UNDERSTANDING YOUR POPULATION

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DHCF
Department of Health Care Finance

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INTRODUCTION

- Value-Based Purchasing (VBP) is an approach that ties payment to the quality and efficiency of healthcare services delivered.
- This resource emphasizes the importance of understanding a patient population for successful VBP and provides foundational understanding of the key considerations in population assessment.

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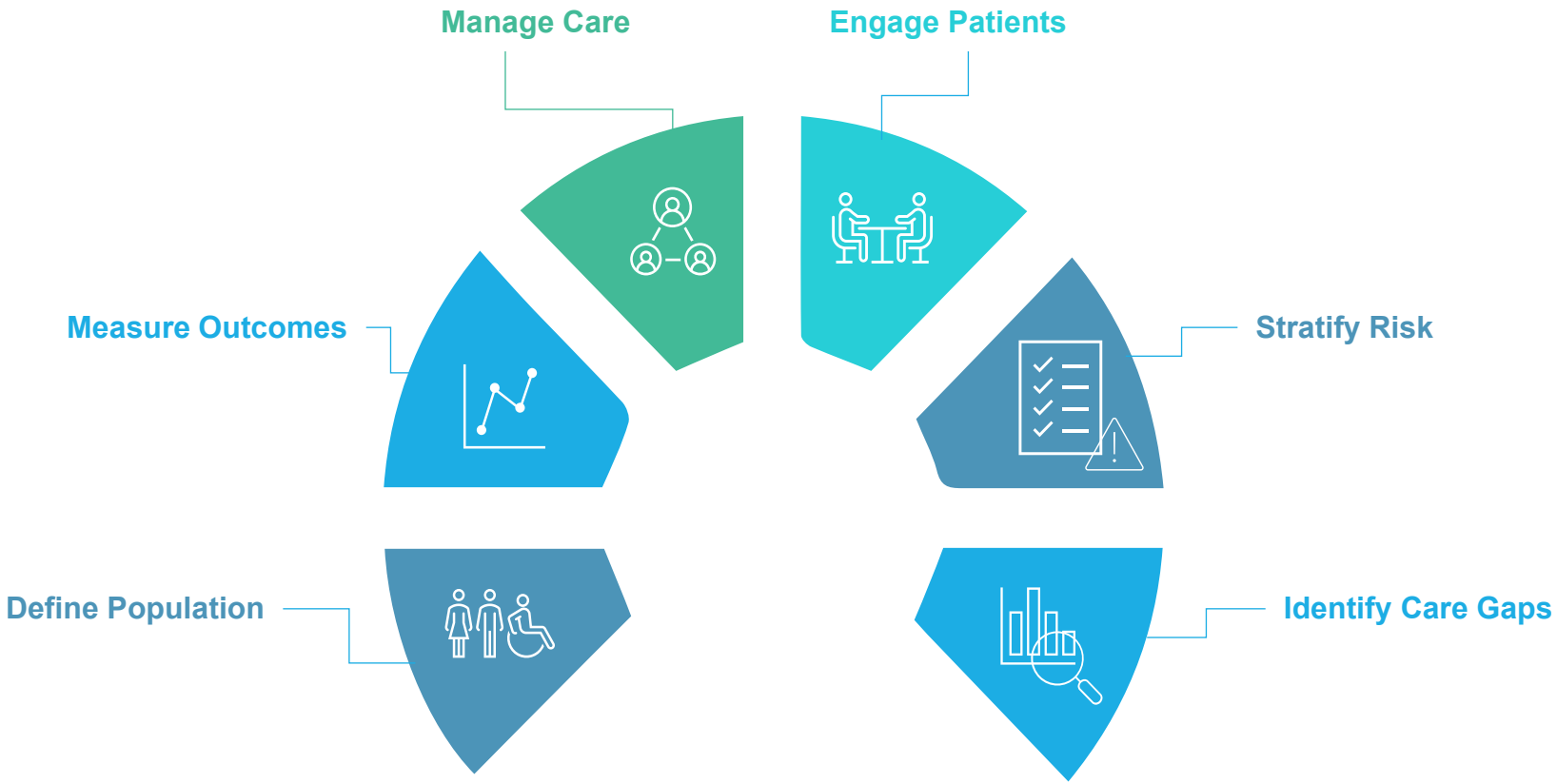
UNDERSTANDING YOUR POPULATION

Healthcare at a macro level involves a variety of determinants.

