Comagine Health



2023 SilverSummit Healthplan Community Investment Agreement Final Outcomes Report:

Southern Nevada Pathways Community HUB Maternal Health Pilot

May 2024

For more information, contact:
Tracy Carver
Tcarver@Comagine.org

Table of Contents

Program Background 3

Outcomes Report 5

SilverSummit Healthplan Member Engagement 11

Success Stories 12

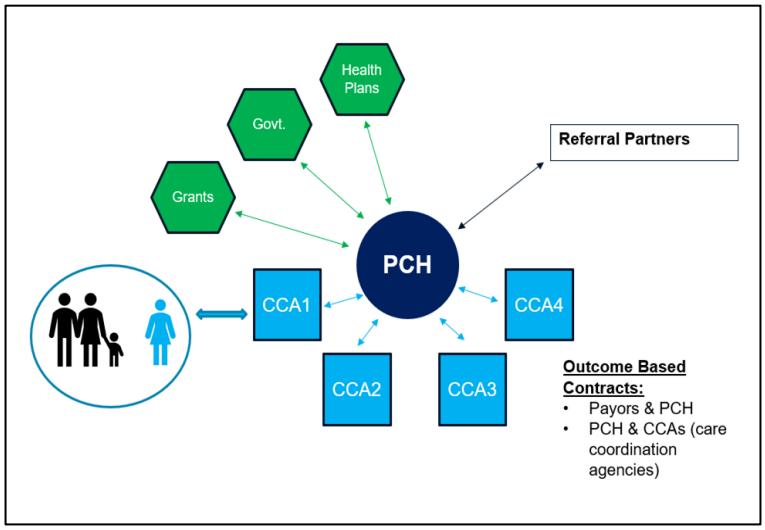
SilverSummit Community Investment Impact Statement 13

Appendices 14

- Appendix A: Additional Data Visualizations for Context/Narrative 14
- Appendix B: Success Stories 18

Program Background

The Southern Nevada Pathways Community HUB (SNPCH), operated by Comagine Health, implemented a one-year maternal health pilot with support from a 2023 SilverSummit Community Reinvestment Grant to build capacity of the SNPCH and demonstrate the effectiveness of the model for serving pregnant people in Clark County, Nevada. Comagine Health staff who operate the SNPCH are trained and supported by the Pathways Community HUB Institute (PCHI) to implement the PCHI model. Comagine Health is currently seeking certification from PCHI for the SNPCH. The Comagine Health SNPCH team contracts with and certifies organizations as Care Coordination Agencies (CCAs) who employ CHWs to implement community and home-based outreach to reach clients referred to the SNPCH. Comagine Health contracted with Dignity Health, a certified CCA, to employ three CHWs to screen and serve pregnant people referred to the SNPCH under the SilverSummit Pilot. CHWs use twenty-one standardized pathways set by PCHI to screen for and address modifiable risk factors. Pathways are opened as needs are identified and closed when a need is meaningfully met, as defined by a standardized benchmark set by PCHI for all certified HUBs.



Source: Pathways Community HUB Institute, 2024

A nationally recognized model. The PCHI model is an evidence-based model for deploying community embedded community health workers (CHWs) to screen for health-related social needs (HRSN) and assist clients in accessing services to address modifiable risk factors. The PCHI model is based on more than 30 years of experience and research. There are currently 31 PCHs recognized by PCHI nationwide.

Program Goal and Objectives

Comagine Health's goal for the SilverSummit Community Reinvestment Grant was to launch the SNPCH to serve Clark County, Nevada and to demonstrate the effectiveness of the PCH model for high needs SilverSummit Medicaid members. Table 1 describes the objectives we set out to achieve for the grant and details on our progress during the performance period.

Table 1. Grant Objectives

Program Objective	Progress made	Objective Met/Other notes
By February 28, 2023, we will complete a subcontract with Dignity Health to facilitate payment for three CHW FTEs to implement the pilot.	We executed an agreement with Dignity Health to serve as the Care Coordination Agency and employ 3 CHWs to implement the pilot on January 5, 2023.	Objective met
By February 28, 2023, we will purchase and launch the certified CCS technology platform and serve the identified ZIP codes in Clark County.	We secured an agreement with Care Coordination Systems to serve as the HUB technology platform on February 10, 2023.	Objective met
By October 31, 2023, we will enroll 60 pregnant mothers into the pilot, at least 30 of whom will be SilverSummit members.	We enrolled 24 SilverSummit Plan Members by October 31, 2023, and the remaining 6 members by December 7, 2023, to reach our target of 30 SilverSummit Plan Members.	Objective met
By October 31, 2023, we will also identify and enroll eligible family members in the HUB and track and report on the number of enrolled family members who are uninsured and enroll in Silver Summit or are already Silver Summit members.	No family members were identified or enrolled into the HUB.	Objective not met. This is an area we identified for process improvement.
December 31, 2023, we will complete an analysis of the data collected on enrolled clients to evaluate and report on outcomes.	We requested a no cost extension to use funds to support continued provision of services and allow for more births to occur before completing our final analysis.	No cost extension granted

Performance Measures and Outcomes

Comagine Health set performance measures for reporting at the start of the grant. The Measures included:

1. **Process measures (collected and reported by CHWs):** number of clients enrolled, number of SilverSummit clients enrolled, client demographics (age, gender[1], ZIP code[2], race, ethnicity), insurance coverage at enrollment and discharge, medical home status at enrollment and discharge, social support structure (partner, family support) at enrollment and discharge, number and timing of prenatal care visits at enrollment and discharge, number of pathways opened and closed by client and by type, COVID 19 vaccination status at enrollment and discharge.
2. **Prenatal and postnatal outcome measures (collected and reported by CHWs) for women enrolled in HUB:** normal birth weight baby (>5lb 8oz/2500 grams), preterm birth (<37 weeks gestation), breastfeeding status, infant death, maternal death, total days in hospital.
3. **Social determinants of health (collected and reported by CHWs):** among women enrolled, measures collected at the time of enrollment and when a pathway is closed: access to stable housing, food security, access and attendance to prenatal appointments and classes, access to transportation, household violence, and substance use[3].

Following is a detailed description of our final performance on these measures during the performance period of January 1, 2023-April 2024.

Outcomes

During the performance period for this pilot, a total of 92 pregnant individuals enrolled in the SNPCH, exceeding our target of 60. Of those enrolled through the pilot, 30 were SilverSummit members, 24 of which were from a hard-to-reach list that SilverSummit provided (Appendix A Figure 1). Overall, pregnant people enrolled in the SNPCH as part of the SilverSummit pilot had significantly better than average outcomes. As of April 2024, 5.6% (4/71) of live births at the time of this reporting were preterm compared to the state average (11%) and 7.2% (5/69) of singleton births had a low birthweight (LBW) baby compared to 9.4% overall in Clark County. The percentage of live births from the priority population of focus (Hispanic and/or Black) that were preterm was lower than the rates for Hispanic and Black infants in Clark County (3.4% compared to 10.4% and 14.4%, respectively) and the LBW rate for the priority population of focus was lower as well (7% compared to 8.2% and 15.3%, respectively).

