How ACOs Can Harness the Power of Social Determinants of Health

LexisNexis® RISK SOLUTIONS | Health Care

Only the strong will survive

Accountable Care Organizations (ACO) come in all shapes and sizes, yet they share one commonality: The need to adapt in a new era of downside financial risk. It's not only about generating shared savings—it's also about avoiding financial loss and expanding access to care. ACOs that survive and thrive in the era of new and changing government rulings will be those that intervene as early as possible to keep at-risk patients healthy and out of high-cost care settings.

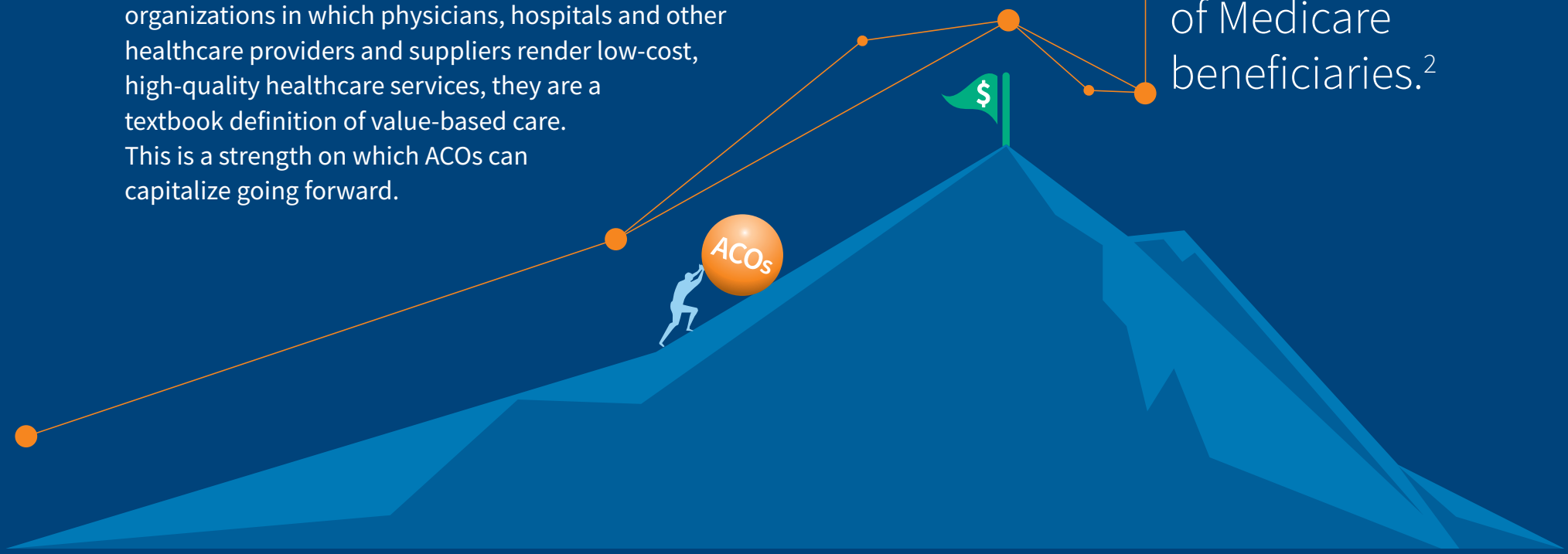
70% of track 1 ACOs may leave the MSSP as a result of having to assume more risk.[1]

Growing potential for bigger payoffs

Fortunately, with greater risk comes the potential for greater rewards. The Next Generation ACO model is a perfect example and it's often touted as a harbinger of what's to come for all ACOs. Those in the Next Generation model receive financial incentives for meeting quality expectations and spending less than pre-determined target amounts. However, Next Generation ACOs have the potential to earn a higher rate of savings than their counterparts in commercial models as well as those in the Pioneer ACO Model and the Medicare Shared Savings Program. One disadvantage? They're also subject to greater financial losses should they fail to meet spending and quality targets.

The good news is that ACOs are already ahead of the game because they possess a strong foundation of collaboration and cost containment. As patient-centered organizations in which physicians, hospitals and other healthcare providers and suppliers render low-cost, high-quality healthcare services, they are a textbook definition of value-based care. This is a strength on which ACOs can capitalize going forward.

