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> We're all trying to solve the same problem from our own perspectives… It's really about just anchoring people to the big problem and saying, I understand you have different perspectives, but this is all the same problem.

TORRIE FIELDS, CEO Votive Health

Funding sources and opportunities

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Introduction

Many complex care programs are initially funded by grants. Although the investment is appreciated, a sustainable financial plan needs to be considered from the start of a new program and revisited annually for existing programs to ensure success. The following table contains important considerations when making a financial plan for your intervention. The source of funding will drive who you serve, how you present the case for complex care, and what metrics you track and report to demonstrate success. For a deeper dive into funding, **Beyond the Grant** is an excellent free resource with many tools and ideas you can use to explore this concept further.

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Funder and opportunity resource map

FUNDING SOURCE	OPPORTUNITY	FOCUS							
		COST AVOIDANCE	REVENUE	QI	COMMUNITY WELLBEING	SATISFACTION SCORES	SPECIFIC POPULATIONS	EQUITY	UTILIZATION
Internal Organization	If you choose a population that meets a need for your organization, long-term funds may be available by continuously demonstrating effective cost avoidance and quality improvement.	X	X	X		X		X	
Community Benefit	Every nonprofit health system has community benefit funds to address community health needs. Access your area's Community Health Needs Assessment through the local health department or health system to find opportunities to partner in meeting a need.			X	X	X		X	
Integration in Organizational Value Based Payment	If your organization participates in an APM/VBP arrangement/ACO, your program could partner to meet the needs of the most complex patients that are at financial risk.	X	X	X		X			X
Local Philanthropy and Businesses	Local philanthropic organizations and businesses with foundations may have an interest in improving health and health equity of certain populations.	X		X		X	X	X	
City or Community Funds	If your program is impacting services like reduction in emergency response (including police and EMS), reduction in criminal justice costs, improvement in behavioral health and substance use outcomes, and improvement in homeless populations, there may be additional avenues for funding from sources like the city, law enforcement, and community development.	X		X		X	X	X	

FUNDING AND OPPORTUNITY RESOURCE MAP

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FUNDING SOURCE	OPPORTUNITY	FOCUS							
		COST AVOIDANCE	REVENUE	QI	COMMUNITY WELLBEING	SATISFACTION SCORES	SPECIFIC POPULATIONS	EQUITY	UTILIZATION
Billing Revenue	Depending on your staffing mix, you may be able to finance your program through direct billing for service. This is very difficult to sustainably achieve. Considering co-locating providers in existing clinics or offering telehealth may be the most efficient way to manage costs. Billing can also be explored as an addition to the financial model but not the sole source of funding. * Also serves advance practice evaluation and management, chronic care management, transitional care management codes, alcohol and drug screening (SBIRT), telehealth and phone-based evaluation, and more.	X	X	X		X		X	
Wellness Funds	If your intervention is involved with a cross-sector community collaborative, a new concept is emerging called Healthy Communities Funding Hubs and Community Wellness Funds.	X		X	X	X	X	X	
Medicaid Waivers and Government Demonstrations	Many state are using 1115 Medicaid waivers, DSRIP, and other financing mechanisms to transform their Medicaid system with special interest in populations with complex health and social needs.	X		X	X	X	X	X	X
Direct Contracting for Services	Some programs contract directly with a payer for a PMPM rate to cover a specific population. (This is covered in-depth in the training program.)	X	X	X		X			X

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Complex care budgeting

In order to access any funding, you will need to describe the costs and calculate the resources you'll need by creating a budget. Included in this toolkit is a resource you can use to model different scenarios for your program. Partnering with finance will help you to accurately predict your costs and also include potential revenue in the equation.

Also, to create a successful value case for your program, think about the most efficient way to achieve outcomes in the population served. The first step is to have a clear budget and plan for the costs of your intervention and the number of people you can reasonably serve. The following tool gives an easy way to test costs of your current intervention and the potential impact your team can deliver over time. It's important to consider what disciplines you need, how you're supporting your team to function at the highest level of their license, and whether team competencies match the needs of your population.

If you'd like to utilize this tool to begin crafting your own budget, download a **blank budget tool** and **instructions**.

