Centering & Celebrating Cultures in Health

Mid-Hudson & Long Island

Regional Consortium
March 14, 2023

Molly Ridley MPH(c)
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Welcome!

NEW YORK STATE | Department of Health

Who's here?

- Name
- Role
- County

Agenda

- Welcome and Introductions
- Overview and Goals of the Consortium
- Dr. Kathleen Cravero
- Q&A Session
- Break
- Dr. Zenobia Brown
- Q&A Session
- Closing/Program Updates

DR. KATHLEEN CRAVERO

- Dr. Kathleen Cravero
  - Distinguished Lecturer and Director of the Center for Immigrant, Refugee and Global Health with CUNY School of Public Health
  - 25+ years of experience working for the United Nations
  - Former President of Oak Foundation

Crisis or Opportunity: Migration and Health in New York State

Dr. Kathleen Cravero

THE IMMIGRANT EXPERIENCE IN NEW YORK STATE

MYTH #1: *IF WE DON'T TIGHTLY CONTROL OUR BORDERS, THERE WILL BE A FLOOD OF IMMIGRANTS TO THE UNITED STATES.*

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Flow of immigrants has been rather steady over time

- Immigrants make up 13.5% of the total US population, same as the 12-15% observed during earlier immigration spikes

No evidence that restrictive policies result in lower numbers

- International migration is driven by structural factors, e.g.:
    - Political conflicts in origin countries
    - Labor market imbalances
    - Inequalities in wealth
- Migration policy has little or no influence on these forces

MYTH #2: *MIGRANTS BRING DISEASES INTO THE UNITED STATES.*

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No evidence linking migrants to modern disease outbreaks

- Allegations that undocumented immigrants have brought measles, hepatitis C, HIV, tuberculosis and Ebola have been unfounded
- Many of these claims emerge from anti-immigration rhetoric and hate campaigns

Immigrants contribute to herd immunity

- Foreign-born populations have higher childhood vaccination rates than that of US-born populations
- Suggesting that these migrants contribute to herd immunity for vaccine-preventable infectious diseases

Immigrants must pass U.S. Domestic Medical Examinations

- There is an extensive health screening process for Immigrants arriving in the US
- The vast majority of migrants have successfully passed

MYTH #3: *MIGRANTS DRAIN HEALTH AND SOCIAL SERVICES.*

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Many migrants not eligible for social services

- Undocumented immigrants not eligible for federal public health benefits:
    - Social security
    - Medicaid
    - Medicare
    - Food stamps
- Most immigrants not entitled to these benefits unless they have lived in the US for 5+ years

Health insurance among migrants

- Approximately 58% of U.S. immigrants had private health insurance in 2019, compared to 69 percent of the US-born population
- From 2013 to 2017, the rate of uninsured immigrants fell from 32% to 20%, and the rate for the native born fell from 12% to 7%.

MYTH #4: *MIGRANTS STEAL OUR JOBS.*

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Immigrants are more likely to create jobs than "steal" them

- Immigrants are twice as likely to start businesses as US-born citizens
- Companies owned by immigrants are more likely to hire employees than companies owned by native-born citizens

Economic stimulation in NYS

- One-third of all self-employed business owners are immigrants
- Their businesses have generated a total of $7.2 billion in total annual revenue in NYS

MYTH #5: *MIGRANTS DON'T PAY TAXES.*

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Federal taxes

- Undocumented immigrants contribute an estimated 8% of their income in state and local taxes
- This is a higher effective tax rate of the top 1% of all taxpayers in the US

State and local taxes

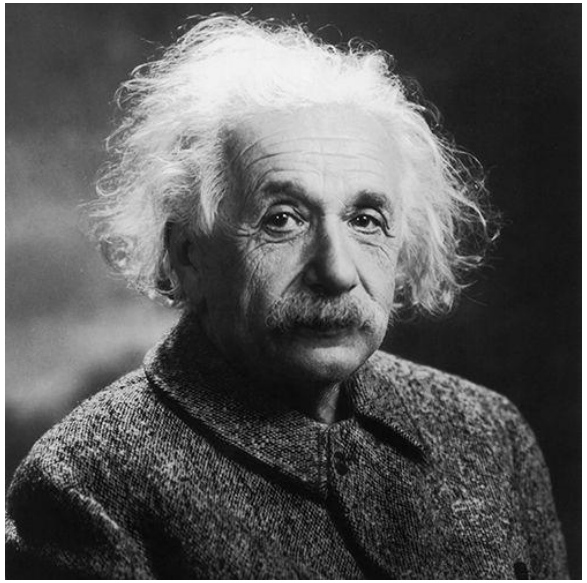
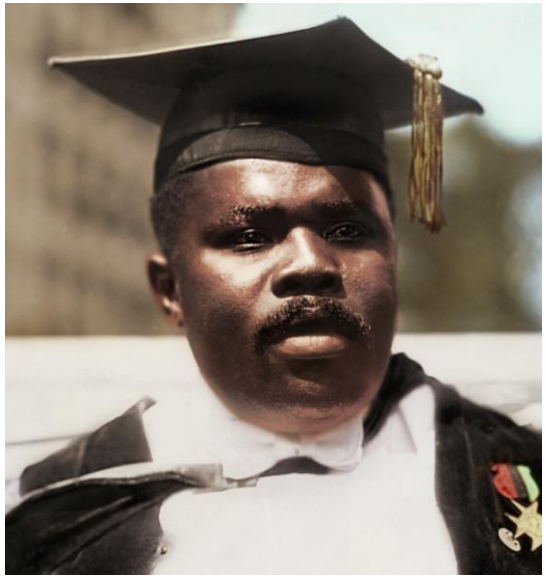
- More than half of all undocumented immigrant households file income tax returns using Individual Tax Identification Numbers
- In 2020, immigrant-led households immigrants contributed:
    - $18.5 billion in combined state and local taxes
    - $33.1 billion in federal taxes in New York State

Sales taxes

- All people pay taxes on goods, services and property taxes on homes that they rent or buy, regardless of immigration status





MIGRATION IN NYS

- 22% of the total population of New York State are immigrants (4.4 million), as of 2019[1]
  - 22% of the state population
  - 28% of the labor force
- Governor says: New York State needs more immigrants to grow its economy
- So: healthy migrants = healthy economy =healthy state

YET ….

- **We seldom “walk the talk” – even when policies improve, action doesn’t follow**
  - Local Law 107 NYC
  - Application for Waiver 1332 – NYS
- **We don’t understand our own biases**
  - Cultural competence
  - Cultural humility
- **We fail to see migration as an opportunity**
  - Evident in the language we use (e.g., crisis”)
  - Reinforced by the lack of priority given to migrant health and well being

IMPLICATION FOR THE NEXT GENERATION OF PUBLIC HEALTH LEADERS

Champion truth and evidence – bust the myths

Embrace migration as an opportunity – make it real

Know what you don't know – push back against your own bias

Dr. Kathleen Cravero-Kristofferson

kathleen.cravero@sph.cuny.edu

CUNY SPH

CENTER FOR IMMIGRANT, REFUGEE & GLOBAL HEALTH

BREAK

Northwell Health®

DR ZENOBIA BROWN

- Senior Vice President and Associate Chief Medical Officer of Northwell Health
- Executive Director of Northwell Health Solutions

The intersection of Value-Based Care, DEI, Population and Community Health

Zenobia Brown, MD, MPH

SVP Population Health

Care Management

March 14th, 2023

Northwell Health®

Agenda

- Northwell Health
  - Journey into population Health
- Value Based Care and Population Health
- Northwell's Approach to DEI
- Community and Population Health
  - Program Examples
- QandA

