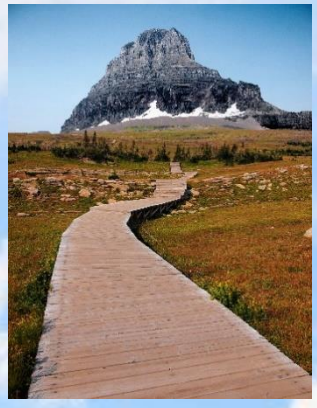
# Montana Asthma Plan
## 2020-2025

MONTANA DPHHS
*Healthy People. Healthy Communities.*
Department of Public Health & Human Services






PublicHealth IN THE 406

MONTANA ASTHMA CONTROL PROGRAM

# Acknowledgements

The following people contributed their time to the development of this strategic plan:

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## Contributing Organizations

American Lung Association
Association of Asthma Educators
Bullhook Community Health Center
Centers for Disease Control — National Asthma Control Program
Family Allergy and Asthma Care of Montana
Montana Academy of Pediatrics
Montana Association of School Nurses
Montana County Health Departments
Montana Department of Environmental Quality
Montana Diabetes Program
Montana Disability and Health Program
Montana Hospital Association
Montana Office of Public Instruction
Montana Tobacco Use Prevention Program
Montana VA Health Care System
Sunny View Pediatrics
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# Purpose

To address the burden of asthma in Montana, the Montana Asthma Control Program (MACP) was created in July 2007 with funding allocated by the MT State Legislature. The MACP was awarded additional funding in the form of 5-year competitive grants from the CDC's National Asthma Control Program in 2009, 2014, and 2019. The program is housed within the Public Health and Safety Division (PHSD) of the MT Department of Public Health and Human Services (DPHHS). Since its inception, the MACP has focused on addressing asthma from a public health perspective within the unique context of rural MT by developing an asthma surveillance system for the state, forging meaningful, multidisciplinary partnerships with stakeholders statewide, and implementing feasible, evidenced-based interventions. The MACP is committed to improving the quality of life for all Montanans with asthma.

The Strategic Asthma Plan was written with input from asthma experts across Montana. The MACP is committed to improving the quality of life for all Montanans with asthma, and actively considers health disparities and inclusion of the most vulnerable populations. The MACP will implement activities through a comprehensive and coordinated approach, reduce duplication, and increase the efficiency of the staff and partners, while leveraging limited resources. This approach includes addressing standards and policies to improve access to asthma control services that affect groups of people (communities, schools, worksites); increasing Montanans' awareness of asthma triggers, disease self-management, and resources (community programs, home-based trigger reduction services, payer sources); working with health care providers to implement quality improvement (QI) strategies that improve delivery and use of clinical services; and linking clinical and community resources.

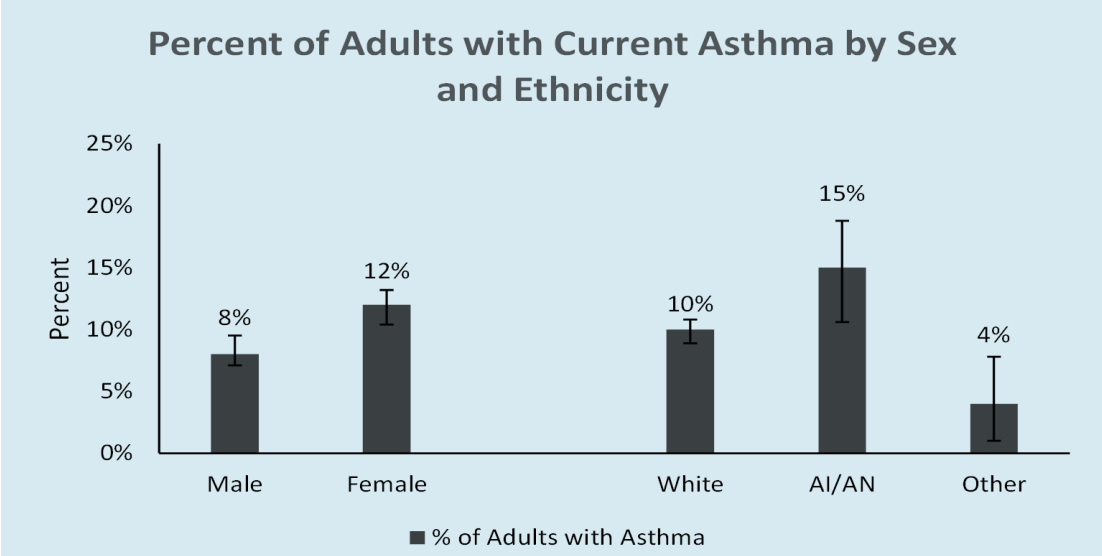
This plan is designed for use by agencies, communities and individuals within Montana that have an interest in addressing the problem of asthma. In the attempt to achieve a balance of aspirational and practical interventions and approaches, the plan is built upon MACP experience, program evaluation findings, surveillance strengths, core competencies of partnering organizations, and new evidence regarding intervention effectiveness and feasibility. Its purpose is to provide structure for coordinated activities across the state to mobilize individuals, organizations, communities, and state and local agencies to collectively take action on asthma over the next five years. Some objectives are easier to implement than others, but they all demonstrate beneficial practices.

We anticipate each individual and organization using this plan will prioritize their efforts based on what they can achieve with their expertise and resources. This document can serve as a resource, providing organizations a choice of options to achieve their goals. Successful implementation of this plan will further reduce the significant burden of asthma in Montana; ensure the appropriate prevention, diagnosis, and management of asthma for individuals in all settings; reduce asthma disparities; and significantly improve the quality of life for Montanans affected by asthma.

Long- term outcomes will contribute to the CDC's goal of preventing 500,000 hospitalizations and emergency department visits among children with asthma within five years, also known as the Controlling Childhood Asthma and Reducing Allergies (CCARE) initiative.

