ASA
American Society on Aging

Generations

Journal of the American Society on Aging

Fundamentals of Community-Based Managed Care: A Field Guide

Improve LTSS Operations.
Enhance Member Quality of Life.

Organizations that provide coordination of long-term services and supports (LTSS) play a vital role in keeping people with disabling conditions and chronic illness as healthy and independent as possible. NCQA LTSS Accreditation programs are a roadmap for delivering integrated, efficient person-centered care. They guide improvement—organizations can use the standards as a gap analysis and focus activities in areas that are most important to individuals, payers and states.

Accreditation program standards are based on industry best practices and include key areas:

The assessment process

Care transitions

Person-centered care planning and monitoring

Measurement and quality improvement

Earning accreditation helps organizations:

- **Improve communication** between organizations coordinating care, leading to better care integration.

- **Become more efficient** by reducing errors and duplicated services.

- **Provide person-centered care,** leading to better care planning and monitoring.

- **Support contracting** needs by demonstrating their readiness to be trusted partners.

If you coordinate LTSS and want to improve the services provide to members, visit ncqa.org/asa or contact 202-350-1487.

NCQA
Measuring quality.
Improving health care.

Generations is the quarterly journal of the American Society on Aging.

Each issue is devoted to bringing together the most useful and current knowledge about a specific topic in the field of aging, with emphasis on practice, research, and policy.

inside **generations**

Fundamentals of Community-Based Managed Care: A Field Guide

The Community's Emerging Role in Value-Based Health and Social Services

By Margie Powers

The role of community-based organizations is expanding as they partner with healthcare entities.

With the simultaneous movement in the healthcare industry toward value over volume, and population-based health management, there is growing recognition that non-medical services are as important as those received in a provider's office, especially for people with high needs, who engender high costs. Social determinants of health—economic stability; education and income status; access to healthcare, food, and housing; and environmentally safe communities (Centers for Disease Control and Prevention, 2017)—are known to substantially determine negative or positive health outcomes, and have a disproportionate impact on health, compared to health behaviors and clinical care (Amarasingham, 2016).

The combination of social, behavioral, and environmental factors contributes substantially to specific health issues, including to more than 70 percent of some types of cancer, 80 percent of heart disease cases, and 90 percent of stroke

cases (Bradley et al., 2016). Healthcare organizations are starting to more closely examine how to address social determinants' impact on health, and one strategy is exploring closer partnerships with community-based organizations (CBO),

'States with higher levels of spending on social services performed better on a list of health outcomes.'

establishing contracting relationships to support high-need, high-cost individuals.

Traditionally, CBOs deliver services that aim to address the social needs of this population. While these services also can affect health, in most cases they are not directly reimbursed by plans or provider organizations. Given the current evolution of the healthcare industry, there is ample opportunity to develop cross-sector payment mechanisms to support high-need,

→**ABSTRACT** Social determinants of health are known to impact health outcomes, and there is growing recognition that non-medical services are as important as those received in a provider's office, especially for high-need, high-cost populations. Healthcare organizations are exploring closer partnerships with community-based organizations (CBO), especially in support of this group. There is ample opportunity to develop cross-sector payment mechanisms to support these individuals and to provide financial stability to valued community organizations. | **key words:** *high-need, high-cost populations, CBOs, social determinants of health, Partners in Care*

high-cost populations, while at the same time providing financial stability to valued community organizations.

CBOs' Role in Improving Health Outcomes

CBOs by their nature have close ties with communities, and often work directly and intimately with people in their home setting, something healthcare providers are rarely able to do. This unique access gives CBOs insights into unmet social needs affecting health status, and even healthcare, hospital, and emergency department utilization patterns. A recent study showed that states with higher levels of spending on social services performed better on a list of health outcomes than states with lower spending levels (Bradley et al., 2016).

Older adults find that managing multiple health issues becomes more difficult when com-

pounded by challenging social situations, and CBOs can play an important role in alleviating these stressors. For example, health problems can be worsened by a lack of adequate housing, nutrition, transportation, and family or caregiver support. If providers are aware of this, and can connect people to community services, clinical treatments are more likely to be successful. Many CBOs view themselves as "non-clinical," but their services influence the health of high-need, high-cost people every day. Table 1 (on this page) shows examples of CBO services that can impact health outcomes.

The Partnership for Healthy Outcomes (Miller, Nath, and Line, 2017) surveyed more than 200 organizations about their partnerships between healthcare organizations and CBOs. The survey revealed a wide variety of partnerships, with no two alike; notably, the survey results also revealed a movement toward financial partnerships between organizations. Some key and promising findings are as follows:

√ Most partnerships focused on immediate clinical needs, such as care transitions, reducing readmissions, and length of stay;

√ Most partnerships have a formal agreement between entities;

√ A majority of partners (65 percent) report achieving some cost-savings as a result of the partnership; and

√ Funding partnership programs is dependent upon multiple sources, but there is interest on both sides in creating a long-term sustainable funding model.

Table 1. CBO Services That Can Impact Health

Interventions/Services	Potential Impacts on Health
Home visits to frail older adults and medically complex patients, providing social support and companionship	Consistent health monitoring, even by non-licensed staff, can flag potential problems before they occur.
Care coordination of transitions between home and hospital or skilled nursing facility	Assessing a person's home, including adequate food and caregiver support, can reduce readmission risk.
Falls prevention in the home for at-risk older adults	Instructing older adults and caregivers on how to reduce risk of falling can reduce accidents and hospital admissions.
Caregiver respite services	Providing support to family and caregivers can improve quality of care for the individual.
Transportation of older adults to medical appointments	Ensuring people get necessary primary and follow-up care can reduce risk of hospitalization.

Source: Pacific Business Group on Health, 2017.

Consistent, Sustainable Program Funding Is Key

CBOs are embracing their expanding roles in community health, but can struggle with securing consistent funding sources to sustain their programs. They seek new payment mechanisms, yet have little expertise in negotiating payment arrangements between healthcare and non-medical service providers. They need guidance on how to integrate social services into the care

Table 2. Payment Methods for High-Cost, High-Need Populations

Payment Model	Considerations
Fee-for-Service CBOs negotiate a payment amount that they will receive for a single event or service. A CBO may contract with a health plan to deliver falls prevention education to patients recently discharged from the hospital. CBOs would then bill the plan for each patient receiving the intervention.	√ CBOs have the ability to negotiate a reimbursement that covers the total cost of each intervention. √ The provider or plan may not be willing to reimburse the total amount, and the CBO would need to find other funding sources to cover the cost difference. CBOs may find that the service costs more than expected, and would need to wait for another contracting period to re-negotiate.
Flat Rate CBOs negotiate to be paid a specific amount over a certain period of time. A CBO may contract with a health system to be paid a specific amount for a one-year period, during which they deliver meals to a defined number of homebound older adults. CBOs may then bill the system monthly or quarterly for a pro-rated amount of the total.	√ CBOs are guaranteed a predictable amount of income, and can build capacity to meet the exact requirements of the contract. √ CBOs need accurate cost information to ensure that the flat rate will cover all of the program expenses.
Population-Based Payment CBOs negotiate a payment based upon outcomes for a specific population. A CBO may negotiate with a health plan to be paid a certain amount per person, per month for care coordination services. The CBO may be asked to ensure certain clinical outcomes or cost-savings.	√ CBOs have the flexibility to provide any services that they deem valuable, within the constraints of their monthly payment amount. √ As CBOs may have a portion of their payment "at risk" if they do not achieve outcomes or cost-savings, they need to provide adequate time to achieve the desired outcomes.

Source: Pacific Business Group on Health, 2017.

of high-need, high-cost individuals, as well as to create a reimbursement strategy to sustain these valuable programs.

'CBOs can directly contract for their own services.'

Existing payment models

Traditionally, CBOs receive funding through government agencies or grants, which can be financially generous but are unpredictable, and dependent upon the changing priorities of the government and funders. Another challenge is that funding often is limited to a specific service or set of services. CBOs then structure their organizational offerings around this specific funding source and provide the necessary services outlined in grants. CBOs can become siloed around funding streams, making it difficult to have a cohesive set of services.

Fortunately, with increased awareness about social determinants' impact on health outcomes, and the valuable roles that CBOs play in communities, trends show that partnerships between CBOs, providers, and payers are moving from informal, ad hoc arrangements to formal agreements that outline service delivery requirements. More than 80 percent of CBOs partnering with health systems create an agreement to address such items as roles and responsibilities of each partner, services covered by each organization, and the duration of the arrangement (Bradley et al., 2016).

Just as traditional provider organizations contract with health plans, CBOs can directly contract for their own services. Some of the emerging payment methods are summarized in Table 2 (above).

How to create successful payment arrangements

CBOs and healthcare organizations are increasingly receptive to formal agreements around service delivery. To sustain programs and solidify the valuable role CBOs play in improving health, funding arrangements must evolve from a dependence upon grant funding to robust payment contracts. To achieve that goal, CBOs can benefit from guidance on selecting partners for payment agreements, as well as on how to create contracts.

Selecting an organization with which to partner on service delivery is an important foundational step in relationship development. The Center for Health Care Strategies, Inc. (2017), highlights attributes of successful partnership, including the following:

√ Mission and values alignment;

√ Ability to leverage complementary areas of expertise;

√ Clear and well-communicated referral process between organizations; and

√ Transparent, frequent communications.

Once partners have established a trusting relationship, they can explore contracting for services.

Opportunities for Expansion Abound

Healthcare systems contracts offer CBOs myriad opportunities to expand their ability to identify and serve those in need and to garner support for their programs. Health providers and payers are increasingly open to these new financial arrangements, and the movement toward value-

---

'For a contract to make financial sense, there must be an appropriate patient volume.'

---

based payment and recognition of the significant impacts of social determinants upon health creates an environment conducive to contracting out for CBO services—a process that can be lengthy, but is in many cases feasible.

CBOs can benefit from shifting the organizational mindset from outputs to outcomes.

Partnership Components Necessary for Success

Partners in Care Foundation (Partners), a Los Angeles–based nonprofit, has extensive experience in direct contracts with providers and plans, with between 20 percent and 30 percent of its revenue generated by contracts with providers and payers. When creating contracts, Partners recommends investing substantial up-front effort in defining contract terms—including realistic volume targets, clear workflows for each organization, and an up-front payment component for start-up costs. Partners also stresses that contracts are more likely to be successful if they include the following components:

Broad service area. Health plans and payers are more likely to contract for services that cover their entire geographic area, including their whole provider network. CBOs will have greater success if they provide services across a wide geography. This may lead to working with other CBOs in their community to provide services.

Clear value proposition. CBOs must understand the health system's needs and demonstrate how their programs can meet these needs. In most cases, this requires collecting program outcomes data and using it to demonstrate program effectiveness. It is also common for a contract to require that a CBO program meet a minimum return on investment, so understanding and controlling program costs are critical. It is vital for the payer to realize that in order to have a real impact, the value proposition cannot be achieved without sufficient volume.

Realistic volume requirements. For a contract to make financial sense, there must be an appropriate patient volume. It is difficult to meet contract terms if there are too few or too many patients; thus it is crucial to use experience to calculate a realistic and reasonable volume. In some of Partners' recent contracts there were arrangements to provide for a guarantee of minimum volume—this provided a better alignment at all levels for both organizations.

This requires a concerted effort to collect data that demonstrate the value and effectiveness of their programs, and to use such data to develop contracting arrangements with health systems. Instead of operating separate, stand-alone programs, CBOs can move toward a coordinated approach within their organizations to deliver care. New contracting practices will provide stability to CBOs, allowing them to continue to fulfill their vital roles within their communities. 🖋

Margie Powers, M.S.W., M.P.H., directs the Medically Complex Patient Program at the Pacific Business Group on Health in San Francisco, California. She can be contacted at mpowers@calquality.org.

References

Amarasingham, R. 2016. "The Potential of Shared-savings Models to Support Integrated Health and Social Services for Complex Patients." Grantee presentation to the Commonwealth Fund via web seminar, August 16, 2016; goo.gl/L9n6fe.

Bradley, E. H., et al. 2016. "Variation in Health Outcomes: The Role of Spending on Social Services, Public Health, and Health Care, 2000–09." *Health Affairs* 35(5): 760–8.

Center for Health Care Strategies, Inc. 2017. "An Inside Look at Partnerships Between Community-based Organizations and Health Care Providers." goo.gl/6pZkSY. Retrieved November 14, 2017.

Centers for Disease Control and Prevention. 2017. "Social Determinants of Health: Know What Affects Health." goo.gl/p1Cm1L. Retrieved November 20, 2017.

Miller, E., Nath, T., and Line, L. 2017. *Working Together Toward Better Health Outcomes.* Final report to the Partnership for Healthy Outcomes. goo.gl/3mh7wU. Retrieved November 20, 2017.

The Value of the Hospital–CBO Partnership in Achieving the Triple Aim

By Bonnie Subira

> When a health system realized its gaps in knowledge and formed multiple partnerships, it learned the value of tackling the social determinants of health.

In the world of managed care, much has been written about the drivers of change that hospitals face, but less about the importance of partnering with community-based organizations (CBO) to meet these challenges. The Affordable Care Act led the Centers for Medicare & Medicaid Services (CMS) to develop regulatory programs such as Pay-for-Performance (P4P) and its Value-Based Purchasing (VBP) and Readmission Reduction initiatives. These programs' requirements seek to embed CMS's concept of value: better health, better care, and lower costs (or, the Triple Aim), and begin to push the evolution from volume-based reimbursement toward alternative payment value-based models.

As hospitals explore strategies to address these new regulations, they must consider that effecting better health, better care, and lower costs requires the combined services of healthcare and CBO communities. Hospitals and the healthcare community cannot achieve these aims by focusing only on clinical practice.

Concurrently, our country has a fast-growing aging population. The impacts of this demographic trend include seeing cohorts with a significantly higher rate of severe chronic health conditions and cognitive impairment; this means older people will have greater functional limitations and require more health and supportive services.

As an example, the California State Plan on Aging 2017–2021 (2017a; goo.gl/y1xuSX) describes the demographic changes as "an age wave" that will be felt in every aspect of society. The economic, housing, transportation, health, and social support implications of this phenomenon must also be viewed in the context of the state's tremendous population growth, which continues to challenge its infrastructure planning. Demographers project that California's population, now nearly 38 million, could by 2050 reach 51 million. At the same time, residents ages 85 and older will have increased 310 percent (California Department of Aging, 2017b; goo.gl/wBsV68).

→ **ABSTRACT** Given the impacts of social determinants of health, the goals of the Triple Aim can only be achieved if hospitals are willing to reach out and strengthen partnerships with their local networks of community-based organizations (CBO). Community Memorial Health System has endeavored to do that in forging their partnership with the Camarillo Health Care District, and in forming the Ventura County Hospital to Home Alliance. This article explores how CBOs can complement and enhance the healthcare community's effort to better manage illness and chronic disease in pursuing the Triple Aim. | **key words:** *Community Memorial Health System, Camarillo Health Care District, Hospital to Home Alliance, Triple Aim*

Where do hospitals begin to meet the daunting mandates imposed by this disruptive demographic, the P4P program, and the Triple Aim? Community Memorial Health System's (CMHS) journey to find an answer has led to the formation of some non-traditional partnerships.

How People Became Patients

Established in 1902, CMHS is a community-owned nonprofit health system serving Ventura County. CMHS operates two hospitals and sixteen community clinics throughout the county and in 2014 established an Accountable Care Organization (ACO).

In an effort to provide better care, the individual receiving care got lost.

The CMHS journey began with a process of self-examination and a look back to better understand how the healthcare industry, and healthcare delivery, had become so impersonal. Throughout the 1960s, as the Medicare program was being signed into law, 85 percent to 90 percent of medical school graduates across the nation were choosing specialty medicine (*What If Post*, 2009). Growth in specialized medicine added to significant advances in medical science in these years, while access to hospital care increased. Healthcare delivery began to change and with it the unintended consequence of people becoming "patients."

As care became more specialized within the hospital setting, the person (now "the patient") became the acute problem for which they received treatment: they were seen as "the heart," "the gallbladder," "the hip." Hospital care became more clinically sophisticated, involving multiple physicians, but at the same time, grew more impersonal. Hospitals were facilities that addressed illness, not wellness, and, in large part, problems, not people.

Somewhere along the line, and in an effort to provide better care, the focus shifted almost exclusively to an emphasis on clinical proficiency and technical excellence, while the individual receiving the care got lost. The healthcare industry established a boundary such that when a patient had a non-clinical need that could negatively impact health status, a common response was "that's a social issue." In its extreme, patients were categorized as non-compliant and judged unwilling to follow medical instruction, when in many cases the issue was the person's unassessed or unmet non-clinical need. This narrow clinical focus further impersonalized care and fostered silos in the healthcare industry.

Today, although more than 95 percent of healthcare dollars is spent on direct medical services, as much as 70 percent of health outcomes can be attributed to the influence of non-clinical factors (Organisation for Economic Co-operation and Development, 2009). In the United States, the disparity between healthcare spending and social service spending is notable; America scores almost last among developed countries.

Answers Lie Beyond Hospital Walls

While continued clinical quality improvement is an essential component in achieving the Triple Aim, it is not enough on its own. Medical treatment alone does not create nor sustain good health. Thus, the starting point for CMHS was to expand the focus from the patient to the person and to consider the non-clinical or social determinants of health.

CMHS wondered how hospitals managed their accountability for health outcomes and costs beyond their scope of services and outside the hospital walls. They reached the conclusion that a hospital could not do it alone, but required improved partnerships with CBOs. Many healthcare colleagues report that they have formed such partnerships and offer as evidence long lists of community resources. While giving patients a list of phone numbers, dialing those numbers, setting up appointments, or providing "warm hand-offs" (in which a primary care provider conducts a face-to-face introduction of

Table 1. Incorporating Social Service Spending

Source: OECD Health Data 2009, Social Expenditure Dataset (Paris, France: OECD, 2009)
Slides from Elizabeth Bradley, Feb 2014 ; Elizabeth.Bradley@yale.edu
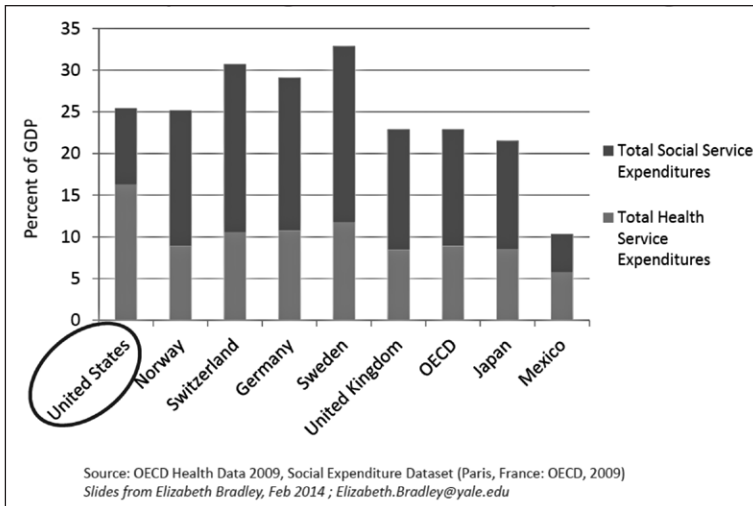
a patient to a behavioral health specialist) does demonstrate a hospital's ability to identify CBO resources and make referrals, there are distinct differences between maintaining a CBO referral list and cultivating a CBO partner.

Partnership is characterized by mutual cooperation and responsibility in the achievement of a specified goal. Over the past five years, CMHS has been fortunate to have formed such a partnership with the Camarillo Health Care District (the District).

The District is a local public agency established in 1969 and was created to provide a range of community-based programs and services designed to promote health and wellness in the community and at home. It offers a wide array of services, but specializes in programs that support the independence and dignity of older adults and people with disabilities through such programs as evidence-based health promotions services, falls mitigation, adult daycare, home-delivered meals, caregiver support services, care transitions, case management, and many others.

In 2012, the District, while known to CMHS, was severely underused. When District staff walked into our hospital and offered to provide care transitions services to our Medicare patients who were being discharged (as part of

the CMS grant-funded Community Care Transitions Program), our response was a guarded yes.

How could a hospital turn down free help to strengthen care transitions? Frankly, we had concerns: What did this social service agency, The Camarillo Health Care District, know about chronically ill Medicare patients? In retrospect, we now know they knew significantly more than healthcare providers had given them credit for. Once our hospital realized the District was not there to provide clinical care, we began to see the value they brought in offering a broader view of a person's needs and the services necessary to address them.

The District has been instrumental in helping to identify the unmet community needs that drive poor health outcomes and increased costs. In our partnership thus far we have joined forces to better address family caregivers' needs and to provide early intervention against cognitive impairment and dementia—conditions that affect health status and thus increase healthcare costs.

'How could a hospital turn down free help to strengthen care transitions?'

Enter the Second Partnership

While CMHS began a relationship with the District, we invested in another new partnership in pursuit of the Triple Aim. For some time, CMHS had been meeting with local home health providers and skilled nursing facilities in an effort to strengthen transitions from the hospital, reduce unnecessary readmissions, and better manage chronic disease in the community. But we were not making the progress we had anticipated. In

concert with the regional CMS quality improvement organization, the Health Services Advisory Group, we reached out to other area hospitals and a large managed care organization to form a coalition to work with the District. The District was an integral part of the coalition, which has become known as the Ventura County Hospital to Home Alliance (Alliance). In its present form, the Alliance comprises ten home health agencies and seven skilled nursing facilities, as well as the District and CMHS.

CMHS's ability to reach beyond the hospital walls has reaped many early benefits.

The larger group did not immediately embrace the idea of including the District as a CBO participant in a predominantly clinical coalition. Initially, the clinical providers did not see the value of the CBO with respect to disease management, or how it might contribute to readmission reduction and care continuum quality. Several home health agencies were threatened by the District's presence, believing it to be a direct competitor for their services.

This scenario afforded the Alliance several opportunities for improvement. First, it needed to create equal understanding between partners about the mandates inherent in healthcare reform and the concept underlying the Triple Aim. Second, it needed to acknowledge the fact that Alliance partners generally work in isolation and are largely siloed by sector. As the group confronted the challenges of moving from business as usual to a value-based environment, it was able to see that many of the barriers it faced in caring for patients were social, not clinical.

When Alliance members realized that social issues did not release them from the responsibility for their patients' improved healthcare outcomes, they made significant progress on partnership goals. The Alliance membership began to understand the power of partnering

with the District, a collaboration that could best address patients' social needs.

As was the case with CMHS, each Alliance member was relatively knowledgeable about community resources, but none had explored the value of community partners. Expanding the continuum of care to include the District allowed the group to engage in multiple process improvement projects that actively identified the social issues interfering with patient transitions and resulted in improved chronic disease management in the community.

Each Alliance member now makes use of the District's robust programing in the areas of caregiver support, cognitive impairment, and chronic disease management by proactively involving the District before patients leave their care setting. As a result, the District now has earlier access to patients and families to help them prepare for care transition and return to the community. Because they are working across the Alliance continuum, the District plays a key role in care coordination and has helped to improve communication and integration of the Alliance's services.

Apart from direct person care, the District has taught CMHS, as well as the Alliance membership, about the world of long-term services and supports (LTSS) that serves older adults and people with disabilities. Our healthcare community sorely lacked awareness about the breadth and depth of programming and advocacy that occurs in promoting health maintenance and wellness for older adults—a knowledge gap that directly contributed to community providers operating in silos. So while the District learns the language and acronyms of healthcare, CMHS and the Alliance are learning the language of the LTSS community: how they operate on national, state, and local levels, and the programs and work being done to benefit the populations we all serve. The District's participation in the Alliance has proven not only how much better we are together, but also that this partnership is essential for meeting the mandates of

providing better health and better care and lowering costs.

Conclusion: We Are Better Together!

