Whole Person Index:

CL2.0 leads mitigation of clinical and financial risk, resulting in improved outcomes at a lower cost- FOR ALL!

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fact

health inequity is both a humanitarian and an economic crisis

- health inequity costs $320 billion today and if we do nothing, it will cost us $1 trillion by 2040
- more than 45% of consumers across all coverage types have some unmet basic need
- 90% of the nation's $3.8 trillion per year healthcare costs is attributed to people with chronic diseases and mental health conditions
- >90% of type 2 diabetes, 80% of CAD, 70% of stroke, and 70% of colon cancer are potentially preventable by (nonsmoking, healthy weight, moderate physical activity, healthy diet, and moderate alcohol consumption)

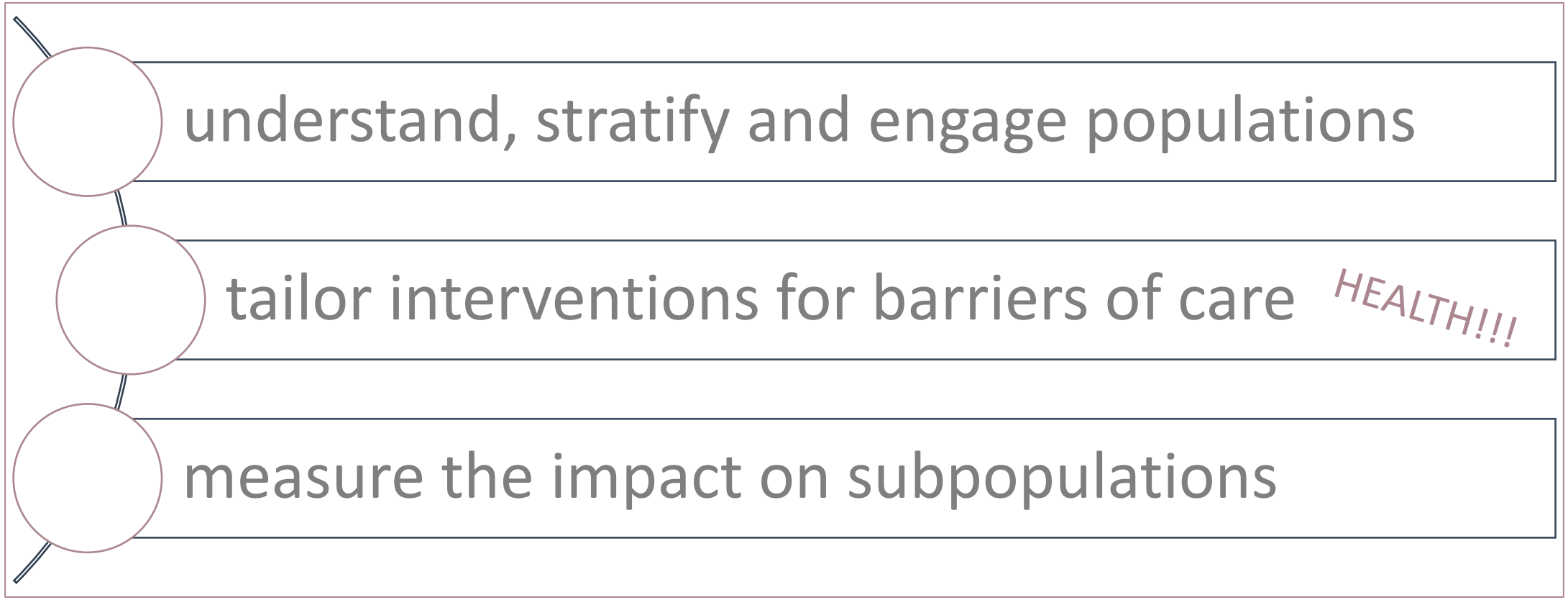
chronic disease is a health equity problem

Better Health is Good Business

building the business model in 3 steps

Veeneta Lakhani

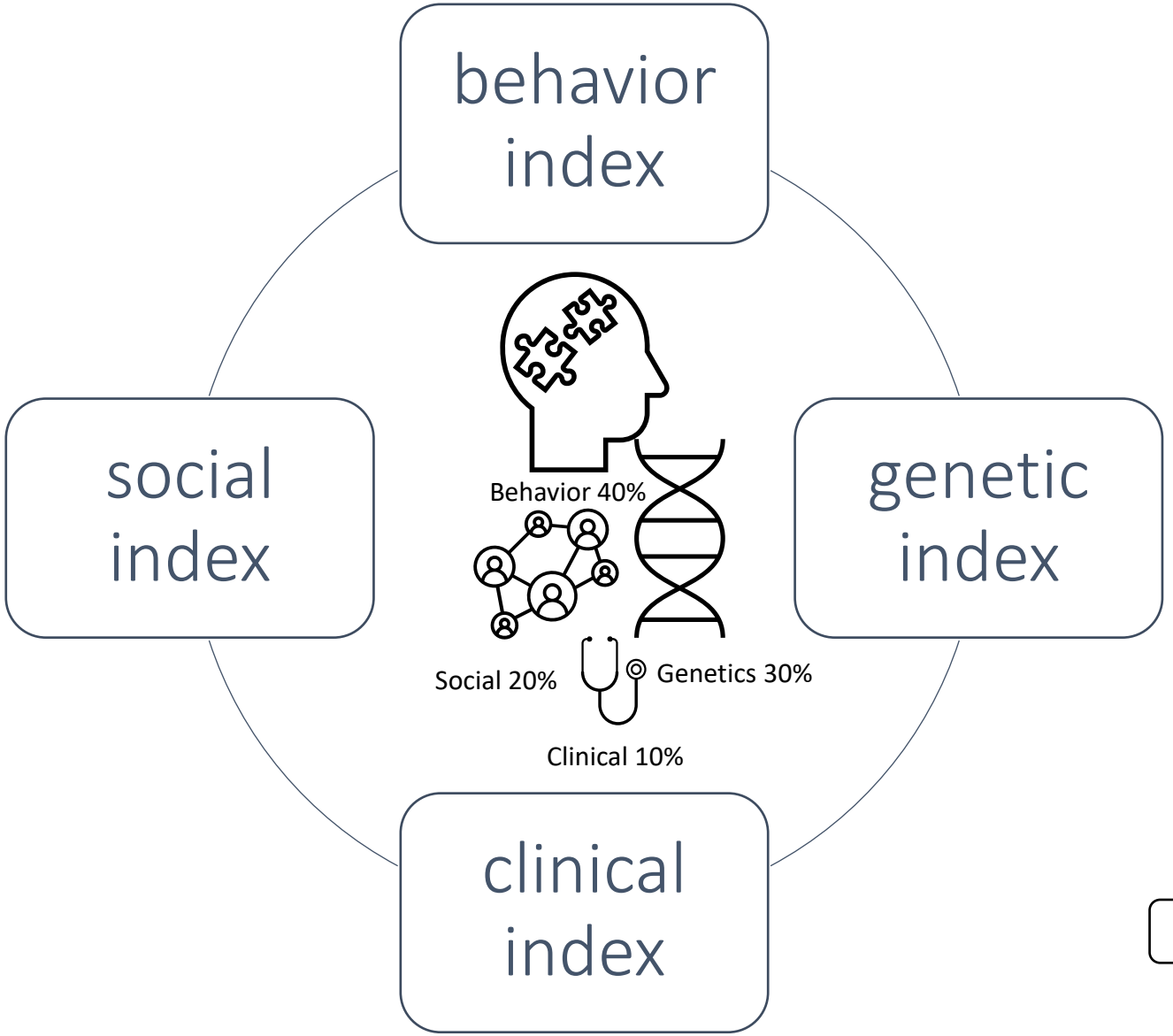
https://www.medicaleconomics.com/view/beyond-social-responsibility-the-missing-business-case-for-health-equity



