



**Preparing California's Community-Based Organizations
to Partner with the Health Care Sector
by Building Business Acumen:**

**Case Studies from the Second Cohort of
Linkage Lab Grantees**

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Executive Summary

The integration of medical care and long-term services and supports through partnerships with community-based organizations (CBOs) is a critical strategy to improve health outcomes while lowering health care spending. Several factors contribute to this positive outcome. These factors include the recent spread of value-based models of health care, prompted by payment and delivery reform provisions; increasing recognition that health is impacted not only by medical care but by a variety of social determinants; and the rapidly aging U.S. demographic.

Although recognition of the importance of partnerships between the health care sector and CBOs has grown, many CBOs lack the necessary business acumen and need to develop a variety of other internal organizational capabilities in order to enter into mutually beneficial contractual relationships with health care payers and providers.

In 2013, The SCAN Foundation (TSF) developed the *Linkage Lab Academy* to help bridge this gap by providing capacity-building support to California CBOs that primarily serve older adults with chronic health conditions and functional limitations. Since that time, two cohorts of CBOs have gained key skills and engaged in organizational transformation through regular seminars and on-the-ground technical assistance. Each cohort consisted of six CBOs. Learn more about the first cohort [here](#).

As of late 2016, the second cohort signed six contracts with health care payers and providers. This report provides case studies of the CBOs participating in Linkage Lab 2:

- [Alzheimer's Family Services Center, Huntington Beach](#)
- [Asian Americans for Community Involvement, San Jose](#)
- [Avenidas, Palo Alto](#)
- [City of Oakland](#)
- [Meals on Wheels and Senior Outreach Service, Walnut Creek](#)
- [St. Barnabas Senior Services, Los Angeles](#)

The case studies show the progress made and challenges faced toward achieving the goal of meaningful partnerships with the health care sector.

About Alzheimer's Family Services Center

[Alzheimer's Family Services Center \(AFSC\)](#), founded in 1980, is the only adult day services provider in Orange County that specializes in dementia care. The organization aims to improve quality of life for families challenged by Alzheimer's disease or another dementia by providing high quality, culturally appropriate services tailored to meet individual needs. These services, which are grounded in research, clinical guidelines, and dementia care expertise, include adult day health care, caregiver support groups, counseling, community education, and care management. AFSC aims to meet the medical and psychosocial needs of the community's most vulnerable older adults – those facing a host of chronic health conditions in addition to dementia at all levels of severity.

Why AFSC Joined Linkage Lab

The AFSC team was acutely aware of the community trends and the growing public concern associated with the Alzheimer's epidemic. They understood first-hand the devastating emotional and financial losses to families, the significant economic burden on an already stressed health care system, and the substantial costs to local businesses because of declining worker productivity among employed caregivers. AFSC also knew that they could be part of the solution to this complex community problem by providing affordable access to a continuum of dementia care services that would better equip families with key skills, respite, support, and knowledge. Through Linkage Lab, AFSC sought to strengthen their organizational capacities and readiness to pursue stronger connections with the health care sector, so that they could partner with payers and providers. This would allow them to serve more older adults in their community who were affected by dementia, as well as help reduce the medical costs associated with the care of this population.

Key Objectives

The AFSC team was committed to achieving objectives that were significant for their organization. They desired to elevate the standard of care for persons with Alzheimer's disease and related disorders in Orange County. They also sought to demonstrate to the health care sector that they could provide complementary services to achieve the health care aim of providing the right care at the right time in the right setting, for vulnerable older adults with dementia. AFSC sought proactive health care partners to collaborate on

a coordinated dementia care system in the community that would support families from onset of dementia, at diagnosis, and through end-of-life care. The coordinated system would include partnerships with hospitals, physician practices participating in Accountable Care Organizations (ACOs), managed care organizations, local businesses, and community-based organizations. The system would strive to provide a full spectrum of dementia-specific programming across all stages of dementia, improve health outcomes for individuals, and reduce medical expenditures.

AFSC sought proactive health care partners to collaborate on a coordinated dementia care system in the community that would support families from onset of dementia, at diagnosis, and through end-of-life care.

To begin this work, AFSC established an initial set of goals. These goals included:

- increasing exposure and brand in the community,
- integrating their core services into a care delivery model,
- identifying research and evaluation methods to measure their impact,
- securing a new location that would allow them to serve more individuals in need of their offerings, and
- entering into a contractual agreement with a health care provider or payer to begin working more closely with the health care sector.

Key Strategies and Processes

The AFSC team knew that the vital first step toward achieving their goals was to engage their Board of Directors. They invited their Board Chair to participate in the Linkage Lab on-site technical assistance sessions and engaged the entire board through a day-long retreat focused on organizational growth opportunities, including the strategy of pursuing partnerships with the health care sector. The Board approved the expansion goal, incorporated partnership development with the health care sector into their strategic plan, and created a strategic board task force made up of a retired hospital Chief Executive Officer, a retired hospital Chief Financial Officer, and a Chief Strategy Officer of a local health system to support goal achievement.

