Partners in Action- National Healthy Homes Month

Partnerships can take a number of forms. Partnerships can integrate diverse organizations and seek to achieve a variety of goals. This section profiles four different partners engaged in a wide range of activities, in different settings. OLHCHH thanks our contributors who provided this information.

PROFILE 1: Healthy Homes Iowa (HHI) developed an innovative, multi-sector community partnership to improve health of children ages 2-18 diagnosed with an asthma or reactive airway disease.

This is a comprehensive profile and story from Annie Wood, Family Outreach Director, at **EveryStep**, our grantee in Des Moines, IA and a nonprofit since 1908. If you would like to learn more, please write Annie at AWood@everystep.org

At HHI, the goal is to integrate a proven population-based approach to support children with a chronic disease and their families improve quality of life. Healthy Homes Iowa (HHI) accepts referrals for children 2 through 18 years of age, diagnosed with asthma or reactive airway disease. The program includes an asthma-related home assessment, supplies to actively reduce asthma triggers, and related home repairs. HHI staff also provide asthma health education and recommendations for changes to maintain a healthy home environment. The HHI program incorporates numerous outcome measures of effectiveness including the Childhood Asthma Control Test (CACT) for children eleven years old and younger as pre and post intervention assessments. A score of 12 or less indicates the child's asthma symptoms may be poorly controlled. A score of 19 or less indicates the child's asthma symptoms may not be as well controlled as they could be.

Stakeholders and partners are the Polk County Health Department, Polk County Public Works Department, Polk County Housing Trust Fund, Mid-Iowa Health Foundation, Broadlawns Medical Center, UnityPoint, Common Good Iowa, and Telligen.

In the family situation below, HHI program services offered to the family included education information, and advocacy about asthma triggers, assessment of their home environment for opportunities to improve the child's asthma control, reduction or removal of asthma triggers in the home, and enhanced care coordination for effective connections to community resources.

Helping A Family

HHI staff received a referral from a pediatric pulmonologist for a child in January 2020. While listening to her mother describe her child's experience with asthma, her mother reported the child's asthma and symptoms as a constant barrier limiting the child's daily activities. The child's mother shared her daughter's struggles with asthma symptoms such as coughing, wheezing, waking up in the night, and limited ability to participate in physical activity with her peers. The pre-intervention CACT score of 14 indicated the child's asthma symptoms could be improved with proper intervention.

Through home visits and phone contacts, HHI staff discussed asthma triggers, prevention, and resources with the family. The family's home was assessed for repairs and supplies. The home assessment revealed concerns with the ventilation system in the family's kitchen and bathroom; the kitchen plumbing; and carpeted areas trapping dust, pollen, and dander. The concerns in the family's home were addressed through repairs offered by HHI. Supplies provided to the family help maintain a healthy home environment. The family received a covered trash can, steam mop, vacuum cleaner with a HEPA filter, air purifier, covered food storage containers, mattress covers, and pillow protectors.

In January 2021, the family described a much different asthma experience. During the post-assessment, the child's mother expressed gratitude and joy regarding her daughter's decreased symptoms and suffering from asthma. The child's mother shared her daughter had not experienced wheezing or coughing from asthma in over a month and struggled to recall a time within the last year of times when coughing or wheezing was an issue for her daughter.

The child no longer wakes during the night due to asthma. The child now participates in physical activity without her asthma symptoms holding her back. The post-intervention CACT assessment determined an improved CACT score of 23, demonstrating a major improvement in asthma control from the child's pre-HHI intervention score of 14. The difference in the child's score indicates a clinically significant improvement in the child's asthma control and a reduction in the child's experience of asthma symptoms. Additionally, the child's mother reports increased confidence in her ability to care for her daughter and a decrease in family stress resulting from her daughter's experience with asthma.

<u>EveryStep's Programmatic Overview</u>

Healthy Homes Iowa communicates specifics about what creates health for children with asthma, offers health education, addresses health access, and reduces health disparities related to economic, social, and environmental disadvantage. With the additional of virtual services, the program is scalable to a statewide level.

HHI development included national guidance and technical assistance from BUILD Health Challenge and Green & Healthy Homes Initiative. HHI operates with and on behalf of families at the intersection of health, human services, housing, and community. The program has worked with over 250 Polk County families.

