

Senate
Finance Subcommittee on Health and Medicaid

Ohio Commission on Minority Health
2020-21 Budget Testimony

Thursday, May 2, 2019 at 9:00 am

Good afternoon Chairman Hackett, Ranking Minority Member Thomas and esteemed members of the Senate Finance Subcommittee on Health and Medicaid. My name is Angela Dawson; I am the Executive Director of the Ohio Commission on Minority Health, where I am honored to serve.

In 1987, Ohio garnered national recognition as the first state in the nation to create a state agency set aside to address health disparities in Ohio's minority populations. The Ohio Commission on Minority Health is dedicated to eliminating disparities in minority health through innovative strategies, financial opportunities, public health promotion, legislative action, public policy, and systems change.

The Commission has maximized local, state and federal resources to address the chronic and persistent problem of health disparities that have resulted in escalating health care costs and premature loss of life within minority communities. The Commission funds community-based models that are culturally and linguistically appropriate, as well as models designed to improve accessibility to resources that prevent chronic diseases and conditions.

“Medical advances and new technologies have provided people in America with the potential for longer, healthier lives more than ever before. However, persistent and well-documented health disparities exist between different racial and ethnic populations and health equity remains elusive, since appropriate care is often associated with an individual's economic status, race, and gender”.¹

Health disparities are defined as significant differences in the overall rate of disease incidence, prevalence, morbidity, and mortality rates between one population and another.² Racial and ethnic health disparities are multifactorial and complex. Major factors include: inadequate access to health care; poor utilization of care; substandard quality of care and social economic status.

When we look across the spectrum of chronic diseases and conditions, significant disparities for Ohio's racial and ethnic minorities continue to persevere.

According to the Ohio Department of Health's most recent reports:

In 2012:

- Black Ohioans had a 36% higher age adjusted stroke death rate when compared to Whites.³
- While Hispanic Ohioans had the highest estimated prevalence of adults age 18 and older ever diagnosed with heart disease.³

From 2009-2013:

- Asian American Pacific Islanders in Ohio experienced significantly higher incidence rates for liver and stomach cancer than Whites.⁴
- Black Ohioans had the highest mortality rates of any racial group for all sites/types of cancer combined with black males and females having 21% and 14% higher cancer, mortality rates compared to White males and females, respectively.⁴

According to the Ohio Department of Health's - 2015 Impact of Chronic Disease Report, most of healthcare costs in Ohio and in the nation are associated with chronic disease and related health behaviors. In Ohio, medical costs associated with chronic disease are expected to rise from \$25 billion in 2010 to \$44 billion in 2020. The report further states that even if Ohioans achieve a modest improvement in chronic disease prevention and early detection services, the state could save billions of dollars in healthcare spending and prevent multiple cases of chronic disease." (Ohio Department of Health, 2015). In the same context, the Commission's demonstration grant initiatives are focused on the prevention of chronic diseases and conditions within racial and ethnic populations.

Similar to disparities in chronic disease, infant mortality reflects the same persistent gap. Infant mortality is a measure of a community's vitality and overall well-being. The infant mortality rate is defined as the death of an infant before his or her first birthday per 1,000 live births. Healthy People 2020 recommends that a state's infant mortality rate be 6.0 per 1,000 live births.

Ohio has increased its attention and efforts to address infant mortality. These efforts included the historic passage of bipartisan legislation, increased infant mortality allocations and the creation of the Commission on Infant Mortality. These efforts linked to the work of the Ohio Collaborative to Prevent Infant Mortality (OCPIM), Ohio Equity Institutes (OEI) and hundreds of additional initiatives across this state.

In 2013, Ohio achieved the Healthy People 2020 goal of 6.0 per 1000 live births for white infants and have continued to achieve this over the last 5 years with 2017 data reflecting a 5.3 white infant mortality rate. However, in that same year, Ohio's Black 2017 infant mortality rate worsened to 15.6 per 1,000 live births, which is nearly three times the White infant mortality rate of 5.3 per 1,000 live births.⁵

Consequently, Ohio is ranked 40th, overall, in the nation for infant mortality and is ranked 49th in the nation for African-American infant mortality (CDC, 2018).

Infant mortality is a significant cost driver in Ohio. In 2013, the Department of Medicaid expended \$596 million dollars in prenatal and delivery care with two-thirds of this cost, or \$373 million dollars, related to the 13.79% preterm birth rate.

In an effort to affect these exorbitant costs, the Commission initiated the scaling of the Certified Pathways Community Hub Model. This is a nationally certified, evidence-based, peer-reviewed, pay-for-performance, care coordination model. This model has received endorsement from the Center for Disease Control and Prevention, Agency for Healthcare Research and Quality, the National Institutes of Health as well as the Center for Medicaid and Medicare.

The Pathways Community Hub National Certification Program (PCHCP) promotes accountable care through the certification of Hub organizations. The Hubs are required to use formal and standardized processes in the delivery of community-based care coordination services. Certification requires the use of the Pathways Community Hub Model, which promotes quality care across 20 pathways to measurably improve birth outcomes and links payment to performance.

