Partnership Profile

How CICOA Aging & In-Home Solutions Uses Data to Activate Services Faster and Deliver Value in Health Care Partnerships

CICOA Aging & In-Home Solutions (CICOA), an Indiana-based Area Agency on Aging, is turning a unique data connection with the Indiana Health Information Exchange into an opportunity to partner with health care entities to provide faster interventions and deliver personalized health-related services to high-risk individuals. For example, when CICOA quickly intervenes in the care of individuals who are at risk for falls, an area of great interest to their health care partners, they experience a reduction in fall rate to 5 percent from 25 percent. The result: happier, healthier community members and satisfied health care partners.

We have all heard the phrase 'knowledge is power.' But, how do we build knowledge in the first place? Knowledge is developed from a blend of available data and the wisdom of experience. CICOA Aging & In-Home Solutions (CICOA), a nonprofit Area Agency on Aging (AAA) focused on providing older adults, people with disabilities, and family caregivers with information, advocacy and support services, such as care management, nutrition services, and transportation, understands this well. CICOA has purposefully sought out and made use of data systems and sources to build greater internal knowledge about the effectiveness of non-medical interventions on health and health care outcomes. CICOA then turns this knowledge into greater power to partner with health care providers who are in the pursuit of better health outcomes for their clients.

CICOA funnels its use of health data to enhance cross-sector collaborations with hospital partners by activating the agency's services for at-risk clients more quickly and more effectively. CICOA has participated in four cross-sector partnerships with health care organizations, providing care management services as part of a multi-disciplinary team. For these partnerships, CICOA's staff has access to real-time data through the Indiana Health Information Exchange (IHIE), which enables them to quickly become aware of health care utilization and health status information for new and existing clients. This allows for immediate

connection with these individuals, often before they even leave the hospital, and ensures that their health-related social service needs are quickly identified and addressed, resulting in more efficient transitions to the community while avoiding unnecessary utilization of the health care system.

CICOA's cross-sector partnership strategy had led to an average annual revenue of $800,000.

The Starting Point for a Data-Centric Approach

In 2010, the CICOA leadership team, with President and Chief Executive Officer Orion Bell at the helm, first took an interest in IHIE. As the largest inter-organizational clinical data repository in the nation, IHIE is an incredibly rich data source for hospitals, physicians, payers and other potential cross-sector partners. Currently, IHIE has data connections with 117 hospitals, more than 15,600 medical practices and more than 14,100 providers, with health information associated with more than 14.4 million patients. Until recently, this was an untapped resource for community-based organizations (CBOs) like CICOA.

"We had a number of collaborative projects with hospital partners where we benefited from having the medical information of some of our clients, and we knew we were able to tailor the services we offered those clients based on our access to that data," explains Bell. "That was the starting point for us wanting to tap into more data resources. We knew IHIE had a vast store of relevant patient health data that could be useful to us. Once we recognized there could be incredible value here, the first step was to ask IHIE how we as a CBO could become a part of the exchange."

That proactive first step got the ball rolling. Leaders from CICOA and IHIE put their heads together to map out a plan, discussing the how and why of this new, unique data connection. "After those conversations, we were invited to participate in the information exchange," says Bell. "From there, we had to put mechanisms in place to make it work.

Fortunately, this data connectivity initiative was a case in which both sides were looking for reasons to say 'yes' rather than 'no.' The IHIE stakeholders already saw value in social service organizations being able to influence better health outcomes, so it was about agreeing upon the logistics, not overcoming objections. As Bell shares, the agency and the exchange had several discussions about creating appropriate permissions, how to determine the appropriate cost basis to participate, and what to use as data input codes—they developed a unique CICOA record entry in IHIE's system to mimic a clinic visit code—to make the connection work.

"We had to source a software and reporting architecture that would enable us to provide information to and communicate with the exchange. We secured funding from the Fairbanks Foundation for an HLS7 software system so that we could have a platform that was compatible with IHIE's. Once we adapted the technology for our community-based setting, we were off and running," he says.

Using IHIE Data to Intervene Faster

With connectivity established, CICOA can access relevant data from the IHIE system. "The data points we are most interested in are about any health events of a client of ours," says Bell. "Having access to IHIE's admission, discharge and transfer (ADT) reports in an automated feed has been the most important benefit for us, providing updates any time a client transitions through the health care system."

Receiving automated ADT reports through the information exchange is a stark difference from how CICOA obtained this information prior to establishing a formal relationship with IHIE. Before CICOA's connection to IHIE was established, it could take quite a while for the agency to become notified of a client's admission to the hospital. For instance, if a client had a fall and went to the emergency room, there was no standard communication method for CICOA to find out; sometimes staff members would learn of the event right away, other times CICOA staff would not learn this information until much later. That information delay created an inability to deliver timely and valuable services to clients when it could have made a difference.

“Today, because of the tools we have, coupled with our staff’s persistence, we have a contact rate as high as 70 or 80 percent.”

“It can be difficult to locate clients over time. People change addresses, or maybe they had a pre-paid phone and they are out of minutes,” explains Donata Barnes, Director of Health Care Collaborations at CICOA. “Because of the ADT data we get automatically from IHIE, we have another opportunity to establish contact with our clients; we know almost immediately where they are because they appear on the IHIE record. Before we received information through the information exchange, a 20 percent contact rate was considered good. Today, because of the tools we have, coupled with our staff’s persistence, we have a contact rate as high as 70 or 80 percent.”

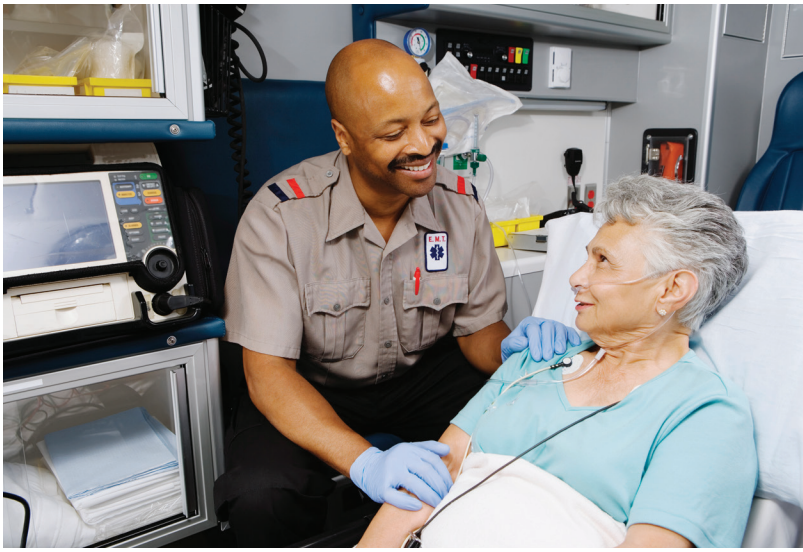
Improved contact rates lead to more reliable and frequent interaction with clients, ensuring their non-medical needs are actively addressed and that health-related concerns are addressed early, rather than after unnoticed complications lead to unnecessary and costly health care utilization, such as a visit to the emergency department.

“We have gained so much from having a system that allows us to access real-time information about admissions, discharges and transfers of our clients,” says Barnes. “When a client goes to the ER or gets hospitalized, we get an ADT alert automatically within 24 hours. Now, we can see that activity and begin planning the next steps with the client right away.”

Health care partners see the benefit, too. “Our hospital partners have tracked the effectiveness of the program, and it isn’t simply the fact that there is a CICOA staff member in the mix, but there is evidence that over time our collaboration can reduce ER admissions and hospitalizations for our community members,” shares Bell.

With access to IHIE’s real-time ADT reports, CICOA receives a snapshot of information about its clients, including why they were admitted, what kind of education they may require once they are discharged, and which social and behavioral determinants of health the agency can address to reduce the likelihood of re-hospitalization. The real-time nature of this data flow allows CICOA to be more proactive with clients; they can make the first call to establish contact with the patient or caregiver before they even leave the hospital, rather than relying on the client to reach out on their own after the fact.

Even with having access to automated ADT reports, CICOA leadership would tell you they are still only scratching the surface of the possibilities with IHIE data. “Having the ADT reports flags to us when a client is admitted—or re-admitted—to the hospital. The next step would be to use more of IHIE’s data capabilities, including their CareWeb tool that would provide a window into our clients’ medical history. What we are doing with data today is making a difference, and we plan to continue exploring new ways to use data systems to build knowledge and personalize services,” says Bell.



> **A person's health story does not end when they exit a hospital's doors.**

Give and Take

CICOA's data-driven strategy is not just about obtaining reports from IHIE; the agency also provides information to the exchange, providing their health care partners a perspective from the community previously unavailable to them—one of significant value in better understanding the conditions and needs of their shared clients.

A person's health story does not end when they exit a hospital's doors. To build a fuller picture of the client as a person, CICOA and other health organizations tapping into IHIE can also learn what happens during transitions of care and long-term management of services and supports at home. When CICOA provides data to the exchange it helps bridge the gap between when people leave the health care setting and when they are back home in the community.

"As an example, we had one client who was not mobile; she couldn't physically get from her home in the building where she lived down to the front door to pick up her medications," says Bell. As a result, she was not adhering to her care plan because she was not taking her prescribed medications, but her health care providers were unaware. CICOA's contact with the client within her home shed light on the problem and allowed the agency to resolve the issue by providing medication delivery as a solution for this client, so she could get her medications without having to go to the front door of the building. This enabled the client to adhere to her care plan and take her medications on time, eliminating the risk of complications of her health condition that could have led to unnecessary utilization of health care services and poor health outcomes.

CICOA is also able to use its data-centric approach as a differentiator when partnering with health care organizations serving the same population. The interface with IHIE allows them to be more intentional with specific interventions for specific clients, with a level of individualized servicing that would not be possible otherwise. "We have the data and performance measurements, so we are able to report out that information in meaningful ways," says Bell. "By tracking our clients' ADT reports and layering our own case note data on top, we have evidence—and confidence—that what we're doing works."

When you speak with CICOA's partners, you hear loud and clear that health care leaders also have confidence that what the agency is doing works.

Christopher Callahan, MD, who serves as the Chief Research and Development Officer at Eskenazi Health; Director of the Indiana University Center for Aging Research (IUCAR); and Cornelius and Yvonne Pettinga Professor at Indiana University School of Medicine, has seen firsthand the value CICOA brings to a health care partnership. "As a community partner, CICOA is effectively our eyes and ears in the in-home setting," he says. "By having CICOA staff embedded within the hospital setting, we are bridging cultures and strengthening relationships across the medical and social sectors. Our ability to share data enables us to constantly come together to refine our programs and provide better service and care to the aging members of our community."

> **"By tracking our clients' ADT reports and layering our own case note data on top, we have evidence—and confidence—that what we're doing works."**

When Data Access Leads to Better Outcomes

If knowledge is power, then knowledge must be put to good use and yield real results.

"Our health care partners see the value in our services and interventions because the improved health outcomes are there," Bell asserts.

How does CICOA know that their investment in data systems is making a difference?

