

BUILDING THE BUSINESS CASE:

COMMUNITY ORGANIZATIONS
RESPONDING TO THE
CHANGING HEALTHCARE
ENVIRONMENT FOR AGING
POPULATIONS

The National Coalition on Care Coordination (N3C) sponsored a symposium at the March 2014 Aging in America Conference of the American Society of Aging. That symposium, “Building the Business Case: Responding to the Changing Environment for the Aging Network,” has informed much of the content and lessons reflected in this brief.

This brief is intended to stimulate thinking, to pose questions that catalyze dialogue, and ultimately, to inspire action. Though the primary audience for this brief is community-based organizations, the larger goal is for this content to have crossover impact. Any healthcare organization (provider or payer) exploring partnership, specifically partnership with community providers, would benefit from engaging with the ideas and reflections in this paper.

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**The SCAN Foundation - advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. For more information, visit www.TheSCANFoundation.org.*

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WHY NOW?

Healthcare providers, payers, and community-based organizations (CBOs) have historically operated as separate care delivery systems, in which the responsibility for communicating and sharing information among providers has been on the client: the older adult, the individual with disabilities, and/or the caregiver. This system of care has inevitably resulted in confusion, duplication of efforts, and most significantly, poor health outcomes and extravagant spending.¹ Clients and family members are often overwhelmed by the realities of managing their health, and are in need of a system that advocates putting the individual at the center of the care plan.

The Patient Protection and Affordable Care Act (ACA) has since prompted the Center for Medicare and Medicaid Services to create a regulatory environment that incentivizes enhanced coordination and collaboration across the continuum, including the involvement of the community provider. These CBOs might include, but are not limited to, Area Agencies on Aging, social service organizations, nutrition programs, adult day care, geriatric care management, attendant agencies, and other organizations both within and outside the Aging Services Network. Initiatives within the ACA – such as Medicaid Managed Care, Accountable Care Organizations, Value-Based Purchasing, Bundled Payment Pilots, and Community-based Care Transitions – are requiring that healthcare providers look beyond a patient's illness or episode and the confines of a medical office or hospital to the patient's overall well-being, as they transition through the continuum to the most appropriate care setting. Rather than re-inventing the wheel, healthcare providers and payers have begun looking to community organizations for their expertise in supporting senior populations in the community.

As such, healthcare organizations, CBOs, and long-term services and supports providers are in the midst of an overhaul, and are being called upon to engage in their transformation to a new, foundational way of working. Furthermore, health systems and CBOs alike are experiencing the need for infrastructure improvements, evaluation of existing programs and services, succession planning, and equipping the next generation of leaders with the competencies and leadership skills to manage effectively in a disrupted market. The environment is ripe for CBOs to ready themselves to engage in the healthcare delivery system, while leveraging their strengths in providing long-term, supportive services to high-cost vulnerable populations.



In the ACA, the Department of Health and Human Services defined its National Quality Strategy, which builds on the Institute for Healthcare Improvement's Triple Aim: to improve patient outcomes, reduce costs, and improve quality of care across the continuum of providers. There is no shortage of ideas on how to make the

National Quality Strategy goals achievable, many of which involve partnerships between payers, health systems, and CBOs. There is, however, a gap in how to bring those ideas to action. Many of the entities that are beginning to consider partnership with community providers are questioning whether CBOs have the business capacity to bridge the service gap and help healthcare organizations (health systems, hospitals, and payers alike) to better control their quality and cost. The reality is that whether the barriers to execution are cultural, financial, and/or operational, the challenge of making ideas happen is experienced by all entities, particularly those coming together to realize visions larger than their own organizations' respective capabilities. This steep learning curve, experienced by health/medical providers, community/social service agencies, and federal agencies alike, has raised the question of how do these distinct entities begin to work together, despite their differing practices and limited understanding of one another?