Understanding your population must go beyond clinical and claim data.

Data analysis can assist in providing an understanding of your population, favorable and unfavorable outcome performance, disparities, and areas of necessary focus.



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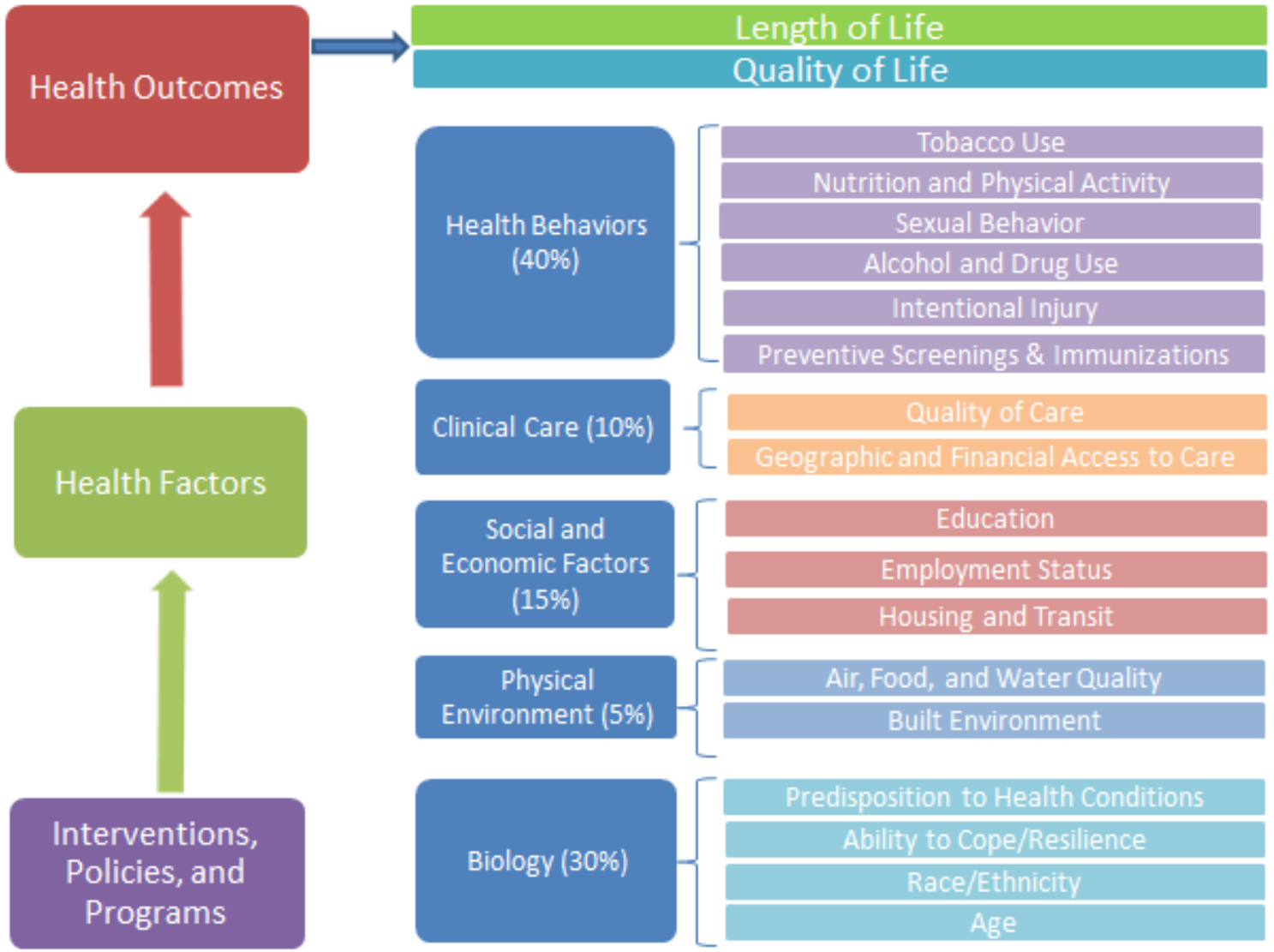
UNDERSTANDING YOUR POPULATION

Understanding your population is important because evidence suggests that health care is responsible for only about 10% of health status.