# Asthma Control in Montana

Asthma is a prevalent chronic condition among Montanans and can have serious health implications if not properly managed. In 2019, 10% of adults and 7% of children (aged 0-17 years) reported currently living with asthma. People with poorly managed asthma suffer from a lower quality of life, reduced activity and productivity, missed days of work or school, frequent ED visits or hospitalizations, and – although rare – death may occur. There were 2,003 Emergency Department (ED) visits and 271 hospitalizations for asthma in that same year. Asthma prevalence was mapped according to the 13 MT Chronic Disease regions and does not vary statistically across the state (range 7.5%-10.4%). However, a higher rate of asthma-related hospital and ED discharges are localized to the central and eastern part of the state, many regions overlapping with American Indian (AI) reservations. Though asthma mortality rates have decreased, asthma deaths still occur. Asthma mortality rates dropped from 9 per million MT residents per year in 2008-2010 to 3 per million residents per year in 2016-2018. Although there is no cure, there are safe, effective ways to control asthma so that individuals can live a normal, active, symptom free life.




*Data Source: 2019 Behavioral Risk Factor Surveillance System*

Although the reasons are unclear, disparities exist between Native Americans and whites and in younger versus older age groups in ED visits and hospitalizations due to asthma[1]. Factors may include severity of disease, a lack of access to health care services, the quality of health care received, lack of opportunities for asthma self-management education, and a range of potential environmental health issues.

***About 50% of adults and 37% of children with asthma report limiting their activities because of asthma.***

***A typical charge for an asthma related hospital stay in 2019 was $13,897.***

The goals, objectives and strategies contained in the 2020-2025 Montana Asthma Plan are directed at improving the lives of Montana citizens with asthma and are considered feasible to implement in the next 5 years. Successful implementation will come only through continued collaboration between public, private, and non-profit partners.

*1. Agency for Healthcare Research and Quality. (2018). NATIONAL HEALTHCARE QUALITY & DISPARITIES REPORT. AHRQ. https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2018qdr-final.pdf*

# Guiding Principles

The MACP has identified a set of guiding principles to inform program strategies and actions and the development of partnerships, including cross-agency partnerships. These guiding principles establish a framework for the MACP and its partners to act collectively to implement comprehensive programs that are efficient, effective, and sustainable. These principles align with those identified in the State Health Improvement Plan and are expected to guide future action to address asthma in Montana.

1. Equity
   Achieve health equity by addressing the social determinants of health, expanding activities into rural communities, and partnering with communities and American Indian tribes to reduce health disparities.
2. Collaboration and Partnerships
   Identify potential linkages and act upon opportunities to cooperate and partner responsibly to achieve greater impacts than can occur in isolation. All health care and public health partners understand, accept and fulfil their roles and responsibilities to ensure enhanced health outcomes for all Montanans.
3. Access to Guidelines Based Care and Community Support Services
   Guidelines-based asthma care, Asthma Self-Management Education (ASME), and appropriate support services are available, accessible and affordable for all Montanans.
4. Evidence-Based
   Relevant and current evidence informs best practices and strengthens the knowledge base to effectively prevent and manage asthma and other chronic conditions. The use of consistent, quality, and real-time data sharing enables monitoring and quality improvement to achieve better health outcomes
5. Patient-centered approaches
   The health care system is designed to recognize and value the needs of individuals, their caregivers and their families, to provide coordinated care and support.

# Cross Cutting Themes

These themes were identified by strategic planning partners as critical to the success of the MACP over the next 5 years. Themes are incorporated into the goals, objectives, and strategies in this plan.

## Leveraging Technology

Technology touches nearly every part of our lives, including our health care. The MACP will explore how technology can improve asthma care, communication, ASME, and program interventions.

## Social Determinants of Health

The social determinants of health (SDOH) are the social circumstances in which people live, work, and play. The MACP will leverage new and existing partnerships to address the social determinants that lead to asthma disparities in Montana.

## Advocacy

MACP is dedicated to providing data and support for partner organizations advocating for policies that improve patient care and asthma-friendly community environments.

# EXHALE Strategies

Services such as asthma home visiting education; health care quality improvements to achieve guidelines-based care; a network of strategic partners; and many others contribute to the MACP's goal of a healthier Montana. Notably, the program seeks to improve quality of life, reduce asthma morbidity and mortality, diminish disparities, and sustain its services. To attain this vision, the MACP has integrated the EXHALE technical package, provided by the National Asthma Control Program, into its decision-making and planning.

Six strategies are proposed in the technical package:

1. **E**ducation on asthma self-management.
2. e**X**tinguishing smoking and secondhand smoke.
3. **H**ome visits for trigger reduction and asthma self-management education.
4. **A**chievement of guidelines-based medical management.
5. **L**inkages and coordination of care across settings.
6. **E**nvironmental policies or best practices to reduce asthma triggers from indoor, outdoor, and occupational sources.

The EXHALE strategies are complementary and intended to work in combination to reinforce each other. They connect program resources, infrastructure, and activities to short-term, intermediate, and long-term goals. The different action-steps, services, events, or infrastructure of the MACP are called activities. Because activities may invoke multiple EXHALE strategies, they have been assigned to all that are applicable.

Progress towards the short-term and intermediate goals will be measured by program evaluations. As the short-term objectives are met, it is believed that intermediate changes will gradually occur. Intermediate changes will subsequently drive broader long-term changes, progressing towards the vision of a healthier Montana.

# Key Priority Areas

The following priority areas were identified as essential to improving asthma control in Montana over the course of strategic planning sessions with asthma stakeholders. These priority areas are incorporated into the programs goals, objectives and strategies.

1. Enhancing Infrastructure and Promoting Care Coordination
2. Achievement of Guidelines-Based Medical Management
3. Provider and Patient Education
4. Tobacco Use Prevention and Cessation
5. Environment and Public Policy
6. Evaluation
7. Communication

# Enhancing Infrastructure/Promoting Care Coordination

**Goal 1:** Increase capacity, infrastructure, and partnerships to support health care and public health linkages.

**Objective 1:** Increase linkages and coordination between public health and health care services and improve systems that encourage team-based care.

