Health Equity

New York HPA Health Plan Association

New York's Health Plans: There for Patients When They Need Them Most

Whole-person care requires more than just medical treatment. A broad range of non-medical factors, including where someone is born, grows up, lives, works and ages, play a role in shaping an individuals' overall health. Yet for too many, social barriers in every-day life – socioeconomic status, education, neighborhood and physical environment, employment, social support networks, and access to health care – contribute to poor health and disparities in treatment.

Social Determinants of Health

Economic Stability

- Employment
- Income
- Expenses
- Debt
- Medical Bills
- Support

Neighborhood and Physical Environment

- Housing
- Transportation
- Safety
- Parks
- Playgrounds
- Walkability
- Zip Code / Geography

Education

- Literacy
- Language
- Early Childhood Education
- Vocational Training
- Higher Education

Food

- Hunger
- Access to Healthy Options

Community and Social Context

- Social Integration
- Support Systems
- Community
- Engagement
- Discrimination
- Stress

Health Care System

- Health Coverage
- Provider Availability
- Provider Linguistic and Cultural Competency
- Quality of Care

Addressing the Social Determinants of Health (SDoH) requires multifaceted, multi-stakeholder approaches, and coordinating health care and social supports to best serve those in need.

Health plans play a critical role in removing barriers to care by helping to coordinate housing, employment, education, and food access for vulnerable members. This includes working with providers and community-based organizations to tackle the underlying social, economic, and environmental factors that affect health outcomes and developing innovative programs that couple coverage of medical care with social approaches to support a patient's health goals.

Examples of innovative programs that HPA members have developed include:

Addressing Maternal Health

Empire/HealthPlus: Improving Maternal/Child Health – In partnership with Public Health Solutions, Empire/HealthPlus developed a referral pathway to support pregnant mothers and families with maternal-infant services and resources. Through the Jamaica Southeast Healthy Start initiative, members in Jamaica, Queens are screened to determine need for community services.

Services Include:

- Case Management and Home Visit
- Child Growth and Development
- Prenatal and Parenting Education
- Breastfeeding Support
- Food Support
- Job Training
- Mental Health
- Father Support Services
- Doulas

The partnership has monthly check-ins on referral status and outcomes, with opportunities to discuss process improvements and program evaluation. Empire has referred 798 women to PHS, 88% of whom were contacted and screened. Of those screened, 59% were referred to home visiting (HV) programs and 26% were referred to other services, including SNAP/WIC application assistance or mental health support services. Of those referred to HV programs, 49% enrolled. The typical enrollment rate is 30%.

A Mother's Success Story:

"Maria," a 27 year old Spanish speaker at 21 weeks pregnant, with no immediate family in the U.S., was referred to Empire's Maternal Child Health programs through an obstetrical screening risk stratification tool. The woman had two ER visits during the first trimester, and reported feeling stressed and occasionally hopeless, and was assigned a Spanish-speaking plan care manager. Through Empire's program, she was provided with a Spanish-speaking psychotherapist, a Doula, connection to WIC and SNAP benefits, the PHS Nurse Family Partnership (NFP) program, dental services, and other services. She delivered a healthy, full-term baby in November 2021, and will remain connected to the Empire OB care manager and the Doula and NFP Nurse through the postpartum period.

Healthfirst - Timely Post-Partum Care – The health plan established a partnership with Mount Sinai to develop an intervention and payment redesign program to improve timely post-partum visits for low-income, high-risk mothers. The intervention provided education about health conditions – for example gestational diabetes and depression - and health behaviors – for example nutrition and exercise. Additional engagement included education about common postpartum symptoms; taught self-management skills; provided enhanced social support; and connected patients with community resources.

The payment reform component included a cost sharing arrangement between the plan and the hospital to cover costs related to employing a social worker and community health worker, and financial incentives for completed postpartum visits (as defined by HEDIS guidelines). Eligible members included pregnant women age 18 and over, who spoke Spanish or English and had at least one of the following: gestational diabetes, hypertension, positive screen for depression, late registration for prenatal care (>20 weeks) or residence in a neighborhood designated as high-risk for hypertension or diabetes.

CDPHP's Pregnancy Notification Program – The health plan's pregnancy notification program identifies pregnant members to connect them to resources that support a healthy pregnancy, including breastfeeding support, healthy eating, staying active during pregnancy, mental health support, and the importance of prenatal and postpartum care. The program links pregnant members to the CDPHP Care Team, which is comprised of specially trained professionals including nurses, dietitians, and licensed social workers, that provides 1-on-1 support to individuals with high-risk conditions and resources to reduce barriers to a healthy pregnancy. This includes assisting members with arranging transportation for medical appointments, obtaining necessary pregnancy and baby supplies, finding and applying for affordable housing, and applying for applicable benefits such as WIC.

In 2022, CDPHP established a partnership with the leading women's and family health digital health platform to expand these efforts, which provides access to unlimited 1-on-1 coaching and more than 50 clinical educational modules, provider conversation guides, and inclusive programming to support positive health outcomes across the entire family health continuum— from preconception to parenting.