Horizon Neighbors in Health

Progress in 2020, Hope For The Future
We empower our members to achieve their best health.

These words - Horizon’s Mission Statement - guide our work every day. They recognize that every member is unique and has different needs to be met in order to achieve their best health. Many New Jerseyans who live in historically underserved areas or who come from communities with significant health disparities face barriers that have either gone unacknowledged or been traditionally considered beyond the reach of the healthcare system. Factors related to where someone lives, works, goes to school, or grows old should not determine their health or their ability to access quality health care. We created the Horizon Neighbors in Health program to help address these kinds of challenges, known as the Social Determinants of Health, because we recognize the role they play in preventing those members from achieving their best health.

Working with our partners across the state, and with a specific focus on the communities and individuals at greatest risk, we have deployed the most comprehensive effort in New Jersey to confront these barriers and reduce health disparities. Creating health equity for those members is essential if they are to achieve their best health. More than that, it is a fundamental shift needed to create a better, healthier New Jersey for everyone. The results achieved during the first year of Horizon Neighbors in Health show what is possible when everyone with a role in health care commits to working together to challenge the status quo and build sustainable partnerships focused on what is best for the patient, and best for New Jersey.

Gary D. St. Hilaire
President and Chief Executive Officer
Horizon Blue Cross Blue Shield of New Jersey
Executive Summary

In the spring of 2020, Horizon Blue Cross Blue Shield of New Jersey set out to launch the state’s, and perhaps the country’s, largest ever program to address Social Determinants of Health. The program, Horizon Neighbors in Health, was created after months of careful thought and collaboration with New Jersey’s leading health care providers. Horizon Neighbors in Health was meant to provide direct, face-to-face interaction between high-risk Horizon members and community members who could provide the services needed to address Social Determinants of Health.

On the eve of the program’s launch, the COVID-19 outbreak began reshaping our world and day-to-day lives. Face-to-face interaction was simply no longer possible: but at the same time, the pandemic only exacerbated the conditions that create Social Determinants of Health in the first place. With this in mind, Horizon and its partners moved forward with the official launch of Horizon Neighbors in Health in April 2020. The results, even in the face of a global pandemic, have been extraordinary.

This report details the story of Horizon Neighbors in Health’s first year. It provides an overview of the program as well as data and statistics that showcase the importance of a program such as this and why expansion of Horizon Neighbors in Health and similar programs must be a focus of lawmakers in 2021 and beyond. More than just statistics and data, however, this report is about real people and real impacts. Horizon Neighbors in Health has changed the lives of thousands as they deal with the pandemic’s impact now and into the future.
Why We Developed Horizon Neighbors In Health

Horizon Neighbors in Health aims to address impeding Social Determinants of Health (SDoH), the complex, integrated and overlapping social structures and economic systems responsible for most health inequities. The COVID-19 pandemic has made addressing these socioeconomic factors – which include quality of education, physical environment, employment and social support networks – even more critical.

These factors are known to impact clinical outcomes as well as access to health care and are modifiable risk factors. Social distancing measures, which became a key component of flattening the coronavirus curve, also highlighted the need for a highly targeted program that reaches out to those communities where resources are needed the most, but currently lacking. Moreover, the health care needs of individuals across New Jersey have changed dramatically and dealing with SDoH requires an ability to adapt to those changes. While traditional care delivery has tried to address SDoH needs, they have been limited by lack of time, skills and community linkages.

39% of New Jerseyans cannot meet their basic needs*

1 in 10 New Jerseyans are food insecure*

Participant Information

*RWJBH.ORG/WHY-RWJBARNABAS-HEALTH/-SOCIAL-IMPACT/
How Many?

24,000

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY MEMBERS

across Commercial, Medicaid and Medicare Advantage will be targeted for inclusion.

Where?

15 counties

127 zip codes* 

Who Does It?

Up to 60 COMMUNITY HEALTH WORKERS — who are hired from within the communities they serve — will be hired, trained and certified to conduct telephonic communication.

How It Works

Our social determinants model utilizes community health workers and personal health assistants in order to address critical elements which currently fall outside of the traditional care delivery model.

