The Patient Care Coordinator Rx:

How to Profit in an Outcomes-Based Health System from Patient Education & Compliance

Presented to

ECRM HHC

by

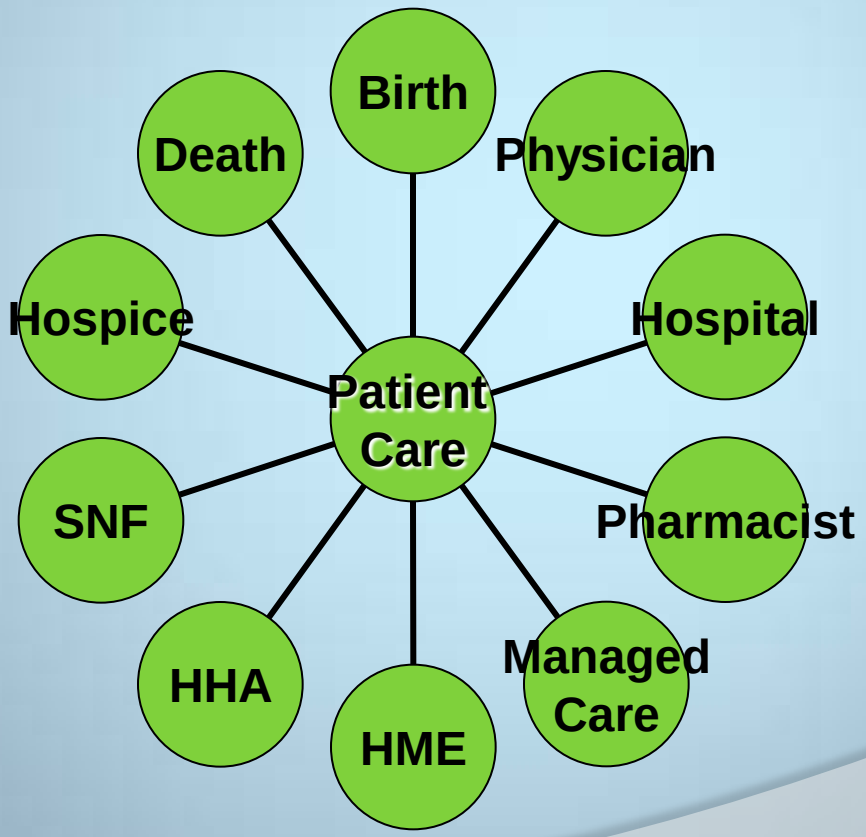
Jack Evans

www.RetailHomeCare.com

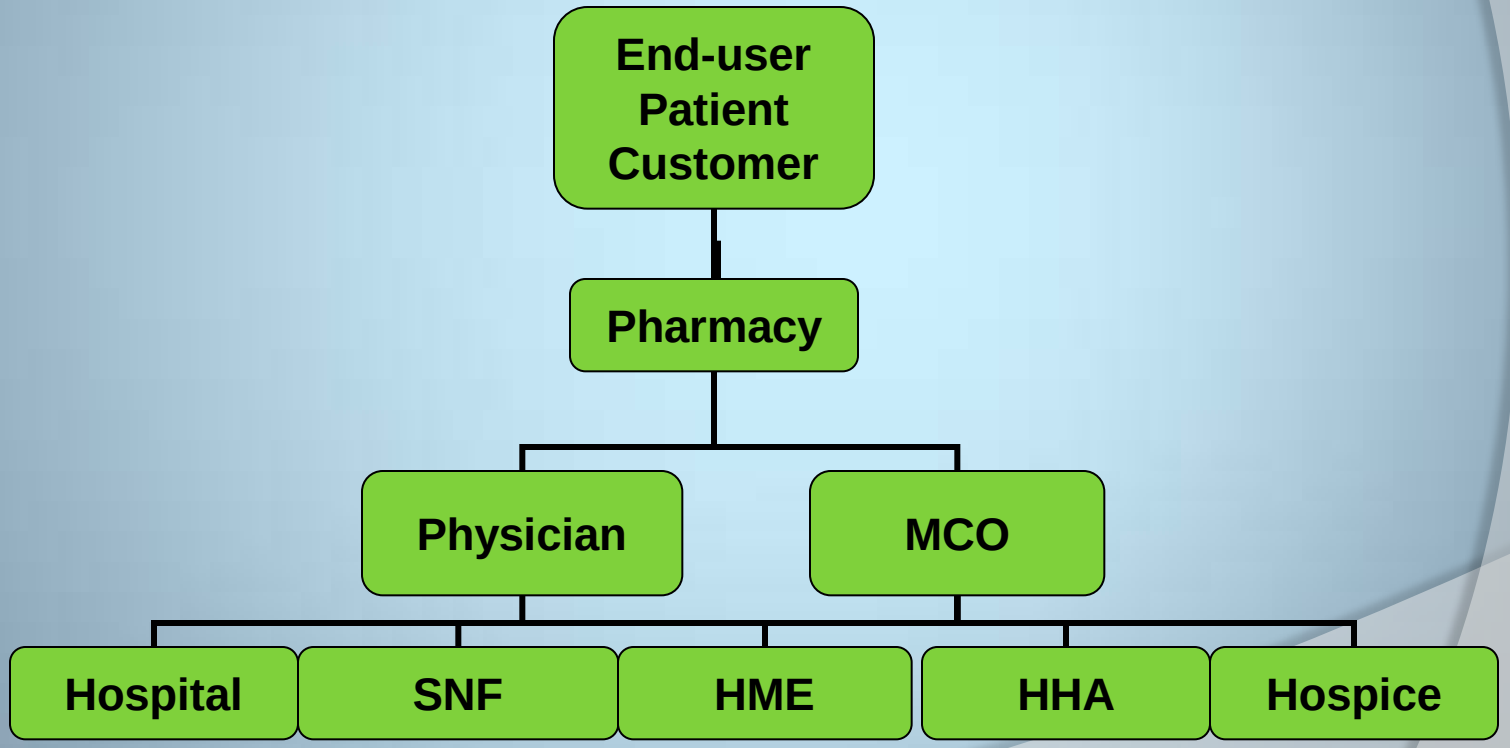
Take-Aways

- **Outcomes-Based Healthcare System Basics:**
  1. **Preventative vs. critical care**
  2. **Patient treatment plans (Dr, Health Plan, CMS)**
  3. ***Healthcare professional to coordinate care***
  4. **Metrics to measure outcomes**
- **Patient Wellness:**
  - **Patient Education**
  - **Patient Adherence**
  - **Patient Compliance**
- **Patient Care Coordinator**
  - **Monitoring on regular basis (i.e. monthly visits in-store or calls if mail order)**
  - **Payment per patient/disease state/mo.**

The Continuum of Patient Care



The Rx for Healthcare: Become the Gatekeeper



The Rx Transition:

Where are you?

Traditional Rx: Reactive

- **Pharmacist behind counter**
- **Pill-counter**
- **Scripts as profit center**
- **OTC's + impulse sales = high sales/customer**

➔ ***Life was good!***

Current Rx: Community Healthcare Center

- Vitamins & Supplements
- Compounding
- Home Healthcare (HME)
- Flu Shots & Immunizations
- "Doc-in-the-Box" Clinics
- Weight Management Programs & Products
- Smoking Cessation Programs & Products

➔ *Dabbling w/o focus*

Chain Hub & Spoke Operation

HC "Hub"

- ✓ HME
- ✓ Immunizations
  - Zoster
  - Pneumococcal
  - Influenza
- ✓ MTM
  - ✓ Patient Education