Key Program Outcomes

- **92** pregnant people served
- **94%** of live births were full-term compared to **89%** state average
- **93%** of singleton births were normal birthweight compared to **91%** state average.
- Preterm births and low birthweight rates for our priority population were significantly lower than the county averages for Hispanic and Black people (**3.4%** compared to **10.4%** and **14.4%,** respectively) and (**7%** compared to **8.2%** and **15.3%**, respectively).

[1] Due to all participants in the pilot being Female, gender is not a demographic used in stratification or analysis.
[2] Due to the difficulty of identifying and engaging members of the initial five zip codes, inclusion parameters were widened to Clark County, 16 of the 92 individuals in the pilot were from one of the five zip codes.
[3] Substance use disorder was not a Pathway that was utilized by pilot participants, thus is not reported on or included in analysis.

Pilot participants were primarily aged between 25-34 years old (50%) and between 35-44 years old (28%) (Appendix A Figure 2). To date, there were a total of 70 deliveries and 71 total live births (one delivery of twins), resulting in zero maternal deaths to date, and with two participants that are still pregnant with estimated deliveries in June. Of the remaining 20 individuals in the pilot: 13 were lost to follow-up, one declined further services, one moved out of the area and five had a loss of pregnancy during enrollment in the Pathways HUB. Seventy-seven percent of enrolled individuals were members of the priority population of focus (Appendix A Figure 3).

Services provided. Of the enrolled participants, 100% were enrolled in more than one pathway with a total of 1,031 opened pathways, and 91% of individuals completed at least one pathway with a total of 811 completed pathways, where a desired outcome was achieved (i.e. normal birth weight baby) (Figure 1). Enrolled pregnant individuals primarily opened Learning, Social Service and Medical Referral pathways and the majority of opened pathways were closed complete, where the desired outcome of the pathway was achieved as shown below in Figure 1. For the Learning pathway, Medical and Behavioral domains were primarily utilized including breastfeeding, positive parenting, pregnant nutrition, shaken baby syndrome and adult/child nutrition education (Figure 2, Appendix A Figure 4). For the Social Service Referral pathway, personal items were primarily utilized including baby items and hygiene items (Figure 3). For the Medical Referral pathway, primary and specialty care were primarily utilized (Figure 4).

Figure 1. Open Pathways, by Completion Status

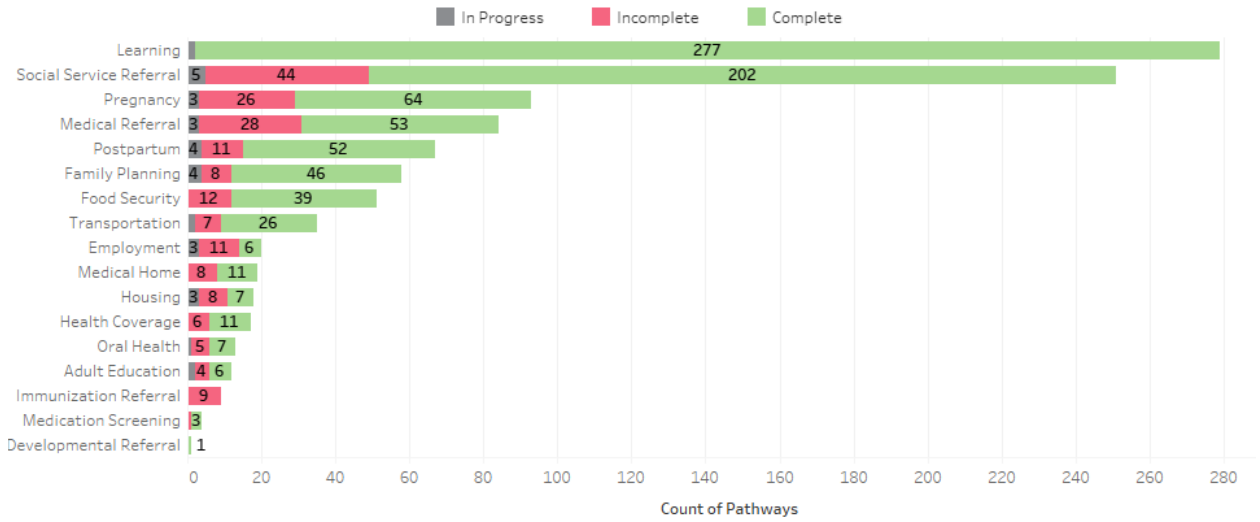


Figure 2. Open Learning Pathways, by Domain and Completion Status

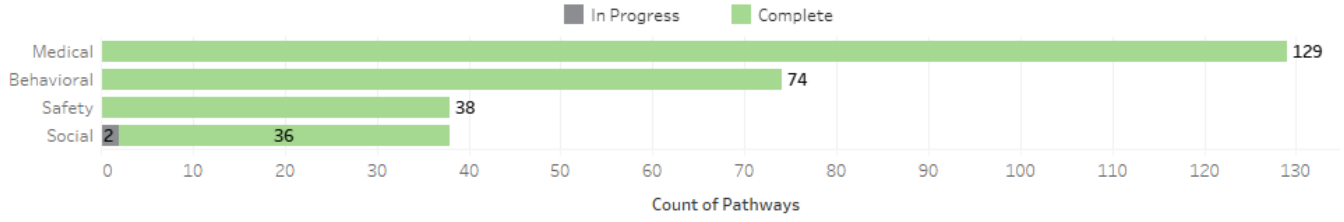


Figure 3. Open Social Service Referral Pathways, by Service and Completion Status

