ASTHMA HOME-BASED SERVICES MANUAL

AND CLIENT EDUCATION CURRICULUM

DEPARTMENT OF HEALTH

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Minnesota Department of Health

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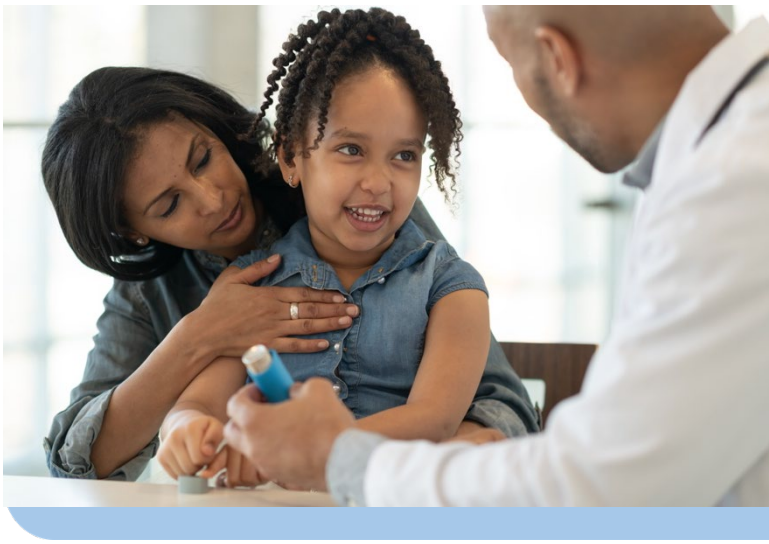
INTRODUCTION

What are Asthma Home-Based Services?



Asthma home-based services (AHBS) provide an opportunity to meet with clients in their homes to create individualized plans of care, provide education on asthma self-management, assess the home environment, and address the specific needs identified in the home assessment. Asthma self-management skills combined with environmental assessments and services have been shown to be very effective in asthma control.

The Dakota County asthma program is an example of a model of how asthma home-based services can be administered within your organization (excerpt adapted from the Population-Based Public Health Clinic Manual/ The Henry Street Model for Nurses 4th Edition).

In 2012, Dakota County Public Health (DCPH) was awarded a grant from the Minnesota Department of Health's Housing and Urban Development-Reducing Environmental Triggers of Asthma Project (HUD-RETA) to implement evidence-based strategies to improve health outcomes for low-income children with asthma by reducing triggers in their homes. After funding ended, DCPH received a grant from the UCare Foundation to continue this great work and support an identified community need. The basis of the model being used is from the MDH grant and was expanded to include reporting capabilities by implementing the Omaha System (a research-based problem classification system designed to enhance practice, information management, and documentation).

Through the program, a public health nurse provides in-home health and environmental assessments to children from birth to age 18 who live in Dakota County and have a diagnosis of asthma. Individual intervention is based on information learned during the in-home assessment, an asthma control test, and review of the child's asthma action plan. This includes education on the pathophysiology of asthma, medications, and strategies to reduce or eliminate asthma triggers. Case management is also provided and is based on the child and family's needs, which may include ensuring the child has a primary care provider, coordination with school staff, and referrals to community resources. The public health nurse visits children and families three to four times over a year. For more complex cases, visit frequency and duration can be adjusted.

Allergen-reducing equipment is provided to eligible children to assist in the reduction of asthma triggers. Eligibility is based on income and can be determined by the child's participation in programs such as Women, Infants, and Children (WIC), enrollment in Medical Assistance or Minnesota Care, or participation in cash or food programs through the county. Equipment most often provided includes a High Efficiency Particulate Air (HEPA) vacuum cleaner, an air cleaning device, bed and pillow encasements, and a holding chamber. Other equipment can be provided based on the child's needs and home environment.

– **Judy Wohnoutka**, BAN, RN, PHN Dakota County Public Health

How to Use This Manual

This manual was created with the intent to provide structure and guidance to develop an AHBS program. The manual is an outline of operational considerations, step-by-step implementation, and workflow guidance.

This resource is meant for local public health organizations, Indian Health Services, health and human service agencies, or other health care focused organizations that wish to build a comprehensive asthma management solution for their defined population.

The manual provides practical steps to consider and implement when developing an AHBS program and is intended to be used in conjunction with support resources that include:

- MDH Asthma Program implementation technical support
- Mentoring from Local Public Health agencies experienced in implementing and operating an AHBS program
- A toolkit of resource links and documents supporting AHBS programs

Asthma Home-Based Services Toolkit

The icons below are used throughout the manual to correlate additional resources that are available on the Minnesota Department of Health's Asthma Home-Based Services Toolkit (www.health.mn.gov/diseases/asthma/professionals/home-basedservicestoolkit.html) web page.

Toolkit Icon Legend


Data


Supporting documents


Clinical forms


Data privacy & forms


Key partnerships


Dakota County


Grant


Professionals providing AHBS


Clinical training


Asthma environmental training


Training opportunity


Environmental health

1

SECTION ONE

INITIAL ASTHMA HOME-BASED SERVICE PROGRAM PLANNING

INITIAL ASTHMA HOME-BASED SERVICE PROGRAM PLANNING

Key Program Elements to Consider

Consider these key program elements when planning the start-up of an AHBS program at your agency:

- Who in your agency should be included in the start-up of a new program?
- Who outside your organization should be included in the start-up process?
- What services will you be providing?
- Where will you be providing these services?
- How will you pay for the program?
- Will you utilize third party payor billing?
- What kind of staffing will be needed?
- Will staff be trained in supplemental or advanced asthma clinical training or will training be more informal?
- Who will be your target population?
- What kind of documentation will you use?
- How will you communicate your program?
- How will you process referrals?
- How will you evaluate whether services are improving participants' asthmas management?
- What kind of data should be gathered?

