South Louisiana Community Health Summit

Session 3 Presentation

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Start with the Session Question…

"How to predict high risk individuals and proactively identify health issues (related to COVID19)?"

First, establish a Common View of Risk.
- ✓ know more about your customers
- ✓ know more about your communities
- ✓ Know more about the available resources

Then, deliver precise, effective, cost-efficient care.

Social Risk Drives Variation in COVID care

What's happening in your community?

Who is at risk?

How are SDOH risks driving access, utilization, and outcomes?
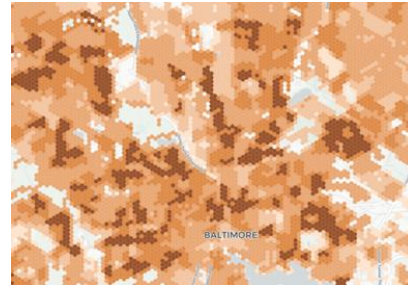

Amongst the Pandemic, now more than ever, we know that social risk is the largest driver of health.

If we're going to improve outcomes and resource allocation, we need a scalable way to identify who is at risk and then act with precision to drive measurable outcomes.

Assessing COVID-19 Risk
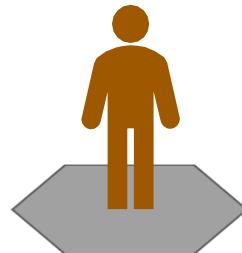
Community-Level

COVID-19 Social Susceptibility Index

Community Factors:
- Age Distribution
- Community Disease Burden
- Crowding
- Economic Stress
- Exposure Potential
- Infrastructure

Common Risk Scale

1 = Little to no risk

2 = Low risk

3 = Moderate risk

4 = High risk

5 = Severe risk

Individual-Level, Longitudinal

COVID-19 Vulnerability Index

Individual Factors:
- Age
- Chronic Disease Burden
- Community COVID-19 SSI
- SDOH Risk Exposure
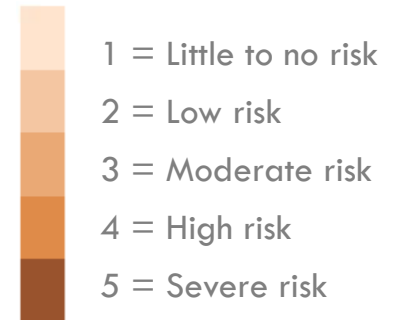
Individual-Level, Time-Bound

COVID-19 Positive Screen

Individual Factors:
- Presence or absence of virus

Risk Factors Among Vulnerable Populations

Vulnerable Populations

Vulnerable populations are at a greater risk for poor outcomes during the COVID-19 pandemic

