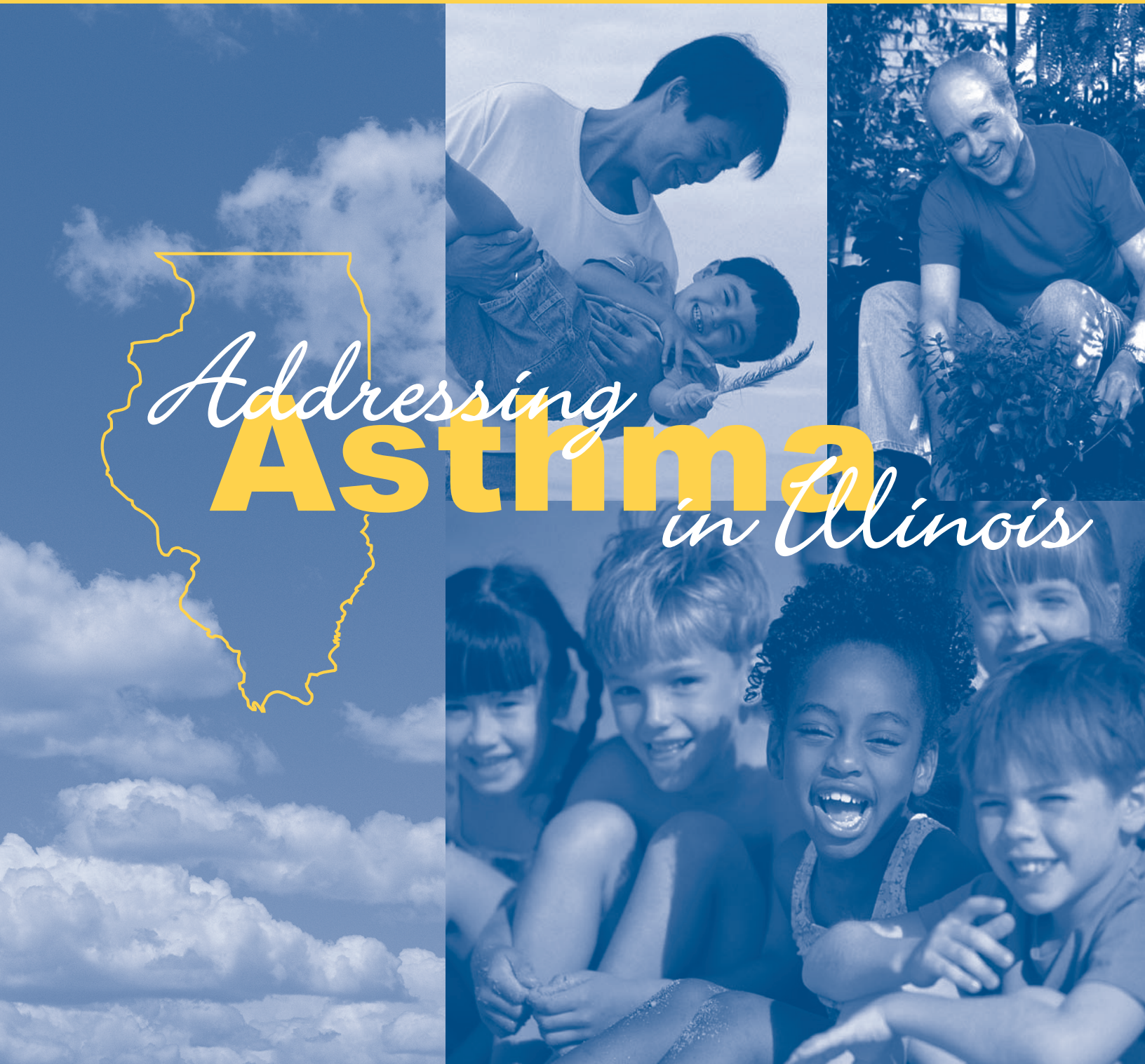
State of Illinois
Rod. R. Blagojevich, Governor

Department of Public Health
Eric E. Whitaker, M.D., M.P.H., Director

Illinois Asthma Partnership Strategic Plan

June 2006

2nd Edition



June 1, 2006

Dear Asthma Partner:

The Illinois Department of Public Health is pleased to share a copy of the *2006 Illinois Asthma Partnership Strategic Plan, Addressing Asthma in Illinois, 2nd edition*. An estimated 20 million persons in the United States suffer from asthma and its prevalence has been increasing over the past 20 years. Illinois has not escaped the burden of asthma. In 2002, there were 247 deaths related to asthma, which is one of the nation's highest mortality rates from asthma related causes.

In 1999, more than 50 organizations joined the Department to form the Illinois Asthma Partnership. In 2002, more than 100 members worked together to create a statewide asthma plan. Due to the expansion of the partnership and the ever-changing needs of asthma, the state plan was updated and revised to better reflect the needs of Illinois citizens.

In 2005, with the partnership comprised of more than 200 partners, the 2nd edition of the state plan was produced. The plan is a framework for action and collaboration. There are six priority areas within the plan with goals and objectives that have been developed by Illinois Asthma Partnership work groups. Each priority area addresses specific concerns and needs using a public health approach to reflect the plan's overarching goal to reduce asthma morbidity and mortality in Illinois.

The Department extends its appreciation to those who served on the executive committee and contributed their time and expertise to the development of this plan. Together, we can reduce asthma morbidity and mortality in Illinois and ensure a better quality of life for persons with asthma.

Sincerely,

Eric E. Whitaker, M.D., M.P.H.
Director

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EXECUTIVE SUMMARY

Asthma is a chronic lung disease associated with significant morbidity and mortality. Prevalence rates for asthma, particularly in children younger than 5 years of age, have been increasing rapidly during the last decade. While the cause of asthma remains unknown, environmental agents and genetics seem to play a role. Currently, asthma is not preventable or curable, but it is controllable. Although careful patient management would allow asthma to be successfully treated on an outpatient basis, billions of dollars are spent annually on inpatient expenses for persons with asthma.

Illinois has not escaped the burden of asthma. Indeed, the state has one of the nation's highest mortality rates from asthma-related causes. The impact of asthma in Illinois paved the way for stakeholders across the state to form an Illinois Asthma Task force in 1998. Initially the task force responded to Public Act 91-0515, which directed the Illinois Department of Public Health (IDPH) to develop a plan to address asthma, especially in high-risk populations. This plan, ***Addressing Asthma in Illinois***, was developed and presented to the Illinois General Assembly in July 2000.

