MONTANA
ASTHMA CONTROL PROGRAM

User Manual
Nov 2020

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ACKNOWLEDGMENTS

The Asthma Control Program and corresponding user manual were prepared for:

ACRONYM LIST

ACT   Asthma Control Test

AKQ   Asthma Knowledge review Quiz

ASME   Asthma Self-Management Education

CDC   Centers for Disease Control and Prevention

CDPHP   Chronic Disease Prevention and Health Promotion

DPHHS   Department of Public Health and Human Services

DPRP   Diabetes Prevention Recognition Program

ED   Emergency Department

E-MAP   Electronic Montana Asthma Home Visiting web-based system

HEPA filter   High efficiency Particulate Air filter

ICS   Inhaled Corticosteroid medication (long term control)

ID   Identification

LM   Leukotriene Modifier (long term control)

MAP   Montana Asthma Home Visiting Program

MACP   Montana Asthma Control Program

MDPHHS   Montana Department of Public Health and Human Services

N/A   Not applicable

PCP   Primary Care Physician

QI   Quality Improvement

Rx   Prescribed medication

THE MONTANA ASTHMA CONTROL PROGRAM

The Asthma Control Program at the Montana Department of Public Health and Human Services is committed to improving the quality of life for all Montanans with asthma.

ABOUT THE WEB-BASED E-MAP APPLICATION

The Montana Asthma Home Visiting Program (MAP) has been actively enrolling children with doctor diagnosed uncontrolled asthma since June of 2010. In 2018, the program was expanded to include adult population. Home visiting staff operate out of 11 sites that serve total of 26 counties. The person enrolled in MAP receives 6 points of contact over a 12-month period with a nurse or respiratory therapist trained in asthma education and trigger removal. A client will receive education, an environmental assessment, allergen-proof pillowcases, mattress covers, and a High efficiency Particulate Air filter (HEPA filter) if there is risk of tobacco smoke exposure. During each visit, the home visiting staff collect health outcome data that is entered into the electronic MAP (E-MAP) web-based system. De-identified data is available to the Montana Asthma Control Program (MACP) and MAP staff. This data is regularly analyzed and findings are shared with the public via MACP factsheets and reports.

COMPUTER REQUIREMENTS

To use the E-MAP application, you will need:

- Access to the Internet through a browser such as Firefox, Chrome, or Internet Explorer — the most recent version of any of these is recommended.

REQUEST ACCESS

In order to be granted access to E-MAP first you must be contracted with Montana Asthma Control Program (MACP) to operate MAP. Contact the MACP Informatics Specialist to set up a user account. You will then receive an email to set up your password.

Ann Lanes
Informatics Specialist
Phone: (406) 444-6894
E-Mail: Lorraine.Lanes@mt.gov

SIGN-IN TO E-MAP APPLICATION:

Use your browser to access the Montana Chronic Disease Prevention & Health Promotion site at: https://chronicdiseasedata.undeerc.org CDPHP Data Collection Sign In prompt will appear. Enter your username and password into the appropriate fields, and click on Sign In.

You will only be granted access to application/s used for programs you are working on with the CDPHP. If you use multiple applications, your username and password will allow you to access all of them. If you use only the E-MAP application, click on the green card labeled "Managing Asthma Program (E-MAP)".
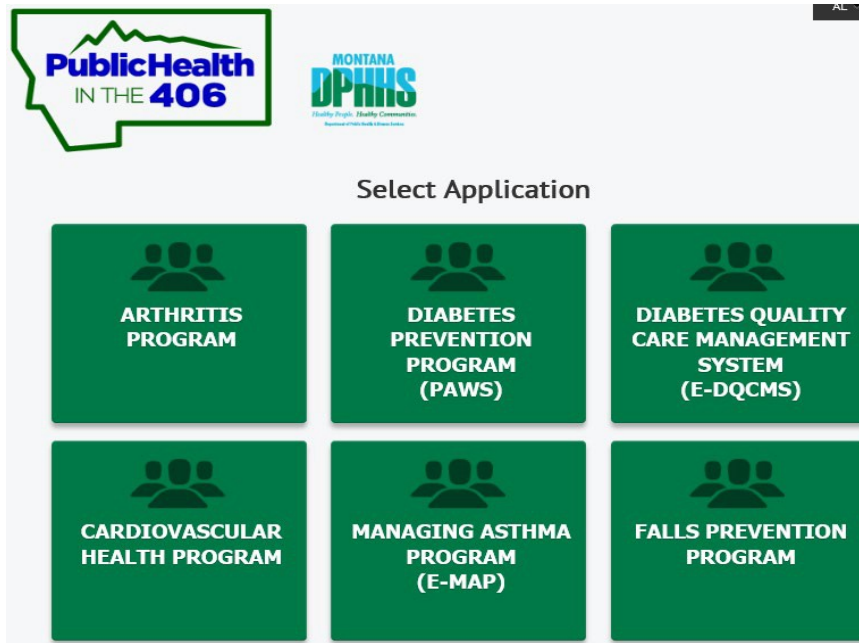
If you have forgotten your username or password, click on Forgot Username or Password located on the CDPHP data collection sign in page. You will be asked for your e-mail address or your username. Or contact DPHHS staff their contact information can be found on the first and last page of this manual or under the HELP button.

The HELP button gives you contact e-mail addresses and phone numbers for technical support. The HELP button is visible on every page of the E-MAP application. Note that after you have signed in, your username will appear on the black bar in the upper-right-hand corner next to the HELP button. Under your username you can edit your account, switch applications or sign out.

QUICK TIPS TO GET STARTED

Pages

The green menu bar at the top of the screen allows users navigate between the Home, Export, Utilities, and Documents pages.

Tabs

Each visit has its own tab. The first visit, 6-month visit, 12-month visit, and Follow-up Survey have sub Tabs.

MENU DESCRIPTIONS

1. **Home Menu**

   1. **+Add Reporting for Another Client** this allows you to add a new client. After clicking on it a box will pop up asking for Caretaker. Select Caretaker type and select **OK**. Client ID # is auto populated. The leading characters of the Client ID# refers to the Site ID.

Client	First Visit	1 Month	3 Month	6 Month	9 Month	12 Month	Follow Up		
As001	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	✏	🗑

+ Add Reporting for Another Client

Show Inactive

2. **The trash can symbol** 🗑 on the Home screen allows you to delete the selected participant from the database. If the button is selected, you will be asked if you are sure you want to delete the participant. Click on **Yes** to permanently delete the participant or on **Cancel** to keep the participant and return to the Participant page. Deleting the participant will remove all available demographic and assessment information associated with the participant.

3. **The pen icon** ✏ allows you to edit Caretaker and Client Status if the client is enrolled, inactive or has completed the program. It also has the option to re-enroll a client. To find clients who have completed the program or who have been Lost to Follow Up click on the **Show Inactive** button.

4. **Show Inactive** allows you to see the Lost to Follow Up clients and clients who have completed the program. If you click on the **pen icon** ✏ you can change Lost to Follow up clients back to enrolled.

Hide Inactive

Completed

Client	First Visit	1 Month	3 Month	6 Month	9 Month	12 Month	Follow Up		
As001	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	✏	🗑

Lost to Follow Up

Client	First Visit	1 Month	3 Month	6 Month	9 Month	12 Month	Follow Up		
As003	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	✏	🗑

2. Notification Menu

The Notification page allows you to send clients their Follow-Up Survey through email. First select client and then select Follow-Up Survey and it will send the Follow-Up survey to the client. The system will email the MAP nurse letting them know that the client completed the program 6 months ago and to login to EMAP to send out the Follow-Up Survey. The system will not let a nurse send out the survey before 6 months. Your client will receive an email to take the survey. Once they have completed the survey the MAP nurse will receive an email notification. The client's responses will automatically generate into the Follow-Up Survey tab in EMAP.

| HOME | NOTIFICATION | EXPORT | REPORTS | UTILITIES | DOCUMENTS |

Recipients
Select Client:

