Putting on AIRS
Asthma Self Management

10/3/2019
Sherry Carlson  RN
POA Coordinator

Connecticut River Area Health District
What is Putting on AIRS

Putting on AIRS is an Asthma self-management program that follows the standards set by the National Heart, Lung and Blood Institute.

- The mission of the program is to reduce asthma associated morbidity and mortality and improve the quality of life for Connecticut residents living with asthma.

<table>
<thead>
<tr>
<th></th>
<th>CT Children</th>
<th>US Children</th>
<th>CT Adults</th>
<th>US Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>9.6 %</td>
<td>9.2 %</td>
<td>9.2 %</td>
<td>8.9 %</td>
</tr>
<tr>
<td>2015</td>
<td>11.7 %</td>
<td>8.5 %</td>
<td>10.5 %</td>
<td>8.8 %</td>
</tr>
<tr>
<td>2016</td>
<td>11.0 %</td>
<td>8.3 %</td>
<td>10.5 %</td>
<td>8.3 %</td>
</tr>
</tbody>
</table>

DISEASE BURDEN:
ASTHMA ACUTE CARE CHARGES = $135 Million (2014)
Home Based Asthma Program

- Based on Wee Breathers Curriculum, developed by the Asthma & Allergy Foundation of America (AAFA)
- Aligned with the NAEPP-EPR3 Asthma Guidelines & CDC Community Guide Recommendations
- Evidence-based program: protocol adapted from the Seattle King County Asthma Program (Krieger)
- Supported by CDC National Center for Environmental Practice, Asthma and Community Health Division of Environmental Health Science and Practice, Asthma Community Health Branch
PUTTING ON AIRS BY REGION

Connecticut Department of Public Health
Putting on Airs (POA) regions. 2019 proposed changes (R5).

Asthma Program
Connecticut
## CT Towns with Highest ED Visit Rates (2017)

<table>
<thead>
<tr>
<th>TOWNS</th>
<th>Child Age-Adjusted</th>
<th>Adult Age-Adjusted</th>
<th>Town Age-Adjusted</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hartford</td>
<td>297.8</td>
<td>169.8</td>
<td>202.8</td>
<td>2501</td>
</tr>
<tr>
<td>Waterbury</td>
<td>261.2</td>
<td>141.7</td>
<td>172.5</td>
<td>1864</td>
</tr>
<tr>
<td>New Britain</td>
<td>207.3</td>
<td>148.8</td>
<td>163.8</td>
<td>1152</td>
</tr>
<tr>
<td>New London</td>
<td>236.7</td>
<td>130.8</td>
<td>158.1</td>
<td>392</td>
</tr>
<tr>
<td>New Haven</td>
<td>208.4</td>
<td>88.3</td>
<td>119.3</td>
<td>1514</td>
</tr>
<tr>
<td>Norwich</td>
<td>146</td>
<td>103.2</td>
<td>114.2</td>
<td>440</td>
</tr>
<tr>
<td>Windham</td>
<td>142.3</td>
<td>99.5</td>
<td>110.5</td>
<td>249</td>
</tr>
<tr>
<td>Bridgeport</td>
<td>166.8</td>
<td>89.7</td>
<td>109.6</td>
<td>1630</td>
</tr>
<tr>
<td>Plainfield</td>
<td>139.7</td>
<td>98.9</td>
<td>109.4</td>
<td>158</td>
</tr>
<tr>
<td>Meriden</td>
<td>106.2</td>
<td>85.0</td>
<td>90.4</td>
<td>522</td>
</tr>
<tr>
<td>Connecticut</td>
<td>92.7</td>
<td>46.8</td>
<td>58.6</td>
<td>18,853</td>
</tr>
</tbody>
</table>
### ED Visit Rates (per 10,000) for Region 5 (2017 Data)