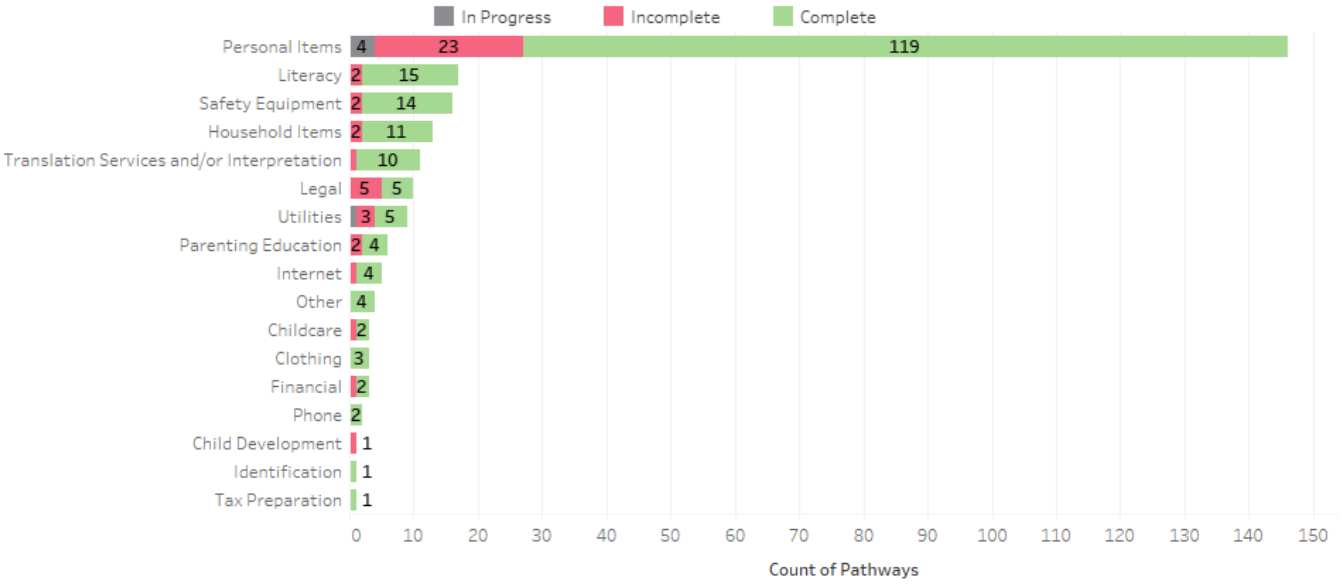
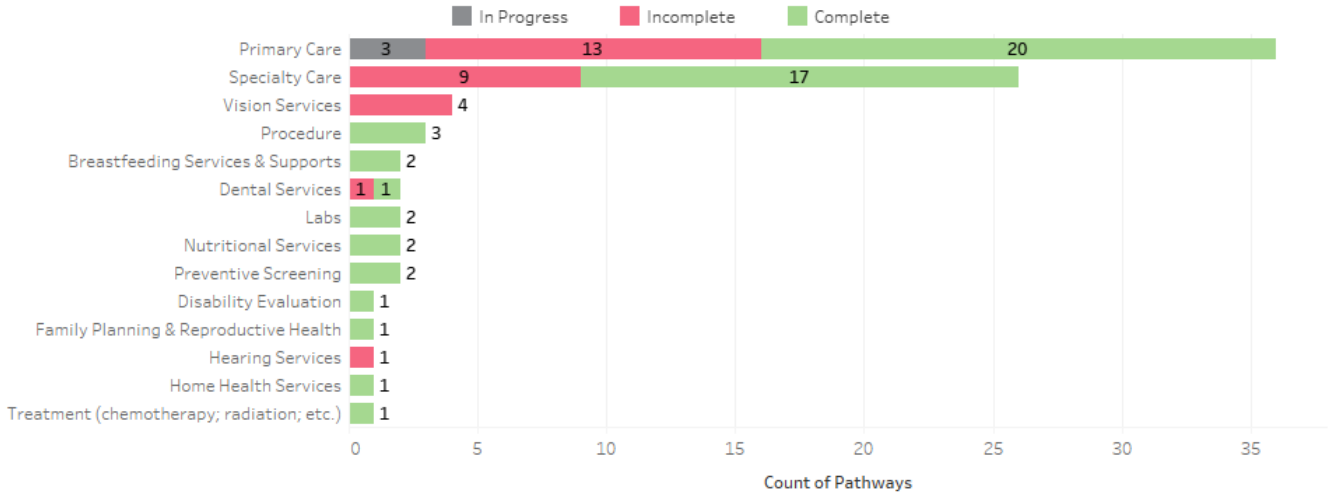


Figure 4. Open Medical Referral Pathways, by Service and Completion Status



Noted Improvements. The Pathways HUB model utilizes visit forms to capture top priorities and/or concerns from participants relating to HRSNs on a per visit basis. Using data from these forms, information was analyzed during the initial visit of a participant and compared to the responses during the last recorded visit. Improvements in four domains (Healthcare Coverage, Medical Home, Poor Pregnancy Outcome and Social Support) were observed for pregnant individuals. As a result of engaging in pathways, the following improvements were observed: 11 of 14 individuals established health care coverage, 17 of 21 individuals established a medical home, 10 of 11 individuals had pregnancy outcome improvements where historical poor pregnancy outcomes were reported and outcomes improved for present deliveries, and 2 of 2 individuals had social support improvements where feelings of isolation and/or not getting along with housemates was no longer reported (Figure 5). Along with connecting mothers to a medical home if

needed, the Pregnancy Pathway also captures if the baby has an established medical home. Of the 71 live births, 93% of babies had an established medical home following delivery (Figure 6).

Figure 5. Pregnancy Domain Improvements

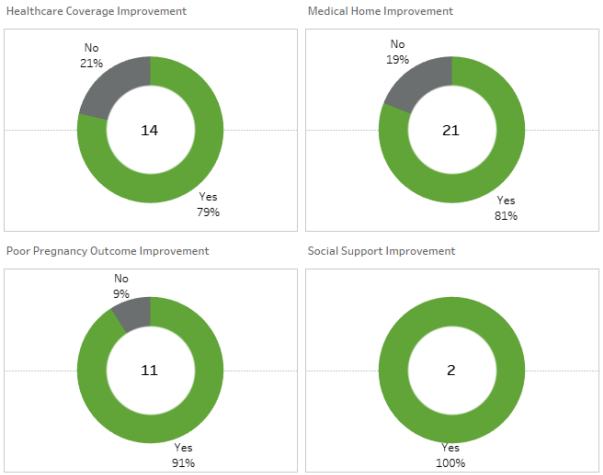


Figure 6. Percent of Babies with Medical Home Following Delivery

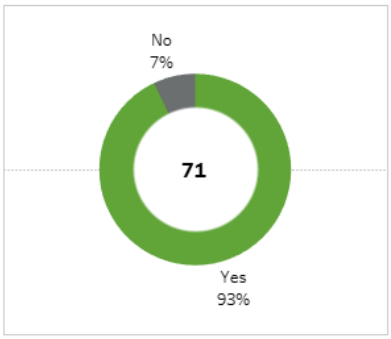


Figure 7. Timeliness of Prenatal Care

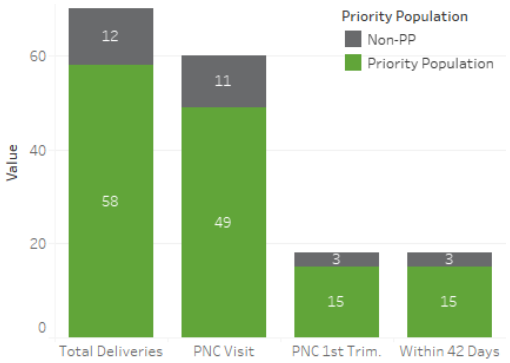
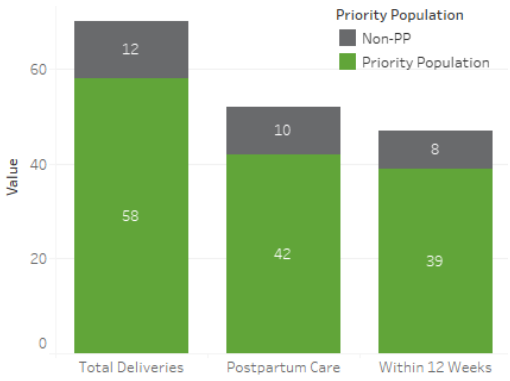


