

PARTNERSHIPS FOR HEALTH: LESSONS FOR BRIDGING COMMUNITY-BASED ORGANIZATIONS AND HEALTH CARE ORGANIZATIONS

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INTRODUCTION

Given the impact that social factors have on health status and expenditures, and the shift toward value-based payment models that reward providers based on outcomes, health care organizations (HCO) and community-based organizations (CBO) across the country are increasingly working together to address patients' social needs. In Massachusetts, the state Medicaid agency, MassHealth, through its Medicaid 1115 demonstration waiver, is investing in accountable care organizations (ACOs) and community partners¹ to integrate physical health, behavioral health, and long-term services and supports. The state is also funding certain approved "flexible services" that address health-related social needs that are not otherwise covered as MassHealth benefits.² To inform these efforts, it is important to examine the strategic, operational, and financial approaches that drive the success of HCO and CBO partnerships. This brief augments learnings from the *Partnership for Healthy Outcomes* — comprised of Nonprofit Finance Fund, Center for Health Care Strategies (CHCS), and the Alliance for Strong Families and Communities, with support from the Robert Wood Johnson Foundation — with insights from the Blue Cross Blue Shield of Massachusetts Foundation (BCBSMA Foundation) June 2017 conference,³ which convened several HCO-CBO partnerships to share promising partnership models. It outlines characteristics of successful HCO-CBO partnerships and provides recommendations to guide the development of successful collaborations between health care and social service organizations.

BRIEF LANDSCAPE AND CHARACTERISTICS OF HCO-CBO PARTNERSHIPS

The national *Partnership for Healthy Outcomes* project was designed to uncover key characteristics of successful cross-sector collaborations between HCOs and CBOs, particularly those that serve low-income and/or vulnerable populations. It included a national request for information (RFI), published in January 2017, to identify promising partnership models and to better understand challenges in building effective HCO-CBO partnerships. More than 200 RFI responses were collected, representing a wide range of partnerships serving all 50 states, and offering key insights about the current landscape of partnerships.

To delve more deeply into core partnership components, the project partners selected four partnerships from the RFI responses to develop comprehensive case studies.⁴ The four targeted programs included a diverse set of partnerships that offered health and social services to a range of populations in different geographic areas, and that were mature enough to be able to reflect on lessons learned. The partnerships detailed in the case studies are:⁵

- Eastern Virginia Care Transitions Partnership (southeastern Virginia);⁶
- Health Access Nurturing Development Services Program (Louisville, Kentucky);⁷
- The Ruth Ellis Health & Wellness Center (Detroit, Michigan);⁸ and
- Transitional Respite Care Program (Spokane, Washington).⁹

List of Acronyms

AAA	— Area Agencies on Aging
ACO	— Accountable care organization
CBO	— Community-based organization
EVCTP	— Eastern Virginia Care Transitions Partnership
F&CP	— Family & Children's Place
HANDS	— Health Access Nurturing Development Services
HCO	— Health care organization
HFHS	— Henry Ford Health System
LMDHW	— Louisville Metro Department of Public Health and Wellness
MCO	— Managed care organization
REC	— Ruth Ellis Center

