STRATEGIC PLAN

for Addressing ASTHMA

in the District of Columbia

2009 - 2013

Government of the
District of Columbia
Adrian M. Fenty, Mayor

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DOH
DEPARTMENT OF HEALTH
Promote. Prevent. Protect.

STRATEGIC PLAN FOR ADDRESSING

ASTHMA

IN THE DISTRICT OF COLUMBIA

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
Adrian M. Fenty
Mayor

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
Pierre N. D. Vigilance, MD, MPH
Director

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Office of the Director

Dear Colleague:

Asthma continues to be a major public health concern in the District of Columbia. Approximately 53,000 children and adults in the District suffer from asthma.

The District of Columbia is pleased to present the "Strategic Plan for Addressing Asthma in the District of Columbia" 2009-2013. This plan is a result of a government/community partnership. Key individual and organizations came together as a result of the "State of Asthma Meeting," small work group discussions, and the DC Asthma Partnership general meeting, to develop the goals, objectives, strategies and activities presented in this report. We appreciate their time and efforts put forth to develop this report.

The District of Columbia Department of Health, Community Health Administration, Asthma Program, **DC C**ontrol **A**sthma **N**ow **(DC CAN)**, and community partners have made progress in addressing the burden of asthma; however, more work is needed. This report builds upon the work done over the past five years and proposes strategies for the next five years to be implemented by the Department of Health and our partners.

The vision of the Department of Health is for everyone who suffers from asthma to have access to quality care; to be educated to self-manage their asthma; to live work and play in asthma friendly environments; and to have access to up-to-date data on asthma.

We encourage your organization or agency to use this plan as a blueprint to assist the Department of Health and our partners in reducing the burden of asthma in the District of Columbia.

Sincerely,

Pierre N.D. Vigilance, MD, MPH
Director

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ACKNOWLEDGEMENTS

We gratefully acknowledge the following individuals and organizations for generously contributing their time and expertise to developing and implementing the *Strategic Plan for Addressing Asthma in the District of Columbia 2009-2013* (*2009 Strategic Asthma Plan*).

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ACRONYMS	
Behavioral Risk Factor Surveillance System	BRFSS
Centers for Disease Control and Prevention	CDC
District of Columbia Department of Health Center for Policy, Planning and Epidemiology	CPPE
District of **C**olumbia **C**ontrol **A**sthma **N**ow	DC CAN
District of Columbia Department of Health Care Finance	DHCF
District of Columbia Department of Health	DOH
District of Columbia Public Schools	DCPS
Early Periodic Screening, Diagnostic, and Treatment	EPSDT
Emergency Department Visits	ED
Environmental Tobacco Smoke	ETS
Environmental Protection Agency	EPA
The George Washington University	GWU
Interagency Collaboration and Service Integration Commission	ICSIC
Managed Care Organization	MCO
National Asthma Education Prevention Program	NAEPP
National Capital Asthma Coalition	NCAC
National Heart, Lung, and Blood Institute	NHLBI
National Institutes of Health	NIH
Standard Medical Record Form	SMRF
Student Access to Treatment Act 2007	SATA 2007

Asthma is a serious public health problem for the District of Columbia (District). This common chronic inflammatory disorder of the airways affects children and adults of all ages. Asthma inflames and narrows airways and limits lung function. The symptoms of asthma include coughing, wheezing, shortness of breath and chest pain, and can range from minor to life-threatening. Without proper treatment, asthma can interfere with one's quality of life, making it difficult to sleep and to engage in daily activities at home, school, and work.

In the District, asthma affects more than one in six children under 18 years of age and nearly the same proportion of adults. According to the 2007 Behavioral Risk Factor Surveillance System (BRFSS) the District of Columbia Department of Health (DOH) estimates that at least 40,000 adults and 13,000 children in the District currently have asthma. Its impact is most pronounced in young children, racial/ethnic minorities, low-income individuals, and other underserved and vulnerable groups.

While asthma has no cure, it is treatable. Effective medications, paired with environmental modifications to reduce exposure to common triggers such as tobacco smoke, could enable most District residents with asthma to lead normal, active lives.

In 2001, after completing a community needs assessment which revealed the growing burden of asthma among District residents, DOH created the Asthma Control Program, **DC C**ontrol **A**sthma **N**ow (**DC CAN**). DOH also applied and received funding through the Centers for Disease Control Prevention (CDC) Air Pollution and Respiratory Health Branch. The CDC funding enabled the District to build an infrastructure to address asthma from a public health prospective. The Program was charged with developing a comprehensive asthma surveillance system to monitor asthma trends and a strategic plan to reduce asthma hospitalizations, emergency department visits, and mortality.

In 2002, the Asthma Program established the **DC CAN** Collaborative. The Collaborative consisted of five subcommittees: **1)** Asthma Health Education; **2**) Environmental and Occupational Health; **3**) Surveillance, Epidemiology and Data Collection; **4)** Health Services and Quality Assurance; and **5)** Policy and Planning.

In 2003, the first Burden of Asthma report was published, providing an epidemiological and statistical analysis of the burden of asthma in the District. Based on the surveillance data, the Collaborative began working on identifying strategies that would improve asthma outcomes in the District.

EXECUTIVE SUMMARY

In 2004, the first Strategic Plan, *Strategic Plan for Addressing Asthma in the District of Columbia (2004 Strategic Plan)* was published. This *2004 Strategic Plan* outlined strategies developed by government/community partners on reducing the burden of asthma. Also, in 2004, **DC CAN** was successful in receiving CDC funding to implement specific strategies outlined in the *2004 Strategic Plan*.

Over the last five years, strategies in the *2004 Strategic Plan* continued to be implemented through a diverse group of partners including: academic, government, public health, nonprofit, corporate, community, and advocacy organizations.

The *Strategic Plan for Addressing Asthma in the District of Columbia 2009-2013* (*2009 Strategic Asthma Plan*), builds upon the substantial work completed by the District's asthma partners. This *2009 - 2013 Strategic Asthma Plan* reflects their renewed commitment toward collaboration with a stronger emphasis on quality improvement in all aspects of asthma care and policy.

Table 1: 2009 Strategic Asthma Plan Goals

GOAL	HIGHLIGHTS
1. Form and Maintain Infrastructure to Unify Asthma Partners to Address Asthma-Related Issues Locally and Regionally	Maintain local partnership and expand into a regional partnership with Maryland and Virginia.
2. Improve Healthcare Quality	Implement a Quality Improvement Initiative to improve the overall quality of care for people who suffer from asthma.
3. Increase Asthma Awareness and Community Involvement in Asthma Education Programs	Expand on existing asthma educational programs for students, parents, caregivers and other District residents affected by asthma.
4. Establish Asthma-Friendly Environments	Promote environmental assessments and asthma education in childcare settings, schools, and senior citizen facilities.
5. Enhance Asthma Surveillance and Evaluation	Expand the asthma surveillance system and evaluate effectiveness of asthma related District-wide programs and interventions.

WHAT IS ASTHMA?

Asthma is a chronic (long-term) disease that inflames and narrows the airways, and makes it hard to breathe.

Asthma can occur at any age; it can emerge very quickly or develop over many years. Asthma arises from a complex interaction of hereditary and environmental factors although the fundamental causes of asthma and why it has affected a growing number of Americans are not fully understood. What is understood is that people with Asthma have very sensitive airways that react to environmental factors that may trigger asthma episodes. An asthma episode or an asthma attack is when symptoms are worse than usual. They can come on suddenly and can be mild, moderate or severe.

What happens during an asthma attack?

- The muscles around your airways tighten narrowing the airways;
- Less air is able to flow through the airways; and
- Inflammation is produced in the airways undermining the flow of air even more.

Common environmental triggers that may cause an asthma episode include:

- dust mites,
- pollens,
- molds,
- pet dander,
- cigarette smoke,
- strong odors, and
- cockroach droppings.

NATIONAL VIEW OF ASTHMA

Approximately 22.9 million Americans (6.8 million Children and 16.1 million adults) had asthma in 2006; a rate of 77.9 per 1,000 population.

The highest prevalence rate was seen in those 5-17 years of age (106.3 per 1,000 population). Overall, the rate in those under 18 (92.8 per 1,000 population) was significantly greater than those over 18 (72.9 per 1,000 population).[1]

In 2006, 10.0 million males and 12.8 million females had asthma. The prevalence rate in females (85.7 per 1,000 population) was 23 percent (23%) greater than the rate in males (69.7 per 1,000 population) overall, and 60 percent (60%) greater in female adults over 18 than male adults over 18 (89.0 per 1,000 population vs. 55.6 per 1,000 population). However, this pattern is reversed amongst children. The current asthma prevalence rate for boys under 18 (109.7 per 1,000 population) was 46 percent (46%) higher than the rate among girls (75.1 per 1,000 population).

