LIVING THE MISSION & VISION

How a sustained, integrated approach to addressing essential needs can improve care delivery and support an organization's financial health

BACKGROUND

As many industry observers have noted, a significant shift is underway in the mindset of many healthcare delivery organizations on the subject of essential needs. The question on most leaders' minds is no longer *if* or *why* they should tackle the social and environmental factors that affect patients' health, but *how* they can do so effectively and efficiently.

The work underway at **Metro Community Provider Network (MCPN)** serves as a potential template for organizations looking to create the "business case" for addressing essential needs in a manner that adds value to our biggest stakeholders: patients, providers and the community. Through a sustained, integrated approach to social determinants of health, MCPN uses quantitative and qualitative evidence along with strategic thinking to inform all programmatic and financial decisions. But perhaps most importantly, MCPN views this approach as an expression of its mission and vision to empower individuals to "live the lives they want through personalized, compassionate healthcare" – improving care delivery and supporting the organization's overall financial health in the process.

ABOUT METRO COMMUNITY PROVIDER NETWORK

Metro Community Provider Network is a multi-site Community Health Center (CHC) with 18 health center locations throughout Metro Denver. MCPN's mission is "to partner with the community to provide excellent, culturally-sensitive health services to meet the needs of each individual…every touch, every time." Their vision is that "individuals are empowered to live the lives they want through personalized, compassionate healthcare."

MCPN understands that patients find value in a healthcare system that is responsive to their health-related social needs – and has used that lens to create a business case for connecting patients to essential resources that address identified social needs.

Health Leads

MCPN
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Your neighborhood health home

ADDRESSING ESSENTIAL NEEDS AS AN INTEGRATED COMPONENT OF WHOLE-PERSON CARE

Navigation services are integrated into MCPN's whole-person model of care delivery and are available to any patient that needs them.

MCPN built its tiered approach to care coordination and navigation over the past eight years, starting with a pilot program that involved a single social worker located in the pediatric clinic who addressed the unmet social and care navigation needs of patients in real time. When these efforts proved beneficial for patients, MCPN used grant opportunities to hire additional staff to provide care coordination services to other specific populations – and eventually to all patients in need of these services.

These efforts are now run under MCPN's Consumer Services Department, which is housed in the Operations division (attachment A). Consumer Care Services staff focus on supporting patients to access needed social, behavioral, and medical services. MCPN integrated coordination and navigation services to ensure that the care being provided addresses what their patients need to be healthy and not only what they need medically. Care coordination services are tiered based on patient risk level and intensity of need for navigation support.

The MCPN team established their care coordination and navigation model into what they refer to as their "Pyramid of Care."

THE MCPN SOCIAL NEEDS INTERVENTION AT A GLANCE

Aim	Integrate and address social needs within a team-based model of care for all patients.
Value Proposition	By integrating social needs into a team-based model of care system-wide, patients will have greater access to the resources they need to be healthy – improving their ability to self-manage. In the near term, this care model may lead to fewer missed appointments, better patient retention and growth, and reduced provider turnover. In the long-term, this model may result in fewer Emergency Department (ED) visits and hospitalizations – as well as sustained improvements in health status. These improved outcomes will, in turn, lead to reductions in total cost of care, which supports the drive toward success in value-based payment arrangements.
Scope of Service	Twelve out of 18 clinical sites – family, pediatric and obstetric practices – have integrated efforts to identify and address patients' unmet social needs into their team-based care model. *Patient Navigators* screen patients and provide referrals to essential resources; *Care Coordinators* follow up with patients who have more complex, longer-term needs. MCPN providers from other non-integrated clinics can refer patients to work with the *Patient Navigation Team*. Both teams help patients navigate to needed preventive and chronic care management services.
Top Social Needs	Use of Emergency Department for Routine Care, Food Resources, Medicaid Information Support, Transportation Assistance, Housing Resources
Workforce	MCPN has deployed 14 *Patient Navigators* and 8 *Care Coordinators* withiin multi-disciplinary care teams to serve patients across the organization, including: • 3 in Pediatrics • 2 in Obstetrics • 12 in Family Medicine • 3 for Cancer Navigation • 2 Additional *Prenatal Engagement Specialists* provide navigation and care coordination between OBGYN and Pediatrics – funded through their ACO
Technology	NACHC's PRAPARE Assessment template[2] integrated into Centricity EMR, plus Tableau and Truven for data analytics
Funding	Majority of funding for Patient Navigation services comes from the General Operating Budget. Sources include: HRSA 330 Grant; sub-contractor with Denver Regional Council of Government for AHC; CMS Innovation Grants; Community Health Provider Alliance ACO; state and private grant opportunities.