  - ✓ Classes
- ✓ Disease Management
  - Diabetes
  - Blood Pressure
  - Lipids
- ✓ Cardiovascular Risk Assessment
- ✓ Smoking Cessation
- ✓ Weight Management

Rx "Spokes"

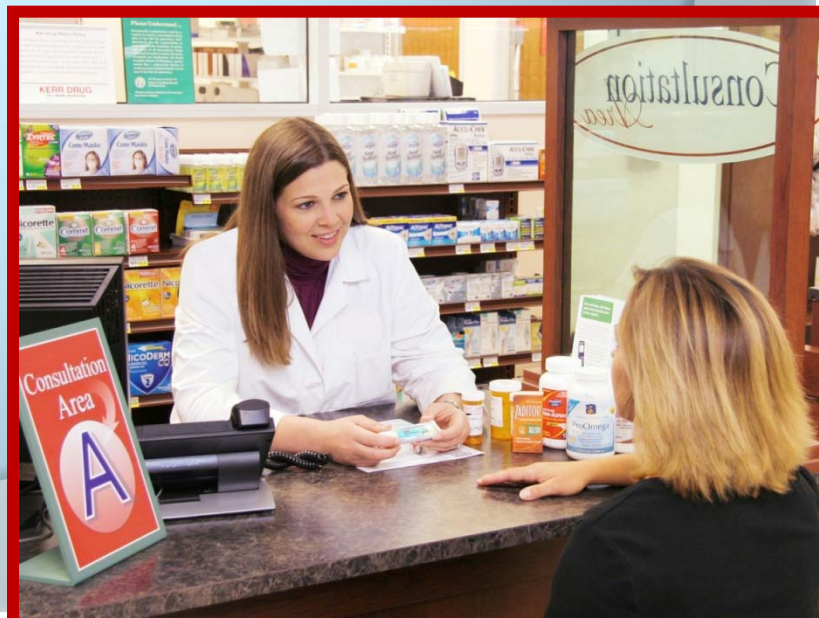
- ✓ Rx
- ✓ OTC's
- ✓ Vitamins & Supplements
- ✓ Flu Shots

Future Rx:
Preventative & Proactive

- Patient <u>Education</u>
- Medication Therapy Management (MTM)

  (= <u>Adherence</u>)
- Disease State Management (= <u>Compliance</u>)
- Partner with Accountable Care Organizations (ACO's) (= <u>Patient Care</u>)

➔ *Patient Care Coordinator*



Re-Defining Rx Customer Service

Chain - Current

1. Short Rx Wait Time
2. Ask if Need Help
3. Direct to Aisle
4. Fast Checkout
5. Courteous Checkout

Chain – Future

1. All of the Above Plus:
2. Qualify for Primary Medical Condition
3. Ask Customers if Following DS Program
4. Introduce to DSM Professional

Mail Order – Current

1. Intake with Smile
2. Ask for 90-day Rx
3. Up-sell & Cross-Sell
4. Generate Reorders
5. Move on to Next Call

Mail Order – Future

1. All of the Above Plus:
2. Query on Well-Being
3. Qualify for DSM Programs
4. Transfer to DSM Professional

Our Aging Populations

65+ Population in G8 Countries

Country	% 65+ Population
Japan	**20.8%**
Italy	**19.7%**
Germany	**19.3%**
France	**16.2%**
U.K.	**16%**
Canada	**13.7%**
Russia	**13.7%**
U.S*	**12.4%**

*34 Mil 65+ population in 2010 doubles to 68 Mil in 2030

Government Reimbursement Programs at Risk? (The End of Entitlement Programs?)