The difference in rates between the sexes was statistically significant in both. Also, in 2006, the current asthma prevalence rate was 23.8 percent (23.8%) higher in Blacks than in Whites (94.2 per 1,000 population vs. 76.1 per 1,000 population respectively). This difference between races was significant. The highest prevalence rates for Whites and Blacks were amongst the 5-17 age group. Whites had the lowest prevalence rates in those less than 5 years old, and blacks had the lowest in those 45-64 years old.[2]

ASTHMA-RELATED TRENDS IN THE DISTRICT OF COLUMBIA

Since the late 1990s, there has been a downward trend in the District's asthma morbidity and mortality rates.

The District continues to rank among the highest in the United States (U.S.) despite the declining morbidity and mortality trends. Asthma affects District residents of all ages, racial/ethnic backgrounds, geographic locations, and socioeconomic levels.

Similar to national trends, however, the District's inner-city, low-income minority children and adults are at greater risk for emergency department (ED) visits, hospitalizations, and deaths due to asthma than the general resident population. Among children, for example, rates of ED visits for asthma are nearly 12 times greater in the District's poorest neighborhoods than among its most affluent.[3]

Across the eight wards that divide the District's 63 square miles, there are substantial differences in the residents' socioeconomic status and racial/ethnic diversity (Table 2) that influence their access to healthcare, chronic disease rates, health status, and mortality.[4]

Table 2: District of Columbia Population, Race and Socioeconomic Distribution by Ward

	a Population	a Race			b Medicaid	a Income	a Unemployed
Ward	**Census 2000**	**Hispanic Latino**	**Black**	**White**	**Number of Recipients**	**Median 1999**	**Percent**
1	73,364	46%	32%	25%	14,794	$36,902	5%
2	68,869	20%	65%	10%	19,891	$44,742	6%
3	73,718	6%	84%	7%	1,460	$71,875	7%
4	74,092	71%	18%	12%	16,116	$46,408	4%
5	72,527	87%	9%	3%	19,246	$34,433	8%
6	68,035	63%	32%	3%	16,068	$41,554	6%
7	70,540	97%	1%	1%	24,988	$30,533	7%
8	70,914	92%	5%	1%	28,724	$25,017	12%
DC	**572,059**	**60%**	**31%**	**8%**	**142,046** c	**$ 40,127**	**7%**

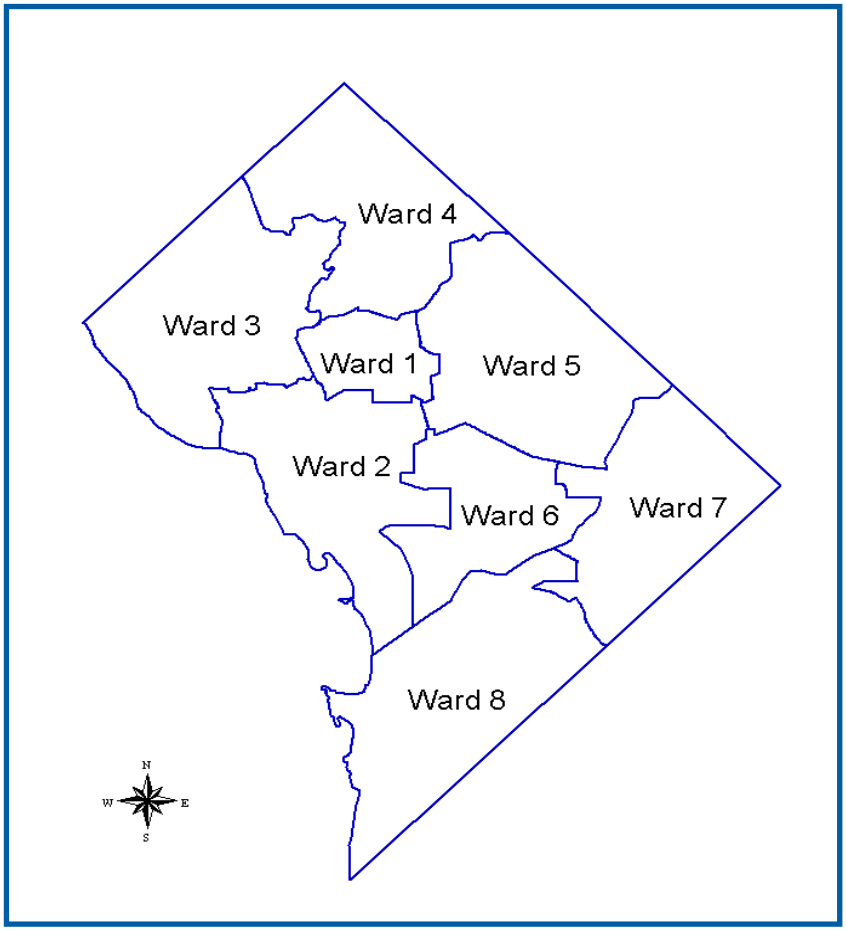
a. DC Office of Planning: Census 2000 Key Demographic Indicators;
b. DC DOH, Medical Assistance Adm.: Working Together for Health: Medicaid Annual Report FY 2007
c. Total includes those missing: ward unknown: 759 Recipients
* All numbers have been rounded-off to the nearest whole number

ASTHMA IS A MAJOR HEALTH PROBLEM IN THE DISTRICT OF COLUMBIA

Subgroups disproportionately affected by asthma in the District include non-Hispanic Black residents; young children ages 0-4 years, especially males; females after puberty (starting from the early teens); adults ages 45-50 years; seniors age 65 years and older; residents who smoke tobacco; residents who are overweight and obese; residents with less than or some high school education; and residents with household incomes less than $15,000.

Individuals living in District wards with larger numbers of residents in these subgroups tend to face a greater asthma burden. Figure 1 represents the ward delineation of the District. African American residents are concentrated in Wards 5, 7, and 8. Wards 7 and 8 also have the largest number of youths under the age of 18. Non-Hispanic White residents are concentrated in Wards 1, 2, and 3. Ward 1 is the most diverse area with a mix of Black/African American, non-Hispanic White, Hispanic/Latino, Asian/Pacific Islander, and "Other" residents.[5]

Figure 1: Map of the District of Columbia by Ward



According to the 2002 U.S. Census, 53,289 (9.4%) of the District's residents are Latino, while the DC Mayor's Office on Latino Affairs puts the figure closer to 13 percent (13%). Latinos are the fastest growing ethnic minority in the District, particularly among children. *The State of Latino in the District of Columbia* published by the DC Council of Latino Agencies (now The Latino Federation of Greater Washington [LFGW]) reports that on average, the District's Latino residents are poorer, less likely to have health insurance, and use healthcare services more than other District residents. It also notes a significantly high incidence of asthma among Latino children, and recommends that bilingual information about asthma prevention and treatment be incorporated into programs for Latino children and parents.[6] The 2000 Census reports that one of every three Latino residents in the District has difficulty speaking English.[7]

According to the U.S. Census' 2006 American Community Survey, the District's Asian population is growing rapidly; up to about 40 percent (40%) since 2000, and nearly 30 percent (30%) from 2005 to 2006 to reach almost 20,000 individuals or 3.4 percent (3.4%) of the District's residents.[8] It also found that the District's Asian Indian population surged by 75 percent (75%) to represent 27 percent (27%) of the District's total Asian population, followed by Chinese 26 percent (26%), Filipino 13 percent (13%), Vietnamese 10 percent (10%), and Korean 7 percent (7%).

- **Current**: Among the District's adults ages 18 years and older, the percentage who reported having been told by a doctor that they currently had asthma averaged 9.1 percent (9.1%) in 2003-2007, 10 percent (10%) higher than the national average of 8.4 percent (8.4%) for the same five-year period.[9] The current asthma prevalence was stable at 9.4 percent (9.4%) in 2007 (Figure 2). An estimated 40,000 District adults currently have asthma.

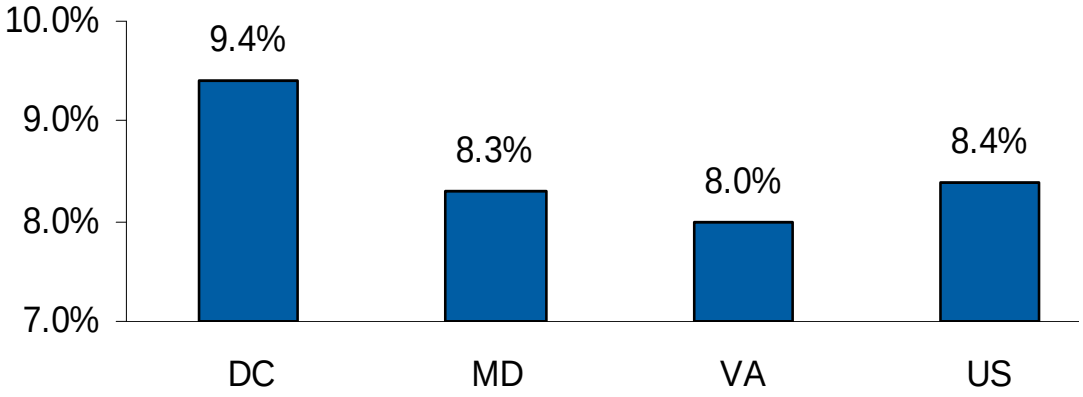
- **Lifetime:** A higher percentage of the District's adults have a history of asthma, with an average of 14.8 percent (14.8%) of District adults in 2003-2007 reporting ever being told by a doctor that they had asthma; 14 percent (14%) higher than the national average of 12.7 percent (12.7%) for the same five-year period. Lifetime asthma prevalence held at 15.2 percent (15.2%) in 2007.