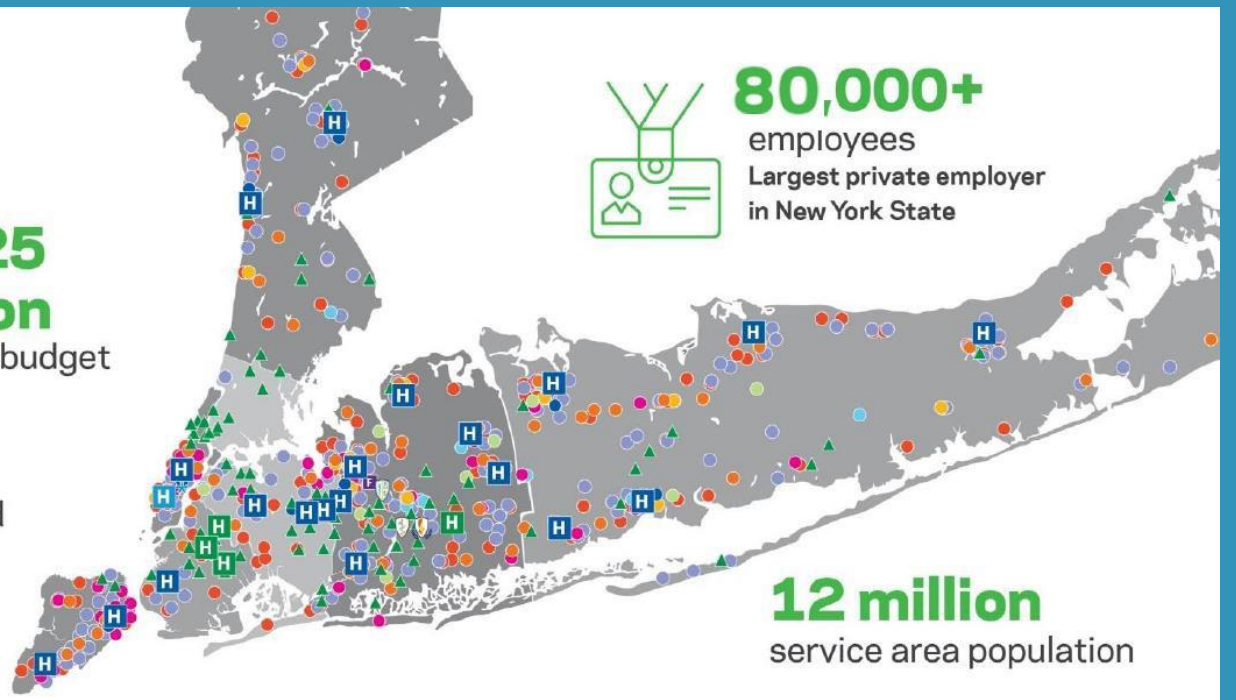
Northwell Health®

$15 billion annual operating budget

$1.25 billion capital budget

21 hospitals } **9** magnet-designated

850+ ambulatory facilities



80,000+ employees
Largest private employer in New York State

12 million service area population

CAREGIVERS

12,000+ credentialed physicians

4,900+ employed physicians

3,500+ advanced care providers

18,000+ nurses

1,900+ residents and fellows in 180 programs

5,000 volunteers

OPERATING STATISTICS

2 million patients treated annually
— 5.5 million patient encounters

37,000+ births

1 million home health visits

850,000+ emergency visits*

250,000+ ambulatory surgeries*

1,000+ active clinical research studies

250+ principal investigators

*2022 budgeted

COMMUNITY IMPACT

$2.7 billion in total benefits contributed to the community. Highlights include:

$485 million in education & research

$465 million in health improvement services & building

$221 million in charity care

Value-Based Care and the Quadruple Aim: Providers

Quality and Population Health

- Improved health outcomes
- Equity of access
- Reduced disease burden

Sustainable Cost

- Cost reduction in service delivery
- Reduced avoidable/unnecessary hospital admissions
- Return on innovation costs invested
- Ratio of funding for primary : acute care

Patient Experience of Care

- Reduced waiting times
- Improved access
- Patient & family needs met

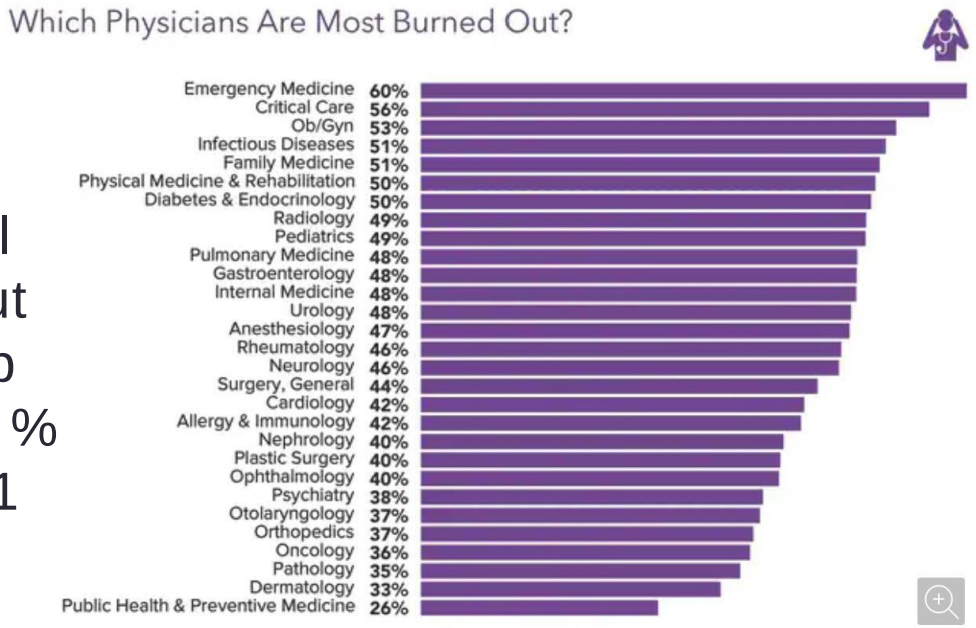
Improved Provider Satisfaction

- Sustainability and meaning of work
- Increased clinician and staff satisfaction
- Teamwork

CMS.gov Centers for Medicare & Medicaid Services

"Paying Providers for Value, not Volume"

47% overall burnout rate up from 42 % in 2021



Physician Burnout & Depression Report 2022: Stress, Anxiety, and Anger

Leslie Kane, MA | January 21, 2022 | Contributor Information

Northwell Health

Value Based Care

Value in health care is measured improvement in an individual's health outcomes relative to the cost of achieving that improvement.

The goal of value-based care transformation is to generate and evidence high quality outcomes leading to enriched financial performance.

Northwell Health

Defining Value

"Value" across most industries is defined by performance on four domains




Accessibility

Can patients access meaningful care in a timely manner?

Service

Do patients have a positive experience of care? Would they recommend us and/or return to us for care?

Effectiveness

Does the care we provide have benefit? Does it improve health? Does it reduce suffering?

Cost

Is the care cost-effective? Are out-of-pocket costs affordable? Could patients continue to pay this much every year?

Payment Reform: Where We've Been and where we are going

10 years of experience testing Medicare Alternative Payment Models under the Affordable Care Act.

Center for Medicare and Medicaid Innovation (CMMI) established to identify, test, and spread new payment and service delivery models

New

Bundled Payments for Care Improvement

New

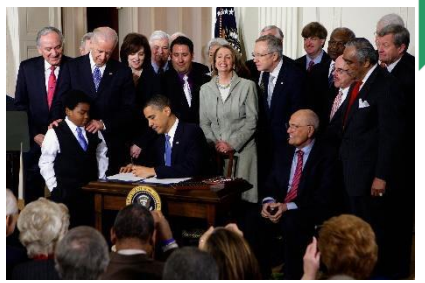
Accelerating Primary Care Redesign: CMS' Innovation Center Announces Five New Transformative Models

Billy Wynne, Katie Pahner, Josh LaRosa

APRIL 24, 2019 10.1377/hblog20190424.956102

2010 | 2012 | 2014 | 2016 | 2018 | 2020 | 2021-2022

Affordable Care Act became law



New

Hospital Readmissions Reduction Program (HRRP)

Independence at Home (IAH)

Medicare Shared Savings Program (MSSP)

Pioneer ACO

New

Comprehensive Care for Joint Replacement

"Let me be clear: Moving away from fee-for-service is something that Secretary Azar and I are committed to, and ensuring quality is an essential component of this," Seema Verma, CMS

Chiquita Brooks-LaSure reiterated the agency's plan to support health equity and expand value-based care for Medicare and Medicaid beneficiaries

New

BRIEF

CMS proposes Medicare ACO revamp to force risk

Kidney Care Choices Model: CKCC Options

CMS

Acute Hospital Care at Home

ACO REACH

Promote health equity and address healthcare disparities for underserved communities

Continue the momentum of provider-led organizations participating in risk-based models

Protect beneficiaries and the model with more participant vetting and monitoring and greater transparency

Northwell Health

Including Equity for Population Health Success

CMS Framework for Health Equity 2022–2032

CMS Office of Minority Health Director's Foreword

"As the nation's largest health insurer, the Centers for Medicare & Medicaid Services has a critical role to play in driving the next decade of health equity for people who are underserved. Our unwavering commitment to advancing health equity will help foster a health care system that benefits all for generations to come."

