

HCA EDUCATION AND RESEARCH
IROQUOIS Healthcare Association
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Mother Cabrini HEALTH FOUNDATION

Collaborative Models of Community Medicine and Paramedicine

Protocol Research

July 2022

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1. Coordination of Care

Patients discharged from acute care /rehab settings require coordinated, multidisciplinary care management in order to provide ongoing quality care, prevent worsening of their acute or chronic medical conditions, and ensure their ability to remain in the home setting. The program will coordinate care among a diverse group of providers with variable skill sets to improve communication, coordinate follow-up care, provide in-home care, and provide assistive home services, as needed.

I. Community Paramedic Toolkit: Minnesota Department of Health

Supervision and Management Protocols

a. Medical Director's Supervision of the CP

- The CP functions under delegated practice of his/her medical director. As such, it is imperative that the CP operates by a set of guidelines developed by this physician.

- To ensure that the process is seamless, a strict adherence to the principles of continuous quality improvement (CQI) must be followed. This concept is no different from what is expected of the EMS medical director in providing supervision for his/her paramedics in the area of emergency 9-1-1 response.

- The components of this supervisory role can be divided into three areas: prospective oversight, concurrent oversight, and retrospective oversight.

- Through prospective oversight, the CP medical director must develop guidelines of patient care that are supported by modules of training.

- As the CP moves into the community to do his/her work, the CP medical director must use concurrent oversight to assess the skills of his/her extenders, by doing "ride along(s)", offering "skills day" training (i.e., training to allow CPs to complete new clinical training requirements), and by being available for consultations as needed (this may be accomplished by various means of telecommunication).

- The CP medical director must provide retrospective oversight by doing periodic case reviews with his/her CP's. This should be done on a regular basis, depending upon the frequency and intensity of the service.

b. Employer's Supervision of the CP

- Supervision of the CP's care delivery is the responsibility of the Medical Director. The CP's day-to-day supervision of assignments, performance, and continuing education training as an employee may be given by a separate manager(s) within the agency. While the ideal supervisory structure would have this position reporting directly to an Operations Manager, organizations have different requirements and needs, and the supervisory structure should fit that need.

- CPs may also have multiple reporting relationships as their schedule could require them to perform as a Paramedic or as a CP. Defining these relationships clearly for day-to-day operations and in the Job Description will allow for effective communication, resulting in less confusion for the CP, agency leaders, and employees.

- Performance management and ongoing communication will help to improve and maintain the CP's performance.

- The process includes setting and evaluating clear and specific expectations and providing periodic informal and formal feedback. When an employee has multiple reporting relationships, it is the responsibility of all supervisors to coordinate this feedback as it relates to the specific duties the employee performs for them. Most agencies will have a performance management process in place for their current employees. The CP should be included in the same process.

PRACTICE TIP: Safety is a concern when CPs are out in the field, working in people's homes – and supervisors need to plan for it. For example, some organizations double-up for certain patients, meet the patient outside of the home or try to avoid the potential for any inappropriate patient behavior by matching patients with CPs of the same gender. Scheduling frequent check-ins while the CP is out in the field is an easy way to maintain contact, and some agencies are using available technology to stay aware of a CPs location. It is a good idea to connect with the patient's providers and consult health records for any history of violence before sending a CP to their home. A CP should always have the option of terminating a visit or ending a course of treatment with a patient.

Direct link:
https://www.health.state.mn.us/facilities/ruralhealth/emerging/cp/docs/2016cptoolkit.pdf

II. Violet Township Fire Department (Ohio)

Clinisync Health Information Exchange:

- Managed by the Ohio Health Information Partnership
- The network has 155 hospitals and thousands of physicians communicating with one another through the electronic transmission of patient medical records
- A longitudinal record that compiles encounters from any hospital or facility that contributes patient information within the CliniSync community
- Can look up a patient's name and view information on demographics, encounters, medications, diagnoses, and more
- More than 15 million patients now exist in a patient index within CliniSync
- Wrap services around the patient

Violet Township Fire Department joined the CliniSync Health Information Exchange in 2017.