EXHIBIT 1. OVERVIEW OF HCO-CBO PARTNERSHIPS PROFILED IN CASE STUDIES

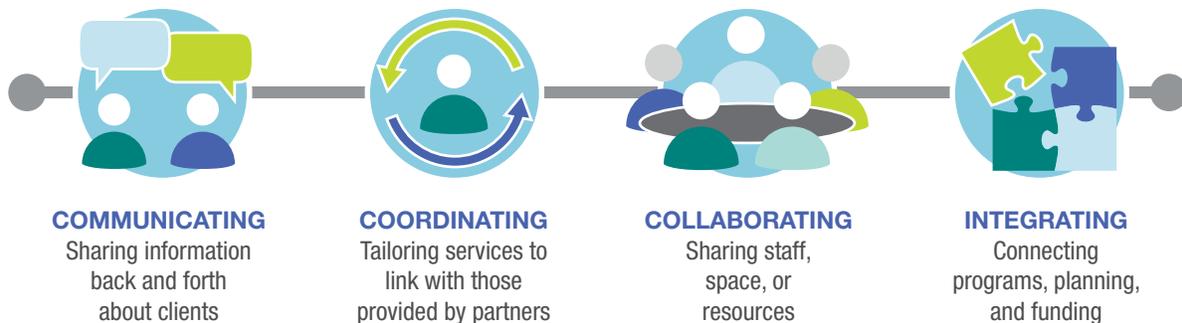
NAME	PARTNERS	GOALS	SERVICES	FUNDING	IMPACT
Eastern Virginia Care Transitions Partnership	<ul style="list-style-type: none"> • 5 Area Agencies on Aging (AAAs); • 4 health systems; • 69 skilled nursing facilities; and • 3 Medicaid managed care organizations (MCOs) 	Reduce hospital/nursing home readmissions and improve care for older adults.	AAA coaches provide direct referral assistance, case management, benefits counseling, family caregiver support, and other non-clinical services such as meals and transportation. Patients are screened for eligibility by partnering hospitals and then referred to AAA coaches, who are embedded into the hospital discharge process.	Per member per month (PMPM) and episodic (per care intervention) reimbursement flows from three participating Medicaid MCOs to AAAs to cover services provided; supplemental funding to AAAs is also provided by select hospital partners for specific projects.	Through the Centers for Medicare & Medicaid Services (CMS) Innovation Center’s Community-Based Care Transitions Program pilot, ¹⁰ the 30-day readmission rate was reduced from 18.2 to 8.9 percent from February 2013 to January 2015, resulting in estimated savings of more than \$17 million through 1,804 avoided readmissions.
Health Access Nurturing Development Services Program	<ul style="list-style-type: none"> • Family & Children’s Place (F&CP); and • Louisville Metro Department of Public Health and Wellness (LMDPHW) 	Improve health and social outcomes for at-risk children and families.	F&CP uses home visits to assess family needs, provide case management and child development education, and make linkages to social supports.	Kentucky Medicaid reimbursement to F&CP (under subcontract from LMDPHW) for assessment and home visitation for eligible first-time mothers. Tobacco settlement dollars and state general funds are used to cover non-Medicaid-eligible enrollees.	The program has reduced the rate of pre-term birth, decreased interaction with child protective services, and increased the rate of meeting development milestones.
The Ruth Ellis Health & Wellness Center	<ul style="list-style-type: none"> • Henry Ford Health System (HFHS); and • Ruth Ellis Center (REC) 	Improve the long-term health outcomes of Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) youth.	HFHS provides primary care and REC provides behavioral health and social services for LGBTQ youth in a safe, convenient environment.	Braided funding comes from the project partners, foundations, private donors, and Medicaid for health care services for eligible members.	Evaluation is in its early stages. Process measures tracked to date include the number of patients served, the number of visits completed, and the types of services delivered. Patient visits are evaluated to obtain feedback about the appointment process and provider relationship. There are plans to measure the program’s return on investment.
Transitional Respite Care Program	<ul style="list-style-type: none"> • Catholic Charities Spokane; • Providence Sacred Heart Medical Center; • MultiCare Deaconess Hospital; and • Volunteers of America 	Provide homeless patients with a safe place for discharge and healing from area hospitals.	Catholic Charities offers post-hospitalization care, short-term housing, and coordinated services for patients experiencing homelessness.	Providence Health System uses community benefit funds to pay a per bed / per day rate for a fixed number of respite beds at each shelter. MultiCare Deaconess Hospital uses a service-level agreement and contract to pay for beds at each shelter.	Efforts to track reductions in emergency department visits, hospital length of stay, and inpatient hospital utilization among homeless patients are under way.

KEY CHARACTERISTICS OF HCO-CBO PARTNERSHIPS

There is diversity among partnerships across the country in terms of the services provided, size of the partnerships, populations served, geographies covered, length of time in operation, and funding and contractual arrangements. Many partnerships involve health care providers and CBOs — but partners also include public health and other government agencies, private insurers, foundations, schools, and supermarkets.