Dr. LaShawn McIver, Director, CMS Office of Minority Health

https://www.cms.gov/files/document/cms-framework-health-equity.pdf

Home > Medicare > Value-Based Programs

Hospital Acquired Conditions | Hosp. Readmission Reduction | Hospital Value-Based Purchasing | Other Value-Based Programs | MACRA: MIPS & APMs

What are the value-based programs?

Value-based programs reward health care providers with incentive payments for the quality of care they give to people with Medicare. These programs are part of our larger quality strategy to reform how health care is delivered and paid for. Value-based programs also support our three-part aim:

- Better care for individuals
- Better health for populations
- Lower cost

Why are value-based programs important?

Our value-based programs are important because they're helping us move toward paying provic patients.

A critical feature of value-based care is organizations taking on downside financial risk and accountability for the cost and quality of care their patients receive

CMS.gov | Centers for Medicare & Medicaid Services

Newsroom Press Kit Data Contact Blog Podcast

Press release

CMS Issues New Roadmap for States to Accelerate Adoption of Value-Based Care to Improve Quality of Care for Medicaid Beneficiaries

Sep 15, 2020 | Quality

Share

Today, the Centers for Medicare & Medicaid Services (CMS) issued guidance to state Medicaid directors designed to advance the adoption of value-based care strategies across their healthcare systems and align provider incentives across payers. Under value-based care, providers are reimbursed based on their ability to improve quality of care in a cost-effective manner or lower costs while maintaining standards of care, rather than the volume of care they provide. Value-based care arrangements may also permit providers to address social determinants of health, as well as disparities across the healthcare system. Moving toward a more value-driven healthcare system allows states to provide Medicaid beneficiaries with efficient, high quality

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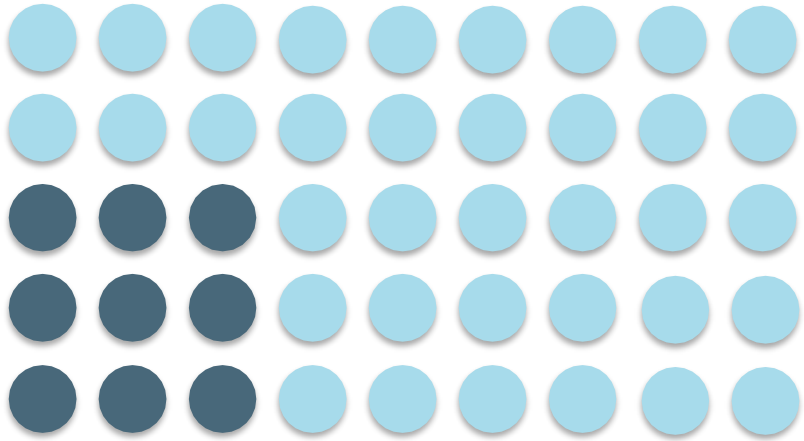
Improve the health of individuals across the continuum of healthcare at the **lowest necessary cost** by applying evidence based clinical strategies and supported by technology and analytics

Health Solutions: Care Management Organization of Northwell



= Targeted Population

i.e. Medicare FFS Patients with a Star Readmission Measure

Support hospital and post acute partners by providing **transitional care management** and **analytics**

- **Program Administration**
- **CareTool**
- **24/7 Call Center**
- **Visiting Navigators**
- **Home Visits**
- **Analytics**

Northwell Health

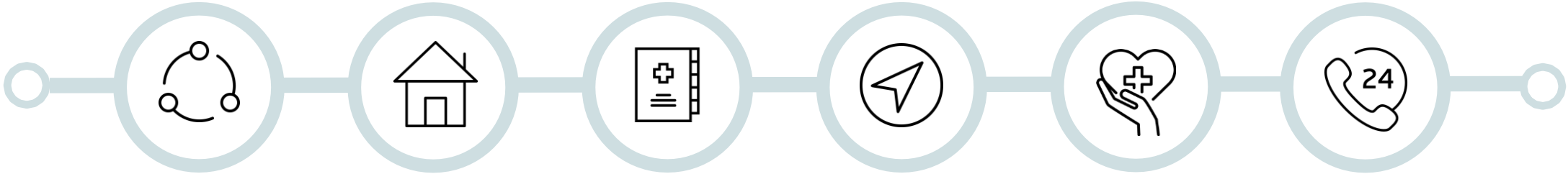
Tools and Infrastructure for Population Health Success

HEALTH SOLUTIONS PROGRAMS

Care Management Organization and Value Based Arm of Northwell Health

Enterprise Value-based Programs

Regional Quality & Value-based Initiatives



- Behavioral Health High Risk Care Coordination
- Advanced illness Home Care/ House Calls
- HEDIS Gaps Outreach & Closure
- Transitional Care Management
- Ambulatory Chronic/Care Management
- Clinical Call Center

Accountable Care Analytics, Research, & Education

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Tools and Infrastructure for Population Health Success

Population Segmentation & Analytics

- Identify patients who meet clinical eligibility criteria early (critical to readmission reduction programs)
- Stratify population to identify high-need, high-cost patients most likely to benefit from interventions

Setting Preferred by the Patient

- Deliver care at home or in the community
- Meet virtually, chat through an app, or talk on the phone
- Capable of delivering comprehensive services in the home

Meaningful Response 24/7

- Care team can be reached 24/7; phones roll-over to the Clinical Call Center for RN triage overnight
- Patients are regularly engaged by the team (calls, chat messages) to catch changes early
- Trusted by patients and families to navigate to the right care
- Team can coordinate home visit, virtual visit, physician appointment or dispatch community paramedicine to address any clinical concerns

HEALTH SOLUTIONS CARE MODEL

Reaches 55k People Annually

WHO: Team-based Care

Advanced Care Providers (NP/PA)

Behavioral Health Care Managers

Care Management Coordinators

Community Health Workers

Peer Advocates

Physicians

Registered Dieticians

RN Care Managers

Social Workers

Triage RN

HOW: Engagement Modalities

- Phone Calls
- Home Visits
- IP Bedside Visits
- Practice-based Appointments
- Mobile Chats (Conversa Health)
- Community Paramedicine
- Telehealth Visits
- Wellness Workshops

Clinical Call Center

Nurse Triage & Navigation

Calls answered by Northwell RNs certified in Emergency Communications & callers navigated to appropriate care level

Diabetes Education Accreditation Program

AADE American Association of Diabetes Educators

Northwell Health

Health Solutions Care CoordinationCompetency: Equity and Making the Connection is key to attainting outcomes

MOMs Navigation Team HealthCare Equity Framework: Training a workforce to mitigate the effects of race on healthcare outcomes

Individual Provider Support Group

- Address Provider stresses and experiences related to racism in healthcare and in life

Engaging and Training Team Members

- COVID University on the Racial Disparities
- Unconscious Bias Workshops (100% mandatory participation)
- Equity & Anti-Racism resources Website
- Educational Series on Healthcare Equity
- March of Dimes Implicit Bias Training specific to maternal care
- Yale University Global Quality Maternal and Newborn Care

Northwell's Approach to Diversity, Inclusion and Health Equity

Northwell's Platform for Advancing Diversity, Health Equity, and Inclusion: Center for Equity of Care

12-Year Track Record of Embedding & Sustaining the Tenets of Diversity, Inclusion and Health Equity for the Organization, Patients and Communities Served