Biology, genetics, and race influence which health conditions a person is predisposed to, and ability to cope and resilience to threats to health account for about 30% of health outcomes.

The remaining 60% of health is attributable to the social and physical environment in which a person lives.



SOCIAL DETERMINANTS OF HEALTH IMPACT EVERYONE

Social determinants of health (SDOH) are the complex circumstances in which individuals are born and live that impact their health.

- They include **intangible factors** such as political, socioeconomic, and cultural constructs, as well as **place-based conditions** including accessible healthcare and education systems, safe environmental conditions, well-designed neighborhoods, and availability of healthful food.

"*The conditions in which people are born, grow, live, work and age*."

World Health Organization definition [1]

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HEALTH-RELATED SOCIAL NEEDS

Health-related social needs (HRSN) are the unmet and adverse social conditions that contribute to poor health and are the result of underlying social determinates of health

- They include factors such as housing instability, homelessness, nutrition insecurity, lack of reliable transportation, safety, affordable utilities, and more.

HRSN are associates with higher chronic disease prevalence and healthcare utilization

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HEALTH RELATED SOCIAL NEEDS VS. SOCIAL DETERMINATES OF HEALTH

Health Related Social Needs

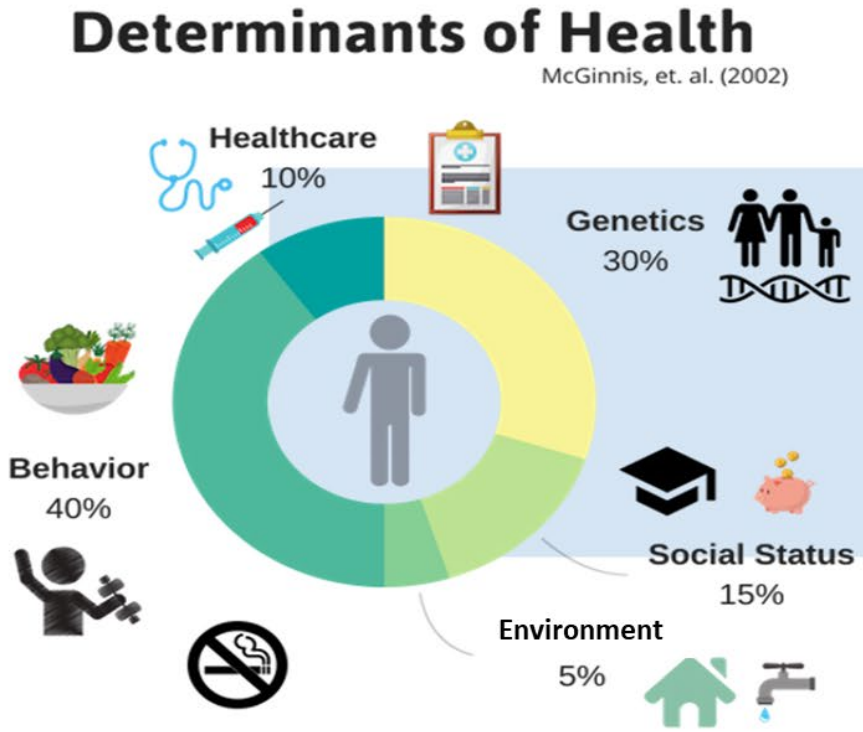
- Refers to the social and economic needs people experience that affect the ability to maintain health and well-being
  - Housing instability or quality
  - Food insecurity
  - Employment
  - Safety
  - Transportation
- HRSN are immediate and personal needs because of SDOH
- HRSN need interventions that address needs in real-time

