HEALTH PERFORMANCE ACCELERATOR by HMA | HealthEC

Webinar Series

Session 1:

Achieving Health Equity for Disadvantaged Populations

HMA - HealthEC Collaboration

Opportunity

Workgroups comprised of subject matter experts from HMA and HealthEC met over several months in 2019 to discuss ways in which **healthcare consulting and advisory services** such as those offered by HMA and **population health management (PHM) and analytics applications** such as those offered by HealthEC could be leveraged more effectively by government agencies, healthcare providers, and payers to address critical needs in select

Focus Areas

1. Health Equity

2. Communicable Disease Outbreak Management

3. Opioids Program Supports

4. Supports to Small/Midsize Health Plans

5. VBP Contract Supports

6. MCO/ACO Performance Management

7. HHS Service and Data Integration

Outputs

Health Performance Accelerator™

Tailored consulting and advisory services that can be coupled with tailored PHM and analytics platform deployments

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Today's Speakers

Jenifer Leaf Jaeger, MD, MPH

Senior Medical Director - HealthEC

Desmond Banks, PhD, MPH

Senior Consultant - HMA

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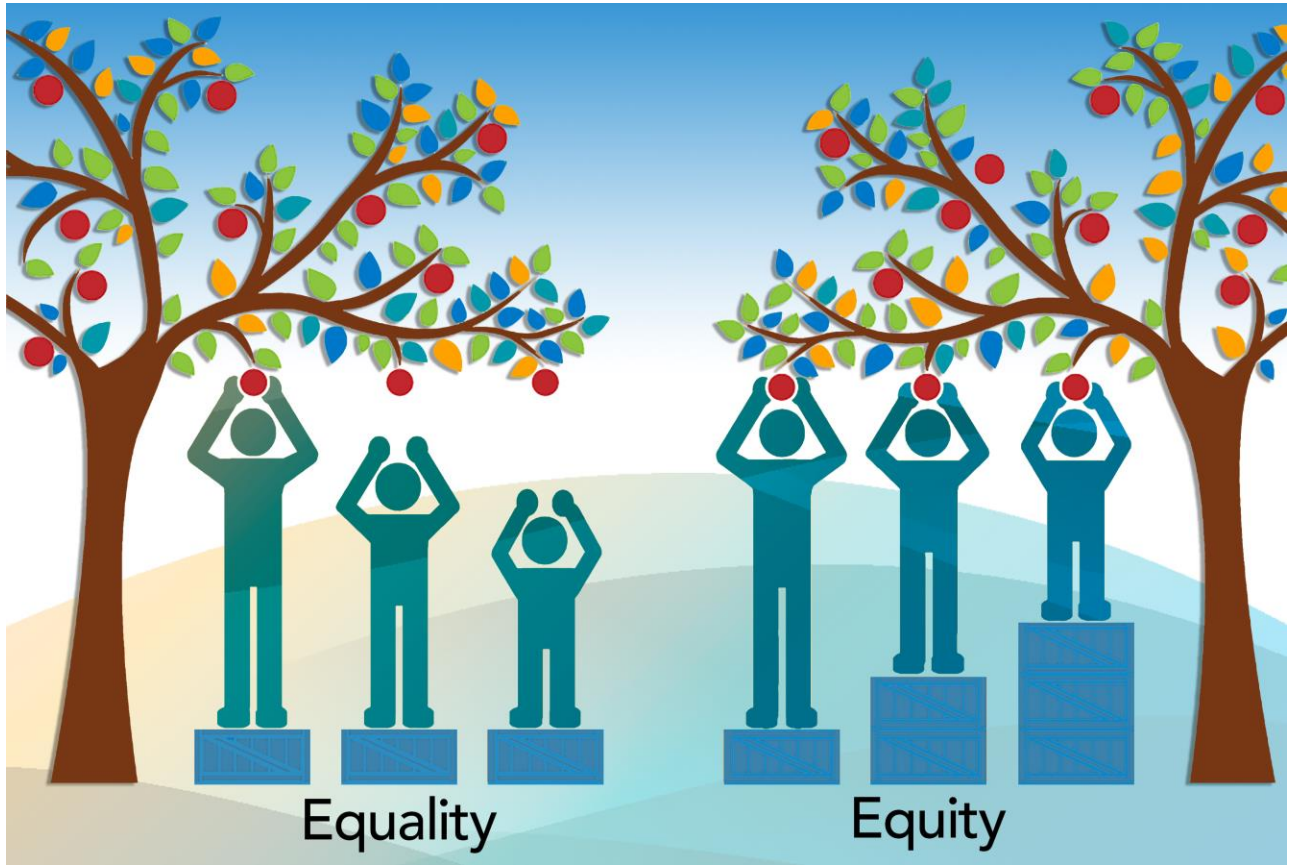
What is Health Equity