Exploring the Impact of Asthma in Your Community – Data and Demographic Information

It may be helpful in your planning process to explore the impact of asthma in your community through available assessments and data. Data source examples may include, but are not limited to:

- School Nurse Surveys
- Minnesota Department of Health's asthma data
- Community health assessments (Dakota County example)
- MN Community Measurement
- Department of Human Service

Supporting Documents and Information – State and National Organizations

Items that may assist in the planning and implementation of an asthma program include:

- Asthma in Minnesota: A Strategic Framework 2021-2030
- Strategies for Addressing Asthma in Homes – Centers for Disease Control and Prevention
- Exhale: A Technical Package to Control Asthma – Centers for Disease Control
- Building Systems to Sustain Home-Based Asthma Services – National Center for Health Housing

Internal and External Participants in the Implementation and On-Going Operations of Your Asthma Program

Internal: Key Players within Your Organization

Local Public Health Leadership

Your agency's Director, Deputy Director or a Community Health Board Administrator could be an expert resource for program planning, financial decision-making, and in garnering leadership support.

Supervisor or Lead

Designate a supervisor or lead to provide project management during implementation and/or on-going operations.

Finance or Billing

Identify a representative from your finance and billing areas who can assist with creating and implementing a process for billing and reimbursement for program services.

Electronic Health Record (EHR)

Identify an electronic health record or system and consult with Information Technology or Informatics to create, adapt and implement asthma visit workflows in the EHR.

Legal

Identify and consult with your legal department or County Attorney who can assist with creation of documents related to data privacy, consents, liability and mitigation concerns.

Communications

Consult with communications staff on a plan for developing a marketing strategy for the program (web, print, digital, social media).

Other

Determine the need to collaborate or consult with other units or departments within your organization that may be working with your target population.

Assess expertise within other parts of your organization and their interest in and ability to consult with or participate in the program. For example, your organization may have a certified environmental assessor on staff.

External: Key Players Outside of Your Organization

Minnesota Department of Health (MDH)

MDH provides technical support, connections to asthma program mentoring, networking opportunities, education, and asthma resources as well as possible access to small grant funding to assist with start-up. Contact the MDH Asthma Program at health.asthma@state.mn.us

Key Partnerships in On-Going Asthma Program Operations

Community Agencies

Consider reaching out to service agencies in your community that can assist with generation of referrals as well as to determine resource support for shared populations served. Community agencies may include local non-profit organizations serving at-risk families. Examples include Head Start, local service agencies and faith-based organizations.

Health Care Providers/Clinics

Consider reaching out to health care providers and clinics that can assist with the generation of referrals, serve as partners in case management and care coordination for clients, and have an interest in asthma-related training for their clinic staff.

Colleagues

Co-workers and colleagues may serve as referral sources, provide back up support for the program and may provide case consultation.

Health Insurance/PMAPS

Form relationships with third party payors for referral generation, to stay appraised of reimbursement opportunities and to serve as a connection to complementary programs such as commercial tobacco cessation for plan members.

Other Local Public Health (LPH) Agencies

Consider partnerships with other LPH agencies that support opportunities for mentoring, collaboration, idea and resource sharing.

Schools

Consider reaching out to area schools for referral generation, to establish relationships with school nurse(s) for care coordination and potential in-service training opportunities.

Other Departments

Consider collaboration with other units and departments such as environmental services and family home visiting, which provide access to other programs that may share a similar mission and populations.

Weatherization Assistance Program (WAP)

The WAP provides free home energy upgrades to income-eligible homeowners and renters to help save energy and make sure a home is a healthy and safe place to live. The Department of Commerce Weatherization Assistance Program is an example.

Contracts

Contracting, if any, will be based on your agency's policies. The asthma program may fall under contracts already in place for a larger organization, such as purchasing of Prepaid Medical Assistant Program (PMAP) contracts.

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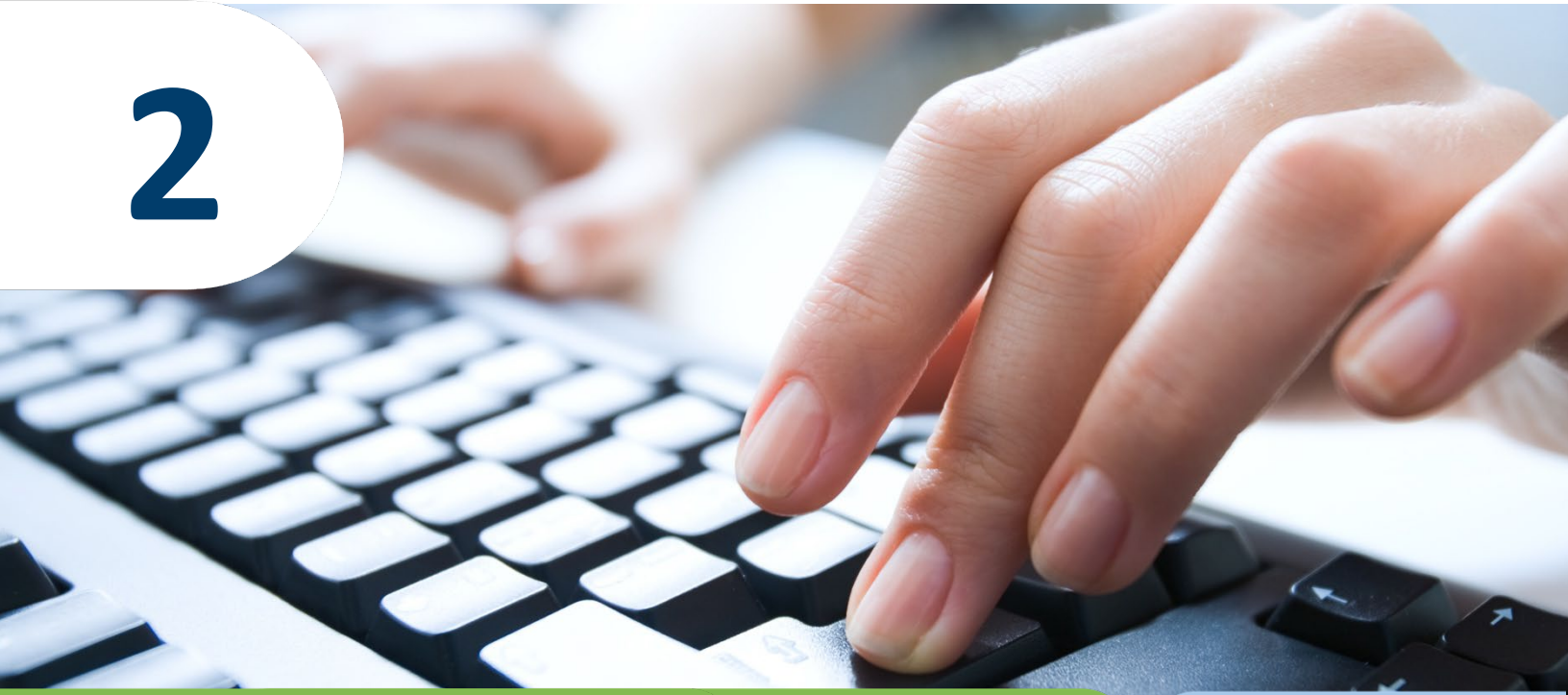