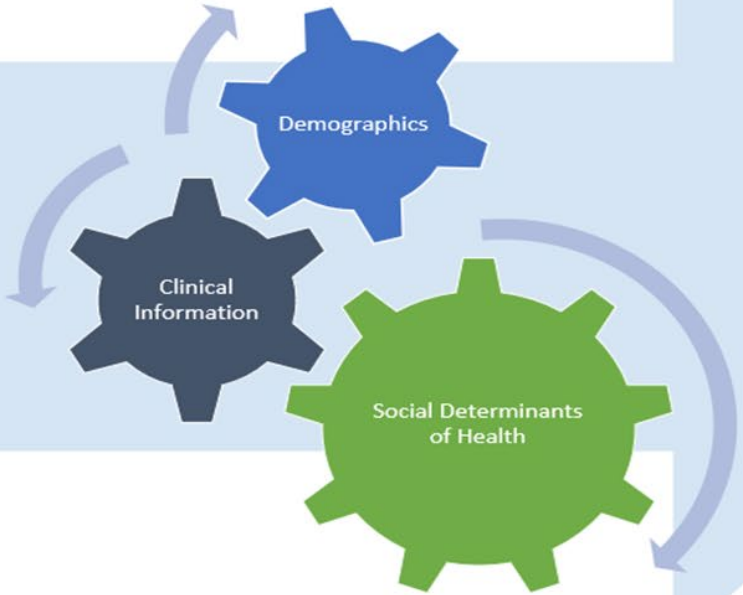
Social Determinates of Health

- Refers to the conditions in which people are born, grow, work, live, and age
  - Shaped by money, power, and resources
  - Impacted by factors such as institutional bias, discrimination, racism, and more
- SDOH is a neutral frame for evaluating how health is shaped
- SDOH need policy solutions

SCREENING FOR NON-MEDICAL DRIVERS OF HEALTH (SOCIAL DETERMINANTS)

Understanding SDOH allows providers to deliver quality care





HEALTH IS VARIABLE!

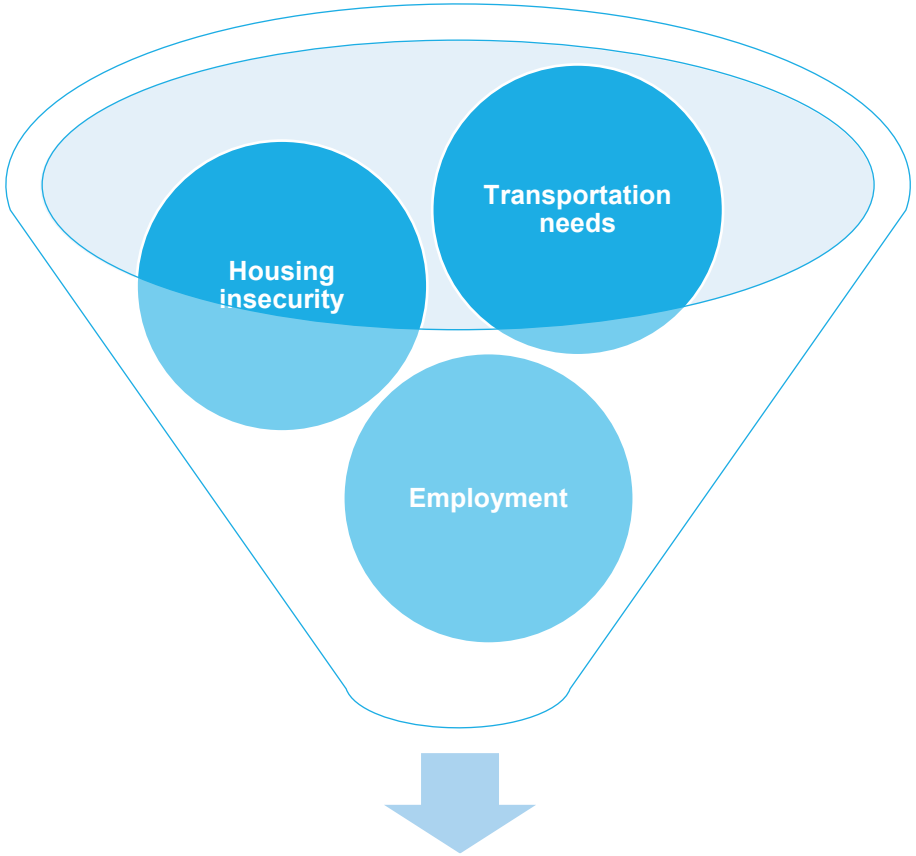
It is important to have a **full picture** of the patient in order to provide appropriate clinical care.