**Strategies:**

- Support the efforts of partner organizations at the state and local level to communicate and share best practices and resources.
- Provide support to partner organizations advocating for environmental policies and health care system improvements that address social determinants of health impacting people with asthma.
- Support health care quality improvement projects that place an emphasis on team-based asthma care in their facility and community.
- Educate providers and payers on coverage and reimbursement for asthma self-management education and home trigger reduction services.
- Encourage and support timely sharing of patient data between primary care providers, allergists and immunologists, pulmonologists, emergency departments, urgent care centers, and hospital inpatient settings and health insurers, including mechanisms for notifying primary care providers about emergency/urgent care treatment and patient discharge instructions.

**Objective 2:** Support and promote the widespread use of the CONNECT bi-directional referral system among health care providers and community support organizations that address social determinants of health.

**Strategies:**

- Encourage contractors, sub awardees, and partners to register their organization with the CONNECT system and establish a plan for how they the system.
- Promote CONNECT during partner meetings and program sponsored events.
- Support the expansion of CONNECT by sharing ideas for potential partners with CONNECT administrators and local coordinators.

**Objective 3:** Increase participation in the Montana Asthma Advisory Group (MAAG) and expand the network of asthma stakeholders providing asthma education and support resources to Montanans with asthma.

**Strategies:**

- Maintain regular communication between the MACP and strategic partners.
- Request input from current MAAG members, assign tasks, and set a consistent schedule for annual meetings.
- Provide networking opportunities for MAAG members on all-member calls and at in-person events sponsored by the MACP or other asthma stakeholders.
- Utilize the MACP website as a platform for asthma education and resources.
- Conduct periodic reviews of apps and other technology that can be promoted by the MACP and partners.
- Increase training for providers in underserved areas on how to identify needs and burdens for people with asthma and connect them to resources.

# Enhancing Infrastructure/Promoting Care Coordination

**Goal 2:** Increase coverage for comprehensive asthma control services.

**Objective 1:** Secure reimbursement for asthma home visiting services.

**Strategies:**

- Continue to partner with Montana Medicaid to secure reimbursement for asthma home visiting services.
- Support the work of the Hometown Medication Therapy Management (MTM) program and other programs that provide ASME to employees and their dependents as part of the employee's health insurance coverage.
- Advocate for expanded coverage of asthma self-management education by presenting the business case for asthma home visiting to private insurers.

**Objective 2:** Support emerging telehealth projects aimed at increasing access to asthma control services for rural Montanans.

**Strategies:**

- Support and evaluate the effectiveness of telehealth services and promote collaboration between allied health professionals to establish telehealth networks.
- Leverage existing technology to facilitate the use of video conferencing through asthma interventions like the asthma home visiting program and pharmacist managed ASME.

**Objective 3:** Work with education partners to provide school nurses, school staff, and childcare providers with educational resources and training necessary to help prevent and manage asthma.

**Strategies:**

- Provide specialized trainings on asthma and environmental asthma triggers to school personnel including but not limited to health professionals, school staff, administrators, teachers, coaches, maintenance, food preparation workers and bus drivers. Utilize online training platforms to increase reach.
- Encourage health care providers to complete Asthma Action Plans for all children with asthma.
- Support linkages between schools, asthma home visiting programs, and health care providers.
- Advocate for the adoption of local school district wellness policies that address asthma and protect a healthy learning environment for all.
- Work with physical education personnel, coaching staff and the Montana High School Association to incorporate standard asthma management principles in high school sports activities for students with asthma.

**Objective 4:** Support culturally appropriate interventions tailored to American Indians living in Montana.

**Strategies:**

- Promote MACP partnership opportunities to Tribal Health Departments and Indian Health Services.
- Partner with public health programs and non-profit organizations to address social determinants of health on Montana reservations.

# Achievement of Guidelines-Based Medical Management

**Goal 1:** Provide access to comprehensive, culturally appropriate, patient-centered asthma care to people in Montana, resulting in optimal prevention, diagnosis, treatment, and management of asthma consistent with national guidelines.

**Objective 1:** Increase access to guidelines-based care.

**Strategies:**

- Distribute evidence based asthma support material to Montana primary care providers to facilitate utilization of evidenced based asthma care management practices.
- Support health care professionals interested in becoming certified asthma educators by hosting Certified Asthma Educator (AE-C) review courses, providing study materials, and facilitating a mentor network. Encourage public, private, and community-based health care payers to reimburse for patient education provided by AE-Cs.
- Support outreach efforts that increase availability of services to underserved populations, such as using mobile health screening and education, mobile clinics, and telemedicine.

**Goal 2:** Increase efforts by payers and health care organizations to improve the quality of asthma care in order to reduce asthma hospitalization and emergency department visits.

**Objective 1:** Promote payment and reimbursement mechanisms to encourage delivery of comprehensive asthma care.

**Strategies:**

- Partner with insurers and the state Medicaid program to identify model payment and reimbursement mechanisms.
- Develop sustainable funding for comprehensive asthma education and care and ensure affordability, accessibility and awareness of asthma medications, diagnostic tests, equipment, and standards of care.
- Support the use of spirometry in assessing asthma patients.


Big Sky Pulmonary Conference 2020

**Objective 2:** Reduce asthma mortality in Montana by improving acute and primary care to effectively manage asthma.

**Strategies:**

- Leverage partnerships with the Montana Primary Care Association and other Montana based health care professionals organizations to promote adoption of guidelines for appropriate asthma diagnosis and management.
- Support training for physician assistants, nurses, pharmacists, respiratory therapists, medical assistants, outreach staff and students on how to provide guidelines based asthma care and education.
- Facilitate asthma quality improvement projects in clinics and emergency departments while expanding the use of health information technology to improve asthma care management.
- Promote the collection of social determinants of health information in the health care setting to better address needs of asthma patients.