"One metric we use as a proxy is tracking how long a person stays enrolled in Indiana's Medicaid waiver program, which gives us a similar measure to days in the home. For someone who qualifies for a nursing-home level of care, we look at how long we can keep that person in the community. On average, this is 1,050 days—more than three years," explains Bell. Reducing the need for institutionalization by providing targeted home and community-based services not only results in better health outcomes for clients, but also results in cost reduction for health care partners looking to control costs.

"When we talk about this with health care payers the comparison we can make is that we know what a year of institutional care costs, and we know what a year of community-based care costs," says Bell. "Generally speaking, community-based care is roughly 50 percent less expensive than institutionalized care; this is tangible and meaningful for health care payers."

CICOA puts great emphasis on tailoring services for clients to produce the best outcomes possible. This approach appears to be working, because CICOA has found that 88 percent of clients receiving care management reported in client satisfaction surveys that their quality of life has "definitely improved."

The financial impact is there, as well. "With the hospitals where we have CICOA staff within facilities, they look at the return on investment, at the cost of having our staff in the environment vs. hiring someone in-house, and they tell us they get a bigger bang for their buck by partnering with us," says Bell.

Building Knowledge and Momentum

CICOA is an impressive example of how CBOs can make use of available data to enable earlier interventions that lead to better health outcomes. And the agency is not stopping here.

"We are in discussions now with several providers to expand our use of data," shares Bell. "We can talk about our ability to integrate our social determinants services to complement the services provided by the health system or insurer. We see more cross-sector and collaborative opportunities, and we feel fortunate that we have 'cheerleaders' in the health care community. They see the value we bring because of our decades of experience and our access to IHIE."

The authors are grateful for the time and insights provided by those who were interviewed for this cross-sector partnership profile, especially Orion Bell, President and CEO at CICOA; Donata Barnes, Director of Health Care Collaborations at CICOA; and, Dr. Christopher Callahan, Chief Research and Development Officer at Eskenazi Health, Director of Indiana University Center for Aging Research (IUCAR), and Cornelius and Yvonne Pettinga Professor at Indiana University School of Medicine.

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Success Stories

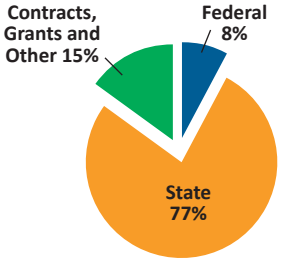
How Elder Services of the Merrimack Valley Replicates Its Cross-Sector Partnership Successes

"Timid" is a word that doesn't seem to exist at Elder Services of the Merrimack Valley (ESMV). At this private nonprofit Area Agency on Aging supporting older adults and people with disabilities in northeast Massachusetts, there is a fearless, let's-make-things-happen energy that you can't help but notice from staff at all levels across the organization. And this energy goes beyond values: **ESMV has translated this attitude into a culture that has been the springboard for a robust portfolio of cross-sector partnerships and community results.**

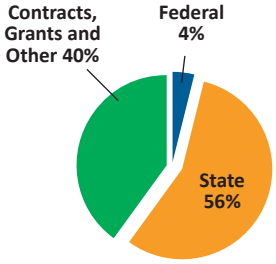
The origins of ESMV's robust cross-sector partnerships can be traced to 2004, when Massachusetts mandated that special needs plans partner with Area Agencies on Aging to address the long-term support needs of individuals who are eligible to receive both Medicare and Medicaid. This experience allowed ESMV to take advantage of the later passage of the Affordable Care Act, which stimulated experimentation in the way care is delivered and reimbursed. It also encouraged organizations across the health and social sectors to work together to reduce costs and improve quality. After participating in the Centers for Medicare & Medicaid Services' (CMS) Community-based Care Transitions Program (CCTP), ESMV leadership realized the success of the program and thought, "This model works. We can make this sustainable even after the pilot concludes."

With this new strategic direction, ESMV eventually secured more than 20 cross-sector partnerships with numerous health care entities, such as hospitals, payers, accountable care organizations (ACOs), Programs for All-Inclusive Care for the Elderly (PACE) and primary care practices. The organization has more than doubled its staff and revenue over the last decade, achieving a significant decrease in reliance on state and federal funding (26 percent and 50 percent decrease, respectively). The success is not limited to ESMV, as its health care partners and clients are also experiencing the value of improved outcomes, such as an 11 percent reduction in hospital readmissions within 30 days, an 18 percent increase in scheduled physician visits within seven days of discharge, a 15 percent decrease in emergency department visits and an 11 percent reduction of health care spending.

THEN
FY 2007
Total Revenue **26.8 million**



NOW
FY 2017
Total Revenue **63.7 million**



- **Agency REVENUE** and **STAFF** more than **DOUBLED in 10 years**
- **26% decrease** in reliance on state funding
- **50% decrease** in reliance on federal funding
- **137% increase** in contracts, grants and other

Of course, you don't get these kinds of results based on culture alone. So how does ESMV do it? What has enabled this organization to replicate success so many times? There are some common denominators that form the foundation of ESMV's partnership success.

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Leave No Stone Unturned

One factor underlying each of ESMV's partnership successes is the idea that if there is possibility, ESMV goes for it. "If there's an opportunity to be had, even if it's remote, we make a point to look into it," shares Joan Hatem-Roy, ESMV's Chief Executive Officer. "Don't close an open door; don't let anything slip by."

ESMV's many productive partnerships run the gamut from ACOs and Managed Care Organizations, to primary care and telehealth technology providers. Designing and building such a diverse portfolio took vision and a willingness to explore opportunities outside of the norm. This leave-no-stone-unturned attitude is a cornerstone of ESMV's partnership success, but it's how the team puts this tenacious attitude into practice that makes all the difference.

What does it mean to leave no stone unturned? At ESMV, it comes down to building an organizational structure where every staff member is encouraged to participate in finding, vetting and incubating partnership opportunities, which the team calls "new innovations." It also includes paying close attention to ESMV's infrastructure, which has provided the foundation for successful contracts.

Evaluating and pursuing new partnership opportunities is on the agenda at numerous regular meetings. "Each week, we have a meeting with our core leadership to discuss new opportunities," says Jennifer Raymond, ESMV's Chief Strategy Officer. "Every other week, we hold the same type of meeting, only we include everyone on the director level. These aren't quick meetings, either; we've made it a priority to spend time making informed decisions about what to explore now, what to put on the back burner and what to pass on." The largest factor in the decision-making process is an alignment with ESMV's mission and values, which include empowering consumers with the information, resources, programs and services necessary to meet their individual goals for living successfully in the community. Additional considerations when taking on a new opportunity include the impact of the work on the critical and foundational strategies of the organization and the ability to collaborate with community partners to make the innovation successful. For example, when presented with the opportunity to address the needs of a younger Medicaid population by contracting with newly developed MassHealth ACOs, ESMV seized the opportunity only after securing the commitment and partnership of its local disability colleague, the Northeast Independent Living Program.

> What makes ESMV different is that these discussions don't end with the leadership team, as they recognize that the champions of the organization's efforts must go beyond its leaders. To instill this practice, ESMV's monthly all-staff meetings include discussions of potential innovations, and everyone, regardless of role, is encouraged to add their perspective to the discussion.

For instance, if an opportunity passed the test in the weekly core leadership meetings, a member of the leadership or director team then presents the idea at the all staff meeting. "We have a three-part presentation template that forces us to boil it down by articulating the opportunity, sharing why we want to pursue it and explaining what it means for our staff," says Raymond. By encouraging everyone to be part of making new opportunities happen, ESMV leaders task staff members with not only delivering the right services once partnerships are live, but also in the strategic decision-making process about which opportunities to pursue—or not.

In addition, ESMV conducts monthly professional development sessions for staff that cover a variety of topics. "Everyone is encouraged to attend, whether the topic is related to their job title or not," shares Raymond. "This continuous exchange of ideas shapes our partnership work—and creates greater awareness of what we do and what is possible for us to achieve as an organization." Professional development sessions often include continuing education units (CEUs) for social workers and nurses, which tends to incentivize attendance and promote professional growth.

Now building a tenacity-driven culture doesn't happen overnight, but there are some initial steps your organization can take if this is an area it would like to develop. Make space in your weekly and monthly schedules to truly focus on energizing the people in your organization to put on their innovation caps. Consider introducing a knowledge-transfer initiative where staff learn about the work being achieved by other departments, hosting a new style of professional development course, or reimagining your staff meetings to encourage more "are we leaving stones unturned?" conversations where all levels of staff are empowered to think creatively.

Rethink the Meaning of the Word 'Competitor'

The second common denominator is a willingness to reframe a competitor as a potential partner. "Let's face it: there's competition everywhere we look. New entrants are coming into our space whether we like it or not, so the question becomes, 'How will we respond?'" Hatem-Roy explains. "We look at the idea of competition in a new way. Is there a risk someone could steal our intellectual property? Sure. But the bigger risk is if they build it without us and end up leaving us behind."

When ESMV became aware of a grant opportunity from the Centers for Disease Control and Prevention (CDC) for innovative statewide approaches to arthritis management, it developed a partnership with a competitor for a good reason—it made sense. "In this situation, the state informed both sides that we were each looking into the grant, so we made a point to sit down and talk about it," says Raymond. "These were not easy conversations, but we both decided that if there is a stronger path to success that includes an equal partner, it's worth exploring. We ended up striking an agreement on a five-year, multi-million-dollar proposal that was ultimately very successful. In the end, we got funding for work that will reach many people, and I don't think either of us could have done it without the other."

It's important to remember, too, that the competitive landscape is changing. With the lines continuing to blur between the health and social sectors, community-based organizations may increasingly see new types of competitors in their communities, but if they take a page from ESMV's book, they may be able to turn competition into a strategic partnership.

> If a new competitor—that may in fact be a possible collaborator—crops up, ESMV does its homework and then engages in a conversation. By talking through each entity's service offerings, ESMV looks for areas where the agency could complement the other organization and offers ideas where ESMV could add value in a collaborative setting.

Sometimes, a potential competitor can become a collaborator simply when they gain a greater awareness of what you do. For instance, when ESMV began speaking with a start-up telehealth technology provider about possible areas of mutual interest, it looked like there could be a potential area of competition when it came to the health navigators service. But, after an illuminating conversation about what ESMV's staff was equipped to handle—including taking on the navigator work—the mindset across both organizations switched from "there are aspects to their business model that could compete with our service offerings" to "they understand now why we are best positioned to take on this aspect of the work."

"If you decide you're not ever going to look at a competitor as a potential collaborator, you're leaving space for everybody else who is a competitor to take that and run with it," warns Raymond. "Your competitors could partner with each other—then what? I'd rather be the entity bringing competitors together as opposed to being on the menu when they come together at their own table. If you think people who are competitors are always going to stay in their lane, you might be left out at the end."

Know Your Value and Communicate It with Confidence

The third factor in ESMV's arsenal is understanding your organization's value—and making sure others understand it as well. "We have spent a lot of time trying to really understand our value. And I don't mean just the services we offer, but the value we can bring to a partnership and to the community," says Raymond. "For instance, when a member of our leadership team sits down to talk with a new health care partner, they feel confident in saying that ESMV will provide the service you said you need, but if we do only that, you may be missing ESMV's value to help you in other ways, such as tapping into our talent and expertise to provide behavioral health counseling, nutrition services and disease management."

