The Better Health Pathways HUB

Virtual Annual Report to the Community-2020
3rd in a Series

August 26, 2020

Better Health Partnership
Collaborating for a healthy community

Welcome!

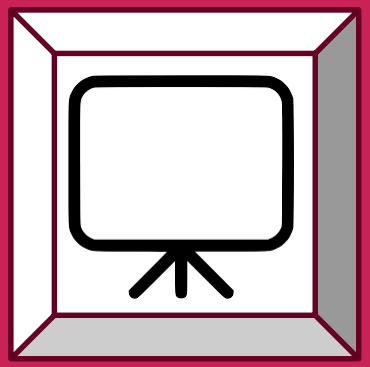
Donald Ford, MD
Chief Medical Officer
Better Health Partnership

Before we begin…

Everyone will be muted.

Submit your questions via the "Chat" window.

We will do Q & A at the end.



Presentations will be posted on our website.

Working together since 2007….

to collectively improve health and reduce health disparities

Better Health Partnership

Vision

Northeast Ohio is one of the healthiest places to live and best places to do business

Mission

We bring health care providers, social services, and other sectors together, to share best practices and accelerate data-informed improvements in equitable population and community health.

Better Health Partnership's Population Health Improvement Priorities *"Twinkle to Wrinkle"*

Infant & Maternal Health (2018 - present)	Children's Health (2016 - present)	Adult Health (2007 - present)
Extreme Prematurity	Obesity, Asthma	Hypertension Diabetes Colorectal Cancer Screening
	Mental/Behavioral Lead Exposure	

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Pathways HUB integrates with all to address SDOH/ improve outcomes

Better Health PATHWAYS HUB Serving Cuyahoga County

The Better Health Pathways HUB
Strategic Partnerships

HUB Care Coordination Agency Partners

Care Alliance Health Center
Care for you. Care for me. Care for a

Carmella Rose Health Foundation

Neighborhood Family Practice
COMMUNITY HEALTH CENTERS

MetroHealth

nli neighborhood leadership INSTITUTE

NEON
NORTHEAST OHIO NEIGHBORHOOD HEALTH SERVICES, INC.

BIRTHING BEAUTIFUL COMMUNITIES

THE CENTERS
HEALTH • FAMILY • WORK • HOPE

Circle Health Services

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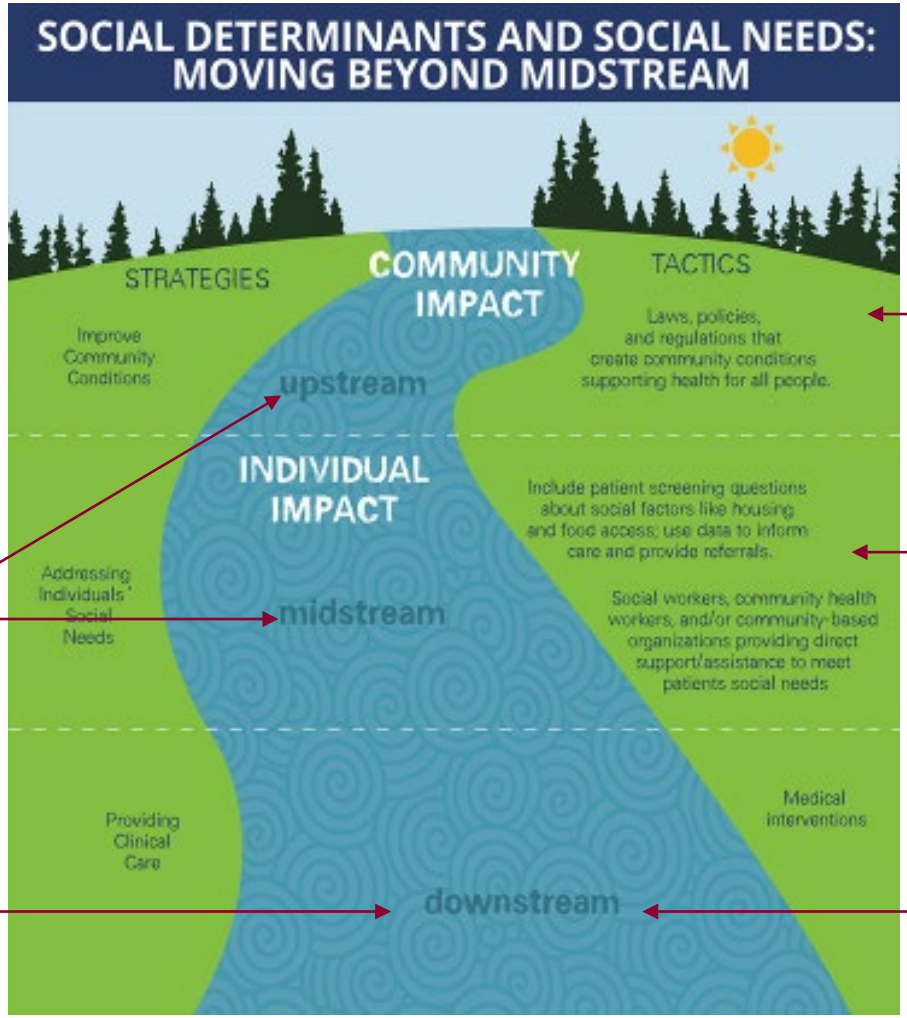
Moving upstream for better health equity and outcomes



80% influence on health

20% influence on health

Pathways HUB Strategic Partnerships:

Upstream Community Impact:
Cross-sector community strategies, policy and advocacy

First Year Cleveland
Lead Safe Cleveland Coalition

Midstream Individual Impact:
Community Health Workers connect clients to resources for social needs

High ED utilizers; homeless patients
Lead exposure- at-risk children
Infant mortality; racial disparities

Downstream Individual Impact:
Community Health Workers connect clients to health care; medical home

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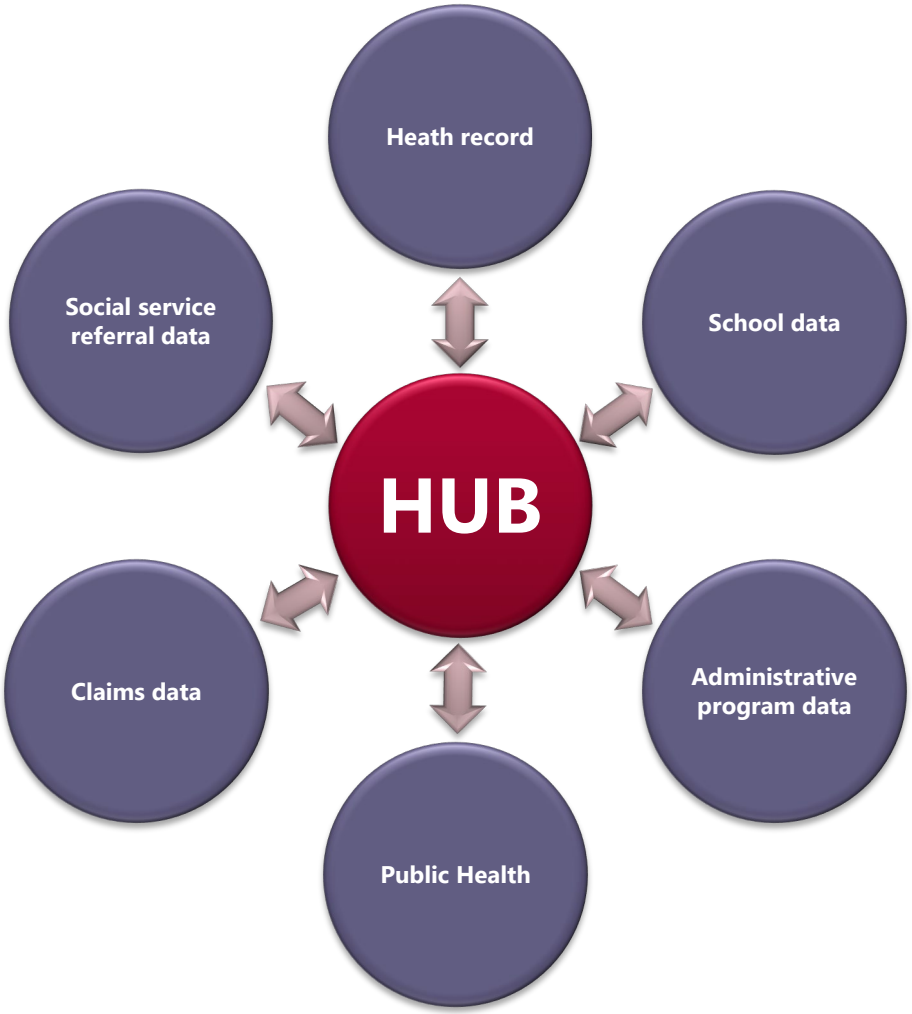
HUB Data Integration is Imperative for Better Care Coordination Across Sectors: *Community Information Exchange (CIE)*



