Wayne Children’s Healthcare Access Program
WCHAP, Inc.

A Private-Public Community Health Collaborative

*Increasing Access, Equity, and Quality
*Improving Child Health and Wellness
*Reducing Costs
*Advancing Systems Change for Medicaid Enrolled Children and Families

Funded By The Kresge and W. K. Kellogg Foundations
WCHAP Mission Statement

WCHAP strives to improve quality, access and health outcomes for children eligible for Medicaid by promoting the Medical Home Model.
Part One: CHAP Overview and Systems Implications

- The ‘Family Centered Medical Home’
- Tackling Equity – Key Child Disparities
  - Birth Outcomes – **ASTHMA** – Obesity – Mental Health – Oral Health

Part Two: Perspectives on Child Health

- ACES – The Adverse Childhood Experiences Study
- Our Environment – Place Matters!
- Now What?
WCHAP’s Triple Aim Outcomes

Better Care

Improve individual experience
- Improve “medical homesness”
- Increase patient satisfaction with healthcare provider
- Delivery of care according to national research-based guidelines

Improve Health
- Asthma outcomes
- Preventive care outcomes (well-child, immunizations)
- Reduced ED/IP use

Reduce Cost
- Control inflation of per capita costs
- Reduced ED/IP use
- Fewer missed days of school/work
What Is a Children’s Medical Home?

...it is ... “an approach to providing comprehensive primary care for the Child in Partnership with Parents/Families

“...The Medical Home Is Not A Final Destination Instead, It Is A Model For Achieving Primary Care Excellence ..”

accessible, continuous, comprehensive, Family Centered, coordinated, compassionate, culturally effective
A medical home is defined as primary care that is

| Accessible | 24-hour access to care with clinician support (e.g., advanced scheduling evening and weekend hours) |
| Continuous, | • Knows the health history and develops a care plan with the child/youth when needed |
| Comprehensive, | Follow up with any other health care providers a child/youth received care from when necessary |
| Family centered, | Partnership with patients and families in their preventive acute and chronic care needs |
| Coordinated, | Continuity and integration of care across all of the patient’s conditions and health care needs |
| Compassionate, | Treat the child/youth with understanding of his/her strengths creating a trusting collaborative relationship |
| Culturally Effective. | Respect and honor the culture and family traditions of the child/youth and their family |
Return On Investment of the CHAP Model

- **National ROI**
- **Patient Centered Medical Home Outcomes**
- **CHAP- Children's Medical Home Pilot Success in Colorado, North Carolina**
- **Denver CHAP Pilot - $160ML Medicaid Savings State-Wide**

- **Michigan ROI Proven**
- **KENT Rationale Study and Role**
- **Priority Health Founding Health Plan Partner with Foundations**
- **KCHAP Year One and Two Evaluation Outcomes and National Recognition**
- **WCHAP Pilot, High Patient, Practice and Partner Satisfaction!**
ROI of the CHAP Model: KCHAP

KCHAP Decrease in inappropriate ED*

- 6.2% decrease in overall ED (Aug 08 – July 09)
- 6.2% decrease in ED use among Cherry Street
- 12.5% decrease in ED use at DeVos Clinic

Decrease preventable hospital admissions

- 6.2% decrease in IP rate
- 25% decrease in IP among Cherry Street

(*1st year evaluation)
In 2009, WCHAP was born out of a community planning process with many city and county-wide leaders from health plans, primary care practices, education, mental health and social services.

1. Most children in Detroit are served through teaching clinics, (DMC, St. John, Oakwood), Federally Qualified Health Centers (FQHC), large health care systems such as Henry Ford Health System or Public Health such as the Institute of Population Health.

2. High volumes in clinics combined with a push by ERs to reduce waiting times, encourages families to seek acute care in ERs rather than in their medical home.
1. Low Medicaid reimbursement makes it difficult for practices to survive, thus reducing the number of providers available.