Opportunity: Better Health, Lower Cost, For All

- Health is driven by **four (4) factors***:
  - clinical (10%)
  - social (20%)
  - genetics (30%)
  - behavior (40%)
- Over **80%** of health spend is on clinical services**
- The current health/care system produces **gaps in care**, creating **health inequity**
- Health will only be improved if all drivers of health are **scientifically** understood, **paid for** and treated in a **balanced** approach

Whole Person Index (WPI) = Clinical + Social + Genetic + Behavior



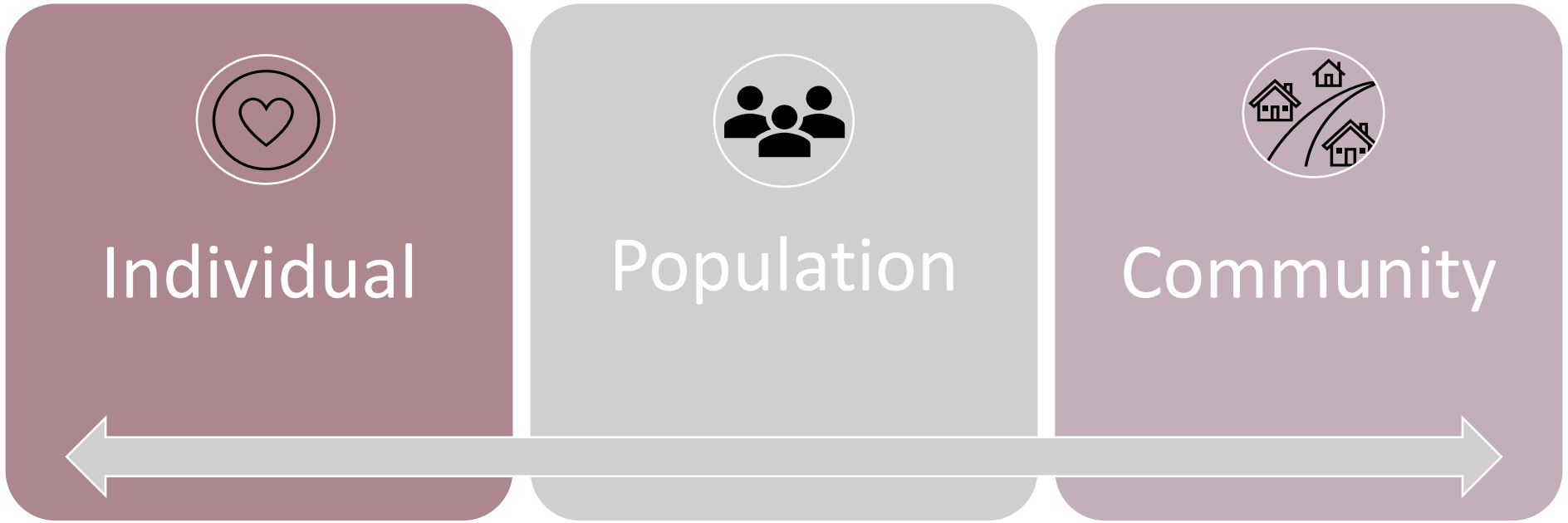
Whole Person Index

Standardized, evidence-based risk assessment across all health drivers; prioritizing action for individual, population and community

behavior 40%	motivation	capability	opportunity	
genetic 30%	single gene	chromosomal	multifactorial	
social 20%	economic	food	housing	environment
clinical 10%	physical status	mental status	diagnosis	