What is Asthma Prevalence?

- **Current asthma prevalence** is the proportion of the population that currently has asthma and is based on self-report by the individual that she/he (or the individual's child) still has asthma.

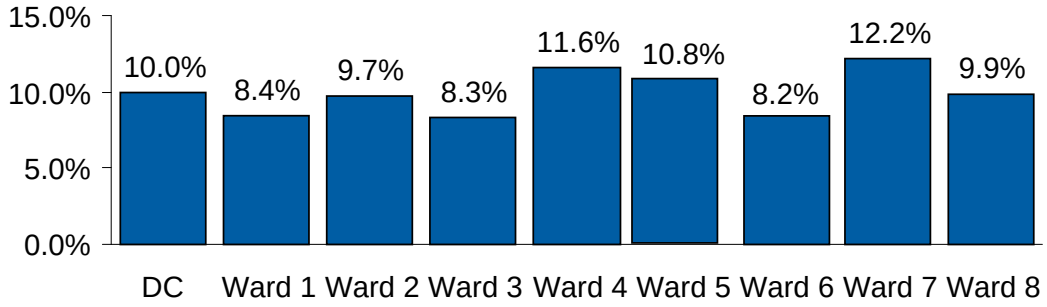
- **Lifetime asthma prevalence** is the proportion of the population that has ever been diagnosed with asthma, and is based on self report that a healthcare provider has, at any time told the individual that she/he (or the individual's child) has asthma.

Figure 2: Current Adult Asthma Prevalence
District of Columbia, Maryland, Virginia & United States, 2007



Source: Behavioral Risk Factor Surveillance System, 2007

Figure 3: Current Adult Asthma Prevalence
District of Columbia by Ward, 2004-2006



Source: RAND Health; Assessing Health and Healthcare in the District of Columbia. Prepared for the Executive Office of the Mayor, District of Columbia. January 2008
Notes: Authors' analyses of data from the Behavioral Risk Factor Surveillance Survey.

Ward: In 2004-2006, Wards 4, 5, and 7 had current asthma prevalence rates for DC adults that appeared to be as high or higher than the statewide average for the same period (Figure 3).

Building on a Solid Foundation

Through a cooperative agreement with the CDC, DOH successfully developed and implemented its first statewide plan in 2004-2008 as a call to action to reduce the District's burden of asthma, and to meet its Healthy People 2010 asthma objectives.

In 2001, DOH launched its **DC C**ontrol **A**sthma **N**ow (**DC CAN**) Program to spearhead a viable, comprehensive, community based, and consumer-centered approach to asthma care. The program recruited key stakeholders to join the **DC CAN** Collaborative, a public-private partnership of diverse health and human service organizations, hospitals, academic institutions, government agencies, respiratory health organizations, coalitions, businesses, and community based groups. Concurrently, **DC CAN** brought together data collection efforts among District government agencies, community based organizations, and consumer groups to build a more comprehensive statewide asthma surveillance system.

In 2002, the **DC CAN** Collaborative organized itself into five working subcommittees: Health Education; Environmental and Occupational Health; Surveillance, Epidemiology, and Data Collection; Health Services and Quality Improvement; and Policy and Planning, with District-wide representation. Aided by its subcommittees, the **DC CAN** Collaborative members analyzed available data and solicited widespread community input through key informant interviews, focus groups, workshops at public conferences, collaborative meetings, and an asthma forum. Six priority areas were identified, and formed the base of the *2004 Strategic Asthma Plan:*

1. Develop interventions to reduce asthma hospitalizations, deaths, and emergency department visits among high-risk populations.
2. Identify barriers in the delivery of asthma care services, particularly to the underserved and high-risk groups.
3. Increase education and awareness programs that are culturally sensitive and linguistically appropriate for all racial/ethnic groups.
4. Promote the use of the National Institutes of Health (NIH) National Heart, Lung, and Blood Institute (NHLBI), the National Asthma Education and Prevention Program's (NAEPP) guidelines for the treatment and management of asthma.
5. Educate persons with asthma and their family members/caregivers, as well as healthcare providers, and health educators.
6. Develop a comprehensive asthma surveillance and data collection system to monitor trends and to evaluate the effectiveness of program interventions in the reduction of asthma morbidity, and mortality.

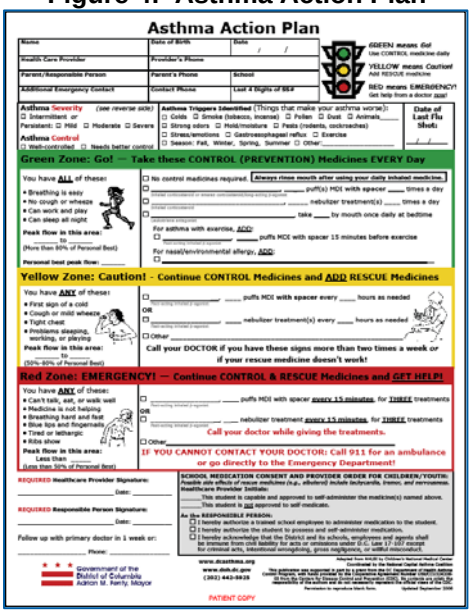
In 2004, the **DC CAN** Collaborative evolved into a Steering Committee to ensure implementation of the *2004 Strategic Asthma Plan*'s priority areas, monitor interventions outlined in the work-plan, review surveillance and program data, and offer feedback to government and community partners.

In addition to the **DC CAN** Steering Committee, local organizations, government agencies, and elected officials worked closely with **DC CAN** to implement the *2004 Strategic Asthma Plan*.

The National Capital Asthma Coalition (NCAC), a nonprofit alliance of more than 70 diverse organizations, and 300 individuals in the District, served as a key liaison with the community. NCAC coordinated joint **DC CAN**-NCAC committee meetings, spearheaded policy changes, trained practitioners, conducted community education programs reaching more than 6,000 residents annually, developed practice tools, and conducted World Asthma Day events with the District's African American and Latino communities.

The District's medical practitioners also worked together to produce tools to close the gap between evidence-based treatment guidelines, and implementation, including the District Asthma Action Plan.

Figure 4: Asthma Action Plan



Additionally, the Council of the District of Columbia, and the Executive Office of the Mayor have been instrumental in establishing legislation, and collaborative initiatives with significant potential to improve asthma outcomes.

The *Student Access to Treatment Act of 2007*, *DC Law 17-107* (SATA 2007), enacted by the District of Columbia City Council, and signed by District Mayor Adrian M. Fenty allows students diagnosed with asthma or severe allergies and who have a valid medication action plan (Figure 2), to possess and self-administer prescribed asthma medications or auto-injectable epinephrine while on school property or at school-sponsored activities.

Finally, the District has launched initiatives to boost collaboration among District government agencies and community partners on priority objectives aimed at improving the health and well being of District residents and at strengthening healthcare delivery. Cross-cutting efforts with specific asthma objectives include the *District of Columbia's State Health Plan* and *DC Healthy People 2010 Biennial Implementation Plan: 2006-2007* led by DOH, and the *Child Health Action Plan* coordinated by the Interagency Collaboration and Service

Integration Commission (ICSIC). Together, these activities have strengthened the District's capacity to address the burden of asthma.

Table 3 highlights selected achievements of **DC CAN** and its partners over the past five years.

Table 3: Highlights of Progress and Achievements to reduce the Burden of Asthma in the District of Columbia: 2003-2008
(Chart adapted from Utah Asthma Plan 2007-2012)

Schools And Child Care	Health Systems / Professionals	Communities	Environment	Other
Provided educational programs to more than 5,000 students in District public and chartered schools.	Developed a standardized District Asthma Action Plan which promotes the use of NIH guidelines for the treatment and management of asthma.	Established the DC CAN Steering Committee.	Held conferences on Children's Health and the Environment.	Established the first asthma surveillance system.
Developed "Managing Asthma and Allergies in DC Schools."	Trained 255 professionals in PACE.	Conducted needs assessments, conferences, and small work groups to develop and revise *2004 Strategic Asthma Plan.*	Conducted environmental home assessments for asthma in public housing, daycare sites, and housing for seniors.	Published first Burden of Asthma in the District of Columbia report.
Passed SATA 2007, enabling students to self-administer medication.	Surveyed 220 local physicians to improve estimates of under-reported work-related asthma in the District.	Held first "State of Asthma Conference" 2006.	Published report on the impact of air quality on asthma in the District.	Collected Emergency Department data on children and adults.
Provided educational seminars to school nurses/ administrators.	Developed Asthma Section for inclusion in the Mayor's Child Health Action Plan that is monitored by ICSIC.	Produced and distributed three asthma educational videos for children, seniors and Latinos.	Implemented EPA Tools for Schools in 10 DCPS.	Completed formal assessment of effectiveness of partnership activities.

