

# BOSTON'S BREATHE EASY AT HOME PROGRAM:

## WEBSITE IMPROVEMENTS




August 2015

# Website Changes

- ❑ As a result of the Failure Modes Effects and Analysis (FMEA) process the Breathe Easy at Home (BEAH) website has undergone some extensive changes.
- ❑ The FMEA team utilized BEAH process knowledge to identify risks within the program, the website being one. BEAH website was found to be time consuming, with unclear entry fields leading to incorrect information entered in the referral as well as login issues for providers.
- ❑ Website modifications will include double entry and mandatory fields in order to ensure the correct information is received. The site will now be easier to navigate and incorporate more detailed fields for health care providers ensuring the BEAH administrator receives the most accurate information.

# Registration

- Super User's email address
- General Password



City of **Boston.gov**  
Official Web Site of the City of Boston

Register Log in

## Log in.

Use a local account to log in.

**Username/Email**

**Password**

Remember me?

[Register as a new user](#)  
[Forgot your password?](#)

## Register.

Create a new account.

**Email** kidsasthma@bmc.org

**Password** .....

**Confirm password** .....

**Contact Name** Asthma Clinicians

**Title**

**Phone Number** 6176388000

**Address Line 1** 1 Boston Medical Place

**Address Line 2**

**City** Boston

**Medical Facility Name** Boston Medical Center

**Zip Code** 02118

**Comments** BMC Pediatrics |

Register

# Creating a New Referral

- Housing Type (Affordable, Market, Section 8, Public)
- Language (English, Spanish, Cape Verdean Creole, Haitian Creole, Mandarin, Cantonese, Vietnamese, Somali, Portuguese, Arabic, French, Farsi)

**Actions**

- [Create New Requests](#)
- [View Pending Cases](#)
- [View Open Cases](#)
- [View Closed Cases](#)
- [Document Repository](#)
- [Account](#)

**\*Required Fields**

**Patient Information**

Salutation:  \*First Name:  \*Last Name:

**Is patient a minor?**

**Contact Information**

\*Phone:  (000) 000-0000 Alt Phone:  (000) 000-0000 Email:

Inspectional Services will need to contact the adult in the home. Please indicate which method you prefer they do so (check at least one)

Phone  
 Email  
 Text

**Address Information**

\*Street Number:  \*Street Name:  \*Apt#/Floor (n/a if none):

\*City:  State: MA

\*Zip:

Housing Type:

**Additional Patient Details**

\*Sex:  M /  F \*DOB:  mm/dd/yyyy

Preferred Language:  Unknown Race:

## Diagonis (Asthma, Sickle Cell, Other)

Select all that apply

\*Nature of Problem:

- Bed Bugs
- Old Carpeting
- Coackroaches
- Chronic Dampness
- Lead
- Leaks
- No Heat
- Peeling Paint
- Rodents
- Structural Damage
- Inadequate Ventilation

Other:

- Is the patient under six years old?
- Has the patient been hospitalized in the past 12 months?

\*Diagnosis:

Disease Status:  Controlled  Uncontrolled

**Referral Information**

Referred By:

**Request Submission**

- Please click here if you would like your patient to receive an asthma home visit for asthma education in addition to a Breathe Easy inspection. By clicking here, an asthma community health worker will get in touch with you via email to complete the referral.
- Please click here if you would like to receive notifications when the Breathe Easy Administrator updates this request.

\*  I have explained the Breathe Easy program to my patient and had the patient or guardian sign the consent form.



# Referral Details

## Initial Inspection Request

Ref#: 209276

### Patient Information

Salutation: Ms. First Name: Test Last Name: Testington

### Guardian Information

Salutation: First Name: Janey Last Name: Testington

### Contact Information

Phone: 6175551234 Alt Phone: 6175554321 Email:

Contact Method: • Text

### Address Information

Street Number: 1010 Street Name: Massachusetts Ave Apt#/Floor: 1

City: Boston State: MA

Zip: 02118

Housing Type: Section 8

### Additional Patient Details

Sex: F DOB: 1/5/2007

Preferred Language: English Race: Black/African American

**Nature of Problem:**

- Bed Bugs
- Old Carpeting
- Coackroaches
- Chronic Dampness
- Leaks
- Rodents
- Structural Damage
- Inadequate Ventilation

**Other:**

- Is the patient under six years old? No
- Has the patient been hospitalized in the past 12 months? Yes

**Diagnosis:** Asthma

**Disease Status:** Is disease controlled? No

### Referral Information

Group Email tteixeira@bphc.org

### Request Submission

Home visit requested? Yes

Receive notifications? Yes

Close

# Closed Case View

Testington, Test (F) Ref#: 209276 [View](#)

DOB: 1/5/2007

**Inspection Type:**

**Resolution Date:** 7/7/2015 12:05:00 PM

**Resolution:** Administratively Closed

**Comments:**



# Managing Account

## Manage.

Change your account settings

**Password:** [ [Change your password](#) ]  
**Registration:** [ [Edit Registration](#) ]  
[ [Cancel](#) ]

## Register.

Create a new account.

<b>Email</b>	<input type="text" value="jtestington@nowhere.org"/>
<b>Password</b>	<input type="password" value="*****"/>
<b>Confirm password</b>	<input type="password" value="*****"/>
<b>Contact Name</b>	<input type="text" value="Janey Testington"/>
<b>Title</b>	<input type="text" value="Tester"/>
<b>Phone Number</b>	<input type="text" value="617-555-1234"/>
<b>Address Line 1</b>	<input type="text" value="1010 MASS AVE."/>
<b>Address Line 2</b>	<input type="text"/>
<b>City</b>	<input type="text" value="Boston"/>
<b>Medical Facility Name</b>	<input type="text" value="BPHC"/>
<b>Zip Code</b>	<input type="text" value="02118"/>
<b>Comments</b>	<input type="text"/>
	<input type="button" value="Register"/>