



The Business of Medicine in Primary Care in the Era of COVID-19: Part 1

PUNTA CANA, DOMINICAN REPUBLIC

October 15, 2021
Dreams Punta Cana Resort
Playa Uvero Alto, Prov. La Altagracia
Dominican Republic

Jointly provided by:
Healthfirst, SOMOS Community Care, and
Albert Einstein College of Medicine — Montefiore Medical Center



The Business of Medicine in Primary Care in the Era of COVID-19: Part 1

PROGRAM OVERVIEW

This Continuing Medical Education activity is designed to update primary care and specialty practices on the evolving strategies for implementing value-based care, new primary care practice models, and evidence-based medicine to meet the needs of communities ravaged by the COVID-19 pandemic. The intent is to inform the attendees on best practices and innovations in addressing racial equity and the needs of special patient populations.

LEARNING OBJECTIVES

At the conclusion of the event, participants will:

- understand evolving models of value-based care
- recognize strategies for applying evidence-based medicine to communities impacted by COVID-19
- have learned best practices to identify and address health equity in the communities that they serve, using data to define standards of care
- adopt pragmatic tools and innovations to address the needs of patient populations

INTENDED AUDIENCE

Medical directors, physicians, physician assistants, nurses, nurse practitioners, health professionals, allied health professionals and workers, and practice and health organization leaders serving displaced, immigrant, and vulnerable patients.

ACCREDITATION STATEMENT

In support of improving patient care, this activity has been planned and implemented by Albert Einstein College of Medicine — Montefiore Medical Center, Healthfirst, and SOMOS Community Care. Albert Einstein College of Medicine — Montefiore Medical Center is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

DESIGNATION STATEMENT

Albert Einstein College of Medicine – Montefiore Medical Center designates this live activity for a maximum of *8.0 AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

SPECIAL NEEDS

Albert Einstein College of Medicine and Montefiore Medical Center fully comply with the legal requirements of the Americans with Disabilities Act. If you require special assistance, please submit your request in writing, *30 (thirty) days in advance of the activity*, to the CCME email address: cme@montefiore.org.

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DESIGNATION STATEMENT

The “Conflict of Interest Disclosure Policy” of Albert Einstein College of Medicine — Montefiore Medical Center, Healthfirst, and SOMOS Community Care requires that faculty participating in any CME activity disclose to the audience any relevant relationship(s) with an ineligible entity (pharmaceutical, product, or device company). Permission to present will be withdrawn from any person whose disclosed relationships create a conflict of interest with regard to their contribution to the activity.

Albert Einstein College of Medicine — Montefiore Medical Center, Healthfirst, and SOMOS Community Care also require that faculty participating in any CME/CE activity disclose to the audience when discussing any unlabeled or investigational use of any commercial product or device not yet approved for use in the United States.” Albert Einstein College of Medicine – Montefiore Medical Center: CCPD staff, has no conflicts of interest with commercial interests related directly or indirectly to this educational activity”.

REGISTRATION

If you need additional information or to register for the conference, please email LaToya Norman, Healthfirst, at lnorman@healthfirst.org or call 212-497-4827.

7:00AM—7:30AM	Registration
7:30AM—8:00AM	<p>Welcome and Greetings Ramón Tallaj, MD <i>Chief Executive Officer and Chairman, SOMOS Community Care</i></p> <p>Pat Wang <i>President and Chief Executive Officer, Healthfirst</i></p> <p>Introduction into the CME Activity and Announcements Susan J. Beane, MD <i>Executive Medical Director, Healthfirst</i></p>
Special Speaker	
8:00AM—8:30AM	<p>Archbishop Vincenzo Paglia <i>Grand Chancellor, Pontifical John Paul II Institute for Studies on Marriage and Family</i></p>
Keynote	
8:30AM—9:15AM	<p>Hypertension Management in the Era of Covid-19 Pandemic via the Lens of Health Equity Olugbenga Ogedegbe, MD <i>Professor of Population Health & Medicine, Chief Division of Health & Behavior and Director Center for Healthful Behavior Change in the Department of Population Health, New York University School of Medicine</i></p>
9:15AM—9:25AM	Question and Answer Session
9:25AM—9:35AM	Break: 10 Minutes

Panel 1: The Business of Medicine in Primary Care in the Era of COVID-19

Moderator: Jacqueline Delmont, MD, MBA, FACP, Delmont Medical Care

Primary Care in Post-COVID New York

Sherry Glied, PhD

Dean, Professor of Public Service, New York University, Wagner Graduate School of Public Service

9:35AM—11:00AM

Telemedicine for Primary Care vs. Specialty in Covid Pandemic: A Bird's-Eye View from a Multi-Specialty Group Practice

Henry Chen, MD

*President, SOMOS Community Care
Chief Executive Officer, Excelsior Integrated Medical Group*

Making the Change to Value Based Healthcare

Jason Helgerson

Founder and Chief Executive Officer, Helgerson Solutions Group

11:00AM—11:30AM

Question and Answer Session

11:30AM—12:30PM

Announcements & Lunch Break: 60 Minutes

Panel 2: Approaches to Addressing Behavioral Health Needs

Moderator: Victor E. Peralta, MD, Excelsior Medical IPA

Mental Health Integration into Primary Care in the Era of COVID-19

Victoria Ngo, PhD

Associate Professor, Department of Community Health and Social Sciences, Director, Center for Innovation in Mental Health, Director, Global Mental Health, Center for Immigrant, Refugee, and Global Health, City University of New York Graduate School of Public Health & Health Policy

12:30PM—1:30PM

Youth with a History of Childhood Trauma: Childhood Maltreatment

Angela Diaz, MD, PhD, MPH

Jean C. and James W. Crystal Professor, Department of Pediatrics and Department of Environmental Medicine and Public Health, Icahn School of Medicine, Director, Mount Sinai Adolescent Health Center, Mount Sinai

1:30PM—2:00PM Question and Answer Session

2:00PM—2:15PM Break: 15 Minutes

**Panel 3:
Equity in Health and Wellness: Healing and Transforming the System
To Deliver a Single Standard of Care**

Moderator: Lidia Virgil, SOMOS Community Care

2:15PM—3:45PM **Managed Care as a Partner in Advancing Equitable Care Models During the COVID-19 Pandemic**

Rashi Kumar, MUP

Director, Research and Policy, Healthfirst

From Policy Statement to Practice: Scaling Social Needs Screening and Outreach in a Large Urban Health System

Kevin Fiori, MD, MPH, MSc

Director, Social Determinants of Health, Office of Community and Population Health, Montefiore Health System

Rapid Transition to Telehealth and the Digital Divide: Implications for Primary Care Access and Equity in a Post-COVID Era

Ji E. Chang, PhD

Assistant Professor of Public Health Policy and Management, NYU School of Global Public Health

3:45PM—4:30PM Question and Answer Session

Putting It Into Action

4:30PM—5:00PM **What Now? Mitigating COVID-19**

Yomaris Peña, MD

*Director, Emergency Medical Response, SOMOS Community Care
Medical Director, YPP New Modern Medicine PLLC*

5:00PM—5:15PM Question and Answer Session

DISMISS SESSION



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ACCREDITATION STATEMENTS

CME Accreditation

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CONFLICT OF INTEREST STATEMENT

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Albert Einstein College of Medicine also requires that faculty participating in any CME activity to disclose to the audience when discussing any unlabeled or investigational use of any commercial product or device not yet approved for use in the United States. “Albert Einstein College of Medicine, CCME staff, has no conflicts of interest with commercial interests related directly or indirectly to this educational activity.”

*The ACCME defines a commercial interest as an entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients.” The ACCME does not consider providers of clinical service directly to patients to be Commercial Interest.



DISCLOSURES

The following course directors and planning committee members reported no conflict of interest in the last 24 months:

Course Directors

- Susan J. Beane, MD
- Allison Stark, MD, MBA

Planning Committee

- Alexandro Damirón, MBA
- Elizabeth Jean-Jacques, MPA
- Jacqueline Delmont, MD, MBA, FACP
- LaToya Norman, MPH
- Raymond Thornhill
- Lidia Virgil





DISCLOSURES

The following course directors and planning committee members reported no conflict of interest in the last 24 months:

- Ji E. Chang, PhD
- Henry Chen, MD
- Angela Diaz, MD, PhD, MPH
- Kevin Fiori, MD, MPH, MSC
- Rashi Kumar, MUP
- Victoria Ngo, PhD
- Olugbenga Ogedegbe, MD
- Yomaris Peña, MD



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DISCLOSURES

The following faculty has disclosed that they had financial relationships with ineligible entities in the past 24 months:

- Sherry Glied has been a Board member and owner of stock in NRX Pharmaceutical.
- Jason Helgerson has been a Consultant in the Helgerson Solution Group

They have attested that their presentations will be objective, fair balance and without commercial bias.



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EVALUATIONS

Your feedback is very important to us. Please complete your evaluation at the end of the activity.

CME Certificate

A certificate will be emailed to you after the activity.

THANK YOU!



Montefiore



Institute for Excellence in Health Equity
Email: ogedeo01@nyulangone.org
Phone: 646-501-3435

Hypertension Management in the Era of Covid-19 Pandemic via the Lens of Health Equity

Gbenga Ogedegbe, MD, MPH

Dr. Adolph & Margaret Berger Professor of Medicine
Director, Institute for Excellence in Health Equity
NYU Grossman School of Medicine

**The Business of Medicine in Primary Care
in the Era of COVID-19**
October 15, Punta Cana, Dominican Republic



Purpose and Objectives

PURPOSE *Re-imagining hypertension care models in the COVID-19 pandemic era.*

OBJECTIVES

1. Understand the effect of the COVID-19 pandemic on health equity.
2. Review innovative strategies for management of hypertension via a health equity lens during the pandemic.
3. Understand the community-clinic linkage as a value-based model for hypertension management in post-pandemic environment.

FINANCIAL DISCLOSURE

Funding from National Institutes of Health and the American Heart Association





Expertise



Expertise

Health Equity; Community-Engaged Research; Implementation Science

Research Focus

Strategies to narrow the racial gap in CVD morbidity & mortality in the U.S. and reduce CVD burden in Africa

Clinical Focus

Director, Hypertension Clinic, Bellevue Hospital

Committees, National Recognition & Honors

NIH/Fogarty International Center Board Member

Member, National Academy of Medicine

Member, U.S. Preventive Services Task Force

Co-authored over 300 pubs including scientific statements nationally and internationally

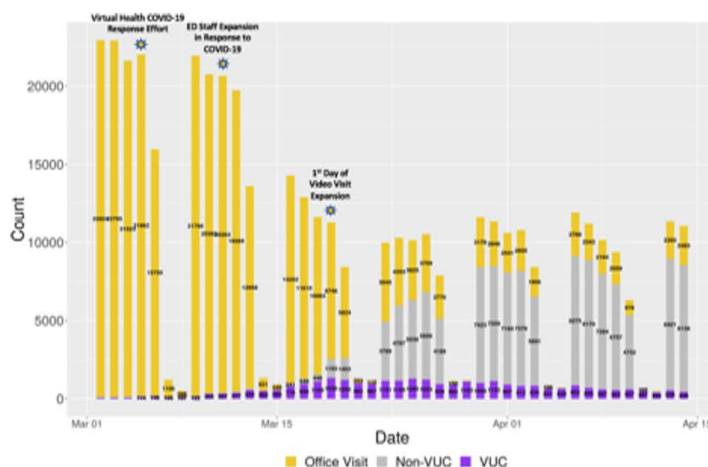
Numerous scientific awards and honors



Effects of COVID-19 Pandemic on Telehealth

- COVID-19 pandemic drove telemedicine use for urgent and non-urgent care
- At NYULH, 4345% increase in non-urgent care virtual visits between March and April 2020
- It remains unclear what impact this will have on care of patients with HTN nationwide

Telemedicine visit volumes increase in urgent and non-urgent care and decrease in traditional office visits



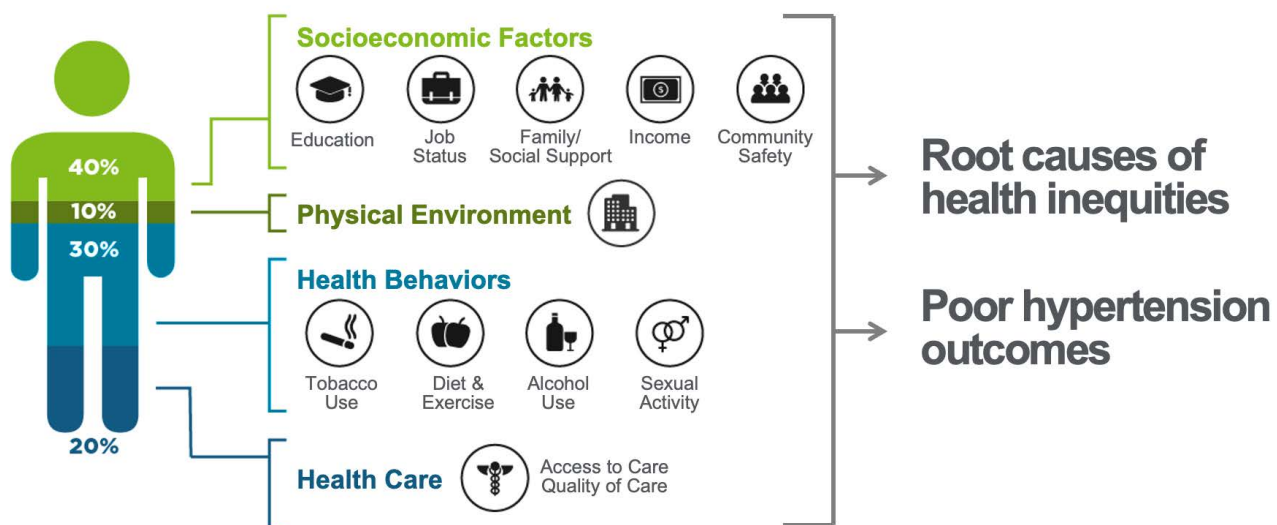


Management of HTN in the era of COVID-19 Pandemic

- Over 42% of US adults are projected to have hypertension by 2035.
- \$70 billion in costs estimated in 2015.
 - Projected to increase to \$150 billion by 2035.
- The pre-COVID cost of hypertension care is not sustainable.
- Increased utilization of telehealth has the potential to reduce the economic burden from costly hospital care attributed to poor hypertension control
- **In addressing telehealth capabilities during COVID-19 pandemic, health equity was not taken into consideration.**
- **What is missing is the health equity lens**

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Social Determinants of Health



Comodore-Mensah Y, et al. Associations between Social Determinants and Hypertension, Stage 2 Hypertension and Controlled Blood Pressure among Men and Women in the US. Am J Hypertens. 2021

National Academies of Sciences, Engineering, and Medicine. 2017. Communities in Action: Pathways to Health Equity. Washington, DC: The National Academies Press.



The Digital Divide is a Health Equity Issue

- Disparate access to technology such as telehealth platforms.
 - Disparate utilization of technology
- Sociocultural barriers
 - limited electronic skill
 - low health literacy
 - low income
 - limited English proficiency
- Structural barriers, including access to broadband capacity
- Access to computers and smart phones
- **At least 1 in every 4 Americans may not have digital literacy skills or access to internet-enabled digital devices to engage in video visits.**

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Advancing Hypertension Management as a Health Equity Issue

- 1** Programs designed to **achieve health equity must mitigate adverse effects of SDOH** that are pervasive in Black communities*
- 2** *Practices like CHCs must partner with Black & Hispanic communities* to develop and implement effective **multi-level strategies** that support adoption of evidence-based interventions
- 3** Health systems **must partner with payors to incentivize community-clinic linkage models** for prevention and management of hypertension in diverse populations
- 4** Researchers **must generate crucial policy and scale-up data to drive action** from stakeholders and policymakers

* National Academies of Sciences, Engineering, and Medicine. 2017. *Communities in Action: Pathways to Health Equity*. Washington, DC: The National Academies Press.

* Havranek et al. *Social Determinants of Risk and Outcomes for Cardiovascular Disease: A Scientific Statement From the AHA*. *Circulation*. 2015;132:873–898.

* Sampson U et al., *Reducing Health Inequities in the U.S.: Recommendations From the NHLBI's Health Inequities Think Tank Meeting*. *J Am Coll Cardiol*. 2016 Aug 2;68(5):517-524.

* Whelton PK et al. *NHLBI Working Group on Research Needs to Improve Hypertension Treatment and Control in African Americans*. *Hypertension*. 2016 Nov;68(5):1066-1072.

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Health



Two approaches that may help address the challenges posed by the COVID-19 pandemic are:

1. Widespread dissemination of home BP telemonitoring (HBTM) and telephonic nurse case management (NCM) in low-income populations
2. Adoption and implementation of community-clinic linkage models using team-based care

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Telehealth and Healthcare Disparities

- Black and Hispanic adults have poorer outcomes than Caucasians.
- Hypertension is a major predictor of racial disparities in CV outcomes including stroke.
- Home BP Telemonitoring (HBPTM) has proven efficacy in addressing multilevel barriers to HTN control.
- **Disparate access and utilization of telehealth platforms may exacerbate health disparities in this era of increased telemedicine.**

Sheinart KF et al. Stroke recurrence is more frequent in Blacks and Hispanics. *Neuroepidemiology*. 1998;17:188–98

Lisabeth LD et al. Ethnic differences in stroke recurrence. *Ann Neurol*. 2006;60:469–75.

Morgenstern LB et al. Excess stroke in Mexican Americans compared with non-Hispanic Whites: the Brain Attack Surveillance in Corpus Christi Project. *Am J Epidemiol*. 2004;160:376–83.

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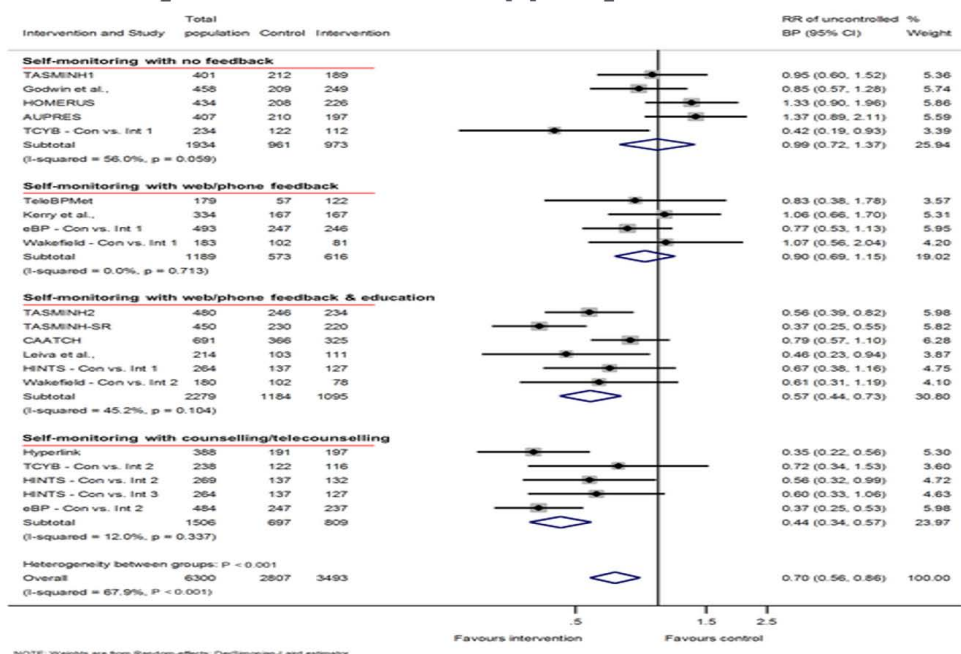
Home BP Monitoring and Multilevel Barriers to HTN Control

- HBPM facilitates improved HTN control by targeting multilevel barriers
 - Improved patient engagement
 - Adherence to medications and behavioral modifications
 - Improved clinician engagement via reduction in clinical inertia
 - Improved access to clinical care coordination
- HBPM with co-interventions yield significant BP reduction
 - Better effectiveness with tele-monitoring, telephonic or web-based patient counseling
- Integration of HBPM into routine practice is sub-optimal in low-income practices and minority patients

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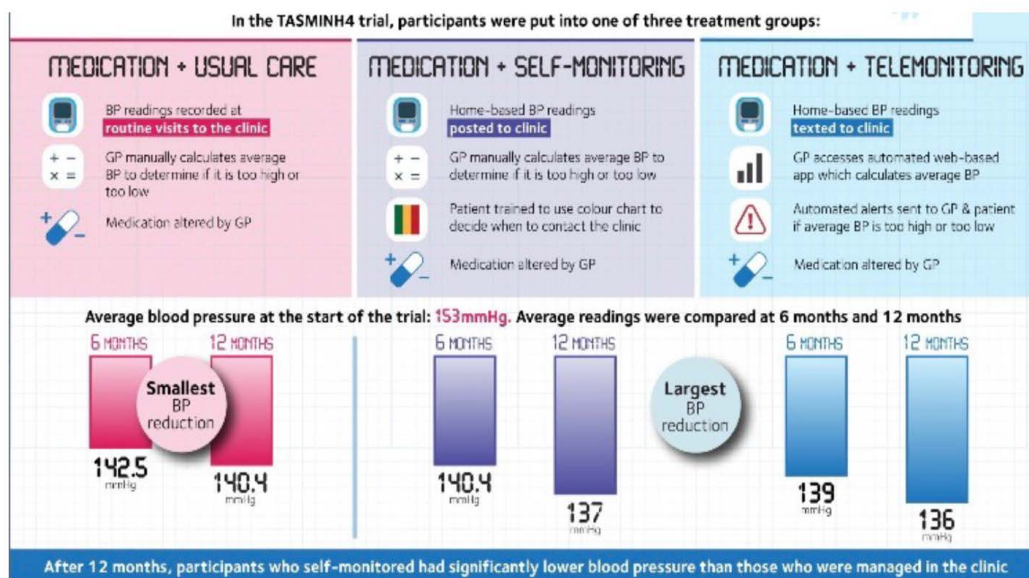


Effect of HBPM [with or without support] on the risk of uncontrolled HTN





Efficacy of HBPM with or without telemonitoring



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Key un-answered question: the role of HBPTM [telehealth] in improving BP control in low-income minoritized populations with significant comorbidity

- **Question:** What is the *comparative effectiveness* of HBPTM alone versus HBPTM plus telephone-based nurse case management [NCM] among Black and Hispanic stroke survivors with uncontrolled HTN?
- Multisite practice-based, comparative effectiveness study
- **Sample:** 450 patients recruited from stroke centers and primary care practices of 6 public hospitals and 3 academic centers in New York City.

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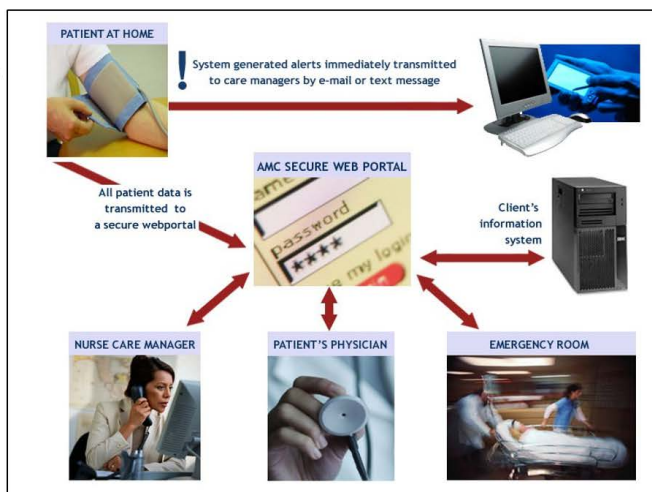
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Stroke Telehealth Study House Calls Telehealth Program (HBPTM+NCM)

HBPTM 3 days per week for 12 months

20 NCM calls over 12 months



Critical BP alerts are monitored

BP summary reports mailed to patients monthly to share with their provider(s)

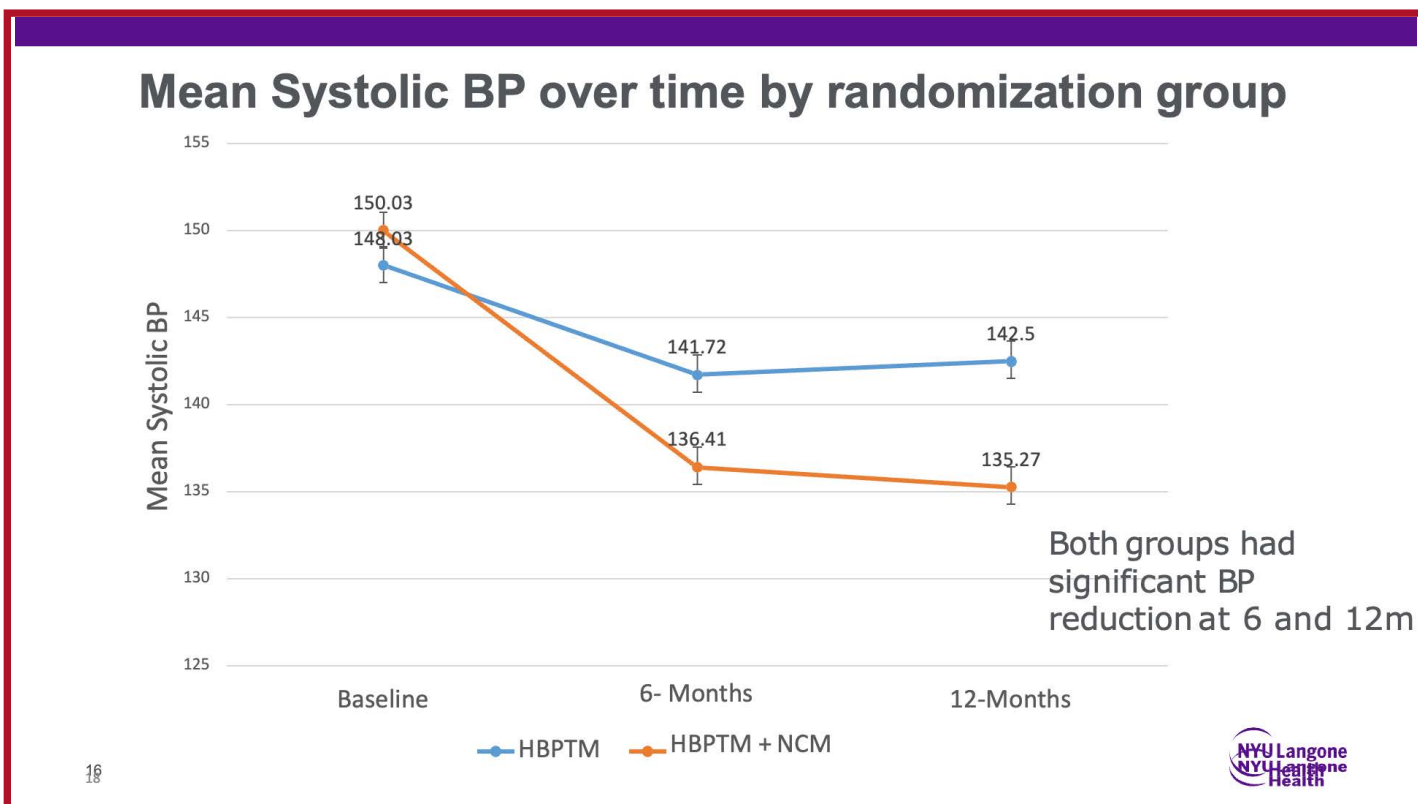
Spruill, T.M., et al. *Trials* 16, 97 (2015).
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Baseline Demographic Characteristics	TOTAL (N=450)	HBPTM (N=226)	HBTM+NCM (N=224)
AGE, Mean (SD)	61.7 (11.0)	61.1 (10.5)	62.3 (11.5)
SEX, Female (%)	44.4	42.0	46.9
RACE, Black (%)	51.3	46.9	55.8
LEVEL OF EDUCATION, \geq High School (%)	51.1	45.3	56.9
EMPLOYMENT STATUS, Employed (%)	18.1	20.0	16.1
YEARLY FAMILY INCOME, <\$24,999 (%)	72.2	72.6	71.9
LANGUAGE, English (%)	61.8	59.7	63.8
MARITAL STATUS (%)			
Single/Never Married	27.4	27.6	27.2
Married/Domestic Partnership	42.1	41.8	42.4



Baseline Clinical Characteristics	TOTAL (N=450)	HBPTM (N=226)	HBTM+NCM (N=224)
Systolic BP, Mean (SD)	149.02 (14.81)	148.03 (14.39)	150.03 (15.20)
Diastolic BP, Mean (SD)	87.82 (12.52)	87.95 (12.72)	87.69 (12.34)
BMI, Obese (>=30) (%)	45.8	45.1	46.5
STROKE TYPE, Ischemic (%)	76.4	77.0	75.9
MODIFIED RANKING SCORE, Mean (SD)	1.68 (1.05)	1.68 (1.06)	1.67 (1.04)
Positive Diagnosis of Diabetes (%)	48.0	49.6	46.4
CIGARETTE SMOKING STATUS (%)			
Currently Smokes	14.4	11.5	17.4
DRINKING STATUS (%)			
Currently Drinks	29.6	30.5	28.7
CHARLSON COMORBIDITY INDEX (%)			
No Comorbid Conditions	20.0	15.6	24.3
1-2 Comorbid Conditions	49.3	50.0	48.6
≥3 Comorbid Conditions	30.7	34.4	27.0





Conclusion

- A telehealth intervention which combines HBPTM with NCM led to greater SBP reduction than HBPTM alone.
- These findings provide strong empirical evidence for widespread implementation in low-income patients with multiple comorbidity
- Policy makers now have the needed evidence to implement HBPTM in low-income minority patients with significant comorbidity.

