Building the Value Case for Complex Care

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The National Center
for Complex Health & Social Needs
An initiative of the Camden Coalition

Acknowledgments

This toolkit was designed to be a simple and accessible way to learn about one of the least understood and challenging aspects of complex care: making the mission and margin align.

Camden Coalition of Healthcare Providers

The National Center for Complex Health & Social Needs

Our work was made possible through the generous financial support of the Commonwealth Fund. We also wish to thank the project team from the Commonwealth Fund, including Mekdes Tsega, Tanya Shah, Melinda Abrams, and Corrine Lewis; Allison Silvers and the Center for the Advancement of Palliative Care; and colleagues at the Camden Coalition, including Emily Wasuna, Natasha Dravid, Katie Wood, Dawn Wiest, Nate Hulfish, Anthony DePietro, and Teagan Kuruna.

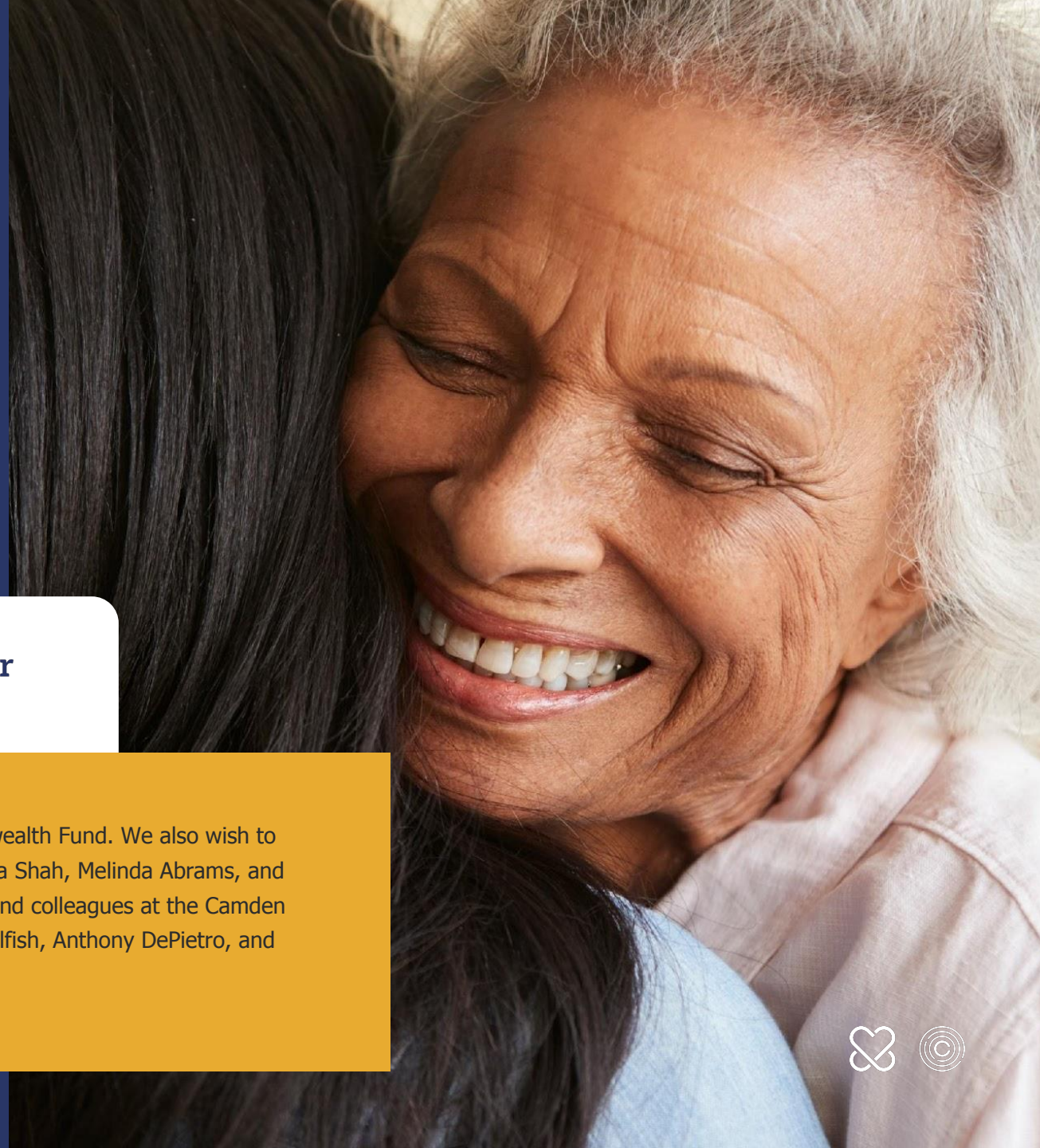

TABLE OF CONTENTS

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I'm hopeful that the endgame is a more human approach.

ANAND SHAH, MD, VP of Social Health, Kaiser Permanente

Introduction

Creating this guide

What is complex care?

The imperative for complex care

Evolving financial models

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As the old adage goes, "No margin, no mission." Making a business case is a core competency of any clinical leader who wants to transform the delivery of healthcare for people with complex health and social needs. While we may know the value of our programs and services, we must also know how to communicate that value to stakeholders who control access to the resources (people, time, space, and technology) to operate these programs.

This toolkit is designed to help you gain support of key stakeholders within your organization, as well as with outside funders, partners, and payers. "Making the case" is not just about showing a financial return on investment. As we've learned from dozens of leaders nationwide, there are financial, quality, moral, personal, and political considerations at play when determining whether a program receives financial support.

Creating this toolkit

With support from the Commonwealth Fund, we interviewed more than 100 health and social system leaders and innovators to understand what matters most in creating the case for complex care, how to adjust the case in times of crisis, and ways to champion efforts in various environments. In partnership with the Center for the Advancement of Palliative Care, we also adapted lessons from their Payment Accelerator course into the toolkit and resources. We've captured those lessons and translated years of experience into accessible tools and resources to help make the case for individual programs.

Know that this tool is iterative, and the "times they are a-changing." We invite you to share your own best practices with us for inclusion in the next version of this guide.

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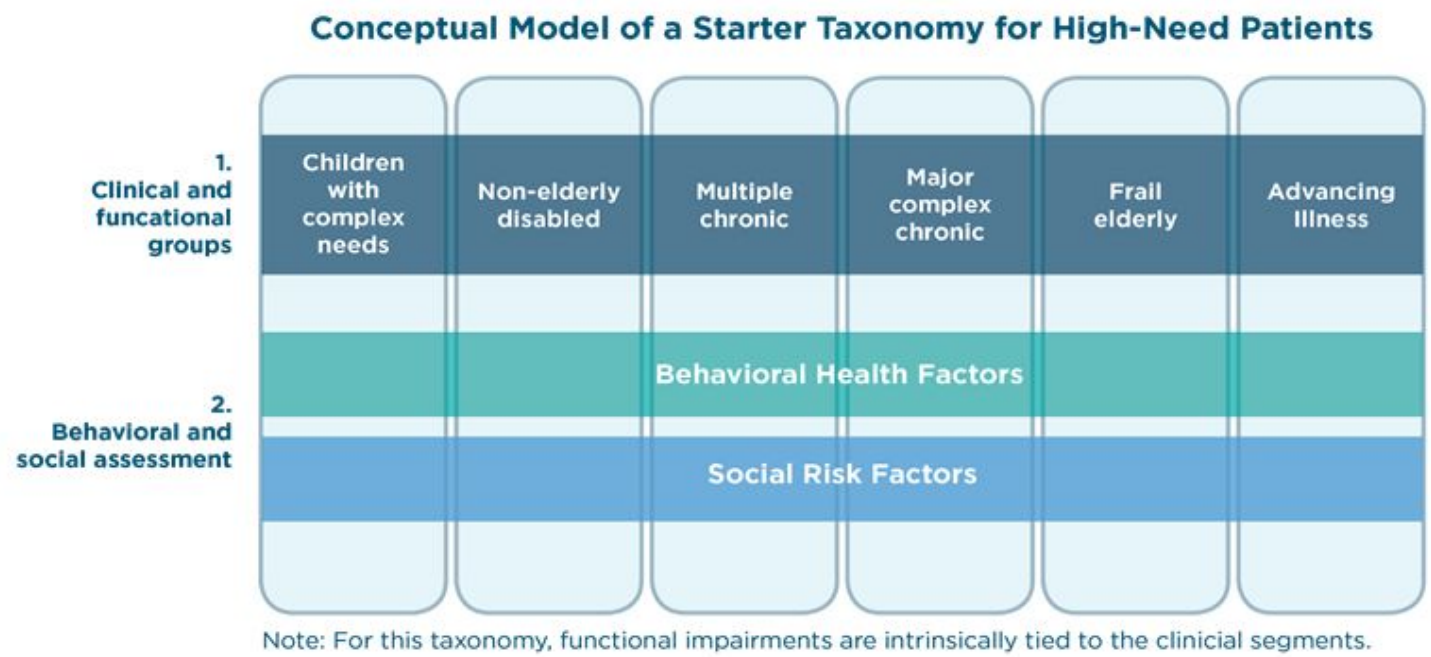
What is complex care?

Complex care is a new field of practice that seeks to improve the health and well-being of individuals who experience combinations of physical, behavioral, and social health needs that result in excessive utilization of the healthcare system. Complex care includes a variety of models, such as comprehensive care management by a health, behavioral health or social services agency, integrated primary care, and coordinated systems of care. These programs can be operated by health plans, primary care clinics, health systems, and community-based organizations to serve a diverse range of subpopulations – from children with complex needs to frail elders facing dementia and other chronic diseases.