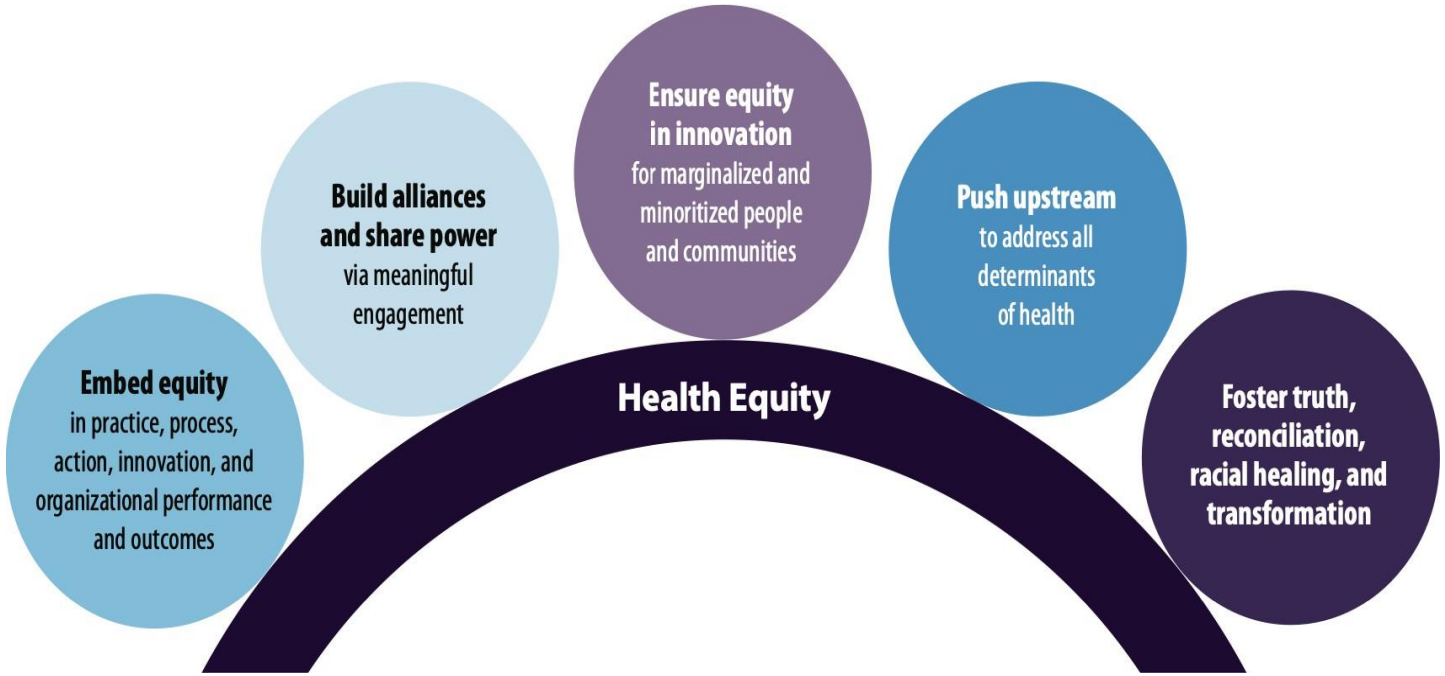
Strategic Partners: Katz Institute for Women's Health, CLI, Patient Experience, Clinical Service Lines, Health Solutions, Community and Population Health , HR/ FEP, Schools of Medicine and Nursing, Procurement, Quality, Feinstein Institute for Medical Research, Clinical Trials, OCIO, Institute for Nursing, Graduate Medical Education, Ambulatory, Physician Partners, Business Development.

Northwell Health

ADVANCING DIVERSITY, INCLUSION, AND HEALTH EQUITY AT NORTHWELL HEALTH

Our Goal :

Use health equity metrics to ensure all our patients receive the highest quality of care to reach their fullest potential and eliminate disparities.



Workforce ED&I: Strategic Priorities

DIVERSITY

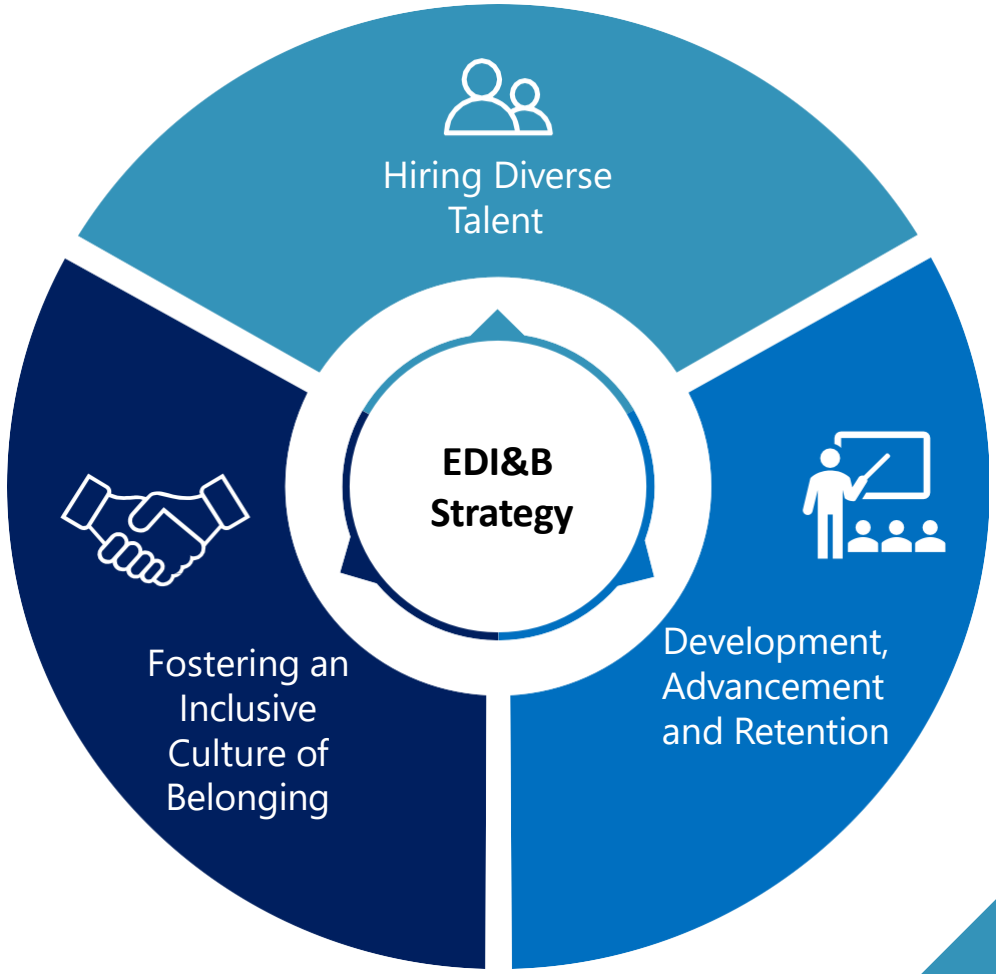
Attract, develop and retain diverse, culturally informed team members that reflect our values, and the patients and communities that entrust us with their care.

EQUITY

Promote fairness in work practices, processes and policies that create opportunities for all.

INCLUSION & BELONGING

Foster a culture where team members feel heard, respected, valued, accepted and supported in their career aspirations.



Additional targeted efforts: Women, Historically Underrepresented Racial & Ethnic Groups, Veterans, Individuals with Disabilities, LGBTQIA+, Generations, Justice Involved, Family Friendly

DiversityInc

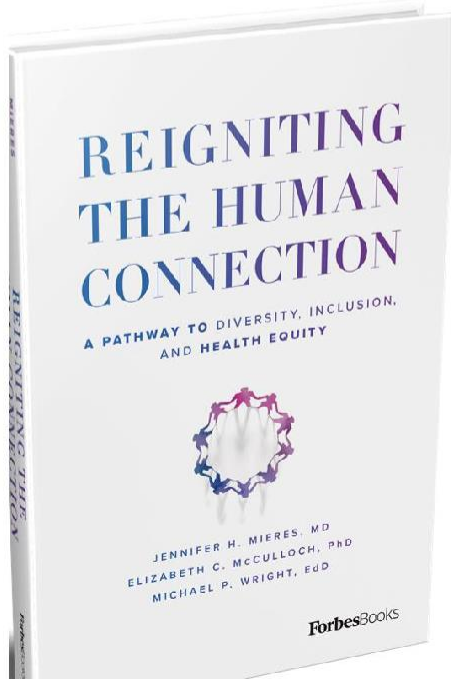
2022 TOP COMPANIES FOR HOSPITALS & HEALTH SYSTEMS

1. Northwell Health
2. Cleveland Clinic
3. Mayo Clinic
4. Hackensack Meridian Health
5. Mount Sinai Health System
6. City of Hope
7. NYU Langone Health
8. Jefferson Health
9. Henry Ford Health System
10. OhioHealth
11. Baylor Scott & White Health
12. New York Presbyterian
13. Seattle Children's Hospital
14. H Lee Moffitt Cancer Center & Research Institute
15. Yale New Haven Health
16. Davita

HUMAN RIGHTS CAMPAIGN FOUNDATION 2022 LGBTQ+ HEALTHCARE EQUALITY LEADER

INSIGHT Into Diversity Health Professions Higher Education Excellence in Diversity Award 2022

Top Colleges for Diversity



Northwell's Approach to Community Health

NORTHWELL'S MISSION-RELATED ACTIVITIES

Northwell's mission is to improve the health of the communities we serve. Northwell invests over $1.44B annually in community benefit programs and services representing almost 12% of operating expenses to address global, national, and local community challenges.