## Provider and Patient Education

**Goal 1:** Increase the number of health care providers (HCPs) and allied health providers (e.g. pharmacists, nurses, respiratory therapists) who receive professional development training on evidenced based asthma management practices.

**Objective 1:** Improve access to education and resources for health care professionals needed to effectively manage their patient's asthma.

**Strategies:**

- Train a variety of school nurses, public health educators, respiratory therapists, and/or asthma educators to implement evidence-based programs.
- Promote programs and resources through the MACP website, social media, and through partnering organizations.
- Offer virtual training events and promote continuing education developed by state and national partners like the American Lung Association (ALA), Environmental Protection Agency (EPA), Center for Disease Control (CDC), National Environmental Education Foundation (NEEF) and others.
- Partner with local institutions of higher learning to incorporate an asthma component within their public health/community health curriculum for health care providers.

**Objective 2:** Improve communication and education with patients admitted to hospitals or treated in the emergency department for asthma.

**Strategies:**

- Provide educational resources for distribution to patients and disseminate information on key asthma management topics for providers to use when seeing patients.
- Identify, publish, and promote decision making aids, and share online toolkits targeting local coalitions and asthma advocates.

**Goal 2:** People with asthma and their families and caregivers will have the knowledge and resources to self-manage their disease.

**Objective 1:** Reduce the percentage of Montanan's with asthma who experience activity limitations due to their asthma.

**Strategies:**

- Increase access to asthma education outside of the primary care setting for individuals with asthma and their caregivers. Promote pharmacy-led medication therapy management and ASME.
- Promote, implement, and evaluate school and community based asthma initiatives.
- Support the expansion of the Montana Asthma Home Visiting Program (MAP).
- Incorporate social determinants of health questions into MAP data collection to better connect families to support services.
- Support youth asthma camps and education events throughout the state.

## Tobacco Use Prevention and Cessation

**Goal 1:** Decrease tobacco use among Montanans with asthma.

**Objective 1:** Increase public awareness of the dangers of secondhand and thirdhand smoke and address exposure to environmental tobacco smoke through a continuum of services, policy recommendations and advocacy efforts.

**Strategies:**

- Support and collaborate on initiatives to implement and enforce tobacco free campuses, work sites, multi-unit housing, and public parks.
- Provide resources and linkages on national, state and regional, evidence based education and tobacco cessation services.
- Support and promote future legislation on reducing smoking and vaping.
- Support the MT Tobacco Use Prevention Program (MTUPP) to encourage policies for multi-unit smoke free housing and work with them to promote available housing and resources for people with asthma.


**Objective 2:** Increase referrals to cessation support services.

**Strategies:**

- Work with primary care providers and specialty clinics to integrate systematic referral to the MT Tobacco Quitline or the My Life My Quit cessation programs for patients that use tobacco and currently have asthma.
- Support public health messaging campaigns designed to promote the Quitline, My Life My Quit, and other cessation services available in Montana.

**Objective 3:** Decrease opportunities to initiate smoking.

**Strategies:**

- Provide evidence to support policy changes intended to reduce rates of youth tobacco use.
- Promote public awareness of the connection between the exposure to tobacco smoke and poor asthma outcomes.

# Environment and Public Policy

**Goal 1:** Identify and reduce exposure to environmental hazards that contribute to increased asthma prevalence and negative asthma outcomes in settings where Montanans live, learn, work, and play.

**Objective 1:** Inform the public about the relationship between asthma and environmental triggers.

**Strategies:**

- Collaborate with environmental public health tracking and illness surveillance efforts.
- Conduct public media campaigns promoting patient education on environmental asthma triggers and home environmental assessments.
- Partner with MTUPP to reduce exposure to environmental tobacco smoke and promote utilization of the MT Tobacco Quit Line.
- Partner with MT DEQ, other state agencies, and non-profit partners to provide consistent information about how individuals with asthma can protect themselves during poor outdoor air quality events.
- Collaborate with housing, energy assistance, and other community support services to address social determinants of health which may contribute to negative asthma outcomes.

**Objective 2:** Reduce the number of missed school and work days among Montanans with asthma.

**Strategies:**

- Encourage adoption and implementation of asthma friendly policies in learning institutions such as schools and childcare settings where health and environmental asthma triggers can be identified and mitigated.
- Promote and support asthma education and awareness programs for students and school staff.
- Partner with school administrators and other education leaders to promote safe environments.
- Promote school and district awareness of and compliance with, existing laws and regulations that impact asthma and recommend new laws/regulations or changes to existing ones as needed.
- Provide technical assistance and training to schools regarding environmental concerns through the DPHHS School Health Mini-Grant Program.

**Objective 3:** Educate decision makers and community business leaders on policies and practices to improve indoor and outdoor air quality.

**Strategies:**

- Promote evidence-based strategies that reduce secondhand smoke exposure.
- Provide work-related asthma resources to groups that are attempting to improve occupational air standards.
- Collaborate with existing partners to develop a shared agenda for healthy housing.

**Goal 2** Support opportunities to increase health care providers' knowledge of environmental and workplace asthma triggers, and support efforts to share this knowledge with patients in order to decrease these exposures.

**Objective 1:** Increase the number of health care providers who understand environmental asthma triggers and provide trigger education to their patients.

**Strategies:**

- Facilitate collaboration among health care providers and state and private organizations and agencies (MT Academy of Pediatrics, MT Primary Care Association, American Lung Association, etc.) to increase health care providers' understanding of indoor and outdoor triggers.
- Promote patient education on environmental asthma triggers as part of guidelines-based care
- Encourage providers to refer patients to community organizations that can help address asthma triggers in the home and workplace.

## Evaluation

**Goal 1:** Use evaluation data to define the burden of asthma, guide policy and program planning and assess the impact of the strategic plan process.