The following content begins to address this question by building on the case that was presented at the symposium referenced in the introduction. This brief will provide insights and actionable approaches that have been employed by industry leaders and organizations proactively seeking to

close the gap between fragmented and patient-centered care to evolve with the direction of the market while serving the larger agenda of better providing for our communities. The principle challenge in this evolution is inevitably translating ideas to action, which requires replacing old behavior with new ways of working.

WHAT ARE THE OPPORTUNITIES?

TO INNOVATE:

Community-based organizations are well-positioned to inform the change the healthcare system is undergoing and to influence the care delivery system to include the provision of person-focused care. Person-focused care, which CBOs have been providing since their inception,



is important, conceptually and in practice, for healthcare organizations as well. It is about understanding the whole person and recognizing their problems in the context of their life circumstances, rather than just focusing on patient care related to a medical diagnosis.² By moving the focus of healthcare organizations from *patient*-centered care to *person*-focused,³ CBOs have the opportunity to reframe the intervention from the treatment of a patient within the context of an illness, to continuous, holistic care management over time. This includes the involvement of community-based services in improving population health through prevention, which is largely socially driven, and would serve to improve the experience of aging in America while lowering costs tremendously.

Social service organizations may not be accustomed to around-the-clock service delivery like a health system, but they are experienced in supporting individuals on a long-term basis. Creating 24/7 capacity will require a significant amount of internal assessment and ongoing development. Without building that capacity, however, forging a sustainable partnership with the medical sector will be increasingly difficult.

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To become a desirable partner of person-focused care requires considering and/or refining how to be a competitive provider, one that can demonstrate measurable value. The Chief Operating Officer of Akron/Canton Ohio Area Agency on Aging, Gary Cook, posed at the

symposium, "What do our new customers want to buy?" The definition of "customer" is evolving. The customer might be the complex patient, the payer, or the prospective business partner. In conducting an ongoing assessment of customer preference, having a business lens is increasingly a necessity. As Professor Ranjay Gulatai of Harvard Business School stated, "The goal is to bring value to customers in ways that are beneficial for them while also creating additional value for the company itself."⁴ The CBO is accustomed to thinking about its own viability, about ensuring funds to keep its doors open while providing for an increasing population in need. That perception of viability, however, has historically been rooted in the individual served. A CBO's sustainability is now also about creating its own value in the marketplace, one that is more about how the organization is going to creatively meet the need, with an accompanying business value proposition.⁵

TO MITIGATE RISK:

CBOs can provide the means for healthcare systems, providers, and plans to comprehensively address the impact of social, environmental, psychological, and cultural factors on patient well-being. A CBO inherently provides a lower cost service and has a history of supporting complex needs of individuals in the community. Through the expansion or creation of a coordinated care service line in conjunction with infrastructure improvements, a CBO has the potential to help an upstream entity manage its financial risk. Whether for a hospital participating in a bundled payment program and becoming a “payer” to downstream providers, or for a managed care plan blending coverage of medical and social services, a CBO’s services can be an essential component of a viable market strategy. Articulating one’s potential value to a healthcare entity is just the first step; it must be accompanied by the consistent delivery of that value, with qualifying outcomes. As Eli Veitzer of Jewish Family Service stated, “It is a dynamic competition. Getting a contract is only the first step. You need to deliver and improve upon cost, value, and reliability to keep the contract.”⁶

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TO TRANSITION PATIENTS THROUGH THE CONTINUUM:

A community-based approach to transitional care – improving transitions from the hospital to the post-acute environment and community setting – is of increasing value in preventing adverse patient outcomes, such as 30-day and longer-term hospital readmissions. CBOs are uniquely positioned to better support the aging population in transition from one setting to

another. CBOs are truly rooted in the community and have the ability to nurture existing or new relationships with other locally based community providers. These providers – whether their focus is nutrition or transportation, or if they are faith-based organizations, home health agencies, or Aging Network organizations – all play a significant role in improving patient outcomes. For higher-need individuals, longer-term community support can provide the infrastructure to help this population age in place, while avoiding prolonged nursing home stays.⁷ As CBOs become more active in effectively supporting patients in their preferred community setting, the hope is that patients will feel that their desire to age in place is a viable one, and, that there is a system in place to prevent the unnecessary trauma of transitioning in and out of multiple care settings.