CMHS's ability to reach beyond the hospital walls has reaped many early benefits. We have gained access to expertise, services, and programs that we cannot provide; we have a better understanding of caregivers' needs; we have access to care mangement programming for dementia patients and their families, along with improved access to other CBOs and social programs. As well, CHMS has a new orientation toward the LTSS community; better services integration; reciprocal and ongoing communica-

tion; and decreased siloed activities and services duplication.

The CMHS–District partnership has yielded powerful tools for achieving the Triple Aim. We look forward to building this relationship—and cultivating others—in order to provide the most effective and respectful care to the people we serve.

Bonnie Subira, M.S.W., is the former director of Case Management, Social Service and Palliative Care programs for Community Memorial Health System in Ventura, California. She now serves as the Health System's project manager for Population Health Programs.

References

California Department of Aging. 2017a. *California State Plan on Aging 2017–2021*. goo.gl/y1xuSX. Retrieved October 17, 2017.

California Department of Aging. 2017b. *California State Plan on Aging 2013–2017*. goo.gl/wBsV68. Retrieved October 17, 2017.

Organisation for Economic Co-operation and Development (OECD). 2009. *OECD Health Data 2009—Comparing Health Statistics Across OECD Countries*. goo.gl/tuFQ4h. Retrieved October 23, 2017.

What If Post. 2009. "History of Health Care." December 20. goo.gl/J8LXPi. Retrieved October 17, 2017.

CareMore Health Tackles the Unmet Challenges of the Aging Population

By Sachin H. Jain

A high-touch, team-based clinical model addresses everything from high blood pressure to loneliness.

CareMore Health originated twenty-five years ago as a medical group, and employs a proactive, high-touch clinical model focused on prevention and education. Founded and led by physicians, the organization is a care delivery system for Medicare and Medicaid beneficiaries that uses an integrated delivery model to provide an individually tailored holistic approach, including chronic disease management, through highly coordinated care. By addressing patients' medical, social, and personal health needs, the resulting clinical outcomes rank well above the national average.

The CareMore Health delivery system was created to care for the most frail, costly, and often underserved patients by proactively identifying and managing specific health needs. Many older adults suffer from chronic disease, and approximately 44 percent of CareMore's patients are enrolled in Medicare Advantage Special Needs Plans (SNP) tailored to treat specific and often chronic health conditions such as diabetes, heart disease, and respiratory ailments. Other SNPs address health and economic status, such as dual eligibility for both Medicare and Medicaid programs (D-SNP) and those patients requiring institutional care.

While also addressing social and psychological health needs, CareMore Health provides specialized programs to help older adults better manage health conditions such as congestive heart failure, chronic kidney disease, end-stage renal disease, chronic obstructive pulmonary disease, diabetes, and more. To provide proactive care and better care management of such conditions, high-risk patients are identified early on, and CareMore staff communicate with them often (depending upon level of need), via telephone and in-person interactions at a CareMore Care Center, to ensure they are maintaining their health.

➜**ABSTRACT** Older adults and others with complex and high-risk medical conditions often lack access to the coordinated care they need to properly manage their chronic issues, resulting in hospitalizations and more spending on treatment. CareMore Health, an integrated values-based care delivery system that provides care to Medicare and Medicaid beneficiaries, focuses on caring for the frailest populations by harnessing the power of teamwork to treat its patients' medical, social, and personal health needs. By investing in prevention, early intervention, education, and partnerships with community-based organizations, CareMore Health achieves fewer hospitalizations, bed stays, and overall better health outcomes for patients compared to beneficiaries covered under fee-for-service Medicare. **| key words:** *CareMore Health, Care Center, integrated care, Togetherness Program*

A Cornerstone of Care

The cornerstone of CareMore's model is the comprehensive Care Center, where patients receive direct care and attention from CareMore-employed clinicians. Care Centers are located in the community and house chronic disease–management programs, post–acute care follow-up for people who have been discharged from

> *Patients with complex medical needs cannot be managed solely by one clinician.*

the hospital, and other services to manage high-risk and high-need patients. The Care Center and clinical team act as an extension of the primary care physician's office. In addition to chronic disease support and post-hospitalization care, integrated services such as dental care, optometry, and drug consultation are offered to maximize visits to the Care Center. Patients have access to case managers, social workers,

behavioral health clinicians, pharmacists, Nifty after Fifty fitness programs (a CareMore partner), and other clinical specialties. CareMore Health currently operates 42 Care Centers across California, Arizona, Nevada, Virginia, Tennessee, Georgia, Iowa, and Connecticut.

Each new CareMore patient undergoes an extensive health assessment (or "Healthy Start" appointment) at the Care Center to create a personalized care management plan. At the appointment, a clinician performs an in-depth interview and exam to proactively identify chronic diseases and other health needs. Based on specific health needs, the patient is then placed in a high-touch, disease-specific program. The clinical assessment is designed to involve patients and family members in making shared decisions about their health plans. The Healthy Start appointment also allows CareMore clinicians to identify other medical concerns, including behavioral and mental health needs (e.g., clinicians query patients to determine their social activity and ask them

to rate their depression level). CareMore considers physical activity to be the fifth vital sign and prescribes exercise into care management plans for those with chronic medical conditions. Patients' primary care providers are kept in the loop through regular phone, email, text, and fax communications.

One clinician alone cannot support individuals with complex medical needs; thus, CareMore's team-based approach harnesses a group of healthcare workers to address patients' overall health needs, working together diligently to keep patients out of the hospital using high-touch care and consistent communication. Using this team-based care approach, the Care Center team works together to coordinate and integrate needed care on the spot, and under one roof, to maximize each visit.

More than 500 patients are actively enrolled in the Togetherness Program.

If patients are admitted to the hospital, CareMore "extensivists" (physician hospitalists who care for older adults in outpatient and skilled nursing facilities) monitor patients during and after the hospital stay. Extensivists ensure that CareMore patients receive holistic health management by working closely with primary care physicians, specialists, and the Care Center team so that all areas of health are considered when deciding treatment options.

Technology helps reduce hospitalizations
In a case study published by The Commonwealth Fund, our most recent analysis shows that compared to beneficiaries covered under fee-for-service Medicare, CareMore has been successful in reducing hospitalizations by 20 percent (Hostetter, Klein, and McCarthy, 2017). CareMore achieves these results through employing the best clinicians, consistent communication with patients, using technology to track health conditions, and providing early intervention through remote-monitoring de-

vices. CareMore clinicians use these devices to monitor patients who are high risk; this helps eliminate unnecessary physician office visits. For example, monitoring the weight of patients with congestive heart failure can provide early notification of decompensated heart failure, or worsening signs and symptoms of heart failure. CareMore provides wireless weight scales to patients and weight gain alerts are sent to CareMore nurse practitioners, who can intervene and prevent decompensated heart failure. CareMore also provides in-home hypertension/blood pressure monitoring, which can be tracked remotely by CareMore clinicians. The use of remote monitoring has proved effective in treating symptoms before they escalate, thus reducing patient hospitalizations.

Programs Address Special Health and Social Needs
Older adults' medical needs can be complex and often vary considerably. CareMore Health has developed a wide array of programs and services to meet its patients' specific health and social needs. A high percentage of these are created in response to direct feedback from patients about their needs. Services like foot care, remote monitoring, transportation, and programs like brain health, dental care, and our Togetherness Program that addresses loneliness and isolation.

Combating loneliness and isolation
Retirement, the loss of friends or family, people moving away, or living alone all can contribute to older adults feeling alone and or isolated (Cotten, Anderson, and McCullough, 2013). More than 43 percent of people ages 65 and older report that loneliness has affected them (Perissinotto, Cenzer, and Covinsky, 2012).

Due to its complexities and masked symptoms, loneliness often is invisible, but has significant health consequences: loneliness can be as damaging to health as smoking fifteen cigarettes a day, and may increase a person's risk of mortality by 45 percent—more than air pollution

(6 percent), obesity (23 percent), and excessive alcohol use (37 percent) (Perissinotto, Cenzer, and Covinsky, 2012; Holt-Lunstad, Smith, and Layton, 2010). It also is a risk factor for numerous serious medical conditions, including cognitive decline, the progression of Alzheimer's disease, and recurrent stroke (Cacioppo et al., 2015).

Despite the fact that loneliness is a common emotional distress syndrome with a high-risk factor for early mortality and the cause of a broad spectrum of physical health and psychiatric issues, it receives scant attention in medical training and in the healthcare setting. CareMore is committed to going beyond traditional care solutions to tackle this issue through its Togetherness Program.

The Togetherness Program is a first-of-its-kind clinical program designed to address loneliness and isolation. Launched in 2017, initial efforts focused on building personal connections with at-risk patients through consistent phone outreach. These calls build relationships, provide constant and positive engagement, support individual healthcare needs, and foster connections to community organizations and resources.

'Our partnership with Lyft makes accessing care easier.'

Through these calls, CareMore tailors and expands its clinical support based on what patients need the most—whether it is connecting with disease management programs operated out of the Care Centers; accessing physical activity at Nifty after Fifty fitness programs or other community resources; or providing hearing aid support. Since the launch of the Togetherness program CareMore has identified 2,000 lonely older adults through screenings; and enrolled more than 500 in an intensive intervention that includes weekly phone calls, home visits, and encouragement and connection to community-based programs. Community-based organizations (CBO) play a vital role in address-

ing loneliness and isolation and CareMore's partnership with CBOs is essential to the success of the program. One community organization, Senior Center Without Walls, is a virtual community where older adults participate in support groups, activities, and other social gatherings via phone or online from their homes. This CBO has helped CareMore to connect patients who may be geographically isolated from society and cannot drive to a nearby senior center. CareMore also works with the Alzheimer's Association of Greater Los Angeles to provide much needed caregiver education and respite care to the caregivers of those suffering from dementia.

Providing affordable transportation

It is estimated that 3.6 million Americans annually miss or delay receiving non-emergency care due to transportation challenges (National Conference of State Legislatures, 2016). Lack of access to consistent, affordable transportation can mean older adults miss medical appointments, which ultimately affects their access to necessary care.

Achieving greater clinical care is possible only if older adults can get to it, so to improve the transportation experience in 2016, CareMore formed an alliance with the ride-sharing company Lyft. Early results of the pilot program are promising, and showed that wait times had been reduced by 30 percent, according to the study, *Non-emergency Medical Transportation: Delivering Care in the Era of Lyft and Uber* (Powers, Rinefort, and Jain, 2016).

The Future of CareMore Health

What started as a medical group caring for older adults in California has become a healthcare delivery system that has expanded to provide care for more than 150,000 Medicare and Medicaid beneficiaries across California, Nevada, Arizona, Virginia, Tennessee, Iowa, Georgia, and Connecticut.

Over the years, CareMore's goal has remained the same—to provide high-touch affordable care to those who need it most. CareMore's commit-

ment to this goal is evidenced through the expansion of its integrated care delivery model. In addition to caring for more Medicare beneficiaries across the nation, the model also provides care to Medicaid and dual eligible beneficiaries in Tennessee, Virginia, Iowa, Connecticut, and parts of Los Angeles County.

CareMore continues to evolve its model of care: in Connecticut, dual eligible, or D-SNP beneficiaries, are cared for through the CareMore at Home model, which brings primary care directly into their homes. The organization's mission is to expand to serve populations that experience challenges accessing needed care, to bring care directly to them, to provide technology solutions, and to offer more primary care services at the Care Centers.

Over the past twenty-five years, CareMore has been an innovator in healthcare by applying common sense to develop programs that address the overall health and well-being of its patients. Continuously adapting its model has allowed CareMore to maintain focus on its top priority—to better serve the needs of the most frail and underserved populations.

Sachin H. Jain, M.D., M.B.A., F.A.C.P., is CEO of CareMore Health System in Cerritos, California.

References

Cacioppo, S., et al. 2015. "Loneliness: Clinical Import and Interventions." *Perspectives on Psychological Science* 10(2): 238–49.

Cotten, S. R., Anderson, W. A., and McCullough, B. M. 2013. "Impact of Internet Use on Loneliness and Contact with Others Among Older Adults: Cross-sectional Analysis." *Journal of Medical Internet Research* 15(2): e39.

Hostetter, M., Klein, S., and McCarthy, D. 2017. "CareMore: Improving Outcomes and Controlling Health Care Spending for High-needs Patients." The Commonwealth Fund. goo.gl/aEMByP. Retrieved January 12, 2018.

Holt-Lunstad, J., Smith, T. B., and Layton, J. B. 2010. "Social Relationships and Mortality Risk: A Meta-analytic Review." *PLoS Medicine* 7(7): e1000316.

National Conference of State Legislatures. 2016. "Non-emergency Medical Transportation: A Vital Lifeline for a Healthy Community." goo.gl/jQ5dR7. Retrieved January 12, 2018.

Perissinotto, C., Cenzer, I., and Covinsky, K. 2012. "Loneliness in Older Persons A Predictor of Functional Decline and Death." *Archives of Internal Medicine* 172(14): 1078–84.

Powers, B. W., Rinefort, S., and Jain, S. H. 2016. "Non-emergency Medical Transportation: Delivering Care in the Era of Lyft and Uber." *Journal of the American Medical Association* 316(9): 921–2.

CBOs and State Medicaid Programs: A Key Partnership for Patient-Centered Care

By Danielle Garrett and Ann Hwang

> Partnering with state Medicaid programs is one way CBOs can improve vulnerable populations' health by addressing social determinants.

Since its creation in 1965, Medicaid has been a crucial source of healthcare coverage for people with some of the most complex health and social needs, including children with disabilities, people with substance use disorders, and frail elders. Over the years, it has become clear that to improve Medicaid beneficiaries' health, only addressing medical issues is often not enough.

For someone who is poor and homeless, finding safe and affordable housing is arguably the most important prescription for better health. Addressing social factors that contribute to poor health can also be extremely cost-effective. Consider that the cost of a one-night hospital stay is usually more than the cost of a month's rent. Taking a person- and community-centered approach to health for Medicaid recipients presents tremendous opportunities for community-based organizations (CBO) to partner with healthcare organizations to improve these beneficiaries' health outcomes.

Why Partner with Medicaid?

For several reasons, state Medicaid programs are a natural fit for CBOs hoping to collaborate with health systems. Medicaid serves the most vulnerable and complex populations. By partnering with Medicaid, CBOs can connect with populations in need of social services, as well as with multiple linkage points (such as hospitals and person-centered medical homes) for serving these populations.

Also, Medicaid is an ideal platform for innovations in care delivery and payment models that address the social determinants of health to better serve people with complex needs. The Centers for Medicare & Medicaid Services (CMS) programs offer states significant flexibility in designing their Medicaid programs, as well as a shared federal and state financing system. This creates ample opportunity for state Medicaid programs to explore new ways of financing the

➜**ABSTRACT** Changes in how we pay for and deliver healthcare present opportunities to address the social and economic factors affecting health. State Medicaid programs are taking advantage of Medicaid's flexibility to integrate social services into healthcare. This provides opportunities for community-based organizations (CBO) to partner with health systems. Success is contingent upon CBOs having the knowledge and tools to build successful partnerships, and state Medicaid programs engaging CBOs to develop and implement these new models of care. | **key words**: *community-based organizations, state Medicaid programs, waivers, Medicaid Accountable Care Organizations, healthcare partnerships*

services CBOs provide and targeting them to the populations that need them the most.

Potential benefits to this kind of cross-sector collaboration are numerous. By engaging CBOs, state Medicaid programs can help improve patients' involvement in their care, promote chronic disease self-management, prevent hospital admission and readmission, and help beneficiaries remain in their homes and communities instead of nursing homes. These benefits could both reduce costs and improve health outcomes. At the same time, health-system partnerships could help CBOs reach new populations and take advantage of new, sustainable funding mechanisms.

Opportunities for CBO Collaboration with State Medicaid Programs

State Medicaid programs recognize the need to address the social determinants of health among Medicaid beneficiaries, as well as the cost-saving potential, so they are taking advantage of Medicaid's flexible structure to integrate social services and healthcare. Using the Medicaid waiver process, states can enter into agreements with the federal government that allow them to waive certain federal requirements in order to test new ways of paying for and delivering care through the Medicaid program. New payment models created by the Affordable Care Act also opened

'State Medicaid programs are a natural fit for CBOs hoping to collaborate with health systems.'

up new opportunities for state Medicaid programs to partner with and reimburse CBOs.

Medicaid Accountable Care Organizations (ACO) represent one opportunity for better integration. ACOs are regional entities made up of service providers (such as primary care physicians, specialists, and hospitals) that take on financial risk for caring for a defined population, and are usually required to meet certain health outcome measures.

Oregon, Massachusetts, and Minnesota, among other states, have used Medicaid waiver authority to transform their Medicaid systems using an ACO model. Incentives to address social determinants of health, such as reimbursement for flexible services and requirements to partner with social service or public health organizations, are included in many of these models. For example, Massachusetts' new ACO model includes coverage of non-medical services that address the social determinants of health and requires ACOs to team up with community partners to meet the behavioral health and long-term-care needs of more complex patients (Lloyd and Heflin, 2016). Historically, Medicaid has only allowed reimbursement of medical expenses, so new models like these allowing reimbursement of non-medical expenses are an important step.

Additionally, efforts to better integrate behavioral and physical healthcare services provide openings for CBOs to collaborate with health systems to help better serve patients with behavioral and mental healthcare needs. Several states are operating "health homes" aimed at providing intensive, coordinated care to patients with behavioral health needs. Along with care coordination and care transition services, these health homes connect patients with the community and social services they may need (Substance Abuse and Mental Health Services Administration, 2012).

There also are opportunities for CBOs serving older adults and people with disabilities to partner with health systems. As an increasing number of states transition their long-term services and supports to a managed care system, there are new opportunities for state Medicaid programs to think carefully about how they integrate CBOs into these new systems. Many states are building incentives into their Managed Long-Term Services and Supports (MLTSS) systems meant to increase the use of home- and community-based services in lieu of nursing home care (Musumeci, 2014).

CBOs, such as area agencies on aging (AAA) and Centers for Independent Living, are long-standing providers of home- and community-based services; their experience and expertise can be invaluable during this transition if state Medicaid programs and CBOs are thoughtful about building and continuing these partnerships.

Tools for Successful Partnerships

There are already many examples of these partnerships working successfully in practice. In Eastern Virginia, hospitals are collaborating with AAAs to provide those enrolled in both Medicare and Medicaid with coaches who can perform in-home assessments and provide links to social services after they are released from the hospital. This partnership, which consists of five AAAs, four health systems, sixty-nine skilled nursing facilities, and three managed care organizations, has led to reductions in hospital readmissions and, between 2013 and 2015, has saved more than $17 million (Kozick, 2017).

Although examples of success are numerous, successful collaboration does not happen overnight. The following are six truisms CBOs should remember when considering a Medicaid partnership:

Realize that not all partnerships look the same. A partnership between a Medicaid program and a CBO can be as simple as sharing information about beneficiaries or as complicated as a risk-based arrangement in which CBOs share in the costs and savings associated with caring for a particular population. These partnerships can involve only two partners and a single funding mechanism or include multiple partners and funding sources. There is no single model for how a Medicaid–CBO partnership can and should look, and it will often differ based on the needs and structure of the Medicaid program and the CBO's capacities.

Expect a learning curve on both sides of the partnership. Medicaid is a complicated pro-

gram and no two state Medicaid programs are the same. Mechanisms around eligibility, enrollment, payment, and reporting will be brand-new for many CBOs. Likewise, Medicaid officials and providers will not necessarily understand the services a CBO provides, how they operate, and the benefits and expertise they can bring. It will take time to get to know one another, and successful partners will plan activities to facilitate this process. To support the integration of community organizations into Massachusetts' new ACOs, Disability Advocates Advancing our Healthcare Rights (DAAHR), a coalition co-led by the Boston Center for Independent Living, held a series of forums, called "Building Bridges," to help forge and strengthen relationships between ACOs and community organizations.

Prepare for new financial and reporting impacts. Although Medicaid partnerships offer an exciting new business opportunity, CBOs need to be prepared to take on new financial and reporting responsibilities. Depending upon the nature of the partnership, CBOs might face new requirements for data reporting, new procedures for billing for services, and in the most complex cases, a system where payment is directly related to the health outcomes of the populations served. CBOs will need to ensure they have properly trained staff and appropriate procedures in place for dealing with new, often complex, requirements. CBOs also should prepare to advocate for themselves during partnership implementation, and push back against any unrealistic requirements.

Understand that strong allies can make the transition easier. Building strong relationships with other community partners can be a key to success as CBOs consider working with state Medicaid Programs. Consumer advocacy groups often make excellent bridges between the Medicaid and CBO worlds, can help ensure that Medicaid programs are implementing CBO-friendly policies, and can help spread consumer awareness of offered services. The aforementioned forums

held by the DAAHR coalition in Massachusetts are a good example of this kind of bridge-building. The Medicare Rights Center in New York and Ohio Consumer Voice for Integrated Care both conducted consumer education efforts about new Medicaid and Medicare programs by working with CBOs having trusted connections to dually eligible consumers (Wiitala and Hwang, 2017).

One partnership has led to reductions in hospital readmissions, and saved more than $17 million.

Strong champions in the healthcare system also can make the work of growing and expanding partnerships easier. In the Eastern Virginia case, one early adopter health system encouraged other health systems to join the partnership (Kozick, 2017).

Be ready to make a value proposition and document impacts. Increasingly, healthcare payers use models that tie payments to specific goals and outcomes, such as reducing emergency room admissions and-or hospitalizations, or meeting enrollment targets for health homes or ACOs. CBOs must make a strong case for how their services can directly contribute to the Medicaid program's goals and outcomes.

Once the partnership is established, collecting data to demonstrate success is crucial and, in some payment arrangements, is required for reimbursement. Data collection allows CBOs to identify areas for correction, improvement, and growth, and can help in making the case for new and expanded partnership opportunities. In the Eastern Virginia example, the organization cites a strong, transparent data-reporting process as a key factor in allowing them to document their success and build an effective business case for expanded funding (Kozick, 2017).

Know that engagement is key. For these collaborations to be successful, it is vital that everyone involved in the partnership is on the same

page and has input into the development and implementation of the projects. This means CBO leadership and staff, direct service providers, and the patients they serve are informed about the new methods of care and delivery, are engaged in the development, implementation, and evaluation of partnerships, and are working toward the same goals. State Medicaid programs can help accomplish this by including CBO representation on Medicaid advisory committees and workgroups and promoting models of care delivery that encourage patients to work in partnership with their healthcare providers and CBOs to meet healthcare goals. CBOs can be active in community education and outreach, and collect feedback on the partnership's success, to ensure the uptake and success of services offered through the partnership.

Conclusion

The healthcare system is changing rapidly and new models of care that address the social and economic determinants of health are crucial for ensuring that there is improved care for vulnerable populations who face the biggest disparities in health outcomes. CBOs can play an important role by partnering with health systems through new Medicaid financing mechanisms. If CBOs have the knowledge and tools necessary to build a successful partnership, and state Medicaid programs actively engage CBOs in the development

and implementation of these new models of care, there is real opportunity to improve health outcomes in communities across the country.

While there is real opportunity however, there also is uncertainty. Recent proposals in Congress to drastically cut spending in the Medicaid program through block grants or per capita caps put the funding and infrastructure

'One early adopter health system encouraged other health systems to join the partnership.'

needed to support these innovative partnerships at risk (Rosenbaum et al., 2017). As CBOs begin to move into the healthcare space with more frequency, they will need to stay attuned to federal healthcare activities and may need to become more vocal advocates for the health programs that are becoming increasingly integral to their work and mission.

Danielle Garrett, M.P.Aff., is strategic policy manager at the Center for Consumer Engagement in Health Innovation, in its Washington, D.C., office. She can be contacted at dgarrett@communitycatalyst.org. Ann Hwang, M.D., is director of the Center for Consumer Engagement in Health Innovation at Community Catalyst in Boston, Massachusetts.

