Celebrating Over 30 Years of Excellence

HMA
HEALTH MANAGEMENT ASSOCIATES

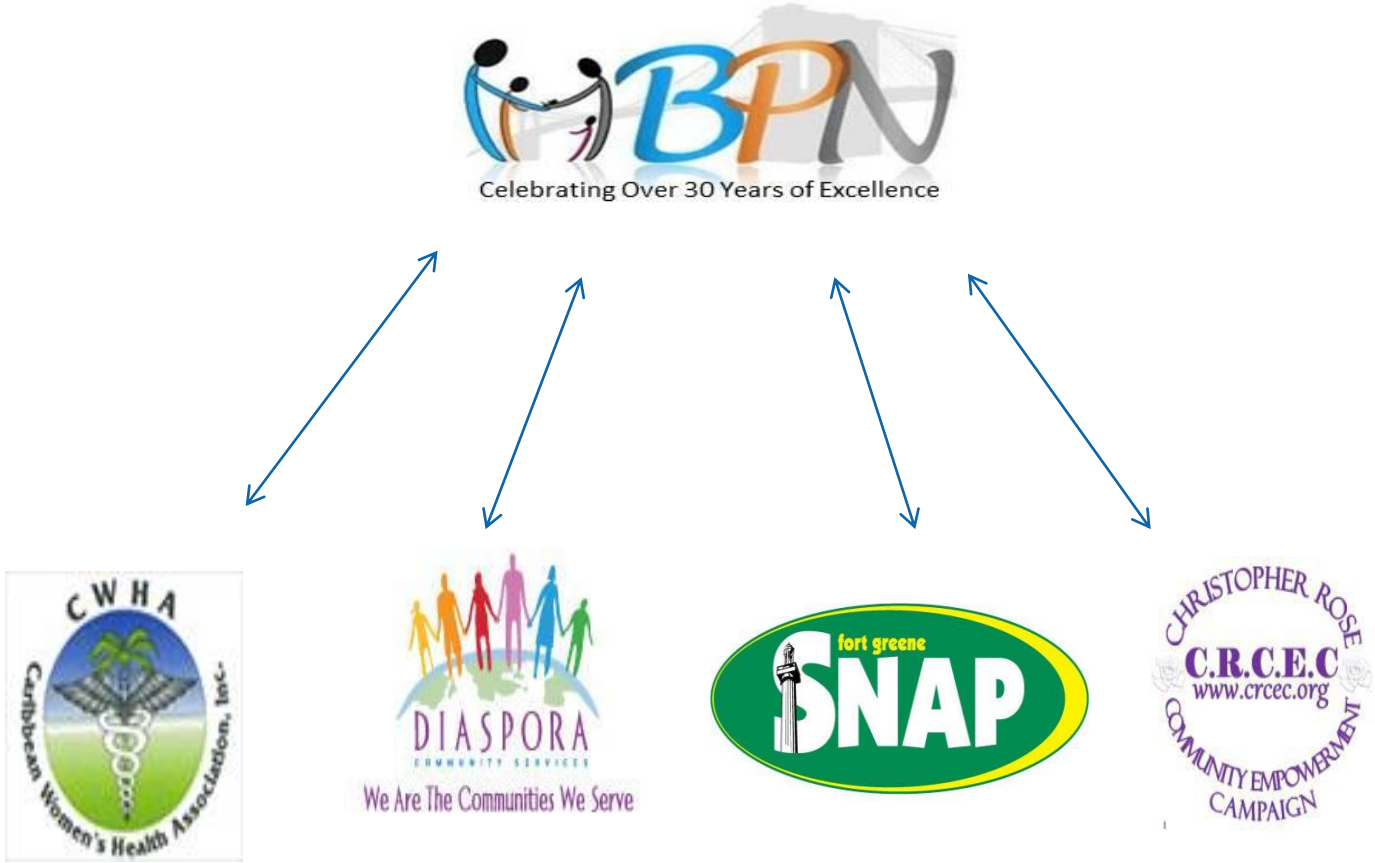
Journey to a Pathways HUB in Brooklyn

Ngozi Moses, Executive Director, Brooklyn Perinatal Network
Cheryl Hall, Executive Director, Caribbean Women's Health Association
Heidi Arthur, Principal, Health Management Associates

April 24, 2019

The Brooklyn Pathways Community Hub Model Maternal Child Health Pilot Initiative

The Coalition Network of CBO's is comprised of:



The Coalition organizations have worked together for 18 years to address the various social determinants of health that underlie poor health outcomes for women interested in childbearing, pregnant/prenatal, postpartum and inter-conception women and those parenting infants and young children to enable chances for the best outcomes.

Central Brooklyn At a Glance

Central Brooklyn

Central Brooklyn At a Glance

Neighborhood	Race	Poverty (% of residents)	Unemployment (% of people 16 and up)	Born Outside of US	Incarceration (per 100,000 age 16 and over)
Brooklyn *Citywide rates where indicated	22% Black* 29% Latino*	21%	9%	37%*	460
Bedford Stuyvesant	64% Black 20% Latino	23%	13%	20%	1045
Brownsville	76% Black 20% Latino	28%	14%	30%	1698
Crown Heights/Prospect Heights	64% Black 12% Latino	21%	9%	30%	872
East Flatbush	88% Black 7% Latino	19%	9%	53%	597
East New York/Starrett City	52% Black 37% Latino	30%	10%	36%	1065

Central Brooklyn At a Glance: Poor Health Outcomes

Neighborhood	Diabetes	Hypertension	New HIV Diagnosis (per 100,000 people)	Obesity	Air Pollution (micrograms per cubic feet)	Child Asthma ER Visits (per 10,000 children ages 5-17)
Brooklyn	12%	29%	22.1	27%	7. 8	186
Bedford Stuyvesant	13%	34%	55.1	29%	8.1	375
Brownsville	13%	33%	67.4	41%	8.0	475
Crown Heights/Prospect Heights	13%	33%	44.3	26%	8.0	342
East Flatbush	15%	36%	35.6	34%	7.8	343
East New York/Starrett City	14%	34%	38.1	35%	7.7	315

Central Brooklyn At a Glance: Premature Death

Neighborhood	Premature Death Rate of death before age 65 per 100,000 people (Number of deaths)	Cancer	Heart Disease	Homicide	HIV	Drug Related **Diabetes related deaths supersede Drug Related deaths
Brooklyn	169.5	46.2	32.9	4.9	5.9	9.4
Bedford Stuyvesant	283.8	66.8	58.3	12.9	18.1	** diabetes related deaths13.4
Brownsville	365.1	80.8	74.2	23.0	25.2	19.2
Crown Heights/Prospect Heights	234.0	60.4	51.8	9.3	11.5	10.4
East Flatbush	206.1	54.4	37.1	12.4	10.0	** diabetes related death 10.5
East New York/Starrett City	264.8	66.4	53.2	10.5	14.3	** diabetes related death 14.8