Figure 8. Postpartum Care

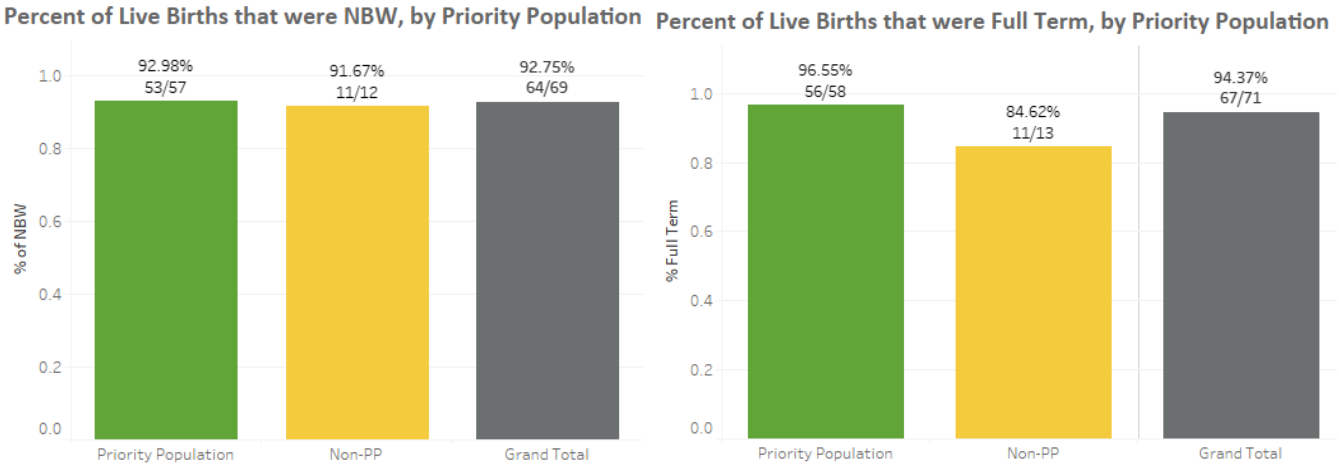


Prenatal and Postpartum Care (PPC) and Birth Outcomes. Perinatal HEDIS measures were used as a basis for analyzing whether pilot participants received adequate prenatal and postpartum care.[4] Timeliness of prenatal care is defined as the percentage of deliveries that received a prenatal care visit in the first trimester, on the enrollment start date or within 42 days of enrollment in the SNPCH. When examining the timeliness of prenatal care of pilot participants, we found that 86% of deliveries had a prenatal care visit, 26% within the first trimester. A little over one quarter (26% of individuals from the priority populations and 27% of non-pp individuals) received a prenatal care visit in their first trimester within 42 days of enrollment into the HUB (26% overall) (Figure 7). Adequate postpartum care is defined as the percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. When examining postpartum care of pilot participants, 74% of pregnant people had a comprehensive postpartum visit after delivery, and 67% of individuals received a comprehensive postpartum care visit between 7 and 84 days after delivery (Figure 8). When looking at LBW outcomes for our priority population (Hispanic and/or Black), we found that the proportion of LBW deliveries was lower than the rates for Hispanic and Black infants in Clark County (7% compared to 8.2% and 15.3%, respectively) (Figure 9).

[4] While HEDIS measures are best practice for measuring adequate perinatal care, it should be noted that a limitation to our analysis is that data is only available once an individual is enrolled. Prenatal care visits prior to enrollment are not accessible thus the assumption is that the first prenatal care visit during enrollment is the first prenatal care visit that an individual has. It should also be noted that our priority population is a hard-to-reach group and will be reflected in HEDIS measure percentages.

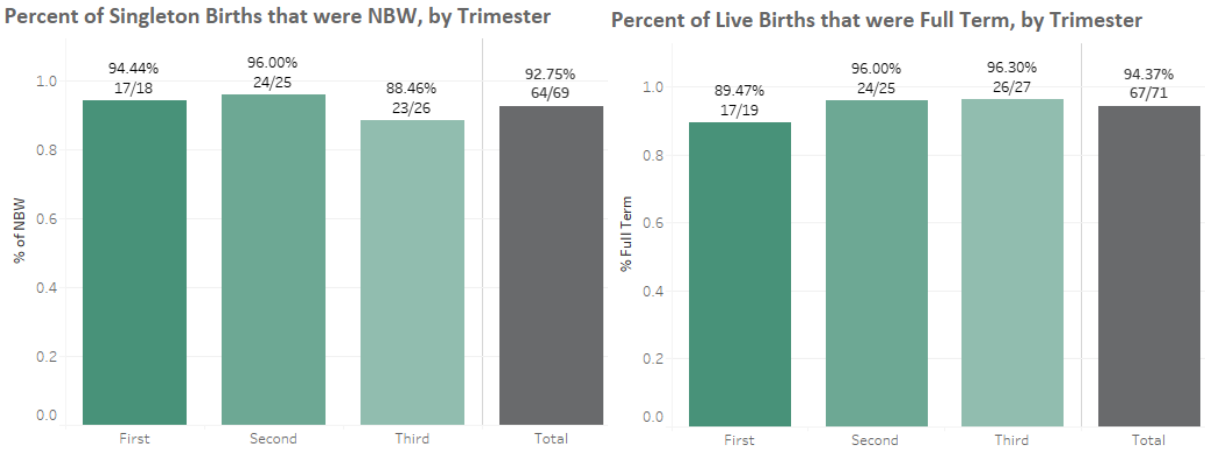
When looking at preterm outcomes for our priority population (Hispanic and/or Black), we found that the proportion of preterm deliveries for priority population individuals was lower than the rates for Hispanic and Black infants in Clark County (3.4% compared to 10.4% and 14.4%, respectively) (Figure 9).

Figure 9. Percentage of Live Births, by Outcome and Priority Population



The distribution of pregnant individuals enrolling into the Pathways HUB was consistent across all three trimesters (30 in the first, 29 in the second, and 31 in the third) (Appendix A Figure 7). When analyzing the same birth outcomes by trimester at enrollment, we found that the proportion of Singleton NBW deliveries was lowest for individuals who enrolled in their third trimester (88% compared to 93% overall). For the proportion of full-term deliveries, individuals who enrolled in their first trimester were lowest compared to the other trimesters (89% compared to 94%) (Figure 10). Sample sizes are too small for each trimester to draw significant conclusions from this sub analysis.