After receiving funds from the U.S. Centers for Disease Control and Prevention (CDC), the IDPH expanded on the initial task force to form the Illinois Asthma Partnership (IAP). During the first year of the CDC grant, partnership members were divided into four work groups: Community and School, Data and Surveillance, Work Site, and Professional and Patient Education. The progress of the work groups and of the IAP's leadership laid a foundation that allowed the initial asthma plan to develop into a comprehensive state plan.

After the development of the comprehensive state plan in 2002, the IDPH received funding from the CDC to implement the Illinois Asthma Plan and continue to build on the efforts of the IAP. Due to the changing needs of asthma and the growth and progress of the partnership, a second edition of the state plan ***Addressing Asthma in Illinois*** was developed. Subsequently, the work groups were reorganized into Data, Assessment and Outcomes, Education, Occupational Asthma, Policy and Advocacy, School and State Coordination.

Through implementation of the plan and the hard work and efforts of the IAP, Illinois will address its goal of reducing morbidity and mortality from asthma, thereby reducing the costs associated with the disease and improving the quality of life for people with asthma and the people who care for them.

NATIONAL ASTHMA DATA AT A GLANCE

Asthma is one of this country's most common chronic conditions. In 2002, an estimated 20 million persons of all ages and races had asthma. In the past 20 years, the number of Americans with asthma has more than doubled. Tragically, the burden of asthma is most felt among specific populations, particularly children, Hispanics and African Americans. Children under 5 years of age experienced the greatest increase in asthma prevalence during this 20-year period.

Asthma affects 6.1 million children and is one of the leading causes of school absenteeism, accounting for more than 14.7 million missed school days annually. Children with asthma miss an average of twice as many school days as other children. Other symptoms also may impair quality of life for a child with asthma, such as by restricting activities.

Among adults, asthma is the leading work-related lung disease. Employed adults 18 years of age and over missed 11.8 million work days due to asthma. Keeping asthma under control can be expensive and imposes financial burdens including lost work days, lost income and lost job opportunities on patients and their families. Asthma also results in disruption to family and caregiver routines.

In addition to growing prevalence rates, the occurrence of adverse asthma mortality and hospitalization has been increasing In 2002, in the United States, asthma accounted for approximately 2 million emergency department visits, an estimated 484,000 hospitalizations and 4,261 deaths.

A Snapshot of National Asthma Data

In 2003, an estimated
- 29.8 million people had been diagnosed with asthma during their lifetime
- 19.8 million people currently were diagnosed with asthma
- 11.0 million people experienced an asthma attack in the previous year

In 2002, asthma accounted for
- 12.7 million doctor visits
- 1.2 million hospital outpatient visits
- 1.9 million emergency department visits
- 484,000 hospitalizations or 17 per 10,000 people
- 4,261 deaths or 1.5 per 100,000 people

Source: CDC National Center for Health Statistics

ILLINOIS ASTHMA DATA AT A GLANCE

The burden of asthma in Illinois mirrors national trends. The state which has one of the highest asthma mortality rates in the nation and experienced an increase in prevalence, morbidity and mortality over the past 20 years. The majority of the state's asthma deaths occur in the city of Chicago and Cook County.

There are several data sources in Illinois that can be used to better understand the statewide burden of asthma: the Behavioral Risk Factor Surveillance System (BRFSS), mortality data and hospital discharge data from the Illinois Department of Public Health, Illinois Center for Health Statistics.

In 2003, it was estimated that 11.1 percent of the adults in Illinois (an estimated 1,044,936 people) have suffered or currently suffer from asthma. Of these persons who self-report doctor-diagnosed asthma, 65 percent currently have asthma. These latter data show that over 7 percent of adults (an estimated 680,417 people) currently have asthma.

The occurrence of adverse asthma mortality and hospitalization in the state has been increasing. In 2003, asthma accounted for approximately 98,035 hospitalizations either as a primary or secondary diagnosis. In 1999, asthma accounted for approximately 74,506 hospitalizations, a 32 percent increase in asthma hospitalizations in the previous four years. Asthma contributed to 1,307 deaths from 1998-2002.

A Snapshot of Illinois Asthma Data

In 2003, an estimated
- 1,044,936 people had been diagnosed with asthma during their lifetime
- 680,417 people currently were diagnosed with asthma
- 21,649 hospitalizations were due to asthma or 17 per 10,000 people
- $237,654,449 were direct charges for asthma hospitalizations

In 2002, asthma accounted for
- 20,708 asthma hospitalizations or 16.5 per 10,000 people
- 247 deaths or two per 100,000 people

Source: Illinois Department of Public Health Center for Health Statistics

The data clearly indicates the burden of asthma and the need to address asthma, in order to reduce morbidity and mortality. For more detailed information on the burden of asthma in Illinois, contact the Illinois Department of Public Health Asthma Program at 217-782-3300.

A PUBLIC HEALTH APPROACH TO REDUCING THE BURDEN OF ASTHMA

Within the health care field, the concept of "adopting a public health approach" to reduce the burden or impact of a disease or condition has emerged over the past 15 years. For purposes of this asthma plan, a public health approach suggests a "a broad, multi-disciplinary perspective that is concerned with improving outcomes in all people who have asthma with attention to equity and the most efficient use of resources in ways that enhance patient and community quality of life."

Public health interventions, like the one proposed for Illinois' asthma plan, focus on community rather than on an individual. These population-based interventions operate at three levels: preventing asthma episodes (primary prevention), preventing disability from asthma in those who have the condition (secondary prevention or reducing the impact) and limiting further deterioration or death (tertiary prevention, or reducing the consequences).

Public health interventions look for methods or strategies that promise the **maximum benefit for the largest number of people.** It is important to recognize that the public health approach *does not abandon care of individual patients.* Instead, it broadens the reach of the health care system to include all persons, particularly, those who might be designated as underserved.

In adopting a public health approach to reducing the burden of asthma, the IAP also has incorporated the core functions of public health systems into the structure of its state plan

1. Assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities;
2. Assuring that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services, and that the effectiveness of that care is effectively evaluated;
3. Formulating public policies, in collaboration with community and government leaders, designed to solve identified local and national health problems and priorities.

The Illinois asthma plan is built on this core functions model. For example, the Data, Assessment and Outcomes Work Group, in conjunction with the IAP, has focused on assessment (systematic collection, analysis and distribution of information on the burden of asthma in Illinois). The School Work Group and the Occupational Asthma Work Group have emphasized projects related to assurance (determining and prioritizing asthma services and ensuring that the population receives the services needed). In addition to incorporating the first two functions, the Education Work Group and Policy and Advocacy Work Group have focused on the policy function by promoting the use of scientific knowledge as a basis for public health decisions related to reducing the burden of asthma.