2. The provider to patient ratio in Detroit is three times worse than the suburbs (1:2250 vs 1:750)

Key CHAP Focus
Reducing Disparities

Children on Medicaid in Michigan and Wayne County have poorer health outcomes than children with private insurance.
Wayne County Need Statement

1. Few private physicians still exist in Wayne County. Most children are served through teaching clinics, (DMC, St. John, Oakwood) or Federally Qualified Health Centers (FQHC), or large health care systems such as Henry Ford Health System.

2. Limited hours of operation in clinics combined with a push by ERs to reduce waiting times, encourages families to seek acute care in ERs rather than in their medical home.

Poor preventative and acute care outside of the medical home are significant in terms affecting ED use and hospitalization rates.
Child – Family System Challenges

Chaotic and inadequate funding of preventative and holistic care and support for children and families

Inadequate professional development to support community based health and wellness geared to the whole child

Poor communication / inadequate coordination between systems and providers

Fiscal and administrative policies that prohibit or adversely impact health and wellness

Social Determinants of Health

Exacerbated by Poverty, Inequality, Inadequate Education and Disparate Economic Opportunity
What Did We Learn?

Need help with
1. Behavioral Health triage, referral and coordination
2. Asthma education
3. High no-show rate
4. Community resources
5. Referral information and coordination w/support programs
6. Improve lead screening rates
7. Obesity management
What Did We Learn?

Need help with

1. Improve HEDIS measures (Well child/adolescent visits, immunizations, lead screening)
2. Reduce ER visits and hospitalizations
3. Increase access for enrolled patients
4. Improve customer satisfaction (families and providers)
5. Improve practice responsiveness to HIT and other innovations
What Did We Learn?

Families Want

1. Education on high frequency common conditions (ear infections, asthma behavior /social-emotional issues (stuff they can do as parents)
2. Consistency of care and information - same doc, staff knowledgeable about their child/family
3. Better hours
4. Respect and compassion
5. Information in a way they can understand
Theory of Change Foundation: WCHAP Has Organizational Capacity and Strategic Partnerships to Fully Implement CHAP Approach (Improve Quality of Children’s Healthcare, Improve Children’s Health Outcomes, and Reduce Healthcare Costs)
Wayne Children’s Healthcare Access Program

**Timetable**

**Phase One:**
- Pilot Planning Initiative
- April – Dec 2010
  (informal began spring 2009)

**Phase Two:**
- Wayne CHAP Pilot Implementation
- Two – three years
- Feb 2011 - 2013

**Phase Three:**
- Going to Scale 2014-Adding Additional Practices
- 4-5 years
  - Expansion and Replication
WKKF Grant Award
$1.5ML 3 Years

Core WCHAP Services and Specialty Services:
Community Linkaging, Care Coordination and Case Management for Families.
Practice and Community Engagement For 3,000 additional vulnerable children and their families

Specialty Areas

- Expanding asthma case management team
- Implementing Fit Kids 360, and advancing evidence-based obesity reduction models
- Strengthening coordination and transitions between maternal and child health providers to improve birth and infant health outcomes
- Increase coordination and integration between physical and behavioral/mental health
- Bolster the Innovation and Incentives Program to assist pediatric practices in meeting medical home standards
WCHAP Primary Care Practices and Child/Family Agencies