SECTION TWO

BILLING, FUNDING AND PROGRAM COSTS

BILLING, FUNDING AND PROGRAM COSTS

Billing Process Options and Considerations

There are two approaches to setting up billing for an asthma program.

Option 1: Add Asthma Program to an Existing Department and Billing Process

Embed the program into an existing department. Placing the program into an existing department or team allows for the utilization of existing billing procedures and staff.

> ***Example:*** *Dakota County's Asthma Program currently resides under the Family Health unit. This allows for utilization of Family Health's billing staff and already established billing processes, rather than needing to create completely new procedures for billing and reimbursement. Minor coding and diagnosis codes had to be added to the process. (See Billing Procedure under Reimbursement Section).*

Option 2: Create New Billing Process

If there is not an existing department to embed the program into, billing processes and procedures will need to be created to submit third party reimbursement and other funding. (See the reimbursement section for potential billing process information.)

Grant Funding Sources

Seek grant opportunities available to assist in funding an asthma home-based services program. Some examples to research for ongoing opportunities include:

- Minnesota Department of Health (MDH)
- The UCare Foundation
- The Medica Foundation
- Health Partners Foundation
- The Centers for Disease Control and Prevention
- The Environmental Protection Agency
- Other foundations focused on health and health equity

Program Costs

When planning for the costs of the program, consider the following:

- Home visiting staff time
- Support staff time – "behind the scenes" staff who provide technical support to the program including things such as making copies, answering phones, creating folders for client handouts, etc.
- Billing, contracting or accounting staff time
- IT support staff time (Data Collection, EHR Support)
- Communications support staff time (program promotions, marketing, website management client materials creation)
- Reimbursement for home visits
- Mileage and staff time reimbursement for traveling to homes
- Staff training
- Office supplies and printing costs (client handouts, marketing materials, etc.)
- Translation of client materials and interpreting services
- Equipment for on-going operations such as computers, phones, cars
- Asthma and allergen reducing equipment, including air cleaners, HEPA vacuum, bed/pillow encasements

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SECTION THREE

STAFFING AND TRAINING NEEDS

STAFFING AND TRAINING NEEDS

When planning for, implementing, and operationalizing an asthma program, consider the staffing resources and training needed to provide a sustainable asthma visit program.

Staffing

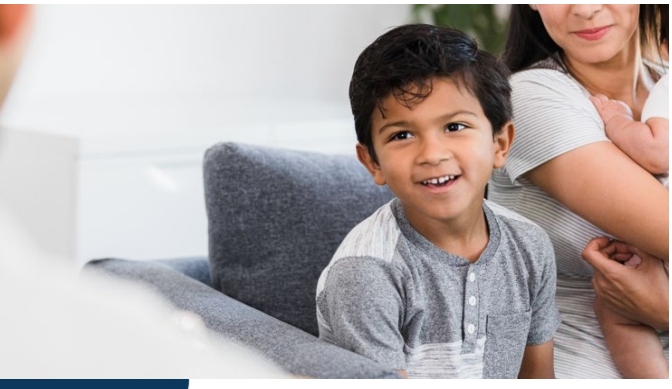
What staff are required? A variety of staff may be involved in supporting the daily operations of the asthma program. A common model for home visits includes a clinical professional providing a home visit and may or may not include an environmental professional providing an environmental assessment. If an environmental professional is not available, the clinical professional may provide an abbreviated home assessment. The qualifications and the scope of work of staff may impact which billing codes may be used.

