Making the Value Case for Complex Care

December 7, 2021, 12:00-1:00 pm ET

Made possible with support from the Seven Foundation Collaborative — Arnold Ventures, The Commonwealth Fund, The John A. Hartford Foundation, the Milbank Memorial Fund, Peterson Center on Healthcare, the Robert Wood Johnson Foundation, and The SCAN Foundation.
Questions?

To submit a question, click the Q&A icon located at the bottom of the screen.
Welcome & Introductions
Find information. The Playbook is a resource center for evidence-based and promising practices for people with complex health and social needs.

Learn about first-person perspectives. Read case studies and join webinars highlighting the real-world experiences of providers, payers, community-based organizations, and policymakers to improve care.

Apply the evidence. Find practical implementation tools to inform providers, payers, policymakers, community-based organizations, and others on strategies to improve care.
About the Better Care Playbook

The Playbook is coordinated by the Center for Health Care Strategies through support from seven leading national health care foundations — Arnold Ventures, The Commonwealth Fund, The John A. Hartford Foundation, the Milbank Memorial Fund, Peterson Center on Healthcare, the Robert Wood Johnson Foundation, and The SCAN Foundation.

BetterCarePlaybook.org
Agenda

- Welcome and Introductions
- Mark Humowiecki and Lauran Hardin, Camden Coalition’s National Center for Complex Health and Social Needs: Making the Value Case
- Susan Cooper and Rick Wagers, Regional One Health: The Value Case in Action
- Paul Leon, Illumination Foundation and Rebecca Ramsay, Housecall Providers: Partnering for the Value Case – A CEO Dialogue
- Moderated Q&A
Today’s Presenters

Lauran Hardin, MSN, CNL, FNAP, FAAN
Senior Advisor, Camden Coalition of Healthcare Providers

Mark Humowiecki, JD
Senior Director and General Counsel, Camden Coalition of Healthcare Providers

Susan Cooper, MSN, RN, FAAN
Senior Vice President and Chief Integration Officer, Regional One Health

Rick Wagers, MBA
Emeritus Executive Vice President and Chief Financial Officer, Regional One Health

Paul Leon, RN, BSN, PHN
President and Chief Executive Officer, Illumination Foundation

Rebecca Ramsay, MPH, BSN
Chief Executive Officer, Housecall Providers
Making the Value Case for Complex Care

Lauran Hardin MSN, CNL, FNAP, FAAN & Mark Humowiecki JD
National Center for Complex Health and Social Needs, an initiative of the Camden Coalition of Healthcare Providers

Supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers, or staff.
Project Goals

- Capture lessons from national leaders in how to make the case for complex populations
- Capture lessons learned from COVID in making the case for complex populations
- Create publications that highlight innovations in finance that land in accessible media
- Translate the CAPC toolkit into a resource for the field of complex care
- Build capacity for making the business case
- Increase financial sustainability of programs for complex populations
Conversations with the field

Interviewed more than 100 executive, financial, and programmatic leaders from diverse organizations (pre and post-COVID):

- Health systems
- Payers
- Innovators
- Community based organizations
- National non-profit organizations
- ACOs
- Successful complex care programs
- CHCS AIM collaborative participants
Lessons from leadership

Overarching themes:

- Chaotic and constantly changing environment
- No time for review of complex information
- Want individualized business case support
- “COVID” brain - overwhelmed

Content themes:

- Targeting your population
- Identifying data sources
- Choosing metrics and evaluation method
- Considering payment sources (VBP, billing, new telehealth codes, grants – federal, state, local, Medicaid Waivers, payment demonstrations)
- Reporting outcomes, integrating quality outcomes
- Seeking sustainable funding after demonstration projects
- Adapting interventions for efficiency in delivery
Building the Value Case for Complex Care

Lauran Hardin, MSN, CNL, FNAP, FAAN
Mark Humowiecki, JD
Victoria Sale, MSN

The National Center for Complex Health & Social Needs
Camden Coalition of Healthcare Providers
Building the value case

**Choosing the Population**

Key Findings from Population Analysis:
- Root Cause Disease Subpopulations
- Root Cause Social Issues

Data Source for Analysis:
- Inclusion Criteria for your Program
- Exclusion Criteria for your Program

**Scaffolding Populations**

- What is the tiering or priority of populations for your organization?
- How does this impact the target population for your intervention?

**Stakeholder Needs**

- Stakeholder Needs
- Stakeholder Threats
- Asset Mapping Key Findings
- Potential Partners Identified
- Thoughts on Adaption

**Demonstrating Value**

What You Will Track:
- Demographics
- Cost Metrics
- Utilization Metrics
- Quality Metrics
- Client/Provider Satisfaction
- Equity Metrics

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Building the value case

**COLLABORATING WITH FINANCE**
- What did you learn from meeting with your CFO?
- What financial metrics have most value in the organization?
- What is the capacity for financial analysis of your program?