References

Kozick, D. 2017. *Collaborating to Reduce Hospital Readmissions for Older Adults with Complex Needs: Eastern Virginia Care Transitions Partnership.* Partnership for Healthy Outcomes. goo.gl/fNByb3. Retrieved November 13, 2017.

Lloyd, J., and Heflin, K. 2016. "Massachusetts' Medicaid ACO Makes a Unique Commitment to Addressing Social Determinants of Health." Center for Health Care Strategies. goo.gl/1BWzAe. Retrieved November 13, 2017.

Musumeci, M. 2014. "Key Themes in Capitated Medicaid Managed Long-term Services and Supports Waivers." Kaiser Family Foundation. goo.gl/3463VC. Retrieved November 13, 2017.

Rosenbaum, S., et.al. 2017. "How Will Repealing the ACA Affect Medicaid? Impact on Health Care Coverage, Delivery, and Payment." The Commonwealth Fund. goo.gl/xNgRVd. Retrieved November 27, 2017.

Substance Abuse and Mental Health Services Administration. 2012. *Behavioral Health Homes for People with Mental Health & Substance Use Conditions: The Core Clinical Features.* goo.gl/AYJUvX. Retrieved November 13, 2017.

Wiitala, K., and Hwang, A. 2017. "Perspectives on How to Engage Consumers in Health System Transformation." *Journal of Ambulatory Care Medicine* (40)4: 283–6.

Teaching CBOs to Develop Business Strategies

By Erin C. Westphal

The SCAN Foundation's Linkage Lab Academy has helped CBOs serve thousands of older adults and adults with disabilities, while generating millions in revenue.

Since the 2010 passage of the Affordable Care Act (ACA), healthcare payments have been transitioning from fee-for-service to fee-for-outcomes. As such, healthcare entities (e.g., health plans, Medicare Advantage, Accountable Care Organizations [ACO], Special Needs Plans [SNP], and hospitals) and their contracted partners (e.g., physician and medical groups, home health, and skilled nursing and rehabilitation facilities) must move to a person-centered approach to care, in which an individual's goals drive the care plan. This has translated to an increased focus on care coordination and transitions and the need for healthcare entities to weigh the value of building new programs to provide services, or buying services through expanding their contracted network to include organizations that provide home- and community-based services.

Healthcare entities are still testing approaches and care models to identify who would most benefit from the services (targeting), which mix of services would deliver improved outcomes (quality of life) for the individual, and which are sustainable (providing return on investment). What is known is that care coordination and transition programs, particularly at times of medical crisis, are essential.

'Working with healthcare entities requires CBOs to re-imagine how they provide services.'

This shift in payment mechanisms and approaches to providing care has presented opportunities as well as challenges for community-based organizations (CBO). Working with healthcare entities requires CBOs to re-imagine how they provide services, moving away from providing services based on funding for specific programs toward providing programs and services that respond to the needs of the healthcare

➜**ABSTRACT** For community-based organizations (CBO) and the healthcare sector, the passage of the Affordable Care Act created new opportunities by shifting the focus from fee-for-service to fee-for-outcomes. To maximize these opportunities, CBOs need to develop business strategies that leverage their strengths. Aligning core competencies, focusing on areas for improvement, and being willing to evolve within the environment can not only sustain organizations, but also allow them to thrive. | **key words**: *Affordable Care Act, value-based care, community-based organizations, Linkage Lab Academy, person-centered care, care coordination, transitions*

Table 1. Core Competencies

Understand the Market and Competitors
Identify Potential Clients
Understand Cost of Care Delivery and Develop Rate Structure/ROI
Design Model/Service
Business Development
Marketing and Branding
Identify Need for Collaborative Partners and Develop Approach
Develop Infrastructure to Operationalize Service Delivery Model
People Development
Develop Contract and Contingency Plan

sector partner—also known as adopting an "outside-in" perspective. Organizations that have begun working in this space and those that are just testing the waters need to have strong leadership (including at the board level), the ability to develop new systems and process, and an openness to understanding the healthcare entity's needs and how their expertise and experience can address those needs.

As payment mechanisms continue to move toward rewarding outcomes and encouraging integration, CBOs have a critical role to play in addressing the long-term support services needs. CBOs must hone their business skills to achieve the transformation necessary to successfully secure and deliver outcomes with new payers.

The Linkage Lab Academy

As a result of this shift in the environment, The SCAN Foundation created the Linkage Lab Academy (Academy). Twelve CBOs in California attended the Academy from 2012 to 2015; the Academy offered these organizations intensive training and education in business development and practices, as well as direct support, through technical assistance, to transform their operations. The Academy's overarching goal was for CBOs to establish new payer relationships with the healthcare sector. With core competencies (see Table 1, on this page) and infrastructure in place, the CBOs entered into more than twenty contracts with new payers to support care coordination and care transitions. They are serving thousands of older adults and generating millions of dollars in new revenue for their organizations—all while illustrating a value or return on investment for payers.

Beyond the work funded by The SCAN Foundation, the Marin Community Foundation and the Colorado Health Foundation have funded efforts similar to the Academy. The Aging and Disability Business Institute (Institute) has taken the Academy to a national level by serving as the go-to source to build the business acumen of CBOs, through acquiring and strengthening skills and knowledge across business disciplines, while looking ahead to the future of aging and disability services. The Institute was created in partnership with the Administration for Community Living, with funding from The John A. Hartford Foundation, The SCAN Foundation, the Colorado Health Foundation, the Marin Community Foundation, and the Gary and Mary West Foundation.

How to Build Business Practices

This section of 2018 Spring *Generations*, "Fundamentals of Community-Based Managed Care: A Field Guide," expands on the core competencies by providing practical information and strategies. The articles include the following:

"Making the Business Case for CBO Services": CBOs are well-positioned to exploit the financial opportunities created by healthcare reform by providing their services in partnerships with the healthcare sector. This article explains the method, steps, and key success factors for CBOs to create and make a business case to potential healthcare partners.

"A Matter of Mindset": Home- and community-based services providers are well-positioned to partner with the medical sector, but this requires an outside-in business mindset. This article outlines the characteristics of such a mindset through a hypothetical case study.

"Strategies for Using Healthcare Dollars to Support Social Services": Understanding the financial arrangements governing the distribution of financial returns and risks to the medical sector is crucial for CBOs as they build potential partnerships. This article describes a range of payment mechanisms that can be used to divide the financial returns and risks involved in the integration of medical and social services.

"Leading—not Managing—Through a New World Order": Change leadership is a large and involved topic. This article outlines the five frames of change: self-awareness, coherence, alignment, first steps, and political savvy.

'The reasons for establishing partnerships between CBOs and the healthcare sector are many and continue to grow.'

"An Introduction to Marketing and Branding": For any organization to thrive they must have customers—often various customers that have competing and complementary goals. Understanding each customer segment and what they value is the key to success. This article lays out how organizations should approach their marketing and branding strategies.

"Monitoring and Evaluation: Key Steps for Long-Term Services and Supports Organizations": Long-term services and supports (LTSS) organizations' success in entering into and maintaining partnerships depends partially on their ability to demonstrate their value. This need to show results makes monitoring and evaluation (M&E) an essential practice for these organizations. They need to plan systematically for M&E, so they can collect and use data to improve programming and communicate value and lessons learned to current and potential partners and other key stakeholders. This article provides an overview of the basic steps in the M&E process.

"Building a Strong Nonprofit Board Goes Beyond Best Practices": Boards are one of the most important parts of an organization. Not only do they govern the organization, but they also must look to the future and adapt to change. This article describes the evolution and responsibilities of boards as they advance the mission of the organizations they govern.

"Understanding Costs: How CBOs Can Build Business Acumen for Future Partnerships": Almost every business decision considered by a CBO requires accurate costs assessment. This article explains fixed and variable costs, break-even analysis, the concepts of scale and scope economies, and the expected learning curve for CBOs assessing costs.

The reasons for establishing partnerships between CBOs and the healthcare sector are many and continue to grow. Older adults, especially those with chronic conditions and functional limitations, often experience poor care transitions, which contributes to increased healthcare utilization and readmissions that drive up costs. Some healthcare entities, such as hospitals, are already facing penalties for these readmissions; other providers, such as ACOs and SNPs, are at risk and therefore are developing innovative approaches to manage the care for a complex population through risk-sharing agreements.

Author's Note

The term CBO, as it is used in this article, refers to nonprofit organizations that address social determinants of health and provide LTSS to older adults and to those people living with disabilities in the community. The healthcare sector is a term used in this article to refer to health plans, ACOs, hospitals, medical groups, and others with an incentive for medical cost avoidance.

Erin C. Westphal, M.S., is a program officer for The SCAN Foundation in Long Beach, California. Westphal's work focuses on building the business case for person-centered care models and integrating the care and financing for medical and social services.

Making the Business Case
for CBO Services

By Victor Tabbush

> The return on investment to any CBO's health partner will have to weigh factors that vary across populations served and payer context.

Community-based organizations (CBO) that provide support services such as care transitions, chronic disease management, medication management, nutrition, transportation, home and family assessments, health benefits counseling, and caregiver support are now well-positioned to exploit the financial opportunities created by healthcare reform by providing these services in partnerships with the healthcare sector.

The potential of these partnerships emanates from two forces: the evolution to new payment models stressing value, which has placed the medical sector at increased risk for the overall costs of medical care (new payment models include capitation, global and bundled payments, shared-savings arrangements, and penalties for hospital readmissions); and the growing evidence that CBO services can reduce the costs of such care by decreasing unnecessary medical care. This article explains the method, steps, and key success factors for CBOs to create and make a business case to potential healthcare partners.

Defining the Business Case

A business case for CBO services exists when CBOs create value for potential clients and partners (hospitals, post–acute care providers, provider networks, and insurers) that is larger than what the clients will be asked to pay for these services. In short, the CBO must present an attractive return on investment (ROI) to the healthcare partner. Most often, the business case starts with the recognition that a patient population, e.g., a cohort of complex care individuals having high needs, creates a financial burden that can be reduced with home- and community-based services compared to usual care.

The case is then built around the CBO's capacity to mitigate that burden by averting costly medical events through the services it provides. Services that are effective in generating benefits seldom do so without expense. So in making the business case, any payment the CBO demands must be subtracted from the gross benefits it confers on its partner. The case will not be

➔**ABSTRACT** Due to recent policy and payment reforms, community-based organizations (CBO) that provide support services increasingly can capitalize on new business opportunities with partners in the healthcare sector. But they must demonstrate that they are creating significant economic benefits for their business partners. This article explains the method, steps, and key success factors for CBOs to create and make a business case to potential partners in the healthcare sector **| key words**: *community-based organizations, healthcare partners, support services, payment models, return on investment*

convincing unless the net benefits for the health-care partner are positive.

Steps in Making a Business Case

There is a logical sequence of six steps that CBOs should take in making its business case to a health sector entity.

Step 1: Adopt perspective

Before assessing the magnitudes involved, a decision must be made as to whose costs and benefits will be considered relevant in the analysis. While a CBO service may generate benefits to parties other than its medical partner, such as to a health plan, to the client, or to an individual and his or her family, the appropriate perspective should be narrow. Consideration should only be given to those financial consequences the investing medical partner would find meaningful.

Step 2: Determine CBO costs

Because a business case will compare the CBO intervention's benefits with its costs, the fees the CBO is planning to charge the healthcare partner must be considered. These charges to the medical partner might be contingent or certain. They would be contingent if the charges were predicated on actual, realized costs, or if a pay-for-performance system is to be the basis for the reimbursement. They would be certain if the fees were set prospectively—meaning set in advance of services delivery. Regardless of the system, the higher the reimbursement sought by the CBO, the less attractive is the business case from the perspective of the medical partner: the reimbursement paid to the CBO must be netted out against the benefits attained by the partner.

Step 3: Estimate benefits to the health partner

In the case of CBO services, the primary economic benefit to the healthcare entity is likely to be the avoidance of medical costs that would have resulted without the CBO's services. CBOs can reduce medical use by curtailing unwanted, unnecessary, and reactive, expensive care. For

example, frequently when individuals use social services there are reductions in the duration and incidence of hospital admissions and readmissions, as well as in emergency room visits.

'The CBO must present an attractive ROI (return on investment) to the healthcare partner.'

In addition, any added revenues to the medical partner from CBO efforts should be added to the benefits of cost avoidance to calculate the gross benefits of the service offering. One potentially important source of added revenue is the shared savings accruing to an Accountable Care Organization under the Medicare Shared Savings Program. Another example might be the Centers for Medicare & Medicaid's (CMS) per member, per month payment for chronic care management under traditional Medicare. (One requirement to receive the payment is for the provider to address the patient's social needs.)

Step 4: Estimate the ROI to the health partner

Once gross benefits to the medical partner and the cost it is expected to pay have been separately estimated, benefits and costs must

be compared to assess the magnitude of the net financial advantage gained from contracting with the CBO. Net benefit is calculated by subtracting program costs from gross benefits. ROI is a shorthand term loosely used to express the net benefit achieved in return for a program outlay. This return often is expressed as a percentage: the net benefit is calculated in the numerator by subtracting the program cost from its gross benefit; the denominator is the cost of the program.

Example: If a service costs $20,000 and results in gross benefits of $40,000, the ROI to the medical partner using this definition would be 100 percent: ($40,000 - $20,000) + $20,000 = 100 percent.

Step 5: Compare the ROI to the health partner's hurdle rate

A demonstration that the CBO can generate a positive ROI for its partner is a necessary but insufficient condition for making a convincing business case. The rate has to be sufficiently high. It must clear a hurdle. The reason it needs to achieve a critical minimum level to be acceptable is that program investments made by the partner have opportunity costs: the investment dollars could be deployed elsewhere. Therefore, for an investment to be warranted, it must generate a return that is at least equal to what the resources could have earned in alternative uses. It should be noted that the hurdle rate inevitably will be set higher when a high degree of uncertainty surrounds the accuracy of the ROI prediction. In that circumstance, the investment is riskier and that risk needs to be balanced by the prospect of a larger return. Some partners may require an estimated return of as much as 200 percent to 300 percent. The inherent feature of riskiness takes us to the final step.

Step 6: Conduct a sensitivity analysis

Conducting a sensitivity analysis is the final step in doing business case calculations. The values of the key variables in the business case assess-

Figure 1. Calculating a Return on Investment
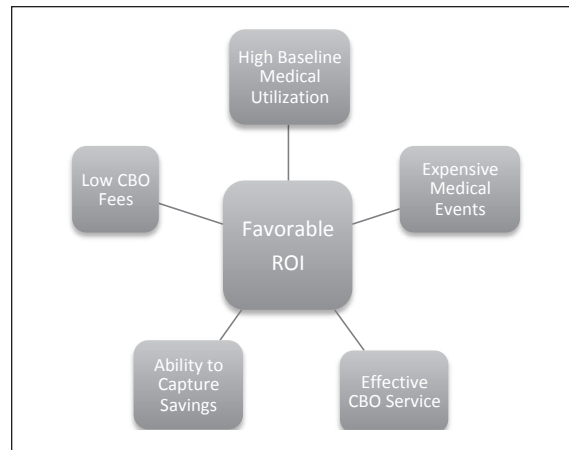
Source: Tabbush et al., 2016.

ment will inevitably be subject to uncertainty and debate. So, instead of positing a single ROI, it is wise for the CBO to suggest a probable range. A simple yet worthwhile approach is to report the ROIs for at least two scenarios. The first scenario is when all independent variables that shape the ROI are assigned "pessimistic" values; the second is when these variables are at their "most likely" values. The values for the variables may be taken from the different studies reported in the published literature or from the CBO's prior experience. If a CBO service is predicted to generate an ROI in excess of the partner's hurdle rate, even under the more pessimistic set of assumptions, the business case might be considered more convincing and overcome lingering skepticism about its strength.

Factors for Making a Strong Business Case

The strength of any business case is crucially dependent on the magnitude of the ROI calculation described below—using the data and specifics of each situation. However, understanding the steps required in making the business case suggests the five factors that make the case predictably stronger. Situations where these factors exist are ones where the CBO will likely find a more receptive audience for its business case.

High baseline incidence of medical utilization

Medical utilization refers to the volume of medical services provided in all inpatient settings, in hospital outpatient and ambulatory care, and in home health. The severity and number of comorbidities possessed by, diagnosed, and treated for in the targeted population are the principal determinants of medical utilization. The higher the level of medical use by the population prior to any CBO services, the greater will be the potential for a CBO to deliver benefits in terms of averted medical events. The implication should be clear: a CBO that targets people with multiple chronic conditions and severe functional limitations will likely show a higher ROI than one focused on individuals who rarely access medical services.

More expensive medical events

Certain medical services are more expensive than others—hospital admissions are especially costly. The total expenses of medical utilization (the focus of CBO services) are the product of the incidence of each medical event multiplied by its respective per unit cost. This total cost of medical utilization prior to the delivery of support services represents the baseline from which cost-savings brought about by the CBO will be calculated. Crucially, hospital admissions and readmissions constitute about 80 percent of the annual per capita patient medical costs for high-risk Medicare beneficiaries (Rodriguez, 2014). Curtailing relatively cheap primary care visits does little to enhance the ROI; similarly, should the CBO's efforts result in a larger number of primary care visits, the adverse impact on the ROI is likely to be minimal.

A more effective CBO service . . .

Effectiveness in this context means the extent to which the CBO intervention reduces medical utilization (and therefore medical costs) in relation to the baseline incidence. The effectiveness will depend upon a number of factors, including the caliber of the leadership and management of the CBO team, the skill and training of those who deliver it, and the amount of resources devoted to the program.

. . . the lower the CBO fees . . .

For any given level of CBO effectiveness, the smaller the fee incurred by the health sector partner to purchase services, the larger is that partner's financial return. Fees charged by a CBO can be made lower under the following four circumstances:

1. When a specific program is not forced to absorb a large portion of CBO overhead.

A CBO targeting people with chronic conditions and severe functional limitations will likely show a higher ROI.

---

2. When the program is expected to run for several years—allowing the upfront expenses of the program's introduction to be spread over more years.

3. When the program scale is larger—allowing fixed costs of operation to be spread more thinly over more patients or clients, thereby achieving scale economics. Such economies refer to a lower unit cost when scale expands.

4. When factors two and three above are incorporated (longevity and scale), it suggests that the "learning curve" can be leveraged by a CBO to lower its fees and create a more attractive value proposition to the medical partner. With cumulated experience comes learning, and with learning comes efficiencies leading to lowered costs that can be passed on to the health sector client.

. . . and the greater the ability of the health partner to capture benefits

If a care model that integrates social services is effective and succeeds in reducing medical utilization, costs are obviously avoided. How-

ever, not all the cost-savings may accrue to the organization that pays for this enhanced level of care and that was responsible for the cost avoidance. Sometimes, third parties in the medical ecosystem might enjoy the savings. For example, a hospital compensated under traditional Medicare fee-for-service might consider investing in a CBO community-based service. Suppose the service then lessens the probability of subsequent hospital admissions. The hospital generally will not benefit financially from the lowered admissions; in fact, it will lose revenues under a fee-for-service system. The beneficiary of these savings in this case is CMS, the payer.

With CMS's increased emphasis on at-risk contracting (Value Based Purchasing, Accountable Care Organizations, Shared Savings Programs, and Bundled Payments), the business case for person-centered care will become increasingly attractive for a more highly integrated medical sector that is quickly evolving to assume more and more responsibility for the total costs of care.

Its role within the health system, the manner in which it derives its revenues, and the degree to which it is at risk for costs of medical utilization are profound influences on the level of enthusiasm that any health organization would likely display toward a CBO's proposed business case.

Conclusion

The framework for developing the business case for CBO services focuses on both medical cost avoidance and, to a lesser degree, the revenue enhancements it might bring to its healthcare partner. The approach suggested here has identified the following factors as the principal ones shaping the strength of the business case: the baseline incidence of medical utilization; unit costs of medical services; both the cost and effectiveness of the CBO intervention; and the ability of the investing health sector partner to secure a large portion of the financial benefits.

The last factor is especially important: capitated systems and recent payment reforms have tended to increase accountability for medical costs, now making cost avoidance a more attractive strategy. Because the strength of the business case is dependent upon these factors, there is no *single* business case for a CBO to make, even for an established service line. The ROI to any healthcare partner will be sensitive to these factors, which will vary across populations served and within each unique payer context. ✎

CBO services are effective if they reduce medical utilization in relation to the baseline incidence.

Author's Note

The term CBO, as used in this article, refers to nonprofit organizations that address social determinants of health and provide long-term services and supports to older adults and to those living with disabilities in the community. The healthcare sector is a term used here to refer to health plans, Accountable Care Organizations, hospitals, medical groups, and others with an incentive for medical cost avoidance.

Victor Tabbush, Ph.D., is professor emeritus at the UCLA Anderson School of Management in Los Angeles, specializing in healthcare economics, healthcare leadership, and management capacity-building. Since 2012, he has worked with The SCAN Foundation to build the management and leadership capacity of community-based organizations that provide long-term services and supports to older adults and disabled individuals.

References

Rodriguez, S., et al. 2014. "Effective Management of High-Risk Medicare Populations." Avalere Health. goo.gl/L7BZt3. Retrieved October 20, 2017.

Tabbush, V., et al. 2016. "Person-Centered Care: The Business Case." goo.gl/TTQrAU. Retrieved October 20, 2017.

A Matter of Mindset

By Victor Tabbush

> Community-based organizations must master "outside-in" thinking to partner up and deliver quality, cost-efficient care.

Recent healthcare policy and payment reforms, such as Medicare's Bundled Payments for Care Improvement (BPCI) initiative, the Hospital Readmissions Reduction Program, and the Value-Based Purchasing Program, among others, share a common feature: each reform incentivizes financial and performance accountability on the part of medical providers. Home- and community-based service providers (CBO) are well-positioned to partner with the medical care sector in these integration efforts. In this new payment environment, CBOs can reduce medical costs and improve health outcomes for potential clients and partners (hospitals, post–acute care providers, provider networks, and insurers). Success in forming and implementing these partnerships require CBOs to adopt an outside-in business mindset.

The Business Mindset: Adopting An Outside-In Orientation

To be an attractive partner to the medical sector, the CBO must become an "outside-in" organization, adopting an external orientation in its thinking and actions. The outside-in approach is driven by the belief that creating value for the partner is key to its success.

The "inside-out" approach, in contrast, is driven by the belief that the organization's strengths are the foundation for a sustainable future. If organizations intend to be successful in marketing their services to the medical sector, they will need to shed the inside-out mindset. This prescription stems from recent work The SCAN Foundation has undertaken to build the business acumen of a dozen CBOs. The four symptoms of an "inside-out" organization are described below.

√ **Using terms that the organization itself understands, but are unfamiliar to the potential partner**

If CBOs are to be invited by medical partners to integrate service delivery, they first must avoid terms that, while standard in the long-term services and supports (LTSS) lexicon, may be poorly understood and confusing to the medical sector partner. Acronyms used mainly within the LTSS sector, such as Adult Day Health Care (ADHC), Adult Day Program (ADP), and Care Management (CM) may need to be avoided.

➜**ABSTRACT** Recent healthcare policy and payment reforms incentivize financial and performance accountability on the part of medical providers. Home- and community-based providers are well-positioned to partner with the medical sector in such integration efforts, but this requires an outside-in business mindset. This article uses a hypothetical case study to outline the characteristics of this mindset. | **key words**: *CBOs, healthcare providers, care transitions, readmissions, price-based costing, outside-in mindset*

Potential partners are not going to invest in learning the CBO language. CBOs must adopt and be fluent in the language spoken by partners. They must learn what is meant by return on investment (ROI), and why this metric is crucial from a medical partner's perspective.

What drives the outside-in approach is the belief that creating value for a potential partner is key to success.