Partnerships have formal agreements with various levels of integration. Most RFI respondents noted that they have at least one formal agreement in place to guide the partnership, typically including structured roles for each partner that build upon the individual partner's strengths and specific referral criteria. The level of integration varies along a spectrum ranging from communication across partnership entities to full integration, such as in instances where partners have become a collective entity (Exhibit 2).

EXHIBIT 2. KEY APPROACHES OF SUCCESSFUL HCO-CBO PARTNERSHIPS



Source: Adapted from E. Miller, T. Nath, and L. Line. *Working Together Toward Better Health Outcomes*. Partnership for Healthy Outcomes, July 2017. Available at www.chcs.org/resource/working-together-toward-better-health-outcomes.

Partners generally provide services to impact immediate-term clinical needs, such as reducing hospital admissions or length of stay. This may be due, in part, to a health care environment that offers payment incentives to support cost reduction. More than half of all respondents reported that their partnerships include care coordination support to better organize services across multiple providers. Fewer partnerships reported providing services that address underlying social determinants to improve health in the long term.¹¹

Partnerships rely on an evolving variety of funding sources. Partnerships use various funding sources that change over time as the program matures, but they generally rely on upfront grant money and in-kind contributions to get started. Partnerships are exploring multi-pronged strategies to sustain and scale their services, including a blend of funding models. Some are focused on achieving economies of scale, building on initial success to expand the services provided to broaden their reach, scope, and impact.¹²

Supporting Effective HCO-CBO Partnerships

Building off the RFI and case study findings, the Nonprofit Finance Fund developed a self-assessment and planning tool and shared it nationally in October 2017.¹³ The Partnership Assessment Tool for Health (PATH) is designed to help CBOs and HCOs already engaged in partnerships gauge their progress toward benchmark characteristics of effective partnerships. The benchmarks are organized into four core themes: (1) internal and external relationships; (2) service delivery and workflow; (3) funding and finance; and (4) data and outcomes. The tool can also be used to help guide strategic conversations among partners and identify areas for development to maximize the impact of their collaborations.

KEY FINDINGS AND LESSONS FOR SUCCESSFUL PARTNERSHIPS

Findings from the RFI and four partnership case studies (see Exhibit 1 above) as well as takeaways from the June 2017 BCBSMA Foundation conference reveal critical success factors and lessons for successful partnerships, from initial relationship building to sustaining and scaling services.

INVEST IN RELATIONSHIPS, CHAMPIONS, AND COMPLEMENTARY EXPERTISE

CBOs and health care partners often leverage existing relationships to pursue new initiatives. Partners consistently noted that aligned organizational missions were instrumental to their success. Providence Health System (Providence) and Catholic Charities in Spokane, Washington, for example, are two like-minded nonprofit organizations that have worked together numerous times over the last century. Their common mission — to address the unmet needs of the poor and vulnerable in their community — made the Transitional Respite Care Program proposal a straightforward opportunity for the Providence Board to support.

HBO-CBO partners noted that sharing each other's goals, values, and principles early on and identifying where there is commonality helped to achieve consensus on the scope and functions of the partnership. Committed and engaged champions from both the CBO and HCO partners helped achieve buy-in within their respective organizations. For the Eastern Virginia Care Transitions Partnership (EVCTP), experienced champions at Riverside Health System and Bay Area on Aging recognized the broad potential of a partnership between Area Agencies on Aging (AAAs) and health systems across Virginia and served as catalysts within their respective organizations to advance their vision.

Identifying and contributing complementary areas of expertise allows partners to leverage one another's strengths while developing an effective work flow. For example, at the Ruth Ellis Center (REC), staff have expertise in meeting the mental health and social needs of LGBTQ youth, strong relationships with the community, and effective outreach channels, all of which are complemented by Henry Ford Health System's (HFHS) clinical and facility development expertise. Similarly, Family & Children's Place (F&CP) has a strong knowledge base around child abuse, neglect, and violence prevention, as well as a longstanding connection to the community, while the Louisville Metro Department of Public Health and Wellness (LMDPHW) has access to technical resources to support operations of the Jefferson County Health Access Nurturing Development Services (HANDS) program.

