



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

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

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Executive Summary

The *Affordable Care Act* created many new care delivery opportunities that are best achieved through strong linkages between services provided in a medical setting and long-term services and supports (LTSS) provided in the community. However, formalized contractual partnerships between the health care sector and community-based organizations (CBOs) are currently uncommon. Most CBOs lack the required business acumen and need to develop a variety of internal organizational capabilities before they are able to enter into mutually beneficial contractual partnerships with the health care sector.

In 2013, The SCAN Foundation (Foundation) developed *Linkage Lab* to help bridge this gap by providing capacity-building support to California CBOs that primarily serve older adults with chronic health conditions and functional limitations. Over a two-year period, six CBOs participated in Linkage Lab, gaining capacity-building skills and organizational transformation through regular seminars and on-the-ground technical expertise. The Foundation also provided modest financial support for critical infrastructure needs associated with developing contractual relationships with the health care sector.

As of early 2015, the first Linkage Lab Cohort signed 27 contracts with health care providers with potential to serve over 16,000 clients annually.

This report provides case studies of the first six Linkage Lab grantees. The case studies show the progress made and challenges faced toward achieving their goal of meaningful partnership with the health care sector:

- [Bay Area Community Services, Oakland](#)
- [Camarillo Health District, Camarillo](#)
- [Institute on Aging, San Francisco](#)
- [Jewish Family Service, Los Angeles](#)
- [Silicon Valley Independent Living Center, San Jose](#)
- [St. Paul's Senior Services, San Diego](#)

About BACS

[Bay Area Community Services](#) (BACS) in Oakland serves both older adults and adults experiencing mental illness, substance abuse, and homelessness primarily in Alameda County. Its mission is to uplift underserved individuals and their families by providing supportive wellness services. BACS's older adult services include adult day programs and case management, while its mental health services include care coordination, wellness centers, an employment program, and a crisis residential program. BACS also offers a variety of housing services, such as interim and supported housing to stop the cycle of homelessness, and medical respite services for homeless adults with chronic health needs.

Why BACS Joined Linkage Lab

BACS sought to establish at least one contractual relationship with a health care payer or provider, and it initially identified a number of issues and opportunities related to this goal. Although BACS provides several points of contact with older adults in need in Alameda County, it lacked formal engagement with health plans, particularly at the corporate level. BACS needed to further develop and better resource key aspects of its infrastructure to engage effectively with new business partners and funding streams. These included information technology (IT) systems, facilities management, quality improvement and quality assurance processes, human resources, and general administration. Before Linkage Lab, funding for BACS's older adult services did not cover its true costs, which tightened cash flow and left the organization without a reserve fund for contingencies and new project start-up.

Key Objectives

A key objective for its Linkage Lab work was to acquire and institutionalize core leadership and management competencies that would permit it to enter into at least one contractual relationship with a health care payer or provider. Such a relationship would enable BACS to deliver cost-effective nutritional, case management, and day care services to older adults in Alameda County. As a result, these individuals would be better able to maintain wellness, leading to reductions in hospital readmissions, emergency room visits, and nursing home placements, consequently lowering costs for payers and providers.

Key Strategies and Processes

The BACS Leadership Team facilitated meetings early on with health care payers and providers to understand their needs for community-based services, how they would evaluate performance, and criteria they would use for partnership. Following these initial meetings, BACS continued to build relationships in one-on-one discussions with payers and providers, as well as through participation in community collaborative meetings where both were present. Using information gained from the meetings and additional market research, the Leadership Team assessed BACS's current service offerings, the ease of service access, and strengths and areas needing improvement among their leadership, management, and line staff. This included conducting a thorough assessment of which programs and services should be grown, which should be maintained as is, and which should be eliminated. As a result of this assessment, a program that was high on resource usage, yet low on return, was eliminated, allowing more attention and resources to be devoted to stronger programs that were better poised for growth. BACS also launched a new medical respite service that maximized its core strengths and met a need of the health system. Simultaneously, the Leadership Team focused on leadership and management development, and hired new talent from other industries, including from the for-profit sector.

BACS built relationships in one-on-one discussions with payers and providers, as well as through participation in community collaborative meetings.

BACS instituted key processes to kick-start the contract negotiation process, including an analysis of service gaps in the community as well as developing business and marketing plans. The Leadership Team met with the provider or payer to discuss its needs, goals, target population, and funding structure. Then BACS created a program package that included the elements of the service delivery model, financial structure, data collection processes, and outcomes sought by the potential partner. BACS developed pricing strategies based on different structures, including fee-for-service, fixed price per bed for a set number of beds per year (regardless of whether the beds are filled), pay-for-success methodology, and others. In negotiations with Sutter Hospital/LifeLong Medical Care, for example, BACS settled on a full bed pay structure that supported budgeted revenue and costs, and the contract was negotiated successfully (see also below).

