**V ISIT # 1**

**Form entered in database Visit #2 scheduled**

**The purpose of this interview is to collect information about you and your home environment as it relates to your asthma and safety. These questions are to guide the type of help you will receive. You do NOT have to answer any questions you do not want to. Your responses will not affect any of the services at the clinic or from your provider.**

**1. How did you hear about the Clean Air for Kids program?** ***[check all that apply]***

 Health Care Provider  Other Agency

 Asthma Education Class  School/Day Care

 Newspaper  TV/Radio Ads

 Friend/Relative/Neighbor  Health Department

 Health Department Mold Line

 Community Event/Health Fair

 Flyer/Brochure *(Other than those received from schools/events)*

 Other:

**2. Why did you decide to have an in-home assessment?**

***[check all that apply]***

 Asthma/ RAD  Smoking

 Mold  Allergies

 Other:

**3. Do you have a primary concern about the health of your home? *[check all that apply]***

 Pet dander/fur  Poor ventilation

 Tobacco smoke  Wood/other smoke

 Mold/mildew/ moisture

 Dust/dust mites/track-in contaminants

 None

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. What type of residence is your home?**

 House Multiplex

 Condo Mobile/Manufactured Home

 Apartment

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. What year was your home built? *(Check County Assessor)***

 1800-1900 1985-1995

 1900-1950 1995-2005

 1950-1975 2005-current

 1975-1985 Not Sure

**6. What race/ethnicity do you identify with?**

 Hispanic or Latino

 Caucasian (not Hispanic or Latino)

 African American (not Hispanic or Latino)

 Native Hawaiian or other Pacific Islander

 Asian (not Hispanic or Latino)

 American Indian or Alaska Native

 Two or more races (not Hispanic or Latino)

 Not Sure

**7. What is your household income?**

 Less than $6,000 $30,000-$40,000

 $6,000-$12,000 $40,000-$50,000

 $12,000-$18,000 $50,000-$60,000

 $18,000-$24,000 $60,000-$70,000

 $24,000-$30,000 More than $70,000

**8. Do you or anyone else in the household smoke or chew tobacco?**

 Yes No

**If yes, do you/they want to quit using tobacco within the next 20-30 days?**

 Yes No

**ASSESSOR - If YES,**

1. **ASK** about tobacco use, and if ready to quit within 20-30 days

2. **ADVISE** to quit

3. **REFER** to appropriate service provider

(1-800-QUIT-NOW or QUITLINE.COM)

**Talking Points**

- Every time you quit is a success/learned something new each time

- Takes 1-3 days to quit and the 1st 3 to 4 days are most difficult to overcome the nicotine addiction

|  |  |  |
| --- | --- | --- |
| Assessor Name: | | Visit date: |
| Client Name: | Environmental Findings:  CO2 \_\_\_\_\_\_\_\_\_ Temp \_\_\_\_\_\_\_\_ RH \_\_\_\_\_\_\_\_\_\_ | |

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Three Visit Model Tool Kit: Appendix 2

Home Visit 1 Form

For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY 711).