Planning for the Next Five Years

Purpose

The overall purpose of the *Strategic Plan for Addressing Asthma in the District of Columbia: 2009-2013* (*2009 - 2013 Strategic Asthma Plan*) is to reduce the physical, economic and emotional burden of asthma in the District. To achieve real gains in asthma morbidity, mortality, and quality of life within the next five years, we must further dedicate ourselves to raising awareness; eliminating asthma disparities among racial/ethnic minorities, and other underserved, and vulnerable populations; aligning clinical practice and asthma self-management with treatment guidelines; and monitoring, evaluating, and reporting surveillance data and outcomes.

This plan sustains and builds upon the successes of the past five years. It combines lessons learned, existing partnerships, and new perspectives to lay out a strategic direction for public officials; healthcare, education, and environmental professionals; community leaders; and consumers to mount an effective response to the District's asthma epidemic.

Renewed Commitment to Collaboration

The District's success to date stems from collaborations among academic, government, health, nonprofit, business, community, and advocacy organizations. Using available data, and their knowledge of the District, the asthma partners revised the *2004 Strategic Asthma Plan's* goals and objectives, and reconfirmed their mutual commitment to reducing the burden of asthma in the District.

Process for Revising the 2004 Asthma Strategic Plan

2006 State of Asthma in the District Conference

On September 13, 2006, more than 50 asthma experts, researchers, medical practitioners, health educators, environmental specialists, health plan representatives, consumer health advocates, state and federal employees, and other interested parties participated in the full-day *State of Asthma in the District of Columbia Conference* organized by The George Washington University , Center for Risk Science in Public Health and Mid-Atlantic Center for Children's Health and the Environment (MACCHE), Department of Environmental and Occupational Health , School of Public Health and Health Services and the DOH DC CAN. The goal was to gather community input for review and consideration prior to revising the *2004 Strategic Asthma Plan*.

To lay the foundation for the afternoon breakout sessions, the morning plenary session featured presentations that summarized the national guidelines for diagnosing, and managing asthma; reported progress on implementing the *2004 Strategic Asthma Plan*; described asthma surveillance data from DOH and Improving Pediatric Care in the District of Columbia (IMPACT DC); and characterized the American Lung Association of the District of Columbia (ALADC) efforts to promote improved air quality. In addition, the Environmental Protection Agency (EPA) shared information about replicable, best practice programs in environmental asthma management and available EPA resources.

Participants then split into smaller groups for facilitated discussions focused on four main topics: (1) pediatric asthma, (2) health education and community initiatives, (3) environmental and occupational health, and (4) health services and quality assurance. The objectives for each of the small group sessions were to:

1. Discuss the *2004 Strategic Asthma Plan* objectives pertaining to each one of the small group's topic.
2. Make recommendations for updating the plan's current objectives and activities.
3. Propose at least three new objectives or activities for the revised *2004 Strategic Asthma Plan* that could be accomplished within the next five years.

Attendees rated the overall conference as very good or excellent in meeting the conference objectives.

Workgroup Discussions

To engage a broader set of decision makers and stakeholders in the strategic planning process, **DC CAN** initiated a series of small group discussion sessions in 2007. **DC CAN** convened small groups lead by a contracted facilitator around the same four topic areas presented at the 2006 *State of Asthma in the District of Columbia Conference* plus two additional groups with clinicians and with consumers, including adults with asthma and caregivers of children with asthma.

DC CAN Steering Committee

The members of the **DC CAN** Steering Committee reviewed the surveillance data and stakeholder input, and offered their additional insights and suggestions.

DC Asthma Partnership

In 2009, the DC Asthma Partnership convened numerous partners with varied backgrounds to review the draft work-plan and prioritized interventions and activities to be implemented over the next five years.

New Five-Year Strategic Plan for Addressing Asthma in the District of Columbia

The following pages describe the goals, objectives, strategies, action steps and potential partners to assist in the implementation of the proposed activities over the next five years.

The plan is organized to meet the five goals listed below:

GOAL 1: Form and Maintain Infrastructure to Unify Asthma Partners to Address Asthma-Related Issues Locally and Regionally

GOAL 2: Improve Healthcare Access and Quality

GOAL 3: Increase Asthma Awareness and Community Involvement in Asthma Education Programs

GOAL 4: Establish Asthma-Friendly Environments

GOAL 5: Enhance Asthma Surveillance and Evaluation

The work-plan included in Appendix I provides a graphic depiction of the plan, as well as performance indicators and a list of potential collaborating partners.

Abbreviations for organizational names are included in Appendix II: Asthma Partners/ Stakeholders.

GOAL 1: FORM AND MAINTAIN INFRASTRUCTURE TO UNIFY ASTHMA PARTNERS TO ADDRESS ASTHMA-RELATED ISSUES LOCALLY AND REGIONALLY

STATEMENT OF NEED

Achieving the *District of Columbia Healthy People 2010 Plan* goal to reduce asthma morbidity and mortality rates far below their baseline measures, and to improve the quality of health of District residents requires a coordinated and integrated infrastructure that brings together local and regional resources, partnerships, interventions, and asthma surveillance to accomplish the agreed-upon goals and objectives in the *Strategic Plan for Addressing Asthma in the District of Columbia 2009-2013.*

Objective: By 2013, maintain and expand viable partnerships with a minimum of 25 local partners and 25 regional partners (50 total partners) that are actively engaged in improving asthma outcomes.

Strategy 1: Maintain and expand the existing (local) DC Asthma Partnership to include at least 25 partners with varied expertise to implement the *2009 Strategic Asthma Plan.*

ACTION STEPS

1.1.1. Maintain the DC Asthma Partnership (local) with partners who have varied expertise and represent: government, private-industry, and community-based organizations to implement the *2009 - 2013 Strategic Asthma Plan*.

1.1.2. Keep partners informed and engaged on critical asthma issues and projects by creating and maintaining a centralized communications system.

1.1.3. Build strong referral linkages between partners with similar outreach/ education interests, to avoid duplication of efforts, as well as consensus on advocacy and changes.

1.1.4. Develop and distribute a monthly e-newsletter.

1.1.5. Hold regularly scheduled, full partnership meetings and workgroup meetings to keep partners informed, aligned, and engaged on critical asthma issues and projects, and ensure implementation of work-plan goals, objectives, and activities.

Strategy 2: Create and maintain a Regional Asthma Partnership that includes state and local health departments and coalitions from neighboring jurisdictions including the District of Columbia, Maryland, and Virginia.

ACTION STEPS

1.2.1. Collaborate with state and local health departments and asthma coalitions in Maryland and Virginia to form an Asthma Regional Partnership.

1.2.2. Collaborate with regional partners on hosting annual meetings to develop strategic approaches to address regional issues.

1.2.3. Form regional workgroups around key issues.

GOAL 2: IMPROVE HEALTHCARE ACCESS AND QUALITY

STATEMENT OF NEED

A comprehensive assessment of the District's health and healthcare delivery system produced in 2008 by RAND Health under contract with the District of Columbia, found substantial gaps between the health needs of individuals and their use of health services.[10] For example, overall rates of primary care use among District residents enrolled in public insurance programs are low, as are rates of specialty use among those individuals with chronic conditions, including asthma. Furthermore, the report found relatively high rates of hospitalization and emergency department (ED) visits among these enrollees.

The District's quality improvement efforts must move the delivery of healthcare services away from acute episodic care for poorly controlled and uncontrolled asthma, which results in otherwise avoidable ED visits, hospitalizations, missed school days, and loss-of-work productivity, and more towards an effective primary care asthma management system. As the RAND Health authors note, "asthma is a condition that can usually be treated by timely access to high quality outpatient care, thus preventing the need for hospitalization."

Objective: By 2013, reduce asthma hospitalizations and emergency department (ED) visits rates by at least 10 percent of the baselines (Baseline: asthma hospitalization rate 171 per 10,000, 2006, and asthma ED visit rate 2.17 per 10,000, 2007).

Strategy 1: Improve the consistency and quality of healthcare delivered to individuals with asthma in the District of Columbia.

ACTION STEPS

2.1.1. Implement a Quality Improvement (QI) and comprehensive chronic disease management approach to asthma within the healthcare delivery and payer systems.

2.1.2. Plan, develop, test, and promote, as part of the QI, the use of a standard asthma medical record form (SMRF) within the District's healthcare delivery and payer systems.

2.1.3. Promote the utilization of the District of Columbia Standard Asthma Action Plan form to improve adherence to NAEPP guidelines for diagnosing and managing asthma.

2.1.4. Identify a mechanism to measure utilization of the asthma action plan.

Strategy 2: Improve quality healthcare by improving asthma knowledge and competency among healthcare practitioners, allied health professionals and community health workers.

ACTION STEPS

2.2.1. Develop a Best Practice Learning educational series to educate clinicians on the best practices for the care and treatment of asthma, which will include but not be limited to NAEPP/NIH guidelines, asthma action plans, and District's Student Access to Treatment Act of 2007, DC Law 17-107 (SATA).

2.2.2. Explore pay for performance (P4P) strategies to compensate providers that routinely implement best practice principles.

