Georgia Department of Community Health

DCH Addressing Health Disparities

Presenters: Kelvin Holloway, MD
Seema Csukas, MD, PhD
James Richardson, MD
Truddie Darden, MD

November 9, 2023

Georgia Department of Community Health

Mission

We will provide Georgians with access to affordable, quality health care through effective planning, purchasing and oversight.

We are dedicated to A Healthy Georgia.

Agenda: Addressing Health Disparities

- Overview
- Systemic, Social & Economic Drivers
- Access to Maternal Care
- Georgia Managed Care Plans
  - CareSource …… Seema Csukas, MD, PhD
  - Peach State Health Plan …… James Richardson, MD
  - Amerigroup Community Care ……..Truddie Darden, MD
- Q & A
- Summary

What is Health disparity?

- Health disparity - the difference in health outcomes between groups within a population, whether unjust or not.

- Health inequity - denotes differences in health outcomes that are systematic, avoidable, and unjust.

- DCH uses Health disparities metrics to measure progress toward achieving health equity.

CDC & World Health Organizations definitions

Evidence of Health Disparities

- Life expectancy
- Birth weight
- Prematurity
- Maternal outcomes
- Deaths & morbidity from chronic diseases
- Access to providers & health services
- COVID deaths & vaccinations

Health Disparities are Driven by Social & Economic Inequities

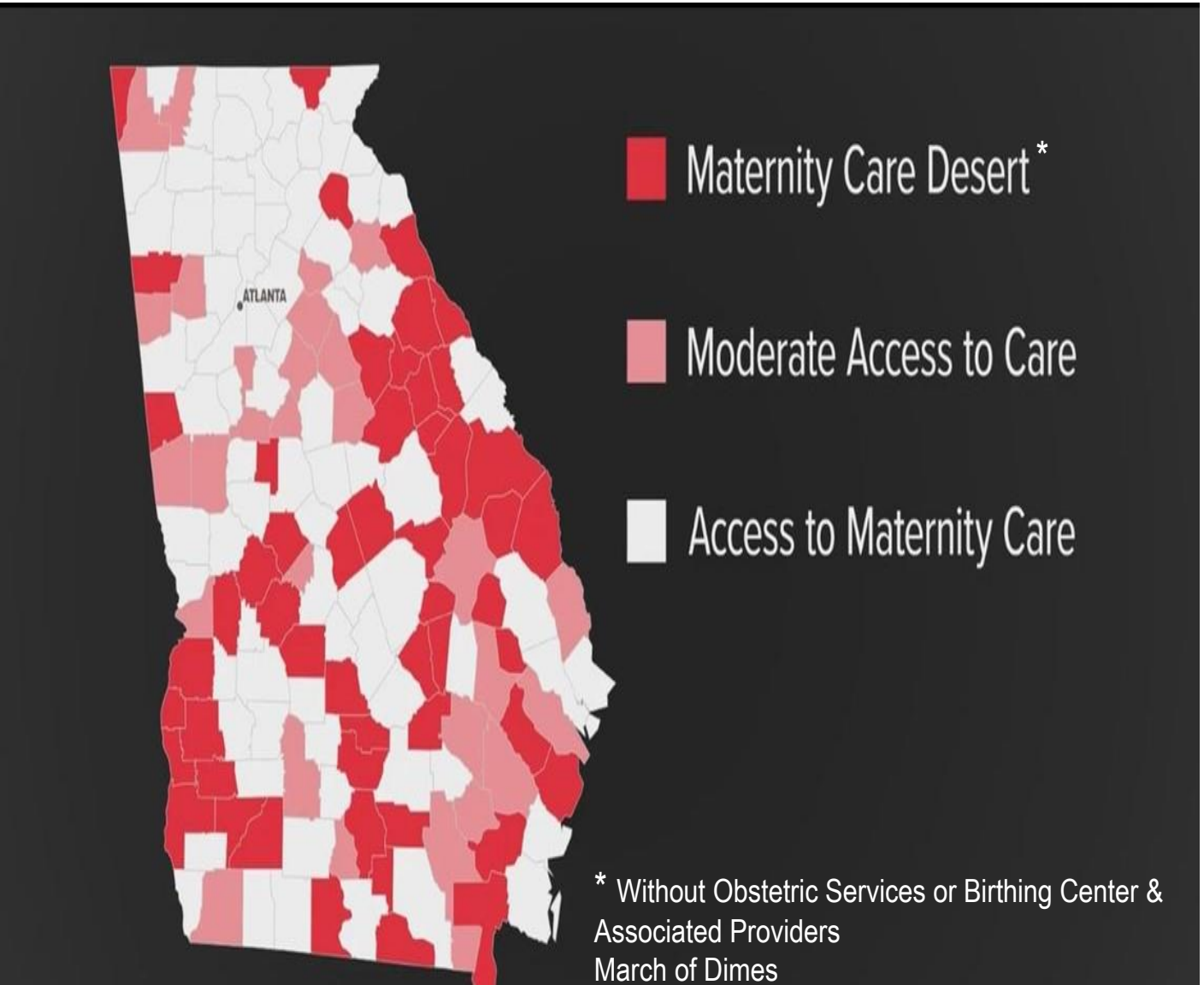
Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social Integration	Health Coverage
Income	Transportation	Language	Access to Healthy Options	Support Systems	Provider Availability
Expenses	Safety	Early Childhood Education		Community Engagement	Provide Linguistic and Cultural Competency
Debt	Parks	Vocational Training		Discrimination	
Medical Bills	Playgrounds	Higher Education		Stress	Quality of Care
Support	Walkability				
	Zip Code/ Geography				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF
HENRY J KAISER FAMILY FOUNDATION

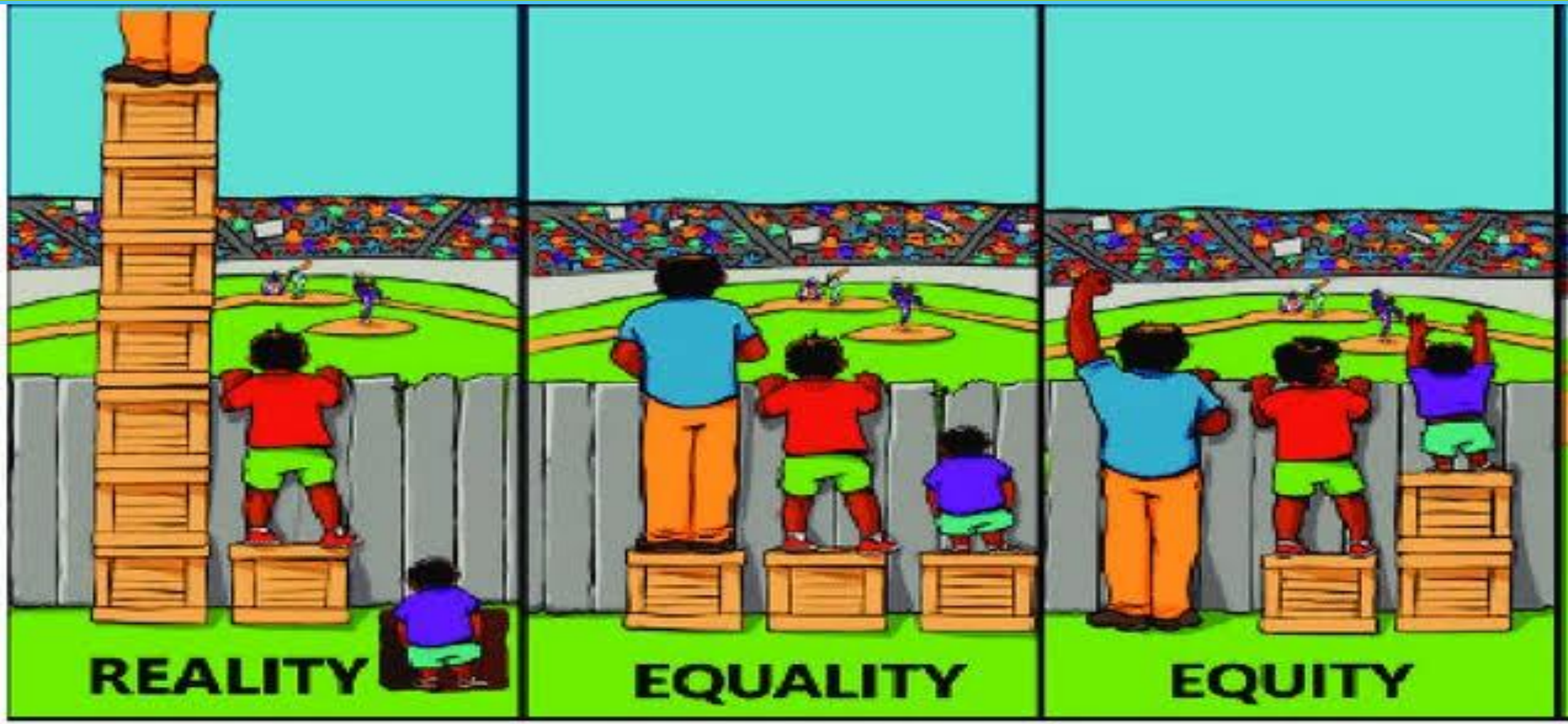
GA Access to Maternal Care



- 35% of counties considered deserts impacting 16% of women (U.S.: 30% & 10%)
- ~50% of predominately Black counties are maternal care deserts
- 41 labor units closed since 1994