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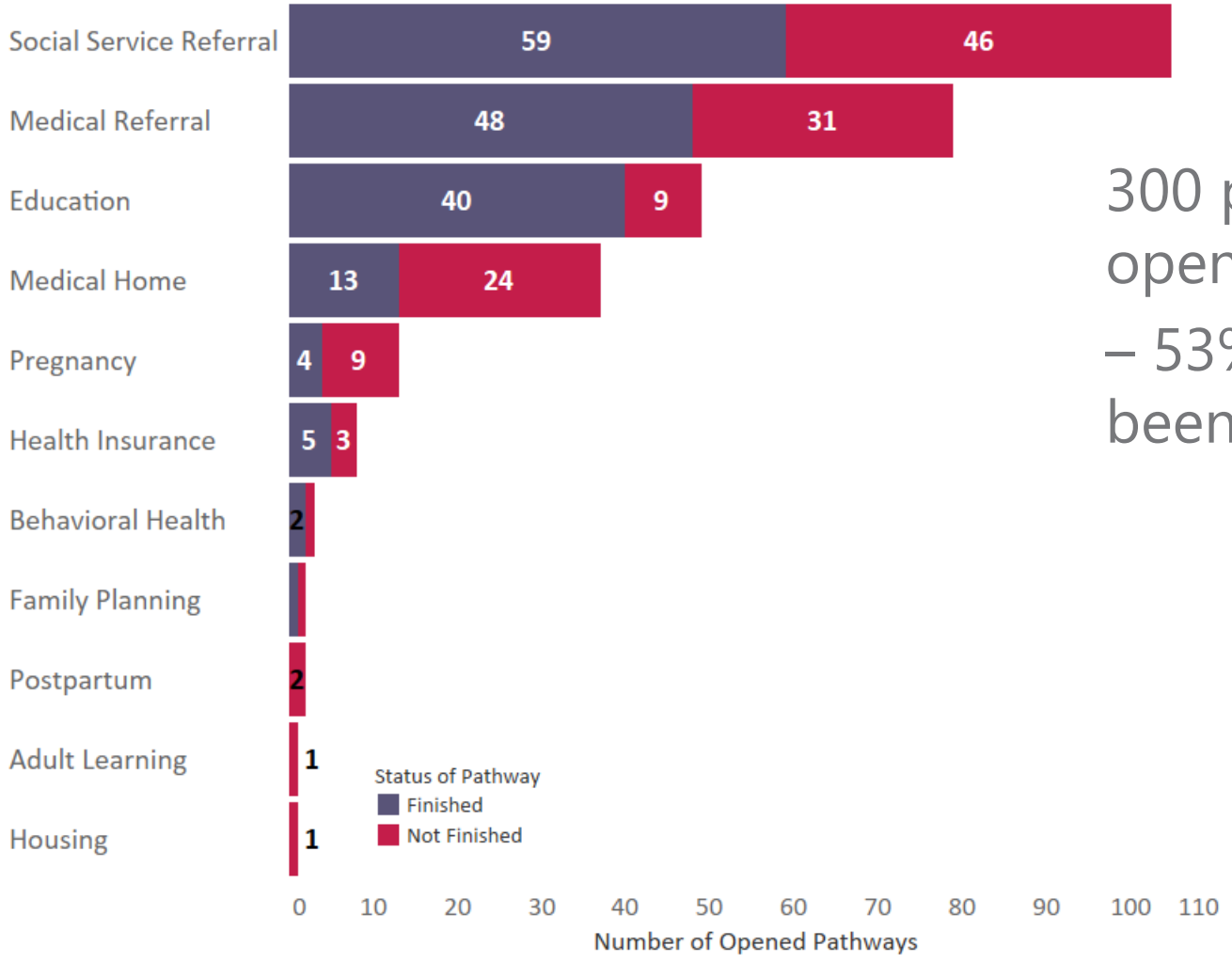
Early HUB Data: Pathways Opened



300 pathways opened

– 53% have already been completed

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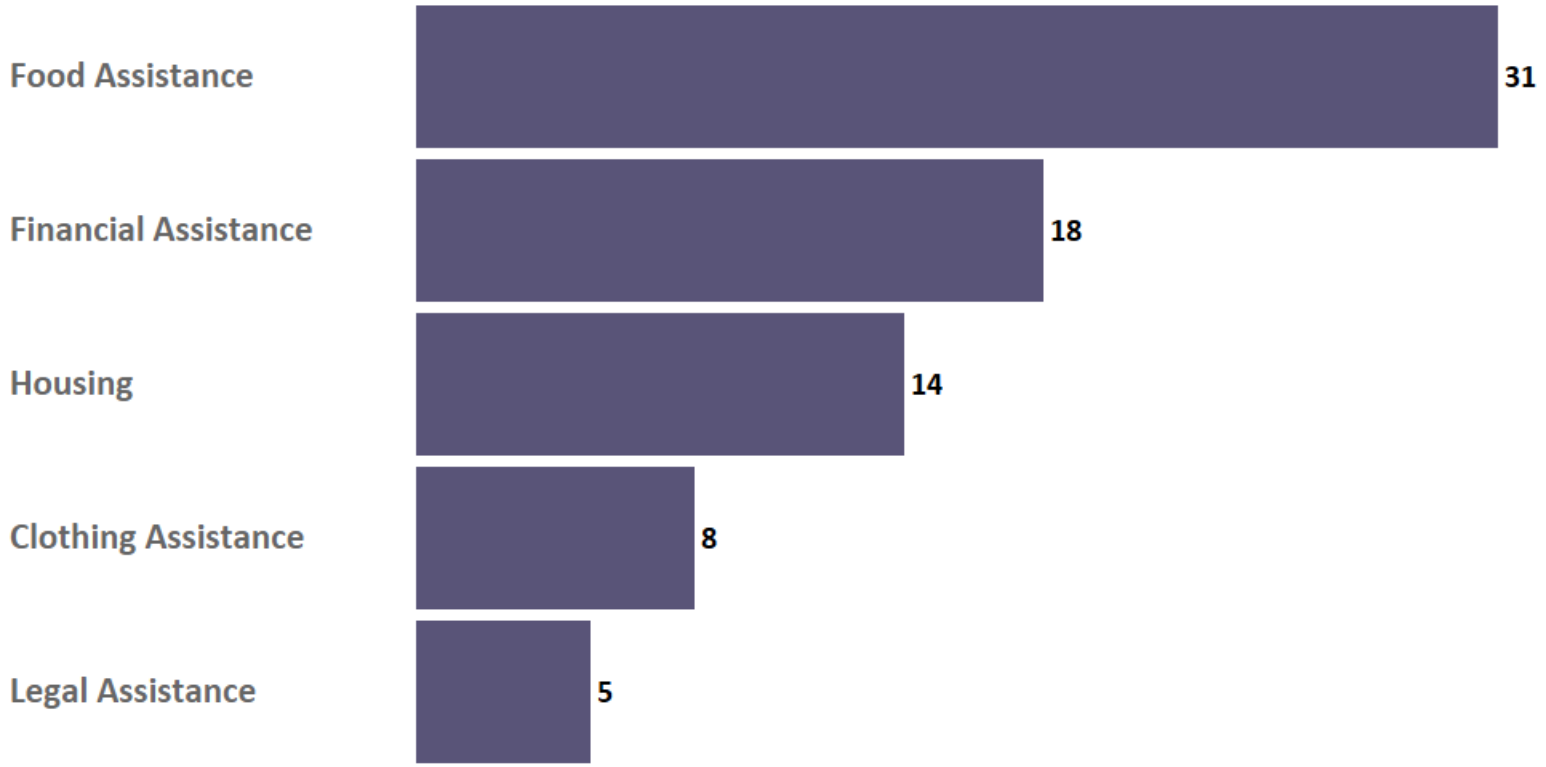
Early HUB Data:
Top Social Service Needs