GOAL 3: INCREASE ASTHMA AWARENESS AND COMMUNITY INVOLVEMENT IN ASTHMA EDUCATION PROGRAMS

STATEMENT OF NEED

Improving individual and community awareness and knowledge about asthma are critical for raising expectations that asthma can be controlled and in establishing policies, services, and behaviors that positively impact asthma outcomes and quality of life. District residents must acquire the tools, confidence, and support needed to achieve and maintain good asthma control, including: being free of symptoms, being able to sleep at night, being able to participate in normal physical activities such as attending school or work, using medications appropriately to prevent or stop asthma attacks, and having fewer or no trips to the hospital for urgent asthma care. Effective communication and coordination among practitioners, individuals, families, and the District's ethnically, racially, religious and culturally diverse populations are essential for achieving these targets.

Objective: By 2013, increase by 50 percent of the 2009 baseline the number of people participating in asthma self-management programs (baseline to be determined).

Strategy 1: To develop an infrastructure to document the number of people participating in asthma self-management programs.

ACTION STEPS

3.1.1. Assess current reporting requirements for asthma self-management classes or programs.

3.1.2. Develop partnership with organizations that currently offer asthma self-management programs to develop a reporting system to document the number of people participating in asthma self-management programs.

3.1.3. Develop a reporting system with policies and procedures to report on the number of people participating in asthma self-management classes.

Strategy 2: Provide culturally and linguistically appropriate asthma self-management education programs District-wide.

ACTION STEPS

3.2.1. Promote the implementation of evidence-based, culturally and linguistically appropriate asthma self- management education programs for people who suffer from asthma and their caregivers.

3.2.2. Implement school-based asthma education programs with a focus on schools in geographic locations that have the highest prevalence of asthma.

3.2.3. Target culturally competent asthma education programs to ethnically diverse groups.

Strategy 3: Increase awareness of the burden of asthma and provide resources and information on how to effectively manage the disease.

ACTION STEPS

3.3.1. Develop a social marketing program to raise the awareness of asthma and to promote available resources in the community.

3.3.2. Conduct needs assessment to learn attitudes and behavior regarding asthma, and asthma management in order to develop cultural appropriate and effective health messages that promote improved asthma management.

3.3.3. Implement a District-wide asthma-social marketing campaign including education materials developed specifically for the ethnically diverse groups that live in the District.

GOAL 4: ESTABLISH ASTHMA-FRIENDLY ENVIRONMENTS

STATEMENT OF NEED

The National Institute of Environmental Health Sciences declares indoor allergens produced by house dust mites, cockroaches, dogs, cats, rodents, molds, and fungi are among the most important environmental triggers for asthma. These allergens are also found in schools, childcare facilities, senior centers, and other indoor sites. Tobacco smoke is a major airway irritant for people who smoke, or who are exposed to environmental tobacco smoke (ETS).

The National Institutes of Health, NAEEP Expert Panel recommends that all patients who have asthma and women who are pregnant be advised not to smoke and not to be exposed to ETS. It is now well established that exposure to ETS increases the severity of asthma, increases the risk of asthma-related ED visits and hospitalizations, and decreases the quality of life in both children and adults.[11]

Objective: By 2013, increase the number of documented asthma-friendly schools, childcare sites, homes and workplaces by 25 percent over the 2008 baseline (baseline to be determined).

Strategy 1: Promote participation in **school-based** indoor/outdoor environmental health programs.

ACTION STEPS FOR SCHOOL SETTINGS

4.1.1. Implement EPA's *Indoor Air Quality Tools for Schools Program* to reduce exposure to environmental factors that impact asthma among children and adults in the District's schools.

4.1.2. Implement policies to minimize exposure of students and school staff to particulates and fumes from idling school buses.

4.1.3. Increase education, awareness, and action to promote safe and healthy outdoor school and community environments.

Strategy 2: Promote participation in "asthma-friendly" environmental health programs in **childcare settings**.

ACTION STEPS FOR CHILDCARE SETTINGS

4.2.1. Conduct environmental assessments to assist childcare settings in addressing environmental quality issues.

4.2.2. Develop and promote standard guidelines and policies for asthma management in childcare facilities by partnering with federal and local government, community-based environmental health organizations, and community stakeholders.

4.2.3. Identify financial assistance to support the child care provider education and training, environmental assessment and remediation for childcare sites.

4.2.4. Provide training to child care providers on environmental health and safety with emphasis on environmental contributions to asthma.

Strategy 3: Promote participation in "**healthy home**" programs.

ACTION STEPS FOR HEALTHY HOMES

4.3.1. Develop and promote guidelines for asthma-friendly housing through partnerships with federal and local government, community based environmental health organizations, and community stakeholders.

4.3.2. Develop and disseminate resource guides and other tools promoting, "healthy homes" and asthma-friendly environments**.**

4.3.3. Build strong referral linkages between partners with similar outreach/education interest to avoid duplication of efforts

4.3.4. Educate District residents on the importance of smoke free environments to improve asthma management and prevention.

4.3.5. Develop policies to promote the "healthy home" concept among the seniors, especially those affected by asthma.

Strategy 4: Promote policies to improve **workplace** environments and the reporting on occupational asthma.

ACTION STEPS FOR WORKPLACE

4.4.1. Develop recommendations on policies and guide-lines to promote the safe use of chemicals and other agents to minimize asthma episodes in workplace settings.

4.4.2. Develop educational material targeted to small business owners to raise awareness of occupational asthma.

4.4.3. Explore options to improve current reporting on the incidence of occupational asthma in the District.

GOAL 5: ENHANCE ASTHMA SURVEILLANCE AND EVALUATION

STATEMENT OF NEED

Program planning and evaluation require disease surveillance data. For example, policy makers need to know the burden of a disease in order to enable them to make sound decisions about providing resources to address the disease[12]. The District's DOH has established a viable asthma surveillance system that enables the ongoing systematic collection, analysis and interpretation of data on a defined set of asthma morbidity and mortality measures. Additional data is needed to monitor the impact of asthma on the quality of life for District residents with asthma, and to assess the quality of public health interventions and asthma care provided across healthcare delivery systems, schools, and programs.

Objective: By 2013, expand the capacity of the District to conduct comprehensive asthma surveillance and program evaluation.

Strategy 1: Establish mechanisms for the timely dissemination of data in easily accessible formats to local, state and federal stakeholders.

ACTION STEPS

5.1.1. Collect data from established sources by maintaining data exchange relationships with existing partners including the DOH, CPPE (BRFSS, hospital discharge, and mortality data) and IMPACT DC (emergency department data).

5.1.2. Create fact sheets summarizing asthma-related data in specific populations (e.g., children, seniors, and ethnic/racial minorities); and in related areas (e.g., avoidable asthma hospitalizations; asthma in childcare settings, schools, and workplaces; asthma and tobacco).

5.1.3. Produce, publish, and disseminate a comprehensive data report every three years that describes the burden of asthma on District residents.

5.1.4. Develop an interactive database to access asthma data from varied datasets.

5.1.5. Collect DC Healthcare Alliance and Medicaid asthma-related data on a regular basis.

5.1.6. Collect school-based asthma-related data from electronic school health records.

5.1.7. Assess the feasibility of including asthma indicators in existing and future electronic medical records systems in the local healthcare community.

Strategy 2: Build the capacity of local programs that implement asthma control initiatives to effectively utilize evidence-based evaluation strategies to measure program and policy impact on reducing the burden of asthma.

ACTION STEPS

5.2.1. Evaluate the efficacy of major program components of the *2009- 2013 Strategic Asthma Plan* in the areas of surveillance, collaboration and intervention.

5.2.2. Use data systems to monitor and give feedback to government officials and community partners on progress toward indicator reports (i.e., DC's Healthy People 2010 Plan objectives, Child Health Action Plan).

5.2.3. Describe the use of evidence-based, standardized evaluation practices to measure the efficacy of asthma related public health interventions.

5.2.4. Conduct a series of seminars and/or workshops on evaluation best practices for community-based programs that implement asthma control initiatives.

APPENDIX I: DC ASTHMA WORK PLAN DELIVERABLES FOR 2009-2013

GOAL 1: **Form and maintain infrastructure to unify asthma partners to address asthma-related issues locally and regionally**

OBJECTIVE: By 2013, maintain and expand viable partnerships with a minimum of 25 local partners and 25 regional partners (50 total partners) that are actively engaged in improving asthma outcomes.

STRATEGY 1: Maintain and expand the existing (local) DC Asthma Partnership to include at least 25 partners with varied expertise to implement the *2009 Strategic Asthma Plan*.

