



MAKING THE CASE FOR ADDRESSING SOCIAL HEALTH IN PRIMARY CARE SETTINGS

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Making the Case for Addressing Social Health in Primary Care Settings

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About CSI: A small business dedicated to improvement and innovation in health care.

Our Mission: *To build sustainable solutions through learning and innovation.*

Our Vision: *To transform health care through the Spread of innovation*

Strategy and Program Development



CSI Solutions provides strategic support, program development, implementation, and sustainability planning to health care agencies and provider organizations. Examples of our expertise include population health management, alternative payment approaches, primary care transformation, and patient/stakeholder engagement.

Collaborative Approaches to Improvement



Improvement programs, Collaboratives, and Learning Communities. Our expertise includes quality improvement methods, curriculum development, measurement systems, team coaching, and project management for large and small improvement efforts.

Training and Technical Assistance



CSI Solutions builds internal client resources to assess needs and provide expert training in areas such as QI methods, population health, optimizing use of technology, service re-design, business case development.

Technology Solutions to Support Improvement



Data reporting and knowledge management systems that facilitate collaboration and health care improvement initiatives. Our secure reporting system provides a full range of data entry, download and graphing capability. Our knowledge management portal supports document sharing and cross-team collaboration.

Client Segments include:

Accountable Care organizations

Employer groups

Community-based organizations

Primary and specialty practices

Federal and state agencies

Hospitals/ Health systems

Managed care/ payers

Professional associations

Objectives

- Summarize elements needed to make a valid business case for any quality improvement initiative.
- Identify potential stakeholders and consider the ways these stakeholders may define value.
- Describe ways to quantify value when value is expressed in qualitative terms.
- Describe ways to quantify value in the absence of perfect data.
- Address some specific questions posed.



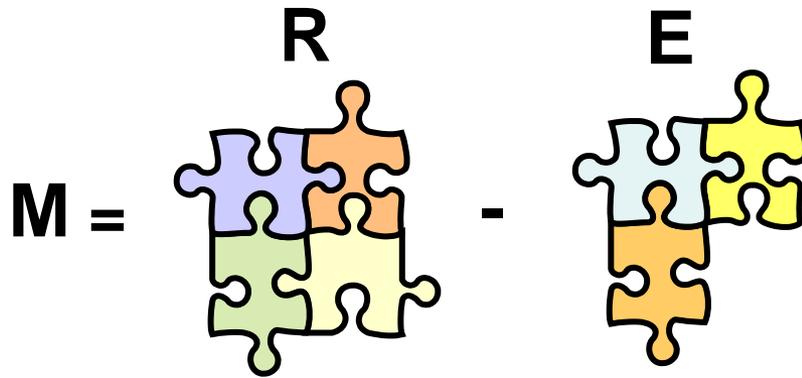
Talking about the business case...why?

- ➔ We want to do the right thing----but mission-driven pilot projects are not enough. The long-term integration of social and physical health requires sustainability planning.
- ➔ We cannot rely on a fee for service approach for compensation. Reimbursement systems are not keeping pace.
- ➔ It takes discipline to think about and document a business case for the work.



The traditional business case---important but not a complete picture.

Margin = Revenue – Expenses



- Margin creates sustainability and the ability to spread, whether internal to the organization or at the system level.
- See CSI's one-page paper on return on investment.

