</td>
</tr>
<tr>
<td>12 month</td>
<td>1.8 (1.3–2.5)</td>
<td>1.5 (1.3–1.8)</td>
<td>1.6 (1.4–1.8)</td>
</tr>
<tr>
<td><strong>2008–2009</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 month</td>
<td>1.1 (.69–1.9)</td>
<td>1.5 (1.2–1.9)</td>
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<td>1.7 (1.2–2.5)</td>
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<td>1.7 (1.5–1.9)</td>
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</tbody>
</table>

**NOTES:**

1. All models controlled for age, gender, race, and rurality and all models except italicized were significant with p<.001

**SOURCE:** South Carolina Medicaid Data, 2007–2009.

Source: Andrews, et. al 2013
## Asthma Measures

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SABA Overutilization

• Increasing use of albuterol is associated with increased risk of death in patients with asthma (Spitzer et. al 1992)

• Use of >1 canister every 1-2 months is associated with increased risk of ED visit or hospitalization (EPR-3)

• RED FLAG: >1 canister/month
SABA Overutilization

<table>
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<tr>
<th>MDI</th>
<th>Dose (size)</th>
</tr>
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<tbody>
<tr>
<td>ProAir</td>
<td>200 actuations (8.5g)</td>
</tr>
<tr>
<td>ProAir RespiClick</td>
<td>200 actuations</td>
</tr>
<tr>
<td>Ventolin</td>
<td>60 actuations (8g)</td>
</tr>
<tr>
<td>Ventolin</td>
<td>200 actuations (18g)</td>
</tr>
</tbody>
</table>

_Do The Math:_

- **Intermittent:** ≤ 2 days/week
  - 4 puffs/week (208/year)
- **Exercise Pre-treatment** (daily)
  - 2 puffs/day (60/month)
  - 3 months or longer
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Asthma Control Tests

• Patient questionnaires
• Gives you the ability to monitor your patient’s level of asthma control over time
• Identifies patients with poorly controlled asthma in need of follow-up or outreach from care manager
Asthma Control Tests

• Two Questionnaires:
  – Childhood Asthma Control Test (C-ACT)
    • Ages 4-11 years
    • 7 questions
  – Asthma Control Test (ACT)
    • Ages 12 years+
    • 5 questions
Asthma Control Test (ACT)

- Developed in 2004 (Nathan et al)
- Tool specifically designed for use in clinical practice
- Good diagnostic accuracy for assessment of controlled and not well-controlled asthma
Asthma Control Test (ACT)

1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or at home?
   - All of the time 1
   - Most of the time 2
   - Some of the time 3
   - A little of the time 4
   - None of the time 5

2. During the past 4 weeks, how often have you had shortness of breath?
   - More than once a day 1
   - Once a day 2
   - 3 to 6 times a week 3
   - Once or twice a week 4
   - Not at all 5

3. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness, or pain) wake you up at night or earlier than usual in the morning?
   - 4 or more nights a week 1
   - 2 or 3 nights a week 2
   - Once a week 3
   - Once or twice 4
   - Not at all 5

4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?
   - 3 or more times per day 1
   - 1 or 2 times per day 2
   - 2 or 3 times per week 3
   - Once a week or less 4
   - Not at all 5

5. How would you rate your asthma control during the past 4 weeks?
   - Not controlled at all 1
   - Poorly controlled 2
   - Somewhat controlled 3
   - Well controlled 4
   - Completely controlled 5

Total

Copyright 2002, by QualityMetric Incorporated.
Asthma Control Test is a trademark of QualityMetric Incorporated.
Childhood Asthma Control Test

- Self-administered tool for identifying children 4-11 years whose asthma is inadequately controlled
- Developed and validated in 2007 (Liu, et al)
- Not mentioned in EPR-3 (published 2007)
Childhood Asthma Control Test

1. How is your asthma today?
   - 0: Very bad
   - 1: Bad
   - 2: Good
   - 3: Very good

2. How much of a problem is your asthma when you run, exercise or play sports?
   - 0: It's a big problem, I can't do what I want to do.
   - 1: It's a problem and I don't like it.
   - 2: It's a little problem but it's okay.
   - 3: It's not a problem.

3. Do you cough because of your asthma?
   - 0: Yes, all of the time.
   - 1: Yes, most of the time.
   - 2: Yes, some of the time.
   - 3: No, none of the time.

4. Do you wake up during the night because of your asthma?
   - 0: Yes, all of the time.
   - 1: Yes, most of the time.
   - 2: Yes, some of the time.
   - 3: No, none of the time.

Please complete the following questions on your own.