√ **Promoting their services and features rather than their benefits—and why these exist**

In its marketing efforts to potential partners, the CBO must communicate the anticipated outcomes of its services. It should not focus on the features of the services, or on the output from them. For example, for a CBO to cite to a health plan the large number of clients it has served is almost meaningless: persuasive power stems from providing evidence on the number of hospital readmissions that have been avoided. A CBO must adopt the customer perspective—identifying its problems and finding solutions. It must stress outcomes and benefits that are meaningful from the external perspective. In short, CBOs need to emphasize the "why" and not the "how" and "what" dimensions of its services.

√ **Failing to see their organization the way others do**

CBOs generally will have a strong sense of their mission, their identity, and how it is trans-forming. But that sense may not be shared effectively with external constituencies; perceptions held by others may be inaccurate and rooted in the past. A CBO will know its history and why it carries the name it does, but it may be a name that misleads and confuses the potential partner. For example, some CBOs' names have references to ethnic and religious groups and affiliations, but do not limit services to them.

A CBO may now regard itself as a business offering its services on a commercial basis. However, the prospective medical partner may still regard the CBO as a traditional social services agency providing free services. The CBO's communications, especially its website, must be up-to-date and provide accurate information to its constituencies. It may need to rethink and restate its mission statement, and even consider a name change to accurately convey its identity.

√ **Pricing its services on the basis of its own costs rather than on the value created for partners**

A common and financially harmful symptom of an inside-out organization is its tendency to base its price on its costs. After all, cost information is easily available internally, and costs should be covered. But cost-plus pricing, meaning basing a price on what the service costs rather than the value it delivers, generally is not recommended. The partner does not care what the CBO's costs are; they care about their own. Instead of cost-based pricing, the CBO should set price based on value (see sidebar on how this might work, below).

An Example of Demonstrated Value

The following example is from a program to transition discharged patients from the hospital to home. The motivation is to reduce thirty-day hospital readmissions, for which it is assumed the hospital bears the full financial responsibility, averaging $10,000 per readmission. The CBO incurs a direct cost of $200 per transition and, using a cost-plus pricing method, might charge the hospital $250, with the extra $50 to cover indirect expenses. If the program is successful in demonstrating the desired outcome—meaning a reduction in readmissions—this inside-out mindset method may leave money on the table. Suppose, for example, that the service reduced the probability of a readmission by 10 percent. Then the value to the hospital of each transition would be 10 percent of $10,000, or $1,000. Conceivably, the CBO with an outside-in orientation could charge a fee in excess of $250, one closer to the value its service creates.

Unlike the ease with which cost can be determined, value is difficult to establish. The outside-in organization must look to the partner's goals and convert its success in achieving them into a dollar measure of value. Clearly, the CBO needs to understand the outcomes that drive value for the partner, must monetize these outcomes, and set prices accordingly. The chief source of value creation is most likely the medical cost avoidance that the LTSS achieve.

'An outside-in CBO adopts the language of its partners.'

Embrace Price-Based Costing

Just as it must avoid cost-based pricing, the outside-in organization should embrace "price-based costing." This form of cost management begins with a recognition that CBO service costs can be reduced without reducing their value. With price-based costing, the CBO establishes a price it believes will make its offering attractive to the medical partner. Then it sets its delivery cost target at such a level that, were the target to be achieved, would allow the CBO to earn a reasonable financial return. The cost target can be met if the CBO does an inventory of the various activities and components that comprise its service operation, and assesses each one's contribution to overall cost, as well as its contribution to creating value. Activities and components that are adding disproportionally to cost relative to the value they create need to be trimmed; similarly, those that contribute value that is disproportionate to their costs need to be expanded. In this process of service redesign, overall cost can be reduced while maintaining or even increasing value.

Here is an example of cost-based pricing. Suppose a hospital system (with the aim of reducing thirty-day readmissions) is prepared to pay a CBO $300 per patient who transitions from an acute care facility back home. The normal bundle of services offered by the CBO might, in our example, include nutritional support, non-emergent transportation, medication reconciliation, and caregiver support. Then suppose that the bundle with the usual service intensity and delivered by the CBO's usual personnel would cost the CBO $325 to deliver. Clearly, it would be a losing proposition to accept $300, unless somehow the CBO can redesign its processes to reduce its costs while simultaneously not reducing its effectiveness in curtailing readmissions.

The CBO can do precisely that by conducting value analysis and reallocating its resources. To conduct value analysis requires that the following two questions be answered:

√ **What are the relative contributions of each service component in the care transition to the goal of reducing readmissions?**

For example, suppose medication reconciliation is thought to be the most influential service—accounting for 40 percent of the transition's success. Caregiver support, say, accounts for just 5 percent. Each component of the transition needs to be evaluated similarly until the CBO can account for 100 percent of the care transition's success.

√ **What are the relative contributions of each service component within the care transition bundle to the $325 overall cost of the service?**

For example, suppose medication reconciliation is the least costly—contributing just 20 percent to total cost. Suppose then that caregiver support comprises 20 percent of the cost. Each component of the transition needs to be costed out until the CBO can account for 100 percent of the total $325.

It should be clear from this hypothetical example (see Table 1 on page 35) that medication reconciliation is contributing to value at a level disproportionate to its cost: its value-to-cost ratio is 2.0 in this case—40 percent divided by 20 percent. In contrast, caregiver support is underperforming, with a value-to-cost ratio of 0.25. (There is rough balance between the value and the cost for all other services.) The path to cost reduction using these data is clear: money now

Table 1. Remedying Imbalance in Value-to-Cost Ratio

CBO Service Offering	Relative Contribution To Client Value	Relative Contribution To CBO Cost	Value to Cost Ratio
Medication Reconciliation	40%	20%	2
Caregiver Support	5%	20%	0.25
Other Services	55%	60%	0.92

spent on caregiver support should be reduced. Some savings can be reallocated to medication reconciliation. The net effect can be for the cost to the CBO to fall below $300, *and* a higher inci-

'A CBO must adopt the customer perspective.'

dence of readmissions averted for the hospital. While this example is hypothetical, it illustrates how price-based costing, which is very much part of outside-in thinking, can bring out CBO profitability.

The value analysis remedy is for less to be spent on caregiver support and more on medication reconciliation.

Summing Up the Outside-In Approach

Payment and policy reform have created many business opportunities for CBOs to partner with the medical sector. A crucial success factor is developing the right business mindset: an outside-in approach to its thinking and actions. This mindset is the foundation for business acumen.

An outside-in CBO adopts the language of its partners, identifies and addresses their problems, emphasizes benefits over features, ensures its external image and identity match its evolving strategic intent, and prices its services based on the value they create.

Victor Tabbush, Ph.D., is professor emeritus at the UCLA Anderson School of Management in Los Angeles, specializing in healthcare economics, healthcare leadership, and management capacity-building. Since 2012, he has worked with The SCAN Foundation to build the management and leadership capacity of community-based organizations that provide long-term services and supports to older adults and disabled individuals.

Strategies for Using Healthcare Dollars to Support Social Services

By Laura M. Gottlieb and
Victor Tabbush

A detailed guide to the costs and payment systems CBOs need to be aware of when managing social health determinants.

Based on a growing recognition that health outcomes are shaped outside the medical sector (Robert and House, 1996; Marmot et al., 1997; Lantz et al., 1998), initiatives to manage high-need, high-cost populations increasingly involve partnerships between healthcare clinical entities, like hospitals and physician groups, and community-based social and mental health service organizations (CBO) (Miller, Nath, and Line, 2017). Making the business case for these partnerships is crucial (Bachrach et al., 2014; Rogan and Bradley, 2016), as is understanding the financial arrangements governing the distribution of financial returns and risks to each partner agency. For partnerships to be sustainable, they must be mutually advantageous. This article describes a range of payment mechanisms that can be used to divide the financial returns and risks involved in the integration of medical and social services.

Addressing Determinants of Health Reaps Financial Benefits

A growing body of observational and experimental data suggests that financial savings are likely to accrue from integrated care delivery (Krieger et al., 2005; Teufel et al., 2009; Kangovi et al., 2014). These financial benefits are related both to the potential for added revenue and the potential for averted medical utilization and its resulting costs. Added revenue can come from programs that incentivize comprehensive service integration. For instance, in the Centers for Medicare & Medicaid Services' chronic care management program, additional payments are given to providers who offer services that include identifying and addressing patients' social and mental health needs (Medicare Learning Network, 2016). Savings from averted costs are based on examples where high-risk populations that are

➜**ABSTRACT** Despite mounting enthusiasm around addressing patients' social and economic barriers as a means of achieving the Triple Aim, little attention has been paid to the feasibility/sustainability of partnerships between healthcare systems and community-based organizations (CBO) required to address patients' social and economic needs. To maximize the sustainability of related interventions, there is a growing need to define payment systems that provide mutually advantageous solutions to healthcare systems and CBOs. This article describes five payment mechanisms that differ in the division of the financial returns and risks. | **key words**: *healthcare–community-based organization partnerships, social and economic needs, payment systems*

provided these kinds of wraparound services show reduced duration and incidence of admissions, readmissions, and emergency room visits (Tabbush et al., 2016).

Predicted financial benefits, whether from incentive programs or averted utilization and costs, depend upon achieving expected outcomes at costs lower than returns. This involves some uncertainty about whether gains will exceed costs; the uncertainty stems from the unpredictability of both outcomes (performance risk) and the actual costs of delivering the services (cost risk). Underlying any partnership between a CBO and a medical entity partner is an agreement about whether and how to share these risks across entities.

Expected Costs of Addressing Health Determinants

A health payer or provider considering stronger integration of social services typically begins by assessing potential financial returns. The return on investment (ROI) calculation requires that incremental costs be compared with the projected benefits of providing the new services.

$$\text{Cost} = \text{Beneficiaries} \times \frac{\text{Cases}}{\text{Beneficiaries}} \times \frac{\text{Services provided}}{\text{Cases}} \times \frac{\text{Cost}}{\text{Services provided}}$$

The cost risk associated with providing services is driven by four factors: the number of beneficiaries, number of cases per beneficiary, number of services provided per case, and cost per service, each of which is described below in more detail.

Beneficiaries: This is the total number of individuals in a high-need, high-cost population that is eligible to receive the integrated care. This eligibility decision, whether based on a health risk assessment or prior utilization history, can be made jointly across partners, but is more commonly made by the health partner. The higher the total number of beneficiaries, the greater the overall costs of the provision of social services.

Cases per Beneficiary (also called case prevalence rate): Not all eligible beneficiaries will be recipients of social services. The case prevalence rate is defined as the proportion of all people eligible for social services who actually receive them. For example, not all beneficiaries will require a hospital transition back to the community, non-emergent transportation, or home-delivered meals during a thirty-day post-discharge window. The greater the case prevalence rate, the higher the total costs.

Financial uncertainty stems from the unpredictability of outcomes and the actual costs of delivering the services.

Services Provided per Case: This ratio is defined as the service intensity of a case. Each case involves a bundle of services of varying intensity provided—dependent on clients' specific needs. For example, each care transition conducted by a CBO during a thirty-day post-discharge window will differ in complexity and required resources. Some cases may require multiple at-home visits by a social worker; others will require only one or two. Cases in which there is more caregiver support may require less service from the CBO. The more service-intensive the case, the higher the total costs of care.

Cost per Service Provided: This ratio is the average cost of a service unit. The service might be a risk assessment, a ride to a physician for a follow up appointment, a home-delivered meal, a visit to a discharged patient by a health coach, or a day spent in a respite shelter. The more expensive each unit of service, the higher the aggregate costs.

Payment Systems Supporting Medical and Social Services Partnerships

Below we describe five risk-sharing models between CBOs and health care partners that involve unique combinations of risks and returns for each partner. Any selected payment system should cover the costs of provided services. To

maximize sustainability, the contractual agreement should be mutually advantageous to both partners.

Cost reimbursement

In cost reimbursement arrangements, the CBO charges the medical partner for each service provided. The payment is set retrospectively, meaning the charges are billed after the service has been delivered and only after the cost is known. Usually the calculation involves accounting for direct costs plus a percentage add-on to cover indirect costs (overhead). This is a common reimbursement mechanism for CBOs providing services under contracts with medical entities.

In this mechanism, there is no "cost risk" for the CBO; any excess expense is insured against. Cost overruns would be fully covered by the fees billed to the health partner. The CBO has no incentive to limit utilization nor to curb the per service unit cost. There is also little upside for the CBO because there is typically no profit margin built into the charges. This payment mechanism is generally one that is optimal for neither the CBO nor the medical partner because there is no alignment of financial interests.

Fee-for-service

Unlike the cost reimbursement mechanism, fee-for-service (FFS) is prospective, meaning costs per service are established in advance of the service being delivered. Service costs are set as part of the terms of agreement governing the partnership between the CBO and the healthcare entity. Under FFS, the CBO receives the stipulated fee from the medical partner for each unit of service delivered. As examples, a CBO specializing in home-delivered meals may charge a hospital $10 per meal or a housing program might charge $125 per patient-day in respite. FFS, like cost reimbursement, is also a common payment system for CBO–healthcare partnerships.

Under FFS, the CBO is at some cost risk because the CBO's service cost per unit could turn out to be higher than was anticipated when the fee was established. Two factors could cause the higher cost per unit: the direct (variable) costs of services could be unexpectedly high; and the volume of services demanded by the healthcare partner could be lower than expected so that the fixed (overhead) expenses are more thinly spread over this smaller volume.

There is some upside potential for the CBO receiving financial rewards under FFS. The CBO has the incentive to set a fee not merely to just cover its costs, but to a level high enough to enjoy a positive margin between the fee and its costs. The higher the fee asked of the partner, however, the lower the partner's return on investment; healthcare partners may balk if the fees are excessive. In this model, the CBO has some incentive to limit its unit-service cost in order to enjoy a positive profit margin.

Rate per case

A CBO and healthcare partner might agree to a case rate payment. Here, the CBO provides a stipulated set of social services to an individual

or to a specific group of individuals for a specified time period, e.g., thirty or ninety days. For example, if a CBO provides care transition services for a patient being discharged from an acute care facility, that patient's transition can be considered a case. The cases can vary in complexity and involve a range of services (e.g., home-delivered meals, transportation, medication reconciliation) with different levels of service intensity (more or less of each service). In this model, the charge is negotiated for bundled services in a case rate rather than for each service unit.

Under a case-rate payment agreement, the CBO assumes more cost risk than it faces under FFS. The risk is that the case (in this example—a transition) may require a more expensive mix of services and-or higher service intensity than anticipated. The costs of providing all the services needed to the case mix might be much higher than the case rate the CBO receives. (Note that the cost risk can be mitigated in part if the CBO limits the population it is prepared to serve, e.g., excluding or charging more for patients that are likely to require more services or more intensive services.)

In a case-rate payment scheme, however, the CBO is protected against excessive case prevalence because more cases do not increase the per-case costs for the CBO; higher numbers of cases instead provide added revenue to the CBO. Financial benefits also can accrue if the CBO succeeds in managing cases at a cost per case that is less than the set case rate. Unlike in a FFS system, the CBO has every incentive under a case-based system to control service intensity. And as with FFS, the CBO has an incentive to control cost per service unit.

Capitation: fee for beneficiary
Under a capitation agreement, a per eligible beneficiary, per month payment is provided to the CBO, which is then obliged contractually to provide all needed and agreed upon services to covered beneficiaries, not just for defined cases or

services. Capitation is a much less common payment mechanism to compensate CBOs for two reasons. First, it often requires the CBO to offer a wide scope of services, either directly or through community partners. Second, it requires a level of actuarial sophistication that many CBOs do not possess.

Under capitation agreements, CBOs are at full cost risk for a designated population—all the risk of spending for designated services are shifted to the CBO. In addition to being at risk for the cost per service and the service intensity, the CBO is also at risk for the prevalence of cases—meaning the proportion of the beneficiaries that become cases. For margins to be earned, all costs must be managed carefully by the CBO.

'Cases where there is more caregiver support may require less service from the CBO.'

Because it shifts the cost risk to the CBO, this payment agreement has a clear advantage to the medical partner.

Gain-sharing
The four systems described above balance cost risks differently between partners. In each, payments to the CBO are independent of the financial benefits generated by providing the service. The implication is that only the medical partner is affected by performance under all four systems. None fosters better CBO performance, though that outcome is largely under the control of the agency providing the supportive services.

Gain-sharing is a value-based, alternative payment system that evaluates financial outcomes to the medical partner and distributes a portion to the CBO. This helps to align interests across partners in that both parties benefit when both service costs are controlled and financial outcomes improved.

Despite the promise of this system for incentivizing CBOs to be accountable for results, gain-

sharing poses two principal challenges. First, the medical partner must be able to monitor medical utilization and be willing to share the results with the CBO partner. Second, payment on the basis of performance puts the CBO at a high level of risk because the targeted outcomes

---

Each payment scheme offers a different risk and reward profile for the two partners.

---

may not be achieved to the extent projected for reasons having little to do with the effectiveness of the CBO's efforts. One solution to the CBO facing excessive performance risk is to have its payment be a hybrid: FFS augmented by a small share of any financial gains.

Conclusion

Unavoidable uncertainty about future service delivery costs and performance characterizes all contracts between CBOs and their healthcare partners. CBOs should be mindful of the range

of payment schemes used in these agreements. Each scheme described above offers a different risk and reward profile for the two partners. CBOs entering into these partnerships need to assess the extent of risk, their internal capacity to manage that risk, and the tradeoffs they are prepared to make between risks and returns. Because it aligns incentives, gain-sharing appears to offer the most promise in achieving mutually advantageous results.

....

Laura M. Gottlieb, M.D., M.P.H., is an associate professor of Family and Community Medicine at the University of California, San Francisco (UCSF), School of Medicine and director of the Social Interventions Research and Evaluation Network at UCSF. Victor Tabbush, Ph.D., is professor emeritus at the UCLA Anderson School of Management in Los Angeles, specializing in healthcare economics, healthcare leadership, and management capacity-building. Since 2012, he has worked with The SCAN Foundation to build the management and leadership capacity of community-based organizations that provide long-term services and supports to older adults and disabled individuals.

References

Bachrach, D., et al. 2014. "Manatt on Medicaid: Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment." goo.gl/BBvsDb. Retrieved October 20, 2017.

Kangovi, S., et al. 2014. "Patient-centered Community Health Worker Intervention to Improve Posthospital Outcomes: A Randomized Clinical Trial." *JAMA Internal Medicine* 174(4): 535–43.

Krieger, J. W., et al. 2005. "The Seattle–King County Healthy Homes Project: A Randomized, Controlled Trial of a Community Health Worker Intervention to Decrease Exposure to Indoor Asthma Triggers." *American Journal of Public Health* 95(4): 652–59.

Lantz, P. M., et al. 1998. "Socioeconomic Factors, Health Behaviors, and Mortality: Results from a Nationally Representative Prospective Study of U.S. Adults." *Journal of the American Medical Association* 279(21): 1703–8.

Marmot, M., et al. 1997. "Social Inequalities in Health: Next Questions and Converging Evidence." *Social Science & Medicine* 44(6): 901–10.

Medicare Learning Network. 2016. "Chronic Care Management Services." goo.gl/qLHnU8. Retrieved October 20, 2017.

Miller, E., Nath, T., and Line, L. 2017. "Working Together Toward Better Health Outcomes." goo.gl/sLPqcD. Retrieved October 20, 2017.

Robert, S., and House, J. S. 1996. "SES Differentials in Health by Age and Alternative Indicators of SES." *Journal of Aging and Health* 8(3): 359–88.

Rogan, E., and Bradley, E. 2016. "Investing in Social Services for States' Health: Identifying and Overcoming the Barriers." goo.gl/VuGrgS. Retrieved October 20, 2017.

Tabbush, V., et al. 2016. "Person-centered Care: The Business Case." goo.gl/ynrecV. Retrieved October 20, 2017.

Teufel, J. A., et al. 2009. "Process and Impact Evaluation of a Legal Assistance and Health Care Community Partnership." *Health Promotion Practice* 10(3): 378–85.

Leading—Not Managing—
Through a New World Order

By Edward O'Neil

Five frameworks help leaders to effectively make major changes in their organizations, including partnering with healthcare entities.

It takes leadership, not merely management, to guide an organization through a rapidly changing external world, and working effectively through change is what distinguishes leading versus managing in an organization. When sector and marketplace environments are stable, there is general buy-in around the values and direction of the organization, resources are adequate, and, with no new competition, most organizations can get by with competent and able managers. But in a climate of continuous change, a clear future direction is instead vague and not necessarily shared by internal stakeholders, traditional sources of support evaporate, and there are disruptive new entrants to the market. This is when leadership is most needed.

Community-based organizations (CBO) that are currently considering partnering with healthcare entities to address social determinants of health are actively responding to the external world. It is not an overstatement to point out that many organizations fail because they try to manage—not lead—toward success in this environment. What is most needed is "change leadership." Change leadership is a large and involved topic, but there are a handful of frameworks—self-awareness, coherence and alignment, first steps, and political savvy—that every leader will need to work within to be successful. These are explicated in the following sections.

Frameworks for Success

First, leaders must be self-aware—especially when it comes to their skill profile. What are the leader's strengths or weaknesses relevant to the change process? Is there a vision that can be communicated clearly? Are external trends well understood and positioned against the organization's mission? Have key relationships been developed and maintained over time? Are decisions being made in a well-informed, clear manner and then communicated throughout the organization? A good grasp of these and many other leadership competencies is essential to success.

A second dimension of self-awareness involves what a leader thinks of the change itself. Perhaps this is a change that is being pushed upon the organization by outside forces or perhaps it is filtering down from higher-ups in a large organization. A leader must be personally committed to the change or unevenness will

➜**ABSTRACT** One way to approach change leadership is to frame some of the critical challenges to insure that the leader keeps them in mind throughout the process. The frames discussed in this article are self-awareness, coherence and alignment, actionable small steps, and political savvy. **|** **key words**: *change leadership, self-awareness, coherence and clarity, alignment, actionable steps, political savvy*

develop in how others perceive the leader's commitment to the change, and this will cause disruption in the process.

Finally, a leader must be aware that most people are averse to change. This means she or he must be a role model for embracing any necessary change.

Coherence and alignment

More than anything else, working through change means ensuring all enlisted stakeholders fully understand the new world order and the changes needed to function within it. Leaders need to be coherent about the change.

Because most people are averse to change, leaders must embrace the necessary change.

Formulating clear and precise answers to the following few core questions can support coherence:

√ What does our organization do that our customers or clients value? (It is best when the customers themselves have expressed this.)

√ What in the external world is threatening the way our organization conducts our business or runs our services?

√ What does our organization need to change to get back to its core undertaking?

Once these responses are clear, information can be piped out in many ways to drive change by defining, inspiring, and aligning the work of others.

Coherence defines, inspires, and aligns; it helps to define what the future will hold. One reason people do not move forward is because they cannot conceive of life outside of the current context. A coherent vision provides an image of the context that is both descriptive and metaphorical.

Coherence also motivates and inspires action. Several elements need to be combined to move a vision into reality. Future goals should be practi-

cal and imaginable, not distant and far-fetched. To be inspiring, the coherent vision must also connect to the underlying culture and values of those who must be moved to action.

Finally, coherence aligns the future work of the organization with consistency. Coherence drives consistency, which becomes a reference point, informing future actions of individuals and, perhaps more importantly, making the collective action of teams and workgroups easier and more effective, because a common direction, purpose, and motivation have been established.

First steps and actions toward change

For leaders who do not know where to start, it can be helpful to keep the bigger picture in mind, while taking small first steps. The following are five things to consider in taking first steps:

√ Long-standing issues that can be directly addressed and advance the change.

√ Easy wins that clearly support the change, but do not cost a lot, even if they are not the highest priority.

√ Immediate opportunities afforded by a shifting environment, even if they are not high on the priority list.

√ Threats, particularly from the outside, which could derail the entire process.

√ Things of deep value to a partner or potential partner.

Another good first step is to work with relationships: leaders should explore where people are (and where they themselves are) with the change, be empathic and listen, and not make premature decisions or try to "fix" things. Try to understand what common ground might exist. Be willing to be surprised by people's perspectives. Try to enlist them to take a more active role in the change process.