Second, AFSC set out to increase exposure of their services and address brand challenges, because they recognized the importance of carving out market share, forming a clear definition of their offerings, and verifying their value. The team believed that a strong AFSC brand would be central to engaging potential health care partners in productive conversations. The marketing and branding work involved the development of succinct messaging; the training of staff, board members, and volunteers; and the design of new marketing materials.

Another strategy instituted early in the process was to collect clinical data for each AFSC participant and to learn to use the data to build a meaningful case for AFSC services geared towards potential health care providers and payers. Specifically, hospitalizations, emergency department (ED) visits, and falls over the previous six months were recorded at pre-enrollment, as well as at six- and 12-month intervals post-enrollment.

A final strategy that AFSC employed was to use membership on health care organizations' boards and committees to increase AFSC's brand recognition and strengthen their relationships with the health care sector. AFSC project team members became members of the Huntington Beach Council on Aging Board and the Monarch Healthcare Clinical Committee.

Contracts with Health Care Payers and Providers

Table 1 summarizes the contract AFSC successfully negotiated during Linkage Lab.

Table 1: Summary of AFSC Contract with California's Health Care Sector						
Health Care Payer/ Provider	Criteria Used to Evaluate AFSC	Contract Timeline	Service Package	Population to Be Served	Pricing Structure	Implementation Status
Monarch HealthCare	History of clinical excellence in caring for patients with dementia; evidence of positive clinical/ health outcomes for patients	1 year with annual renewal	Joint study to analyze the impact of adult day health care on patient measures (e.g., ER visits, falls)	Monarch members diagnosed with dementia who may benefit from AFSC's programs and services	Fixed fee per member per day	Implemented

Monarch Healthcare serves 65,000 older adults across their network in Orange County. They entered into a contract with AFSC for a joint study of the impact of AFSC's adult day health care services on key health measures among individuals with dementia, including ER visits and falls. By the end of the program, Monarch had made more than 60 referrals to AFSC.

Additional Successes

In addition to securing a new contract with Monarch HealthCare, AFSC experienced several other successes. The agency secured a three-year legacy Memorandum of Understanding with Hoag Hospital for core operating support, and a UniHealth Foundation grant to initiate development of a Medicare-approved Intensive Outpatient Program to be piloted with the St. Joseph Hoag Healthcare System. In addition, AFSC entered into formal discussions about potential contracts with several other providers and payers.

AFSC assumed a leadership role in a countywide collaboration that included representation from six hospital systems, a psychiatric hospital, a variety of community based organizations, assisted living providers, and medical groups to strengthen cross-sector relationships and create an integrated system of care delivery. AFSC also made multiple presentations on their Linkage Lab work, including at a conference sponsored by the California Association for Adult Day Services.

Challenges

AFSC experienced two main project challenges. First, the health care landscape was in constant flux, and as such, AFSC developed its service package and engaged in contractual discussions that required constant adaptation to meet changing processes. In addition, once a contract with Monarch Healthcare was signed, AFSC found that its referral processes were taking longer than expected. AFSC addressed this challenge by scheduling weekly phone calls with Monarch to identify and discuss which members might be candidates for enrollment.

Lessons Learned

Key lessons for AFSC:

- Given the many competing priorities for limited staff time, setting regular meeting dates and milestones for the project team can help ensure that project work gets done in a timely way.
- An interested and involved board has the potential to facilitate project work.
- It is important to be open to learning opportunities, particularly concerning the needs of potential partners, and to seek common ground with payers and providers.

About Asian Americans for Community Involvement

Founded in 1973, [Asian Americans for Community Involvement \(AACI\)](#) aims to improve the health, mental health, and well-being of individuals and their families through direct service, education, and advocacy. The organization's programs include: a) mental health services; b) school-based mental health and family support services; c) senior services; d) prevention and early intervention services for refugees and survivors of torture; e) primary care health services; f) substance abuse prevention, education, and treatment, including a transitional housing unit; g) HIV education and testing; and h) domestic violence emergency shelter and services. AACI is Santa Clara County's largest community-based organization focused on Asian Americans in the community, serving close to 15,000 clients each year. Its staff speaks more than 40 languages and dialects.

Why AACI Joined Linkage Lab

AACI's strategic plan (2014-2016) included a focus on growth and the development of new care models that aligned with new value-based reimbursement structures. Closely monitoring trends emerging in the health care environment, AACI understood that the fee-for-service model would be challenged, and that they could be part of the solution by designing and implementing models rooted in coordinating care across medical and social care settings. With their decades of experience working with the most underserved individuals in Santa Clara County, they saw an opportunity to help the county's local safety-net health plan members access cost-effective medical and social services, with the aim of improving their overall health and reducing the total cost of care. In a context of so much change and opportunity, AACI's leadership team determined that participating in Linkage Lab would help them acquire the skills they needed to create a productive relationship with a local health plan; better understand viable financial structures, including at-risk arrangements; use data in a meaningful way; and negotiate a mutually beneficial agreement to provide an integrated model of medical and social services to the health plan's members.