Demographics and clinical information alone do not provide the full picture

Patients may need support with several SDOH in order to achieve desired clinical results

MEMBERS MAY NEED SUPPORT WITH SEVERAL SDOH IN ORDER TO ACHIEVE DESIRED CLINICAL RESULTS

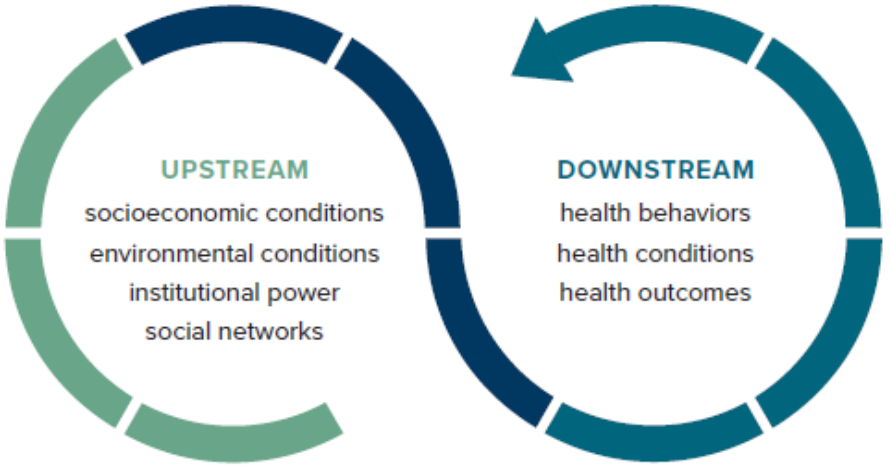
*Data and research indicates that the **SDOH have a higher impact on population health** than healthcare, and that a higher ratio of social service spending versus healthcare spending results in improved population health.*[3]



Data on SDOH equips providers to address complex member needs, including making appropriate referrals

WHY IS IT IMPORTANT TO ADDRESS SDOH?

- Organizations are accountable for improving health outcomes and lowering costs
- SDOH can encompass socioeconomic conditions, environmental conditions, institutional power, and social networks.



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SCREENING TOOLS FOR NON-MEDICAL DRIVERS OF HEALTH (SOCIAL DETERMINANTS)

PRAPARE [4]
Developed by the National Association of Community Health Centers
- 21 questions
- 5 domains

AHC-HRSN [5]
Developed by Centers for Medicare and Medicaid Services
- 10 questions
- 5 domains

The People's Tool [6]
Developed by The People's Health Center in Austin, Texas
- 8 questions
- 5 domains

Social Needs Screening Tool[7]
Developed by AAFP
15 questions
5 domains

Psychosocial Assessment

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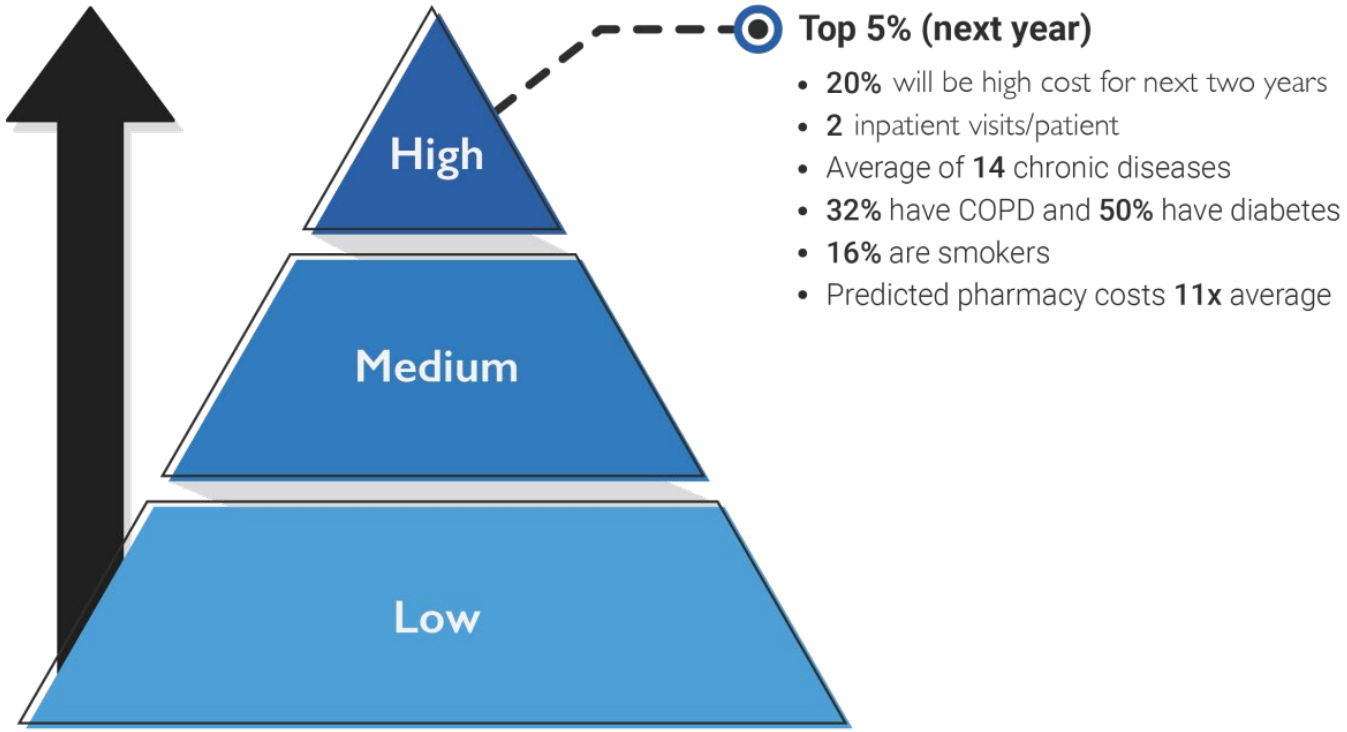
RISK STRATIFICATION: ADJUSTED CLINICAL GROUPS (ACG)