ENGAGE CLIENTS AND OTHER STAKEHOLDERS IN PROGRAM DESIGN AND MANAGEMENT

Actively involving clients and other stakeholders, such as providers, CBO leadership, and community members, in program design and educating them about program mechanics has helped to operationalize HCO-CBO efforts among the partnerships studied. Cross-partner engagement is particularly important for (1) establishing clear program goals and identifying target populations; (2) streamlining workflows; and (3) providing education and training. For example, there was a point at which the Transitional Respite Care Program shelters were unintentionally providing hospice care to dying clients as a result of referrals from the local hospitals, although providing such care was not within the purview of the program. To resolve this issue and redefine patient eligibility requirements for the program, Catholic Charities Spokane worked with its health care partners to help them identify patients who demonstrated potential to improve their health in respite care. They created a provider referral form that embedded respite program admission criteria into a simple checklist to ensure referred patients meet eligibility criteria. While program staff initially spent significant time educating providers about the program and referral

criteria, the form now functions as a training tool for new hospital staff and has helped standardize expectations among the partners. The form helps hospital social workers understand who is eligible for the respite program and what information needs to be transferred with patients to the shelters.

Engaging stakeholders in shared governance models is also an effective way to facilitate trust, dialogue, and shared decision-making in HCO-CBO collaborations. Early on, EVCTP established a shared, independent board including designees from each of the participating AAAs and health systems. Effective partnerships also engage clients' opinions to improve service delivery. For example, REC requested direct feedback from its clients on the design of its integrated center to ensure it was a welcoming place for the target LGBTQ population. The center also established a client youth advisory committee to help identify unmet needs in the community.

BUILD AND SUPPORT CAPACITY OF PARTNERS

There may be a need for upfront capacity-building support, particularly among CBOs, to develop staff skills and expand bandwidth. For example, measuring program results from the perspective of the impact on medical cost savings and/or reductions in utilization of health care services (e.g., emergency department visits), is not likely an area CBOs are accustomed to assessing. As a result, this type of program monitoring or evaluation may present them with challenges. This can be due to a lack of staff with the relevant expertise and training; limited bandwidth to add these responsibilities to existing staff; and/or a lack of systems and processes in place to collect data necessary to measure program results. Understanding true program costs and how much to charge partners for services is another area where there is a financial acumen learning curve. This was the case for EVCTP as the AAAs were not well versed on the specific costs of partnership-related services, such as embedding dedicated AAA coaches into the partner hospitals' discharge process and connecting them with hospital discharge planners post-discharge to monitor patients' status. Similarly, the LMDPHW provided technical assistance to familiarize F&CP staff with Medicaid billing and auditing procedures for the HANDS program. Leveraging LMDPHW's Medicaid knowledge was invaluable for F&CP; understanding Medicaid reimbursement protocol enabled F&CP to optimize HANDS program spending, resulting in improvements to service delivery and the ability to reinvest savings into prevention programs. Catholic Charities Spokane benefited from technical assistance provided by a local health district and paid for by Providence to support staff with data collection and tracking outcomes. This enhanced staff capacity, and ultimately, improvement in tracking outcomes will help inform the health system's evaluation of the program's overall value.

In designing a new integrated primary care and behavioral health and wellness center, HFHS "loaned out" its directors of facility development to provide in-kind expertise to staff at REC. HFHS also agreed to set up and maintain the electronic medical record system at no cost to its partner. In turn, REC guided HFHS in making the new health and wellness center a welcoming place for LGBTQ youth and understanding existing barriers for them in seeking medical care at the hospital. This process leveraged the complementary expertise of each organization and further built trust among partners.

SHARE PATIENT-LEVEL DATA

Sharing patient-level data is key to informing patient care and decision-making. Most partnerships studied from the RFI responses have data-sharing systems in place, though these vary in complexity and sophistication. In three of the profiled partnerships, data-sharing agreements allowed the health care partners to provide the CBOs with in-kind access to select electronic medical record information, enabling partners to effectively identify and deliver needed services. While the requirements of the Health Insurance Portability and Accountability Act (HIPAA) was

cited as posing challenges to sharing patient information, most partnerships developed successful strategies to overcome data-sharing limitations. REC staff, for example, underwent Community Connect HIPAA Compliance and Protected Health Information Training, and leadership signed a memorandum of understanding to safeguard protected health information. Similarly, Catholic Charities Spokane receives paper referral forms via secure fax from partner hospitals, a protocol established to ensure appropriate, HIPAA-compliant patient referrals.