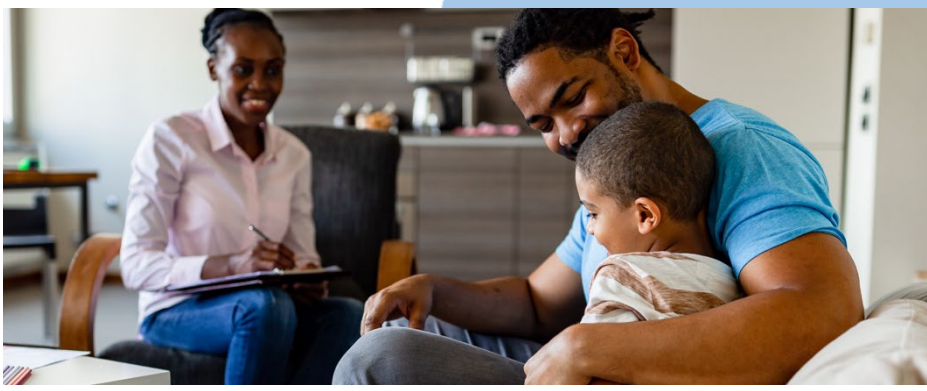
Supervisory/Management

If possible, utilize a supervisor or manager already on staff at your agency to oversee the program under their current unit. Consider an existing family health unit supervisor or supervisors from related units such as disease prevention and control, environmental services, or health promotion.

> ***Example:*** *Dakota County was able to identify an existing family health unit supervisor to oversee the Asthma Program.*

If it is not feasible to use existing staff, a new supervisory position will need to be established for your asthma program.





Professional Providing AHBS

Primary home visitors may consist of one of the following professionals or may consist of a combination team approach.

Clinical:

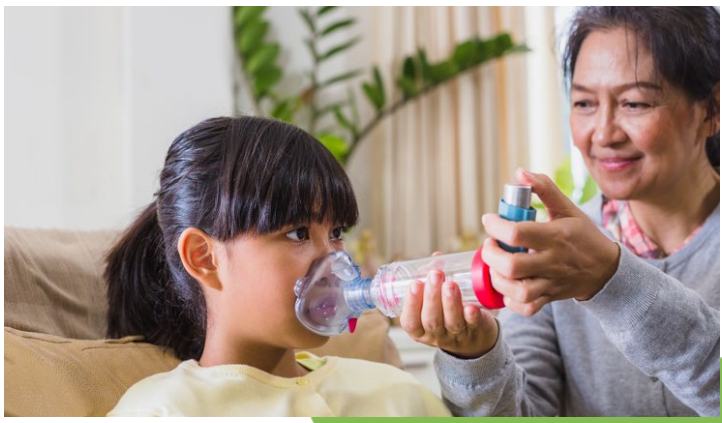
- Registered Nurse or Public Health Nurse
- Respiratory Therapist
- Community Paramedic
- Community Pharmacist

Environmental/Home Assessments:

- Healthy Homes Specialist (defined and credentialed as a Health Home Evaluator by the Building Performance Institute as credentialed and defined by MDH)
- Registered Environmental Health Specialist defined and credentialed by MDH

Other staff to consider involving in an asthma program:

- Community Health Workers (CHW) – CHWs are trained roles that are trusted, knowledgeable members of a community who can assist in providing education, barrier mitigation, program information, referrals, and support.
- Health Educators – May assist in providing education on asthma and healthy behaviors.
- Support Staff – Support staff to assist home visitors and supervisors in the maintenance of the asthma program by providing technical and administrative support.



Training

Asthma Program Training

To determine staff training needs, consider staff capabilities, interest, experience in home visiting, history of work in asthma care and capacity to attend trainings. There are a variety of training resources and options.

- **Home Visitor Training** for those with no or minimal experience in home visiting.
- **Workplace/Personal Safety Training** for home visitors as identified by your organization.
- **Privacy/HIPAA Training** may be needed and required. What is offered within your organization?
- **Technical Training** may be needed for staff documenting in your electronic health record. Consult your agency's staff training process and policy.

Asthma Clinical Training

- The American Lung Association's "Asthma Basics" is a free, online training appropriate for those with limited knowledge of asthma and is a precursor to the ALA's Asthma Educator Institute training.
- The United States Environmental Protection Agency's "What is Asthma" (web) training provides information on asthma, asthma triggers, and asthma resources.
- The American Lung Association's Asthma Educator Course is an advanced asthma training. This is highly recommended for the professional selected to provide home visits. The course is a preparatory course required prior to taking the Asthma Educator certification exam. However, the course can also be taken for educational purposes only. There is no requirement that the participant must take the certification exam.
- The Association of Asthma Educators has an asthma training available for Community Health Workers.
- MDH's Asthma Program and St. Paul College collaborated to create an online, self-paced course (1 CEU available) around the four components of asthma motivational interviewing. The course supports optimal health education and coaching skills for the professional providing home visits.

Asthma Environmental Training

- The Minnesota Department of Health's Asthma Program provides a free 40-minute online Reducing Environmental Triggers of Asthma in the Home (RETA) training course.
- The US Environmental Protection Agency (EPA) provides a recorded 30-minute webinar on the Home Characteristics and Asthma Triggers Checklist and Training for Home Visitors: Making Homes Healthier.
- The US Environmental Protection Agency (EPA) offers information and guidance on their Introduction to Integrated Pest Management web page.
- The Centers for Disease Control and Prevention (CDC) offers strategies and guidance about asthma environmental triggers in the home on the CDC Asthma Public Health Professionals web page.