Ex: A community paramedic at Violet Township Fire Department looks up information to assist him in his assessment and to remind doctors and others what patients need. "say Mrs. Smith got discharged, and it looks like she was supposed to have these certain meds but nothing has been called into the pharmacy. I can notify the doctor or pharmacist to remind them," he says." Hospitals discharge so many patients in a day that someone may have thought they sent an electronic pharmacy order but didn't, he explains".

Direct link: https://clinisync.org/2020/12/11/community-paramedics-bridging-the-healthcare-gap/

III. Mobile Integrated Health and Home Health Coordination

Partnerships between home health and EMS-Based MIH services:

- The EMS MIH program provides a cost-effective solution to night and weekend coverage for a home health agency.

- Registering home health patients into the EMS agency's 9-1-1 dispatch system so if the patient calls 9-1-1, the care and disposition of the patient can be coordinated with the home health agency.

- The EMS agency provides call center services for the home health agency for nights and weekends.

Direct link: https://www.naemt.org/docs/default-source/community-paramedicine/mih-cp-toolkit/ems_homehealth.pdf

2. Reducing ED Admissions

Patients often use the Emergency Department as their only or last resort location for low acuity care needs. The program will work to allow EMS providers to assess and treat patients' low acuity complaints with onsite care and/or referral to treatment locations/providers other than the ED, so as to reduce Emergency Department admissions. This will be done in coordination with other community services (i.e.- social service, home care) to ensure appropriate ongoing care needs are met.

I. Colorado Springs Fire Department

- Bringing hospitals, emergency services, and a payer source together to assess community needs

- The fire department and local hospitals came together to study the overuse of 911 and emergency departments

- They found that patients needed education on managing chronic diseases, lacked transportation to pharmacies or doctor's offices or were in need of resources to assist with psychosocial or economic issues (an easy button was 911), physicians were needed for many cases

- Community mental health
- CARES program (Community Assistance Referral and Education Services)
- Partnering with hospitals, Medicaid care coordination organization to reduce 911 calls
- Expansion of the program to include a mobile urgent care unit (includes paramedic or EMT paired with a nurse practitioner) and a Community Response Team (includes a paramedic, behavioral health clinician and law enforcement officer)

Direct link: https://www.naemt.org/docs/default-source/community-paramedicine/Toolkit/colorado-springs-case-study-1.pdf

3. Reducing Hospital Readmission

Patients discharged from acute care facilities are often readmitted within a short period of time, often for issues that could be managed with improved care coordination and integrated home care. The program will develop and offer a multidisciplinary team approach to ensure discharged patients have access to help manage their post-acute care. Examples would include assessment of social/medical support, medication management (as below), mobility assistance, management/referral for low acuity medical problems, nutrition assistance, etc.

I. NVNA and Hospice Collaboration with Brewster Ambulance Services

- Brewster engaged as a key partner to avoid re-hospitalization (through service as an overnight customer service center for NVNA and Hospice and monitoring of telehealth patients over the weekend)

II. Abbeville (South Carolina)

- Aims to help tackle readmissions among patients identified as “frequent users”
- ACEMS arranges a home visit soon after discharge, where the community paramedic will be able to help clarify physician orders, go over medication

lists and compliance or address other needs with the patient and family members

Questions to answer before starting a program to understand your community's healthcare environment:

1. What discharge diagnosis is the most likely to be readmitted within 30 days to the hospital in your community?

    - Hospital compare tool: http://www.medicare.gov/hospitalcompare/search.html

2. What quality initiative is the hospital currently implementing to help reduce readmissions?
3. Are chronic disease and poor management of chronic disease a contributor to the readmission?

Direct link: https://nosorh.org/wp-content/uploads/2014/08/SC-Community-Paramedicine-Blueprint_V1-Melinda-Merrill-and-Michele-Staneck.pdf

4. Medication Management

Patients discharged from acute care facilities often do so with multiple new or changed medication prescriptions. Especially for the elderly with poor support structure, medication errors can result in adverse drug reactions, disease relapse, and hospital readmission. The program will develop mechanisms, with multidisciplinary teams to assist patients in obtaining needed medications, and ensuring proper use, thus decreasing potential medication errors and adverse medication reactions.