Central Brooklyn At a Glance: Social Determinants of Health

- Inadequate local, quality health service facilities
- Poor housing affordability and quality
- Low levels of employment, high levels of job instability and inadequate local job opportunities
- Inadequate childcare options
- High rates of crime and violence
- Poor access to quality food
- Racism

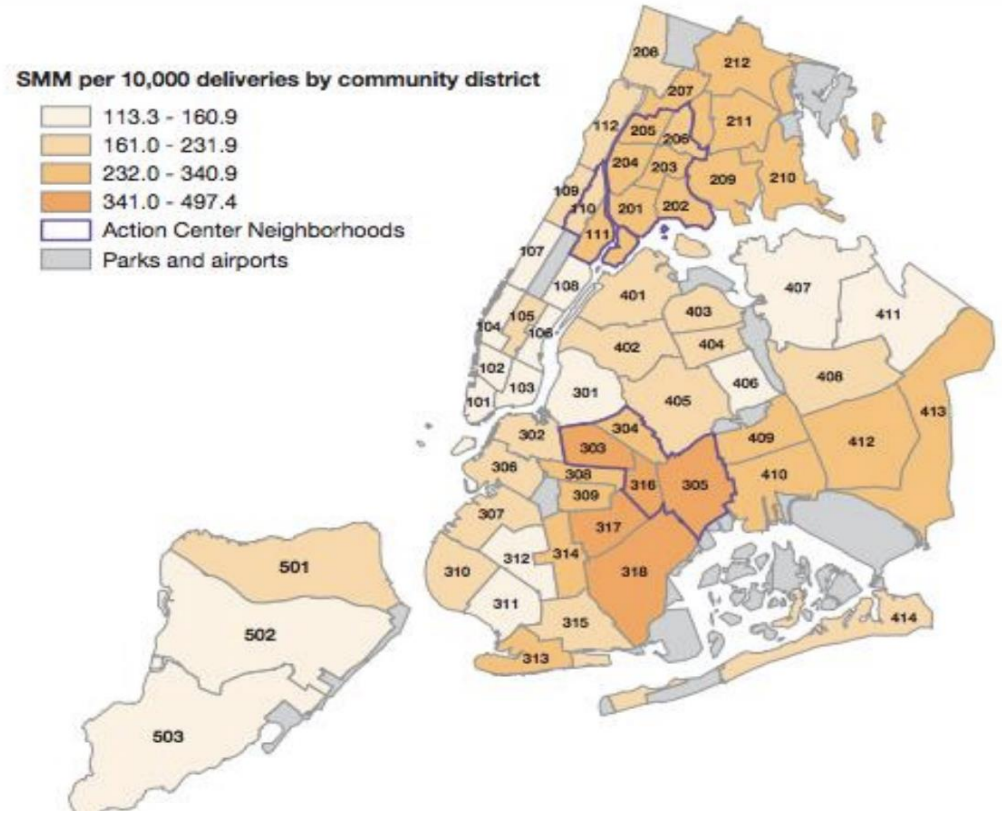
Central Brooklyn At a Glance: Community Based Organizations (CBO)

- CBO Challenges
  - Inconsistent project based funding streams
  - Limited opportunities to engage with healthcare delivery system while serving the same clients
  - Limited organizational infrastructure and access to resources
  - Limited IT and data management/tracking capacity
  - Culturally competent understanding of community needs is often borrowed by larger public and private entities to create programs/interventions that do not effectively include CBOs or the communities they serve

Central Brooklyn At a Glance: Maternal and Child Health

Neighborhood	Late/No Prenatal Care	Preterm Birth %	Infant Mortality (per 1,000 live births)
Brooklyn	6.2 %	8.3%	3.6
Bedford Stuyvesant	5.9%	9.5%	5.7
Brownsville	13.3%	12.7%	4.9
Crown Heights/Prospect Heights	7.4%	9.2%	5.4
East Flatbush	15.6%	12.6%	7.1
East New York/Starrett City	10.7%	11.0%	6.2

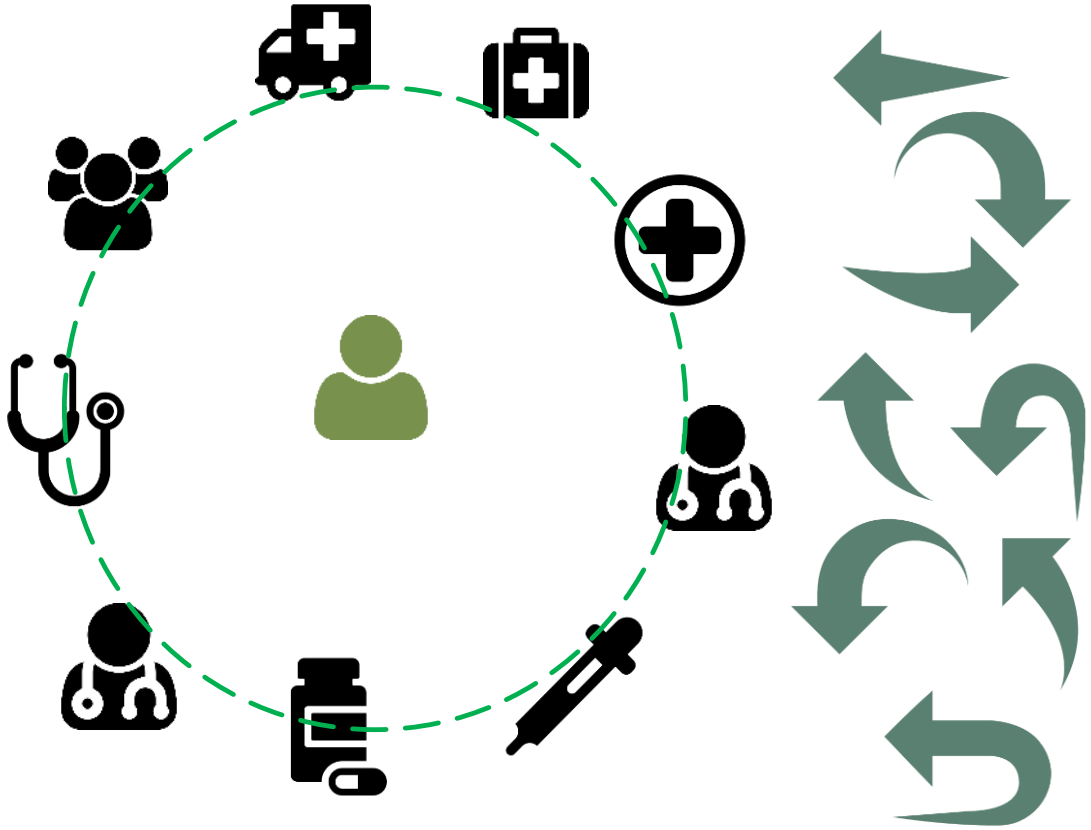
Figure 16. Map of Severe Maternal Morbidity by Community District of Residence, New York City, 2008–2012



Brownsville has the highest SMM rate in all of NYC.