Key Objectives

The AACI team had several areas of focus, including becoming better prepared to negotiate and secure a new and viable contract with a local health plan or provider, building partnerships with other community-based organizations that provide complementary

long-term services and supports (LTSS), and understanding the total cost of care across a spectrum of services, such as in-patient, ambulatory, and LTSS. This last objective would help AACI to create a better pricing structure for their contracts with health care sector organizations.

Key Strategies and Processes

The AACI team launched their work by carrying out a detailed analysis of their current senior service offerings, which included mapping the service delivery process to understand the associated costs and identify potential areas for redesign and improvement. The team used this exercise to establish an organizational protocol for determining cost of service delivery, and an ongoing process for evaluation and refinement. Following this exercise, they brainstormed how to repurpose and repackage the services for contracts with payers and providers.

A second strategy was to create a value proposition appealing to those organizations that they had identified as potential health plan partners, as well as to refresh the AACI brand to reflect the perception they wanted to create among community members and their existing program and service participants. AACI also continued to facilitate relationships with other community-based organizations as potential partners to create an enhanced offering to providers and payers.

Finally, the AACI team worked closely with the Linkage Lab technical assistance team to enhance their understanding of managed care contracting, pricing, and strategies for renegotiating agreements that were no longer financially viable.

They also continued to improve their understanding of total service delivery cost across their medical and non-medical services, to help them establish stronger managed care contracts in the future. AACI deemed this as a critical step toward experimenting with risk- and performance-based agreements.

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Contracts with Health Care Payers and Providers

Table 1 summarizes the contract AACI successfully negotiated during Linkage Lab.

Table 1: Summary of AACI Contracts with California's Health Care Sector						
Health Care Payer/ Provider	Criteria Used to Evaluate AACI	Contract Timeline	Service Package	Population to Be Served	Pricing Structure	Implementation Status
Santa Clara Family Health Plan	Ability to deliver high quality, culturally sensitive integrated care	1 year with annual renewal	Integrated primary care and behavioral health for patients at our Federally Qualified Health Centers (FQHCs) at two locations	Patients with mild to moderate mental health diagnoses	Medi-Cal/ Medicare rates for services rendered	Implemented
Santa Clara County Valley Health Plan	Ability to deliver high quality, culturally sensitive integrated care	1 year with annual renewal	Integrated primary care and behavioral health for patients at our FQHCs at two locations	Patients with mild to moderate mental health diagnoses	Medi-Cal/ Medicare rates for services rendered	Implemented
Physicians Medical Group of San Jose	Ability to deliver high quality, culturally sensitive integrated care	1 year with annual renewal	Primary Care and integrated behavioral health services	Patients needing primary care and behavioral health services	Per member per month	Implemented

Prior to participating in Linkage Lab, AACI received a grant from Santa Clara County to provide behavioral health services to county health plan clients. The grant terms required that Santa Clara Family Health Plan and Santa Clara County Valley Health Plan subsequently contract with AACI for behavioral health services for patients with mental health diagnoses. These two contracts, which were informed by the technical assistance providers, were signed during the program period and are currently in implementation.

In addition, AACI signed a contract with Physicians Medical Group of San Jose (PMG), an independent practice association, to increase AACI's access to different payers. PMG negotiates with payers on behalf of AACI and provides AACI with a pre-set per member per month payment.

Additional Successes

AACI also capitalized on other grant funding to better position itself for securing future contracts with the health care sector. Specifically, AACI strengthened its relationship with Kaiser Permanente in San Jose by receiving a Community Benefit Grant that involved outreach to the Vietnamese community through a new local Vietnamese television series focused on health and wellness.

AACI additionally gained visibility through numerous presentations on their Linkage Lab-related work to their peers at trainings, conferences, and meetings. Sponsors of these events included (but were not limited to) Community Health Partnership, a community health center consortium based in San Jose; and the Behavioral Health Contractors' Association of Santa Clara County.

Challenges

AACI faced a number of challenges. Internally, their organization experienced significant staffing changes with the project team decreasing from four to two members. As a small organization, it was particularly difficult to allocate multiple senior leadership members' time to engage in the work.

Externally, AACI found that the market was changing substantially. Due to the Section 1115 Medicaid Waiver, many hospitals and safety net providers could redesign care for individuals with Medi-Cal (California's Medicaid). AACI struggled to understand what would be possible under this waiver, while simultaneously building new behavioral health service offerings. Additionally, AACI's work with Santa Clara County payers was complicated by the County's ongoing efforts to rebuild their hospital and put in place a new electronic health records (EHR) system.