Understanding your organization's value builds off of engaging competitors and searching for opportunities—where a tenacious, collaborative culture combined with a willingness to reframe competition and challenges culminates in a culture of accountability in action. Here, ESMV goes beyond the typical quantity measures of saying, "We served thousands of people this year" and instead assessing the quality and impact of the service. The shift in focus from *quantity* to *quality* contributed to ESMV's recent pursuit and achievement of a three-year accreditation by the National Committee for Quality Assurance (NCQA), which helps to demonstrate ESMV's commitment to quality service.

Before jumping into the work of finalizing a partnership agreement, ESMV thinks about how to measure success, and uses satisfaction surveys, patient activation measures and patient-reported outcomes to capture information that demonstrates how well they are performing. Instead of focusing only on the number or people served or the number of services provided, ESMV can provide evidence that the outcomes are there because of ESMV's services. For instance, ESMV uses their outcomes-focused surveys to communicate points such as: how did compliance rates change with individual care plans, by how much were fall rates reduced and to what extent are patients and caregivers more satisfied with their programs and care.

> It's one thing to conduct an internal rethink on metrics and measurement; it's another to take those results and use them to communicate influentially with partners and potential partners.

"One example that illustrates our focus on outcomes accountability is with one of our dual-eligible health plan partners here in Massachusetts," says Raymond. "They were struggling with no-shows, non-compliance with care plans, and even some members leaving to go to competitor plans. When we did a pilot program to provide a suite of evidence-based programs to their members, we collected data based on satisfaction and we were able illustrate within six months that the people served by the program had increases in care plan activation, compliance and confidence. Being able to demonstrate and communicate our value in that way was the reason that we still have a contract and strong relationship with this partner to this day."

One way that ESMV gets serious about elevating the organization's value is by convening meetings at which local organizations focused on community health can talk shop. Yvette Bailey, Director of Case Management at Anna Jaques Hospital, a longtime ESMV partner, has seen this in action. "ESMV is like our community think tank," she says. "They don't just join the conversation, they lead the conversation in our area. They proactively bring different players together to ask: How can we help you? How can we add value? Where can we do more? To me, that is visionary."

As ESMV demonstrates, recognizing the value your organization brings to a partnership and articulating it in a way that means something to potential and current partners fuels the replication of success. This requires going beyond a theoretical conversation and demonstrating substance as to what "value" means, using outcomes and examples. Once you have established what you can achieve and bring to a partnership, ensure that this is understood throughout your organization—and don't underestimate the value of practicing the delivery of this message. This will ensure that you will be ready when opportunities, whether formal or informal, arise. Though it is important to proactively schedule and engage in conversations and meetings with your desired audiences, it is equally important to be prepared for unexpected opportunities to educate others and raise awareness of the extent of the value you can bring to the partnership.

Blazing Trails

As one of ESMV's partners, Bailey, puts it, "Anyone in health care knows we need to be innovative and think of ways to be of service to people while being sustainable and nimble in an environment that can require change at the turn of a dime. People are in the hospital for a short time, so we need strong relationships with community organizations to ensure positive outcomes once they leave our building. We have that in ESMV. They have such a strong culture of service, producing results and understanding their mission."

With its common denominators driving decisions and behaviors both internally and externally, ESMV is changing the meaning of organizational culture from *"this is what we believe"* to *"this is how we operate."*

So often we hear the same push to enhance or revitalize our culture, but that's only the beginning. As ESMV shows, it's how an organization operationalizes its culture that will propel its ability to explore more cross-sector partnership opportunities. So what's next for ESMV? Even with its success, ESMV continually looks for ways to improve. This includes further instituting the practices and processes that comprise their organizational culture by making them documented policies. And, of course, they will continue to respond to and seek new opportunities for partnership and to raise the awareness of ESMV's vital role within the community.

The authors are grateful for the time and insights provided by those who were interviewed for this piece, including Joan Hatem-Roy, ESMV Chief Executive Officer; Jennifer Raymond, ESMV Chief Strategy Officer; and Yvette Bailey, Director of Case Management at Anna Jaques Hospital.

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Partnership Profile

How the Boulder County Area Agency on Aging Is Building Demand for Cross-Sector Partnerships in Their Community

There are many roads that community-based organizations (CBOs) can take to begin the journey to cross-sector partnerships. For some, state governments mandate the creation of programs that lead to partnership opportunities between health care entities and CBOs. For others, cross-sector partnerships begin with an initiative that promotes engagement across sectors to improve health system performance. And in markets where mandated opportunities and cross-sector initiatives have not yet developed, the cross-sector partnership journey begins when a CBO decides it wants to get noticed by its local health care providers and payers, opening doors that had been otherwise closed. This is how the Boulder County Area Agency on Aging (BCAAA) embarked on its journey to cross-sector partnerships.

A focus on creating more accountability in the health care sector, a growing uncertainty around sustainable funding within the social sector, changing demographics among the aging population and related increases in the demand for health and social services create an environment in which great potential exists for integrating the medical and social sectors to create better health systems. The convergence of these conditions illustrates the value inherent in having the medical and social sectors work together more efficiently to better meet the needs of older adults and people with disabilities—while producing mutually beneficial financial and operational results.

But even when market need appears to exist, the demand for the health care sector to invest in and partner with social services isn't automatic. In this scenario, it is often up to CBOs to proactively generate attention, build demand and demonstrate compelling value[i] for their services. Recognizing this dynamic, BCAAA concluded that it would have to start from scratch to build the needed business acumen to create the conditions for thriving cross-sector partnerships.

Identifying the Potential for Partnerships

As the only Area Agency on Aging (AAA) in Boulder, BCAAA's mission is to deliver, fund and advocate for services that promote the well-being, independence and dignity of the older adults, people with disabilities, family caregivers and veterans in its community.

In 2014, to better understand the Boulder landscape and to evaluate the potential for partnerships, BCAAA identified several factors that it could use to its advantage when creating cross-sector partnerships:

- Changing demographics of the aging population would likely lead to a growing need for BCAAA's services
- The growing size of the aging population could create possible challenges for health care systems
- A trend in health care systems toward rewarding accountability for the delivery of cost-effective, efficient and quality care could present an opportunity for health care partnerships

BCAAA realized that the response to these trends would likely provide a clear incentive for a coordinated system to support the overall health and well-being of individuals in the community. Furthermore, traditional funding sources for AAAs, including government funding and grants, were becoming increasingly uncertain, leaving BCAAA with the issue of needing to provide services to a growing population while having less funding from traditional sources.[ii]

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An analysis of the internal concerns about the agency's sustainability and the trends noted earlier led BCAAA to realize that it should pursue revenue-generating cross-sector partnerships with health care organizations.

To inform this decision, BCAAA looked beyond the Boulder area to gain a wider view of how similar agencies in other parts of the country were addressing these trends in their own communities. With focused curiosity, the BCAAA team learned about approaches other AAAs were taking to develop more sustainable, diverse funding streams—particularly by engaging in cross-sector partnerships with health care providers and payers.

Armed with examples of ways other CBOs successfully pursued cross-sector partnerships, BCAAA secured an opportunity to participate in the Linkage Lab program.[iii] Sponsored by the Colorado Health Foundation,[iv] the goal of the Linkage Lab program is to help CBOs build the business acumen required to establish revenue-generating partnerships with health care—a perfect fit for BCAAA.

Responding to New Opportunities with New Talent

BCAAA leadership realized that, in order to pursue partnerships in a proactive way, the agency needed someone to lead the charge. In 2015, BCAAA took the opportunity to redefine the job description for an open position on its leadership team and decided to seek a candidate who could focus on business results and partnership development.

This decision led to the creation of a Business Results Manager role, which would be responsible for leading BCAAA's health care integration and partnership development efforts. The position would also be responsible for leading the BCAAA team through in-depth market research, a redesign of its service offerings, the development of a value proposition and the implementation of a pilot program with a local hospital. As part of this implementation, the BCAAA team was tasked with critical steps, such as contract negotiation, operational process development and training, and developing a monitoring and evaluation program.

Of course, the agency needed the right person to breathe life into this new role—and to design an infrastructure that emphasizes cross-sector collaboration as a path to revenue. Enter: Jacob Bielecki. "The agency leadership was ready to take a keen awareness of the market opportunities and funnel that into a realistic vision and strategy for creating new business," says Bielecki.

CBOs adding a Business Results Manager or someone to initiate and advance their cross-sector partnership strategy should look for individuals with a mix of vision, discipline, and a thirst for knowledge to bring to the role.[v] "When I came in, I read everything I could find about the aging services and health care sectors. I sought new networking opportunities with hospitals and physicians to help me understand their challenges and learn how they view community-based service providers," Bielecki says.

Building the Knowledge Foundation for Cross-Sector Alignment

To dig into the new position and begin the knowledge-building necessary to determine where potential health care alignments and partnerships could exist, Bielecki sought resources that would help him understand the health care space, including regulatory factors and payment transformation. BCAAA recommends that anyone assuming a new role like Bielecki's train their eye to pick up on certain words and phrases like "value-based purchasing" and "bundled payments" anywhere they can find it—such as in national literature, newsletters and other publications.

From there, Bielecki recommends that agencies take knowledge gained at the national level and apply it locally. "We had informal relationships with local hospitals in Boulder County, so that was a natural place to start. We looked at local performance data and asked questions in a way that demonstrated we understand what health care organizations are facing. 'How are you performing in the Bundled Payment experiment?'…'What pressures are you facing due to health system reform?'… 'What are you doing about your readmission rate?'"

BCAAA's new knowledge of the national and local landscapes served as the perfect complement to BCAAA's participation in the Colorado Health Foundation's Linkage Lab program, which kicked off around the same time Bielecki joined the agency.

An invaluable starting point for someone new to the space, and for an agency early in its cross-sector partnership journey, the Linkage Lab program afforded the BCAAA leadership team an opportunity to gain formalized training and insights that would be invaluable as the agency pursued new partnerships with health care providers and payers.

"Being a part of Linkage Lab was a major driver of success for us. When we began the program, we struggled to define our business case and value proposition for health care partnerships. Participating in the Linkage Lab program helped us start aligning the services we offer to the interests and needs of health care entities and understand the return on investment of addressing social determinants of health," says Bielecki.

The Linkage Lab program was one step on BCAAA's journey to preparing for and pursuing health care partnerships. Though the program set the tone and provided guidance for what BCAAA needed to do, it was up to the agency to fully incorporate and maintain new processes and practices well beyond the timeline of the Linkage Lab program—a task that the BCAAA team was unequivocally committed to.

Taking Advantage of Every Touchpoint

One of the first steps BCAAA took to apply its new knowledge was by using something it calls its "touchpoint strategy," which helps the agency kick off the pursuit of cross-sector partnerships. Bielecki says this strategy is critical to identifying any and all existing touchpoints between BCAAA and health care entities.

"A key question CBOs interested in health care partnering should ask themselves early on is 'Who on our staff is already interfacing with health care professionals?'" explains Bielecki. "Whether it is a social worker, nurse, discharge planner or wellness coordinator, it's important to know where the existing touchpoints are, determine who they are affiliated with and understand what information is being relayed back and forth."

