Health Leads | Network

# Opportunities to Inform a Business Case for Upstream, Equitable and Community-Centered Prevention

A 58 year-old woman lives alone, suffers from depression and cardiovascular disease. While support groups are critical to her well-being, financial hardships make it difficult to manage her medical conditions and engage in mental health treatment. While she receives $420/month from General Relief, she finds it very difficult to pay for basic resources, including her water bill and stable housing. Over time, she is able to get connected with various social service providers in areas such as criminal justice, housing, health management, nutrition, and utilities. With that support, she has been able to begin her journey towards economic and health stability.

This case is far from unique. With conditions like heart disease and mental illness costing the healthcare system billions each year, stories like these have sustained the argument that healthcare investment in social health interventions make sense. But while the COVID-19 pandemic has only increased existing demand for essential resources that are critical to our health, with a disproportionate impact on people of color, the current healthcare payment system is designed to enable those in power to financially benefit from these health inequalities.

Healthcare continues to be disincentivized to establish a business case to fund effective upstream prevention, as financial incentives continue to be positively correlated with the volume and severity of presenting patient health challenges. Even as value-based care slowly takes hold, the perceived financial benefits of investing in direct service providers continue to fall short of what may be required to substantially shift healthcare's investment.

However, we are at a crossroads. Healthcare, as well as other sectors, are starting to reckon with the history and current realities of racism and inequality in our systems. We continue to see investments in SDOH programs on the rise among healthcare institutions, providing new opportunities to redesign systems and improve coordination. And while the number is growing, it is important to note that investment today represents only 2% of overall dollars spent as part of healthcare's Community Benefit programs, and the sector is still challenged with trying to establish a robust value story that could support long-term investment in such programs. A closer look at program structures and financial incentives across stakeholders provide insights to overcoming this challenge.

Addressing health inequities requires a dedicated focus on creating conditions in which all people can achieve health and wellbeing. In recent years, Health Leads has deepened and expanded its engagement with primary care and community-based partners to investigate the challenges associated with building a sustainable business case for social health interventions.

This paper highlights the key learnings and insights we've gained from two bodies of work that have focused on exploring more equitable funding structures to support community health. We aim to offer a starting point to address power imbalances in healthcare payment structures, build a more equitable, community-centered reimbursement, funding and incentive systems, and shift resources to include upstream, preventive interventions.

## Addressing Essential Resource Needs within Primary Care Delivery

In October 2019, we completed a two year learning initiative focused on how to sustain and spread the integration of social health interventions into primary care, the Collaborative to Advance Social Health Integration (CASHI), funded by The Commonwealth Fund. Within this collaborative, 12 primary care teams from across the country received coaching support to develop contextually tailored business cases to sustain their social health interventions. Social health interventions included the staff and technology necessary to identify and address unmet essential resource needs among patients accessing primary care services. CASHI's business case curriculum focused on demonstrating value to stakeholders, including those in a position to invest. A framework (Figure 1) guided teams' efforts, with the goal that all could articulate value created in the form of financial and non-financial benefits, clarify actual funds needed, and identify opportunities to bring in additional funds if necessary.


## Addressing Essential Resource Needs through Community-Level Navigation

A Community Information Exchange (CIE) is an ecosystem of a multidisciplinary network of partners that use a shared language, a resource database, and an integrated technology platform to deliver enhanced community care planning. Care planning tools enable partners to integrate data from multiple sources and make bi-directional referrals to create a shared longitudinal record. By focusing on these core components, a CIE enables communities to shift away from a reactive approach to providing care toward proactive, holistic, person-centered care.

Over time, through CIE's continued efforts, individuals and families will benefit from increased access to services they need to be healthy. Health and social service providers will be armed with higher quality information about their clients to better serve them. The data collected through the platform inherently through shared service provision could arm CIE service providers with the type of leverage they may need to demonstrate real outcomes to prospective funders and alternative funders — which could enable real growth in their respective operations.

However, cross-agency collaboration models, such as CIE, continue to grapple with the question of financial sustainability, as many of these efforts have historically been seeded by philanthropic and/or government funding for the build of the program's infrastructure. The challenge to sustainability for CIEs and similar cross-agency data systems is as much about putting communities at the center of value discussions for these systems, as it is about identifying a diverse set of funding streams who are collectively willing to fund the solution for the long haul.

In 2019, Health Leads conducted a value-based sustainability assessment for the CIE, focusing on the identification of financial and societal value derived from adoption and usage of the platform. The assessment leveraged components of ReThink Health's Financing Workbook to begin to determine the "return on investment" of the CIE and strengthen the business case around the necessity of others supporting this work.

## Our Findings

### The value of SDOH programs continues to be measured by their ability to generate a positive return-on-investment (ROI) among stakeholders who are most in a position to invest.