Lessons Learned

Key lessons for AACI:

- Data is important for determining directions and demonstrating success, but it is not always possible to obtain all of the data that an organization needs.
- Partnership building is challenging and requires compromises.
- Developing new relationships with diverse types of organizations can expand horizons and shed light on new niches and directions for services, as well as potential partnership opportunities.

About Avenidas

For more than 40 years, [Avenidas](#) has been creating innovative programs, providing resources, and coordinating services for older adults and their families on San Francisco Bay Area's Mid-Peninsula. Avenidas's vision is to be a leader in the creation of a community that supports and celebrates its older adults and to proactively respond to the changing needs and desires that come along with the aging process. Headquartered in the heart of downtown Palo Alto, Avenidas provides adult day health care; a membership program that includes access to services, activities, and volunteer opportunities to adults over 50 wanting to age in their homes; health and wellness programs; transportation; and information and counseling.

Why Avenidas Joined Linkage Lab

The Avenidas team recognized that the elder population in their service area was expected to double over the next decade. To be a leader in creating a community that would support older adults, Avenidas needed to continue responding to the aging population's changing needs, improve their organization's operational health, strengthen their financial performance, and achieve longer-term sustainability of their programs.

At the onset of the program, Avenidas already held several contracts with local managed care organizations to provide adult day health care services, as mandated by the Cal Medi-Connect Program, California's dual-eligible Medi-Cal (California's Medicaid) and Medicare coordinated care demonstration. However, these contractual arrangements needed to be reviewed for possible service expansion opportunities and possibly renegotiated. Avenidas's care model and operations also needed to be evaluated and redesigned to remain financially viable within the contractual structure. In addition, the Avenidas team recognized an opportunity to grow and serve more individuals in need through the relationships that they had cultivated with managed care organizations. They had identified potential services that could be designed and developed as part of their strategy to enhance their managed care relationships and contracts. These services included health risk assessments, community-based care management, medication management, and center-based physical, occupational, and speech therapy. Avenidas also wanted to learn more about operational improvement tactics, financial modeling, care model redesign, and successful pricing methodologies when contracting with managed care organizations.

Key Objectives

The Avenidas team decided to focus on several key objectives. These included strengthening existing relationships with managed care organizations and understanding their contracting priorities, as well as the challenges they were experiencing with beneficiaries in need of long-term services and supports (LTSS). Second, the Avenidas team needed to work toward improving their adult day health care operations by testing out multiple tactics. A third objective was to establish new contracts, and/or to build on existing agreements, to expand their service offerings. One potential pathway could involve partnering with another community-based organization to provide complementary services.

Key Strategies and Processes

The Avenidas team employed a variety of strategies during Linkage Lab to achieve their objectives. They started with an internal approach of working with the Linkage Lab technical assistance team to conduct a deep-dive analysis of the financials and business model of their financially challenged adult day health care center. This resulted in the identification of eight opportunities to increase revenue, reduce expenditures, and bring the center closer to financial health over a three-year transitional time. They also hired an external consultant to conduct an evaluation of their current technology systems and develop a roadmap for system improvement that was to be implemented over three years.

Additionally, Avenidas recognized that recruiting and retaining the right talent was key to bolstering current operations and achieving partnership objectives. They therefore designed and approved a new Human Resources position.

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Avenidas's next step was to focus externally. Two strategies were implemented in parallel. One strategy was to develop stronger relationships with managed care organizations by participating in quarterly stakeholder meetings hosted by a local managed care organization, and becoming an active member of the LTSS sub-committee; inviting representatives from managed care organizations to attend client educational meetings; and conducting one-on-one meetings with leaders of these organizations to gain insights about their operations and contracting priorities. The second external strategy was to build stronger relationships with community-based organizations that could be possible collaborators in the future.

This included engaging in multiple idea-generating conversations with another Linkage Lab participant to explore potential for collaboration.

A final strategy that was implemented to support partnership development objectives was to launch a Community-Based Health Home pilot program, with nurse navigator staffing, and begin cultivating relationships beyond managed care providers. Relationship development included a focus on a local community hospital that was seeking to work with community providers to address the transportation issues facing many of their patients.

Contracts with Health Care Payers and Providers

Avenidas did not enter into any new contractual arrangements with payers or providers during Linkage Lab. However, they did renew an existing contract to continue serving as an alternate care site for the On Lok Lifeways PACE¹ Program. They also cultivated relationships with health care entities (described above), and entered into other funding arrangements (described below) that have better positioned the agency to secure health care sector contracts in the future.

