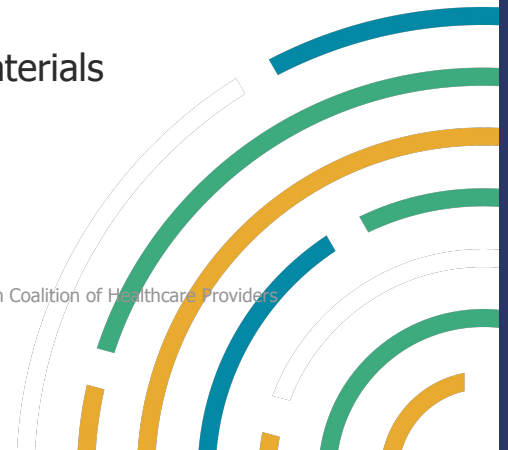
TABLE OF CONTENTS



> To me, even as a finance person, the term ROI is almost too simplistic. Other things are just as important to the holistic picture.

RICK WAGERS, Senior Vice President and CFO, Regional One Health

Demonstrating value beyond cost savings

Introduction

Integrating equity in the value equation

Choosing metrics

Example of cross-sector metrics

Value case summary

Introduction

Once you have an understanding of your stakeholders and their needs, you can choose outcomes and measures that demonstrate the value of your program for multiple stakeholders. Impacting healthcare utilization may benefit a payer or ACO but could be perceived as negative to another stakeholder who benefits from revenue generated by utilization.

For this reason, it's essential to choose a suite of metrics that are feasible to track and demonstrate value in several directions. Evaluate these measures for 12 months before intervention and at subsequent intervals of 12 months after intervention to compare the impact over time. If you have more robust data support, evaluate it against a comparison population without intervention, whether through actual randomization or in a quasi-experimental fashion.

MORE ON VALUE

You may need a process to show quick wins if you are starting a new program. Reporting changes in three-month intervals for the first year can generate support and excitement about your intervention. It is not recommended that you follow this cadence after the first year of proof of concept, however, unless you have robust data analytic support.

As a baseline, it is recommended that complex care programs track demographic data, including name, gender identity, medical record number, date of birth, race/ethnicity, zip code, insurance, and start and end dates of intervention. Adding language can be helpful as you consider the case for equity. In addition to this foundational data, tracking metrics and outcomes in each of the cost, quality, utilization, and patient/provider experience will round out the case for your intervention.

As programs progress, other value cases naturally emerge. Models like the Nurse Family Partnership and Housing First proved their efficacy not only by justifying their cost savings to healthcare and housing, respectively, but also to cross-sector systems within communities like education, criminal justice, and child welfare. By aligning your work across your community, and beyond healthcare, you may find that you can build support and access funding from multiple systems for the long-term.

Is it our job to make others healthier with compassion and empathy, or is it basically just to do spot medicine?

SCOTT REINER, CEO Adventist Health

Integrating equity in the value equation

Now more than ever, it's important to be explicit in showing the impact on health equity as part of your value case. Tracking race/ethnicity, zip code, gender identity, disability status, language, and economic status of the population served by your program can enable you to describe your target population using a health equity lens. Evaluating your impact on housing, food security, access to care and benefits demonstrates your positive impact on health disparities and your organization's investments to improve outcomes among members of marginalized communities. The use of **Z codes** is growing across the industry as a way to nationally track health-related social needs and equity indicators. Including those in your value equation will deepen the case for your work.

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

EXAMPLES OF EQUITY METRICS

A recent brief released by the Center for Healthcare Strategies (CHCS) titled **"Assessing the Impact of Complex Care Models: Opportunities to Fill in the Gaps**," suggested metrics of equity that are captured below.

EQUITY		
Our organization ensures a safe and accessible environment (physical, emotional, and cultural) for all individuals, regardless of gender, sexual orientation, race, ethnicity, socioeconomic status, disability status, and language.†	a.	Created for AIM
Our organization's mission, vision and policies clearly state that equity is a high priority.	a.	NQF Environmental Scan
Our organization's leadership are committed to equity as a high priority.	a.	NQF Environmental Scan
Our organization is responsive to individual patient preferences, needs, and values.	a.	Medical Office Survey on Patient Safety Culture
Our organization makes accommodations in how we practice in order to respond to the needs of patients that may have difficulty with things such as keeping appointments, or following treatment plans.	a.	Created for AIM
To ensure care is equitable, our organization identifies the needs of diverse populations and implements steps to help meet those needs.	a.	Created for AIM
We regularly use feedback from patients and families to improve services.	a.	PSPIC

Choosing Metrics

COST METRICS

Complex care programs typically demonstrate success through evidence of cost avoidance or reduction in cost year-over-year in a complex population. Every program will have different access to financial analytics. Tracking total cost of care before and after intervention is a baseline measure all programs should monitor. It can be helpful to differentiate changes in cost between inpatient admissions, emergency department visits, post acute care stays, and primary care visits. The strongest business case is demonstrated by showing changes in variable costs such as pharmacy, length of stay, and unnecessary testing because reductions in these costs are a net savings to health systems even if there isn't a reduction in total encounters.