Training Process

Penn Medicine provides training through its IMPaCT Training and Certification Program for CHWs, managers, directors and coordinators. This includes:

• 10 days each year of in-person or virtual CHW training on critical topics;
• 3 days each year of in-person supervisor training on core skills;
• 1 day each year of in-person executive education to support the Customer’s leadership;
• 1 half-day each year of in-person or “virtual” coordinator training to help develop efficient workflows related to patient identification and screening, outreach and enrollment, and evaluation and reporting; and
• Initial certification of completion for individuals who successfully demonstrate mastery of core competencies for their role, and certification renewals every three years thereafter.
Horizon Neighbors in Health leverages Social Determinant information along with legacy data to identify candidates for various community programs.

Social Determinants are captured through purchasing information, census data and marketing engines. Attributes include household income, education levels, ethnicity, economic stability and demographics.

Given the complexity of clinical data, this information should help focus on populations that would benefit from these care management interventions.

Medical claims information is integrated with predictive risk scores and social aspects in order to provide a comprehensive profile on our population.

NowPow's platform supports participants in the referral process by building and managing community resource networks.

With a focus on referrals that address basic needs and chronic disease management, NowPow partners with health care providers and community-based organizations to identify these needs, provide highly matched referrals, facilitate closed loop referrals, support bi-directional patient engagement and document referral outcomes.

In addition to delivering targeted self-care interventions, NowPow also supports automated interventions that build resource awareness across large populations. Through its community resource network management strategy, NowPow supports ecosystem data aggregation to capture insights at a macro level.

Ensures quality referrals and adds new Community Based Organizations (CBO).
Pilot Program: The Newark Initiative

Horizon Neighbors in Health is modeled after an April 2017 - April 2019 pilot program where Horizon Blue Cross Blue Shield of New Jersey partnered with Robert Wood Johnson Barnabas Health System to launch a community-based model, built on the integration of payer, provider and local community resources to address the social barriers to health for identified members. The model incorporated a Horizon BCBSNJ care transformation specialist, personal health assistant, health system-based social worker and community health workers recruited from the neighborhoods served.

For the pilot program, ~1k Commercial Fully Insured high/rising risk members were identified within four zip codes in Newark. These members were provided with support such as referrals to specialty care, education, wellness/preventive screenings, primary care physician appointment scheduling/follow-ups, face to face and telephonic support. The pod team connected members to social, community and health care resources in order to mitigate their social barriers.

Outcomes
For the engaged population and over the course of 1 year, we achieved approximately:

- 25% reduction in total cost of care
- 60% increase in behavioral health treatment or utilization
Outcomes

Member A

MEMBER PROFILE
62-year-old female, retired State worker experiencing financial constraints due to limited income. Member suffers with hypertension and does not have a Primary Care Physician. Member is on the verge of losing rental housing due to homeowner’s foreclosure, as the member has been a lifelong renter. Family composition includes a disabled adolescent child and a child with developmental delays.

INTERVENTION
To assist with hypertension management, member was connected to a Horizon BCBSNJ Case Manager. To address housing concerns, the personal health assistant (PHA) collaborated with the SW (part of the Newark Initiative team) to assist member with housing by discussing options for buying/renting. SW connected member to mortgage broker and walked through the process with her. The SW also offered supportive counseling, motivational interviewing and resource information for other family members living in the household.

• To address social isolation and limited community engagement, the member was provided with empowerment counseling and invited to a move event with extended family members to foster trust and provide a small respite/outlet for relaxation and stress relief. During the event, family members were provided with education/literature on ideas for a healthier lifestyle and health management.

OUTCOME
Regarding housing, a one-month extension was granted to avoid foreclosure. Member retained pro-bono law services with NJ legal group to assist with housing goals/process due to SW intervention.

• Member’s credit was improved since her student loan was taken out of default status. The member was approved for a mortgage loan and was able to purchase her home.

• Member feels hopeful for the future and expressed that she feels happy to be part of this program.

• She is looking forward to utilizing the health services offered.

Member B

MEMBER PROFILE
The patient is a 16-year-old daughter of a member. She had attempted suicide for the second time and was admitted to the hospital. Subsequently, a behavioral health appointment was scheduled several weeks out.

INTERVENTION
While in the hospital, the Care Coordinator met with member to identify critical barriers to care delivery and help member/dependent navigate the treatment process.

• The Care Coordinator expedited the member’s existing behavioral health appointment to an earlier time to ensure immediate intervention and scheduled a family meeting at a local wellness center. Care Coordinator also connected the member and her family with various community support resources to develop a comprehensive treatment plan.