		Year 1	Year 2	Year 3	Year 4	Year 5
Staffing	**Title**	**Project FTE %**	**Project FTE %**	**Project FTE %**	**Project FTE %**	**Project FTE %**
Staffing						
CHW	Community Health Worker	10%	10%	10%	10%	10%
MD	Medical Doctor	10%	10%	10%	10%	10%
SW	Social Worker	20%	20%	20%	20%	20%
Medical Assistant	Sr Program	10%	10%	10%	10%	10%
		20%	20%	20%	20%	20%
MD	Medical Doctor	5%	5%	5%	5%	5%
		10%	10%	10%	10%	10%
	Total	**0.85**	**0.85**	**0.85**	**0.85**	**0.85**

Item		**Annual Project Year Budget**					
		Year 1	Year 2	Year 3	Year 4	Year 5	Total
Compensation:	Salary Expense	$ 64,451.	$ -	$ -	$ -	$ -	$ 64,451.50
	Fringe	$ 20,624.	$ -	$ -	$ -	$ -	$ 20,624.48
Total Compensation		**$ 85,075.**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 85,075.98**
							-
Mgmt & Contracted Services:	Web Development Services	-	-	-	-	-	-
	IT Consulting Services	-	-	-	-	-	-
	Contracted Clinical Specialist Services	-	-	-	-	-	-
	Contracted Community Services	-	-	-	-	-	-
	Enhanced Provider Payments	-	-	-	-	-	-
	Other Consulting & Management Fees	-	-	-	-	-	-
	Legal Services	-	-	-	-	-	-
	Total Mgmt & Contracted Services:	**-**	**-**	**-**	**-**	**-**	**-**
Patient Expense:	Patient Costs	-	-	-	-	-	-
	Patient Rent	-	-	-	-	-	-
	Total Patient Expense:	**-**	**-**	**-**	**-**	**-**	**-**
Staff Development:	Staff Training	-	-	-	-	-	-
	Dues, Books & Subscriptions	-	-	-	-	-	-
	Licenses and Certifications	-	-	-	-	-	-
	Accreditation Licensing Fees	-	-	-	-	-	-
	Total Staff Development:	**-**	**-**	**-**	**-**	**-**	**-**
Travel & Meeting:	Travel - Lodging	-	-	-	-	-	-
	Travel - Mileage	-	-	-	-	-	-
	Travel - Transportation/Parking	-	-	-	-	-	-
	Travel - Meals	-	-	-	-	-	-
	Food & Catering	-	-	-	-	-	-
	Meetings Expense	-	-	-	-	-	-
	Honorarium	-	-	-	-	-	-

COMPLEX CARE BUDGETING TOOL

Dosing and program efficiency

As complex care programs mature, they are often asked how the work could be delivered more efficiently either with less expensive staff or with less time intensity. In this section, you will find resources to help you begin thinking about how to most efficiently staff and deliver your program.

One way to prepare for this kind of assessment is to develop standard expectations for the intensity of care different types of clients may require. Two examples of this type of resource include the **CAPC stratification tool** which helps staff to determine the cadence of visits based on evidence-based tools evaluating clinical status.

Another example is the **Triage tool** which assigns an expected visit cadence based on clinical and social complexity and gives staff a reference for what milestones may need to be addressed to decrease complexity.

Using your annual data analysis, ROI analysis and population root cause analysis as a basis for discussion about adaptation of your intervention. The lessons you learn from these tools can be used to continuously adapt your intervention to better meet the needs of the population you serve.

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CAPC POPULATION STRATIFICATION TOOL

This document gives guidance to "dosing" interventions, so that patients get the care they need when they need it, and the program may use its resources efficiently. These are based on the ProHealth and AAHPM Patient and Caregiver Support for Serious Illness (PACSSI) models, but should be modified as needed for each program's population, service model, and local resources.

See **CAPC's Palliative Care in the Home: A Guide to Program Design** for care delivery information.

Risk level	High	Medium	Low
Care intensity	Visits 2+ month and phone video calls 2+/month	Visits 1/ month and phone/video call 1/month	Visits every 2 months and phone/video calls 1/month
Utilization	2	1	None
ADL	Dependence in 1+ new ADL in past 3 months	Some functional impairment	Minimal or no functional impairment
Palliative Performance Score	PPS <=40	PPS <=60	Normal function
Medical	Advanced illness or multiple chronic conditions AND significant deterioration in clinical status	Advanced illness or multiple chronic conditions	Advanced illness or multiple chronic conditions
Psychosocial	Lives alone or high caregiver burden or financial distress or remote rural location	Lives with caregiver or good support network	Lives with caregiver and good support network

CAPC POPULATION STRATIFICATION TOOL

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TRIAGE TOOL

You will also want to consider the dose and timing of your intervention to ensure you are using your resources to the best impact for the population. Complex care programs have developed triage, tiering, visit dosing and length of service guidelines for their interventions to guide staff in effective delivery. Some best practices for efficiency include identifying:

- which discipline is best to take lead based on the patient's needs,
- your program's definition of crisis, acute and stable and
- what cadence of visits will continue to monitor the patient and anticipate and prevent future crises that result in an increase and utilization and cost.