TO SUPPORT PATIENTS AT THE END OF LIFE:

Supporting patients as they near the end of life is an area in which the involvement of community providers will be integral to both lowering cost and to honoring the needs and preferences of the patients. Twenty-five percent of Medicare dollars are spent on end-of-life treatment.⁸ According to Dr. Diane Meier, Director of the Center for Advance Palliative Care, “If you meet [patients’] needs, treat their pain, treat their depression, get them some help in the house, costs will plummet,” in

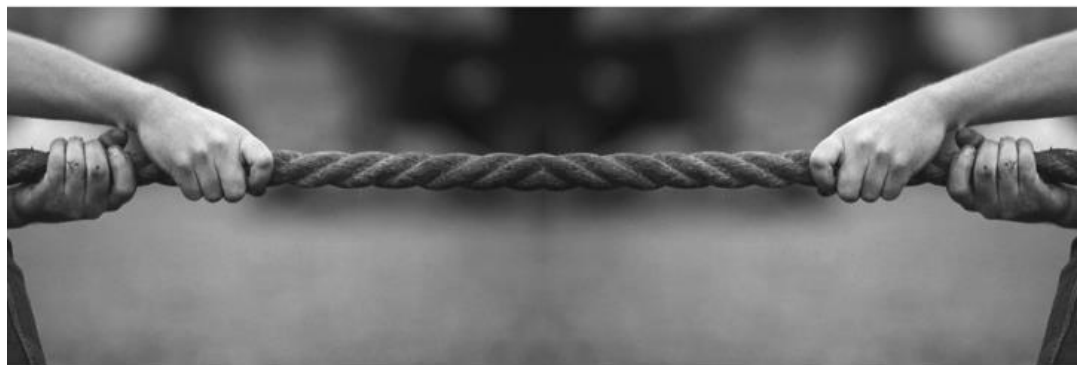


addition to enabling patients to remain in their homes without the added stress and psychological impact of hospital visits.⁹ Some CBOs are equipped to address many of the psychosocial needs that arise as patients and families transition through this stage, and are also well-positioned to explore the

community-based palliative care market, which remains largely untapped relative to the inpatient setting.¹⁰ It is ultimately about securing the right partnership to be able to provide the entirety of those services in a coordinated manner.

WHAT ARE SOME OF THE CHALLENGES AND BARRIERS TO ENGAGING WITH THE HEALTHCARE COMMUNITY?

There are many challenges inherent to the partnership between a healthcare system, a payer, and a community-based organization, which is true of any cross-industry relationship. This partnership is particularly charged because the participants have historically operated as distinct systems, despite serving much of the same population and often interacting informally with one another in service of the patient. The usual pattern of pursuing disparate agendas must be overcome. The overarching challenge is to evolve the normative behavior from “isolated impact” to that of “collective impact.”¹¹ This notion is essentially about an organization shifting its mindset to thinking about how it can effect change in conjunction with other entities, rather than how it can independently be successful. How can collective action become the vehicle that drives healthcare reform?



TO ENGAGE:

When either entity makes the strategic decision to consider the value of the other, there can be difficulty early on in the engagement. How does a CBO approach the healthcare community and vice versa, seeking to understand one another's language and services, and determining how they can provide shared value?¹² For example,

The engagement will require openness, transparency, and voicing of concerns in order to create the trust that is necessary to build a sustainable relationship.

understanding the *medical loss ratio (MLR)* is a key component of learning how the medical world now operates under the ACA and where a CBO might complement that structure. The MLR measures the ratio between an insurance company's costs paid toward enrollees' claims/services and the company's total expenditures.¹³ Under the MLR, at least 80% of money must be spent on medical claims and care. The ACA also expanded what qualifies as care to incorporate "Quality Improvement Expenditures," which includes care coordination, transitional care services, and medication compliance initiatives. The question inevitably becomes, how does a CBO legally provide a service on the claims side? One option for CBOs, which is still evolving, is to pursue accreditation (National Committee for Quality Assurance or Commission on Accreditation of Rehabilitation Facilities); some organizations are temporarily sub-contracting with medical group(s) that already provide in-home services, until accreditation can be acquired.¹⁴

