

Montana Asthma Plan 2020-2025



Healthy People. Healthy Communities.

Department of Public Health & Human Services



MONTANA
ASTHMA CONTROL
PROGRAM

Acknowledgements

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Montana Academy of Pediatrics
Montana Association of School Nurses
Montana County Health Departments
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Purpose

To address the burden of asthma in Montana, the Montana Asthma Control Program (MACP) was created in July 2007 with funding allocated by the MT State Legislature. The MACP was awarded additional funding in the form of 5-year competitive grants from the CDC's National Asthma Control Program in 2009, 2014, and 2019. The program is housed within the Public Health and Safety Division (PHSD) of the MT Department of Public Health and Human Services (DPHHS). Since its inception, the MACP has focused on addressing asthma from a public health perspective within the unique context of rural MT by developing an asthma surveillance system for the state, forging meaningful, multidisciplinary partnerships with stakeholders statewide, and implementing feasible, evidenced-based interventions. The MACP is committed to improving the quality of life for all Montanans with asthma.

The Strategic Asthma Plan was written with input from asthma experts across Montana. The MACP is committed to improving the quality of life for all Montanans with asthma, and actively considers health disparities and inclusion of the most vulnerable populations. The MACP will implement activities through a comprehensive and coordinated approach, reduce duplication, and increase the efficiency of the staff and partners, while leveraging limited resources. This approach includes addressing standards and policies to improve access to asthma control services that affect groups of people (communities, schools, worksites); increasing Montanans' awareness of asthma triggers, disease self-management, and resources (community programs, home-based trigger reduction services, payer sources); working with health care providers to implement quality improvement (QI) strategies that improve delivery and use of clinical services; and linking clinical and community resources.

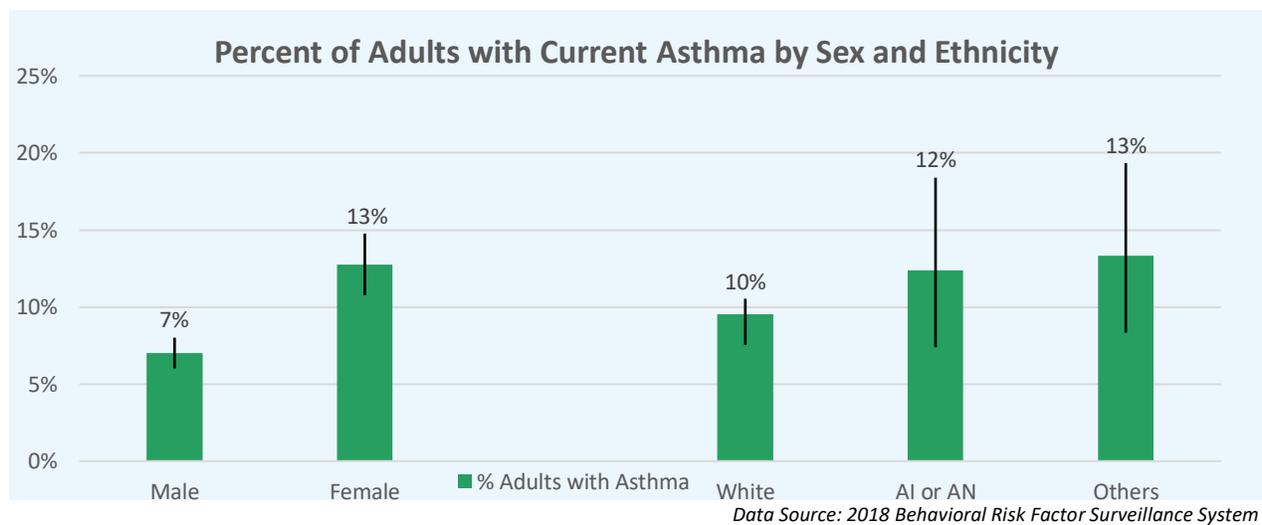
This plan is designed for use by agencies, communities and individuals within Montana that have an interest in addressing the problem of asthma. In the attempt to achieve a balance of aspirational and practical interventions and approaches, the plan is built upon MACP experience, program evaluation findings, surveillance strengths, core competencies of partnering organizations, and new evidence regarding intervention effectiveness and feasibility. Its purpose is to provide structure for coordinated activities across the state to mobilize individuals, organizations, communities, and state and local agencies to collectively take action on asthma over the next five years. Some objectives are easier to implement than others, but they all demonstrate beneficial practices.