As009 ⌄

Message
Preferred Method: **Email**

Note: Do not include any sensitive information, including identifiers, health status, provision of health care, or payment information. This is not a secure form of communication.
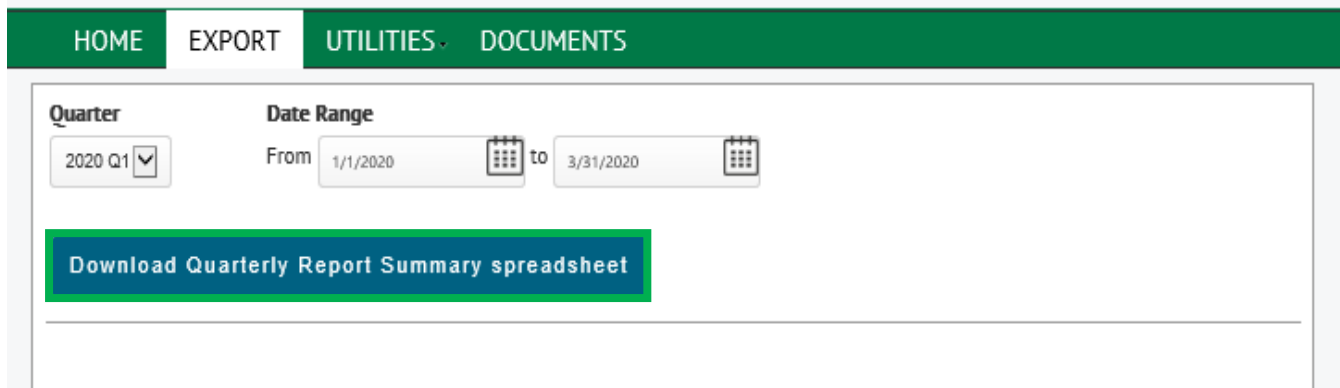
Follow-Up Survey

Please avoid special characters. Characters Remaining: 500

Send Notification

3. Export Menu
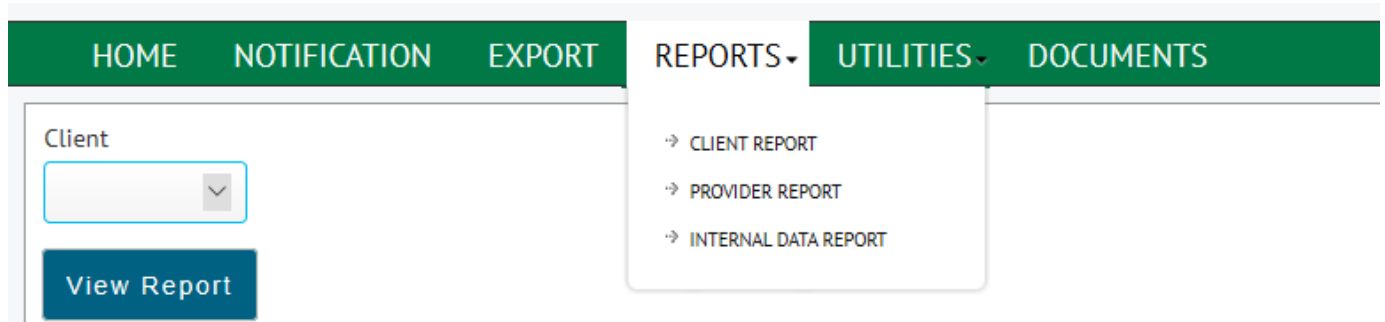
The Export page allows you to export data into an excel spreadsheet. Select **Quarter** from the drop down. It will auto fill date range and then click on the "**Download Quarterly Report Summary Spreadsheet".** If you are wanting a different date range other than a quarter, click on **Date Range** and input dates and then click on the **"Download Quarterly Report Summary Spreadsheet**".

4. Report Menu

The Report drop-down consist of three reports client report, provider report, and internal data report.

5. Utilities Menu

The Utilities drop-down has the options site info and offline.

UTILITIES ▾

▸ SITE INFO
▸ OFFLINE

1. **Site Info**- To update site info click on site info from the utilities drop-down menu. Update site information and then click save.

| HOME | EXPORT | UTILITIES ▾ | DOCUMENTS |

Site Information

*Site Name

Asthma TestSite

*Site Short Name

AsthmaTest

Address

address

City

city

State

AB ▾

Zip

45645
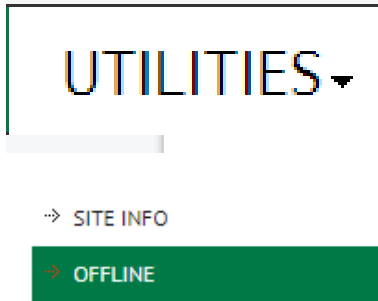
*Required

Save

2. E-MAP Offline

*** *Firefox and Chrome are the only browsers that support E-MAP's offline functionality.* ***

Step 1: Go to the Utilities page drop down and select offline.

UTILITIES ▾

⇢ SITE INFO

⇢ OFFLINE

Step 2: You may be prompted by the browser to allow persistent storage please accept. Click the Download/refresh local database from server button to initially download the offline functionality. Then click on the E-MAP Offline link and bookmark it.

Offline

Firefox and Chrome are the only browsers that support E-Map's offline functionality. You may be prompted by the browser to allow persistent storage, please accept. Click the 'Download/refresh local database from server' button to initially download the offline functionality.

Bookmark this link to acces E-Map Offline

Click this button to download the offline app or to refresh your offline data. This will also **DELETE** data you entered offline.

Download/refresh local database from server

Click this button to upload data you entered when you were offline.

Upload locally entered data

Step 3: Once offline click on your saved bookmark tab for E-MAP offline. Select the client ID from the drop down or if it's a new client create a temporary client code and then select Caretaker type.

Client	*Client Code	*Caretaker		
▾		▾	**Save**	**Clear**

To add a new client, click 'clear' and enter a temporary client code. A new client code will be assigned when uploading to the online site.

Step 4: Then select the visit and input data in the forms, (note the PHI fields have been removed in offline) and then click Save.

First Visit	1 Month	3 Month	6 Month	9 Month	12 Month	SDOH

When did you visit the client?   Type of Visit?

[   ]   [▾]

Entry Survey	Health Care and Impairment	Asthma Medications	Other Information

How would you rate the severity of your or your child's asthma? ⓘ   [▾]

How much do you think that you know about asthma? ⓘ   [▾]

How much would you say that you know about asthma medication? ⓘ   [▾]

How much would you say that you know about the relationship between asthma and the home environment? ⓘ   [▾]

How confident are you in your ability to handle an asthma attack at home? ⓘ   [▾]

How many years have you or your child had asthma? (99 for Unknown)   [   ]

Does anyone living in your home currently smoke tobacco?   [▾]

If Yes, does the client smoke tobacco?   [▾]

Does the client ever ride inside cars with people who are smoking?   [▾]

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Step 5: Once reconnected to the internet upload data entered offline by clicking on the Upload locally entered data. Don't store data in the offline mode it is not meant to be used for storage, upload as soon as internet is available. Once uploaded you will be presented with a list of the uploaded clients. If the client was new and was given a temporary client code offline this will show their new client codes. These are autogenerated by the database (which is not available offline), so please note the change to the temporary code used in offline mode.

Step 6: After data is uploaded click on Download/refresh local database from server to clear/delete data that is stored in offline mode. ***This will permanently delete the offline data, be sure to upload the offline data first.

6. Documents Menu

The Documents page allows you to download the most up to date MAP program documents. Documents that can be found on here include client surveys and checklists, Asthma Control Test, Asthma Knowledge Quiz, MAP onboarding manual, advertising, and educational materials.

1. **Downloading documents** click on **view** to download one document or **Download All** to download all MAP documents.
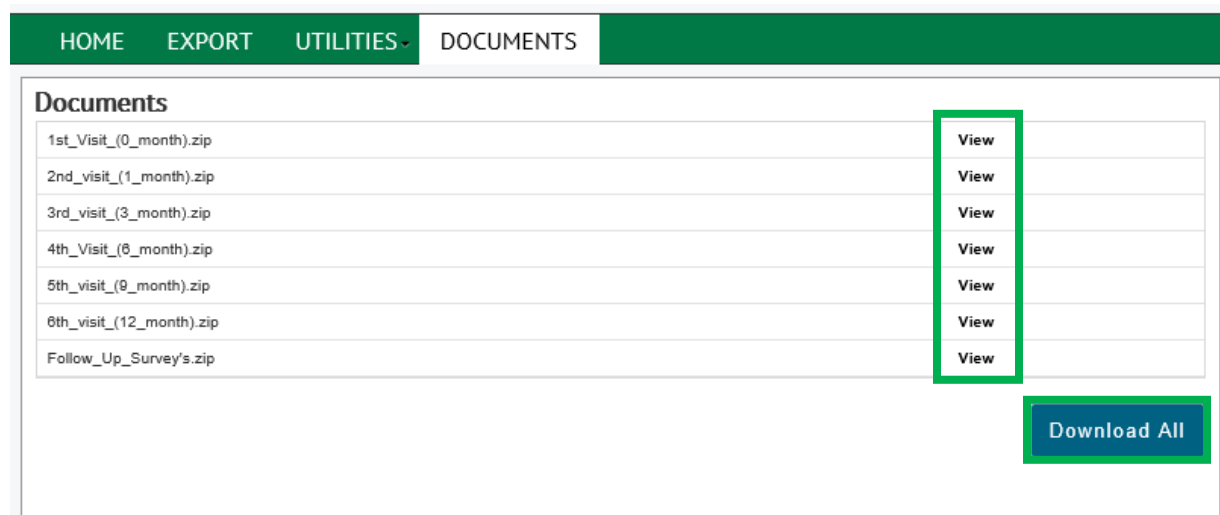
2. A question box will pop up asking what you want to do with the file. Click Open.
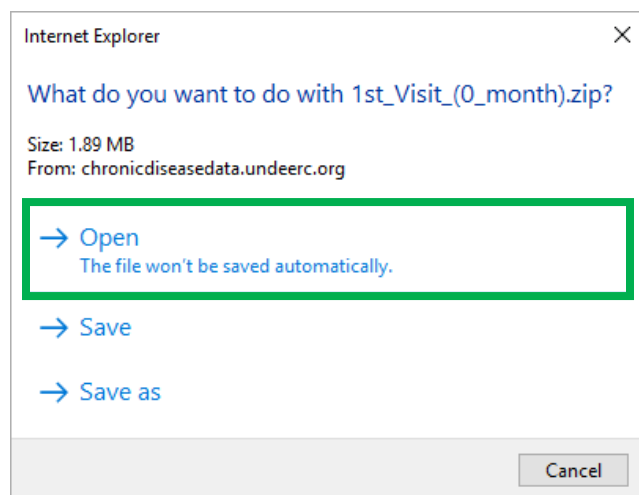
3. A security message will pop up click Allow.