ENHANCE OUTCOME MEASUREMENTS

Collecting program-level data is essential for partnerships to (1) demonstrate outcomes and return on investment; and (2) communicate progress toward partnership goals internally and externally. Reaching consensus on effective outcomes and reporting processes is both time-intensive and complex. Partners need to agree on program goals and then identify measures that demonstrate progress toward those goals and establish data collection mechanisms.

For some partnerships, shared impact measures evolved from basic utilization measures to more sophisticated trend analyses and quality improvement indicators. Using basic measures upfront can help demonstrate results, and these early wins help generate support. Bay Area on Aging, the lead AAA in the EVTCP partnership, refined its program monitoring and evaluation approach over several months to resonate with hospital executives, whose support was essential for the program. Bay Area on Aging initially developed a detailed monthly report that included metrics related to the AAAs' investments in hiring and training coaches, rather than focusing more explicitly on the readmissions and cost avoidance data that resonated more with hospital partners.

Tracking outcomes helps make the business case for continued partnership, enabling participants to garner support to sustainably finance the program, scale services, and/or expand their reach. For example, the Kentucky Department of Public Health commissioned an evaluation of the HANDS program, which tracked outcomes for gestation length, birth weight, infant mortality, and infant and child development goal attainment. The evaluation demonstrated a positive impact for high-risk, first-time parents and their children, generating support from the state.

Given that some CBOs are not accustomed to formal data collection and reporting, an investment in data capacity — including systems and staff — is essential to show progress toward program goals. Articulating how the data will ultimately be used can also help with staff buy-in. To assist with their measurement efforts, which were initially perceived as added work, REC leadership reframed their data collection requests to busy social worker staff as a means for the staff to help demonstrate the impact of their work on their client lives.

SUSTAIN PARTNERSHIPS

Most partnerships draw on multiple sources of funding, including philanthropies, private donors, state and tribal governments, in-kind services, and private and public insurance. In most instances, grants were important sources of funding during startup phases, such as the community benefit grant from Providence that funds a fixed number of respite beds per night as well as client meals and prescriptions, staffing, staff training, case management, and select operating costs for the respite program. Such in-kind contributions from partners can help in building trust and getting a program off the ground. However, to support ongoing or expanded programming, partners must identify more sustainable payment models and funding sources.

Challenges to establishing sustainable funding include (1) collecting robust outcomes and cost savings data to demonstrate value; (2) understanding the true costs of services delivered; (3) blending or braiding multiple sources

of funding; (4) structuring the payment model so that it is a win-win for the partners; and (5) changes in local/state policy and the regulatory environment that impact which services are covered.

Some of the partnerships surveyed were launched with grants but have been able to develop more sustainable funding sources. The EVCTP partnership was initially a federally funded pilot through CMS' Community-Based Care Transitions Program, but once that program ended, given preliminary positive outcomes, the program received one-time state funding from the Virginia General Assembly to launch a Medicaid pilot. EVCTP also pursued new lines of Medicaid revenue directly from health plans, and now three participating MCOs cover care transition, care coordination, and in-home assessments for dually eligible Medicare and Medicaid enrollees. Given EVCTP's success, additional funding is also provided by the health systems for special projects. For example, partner health systems are using hospital foundation funds to support new EVCTP projects including (1) an advance care planning initiative; (2) enhanced chronic disease care management; (3) emergency department diversion and alignment with medical homes; and (4) telehealth efforts, which are also funded by a grant from the Health Resources and Services Administration.

