

**Goal Setting and Action Plans- Creating True Collaboration:
Providing Clinical Staff with the Skills Necessary to Provide Self-
Management Support
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In the fall of 2000 a multi-disciplinary group of health care providers from our primary care clinic applied for and received *California Asthma Initiative* (CAI) funding to begin to address the burgeoning local asthma epidemic. This funding earmarked for safety net services for children 0-5 with asthma and continuous quality improvement was well spent. As a result of this funding our medical providers were educated about best practices in managing asthma, a dedicated pediatric asthma clinic was established, and partnerships were developed amongst the clinic support staff **and** with other asthma-focused health care and community based organizations.

When the program was evaluated, asthma outcomes and quality of life measures showed significant improvement for children served in our clinic. Participants in a pilot study showed a 70% reduction in ED visits and hospitalizations for when they were seen at both at our clinic and also received home based services from our community partners at the Alameda County Public Health Dept.

The success of this local program, appropriately named *Asthma Start*, set the stage for additional funding and was instrumental in the establishment of The Oakland Berkeley Asthma Coalition (OBAC). Over the past five years working with OBAC we've built the infrastructure to address asthma in a more coordinated and comprehensive manner both at our primary care clinic and in the greater community.

Our primary care based asthma program continues to foster similar partnerships amongst clinic staff as well as with patients/ families with the ultimate goal of improving self-management skills related to asthma. Recently we've been asked to share our knowledge about collaborations within our community. Asthma Tools and Training Advancing Community Knowledge (ATTACK ASTHMA) is our way or bringing what we've done at our own primary care clinic to other providers in the community.

This four to eight week curriculum is designed to foster partnerships within the primary care practice. In this way all staff can pitch in with the education and care coordination needed to address asthma in the clinical setting with the ultimate goal of empowering patients to improve their self-management skills. The curriculum focuses not only on management and education within the clinic setting but also on coordination of care with other community-based resources. For example, clinic staff might refer families for home environmental assessments, or inform them about subsidized asthma camps.

For those communities interested in stemming the tide of asthma I suggest partnerships within your community, within your clinic and with your patients