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<tbody>
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<td>1.</td>
<td><strong>ADVANTAGE HEALTH CENTERS</strong></td>
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<td>2.</td>
<td><strong>BOSTFORD PEDIATRIC</strong></td>
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<td>3.</td>
<td><strong>CHILDREN’S HOSPITAL OF MI</strong></td>
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<td>4.</td>
<td><strong>COVENANT COMMUNITY CARE (2 CLINICS)</strong></td>
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<tr>
<td>5.</td>
<td><strong>DETROIT COMMUNITY HEALTH CONNECTIONS (3 CLINICS)</strong></td>
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<td>6.</td>
<td><strong>DETROIT RIVerview PEDIATRICS</strong></td>
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<td>7.</td>
<td><strong>MORANG CHESTER CLINIC</strong></td>
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<td>8.</td>
<td><strong>NEW CENTER COMMUNITY</strong></td>
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<td>9.</td>
<td><strong>NORtheast GUIDANCE CENTER</strong></td>
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<td>10.</td>
<td><strong>WESTERN WAYNE FAMILY HEALTH CENTERS (2 CLINICS)</strong></td>
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<td>11.</td>
<td><strong>WAYNE STATE UNIVERSITY PHYSICIANS GROUP</strong></td>
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<td>12.</td>
<td><strong>SCHOOL BASED HEALTH CENTERS</strong></td>
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<td><strong>HENRY FORD HEALTH SYSTEMS</strong></td>
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<td></td>
<td><strong>COVENANT –NEwTON CENTER</strong></td>
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MI-CHAP

Now 10 Counties!

2 in Implementation
2 Partial Funding for 2013
6 Planning Stage - unfunded

Collaborators – CHAP Teams
- MI American Academy of Pediatricians
- MI Dept. Community Health
- Public Health, Health Plans
- Hospitals, Federal Clinics
- Office of Great Starts
- Parents, Family Advocates
- Education, Policy Makers,
- Mental Health,

Kent and Wayne CHAP are leading the way in this statewide collaborative
The “ABC's of CHILD HEALTH DISPARITIES

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<tbody>
<tr>
<td>A</td>
<td>Asthma</td>
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<td>B</td>
<td>Birth Outcomes Behavioral Health</td>
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<tr>
<td>C</td>
<td>Childhood Obesity</td>
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<tr>
<td>D</td>
<td>Dental Health</td>
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<tr>
<td>E</td>
<td>Equity</td>
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WCHAP
Connecting, Linkaging, Coordinating Advancing Innovation, Policy and Systems Change!
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<thead>
<tr>
<th>A</th>
<th><strong>Asthma</strong></th>
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<tbody>
<tr>
<td></td>
<td>Coventry Health Plan/Aetna and Glaxo Smith Kline, MDCH, WSU – WCHAP</td>
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<td></td>
<td>Asthma Practice Transformation Pilot</td>
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<td>Detroit Promise Neighborhoods and Clear Corps – Asthma Education, Intervention and Community Linkaging</td>
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<th>B</th>
<th><strong>Birth Outcomes</strong></th>
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<td></td>
<td><strong>Behavioral Health</strong></td>
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<td></td>
<td>Starfish Family Services – Behavioral Health/ Integrated Healthcare &amp; WCHAP. Det-Wayne Community Mental Health – Joint Professional Development/Presentations at State Mental Health Conferences</td>
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<tr>
<th>C</th>
<th><strong>Childhood Obesity.</strong></th>
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<tr>
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<td>Fit Kids 360 at Children’s Hospital of Michigan. Coming Soon! Collaboration w/Kidney Foundation, MSU-Extension and Bilingual Fit Kids Curriculum</td>
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<tr>
<th>I</th>
<th><strong>New Innovations!</strong></th>
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<td></td>
<td>United Way Community Services – Literacy, Health Advocacy and Parent Empowerment</td>
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Is Infant Mortality Really News... *Still*?

- Infant Mortality is the No. 1 killer of Detroit children; violence is second. In 2011 alone, 130 of the 208 Detroit children who died that year had not yet marked their first birthday.

- More babies are born prematurely in Detroit than in any major city in the United States, a Detroit News investigation found.

- Prematurity, whose deadly side effects include brain hemorrhages, collapsed lungs and failing organs, is the leading killer of Detroit’s babies. It’s the major component of infant mortality — a catch-all term comprising all conditions that claim children before their first birthday.