Ratio of FTE's Supporting each Medicare Beneficiary:

US

- **2010: 4 to 1**
- **2020: 1 to 1**

Canada

- **2010: 5 to 1**
- **2040: 2.5 to 1**

The Universe of Part B Providers

Before Accreditation

- 105,000 total

After Accreditation

- 89,400 remain

After Competitive Bidding

- *CMS: 2000 Bid Winners*

Is the glass half-full or half-empty?

New HHC Business Model

Government Reimbursement Decreases

- **Entitlements phased out over a period of years**

Private Pay Increases

- **Need for HHC continues to grow**
- **Homecare insurance as hot seller**
- **HHC becomes cash commodity**
- **Contracted & private pay opportunities grow:**
  - **Hospice**
  - **VA & TRICARE**
  - **Prisons**
  - **Workers' Comp**
  - **Self-insured Corporations**

Making HME Affordable

1. **Lowest Acquisition Cost Line**
   a) **Private Label**
   b) **Generic**
2. **Lay-Away Program**
3. **Financing Program**
4. **Third-Party Insurance**
5. **Used HME**

Rx Customer's Shopping List

(His wife just had a stroke)

- ✓ Prescription
- ✓ Green Peppers
- ✓ Lettuce
- ✓ Salad Dressing
- ✓ Walker
- ✓ Underpads
- ✓ Beer
- ✓ Wine

Why Retail HHC?

Decreasing

- ⇩ Hospital Stays
- ⇩ Government Reimbursement
- ⇩ HMO Coverage
- ⇩ Extended Family Care
- ⇩ Seniors as Customers
- ⇩ Demand for Basic Medical Necessity Products

Increasing

- ⇧ Aging Population
- ⇧ "Quicker & Sicker" Patient Discharges
- ⇧ Health & Wellness
- ⇧ Self-Care
- ⇧ Baby Boomers as Customers
- ⇧ Demand for Better Lifestyle Products

Before:

Cards & Candy

After: HHC


GETGO
ROLLING WALKER


JOBST
Anytime, anywhere


BRIGHT PLAZA
PHARMACY

Results:

1 Week Net Sales for HHC was GREATER than 1 Year Net for Cards & Candy!

i.e. How many cards/candy bars/rolls of paper towels or toilet paper = GPM on 1 Lift Chair?

Retail Showroom ROI

12’ HME Planogram (i.e. chains) **40% GP**

= $10,000 - $15,000/gross sales/yr

400 sq ft

$150 - $200/sq ft/ gross sales/yr

= approx. $60,000 - $80,000/yr

800 sq ft **45% GP**

$250 - $400/ sq ft/gross sales/yr

= approx. $200,000 - $350,000/yr

1500 sq ft **50% GP**

$800/sq ft/gross sales/yr

= $1 Mil+/yr

The HHC Rx

- ✓400 sq. ft min Front-End Floor Display
- ✓Designated Salesperson

Baby Boomers & Family Caregivers as HHC Customers

The Facts:

- **44.5 Million "First Wave" Baby Boomers**
- **15 Million are Active Caregivers**
- ***Represent 65% of current Rx and retail HME customers***
- ***75% make their purchasing decision in-store***

The Concept:

- **# Boomers = # Californians**
- **California = 5th largest economy in the world**
- **Imagine the potential HHC sales!**

(think Rock n Roll, SUV's, Starbucks, Botox & Viagra!)

Where Do Caregivers Go for Healthcare Information?

- **Pharmacist**
  - **Most trusted/first consulted healthcare professional**
- **Online**
  - **45% all searches are healthcare related**
- **Home Healthcare Professional**
- **Physician**

Why Patient Care in the Rx?

1. **Pharmacist is usually the first healthcare professional consulted outside of the immediate family.**
2. **Pharmacist is the most trusted medical professional known by customers.**
3. **HC customer = Rx customer**
4. **15% - 20% of Rx customers need HC products.**

Healthcare Reform: Accountable Care Organizations

- Medicare to pay Accountable Care Organizations (ACO's) for outcomes instead of fee-for-service.
- Payments per patient per disease state per month (both Parts A & B).
- Includes hospitals, physicians and joint ventures with other healthcare professionals
- Minimum of 5,000 beneficiaries
- By meeting quality performance standards, ACO entitled to share in cost savings.

ACO Goals

1. Reduce healthcare costs by improving care
2. Improve beneficiaries health and outcomes
3. Coordinate patient care to eliminate duplication of services
4. Focus on preventative care
5. Avoid high-cost services such as unnecessary specialists or hospital stays
6. Avoid restricting care via quality metrics as safeguards

Accountable Care Organizations

New Trend

- **Health Systems as ACO's are buying up physician practices.**
- **Physician becomes their employee, physician's patients their patients.**
- **Also buying/opening/*joint venturing* with Rx's, HME's, IV providers, and HHA's.**
- **Health Systems as ACO's want capture both acute and post-acute Medicare per-patient payments.**

ACO's Latest Trend:

Third-party insurance companies want to become ACO's as well!

