



CALIFORNIA ASSOCIATION of
**PUBLIC HOSPITALS
AND HEALTH SYSTEMS**



CALIFORNIA HEALTH CARE
SAFETY NET INSTITUTE

QIP WEBINAR: Q-PC4 ASTHMA MEDICATION RATIO

STRATEGIES TO IMPROVE ASTHMA CONTROLLER USE IN PERSISTENT ASTHMA

Wednesday, March 27, 2019; Noon – 1pm

[Recording Link](#)

Agenda

Time	Topic	Lead(s)
5 min	Welcome: Speaker Introduction, Housekeeping & QIP Context	Kristina Mody
30 min	Strategies to Improve Asthma Controller Use in Persistent Asthma	Marilyn Li, MD
15 min	Peer Questions & Sharing	All Hunter, Marilyn
5 min	Next Steps & Wrap Up	Hunter, Kristina

Speakers



Kristina Mody
Sr. Program
Associate, SNI



Hunter Gatewood
Owner, Signal Key
Consulting



Marilyn Li, MD
Clinical Associate
Professor of Pediatrics
Clinician Educator
Keck School of Medicine,
University of Southern
California

Housekeeping



Please mute locally



At any time, feel free to chat your question & we will read out



Webinar will be recorded



Deck & tools will be saved on

[SNI Link/Ambulatory Care](#) and
[SNI/QIP/Implementation Tools](#)

QIP Context

Q-PC4: Asthma Medication Ratio

Specification Source: HEDIS 2018

Numerator: Denominator individuals who had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Denominator: Individuals 5–64 years of age who were identified as having persistent asthma during both the measurement year and the year prior to the measurement year

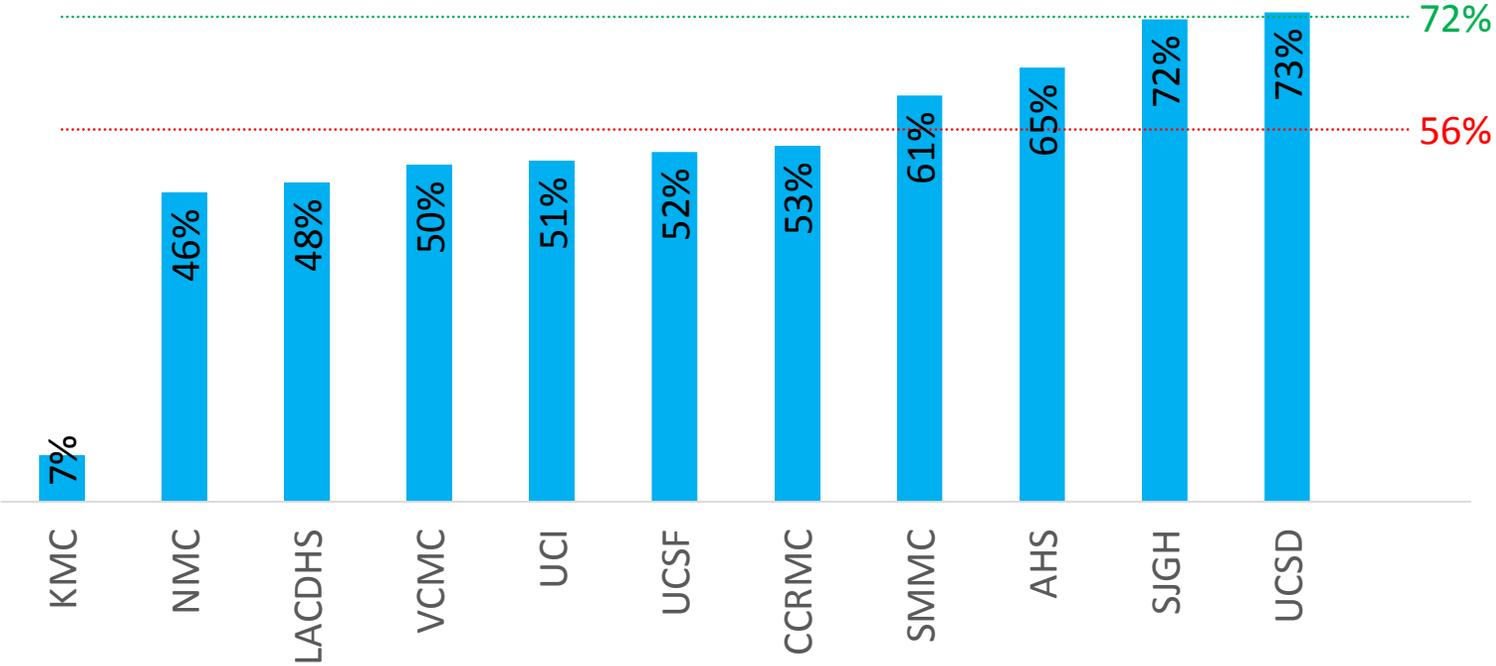
Measure background:

- In HEDIS, part of CMS Adult and Child Core Measure Set (therefore CA External Accountability Set)

Nuances for QIP:

- Prescription must originate from DPH, “Asthma Encounters” must have been at DPH
- ICD-9 codes to be removed from future measure specifications

PY1 Reported Data: PC4 Asthma Medication Ratio



*Rates with denominator < 30 not shown
Data not yet approved by DHCS.*

STRATEGIES TO IMPROVE ASTHMA CONTROLLER USE IN PERSISTENT ASTHMA.