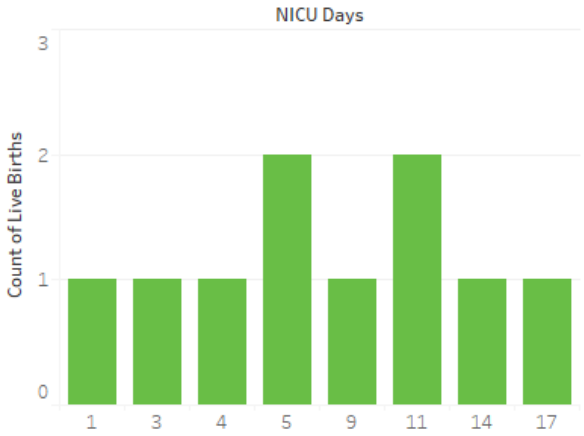
Figure 10. Percentage of Live Births with Positive Outcomes by Trimester[5]



[5] Of the 5 low birth weight singleton births, 3 were also pre-term. Of the 4 pre-term births, 3 were also low birth weight.

After delivery, data on breastfeeding status and total days in the hospital are recorded by the SNPCH. Out of the 71 live births, a total of 83% of infants were reported as being breastfed. A majority of live births resulted in 0 NICU and/or Special Care days. Of the live births that did result in hospital days, there were a total of 10 live births ranging from 1 to 17 hospital days (Figure 11).

Figure 11. Distribution of Live Births Resulting in Hospital Days

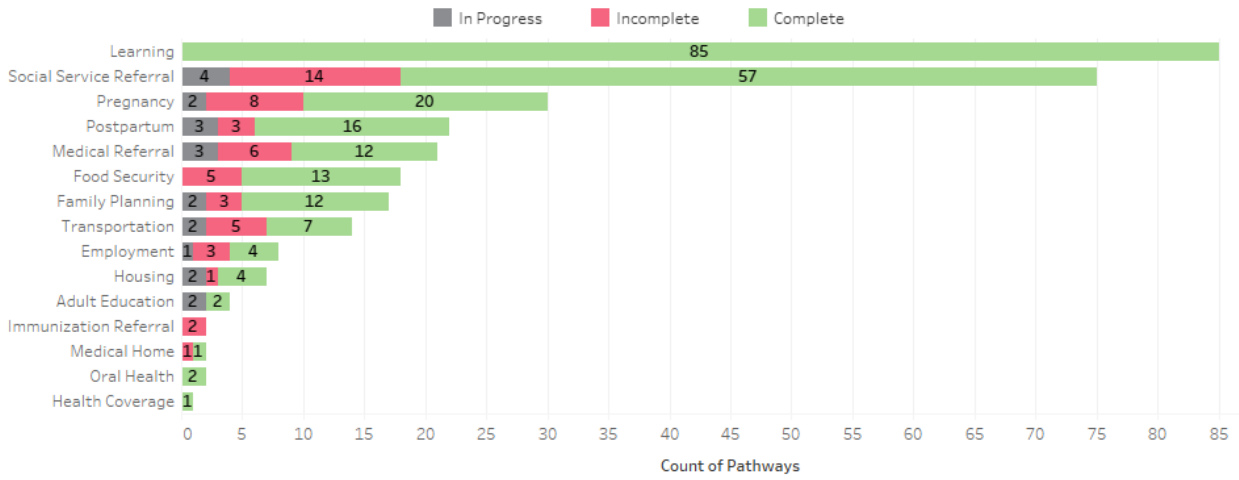


COVID-19 Vaccination Status. Pilot participants were also given a questionnaire at enrollment to assess their COVID-19 vaccination status. Those that reported not getting their vaccination would potentially be enrolled into the Immunization and COVID-19 Vaccination Hesitancy pathways. From the SNPCH data, it was found that 64% of individuals had received the vaccine when surveyed at enrollment, 33% reported that they did not receive the vaccine and 3% did not answer. Of the individuals that did not report getting the vaccine, nine were enrolled into the immunization pathway (along with two of the nine being enrolled into the COVID-19 Vaccination Hesitancy pathway). Approximately 72.7% of individuals that did not report getting the COVID-19 vaccine were not enrolled into the Immunization or Vaccine Hesitancy pathways. This information will be used to improve our process of identifying and engaging those that did not receive vaccinations and whether it is due to hesitancy for future enrollments.

SilverSummit Member Analysis

Of the 92 pregnant individuals that were enrolled into the Pathways HUB, 30 were identified as being SilverSummit Health plan Members, based on the plan documented at time of enrollment into the SNPCH. **Of the 30 SilverSummit members, 24 were enrolled from the SilverSummit provided hard-to-reach list.** Of this group, 73% were members of our priority population (Hispanic and/or Black). A total of 308 pathways were opened resulting in 90% of individuals closing at least one pathway. A total of 236, or approximately 77%, of pathways were completed successfully by SilverSummit members. Pathways that were utilized the most during the pilot were Learning pathways (primarily learning around breastfeeding, nutrition, primary care & preventive screening, positive parenting, shaken baby syndrome and avoiding eviction were opened) and Social Service Referrals (including personal items like baby items or hygiene items) (Figure 12). Notably for SilverSummit members enrolled in the SNPCH, thirteen individuals achieved food security, four individuals were placed in stable housing, and seven individuals reported resolved transportation challenges. Of the 30 members, 23 had live births which included 22 full term deliveries (20 of which were also normal birth weight). For the remaining seven members, five had experienced a loss of pregnancy and two are slated to deliver in June.

Figure 12. Opened Pathways for SilverSummit Members



SilverSummit Healthplan Member Engagement

The SilverSummit Pathways Pilot aimed to address maternal health disparities in Clark County, Nevada using a nationally recognized evidence-based model for screening and mitigating modifiable clinical and social risk factors associated with worse maternal and infant outcomes. The population of focus for the pilot was pregnant individuals and their families who are SilverSummit members or uninsured, with a priority focus of outreaching to Hispanic/Latino and Black pregnant individuals and their families who reside in these communities. Initially the pilot proposed to serve priority populations in a subset of Clark County zip codes: 89101, 89106, 89030, 89169, and 89115. However, to meet the needs of our partnership with SilverSummit's Population Health Case Management team and in recognition of the finite performance period for the pilot, we expanded the inclusion criteria to those who met the eligibility criteria for the Nevada WIC program or who were on the SilverSummit provided hard-to-reach list. Comagine Health's SNPCH team worked closely with community partners who serve on the SNPCH Core Team to identify and establish referral partnerships in support of this pilot. The Core Team's purpose is to help the SNPCH identify areas of priority and target populations of focus. The Core Team also informs and collaborates on SNPCH development activities and care coordination gaps in the community to steer the direction of the SNPCH. For this pilot, the Core Team advised the SNPCH staff on potential referral partners to engage. Due to the limited size of the pilot, we opted to focus on establishing referral agreements with three community partners, SilverSummit, WIC and Baby's Bounty. Additional community-based partners were identified through this process that the SNPCH is interested in onboarding as referral partners in the future as we are able to secure resources to meet the potential demand of more clients. Specifically, SilverSummit members and others served were identified and referred into the SNPCH through the following referral partners:

SilverSummit Population Health Case Management Team. SilverSummit Health Plan's Population Health Case Management Team provided a list of hard-to-reach members that they were not able to contact. The SNPCH team used the list to route referrals to the CHWs who then conducted outreach to the members. SNPCH continued to route referrals as CHW caseloads allowed and met regularly with the SilverSummit Case Management Team to review progress and needs of their members being served by the SNPCH. The SNPCH enrolled 24 members from the hard-to-reach list.