- **UnitedHealth just purchased 3rd physician group in CA**
- **WellPoint is contracting with physician groups to create their own ACO**
- **Humana bought Concentra (urgent and occupational care clinics in 40 states)**
- **Highmark bought W. Penn Health System (5 hospitals in PA)**

New 2012 Insurer's Payment Plans

Wellpoint

- Pay primary care doctors 10% more
- Result in fewer ER visits & hospital stays
- Pay bonuses = 50% more
- Pay for developing treatment plans for patients with chronic diseases
- Pay 20%-30% of any savings they achieve

Aetna

- Pay primary care doctors certified as "patient-centered medical homes"
- Longer hours of access
- Coordinate care with specialists
- Savings projected to be double cost of this program

Who will implement these patient care treatment plans???

UnitedHealth's New Compensation Model

- **New national program for hospitals and physician groups that financially rewards for better – vs. more – care**
- **Hospital payments based upon rate of readmissions, mortality rates, hospital-acquired infection rates, and patient satisfaction**
- **Physician rates based upon ER utilization, total cost of patient care, and percentage of patients getting preventative screenings**
- **Savings to equal double cost of this program**
- **Payments calculated as share of overall savings achieved**
- **ACO's to receive $1 to $5 per member per month bonuses**
- ***"Clinical integration fees" available for HC providers coordinating patient care***

ACO's To Date

- 60% = Health Systems
- 23% = Physician Groups
- 16% = Health Plans

Costs to Form ACO:

- $10 - $15 Mil
  - Consulting services
  - IT system conversions
  - New IT staff
  - New care managers

Ideal ACO Outcomes

- **Medicare patients are healthier**
- **Their medical costs are reduced**
  - **Compared to current Medicare costs per patient/disease state/year**
- **Medicare's savings are shared with ACO's**
  - **60%-70% of their savings/patient/yr**

How do Rx's share in savings???

Establishing the Rx Value for ACO's

= *Patient Care Coordinator*

1. **Collect patient data**
2. **Educate patients**
3. **Demonstrate services are cost-effective**
4. **Demonstrate services lead to better patient outcomes**
5. **Document a reduced number of patient hospital readmissions and ER visits**
6. **Charge per patient/disease state/mo**

HC Hubs

KERR Health

- *Patient Education*
- *Patient Compliance*


Refresh, Invigorate & Maintain
Cosmetics & Hair Care
Explorer
hugo
Rolling Walker
roller walker
Ultra-Light Rollator


Pharmacy Consultation Area
Pharmacy
Prescription Drug Info


Healthy Living
Incontinence Aids
Community HEALTHCARE Center
Clinical HEALTHCARE
Room 1
Room 2
Splenda
Diabetic Cookbook
NICODERM
ASPIRIN
Contour
ONE TOUCH
TRUE

Primary HHC Disease Management Programs

1. Asthma
2. Cancer
3. Congestive Heart Failure
4. COPD
5. Diabetes
6. High-risk Pregnancy
7. Hypertension
8. Obesity
9. Sleep Apnea

Disease Management Program Outline

1. **Identify the Patient**
2. **Patient Evaluation**
3. **Evaluate Drug Therapy (Comprehensive Medication Review)**
   - **Prescriptions**
   - **OTC's**
   - **HHC/HME**
4. **Referral Source Loop**
   - **Physician**
   - **Case Manager**
   - **National/Local Associations**

Disease Management Program Outline

5. **Patient Education**
   - **HHC Programs**
   - **HHC Products**
6. **Written Self-Management Plan**
7. **Monitor & Evaluate Treatment Plan**

Patient Education:

The missing link in the continuum of care.

1. ***Explain*** **the purpose and advantage of using a specific product (or program).**
2. ***Demonstrate*** **to the patient the correct use of the product.**
3. ***Ask*** **the patient to demonstrate to you the correct use of this product (or program).**

The Psychological Component in Disease Management Programs:

Victim

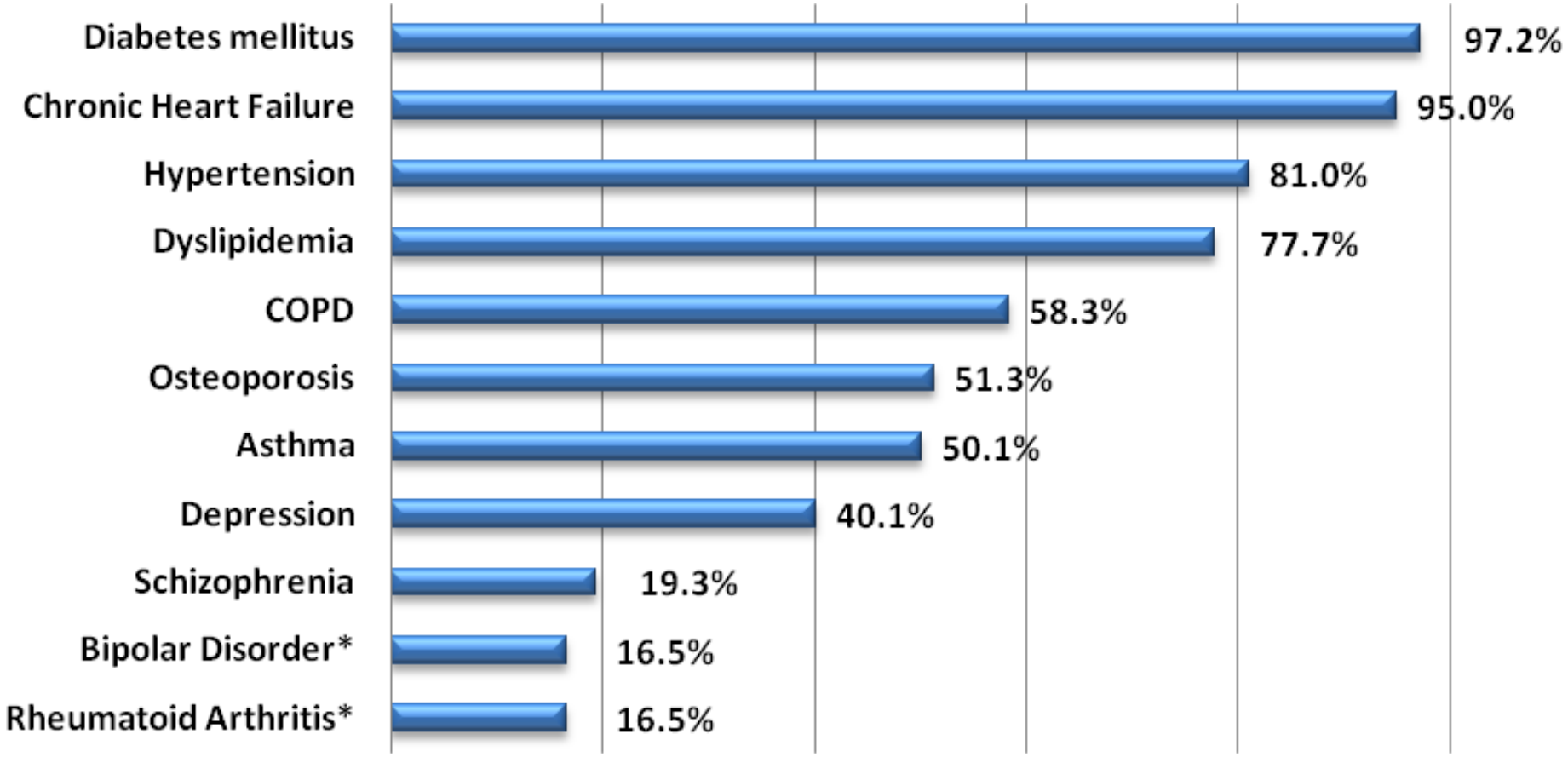
Vs.

Empowerment

- ***The patient learns through education that they are able to modify and even rectify risk factors by changing their behavior.***

2011 MTM Top Disease States

Figure 2. Percent of 2011 MTM Programs with Top Ten Targeted Diseases (*tied)



UN NCD Summit 2011 Findings

- **$47 *Trillion* cost to global economies over next 20 years**
- **Five medical conditions:**
  1. **Cancer**
  2. **Diabetes**
  3. **Mental Illness**
  4. **Heart Disease**
  5. **Respiratory Illness**
- **Increase from 63% to 80% of all deaths over next 20 years**
- **Health challenge for individuals = economic challenge for world**
- **Needed measures to slow rate of NCD's:**
  - **Promoting physical activity & healthier diet**
  - **Blood pressure screening**
  - **Higher taxes on alcohol and tobacco**

5 Lifestyle Changes = 80% reduction in risk of developing Type 2 Diabetes*

1. Maintain healthy diet
2. Exercise regularly
3. Not smoke for at least 10 years
4. Moderate alcohol consumption
5. Maintain normal body weight (i.e. BMI 18.5-24.9)

*NIH-AARP study just released

Chronic Disease Risk Summary Report

Name:	John Smith	**DOB:**	03/01/1961
Age:	45	**Gender:**	Male
Ethnicity:	African American	**Date:**	02/14/2007

KnowYourNumber™
The Key To Proactive Good Health

CLINICAL MEASUREMENT	VALUE	REFERENCE
Body Mass Index (BMI)	31.2	<25 kg/m²
Waist	41	<=40 inches
Blood Pressure Systolic	115	<120 mmHg
Blood Pressure Diastolic	78	<80 mmHg
Fasting Glucose	108	<100 mg/dL
Pulse Rate	110	60-100 bpm
Total Cholesterol	234	<200 mg/dL
HDL Cholesterol	38	>=40 mg/dL
LDL Cholesterol	171	<130 mg/dL
Triglycerides	126	<150 mg/dL

<25	Normal
25-29	Overweight
30-34	Obesity 1
35-39	Obesity 2
>=40	Obesity 3

<120/80	Normal
120/80-139/89	Prehypertension
140/90-159/99	Hypertension I
>=160/100	Hypertension II

<99	Normal
100-125	Prediabetes
>=126	Diabetes

<200	Desirable
200-239	Borderline High
>=240	High

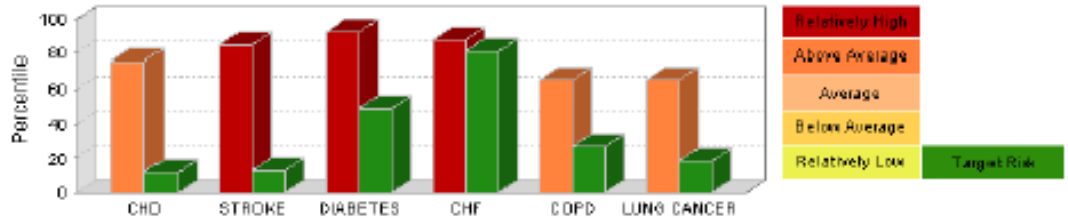
<100	Optimal
100-129	Near Optimal
130-159	Borderline High
160-189	High
>=190	Very High