**Objective 1:** Conduct program evaluation according to the MACP Strategic Evaluation Plan

**Strategies:**

- Package results of data analysis and interpretation and disseminate in an updated burden report, fact sheets, press releases, issue briefs and other media.
- Make presentations at local, regional and national meetings and conferences.
- Produce scientific manuscripts on the effectiveness of interventions and lessons learned.
- Support evaluation of different partnership and collaboration models to determine their effectiveness in prevention, management, and treatment of asthma.
- Incorporate partner data into statewide surveillance and evaluation process.
- Analyze Medicaid and other data sets to identify potential improvements in asthma care and linkages to patient support services.

# Communication

**Goal 1:** Increase public awareness and understanding of asthma as a public health issue.

**Objective 1:** Disseminate consistent evidence-based messaging for various audiences promoting asthma self-management, guidelines-based care, and MACP programs.

**Strategies:**

- Conduct public awareness campaigns using various media platforms. Leverage advertising technology to target messaging to different subsets of the population.
- Enhance emergency preparedness communication efforts to address health issues related to asthma.
- Maintain and promote the utilization of the MACP website and social media accounts.
- Highlight asthma disparities and related social determinants of health in surveillance reports and other publicly shared materials.

**Goal 2:** Increase awareness of guidelines based asthma care, MACP programs, and policy changes among health care providers and public health partners.

**Objective 1:** Stakeholders receive consistent communication from the MACP.

**Strategies:**

- Ensure communication of relevant changes and/or new laws and regulations to improve asthma management and environmental quality in schools.
- Promote resources through the MACP website, social media, newsletters, webinars, and through partnering organizations.
- Conduct stakeholder meetings and conferences.

## Appendix- A

CDC Performance Measures

### Performance Measure A: Analysis and Use of Core Data Sets

***Performance Measure:*** Number and percentage of core measures updated, analyzed and disseminated/used during the reporting period.

Core data sets:

- Hospital Discharge
- Emergency Department Visits
- BRFSS Core
- BRFSS Child Prevalence Module
- BRFSS Random Child Selection Module
- Asthma Call-back Survey (adult)
- Asthma Call-back survey (child)
- Vital statistics/mortality

### Performance Measure B: Linking Activities and Outcomes

***Performance Measure:*** Documented activities of the recipient, and outcomes achieved, to establish and/or expand linkages between components of the EXHALE technical package at the organizational level (e.g., linkages that promote reimbursement or referrals; systems to share information across providers; mechanism to link health plans with home-based services or schools, data sharing across sectors).

### Performance Measure C: Comprehensive Service Expansion in High Burden Areas

***Performance Measure:*** Number and description of existing, new, and discontinued services supported by the recipient and their partners, by geographic area and intervention type; and alignment of services with high burden geographic areas.

### Performance Measure D: Quality of Guidelines-Based Care

***Performance Measure:*** Documented improvements in the quality of care or health outcomes (e.g., asthma control; emergency department visits; hospitalizations; asthma self-management education) as a result of Quality Improvement (QI) initiatives.

### Performance Measure E: Use of Evaluation Findings

***Performance measure:*** Actions taken or decisions made during the reporting period to improve program activities and increase program effectiveness as a result of evaluation findings.

### Performance Measure F: Asthma Self-management Education Completion Rates

***Performance measure:*** Number and demographics of people with asthma who initiated and attended at least 60% of sessions of guidelines-based asthma self-management education (ASME); and description of the setting and curriculum of ASME courses.

### Performance Measure G: Improvement in Asthma Control among ASME Completers

**Performance measure:** The number of participants with poorly controlled asthma on enrollment (a subset of the previous measure) who report their asthma is “well-controlled” one month or more after attending at least 60% of asthma self-management education sessions.