We anticipate each individual and organization using this plan will prioritize their efforts based on what they can achieve with their expertise and resources. This document can serve as a resource, providing organizations a choice of options to achieve their goals. Successful implementation of this plan will further reduce the significant burden of asthma in Montana; ensure the appropriate prevention, diagnosis, and management of asthma for individuals in all settings; reduce asthma disparities; and significantly improve the quality of life for Montanans affected by asthma.

Long-term outcomes will contribute to the CDC's goal of preventing 500,000 hospitalizations and emergency department visits among children with asthma within five years, also known as the Controlling Childhood Asthma and Reducing Allergies (CCARE) initiative.

Asthma Control in Montana

Asthma is a prevalent chronic condition among Montanans and can have serious health implications if not properly managed. In 2018, 10% of adults and 5% of children (aged 0-17 years) reported currently living with asthma. People with poorly managed asthma suffer from a lower quality of life, reduced activity and productivity, missed days of work or school, frequent ED visits or hospitalizations, and – although rare – death may occur. There were 2,022 Emergency Department (ED) visits and 291 hospitalizations for asthma in that same year. Asthma prevalence was mapped according to the 13 MT Chronic Disease regions and does not vary statistically across the state (range 7.5%-10.4%). However, a higher rate of asthma-related hospital and ED discharges are localized to the central and eastern part of the state, many regions overlapping with American Indian (AI) reservations. Though asthma mortality rates have decreased, asthma deaths still occur. Asthma mortality rates dropped from 9 per million MT residents per year in 2008-2010 to 3 per million residents per year in 2016-2018. Although there is no cure, there are safe, effective ways to control asthma so that individuals can live a normal, active, symptom free life.



Although the reasons are unclear, disparities exist between Native Americans and whites and in younger versus older age groups in ED visits and hospitalizations due to asthma¹. Factors may include severity of disease, a lack of access to health care services, the quality of health care received, lack of opportunities for asthma self-management education, and a range of potential environmental health issues.



About 50% of adults and 37% of children with asthma report limiting their activities because of asthma.



A typical charge for an asthma related hospital stay in 2018 was \$13,024.

The goals, objectives and strategies contained in the 2020-2025 Montana Asthma Plan are directed at improving the lives of Montana citizens with asthma and are considered feasible to implement in the next 5 years. Successful implementation will come only through continued collaboration between public, private, and non-profit partners.

1. Agency for Healthcare Research and Quality. (2018). NATIONAL HEALTHCARE QUALITY & DISPARITIES REPORT. AHRQ. <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqdr/2018qdr-final.pdf>

Guiding Principles

The MACP has identified a set of guiding principles to inform program strategies and actions and the development of partnerships, including cross-agency partnerships. These guiding principles establish a framework for the MACP and its partners to act collectively to implement comprehensive programs that are efficient, effective, and sustainable. These principles align with those identified in the State Health Improvement Plan and are expected to guide future action to address asthma in Montana.

1. Equity

Achieve health equity by addressing the social determinants of health, expanding activities into rural communities, and partnering with communities and American Indian tribes to reduce health disparities.

2. Collaboration and Partnerships

Identify potential linkages and act upon opportunities to cooperate and partner responsibly to achieve greater impacts than can occur in isolation. All health care and public health partners understand, accept and fulfil their roles and responsibilities to ensure enhanced health outcomes for all Montanans.

3. Access to Guidelines Based Care and Community Support Services

Guidelines-based asthma care, Asthma Self-Management Education (ASME), and appropriate support services are available, accessible and affordable for all Montanans.

4. Evidence-Based

Relevant and current evidence informs best practices and strengthens the knowledge base to effectively prevent and manage asthma and other chronic conditions. The use of consistent, quality, and real-time data sharing enables monitoring and quality improvement to achieve better health outcomes

5. Patient-centered approaches

The health care system is designed to recognize and value the needs of individuals, their caregivers and their families, to provide coordinated care and support.

Cross Cutting Themes

These themes were identified by strategic planning partners as critical to the success of the MACP over the next 5 years. Themes are incorporated into the goals, objectives, and strategies in this plan.

Leveraging Technology

Technology touches nearly every part of our lives, including our health care. The MACP will explore how technology can improve asthma care, communication, ASME, and program interventions.

