State of Illinois
Illinois Department of Public Health

Illinois Asthma State Plan

Addressing Asthma in Illinois

2021 – 2026

IDPH
Illinois Department of Public Health

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525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

March 2021

Dear Colleague:

The Illinois Department of Public Health (IDPH) is pleased to share the 2021 – 2026 *Illinois Asthma State Plan – Addressing Asthma in Illinois (Plan)*. The Plan is regularly updated and revised to better reflect strategies and interventions that address asthma and improve asthma outcomes and health disparities. The Illinois Asthma Partnership (IAP) is well-established and comprised of health professionals and community members dedicated to improving the lives of Illinois residents with asthma. That commitment remains today, as this plan was developed with thoughtful input and assistance from partners. We thank them for their efforts and their continued steadfast support.

The Plan is a framework for action and collaboration. While surveillance indicates asthma outcomes are improving in Illinois, there is much work to be done as significant health disparities remain. IDPH and the IAP are committed to implementing activities and interventions that align with the Centers for Disease Control and Prevention's Initiative, Controlling Childhood Asthma Reducing Emergencies (CCARE), and are designed to improve asthma outcomes and prevent hospitalizations, particularly in communities of greatest need. We invite you to be part of a shared vision of improving asthma in Illinois and reducing disparities. To learn more about this plan or for information on the IAP, please find the contact information below.

IDPH extends its appreciation to those who serve on the IAP and contributed their time and expertise in the development of this plan. Together, we can reduce the burden of asthma in Illinois and ensure a better quality of life for persons with asthma.

Sincerely,

Ngozi Ezike, M.D.
Director

For more information, please contact:

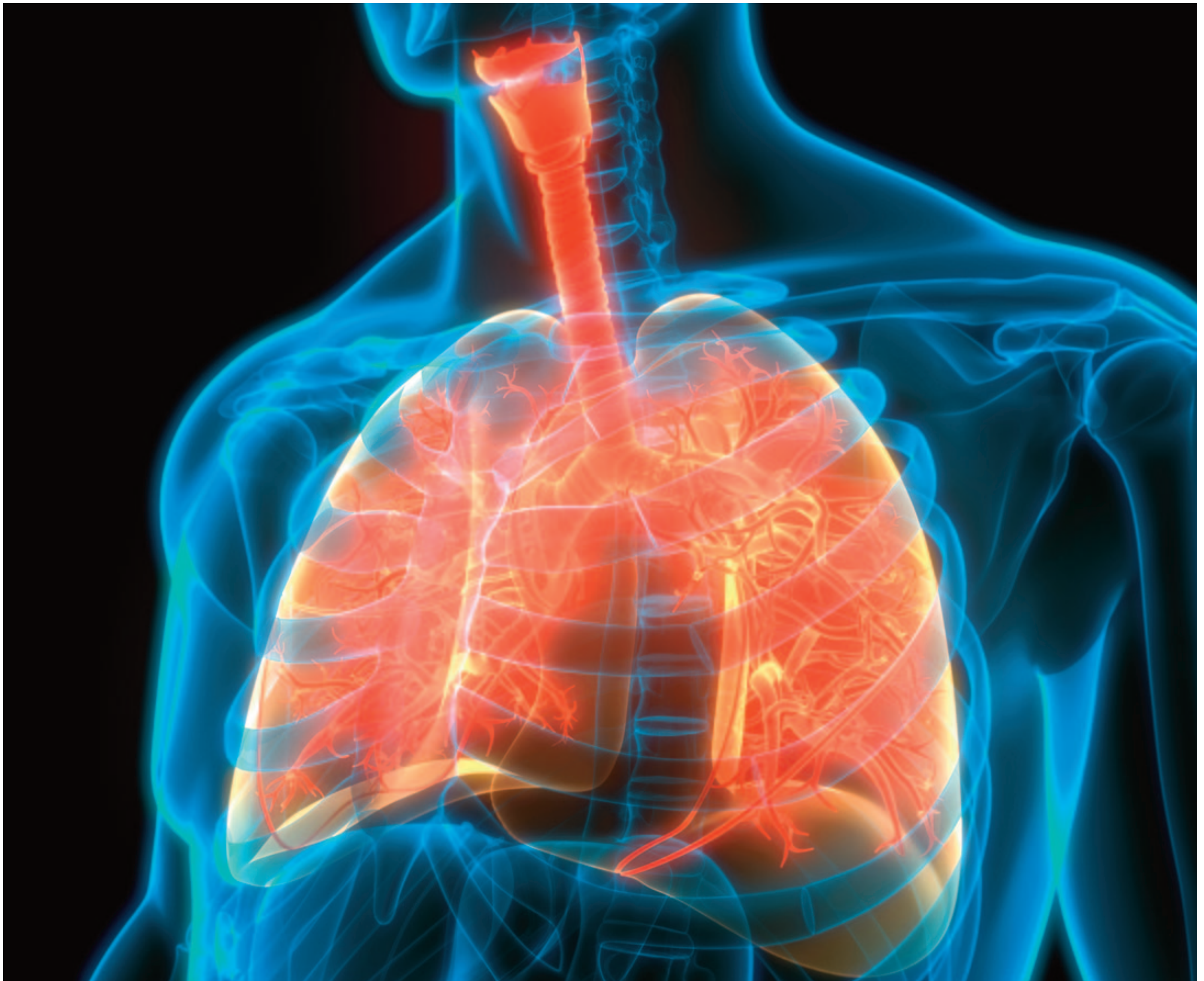
Office of Health Promotion
535 W. Jefferson St., 2nd Floor
Springfield, IL 62761
217-782-3300

Introduction

The Illinois Department of Public Health (IDPH) is pleased to share the 2021 – 2026 Illinois Asthma State Plan, Addressing Asthma in Illinois, 5th edition. The asthma strategic plan is regularly updated to reflect innovation in the strategies and interventions designed to address asthma in Illinois.

The Illinois Asthma State Plan is a framework for action, collaboration, and communication. The plan reflects strategies outlined in the U.S. Centers for Disease Control and Prevention's (CDC) EXHALE Technical Package with goals and objectives that have been developed by the Illinois Asthma Partnership (IAP). Activities align with the CDC's initiative, Controlling Childhood Asthma and Reducing Emergencies (CCARE) , and are designed to improve childhood asthma outcomes and prevent childhood hospitalizations and emergency department visits.

IDPH extends its appreciation to those who serve on the IAP and contributed their time and expertise to the development of this plan.



Acknowledgements

The Illinois Department of Public Health's Illinois Asthma Program appreciates the many individuals and organizations that participated in the planning process of the 2021 – 2026 Illinois Asthma State Plan. This document was made possible through the invaluable time, input, and consideration from the following individuals, in collaboration with Illinois Asthma Program staff.

Illinois Asthma Partnership State Plan Workgroup Members

Nancy Amerson, Illinois Department of Public Health

Jerrica Ampadu, Southern Illinois University Edwardsville, School of Nursing

Kathy Boon, Northwestern/Center for Food Allergy & Asthma Research

Kim Branch, Chicago Asthma Consortium

Anna Browar, Ann & Robert H. Lurie Children's Hospital of Chicago

Kristi Bunn, Illinois Department of Public Health

*Cathy Catrambone, PhD, Rush University

Lynette Clontz, Illinois Department of Public Health

*Maithili Deshpande, Southern Illinois University Edwardsville/Southern Illinois University School of Medicine

Enoch Ewoo, Illinois Department of Public Health

*Felicia Fuller, American Lung Association

Tricia Fusilero, Chicago Asthma Consortium

Sarah Geiger, University of Illinois at Urbana-Champaign

*Margie Getz, Methodist College

Elena Grossman, BRACE – Illinois

*Stacy Ignoffo, Sinai Urban Health Institute

***Illinois Asthma Partnership Executive Committee Members**

Cassandra Johnson, University of Illinois at Urbana-Champaign

Tyra Jones, Southern Illinois University School of Medicine

Kristin Kan, MD, Ann & Robert H. Lurie Children's Hospital of Chicago

Arlene Keddie, Northern Illinois University

Brianna Klein, Illinois Department of Public Health

Chris Martinez, Asthma & Allergy Foundation of America, St. Louis Chapter

Reagan Nelson, Asthma & Allergy Foundation of America, St. Louis Chapter

Andrea Pappalardo, MD, University of Illinois College of Medicine

*Vicky Persky, MD, University of Illinois at Chicago

Samantha Saini, Illinois Department of Public Health

*Erica Salem, Respiratory Health Association

Matt Siemer, Mobile Care Chicago

Tracey Smith, Illinois Public Health Association

Anna Volerman, MD, University of Chicago Medicine

Nikki Woolverton, Illinois Department of Public Health

Executive Summary

Asthma is a chronic lung disease involving inflammation of the airways leading to clinical signs and symptoms of airflow obstruction. Asthma episodes or attacks can vary from mild to life-threatening, and an individual's age of presentation, symptoms, and course may vary, not only in comparison to others, but also within an individual's own lifetime. Asthma is a long-term illness, which may have both acute and chronic inflammation, and individuals with asthma require consistent interaction with the health care system to ensure proper asthma management. With guidelines-based access to care, individuals with asthma can live normal lives and avoid in-patient hospitalizations and emergency department visits.