Contracts with Health Care Payers and Providers

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

Table 1: Summary of BACS Contracts with California's Health Care Sector						
Payer/ Provider	Criteria Used to Evaluate BACS	Contract Duration	Service Package	Population to Be Served	Pricing Structure	Implementation Status
Alameda Alliance Health Plan	Utilization of emergency services based on baseline and after treatment	One year with annual option for renewal	Medical respite, care coordination, and discharge meal program	100 clients in Alameda County; dual eligibles, homeless, high-utilizers	Fee-for-service	In implementation
Sutter Hospital/ LifeLong Medical Care	Utilization of emergency services first 30 days post-in-patient discharge	One year with annual option for renewal	Medical respite	50-100 homeless clients at Sutter Hospital Alameda County	Fixed price per bed for set number of beds per year	Fully implemented

In entering into a contract with Sutter Hospital/LifeLong Medical Care, BACS was responding to a community need for medical respite and recuperative care services for homeless adults ending an in-patient hospital stay. A Federally Qualified Health Center (FQHC) served as the liaison between the hospital and BACS, and provided care coordination and discharge planning. BACS provided room and board, wellness checks, and housing coordination services. The contract was based on three beds purchased, whether occupied or not. In the first phase of the pilot program, 98% of medical respite participants were not re-hospitalized for their condition, and 30% were transitioned from the medical respite program to permanent housing.

Additional Successes

BACS has many successes beyond what was originally anticipated by engaging in Linkage Lab. It increased focus on behavioral health in all of its programming agency-wide. BACS made critical staffing changes to better position itself in this rapidly evolving health care marketplace. Additionally, it developed quality improvement and assurance systems, allowing BACS to have quantifiable outcomes for the first time. These data helped BACS obtain a three-year international accreditation through CARF (formerly the Commission on Accreditation of Rehabilitation Facilities) for its older adult, behavioral health, and homeless programs.

Challenges

BACS faced several challenges during this organizational change. The Leadership Team found it difficult to free up sufficient time to focus on strategic initiatives, market trends, and business development given competing responsibilities. They also found it difficult to recruit qualified program managers who could readily adopt business approaches. By the end of Linkage Lab, BACS did not have an integrated electronic health record system that covered all business lines with true interoperability, both internally across programs and service lines and externally to interface with payers. In addition, while BACS was comfortable proposing new service offerings in response to Requests for Proposals (RFPs) from other entities, it was not accustomed to conceptualizing and planning new offerings on its own initiative.

Lessons Learned

Key lessons for BACS through Linkage Lab:

- Invest time and energy in building organizational infrastructure, developing leadership and management capacities, and effecting change in your organization's culture toward a greater orientation toward business.
- Let go of programs that are resource intensive and do not produce a good return.
- Understand that building cross-sector relationships takes time and requires patience and persistence.
- Look beyond external RFPs to support the development of new programs and services; build internal structures and processes that facilitate proactive development of new initiatives, based on market analysis and identified needs.

About Camarillo Health Care District

The [Camarillo Health Care District](#) (District) is a public agency in Camarillo, California (Ventura County) that serves the residents of Pleasant Valley and surrounding areas. Its mission is to meet the health and wellness needs of the community by promoting, coordinating, and managing quality, affordable health-related services. The District fulfills this mission by providing a range of services for adults, older adults, caregivers, and children. Services for older adults include an adult day center, care transition services, caregiver respite, education and training, a congregate and home-delivered meals program, a senior support line, transportation, screening and support to address depression, short-term loans of durable medical equipment, fall prevention and home modifications, immunizations, and a wide array of evidence-based health promotion self-management programs.

Why the District Joined Linkage Lab

The District needed to deepen relationships with health care organizations and demonstrate to them that it was a vital resource for reducing hospital readmissions. It also needed to build stronger links with community-based organizations (CBOs) serving patients discharged from hospitals (such as skilled nursing and rehabilitation facilities), with which it could collaborate to create integrated care transition standards and practices in Ventura County. Internal challenges the District faced included allocating resources to create systems, policies, and procedures for a countywide care transitions program. It did not have an electronically integrated service and client data system, nor a set of uniform standards for cross-program data collection. It needed a formalized system for cost accounting, as well as an integrated service delivery and billing system that would facilitate billing of managed care organizations, Medicare, and Medi-Cal (California Medicaid). The District sought support through Linkage Lab in making this substantial transition.

Key Objectives

The District sought to develop a business model for a line of services, as well as a robust infrastructure to support it. Specifically, the District wanted to establish a health care partnership in which it would provide contracted services for care transitions, with the aim of reducing preventable hospital readmissions. A second objective was to develop an integrated record management system to support, analyze, and evaluate the District's health care partnerships.

Key Strategies and Processes

The District developed and launched a transitional care (TC) program for the Ventura County Community Care Transitions Program, under a demonstration project funded by the Centers for Medicare & Medicaid Services (CMS). It developed a system to track the performance and outcomes of the TC program and used this program to link TC participants to its other service offerings (e.g., transportation, chronic disease management classes) and to other community resources.