Data set: curated from research; binary; populate by survey or existing data

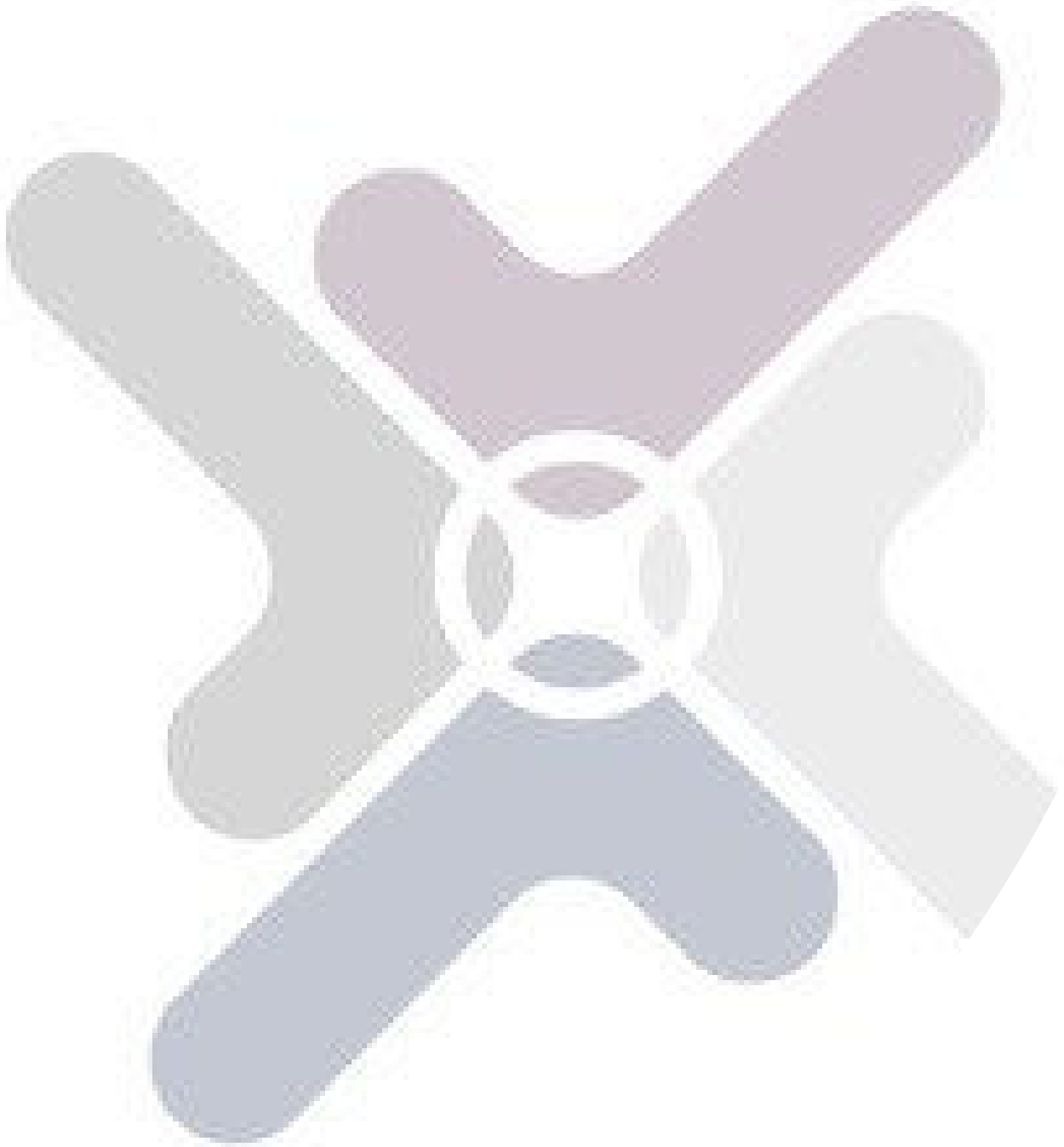
Whole Person Index (WPI): Individual + Population + Community



Return on Investment (ROI): Better Health, Lower Cost, For All		
utilization, incidence, habits, cost	utilization, incidence, premiums, cost	policy, private/ public partners, cost

Whole Person Index (WPI):
Change the Scoreboard, Change the Game

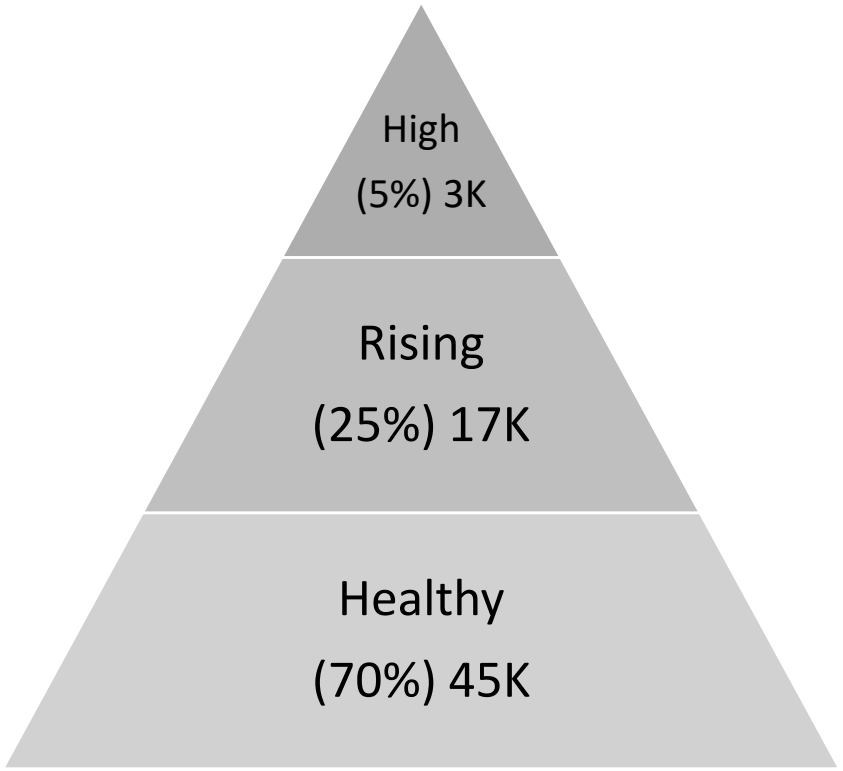
- Health definition
- Health acuity
- Democratize the data: individual, population and community
- Re- align current spend to highest, best use based upon impact and outcome



