

**Regional One Health case study:** Review these case studies to see how successful complex care programs applied the concepts and developed their value case.

# An exemplar of the value case principles in action: Regional One Health, Memphis TN

The National Center for Complex Health has partnered with dozens of communities around the country to partner in strengthening their ecosystems of care. The case study below has been selected for your learning. The goal of this case study is to give you an opportunity to see how a safety-net health system started by examining root cause themes of their most high frequency patients, and over time developed a strong business case for their work.

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.

# 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.

https://www.regionalonehealth.org/blog/2018/07/03/one-health/

## Scaffolding populations

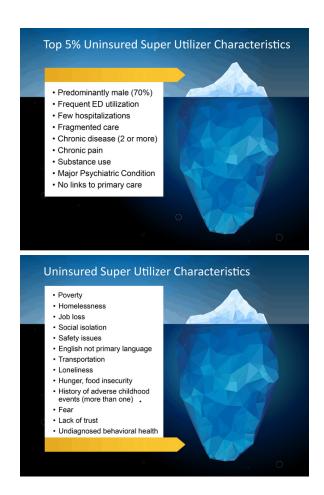
For Regional One, the needs of the uninsured are so great, the team has remained focused on this population. The team has used the same methodology to consider adding other populations in the future based on the scaffolding of financial impact to the health system.

#### Stakeholder needs

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.

This resource was shared as part of the Building the Value Case for Complex Care Toolkit from the National Center for Complex Health and Social Needs, an initiative of the Camden Coalition. Find the full toolkit at www.nationalcomplex.care/value-case.

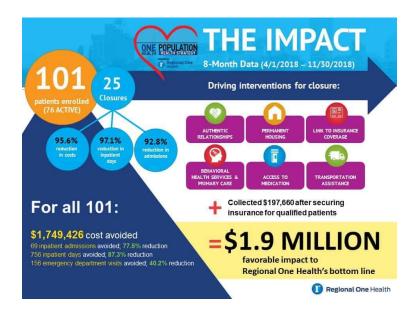




## Demonstrating value

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.





**Vaida, B.** (September, 2019). *For the Uninsured in Memphis, a Stronger Safety Net.* **Health Affairs.** <a href="https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00999">https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00999</a>

## 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.

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**Cooper, S. & Wagers, R.** (August, 2020). *Building the Business Case for Complex Care*. HFMA Annual Conference. <a href="https://learn.hfma.org/learn/video/building-the-business-case-for-complex-care">https://learn.hfma.org/learn/video/building-the-business-case-for-complex-care</a>

#### 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.

ONE Health 12 Month Update: Data Shows Real Opportunity

ONE Health Update: New numbers highlight significant human and financial benefit of innovative complex care initiative

America's Essential Hospitals (September, 2019). *Gage Award: Population Health Honorable Mention* <a href="https://www.youtube.com/watch?v=jH8fjqqvYjk&feature=youtu.be&list=PLC3uOjwmHMrxlcZRrJ54Wx9UWoUSobLyj">https://www.youtube.com/watch?v=jH8fjqqvYjk&feature=youtu.be&list=PLC3uOjwmHMrxlcZRrJ54Wx9UWoUSobLyj</a>