I. Eagle County Paramedic Services

Home Medications

a) Policy:

- The Community Paramedic will respond to a residence on order from the medical provider requesting community paramedic care and follow guidelines outlined by the medical provider's orders for home medication checks.

b) Purpose:

- To assist the patient in proper usage of home medications through information/education and vital sign checks.

- To assist the medical provider in thorough documentation of all prescription and non-prescription medications for the purpose of avoiding adverse drug reactions.

- To ensure proper continuum of care during medical provider care provider transitions.

c) Procedure:

1. Obtain and review the patient's health history and medical provider's order prior to appointment.

2. Follow medical provider's orders.

3. Review history and physical.

4. Review patient's information with the patient, including medical and medication history, current medications the patient is receiving and taking, compliance, time of doses, medical provider who prescribed medications and sources of medications such as the pharmacy.

5. Ask the patient if there are any other medications or supplements, they take that might be from another medical provider or over the counter.

6. Assess vital signs

7. Assist patient in sorting medications.

8. Stress importance of medication compliance.

9. Contact referring medical provider if paramedic or patient has concerns.

Direct link: https://idph.iowa.gov/Portals/1/userfiles/177/Operations-Protocols%20%20%20ECPS_CP_Protocols.pdf

II. Kentucky Board of Emergency Medical Services

Medication Compliance and Reconciliation

a) Purpose:

- The purpose of this service is to evaluate the patient's medications to determine whether they are taking and storing them correctly.

- Elderly patients in particular may be on multiple medications, which can create confusion. The CP will evaluate whether the patient is taking each one of their prescribed medications, at the appropriate time and correct dosage, and whether they are safely and properly storing them.

- The goal for the Community Paramedic is to help the client organize and correctly understand how and when to take their medications.

b) Procedure:

- Before visiting with the patient, the physician's office will fax a copy of the most current medication list, history, and orders to the Community Paramedic office so that the visiting paramedic knows exactly what plan the patient is supposed to be on.

- Through inspection of the medications, organizational containers, and interview techniques, the paramedic will determine if the patient is following their prescribed medications and routine. If during the visit, the paramedic finds that there is a discrepancy in how the patient is handling their medications, the physician will be contacted and discussions will be made on how to correct the problem.

- The paramedic will NOT change any medications, doses, or advise the patient on how to resume a normal schedule once the patient has gone off their prescribed meds or routine. The physician will make any and all decisions regarding the patient's medications, and the paramedic is in an assistance role only.

III. Community Paramedicine Models for Prevention and Health Education: Medication Management

One important role for community paramedics is to help patients manage medications. Community paramedics can help set up reminders, explain dosing instructions, identify

medication management issues like improper storage, and uncover errors in their medication list.

Medication reconciliation has three steps:

- **Verification:** Developing a comprehensive list of all current prescriptions
- **Clarification:** Confirming medications and dosage are appropriate
- **Reconciliation:** Making necessary adjustments to the list to ensure no errors, duplications, or omissions

Community paramedics can work with patients and other healthcare providers to conduct all three steps of this process. Using the Medication Management Strategy (https://www.ahrq.gov/patient-safety/reports/engage/interventions/medmanage.html) from the Agency for Healthcare Research and Quality (AHRQ) or another method, community paramedics can help patients develop a comprehensive list of their current prescriptions.

Once the list is correct, the community paramedic confirms its contents with the patient's providers, ensuring that all dosages are correct and all medications are still currently needed to manage their health. Then, either on their own or with support from a community pharmacist, the community paramedic conducts a medication reconciliation process, which will ensure there are no contraindications, drug-drug interactions, or drug-disease interactions that may cause harm.

A final responsibility of medication management is to provide patient education. The community paramedic can work with the patient and their family or caregiver to ensure they understand how and when to take each medication, along with any potential warning signs of adverse drug events that should be shared with their primary care provider.