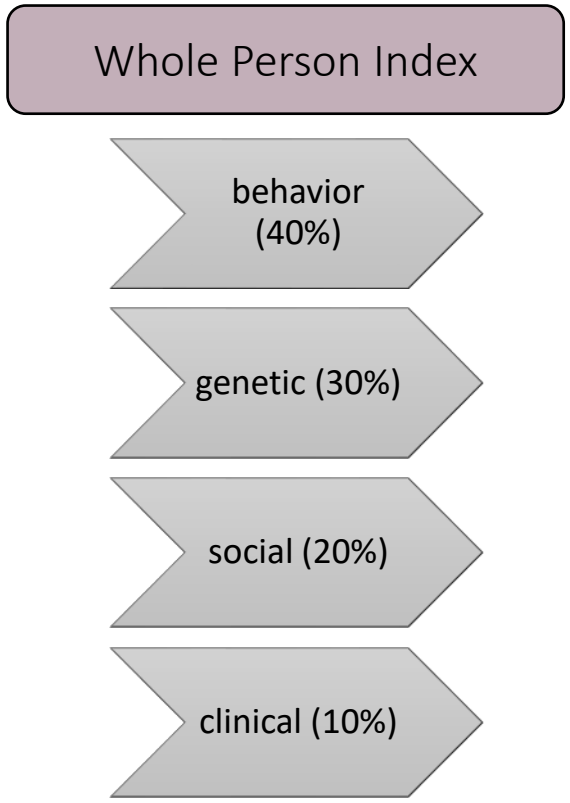
Whole Person Index:
In Action

Creating a Better System of Health: 4 Key Steps

1. Identify Population(s)

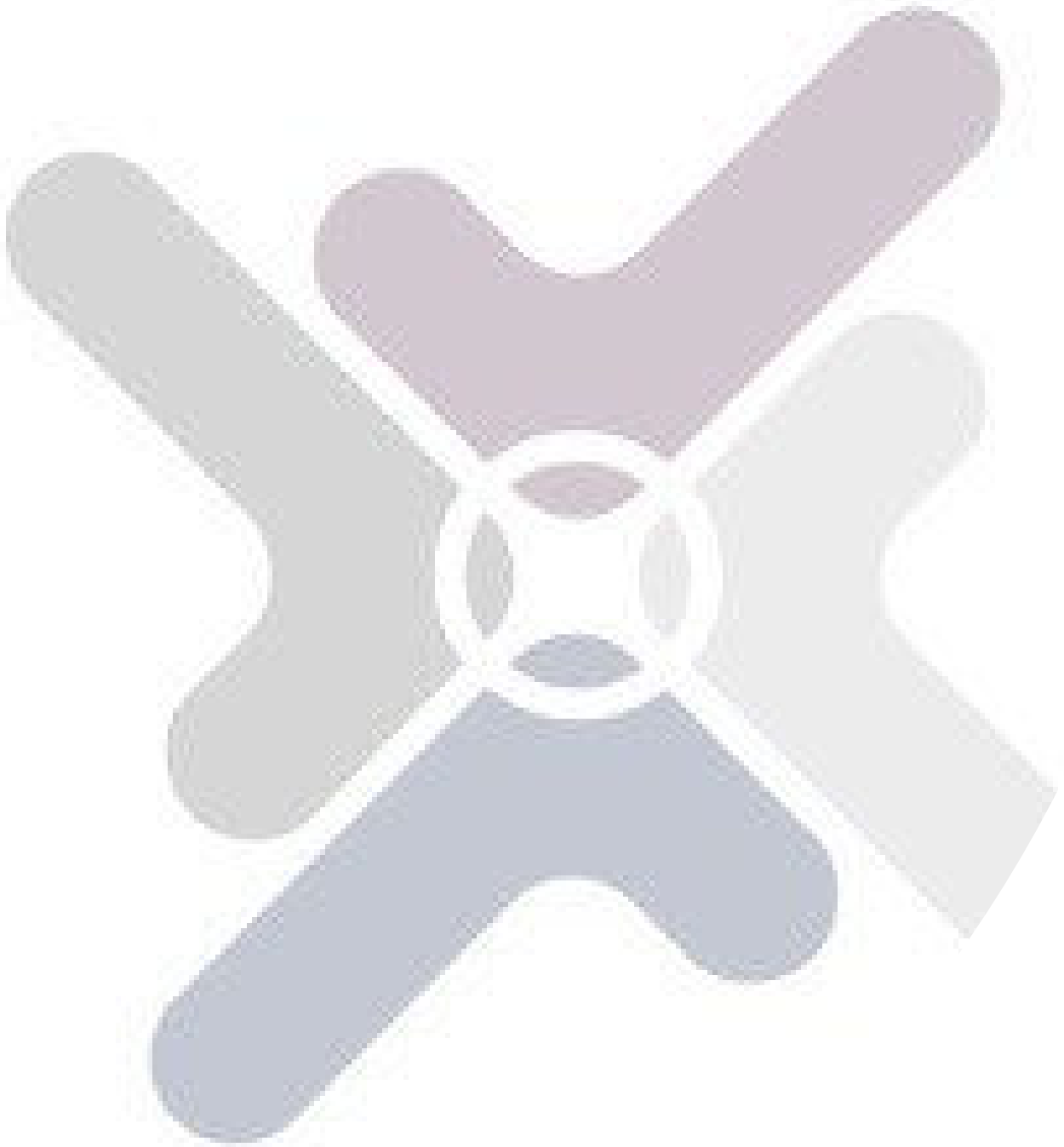


2. Understand what is impacting health across all drivers- apply WPI



3. Create a marketplace of solutions across health/care (sustainable business model)

4. Scale to improve outcomes at a lower cost, for ALL



WPI: Case Study #1
Employer

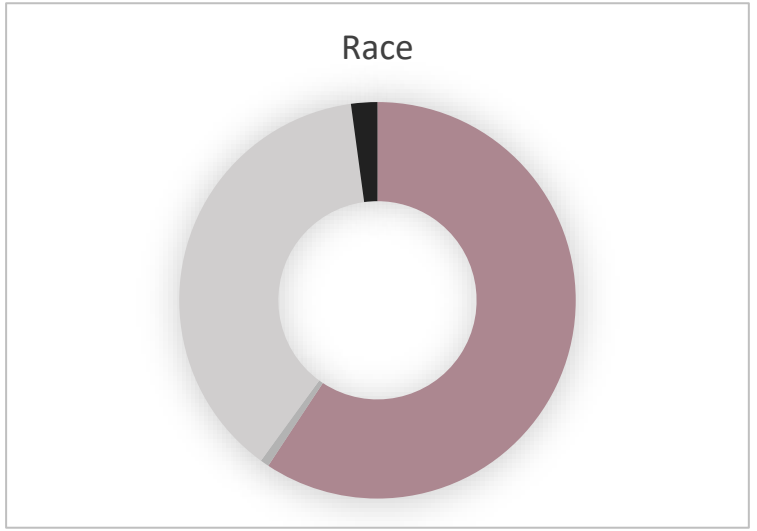
Whole Person Index: Population (n=2500)