Social Determinants of Health

The social determinants of health (SDOH) are the social circumstances in which people live, work, and play. The MACP will leverage new and existing partnerships to address the social determinants that lead to asthma disparities in Montana.

Advocacy

MACP is dedicated to providing data and support for partner organizations advocating for policies that improve patient care and asthma-friendly community environments.

EXHALE Strategies

Services such as asthma home visiting education; health care quality improvements to achieve guidelines-based care; a network of strategic partners; and many others contribute to the MACP's goal of a healthier Montana. Notably, the program seeks to improve quality of life, reduce asthma morbidity and mortality, diminish disparities, and sustain its services. To attain this vision, the MACP has integrated the EXHALE technical package, provided by the National Asthma Control Program, into its decision-making and planning.

Six strategies are proposed in the technical package:

1. Education on asthma self-management.
2. eXtinguishing smoking and secondhand smoke.
3. Home visits for trigger reduction and asthma self-management education.
4. Achievement of guidelines-based medical management.
5. Linkages and coordination of care across settings.
6. Environmental policies or best practices to reduce asthma triggers from indoor, outdoor, and occupational sources.

The EXHALE strategies are complementary and intended to work in combination to reinforce each other. They connect program resources, infrastructure, and activities to short-term, intermediate, and long-term goals. The different action-steps, services, events, or infrastructure of the MACP are called activities. Because activities may invoke multiple EXHALE strategies, they have been assigned to all that are applicable.

Progress towards the short-term and intermediate goals will be measured by program evaluations. As the short-term objectives are met, it is believed that intermediate changes will gradually occur. Intermediate changes will subsequently drive broader long-term changes, progressing towards the vision of a healthier Montana.

Key Priority Areas

The following priority areas were identified as essential to improving asthma control in Montana over the course of strategic planning sessions with asthma stakeholders. These priority areas are incorporated into the programs goals, objectives and strategies.

1. Enhancing Infrastructure and Promoting Care Coordination
2. Achievement of Guidelines-Based Medical Management
3. Provider and Patient Education
4. Tobacco Use Prevention and Cessation
5. Environment and Public Policy
6. Evaluation
7. Communication

Enhancing Infrastructure/Promoting Care Coordination

Goals, Objectives, Strategies

Goal 1: Increase capacity, infrastructure, and partnerships to support health care and public health linkages.

Objective 1: Increase linkages and coordination between public health and health care services and improve systems that encourage team-based care.

Strategies:

- Support the efforts of partner organizations at the state and local level to communicate and share best practices and resources.
- Provide support to partner organizations advocating for environmental policies and health care system improvements that address social determinants of health impacting people with asthma.
- Support health care quality improvement projects that place an emphasis on team-based asthma care in their facility and community.
- Educate on coverage and reimbursement for asthma self-management education and home trigger reduction services.
- Encourage and support timely sharing of patient data between primary care providers, allergists and immunologists, pulmonologists, emergency departments, urgent care centers, and hospital inpatient settings and health insurers, including mechanisms for notifying primary care providers about emergency/urgent care treatment and patient discharge instructions.

Objective 2: Support and promote the widespread use of the CONNECT bi-directional referral system among health care providers and community support organizations that address social determinants of health.

Strategies:

- Encourage contractors, sub awardees, and partners to register their organization with the CONNECT system and establish a plan for how they use the system.
- Promote CONNECT during partner meetings and program sponsored events.
- Support the expansion of CONNECT by sharing ideas for potential partners with CONNECT administrators and local coordinators.

Objective 3: Increase participation in the Montana Asthma Advisory Group (MAAG) and expand the network of asthma stakeholders providing asthma education and support resources to Montanans with asthma.

Strategies:

- Maintain regular communication between the MACP and strategic partners.
- Request input from current MAAG members, assign tasks, and set a consistent schedule for annual meetings.
- Provide networking opportunities for MAAG members on all-member calls and at in-person events sponsored by the MACP or other asthma stakeholders.
- Utilize the MACP website as a platform for asthma education and resources.
- Conduct periodic reviews of apps and other technology that can be promoted by the MACP and partners.
- Increase training for providers in underserved areas on how to identify needs and burdens for people with asthma and connect them to resources.

Enhancing Infrastructure/Promoting Care Coordination

Goal 2: Increase coverage for comprehensive asthma control services.