A financial impact analysis also requires you to track revenue. If your program is increasing appropriate utilization (such as increased primary care visits), you may report this as positive income to the system. If your program is helping uninsured patients obtain coverage, the insurance payment for services can also be reported as revenue to the healthcare system.

Finally, looking at reduction in 30-day readmissions, and corresponding readmission penalties, are a financial value to your healthcare system that should be incorporated in your analysis.

UTILIZATION METRICS

Changes in unnecessary utilization or encounters are core metrics that should be tracked by all complex care programs. Differentiating changes in utilization between inpatient admissions, emergency department visits, long-term care stays, and primary care visits is key. If you have more robust data analytic support, analyzing changes in length-of-stay days, emergency department visit minutes, primary care visit minutes, and decrease in no-shows for visits can underscore the impact of effective care coordination and add to the case for your complex care program.

QUALITY METRICS

There are numerous quality metrics you can choose from to demonstrate the impact of your program. **Consider** the focus of your intervention and your stakeholders' values, including measures that your organization may already be accountable for, and select only the few data points that demonstrate the most value across the board. Complex care programs have utilized changes in disease management metrics like A1C, hypertension, and BMI, though these measures aren't always appropriate when dealing with a patient population with multiple and heterogeneous clinical conditions exacerbated by social and behavioral health conditions.

Consider if your organization is utilizing **HEDIS** measures and, if so, include one or two measures that are impacted by your intervention. A recent study by Center for Health Care Strategies identified promising measures to consider to fill the gaps and demonstrate value.

Access to services is an important quality metric. Tracking change in connection to primary care, access to benefits, housing status, Vi-SPDAT scores, behavioral health or substance use treatment, access to medical legal support, or social determinant of health changes like the **Arizona Self Sufficiency Matrix** can be helpful.

Improvement in **functional status** or **patient activation measures** can also show a change in quality of life for complex populations. For a more complete list of promising complex care measures, see **Measuring Complexity.** An expert group also developed recommended measures for complex care programs through a modified Delphi process.

Another promising area to consider including is patient-reported outcome measures. A **recent report** from the Center for Health Care Strategies describes engaging patients and community members in the process of choosing what metrics matter most.

PROVIDER SATISFACTION

Provider satisfaction is another important value provided by complex care intervention. Clients served by complex care models are often complicated in a way that is time consuming for providers across systems and may present with complex behavioral health, substance use disorders or health issues resulting from the effects of social determinants of health that are uncomfortable for some providers. Complex care programs provide additional support to patients, which eases the burden on providers and can reduce provider burnout and improve efficiency. Having a simple, annual evaluation of provider satisfaction can round out the case for complex care. Recording testimonials directly from providers can also be powerful evidence in making the case for program sustainability and investment.

Successful complex care programs integrate these measures and resources in their annual reports and highlight stories of success in monthly communications to leadership and other stakeholders to generate investment across the community.

DEMONSTRATING HUMAN IMPACT

While patient experience is often measured through patient satisfaction surveys, individual patient stories are often a more compelling means of showing the value of complex care on those served. Stakeholders love to hear the story of a successful intervention – especially when shared directly by a patient.

The national movement to attend to health equity also highlights the importance of hearing from consumers about their lived experiences. Done well, this can be an empowering experience for the consumer themselves. You can find a guide to helping individuals tell their own stories for impact **here** and a simple example of the power of this resource in the **Project Restoration video from Adventist Health**.

A patient consent form example is included in the worksheets and supplemental material section.

Example of cross-sector metrics dashboard

As your program progresses, you will likely find that multiple systems in a community work with the same individuals and families. As such, you may begin tracking outcomes important to your community partners such as EMS calls/visits, jail days, police encounters, school absences, and child and family services calls. The dashboard on the right demonstrates a visualization of ED and inpatient data metrics alongside community metrics with an overall representation of cost savings for "Health Care" and "Community" at the bottom. Tracking outcomes in this way sets the foundation for communities to achieve cross-sector funding and increases the sustainability of complex care work. This means, when the grant goes away, the programs you've built don't.

Example: Value case summary

As you demonstrate the ROI of your program, include the metrics you choose in each of the value case segments. Common metrics are included here for your consideration. See the tools section for examples of how sites have applied this framework.

VALUE CASE SUMMARY SHEET

Total individuals served: **Time frame of analysis:**	
COST IMPACT • Inpatient Impact • ED Impact • Primary Care Impact • Pharmacy Impact • Readmissions Impact • Total Cost of Care	**UTILIZATION IMPACT** • Inpatient Impact • ED Impact • Primary Care Impact • Length of Stay Days • Readmissions Impact • Total Change in Utilization
QUALITY IMPACT • Quality Measure: • Quality Measure: • Quality Measure:	**SATISFACTION IMPACT** • Provider Satisfaction: • Patient Satisfaction: • 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	

Key takeaways

- Develop a standard demographic measure set for your population
- Choose 1-2 metrics in each quadrant that demonstrate the value of your intervention
- Evaluate metrics 12 months before and after intervention
- Complete annual analysis to evaluate your impact
- Consider a paired evaluation of a population without intervention to further demonstrate the value of your intervention