Another engagement challenge in partnership development comes from differences in the speed at which entities deliver their services and scope of offerings. The acute setting is fast-paced, with a menu of service offerings for every course of treatment, while the community setting operates with less urgency and more limited resources. Is that disparity

interpreted simply as a difference, or as one lacking in capacity and efficiency? These subtle interpretations are important to understand and work through, as they set the tone of the engagement and may serve as a distraction from getting the work done. The engagement will require openness, transparency, and voicing of concerns in order to create the trust that is necessary to build a sustainable relationship.

TO FINANCIALLY ALIGN:

In the financial negotiations between a healthcare system and a CBO, the healthcare system, as a result of its financial strength and relative size, is often in the driver seat. The challenge for the community provider is to advocate getting a fair relative share of the savings it helps create. Whether proposing its daily service rate or setting a standard with incentive payment on the back end (contingent on savings produced), the community provider has the challenge of negotiating a fair contract. It is not only about mitigating the financial risk of the other entity; it is about sharing in the benefits of the value one's services deliver.



TO MEASURE AND SHARE DATA:

Community organizations, some of which continue to track progress in a narrative form, have the added responsibility of developing a practice, and ultimately a culture, of measurement to demonstrate its value to a health entity. Data may not be readily available, even for more sophisticated community organizations, which can make real-time decision-making more difficult. How then does a CBO make retrospective results attractive to a health plan or a hospital system, or seek to create real-time data? These questions are becoming more and more prevalent because health systems, payers, and foundations are moving toward prioritizing data collection in evaluating their prospective and existing partners and/or grantees. Demonstrating value in a measurable way is becoming the primary indicator of capability and success.

TO CREATE CULTURAL ALIGNMENT:

In addition to the more concrete challenges, cultural differences also contribute to fundamental partnering issues of trust, control, alignment of resources, and information sharing.¹⁵ When a CBO is trying to secure a contract with an established

Resistance to change must be expected and managed along the way to provide momentum that propels the partnership and to avoid overwhelming resistance that can lead to the demise of a relationship.

business entity, the community entity often bears the brunt of confronting those challenges head on, due to competition with other organizations vying for that same relationship. It is not just about moving from a social service outlook to that of a business outlook, rather a larger mindset and capacity shift must take place from senior leadership all the way through to the front-line service providers. The cultural component of partnership is

often not an organizational priority, but if it is not proactively addressed, there is a high likelihood that time and resources will need to be devoted later, causing further delay and/or the need to correct course. Resistance to change must be expected and managed along the way to provide momentum that propels the partnership and to avoid overwhelming resistance that can lead to the demise of a relationship.

TO TRANSLATE AWARENESS INTO ACTION:

The key challenge for both CBOs and healthcare entities is to become “outside-in” organizations, as referenced by Dr. Victor Tabbush at the symposium. Organizations with an *inside-out* perspective strive to address a client need by looking inward to the organization and exploring ways to adapt the service to meet the evolving need. An *outside-in* perspective looks to the marketplace first, explores the issue from the lens of the customer, and uses that perspective, coupled with the capability of the organization, to shape the solution.¹⁶ In order to shift from an inside-out to an outside-in organization, one's internal climate must also shift to support that new way of thinking. As was poignantly stated by Steve Dennings in Forbes:

*The managers and the people doing the work have to transform themselves. They need to be looking at the world through the lens of **other** - regarding behaviors and values. Instead of creating wins for themselves, they need to be creating wins for the customer. As individuals, they also have to adopt an outside-in perspective. Instead of telling people what to do, they need to be having adult-to-adult conversations.¹⁷*

These organizations have to build awareness of what is happening in their marketplace, while also attuning to their respective internal environments. To create alignment between an awareness of the need and the action it will require to drive the solution, leadership requires an intimate

knowledge and understanding of both.¹⁸ How does an organization begin to cultivate an “outside-in” capability? This question is posed in an open-ended fashion to encourage the reader to engage with this idea, to begin to question their organization’s approach and to reflect on how an “outside-in” capability might enhance the way they work and the “customer’s” experience of their organization.