In 1998, the Illinois Asthma Task Force was formed to address the burden of asthma in Illinois, and through collaborative action, the task force developed the *Addressing Asthma in Illinois* Plan. In 1999, IDPH received a three-year grant from the CDC to develop a program that included a statewide asthma partnership. The partnership became known as the Illinois Asthma Partnership (IAP), consisting of community-based organizations, educators, health care providers, health care professionals, and community members. The IAP has since been instrumental in the development of subsequent versions of the *Illinois Asthma State Plan*.

In September 2019, IDPH was awarded a competitive five-year grant from CDC to improve the reach, quality, effectiveness, and sustainability of asthma control services with the goal of reduction of asthma morbidity, mortality, and asthma health disparities by implementing evidence-based strategies across multiple sectors. Activities align with the CDC CCARE Initiative and are designed to improve childhood asthma outcomes and to prevent childhood hospitalizations and emergency department visits. IDPH, along with its partners, will strengthen infrastructure to expand the reach of services through six strategies outlined in the CDC EXHALE Technical Package:

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

National Asthma Data At-A-Glance

Asthma is a significant health and economic burden in the United States. Of the 24.8 million U.S. residents who reported having asthma in 2018, 11.2 million experienced an asthma attack during the previous year, and 3,441 individuals died.[3] Asthma affects people of all races, sexes, and ages, living in every region of the U.S. Asthma occurs more often among boys (age <18 years), adult women (age 18+ years), non-Hispanic Black children and adults, people of Puerto Rican descent, people living in the Northeast and Midwest, and those living below the federal poverty level.[1]

Asthma affects approximately 5.5 million children in the U.S.,[4] and is the leading health-related cause of school absenteeism.[5] Asthma is the third leading cause of preventable hospitalizations,[6] and may affect a child's overall achievement.[7] Other symptoms also may restrict activities and impair the quality of life for a child with asthma.

Among adults, asthma is the leading work-related lung disease. In 2018, employed adults 18 years of age and over missed 14.2 million workdays due to asthma.[8] Keeping asthma under control can be expensive; it causes financial burdens, including lost workdays, reduced productivity, lost income, and low quality of life for persons with asthma, and disruption to family and caregiver routines.

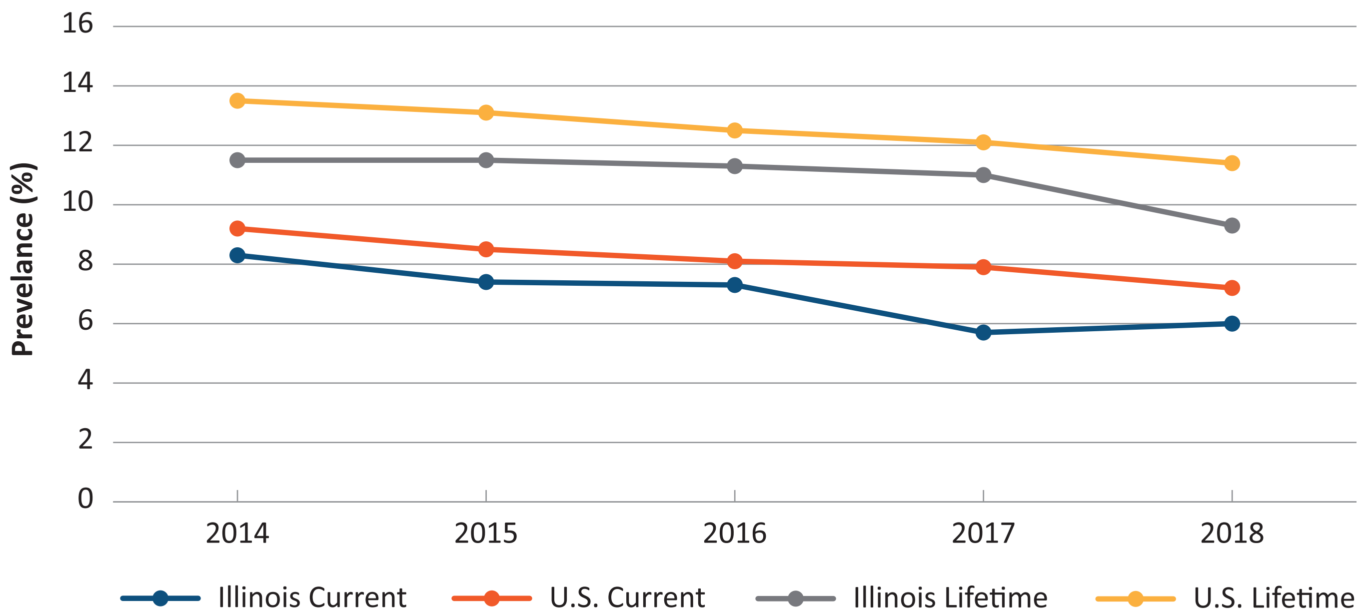
A Snapshot of National Asthma Data[6]

- 19.2 million adults have asthma
- 5.5 million children have asthma
- 50% of adults with asthma and 40% of children with asthma do not have control of their disease
- Estimated annual cost of treating asthma in the U.S. is $62.8 billion
- Each year, asthma accounts for approximately:
  - 439,000 hospitalizations
  - 1.6 million emergency department visits
  - 10.5 million physician office visits
  - 13.8 million missed school days
  - 14.2 million missed workdays

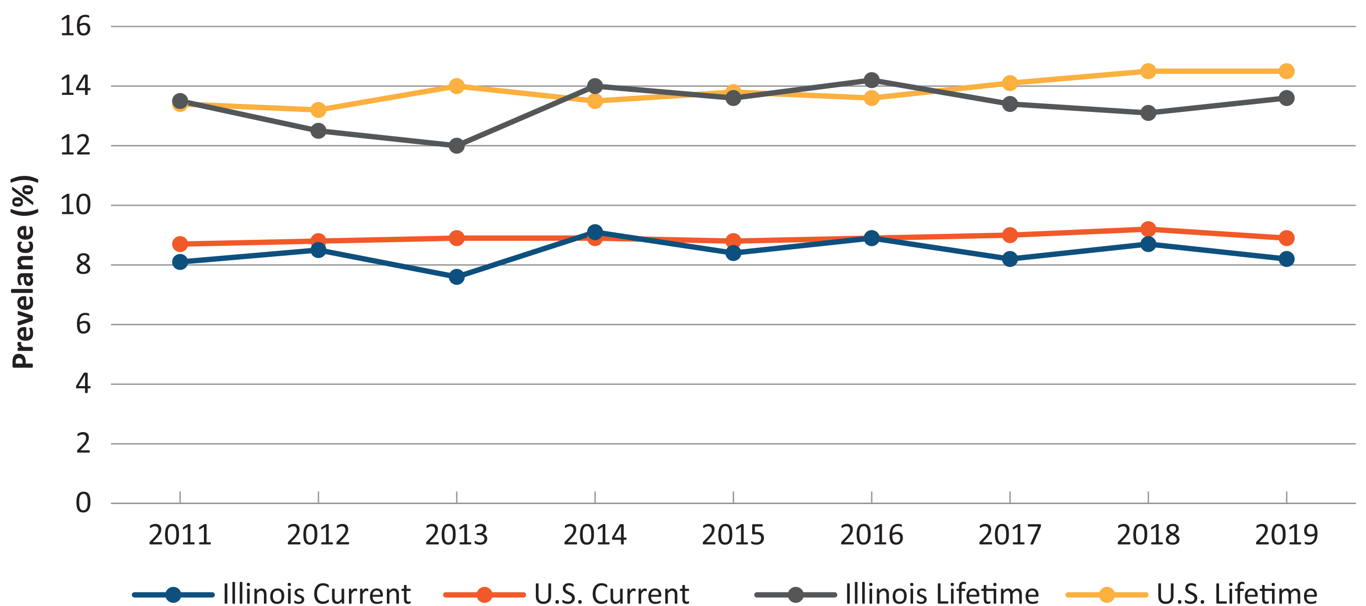
Illinois Asthma Data At-A-Glance

In Illinois, the past few years have shown some promising trends – child asthma prevalence has declined; adult asthma prevalence has remained stable since 2011,[9] as has emergency department (ED) visits and hospitalizations in recent years (2016-2019);[10] and there have been declines in asthma mortality overall.[11] Despite these gains, asthma disparities remain.