<150	Normal
150-199	Borderline High
200-499	High
>=500	Very High

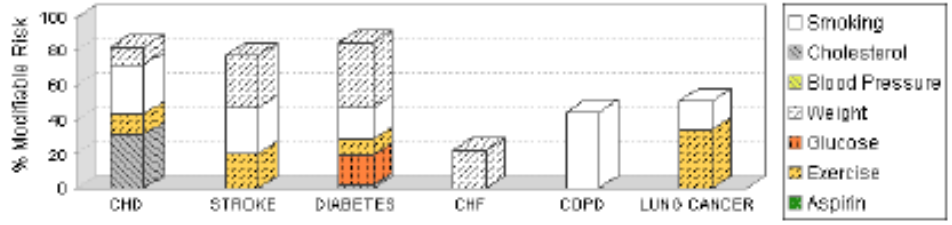
Metabolic Syndrome	Yes, >=3 of the following:Waist>40; Triglycerides>=150; HDL Cholesterol<40; Blood Pressure>=130/85; Fasting Glucose>=100
On Medication For	Aspirin to prevent heart attack
Lifestyle Factors	Low physical exercise; Current smoker 15 cig/day for 10 years; 0.429 alcoholic drinks/week; 0 servings red meat/week

Risk	CHD	Stroke	Diabetes	CHF	COPD	Lung Cancer
Current 5-year risk of onset	5%	2.6%	17%	1.4%	3.8%	0.013%
Percent of current risk that is modifiable	82%	77%	85%	22%	44%	51%
Percentile (compared to other 45 year old men)	76%	85%	92%	88%	65%	65%

Risk Percentile: Current vs. Target



Modifiable Risks & Where They Come From



The impact of changing one risk factor could be higher than shown. Modifying one risk factor is likely to cause changes in others.

This report is not intended to diagnose or to recommend treatment for any disease but to predict the likelihood of occurrence based on established risk factors. Do not undertake any changes to your health without consulting your physician.

Know Your Number® is a service provided by BioSignia, Inc.

Medication Therapy Management (MTM) Medicare Reimbursement (Part D)

Basic Rx Implementation

- **Annual comprehensive review of medications by pharmacist**
- **Quarterly assessment medication usage by pharmacist of all patients who are "at risk but not enrolled in MTM program."**
- **Written summary of review in a standardized format**
- **Action plan**
- **See HR 3590, Sec.10328**

Medication Therapy Management (MTM) Medicare Reimbursement

Patient Education & Compliance

- Patients with multiple chronic diseases such as asthma, diabetes, hypertension, congestive heart failure, or high cholesterol
  - "…to award grants for pharmacist-provided medication therapy management services for chronically-ill patients."
- Patients with high annual drug costs of over $3,000/year who take a min. of 8 Part D drugs
- Medicare Part D PBM's specify requirements for reimbursement (i.e. $60 per 30-minute session)
- Presented by pharmacist or "other qualified provider"
- www.mirixa.com

MTM Best Practices 2011

- 80% target beneficiaries with 3 or more chronic diseases (20% only require 2)
- 60% require beneficiaries to be taking 8 or more Part D drugs
- 75% target beneficiaries quarterly (20% target monthly)

MTM Program Requirements

- **All Part D Plan Sponsors to include an MTM program with interactive, person-to-person consultations**
  - **Service targeted beneficiaries using an opt-out method of enrollment**
  - **Target beneficiaries for enrollment at least quarterly**
- **Proposed Standardized MTM model:**
  1. **1-hr initial pharmacist assessment**
  2. **6-hr approved diabetes education program (3x 2-hr group sessions)**
  3. **3 pharmacist follow-up visits**
     a) **Maintenance visits every one to three months**
     b) **Physical assessments to include blood pressure, foot exam and weight**

MTM Best Practices
(from Mirixa.com)

Tech: Coordinate

- Contact Dr.'s offices re: changes in meds
- Set up MTM appointments
- Gather medical condition info
- Ask patients about meds they are taking

Pharmacist: Educate

- Review patient's meds
- Assess therapeutic interchanges and safety issues
- Call patient's Dr. if necessary
- Meet with patient
- Responsible for all direct patient care

Diabetes Disease Management Educational Program

by Jack Evans with Deborah Childers, RD, CDE, Home Diagnostics Inc.
Sponsored by H.D. Smith

Program Outline

1. Patient Flow Chart
2. Diabetes Overview
3. Diabetes Self-Management
4. Blood Glucose Monitoring
5. Hypoglycemia and Hyperglycemia
6. Understanding Insulin Therapy
7. Eating Healthy, Eating Right
8. Physical Exercise and Weight
9. Stroke, Heart Attack and Cardiovascular Disease
10. High Cholesterol
11. Foot, Leg and Skin Care
12. Eye and Oral Care
13. Smoking Cessation

Bottom of Every Sheet:

My healthcare professional has reviewed the above with me and I have a working knowledge of these concepts.

_____	_____
Healthcare Professional	**Patient**
_____	_____
Company or Profession	**Date**

Patient HHC Continuum of Care

1. **Market educational programs and related products to referral sources**
2. **Inservice their staff on above**
3. **Educate patient referrals**
4. **Document how you ensure patient compliance for physician:**
   - **Have patients sign-off and date sheets**
   - **Fax or drop off at referral's office**
   - **Maintain own patient files for ACO ‘s**
5. **Patient referrals will continue to be sent on a regular basis.**

2. Diabetes Self-Management

What is Good Diabetes Self-Care?