Additional Successes

Avenidas received funding from the Santa Clara County Social Services Agency and a Kaiser Permanente Community Benefit grant for a Community-Based Health Home pilot program to serve dual-eligible Medi-Cal (California's Medicaid) and Medicare beneficiaries. Additionally, Avenidas contracted with the transportation provider Lyft to provide local rides to seniors who do not drive so they can get to medical appointments and community activities. This partnership complements Avenidas' Volunteer Transportation Service (Avenidas Door-to-Door) and enables the organization to respond flexibly to demands from its clients and LTSS partners. Avenidas also increased average daily attendance at their adult day center by 22 percent, as a result of improved outreach and referral relationships. At the 2015 Bay Area Senior Health Policy Forum, Avenidas' President and Chief Executive Officer co-moderated a panel on "Building Capacity for the Future: Innovations within LTSS" in which she shared information on Avenidas' Linkage Lab activities and outcomes.

¹ PACE (Programs of All-Inclusive Care for the Elderly) is a Medicare and Medicaid program that helps people meet their health care needs in the community, instead of going to a care facility.

Challenges

Avenidas experienced significant internal challenges throughout the project. These include lack of a clear organizational focus, mission, and vision; inappropriate staffing and turnover at multiple levels of the organization, and an extended leave of the Chief Executive Officer; and an outdated information technology (IT) system. Avenidas implemented positive staffing changes during the program, such as outsourcing employee benefits administration and IT services. The organization also identified IT system elements that needed to be updated or replaced, and initiated multiple major improvement projects. Externally, a challenge was that the local Medi-Cal managed care organization was slow to address populations and services under Community-Based Adult Services (CBAS, California's adult day health care program), due to ongoing changes in various related initiatives. This slowed Avenidas's efforts to maximize its relationship with managed care organizations and to expand its related service offerings.

Lessons Learned

Key lessons for Avenidas:

- It is essential to lay the groundwork for successful contractual partnerships with the medical sector by first strengthening various aspects of the organization.
- Opportunities to partner with managed care abound and need to be carefully explored.

About City of Oakland

The City of Oakland’s Human Services Department serves children, youth, older adults, and other adults in Oakland, the Alameda County seat. Their mission is to build strong communities by enriching the quality of life for individuals and families in Oakland. For more than 30 years, the Human Services Department’s Aging and Adult Services Division has been developing partnerships and providing services, such as job training programs, in-home care management of frail clients, and activities at four city-operated senior centers. Its goal is to support Oakland residents to remain independent in their homes and thrive in the community.

Why City of Oakland’s Aging and Adult Services Division Joined Linkage Lab

The [City of Oakland’s Aging and Adult Services](#) leadership team understood that two intersecting trends– diminishing public funding and a growing population of older adults– would eventually require them to adjust business models and design new ways to deliver services in order to keep older adults in Oakland independent and thriving in the community. Creating and launching innovative care management strategies would be essential to maintaining and growing long-term care services and supports for older adults, as would demonstrating positive outcomes of these services. With their local health care market moving toward value-based initiatives that require multi-provider partnering, the City of Oakland team was also looking for opportunities to enter into cross-sector partnership arrangements. Through Linkage Lab 2, the team sought to acquire the capacities and skills to think differently about their service offerings, redesign core programs, and start dialogues with local health care providers and payers.

Key Objectives

The City of Oakland team focused their attention on three key areas: shifting their departmental culture to work across departments more effectively and dedicate more energy to potential external collaborative opportunities; exploring the redesign of their programs and services; and partnering with health care providers and payers. These efforts were in service of one priority objective, which was to design and launch a self-sustaining model of case management geared toward supporting healthy aging in place for older adults in Oakland.

Key Strategies and Processes

To achieve the priority objective of designing and launching a self-sustaining model of case management, the City of Oakland team knew that they would need to spend time understanding the work flows and cost of their current model. With support from the Linkage Lab technical assistance team, they developed a flow chart that highlighted their model from referral to program discharge and started the work of analyzing each step of the process and the associated cost. This work also shed light on areas in which efficiency could be improved and highlighted the need for tracking tools. This need was later addressed through technology updates and adoption of new case management tools. Improving the delivery of their current case management model was the team's first step toward designing and launching a self-sustaining approach to supporting more aging individuals in their community.

Improving the delivery of their current case management model was the team's first step toward designing and launching a self-sustaining approach to supporting more aging individuals in their community.

Contracts with Health Care Payers and Providers

The City of Oakland's Aging and Adults Services Division did not enter into any contracts with medical payers or providers during the program. However, the team did cultivate new relationships and engage in activities that have better positioned them to secure health care sector contracts in the near future.

Additional Successes

The City of Oakland's Aging and Adult Services Division developed better working relationships and increased information sharing with both other divisions within city government and outside entities. On the external front, they engaged in conversations to strengthen relationships with Sutter Health hospitals (i.e., Summit, Alta Bates) and the Alameda Alliance for Health. They also participated in development of the Alameda County 2017-2020 Plan for Older Adults, which includes a focus on coordination of services. In addition, they established a flexible gap funding source for their Targeted Case Management services, which serve Medi-Cal (California's Medicaid) beneficiaries in specific populations,

including older adults. The flexible gap funding permits the Aging and Adult Services Division to sustain a pool of case managers during gaps in health care referrals. Finally, City of Oakland became the coordinator of Oakland Paratransit for the Elderly and Disabled (OPED), which provides non-emergency transportation to medical appointments, shopping, and other local destinations.