Objective 1: Secure reimbursement for asthma home visiting services

Strategies:

- Continue to partner with Montana Medicaid to secure reimbursement for asthma home visiting services.
- Support the work of the Hometown Medication Therapy Management (MTM) program and other programs that provide ASME to employees and their dependents as part of the employee's health insurance coverage.
- Advocate for expanded coverage of asthma self-management education by presenting the business case for asthma home visiting to private insurers.

Objective 2: Support emerging telehealth projects aimed at increasing access to asthma control services for rural Montanans.

Strategies:

- Support and evaluate the effectiveness of telehealth services and promote collaboration between allied health professionals to establish telehealth networks.
- Leverage existing technology to facilitate the use of video conferencing through asthma interventions like the asthma home visiting program and pharmacist managed ASME.

Objective 3: Work with education partners to provide school nurses, school staff, and childcare providers with educational resources and training necessary to help prevent and manage asthma.

Strategies:

- Provide specialized trainings on asthma and environmental asthma triggers to school personnel including but not limited to health professionals, school staff, administrators, teachers, coaches, maintenance, food preparation workers and bus drivers. Utilize online training platforms to increase reach.
- Encourage health care providers to complete Asthma Action Plans for all children with asthma.
- Support linkages between schools, asthma home visiting programs, and health care providers.
- Advocate for the adoption of local school district wellness policies that address asthma and protect a healthy learning environment for all.
- Work with physical education personnel, coaching staff and the Montana High School Association to incorporate standard asthma management principles in high school sports activities for students with asthma.

Objective 4: Support culturally appropriate interventions tailored to American Indians living in Montana.

Strategies:

- Promote MACP partnership opportunities to Tribal Health Departments and Indian Health Services.
- Partner with public health programs and non-profit organizations to address social determinants of health on Montana reservations.

Achievement of Guidelines-Based Medical Management

Goals, Objectives, Strategies

Goal 1: Provide access to comprehensive, culturally appropriate, patient-centered asthma care to people in Montana, resulting in optimal prevention, diagnosis, treatment, and management of asthma consistent with national guidelines.

Objective 1: Increase access to guidelines-based care.

Strategies:

- Distribute evidence based asthma support material to Montana primary care providers to facilitate utilization of evidenced based asthma care management practices.
- Support health care professionals interested in becoming certified asthma educators by hosting Certified Asthma Educator (AE-C) review courses, providing study materials, and facilitating a mentor network. Encourage public, private, and community-based health care payers to reimburse for patient education provided by AE-Cs.
- Support outreach efforts that increase availability of services to underserved populations, such as using mobile health screening and education, mobile clinics, and telemedicine.

Goal 2: Increase efforts by payers and health care organizations to improve the quality of asthma care.

Objective 1: Promote payment and reimbursement mechanisms to encourage delivery of comprehensive asthma care.

Strategies:

- Partner with insurers and the state Medicaid program to identify model payment and reimbursement mechanisms.
- Develop sustainable funding for comprehensive asthma education and care and ensure affordability, accessibility and awareness of asthma medications, diagnostic tests, equipment and standards of care.
- Support the use of spirometry in assessing asthma patients.



Big Sky Pulmonary Conference 2020

Strategies:

- Leverage partnerships with the Montana Primary Care Association and other Montana based health care professionals organizations to promote adoption of guidelines for appropriate asthma diagnosis and management.
- Support training for physician assistants, nurses, pharmacists, respiratory therapists, medical assistants, outreach staff and students on how to provide guidelines based asthma care and education.
- Facilitate asthma quality improvement projects in clinics and emergency departments while expanding the use of health information technology to improve asthma care management.
- Promote the collection of social determinants of health information in the health care setting to better address needs of asthma patients.

Provider and Patient Education

Goals, Objectives, Strategies



Goal 1: Increase the number of health care providers (HCPs) and allied health providers (e.g. pharmacists, nurses, respiratory therapists) who receive professional development training on evidenced based asthma management practices.

Objective 1: Improve access to education and resources for health care professionals needed to effectively manage their patient's asthma.

Strategies:

- Train a variety of school nurses, public health educators, respiratory therapists, and/or asthma educators to implement evidence-based programs.
- Promote programs and resources through the MACP website, social media, and through partnering organizations.
- Offer virtual training events and promote continuing education developed by state and national partners like the American Lung Association (ALA), Environmental Protection Agency (EPA), Center for Disease Control (CDC), National Environmental Education Foundation (NEEF) and others.
- Partner with local institutions of higher learning to incorporate an asthma component within their public health/community health curriculum for health care providers.