The pathways are the metrics that focus on successful resolution of an identified risk or issue. The comprehensive assessment identifies the risk or issue and then opens the pathways that can address social determinants of health, or barriers to adequate and early pre-natal care.

The model's effectiveness is largely connected to the use of certified community health workers who work with the high-risk mothers and coordination care related to appropriate and timely prenatal clinical care but also address education, employment, housing, behavioral health, and other linkages to essential services. This coordination effort ensures that the high-risk mother has a connection to the resources that will stabilize the living environment for her infant.

Preliminary data for Program Year 2018 shows that five of six active Hubs improved preterm rates for African American singleton births for their respective counties. One Hub had no county African American preterm birth rate reported, as birth counts in the target population were less than 20 for the county. Additionally, six of the six active Hubs improved the low birth weight rate for African American singleton births in their respective counties.

Collectively, with Commission funding in 2018, the six Hubs served 605 high-risk pregnant women of which 62% were African American.

Currently, all of the Ohio Medicaid Managed Care plans contract with this model. Buckeye Health Plan conducted a retrospective cohort study of over 3,700 deliveries from 2013-2017, focusing on the Toledo Hub. This study identified a 236% return on investment with per/member per/month savings for high, medium and low risk members.⁶ In addition, the study highlighted that high-risk pregnant women in the Hub's area who did not participate in the Hub's services had a 1.55 times greater likelihood of having an infant that needed Special Nursery Care or Neonatal ICU Services.⁷ According the March of Dimes, the average length of stay for a baby admitted to the NICU is 13.2 days. The average cost of a NICU admission is \$76,000 with charges exceeding \$280,000 for infants born prior to 32 weeks gestation (March of Dimes, 2011). As we seek out strategies to improve African American infant mortality rates, this model has proven it is worth the investment.

The Commission was charged through Amended Substitute House Bill 171 and 152 to fund grants that promote health and prevent disease among Ohio's minority populations. To this end, the Commission funds grant programs. Graphic displays of the age, gender and racial breakdown of specific grant initiatives, along with additional information on our grant programs are at the end of this testimony for your review.

The Commission provides monitoring and oversight of grantee program progress in several ways:

- Grantees are required to submit quarterly program, evaluation, and fiscal reports;
- Staff conduct annual administrative compliance reviews and provide technical assistance as needed;
- Staff conduct on-site program and fiscal visits that involve the observation of service delivery, review of program and fiscal documentation, evaluation mechanisms as well as the review of internal fiscal procedures; and
- The Research Evaluation Enhancement Program (REEP) provides evaluation oversight of major programs on an ongoing basis. REEP is a statewide network of academic and community researchers and evaluators.

Collaboration Efforts

The Commission has participated in multiple collaborations to include:

- The collaboration with the Ohio Department of Health and the former Office of Medicaid to implement the National Academy of State Health Policy (NASHP) policy initiatives, that resulted in the inclusion of disparity language in the Medicaid Managed Care Contract.
- The collaboration with the Ohio Department of Health to influence the selection of the Patient Centered Medical Home (PCMH) sites to maximize access to services by racial and ethnic populations and locate them within “medical hot spots.”
- In addition, the Commission serves on the council of the Ohio Patient Centered Primary Care Collaborative, a coalition effort to create a more effective and efficient PCMH model of health care delivery in Ohio.

2020/2021 As Introduced Budget

The Governor’s recommended funding level will allow the Commission to stabilize existing grant programs at the FY19 funding levels and maintain the current essential staffing needed to ensure oversight of the day-to-day agency operations, grants management and administrative rule compliance.

The Commission continues to be a good steward of the state’s resources through focused efforts to increase access to chronic disease prevention programs and expansion of care coordination efforts to reduce preterm birth, which can yield improved health outcomes and a return on investment.

Untreated chronic diseases and unaddressed disparities will continue to result in uncontrollable healthcare costs for Ohio. According to the Health Policy Institute of Ohio, to improve health value, Ohio must address the many factors that impact population health outcomes and healthcare costs.⁸

The future health of our state and our nation as a whole will be largely determined by how effectively we work with communities to reduce and eliminate health disparities between non-minority and minority populations, with minority populations experiencing disproportionate burdens of disease, disability, and premature death.⁹

In summary, the Commission has been visible and active in state and national efforts to reduce minority health disparities and its associated costs. We appreciate the support of our mission and the opportunity to share with you today.

I would like to inform you that I have aided hearing which will likely require me to ask you to repeat your questions. Thank you in advance for your accommodation. I will be happy to answer any questions you may have at this time.