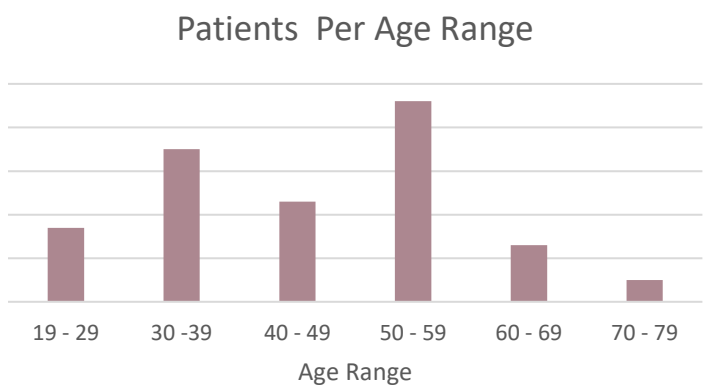
Total Participants:
90%
2250/2500

Female: 62%
Male: 38%

State Counties: 2

Employed: 100%;
> 1 job: 20%





Primary Care Provider (PCP):
Yes: 86%

Dentist in last year:
Yes: 64%

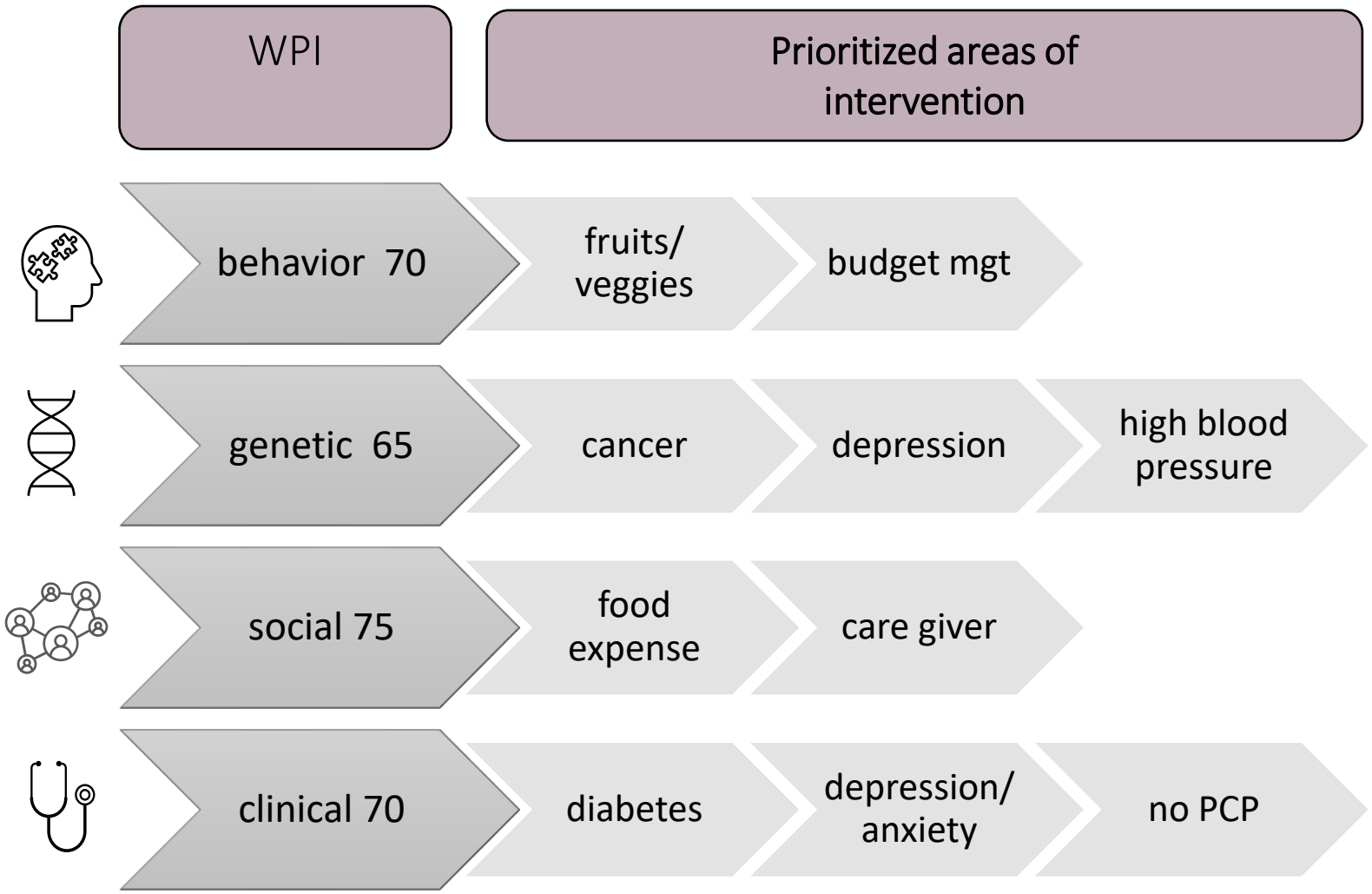
ED Utilization: 31%

Area Deprivation Index (ADI)*
Census Blocks: 69

Average ADI Rank: 8
(scale 1-10; high = more vulnerable)

**ADI is a national evaluation of a regions socioeconomic conditions linked to health outcomes*

Whole Person Index: Individual



Health Plan

Financial:
SNAP; budget mgt; care giver support

Nutrition:
food access/ education

Behavioral Health:
virtual; in community?

Provider:
diabetes plan/ PCP access
document DOH/refer

Whole Person Index: Population (N=2250)

WPI:	Highest Prevalence			
behavior: 65	no flu shot	fruits veggies	savings account	physical activity
genetic: 63	high blood pressure	diabetes	cancer	obesity
social: 91	caregiver	food expense		
clinical: 79	prescription meds	high blood pressure	ED utilization	

Index: 0-100; higher = increase health stability

A-HA Moments

diabetes
family history: 64%
diagnosed: 10%

cancer
family history: 54%
diagnosed: 6%

high blood pressure
family history: 70%
diagnosed: 20%

womens health
High % female; over 40% of employees age 19-39

Whole Person Index: Community

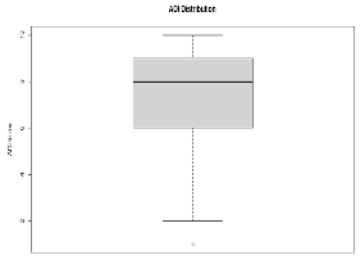
Definition: ***Area Deprivation Index (ADI):*** *A ranking of neighborhoods by socioeconomic disadvantages in a region of interest. Informs* ***Health Equity Benchmark Adjustment (HEBA)***