March 27, 2019

Marilyn Li MD

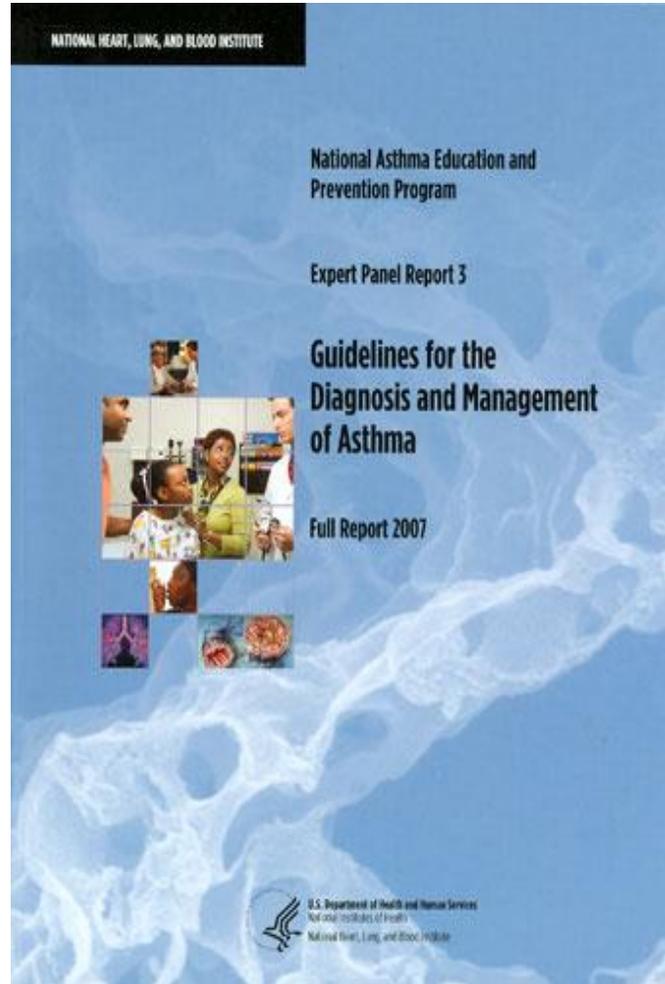
Disclosures

- No commercial support for this activity.
- Past president Los Angeles Society Allergy Asthma and Clinical Immunology
- Officer, Treasurer, California Society Allergy Asthma and Immunology

Objectives

- Review Asthma Controller therapy in persistent asthma
 - Define persistent asthma
 - Define Controller
- Discuss the Asthma Medication Ratio, AMR
- Review patient non-adherence
- Review provider non-adherence
- Discuss strategies to improve adherence
- Discuss strategies to improve the AMR

EPR-3 Summary Report



The NAEPP released the *Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma*, in August 2007

<http://catalog.nlm.nih.gov/catalog/product/Expert-Panel-Report-3-EPR3-Guidelines-for-the-Diagnosis-and-Management-of-Asthma/10-4051>

Persistent Asthma Controller

- **Asthma definition: Chronic disease involving the airways.**

- Cough, chest tightness, shortness of breath, wheeze

- **Persistent Asthma definition:**

- Daytime symptoms >2 days /week but not daily
- Nighttime awakenings 1-2x/month (0 to 4years) or 3-4x/month (5 years and older)
- Rescue (SABA) use >2 days/week
- Any interference with normal activity
- RISK of exacerbations
 - Age 0-4years 2 or more exacerbations in 6 months or +API
 - Ages 5 and older 2 or more asthma exacerbations requiring OCS

- *Long-term control medications:* Prevent symptoms and are taken daily

- **Inhaled Corticosteroids (Including Combination Inhalers):** The most consistently effective long-term control medication.

- **Long-Acting Beta-Agonists (LABAs):** These are used in combination with inhaled corticosteroids.

- **Anticholinergics:** Used as alternative controller medications.

- **Cromolyn, Theophylline and Phosphodiesterase Inhibitors:** Used as alternative controller medications (not preferred).

- **Leukotriene Modifiers:** Used as alternative controller medications.

- **Immunomodulators:** Monoclonal antibodies modify the allergic immune response

FIGURE 4–6. CLASSIFYING ASTHMA SEVERITY AND INITIATING TREATMENT IN YOUTHS ≥12 YEARS OF AGE AND ADULTS

— Assessing severity and initiating treatment for patients who are not currently taking long-term control medications

Components of Severity		Classification of Asthma Severity ≥12 years of age			
		Intermittent	Persistent		
			Mild	Moderate	Severe
Impairment Normal FEV ₁ /FVC: 8–19 yr 85% 20–39 yr 80% 40–59 yr 75% 60–80 yr 70%	Symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	≤2x/month	3–4x/month	>1x/week but not nightly	Often 7x/week
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week but not daily, and not more than 1x on any day	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
	Lung function	<ul style="list-style-type: none"> • Normal FEV₁ between exacerbations • FEV₁ >80% predicted • FEV₁/FVC normal 	<ul style="list-style-type: none"> • FEV₁ >80% predicted • FEV₁/FVC normal 	<ul style="list-style-type: none"> • FEV₁ >60% but <80% predicted • FEV₁/FVC reduced 5% 	<ul style="list-style-type: none"> • FEV₁ <60% predicted • FEV₁/FVC reduced >5%
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year (see note)	≥2/year (see note) 		
		Consider severity and interval since last exacerbation. Frequency and severity may fluctuate over time for patients in any severity category. Relative annual risk of exacerbations may be related to FEV ₁ .  			
Recommended Step for Initiating Treatment		Step 1	Step 2	Step 3	Step 4 or 5
(See figure 4–5 for treatment steps.)		In 2–6 weeks, evaluate level of asthma control that is achieved and adjust therapy accordingly.			
		and consider short course of oral systemic corticosteroids			

Key: FEV₁, forced expiratory volume in 1 second; FVC, forced vital capacity; ICU, intensive care unit

