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# Providing Pediatric Asthma Home Visits by Community Workers -- Lessons Learned

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## **Providing Pediatric Asthma Home Visits by Community Health Workers – Lessons Learned**

Hi! I'm David McCarthy, a 4<sup>th</sup> year medical student at the University of Massachusetts Medical School. I had the opportunity to get involved in the [Prevention Wellness Trust Fund](#) (PWTF), a project run by the Massachusetts Department of Public Health that works to combat treatable chronic medical conditions by integrating clinical and community interventions. I chose to focus on the pediatric asthma intervention of the City of [Worcester's PWTF](#), which utilized a series of Community Health Worker (CHW) home visits. As part of this project's evaluation, I interviewed CHWs and Care Coordinators about their experiences providing home visits for patients with pediatric asthma and their families. In this blog, I summarize some tips and tricks that I learned that could help refine a community-based care model and be used as benchmarks for future care model evaluations.

### **Hot Tip: Let those with the contacts help with the networking**

Initially, getting patients referred for enrollment in the intervention was difficult due to lack of medical provider education about the program. The solution had two components. First, increasing the frequency of Worcester PWTF asthma workgroup meetings improved coordination between the different groups involved and overall program engagement. Second, provider champions at each site reached out directly to other providers taking care of patients within the focus population, which expanded the project reach. Eventually, referral numbers improved, as they were coming in from nearly all care team members.

### **Hot Tip: Think outside of office hours when coordinating visits with families**

We needed to be flexible scheduling home visits outside of typical business hours, including weekends, to accommodate families' schedules. CHWs also needed to be available to patients by cell phone for calls and text messaging. This scheduling and options for availability helped to build trust with families and further helped retention of patients in the program.

**Hot Tip: Consider care provider's safety**

As with any intervention that requires home visits or meeting parents/families in their own space, it's always good to remember that the safety of study team members is paramount when going to unfamiliar sites. As part of this project, we provided personal safety training for CHWs who were entering patient homes. Where possible, a team of 2 CHWs conducted each home visit and CHWs confirmed dates and times with families before each visit.

**Lesson Learned: Account for the varied needs of patients and families**

CHWs provided a standardized set of asthma management supplies to families at each visit, including medication pill boxes, trash cans, mattress and pillow covers, and vacuums. This was designed to incentivize their engagement and compliance with their asthma management plan. However, these supplies didn't always match individual families' needs. Future intervention efforts should tailor supply sets for each family based on their existing individual home environment.

Overall, our evaluation efforts identified that an integrated clinical program to address social determinants of health through CHWs represents an innovative healthcare delivery system and is very feasible to implement.