Action Steps	Indicators	Potential Collaborators
1.1.1. Maintain the DC Asthma Partnership (local) with partners who have varied expertise and represent government, private industry, and community-based organizations to implement the *2009 Strategic Asthma Plan*.	Number of partners committed to implementing the *2009 Strategic Asthma Plan*	Individuals and organizations working on asthma issues
1.1.2. Keep partners informed and engaged on critical asthma issues, and projects by creating and maintaining a centralized communications system.	Asthma listserve and websites available and utilized by partners	DC Asthma Partnership
1.1.3. Build strong referral linkages between partners with similar outreach/educational interests (to avoid duplication of efforts) as well as build consensus on advocacy and changes.	Centralized repository of information created to which each partner can look for information about what others are doing	DC Asthma Partnership
1.1.4. Develop and distribute a monthly e-newsletter.	Minimum of 12 newsletters created and distributed annually	DC Asthma Partnership
1.1.5. Hold regularly scheduled, full partnership meetings and workgroup meetings to keep partners informed, aligned, and engaged on critical asthma issues and projects and ensure implementation of work-plan goals, objectives, and activities.	▪ One full meeting of the DC Asthma Partnership (DCAP) held per year ▪ Four DCAP workgroup meetings held per year ▪ Lessons learned documented in execution of workplan activities ▪ Partners engaged in determining appropriate next steps	DC Asthma Partnership

APPENDIX I: DC ASTHMA WORK PLAN DELIVERABLES FOR 2009-2013

GOAL 1: **Form and maintain local and regional infrastructures to unify asthma partners to address asthma issues locally and regionally**

OBJECTIVE: By 2013, maintain and expand viable partnerships with a minimum of 25 local partners and 25 regional partners (50 total partners) that are actively engaged in improving asthma outcomes.

STRATEGY 2: Create and maintain a Regional Asthma Partnership that includes state and local health departments and coalitions from neighboring jurisdictions including the District of Columbia, Maryland and Virginia.

Action Steps	Indicators	Potential Collaborators
1.2.1. Collaborate with state and local health departments and asthma coalitions in Maryland and Virginia to form an Asthma Regional Partnership.	Regional partnership formed with at least 25 partners	DC DOH, DC Asthma Partnership, Maryland DHMH, Virginia DH, State and Local Asthma Coalitions
1.2.2. Collaborate with regional partners on hosting annual meetings to develop strategic approaches to address regional issues.	▪ General meeting planned and convened ▪ Number of participants attending meetings documented	DC DOH, DC Asthma Partnership, MD DHMH, Virginia DH, State and Local Asthma Coalitions
1.2.3. Form regional workgroups around key issues.	▪ Number of workgroup meetings held Four DCAP workgroup meetings held per year ▪ Number of participants attending meetings documented	DC DOH, DC Asthma Partnership, MD DHMH, Delaware DHSS, Virginia DH, State and Local Asthma Coalitions

GOAL 2: **Improve Healthcare Access and Quality**

OBJECTIVE: By 2013, reduce asthma hospitalizations and emergency department (ED) visit rates by at least 10 percent of the baselines (Baseline: asthma hospitalization rate 171 per 10,000, 2006 and asthma ED visit rate 2.17 per 10,000, 2007).

STRATEGY 1: Improve the consistency and quality of healthcare delivered to Individuals with asthma in the District of Columbia.

Action Steps	Indicators	Potential Collaborators
2.1.1. Implement a Quality Improvement (QI) and comprehensive chronic disease management approach to asthma within the healthcare delivery and payer systems.	Quality Improvement Plan developed	CNMC, DC AAP, DC CAN, DC PICHQ, DHCF, MCOs
2.1.2. Plan, develop, test, and promote, as part of the QI, the use of a standard asthma medical record form (SMRF) with the District's healthcare delivery and payer systems.	SMRF for asthma piloted, evaluated and incorporated into physician practices	CNMC Asthma Team, Mary's Center, MCOs, Unity Healthcare, Inc., DCPCA
2.1.3. Promote the utilization of the DC Standard Asthma Action Plan form to improve adherence to NAEPP guidelines for diagnosing and managing asthma.	▪ Asthma action plan routinely used by providers ▪ Asthma action plan made available electronically on DOH website and DC Asthma Partnership website	DC CAN, DC Asthma Partnership, Local Medical Facilities and Healthcare Providers
2.1.4 Identify a mechanism to measure utilization of asthma action plan.	▪ Partnership of healthcare organizations formed to develop reporting system on the utilization of the asthma action plan ▪ School nurses reporting on asthma through the electronic school health record system documented	DC CAN, MCO, Public Health Clinics

GOAL 2: **Improve Healthcare Access and Quality**

OBJECTIVE: By 2013, reduce asthma hospitalizations and emergency department (ED) visits rates by at least 10 percent of the baselines (hospitalization baseline year 2006 and ED baseline year 2007).

STRATEGY 2: Improve quality healthcare by improving asthma knowledge and competency among healthcare practitioners, allied health professionals and community health workers.

Action Steps	Indicators	Potential Collaborators
2.2.1. Develop a Best Practice Learning educational series to educate clinicians on the best practices for the care and treatment of asthma, which will include but not be limited to NAEPP/NIH guidelines, asthma action plans, and the District's SATA.	Number of health professionals participating in educational series documented	CNMC, MCOs, Public Health Clinics
2.2.2. Explore pay for (P4P) performance strategies to compensate providers that routinely implement best practice principles.	P4P strategies implemented	DOH, Local providers, Public Health Clinics

GOAL 3: **Increase Asthma Awareness and Community Involvement in Asthma Educational Programs**

OBJECTIVE: By 2013, increase by 50 percent of the 2009 baseline, the number of people participating in asthma self-management programs (baseline to be determined).

STRATEGY 1: To develop an infrastructure to document the number of people participating in asthma self-management programs.

Action Steps	Indicators	Potential Collaborators
3.1.1. Assess current reporting requirements for asthma self-management classes or programs.	Needs assessment of asthma self-management classes or programs conducted	DOH, DHCF, MCOs
3.1.2. Develop partnership with organizations that currently offer asthma self-management programs to develop a reporting system to document the number of people participating in asthma self-management programs.	Asthma self-management reporting system partnership meetings held	DOH, DC CAN, DHCF, MCOs, Local Public Health Clinics and Providers
3.1.3. Develop a reporting system with policies and procedures to report on the number of people participating in asthma self-management classes.	▪ Asthma self-management reporting system established ▪ Asthma self-management reporting system data is routinely collected	DOH, DC CAN, DHCF, MCOs, Local Public Health Clinics and Providers

APPENDIX I: DC ASTHMA WORK PLAN DELIVERABLES FOR 2009-2013

GOAL 3: **Increase Asthma Awareness and Community Involvement in Asthma Educational Programs**

OBJECTIVE: By 2013, increase by 50 percent of the 2009 baseline, the number of people participating in asthma self-management programs (baseline to be determined).

STRATEGY 2: Provide culturally and linguistically appropriate asthma self-management education programs District-wide.

Action Steps	Indicators	Potential Collaborators
3.2.1. Promote the implementation of evidence-based, culturally and linguistically appropriate asthma self-management education programs for people who suffer from asthma and their caregivers.	Number of people participating in asthma self-management programs documented.	DC Asthma Partnership
3.2.2. Implement school-based asthma educational programs with a focus on schools in geographic locations that have the highest prevalence of asthma.	Number of students participating in asthma educational programs documented	B.E.A.T. for Health, ALA-DC, IMPACT DC, DCPS, DC CAN
3.2.3 Target culturally competent asthma education programs to ethnically diverse groups.	Asthma education programs targeted to specific ethnic populations conducted	DC Asthma Partnership, DC CAN, Mayor's Office on Latino Affairs, Mayor's Office on Asian and Pacific Islander Affairs

GOAL 3: **Increase Asthma Awareness and Community Involvement in Asthma Educational Programs**

OBJECTIVE: By 2013, increase by 50 percent of the 2009 baseline the number of people participating in asthma self-management programs (baseline to be determined).

STRATEGY 3: Increase awareness of the burden of asthma and provide resources and information on how to effectively manage the disease.

Action Steps	Indicators	Potential Collaborators
3.3.1. Develop a social marketing program to raise the awareness of asthma and to promote available resources in the community.	Social marketing campaign targeted to specific age, race and ethnicity developed	DC Asthma Partnership
3.3.2. Conduct needs assessment to learn attitudes and behaviors regarding asthma and asthma management in order to develop culturally appropriate and effective health messages that promote improved asthma management.	Focus groups conducted	DC Asthma Partnership
3.3.3 Implement a District-wide asthma social marketing campaign including education materials developed specifically for the ethnically diverse groups that live in the District.	Public outreach campaign launched including materials, events, and presentations with phone numbers and web links to asthma services and related resources	DC Asthma Partnership

APPENDIX I: DC ASTHMA WORK PLAN DELIVERABLES FOR 2009-2013

GOAL 4: **Establish Asthma-Friendly Environments**

OBJECTIVE: By 2013, increase the number of documented asthma-friendly schools, childcare sites, homes and workplaces by 25 percent over the 2008 baseline (baseline to be determined).

STRATEGY 1: Promote participation in **school-based** indoor/outdoor environmental health programs.