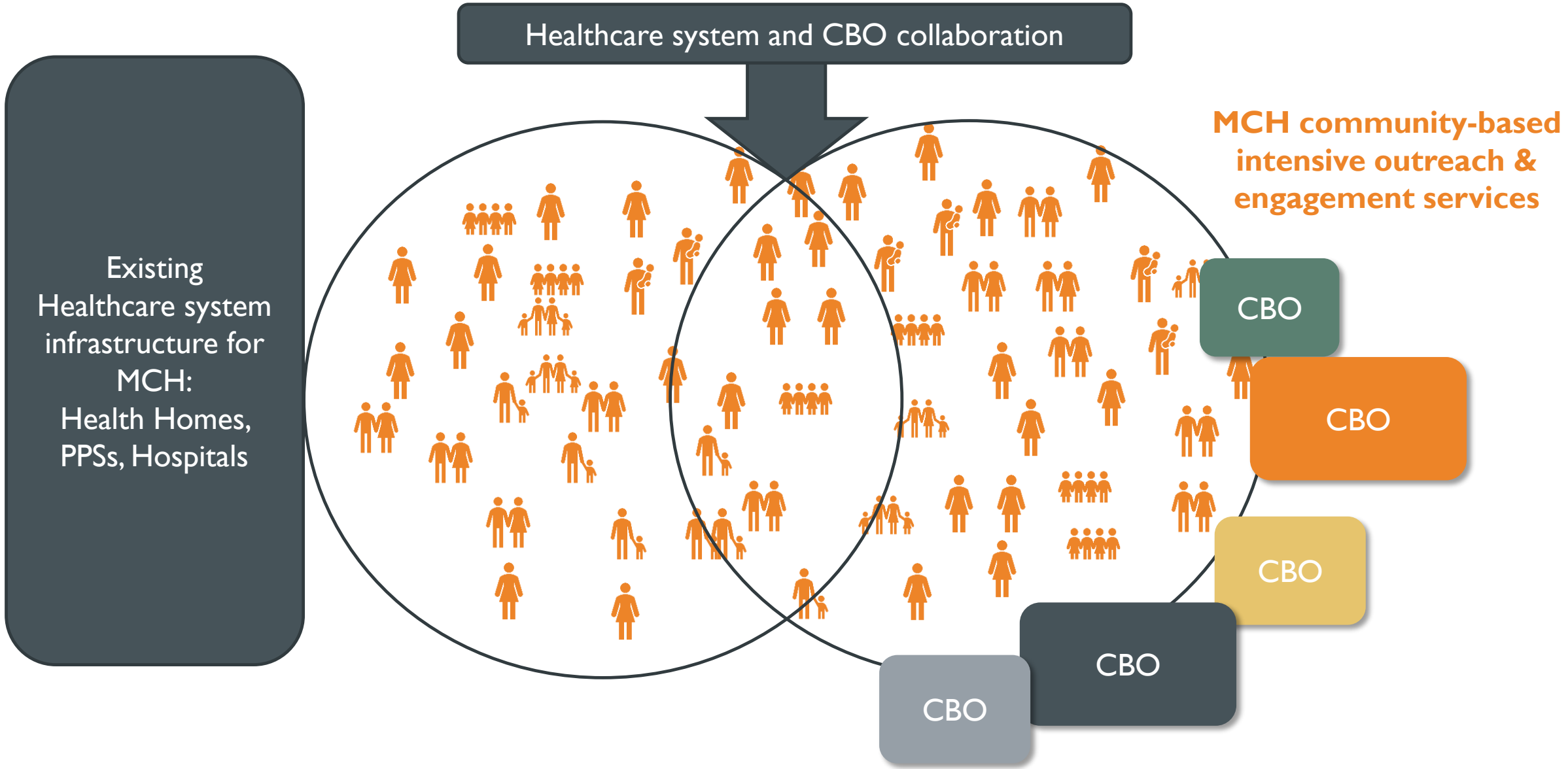
CBOs Addressing MCH Lack Alignment Within Delivery System

Healthcare Services and Health Homes



Community-Based Organizations addressing SDOH

MCH Population: LOST Within the System of Care



Journey to a Pathways HUB in Brooklyn

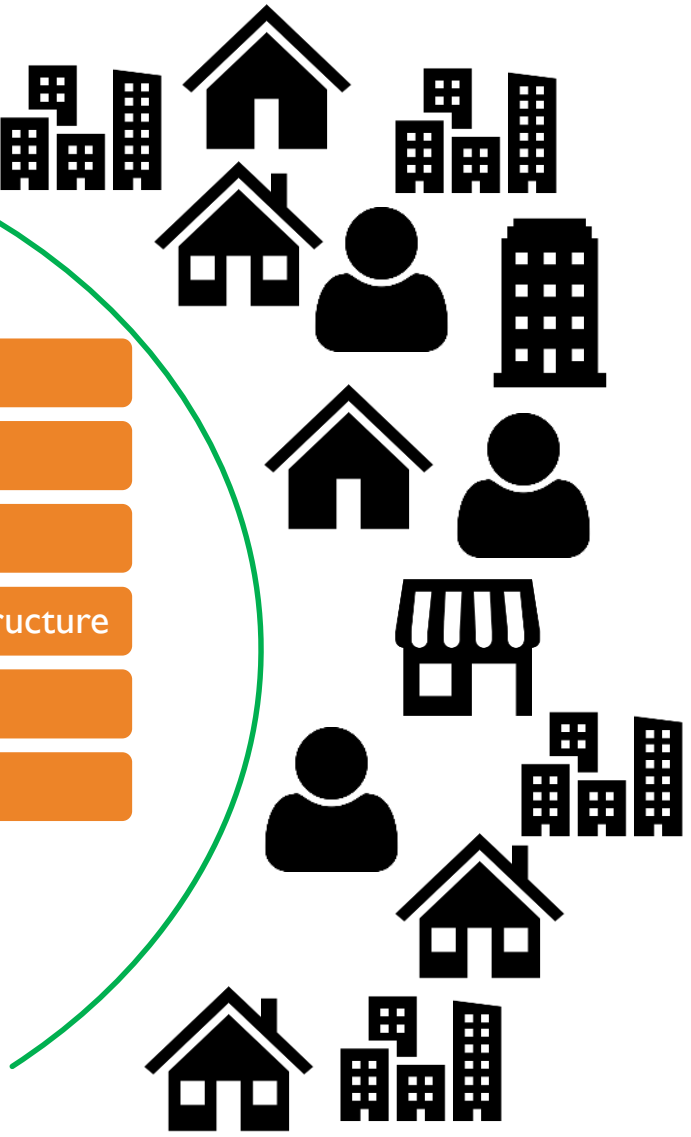
- 2011
  - BPN attends CJA Conference and meets Mark Redding
- 2012-2017
  - Coalition Leadership Team (CLT) commences search for effective service delivery model
- 2017
  - BPN attends CJA Conference and invites Mark Redding to Brooklyn
  - CLT introduces the HUB and Mark Redding to Maimonides Medical Center (MMC)
  - Coalition hosts the MMC sponsored 2017 Community Maternal Health Forum and introduces the Pathways Hub Model to Brooklyn Stakeholders
  - CLT begins meetings with various Brooklyn stakeholders and commences collaboration with Health Management Associates (HMA)
  - Ngozi Moses introduces HUB concept to Jason Helgerson, Director, New York State Medicaid who invited BPN to submit a concept paper focused on the alignment between the Health Home Program and Community Health Workers in Brooklyn