GOALS AND OBJECTIVES

Six priority areas were identified through a strategic planning process undertaken by the Illinois Asthma Partnership. In alphabetical order, these areas are: data, assessment and outcomes, education, occupational asthma, policy and advocacy, school, and state coordination. Within each of these priority areas, goals have been identified that incorporate the three core functions of public health: assessment and monitoring, assurance, and policy, which are described earlier in this document. The objectives provide general information on achieving the goals. A separate document, known as the *Illinois Asthma Partnership Implementation Guid*e, was developed by each of the work groups to address the six priority areas. The implementation guide elaborates on the goals and objectives by providing a more specific lay out of each objective. The guide serves as an internal document for each work group, but copies can be requested by contacting the Illinois Asthma Program.

DATA, ASSESSMENT AND OUTCOMES

Scope of Work: Obtain scientific information related to asthma in Illinois, disseminate this information to those who are interested and who need to know, promote the use of this information as the foundation for action in alleviating the burden of asthma in Illinois and provide an evaluation and feedback mechanism that will help the Illinois Asthma Partnership assess the usefulness of this information.

#1 Goal • Improve asthma surveillance capacity.

Objectives

1. By March 31, 2006, establish standard asthma indicators, using best available data sets, for statewide use.
2. By December 31, 2006 and annually thereafter, develop a report that describes the data needs of the Illinois Asthma Partnership. Information in the report should include a description of the existing and planned population-based longitudinal data systems and information sources that will be utilized to monitor the incidence, prevalence and impact of asthma.
3. By December 31, 2006, identify and share information data set systems to provide local communities and groups with asthma data.
4. By December 31, 2006, identify and advocate for new surveillance systems and sources.
5. By December 31, 2007, assemble and disseminate a comprehensive list of asthma-related costs.

#2 Goal • Use data to identify and evaluate asthma interventions and assess the impact of asthma outcomes.

Objectives

1. By December 31, 2006 and annually thereafter, develop a report on the effectiveness of existing asthma interventions.
2. By December 31, 2006, coordinate a work shop to educate asthma partners and others throughout the state on the need for asthma data and how to understand and collect asthma data to meet their program needs.
3. By December 31, 2007, identify geographic areas and populations that have limited resources and are at high-risk for suboptimal asthma outcomes.
4. By December 31, 2007, with the assistance of the Education Work Group, survey primary care providers on treatment strategies and on their beliefs about asthma.

EDUCATION

Scope of Work: To promote asthma education and asthma awareness using the National Heart Lung and Blood Institute (NHLBI) asthma guidelines.

#1 Goal • Facilitate provision of asthma education for people with asthma and those involved in the care of people with asthma.

Objectives

1. By March 31, 2006, identify and promote effective asthma self-management programs, based on the NHLBI guidelines, with emphasis on high-risk populations.
2. By December 31, 2006 and annually thereafter, provide effective asthma training, based on the NHLBI guidelines, for community health workers and peer educators who will serve as asthma educators.
3. By December 31, 2006, identify and disseminate effective educational resources to caregivers of people with asthma, including resources pertaining to identification and to management of asthma emergencies.
4. By December 31, 2006, establish a statewide database in Illinois to identify and briefly describe effective asthma education programs, including self-management programs.

#2 Goal • Promote asthma training for health care professionals who work with asthma patients.

Objectives

1. By March 31, 2006 and annually thereafter, identify partners who are providing asthma training to primary care providers (e.g., pediatricians, family practice physicians and internists, emergency physicians, nurse practitioners and physician assistants).

2. By March 31, 2006 and annually thereafter, provide asthma training for allied health professionals (e.g., nurses, nurse practitioners, respiratory therapists, physician assistants) who will use train the trainer concepts and serve as asthma educators to improve the system of asthma care in their setting.
3. By December 31, 2006, develop and implement a system to promote the national asthma certification program for asthma care.

#3 Goal • Promote asthma awareness, education and screening programs in communities.

Objectives

1. By March 31, 2006, provide a list of asthma educational materials that promote the NHLBI asthma guidelines, including materials that are usable by individuals with low literacy, available in multiple languages and culturally appropriate for various populations.
2. By March 31, 2006, designate a clearinghouse for asthma information based on the NHLBI guidelines that can be used by health care professionals and by the general public.
3. By December 31, 2006, identify asthma experts who will provide education and/or screening.
4. By December 31, 2007 and annually thereafter, identify effective methods to reach target populations in the community and utilize local asthma experts who will provide education and disseminate NHLBI guidelines.

OCCUPATIONAL ASTHMA

Scope of Work: Work with epidemiology specialists to determine the burden of asthma in the workplace, work through local or regional public health agencies to provide information to local businesses that address asthma as a public health issue in the workplace, work with businesses directly (or indirectly through insurance carriers), to distribute information related to prevention of asthma in the workplace, advocate that people affected by asthma in the workplace receive the support and services they need.

#1 Goal • Increase awareness of work-related asthma (in addition to occupational asthma), including its impact, the importance of early diagnosis and the availability of effective treatment and prevention strategies, in working adults.

Objectives

1. By June 30, 2006, identify business/industrial environments that potentially have high asthma prevalence rates.
2. By December 31, 2006, increase awareness and education of work-related asthma and the importance of early diagnosis for clinicians.
3. By December 31, 2007, identify best practices locally, statewide and nationally that prevent both the workplace exacerbations of asthma and the development of occupational or workplace asthma.
4. By December 31, 2007, identify and/or develop effective asthma education programs for working adults.

#2 Goal • Identify effective methods of accommodation in the workplace for employees with asthma that will help prevent them from work-related exacerbations.

Objectives

1. By March 31, 2006, in collaboration with the IDPH Tobacco Prevention and Control Program, offer resources to businesses for smoking cessation programs.
2. By December 31, 2006, develop asthma messages that are consistent and are designed to reach specific employee populations, particularly those designated as underserved.

3. By December 31, 2006, in collaboration with the IDPH Tobacco Prevention and Control Program, identify businesses exempt from the Clean Indoor Act.
4. By December 31, 2007, in collaboration with the IDPH Tobacco Prevention and Control Program, offer assistance to develop smoking cessation policies for those businesses exempt from the Clean Indoor Act.
5. By December 31, 2009, develop programs with collaboration from insurers that focus on making employee-based health care systems more responsive to the needs of workers with asthma.

#3 Goal • Increase awareness among administration, management and human resource personnel in businesses concerning occupational asthma, including risk factors, impact, prevention strategies and management.

Objectives

1. By December 31, 2006, pilot the implementation of the Illinois Occupational Asthma Toolkit in 5-10 businesses.
2. By December 31, 2006, develop a mechanism to provide public recognition to businesses that improve the workplace environment.
3. By December 31, 2007, educate 20 businesses regarding integrated pest management (IPM) and other techniques that reduce worker exposure to potential asthma risk factors.