Portfolio of Services:

- Assessment of home environment of asthma triggers
- Provide home remediation and health education to reduce the burden of childhood asthma
- Conduct pre- and post-intervention asthma control assessments
- Increase asthma-related housing mitigation efforts
- Offer home assessment, mitigation, education, introduction of safe cleaning supplies, and enhanced care coordination to support additional social determinants of health needs
- Provide direct follow up and support to families
- Partner with community-based resources to support families
- Increase adult understanding and parenting confidence of asthma care management
- Provide feedback to healthcare providers and other referral sources about each child's progress
- Current focus – Polk County

FY22 Outcomes Measures:

1. Achieve clinically significant improvement in post-intervention asthma control indicators by 3 or more points for children 12 years and older; improve indicators by 2 or more points in children 11 years and younger.
2. Reduce emergency department visits by 10%.
3. Increase number of symptom-free days by 10%.
4. Program satisfaction of 75% or greater.

PROFILE 2: - Partnering In Vermont

Building Bright Future's moto is "When we work together, children shine". This project comes via the Vermont Housing and Conservation Board originating as HUD funds to the state.

According to Beth Truzansky, deputy director at Building Bright Futures (BBF) works to improve the wellbeing of children and families in Vermont by using evidence to inform policy and bringing voices together across sectors and within regions to discuss critical challenges and problem-solve. You can write Beth at btruzansky@buildingbrightfutures.org

BBF is partnering with the Vermont Housing Conservation Board and Department of Health toward a shared goal 'All Children Have A Healthy Start' outlined as one of the goals in Vermont's Early Childhood Action Plan. BBF is engaging state and regional partners to help educate families, and those working with families, about the importance of healthy homes and hazards of lead poisoning in young children. Additional information can be found at **2020 How Are Vermont's Young Children and Families? Report**

PROFILE 3 -How the Healthy Homes Partnership Connects with Community Health Workers

The **Healthy Homes Partnership** (HHP) is national network of university-based educators, funded by HUD's Office of Lead Hazard Control and Healthy Homes. For more than 20 years, the HHP has assisted in advancing healthy homes concepts, dealing with indoor environmental health hazards such as mold, radon, asbestos, lead, and more. This overview was provided by Graham McCaulley, PhD, Assistant Extension Professor and State Specialist, Dept. of Personal Finance Planning, University of Missouri.

Graham says "Framing our Healthy Homes efforts in this way has broadened our reach and led to some new collaborations. However, the CHW model isn't unique to Missouri. If you haven't already, you may consider exploring cross-listing your efforts with frontline health workers in your state." You can write Graham at McCaulleyG@missouri.edu

Who are Community Health Workers?

As Healthy Homes educators, we all know of the critical link between the quality of our housing and our health. However, this may not always be top of mind for those working in health/medical settings. This is an overview of how we've worked to connect Healthy Homes education to community health workers in Missouri.

Missouri has an emerging model/population of "Community Health Workers" (CHW). These frontline health professionals address (among other things) social determinants of health (SDOH). The CHW network is comprised of frontline public health workers who are trusted members of, and have a close understanding of, the communities they serve. This relationship of trust enables the CHW to serve as a liaison, link, and intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

What are Social Determinants of Health?

The World Health Organization defines SDOH as "the conditions in which people are born, grow, live, work and age." These environmental, social, and behavioral factors affect overall health outcomes, such as how long and how well we live, as well as related factors such as access to and quality of medical care. Although what happens in medical settings remains critical, research shows social and environmental factors play a greater role in individual and community health.

How does this relate to Healthy Homes education?

Our project connects Healthy Homes education with faculty cross-trained in personal finance, who then work to frame both to CHWs and other health-related stakeholders as SDOHs to act on. We know what begins as housing or financial issues can quickly snowball into a complex set of interacting problems related to SDOH and negatively affect overall health. Because they are inextricably linked, touching on both in our outreach efforts addresses environmental and behavioral factors that positively impact health outcomes.

What did it look like?

We have worked in partnership with the statewide association of CHWs as well as our state's department of health and senior services to frame indoor air quality as an important SDOH factor. Specifically, through meetings and webinars we connect these frontline workers and consumers to healthy homes educational materials. Most recently, this has taken the form of webinars stressing importance of testing for radon and mitigation where necessary. This partnership has led to other opportunities, such as inclusion on other statewide, health-related working groups. As we look to the future, we aim to expand into CEU offerings for CHWs.

PROFILE 4 City of Omaha, Nebraska, Omaha Planning Department's Lead Information Office

So far, the City of Omaha has been able to complete 76 homes; for inspections, we have completed 101 homes impacting 145 children. Of these properties, healthy homes interventions have been completed on 68. Sarah A. Frederick at the City of Omaha provided this before and after photo.

"Before and after" exterior photos to show one property's transformation.


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