The Adjusted Clinical Groups (ACG) model is a patient classification system that groups people according to their age, sex and medical conditions, these people have a similar consumption of health resources over a given period of time.



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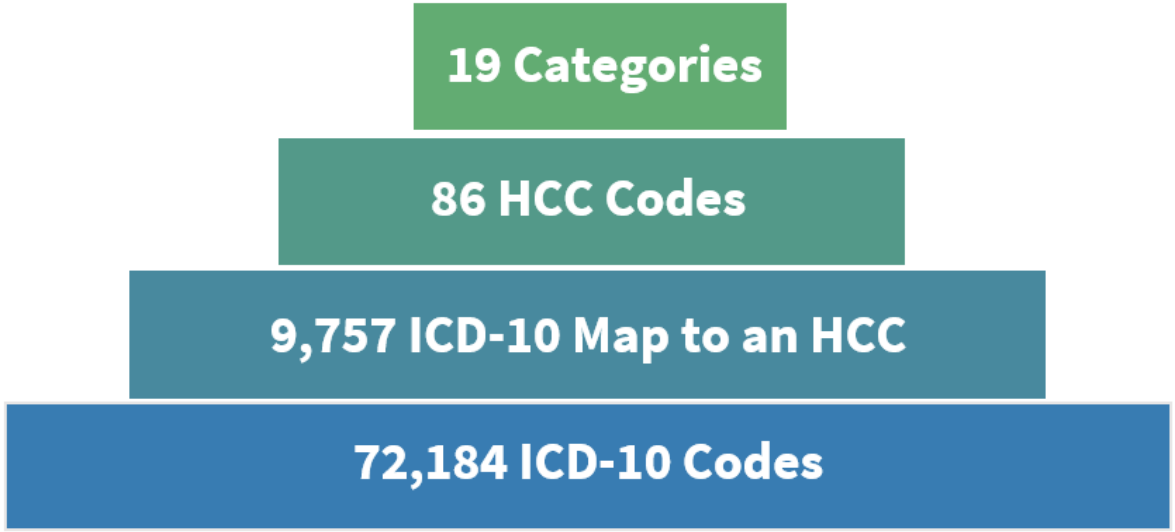
RISK STRATIFICATION: HIERARCHAL CONDITION CATEGORIES (HCC)

Hierarchal Condition Categories (HCCs) play a crucial role in predicting healthcare costs and adjusting payments in the industry through risk adjustment coding.

HCCs are sets of medical codes linked to specific clinical diagnoses used by the Centers for Medicare and Medicaid Services (CMS) to identify individuals with serious acute or chronic conditions.

HCCs are assigned to patients based on their medical conditions and demographics, and accurate risk coding is essential for their success.



