Georgia Health Policy Center

CSI solutions

The Business Case for Addressing Social Determinants of Health in a Rural Primary Care Setting

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The Business Case for Addressing Social Determinants of Health in a Rural Primary Care Setting

Overview

At a systems level, addressing social determinants of health (SDOH) has been shown to lower the total cost of care. However, until some of these savings begin to be routinely passed down to the primary care setting, the business case for integrating social health into primary care is not always obvious or well understood This means we need to think about a business case for the work that goes beyond traditional approaches of getting paid for our services. Can a sustainable business case be made for any SDOH intervention we choose to undertake? Definitely not, but we can have a disciplined approach to the analysis of both indirect and non-financial benefits that might influence decisions on addressing SDOH when weighed against the cost of the program. This paper discusses the importance of this analysis and how to approach it within a rural practice, providing tools and resources to support practices seeking to make that business case The keys are understanding cost and thinking about value.

Defining Social Determinants of Health (SDOH)

When we think about keeping people healthy, we naturally think about the health care delivery system. A patient comes to a rural clinic or hospital, and the health care team uses its skills, training, and knowledge to help the patient maintain his or her health or address an urgent condition. However, for most patients, their interactions with the health care team amount to only a few hours per year. The National Academy of Medicine has estimated that less than 20% of a person's health is being influenced by the health care team while the other 80% is influenced by the physical environment (e.g., air and water quality, housing, transportation), health behaviors (e.g., smoking, drinking, etc.) and social factors (e.g., income insecurity, community safety, etc…).[1] The Healthy People 2030 initiative suggests that SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[2]

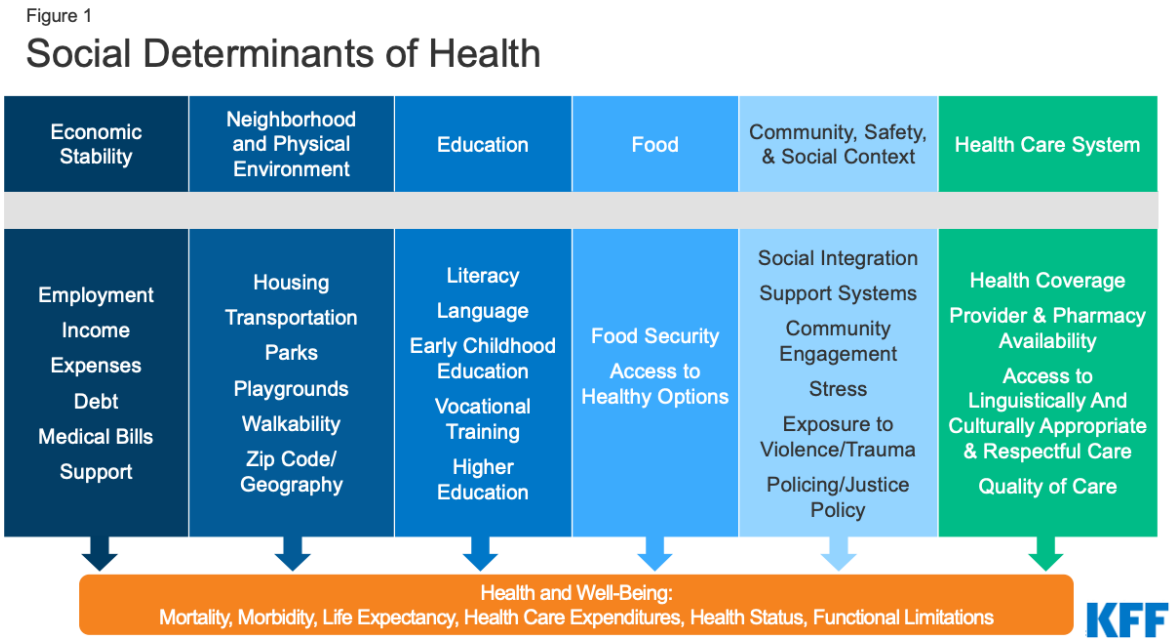
Patient Georgia provides an example. She lives on a farm with her husband and three children. She arrives at a rural clinic with complaints of upper respiratory congestion, dizzy spells, constant thirst, and fatigue. She is evaluated and is diagnosed with seasonal allergies but chronic conditions including obesity, hypertension and diabetes are also addressed. She is provided nasal saline, counseling about weight loss and a prescription for both her high blood pressure and her diabetes. As it turns out, the family borrowed the farm truck to come to the appointment. Their rental home is adjacent to the silo where the corn is harvested and stored which creates significant contaminants in the air during harvest season. The family has experienced significant financial hardships and do not have the resources to afford her diabetes and blood pressure medicine each month. The entire family, including children, are obese and the family joke is about the genes they all inherited. In reality, even though they are on a farm, their food choices all gravitate toward sugar and high fructose-based foods, drinks, and snacks. They have to travel quite a distance to get groceries, so they find processed foods are easier to manage as they are more shelf stable than fresh produce which does not last long.