Internet Explorer Security ✕

⚠ **A website wants to open web content using this program on your computer**
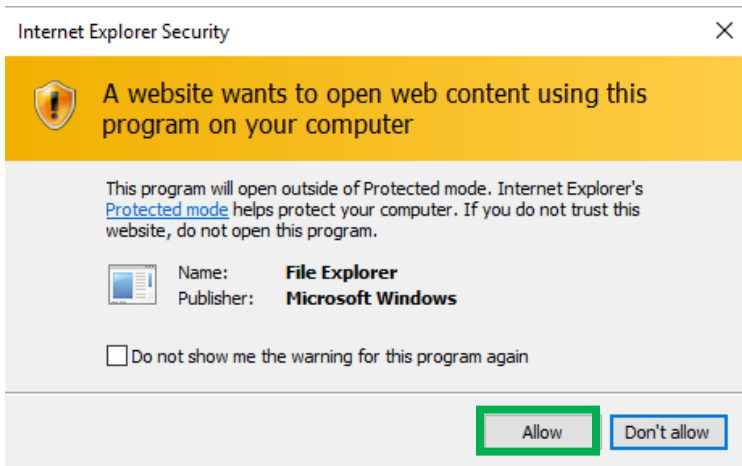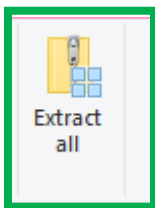
This program will open outside of Protected mode. Internet Explorer's Protected mode helps protect your computer. If you do not trust this website, do not open this program.

Name: **File Explorer**
Publisher: **Microsoft Windows**

☐ Do not show me the warning for this program again

[Allow] [Don't allow]

4. Then click on Extract all.

Extract all

5. A box will pop up wanting to know where to save the file click on **Browse** to select the location you want to save this file. Then click on **Extract**.

✕

← Extract Compressed (Zipped) Folders

Select a Destination and Extract Files

Files will be extracted to this folder:

[|] [Browse...]

☑ Show extracted files when complete

[Extract] [Cancel]

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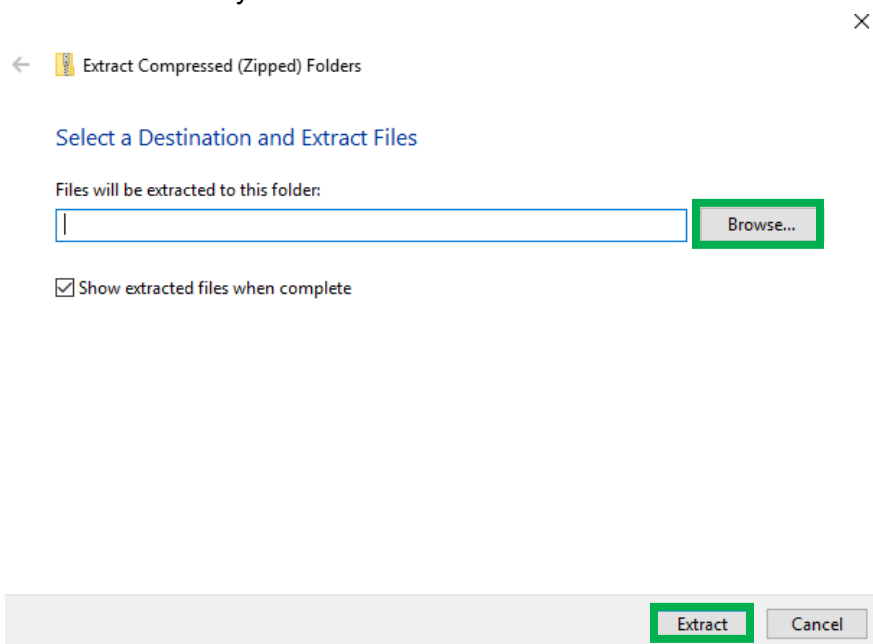
DATA ENTRY

The Visit for a client can be entered by clicking on the Incomplete button on the Home page. The Visit tab allows you to enter data collected at the clients visit. In visits *First Visit, 6-Month, 12-Month, and Follow-Up Survey* have Sub Tabs.

The ⓘ symbol is called an *info button*, and it contains helpful tips for data entry. Move your cursor over the symbol to read the information it holds.

Required fields in the E-MAP application are denoted with a Red asterisk (*****).

1. Select **Incomplete** under Visit you are inputting.

HOME	EXPORT	UTILITIES	DOCUMENTS						
+ Add Reporting for Another Client									
Client	First Visit	1 Month	3 Month	6 Month	9 Month	12 Month	Follow Up		
As002	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	✏	🗑

2. Complete each sub tab for the visit.

| First Visit | 1 Month | 3 Month | 6 Month | 9 Month | 12 Month | Follow-Up Survey |

*When did you visit the client?

| Entry Survey | Health Care and Impairment | Asthma Medications | Other Information |

*How would you rate the severity of your or your child's asthma? ⓘ

*How much do you think that you know about asthma? ⓘ

*How much would you say that you know about asthma medication? ⓘ

*How much would you say that you know about the relationship between asthma and the home environment? ⓘ

*How confident are you in your ability to handle an asthma attack at home? ⓘ

*How many years have you or your child had asthma? (99 for Unknown)

*Does anyone living in your home currently smoke tobacco?

*If Yes, does the client smoke tobacco?

*Does the client ever ride inside cars with people who are smoking?

*If the client who is receiving home visiting services for asthma lives part time in another home, does anyone living in this home currently smoke tobacco?

*Does anyone living in your home currently use an electronic vapor product?

*If yes, does the client use an electronic vapor product?

*What is your client's date of birth?

*Is your client Hispanic or Latino?

*Which category best describes your client's race?

*What is the client's sex?

*Is the client pregnant?

*Date Pregnancy Reported
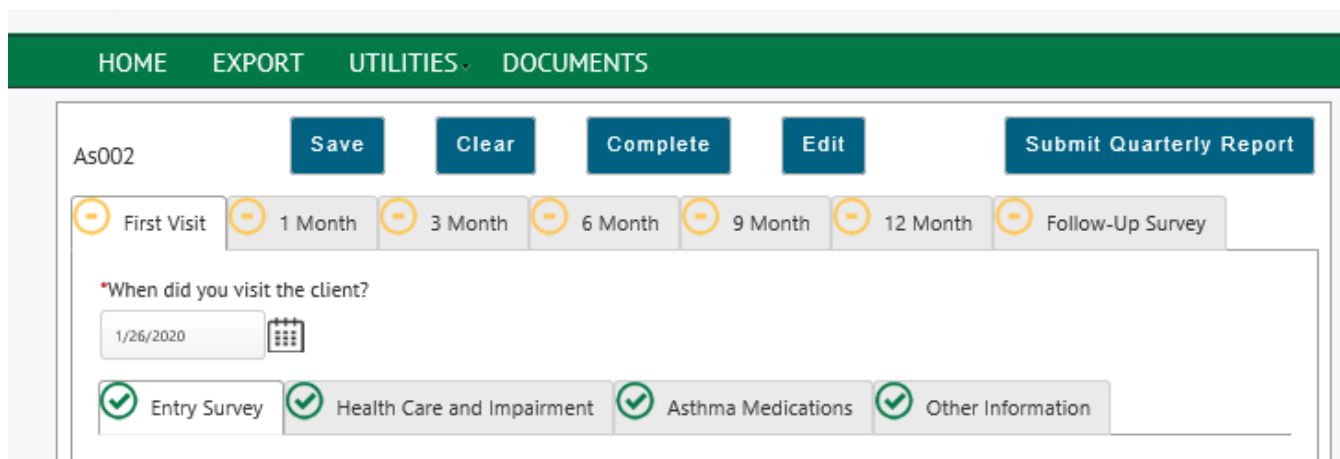
*What type of insurance coverage does the client have?

