How One FQHC Reached Off-the-Chart Results During COVID-19

"We started this program in early April when I was personally running our full time COVID clinic...so I maintain that if you think you don't have time to do this... that's when we rolled this out!"

- Meredith Gentes, FNP-BC,
Senior Director of Population Health

OVERVIEW

Ryan Health, a Federally Qualified Health Center (FQHC) based in Manhattan, has been committed to providing high-quality, comprehensive and affordable care to New York's communities since 1967. With seven primary care locations, Ryan Health serves more than 50,000 patients through more than 194,000 visits per year. As a FQHC, Ryan Health is accustomed to treating a physically, economically and socially diverse and complex patient population. As their aging population grows, augmenting the preventative services provided to these patients has become a high priority.

Ryan Health
Caring for New York. Here for You.

chartspan®

APPROACH

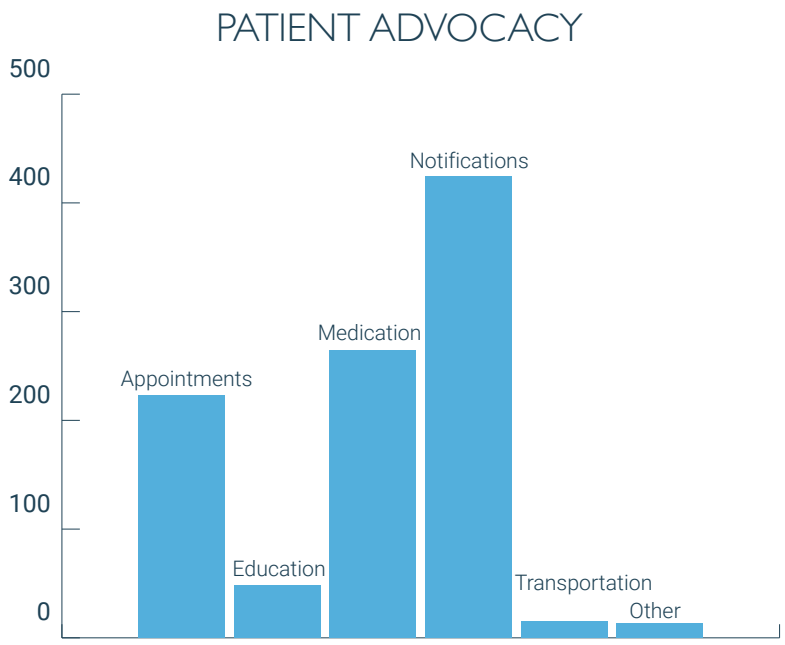
Ryan Health's Senior Director of Population Health, Meredith Gentes, FNP-BC is a champion for comprehensive and holistic care. In her role, Ms. Gentes leverages care management and disease management for acutely ill patient populations to improve patient outcomes. In addition, she led Ryan Health's evaluation of preventative programs for the chronically ill. The demands of maintaining access to care amidst an evolving pandemic accelerated the commitment to launching a Chronic Care Management (CCM) program.

Meredith reflects back on their evaluation period, "We were thinking about what kind of program we could have that will give our patients better access to care. Of course during COVID there were major cutbacks in the amount of visits we were seeing, so a program that could be a source of revenue would be beneficial, but more importantly, we were thinking about our patients and being in value-based contracts - how we can keep them out of the emergency room and keep them healthier." For these reasons, Meredith and the Ryan team pressed "Go" on their commitment to CCM.

SERVING PATIENTS

ChartSpan's CCM program is a perfect fit for Ryan Health's focus on addressing social determinants and breaking down barriers to care. Through the CCM program, enrolled patients have 24/7 access to a nurse line available every day of the year. In addition, ChartSpan's care coordination team assists with a variety of activities that address social determinants as well as screening for barriers to care. In a unique pilot, ChartSpan worked to customize monthly clinical calls to include screening questions for Ryan Health's PRAPARE[1] program. PRAPARE (the Protocal for Responding to and Assessing Patients' Assets, Risks and Experience) is the conceptual framework for barriers to care that Ryan Health follows. Based on patient survey responses, ChartSpan and Ryan Health work to refer patients to available programs in their area. Through their analysis of reported data, Ryan Health can accelerate population health planning, facilitate benchmarking across the organization, and document patient complexity that can inform payment models and risk adjustment.

- 24/7 Nurse Access
- Addressing Social Determinants
- PRAPARE Pilot Program



"We also wanted to think about how our patients can be happier with the program we are giving them. Patients like to feel like they can contact their provider at any time."

- Meredith Gentes, FNP-BC

(1) PRAPARE - NACHE, nachc.org, https://www.nachc.org/research-and-data/prapare/ (last visited January 19, 2021)

PATIENT SATISFACTION

Ryan Health takes their patient feedback seriously as their goal is to drive patient engagement and provide a high-quality program for their patients. ChartSpan closely monitors patient satisfaction and regularly surveys patients using the Net Promoter Score (NPS) methodology. Ryan Health's NPS scores have produced off-the-chart results, with a score of 95, which is far beyond the average NPS score for a primary care provider in the US: **30**.

FINANCIAL RESULTS

At the end of the day, the sustainability of a CCM program relies ultimately on the financial results...the program must produce revenue and a positive margin in line with or exceeding the clinic's current operating margin. Based on the existing enrollment numbers, the estimated net profit over a 12-month period would be just over $200,000 per year. But it doesn't stop there - projected revenue is expected to be 3 times this early impact as enrollment in the program continues to grow. All of this with a net margin far above industry standards for a service-based model, at nearly 48%.

$202,043

Historic Net Profit Annualized*

$734,982

Projected Annual Net Profit

48%

Projected Annual Net Margin

**Reflects gradual increase in initial enrollment period of 4 months*

Ready to transform your practice with Chronic Care Management? Talk to an expert today by calling **(864) 520-6782** or visiting us online at **info.chartspan.com/RH**