[1] https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/
[2] https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Georgia's situation is likely to result in long term continued exacerbation of her conditions, the management of which presents the health care team with significant challenges. Her transportation limitations may cause her to be a periodic no-show for medical appointments. Her diabetes, obesity, and blood pressure issues are unlikely to be well controlled in light of her challenges with transportation and access to medications, limited access to quality food, and her personal food choices. Absent some major changes in Georgia's overall situation, the health care team will probably feel they cannot control or influence Georgia's outcomes, yet they are held accountable for them.

Georgia's story highlights only a few of the social determinants that can have a significant impact on both physical and mental health. The Kaiser Family Foundation summarizes the major social determinants of health in the following framework:[3]

Figure 1 Social Determinants of Health



Whose job is it anyway and what can we do in a rural primary care setting?

Rural providers and hospitals face many challenges in trying to meet the healthcare needs of their patients. Can they really be expected to take on social determinants of health as well?

Drs. Sidney and Emily Kark, family physicians practicing in rural Soweto, South Africa in the 1940's, recognized that if they did not take a broader view of health, their medical interventions would be temporary and have little impact on the overall health of the population they were serving. They took a more systematic approach to address some of the social issues such as malnutrition, health literacy, and

[3] https://www.kff.org/coronavirus-covid-19/issue-brief/implications-of-covid-19-for-social-determinants-of-health/

water filtration. Their work led to their attribution as the architects of what is now known as the Community Oriented Primary Care model (COPC).[4]

A short time later in the United Stated, Dr. Jack Geiger, a family physician, observed similar challenges working in rural Mound Bayou, Mississippi and was influenced by the work of the Karks. Dr. Geiger's own efforts to build a more comprehensive approach to health resulted in the formation of the Federally Qualified Health Center (FQHC) program within the Public Health Service. Over time these early efforts have influenced the evolution of the Federal Office of Rural Health Policy and specific initiatives to support rural healthcare providers. The role of rural clinics and hospitals in engaging in social determinants of health are steeped in the rural health center movement.

The historical perspective is important, but widespread recognition of the role social issues play in health has come more recently with the growing emphasis on population health management and on the evidence that resolution of one or more social needs can have a positive impact on the health of a population. Much of the literature on impact derives from large system-level interventions, but impact can be felt on a more local level as well. One small example of this in the Bronx at Urban Health Plan, an FQHC. The clinic was experiencing high asthma rates of children only to discover that a large segment of their population was walking to school past a trucking depot where trucks idled every morning. By working with the trucking company, they were able to reduce air emissions and had a decrease in asthma exacerbations as a result. This was a low-cost effort and stemmed from recognizing the issue and playing a role in addressing the problem.

On whom does the responsibility for addressing this type of social issue fall? The answer needs to be everyone - individuals taking responsibility where they can, communities taking on systemic issues, and health care provider organizations as well. This is not to say that rural health providers should be expected to take on the burden of addressing all the social determinants their communities face, but there is a role they can and should play as a convener and contributor to addressing some of the compelling SDOH issues. In the next section we talk about some of the processes that support these roles. From there we move to the discussion about balancing the moral and clinical imperatives for this work with the realities posed by the business case.