REINVENTION AND PRE-WORK

Whether the objective is a contractual relationship with a health plan, becoming a preferred provider for a hospital, or developing a transitional care program for an ACO, success is contingent on the organizational capability and readiness to engage in new behavior and to deliver. This concept was exemplified in this exchange between senior leadership, as referenced by Brian Evje in Inc.: The CFO asks the CEO, “What happens if we invest in developing our people and then they leave us?” The CEO responds, “What happens if we don’t and they stay?”¹⁹ The commitment to investing in people, as well as in process, function, and infrastructure, requires linking short-term action with long-term goals. Though there is no immediate assurance of a tangible outcome, without investment, organizations are left with a strategy, but without the capability to bring it to form. Perpetuating stagnation is a much more



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FORM FOLLOWS FUNCTION:

An organizational structure is put in place to balance internal operations with external demand. As the industry landscape evolves, the organizational infrastructure must be re-imagined to remain relevant and to nurture employees who are learning to operate in a new system. For example, community-based organizations have been

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responding to the market by seeking to become more business-oriented and outcomes-focused. In this evolution, they are recognizing the importance of a leadership position devoted to business development and innovative practices. However, how that position is created is critical to its effectiveness. Does an existing leader take on this title and expand his/her role and responsibilities, or does the organization create the capacity to hire on additional staff with specific expertise in business development? In a similar vein, managers formerly operating as clinical supervisors will need further education and training to cultivate a business orientation. In order to drive favorable business outcomes, this individual needs the acknowledgement that his/her role is changing with the requisite resources to meet the demand of the role. The structure must evolve to meet the direction of the organization; it will otherwise continue to promote old ways of working and behavior.

ORGANIZATIONAL PERFORMANCE:

Funding patterns are shifting. Funders are rewarding organizations that achieve desired outcomes, as opposed to allocating money to organizations based on need.²¹ The emphasis has moved from identifying and articulating the external population need, to looking intra-organizationally, and creating a culture of performance that drives the quality that best responds to the need. It is incumbent on leadership to evaluate whether upper management has the right people in the right positions, to both inhabit and model the values and behavior that will ultimately permeate the organization and drive a culture of high performance. The line of sight between desired change and the internal environment in which people work is critical. Processes such as accountability, realistic goal setting, ongoing feedback, and engagement are the pillars through which the workforce becomes connected to the purpose of the work and invested in both contributing to and driving the outcomes.



As the author Simon Sinek conveys, it is leadership's responsibility to create the environment in which great ideas can thrive; it is the collective's responsibility, rather, to come up with the ideas.²² Asking an employee to contribute an idea is not enough. It is about modeling the behavior that nurtures ideation and supports the expression of that idea. The leader that provides constructive feedback, and creates an environment marked by trust, openness, and information sharing, helps create the type of workplace where individuals feel safe to explore freely and to ask the right questions.

NEW WAY OF THINKING:

It is important to consider strategy and planning as a two-part process. The strategic thinking process is intended to focus on the long-term positioning of the organization, whereas planning is tactical, short-term, and should not require the same breadth of participation and perspective.²³ A CBO that is reimagining its strategy must be open to a new way of thinking that is non-linear, and challenges the perspective of the decision-makers by incorporating ideas and thinkers who bring new information to the table, or who interpret old information through a fresh lens. Ultimately, decisions must be made, but the way the future is explored and strategy is created could benefit from a process that is marked by a new way of working.