  (More in predominately Black counties)
- ~ 25% of Black Georgians live in counties w/ little to no access
- In Georgia, 62.3% of the counties have a higher percent of women without health insurance than the state average (17.2%)
- Women w/ chronic health conditions 48% increase in preterm births

Approaches to Address Disparities

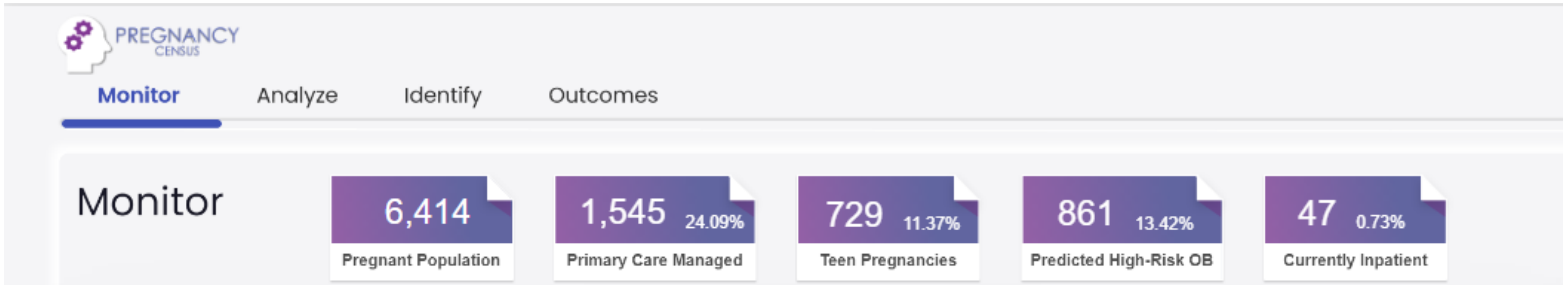


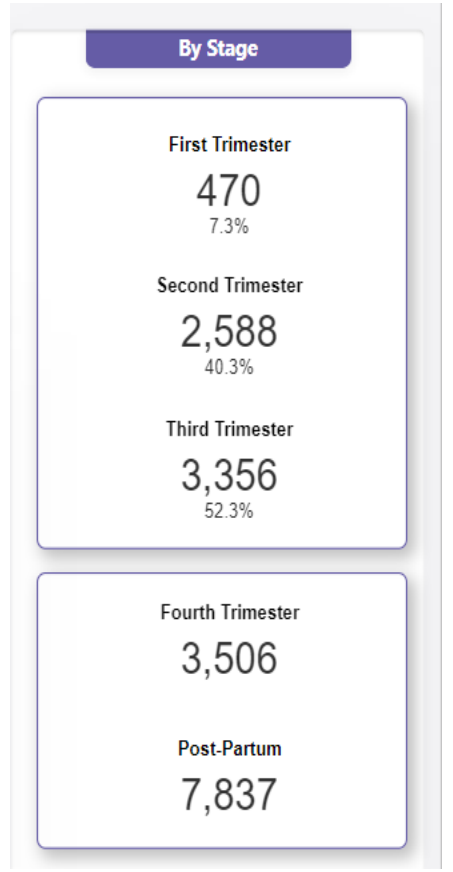
CARESOURCE GEORGIA

Seema Csukas, MD, PhD
Chief Medical Officer

November 9, 2023

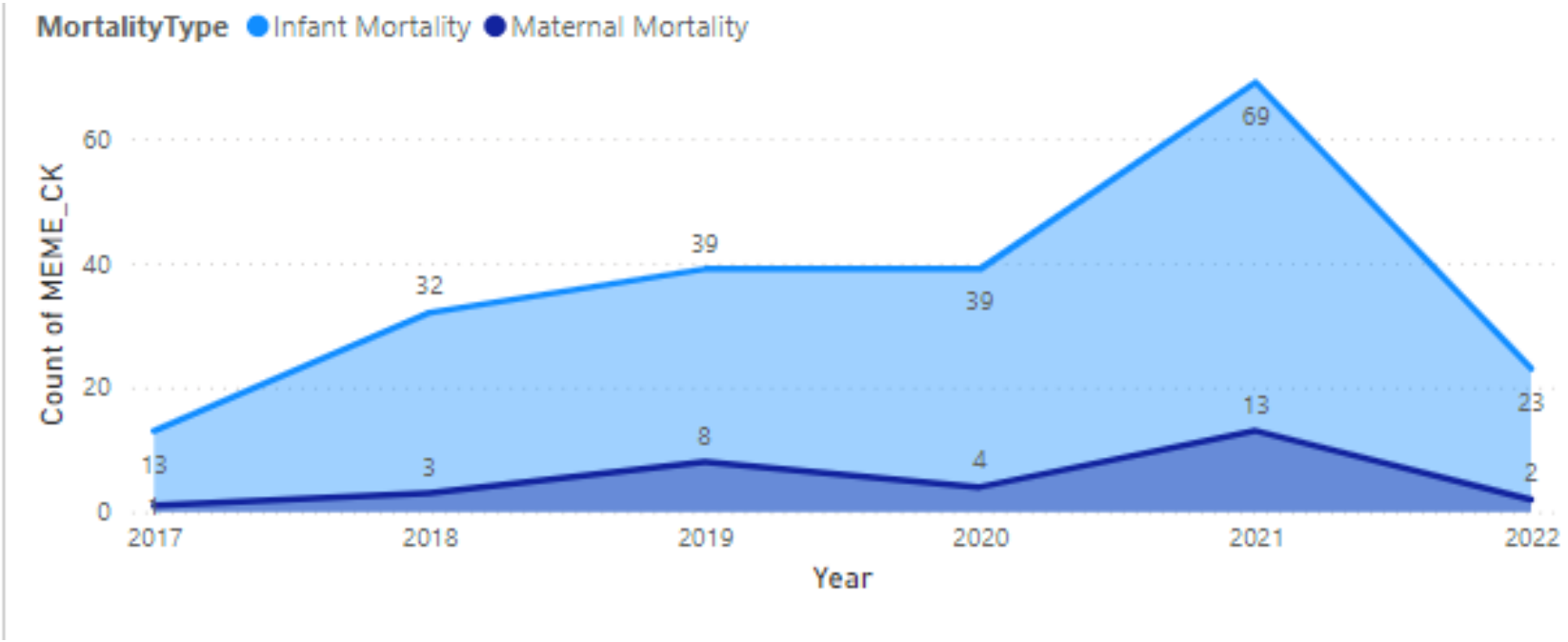
Understanding Our Maternal Members





- There are approximately **29,000** pregnant members in the Medicaid health plan each year.
- Most of them are between the ages of **22-30**.
- They are concentrated in the **Atlanta**, **Central** and **North** regions of the state.
- Of our pregnant women, our top chronic conditions are **obesity**, **hypertension**, and **diabetes**.