1. *The Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) has templates built into several Electronic Health Records, including Centricity, EPIC, NEXT GEN and eClinical Works. See http://bit.ly/HLprapare916 for a PDF sample of the assessment.*

THE MCPN SOCIAL NEEDS INTERVENTION AT A GLANCE

Demonstrated Impact

Among the documented improvements to-date:

- 55% of patients who worked with a navigator completed follow-up appointments
- Quadrupled cancer screening rates for uninsured patients
- 20% of patients who have worked with patient navigation or care coordination over the last year have self-reported improving their health from 'poor or fair' to 'good or excellent'; 59% self-reported being able to maintain good or excellent health during the intervention
- 100% of patients who have screened positive for food insecurity have been given a community resource referral

Desired Impact

In the future, MCPN plans to track:

- ACO key performance indicators related to wellness visits, reductions in ED visits, increases in dental visits
- Improvements in clinical quality and outcomes leading to increased incentive payments
- Patient loyalty over time

VALUE ROOTED IN INDIVIDUALIZED, WHOLE-PERSON CARE

Addressing the essential needs of patients and communities is a core component of MCPN's mission and vision. They recognize that identifying patients' unmet needs – and connecting them to resources in their communities – accrues value for patients, providers, staff, and community partners. MCPN's leaders feel the positive impact of this work on key stakeholders more than justifies the investments made in navigation services.

PATIENTS

MCPN sees patients as the biggest stakeholder, with a leadership team and board that are enthusiastic about improving responsiveness and overall patient engagement. To MCPN, providing care that is responsive to patients' needs doesn't just improve quality and build trust. It also increases revenue generated per-patient through stronger satisfaction and retention – and drives growth as positive word-of-mouth draws in new patients.

To this end, MCPN began convening Patient Advisory Panels in 2016 to inform its social needs strategy. Patient leaders have helped to flag gaps in service delivery and identified community-based organizations that MCPN has built relationships with to improve resource connections. Patient Navigators also gather feedback directly from patients, following with up with samples of each other's clients to obtain input about their experience with clinic programs. Future panels will harness this information to improve navigation services within MCPN health centers.

Over time, MCPN's work to connect patients to essential resources will support individuals' ability to self-manage and improve their overall health - leading to fewer ED visits and re-admissions. Deeper understanding of their navigation services' effect on outcomes, utilization and cost will also enable MCPN to more effectively manage the health of the populations it serves - placing the organization in a stronger position to succeed in value-based payment arrangements.

PROVIDERS & STAFF

MCPN's leadership understands that the satisfaction of their providers and staff is critical for providing compassionate care. Although data related to burnout is not consistently collected, the opinions and perspectives of providers factor heavily into investment decisions. MCPN's clinicians have appreciated the efficiencies gained and improvements in care team functioning with the integration of *Patient Navigators* and *Care Coordinators*. They no longer need to spend appointment time working to address patients' unmet essential needs – leaving more time to focus on medical issues that can only be addressed by a clinician. Having the support of a multidisciplinary team also helps to relieve negative feelings that may result from the limited ability to help patients achieve health due to social factors. This is particularly important among providers in traditionally-underserved communities, where related challenges have been a documented cause of burnout.[2]

COMMUNITY

MCPN's investments in technology and data collection to support their population health efforts – which includes addressing unmet social needs – are justified by the long-term value provided to health centers and the communities they serve. Consistent collection of social health data over time has allowed MCPN to identify and address barriers to care at the community level. For example, the navigation and care coordination teams have gathered data on patients who struggle to make it to appointments due to transportation challenges. The data has informed a pilot program with *Ride Health* – a partnership that provides transit assistance to patients who do not otherwise qualify for non-emergency medical transportation services..

Data capabilities, robust care coordination and navigation work are also viewed as critical to success in new, regionally-based models that has placed MCPN "ahead of the curve." This has improved the organization's ability to attract outside funding. For example, MCPN data that demonstrates improved screening rates as a result of navigation services is being used to support fundraising efforts for breast cancer screening.