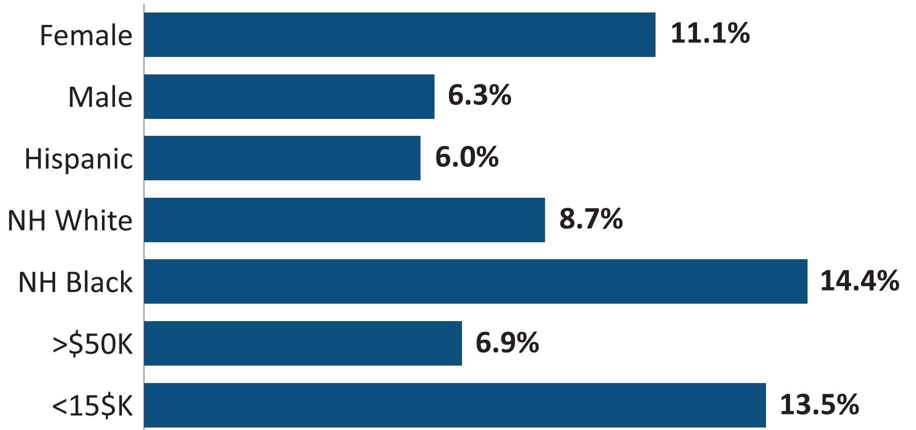
Current and lifetime child asthma prevalence has decreased in Illinois and the U.S.

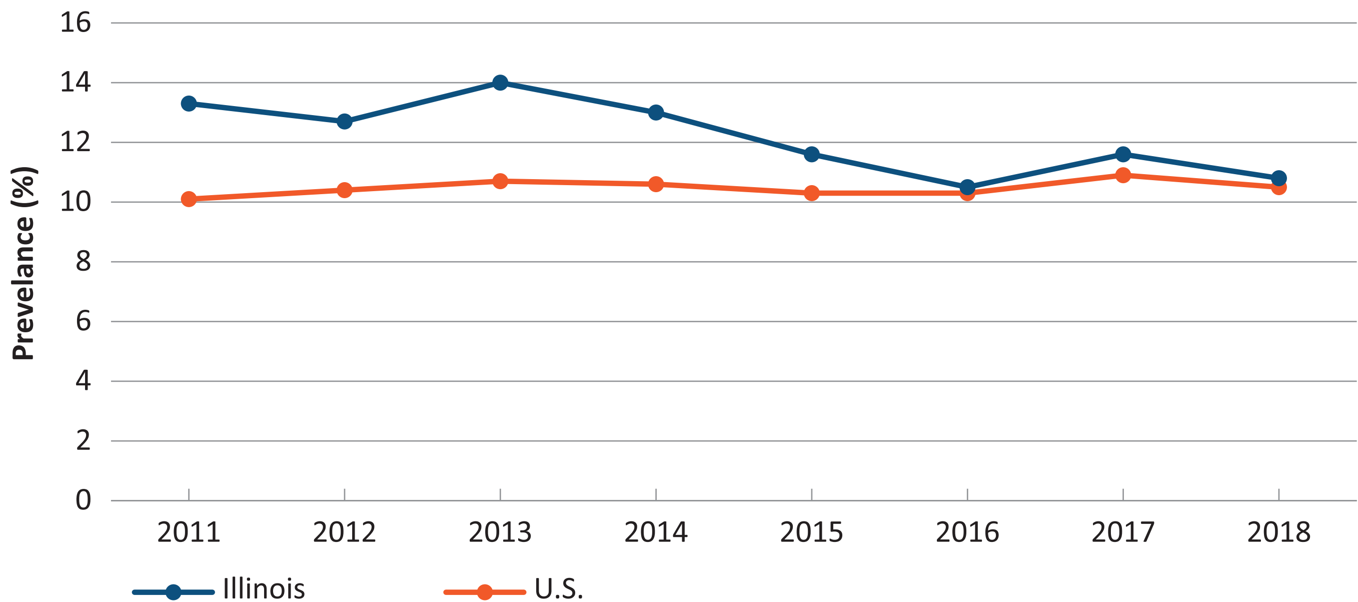


Current and lifetime adult asthma prevalence has remained stable in Illinois and the U.S.

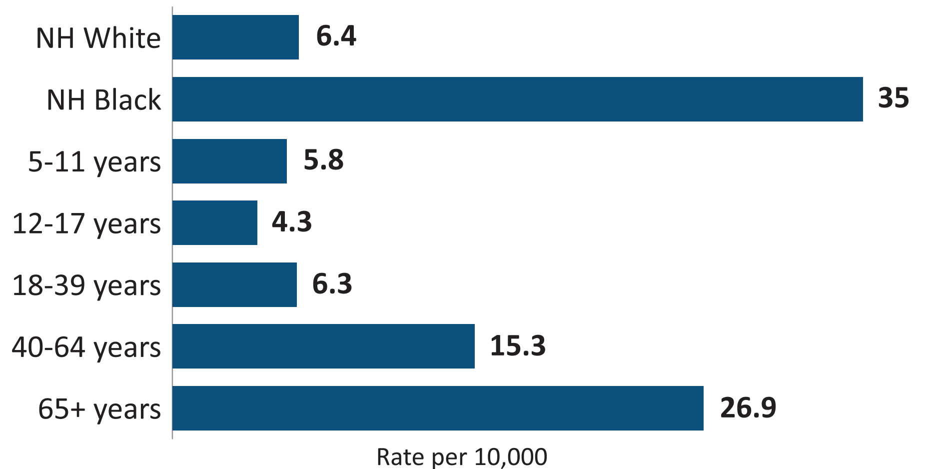


Asthma prevalence in women is nearly two times higher than in males (11.1% vs. 6.3%), it is highest in the non-Hispanic Black population (14.4%), and highest among those in low-income brackets (13.5% among those making under $15,000 per year).[9]

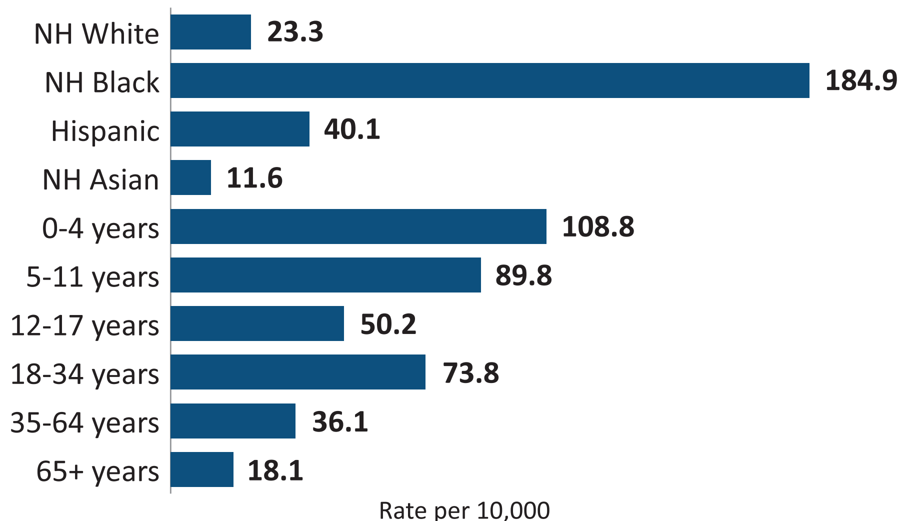




Mortality disparities are quite alarming; the rate is four times higher for Blacks compared to Whites (35.0 vs. 6.4 per 1,000,000).[11] It is also highest among the older populations.