References

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2. [Minority Health and Health Disparities Research and Education Act](#) United States Public Law 106-525 (2000)
3. Ohio Department of Health, 2015. The Impact of Chronic Disease in Ohio: 2015. Chronic Disease Epidemiology and Evaluation Section, Bureau of Health Promotion, Ohio Department of Health, 2015 Retrieved from:
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5. Ohio Department of Health, (2018). 2017 Ohio Infant Mortality Data: General Findings. Retrieved from: <https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/infant-and-fetal-mortality/reports/2017-ohio-infant-mortality-report-final>
6. Buckeye Health Plan, (2018). Lower First Year of Life Costs for Babies through Health Plan and Community Hub Partnership.
7. Buckeye Health Plan, (2018). Improved Birth Outcomes through Health Plan and Community Hub Partnership.
8. Health Policy Institute of Ohio. (2014, December 16). *2014 Health Policy Dashboard*. Retrieved from: <http://www.healthpolicyohio.org/2014-health-value-dashboard/>
9. Centers for Disease Control and Prevention (US), Office of Minority Health and Health Equity. OMHHE's guiding principle. Retrieved from:
URL:<http://www.cdc.gov/minorityhealth/about/OMHHE.pdf>

Additional Resources

1. Health Policy Institute of Ohio. (2017, March 1). *2017 Health Policy Dashboard*. Retrieved from <https://www.healthpolicyohio.org/2017-health-value-dashboard/>
2. National Partnership for Action. National Stakeholder Strategy. (2011, April). US Department of Health and Human Services Offices of Minority Health. Retrieved from <http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286>.

OCMH – Testimony – Additional Information

Commission significant accomplishments and firsts:

- The creation of Minority Health Month in 1989. This high visibility, statewide wellness campaign which is held each year in April became a national initiative in 2000.
- The creation of the National Association of State Offices of Minority Health (NASOMH) in 2005.
- The creation of a local level infrastructure for minority health by funding Local Offices of Minority Health as well as the creation of national performance standards for the local offices in collaboration with NASOMH.
- The creation of the Research Evaluation Enhancement Project (REEP). REEP is a statewide network of academic and community researchers and evaluators who provide oversight to the evaluation components of the Commission's major grant projects, as well as to promote capacity building.

Sustainability of funded efforts

The Commission provides capacity building training for grantees to support the sustainability of program efforts. Some examples of sustained efforts are as follows:

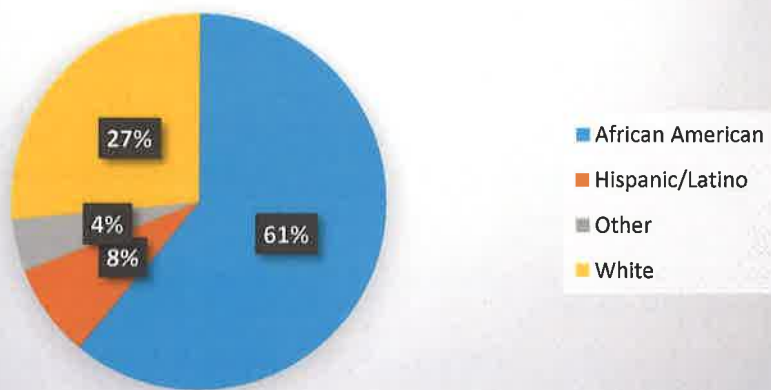
- Asian Services in Action, Inc. (ASIA) located in Akron, received initial funding from the Commission and began as a pilot project funded to serve Asian communities. In 2015, we celebrated with ASIA when they opened their International Community Health Center.
- Community Health Access Project (CHAP) located in Mansfield was provided initial funding from the Commission. CHAP has developed what is now a nationally recognized model of community-based care coordination. This model has been expanded through federal grants and managed care contracts. In FY16 and FY17, the Commission received increased funding support to initiate bringing this model to scale in Ohio.

2017 and 2018 Grant Demographics

A total of approximately 101,000 Ohioans received services during 2017 and 2018. Commission funded projects serve all Ohioans who present for services. Listed below are the age, gender, and ethnic breakdowns for specific grant initiatives can be found on the attached pie charts.

2017 and 2018 Infant Mortality Hub Grants

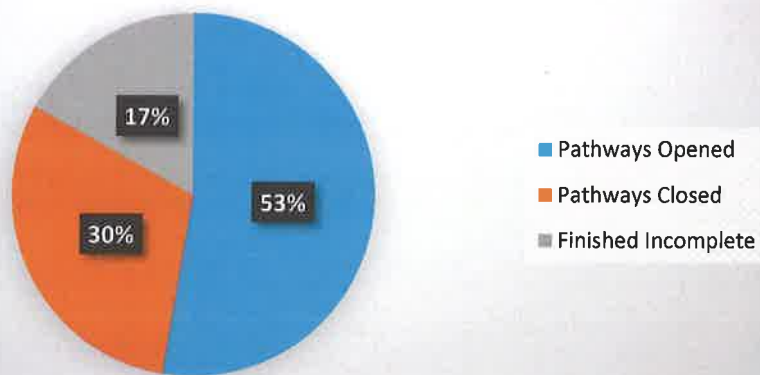
**2017 Infant Mortality Hub Program
Total Served by Race and Ethnicity**