As strategy begins to take shape, it is also helpful to engage various levels of the workforce early on in the process. For example, a community provider who is looking to partner with another local organization to streamline its service offerings typically might only involve the workforce once the strategy is moving into implementation. Why not include those on the front line in the conversation at the outset and ask questions, such as: Which local organizations might be a good partner? Why? What does the organization refer out to other providers that is cumbersome and inefficient, and could be managed more effectively with a formal relationship? Engaging the workforce in strategic thinking will lead to a heightened sense of ownership and a deeper commitment to the work, as well as strategy that is rooted in the reality of the day-to-day operation.





FROM IDEAS TO ACTION: HOW DO YOU BUILD IT?

Every system is flooded with perceptions about what is and what is not working, as well as insights for a more desirable future. How does a system make sense of all the noise and engage in a thoughtful, intentional, creative process around gathering information, committing to a path and taking action?

It begins with leadership:

- I. **Engage in pre-work:** Re-visit the organizational vision, mission, and values in relation to this initiative. Confirm objectives of the initiative/ partnership and desired outcomes. Identify prospective individuals who will make up the project team and be accountable to the success of the initiative. Confirm logistics, timelines, and standards around communication and follow-up.

- II. **Explore externally:** Scan your market and your competitors, and learn about the evolving needs of the current and desired population you serve. What are the emerging trends? Which trends will impact the way we work and how can we get ahead of them? Who are our competitors and prospective partners? Which entities hold the financial risk and will benefit most from the organization's services and positioning on the continuum? Which organizations have employed desired practices and how can we engage them in a conversation?



- III. **Listen closely:** This phase is about listening to existing and prospective clients and partners, and attuning to what they need to further their objectives. Though every organization brings a variety of expertise to every client or partner relationship, it is ultimately about meeting the client or partner where they are and seeking to understand their experience of the relationship or potential gain from the partnership. How has this arrangement been impactful thus far? What areas need improvement? How can we collectively better serve our clients? How can this arrangement be of shared value?
- IV. **Assess internally:** Conduct a comprehensive assessment of the organization, and engage in collaborative, multi-level dialogue to explore what the organization needs to stop doing and what will require further investment. Success will be contingent on consistently delivering value, which is dependent on a high performing workforce with a clear, mission-driven direction.

- V. **Translate findings and think creatively:** Before creating a strategic plan, engage in a new way of thinking about the organization. As Professor Henry Mintzberg stated, "Strategic thinking is about synthesis. It involves intuition and creativity. The outcome of strategic thinking is an integrated perspective of the enterprise, a not-too-precisely articulated vision of direction."²⁴ Let the thinking and planning be separate processes. Allow the thinking to be non-linear and informal. Create the space for the previous phases to be synthesized and ideas to be nurtured.
- VI. **Craft strategy:** Designate a planning phase, incorporating a long-term "vision of direction" with short-term action and realistic goal setting. What services does the organization currently offer and what might that evolve to look like to incentivize a potential partnership? What is being referred out to other providers that the organization can potentially take ownership over to enhance its own capability? How will the organization quantitatively demonstrate the viability and value of its services? What impact can you communicate with your data?
- VII. **Begin cultivating the relationships early on:** The crux of any partnership is built on trust. Building the relationships, the team, and the vehicle for carrying out the initiative is imperative. Without that foundation, one's value proposition will only go so far before more resources are expended on checks and balances to manage the relationship, rather than on cooperative efforts toward delivering value.²⁵ In establishing trust, it is also important to demonstrate a basic understanding of the language and regulatory obligations of the medical service provider. For example, many payers use the



term “assessment” for various components of their business, and as such, a CBO’s version of an assessment might be better coined as “evaluation.” Additionally, acknowledging the medical provider’s fears around its own liability in the partnership, HIPAA compliance, etc., and how the CBO is working towards operating within that structure, will go a long way.