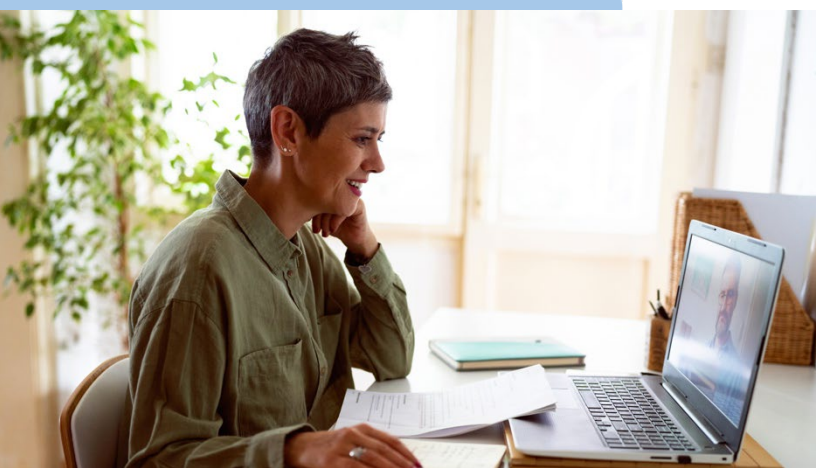
Training frequency and selection will depend on the following:

- Budget and funding available for staff training
- Internal and external training opportunities
- Individual staff training needs based on skills and experience

Additional Training Opportunities

Asthma program staff can sign up to receive email notifications of asthma training opportunities from credible national asthma organizations, including:

- Allergy & Asthma Network
- American Lung Association
- Asthma and Allergy Foundation of America
- National Heart, Lung, and Blood Institute
- National Environmental Education Foundation (NEEF)



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SECTION FOUR

REFERRAL IMPLENTATION AND OPERATIONS

REFERRAL IMPLEMENTATION AND OPERATIONS

Referral Implementation

There are two approaches to setting up your asthma program's referral process.

Option 1

Utilize your agency's existing referral process. The process may need to be adapted to include information pertinent to the asthma program. (See Dakota County example below.)

Option 2

Create a new referral process. If a new referral process specific to your asthma program needs to be created, consider the following during planning and implementation:

- How will referrals be made? Phone, e-mail, fax and/or online?
- Which staff will be monitoring, processing, and validating the referral information?
- What information should be collected?
- How will the referral be assigned to the home visiting staff?

Sample Referral Process and Workflow from Dakota County

Dakota County Public Health Intake referral process:

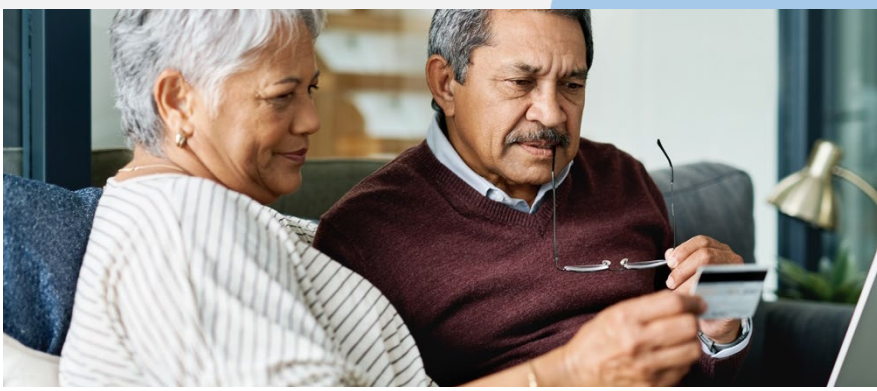
1. Referrals are made either by phone, email, fax, or using an online form that, once submitted, is routed directly to the program's intake area (preferred method).
2. Public Health Intake staff validate information received on referrals through Public Health Systems (Client index, Medicaid Management Information System, Birth Certificate Records, EHR). Staff correct misinformation and add other pertinent information such as insurance and demographics.
3. Client information is then entered into our EHR (PH Doc) or updated if the client already exists in the EHR.
4. A referral is created in PH Doc and assigned to appropriate Public Health Nurse (PHN) for follow up (the Asthma PHN).

Referral criteria from Dakota County asthma program:

- Children up to age 18
- Diagnosed with Asthma
- Live in Dakota County
- Must be income eligible to receive the equipment provided under the program

Information to be collected:

- Name
- Date of Birth
- Family members (if applicable)
- Address
- Phone
- How client prefers to be contacted and if ok to leave a message
- Primary language
- Demographics-ethnicity, gender, race
- Referral source contact information
- Insurance
- Reason for referral
- Concerns/Needs
- Diagnosis and other health conditions



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SECTION FIVE

ASTHMA PROGRAM WORKFLOW

ASTHMA PROGRAM WORKFLOW

Client Visits

Contacting Clients

Consider the following questions when planning for engaging clients.

1. How will you contact the client by phone, text, email, mail, or a combination of all methods?
2. What is the typical number of contact attempts your agency plans to make to reach each client?
3. What is the best time to call clients? After 10 a.m. and during business hours?
4. Will you offer in-person and virtual visits?
5. Will visits need to be during business hours or will the times be flexible to accommodate school and work schedules?

Visit Frequency

Consider the following questions when planning visit frequency:

- Will the number of home visits offered be the same for every client/family or will there be flexibility to increase or decrease visit frequency based on the client's needs? For example, will everyone receive four visits over one year or will some clients have visits monthly or more often?
- Will the client/family receive asthma home-based services indefinitely or will it be based on a specific time frame or number of home visits completed? For example, will the program provide services to families for a year and then close them to services or may clients remain open to services for a more extended period of time?