Women, Infant and Children (WIC) Program. CHWs identified pregnant people in need through a partnership with the Dignity Health Women, Infants and Children (WIC) Program and screened for SilverSummit Members during the initial visitation assessment when recording client insurance provider. The SNPCH enrolled 47 participants from WIC referrals.

Community based organizations. The SNPCH received referrals from community referral partners, including Baby's Bounty, Miracle in Progress, and First Choice Pregnancy. Ten participants were enrolled from referrals from these local community-based organizations (CBOs).

Other referral sources. The remaining 11 participants were referred as follows. Four participants were referred by community health workers (CHWs), four participants were enrolled through self-referral, and 3 did not specify their referral source at enrollment.

Once clients were identified by the SNPCH staff and assigned to a CHW, the CHWs used several tactics to engage and enroll members including calling, sending text messages, mailing fliers, and offering incentives of gift cards and baby supplies to potential clients. The CHWs took time to engage referred individuals and build trusting relationships. All visits were done in the referred individuals' homes, onsite at the Care Coordination Agency offices, or virtually.

Success Stories

Please refer to Appendix B for two success stories from Silver Summit Clients. Release of information to share their names and stories is on file at Comagine Health.

SilverSummit Community Investment Impact Statement

The SilverSummit Community Reinvestment grant has been instrumental to launching the Southern Nevada Pathways Community HUB and demonstrating significant impact for a high need population in Clark County. As a result of this pilot, a total of ninety-two pregnant individuals enrolled in the SNPCH. Of those enrolled through the pilot, 30 were SilverSummit members, 24 of which were from a hard-to-reach list that SilverSummit provided. Overall, pregnant people enrolled in the SNPCH as part of the SilverSummit pilot had significantly better than state and county average outcomes. As of April 2024, 5.6% (4/71) of live births at the time of this reporting were preterm compared to the state average (11%) and 7.2% (5/69) of singleton births had a low birthweight baby compared to 9.4% overall in Clark County. The percentage of live births from the priority population of focus (Hispanic and/or Black) that were preterm was lower than the rates for Hispanic and Black infants in Clark County (3.4% compared to 10.4% and 14.4%, respectively) and the LBW rate for the priority population of focus was lower as well (7% compared to 8.2% and 15.3%, respectively).

This grant has set the stage for the vision we, along with Dignity Health and our partners on the Pathways Core Team, have for realizing a fully functioning Pathways HUB in the region. This grant enabled us to establish a subcontract with our first Care Coordination Agency who hired three CHWs to support the pilot, transition from excel tracking to a certified data system, and pilot implementing the program model. Through this process, we learned a number of key lessons, including where to find pregnant people who

may not yet be connected to care, strategies for engaging and retaining hard to reach health plan members which yielded positive birth outcomes, and working with a health plan case management team. Through this process, we exceeded our goals for enrollment and saw better than expected results for the moms we were able to engage and serve. This grant had made a significant difference in the lives of many pregnant women and their infants who without it, may not have received the support they needed to achieve positive birth outcomes. It also provided us with the forum to apply for and receive additional funding, including the HRSA Integrated Maternal Health Services Grant, of which we were one of five recipients nationwide. With the additional funding we have been able to secure, we have onboarded a second Care Coordination Agency and have two more entities (Southern Nevada Health District and Nevada Health Centers) on track to onboard this Fall. As a result of our collective efforts, bolstered by this important investment made by SilverSummit, we are now on track to realize a fully operating Pathways HUB in Southern Nevada.