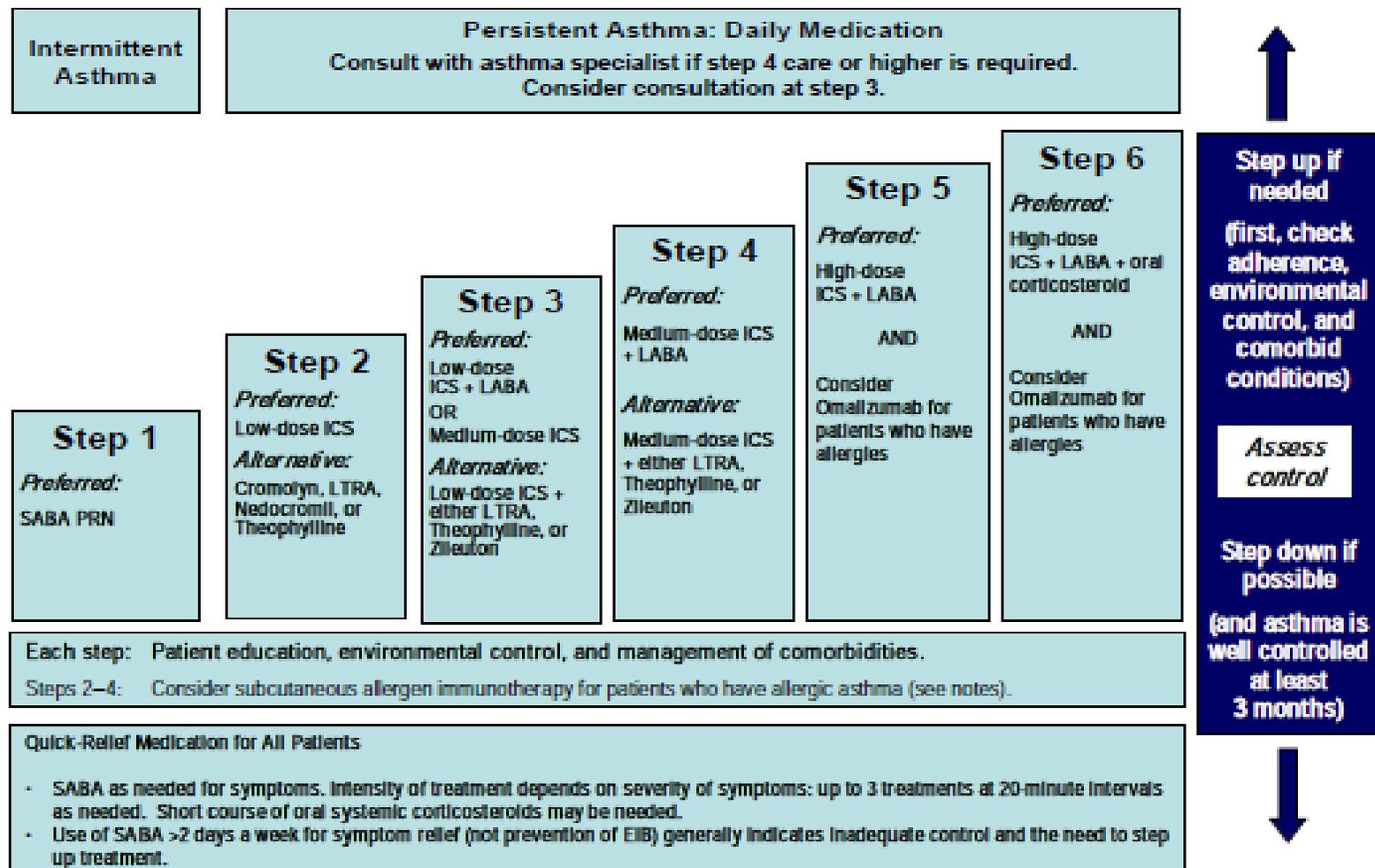
FIGURE 4-7. ASSESSING ASTHMA CONTROL AND ADJUSTING THERAPY IN YOUTHS ≥12 YEARS OF AGE AND ADULTS

Components of Control		Classification of Asthma Control (≥12 years of age)		
		Well Controlled	Not Well Controlled	Very Poorly Controlled
Impairment	Symptoms	≤2 days/week	>2 days/week	Throughout the day
	Nighttime awakenings	≤2x/month	1–3x/week	≥4x/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
	FEV ₁ or peak flow	>80% predicted/ personal best	60–80% predicted/ personal best	<60% predicted/ personal best
	Validated questionnaires			
	ATAQ ACQ ACT	0 ≤0.75* ≥20	1–2 ≥1.5 16–19	3–4 N/A ≤15
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year	≥2/year (see note)	
		Consider severity and interval since last exacerbation		
	Progressive loss of lung function	Evaluation requires long-term followup care		
	Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		
Recommended Action for Treatment (see figure 4-5 for treatment steps)		<ul style="list-style-type: none"> • Maintain current step. • Regular followups every 1–6 months to maintain control. • Consider step down if well controlled for at least 3 months. 	<ul style="list-style-type: none"> • Step up 1 step and Reevaluate in 2–6 weeks. • For side effects, consider alternative treatment options. 	<ul style="list-style-type: none"> • Consider short course of oral systemic corticosteroids. • Step up 1–2 steps, and Reevaluate in 2 weeks. • For side effects, consider alternative treatment options.

*ACQ values of 0.76–1.4 are indeterminate regarding well-controlled asthma.

Key: EIB, exercise-induced bronchospasm; ICU, intensive care unit

FIGURE 4-5. STEPWISE APPROACH FOR MANAGING ASTHMA IN YOUTHS ≥12 YEARS OF AGE AND ADULTS



— **Key:** Alphabetical order is used when more than one treatment option is listed within either preferred or alternative therapy. EIB, exercise-induced bronchospasm; ICS, inhaled corticosteroid; LABA, long-acting inhaled beta₂-agonist; LTRA, leukotriene receptor antagonist; SABA, inhaled short-acting beta₂-agonist

HEDIS[®] 2018 Measure: AMR

- Asthma Medication Ratio (AMR): **Assesses** adults and children 5–85 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Objectives

- Review Asthma Controller therapy in persistent asthma
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- Discuss strategies to improve the AMR

ADHERENCE Definitions

Osterberg&Blaschke (2006)

- “Adherence to (or compliance with) a medication regimen is generally defined as the extent to which patients take medications as prescribed by their health care providers. “