Many partnerships were able to use new skills and lessons gained from their collaborative efforts to identify new funding opportunities and expand their program reach. Based on the success of its partnership with Providence, the Transitional Respite Care Program expanded the program to another hospital partner, MultiCare Deaconess Hospital, and initiated a new opportunity to contract for more shelter beds paid for by a local behavioral health organization. The program is also planning to offer employment services to clients. Some CBOs have secured sustainable funding arrangements with new partners, such as MCOs. For EVCTP, there was misalignment at the outset between the health systems' and AAAs' business models. Acute care hospitals seek to avoid penalties associated with avoidable readmissions but are concerned about lowering other admissions that provide revenue. AAAs, on the other hand, aim to address the social-service-related issues that are known to contribute to admissions, with PMPM and episodic reimbursement generally tied to in-home supports provided, not admissions. While the AAAs continue to partner with the health systems on targeted projects, the differences in funding motivations have led the AAAs to look to health plans as new partners, which often have better-aligned business models.

MOVING FORWARD

In the context of value-based payment, in which providers are reimbursed based on quality, cost, and patient outcomes, the health care community is increasingly shifting its focus to the social factors that influence health outcomes and the total cost of care.

As mentioned at the outset of this brief, the state's movement toward ACOs as the key entities for care delivery in the MassHealth program highlights the growing adoption of new care delivery and value-based payment models aimed at reducing health care spending while driving improvements in population health. MassHealth's Delivery System Reform Incentive Program (DSRIP) includes funding for developing ACOs and community partners, as well as for certain health-related flexible services for individuals who meet defined criteria or who have specific conditions. While direct funding for these services may only be available under the five-year waiver, the transition to new ACO payment models creates longer-term opportunities to sustain these partnerships financially.

With implementation of the ACO program looming, there is growing need for replicable partnership models that social service and health care organizations can look to in order to accelerate the development and spread of these partnerships. Based on review of the partnership case studies, RFI responses, and key takeaways from the

June 2017 BCBSMA Foundation convening, there are several factors critical to enabling the development and success of HCO-CBO partnerships, including:

1. Identifying financing and potential payment models to support partnership activities;
2. Building appropriate capacity among both HCO and CBO partners;
3. Developing the partnership's capacity to share data at the patient level;
4. Establishing measurement strategies and supporting evaluation efforts that will demonstrate return on investment and the value of partnership programs; and
5. Helping CBOs develop their business case to partners.

As ACOs, community partners, and CBOs move forward to initiate and build these partnerships, they might also look ahead to the operational phase of the partnership and develop plans to jointly address the key issues noted above. The value of investing in partnerships between CBOs and HCOs must not be overlooked by stakeholders seeking to transform the health care delivery system. After all, health care and social services organizations ultimately share the same objective of developing a healthy population.

ENDNOTES

- 1 For more information, see *MassHealth Selects 26 Community Partners to Help Improve Health Care for 60,000 Members*. Executive Office of Health and Human Services (EOHHS), 2017. Available at www.mass.gov/eohhs/gov/newsroom/press-releases/eohhs/masshealth-selects-26-community-partners.html.
- 2 The MassHealth Waiver. Amendment and Extension, 2017-2022. Available at www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/ma-1115-waiver-summary.pdf.
- 3 Partnerships for Health: Bridging Community-Based Organizations and Health Care. Available at www.bluecrossmafoundation.org/event/partnerships-health-bridging-community-based-organizations-and-health-care.
- 4 For more information, see E. Miller, T. Nath, and L. Line. *Working Together Toward Better Health Outcomes*. Partnership for Healthy Outcomes, coordinated by the Nonprofit Finance Fund, the Center for Health Care Strategies, and the Alliance for Strong Families and Communities, July 2017. Available at www.chcs.org/resource/working-together-toward-better-health-outcomes.
- 5 S. Chazin, B. Freda, D. Kozick, and A. Spencer. "Bridging Community-Based Human Services and Health Care: Case Study Series." Partnership for Healthy Outcomes, coordinated by the Nonprofit Finance Fund, the Center for Health Care Strategies, and the Alliance for Strong Families and Communities, October 2017. Available at www.chcs.org/resource/bridging-community-based-human-services-health-care-case-studies.
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- 12 Ibid.
- 13 Partnership Assessment Tool for Health. Available at www.nff.org/fundamental/partnership-assessment-tool-health.



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