The City of Oakland team shared information about their Linkage Lab work in meetings and conferences held by different groups, including the Alameda Alliance for Health, Senior Services Coalition of Alameda County, and Alameda County's Area Agency on Aging. The team reported that because of their participation in Linkage Lab, they are now seen as an innovator among potential partner agencies, both within and outside the health care sector.

Challenges

The City of Oakland Aging and Adult Services Division experienced several key challenges. Government policies, processes, and culture made it difficult to access the staff they needed for their work, and to effect changes in division procedures. They also lacked resources to purchase an adequate database system. Delays in reimbursement for Transitional Care Management created further resource challenges.

Lessons Learned

Key lessons for The City of Oakland:

- Funding for one program, or multiple programs, fuels opportunities to develop new or adapted programs.
- It is essential to be fluent in the language used by potential partners.
- An organization needs to set aside preconceptions in order to be open to discovering new opportunities in unexpected places.

About Meals on Wheels and Senior Outreach Services

Established in 1968, [Meals on Wheels and Senior Outreach Services \(MOWSOS\)](#) in Walnut Creek seeks to enhance the lives of older adults in Contra Costa County who have a full range of needs, by providing coordinated care that enables them to live independently and with dignity. Services include C. C. Cafés, which are lunch and socializing opportunities hosted by senior centers and recreational facilities; care management; fall prevention; Friendly Visitors; health and wellness services; and delivery of hot, nutritious meals to seniors' homes.

Why MOWSOS Joined Linkage Lab

The MOWSOS leadership team understood that the Affordable Care Act was creating demand among health care sector entities for the services that community-based organizations (CBOs) could offer. Although MOWSOS was already considered by many health care organizations to be the “go-to” agency for long-term services and supports for older adults in Contra Costa County, they lacked both adequate funding relationships with the health care sector and formal agreements with other CBOs that could offer complementary services. In addition, MOWSOS lacked the infrastructure to establish fee-for-service tracking and pricing, a marketing plan for outreach, and expanded staffing capacity to serve new clients. Through Linkage Lab 2, MOWSOS sought to solidify their new business model and put in place the infrastructure and marketing plan to support it. They also aimed to strengthen external relationships so that they could use their model in new contractual arrangements with the health care sector.

Key Objectives

MOWSOS focused their attention on achieving four objectives. First was to secure a fee-based contract for services with a health care entity, such as an insurer, hospital, or skilled nursing facility. Second, MOWSOS sought to create infrastructure to handle a fee-for-service business model, which required capacity to track agency expenses per client and to bill for the specific services rendered. MOWSOS understood that accurate billing and tracking were key components to assuring the long-term sustainability of their new service model. Third was to align staffing to accommodate the new delivery model. Finally, MOWSOS sought to ensure the new model was embraced by agency staff, volunteers, Board of Directors, and partners as this transformation represented a significant paradigm shift.

Key Strategies and Processes

MOWSOS used support from the John Muir/Mt. Diablo Community Health Fund (initiated prior to Linkage Lab) to improve their information technology (IT) systems and internal service coordination. Specifically, MOWSOS purchased a customizable case management IT system that permitted the agency to better link with future hospital system partners, created tracking and billing modules, and implemented a more streamlined, client-centered intake and referral process.

Another important strategy was to learn about the changes and trends emerging in the health care environment on a national, state, and local level. The team launched a discovery process that included a literature review, health care conference and webinar participation, and numerous meetings with local health care providers and payers to better understand the challenges and demands they were facing due to the changing environment.

A synthesis and analysis of the information gained helped MOWSOS to create a compelling value proposition and a strategy to begin developing partnerships with the health care sector as well as with other community-based and post-acute care organizations.

Finally, the team used visionary, consistent, and structured communication about the importance of the partnership development work to keep their Board of Directors and the entire MOWSOS staff informed and engaged. Because a key objective was to shift the organizational culture toward adoption of a fee-for-service business model, this communication was vital to obtaining the buy-in needed to launch new partnerships successfully.

The team launched a discovery process that included a literature review, health care conference and webinar participation, and numerous meetings with local health care providers and payers to better understand the challenges and demands they were facing due to the changing environment.

Contracts with Health Care Payers and Providers

Table 1 summarizes the contracts MOWSOS successfully negotiated during Linkage Lab.