ADI Range by Census Block:

Min: 1

Median: 8

Max: 10



Definition: ***Community Health Needs Assessment (CHNA):*** *health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis*

County Top Priorities

- X Co: Substance Misuse; Healthy Living; Mental Health
- X Co: Physical Activity and Nutrition; Substance Abuse and Mental Health

Definition: ***Healthcare Effectiveness Information Data Set (HEDIS):*** *Standardized measures to provide consumers information needed to assess health plan performance*

Relevant Benchmarks

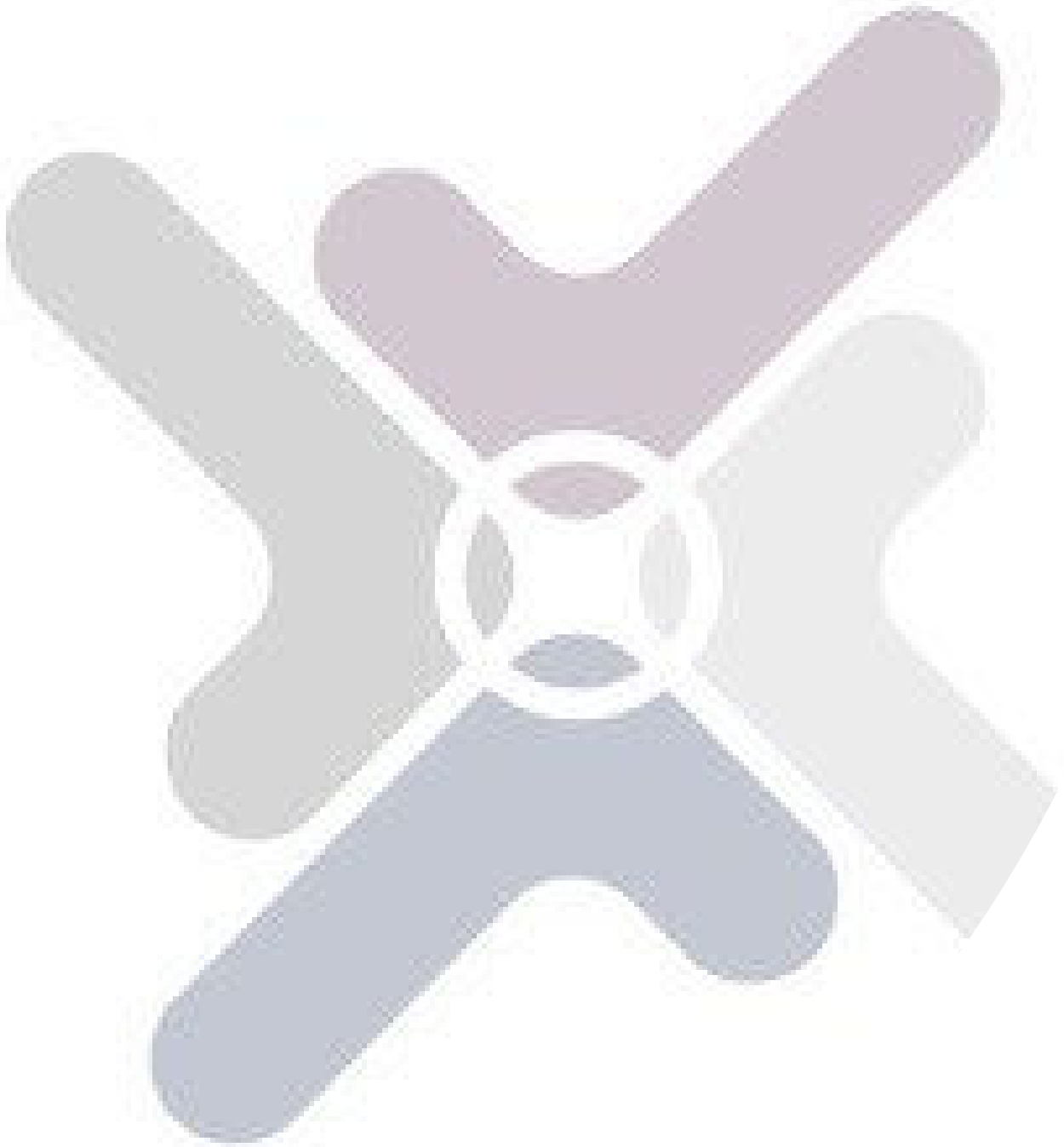
- Cancer Screening (Breast, Colorectal, Cervical)
- Depression Screening
- Diabetes Screening
- High Blood Pressure Management

Utilization Opportunities

- Prescription Drug Expense
- ED Utilization

WPI: Action Plan for Better Health

Opportunity (Gap)	WPI Metric	baseline	Return on Investment	Action/ Accountable
HEDIS- quality benchmarks (cl)	diagnosed pop prescription meds	payer data	HEDIS compliance HEBA Utilization	payer
access to care (cl)	PCP/ dentist ED utilization	86%/64% 31%	shift utilization	payer; health system; provider
vaccine/ preventive screenings (c,b,g)	flu shot genetic history	68% (no)	prevent utilization preventive screen/ behavior	employee education/ adherence
nutrition (s, b)	food affordability & access eat fruits/ veggies	28% 47%	absenteeism; turnover claims	community partnership/ access/ education
mental health(cl)	PHQ2/9	20%	absenteeism; turnover claims	payer; health system; provider
caregiver support	TBD	28%	absenteeism; turnover	new space for innovation



WPI: Case Study #2

Payer

Whole Person Index: Case Study

A New Mexico Medicaid retrospective cohort evaluating hemoglobin A1C attainment and associations with drivers of health

Goal: Utilize existing laboratory data to understand:

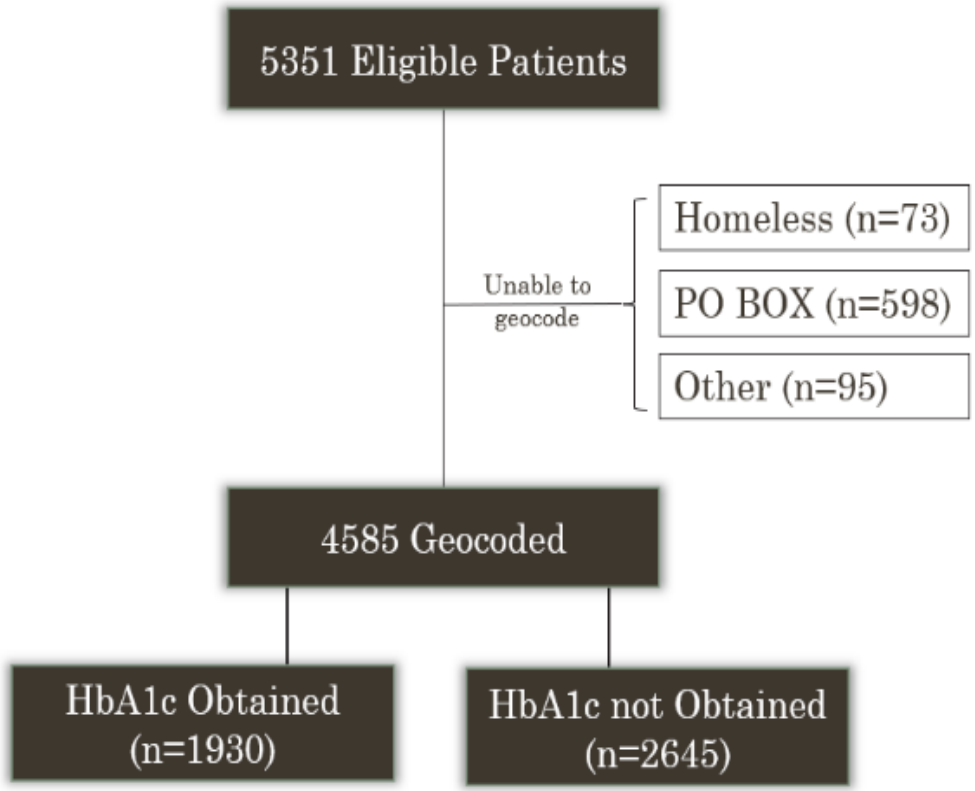
- Drivers of compliance with guidelines for care care
- Determine actions to close gaps to improve compliance
- Realize shared savings goals ($3M)

Population:

- Schizophrenia and bipolar disorders; prevalence of diabetes is 2-3 x higher than general pop
- Diabetes presence or severity can be screened for with a hemoglobin A1c (HbA1c) lab test.

Inclusion Criteria:

- All Medicaid with a schizophrenia, schizoaffective disorder, or bipolar disorder ICD-10 code
- Full Year 2022
- Ages 18 and 64 years



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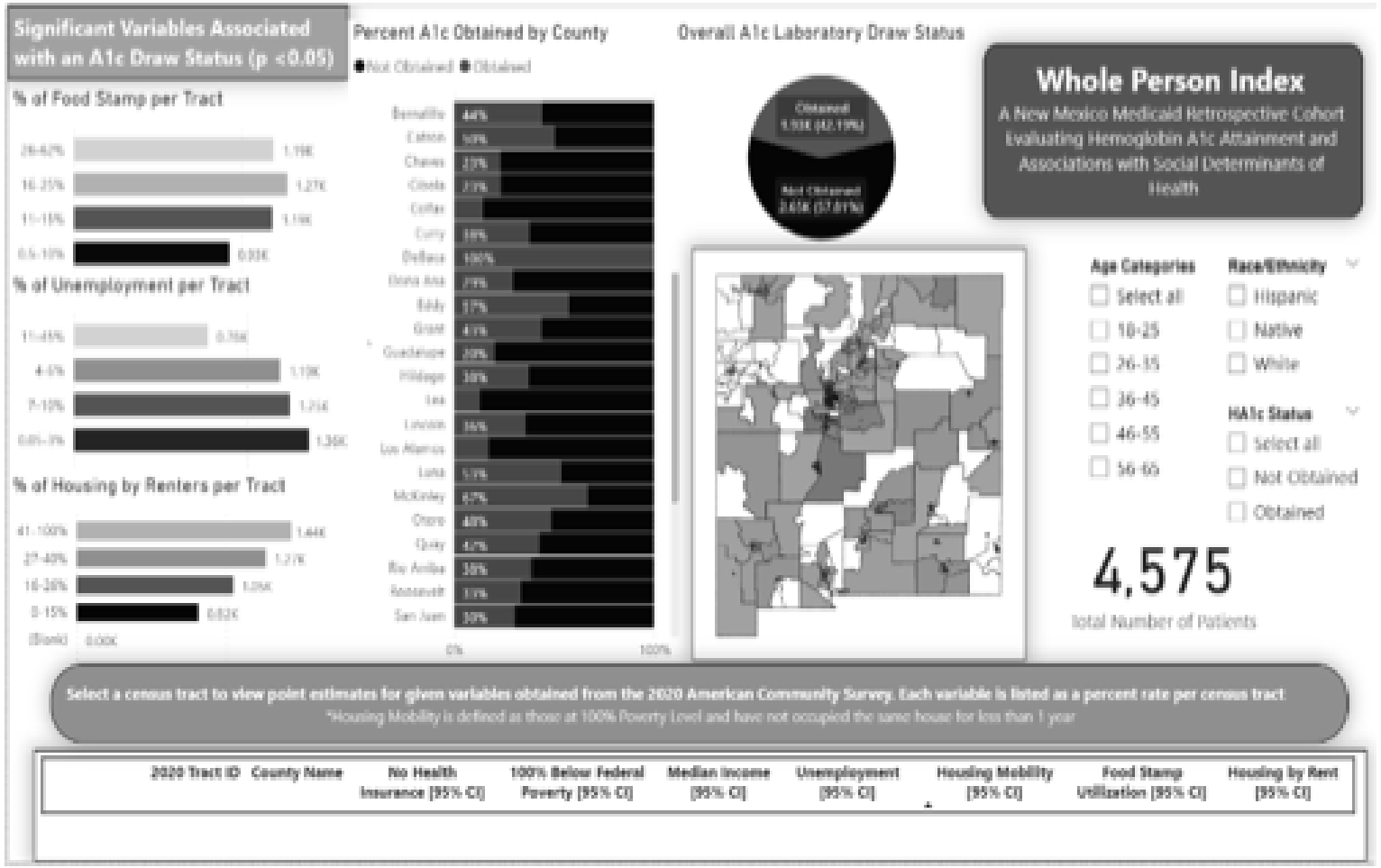