Maternal & Infant Mortality Data



Maternal

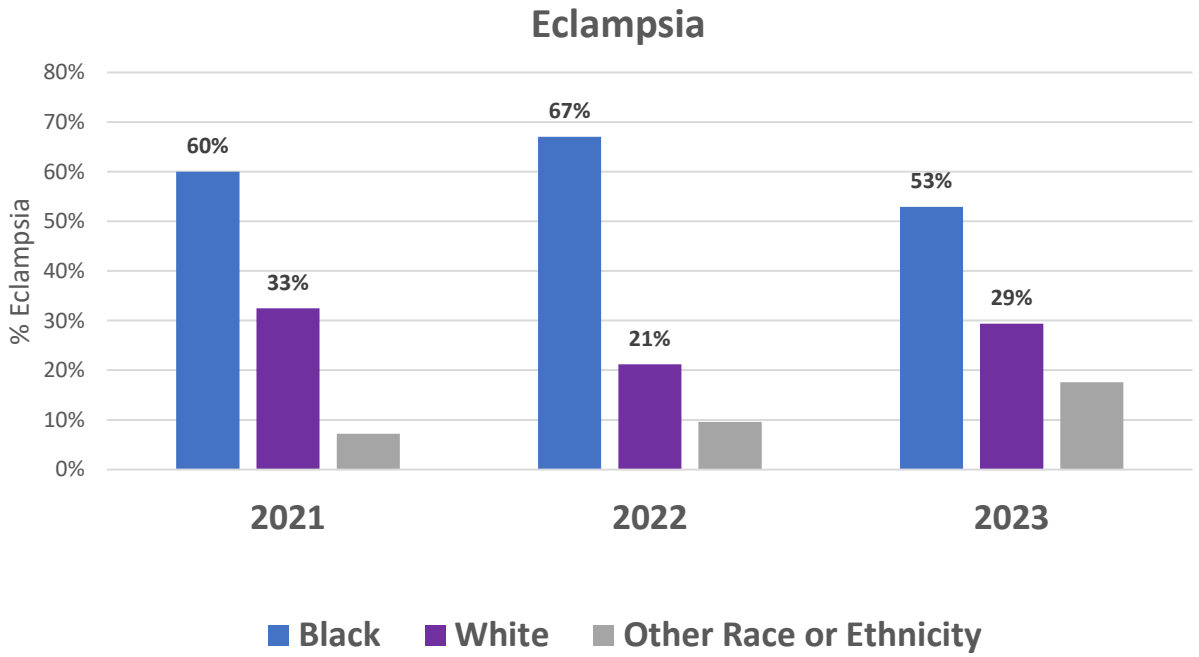
- Overall maternal mortality decrease YoY
- Black maternal mortality is **2x** higher than the white population

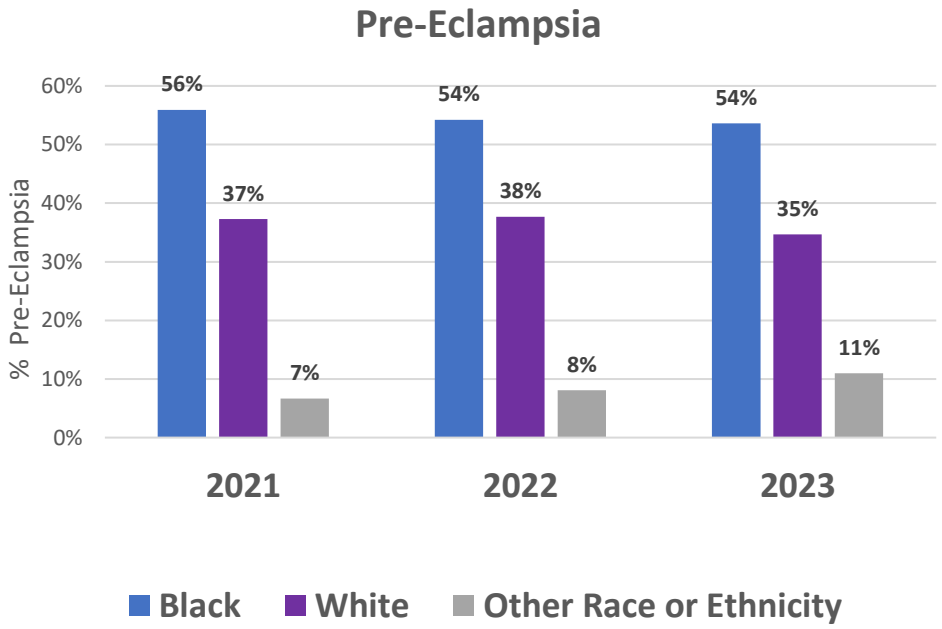
Infant

- Overall infant mortality decrease YoY
- Black infant mortality is slightly higher than the white population

**Based on claims data*

Eclampsia and Pre-Eclampsia





The black population is 2x higher for eclampsia and pre-eclampsia.

Mom & Baby Beginnings™

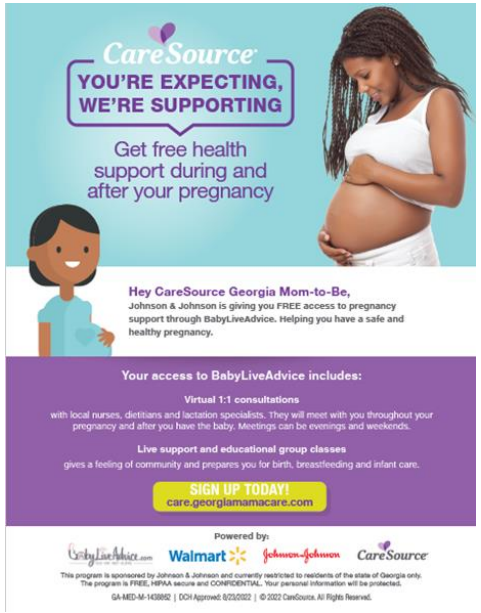
- Support is provided by diverse team of maternal health professionals
- Outreach to all pregnant members upon notification of pregnancy
- Conduct pregnancy, risk, and social needs assessment to coordinate the appropriate level of care and support
- Ensure each member in case management has a provider
- Provide maternal health education during the prenatal and postpartum periods
- Enroll members in incentive programs and value added benefits

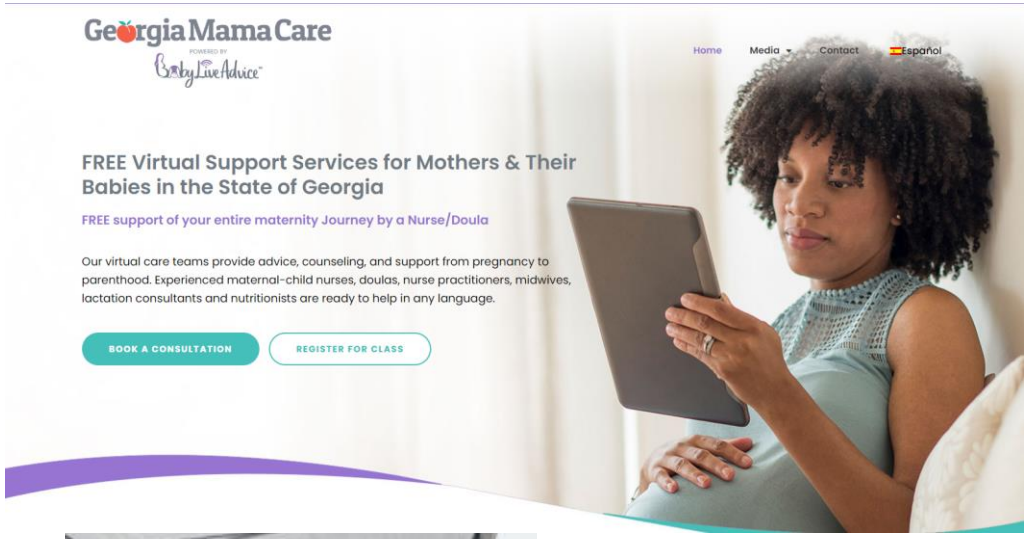
Postpartum postcards are sent to members as reminders

- Member incentives for prenatal, postpartum, and well-baby visits
- Nurse Practitioner (NP) postpartum telehealth visits
- Community partnerships and investments with wraparound supports
- Text/email campaigns with postpartum and well child reminders
- Prenatal/postpartum packets, postcards, and checklists