Equity in Care: Quality Access & Affordability

- Financial Assistance Policy Charity Care
- Financial Navigators
- Informing Patient/ language diversity
- Online cost estimating tools
- Facilitated enrollment
- Financial ombudsman

Social Determinants

- Food insecurity
- Education Program
- Faith-based partnerships and communities
- Community health education
- COVID testing/vaccination
- Health literacy
- Population health management
- Gender Equity: LGBTQIA+
- Veteran services
- iness Employee
- ource Groups

Health Promotion & Disease Prevention

- Diabetes/Obesity
- Mental Health Faith-based Initiatives
- Maternal Mortality
- Cancer Prevention
- School-based health
- Substance Misuse
- Tobacco Cessation Program

Violence Prevention

- Gun violence safety
- Sexual assault nurse examiner
- Human trafficking
- Domestic Violence

Environmental Responsibility

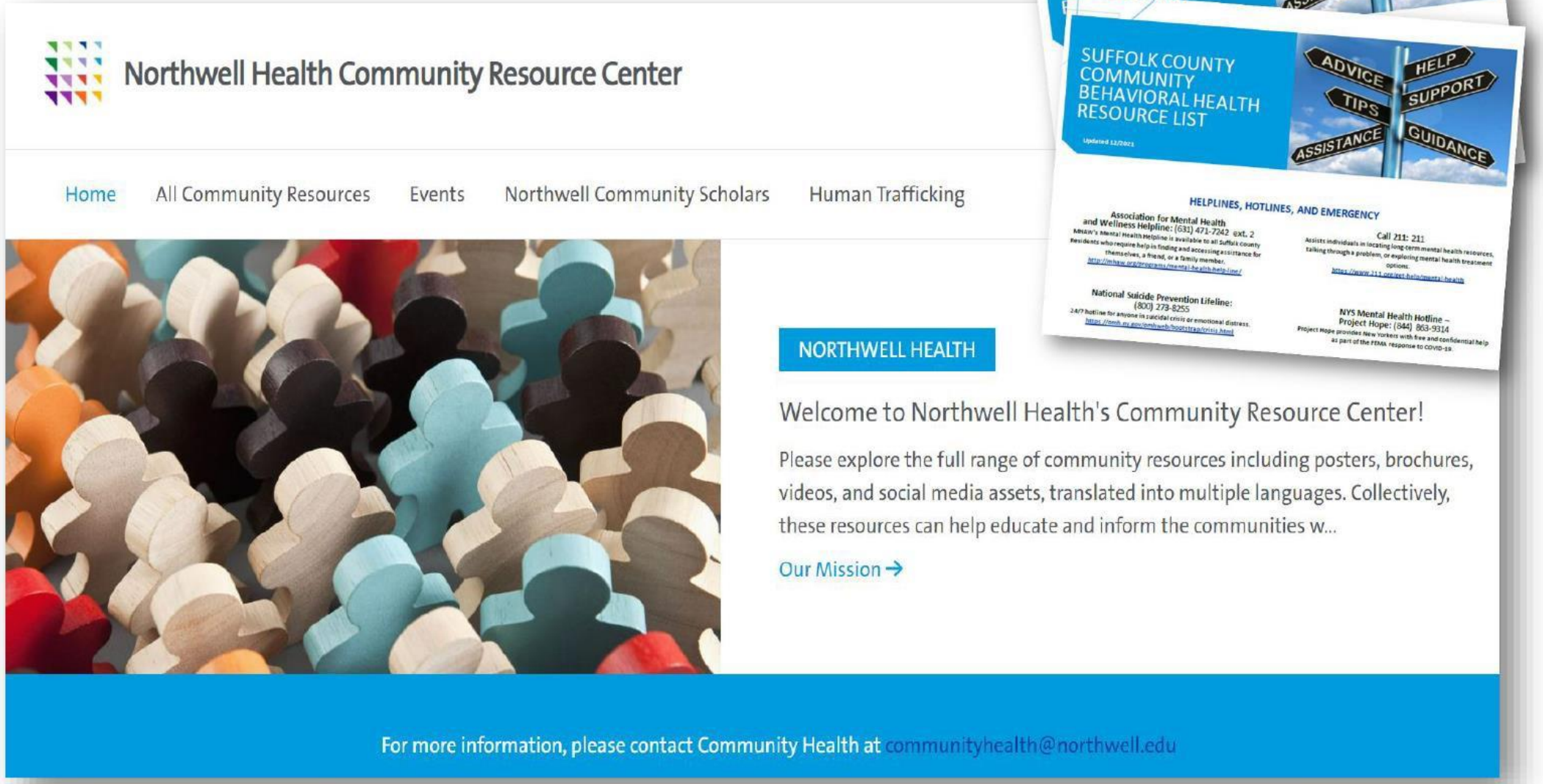
- Green building
- Sustainable energy
- Reducing energy emission
- Waste stream reduction
- Sustainable supply chain

Safety Net Partners

- Federally Qualified Health Centers
- One Brooklyn Health
  - Brookdale Hospital
  - Interfaith
- Wycoff Medical Center
- NYC Health & Hospitals
- Nassau University Medical Center

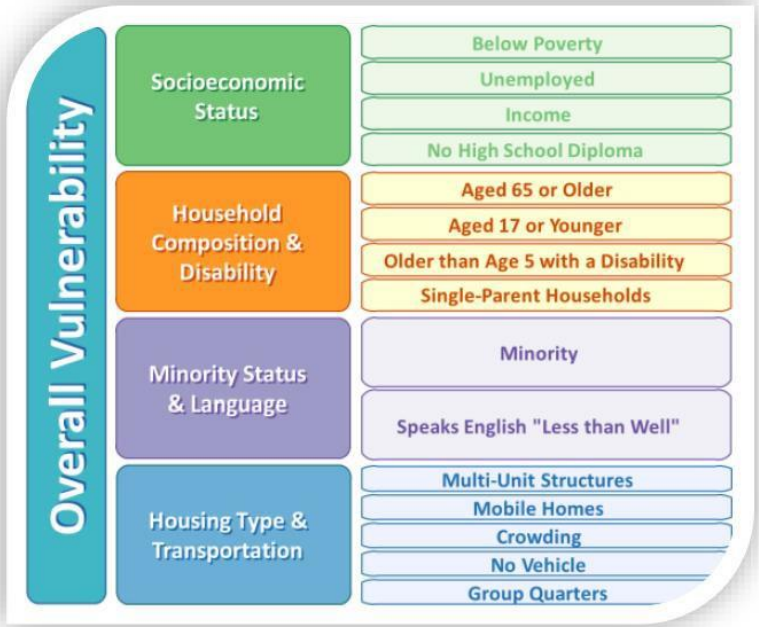
Northwell Health®

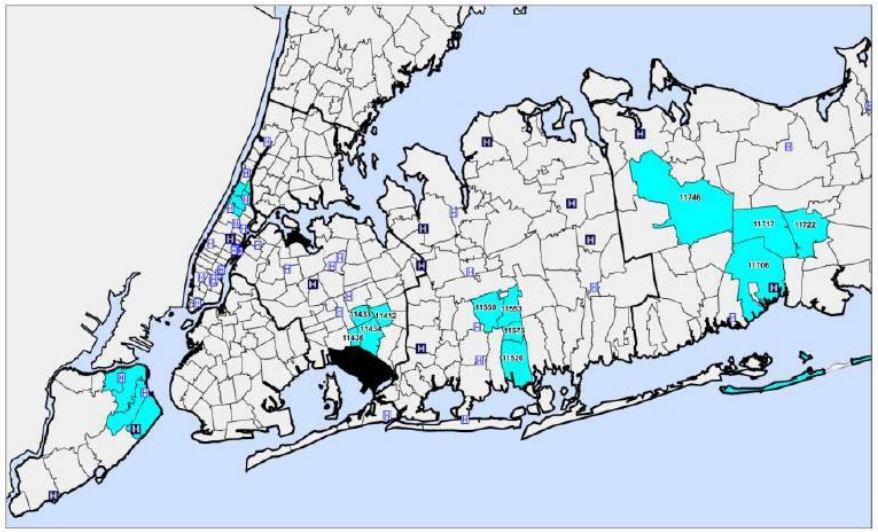
Community Resource Center



communityresources.northwell.edu

Northwell's Focus on 12 'Most' Vulnerable Neighborhoods





Neighborhoods of Focus	
Brentwood	Uniondale
Central Islip	Freeport
Huntington Station	Southeast Jamaica
Bay Shore	Harlem
Roosevelt	Stapleton, Staten Island
Hempstead	Westchester *UPCOMING*

CDC Social Vulnerability Index indicators

High Medicaid ED Utilization Rates & percentage of population aged 65+

High COVID Positivity Rates

Data Integration

Geospatial Mapping

Granular geospatial mapping of results helped to identify areas of greatest need.

Community Profile

CENTRAL HARLEM

Located in Upper Manhattan in New York City, the neighborhood of Central Harlem has been known as a Black mecca and cultural center since the Harlem Renaissance. Central Harlem is part of Manhattan Community District 10. Central Harlem has a racial diversity index of .62. The povery rate in Central Harlem is 23.9%.

COMMUNITY ASSETS

Food Pantries: First Corinthian Baptist Church, Food Bank for New York City, Safe Horizon, West Side Center for Children & Family Services

Northwell Community Partners: Mother AME Zion Church

Parks: Central Park, St. Nicholas Park, Jackie Robinson Park, Marcus Garvey Park, Morningside Park

School District(s): NYC Department of Education

Transportation: MTA Bus, MTA Subway

POPULATION

Central Harlem	Manhattan
222,031	1,629,153

LIFE EXPECTANCY

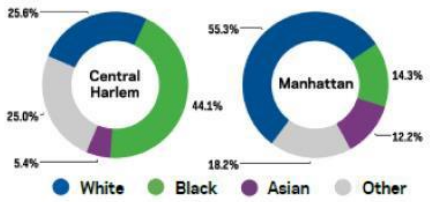
Central Harlem	Manhattan
77.8	81.9

COVID-19 VACCINATION

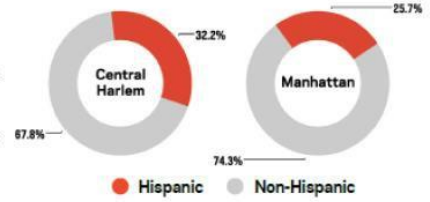
People with completed vaccine series

Central Harlem	Manhattan
69.9%	85.7%

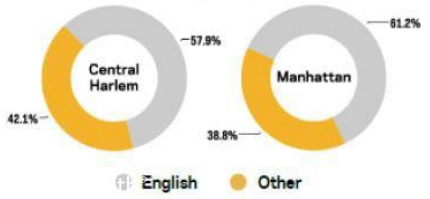
RACE



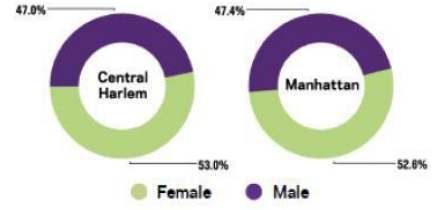
ETHNICITY

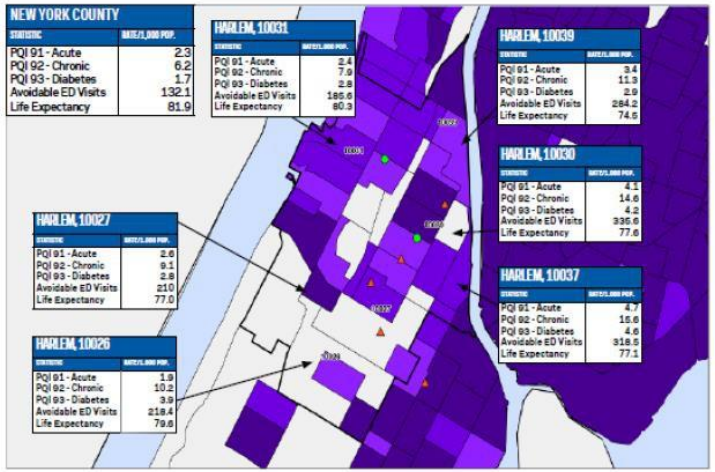


LANGUAGES SPOKEN AT HOME OTHER THAN ENGLISH



GENDER





Source: NYSDOH SPARCS/Inc
Current faith-based centers include permanent sites; Other faith-based centers were provided by Community Relations; Avoidable ED Visits defined by NYU Algorithm; Prepared by the Office of Strategic Planning

POVERTY

Below 100% Federal poverty

Central Harlem	Manhattan
23.9%	15.6%

UNEMPLOYMENT RATE

Central Harlem	Manhattan
5.1%	3.8%

HOUSING BURDEN

Monthly housing cost (i.e.: rent/mortgage as a percentage of household income in the last 12 months

Central Harlem	Manhattan
44.4%	37.7%

TRANSPORTATION

Households with no vehicles available

Central Harlem	Manhattan
48.1%	77.6%

EDUCATION

Less than high school diploma

Central Harlem	Manhattan
17.6%	12.2%

PRENATAL CARE

Late or no prenatal care

Central Harlem	Manhattan
9.1%	4.7%

GOING UPSTREAM

	STRATEGIES	TACTICS
UPSTREAM	**Improve community conditions and addressing adverse social determinant of health**	Programs that support populations and communities Policies, and regulations that create community conditions supporting health for all people
MIDSTREAM	**Addressing individuals' social needs**	Patient screening questions about social factors like housing and food access Using data to inform individual's care and provide referrals Use of social workers, community health workers, and/or community-based organizations provided direct support to meet patient's social needs
DOWNSTREAM	**Providing clinical care**	Medical and health care interventions