POLICY AND ADVOCACY

Scope of Work: Identify key issues to be addressed from a policy/advocacy perspective, identify strategies that will increase Illinois policy makers' awareness of asthma as a public health problem, secure Illinois legislative support for state and local asthma initiatives and support policies that provide environmental protection for individuals with asthma in multiple settings (including, but not limited to, schools, child care centers, workplaces and public places).

#1 Goal • Seek passage of legislation to improve indoor and outdoor air quality.

Objectives

1. By December 31, 2005, introduce legislation to amend the Illinois Clean Indoor Air Act to allow local governments to strengthen clean indoor air laws.
2. By December 31, 2007, provide education and support to local communities to eliminate leaf burning.
3. By December 31, 2007, seek an increase in the number of filling stations that offer ethanol fuel, with specific emphasis on downstate Illinois.

#2 Goal • Advocate for access to treatment and education for all persons with asthma.

Objectives

1. By December 31, 2006, research the utilization for health care professionals to receive reimbursement for providing asthma education to patients.
2. By December 31, 2007, introduce legislation to require every school system to have an asthma action plan for each student with asthma.
3. By December 31, 2008, introduce legislation for reimbursement for health care providers writing asthma action plans.
4. By December 31, 2008, introduce legislation to require asthma education and training for all school personnel (e.g., security, teachers, nurses, school bus drivers, clerical staff, administration, maintenance).
5. By December 31, 2008, introduce legislation for expansion of health care insurance coverage for school age children to have needed asthma supplies (spacer and peak flow meter).

#3 Goal • Develop a statewide communication network to effectively advocate for the positions of the local asthma coalitions.

Objectives

1. By December 31, 2006, develop a centralized communication system to periodically update the Illinois Asthma Partnership on asthma policy and advocacy issues.
2. On an ongoing basis, identify potential partners who can effectively advocate for the positions of the asthma coalitions such as the American Disability Association, American Association of People with Disabilities and American Lung Association, at the local level.

#4 Goal • Seek passage of legislation to reduce tobacco use.

Objectives

1. By December 31, 2006, introduce state legislation to increase the tobacco excise tax and earmark funds for asthma programs.
2. By December 31, 2006, introduce state legislation that requires a smoke-free policy in dormitories and campus housing of private and public colleges/universities.
3. By December 31, 2007, collaborate with insurance carriers to improve private insurance coverage of smoking cessation aides.
4. On an ongoing basis, advocate for funding at U.S. Centers for Disease Control and Prevention recommended levels for tobacco prevention and control.
5. On an ongoing basis, support local efforts and provide resources for communities and their citizens to go smoke-free.

SCHOOL

Scope of Work: Provide effective asthma educational materials and resources to increase awareness about asthma to child care providers and the school community, including, but not limited to school parents, students nurses, teachers, administrators, secretaries, security, maintenance, dietary, bus drivers, lunch and playground staff, coaches and athletic directors; promote a consistent message on the management of asthma and provide school personnel across the educational continuum, **including child care through college**, with the necessary information and tools to develop strategies and policies in the management of asthma.

#1 Goal • Encourage child care providers and schools to obtain an appropriate written asthma action plan for every child with asthma.

Objectives

1. By December 31, 2005, in collaboration with the Education Work Group, identify asthma action plans based on the National Heart, Lung and Blood Institute (NHLBI) guidelines.
2. By July 31, 2006, collaborate with appropriate organizations to provide information about effective educational programs regarding asthma action plans to child care centers and schools.
3. By July 31, 2007, identify and publicly recognize at least 20 school districts and 20 child care centers that require written asthma action plans on file at the center/school for each child with asthma.

#2 Goal • Identify asthma education programs for the child care, school and college communities.

Objectives

1. By December 31, 2006, and annually thereafter, identify asthma educational opportunities that offer continuing education credits to teachers and personnel.
2. By December 31, 2006, provide education to child care/school personnel from at least 100 Illinois child care centers/family providers and school districts on asthma management and the proper use of asthma equipment such as peak flow meters, nebulizers, spacers and medications.

3. By December 31, 2007, provide all Illinois child care providers, schools and colleges with information on how to access effective asthma educational opportunities for teachers, personnel, parents and students.

#3 Goal • Support the development of indoor air quality and environmental improvements in child care and school communities.

Objectives

1. By June 30, 2006, identify effective indoor air quality assessment methods.
2. By December 31, 2006, provide information to at least 100 child care centers/family providers and schools on indoor air quality.
3. By December 31, 2007, notify child care centers/family providers and schools of identified funding sources to improve their indoor air quality and environment.

#4 Goal • Improve access to asthma medications and supplies for all children with asthma in child care and school communities.

Objectives

1. By December 31, 2006, assist at least 30 schools/child care center/family providers in the implementation of a system that will allow students to access their asthma medication and supplies.
2. By December 31, 2007, assist schools/child care centers/family providers in identifying resources available for families to obtain asthma medication and supplies such as peak flow meters, nebulizers, spacers and medications.

STATE COORDINATION

Scope of Work: Link asthma initiatives with other chronic disease and environmental initiatives and build on existing co-morbidity projects.

#1 Goal • Expand the Illinois Asthma Partnership to include organization/agencies not currently involved, but which serve the same or similar target populations and address asthma, or have the potential to address asthma.

Objectives

1. On an ongoing basis, identify target populations to implement work group and coalition projects of the Illinois Asthma Partnership.
2. On an ongoing basis, identify and collaborate with organizations and agencies that do work with target populations and do address asthma.
3. On an ongoing basis, identify and collaborate with organizations and agencies that work with target populations, but do not focus on asthma (e.g., tobacco cessation programs, youth programs and inner-city clinics).

#2 Goal • Expand the Illinois asthma initiative to include other chronic diseases and/or other asthma-related factor areas.

Objectives

1. By December 31, 2006, identify resources available in the Illinois Asthma Partnership and in initiatives addressing related problems (e.g., obesity, tobacco and other environmental exposures).
2. By December 31, 2007, develop a written list of resources and collaborate with other initiatives to maximize efforts through shared resources.

#3 Goal • Obtain additional funding to support the Illinois Asthma Plan.

Objectives

1. By December 31, 2006, identify areas within the plan that need funding to implement strategies.
2. On an ongoing basis, identify potential sources of funding.
3. By December 31, 2007, seek additional funds to support the long-term implementation of the Illinois Asthma Plan.