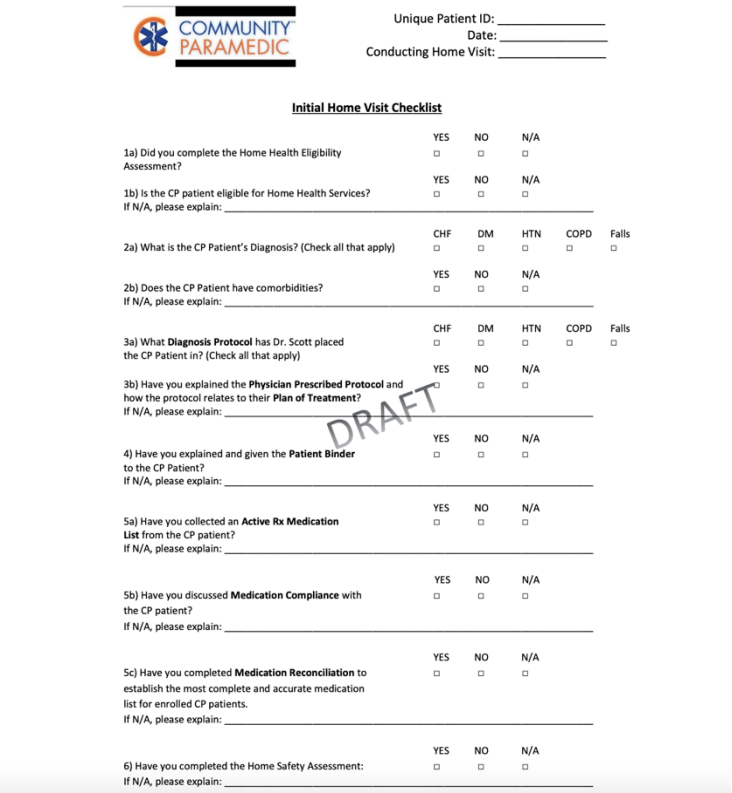
Direct link: https://www.ruralhealthinfo.org/toolkits/community-paramedicine/2/prevention-and-health-education

5. Home Inspection

For patients discharged from acute care facilities, a return to home is often fraught with safety issues relating to personal mobility, physical safety hazards, and location challenges. The program will develop and implement multi-disciplinary home assessment teams to work with discharged patients to ensure their home circumstances are safe and can contribute positively to their ongoing care needs.

I. Abbeville Community Paramedicine Program

South Carolina Office of Rural Health: Initial Home Visit Checklist



COMMUNITY PARAMEDIC

Unique Patient ID: _____
Date: _____
Conducting Home Visit: _____

Initial Home Visit Checklist

1a) Did you complete the Home Health Eligibility Assessment?	YES ☐	NO ☐	N/A ☐			
1b) Is the CP patient eligible for Home Health Services? If N/A, please explain: _____	YES ☐	NO ☐	N/A ☐			
2a) What is the CP Patient's Diagnosis? (Check all that apply)	CHF ☐	DM ☐	HTN ☐	COPD ☐	Falls ☐	
2b) Does the CP Patient have comorbidities? If N/A, please explain: _____	YES ☐	NO ☐	N/A ☐			
3a) What **Diagnosis Protocol** has Dr. Scott placed the CP Patient in? (Check all that apply)	CHF ☐	DM ☐	HTN ☐	COPD ☐	Falls ☐	
3b) Have you explained the **Physician Prescribed Protocol** and how the protocol relates to their **Plan of Treatment**? If N/A, please explain: _____	YES ☐	NO ☐	N/A ☐			
4) Have you explained and given the **Patient Binder** to the CP Patient? If N/A, please explain: _____	YES ☐	NO ☐	N/A ☐			
5a) Have you collected an **Active Rx Medication List** from the CP patient? If N/A, please explain: _____	YES ☐	NO ☐	N/A ☐			
5b) Have you discussed **Medication Compliance** with the CP patient? If N/A, please explain: _____	YES ☐	NO ☐	N/A ☐			
5c) Have you completed **Medication Reconciliation** to establish the most complete and accurate medication list for enrolled CP patients. If N/A, please explain: _____	YES ☐	NO ☐	N/A ☐			
6) Have you completed the Home Safety Assessment: If N/A, please explain: _____	YES ☐	NO ☐	N/A ☐			