OUTCOME
Since the intervention, the member enrolled in camp, maintained successful attendance at school and is now seeing a behavioral health specialist for therapy. As a result, member is well on her way to a healthy and happy lifestyle.
Launching Horizon Neighbors in Health

The success of the Newark PILOT led Horizon to develop a larger program that would help at-risk members across the state. Working throughout 2019 and early 2020, Horizon BCBSNJ focused on developing a list of members and areas most in need, coupled with health systems who had in the in-house know-how and ability to reach these populations. Matching these health systems with the training of Penn Medicine and the technological expertise of NowPow, Horizon Neighbors in Health was set to launch in the spring of 2020.

As the launch date approached, it became clear that, as with so many other aspects of day-to-day life, COVID-19 was going to dramatically alter when and how Horizon Neighbors in Health began and operated. Recognizing that the underlying conditions that caused Social Determinants of Health were not going to disappear – that, in fact, the pandemic would make those conditions worse – Horizon acted quickly to transition the program from face-to-face interaction to telephonic communication.

Despite the obstacles moving from in-person to telephone communication created, the first year of the program proved highly successful. Over 2,500 people were enrolled in the program, with 730 having graduated (meaning their program specific needs were met). Individual examples of assistance provided and success stories are included below. The following are program statistics compiled as of December 31, 2020.

Program Statistics

<table>
<thead>
<tr>
<th>Financial Stability</th>
<th>Food</th>
<th>Basic Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,588 TOTAL # ENROLLED</td>
<td>730 TOTAL # GRADUATED (28%)</td>
<td>TOP NEEDS IDENTIFIED</td>
</tr>
</tbody>
</table>

TOTAL # ENROLLED

TOTAL # GRADUATED (28%)
Top Needs Identified

- Resources for Daily Life - Financial Stability: 18%
- Health Behavior - Basic Healthcare: 15%
- Resources for Daily Life - Food: 13%
- Resources for Daily Life - Employment: 7%
- Resources for Daily Life - Transportation: 5%
- Psychosocial Support - Behavior Health: 5%
- Resources for Daily Life - Housing Stability: 5%
- Resources for Daily Life - Education: 5%
- Resources for Daily Life - Household Items: 5%
- Resources for Daily Life - Housing Quality: 4%
- Psychosocial Support - Childcare: 3%
- Health Behavior - Safety: 2%
- Resources for Daily Life - Homelessness: 2%
- Health Behavior - Substance Use: 2%
- Resources for Daily Life - Legal: 1%
- Health Behavior - Reproductive Healthcare: 1%
- Psychosocial Support - Caregiver - Dependent Adult: 1%
- Health Behavior - In-Home Care: 1%

Top 10 Referrals by Service Type

- Food pantry: 2,128
- Utility payment assistance: 1,775
- Rent and mortgage payment assistance: 1,429
- Emergency-only financial assistance: 967
- Soup kitchen or free meals: 763
- Dental care: 751
- Individual counseling: 750
- SNAP registration assistance: 546
- Public benefits application assistance: 462
- Primary care: 455

Service Provider Summary

- St. James Social Service Corporation: 613
- Urban League of Essex County: 578
- Isaiah House: 524
- Newark Emergency Services For Families, Inc.: 414
- New Community Corporation - Family Resource Success Center: 401
- North Jersey Community Research Initiative: 320
- Catholic Charities Archdiocese of Newark - Parish Access Center - Essex County: 279
- Catholic Charities Diocese of Paterson - Headquarters: 254
- Le Casa De Don Pedro - Community Improvement & Economic Development: 225
- Town of Secaucus - Social Services Department: 216
As COVID-19 began reshaping our everyday lives, Jay was already struggling to maintain hers. She has tried for years to provide her three autistic sons with a quality education but often runs into issues with her school district. Once the pandemic hit, she was providing at-home schooling to all three, from language arts to math to functional living skills. Because of the different ages of her children, she had to teach at different levels of learning. Jay herself has struggled with chronic nerve pain for years while also dealing with seizures and stress-induced pain.

There are thousands of New Jerseyans like Jay, struggling to deal with daily issues – from schooling and feeding their children to maintaining their own mental and physical health – which were difficult before COVID-19. For them, the pandemic has been especially cruel.