An interesting application of the agency's health care "touchpoint strategy" occurs within the agency's call center. BCAAA receives thousands of calls per year on a host of issues—both from clients and health care professionals. BCAAA captures those calls and case managers work to ensure the needs are met. But now, BCAAA takes it a step further.

"On the back end of the call center system, we analyze who is calling and what they are calling for, and we factor that into our health care partnership marketing strategy," explains Bielecki. The agency has started asking some clients about their health coverage, whether they are willing to share contact information for their primary care physicians and if they give the agency permission to mention they are working with the client. "This tactic enables us to communicate directly with physicians about the types of services their clients are receiving from us," Bielecki says. "We're gathering more health information from clients who grant us permission, so we can close the loop ourselves with their physicians. This helps us ensure that our messaging to potential partners has even more of an impact."

Painting a Local Picture of Aging

In terms of expertise on aging in community, the buck stops at the AAAs. BCAAA leverages this expertise and funnels it into data-driven reports that it can use to help boost the agency's credibility with health care organizations. "A local community foundation produces and distributes a robust trend report every two years, which includes and references data BCAAA collects and publishes. This gives us credibility on aging at a level that no other local organizations have," says Bielecki.

"Health systems see the value in this sort of data too—and we see it resonating with potential health system partners as it finds its way into their community health needs assessments."

BCAAA is currently developing what promises to be the most robust report on aging that Boulder County has ever seen. Bielecki believes that the fusion of BCAAA data with that of other local agencies and departments, as well as secondary data from other organizations, will help paint a richer picture of what aging looks like in Boulder. "This will help us build even more legitimacy at the institutional level, which we believe will help us earn even more legitimacy as a cross-sector partner," Bielecki says.

BCAAA uses data points to help it paint a picture of how older adults live in the community for potential health care partners. For example, BCAAA is able to use its own data to show that there will be a 250 percent increase in the number of older adults age 80 and older in the Boulder area over the next 20 years. "Population increase trends create a strong visual for potential health care partners who respond to numbers and volume data points," Bielecki says. "We also have data from focus groups about the accessibility of services, perceptions on the cost of care and needs such as transportation—market intelligence that health care organizations find valuable but don't have easy access to. It's important for AAAs to relay their expertise and paint that picture of aging in the community, particularly as the health care sector starts to think more socially."

BCAAA is able to use its data and expertise to paint the picture of aging as the backdrop for conversations where it can ask potential health care partners, "What are you going to do in response to these demographic trends?"

Reaching Potential Health Care Partners Where They Are

As BCAAA is actively capturing micro-opportunity touchpoints and bolstering its credibility as an expert on aging in the community, it is also seeking to initiate conversations where potential health care partners are networking. Embracing a hyper-local marketing strategy to build demand, BCAAA is proactively pursuing as many networking opportunities as possible.

"Once we began participating in local committees and advisory groups, we met a lot of people who are aligned with us and who now understand what BCAAA does. We started looking at these committee opportunities not just from a community involvement standpoint, but through a lens of networking with potential health care partners. We'd say, 'We're in this together, but we could be doing so much more. How can we add value to each other's organizations and to the community as a whole?'"

As far as generating interest from health care providers and payers, BCAAA is focused on aligning its services with programs that health care entities are participating in, with the goal of delivering better health outcomes at lower cost, with one example being the local hospital's bundled payment program. Bielecki says, "To generate potential partnership opportunities, we are honing our ability to communicate that we understand the risk that health care organizations are taking with new payment and delivery models, and hence we can customize our portfolio of social services to help mitigate that risk. When we align our services, we can nudge key metrics like readmissions and post-acute care utilization in a way that can save significant sums for health care organizations, while also producing better health outcomes for aging members of the community."

Another key element of activating the hyper-local marketing strategy comes in the form of a new web page that will communicate key messages and convey the agency's vision to potential health care partners. "The development of our new landing page, which is inspired by what we've seen from technology and app companies that also market to health care companies, will be a major driver for our marketing and sales efforts," shares Bielecki. "We are putting forth an idea to potential health care partners to get people thinking: 'Imagine if we formalized a cross-sector relationship to create a more coordinated system of care in the Boulder community.'"

Achieving Results and Gaining Momentum

This go-getter approach to creating new cross-sector opportunities has already yielded results for BCAAA. Most notably, the agency has recently developed a cross-sector partnership with a local hospital in a pilot program to provide individuals who are high-risk for experiencing complications following a joint replacement with care management services. The agency also has secured two new partnerships, one with a health plan broker and another with a Program of All-Inclusive Care for the Elderly (PACE) to provide the National Diabetes Prevention Program[vi] (DPP), which enables BCAAA to receive payments for delivering DPP when their participants hit certain benchmarks, including retention and weight-loss.

These initial partnerships have quickly taught BCAAA which services provide the most value, leading to new opportunities for the agency, Bielecki says. "While we have received some income from this work already, we see the future as full of opportunities. Our efforts have led us to pursue becoming a Medicare supplier for the Diabetes Prevention Program, providing the opportunity to directly bill Medicare for this service. This will allow us to expand partnerships with health care payers and providers—and open doors to offer other valuable services."

BCAAA is now moving from pilot mode to permanence. "We're in this for the long run. Right now, I am focusing on solidifying our infrastructure to support the growth of our partnership work over time. We are customizing our information technology systems to improve operational efficiency, refining our projection modeling based on our experience with certain risk populations and further professionalizing our case management staff through trainings and certifications," shares Bielecki. "And, we are getting creative with how we can work with payment and provider systems for value-based and non-traditional care. Ultimately, we're building up our ability and long-term commitment to deliver as a community partner to health care organizations."

As Bielecki puts it, "This is the future of aging services. The future has to include an alignment between community organizations and the health care system—and there will be opportunities large and small for CBOs to be included as long as we are willing to be proactive and open to the possibilities."

The authors are grateful for the time and insights provided by those who were interviewed for this cross-sector partnership profile, especially Jacob Bielecki, Business Results Manager at BCAAA.

i. Measuring the Value of AAA Services: https://www.n4a.org/files/n4a_ROI_Report_July2018_Final.pdf
ii. 2017 National Survey of Area Agencies on Aging: https://www.n4a.org/Files/2017%20AAA%20Survey%20Report/AAANationalSurvey_web.pdf
iii. https://coloradohealth.org/funding-opportunities/funding-opportunity-long-term-services-and-supports-colorado-linkage-lab
iv. https://www.coloradohealth.org/
v. Sample job description for a Business Development Manager: https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2018/10/ADBI-JobDes-BDM-508.pdf
vi. https://www.cdc.gov/diabetes/prevention/index.html

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Partnership Profile

How the Council on Aging of Southwestern Ohio Balances Cross-Sector Relationship Development with Smart Business Decision-Making

Developing relationships is a crucial component to creating—and sustaining—long-lasting cross-sector partnerships. The process of developing relationships thrives on mutual respect, balancing risk among partners—and knowing when to say 'no' and not allowing the desire to build a good relationship to override the imperative to make good business decisions.

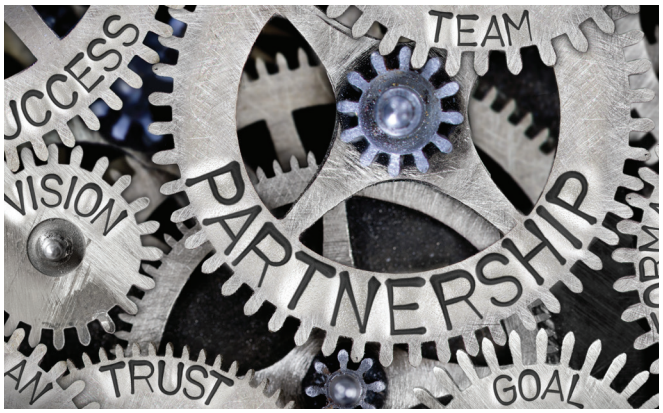
The Council on Aging (COA) of Southwestern Ohio is a master of balancing the needs of all sides and often plays the role of tough negotiator and collaborative partner to their health care clients to help ensure that each partnership brings value to everyone involved.

As COA's CEO Suzanne Burke explains, "You must balance what is right for your business with the importance of nurturing cross-sector relationships. You cannot value the relationship so much that you end up making a bad business decision for your agency. Negotiations can get tough—and they will get tough—but you have to hold your ground and do what is right for your business."

Maintaining this balance has paid off, as COA enjoys a robust portfolio of partnerships with several health plans, producing $12.3 million in commercial revenue. These partnerships have helped health plans reduce health costs and institutional spending while improving health outcomes and the member experience.

Early on in the agency's experience with cross-sector partnerships, COA engaged with a large national health system as part of a statewide program focused on managing health care and home and community-based waiver services for Ohio's population of older adults who are eligible for both Medicare and Medicaid.

The contract requirements were, as Burke puts it, extensive. Community-based organizations (CBOs), she warns, must read contracts thoroughly and look for requirements hidden within clauses that may influence the way services are delivered, thus affecting the costs associated with service delivery.



In COA's experience, health care plans partnering with CBOs often bring to the table contracts that refer to underlying documents that are full of requirements. The most common types of underlying documents COA has seen are three-party agreements involving the Centers for Medicare & Medicaid Services (CMS), the state of Ohio and health plans. In these instances, COA had to adhere to requirements of both its health plan partner and CMS, including many requirements that were not explicitly referred to in the text of the contract. "You may read a contract and see a straightforward service agreement, but in order to comply with the agreement, you actually have to find and understand the 200-page document it points to," Burke says.

In other words, what may appear to be a straightforward and simple clause may end up requiring much more of the CBO than it had anticipated. Yet, CBOs are required to abide by all requirements of a contract, including those referred to in underlying documents, rules and regulations. COA has seen

requirements related to the programmatic—describing how it will provide care management and how it will classify individuals—to the non-programmatic—the number of required chart reviews and guarantees for staff trainings.

Burke stresses, "You've got to have a full-picture understanding of the ultimate contract your organization is being asked to sign before you agree on rates, otherwise you could wind up with surprises that impact business and the cost to deliver on what you've agreed to."

If the first step of creating durable cross-sector partnerships is identifying whether a potential partnership opportunity is a relationship worth pursuing, the second step would be understanding the totality of what the health care partner is asking of your CBO. The third step is smart negotiation.

Determine Your Guiding Principles for Negotiation

Burke, a seasoned negotiator, and her team at COA have identified guiding principles that they now use as a framework for all contract negotiations. Guiding principles will be different for each CBO, but Burke recommends that all CBOs begin with identifying deal-breakers, the rationale for each and end with having the confidence to walk away from a potential partnership if the proposed contractual agreement is not aligned with what your CBO is willing—or able—to do.

Financial Viability

One of COA's guiding principles is that the agency will not enter an agreement in which they believe they're setting themselves up to lose money over the long term.

Of course, understanding whether a contract will cause your CBO to lose money over the long term requires that your CBO have a strong grasp of its financial model, the costs of service delivery and costs associated with any of the contract's underlying requirements. COA's leadership team has a solid understanding of the agency's financials and they make a point to closely examine contracts, helping COA pinpoint any areas that may have a negative financial impact.

"You've got to have a full-picture understanding of the ultimate contract your organization is being asked to sign before you agree on rates, otherwise you could wind up with surprises that impact business and the cost to deliver on what you've agreed to."