Health Care Payer/ Provider	Criteria Used to Evaluate MOWSOS	Contract Timeline	Service Package	Population to Be Served	Pricing Structure	Implementation Status
Blue Shield of California contracted Partners in Care, which sub-contracted with MOWSOS	Ability to address social determinants of health that relate directly to mental health issues	1 year with annual renewal	Social support for high-risk patients with chronic conditions after they leave the hospital	Seniors and older adults with chronic conditions who could benefit from 30 days of in-home visits from a social worker	Fixed fee per member per month	Implemented

Partners in Care Foundation, a CBO, approached MOWSOS about collaborating to offer care coordination and social support services to the health care sector. MOWSOS moved forward with this arrangement, seeing it as an opportunity to increase their experience collaborating within and across sectors. Partners in Care Foundation subsequently signed a contract with Blue Shield of California to provide care coordination to high-risk patients with chronic conditions being discharged from the hospital, with MOWSOS to provide social support services. The goals of the collaboration were to (1) reduce hospitalizations through evidence-based care coordination; (2) improve health outcomes by addressing social determinants of health; and (3) reduce health care costs.¹

MOWSOS learned important lessons from this partnership, including what internal processes they needed to improve, and how to work with insurance companies and paying clients. They also learned that their care managers needed to embrace technology and time-sensitive work processes.

¹ MOWSOS. Press Release. MOWSOS Signs Contract with Partners in Care Foundation. February 18, 2016.

Additional Successes

In addition to entering into a new contract involving a community-based organization and a health care payer, MOWSOS used grant funding from the John Muir/Mt. Diablo Community Health Fund to pilot their patient services and measure associated outcomes with Kaiser Permanente Walnut Creek. MOWSOS also engaged in conversations with several other payers and providers about potential partnerships and is optimistic that such efforts will lead to additional contracts with health care sector entities.

MOWSOS has made multiple presentations on its Linkage Lab-related work at meetings of organizations such as the National Resource Center on Nutrition and Aging (NRCNA), and the agency recently wrote a primer on the process for Meals on Wheels America and the NRCNA. MOWSOS reports that one outcome of its work is that the organization is recognized as an innovator by other agencies.

MOWSOS learned important lessons from this partnership, including what internal processes they needed to improve, and how to work with insurance companies and paying clients. They also learned that their care managers needed to embrace technology.

Challenges

MOWSOS was challenged to carry a heavy workload, despite their small organizational size, as they engaged simultaneously in both internal and external re-framing. The agency was also overloaded by considerable data collection and presentation requirements for multiple ongoing projects.

Lessons Learned

Key lessons for MOWSOS:

- Nonprofits need to think and operate like businesses to be successful.
- Once an organization decides which direction to move in, its objectives should be the focus of every action that the organization takes.

About St. Barnabas Senior Services

[St. Barnabas Senior Services \(SBSS\)](#) is a dynamic senior service agency grounded in the belief that older adults have the right to age with dignity. For over 100 years, SBSS has been serving older and economically vulnerable residents of Los Angeles by providing comprehensive senior services while promoting a vibrant community life. SBSS operates in various locations throughout Los Angeles, including operating three multipurpose senior centers and providing meals at 11 community sites. In addition, SBSS provides social support services along with health and wellness programs to older adults living in senior housing. SBSS serves nearly 18,000 older adults annually in an ethnically diverse, low income, and densely populated area. Its services include transportation, home delivered and congregate meals, social services, case management, health and wellness education, recreation, art, and exercise, among others. SBSS clients are typically in their mid-70s, live alone, have few relatives or friends to assist them, and speak minimal English. Every day, SBSS strives to exceed its mission “to empower a diverse community of older adults to Live Well, Feel Well, and Age Well in the community with dignity and respect”.

Why SBSS Joined Linkage Lab

Emerging market opportunities afforded SBSS the chance to pursue both continuous improvement and mission expansion. Specifically, SBSS decided to repurpose some programs and services to align with the needs of health care payers and providers in the Los Angeles marketplace that were participating in value-based care delivery and reimbursement initiatives. The SBSS leadership team decided to join Linkage Lab to be able to compete for contracts in the health care arena successfully, while also continuing to provide a comprehensive range of services to existing SBSS clients. SBSS sought to build capacities and organizational readiness to initiate, design, and launch partnerships with the health care sector, building on their comprehensive community-based care management model that focused on keeping older adults well, healthy, and out of expensive care settings.

Key Objectives

The SBSS team realized that to enter into contractual agreements with health care organization, they would need to better understand the needs of the targeted population, design a more integrated model of community-based care management services, and

determine a pricing methodology. They would also need to formalize systems and protocols for contracting with health care payers and providers.

Key Strategies and Processes

The SBSS team first connected their ideas to market opportunities based on a changing policy and delivery system environment. Next, they educated their Board of Directors on how SBSS services could help health care payers and providers to improve the health and wellness outcomes of older adults, and how this strategic direction could open up a new source of revenue for SBSS. The Board endorsed this new direction and incorporated an initiative to create health care sector partnerships into the organization's five-year strategic plan. In addition, SBSS recruited an influential Board member to participate in the on-site technical assistance provided by the Linkage Lab technical assistance team. These initial steps established partnering with the health care sector as a priority throughout the organization.