5. During the last 4 weeks, on average, how many days per month did your child have any daytime asthma symptoms?
   - 5: Not at all
   - 4: 1-3 days/mo
   - 3: 4-10 days/mo
   - 2: 11-18 days/mo
   - 1: 19-24 days/mo
   - 0: Everyday

6. During the last 4 weeks, on average, how many days per month did your child wheeze during the day because of asthma?
   - 5: Not at all
   - 4: 1-3 days/mo
   - 3: 4-10 days/mo
   - 2: 11-18 days/mo
   - 1: 19-24 days/mo
   - 0: Everyday

7. During the last 4 weeks, on average, how many days per month did your child wake up during the night because of asthma?
   - 5: Not at all
   - 4: 1-3 days/mo
   - 3: 4-10 days/mo
   - 2: 11-18 days/mo
   - 1: 19-24 days/mo
   - 0: Everyday

Please turn this page over to see what your child's total score means.
Scoring

- Score of **19 or less** indicate asthma is not well-controlled for both ACT and C-ACT
- Scores may be used to guide therapy*

<table>
<thead>
<tr>
<th></th>
<th>Well-Controlled</th>
<th>Not Well-Controlled</th>
<th>Very Poorly-Controlled</th>
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</thead>
<tbody>
<tr>
<td><strong>ACT</strong></td>
<td>$\geq 20$</td>
<td>16-19</td>
<td>$\leq 15$</td>
</tr>
<tr>
<td><strong>C-ACT</strong></td>
<td>$\geq 20$</td>
<td>13-19</td>
<td>$\leq 12$</td>
</tr>
<tr>
<td><strong>No change</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Follow-up 1-6 months</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Step-up 1 step</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Follow-up 2-6 weeks</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Step-up 1-2 steps</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Follow-up 2 weeks</strong></td>
<td></td>
<td></td>
<td></td>
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Building a Care Coordination Team

- Useful frameworks for planning
- Assembling your team(s)
- Asthma measures in action (ACT/C-ACT)
- Office (and organization) mobilization
Useful Frameworks for Planning

- Institute for Healthcare Improvement (IHI) Triple Aim (or “Quadruple Aim”)
- Chronic Care Model
- CDC CCARE & E.X.H.A.L.E. framework
- NYS DOH Project BREATHE NY
- Quality Improvement
The IHI Triple Aim

Population Health

Experience of Care

Per Capita Cost
Chronic Care Model (CCM)

- Framework developed by in 1998 to address deficiencies in chronic disease management
  - Rushed practitioners not following established practice guidelines
  - Lack of care coordination and planned care
  - Lack of active follow-up to ensure the best outcomes
  - Patients inadequately trained to manage their illnesses
The Chronic Care Model

Community
- Resources and Policies
- Self-Management Support

Health Systems
- Organization of Health Care
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Improved Outcomes
- Informed, Activated Patient
- Prepared, Proactive Practice Team

Productive Interactions
CDC CCARE and **E.X.H.A.L.E.**

<table>
<thead>
<tr>
<th>EXHALE</th>
<th>Strategy</th>
<th>Approach</th>
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<tbody>
<tr>
<td>E</td>
<td>Education on asthma self-management</td>
<td>• Expanding access to and delivery of asthma self-management education (AS-ME)</td>
</tr>
</tbody>
</table>
| X      | Extinguishing smoking and secondhand smoke | • Reducing tobacco smoking  
• Reducing exposure to secondhand smoke |
| H      | Home visits for trigger reduction and asthma self-management education | • Expanding access to and delivery of home visits (as needed) for asthma trigger reduction and AS-ME |
| A      | Achievement of guidelines-based medical management | • Strengthening systems supporting guidelines-based medical care, including appropriate prescribing and use of inhaled corticosteroids  
• Improving access and adherence to asthma medications and devices |
| L      | Linkages and coordination of care across settings | • Promoting coordinated care for people with asthma |
| E      | Environmental policies or best practices to reduce asthma triggers from indoor, outdoor, and occupational sources | • Facilitating home energy efficiency, including home weatherization assistance programs  
• Facilitating smokefree policies  
• Facilitating clean diesel school buses  
• Eliminating exposure to asthma triggers in the workplace whenever possible  
• Reducing exposure to asthma triggers in the workplace (if eliminating exposures is not possible) |
NYSDOH Asthma Control Program

Project BREATHE NY

Integrating sustainable evidence-based asthma care coordinated across settings.
Quality Improvement

- Education, tools, and training available from a variety of sources
- Performance improvement activities required for MOC (FM, IM, Peds)
- Institute for Healthcare Improvement
  - IHI Open School Online Courses
Building a Care Coordination Team

- Useful frameworks for planning
- Assembling your team(s)
- Asthma measures in action (ACT/C-ACT)
- Office (and organization) mobilization
Assembling your Team(s)