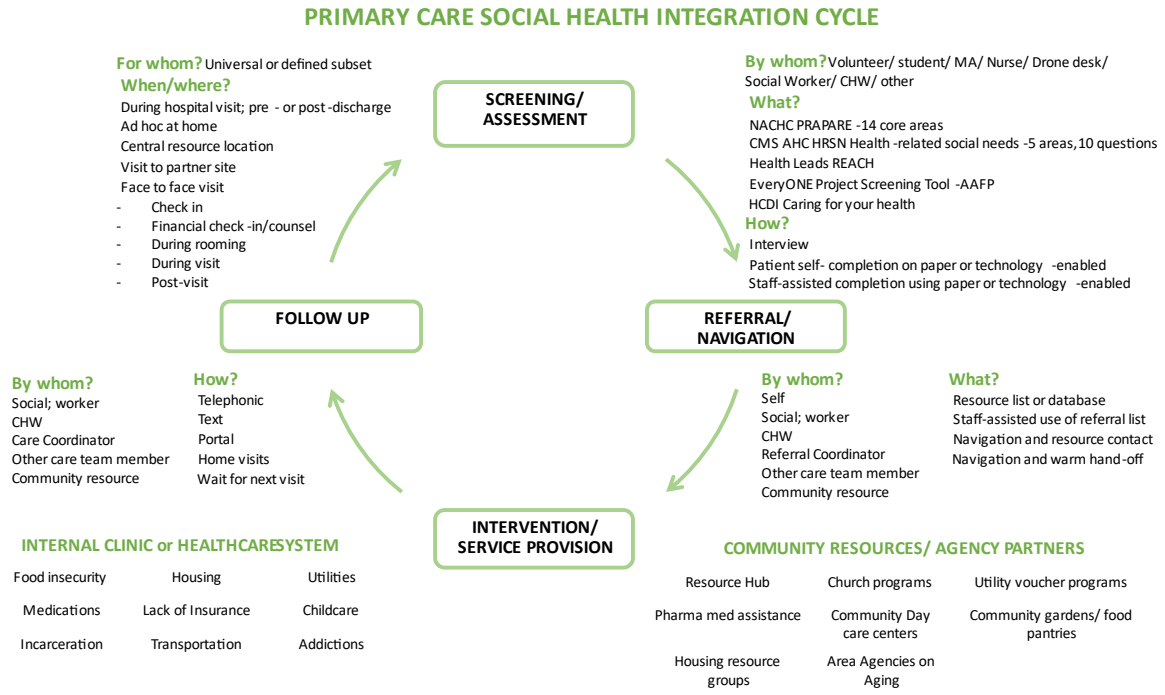
Models for Integrating Care for Social and Physical Health

One of the primary ways a rural provider in a clinic or hospital setting can contribute to addressing social needs is to implement a system that identifies individual needs and makes connections to associated resources or services to address them. Four key processes need to be part of such a system: screening and assessment, referral, interventions, and follow-up. In a rural setting, one of the biggest challenges is the availability of the intervention resources and services. In some cases, the clinic, hospital, or health system will choose to provide those; in others, there is a dependence on community partners. There can also be significant variation in how the other three processes are implemented. This paper is not intended to be an in-depth guide to developing such a social health integration system. However, a basic understanding of these processes is essential as each part of the system carries both a cost and the related decisions of "for whom", "by whom" and "how" that must go into business case thinking. We will talk more about cost later in this paper.

[4] https://academic.oup.com/ije/article/32/5/882/665742

Figure 2 presents a diagram of such a system.

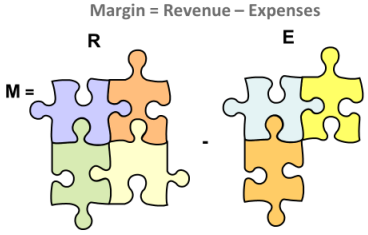
Figure 2



Elements of the Business Case

The traditional approach to making a business case for any initiative is a simple equation as depicted in the following formula:

Margin = Revenue - Expenses



The revenue we derive from the initiative minus the initial cost and ongoing operational expenses creates a margin. That margin can be positive or negative. When the margin is positive it is relatively easy to justify either starting or retaining an initiative. When it is negative, we generally receive pushback and have difficulty justifying initiating or sustaining the intervention or program. This is a simplistic way to evaluate the merits of a program, but one that fits many initiatives. A more sophisticated approach is to add a fourth variable to the equation. This is the concept of "value"— the perceived importance, worth, or significance of something. Working on the business case for social health integration requires us to examine, understand, and try to influence each of these variables. In the end, however, it can be value that offsets any lack of balance among the others. We will now consider each of the variables in the Business Case equation.

Variable 1 - Cost

We start our discussion of the business case with the cost variable for two reasons. First, it is the variable over which a rural provider organization has the most control. Also, it is imperative to know how much funding or quantified value is required as we try to demonstrate the long-term sustainability of whatever integration model we implement.