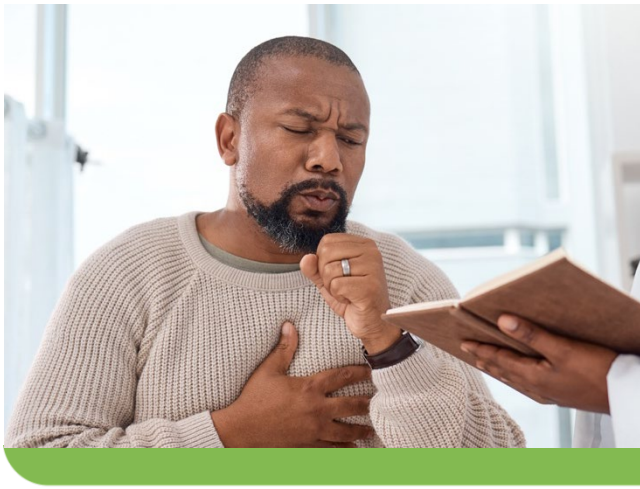
Visit Frequency Variation

Consider situations that may suggest a need for additional visits or where fewer visits are needed. For example:

- Client and/or family is high risk and/or high need based on socioeconomic factors, resource needs, mental health status, or requiring assistance with follow-up recommendations
- A child's asthma is not well-controlled, as demonstrated by one or more of the following: low Asthma Control Test score, increase in symptoms, not following medication recommendations, recent asthma-related emergency department (ED) visit or hospitalization, or the visiting professional's clinical judgement

Consider each family's circumstances and each situation when determining the number of visits for optimal care

Clients Lost to Follow-up / Unable to Reach



If unable to reach clients referred for first visits after planned number of contact attempts:

1. Close out referral to assigned staff in EHR
2. Inform referral source that unable to reach referred client

If unable to reach clients that are considered enrolled in the program because they have completed one or more visits and the planned number of contact attempts have been made, consider the following:

1. Keep client open until next scheduled visit interval and try again
2. Discontinue AHBS services and complete necessary charting in EHR according to your agency procedures
3. Document all contact attempts in EHR
4. Send Closure Letter to provider/referral source

Special Circumstances to Consider

- Will you serve families of children with chronic respiratory issues or just those with a diagnosis of asthma? For example, it may be difficult to distinguish if a young child with ongoing respiratory symptoms has an illness like Respiratory Syncytial Virus (RSV) or asthma so they may not have been given a formal diagnosis of asthma.
- Will families be allowed to re-enroll in the program or will it be a one-time service?
- If the child resides at multiple residences, will services be provided in each residence?
- If providing equipment, determine if equipment is a one-time benefit. Additionally, determine your agency's policy on whether equipment will be replaced if broken or not functioning when the warranty does not cover product.

Notify the Provider

1. Consider sending a letter to client's primary or specialty provider after the initial home visit to alert them that the child is enrolled in an asthma program. This also opens communication and case management possibilities and may generate additional referrals for your program.
2. Consider sending a brief visit report after subsequent visits to the client's current health care provider.

Documentation

1. Documentation should be completed in the EHR consistent with other programs in your agency.
2. Additional medical records received, referrals and paper documents should be uploaded to you EHR
3. HIPAA and legal consents – Consult your agency's legal department/county attorney on required documents. You may use existing forms from other program areas if applicable or create new forms specific to your asthma program.
4. Administrative forms – Forms may be completed with clients in-person using hard copy or electronically using a platform such as DocuSign.
5. Consider having forms available in English and then translated into other client languages

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SECTION SIX

FORMS, LETTERS AND CONSENTS

FORMS, LETTERS AND CONSENTS

Forms, letters, and consents to consider as part of your asthma home-based services program.

Dakota County Specific Forms

- **HIPAA/Notice of Privacy** – Document that explains how a client's private data is collected, retained, and how it can be shared
- **Data Privacy Tennessen Warning** – Document that explains how a client's private data is collected, retained, and how it can be shared
- **Rights, Responsibilities, and Grievance Notice** – Document to inform clients of their rights and responsibilities as well as how to report a grievance
- **Consent to Release Information to an Outside Entity** – Document that allows a client to give your organization permission to release information to a specified entity. For example, a clinic, school, or insurance provider
- **Tele-health Consent (Video/Audio)** – Document that indicates a client is consenting to participate in video or telephone visits/services
- **Equipment Recipient Release/Consent** – Document that indicates the client is agreeing to the terms and conditions of the equipment being provided
- **Asthma Health and Environmental Assessment/Home Visit Form** – Documentation form of the health and environmental assessments completed at the initial asthma visit
- **Equipment Home Visit Form** – Documentation form completed during the equipment home visit
- **Asthma Follow Up Visit Forms** – Documentation forms completed at subsequent follow up asthma visits
- **Visit Documentation -** Documentation in your EHR for the asthma visit and workflow will depend on your agency's current method of documentation or EHR

General Data Privacy Forms Available for MN

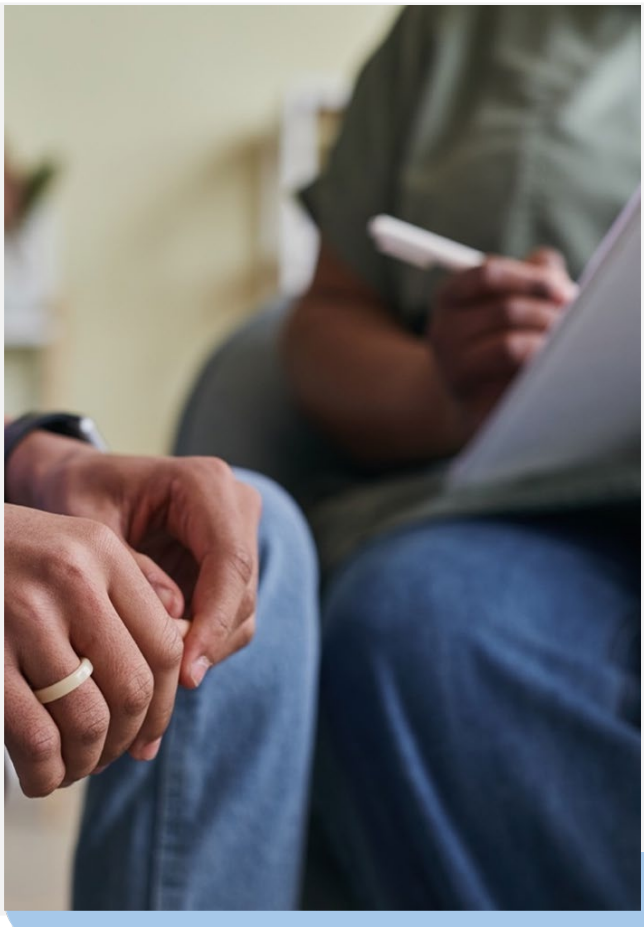
- Minnesota Standard Consent Form to Release Health Information – A standard patient consent for a person to release their health information
- Access to Health Records Notice of Rights – Summary of official legal language references in the Access to Health Records Notice