Health equity refers to the condition in which everyone has a fair and just opportunity to be as healthy as possible. *(RWJF, 2017)*

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Why Health Equity Matters

Gaps in health and healthcare nationwide are increasing and often related to disparities access and in the social determinants of health (SDOH)

US ranks 43rd in the world on average life expectancy at birth

Critical to identify and measure health-related outcome indicators to assess progress in reducing barriers to health and closing gaps in health outcomes

Impact of Health Equity

- Health disparities cost the U.S. ~$60 billion in excess medical costs and ~$22 billion in lost productivity in 2009
- COVID-19 response – vulnerable individuals, patients with chronic conditions, and persons facing economic, housing, insurance and food insecurity issues are disproportionately impacted

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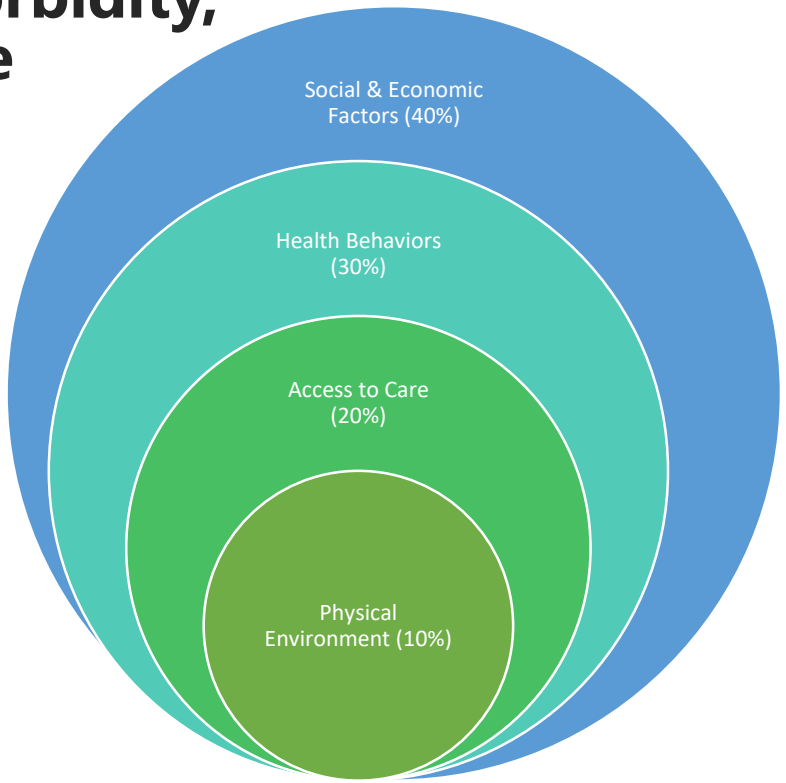
Measuring Health Disparities

- Gaps in health and healthcare are related to access and the social determinants of health (SDOH)
  - **Result in preventable morbidity, mortality and health care expenditures**
- Identify and measure health-related outcome indicators to assess progress in reducing barriers to health and closing gaps in health outcomes



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Aggregating Data from the Healthcare Ecosystem