## Appendix B

MACP 2020 Workplan

| Montana Asthma Control Program Work Plan 9/1/2020 – 8/31/2021 | | | | | |
|---|---|---|---|---|---|
| **Strategies and Activities** | **PM** | **Lead Person** | **Dates** | **Baseline** | **Target** |
| ***Category A: Enhance Program Infrastructure*** | | | | | |
| *A1: Leadership and Program Management* | | | | | |
| A1.A: Participate in the implementation of the MT State Health Improvement Plan to address Priority Area 2: Chronic Disease Prevention and Self-Management, specifically asthma. | B | Jessie Fernandes<br>William (BJ) Biskupiak | Sep 2020 - Aug 2021 | 0 quarterly SHIP workgroup meetings | 4 quarterly SHIP workgroup meetings |
| A1.B: Host stakeholders and other partners at meetings to draft plans for implementing the strategic plan. | B | BJ Biskupiak | Sept 2020 - Nov. 2020 | 0 meetings | 1 meeting |
| A1.C: Maintain the DPHHS performance management system HealthSTAT and provide program updates to partners via MAAG meetings. | B | BJ Biskupiak | Sep 2020 - Aug 2021 | 0 meetings<br>0 updates | Hold 3 MAAG Meetings<br>Update HealthSTAT quarterly |
| A1.D: Maintain regular communication with partners via monthly calls or quarterly meetings to provide shared learning opportunities. | B | BJ Biskupiak, Jennifer Van Syckle | Sep 2020 - Aug 2021 | 0 newsletters<br>0 calls<br>0 monthly calls | 4 quarterly newsletters<br>6 Bi-monthly MAP calls<br>12 Monthly pharmacy contactor calls |
| A1.D: Maintain comprehensive, informative, and ADA compliant websites, including the Asthma Control Program and the coordinated school health sites that house trainings, surveillance and evaluation information. | B | BJ Biskupiak, Ann Lanes | Sep 2020 - Aug 2021 | 0 monthly reviews | 12 monthly maintenance updates on the MACP website |
| A1.D: Participate on other partners' meetings (DEQ-DPHHS Coordination, EPA's Children's Environmental Health Network). | B | BJ Biskupiak,<br>J Fernandes | Sep 2020 - Aug 2021 | As needed | At least 3 meetings |
| A1.D: Collaborate with MT Medicaid to establish reimbursement of asthma home visiting services and/or ASME. | B | BJ Biskupiak<br>J Fernandes | Sep 2020 - Aug 2021 | 0 follow up meetings | 2 follow up meetings<br>1 State Plan submitted to allow Medicaid reimbursement of asthma home visiting services. |
| Anticipated activities for Years 3-5: Maintain websites, track program efficiency using HealthSTAT and other performance management systems, and continue to communicate with partners through MAAG meetings, regularly scheduled project calls, and participation in coordinated group meetings. Implement and evaluate the MACP strategic plan. Promote MAP reimbursement opportunities to eligible partners | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| and assess Medicaid claims and reimbursement related to asthma home visiting. Approach other payers. Assist the Community Emergency Medical Services Program in the expansion and evaluation of the Community Integrated Health Program. | | | | | |
| *A2: Strategic Partnerships* | | | | | |
| A2:A: Maintain the MAAG, recruit new members from multiple sectors, and hold 3 meetings per year to discuss asthma in MT, including health disparities and evaluation. | B | BJ Biskupiak | Dec 2020 - Aug 2021 | 0 meetings | 3 MAAG Meetings |
| A2:B: Share information quarterly with key partners on priority populations and goals to increase impact and reduce duplication. | B | BJ Biskupiak<br>J Van Syckle | Sep 2020 - Aug 2021 | 0 newsletters | 4 quarterly newsletters |
| Anticipated activities for Years 3-5: Continue to recruit strategic partners to the MAAG and distribute quarterly newsletters. Implement strategic plan to reduce duplication. | | | | | |
| *A3: Surveillance* | | | | | |
| A3:A: Support the collection, analysis, reporting, and dissemination of core program and population level data through collaborations with data partners including BRFSS/ACBS, the Adult Tobacco Survey, Hospital Discharge Data System, and others. | A | Mary Duthie | Sep 2020 - Aug 2021 | -- | Collect data from core and supplemental data sets for analysis. |
| A3.A: Identify additional or new data sources for asthma from surveys, schools, health systems or other relevant sources. | A | Mary Duthie | Sep 2020 - Aug 2021 | 0 new data sources | 1 new data source |
| A3.B: Disseminate 3 surveillance reports to health care providers and other asthma partners and submit 1 abstract to a journal or national conference with analysis of MACP data with an emphasis on disparities. Use results for program planning. | A | Mary Duthie | Sep 2020 - Aug 2021 | 0 reports<br>0 abstracts | 3 surveillance reports<br>1 Journal abstract |
| A3.B: Update program maps to demonstrate alignment of program activities and burden. | A | Mary Duthie | Sep 2020 - Dec 2020 | 0 updates | Update program maps at least 2 times per year |
| Anticipated activities for Years 3-5: Analyze asthma trends from various data to implement focused programs. Produce 3 surveillance reports and submit at least 1 abstract to conferences and journals annually. Continue to identify or establish new data sources. Address disparities. Incorporate surveillance data into program evaluation reports to improve program efficiency. | | | | | |
| *A4: Communication* | | | | | |
| A4.A: Distribute quarterly newsletters summarizing latest asthma information and program activities to key stakeholders. | D | J Van Syckle | Sep 2020 - Aug 2021 | 0 newsletters | 4 quarterly newsletters |
| A4.A: Create and disseminate outreach materials highlighting key ASME skills (i.e. Health in the 406, small media). | C | BJ Biskupiak, Linda Krantz | Sep 2020 - Aug 2021 | 0 FB posts<br>0 HIT406 messages | $\geq$ 2 FB posts/month<br>3 HIT406 messages |
| A4.A: Partner with county health departments to conduct social media campaigns and events to support asthma management and address asthma triggers in indoor and outdoor environments. | C | BJ Biskupiak<br>L Krantz | Sep 2020 - Aug 2021 | 0 sites | 10/10 local MAP sites post on social media. |
| A4.B,C: Work with Asher Agency to tailor messages to audiences using digital, print, and other media with focus on EPR-3 Guidelines. | C | BJ Biskupiak, L Krantz | Sep 2020 - Aug 2021 | 0 reached | Reach 150,000+ Montanans through various media channels. |

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| Anticipated activities for Years 3-5: Continue to distribute quarterly newsletters to key stakeholders. Work with Asher Agency to develop new messaging and materials to be used in targeted media and marketing campaigns promoting ASME skills, asthma awareness, and MACP programs and events. Develop behavioral communication products. | | | | | |
| *A5: Evaluation* | | | | | |
| A5:A: Meet with partners to implement the EPMP. Implement individual evaluation plans for specific activities. Include economic data when possible. | E | Mary Duthie | Sep 2020 - Aug 2021 | 0 evaluations | Conduct 2 Program Evaluations |
| A5:B: Attend the AEA Evaluation Annual Conference or another evaluation training to build capacity/network with other evaluators | E | Mary Duthie | Sep 2020 - Aug 2021 | 0 conferences | Attend 1 or more evaluation conferences |
| A5:B: Present evaluation findings to key partners through reports and oral presentations | E | Mary Duthie | Sep 2020 - Aug 2021 | 0 presentations | Present evaluation findings at 1 MAAG Meeting |
| A5:C: Continue refining business case and disseminate information from continued economic evaluation of MAP and Medicaid clients. | E | BJ Biskupiak, Mary Duthie | Sep 2020 - Feb 2021 | 0 updates | 1 business case finalized and updated |
| Anticipated activities for Years 3-5: Use outcome evaluation plans to monitor and improve program efficacy. Continue to attend trainings, conferences, and partner meetings to build evaluation capacity and present evaluation findings, including business cases. Revise EPMP as necessary. | | | | | |
| **Category B: Leverage Partnerships to Expand EXHALE** | | | | | |
| *B1: Education on Asthma Self-Management* | | | | | |
| B1:A: Work with The Asher Agency to tailor media messages for specific audiences to encourage participation in ASME programs | C | BJ Biskupiak | Sep 2020 - Aug 2021 | 0 reached | Reach 150,000+ Montanans through digital media advertising |
| B1:A: Continue work with partners on asthma home visiting expansion and/or ASME provision | C | J Fernandes, BJ Biskupiak | Sep 2020 - Aug 2021 | 10 current sites | 11 sites |
| B1:B: Host two AE-C Review Courses to support healthcare providers and educators to become certified asthma educators | C | J Van Syckle | Sep 2020- May 2021 | 0 | 2 AE-C Review Courses |
| B1:B: Promote and track the use of the asthma education training websites for coaching, childcare, and school staff | C | BJ Biskupiak | Sep 2020 - Aug 2021 | <u>School Staff/Coaches Trained</u><br>0<br><br><u>Childcare Providers Trained</u><br>0 | <u>School Staff/Coaches Trained</u><br>150<br><br><u>Childcare Providers Trained</u><br>50 |
| B1:B: Provide 1 annual training for MAP staff on emerging or requested topics | C | BJ Biskupiak | March 2021 | 0 trainings | 1 annual MAP training completed |
| B1:C: Fund 5 sub-awards to school nurses, counselors, AE-Cs, or other public health staff to provide asthma education to parents, school staff, or coaches | C | BJ Biskupiak | Sep 2020 - May 2021 | 0 sub awards | 5 sub awards |