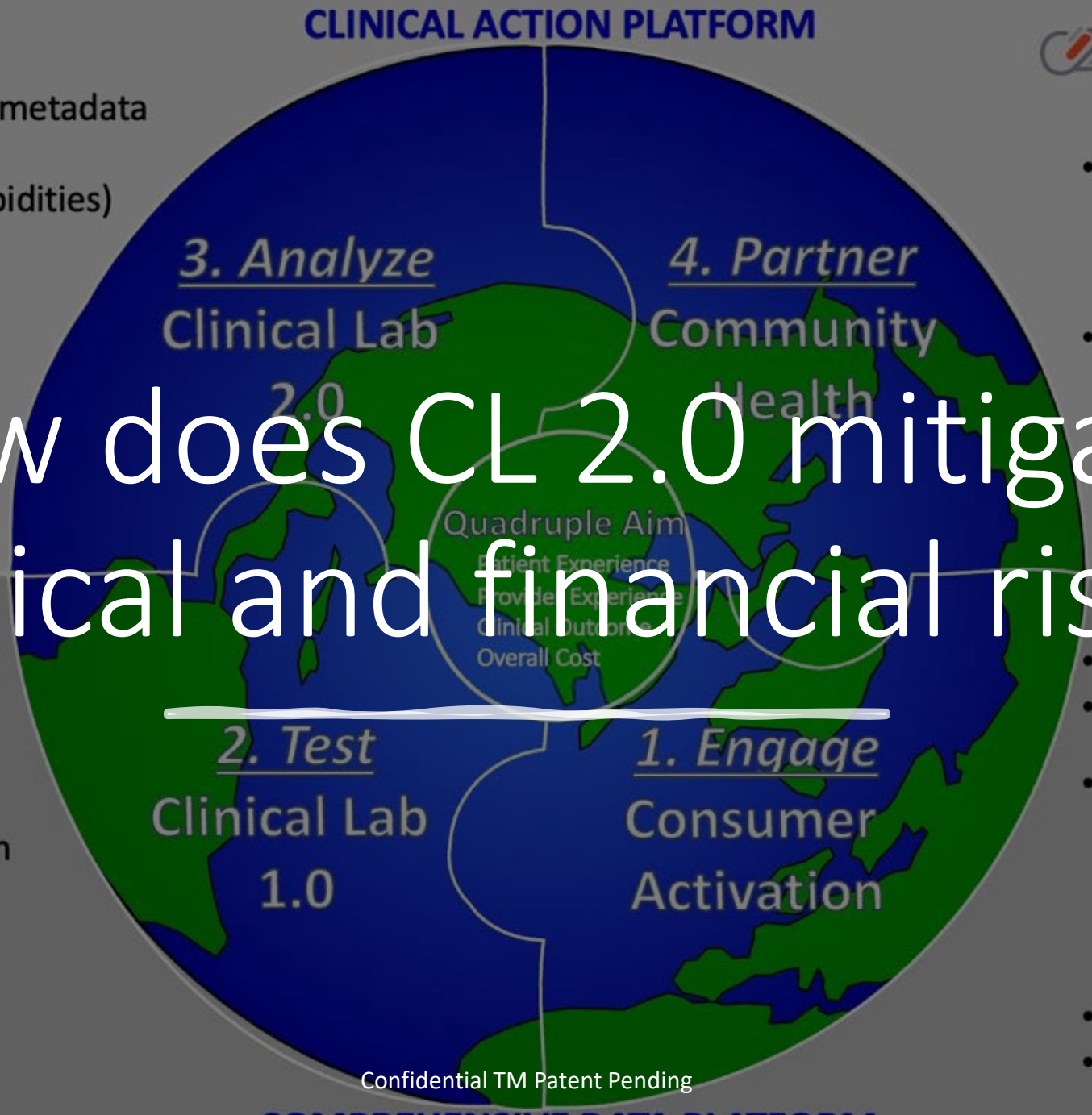
Key Findings for risk of missing HbA1c:

- Food stamp use rate between 27% and 62% = 1.54 times greater risk
- Unemployment rates between 11% and 44% = 1.29 times greater risk

Value:

- Comprehensive care pathways to include A1c- decrease disease incidence
- Focus efforts for adherence on hot spot areas
  - partners to address drivers of health- SDoH (food/ employment)
- Meet shared savings goal

How does CL 2.0 mitigate clinical and financial risk?



- Longitudinal lab results + metadata
- Clinical surveillance
- Risk stratification (comorbidities)
- Care gap identification
- High risk identification
- Facilitated intervention
  - Prevention
  - Cost avoidance
- Improved outcome
- Cost/population

- Pathology domain knowledge
- Accuracy
- TAT (turn around time)
- Test menu & test selection
- Test utilization
- Supply chain - cost/unit
- Robust POCT
- BMI - vitals
- Uber Phlebotomy

CLINICAL LAB 2.0
A PROJECT SANTA FE FOUNDATION INITIATIVE

- Population Health
  - Chronic Care Management
  - Quality & Safety
  - Public Health
  - Health Policies
- Private/Public Partnerships
  - Public Health
  - Healthcare Providers
  - Payer/ ACO
  - HIE
  - Policy makers

- Social determinants
- New models of care
  - Improved access
- Consumer engagement
  - Patient portal
  - c-MPI (community master patient index)
  - Shared decision-making
  - Confidential, specific education
  - Self-efficiency
- Facilitated care
- Facilitated intervention

Lab Leadership: CL 2.0 mitigates clinical and financial risk

- Understand all drivers and be the gateway for the person/ community health
- Design a standard set of labs to run depending on WPI results- focused on surveillance and early detection to prevent disease
  - individual
  - population
  - community
- Design new comprehensive care pathways
- Proactively identify high risk patient populations (moms, pre diabetic, flu/ Covid)

- Engage with payers on at-risk contracts to understand what tests to bundle and how to engage patients for compliance
- Provide longitudinal, trended data to support outcomes mgt and continuous improvement
- Take advantage of new revenue opportunities to provide clinical support + other drivers (i.e. SDoH)
- Access to appropriate genetic testing/ education

Discussion

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