Read the National Academy of Medicine **report** on the heterogeneity of high need populations

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DEFINITIONS OF POPULATIONS FROM THE CONCEPTUAL MODEL

- **Children with complex needs**: Have sustained severe impairment in at least four categories together with enteral/parenteral feeding or sustained severe impairment in at least two categories, and requiring ventilation or continuous positive airway pressure. Categories for children with complex needs are: learning and mental functions, communication, motor skills, self-care, hearing, and vision

- **Non-elderly disabled:** Under 65 years and with end-stage renal disease or disability based on receiving Supplemental Security Income

- **Multiple chronic conditions:** Only one complex condition and/or between one and five non-complex conditions

- **Major complex chronic**: Two or more complex conditions or at least six non-complex conditions. Complex conditions, as defined in Joynt et al., 2016, are listed in Table 2–1. Non-complex conditions, as defined in Joynt et al., 2016, are listed in Table 2–1.

- **Frail elderly:** Over 65 years and with two or more frailty indicators. Frailty indicators, as defined in Joynt et al., 2016, are gait abnormality, malnutrition, failure to thrive, cachexia, debility, difficulty walking, history of fall, muscle wasting, muscle weakness, decubitus ulcer, senility, or durable medical equipment use.

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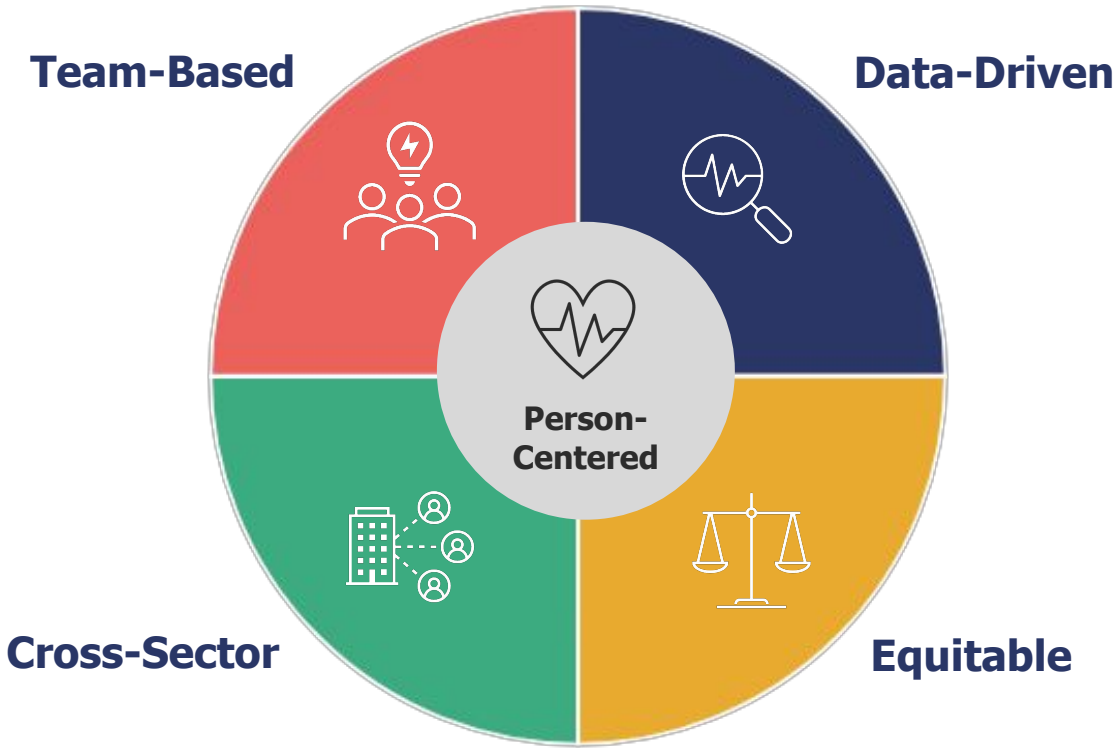
Despite the heterogeneity of models, settings, and populations, complex care programs share common elements and embrace the following principles:

- **Person-centered**
- **Team-based**
- **Cross-sector**
- **Equitable**
- **Data-driven**

While many complex care programs begin as a single care management program, the principles of care are best realized in a complex care ecosystem. Ecosystems are organizations across sectors within a community that work collectively and intentionally to better address the root causes of poor and inequitable health and well-being among populations with complex health and social needs. You can learn more about these concepts in the **Blueprint for Complex Care.**



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The imperative for complex care

COMPLEX CARE IN THE TIME OF COVID-19

Making the case for complex care has never been more important, as the COVID-19 pandemic shed light on systems failures that impact the health of every individual in the nation. The pandemic has highlighted the vulnerability of the homeless, the fragility of isolated seniors, children's dependence on school for regular meals, the need for safe harbor for those in domestic violence situations, and the abundance of people one paycheck away from financial disaster. Furthermore, behavioral health needs and **deaths from drug overdoses** skyrocketed, and the spike in unemployment exposed the problematic connection between insurance and employment. All this is against a backdrop of rising inequality and increasing violence against Black, Indigenous and People of Color (**BIPOC**) communities that reveal deep cultural divides.

The explicit link between social determinants of health and physical health is well-established in the literature. We know that communities of color are disproportionately impacted by issues like unstable housing, lack of food security, and the deeper implications of poverty.

In the context of the pandemic, these social determinant factors had compounding implications for the physical health of BIPOC communities. The work of complex care is the deep systems work needed to change the trajectory of racial health equity in our country.

Policy changes in response to the pandemic have opened new possibilities for complex care. The expansion of **telehealth**, cross-state delivery of care, and integration of other disciplines signal progress, as does a shift in **bringing care into the home** to avoid hospitalization, and new community partnerships to facilitate **distributed models** of care. More emphasis is also being put on the need to address the housing and homelessness crises, and the value of **wraparound care** management services. **Virtual behavioral** health and addiction treatment interventions for social isolation have identified new levers for better access and outcomes. These important changes are expanding opportunities for complex care programs to think differently about historically underserved populations in new and collaborative ways.

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Evolving financial models

The challenge of making the case for complex care is further complicated by the fact that our healthcare system is in the midst of a transition from fee-for-service to value-based care. Policymakers have long identified the fee-for-service system as a source of rapidly growing spending and misplaced financial incentives, pushing CMS to shift financial incentives in healthcare through programs like Accountable Care Organizations, bundled payments, and direct contracting. All these programs aim to realign incentives so that providers and health systems can benefit financially by delivering care more efficiently.

At the most basic level, making the financial case for complex care is more challenging in a fee-for-service (FFS) environment. This is because individuals living with complexity often frequent hospitals, and in a fee-for-service environment each visit is a reimbursable event, increasing hospital revenue. Therefore, understanding root causes, and driving people away from "sick care" results in diminished returns for the healthcare system. In a value-based environment, incentives are more aligned with reimbursement based on making people better, rather than simply paying a "fee for each service" rendered. This toolkit provides resources to make the value case in both settings or somewhere in between.

The pandemic further complicated the financial picture and exposed the vulnerability of a healthcare system in a fee-for-service model.

In 2020, health systems lost significant amounts of revenue from the cancellation of elective procedures and the increased cost of scaling up to provide staffing and care. Primary care, dental care, specialty care, community-based behavioral health, and federally qualified health centers have experienced declining revenue from patient visits and increased costs to obtain personal protective equipment, redesign delivery for COVID-19 safety, and implement telehealth and other workflows to provide care while physically distancing. These actions, although necessary, have resulted in layoffs and furloughs of healthcare workers, as well as the closing of some sites of delivery.

In 2021, new funding emerged to accelerate re-building communities and public health in response to the pandemic. Cities, counties and states received grants to accelerate attending to the needs of marginalized populations and building stronger cross community collaboration. Building understanding of these various financial models and how to articulate your value case in the context of your unique community is covered in this toolkit.

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TABLE OF CONTENTS

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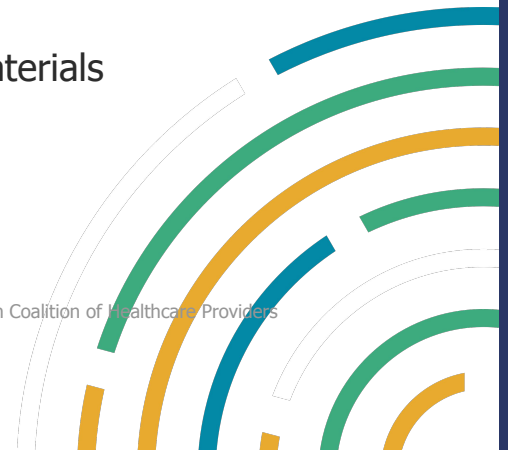

If you come to an emergency department 85 times over the course of 18 months, maybe we're treating the wrong thing

SUSAN COOPER, MSN, Senior Vice President and Chief Integration Officer, Regional One Health

Getting started in complex care

Introduction

A primer on using data

Visualizing high-frequency utilization

Learning root cause themes

Deciding which patients to work with first

High utilizers of emergency department

High utilizers of inpatient admissions

Integrating palliative care

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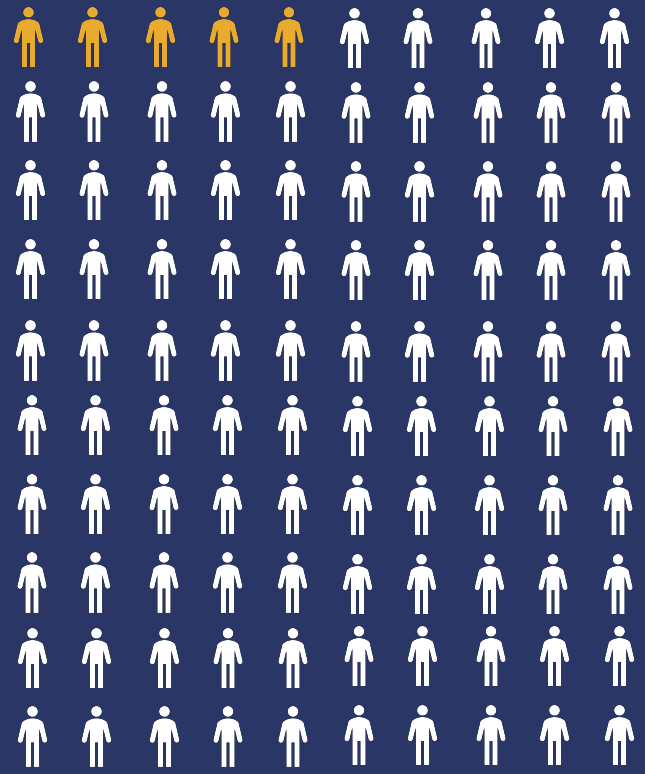
Introduction

One of the most important foundational concepts to building the value case for complex care is effectively understanding and intentionally targeting the population you will serve. In this section you will learn different ways to use data to visualize populations and techniques for understanding their needs.