CHAMPIONS ACROSS DEPARTMENTS

MCPN ensures close collaboration between the *Consumer Care Services* team, medical services, IT, operations and financial staff. For example, the *Consumer Care Services* team takes part in MCPN revenue meetings, during which each department shares how they are helping with the organization's bottom line. The team shares data on improvement in no-show rates, patient engagement and clinical quality measures – all of which are important both to MCPN's mission and overall outlook. This collaboration is also an opportunity to educate leadership and staff from other departments on the role and value of care coordination and navigation services.

The MCPN *Consumer Care Services* team also shares with colleagues any new guidance or requirements regarding screening for unmet social needs and related resource navigation from Health First Colorado (Colorado's Medicaid program), their ACO, and their Regional Accountable Entity. Understanding local and national market shifts to address the social determinants of health (SDoH) as a part of care delivery is valuable to MCPN's leadership, and is a key factor in their decisions to invest in these initiatives.

[2] *Hayashi AS, Selia E, McDonnell K., Stress and Provider Retention in Underserved Communities. Journal of Health Care for the Poor and Underserved. 2009;20(3):597-604 – available at http:// bit.ly/ HLacu8109.*

STRONG SYSTEMS & PROCESSES KEEP COSTS IN LINE

A major factor in MCPN's success with integrating efforts to address social needs is their focus on operational efficiency and alignment. Not only does this help to manage costs and reduce duplication, it also improves the overall staff experience. Programs and services are aligned and standardized so that providers and staff can focus on providing one streamlined model of care to all patients.

Specifically, MCPN effectively manages their operations and costs via:

OPTIMIZED, STANDARDIZED WORKFLOWS ACROSS ROLES AND SITES

MCPN has designed standard workflows and clear roles and responsibilities of the staff providing care coordination and navigation services. As the intervention is spread to other locations, the Consumer Care Services Manager spends time on site to ensure that roles and responsibilities of social needs staff are understood – and that workflows are being adopted accurately. The manager also engages providers to design a functional team-based care structure that results in better use of primary care physicians' time. Task shifting has also proven critical to working efficiently and, by extension, managing costs.

Workflows that support team-based care delivery also fulfill other program requirements – including patient-centered medical home recognition, behavioral health integration and UDS quality metrics.

USE OF TECHNOLOGY TO SUPPORT CARE TEAM EFFICIENCY, EVALUATE IMPACT AND IDENTIFY OPPORTUNITIES FOR IMPROVEMENT

Social health information for all patients is stored in Centricity EHR using a series of ICD-10 Z-codes[3] – harnessing the coding system that was designed to track factors that influence health status, and applying it specifically to track social determinants of health. Z-codes are accessible to all members of the care team, appearing on each patient's 'problem list' to easily communicate any present social need to providers.

Care Coordinators and *Patient Navigators* also document their work with patients in the 'social health' section of the chart. And the use of common codes across the care team supports tracking and analytics of social health data.

Patient record and data analytics technology is used to optimize workflow efficiencies and to track data critical to understanding the impact of their work. For example, cancer navigators process referrals and track individual screening diagnostics among the patients they serve. MCPN uses the collected data to see how navigation impacts overall quality metrics and identify opportunities for improvement.

[3] *The Health Information Technology, Evaluation & Quality Center offers details on which ICD-10 Z-Codes apply to common social determinants of health. Full chart available in the Health Leads Resource Library at http://bit.ly/HLhiteq3119.*

INTENTIONAL EVALUATION OF GRANT OPPORTUNITIES AND SDOH INITIATIVES

The *Consumer Care Services Team*, which houses the care coordination and navigation services, works closely with MCPN's Development Department to evaluate new grant opportunities and initiatives. New opportunities are evaluated based on the level of alignment between required activities and measures – and how the opportunity will allow MCPN to expand its work in a sustainable way. MCPN seeks to avoid double-documentation and duplicative work whenever possible, as this could increase staff burnout and may even end up costing more than the grant award. When possible, the Development Team often negotiates with funders to ensure that grant terms are in line and supportive of MCPN's overall strategy.

Trade-offs are also considered. For example, participating in the CMS Accountable Health Communities (AHC) grant requires staff to double-document due to specific CMS data collection and reporting requirements. While MCPN leadership knew this could burden staff, participation in the AHC program is of high strategic value – supporting deeper connections with community partners and helping MCPN continue to be a local leader in this work.