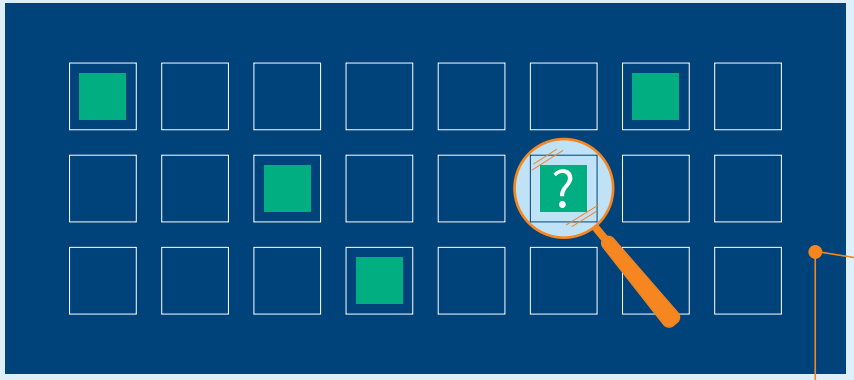
As of 2018, approximately 12.3 million Medicare beneficiaries are part of ACOs, representing over 20 percent of Medicare beneficiaries.[2]



Looking beyond clinical data

How can ACOs improve? They need to look beyond clinical data and pull from external data sources, when necessary, to understand *why* certain patients drive the bulk of healthcare costs and experience negative health outcomes. Identifying these at-risk populations from a clinical perspective is only part of the equation.

The next—and perhaps most critical step—is to look at a patient holistically to understand why they are experiencing negative health outcomes. *Why* is it harder for certain patients to manage their obesity? *Why* are certain patients with heart disease frequently readmitted to the hospital? *Why* do certain patients with diabetes frequently visit the ED?



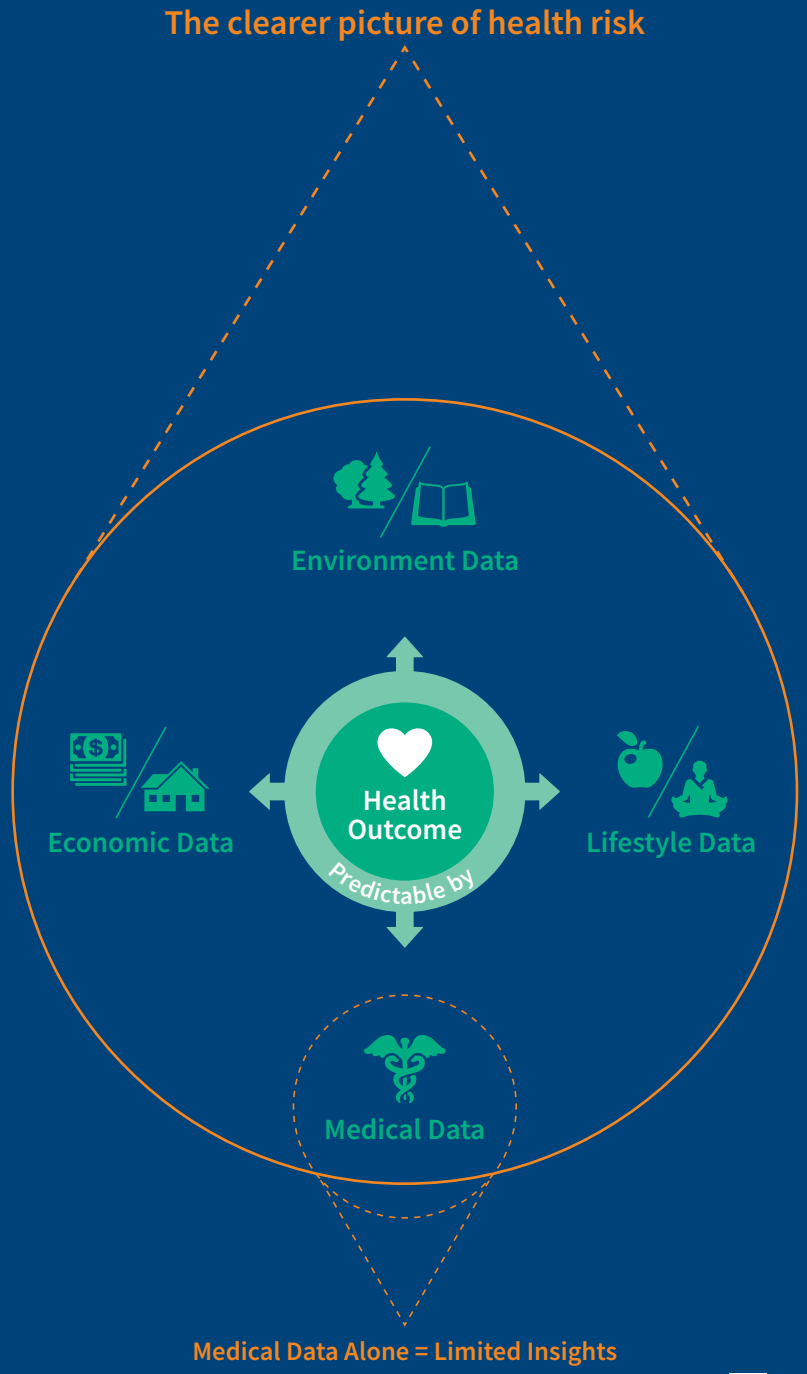
"Today's ACOs need to understand why certain patients drive the majority of their costs and poor outcomes. The 'why' is a complex question that can only be answered by layering robust analytics on top of social determinants of health data."