Total numbers served for IM Hub Grants for FY17 - served 822 Ohioans

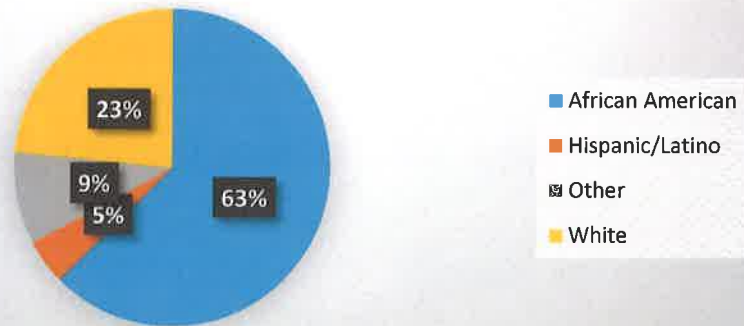
African American	Hispanic/Latino	Other	White
501	66	37	218

**2017 SOCIAL DETERMINANT
PATHWAYS**



Total number of Social Determinant Pathways for FY17 - 5682

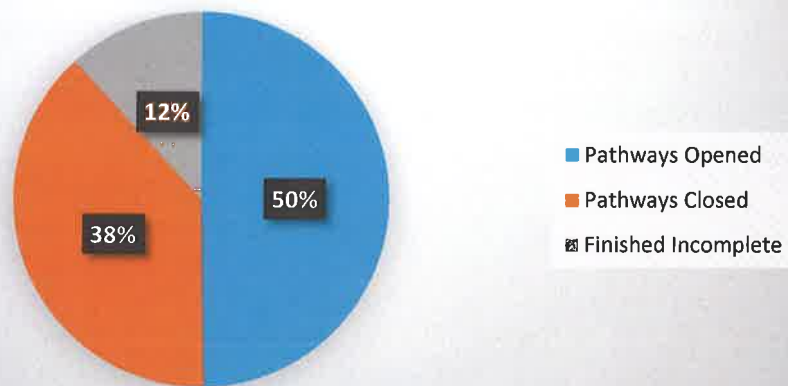
2018 Infant Mortality Hub Program Preliminary Data - Total served by Race and Ethnicity



Total numbers served for IM Hub Grants for FY18 – served 605 Ohioans

African American	Hispanic/Latino	Other	White
378	28	57	142

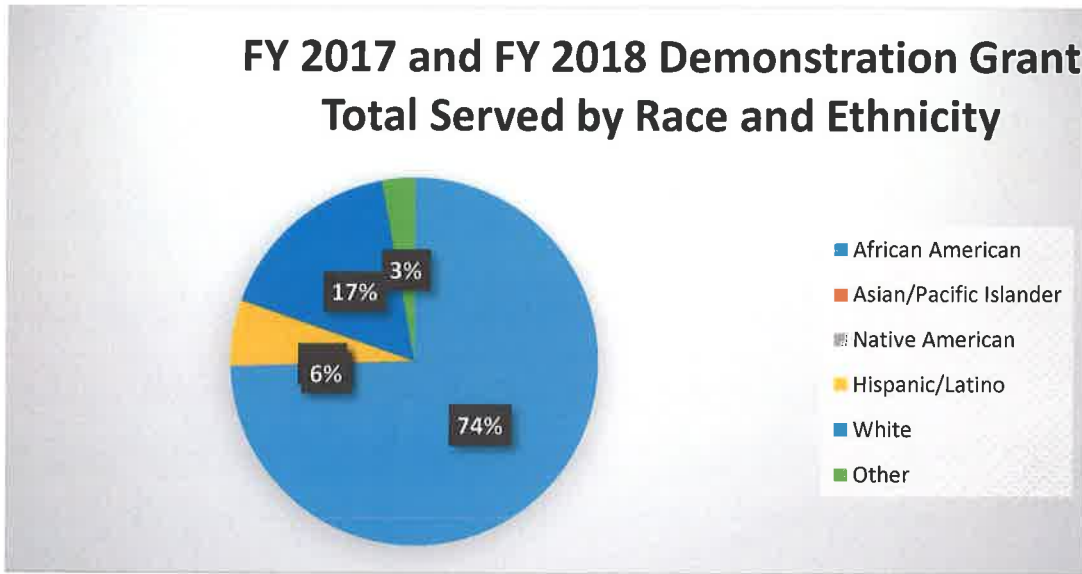
2018 PRELIMINARY SOCIAL DETERMINANT PATHWAYS