PROGRAM COSTS

Cost categories for MCPN's care coordination and navigation services are summarized below. Staff are integrated at 12 out of 18 clinical sites; however, *Patient Navigators* are assigned to float across clinics. *Patient Navigators* do not carry a caseload, but provide an average of 3-5 encounters per patient served. If a patient needs additional assistance, s/he is transferred to a *Care Coordinator* who carries a case load of approximately 70-100 patients.

PERSONNEL COSTS (70% OF OVERALL BUDGET)	FUNDING SOURCE
2.0 FTE for Navigators	Grants
2.0 FTE for Navigators	ACO KPI incentives
1.0 FTE for Manager 0.3 FTE for Director 0.5 FTE for Associate Director 8.2 FTE for Navigators	General operating budget – including 330 Grant and ACO per-member, per-month funds
PROGRAM COSTS (30% OF OVERALL BUDGET)	**FUNDING SOURCE**
Training Translation Services Transportation Meeting Costs	General operating budget
TECHNOLOGY COSTS (SHARED ACROSS DEPTS.)	**FUNDING SOURCE**
PRAPARE Integration into Centricity EHR Tableau and Truven for data analysis	General operating budget

REVENUE AND FUNDING: CURRENT OPPORTUNITIES AND PLANNING FOR THE FUTURE

As described in the Cost Table, **MCPN mainly funds the navigation and care coordination staff with operational dollars from the 330 grant funds they receive as a Community Health Center.** To justify use of dollars in this way, the Consumer Care Services team has been able to show improvements that contribute to the bottom line. For example, 55% of patients who worked with a navigator completed their follow-up appointments with primary care post discharge from the hospital. MCPN has also been able to quadruple their cancer screening rates among their uninsured patients, which indicates that this intervention is likely to improve cancer screening rates among insured populations as well.

These nearer-term outcomes do have financial implications for the health center. Not only are many of these encounters billable visits, but they also impact the quality measures that must be shared by the health center through its UDS reports. How well a health center performs on its UDS measures can affect its ability to obtain future grant funds and negotiate contracts with managed care organizations.

MCPN is also starting to see indications of improvements in patients' health that could have longer-term financial impacts. For example, 20% of the patients who have worked with patient navigation or care coordination over the last year have self-reported improving their health from poor or fair to good or excellent, and 59% self-reported being able to maintain good or excellent health during their intervention. Questions about patient reported health are included in MCPN's care coordination assessment in their EHR (Attachment B).

In the long-term, these improvements in self-report health may also result in fewer ED visits, hospitalizations, and complications over time – something MCPN is working on tracking in the future. Importantly, the financial benefits should serve MCPN well in both the current predominantly fee-for-service payment model, and as they transition to more value-based payments.

Similar to the experience of other healthcare delivery organizations, finding external revenue sources that cover the costs of making care coordination and navigation services available to all patients is a challenge for MCPN. The CHC receives some funding for care coordination services for Medicaid patients through their Regional Accountable Entity (RAE), which serves as a Colorado Medicaid's accountable care organizations (ACOs). In Colorado's ACO program, these payments are based on the number of patients attributed to the ACO and MCPN as a primary care provider. This means that the amount MCPN receives in per-member-per-month (PMPM) payment through the ACO may vary year to year. It also must figure out how to cover the costs of providing navigation services for uninsured patients and those outside of the ACO. MCPN relies heavily on its 330 grant funding and other private grants to cover the costs for these patients.

As the health care payment system in Colorado becomes more value-based, MCPN is focusing on how it can obtain more external funding from the system to support their navigation and care coordination work. Continuing to build a robust data infrastructure will allow them to show the impact of their care coordination and navigation services on health care costs and outcomes. While other stakeholders, including payers and hospitals, also benefit financially from the care coordination and navigation services through reductions in total cost of care and hospital readmissions, it can be challenging to persuade these stakeholders to contribute to funding this work. Access to impact data will support health center leadership to be in a better position to negotiate with these stakeholders and convince them to help cover the costs of these services.

PREPARING FOR THE FUTURE

MCPN's efforts to address patients' unmet social needs have laid the groundwork for an advanced model of primary care with a focus on integrated community- and population-health. As they move forward, the health center plans to strengthen the team-based care model and improve the overall patient experience. Honing in on these areas will also help to improve overall clinical quality measures and impact value-based payment measures. The more MCPN can show that navigation is an essential part of team-based care, the stronger the message is that this work needs to be a funded aspect of the core team.