Brooklyn Maternal Child Health Pathways Hub Pilot Initiative Planning Team

- Brooklyn Coalition for Health Equity for Women and Families Coalition Leadership Team
  - Brooklyn Perinatal Network
  - Caribbean Women's Health Association
  - Christopher Rose Community Empowerment Campaign
  - Diaspora Community Services
  - Fort Greene Strategic Neighborhood Action Partnership
- Healthfirst NY
- Maimonides Medical Center – Community Care Brooklyn
- Health Management Associates
- Pathways Community Hub Institute, Ohio
- SUNY Downstate School of Public Health
- Columbia University Mailman School of Public Health
- Long Island University – Brooklyn, School of Health Professions, Public Health Program

Pathways HUB Approach

- Standardized Risk Assessment approach
- Standardized documentation
- Standardized performance metrics
- Centralized contracting & administration infrastructure
- Coordinated CBO engagement
- Standardized P4P approach



P-HUB Core Features

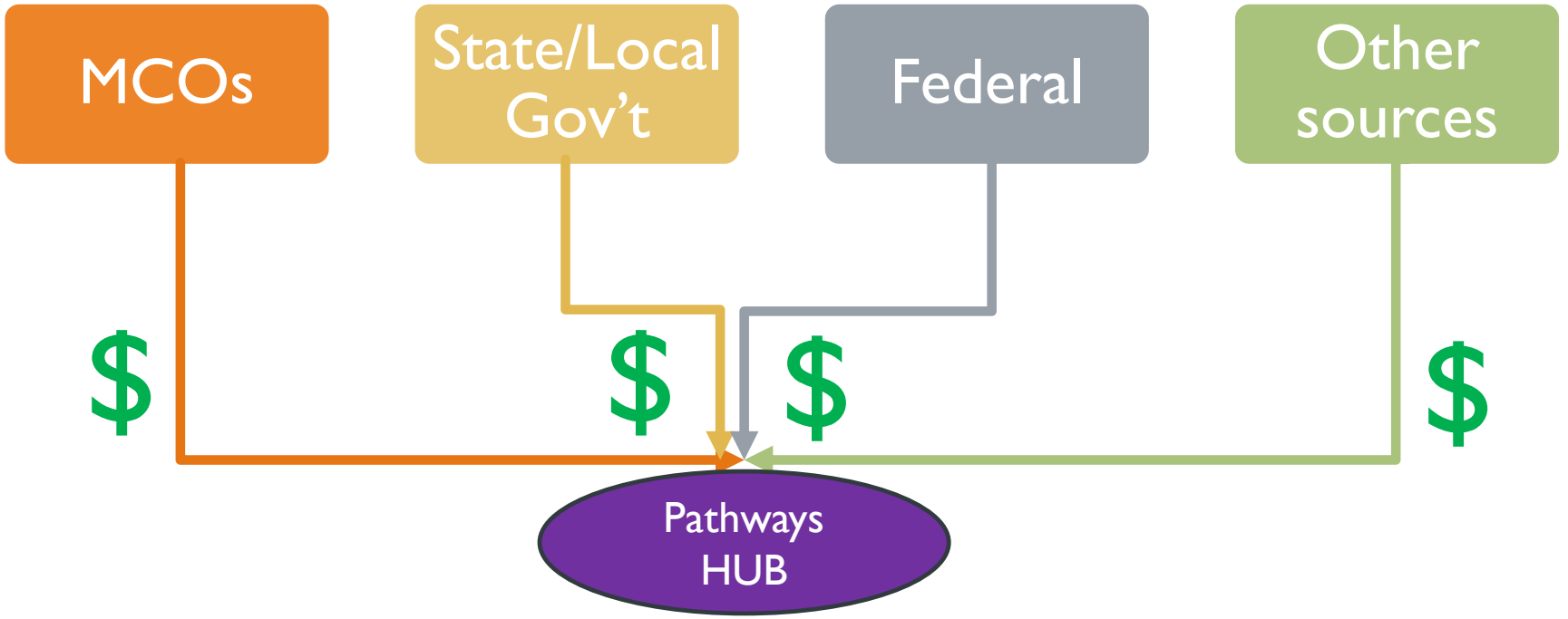
- Community hubs use community health workers to find at risk individuals, assess and lower risk, find and remove barriers to clinical care and then connect to effective clinical care
- Methodology to align CBO efforts with delivery system
- P4P approach incentivizes outreach and engagement to highest risk
- Shared metrics around "mitigated risk factors" facilitates collective efforts
- Extension of the care management from Medicaid managed care
- Outreach and structured SDOH reinforcement for those who are health home eligible