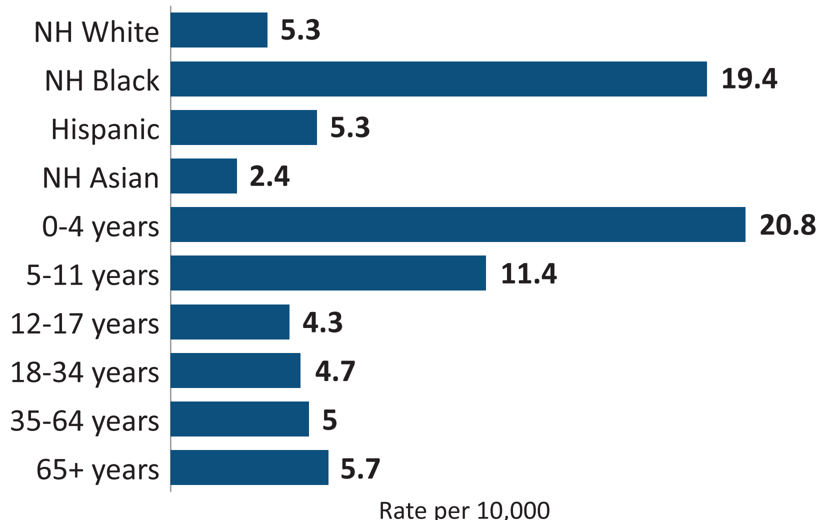


Asthma ED disparities exist by race/ethnicity and age.[10]



Asthma ED visit rates are highest in youth under 0-4 years followed by 5-11 years and are highest among NH Blacks.[10] ED visit rates for NH Blacks are more than eight times higher than NH White.[10]

Asthma inpatient disparities exist by race/ethnicity and age.[10]



Asthma inpatient visit rates are highest in youth 0-4 years and are highest among NH Blacks.[10] Asthma inpatient visit rates are more than five times higher compared to NH White.[10]

A Snapshot of Illinois Asthma Data

- 860,000 adults currently have asthma[12]
- 160,000 children currently have asthma[10]
- 7,864 hospitalizations with asthma as a primary diagnosis in 2019[9]
- 64,104 emergency department visits with asthma as the primary diagnosis in 2019[9]
- 137 asthma deaths in 2018[8]

For more information on Illinois asthma surveillance, visit http://www.dph.illinois.gov/topics-services/diseases-and-conditions/asthma/il-asthma-surveillance.

Addressing Health Equity in Asthma Interventions

In Illinois, and throughout the nation, asthma affects certain groups disproportionately, rendering significant disparities. Many complex factors, including health care coverage, limited access to care, socioeconomic status, geography, housing, transportation, and individual genetics, behavior, and literacy, all contribute to health disparities.

The Asthma Program has traditionally examined health disparities and has made concerted efforts to promote comprehensive asthma delivery services in priority communities with significant disparities. The program also recognizes there is much work to be done and commits to utilizing a health equity lens in interventions, assuring cultural competence, cross-sector partnerships, and a comprehensive approach that addresses environmental and social determinants of health. Therefore, the program will begin to utilize the newly developed Health Equity Checklist (page 25) in intervention and grant programming. The program and IAP are determined to work toward an equitable future for all Illinoisans with asthma.

Health Equity Checklist

The Health Equity Checklist was jointly developed by the Office of Governor JB Pritzker and the Illinois Department of Public Health as a result of the COVID-19 pandemic and the negative impact of social determinants of health in marginalized communities. The Health Equity Checklist is designed to:

- Articulate how a proposed intervention strategy will improve overall health and advance health equity by reducing disparities and/or health inequities in disparately impacted communities.
- Proactively identify any barriers or undue burdens the proposed intervention strategy may impose upon disparately impacted communities that would limit the effectiveness of the intervention strategy.
- Ensure that members of disparately impacted communities are engaged and consulted in the planning and implementation of the intervention strategy.
- Assess the intervention strategy's impact on disparately impacted community members over time.

For more information on the Health Equity Checklist, see page 25.

State Plan Framework

In alignment with the national asthma priorities set for the nation by the CDC, the Asthma Program and State Plan focus on the EXHALE strategies that have the greatest potential impact on controlling asthma.

EXHALE		
	Strategy	**Approach**
E	Education on asthma self-management	• Expanding access to and delivery of asthma self-management education (AS-ME).
X	X-tinguishing smoking and secondhand smoke	• Reducing tobacco smoking. • Reducing exposure to secondhand smoke.
H	Home visits for trigger reduction and asthma self- management education	• Expanding access to and delivery of home visits (as needed) for asthma trigger reduction and AS-ME.
A	Achievement of guidelines-based medical management	• Strengthening systems supporting guidelines-based medical care, including appropriate prescribing and use of inhaled corticosteroids. • Improving access and adherence to asthma medications and devices.
L	Linkages and coordination of care across settings	• Promoting coordinated care for people with asthma.
E	Environmental policies or best practices to reduce asthma triggers from indoor, outdoor, and occupational sources	• Facilitating home energy efficiency, including home weatherization assistance programs. • Facilitating smoke-free policies. • Facilitating clean diesel school buses. • Eliminating exposure to asthma triggers in the workplace whenever possible. • Reducing exposure to asthma triggers in the workplace (if eliminating exposures is not possible).

Hsu J, Sircar K, Herman E, Garbe P. (2018). *EXHALE: A Technical Package to Control Asthma*. Atlanta, GA: National Center for Environmental Health, Centers for Disease Control and Prevention.

To most effectively achieve the aim of the CDC award, *A Comprehensive Public Health Approach to Asthma Control Through Evidence-Based Interventions*, the Asthma Program is working to enhance existing infrastructure and mobilize key partners across multiple sectors to coordinate the delivery of asthma control services in priority populations with significant disparities. Funded core projects include a Home Visiting Collaborative (HVC), which is incorporating home visiting programs equipped to implement EXHALE strategies located in high-burden, disparate populations areas across the state; the development of both a community health worker (CHW) and health care provider Extension for Community Healthcare Outcomes (ECHO) model; and statewide initiatives, including seeking third-party payer reimbursement for asthma interventions, improving access to medications and devices while eliminating barriers such as prior authorization or refill limits, and advocating for clean environmental policies.

A Comprehensive Public Health Approach to Asthma Control Through Evidence-Based Interventions – Funded Interventions

Home Visiting Collaborative

As home visiting programs are in a unique position to deliver EXHALE strategies as a coordinated package, the HVC was created to enhance existing home visiting programs. Over the course of funding, four intensive asthma home visiting programs have provided comprehensive asthma home visiting services and asthma self-management education over varying lengths of time. Each HVC grantee has its own service area and clients, while the HVC serves as a learning community where successes, challenges, opportunities for expansion, policy, reimbursement, and quality improvement (QI) initiatives are discussed.

- American Lung Association primarily serves Cook County (Chicago area) and the city of Kankakee.
- Sinai Urban Health Institute serves Chicago.
- Southern Illinois University School of Medicine serves Springfield.
- Southern Illinois University Edwardsville, School of Nursing, serves St. Clair and Madison counties.

In addition to unique materials suited to the populations they serve, HVC grantees use a standardized assessment tool for data collection and prompts for the home visitor. The tool is evidence-based and includes demographic data, environmental asthma trigger information, clinical outcomes, asthma severity, and how to tailor an action plan for the client. Home visitors provide intensive AS-ME using evidence-based programs based on National Asthma Education and Prevention Program (NAEPP) guidelines[14], including Asthma Basics[15], and utilize partnerships with housing, home weatherization, and other social service agencies as needed, to address barriers clients may have in achieving asthma control.