Bill Johnson from Forbes recommends the following “Rules of Engagement” in the beginning of relationship building:²⁶

Rules of Engagement:

- ◆ *Alignment of principles and key decision-makers*
- ◆ *Laser-like identification of the opportunities*
- ◆ *Elimination of hidden or conflicting agendas*
- ◆ *Firm establishing of mutual trust and respect*
- ◆ *Delineation of clear goals, objectives, and priorities*
- ◆ *Definition of relentless staff members who will be held accountable for producing results*

VIII. Acquire the funding: As organizations evolve to meet the needs of the marketplace, it is important to look for funding opportunities that support collaboration and capacity building. Those are the vehicles through which the organization invests in a parallel process of development. In articulating the organization’s need to a prospective funder, whether it be a foundation or a health plan, it is imperative to communicate how the organization will address the need with an evolved set of tools, creativity, and meaningful allocation of resources.

IX. Crunch numbers: Translating strategy into action requires linking strategic objectives to the finances allotted. In addition, there must be a clear understanding of the cost of service or the model that is being proposed so the pricing can be appropriately determined before contract negotiations. Once the arrangement is in place it becomes

increasingly more difficult to make those modifications. The investment in redesigning services and restructuring the organization to allow for new ways of working with new types of clients should also be considered when crunching the numbers.

- X. **Commit to Action:** Once the strategies have been established, *how* are they carried out? Successful implementation requires a deep commitment by key stakeholders, and an established purpose, coupled with formal processes, change management practices, accountability, timelines, etc.

ORGANIZATIONS FUNDING AND DOING THIS WORK

ORGANIZATIONS FUNDING THE WORK:

The SCAN Foundation:

Funded by The SCAN Foundation, six California community-based organizations, each serving vulnerable adults with chronic health conditions and functional impairment, participated in a 24-month “Linkage Lab” whereby each CBO employed a project team to attend program seminars about strategic orientation, cost analysis, and change leadership; in teaching assistance calls and meetings; and implemented specific tasks such as developing a service integration plan and determining cost of care delivery. As part of Linkage Lab, these CBOs worked on developing specific skillsets to engage the medical sector, like assessing information technology gaps, client negotiation, creating a value proposition, conducting a market scan, etc. All of the CBOs have since made notable strides in preparing for and/or pursuing partnerships with the medical sector. The SCAN Foundation is in the process of rolling out their second round of funding for this initiative.

The John A. Hartford Foundation:

The John A. Hartford Foundation is working to improve the health of older Americans through grant initiatives that will put geriatrics expertise to work in all health care settings. The current grantmaking strategy focuses on: advancing practice change and innovation; supporting team-based care through interdisciplinary education of all health care providers; supporting policies, regulations, and a health care infrastructure that promote better care; and developing and disseminating new evidence-based models that deliver better, more cost-effective health care.

Administration for Community Living (ACL):

In 2013, ACL selected nine networks of community-based organizations around the country, that have been serving seniors and persons with disabilities in the community for years, to participate in a learning collaborative to better position themselves to build business relationships with healthcare partners. These networks have received training and technical assistance in marketing, contracting, and pricing their services.

Identified Participants:

- ◆ AAA of Erie County and Niagara County (NY)
- ◆ San Francisco Department of Aging and Adult Services (CA)
- ◆ Elder Services of the Merrimack Valley (MA)
- ◆ PA Association of AAA, Inc., in partnership with the PA Center for Independent Living (PA)
- ◆ Partners in Care Foundation (CA)
- ◆ Minnesota Metro Aging and Business Network (MN)
- ◆ The Senior Alliance and the Detroit Agency on Aging (MI)
- ◆ Alliance for Aging Inc., Miami and ADRC of Broward County (FL)
- ◆ North Central Texas Council of Governments (TX)

In recognition of the importance of this work, ACL selected another cohort of participants for a new learning collaborative in early 2015. This round will build on content from the pilot cohort—including disability service organizations as participants, and focusing on information technology, including protected health information, as well as focusing on accreditation and standards for metrics.



ORGANIZATIONS DOING THE WORK:

Institute on Aging:

The Institute on Aging (IOA), a participating CBO in the aforementioned Linkage Lab, has secured agreements with two health plans and a neighboring county to provide community-based care management services. Through various capacity building initiatives, namely organizational restructuring and aligning and developing their leadership team, IOA was able to establish a clear vision and bring it to form.