NYS Facilitators for P-HUB Approach to MCH Population

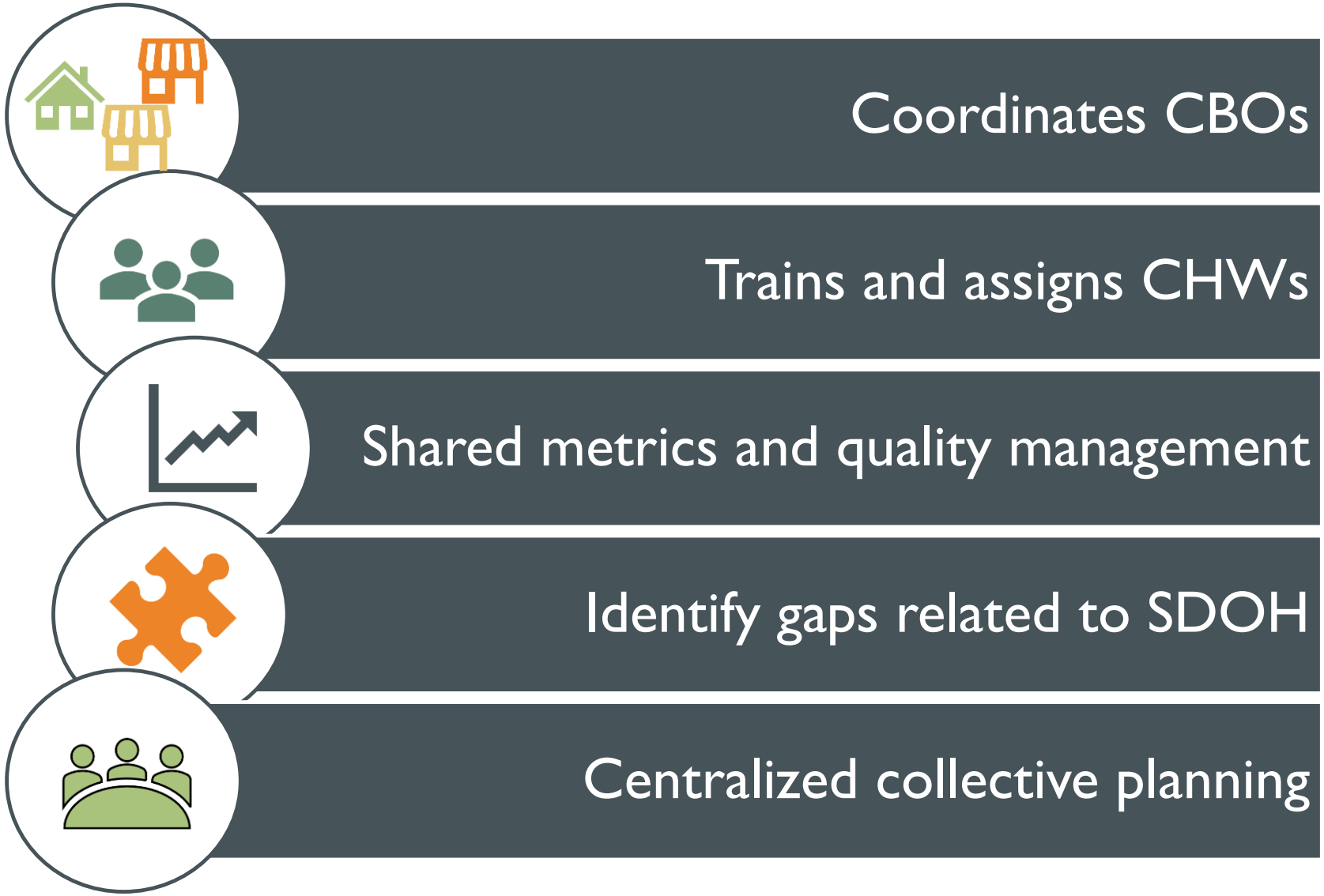
- NYS DOH policies driving CBO engagement
- Required Tier I involvement for contracts under VBP
- Promotion of CHWs
- First 1,000 Days on Medicaid Initiative
- Doula program (now billable!)
- The Maternity Bundle

P-HUB Infrastructure for CBO Contracting

HUB facilitates contracting with multiple payers;
braids and blends funds from an array of sources.



The HUB: Infrastructure for CBO Coordination & Quality Management



Pathways in Brooklyn: P4P methodology based on risk reduction

Outreach to the highest risk individuals and support the whole family

Shared risk screening tool identifies "pathways" for risk reduction

Assessments of health, behavioral health, and social risks

Tracks each identified health risk as a standardized *Pathway* for connection to evidence-based and best practice interventions

Home visits and relationship building in community settings (wherever and whenever)

Payment for Pathways, once risks are mitigated, which trigger payment and collect data

Journey to a Pathways HUB in Brooklyn

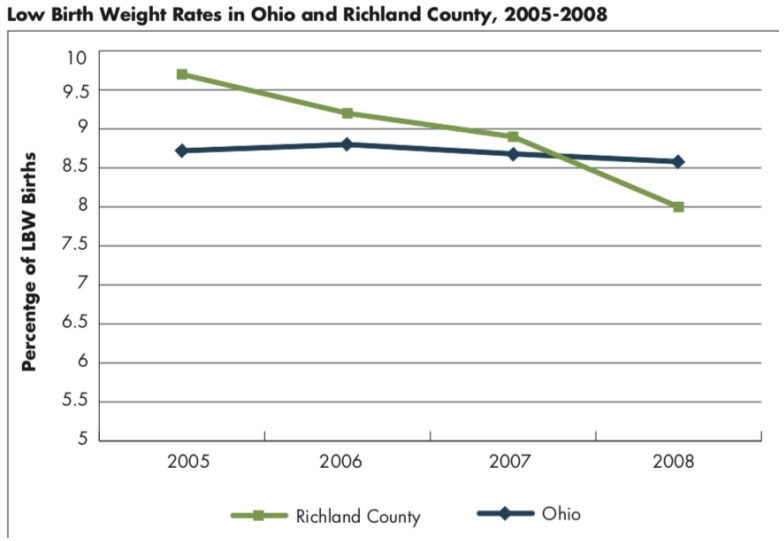
- 2018
  - Members of CLT community sponsored team of CBOs attend CJA Conference
  - CLT presents Brooklyn Hub Proposal Concept to local healthcare stakeholder leadership
  - Maimonides Medical Center hosts a Feasibility Study to explore the applicability of the Pathways Hub in the New York City environment
  - CLT meets with NYS Medicaid leadership and is invited to submit a proposal for consideration that could intersect with the NYS Value Based Payment Maternity Bundle, Health Home Program and First 1000 Days Initiatives
  - CLT and HMA utilize Study findings to further flesh out proposal concept
  - CLT meets with Managed Care Organizations to discuss opportunities for Value Based Payment engagements
  - CLT meets with local elected officials to present HUB Proposal Concept
- 2019
  - CLT hosts the 2019 Community Maternal Health Forum: A Community Response to Addressing Maternal Morbidity and Mortality sponsored by NYS Assembly Member Tremaine Wright, City Council Member Helen Rosenthal and Brooklyn Borough President Eric Adams
  - CLT has conversations with NYSDOH Office of Health Insurance, Bureau of Social Determinants and Bureau of Women, Infant and Adolescent Health

What's in it for Central Brooklyn?