Objective 2: Improve communication and education with patients admitted to hospitals or treated in the emergency department for asthma.

Strategies:

- Provide educational resources for distribution to patients and disseminate information on key asthma management topics for providers to use when seeing patients.
- Identify, publish, and promote decision making aids, and share online toolkits targeting local coalitions and asthma advocates.

Goal 2: People with asthma and their families and caregivers will have the knowledge and resources to self-manage their disease.

Objective 1: Increase access to asthma education outside of the primary care setting for individuals with asthma and their caregivers.

Strategies:

- Promote pharmacy-led medication therapy management and ASME.
- Promote, implement, and evaluate school and community based asthma initiatives.
- Support the expansion of the Montana Asthma Home Visiting Program (MAP).
- Incorporate social determinants of health questions into MAP data collection to better connect families to support services.
- Support youth asthma camps and education events throughout the state.



Tobacco Use Prevention and Cessation Goals, Objectives, Strategies

Goal 1: Decrease tobacco use among Montanans with asthma.

Objective 1: Increase public awareness of the dangers of secondhand and thirdhand smoke and address exposure to environmental tobacco smoke through a continuum of services, policy recommendations and advocacy efforts.

Strategies:

- Support and collaborate on initiatives to implement and enforce tobacco free campuses, work sites, multi-unit housing, and public parks.
- Provide resources and linkages on national, state and regional, evidence based education and tobacco cessation services.
- Support and promote future legislation on reducing smoking and vaping.
- Support the MT Tobacco Use Prevention Program (MTUPP) to encourage policies for multi-unit smoke free housing and work with them to promote available housing and resources for people with asthma.

Objective 2: Increase referrals to cessation support services.

Strategies:

- Work with primary care providers and specialty clinics to integrate systematic referral to the MT Tobacco Quitline or the My Life My Quit cessation programs for patients that use tobacco and currently have asthma.
- Support public health messaging campaigns designed to promote the Quitline, My Life My Quit, and other cessation services available in Montana.



Objective 3: Decrease opportunities to initiate smoking.

Strategies:

- Provide evidence to support policy changes intended to reduce rates of youth tobacco use.
- Promote public awareness of the connection between the exposure to tobacco smoke and poor asthma outcomes.

Environment and Public Policy

Goals, Objectives, Strategies

Goal 1: Identify and reduce exposure to environmental hazards that contribute to asthma in settings where Montanans live, learn, work, and play.

Objective 1: Inform the public about the relationship between asthma and environmental triggers.

Strategies:

- Collaborate with environmental public health tracking and illness surveillance efforts.
- Conduct public media campaigns promoting patient education on environmental asthma triggers and home environmental assessments.
- Partner with MTUPP to reduce exposure to environmental tobacco smoke and promote utilization of the MT Tobacco Quit Line.
- Partner with MT DEQ, other state agencies, and non-profit partners to provide consistent information about how individuals with asthma can protect themselves during poor outdoor air quality events.
- Collaborate with housing, energy assistance, and other community support services to address social determinants of health which may contribute to negative asthma outcomes.

Objective 2: Encourage adoption and implementation of asthma friendly policies in learning institutions such as schools and childcare settings where health and environmental asthma triggers can be identified and mitigated.

Strategies:

- Promote and support asthma education and awareness programs for students and school staff.
- Partner with school administrators and other education leaders to promote safe environments.
- Promote school and district awareness of and compliance with, existing laws and regulations that impact asthma and recommend new laws/regulations or changes to existing ones as needed.
- Provide technical assistance and training to schools regarding environmental concerns through the DPHHS School Health Mini-Grant Program.

Objective 3: Educate decision makers and community business leaders on policies and practices to improve indoor and outdoor air quality.

Strategies:

- Promote evidence-based strategies that reduce secondhand smoke exposure.
- Provide work-related asthma resources to groups that are attempting to improve occupational air standards.
- Collaborate with existing partners to develop a shared agenda for healthy housing.



Goal 2 Support opportunities to increase health care providers’ knowledge of environmental and workplace asthma triggers, and support efforts to share this knowledge with patients in order to decrease these exposures.