*What type of secondary insurance does the client have?

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3. As each sub-tab is completed the sub-tab icon will change to a green check mark ✅. If it does not, check sub-tab for missing data or incorrect dates.
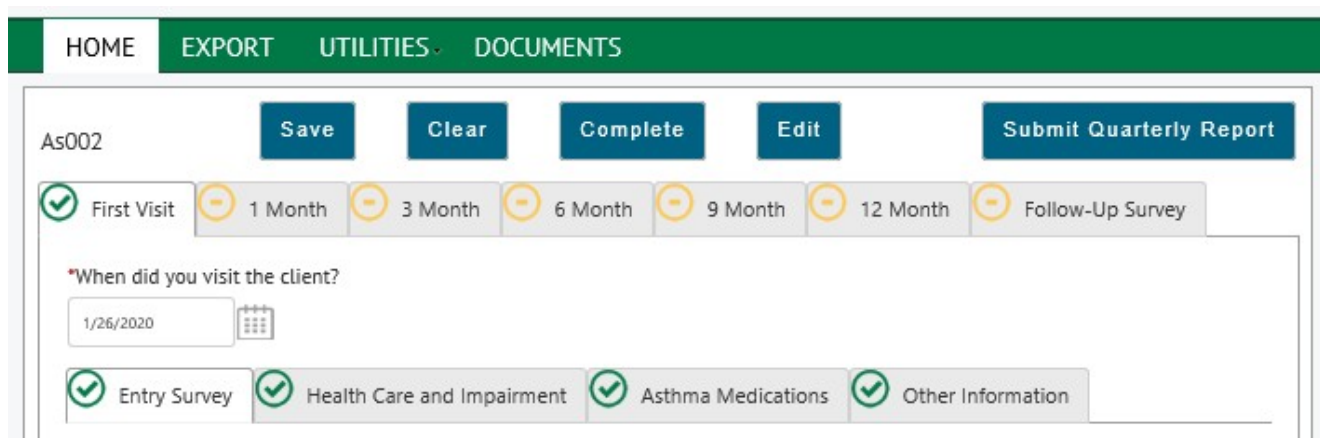
✅ Entry Survey ✅ Health Care and Impairment ✅ Asthma Medications ✅ Other Information

4. If unable to finish during one session click the **Save** button. To clear all answers and start over click the **Clear** button. When complete with visit click on **Complete** button at the top. To edit after the form is marked completed, click the **Edit** button it will pop up with a warning asking, "Are you sure you want to unlock the current form?" When finished with a visit or when quarterly data submission is due click **Submit Quarterly Report** button.

5. The tab icon next to the visit will change to a green check mark ✅ when marked completed showing that visit is complete.

6. The tab icon next to the visit will change to a star ![star icon] when the Quarterly Report has been submitted.

7. Home screen will also change to **Complete** or **Submitted**.

1. Quarterly Data Submission

1. Data is due quarterly on January 10th, April 10th, July 10th, and October 10th. To submit data, go to home page and click submit quarterly report. All visits that have been marked Complete will be sent to the MACP.

2. Another option for submitting quarterly data is click on **Complete (1)** visit. And then click on **Submit Quarterly Report (2).** If visit shows only completed, then it has not been submitted to the Montana Asthma Control Program.

3. If on the Home Screen it shows **Submitted**, then your data for that visit has already been sent to the Montana Asthma Control Program.

DATA COLLECTED

Each tab and sub-tab consist of multiple questions. Any question with a red asterisk (*) is required.

1. First Visit Tab

A. *Entry Survey Sub-Tab*

1. **When did you visit the client? *** – Date of visit in MM/DD/YYYY format.

2. **How would you rate the severity of your or your child's asthma? *** – On a scale of 1-5, with 1 being the least, 5 being the most and 9 being unknown.

3. **How much do you think that you know about asthma? *** – On a scale of 1-5, with 1 being the least, 5 being the most and 9 being unknown

4. **How much would you say that you know about asthma medication? *** – On a scale of 1- 5, with 1 being the least, 5 being the most and 9 being unknown.

5. **How much would you say that you know about the relationship between asthma and the home environment? *** – On a scale of 1-5, with 1 being the least, 5 being the most and 9 being unknown.

6. **How confident are you in your ability to handle an asthma attack at home? *** – On a scale of 1-5, with 1 being the least, 5 being the most and 9 being unknown.

7. **How many years have you or your child had asthma? *** – Enter the # of years or 99 for unknown.

8. **Does anyone in your home currently smoke tobacco? *** – Select from drop-down menu No, Yes, N/A, or Unknown.

9. **If Yes, does the client smoke tobacco? *** - Will default to N/A unless yes is selected in the previous question. If yes was selected in previous question select from the drop- down menu No, Yes, N/A, Unknown.

10. **Does the client ever ride inside cars with people who are smoking? *** Select from drop-down menu No, Yes, N/A, or Unknown.

11. **If the client who is receiving home visiting services for asthma lives part time in another home, does anyone living in this home currently smoke tobacco? *** Select from drop-down menu Yes, No, Don't Know, does not live in another home, N/A, Unknown

12. **Does anyone living in your home currently use an electronic vapor product? *** Select from drop-down menu Yes, No, N/A, Unknown

13. **If yes, does the client use an electronic vapor product? *** Will default to N/A unless yes is selected in the previous question. If yes was selected in previous question select from the drop-down menu No, Yes, N/A, Unknown.

14. **What is your client's Last Name? *** Enter the client's Last Name.

15. **What is your client's First Name? *** Enter the client's First Name.

16. **What is your client's date of birth? *** Enter the client's date of birth, (DD/MM/YYYY).

17. **Is your client Hispanic or Latino? *** Select from drop-down menu Yes, No, N/A, Unknown.

18. **Which category best describes your client's race? *** Select from drop-down menu African American/Black, American Indian/Alaska Native, Asian, Caucasian/White, Pacific Islander/Native Hawaiian, Other, Multiple Race, N/A, Unknown.

19. **What is the client's sex? *** Select from drop-down menu Female, Male, Other, N/A, Unknown.

20. **Notification Preference?** Select from the option Email or Text depending on if the client would like to receive texts or emails. If the client does not want to receive text or email leave this question unanswered.

21. **Client's Email?** This is optional field to input the client's email if they would like to receive emails.

22. **Client's cell phone?** This is an optional field to input the client's cell phone is they would like to receive text messages.

23. **Is the client pregnant? *** If client is under 14 years old or Male this will default to N/A. Otherwise select from the drop-down menu Yes, No, N/A, Unknown.

24. **If yes, what date did you (the home visitor) become aware you client was pregnant? *** This only needs to be answered if client is pregnant. Answer in (MM/DD/YYYY) format.

25. **What type of insurance coverage does the client have? *** Select from the drop-down menu IHS, Private Insurance, Uninsured, Medicaid, N/A, Unknown.

26. 21. **What type of type of secondary insurance does the client have? *** Select from the drop-down menu IHS, Private Insurance, Uninsured, Medicaid, N/A, Unknown.

27. **How did you find out about this program? *** This section asks you to check the boxes for all ways the participant reports having heard about MAP.

28. **For home visitor: Was this referral made using the CONNECT system?** Select Yes or No for if the referral was made using the Connect system.

29. **Do you or your child have any of the following disabilities**? This selection asks you to check the boxes for disabilities. The options Decision making, and

Walking/Stairs difficulty does not apply to clients under 5 years old.

30. Have you ever received educational support or services related to your disability? * Select from drop-down menu Yes, No, N/A, Unknown.

31. Has a doctor or other health professional ever taught the client or parent/guardian of the child, how to recognize early signs or symptoms of an asthma episode? * Select from drop-down menu Yes, No, Don't Know.

32. Has a doctor or other health professional ever taught the client or parent/guardian of the child, what to do during an asthma episode or attack? Select from drop-down menu Yes, No, Don't Know.

33. A peak flow meter is a handheld device that measures how quickly you can blow air out of your lungs. Has a doctor or other health professional ever taught the client or parent/guardian of the child, how to use a peak flow meter to adjust his/her daily medications? * Select from the drop-down menu Yes, No, Don't Know.

34. A spacer or holding chamber is a device that attaches to an asthma inhaler and helps to deliver asthma medication. Does the client currently use a spacer or holding chamber with his/her asthma inhaler? * Select from the drop-down menu Yes, No, Don't Know.

35. An asthma action plan, or asthma management plan, is a form with instructions about when to change the amount of medicine, when to call the doctor for advice, and when to go to the emergency room. Has a doctor or other health professional ever given the client or parent/guardian of the child, and asthma action plan? * Select from drop-down menu Yes, No, Don't know.