- Comprehensive family-centered support with cross-sector care coordination with medical and behavioral health, social service and CBO delivery systems
- Robust community-based support via relationships with community health workers and CBOs
- Effective coordination with NYS and NYC Department of Health Programs
- Effective coordination and integration of community based Doula services
- Increased Health Equity
- Improved Maternal and Child and Overall Health outcomes
- Improved social determinant related outcomes
- Expanded local workforce opportunities within the health and social service sector
- Expanded available health and social determinant related data to help shape local policy, programming, services, research and resources

What's in it for Women and Children?

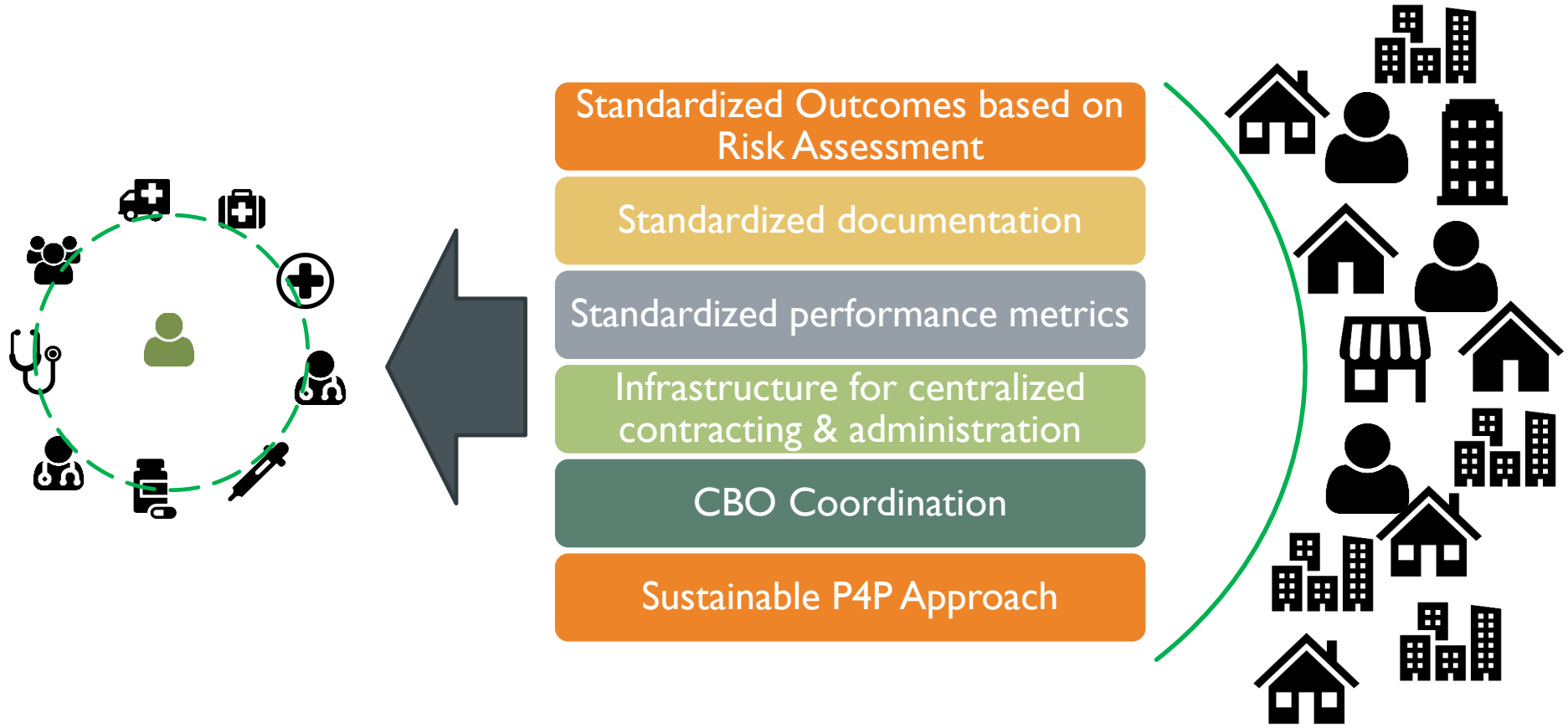
- **Improved outreach** from a coordinated network of CHWs well connected to the delivery system
  - Black women in NYC are facing significant and unique disparities in maternal health outcomes
  - *Black women are **12x more likely to die** from pregnancy-related causes than white women*
- **"Whatever it takes" effort to mitigate health risk factors**
  - Neighborhoods at highest risk for maternal death and maternal morbidity also have many community-level concerns, like housing and jobs
  - Strategies to address these disparities should be addressing the social determinants of health at play in affected communities
  - Culturally competent care coordination provided by local agencies and CHWs who understand neighborhood environments and traditions that impact quality of life and care



*"Pregnant women who participated in CHAP, a structured community-based care coordination program provided by CHWs and coupled with Pathways tracking and payment for outcomes, had a **significantly lower probability of delivering a LBW infant**."*

What's in it for Brooklyn CBOs?

Sustainable Administrative and Service Infrastructure, Coordination and Capacity for CBOs



WHAT'S IN IT FOR MCOS?

Improved Outcomes

Retrospective Cohort Study

- 3,702 deliveries in Health Council of Northwest Ohio
- All deliveries between March 2013-February 2017
- Variables included: mother's age, race/ethnicity, gestational age, birthweight, and whether the baby needed neonatal care.

Methodology

- Bivariate and multivariate analysis to identify odds ratios for Neonatal/NICU Admission by select predictors for all deliveries and separately for deliveries to high-risk, moderate-risk, low-risk, and unknown risk mothers in the service area.

Results of Community Hub Enrollment	
High Risk Pregnancy	Significantly less chance of neonatal admission
All Risk Levels	Approached significance in reduced chance of neonatal admission

Source: Lucas, B., Detty, A. "Improved Birth Outcomes through Health Plan and Community Hub Partnership." December 2018. BuckeyeHealthPlan.com.

What's in it for MCOs?