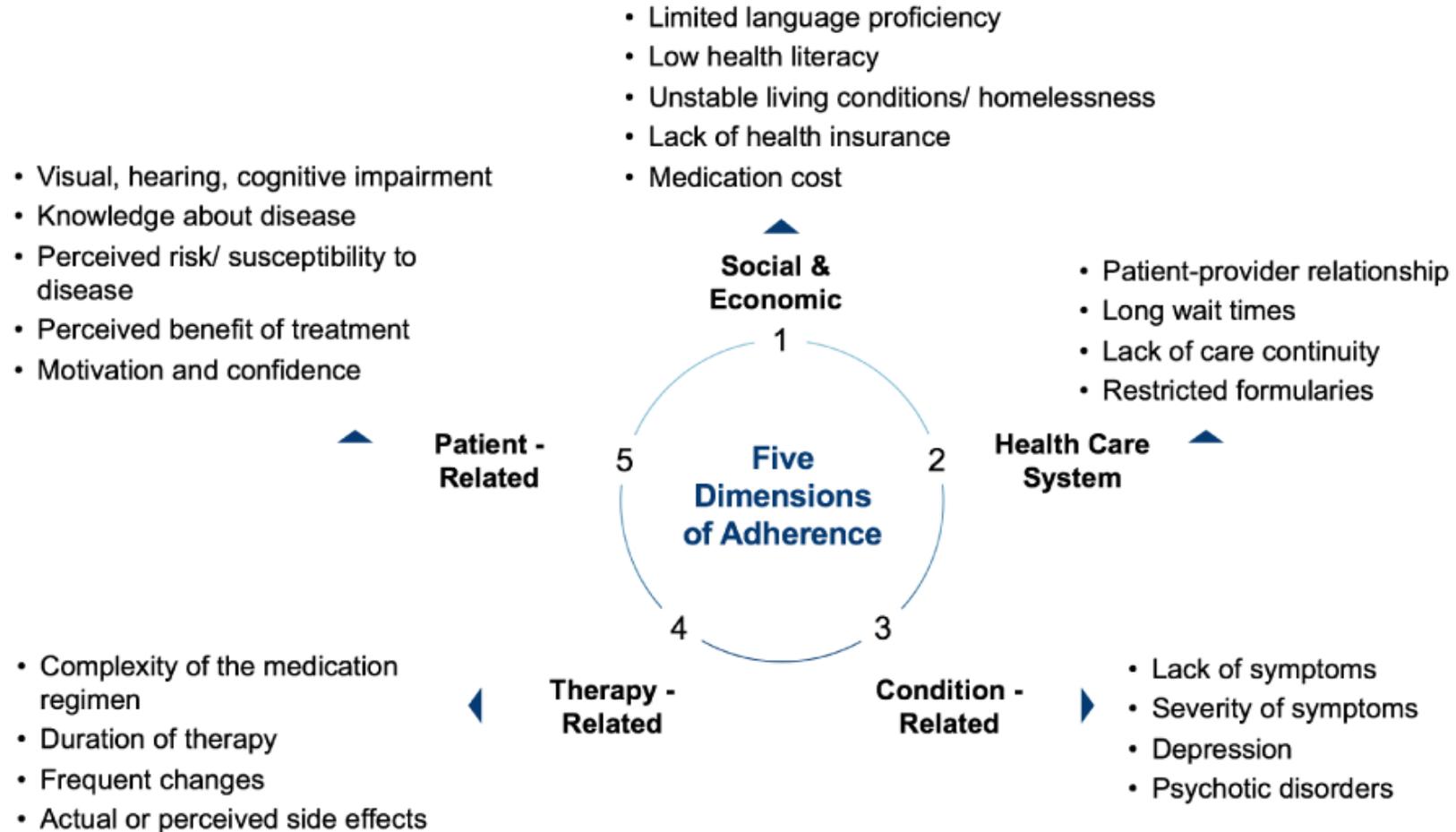
World Health Organization (2003)

- “ the degree to which use of medication by the patient corresponds with the prescribed regimen.”
- “diversity and complexity of adherence behavior.”

Factors Contributing to Non-Adherence

- Social and Economic factors
- Patient related factors
- Medication related factors
- Condition related factors
- Health-care system related factors

Diagram Outlining the Factors Related to Non-Adherence.



Source: Sabaté, Eduardo. Adherence to long-term therapies: evidence for action. World Health Organization, 2003.

NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

Adherence Interventions

- Adherence education 20% (8% to 33%)
- Electronic trackers or reminders 19% (14 to 25%)
- Simplified drug regimens 4% (2% to 6%)
- School based directly observed therapy

Clinician Factors

- Provider Communication skills
- Implementation of asthma self management education plans
- Provider feedback on medication use and patient progress
 - Electronic monitors on ICS increased adherence by 78% in a 10 week outpatient study
- Practice related factors including fewer patients per hour, longer appointment length, evening hours, multilingual staff, consistency of care, ease of appointments and telephone interactions, telephone reminders and follow-up.

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Strategies to improve Asthma Control and improve the AMR

- Provider education, both system and individual
 - Large group seminar, lecture, workshops
 - Include all providers that interface with patients
 - Individual clinic evaluation and recommendations for asthma interface
 - Follow up semi annual or annual workshop to review and reinforce asthma skill sets
- Patient education (as part of an asthma visit, or separately)
 - Group or individual counseling sessions
 - Follow up interactions via phone, computer, other
 - Reminders and Routine visits.
- Community education
 - Ad campaigns, videos, print materials
 - Debunk myths, advocate patient-provider partnerships, provide resources
- Health care interface, including pharmacy and insurers
 - Pharmacy cooperation and education for staff

What Patients Want

Studies show many asthma patients do not always follow their prescribed treatment plan.
How can doctors provide better support and improve adherence?

Allergy & Asthma Network partnered with pediatric pulmonologist Bruce K. Rubin, MD, and board-certified allergist Wei Zhao, MD, both of Virginia Commonwealth University School of Medicine, to survey nearly 1,000 parents of children with asthma.

Common barriers to asthma care reported by parents of children with asthma...



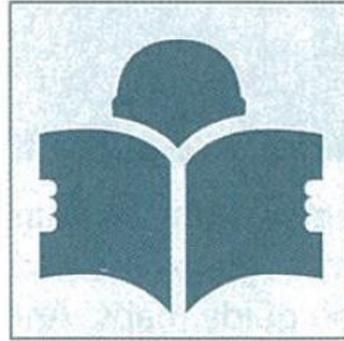
Financial concerns:
38%



Medication side effect concerns:
36%



Time concerns:
30%



Lack of knowledge:
29%



Feeling overwhelmed managing the disease:
25%



Denial regarding the disease:
11%

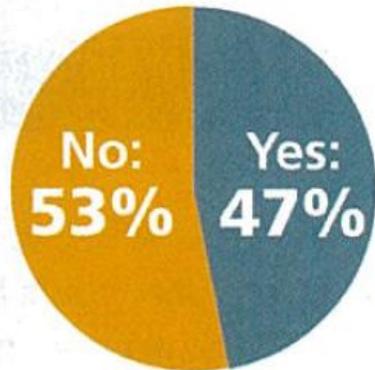
What patients want...

- **Greater access to their doctor** – Convenient location and more flexible office hours; more time per visit
- **Authenticity** – A thorough discussion of symptoms and treatment; eye contact and empathy
- **Shared Decision Making** – A doctor-patient partnership with greater interaction and listening by the healthcare provider
- **Patient-Friendly Education** – Information on support services and prescription assistance

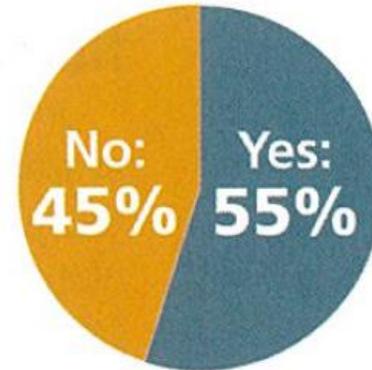
What patients can do...