36. Has the client or parent/guardian of the child ever taken a course or class on how to manage his/her asthma? Select from drop-down menu Yes, No, Don't Know.

37. Has a doctor or other health professional ever talked to the client or parent/guardian of the child, about environmental asthma triggers in the home and about how to mitigate and/or reduce those triggers? * Select from the drop- down menu Yes, No, Don't Know.

B. _Health Care and Impairment Sub-Tab_

1. **Number of ED Visits for Asthma in the last 6 months*** – Enter 99 if unknown.

2. **Number of asthma exacerbations that required a course of oral systemic corticosteroids in the last year*** – Enter 99 if unknown.

3. **Number of Urgent Care and/or Unscheduled Medical Office Visits for Asthma in the last 6 months*** – Enter 99 for unknown.

4. **Number of hospital visits for Asthma in the last 6 months *** – Enter 99 for unknown.

5. **Has the client seen the healthcare provider for a routine asthma visit in the past month *** – Select from the drop-down menu Yes, No, N/A, Unknown.

6. **How many routine visits *** – Enter 99 for unknown.

7. **How many days did the client wake up at night due to asthma symptoms in the past month *** Enter 99 for unknown.

8. **How many days did the client experience asthma symptoms during the past month *** Enter 99 for unknown.

9. **During the past month, to what extent have the client's asthma symptoms interfered with his/her normal activity? *** Select from the drop-down menu None, Some Limitations, Extreme Limitations, N/A, Unknown.

10. **Number of school days missed in the last 6 months. *** Enter 999 for too young for school.

11. **Number of Days Short-Acting Beta Agonist Medication was used in the last month. *** Enter 99 for unknown.

12. **Number of workdays parent/guardian missed in the last 6 months due to their child's asthma. *** Enter 999 for unknown.

13. **Number of workdays the adult client missed in the last 6 months due to their asthma. *** Enter 999 for unknown.

C. *Asthma Medications Sub-Tab*

Enter client's asthma medications into the fields. *Days per week Rx* is the number of days a week the provider prescribed the medication. *Days per week used* is the number of days a week the client uses that medication. *Use all year* is if the client uses the medication all year or just seasonally.

⊘ Entry Survey	⊘ Health Care and Impairment	⊖ Asthma Medications	⊖ Other Information

*ICS-1: What Inhaled Corticosteroid Medication (Long Term Control) is the client taking? ⌄

ICS-1: Days per week Rx

ICS-1: Days per week used

ICS-1: Use all year? ⌄

*Rescue-1: Please select which rescue (quick relief) medications the client is prescribed ⌄

Rescue-1: Days per week used

Rescue-1: Use all year? ⌄

*LM-1: Which Leukotriene Modifier is the client prescribed? ⌄

LM-1: Days per week used

LM-1: Use all year? ⌄

1. **Other Asthma medication** – List the names of other asthma medications not listed above.

2. **What is the average cost of the client's asthma medications monthly: *** – Enter 999 for unknown.

D. *Other Information Sub-Tab*

1. **Asthma Knowledge Review *** – Enter the Asthma Knowledge Review Score (0-11, 999 for unknown).

2. **Asthma Control Test (ACT)*** – Will default to N/A if client is under 4. Enter 999 for unknown.

3. **Did the client already have a peak flow meter? * -** Select from the drop-down menu No, Yes, N/A, Unknown.

4. **Prior to any instruction, did the client demonstrate correct inhaler technique?** ∗ – Select from the drop-down menu No, Yes, N/A, Unknown.

5. **Does the client have an asthma action plan? *** Select from the drop-down menu No, Yes, N/A, Unknown.

6. **If the client has an asthma action plan, has it been reviewed by a healthcare provider and/or updated within the last 6 months? *** Select from the drop-down menu No, yes, N/A, Unknown.

7. **Was a home assessment completed? *** Select from the drop-down menu No, Yes, N/A, Unknown.

8. **What was the one thing that you and the client and/or parent/guardian agreed would be changed by the next visit? *** This is a free text box to input the changes that are to be made by the next visit.

9. **Enter the amount of time in minutes that you spent conducting the visit: *** Enter 999 for unknown.

10. **Miles traveled to reach this home (one way): *** Enter 999 for unknown.

11. **Phone Call or Visit? *** Select from the drop-down menu how the visit was performed.

12. **First two letters of the client's last name: *** Enter first two letters of client's last name the box will only allow two letters.

13. **Client's county of residence: *** Select the county in which the client currently lives in from the drop-down menu.

14. **Please add any additional comments about this visit: *** This is a free text box to write down any additional comments the home visitor has regarding the visit.

1-month Tab

1. **When did you visit the client? *** – Date of visit in MM/DD/YYYY format.

2. **Has the environmental change that you and the family previously agreed upon been made? –** This is the change that was agreed upon in the First Visit. Select from the drop-down menu No, Yes, N/A, Unknown.

3. **If the environmental change agreed upon at the first visit has not been made, why not? *** – This is a free text box to explain why changes have not been made. Enter N/A if the change has been made.

4. **How many days did the client wake up at night due to asthma symptoms in the past month? *** – Enter 99 for unknown.

5. **How many days did the client experience asthma symptoms during the past month? *** – Enter 99 for unknown.

6. **During the past month, to what extent have the client's asthma symptoms interfered with his/her normal activity? *** – Select from the drop-down menu None, Some Limitations, Extreme Limitations, N/A, Unknown.

7. **Number of Days Short-Acting Beta Agonist Medication was used in the last month: * –** Enter 99 for Unknown.

8. **Has the client seen a healthcare provider for a routine asthma visit in the past month? * –** Select from the drop-down menu No, Yes, N/A, Unknown

9. **Is the family using the allergen impermeable covers that were provided at the first visit? * -** Select from the drop-down menu No, Yes, N/A, Unknown.

10. **Does the client demonstrate correct inhaler technique? * -** Select from the drop-down menu No, Yes, N/A, Unknown.

11. **Asthma Knowledge Review Score: *** 0-11, 999 for unknown.

12. **Did you provide a HEPA purifier to the family? *** Select from the drop-down menu No, Yes, N/A, Unknown.

13. **If you provided a HEPA purifier to the family, why did you do so? * -** Select from the drop-down menu Secondhand smoke, Cat/Dog, Both, N/A, Unknown.

14. **Does the client have an asthma action plan? * -** Select from the drop-down menu No, Yes, N/A, Unknown.

15. **If the client has an asthma action plan, has it been reviewed by a healthcare provider and/or updated within the last 6 months? *** Select from the drop-down menu No, Yes, No action plan, N/A, Unknown.

16. **Enter the amount of time in minutes that you spent conducting the visit:** Enter 999 for unknown.

17. **Miles traveled to reach this home (one way):** Enter 999 for unknown.

18. **Phone Call or Visit? *** Select from the drop-down menu how the visit was performed.

19. **Please add any additional comments about this visit: *** This is a free text box to write down any additional comments the home visitor has regarding the visit.

3 Month Tab

1. **When did you visit the client? *** – Date of visit in MM/DD/YYYY format.

2. **Phone Call or Visit? *** Select from the drop-down menu how the visit was performed

3. **Enter the amount of time in minutes that you spent conducting the visit:** Enter 999 for unknown.

4. **Miles traveled to reach this home (one way):** Enter 999 for unknown.

5. **Please add any additional comments about this visit: *** This is a free text box to write down any additional comments the home visitor has regarding the visit.

6 Month Tab

A. *Health Care and Impairment Sub-Tab*

1. **Number of ED Visits for Asthma in the last 6 months*** – Enter 99 if unknown.

2. **Number of Urgent Care and/or Unscheduled Medical Office Visits for Asthma in the last 6 months*** – Enter 99 for unknown.

3. **Number of hospital visits for Asthma in the last 6 months *** – Enter 99 for unknown.

4. **Has the client seen the healthcare provider for a routine asthma visit in the past month *** – Select from the drop-down menu Yes, No, N/A, Unknown.

5. **How many routine visits *** – Enter 99 for unknown.

6. **How many days did the client wake up at night due to asthma symptoms in the past month *** Enter 99 for unknown.

7. **How many days did the client experience asthma symptoms during the past month *** Enter 99 for unknown.

8. **During the past month, to what extent have the client's asthma symptoms interfered with his/her normal activity? *** Select from the drop-down menu None, Some Limitations, Extreme Limitations, N/A, Unknown.

9. **Number of school days missed in the last 6 months.** * Enter 999 for too young for school.

10. **Number of Days Short-Acting Beta Agonist Medication was used in the last month.** * Enter 99 for unknown.

11. **Number of workdays parent/guardian missed in the last 6 months due to their child's asthma.** * Enter 999 for unknown.

12. **Number of workdays the adult client missed in the last 6 months due to their asthma.** * Enter 999 for unknown.