EVALUATION

The evaluation process answers several important questions: “Are the right things being done?” and “Are they being done correctly?” There are four types of evaluations commonly used in community and public health: formative, process, impact and outcome. The U.S. Department of Health and Human Services defines these types in the document, *Demonstrating Your Program’s Worth*:

Formative Process of testing program plans, messages, materials, strategies or modifications for weaknesses and strengths before they are put into effect. It is also used when an unanticipated problem occurs after the program is in effect.

Process The mechanism for testing whether the program’s procedures for reaching the target population are working as planned.

Impact The process of assessing the program’s progress toward its goals (i.e., measuring the immediate change brought about by the program in the target population).

Outcome The process of measuring whether the program met its ultimate goal of reducing morbidity and mortality.

The work groups will oversee evaluation of the goals for their respective priority areas. Each work group also will develop an evaluation plan for the goals it will be working toward and will address the four types of evaluations for each goal, as appropriate. The evaluation plans will be developed during the planning phase to implement goals of the state plan. The executive committee will review each of the evaluation plans to provide technical assistance.

The CDC's "Framework for Program Evaluation in Public Health" (MMWR, September 17, 1999, Vol. 48 No. RR-11) will be adopted to provide a structured basis for the evaluations. Below are key steps for this process.

3.1 Engage key stakeholders in acceding to the importance of an evaluation by assembling an evaluation team and addressing common concerns.

3.2 Describe the evaluation goals.

Identify the evaluation design (understanding utility, feasibility, propriety, and accuracy of methods).

Agree on responsible parties to conduct the evaluation.

Decide on type of evaluation.

Focus the evaluation design.

Select measures of effectiveness.

Decide who to select as respondents.

Gather credible evidence by selecting measurement methods, developing data collection instruments, deciding on sample size, defining time frame for data collection, collecting data and analyzing data.

Interpret data.

Justify conclusions.

Report results.

Ensure use of materials.

Share lessons learned.

The executive committee will oversee the evaluation of the state plan. Meeting quarterly, it will review and discuss the progress of the plan, activities of the work groups and dataissues. The executive committee will provide a progress report and updates to the IAP annually.

SUSTAINING ILLINOIS' ASTHMA INITIATIVES

The structure of the Illinois Asthma Initiative (IAI) includes a partnership with more than 200 members throughout the state of Illinois, five work groups (Data, Assessment and Outcomes, Education, Occupational Asthma, Policy and Advocacy, and School) and community coalitions. The Illinois Asthma Partnership (IAP) meets semi-annually, face-to-face in central Illinois. On an annual basis, the Illinois Department of Public Health (IDPH) surveys the IAP members. The purpose of the survey is to get feedback on meeting content, leadership, direction, and needed topics and focus. Based on the results of the past survey, IAP reformatted and refocused to meet the needs of the members. The members agreed that the IAP needed statewide ownership and involvement from members. Two members were selected as chair and co-chair of the partnership and an executive committee was formed to identify concerns or issues regarding the IAI. Members of the executive committee are selected based on criteria established by the IAP.

Each partner is key to sustaining the IAP. The chair and co-chair will coordinate the partnership meetings. The executive committee will oversee and evaluate the Asthma State Plan and provide a progress report and updates to the partnership. The IAP will serve as the centralized link for asthma resources and information on projects being implemented throughout the state. The IDPH will provide technical assistance to the IAP and work groups and disseminate the annual partnership satisfaction survey.

As asthma continues to increase, more and more community asthma coalitions are being formed. The coalitions are an important component in the battle against asthma. Their strong ties to thecommunity, to gatekeepers and to key stakeholders often serving as members, make coalitions important liaisons between their communities and the IAP.

To support community efforts to assist in reaching the goals of the state asthma plan, both development and implementation local grants are provided. Currently, there are four coalitions implementing program activities and evaluations to support the state plan. There also are a number of communities that receive "seed money" to develop a coalition by building capacity and planning for implementation. The coalitions are located across the state. They may vary in organizational structure, but they share common goals: to increase awareness and education about asthma to improve the diagnosis and management of asthma and to strengthen community resources. Many of the coalitions receive a wide variety of resources to support their growth and development. The IAP believes that coalitions are powerful and effective mechanisms for implementing change at the community level. Because of this, the partnership will provide assistance and support the collaborative activities of the coalitions.

In order to sustain these coalitions the IAP will encourage a collaborative effort to eventually expand the coalitions' services and interventions to other communities in need and work to identify additional funding sources.

The IAP work groups have accomplished a great deal and will continue to build on their successes and on the partnership's efforts to achieve goals set in the state plan. A state plan implementation document was created to address the goals and objectives of the state plan and serve as a blueprint for work group projects. The IAP will allocate funding for special work group projects and the groups will continue to identify other possible funding sources for their projects. The work groups will report on their activities at partnership meetings and provide information on how they are progressing toward plan goals.

Often, for the goals of an initiative to be reached, efforts must be in place for more than a few years. The IAP, created more than five years ago, continues to recruit new members and to identify new strategies and resources to accomplish the overarching state asthma plan goal of reducing the morbidity and mortality of asthma. Sustaining the hard work and efforts of the IAP requires planning.

To supplement the level of commitment, the process proposed by the Center for Civic Partnerships will be adopted as a formal framework to keep the IAP focused (Center for Civic Partnership Sustainability Tool Kit. *10 Steps to Maintaining Your Community Improvements*. Public Health Institute, Sacramento CA: 2001. <http://www.civicpartnerships.org/default.asp?id=227>). In addition, the Community Tool Box Work Station also will be utilized to assist in strengthening the framework and support for planning for long-term sustainability (KU Work Group on Health Promotion and Community Development. [2005]. Sustaining the Work or Initiative: University of Kansas. Retrieved August 10, 2005, from the World Wide Web, <http://ctb.ku.edu/tools/tk/en/tools_tk_16.jsp>). Through this process the IAP will determine which efforts should be maintained and decide how to successfully continue ongoing asthma initiatives.

APPENDIX A • ACRONYMS

AAP - American Academy of Pediatrics

ALA - American Lung Association

ACSLGME - Asthma Coalition for the St. Louis Greater Metro East

BRFSS - Behavioral Risk Factor Surveillance Survey

CAC - Chicago Asthma Consortium

CDC - U.S. Centers for Disease Control and Prevention

EPA - Environmental Protection Agency

IAP - Illinois Asthma Partnership

HP2010 - Healthy People 2010

IDHS - Illinois Department of Human Services

IDPH - Illinois Department of Public Health

ISBE - Illinois State Board of Education

NAEPP - National Asthma Education and Prevention Program

NIH - National Institutes of Health

NHLBI - National Heart, Lung and Blood Institute

RAC - Rockford Asthma Coalition

SAC - Suburban Asthma Consortium

APPENDIX B • HEALTHY PEOPLE 2010

Asthma - Related Objectives

24-1 Reduce asthma deaths.