- Request a longer appointment if you have multiple questions and concerns.
- Prioritize questions you want to address at the appointment to help you maximize your time with the doctor.
- Provide medical records from hospitals or other clinics as needed.
- Bring copies of school or camp health forms that need to be completed by the doctor.
- Bring materials to take notes.
- Request asthma education and an Asthma Action Plan if you don't already have one; an Asthma Action Plan is a written document that spells out how to treat asthma daily and what to do when symptoms get worse.

Asthma education covered by insurance?



Do you have an Asthma Action Plan?



Ideal
AMR



ASTHMA
CONTROL

PATIENT PRESCRIPTION RECORD
01/01/2018 THRU 12/31/2018

Date: 02/18/2019 Time: 4:15:19 PM

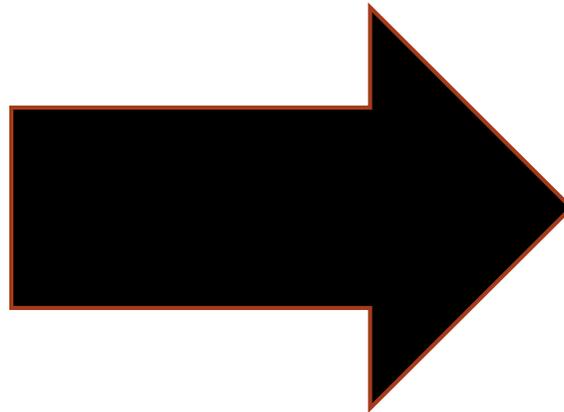
PHARMACY NAME:
ADDRESS:
CITY, ST, ZIP:

PATIENT KEY:
PATIENT NAME:
ADDRESS:
CITY, ST, ZIP:

TELEPHONE:
BIRTHDATE:
GENDER:
RELATIONSHIP

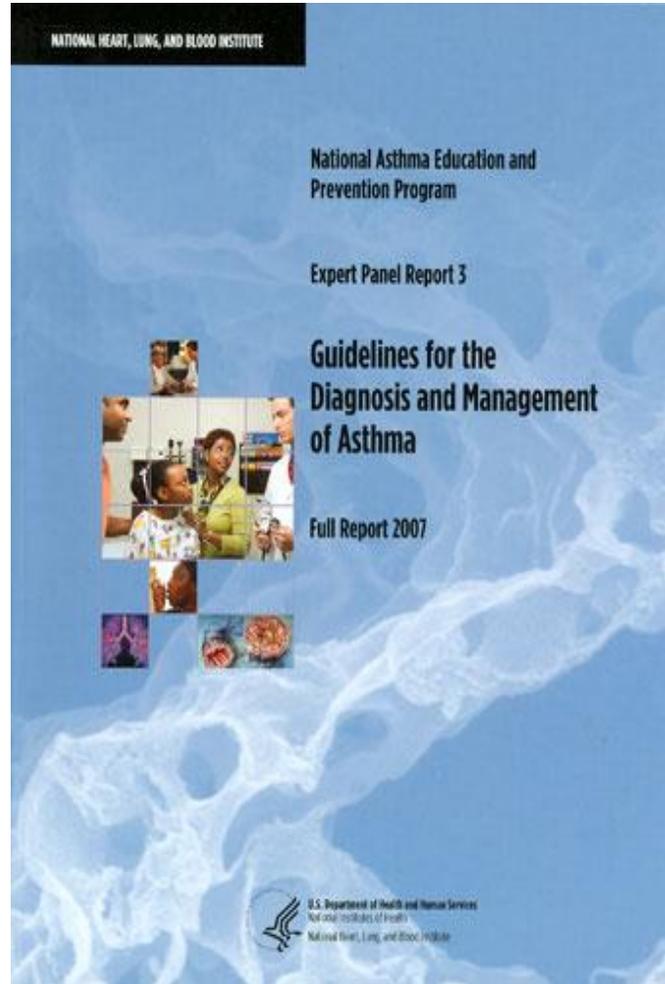
STORE NO #	RX NUMBER	RFL	NDC NUMBER	DRUG DESCRIPTION	PRESCRIBER NAME	DATE FILLED	QUANT DISP	PATIENT PD AMT
				AFLURIA QUAD 2018-2019 SYRINGE		08/25/2018	0.50	0.00
				AMITRIPTYLINE HCL 10 MG TAB		12/12/2018	30.00	0.00
				AMOXICILLIN 500 MG CAPSULE		08/25/2018	30.00	0.00
				ASPIRIN EC 81 MG TABLET		12/14/2018	30.00	0.00
				CETIRIZINE HCL 10 MG TABLET		05/15/2018	30.00	0.00
				DICLOFENAC SOD DR 75 MG TAB		03/15/2018	60.00	0.00
				DICLOFENAC SOD DR 75 MG TAB		04/13/2018	60.00	0.00
				DICLOFENAC SOD DR 75 MG TAB		08/03/2018	60.00	0.00
				DULERA 200 MCG/5 MCG INHALER		01/03/2018	13.00	0.00
				DULERA 200 MCG/5 MCG INHALER		05/15/2018	13.00	0.00
				FLUTICASONE PROP 50 MCG SPRAY		05/15/2018	16.00	0.00
				FLUTICASONE-PROP-50-MCG-SPRAY		11/27/2018	16.00	0.00
				FLUTICASONE-SALMETEROL 232-14		11/28/2018	3.00	0.00
				HEATHER TABLET		07/13/2018	84.00	0.00
				HEATHER TABLET		10/05/2018	84.00	0.00
				HEATHER TABLET		12/26/2018	84.00	0.00
				HYDROCODONE-ACETAMIN 7.5-325		08/07/2018	120.00	0.00
				HYDROCORTISONE 0.5% CREAM		01/05/2018	28.35	0.00
				LORATADINE 10 MG TABLET		01/02/2018	30.00	0.00
				LORATADINE 10 MG TABLET		05/15/2018	30.00	0.00
				METHYLPREDNISOLONE 4 MG DOSEPK		11/27/2018	21.00	0.00
				METOCLOPRAMIDE 5 MG TABLET		09/03/2018	15.00	0.00
				MONTELUKAST SOD 10 MG TABLET		01/02/2018	30.00	0.00
				MONTELUKAST SOD 10 MG TABLET		05/15/2018	30.00	0.00
				NITROGLYCERIN 0.4 MG TABLET SL		12/14/2018	25.00	0.00
				SULINDAC 200 MG TABLET		10/08/2018	60.00	0.00
				SULINDAC 200 MG TABLET		11/14/2018	60.00	0.00
				TOPIRAMATE 25 MG TABLET		12/27/2018	30.00	0.00
				VENTOLIN HFA 90 MCG INHALER		12/27/2018	18.00	0.00