1. **Physical exam**
2. **Dilated eye exam**
3. **Dentist**
4. **Vaccinations**
5. **Feet**
6. **Don't smoke**
7. **Blood pressure**
8. **Manage stress**
9. **MedicAlert Card**
10. **OTC medications**
11. **Diabetes healthcare team**

Diabetes Self-Management Checklist

Action Month	Weight	Blood Pressure	Physical Exam (annually)	Foot Exam	Eye Exam	HbA1c (quarterly)	Urine Test	Total Cho-lesterol/LDL
Jan.								
Feb.								
March								
April								
May								
June								

9. Stroke, Heart Attack & Cardiovascular Disease

Diabetics have two to four times' greater risk of developing cardiovascular disease, including stroke, heart attack, chest pain (angina) and narrowing of the arteries.

These major risk factors include:

- **High Blood Glucose Levels**
- **Hypertension or High Blood Pressure**
- **High LDL (bad) Cholesterol/Low HDL (good) Cholesterol**
- **High Triglycerides**
- **Obesity**
- **Smoking**
- **Limited Physical Activity**

NOTE: You are not a victim of these major risk factors. You can change/modify/rectify them by changing your behavior

11. Foot, Leg and Skin Care

- ***Why do diabetics need to monitor their feet on a daily basis?***
- ***How can diabetics avoid these serious foot infections?***
- ***What is Peripheral Artery Disease (PAD)?***
- ***What are the Symptoms for PAD?***
- ***What Treatment is Recommended for Diabetics with PAD?***
- ***How can Diabetics Reduce their Risk of PAD?***

<u>Related Products</u>

- **Diabetic Shoes**
- **Diabetic Socks**
- **Orthotics**
- **Compression Hosiery**
- **Urea Skin Care**

Foot Exam for Diabetics

Condition	Right Foot	Left Foot	None
Foot ulcer			
Pain			
Loss of sensation			
Callus build-up			
Blister			
Redness			
Swelling			
Dryness			
Skin cracking			

Diabetic Products

We have provided you with: _____.

We believe that one or more of the following related products might also be helpful to you:

Glucose Control	Foot/Leg Care	Diabetes Care
Blood Glucose Monitor	Shoes	B P Monitor
Test Strips	Socks	Skin Care
Syringes	Compression Stockings	Eye Care
Lancets	Insoles & Orthotics	Oral Hygiene
Glucose	Heel, Metatarsal & Toe Pads	Sugar/Alcohol-Free OTC's
Insulin	Night Splints	Erection Aids

Diabetics are Loyal Repeat Customers!

- 4-12 visits/yr for strips
- 2-3 visits/yr for OTC's
- 3-7 visits/yr for shoes
- 2-3 visits/yr for socks
- 2-3 visits/yr for compression stockings

= $5,000 - $6,000/patient/location/yr

Hypertension:

American Heart Assoc. Stats

- One-third of American adults have high blood pressure (HBP)
- There are no symptoms (asymptomatic)
- One-third of this group are unaware they have HBP
- Uncontrolled HBP leads to:
  - Stroke
  - Heart Attack
  - Heart Failure
  - Kidney Failure

Hypertension:
American Heart Assoc. Stats (con't.)

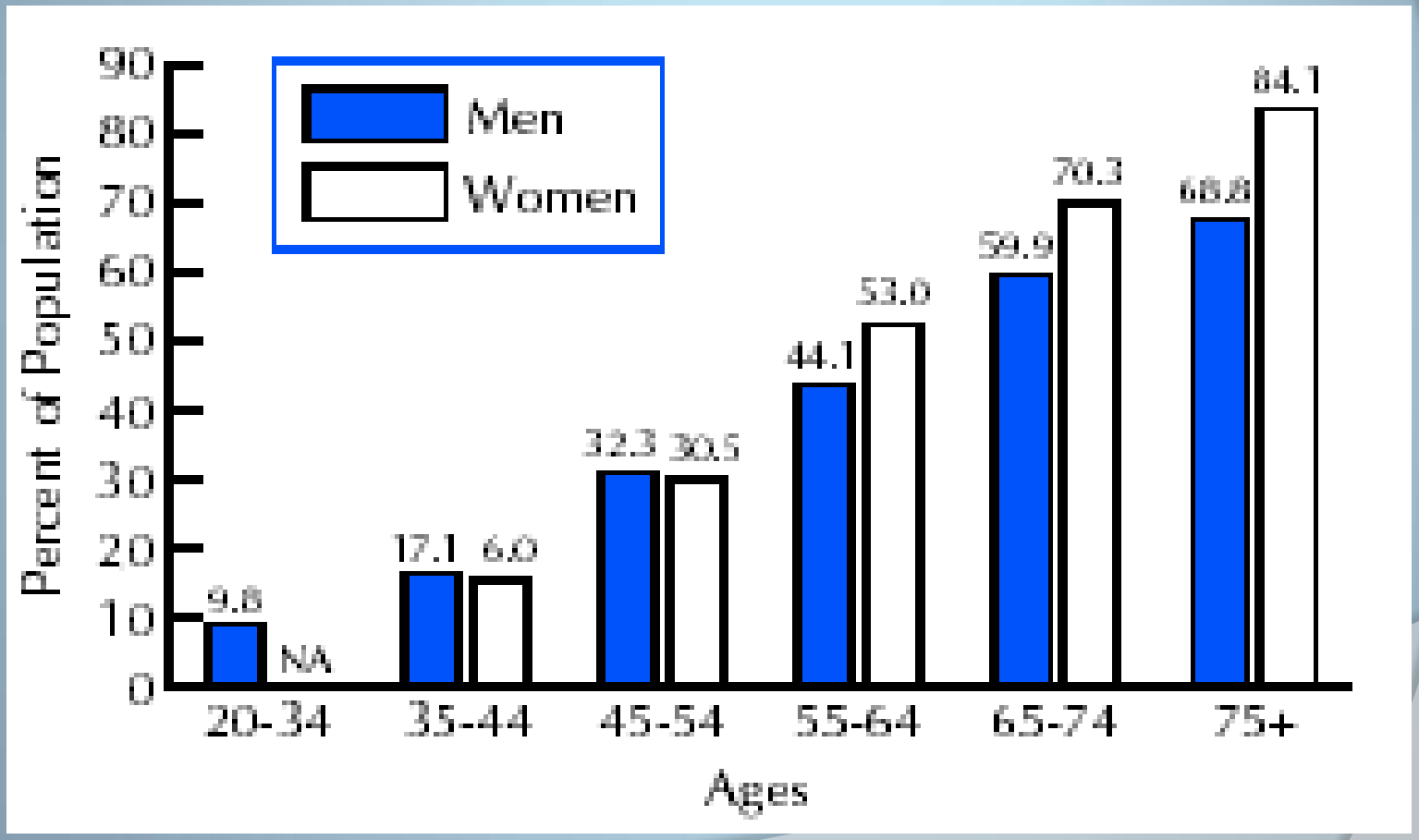
- **81 Mil. Americans have one or more types of cardiovascular disease (CVD)**
- **CVD is the leading cause of death in the U.S.**
- **CVD includes:**
  - **Angina**
  - **Stroke**
  - **Congestive Heart Failure**
  - **Hypertension (HBP)**