One step that leaders often miss is to identify something that is already being done well that fits with the new change agenda. An extant organizational process or procedure may need a little retrofitting to be understood or seen in a new light, but once done, point it out and declare victory.

This step will also allow others to look for similar organizational adaptations they can make, and thus be more comfortable with the change.

Once leaders have a good grasp on how they feel about the change and embrace it, they need to focus on how to align other stakeholders with the change process.

People do not change because they are presented with facts. A crucial part of any human change process involves emotions, relationships, and values. An organization must consider all its stakeholders and think through what is important to each one. If no one knows what stakeholders value, they should be asked. Guesswork can derail change. Thus, a key question to ask is "What do they (internal and external stakeholders) value?"

The first thing to remember is that not everyone has the same size stake in the change process. For example, if two technology units in a

---

'The ideal must be balanced with the achievable in a way that keeps engagement and spirits high.'

larger company are merging, it will undoubtedly have an impact on everyone that uses the technology. But none of these users will be affected as much as the two merging units. For others, it might be a distraction or inconvenience, but for those involved in merging, it is existential.

When leading a change process often there is an impulse to explain the change so that others can understand and value it in the same way. While the motivation to do this is admirable and communication is always helpful, it is essential for the change agent to understand how others see the disruption from their vantage point, not that of the change agent.

It is better to ask questions and listen attentively than rush to explanations. Developing answers to these questions for key stakeholders will move the program forward much faster than trying to sell them on the change.

The following are six key questions to ask stakeholders:

√ What do you find most challenging about the proposed change?

√ What do you think is most important about this change for those we serve?

√ Where do you think the most difficult step in implementation lies?

√ What makes you the most anxious about this change?

√ Are there parts of this change that you find exciting?

√ What do you think you will need to be successful in this change process?

Any change in an organization can be threatening for the people involved. They need time and patience to come to their own understanding about what the change means, how it will affect them, and believe that they can survive this process.

Every individual and group that leaders work with will start in a different place, with varying perceptions of the change, how it will affect them, whether or not they want to be a part of the future, and how much they want to be involved. Because there cannot be an individual change strategy for each person, it will be helpful to group most people into categories; this can give leaders important insight into the work at hand.

Political savvy

Sustaining change over the long haul requires political savvy. Most of us are not comfortable in the overtly political realm, but to achieve change, the ideal must be balanced with the achievable in a way that keeps engagement and spirits high, recognizes difficulties, and moves in a positive direction. There are many ways to be effective in this domain, but there are four that seem most important: be savvy, engage, communicate, and keep your balance.

Being savvy as a change leader means being adaptable, but in a way that keeps the big picture in mind and adjusts to a constantly shifting set

of circumstances. One of the great change theorists, Machiavelli, suggested to the Prince that it was important to advance multiple agendas on various fronts because no one could anticipate the resistance that would emerge once the change began. He also wanted his boss to have a clear idea of priorities, but an even clearer idea of how to trade and balance them as needed. He welcomed as much information about the

'There is no perfect plan, just perfect adaptations.'

"other" as he could get. The more he knew about them, the better able he was at knowing how to advance his agenda and which agenda to push. Finally, in spite of the modern day adjective Machiavellian, which has come to mean, inaccurately, to scheme in a purely political way, the real Niccolo insisted that the Prince be purposeful as only a Renaissance master could have understood.

The Complexities of Change Leadership

Change leadership is complex and it is easy to let small problems slip, either out of distraction or a wish to let one thing slide. But to be successful, it is important to fight this instinct. If problems emerge, do not think they will fix themselves. Identify them, gather the relevant team members to assess the issue and explore solutions, decide what to do, and move forward. Hesitating to deal with problems as they emerge can kill a change process. Change will mean having a number of difficult conversations for a host of reasons.

Do not shy away from these, but remember to approach them with empathy and concern.

Change is hard for everyone. There can be a tendency for people to scapegoat, blame, and attack when the change becomes emotionally draining. Do not create personality wars. Keep people focused on the work and willing and able to let honest mistakes go without drama. Finally, do not be afraid to focus, adjust, and redirect as needed. There is no perfect plan, just perfect adaptations.

When things are changing, it is essential to communicate key messages often, through a variety of media, and as consistently and transparently as possible. Elegance is not the byword in communication around change; rather, repetition is where effective leadership lies.

Maintaining balance involves the leader's personal relationships. First, be present. Phone calls and email cannot take the place of face-to-face interaction, so reducing travel time is important, as is being visible within the organization's environment. When meeting with anyone involved in the change, a leader must focus on them, listen and learn, be empathic, and be as transparent as possible. Do not reveal all, but rather err on the side of sharing. Transparency should include an authentic assessment of the challenge ahead. Acknowledging it will be difficult, but be positive, as that a positive tone is what stakeholders need to hear—and will remember.

Edward O'Neil, Ph.D., M.P.A., F.A.A.N., is the owner of O'Neil & Associates, a management consulting and leadership development firm focused on change and renewal in the healthcare system, in Alameda, California.

An Introduction to Marketing and Branding

By Andres Terech

A community-based organization, like any other company, must learn how to compete in a marketplace and manage its brand.

Community-based organizations (CBO), as well as other institutions and companies, can succeed only if they have customers (i.e., patients, users, clients, payers—including the healthcare sector—or consumers) interested in purchasing or contracting for CBOs' products and services. Acquiring and retaining customers, and growing customer engagement, rests on marketing.

CBOs seeking to take advantage of the opportunities created by healthcare reform need an effective marketing strategy**.** A marketing strategy consists of three steps: *understand the market, choose a strategy,* and *execute it.* The first two steps are, to a large degree, abstract and intellectual: they require analysis and discussion. Only when an organization knows first *why* it wants to compete in the marketplace, and second, *how* it wants to compete in the marketplace is it prudent to invest money in the execution.

Many organizations jump straight to investment and execution: they create services, build brands, develop advertising campaigns, decide on prices and promotions, and set partnerships without a deep analysis of the market's dynam-

ics. Sometimes this works, but generally by suboptimizing and misusing the organization's two critical and scarce resources: money and time. Additionally, because regulations, competitors, partners, and consumers' needs change constantly, the "how" and the "why" need to be constantly reviewed and the marketing strategies adjusted accordingly.

Understanding the Market

The first step in the process intends to answer questions such as: What business does our organization want to be in? With whom would we be competing? Can we add value? Is there an opportunity?

This step involves the "5 Cs model," which consists of assessing consumers (including medical sector partners), company (CBO), competitors, context, and collaborators. The analysis always starts by identifying which consumers' needs and desires the company will attempt to satisfy. A CBO might want to focus on medical partners' desire to provide nutrition, caregiver support, or transportation for high-need, high-risk individu-

➜**ABSTRACT** Without customers, there is no business. This article outlines a three-step marketing strategy framework to help community-based organizations (CBO) understand the market in which they compete, identify how to create value, build a unique brand positioning, and develop a service that people want to use and to pay for. **|** **key words**: *marketing strategy, segmentation, targeting, positioning, marketing mix, branding*

als. Not having a clear purpose or trying to satisfy all possible needs limits the CBO's ability to understand and serve its customers.

It is then crucial to consider what skills, knowledge, or capabilities the company must possess in order to satisfy those consumers' desires. For instance, a CBO created with the right social intentions and motivations but lacking a competitive advantage relative to other local institutions will find it very challenging to thrive and sustain the business in the long term. Thus, it is important to identify what other par-

---

A marketing strategy has three steps: understand the market, choose a strategy, and execute the strategy.

---

ties are competing with the company in trying to satisfy the same consumer needs and desires, and to learn about competitors' strengths and weaknesses (e.g., competitors' brand awareness, financial resources, prices, partners, staffing, etc.). For example, using paratransit to and from medical facilities might compete not only with other CBOs, but also with a good public transportation network and even a medical provider of virtual visits.

The context (i.e., economic, technological, sociocultural, regulatory, and physical environments) in which the company operates can limit what is possible. Because most organizations do not work in isolation, but instead partner with different collaborators (e.g., local governments), it is also crucial to study whether or not collaborators can help support the marketing to consumers.

Choosing a Strategy

Not all persons, partners, or consumers want the exact same product or service, so a sound marketing strategy must segment all potential buyers based on the differences in what they want, decide which segments to target, and show how to position the organization relative to the other competitors or substitutes available in the market. This

process is typically referred to by the acronym STP (or, segmentation, targeting, positioning).

Segmentation

Segmentation consists of grouping consumers based on the similarities and differences in their preferences. In the CBO transportation service example given above, some individuals may prefer paratransit, others might like ride-sharing. Some may need flexibility to allow a caregiver to accompany them and others will use public transit. These preferences may also be in conflict with the approach to providing transportation that the payer (i.e., the healthcare entity) is able or willing to pay for. If only one type of transportation service were to exist, some needs and preferences would go unfulfilled. Not understanding the different parties' wants and treat-ing them all equally will lead to an unproductive use of marketing resources and, often, to failure.

Effective segmentation maximizes the intragroup similarities and, at the same time, maximizes the differences between groups. It is for this reason that demographic characteristics are typically used as a segmentation criterion (e.g., you are either young or old, or an enrollee in a Medicare Advantage [MA] or Special Needs Plan [SNP]). Yet demographic characteristics are seldom the best criterion by which to assess business potential; a person might have different preferences for transportation services, but not merely because he or she is tall or short, rich or poor, or a purchaser of services (MA or SNP). Though more difficult to do, segmenting based on hard-to-measure criteria, such as benefits sought, lifestyle, or loyalty, generally leads to groups of individuals who share similar preferences and responsiveness toward a marketing strategy. This, in turn, leads to a more effective and efficient use of marketing resources.

An important consequence of segmenting the market is the realization that not all segments are a good fit for the organization. Some will be too difficult to attract, others might not have

enough loyalty, while others may want things the organization cannot offer.

Targeting

Choosing which segments to target requires that organizations have a deep understanding of their capabilities and cost structures. Basic economic analyses such as cost-to-serve, margins, break-even, and customer lifetime value are critical. It also is important to understand the degree to which the segments fit with the organization's goals and mission. It is possible, for example, that a particular segment is not economically attractive, but it is necessary for building a brand image or to learn a skill needed to serve other more lucrative segments. A case in point would be CBOs that serve pro bono patients for specific reasons other than economic attractiveness.

When deciding which segments to target, organizations also should consider a segment's competitive intensity. Some segments are under-served, making it easier to acquire customers. In others, competitors might be willing to defend their market shares, even at a loss.

Positioning

Once a target segment has been selected, the fundamental question is how to position the organization's offering in a way that, relative to other competitors, buyers perceive it as unique and valuable. Individuals and families make choices based on their perceptions of the intrinsic value of a product or service, while healthcare entities might be concerned with the organization's ability to reduce medical costs. As the saying goes, "In marketing, perception is reality." Therefore, it is essential that an organization understands and measures how purchasers perceive the value it brings to the market.

Again referring back to the transportation service example, if the selected target segment comprises mainly individuals in need of para-transit, they may have cognitive or functional limitations that require additional support and a door-to-door service. Thus, an illustrative posi-

tioning statement may be "For those people who need extra assistance and prompts in their door-to-door transportation service, our organization is the only paratransit company that trains drivers to help all kind of patients in need. Over the past 20 years, we have worked with doctors, nurses and psychologists to developing a proprietary training program." This positioning specifically identifies the target segment, the competitor set, what makes this particular CBO unique, and why the target segment will believe in their claim.

'A sound marketing strategy must segment all potential buyers.'

Clear and unique positioning reduces customer acquisition costs and aligns the organization actions and investments. Good positioning can also refine the market potential by pushing away those customers who do not value the benefits offered, and who might become too expensive to serve.

The intended positioning is developed in the organization's boardroom; but the actual positioning resides in consumers' minds. Executing the marketing strategy links the two. Many times, after a correct analysis of the 5 Cs and SPT, organizations fail to execute. A famous example of this is the 1985 launch of the New Coke (Keller, 1998).

Executing the Strategy

The last step focuses on transforming ideas into reality, and considers the following practical questions:

√ What characteristics should the service have?

√ How should the organization deliver the service?

√ What should the organization's partners do?

√ How much should the organization charge and who should pay for it?

√ How should the organization raise awareness about its service?

A central part of execution is deciding what

specific attributes (tangible and intangible) the product or service will have in order to deliver the expected benefits. For instance, will the driver have an app to connect with riders, will the van be wheelchair-friendly, will it pick up at set times or on demand, will it wait at the doctor's office or will a return pickup time need to be scheduled?

Next, the organization must decide what type of promotion or communication campaigns it will conduct to create awareness of its existence and highlight unique and valued benefits and, of course, also to generate referrals. In many cases, an organization needs to co-locate staff to new areas or places to reach the target group. Other important decisions are what price to charge for the service, who will pay for it, and if any financing will be offered.

These four decisions (product, promotion, place, and price) are known as the marketing mix, or the 4 Ps (McCarthy, 1960). When it comes to services, a fifth "P" generally is added

---

'One of the most important intangible attributes of every product and service is the brand.'

---

to the marketing mix elements: people. Services, as opposed to products, are produced, delivered, and consumed in the same moment and, in that event, the performance, attitude, and knowledge of the service delivery team significantly influence the satisfaction of those who are receiving the service.

One of the most important intangible attributes of every product and service is the brand. A brand could be defined as a "name, term, design, symbol, or any other feature that identifies one seller's good or service as distinct from those of other sellers" (American Marketing Association, 2014). In practical terms, a brand is the carrier of the promise an organization makes to its users, partners, and buyers to consistently deliver a specific set of features and

benefits. Because of its abstract nature, a brand is built through developing associations, by connecting or linking the organization's name or logo with images and meanings residing in a consumers' mind. These associations are reinforced or weakened by the rest of the marketing mix and change over time.

One of the biggest challenges in building and managing a brand is that brand associations and image are built not only by the organization, but also are created by purchasers of the services (as well as by people who do not use the services) through word of mouth and social media posts. The brand image and meaning also are affected by competitors' communication actions; pop culture reflected in movies, TV shows, or books; influential people, such as experts; specialized online and printed publications; and by members of the service delivery team. Brand perceptions need to be monitored continuously and managed actively.

Conclusion

CBOs are no different from any company or organization, whether they are for-profit or not-for-profit: CBOs also need to acquire and retain customers. They must take a systematic approach

to developing a marketing strategy and to shaping their brand identity. The crucial consideration in crafting a marketing strategy is to identify buyers' preferences and needs and what features drive value for buyers.

In most instances, a CBO will have dual customers—the person receiving the service and the entity that funds the purchase of those services. Each customer segment will adopt its own perspective about how it values the service being offered. The STP framework will help CBOs to develop appropriate value propositions for each customer segment.

Marketing and branding are not one-time activities. CBOs will need to regularly assess their brand perceptions and to update their marketing strategy as the marketplace environment evolves. 🖋

Andres Terech, Ph.D., M.B.A., is an adjunct associate professor of Marketing at the UCLA Anderson School of Management in Los Angeles.

References

American Marketing Association. 2014. "Dictionary." goo.gl/P3PMZe. Retrieved September 27, 2017.

Keller, K. 1998. *Strategic Brand Management, Building, Measuring, and Managing Brand Equity.* Upper Saddle River, NJ: Prentice Hall.

McCarthy, E. J. 1960. *Basic Marketing: A Managerial Approach.* Homewood, IL: Irwin.

Monitoring and Evaluation:
Key Steps for Long-Term Services and Supports Organizations

By Julie Solomon

A step-by-step plan outlines how to conduct monitoring and evaluation to demonstrate community reach and positive outcomes.

The Patient Protection and Affordable Care Act (ACA) aimed to change healthcare delivery and long-term services and supports (LTSS) systems for older adults, with the ultimate goal of providing the right services, at the right time, for each older American (The SCAN Foundation, 2015). These changes in the healthcare landscape, along with an increased understanding of the effects of social determinants on health, have opened opportunities for healthcare entities and community-based organizations (CBO) to become partners in care and support. CBOs' success in entering into and maintaining such partnerships depends partially on their ability to demonstrate reach in the community, better patient experience of care, improved health outcomes, and lower costs to the healthcare system (Shier et al., 2013; Miller, Nath, and Line, 2017). This need to show outcomes makes monitoring and evaluation (M&E) an essential practice for CBOs.

This article provides an overview of the M&E process, to help CBOs plan systematically for M&E so they can collect and use data to improve programming and communicate value and lessons learned to current and potential partners and other stakeholders.

What Is M&E?

M&E can include a wide range of activities, such as documenting how many older adults receive a service, how satisfied they are with that service, and the impacts on their health and well-being as a result of the service. Evaluation is a broad term that can be defined as the systematic collection, analysis, and interpretation of data (or information) to inform judgments about whether a program or service has met its objectives, sup-

➜**ABSTRACT** Recent changes in healthcare and long-term services and supports systems have created opportunities for community-based organizations (CBO) to partner with healthcare entities to serve older adults. With such opportunities comes the need for CBOs to conduct monitoring and evaluation (M&E) to demonstrate community reach and positive patient and system outcomes. Developing an M&E plan, executing agreements, developing data collection tools, collecting data, analyzing and interpreting it, and communicating and using findings are key M&E steps that can improve programming and communicate value and lessons learned to all stakeholders. | **key words**: *monitoring and evaluation, M&E, community reach, improved outcomes*

port program or service improvements, and-or inform decisions about future programs or services (Patton, 1997).

Sometimes the term "monitoring" refers to a continuous process of obtaining, analyzing, and interpreting data regarding program or service implementation and progress toward objectives, while "evaluation" designates a periodic, formal assessment of monitoring and other data, in order to make summative judgments about program achievements (Markiewicz and Patrick, 2016). Regardless of whether or how one distinguishes the "M" from the "E" in M&E, it is critically important to plan for M&E in conjunction with program or service planning; this drives implementation of the systems and practices necessary to collect, analyze, and interpret the right data, at the right time.

It is critical to plan for M&E in conjunction with program or service planning.

The M&E Process

The M&E steps outlined below can help organizations to systematically plan for and implement M&E. Although the steps are presented in a linear order, in practice they may be iterative. For example, if a CBO finds itself unable to execute the agreements needed to obtain a dataset from another agency in Step 2, it may be necessary to revise the M&E plan developed in Step 1.

Step 1: Develop an M&E plan

The M&E plan succinctly lays out the what, how, when, who, and why in the M&E process. Commonly, the plan addresses both process evaluation and outcome evaluation. In the LTSS sector, process evaluation tends to focus on the number of service units delivered and the number of patients or clients reached. Outcome evaluation frequently documents changes in patient or client knowledge, skills, behaviors, health, and well-being; use of healthcare services, such as

emergency department or in-patient hospital services; and cost-savings to healthcare payers or providers. In the medical field, assessment of satisfaction with care is generally considered an outcome evaluation, while in the social services sector, assessment of program or service satisfaction often is considered a process evaluation. Seven key elements that should be defined in the M&E plan are described briefly below; a sample M&E plan template, with examples, is provided in Table 1 (see page 52).

Program or service objectives are the specific, measurable, achievable, realistic, and time-delineated (SMART) process and outcomes objectives to be measured through M&E.

Indicators are specific, measurable characteristics of people, services, organizations, or systems that permit assessment of progress toward process and outcome objectives. To measure changes in outcomes, indicators are measured at different times, such as at baseline (i.e., just prior to implementation of or exposure to the intervention) and at one or more follow-up points after intervention, and then compared.

Data sources may be primary or secondary. Primary data are collected specifically for M&E purposes, while secondary data are collected by one's own organization or another organization for other purposes (see examples in Table 2, on page 53). Public use data are secondary data collected by third parties with the intent that other organizations will use the data. In selecting data sources, it is necessary to consider the data's accessibility, quality, timeliness, and completeness.

M&E designs commonly used in evaluation of LTSS programming include pre-test/post-test and time series. A pre-test/post-test design assesses key indicators at baseline and one or more time points after program implementation or exposure. A time series design assesses indicators at multiple time points before and after implementation or exposure. M&E may include data collection with, or about, those who receive the LTSS intervention (i.e., the intervention or

Table 1. M&E Planning Table Template, with Examples

a. (SMART) Objective	b. Indicator(s)	c. Data Source(s)	d. Design / Data Collection Methods	e. Data Collection Timing	f. Responsible Parties for Data Collection & Analysis
Process Evaluation					
EXAMPLE: In 2018, provide 4 in-home coaching sessions in self-care, home safety, and medication management to 400 Medicare beneficiaries being discharged from the hospital	Number of Medicare beneficiaries who receive any coaching sessions Number of Medicare beneficiaries who receive 4 coaching sessions	Program log	Staff member completes log indicating each participant's session dates	Every time a coaching session is provided	Coaching staff collect data Data Analyst conducts analyses
Outcome Evaluation					
EXAMPLE: Decrease of 20% in 30-day hospital re-admissions by end of 2018, for the 400 in the program	Rate of 30-day hospital readmissions	Health plan claims database	Design: Pre-/post with a comparison group Methods: Health plan provides a data file with patients meeting agreed upon criteria	Baseline rate: 2017 data; follow-up rate: 2018 data Data files to be obtained on a quarterly basis with a 1-quarter lag period	Program Director negotiates arrangements to obtain database files Data Analyst conducts analyses

Source: Solomon Consulting, 2017.

treatment group), or both the intervention participants and a well-matched comparison group that receives either no intervention, the existing standard of care, or an alternate intervention. Comparison groups may be formed through randomly assigning individuals to intervention or comparison conditions; partnering with other organizations to identify similar program or service populations; or using secondary data sets with existing records to identify similar health plan or community members.

Many **data collection methods** commonly employed to monitor and evaluate LTSS programs and services are quantitative, such as those that include multiple-choice items in surveys and secondary analyses of administrative or financial databases. However, keep in mind that qualitative methods, such as semi-structured interviews and focus groups, and including open-ended survey items, can provide key insights into why and how interventions achieve, or fail to achieve, their objectives.

Data collection timing includes when to initiate data collection and the frequency of data collection. In determining this, factors to consider are the timing of clients' participation in the program or service undergoing M&E; the expected time lapse for measurable change to occur; the time needed for data held by partners

'Once an M&E plan is complete, it is important to budget for M&E activities.'

or third parties to be made available; and reporting deadlines with funders or partners.

Responsible parties for key data collection and analysis tasks should be identified in the M&E plan. This helps to ensure that appropriate resources are available for M&E efforts.

Once an M&E plan is complete, it is important to budget for M&E activities. Costs to consider include human resources; hardware and software; information systems needed for data collection, analysis, and reporting; any incentives for clients and comparison group members to provide data via surveys, interviews, or focus

groups; and any fees for obtaining secondary datasets for analysis.

Step 2: Execute agreements

In Step 1, CBOs often determine that partner organizations, third-party organizations, and-or consultants will have a role in the M&E process. Executing agreements with these parties is essential to define roles and responsibilities and to see that M&E activities can be carried out legally. Common types of agreements include contracts, memoranda of agreement, data use agreements, and HIPAA business associate agreements. If the evaluation activities can be considered research with human subjects as per federal definitions, then evaluation plans also may need to be reviewed by an Institutional Review Board (IRB; see goo.gl/QedSyB for further details).

Table 2. Examples of M&E Data Sources for LTSS Organizations

Data Source	Examples of Information Provided
Primary Sources	
Client/patient satisfaction survey	• Satisfaction with care or services • Recommendations for improvement
Client/patient behavioral survey	• Knowledge, attitudes, intentions, skills, and behaviors
Observational checklist (completed by staff)	• Client's skills at engaging in tasks (e.g., self-care) • Safety of the home environment
Focus groups or interviews	• Satisfaction with care or services • Recommendations for improvement • Knowledge, attitudes, intentions, skills, and behaviors
Private Secondary Sources	
Administrative or financial databases	• Client/patient demographic information • Services provided • Cost of services
Electronic health records	• Medical history • Diagnoses • Treatment plans
Public Use Secondary Sources	
Health Resources and Services Administration (HRSA) Area Health Resource Files (goo.gl/PmfNe7)	• At the national, state, and county levels: • Hospital utilization • Hospital expenditures
Centers for Medicare & Medicaid Services Geographic Variation Public Use File (goo.gl/TEKRCB)	• At the state level, hospital referral region level, and county level, for the Medicare fee-for-service population: • Demographics • Spending • Utilization • Quality indicators
U.S. Census (goo.gl/aW7whS)	National, state, county, and local demographics

Source: Solomon Consulting, 2017.