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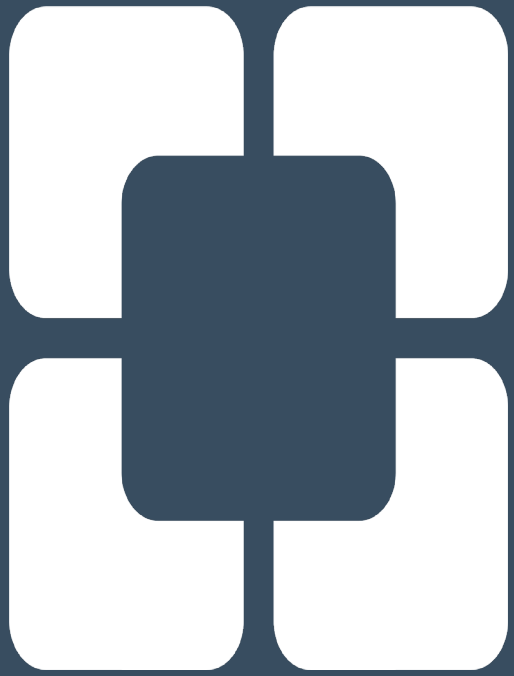
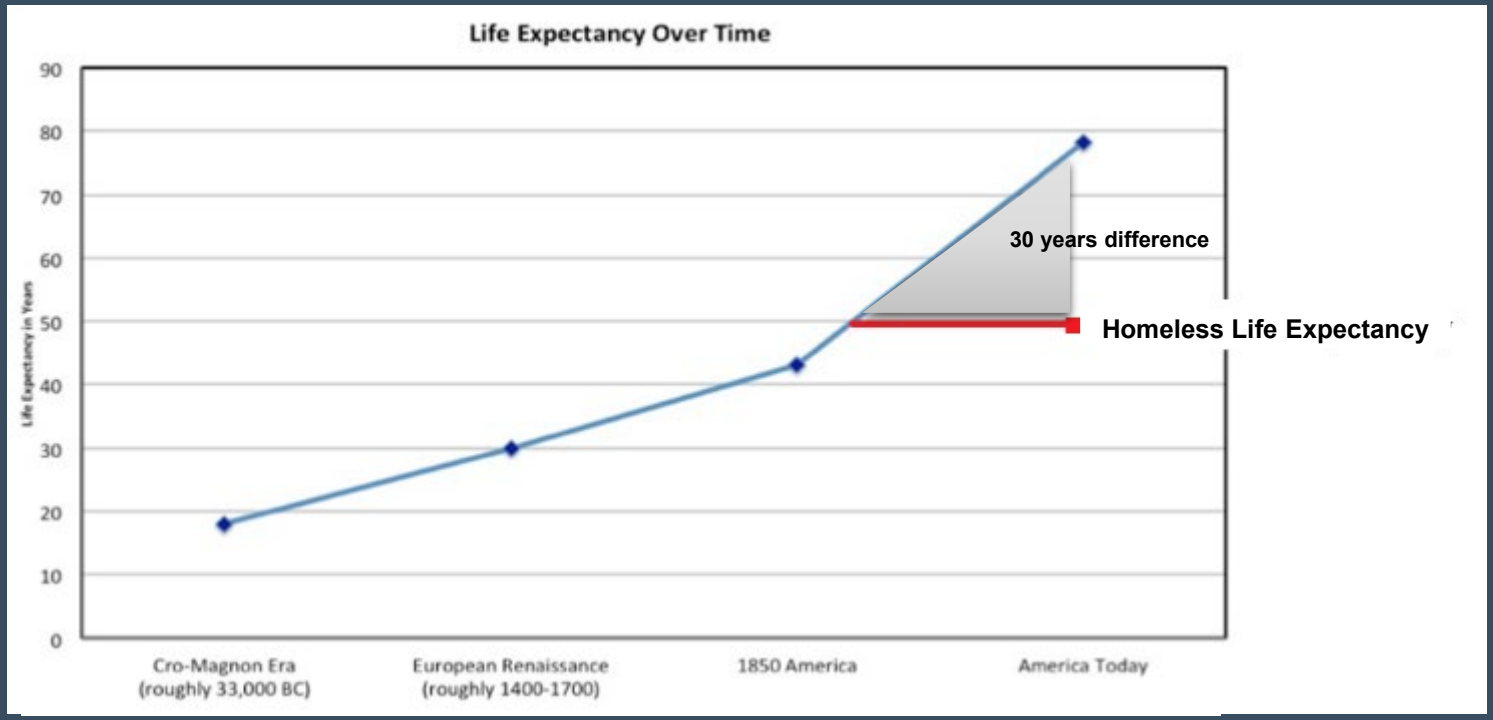
Jeremy Weleff, DO
Cleveland Clinic Health System

Impact on CCF High Utilizing Homeless Patients

Homelessness, Hospitals, and Housing
BHP – CCHS Pilot



Life expectancy in the developed world since Cro-Magnon man



This is a population that has not benefitted from the improvement in health that we enjoy living in the modern world

- Consistent across developed countries: England/France/Europe ~49 years, Toronto/Boston/North America ~48 years. In some places, life expectancy is closer to the low 40s.