Use of HBPTM in routine practice: Still many rivers to cross

- **1st river** is assurance of patient confidentiality
- **2nd river** is the formulation of realistic reimbursement models for providers similar to use of glucometers in the management of diabetes
- **3rd and most important river** to cross, is restriction for direct transfer of HBPTM data to providers using valid data transfer protocols that protect patients' health information
- Privacy and security concerns prohibit automatic input of HBPM into most EMRs via web-based interfaces.
- This is a major barrier preventing the full realization of the HBTM as an effective tool for HTN management.



Implementation Challenges for Use of HBPTM

- Coverage of HBPM is variable among private payers and Medicaid programs
 - There are currently no national coverage determinations (NCD) or local coverage determinations (LCD) that address use of home BP monitors.
 - CMS recently finalized an NCD for ambulatory BP monitoring, but no coverage for HBPM.
- Once a HBPM is obtained by patient, clinical support services for use the data is lacking.
- Poor Internet access to transmit HBPM data to the clinic for virtual care.
- Lack of a private space in which to conduct the virtual appointment
 - Multigenerational household does not allow privacy – lack of privacy
- Lack of direct integration of HBPM data into most EMRs
- Poor integration of clinical decision support

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Implementation Opportunities in Minoritized Patient Populations

- Coronavirus Aid, Relief, and Economic Security (CARES) Act
 - \$1.32 billion toward COVID-19 response and maintaining CHC capacity.
- Restructuring of healthcare is essential for survival in days of COVID.
 - Expanded reimbursement to cover COVID-19-related services via telehealth
- Permanent formulation of realistic reimbursement models for Telehealth for non COVID-19 related services
- The most widely used health care performance metric [HEDIS] recently added the use of HBPM data to assess BP control.

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AJPH PERSPECTIVES

A Cross-Cutting Workforce Solution for Implementing Community–Clinical Linkage Models



See also Dasgupta, p. S174.

Federal agencies have identi- physicians in the United States they serve. These initiatives

serve. CHWs represent a cost-effective strategy to improve patients' self-management, adherence to treatment of chronic disease, and connections to community resources.^{4,5} However, information is lacking on how to integrate CHWs successfully into small, independently owned practice settings, which tend to lack the infra-

Nadia Islam, Erin S. Rogers, Antoinette Schoenthaler, Lorna E. Thorpe, Donna Shelley, "A Cross-Cutting Workforce Solution for Implementing Community–Clinical Linkage Models", *American Journal of Public Health* 110, no. S2: pp. S191-S193.

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What are community-clinical linkage models?

- Integration between healthcare and social services to address social determinants of health and achieve health equity is well stated by federal agencies.
- Community–clinical linkage models are partnerships to help connect
 - health care providers,
 - community organizations, and
 - public health agencies

To improve patients' access to preventive, chronic care, and social services.

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Actions to Decrease Disparities in Risk and Engage in Shared Support for BP Control in Blacks

- Improve BP control among Blacks via use of Practice Facilitation (PF) to implement a Community-Clinic Linkage Model (CCL) of 3 multi-level evidence-based interventions Peer Support and Community Engagement (PACE):
 - 1) Nurse Case Management
 - 2) Home BP Monitoring
 - 3) Community Health Workers
- **Sample:** 500 Black patients with uncontrolled in 20 practices

Components of PACE and timing of each component

1. Nurse Case Management (NCM)
2. Home BP Monitoring (HBPM) } Months 1-6



After 6 months, patients with uncontrolled BP (>140/90mmHg) are referred to CHWs

3. Community Health Workers (CHWs) → Months 6-12



SUMMARY

- Regarding the integration of home BP monitoring into routine practice, we have come a long way from demonstration of its efficacy to proof of its effectiveness
- Currently, most health systems use a combination of video and telephone visits
 - video communication is associated with higher patient understanding and satisfaction compared with telephone communication
- While HBPM is available in most households, use of HBPTM is sub-optimal.
- Integration of HTN management into existing practice workflow is sub-optimal
- HTN management algorithms should be integrated into EMR
- Community-based strategies must be taken into consideration and community-clinic linkage models are crucial in addressing equity in HTN management

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The RESTORE Network

Addressing Social Determinants of Health to Prevent Hypertension

Gbenga Ogedegbe, MD, MPH, FAHA, Coordinating Center Director

Dr. Adolph & Margaret Berger Professor of Population Health and Medicine
Director, Institute for Excellence in Health Equity

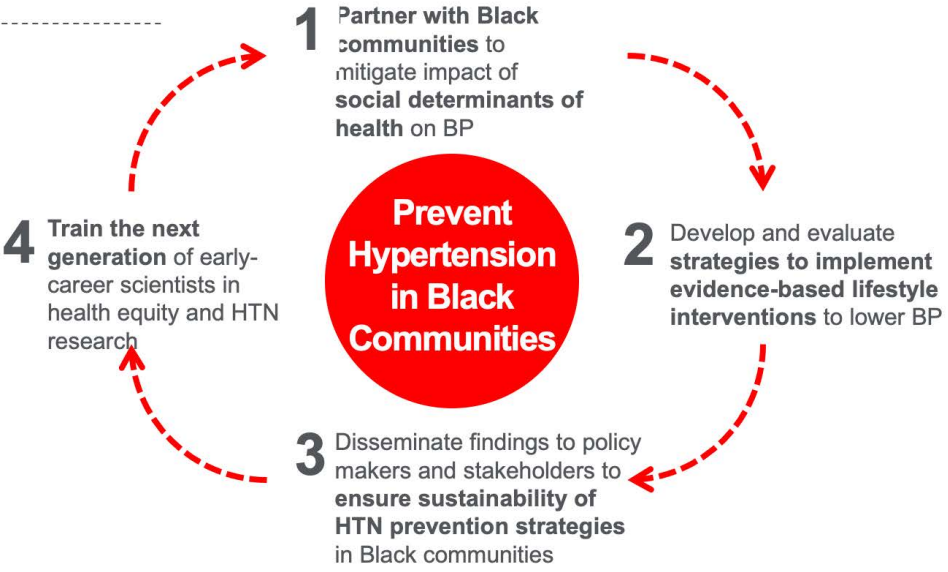
Tanya Spruill, PhD, FAHA, Coordinating Center Co-Director

Associate Professor of Population Health and Medicine

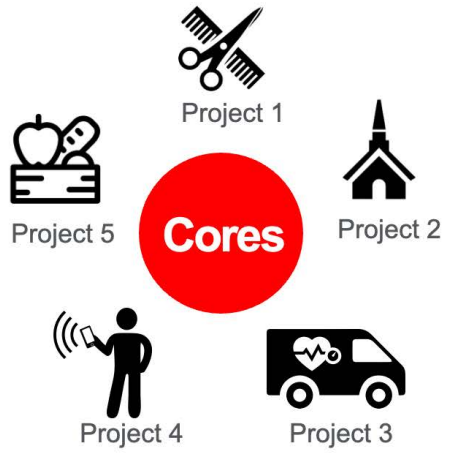
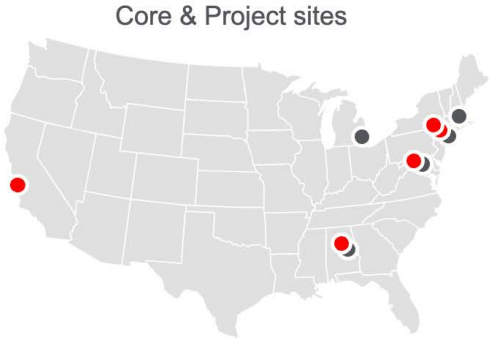


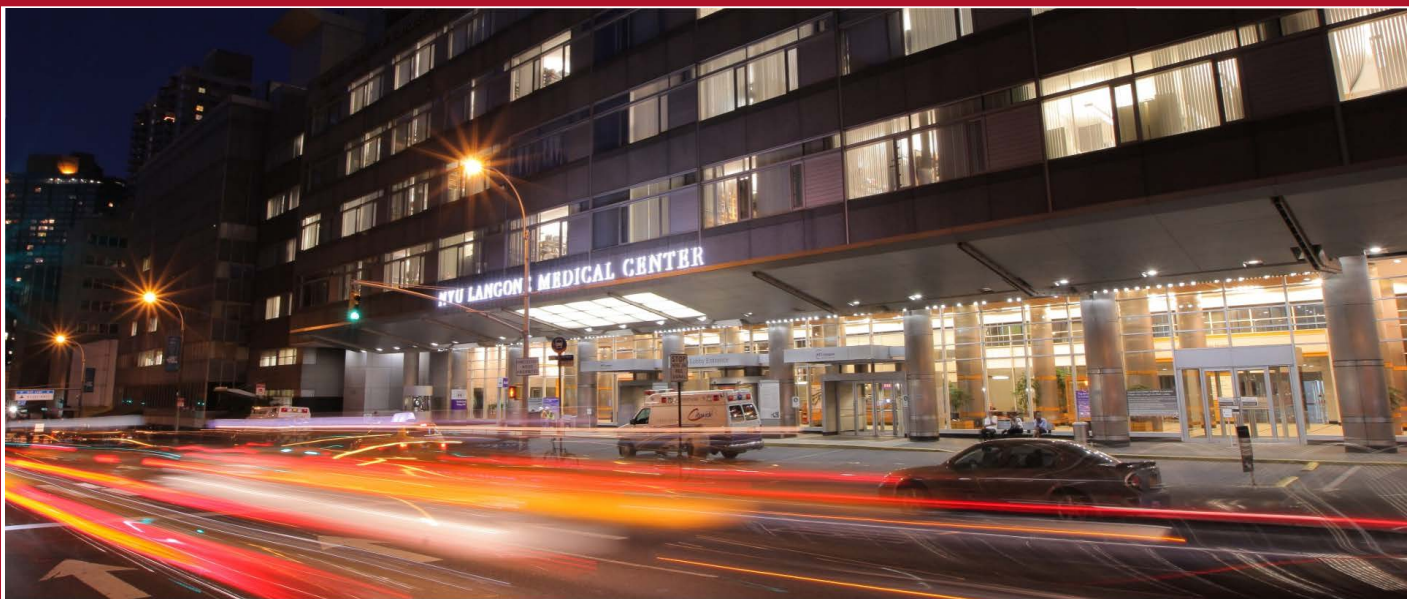


RESTORE Aims



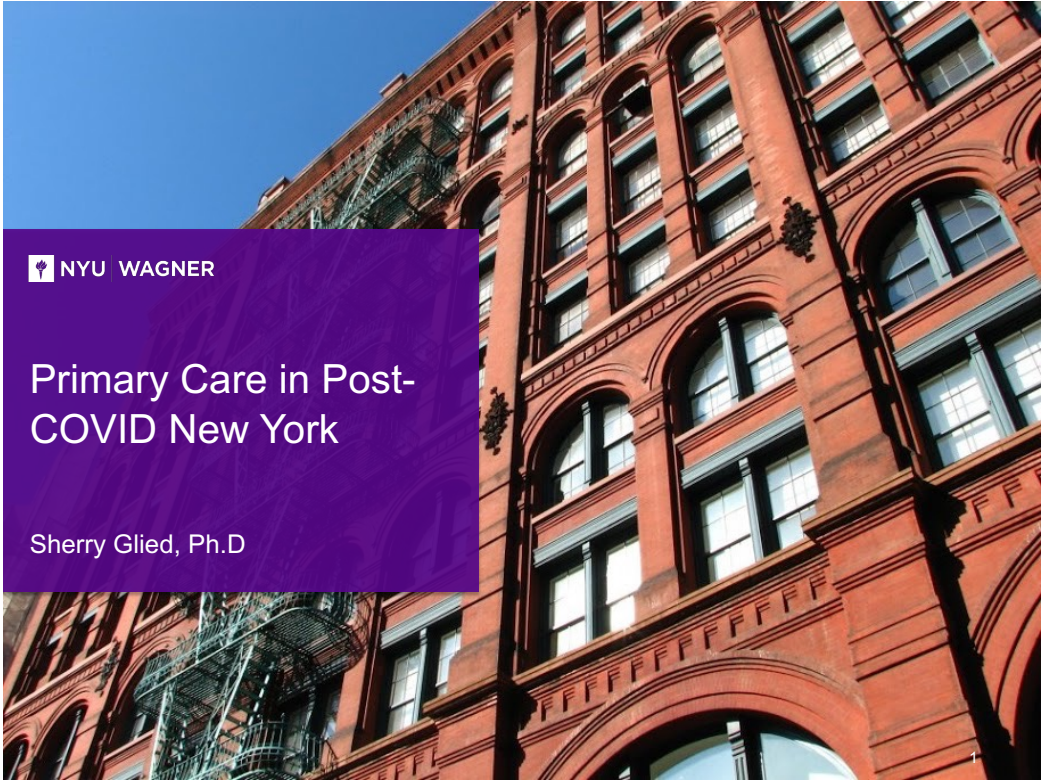
RESTORE Network





THANK YOU





 NYU WAGNER

Primary Care in Post-COVID New York

Sherry Glied, Ph.D

Purpose and Objectives

PURPOSE

Understand how the Context of Primary Care has Changed since the COVID-19 Pandemic

OBJECTIVES

- Understand how the payment, policy, economic, and technological contexts affect primary care
- Assess how these have changed since COVID-19
- Evaluate possible primary care responses

FINANCIAL DISCLOSURE

I am a member of the Board of NRXPharmaceuticals.



About NYU Wagner

- Since 1938, NYU's Robert F. Wagner Graduate School of Public Service has been preparing public service leaders to translate ideas into actions that have a lasting impact on the public good.
- We are ranked #2 nationally in Health Policy and Management among US Public Affairs and Policy Schools.
- Our three health-focused programs are an MPA in Health Policy and Management, a fully-online MHA program, and our newly launched MS in Health Law and Strategy (joint with NYU Law School)

Contact Information

Sherry Glied

Dean and Professor of Public Service

Robert F. Wagner Graduate School of Public Service, New York University

Sherry.glied@nyu.edu

212-998-7527

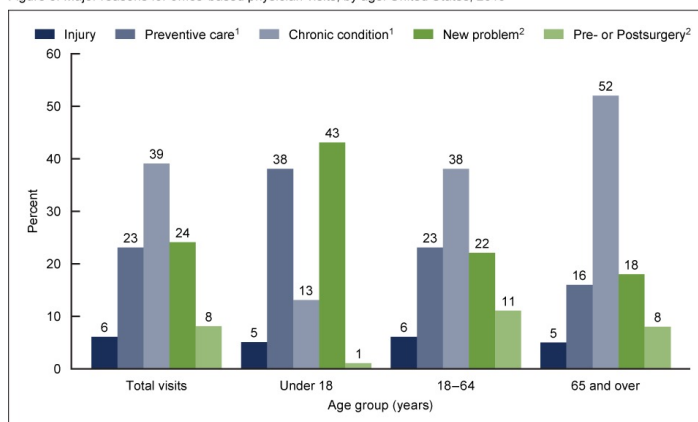


Outline

- Some data and an economic perspective on primary care
- What has changed post-COVID?
- What does it mean for primary care?

People Seek Primary Care for:

Figure 3. Major reasons for office-based physician visits, by age: United States, 2018



¹Significant difference in estimates among all age groups.

²Significant difference in estimates between those under age 18 and both those aged 18-64 and 65 and over.

NOTES: Provider-assessed major reason for visit was combined with injury to create a combined mutually exclusive reason for visit, with an injury visit having precedence over all other reasons. Total visits includes all visits by patients of all ages. Numbers may not add to 100% due to rounding. Figure excludes 2.4% (weighted) of visits for which data were missing either injury or reason for visit. Access data table for Figure 3 at: <https://www.cdc.gov/nchs/data/databriefs/db408-tables-508.pdf#3>.

SOURCE: National Center for Health Statistics, National Ambulatory Medical Care Survey, 2018.



Policy Logic

- Preventive services, chronic care management
 - Primary care often more cost-effective than other care
 - NOTE: not cost-saving, but better value
- New problems, referrals
 - Primary care often less costly than other sources of care (EDs, specialists)
 - PCPs might be able to make more “efficient” referral choices

Pre-COVID

- Policy interest in primary care
 - Expanded preventive services benefits in ACA
 - Patient-centered medical home
 - Accountable care organizations
 - Goal of shifting care toward more efficient providers/sources



Limited Payoff to Policy Efforts

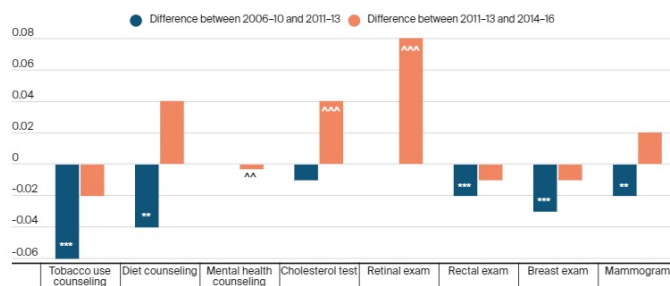
- Limited savings through investments in primary prevention and chronic disease management
- Savings and quality improvements from alternative payment approaches more modest than anticipated

Preventive Care Quality Stable

EXHIBIT 3

Trends in Adjusted Preventive Screenings and Counseling, Primary Care Physicians, 2006–10/2011–13 and 2011–13/2014–16

For adult patients ages 18–64



[Download data](#)

Notes: Only significant differences of $p < 0.05$ shown. Stars indicate significant difference between the 2006–2010 and 2011–2013 periods; carets indicate significant difference between the 2011–2013 and 2014–2016 periods.
* $p < 0.05$ ** $p < 0.01$
*** $p < 0.001$



Chronic Condition Care Stable to ↑

EXHIBIT 4

Trends in Adjusted Rates of Guideline-Concordant Care

	Unadjusted mean in 2006-2010	Adjusted difference between 2006-10 and 2011-13	Adjusted difference between 2011-13 and 2014-16
Treatment of CHF	0.34	-0.06	0.07
Beta blockers for CAD	0.41	-0.03	0.02
Hypertension treatment	0.57	-0.02	0.05^
Statins for hyperlipidemia	0.42	-0.02	0.00
Statins for DM	0.34	-0.01	0.04
Statins for CAD	0.48	-0.11**	0.08
Asthma treatment	0.46	-0.03	0.04
Treatment of depression	0.55	-0.04*	0.03

Download data

Notes: Guideline-concordant care for adults ages 18-64. CHF = chronic heart failure; CAD = coronary artery disease; DM = diabetes mellitus. Stars indicate significant difference between 2006-10 and 2011-13 periods; carets indicate significant difference between 2011-13 and 2014-16 periods.

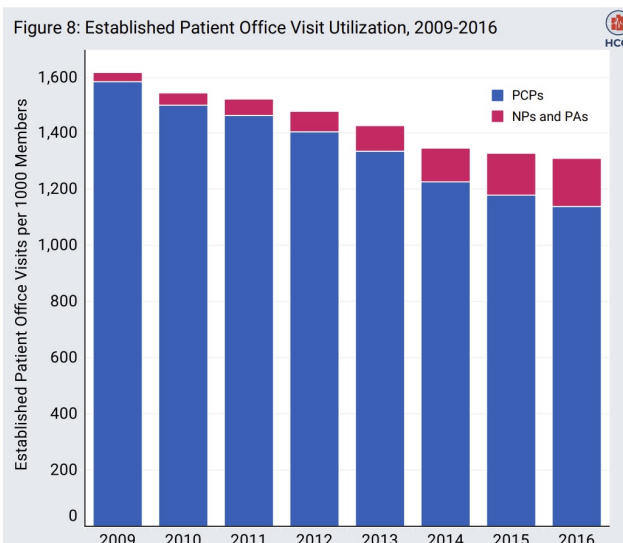
*p<0.1**p<0.05

^p<0.1

Data: Authors' analysis of the National Ambulatory Medical Care Survey (NAMCS), 2006-2016.

Source: Benjamin Zhu and Sherry Glied, *More Is More: Expanding Access to Primary Care While Maintaining Quality* (Commonwealth Fund, July 2021). <https://doi.org/10.26099/bxibx-fq35>

Demand has been Declining

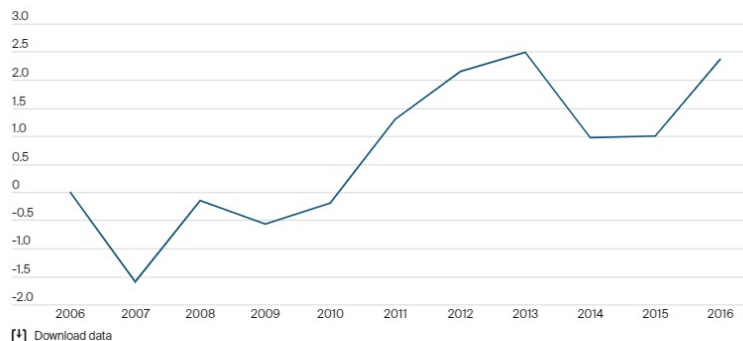




Pre-COVID Risk-Adjusted Visits were Getting Longer

Adjusted Change in Visit Duration, Primary Care Physicians, 2006–2016

For adult patients ages 18–64



Data: Authors' analysis of the National Ambulatory Medical Care Survey (NAMCS), 2006–2016.

Source: Benjamin Zhu and Sherry A. Glied, *More Is More: Expanding Access to Primary Care While Maintaining Quality* (Commonwealth Fund, July 2021). <https://doi.org/10.26099/tbxb-7q35>

Meanwhile...

- Big – and largely unanticipated -- changes happening on the supply side of the primary care market



The PCP Landscape has Changed Considerably

Table 1. U.S. primary care workforce by provider type, 2010

Primary care provider	Number
Physicians	208,807
Nurse practitioners	55,625
Physician assistants	30,402
Total	294,834

Source: AHRQ Primary Care Workforce Facts and Stats [#1](#) and [#2](#).

Exhibit 1 Number and average annual earnings of full-time-equivalent (FTE) nurse practitioners (NPs) in the US, 2010–17



SOURCE Authors' calculations based on data from the American Community Survey. NOTES The earnings data are for survey respondents who worked at least thirty hours per week. The amounts were adjusted for inflation using the Consumer Price Index for All Urban Consumers and are reported in 2017 dollars.



Labor Supply and Organizational Change

- Rapid increase in NPs corresponds with changes in organization
- Urgent care and similar settings make most effective use of NPs and reduce barriers to use

Urgent Care

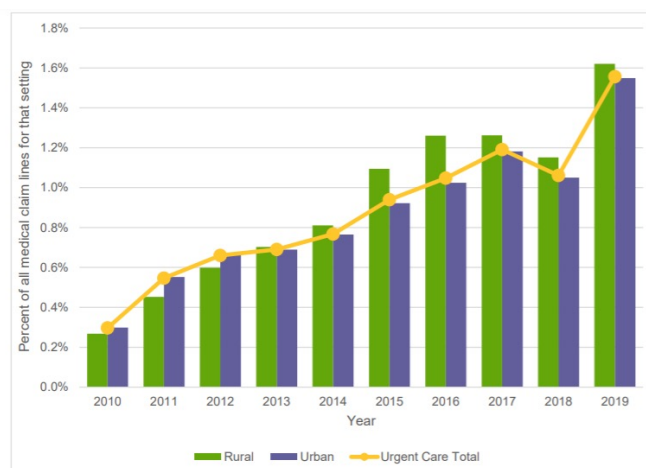


Figure 10. Claim lines with urgent care center usage as a percentage of all medical claim lines by rural, urban and national settings, 2010-2019



New York is Quite Typical

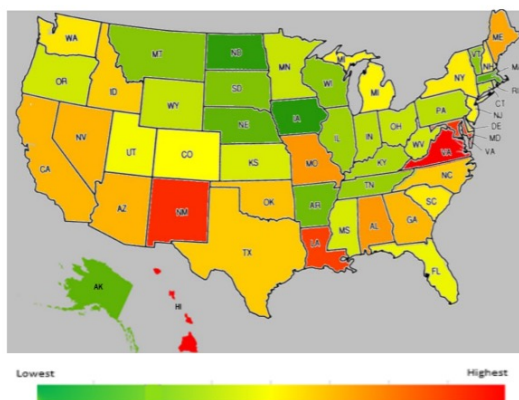


Figure 11. Percent of claim lines with urgent care center usage compared to all medical claim lines by state, 2019

Pre-COVID Increases in Telehealth

- Another organizational change pre-COVID was the introduction of telehealth
- Often by new entrants – dedicated providers
- But scale was tiny



1/8 as high as Urgent Care

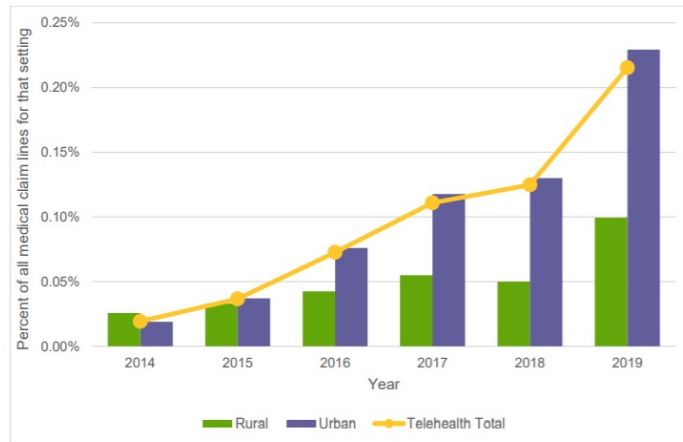
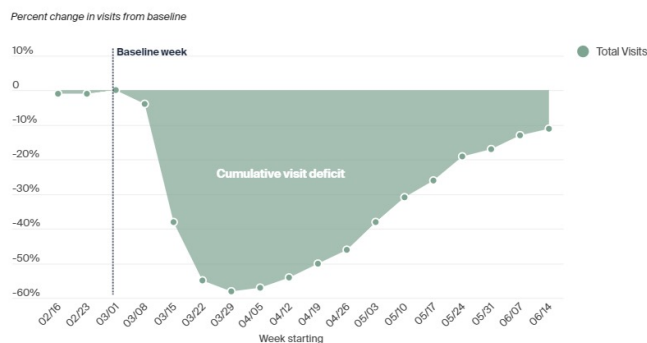


Figure 20. Claim lines with telehealth usage as a percentage of all medical claim lines by rural, urban and national settings, 2014-2019

COVID

The number of visits to ambulatory practices had declined nearly 60 percent by early April. Since that time, the numbers have rebounded substantially, though the rebound may be beginning to plateau.