From The Detroit News: Winter 2014

- [http://www.detroitnews.com/article/20140130/LIFESTYLE03/301300005#ixzz31ly4aHCx](http://www.detroitnews.com/article/20140130/LIFESTYLE03/301300005#ixzz31ly4aHCx)
Great Start Collaborative
Wayne
Pediatric and Family Health
Action Team

Goal One: All infants and young children have access to a comprehensive Medical Home providing continuity and integration of quality health care.

Goal Two: Family planning, healthy pregnancy, and maternal and child health services are available, thereby improving child health and reducing infant death, illness and disabilities.

Co-chairs – Jametta Lilly, WCHAP. Yolanda Ashford Hill, WINN

Of All the Forms of Inequality, Injustice in Healthcare is the Most Shocking and Inhumane.
Martin Luther King, Jr.
Collective Impact to Reduce Infant Mortality and Improve Women’s and Infant’s Health

Training, Technical Assistance and Professional/Community Resources

**A Healthy Baby Begins With You**

- Infant Mortality and Morbidity Awareness for Staff, Families, Organizations, Policy Makers

**Pre & Inter-Conceptional Care PICC**

- Re-thinking program models and best practices to advance PICC (March of Dimes & CDC Standards)

**Life Course**

- Workshops exploring self development, health, relationships, career, education & family planning within an ecological framework ie. social determinants

**Intake Q's**

- Using the 5 A's Ask - about sexual activity / contraception / prior pregnancy and birth history. Provide resources

Knowledge, Skills, Experiences = Best Practices, Behavioral and Systems Change
WCHAP Innovations
Perinatal to Pediatric Transitions

Think Tank, P2P

Think Tank Leadership

Co-Chairs
Theodore Jones, M.D.  Vice-Chairman, Oakwood/WSU Programs
Charles Barone, M.D.  Chief of Pediatrics, Henry Ford Medical Group

Think Tank Team - Staffing

Jametta Lilly, MPA-HCA Candidate.  Chief Executive Officer  WCHAP
Gwendolyn S. Norman, PhD, MPH, RN.  Maternal Child Health Consultant ,WCHAP
Latisha Carter Blanks, MD.  MPH Candidate.  P2P Team.  Childrens’ Hospital of MI

Primary Goals – Working Across Health Systems and Disciplines

1. Facilitate medical homeness
2. Identify/solve systems barriers
3. Recommend/implement policy
4. Incorporate Health Equity in all change, local and state levels

Members:  Multi-Sector, Multi-Disciplinary Leaders in Hospital, Federally Qualified Health Clinics and Public Health Settings in Detroit-Wayne
Schedule:  Nov, Feb, April, June (retreat), Sept (City Wide Nat’l Infant Mortality Month) Quarterly Thereafter w/Workgroups thru 2015
Why A Think Tank?

Unacceptable High IMR and Morbidity
Intrinsic Systems Fragmentation
Persistent Health Policy Disparities

• Children born to low-income parents face challenges from birth, which, if not addressed, will severely compromise their opportunities throughout life. In the fall of 2013, WCHAP actualized the Perinatal to Pediatric Transitions Think Tank to tackle the abiding disparities in birth outcomes in the Detroit-Wayne County with a Medical Home lens. Although Michigan guidelines recommend selection of a pediatrician at the first prenatal visit, many new mothers leave the birthing hospital without having a pediatric care provider identified, or a newborn visit scheduled. Because vitally important events occur the prenatal, postpartum and newborn visits that have long term consequences for the health and well-being of both mother and child, a multidisciplinary approach between obstetric and pediatric care providers was deemed essential to meet the needs of mothers and their children.

• Therefore, multi-sector and multi-disciplinary stakeholders were convened to address health disparities and build solutions. The primary plan was to 1) facilitate a more seamless approach toward “medical homeness” between the obstetrician and the pediatrician, in partnership with the primary care provider and 2) to identify barriers, best practices, and community messaging and metrics o address the obstetric to pediatric transition. The outcome will be a ‘white paper’ with Action Steps to the State and key associations and institutions in the region.
Perinatal to Pediatric Transitions
Think Tank

Obesity Continuum

Evidence Based – Acute Child-Family Interventions and Clinic Education

• Fit Kids360!
  • Coming! FK 360 for Toddler/Pre-Schoolers and Teen
  • FK At your Location!