Although SDOH programs have demonstrated value to patients, communities and service providers, leaders of health systems, health plans and community based organizations (CBO) are often forced to side with the bottom line when deciding to sustain or spread this efforts.

**Here is why a sole focus on ROI for the health system is problematic:**

1. **It drives resources and attention away from activities that could go further to prevent essential resource needs among those not yet in crisis.** CASHI teams that evaluated the impact of the social health intervention on clinical quality measures saw improvements in less than one year mainly with high cost, high need patients. As a result, many teams made projections about the potential cost savings or additional earned revenue over time based on early data. Some health system leaders and payers considered these early results to be promising, but not so much that they would substantially invest in the workforce and technologies needed to significantly spread these interventions in a way that would meet the true level of need in the community. At best, these early results were compelling enough to incrementally expand patient access to these programs, particularly for high-risk, high need populations.

2. **The strong focus on utilization outcomes has proven to be a significant barrier in engaging (CBOs) in these efforts.** Utilization data requirements have medicalized SDOH programs and put pressure on agencies outside of healthcare to track and be accountable to these data as a requirement for full engagement in programs. For example, funding for CIE programs has increasingly been sourced from the healthcare sector. As a result, some CIE programs have been largely centered around understanding the impact of shared client data in helping to address ER admission rates particularly among high-utilizers. This takes time and energy away from quantifying the impact and value of a CIE to its stakeholders outside of healthcare.

3. **It weakens the incentive to participate among direct services providers.** As part of our CIE work, we found that willingness to invest in the CIE program was largely being driven by stakeholder's ability to quantify a financial ROI. This mindset has resulted in most healthcare organizations' willingness to invest solely in the "information and referral" component of the solution, to enable referrals to local CBOs, and a reluctance to invest in the shared care planning component. Insufficient funding for community planning often has resulted in sub-optimal participation levels in these types of programs by the community, as they grapple with questions of effort required for participation vs impact.

## The true costs and time involved in SDOH program participation are often underestimated and need to be fully understood.

Integration of essential needs support in SDOH intervention programs often place an increased burden on the community-based organizations and social services agencies without the recognition that many of these organizations are already overwhelmed with client demand for their services. For these organizations and agencies, full participation in these new SDOH intervention programs would require overtaxing workers who are often already at capacity, as well as the development of new, or modification of existing, workflows and processes to ensure the type of collaboration required with healthcare partners, and each other. As a consequence, the true costs to CBO and SSO engagement for these programs are often underestimated: government program funding along these lines often fall significantly below what is needed for community organizations to effectively engage, and the value case of Healthcare taking on this cost burden has yet to be established.

For example, in our CIE work, we found that organizations' willingness to engage in the program was largely informed by the program's ability to help the organization to decrease operational costs, taking into consideration the risks of sharing data borne through program participation. Frontline workers within community organizations were often disinclined to participate in cross-agency information sharing given capacity constraints, concerns over client privacy, and the number of systems they already needed to report into to comply with the reporting requirements of their multiple funders.

On the clinical side, staff in primary care practices often feel overworked with competing demands. Among the teams in CASHI, we learned these programs can be costly to administer depending on the program structure and the level of collaboration with CBOs. The operational costs associated with these programs are not well understood, and thus were investigated as part of the business case work in CASHI. Teams used time-based cost studies to understand cost drivers, identify opportunities for efficiencies, and plan for spread. These analyses measured the average time it took staff to complete each step in the intervention, from administering screening through following up on the outcome of the resource referral.

**Key findings from this segment of our CASHI work were the following:**

1. Screening was found to be relatively inexpensive to implement. The largest cost driver was time spent locating and following up with patients served.
2. Several teams recognized the need for solutions to improve efficiencies with closing the loop on referrals, including leveraging social health technology.
3. However, teams recognized that referral pathways and communication with community partners would also need to be improved for closed loop technology solutions to be useful at bringing down costs. For example, one participant found that per patient costs associated with following up on resource referrals went from $23.75 to $2.00 per year when a patient was enrolled in their local CIE.

## The voices of frontline workers and individuals interacting with SDOH programs are critical to understanding the true value of these programs relative to their costs.

We believe that community-based organizations already have a good understanding of the synergy that could result from sharing client information amongst neighboring agencies that may provide complimentary services, and believe many are practicing this informally as part of their established case management processes. An SDOH program that builds off this knowledge and the proven impact to society may go a long way in terms of ensuring the type of community organization, and community member buy-in that is necessary to effectively prove the value case for program collaboration across stakeholders.