The “Ownership” of Homelessness

- Government? Social Services? Community Organizations?
- What about when it has LARGE impact on health measures/outcomes/mortality?
  - Healthcare systems?
  - Public health?
- Multiple National & International examples of how healthcare systems/insurance companies have invested in housing for these patients to:
  - 1) improve health; 2) decrease cost

What do we need to do about this?

1. Effectively Identify Homeless Patients as they interact with the healthcare system – **Every Touch is an Opportunity**

2. Have **the services in place** to act on these opportunities to change lives / impact health by improving housing situations
   - Stronger Gov't/Community organizations links in hospitals?

3. Have established Healthcare/Governmental/Community connections in place to **bridge from Hospital/SNF to Housing**

Scope of the work so far…

- **Address field search – from 2014 to 2019**
  - **~7,500 patients identified as homeless by address**
  - **~70,000 ED visits; Patterns of high ED utilization**
  - **60% had psychiatry admission (12,884 admissions)**
  - **Children to Geriatric age**

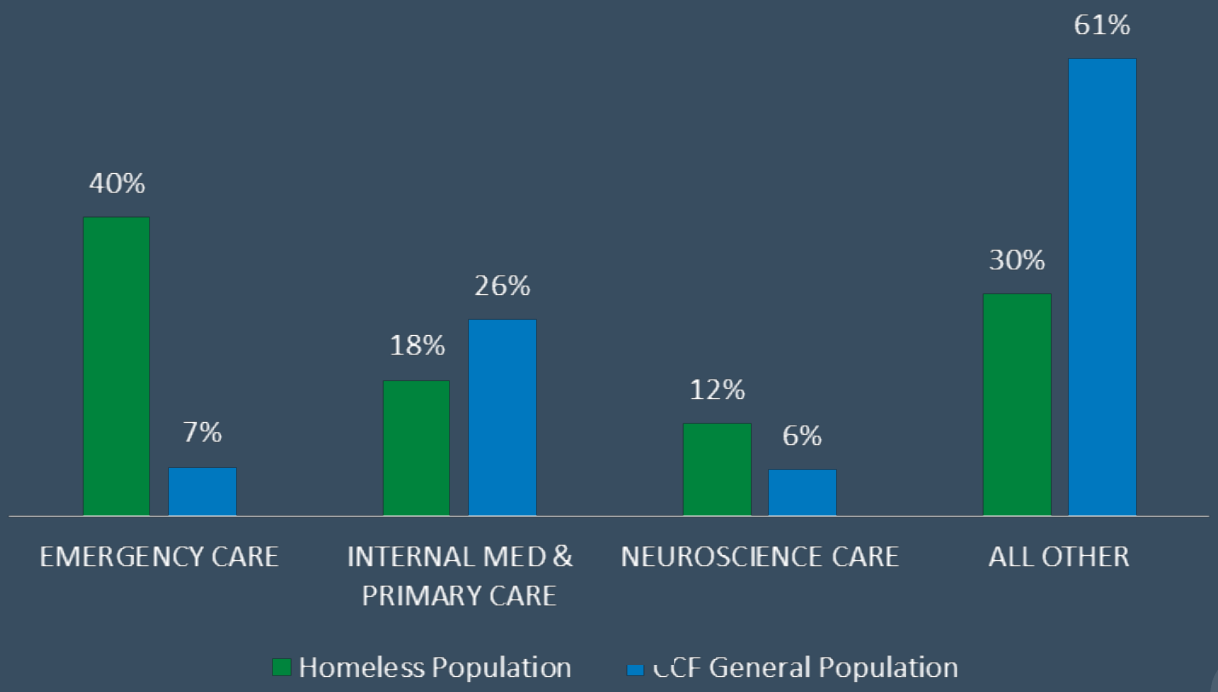
Age group at 1st ED encounter	
< 18 years	934 (12.3)
18 - 45 years	3,828 (50.5)
46 - 64 years	2,285 (30.2)
65+ years	529 (7.0)

ED Utilization	
Low (1-3 visits/year)	5,736 (75.6)
Moderate (4-9 visits/year)	1,559 (20.6)
High (10+ visits/year)	290 (3.8)

- **Registration Changes – from Sept/2019 to now**
  - **~2000 patients across the system identified since starting**