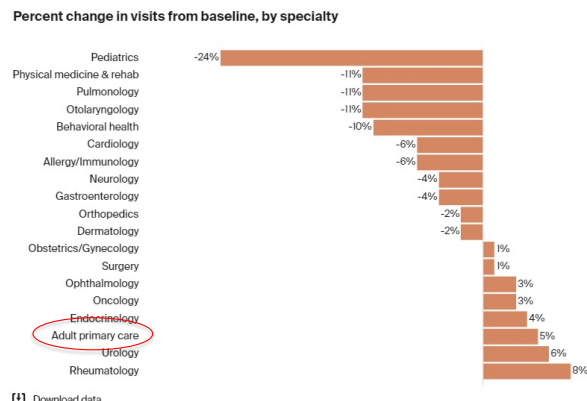


Download data

Note: Data are presented as a percentage change in the number of visits in a given week from the baseline week (March 1-7).
Source: Ateev Mehrotra et al., *The Impact of the COVID-19 Pandemic on Outpatient Visits: Practices Are Adapting to the New Normal* (Commonwealth Fund, June 2020). <https://doi.org/10.26099/2v6l-9y63>



Recovery by End of 2020



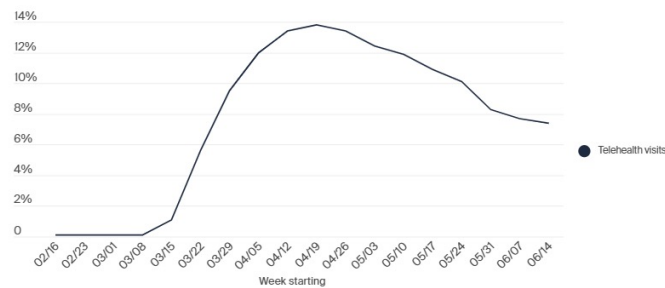
Note: Data are for the last three full weeks in 2020 compared to the baseline week (March 1-7). We did not include weeks with holidays or the shortened week at the end of the year. Data are for the selected specialties shown only. The decline in visits is reflective of all visit types – in-person and telemedicine. Visits from nurse practitioners and physician assistants are not included. Urgent care center visits are not included in adult primary care or pediatrics. Results from dermatology differ from our previous reports because of changes in our sample, as described in our methods below. The relative increase in some specialties compared to the baseline week may be driven by seasonal patterns. For example, in primary care, practices typically have more visits in the winter than at other times of the year.

Source: Ateev Mehrotra et al., *The Impact of COVID-19 on Outpatient Visits in 2020: Visits Remained Stable, Despite a Late Surge in Cases* (Commonwealth Fund, Feb. 2021). <https://doi.org/10.26099/bvhl-e411>

Rapid Switch to Telehealth

The number of telemedicine visits (as a percentage of visits during the baseline week) rose rapidly through mid-April but has since been steadily declining.

Number of telehealth visits: in a given week as a percent of baseline total visits



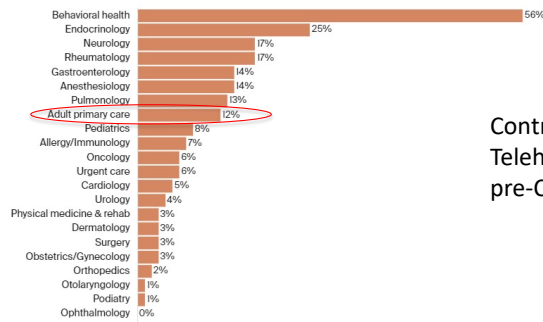
Data are presented as a percentage, with the numerator being the number of telemedicine visits in a given week and the denominator being the number of visits in the baseline week (March 1-7). Telemedicine includes both telephone and video visits.

Source: Ateev Mehrotra et al., *The Impact of the COVID-19 Pandemic on Outpatient Visits: Practices Are Adapting to the New Normal* (Commonwealth Fund, June 2020). <https://doi.org/10.26099/2c5s-8y63>



Remains Somewhat Elevated

Telemedicine visits as a percentage of baseline



Contrast with 0.2% Telehealth share pre-COVID

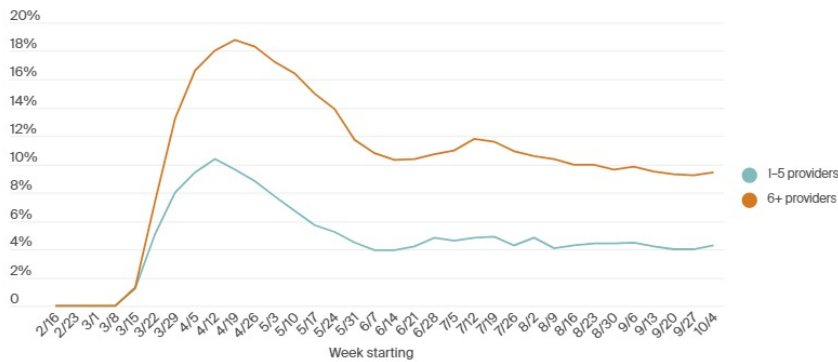
Download data

Note: Data presented are for the selected specialties shown only and expressed as a percentage: the number of telemedicine visits over the final three nonholiday weeks of 2020 is the numerator, while the number of visits in the baseline week (March 1-7), multiplied by three, is the denominator. Telemedicine includes both telephone and video visits. We did not include weeks in December with holidays or the shortened week at the end of the year.

Source: Ateev Mehrotra et al., *The Impact of COVID-19 on Outpatient Visits in 2020: Visits Remained Stable, Despite a Late Surge in Cases* (Commonwealth Fund, Feb. 2021). <https://doi.org/10.26099/bv4f-e411>

Larger provider organizations are using more telemedicine. For example, among adult primary care providers, organizations of six or more clinicians use more telemedicine than practices of one to five.

Telehealth usage as percent of total visits during baseline week, by provider size



Download data

Data are presented as a percentage: the number of telemedicine visits in a given week is the numerator, while the number of visits in the baseline week (March 1-7) is the denominator. Telemedicine includes both telephone and video visits. The size of the provider organization is based on the total number of providers of any specialty. We show data only for adult primary care providers to demonstrate that there is variation even within a given specialty.

Source: Ateev Mehrotra et al., *The Impact of the COVID-19 Pandemic on Outpatient Care: Visits Return to Pre-pandemic Levels, but Not for All Providers and Patients* (Commonwealth Fund, Oct. 2020). <https://doi.org/10.26099/41xy-9m57>



WHAT COMES NEXT?

COVID Changes of Lasting Relevance

- Changing patterns of work
 - More workplace flexibility
 - Potential changes in residential location
- Paid sick leave during COVID (and in NYC)
- Telehealth infrastructure
 - Patients are more familiar with telehealth
 - Many more providers now offer telehealth
 - Rapid growth in independent telehealth



Changing Patterns of Work

- Some workers (20% of workforce?) may shift toward more hybrid work schedules
- Shift in geographic location
 - Away from center cities
 - Broader commuting watershed
- May also affect supply side
 - Greater interest in providing telehealth from remote work locations

Paid Sick Leave

- Expansion of paid sick leave during COVID-19
 - Federal through 12/2020
 - NYS continues
- NYC paid sick leave since 2014
 - Associated with reduced ER use, increased Primary care use (glycated hemoglobin A_{1c} level testing, blood cholesterol testing, and colon cancer screening (Ko and Glied, 2021)



Telehealth

- Greater familiarity and “infrastructure” (apps, laptops, cameras) investment by both providers and patients
- Payment challenges
 - Increased consumer demand since time cost ↓
 - Potential for misuse of FFS codes
 - Capitation challenges (consumer demand; patient severity; monitoring use)

Preventive Care

Remote Work	Telehealth	Policy and Organizational Responses
- Location of primary care services may change; easier access and more flexibility for care near home	- Limited opportunity to shift preventive care visits to telehealth	- Paid sick leave?



Chronic Disease Management

Remote Work	Telehealth	Policy and Organizational Response
<ul style="list-style-type: none">- Flexibility may allow more frequent follow-up	<ul style="list-style-type: none">- Routine monitoring of chronic disease through telehealth is feasible and could improve outcomes	<ul style="list-style-type: none">- Paid sick leave?- Tele-chronic care by larger practices- New payment modalities for chronic care?

Acute Care

Remote Work	Telehealth	Policy and Organizational Response
<ul style="list-style-type: none">- Change in location of acute care episodes?	<ul style="list-style-type: none">- Likely continued shift (+urgent care)- Challenge: acute care visits are often occasions for key preventive services....	<ul style="list-style-type: none">- Payment for acute telehealth- Urgent care/telehealth organizational changes



Referrals

Remote Work	Telehealth	Policy and Organizational Response
- Probably n/a	- Could shift referral patterns if acute care providers shift	- Greater incentives for efficient referrals

Lessons for the Future

- Focus on what services need to be provided, not who provides them
 - Workforce projections missed urgent care and NP combination
- Payment changes alone have modest effects
 - Organizational changes have much bigger effects
- Savings more likely from shifting/reducing services than from adding
 - Better referrals, shift services to PCPs – not more care management, more prevention



THANK YOU



Telemedicine for Primary Care vs Specialty in Covid pandemic-a birds view from a multi-specialty group practice

Henry Chen, MD., CEO

Excelsior Integrated Medical Group

October 15, 2021

For the Dominican Medical and Dental Annual Conference



Purpose and Objectives

PURPOSE

To share the experience of surviving Covid pandemic with technology in medical practice

OBJECTIVES

- Learn how to adopt new technology during the crisis
- Understand the value of the primary care in the group practice

FINANCIAL DISCLOSURE

None



Disclosure

- None



Agenda

- Introduction of Excelsior Integrated Medical Group PLLC (EIMG)
- Impact of Covid pandemic on primary care vs specialty
- The recovery



As of October 15, 2020 Excelsior has...

83

Providers

300+

Employees

21

Divisions

83,000+

Lives Covered

43

Clinics & Labs

1

Tax ID & EMR Platform

Excelsior Medical : Value Based Healthcare Company *in the community*

Practices located throughout Manhattan, Brooklyn, and Queens;
substantial focus in Lower Manhattan, Sunset Park, Bay Ridge,
Bensonhurst & Flushing

- **Currently comprised of:**
 - 10 primary care divisions
 - 11 specialty divisions
 - over 90 providers,
 - 45 office locations
 - > 420+ employees
- **Practice Sites & Services including:**
 - 25 primary care sites
 - 4 cardiology sites
 - 4 Ophthalmology sites
 - 3 GI sites
 - 3 oncology sites
 - 3 PMR & physical therapy sites
 - 2 diagnostic imaging sites
 - 2 podiatric sites
 - 1 pulmonary-sleep medicine-critical care site
 - 1 clinical diagnostic laboratory
 - 1 interventional radiology center





Practice Without Walls - Henry Chen, MD
HChen@jennanmedical.com

Home » Resources » Survival of Independent Practice

Introduction

MSSNY's Task Force on Survival of Independent Practice presents these recommendations on options physicians can consider in order to practice successfully in an independent environment.

The Task Force was charged with exploring options for independent physicians to collaborate and create practice models to achieve the goals of diversity of service, economy of scale and collective negotiations. **We present real practice models** that have been creative in exploring what can be done and that have worked for independent practices, making them successful financially and freeing them from many administrative frustrations. These models are offered as options for members to consider, modify or build on.

The Task Force recognizes that one size does not fit all. We therefore present both collaborative models of care as well as ideas to help those who wish to remain completely independent. Some general recommendations are applicable to all physicians. Other recommendations may be more applicable either to solo or small group practices, while others are more suited to a larger single or multi-specialty setup.

Please note that the practice models presented here are not specifically endorsed by the Task Force or by MSSNY, and they have not been subject to legal review. Members interested in these concepts are advised to perform their own due diligence. Physicians should never enter any form of practice without legal guidance. MSSNY's General Counsel, the law firm of [garfunkel, Wild P.C.](#) offers MSSNY members a free consult and reduced hourly rates.

Excelsior Integrated Medical Group PLLC (EIMG), a New York professional limited liability company, is a clinically and financially integrated medical group that qualifies as a group practice for purposes of the federal anti-referral prohibition, known as the Stark law. It is governed by a centralized board, yet provides a meaningful level of autonomy to its operating divisions to operate efficiently and harmoniously. [Read more here.](#)

Excelsior Medical Model

In 2016, the Excelsior Practice Model was recommended by MSSNY as a "survival independent private practice." We had just completed our practice integration and were picking up steam. Please visit mssny.org and search for survival independent practice for more information



Excelsior: Provider & Revenue Mix

2016: 10 locations

Provider Mix	75% (15)	5% (1)	10% (2)	10% (2)
Revenue Mix	90%	5%	3%	2%



2020: 45 locations

Provider Mix	57% (45)	18% (14)	22% (17)	3% (2)
Revenue Mix	75%	11%	13%	1%

Total Providers for 2020: 83
End of 2019: 75



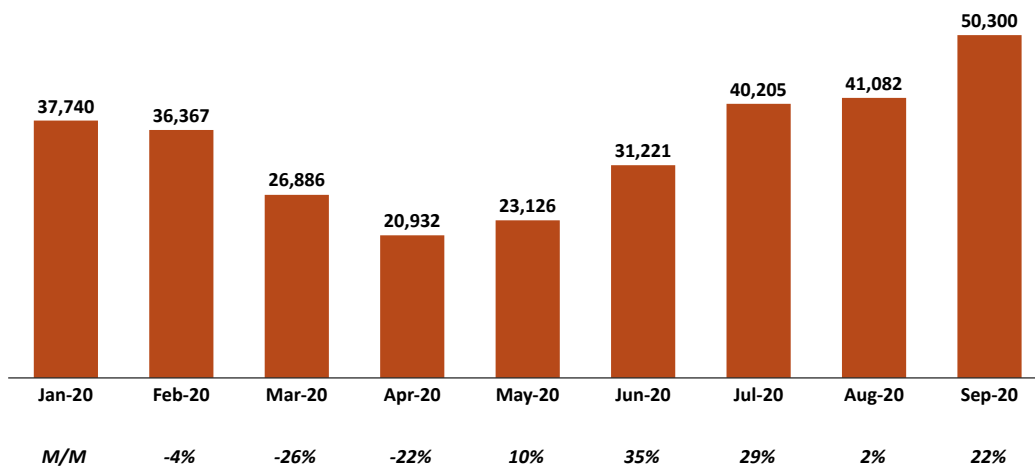


Financial report

- Impact from Covid 19 pandemic: the downtime and the recovery
- The PCP vs Specialists
- The new technologies

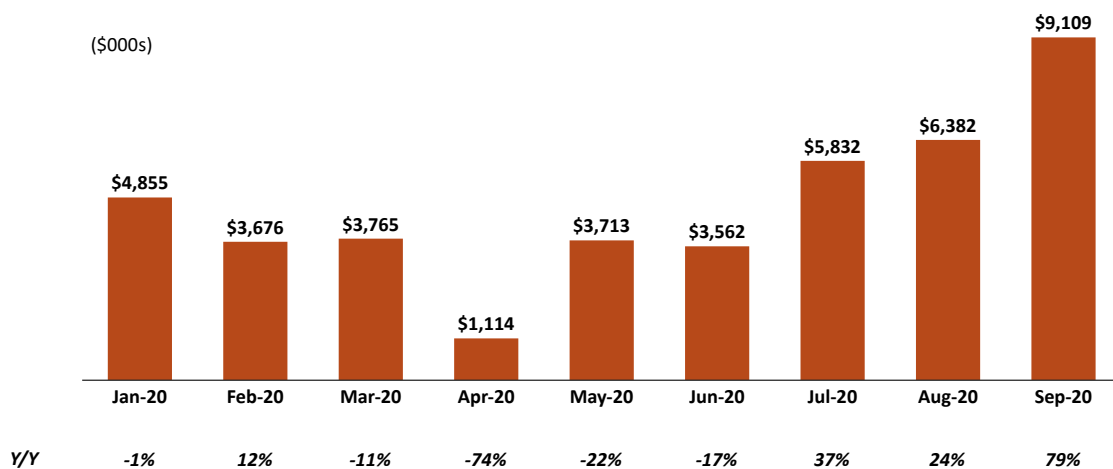


COVID Impact: Patient Volume

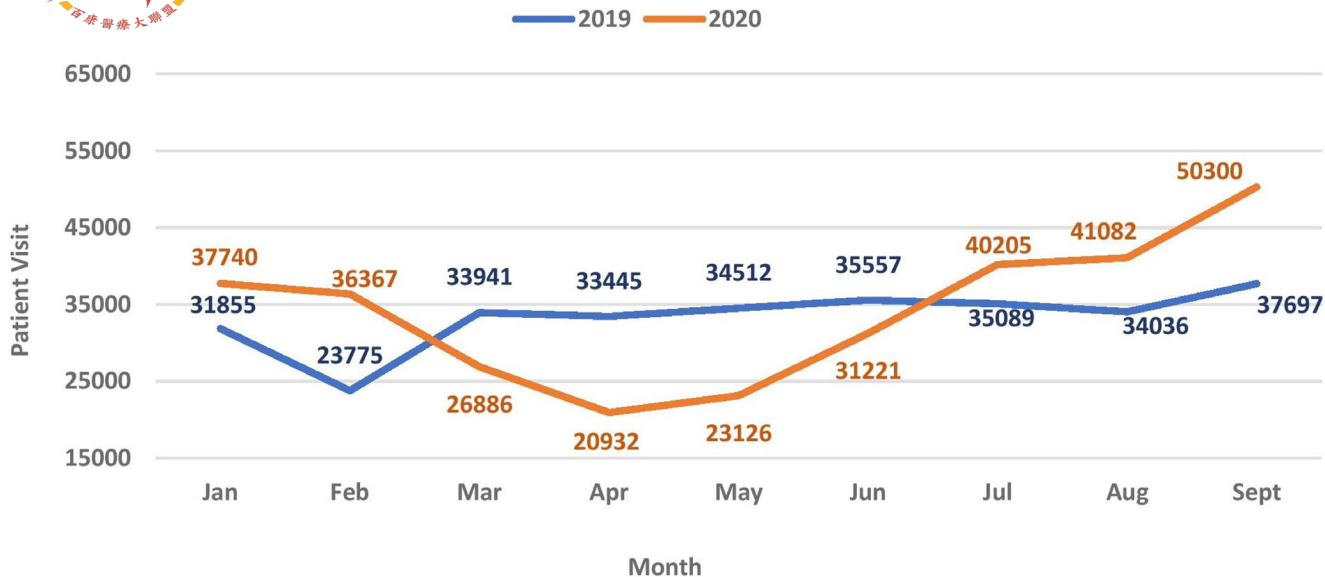




Revenue



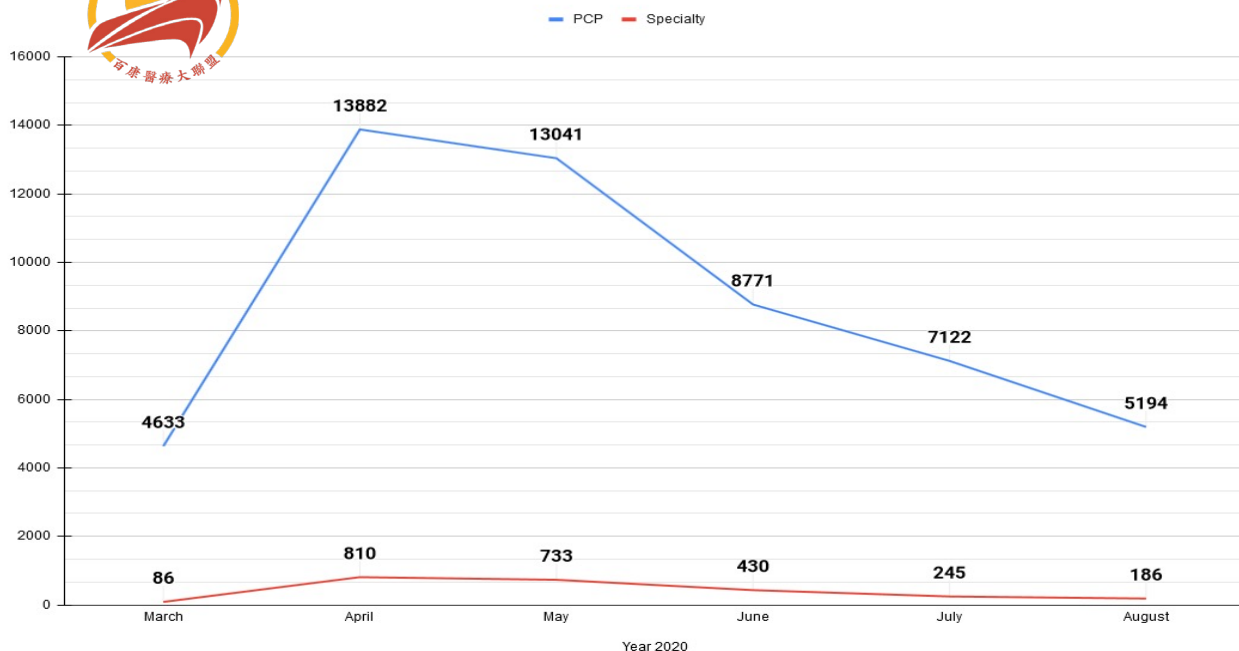
2019-2020 EIMG Patient Volume Comparison



Confidential and Privileged Information



Total Telehealth Visit



The recovery



- Value based contracts
 - 60% contracts are capitation model for PCP
 - Value based contracts level II and III risk adjustment
 - ACO participation: CCACO >> SOMOS ACO
- Insurance Mix
 - Commercial 10%
 - Medicaid 5%
 - Medicaid HMO 53%
 - Medicare 12%
 - Medicare Advantage 20%
- Top 10 payors
 - Fidelis (29%), UHC (25%), Medicare (11.6%), HealthFirst (11%), WellCare (6%)
 - Medicaid (5%), BCBS (3.8%), Emblem (2.1%), 1199 (1.6%), Affinity (1.5%)
- The practice continue expansion despite Covid 19 pandemic
 - Provider recruitment
 - Patient enrollment
 - Practice site expansion
 - Strong rebound from Pandemic:
 - Surge of visit volume
 - Revenue even higher than prior to pandemic
 - Strong balance sheet



New initiatives-I Healthcare System without hospital bed

- Urgent Care Center
 - 729 61st Street, Brooklyn
 - Potential 2 more in lower Manhattan and Flushing, Queens near Excelsior PCP practice sites
- Ambulatory Surgical Center
 - 833 65th Street, Brooklyn
 - Multispecialty center, 10,000SF, 4-5 operating rooms
 - Focus on GI, Podiatry, Ophthalmology, ENT
 - Blessing from NYU, wants to rent one room
- New territory
- IT, MDLand and RPM



Integrated EMR platform

- Single EMR platform for entire Excelsior: MDLand
 - Offers excellent EMR for PCP and specialties
 - Full range of functionalities for practices: appointment, medical record, remote access, revenue cycle, patient access, etc.
- Improvements needed
 - Admin function at organization level
 - Accurate stats: number of pts (capitation), insurance mix, referrals
 - Quality control at organization level
 - Monitor HEDIS measurements and gap close: CPT/ICD codes
 - Preventable ER/admission
 - Single account at organization level
 - To share all pt information throughout Excelsior
 - Standardize the format and template



Category of Codes	CPTII Codes	CPTII Reimbursement Amount
HbA1c Results	3044F Most recent hemoglobin A1c (HbA1c) <7%	\$10.00
	3045F Most recent hemoglobin A1c (HbA1c) 7%–9%	\$.01
	3046F Most recent hemoglobin A1c (HbA1c) >9%	\$10.00
	NEW 3051F Most recent hemoglobin A1c (HbA1c) result >7%–8%	\$.01
	NEW 3052F Most recent hemoglobin A1c (HbA1c) result >8%–9%	\$.01

	Pool	Distribution Basis	\$ PMPM
Fixed	PCP Capitation	Fixed \$32 PMPM payment (for capitated PCPs)	\$32 PMPM
	Quality	Up to 2% of premium, allocated based on performance in SOMOS internal quality program	\$8 PMPM
Variable	VBC Savings	25% of VBC Savings allocated based on select "Partnership" behaviors that benefit the IPA – Innovator growth, encounter submission, etc. Remaining 75% of VBC Savings retained by savings-generating practices	\$2 PMPM
			\$6 PMPM
			Total: (\$48 PMPM)

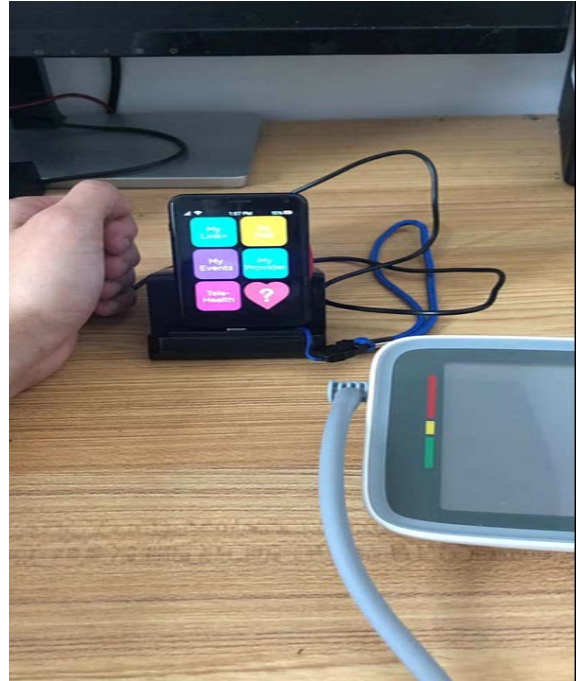
Based on full funding at 2% of premium (\$3400 PMPM cap). Example: based on 80% ALE, \$8-\$10 = 2% 40% of 5% = 2% of premium, i.e. \$8. 50% Bonus above capitation rate, for a high-performing practice.



DATA is the key to success



Remote Patient Monitoring (RPM)



Not Just A Gadget



- Partner with MDland-Dedicated transmission device
 - No need for patient to operate cell phone or software
 - They just press the button and readings go to chart (BP, O2, Pulse, Weight, Temp)
- Enables doctors to monitor patients vitals several times a day
- Better management of the elderly
- Better outcomes –
 - Avoid unnecessary medication
 - Prevents hospital admissions
 - Increases revenue while decreasing utilization and increasing value based bonus



Remote Patient Monitoring CPT codes 2020



CPT Code	CPT Amount (approx.) per consultation	Description
99458 (NEW)	~ \$26 ppm	Additional 20 minutes of clinical staff, physician, or QHCP time spent above and beyond the initial 20 minutes provided for by CPT Code 99457.
CPT 99457	~ \$54 ppm	20 minutes (or more) of clinical staff time in a calendar month requiring interactive communication with the patient/caregiver during the month.
CPT 99453	~ \$21 ppm	Initial set up and education on the use of the equipment for the remote monitoring of physiologic parameter(s).
CPT 99454	~ \$69 ppm	Monitoring the daily recording(s) or programmed alert(s) transmission of physiologic parameter(s), each 30 days.
CPT 99091	~ \$58 ppm	At least 30 minutes of time must be spent in the collection and interpretation of physiologic data digitally stored and/or transmitted by the patient/caregiver.

Potential Revenue for The Entire Group



- Enrolled RPM patient # for the group: **1,200** (10%)
- Total eligible patient # in the group: **12,000**
- **Option 1:** Monthly revenue per patient if only viewed RPM :
 - 99453 for set-up and education \$21 (*first month only*)
 - 99454 for RPM data \$69
 - Total potential first year revenue: **\$1,018,800**
- **Option 2:** Monthly revenue per patient if viewed data and spent 20 min time:
 - 99453 for set-up and education \$21 (*first month only*)
 - 99454 for RPM data \$69
 - 99457 for 20 min \$54
 - Total potential first year revenue: **\$1,796,400**
- Cost: \$49 initially and \$19/month



Contact Information:

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Mental Health Integration into Primary Care in the Era of COVID-19

Victoria K. Ngo,
PhD Associate
Professor

CUNY SPH Community Health and Social
Sciences Director, Center for Innovation in
Mental Health



GRADUATE SCHOOL OF PUBLIC HEALTH & HEALTH POLICY

INTRODUCTIONS

Victoria K. Ngo, MS, PhD

Dr. Ngo is an Associate Professor of Community Health and Social Sciences and Director of the Center for Innovation in Mental Health. Her research focuses on developing mental health and psychosocial support interventions and strategies to increase access and quality of community-based mental health services for underserved communities globally.