DRAFT

Direct link: https://nosorh.org/wp-content/uploads/2014/08/SC-Community-Paramedicine-Blueprint_V1-Melinda-Merrill-and-Michele-Staneck.pdf

II. Eagle County Paramedic Services

Home Safety Assessment

a) Policy:

- The Community Paramedic will respond to a residence on order from the medical provider requesting community paramedic care and follow guidelines outlined by the medical provider's orders for a home safety assessment.

b) Purpose:

- To ensure the home is in safe condition to meet the medical needs of the patient. Can be used to conduct a pre-surgical assessment, post-operative assessment, or an evaluation of the safety of the home at anytime.

c) Procedure:

1. Follow the Home Safety Inspection checklist including the inspection of the following areas of the home:
   - Outside of the house
   - Living room
   - Kitchen
   - Stairs
   - Bathroom
   - Bedroom
   - General Inspection
2. Complete the *Overall Tips* inspection
3. Complete comments on any sections marked "no" during the inspection
4. Complete recommendations for the resident and possible referrals
5. Discuss the findings with the patient and resources to remedy
6. Have the patient sign off the report with the understanding they understand the recommendations
7. Complete the report and return a copy to the ordering medical provider.
8. If any life-threatening issues are identified, notify the ordering provider immediately.

Direct link: https://idph.iowa.gov/Portals/1/userfiles/177/Operations-Protocols%20%20%20ECPS_CP_Protocols.pdf

III. Kentucky Board of Emergency Medical Services

Home Safety Assessment Tool

a) Purpose:
   - The home safety assessment is designed to provide a detailed walkthrough of the client's home, identify safety hazards and make recommendations when needed.

b) Procedure:

   - The paramedic will look at many factors that have been shown to cause injuries to members of the home, especially the very young and elderly.

   - With a specially designed checklist, (Attachment A) the assessment begins at the driveway or walkway and ends at the back yard. Note, this assessment is not a mechanical inspection of the home and is not designed to look at the safety of electrical wiring, hot water heaters, plumbing or any other mechanical features of the house. Rather, it is designed to focus on things such as trip hazards, kitchen safety, adequate lighting in the home and in walk areas, grab bars and lift handles if applicable, and other notable safety features.

   - A Community Paramedic does not perform the role of a physical therapist and will therefore not be analyzing the persons gait or movement, nor advising about exercises or physical therapy.

   - If a Community Paramedic notices the client is having difficulty moving around, they should make the necessary referrals to organizations that can provide walkers, canes and other mobility devices, and also link them with their primary care physician, so that they can be referred to a physical therapist.

   - If hazards are found, the paramedic will recommend changes that need to be made and, if needed, refer the client to the appropriate community resources that can then provide further assistance.

Home Safety Assessment Checklist:

ATTACHMENT A

Home Safety Assessment Checklist

Date of visit:

Occupant name: *Paramedic Name:*

OUTSIDE OF HOUSE

1. *Sidewalk and/or pathway to house is level and free from any hazards.*	*Yes*	*No*	*N/A*
2. *Driveway is free from debris/snow/ice.*	*Yes*	*No*	*N/A*
3. *Outside stairs are stable and have sturdy handrail.*	*Yes*	*No*	*N/A*
4. *Porch lights are working and provide adequate lighting.*	*Yes*	*No*	*N/A*