The District created a tool to clarify the cost of each service line it offered for use in establishing rates and projecting growth opportunities. To promote a proactive approach to growth, the agency set criteria for new business opportunities. It then identified categories of potential clients (i.e., accountable care organizations, skilled nursing facilities, managed care organizations, assisted living facilities, and physician practices) and undertook a process of value proposition definition: understanding the needs of potential clients and the value that the District could bring to each of them. Following these steps, the District created service packages, initiated ongoing discussions with potential clients, and set prices. In addition, the agency developed a collaborative partnership with a network of CBOs as a channel for growth, completed a process to identify technology needs, and vetted technology vendors.

Contracts with Health Care Payers and Providers

Table 1 summarizes the contracts the District successfully negotiated during Linkage Lab (all for services in Ventura County).

Payer/ Provider	Criteria Used to Evaluate the District	Contract Duration	Service Package	Population to Be Served	Pricing Structure	Implementation Status
A national managed care organization	Ability and existence of established programs to support the reduction of emergency room visits and skilled nursing facility usage	12 months	Case management, care transitions, health promotion self management programs	Approximately 348 persons; older adults with chronic conditions, disabled persons, and any adult with a chronic condition	Fee-for-service	Current

Table 1: Continued						
Payer/Provider	Criteria Used to Evaluate the District	Contract Duration	Service Package	Population to Be Served	Pricing Structure	Implementation Status
Centers for Medicare & Medicaid Services Community Care Transitions Program	Existing transitional care program in place; partnership or relationship with hospitals	18 months	Coleman Care Transitions Intervention	3,127 fee-for-service Medicare beneficiaries	Fee-for-service	Contract terminated October 2014

Additional Successes

The District identified additional opportunities with accountable care organizations and local hospitals to provide transitional care services, case management, and evidence-based chronic disease programs. Participation in a CBO network led to the District contracting additional services through the network to entities such as a national managed care organization.

Challenges

The District faced a number of challenges. Although it received a grant from the Linkage Lab to develop its infrastructure, identifying the most appropriate technology solution to integrate all record management while also integrating with the CBO network proved elusive. It took time for the District to understand the health sector's needs and align its own values with those needs. In regard to organizational culture, it was not easy to transition from reacting to every potential business opportunity to proactively focusing on a smaller number of priority opportunities that met pre-established criteria. It was also difficult to project and plan for service volume that was anticipated but not guaranteed, and to maintain sufficient cash flow during ramp-up periods while a new service was being launched. Finally, as a subcontractor on one project, the District found that progress and success depended in large part on the lead organization, affording it only limited control over project performance and outcomes.

The District created a tool to clarify the cost of each service line it offered for use in establishing rates and projecting growth opportunities.

Lessons Learned

Key lessons for the District through Linkage Lab:

- Believe in the value of your organization's business case and value proposition, and be able to articulate that value in a way that will resonate with payers and providers.
- Understand the costs of services and the desired margin before negotiating contracts with payers and providers.
- Recognize that belonging to a network of CBOs can give you a competitive advantage, by permitting shared IT costs and analytics, increased geographical reach, rapid-cycle learning, and broader best practice sharing for continuous quality improvement.
- When collaborating with other CBOs for service delivery (such as through a CBO network), make sure the "rules of engagement" are clear and agreed upon upfront.
- Plan to invest in technology early in the process, and investigate potential funders' interest in supporting technology solutions.
- Understand your organization's technology needs and gaps, and go through a formal vetting process with potential vendors.

About Institute on Aging

The [Institute on Aging](#) (IOA), based in San Francisco, serves older adults, adults with disabilities, and their caregivers in San Francisco, Marin, San Mateo, and Santa Clara Counties. IOA's mission is to enhance the quality of life of adults as they age by enabling them to maintain their health, wellbeing, independence, and participation in the community. Its innovative community-based programs—such as the Multipurpose Senior Services Program (MSSP), the Community Living Fund, the Community Living Connection, and the Community Care Settings Pilot (CCSP)—allow individuals to live at home as long as possible. IOA also educates providers, advocates, and the community on the needs of its various populations.

Why IOA Joined Linkage Lab

IOA recognized that health plans were looking to community-based organizations (CBOs) as potential partners in reducing hospitalizations and lowering other costs of care. Given its history of providing an array of services to individuals with complex needs to help them remain safely at home, IOA believed in its potential to address these interests yet lacked capacity and experience to showcase the value of its services. Specifically, IOA had limited data system infrastructure and could offer only anecdotal information about the outcomes and impacts. IOA also lacked financial and analytical expertise needed to develop a comprehensive business plan to present to the health care sector.

Key Objectives

Through the Linkage Lab, IOA sought to fill its organizational gaps in order to establish a contract with a health plan that would provide financial and qualitative value to the plan while generating a positive net income of at least 5%. IOA also sought to develop a model of care and a fee structure that would be both scalable and adaptable for future contracts.