- ***24-1a.*** Children under age 5 years
- ***24-1b.*** Children aged 5-14 years
- ***24-1c.*** Adolescents and adults aged 15-34 years
- ***24-1d.*** Adults aged 35-64 years
- ***24-1e.*** Adults aged 65 years and older

24-2 Reduce hospitalizations for asthma.

- ***24-2a.*** Children under age 5 years
- ***24-2b.*** Children and adults aged 5 to 64 years
- ***24-2c.*** Adults aged 65 years and older

24-3 Reduce hospital emergency department visits for asthma.

- ***24-3a.*** Children under age 5 years
- ***24-3b.*** Children and adults aged 5 to 64 years
- ***24-3c.*** Adults aged 65 years and older

24-4 Reduce activity limitations among persons with asthma.

24-5 (Developmental) Reduce the number of school or work days missed by a person with asthma due to asthma.

24-6 Increase the proportion of person with asthma who receive formal education, including information about community and self-help resources, as an essential part of the management of their condition.

24-7 (Developmental) Increase the proportion of persons with asthma who receive appropriate asthma care according to the NAEPP Guidelines.

- ***24-7a.*** Persons with asthma who receive written asthma management plans from their health care provider.
- ***24-7b.*** Persons with asthma with prescribed inhalers who receive instruction on how to use them properly.
- ***24-7c.*** Persons with asthma who receive education about recognizing early signs and symptoms of asthma episodes and how to respond appropriately, including instruction on peak flow monitoring for those who use daily therapy.
- ***24-7d.*** Persons with asthma who receive medication regimens that prevent the need for more than one canister of short-acting inhaled beta agonists per month for relief of symptoms.
- ***24-7e.*** Persons with asthma who receive follow up medical care for long-term management of asthma after any hospitalization due to asthma.
- ***24-7f.*** Persons with asthma who receive assistance with assessing and reducing exposure to environmental risk factors in their home, school and work environments.

24-8 (Developmental) Establish in at least 25 states a surveillance system for tracking asthma deaths, illness, disability, impact of occupational and environmental factors on asthma, access to medical care and asthma management.

APPENDIX C • ILLINOIS ASTHMA PARTNER LIST

Name	Organization Name
Ingrid Alexander	Springfield Clinic, LLP
Jennifer Anderson	BREATH Consortium
Angela Anselm	Millikin University
Evelyn Azofeifa	American Lung Association of Metro Chicago
Angela Bailey	Jackson County Health Department
Tina Barnard	American Lung Association
Sheila Batka	US EPA Region 5
Kelly Bay	Peoria City/County Health Department
Casey Beaver	Egyptian County Health Department
Frances Belmonte-Mann	Chicago Public Schools
SandieBenen	Glaxo SmithKline
Karen Berg	IL Coalition for School Based Health Center
Betty Birchler	Sparta Community Hospital
Mark Bishop	Healthy Schools Campaign
Lillian Bogan	Department of Child and Family Services
Brian Bothast	OSHA
LeeAnn Brandt	Rural Health Inc.
Jackie Brenchley	Advocate Illinois Masonic Medical Center
Fayette Bright	US EPA Region 5
Joyce Bruno	American College of Chest Physicians
Karen Burget	Greater E. St. Louis Asthma Coalition
Lynette Cale	McDonough County Health Department
Missy Cartwright	Springfield Public Schools c/o Fairview School
Cathy Catrambone	Rush University College of Nursing
Julie Clark	Ford-Iroquois Health Dept.
Turron Clayton	Healthcare Consortium of Illinois
Carol Coady	Genentech
Rhonda Comrie	SIUE - School of Nursing
Sandy Cook	Chicago Asthma Consortium
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Lenore Coover	Pediatric Case Management Services
Cathy Copley	Illinois Department of Public Health
Linda Cress	Springfield Department of Public Health
Mary Fran Crist	Hygienic Institute
Don Cui	Litchfield Family Practice
Maureen Damitz	American Lung Association of Metro Chicago
Beth Darling	Madison County Health Department
Margaret Davis	Healthcare Consortium of Illinois

Arlene Davis	Peoria City/County Health Department
Vivienne Dawkins	Illinois Department of Human Services
Pam Doloszycki	Proctor In-School Health
April Dowdee	Pharmacia Diagnostics, AB
Marcia Dowling	Logan County Health Department
Kathy Drea	American Lung Association of Illinois
Diana Dummitt	UIUC College of Education
Barb Dunn	Decatur Community Partnership
Christine Durbin	Southern Illinois University-Edwardsville, School
Michelle Dzulynsky	Illinois American Academy of Pediatrics
Debra Ellis	Springfield Department of Public Health
Ray Empereur	Rockford Health Counci
Beverly English	Illinois Department of Human Services
Angela Evans	Illinois Department of Human Services
Lloyd Evans	Illinois Department of Public Health
Andrea Evans	Sangamon County Health Department
Mirian Franklin	Illinois Department of Human Services
Babette Frederking	Washington County Health Department
Laura Fullerton	Knox County Health Department
Myrna Garcia	Chicago Public Schools
Jessica Gerdes	DuPage County Health Department
Heidi German	McLean County Health Department
Barbara Germann	Springfield Public Schools
Marjorie Getz	Bradley University
Kim Good	Whiteside County Health Department
Leslie Grammer	Northwestern University
Evalyn Grant	Rush Presb. St. Luke's
Semone Green	Roseland Community Asthma Reduction Effort
Marilyn Green	Department of Human Services, Region 5
Paul Greenberger	Illinois Society of Allergy, Asthma & Immunology
Susanne Hack	Lt. Governor's Office
JoAnn Hairston-Jones	Beu Health Center, Western Illinois University
Jennifer Hamerlinck	Mercer County Health Department
Judie Hastings	Perry County Health Department
Edward Hertenstein	University of Illinois
Michael Hickey	GlaxoSmithKline Pharmaceuticals
Ricki Horowitz	Department of Children and Family Services
Brandi Hudson	Southern Illinois Healthcare Foundation
Monica Hurt	Southern Illinois Healthcare Foundation
Stacy Ignoffo	American Lung Association
Cindy Jackson	Will County Health Department