**FUNDING AND EFFICIENCY**
- What’s your current financing strategy?
- What long term strategy will you explore for your program?
- What is your budget?
- What is your standard for dosing and delivery of the intervention?

**RETURN ON INVESTMENT**
- What will your process be for ROI evaluation?
- What will your process be for reporting outcomes and celebrating success?
Demonstrating value

Choosing your metrics

- Cost
- Utilization
- Quality
- Client and Provider Experience/Story

OUTCOMES & MEASURES
Health equity and quality measurements are more central today. Addressing social context is one way to help create equitable outcomes. While I don't know that I have new data around financial returns, I think it's allowing folks to look for returns in quality outcomes or equitable outcomes that are a different kind of impact. That is increasing the impetus for this work.

ANAND SHAH, MD, VP of Social Health, Kaiser Permanente
Value case summary

As you demonstrate the value of your program, consider choosing 1-3 metrics in each quadrant to demonstrate impact.

| Total population served: |
| Timeframe of analysis: |

| COST IMPACT | UTILIZATION IMPACT |
| • Inpatient Impact | • Inpatient Impact |
| • ED Impact | • ED Impact |
| • Primary Care Impact | • Primary Care Impact |
| • Pharmacy Impact | • Length of Stay Days |
| • Readmissions Impact | • Readmissions Impact |
| • Total Cost of Care | • Total Change in Utilization |

| QUALITY IMPACT | SATISFACTION IMPACT |
| • Quality Measure: | • Provider Satisfaction: |
| • Quality Measure: | • Patient Satisfaction: |
| • Quality Measure: | • Partner Satisfaction: |

| EQUITY IMPACT |
| Demographics of Population Served: |
| • Impact on Access |
| • Impact on Housing |
| • Impact on Benefits |
| • Impact on Food Security |

TOTAL RETURN ON INVESTMENT
Value case summary example

<table>
<thead>
<tr>
<th>COST IMPACT</th>
<th>UTILIZATION IMPACT</th>
</tr>
</thead>
</table>
| Inpatient cost – 60% decrease  
Pharmacy cost – 40% decrease  
Total cost of care – 30% decrease | Inpatient admissions – 50% decrease  
ED visits – 60% decrease  
Length of stay days – 60% decrease |

<table>
<thead>
<tr>
<th>QUALITY IMPACT</th>
<th>SATISFACTION IMPACT</th>
</tr>
</thead>
</table>
| Engaged and completed MAT – 80%  
Arizona Self Sufficiency Score – 60% improved  
PHQ9 depression score – 60% decrease | Provider satisfaction: Improved delivery 90%  
Patient satisfaction: Services help me live a better life 90%  
Partner satisfaction: Meaningful collaboration 92% |

<table>
<thead>
<tr>
<th>EQUITY IMPACT</th>
<th>TOTAL RETURN ON INVESTMENT</th>
</tr>
</thead>
</table>
| Demographics of Population Served:  
75% White  
20% Black or African American  
5% Asian  
80% Homeless on Admission | • Impact on access – connected to primary care 80%  
• Impact on housing – housed 70%  
• Impact on benefits – connected to benefits 80%  
• Impact on food security – connected to SNAP 100% |
Adventist Health Project Restoration
Value Case Summary

- **49.7% Reduction** in Admissions
- **40.7% Reduction** in Emergency Visits
- **50.7% Reduction** in Inpatient Days
- **91.2% Reduction** in EMS Response
- **49% Improved** Capitation financial performance

**Provider Satisfaction**
- Meaningful collaboration: 92%
- Cross-continuum functionality: 83%
- Positive patient outcomes: 100%

**Community Linkages**
- Exit to stable housing: 32%
- Linked to public benefits: 87%
- Follow on grants: $1-10m

**Location**
- Data represents 683 patients in eco-system pilot
Top 3 Key Insights
Collaborating with stakeholders

Organizational leadership
Finance
Payers
Community partners
Redefining value & ROI

Including equity & social needs
Valuing relationships & community partnerships
Holistic view of impact
Building strength and sustainability

Regular review of efficiency in delivery
Learn to speak many languages
Holistic evaluation of potential revenue
Annual sharing of success

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Next Steps

Series of blogs and articles in 2022

Opportunity for individual TA

Exploring possible learning collaborative or course to apply lessons
Thank you!