As noted earlier, each component of the social health integration cycle carries a cost and most of that cost is associated with staffing. This means that the total cost of the integration cycle becomes a function of what tasks are included in each of the system components, as well as who does the work, how long it takes, and how many of each task are being completed. These questions that can be asked and the accompanying level of detail regarding cost can be very complex. Process mapping the social health integration cycle is a good way to visualize the workflow, identify the staff involved, and assess whether any parts of the process can be simplified, or an alternate resource used to complete it. Once you fully understand the steps in the cycle, estimated costs can be calculated by answering each of those questions about what, who, how long, and how many.[5] An Excel tool, available in **Appendix A** provides specific guidance about the critical data elements to make these estimations. Figure 3 at the end of this section depicts an example of a completed tool and illustrates one framework to understand the associated costs.

To complete the spreadsheet, time studies are recommended, recording the actual minutes spent on each activity and then averaging them for some designated period of time. This can be done on a sampling basis, observing the event over a period of time and including different staff members as they address the most common issues addressed in the practice. If this level of detail seems unnecessary or overwhelming, an alternative approach can simply be to divide total current expenses by number of patients who are screened or served; this can develop an average cost per patient that can be used to project future costs as volume changes. Regardless of the approach you use, there are certain basic concepts that are important.

- Understand your current processes to make it easier to consider modifications.
- Understand the elements of cost and their relationship to each other so that you know what the trade-offs are as decisions are made (e.g., universal screening versus targeted screening, providing navigation to essential resources versus a list of resources and phone numbers, screening tool administered by a medical assistant versus a nurse, telephonic follow-up versus mail or email).
- Strive for efficiency.
- Designate staff responsibilities at the top of their licenses.
- Focus where the need is greatest.
- Leverage partnerships to avoid internal cost where possible.

Keep in mind that even without a specific program to address SDOH, it is likely that your staff work to meet the needs of patients in every way they can. Those efforts impact staff productivity as well as the sense of agency to care for their patients but are often not explicitly captured as costs. The discipline of codifying the less formal efforts may help leaders recognize that these "hidden" costs are already at

[5] Microsoft users can find free process mapping tools at https://templates.office.com/en-us/process-map-for-basic-flowchart-tm16400363

play. As an example, a clinic in Colorado wanted to set up a formal social health integration program but knew that asking leadership for more money was not an option. The staff also knew that a lot of "informal" help to meet SDOH needs was already being provided by the nursing staff, and they estimated the time and money this represented. Using this estimate as the program budget, they launched a formal program. They started with transportation. By formalizing the approach and changing who was doing what, they improved equity and reliability as well as the volume of services provided. The substitution of an LCSW instead of a nurse to take on the duties of linking patients to resources enabled the clinic to continue and grow the fomal SDOH program without adding cost.

Understanding the SDOH needs of the population and the costs incurred in meeting them allows organizations to be more purposeful, efficient, and reliable in meeting these needs for their patients.

Regardless of how your organization thinks about funding the work of social health integration, it is imperative that you know the cost of the work and that you are confident that you are doing the work in the most efficient manner and at the lowest cost possible.

Figure 3

ORGANIZATIONAL COST ASSUMPTIONS						
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				
Staffing						
	Avg hourly rate	**Fringe %**	**Total hourly paid**	**Internal/ external**	**Minutes to complete**	**Cost per patient or month**
Screen Staff type 1	$ 19.23	25.0%	$ 24.04	I	5	$ 2.00
Referral staff type 1	$ 31.25	25.0%	$ 39.06	I	0	$ -
Navigation staff type 1	$ 31.25	25.0%	$ 39.06	I	20	$ 13.02
Follow-up staff type 1	$ 19.23	25.0%	$ 24.04	I	10	$ 4.01
Monthly follow up data collection staff	$ 19.23	25.0%	$ 24.04	I	45	$ 18.03
Monthly analysis staff	$ 38.46	25.0%	$ 48.08	I	60	$ 48.08
Other direct costs per patient screened		Other direct costs per patient referred/navigated				
Other annual direct costs related to screening		Other annual direct costs related to referral/navigation				
supervisor MA	$ 12,500.00	program supervisor				$ 60,000.00
Other annual indirect costs related to screening		Other annual indirect costs related to referral/navigation				
Other annual direct costs related to patient follow up		Other annual direct costs related to data collection/ analysis				
		monthly staff costs(from above)				$ 793.27
Other annual indirect costs related to patient follow up		Other annual indirect costs related to data collection/ analysis				

Variable 2 – Revenue/Funding

In a clinic or hospital setting, when we think about funding any initiative, the most direct approach is to look for payment for the services being provided. Provide a service and then get paid. Unfortunately, interventions to address social health have generally not been part of the services that are reimbursed, but there is a slow evolution that is taking place.