Carolyn Jackson	Roseland Community Hospital
Vyki Jackson	Illinois Department of Human Services
Diane Johner	Macon County Health Department
Jeff Keim	IVAX
Dana Keim	Stephenson County Health Department
Debra Kinsey	Department of Children and Family Services
John Knight	Safer Pest Control Project
Anne Krantz	John H. Stroger, Jr. Hospital of Cook County
Mike Krug	Sepracor
Mark Kruszewski	Lawndale Christian Health Center
Sharron Lafollette	University of Illinois at Springfield
Brian Lantzy	Sepracor
Debbie Lay	Fayette County Health Department
Pat Lebahn	Bureau County Health Department
Robert Leonard	Occupational Safety and Health Administration
Penny Lewis	Fayette Asthma Coalition Team
Joe Lewison	Illinois Department of Labor
Miriam Link-Mullison	Jackson County Health Department
Angie Loftus	Occupational Safety and Health Administration
Mary Lund	Henry/Stark County Health Dept.
Nawal Lutfiyya	University of Illinois-College of Medicine
Evelyn Lyons	Loyola University Medical Center
Robert Mack	Sepracor
Tom Malamos	Naperville District 203
Matt Maloney	American Lung Association of Metropolitan Chicago
Mary Marcano	Chicago Department of Public Health - West Town
Andrea Martin	American Lung Association of Metro Chicago
Doria Martuzzo	Bureau County Health Department
Joel Massel	Chicago Asthma Consortium
Courtney Matevey	Capitol Area Asthma Coalition
Evelyn Maurer	Aunt Martha's, Women's Health Center
Roy Maxfield	Illinois Department of Public Health
Katherine McCrery	Knox County Health Department
Joel McCullough	Chicago Department of Public Health
Dawn McCullough	Community Health Improvement Center
Angela McDonnell	St. Johns Hospital
Patrick McDonough	Glaxo Smith
Catherine McNamara	Oak Park Department of Public Health
Peggy Mechling	Decatur Community Partnership
Rene Megan	Swedish American Health System
Amy Miller	Mobile C.A.R.E. Foundation
Norma Mills	Chicago Public Schools

Bruce Mims	Illinois Department of Public Health
Jan Morris	McLean County Health Department
Barbara Nation	Illinois Department of Human Services
Edward Naureckas	University of Chicago
Anjuli Nayak	Sneeze, Wheeze and Itch Associates
Carrie Neff Andrews	Knox County Health Department
Jim Nelson	Illinois Public Health Association
Kathy Newhall	Macoupin County Health Department
Jerry Obst	St. Clair County Health Department
Trimina O'Connor	LaRabida Children's Hospital
Luna Okada	Genomics & Chronic Disease Prevention Programs
Florence O'Leary	Illinois Department of Human Services
Marc Ontell	Sepracor
Julie Palmer	Sangamon County Health Department
C. Lucy Park	University of Illinois Chicago
Roosevelt Peabody	Washington University School of Medicine
Anne Perry	SIUE - School of Nursing
Vicky Persky	UIC - School of Public Health
Mark Peters	St. Clair County Health Department
Mike Pohl	IVAX
LaTrice Porter-Thomas	Cook County Health Department
Linda Potts	Capitol Area Asthma Coalition
Sabrina Provine	Advocate Health Centers
Jim Rompel	Safe Effective Alternatives, Inc.
Rachel Rosenberg	Safer Pest Control Project
Kim Rouse	Lawndale Christian Health Center
Marc Rubin	Osco Drug
Cindy Sabo	Illinois Department of Public Aid
Dorothy Saldanha-David	McDonough County Health Department
Steve Saunders	Department of Human Services
Tiffanie Saxer	Illinois Department of Public Health
Carol Schank	American Lung Association
Tad Schlake	American Lung Association of Illinois/Iowa
Shirley Schultz	Memorial Hospital
Brett Scott	Illinois Department of Public Health
John Shannon	John A. Stroger Hospital
Shirla Short	Springfield Department of Public Health
Sona Siegel	Methodist School Health
Jim Simari	Sepracor
Bryan Smith	Oak Park Department of Public Health
Angelo Smith	Healthcare Consortium of Illinois
Jeanne Smith	Advocate Hope Children's Hospital

Sandra Sommer	Henry/Stark County Health Dept.
Ann Stahleber	Rural Health Inc.
Bruce Steiner	Illinois Department of Public Health
Geri Stuart	McLean County Health Department
Maryann Suero	US EPA Region 5
Myrtis Sullivan	UIC School of Public Health
Kent Tarro	Macoupin County Health Department
Prentiss Taylor	Amerigroup Illinois
Bev Terveer	St. Clair County Health Department
John Tharp	Illinois Department of Public Health
Kevin Thomas	Healthcare Consortium of Illinois
Sandra Thomas	Chicago Department of Public Health
Mary Tolliver	Illinois Department of Human Services
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Beverly Van Riper	Community Medical Center
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Keith Winn	Cook County Health Department
Patricia Wood	Union Health Service
Nikki Woolverton	Illinois Department of Public Health
Dorene Wright	Illinois Department of Human Services
Judy Yeast	Western Illinois University
Cecilia Yonker	Illinois Department of Public Aid
Lori Younker	American Lung Association of Illinois/Iowa
Kimi Yuchs	Illinois Department of Human Services
Howard Zeitz	Rockford Health Council