-Richard Morino, Director of Strategic Solutions at LexisNexis

A new approach to population health

When it comes to understanding why patients are at risk, medical care and current health status provide limited insights. Social determinants of health (SDOH), the economic and social conditions that influence individual and group differences in health status, are actually most important.

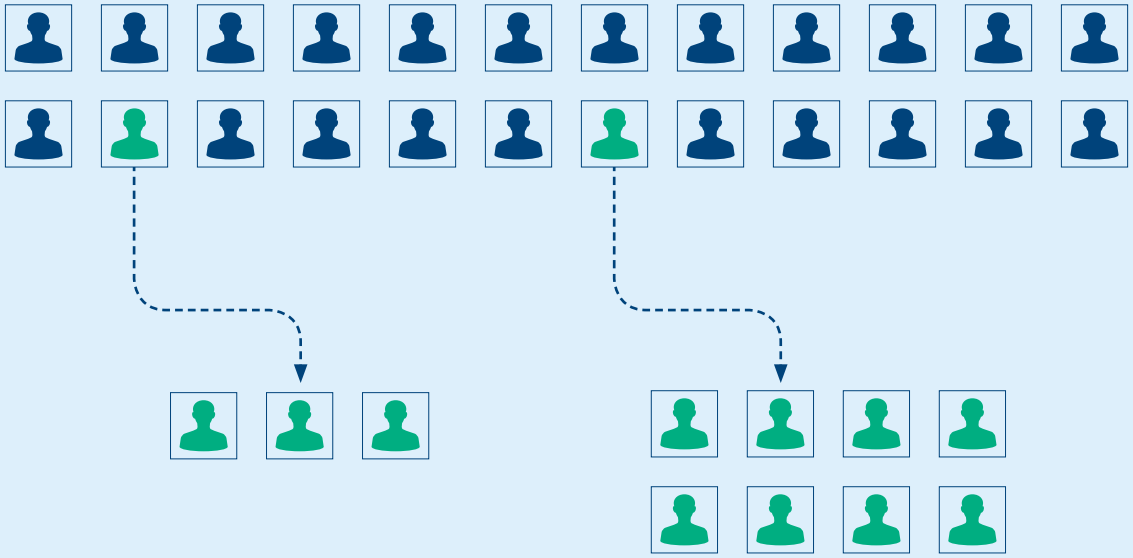
SDOH data gives providers a well-rounded view of a person's lifestyle, environment, situation and behaviors—many of which have been proven to correlate with health outcomes. Does the patient live in a food desert? Lack access to transportation? Are they socially isolated? Low income? Live in a high-crime neighborhood? All of this matters in terms of health outcomes. SDOH data doesn't replace the value of medical data—it serves as a supplemental data source to paint a clearer picture of health risk so clinical and social services can intervene immediately. What is also critical is looking at how those factors combined contribute to outcomes and readmissions risk.