In order to make wise decisions, CBOs should make these calculations and projections before negotiations begin. COA's financial model assumes that there will be some unrecovered startup costs, but the financial model is also designed to project how the agency will recover these funds in the long term. If the proposed rates do not align or do not enable COA to recoup any initial losses—and make a profit over time—the agency will not enter into the partnership.

Burke and her team have learned to request a contract template—and any related attachments—from potential health plan partners early in the process, giving the COA team the ability to preview any requirements that may generate additional costs before discussions about commitments and rates begin. Offering another example, Burke explains, "Health plans have significant HIPAA (Health Insurance Portability and Accountability Act) requirements, particularly around technology, and some plans are requiring community partners to have Health Information Trust Alliance (HITRUST) certification, which can be a six-figure commitment. Understanding this contractual requirement and the associated cost is critical for rate negotiations."

Mutually Beneficial Agreements

COA's second guiding principle puts emphasis on the term "mutual."

Cross-sector partnerships cannot be too one-sided, particularly when it comes to the contract language. For COA, determining how to balance the benefits of partnering starts in the early phases of relationship development and gets solidified during contract negotiations.

One area where mutual responsibility is critical is in indemnification. Many of the contracts COA has with health care partners include indemnification clauses, which are essentially promises that your partner cover your agency's losses if they do something that causes you harm or causes a third party to sue you.

Burke finds that most initial versions of partnership contracts have one-sided language around indemnity—meaning the health plan would expect COA to cover its losses without doing the same for COA. When COA receives such a contract, Burke says COA will always negotiate to turn one-sided indemnity language into mutual indemnity language.

COA does the same with termination clauses. Burke recommends that CBOs entering into contracts with health care partners ensure that their contracts include a clause that enables each involved party to terminate the agreement if needed. Burke stresses, "You need mutual termination language in your agreements." It is important to have mutual language that balances risk across both partners as a means to protecting your organization in cases where there are issues or surprises. COA's emphasis on requiring mutual language in contracts speaks to the agency's steadfastness in protecting its business.

Ownership of Intellectual Property

COA's third guiding principle for reviewing contracts has to do with ownership. For example, COA believes that if it has designed the intervention, it owns the intellectual property for that intervention.

CBOs do valuable work and spend a considerable amount of time designing and delivering services and interventions that are unique to their organization. Why should a partner own that work? Burke recommends that CBOs take COA's lead by pushing back on contract language that may allow a partner to take any ownership of the CBO's work. In one case, one of COA's current partners sought to include language that would give it ownership of a brand that was a wholly-owned subsidiary of COA. Burke had no qualms about telling this potential partner that COA would have to walk away from the collaboration if that contract language did not change. And it worked—COA now enjoys a relationship with this health care plan.

Preserve Your Operations

COA's fourth guiding principle is that the agency will not sign an agreement that attempts to dictate how COA runs its business. "CBOs should feel empowered to run their businesses as they see fit," says Burke. "We won't relinquish control over how we run our business. For example, we would not sign a contract specifying that we must adhere to the health plan's holiday schedule, working rules or employee dress code." CBOs must raise a red flag if there are circumstances in which a potential partner may be overstepping boundaries.

"We're always thinking in terms of, 'Is this a good business decision?'" Burke says. "We've gotten pretty good at identifying problematic areas by using our guiding principles as our baseline negotiation framework, and when we need it, we also have good legal counsel."

Leaders of CBOs must determine where they will draw the line on partnership contracts with health care organizations. COA's guiding principles serve as a good starting point for any CBO that is pursuing partnerships as it determines which contract requirements it should

consider. CBOs that know their business boundaries will be in a better position make good business decisions. CBOs following COA's example are more likely to enter into partnership contracts that enable their agencies to (1) ensure that they aren't put in a position that may cause them to lose money, (2) protect their intellectual property and (3) maintain control over their operations.

COA's aptitude for negotiation enabled it to enter into a contract that expanded the agency's cross-sector work to include a new kind of intervention aimed at managed care members who have substance abuse disorders.

In the early stages of this new partnership opportunity, there were some "no-go" clauses that Burke and her team knew they could not agree to—and the COA team held its ground. "It can be a tricky rope to walk," says Burke. Where some organizations may have been tempted to overlook some of the tough negotiations that were needed to get a mutually beneficial agreement in place, COA's leadership team stuck to their guiding principles and did not let the desire to launch the partnership override the need to make a wise business decision.

Find Your Leverage Points

From COA's perspective, understanding leverage points means understanding how much the potential partner needs your agency and its services. This also means understanding the context for the opportunity—the who, what, why and when of the potential partnership. The more you know about the potential partner's motivations, challenges and needs, the more easily your agency can determine what leverage it has in the negotiating process.

Finding your point of leverage, or your strongest platform to stand on for negotiation, requires doing your homework to understand everything you can about the potential health care partner, the opportunity and the competition. To discover where your CBO has leverage, Burke urges CBOs to prioritize knowing what current initiatives potential partners are involved in and the corresponding requirements and risks, how these requirements influence the potential partnership arrangements, who else the potential partner is courting for partnerships, and your CBO's position in the list of organizations being courted.

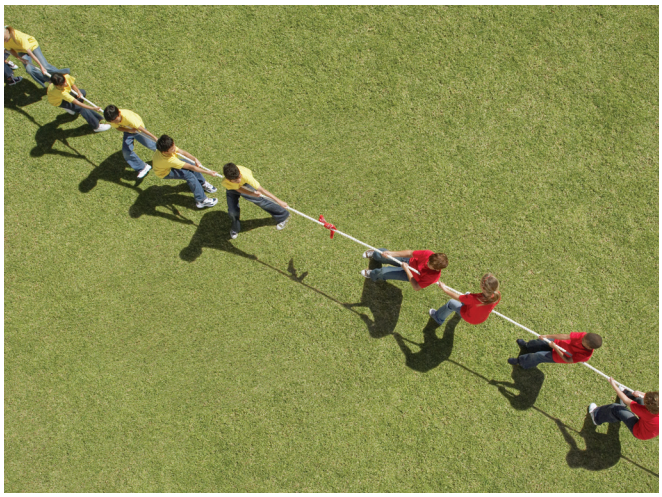
From COA's perspective, understanding leverage points means understanding how much the potential partner needs your agency and its services. This also means understanding the context for the opportunity—the who, what, why and when of the potential partnership.

A CBO's leverage point will likely be different for each negotiation. Your CBO may find that it is the only agency the health care entity is considering for a potential partnership. If this is the case, and, if the health care entity cannot take its business elsewhere, then you have leverage in the negotiation. As a result, your CBO may be able to push harder for what it wants in the final contract because the health care entity has no choice but to find a way to work with you. In another instance, your CBO may find that one of its programs is known for being the best of its kind in the community. If your CBO knows that a health care entity wants to partner with the best service provider in the area, you will have leverage in negotiations. Or, your CBO may be approached by a health care entity that has a short period of time to submit a bid for a statewide contract. If the health care entity cannot convince your CBO to partner with them on the contract, it may lose the opportunity, giving you a leverage point in negotiations. Knowing just how much a potential partner needs you—and what this means—will reveal the leverage points your CBO can use as it negotiates contracts with confidence, giving you more power in negotiations.

As COA's experience shows, knowing your leverage points is helpful in any negotiation. Burke remembers that in the midst of negotiations, a health plan partner was gung ho about kicking off a program, including training for COA staff, by a certain start date, even though the COA and the health plan partner hadn't yet agreed on a rate. "The terms weren't finalized, so I had to make the decision that I wasn't going to send COA staff for training until we finalized all the other details of the agreement, including a rate," recalls Burke. "This was our point of leverage in this deal because we knew that without our staff getting the training, the work couldn't start in the timeframe desired by the health plan. The next day, after I canceled our staff's participation in the scheduled training, the health plan team was more motivated to finalize the rate quickly so that we could keep the initiative on track."

While asserting your power— and using any leverage points your CBO may have—in cross-sector partnership negotiations may feel uncomfortable, CBOs should not worry about damaging relationships with potential partners.

As Burke would attest, you are up against skilled negotiators, and at the end of the day, it's business. "It's business throughout the whole process of contract negotiation. It's business for them and it is business for us. We have numerous examples of getting uncomfortable during the negotiation process, but once the agreement was settled and signed, the relationship moved on," she says. "We've never had anyone hold a grudge because they thought we were difficult to negotiate with."



Understanding How Risk is Balanced Across Partners

While it is natural for CBOs to get excited about the operationalization of a new cross-sector partnership, it all comes down to the contract. And that contract should not only outline the specifics of the work your agency will undertake and the rates you have agreed upon with your partner, the contract should also serve as a template of how risk will be balanced across each organization.

The size of the partners involved should not matter—even if one organization is a large national health plan and the other is a small CBO. A partnership contract should be fair and balanced across all involved parties.

For a CBO, Burke says, "You are taking on risk when you enter a contract that represents your agency taking on a new payment structure, product or outcome." This is especially true when the partnership is new and there are many unknown elements that can become risks. For instance, while the contract terms may be fair and balanced, a CBO may find that the health care entity has incomplete or incorrect data about their members—creating an obstacle. COA's experience shows that CBOs will encounter unanticipated issues once the work begins. What is key to a good partnership is ensuring the contract agreement balances risk and emphasizes an underlying mutual desire to collaborate on finding solutions.

Keeping that idea in mind, it is also important for CBOs to remember that health care partners are also taking on risk. In addition to being accountable for partnership outcomes and adjusting to new reimbursement models that attach financial incentives to performance, reputational risk is a factor. If a health plan contracts with a CBO to provide services on its behalf and the CBO falls short or makes a poor impression on the plan's members, that could be very problematic for the health plan.

"The agreement has to be fair for both parties. I can't stress that enough. You don't want to lose out, but you don't want a contract that is unfair to the plan either. The partnership starts and ends with the contract. That's what the work falls back on," says Burke.

Be a Strong Negotiator and a Strong Partner

If you ask Burke whether cross-sector partnering is worth it, her answer is yes.

COA's biggest piece of advice for CBOs entering into cross-sector partnerships is that CBOs must not place the excitement of relationship-building ahead of sound business decision-making. CBOs need to think of themselves as being on an equal footing with potential health care partners. It is critical to identify where your CBO needs to draw its "business boundaries" and hone its skills around reviewing contracts and isolating any problematic clauses that could strip your CBO of its power over your business or cause your CBO to lose money. When your CBO enters negotiations with a sense of confidence that you are approaching a contract negotiation with your business' best interests as well as a desire to work effectively and collaboratively across the sectors, it will be in a position to build durable, mutually beneficial cross-sector partnerships.

"You can't underestimate the magnitude of sectors working together to be successful," Burke adds. "There are great opportunities for CBOs out there. If you don't already have strong negotiators in your organization assessing cross-sector partnership contracts, it's a skill you need to bring in. Remember: this is your business."

The authors are grateful for the time and insights provided by Suzanne Burke, Chief Executive Officer at the Council on Aging of Southwestern Ohio.