Key Strategies and Processes

The IOA Linkage Lab team began by establishing a concrete organizational objectives. The CEO set the tone by making this objective an organizational priority, allocating resources to it, and garnering support from the Board of Directors. The team initiated preliminary

discussions with health care payers and providers to gain a better understanding of their needs, expectations, and willingness to engage in contractual relationships with IOA. The team also analyzed which interventions or services might be effective in helping providers and payers meet their objectives by looking at its current service delivery model and cost of delivery. Ultimately it made key delivery model refinements. Meanwhile, the team cultivated relationships with payers and providers, positioning IOA as an expert in working with older adults and their caregivers. IOA identified potential collaborators that could bring complementary expertise and resources.

Before Linkage Lab, IOA had limited data system infrastructure and could offer only anecdotal information about the outcomes and impacts.

Concurrently, the team initiated internal infrastructure changes, such as reallocating some responsibilities and freeing up a person to spend a portion of his time on new business development. IOA recruited a Chief Financial Officer from outside the industry who had both a strong financial background and experience in new business start-ups and technology.

IOA developed a standardized approach to negotiating with payers and providers. Initial meetings lead to a defined scope of service, followed by a pricing proposal with options to scale as the business grows.

Contracts with Health Care Payers and Providers

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

Payer/ Provider	Criteria Used to Evaluate IOA	Contract Duration	Service Package	Population to Be Served	Pricing Structure	Implementation Status
Kaiser Permanente	Geographic presence; service offerings	17 months	Community connector for identified Kaiser patients	40-60 members per month in San Francisco and Marin Counties; identified via a triage process to be at risk for high health care utilization (e.g., emergency room)	Negotiated monthly fixed fee per full-time employee serving Kaiser members	In implementation

Table 1: Continued						
Payer/ Provider	Criteria Used to Evaluate IOA	Contract Duration	Service Package	Population to Be Served	Pricing Structure	Implementation Status
Health Plan of San Mateo (HPSM)	Formal RFP process	11-month term, with option to renew for four additional years	<ul style="list-style-type: none"> • Intensive care management services (skilled nursing facility to home) • Coordination of services and waivers • Management of referrals and assessments 	Estimated 120 persons in the first 11 months and 875 over 5 years; seniors and persons with disabilities in San Mateo County who have Medi-Cal only, as well as some with CareAdvantage/ Cal MediConnect; mostly persons transitioning out of nursing facilities, but also some who need services and supports to remain in their homes	Year 1: Cost plus margin; Years 2-4: Cost plus shared savings (model yet to be developed). In addition, incentives for reaching key performance indicators will be explored after a period of collecting outcome data.	In implementation

The contract with Health Plan of San Mateo (HPSM) was particularly well aligned with IOA's organizational objective. With the onset of the state's duals demonstration (Cal MediConnect) and the Coordinated Care Initiative (CCI), HPSM became the accountable entity responsible for the full array of medical and social services for those needing long-term services and supports (LTSS) in San Mateo County. An assessment conducted by HPSM and County Health System staff concluded that housing and care management are critical factors in the health of beneficiaries and the ability to achieve successful LTSS integration.

Consequently, HPSM staff developed the concept of a Community Care Settings Pilot (CCSP) and released a Request for Proposals (RFP) to identify partners with experience in housing and care management for frail individuals. IOA collaborated with Brilliant Corners, a non-profit organization that provides affordable, community-based supportive housing for individuals with developmental disabilities and other functional needs, and together they were awarded the project. IOA will provide services such as intensive care management, coordination of programs and waivers, management of referrals and assessments, development of a vendor network, program monitoring and evaluation, and management of county, provider, and community partnerships.

Additional Successes

Through its work with HPSM, IOA has developed a framework for successful partnerships, and it has been able to use the HPSM project as a reference and model. This has led to other opportunities with Santa Clara Family Health Plan, which is now contracting with IOA to provide assessments for Community-Based Adult Services (CBAS) programs and is considering other collaborative opportunities.

Challenges

IOA faced several internal challenges in seeking to secure contracts with payers and providers. These included financial struggles; allocating staff to the work of securing new contracts; and balancing the imperative to launch a new initiative with the need to generate a financial return in the short term.

IOA also experienced challenges partnering with the health plans given that the plans faced many unknowns regarding regulations and requirements, and were hesitant to enter into new contractual relationships. IOA also had difficulty in negotiating pricing with health plans, given the plans' culture of taking the lead on price setting for vendored services.

Lessons Learned

Key lessons for IOA through Linkage Lab:

- Identify the specific need of the payer or provider.
- Communicate in a compelling way the value added by your organization providing LTSS, including the potential savings to the payer or provider.
- Make clear how your organization's programming could be adapted and integrated into the payer's or provider's existing structure.
- Structure the pricing proposal so that the payer can easily differentiate care costs from administrative costs. The direct care costs can be paid from member premiums, which strengthens the return on investment for the payer.
- Prepare different pricing approaches to respond to requests for cost reductions during the negotiation process.
- Establish initial partnerships, such as pilot projects, to demonstrate the potential return on investment.

About JFS

[Jewish Family Service of Los Angeles](#) (JFS) seeks to strengthen and preserve individual, family, and community life by providing a wide range of human services to community members at every stage of the life cycle, especially those who are poor and disadvantaged. Guided by the ethical and spiritual values of Judaism, JFS serves older adults and people with disabilities through a mix of services including at-home health and wellness, mental health, meals, transportation, and social and physical activities.