Within the HVC, both CHW and health care provider Project ECHO (Extension for Community Healthcare Outcomes) models are implemented to increase capacity, especially in areas with limited access to care. ECHO[13] is an innovative, recognized model for tele mentoring and uses a hub-and-spoke knowledge sharing approach to increase capacity and provide best practices while also addressing disparities. Through ECHO, extensive education is provided to home visiting staff, and clinical providers are provided with the most current NAEPP guidelines and asthma QI initiatives. Both ECHO models provide methods to enhance team-based care.

Statewide Asthma Initiatives

Asthma Control and Health Plans

The Asthma Program works closely with the Illinois Primary Health Care Association in sharing the CDC 6|18 Initiative[16] evidence-based preventive practices with state Medicaid managed care organizations and health plans. Such interventions include, using NAEPP guidelines in clinical practice, promoting strategies that improve access and adherence to asthma medications and devices, and expanding access and reimbursement to AS-ME and home visits. These practices complement EXHALE strategies by advocating for access to and reimbursement for asthma self-management education, home visiting, and elimination of barriers to asthma medications and devices.

Asthma Education and Policy

The Respiratory Health Association (RHA) leads in identifying and advocating for strengthened asthma policy, including clean diesel engines, retrofitting older engines, and limiting vehicle idling. Additionally, RHA provides guidelines-based asthma management training for school and child care facility staff. The Chicago Asthma Consortium (CAC) utilizes the strength of its membership to provide guidelines-based education and training to include, but not limited to, health care providers, public health professionals, school nurses, and community-based organizations.

Methodology for Target Populations and Location Selections

The Asthma Program utilized geographic information systems (GIS) to examine a series of city- and county-level maps analyzing percent of families with children under 18 years of age, percent of families in high poverty areas, percent of African American families, hospitalization rates for children under 18 years of age, emergency department visit rates for children under 18 years of age, and ambulance visits to schools for children aged 5-18 years. With these measures in mind, Chicago, six central and southern cities, and East St. Louis were identified as high-burden areas in need of comprehensive asthma services that address multiple social determinants of health.

Goals and Objectives

Since the inception of the IAP, the Executive Committee and partners have crafted an overall partnership mission and associated goals.

IAP Mission

Improve the quality of life for persons with asthma and their caregivers by enhancing infrastructure and leveraging partnerships to expand access to comprehensive asthma control services.

IAP Goals

- Expand the number of persons with asthma who have better control of their disease and better quality of life.
- Expand comprehensive asthma control services statewide.
- Decrease disparities in asthma care, management, and health outcomes.
- Reduce morbidity and mortality from asthma.
- Sustain and improve asthma prevention, control, and education efforts statewide.

Utilizing CDC Funding for Further Action

The Illinois Asthma Program has been fortunate to receive competitive CDC funding to accomplish the mission and goals of the IAP. Over the course of the CDC grant project period, the Asthma Program and its partners will implement strategies in two major categories: 1) Enhance Program Infrastructure and 2) Leverage Partnerships to Expand EXHALE. The following were identified by the Asthma Program and partners as important areas for action to address asthma in Illinois.

Enhance Program Infrastructure

Asthma partners in multiple sectors will strategically coordinate delivery of asthma control services to priority populations. Asthma data and surveillance systems will be enhanced and used to guide policy decisions, deliver asthma control services, and expand partnerships. Program and intervention evaluation findings will guide continuous program and activity improvement.

Goal 1: Expand and sustain comprehensive and effective asthma control services to priority populations.

- On an annual basis, develop a surveillance and disparity map to identify priority counties and populations.
- On an annual basis, identify and share best practices and learning opportunities to assist partners in implementing coordinated and effective asthma programs, policies, and care.
- On an ongoing basis, tailor guidelines-based health communication activities, such as health education and community awareness, to address specific needs of priority populations.
- Increase membership/participation on the IAP by identifying and recruiting new members to support collective impact and expansion of services.

Goal 2: Raise awareness about the burden of asthma in local communities.

- Maintain and expand statewide surveillance data sources.
- On an annual basis, disseminate surveillance and evaluation findings to key stakeholders. Surveillance and evaluation products may include:
  - IAP presentations
  - Asthma burden and trend reports

  Key stakeholders may include:
  - State government
  - Local health departments
  - Schools
  - Health professionals
  - Community-based organizations
  - Community members
- By December 31, 2021 and annually thereafter, monitor and improve the efficacy of asthma control services through the implementation of individual evaluation plans for priority areas identified in the Illinois Asthma Strategic Evaluation Plan.

Leverage Partnerships to Expand EXHALE

Asthma partners will expand access to comprehensive asthma control services by implementing activities in each of the six EXHALE strategies: Education on asthma self-management; X-tinguishing smoking and exposure to second-hand smoke; Home visits for trigger reduction and asthma self-management education (AS-ME); Achievement of guidelines-based medical management; Linkages and coordination of care; and Environmental policies or best practices to reduce indoor and outdoor asthma triggers.

E: Education on Asthma Self-Management

Goal 1: Expand access to and delivery of evidence-based AS-ME programs to people with asthma and their caregivers.

- Continually seek partnerships with health care organizations, schools, and other entities to serve as referral sources for AS-ME programs.
- By June 2021, identify proven models and potential pathways for sustaining delivery of AS-ME.
- By May 2022, expand AS-ME programs into various clinical and community settings, such as homes, schools, child care centers, clinics, workplaces, and pharmacies.
- By December 2022, develop a team of diverse instructors, such as nurses, certified asthma educators, and community health workers, to deliver AS-ME in various settings in priority populations.
- By September 2023, leverage technology and utilize virtual platforms to expand the delivery of AS-ME programs throughout the state.
- By January 2024, identify proven models and potential pathways for sustaining delivery of AS-ME and utilize partnerships with Medicaid managed care organizations to obtain coverage and reimbursement for AS-ME.

X: X-tinguishing Smoking and Exposure to Second-Hand Smoke

Goal 2: Reduce tobacco use and second-hand smoke exposure among persons with asthma and their caregivers.

- Promote tobacco cessation interventions, medications, or counseling services to AS-ME and home visiting participants.
- By September 2024, partner with the IDPH Illinois Tobacco Prevention and Control Program to obtain coverage and reimbursement for tobacco cessation services.

H: Home Visits for Trigger Reduction and AS-ME

Goal 3: Expand access to and delivery of home visits for environmental asthma triggers and asthma control.

- Continually seek partnerships with health care organizations, schools, and other entities to serve as referral sources for home visiting programs.
- Twice a year, share or provide training on topics, such as environmental assessment tools, health literacy, and cultural sensitivity, to home visiting programs.
- By June 2022, identify partnerships in priority counties and service areas to explore expansion opportunities for asthma home visiting programs.
- By January 2024, identify proven models and potential pathways for sustaining delivery of home visiting programs and utilize partnerships with Medicaid managed care organizations to obtain coverage and reimbursement for asthma home visits.

A: Achievement of Guidelines-Based Medical Management

Goal 4: Strengthen systems and quality improvement initiatives to support guidelines-based medical care.

- On an ongoing basis, advocate with hospitals and local health departments for the inclusion of asthma treatment and control strategies in Community Health Improvement Plans and in community health needs assessments.
- Continually collaborate with health systems to use administrative and clinical data to identify persons with poor asthma control to provide comprehensive asthma services.
- By August 2022, facilitate team-based care training to support asthma care among health care providers, such as physicians, nurses, community health workers, respiratory therapists, and pharmacists.
- By September 2022, advocate for asthma quality improvement initiatives and partner with Medicaid, managed care organizations, and health plans to implement these initiatives.
- By January 2024, utilize partnerships with Medicaid and managed care organizations to align coverage with guidelines-based care and eliminate barriers, including non-preferred drugs, co-payments, prior authorization, and refill limits, to obtaining and using asthma medications and devices.

L: Linkages and Coordination of Care

Goal 5: Encourage coordinated care across settings and ensure linkages to community resources.

- Continually build and expand linkages within and across health systems and community services to address medical and social needs of individuals in order to improve health, access to medications, and asthma outcomes.
- Continually maintain and expand partnerships with local, state, or national organizations that address social determinants of health, including transportation, integrated pest management, home weatherization, and tenant advocacy.

- By December 2022, support health care organizations, schools, and community-based organizations in promoting coordinated care for asthma.
- Continually promote coordination of care and bi-directional sharing of information between health care providers, schools, community-based organizations, and other social service providers.

E: Environmental Policies or Best Practices to Reduce Indoor and Outdoor Asthma Triggers

Goal 6: Promote the adoption of environmental policies and best practices to reduce indoor air and outdoor asthma triggers.

- By September 2021, promote education and methods to improve indoor air quality in homes, schools, and workplaces.
- Continually collaborate with partners to encourage home energy efficiency, including home weatherization and structural improvements, for persons with asthma.
- By September 2023, advocate for environmental best practices, such as the adoption of clean diesel technology and retrofitting, modifying school buses with older diesel engines, and expanding usage of electric vehicles.
- Maintain partnership with the IDPH Illinois Tobacco Prevention and Control Program to monitor and promote local smoke-free policies.
- By September 2022, inform governmental and non-governmental decision makers about air quality benefits from clean energy.

Expected Outcomes of EXHALE Implementation

Short-term outcomes (1-3 years)

- Expanded capacity to deliver or refer persons with asthma to begin AS-ME.
- Expanded access, referral to, and delivery of coordinated services in high-burden areas.
- Improved systems that encourage team-based asthma care.
- Use of surveillance and evaluation data for program improvement.

Intermediate outcomes (4-5 years)

- More persons with asthma receive appropriate medical assessments, essential medications, and devices.
- More persons with asthma receive AS-ME.
- Established linkages and coordination across public health and health care systems.
- Increased asthma care coverage and reimbursement for asthma service delivery.

Long-term outcomes (5+ years)

- More individuals have well-controlled asthma, fewer asthma attacks, and fewer missed school or workdays.
- Fewer asthma-related ED visits, hospitalizations, and deaths.
- Decreased disparities in asthma prevalence and morbidity.

Evaluation

A fundamental part of Illinois' efforts to address the burden of asthma has consistently been to conduct evaluations of the work to inform progress and to guide future activities based on programmatic needs. The evaluation process puts value on this work by using a range of research methods to systematically investigate effectiveness, implementation, outcome, and impact. Partners and other stakeholders will use evaluation findings to reexamine strategies and specific activities as needed. The Strategic Evaluation Plan (SEP) will be updated annually to track and guide progress.

For 2021-2024, the evaluation team will be conducting various individual evaluation plans (IEPs) prioritized by the strategic evaluation planning team (EPT). These IEPs will utilize both qualitative and quantitative data while aligning with and reporting on appropriate performance measures like linking activities and outcomes and changes in population-level outcomes. The specific IEPs are an:

1) Evaluation of asthma home visiting programs costs and benefits.
2) Effectiveness evaluation of AS-ME administered in home visiting programs.
3) Expanded evaluation of the facilitators and barriers to participation in home visiting programs.
4) Evaluation of ECHO, the training of community health workers to conduct home visits.

All current evaluations will be conducted in a culturally competent manner, and are centered on the home visiting educational components, expanding its access, and improving asthma control to make progress toward achieving health equity.

Specific evaluation activities include, but are not limited to, standardizing data collection tools, participating in various workgroups focused on data and surveillance and reimbursement, and disseminating findings through various communication routes. These activities play a key role in home visiting accessibility and expansion especially in regard to creating a robust partnership with Medicaid managed care organizations. This result is a direct reflection of the benefits of evaluation: to help increase funding opportunities and stakeholder buy-in to the evaluation process.

Communication

The Illinois State Plan 2021 – 2026 demonstrates a renewed commitment to effective use of communication resources to achieve identified goals. Strategies will be directed to areas defined as health communication (changes in knowledge, attitudes, and behavior); policy/stakeholder communication (coordination and replication of recommended activities); and dissemination of surveillance and evaluation findings.

Health Communication

The IAP recognizes that excellent resources are available both on the national- and state-level to educate people with asthma in self-management skills. The use of social media and technology can also expand access and outreach efforts. Through program and partner websites and home visiting programs, training resources will support various medical and public health professionals, caregivers, and community programs/workers in their efforts to inform and to support individuals with asthma.

Policy/Stakeholder Communication

The IAP is committed to promoting best practices in community-based approaches to promote coordinated, evidence-based asthma care and disseminate these approaches, targeting areas with a disproportionate burden of asthma. In an effort to align asthma control services across public health and health care sectors, the IAP will expand its membership and leverage member resources. In addition, it will review current policies at the state- and local-levels, identify gaps, and develop a list of evidence-based policies supportive of asthma control.

The IAP will provide this information to medical professional and association websites and newsletters and speak at regional professional conferences to educate health care professionals about asthma control policies. It will also utilize the program and partner listservs and newsletters to inform local health departments, schools, and other community organizations and businesses about asthma control policies. Information about the Illinois asthma burden, the impact of comprehensive asthma control services, and guidelines-based care will be shared with the Medicaid system and other health insurance programs to promote coverage and reimbursement for asthma control services.

Dissemination of Surveillance and Evaluation Findings

The IAP recommends the use of the existing surveillance systems (hospital discharge, Behavioral Risk Factor Surveillance System (BRFSS) surveys, and asthma call-back surveys (ACBS) to identify areas of disproportionate asthma burden, to define and to inform about the burden of asthma in Illinois, and to monitor and to improve programs through evaluation. The IAP will continue its lead role in development and publication of burden briefs and trend reports utilizing an enhanced list of statewide surveillance data sources. The IAP will be actively involved in the development of the Illinois Strategic Evaluation Plan and in the development and monitoring of individual evaluation plans for priority areas. Each of these plans will include a communication plan to ensure lessons learned are shared with targeted stakeholders.

Illinois Policies Supporting EXHALE

The integration of asthma policies at national, state, and local levels is important in promoting asthma-friendly environments and supporting EXHALE implementation. Illinois is fortunate to have stakeholders who seek to influence the development of such policies and identify collaborative opportunities for future efforts. Below are examples of policies that support EXHALE implementation in Illinois.

Asthma Medication Self-Carry and Self-Administration, Public Act 096-1460.
Schools must permit students with asthma to self-carry and self-administer asthma medications.

Asthma Episode Emergency Response Protocol, Public Act 99-0843.
Illinois primary and secondary schools must adopt an asthma emergency response protocol, schools must request asthma action plans from parents of students with asthma, and school personnel who work with students must complete training every two years on asthma management, prevention of asthma symptoms, and emergency response in the school setting. Illinois State Board of Education has developed a model asthma emergency response protocol.

Stock Asthma Rescue Medications in Schools, Public Act 100-0726.
Schools may stock undesignated asthma medication and administer to a person experiencing symptoms of respiratory distress, regardless if that person has been diagnosed with asthma. The Respiratory Health Association and its partners developed a toolkit designed to provide participating schools with guidance on how to implement the stock albuterol policy.

Smoke-Free Illinois Act, 410 ILCS 82.
The Smoke-Free Illinois Act protects the public from the harmful effects of exposure to tobacco smoke by prohibiting smoking in public places and places of employment and within 15 feet of any entrance, exit, windows that open, or ventilation intake of a public place or place of employment.

Tobacco 21, Public Act 101-0002.
In July 2019, Tobacco 21 raised the state minimum legal sales age to 21 for all tobacco products, including e-cigarettes and vaping products. The public act includes amendments to state statutes, including, the Prevention of Cigarette Sales to Persons under 21 Years of Age Act, 720 ILCS 678; and the Prevention of Tobacco Use by Persons under 21 Years of Age and Sale and Distribution of Tobacco Products Act, 720 ILCS 675.

In December 2019, national legislation amended the federal Food, Drug, and Cosmetic Act, and raised the federal minimum age for sale of tobacco products from 18 to 21 years of age. Legislation prohibits retail establishments to sell any tobacco product, including cigarettes, cigars, and e-cigarettes, to anyone under 21.

Smoke-Free Public Housing
Nationally, public housing agencies/authorities must implement a policy prohibiting smoking in all indoor areas, including dwelling units, and within 25 feet of all indoor areas.

Illinois Vehicle Code, Public Act 101-0468
Prohibits smoking in a motor vehicle, in motion or at rest, containing a person under 18 years of age. Smoking is defined as inhaling, exhaling, burning, or carrying a lighted cigarette, cigar, pipe, plant, regulated narcotic, or other combustible substance.

Collaboration and Leveraging of Resources

The IAP promotes efforts for collaborative action in implementing asthma control services that align with best practices and increased quality of life for people with asthma. Asthma itself is a complex, multi-factorial disease associated with genetic, environmental, socioeconomic, and allergenic influences. In order to effectively prevent asthma morbidity and mortality, a combination of coordinated efforts is recognized and encouraged.

Illinois is fortunate to have a robust and active statewide partnership. The IAP is comprised of individuals and organizations that bring premier subject matter expertise, experience, and integrity. Partners often lend their time and expertise in providing educational presentations, assisting in the development of data and surveillance reports, offering guidance and strategic direction for achieving IAP goals, and connecting to innovative collaboration with multiple sectors.

The HVC programs leverage partners to expand their reach in existing communities and to seek expansion to new communities. Local health systems in home visiting service areas assist in providing clinical data and referring patients with poorly controlled asthma. A variety of traditional and non-traditional partners are critical in the work of home visiting and addressing individualized client asthma and general health and well-being needs. Partners include medical providers, pharmacists, CHWs, social workers, housing, transportation, home weatherization, law enforcement, truancy, and judicial systems. The HVC serves as a learning community where programs can discuss progress, barriers, ideas, and referral sources with one another. Each program brings a different perspective and uses these experiences to enhance the collaborative and resources at all sites.

The Asthma Program collaborates with local CDC programs, specifically the Illinois BRFSS, DP18-1815 Chronic Disease grant (community health worker initiatives), Tobacco Prevention and Control (shared publications), Environmental Health (technical advisor), and BRACE-Illinois (environmental workgroup, education for HVC programs, environmental policy initiative support).

Illinois Asthma Partnership

The IAP was created in 2000. The partnership has met consistently during this time and currently meets in-person annually. The partnership is comprised of four workgroups and an executive committee, with each meeting every other month via conference call.

IAP Member Roles

- Implement the Illinois Asthma State Plan.
- Identify and analyze data sources for asthma surveillance and evaluation.
- Develop professional knowledge and skills in asthma.
- Communicate with IDPH and grant recipients.
- Advise IDPH staff on issues related to asthma in Illinois.

Asthma Program Staff Roles

- Guide the implementation of the Illinois Asthma State Plan.
- Serve as a vehicle to coordinate communication between the local asthma consortia, Illinois' evidence-based asthma interventions, and the IAP.
- Coordinate the activities of the IAP workgroups and in-person meetings.
- Communicate state program priorities.
- Address needs voiced by IAP workgroups and members.
- Provide technical assistance and resources for programs implemented through the IAP.
- Document workgroup meetings.

IAP Executive Committee

Two members serve as chair and co-chair. Members of the executive committee include the two co-chairs of each workgroup and designated members at large. Annually, Executive Committee members confirm their commitment to continue leadership roles with the IAP. When vacancies arise in chair or co-chair positions of the Executive Committee or co-chair positions of the workgroups, nominations are requested from participating members, with individuals selected by Asthma Program staff based upon input from participating members and in consultation with the chair and co-chair of the Executive Committee. Members at large are selected by Asthma Program staff in consultation with the chair and co-chair of the Executive Committee, with the number and expertise of members at large reflecting the needs and priorities of the program.

Duties

- Assist with planning the annual partnership meetings.
- Provide direction on annual priorities, strategies for leveraging health care reform for comprehensive asthma control services, and policies supportive of comprehensive asthma control.
- Lead in the development of the state asthma plan (every five years) and update the plan as needed.
- Provide input to the Asthma Program's strategic evaluation plan development and implementation.
- Facilitate respective workgroup conference calls, including agenda development.

Workgroups

Surveillance and Evaluation Workgroup: This workgroup compiles scientific information related to asthma, disseminates information to those who are interested and who need to know, guides the process of program evaluation by the IAP and its collaborators, and promotes the use of information as the foundation for action in alleviating the burden of asthma.

School and Education Workgroup: This work group promotes education and awareness using the NAEPP asthma guidelines and evidence-based programs by providing materials and resources to increase awareness about asthma to allied health professionals, child care providers, and the school community (e.g., school parents, student nurses, teachers, administrators, secretaries, security, maintenance, dietary, bus drivers, lunch and playground staff, coaches, and athletic directors) to promote consistent messaging on the management of asthma.

Environmental Asthma Workgroup: This workgroup works with local, state, and national partners to support efforts to address air pollutants and advocate for best practices and adoption of clean environmental policies, such as clean diesel engines, retrofitting older engines, and limiting vehicle idling.

Asthma Reimbursement Workgroup: This workgroup promotes evidence-based preventive practices, including the CDC 6|18 Initiative related to Asthma Control, with Medicaid managed care organizations and health plans. Activities are framed around the four asthma interventions as described in the 6|18 Initiative Control Asthma Evidence Summary: 1) Promote evidence-based medical management following the 2007 NAEPP Guidelines; 2) Promote strategies that improve access and adherence to asthma medications and devices; 3) Expand access to intensive self-management education for individuals whose asthma is not well-controlled with the 2007 NAEPP Guidelines-based medical management alone; and 4) Expand access to home visits by licensed professionals or qualified community health workers to improve self-management education and to reduce home asthma triggers for individuals whose asthma is not well-controlled with the 2007 NAEPP Guidelines-based medical management and intensive self-management education.

For More Information or to Join the IAP

Contact the Illinois Asthma Program Manager at:

Illinois Department of Public Health
Office of Health Promotion
Division of Chronic Disease Prevention and Control
535 W. Jefferson St., 2nd Floor
Springfield, IL 62761-0001
217-782-3300

Health Equity Checklist

Introduction

COVID-19 has exposed the negative impact of the social determinants of health within communities of color where the rate of infections and deaths are the highest especially among racial and ethnic minorities. A growing body of evidence has shown that if we address unmet social determinants of health, we can improve health outcomes. Participating entities should pay special attention to community members who have historically been marginalized, whether according to race, ethnicity, age, gender, sexual orientation, gender identity, disability, religion, or language, among others, and develop intervention strategies designed to address health disparities and/or health inequities with the end result of furthering health equity.

What is health equity?

"A basic principle of public health is that all people have a **right to health**. Differences in the incidence and prevalence of health conditions and health status between groups are commonly referred to as **health disparities**. . . . .Most health disparities affect groups marginalized because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location, or some combination of these. People in such groups not only experience worse health but also tend to have less access to the **social determinants or conditions** (e.g., healthy food, good housing, good education, safe neighborhoods, disability access and supports, freedom from racism and other forms of discrimination) that support health. . . . .Health disparities are referred to as **health inequities** when they are the result of the systematic and unjust distribution of these critical conditions. **Health equity**, then, as understood in public health literature and practice, is when everyone has the opportunity to "attain their full health potential" and no one is "disadvantaged from achieving this potential because of their social position or other socially determined circumstance."[1]

Why this Checklist is important.

Given that social disparities are rooted in institutional structuring, quality and controls of the underlying infrastructure and resource sectors that support the community members, it is imperative that participating entities engage in a structured inquiry that identifies unmet social determinants of health that communities of color are enmeshed within which have resulted in a population-based disparity of chronic medical conditions, such as obesity, diabetes, hypertension, asthma, lung disease, and cancer. This is especially true in the wake of the COVID-19 pandemic, where the recovery period for communities of color will be more prolonged and exceedingly difficult to resolve.

Objectives

1. To encourage State, County, and Local participating entities to apply an efficacious health equity lens to any proposed intervention strategy designed to address health disparities and/or health inequities.
2. To use this Health Equity Checklist to think through determinants that may have unintended consequences on the health and well-being of community members disparately impacted by COVID-19.
3. To promote the development of a strategy to address the complex factors that influence health and equity, including educational attainment, housing, transportation, disability accessibility, and neighborhood safety.[2]

4. To incorporate this checklist as an integral component of any participating entities' strategy development process.

Health Equity Checklist designed to:

- Articulate how a proposed intervention strategy will improve overall health and advance health equity by reducing disparities and/or health inequities in disparately impacted communities.
- Proactively identify any barriers or undue burdens the proposed intervention strategy may impose upon disparately impacted communities that would limit the effectiveness of the intervention strategy.
- Ensure that members of disparately impacted communities are engaged and consulted in the planning and implementation of the intervention strategy.
- Assess the intervention strategy's impact on disparately impacted community members over time.

Key Definitions:[3]

Disparately impacted communities: include, but are not limited to, racial and ethnic minorities, refugees, immigrants, seniors, low-income earners, uninsured individuals, undocumented individuals, individuals with limited English Proficiency, individuals with disabilities and the homeless.

Health equity: Health equity is attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Health Disparities: means differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes.

Health Inequalities: a term sometimes used interchangeably with the term health disparities. It is more often used in the scientific and economic literature to refer to summary measures of population health associated with individual - or group – specific attributes (e.g., income, education, or race/ethnicity).

Health Inequities: a subset of health inequalities that are modifiable, associated with social disadvantage, and considered ethically unfair.

Intervention Strategy: any plan, guidance, proposal, policy, practice, communication, or directive, developed by statewide, regional and local level entities to treat, diagnose, study, provide awareness of, or otherwise address COVID-19 in Illinois residents, including in disparately impacted communities.

Social determinants of health: the conditions in the environments in which people are born, live, learn, work, play, worship, and age, that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Community Health Needs Assessment (CHNA)[4]: assessment of a specific community being serviced and typically performed by a consortium of not-for-profit hospitals and community-based organizations. Although they vary by community, CHNAs "enable communities to identify issues of greatest concern and decide how to allocate resources to address those issues."[5]

Considerations for Assessing Health Equity

Participating entities should use the questions below to assess both the short and long-term impacts to health equity, health inequalities and health inequities of a particular intervention strategy. Short-term initiatives might prioritize currently prevalent comorbidities for a disparately impacted community, whereas long-term initiatives might prioritize issues such as food insecurity, inadequate housing or limited access to health care that widen health disparities.

1. **What persons/communities are most likely to benefit from this intervention strategy?** Which disparately impacted communities are most affected by this intervention strategy?
   For example, consider the use of the following resources to identify and inform where the most health needs are in your community.
   - Your Community Health Needs Assessment[6]
   - Community Health Rankings
   - The CMS AHC Screening Tool for the Social Determinants of Health
2. **How does this intervention strategy benefit disparately impacted persons/communities?**
   - What specific health conditions (e.g., diabetes, asthma, hypertension, etc.) and inequities will be addressed with this intervention strategy?
   - What social determinants are targeted for intervention?
   - How will the members of each disparately impacted community be affected?
3. **Will the proposed intervention strategy expand socio-economic opportunities for disparately impacted persons/community members and their overall health?**
   - If yes, how?
   - If no, how can the proposed intervention strategy be revised to address that?
4. **Will the proposed intervention strategy promote inclusive collaboration and/or civic engagement of all disparately impacted communities?**
   - Is there community support for the intervention strategy?
   - If yes, who are your collaborating partners?
   - If no, which communities are in opposition, why does that opposition exist (i.e., what interests are in conflict with the intervention strategy), and how do you plan to address it?
   - Have you or do you plan to engage the disparately impacted community in a dialogue?
   - If there are unintended consequences or barriers to racial equity as a result of the proposed intervention strategy, what strategies are in place to mitigate any negative impacts? Are revised strategies needed to address those consequences?
5. **Will your intervention strategy ensure support of workforce equity and/or contracting equity?**
   - If yes, how?
   - What goals are contemplated for workforce equity and/or contracting equity?
   - If no, what modifications are needed to ensure the intervention strategy supports workforce equity and/or contracting equity?

6. **How will this intervention strategy achieve greater health equity for disparately impacted persons/communities?**
   - Can you demonstrate how this intervention strategy improves health equity?
   - If not, why not, and what modifications are needed to ensure the plan meets the health equity goals?
7. **Are methods/metrics in place to ensure health equity goals are met?**
   - If yes, what key performance indicators will be used to gauge the plan's performance over time?

Additional Resources

United States, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2017, September 05). Accountable Health Communities Model. CMS AHC Screening Tool. Retrieved from https://innovation.cms.gov/initiatives/ahcm.

Entities in need of technical assistance utilizing this checklist should contact the IDPH COVID-19 Equity Team at DPH.COVID19Equity@Illinois.gov.

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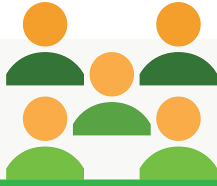
HISTORY OF THE ILLINOIS ASTHMA PARTNERSHIP



1998 - 1999

- The Illinois Asthma Task Force was formed 1998 and developed the first Addressing Asthma in Illinois State Plan.
- In 1999, the IDPH received a three-year grant from the CDC to develop a state Asthma Program that included a statewide asthma partnership.

2000 - 2002

- With new funding, the Illinois Asthma Partnership is formally created in 2000.
- Satellite conferences are held for school staff asthma education, and asthma calendar contests are held for students.
- In 2001, Public Act 92-0402 allows students to self-administer asthma medications while in school.
- Students may also carry quick-relief asthma medication at school with physician and parent approval.
- In 2002, the Asthma Program is awarded a competitive CDC grant for a 5-year project period to continue building infrastructure in the state.

2003 - 2008

- Grant activities focus on community education and awareness and building asthma coalitions. Statewide asthma educational conferences are held for health care professionals, satellite conferences are held for school and child care providers. The Occupational Asthma Toolkit is developed.
- In 2005, Public Act 94-670 allows children with asthma to self-carry and self-administer asthma medication while at recreation camps.
- In 2006, Public Act 94-0792 allows students to self-carry and self-administer prescribed epinephrine in schools.
- The 2nd edition of the Addressing Asthma in Illinois State Plan is released in 2006.
- In 2008, the Asthma Program is awarded a competitive CDC grant for a 5-year project period.

2009 - 2014

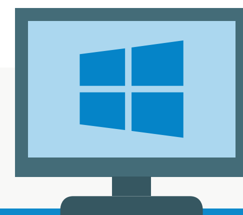
- Grant activities include providing AS-ME in community settings, hosting educational conferences for health care providers and child care provider training, and revisions of asthma educational toolkits for child care facilities and work-related asthma.

HISTORY OF THE ILLINOIS ASTHMA PARTNERSHIP

- The 3rd edition of the Addressing Asthma in Illinois State Plan is released in 2009.
- In 2010, students are allowed to self-carry and self-administer asthma medications at schools with only parental consent and a copy of their prescription.
- In 2013, the Program evaluation team received the first place National Asthma Control Program Evaluation Award recognizing outstanding evaluation practices.
- In 2014, the Asthma Program is awarded a competitive CDC grant for a 5-year project period.

2015 - 2019

- Primary grant activities include AS-ME in schools and homes, home visiting, quality improvement programs in schools and clinics, policy forums, and provider education.
- The 4th edition of the Addressing Asthma in Illinois State Plan is released in 2015.
- In 2016, Public Act 099-0843 requires Illinois State Board of Education to develop a model asthma episode emergency response protocol and for schools to adopt an asthma emergency response protocol with all components of the model. Schools are required to request asthma action plans, and school staff who work with students must complete training on asthma management, prevention of asthma symptoms, and emergency response in the school setting every two years.
- In 2018, Public Act 100-0726 allows schools to stock undesignated asthma rescue medications and school nurses and trained staff to administer at the first signs of respiratory distress.
- In 2019, the Asthma Program is awarded a competitive CDC grant for a 5-year project period.



2020

- The Home Visiting Collaborative (HVC) is created, comprising four comprehensive home visiting programs. HVC programs implement EXHALE strategies within each program.
- Primary grant activities include home visiting and AS-ME, promoting the CDC 6|18 Initiative evidence-based preventive practices to State Medicaid Managed Care Organizations and health plans, promoting environmental best practices, and provider education.
- An Extension for Community Healthcare Outcomes (ECHO) model was developed for community health workers on how to implement EXHALE strategies within home visits.
- New workgroups are created to focus on reimbursement and care coverage, environmental best practices, and the creation of the 5th edition of the Addressing Asthma in Illinois State Plan.
- Partners adjust to the impact of the COVID-19 pandemic.
- In July 2020, a webinar on COVID-19 and return to schools is held.

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