Action Steps	Indicators	Potential Collaborators
4.1.1. Implement EPA's *Indoor Air Quality Tools for Schools Program* to reduce exposure to environmental factors that impact asthma among children and adults in the District's schools.	▪ Number of District schools that participate in EPA's *Indoor Air Quality Tools for Schools Program* each year documented ▪ Number of *IAQ/TfS* environmental assessments completed	DDOE, DCPS, EPA, EPA Region 3
4.1.2. Implement policies to minimize exposure of students and school staff to particulates and fumes from idling school buses.	▪ EPA *Clean School Bus USA Idling Policy* adopted by District school administrators ▪ Retrofit of 22 DCPS buses with Catalyzed Continuously Regenerating Technology to eliminate 85%-95% of particulate matter exposure completed	DC CAN, DC Schools, DCPS, OSSE, EPA, EPA Region 3
4.1.3. Implement programs to increase awareness and action to promote safe and healthy outdoor school and community environments.	*Clean Air Partners' On the Air: Exploring Air Pollution Source and Solutions* completed by District schools, camps, and youth groups	MWCOG-Clean Air Partners, DCPS, DC Schools, Community partners

GOAL 4: **Establish Asthma-Friendly Environments**

OBJECTIVE: By 2013, increase the number of documented asthma-friendly schools, childcare sites, homes and workplaces by 25 percent over the 2008 baseline (baseline to be determined).

STRATEGY 2: Promote participation in indoor/outdoor environmental health programs in **childcare settings.**

Action Steps	Indicators	Potential Collaborators
4.2.1. Conduct environmental assessments to assist childcare settings in addressing environmental quality issues.	Environmental assessments conducted for at least 20 childcare sites per year (100 sites)	CEHN- HCCEP Task Force, DOH, GWU-MACCHE, DHS – CCSD, OSSE, DCRA, Child Care Providers/Directors UPO
4.2.2. Develop and promote standard guidelines and policies for asthma management in childcare facilities by partnering with federal and local government, community-based environmental health organizations, and community stakeholders.	New policies and guidelines developed that are preventive and protective of children's health in childcare settings.	UUDistrict Agencies: DCRA, DCHA, DDOE, DOH-CHA, DC CAN, Mayor's Office of the Clean City Organizations: AFHH, CEHN, DC Environmental Health Collaborative, GWU-MACCHE, NCHH, NNCC-LeadSafe DC, UDC-CES, -RTP
4.2.3. Identify financial assistance to support the child care provider education and training, environmental assessment and remediation for childcare sites.	Funding identified	DOH, CEHN, EPA, HUD, CDC
4.2.4. Provide training to child care providers on environmental health and safety with emphasis on environmental contributors to asthma.	100 child care providers trained in environmental contributors to asthma	CEHN- HCCEP Task Force, DOH, GWU-MACCHE, DHS-ECEA , DCRA UPO

GOAL 4: **Establish Asthma-Friendly Environments**

OBJECTIVE: By 2013, increase the number of documented asthma-friendly schools, childcare sites, homes and workplaces by 25 percent over the 2008 baseline (baseline to be determined).

STRATEGY 3: Promote participation in "**healthy home**" programs

Action Steps	Indicators	Potential Collaborators
4.3.1. Develop and promote guidelines for asthma-friendly housing through partnerships with federal and local government, community based environmental health organizations, and community stakeholders.	▪ Form Working Group to develop guidelines ▪ Issue guidelines ▪ Distribution plan formulated	DC Agencies: DCRA, DCHA, DDOE, DOH-CHA, DC CAN, Mayor's Office of the Clean City Federal: CDC, EPA Region 3, DOE, HUD Organizations: AFHH, CEHN, DC Environmental Health Collaborative, GWU-MACCHE, NCHH, NNCC-LeadSafe DC, UDC-CES, -RTP.
4.3.2. Develop and disseminate resource guides and other tools promoting, "healthy homes" and asthma-friendly environments.	Number of materials distributed	DC Agencies: DC CAN, DCHA, DCRA, DDOE, DHCD, DOH-TCP National and community: CEHN, GWU-MACCHE, NCHH, NNCC-Lead Safe DC, UDC-CES, UDC-RTP, The HSC Fdn.
4.3.3. Build strong referral linkages between partners with similar outreach/education interest to avoid duplication of efforts	Establish "healthy homes" workgroup	DOH, DDOE, CEHN, EPA, CESC, GWU
4.3.4. Educate District residents on the importance of smoke-free environments to improve asthma management and prevention.	▪ The DC Quitline® (1-800-QUIT NOW)report increase in number of calls ▪ Increase number of smoking cessation programs available District-wide	DC Tobacco Free Families (ACS, ALADC, DOH-TCP) DOH-TCP, ALADC, Mary's Center
4.3.5. Develop policies to promote the "healthy home" concept among the seniors, especially those affected by asthma.	Healthy homes concept integrated into Office on Aging education programs	DC Office on Aging

GOAL 4: Establish Asthma-Friendly Environments

OBJECTIVE: By 2013, increase the number of documented asthma-friendly schools, childcare sites, homes and workplaces by 25 percent over the 2008 baseline (baseline to be determined).

STRATEGY 4: Promote policies to improve **workplace** environments and the reporting on occupational asthma.

Action Steps for Workplace	Indicators	Potential Collaborators
4.4.1. Partner with government/private agencies and community groups to develop recommendations on policies and guide-lines to promote the safe use of chemicals and other agents to minimize asthma episodes in workplace settings.	▪ Policy and guideline recommendations developed ▪ Outreach plan developed	DOH, DDOE, CEHN, EPA, CESC, GWU
4.4.2. Develop educational materials targeted to small business owners to raise awareness of occupational asthma.	▪ Occupational asthma small business education materials developed ▪ Distribution plan developed	DOH, DDOE, CEHN, EPA, CESC, GWU
4.4.3. Explore options to improve current reporting on the incidence of occupational asthma in the District.	▪ Recommendations on how to improve current reporting practices on occupational asthma developed ▪ Proposed legislative language on reporting requirements drafted	DOH, DDOE, CEHN, EPA,, CESC, GWU, DCRA

GOAL 5: **Enhance Asthma Surveillance and Evaluation**

OBJECTIVE: By 2013, expand the capacity of the District to conduct comprehensive asthma surveillance and program evaluation.

STRATEGY 1: Establish mechanisms for the timely dissemination of data in easily accessible formats to local, state, and federal stakeholders.

Action Steps	Indicators	Potential Collaborators
5.1.1 Collect data from established sources by maintaining data exchange relationships with existing partners including the DOH, CPPE (BRFSS, hospital discharge, and mortality data), and IMPACT DC (emergency department data).	Established datasets continuously acquired	DOH, CPPE, IMPACT DC
5.1.2 Create fact sheets summarizing asthma-related data in specific populations (e.g., school-age children, seniors, and ethnic/racial minorities), and in related areas (e.g., avoidable hospitalizations for asthma; asthma in childcare settings, schools, and workplaces; and asthma and tobacco).	Data fact sheets distributed	DC CAN DC CAN Outreach Group

GOAL 5: **Enhance Asthma Surveillance and Evaluation**

OBJECTIVE: By 2013, expand the capacity of the District to conduct comprehensive asthma surveillance and program evaluation.

STRATEGY 1: Establish mechanisms for the timely dissemination of data in easily accessible formats to local, state and federal stakeholders.

Action Steps	Indicators	Potential Collaborators
5.1.3. Produce, publish, and disseminate a comprehensive data report every three years that describes the burden of asthma on District residents.	*Burden of Asthma in the District of Columbia* report published and disseminated	DC CAN, DOH-CHA, DOH-CPPE, DHCF, IMPACT DC
5.1.4. Develop an interactive database to access asthma data from varied datasets.	Interactive database developed	DOH-CPPE, DC CAN
5.1.5. Collect DC Healthcare Alliance and Medicaid asthma related data on a regular basis.	Medicaid data acquired	DOH, DHCF, Medicaid MCOs
5.1.6. Collect school-based asthma-related data from electronic school health records.	Aggregate asthma-related data from electronic school health records reported	DOH, CHA, CASH Bureau, DCPS School Health Program, School Nurse Program
5.1.7. Assess the feasibility of including asthma indicators in existing and future electronic medical records systems in the local healthcare community.	Listing of current and future e-medical records systems compiled	DHCF, Medicaid MCOs, OCTO, DC CAN, DC Asthma Partnership

GOAL 5: **Enhance Asthma Surveillance and Evaluation**

OBJECTIVE: By 2013, expand the capacity of the District to conduct comprehensive asthma surveillance and program evaluation.

STRATEGY 2: Build the capacity of local programs that implement asthma control initiatives to effectively utilize evidence-based evaluation strategies to measure program and policy impact on reducing the burden of asthma.