The introduction of Z codes in 2020 (See **Appendix C**) sets up a mechanism for third party payors to directly pay for certain services related to patient screening and addressing social health needs.

In 2019 the Centers for Medicare and Medicaid Services (CMS) issued guidance to allow Medicare Advantage plans and Medicaid agencies flexibility in starting to pay for certain interventions that mitigate the negative impact of SDOH. Examples include such things as air conditioners for people with asthma, healthy groceries for people with prescriptions for specific diets, home-delivered meals for people who are immunocompromised, and rides to medical appointments for people without transportation. [6]

Other health care delivery and payment transformation efforts that contribute to the evolving payment landscape include the following:

- Whole person approaches to care delivery, including Patient Centered Medical Homes (PCMH), behavioral health integration, and complex care management, require or emphasize actions to identify and address unmet social needs among patients served.
- Accountable Communities of Health, such as those in Washington State, are providing resources to address health care and social health issues working with community stakeholders.
- Value-based payment models, particularly in the Medicaid space, are catalyzing experiments to determine what incentives and infrastructure can support better coordination within the health care system and across human service sectors. [7]
- Other alternative payment models may provide an inherent incentive to invest in activities to address SDOH as a way to reduce the total cost of care and sustain improvements in health outcomes at the population level. As an example, if the rural provider organization shares in savings or is rewarded for outcomes improvement, these dollars can offset the investment made.[8]
- In some cases, accountable care organizations or others that take on risk for the total cost of each patient's care will provide direct program support to pay for elements of social health integration. This practice acknowledges that for many of the populations served you cannot influence their overall cost of care delivery unless you deal with the SDOH issues. Examples include:
    - Kaiser Permanente is advancing a Total Health framework to communities by focusing on health–promoting policy, system, and environmental changes. Kaiser is now systematically screening patients for unmet social needs.

[6] https://www.cms.gov/newsroom/press-releases/cms-issues-new-roadmap-states-address-social-determinants-health-improve-outcomes-lower-costs
[7] https://www.hca.wa.gov/about-hca/medicaid-transformation-project-mtp/accountable-communities-health-achs
[8] https://qpp.cms.gov/apms/overview

- Humana has launched a pilot in seven communities with a goal of improving health in these communities by 20%.
- CareSource, a Medicaid payer, launched a program in three states to help members get and keep jobs by addressing education and skill gaps and linking members to employer partners.[9]

In the absence of any identifiable revenue streams, there are still several potential funding sources for an SDOH initiative. The first is budgeted resources from within your own organization. This involves the leadership team determining that the value of program is sufficient to use margin created elsewhere in the organization to subsidize activities to integrate social health. This could be in the form of a position such as a social worker or community outreach worker or budgeted resources for supporting an intervention such as transportation vouchers.

The last source of funding we consider in the "revenue" puzzle piece is philanthropy. Like program support, these revenues are often from local or regional foundation with targeted interests. Like all other stakeholders they are seeking an impact for the resources they may be pledging.

It is common to see organizations starting an SDOH initiative to piece together their funding sources from all these varied resources until they have confidence in the impact and value of the services provided. Once this can be documented, it can lead to longer term sustained funding.

Variable 3 – Margin

Margin is the easiest variable to explain as it is simply the different between revenue and expense. It usually does not consider funding sources such as grants or philanthropy that are not coming from a third-party reimbursement system.

Variable 4 -- Value

Value is the final variable in our business case discussion and as noted earlier, value can be the key to making a business case when the direct revenue and cost variables are not in balance. Value is the importance, worth, or significance inherent to something and it can greatly influence decisions about organizational initiatives, even in the absence of a positive margin. For example, contribution to an organization's mission is an aspect of value. If an initiative costs a thousand dollars a year but is exemplary of fulfilling an organization's mission, it may move forward even without any attached revenue source. If it costs a hundred thousand dollars it may not. Somewhere in between those two extremes, a value decision can be made by the stakeholders.

To understand the potential contribution of value, it is critical that you understand who your key stakeholders are and how they define value. A tool to help identify what your stakeholders' value is the "SDOH Business Case Value Lens," (**Appendix B**). One approach to get started is to simply meet with your stakeholders and have them define what brings value to them. For example, if you intend to partner with a local YMCA in an effort to provide healthy options to engage in physical fitness for an underserved community, you might find that "member retention" is a key driver for them. If your SDOH partnership enables their members to be retained in their program, then that value may be worth their contribution, whether in-kind or monetary. A management team might not see the value, but a philanthropic source might if the intervention aligns with their aims and mission. At the same time, the

[9] AHIP- Beyond the Boundaries of Health Care: Addressing Social Issues (www.AHIP.org)

management team may see value in lower provider turnover rates that result from a better work experience when patients' social issues can be addressed. In all cases wherein value is identified, an attempt to quantify the benefit should be made. What is the cost of member turnover to the YMCA or what is the cost of provider turnover to your clinic?