Appendices

Appendix A: Additional Data Visualizations for Context/Narrative

Figure 1. Insurance Type/Plan Name of Participants

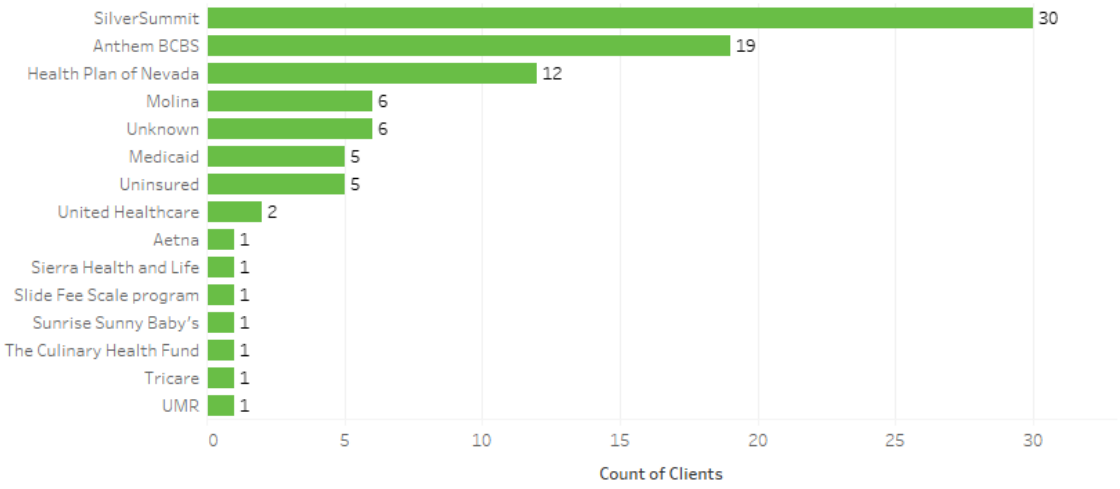


Figure 2. Age Mix of Participants

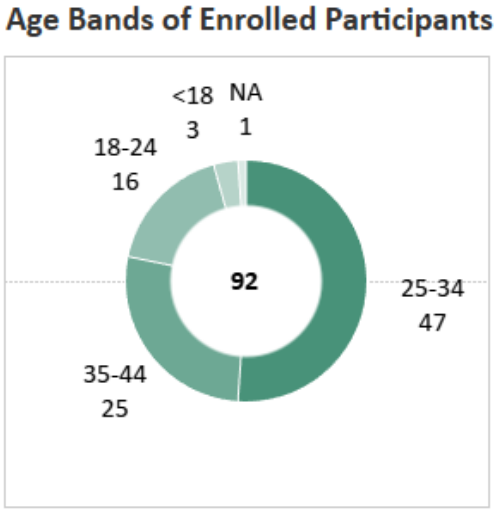


Figure 3. Race/Ethnicity Mix of Participants

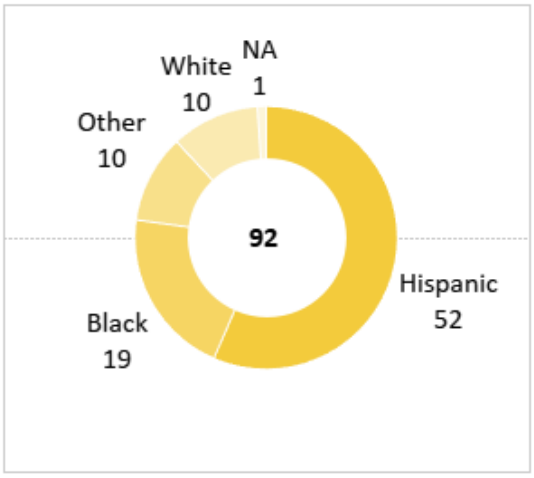


Figure 3-1. Race and Ethnicity Mix of Participants

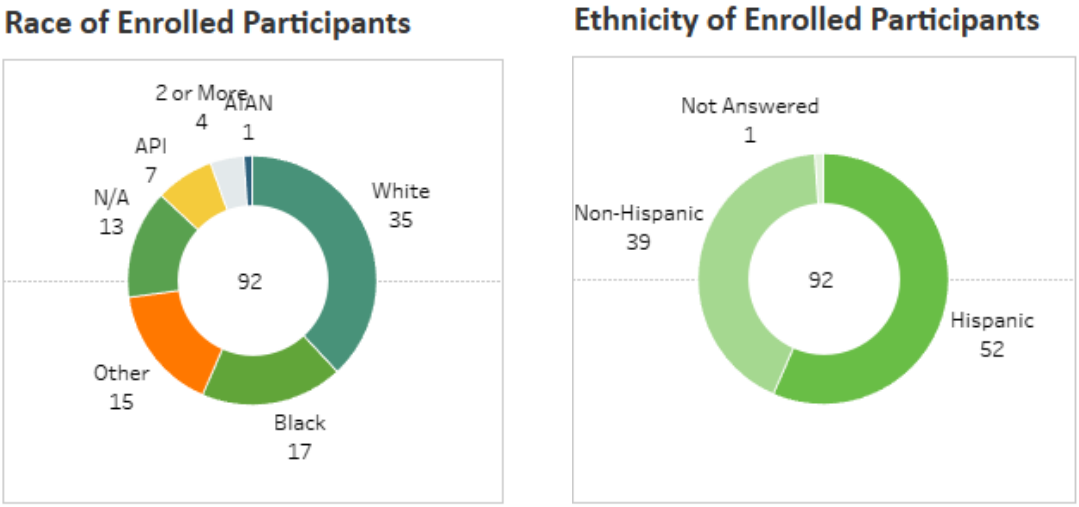


Figure 4. Open Learning Pathways, by Domain/Service and Completion Status

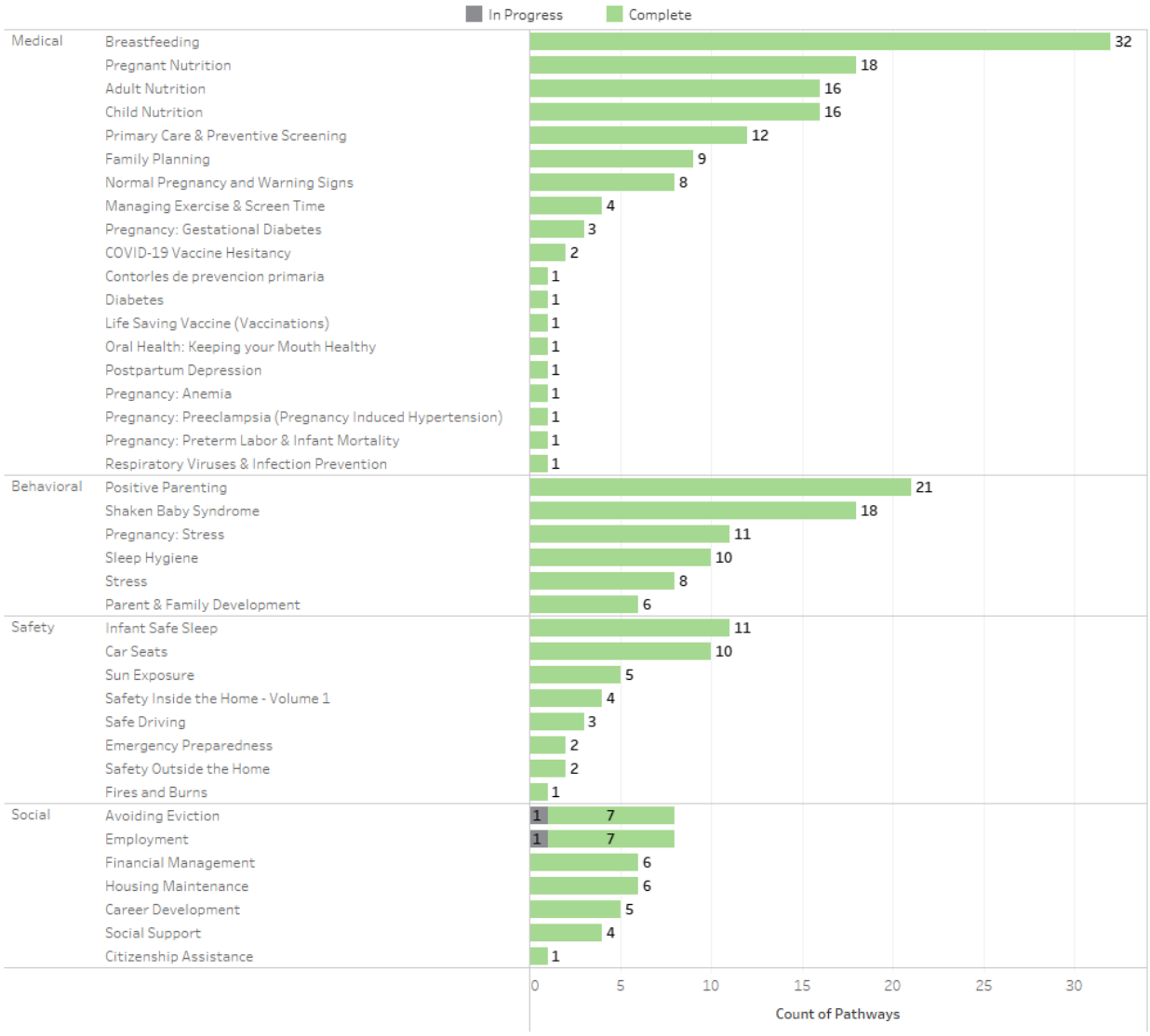


Figure 5. Percentage of Live Births with Normal Birth Weight Outcome, by Race/Ethnicity