Community Partnerships & Investments

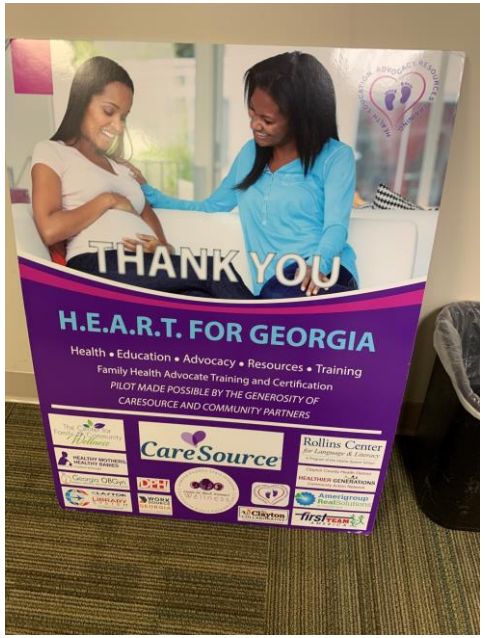
- Partnership focuses on maternal health
- Provided cultural competency training to over 7k maternal health providers nationally
- Provides access to digital maternal health platform Georgiamamacare.com
- Includes in-store education events focused on the whole family; attendance 1200+ per event





Community Partnerships & Investments

- Trained community advocates to serve as family support advocates for pregnant women
- Leveraged the national community health worker program as the training curriculum
- Started in Clayton County and has expanded statewide in Georgia plus North and South Carolina; 70 people trained since inception



Community Partnerships & Investments

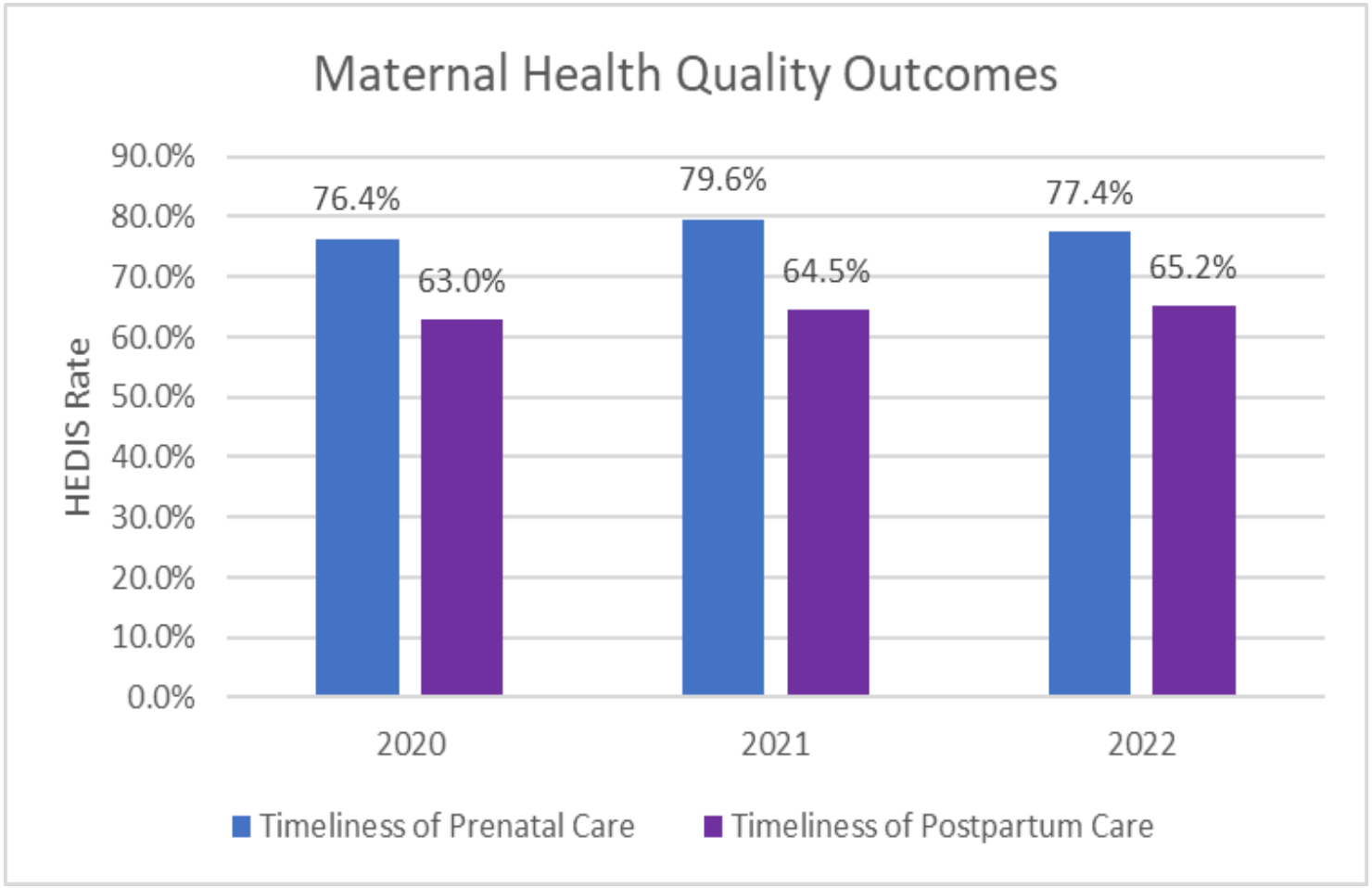
Phoebe

Nurse-Family Partnership
Helping First-Time Parents Succeed®

- Supported the implementation of the Nurse-Family Partnership program in southwest Georgia
- Funds support three registered nurses, a nurse supervisor and a program administrator to launch the program
- 72 clients are currently enrolled in the program

Nurse-Family Partnership | CareSource | Phoebe

Timeliness of Prenatal Care and Postpartum Care



Addressing Health Disparities

Dr. James Richardson
November 9, 2023

Pregnancy Population – December 2022 - Current

- 20,798 Live Birth Deliveries
  - 18,572 by women 21 years of age and older
  - 2,226 by women 20 years of age and younger
  - 10,702 deliveries by Black or African American women, 8,033 by white women
  - Atlanta had the highest number of deliveries at 9,698 followed by the Central region with 2,988
  - American Indian and Alaska Native had the highest compliance with postpartum visits at 61.90% while Native Hawaiian and Other Pacific Islander had the lowest at 33.33% (Denominators for both groups are relatively low)
  - Asian members had a total of 214 deliveries with the highest compliance with timely prenatal care at 59.35%, followed by Black or African American at 55.48% compliance with timely prenatal care
- The Southwest region posted the highest compliance rate for both Prenatal Care (61.46%) and Postpartum Care (55.21%)
- The Southeast region had the second highest compliance rate for Postpartum care with 49.45%, while the North region had 58.32% compliance related to timeliness of prenatal care
- The region with the lowest prenatal rate is the East (35.04%) and Atlanta has the lowest postpartum compliance rate (40.25%)

Strategies to Address Health Disparities

Education

The Start Smart For Your Baby Program promotes the early identification and assessment of pregnant members and encourage appropriate prenatal care and follow-up. The overall goal of the program is to improve birth outcomes.

Care Management Support

The High Risk OB Care Management Program is intended to improve birth outcomes. The Case Manager work with the member, family, and OB to complete a comprehensive assessment of health and pregnancy risk factors, and develops and implement an individualized care plan that addressed the member's full range of physical health, behavioral health, social, and other needs.

Access to Care

Increase in the number of completed behavioral health screenings and dental care provided as part of pre-natal care. Improving access in areas with

Social Determinants of Health

The SDOH Program promotes assessment of SDOH needs and uses a system of care approach to improve barriers resulting in better health outcomes.