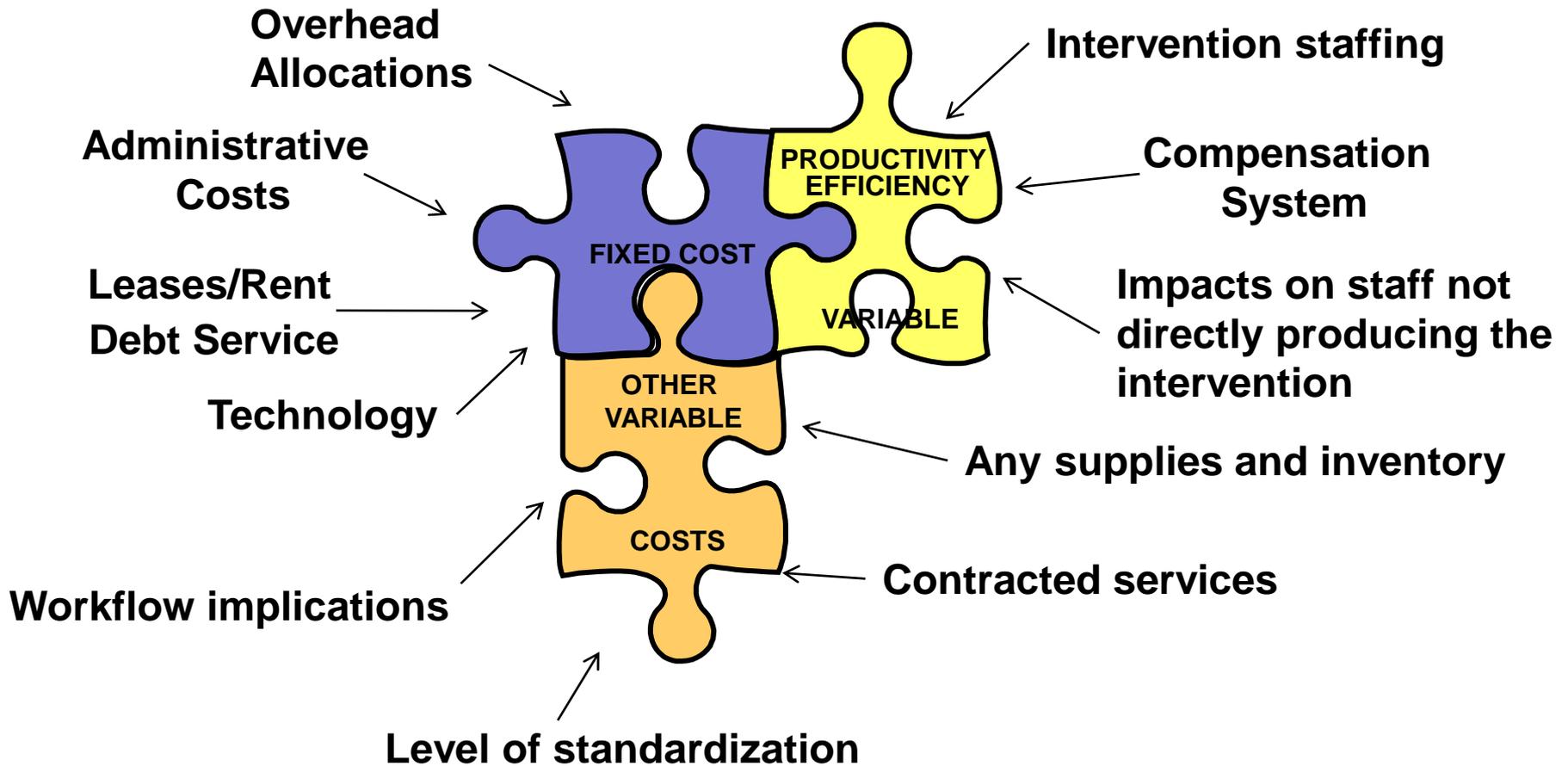


Where to start

- ➔ Understand what is happening within your clinic--- the intervention and what the work **costs**
- ➔ Know who the **stakeholders** are that can support funding and sustainability
- ➔ Know how these stakeholders define **value**
- ➔ Document that value in **qualitative and quantitative terms**



Understanding Cost---It can be complicated. Do not let perfection can get in the way of good.



Variables impacting cost

⇒ Think about all the costs and what drives them

- Referral versus navigation
- Cost of actual service provision (MLP, transportation, etc.)
- What kind of follow up is included? When, how often, how contacts are made?
- Do you count non-patient-facing costs?
- Do you include non-labor costs---direct or indirect allocations to the clinic?

⇒ Variations in efficiency of how the work is done

- Screening workflow-how integrated is it?
- How long is the survey? How many domains are being assessed?
- Who does what work? Top of skill set and license?
- Use of technology support.
- What percentages of those screened have needs? Accept assistance? How many are lost to follow up? ----work being done not reflected in the numbers



As you plan spread, understanding cost becomes even more important

- ➔ What is different about the spread site? How will number of patients ultimately served compare?
 - Total number of patients
 - Number screened
 - Number positive
 - Number accepting referral
 - Number following through on service
- ➔ What costs now vary based on the number of patients included at each step in the process? What staff are involved at each step? Will your tools and workflow be identical at the spread site?
- ➔ Will you provide the same services through the spread site?
- ➔ Is there any cost that can be shared, such as supervision?



Who are the stakeholders?