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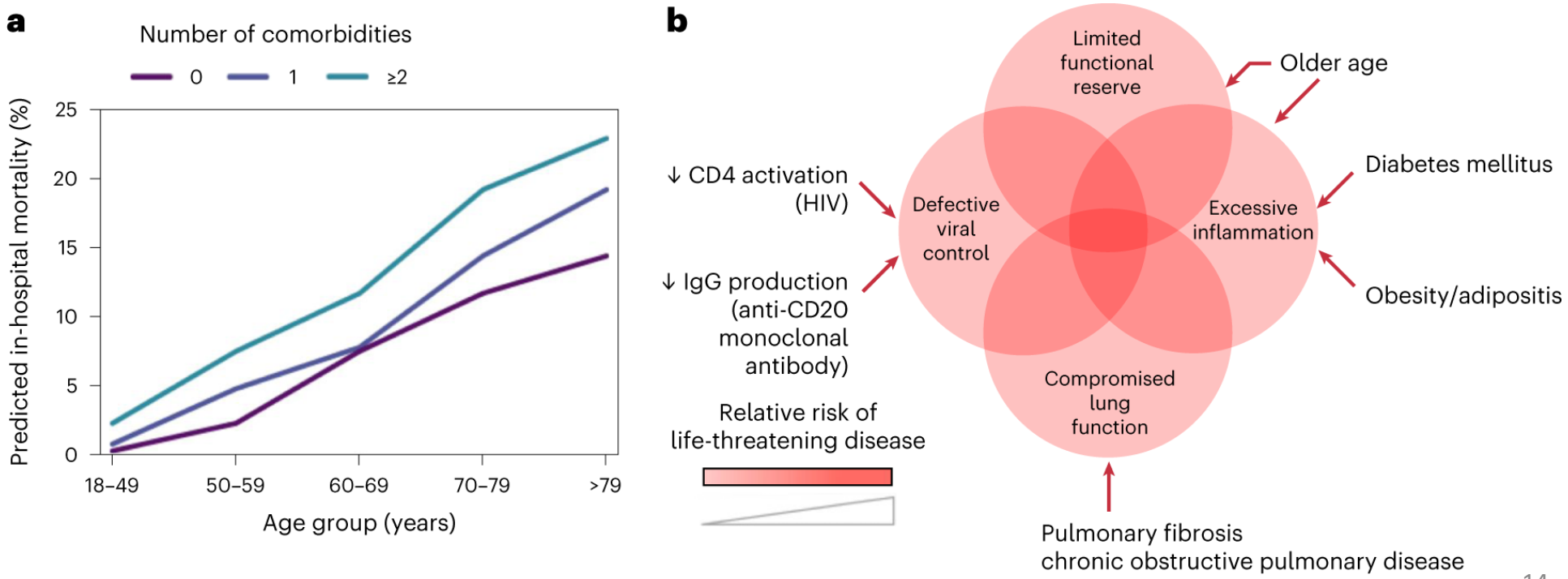
RISK STRATIFICATION: CHRONIC COMORBIDITY COUNT (CCC)

Based on the publicly available information from Agency for Healthcare Research and Quality (AHRQ)'s Clinical Classification Software, Chronic Comorbidity Count (CCC) is the total sum of selected comorbid conditions grouped into six categories.



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CLOSED LOOP REFERRAL SYSTEM HELPS TRACK NON-MEDICAL RESOURCES

What are they?

- A closed-loop referral is one that successfully secures the right resources for patients at the right time, ensuring that the patients' needs are met.

How do they work?

- The "closed-loop referral" is a tech-enabled workflow that provides this real-time view of the status of the patient, while also exchanging data amongst the team, assigning tasks, and reporting on outcomes.

How is the loop actually closed?

- Far beyond confirming the appointment was attended, a closed-loop referral includes workflow steps that help the care team to understand the outcome and, more importantly, any required next steps beyond the referral itself.

PULSE CHECK AND QUESTIONS TO CONSIDER

- Do you screen for health-related social needs? If so, what do you do with this information?
- Do you use a risk stratification tool to assess factors beyond utilization that incorporates health related social needs?
- Do you use a closed loop referral system to refer clients to social services and other services (e.g., housing, transportation, food, childcare)?
- How do you use this understanding to think about cost of care?

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MINI SELF ASSESSMENT

Photo by Glenn Carstens-Peters on Unsplash

Knowledge	1	2	3	4	5	6	7	8	9	10
Comfortability	1	2	3	4	5	6	7	8	9	10
Confidence	1	2	3	4	5	6	7	8	9	10

Reflect & Connect:

What do you think your organization may look like 5 -10 years from now if you incorporate and build upon these concepts?

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HMA

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