OVERVIEW

- Impact of COVID-19 on mental health
- Need for Mental Health Integration in Primary Care
- Solution: Task-sharing of mental health
- Lessons Learned and Recommendations

Financial Disclosure: No financial conflicts to disclose



Impact of COVID-19 on Mental Health



MENTAL HEALTH CRISIS

Rates of mental health
problems have doubled and
tripled during COVID-19

COVID-19 AND STRESS IN AMERICA

- 67% report increased stress throughout pandemic
- 61% experienced undesired weight changes
- 67% had more or less sleep than desired
- 23% reported drinking more alcohol to cope with stress
- 31% reported that their mental health has worsened compared to before the pandemic



COVID-19 ASSOCIATED STRESSORS



Long COVID-19



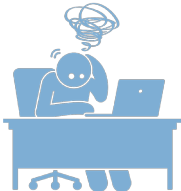
Separation from family members



Unemployment and Financial Problems



Challenges in child care with remote work



Work Stress



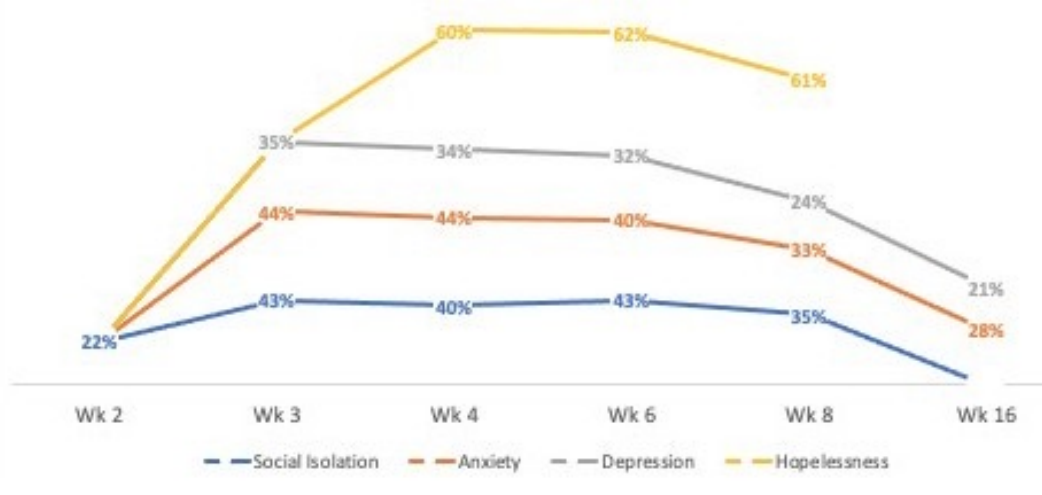
Loss of family/friends



Global effects

COVID-19 ASSOCIATED STRESSORS

NYC - Feb 2020 to June 2020





RISK GROUPS AND FACTORS

- Some vulnerable groups are disproportionately affected due to
 - Health issues:
 - Long COVID-19
 - chronic health conditions
 - compromised immune systems
 - Social and economic issues:
 - weakened social support structures
 - socioeconomic stressors
 - unequal access to healthcare and social services
 - unstable living condition
 - socially isolated
 - undocumented individuals

RISK GROUPS AND FACTORS

- Some vulnerable groups are disproportionately affected due to
 - Greater exposure to risk:
 - essential workers
 - healthcare setting
 - social service settings
 - nursing and group homes
 - police force
 - barriers to care
 - lack of information or misinformation



RISK GROUPS AND FACTORS

- Ethnic minorities, particularly African Americans and Latinos
- Families with school-age children have higher stress
 - 47% of mothers report worsened mental health
 - 30% of fathers report worsened mental health, 48% report drinking more to cope
- Health care and front-line workers
 - Increased MH risks for frontline workers, such as depression, anxiety, and insomnia, are associated with increased direct contact with COVID-19 patients
 - more than twice as likely as those who are not to have received treatment from a mental health professional (34% vs. 12%) and to have been diagnosed with a mental health disorder since the coronavirus pandemic started (25% vs. 9%).

IMPACT OF MENTAL HEALTH ON HEALTH

- People with depression of all ages are at increased risk of developing a variety of physical illnesses
 - Less access to quality medical care
 - Difficulty with self-care
 - Potential physiological changes
- During COVID-19, people with moderate to severe depression, anxiety, and life satisfaction symptoms reported a larger reduction in physical activity than those with no or mild symptoms



WIDENING DISPARITIES

- Disparity in COVID-19 infections
- Disparity in chronic health problems in ethnic minority communities
- Disparity in mental health in ethnic minority communities
- Ethnic minorities are overrepresented in risk groups:
 - Essential workers
 - Restaurants
 - Uninsured
 - Job Insecurity
 - Food Insecurity
 - Housing Insecurity



Need for Mental Health Integration in Primary Care



BURDEN OF MENTAL HEALTH

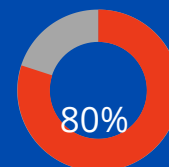
- 1 in 5 people in the world suffer from a mental health condition in any given year, but 75-85% do not receive care
- Great cost to individual functioning, family life, work, and society
- Poverty and mental health interact in a negative cycle

Pre-COVID Treatment Gap

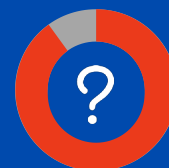
Common Mental Health Condition Gap



Mental Health Treatment



COVID Treatment Gap





EFFECTIVE TREATMENTS

- Psychological Interventions:
 - Cognitive Behavioral Therapy
 - Behavioral Activation
 - Problem Solving Therapy
 - Mindfulness
- Psychotropic Medications
- Family Support Therapy
- Group Therapy
- Support Groups
- Technology-based Interventions
- Self-Management

CHALLENGES IN MENTAL HEALTH

- Lack of access to mental health services
- Poor quality of mental health services
- Health system, mental health system, social service, and community systems are siloed
- Poor coordination of care

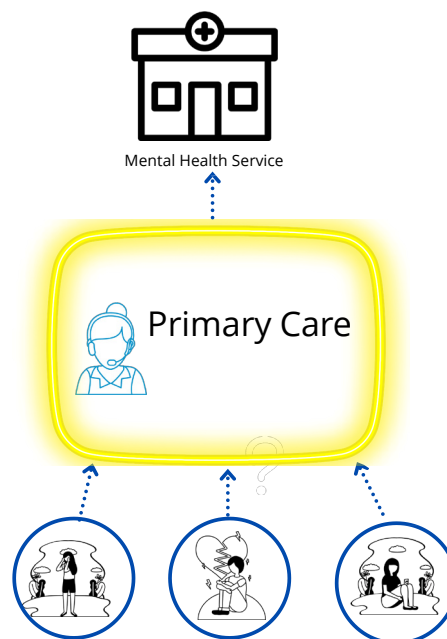


NEED FOR SYSTEMS OF CARE COORDINATION

- Systems of Care that are coordinated and are multi-sector
- Mental Health integration in Primary Care, Schools, Communities, in Workplaces
- We need to train people to have greater mental health awareness

PRIMARY CARE CAN BRIDGE THIS GAP

- Primary Care can support
 - Mental Health promotion
 - Provide basic mental health information and resources
 - Facilitate linkage to care

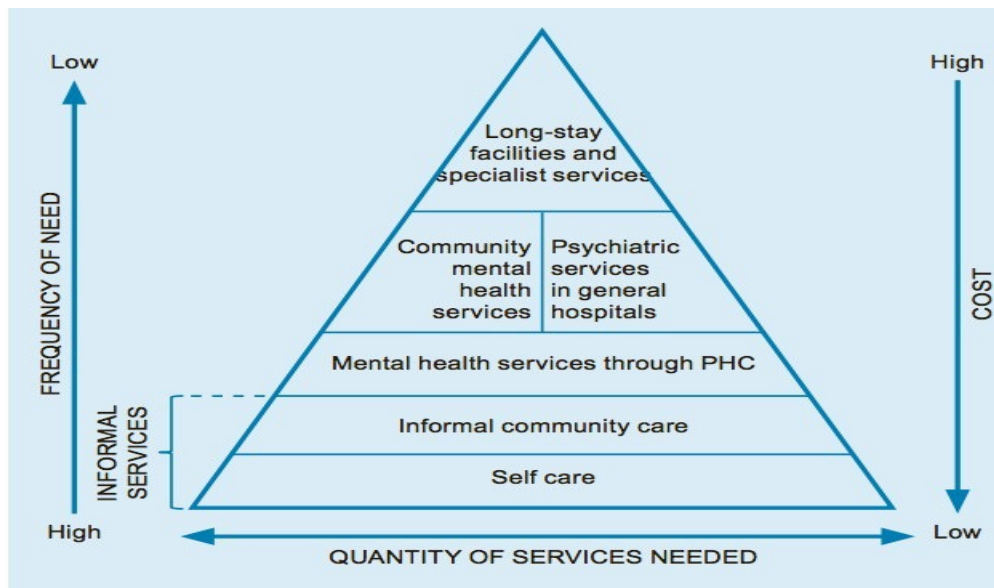




3

Task-Sharing Mental Health

OPTIMAL MIX OF SERVICES



World Health Organization. The optimal mix of services. Geneva: World Health Organization; 2007



WHY TASK-SHARING MAKES SENSE

- Shifting components of mental health tasks to primary care can make more **effective use of existing human resource and support systems** in the community.
- It can **ease bottlenecks** in service delivery in overburdened mental health systems.
- It can also **increase access** by providing much needed **identification**, brief and simple **interventions** in settings that are more convenient, natural, and less stigmatizing for individuals suffering from depression

The stepped care model

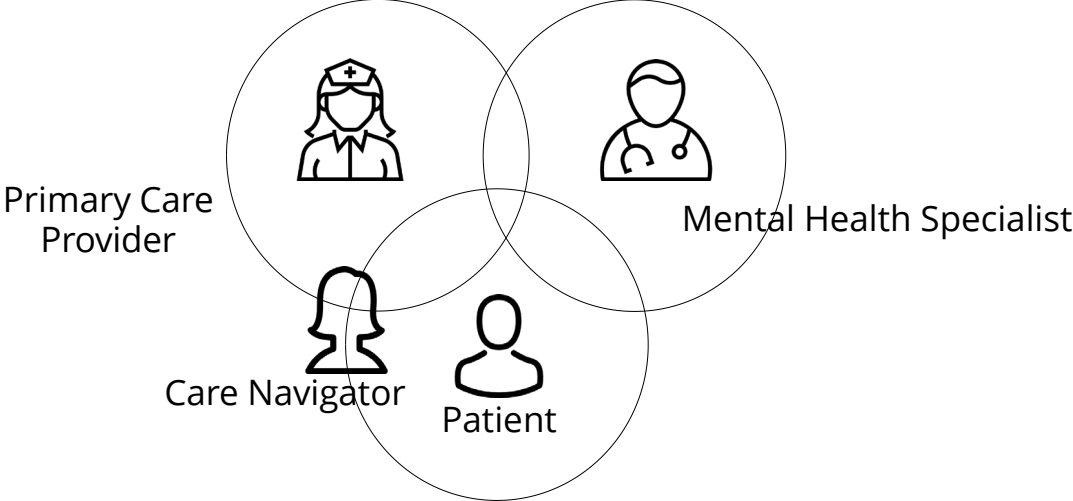
The recommendations in this guideline are presented within a stepped care framework that aims to match the needs of people with depression to the most appropriate services, depending on the characteristics of their illness and their personal and social circumstances. Each step represents increased complexity of intervention, with higher steps assuming interventions in previous steps.



	Who is responsible for care?	What is the focus?	What do they do?
Step 5:	Inpatient care, crisis teams	Risk to life, severe self-neglect	Medication, combined treatments, ECT
Step 4:	Mental health specialists, including crisis teams	Treatment-resistant, recurrent, atypical and psychotic depression, and those at significant risk	Medication, complex psychological interventions, combined treatments
Step 3:	Primary care team, primary care mental health worker	Moderate or severe depression	Medication, psychological interventions, social support
Step 2:	Primary care team, primary care mental health worker	Mild depression	Watchful waiting, guided self-help, computerised CBT, exercise, brief psychological interventions
Step 1:	GP, practice nurse	Recognition	Assessment



COLLABORATIVE CARE FOR DEPRESSION

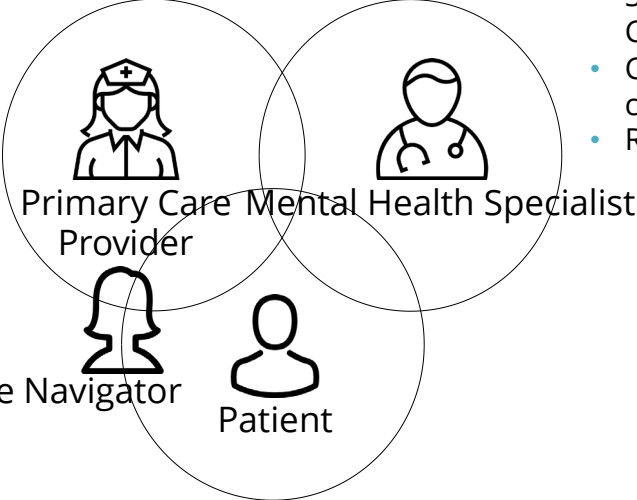


COLLABORATIVE CARE FOR DEPRESSION

- Screening
- Assessment
- Patient Education
- Brief EBPs
- Med Management
- Referral

- Supervision/ Coaching
- Consultation for challenging cases
- Referral source

- Screening
- Patient Education
- Care Coordination
- Referral





EVIDENCE BASE FOR PRIMARY CARE-BASED COLLABORATIVE CARE MODELS

- Has largest body of evidence-base supporting effectiveness in depression management, compared to other models of integrated care
- Robust evidence base for collaborative care models
- Controlled trials show model is twice as effective compared to usual depression management in primary care
- People receiving collaborative care have shorter time in reaching remission, resulting in less time living with depression



CHALLENGES IN IMPLEMENTATION

- Mental health stigma
- Organizations' prioritization of mental health services
- Provider self-efficacy in delivering care
- Resistance to task-sharing approaches
- Time constraints and competing health initiatives
- Data collection and reporting barriers
 - Access to technology





4

Lessons Learned and Recommendations

LESSONS LEARNED

- Mental health task-sharing can be effective
- Put communities at the center
- Collaborations are necessary
- Support and supervision are key to effective implementation
- Implementation planning at the outset
- Breaking down walls between professions requires an articulation of common language, goals, and values



RECOMMENDATIONS

- Build from existing programs and evidence-based practices
- Keep your eyes on the metrics
- Quality improvement is continuous
- Create an environment and culture for innovation and learning
- Top down and bottom-up approaches are both needed
- Be guided by evidence – both from the science and field
- Employ multidisciplinary perspectives and multisectoral collaborations





Thank you!

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Youth with a History of Childhood Trauma: Childhood Maltreatment

Angela Diaz, MD, PhD, Director
Mount Sinai Adolescent Health Center

Financial Disclosure:
No Financial Conflicts to Disclose



**Mount
Sinai** *Adolescent
Health Center*

Adolescence is a period of extraordinary opportunity for learning, exploring, and laying a strong foundation for a successful life.



Trauma and Adversity: Adverse Childhood Experiences (ACEs)

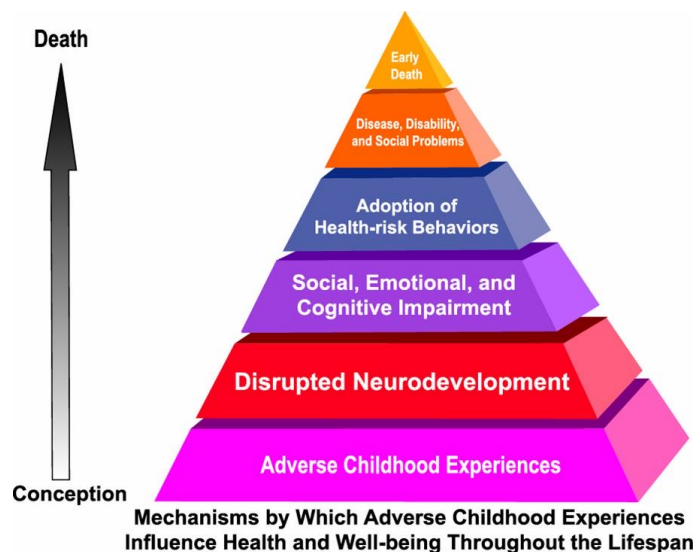
ACEs: All types of abuse and neglect and other potentially traumatic experiences that occur to people under the age of 18 years (CDC).

The original ACEs study included:

1. Verbal Abuse	6. Witnessing IPV
2. Physical Abuse	7. Substance Abuse in Home
3. Sexual Abuse	8. Separated/Divorced Parents
4. Physical Neglect	9. Family Member Incarcerated
5. Emotional Neglect	10. Family Member Mentally Ill or Suicidal

Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study Vincent J. Felitti, MD, FACP, Robert F. Anda, MD, MS, Dale Nordenberg, MD, David F. Williamson,

How ACEs impact well-being



Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study Vincent J. Felitti, MD, FACP, Robert F. Anda, MD, MS, Dale Nordenberg, MD, David F. Williamson,



Estimates of prevalence of sexual abuse

- ▶ Childhood abuse is defined as abuse that occurred from birth through age 17.
- ▶ By age 17 about 26.6% girls and 5.1% of boys have experienced sexual abuse.
- ▶ 66.3% of episodes are not reported.

Gewritz-Meydan and Finkelhor, Sexual Abuse and Assault in a Large National Sample of Children and Adolescents, Child Maltreatment 1-12, 2019

Commonwealth Fund Study methods

- ▶ Study Design and Population
 - Cross-sectional survey of a national representative school-based sample of adolescents in the United States
 - 6,748 adolescents in grades 5 to 12 in 265 schools which participated in the 1997 Commonwealth Fund Adolescent Health Survey conducted by Louis Harris & Associates, Inc. NYC
- ▶ Study Population
 - Girls in grades 5 to 12 (n=3,015)
 - Girls who responded to both questions related to sexual and physical abuse
- ▶ Used only 2 questions:
 - Have you ever been physically abused?
 - Have you ever been sexually assaulted?

1997 Commonwealth Fund Adolescent Health Survey conducted by Louis Harris & Associates, Inc.



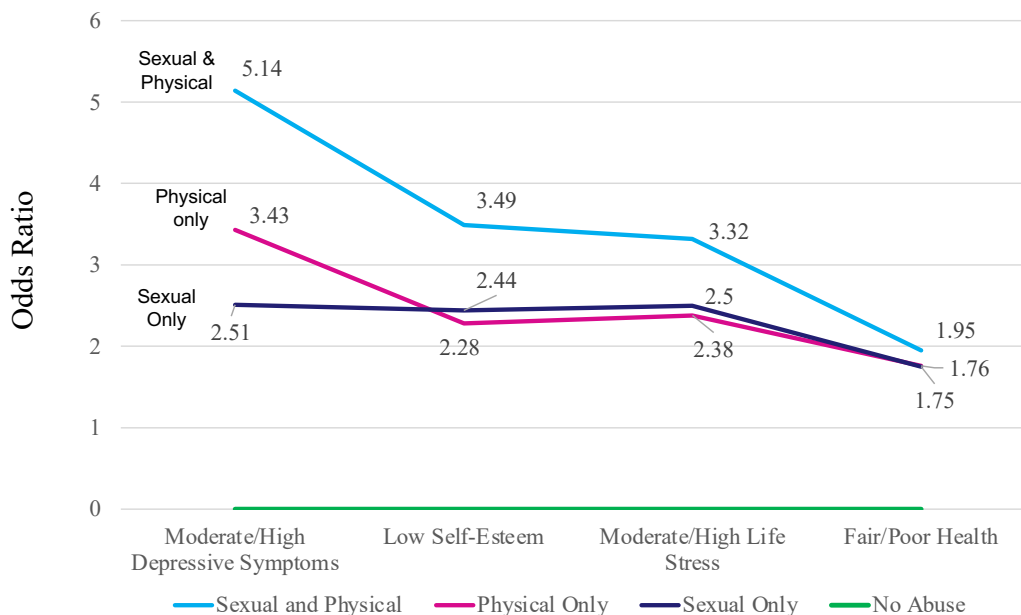
Results

Of the 3,015 girls in this sample...

- ▶ 546 (18%) reported a history of physical and/or sexual abuse.
 - 246 (8%) reported experiencing only physical abuse.
 - 140 (5%) reported experiencing only sexual abuse.
 - 160 (5%) reported experiencing both types of abuse.
- ▶ Only 27% of the girls who disclosed sexual abuse reported seeing a mental health counselor for any reason.

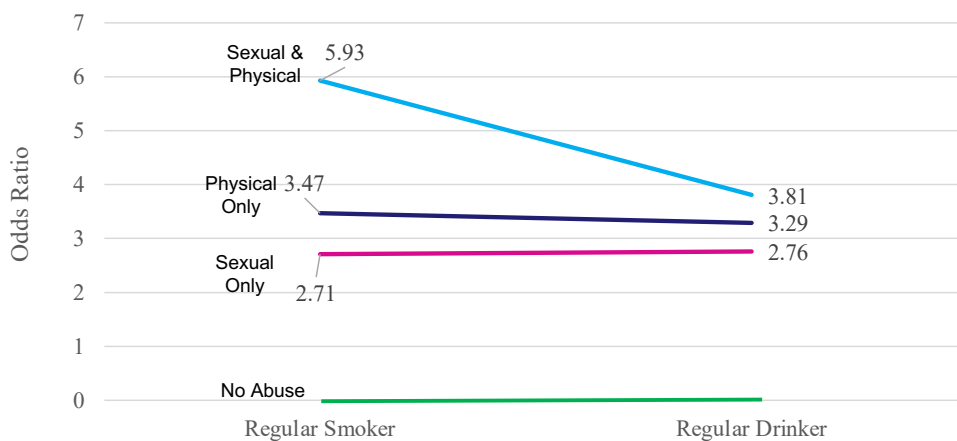
Diaz A, Simatov E, Rickert VI. Effect of abuse on health: results of a national survey. Archives of Pediatric Adolescent Medicine. Aug 2002;156(8):811-817

Independent associations between abuse, mental health, and health status

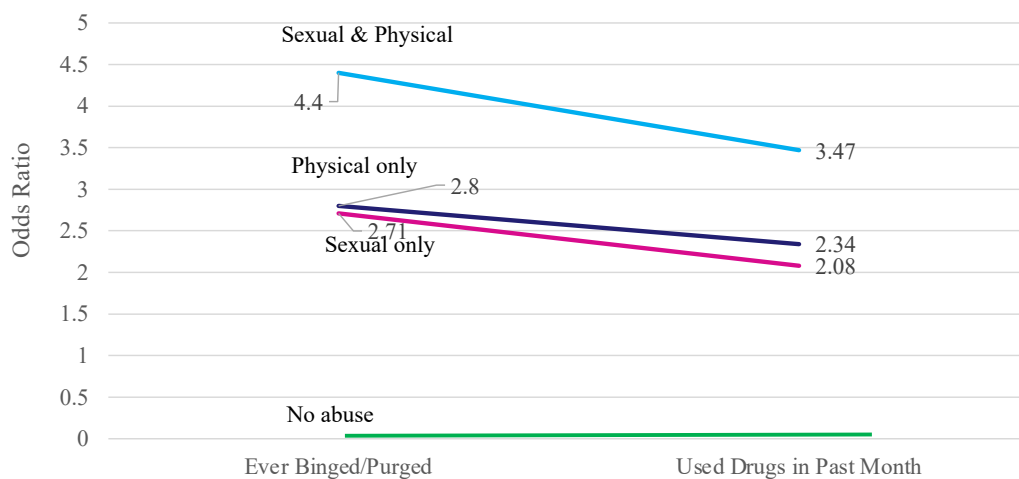




Independent associations between abuse and substance use



Independent associations between abuse, illicit drug use and binge/purge behaviors





Findings from the Mount Sinai Adolescent Health Center

Child sexual abuse

- ▶ 22.7% of my patients disclosed a history of sexual abuse when asked directly during a routine medical screening.
 - 85% abused by family member
 - 66% abused by blood related family members (consistent with incest)
- ▶ 81% of these patients accepted referrals to counseling as a result of this disclosure.



Mount Sinai Adolescent Health Center Sexual Abuse Study: Age at Onset of Sexual Abuse

70% of child sexual abuse began pre-pubertal

- For 51% of females, abuse started and ended before menstruation
- For 19% of females, abuse started before menstruation and ended after

30% of abuse began after menstruation

Profile of sexual victimization

Age of Victim at First Episode*

Age (years)	N
3-4	12
5-6	19
7-8	16
9-10	22
11-12	13
13-14	11
15-17	7

*Mean age at first episode was 8.8 years



Profile of sexual victimization

Age of Perpetrator at First Episode*

Age (years)	N
10-19	20
20-29	19
30-39	28
40-49	20
50-59	5
60-69	7
70-79	3
Unknown	4

*Mean age of perpetrator was 32 years

Profile of sexual victimization

Who Were the Perpetrators?

	First Episode N	All Episodes N (%)
Father	31	34 (21%)
Father Surrogate	22	32 (19%)
Mother or Surrogate	2	3 (2%)
Siblings	7	13(8%)
Other relatives	23	36 (22%)
Nonrelatives	15	47 (8%)
Total	100	165 (100%)



Profile of sexual victimization

Total Number of Perpetrators

	Victims N	Perpetrators N
One	67	67
Multiple	33	98
Total	100	165

Profile of sexual victimization

Frequency of Abuse by First Perpetrator

Frequency	N
Once	21
Over 1 month apart	9
1-3 times per month	13
1-4 times per week	31
5-7 times per week	20
Do not remember	6

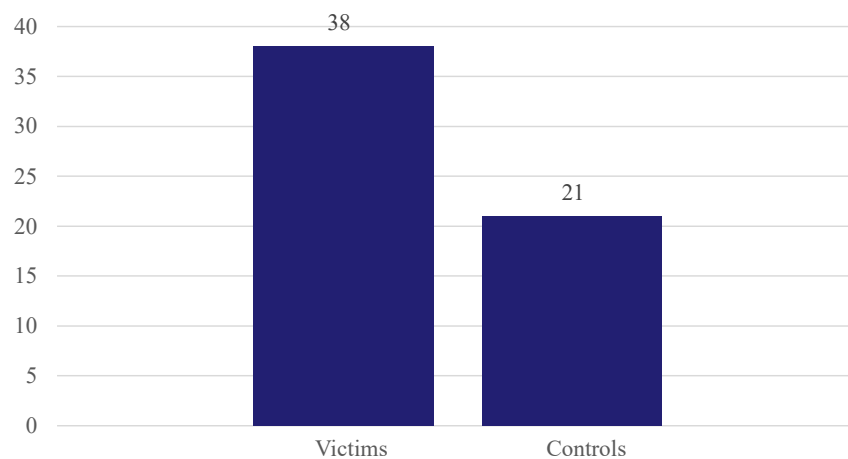


Profile of sexual victimization

Duration of Abuse by First Perpetrator

Duration	N
One day	21
2-6 days	1
1-3 weeks	3
1-5 months	9
6-11 months	4
12-23 months	11
2-5 years	30
6-10 years	18
>10 years	2
Did not remember	2