As you explore stakeholder value, you will likely find that many stakeholders value things that are more easily quantified, like a reduction in total cost of care or some level of cost avoidance. The total cost of care is an important variable, and perhaps the most important variable, for those who are responsible for paying for the medical care for a population of patients. The total cost of care, or TCOC, typically includes all payments made for clinical services---primary care providers, inpatient and outpatient facilities, specialty services, ancillary services, and durable medical equipment. It typically would not include the administrative costs of a health plan, payer, or self-insured employer. Payers often have resources to help their provider networks manage total cost of care. One such example is Understanding the Full Picture of Total Cost of Care. Targeted reductions in the total cost of care are often tied to incentive payments to provider organizations. Similarly, shared savings payments to providers depend on total cost of care calculations. Effective social health integration has been shown to impact the total cost of care. For example, providing transportation assistance within the rural provider organization could lead to decreased no-show rates and better success in patient self-management, which can in turn lead to fewer emergency visits. Similarly, medication assistance programs administered by a rural clinic can help patients achieve better clinical outcomes and again reduce emergency visits or inpatient admissions. All of these factors can result in reductions in total cost of care. The challenge comes in the fact that interventions are introduced in one part of the health system- in this case rural provider organizations - and the cost impact is seen in another part of the health system. For this reason, it is important to quantify and document all aspects of and contributors to value. A quantification of value can be the factor that tips the funding scale in the direction of support for social health integration, even in the absence of traditional revenue.

Quantifying Your Business Case

Documentation of the business case and the value contribution a rural organization makes has to be a deliberate process because of the varying definitions of value and the indirect relationships that often create it. **Appendix A** provides an Excel tool that can be used to quantify the business case and model various scenarios.

One of the common challenges faced in trying to document a business case is the lack of adequate data to demonstrate impact. Lack of access to the claims data needed to document changes in total cost of care is probably the most significant of these challenges. Rather than simply declare defeat, teams are instead encouraged to use whatever information is available as a starting point for making projections or supporting a hypothesis about a broader population. This type of "What if…" analysis may not be enough for complete stakeholder buy-in, but it can be sufficient to raise awareness, generate interest, or gain assistance in getting access to the full data set needed to build your case.

A very common challenge is working with small sample sizes or not having data for the population as a whole. This is where a patient story can provide you a starting point of a business case.

Using a patient story….

One approach is to identify a patient for whom you believe you have a compelling story about impact. Develop the overall story you would like to tell about this patient, THEN…

1. Collect real data that can be used to address the business case for helping that single patient. Consider clinical outcomes improvement from the electronic health record (EHR), reductions in utilization as documented in the record or self-reported by the patient, or actual charge information from claims data. In order to assess impact, you must be able to obtain the chosen metrics for a time period before your SDOH intervention and for a similar time period following the intervention.
2. Analyze the pre- and post-intervention data to determine what you can say about impact. If there is no measurable impact, you may need to reconsider the selected patient and choose another patient instead.
3. Translate utilization or clinical outcomes improvement to dollars. Use local average charge data for savings related to utilization reductions. Improvement in clinical outcomes creates value on its own and over time these improvements also drive utilization and cost reductions. Quantifying these reductions generally relies on reference to the literature and studies that have been done to document a financial impact associated with some change in a clinical metric. Studies do exist for measures such A1c in diabetes, blood pressure, and depression remission. However, when using these studies to calculate cost savings for an individual patient or individual clinic, care must be taken to ensure fidelity to the parameters of the study. This means that patient characteristics and timeframe must align.
4. Make assumptions about the applicability of the impact seen for that single patient to a broader population. This could be the entire population, those patients that have a similar need or condition as your story patient, or subset of one of these groups. You may also assume that the impact on additional patients may not be as great as on that one patient, so a percentage of that impact may be assumed. This is particularly important if the story patient you select can be viewed as an outlier in clinical condition, utilization, or cost.
5. Apply all or a percentage of the dollar impact for your single patient to the broader population based on the assumptions made. This answers the question: “What if we had a similar impact on others?”