Step 3: Develop data collection tools and train staff

When the M&E plan includes collection of primary data, the most efficient and useful approach often is to adopt validated tools that have been shown in other M&E projects or research studies to yield high-quality data. However, such tools may not be publicly available, may not address the right objectives or indicators, or may not be appropriately tailored to the populations that will be engaging with them. In these situations, existing tools will need to be adapted or, in some cases, new ones developed from scratch. When adapting instruments for use with clients, consider cultural and linguistic background and literacy level. Pilot-testing draft instruments can provide key information about issues that should be dealt with before the instruments are fully deployed.

If staff will be conducting surveys, interviews, or focus groups with clients, administration protocols should be written down, and staff should be trained in their use. This can help to promote data quality and completeness, as well as support protection of clients' or patients' privacy and confidentiality during the data collection process.

Step 4: Implement and monitor data collection

Once data collection is underway, it is crucial to monitor the process and ask: Are we obtaining the expected data? If not, why, and how can we address challenges? Can data collection procedures be further streamlined without compromising data quality and completeness? Proactively responding to data collection issues helps to produce high-quality data and confidence in M&E findings.

Step 5: Manage, analyze, and interpret the data

Once collected, the data need to be managed, analyzed, and interpreted. Data management involves data storage, organization, cleaning, and protection. A team, which might include a program manager, data analyst, and information technology

specialist, should determine the best data management procedures for a particular M&E effort.

In M&E of LTSS programming, data analysis and interpretation commonly focus on whether changes over time, or differences between intervention and comparison groups, were likely due to chance, or to the LTSS intervention and-or other factors. Analysis and interpretation should also aim to identify the reasons for negative findings, such as incomplete service delivery or a challenge with data collection. While analysts who specialize in specific methods and types of data generally conduct data analysis, a broader team that may include service staff, partner agency representatives, and members of the beneficiary popula-

---

Having an M&E communications and use plan can help with dissemination and use of findings.

tion should interpret findings. Interpreting the data appropriately may require a wide variety of information and experience.

Step 6: Communicate and use the findings

Investing resources in M&E is only worth it when findings are used to improve services; demonstrate value to stakeholders (e.g., program staff, boards of directors, partner organizations, funders, program beneficiaries, and community members); and, where appropriate, inform policy and practice in the broader field. Having an M&E communications and use plan can help with findings dissemination and use. This plan should summarize the purposes for sharing findings; the target audiences; what is to be shared, and how and when it will be shared; and the resources needed to carry out the intended communications. A sample communications and use plan template, with an example, is provided in Table 3 (see page 55).

We know that the content and format of communications about findings should be tailored

Table 3. M&E Communications and Use Plan Template, with Example

1. Objective for communication/ use of findings	2. Audience(s)	3. Information to be shared	4. Formats/Media	5. Timing	6. Responsible Parties
EXAMPLE: Demonstrate to our new payer partner that our services provide the value that we have promised	Team of 3–5 representatives of healthcare payer partner organization	Description of services provided Number of payer's patients served Hospital readmission rates: pre and post, among payer's clients and a comparison group	Factsheet (on website and sent via email) Ppt. presentation to payer stakeholder group	February 2019 for factsheet posting and Ppt. presentation	Communications Director: Oversees materials development Data Analyst: Provides data content Director of Development: Reviews materials and coordinates meeting with payer

Source: Solomon Consulting, 2017.

to specific audiences. But research has shown that certain common elements can make reports, slide sets, fact sheets, and other data presentations more effective, regardless of the audience. Evergreen (2014) and Evergreen and Emery (2014) provide information on graphics, colors, and arrangements that can maximize the impact of data presentations and promote data use.

Getting the Most Out of M&E

It can be challenging to carry out all of these M&E steps, particularly in an environment in which resources for service delivery are already limited. It is essential to remember that M&E can help organizations to use their resources more effectively, to better serve older adults and the broader community, and to secure and maintain partners and funders. Engaging everyone in the organization, from board members to line staff, in understanding, contributing to, and using M&E can create an organizational culture that will help to maximize the benefits of monitoring and evaluation efforts. 🖋

Julie Solomon, Ph.D., is principal and a member of J. Solomon Consulting, LLC, a program evaluation consulting company in Mountain View, California. She can be reached at julie@jsolomonconsulting.com.

References

Evergreen, S. S. H. 2014. *Presenting Data Effectively: Communicating Your Findings for Maximum Impact*. Thousand Oaks, CA: Sage.

Evergreen, S., and Emery, A. K. 2014. "Data Visualization Checklist." goo.gl/nebc9u. Retrieved September 27, 2017.

Markiewicz, A., and Patrick, I. 2016. *Developing Monitoring and Evaluation Frameworks*. Thousand Oaks, CA: Sage.

Miller, E., Nath, T., and Line, L. 2017. "Working Together Toward Better Health Outcomes." goo.gl/kmk15Z. Retrieved September 27, 2017.

Patton, M. Q. 1997. *Utilization-Focused Evaluation: The New Century Text*. Thousand Oaks, CA: Sage.

Shier, G., et al. 2013. "Strong Social Support Services, Such as Transportation and Help for Caregivers, Can Lead to Lower Health Use and Cost." *Health Affairs* 32(3): 544–51.

The SCAN Foundation. 2015. "Transforming the System of Care for Older Adults: The Affordable Care Act Five Years Later." goo.gl/C5H9DP. Retrieved September 27, 2017.

Building a Strong Nonprofit Board
Goes Beyond Best Practices

By Gayle Northrop

Board evolution involves changing how board members think, act, and interact with one another.

As president of Northrop Nonprofit Consulting, I have worked with nonprofits and nongovernmental organizations around the world on strategy, organization development, governance, and change management. From my experience, I have learned that despite significant differences in the context and communities in which nonprofit boards work, the fundamentals of building a strong board are the same across all types of nonprofits. I hope that the information in this article will resonate with and prove valuable to readers striving to build partnerships between community-based organizations (CBO) and healthcare entities.

Board Stages of Development

"Boards are not—and should not—be static. To be effective, they must change and evolve as their organizations change and grow" (Board-Source, 2017a). This is as much the case in the healthcare space as any other segment of the nonprofit sector, and I have certainly found it to be true in my twenty years of working with nonprofit boards. On the other hand, best practices in governance—a set of structures and activities that boards should consistently implement—does connote something static, or rigid. Can the same set of best practices be applied to boards at different stages in their development? I would argue that not only can they be applied, but also that nonprofit leaders can use many of these practices to help move their organization through the development stages.

BoardSource, the leading organization in the United States focused on strengthening and supporting nonprofit board leadership, describes the following stages in a nonprofit board's development or lifecycle: Organizing/Founding; Governing; and Institutional (BoardSource, 2017a). In each stage, boards tend to have common characteristics, and experience similar challenges and strains, regardless of the type of organization or scope of its operations. Understanding these stages and the common passages or transitions between them can give nonprofit leaders perspective about where their board is in relation to other boards and stages, provide relief in knowing they're not alone in what they are experiencing and, in some cases, motivate urgency to accelerate their organization's transition to the next stage.

➜**ABSTRACT** The fundamentals of building a strong board of directors are relevant across the nonprofit sector, and most boards go through three stages: Organizing/Founding; Governing; and Institutional, which do not necessarily correlate with the amount of time since the board's founding. Boards need a governance committee and an established assessment process, as well as a plan for cultivating diversity. | **key words**: *board governance, board growth, board development, board diversity, best practices*

Recently, I led a governance training in which participants spent time exploring both of these ideas—best practices and stages of development—and determined that the board in question is a Founding Board, in the process of transitioning to a Governing Board. In learning about the stages, the group said they took great comfort in knowing that what they were experiencing is typical, and even greater comfort in learning best practices that would ease them into the next phase.

It is important to note that the stages of nonprofit board development do not necessarily correlate with the length of time since an organization's founding; I have worked with Organizing/Founding Boards that have been serving the community for more than thirty years, and with Governing Boards that are within a few years of starting up. While organizations may function effectively and for extended periods of time in one phase, the fact that boards should not be static remains true: boards must grow and evolve to meet the changing needs of an organization and clients it serves.

Best Practices for Board Growth and Development

Which best practices can help a board grow and move from one stage to another? Performing an intentional strategic planning process and then using the new strategic plan are key. When an organization's mission, strategy, and priorities are clear, the makeup of the board to support that strategy also becomes clear. A strategic plan ensures that changes to the board (particularly board composition) are not only aligned with an organization's mission and goals, but also allows making those changes to be less personal.

One of the most valuable practices for evolving and building a board is to have a designated Governance or Board Development Committee. The most obvious reason is that this committee has the following fundamental responsibilities that pertain to good governance:

√ Helps create and clarify board roles and responsibilities;

√ Pays attention to board composition;

√ Facilitates board orientation (also known as on-boarding), education, and exit;

√ Encourages board development and supports board engagement;

'Boards must grow and evolve to meet the changing needs of the organization and clients they serve.'

√ Assesses and addresses individual and collective board effectiveness; and

√ Ensures strong board leadership and succession.

Sometimes boards can perform these functions without a Governance Committee, for example through an Executive Committee. I have found, however, that all too often these functions get lost in the hierarchy and prioritization of more pressing issues and thus tend to be neglected. A Governance Committee gives the board and executive management a forum and a vehicle for dealing with questions about tough board issues, such as the following:

√ Should we institute term limits?

√ How can we be more responsible and accountable for our own effectiveness, meetings, and functioning?

√ Is it time to encourage our board chair of many years (or any other board member) to move on?

√ How can we stop discussing and instead begin bringing on more diverse, more fundraising-focused, more [fill-in-the-blank] board members?

A Governance Committee can be hugely helpful in addressing these and other issues that relate to board functioning and effectiveness.

Other Drivers for Board Change

Another key lever for driving board change is a formalized board assessment process. Accord-

ing to BoardSource's most recent "Leading with Intent" article, only a slight majority (51 percent) of organizations report using a formal evaluation instrument to assess their board effectiveness, despite it being a best practice (BoardSource 2017b).

Some boards conduct self-assessments that ask members how they feel the board is doing—what is going well and what they think needs to be improved in terms of board effectiveness. This is the S-W of a SWOT analysis—the assessment of an organization's internal environment, its Strengths (S) and Weaknesses (W), coupled with an analysis of the external environment, the Opportunities (O), and the Threats (T) the organization faces. That kind of assessment gathers board members' impressions and perceptions of board effectiveness, rather than evaluating the board against what the board should look like or be doing—i.e., against governance best practices.

Of the many best practices commonly discussed in governance articles, websites, books, and blogs, knowing the roles and responsibilities of board members is probably the most important information for nonprofit leaders. At any stage in its development, there are ten basic responsibilities of a nonprofit board (Ingram, 2015), as follows:

Determine mission and purpose. It is the board's responsibility to create and review a statement of mission and purpose that articulates the organization's goals, means, and primary constituents served.

Select the chief executive. Boards must reach consensus on the chief executive's responsibilities and undertake a careful search to find the most qualified individual for the position.

Support and evaluate the chief executive. The board should ensure that the chief executive has the moral and professional support he or she needs to further the goals of the organization.

Ensure effective planning. Boards must actively participate in an overall planning process and assist in implementing and monitoring the plan's goals.

Monitor and strengthen programs and services. The board's responsibility is to determine which programs are consistent with the organization's mission and monitor their effectiveness.

Ensure adequate financial resources. One of the board's foremost responsibilities is to secure adequate resources for the organization to fulfill its mission.

Protect assets and provide proper financial oversight. The board must assist in developing the annual budget and ensuring that proper financial controls are in place.

Build a competent board. All boards have a responsibility to articulate prerequisites for candidates, orient new members, and periodically and comprehensively evaluate their own performance.

Ensure legal and ethical integrity. The board ultimately is responsible for adherence to legal standards and ethical norms.

Enhance the organization's public standing. The board should clearly articulate the organization's mission, accomplishments, and goals to the public and garner support from the community.

How well do boards fulfill these responsibilities? Most boards are pretty effective when it comes to legal and fiduciary oversight, often because nonprofit boards recruit people from the private sector who have expertise in these areas, and the skills are highly transferable. Organization and management oversight tends to be more of a mixed bag. Boards generally perform well when it comes to strategy and program management oversight, but not as well in monitoring program strength or holding management accountable for impact assessment. And, from my experience, boards tend to perform poorly the important job of regularly evaluating the organization's executive director.

My toughest critique, though, involves the fundraising side. In my years of doing this work, I do not think I have met an executive director who does not want more fundraising efforts from

his or her board, nor have I encountered a board that feels it is maximizing its fundraising potential. The "Leading with Intent" survey data back up my impressions, including my observation that boards continue to struggle with the fundraising role. The article also notes a critical, persistent gap in nonprofit boards: board diversity. The latest survey reveals that not only are boards still struggling with the issue, but also the problem is getting worse (BoardSource, 2017b).

How to Cultivate Board Diversity

How then can boards use best practices to address the persistent issue of lack of diversity and other issues of board evolution? Establishing board member terms can help. Terms are simply a length of service, or minimum number of years that the member commits to board service. Terms usually range between two and six years; three-year terms are the most common.

If implemented properly, terms force a board (usually via its Governance Committee members) to have regular conversations with each board member about his or her board performance,

engagement with the organization, and interest in continuing to serve. For members who have been missing meetings, not contributing financially (if that is a requirement), or not fulfilling their role in other ways, the end of a member's term is the ideal time to have what I call a

A key lever for driving board change is a formalized board assessment process.

"grown-up conversation." While sometimes uncomfortable, these conversations should lead to the person either leaving the board or stepping up their level of engagement.

Term limits can be a more conflicting, complex issue. Term limits limit how many consecutive terms a board member can serve (usually two), and they are a best practice. Term limits help prevent the accumulation of power in one individual over the rest of the board; they help the board keep up with and adapt to changing times; they force change, often helping to bring

new talent, skills, and perspectives to the board; and they help prevent burnout by eventually moving everyone off the board. In the earliest possible stage of development, term limits should be instituted and codified in a nonprofit's bylaws.

However, when an organization's executive director or board member tells me that their board needs to institute term limits—because they want to remove a member who is not contributing, has been around too long, is not helpful, or worse yet, is toxic—they hate hearing that term limits probably will not solve their problem,

---

Not only are boards still struggling with diversity, but the problem is getting worse.

---

at least quickly. The challenge lies in the fact that the board that is trying to evolve, in this case by instituting term limits, is the same body that has to discuss, debate, and ultimately approve the term limits. Too often these conversations drag on, or become contentious or personal, and eventually those leading the change effort lose the will to fight. Instead of focusing on term limits, I encourage boards to use board terms and the "grown-up conversation" strategy to nudge stagnant members off the board. Once the board has done this and been able to transition and evolve a bit, it is easy to implement term limits.

The more time I spend in the nonprofit sector and the more organizations I work with, the more I see that not only do best practices apply in all stages of an organization's development, but they also apply across types of organizations (e.g., direct service, advocacy, membership) and fields (e.g., human service, education, social justice, health). I also have seen that beyond best practices, board evolution is about leading change—changing the way people think about things, do things, and interact with one another—and this is the tough part. But if a nonprofit board can consistently reflect on its purpose and evolve, it will be well on its way to building board strength.

Conclusion

Nonprofit boards move through different stages of development and must evolve and grow as their organizations grow. Governance best practices should be implemented by boards at every stage of development and are a key lever to help nonprofit boards transition to the next phase. Being clear on roles and responsibilities, establishing a governance committee, instituting terms and term limits, and using a formal board assessment process will strengthen both the board and the organization to ensure quality service delivery and mission fulfillment.

Gayle Northrop, M.B.A., is the president of Northrop Nonprofit Consulting and a lecturer and senior faculty advisor at UCLA Anderson School of Management in Los Angeles, California, where she teaches social entrepreneurship, impact measurement, and nonprofit governance.

References

BoardSource. 2017a. "Board Passages: Three Stages in a Nonprofit Board's Lifecycle." goo.gl/z1g5u5. Retrieved October 15, 2017.

BoardSource. 2017b. "Leading with Intent." goo.gl/hfcFFx. Retrieved October 15, 2017.

Ingram, R. T. 2015. *Ten Basic Responsibilities of Nonprofit Boards* (3rd ed.). Washington, DC: BoardSource.

Understanding Costs: How CBOs Can Build Business Acumen for Future Partnerships

By Victor Tabbush

Comprehending the meaning and financial implications of numerous economic principles will serve CBOs well in new partnerships.

Community-based organizations (CBO) must possess business acumen if they are to engage in mutually beneficial commercial partnerships with medical-sector entities such as health plans, Accountable Care Organizations, and hospitals. Business acumen means keenness and quickness in understanding and dealing with a business situation to achieve a favorable financial outcome. CBOs face business situations and decisions that almost always involve cost considerations. Knowing what costs are relevant to a business decision, how to assess these costs, and how they might change or be shaped, are fundamental considerations for making wise choices. This article will attempt to convey this knowledge.

Costs for Financial Reporting Versus Costs for Decisions

We need to think differently about costs than in the way they are typically compiled for reporting by a CBO's accounting or finance department; specifically, there are four differences.

First, CBOs' financial departments generally report costs to satisfy financial reporting requirements of donors, parent organizations, and regulatory bodies. As a result, cost accounting systems are not usually designed to support management decisions.

Second, when reporting costs, financial systems array them by categories such as operating costs, marketing expenses, overhead, staff benefits, etc. What often is needed instead is an expression of costs by the specific service line or program that triggers them. Furthermore, management decisions often require that costs be calculated on a per-unit basis—such as cost per service, cost per client, or cost per case. Traditional accounting systems, on the other hand, express costs on a per-period basis: costs per quarter or per annum.

➜**ABSTRACT** Almost every business decision considered by a community-based organization (CBO) requires accurate costs assessment. This is imperative when setting fees with a healthcare partner—a poor understanding of costs can lead to the CBO's financial ruin. For wise financial decisions, costs must be expressed to support management decisions: as a function of volume rather than per time period. CBOs must understand and apply the distinction between fixed and variable costs, breakeven analysis, the concepts of scale and scope economies, and the learning curve. **|** **key words**: *fixed and variable costs, breakeven analysis, scale and scope economies, community-based organizations*

Third, costs that accountants report tend to be historical—meaning already incurred costs. But what is often required is to know what something will cost in the future.

Fourth, traditional cost accounting systems do not differentiate between fixed and variable costs. Ignoring this distinction conceals information useful for making sound financial decisions; observing it allows the deployment of a vital business tool called breakeven analysis (BEA).

CBOs often need to express costs by the specific service line or program that triggers them.

Distinguishing Fixed from Variable Costs

A familiar dichotomy is that between fixed and variable costs. This cost terminology often is used, but people often forget the crucial modifier: with respect to volume.

A fixed cost is one that does not change regardless of what happens to the volume of an activity. An example of a fixed cost would be the capital expense to equip a kitchen facility to produce home-delivered meals. This equipment expense likely will be the same regardless of how many meals are actually delivered—at least within a reasonable range of volume.

A variable cost is one that rises in rough proportion to the volume of the activity. As the number of meals rises, so will the cost of the ingredients used in the meal preparations. This distinction is important when considering the wisdom of scale and scope expansions: a high ratio of fixed to variable expense means that per unit (total) costs diminish with expansion. This tends to make expansion more attractive. It also exposes the risk from volume falling short of expectations and then failing to cover those fixed expenses.

Breakeven Analysis

As CBOs formulate plans to contract with healthcare partners, they will need to be astute in assessing the financial terms. Being able to conduct BEA will assist CBOs in assessing the possible financial rewards and risks they face. To conduct BEA requires arraying costs as a function of the volume of a specific service provided. The service could be care transitions, or home-delivered meals, or non-emergent transportation. This manner of expressing costs as a function of volume is necessary to accurately assess the terms of a contract with a healthcare partner.

BEA calculates the volume of a service that, were a CBO to provide it, it would neither make nor lose money. Put another way, the breakeven quantity (BEQ) occurs where total costs (fixed and variable costs, combined) are just equal to total revenues. If the actual volume of the service delivered exceeds the BEQ, money is made; if the actual volume falls short of the BEQ, money is lost. So when CBOs forge contracts, they need to know not just the price they will receive, but also the service volume to expect from the healthcare partner. With significant fixed costs, CBOs must be assured they will be asked to provide sufficient volume to warrant the financial outlay.

The Benefits of Scale

When fixed costs exist, a CBO may be in a favorable position to capture the financial benefits of expanding the scale of a program. Economies of scale exist when the per-unit cost of a service diminishes as volume expands. With an expanding scale, the fixed costs become spread over ever larger volumes—reducing the per-unit cost. The existence of economics of scale can be a crucial factor in pricing services: the CBO could consider stimulating additional volume through the offer of a concessionary price with the knowledge that the added volume will drive costs down. How to drive volume? Aggressive marketing and attractive pricing are sensible strategies when economies of scale are present.

Economies of Scope

Another economic phenomenon worth knowing about—economies of scope—is similar to econo-

The Breakeven Analysis Calculation

All a CBO needs to know to make the BEA calculation are just three numbers: the **total fixed cost** (TFC); the **average variable cost** (AVC); and the **revenue per unit** (R).

The breakeven quantity (BEQ) is derived by setting total costs equal to total revenues and solving for the volume that achieves this breakeven position.

The resulting formula for the BEQ is:

$$BEQ = \frac{TFC}{R - AVC}$$

This makes intuitive sense: R – AVC is the contribution to fixed cost that the sale of each unit makes. The fixed cost is then fully covered when the volume sold multiplied by the contribution per unit equals that fixed cost.

Let's take a hypothetical example. Suppose the numbers are as follows:

TFC: $10,000; R: $250; AVC: $100:

$$BEQ = \frac{\$10,000}{\$250 - \$100} = 67$$

mies of scale, but scale means more of the same and scope means a wider variety. This example illustrates the distinction: If the volume of one service quadrupled and it results in less than a quadrupling of costs—that is scale economies. (Costs do not rise proportionately because an element of cost, the fixed portion, does not rise.) With scope economies, the context is not one of expanding the volume of a particular service. Rather, the context is of expanding the number of different services—broadening the variety of a service line.

For example, suppose a CBO currently provides just a single non-medical service, such as non-emergent transportation, but is considering expanding the portfolio offerings to include home-delivered meals, a falls prevention program, and housing respite. If the service portfolio quadrupled to include all four services, the overall expense should be less than the total if each service were instead delivered by separate orga-

nizations. What might trigger scope economies? There are at least two possibilities, as follows:

√ Centralized functions such as IT, finance, or marketing do not require four separate systems, but can be shared across all service lines.

√ Services may be complementary, meaning they are typically used together—almost as a bundle. Providing one service may stimulate the demand for another related service. For example, a CBO providing care transitions to a hospital may be able to leverage its relationship by extending its offerings to include transportation to follow-up medical appointments.

Two business implications of economies of scope should be highlighted. One is that specialization by providing a single service may be too costly, and not be a viable business model. To be cost-competitive, a CBO may need to offer an array of services, thereby defraying those fixed expenses across multiple service lines. It may be challenging for other specialized service organizations to compete with one that offers this variety of services.

A second implication is that scope economies may provide the one-stop shopping experience that healthcare partners may find attractive in a CBO because of its contracting convenience—thereby conferring a competitive advantage over specialized providers.

'Specialization by providing a single service may be too costly, and not be a viable business model.'