Percent of youth with a history of running away

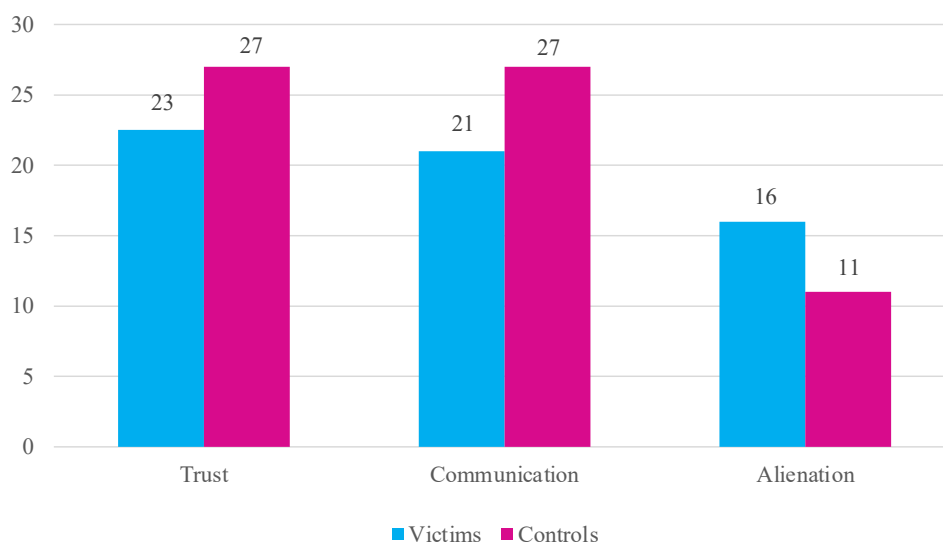




Comparison of Coopersmith Self-Esteem Scores

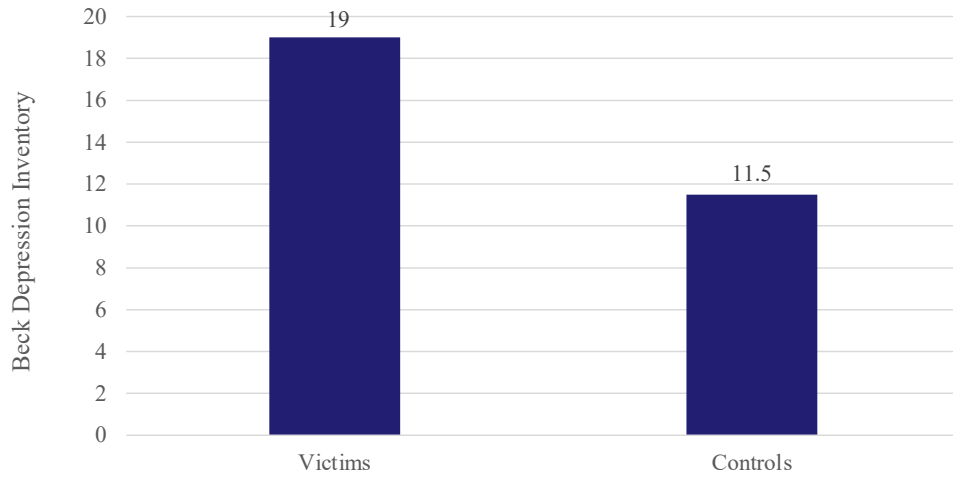


Comparison of perceived relationship with mother

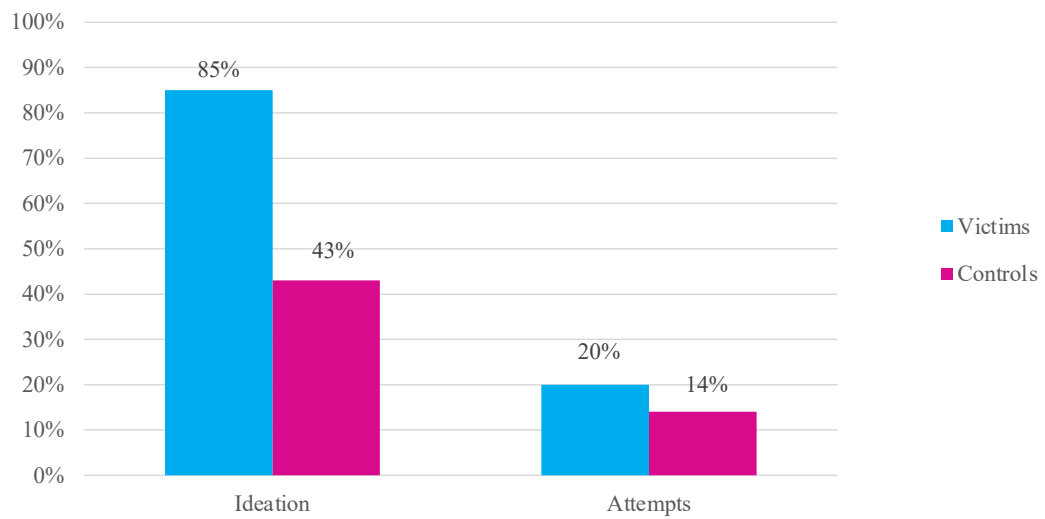




Comparison of depressive symptoms



Comparison of suicidality





Methods used during suicide attempts

Pill overdose	Gun to head
Cut wrists	Poison
Self mutilated	Hanging
Walked in front of car	Inserted stick in vagina
Jumped out a window	

Victimization

Type of Abuse	N
Sexual	100
Physical	68
Emotional	59
Other sexual assault	28

Relationship Status	N
Ever been in a relationship	83
Currently in a relationship	52
Never in a relationship	17

Relationship Abuse	N
Ever experienced abuse in a relationship	25 (30% of victims who had ever been in a relationship experienced relationship abuse)



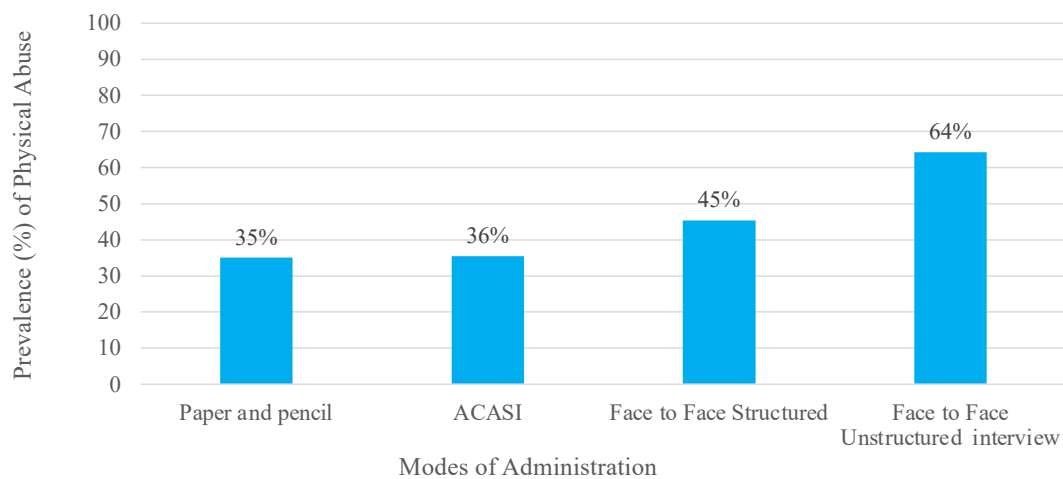
Screening and Disclosure

Comparing modes of administration of a screen for physical abuse

- ▶ Four modes of administration of screens were compared in a sample of 506 adolescents and young adults of all genders ages 12-24 years seeking general health services in primary care
- ▶ Comparisons were made between:
 - Paper and pencil screen
 - Audio Computer Assisted Self Interview (ACASI) screen
 - Face to face structured screen
 - Face to face unstructured clinician interview
- ▶ The paper and pencil, ACASI, and face to face structured screens all used the Childhood Maltreatment Interview Schedule-Short Form (CMIS-SF; John Briere)



Comparison of disclosure of physical abuse by each of the four screening methods



Disclosure of physical and sexual abuse

- ▶ 54.1% of participants disclosed childhood physical and/or sexual abuse
- ▶ 44% disclosed physical abuse
 - 29.6% disclosed physical abuse only
 - 14.5% disclosed physical and sexual abuse
- ▶ 24.5% disclosed sexual abuse
 - 10% disclosed sexual abuse only
 - 14.5% disclosed sexual abuse and physical abuse
- ▶ Among participants reporting sexual abuse, the majority (59.6%) also reported a history of childhood physical abuse

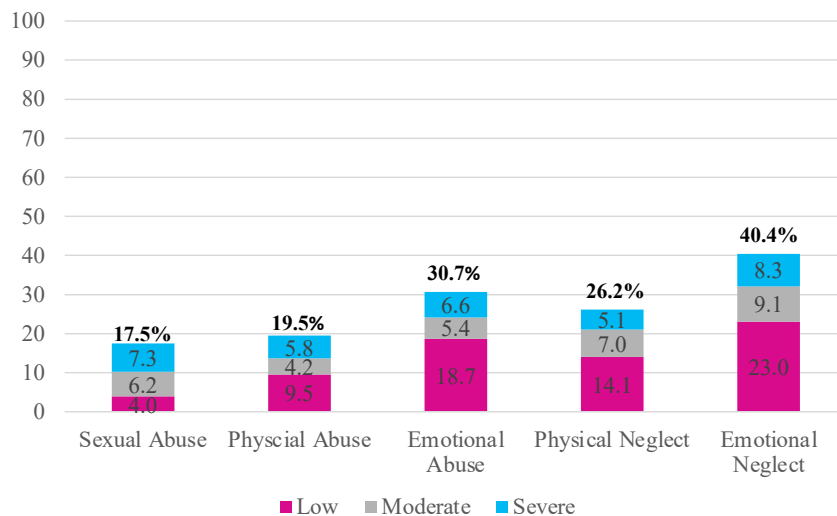


Childhood abuse and neglect in a cohort of adolescent and young adult females from an HPV surveillance study

- ▶ A cohort of adolescent women participating in a HPV vaccine surveillance study between 2012 and 2017
- ▶ 882 inner-city African-American and Hispanic young women 12-20 years of age
- ▶ Used the Child Trauma Questionnaire (CTQ)
- ▶ Cross-sectional study involving self-report surveys

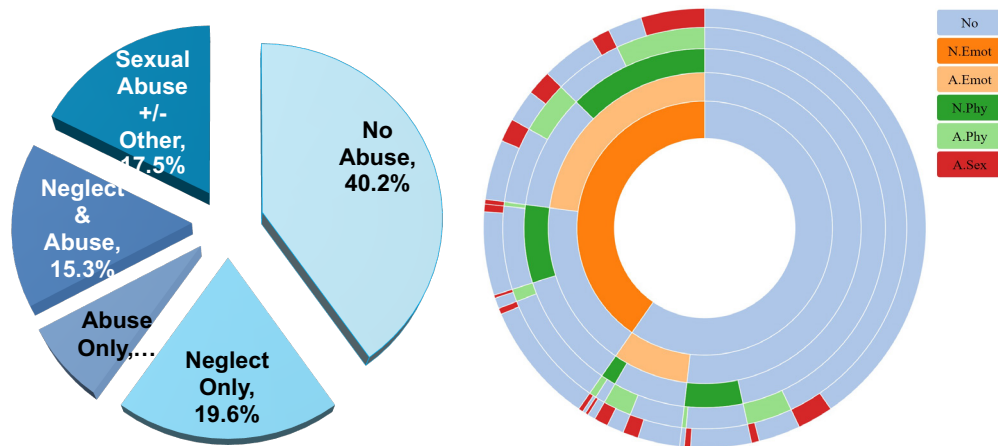
Disclosure of childhood abuse and neglect in a cohort of adolescent and young adult females from an HPV surveillance study

- ▶ 60% experienced childhood abuse or neglect (of any type).
- ▶ 37% experienced childhood physical and/or sexual abuse.





Disclosure of childhood abuse and neglect by adolescent women participating in an HPV surveillance study



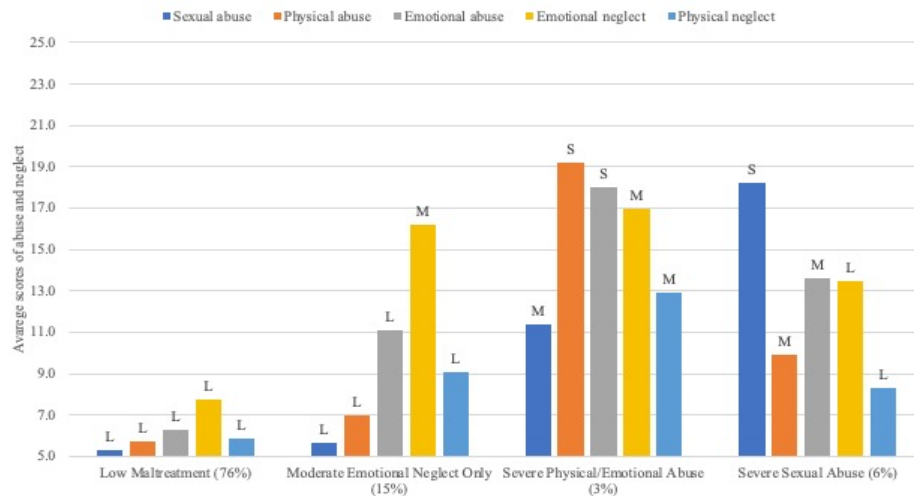
Diaz et al. Child Abuse & Neglect 2020

Female Cohort Demographics at Enrollment

Sexual Activity		History of STIs and Pregnancy	
# of recent partners		Any	43.5%
1	18.3%	Chlamydia	30.7%
2	17.5%	Trichomoniasis	5.1%
3 to 4	29.3%	Gonorrhea	5.2%
5 to 9	24.6%	Bacterial Vaginosis	17.2%
10 or more	10.4%		
Sex of partners		Ever Pregnant	
WSW only	77.1%	No	71.7%
WSW/WSMW	21.9%	Yes	28.3%

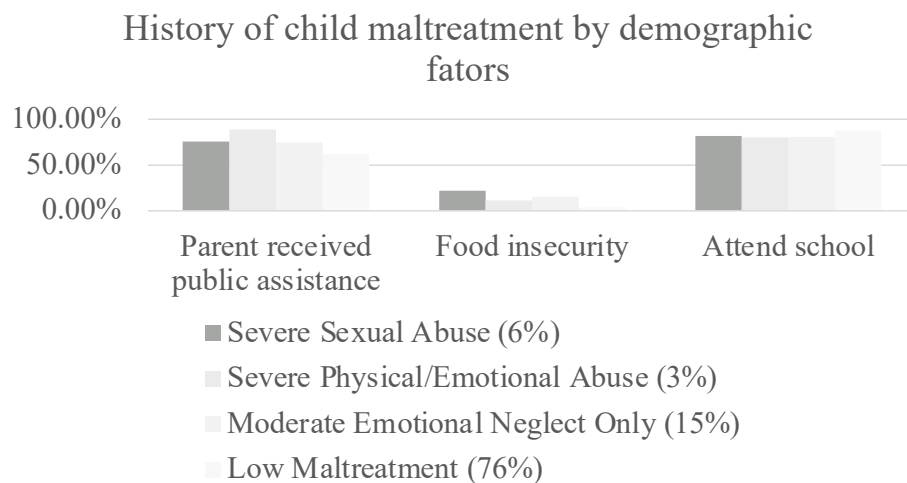


Average abuse and neglect of the four identified profiles



Niu et al. Child Development 2020

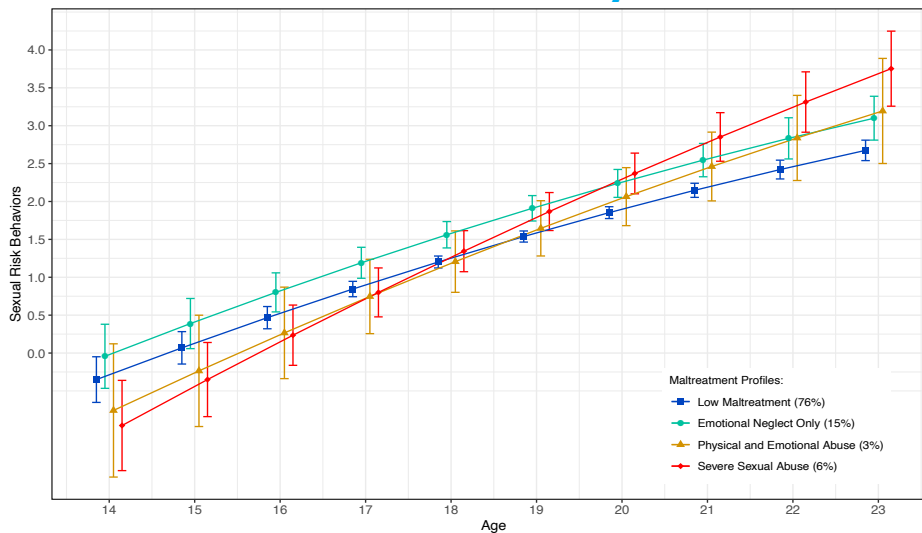
Food insecurity occurred more often among adolescent women with a history of Sexual abuse



Niu et al. Child Development 2020



Victims of childhood abuse and neglect more likely to engage in risky sexual behaviors during adolescence and into early adulthood



Niu et al. *Child Development* 2020

All forms of childhood abuse and neglect is associated with multiple forms of risky sexual behaviors during adolescence and early adulthood

Diaz et al. *Child Abuse & Neglect* 2020
Mar;101:104347. doi:
10.1016/j.chiabu.2019.104347

Independent models	Lifetime # of sex partners	Anal sex ever	Sex partner ≥ 5 years older [‡]	Unprotected sex under influence
Sexual abuse	2.3 (1.3, 4.2) [†]	1.7 (1.0, 2.7)	1.9 (1.1, 3.3)	1.4 (0.9, 2.1)
Physical abuse	1.6 (1.1, 2.3)	2.1 (1.3, 3.3)	2.0 (1.2, 3.3)	1.6 (1.1, 2.5)
Emotional abuse	1.5 (1.1, 2.1)	1.8 (1.2, 2.7)	1.8 (1.1, 2.8)	1.5 (1.0, 2.1)
Physical neglect	1.4 (1.0, 1.9)	1.5 (0.9, 2.3)	1.7 (1.0, 2.6)	1.3 (0.9, 1.8)
Emotional neglect	1.5 (1.1, 2.1)	1.6 (1.1, 2.4)	1.6 (1.0, 2.6)	1.1 (0.8, 1.6)

Diaz et al. *Child Abuse & Neglect* 2020



Physical and emotional abuse and neglect remain associated with risky sexual behaviors even in the absence of sexual abuse

Independent models	Lifetime # of sex partners	Anal sex ever	Sex partner ≥ 5 years older [‡]	Unprotected sex under influence
Physical abuse	1.6 (1.0, 2.4)	2.4 (1.4, 4.1)	2.5 (1.3, 4.9)	2.0 (1.2, 3.4)
Emotional abuse	1.5 (1.1, 2.2)	2.0 (1.2, 3.2)	1.8 (1.0, 3.1)	1.5 (1.0, 2.4)
Physical neglect	1.4 (1.0, 1.9)	1.2 (0.8, 2.0)	1.4 (0.8, 2.4)	1.3 (0.8, 2.0)
Emotional neglect	1.5 (1.1, 2.1)	1.5 (1.0, 2.3)	1.7 (1.0, 2.8)	1.2 (0.8, 1.7)

* Excluding individuals reporting a history of sexual abuse

Diaz et al. *Child Abuse & Neglect* 2020

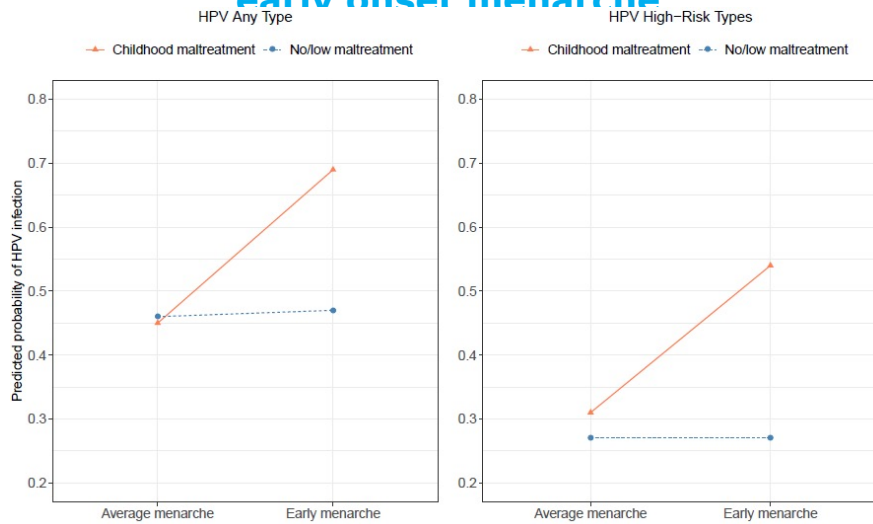
History of childhood abuse and neglect and adolescent pregnancy and contraceptive use

Independent models	Age @ 1 st intercourse [†]	Any Pregnancy [‡]	Little or no contraception use
Sexual abuse	1.2 (0.8, 1.9)	1.2 (0.7, 1.8)	1.0 (0.6, 1.6)
Physical abuse	1.2 (0.8, 1.8)	0.9 (0.6, 1.5)	1.3 (0.8, 1.9)
Emotional abuse	1.2 (0.8, 1.7)	1.0 (0.7, 1.6)	1.1 (0.7, 1.6)
Physical neglect	1.0 (0.6, 1.4)	1.0 (0.7, 1.5)	1.2 (0.8, 1.8)
Emotional neglect	1.1 (0.8, 1.7)	0.8 (0.5, 1.1)	1.3 (0.9, 1.9)

Diaz et al. *Child Abuse & Neglect* 2020
 Mar;101:104347. doi:
 10.1016/j.chiabu.2019.104347

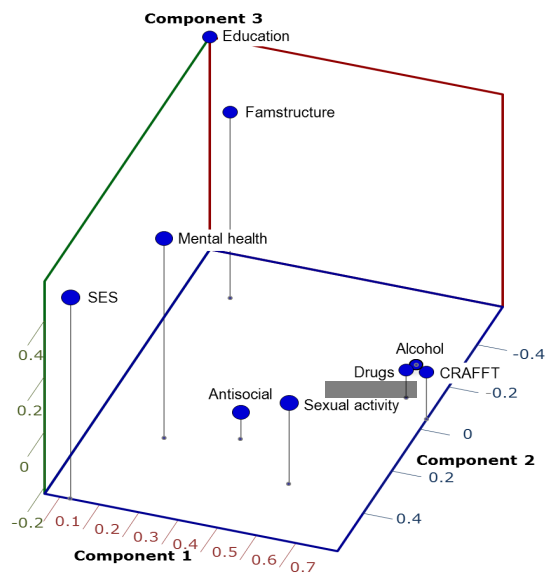


Consequentially, childhood maltreatment is associated with HPV infection in adolescents with early onset menarche



Niu et al. Preventive Med 2020

Substance use and psychosocial stress contribute to risk of 'breakthrough' HPV infections



Linares et al. J Dev Behav Pediatr 2015



Adjusted Associations Between Psychosocial Risk Indices and Detection of Cervical HPV

Psychosocial risk index	Cervical HPV detection			
	Any type	p	Vaccine types	p
Weighted index (8 variables)*	1.08 (0.92, 1.27)	0.345	1.42 (1.05, 1.94)	0.024
Number of recent sex partners	1.21 (1.06, 1.37)	0.002	1.09 (0.91, 1.32)	0.350

* OR (95% CI) for a unit increase in weighted psychosocial risk index score and number of recent partners modeled as separate variable, adjusted for age, ethnicity, history of chlamydia, and vaccination dose.

J Dev Behav Pediatr 2015

History of childhood abuse and neglect is also associated with risky behaviors and depression in adolescents

Independent models	Depressive symptoms	Antisocial behavior	Drug or Alcohol use	Peer Deviancy
Sexual abuse	5.1 (3.2, 8.5)	1.8 (1.1, 2.8)	3.0 (1.9, 4.6)	3.2 (2.1, 5.1)
Physical abuse	4.9 (3.0, 7.9)	1.9 (1.2, 2.9)	3.4 (2.3, 5.3)	3.7 (2.4, 5.8)
Emotional abuse	6.4 (4.0, 10.0)	1.7 (1.1, 2.5)	3.1 (2.1, 4.6)	2.9 (2.0, 4.3)
Physical neglect	3.7 (2.3, 5.7)	1.6 (1.0, 2.4)	2.5 (1.7, 3.6)	2.0 (1.3, 3.7) [†]
Emotional neglect	4.4 (2.8, 6.7)	1.5 (1.0, 2.2)	2.0 (1.4, 2.9)	2.2 (1.4, 3.3) [†]

Diaz et al. *Child Abuse & Neglect* 2020
Mar;101:104347. doi:
10.1016/j.chiabu.2019.104347

Diaz et al. Child Abuse & Neglect 2020



Physical and emotional abuse and neglect without sexual abuse are associated with risky behaviors and depression in adolescents

Independent models	Depressive symptoms	Antisocial behavior	Drug or Alcohol use	Peer Deviancy
Physical abuse	2.7 (1.5, 4.8)	1.9 (1.1, 3.3)	3.1 (1.9, 5.2)	3.2 (1.9, 5.4)
Emotional abuse	5.1 (3.1, 8.4)	1.5 (1.2, 2.4)	3.2 (2.0, 4.9)	2.8 (1.7, 4.9) ^{&}
Physical neglect	2.7 (1.6, 4.4)	1.6 (1.0, 2.5)	2.0 (1.3, 3.1)	1.3 (0.8, 1.9)
Emotional neglect	3.5 (2.2, 5.5)	1.4 (0.9, 2.1)	1.8 (1.2, 2.8)	1.5 (1.0, 2.2)

** Excluding individuals reporting a history of sexual abuse*

Diaz et al. Child Abuse & Neglect 2020



Identification and Healing at the Mount Sinai Adolescent Health Center



Resilience: Three Critical Conditions

- 1) Growing up in distressing life conditions and demanding societal conditions that are considered significant threats or severe adversities
- 2) The availability of protective factors, including internal assets and external resources that may be associated with counteracting the effects of risk factors
- 3) The achievement of positive adaptation despite experiences of significant adversity

G. Windle, "What is resilience? A review and concept analysis," *Reviews in Clinical Gerontology*, vol. 21, no. 2, pp. 152–169, 2011

Protective factors

Taxonomies of protective factors share common elements:

- ▶ Bonding or close relationships with a mature and supportive adult and with a parent who maintains a positive family environment
- ▶ Competence and self-efficacy, including good cognitive abilities, good self regulation, positive self-perception, talents valued by society, social competence, and faith or a sense of meaning in life
- ▶ Supportive environment: an organized home, structured and warm parenting, socio-economic advantage, effective schools, safe neighborhoods with good public health, and access to health care

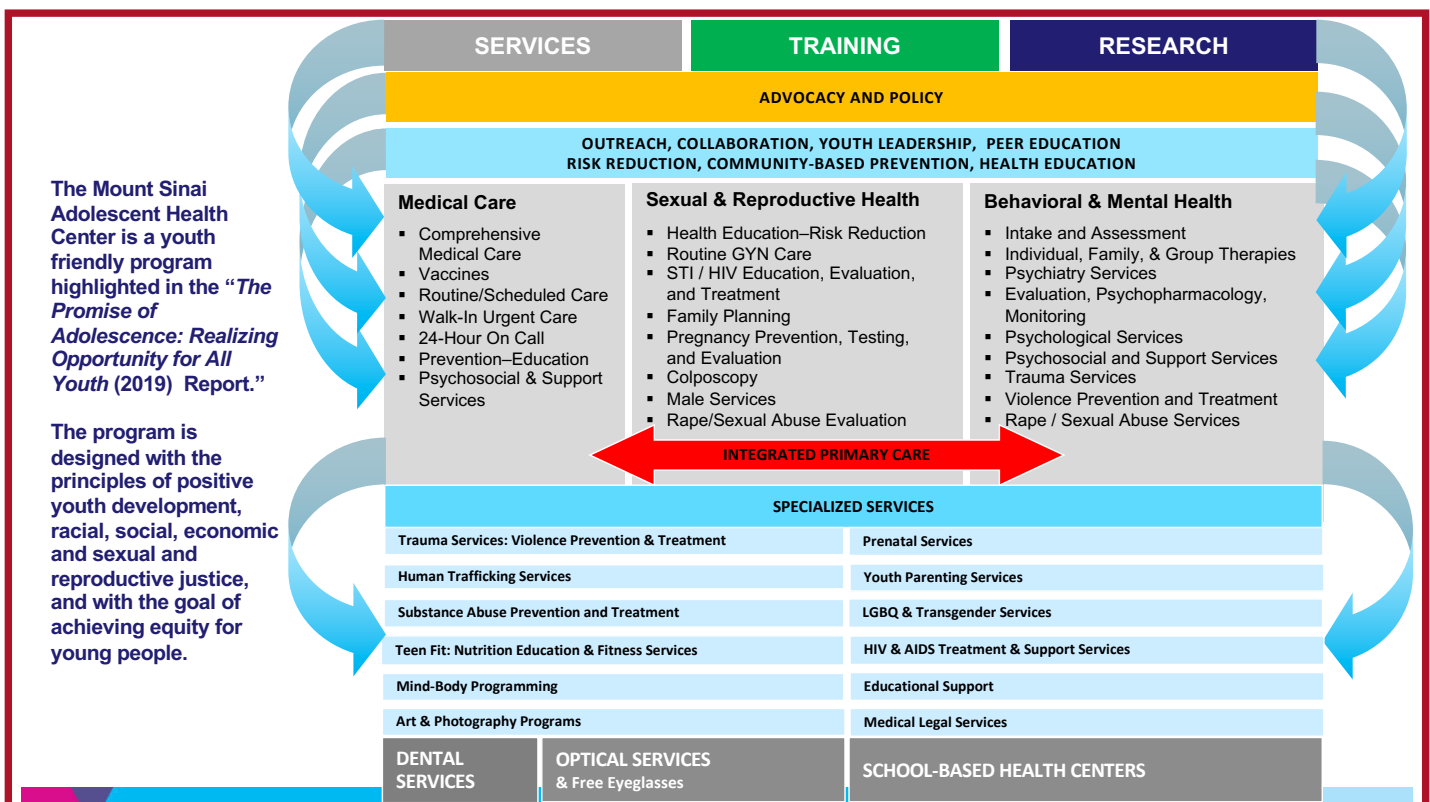
Lee, Cheung, and Kwong, Resilience as a Positive Youth Development Construct: A Conceptual Review, *The Scientific World Journal* Volume 2012



Protective and Compensatory Experiences (PACES)

Relationships and connections	Resources and environments
Give and receive unconditional love	Have an engaging hobby
Have at least one best friend	Get regular exercise
Volunteer	Live in a physically safe home (clean, uncluttered, healthy meals)
Have a mentor	Opportunities for continued learning
Be active in a social group	Have regular routines and habits that promote well-being