- ➔ Patients and families
- ➔ Organizational leadership
- ➔ Internal staff
- ➔ Payers
- ➔ Community agencies
- ➔ Others

What matters to each group?



Using multiple value lenses: Use each lens to ask key questions and identify data sources

- ➔ Impact on clinical outcomes/ quality
- ➔ Patient experience
- ➔ Staff experience
- ➔ Productivity/ efficiency
- ➔ Cost reduction
- ➔ Cost avoidance
- ➔ Revenue
- ➔ Impact on external stakeholders



Value Lens Tool

Business Case Lens	Key Questions	Potential Data and Source	(CONT.)		
Impact on Clinical Outcomes/Quality	<p>What clinical outcomes would we expect our intervention to impact?</p> <p>Is there a difference in the clinical outcomes of patients after receiving social health support?</p> <p>Is there a difference in clinical outcomes between patients who screen positive and receive support and those who may screen positive but choose not to receive any support?</p>	EHR	Cost Reduction	<p>Has total cost of care been reduced for patients receiving a social health intervention---compared to before the intervention or compared to patients who did not receive the intervention?</p> <p>How has care utilization changed for patients receiving a social health?</p>	<p>Available claims data</p> <p>Payer data reports</p> <p>Volume data for ED visits, Hospital admissions or readmissions , Clinic visits</p>
Patient Experience	<p>Has implementation of your social health integration program had an impact on those receiving support that is different from prior to implementation or from patients not receiving the social health intervention?</p>	<p>Patient activation metrics</p> <p>Follow up surveys</p> <p>Existing organizational surveys</p>	Cost Avoidance	<p>For patients without insurance...are patients who receive a social health service experiencing fewer ER visits and readmissions?</p>	<p>Hospital records</p>
Staff Experience	<p>Is the social health integration program having an impact on staff experience (joy in work)?</p>	<p>Sample interviews</p> <p>Surveys</p>	Revenue	<p>Are there any impacts on clinic revenue?</p> <ul style="list-style-type: none"> • New patients? • Generation of additional service-related fees? (E.g., social work fees, CCM) • Are there any current incentive-based contracts relevant to persons receiving a social health intervention? 	<p>Practice management system</p>
Productivity/Efficiency	<p>Is the social health integration program having an impact on care team productivity?</p> <p>Have no-shows been reduced?</p> <p>Have providers been able to see more patients?</p> <p>Have internal clinic costs been reduced in any way?</p>	<p>No show data</p> <p>Visit volumes</p> <p>Clinic expenses normalized by volume</p> <p>Practice management system</p> <p>Visit Logs</p>	Impact on Stakeholders	<p>Has the social health integration had a positive impact on any key stakeholders (e.g., patients, community providers, etc.?). What data do they need and track? How does your work help their mission?</p>	<p>Key interviews</p>

Convert value to dollars where possible. Quantify non-financial benefits. Make the case to stakeholders.

Collect and analyze data on impact

- **For a small group** of patients for whom you have some data
- **Or even for a single patient** with a compelling impact story
- Data from before intervention and after (for similar time period)

Translate improvement to dollars

- **For improvement in clinical outcomes:** Use literature for documented savings
- **For improvement in utilization:** Use local average charge data to calculate savings

Scale Up: What if you had a similar impact on a broader population?

- **To what population segment** will the impact apply?
- Assume same **level of impact** or a percentage
- Project the potential impact



Making a difference one patient at a time...

Working with limited data

- ➔ Identify a patient with a compelling story about impact
- ➔ Collect real data about that single patient---clinical outcomes improvement, utilization, actual claims ---for a time period before and after your SDOH intervention.
- ➔ Analyze the data to determine what you can say about impact
- ➔ Translate utilization or clinical outcomes improvement to dollars (Use literature or local average charge data)
- ➔ Make assumptions about the applicability of the impact seen for that single patient to a broader population.
- ➔ Use assumptions to apply all or a percentage of the dollar impact for your single patient to the broader population. This answers the question....what if we had a similar impact on others?

See CSI White Paper with examples.