B. *Asthma Medications Sub-Tab*

Enter client's asthma medications into the fields. *Days per week Rx* is the number of days a week the provider prescribed the medication. *Days per week used* is the number of days a week the client uses that medication. *Use all year* is if the client uses the medication all year or just seasonally.

1. **Other Asthma medication** – List the names of other asthma medications not listed above.

2. **What is the average cost of the client's asthma medications monthly:** * – Enter 999 for unknown.

C. *Other Information Sub-Tab*

1. **Asthma Knowledge Review *** – Enter the Asthma Knowledge Review Score (0-11, 999 for unknown).

2. **Asthma Control Test (ACT)*** – Will default to N/A if client is under 4. Enter 999 for unknown.

3. **Did the client demonstrate correct inhaler technique? *** – Select from the drop-down menu No, Yes, N/A, Unknown.

4. **Does the client have an asthma action plan? *** Select from the drop-down menu No, Yes, N/A, Unknown.

5. **If the client has an asthma action plan, has it been reviewed by a healthcare provider and/or updated within the last 6 months? *** Select from the drop-down menu No, yes, N/A, Unknown.

6. **Enter the amount of time in minutes that you spent conducting the visit: *** Enter 999 for unknown.

7. **Miles traveled to reach this home (one way): *** Enter 999 for unknown.

8. **Phone Call or Visit? *** Select from the drop-down menu how the visit was performed.

9. **Please add any additional comments about this visit: *** This is a free text box to write down any additional comments the home visitor has regarding the visit.

9 Month Tab

1. **When did you visit the client? *** – Date of visit in MM/DD/YYYY format.

2. **Phone Call or Visit? *** Select from the drop-down menu how the visit was performed

3. **Enter the amount of time in minutes that you spent conducting the visit:** Enter 999 for unknown.

4. **Miles traveled to reach this home (one way):** Enter 999 for unknown.

5. **Please add any additional comments about this visit: *** This is a free text box to write down any additional comments the home visitor has regarding the visit.

12 Month Tab

A. Health Care and Impairment Sub-Tab

1. **Number of ED Visits for Asthma in the last 6 months*** – Enter 99 if unknown.

2. **Number of asthma exacerbations that required a course of oral systemic corticosteroids in the last year**: * – Enter 999 for unknown.

3. **Number of Urgent Care and/or Unscheduled Medical Office Visits for Asthma in the last 6 months*** – Enter 99 for unknown.

4. **Number of hospital visits for Asthma in the last 6 months *** – Enter 99 for unknown.

5. **Has the client seen the healthcare provider for a routine asthma visit in the past month *** – Select from the drop-down menu Yes, No, N/A, Unknown.

6. **How many routine visits *** – Enter 99 for unknown.

7. **How many days did the client wake up at night due to asthma symptoms in the past month *** Enter 99 for unknown.

8. **How many days did the client experience asthma symptoms during the past month *** Enter 99 for unknown.

9. **During the past month, to what extent have the client's asthma symptoms interfered with his/her normal activity? *** Select from the drop-down menu None, Some Limitations, Extreme Limitations, N/A, Unknown.

10. **Number of school days missed in the last 6 months. *** Enter 999 for too young for school.

11. **Number of Days Short-Acting Beta Agonist Medication was used in the last month. *** Enter 99 for unknown.

12. **Number of workdays parent/guardian missed in the last 6 months due to their child's asthma. *** Enter 999 for unknown.

13. **Number of workdays the adult client missed in the last 6 months due to their asthma. *** Enter 999 for unknown.

B. *Asthma Medications Sub-Tab*

Enter client's asthma medications into the fields. *Days per week Rx* is the number of days a week the provider prescribed the medication. *Days per week used* is the number of days a week the client uses that medication. *Use all year* is if the client uses the medication all year or just seasonally.

1. **Other Asthma medication** – List the names of other asthma medications not listed above.

2. **What is the average cost of the client's asthma medications monthly: *** – Enter 999 for unknown.

C. *Other Information Sub-Tab*

1. **Asthma Knowledge Review *** – Enter the Asthma Knowledge Review Score (0-11, 999 for unknown).

2. **Asthma Control Test (ACT)*** – Will default to N/A if client is under 4. Enter 999 for unknown.

3. **Did the client demonstrate correct inhaler technique? ∗** – Select from the drop-down menu No, Yes, N/A, Unknown.

4. **Does the client have an asthma action plan? *** Select from the drop-down menu No, Yes, N/A, Unknown.

5. **If the client has an asthma action plan, has it been reviewed by a healthcare provider and/or updated within the last 6 months? *** Select from the drop-down menu No, yes, N/A, Unknown.

6. **Enter the amount of time in minutes that you spent conducting the visit: *** Enter 999 for unknown.

7. **Miles traveled to reach this home (one way): *** Enter 999 for unknown.

8. **Phone Call or Visit? *** Select from the drop-down menu how the visit was performed.

9. **Please add any additional comments about this visit: *** This is a free text box to write down any additional comments the home visitor has regarding the visit.

D. *Social Determinants of Health (SDOH) Tab*

Personal Characteristics

1. *Have you been discharged from the armed forces of the United States?*
   Yes
   No
   I choose not to answer this question

Family & Home

2. *What is your housing situation today?*
   I have housing (own)
   I have housing (rental)
   I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a vehicle, or in a park)
   I choose not to answer this question

3. *Are you worried about losing your housing?*
   Yes

No
I choose not to answer this question

4. ***Do you feel physically and emotionally safe where you currently live?***
Yes
No
Unsure
I choose not to answer this question

5. ***Think about the place you live. Do you have problems with any of the following? (check all that apply)***
bug infestation
mold
lead paint or pipes
inadequate heat
oven or stove not working
no or not working smoke detectors
water leaks
utilities
accessibility into/within residence
refrigeration availability
none of the above
I choose not to answer this question

6. ***What is the zip code of your home?***

Money & Resources

7. ***What is the highest level of school that you have finished?***
Less than high school degree
High school diploma or GED
Some college or vocational
College degree
I choose not to answer this question

8. ***What is your current work situation?***
Unemployed
Part-time or temporary work
Full-time work
Retired
Student
Homemaker
Other Please write:
I choose not to answer this question

9. ***At any point in the past 2 years, has seasonal or migrant farm work been your or your family's main source of income?***
Yes
No
I choose not to answer this question

10. **During the past year, what was the total combined income for you and the family members you live with?**

    <$15000

        $15,000-$24,999

        $25,000-$49,999

        $50,000-$74,999

        $75,000+

        I choose not to answer this question

11. **In the past year, have you or any family members you live with been <u>unable</u> to get any of the following when it was <u>really needed</u>? Check all that apply.**

        Clothing: Yes No

        Child Care: Yes No

        Medicine or Medical care: Yes No

        Any Other Health Care (Dental, Mental Health, Vision): Yes   No

        Phone/Cell-phone: Yes No

        Other (please write): Yes   No

        I choose not to answer this question

12. **Within the past 12 months, were you worried whether your food would run out before you and your family got money to buy more?**

        Often true, sometimes true, never true

13. **Within the past 12 months, did you run out of the food you bought, and you didn't have money to get more?**

        Often true, sometimes true, never true

14. **Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.**

        Yes, it has kept me from medical appointments or from getting my medications

        Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need

        No

        I choose not to answer this question

Social and Emotional Health

15. **How often do you see or talk to people that that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)**

        Less than once a week

        1 or 2 times a week

        3 to 5 times a week

        5 or more times a week

        I choose not to answer this question

16. **Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?**

        Not at all

        A little

        Somewhat

        Quite a bit

Very much

I choose not to answer this question

Optional Additional Questions

17. *In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?*
    Yes
    No
    I choose not to answer this question

18. *In the past year, have you been afraid of your partner or ex-partner?*
    Yes
    No
    Unsure
    I have not had a partner in the past year
    I choose not to answer this question

19. *Would you like to be referred to services to help address your needs?*
    Yes
    No

For Coordinator/Coach/Educator/CIH

1. *If the patient would like additional help, which community resource(s) were they referred to? List all.*

2. *How was this referral made?*
    CONNECT, Fax, Phone, Other

E. *Exit Survey Sub-Tab*

1. **Do you believe that asthma symptoms have improved because of the program? *** – Select from the drop-down menu No, Yes, N/A, Unknown.

2. **How would you rate the severity of your or your child's asthma? *** – On a scale of 1-5, with 1 being the least, 5 being the most and 9 being unknown.

3. **Do you feel that you know more about asthma as a result of the program?** * – Select from the drop-down menu No, Yes, N/A, Unknown.

4. **How much do you think that you know about asthma? *** On a scale of 1-5, with 1 being the least, 5 being the most and 9 being unknown**.**

5. **Do you feel that you know more about asthma medication because of this program? *** Select from the drop-down menu No, yes, N/A, Unknown.

