

**Goal:** Reduce the prevalence of uncontrolled asthma in Albany and Rensselaer Counties with particular

**Strategy 1:** Increase the number of patients engaged in all components of the asthma care loop through strong care transition policies that encourage hospital visit follow-up with primary care, community medical providers, reduction of asthma triggers, and improved self-management.

Tactics:

-  1.1 Expand Lung Center care transition program to provide asthma education, support medication retention and primary care transition to all asthma patients across the St. Peter's Health Partners network. By December 2017, 100% of patients at St. Peter's Health Partners have access to Lung Center.
-  1.2 Develop a primary care provider referral initiative in Troy to encourage physicians to refer their asthma patients to local asthma education and self-management programs. By December 2017, 75% of contacted physicians referring patients.
-  1.3 Develop a care transition program in emergency departments that identifies and refers patients who could benefit from an in-home Asthma Program reducing asthma triggers at discharge. By December 2017, 100% of emergency departments have a care transition program in place.

**Strategy 2:** Increase utilization of asthma action plans to affirm knowledge of how to control asthma through the support of community medical providers.

Tactics:

-  2.1 Encourage policies in city schools to require students with asthma to submit an asthma action plan. By December 2017, 100% of schools have implemented an asthma action plan initiative.
-  2.2 Reinforce the effective use of asthma action plans by offering at least 10 community based asthma self-management classes serving 100 people per year. By December 2017, 300 people attended community based asthma self-management classes.
-  2.3 Increase support of the asthma action plan by community medical providers, such as schools, pharmacies, care coordinators, insurers, asthma educators and nurses through education, materials and workflow adjustments. By December 2017, asthma action plan materials delivered to 200 community partners.

**Strategy 3:** Increase access to and utilization of asthma controller medications.

Tactics:

-  3.1 Home care patients will be educated about affordable prescription options and receive resources and support for fulfilling their prescriptions. By December 2017, 100% of home care providers will have educational material about affordable prescription options to share.

-  3.2 School nurses in the Albany, Troy, and Lansingburgh School Districts will be trained to support asthmatic students, and will be provided with the necessary educational resources. By December 2017, 90% of school nurses in Albany, Troy and Lansingburgh will be provided educational resources on asthma.
-  3.3 Improve the asthma management and outcomes of underserved patients (Medicaid, Medicaid managed, and uninsured) age 0-40 years with “not well controlled” or “poorly controlled” asthma through a community pharmacist intervention program that assesses and counsels patients on 1) knowledge and use of controller and rescue medications, and 2) self-management skills. By December 2017, 5 community pharmacist intervention programs established.

**Strategy 4: Promote a community environment that helps prevent and manage asthma.**

Tactics:

-  4.1 Provide education, pulmonary screenings, and interventions to the community through faith community nurses and already-established community events. By December 2017, community asthma education reach over 200 people annually.
-  4.2 Reduce exposure to secondhand smoke in public and affordable housing facilities through assisting housing managers implement no-smoking policies. By December 2017, 25% of contacted housing managers implementing no-smoking policies.
-  4.3 Engage community champions in asthma education and smoking cessation. By December 2017, 10 community champions participate in asthma reduction events.
-  4.4 Provide perinatal information to prospective parents about environmental issues related to asthma and asthma triggers. By December 2017, 100% of prospective parents provided asthma information. Identify and refer appropriate expecting and new mothers to the Center for Smoking Cessation. By December 2017, 100% of appropriate expecting and new mothers referred to Center for Smoking Cessation.

**Strategy 5: Strengthen collaborative efforts around the self-management and prevention of asthma.**

Tactics:

-  5.1 Establish a task force to coordinate implementation of the CHIP and plan future strategies. By December 2017, 80% of coalition members attending quarterly meetings.
-  5.2 Gather research and data regarding asthma to be considered for future CHIP inclusion in the CHIP.