Objective 1: Increase the number of health care providers who understand environmental asthma triggers and provide trigger education to their patients.

Strategies:

- Facilitate collaboration among health care providers and state and private organizations and agencies (MT Academy of Pediatrics, MT Primary Care Association, American Lung Association, etc.) to increase health care providers’ understanding of indoor and outdoor triggers.
- Promote patient education on environmental asthma triggers as part of guidelines-based care
- Encourage providers to refer patients to community organizations that can help address asthma triggers in the home and workplace.

Evaluation

Goals, Objectives, Strategies

Goal 1: Use evaluation data to define the burden of asthma, guide policy and program planning and assess the impact of the strategic plan process.

Objective 1: Conduct program evaluation according to the MACP Strategic Evaluation Plan

Strategies:

- Package results of data analysis and interpretation and disseminate in an updated burden report, fact sheets, press releases, issue briefs and other media.
- Make presentations at local, regional and national meetings and conferences.
- Produce scientific manuscripts on the effectiveness of interventions and lessons learned.
- Support evaluation of different partnership and collaboration models to determine their effectiveness in prevention, management, and treatment of asthma.
- Incorporate partner data into statewide surveillance and evaluation process.
- Analyze Medicaid and other data sets to identify potential improvements in asthma care and linkages to patient support services.



Communication

Goals, Objectives, Strategies

Goal 1: Increase public awareness and understanding of asthma as a public health issue.

Objective 1: Disseminate consistent evidence-based messaging for various audiences promoting asthma self-management, guidelines-based care, and MACP programs.

Strategies:

- Conduct public awareness campaigns using various media platforms. Leverage advertising technology to target messaging to different subsets of the population.
- Enhance emergency preparedness communication efforts to address health issues related to asthma.
- Maintain and promote the utilization of the MACP website and social media accounts.
- Highlight asthma disparities and related social determinants of health in surveillance reports and other publicly shared materials.

Goal 2: Increase awareness of guidelines based asthma care, MACP programs, and policy changes among health care providers and public health partners.

Objective 1: Stakeholders receive consistent communication from the MACP.

Strategies:

- Ensure communication of relevant changes and/or new laws and regulations to improve asthma management and environmental quality in schools.
- Promote resources through the MACP website, social media, newsletters, webinars, and through partnering organizations.
- Conduct stakeholder meetings and conferences.

Appendix- A

CDC Performance Measures



Performance Measure A: Analysis and Use of Core Data Sets

Performance Measure: Number and percentage of core measures updated, analyzed and disseminated/used during the reporting period.

Core data sets:

- Hospital Discharge
- Emergency Department Visits
- BRFSS Core
- BRFSS Child Prevalence Module
- BRFSS Random Child Selection Module
- Asthma Call-back Survey (adult)
- Asthma Call-back survey (child)
- Vital statistics/mortality



Performance Measure B: Linking Activities and Outcomes

Performance Measure: Documented activities of the recipient, and outcomes achieved, to establish and/or expand linkages between components of the EXHALE technical package at the organizational level (e.g., linkages that promote reimbursement or referrals; systems to share information across providers; mechanism to link health plans with home-based services or schools, data sharing across sectors).



Performance Measure C: Comprehensive Service Expansion in High Burden Areas

Performance Measure: Number and description of existing, new, and discontinued services supported by the recipient and their partners, by geographic area and intervention type; and alignment of services with high burden geographic areas.



Performance Measure D: Quality of Guidelines-Based Care

Performance Measure: Documented improvements in the quality of care or health outcomes (e.g., asthma control; emergency department visits; hospitalizations; asthma self-management education) as a result of Quality Improvement (QI) initiatives.



Performance Measure E: Use of Evaluation Findings

Performance measure: Actions taken or decisions made during the reporting period to improve program activities and increase program effectiveness as a result of evaluation findings.



Performance Measure F: Asthma Self-management Education Completion Rates

Performance measure: Number and demographics of people with asthma who initiated and attended at least 60% of sessions of guidelines-based asthma self-management education (ASME); and description of the setting and curriculum of ASME courses.



Performance Measure G: Improvement in Asthma Control among ASME Completers

Performance measure: The number of participants with poorly controlled asthma on enrollment (a subset of the previous measure) who report their asthma is “well-controlled” one month or more after attending at least 60% of asthma self-management education sessions.