DOH 345-341 August 2014

**9. Please tell us about everyone that lives in your home, beginning with yourself.**

|  |  |
| --- | --- |
| **Name:** | **Name:** |
| **Gender:** Male Female | **Gender:** Male Female |
| **Age:** 0-10 10-18 18-25  25-35 35-45 45-60  60-80 80+ | **Age:** 0-10 10-18 18-25  25-35 35-45 45-60  60-80 80+ |
| **Years lived at** 0-5 5-15 15-25  **this address:** 25-40 40+ | **Years lived at** 0-5 5-15 15-25  **this address:** 25-40 40+ |
| **Asthma?** No Yes | **Asthma?** No Yes |
| **Severe Allergies?** No Yes | **Severe Allergies?** No Yes |
| **Tobacco Use?** No Yes  **If yes, how much?** | **Tobacco Use?** No Yes  **If yes, how much?** |
|  |  |
| **Name:** | **Name:** |
| **Gender:** Male Female | **Gender:** Male Female |
| **Age:** 0-10 10-18 18-25  25-35 35-45 45-60  60-80 80+ | **Age:** 0-10 10-18 18-25  25-35 35-45 45-60  60-80 80+ |
| **Years lived at** 0-5 5-15 15-25  **this address:** 25-40 40+ | **Years lived at** 0-5 5-15 15-25  **this address:** 25-40 40+ |
| **Asthma?** No Yes | **Asthma?** No Yes |
| **Severe Allergies?** No Yes | **Severe Allergies?** No Yes |
| **Tobacco Use?** No Yes  **If yes, how much?** | **Tobacco Use?** No Yes  **If yes, how much?** |
|  |  |
| **Name:** | **Name:** |
| **Gender:** Male Female | **Gender:** Male Female |
| **Age:** 0-10 10-18 18-25  25-35 35-45 45-60  60-80 80+ | **Age:** 0-10 10-18 18-25  25-35 35-45 45-60  60-80 80+ |
| **Years lived at** 0-5 5-15 15-25  **this address:** 25-40 40+ | **Years lived at** 0-5 5-15 15-25  **this address:** 25-40 40+ |
| **Asthma?** No Yes | **Asthma?** No Yes |
| **Severe Allergies?** No Yes | **Severe Allergies?** No Yes |
| **Tobacco Use?** No Yes  **If yes, how much?** | **Tobacco Use?** No Yes  **If yes, how much?** |

**ASSESSOR**

1. **Explain basic facts about Asthma:**

1. The role of inflammation, mucous, and bronchospasms.

2. What happens to a person’s airways during an asthma attack?

1. **Have each person with asthma fill out the “ACT” or “TRACK” appropriate for their age.**
2. **Explain what “well controlled” means.**

Asthma patients are considered to have

“well controlled asthma” when:

1. Daytime symptoms are fewer than two days per week

***AND***

2. Waking up at night from asthma symptoms occurs less than two times a month

***AND***

3. There are no limitations of activities

**10. Questions for Children with Asthma, ages 1-3**

|  |  |
| --- | --- |
| During the past **4 weeks, how many days** of work did you miss due to your child’s asthma? | **4+ 3 2 1 0**  ***(Circle One)*** |
| In the **last year, how many times** has your been hospitalized due to asthma? | **4+ 3 2 1 0**  ***(Circle One)*** |
| In the **last year, how many times** has your child visited the Emergency Room due to asthma? | **4+ 3 2 1 0**  ***(Circle One)*** |
| In the **last year, how many times** has your child visited Urgent Care or had a same day visit with their provider due to asthma? | **4+ 3 2 1 0**  ***(Circle One)*** |

**11. Questions for Children with Asthma, ages 4-11**

|  |  |
| --- | --- |
| During the past **4 weeks, how many days of school/daycare** did your child miss due to asthma? | **4+ 3 2 1 0**  ***(Circle One)*** |
| During the past **4 weeks, how many work days** did you miss due to your child's asthma? | **4+ 3 2 1 0**  ***(Circle One)*** |
| In the **last year, how many times** has your child been hospitalized due to asthma? | **4+ 3 2 1 0**  ***(Circle One)*** |
| In the **last** year, how many times has your child visited the Emergency Room due to asthma? | **4+ 3 2 1 0**  ***(Circle One)*** |
| In the **last year, how many times** has your child visited Urgent Care or had a same day visit with your provider due to asthma? | **4+ 3 2 1 0**  ***(Circle One)*** |

**12. Questions for Adults with Asthma, ages 12 & up**

|  |  |
| --- | --- |
| During the past **4 weeks, how many days** of school or work did you miss due to asthma? | **4+ 3 2 1 0**  ***(Circle One)*** |
| In the **last year, how many times** have you been hospitalized due to asthma? | **4+ 3 2 1 0**  ***(Circle One)*** |
| In the **last year, how many times** have you visited the Emergency Room due to asthma? | **4+ 3 2 1 0**  ***(Circle One)*** |
| In the **last year, how many times** have you visited Urgent Care or had a same day visit with your provider due to asthma? | **4+ 3 2 1 0**  ***(Circle One)*** |