Dakota County Client and Provider Letters

- **Initial Letter to the Health Care Provider** – explaining the program and notifying them of the client's enrollment
- **Letter to Referral Source** – noting referral received and completed visit or family was unable to be reached at home
- **Visit Report/Follow Up Visit Report Form for Health Care Provider** – to inform them of findings of health and environmental assessments completed and recommendations made along with any other pertinent information (concerns, asthma control)
- **Unable-to-reach letters for clients** – sent if unable to reach after planned number of contact attempts for initial or follow-up visits
- **A closing letter** to the health care provider informing them the client will be closed to services, the reason for closure, number of visits, and client asthma control status

Clinical Forms

- **Asthma Action Plan** – Individualized asthma self-management plans
- **Asthma Control Test (ACT), child Asthma Control Test (cACT) or other validated test/questionnaire to measure asthma control** – recommend for each visit
- **Test for Respiratory and Asthma Control in Kids (TRACK)** – asthma control assessment for children under age 5-recommeded for each visit
- **Asthma Control Questionnaire (ACQ)**
- **Visit Documentation** – Documentation in your EHR for the asthma visit and workflow will depend on your agency's current method of documentation or EHR



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SECTION SEVEN

REIMBURSEMENT

REIMBURSEMENT

Covering the cost of providing services will be unique to your agency. Program costs may be covered by grants, existing agency budget, third party reimbursement, or through a combination of sources.

Consult your agency's billing specialist to determine internal processes needed to bill for asthma visits. Example billing procedure document linked under Key Manual Resources Dakota County Specific Forms and Letters.

- **Billing for Child:**
  - Child Visits: Visits are billed to the child using ICD – 10 Code J45.21.
  - Childhood Asthma: Initial Visit – billed as HCPC- S9123
  - Childhood Asthma: Follow-up Visit – billed as HCPC- S9123
  - Childhood Asthma: Equipment – billed as HCPC- S9123
  - Childhood Asthma: Education – billed as HCPC- S9441
  - Initial, follow-up and equipment visits billed to the child as S9123 where asthma education was completed AND visit length is greater than 31 minutes qualify for the use of the S9441 code in addition to S9123.
- **Billing for Parent:**
  - Visits are billed to the parent's insurance using HCPC- S9123 and ICD-10 Code Z71.89 when education is provided to the parent and the visit length is greater than 31 minutes.
- **Billing Code Requirements:**
  - If you bill using the S9123 code, this must be done by a Registered Nurse (RN); no other provider types are allowed and there is a minimum of a 31-minute visit, and a one-unit max allowed per day.
  - If billing using S9441 code as a non-ordering provider, there is no time requirement, and it is billed per visit.
- **Medical Assistance or Minnesota Care insured Clients:**
  - There is potential to receive third party reimbursement through Medical Assistance (Medicaid) or Minnesota Care insurance. Counties are reimbursed at varying rates based on individual contracts.
- **Uninsured Clients:**
  - Clients are not billed for public health services if they do not have health insurance, or their health insurance does not cover these services. They may be covered by a combination of county levy money and grant funds.
- **Purchasing Allergen-reducing Products:**
  - Determine if this can be paid for by grants, county budget funds or other funding sources.
  - Example: Currently at Dakota County, Allergen-reducing products are purchased using funds from a grant received from the UCare Foundation.

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SECTION EIGHT

SUPPLIES

SUPPLIES

Supplies for Client Visit

Patient Education

Client education materials that include information on asthma, asthma triggers, managing asthma, asthma medications, tobacco cessation programs, and other community resources or guides may be part of the client packet.

Medication demonstration toolbox

Took box may include tester or demo versions of various types of inhalers, holding chambers and/or peak flow meters.

Durable Medical Equipment

Durable Medical Equipment (DME) for asthma management is a valuable resource for trigger mitigation in the home. If your asthma program has funding available through your agency, grants, or other finance streams, consider the following for inventory and distribution.

Programs may choose to have routinely distributed products on hand and less common items to be ordered on an as-needed basis upon assessment of client asthma triggers.

Products to Consider*

- HEPA vacuum
- Filtration-type air cleaning devices
- Bed encasements
- Pillow encasements
- Holding chambers
- Dehumidifiers
- Furnace filters
- Cleaning products

** Research may need to be done on products—the resources to follow may assist you in gathering information on the best products to purchase for your program.*

Environmental Health Resources (Durable Medical Equipment)

- **The Asthma Home Environmental Checklist** developed by the EPA, CDC, & HUD provides information on identifying environmental triggers in the home along with strategies to reduce these triggers that includes providing durable medical equipment
- **EPA Guide to Air Cleaners** – guide to portable air cleaners and furnace or Heating, Ventilating, and Air Conditioning (HVAC) filters in the home
- **California Air Resource Board** provides information on selecting a safe and effective air cleaner
- **The Association of Home Appliance Manufacturers (AHAM) site**: Discussion of Clean Air Delivery Rates (CADR)
- **Make your own solutions** – American Academy of Allergy Asthma & Immunology resource for safe cleaning practices and solutions for those with asthma

Where Can I Order Products From?

Local hardware stores or large box retail stores vary by regional area. Or online vendors.