• 2012
  – AMC Pediatric Asthma QI Team*

• 2015-17
  – Asthma Control Test in clinic
  – EMR Enhancements

• 2018
  – Asthma Care Coordination Team
  – Asthma Community Pharmacy Coalition

• 2020
  – ED/Hospital Transition of Care
AMC Pediatric Asthma QI Team

- Multidisciplinary team
  - AMC Physicians: ED, Hospitalist, Pulmonary
  - Ambulatory Pediatrics (Asthma Coordinator)
  - Nursing
  - Pharmacy
  - RT
  - Data Analytics
  - Community Partners: PPS, VNA
  - DOH
AMC Pediatric Asthma QI Team

• 2020: Improving discharge process
  – Referral to case-management
    • Performing Provider System (PPS) Case Manager
      – VNA
      – DOH
      – Healthy Neighborhoods Program
  – Referral to home-based asthma environmental and educational services
    • Healthy Neighborhoods Program
    • Aligned with Project BREATHE NY
Asthma Care Coordination Team

- Stephanie Iati, RN
- Kate Musto, RN
- Shared position:
  - Gen Peds
  - Pediatric Pulmonary
- Patient Education
- Care Coordination
- Community Outreach
Asthma Care Coordination

• Process “gap lists” from managed care organization
• Track high-risk patients (e.g. ACT ≤19)
• Ensure transition of care
  – ED/Hospital to PCP
  – PCP to Specialist
  – Referral to home education services
  – Environmental health related services
EMR Reporting Team
Asthma Population Health Report
Run Chart: Asthma Severity Classification

<table>
<thead>
<tr>
<th>% Severity Classification</th>
<th>Severity Classification</th>
</tr>
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<tbody>
<tr>
<td>89%</td>
<td>Jan-18 - Mar-18</td>
</tr>
<tr>
<td>91%</td>
<td>Apr-18</td>
</tr>
<tr>
<td>91%</td>
<td>May-18</td>
</tr>
<tr>
<td>81%</td>
<td>Jun-18</td>
</tr>
<tr>
<td>79%</td>
<td>Jul-18</td>
</tr>
<tr>
<td>85%</td>
<td>Aug-18</td>
</tr>
<tr>
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<td>Sep-18</td>
</tr>
<tr>
<td>79%</td>
<td>Oct-18</td>
</tr>
<tr>
<td>64%</td>
<td>Nov-18</td>
</tr>
<tr>
<td>57%</td>
<td>Nov-18</td>
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</tbody>
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Jan-18 - Mar-18
Community Pharmacy Coalition

• Collaboration with:
  – Local, regional, and national pharmacy chains
  – College of Pharmacy
  – Managed Care Organizations

• Improve patient education and medication adherence
Building a Care Coordination Team

- Useful frameworks for planning
- Assembling your team(s)
- Asthma measures in action
- Office (and organization) mobilization
## Asthma Measures

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EMR Enhancements

• Daily asthma pre-visit planning report
• ACT/C-ACT as a vital sign
• Asthma Population Health Report
• Electronic referral order to NYS DOH Healthy Neighborhoods Program
Team Huddle (Nursing)

Provide ACT (Nursing)

ACT Completed (Parent/Patient)

Review ACT (Physician)

“Not Well-Controlled” ACT Score: ≤19

Order Follow-up visit (within 1 week)

Place ACT in “To Be Scanned” Bin

Nursing reminds physicians to review ACT on eligible* patients

*Eligible for ACT if age ≥4 years AND any of the following diagnoses:
- Asthma
- Reactive Airway Disease
- Wheezing
- SABA in medication list

There are two versions:
Age 4-11 years: C-ACT
Age 12 years+: ACT

“Controlled” ACT Score: ≥20

Physician may elect to also manage asthma at time of visit instead of scheduling a follow-up visit

Clerical will save copy of ACT for Qi Project Coordinator for tracking
ACT as a Vital Sign
Low Score by Visit (n=19)

- 32% for Follow-Up
- 32% for Sick Visit
- 37% for Routine
## Low Score by Visit (n=19)

<table>
<thead>
<tr>
<th>VISIT TYPE</th>
<th>REASON</th>
<th>ACT SCORE</th>
</tr>
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<tbody>
<tr>
<td>Routine</td>
<td>N/A</td>
<td>4</td>
</tr>
<tr>
<td>Routine</td>
<td>N/A</td>
<td>9</td>
</tr>
<tr>
<td>Follow-Up</td>
<td>Contraception</td>
<td>11</td>
</tr>
<tr>
<td>Sick</td>
<td>Asthma</td>
<td>12</td>
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Building a Care Coordination Team

• Useful frameworks for planning
• Assembling your team(s)
• Asthma measures in action
• Office (and organization) mobilization
Office (organization) mobilization

- Identify physician champion(s)
- Meet regularly
- Executive “sponsorship”
- Funding sources
- Protected time
In Summary

- Care coordination is important for patients with asthma
- Collaboration between organizations and across health care settings is essential
- Together, we can make a difference
“Because if you can’t breathe, nothing else matters…”
References


References