Click **here** for additional reading.

5% of the population accounts for 50% of healthcare costs



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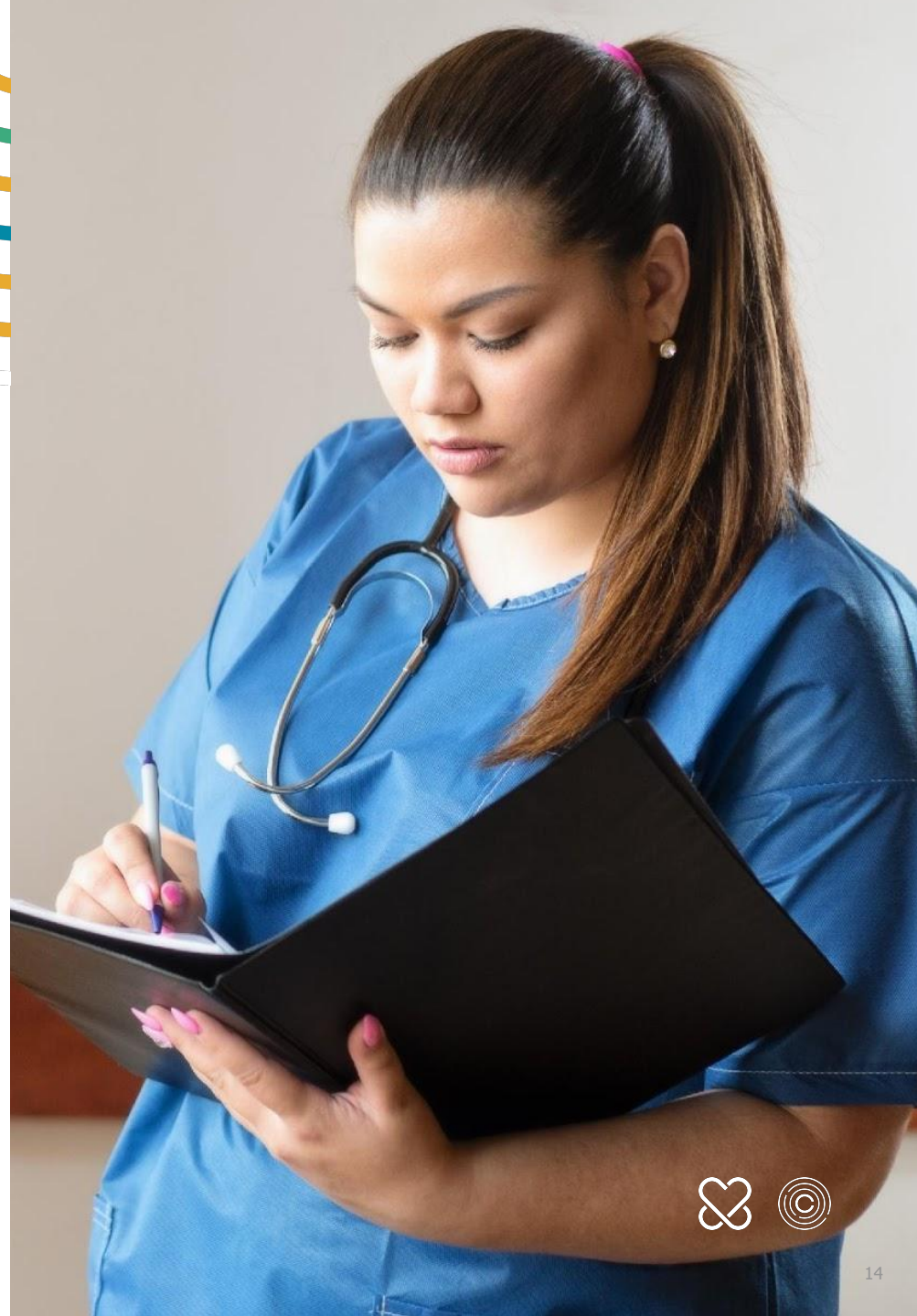
A primer on using data

Data analytic support is the holy grail when making the case for complex care. Most programs – even in large health systems – have minimal data support for identifying populations for intervention or analyzing outcomes. As you read through the next section of this toolkit and become inspired to visualize data of your population, check to see what reports are already available within your system. You may be surprised to discover data reports needed for complex care already exist. For example, do case managers in the emergency department already have an "ED Utilization Report?". Programs use the following sources to access population and outcome data:

- EHR and cost accounting systems
- Readmissions data
- **Community health needs assessments**
- Health Information Exchanges
- **Hospital association analysis**
- Claims data from payers
- ACO/Capitation data
- **Cross-sector community data**

Programs have also partnered with a motivated data or financial analyst — or even a graduate student from a local university — to do an initial data analysis. When possible, complex care programs integrate funding for data analysis into grants or budget a data analytic FTE as part of the intervention.



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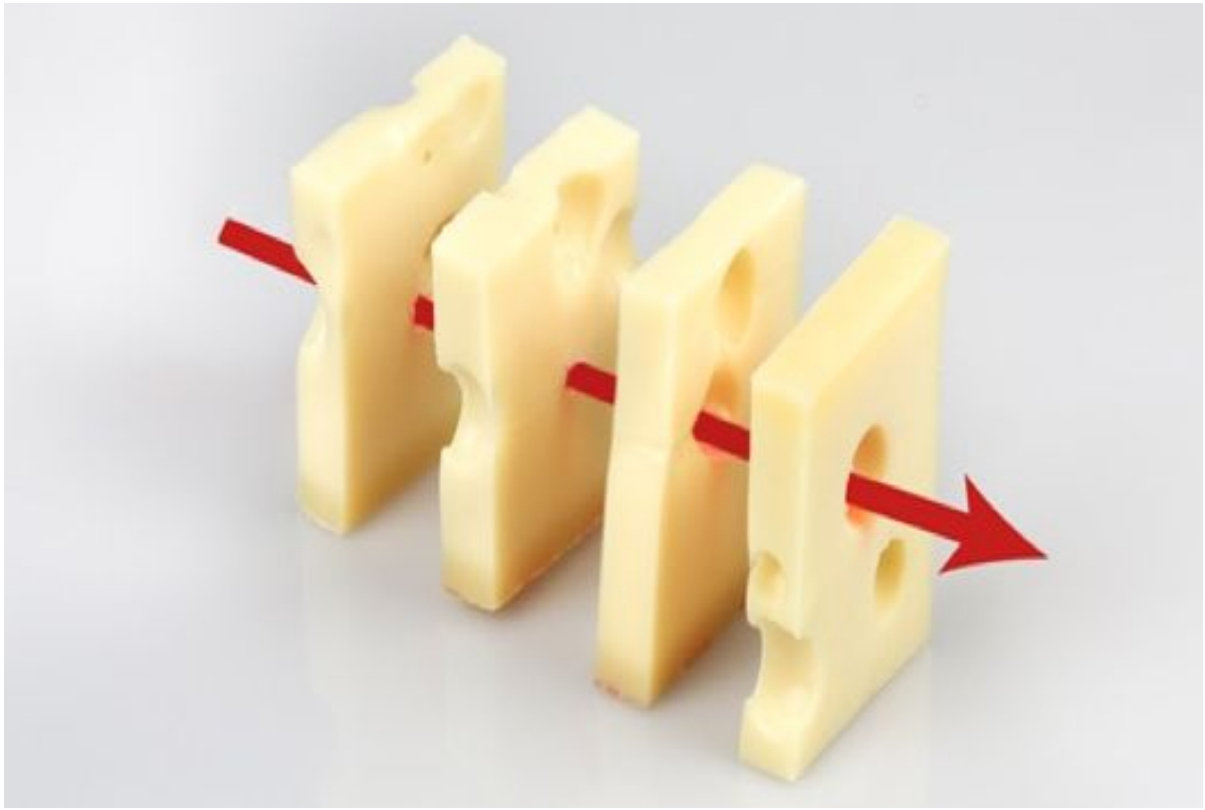
EXAMINING DATA THROUGH THE LENS OF OUTLIERS POINT US TO "SWISS CHEESE HOLES" IN THE SYSTEM

People living with complexity often become complex because all the Swiss cheese holes that exist in the system have lined up for them to fall through. Learning the stories and cases of outliers within our systems can help us understand themes of systems failures that likely exist for anyone navigating the healthcare system.

A secondary benefit of a complex care analysis — rarely leveraged in our experience — is that the review identifies process improvements that could help the entire patient population.