For Jay, Horizon Neighbors in Health has been a lifeline. Cheryl Towns BSN, RN, a Nurse Care Manager and Community Health Worker for Trenton Health Team Care Management Team, has been able to help Jay deal with a variety of issues. Cheryl sees Horizon Neighbors in Health as vital in finding and assisting people who might not otherwise be looking for, or willing to accept, help.
“We have been able to feed countless families, pay for prescriptions, even help get someone a laptop so they can enroll into classes to start school,” said Cheryl. “And the first thing they say is, ‘Through my insurance company? I’ve never heard of that. This must be a scam.’ No, it’s not a scam. It’s that your insurance company cares for you, the member.”

Cheryl reached out to Jay, who was initially hesitant to engage. Jay had told her story to people before only to hear they could not help her. Cheryl did not want to be the next person to tell her sorry.

“I pulled up to her house and got her a month, two months’ supply of diapers for one of her kids. We were also able to give her a $200 gift card from ShopRite.”

For Jay, the program has helped provide some stability during uncertain times. Cheryl has helped her locate community resources to help with academics and recreational activities for her children.

“Cheryl, in the midst of this whole big storm, has been a breath of fresh air,” said Jay. “She was my lifeline. It’s like when you’re in a cave and you see this glimmer of light. I didn’t have to wait. I didn’t have to check in with her. She kept checking in with me. She continues to check in with me and she’s just been a blessing because she’s taken a little bit off my plate, which I can always use less on my plate.”

Horizon’s Personal Health Assistant (PHA), Leigh Santorelli, served as the first point of contact to Jay, engaging in an empathetic dialogue regarding the impact of the pandemic on her family and the challenges she was experiencing. Following an in-depth conversation that enabled Jay to share her need for support, Leigh referred Jay to the NIH Trenton Health Team Program. Leigh and Cheryl worked together to ensure Jay’s basic and medical needs were addressed. Leigh identified and coordinated her medical appointments and connected with a Horizon case manager. Leigh and a case manager are working together to identify a medical provider who will address Jay’s long standing chronic pain concerns.

Through the PHA, Jay’s children also were enrolled in case management programs to assist with care coordination, alleviating some of the stress Jay was experiencing. A relationship was fostered among this collaborative team, with ongoing conversations reinforcing the importance of wellness visits and vaccines to keep Jay and her family healthy. This program continues to provide Jay with the tools needed to seek to improvements for her and her family’s emotional and physical health.

“Whoever created this program, God bless them,” said Jay. “It should be offered across the board.”
Community Health Workers: Making a Difference, One Horizon Member at a Time

Community Health Workers (CHWs) are the driving force behind Horizon Neighbors in Health and the initial point of contact for the program. Working in consultation with Personal Health Assistants (PHAs), who assist with health plan research, provider access and overall Horizon support, CHWs are members of the communities in which they are working. This familiarity provides a level of comfort to program participants that is sometimes lacking in the everyday health care they receive. Horizon is committed to supporting CHW’s through forums for networking, shared learning and best practices, as well as providing the tools needed to support career advancement and an annual membership for the National Association for Community Health Workers.

Number of Community Health Workers By HNIH Partner*

<table>
<thead>
<tr>
<th>Partner</th>
<th>CHWs</th>
</tr>
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<tbody>
<tr>
<td>RWJ Barnabas Health</td>
<td>12</td>
</tr>
<tr>
<td>St. Joseph’s Health</td>
<td>9</td>
</tr>
<tr>
<td>University Hospital of New Jersey</td>
<td>2</td>
</tr>
<tr>
<td>Camden Coalition of Healthcare Providers</td>
<td>2</td>
</tr>
<tr>
<td>Tieton Health Team</td>
<td>2</td>
</tr>
<tr>
<td>Atlantic Health System</td>
<td>6</td>
</tr>
<tr>
<td>Hackensack Meridian Health</td>
<td>8</td>
</tr>
</tbody>
</table>

In 2020, CHWs provided a myriad of essential services for Horizon Neighbors in Health program participants. Among just some of the many examples are:

- Linked several members with the Horizon Education Works program for GED completion
- Assisted a patient with emergency housing to avoid homelessness for himself and his family. Patient is now in the process of securing more permanent housing.
- Helped a patient link with several different community services that worked together to pay for and install a ramp outside of her home
- Assisted members with securing food for themselves and their families through local food pantries and delivery services