Cincinnati Area Agency on Aging:

Cincinnati Area Agency on Aging is an example of a CBO that has prioritized building internal organizational capability to better position themselves for partnership. A key change that they instituted after extensive assessment is the creation of a new leadership position with a business, outcomes, and innovation focus, in conjunction with eliminating

the chief operating officer position. They also removed all first-line supervisor positions, formed business units with business managers, and reinvested the savings into funding positions and infrastructure designed to support data-driven decision making and quality management. Lastly, they expanded telecommuting, to reach a broader, more diverse workforce, while increasing employee satisfaction in the workplace, thereby enhancing engagement and productivity.

Partners in Care Foundation:

Partners in Care Foundation has created broad, diverse product lines to meet the evolving needs of payers and providers. They have created a structure for multiple agencies to work together under a single contract. This network is designed to achieve regional coverage for the payers and incorporate the CBOs through a shared infrastructure so each organization can continue to do what they do best, while still thriving in the changing environment. From care transitions, to evidence-based self-management, to LTSS, Partners in Care Foundation has formed partnerships with multiple local and statewide entities to address the entirety of patients' needs as they transition through the continuum.

Elder Services of Merrimack Valley (ESMV):

ESMV has created a collaborative with six acute care hospitals, which also involves multiple post-acute care agencies (both skilled nursing facilities [SNF] and home health agencies), as well as primary care practices and a Federally Qualified Health Center. ESMV and the partnering hospitals have been guided by a learning collaborative through the Institute for Healthcare Improvement, called State Action to Avoid Rehospitalization. ESMV's main intervention is the use of the Eric Coleman Model, CTI, in conjunction with targeted programs for the identified root causes of readmission, which are home safety, primary care follow-up, care

coordination, and care transitions from SNF to home for the higher risk patients. With the use of mobile technology and interoperability within the ACA's Community-based Care Transitions Program, ESMV and partners allow for the sharing of real time information, not only from the patients' homes back to the AAA to prevent an ED visit or a readmission, but to the hospitals so that system changes can be made internally. Rapid cycle quality improvement has allowed the program to make necessary changes that customize the program to the patient population.

IN CLOSING

The case has been built for the involvement of the community provider on the continuum, but how to become a valued partner is a process contingent on each organization's respective capability and capacity to continuously improve. Health Affairs conducted a study on this in support of the work by the Robert Wood Johnson Foundation Commission to Build a Healthier America. In their 2013 study of 661 collaborations between community partners and health organizations, they found that the respondents identified *skilled leadership, mutual respect and understanding, and shared vision and common goals* as the factors that most influenced the success of their joint initiatives. Health Affairs made three recommendations, based on their comprehensive data analysis, to further cross-sector collaboration as we look towards the future:²⁷

- ◆ Entities that finance community involvement often have difficulty capturing the health impacts of their projects. Beyond financing the initiative, it is recommended to include the funding entity in the later stages of the project, to enhance their understanding of how the project actually works and to increase their ability to better assess and quantify impact.
- ◆ Organizations pursuing collaborative efforts need to increase

their understanding of – and ability to implement – measurement of outcomes.

- ◆ Focus on building relationships and communication platforms across sectors. Many respondents indicate that a lack of established relationships and communication pathways are a hindrance to collaboration between potential partners.

As we have highlighted, the symposium that N3C hosted at the March 2014 American Society on Aging conference emphasized many important considerations for community-based organizations and their potential partners to keep in mind as they forge new relationships and provide services in partnership with one another. As more and more CBOs pursue this route themselves, it is important for them to learn from the experience of those who have already begun navigating the complex process of asking critical questions of themselves and their organizational structure, crafting a strategy to lead their organizations forward, and developing working relationships and mutually-beneficial agreements with payers and health systems. We believe that CBOs are vital players in ensuring that the reform of the healthcare system is harnessed to improve how we provide services for and meet the growing needs of our communities. The concepts in this brief are important considerations as CBOs move to take on that challenge.



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