Why JFS Joined Linkage Lab

When the *Affordable Care Act* was enacted, JFS staff immediately began to engage with health care payers and providers about potential partnerships. At the same time, California legislators were discussing the transition of the Multipurpose Senior Services Program (MSSP) into managed care as part of California's duals demonstration (Cal MediConnect) and Coordinated Care Initiative. This represented a significant change for MSSP, which was first piloted 30 years ago at JFS. In addition, JFS was in the process of applying for a contract with the Centers for Medicare & Medicaid Services (CMS) to provide care transition services, and it realized the complexity of this kind of work. JFS was motivated to participate in the Linkage Lab for three main reasons: 1) to gain a better understanding of business relationships with health care entities; 2) build its management team's skills in the areas of contract negotiation, business development, data collection, and evaluation; and 3) learn about the dynamics of the current health care landscape. In this way, JFS sought to enhance its ability to provide appropriate, high-quality, cost-effective services.

Key Objectives

JFS sought to contract with at least two health care payers and/or providers (e.g., such as health plans, hospitals, and Federally Qualified Health Centers) to provide home- and community-based services in a way that would both be cost-attractive to these entities and generate profit for JFS. JFS also focused on case volume, revenues, and margin, as well as the expansion of service capacity, the adaptation of service delivery models, and organizational development. Specifically, the organization aimed to serve at least 3,500 clients annually; generate a minimum of \$5 million in annual revenue, with a 10% margin; and expand its older adult service capacity in the areas of care management, behavioral health services, and care transitions.

In addition, JFS aimed to enhance service effectiveness by developing more integrated models of care and the capacity for co-location, and by exploring strategic partnerships with other disability and substance use service providers. Finally, JFS sought to use the operational and cultural changes engendered by this work to foster organizational development across the agency, including improved operational and management systems to support more data-driven, outcome-based planning and service delivery.

Key Strategies and Processes

JFS created a work team to establish strategies and tasks, ensure accountability, and monitor progress. Immediately, the team questioned the organization's infrastructure, and ultimately it undertook organizational restructuring, starting with the leadership. JFS identified health care payers and providers to target for contractual relationships and engaged in relationship-building. Conversations were focused on JFS's ability to effectively implement programs and services beyond its traditional offerings such as private duty home and transitional care services. JFS leveraged its transitional care program work by extending these services to multiple hospitals, after initially demonstrating positive performance in reducing readmissions.

JFS analyzed its existing MSSP model and structure to inform both contractual negotiations and model improvements. Areas of focus included staffing evaluation, accountability, performance, new ways to deliver services, and data collection. In parallel with this work, JFS engaged its board members in an educational session at their annual retreat, provided consistent progress reports, and created a small council of board members to participate in the leadership restructure. It also initiated an accreditation process with CARF (originally the Commission on Accreditation of Rehabilitation Facilities) to drive standardization of processes and best practices.

Contracts with Health Care Payers and Providers

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

JFS participated in Linkage Lab to:

- gain a better understanding of business relationships with health care entities
- build its management's skills in contract negotiation, business development, data collection, and evaluation
- learn about the dynamics of the current health care landscape.

Table 1: Summary of JFS Contracts with California's Health Care Sector						
Payer/ Provider	Criteria Used to Evaluate JFS	Contract Duration	Service Package	Population to Be Served	Pricing Structure	Implementation Status
Health Net	Ability to handle complex case management for older adults and people with disabilities in a cost-effective manner	One year	Psychosocial assessment, care plan implementation, and case management services	Older adults with complex case management needs	Capitated payment per member	In implementation
Care1st Health Plan	Ability to handle complex case management for older adults and people with disabilities in a cost-effective manner	One year	Psychosocial assessment, care plan, and case management services	Older adults with complex case management needs	Capitated payment per member	In implementation
Anthem Blue Cross	Ability to handle complex case management for older adults and people with disabilities in a cost-effective manner	One year	Assessment and case management services	Older adults with complex case management needs	Capitated payment per member	In implementation
L.A. Care	Ability to provide mandated assessments in the required timeframe	One year	Eligibility assessments for Community-Based Adult Services (CBAS)	200 members annually	Capitated payment per member; tiered based on service package	In implementation
CMS	Ability to provide evidence-based care transition services through partnership with hospitals	One year	Care transitions services	Medicare fee-for-service patients being discharged from hospitals, at risk for re-admission; 3,300 patients served annually	Capitated payment per beneficiary	In implementation