Continuum of Obesity Interventions and Education in Clinic and Community Settings

• Families Moving in the D
• Yoga & Fitness 4 Health
• Food, Nutrition and Fitness Partnerships
Eleven States with the highest obesity rate
2011

<table>
<thead>
<tr>
<th>State</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Alabama</td>
<td>32%</td>
</tr>
<tr>
<td>Arkansas</td>
<td>30.9%</td>
</tr>
<tr>
<td>Indiana</td>
<td>30.8%</td>
</tr>
<tr>
<td>Kentucky</td>
<td>30.4%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>33.4%</td>
</tr>
<tr>
<td>Michigan</td>
<td>31.3%</td>
</tr>
<tr>
<td>Mississippi</td>
<td>34.9%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>31.1%</td>
</tr>
<tr>
<td>Texas</td>
<td>30.4%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>30.8%</td>
</tr>
<tr>
<td>West Virginia</td>
<td>32.4%</td>
</tr>
</tbody>
</table>

Source: "Fat in Fat", 2012
http://healthyamericans.org/assets/files/TEA1202FatInFat18.pdf, HealthyAmericans.org
Study by the Trust for America's Health
the Robert Wood Johnson Foundation (RWJF)

Michigan’s obesity rate

Source: America's Health Rankings
Figure 3. Prevalence of obesity among children and adolescents aged 2–19 years, by education of household head, sex, and race and ethnicity: United States, 2005–2008

![Bar chart showing prevalence of obesity by education level, sex, and race/ethnicity.](chart)

†Significant trend.

NOTE: Persons of other race and ethnicity included in total.

WCHAP Highlights – Service Achievements

*In 2013, the Wayne Children’s Healthcare Access Program received more than 1,400 referrals from primary care providers. Of these referrals, service was provided to 957 children.

* WCHAP’s successes during this past year include serving 68% more children in 2013 versus 2012. From the six month report completed July 1, 2013, there was close to a 60% increase in the number of children referred from the first six months of 2013 to the second six months of 2013. These increases reflect both the number of children in WCHAP’s core services as well as those served through specialty services.

<table>
<thead>
<tr>
<th>WCHAP – WKKF 2013 Service Goals</th>
<th>Projected</th>
<th>Achieved</th>
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<tbody>
<tr>
<td>Type of Service</td>
<td></td>
<td></td>
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<tr>
<td>Core CHAP Services (individual children)</td>
<td>700 - 1,000</td>
<td>657</td>
</tr>
<tr>
<td>Specialty Services</td>
<td>300 – 500</td>
<td>748 (subtotal of asthma, Fit Kids, New Programs)</td>
</tr>
<tr>
<td>Asthma Case Management</td>
<td>200</td>
<td>479</td>
</tr>
<tr>
<td>Fit Kids 360 (Childhood Obesity)</td>
<td>100</td>
<td>251</td>
</tr>
<tr>
<td>Outreach and Education</td>
<td>250</td>
<td>973 (120 were children)</td>
</tr>
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WCHAP Highlights

2013 WCHAP Children

<table>
<thead>
<tr>
<th>Category</th>
<th>Ages 0-5</th>
<th>Ages 6-10</th>
<th>Ages 11-13</th>
<th>Ages 14-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>13%</td>
<td>48%</td>
<td>40%</td>
<td>33%</td>
</tr>
<tr>
<td>Missed Well Child Visits</td>
<td>74%</td>
<td>13%</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>Missed Immunizations</td>
<td>5%</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Childhood Obesity</td>
<td>6%</td>
<td>36%</td>
<td>36%</td>
<td>36%</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Failed Hearing</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>No Show</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
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</table>
WCHAP Highlights