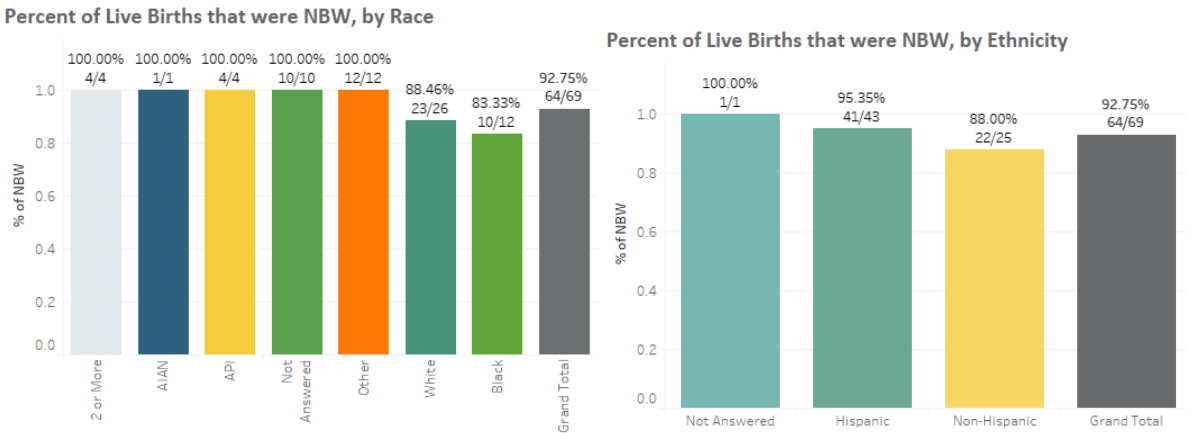


Figure 6. Percentage of Live Births with Full Term Outcome, by Race/Ethnicity

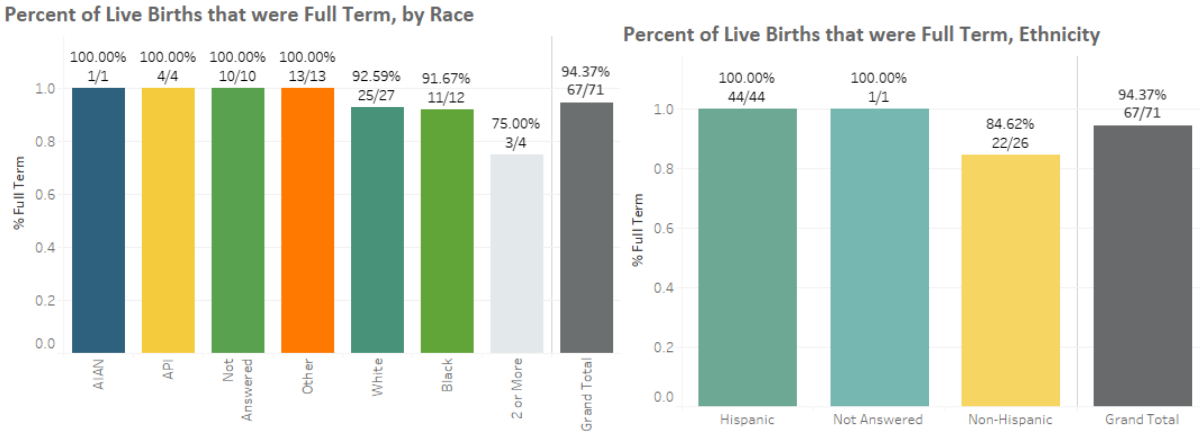
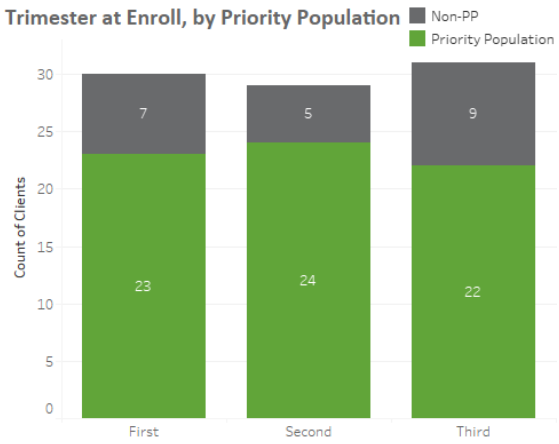


Figure 7. Count of Trimester at Enrollment by Priority Population



Appendix B: Success Stories

Success Stories (1) - A Journey of Resilience and Growth with Pathways

Meet Sarah, a 28-year-old single African American mother of two who embarked on her transformative journey with Pathways on October 24, 2023. Living on an annual income of $20,000, Sarah faced significant challenges, including a lack of prenatal care and a history of preterm birth.

Upon enrolling in Pathways, Sarah received the support she desperately needed. Her prenatal care journey began, and despite delivering her baby at 34 weeks on December 24, 2023, the infant was born healthy at 5 lbs., with no need for NICU days.

Sarah's dedication and resilience are evident in her achievements within the Pathways program. She has completed 13 pathways, addressing crucial areas such as food security, postpartum care, transportation, and obtaining essential baby and personal items through social services referrals. Furthermore, she has engaged in Learning Pathways, enhancing her knowledge in Child Nutrition, Primary Care and Preventative Screening, managing Pregnancy Stress, Breastfeeding, Sleep Hygiene, and Avoiding Eviction.

Sarah continues to work on two remaining pathways: securing Employment and obtaining a Medical Referral for Primary Care. Her journey with Pathways has empowered her, providing stability and the tools needed to improve her family's well-being.

Sarah’s story is a powerful testament to the impact of Pathways. It turned her challenges into a path of growth and resilience, ensuring a brighter future for her and her children.

Member Testimonial

“To a company I knew nothing about. I was contacted by a sweet woman by the name of Rosa Cervantes, who reached out to me regarding the program I was eligible for through my insurance, I believe. Honestly, I didn't expect to keep up with the program or take the help. Let me tell you I am so happy I took the opportunity to be a part of this program. I am more than grateful for Rosa and the Pathways program. They offer as much help as possible during your pregnancy and after. I love how they stick with you after delivering your baby. Rosa has been wonderful to me. I’ve been provided with bus passes to get back and forth to appointments and gift cards to keep up with my kids' essentials. She has been amazing trying to help me find employment and providing other resources like housing, medical, food. I would definitely recommend this program to any female who is able to join.”

Success Stories (2) - Empowering a Young Mother Through Pathways

Maria, a 25-year-old Spanish-speaking single woman, faced significant challenges when she first connected with Pathways on October 24, 2023. Recently unemployed with an annual income of $30,000, she had completed trade school but was not receiving prenatal care. Identified through the Silver Summit hard-to-reach list, Maria's journey towards a healthy pregnancy and self-sufficiency began.

With the dedicated support of a Community Health Worker (CHW), Maria received 15 visits, transforming her experience. Before enrolling, she had no prenatal care. However, after joining Pathways, Maria attended four crucial prenatal appointments, leading to the birth of her baby at 37 weeks on December 1, 2023. Despite her baby being born one ounce below the healthy birth weight at 5 lbs. 7 ounces, the pregnancy was otherwise healthy.

Pathways opened 22 pathways for Maria and successfully closed 21, including vital areas like Adult Education, Employment, Food Security, and Health Care Referrals. Notably, she completed 10 Learning Pathways, gaining essential knowledge in Breastfeeding, Child Nutrition and Financial Management.

Maria now feels more independent and confident in accessing community resources. Her story is a testament to Pathways' power to stabilize and support those in need, turning challenges into triumphs.