LIVING ROOM

1. *Furniture is of adequate height and offers arm rests that assist in getting up and down.*	*Yes*	*No*	*N/A*
2. *Floor is free from any clutter that would create tripping hazards.*	*Yes*	*No*	*N/A*
3. *All cords are either behind furniture or secured in a manner that does not cause trip hazards.*	*Yes*	*No*	*N/A*
4. *All rugs are secured to floor with double-sided tape.*	*Yes*	*No*	*N/A*
5. *Lighting is adequate to light room.*	*Yes*	*No*	*N/A*
6. *All lighting has an easily accessible on/off switch.*	*Yes*	*No*	*N/A*
7. *Phone is readily accessible near favorite seating areas.*	*Yes*	*No*	*N/A*
8. *Emergency numbers are printed near all phones in house.*	*Yes*	*No*	*N/A*

KITCHEN

1. *Items used most often are within easy reach on low shelves.*	*Yes*	*No*	*N/A*
2. *Step stool is present, is sturdy and has handrail.*	*Yes*	*No*	*N/A*
3. *Floor mats are non-slip tread and secured to floor.*	*Yes*	*No*	*N/A*
4. *Oven controls are within easy reach.*	*Yes*	*No*	*N/A*
5. *Kitchen lighting is adequate and easy to reach switches.*	*Yes*	*No*	*N/A*
6. *ABC fire extinguisher is located in kitchen.*	*Yes*	*No*	*N/A*

Home Safety Checklist, cont.

STAIRS

1. *Carpet is properly secured to stairs and/or all wood is properly secured.*	*Yes*	*No*	*N/A*
2. *Handrail is present and sturdy.*	*Yes*	*No*	*N/A*
3. *Stairs are free from any clutter.*	*Yes*	*No*	*N/A*
4. *Stairway is adequately lit.*	*Yes*	*No*	*N/A*

BATHROOM

1. *Tub and shower have a non-slip surface.*	*Yes*	*No*	*N/A*
2. *Tub and/or shower have a grab bar for stability.*	*Yes*	*No*	*N/A*
3. *Toilet has a raised seat.*	*Yes*	*No*	*N/A*
4. *Grab bar is attached near toilet for assistance.*	*Yes*	*No*	*N/A*
5. *Pathway from bedroom to bathroom is free from clutter and well lit for ease of movement in the middle of the night.*	*Yes*	*No*	*N/A*

BEDROOM

1. *Floor is free from clutter.*	*Yes*	*No*	*N/A*
2. *Light is near bed and is easy to turn on.*	*Yes*	*No*	*N/A*
3. *Phone is next to bed and within easy reach.*	*Yes*	*No*	*N/A*
4. *Flashlight is near bed in case of emergency.*	*Yes*	*No*	*N/A*

GENERAL

1. *Smoke detectors in all areas of the house (each floor) and tested.*	*Yes*	*No*	*N/A*
2. *CO detectors on each floor of house and tested.*	*Yes*	*No*	*N/A*
3. *Flashlights are handy throughout the home.*	*Yes*	*No*	*N/A*
4. *Resident has all medical information readily available and in an area emergency providers will easily find.*	*Yes*	*No*	*N/A*
5. *All heaters are away from any type of flammable material.*	*Yes*	*No*	*N/A*

Home Safety Checklist, cont.

OVERALL TIPS

1. *Homeowner has good non-skid shoes to move around house.*	*Yes*	*No*	*N/A*
2. *All assisted walking devices are readily accessible and in good condition.*	*Yes*	*No*	*N/A*
3. *There is a phone near the floor for ease of reach in case of a fall.*	*Yes*	*No*	*N/A*
4. *All O2 tubing is less than 50 ft. and is not a trip hazard.*	*Yes*	*No*	*N/A*
5. *Resident has had an annual hearing and vision check by a physician.*	*Yes*	*No*	*N/A*
6. *Resident has the proper hearing and visual aids prescribed and are in good working order.*	*Yes*	*No*	*N/A*
7. *All medications are properly stored and labeled to avoid confusion on dosage, time to take, and avoidance of missed doses.*	*Yes*	*No*	*N/A*

FOR ALL SECTIONS MARKED 'NO' THE FOLLOWING RECOMMENDATIONS ARE NOTED BELOW

After evaluation I recommend the resident be considered for the following referrals.