Consider lead time and best cost practices when deciding which products or supplies to purchase.

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SECTION NINE

PROGRAM COMMUNICATION AND MARKETING

PROGRAM COMMUNICATION AND MARKETING

Promotion and Marketing

Collateral

Marketing materials for your asthma program can take a variety of forms, including:

- Downloadable (web-based) documents
- Printed outreach materials
- Digital e-mail communications (template)
- Power Point presentation
- Video
- Social Media – Facebook, Instagram, Twitter, LinkedIn

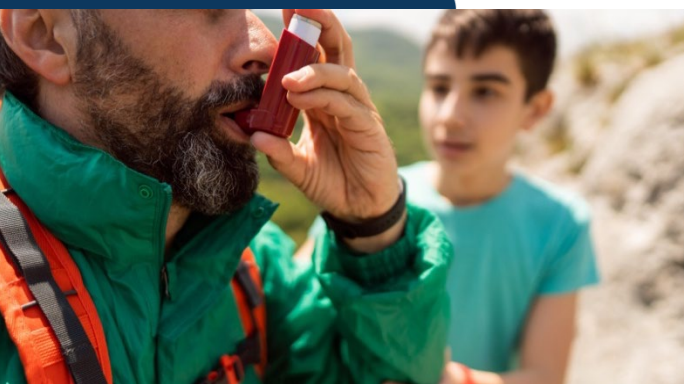
Outreach: Internal and External

Internal

Consider internal communication announcements or postings on various internal platforms to support outreach opportunities to heighten awareness about your asthma program. This will support the initial and continued generation of referrals.

Internal outreach may consist of presenting to or attending meetings in other agency departments and/or provision of marketing materials to programs that engage with your target audience.

> ***Example:*** *At Dakota County, internal marketing includes regular attendance at other department unit meetings (Family Health, Disease Prevention and Control, Emergency Preparedness, Health Promotion, WIC)*



External

Consider external outreach strategies through virtual or in-person meetings. Potential outreach partners may include:

- Local clinics
- Hospitals
- Schools
- Community or club organizations
- Faith-based communities

Outreach can also be via e-mail/phone or mailed information to key partners or organizations. Provide referral process information to the Minnesota Department of Health for additional technical and communication support to increase program awareness.

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SECTION TEN

DATA COLLECTION, EVALUATION, AND QUALITY

DATA COLLECTION, EVALUATION, AND QUALITY

Data Collection

After program establishment, you may want to consider adding data collection, reporting, and analysis processes to your program. Data collection will be unique to your agency depending on agency reporting requirements and your ability to pull reporting from your electronic health record. During implementation of your program, consult your data analyst or technical lead about any electronic health record build-out that may support asthma program reporting.

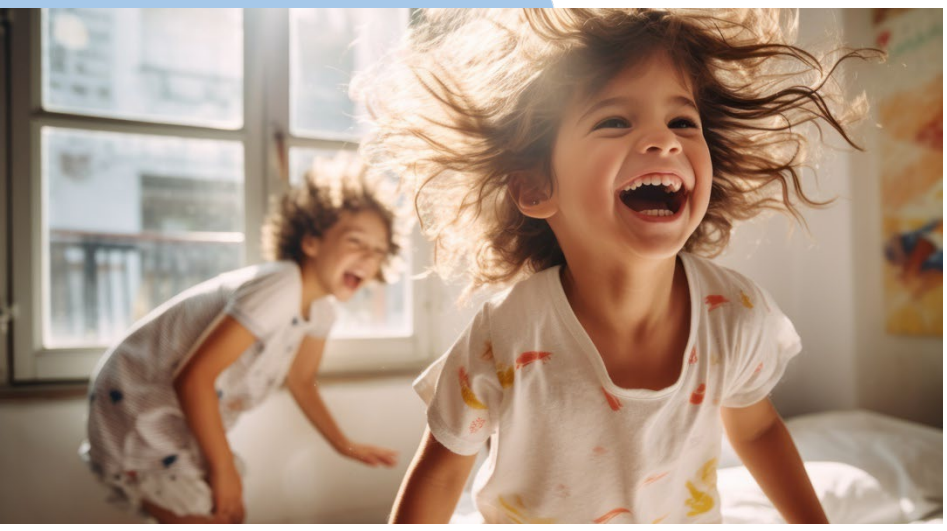
Internal Agency Reporting

Your agency may require reporting to a health board or county board. Some data collection methods to consider, depending on electronic health record capabilities:

1. Electronic health record (EHR) data pull
2. Asthma Control Test results
3. Staff time reporting entries
4. Consider internal monthly reporting for program evaluation that includes:
5. Number of referrals
6. Referral sources
7. Number of asthma home visits completed
8. Initial
9. Follow-up
10. Completion
11. Number of outreach attempts
12. Caseload analysis
13. Breakout of type of visit (virtual, in person, initial, follow up)

Example of Dakota County reporting via PHDoc (their EHR):

- **Asthma Visits Report** – Quarterly aggregate data from client visit documentation providing the total number of asthma home visits completed by AHBS staff and further delineating by type of visit, for example initial visit, follow up, education, etc.
- **Asthma Visits Billed Report** – Quarterly aggregate data capturing the number of visits billed to medical assistance or pre-paid medical plans.
- **Asthma Time by Activity Code** – Quarterly report from staff time that is entered each month into EHR and provides a report noting the amount of indirect or direct staff time that was used for each program. This would include time for home visits, meetings, case management and program planning.
- **Caseload Analysis Report** – Staff report for management denoting number of clients a staff is working with each month – this is helpful when evaluating staffing and for program planning.
- **Referral Reports** – Information on number of referrals received monthly by source to guide outreach efforts. Determine overall number of asthma referrals received monthly for staffing and programmatic changes



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