6. **How much would you say that you know about asthma medication? *** On a scale of 1-5, with 1 being the least, 5 being the most and 9 being unknown.

7. **Did you make the environmental changes suggested? *** Select from the drop-down menu No, yes, N/A, Unknown.

8. **Why didn't you make the environmental changes suggested? *** This is a free text box to type client's response. Enter N/A if the change was made.

9. **How much would you say that you know about the relationship between asthma and the home environment? *** On a scale of 1-5, with 1 being the least, 5 being the most and 9 being unknown.

10. **How confident are you in your ability to handle an asthma attack at home? *** On a scale of 1-5, with 1 being the least, 5 being the most and 9 being unknown.

11. **Does anyone live in your home currently smoke tobacco? * -** Select from the drop-down menu No, Yes, N/A, Unknown.

12. **If Yes, does the client smoke tobacco? * -** Will default to N/A unless yes is selected in the previous question. If yes was selected in previous question select from the drop down No, Yes, N/A, Unknown.

13. **Does the client ever ride inside cars with people who are smoking? *** Select from drop down No, Yes, N/A, or Unknown.

14. **If the client who is receiving home visiting services for asthma lives part time in another home, does anyone living in this home currently smoke tobacco? *** Select from drop down Yes, No, Don't Know, does not live in another home, N/A, Unknown

15. **Does anyone living in your home currently use an electronic vapor product?**
    * Select from drop down Yes, No, N/A, Unknown

16. **If yes, does the client use an electronic vapor product? *** Will default to N/A unless yes is selected in the previous question. If yes was selected in previous question select from the drop down No, Yes, N/A, Unknown.

17. **Has a doctor or other health professional ever given the client an asthma action plan? *-** Select from the drop-down menu No, yes, N/A, Unknown.

18. **Overall, how does the client or parent/guardian of the child rate the program? * -** On a scale of 1-5, with 1 being the least, 5 being the most and 9 being unknown.

19. **Would the client or parent/guardian of the child recommend this program to others? * -** Select from drop down No, Yes, N/A, or Unknown.

20. **If the client or parent/guardian of the child would not recommend this program, why not? * -** This is a free text box for the asthma home visitor to put the client's comments. If they would recommend program enter N/A.

21. **What could the program staff have done better to help the family and the client? * -** This is a free text box for the asthma home visitor to put the client's comments.

22. **What did the client and/or family like best about the program? * -** This is a free text box for the asthma home visitor to put the client's comments.

23. **What did the client and/or family like least about the program? * -** This is a free text box for the asthma home visitor to put the client's comments.

24. **Other comments: * -** This is a free text box for home visitor to put comments.

Follow-Up Survey Tab

This survey is sent out to clients 6 months after completion of the program. Either by mail or through email or text if client's preference is marked to receive notifications. Asthma home visiting nurse needs to include the client's ID # when sending this to the client. Depending on the clients age there are four different survey's:

Age Under 4

Age 4 years to 11

Age 12 years and older

Adult

The Follow-up survey tab includes four tabs. Introduction, and Healthcare Utilization will consist of the same questions for all age groups but will be worded slightly different depending on if the survey is for an adult or child. The Asthma Burden and Control Tab will be different for all four age groups. The Asthma Knowledge tab will be the same for all age

groups.

A. *Introduction Sub-Tab*

1. **When did you complete this survey? *** – What date did the client complete survey (MM/DD/YY) format.

2. **What is your ID number? *** – This needs to be provided by the Home Visiting nurse.

3. **When did you complete the program? *** – Select from the drop-down menu 6-9 months ago, 9-12 months ago, over a year ago.

4. **In which county did you/your child receive home visiting services? *** Select clients county from the drop-down menu**.**

B. *Healthcare Utilization Sub-Tab*

1. **How many emergency department visits for asthma have you had in the last 6 months? *** Enter number.

2. **How many urgent care and/or unscheduled medical office visits for asthma have you had in the last 6 months? *** Enter number.

3. **Have you been admitted to the hospital for asthma in the last 6 months? *** Select Yes or No.

4. **Do you have a healthcare provider you usually see? *** Select Yes or No.

5. **During the past 12 months, how many times did you see your usual health care provider for a routine checkup of your asthma? *** Enter number.

6. **Do you have a current prescription for a long-term controller medication? *** Select Yes or No.

7. **Is the long-term controller medication prescribed for year-round use or seasonal use? * -** Select Year-round or Seasonal.

8. **Do you take controller medication? * -** Select from drop-down menu. Some days (1 to 3 days of the week), Most days (4 to 6 days of the week), All the time (7days), Never (0 days).

C. *Asthma Burden and Control Sub-Tab*

Under 4 years old

1. **How many days of school has your child missed in the last 6 months? *** Enter # of days.

2. **How many workdays did the parent/guardian miss in the last 6 months due to the child's asthma? *** Enter # of days.

3. **What was the age of your child when he or she participated in the program? *** Select from drop down menu child's age at time of participating in program.

4. **How would you rate your child's asthma control during the past 4 weeks? *** Select from the drop-down menu Not controlled at all, poorly controlled, somewhat controlled, well controlled, completely controlled.

Age 4 to 11 years old

1. **How many days of school has your child missed in the last 6 months? *-** Enter # of days.

2. **How many workdays did the parent/guardian miss in the last 6 months due to the child's asthma? * -** Enter # of days.

3. **What was the age of your child when he or she participated in the program? * -** Select from drop down menu child's age at time of participating in program.

4. **How is your child's asthma today? * -** Select from drop-down menu Very bad, Bad, Good, Very Good.

5. **How much of a problem is your child's asthma when he or she runs, exercises, or plays sports? * -** Select from the drop-down menu It's a big problem; they can't do what they want to do, it's a problem and they don't like it, It's a little problem but it's OK, It's not a problem.

6. **Does your child cough because of his or her asthma? * -** Select from the drop-down menu All the time, Most of the time, Some of the time, None of the time.

7. **Does your child wake up during the night because of his or her asthma? * -** Select from the drop-down menu All the time, Most of the time, Some of the time, None of the time.

8. **In the past 4 weeks, how many days did your child have any daytime asthma symptoms? * -** Select from the drop-down menu Not at all, 1-3 days, 4-10 days, 11-18 days, 19-24 days, Every day.

9. **During the past 4 weeks, how many days did your child wheeze during the day because of asthma? *** Select from the drop-down menu Not at all, 1-3 days, 4-10 days, 11-18 days, 19-24 days, Every day.

10. **During the past 4 weeks, how many days did your child wake up during the night because of asthma? *** Select from the drop-down menu Not at all, 1-3 days, 4-10 days, 11-18 days, 19-24 days, Every day.

Age 12 years old or older

1. **How many days of school has your child missed in the last 6 months? *-** Enter # of days.

2. **How many workdays did the parent/guardian miss in the last 6 months due to the child's asthma? * -** Enter # of days.

3. **What was the age of your child when he or she participated in the program? *** **-** Select from drop down menu child's age at time of participating in program.

4. **In the past 4 weeks, how much of the time did your child's asthma keep him or her from getting as much done at work, school, or at home? * -** Select from the drop-down menu All the time, Most of the time, Some of the time, None of the time.

5. **During the past 4 weeks, how often has your child had shortness of breath? *** **-** Select from the drop-down menu More than once a day, Once a day, 3-6 times per week, Once or twice a week, Not at all.

6. **During the past 4 weeks, how often did your child's asthma symptoms (wheezing, coughing, shortness of breath, chest tightness, or pain) wake him or her up at night or earlier than usual in the morning? * -** Select from the drop-down menu 4 or more nights a week, 2 or 3 nights a week, Once a week, Once or twice, Not at all.

7. **During the past 4 weeks, how often has your child used his or her rescue inhaler or nebulizer medication (such as albuterol)? * -** Select from the drop-down menu 3 or more times per day, 1 or 2 times per day, 2 or 3 times per week, Once a week or less, Not at all.

8. **How would you rate your child's asthma control during the past 4 weeks? * -** Select from the drop-down menu Not controlled at all, Poorly controlled, Somewhat Controlled, Well controlled, Completely controlled.

Adult

1. **How many workdays did you miss in the last 6 months due to your asthma? *-** Enter # of days.

2. **What was your age when you participated in the program? * -** Select from drop down menu age at time of participating in program.

3. **In the past 4 weeks, how much of the time did your child's asthma keep him or her from getting as much done at work, school, or at home? * -** Select from the drop-down menu All the time, Most of the time, Some of the time, None of the time.

4. **During the past 4 weeks, how often have you had shortness of breath? * -** Select from the drop-down menu More than once a day, Once a day, 3-6 times per week, Once or twice a week, Not at all.

5. **During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness, or pain) wake you up at night or earlier than usual in the morning? * -** Select from the drop-down menu 4 or more nights a week, 2 or 3 nights a week, Once a week, Once or twice, Not at all.