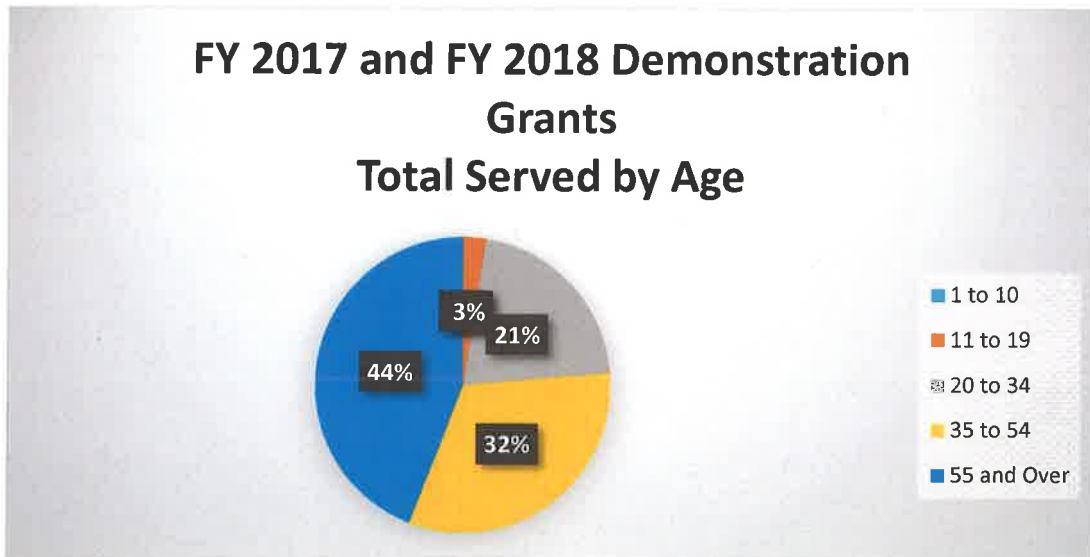
Total number of Social Determinant Pathways for FY18 - 8982

2017 and 2018 Demonstration Grant Programs

These grantees are funding for two-year projects that address the prevention of infant mortality and diabetes. These projects target culturally appropriate strategies to address measurable behavior change.



Total numbers served for Demonstration Grants for FY17 and FY18 – served 575 Ohioans

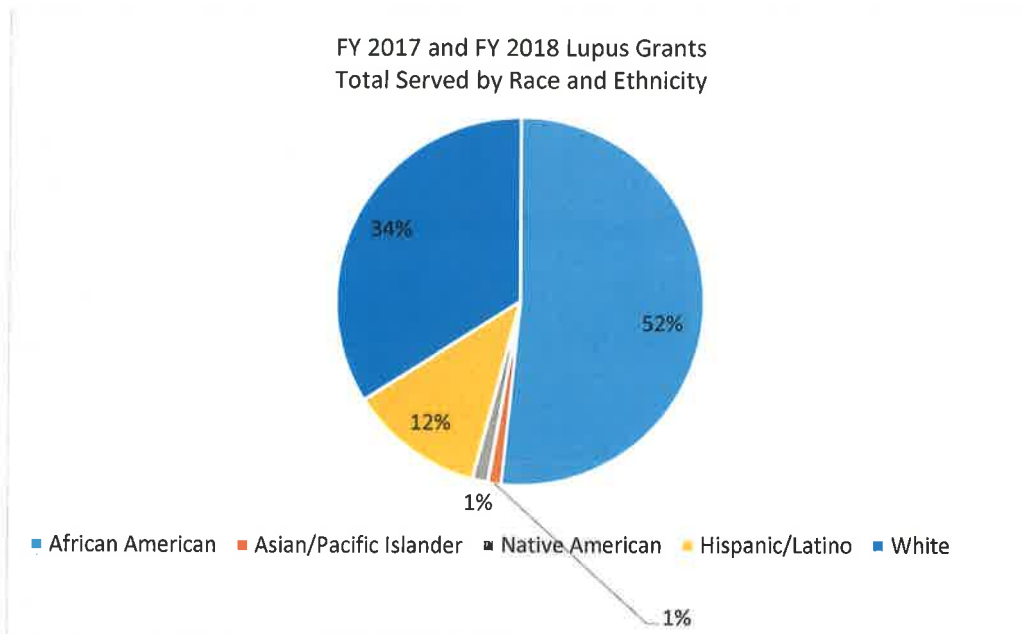


FY 2017 and FY 2018 Demonstration Grants Total Served by Gender



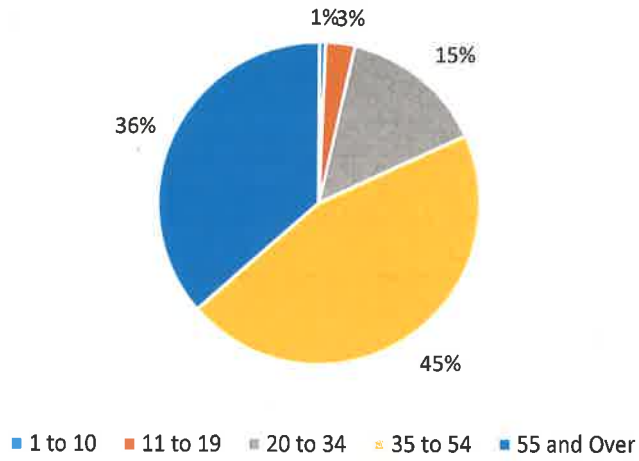
2017 and 2018 Lupus Grant Programs

Systemic Lupus Erythematosus is an autoimmune disease that can affect multiple organs. The disease is difficult to diagnose, and onset is often during the reproductive years.