<table>
<thead>
<tr>
<th>Region 5 Towns</th>
<th>ED Adjusted Rates</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Westbrook</td>
<td>51.8</td>
<td>28</td>
</tr>
<tr>
<td>Middletown</td>
<td>49.8</td>
<td>217</td>
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<tr>
<td>Chester</td>
<td>40.3</td>
<td>14</td>
</tr>
<tr>
<td>East Hampton</td>
<td>38.8</td>
<td>50</td>
</tr>
<tr>
<td>Portland</td>
<td>30.1</td>
<td>24</td>
</tr>
<tr>
<td>Middlefield</td>
<td>25.8</td>
<td>8</td>
</tr>
<tr>
<td>Old Saybrook</td>
<td>25.4</td>
<td>25</td>
</tr>
<tr>
<td>East Haddam</td>
<td>24.3</td>
<td>20</td>
</tr>
<tr>
<td>Deep River</td>
<td>23.6</td>
<td>11</td>
</tr>
<tr>
<td>Clinton</td>
<td>22.5</td>
<td>29</td>
</tr>
<tr>
<td>Killingworth</td>
<td>20.6</td>
<td>10</td>
</tr>
<tr>
<td>Cromwell</td>
<td>18.1</td>
<td>21</td>
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<tr>
<td>Essex</td>
<td>16.0</td>
<td>10</td>
</tr>
<tr>
<td>Durham</td>
<td>15.7</td>
<td>9</td>
</tr>
<tr>
<td>Haddam</td>
<td>9.4</td>
<td>7</td>
</tr>
<tr>
<td>REGION 5</td>
<td>------</td>
<td>483</td>
</tr>
<tr>
<td>CT ED RATE</td>
<td>58.6</td>
<td>18,853</td>
</tr>
</tbody>
</table>
Putting on AIRS consist of 3 one on one sessions with an Asthma Educator and Community health worker (min. one session inside the home) that provide the following:

1. Education on Asthma Pathophysiology, medication review and confirmation of medications Provider has ordered; Inhaler techniques; Asthma management, obtain and review written asthma action plan per provider; use of spacer; with return demonstration

2. Environmental specialist will evaluate the home for potential Asthma triggers and educate on potential solutions to alleviate the trigger.

3. Community Health care workers also help to link families to community services that will help address health disparities, barriers to health, or gaps in care.
Eligibility

- Poorly Controlled as defined by Asthma Control Test (<19)
- > 1 ED visit or hospitalization or unscheduled medical visit in last 6 months
- Non Adherence to inhaled Corticosteroids
- Self-Administered of 3 rescue inhaler canisters in 6 months
- Activity limits due to Asthma
- School Absences: missed > 2 school days in the last year
- School nurses office visit > 2 times per week due to Asthma
- Work Absenteeism: missed > 2 work days in the past year

Referral must meet ONE or More of the above criteria.
POA Protocol

HCOs
Hospitals-
Community
Providers-
FQHCs
School Nurses

REFERRALS

POA Coordinator from each Regional Agency

Initial CALL

Disposition letter

Visit 1

Visit 2

Visit 3

6 months Follow-up Call

1-3 weeks

2-6 weeks

4-16 weeks

24-28 weeks

Progress Report
Core Elements of a Home Visit

**ASTHMA EDUCATION:**
- What is Asthma
- Medications and Devices
- Asthma Action Plans

**HOME EXPOSURE ASSESSMENT TO ASTHMA TRIGGERS**
- PETS - CHEMICALS
- SMOKING- WOOD
- SMOKE-DUST-PESTS
- ENVIRONMENTAL RECOMMENDATIONS

**ADDITIONAL ELEMENTS:**
- Home Cleaning
- Allergen Avoidance Supplies
- Educational Materials

**PARTNERING & RESOURCES:**
- Communications with providers, pharmacists, School Nurses, Healthy Homes, Services in Community, Smoking Cessation, Remediation etc.

**CHILD/ADULT/FAMILY**
How to Refer to Putting on AIRS

**How to Introduce “Putting on AIRS” to Patients**

As patients trust their health providers, receiving the information about the POA Program directly from them is critical in facilitating the patients’ decision and desire to participate.

When referring patients to the “Putting on AIRS” (POA), it is essential to:

1) **Describe briefly what the POA is about:**
   - Over the next 6 months: you will have 3 visits with an Asthma Educator, who will review asthma pathophysiology, prescribed medications, how to use different inhalers, work closely with you so you can better manage your asthma symptoms. Educational materials will also be provided to you.
   - At least one visit will be in your home with an Environmental Specialist to educate you about asthma triggers in the home and to conduct a home assessment and help you on how to eliminate triggers.