**13.Does the person/people with asthma have a health care provider that they see for respiratory care?**

 No

List anyone with asthma who ***does not*** see a health care provider for respiratory care, and the reason:

 Yes

List anyone with asthma who ***does*** see a health care provider for respiratory care, their provider’s name, clinic, and date of the last visit:

**ASSESSOR**

**Have the person/ people with asthma demonstrate their inhaler/spacer technique.**

**14. Has the person/people with asthma been shown how to correctly use their medication(s) by their health care professional?**

 No, how many:

List anyone with asthma who has not had a health care professional explain it to them:

 Yes, how many:

List anyone with asthma who has had a health care professional explain it to them:

**15. Does the (person/people with asthma) demonstrate how to correctly use their inhaled medication?**

 Yes\_\_\_ No\_\_\_ Does not have medication\_\_\_

**16. On average, per week, how often do you use your control medication as prescribed?**

 As Prescribed- All doses are taken per week

 5- 6 days per week

 3-4 days per week

 1-2 days per week

 Not at all

 Have not been prescribed control medication

**If not at all, why are they not using medication as prescribed?**

**16. In the past year, has a care provider developed an ASTHMA ACTION PLAN and reviewed it with the person/people with asthma?**

 No

List anyone with asthma who ***does not*** have an

Action Plan:

 Yes

List anyone with asthma who ***does*** have an Action Plan, their provider’s name, clinic, and date of the last time the plan was updated:

**Name:** Provider: Clinic:

Date of Last Plan Update:

**Name:** Provider: Clinic:

Date of Last Plan Update:

**Name:** Provider: Clinic:

Date of Last Plan Update: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSESSOR**

**Explain what an Action Plan is and give one to the resident to take to a health care provider.**

Review the following actions:

 Take daily actions to control asthma

 Assess level of asthma control

 Monitor symptoms

 Recognize early signs and symptoms of worsening asthma

 Adjust rescue medication in response to signs of worsening asthma

 When to seek medical care

**ASSESSOR : Discuss any suggestions that apply to the resident. Check one box for every suggestion.**

**17. Tasks & Messages**

|  |  |  |  |
| --- | --- | --- | --- |
| **Task and Message for Asthma** | **Recommend** | **Compliant** | **Does Not Apply** |
| Asthma will be better and worse at times. Track all symptoms in the journal provided. Write down where you were, what time of day, and what you were doing to establish triggers.  **ASSESSOR: Explain Symptom Journal** |  |  |  |
| If you have a health care provider, make an appointment to be seen for asthma if you have not been recently.  Adults with asthma should see their provider at least once a year. Children with asthma should see their provider at least every six months. |  |  |  |
| If you do not have a health care provider, attempt to make an appointment for asthma management at one of the clinics suggested.  **ASSESSOR: Give Free Clinic or other local resources brochures.** |  |  |  |
| Use the form provided to you to develop an Action Plan with a health care provider. Update it every year or when there are changes in your condition. |  |  |  |
| Use spacers and/or masks as directed when using inhaled medications. Use the information provided on how to use inhaled medications properly.  **ASSESSOR: Give client a spacer and show them how to use it. Hand out written instructions.** |  |  |  |
| Use controller medications if prescribed by your provider. Asthma is not controlled if using rescue medication more than 2 times a week. Let your provider know if your asthma is not controlled. |  |  |  |
| The goal is to have well controlled asthma. The second visit to learn more about reducing asthma triggers at home is scheduled for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **ASSESSOR: Give client their copy of tasks/messages.** |  |  |  |

|  |  |  |
| --- | --- | --- |
| **ASSESSOR: Supplies given to family. Check all that apply** | | |
|  Pillow cover   Mattress cover   Spacer   Nebulizer |  Mold DVD   Mold packet   Hygrometer   CO detector |  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**ASSESSOR: Length of Assessment**

 30 - 60 minutes 90 - 120 minutes  60 - 90 minutes 120 + minutes