Table 1: Continued						
Payer/ Provider	Criteria Used to Evaluate JFS	Contract Duration	Service Package	Population to Be Served	Pricing Structure	Implementation Status
CMS and Cedars-Sinai Medical Center	Ability to provide evidence-based care transition services through partnership with hospitals	Contract ended 12/31/14	Expand care transitions services to patients discharged from Cedars-Sinai Medical Center	Medicare fee-for-service patients discharged from hospital, at risk for readmission	Capitated payment per beneficiary	Contract ended
Cedars-Sinai Medical Center	Ability to provide warm handoff and anchor patients in the community	One year	Behavioral Health Transition Care Navigator pilot	Annually, 100 older adult hospital patients with psychiatric diagnosis who need connections to community resources	Program rate	In implementation
Comprehensive Community Health Centers	Ability to provide consultation and direct services that will achieve greater integration of services	Two years	Behavioral health and community social service case management for patients at four FQHCs; integration of primary care, behavioral health, and social services	Patients at four clinics who need linkages to community resources to help achieve medical stability	Program rate plus additional fee for patients who receive case management	In implementation
St. Francis Medical Center and St. Vincent Medical Center	Ability to provide transition care services for patients discharged from the hospital with chronic health conditions	Currently month-to-month	Pilot post-discharge services	Dual eligible Medi-Cal/ Medicare patients at high risk for readmission, with chronic health conditions	Hourly rate with a cap on hours	In implementation

Additional Successes

JFS's participation in the Linkage Lab helped it focus on its capacity to obtain future business with health care payers and providers. JFS re-evaluated its leadership structure, which led to a major restructuring of agency leadership toward a more integrated, flexible, and accountable model that better positioned the organization for data- and price-driven interactions with payers and providers.

Skill-building through Linkage Lab enabled JFS to interact with health care payers and providers more strategically and to present its business case more effectively—presenting itself as offering cost-effective and efficient services. JFS was able to more effectively evaluate potential contracts so that they did not accept prices being offered if it did not make financial sense for JFS.

Challenges

The principal challenge that JFS experienced in working toward its objectives was translating signed contracts into new business. JFS found it difficult to devote enough time to develop new service models and maintain engagement with new payer and provider clients while concurrently managing service ramp-up, building internal capacities, and effecting organizational restructuring. It was also challenging to generate sufficient referrals from new clients to support the cost of delivering services and validate the effectiveness of service. In the area of costs, JFS found that for-profit and payer/provider in-house competition could tolerate greater financial risk than it could.

The necessary transformation of JFS's organizational culture was also difficult. Moving away from the traditional social service model toward one in which pricing, quality, and impact are all closely interrelated was at odds with the reason some staff members had chosen to work for a community-based charity.

Lessons Learned

Key lessons for JFS through Linkage Lab:

- Winning a contract is a critical step, getting actual referrals from the contract and continuous communication with the payer are essential to long-term success.
- Referral and volume expectations, as well as potential implementation challenges, need to be addressed proactively and interactively with health care payers and providers.
- Clear outcome goals should be jointly established and then measured to demonstrate service value.
- Strong relationships with stakeholders in payer and provider organizations—beyond those who negotiate the contracts—need to be developed to support successful contract implementation.
- Opportunities and competition are increasing; community-based organizations must demonstrate that they add unique value and are reliable and effective providers.

About SVILC

[Silicon Valley Independent Living Center](#) (SVILC) is a cross-disability, intergenerational, multicultural disability justice organization based in San Jose and serving Santa Clara County. Operated both by and for people with disabilities, SVILC strives to create fully inclusive communities that value the dignity, equality, freedom, and worth of every human being. SVILC's Community Transition Program provides comprehensive care coordination and intensive case management and monitoring to assist people with disabilities moving into a community living setting. The Stepping Stones Program helps people with disabilities live successfully in the community and avoid returning to a nursing home or institution. SVILC also provides information and referrals, peer support, assistive technology and lending library, personal care attendance services, housing search assistance, and independent living skills training. Finally, SVILC actively advocates for change in systems serving those with disabilities.

Why SVILC Joined Linkage Lab

SVILC identified that it had operational and resource gaps that would have to be filled in order to be ready for contracting with the health care sector. It had inadequate staffing to meet demand for its community care transitions programming and wrap-around services, as well as for its human resources function. Its IT, electronic health record (EHR), and billing systems were outdated and not compatible with those of potential health sector business partners. Its program structure was siloed, and there was a need for a team model to ensure holistic and timely services for those experiencing care transitions. SVILC lacked the unrestricted funding needed to cover upfront costs for new business arrangements before reimbursement funds begin to flow.

Key Objectives

SVILC sought to enter into contractual relationships with the duals demonstration health plans in Santa Clara County under which it would provide care transition coordination and independent living services to plan members. By doing so, SVILC sought to deinstitutionalize 20% of the dual eligibles (persons eligible for both Medicare and Medicaid [Medi-Cal]) currently living in long-term care facilities in the county, as well as gain a sustained source of revenue that could be reinvested in the organization's service lines. Specifically, SVILC recognized that it needed to build the leadership and management competencies and infrastructure required to successfully plan and promote its long-term services and supports

(LTSS), make the business case for care transitions, deliver its LTSS profitably and successfully, and evaluate its services.