2) **Obtain permission from your patient to be referred to the POA**

3) **Tell your patients that they should expect a phone call from the Coordinator of the POA program to enroll them.**

4) **Complete referral form and submit to the WHD POA Coordinator**

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**Putting on AIRS**

**PHYSICIAN REFERRAL FORM**

Connecticut River Area Health District

**Patient Name:** ______________________________  
**DOB:** ______________________

**Parent/Guardian Name:** ______________________________

**Address (Street/City/Zip):** ______________________________

**Phone Number:** ____________________  **Alternate #:** ______________________________

**Preferred Language:** ______________________________

**Diagnosis of Asthma in past 12 months** [ ]  **Diagnosis of Asthma over 1 year ago** [ ]

**Asthma Action Plan REQUIRED prior to first home visit. Please send with referral.**

**Documentation pertaining to legal guardian REQUIRED if not parent. Please send with referral.**

**Eligibility requirements: one or more of the following criteria. Check all that apply:**

- Poorly Controlled as defined by Asthma Control Test (<19)
- >1 ED visit or hospitalization or unscheduled medical visit in the last 6 months
- Non adherence to inhaled Corticosteroids
- Self-Administered 3 rescue inhalers in 6 months
- Activity limits due to asthma
- School Absences: missed > 2 school days in the last year
- School nurses office visit > 2/week
- Work Absenteeism: missed > 2 work days in the last year

**Areas of Concern:**

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**Physician Name:** ______________________________

**Name of Practice:** ______________________________

**Address (Street/City/Zip):** ______________________________

**Phone Number:** ______________________________

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**PLEASE FAX THIS FORM TO:**

Putting on AIRS  
**Email:** puttingonairs@ct.gov

**Office:** 860-661-3333  **Cell:** 860-227-8492

For information or questions contact Sherry Carlson, Region 5 Putting on AIRS Coordinator

Office: 860-661-3300 / Cell 860-227-8492
Putting on AIRS Coordinator will give primary care providers feedback on results of visits, concerns in the home that may be affecting outcomes, compliance with treatment regiment prescribed by provider and also informing provider should the family no longer agree to participate in the program.

February 19, 2018

XXXXXHealth Center
XXXXXXX Ave
New Haven, CT 06511
Attn: Dr. XXXXXXX

Re: Putting on AIRS-Asthma Self-Management program

Your patient xxxxxxx was referred to the Putting on AIRS program by the Yale New Haven Health System Pediatric Emergency Department. An initial home visit was completed on February 2nd. With a follow up visit scheduled on February 23rd. Enclosed is the signed release which permits the program to make available the summary of the visit. In addition, you will find his completed “Test for Respiratory and Asthma Control in Kids” (TRACK) which is taken from the Measures of Asthma Assessment and monitoring document page 67; “Patient Self-Assessment” (EPR-2 1997). The TRACK was completed during the visit by xxxxxx mother xxxxxx.

During the initial visit, staff reviewed in detail using model lungs, asthma video, illustrated, and written instructions to teach asthma pathophysiology, the purposes, preferred delivery methods, and care of his prescribed asthma medications. In addition, the environmentalist assessed the home, and provided education on known and potential asthma triggers. As well as, provided non-allergen bedding and assorted cleaning supplies to aid in reducing dust mite exposure. All supplies were delivered at no expense from the New Haven Health Department Triggers Be Gone program. Before completing the visit, Ms. xxxxx was provided an opportunity to “teach back” her medication delivery skills, and comprehension of the asthma management discussion.

A brief summary of some of the recommendations include:

1. Obtain an Asthma Action plan to reinforce the remembering of the medication plan. As noted xxxxxx
2. Talk over the TRACK score with your office – 30/100.
3. Reducing exposure to second and third hand smoke; four people in the home smoke in the house.

See the enclosed report for additional recommendations and details.

Please let me know any questions.

In Good Health,

Sherry Carlson RN
Region 5 Putting on AIRS
Coordinator/Asthma Educator
860-661-3000

Encl: In-Home Summary
TRACK
Release of Information
Copy of referral
Data 09/01/2016-04/01/18 on Referrals and participation in program.

- For the State of CT: 9/01/2016- 4/1/2018

- 843 Patients referred
- 645 Patients were eligible
- 434 Consented to participate
Goals for 2019-2024
Related to Environment

• Engage in Environmental Policies that reduce Asthma Triggers:
  • Work local/regional partners to support the reduction of diesel emissions: identify data
  • Work with local organizations that offer low-cost home remediation services (weatherization, energy efficiency)
  • Work towards reducing asthma triggers in the workplace
    • Disseminate information about workplace air quality
    • Identify working sectors most affected by workplace air quality

• Continue to increase provider referrals and compliance to complete all three home visits of referred patients to Program.
Thank you for your Time and Attention Questions???