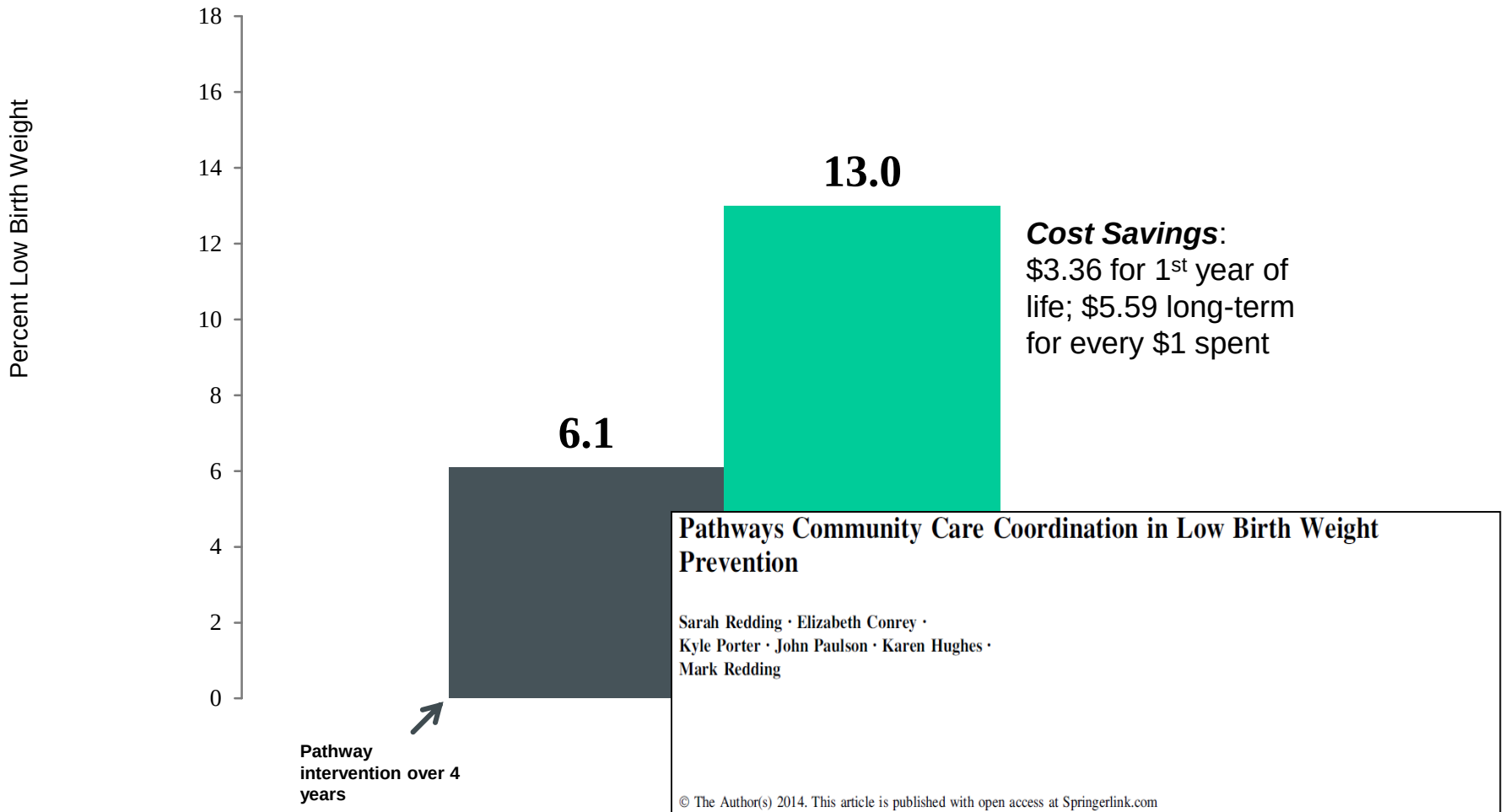
Return on Investment

For every dollar spent on Community Hub activities, there was a savings of $2.36. ROI: 236%

- High risk: PMPM cost savings of **$403**
- Medium risk: PMPM cost savings of **$252**
- Low risk: PMPM cost savings of **$171**
- High risk have highest cost savings through inpatient services (94%)
- High risk: inpatient PMPM cost savings of **$379**

Source: Lucas, B., Detty, A. "Lower First Year of Life Costs for Babies through Health Plan and Community Hub Partnership." December 2018. BuckeyeHealthPlan.com.

First Published Study on Results



Cost Savings: $3.36 for 1st year of life; $5.59 long-term for every $1 spent

Pathways Community Care Coordination in Low Birth Weight Prevention

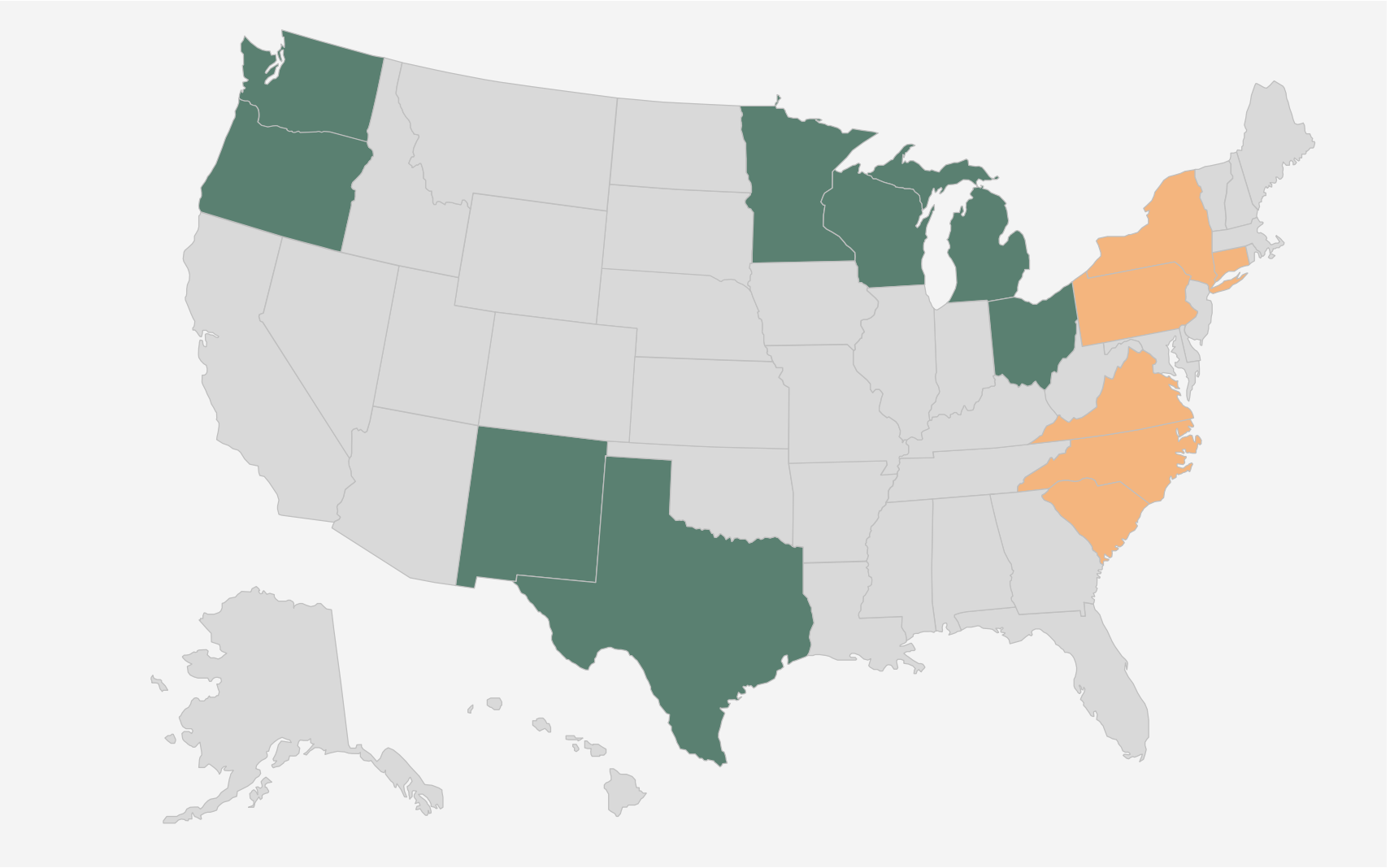
Sarah Redding · Elizabeth Conrey · Kyle Porter · John Paulson · Karen Hughes · Mark Redding