By identifying "Swiss cheese holes" (aka process improvements) for one case, then multiple cases, we can identify the greatest opportunities within our systems to "plug the holes" and proactively change the trajectory for individuals in the rest of the population before they become complex. Thus, impacting many more individuals than just those experiencing complexity.



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Visualizing high-frequency utilization

Whether you're starting a new program, making the case for an existing one, or looking to support growth and sustainability of a complex care program, the first step is understanding the opportunity in your market.

Many systems tend to start by segmenting their population by disease state, but we encourage you to start by examining your population through the lens of patient utilization. The chart on this page shows one way to visualize the population that accesses a system in a given year, as well as distribution by utilization and cost.

The individuals in the pink box are often the greatest teachers of where our systems fall short in caring for people living with complexity. By understanding the stories of the people in this segment, we gain insights into systems' Swiss cheese holes that, if fixed, can proactively impact the trajectory of the rest the other patient segments.

EMERGENCY DEPARTMENT AND INPATIENT UTILIZATION

<table>
<tr><th rowspan="2">ED visits</th><th colspan="5">Inpatient visits</th></tr>
<tr><th>0</th><th>1</th><th>2</th><th>3 to 4</th><th>5+</th></tr>
<tr><td>0</td><td colspan="2" rowspan="3">44,728 (85%) patients
• 5,210 Inpatient visits
• 63,489 ED visits
• $28,000,000 (50%) IP payment
• $25,800,000 (59%) ED payment</td><td rowspan="8">985 (2%) patients
• 1,856 IP visits
• 4,129 ED visits
• $10,000,000 (17%) IP payment
• $1,700,000 (4%) ED payments</td><td rowspan="8">503 (1%) patients
• 2,026 Inpatient Visits
• 4,144 ED Visits
• $10,900,000 (20%) in IP payment
• $1,700,000 (4%) in ED payment</td></tr>
<tr><td>1</td></tr>
<tr><td>2 to 3</td></tr>
<tr><td>4 to 5</td><td rowspan="4">4,961 (9%) patients
• 28,447 ED visits
• $11,500,000 (27%) in ED payment</td><td rowspan="4">1,563 (3%) patients
• 1,239 IP visits
• 6,962 ED visits
• $6,700,000 (18%) in IP payment
• $2,800,000 (6%) in ED payment</td></tr>
<tr><td>6 to 7</td></tr>
<tr><td>8 to 9</td></tr>
<tr><td>10 +</td></tr>
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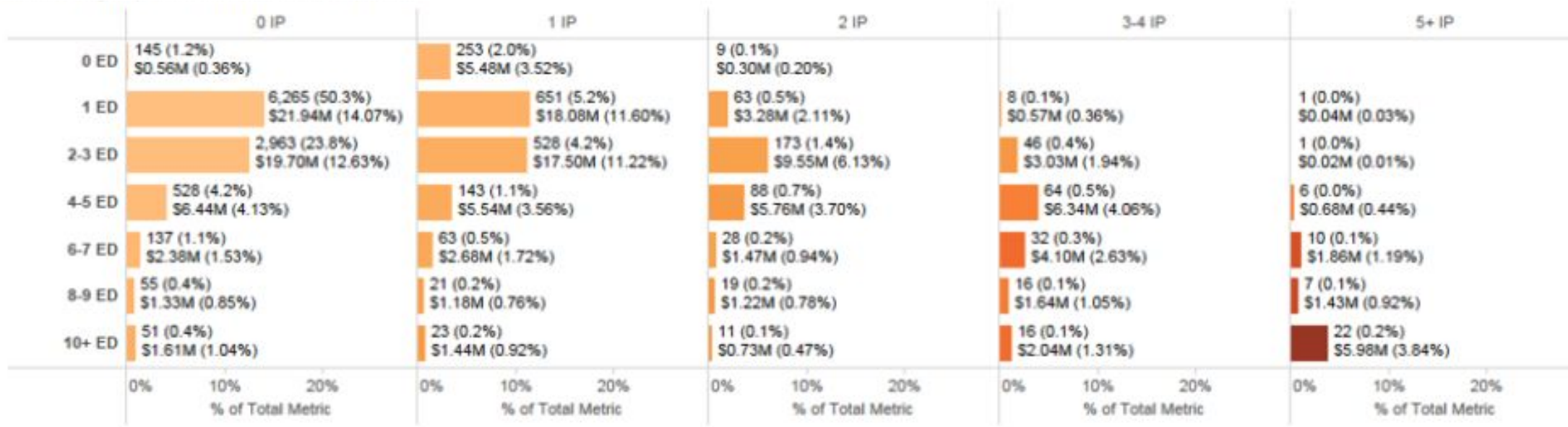
ANOTHER EXAMPLE OF VISUALIZING POPULATION UTILIZATION FREQUENCY



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WHAT IS POSSIBLE WITH SOPHISTICATED DATA

NYC Health+Hospitals uses sophisticated population health analytics to score individual risk through combinations of data that include prior utilization and cost, pharmacy, clinical diagnoses, and demographics. The goal is to track clusters of the population over time to understand opportunities for system-wide process improvement that address root causes. A recent webinar describing this approach **Using Population Health Strategies to Tailor care for Individuals with Complex Needs** can be found on the Better Care Playbook.

NYC HEALTH+ HOSPITALS | POPULATION HEALTH

Review the latest **toolkit from NYC Health+Hospitals**

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Learning root cause themes

HOW TO START WITHOUT SOPHISTICATED DATA SUPPORT

It's also possible to start a complex care program and gain an understanding of your population without data analytic support. Many programs are under-resourced and have created lists of the top 100 clients (by cost and by utilization) seen by their organization or partner organizations. Staff then analyze their characteristics and root causes of utilization to differentiate targeting of a specific population. Programs with minimal resources also ask providers and community agencies to identify their top 20 complex and vulnerable members, and a similar assessment and root cause analysis is completed to identify opportunities

Completing this type of analysis will help you identify individuals in your population who are experiencing the most systems gaps. Recreating the analysis on an annual basis will also reveal changes in the population over time or identify new subpopulations on which to intervene.

Client Initials: (removed)
Age: 44

Please fill in the boxes below based on any information you know about the individual you're working with:	
Medical	**BH and Substance Use Disorder**

• Skin and blood infections related to IV drug use
• Needs 6 weeks on IV antibiotic treatment in supervised facility
  ○ Hospital started him on methadone maintenance therapy
  ○ Schedule to see Psychiatry as well to discuss mental health treatment options
	• Opioid use disorder
	• Bipolar disorder
	• Not currently on medication, in treatment or associated with a program
	• High risk for overdose
	• Limited access to clean needles and supplies

Social	**Systems**
• Experiencing homelessness • Disconnected from immediate family, but in contact with best friend • Lost visitation privileges with his daughter • Lost identification • Not receiving any income • Has unresolved court/legal issues • Owes back child support • Significant history of emotional trauma in childhood – father died of an overdose	• Hospital unable to discharge for his IV antibiotic therapy, subacute facility will not accept him because of drug use history • Hospital staff has confrontational relationship with him – labeled "high risk" and "non-compliant" • Inpatient hospital unit unable to manage his personality and significant psychosocial needs. • No medical respite service in area

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CONTINUING WITH MINIMAL DATA SUPPORT: FIND THEMES AMONGST INDIVIDUAL ROOT CAUSES

Once you've gathered enough individual root cause cases, a tracker like this one shows an example of how to collate multiple individual cases to better understand themes amongst the individual cases.

Whatever method you decide to use to analyze themes, it is important to look across common systemic barriers patients may face within medical, social, behavioral, and system domains.

PATIENT IDENTIFICATION			DEMOGRAPHIC VARIABLES					NUMBER OF ENCOUNTERS 12 months prior to intervention				ROOT CAUSE DIAGNOSES Diagnoses driving access				SOCIAL ISSUES DRIVING ACCESS							
MRN Number	Patient Name	DOB	Age	Gender	Insurance	Zip Code	Race	ED/UC	IP/OBS	OP (clinic)	Length of stay days	ICD 10s for inpatient admissions	Chief complaint for ED visits	Behavioral health diagnosis?	Substance use disorder diagnosis?	Lack of primary care?	Lack of housing?	Food insecurity?	Transportation issues?	Legal issues?	Safety issues?	Social isolation?	Disabilities?

ROOT CAUSE ANALYSIS TOOL

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Deciding who to work with first

New programs often make the mistake of attempting to work with people who have the highest visit frequency in the healthcare system without regard to the underlying clinical or social needs. The rationale is appealing: if we can reduce the utilization of just three of the people with over 100 visits each year, we will improve costs. But if you are unable to impact the root cause(s), you cannot expect success.

Translating individual root causes to more broadly impactable systems change requires, among other things, clinical experience and judgment. Performing root cause case reviews can allow you to identify individuals with similar characteristics whose utilization is far higher than expected. When we see common themes linked to high frequency of utilization, it's an indicator that a gap exists within the system. For example, if people living with homelessness and substance use disorder appear as common visitors of the emergency department, it's likely that gaps exist in housing and substance use treatment within your broader community ecosystem.

By starting with root causes that can be appropriately addressed for an individual, you'll have a dramatic impact on the patient's overall clinical health and utilization. Over time, the processes you develop to help one person can translate into sustainable, scalable, process improvements that help whole groups of people with similar needs.

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High utilizers of the emergency department

Individuals who frequent the emergency room often cross the intersection of physical, behavioral and social complexity. Anecdotally, after working with many health systems on strategies to address their populations, those who average 100 visits in a year include subpopulations of people experiencing chronic homelessness, long-term substance use combined with age over 50 and complex life circumstances. The group is historically extremely underserved, and deserving of a new approach to care. For success in the population, you will need integrated behavioral health and substance use disorder treatment in your model and a partnership for accessing housing with a harm reduction approach.