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Partnership Profile

How Partners in Care Foundation Leverages a Large-Scale CBO Network to Improve Health Outcomes for One of California's Largest Health Plans

Plenty of organizations with big visions for improving the health care system see integration across the medical and social sectors as an important conduit for improving the quality of care for people in their communities. But big vision only goes so far without a robust plan and the discipline to implement it. Partners in Care Foundation (Partners), a nonprofit community-based organization (CBO) in California with a strong reputation for promoting a better system of health and health care by bringing together stakeholders across the entire medical-social spectrum, knows all about taking the leap from dreaming to doing.

When one of the state's major health plans approached Partners about a partnership to provide disease management services to 50,000 high-risk individuals throughout California *and* community-level case management for individuals referred to the agency by plan case managers, Partners saw a tremendous opportunity to gain hands-on experience as the lead agency operating the largest network of CBOs in the nation's most populous state.

The catch? The network didn't exist yet, and Partners had only six months to make it a reality.

Pressure to perform, however, can be an intense motivator to operationalize a big idea. Within that six-month period, Partners established itself as the lead agency, overseeing the Partners at Home Network (PAH Network), which included Partners and 24 other California CBOs. As Partners would learn over the course of the program's first few years, building the PAH Network was only the beginning. Over time, Partners' journey as lead agency has been marked by constant improvement and innovation. It has also been marked by constant learning, with lessons that can be applied by any organization looking to build and sustain a multi-agency network of its own.

Partners' constant improvement is best demonstrated by the growth in the number of its health care partnerships. Partners now has 30 different health care–related contracts and is achieving significant results, such as a 50 percent improvement in medication adherence and a 24 percent reduction in 30-day readmission rates.

From Building the Network…

Building a CBO network of this scale was uncharted territory for Partners, and there was no playbook to follow. Consequently, the organization's leadership learned to blend smart thinking and agile doing with a high degree of flexibility to adapt its approach.

Fortunately, Partners had already been exploring potential collaborations with a group of CBOs that had been participating in the Centers for Medicare & Medicaid Services (CMS) Community-Based Care Transitions Program (CCTP). These CBOs made for ideal early partners, as they were experienced in working with the health care sector due to their participation in the CMS pilot program. Beyond this initial group, Partners' President and Chief Executive Officer, June Simmons, and Vice President for Health Services, Anwar Zoueihid, leaned heavily

on their personal relationships to attract and engage CBOs throughout California. By mining long-term relationships with board-level leaders at organizations known for their ability to deliver high-quality programs and services, then screening additional entities based on loose qualitative criteria such as strategic alignment and entrepreneurial spirit, Partners succeeded in quickly creating a statewide network. This effort was made possible through funding from The John A. Hartford Foundation and matching grants from the Archstone Foundation and The Ralph M. Parsons Foundation.

Even several years later, Partners recognizes that it makes sense to start with who you know. As Vice President, Network Services, Ester Sefilyan, explains, "Any organization looking to build its own provider network should start from their own extended relationship lists and organizations they've already worked with." However, over time Partners has learned that assembling the best possible network capable of consistently meeting the stringent demands of a large health plan client takes more than just familiarity; it requires rigor.

...To Optimizing the Network

Rigorous Requirements Result in a Better-Performing Network

Today, Partners uses an extensive checklist of criteria to ensure prospective CBO partners have the capacity and capabilities to deliver home-based services that meet the standards they and their health plan client expect. Key criteria include qualified and sufficient staffing, geographic footprint, adequate operational capacity and ability to grow, languages spoken, and positive testimonials, as well as an ability to adhere to important contract terms such as required insurances and stringent requirements for assessment, turnaround time and reporting.

> "It's gratifying work, but it is also hard work and the prospective CBO partner really needs to understand the operational details they are committing to deliver."

In fact, the Partners team has found that sharing the Statement of Work (SOW) for its health plan client with prospective CBO partners has enabled them to successfully screen prospective partners. "We send them our SOW, our requirements for insurance and staffing, and our assessment tool. When we meet with them a week or so after, we can tell from their questions how much or how little they understand," says Sefilyan.

Audra Hindes, Director of Provider Network Operations, adds, "We strive to ensure that the individuals responsible for service delivery understand the nature of the work from the beginning. It's gratifying work, but it is also hard work and the prospective CBO partner really needs to understand the operational details they are committing to deliver."

Quality Beats Quantity

Meeting the health plan's requirements for geographic coverage required Partners to create a network that, at its height, consisted of 24 CBOs. However, one of the resulting challenges was that some CBOs received few referrals each year, preventing them from gaining the experience necessary for sufficient familiarity with the contractual requirements and the PAH Network service delivery quality standards. "Until people have enough experience, it's really hard to manage quality across multiple organizations in multiple locations," says Sandy Atkins, Vice President, Strategic Initiatives.

As the program matured, Partners realized that it could provide its health plan clients with a more effective solution if it focused its energy on a network with fewer but better-performing CBO partners.

"We had some network agencies that were on hold because they didn't have capacity to take on referrals because the volume is inconsistent," Sefilyan says. "For these agencies, the volume isn't always there; it varies month by month. So in lieu of continuing to nurture those network agencies, we actually expanded the work of other, higher-performing agencies to cover more area, which resulted in more referrals for them. We decided that instead of having 20+ agencies, we'd rather have ten that could do a better job."

The agency's effort to assemble the best-performing network has driven it to identify, recruit and partner with qualified providers from the private sector. This move reinforces Partners' position that service quality, business capacities and the ability to deliver are what matter most. In Partners' view, other agencies seeking to build multi-stakeholder networks should not shy away from considering potential partners beyond other nonprofits.

Ultimately, Partners' decisions to be more disciplined in its screening of new agencies, willing to prune its network when appropriate, and open to exploring partnerships with the for-profit sector all stem from a key insight: *It's all about ownership and accountability.*

Ownership and accountability require that Partners makes smart choices about how to deploy its internal network management team, how that team engages with PAH Network agencies by leading through influence, and how success is measured and shared.

Understanding how Partners addressed each of these areas—not only at the start but as needed over time—can help other organizations make their own strategic choices about how to assume the mantle of network leadership.

...To Running the Network From a Central 'Network Hub'

When your organization is accountable for an entire network's output and outcomes, oversight is essential. While some agencies may be tempted to manage a CBO network with existing resources and within an existing operating structure, Partners found that having a dedicated team with well-defined processes that are enabled by the right business systems to be a critical factor in the success of the PAH Network.

Building the Right Network Management Team

Partners initially built its network management team around a small, nimble core of two senior leaders, Simmons and Atkins, both of whom had the relationships and credibility necessary to recruit and onboard partners quickly. Simmons and Atkins were ideally suited to secure high-level conversations with prospective health plans and CBO partners, evangelize the network vision, and rapidly recruit an array of CBOs as partners in service delivery. While the two remain vital members of the network team today, Partners recognized over time that running an efficient, effective program requires a diverse team of experts with a wide range of specialties and skills.

So which skills are most important for an organization looking to take on master agency duties? For Partners, a few fundamental areas of expertise stand out.

Project Management: "It's essential to have somebody with real project management skills," says Hindes. "Without an experienced project manager in place, things slip through the cracks or work is duplicated." While Partners didn't have a dedicated project manager in place at the outset, adding this function over time has resulted in significant improvements in operational efficiency. For example, when the project manager identifies

For tips on negotiation with health care payers, see our *Partnership Profile: How the Council on Aging of Southwestern Ohio Balances Cross-Sector Relationship Development with Smart Business Decision-Making.* https://www.aginganddisabilitybusinessinstitute.org/how-the-council-on-aging-of-southwestern-ohio-balances-cross-sector-relationship-development-with-smart-business-decision-making

an operational concern, this issue is addressed immediately by the appropriate leader on Partners' team.

Relationship Management: Lead agencies must recognize that network agencies, once onboard, require constant care and support beyond day-to-day project management. This requires dedicated staff who maintain open lines of communication, provide oversight, deliver ongoing education and identify opportunities to drive more referrals to the highest-performing agencies. For example, Partners has implemented frequent reminder calls to their network providers, serving as a contact point to review and discuss expectations, such as turnaround times.

Contracting Know-How: "Especially when you're dealing with large health plans, the contract language and negotiation is intense. You need a really strong contracting person at the table from the very beginning," says Sefilyan. "This person not only needs to be able to negotiate the right terms with the health plan, but also know how to translate the applicable terms to the network CBOs so they deliver on what we've agreed on. It's complicated because as the lead, you're responsible for everything in the agreement, but dependent on the network members to implement. And even after the contracts are in place, amendments may be required as the work evolves over time."

Enabling the Network Management Team with Technology

Managing a large-scale partner network requires more than just the right people. The complex nature of the task also benefits greatly from having the right technology, and Sefilyan stresses that it is never too early to put systems in place. She advises any CBO that is considering taking on a lead agency role in the design and implementation of a multi-provider network to, "start off with a technology system to help streamline communication across the network. If we were starting today, we would have a system in place with the network agencies first, to be able to communicate, submit the referrals through an online portal and record completed assessments in the system. Tracking all of this manually can be daunting, so this would be a first priority. Don't even think about starting without a technology system."

For example, for the disease self-management portion of Partners' contract, the health plan provided Partners with a database containing information on 50,000 members who have chronic conditions, organized geographically across the state. Partners formed a contact center with Televox and InContact patient communication support and a Salesforce database. Staff determined how to integrate geo-mapping with Salesforce to support the creation of self-management classes out of a list of about 1,200 health plan members in specific geographic areas (within a seven-mile radius of their homes). This system provided PAH Network CBOs with access to geographic information about health plan members, which they then used to conduct outreach to drive attendance at the chronic disease self-management workshops they provided.

... And Leading Through Influence

Of course, having a centralized command center doesn't necessarily mean you're in control. Unlike in a more traditional organizational structure where leaders wield direct authority over their team, delivering results in a network depends upon leading through influence—a style of leadership that inspires action by building trust, encouraging transparency and empowering others to do their best work.

> "In terms of making sure our CBO partners have what they need operationally—the right information, the right training, the right tools—my role is to set them up for success from the get-go about what's required of this program."

This is one of the most important lessons that Partners can transfer to any organization looking to lead a CBO network—a lesson Hindes knows well:

"Health plans want what they want, when they want it. They don't necessarily care that the work is subcontracted out to one of our network partners. The professionals working in the field work for our CBO partners and certainly don't report to me from an organizational chart standpoint, but as far as our health plan client is concerned, Partners is accountable for delivery and results. So, in terms of making sure our CBO partners have what they need operationally—the right information, the right training, the right tools—my role is to set them up for success from the get-go about what's required of this program."

Engage Frequently

Given the importance of making sure every CBO's coaches—client advocates who help individuals transition from a medical facility setting back to their home—have the right information, training and tools, it is no surprise that communication is one of Partners' most important functions. It's an important way of leading through influence to drive consistency, quality and success.

Hindes explains, "As the program matures, we have been doing a better job of scheduling frequent (but not too frequent) reminder calls with our network coaches. Just quick reminders about the agreed-upon terms regarding turnaround time, things like that." Hindes explains that these regular check-in calls can serve as refreshers or level setting for coaches who may not have received training on certain topics. "We've found that if we can schedule refresher calls regarding some of the critical areas in terms of meeting the health plans requirements, we can ensure that every existing and new coach knows exactly what's expected of them and how we're measuring performance."