- **Numerous pilot projects related to Transportation etc**

Service Utilization by Population

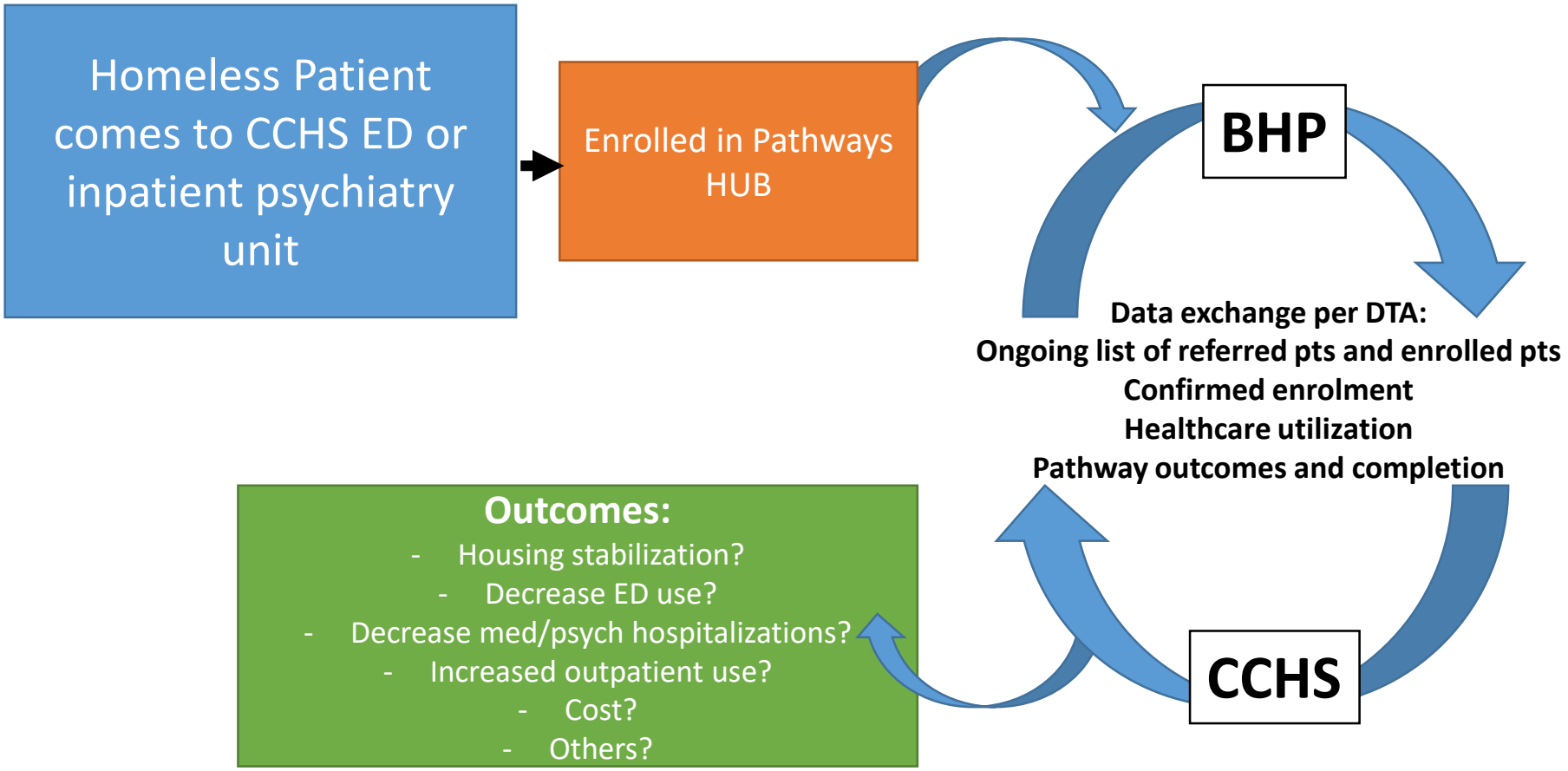


40% of homeless patients' encounters are in the Emergency Services Institute (~5x higher than overall average). Primary care is a smaller portion of the total care in this population than in the general population.

BHP/CCHS Pilot Overview

- 20 homeless patients from ED/Inpatient Behavioral Health
  - Linked with BHP through referral
- Followed by Community Health Workers (CHWs) through community organization (Carmella Rose)
- Ongoing data sharing to monitor completion of Pathways/Housing Pathway, Healthcare Utilization, costs

BHP/CCHS Pilot Overview



Rebekah Dorman, PhD
Director
Invest in Children; Cuyahoga County Office of Early Childhood

Impact on Lead Testing and Referrals to Early Intervention

Lead Exposure: Some Facts….

Still widespread, mostly from lead paint in deteriorating housing, also in the soil

- Disproportionately affects Black children
- 25% of incoming CMSD kindergartners have elevated lead (an underestimate)

  Despite Medicaid rules that mandate testing at ages 1 and 2, only 50% of the children were tested at age 1 and 34% of children at age two years.

Why Does This Matter?

Children with elevated lead levels are ***half as likely*** as their peers to score on track for language and literacy on the kindergarten readiness assessment, even after controlling for a range of background factors.

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Why so little testing if there is already a mandate?

- A policy is a starting place: it is not a guarantee.
- A combination of factors: some reside within health care systems and some with families
  - How is referral for test done?
  - Logistics of getting to the lab where it's done
  - Venous blood draw to confirm
  - Competing priorities for the family
  - Fear of stigma for child
  - Family may wonder: why do it?

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How will HUB help?

- The HUB will be able to identify families missing the test using data from participating health care practices and target them for the lead pathway, as well as assess other needs.

- Provide the trusted person to inform, support and help the family navigate the health care setting to ensure the lead testing happens.

- If there is an elevated lead level (above 5 µg/dL) there will be a warm hand off to Early Intervention.

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The Future:
What will Success Look Like?

- We are hoping that with the success of the Lead Safe Cleveland Coalition focused on prevention, soon the lead pathway will not be needed. We're tired of children being the canary in the mine…. With so many other challenges children in Cleveland face, this is one in our power to change.

- Until then, we want children at high risk to be tested and those with elevated lead to be connected with services, early intervention and other needed assistance when they enter school. There are clear metrics to show progress here and it is in our power to measure them.