The other complexity you will likely encounter in people who visit the ED in the triple-digits annually is complex behavioral health, personality disorders, diagnoses like Munchausen's, and issues where the hospital has become a safe place for meeting other needs.

Success will require behavioral health services, partnerships across systems in your community, a long-term intervention, and organizational support for setting boundaries and sharing plans of care across settings. Staff will require dedicated training to shift techniques and mindsets of how to create these cross-system partnerships and sustainably support long-term process improvements for community care.

When deciding to work with people who frequent the ED, it's helpful to start with a target of 10 to 20 visits in the previous year. You can serve those with less utilization, but if your threshold of visits is too low, you may be accessing people who had an acute episode that resolved by itself, and it will be hard to show the business case for the population. If you choose higher numbers of visits, you may tap into a population that requires resources and long-term intervention that your program may not be adequately funded for at its onset.

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High utilizers of inpatient admissions

Tracking inpatient utilization can be a helpful way to target a high needs population. Two areas to watch out for with this metric are setting the bar too low and not using a triage process for types of admissions.

If you set the entry point too low (less than three inpatient admissions in a year), you may be tapping into a subpopulation with an acute event that resolved on its own. It's difficult to show a financial return for your program if the utilization or cost wasn't high from the beginning.

Consider the root cause and your ability to impact utilization and cost. Some programs exclude cancer patients or dialysis patients because expected utilization and cost may be high for these populations. While there is opportunity to improve quality and decrease cost in these populations, you will need organizational support and partnerships with specialists to make a significant difference.

Recent resources from the Better Care Playbook and publications from Anna Davis, et al. give an excellent foundation to inform your choice of a population of focus.

- **Defining complex patient populations: Implications for population size, composition, utilization, and costs**
- **Identifying populations with complex needs: Variation in approaches Used to select complex patient populations**
- **Using population identification strategies to tailor care for individuals with complex needs**

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Integrating palliative care

One common mistake complex care programs make is not considering the **prognosis** of the client and their appropriateness for hospice or palliative care. High inpatient utilization or cost can indicate a person is declining with a chronic disease. This can be missed between systems and from admission to admission. Your program may be well-positioned to serve people at the end of life. It's important to consider what kind of care they wish to receive and the decisions they need to make. The hospice insurance benefit provides a wide range of services at minimal cost to patients and families. Palliative care teams are deeply knowledgeable in proactive symptom management and complex decision-making that comes along with decline from a chronic disease. Your program will have a difficult time making the business case if you take on clients that are best served by another field with comprehensive services and insurance coverage.

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Key takeaways

- Use data to visualize utilization across the system as a starting point and an annual evaluation point
- Evaluate root causes of utilization to identify subpopulations to serve.
- Individuals with similar characteristics who also have high frequency often point to systems failures that can benefit from process improvement
- Use this analysis to identify potential inclusion and exclusion criteria for who will be served by your program

TABLE OF CONTENTS

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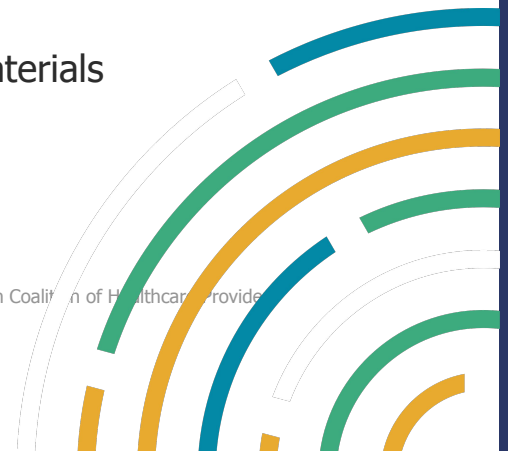

> We're all better off by accommodating those that really need to be in the emergency room, rather than those that are there because they don't have the support they need to stay out of the emergency room.

DAN GREEN, CFO Mercy Health Saint Mary's

Scaffolding the population

Introduction

Moving to value-based payment

Understanding the language

Scaffolding populations for impact

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Introduction

While hospitals are required to serve all patients who need emergency department or inpatient services regardless of their ability to pay, the hospital's revenue for the same services can range dramatically. If the patient is uninsured or is covered by Medicaid, the hospital may actually lose money on the service, while hospitals fare better financially for patients covered by Medicare or commercial insurance. If you can reduce unnecessary utilization of those with the lowest reimbursement source, you will continue to generate buy-in and support from the organization for ongoing intervention and expansion of complex care. Taking this approach also allows you to prioritize equity by first serving those with the least resources.

Learning how your organization perceives the financial impact level of different populations helps you target and stage the populations you work with, generate buy-in and create financial sustainability for your program.

In this section, you will learn about different value-based payment concepts and how different payment structures and levels can influence your programs' financial impact and choice of population.

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INSIGHTS FROM EXPERIENCE: BALANCING THE MARGIN AND MISSION POLARITY

As a clinician, it was my instinct to help everyone I could. After having intervened with a high-utilizing population, demonstrating double-digit reduction in utilization, and receiving a lukewarm response from the senior executives regarding the (negative) financial impact, the CFO clued me into a key secret of success in the business case: you can't help everyone at once. He taught me one of the best lessons: I had considered mission, but not margin. I had unintentionally reduced millions of dollars in hospital revenue for which the executives in my organization had to compensate. Depending on the financial goals of your institution: consider starting with a small population. After this feedback from the CFO, he became my partner in the work. Together, we identified which patients to work with first, and how to stage the populations for intervention in a way that prioritized **equity, need and mission** while balancing margin. This wasn't intuitive to me as a clinician. I never thought about segmenting patients by financial impact, but I realized that for the work to move forward, I had to consider it. If I had ignored the CFO's recommendation, I'm not sure the complex care program at the hospital would still exist years later. - **LAURAN HARDIN**

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Moving to value-based payment

While the ACA has been subject to court battles and political threats since its passage in 2010, there is general consensus within both parties and health policy experts about the need to move from fee-for-service (FFS) to value-based payment (VBP). The pace of the transition from FFS to VBP varies dramatically by geography and provider type.

Created in 2010, the Center for Medicare and Medicaid Innovation (CMMI) was established to improve healthcare quality and reduce costs in the Medicare, Medicaid and CHIP programs. **CMMI** has introduced a steady stream of new payment models that seek to align financial incentives between payer and provider. The goal of VBP is to improve care for people and hold the healthcare system accountable for a "health" instead of "sick" outcome, improving quality at the same of lower costs. Models range from disease-specific bundled payments to population-level shared savings and direct payment programs. Many of these models originally retained some element of FFS, adding VBP incentives when payments were below the target.

Over time, models have required an increasing amount of risk, with providers taking downside *and* upside risk, and payments moving to fixed price (capitation).

Insurance companies and state Medicaid plans have also been adopting VBP models gradually for both public and privately financed coverage.

While the healthcare system transitions from FFS to VBP, the pace of that transition varies dramatically by provider type and geography. Recent studies estimate that the vast majority of physician practice revenue remains FFS as health systems are increasingly subject to VBP, and most revenue is earned in a hybrid structure. It is expected that the trend toward VBP will continue over the next decade, and that healthcare providers will strengthen their capacity to operate at risk.

Understand the VBP models in which your system participates by **accessing the CMS website** and asking your CFO. Many health systems participate in multiple ACOs and other arrangements with different payers. Financial leaders are often more supportive of complex care models if they feel it will help prepare the system to operate at greater risk.

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UNDERSTANDING THE LANGUAGE

ACCOUNTABLE CARE ORGANIZATION (ACO)

Group of doctors, hospitals, and other providers who voluntarily cooperate to give coordinated high-quality care to a given population of patients

ALTERNATIVE PAYMENT MODEL (APM)

Claims reimbursement structure that rewards providers for high-quality, cost-efficient care

BUNDLED PAYMENT

Payment model in which a health system is paid a specified amount for an episode of care and required to fulfill certain quality measures rather than being paid separately for each individual service provided

DIRECT CONTRACTING

CMS payment model in which a set of providers participate in a variety of VBP arrangements for their Medicare FFS population

GLOBAL CAPITATION PAYMENT

Payment model in which providers receive a fixed amount to pay for the entire care of a participant or population (often paid on a per-member, per-month basis)

MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT (MACRA)

Medicare reimbursement tied to CMS for quality improvement and cost efficiency

SHARED SAVINGS

Payment model in which an ACO or other provider group earns a portion of the net reduction in cost calculated against the expected expenditure; the share of savings typically depends on achieving certain quality metrics

VALUE BASED PAYMENT (VBP)

A concept by which purchasers of healthcare (government, employers, and consumers) and payers (public and private) hold the health care delivery system at-large (physicians and other providers, hospitals, etc.) **accountable for both quality and cost of care**.

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Scaffolding populations for impact

When thinking about which populations to work with first, in a mixed fee-for-service and value-based payment environment, it's important to consider prioritization. In the complex care model I operated, I served all populations and all payers. In order to balance the financial model, this meant working with 100% of the uninsured population with five or more visits annually, whereas the utilization threshold was higher for populations with more favorable reimbursement. This allowed me to address equity and vulnerability by caring for *all* populations with high utilization. Prioritizing those with the least resources (the uninsured) helped to balance the mission and margin polarity.