WCHAP Children with Service

- Ages 0-5: 48%
- Ages 6-10: 21%
- Ages 11-13: 14%
- Ages 14-18: 17%
WCHAP Highlights – FitKids 360!
Data and Achievements

Nutrition Changes in Fit Kids 360 (n=34)

- Daily Fruit Intake (servings/d)
- Daily Vegetable Intake (servings/d)
- Daily Dairy Intake (servings/d)
- Daily Soda Intake (servings/d)

Physical Activity Changes in Fit Kids 360 (minutes per day) n=34

- Physical Activity (minutes per day)
William - Before and After

[Two images of a boy, one before and one after, showing growth and change.]
WCHAP Highlights: Our Family and Physician Voices

• “I don’t know what you guys are doing, but I have never seen anything like it. Our patients love it and the results have been great!”- Dr. Treece (DRP)

• “Fit Kids really changed his attitude and made him look at things differently. He is so proud! Dr. Mosby kept yelling, “Where is William?” around the office because he couldn’t believe the difference in him in his last checkup.”- LaTonya Peterson (Mom of William)

• “I thank Fit Kids, I just need someone to believe in me and give me a push”.

• “This program has changed my life for the better.” Melvin Hall

• “This program has done for Melvin what four doctors were not able to do in the last few years!”- Belinda Williams (Melvin’s Mom)
**ASTHMA**

**2013 Program Snapshot**

MATCH Model Implementation and WCHAP Value-Adds

MATCH — Managing Asthma Through Case Management in Homes

**Asthma Case Management** = 431 children served

- MATCH Model: Assessment, Home and Clinic/School Visits, Evidence Based Tools, Coordination with Physician, Health Plans, Juniper and On-going Follow-Through

**Asthma Practice Engagement** = 5 PCPs

**Asthma Training and Meetings** = 11

- Including: Spirometer Training, Asthma Practice Transformation Pilot Steering Committee and PCP Presentations

**Asthma Education** = 400+ children & adults in schools, clinics and agencies

*Services by a Certified Asthma Team!*

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**Agreed Quality Improvements**

1. Use of an Asthma Control Test (ACT) with every asthma patient at every visit.
2. Every asthma patient will be given and Asthma Action Plan (AAP) and know how to use it before leaving the office visit.
3. Practice will create and utilize an Asthma Registry

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**DETROIT — ASTHMA EPICENTER FOR MI**

**ASTHMA in the US....**
- is the most common chronic disorder, affecting 9 million children and teens
- Annual economic cost is $19.7 billion

**Asthma in Detroit (2004-2005)**
- Impacts 22% of high school students
- Emergency room use for Detroit children with asthma is 60% higher than the average for the State
- Hospitalization for Detroit children with asthma is 3 times the rate for the State
- Detroit children with asthma die at twice the rate for the State
Asthma Hospitalizations by Zip Code (2007 - 2009 Average)
Overlayed with Total On Site Air Emissions (2009)
Detroit, MI

Hospitalization Rate per 10,000 People

- 1.52 - 10.22 (Much Lower than Tri-County average)
- 10.22 - 24.9
- 24.90 - 39.58
- 39.58 - 86.20 (Much Higher than Tri-County average)

*Only Detroit 2009 Data is Shown. On-site emissions includes both fugitive and point-source emissions.*

Sources: EPA TRI, Michigan Health and Hospital Association
Data Driven Detroit. Created August 2012.
CLEARCorps/Detroit is pleased to announce Healthy Homes + Asthma, a new program generously funded through The Jewish Fund. Beginning February 1, 2014, CLEARCorps/Detroit will be partnering with Wayne Children’s Healthcare Access Program (WCHAP) to provide intensive asthma education, asthma trigger-reducing products, and referrals to beneficial programs to Detroit families whose children have asthma. Healthy Homes + Asthma will complete 40 homes as part of the grant, and is available citywide. To qualify, you must live in the City of Detroit, be considered low or moderate income, and you must have a child (age 17 or younger) living in your home with diagnosed asthma.