	Red: **In Crisis**	Yellow: **Vulnerable**	Green: **Stable/Empowered**	Blue: **Graduated/Monitored**
Utilization Characteristics	Met program criteria: 10 ED in 2 yrs and/or 4 IP in 2 yrs OR 5 ED in 1 yr and/or 2 IP in 2 yrs	Continuing IP admits or ER visits	Not regularly admitting to IP or visiting ER	Not regularly admitting to IP or visiting ER
Program Characteristics	Rapid cycle comprehensive intervention focused on stabilizing patient	Plan in place to address gaps in medical and social needs Vacillates between crisis/disengaged and stable/engaged	Connections have been made with services; patient is stable Patient may be awaiting income source to help obtain insurance or pay for medications	All identified domains have been addressed
Average Score Per Domain (SDOH or other tool)				
Medical Characteristics	Hospice appropriate Acute sx uncontrolled Acute dz uncontrolled No access to PCP No access to regular specialty care	Plan in place for hospice Plan in place to address acute sx Plan in place to address dz Plan in place to connect with PCP No access to regular specialty care	Connected to hospice All acute symptoms managed to be chronic Disease managed, with assistance from complex case manager Connected with PCP Connected with regular specialty care	Transitioned into hospice care Connected to specialty provider and EB symptom management plan Connected to site case manager or BH provider for persistent mental illness Connected to PCMH/case manager to manage disease, (or can independently manage disease) Connected to PCP Connected to regular specialty care
Social Characteristics	Homeless/unsafe housing Suicidal and/or danger to others Active substance abuse with required Tx Food access/insecurity issues	Plan in place for housing and/or safe housing environment Plan in place to address mental health Plan in place to address substance abuse Plan in place to address food access	Plan in place for housing or housed Connected to mental health services Substance abuse addressed Food insecurity addressed	Housing is stable and safe Connected to mental health services Substance abuse addressed and in treatment Has reliable food supply
Type/Frequency of Engagement	2-3x/week in-person or phone 15-20 hours intervention follow-up work (2 hours for initial visit)	2x/month in-person or phone 10 hours intervention follow-up work	1-2 month in-person or phone 0-2 hours intervention follow-up work	Monitor 1x month by CHW or MA via phone Round on all inpatient visits (closed, active, disenrolled)
Core Components	Focus on connecting with PCP, mental health providers/treatment, transportation, housing, medication, SNAP Screen for insurance/disability/SS benefits	Focus on building sustainable provider relationships	Focus on building source of income (disability or job)	Focus on maintaining adequate income Focus on retaining relationships and connection to socialization for stabilization
Increase Engagement when:		Reassessment of xxx scores decrease utilization	Patient has pattern of 5+ ED visits	5+ ED visits and/or 2+ IP admissions in 6 months Social needs move into "Red" category

TRIAGE TOOL

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Considering billing

NON-PHYSICIAN BILLING CODES

If your complex care intervention includes nurse practitioners, physician assistants or physicians, you may already have the infrastructure to bill insurance for care provided when appropriate.

Many complex care programs are led and delivered by social workers, nurses, community health workers and other disciplines.

New codes have been emerging to allow billing for services by those who are not advanced practice providers. Consider if your program should bill for services. This adds revenue to the value case and may help to support ongoing investment in the services you provide.

A resource with potential billing codes is included in this section.

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Billing resource: Consider if your program should bill for services. This adds revenue to the value case and may help to support ongoing investment in the services you provide. Use this guide to explore various billing codes.

State

Type of service	State (CA)
Virtual Group Therapy	Should use Medi-Cal providers should use Healthcare Common Procedure Coding System (HCPCS) codes G2010 and G2012 for brief virtual communications
Telephonic follow up	HCPCS codes G2010 and G2012 for brief virtual communications HCPCS: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report E/M, provided to an established patient. CPT code – Medi-Cal providers may be reimbursed using the HCPCS codes G2010 and G2012 for brief virtual communications.

Federal

Virtual group therapy	• Reimbursement: $14.48 per client- Group Therapy in BH setting max 12 people in a group • Medi-Cal providers should use Healthcare Common Procedure Coding System (HCPCS) codes G2010 and G2012 for brief virtual communications • CPT Code- 90853 addressed in DHCS' Behavioral Health Information Notice 20-009
Transitional Care Management Service	• CPT 99495 and 99496

BILLING RESOURCE

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Key takeaways

- Create a budget for your program
- Develop a short and long-term financial plan
- Identify what level of staffing is needed for efficient delivery
- Set a standard for visit cadence and delivery
- Use your data to evaluate and adapt your program on an annual basis
- Consider billing for your service

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