I therefore prioritized intervention based on the financial impact until the program grew enough to demonstrate a return on investment for multiple populations. This gave me time to grow the business case and organizational support across many populations. You will need to apply the lens of your organization to this equation. Examining your population through the lens of utilization and the associated costs provides a good starting point. **- LAURAN HARDIN**

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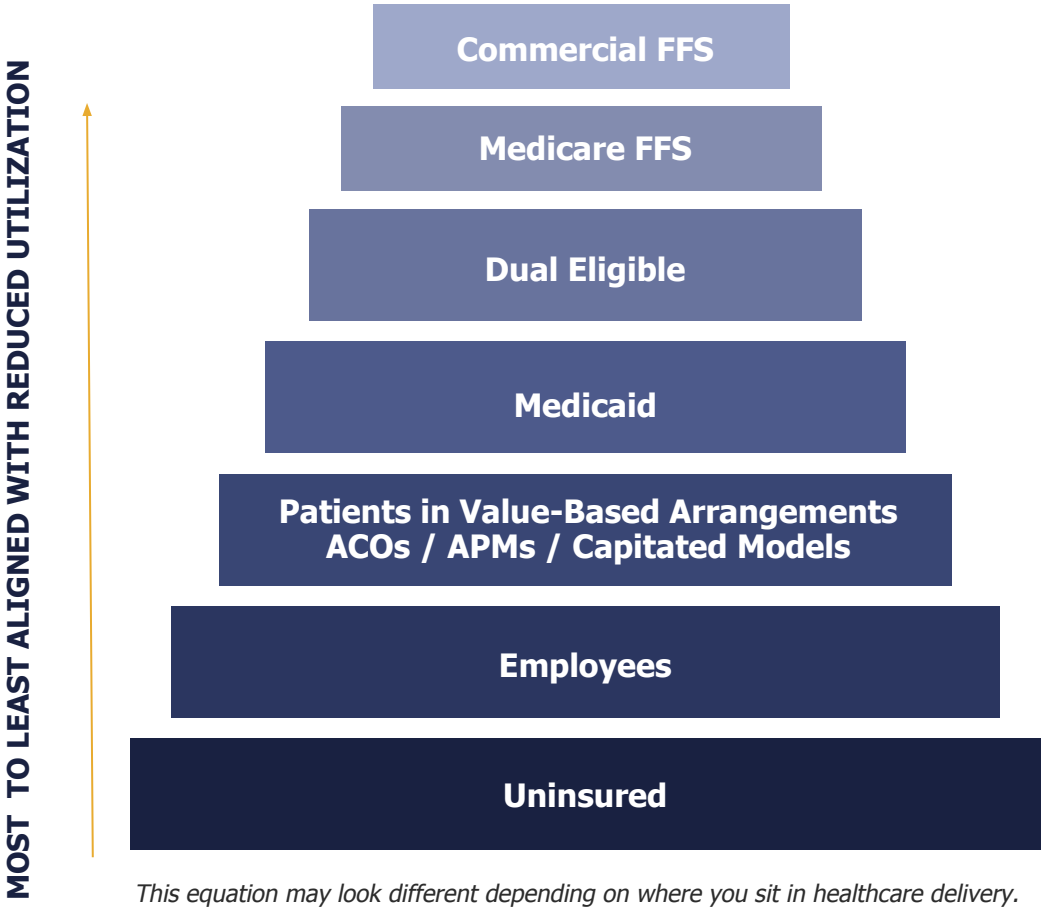
DISTRIBUTION FOR MOST HEALTHCARE SYSTEMS

The graphic shows the populations by insurance type in which the health systems' financial outcome is aligned with reductions in utilization



This equation may look different depending on where you sit in healthcare delivery.

COST MAPPING TOOL

UNINSURED

Populations without a payer source can have a significant financial impact on a health system.

EMPLOYEES

You may not think of health system employees as a population at financial risk, but organizations directly bear the healthcare costs of their workforce. Improving care for this population impacts the company's financial health.

VALUE-BASED ARRANGEMENTS

Populations in value-based contracts like an ACO or capitated payment are ideally situated for a complex care program. The population has moved out of fee-for-service care, which incentivizes increasing volume of visits. In VBP, the focus is on reducing costs and utilization, and improving quality – often shifting care into the home and community.

DUAL ELIGIBLE AND MEDICAID

Depending on your market, reimbursement for Medicaid visits may be lower than the actual cost of delivering the care. You can ask your finance leader or care management leader about how this plays out in your organization. Improving care for the Medicaid population, and thereby reducing unnecessary utilization, is thus a priority from a financial perspective for most organizations. In addition, when hospitals are operating near capacity, reducing utilization of low reimbursement payers can improve revenue by freeing up a bed for a patient with more favorable coverage. Dual eligible populations have both Medicare and Medicaid which impacts cost and reimbursement in a similar fashion.

If we continued to complete the top of the scaffolding, the next tier up in terms of cost and impact to the system would be **Medicare Fee for Service (FFS)**, and then **commercial or private insurance FFS**.

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SCAFFOLDING PATIENTS IS NOT ONE-SIZE-FITS-ALL

An important perspective about scaffolding patients is that depending on your setting and context, patients for whom reduced utilization is most beneficial who are may vary. For example, if the setting where you work is a clinic that receives payment by individual appointments, revenue is maximized by seeing a high volume of patient appointments. Therefore, from the perspective of clinic revenue, the most costly patients to the system are those who require the most time during appointments. So, it may be worthwhile to begin working with individuals who providers spend the most time with during appointments.

On the other hand, it may not be wise to begin working with privately insured patients paid on a FFS basis, and begin diverting them from coming to the clinic for appointments. Such a decision may negatively impact the clinic's financial revenue.

Over time, as the work of complex care builds momentum, the clinic may shift their strategy to include more equitable value-based payments which incentivize quality instead of volume of visits. This may then allow for you to work with all patients. The key point here is scaffolding the patient population to determine which patients are best to work with first to gain leadership buy-in and build support for the complex care work broadly.

TYING IT TOGETHER: SCAFFOLDING A PATIENT POPULATION

Let's revisit the utilization dashboard. Pictured on the right is your population. There are decision points built into this data that start conversations. Let's revisit some key lessons from the experts up to this point:

- Before broadly designing care pathways for a specific "population box," first understand the business case. What is the payer mix of the patients within these utilization boxes? If the hospital is consistently providing services to a group of patients and not receiving reimbursement, it may be helpful to start with those patients, because you'll be able to demonstrate cost savings. As hard as this is to accept clinically, designing care pathways that divert high-paying patients away from the hospital can forge a difficult road to gaining leadership support. By scaffolding the population, starting with patients in VBP or without payment, it can create an early win that gains attention and long term support.
- You don't have to solve this problem alone! What types of resources already exist in your local ecosystem? Start with the network you already have and partner with finance or your care management leadership to determine which patients you're most well-positioned to help.

<table>
<tr><th rowspan="2">ED visits</th><th colspan="5">Inpatient visits</th></tr>
<tr><th>0</th><th>1</th><th>2</th><th>3 to 4</th><th>5+</th></tr>
<tr><td>0</td><td colspan="2" rowspan="3">44,728 (85%) patients
• 5,210 Inpatient visits
• 63,489 ED visits
• $28,000,000 (50%) IP payment
• $25,800,000 (59%) ED payment</td><td rowspan="6">985 (2%) patients
• 1,856 IP visits
• 4,129 ED visits
• $10,000,000 (17%) IP payment
• $1,700,000 (4%) ED payments</td><td rowspan="6" colspan="2">503 (1%) patients
• 2,026 Inpatient Visits
• 4,144 ED Visits
• $10,900,000 (20%) in IP payment
• $1,700,000 (4%) in ED payment</td></tr>
<tr><td>1</td></tr>
<tr><td>2 to 3</td></tr>
<tr><td>4 to 5</td><td rowspan="4">4,961 (9%) patients
• 28,447 ED visits
• $11,500,000 (27%) in ED payment</td><td rowspan="4">1,563 (3%) patients
• 1,239 IP visits
• 6,962 ED visits
• $6,700,000 (18%) in IP payment
• $2,800,000 (6%) in ED payment</td></tr>
<tr><td>6 to 7</td></tr>
<tr><td>8 to 9</td></tr>
<tr><td>10 +</td></tr>
</table>