COMMUNITY IMPACT

INDIVIDUAL IMPACT

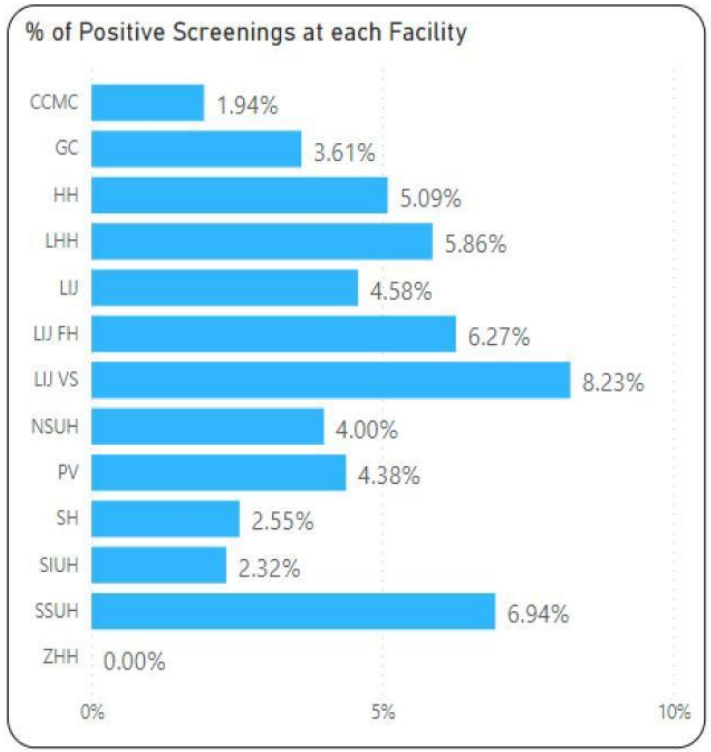
Social Determinants of Health

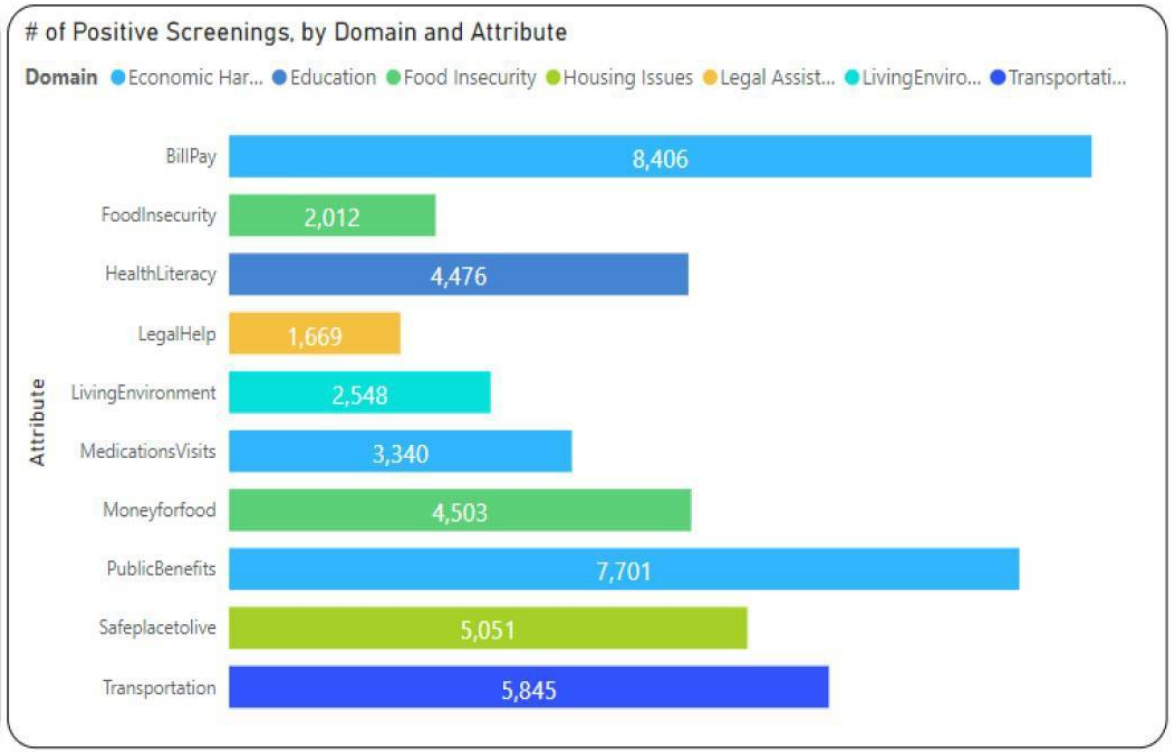
Meeting Health-Related Social Needs

SDoH Dashboard

2019	2020	2021	2022

470,293	22,131	5%
#ofScreens	#Positive	%Positive





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Northwell Community and Population Health Programs

Nutrition Pathways Program

In partnership with the Dolan Family Health Center in Huntington, Island Harvest provides patients who screen positive for food insecurity with **12 personalized nutrition counseling sessions, access to nutritious foods from their on-site healthy food pantry, referrals to community resources, and assistance with SNAP, as well as a weekly community food distribution** to area residents in need.

As of August 31, 2022 – After 1 Year of Operation

PROGRAM DETAILS

- 162 individuals enrolled
- 1,139 counseling sessions conducted
- 250 individuals participate in the weekly food box distribution
- 15,024 meals provided to participating patients through weekly one-on-one sessions
- 25,650 meals provided through the weekly on-site community food box distribution

OUTCOMES

- 44% improvement in Body Mass Index
- 42% reduction in blood pressure
- 51% reduction in A1C
- 55% increased consumption of healthy foods
- 58% reduced consumption of unhealthy foods
- 25% reduction in number of meals eaten away from home
- 45% increased physical activity

Community Work on Maternal Health

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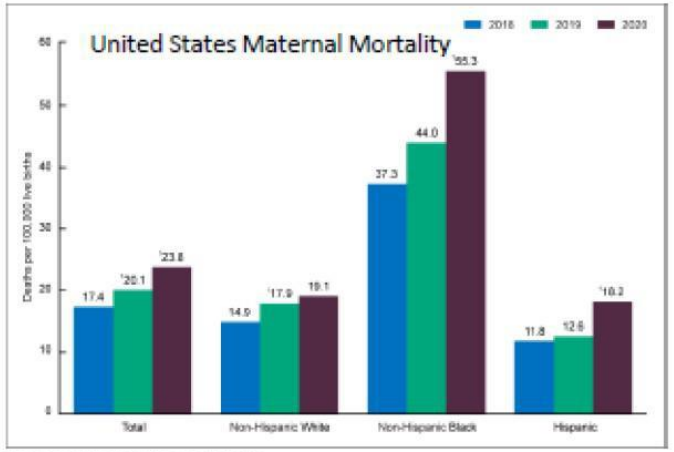
Center for Maternal Health

Mission Statement:

To achieve the highest quality maternity care and outcomes through addressing community and health inequities that contribute to severe maternal morbidity and mortality.



Challenges: Disparities

- Improve the Northwell Health's workforce knowledge of the impact of structural racism and implicit bias
- Investigate to further understand the increased prevalence of comorbidities in Black women (CMI 2.5 vs 1.5)
- Address the inherent underlying preeclampsia rate in Black women (14% vs 6%)
- Address the increased Cesarean delivery rate in Black women (37% vs 24%)
- Explore access to care challenges (underinsured, lack of trust, limited provider choices, language and literacy)
- Explore every maternal death to identify factors that can be modified to prevent future tragedies

The Solution: Action Plan

- Continue to improve in-hospital care through standard protocols and guidelines
- Continue the work of the Cesarean Delivery Reduction Initiative
- Expand Implicit Bias Training
- Expand the care navigation program with Pregnancy Chatbot support
- Address co-morbidities and risk preconception
- Utilize the Comorbidity and Social Vulnerability Index to target patients at highest risk for Severe Maternal Morbidity
- Enhance Behavioral Health Screening and Resources
- Partner with and provide educational resources to the community
- Develop and disseminate a Pregnancy Wellness Assessment
- Develop community advisory board/collaborative with other organizations in the community

Program Initiatives

Provide ongoing support to our highest risk mothers and newborns through individualized navigation by a team of healthcare professionals

Educate and empower patients through individualized, supportive interactions via the Northwell Health Pregnancy Chatbot

Address the causes and disparities in maternal outcomes for all birthing patients through the Maternal Mortality & Severe Maternal Morbidity (SMM) Review Committee

Improve maternal health in our communities and beyond by establishing a Patient and Family Advisory Council with members that have lived experience with maternal morbidity and mortality

Provide access to evidence-based prevention in non-traditional setting with a focus on risk factors and modifiable behaviors that affect pregnancy outcomes

ASCERTAIN

Use artificial intelligence and machine learning to seamlessly detect an increased clinical risk for preeclampsia and other adverse pregnancy outcomes

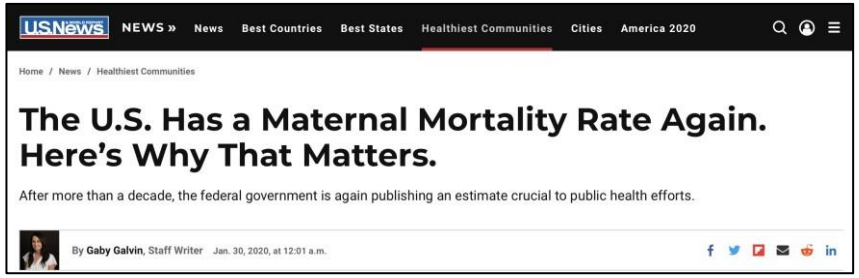
Northwell Health
Obstetrics & Gynecology

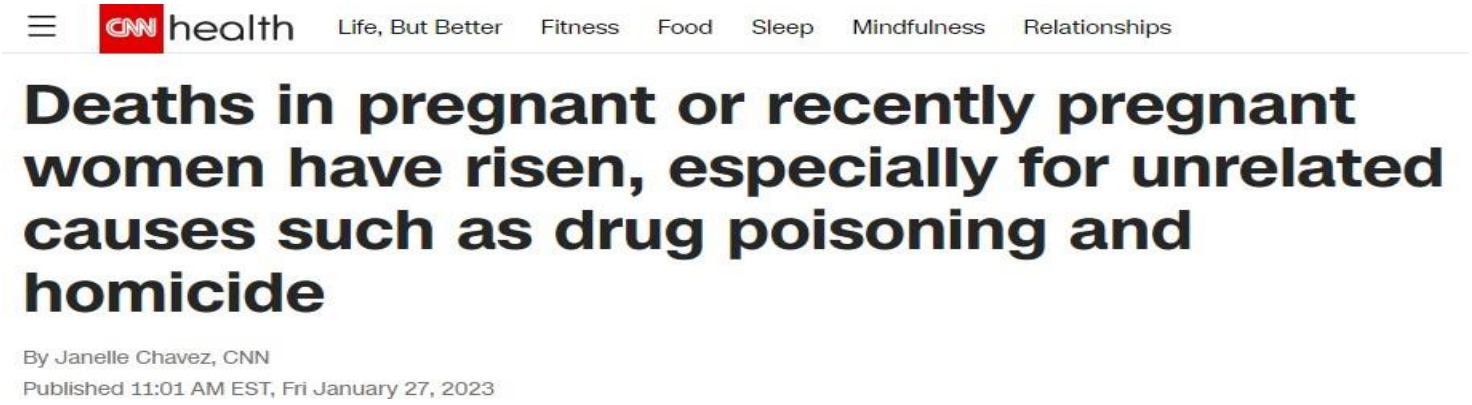
Northwell Health
Katz Institute for Women's Health

"Supporting women entering motherhood to not only survive, but thrive"

Northwell Health MOMs (Maternal Outcomes) Navigation Program

A Pervasive National Problem





Northwell Health
Obstetrics & Gynecology

Maternal Outcomes (MOMs) Navigation Program:

We are a multidisciplinary team with a mission to decrease Preventable Maternal Morbidity and Mortality.