Measuring and Sharing Success

The health plan requires quarterly audits of client cases, including a review of documentation and performance. Initially, an outside firm conducted these audits and each assessment, care plan and progress note were reviewed by an independent Licensed Clinical Social Worker—a costly and time-consuming process. As Partners established trust and credibility with its client, it earned the right to perform its own audits in-house.

Today, the Partners network team reviews a random sample of cases each quarter (25 percent of all cases handled) across all CBO partners and performs its own stringent analysis. The resulting report includes Partners' own proprietary data for success indicators, such as medication reconciliations and possible emergency department and hospital avoidances. Partners has found that this report is a useful tool and provides key insights about the effectiveness of the program, the extent to which participating agencies meet program standards and working assumptions about the overall impact of the PAH Network on the health of the people it serves.

It's important to note that the results of these audits are not merely a matter to be addressed in closed-door quarterly meetings of the Joint Operating Committee (JOC) formed between the health plan and Partners. The Partners leadership team realized the value in sharing the findings with PAH Network agency leaders. Following each quarterly JOC session, Partners coordinates a call with its network agencies to discuss key data on home visits and member satisfaction scores, along with the quarterly audit results and any relevant JOC feedback.

Hindes highlights the importance of involving PAH Network agency leaders in conversations about performance, as a means of highlighting the important work their teams are doing. She says, "We have a lot of one-to-one conversations with the CBO coaches, working individually with them, but the agencies' CEOs should also be aware of how their coaches are doing."

"For example, we recently had a conversation with the CEO from one of our network organizations and were able to discuss the dashboard results, which illustrated the referrals they received and the results of the audit. Since the CEO is not involved in the day-to-day stuff, it was really good for her to have this understanding and to be informed of the results they are achieving. Sharing this snapshot led to some healthy conversations around how they could do some things differently and better and how we could as well. Being transparent with our data is another mechanism for strengthening our relationships with our partners and better managing the quality of service."

Overseeing a large, distributed network of CBOs that serves 50,000 individuals who have chronic conditions from one of the largest health plans in the nation's most populous state was a challenging proposition—one that Partners rose to meet not just when launching its program, but as it implements, learns and optimizes over time.

As upfront agility gives way to the rigor, structure, consistency and accountability necessary to sustain and grow a complex, large-scale network of partners, Partners has delivered the ultimate win/win/win scenario for the health plan, network agencies and Partners. Members of the health plan will receive high-quality, community-based services. PAH Network agencies will capture a new source of referrals, gain a better understanding of what is required to work with the health care sector and improve the lives of more people living in their communities. And Partners will solidify its position as a viable partner to the health care sector and a pioneer in the area of medical-social integration.

As Sefilyan sees it, lead agencies that can pull off large, complex partnership programs are well-positioned for the future: "This level of cross-sector integration is the next phase. It's the future of health care."

The authors are grateful for the time and insights provided by the Partners in Care Foundation team members who were interviewed for this piece, including Sandy Atkins, Vice President, Strategic Initiatives, Ester Sefilyan, Vice President, Network Services, and Audra Hindes, Director of Provider Network Operations.

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Partnership Profile

Navigating Obstacles in Cross-Sector Partnership Development: The Camarillo Health Care District Story

Many people will tell you that cross-sector partnerships are important, but few would tell you that they're easy. When you consider the complexity inherent in managing the perspectives, objectives and expectations of multiple stakeholders, and factor in a wide array of internal and external variables that might shape the success of any program, it makes sense that community-based organizations (CBOs) will face a number of pivotal moments on the path to building successful cross-sector partnerships. What sets successful partnerships apart from the rest is how the organizations involved anticipate, respond to—and sometimes recover from—surprises that can arise at every stage of the partnership development cycle.

Camarillo Health Care District (the District), a public agency formed in 1969 to provide meaningful, effective, integrated community-based services that optimize health and wellness for residents of Ventura County, CA, experienced this first-hand when it pursued and piloted a cross-sector partnership with the Accountable Care Alliance of Ventura (ACAV), an accountable care organization (ACO) sponsored by Community Memorial Health System (CMHS).

Over the course of the pilot partnership, the District grappled with the unexpected, facing down challenges and curve balls that could have derailed or threatened the initiative, but the agency persevered. Giving up isn't in the District's DNA, and the lessons it learned in the process provide valuable insights for any CBO developing cross-sector partnerships.

As graduates of The SCAN Foundation's first Linkage Lab, a leadership and management development program that helped prepare select California CBOs for effective partnerships with health care organizations, leaders from the District had learned the essential skills for starting and sustaining productive relationships with local providers—and they were ready to pursue opportunities. As a result, the District targeted CMHS as a potential partner and later its ACO. CMHS is a community-owned, not-for-profit health system that operates two hospitals and a network of family practice health centers that serve various communities in Ventura County. With the formation of ACAV, CMHS had its own motivation for exploring CBO partnerships: a commitment to coordinated care. "For us, partnerships are an important way to extend our reach into the community and better serve the patients we're touching," explains Bonnie Subira, MSW, who was the CMHS ACO Manager at the time the partnership began.

"Historically, the hospital's reach ends at the door of the building. But as our mandate evolved toward a more value-based approach to health care, it was clear that we would need to engage with organizations performing services out in the community in order to get there."

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Bonnie Subira, MSW, CMHS ACO Manager

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Still, when the two organizations joined together to improve health outcomes in their community, they found that the road to providing shared value for the population they both serve was not a straight path. But the District stayed clear-eyed about navigating any curves that came its way and the lessons it learned can help any CBO structure its own successful partnerships.

Create a Focus for Better Pilot Design

Obstacle to Avoid: Taking on Too Much to Start

The District's broad mission allows it to work with diverse groups of Ventura County residents—from children interested in improving their babysitting skills to older adults in need of supportive services and social activities. As an ACO, ACAV aims to provide quality care to Medicare beneficiaries who have a wide range of needs. Despite these differences, both the District and CHMS understood that agreeing on a well-defined target population would make the most of the existing funding and facilitate the design of a focused pilot intervention.

"In the beginning, we engaged with one doctor who had a certain idea of what he wanted to do, but we had to clarify the realities and limitations based on the funding we had at the time. It was critical at this point to ensure that we were on the same page with this doctor about what was possible."

Lynette Harvey, RN, BSN, CCM,
District's Director of Clinical Services

The District and ACAV pinpointed individuals who were living with at least one chronic health condition, had been prescribed multiple medications, and had some form of memory impairment (ranging from slight memory loss to dementia). Approximately one-third of this population lived alone, while the remaining two-thirds lived with a spouse or other family member. In addition, approximately one-third of this population had experienced recent hospitalizations.

Establishing this tight focus on a specific population served two purposes: ACAV was able to use an existing software tool to identify the number of clients who would benefit from potential interventions and ACAV physicians were able to gain a clear understanding of the target population in order to make appropriate referrals from among their own patients.

These parameters allowed the District to fund the pilot through an existing grant for serving cognitively impaired adults with chronic disease, and led to the design of a structured 90-day intervention consisting of three components: psychosocial assessment and coordination; family caregiver education and support; and evidence-based health promotion programs, such as the Chronic Disease Self-Management Program, falls prevention programs and more.

Specifically, this pilot enabled the District to:

- Conduct initial in-home visits to perform detailed assessments, observe a range of psychosocial factors and gauge the individual's ability and motivation to be an active participant in their own care, and complete a HomeMeds[1] medication reconciliation. This in-home visit resulted in developing a person-centered care plan with the client, aimed at closing any gaps in care, educating the individual and their caregivers, and improving health.
- Hold routine weekly phone calls and two additional monthly visits, which enabled District staff to track goals and provide ongoing feedback to ACO physicians while connecting the clients to needed social support services that address the social determinants of health, including access to reliable transportation, healthy food, home repairs, respite care and more.
- Educate clients and their caregivers about their chronic conditions and refer them to evidence-based community health promotion classes.

By clearly defining the target population and subsequently designing interventions that address the needs of this community, the District was able to foster a better understanding among ACAV physicians about

[1] Learn more about HomeMeds at www.picf.org/homemeds.

the patients being served by the partnership, the types of services it was built to deliver, and what was realistic and reasonable given the parameters of the program.

"In the beginning, we engaged with one doctor who had a certain idea of what he wanted to do, but we had to clarify the realities and limitations based on the funding we had at the time," says the District's Director of Clinical Services, Lynette Harvey, RN, BSN, CCM. "It was critical at this point to ensure that we were on the same page with this doctor about what was possible."

Agree on a Shared Definition of Success

Obstacle to Avoid: Different or Unclear Expectations

While program design is critical for defining the parameters of cross-sector partnerships, getting on the same page with key stakeholders (like the doctor mentioned above) also depends upon a clear definition of success. For this reason, it was vital that the District and ACAV establish and articulate a clear and compelling goal for the partnership, as well as a series of actionable and measurable objectives by which their shared success could be measured.

For the pilot, the District and ACAV aligned around a single objective that would benefit individuals while enabling both partners to better achieve their mandates for delivering high-quality, coordinated care. Their objective was to have a positive impact on the health of at-risk patients in the target population by addressing both the cognitive issues and social determinants of health that might otherwise limit the effectiveness of the ACO's traditional, medical interventions.

A single broad, aspirational goal (or "big, audacious goal") (BAG) can serve as a guide for CBO-provider partnerships, but must be supported with a set of specific criteria for tracking whether joint activities actually achieve the intended outcome. For the District and ACAV, it was important that each objective accomplished three tasks: deliver the benefits desired by each organization, demonstrate value to key stakeholders (like the ACO physicians), and of course improve the health and well-being of the individuals served.

- **For the District,** engagement in the program was vital, as this represented a key measure of whether the partnership would provide it the opportunity to serve more individuals within the target population. Accordingly, the District set effective partnerships with ACAV physicians as an important indicator of success because those physicians introduce potential clients to the program and present the District heath coach as an integral member of the care team.
- **For ACAV,** engaging the District to help patients better manage their care at home would reduce inappropriate or unnecessary utilization in high-cost areas like emergency and inpatient services, and help shorten or even avoid skilled nursing facility stays.
- **For the ACAV physicians,** a successful pilot would demonstrate the value that a CBO like the District brings to the care team by providing doctors with better information about patient progress and barriers by opening a window into their patients' lives beyond the medical setting.
- **And, naturally, for patients and their families,** a successful program would increase involvement of the patient and/or family caregiver in actively managing care, resulting in improved health outcomes for the individual.

Finally, because this partnership began as a pilot funded by an existing grant, the District saw the eventual transition into a long-term contract for paid services as its ultimate measure of success.

"During our meetings with ACAV's key decision-makers and physicians, we verbalized early and often that our expectation was that once we demonstrated value in the pilot, we would move toward a longer-term partnership contract," shares Sue Tatangelo, MAOM, Camarillo Health Care District's Chief Resource Officer. "In response, ACAV was clear that it was working to identify funding streams to pay for our services beyond the pilot's conclusion."