Beyond the clinic walls, MCPN also hopes to increase collaboration with community partners. The health center will create common goals that fill gaps in unmet needs in the community, with navigators serving as a critical bridge between care teams and the communities they serve.

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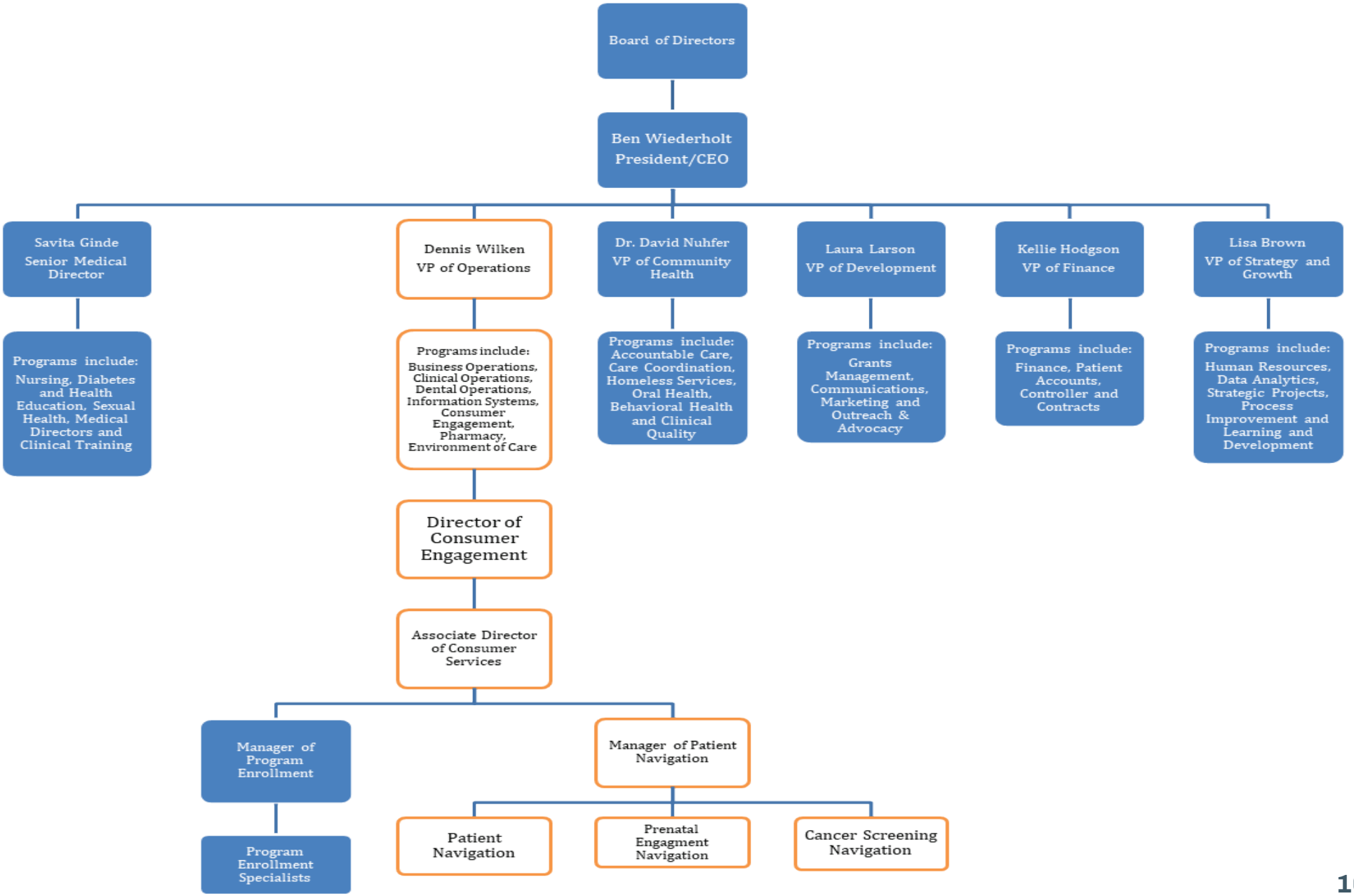
ATTACHMENT A



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ATTACHMENT B