Timely Follow-Up Care

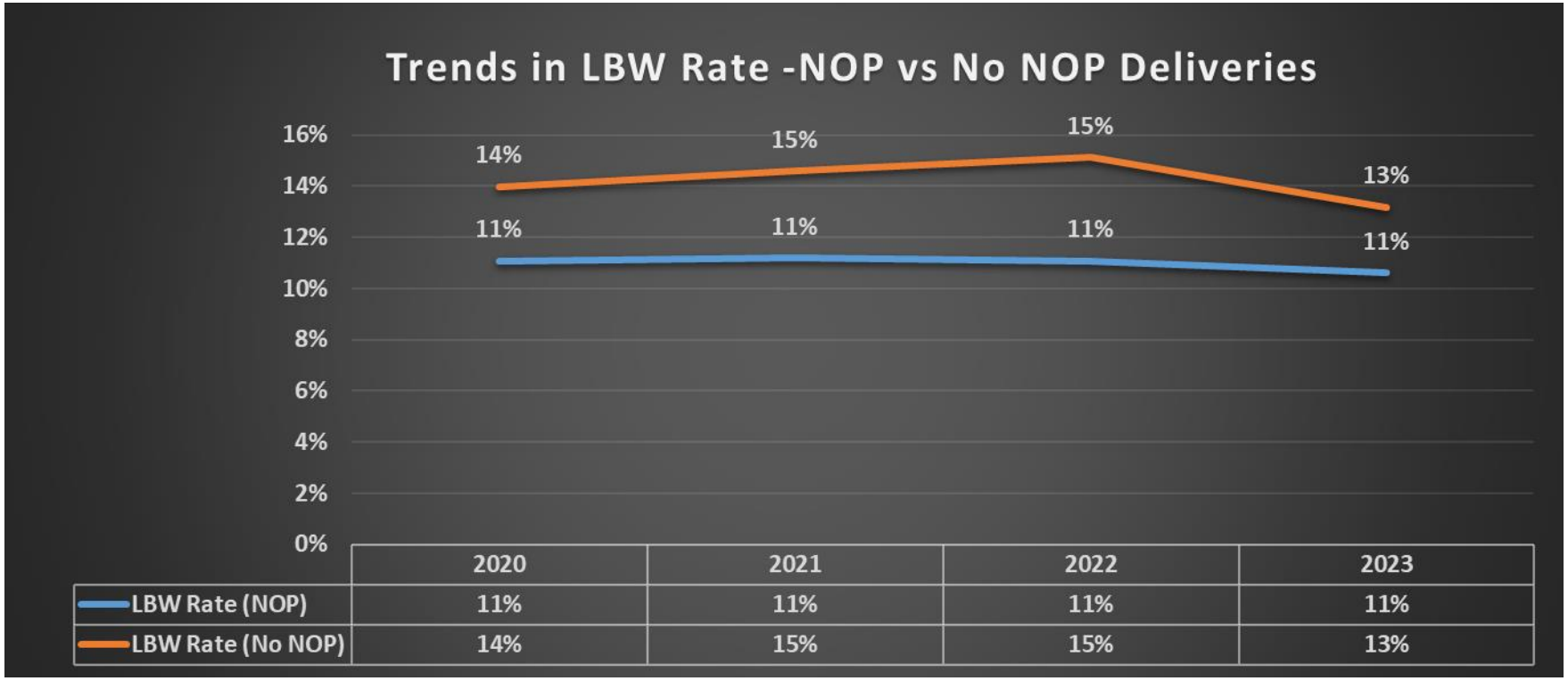
Increasing the number of member completing all prenatal and post-partum appointments. Early notification of pregnancy using incentives for early outreach resulting in timely follow up. Resource Mothers to follow members post-delivery for up to one year.

Cultural Competency

Increasing cultural awareness of the population needs. Completing a detailed analysis of population ensuring members are connected with the right provider and cultural competency plans are in place.

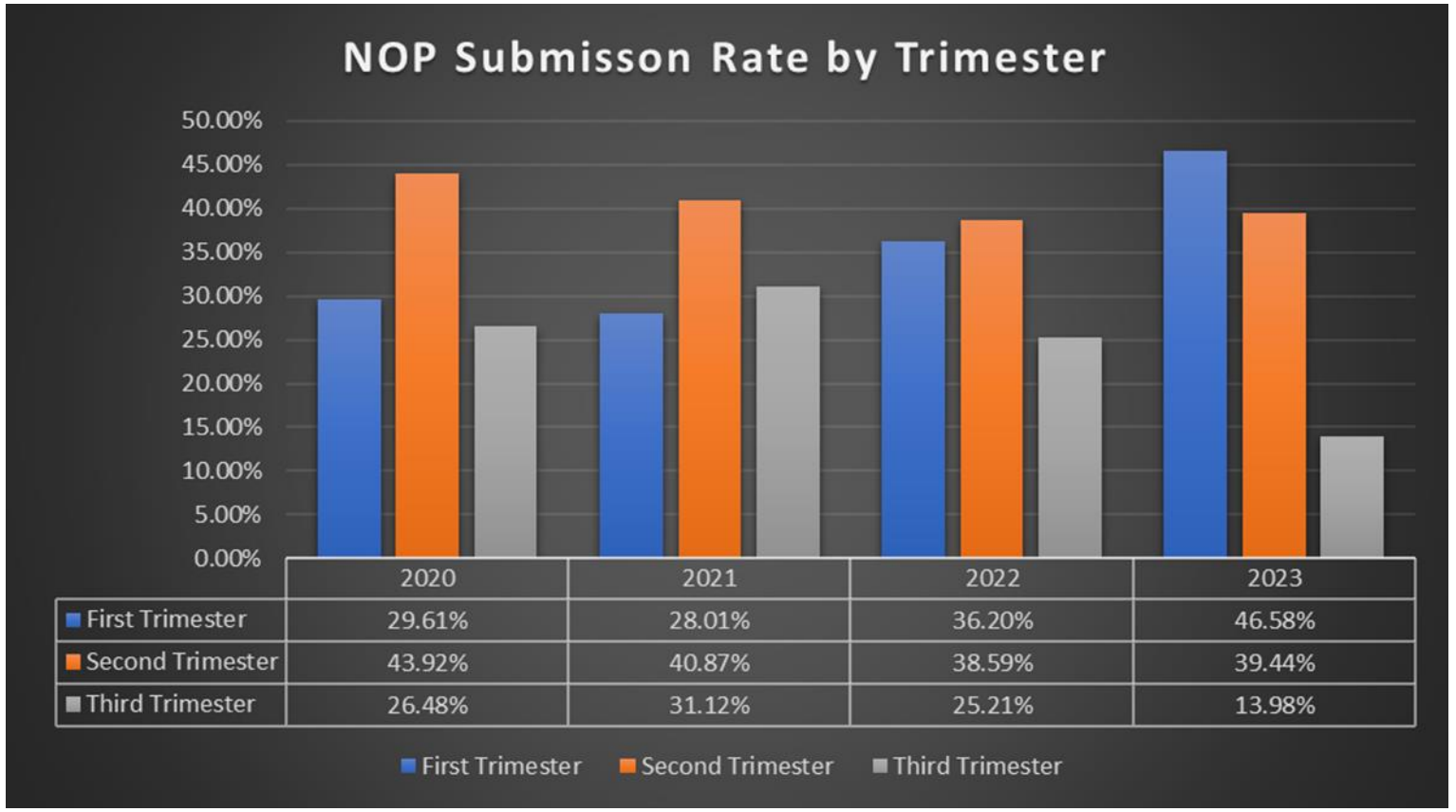
Notification of Pregnancy – Prenatal Intervention

In 2023, 89 more deliveries per 1000 had NOPs compared to 2020
Average LBW for deliveries with a NOP was 11% versus 14% for those without



	2020	2021	2022	2023
LBW Rate (NOP)	11%	11%	11%	11%
LBW Rate (No NOP)	14%	15%	15%	13%

Notification of Pregnancy – Prenatal Intervention



	2020	2021	2022	2023
First Trimester	29.61%	28.01%	36.20%	46.58%
Second Trimester	43.92%	40.87%	38.59%	39.44%
Third Trimester	26.48%	31.12%	25.21%	13.98%

Affinity Group – Postpartum Intervention

Peach State health plan conducted a pilot focusing on improving postpartum care rates in the East, Southeast and Central regions. The goal was to increase postpartum care rates by providing education to providers on timing of care and how to provide data outside of global billing to CMOs for increased ability to monitor care given to membership.

Region	Interventions
East	Flyer emailed to OB/GYNs sharing the availability of an incentive for sharing the post-partum visit with the CMO outside of global billing.
Central	Quality Improvement Practice Advisor (QPA) in person visits to all OB/GYNs sharing importance of complying with the HEDIS PPC measure and the availability of an incentive for sharing the PPV with the CMO outside of global billing. In addition, flyers emailed to OB/GYNs sharing the availability of an incentive for sharing the PPV with the CMO outside of global billing.
Southeast	Quality Improvement Practice Advisor (QPA) in person visits to all OB/GYNs sharing importance of complying with the HEDIS PPC measure No incentive is offered to this region.