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Connecting Children Across Pathways Improve Lead Testing and Referrals

In July, 2020, BHP joins Lead Safe Cleveland Coalition to improve lead testing rates and connections to developmental services for early intervention. Our partners include:

University Hospitals Rainbow Babies & Children's

MetroHealth

Neighborhood Family Practice COMMUNITY HEALTH CENTERS

Care Alliance Health Center
Care for you. Care for me. Care for all.

Bright Beginnings
grow • learn • develop

Invest in Children Cuyahoga County

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Karen Butler, MBA
Chief Operating Officer
Northeast Ohio Neighborhood Health Centers (NEON)

Care Coordination Agency Experience and HUB Impact on Infant Mortality

Infant Mortality- What We Know…

Infant Mortality is the death of an infant before his or her first birthday.

- Prematurity-related conditions remain the leading cause of death in Ohio.
- Sleep-related infant deaths are the second leading cause of infant deaths.
- Black infants still die at 2.5 to 3 times than white infants.

Why Should We Be Concerned about Infant Mortality?

The infant mortality rate is an important measure of how well a society cares for its women and babies and the overall health of a society. Infant mortality is everyone's problem and we can only solve it by working together at the community level.

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Northeast Ohio Neighborhood Health Services, Inc.
MOMS & BABIES FIRST PROGRAM
Ohio's Black Infant Vitality Program

- **Moms and Babies First** is a free voluntary program for eligible pregnant women that promotes healthy pregnancies and positive birth outcomes.
- The program supports and reinforces:
  - Infant and Toddler Development
  - Parenting Skills
  - The development of healthy behaviors (Healthy eating and nutrition, safe sleep, breastfeeding, immunizations, etc.)
  - Connecting to prenatal and primary care
  - Accessing in-home education during pregnancy and until the baby is a year of age.
  - Obtaining referrals for continued social services.

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NEON Teams up with other Care Coordination Agencies in 2020 to provide HUB services

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How Does the HUB Help?

- The Pathways HUB assists in meeting the needs of the client holistically, such as, housing, mental health, health insurance and educational needs etc.

- The Pathways HUB helps the community health workers to more effectively determine whether the issues presented by the client have been fully resolved.

- The HUB model is particularly helpful in minimizing the stress of the mom in meeting her basic needs. This supports the health of the mom and baby thereby contributing to healthier birth outcomes.

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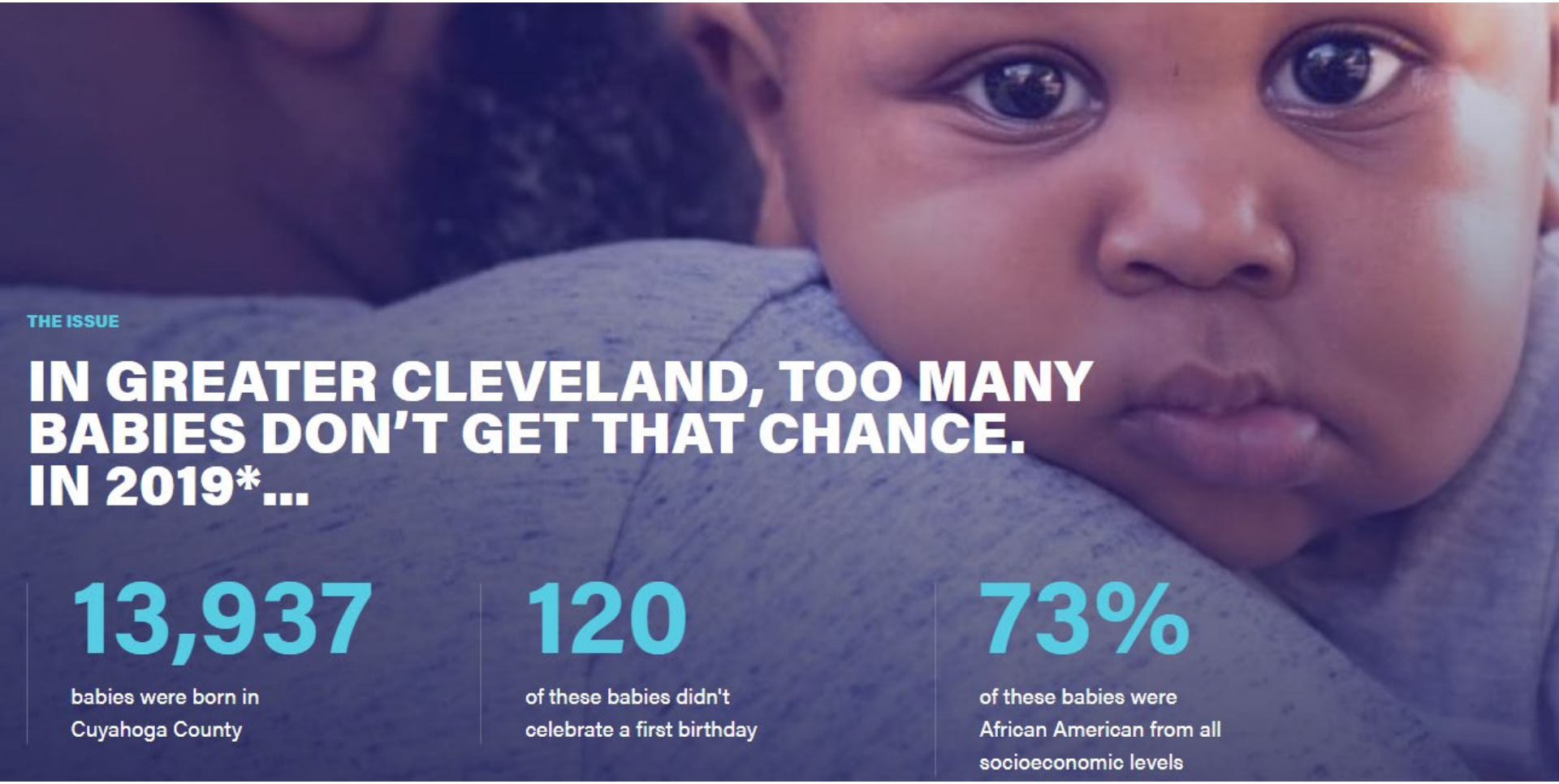
Pathways HUB and Infant Mortality