Signature of resident:

Signature of Community Paramedic:

References: Centers for Disease Control and Prevention / http://www.cdc.gov
A. „Check for Safety" A Home Fall Prevention Checklist for Older Adults
B. U.S. Fall Prevention Programs for Seniors – Selected Programs Using Home Assessment and Modification.

Direct link: https://kbems.kctcs.edu/media/medical-direction/community-paramedic-handbook-version-1-9-14.pdf

6. Training Resources

I. Abbeville (South Carolina) Community Paramedic Training

- Community Paramedicine education should prepare Paramedics with the skills to be able to identify community health needs and help them to address the gaps revealed by a community assessment.

- It should help Paramedics become more familiar with, and able to accept, their new role as part of the primary care team. The training needed to accomplish these goals is fundamental to any CP program development.

- The first such aspect is the didactic training that the CPs will receive. Several in-house training programs exist for those services with the resources and time to develop these. There is also a national curriculum that has been developed which is currently in its third revision. The standardized curriculum created by Community Healthcare and Emergency Cooperative (CHEC) of the North Central EMS Institute has two phases. CHEC defines these phases as:

a) Foundational Skills:

- Comprehensive didactic instruction: advocacy; outreach and public health; performing community assessments; developing strategies for care and prevention

- 100 hours: based on experience

b) Clinical Skills:

- Supervised training: medical director; nurse practitioner; physician assistant and/or a public health provider

- 15-146 hours: based on experience

Within these two phases, there are seven modules. As defined by CHEC; these are:

Didactic:

1. Community Paramedic's Role within Healthcare System
2. Social Determinants of Health

3. CP Role within Public Health and Primary Care
4. Culturally Competent Care
5. Community Paramedic's role within the Community
6. Community Paramedic's role in Personal Safety and Wellness

Clinical:

1. Customized to individual communities: allows for the CPs to address the care gaps in their particular community
   - The CHEC curriculum is currently being taught nationally in one venue, through Hennepin Technical College in Minnesota. The College is able to provide distance learning opportunities for students from other parts of the nation to attend.

   - A program for on-going in-service training should be developed and strictly followed as well. No national examples of CP IST currently exist.

Direct link: https://nosorh.org/wp-content/uploads/2014/08/SC-Community-Paramedicine-Blueprint_V1-Melinda-Merrill-and-Michele-Staneck.pdf

II. IBSC Community Paramedicine (CP-C) Examination

- Credentialing process is designed to validate essential knowledge and judgment for safe and competent practice

- Recertification every 4 years

Direct link: https://www.ibscertifications.org/roles/community-paramedic

III. NAEMT: Community Paramedicine Series to prepare for CP-C Examination

Semester-long community paramedicine program

Courses include:

- Motivational interviewing

- Wellness and nutrition
- Hospice and palliative care
- Mental health and substance abuse
- Geriatrics
- Pediatrics/children with special health care needs
- Endocrine disorders
- Respiratory disorders
- Cardiovascular disorders
- Pharmacology
- Neurological disorders
- The Clinical Medicine of Community Paramedicine
- Introduction to Community Paramedicine and Mobile Integrated Health
- Clinical rotations

Direct link: https://www.naemt.org/education/CP

IV. The New York State Healthy Neighborhoods Program (HNP)

- A longstanding program run by the New York State Department of health

- The program provides in-home assessments and interventions for:

  - Asthma
  - Tobacco Cessation
  - Indoor air quality
  - Lead
  - Fire safety
  - Other environmental hazards

- Seeks to reduce the burden of housing-related illness through a holistic, healthy homes approach

- Targets high-risk areas that are identified using housing, health, and socioeconomic indicators from census and surveillance data

- Uses door-to-door canvassing (roughly 67 percent of visits) and referrals (32 percent of visits)

- When problems or potential hazards are identified during the visit an outreach worker provides education (written and verbal), referrals, and products to correct or reduce the hazard

- Studies show that this program improves asthma outcomes for low-income New Yorkers and helps people with asthma achieve better health while saving money and improving household conditions