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| B1:C: Enroll at least 100 people with uncontrolled asthma in the MAP and train and reinforce them and their caregivers on ASME | C | BJ Biskupiak | Sep 2020 - Aug 2021 | 0 enrollees | 100 enrollees |
| B1.C: Partner with IPHARM to deliver ASME in underserved areas. Refer participants to additional healthcare services. | C | J Fernandes | Sep 2020- Aug 2021 | 0 events | 3 events to assess asthma in high burden areas. |
| B1.C: Partner with IPHARM to explore opportunities for providing ASME via telehealth platforms. | C | J Fernandes | Sep 2020- Aug 2021 | 0 partnerships | Coordinate with at least 5 community pharmacies and/or clinics and at least 2 employers for at least 1 month each to provide ASME and medication review. |
| B1.C: Partner with MAP sites to explore opportunities for providing ASME via telehealth platforms. | C | BJ Biskupiak | Sep 2020 - Aug 2021 | 20% sites | 100% MAP sites have conducted a virtual home visit. |
| B1:D: Collect outcome data from MAP, online training, and AAE Review Course participants. | F, G | Ann Lanes, Program | Sep 2020 - Aug 2021 | 100% MAP sites | 100% MAP sites submitting on time data<br><br>At least 75% return rate on AAE course evaluation |
| B1:D: Implement SDoH data collection in E-MAP system for all MAP participants. | F, G | Ann Lanes, Mary Duthie | Sep 2020 - Aug 2021 | 0% sites | 100% MAP sites are collecting SDoH data. |
| Anticipated activities for Years 3-5: Educate MAP staff on fee schedule changes or other successful ASME reimbursement measures. Provide live asthma trainings to school staff, coaches, and childcare staff, grant sub-awards to schools to support asthma education, expand enrollment in the MAP, and provide annual training for MAP staff. Coordinate IPHARM events in newly identified underserved areas. Approach non-Medicaid healthcare payers about ASME reimbursement options. Explore telehealth. | | | | | |
| *B2: Extinguish Smoking and Exposure to Second-hand Smoke* | | | | | |
| B2:A: Provide advanced training to MAP staff on smoking cessation and promote referrals to the MT Quit Line and the My Life My Quit line among MAP participants. | B, C | BJ Biskupiak | Sep 2020 - Aug 2021 | 0 trainings | 1 training for MAP staff on referring to tobacco cessation services |
| B2:A: Promote smoking cessation-related QI projects for healthcare facilities with a focus on patients with asthma. Emphasize QuitLine resources in trainings. | D | J Van Syckle | Sep 2020 - Aug 2021 | 0 projects | 1 project |
| B2:A: Partner with IPHARM and CIH programs to promote referrals to QuitLine resources. | B,C | J Fernandes<br>BJ Biskupiak | Sep 2020- Aug 2021 | 0 referrals | 25 referrals |
| B2:B: Collect information on smoking status, exposure to smoke and referrals to cessation programs and report PMs C and F. | C, F | Ann Lanes, Mary Duthie | Sep 2020 - Aug 2021 | 0% reporting | 100% contracted partners report on tobacco |
| Anticipated activities for Years 3-5: Continue with healthcare QI activities, prepare a document for health care facilities demonstrating innovative tools to address tobacco cessation in EHRs. Establish new projects with pharmacists and other members of the healthcare team (CHEMS, IPHARM) to refer to cessation | | | | | |

