Asthma Community Network – Conversations for Advancing Action Podcast Series

Episode Transcript

Episode 2 – Home Visits

Narrator: Welcome to "Asthma Community Network – Conversations for Advancing Action" –a podcast series from AsthmaCommunityNetwork.org - an online Network designed for people committed to improving asthma outcomes in their community. This podcast series is designed to share best practices for reducing the impact of asthma through delivery of comprehensive, community-based care, especially in underserved communities. In these podcasts you'll learn about strategies for managing effective program delivery systems, addressing environmental triggers, and leveraging community assets through partnerships.

Today's topic is home visits.

Karen Meyerson: We do some education in the clinical setting as well, but we've been doing this for 14 years and we found that home-based component was tremendous because we really are the physicians' eyes and ears in the home.

Narrator: That's Karen Myerson, the manager of the Asthma Network of West Michigan. Her experience has taught her that incorporating home visits into an asthma management program is the best way to build on the efforts of the medical professionals treating asthma patients. Home visits can identify and begin to address barriers that hinder a family's efforts to manage asthma.

Karen Meyerson: Because they can be providing education in the office and yet they have no idea what these families are going back to. By being in the homes and identifying their home environment and by identifying family dynamics, any other issues that might develop, in a home visit that's really critical. Because those are competing with the family's ability to manage asthma. So if we can address some of those basic needs – sometimes it's just lack of food, or transportation or their housing, they may be evicted, they'll be homeless – so address those basic needs first, so they can better focus on asthma. You don't necessarily know what those things are until you are in the homes.

Narrator: The Coordinated Federal Action Plan to Reduce Racial and Ethnic Asthma Disparities emphasizes actions that address preventable factors that contribute to the disparities in the burden of asthma. One area of focus is to reduce environmental exposures in homes.

A home visit program enables primary care providers to better support their patient's ability to manage asthma. A home visitor gathers information on the home environment in order to better understand what asthma triggers and physical and psycho-social barriers might be present. Through home visits, a health provider learns about other challenges that may exist that would affect a patient's health or their ability to address their health needs.

Karen Meyerson: There are definitely gaps in services, in terms of guideline-driven care. There are individuals who can't access medications or have transportation issues. Many individuals, especially in at-risk families, have numerous competing priorities and asthma is just one of them. They have many psycho-social issues. That's why our case management program has been successful because we address those barriers to care. We have full time asthma educators go into homes to educate families where they live about asthma. We have a full time social worker on staff and she helps the families overcome many of those psycho-social barriers so they can then focus on asthma education.

Narrator: Better asthma self-management education often means improved outcomes for asthma patients, because comprehensive asthma care reduces hospitalizations and emergency department visits. But home visits may also benefit program managers in another tangible way. They can gather relevant data on patients during these visits and demonstrate the level of success of their program. Karen Meyerson said, because of the data the Asthma Network of West Michigan has gathered in regularly evaluating the effectiveness of their program, it has convinced several health plans in her region to reimburse the Network for that patient care.

Karen Meyerson: We are believed to be the first grass roots asthma coalition to get third party reimbursement for these services. It has helped us quite a bit throughout the years. We continue to measure our outcomes: patient satisfaction, quality of life, asthma control through our asthma control tests, hospital days, length of stay, emergency department visits, school days missed - we try to measure as much data as we can.

Narrator: In addition to the improved patient care and the ability to turn demonstrated success into financial rewards, Karen Meyerson has found another benefit to the home visit component of her program. It's a way to change lives.

Karen Meyerson: A case manager was visiting a young girl and she asked what she liked to do for activities. The parent said she really can't go out for any sports because she's got asthma, but she loves soccer. The case manager said, well, we're going to help her play soccer. They didn't realize she needed to get her asthma under control and then she could really do anything she wanted, it was really limitless. By working with her provider, working on an action plan, providing her with education, making sure she knew how to take her medication, how to prepare for exercise, plugging all of those gaps and followed all of those steps, she started playing soccer. She never realized she could play soccer and now she's a star soccer player. That's just one story, just one child, when you multiply that over the 2,000 families that we've served, that's just tremendous.

Narrator: For additional resources on home visits and to hear other podcasts in this series, visit asthmacommunitynetwork.org/podcasts.

And for more information on asthma management, go to AsthmaCommunityNetwork.org – an online Network for people committed to improving asthma outcomes in their community.