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> What I've seen really make things work is when there's enough co-design where the people and the culture have their own fingerprint on what happens, and enough voice and autonomy in the process where they feel like they developed it.

**MARGIE POWERS,** Chief Improvement Officer, Vayu Health

# Sharing your success

**Introduction**

**Creating a pitch deck**

# Introduction

In the flurry of meeting complex patient needs, programs often forget the importance of sharing the impact of their work with diverse stakeholders. To continue to generate buy-in, partnership, support and sustainable funding, it's important to develop a regular cadence of reporting in different formats that link back to what matters most to different stakeholder groups.

Creating a standard pitch deck that includes 5 to 10 slides showing the opportunity, the problem you're trying to solve, and the impact of your intervention on cost, utilization, quality, satisfaction, and equity is a powerful practice to highlight your success. Including a short video of a patient, provider, or partner interview can round out the story of impact.

Telling the story of your success can also generate new partnerships and additional funding. Successful complex care programs have developed a range of approaches including quarterly newsletters, presentations to partners and community stakeholders and publications to continuously highlight the impact on the population and the possibility of impact for the community. Examples are found in the case studies on Regional One Health and Adventist Health.

# Creating a pitch deck

Creating a standard deck of slides to share your success will give you a great resource to share with your leadership team, payers, stakeholders and community partners. You can adapt this deck to describe your program and outcomes.

Including patient stories or videos can really translate the importance of complex care intervention. Successful complex care programs have built an audio/video consent form into their delivery process. An example is included in this section.

Review the links in the Adventist Health and Regional One case studies to see how other programs have utilized this concept.


**SAMPLE PITCH DECK**

# SHARING YOUR SUCCESS CASE STUDIES - *ADVENTIST HEALTH - Clearlake, CA.*

Adventist Health (AH) Clear Lake and the National Center for Complex Health and Social Needs partnered in the Project Restoration initiative to design a model for complex patients in Clearlake, CA. As a rural critical access hospital located in Lake County with some of the worst health outcomes in the State of CA and plagued by devastating wildfires, the community had complex challenges with limited resources to address needs. Project Restoration was created to meet the needs of vulnerable community members who had high utilization of the healthcare, EMS and criminal justice systems. The full case study can be found **here**.

## Understanding population utilization

The community used two approaches to understand the population – system level analysis of all patients who accessed the health system in one year and a community collaborative sharing lists of the highest utilizers of the healthcare, EMS and criminal justice systems. AH used data from the electronic health record and the cost accounting systems for this analysis.

## Scaffolding populations

The population with the highest financial impact on the system was those with managed Medicaid. The community began with this population and added others as support for the initiative grew.

## Stakeholder needs & asset mapping

The leader of the initiative met individually with key stakeholders to assess their needs, shared vision and potential for collaboration. The community completed asset mapping through internet search for key domains of resources needed for complex patients. They also held a community event with a gallery walk where community members could add resources that hadn't been captured in the initial search. This was translated into a paper directory and simple web-based resource that is updated annually by the community.

## Demonstrating value

The Project Restoration team identified metrics that mattered to the community partners and tracked changes in cost and utilization for each of the three systems, change in access to housing and primary care (quality) and provider and patient satisfaction. Comprehensive demographics are tracked for the population to highlight the equity issues that are addressed through the model.

## Collaborating with finance

The CFO was included as a partner in the community collaborative that developed the initiative. Partnering with the CFO has resulted in co-design of the next phase of evaluation and creation of a dashboard for the community to track outcomes for multiple initiatives that have subsequently been developed based on the success and learnings from Project Restoration.

## Funding and efficiency

The model was initially funded through community benefit dollars from the health system. As the program and outcomes grew, a relationship was established with a Medicaid plan for partial funding. The city has dedicated $500,000 to the initiative due to the positive impact on community costs. Grants have been received from several sources to fund additional services like a shower trailer for the homeless. The community is now working on an ecosystem analysis to identify the next phase of sustainable funding to support the growth of the work.

The team has creatively addressed staffing and delivery including being led by a Pastor highly experienced with building authentic relationships and lasting change with the homeless population, using Americorp Volunteers, integrating SW students in delivery, co-locating services with other community partners, using peer supports and hiring graduates of the Project Restoration program as staff.

## Celebrating success

The Project Restoration team has excelled at sharing outcomes and including the community in the story of impact and success. A regular newsletter and facebook page bring the personal story directly to community members. The team has created several videos that are broadly shared and works with the media to highlight important milestones in the news as the program grows.

# SHARING YOUR SUCCESS CASE STUDIES - *Regional One Health - Memphis TN*

Regional One Health (ROH) and the National Center for Complex Health and Social Needs partnered in the ONE Health initiative to design a model for uninsured patients in Memphis, TN. As a safety net hospital located at the intersection of four states, they serve complex populations ranging from trauma and burn patients to neonatal and high-risk OB populations. The State of Tennessee did not expand Medicaid and the hospital had a 34% uninsured rate at the beginning of this initiative. Read the full case study **here**.

## Deciding which patients to work with first

Regional One began the work of developing a model by analyzing the population of patients who accessed the health system in one year. ROH used data from the electronic health record and the cost accounting system for the analysis. By looking at the uninsured population they found the top 5% of uninsured utilizers represented 62.6M in costs and the top 25 patients represented 6.3M in costs. The team analyzed the root causes of the highest utilizers and found the characteristics represented below. This information helped to generate support across stakeholders and helped the team to target the model to those most in need of service.

## Scaffolding Populations

For Regional One, the needs of the uninsured are so great, the team has remained focused on this population. The team has used the same methodology to consider adding other populations in the future based on the scaffolding of financial impact to the health system.

## Stakeholder needs & asset mapping

Several individual meetings were held to identify stakeholder needs and potential partners. Community events were held on a quarterly basis to discuss potential collaboration and share developments in the model. Comprehensive asset mapping was completed of all the resources in the community for complex patients and this was included in the build of an Aunt Bertha site that is available to the community. Interviews and asset mapping resulted in identification of partners who could meet behavioral health and substance use disorder needs of the population, rather than including these competencies directly in the team hired for the model.

## Demonstrating value

The team utilizes comprehensive outcomes measures to analyze impact on cost and utilization (inpatient, ED, length of stay and variable cost analysis), Arizona Matrix to measure impact on quality and videos of patient stories to measure impact on satisfaction. Comprehensive demographics are tracked on the population to identify the impact on equity.

## Collaborating with finance

The CFO was a partner from the beginning in the development of the model. Comprehensive financial analysis was developed to track impact on fixed and variable costs and impact on operating margin.

## Funding and efficiency

Development of the model was initially funded by a grant from a local foundation. Success in delivery and cost avoidance outcomes resulted in the program being integrated in the health system budget as a key initiative. Additional funding from diverse sources including The Plough Foundation, United Health Care, AutoZone, Qsource and Goldman Sachs has continued to fund expansion of the program.

## Return on investment

By partnering early with the CFO and tracking comprehensive metrics from the beginning of the program, ONEHealth was able to demonstrate a strong story of impact. The team takes into consideration the financial, health, utilization, self sufficiency and community return on investment. For the first 430 people served, the organization identified a 17M positive impact on the bottom line which the CFO identified as an 800% ROI.

## Celebrating success

The ONEHealth team uses several avenues to report outcomes and generate community excitement for the impact from the program. A regular blog including patient videos is housed on the health system website. A cadence of public community meetings is held to report outcomes and work on additional collaborations. National presentations and awards have furthered the story of impact.




# Key takeaways

- Create a pitch deck to share your success
- Create an annual plan for how and when you will report outcomes