Post Partum Compliance			
Region	Performance before Intervention	Performance after Intervention	% Increase / Decrease
Central	42.95%	54.63%	11.68%
East	32.73%	46.64%	13.91%
Southeast	38.08%	51.51%	13.43%

Meeting of the DCH Board Care Management Committee
and
Amerigroup Community Care

November 9, 2023

Dr. Truddie E. Darden, MD, FAAP
Plan Performance Medical Director, GA
Elevance Government Division
Amerigroup Community Care

Amerigroup RealSolutions in healthcare

Health Disparities & Health Equity

Maternal and infant health outcomes are the worst in communities of color, most notably among Black birthing parents and babies. There are multiple reasons for those disparities, but many maternal health inequities can be traced back to issues of access, including access to medical care, community support, and nutritious food.

Access to Medical Care

Where we live is one of the biggest social drivers of health. According to Elevance Health data, pregnant women who live more than 50 miles from a delivery facility are twice as likely to experience preterm birth.

Inequities in Access to Care

Every year about 700 people die during pregnancy, or in the year thereafter, with another 50,000 people experiencing severe complications during pregnancy. But pregnancy-related deaths do not impact everyone equally: Black people are three times more likely to die from a pregnancy-related cause than White people.

Access to Nutritious Food

The food we eat directly correlates to our health, and this is especially true during pregnancy. Pregnant people need sustainable nutrition for themselves as well as their growing baby.

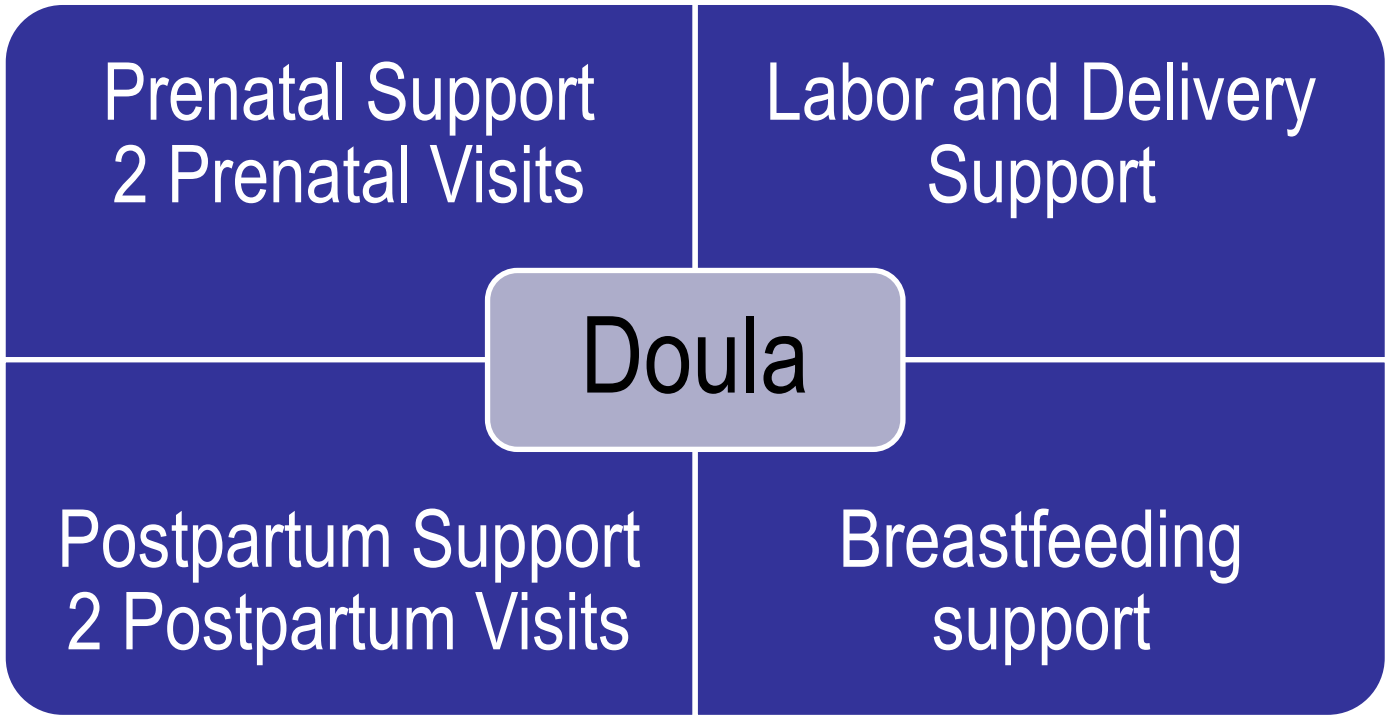
**Turning the Tide on Maternal Health, December 12, 2003, Elevance Health https://pulse.elevancehealth.com/v3/Article/AEPULSE*

Amerigroup RealSolutions in healthcare

Amerigroup's Real Solutions

Access to Medical Care: The Doula Pilot Launched April 2022

Doulas provide person-centered care to pregnant and postpartum women through information, education, physical, social, and emotional support. The objective of Amerigroup's Doula Pilot was to address health inequities and disparities particularly in rural counties where there is a lack of maternal centers and hospitals. The targeted enrollment for the pilot was 65 members.

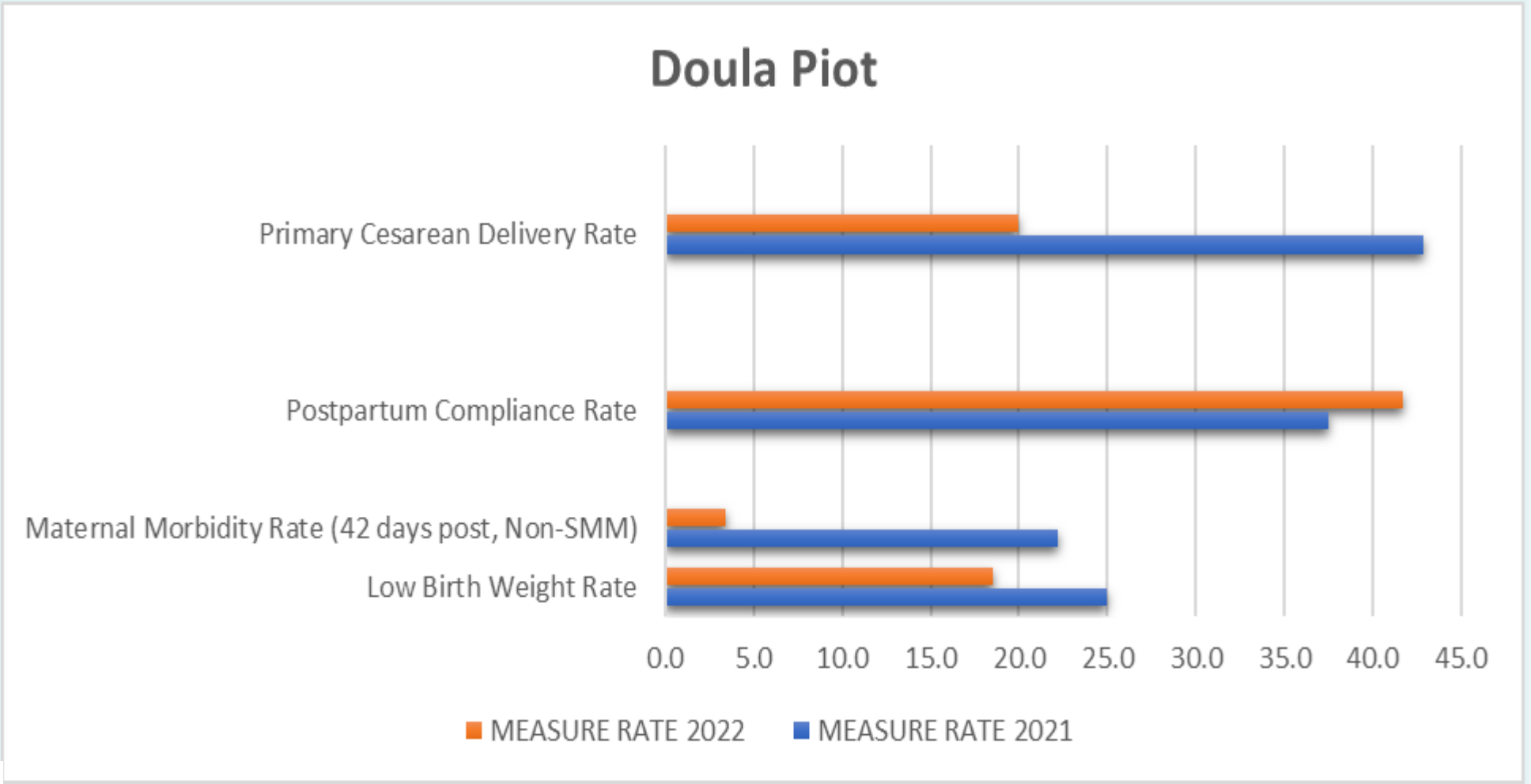


Amerigroup RealSolutions in healthcare

Amerigroup's Real Solutions

Program Outcomes:

Comparison of Deliveries in 2021 vs 2022



Amerigroup RealSolutions in healthcare

Amerigroup's Real Solutions

Doula Expansion Program: Community Care Doula Program

- Targeted Enrollment: 225 women
- Expand to Southeast rural counties and metro Atlanta
- 40 Doulas have been trained (Valdosta and Savannah)
- 21 Doulas have been credentialed and hired
  - Doula Certification
  - First Aid and CPR Training
  - Level 2 Background Screening
  - HIPAA Training
- Cultural Diversity: African American, Latino, Caucasian
- Go Live 10/2/23 and 20 members referred

Amerigroup RealSolutions in healthcare

Amerigroup's Real Solutions

Inequities in Access to Care: Mom's Heart Matters (MHM) Launched 6/26/23

Mom's Heart Matters is a maternal remote patient monitoring program (RPM) with a focus on the group most impacted by hypertension which is black and brown moms.

Program Objectives:

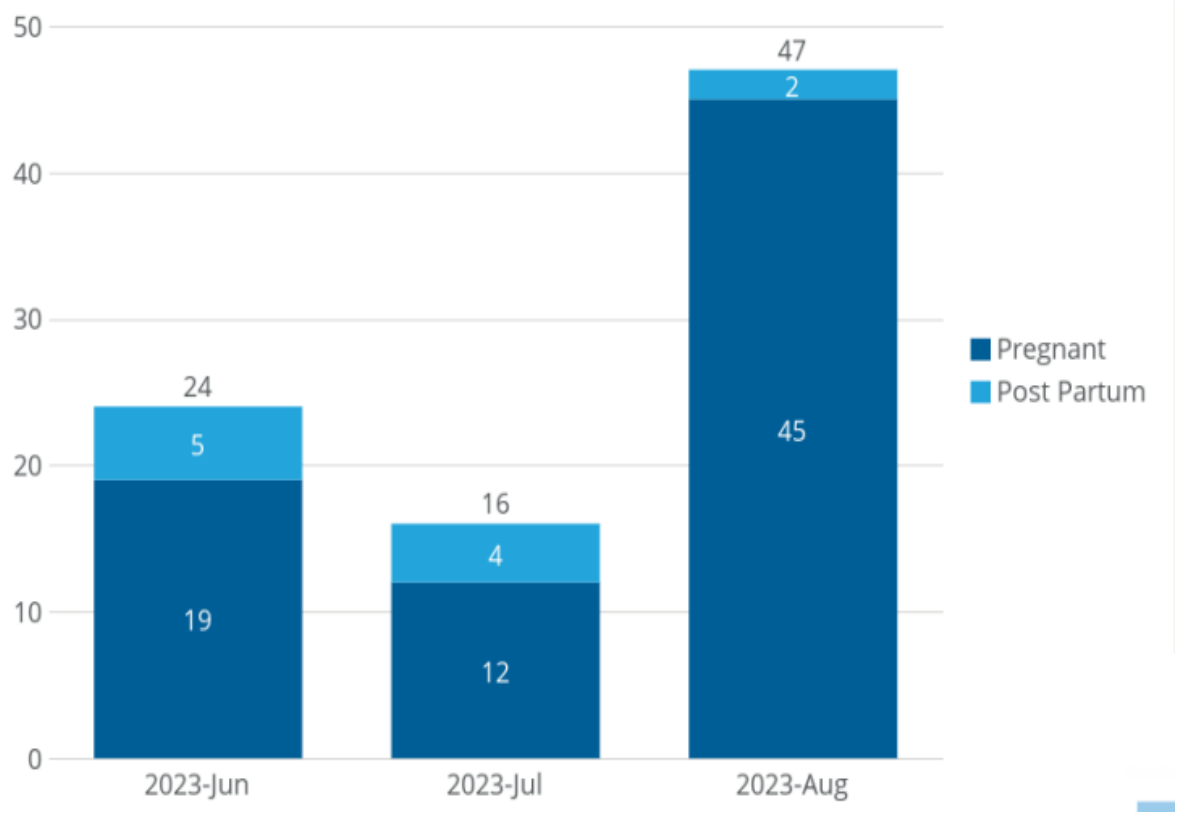
- Reduce the rate of hypertension related mortality among pregnant and postpartum women
- Meet ACOG guidelines for perinatal/postpartum blood pressure readings
- Improve likelihood that women will be seen by a cardiologist
- Reduce ER visits and inpatient admissions

Services provided:

- Remote Patient Monitoring
- Non-connected Device Program (Member self-monitors)
- Education and resources provided to manage hypertension

Amerigroup RealSolutions in healthcare

Amerigroup's Real Solutions



MHM Program Outcomes

Total Program Enrollments 87

Pregnant 76 / Post Partum 11

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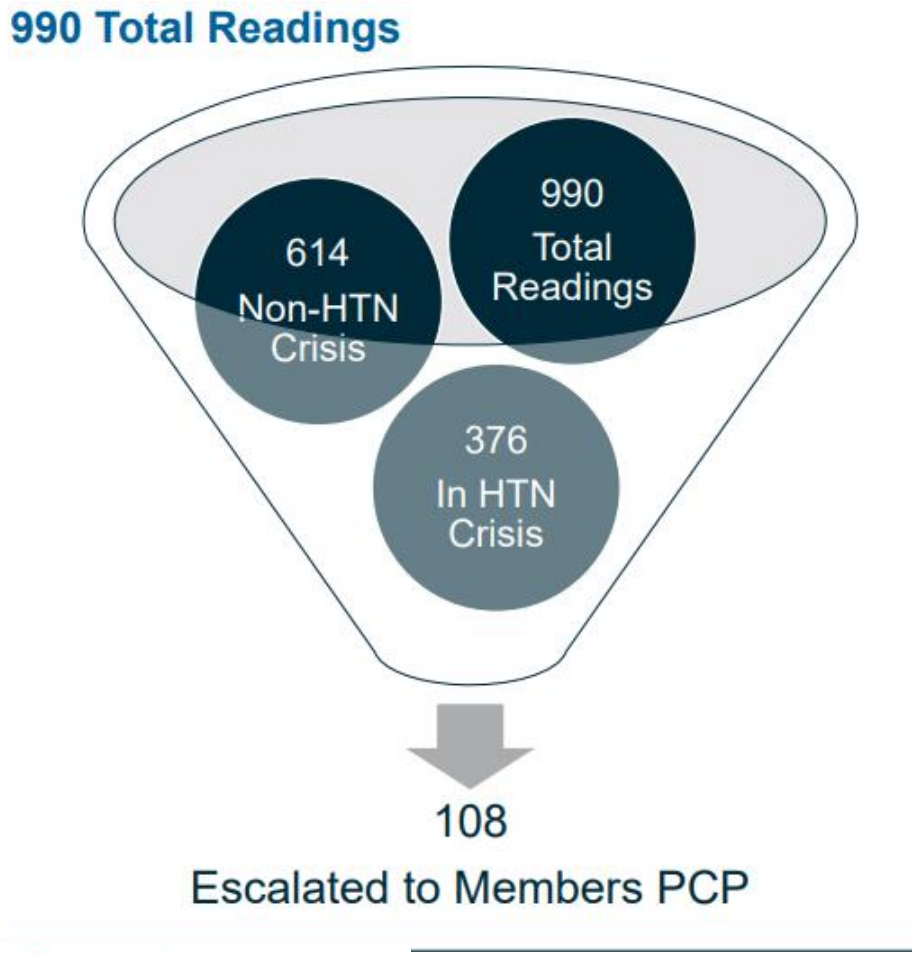
Amerigroup's Real Solutions