Case Study Example

Rogue Community Health Center (Rogue) is a primary care organization providing services to rural areas of southern Oregon. Rogue supports clinics in small communities such as White City, Oregon (population 455) and Butte Falls, Oregon (population 423), in addition to the main clinic and administrative office in Medford, Oregon. The populations they serve face all of the same challenges and disparities many rural communities face including transportation, food insecurity, income insecurity, and access to services. As an FQHC Rogue had the opportunity to use a social determinant of health screening tool called the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) developed by the National Association of Community Health Centers. Like most organizations, they were neither financially able or ready from an infrastructure perspective to screen their entire population and coordinate services for those identified with an SDOH issue.

Rogue is providing services in a state with an alternative payment model for reimbursement where they could benefit from both capitated managed care contracts and also be part of a Coordinated Care Organization and benefit from either direct support or shared savings opportunities. But they had to be able to make their business case.

They also had already formed strong relationships within their community referral partners. They decided that since they could not fix all the social problems in their communities what they could do is play a role as a convener while pursuing funding opportunities for their SDOH efforts. They began with five partners including the Southern Oregon Head Start, Southern Oregon Goodwill, Family Nurturing Center, the Addictions Recovery Center, and the Rogue Valley YMCA. They quickly discovered each partner was trying to support the people they served, who overlapped with many of the same services. They all realized it was far more cost effective to pool their resources and establish a coordinating center infrastructure than for each program to develop its own resources and continue working in a silo which was inefficient and unnecessarily redundant.

The group formed what they labelled as the *Rogue Challenge*. Each partner offered their own in-kind services as part of their core mission but also provided some nominal funding to support acquisition and coordination of software to screen and track patients referred for services and manpower that could be shared across the partners. Rogue, as the architect, was contracted to manage the execution and longer-term oversight of the coordinating center which began with a single staff person and grew to include community outreach and social work staff supporting the program.

While rolling out their program, they began seeking longer term funding sources. Their leadership worked with the Coordinated Care Organization (CCO) to explore funding support. Although the CCO was aligned philosophically, it asked the tough questions of how much money do you need (cost) and how will it be used (efficiency)? They asked how will you know you are making a difference (measurement and tracking outcomes)? Can you translate the costs into a per member per month formula to be able to compare these costs to other expense items the payer was funding? They quickly realized they needed to develop a business case and also understand the language and metrics these stakeholders utilize.

Rogue began the business case journey by doing a stakeholder mapping exercise and then asking their stakeholders how they might define value. They found that most of their stakeholders had similar issues in terms of needs to demonstrate value to their own upper leadership and they too did not have the data they

needed on outcomes as every entity was working in its own silo and community wide data was not available. These partners were not aware of their own cost structure and could not translate costs into per member per month metrics. Many of their partner stakeholders were concerned about keeping their clients in care and not lost to follow-up. They shared many common interests and need for data and welcomed the opportunity for the Rogue Challenge to help them with their own mandates and reporting needs.

Using the spreadsheet tool shared in this monograph, they went about translating their work into a cost model. By observing their workflows, they developed a model that showed screening cost $.65 per-member-per-year (PMPY), their referral process cost $3.75 PMPY and their follow-up cost $8.75 PMPY. This gave them a basis to negotiate with their payer sources and also convince them they had a professional and business-like approach to their SDOH program and a level of competency to be able to provide data on the needs in the community. They next started working on value from the lens of the key stakeholders they needed to convince to support that work. That included their own internal leadership, leadership of the payers and CCO, and other funding sources in the community.

In terms of their own business case, they found that by addressing their own patients SDOH challenges they could keep patients in care who were depending on those service supports. This translated into fewer no-show rates, less patient turnover, and improvements in their competitive position in their managed care market. They also found by serving as the convener of these community partners they were getting increased referrals of new patients who do not have a consistent primary care medical home (relying on emergency room care as their last resort). At an approximate rate of $68 per member per month the revenue potential alone from new business was a very high multiple return on investment for their time and resources. As an example, the local Head Start program identified six hundred families, most of whom were not connected to care and could be potentially converted to managed care beneficiaries supported by Rogue at the $68 per member per month rate.