APPENDIX D • LOCAL ASTHMA COALITIONS

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Will/Kankakee Asthma Network
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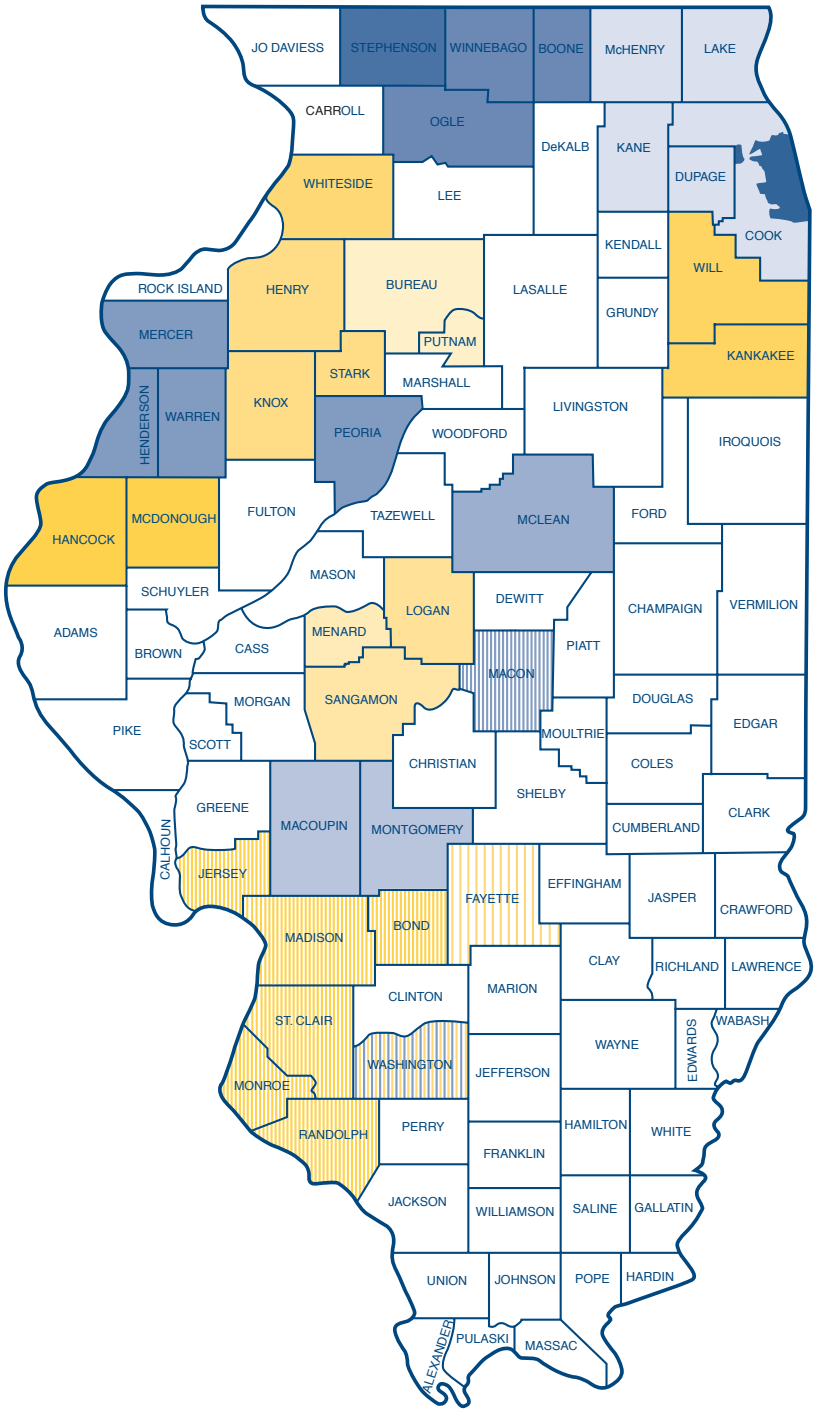
For more information on the Illinois Asthma Coalition, contact the Illinois Department of Public Health at 217-782-3300.

APPENDIX E • LOCAL ASTHMA COALITIONS MAP



APPENDIX F • ILLINOIS CALL TO ACTION FORM

Illinois Asthma Partnership

Call To Action "Are you willing to make a sustained commitment in furthering the statewide agenda for asthma? Are you willing to assist with the implementation of objectives identified in the state's plan - *Addressing Asthma in Illinois*?"

After reviewing the state plan and your own organization's mission and goals, please identify **at least one** work group in which you or a representative from your organization will participate. Work groups will meet via conference call. An Illinois Department of Public Health staff person will coordinate calls and provide minutes of the calls for each work group. If you have questions about participating in the state's asthma program, call 217-782-3300.

___ **Data, Assessment and Outcomes Work Group**
Scope of Work: Obtain scientific information related to asthma in Illinois, disseminate this information to those who are interested and who need to know, promote the use of this information as the foundation for action in alleviating the burden of asthma in Illinois and provide an evaluation and feedback mechanism that will help the Illinois Asthma Partnership assess the usefulness of this information.

___ **School Work Group**
Scope of Work: Provide effective asthma educational materials and resources to increase awareness about asthma to child care providers and the school community, promote a consistent message on the management of asthma and provide Illinois school personnel across the educational continuum, **including child care through college**, with the necessary information and tools to develop strategies and policies in the management of asthma.

___ **Occupational Asthma Work Group**
Scope of Work: Work with epidemiology specialists to determine the burden of asthma in the workplace; work through local or regional public health agencies to provide information to local businesses that addresses asthma as a public health issue in the workplace, work with businesses directly to distribute information related to prevention of asthma in the workplace and advocate that people affected by asthma in the workplace receive the support and services they need.

___ **Education Work Group**
Scope of Work: To promote asthma education and asthma awareness using the National Heart Lung and Blood Institute (NHLBI) asthma guidelines to the people of Illinois.

___ **Policy and Advocacy Work Group**
Scope of Work: Identify key issues to be addressed from a policy/advocacy perspective, identify strategies that will increase Illinois policy makers' awareness of asthma as a public health problem, secure Illinois legislative support for state and local asthma initiatives; support policies that provide environmental protection for individuals with asthma in multiple settings, including, but not limited to schools, day care centers, work places and public places) in Illinois.

Name_____ Organization_____

Address_____ City_____ State_____ Zip_____

Phone_____ FAX_____ E-mail_____

Please return form to:
Illinois Department of Public Health, 535 W. Jefferson St., Springfield, Illinois 62761 • Fax 217-782-1235

APPENDIX G • ASTHMA DATA PROFILE

Asthma Profile – Illinois

Demographic Data, 2003:

People Quick Facts	*Illinois*
Population, 2003 estimate	12,653,544
Population, percent change, April 1, 2000 to July 1, 2003	+1.9%
Population, 2000	12,419,293
Population, percent change, 1990 to 2000	+8.6%
Persons under 5 years old, percent, 2000	7.1%
Persons under 18 years old, percent, 2000	26.1%
Persons 65 years old and over, percent, 2000	12.1%
Female persons, percent, 2000	51.0%
White persons, percent, 2000 (a)	73.5%
Black or African-American persons, percent, 2000 (a)	15.1%
American Indian and Alaska Native persons, percent, 2000 (a)	0.2%
Asian persons, percent, 2000 (a)	3.4%
Persons of Hispanic or Latino origin, percent, 2000 (b)	12.3%
White persons, not of Hispanic/Latino origin, percent, 2000	67.8%

Source: U.S. Census Bureau State & County QuickFacts

(a) Includes persons reporting only one race.

(b) Hispanics may be of any race, so also are included in applicable race categories.

Mortality, 1998-2002:

Area	*Total*	*Race*				*Sex*	
		White	Black	API	Other	Female	Male
Illinois	1,307	687	602	17	1	777	530

Hospitalizations, 2003:

Area	*Discharges*	*Age Adj. Rate/ 10,000 Population*	*Total Days*	*Average Length of Stay (days)*	*Total Charges*	*Average Charges*
Illinois	21,649	17.56	70,099	3.2	$237,654,449	$10,978

Prevalence, 2003:

2003 Illinois BRFSS - Adults		*Count*	*Percent*
Told by a doctor had asthma	Yes	1,044,936	11.1%
	No	8,349,884	88.9%
	Total	9,394,821	100.0%

Source: IDPH, Illinois Center for Health Statistics

Addressing Asthma in Illinois

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