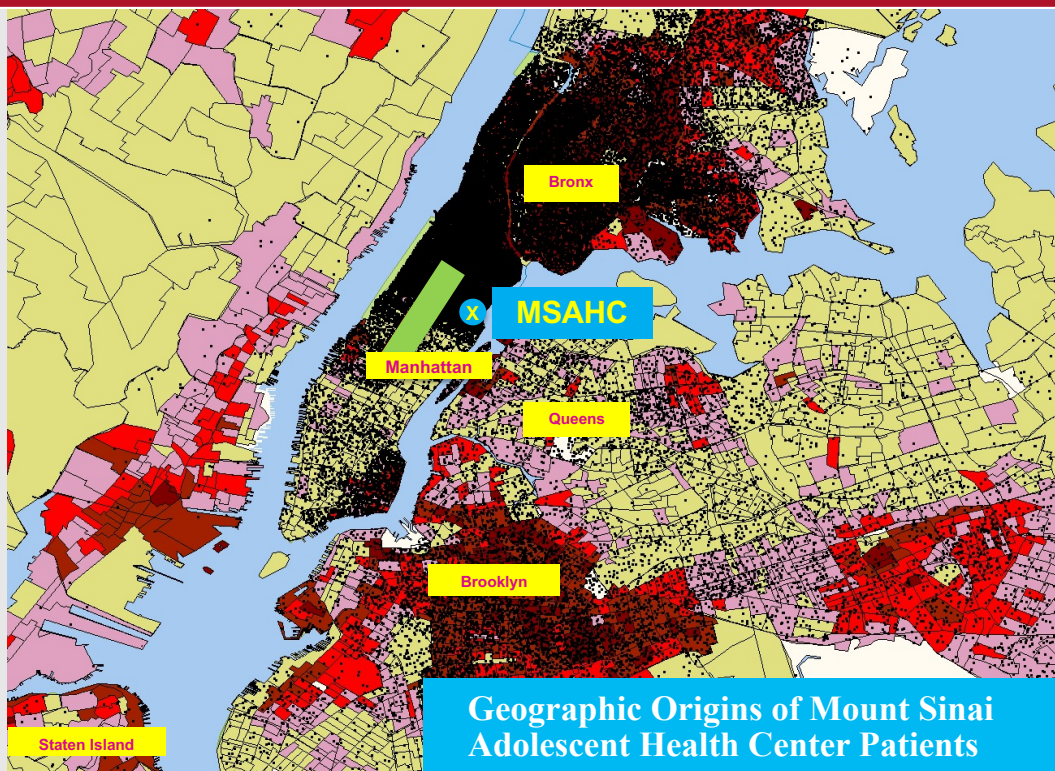
Morris, Hays-Grudo et al (2015)





Trauma-informed & healing-centered care

- ▶ Be aware of trauma and its impact
- ▶ Adopt a safe, patient-centered treatment approach
- ▶ Provide trauma-responsive and healing-centered care
- ▶ Ensure that all staff maintain appropriate interpersonal boundaries
- ▶ Provide a supportive, holistic, integrated, non-judgmental approach
- ▶ Empower the victim/survivor
- ▶ Provide clear and consistent messages about what will happen during each visit, giving patients choice and control
- ▶ Ensure patient's rights to information, privacy, bodily integrity and participation in decision making





Contact Information

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Maternal Health Equity in the Era of COVID-19

Rashi Kumar, MUP
Director, Research and Policy



Purpose and Objectives

PURPOSE	<i>To highlight evidence-based practices to improve maternal health equity</i>
OBJECTIVES	<ul style="list-style-type: none">• Review updated standards of maternity care• Use data to identify current disparities in maternal healthcare and recognize COVID-19's impact on access and equity• Understand evidence-based model implemented by Healthfirst to improve postpartum care among high-risk women• Learn best practices to improve maternal health equity and address patient needs in local communities
FINANCIAL DISCLOSURE	<i>None</i>





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Four-Star-Rated Medicare Advantage Plan out of five stars in 2020²



Five-Star-Rated Medicaid Plan out of five stars 5 years in a row

¹ 2019 Quality Rating by NY State of Health, the official health plan marketplace. Rating is based on a 5-star system. Based on indicators chosen by the New York State Department of Health and published in its annual Quality Assurance Reporting Requirements (QARR) ratings.
² Every year, Medicare evaluates plans based on a 5-star rating system.
*Telemedicine (Teladoc) isn't a replacement for your Primary Care Provider (PCP). Your PCP should always be your first choice for care (both in-person and virtual visits).

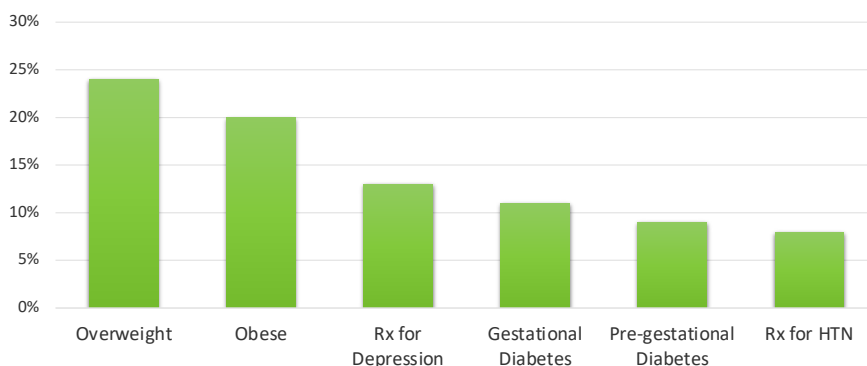
Agenda

- 1 The state of maternal health equity
- 2 The impact of COVID-19 on maternal health
- 3 Updates to the standards of maternal care
- 4 Evidence-based intervention to improve access to postpartum care for high risk women
- 5 Takeaways: pragmatic opportunities for health systems



An increasing proportion of women enter pregnancy with a chronic or mental health condition

Self-Reported Health Conditions in the Listening to Mothers III survey



Creanga, A. A., et al. (2014). Maternal mortality and morbidity in the United States: where are we now?. *Journal of women's health* (2002), 23(1), 3–9. <https://doi.org/10.1089/jwh.2013.4617>

Declercq, E. R., et al. (2014). Major Survey Findings of Listening to Mothers(SM) III: New Mothers Speak Out. *The Journal of perinatal education*, 23(1), 17–24. <https://doi.org/10.1891/1058-1243.23.1.17>

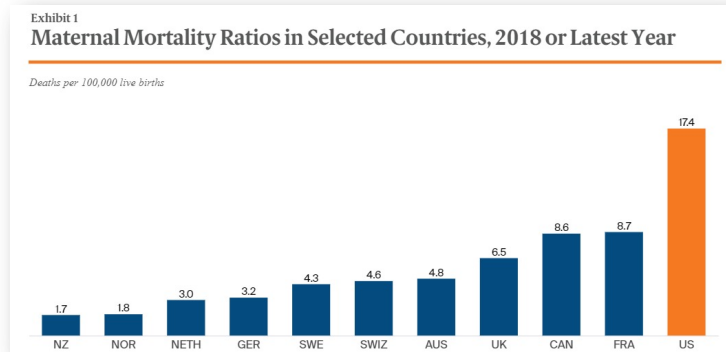
An increasing proportion of women enter pregnancy with a chronic or mental health condition

- Retrospective, cross-sectional analysis using 2005 to 2014 data for delivery hospitalizations:
 - Identification of at least one chronic condition increased from by 40% from 66.9 to 91.8 per 1,000 delivery hospitalizations
 - Prevalence of multiple chronic conditions increases from 4.7 to 8.1
 - Greatest increases in chronic respiratory disease, chronic hypertension, substance use disorder, and pre-existing diabetes

Admon, L. K., Winkelman, T., Moniz, M. H., Davis, M. M., Heisler, M., & Dalton, V. K. (2017). Disparities in Chronic Conditions Among Women Hospitalized for Delivery in the United States, 2005-2014. *Obstetrics and gynecology*, 130(6), 1319–1326. <https://doi.org/10.1097/AOG.0000000000002357>



The US has the highest maternal mortality rate among developed countries

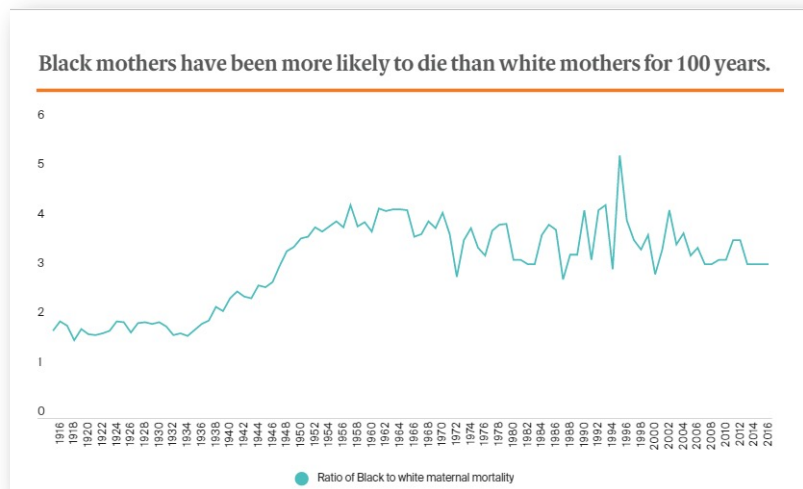


Despite a global decline in maternal mortality, a UN report noted that the United States was one of only two countries globally where the **MMR** (ratio of all pregnancies that result in death) **increased from 2000 to 2017**.

Tikkanen, R., Gunja, M. Z., FitzGerald, M., & Zephyrin, L. (2020, November 18). Maternal mortality and maternity care in the United States compared to 10 other developed countries. Maternal Mortality Maternity Care US Compared 10 Other Countries | Commonwealth Fund. Retrieved September 28, 2021, from <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries>.



Pre-existing health does not explain disparities in maternal mortality



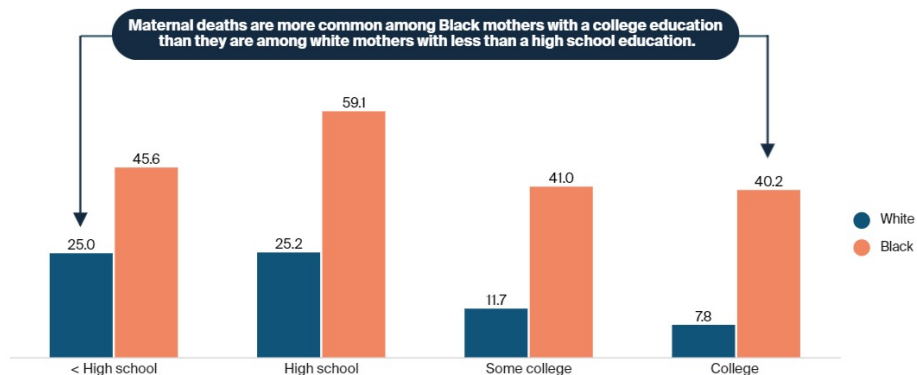
Declercq, E., & Zephyrin, L. (2020, December 16). Maternal mortality in the United states: A primer. Issue Brief & Report. Retrieved September 28, 2021, from <https://www.commonwealthfund.org/publications/issue-brief-report/2020/dec/maternal-mortality-united-states-primer>.





Socioeconomic status does not explain disparities in maternal mortality

A Black mother with a college education is at **60 percent greater risk** for a maternal death than a white or Hispanic woman with less than a high school education.



Tikkanen, R., Gunja, M. Z., FitzGerald, M., & Zephyrin, L. (2020, November 18). Maternal mortality and maternity care in the United States compared to 10 other developed countries. *Maternal Mortality Maternity Care US Compared 10 Other Countries* | Commonwealth Fund. Retrieved September 28, 2021, from <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries>.



Racism impacts maternal and infant health

- Experiences of systematic racial bias lead to chronic stress and “weathering,” which in turn leads to immune suppression
 - AA women are more likely to earn less (63%) and have jobs without structural supports
 - 72% of AA mothers are single heads of households
 - AA families face housing discrimination
 - Health of AA women deteriorates more rapidly during childbearing years

Black women are **50% more likely to have preterm birth** than white women

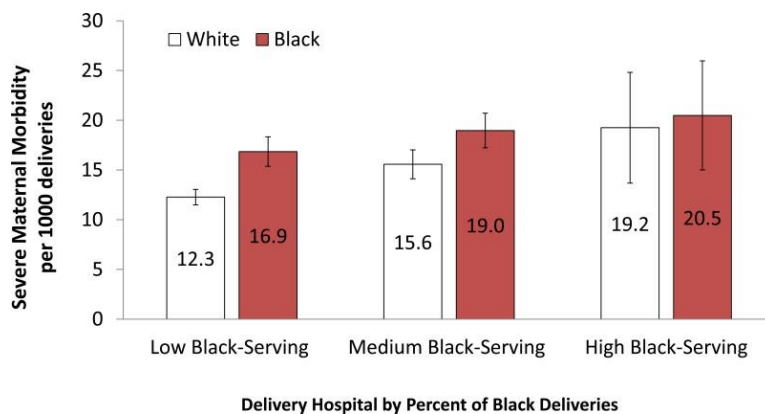
Novoa, C., & Taylor, J. (2018, February 1). *Exploring African Americans' high maternal and infant death rates*. Early Childhood. Retrieved September 28, 2021, from <https://www.americanprogress.org/issues/early-childhood/reports/2018/02/01/445576/exploring-african-americans-high-maternal-infant-death-rates/>

Centers for Disease Control and Prevention. (2020, October 30). *Preterm birth*. Reproductive Health. Retrieved September 28, 2021, from <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm>





Site of care matters for maternal outcomes



Am J Obstet Gynecol. 2016 January ; 214(1): 122.e1–122.e7. doi:10.1016/j.ajog.2015.08.019.

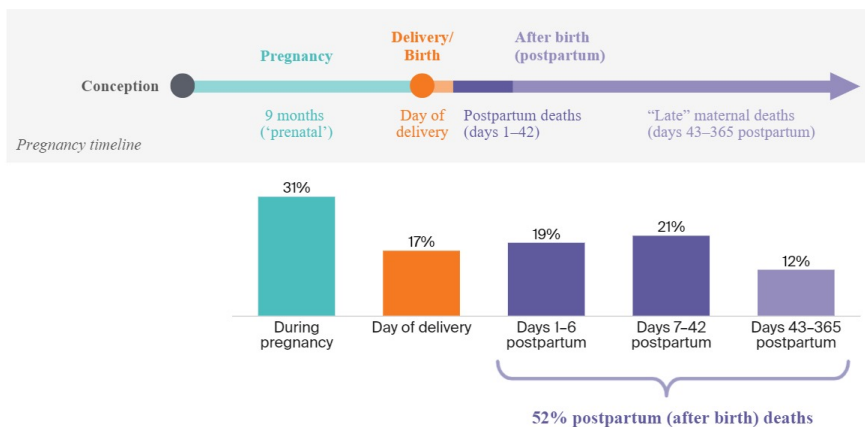
Black-White Differences in Severe Maternal Morbidity and Site of Care

Elizabeth A. HOWELL, MD, MPP, Natalia EGOROVA, PhD, MPH, Amy BALBIERZ, MPH, Jennifer ZEITLIN, DSc, MA, and Paul L. HEBERT, PhD



Late maternal deaths could be impacted by improved care access

Timing of U.S. Maternal and Pregnancy-Related Deaths, 2011–2015



Tikkanen, R., Gunja, M. Z., FitzGerald, M., & Zephyrin, L. (2020, November 18). Maternal mortality and maternity care in the United States compared to 10 other developed countries. *Maternal Mortality Maternity Care US Compared 10 Other Countries* | Commonwealth Fund. Retrieved September 28, 2021, from <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries>.





COVID-19's impact on maternal outcomes

Access to care

Disruption in access to obstetric health care for pregnant women

Mental health

Increased levels of pandemic-related stress, anxiety, and depression among pregnant women

Exacerbation of disparities

Pregnant women, especially Black and Latinx, at high risk for serious COVID-19-related morbidity and mortality.

Symptomatic COVID-19 dx in pregnancy was associated with higher risk of:

- ICU admissions (aRR 3.0)
- Invasive ventilation (aRR 2.9)
- Death (aRR 1.7)

Preis, H., Mahaffey, B., Heiselman, C., & Lobel, M. (2020). Vulnerability and resilience to pandemic-related stress among U.S. women pregnant at the start of the COVID-19 pandemic. *Social science & medicine* (1982), 266, 113348. <https://doi.org/10.1016/j.socscimed.2020.113348>

Zambrano, L. D., et al. (2020, November 5). Update: Characteristics of symptomatic women of reproductive age with laboratory-confirmed SARS-CoV-2 infection by pregnancy status - United States, January 22–October 3, 2020. *Morbidity and Mortality Weekly Report* (MMWR). Retrieved September 28, 2021, from <https://www.cdc.gov/mmwr/volumes/69/wr/mm6944e3.htm>.

ACOG's Updated Standards of Postpartum Care (2018)

Postpartum Care: previous standard was one visit 21 to 56 days after delivery

New standards

Rationale

1	Initial assessment within 3 weeks	Morbidity in early postpartum period
2	Ongoing care as needed	Burden of chronic disease among birthing populations
3	Comprehensive postpartum care 12 weeks after birth (individualized, person-centered timing)	40 percent of mothers do not receive postpartum care
		Access to contraceptives (birth spacing, avoidance of subsequent pre-term birth)

New mothers need ongoing care during the 'fourth trimester.' We want to replace the one-off checkup at six weeks with a period of sustained, holistic support for growing families. "Our goal is for every new family to have a comprehensive care plan and a care team that supports the mother's strengths and addresses her multiple, intersecting needs following birth."

Alison Stuebe, M.D., lead author of the Committee Opinion



Evidence-based intervention to improve access to postpartum care

A study by Healthfirst, Mount Sinai, and the New York Academy of Medicine funded by the Robert Wood Johnson Foundation

AJPH PRACTICE

Timely Postpartum Visits for Low-Income Women: A Health System and Medicaid Payer Partnership

Elizabeth A. Howell, MD, MPP, Amy Balbierz, MPH, Susan Beane, MD, Rashi Kumar, MUP, Tom Wang, MPH, Kezhen Fei, MS, Zainab Ahmed, BA, and José A. Pagán, PhD

15 9/30/21

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Evidence of Problem

- Significant disparities in receipt of postpartum care
- Postpartum visits LOW among high-risk minority mothers
 - Healthfirst patients (58%); patients w/ HTN (46%) and diabetes (50%)
 - Earlier study of 312 women w/ gestational diabetes, 60% went for postpartum visit; 42% of those completed glucose test
- Postpartum visits HIGH among low-risk white mothers
 - Low-risk commercially insured, 80-90%
- Multiple barriers: poor clinician communication, transportation

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Project Objectives

- Improve quality of care for high-risk postpartum mothers by combining case management intervention and payment reform
- Increase rates of timely postpartum care among high-risk obstetrical patients
- Evaluate the impact of the intervention on receipt of postpartum care, ED Visits, hospitalizations, maternal depression, and cost



Multi-level Intervention

Care delivery

- Evidence-based case management intervention* aimed at increasing rates of postpartum visits and connecting women with care
- Prepare/educates women about GDM, HTN, depression, bolsters support and self-management
- Increases access to community resources; reduces barriers to f/u care

Delivery system

- Cost-sharing arrangement between Mount Sinai and Healthfirst) to cover staff, provide clinician education & incentives
- Patient Incentives – postpartum visit payments, roundtrip Metrocard, raffle
- Physician Incentives
- Nonfinancial Incentives: clinician education, performance feedback

18 * Howell, E. A., et al. (2012). Reducing postpartum depressive symptoms among black and Latina mothers: a randomized controlled trial. *Obstetrics and gynecology*, 119(5), 942–949. <https://doi.org/10.1097/AOG.0b013e318250ba48>





Target Population

- Postpartum women, age ≥18; insured by Healthfirst
 - Hypertension
 - Gestational diabetes
 - Late registrants for prenatal care
 - Depressive symptoms
 - High risk neighborhoods (zip codes) for diabetes and hypertension according to the NYC DOH
- Recruited/enrolled during postpartum hospital stay
- Goal: Enroll 510 women w/ Healthfirst Insurance

Matched Healthfirst comparison groups created

	Before propensity score matching			After propensity score matching	
	Intervention Group (HEDIS)	Comparison Group (HEDIS)	Standardized difference	Comparison Group (HEDIS)	Standardized difference
Matching Variable	N = 363	N = 37,912		N = 726	
Age	29.13	29.14	0.002	29.53	0.068
Language					
English	69.1% (251)	62.9% (23,840)	0.133	67.6% (491)	0.033
Spanish	30.6% (111)	25.4% (9,640)	0.115	32% (232)	0.03
Other	0.3% (1)	11.7% (4,432)	0.496	0.4% (3)	0.024
Clinical High Risk					
Diabetes	11.3% (41)	13.1% (4,968)	0.055	11.8% (127)	0.017
Hypertension	9.6% (35)	5.5% (2,072)	0.159	9.6% (105)	0
Mental Illness	1.9% (7)	2.4% (904)	0.031	1.1% (15)	0.068
Pre-delivery Enrollment Days	408.3	429.1	0.033	396.6	0.05
UHF Zip Codes	**	**	**	**	**

** results not shown



Outcomes: Improved Care Access and Satisfaction

	Intervention	Matched Control	p-value
Timely Postpartum Visits (HEDIS 21-56 days)	66.9%	56.0%	<.01
Postpartum Care (7-90 days)	73.7%	67.2%	.03
Outpatient care up to 90 days postpartum	90.2%	83.4%	<.01
Enrolled in plan 6 months after delivery	79.1%	73.3%	.02

Of 375 mothers who completed the 3-week survey

- 86% reviewed educational materials at home
- >99% of them found the materials helpful

Lessons Learned

- Multiple stakeholders and a multilevel intervention (patient education, care coordination, clinician and staff education, community and medical resources) were necessary to achieve outcomes
 - Aligned incentives between a Medicaid managed care organization and large health care system
 - Cost share to support team-based care
- Next phase: bridging high-risk women back to primary care



Policymakers are exploring other evidence-based models

Midwifery

- Increased rates of vaginal delivery
- Lower rates of c-section, preterm births and LBW¹

Pregnancy Medical Homes

- TX, NC
- Shared decision making
- Expanded hours
- Care coordination
- Reduction in LBW¹

Community-based doulas

- More care satisfaction
- Lower rates of LBW and birth complications¹

Group Prenatal Care

- Reduces preterm birth, NICU admissions, LBW; increases breastfeeding, patient/physician satisfaction
- Improves health outcomes among Black people w/low income²

1. Zephyrin, L., Seervai, S., Lewis, C., & Katon, J. G. (2021, March 4). Community-based models to improve maternal health outcomes and promote health equity. Issue Briefs. Retrieved September 28, 2021, from <https://www.commonwealthfund.org/publications/issue-briefs/2021/mar/community-models-improve-maternal-outcomes-equity>.

2. New York State Taskforce. (2019). Maternal Mortality and Disparate Racial Outcomes. Recommendations to the Governor to Reduce Maternal Mortality and Racial Disparities. Retrieved September 28, 2021, from https://www.health.ny.gov/community/adults/women/task_force_maternal_mortality/docs/maternal_mortality_report.pdf.

Gaps and Barriers to Comprehensive Primary Care for Women

- Sex and gender-based bias: dismissing concerns reduces willingness to access care
- Racial bias and negative patient-provider interactions
- Blacks and Hispanics are less likely to cite a usual source of care (medical home)



Zephyrin, L., Suennen, L., Viswanathan, P., Augenstein, J., & Bachrach, D. (2020, July 16). Transforming primary health care for women - Part 1: A framework for addressing gaps and barriers. Fund Reports. Retrieved September 28, 2021, from <https://www.commonwealthfund.org/publications/fund-reports/2020/jul/transforming-primary-health-care-women-part-1-framework>.



Summary

- Maternal health outcomes are influenced by disease burden as well as systemic issues, including racism and discrimination.
- COVID-19 exacerbated existing inequities by reducing access to care and worsening mental health. Pregnant women who contracted COVID-19 were at higher risk for adverse maternal outcomes.
- Healthfirst and Mount Sinai leveraged value-based arrangements to deploy a care navigator who increased access to postpartum care – helping high risk minority women overcome systemic issues.
- Facilitating access to care, including comprehensive primary care, is key to changing the maternal health equation.

Thank You

- Thanks to the Healthfirst Research and Policy Team contributors!
 - Hannah Ashkinaze, MPH
 - Shelley Shen, MPH





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From policy statement to practice

Scaling social needs screening and outreach in a large urban health system

Kevin Fiori MD, MPH, MSc
Director- Social Determinants of Health
Office of Community & Population Health
Montefiore Health System

Purpose and Objectives

PURPOSE

To describe one urban health system's experience integrating social needs screening and outreach

OBJECTIVES

- Review evidence to date and recommendations for integrating social care into health care delivery
- Summarize past & present social need assessment activities in one health system (Montefiore)
- Share learning and best practices in scaling social needs screening within a large ambulatory network

FINANCIAL DISCLOSURE

I have documented no financial relationships to disclose or Conflicts of Interest (COIs) to resolve.



Agenda

- Policy
 - Terminology
 - Integrating social care
- Practice
 - Social needs screen
 - Community assets
 - Data feedback loops
- Results & Learning
 - Implementation in “real world” setting
 - Elements of best practice

Terms: Social Determinants of Health, Social Risk Factors vs. Social Needs

THE MILBANK QUARTERLY
A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

Perspective

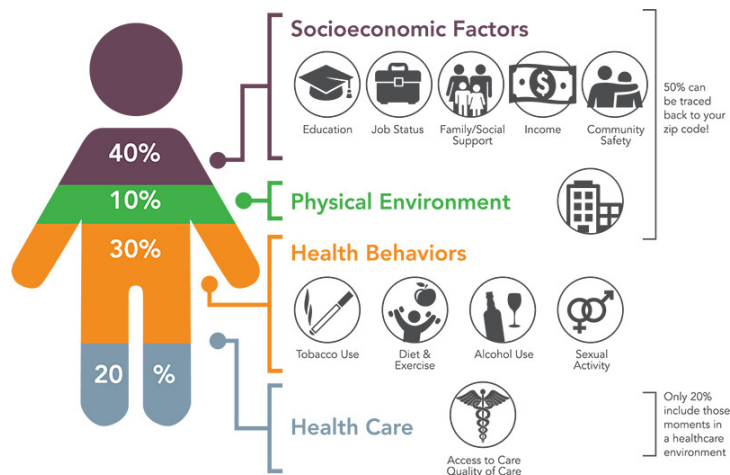
Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems

HUGH ALDERWICK^{*†} and LAURA M. GOTTLIEB[†]

Social Determinants of Health: conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

Social Risk Factors: specific adverse social conditions that are associated with poor health, like social isolation or housing instability

Social Needs: depend on people’s individual preferences and priorities. Distinguishing between social risks and social needs emphasizes the patient’s role in identifying and prioritizing social interventions.



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)



Rethinking Comprehensive Primary Care: Social Needs Assessment

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Poverty and Child Health in the United States

COUNCIL ON COMMUNITY PEDIATRICS

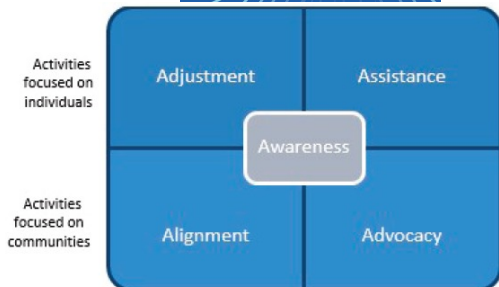
“Screen for risk factors within social determinants of health during patient encounters. Practices can use a brief written screener or verbally ask family members questions about basic needs, such as food, housing, and heat.”