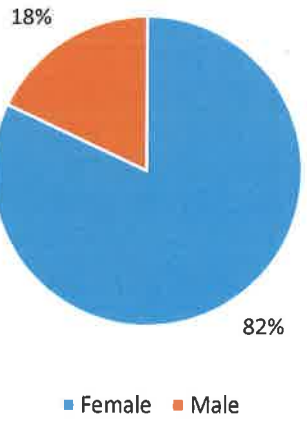


Total numbers served for Lupus Grant programs for FY17 and FY18 - 362

FY 2017 and FY 2018 Lupus Grants Total Served by Age

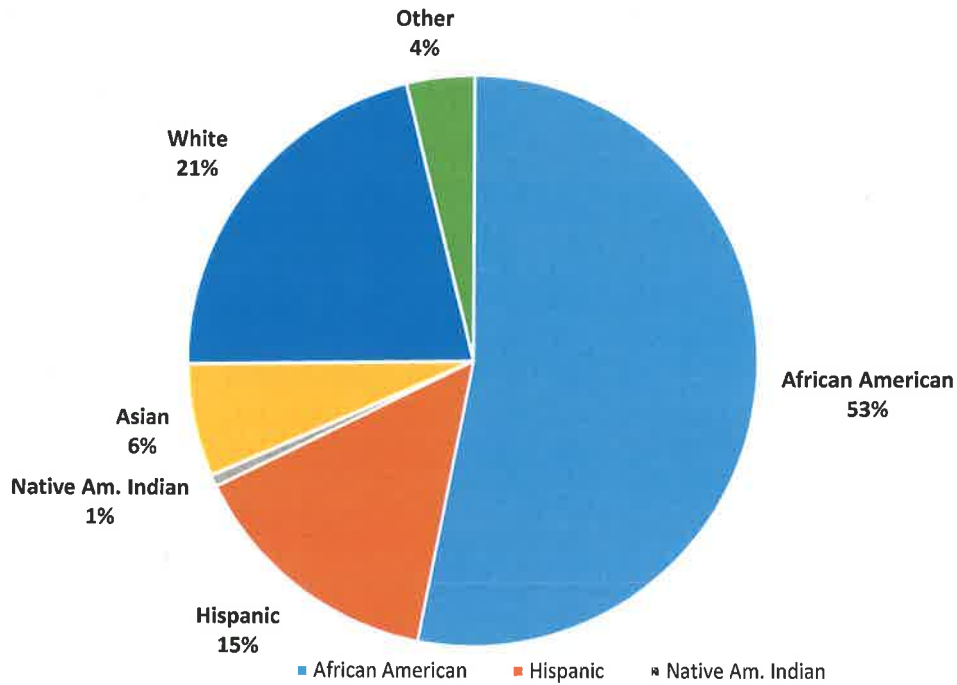


FY 2017 and FY 2018 Lupus Grants Total Served by Gender



Minority Health Month is a statewide 30-day, high visibility and wellness campaign held annually in April.

FY 2017 and FY 2018 Minority Health Month Participants by Race and Ethnicity



Ohioans served during Minority Health Month FY17 and FY18 was 16,639

Lower First Year of Life Costs for Babies through Health Plan and Community Hub Partnership

Authored by: Dr. Brad Lucas ■ Amber Detty, MA, CHDA

BACKGROUND

The impact of non-clinical barriers to care on direct medical costs should be accepted as a major impediment to our ability to impact major determinants of community vitality such as Infant Mortality.

Buckeye Health Plan has long partnered with Community Hubs to help reduce our members' non-clinical/social determinant barriers. We have shown that the combination of community coordination of social services and health plan care management improves birth outcomes in high risk pregnant members.*

We asked whether health plan investment in reduction of non-clinical barriers could lead to healthcare savings... it does.

*See our poster on the success of Community Hub Partnerships for more information.

METHODS

- A retrospective cohort study of 3,702 deliveries in the footprint of our busiest Community Hub (Health Council of Northwest Ohio). All deliveries in these areas between March 2013-February 2017 included.
- Analysis included the mother's age, race/ethnicity, gestational age, birthweight, and whether the baby needed neonatal care.
- Bivariate and multivariate analysis to identify odds ratios for Neonatal/NICU Admission by select predictors for all deliveries and separately for deliveries to high-risk, moderate-risk, low-risk, and unknown risk mothers in the service area.
- Total paid amounts (medical and pharmacy) for baby's cost of care in their first year of life were calculated to best determine any savings. Babies whose mothers were enrolled with a Community Hub through delivery were compared to babies whose mothers who did not have care through a Community Hub.