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| resources. Provide training and resources to partners on emerging E-cigarette data and trends. Analyze data on cessation rates. | | | | | |
| *B3: Home Visits for Trigger Reduction and AS-ME* | | | | | |
| B3:A: Continue work with MT Medicaid partners on asthma home visiting expansion and promote available resources. | B, C | J Fernandes, BJ Biskupiak | Sep 2020 - Aug 2021 | 0 follow up meetings | 2 follow up meetings<br>1 State Plan submitted to allow Medicaid reimbursement of asthma home visiting services. |
| B3:A: Provide 1 training for new and existing MAP staff on emerging or requested topics including smoking cessation, trigger assessment and removal, and billing/reimbursement. | C | BJ Biskupiak | Mar 2021 | 0 trainings | 1 training for MAP staff |
| B3:A: Partner with CIH program to address asthma in the home of clients being seen by EMTs. | C | J Fernandes, Nicole Steeneken | Sep 2020 - Aug 2021 | 0 clients | 15 clients |
| B3:B: Collect MAP and CIH participant data and report on asthma outcomes. | A, E | Ann Lanes, Mary Duthie | Sep 2020 - Aug 2021 | 100% of sites reporting data | 100% of sites reporting data |
| Anticipated activities for Years 3-5: Support EMTs addressing asthma in the home of clients and provide asthma education to EMTs. Explore opportunities to link the energy assistance and weatherization programs with the MAP and increase the number of homes receiving these services. Continue to provide annual trainings for MAP staff and collect asthma outcome data. | | | | | |
| *B4: Achievement of guidelines-based medical management* | | | | | |
| B4:A: Partner with the Hometown MTm project to promote and monitor the provision of ASME to State of MT employees. | D, G, F | J Van Syckle | Sep 2020 - Aug 2021 | O activities | At least 1 promotional activity |
| B4:A: Recruit 2 clinics and 2 EDs to participate in DMA, AHEAD, and/or spirometry training and a QI project. Focus on CCARE. | D | J Van Syckle | Sep 2020 - Aug 2021 | 0 sites | 2 DMA sites<br>2 Sites<br>2 Scheduled Spirometry Trainings |
| B4:A: Work with the MASN, MT OPI, school district officials and clinicians to promote statewide policy change to include an Asthma Action Plan (AAP) with the asthma medication consent process. | B | BJ Biskupiak | Sep 2020 - Aug 2021 | 0 meetings<br>0 proposals | 2 meetings to discuss topic<br>1 draft of proposal |
| B4: Hold annual Big Sky Pulmonary Conference to promote statewide coordination and expansion of asthma activities and resources and educate on evolving health care practices. | D | BJ Biskupiak | Sep 2020-Mar 2021 | -- | 130 conference attendees |
| B4:B: Work with Skaggs School of Pharmacy partners to increase the number of collaborative practice agreements (CPA) allowing pharmacists to distribute spacers and nicotine replacement therapy. | B, D | J Van Syckle | Sep 2020 - Aug 2021 | 1 CPA | 3 established CPAs |
| B4:C: Collect data from the Hometown MTm, DMA, and AHEAD projects on adherence and patient outcomes. | D | Mary Duthie | Sep 2020 - Aug 2021 | -- | 100% of sites submitting data |
| Anticipated activities for Years 3-5: Educate healthcare providers about AAP requirements in public schools. Continue to increase the number of pharmacies in the Hometown MTm project. Analyze data from Hometown MTm, DMA, and AHEAD and adjust program activities if needed. Continue to hold the | | | | | |

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| annual BSPC featuring any changes in guidelines-based medical management of asthma. Share sample CPAs with pharmacies and other health care providers statewide. | | | | | |
| *B5: Linkages and Coordination of Care Across Settings* | | | | | |
| B5:A: Partner with CIH program to address asthma in the home of clients being seen by EMTs. | B, C | J Fernandes, N. Steeneken | Sep 2020 - Aug 2021 | 0 clients | 15 clients |
| B5:A: Support and promote the growth of the CONNECT bi-directional referral system including referrals between and among school nurses, MAP staff, healthcare facilities, community support services and other organizations that address social determinates of health | B, C | J Fernandes, Kara Hughes | Sept 2020 - Aug 2021 | 70% of MAP sites onboarded for CONNECT | 90% of MAP sites onboarded for CONNECT |
| B5:A: Promote coordinated care by having at least 1 speaker at the BSPC address team-based care and/or community linkages. | B, C | BJ Biskupiak | March 2021 | 0 speakers | 1 speaker |
| B5:B: Support and promote the statewide growth of the CONNECT bi-directional referral system | B, C | J Fernandes, Kara Hughes | Sep 2020 - Aug 2021 | 0 new agencies onboarded | 10 asthma-related partners onboarded |
| B5:C: Collect and report CIH and CONNECT data including referral rates and participant outcomes. | B, C | Mary Duthie, Erika Karcher | Sep 2020 - Aug 2021 | -- | 100% of partners reporting on time data |
| Anticipated activities for Years 3-5: Reinforce the importance of team-based asthma care at the Pulmonary Conference and other conferences or trainings. Support EMTs addressing asthma in the home and promote further linkages. Continue the statewide growth of CONNECT by highlighting success stories and educating partners on how to best use the system to address asthma. Collect and evaluate CHEMS and CONNECT data regularly to drive strategic program improvement. | | | | | |
| *B6: Adopt Environmental Policies or Best Practices to Reduce Indoor and Outdoor Asthma Triggers* | | | | | |
| B6:A: Partner with the MT Tobacco Use Prevention Program to support multi-unit housing policies that promote tobacco-free campuses and promote the Quit Line and other cessation tools. | C | BJ Biskupiak, Nicole Aune | Sep 2020 - Aug 2021 | -- | 1 map is up to date and quarterly promotion<br>75% of MAP participants with tobacco use are referred to QuitLine |
| B6:A: Participate in the Children's Environmental Health Network meetings and implement the update of school administrative rules. | B | BJ Biskupiak | Sep 2020 - Aug 2021 | -- | Participate in at least 75% of meetings. |
| B6:A: Fund 5 sub-awards to school nurses to educate their administrators on asthma related policies, current status of policies, and make recommendations for new policies. | B | BJ Biskupiak | Sep 2020 - May 2021 | 0 awards | 5 awards |
| B6:A: Promote and refine the response to poor outdoor air quality during wildfire season and cold weather inversions. | B | J Fernandes, BJ Biskupiak | Sep 2020 - Aug 2021 | -- | 1 updated guidance document<br>Documents prepped by June for 2021 wildfire season |
| B6:B: Collect and report data on adoption and revision of relevant asthma-related policies. | B, E | Mary Duthie | Sep 2020 - Aug 2021 | -- | 100% of contractors report data |

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| B6:A: Coordinated with the Low Income Energy Assistance Program to determine a process for prioritizing asthma as criteria for housing and energy support services. | C, E | BJ Biskupiak<br>Mary Duthie | Sep 2020<br>Aug 2021 | 0 data products<br>0 meetings | 1 data product<br>4 quarterly meetings to maintain support |
| Anticipated activities for Years 3-5: Provide support for tobacco free housing and public places and promote tobacco cessation tools across all asthma programs. Provide TA to schools implementing updated school administrative rules related to reducing asthma triggers and continue to offer sub-awards to improve school policies. Collect data on Quit Line referrals or other tobacco cessation services and the impact of asthma-related policy changes and outdoor air quality messaging. Explore new opportunities to provide coordinated air quality and public health messaging. | | | | | |