Data from ANY SYSTEM

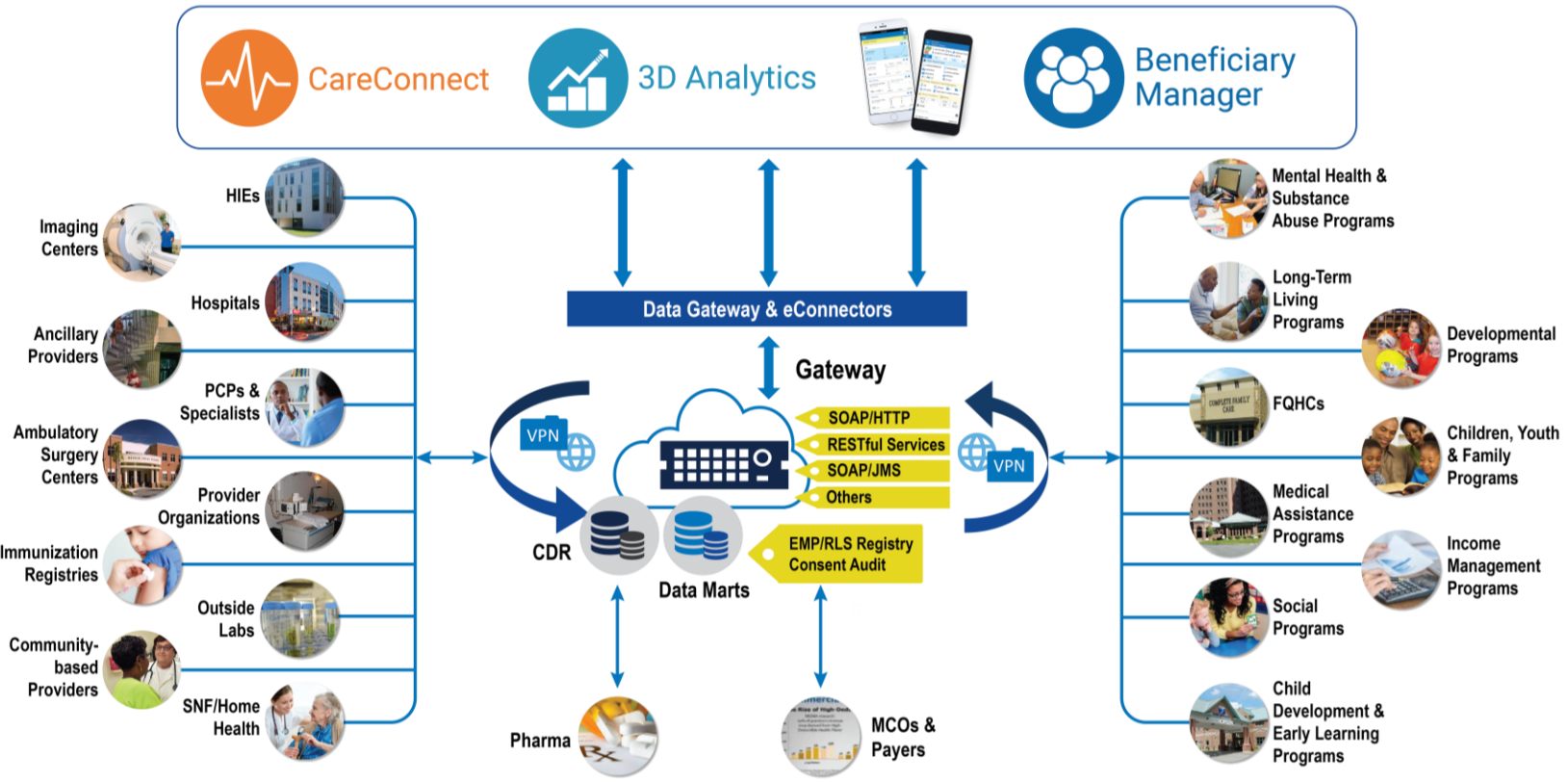
- ✓ EMRs/EHRs (200+ adapters live)
- ✓ Patient scheduling
- ✓ Laboratory
- ✓ Pharmacy benefits manager
- ✓ Claims and remittance, payer adjudication, MMIS
- ✓ Data warehouses
- ✓ Registries and local and regional HIEs

Data from ANY CARE SETTING

- ✓ Hospital (IP, OP, ER), ambulatory, and post-acute care (rehab, SNF)
- ✓ Behavioral health
- ✓ Home health
- ✓ Case management/care coordination
- ✓ County and state clinics
- ✓ Pharmacies and reference labs

Data in ANY FORMAT

- ✓ CCD/A, CCR
- ✓ EDI 837, 835
- ✓ HL7 ADT, ORU, ORM, FHIR
- ✓ Proprietary files
- ✓ CCLF, NCPDP, SQL statements
- ✓ Any protocol: Web service, batch, API, etc.