Costs and the Learning Curve

It was explained above that per-unit costs would decline with volume when fixed costs are significant, thus making larger service volumes more attractive to deliver. Per-unit costs may decline predictably and naturally by virtue of another reason: cumulated experience in providing a particular service. This phenomenon is called the learning curve, or the learning effect. It was first noted in the production of goods, where for

every doubling of cumulated experience, production costs per unit dropped by 20 percent.

The learning effect has also been applied to service businesses. The mechanism for learning resulting in cost reduction is intuitive: proficiency increases with repetition through newly discovered techniques, better training, labor-saving technologies, and more efficient staffing approaches. This added proficiency reduces the input of time required for each unit of service provided. Thus, the more experience—that is, the longer and deeper the history of delivering a service—the lower will be the cost for each unit. The steepness of the learning curve refers to how dramatically per-unit cost declines with experience.

A CBO must recognize that in the early years of a multi-year contract, it may lose money.

Let's take a numerical example based on that rule of thumb that a unit of service will cost 20 percent less after cumulated experience (volume) doubles. What does this mean exactly? Doubling cumulated volume means that if the per-unit cost were $100 for a program that has delivered 100 units of service, when it delivers that 200th unit, cost will be just $80 per unit—a 20 percent reduction.

Note that cumulated volume is not the same as the quantity of a service delivered per unit time. The quantity of a service delivered per unit time is the rate of service delivery—the number of care transitions in a year, for example. Cumulated volume, in contrast, has no time dimension. It refers to the number of such transitions that have been conducted over the many years of the CBO's experience.

It is crucial for a CBO to account for the learning effect and to build it into its financial calculations and decisions. For example, when a CBO conducts a pilot program for a new service, it is often for the purpose of assessing its cost once implemented. Knowing that costs will cer-

tainly drop if and when the pilot is implemented and brought to scale, the service can be budgeted and priced appropriately. But even if the service were not part of a pilot offering, the CBO should still consider the learning effect when budgeting and setting a price. It must recognize that in the early years of a multi-year contract, it may lose money. Later, however, that loss can be recovered as the learning that comes with cumulated experience will drive down per-unit costs.

To maximize learning, an organization needs to create a culture where learning is an explicit goal, is formally documented, and is deliberately shared. Even if learning does become diffused throughout an organization, there will be key individuals that have exceptional proficiency gained through deep experience. The organization needs to exert strong retention efforts to ensure these employees' continued tenure and loyalty A CBO can also attempt to accelerate down the learning curve by hiring experienced individuals from other organizations.

Conclusion

CBOs need to look beyond the standard income statement method of expressing costs by line items and in terms of a period of time. To support sound management decisions, costs need to be divided between fixed and variable components: they also need to be arrayed by program, by volume, and by cumulated experience. Understanding the meaning and financial implications of breakeven analysis, scale and scope economies, and the learning effect are crucial aspects of building CBOs' business acumen.

....

Victor Tabbush, Ph.D., is professor emeritus at the UCLA Anderson School of Management in Los Angeles, specializing in healthcare economics, healthcare leadership, and management capacity-building. Since 2012, he has worked with The SCAN Foundation to build the management and leadership capacity of community-based organizations that provide long-term services and supports to older adults and disabled individuals.

Shifts in Mindset and Practice Are Key to Cross-Sector Partnerships

*By Erin Lockwood and
Lori Peterson*

New ways of thinking, behaving, and working are necessary to succeed in today's complex healthcare terrain.

Our healthcare system can and should be better. As the value-based care delivery movement accelerates, this sentiment is echoed throughout organizations in all segments of the healthcare sector; however, for many working in healthcare, it is unclear how any single organization can effect change for a better future—one in which all people receive high-quality, person-centered, and cost-efficient care. The disconnect between the challenges the system faces and workable solutions stems from the fact that the underlying problems are not merely complicated but complex—hard to solve and riddled with unknowns, dependent upon interrelated factors, and often resistant to replication.

Rooted in this complexity is the reality that improving the health of a population not only is influenced by people's ability to gain access to high-quality healthcare services, but also is influenced by their economic circumstances, living conditions, diet, and psychological well-being. Addressing just one of these factors is

difficult, but accounting for all of them and understanding the relationships between them is even more so—particularly when these relationships are constantly in flux. As the healthcare landscape changes, solutions to systemic problems also must change. What worked once, under a specific set of conditions, may not be replicable or produce predictable outcomes. This leads many to ask how we can achieve improvements to the healthcare system.

The answer sounds deceptively simple: A paradigm shift.

A New Paradigm: Partnerships Can Drive Positive Change

For such a paradigm shift to occur, old ways of thinking and working must be replaced. Working in such a complex terrain requires shifts in mindset, approach, and strategy. It requires a fundamental change in mindset from "my patient" to "our population" and a redefinition of health that extends beyond medical care to

➜**ABSTRACT** Experts agree the healthcare system has the potential to be better, but achieving this aim requires moving beyond current approaches to address complex issues. Cross-sector partnerships are a promising but complicated strategy for improving the system. To partner successfully, organizations must be willing to adopt new mindsets and approaches, believing in the strategy of cross-sector partnership, adopting new perspectives about the healthcare system, and accepting that the process of partnering does not come with a standard playbook. **|** **key words**: *cross-sector partnership, social determinants of health, transformation, shifts in mindset*

incorporate overall well-being and considers the social, environmental, and behavioral determinants of health.

Shifts in leadership style and approach are necessary, with leaders using influence and leverage rather than control because addressing the challenges within the healthcare system necessitates collaborating with multiple organizations and across the sectors, and integrating programs and services to get better results. Thus, organizations' strategies also must evolve so as to create strong partnerships across the medical and social sectors, uncover points of alignment, establish a common language, and explore new ways of working together to fulfill a shared vision.

What worked once may not be replicable or produce predictable outcomes.

Cross-sector partnerships have shown great potential for shaping meaningful change in the healthcare system. But cross-sector partnerships come with their own sets of complexities. Vital for success are partners' abilities to embrace new mindsets and approaches that go beyond a partnership's structural elements. Once the mechanics of a partnership are established, the focus must then move to fully optimize the dynamics and relationships among individuals responsible for bringing the partnership to fruition in order to accelerate (and not derail) partnership strategies.

In the articles that follow in this section, three community-based organizations (CBO) share stories of pursuing cross-sector partnerships with healthcare entities. They describe the internal shifts in mindset, strategy, and approach that allowed them to successfully secure partnerships to meet their goals of forging a better healthcare system for the communities they serve. Each organization addresses, from their unique perspectives, the question underlying

these partnerships: Are there clear indicators or actions to take to ensure success?

While the answer to this question is a resounding yes, there is no standard playbook, checklist, or number of steps that guarantee success. Instead there are subtle adjustments in ways of thinking, behaving, and working that tend to produce noticeable results and distinguish those organizations that achieve successful partnership models and outcomes from those that do not.

Common Shifts in Thinking and Ways of Working

The first common shift in mindset is a need to believe in cross-sector partnership development as an effective strategy. This belief must be backed by a deep understanding of the health and healthcare needs of the population being served, and be shared with other providers in the community. The second shift is to adopt new perspectives about the healthcare system that challenge long-standing narratives by learning to understand the system as a whole and not merely in disparate parts. The third shift is to fully accept that a cross-sector partnership strategy comes with no standard playbook. Despite this fact, organizations must act and evolve. As the articles that follow demonstrate, each of these mindset shifts can produce changes in behavior and ways of working that propel CBOs toward their desired outcomes.

Believe in the potential of cross-sector partnerships

Developing a firm belief in cross-sector partnership development as a strategy for improving the healthcare system also means believing that those involved have a strong role to play and can bring value to any partnership. When an organization holds this belief, a positive influence resonates throughout and encourages active pursuit of cross-sector partnership development; this strategy would otherwise be hard to achieve if pursued solely out of obligation or the belief that

it would lead to nothing more than grant funding. Learning from CBOs that have achieved success through cross-sector partnerships can help cultivate this belief. The important next step is for an organization to ready itself for partnership.

CBOs can evaluate their readiness to operate on an equal footing with healthcare organizations through conducting an internal readiness assessment. In this process, CBOs assess capacities for leadership, adaptability, operations, financial management, data collection, and business development, gaining insight into how they can develop new skills suitable for partnerships. Organizations that take assessment results and seek change and growth within needed areas exhibit shifts that often lead to success.

'There is no standard playbook, checklist, or number of steps that guarantee success.'

Some organizations need to develop an understanding of costs and pricing, others must establish how to collect and analyze data, and others require staff-level skills development. Regardless of the need, the value of assessment lies in responsive action. Understanding organizational readiness for partnering empowers CBOs to make the specific changes necessary, which in turn reinforces a belief in successful cross-sector partnering.

See the system as a whole

Learning to see the healthcare system from others' perspectives allows for a more clear understanding of the problems facing the population being served, how a range of organizations in the health and social sectors aim to address those problems, and the changing dynamics that might help or impede partnership success. With this holistic view, CBOs might gain perspective on how disparate organizations, programs, interventions, or solutions could come

together and-or combine to influence the most optimal outcomes.

CBOs seeking to better understand the system typically educate themselves on key trends, policies, and programs that affect and motivate healthcare organizations and shape the current environment. They learn about organizations across the health and social sectors that share similar missions, visions, and goals, that serve similar populations, and address similar challenges. Further they learn about these organizations' leadership, operations, programs, outcomes, and impacts. Often they connect with these organizations to find points of alignment, exploring new ways of working together to implement a shared vision for a better system. Thus constantly challenging outdated opinions and perceptions accrued from past experience.

Act! (even without a playbook)

Leaders of an organization must realize and accept there is no simple guide or established playbook that will help them through the process of preparing, designing, securing, and implementing a cross-sector partnership. Instead, they must develop a new understanding that they rely on many factors and considerations that are not universal for every organization or partner, or the communities they serve. CBOs need to understand their communities by researching their unique populations' specific needs, priorities, and characteristics, and by recognizing that each potential partner organization has separate motivations, systems, and culture—all of which can affect the success and sustainability of a partnership.

Acting in the absence of a playbook puts the onus on a CBO to think beyond traditional practices and boundaries of business as usual. It involves engaging multiple stakeholders in every aspect of the strategic thinking and planning process, whether this means their frontline staff, representatives of other organizations, and-or members of the community likely to be

affected by the partnership. By incorporating multiple points of view, the resulting partnership aligns with what is needed, rather than adhering to one organization's belief in what might work.

Though potentially daunting to act with no playbook, transformation is possible when

---

Transformation is possible when a CBO embraces learning and experimenting, and even the risk of failure.

---

a CBO embraces learning, experimentation, and even the risk of failure. Embracing these tenets can open an organization to new ways of working that encourage innovation in the partnership design process, and allow for the development of partnerships that meet all the parties' needs and interests. Ideally, organizations that succeed create the playbook collaboratively,

working through challenges to arrive at mutually beneficial changes, and designing new care models that can be delivered effectively in their communities.

Ultimately, the next step is for CBOs to accept that new ways of thinking, behaving, and working are necessary to thrive in today's complex landscape. In doing so, they can play an important role in achieving meaningful and much needed improvements to our nation's healthcare system.

Erin Lockwood is a consultant with Collaborative Consulting in Columbus, Ohio. She can be contacted at erin@collaborativeconsulting.net*. Lori Peterson, M.A., is founder and CEO of Collaborative Consulting in San Francisco, California. She can be contacted at* lori@collaborativeconsulting.net*. Collaborative Consulting was a technical assistance provider for The SCAN Foundation and Colorado Health Foundation Linkage Lab Programs.*

Business Acumen in Government:
One County AAA's Healthcare Integration Experience

By Jacob Bielecki

Two new partners expect a lower cost of care for clients and improved overall performance that could migrate to other populations.

Compared to the growing healthcare integration work of many nonprofit community-based organizations (CBO), agencies in local governments are not as commonly known for innovation and entrepreneurialism. This is likely due to a variety of factors—government bureaucracy, risk avoidance, funding restrictions, and changes in elected leadership, which often lead to shifts in philosophical approaches to public service.

Despite these challenges, the Boulder County Area Agency on Aging (BCAAA) in Colorado has experimented with healthcare integration on two fronts—evidence-based wellness classes and care transitions case management. In 2017, BCAAA executed its first service agreements with a local healthcare system and a preventive care benefits management company, via forward-thinking public service philosophies, business acumen development, and relationship-building.

The Building Blocks to Partnership

The BCAAA's ties to healthcare entities have historically been informal. But when Kathy Greenlee, former Assistant Secretary for Aging, and the national aging network began to encourage area agencies on aging (AAA) to turn their energies toward partnering with healthcare entities and building business acumen, agency management took the advice and began identifying opportunities for future partnerships and new business lines. Fortunately for the Community Services Department (which houses BCAAA), its sister departments (Boulder County Public Health and Boulder County Department of Housing and Human Services) were also building partnerships and relationships with the local healthcare system, as a way for Boulder County to address increased enrollment through the state's Medicaid expansion and healthcare exchanges. This included prioritizing the County's role in sup-

➜ABSTRACT Compared to the growing healthcare integration work of many nonprofit community-based organizations (CBO), local government organizations are not known for innovation and entrepreneurialism. Despite common challenges for government agencies to build business acumen and partner with healthcare entities, the Boulder County Area Agency on Aging (BCAAA) in Colorado has experimented with healthcare integration on multiple fronts. In 2017, BCAAA executed its first service agreements with a local healthcare system and a health plan wellness programs broker, via forward-thinking public service philosophies, business acumen development, and relationship-building. | **key words**: *Boulder County Area Agency on Aging, Colorado Health Foundation, Boulder Community Health, business acumen*

porting the bridge between healthcare and the social determinants of health.

BCAAA established its first healthcare partnership in 2011 with an unfunded, year-long care transitions pilot with Boulder Community Health (BCH), a community-owned and operated nonprofit health system that includes twelve primary care clinics and one central hospital. The pilot was successful, reducing thirty-day congestive heart failure patient readmissions by half. In the end, BCH decided to build a new Transitional Care program rather than move from a pilot to a partnership with BCAAA.

To help build business acumen, BCAAA created a new role: Business Results Manager.

Building the team, learning business acumen

In early 2015, to fulfill the aging network's calls to build business acumen, BCAAA created and filled a new role, Business Results Manager. This person would oversee a small team of direct service, advocacy, and compliance staff, liaise with the agency's nonprofit foundation, and help lead the agency's business acumen and healthcare integration efforts.

Fortuitously, at the same time, the Colorado Health Foundation announced its first Colorado Linkage Lab, a business development incubator program for Colorado organizations seeking to build mutually beneficial partnerships with healthcare entities. BCAAA applied for and won entry to the Linkage Lab. Modeled after The SCAN Foundation's Linkage Labs in California, the program provided intensive business and management courses led by nationally recognized subject matter experts (see Westphal article on page 24).

Once BCAAA's Business Results Manager was in place, and the agency had started the Linkage Lab program, the organization's healthcare integration and organizational development efforts accelerated. The Linkage Lab program provided a strong project management frame-

work, MBA-level learning sessions, and ongoing technical assistance that propelled BCAAA's healthcare integration efforts, while challenging staff assumptions and comfort zones.

Using market research to plan strategy

With the available staff capacity to manage integration efforts, and the available expertise and resources to sustain this strategy, BCAAA conducted local and regional market research to understand its local healthcare systems' strategic priorities and challenges, determine most-needed services, identify internal strengths and service lines that could meet those demonstrated demands, and plan a strategy toward building new partnerships.

BCAAA staff met with associates from local health systems—usually mid-level employees who had familiarity with the agency and its trust—and explained the Linkage Lab goals. The agency also began to take its identity and brand more seriously. Prior to this effort, there wasn't an imperative to focus on brand quality or organization image. Now that BCAAA's service orientation was expanding from direct-to-consumer to integrating services with those of other organizations, there was greater emphasis on the agency's business savvy and appearance. It published its first annual report, upgraded its website, refreshed brochures and printed materials, placed a stronger focus on social media and e-newsletters, and updated the mission statement.

Garnering support, creating a model

To build support for the effort, all agency personnel attended workshops at staff meetings, tying the work and mission of the agency into the new business development strategy. This included communicating fiscal projections and needs, exploring their competitive advantage among service providers, diagramming the evolving business model and emerging business cases for the agency, and articulating the ways in which their work contributes to the Triple Aim and addressing the social determinants health.

to begin to understand the healthcare landscape, federal policies and programs, industry language, and where the work of the agency aligns with emerging healthcare partnership opportunities.

Coordinated Leadership Works to Secure the Partnership

BCAAA needed its leadership team also to be engaged in and committed to the project. The agency's Division Manager entrusted the Business Results Manager to take the lead on the project and carry it forward, with additional program managers flanking as necessary. Instead of taking an executive-level approach to initiate dialogue, BCAAA approached the healthcare system with which the agency has had the closest working relationship—and strongest mission alignment—Boulder Community Health. A dialogue was initiated with a community-facing mid-level manager from BCH's care transitions efforts, which established the path toward developing their first formal partnership agreement.

Through skills gleaned in part during the Linkage Lab, BCAAA developed an operational model to determine the scale and associated costs of their new service line. This was then applied to a financial model to determine value based on projected program performance. The agency is now using this model to determine pricing as it plans for a formal launch of the "Next Step" program later in 2018 (see details below). These value proposition and operational modeling tools have been extremely valuable for BCAAA. They solidified the agency's modeling capabilities that have since migrated to other healthcare and revenue-development projects.

Adding the Business Results Manager role expanded capacity and brought new energy to the healthcare integration initiative. Even once engaged in the Linkage Lab, BCAAA had to conduct an enormous amount of market research

BCAAA used the data from its prior care transitions pilot with the health system to reintroduce the idea of partnership and build its business case. Being clear as early as possible about their expectation to be compensated for adding value to BCH's performance objectives made it much easier, when the time came, for the agency to ask for investment in the pilot.

BCAAA had a service concept in mind when approaching BCH, but intentionally left room for flexibility and adaptation. Teams from each organization held educational sessions to clarify BCAAA's work, BCH's challenges, and to

imagine solutions together. Taking a co-design approach with mid-level staff helped to understand which services the health system could benefit from and endorse in partnership.

As the business development and operational leads for BCAAA, the Business Results Manager and Community Living Programs Manager (respectively) led the effort to solidify the emerging partnership with BCH's Directors of Medical-Surgical Nursing, Case Management, and Clinical Integration. Both teams, working together, brought the service line to fruition, determining the client population, workflows, and service parameters.

As the project concept and initial agreements with BCH took shape, the health system shared performance data with BCAAA, which the agency used to identify ways in which it could

It takes political will to explore and create new service integration partnerships in healthcare.

contribute toward improving BCH's readmissions, patient engagement, and post–acute care performance. By tying program performance goals to estimated cost-savings, BCAAA was able to deliver a stronger business case and value proposition to the health system's Chief Financial Officer. The concept and case was then brought to the health system's leadership team, which awarded funding to pilot the current proof of concept. The program has funding, in three equal parts, from BCAAA, the Colorado Health Foundation, and BCH.

In Fall 2017, the agency and BCH entered into a Memorandum of Understanding outlining the service parameters, goals, and expectations to pilot the new program, which is called "Next Step." In the Next Step program, a BCAAA Resource Options Counselor delivers counseling and case management to discharged Medicare beneficiaries in BCH's Comprehensive Joint Replacement (CJR) program. The agen-

cy's client services in the program include a social risk and patient activation assessment; periodic in-person check-ins, communications via telephone, text, and email; community resource navigation; and coordination of supportive social services to encourage stronger connections between patients and available community resources.

Next Step participants receive varying levels of case management, depending upon their care setting, risk assessments, and particular needs for up to ninety days post-discharge. Because of the bigger lower risk pool of the CJR population, the caseload structure reflects more of a population health than intensive case-management model.

Through the Next Step Program, BCAAA and BCH expect to see decreases in avoidable readmissions and post–acute care use, increases in client satisfaction and experience, increases in awareness and use of available community resources, and, due to the expanded focus on social well-being, increases in BCH nurse satisfaction as they focus less on Medicare beneficiaries' social needs and more on their medical needs. Based on the evidence from similar models, and on historical data, the agency and BCH expect these effects will result in a lower cost of care for patients and improved overall performance that could migrate to other patient populations in the health system.

Meeting the Challenges of Securing a Partnership

The BCAAA Linkage Lab project team's ongoing involvement with staff throughout the development process helped to encourage a shared sense of direction, as did holding workshops on tying the agency's services to the social determinants of health and healthier client outcomes.

One of BCAAA's most valuable success drivers was building confidence in how to construct and deliver its business case and value proposition to potential partners. The Linkage Lab modules and expert technical assistants provided key insights, tools, and challenges for the agency's

leadership team in learning how to engage with healthcare partners.

In searching for new partners in healthcare, the BCAAA team saw right away that quite a few healthcare providers were unfamiliar with their agency, its services, and role in the community. To address this, the team created an annual report and diagrams that summarized and clarified the agency's services and activities.

As BCAAA did not have the budget to hire personnel to deliver the new services, it relied upon adjusting the focus of an established Options Counselor and Coleman Model Coach who had contributed to the success of the earlier care transitions pilot. The agency revised its earlier model framework and added assessment and intervention elements to meet the current needs of BCH.

The leadership of the Business Results Manager and Community Living Programs Manager helped to solidify the partnership.

Limited internal IT and healthcare compliance functions also were challenges for the agency. Unaware of the extent to which infrastructures would have to be built to conduct business with new healthcare partners, BCAAA opted to wait until needs emerged. This slowed the development process, but ensured that investments in IT and healthcare compliance enhancements were necessary.

Lessons Learned

BCAAA recommends a few first steps for organizations just starting out on the healthcare integration journey.

Having learned about what it takes to engage in cross-sector partnerships and build internal capacities to do so, BCAAA would have freed up additional compliance staff time to build and embed compliance protocols more responsively, and would have broadened its market research earlier to target and understand the emerging needs of commercial health plans and their accountable care organization partnerships.

Before developing a robust service offering to a potential healthcare partner, it is important to initiate exploratory conversations with healthcare entities and professionals who already know about the activities and outcomes of the organization's services. These conversations can introduce healthcare entities to the idea of partnership and help integrate the possibility of partnership into their planning.

It is vital to create and expand roles inside the organization to take charge of the developmental aspects of the initiative. Doing so can help implement the strategic approach and create the option of building necessary infrastructures for case study research, healthcare and IT compliance, and program monitoring and evaluation. Making the business case to staff can help the organization's culture to buy into new (and, at times, uncomfortable) healthcare initiatives.

While local government-based service organizations embracing healthcare integration opportunities face similar and different challenges than nonprofits, there are paths to success. The political will to explore and create new service integration partnerships in healthcare, and, in the case of Boulder County, having champions within the healthcare community and the internal capacity to conduct market research, solidify relationships, and co-design new service lines are factors that can foster a successful healthcare integration strategy.

Jacob Bielecki, M.Sc., is the business results manager with the Boulder County Area Agency on Aging in Boulder, Colorado.

A Colorado-Based CBO Launches a Pilot to Keep People with Disabilities out of Nursing Homes

By Patricia Yeager

A shift in mindset to seeing the hospital as a customer allowed a complex program to fall into place.

The Independence Center (The IC), in Colorado Springs, Colorado, a state-certified Center for Independent Living, is a civil rights and services community-based organization (CBO) that is governed, managed, and staffed by a majority of persons who have a wide variety of disabilities. The IC's goal is to help people with disabilities shed society's diminished expectations of them and to help them create fulfilling lives. This calls for peer support, role-modeling, information and training, and advocacy.

People with physical disabilities or mental health issues typically first come to The IC for socialization and recreation such as bowling or kayaking; they see that all can participate in having fun. A subset group seeks out additional information and support through participation in support groups. A support group core tenet is to help individuals set goals such as learning to use the transit system, finding housing,

or exploring what assistive technology could be helpful. Additional support includes identifying employment opportunities, accessing programs to support independent living (e.g., home modifications), as well as assessing benefit impacts. Often, consumers will help others by volunteering in the peer support and advocacy programs.