Key Strategies and Processes

The SVILC team began by identifying health care payers participating in the duals demonstration (Cal MediConnect) and developing strategies for approaching them. The team also mapped out SVILC's current services and service delivery flow and identified areas for improvement, as well as potential options that could be packaged and sold to payers. Next, the organization launched an initiative to streamline its program processes, procedures, and service delivery. It worked closely with the Linkage Lab technical assistance providers to negotiate the first payer contract, building skills to negotiate other contracts on its own. After contracts were signed, SVILC initiated a pilot referral program with the payers as a way to build relationships and SVILC's credibility.

While working to obtain contracts, SVILC cultivated relationships with other community entities, such as the Area Agency on Aging, the Department of Health Care Services, and the Housing Authority, with the hope of establishing an Aging and Disability Resources Center (ADRC). Although SVILC had not established an ADRC by the time its Linkage Lab participation ended, it identified potential opportunities to subcontract specialty services with other community organizations and moved forward with joint proposals.

At the same time it was engaged in these activities, SVILC initiated a process to improve its infrastructure. With funding from services provided under its Independent Living Center (ILC) designation, program staffing was increased, program processes and procedures streamlined, and data tracking and reporting structures improved. SVILC also identified appropriate, enterprise-wide solutions for its EHR and phone system challenges and initiated implementation of these solutions, using a Linkage Lab infrastructure grant.

SVILC recognized that it needed to build the leadership and management competencies and infrastructure required to successfully plan and promote its LTSS, make the business case for care transitions, deliver its LTSS profitably and successfully, and evaluate its services.

Contracts with Health Care Payers and Providers

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

Table 1: Summary of SVILC Contracts with California's Health Care Sector						
Payer/ Provider	Criteria Used to Evaluate SVILC	Contract Duration	Service Package	Population to Be Served	Pricing Structure	Implementation Status
Santa Clara Family Health Plan (SCFHP)	Only Independent Living Center in the county with track record of successful transition from skilled nursing facilities, acute care, and sub-acute care to home	One year initially, with annual renewal option until terminated	Care coordination and nursing home transition and diversion services	Older adults and people with disabilities residing in nursing home; high utilizers of urgent care and hospitals	Hourly rate for each service and flat rate reimbursement of certain expenses	In implementation
Anthem Blue Cross	Only Independent Living Center in the county with track record of successful transition from skilled nursing facilities, acute care, and sub-acute care to home	One year initially, with annual renewal option until terminated	Care coordination and nursing home transition and diversion services	Older adults and people with disabilities residing in nursing home; high utilizers of urgent care and hospitals	Hourly rate for each service and flat rate reimbursement of certain expenses	Not yet in implementation

Recognizing its niche, SVILC packaged its transition and care coordination services together to solicit and negotiate contracts with both of the health plans participating in the Santa Clara County Cal MediConnect. Through Linkage Lab, SVILC gained an understanding of the market as impacted by the changing health care environment. The organization worked closely with the Linkage Lab technical assistance providers to establish competitive rates for each service in the package, and it then leveraged its specialized staff competencies and core independent living services to demonstrate to the health plans the sustainability of the community transition beyond the contracted services.

Additional Successes

By bolstering its internal systems capacity, opportunities arose for SVILC to collaborate and subcontract with other community-based organizations (CBOs) to provide a niche offering to

health care payers and providers. SVILC also added disability awareness training to its service offerings and targeted local employers as possible new clients.

Challenges

SVILC faced both external and internal challenges during its participation in Linkage Lab. Externally, payers were still preparing for Cal MediConnect and were often not focused on developing new business arrangements with CBOs. SVILC found it challenging to make payers aware of what services it offered and what differentiated them. Once contracts were signed, it was not easy to generate referrals from the payers.

Internally, SVILC found it difficult to build infrastructure, improve processes and programs, and generate new business opportunities all at the same time. Even with an infrastructure grant, there was insufficient funding to address multiple technology needs. Hiring medical staff for program improvement was a challenge. Finally, there was turnover in multiple key leadership positions, forcing the team to do more with fewer human resources.

Lessons Learned

Key lessons for SVILC through Linkage Lab:

- Understand what differentiates your organization and be able to articulate and sell this to the health care sector.
- Consider collaborating with other CBOs as a way to grow business and co-create packages of service offerings.
- Think about repurposing organizational competencies and service offerings to meet external market needs.
- Do not underestimate the need to address volume expectations and referral processes with payers during initial discussions.
- Run the non-profit organization like a business, making appropriate adjustments that support relevancy and sustainability.

About St. Paul's

[St. Paul's Senior Services](#) (St. Paul's) is a full-service, non-profit retirement community in San Diego. It includes independent, assisted living, and skilled nursing communities, as well as an intergenerational day care program and a Program of All-Inclusive Care for the Elderly (PACE). The mission of St. Paul's is to provide a continuum of innovative and comprehensive programs in a secure, interfaith environment, with great value placed on optimal independence at all stages of life.