RISK FACTORS

Underlying chronic health conditions

Social Determinants of Health

Frequent utilization of healthcare resources

Barriers to following public health measures (e.g. social distancing, self-isolation) or seeking care, such as lack of permanent housing, economic necessity, or fear of deportation, etc.
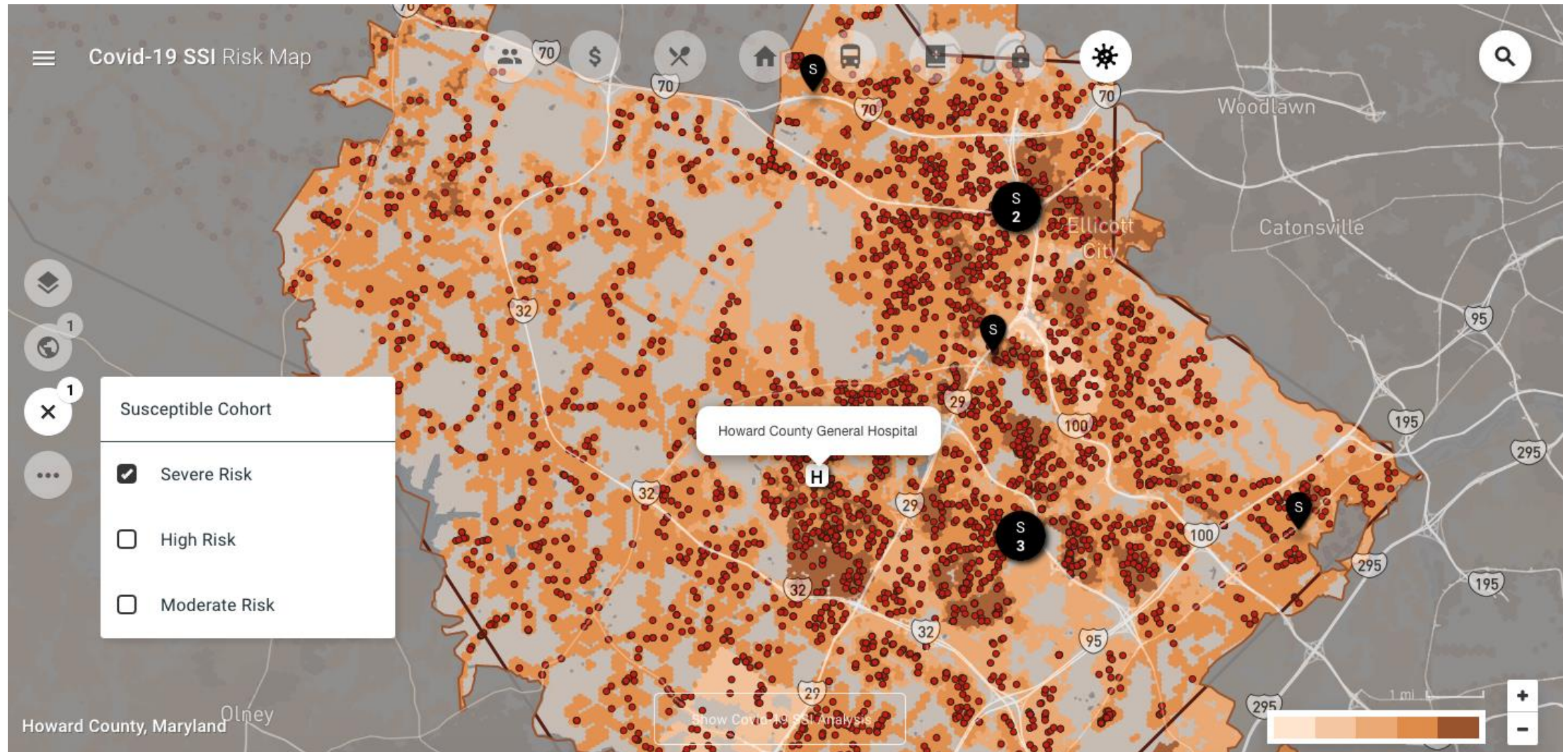
Higher risk of COVID-19 morbidity and mortality

Higher burden on healthcare resources, when capacity is needed the most

Resource planning to address specific needs
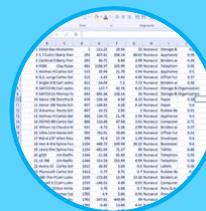
Common View of Risk, Resources and At-Risk Individuals

Coordinated Response to ensure Resources provided to Populations at Greatest Risk

~6 M
Total residents

~2.6 M
On Medicare or Medicaid

~900K
Elevated risk individuals identified

~150K
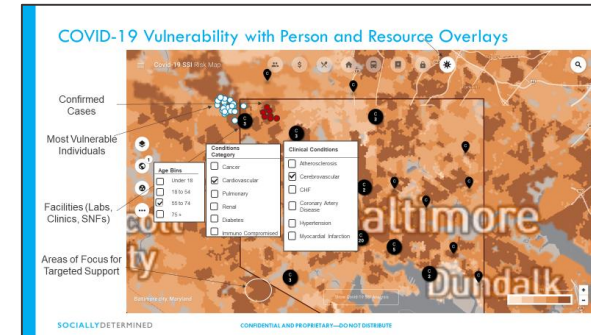**High-risk individuals identified**

Health Departments and LHICS to reach out to high risk communities and individuals

Health Systems and Primary Care Practices to reach out to high risk attributed members

Managed Care Organizations to reach out to high risk attributed members

Providing Targeted Resources to Vulnerable Populations

Testing and Manage-in-place Teams

COVID-19 Vulnerability with Person and Resource Overlays

Confirmed Cases

Most Vulnerable Individuals

Facilities (Labs, Clinics, SNFs)

Areas of Focus for Targeted Support

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Homeless Population

6K HOMELESS IN THE STATE

- **Homeless 1.6x** relative risk of death to general population historically
- Estimated rate of current undiagnosed COVID infection **>40%**
- **Homeless shelters don't have clinical teams or ability to socially distance at all**

Elderly in Congregated Housing

641 ASSISTED LIVING FACILITIES IN THE STATE

- Congregate settings known to source of heavy outbreaks and poor outcomes in other states
- Older adults, 65 years and older, make up to **27%** of total COVID related deaths
- **At best, this population today is getting remote outreach**

Individuals with No Healthcare Access

36K UNINSURED IN STATE

- Many are non-English speakers who are missing the public education campaigns
- Often essential workers
- Often live in overcrowded residential spaces
- **Often lack means of transportation for clinics or drive through testing centers**

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