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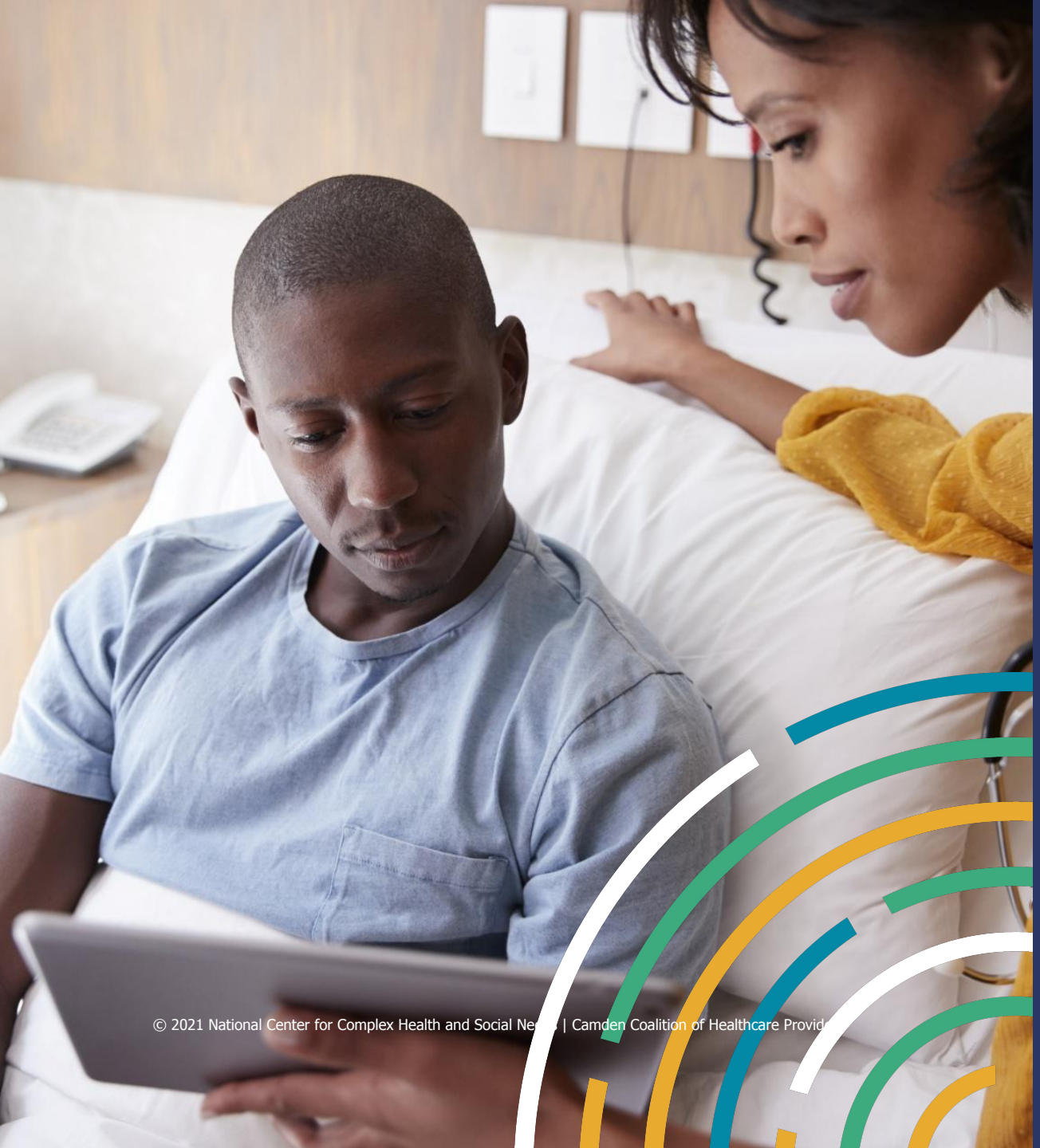

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Key takeaways

- Based on your understanding of your organization's financial incentives, review the populations for whom reduced utilization is beneficial.
- Consider equity in your choice of populations to serve.
- Schedule time with leadership or CFO/financial analyst to discuss appropriate scaffolding of the population
- Consider adapting the population you start with first to those whose utilization is most impactful to your system.

TABLE OF CONTENTS

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Leaders like chief nurses need to be translators. They need to understand other languages in order to translate the story to people who have never been in a clinical setting and don't know this world. Other people grew up with a different mental model. Physicians, nurses, finance – you have to understand them enough to understand their framework.

GAY LANDSTROM, SVP and Chief Nursing Officer, Trinity Health

Collaborating with finance

Introduction

The language of finance

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Introduction

In one of the most interesting interviews for this toolkit, Chief Medical Officer for the National Association of Community Health Centers, Ron Yee, MD, MBA, jokingly referred to his most common title being "the C-F-NO." Clinicians and finance executives are regularly on opposing sides of the aisle when it comes to implementing programs for complex populations, a divide often attributable to a lack of understanding of each other's language and objectives. CFOs are charged with managing the finances to keep the doors open so that clinicians can keep doing the important work of healing. As such, they're bombarded by requests for a variety of resources, which is even more challenging in the wake of the COVID-19 pandemic. Conversations that lead with reducing utilization can be disregarded or ignored if the organization is focused on volume of visits to generate revenue.

Your most effective champion for complex care can be your CFO or a financial analyst if you work to understand what matters most to the organization and how you can position your program design to generate the outcomes that enhance both patient and organization success.

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“

The workaround that everyone is using is the specter of value-based payment. It's like, ‘Look, this is going to be here, and you don't want to be caught without a plan. I've got a plan for you.’ Even if there is a little bit of a revenue hit, that's why we're here. We need to work with finance to find revenue so we can do what's right by our patients.

DAVE A. CHOKSHI, Health Commissioner of New York City

The language of finance

For an effective collaboration, it’s vital to (1) understand basic concepts in finance and budgets and (2) focus on costs. Healthcare systems often use these terms to describe financial outcomes:

COST

To payers: the amount they pay to providers for services rendered

To patients: the amount they pay out-of-pocket for services

To hospitals: The amount of money it costs to deliver a service.

CHARGE OR PRICE

The amount asked by a provider for a healthcare good or service, which appears on a medical bill

REIMBURSEMENT

Payment made directly, or more typically, by a third party to a provider for services; this may be an amount for every service delivered (fee-for-service), each day in the hospital (per diem), each episode of hospitalization (e.g., diagnosis-related groups, or DRGs), or each patient considered to be under their care (capitation)

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There are two different kinds of cost that are important to understand:

FIXED COSTS include basic overhead to keep the organization running including electricity, facility maintenance, major equipment and costs for land.

VARIABLE COSTS include things like employee compensation, costs of supplies, and medications.

Complex care programs impact variable costs by decreasing staff time, readmissions, length of stay, and costs of supplies, and improving appropriate use of medications.

When discussing profitability, you will often hear three terms (below), which vary by organization. Systems also value these metrics differently based on their own culture. Your CFO will be able to provide insight to support the development of your intervention, as well as indicate what level of analysis is possible from your cost accounting system.

OPERATING MARGIN is the revenue that remains after subtracting fixed and variable costs.

CONTRIBUTION MARGIN is the revenue that remains after subtracting variable costs.

EBITDA is Earnings Before Interest, Taxes, Depreciation and Amortization.

ADDITIONAL RESOURCES

How Health Care Providers Can Improve Their Profit Margins
What is the difference between operating margin and EBITA?
Contribution Margin: What It Is, How to Calculate It, and Why You Need It
Improving financial and clinical collaboration

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SUMMARY | 12 MONTHS BEFORE AND 12 MONTHS AFTER DATE OF INTERVENTION

Evaluating margin is a more sophisticated and complex view of a program's financial impact. This analysis shows significant improvements to both **contribution** and **operating** margin, despite reductions in overall visits and charges. You will need to partner with finance to complete this. Although these concepts may be foreign to clinicians, there's strong value in understanding the basics. The more closely your analysis matches the culture, values, and language of the organization, the stronger case you will be able to make for continued investment in care for your population.

Operating margin →

Contribution margin →

	Total		Total	Per Case		Per Case
	12 Months Before Date of Intervention	12 Months After Date of Intervention	12 Months Before - 12 Months After	12 Months Before Date of Intervention	12 Months After Date of Intervention	12 Months Before - 12 Months After
Sample Size	341	341	0	341	341	0
Total						
Cases	5,052	3,160	(1,892)	5,052	3,160	(1,892)
Gross Charges	13,307,204	7,285,379	(6,021,826)	2,634	2,305	(329)
Net Revenue	4,098,346	2,386,934	(1,711,412)	811	755	(56)
Collection %	31%	33%	2%	31%	33%	2%
Direct Expenses	3,714,001	1,962,198	(1,751,803)	735	621	(114)
Contribution Margin	384,345	424,736	40,391	76	134	58
Contribution Margin %	9%	18%	8%	9%	18%	8%
Indirect Expenses	1,256,622	664,335	(592,287)	249	210	(39)
Operating Margin	(872,276)	(239,599)	632,678	(173)	(76)	97
Operating Margin %	-21%	-10%	11%	-21%	-10%	11%
Inpatient:						
Cases	439	244	(195)	439	244	(195)
Gross Charges	7,040,389	3,998,654	(3,041,735)	16,037	16,388	351
Net Revenue	2,958,776	1,718,350	(1,240,426)	6,740	7,042	303
Collection %	42%	43%	1%	42%	43%	1%
Direct Expenses	2,222,488	1,219,393	(1,003,094)	5,063	4,998	(65)
Contribution Margin	736,288	498,957	(237,332)	1,677	2,045	368
Contribution Margin %	25%	29%	4%	25%	29%	4%
Indirect Expenses	575,358	308,255	(267,103)	1,311	1,263	(47)
Operating Margin	160,930	190,702	29,772	367	782	415
Operating Margin %	5%	11%	6%	5%	11%	6%

FINANCIAL ANALYSIS CHART

Continue with Outpatient and Emergency Cases

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Key takeaways

- Meet with your CFO or finance team
- Identify what financial metrics matter most in the organization
- Identify what level of analysis the finance department could provide for your intervention

TABLE OF CONTENTS

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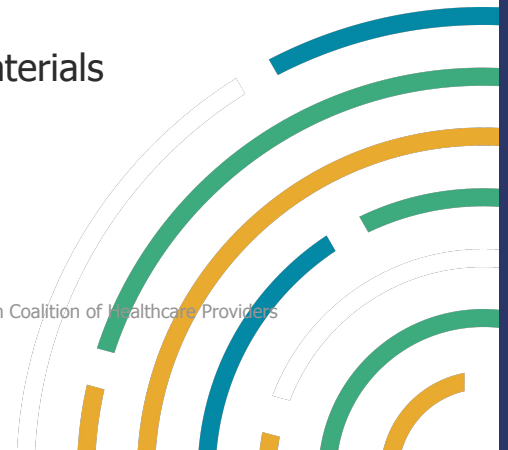

> We have to invest however much it takes for however long it takes to build trust with the people
>
> **MELANIE BELLA, MBA,** Chief of New Business and Policy, CityBlock Health

Stakeholders and assets

Evaluating the needs of stakeholders

Asset mapping

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Evaluating the needs of stakeholders

Once you know your population of interest, take a 360-degree view of the stakeholders who intersect or have an interest in the same population. Thinking about their values and challenges will help you hone your processes and metrics to demonstrate a value proposition that has meaning for multiple partners. Considering the needs of stakeholders also offers you the opportunity to identify future champions and partners in delivery.