*Numbers as of December 31, 2020
• Connected patient with a community resource to obtain baby supplies (formula and diapers) for newborn
• Linked members with a PHA, who helped them navigate health care benefits in order to get required testing authorized (MRIs, CT scans, neurological testing)
• Assisted members in navigating social services, applying for benefits, and securing assistance for rent and utilities
• Assisted member with securing food for himself through a local food pantry and dropped it off for him
• Linked member with a PHA who helped find the member a new sleep doctor
• Connected patient with a community resource to obtain baby formula for her newborn and food for the rest of her family
• Assisted with application for rent/utility bill relief through NJ Shares
• Assisted members in getting diapers for their infants through CBOs and the mitigation fund
• Assisted various members to get baby and adult clothing
• Connected members with food panties and SNAP registration for food
• Engaged clergy to support discussions about health with the community
• Provided rental/utilities assistance
• Connected member to case manager from Horizon for continued support
• Linked member to CBOs for proper cleaning supplies to disinfect their home
• Connected member to CBOs for baby formula
• Connected member to CBOs to register for ESL course
• Assisted various members in their job search by sending them links to open positions in their preferred field
• Linked multiple members with food resources to help them circumvent food insecurities during the COVID-19 pandemic
• Assisted a pregnant patient in avoiding homelessness for herself and her daughter
• Assisted members in applying and receiving disability benefits
• Helped link members to community resources to assist in rental assistance
• Helped link a patient to get her home inspected by the county in preparation of the upcoming winter
Like Horizon Neighbors in Health program participants, numbers do not tell the full story of the program’s CHWs. They are not only changing the lives of those they serve through the program, but the program itself is positively changing the lives of its CHWs. Here is one example of how Horizon Neighbors in Health is making a real impact through and for CHWs.

Born in South America, Luis* came to the United States with his family when he was 7, growing up in Bergen County. Interested in health care and helping others, he went to nursing school but eventually had to leave and began work as a massage therapist. The job provided him a great opportunity to help people and a reliable way to make a living.

Six years into his job, the pandemic hit. Given that his job relied on direct, person-to-person interaction, COVID-19 made it all but impossible for Luis to continue earning a living. He was having trouble paying his bills and the part-time work he was able to find was not enough. In the Fall of 2020, he got a call from Jessica. Jessica is a CHW with the Health Coalition of Passaic County (HCPC) who is serving as a project partner with St. Joseph’s Health in Paterson on the Horizon Neighbors in Health program. Jessica wanted to know how she could help Luis.

Jessica was able to assist with some of his needs, “but my biggest need was a job,” said Luis. One day, Jessica called with good news: would Luis like to come and interview for a job as a CHW in the program. “I was wowed by the offer,” said Luis, who got the job and could not wait to get to work.

On the Monday before Thanksgiving 2020, Luis began his first day of work as a HCPC CHW with St. Joseph’s Health. The full-time employment has helped him stabilize his life and regain some normalcy. He admits that the work is challenging, but it’s a great fit for what he wants to do in life: help others.

Luis now spends his days not worrying about his own needs but trying to help others deal with their Social Determinants of Health. His work puts him in contact with residents throughout Passaic County, many of whom are dealing with some of the same issues Luis was trying to navigate just a few months ago. His daily activities include reaching out to potential new programs participants and following up with current members during the day. He checks to see if there is interest in joining Horizon Neighbors in Health, what immediate needs must be met and if they are being met.

It’s an instance of the Horizon Neighbors in Health program coming full circle, with someone who benefited from the outreach of a CHW now looking to pay it forward as CHW themselves.

What does Luis recommend someone do if they get the same call he got from a CHW?

“Take the opportunity,” said Luis. “It’s reliable and it could change your life.”

*At the request of the Community Health Worker, we have changed his name to protect his privacy.
Goals for 2021

Enhanced community engagement focused on preventive and chronic care management

COVID 19 and vaccine education

Collaboration with CBO’s and NJ’s Department of Health addressing health disparities to support long-term health outcomes

Program expansion (potential areas of growth include Bergen and Atlantic Counties and additional counties in South Jersey)

Increased Provider engagement, including resources, training and education to address SDOH barriers to support their patients

Ongoing trainings for CHW’s to refine and enhance expertise to respond to the needs of the community

Increase enrollment to ensure our members in need have the necessary resources to thrive and improve their overall health.