The IC's Roots and Services

The IC began in 1987 as a Medicaid home health agency that catered to people with significant disabilities who did not want to live in a nursing home. The IC hired certified nursing assistants, nurses, and other professionals to provide daily activities of living (ADL) in the home. When home- and community-based services were established as a Medicaid benefit (more specifically, in-home support services), The IC became an "agency of choice" that hired, as caregivers, family members and friends selected by the

➜ ABSTRACT This article describes the business acumen processes a community-based organization used to identify and plan a Hospital to Home transition program to disrupt the pipeline of people with disabilities going into long-term nursing facilities after an acute hospitalization. A non-residential Center for Independent Living offering social determinants of health services, including home health services, for persons with disabilities of all ages will conduct a pilot project with a local hospital in 2018 to test this idea. | **key words**: *people with disabilities, Center for Independent Living, Hospital to Home transition services, social determinants of health*

ple out of nursing homes, helping people avoid nursing homes altogether, and assisting young people with disabilities to transition from school to work. In 2016, The IC's Independent Living division, with approximately forty-two full- and part-time staff, served 800 people with all types of disabilities across six counties in the Pikes Peak area of Southern Colorado.

Undoing Helplessness: Supporting People to Live in Community

National and local disability civil rights communities hold the belief that people with disabilities can live in the community with the appropriate supports, while institutions such as nursing homes provide support with activities of daily living, but often are not person-centered, nor do they promote active engagement in the community.

Repeatedly, The IC Community Transition staff found people with disabilities in nursing homes who did not need to be there. When a person has resided in an institution where choice and self-sufficiency are not part of the culture, Center staff have observed that people devolve into helplessness—an outcome that occurs regardless of the length of stay. The IC staff wondered, "Was it better to go home from the hospital with medical and social supports for thirty to ninety days to recover rather than stay in a long-term nursing facility for months or years?"

To address this question, The IC built the Hospital to Home Transitions Program to test the idea that going home to recover with the right supports provides a value proposition to hospitals to create healthier outcomes, reduce uncompensated bed days, and prevent readmissions. Insurance and managed care companies, state Medicaid, and state workers compensation programs also could value bottom-line benefits of reducing hospital and-or long-term nursing facility stays by transitioning people from hospital to home.

The IC staff's skills range from extensive experience in transitioning people out of nursing

consumer. Caregivers were trained, often by the consumer, to provide help with ADLs and medical services (e.g., assisting with feeding tubes, vents, catheters, etc.).

Today, 232 clients between the ages of 6 and 105 years receive long-term services in their homes from approximately 250 caregivers. With thirty years of experience in providing services in the home, The IC has successfully kept people with disabilities of all ages out of institutions. The IC has extensive knowledge of Medicaid and private insurance billing.

In 1994, The IC became a Center for Independent Living, offering the following services that assist with social determinants of health: information and referral; peer support (which is critical for helping people to accept that they have a disability); independent living training; self- and systems-change advocacy; and transition services, which focus on transitioning peo-

homes to helping others procure home assessments and make modifications that allow easy access. The staff also discuss the benefits of assistive technology with all consumers, and offer peer support that can help people understand their disability and accept it as part of their self-image. The IC motto is "One cannot step into the person one is becoming until one has let go of the person that once existed."

The IC encourages consumers to develop practical skills to support participation in recreation and employment; these help forge connections to the community for people who are isolated because of the stigma associated with having a disability. Their disability may prevent access to transit; their self-image may be such that they avoid others because of the fear of rejection because of their disability.

Building on The IC's existing skill set and values, offering a Hospital to Home transition service to the healthcare system seems to be a beneficial extension of what The IC does best and would generate much needed income for other programs. Thus the idea of "disrupting" the pipeline between the hospital and long-term nursing facilities was born.

Preparing for Partnership

The next question was "Who would pay for it?" Colorado is a fee-for-service, Affordable Care Act state. The state is divided into seven regions; each region has a care-managing entity that looks at primary and specialty care for Medicaid and Medicaid-Medicare recipients, but not acute care. However, the state's Medicaid program is increasing its interest in improving hospital transitions, as evidenced by the State Medicaid Division's most recent Request for Proposal for "Regional Accountability Entities" to manage both physical and behavioral health services for Medicaid and Medicaid-Medicare recipients. The new application calls for Hospital to Home Transition Program services to be developed beginning in 2019. The IC plans to be well-positioned to pro-

vide leadership in community partnerships for hospital transitions to home.

In 2015, The IC was invited to participate in The Colorado Health Foundation's Linkage Lab. Modeled after California-based The SCAN Foundation's program, it teaches nonprofit service organizations how to identify a need for health support services, develop a business case, set price, determine the market, and contract with a healthcare provider. The IC realized that 95 percent of the funding for its $10 million dollar budget relied on one funder: Medicaid. Clearly, diversification of the Medicaid service

---

Repeatedly, The IC's staff found people with disabilities in nursing homes who did not need to be there.

---

was necessary. Such diversification could allow for more collaboration within The IC between its Home Health and Center for Independent Living divisions to provide higher impact services to people with disabilities. That realization led to the next question: "Who has the money (and cares enough) to pay to keep people with disabilities recovering in the community where they are happier and more socially connected, and can pursue employment, volunteerism, or other activities of a personally satisfying life?"

Hospitals are incentivized to discharge patients safely and quickly, and often have people waiting to be admitted so they are invested in turning over beds to meet that need. Given the scramble for discharge managers to find a safe place to discharge patients, The IC noticed that many people were sent to nursing homes. One physician told The IC CEO, "I don't really know what happens to that disabled patient after receiving our care." It had never occurred to him to ask.

The IC team attending the Linkage Lab for 19 months included the CEO, the administrator for Home Health, the director of Independent Living, and the CFO. The team observed

that hospitals did not have a mechanism to help people with disabilities live in the community. They analyzed this gap in terms of its impact on patients and researched the consequences of disabled patients overstaying the allowable days for their diagnosis or of not having insurance—two scenarios that can create uncompensated expenses for medical facilities. The IC team knew they could prevent this problem by surrounding patients with in-home medical and community supports.

The team came to appreciate the different skills and knowledge that each team member

Could the person with a disability go straight from the hospital to home to recuperate?

brought to the table and regularly practiced positive conflict skills. Rather than design a program on the back of a napkin, team members used a structured process to identify the need for services and the customer (in this case, the hospital, with the patient or consumer being the beneficiary). With the help of the Linkage Lab training and an IC staff member skilled at mind-mapping, project management, and creating flow charts, the group was able to create a picture of the service and several "straw person" scenarios; these activities guided the group's thinking on what community organizations should be a part of The IC's Disability Services Transition team, as well as to develop a cost model for the Hospital to Home Transition service.

The team identified all the services that a person coming out of the hospital might need to recuperate successfully and safely at home. It was assumed that in the first month medical services would be intensive, as would case management. Months two and three would entail ramped-up community supports, while medical services and case management could wind down. The number of hours for each service, for each month, were calculated. Next, the team

determined the hourly cost for each service and if there were other payers (e.g., Medicaid, Medicare) who could be billed. Finally, the team identified what organizations could provide the services that The IC did not offer, i.e., providing medical transportation and food, picking up prescriptions ordered by the healthcare professional, and accessing durable medical equipment.

Comparing the costs of the program to that of an extended hospitalization, nursing home stay and-or readmission, The IC team believed there was a positive return on investment. Next, the team worked to ensure marketing materials were brief and targeted.

The team had never before used such intentional processes—a structured approach so helpful that it is now incorporated into The IC's decision-making processes when considering all new and existing programs. Senior- and mid-management-level staff now ask much better questions and do more thorough research before starting any new venture; the goals for each program review are consumers' self-sufficiency, positive impacts on the lives of persons with disabilities, and contributions to The IC's financial strength.

The Partnership Structure

Early on in the Linkage Lab experience, it was suggested that nonprofit organizations consider bringing on a board member who has healthcare experience. The IC invited the local hospital's director of In-Patient Rehabilitation to join the board. He was engaged with helping The IC develop the Hospital to Home Transition Program. He advised the team on program design, workflow, communications with hospital staff, and the need for families to be assessed for their ability provide ongoing support at home.

Through mentoring and sharing information about the hospital's processes, the new board member played a big role in The IC's success in creating a pilot and helping to market the program it to the right people. He was instrumental in getting the hospital to agree to start the pilot

on first quarter 2018, and to support it financially. After six months of operation, the hospital CEO and The IC CEO will meet to review the pilot with an eye toward establishing an ongoing contract if the pilot is successful.

Community partners in this project include a local pharmacy to fill and deliver prescriptions; Rocky Mountain Health Services for medical transport and food; and a local medical supply company for durable medical supplies and perhaps temporary and basic home modifications. The Home Health administrator is working on an agreement with a Medicare-only home health agency to provide the post-acute in-home

---

Team members had to perform a transition or two before figuring out the hospital's necessary financial participation.

---

medical services. The IC will provide the homecare for ADLs as well as peer support, benefits counseling, and intensive case management services. The IC's CFO is in the process of putting together MOUs for each entity that detail how the billing and payment systems will function and how communication processes will work.

Conclusion: Lessons Learned

Evaluation and process mapping are fundamental to program design. Until a staff member who had monitoring and evaluation (M&E) skills joined the team and guided the discussion of design and evaluation, The IC team's four senior directors were "spinning in the wind," given the challenge of also fulfilling their other organizational responsibilities. The IC is now so convinced of the importance of M&E activities that plans and budget are in place to grow an internal M&E program for the organization.

Get a handle on costs, the pilot duration, and number of patients served. In a "chicken or the egg"–type situation, the team members needed to complete a transition or two before

they could confidently price the program and negotiate the cost to the hospital. But this was not an option, which meant costs were only projected, recognizing the variability in the severity of the disability. The total cost of the pilot is $179,000 for six to eight months; the local hospital will contribute $15,000, and The IC Board and The Colorado Health Foundation will contribute $82,000 each. The IC should have made a better financial case and The IC CEO should have cultivated a relationship with the hospital CEO prior to proposing the pilot.

Be open and flexible to new information that leads to new directions. During the course of conversations with the hospital, it became clear that their most troubling type of "complex patient" was someone who was homeless and had no safe place to live. These patients could occupy a hospital bed for six months or longer, with no reimbursement for the hospital. This revelation caused the team to think about a two-path program: one for those patients who had a home and one for those who did not. The team sought out several partners in the homeless services community but only one, a homeless respite care program, had the medical understanding and housing connections conducive to patients' healing. This organization also has experience working with people with addictions and the homeless. Working with them, The IC staff add one homeless transition to our pilot deliverables.

This work represented a huge and important shift in the team's thinking, especially The IC's senior management, to see the hospital as the customer because The IC is so used to serving people with disabilities and their families. When the team started to see how the consumers The IC traditionally serves would benefit through a partnership with a healthcare provider, the process began to make sense, and the roles of each partner more easily fell into place.

Patricia Yeager, Ph.D., is CEO of The Independence Center in Colorado Springs, Colorado.

Building Relationships and Reducing Barriers Through Building Business Acumen

By Sue Tatangelo

> The Camarillo Health Care District is involved in multiple productive partnerships with healthcare entities due to its planned, intentional approach.

To seize opportunity in the rapidly changing healthcare environment, a community-based organization (CBO) needs vision, leadership, business skills, strategy, and tenacity. For the Camarillo Health Care District, it has been a transformative journey. Vision alone was not enough to succeed, but success also required committed leadership, new business skills, strategic positioning, and resilient problem-solving.

The Camarillo Health Care District (the District) is a public agency established in 1969 and defined by the California Health and Safety Code, governed by an elected board, and created to provide a wide range of health services to the community. Nearly 24 percent of the total population of the District's assigned boundaries is older than age 60, and includes many people with multiple complex chronic health conditions, daily functional limitations, and families experiencing caregiver burden.

Given this scenario, the District developed a broad base of safety net services for older adults, such as adult daycare, a home-delivered meal program, a federally designated Family Caregiver Resource Center, transportation services, and evidence-based health promotions programs, but it did not yet have a fully formed vision of how to build relationships with health sector partners. In 2012, that changed with the launch of the Affordable Care Act's Triple Aim—to achieve better health, better care, and lower costs.

As did many others in the healthcare sector, the District then became acutely aware of the change afoot. For what seemed to be the first time, there was an opportunity for CBOs to be critical partners in the healthcare continuum. When the Centers for Medicare & Medicaid Innovation Center announced funding for a time-limited Community-Based Care Transitions Program Demonstration Project (CCTP), the District joined with its local area agency on aging in an application to reduce hospital readmissions through an evidence-based care transitions intervention, and was awarded the contract.

➔**ABSTRACT** How can community-based organizations (CBO) prepare to seize contract opportunities in a changing healthcare environment? This article describes how one CBO became a high-value partner by increasing its business acumen, growing strategic partnerships, and reducing barriers through reciprocal learning, all of which resulted in multi-level health sector contracting. **|** **key words**: *business acumen, infrastructure capacity, strategic positioning, vulnerable populations, high-value partners, reciprocal learning, health sector contracts*

It soon became apparent that for the District to succeed in testing this new model of care, it would require new business skills, nimbleness, staffing ramp-up, the ability to manage data for real-time outcomes monitoring, value and quality measures, breakeven points, profit margin goals, rapid-cycle learning, and more. The District needed to acquire business acumen and the capacity to deliver its contract requirements.

The District applied to The SCAN Foundation's Linkage Lab and became one of six California CBOs in its first cohort, simultaneously with the District becoming a CCTP provider. Theory met practice at a most opportune time.

The Linkage Lab's assessment exposed the District's weaknesses, such as a lack of an enterprise-wide IT platform and a dearth of experience in contract negotiations. It also revealed its strengths, such as expertise in community-based services, a dedication to providing solutions for better health outcomes, and a passion for quality service delivery. The Linkage Lab experience, which was essential to the District's work, supported its development and articulation of a business plan, and guided the development of an infrastructure that could support health sector contracts and data management.

Planning for Post-CCTP Partnerships

Knowing the CCTP was temporary, the District's key objective from Linkage Lab was to establish at least one healthcare post-CCTP partnership, and to develop an integrated records management system with which to evaluate the District's future healthcare partnerships. Another key objective was to create a tool to evaluate and establish minimum contracting costs for the District's other traditional services, such as its evidence-based health promotion suite of programs and caregiver support services, to be ready for future partnership growth opportunities.

To promote a strategic approach to growth, the District also had to set criteria for evaluating and selecting new business opportunities, which included identifying potential clients

(i.e., Accountable Care Organizations (ACO), hospitals, health plans, skilled nursing facilities, managed care organizations, and physician practices) and developing value propositions for each in order to articulate the business case to potential contractors.

During the CCTP Demonstration Project, a group of Southern California CBOs met regularly to share best practices. When the demonstration project ended, this informal group saw the value of formalizing a California CBO network in which each partner provides regional service, increasing the network's overall geographic reach, to attract large health plans to this specialty network. The Partners in Care Foundation championed that idea and the Partners At Home

---

'Theory met practice at a most opportune time.'

Network was born, offering to health plans high-value targeted home visits, including care transitions, medication adherence support, coaching for self-management, falls risk management, and person-centered care.

The District recognized that being a member of a specialty network made good business sense, as it minimized contracting costs and provided substantial competitive advantage through such elements as shared IT and analytics costs, increased geographical reach, negotiating leverage, and broad best practices for quality improvement. This was the next "right" step for the District. It wasn't long before the Partners At Home Network secured a national health plan contract that is now in its third year of renewal. While being part of a California network made good business sense, the District also could see its future in developing contracts locally with health sector partners.

Next Steps: Building Ongoing Relationships

The optimistic assumption following the CCTP Demonstration Project was that at least one of

the District's partner hospitals would develop a continuing contract for those services. At the time, the average readmission rate at Ventura County hospitals was 16.8 percent, but for patients participating in the District's CCTP, the average readmission rate was reduced to 8.4 percent. The District was successful in substantially reducing avoidable hospitalizations and had proven its value proposition. Developing a contract for ongoing care transitions services seemed like the logical next step.

Community Memorial Hospital Systems (CMHS), in Ventura, California, was interested in exploring of this type of partnership. The hospital had just launched an ACO and, in an effort to continue building the relationship with the hospital, the District offered a six-month, no-cost pilot project. That pilot ended with a similar positive reduction in avoidable hospital readmission rates, and also highlighted the positive effects of having a community-based health coach embedded in the hospital to collaborate with clinical staff and improve the communication loop between the hospital, home health, and community-based care.

Also, patients in the pilot noted that the post-discharge home visits by the District health coach were helpful in managing their health conditions, and made them feel as if the hospital remained invested in their care long after discharge.

As a result of this successful ACO pilot, CMHS requested a full proposal. The District worked with hospital leadership to identify the pilot patients' group of conditions, and designed the intervention elements to ensure standards of care and quality improvement. The interventions included evidence-based health promotion programs such as the Stanford University Self-Management suite of programs, and leveraged patient access to a wide variety of other community-based services and supports. Although CMHS had originally submitted its priorities to the District during the proposal process, these had shifted (CMHS was anticipating an extensive building expan-

sion); while not denied, the proposal went into CMHS's "not now" file.

Building the relationship with CMHS has proven to be invaluable. The hospital deepened its understanding of the District's value about how a skilled community partner can extend

The District successfully and substantially reduced avoidable hospitalizations, proving its value proposition.

quality care beyond hospital walls. The hospital has also broadened its idea of healthcare by intentionally and continually acknowledging the importance of having a partner that can address the social determinants of health in the home, including support for family caregivers.

Additionally, the hospital provided frank feedback on how the District could further increase its value as a partner by having a clinical program supervisor overseeing the intervention. The District hired a registered nurse with extensive experience in hospital, home health, and national health plan management, which distinguished the District's intervention from its competitors. The hospital had said that enhanced clinical review during the intervention would help identify a worsening health condition at home, should it occur. Having a clinician available to inform the hospital of a patient's health setback would mean greater opportunity to reduce avoidable hospital readmissions.

CMHS continues to champion community-based partnerships by creating pathways that allow the District to work with other health plans and providers for contracted services, inside its hospital. CMHS established a Memorandum of Understanding allowing the District to embed health coaches in the hospital, to determine patient eligibility, and to have patient bedside access to explore their interest in participating in the District's intervention. These pathways have facilitated contracts and grant

funding from Medi-Cal Managed Care and other health plans interested in expanding their members' care. To expand services, the District is now testing new care models for patients with cognitive impairments, as well as for patients with complex conditions, and those who are being discharged from skilled nursing facilities and/or completing their health plan's home health service.

New Partnerships Form
CMHS asked the District to join the Ventura County Hospital to Home Alliance, which proved to be a strategic move. Formed in 2014, the Alliance is a unique body of hospitals, home health organizations, skilled nursing facilities, and independent physician groups, all supported by the California quality improvement organization, Health Services Advisory Group. The District serves as its CBO representative. Historically, CBOs had not been part of the healthcare continuum and some Alliance members had difficulty relating to a social model of care in its network. The Alliance hospitals were very progressive in their vision by appointing the District to the Alliance's Steering Committee as an equal partner. The hospitals provided consistent messaging to Alliance members that social issues are health issues and emphasized the value of having a community-based partner. The District was also able to gain greater insight to health sector barriers for integrated care and take an active role in solutions.

Three years ago, the Alliance's mission made no mention of CBOs. Today, the mission is explicit in the integration of long-term services and supports (LTSS) into the healthcare continuum to improve health outcomes and reduce hospital admissions. Alliance members have become advocates who support policy changes for LTSS integration into the care continuum.

With Alliance member partnerships, the District has gained strategic positioning, which has resulted in innovative contracts and grants to test new approaches to care. CMHS, an Alliance

hospital member, recently applied to the Hospital Association of Southern California to participate in a three-year Person-Centered Care Initiative, and selected certain Alliance partners to participate in the initiative, confident that these agencies shared a common vision of improving care. The District was included in this effort.

Dignity Health, an Alliance hospital member, is leading the development of a social innovations project and selected the District as a project partner. The project introduces students from a local university to the healthcare continuum in order to achieve the following: to promote older patients' productive recovery and greater self-determination as they are dis-

---

'Continuous quality improvement accreditation increased the District's credibility as a quality care provider.'

---

charged from the hospital; to reduce inappropriate or over-use of care; to decrease isolation and increase self-empowerment; and to enhance geriatric competence in the future healthcare workforce. The District's role in this contract is to provide community resource education to the students and weekly student coaching.

Recently, Ventura County's Medicaid managed care program released funding to address the social determinants of health and increase access to quality care. The District was funded to test a new thirty to ninety-day intervention based on acuity of targeted older adults and persons with disabilities being discharged from skilled nursing facilities or from home health, and being at high risk of readmission to a higher level of care without linkages to critical social community supports. The District partnered with seven Alliance members based on their interest in building Medicaid capacity and testing new care models.

As the District increased its dialogue with health plans, it became aware that continuous quality improvement accreditation increased its

credibility as a quality care provider, and that it could better prepare itself for the needs of vulnerable Medicare-Medicaid populations, as well as distinguish itself from others entering the marketplace. When the National Committee for Quality Assurance developed accreditation in LTSS case management, the District became an early adopter.

The District's mission is to be a highly respected, preferred partner in Ventura County's healthcare continuum by providing valuable, effective, measurable, and integrated community-based health services. Today, the District's value as a CBO is demonstrated in its varied contracts as a subcontractor in a statewide network with a national health plan and a lead organization in a local network of evidence-based health pro-

motion program providers. The District also has secured multiple sole contracts with local managed care, and has become the partner of choice in contracts with other local healthcare providers.

Looking back, it is amazing to see the distance the District has traveled from its initial experience with the Linkage Lab to now. This journey necessitated a fundamental grounding in business practices to map the vision, reciprocal learning from like-minded visionaries and fearless partners—as well as with the tenacity to navigate the detours along the way.

Sue Tatangelo has a master's degree in Organizational Management and is the chief resource officer at the Camarillo Health Care District in Camarillo, California. She can be contacted at statangelo@camhealth.com.

Economic and Social Inequality in America

Karen D. Lincoln, **Guest Editor**

Levels of economic inequality have hit unprecedented levels and are rising. In 2014, the average income of the lowest 90 percent of U.S. households was about $33,000, compared to the top 1 percent, which was more than $6 million. This extreme disparity in income and wealth distribution has a distinct impact on older adults. More than 6.4 million older adults live below the Federal Poverty Line, and economic insecurity is concentrated among older women and people of color. We now recognize that economic inequality is due to a convergence of factors—political, social, and economic—that intersect to contribute to the problem. Racism and sexism, lack of healthcare access and educational opportunities, and environmental risks and hazards all contribute to inequality—particularly among those affected by more than one of these issues. How older adults experience inequality is the result of a lifetime of experiences. This issue of *Generations* will explore the societal factors that create and maintain economic and social inequality among older adults, and feature articles on programs designed to ameliorate them.

COMING UP IN
Summer 2018

Generations

ASA/USC Online Courses Continue in 2018!

ASA and the University of Southern California Leonard Davis School of Gerontology are partnering again to bring you four courses pertinent to your work with older adults in a flexible online format.

- Understanding Abuse and Neglect
- Prevention of Abuse and Neglect
- Fundamentals of Gerontology
- Managing Health and Chronic Conditions in Older Adults

Successful participants will earn a certificate of completion from USC, and CEUs are offered from select accreditation providers.

The cost of each five-week online program and certificate of completion is $500.

All courses will take place April 16–May 18 and August 27–September 28.

"This course presented an incredible amount of information which applies to my job and home life alike. I appreciate ASA's commitment to sharing pertinent timely information about the important aspects in the field of gerontology!"

—*Gina Maguire, Stockton Center on Successful Aging*

www.asaging.org/USC-gero