Examples of making a difference one patient at a time

	Impact shown with one patient in one clinic	What if ...
Medication Assistance Program	<p>Mary G. 62 y/o with diabetes; 20 ED visits in past year; Screener indicated issues with affording meds; connected to medication assistance program.</p> <p>ED visits in past 4 months down to 1</p> <p>System savings = $(20 \times \\$1100) - (3 \times \\$1100) = \mathbf{\\$18,700}$</p>	<p>24,000 total clinic patients, 10% DM prevalence = 2400 w/DM</p> <p>Screener picking up 23% of DM patients unable to afford meds = 552 people with med issues</p> <p>Assume 10% have a result similar to Mary= 55</p> <p>System savings potential = $55 \times \\$17,600 = \mathbf{\\$968,000}$</p>
Insurance Eligibility	<p>Delia T 25 y/o pregnant immigrant with no fixed address. Clinic referred Delia for housing assistance and secure funding for prenatal care and delivery costs</p> <p>Hospital avoided \$6800 uncompensated care cost for delivery</p>	<p>Hospital now does 30 free deliveries each year.</p> <p>Potential offset to cost = $(\\$6800 \times 30) = \mathbf{\\$204,000}$ if women can be identified and assistance prospectively provided</p> <p>One preterm delivery with NICU baby = additional \$122,000 cost offset</p>

Example of projecting clinic impact to system impact

	Impact shown in one clinic	What if ...
<p>Medication Assistance</p>	<p>Clinic has tracked 300 patients with diabetes who are screened and receive medication assistance and has used available data to show that ED use went down from 120 in a quarter to 80 following intervention.</p> <p>Without access to the claims data, the clinic uses an average charge of \$1100 for an ED visit. The 33% reduction over a full year = a reduction of 160 ED visits</p> <p>$\\$1100 \times 160 =$ \$176,000 annual savings realized</p>	<p><u>System-wide expansion---small to large</u></p> <p>System cares for 180,000 adults Assume 10% DM prevalence = 18,000 people</p> <p>Based on positive screen rate in the clinic of 23% with medication affordability issues = 4120 potential people with issues in the system.</p> <p>Because elsewhere in the system the patients are less likely to have medication issues, an assumption is made that the rate will be half that in the primary clinic or 11.5%</p> <p>Assume 33% reduction in ED visits @ \$1100 each can be realized</p> <p>System savings would be $(\\$1100 \times 11.5\% \times .33 \times$ ED visits in year for all people with DM)</p>



Working on revenue...

	Historic no show rate	Current no show rate	Impact
Transportation Assistance Program	24%	20%	Annual clinic visits = 30,000 Average visit reimbursement = \$110 Fewer missed visits in a year = $(.24-.20) \times 30,000 = 1200$ Potential additional revenue = $1200 \times \\$110 = \\$132,000$



Revenue opportunity--FQHC Example

	Key Assumptions	Opportunity	Impact
Community Hub referring 800 new families from Head Start previously being referred elsewhere.	800 families represents 3.4 people. 30% Capture Rate.	Medicaid pays \$68 per member per month for primary care.	<p>Members potentially represented: (Members x 3.4 x 30%)=2720</p> <p>Member Months (Members x 12) = 9792</p> <p>Revenue Potential (Member Months x \$68)= \$665,856</p> <p>Original Cost = \$50,000</p> <p>First year return= \$615,856 or 12:1 ROI</p>

Background:

- Robust SDoH program as an FQHC with universal screening.
- Community Hub program-launched in 2018---New program engaging community partners and working to screen and refer with community partners.
- Referral system enables engaging 800 families and potentially enroll them into our system.
- Capitated for primary care by the state through MCOs.



Qualitative to quantitative value...

	Qualitative value	Potential for Financial Impact
Student rotations	<p>Contribution to teaching mission</p> <p>Opportunity to spread importance of SDOH as student enters workforce</p>	<p>Substitution of students in 3-month rotation for paid staff</p> <p>Total screening and referral minutes x hourly rate $5000 \text{ pts} \times 9 \text{ min} \times \\$0.40 = \\$18,000$</p> <p>Cost avoidance of hiring an experienced student to fill a full-time position; include recruitment and training time Estimate = \$8000 based on literature estimate of 20% of salary</p>
Care team joy in work	<p>Can result in greater staff productivity</p> <p>Reduction in turnover</p>	<p>Avoidance of turnover of just one physician position can result in cost avoidance of up to \$500,000 (Source: AMA)</p> <p>Losing a nurse due to burnout could cost \$15-20,000. Average cost of turnover = 20% of annual salary.</p>



Telling a story about how your clinic's SDoH work has impacted patients' lives...