6. **During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)? * -** Select from the drop-down menu 3 or more times per day, 1 or 2 times per day, 2 or 3 times per week, Once a week or less, Not at all.

7. **How would you rate your asthma control during the past 4 weeks? * -** Select from the drop-down menu Not controlled at all, Poorly controlled, Somewhat Controlled, Well controlled, Completely controlled.

D. *Asthma Knowledge Sub-Tab*

1. **On a scale of 1 to 5, how confident are you in your ability to handle an asthma attack at home? *-** Select from the drop-down menu

2. **Which of the following are common asthma symptoms? * -** A "symptom" is a sign or warning that a person's asthma is becoming worse. Select all that apply.

3. **Which of the following may be asthma triggers for some people? * -** A "trigger" is something that causes or brings on asthma symptoms when a person with asthma comes into contact with it; triggers are different for different people. Select all that apply.

4. **Which of the following is an allergen? * -** An "allergen" is something that causes the body to react by sneezing or forming a rash because you have an allergic, or bad reaction to it. Select from the drop-down menu Ozone, Pollen, Tobacco smoke, Volatile organic compound, Vehicle exhaust.

5. **Which main type of asthma medication is taken only when symptoms develop or before exercise? * -** Enter answer in the box.

6. **Which main type of asthma medication, if prescribed, is taken on a daily basis? * -** Enter answer in the box

7. **Asthma causes symptoms because the airways in the lungs become narrowed. * -** Select true or false

COMMONLY ASKED QUESTIONS

How Do I Create or Reset a Username or Password?

Only Montana Asthma Control State administrators can create or reset a username or password. These contacts are listed below for assistance with your username or password.

Ann Lanes
Informatics Specialist
Phone: (406) 444-6894
E-Mail: Lorraine.Lanes@mt.gov

How Do I Create a New Client?

Step 1. Go to **Home page** on the main menu bar and select **+Add Reporting for a new client**.

Step 2. Select Caretaker in the Add New Client pop up box. Then Select OK.

How Do I Generate an Excel Spreadsheet?
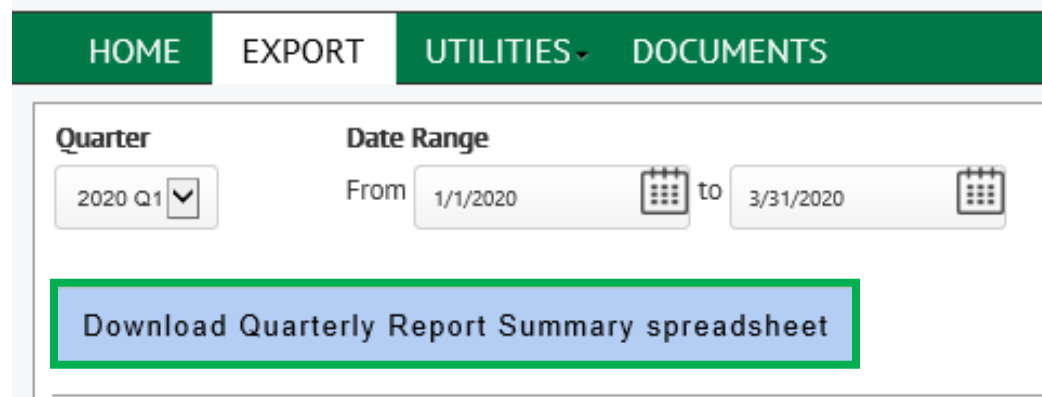
Step 1. Go to the **Export page**.

Step 2. Then choose **Quarter** or **Date Range**.

Step 3. Click on **Download Quarterly Report Summary Spreadsheet**.

Step 4. Then Select **Open**.

Step 5. Then select **Allow** on the security pop up.
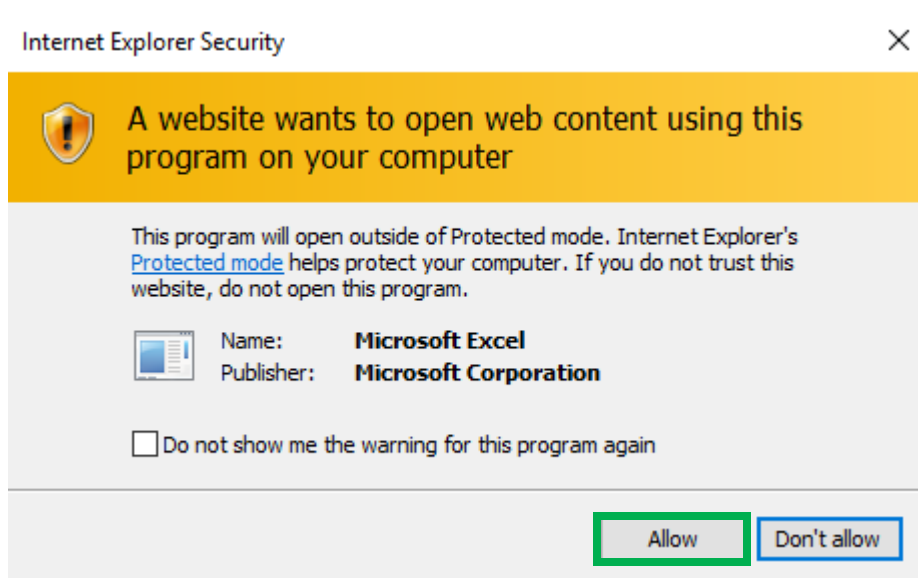
How Do I Download Documents?

Step 1: Go to the **Documents page**.

Step 2: Click on **view** to download one document or **Download All** to download all MAP documents

Step 3: Click **Open** on pop up box.

Step 4: A security box will pop up click **allow**.

Internet Explorer Security ✕

⚠️ **A website wants to open web content using this program on your computer**

This program will open outside of Protected mode. Internet Explorer's Protected mode helps protect your computer. If you do not trust this website, do not open this program.

🖥️ Name: **File Explorer**
Publisher: **Microsoft Windows**

☐ Do not show me the warning for this program again

Allow   Don't allow

Step 5: Click on **Extract all**.
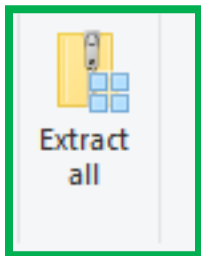
Extract all

Step 6: A box will pop up wanting to know where to save the file click on **Browse** to select the location you want to save this file. Then click on **Extract**.

✕

📦 Extract Compressed (Zipped) Folders

Select a Destination and Extract Files

Files will be extracted to this folder:

[   ]   Browse...

☑ Show extracted files when complete

Extract   Cancel
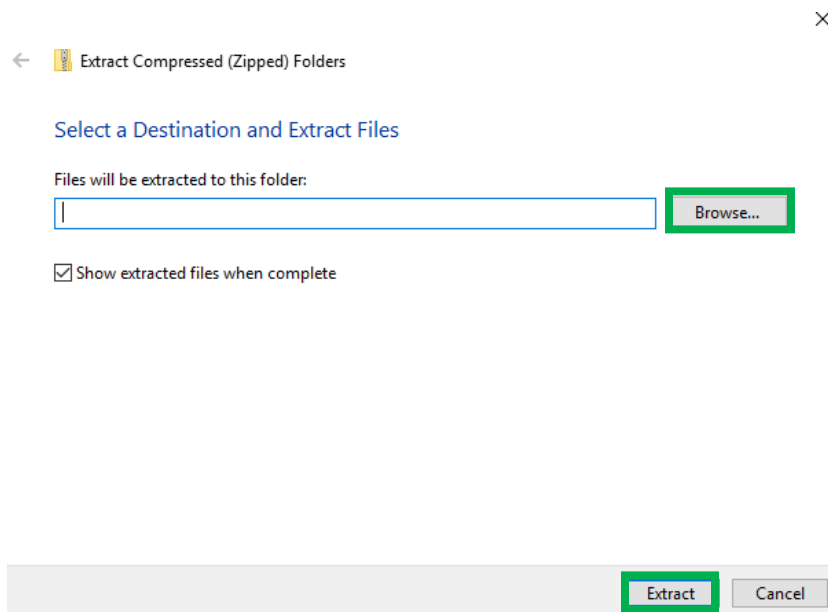
How Do I Submit my Data?

Step 1: First Input data for Visit.

Step 2: Next click on **Complete** button to finish Visit.

Step 3: Then click on **Submit Quarterly Report** to submit your data to MACP**.**

*If on the Home Screen it shows **Submitted**, then your data for that visit has been sent to the Montana Asthma Control Program.*

TECHNICAL SUPPORT

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For technical support, please contact the following:

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PROGRAMMATIC SUPPORT

For more information, please refer to https://dphhs.mt.gov/Asthma/asthmahomevisiting. For support related to the Montana Asthma Home Visiting Program, please contact the following:

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