Buckeye Newborns: Inpatient Cost Through First Year of Life When Enrolled with Start Smart and Hub Enrollment at Delivery, 2013-2016			
Risk Level	Hub Group	Newborn Inpatient PMPM Through 1st Birthday	Enrolled with Hub at Delivery Inpatient PMPM Savings*
High Risk	Enrolled with Hub at Delivery	\$301.38	\$378.72
	Participated in the Hub, but not through delivery	\$186.34	
	Not Enrolled with Hub	\$680.10	
High Risk Total		\$596.44	
Medium Risk	Enrolled with Hub at Delivery	\$192.67	\$209.13
	Participated in the Hub, but not through delivery	\$102.84	
	Not Enrolled with Hub	\$401.80	
Medium Risk Total		\$386.60	
Low Risk	Enrolled with Hub at Delivery	\$101.81	\$161.87
	Participated in the Hub, but not through delivery	\$54.54	
	Not Enrolled with Hub	\$263.68	
Low Risk Total		\$257.04	
Unknown Risk (Not Enrolled in Start Smart)	Enrolled with Hub at Delivery	\$483.25	\$131.78
	Participated in the Hub, but not through delivery	\$1,261.39	
	Not Enrolled with Hub	\$615.04	
Unknown Risk Total		\$616.78	
Total		\$551.60	

*Compared to Not Enrolled with Hub

WHAT WE FOUND

Active use of Community Hubs combined with traditional health plan care management to reduce non-clinical barriers to care leads to a lower total cost of care in baby's first year of life.

For every dollar spent on Community Hub activities for our members there was a savings of **\$2.36**.

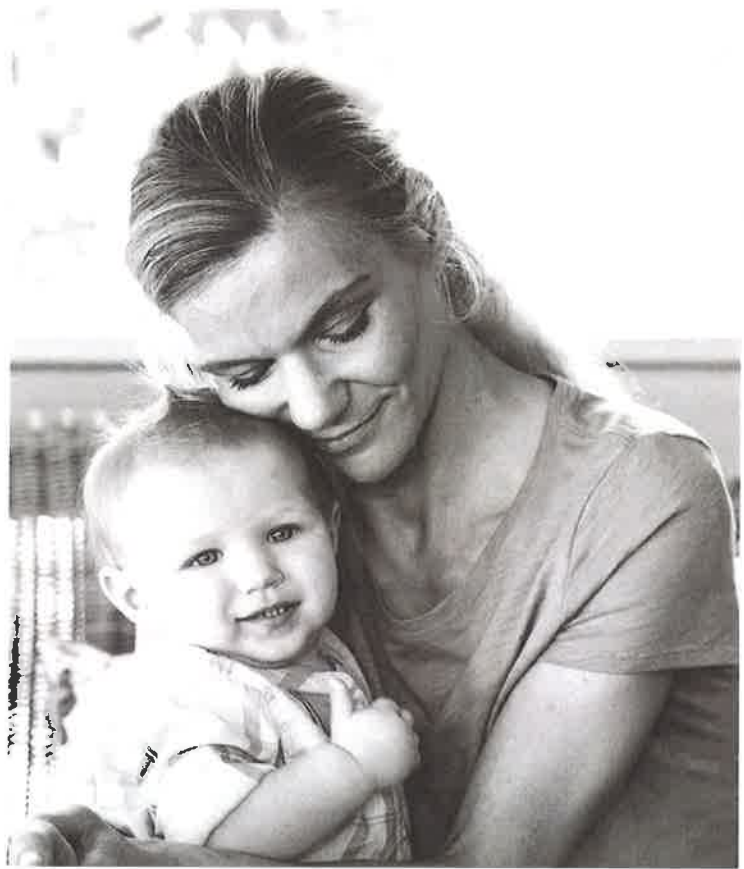
ROI: 236%

While newborns born to mothers at high risk have the greatest overall PMPM cost savings (**\$403**) during their first year of life when comparing those born to mothers enrolled with the Hub at delivery to those not enrolled with the Hub, there is an overall PMPM cost savings at all risk levels.

Newborns born to mothers at medium risk have an overall PMPM cost savings of **\$252**, while newborns born to mothers with low risk have an overall PMPM cost savings of **\$171** for infants born to mothers enrolled with the Hub at delivery to those not enrolled with the Hub.

Most of the cost savings (**94%** for newborns born to mothers at high risk) is through inpatient cost savings.

Newborns born to mothers at high risk have an inpatient PMPM cost savings of **\$379** during the first year of life when comparing those born to mothers enrolled with the Hub at delivery to those not enrolled with the Hub.



SOME EXAMPLES OF REIMBURSABLE ACTIVITIES ARE:

- Attaching a member to safe housing for 6 months
- Documented smoking cessation
- Connecting member to 3 behavioral health visits
- Referral to Buckeye's Addiction in Pregnancy Program



Improved Birth Outcomes through Health Plan and Community Hub Partnership

Authored by: Dr. Brad Lucas ■ Amber Detty, MA, CHDA

BACKGROUND

The impact of non-clinical barriers to care on direct medical costs should be accepted as a major impediment to our ability to impact major determinants of community vitality such as Infant Mortality.