Why St. Paul's Joined Linkage Lab

St. Paul's initially identified a number of issues and opportunities they needed to address in order to successfully contract with the health care sector. A key external issue was that state and federal entities had not yet provided regulations for payers and providers on liabilities or reimbursement rates for dual eligibles (persons eligible for both Medicare and Medicaid [Medi-Cal]). This was preventing payers/providers and community-based organizations (CBOs) from negotiating CBO rates for services. Internally, St. Paul's lacked the IT and communication systems needed to enter into successful relationships with payers and providers, as well as the financial resources to cover start-up costs for such relationships. In addition, although the organization had a basic pricing structure for services, it did not have a strategy for addressing services needed by patients but not covered by payers. Through the Linkage Lab, St. Paul's sought to address these challenges.

Key Objectives

St. Paul's sought to build a financially sustainable relationship with four managed care organizations (MCO) under California's duals demonstration (Cal MediConnect) and the Coordinated Care Initiative, by offering these plans innovative solutions for post-acute care and the health and social needs of patients. Specifically, it wanted to implement a plan to coordinate social and medical needs of older adults in advance of leaving the hospital so that at least 90% would not return to the hospital for the same diagnosis within 30 days. To accomplish these aims, St. Paul's sought to develop a model of service, establish a memorandum of understanding with other community providers, develop a budget for services, negotiate a rate structure with the health plans, finalize subcontracts with community providers, and hire and train case management staff.

Key Strategies and Processes

The St. Paul's team began by leveraging the organization's existing competencies as a PACE provider and exploring a variety of home- and community-based models and services that could be packaged for health care payers and providers. Next, the team created a menu of services and presented it to several health plans. Meanwhile, team members cultivated relationships and kept informed about emerging market activity through participation in a community collaborative focused on transitional care programs. Internally, St. Paul's assessed its infrastructure, existing resources, and need for new talent, and it ultimately implemented a significant organizational restructuring and a new electronic health records (EHR) system.

St. Paul's consulted with a Linkage Lab technical assistance provider with experience in managed care contracting to better understand the potential perspectives of MCOs. Key St. Paul's staff then made contact with each of the four MCOs contracted under Cal MediConnect in San Diego County and met one or more times with each of them. St. Paul's presented to each MCO a menu of available services, both à la carte and packaged, with proposed pricing.

Contracts with Health Care Payers and Providers

Table 1 summarizes the contract St. Paul's successfully negotiated during Linkage Lab.

Payer/ Provider	Criteria Used to Evaluate St. Paul's	Contract Duration	Service Package	Population to Be Served	Pricing Structure	Implementation Status
Care1st	St. Paul's offered comprehensive post-acute care	Initial one- year period, with renewals for successive one-year terms	All social and medical post-acute care for 30 days; could be extended to 60 days if approved by Care1st	Over the age of 55, medically frail, with limited social supports	Package for set level of care, or individual services as requested by Care1st team	Not yet in implementation

Before the two organizations entered into a contract, Care1st made site visits to St. Paul's, and St. Paul's provided education to Care1st staff on the social needs of sub-acute patients discharged from the hospital to their homes. The two entities also engaged in negotiations on pricing structure. It was decided that the model of care to be implemented by St. Paul's would follow the PACE plan. St. Paul's staff and management were well-positioned to implement this plan following a corporate reorganization. Also contributing to St. Paul's success was an increased awareness within the organization that its other facilities (i.e., skilled nursing or assisted living) could be called upon on a temporary basis to provide rehabilitation to this population.

St. Paul's assessed its infrastructure, existing resources, and need for new talent, and ultimately implemented a significant organizational restructuring and a new EHR system.

Additional Successes

St. Paul's experienced several successes through this work, including the following:

- An organizational restructuring, which included working with a Linkage Lab technical assistance provider to assess the organization's infrastructure, people, and processes;
- Implementation of an EHR system across the organization to create data collection capability and facilitate sharing of health care information with health plans in a HIPAA-compliant manner;
- Creation of a new staff position to focus on growth of home- and community-based services;
- Strengthening of St. Paul's overall market position through participation in a community collaborative and conversations with local health care payers and providers; and
- Enhanced community awareness of St. Paul's PACE offerings and PACE's value to MCOs as an alternative for their most challenging members.

Challenges

Issues identified by St. Paul's at the outset continued to be challenging during its participation. Externally, the organization was unable to control certain factors related to Cal MediConnect plan reimbursement, start date, service rates, and enrollment projections.

These unknowns made MCOs reluctant to finalize and implement service contracts. St. Paul's also found it difficult to implement multiple initiatives at the same time, given that its team was already stretched to capacity before completion of the reorganization.

Lessons Learned

Key lessons for St. Paul's through Linkage Lab:

- Develop organizational infrastructure to support growth opportunities.
- Invest in current employees and attract new talent to maintain relevance in a rapidly evolving environment.
- Understand the needs of payers and providers and be able to demonstrate your organization's value through data on outcomes.
- Invest time and resources in building your organization's brand in the community and with payers and providers; this includes education on CBO services and the value these services can have in reducing costs of care.
- Promote diversification of service and revenue and invest adequate resources to ensure successful execution and sustainability of new services and programs.

Webinar

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

Online Resources and Tools

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

TSF Perspectives

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