Source: First Year Cleveland

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Northwest Ohio Pathways HUB: Impact on Infant Mortality

Lucas County 2018 Buckeye Health Plan study

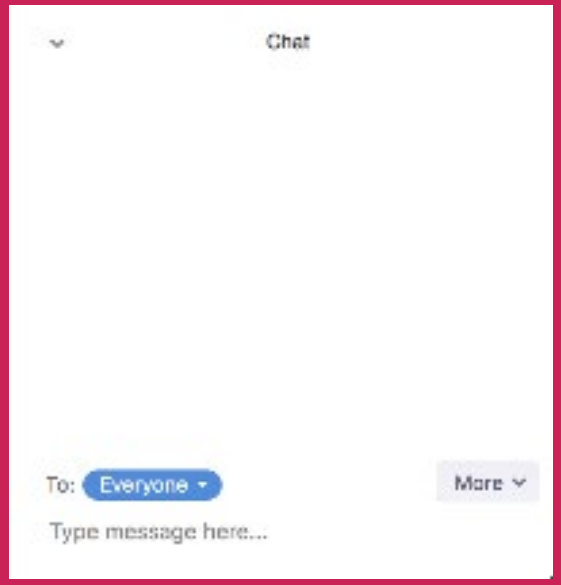
Infant Mortality in Lucas County

	Lucas County IM Rate 2017-2018	Pathways HUB IM Rate 2017-2018
African American/ Black	**15.2**	**8.7**
White	5.7	4.1
Other	6.5	N/A*
Total	8.5	6.9

High-risk mothers without HUB intervention were **1.55 times more likely** to deliver a baby needing Special Care Nursery or NICU care than those with HUB intervention

* Numbers too small to determine rate.

Questions?
Please submit through chat function



Register for Future Webinars

- **September 3**

  Prioritized Findings from First Year Cleveland's Action Team #4
  Extreme Premature Births

- **September 23**

  Prioritized Findings from First Year Cleveland's Action Team #1
  Patient Experiences; Racial Disparities

Need more information?

Please send your requests to Carol Kaschube ckaschube@metrohealth.org

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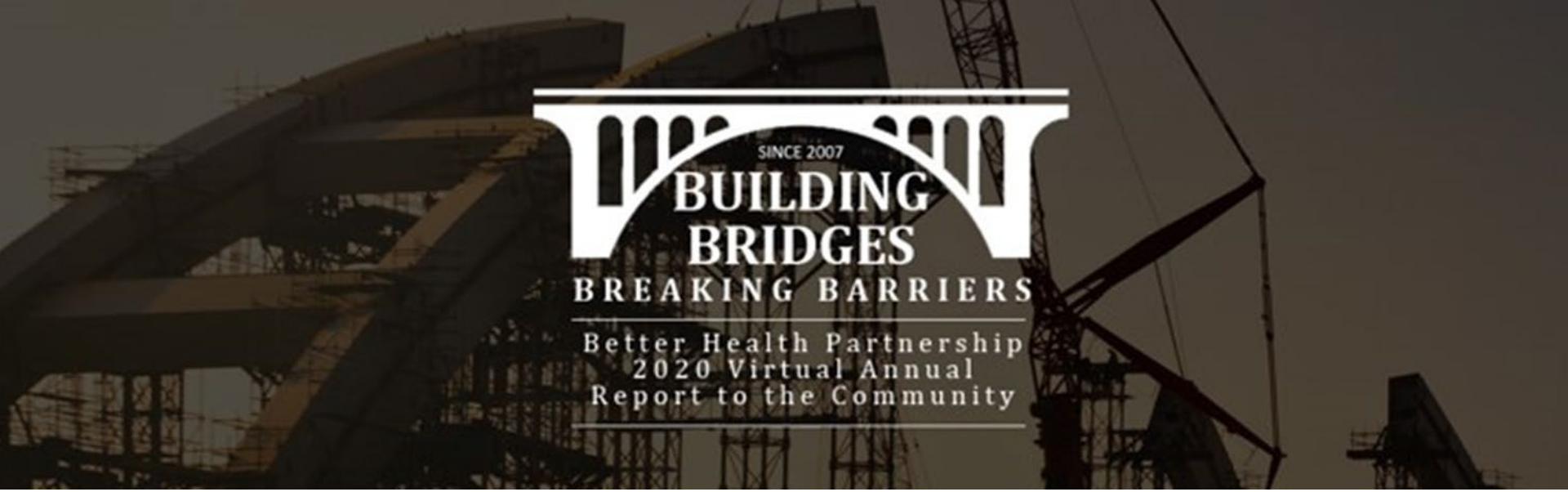

Thank You!

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www.betterhealthpartnership.org