- Community hubs use community care coordinators—mostly licensed community health workers to find at risk individuals, assess and lower risk, find and remove barriers to clinical care and then connect to effective clinical care.
- Buckeye Health Plan has long partnered with Community Hubs to help reduce our members' non-clinical/social determinant barriers.
- We have shown previously that participation in health plan pregnancy management programs improves birth outcomes in women who are at risk for low birthweight deliveries.¹
- This additional care is a natural extension of the care management work that occurs in the world of Medicaid managed care.

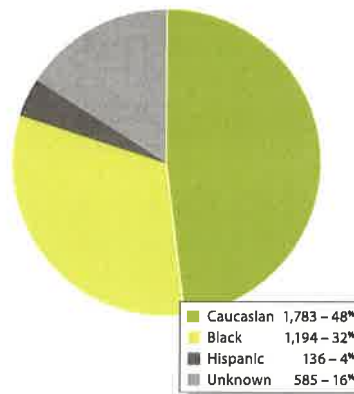
We asked ourselves whether this partnership made a measurable and statistically significant difference in outcomes.

¹Management of Pregnancy in a Medicaid Population. Mason, Lucas et al. Managed Care, March 2011.

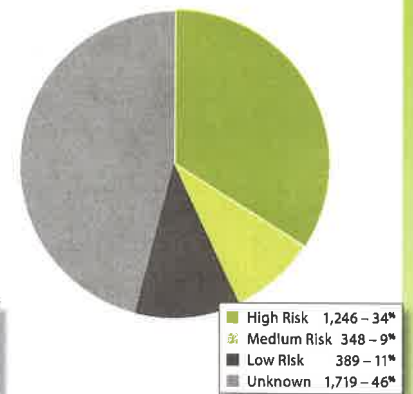
ANALYSIS AND METHODS

- A retrospective cohort study of 3,702 deliveries in the footprint of our busiest Community Hub (Health Council of Northwest Ohio). All deliveries in these areas between March 2013-February 2017 included.
- Analysis included the mother's age, race/ethnicity, gestational age, birthweight, and whether the baby needed neonatal care.
- Bivariate and multivariate analysis to identify odds ratios for Neonatal/NICU Admission by select predictors for all deliveries and separately for deliveries to high-risk, moderate-risk, low-risk, and unknown risk mothers in the service area.

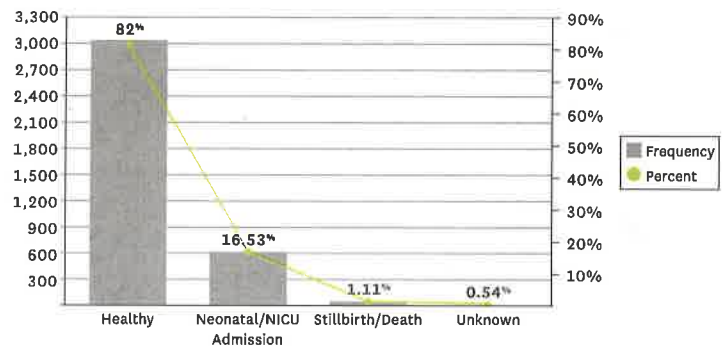
Deliveries by Mother's Race/Ethnicity



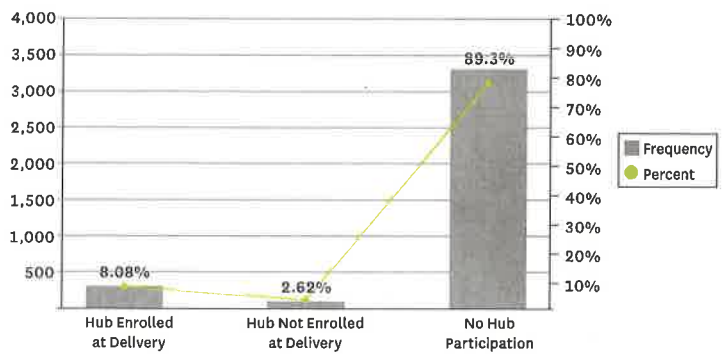
Deliveries by Mother's Risk Level



Deliveries by Newborn Outcome



Deliveries by HUB Enrollment



WHAT WE FOUND

High-risk mothers in a community hub service area where the member was not exposed to any community hub activity were 1.55 times more likely to deliver a baby needing Special Care Nursery or NICU care when compared to high risk members who received hub services through delivery.

ACTION	RESULT
Community Hub enrollment through delivery and high risk	Significantly less chance of neonatal admission
Community Hub enrollment through delivery for all risk levels	Approached significance in reduced chance of neonatal admission
Community Hub enrollment through delivery for low risk pregnancy	No effect on risk of neonatal admission

This data shows Community Hub activity combined with Medicaid health plan clinical program/care management activity improves birth outcomes in high risk pregnancies compared to high risk pregnancies that are not exposed to this intervention.



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