Graphic from HealthLeads 2019



Example Balanced Scorecard for Energy Assistance

Patient Experience:

Undocumented and unemployed because of his medical condition he was still able to make a financial contribution to his family.

Clinical Outcomes:

Patient is S/P CVA with a pacemaker and on several medications. He keeps his appointments and is medically stable. Multiple family members also receive care at clinic.

APA, a 54-year-old member of a large Hispanic family came to the clinic in January 2019. The advocate who did the PRAPARE screen encouraged him to apply for energy assistance because a member of his family has legal status in the US. He was awarded \$1,236.

Cost to the Health Care System:

Potentially reduces costs of ED or IP visits related to lack of heat for large family during cold Wisconsin winter.

Impact on Staff and the Community:

Success with SDOH such as energy assistance increases the patient confidence in managing other health and social challenges. WE Energies benefits by payment and avoiding costs of utility shut offs. Grateful patients are rewarding to clinic staff.

Example for Insurance Assistance

Patient Experience:

Advocate made immediate contact with hospital financial counselor. Patient received supportive counseling and transitional medical care. She now has insurance and is able to get needed follow-up care

Quality Clinical Outcomes:

Biopsy done in short time by timely intervention on insurance and bridging of clinical care by clinic MD. Surgery successfully removed the tumor and has been followed by chemotherapy

YH was discharged from an ED after being told that she had a renal mass that needed a biopsy. She was an employee of that hospital but uninsured because she had not enrolled in the health plan that was offered. Staff worked with her to get her insurance and arranged to have the biopsy done with MD providing preop medical evaluation. Biopsy showed cancer and she underwent successful removal of the tumor.

Cost to the Health Care System:

Hospital received payment for biopsy and surgical procedures and follow-up chemotherapy from an insured patient

Impact on Staff and Community:

Patient has retained her employment and maintain her living situation without major health care bills. Patient called Advocate after surgery to report progress and express her appreciation for the help with navigating the insurance and the procedures.

Important Take-aways

- ➔ Even when a social and moral imperative drives the actions, there is value in the disciplined process of working on the business case.
- ➔ Understanding the cost of social health integration provides insight into opportunities for efficiencies and how to intentionally spread to new sites or populations.
- ➔ It is impossible to make a case without understanding what brings value to various stakeholders.
- ➔ Qualitative data to support assertions related to impact on value is important, but qualitative data should not be overlooked if other data is not available. **A business case must consider both types of data.**



Some Observations based on Questions

- ➔ Tools health centers are using
- ➔ Approaches to addressing SDoH
- ➔ The payment crystal ball

Other Questions?



COST CALCULATOR TOOL

COMPLETE INTERVENTION COST			
Screening Component			
			Current resource
Title or staff type			
Cost per patient	\$	2.00	
Current Annual Cost	\$	21,514.42	
Annual cost if all eligible are screened	\$	22,516.03	
Referral component			
			Current resource
Title or staff type			
Cost per patient	\$	7.81	
Total current cost to research and refer	\$	82,500.00	
Navigation component			
			Current resource
Title or staff type			
Cost per patient	\$	-	
Total current cost to research and refer	\$	-	
Service provision component			
			Services Total
Total annual service cost	\$	100,000.00	
Average per patient cost	\$	43.40	
Patient Follow up			
			Current resource
Title or staff type			
Cost per patient	\$	4.01	
Total annual cost	\$	11,538.46	
Follow up data collection and analysis			
Estimated annual cost	\$	793.27	
Total Annual Cost			
	\$	216,346.15	
Annual Cost per Pt Screened	\$	48.08	
Annual Cost per Pt Served	\$	93.90	
Annual Cost as a PMPM	\$	4.01	

Staffing is the major cost category. Other direct and indirect costs may not be important, depending on the organization and how cost allocation is done.

Calculate cost per patient using actual time and materials or based on budget.

Need to consider all parts of the intervention and the volume of patients involved at each step. Use assumptions for current and any planned spread.

Number of patients		
Total patient visits in one year	10000	
Unique patients seen in one year	6000	
Criteria for screening		
screen all patients seen who have no previous screen in the system in past 12months		
Total patients eligible for screening	5000	
Total patients currently being screened	4500	
% positive screen requiring referral	60%	3600
% of + referral accepted	80%	2880
% of referred offered a service	100%	2880
% following up to complete the referred service	80%	2304

Questions?

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Thank you!

Please complete our short evaluation.

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