In our CASHI work, for many teams the decision to sustain and spread their SDOH program was made independently of efforts to develop a business case. Participants in CASHI were skewed towards early adopters with strong commitments by leadership at the onset of the collaborative. Interestingly, demonstrating a more direct ROI was less important to teams' leadership than it was to inform how to sustainably integrate their work and invest resources well.

Two teams in particular saw themselves as both catalysts and collaborators in the local ecosystem to drive community health. Leadership saw value in this from both a mission perspective and to support long-term success in value-based care. Figure 2 shows how two teams aligned their institutional business case with the broader value created for the community.

### Examples: Aligning sources of value for the community with the institutional business

| | Demonstrate community benefit and value to healthcare stakeholders | Focus on community well-being also supports increases in revenue and efficiencies |
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| **Institutional business case**  | A free clinic in WI fulfills its mission of providing whole person care to uninsured residents, and sustains funding from a local coalition of healthcare systems by demonstrating decreases in uncompensated care (ER diversions) | An FQHC in OR developed a cross-sector care coordination network with long-term community health goals. This has led to increased revenue from new patient referrals via community partners, improved productivity (less time spent on follow up, rates of successful referrals), and expected improvements in triple aim at institution level |
| **Value created for the community**  | • $ value of benefits received by residents<br>• Increased rates of insurance enrollment<br>• Community-level improvements in utilization (unnecessary ED use, medical home for uninsured)<br>• Opportunity to provide screening and navigation service to CBOs<br>• Influence Medicaid policy and billing opportunities by sharing cost and benefit data | • Improved community health and well-being (e.g. person-reported well-being, A1c, depression, blood pressure)<br>• Improve ease of access to essential resources<br>• Decrease community-level costs and improve efficiency of service delivery<br>• Improvement in early education/other social milestones<br>• Reallocation of funds aligned with residents' priorities for health and well-being |

To drive community health and equity, we believe the sector will need to move beyond a business case that enables healthcare institutions' participation in addressing social needs to one that enables community-level collaboration. Applying the CASHI business case framework at a community level across partners could enable practical understanding of the costs and value created by each partner and collectively, providing information to support more efficient resource use and allocation. As one CASHI team found, this requires a more rigorous understanding of benefits to community, beyond just healthcare, and inclusion of community members in analyses of value created and required.

## The path forward: Broaden the ROI conversation to include cross-sector, community-level costs and impacts

Given the reliance of SDOH programs on the collaboration and cooperation with communities to achieve impact, the lack of a proven financial and societal impact sufficient to incent community organizations to fully lean in to these efforts is problematic. More research is needed to understand both the cost burdens and the unique value that these programs accrue to participating organizations and the community at large. This will help to move the financial value conversation away from ROI for only healthcare to a compelling value case across sectors, which can also lead to discussions about how to better balance cost burdens and work more efficiently across organizations, so that all participants thrive.

SDOH programs hold tremendous promise to ensure that community members' essential resource needs are met and to provide the infrastructure to support cross-sector efforts that focus on prevention, while building a true "Culture of Health." However, it's clear that the current funding and power structures associated with SDOH programs fall short of bringing communities together to reach these goals. As we look to advance and redesign systems to better support the health of our communities, our efforts should be guided by the following learning questions:

- What level of influence does the community have in determining the financial value of SDOH programs and how that is measured?
- Do these investments reflect the community's preferences? Do they contribute to building a sustainable infrastructure that supports the health and economic wellbeing of communities affected by systems of oppression?
- Are dollars being used effectively to meet the true needs of the community? What's not funded or reimbursed but should be?
- How are the contributions of community partners understood and valued by the health system?
- How can SDOH programs be structured and adequately funded in a way that gives all stakeholders equal power in cross-sector work and keeps them at the table?

The current climate presents a great opportunity for a shift in the way we think about funding for SDOH interventions. There's a growing anticipation that broader and deeper support for social services infrastructure from public funding sources is just around the corner. This opens up space for folks to think even more deeply about innovative financing models designed to not only support social services infrastructure but also much needed capacity building and funding for service providers (network members) whose incentives for engagement are severely limited by capacity constraints.

This necessary shift in power to community should not be expected to come organically but if we can be stewards of solutions that keep community interests in the center, we all can play a role in building toward more equitable systems of health.

### ABOUT THE NETWORK

The Health Leads Network is a community of healthcare practitioners and caregivers who are taking action to address essential needs within our organizations. Network members work in a wide range of health system roles and settings — but share a commitment both to drive improvement initiatives on the ground, and to advance health equity in their communities.

The Network was created to bring action-oriented practitioners together to collaborate, share and learn from each other. We translate critical front-line experience into tangible tools, guidance and learning opportunities — all designed to support members in advancing the integration of essential needs into community-led health initiatives.

Learn more at healthleadsusa.org/network — or email network@healthleadsusa.org for additional information.