*Sources:

- 1) Garg et al. Linking Urban Families to Community Resources in the Context of Primary Care. *Patient Educ & Counseling* 2010.
- 2) Garg et al. Addressing Social Determinants of Health at WCC visits: A Cluster RCT. *Pediatrics* 2015.
- 3) Gottlieb et al. Effects of Social Needs Screening and In-Person Service Navigation on Child Health. *JAMA Peds* 2016.
- 4) Berkowitz et al. Addressing Unmet Basic Resource Needs as Part of Chronic Cardio-metabolic Disease Management. *JAMA Intern Med* 2017.
- 5) Kangovi et al. Community Health Worker Support for Disadvantaged Patients With Multiple Chronic Diseases: A Randomized Clinical Trial. *Am J Public Health*. 2017

Integrating Social Care: National Academy of Sciences Report (2019)



Activity	Definition	Transportation-Related Example
Awareness	Activities that identify the social risks and assets of defined patients and populations.	Ask people about their access to transportation.
Adjustment	Activities that focus on altering clinical care to accommodate identified social barriers.	Reduce the need for in-person health care appointments by using other options such as telehealth appointments.
Assistance	Activities that reduce social risk by providing assistance in connecting patients with relevant social care resources.	Provide transportation vouchers so that patients can travel to health care appointments. Vouchers can be used for ride-sharing services or public transit.
Alignment	Activities undertaken by health care systems to understand existing social care assets in the community, organize them to facilitate synergies, and invest in and deploy them to positively affect health outcomes.	Invest in community ride-sharing or time-bank programs.
Advocacy	Activities in which health care organizations work with partner social care organizations to promote policies that facilitate the creation and redeployment of assets or resources to address health and social needs.	Work to promote policies that fundamentally change the transportation infrastructure within the community.

National Academies of Sciences, Engineering, and Medicine. 2019. *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25467>.



Tools: Integrating Social Needs Screening in Clinical Practice

Montefiore: Integrated Social Needs Screening & Outreach (2017-2021)

Standardized Social Needs Screen

Referrals

Resource Navigation

SOCIAL NEEDS SCREENING TOOLKIT

Question	YES/NO
Are you worried that in the next 2 months, you may not have a safe or stable place to live? (eviction, being kicked out, homelessness)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you worried that the place you are living now is making you sick? (has mold, bugs/rodents, water leaks, not enough heat?)	<input type="checkbox"/> YES <input type="checkbox"/> NO
In the last 12 months, did you worry that your food could run out before you got money to buy more?	<input type="checkbox"/> YES <input type="checkbox"/> NO
In the last 3 months, has the electric, gas, oil or water company threatened to shut off services to your home?	<input type="checkbox"/> YES <input type="checkbox"/> NO
In the last 12 months, has lack of transportation kept you from medical appointments or getting your medications?	<input type="checkbox"/> YES <input type="checkbox"/> NO
In the last 3 months, did you have to skip buying medications or going to doctor's appointments to save money?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you need help getting child care or care for an elderly or sick adult?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you need legal help? (Child/Family services, immigration, housing, discrimination, domestic issues, etc.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you finding it so hard to get along with a partner, spouse, or family members that it is causing you stress?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does anyone in your life hurt you, threaten you, frighten you or make you feel unsafe?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you want help?	<input type="checkbox"/> YES <input type="checkbox"/> NO

FOOD AND NUTRITION

FOOD PANTRY
City of Faith Church of God - Food Pantry
1000 Broadway Ave, Bronx, NY 10467
Language: English
Hours: Tue - 10:00 PM - 2:00 AM
Phone: (718) 278-8522
View Website

Handicare NY Prevention Center
1000 Broadway Ave, Bronx, NY 10467
Language: English, Spanish
Hours: Mon - 12:00 PM - 2:00 PM
Phone: (718) 555-3648
View Website



Screen Development: Versions of Screening Tool

Ver 1.0 May 2017 – Apr 9, 2018

Ver 2.0 Apr 10, 2018 – Dec 8, 2019

Ver 3.0 Dec 9, 2019 – Present

Screener Changes

Version 1

- Modified from Health Leads Survey
- Seven questions

Version 2

- Increased screener to 10 questions
- Added Legal Questions
- Added Household Quality

Version 3

- Reduced time period to 3 months from 12 months on Transportation, Medication and Utility Questions
- Added stress aspect to familial relationship question
- Added Do You Want Help Question

		YES / NO
	Are you worried that in the next 2 months, you may not have a safe or stable place to live? (risk of eviction, being kicked out, homelessness)	<input type="checkbox"/> <input type="checkbox"/>
	Are you worried that the place you are living now is making you sick? (has mold, bugs/rodents, water leaks, not enough heat)	<input type="checkbox"/> <input type="checkbox"/>
	In the last 12 months, did you worry that your food could run out before you got money to buy more?	<input type="checkbox"/> <input type="checkbox"/>
	In the last 12 months, has the electric, gas, oil or water company threatened to shut off services to your home?	<input type="checkbox"/> <input type="checkbox"/>
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	In the last 3 months, did you have to skip buying medications or going to doctor's appointments to save money?	<input type="checkbox"/> <input type="checkbox"/>
	Do you need help getting child care or care for an elderly or sick adult?	<input type="checkbox"/> <input type="checkbox"/>
	Do you need legal help? (child/family services, immigration, housing discrimination, domestic issues, etc.)	<input type="checkbox"/> <input type="checkbox"/>
	Are you finding it so hard to get along with a partner, spouse, or family members that it is causing you stress?	<input type="checkbox"/> <input type="checkbox"/>
	Does anyone in your life hurt you, threaten you, frighten you or make you feel unsafe?	<input type="checkbox"/> <input type="checkbox"/>
	Do you want help?	<input type="checkbox"/> <input type="checkbox"/>

Phone Number: _____

Best time to Call: _____

Social Determinants of Health
Disclaimer: This screening tool is a derivative of Leads (https://healthleads.org) for 4.0 International License (https://creativecommons.org/licenses/by/4.0/).
Montefiore Health System Community

Best time to Call: _____

Montefiore Social Determinants of Health Survey
As of March 9, 2018
Disclaimer: This screening tool is a derivative of Leads (https://healthleads.org) for 4.0 International License (https://creativecommons.org/licenses/by/4.0/).
Montefiore Health System's Office of Community Health



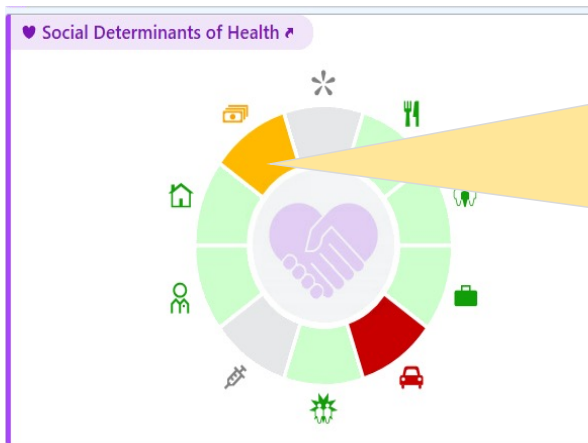
EHR Integration: Standardized Screen in Electronic Health Record

The screenshot shows a patient's EHR record with a 'Screenings (Pediatric)' section. The screening tool is integrated into the chart, showing questions and their status (Accepted/Declined). A 'Chart Review' window is open, displaying a detailed view of the patient's health, including a 'Social Determinants of Health - Social Determinants of Health' section. This section includes a survey status, a list of questions, and a detailed chart review of the patient's health data, including asthma management and social determinants of health. The chart review shows a 'My Last Review Note' dated 2/24/2020, detailing the patient's asthma symptoms, current symptoms, and management plan. The 'Social Determinants of Health' section includes a 'DIET' section with a 'DIET' icon, a 'DIET' section with a 'DIET' icon, and a 'DIET' section with a 'DIET' icon.





EHR Integration: Information On Social Need And Risk Level



▼ Social Determinants of Health

Economic Stability

8/2017 Today

AUG 3 2020 Medium Risk

In the last 3 months, has the electric, gas, oil or water company threatened to shut off services to your home?
No

In the last 3 months, did you have to skip buying medications or going to doctor's appointments to save money?
Yes

Referral Order (“Community Health”): Support By CHWs

CHW REFERRAL

Ambulatory referral to Community Health

Internal Referral

Class: Internal Ref

Referral: Override restrictions

Linkage and Referral

Care Coordination and Navigation

Health Promotion and Coaching

Comments:

Status: Normal Standing Future

Search

Title

- Housing / Utilities
- Food Assistance
- Transportation
- Childcare support
- Employment / vocational/ career training
- Benefits (SSD/SSI)
- Legal Services

Search

Title

- Appointment adherence
- Patient care navigation & accompaniment
- Home visits

Search

Title

- Healthy lifestyle activities (i.e. walking groups, nutrition, tobacco cessation)
- Care plan support (i.e. increase health literacy, offer follow up, help navigate challenges)
- Other

Sched Order Workqueue - COMMUNITY HEALTH SCHEDULED ORDERS (12391) - Restricted View Last refreshed: 12/21/2018 11:57:33 AM

Active (Total: 3)	Deferred (Total: 0)	Removed (Total: 4)	Ordering Department	Procedure	Priority	Title	Phone Number	# Ca.	Notes	Category
			COMPREHENSIVE HEALTH CARE CENTER MG PEDIATRICS	AMB REFERRAL TO COMMUNIT...	Routine	Needs Sche...		0	OP REF ORD BAHN	OP REF ORD BAHN
			COMPREHENSIVE HEALTH CARE CENTER MG PEDIATRICS	AMB REFERRAL TO COMMUNIT...	Routine	Needs Sche...		0	OP REF ORD BAHN	OP REF ORD BAHN



Feedback loop: CHW Note in Electronic Health Record

My Note

History

No past medical history on file.
No past surgical history on file.

Social History

Socioeconomic History

- Marital status: Single
- Spouse name: Not on file
- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Tobacco Use

- Smoking status: Current Some Day Smoker
- Smokeless tobacco: Never Used

Family History

Problem	Relation	Age of Onset
• Asthma	Mother	
• CHF	Father	
• Congenital heart disease	Brother	

Patient Categories

(Patient Categories:23925)

Patient Needs

(Housing Needs:23926)
(Employment/Vocational/Career Needs:23927)
(Benefits/Entitlement Needs:23928)
(Care Coordination & Navigation Needs:23931)

Plan

(Housing Needs:23942)
(Employment/Vocational/Career Needs:23943)
(Benefits/Entitlement Needs:23944)
(Care Navigation Needs:23945)
(Legal Needs:23946)
(Youth & Family Services:23948)

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EINSTEIN Montefiore
Albert Einstein College of Medicine

Identifying Community Assets: Social Service Directory & Resource Sheets

Our team is updating 25,916 services in the New York area with COVID-19 statuses to reflect changing availability. More information can be found [here](#). If you know of any service changes in your community, submit an update to [update@nowpow.com](#).

Browse Food pantry

Showing 1 - 50 of 206 results for "Food pantry" within 10 miles of: 10467

Montefiore Medical Center - Project Bravo

COVID-19 Status: Pickup

Food pantry

Address: 3028 Bainbridge Ave Bronx, NY 10467
Distance: .66 miles
718-231-3276
Hours: Mon - 12:00 PM - 2:00 PM
Fees: Free
Restricted To: Residents of Bronx, County

Inmaculate Conception Church

COVID-19 Status: Service Unavailable

Food pantry

Address: 754 E Gun Hill Rd Bronx, NY 10467
Distance: .66 miles
718-653-2200
Hours: Sat - 10:00 AM - 12:00 PM
Fees: Free
Caters To: Homeless, Unemployed

Christ Disciples International Ministries, Inc.

COVID-19 Status: Pickup

Food pantry

Address: 3031 Webster Ave Bronx, NY 10467
Distance: .66 miles
646-294-7726
Hours: Mon - 10:30 PM - 5:00 PM
Fees: Free

Montefiore Medical Group
Comprehensive Health Care Center

Montefiore Health System (MHS) provides healthcare services to residents of the Bronx and Westchester County. We are dedicated to advancing the health of the communities we serve. Through our commitment to supporting your health and wellbeing, we partner with local organizations to best connect you and your family with community resources, as needed.

(718) 579-2500
<http://www.montefiore.org/mmg>
305 East 161st Street
Bronx, NY 10451
N/A

Child Care and Parenting

After-school program

1 Bronx River Art Center (BRAC) - Art Education Program Distance: 1.15 miles
COVID-19 Status: Phone/Visual
1007 E Tremont Ave Bronx, NY 10460 | Language: English, Spanish | Hours: Mon - Fri 10:00 AM - 6:00 PM, Sat 12:00 PM - 5:00 PM | Fees: Self Pay, Sliding Fee
(718) 589-5819 | info@bronriverart.org | <http://bronriverart.org>

Employment

Job search assistance

2 Catholic Charities Community Services - Blackrock Avenue Distance: 0.68 miles
2155 Blackrock Ave Bronx, NY 10472 | Language: English, Spanish | Hours: Mon - Fri 9:00 AM - 5:00 PM | Fees: Free
(718) 414-1050 | nawinsing@archny.org | <http://catholiccharitiesny.org/>

3 Catholic Charities Community Services - Garrison Avenue Distance: 2.31 miles
890 Garrison Ave Bronx, NY 10474 | Language: English | Hours: Mon - Fri 9:00 AM - 5:00 PM | Fees: Free
(603) 239-9630 | webster.fernandez@archny.org | <https://catholiccharitiesny.org/our-agencies/catholic-charities-community-services-homebase-ii>

Your code from today's visit is XXN30R00V8
To see this HealthRx online, please visit <https://app.nowpow.com/patient>

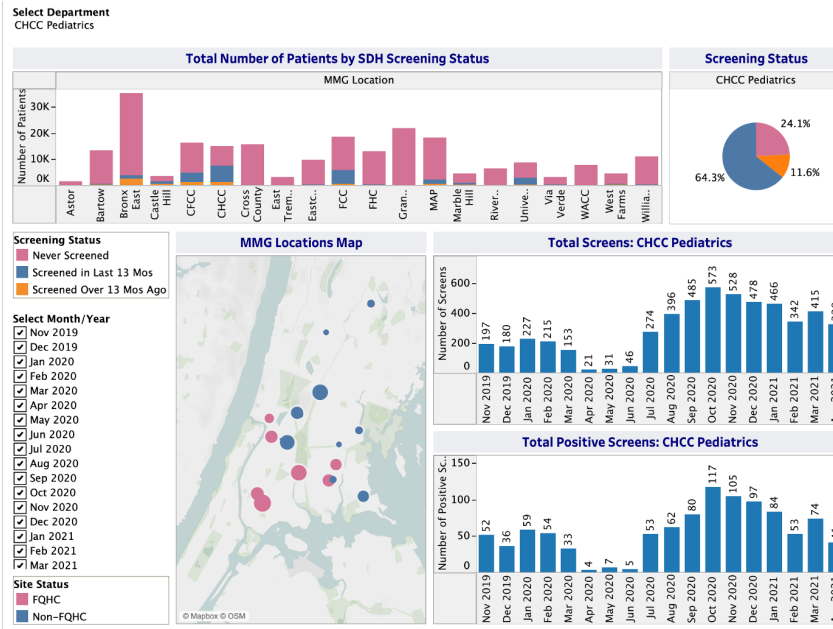
DISCLAIMER NowPow does not endorse any service providers mentioned in this HealthRx. NowPow does not guarantee that the services mentioned in this HealthRx will be available to you or will improve your health or wellness.

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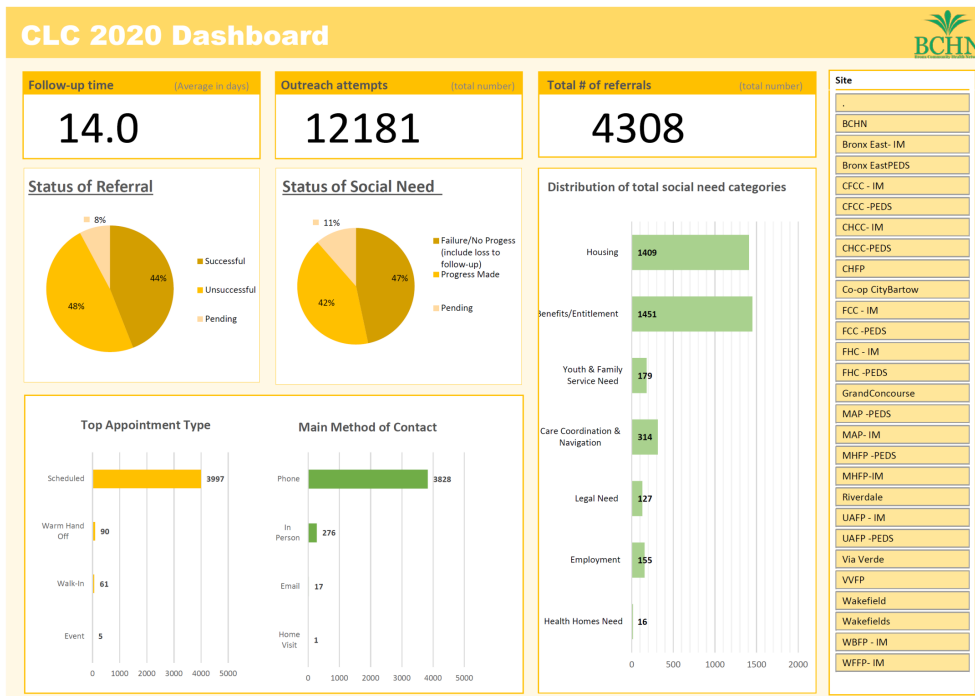
PAGE 1 OF 12



Data feedback: Dashboards for Clinical Teams on Screening Outcomes



Data feedback: Dashboards for Clinical Teams on CHW Referral Outcomes

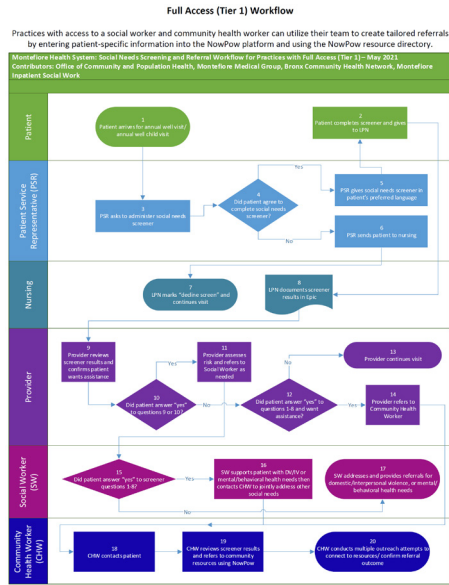




Toolkit

Montefiore Health System Social Needs Screening and Referral Toolkit

Office of Community and Population Health
May 2021

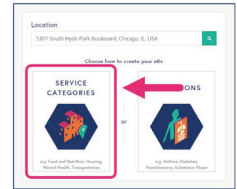


Creating a HealthRx by Service Categories

- Step 1:** Navigate to the eRx Tab.
Then, enter a location around which you would like to search for services.
You may enter:
1. Zip Code
 2. Neighborhood
 3. Cross Street
 4. Street Address



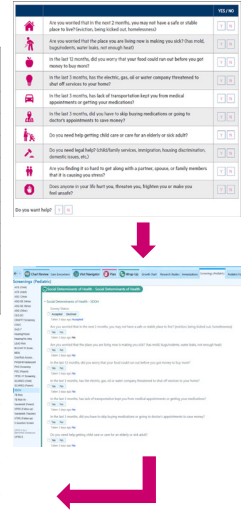
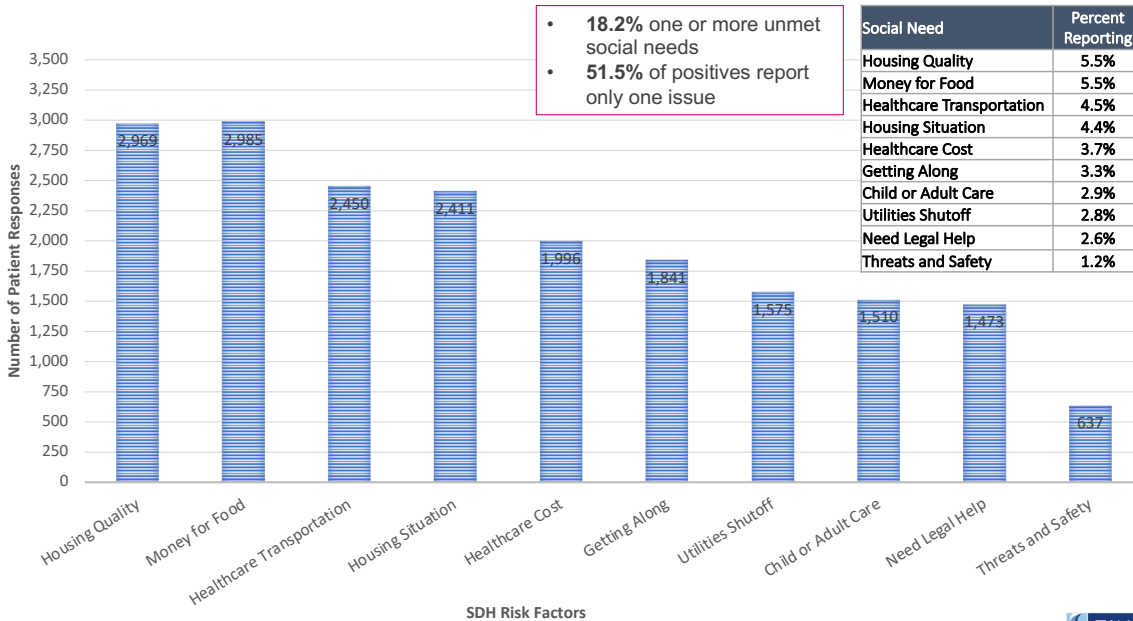
Step 2: Select Service Categories.



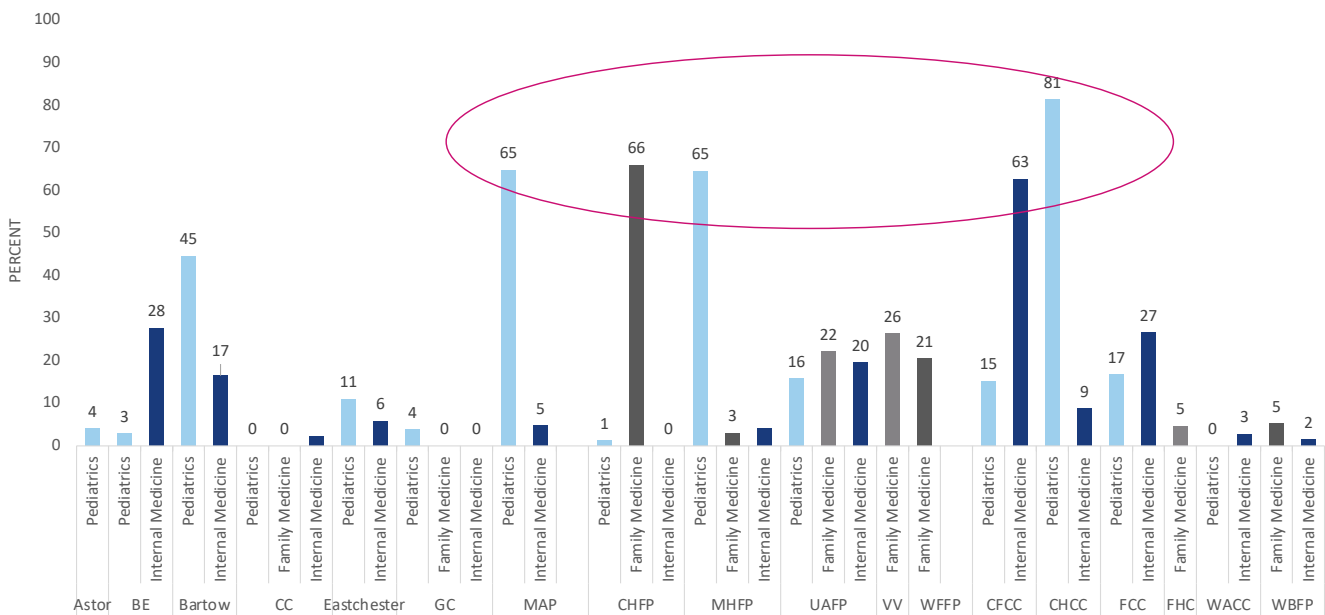
Results & Learning: improving implementation & understanding impact of social needs



Social Needs Prevalence: 53,806 patients (Apr 2018- Dec 2019)



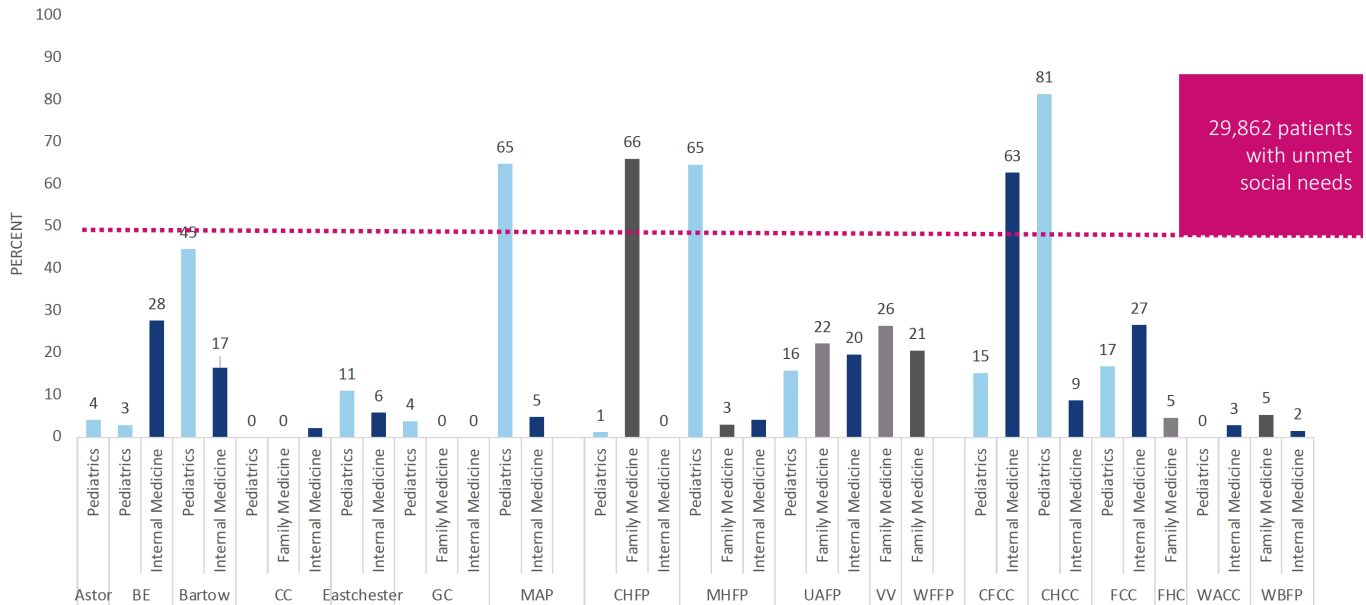
Implementation: Active Patients Screened, 22% (n=244,764)



Denominator includes unique patients with visits to screening specialties between April 2018-December 2019
Median excludes specialties that are not screening

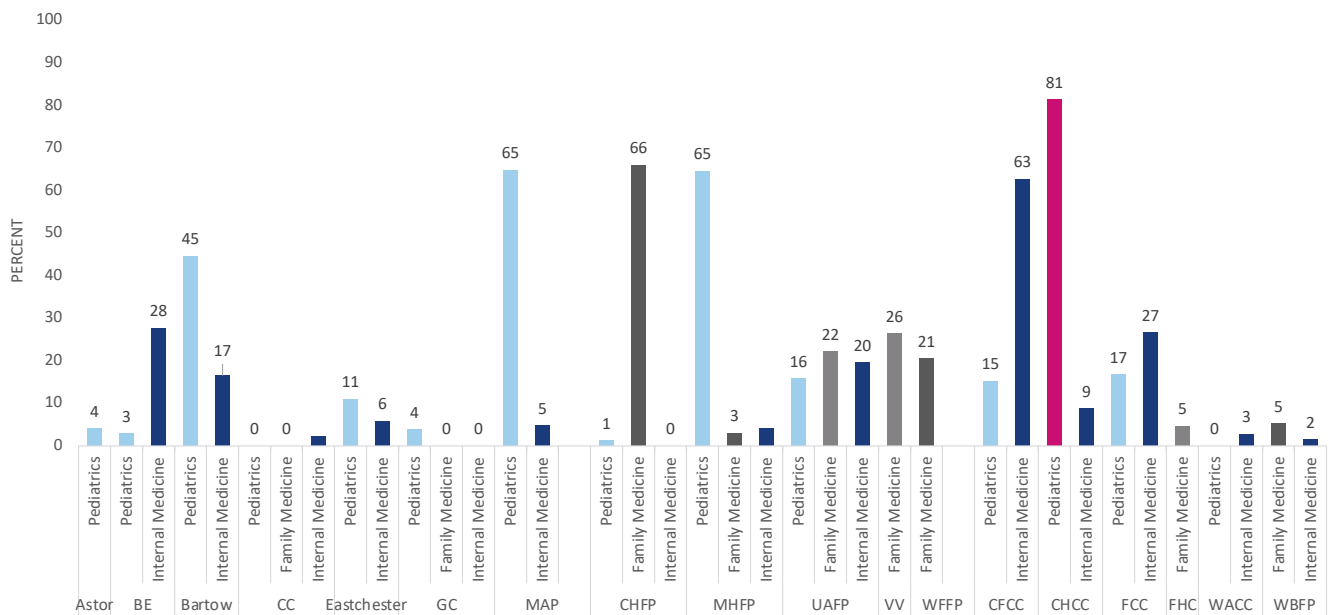


Opportunity (10,284 vs 29,862 patients identified)