Nine Global Risk Factors for Heart Attack*

1. Abnormal Cholesterol
2. High Blood Pressure
3. Current Smoking
4. Abdominal Obesity
5. Depression
6. Weight
7. Diet
8. Exercise
9. Alcohol consumption

*European Society of Cardiology 2005

9 out of 10 American adults will at some point develop HBP



NHANES IV: 1999-2000

Hypertension Disease Management Program

1. Understanding systolic and diastolic BP
2. Physical affects of high blood pressure
3. Understanding of hypertension and prehypertension
4. Benefits of measuring BP
5. How to measure BP at home

JNC – 7 Guidelines for BP

BP Classification	Systolic BP (mmHg)		Diastolic BP (mmHg)
Normal	<120	and	<80
Prehypertension	120 – 139	or	80 – 89
Stage 1 Hypertension	140 – 159	or	90 – 99
Stage 2 Hypertension	≥160	or	≥100

Source: The Seventh Report of the Joint National Committee on Prevention, Evaluation and Treatment of High Blood Pressure. National Heart, Lung and Blood Institute - May 2003.

Obesity in the US

- One-third of US adults
- Caused by energy imbalance:
  - Eating too many calories
  - Not getting enough physical activity
- Behavior and environment are greatest areas for prevention and treatment
- 17% of children
- Obese children are developing:
  - High blood pressure
  - High cholesterol
  - Diabetes
  - Sleep apnea and asthma

Obesity-Related Medical Issues

1. Hypertension
2. Heart Disease
3. High Cholesterol
4. Diabetes
5. Stroke
6. Cancer

Weight Loss Program Goals

1. **Initial target goal is 10% weight loss**
2. **Improvement in glucose tolerance**
3. **Improvement in lipid profile**
4. **Lowering CVD risk**

Weight Loss Program Components

1. **Exercise**
2. **Self-Help**
3. ***Counseling***
4. **Diet**
5. **Maintenance**

> Best results = intensive lifestyle intervention + therapy

Asthma Stats

- 300 Mil. Worldwide
- 8% of US population = 24 Mil.
- Approx. 2 Mil ER visits annually
- 500,000+ hospital admissions annually

Asthma Disease Management Program Outline

1. **Establishing a Partnership to Manage Asthma**
   - **What is Asthma?**
2. **Basic Information and Resources about Asthma**
   - **If you have Asthma and You are Pregnant**
   - **If You Have Asthma and You are Over 55**
   - **If Your Infant has Asthma**
   - **Resources for Patients and Families with Asthma**

Asthma Disease Management Program Outline

3. **Developing a Medicine Plan**
   - **What you Need to Know about Medicines for Asthma**
4. **Correct Use of Inhalers and Spacers**
   - **Correct use of a Metered Dose Inhaler**
   - **Correct use of Spacers**
5. **Use and Care of a Nebulizer**
   - **Use and Care of a Nebulizer**
6. **Home Peak Flow Monitoring**
   - **How to Use a Peak Flow Meter**
   - **My Weekly Asthma Symptom and Peak Flow Diary**

Asthma Program Outline

7. **Developing an Asthma Management Plan**
   - **Warning Signs of Asthma Episodes**
   - **Personal Asthma Control Plan for (Patient)**
   - **Summary of Steps to Manage Asthma**
8. **Identifying and Reducing Asthma Triggers**
   - **Asthma Trigger Control Plan**
   - **Find Your Asthma Triggers**
9. **Managing Exercise-Induced Asthma**
   - **Plan for Staying Active – Adults**
   - **Plan for Staying Active – Children**
   - **How to Set Appropriate Guidelines for Your child's Activities**

Asthma HHC Products

Core Products

- Nebulizers
  1. Compressor/Home
  2. Handheld for School/Sports
- Peak Flow Meters
- MDI's
- Pediatric

Related Products

- HEPA Air Cleaners
- Allergy Control Products
  1. Pillows
  2. Sheets
  3. Bed Covers
  4. Dust Mite Sprays
- Vaporizers
- Humidifiers