For CBOs looking to establish a new cross-sector partnership, grant-funded pilots can be an effective approach to both jump-start the relationship and demonstrate value. When taking this route, two steps taken by the District are critical: (1) being clear with your partner about your goal of having a paid contractual arrangement and (2) structuring the pilot to deliver on the key milestones that will trigger the next step. These steps reinforce the importance of having clear, mutually agreed-upon objectives and criteria for success.

These actions also compel the CBO to take the steps necessary to ensure engagement at all levels within the partner's organization, particularly with stakeholders that may serve as the primary gatekeepers to the target population. In the case of the District's ACAV pilot, the physicians held this powerful position.

"During our meetings with ACAV's key decision-makers and physicians, we verbalized early and often that our expectation was that once we demonstrated value in the pilot, we would move toward a longer-term partnership contract. In response, ACAV was clear that it was working to identify funding streams to pay for our services beyond the pilot's conclusion."

Sue Tatangelo, MAOM, Camarillo Health Care District's Chief Resource Officer

Build Strong Relationships with All Types of Stakeholders

Obstacle to Avoid: Failing to Engage the Wider Organization

In any productive cross-sector partnership, leadership teams in both organizations will naturally work closely to deliver results. The District and ACAV teams achieved this by creating a joint operating committee that reviewed progress, identified areas for improvement and defined solutions to any issues. But the District team learned early on that its main points of contact weren't the only stakeholders who required attention. Given the central role of the ACO's physicians in connecting District health coaches to their patients, physician engagement (a key measure of success, as noted above) would prove to be a both an obstacle and an important opportunity.

"Early on, many of the physicians did not really have an understanding of CBOs and what we do," said the District's Harvey. In fact, one of the District's challenges lay in its ability to establish its role as a complement to and not a replacement for medical care. As Subira adds, "We needed a plan to help our physicians view the District as a resource rather than be intimidated or frustrated because thinking outside of the medical environment is so out of their realm of experience. Our doctors needed to learn that they can maintain their clinical autonomy while partnering with others to serve their patients."

Learn How to Express Your CBO's Value

For the District, part of the solution lay in old-fashioned storytelling—sharing anecdotes that demonstrate the value of their "living room" perspective and how they can bring new insights to health care providers. When meeting with one reticent physician, Harvey described a patient living with diabetes who was so concerned about his physical safety while living in his home that he was unable to adequately address his physical health—a reality she learned through a routine home visit. "The doctor said, 'I wouldn't even have the first clue about how to address that.' And I said, 'Yet, until we address it, he can't even think about controlling his diabetes." This anecdote reinforces the importance of addressing the social determinants of health, which an increasing number of health experts and policymakers are recognizing as key issues to address when working with patients to improve their health and well-being.[2]

Formalize Your Plan of Engagement-at-Scale

Sharing this anecdote helped this one physician understand the importance of the work, but the District needed to scale these "aha" moments to address all participating physicians. So, it created a formal and structured physician education initiative. "By providing educational sessions for the doctors and attending their routine meetings on a regular basis, the District gained an exciting opportunity to build alignment and clarity around the value of the District being involved in patient care. Through our discussions, we gained an understanding of the kind of support the physicians needed from us and we piqued their interest in expanding our working relationship," said the District's Tatangelo.

Make it Easy for Stakeholders to Work With You

The next step, after education, was providing the ACO physicians with an easy way to do exactly what the District hoped: introduce their patients to the CBO as an integral part of the care team. "I believe one of the reasons we achieved a high acceptance rate among the individuals the ACO referred to us was that we created a packet for physicians to give patients that looked and sounded like it was written in the doctor's own words," shares Harvey. "The packet included an informational letter about our services from the doctor's perspective, explaining why the physician was partnering with the District, along with a consent form. So, when the doctor was speaking with the patient, the District was presented as a part of the health care team."

"Our goal was to build relationships by showing how we could work alongside the hospital's case managers, discharge planners and be an extension of care in the community. In doing so, we showed that they could view the District as a partner and that they could welcome us as part of the health care team."

Lynette Harvey, RN, BSN, CCM, Clinical Services Director, Camarillo Health Care District

As these examples show, it is vital for CBOs to be strategic about fostering relationships within partner organizations, working directly with frontline staff and taking the necessary steps to reflect their realities and needs. Further, as the District's example makes clear, it is important that CBOs have a clear sense of the value they provide and become skilled at conveying that value to key stakeholders in a compelling way.

While the District prioritized physician relationships, these same principles applied across ACAV.

"Our goal was to build relationships by showing how we could work alongside the hospital's case managers, discharge planners and be an extension of care in the community. In doing so, we showed that they could view the District as a partner and that they could welcome us as part of the health care team," said Harvey.

2. *2020 Final Call Letter Offers Guidance and Structure for Medicare Advantage Supplemental Benefits* to learn more. Read it online at https://www.aginganddisabilitybusinessinstitute.org/2020-final-call-letter-offers-guidance-and-structure-for-medicare-advantage-supplemental-benefits.

Cross-sector partnerships work best when the right processes, systems and structures are in place to capture quantitative performance data and qualitative feedback.

Persistence Pays Off

Obstacle to Avoid: Inability to Connect Achievements to Objectives

These efforts—striking the right focus, setting clear measures of success, and stacking the deck for success—become worthwhile when the stakeholders see the impact they're having for their own organizations, each other and the target population. By the time the pilot had concluded:

- The District had engaged a core set of ACAV physicians in the program. Seventy-five percent of patients who learned about the program through their physicians engaged with the District for the 90-day intervention, a significantly higher rate than when a District health coach presented the program directly to patients.
- ACAV found that patients who participated in the program were better educated about more cost-effective alternatives such as palliative care and hospice support. Additionally, none of the patients visited the Emergency Room (ER) or were readmitted to the hospital for the original reasons of their referral to a District health coach, though 13 percent of participating patients did visit the ER for unrelated, unavoidable circumstances. While the total number of cases was not statistically significant, ACAV certainly saw the pattern as encouraging and indicative of the partnership's long-term potential.
- The physicians saw that, as a result of the pilot, participating patients were taking steps to gain control of their health, had an increased understanding of their medical conditions and how to manage them effectively. Physicians also saw how addressing issues surrounding cognitive impairment and the CBO's participation in supporting the social needs of the patients and their caregivers could improve their overall health.
- Most importantly, 74 percent of the participating patients improved their activation rate by at least one point (out of a possible 10 points). Of those, 67 percent improved by two or more points—showing that medical-social partnerships can indeed give at-risk individuals greater control over their own health.

Naturally, the District's ability to point to these outcomes was a direct result of the steps the partners took early in their relationship to establish measures for shared success. Just as important was having a measurement plan in place.

Cross-sector partnerships work best when the right processes, systems and structures are in place to capture quantitative performance data and qualitative feedback.

As Tatangelo put it, "You've got to have a data plan before you get started. You have to know the benchmarks that you're going to compare your results to, and you need to collect and share convincing evidence that will speak to the true value of what you accomplished."

While measurement remained a work-in-progress throughout the entire pilot, even an imperfect process for capturing data, collecting feedback and demonstrating value beats a lack of evidence. CBOs will find it difficult for their cross-sector partnerships to succeed if they wait too long to establish measurement processes and define their objectives to establish clear accountability, or fail to establish and track against mutually agreed-upon benchmarks.

"Someone once told me that if you hear a 'no,' it just means the conversation will be longer. I'm just not sure we realized going in how long this conversation could be. The reality is that it takes time to build the kind of relationship and trust that is key to a successful partnership."

Sue Tatangelo, MAOM, Camarillo Health Care District's Chief Resource Officer

Stay the Course, Even in the Face of Unexpected Obstacles

Obstacle to Avoid: Being Deterred When Things Don't Go As Expected

Despite the strong relationships built, good will earned and initial results achieved through the District's partnership with the ACAV, it's worth noting two significant obstacles the partners faced.

The Factor of Time

Before the pilot, the District had been building its collaboration with CMHS for more than five years, always seeking ways to demonstrate value and cement the agency's position as a viable partner. "We have invested a lot of time and energy into courting the hospital and running pilots," says Tatangelo.

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If time to pilot is an obstacle, the risk lies in giving up too soon. "I see many organizations that throw in the towel after six months if they don't make headway. And then that's that," says Tatangelo. Where some CBOs may have abandoned the idea of pursing cross-sector partnerships because of the time it can take to build relationships, activate integrated models and recognize new revenue, the District has stayed the course, opting to forge ahead despite the longer-than-anticipated timeline.

Any CBO seeking to establish productive cross-sector partnerships must be prepared for the long sales cycle, the sheer amount of time and effort it may take to convince a high-potential health care partner to take a chance on a new collaborative model to deliver care to patients.

Surprising Changes Outside Your Control

Just before it cemented the next stage of its partnership beyond the pilot with ACAV, the leadership team at the District found itself facing an unexpected scenario when Community Memorial Health System disbanded ACAV and discontinued its ACO services, withdrawing from the Medicare Shared Savings Program that fueled the ACO's existence. For the District this was a situation it had not anticipated—and one over which it had no control.

"The physicians who regularly referred patients to District were impressed with the partnership and its outcomes. They really felt that their patients' issues were being addressed in ways that they couldn't accomplish on their own," says Subira. "There was definite value and a willingness to establish a formal partnership with the District, but with the ACO disbanding, cost became a barrier to formalizing the program." Today, CMHS is not involved with any risk-based programs but remains interested in re-opening contract discussions with the District if and when the situation changes.

Where another CBO might be soured on partnerships and gun-shy about initiating new relationships in light of unforeseen obstacles, the District views its experience with ACAV as a learning opportunity, an experiment in designing effective offerings in partnership with a provider, and a model to build upon as it continues to explore ways to work with health care organizations throughout its community.

In Tatangelo's view, ACAV disbanding was a mere "hiccup." The agency isn't giving up on the potential of this partnership. "Our ACAV pilot was successful by nearly every measure we defined—short to getting to a long-term contract due to circumstances beyond our control," she said. "We got the physicians engaged, they understand what we do, and they truly saw the importance and value of collaborating with us. Clients were more involved in their own care and early signs pointed to our intervention's ability to reduce unnecessary hospital utilization by providing better education and support."

Although, as of this writing, the District is still grappling with the unexpected twist of ACAV's demise, the agency's leaders know they built something that remains worth pursuing for future opportunities with CMHS and beyond. Just as important, CMHS's leaders know this, too. "Cross-sector partnerships between medical and social providers is unchartered territory and selecting the right partner is critical. What ends up being important is working with people and organizations that truly understand the communities they serve. And having a partner who can make connections to the community and offer new insight into what you know and what you don't is key," said Subira.

CBOs must remember that successful cross-sector partnerships can be time-consuming, require both effort and rigor, and may not always work out as you might have anticipated. But, by following the District's lead, a focused pilot, early accountability, strong multi-faceted relationships supported with structured engagement programs, and resilience in the face of unexpected obstacles can pay off and pave the way for the next phase of your organization's cross-sector partnership journey.

The authors are grateful for the time and insights provided by Bonnie Subira, MSW, Manager High-Risk Case Management, Community Memorial Health System; Lynette Harvey, RN, BSN, CCM, Clinical Services Director, Camarillo Health Care District; and Sue Tatangelo, MAOM, Chief Resource Officer, Camarillo Health Care District.

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