ASTHMA
CONTROL



IDEAL
AMR

EPR-3 Summary Report



The NAEPP released the *Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma*, in August 2007

<http://catalog.nlm.nih.gov/catalog/product/Expert-Panel-Report-3-EPR3-Guidelines-for-the-Diagnosis-and-Management-of-Asthma/10-4051>

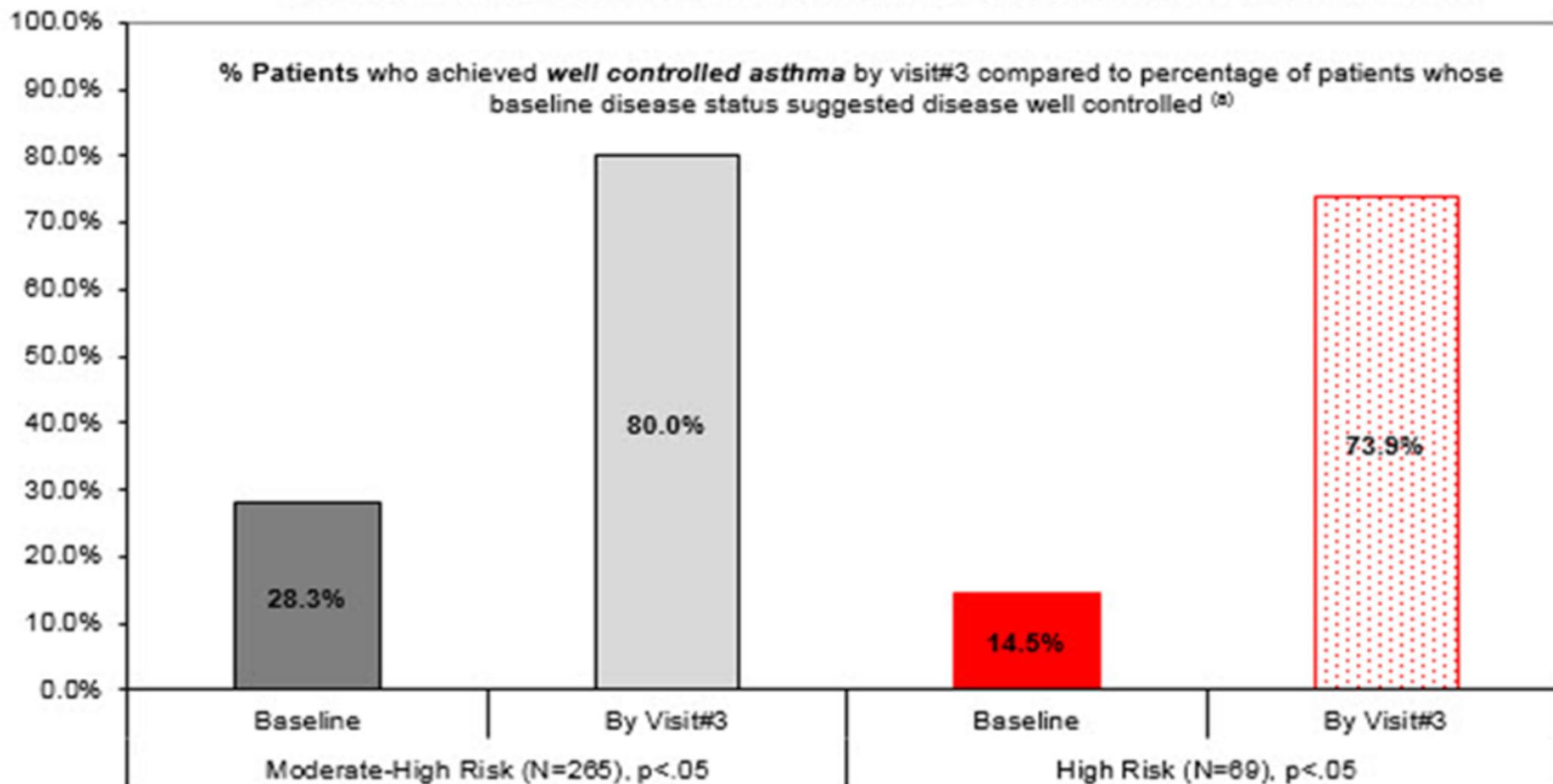
Case Study CHOC Breathmobile Program

- CHOC support for Asthma Initiative
 - Standardized education about asthma to all health care providers, including staff
 - Point of Care testing, validated skills
 - Lunch and learn opportunities to improve asthma knowledge
 - Use of Cerner's Health Intent Registry
 - Application of asthma action plans for all asthma patients
 - Asthma Action Plan 'Scorecard'