Our Vision

No mother should ever die because of something preventable.

Our daily work revolves around eliminating disparate outcomes and making childbirth safer for everyone.

Northwell Health

Northwell MOMs (Maternal Outcomes) Navigation Program

WHO We Serve: Women with **High-Risk (Severe Maternal Mortality and Morbidity) diagnoses:**

- Pregnancy-related Hypertensive Disorders, Diabetes, Behavioral Health, Venous Thromboembolism

WHY We Care / Challenges Observed:

- Women have **multiple concurrent medical and socioeconomic risks** that cause death and morbidity
- New moms struggle to be the priority
- Pregnant and postpartum women **don't have adequate resources** for themselves or their infants
- Behavioral health is either ignored or unavailable
- Providers often unaware of the obstacles and barriers faced by their patients

WHAT We Provide:

Our program was designed to disrupt those factors and keep mothers and babies thriving

Advocacy | **Connection** | **Resources** | **Education** | **Social Support**

Northwell MOMs (Maternal Outcomes) Navigation Program

No mother should ever die because of something preventable. Our program works to eliminate disparate outcomes and make childbirth safer for everyone.

Right Patient

Diagnosis-Specific Identification
Focus on Clinical & Social Risk Factors

Right Place

Home Visit
Telephonic
Telehealth
Texting/ Pregnancy Chats

Right Time

Real-time Automated Case Finding
Availability 24/7/365
ED Presentation Engagement

Right Care

Patient Advocacy
Culturally-Informed Program Design
Partnering with OB/GYN Providers
Community Connections

Northwell Health

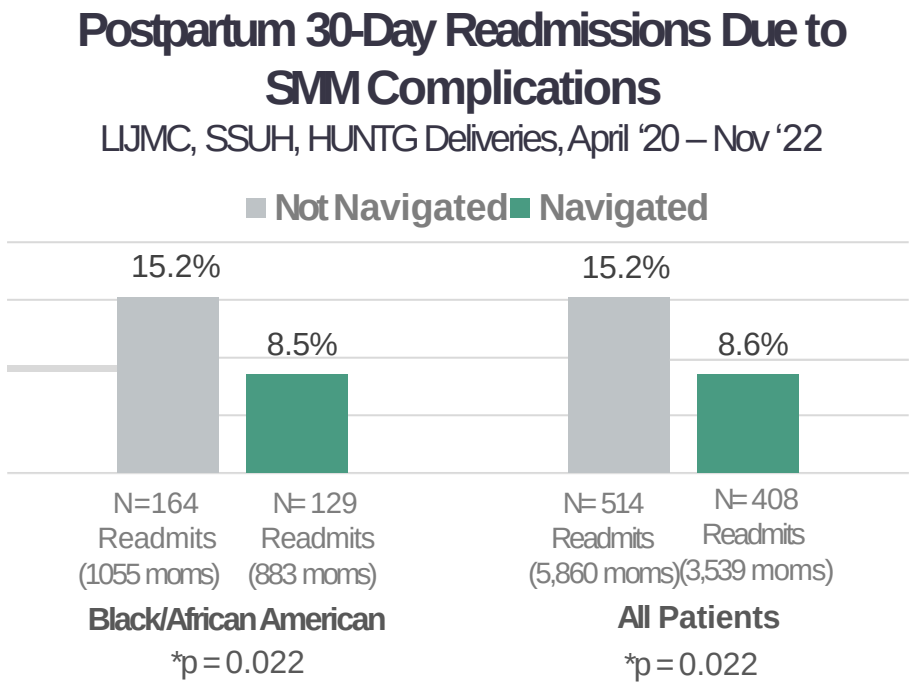
MOMs Navigation Program Today

Identifying mothers with SMM Risk Factors allows us to partner with them, become their advocates, and connect them with relevant resources to promote their optimal health and prevent adverse outcomes.

4,382

Total Moms Enrolled

April 2020 – December 2022
Primarily Postpartum from
LIJMC, HUNTG, SSUH



AJOG American Journal of Obstetrics & Gynecology

ORIGINAL RESEARCH: OBSTETRICS | ARTICLES IN PRESS

Postpartum Navigation Decreases Severe Maternal Morbidity Most Among Black Women

Zenobia Brown [1], Choukri Messaoudi [2], Emily Silvia [2], Hallie Bleau [2], Ashley Meskill [2], Anne Flynn [2], Amparo C Abel-Bey [2], Trever J Ball [2]

DOI: 10.1016/j.ajog.2023.01.002

> *The nurse who called me also called my doctor because I had a headache and shortness of breath. The doctor insisted I go back to the hospital.* ***The nurse saved my life*** *because I never would have gone back to the hospital.* – *MOMs Patient*

Northwell Health

Thank you !

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Closing, Announcements, Updates, Save the Date

Announcements & Updates

- Please complete the Consortium Meeting Evaluation Survey which will be sent via email following this meeting
- Be sure to join the NYSPHC Fellowship Program LinkedIn Group to continue networking and professional development

NYSPHC Training and Resources Website

https://nysphcresources.health.ny.gov/training-resource-center

New York State Public Health Corps

Fellowship Program

Training Resource Center Home

About the NYSPHC

Fellow Training Resources

Mentor Training Resources

Resources by Region

Workgroup Resources

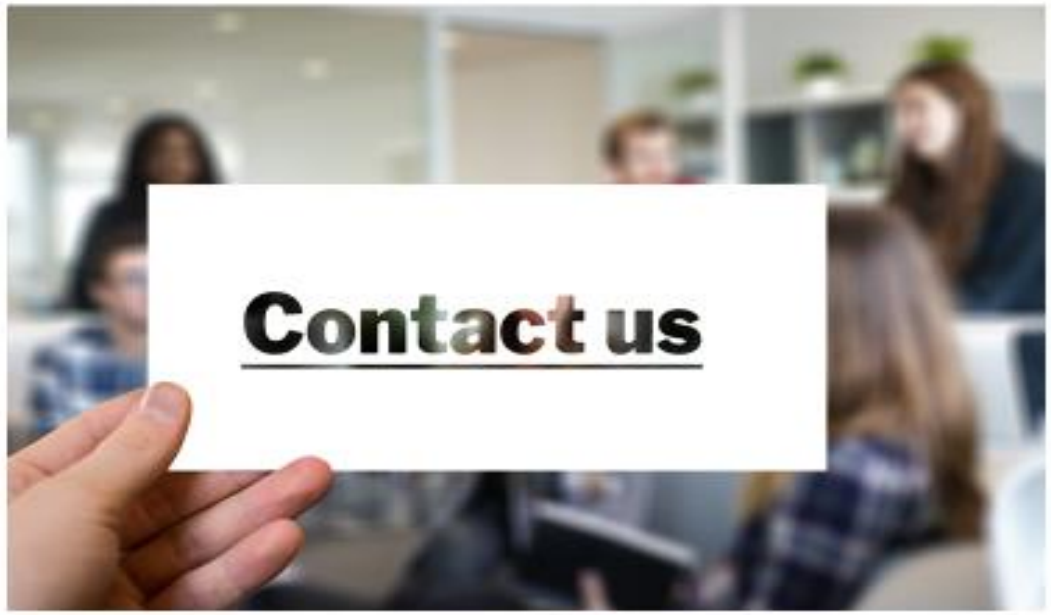
NYSPHC Events Calendar

NEW YORK STATE Department of Health

Save the Date!

Save the date for the following upcoming Regional Consortium meetings:

- ❑ Educational Series – JEDI Wednesday, April 12th
- ❑ Regional Consortia June 2023
- ❑ Summit (FALL)
- ❑ Upcoming Cornell cohort



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Q&A and Fellowship Project Sharing

Please unmute and comment on the following:

- Remind us of your name and county affiliation
- If you have a placement location external to the LHD, please state it.
- In a minute or two, explain your Fellowship project/job responsibilities.
- State your favorite aspect of your Fellowship so far
- We will go in alphabetical order of counties with active Fellows: Dutchess, Orange, Putnam, Suffolk, Westchester