

Illinois Asthma Program

Home Visiting Program

Grant Year 2 (September 1, 2020 - August 31, 2021)

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Illinois Key Facts

State population: 12.67 million

Urban: 88.5%

Rural: 11.5%

Asthma prevalence: 8.7% (adults), 13.5% (children)

Asthma emergency department visits: 261,000+ in
2016



Illinois Asthma Program

The Illinois Asthma Program (IAP) has been in existence for 20 years. It is funded by the U.S. Centers for Disease Control and Prevention (CDC) to address asthma in Illinois. The IAP is led by the Illinois Department of Public Health (IDPH) and it implements the Illinois Asthma Plan. This plan was developed by key stakeholders participating in the Illinois State Plan Workgroup and focuses on action and collaboration to accomplish the CDC-sponsored national Controlling Childhood Asthma and Reducing Emergencies (CCARE) goal of reducing emergency department visits and hospitalizations due to asthma.

Various priorities, strategies, and activities are included in the plan's framework. These components follow the CDC's **EXHALE** strategies which are:

- **E**ducation on asthma self-management (AS-ME)
- **eX**tinguishing smoking and exposure to secondhand smoke
- **H**ome visiting for trigger reduction and asthma self-management education
- **A**chievement of guidelines-based medical management
- **L**inkages and coordination of care across settings
- **E**nvironmental policies or best practices to reduce indoor and outdoor asthma triggers.

To best achieve these goals, the IAP has set the following priority areas:

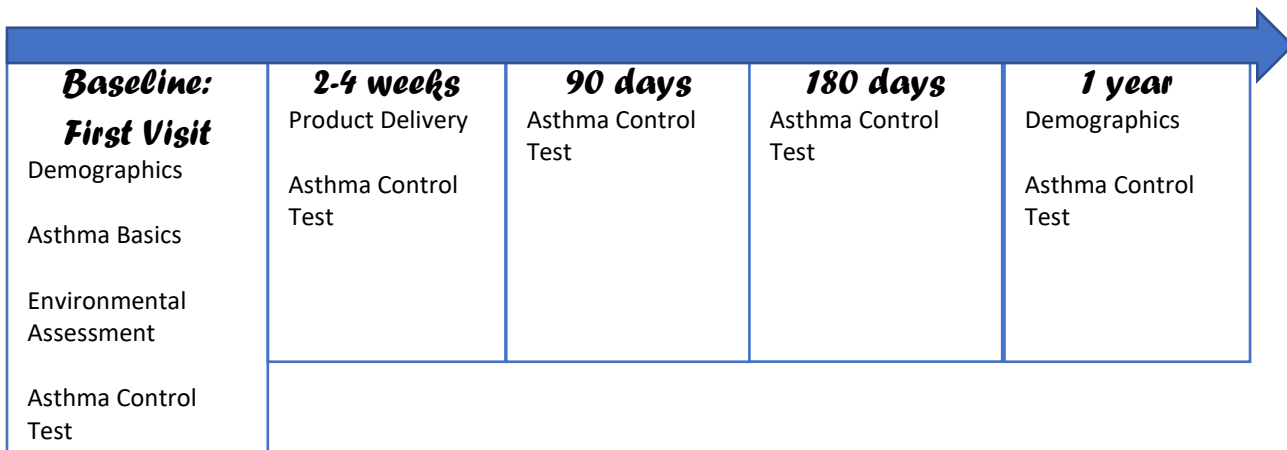
- Expanding access to and delivery of asthma self-management education in the form of a web-based program, called Asthma Basics.
- Lowering absenteeism due to asthma.
- Reducing asthma-related emergency department visits, hospitalizations, and deaths.

Home Visiting Collaborative Overview

In 2020, the Home Visiting Collaborative (HVC) began meeting virtually once a month to build individual program capacity, to aide in state plan evaluation efforts, and to ensure the delivery of effective asthma programs in various locations throughout Illinois.

To date, there are four state-funded programs that share common characteristics targeting children with asthma, ages 0-17, living in high-burden areas of Illinois. Each of these programs collect participant data during five standardized home visits utilizing Asthma Basics for asthma self-management education, tracking referrals and referral sources, and measuring progress with the standardized Asthma Control Test. The five home visits per client family are shown in the diagram below. Currently, because of the COVID-19 pandemic, visits are occurring virtually or by telephone.

Figure 1. Timing of Home Visits



Individual Home Visiting Programs

Just as an Asthma Action Plan is designed for each participating family, each of the four programs is unique.

What follows is a description of each one.



American Lung Association (ALA)

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Areas Served: Chicago, Chicagoland, Kankakee, and other rural areas of Illinois

Years Served: Implemented home visits for the last seven years

Overview

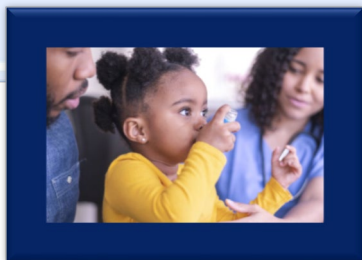
Home visits are provided by trained ALA staff to assist families address asthma management concerns while identifying and remediating asthma triggers within their homes. During the home visit, ALA staff assesses the home environment for asthma triggers and shares information and resources with the family to reduce and/or eliminate them. Traditionally, low-cost products are delivered to the home that help these efforts. Moreover, ALA staff develops an Asthma Action Plan with the family and reviews asthma symptoms and asthma medications.

Why it is Unique

- Receives most of its referrals from federally qualified health centers (FQHCs) and school-based clinics, where potential participants must have uncontrolled asthma.
- Bilingual staff is available.
- Provides incentives like gift cards, trigger reduction products, and services like carpet cleaning.

“We have a referral of a 12-year-old male who has severe asthma and had been absent from school 15 times in a three-month span. At baseline, his ACT score was an 8 and he would have to use his nebulizer almost every day. He was also taking his quick relief medicine every day. [By the three-month follow up], he was no longer taking his quick relief medication every day... His asthma symptoms as a whole had decreased, and his new ACT score was now 22.”

- Dr. Felicia Fuller



Sinai Urban Health Institute (SUHI)

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Areas Served: Chicago and suburban Cook County

Years Served: 20

Affiliated with Sinai Health System: Mount Sinai Hospital, Holy Cross Hospital, Schwab Rehabilitation Hospital, Sinai Children’s Hospital, Sinai Community Institute, Sinai Medical Group

Overview

Since 2000, SUHI has implemented and evaluated a series of seven comprehensive interventions aimed at decreasing asthma-related morbidity and improving the quality of life of inner-city children and adults with asthma and their families. Programs have employed an evidence-based intervention and a community health worker (CHW) model. The CHW model is at the heart of each of SUHI’s tested asthma programs. Interventions have varied in length from three months to one year, with three to six home visits by a trained CHW over that interval. Whenever possible, CHWs are recruited from the specific communities targeted by the interventions, which focus on asthma education, trigger reduction, and asthma management.

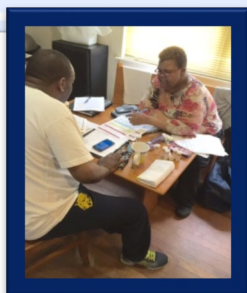
Why it’s Unique

- Bilingual CHWs available
- In addition to intensive training in asthma, CHWs participate in 40-hour training encompassing CHW core competencies such as motivational interviewing, adverse childhood experiences (ACEs) and cultural humility. Prior to embarking on home visits, they are evaluated using a three-level role-play evaluation process.
- CHW training is provided by the **C**enter for CHW **R**esearch, **O**utcomes, and **W**orkforce **D**evelopment (CROWD). CROWD grew from SUHI’s vast leadership implementing and evaluating CHW interventions, and in the hiring, training, and deployment of CHWs. Through CROWD, SUHI supports health plans, health systems, organizations, and research studies in hiring, training, supervising, and evaluating CHWs.

SUHI’s CHWs continue to share their wisdom with stakeholders:

“CHWs can often hear what patients are not saying.”- Rhonda Lay

“Recognize that children understand more. Trust them in managing their own asthma.”-Adelaide Holloway



Southern Illinois University-Edwardsville (SIUE)

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Areas Served: St. Clair and Madison Counties

Years Served: Six

Affiliated with Southern Illinois University-Edwardsville School of Nursing

Overview

For six years, asthma home visits have helped residents in and around Edwardsville and East St. Louis to control their asthma through the WE CARE clinic employing advanced practice nurses, certified health coaches, social workers, pharmacists, and collaborating physicians. This clinic serves patients ages 2 and up, specializing in primary care needs, including chronic disease management, and provides “holistic, culturally competent care.” The clinic’s asthma-specific program, *Asthma Trigger Assessment Program (ATAP)*, is offered through the clinic. ATAP employs a full-time health educator to improve patient access to care.

Why its Unique

- Receives most of its referrals from primary care doctors and the Allergy and Asthma Foundation.
- Offers interpreter services.
- Visits involve air quality readings and focus on respiratory health issues as a whole.
- The WE CARE clinic offers guidelines-based coordinated care on a weekly basis.

"There were many asthma triggers in my home that I did not know about." - HV participant

"This program really helped me manage my asthma at home. I was able to increase my activity level because I feel so much better." - HV participant

Southern Illinois University- School of Medicine (SIUSOM)

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Areas Served: Sangamon County

Years Served: Five

Affiliated with SIU Medicine, Memorial Medical Center, St. John's Hospital, and Springfield Clinic

Overview

SIUSOM services Sangamon County. This area has one of the highest rates of asthma and asthma-related hospitalizations in Illinois. The Children's Asthma Program, offered by SIUSOM, targets the community's most vulnerable children and seeks to improve childhood asthma morbidity rates and quality of life. The program created a community coalition to identify children most at risk for asthma and those who missed school due to their asthma. These children are eligible for the program's services that "provide a medicine and home-based trigger reduction strategy to improve their health outcomes." SIUSOM's asthma program takes a holistic approach by utilizing CHWs to conduct home visits and the program does not set limits on the number of visits allowed.

Why its Unique

- Trains Community Health Workers (CHWs) through the *Expanding Community Health Outcomes* (ECHO) program.
- Delivers *Asthma Trigger Mitigation Tool Kits* that may include items like mattress covers and HEPA-filtered vacuums.
- Offers interpreter services.
- Developed the *Environmental Assessment Application* for smart phones.
- Strong partnerships with local churches.
- Links participants to local food banks.

CHWs also work with doctors to help the participant obtain appropriate medication. One CHW stated, "The patient's asthma is now controlled...She no longer has confusion on what she should be using. This has given the [participant] peace of mind." - Tyra Jones

Additional Resources

- [American Lung Association's Asthma Basics Course](#)
- [CDC: Asthma](#)
- [Illinois: Asthma](#)