The chart at right can help you complete an assessment. Consider interviewing key stakeholders to capture their perspectives, as well. Start with the individuals with whom you have access and ask for introductions to or recommendations for others.

Presenting this as a half-hour relationship-building session is a valuable way to open the door. Most people love to talk about what they do and what they care about as long as it doesn't involve excessive time on their part.

Depending on your organization, you may also want to consider other executive leaders' needs including the CNO, CMO, etc.

Stakeholder	What matters most to this person?	What problem are they trying to solve?	What keeps them up at night?	How does the action help meet their needs?	What impact will your work have on their day-today?	How is your work a threat to their goals?	How can you minimize the threat or maximize the partnership?
Board							
CEO							
CFO							
Leadership							
Clinicians							
Partner Agencies							
Community							
Business							
Payers							
Government							
Other							

EVALUATING THE NEEDS OF STAKEHOLDERS WORKSHEET

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Asset mapping

For efficiency in delivery, many programs also complete **asset mapping** before finalizing their intervention or as an annual assessment to determine potential changes in their intervention. Asset mapping allows you to review your community and identify who else is meeting the needs of the population or who else you could potentially partner with to improve delivery. Co-delivery, co-location, and shared intervention across the community can reduce cost, improve outcomes and strengthen the business case for your program. One of the places you may want to consult is your hospital's community benefit program as well as the work of other systems, like child welfare, who also aim to navigate families through services. In many cases, individuals in these departments have already done extensive mapping of community resources that can save you time and effort.

Some communities already have a web-based directory of assets built through **United Way 211, Aunt Bertha, Unite Us, NowPow,** or other technology platforms that have emerged in the last few years. Using this resource in your community will save time in the analysis.

Technology isn't required, however, to complete asset mapping. You can learn from your stakeholder interviews and tap into the knowledge of experienced case managers in your community. It is a growing norm in the industry to pay people with lived experience for their time when informing you of community resources, and offering their perspective. Keep this in mind (and in your budget) if you are planning to interview individuals who live in the community.

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Learn more about asset mapping in the **Start up Toolkit** from the National Center for Complex Health and Social Needs

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Key takeaways

- Evaluate the needs of stakeholders to identify key metrics for your program
- Consider adapting your program to better meet the needs of stakeholders
- Identify potential partners and champions from stakeholder analysis
- Complete asset mapping to identify resources for the population you serve

TABLE OF CONTENTS

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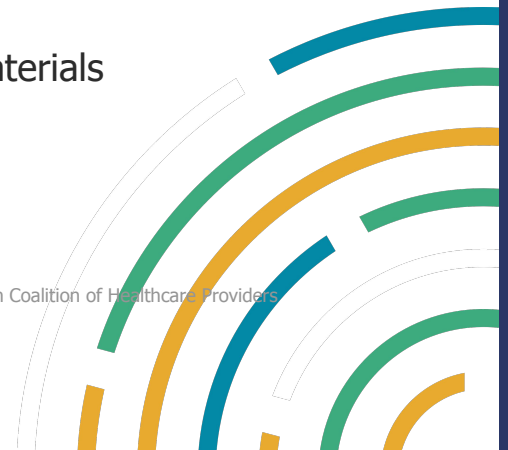

> To me, even as a finance person, the term ROI is almost too simplistic. Other things are just as important to the holistic picture.

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

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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.

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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.

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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.

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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

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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.

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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.

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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.

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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.

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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	

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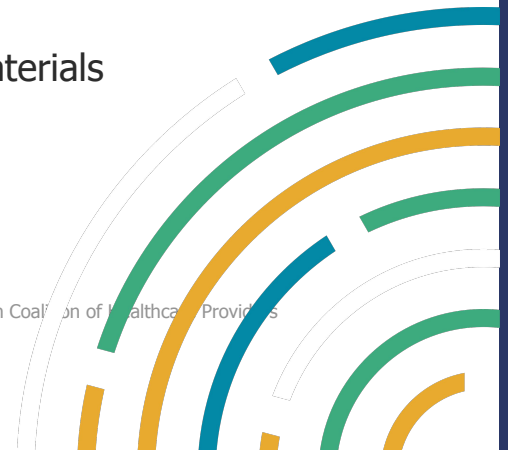
Key takeaways

- 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

TABLE OF CONTENTS



If you're ever in doubt, do what's right for the patient and you'll always make the right decision.

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

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Return on investment

Introduction

Demonstrating ROI

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Introduction

If you followed all the steps so far in this guide, you should now be ready to calculate the Return on Investment from your complex care intervention. Thinking about ROI for vulnerable populations can be challenging. We often think of ROI as a purely financial calculation but as we've demonstrated, there are multiple values or "returns" achieved by your program: equity, trust in the community, transformed lives, and doing the right thing for people who deserve better care. When presenting your ROI, you should include both financial and non-financial value.

Nevertheless, while non-financial considerations are relevant, many health systems will expect a rapid and positive financial ROI on care management to continue investing. It often takes longer than one year to demonstrate ROI, yet impact within 12 months is often the expectation. Highlighting quick wins like access to benefits, reduction in ED visits, and increased primary care visits can be helpful to show value while gathering data on longer-term impact.

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Demonstrating ROI

The Commonwealth Fund has published a **guide to calculating the ROI** of your program and provides evidence in support of various interventions including care management, housing, transportation, and nutrition. **Beyond the Grant** also offers a framework.

Your best partner in developing ROI specific to your intervention and organization is your CFO. Using the metrics and outcomes you collaboratively identify, have finance complete an annual assessment of your progress. Reporting movement in all the quadrants (cost, utilization, quality, satisfaction and equity) will also round out the case of ROI for different stakeholders.

Note: Complex care programs always have to contend with the argument of regression to the mean (that utilization would have naturally decreased) and have challenges demonstrating that the intervention caused improvements in outcomes. Within complex populations, there are subpopulations whose high utilization is more lasting (those with SUD and mental illness) and therefore less susceptible to regression to the mean. Integrating the number of years of prior high utilization can demonstrate impact.

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> You've got to be able to tell the story, no matter how hard or incomplete it is. A lot of people need that perspective for validity. It may not be the tightest ROI, but at least you've struggled through it. Then they'll be willing to listen to the rest of it.

GAY LANDSTROM, SVP and Chief Nursing Officer, Trinity Health

Key takeaways

- Create a plan with your CFO or financial analyst for ROI analysis
- Identify your plan for reporting outcomes to multiple stakeholders
- Based on the ROI analysis - Consider changes to be made to your intervention to generate ongoing support

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TABLE OF CONTENTS

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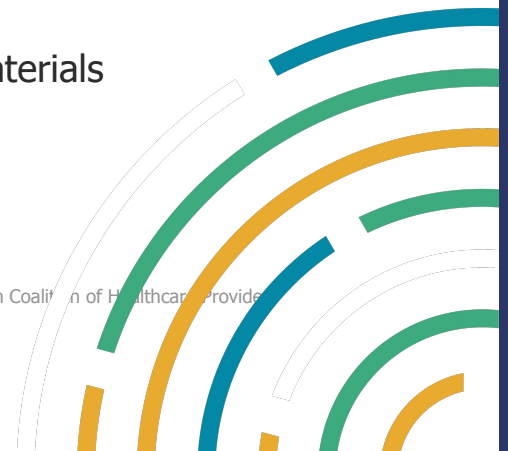

> What I've seen really make things work is when there's enough co-design where the people and the culture have their own fingerprint on what happens, and enough voice and autonomy in the process where they feel like they developed it.

MARGIE POWERS, Chief Improvement Officer, Vayu Health

Sharing your success

Introduction

Creating a pitch deck

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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.

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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.

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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.

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Key takeaways

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

TABLE OF CONTENTS

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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

Introduction

Funder and opportunity resource map

Complex care budgeting

Dosing and program efficiency

Considering billing

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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

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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TABLE OF CONTENTS

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You have to start marrying the clinical rationale with the financial imperative. It's really about communicating that in a way that stays true to the mission and is savvy enough to generate the resources to actually address the problem. Let's rededicate ourselves to that approach.

DAVE A. CHOKSHI, Health Commissioner of New York City

Worksheets and supplemental materials

- **Building the value case summary tool**
- **Root cause analysis tool**
- **Impact mapping tool**
- **Evaluating the needs of stakeholders**
- **Financial analysis chart**
- **Value case summary sheet**
- **Example: Value case summary: Cross sector**
- **Example: Value case summary: FQHC**
- **Example: Value case summary: Hospital based**
- **Example: Value case summary: Payer**
- **Sample pitch deck**
- **AV Consent form**
- **Sharing your success: Case study - Adventist Health**
- **Sharing your success: Case study - Regional One Health**
- **Funder and opportunity resource map**
- **Complex care budget template**
- **Complex care budget instructions**
- **CAPC population stratification tool**
- **Triage tool - example**
- **Triage tool - blank**
- **Billing resource**

Camden Coalition
of Healthcare Providers

The National Center
for Complex Health & Social Needs
An initiative of the Camden Coalition

The Camden Coalition works to advance the field of complex care by implementing person-centered programs and piloting new models that address chronic illness and social barriers to health and well-being. Supported by a robust data infrastructure, cross-sector convening, and shared learning, our community-based programs deliver better care to the most vulnerable individuals in Camden and regionally. Our local work also informs our goal of building the field of complex care across the country.

Through our National Center for Complex Health and Social Needs (National Center), an initiative of the Camden Coalition, we connect complex care practitioners with each other and support the field with tools and resources that move complex care forward. The National Center's founding sponsors are the Atlantic Philanthropies, the Robert Wood Johnson Foundation, and AARP.

Interested in learning more about technical assistance from the Camden Coalition? Please email **camdenTA@camdenhealth.org**.

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