Abstract The evidence is limited on the effectiveness of home visiting care coordination in addressing poor birth outcome, including low birth weight (LBW). The Community Health Access Project (CHAP) utilizes community health workers (CHWs) to identify women at risk of having poor birth outcomes, connect them to health and social

Women participating in CHAP and having a live birth in 2001 through 2004 constituted the intervention group. Using birth certificate records, each CHAP birth was matched through propensity score to a control birth from the same census tract and year. Logistic regression was used to examine the association of CHAP participation

PHUB Recognition

TRIED AND TESTED



Active HUBs

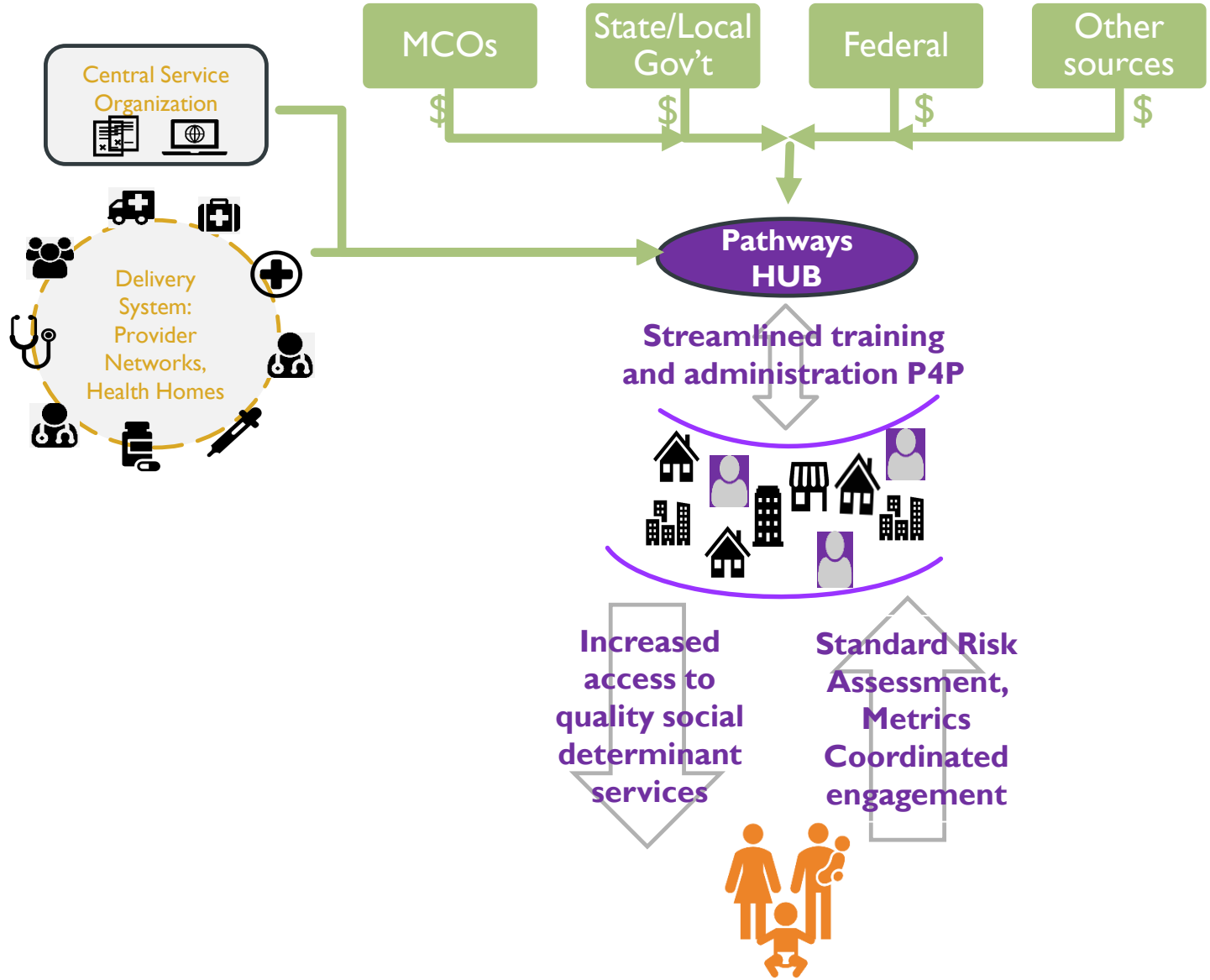
Ohio, Michigan, Washington, Oregon, Texas, New Mexico, Wisconsin, Minnesota

Developing HUBs and Pathways Programs

Pennsylvania, New York, North Carolina, South Carolina, Connecticut Virginia

There are 4-5 other states in an exploratory Phase

Feasibility Study→ Design for this Pilot



Journey to a Pathways HUB in Brooklyn

- Challenges faced in obtaining support
- Challenges faced in obtaining financing

Journey to a Pathways HUB in Brooklyn

- Strengths (our recommendations)

CONTACT

NGOZI MOSES
Executive Director
Brooklyn Perinatal Partnership
nmoses@bpnetwork.org

CHERYL HALL
Executive Director
Caribbean Women's Health Association
chall@cwha.org

HEIDI ARTHUR
Principal
Health Management Associates
harthur@healthmanagement.com