PACI arms had an additional gain of 6.5 and 13.3 SFDs per year, respectively, compared with the usual-care arm. When the costs of development were excluded, the cost for SFDs gained compared with usual care was $18 for PLE and $68 for PACI.

CONCLUSIONS. It is possible to increase SFDs in children and to move organizations toward guideline recommendations for asthma management. However, the improvements were associated with an increase in the costs associated with asthma care.

REVIEWER COMMENTS. This trial was designed to provide cost analyses to both health care providers and health maintenance organizations. It is difficult, however, to establish a threshold for cost-effectiveness. The authors cite other trials to provide a context for this question. For example, the cost-effectiveness of inhaled corticosteroids in the treatment of children ranges from $7 to $12 per SFD gained. A social worker–based intervention had a cost-effectiveness ratio of $9 per SFD gained. What is it worth to patients, their families, and their health care providers to have an extra SFD?

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REVIEWER COMMENTS. Asthma is a complex disease, and there are many barriers to effective care. These barriers include steroid phobia, cost of medication, denial of the presence or severity of the disease, access to health care, exposure to asthma triggers, and poor adherence to treatment. It is concerning that another barrier to effective care of asthma, as illustrated by this study, is a poor response of health care providers to supportive education, such as treatment guidelines. In an effort to better understand this deficit, the authors queried the providers: “Was the information in the original notification helpful?” Only 27 of 73 providers responded: 10 said the information was helpful (7 changed medications); 9 replied that their patients had mild, intermittent asthma and did not need changes; 4 replied that their patients already were on preventive medications; and 4 replied that they were unable to contact their patients for follow-up.

A Randomized Trial of Primary Care Provider Prompting to Enhance Preventive Asthma Therapy

PURPOSE OF THE STUDY. To determine if systematic school-based asthma screening, coupled with primary care provider notification of asthma severity, would prompt providers to prescribe a new preventive medication or change a current dose.

STUDY POPULATION. The study included 151 children (aged 3–7 years) with mild persistent to severe asthma living in an urban setting.

METHODS. A routine school health-and-development form was sent to parents of schoolchildren. When asthma was indicated on this form, the parents were contacted by telephone. To be eligible for the trial, the child’s parent needed to report that a physician had diagnosed their child as having asthma, and the child’s symptoms needed to be consistent with mild persistent asthma or worse according to National Heart, Lung, and Blood Institute guidelines. The intervention arm of the study involved notification of the primary care providers via fax of the child’s symptoms and recommendations for action on the basis of national criteria. Confirmation of receipt was received from 90% of providers. In the control arm of the study, primary care providers were not contacted. Interviewers then contacted the parents 3 to 6 months later to determine if preventive actions were taken.

RESULTS. Children in the provider-notification group were not more likely to receive a preventive medication action than children in the control group (21.9% vs 26%). Additional preventive measures such as encouraging compliance with medications, recommending environmental modifications, and referrals to specialty care also did not differ between the 2 groups. The only factors that significantly predicted the occurrence of a preventive action were acute visits for asthma and baseline use of preventive medications. At the end of the study, 52.4% of children in both groups with no medications change were still experiencing symptoms.

CONCLUSIONS. School-based asthma screening identified many symptomatic children in need of medication modification, but notification of their primary care providers did not improve preventive care.

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Asthma-Related Health Care Resource Use Among Asthmatic Children With and Without Concomitant Allergic Rhinitis

PURPOSE OF THE STUDY. To determine the incremental effect of allergic rhinitis on health care resource use in children with asthma.
A Randomized Trial of Primary Care Provider Prompting to Enhance Preventive Asthma Therapy
Brian A. Smart

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