Improved Asthma Control

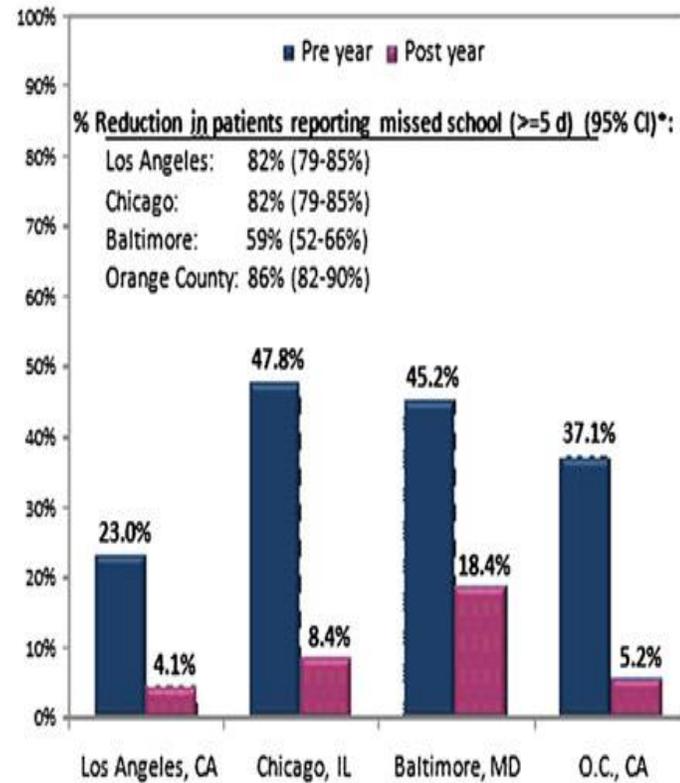
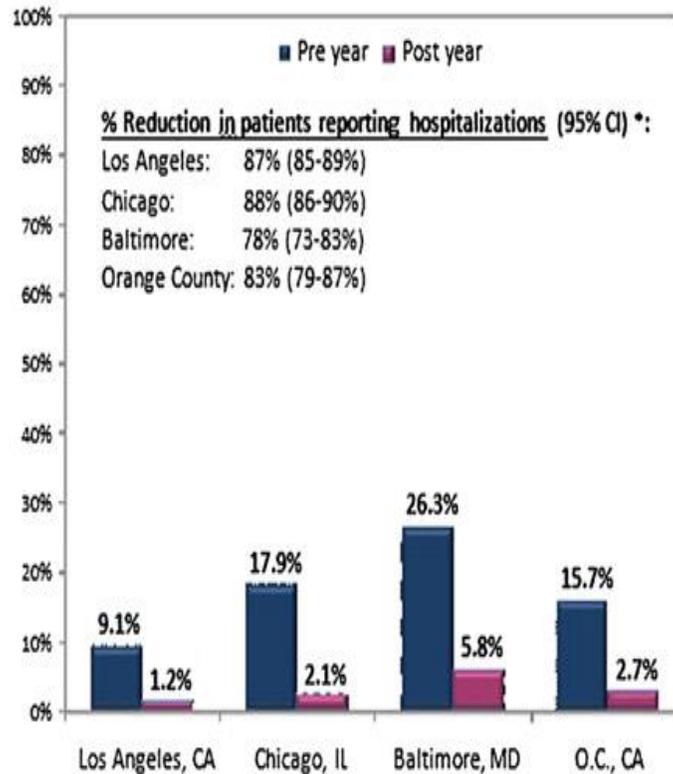
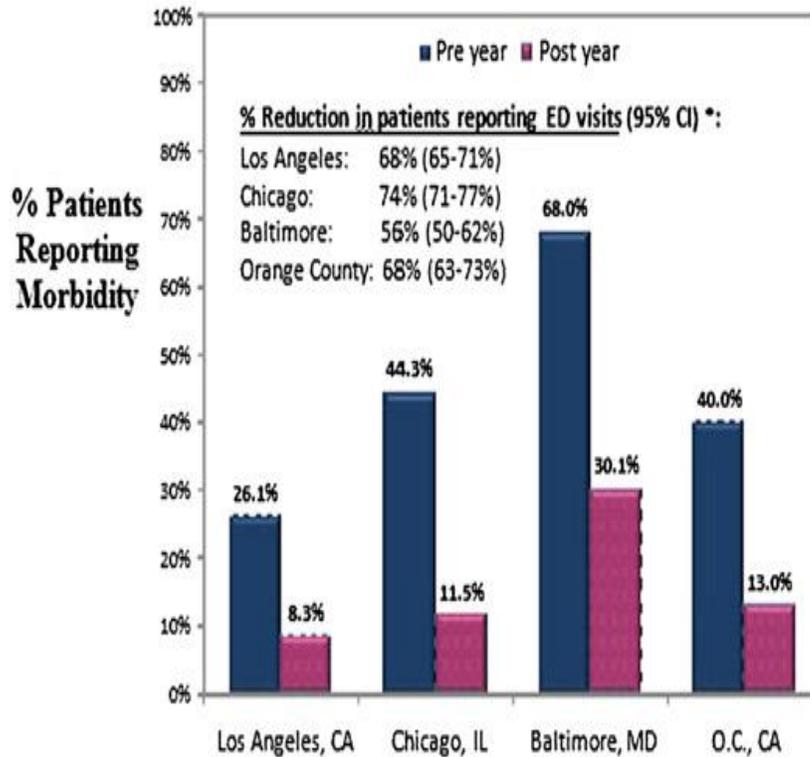
Breathmobile Group (>=3 visits to program by study endpoint)

[Evaluated in patients with provider assessed severity at baseline and control status at visits 2&3]

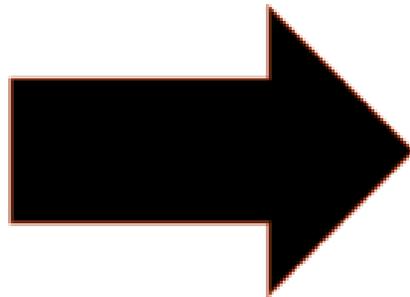


Morbidity Pre vs. Post Year of Entry

Among study patients who entered and received ongoing care (≥ 1 year) in regions operating programs during the 5 year period (2002-2006)



ASTHMA
CONTROL



IDEAL
AMR

0.75

ASTHMA TOOLKITS

- Anatomic models
- Device demonstrators
- Pictures/posters/videos
- Asthma Action Plans
- Patient Centric Questionnaires
- Informational brochures
- Web based applications
- From a 2017 article by Tinschert P et al, 523 asthma apps found



Un vistazo a 2016

los inhaladores respiratorios

La Red de Alergia y Asma es una organización sin fines de lucro dedicada a terminar con la muerte y el sufrimiento innecesario debido a asma, las alergias y otras condiciones relacionadas, a través de alcance comunitario, educación, abogacía e investigación.



AllergyAsthmaNetwork.org

800.878.4403

Broncodilatadores beta-agonistas de corta duración

Alivian los síntomas de los ataques de asma y previenen el inicio de los ataques de asma por 24 horas.

ProAir® HFA



ProAir® RespiClick
sulfato de albuterol polvo para inhalar



Proventil® HFA
albuterol



Ventolin® HFA
albuterol



Xopenex HFA®
levalbuterol



Arcapta® Noxahaler®
indacaterol polvo para inhalar



Serevent® Diskus®
salmeterol polvo para inhalar



Spirivent® Respiromat®
tiotropio metilbromuro



Corticosteroides inhalados

Reducen y previenen la inflamación del tracto que causa los síntomas respiratorios, así como el inicio de los ataques de asma.

Aerospace®
80 mcg fluticasona



Alveo® HFA
36 mcg, 108 mcg mometasona



Arcady® Ellipta®
100 mcg, 200 mcg fluticasona
polvo para inhalar



Asmanex® HFA
fluticasona formosa



Asmanex® Twisthaler®
110 mcg, 220 mcg fluticasona
polvo para inhalar



Flovent® Diskus®
54 mcg, 108 mcg, 220 mcg propionato de fluticasona
polvo para inhalar



Flovent® HFA
44 mcg, 110 mcg, 220 mcg propionato de fluticasona



Pulmicort Flexhaler®
36 mcg, 108 mcg budesonida
polvo para inhalar



QVAR® (HFA)
48 mcg, 80 mcg beclometasona



Medicinas combinadas

Combinan beta-agonistas de larga duración y corticosteroides inhalados.

