

ACHIEVING HEALTH EQUITY FOR DISADVANTAGED POPULATIONS

Improve the health and well-being of disadvantaged populations through tailored programs and data-based interventions



A growing understanding of how race has correlated historically to healthcare access and outcomes has led to an unprecedented focus on health equity, with the goal of acquiring, aggregating, and analyzing data on social determinants of health (SDOH) to help identify and address the root causes of health disparities. At this critical juncture, the Health Management Associates (HMA) and HealthEC Health Performance Accelerator (HPA) solution set can be deployed by states, health plans, and providers to fast-track the design, development, and implementation of effective health equity initiatives.

THE CHALLENGE

State Medicaid Agencies (SMA), health plans, and providers are constantly working to ensure the health and well-being of disadvantaged populations. Systemic disparities in education, employment, income, housing, transportation, and other SDOH have contributed to inequities in healthcare access, outcomes, and overall health status. These disparities have resulted in preventable morbidity, mortality, and healthcare expenditures with the differential impact of the COVID-19 pandemic on Blacks and Hispanics is evidence of this. Additionally,

- » Gaps in health and healthcare nationwide are increasing and are often related to disparities in access and in the SDOH
- » It is critical to identify and measure health-related outcome indicators to assess progress in reducing barriers to health and closing gaps in health outcomes

THE SOLUTIONS

The HPA solutions are designed to help SMAs, health plans, and providers focus on health equity and ensure they can achieve, sustain, and monitor improved health outcomes among vulnerable populations.



10%	Physical Environment
20%	Access to Care
30%	Health Behaviors
40%	Social & Economic Factors

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KEY SOLUTION FEATURES

HMA solution features:

- » Support the development and implementation of health equity initiatives – specific outreach and education, prevention and wellness, care management, and monitoring, and evaluation interventions designed to close health disparities
- » Support of care/case management teams in process redesign and improvements
- » Develop socially- and culturally relevant and demographic-specific health needs assessments
- » Analysis of provider access and network adequacy issues
- » Development and delivery of provider training that addresses these issues
- » Support to implement telehealth, provider reimbursement innovations and other initiatives designed to close provider network “gaps” for disadvantaged populations
- » Perform rapid-cycle interventions aimed at addressing public health emergencies
- » Assess the readiness of states, health plans, and providers to address concerns over the impact of health equity on the morbidity and mortality of disadvantaged populations

HealthEC solution features:

- » Support the acquisition, aggregation, and analysis of SDOH and health outcomes data to conduct root-cause analysis on health disparities
- » Automate intervention outreach to appropriate community-based organizations to fulfill services needs
- » Identify and measure health-related outcome indicators to assess progress in reducing barriers to health and closing gaps in health outcomes

PROVEN RESULTS

HMA assisted a large county that addressed SDOH and used disease-based assessment tools to identify barriers and expedite access to resources with the following results:

- » A 21.9% reduction in overall hospital and emergency department utilization
- » A 17% reduction in healthcare costs of high-risk patients receiving care coordination services
- » For 102 patients tracked between 2017 and 2018 over a 12-month period, the in-patient cost savings were more than \$400,000.

A large practice alliance of community-based health providers using integrated care management and SDOH referral utilized HealthEC’s platform to integrate care and health data from assessments, multiple physicians, and community-based organizations to drive care management and analytics activities. Some noteworthy results include:

- » A 45% improvement in completed health risk assessments (HRA)
- » A 41% improvement in completed health risk screenings (HRS)
- » A 39% improvement in completed client care plans
- » A 32% improvement in completed care transitions

HMA worked with a state human services department and the disability policy consortium to analyze the root causes of health disparities among Medicaid populations and provided recommendations on how to achieve health equity.