Denominator includes unique patients with visits to screening specialties between April 2018-December 2019
 Median excludes specialties that are not screening

Best Practices



Denominator includes unique patients with visits to screening specialties between April 2018-December 2019
 Median excludes specialties that are not screening



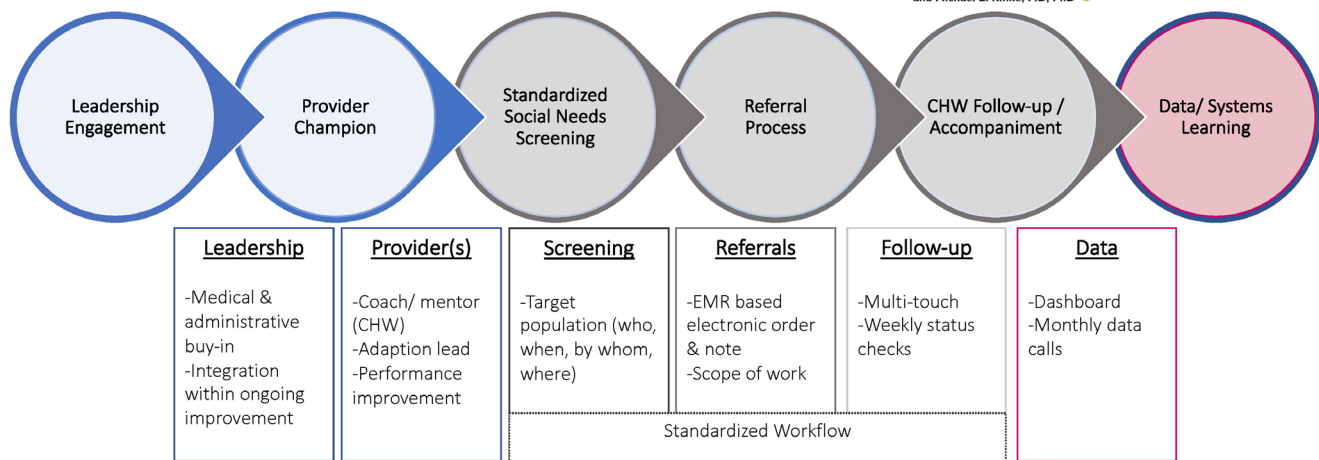
Community Linkage to Care (CLC) Program: core program elements @ practice-level

Original Article

Integrating Social Needs Screening and Community Health Workers in Primary Care: The Community Linkage to Care Program

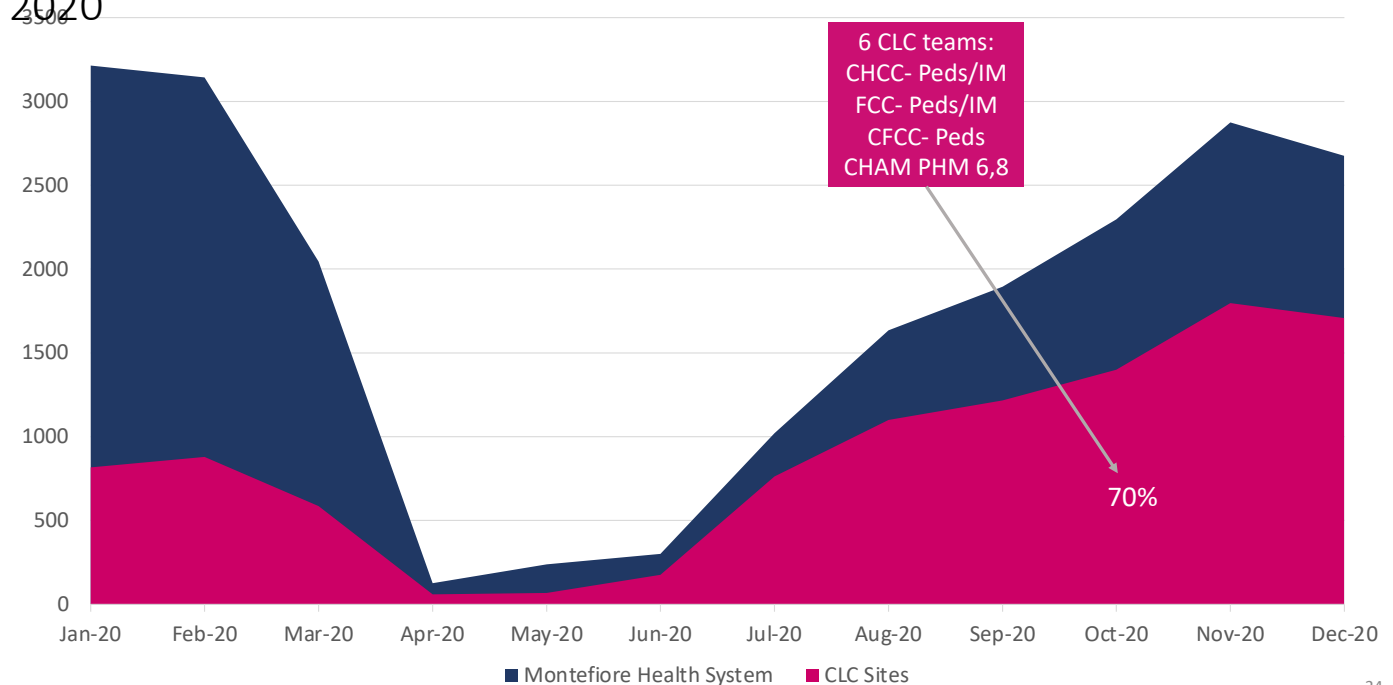
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 MD
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Kevin P. Fiori, MD, MPH, MSc^{1,2,3}, Colin D. Rehm, PhD, MPH^{4,5},
 Dana Sanderson, MD^{1,2}, Sandra Braganza, MD, MPH^{1,2},
 Amanda Parsons, MD, MBA^{1,5}, Tashi Chodon, BSN, MPH⁴,
 Renee Whiskey, MPH⁴, Patricia Bernard, MPH⁴,
 and Michael L. Rinke, MD, PhD^{1,2}



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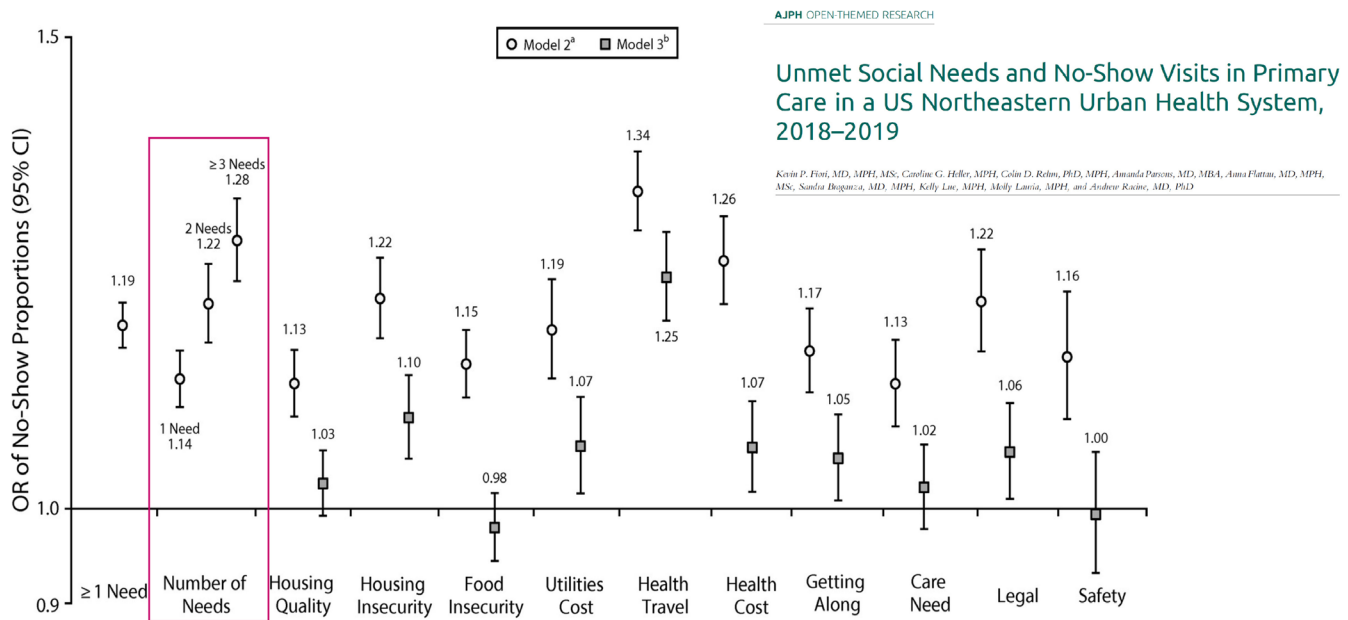
Practices adopting CLC approach: 54% of screens in 2020, 70% in Q4 2020



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Costs/opportunity: missed appointments & unmet social needs



^aModel 2 adjusted for age, sex, race/ethnicity, preferred language, payer, area-based poverty, public housing status, and Elixhauser comorbidity score;

^bModel 3 adjusted for each social need plus model 2 covariates.

Lessons Learned

- *Guidelines & Tools: required & insufficient*
 - Feasibility
 - Buy-in by clinical teams (acceptability & ownership)
- *Start at the End*
 - Assets available inform screen
 - Existing partnerships
- *Adapt, implement, analyze, improve....*
 - Core vs adaptive Elements (*adaptive standardization*)
 - Data feedback essential



Summary

- Examples of tools, investments and approaches of one health system's experience integrating social care in practice
- Discussion of challenges translating policy and guidelines in real world practice
- Summary of opportunities and strategies that may be useful in your context

Thank you & Contact Information

Name: Kevin Fiori

Title: Director, Social Determinants of Health

Organization: Montefiore Health System

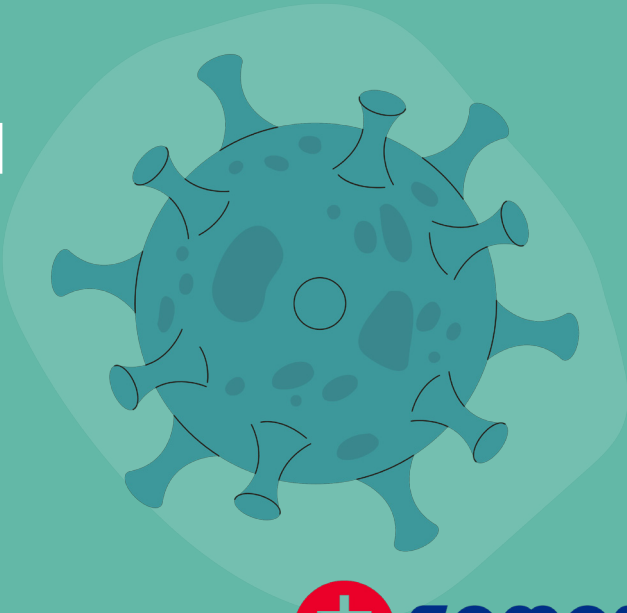
Email: kfiori@montefiore.org

Phone: 718-920-8133



COVID-19

Where are we, and where are we going?

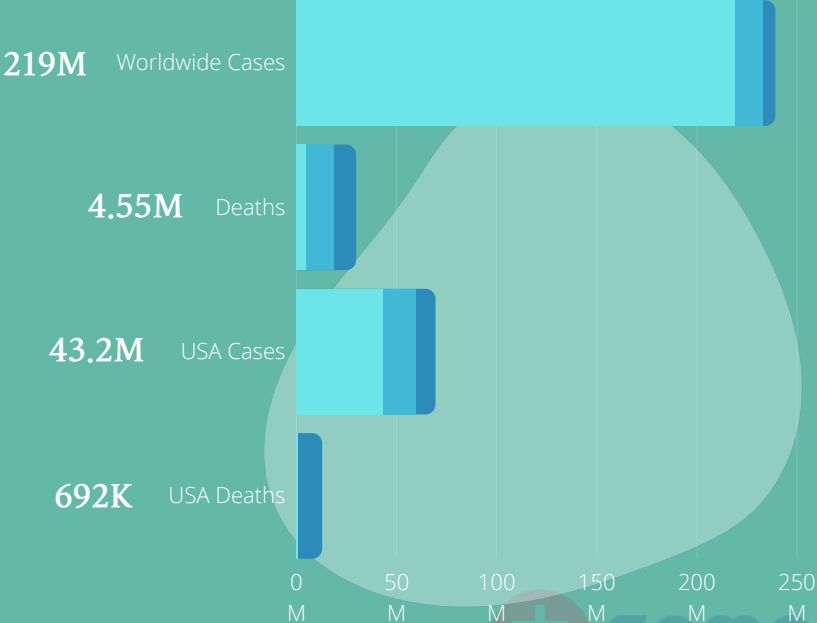


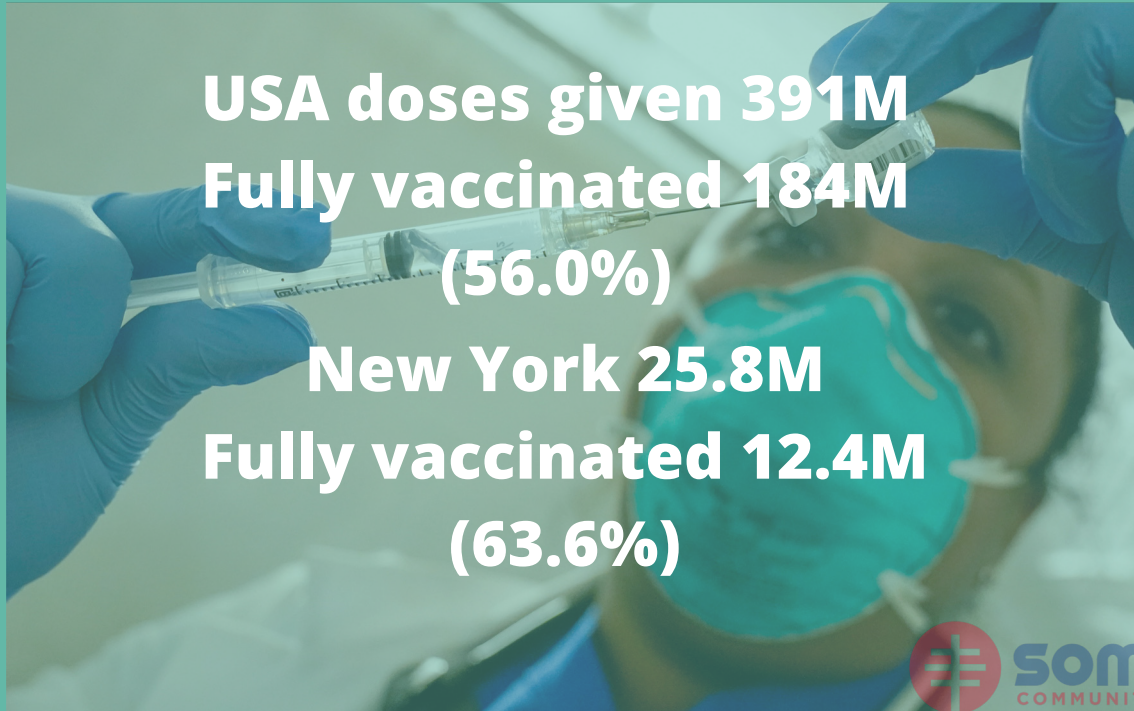
Yomaris Pena, MD.
Internal Medicine Physician
Director of Emergency Medical Response
Somos Community Care

Financial Disclosure: No Financial Conflicts to Disclose



Speaking In Numbers





USA doses given 391M
Fully vaccinated 184M
(56.0%)

New York 25.8M
Fully vaccinated 12.4M
(63.6%)



Variants Being Monitored

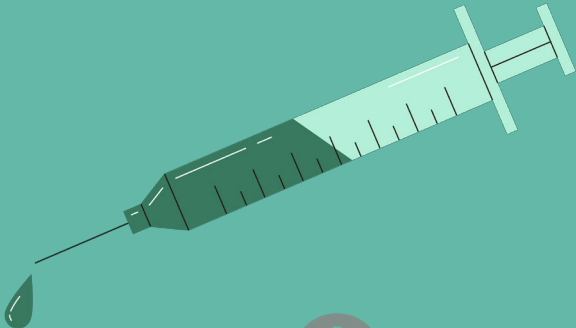
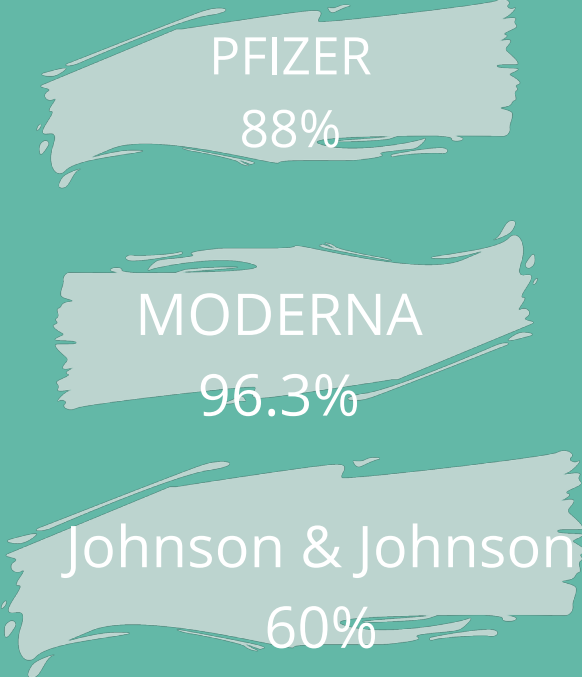
- Alpha (B.1.1.7, Q.1-Q.8)
- Beta (B.1.351, B.1.351.2, B.1.351.3)
- Gamma (P.1, P.1.1, P.1.2)
- Epsilon (B.1.427 and B.1.429)
- Eta (B.1.525)
- Iota (B.1.526)
- Kappa (B.1.617.1)
- B.1.617.3
- Mu (B.1.621, B.1.621.1)
- Zeta (P.2)

- Vaccines approved and authorized for use in the United States are effective against these variants and effective therapeutics are available. CDC continues to monitor all variants circulating within the United States.
- A variant with specific genetic markers that have been associated with changes to receptor binding, reduced neutralization by antibodies generated against previous infection or vaccination, reduced efficacy of treatments, potential diagnostic impact, or predicted increase in transmissibility or disease severity.





Efficacy

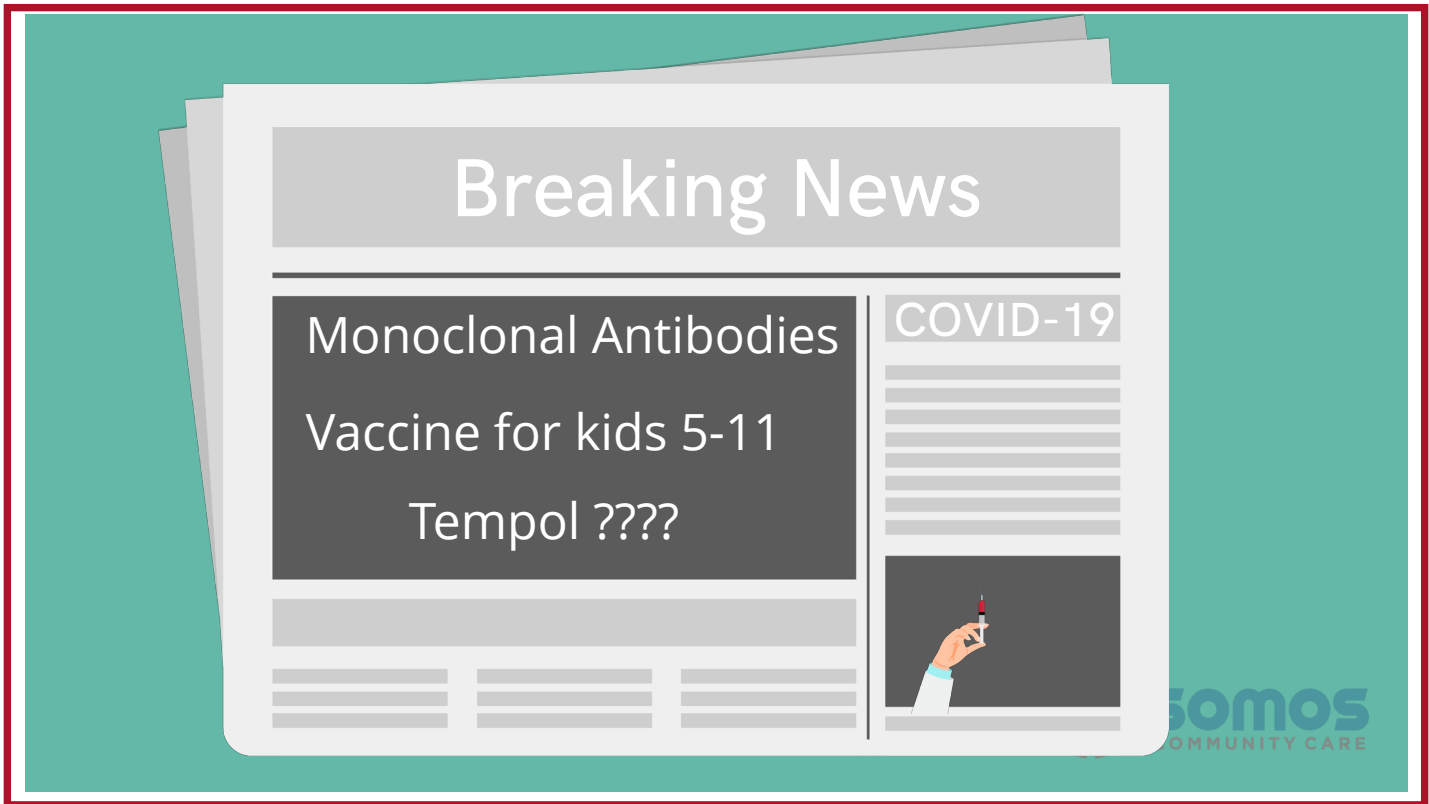


Vaccine Boosters

Approved for patients :

- Older than 65 y old
- Immunocompromised patients:
Post-Transplant, CKD, pts on
Immunomodulators and corticosteroids
- Health care workers
- Long term residents
- 18+ who have underline medical
conditions.





Recommendations

When using monoclonal antibodies, treatment should be started as soon as possible and within 10 days of symptom onset.

Guidelines recommend using one of the following anti-SARS-CoV-2 monoclonal antibody regimens to treat nonhospitalized patients with mild to moderate COVID-19 who are at high risk of clinical progression.

- Bamlanivimab plus etesevimab; or
- Casirivimab plus imdevimab; or
- Sotrovimab 500 mg intravenous (IV) infusion

When using casirivimab plus imdevimab, the Panel recommends:

- Casirivimab 600 mg plus imdevimab 600 mg IV infusion (AIIa)
- If IV infusions are not feasible or would cause a delay in treatment, casirivimab 600 mg plus imdevimab 600 mg administered by four subcutaneous (SQ) injections (2.5 mL per injection) can be used as an alternative (BIII).





Eligibility

- Be at least 65 years old
- Have a BMI of more than 25 kg/m², or if age 12-17, have BMI above the 85th percentile for their age and gender based on CDC growth charts
- Currently Pregnant
- Have a medical condition, including:
 - Chronic kidney disease
 - Cardiovascular disease (including congenital heart disease, hypertension)
 - Diabetes
 - Down syndrome
 - Dementia
 - Liver disease
 - Chronic lung disease
 - Sickle cell disease
 - Immunosuppressive disease or immunosuppressive treatment
- Current or former smoker
- History of stroke or cerebrovascular disease
- Current or history of substance abuse
- Neurodevelopmental disorders or other conditions that confer medical complexity
- Have a medical-related technological dependence (e.g., tracheostomy, gastrostomy)



The Race For A Better Future

-Mandates

-Oral pills (ongoing trials)- Tempol

-Pfizer starts global phase 2/3 epic study
(Evaluation of Protease Inhibition for Covid-19 -pep for Post Exposure Prophylaxis)

-Vaccine Approval in children ages 5-11
(dose of 0.1 ml or 10 mcg)

-Trials for younger age





**THIS PANDEMIC HAS SHOWN THE
IMPORTANCE & POWER OF PATIENT-
PHYSICIAN RELATIONSHIPS AT THE LEVEL OF
PRIMARY CARE.**

**LISTEN TO THE PATIENT, EDUCATE THEM AND
WE WILL HELP PREVENT THE DISPARITIES IN
HEALTH CARE AS OUR PEOPLE ARE THE MOST
AFFECTED**

**Be Ready for the Next Challenge and
Medicine Changing as we know it.**



Thank You

Yomaris Pena, MD.
Internal Medicine Physician
Director of Emergency Medical Response
Somos Community Care
modernmedicineny@hotmail.com

Thank you for attending “The Business of Medicine in Primary Care in the Era of COVID-19: Part 1,” provided by Healthfirst, SOMOS Community Care, and Albert Einstein College of Medicine – Montefiore Medical Center.

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Yomaris Peña, MD

About Healthfirst

Healthfirst is New York's largest not-for-profit health insurer, earning the trust of 1.6 million members by offering access to affordable healthcare. Sponsored by New York City's leading hospitals, Healthfirst's unique advantage is rooted in its mission to put members first by working closely with its broad network of providers on shared goals. Healthfirst takes pride in being pioneers of the value-based care model, recognized as a national best practice. For more than 25 years, Healthfirst has built its reputation in the community for top-quality products and services New Yorkers can depend on. It has grown significantly to serve the needs of members, offering market-leading products to fit every life stage, including Medicaid plans, Medicare Advantage plans, long-term care plans, qualified health plans, and individual and small group plans. Healthfirst serves members in New York City and on Long Island, as well as in Westchester, Sullivan, and Orange counties.

For more information on Healthfirst, visit healthfirst.org.

About SOMOS

SOMOS is a non-profit, physician-led network of over 2,500 health care providers serving over 700,000 Medicaid beneficiaries in New York City. Launched in 2015 by its Chairman Dr. Ramon Tallaj, SOMOS is the largest and only physician-led performance provider system participating in the New York State Delivery System Reform Incentive Payment Program (DSRIP). The SOMOS network includes providers delivering culturally competent care to patients in some of New York City's most vulnerable populations, particularly Latino, Asian, African-American and immigrant communities throughout the Bronx, Brooklyn, Manhattan and Queens.

About Albert Einstein College of Medicine – Montefiore Medical Center

The mission of Montefiore is to heal, to teach, to discover and to advance the health of the communities we serve. From its beginning in 1884, as a facility for the care of patients with tuberculosis and other chronic illnesses, to the new millennium, Montefiore has been at the forefront of patient care, research and education and steadfast commitment to its community. As the academic medical center and University Hospital for Albert Einstein College of Medicine, Montefiore Medical Center is nationally recognized for clinical excellence—breaking new ground in research, training the next generation of healthcare leaders, and delivering science-driven, patient-centered care.

Montefiore's partnership with Einstein advances clinical and translational research to

accelerate the pace at which new discoveries become the treatments and therapies that benefit patients. Together, the two institutions are among 38 academic medical centers nationwide to be awarded a prestigious Clinical and Translational Science Award (CTSA) by the National Institutes of Health. At the intersection of Einstein science and Montefiore medicine is our commitment to scientific inquiry. This commitment has resulted in the creation of the Montefiore-Einstein Centers of Excellence in cancer care, cardiovascular services, transplantation and children's health, where nationally recognized investigators and multidisciplinary clinical teams collaborate to develop and deliver advanced, innovative care.

The second-largest medical residency program in the country, with 1,251 residents and fellows across 89 programs, Montefiore provides the doctors of tomorrow a unique opportunity for education and training in one of the most diverse urban areas in the country — one where the population is global, the disease burden is high, and the need for quality care is great. The partnership is further strengthened by the dual appointments of faculty and physicians across both organizations—enhancing synergies and collaborations for research, teaching and patient care.



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