Advair® Diskus®
100/50, 250/50, 300/50 propionato de fluticasona y salbutamol



Advair® HFA
45/21, 110/21, 300/21 propionato de fluticasona y salbutamol



Breo® Ellipta®
100/25 mcg, 300/25 mcg fluticasona y vilanterol



Dulera®
180/5, 300/5 formoterol y formoterol



Symbicort® (HFA)
60/4.5, 120/4.5 budesonida y formoterol



Anoro® Ellipta®
100/5, 200/5 formoterol y vilanterol
polvo para inhalar



Stairto® Respiromat®
budesonida y formoterol



UtiBron® Noxahaler
indacaterol y glicopirronio
polvo para inhalar



Antagonista muscarinico (anticolinérgico)

Alivia la tos, la producción de moco, el sibilante y el apretamiento del pecho asociados con la bronquitis crónica y el asma.

Abevor® HFA
ipratropio



Serevent® Noxahaler®
glicopirronio polvo para inhalar



Incroas® Ellipta®
umecridilo polvo para inhalar



Spiriva® HandiHaler®
tiotropio polvo para inhalar



Spiriva® Respiromat®
1.5, 3.5 mcg tiotropio de bromuro



Tudorza® Pressair®
acilfenazona polvo para inhalar



Combinadas
ipratropio y beta-agonista de larga duración

Combivent® Respiromat®
ipratropio y albuterol



DISC = CONTADOR DE DOSIS A = ASMA E = EPOC * = INCLUYE CÁMARA ESPACIADORA

Medicinas en español revisadas por Antonio Castillo MD, FAAPM

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ASTHMA ACTION PLAN

Create the Asthma Action Plan below, then click the "Generate Printable Document" button at the bottom for a printable Asthma Action Plan report. The report includes pictures of each selected medicine and an area to handwrite patient information.

Name: _____	Date: _____
Emergency Contact: _____	Relationship: _____
Cell Phone: _____	Work Phone: _____
Health Care Provider: _____	Phone Number: _____
Personal Best Peak Flow: _____	

GREEN ZONE: Doing Well

- ✓ No coughing, wheezing, chest tightness, or difficulty breathing
- ✓ Can walk, play, exercise, perform usual activities

Take these medicines every day for control and maintenance:

Medicine	How much to take	When and how often
<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>
<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>

Enter Name _____
 Enter Address _____
 Enter City/State/Zip _____

Today's Date: _____
 Patient's Name: _____

FOR PATIENTS:

Take the Asthma Control Test™ (ACT) for people 12 yrs and older.
Know your score. Share your results with your doctor.

- Step 1** Write the number of each answer in the score box provided.
Step 2 Add the score boxes for your total.
Step 3 Take the test to the doctor to talk about your score.

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?						SCORE <input type="text"/>				
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?							<input type="text"/>			
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?							<input type="text"/>			
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)?						<input type="text"/>				
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?						<input type="text"/>				
Not controlled at all	1	Poorly controlled	2	Somewhat controlled	3	Well controlled	4	Completely controlled	5	
						TOTAL <input type="text"/>				

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

If your score is 19 or less, your asthma may not be controlled as well as it could be. Talk to your doctor.

FOR PHYSICIANS:

The ACT is:

- A simple, 5-question tool that is self-administered by the patient
- Recognized by the National Institutes of Health
- Clinically validated by specialist assessment and spirometry¹

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The
Los Angeles
Breathmobile
Program

Keeping Kids Out of
the Emergency Room
and in School



PEER QUESTIONS & SHARING



Peer questions... how do you:

- Standardize management of asthma patients?
- Engage patients?
- Address poor compliance with use of controllers and a model for asthma education... that works?
- Improve data capture?
- Increase staff buy in to improve AMR?
- Integrate ED approach to asthma with primary care?

Upcoming Dates

Apr 2(1-2): QIP PY2 Manual Walkthrough Webinar [[link](#)]

Apr 11 (12-1): PRIME/QIP Office Hours

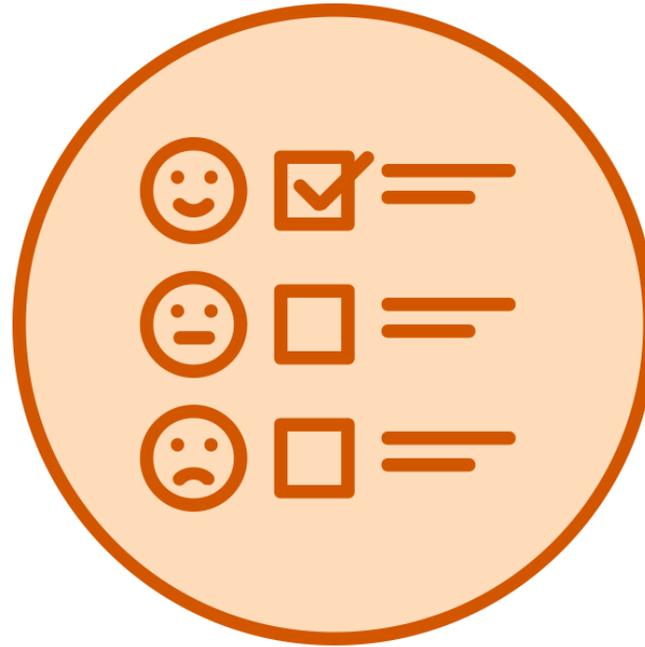
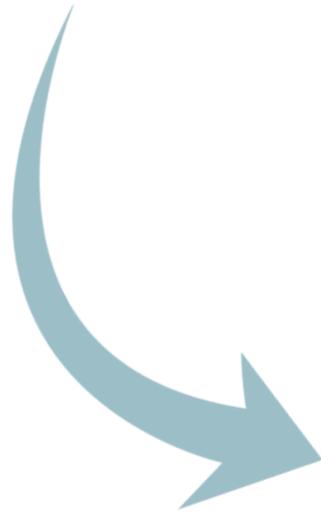
Apr 22 (12-1): QIP Leads Webinar

May 2 (Oakland, CA): Care Delivery Workshop – Better Screening for Improved Health (details [here](#))

M	T	W	Th	F
April				
1	2	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26

May				
29	30	1	2	3

SHARE YOUR FEEDBACK!



How did we do?

What did you learn?

Do you have suggestions for future topics or content?

**PLEASE COMPLETE
OUR POP-UP SURVEY**