RPM Maternal Population

- 990 Total Readings
- 376 BP readings at or above HTN crisis
- All received live outreach from vendor
- 108 Escalated to PCP & received a follow up call within ~24 hours

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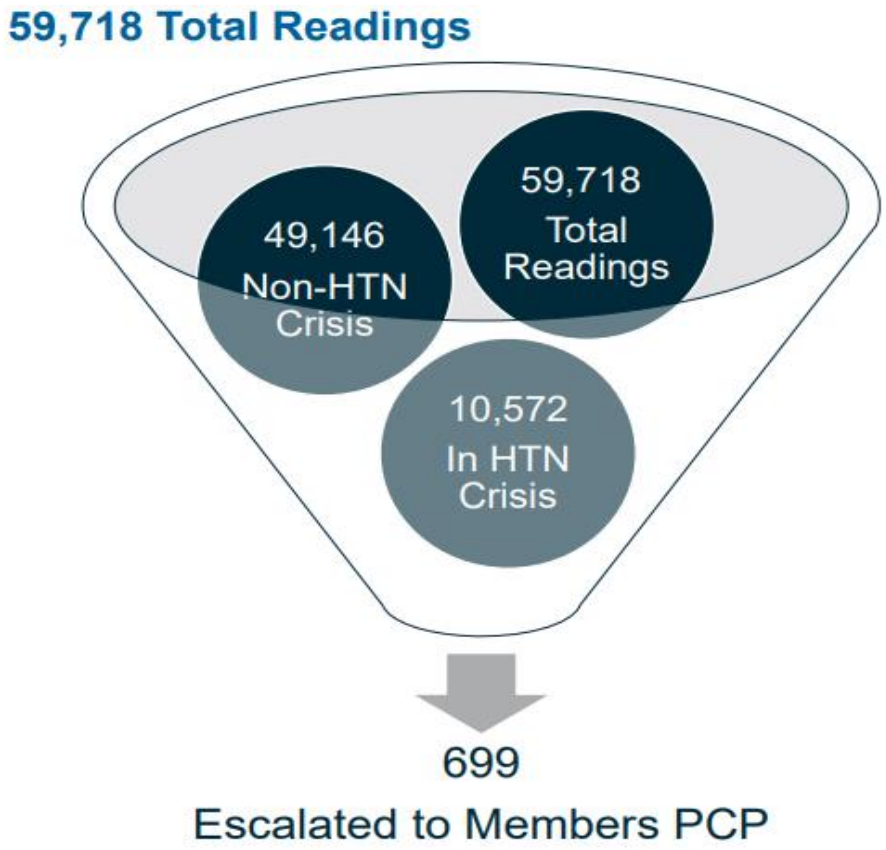
Amerigroup's Real Solutions



Physical Health Population

- 59,718 Total Readings
- 10,572 BP Readings at or above HTN crisis
- All received live outreach from vendor
- 699 Escalated to PCP and received follow up calls within ~ 24 hours

Amerigroup RealSolutions in healthcare

Amerigroup's Real Solutions

Access to Nutritious Food: Mom's Meals Launched September 2021

Mom's Meals Program provides nutritionally tailored diabetic friendly meals to support women diagnosed with type 1 or gestational diabetes and who may be at risk with their pregnancy.

Program goal:

Provide women with the nutrition needed to support their own health as well as the health of their baby.

In Q3 '23 nutritional counseling will be added to the Mom's Meals program to further assist women with glucose control and weight management. Program expanded in Q3 '23 to HTN friendly meals as a menu option to support women who have diabetes and high blood pressure.

- The program provides 2 refrigerated meals per day (14 per week) up to 10 months
- Meals are delivered to the doorstep within 5 business days after receipt of referral

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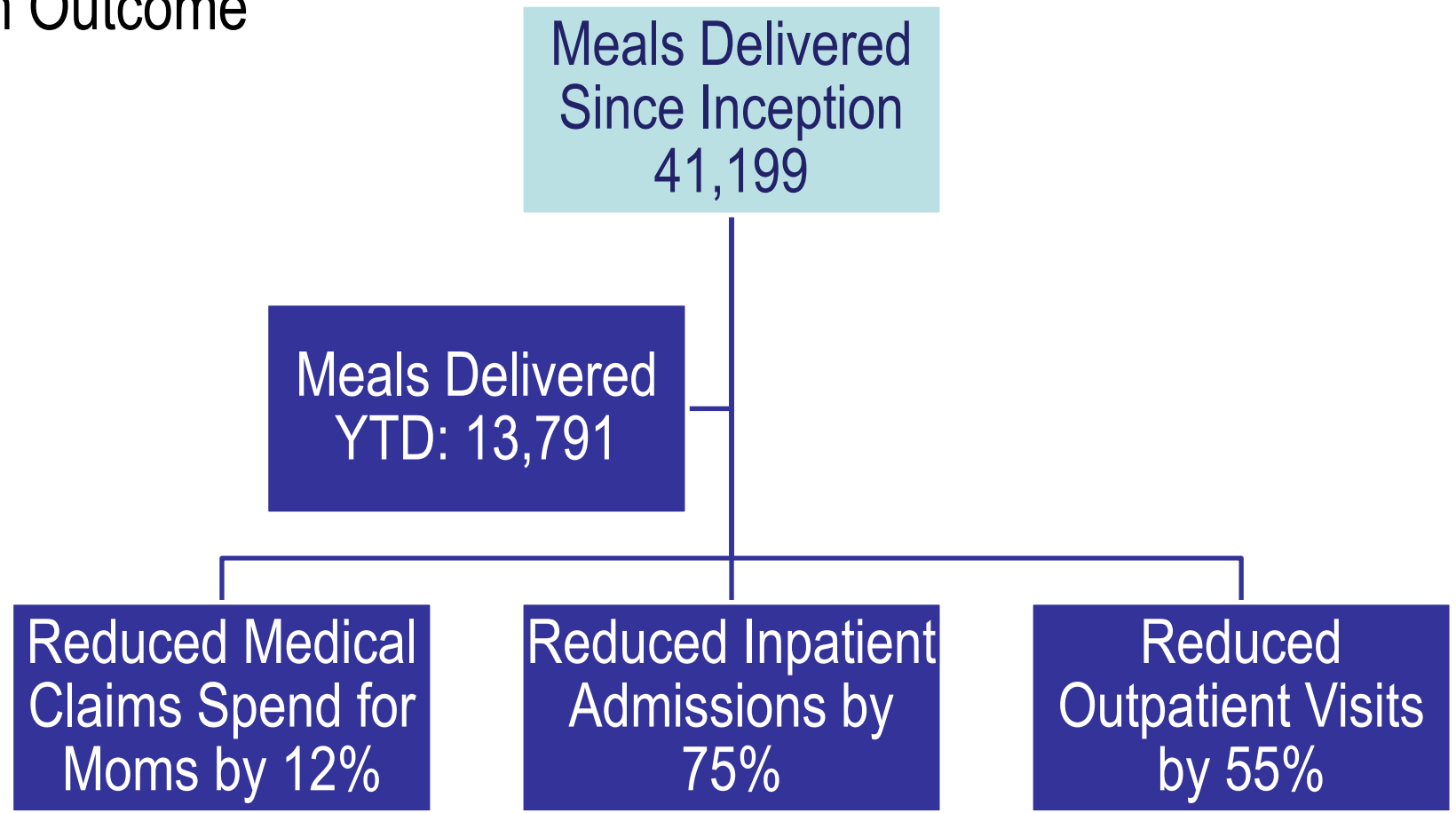
Amerigroup's Real Solutions

Moms Meals Program Outcome



Amerigroup RealSolutions in healthcare

SUMMARY

Amerigroup continues to impact the maternal child health communities through wellness and chronic disease management as evidenced by examples of programs presented.

Amerigroup RealSolutions in healthcare


Q&A

Addressing Health Disparities: Key Take-aways

- Understanding & capturing member characteristics is essential
- Measuring key stratified Health outcomes is a must
- Improvement efforts must be targeted/tactical to have the greatest impact to achieve Health Equity