With some estimates placing Detroit’s asthma rate at around 20%, CLEARCorps is excited about this new initiative to reduce the effects asthma has on Detroit’s children.
A comparison of asthma hospitalization rates (age-adjusted) in Wayne County and the state of Michigan from 2000-2002 with Healthy People 2010 targets by age.
Asthma* Among Adults Aged 18 and Older, by Poverty Status** and Sex, 2008–2010

*Reported that (1) a health professional has ever told them that they have asthma, and (2) they still have asthma.

**Poverty level, defined by the U.S. Census Bureau, was $22,314 for a family of four in 2010.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey with multiply imputed poverty data, 2008-2010. Analysis conducted by the Maternal and Child Health Bureau.
## WCHAP Highlights – Asthma WCHAP Savings

<table>
<thead>
<tr>
<th>Child</th>
<th>Total ED Visits Pre WCHAP Service</th>
<th>Total ED Visits Post WCHAP Service</th>
<th>Total estimated Cost of ED Visits*</th>
<th>Total Hospitalizations Pre Service</th>
<th>Total Hospitalizations Post Service</th>
<th>Total Estimated Cost of Hospitalizations#</th>
<th>Total WCHAP Cost in 2013 (these kids are about 2% of the total 479 asthma, should we take 2% of the cost?)</th>
<th>Total Estimated Savings to the Healthplans</th>
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<tbody>
<tr>
<td>WM</td>
<td>2</td>
<td>1</td>
<td>$1300</td>
<td>1</td>
<td>-</td>
<td>$11,992</td>
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<tr>
<td>LM</td>
<td>1</td>
<td>-</td>
<td>$1300</td>
<td>-</td>
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<td>-</td>
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<tr>
<td>JW</td>
<td>3</td>
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<td>$3900</td>
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<td>AP</td>
<td>2</td>
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<td>$2600</td>
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- $1300 per visit Cost estimated from University Hospitals Medical Center. “Young Children with Asthma visit ER Most Often.” Science Daily, 27 October 2013
Children Die from Asthma, a Manageable and Often Preventable Disease.

African American Children Die at 3-4 times the Rate of Caucasian Children.

More than a Disparity… Asthma is an Issue of Social, Economic and Health Equity.
1. The prevalence, the emergency room use, the hospitalization rate, and the death rate due to ASTHMA is significantly disparate between African Americans and Non-Hispanic Whites.

2. According to a 2008-2010 report by the Michigan Department of Community Health, African American children had a higher prevalence of >= 2 Emergency Department visits or urgent care visits due to asthma in the prior 1 year period than White children.

3. Asthma **deaths** for African Americans **occur at a rate 3.9 times** that of Whites.

4. **Detroit’s asthma hospitalization rate is 3 times higher** than Michigan’s overall rate and highest amongst all high asthma burdened communities in the state.
• Mom said “I can finally sleep at night now. [with child’s asthma controlled.]”

• Mom says “I am able to complete my GED and get a job because I am more confident M’s asthma is controlled and I do not need to pick him up from school as much.”

• Asthma Educator reported that an Asthma Control Test went from 7 to 23 on a child under 1 years of age and this baby has now caught up to the other twin in weight and height.
2015 Key Outcome Goals

1. **FAMILIES:** Improved Child Health and Increased Family Health Partnerships

2. **PRACTICES/PARTNERS COLLECTIVE IMPACT**
   a. Improved Quality and Family Centered Medical Homeness – WCHAP Practices, Families and Partners
   b. Multi-Sector Shared Messages, Metrics and for Child Health and Wellness Best Practices and Policy

3. **SYSTEMS:** Health Equity - Reduction in Disparate Resource Allocations and Policy Barriers at State-County-City Levels. Achieve State Recognition/Support for MI CHAP.

4. **WCHAP:** Sustainability of Model at local and across state w/a MI CHAP with two new CHAPs in sister Counties.