National Center for Complex Health and Social Needs
An initiative of the Camden Coalition of Healthcare Providers

www.nationalcomplex.care
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Camden, NJ 08102
One Health: Building the Value Case

Susan Cooper MSN, RN, FAAN
Chief Integration Officer, Senior Vice President

Rick Wagers, MBA
Emeritus, Executive Vice President, CFO
Regional One Health

- Oldest hospital in the state
- Serves as the safety net or essential hospital for a multistate region
- Non-expansion state for Medicaid
- Uninsured as a percent of gross charges (24%, 30% when program began)
- Medicaid as a payer (31%)
- Required new ways of thinking: Uninsured as our largest capitated population
Leadership Think Tank

Chief Executive Officer

Chief Integration Officer

Chief Financial Officer

Chief Development Officer

One Health

Data
Framing the opportunity
Making the Business Case
Develop Grant Proposal and model, identify potential funders
Senior Leader Buy-in
Setting tone for innovation in care delivery
Willingness to challenge the status quo
EVERY MEMPHIAN DESERVES GREAT HEALTH
Goals of the One Health Program

• To improve the health of our uninsured, medically and socially complex patients by addressing the root cause(s) of their health seeking behaviors
• To bend the financial cost curve for these frequent utilizers
Seeding and Growing the Program

November 2016
Consultation with Camden Coalition and submission of grant proposal

July-Dec 2017
- Community Meeting
- Data analysis
- Community Asset mapping
- Program design
- One Health Connect

April-Present
- 3 teams + Director
- Data Analyst
- 707 people enrolled
- Monthly data analysis
- Multiple grants received (additional $1.83 million)

June 2016
Development of proposal for new program for uninsured, socializing of concept internally

Feb-June 2017
Received $1 million over 3 years for program development and implementation

Feb-April 2018
- Hire staff
- Identify cohort
- Interventions begin
- First patient enrolled
Rethinking Return on Investment

- Health
- Self-sufficiency
- Utilization
- Financial
- Community
Enrollee Metrics as of 10.31.21

<table>
<thead>
<tr>
<th>Enrollees</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total enrollees</td>
<td>707</td>
</tr>
<tr>
<td>Active enrollees</td>
<td>239</td>
</tr>
<tr>
<td>Graduated enrollees</td>
<td>303</td>
</tr>
<tr>
<td>Disengaged enrollees</td>
<td>165</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>489=69%</td>
</tr>
<tr>
<td>Female</td>
<td>218=31%</td>
</tr>
</tbody>
</table>
Outcomes: Health and Self-Sufficiency

- 65% reduction in HgA1C
- 47% with BP < 140/90
- 46 Homes secured, 132 houses stabilized
- 293 Insurance obtained
- 12,120 Medication filled
- 5485 Rides completed
- 460 Health homes
- 211 Behavioral health connection
- 734 Medically tailored meals delivered
## Finance and Utilization Aggregate Data through 10.31.21

<table>
<thead>
<tr>
<th>Total enrollees 36 months: 707</th>
<th>Pre-enrollment</th>
<th>Post-enrollment</th>
<th>Difference/ Percent reductions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cost</td>
<td>$26,472,090</td>
<td>$12,271,582</td>
<td>$14,200,508 53.64% reduction</td>
</tr>
<tr>
<td>Variable Cost</td>
<td>$12,584,995</td>
<td>$5,589,261</td>
<td>$6,995,734 49.26% reduction</td>
</tr>
<tr>
<td>Total payments received</td>
<td>$0</td>
<td>$9,250,967</td>
<td>$9,250,967</td>
</tr>
<tr>
<td>Emergency Department Visits</td>
<td>4730</td>
<td>2835</td>
<td>1895 visits 40% reduction</td>
</tr>
<tr>
<td>Inpatient admissions</td>
<td>1015</td>
<td>439</td>
<td>576 56.75% reduction</td>
</tr>
<tr>
<td>Length of stay (days avoided)</td>
<td>8357</td>
<td>3241</td>
<td>5116 61.2% reduction</td>
</tr>
<tr>
<td>LOS (Acute care admissions only)</td>
<td>7.31 days</td>
<td>5.81 days</td>
<td>1.5 day reduction 20.5% reduction</td>
</tr>
</tbody>
</table>
Secret Sauce

• Create a common goal
• Partner with finance from the beginning
• Align measures of success
• Improvements in health and finance can coexist
• Be willing to challenge the status quo
• Engage the hearts and minds of all involved
Partnering for the Value Case – A CEO Dialogue

Paul Leon, RN, BSN, PHN, President and Chief Executive Officer, Illumination Foundation

Rebecca Ramsay, MPH, BSN, Chief Executive Officer, Housecall Providers
Questions?

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Share Your Successes on the Playbook

- Have you established a promising practice?
- Published a study about your complex care program?

The Playbook welcomes content submissions to help spread best practices in complex care.

www.BetterCarePlaybook.org
Thank you!

Please submit your evaluation survey.