- Life Circumstance Data
  - Demographic and Socio-Economic Variables
  - Consumer Residential Profiling Variables
  - Lifestyle and Engagement Group Variables
  - -- Ethnicity and Language Variables
  - -- Household Unit Profiling Variables

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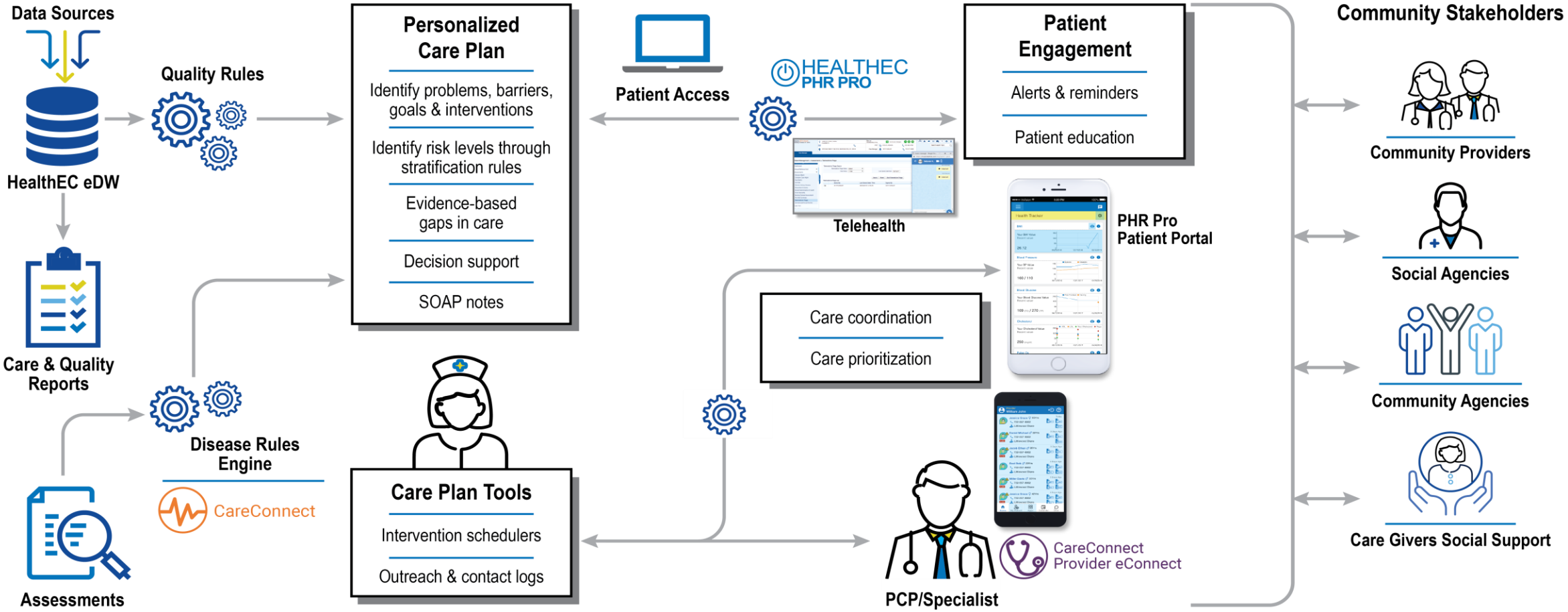
Community Health Record



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Leveraging Data to Support Health Equity Initiatives

PRAPARE tool – SDOH needs survey

MMIS for State Medicaid populations

- Medicaid and CHIP enrollment and claims data, TANF

Food and Nutrition Service, USAD

- WIC, SNAP, Emergency Food Assistance, etc.

State and local housing authorities; Food Deserts; Heat Islands

State HIEs – ADTs

Claims – cost and utilization

- By condition, demographics including zip code

EMRs – clinical data, e.g., BMI

State Prescription Monitoring Programs

PBM, Surescripts – track refills, adherence, etc.