The costing exercise helped them improve their own efficiencies but also empowered them with information and data needed to make their business case. They have grown their program to thirty partners in eleven different locations. They are not single handedly addressing every social determinant of health in their communities, but they have helped bring together the right partners to better optimize existing resources and tackle broader issues as a collective effort.[1]

Summary and Getting Started

The business case for addressing social determinants in a primary care setting may not always be intuitive and it sometimes requires a practice to think outside the boundaries of traditional return on investment calculations. This paper has highlighted approaches to this type of thinking and provided guidance on how to get started, along with an appendix of tools to assist in this work. By taking a disciplined approach to understanding the costs of a program to address social needs, as well as both its financial and non-financial benefits, a practice can work with its stakeholders to build the case for sustainability.

Appendix A - Business Case Cost Calculator for Addressing Social Needs

This workbook was created by CSI Solutions, in partnership with the Georgia Health Policy Center, to assist primary care practices in developing a business case for aspects of their work. This version of the workbook focuses on activities designed to screen for and address needs related to social determinants of health. There are 5 tabs in the workbook:

I. Introduction
II. Current Intervention Costs
III. Organizational Assumptions
IV. Service Delivery Cost
V. Revenue and Funding

To get started with the workbook please click on the following link to download and use the tool:

Business Case Cost Calculator for Addressing Social Needs

Value Lens for Provision of Services for Social Determinants of Health

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play worship, and age that affect a wide range of health, functioning and quality-of life outcomes and risks.

Consider internal and external stakeholders: clinic as an entity, staff, patients and families, other departments/entities if you are part of a larger organization, community partners, payers, foundations, other funding sources.

Who are your stakeholders?	How do they perceive value? What matters to them?

Consider value in multiple ways.

Business Case Lens	Key Questions
Impact on Clinical Outcomes/Quality	• What clinical outcomes would we expect our intervention to impact? • Is there a difference in the clinical outcomes of patients after receiving SDOH support?
Patient Experience	• Has implementation of your SDOH integration program had an impact on those receiving support that is different from either documented experience prior to implementation or the experience of patients not receiving the SDOH intervention?
Staff Experience	• Is the SDOH integration program having an impact on staff experience (joy in work)?
Productivity/Efficiency	• Is the SDOH integration program having an impact on care team productivity that results being able to see more patients? • Have no-shows been reduced? • Have internal clinic costs been reduced in any way?
Reduction in cost to those paying for care	• Has total cost of care been reduced for patients receiving a SDOH intervention---compared to before the intervention or compared to patientswho did not receive the intervention? • Has any utilization been reduced for patients receiving a SDOH service as compared to before the program was in place or compared to patients not receiving the service? Consider rates of ED visits, inpatient admissions, outpatient visits.
Cost Avoidance	• For patients without insurance…are patients who receive a SDOH service experiencing fewer ER visits and readmissions?
Clinic Revenue	• Are there any impacts on clinic revenue that have resulted from implementation of the SDOH integration program? • Has the clinic added any new patients? Additional service-related fees been generated? (E.g., social work fees, CCM) Current incentive-based contracts that provide rewards for improved clinical outcomes or reduced utilization?
Other indicators of value	• Has the SDOH integration program had a positive impact on any partners or other parts of your larger organization (e.g., obtaining referrals, perceptions of collaboration, actual funding or revenue increases, meeting enrollment or volume requirements, contributing to organization community benefit accounting, etc.?). • Is the organization feeling a better sense of readiness for future value-based payment arrangements?

Social Determinants of Health Z Codes for ICD-10

Z55 – Problems related to education and literacy

Z56 – Problems related to employment and unemployment

Z57 – Occupational exposure to risk factors

Z59 – Problems related to housing and economic circumstances

Z60 – Problems related to social environment

Z62 – Problems related to upbringing

Z63 – Other problems related to primary support group, including family circumstances

Z64 – Problems related to certain psychosocial circumstances

Z65 – Problems related to other psychosocial circumstances

Each of these codes has sub-codes providing a more specific description of the problem. Some of these codes describe issues traditionally recognized as related to socioeconomic status:

Z59 – Problems related to housing and economic circumstances

Z59.0 – Homelessness

Z59.1 – Inadequate housing

Z59.4 – Lack of adequate food and safe drinking water

Z59.5 – Extreme poverty

Z59.6 – Low income

Z59.7 – Insufficient social insurance and welfare support

Z60.2 – Problems related to living alone

Z60.3 – Acculturation difficulty

Z60.5 – Target of (perceived) adverse discrimination and persecution

Z63.1 – Problems in relationship with in-laws

Z62.1 – Parental overprotection

Also please refer to the National Health Care for the Homeless Council's policy brief on how to Ask and Code for Homelessness using ICD-10-CM Z59.0