Additionally, to help balance resources between maximizing existing operations and developing new services for the future, the team created a detailed project plan that outlined each major line of work with associated action steps, timelines, and accountability. A member of the leadership team was tasked with overseeing this process and ensuring timelines and deliverables were achieved.

With a solid foundation of endorsement and a clear plan of action, the SBSS team then initiated efforts to understand target population needs, identify several potential new partner categories (e.g., hospitals, managed care organizations, physician practices), and craft a value proposition that would highlight SBSS's differentiators and resonate with each potential partner. SBSS also facilitated initial conversations with potential health care partners to better understand their challenges with the population that SBSS had been serving for decades. SBSS then refined their service offerings to be in alignment with what they believed these providers would want to purchase.

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Another critical process that the SBSS team completed was to review all the incremental steps of their care management model, including referral, intervention, documentation, and transition out of services, and to build a fluid financial model to account for volume, service mix, staffing, and infrastructure costs, such as new technology. This financial model was then used for creating and experimenting with a variety of possible pricing mechanisms, such as fee-for-service, a bundled service package, and a per member per month arrangement.

Contracts with Health Care Payers and Providers

Table 1 summarizes the contract SBSS successfully negotiated during Linkage Lab.

Table 1: Summary of SBSS Contract with California's Health Care Sector						
Health Care Payer/ Provider	Criteria Used to Evaluate SBSS	Contract Timeline	Service Package	Population to Be Served	Pricing Structure	Implementation Status
White Memorial Medical Center (WMMC)	Interest in expanding WMMC's Vive Bien program to SBSS's service area and clients	1 year	Health education pilot for seniors in the community through the hospital's Vive Bien Senior Wellness Program	Older Adults at SBSS Echo Park Senior Center and Mid-City Senior Center, age 60+	No fee during pilot	Implemented

SBSS's agreement with White Memorial Medical Center for *Vive Bien* ("Live Well" in Spanish) programming brings health education content, including exercise programs, to SBSS clients via a "club-like" relationship. Specifically, clients are registered with Vive Bien, are tracked for participation, and receive health education and exercise programs, such as tai chi, at SBSS's Echo Park Senior Center. Future expansion is expected to include bringing *Vive Bien* to SBSS's Mid-City Senior Center. Currently, this is a no-cost agreement based on a collaboration to bring services to SBSS clients. In addition, SBSS and White Memorial Medical Center are currently discussing the possibility of SBSS furnishing pre- and post-surgery home assessments and education to older adults scheduled for hip and/or knee replacement surgery. The intent is to develop a sustainable model whereby SBSS can seek funding from one or more health plans.

Additional Successes

SBSS also entered into a new contract with the City of Cudahy in Los Angeles County to provide case management services to older adult residents. In addition, the agency engaged in discussions with payers and providers about three potential pilot projects and two potential contracts. SBSS is hopeful that these activities will lead to future contracts with health care sector entities. SBSS has shared information about its Linkage Lab work through participation in a focus group at the Meals on Wheels National Conference and through an interview for an American Society on Aging publication.

Challenges

SBSS experienced several important challenges in carrying out their work. At the time the program began, the organization was simultaneously expanding and opening new senior centers, so its resources were stretched very thin. In addition, SBSS's information technology (IT) and accounting systems were outdated, and the agency was challenged to develop and demonstrate a service package that would be scalable. SBSS was also told by potential health care partners that given its lack of experience with this sector, it would need to prove itself through pilot projects. Obtaining accreditation for SBSS's case management services would have helped to bolster the organization's credibility as well, but an organizational assessment supported by the Linkage Lab technical assistance team showed that SBSS was not yet ready for that process. Finally, SBSS also noted that its costing model was still high compared to market.

Lessons Learned

Key lessons for SBSS:

- Setting aside a regular dedicated meeting time for the project team can help to ensure that project work is completed in a timely fashion.
- Development of systems infrastructure and comprehensive analyses of organizational needs and assets can help lay the foundation for work with the health care sector.
- Engaging with the health care sector demands different thinking, language, and technology.
- It is important to manage expectations for what can be accomplished in a given timeframe, as change requires considerable resources.

Webinar

- Watch a [webinar](#) on overall results of the second cohort of the Linkage Lab Program.

Online Resources and Tools

- [E-Learning modules on Building Business Acumen of CBOs](#)
- [CBO Toolkit on Pricing and Sustainability](#)
- [Background brief](#) on preparing CBOs for successful health care partnerships
- [Webinar](#) and [report](#) on training care coordinators for integrated care models.

TSF Perspectives

- [Perspectives](#) from Dr. Bruce Chernof on the importance of forming effective health care and CBO partnerships.

All products available at
www.TheSCANFoundation.org/Linkage-Lab-Initiative