Action Steps	Indicators	Potential Collaborators
5.2.1. Evaluate the efficacy of major program components of the *2009 Strategic Asthma Plan* in the areas of surveillance, collaboration, and intervention.	Comprehensive evaluation plan developed and implemented	DOH Office of Grants Monitoring and Evaluation, Local Evaluator, DC CAN Steering Committee
5.2.2. Use data systems to monitor and give feedback to government officials and community partners on progress toward indicator reports (i.e. DC's Healthy People 2010 Plan objectives, Child Health Action Plan).	Indicators of DC Healthy People 2010 Plan objectives periodically reviewed and updated	DC CAN, DOH, DC Asthma Partnership
5.2.3. Describe the use of evidence-based, standardized evaluation practices to measure the efficacy of asthma related public health interventions.	Survey describing current evaluation methods of community-based programs administered and findings reported	DC Asthma Partnership, DC CAN
5.2.4. Conduct a series of seminars and/or workshops on evaluation best practices for community-based programs that implement asthma control initiatives.	Evaluation seminars conducted	MWPHA, DC Asthma Partnership, DC CAN

ASTHMA PARTNERS/STAKEHOLDERS	WEBSITES
ELECTED OFFICIALS	
Advisory Neighborhood Commissions (ANCs)	www.anc.dc.gov
Council of the District of Columbia ("DC Council")	www.dccouncil.washington.dc.us
Mayor of the District of Columbia	http://dc.gov/mayor/index.shtm
State Board of Education	http://sboe.dc.gov/sboe/site/default.asp
DISTRICT OF COLUMBIA GOVERNMENT AGENCIES	
Child and Family Services Administration (CFSA)	www.cfsa.dc.gov
DC Office on Aging	www.dcoa.dc.gov
Department of Consumer and Regulatory Affairs (DCRA)	www.dcra.dc.gov
Department of Health Care Finance (DHCF)	www.dhcf.dc.gov
Department of Housing and Community Development (DHCD)	www.dhcd.dc.gov
Department of Human Services (DHS) Early Care and Education Administration (ECEA)	www.dhs.dc.gov
Department of Parks and Recreation (DPR)	www.dpr.dc.gov
Department of Youth and Rehabilitative Services (DYRS)	www.dyrs.dc.gov
District of Columbia Department of Health (DOH) Community Health Administration (CHA) Asthma Control Program, DC Control Asthma Now (DC CAN) Children, Adolescent and School Health Bureau (CASH) Tobacco Control Program (TCP) Health Regulation and Licensing Administration (HRLA) Bureau of Community Hygiene (BCA)	www.dchealth.dc.gov
District of Columbia Housing Authority (DCHA)	www.dchousing.org
District of Columbia Public Library	www.dclibrary.org
District of Columbia Public Schools (DCPS) Division of Transportation (DCPS-DOT)	www.k12.dc.us
District of Columbia Department of the Environment (DDOE)	www.ddoe.dc.gov
District of Columbia Department of Transportation (DDOT)	www.ddot.dc.gov
DC Office of the State Superintendent (OSSE)	www.osse.dc.gov
Executive Office of the Mayor (EOM)	www.dc.gov
Mayor's Office on African Affairs	www.oaa.dc.gov
Mayor's Office on Asian & Pacific Islander Affairs	www.apia.dc.gov
Mayor's Office on Latino Affairs	www.ola.dc.gov
Mayor's Office of the Clean City	www.cleancity.dc.gov
University of the District of Columbia (UDC) Cooperative Extension Services (UDC-CES) Respiratory Therapy Program (UDC-RTP) Nursing and Allied Health Program (UDC-Nursing)	www.udc.edu
COMMUNITY AND NATIONAL PARTNERS	
Allergy & Asthma Network Mothers of Asthmatics (AANMA)	www.aanma.org
Alliance for Healthy Homes (AFHH)	www.afhh.org
American Academy of Pediatrics, DC Chapter (DC AAP)	www.aapdc.org
American Cancer Society (ACS)	www.cancer.org
American Lung Association of the District of Columbia (ALADC)	www.aladc.org
Assembly of Petworth	
Association of Clinicians for the Underserved	www.clinicians.org
Association of State and Territorial Health Officials	www.astho.org
Asthma and Allergy Foundation of America (AAFA)	www.aafa.org

APPENDIX II: ASTHMA PARTNERS/STAKEHOLDERS

ASTHMA PARTNERS/STAKEHOLDERS	WEBSITES
Asthma and Allergy Foundation, Maryland-Greater DC Chapter (AAFA-MD,DC)	www.aafa-md.org
AstraZeneca	www.astrazeneca.com
Building Educational Alternatives Together for Health (B.E.A.T. for Health)	www.beat-for-health.com
Campaign for Tobacco-Free Kids (CFTFK)	www.tobaccofreekids.org
Children's Environmental Health Network (CEHN)	www.cehn.org
Children's National Medical Center (CNMC) Children's Health Project of DC (CNMC-CHP) Children's School Services (DC school nurses) (CNMC-CSS) Goldberg Center for Community Pediatric Health	www.childrensnational.org
Coalition for Environmentally Safe Communities	http://www.cesckids.org/aboutcesc.html
Community of Hope	www.communityofhopedc.org
DC Area Health Education Center (DC AHEC)	www.dcahec.org
DC Chartered Health Plan, Inc.	www.chartered-health.com
DC Hospital Association	www.dcha.org
DC Partnership to Improve Children's Healthcare Quality (DC PICHQ)	www.brightfutures.org/ health-check/DCPICHQ.html
DC Pharmaceutical Resource Center	
DC Primary Care Association	www.dcpca.org
Delmarva Foundation	www.delmarvafoundation.org
District of Columbia Association of Health Maintenance Organizations (DCHMO Association)	
District of Columbia School Nurses Association	www.nasn.org/Default.aspx?tabid=478
Food Allergy & Anaphylaxis Network	www.foodallergy.org
George Washington University, The (GWU) Center for Risk Science and Public Health, The Department of Environmental and Occupational Health, School of Public Health and Health Services The George Washington University Medical Center	www.gwu.edu
Georgetown University Hospital/MedStar Health Kids Mobile Medical Clinic	www.georgetownuniversityhospital.org
GlaxoSmithKline	www.gsk.com
Health Information Partners (GWU-HIPS)	www.connectforhealth.gwu.edu
Health Right, Inc.	www.healthright-dc.com
Health Services for Children with Special Needs, Inc.	www.hscsn-net.org
Healthcare Services Development Corporation	
HMI Home Health	www.hmi-usa.com
Howard University Howard University College of Medicine Community Outreach for Asthma Care at Howard University Howard University Hospital	www.howard.edu
HSC Foundation, The (The HSC Fdn.)	www.hscfoundation.org
HSC Pediatric Center, The	www.hscpediatriccenter.org
Improving Pediatric Asthma Care in the District of Columbia (IMPACT DC)	www.impact-dc.org
Mary's Center for Maternal and Child Care (Mary's Center)	www.maryscenter.org
Medicaid Health Plans of America	www.mhpa.org
Medical Society of the District of Columbia	www.msdc.org
Merck Childhood Asthma Network, Inc.	www.mcanonline.org
Mid-Atlantic Center for Children's Health and the Environment, The George Washington University (GWU-MACCHE)	www.health-e-kids.org

ASTHMA PARTNERS/STAKEHOLDERS	WEBSITES
National Association of School Nurses (NASN)	www.nasn.org
National Center for Healthy Housing (NCHH)	www.centerforhealthyhousing.org
National Children's Museum	www.ncm.museum
National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)	www.ncqa.org
National Nursing Centers Consortium (NNCC) Lead Safe DC	www.nncc.us
Partnership for Prescription Assistance	www.pparx.org
Project HEALTH	www.projecthealth.org
RAND Health	www.rand.org
Robert Wood Johnson Foundation, The (RWJF)	www.rwjf.org
Soap and Detergent Association, The	www.cleaning101.com
Society for Public Health Education, National Capital Chapter	www.ncasophe.org
Student Support Center	www.studentsupportcenter.org
Unison Health Plan of the Capital Area, Inc.	www.unisonhealthplan.com
United Planning Organization (UPO)	www.upo.org
Unity Healthcare, Inc.	www.unityhealthcare.org
Visionary Health Education Consulting Services	
Washington Child Development Council	www.daycareindc.org
Washington Hospital Center	www.whcenter.org
Washington Tennis & Education Foundation	www.wtef.org
Whitman-Walker Clinic	www.wwc.org
REGIONAL PARTNERS	
Fairfax County Health Department	www.fairfaxcounty.gov/hd
Maryland Department of Health and Mental Hygiene	www.dhmh.state.md.us
Metropolitan Washington Council of Governments (MWCOG) Metropolitan Washington Air Quality Committee (MWAQC)	www.mwcog.org
Mid-Atlantic Regional Asthma Initiative (MARAI)	www.epa.gov/reg3artd/asthma/marai.htm
Virginia Department of Health	www.vdh.state.va.us
FEDERAL PARTNERS	
Agency for Healthcare Research and Quality (AHRQ)	www.ahrq.gov
Centers for Disease Control and Prevention (CDC) Agency for Toxic Substances and Disease Registry (ATSDR) Behavioral Risk Factor Surveillance System (BRFSS) National Center for Health Statistics (NCHS) Youth Risk Behavior Surveillance System (YRBS)	www.cdc.gov
US Department of Energy (DOE)	www.energy.gov
US Department of Health and Human Services National Heart, Lung, and Blood Institute National Institute of Allergy and Infectious Diseases Office of Public Health and Science, Region III Office	www.dhhs.gov
US Department of Housing and Urban Development (HUD)	www.hud.gov
US Environmental Protection Agency (EPA) The Mid-Atlantic Region (EPA Region 3) Office of Children's Health Protection Office of Pesticide Programs	www.epa.gov

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