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Executing SDOH Strategy

Chronic Care Management

Intelligent Analytics

Utilization

Network Efficiency

Case Study: Prince George's County Health Department

- 3500 patient care coordination pilot
- 2015 to 2018
- Enrolled 492 high risk clients
- Completed over 13,500 client contacts (phone, in-person, etc.)
- Created 2,800 pathways with Over 100 outreach events
- Conducted disease self-management and health literacy seminars
- Documented in HealthEC, tracked and measured outcomes

HEALTH DEPARTMENT
Prince George's County

Results

"This contributed to a **21% reduction in hospital and** emergency department visits for two local hospitals, and a **17% reduction in healthcare costs** for the high-risk patients receiving our care coordination services."

—Dr. Ernst Carter

6 Months Pre/Post

Hospital Utilization Volume

VOLUME	6 mo pre-	6 mo post-
ED Visits	241	223
Admissions	238	156
Obs Stays	61	43
Hospital Utilization	**540**	**422**

21.9% reduction in overall hospital utilization

Hospital Utilization Costs

CLAIM PAYMENTS	6 mo pre-	6 mo post-
ED Visits	$122,828	$120,727
Admissions	$2,814,199	$2,350,541
Obs Stays	$216,162	$140,040
Hospital Utilization	**$3,153,189**	**$2,611,307**

17.2% reduction in overall hospital utilization costs

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Upcoming Webinars

Communicable Disease Outbreak Management

Thursday 9/3

Managed Care Organization (MCO)/Accountable Care Organization (ACO) Performance Management

Tuesday 9/8

Supports to Small/Midsize Health Plans

Thursday 9/10

Value-Based Payment (VBP) Contract Supports

Tuesday 9/15

Opioids Program Supports

Thursday 9/17

Health & Human Services (HHS) Service and Data Integration

Tuesday 9/22

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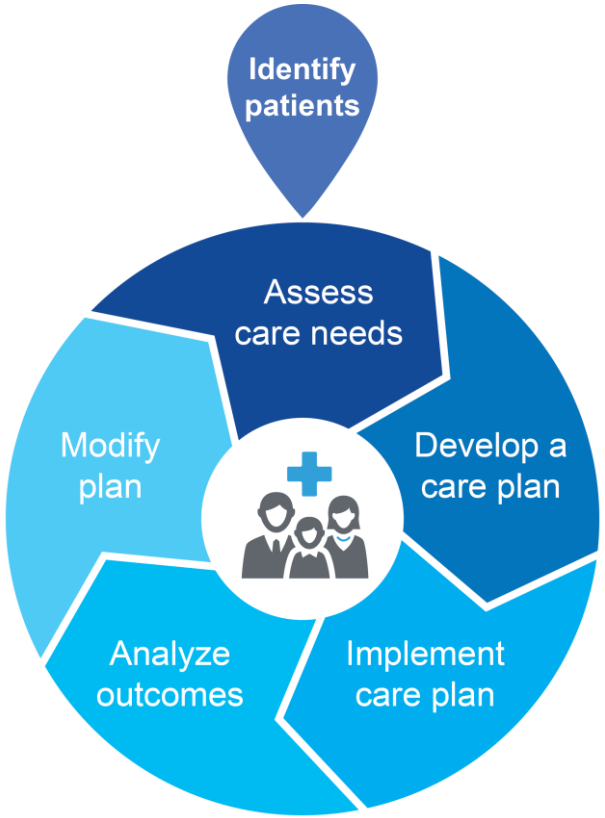
Community Based Services



ZIP CODE SPECIFIC

Other Community-type Organizations

FreeRehabCenters.org

HSD Helping the Needy

HOMELESSSHELTERDIRECTORY
Helping The Needy of America

goodmap

COMMUNITY COMMONS

purplebinder

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Platform Adaptability to Various Market Segments

Health Plans	HHS – States	IDNs and CINs	Value-based Contracts
Data Aggregation and Universal Data Warehouse	Data Aggregation and Universal Data Warehouse	Data Aggregation and Universal Data Warehouse	Quality Reporting
VBC Support and Performance Monitoring	MCO Performance Monitoring	VBC Support and Performance Monitoring	Utilization and Financial Performance Monitoring
Provider Engagement	Claims Analytics	Provider Engagement	Care Management and Coordination
Quality and Risk Reporting	Quality Reporting (Quality Improvement Program)	Quality Reporting	Provider Engagement

Priority

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