Why SDOH data matters to ACOs

SDOH data enables ACOs to further segment at-risk populations into smaller subgroups with similar needs. This is more advantageous than using single disease-focused segments that fail to address the social determinants barriers that may prevent a patient from being able to achieve optimum health outcomes. By addressing social and economic barriers upstream, ACOs can:

- Allocate limited resources more effectively
- Predict health risk based on social determinants
- Take preventive measures to improve outcomes and reduce costs
- Treat the patient as a whole person and not just as a medical condition
- Partner with community care resources to fill in gaps in care
- Understand previously unknown barriers to health management



Eighty percent of ACOs reported using some type of population-based analytics solution in 2017, according to a poll by the National Association of ACOs and Leavitt Partners.[3]

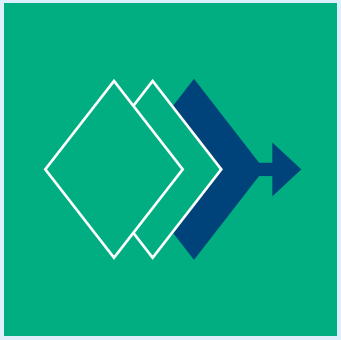
SDOH data access challenges

Access to SDOH data comes with its own set of unique challenges. ACOs typically rely on health risk assessments as well as basic demographic information, survey results and other data within the EHR to glean social and economic insights. This data alone has limited potential for improving outcomes. Here are three reasons why:

1. Demographic data becomes outdated very quickly.
2. EHR data may be stored in an unstructured format, making it difficult to incorporate into data analytics efforts.
3. Survey data is not comprehensive, as surveys are limited in length and scope.

Instead, ACOs need a data source of comprehensive SDOH data that is:

Based on reliable sources such as public records that is **continually refreshed and standardized.**



Layered with analytics to make the **data actionable**.

Inclusive of data that has been clinically validated to **predict healthcare outcomes**.

Partnering with a third-party vendor to access this depth and breadth of data becomes critical and it's why many ACOs have already begun to ramp up data-driven population health efforts.

Viewing patients holistically using SDOH data

What does this type of data-driven effort entail? It requires ACOs to view each patient holistically across four categories of social determinants:

- Economic stability (assets, income, professional licenses and financial health)
- Education (level, quality and area of study)
- Neighborhood and built environment (household demographics, housing types and crime and income indices)
- Social and community context (accidents, crimes, weapons and sporting licenses, voter registration and relatives/associates)

Providers can't draw conclusions from each of these attributes in isolation. Instead, they must be able to quickly consider hundreds of attributes when determining an individual's health risks. They must also be able to layer analytics on top of these attributes to gain insights. For example, a patient might be considered high-income, but what if they also live in a high-crime area or lack access to transportation? These factors affect health risk and outcomes.

Medical care determines only 20 percent of overall health while social, economic and environmental factors determine 50 percent of overall health.[4]

Putting SDOH data to work

SDOH data provides critical insight into healthcare utilization and spending, even risk of hospital readmissions that can impact Medicare reimbursement rates and Star ratings. SDOH data can also help ACOs prepare for important changes to the CMS Quality Payment Program (QPP) in 2019, particularly an increase in the weighting of the MIPS cost category to 15 percent (up from 10 percent in 2018).[5]

ACOs can correlate spending trends with SDOH data to most efficiently allocate care resources and contain unnecessary spending. They can also correlate utilization data (e.g., ED visits and acute care hospital days per 1,000 beneficiaries) with SDOH data to understand why certain patients access high-cost services and steer these patients toward lower-cost settings.

Consider these three examples:

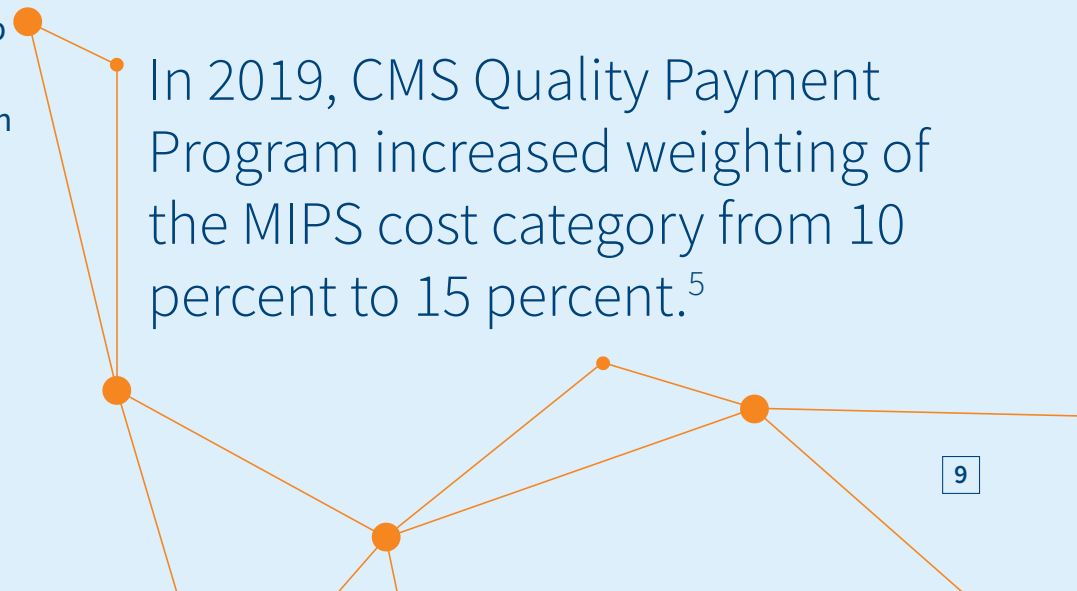
1. An ACO notices an uptick in spending for patients with heart disease. SDOH data (e.g., relatives, associates and zip code) helps the ACO identify patients who may be socially isolated so it can proactively connect these individuals with community resources to provide social support.

2. An ACO sees an increase in its ED visits for diabetic patients. SDOH data (e.g., income and education level) helps the ACO identify patients who may benefit from care coordinators who provide ongoing education and support to ensure these individuals take their insulin properly.

3. An ACO decides to target obesity in an effort to improve health outcomes. SDOH data (e.g., income, crime index and address) helps the ACO identify patients who may benefit from nutritional counseling and access to healthy food options.

Of course, none of these interventions would be possible without having accurate patient contact information, including address, phone number and email address. Accurate contact information also enables ACOs to remind patients of preventive services (e.g., annual wellness visits) that can ultimately drive down costs and improve outcomes.

In 2019, CMS Quality Payment Program increased weighting of the MIPS cost category from 10 percent to 15 percent.[5]



SDOH data and the clinical workflow

ACOs can use SDOH data at the point of care to alert physicians to contact care coordinators immediately. They can also use this data to prompt other types of providers (e.g., care coordinators, health coaches or social workers) to ask questions that dig more deeply into potential risk factors, connect patients with social services and provide support in a variety of other ways—all with the goal of keeping patients healthy.

Conclusion

To ensure success under value-based payment models, ACOs must look beyond clinical data and dig more deeply into SDOH data that continues to account for the majority of health outcomes. SDOH data has the potential to revolutionize preventive care and the ability for ACOs to intervene as early in the patient care journey as possible. ACOs are at the forefront of the move to value-based care. How they harness and leverage data to mitigate risk and better care for patient populations could be a game changer for all provider organizations in the future.

To learn more about how this data can help ACOs mitigate financial risk by optimizing health outcomes, call 866.396.7703 or visit **risk.lexisnexis.com/healthcare**

LexisNexis® RISK SOLUTIONS | Health Care

About LexisNexis® Risk Solutions

LexisNexis Risk Solutions harnesses the power of data and advanced analytics to provide insights that help businesses and governmental entities reduce risk and improve decisions to benefit people around the globe. We provide data and technology solutions for a wide range of industries including insurance, financial services, healthcare and government. Headquartered in metro Atlanta, Georgia, we have offices throughout the world and are part of RELX (LSE: REL/NYSE: RELX), a global provider of information and analytics for professional and business customers across industries. For more information, please visit www.risk.lexisnexis.com and www.relx.com.

Our healthcare solutions combine proprietary analytics, science and technology with the industry's leading sources of provider, member, claims and public records information to improve cost savings, health outcomes, data quality and compliance and minimize exposure to fraud, waste and abuse.

---

[1] https://www.naacos.com/press-release-may-2-2018

[2] https://www.naacos.com/overview-of-the-2018-medicare-aco-class

[3] https://www.beckershospitalreview.com/accountable-care-organizations/your-aco-just-took-on-downside-risk-what-s-your-data-strategy.html

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863696/

[5] https://www.federalregister.gov/documents/2018/11/23/2018-24170/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions