Working Together Toward Better Health Outcomes

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Partnership for Healthy Outcomes
Bridging Community-Based Human Services and Healthcare

A Collaborative of

Authored by Nonprofit Finance Fund

Elise Miller

Trishna Nath

Laura Line, Consultant

Report Contributors

Kristin Giantris, Nonprofit Finance Fund

Tricia McGinnis, Center for Health Care Strategies

Phyllis Richards, Alliance for Strong Families and Communities

Polina Makievsky, Alliance for Strong Families and Communities

About the Partnership for Healthy Outcomes

The Partnership for Healthy Outcomes, a year-long project of Nonprofit Finance Fund (NFF), the Center for Health Care Strategies (CHCS), and the Alliance for Strong Families and Communities (Alliance), with generous support from the Robert Wood Johnson Foundation, captured and shared insights for partnerships between healthcare and community-based organizations, particularly those that serve low-income and/or vulnerable populations.

Nonprofit Finance Fund

Nonprofit Finance Fund (NFF) unlocks the potential of mission-driven organizations through tailored investments, strategic advice, and accessible insights. Since 1980, we've worked to help organizations connect money to mission effectively, providing a continuum of consulting, financing, and advocacy services to nonprofits and funders nationwide. In 2016, NFF provided more than 52,000 hours of one-on-one support to over 253 organizations, helping to build the capacity and adaptability of these organizations to enable a more just and vibrant society. A leading CDFI with over $250 million in assets under management, NFF has provided $620 million in financing and access to additional capital in support of over $2.3 billion in projects.

Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a national nonprofit health policy center dedicated to improving the health of low-income Americans. CHCS achieves its mission by working with state and federal agencies, health plans, providers, and consumer groups to advance innovative and cost-effective models for organizing, financing, and delivering health care services. Its work focuses on enhancing access to coverage and services; advancing delivery system and payment reform; and integrating services for people with complex needs. CHCS is recognized for providing actionable technical assistance, training, and policy analysis to improve the quality of publicly financed care and has worked with nearly all 50 states, health plans, federal agencies, and community based-organizations, and providers across the country.

Alliance for Strong Families and Communities

The Alliance for Strong Families and Communities is a strategic action network of thousands of committed social sector leaders driving to achieve a healthy and equitable society. We aggregate the very best sector knowledge and serve as an incubator for learning and innovation to generate new solutions to the toughest problems. We accelerate change through dynamic leadership development and collective actions to ensure policies and systems provide equal access and opportunity for health and well-being, educational success, economic opportunity, and safety and security.

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Today, a low-income senior admitted to a hospital in an Ohio community may find herself with a new level of comprehensive support to get well and to stay healthy at home. This is thanks to one of many partnerships emerging across the country that integrate health with human services to improve care. Several years ago, a large healthcare provider was experiencing disproportionately high hospital utilization by low-income elderly patients. Meanwhile, a local community-based organization (CBO) serving this same population recognized that to achieve its goals of delaying nursing home admissions, it would need to coordinate more closely with medical providers. Shared health improvement and cost savings goals led these organizations to a new, integrated model of care, where CBO staff came into the hospital to meet with seniors and create a post-discharge care plan. Hospital readmissions rates dropped, and the success of this initial collaboration fostered numerous formal partnerships between hospitals, health systems, and CBOs across counties – and now states – positively impacting the lives of countless seniors in need.

Executive Summary

With rising costs, persistent health inequities, and gaps in care access, there is a heightened focus across sectors on new approaches to achieve better health outcomes. Policy and industry practices are shifting to prioritize value over volume. New payment and delivery models, and value-based contracting are aiming to reduce costs while improving patient care and community health. In addition, a broadening recognition of the critical role of the social determinants of health is forging increasingly common ground for providers of healthcare and human services.

There are myriad permutations of partnerships between healthcare organizations and community-based organizations (CBOs) emerging across the US. Leaders are navigating new relationships, programs, and processes – even new definitions of "health" and "outcomes" – among their many, varied stakeholders, driven by a shared desire to improve the health and well-being of people and communities, while keeping costs down.

The Partnership for Healthy Outcomes – comprised of Nonprofit Finance Fund (NFF), Center for Healthcare Strategies (CHCS), and the Alliance for Strong Families and Communities (Alliance), with support from the Robert Wood Johnson Foundation (RWJF) – set out to capture and analyze the lessons emerging in this dynamic space, as organizations explore partnerships to achieve greater outcomes together than they could on their own. A national request for information (RFI) asked specifically about partnerships between healthcare organizations and CBOs. It produced a wealth of data from a wide range of partners in a wide variety of partnerships. Among the key insights:

- **There's no one-size-fits-all formula:** Respondents represented partnerships of many sizes, shapes, and contractual and funding arrangements; many were among healthcare providers and CBOs – but partners also included public health and other government agencies, private insurers, foundations, schools, supermarkets, and more.

About the RFI: In January 2017, NFF, CHCS, and Alliance published an online RFI to gather information about partnerships between healthcare organizations and CBOs, especially those serving low-income or vulnerable populations. During a three-week period, more than 200 people responded, 67% representing nonprofit CBOs, 13% from healthcare organizations, and 9% from government entities, with the rest from foundations, research institutions, consulting organizations, and for-profit CBOs. Responding partnerships serve all 50 states, led by California, New York, Colorado, Pennsylvania, and Minnesota.

- **Shared goals provide common ground:** Most of the responding partnerships were initiated by CBOs and noted the value of developing shared goals to improve health outcomes and contain or reduce costs.

- **Most partnerships have some sort of formal agreement in place**, though partner integration varied from:
    - Communicating (sharing client information) to
    - Coordinating (aligning services toward better client outcomes) to
    - Collaborating (sharing staff, space, or resources) to
    - Integrating (becoming a collective entity with connected programs, planning, and funding).

- **Most commonly, partnerships provided services to impact immediate-term clinical needs, such as reducing hospital admissions or length of stay**. This may be due, at least in part, to a funding environment with incentives for cost reduction.
    - More than half of 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.
    - A majority (65%) of partnerships reported realizing cost savings.

- **Partnerships rely on an evolving variety of funding sources**, including private foundations, healthcare systems, and government entities, and typically more than one. A number of partnerships were established through a one-time grant and have developed – or are developing – a long-term, sustaining funding model.

- **Nearly all organizations acknowledged expanding skills and capacities through partnership**, particularly in network-building, improving programs, and generating new funding.

- **Advancing the field will require partners and funders to**:
    - Prioritize and invest time in relationship-building – the key ingredient to effectiveness.
    - Engage a wide range of stakeholders, including community members, early on and throughout the partnership.
    - Identify and fund the full cost of partnership to effectively support development and evolution.
    - Stay adaptable and nimble in an ever-shifting environment.

The lessons from these partnership efforts can continue to inform the drive to improve health outcomes and reduce costs. Given today's uncertainty in the US healthcare landscape, continued research into how different types of partnerships operate is essential to foster more effective communication, coordination, collaboration, and integration, and ensure that – working together – healthcare organizations and CBOs can achieve more.

The wide array of RFI responses provided a wealth of quantitative and qualitative information about core partnership components. For a deeper dive, four partnerships, varied across partner type, geography, goals, funding, and more, were chosen to explore through in-depth interviews and comprehensive case studies, due for publication in summer 2017. The Partnership for Healthy Outcomes will also develop and share self-assessment tools to help partnering organizations assess gaps and opportunities.

A Changing Landscape

The delivery and funding of healthcare in the US are rapidly evolving. Costs are rising, yet poor outcomes, significant health disparities, and gaps in healthcare access persist. At the national, state, and local levels, policies and programs have aimed to redefine healthcare, shifting from a disproportionate focus on hospital-based acute care to a range of health interventions in communities, homes, and primary care practices.

Communities have long worked across sectors to address population health concerns. However, with the passage of the Affordable Care Act (ACA) and with a refined understanding of the social determinants of health, health and human services providers are increasingly invested in building health together. While the future of the ACA and US healthcare policy is uncertain, the movement toward outcomes-based, cross-sector approaches is a promising and viable path forward.

Healthcare Policy Shifts

Policies and industry practices have begun prioritizing value over volume to improve population health and the patient experience of care while reducing per capita cost. When the Affordable Care Act (ACA) passed in 2010, it created new opportunities aimed at improving – and paying for – health outcomes.[1] An expanded role for Centers for Medicare & Medicaid Services (CMS) has fostered new payment and delivery models, through Accountable Care Organizations, the Medicaid Innovation Accelerator Program, and the Delivery System Reform Incentive Payment (DSRIP) program, among several other initiatives.[2] The establishment of the Prevention and Public Health Fund, for example, has increased investment into community and clinical prevention initiatives, research, and public health infrastructure.

Moreover, the ACA has increased healthcare access across the country. Subsidies for private insurance and expansion in eligibility for Medicaid and the Children's Health Insurance Program (CHIP) have provided access to millions more people, in particular low-income and vulnerable populations.[3] This expansion in coverage shifted the conversation around healthcare from, "How can more people access more healthcare services?" to "How can people improve their health by better utilizing a wide array of healthcare services?"

Social Determinants of Health

In the last decade, public health research has also spurred a growing recognition of the full range of factors impacting health, including the important role that social determinants – such as housing, food security, education, and employment – play in influencing health outcomes and healthcare spending.[4] The health of individuals and communities is deeply influenced by socioeconomic factors – not only by genetics and quality of care; these factors are traditionally addressed by the human services sector, rather than the healthcare sector. Given the link between socioeconomic factors and health, low-income individuals and communities often face greater challenges in leading healthy lives.[5]

A better understanding of the impact of social determinants of health has led healthcare organizations and community-based organizations (CBOs) that provide human services to explore partnerships to improve health outcomes and lower costs by addressing medical as well as social, environmental, and behavioral needs. Evidence suggests that population health improvement will rely on continued and enhanced collaboration between the healthcare and human services sectors.[6]

1   "Affordable Care Act in Action at CMS," *Centers for Medicare & Medicaid Services*, accessed May 12, 2017. https://www.cms.gov/about-cms/aca/affordable-care-act-in-action-at-cms.html
2   "Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts," The Henry J. Kaiser Family Foundation, last modified June 22, 2017. http://www.kff.org/medicaid/fact-sheet/medicaid-delivery-system-and-payment-reform-a-guide-to-key-terms-and-concepts/
3   "Effect of the Affordable Care Act on Health Care Access," The Commonwealth Fund, accessed May 22, 2017. http://www.commonwealthfund.org/publications/issue-briefs/2017/may/effect-aca-health-care-access
4   Lauren A. Taylor, Caitlin E. Coyle, Chima Ndumele, Erika Rogan, Maureen Canavan, Leslie Curry, and Elizabeth H. Bradley, "Leveraging the Social Determinants of Health: What Works?" *Blue Cross Blue Shield of Massachusetts Foundation,* accessed May 12, 2017. https://bluecrossmafoundation.org/sites/default/files/download/publication/Social_Equity_Report_Final.pdf
5   "Health Impact Assessment, The determinants of Health," *World Health Organization*, accessed May 12, 2017, http://www.who.int/hia/evidence/doh/en/
6   Stephen M. Shortell, "Bridging the Divide between Health and Health Care," Relational Coordination Research Collaborative, accessed May 12, 2017. https://rcrc.brandeis.edu/events-webinars/Bridging%20the%20Divide%20Between%20Health%20and%20Health%20Care.pdf

Outcomes-Oriented Partnerships

Across the US, partnerships between healthcare organizations and CBOs are emerging. Many of these partnerships are nascent, in an exploratory or pilot phase. Some are complex, involving new relationships, new programs, or even a new definition of "health." Most are dynamic, adapting and evolving as people, processes, and policies change. Across a wide array of stakeholders, from practitioners to policymakers and researchers, there is interest in healthcare organization-CBO partnerships. When is partnership appropriate? What drives effective partnership? How can partners work to achieve more together than each could achieve on their own? How can partnership improve the health and wellbeing of people and communities across the US?

In September 2016, with support from the Robert Wood Johnson Foundation (RWJF), Nonprofit Finance Fund (NFF), Center for Healthcare Strategies (CHCS), and the Alliance for Strong Families and Communities (Alliance) began a collaborative effort – Partnership for Healthy Outcomes – to analyze the landscape of partnerships between healthcare organizations and CBOs. Through a national request for information and the creation of in-depth case studies, we set out to identify examples and lessons from current partnerships to inform funding and policies and to advance effective practices across the nation. The following report captures key learnings from the request for information and is intended to share tangible insights about current partnership models.

Request For Information: Methodology and Overview

In January 2017, NFF, CHCS, and Alliance released a request for information (RFI) about partnerships between healthcare organizations and CBOs, especially those that serve low-income or vulnerable populations. Development of the RFI was informed by a literature review and input from an interest group of health funders across the country. To capture an array of viewpoints, any representative engaged in partnership – regardless of organization type and role – was encouraged to submit a response to share information about partnership characteristics, funding and payment, data and outcomes, challenges and lessons, and goals.

The online RFI was distributed widely via project partner and funder networks. During a period of three weeks, over 200 people responded, including 67% from nonprofit CBOs, 13% from healthcare organizations, 9% from government entities, and the remaining from foundations, research institutions, consulting organizations, and for-profit CBOs. While the responses were self-selected and therefore not a representative sample, there is a wealth of insight and experience – and great deal of diversity – reflected.
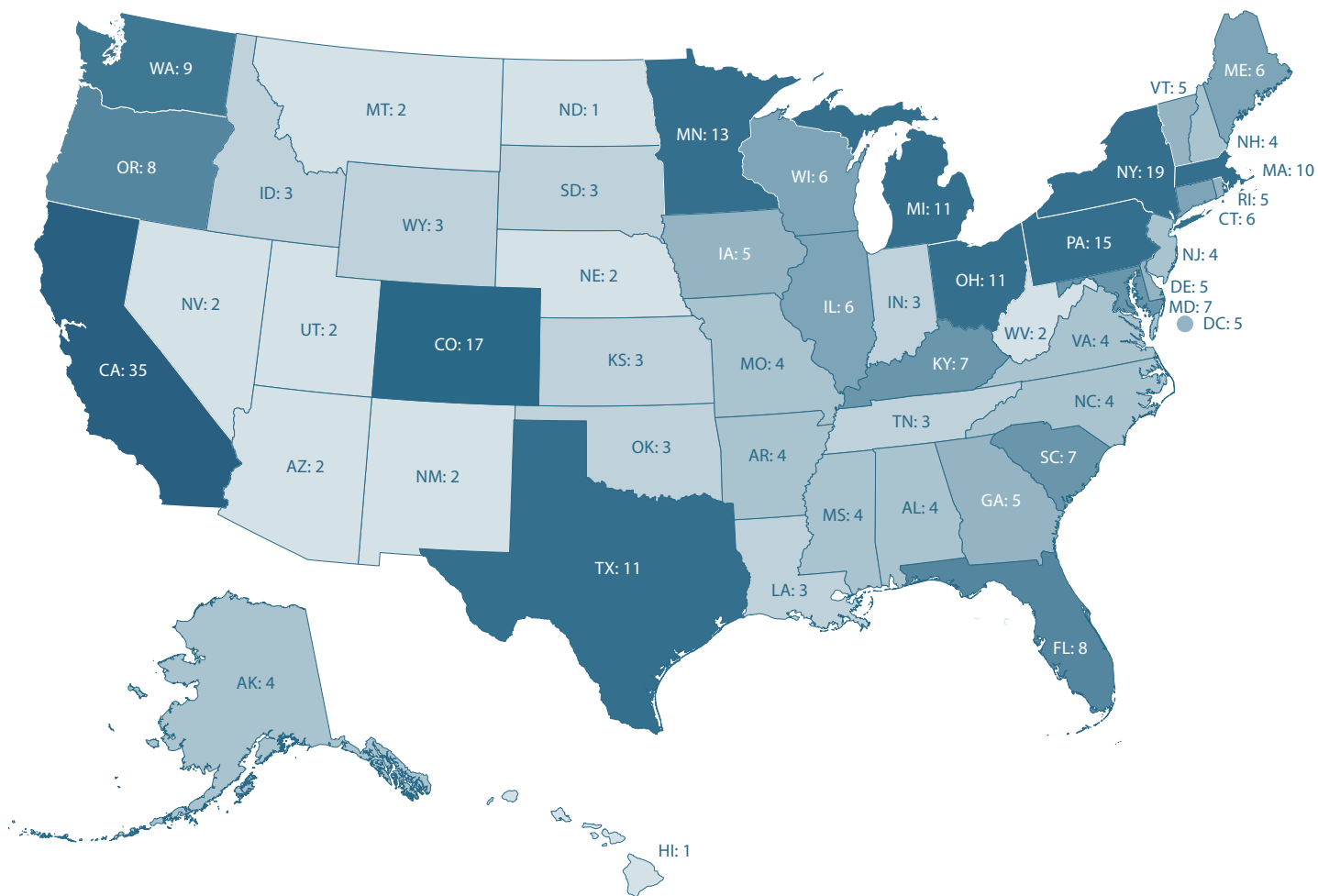
Representatives responded on behalf of partnerships serving all 50 states, with the highest number of partnerships serving California, New York, Colorado, Pennsylvania, and Minnesota. Among responding partnerships, over three-quarters began after 2010, with nearly 60% established in 2014 or later. There is also considerable variation in partnership size and scope. Fifty-four percent of partnerships serve less than 1,000 people annually, while 12% serve more than 20,000 people – in some cases, entire communities – each year.

Of the more than 200 partnerships captured in RFI responses, no two are identical. The landscape is vast and varied. Organizations differ in their approaches to partnering for better health outcomes, and sometimes differ in their view of what defines a "health outcome" itself. And yet, while partnership diversity is a consistent theme woven throughout our findings, there are also commonalities around specific partnership structures, goals, services, funding, data, challenges, and best practices.

> **Request for Information:** Recognizing the broad and dynamic nature of the term, the RFI defined partnership as, "A structured arrangement between a healthcare organization (e.g. health system, hospital, provider, insurer, state or local public health department) and nonprofit or for-profit community-based organization (e.g. housing organization, workforce development agency, food bank, early childhood education provider) to provide services to low-income and/or vulnerable populations."

Though we cannot draw from the information one formula for effective partnership, the data and stories gathered elucidate how organizations are navigating partnership in the current climate – and commonalities in their financial, operational, cultural, and strategic approaches.

Identify the state(s) where the partnership's efforts occur (n = 208)

State	Value
WA	9
OR	8
MT	2
ND	1
MN	13
WI	6
MI	11
ME	6
VT	5
NH	4
NY	19
MA	10
RI	5
CT	6
ID	3
SD	3
IA	5
OH	11
PA	15
NJ	4
WY	3
IL	6
IN	3
DE	5
MD	7
DC	5
CA	35
NV	2
UT	2
CO	17
KS	3
MO	4
KY	7
WV	2
VA	4
NC	4
TN	3
SC	7
AZ	2
NM	2
OK	3
AR	4
GA	5
MS	4
AL	4
TX	11
LA	3
FL	8
AK	4
HI	1

Please select the targeted population(s) served by the partnership (n=203)

Population	Percentage
Adults	71%
Persons with chronic conditions	64%
Medicaid recipients	61%
Older adults (65 and older)	59%
Persons with mental health needs	50%
Medicaid and Medicare dual eligible	50%
Families	50%
Persons with disabilities	49%
Racial and/or ethnic minorities	47%
Medicare recipients	45%
Low-income or unemployed workers	45%
Persons with substance use disorders	35%
Infants, children and/or adolescents	35%
Obese adults and/or children	31%
Homeless	30%
Victims of domestic violence	23%
Pregnant or parenting teens/young adults	23%
Formerly incarcerated persons	23%
Transitional age young adults	20%
Other	20%
WIC participants	17%
Undernourished youth	15%

What Is Driving Partnership?

Partnership Goals

Driven by diverse local needs and dynamics in communities across the country, partnerships detailed in the RFI responses reflected a wide range of goals. Most frequently, partnerships were designed to address patient-level, clinical health needs, including to reduce hospital admissions, reduce length of hospital stays, or reduce emergency department usage. Often, partnerships focused on the transition from acute care settings to more cost-effective or patient-friendly care settings.

Responses highlighting the breadth of specific partnership goals include:

- "To improve access to and utilization of mental health services"
- "To improve member outcomes in key metrics, including avoidable readmissions, ER use, medication adherence, activities of daily living (ADL) support needs, and nursing home placement"
- "[To minimize] prevalence of pediatric asthma in neighborhoods by getting to the source of what's making children sick in their homes"
- "To increase the incidence of healthy pregnancies, positive birth outcomes, and healthy infants in a vulnerable population of women and infants who are court-involved"

- "[To provide] homeless patients who are transitioning out of an acute care hospital with basic medical oversight in a clean, safe environment… with the ultimate goal of connecting them to supportive housing."

In describing partnership goals, about 15% of respondents explicitly alluded to cost savings as a need the partnership was designed to meet. In a related question, a majority of respondents – approximately 65% – indicated that cost savings have been realized through the partnership. Several of these partnerships reported working with high-needs populations, such as homeless or aging populations, to minimize avoidable hospital usage.

Partnership goals to reduce hospital-based acute care usage reflect recent priorities of the national healthcare system and an ACA-spurred focus on how individuals can better utilize healthcare. Responses also align with policy changes incentivizing the reduction in acute care usage, such as Medicare's "no-payment" policy in the case of avoidable hospital readmissions.[7]

Finding Common Ground

CBOs were most often the driving entity behind partnership development, initiating the partnership in nearly half of responses. Approximately 20% of partnerships were initiated by a healthcare organization (not including managed care, health plans, or CMS), and 10% were initiated by a government entity, such as a Department of Public Health, Public School, or Department of Aging. A small number of partnerships were initiated by managed care or health plans, foundations, and academic institutions.

Whether the partnership was initiated by a CBO, healthcare organization, or other entity, respondents described having unified goals across partners. However, CBOs and healthcare organizations often expressed differences in their motivation to engage in partnership. CBO respondents frequently sought to address social determinants and improve the experiences of those they serve. Healthcare organizations expressed motivations to improve care quality and reduce cost. While respondents emphasized the importance of common goals, differences in partner motivation reflect a natural tension between the traditional role of healthcare organizations to address acute needs and the traditional role of CBOs to address underlying socioeconomic needs.

> *A respondent from a partnership initiated by a California CBO described, "...in entering into a partnership with the hospital, [CBO] was responding to a community need…[the partnership] met the needs of [CBO] to fulfill its mission to care for individuals in need of recuperating in a safe place as opposed to on the streets, [and to reduce] recidivism rates to hospitals and re-traumatization of participants." In describing the healthcare organization's motivation to partner, the respondent commented how the partnership also meets "the needs of the hospital in its desire to reduce cost and minimize length of stay of its patients."*

How Are Partnerships Structured?

Partnering Organizations

Within the landscape of healthcare organization-CBO partnerships, there are numerous structures. Respondents listed several types of CBO partners – from human service providers, to community coalitions, and public schools – and a similarly varied mix of healthcare organizations – from nonprofit hospitals, to private insurers, and dental clinics. Most commonly, partnerships involved a nonprofit CBO and a healthcare provider, such as a hospital, but many also indicated as partners government entities such as Departments of Public Health, Mental Health, Aging, and Police, or other partners such as health plans or foundations.

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7   Julia James, "Health Policy Briefs: Medicare Hospital Readmissions Reduction Program," Health Affairs, accessed May 12 2017, http://www. healthaffairs.org/healthpolicybriefs/brief.php?brief_id=102

Multi-Party Partnerships

Partnerships are frequently multi-party in structure. While the RFI defined partnership as between two parties – healthcare organizations and CBOs – over 70% of respondents listed more than two partners, and often more than two types of partners, involved in the partnership. For instance, a hospital, food bank, supermarket, and nutrition education organization in California are working together to lower obesity in their community. In Virginia, a CBO is working with multiple hospitals, managed care plans, and Area Agencies on Aging to better coordinate care for older adults. Many partnerships extend beyond the healthcare and human services sectors to bring new stakeholders, services, and resources together in pursuit of shared goals.

> *"Our partnership is designed to meet the needs of vulnerable populations. [CBO] addresses social determinants of health that the medical system is not effectively designed to impact and [Hospital] addresses health conditions that are barriers to social and economic outcomes." - Respondent from partnership based in Michigan*

Partnership Leaders

Most frequently, partnerships are led by a CBO partner. While a majority of partnerships have a designated lead, about one-third of respondents indicated that their partnership has no lead partner. Several more indicated having multiple lead partners. For many partnerships without – or with multiple – designated leads, respondents noted how authority and accountability are shared, with "equal leadership and decision-making across all organizations," as referenced by one Colorado-based partnership.

Partnership Integration

There is significant variation in how, structurally, partners are working together. A spectrum of integration exists among partnering organizations, with partners working together in numerous ways. Partners range from *communicating*, sharing information with each other about clients, to *coordinating*, aligning services toward better client outcomes, to *collaborating*, sharing staff or space or resources, to *integrating*, becoming a collective entity with integrated programs, planning, and funding. Most respondents are coordinating or collaborating through their partnerships.

Communicating

A California-based partnership between hospitals, public health agencies, health and behavioral health centers, and CBOs works to create a safety net of services for maternal depression. Partners share client information with each other and provide direct service referrals.

Coordinating

A Pennsylvania-based partnership between a health plan and CBO works to improve health outcomes and reduce costs through a focus on nutrition. The CBO partner provides medically-tailored meals and nutrition counseling to at-risk individuals identified by the health plan.

Collaborating

A Washington-based partnership between a health center, CBO, and health foundation works to provide diabetes education to older adults. Partners share staff and resources to provide interdisciplinary classes, coaching, and a formal diabetes management program.

Integrating

A Colorado-based partnership between hospitals, clinics, government, behavioral health centers, insurers, and CBOs works to expand access to care, improve quality, control costs, and eliminate health disparities. Partners formed a backbone organization to share expenses, expertise, space, and fundraising.

Formal Agreements

A look at the formal agreements that partnerships have implemented provides further insight into how – and how deeply – partners are integrating. More than 80% of respondents indicated having at least one formal agreement in place, with most of these respondents having multiple agreements in place. Most frequently – in about one-third of responses – partnerships have a Memorandum of Understanding (MOU) in place. In about one-quarter of responses, partners have formal contracts with each other, which unlike MOUs and other agreements, may be legally-binding and define specific financial terms or conditions.

Most partnerships have made it a priority to formalize how they are working together through written agreements, and many respondents cited this formalization as a practice that has promoted effective partnership. Amid complexity and newness, formal agreements have clarified the specific roles and responsibilities of each partner. Formal agreements have also solidified the accountability and sense of ownership critical for enduring partner engagement. "Established protocols …[such as our] Data Stewardship Agreement guiding data use, [give] stakeholders ownership of important work products," shared one California-based partnership working to reduce hypertension through coordination of healthcare and community resources.

A respondent from a partnership that helps seniors in Colorado navigate a variety of services explained, "we have a Memorandum of Understanding that includes a data-sharing agreement, leadership structure, and marketing, programmatic, and outreach commitments. We utilize a shared database and have vetted the data sharing piece through each agency's legal department to ensure compliance with HIPAA requirements. We also have a formal contract with our biggest funder, which includes a financial component."
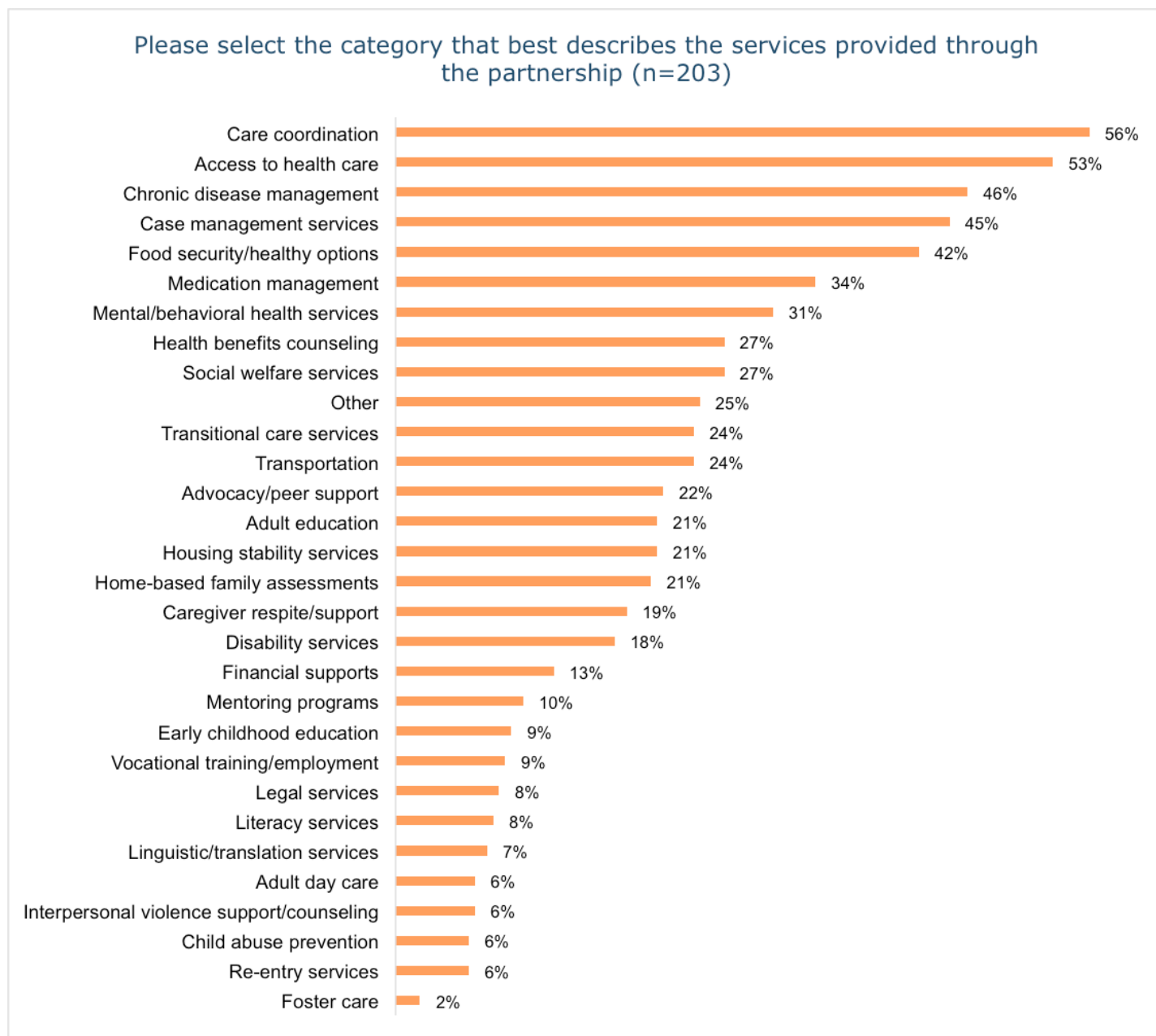
Partnership Services

To achieve goals – whether patient-level, population-level, or related to cost – over half of respondents shared that their partnerships include care coordination services to better organize services across multiple providers. In addition, almost half provide access to healthcare, chronic disease management, or case management services, with many providing a combination of these services.

Many partnerships that provide coordination and clinical support services (e.g. access to healthcare, chronic disease management) focus on the transition between hospital and home, or a transitional facility, such as a respite care or rehabilitation facility, and are most often geared to vulnerable populations: older adults, adults dually eligible for Medicaid and Medicare, people with chronic conditions, and people with mental health or substance use disorders. For example, in Pennsylvania, a local hospital, health center, and local aging office have partnered to ensure coordination among primary care providers, pharmacists, and community-based service providers for older adults transitioning out of a hospital or nursing home. In California, a partnership between a hospital, health clinic, independent living center, and CBO is providing care transition coaching to ensure "no wrong door" access to medical and behavioral healthcare for people with substance use disorders.

"Coordinating care for adults and children has become one of the fastest growing and most complicated challenges facing communities today… The ease of securing necessary supports for persons with complex health needs is paramount to patient well-being. Using technology, real-time confirmation of services availability reduces frustrating 'dead ends' for both clients and providers, and ensures a feedback loop that makes follow-up on referral outcomes possible so clients are less likely to 'slip through the cracks.' " - Respondent from partnership based in Washington

Compared to coordination and clinical support services, fewer partnerships are providing services that focus on long-term health improvement through addressing underlying socioeconomic factors. Among those that do, partnerships frequently indicated providing services related to food security, social welfare, adult education, or housing stability. While evolving health policy in the US has drawn greater attention to the impact of preventative care on health outcomes, communities have less frequently implemented partnerships addressing

long-term health improvement. Partnership efforts exist amid a landscape where monetary incentives for cost reduction and opportunities for outcomes-based payment are increasingly prevalent.[8] At the same time, demonstrating holistic health outcomes in a short-term time horizon can be difficult, complex, and costly. This reality may be a contributing factor to the magnitude of partnerships providing coordination and clinical support services, where results can often be understood in the near-term. Many partnerships and funders have recognized the significant return on investment – through reduced hospital readmissions, for example – in addressing patient-level, clinical needs through these services.

Please select the category that best describes the services provided through the partnership (n=203)

Category	Percent
Care coordination	56%
Access to health care	53%
Chronic disease management	46%
Case management services	45%
Food security/healthy options	42%
Medication management	34%
Mental/behavioral health services	31%
Health benefits counseling	27%
Social welfare services	27%
Other	25%
Transitional care services	24%
Transportation	24%
Advocacy/peer support	22%
Adult education	21%
Housing stability services	21%
Home-based family assessments	21%
Caregiver respite/support	19%
Disability services	18%
Financial supports	13%
Mentoring programs	10%
Early childhood education	9%
Vocational training/employment	9%
Legal services	8%
Literacy services	8%
Linguistic/translation services	7%
Adult day care	6%
Interpersonal violence support/counseling	6%
Child abuse prevention	6%
Re-entry services	6%
Foster care	2%

Funding Models

From development to implementation and maintenance, partnership requires an investment of staff and resources. There is a price tag – often a large one – that comes with communication, coordination, collaboration, or integration between healthcare organizations and CBOs. Partnerships rely on support from a wide range of public and private resources, with just over half indicating that multiple entities provide partnership funding.

Represented in RFI responses is a spectrum of funding models, from simple approaches funded by a single grant to complex models that braid and blend funds from myriad public and private sources. A handful of partnerships – around 5% – exist in the absence of any funds being exchanged; around 25% described funding models that include Medicare, Medicaid, or private insurance reimbursement for services provided through the partnership. Ten partnerships cited having shared-risk or performance-based funding arrangements.

> *A respondent from a partnership that focuses on refugee health noted when describing challenges in the funding landscape, "...the bias is to lean towards short-term gains, which may run counter to what is needed long-term."*

Partnership Funding

Nearly 45% of partnerships are funded – at least in part – by private foundations; often this funding was an initial or primary source of support for the partnership.[9] In 25% of responses, a healthcare system provides funding for the partnership, including through fee-for-service contracts or community benefit programs. Federal funding, either directly from an agency or run through state or local agencies – CMS, Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), United States Department of Agriculture (USDA), Administration for Community Living (ACL), for example – is significant in many partnerships. This may be reflective of new funding opportunities through agencies like CMS and HRSA that emerged through the ACA. A better understanding of the impact of social determinants of health has also led to new opportunities through agencies like USDA and ACL, which frequently fund human services.

While funding models vary, a common theme is the evolution of the funding model over a partnership's lifecycle. Several respondents indicated how their funding model has changed, or will change, in response to internal or external dynamics. For example, some partnerships were seeded through a pilot funded by a foundation and have transitioned to fee-for-service, insurance reimbursement, or contract-based funding models. In one case, an Ohio-based partnership designed to address Adverse Childhood Experiences (ACEs) began with three-year funding from a foundation and government entity, and is now developing a funding model based on fee-for-service contracts and public and private insurance reimbursement. RFI results do not confirm one specific funding model tied to "effectiveness." However, the many stories of funding evolution emphasize the important role that financial adaptability has played and, amidst an ever-changing landscape, will continue to play in partnership continuance over the long-run.

Resource Challenges

Regardless of the types of funding received, many partnerships find that covering their full, ongoing costs is a primary challenge, with nearly half of respondents citing resource needs as a key factor inhibiting the effectiveness of their partnership. Even partnerships that have developed sustainable income still rely on multiple funding streams. For example, the majority of partnerships with services funded through insurance reimbursement must still subsidize costs through other funding sources, such as grants, United Way funds, hospital community benefit dollars, or individual donations. Several partnerships, both emerging and established, also cited reliance on in-kind resources such as staff support or office space as an integral partnership resource. For many partnerships, it appears that insurance reimbursement, government contracts, grants, and other sources of funding alone are not enough to support the intricacies – from the development, to implementation and maintenance – of partnership.

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9   Respondents were presented with a list of several entities and asked to indicate any that provide funding for the partnership.

Outcomes are meaningful changes over time for those served by a program, generally defined as changes in knowledge, skills, attitudes, behavior, condition, or status. When used in connection with outcomes-based financing models, outcomes can mean measurable changes linked directly to the efforts of a program. Outcomes may be short-term, medium-term, or long-term, and can focus on an individual, organization, system, or community.

The Role of Data

Data is a critical component of partnerships, and is required to understand and articulate the effort's value in improving health or reducing costs. In many cases, data is also required to get paid. As outcomes-based funding becomes more prevalent, the ability to collect quality data is an essential component of partnership. The ACA, Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), and numerous other laws have ushered in value-based payment structures.[10] The Department of Health and Human Services (HHS) has a goal to tie 50% of payments for traditional Medicare benefits to value-based payment models by 2018.[11] Private funders, too, are increasingly incorporating outcomes data in determining how to achieve greater impact with their money.[12] Beyond funding, data also plays an ever-important role in prudent partnership management – to understand growth opportunities, to course-correct, and to continually improve programs and processes.

Measuring Results

Approximately 80% of RFI respondents reported that their partnership collects outcomes data. However, a closer scan of the results reveals multiple interpretations of the term "outcome." Many partnerships that responded to an RFI question on outcomes provided information not on outcomes – such as decreased rate of heart disease in a community – but on outputs, indicators, or other measures, such as clients served or services delivered. While there is nuance in the term "outcome," responses provide insight into how partnerships are using data to measure their results. Partnerships collect a wide range of data, including outputs, outcomes, satisfaction, knowledge and behavior change, and organizational capacity change, with partnerships most frequently collecting data on clinical measures, such as emergency room admissions and readmissions.

Approximately one-third of partnerships reported collecting data on both clinical measures of health and social determinants of health, for example, housing stability or employment. As one New York-based respondent noted, the partnership collects data on "food access, job creation, crime, and [over time], decrease in chronic disease." About 15% of partnerships reported collecting data on population health, for example, "population-level data to monitor the wellbeing of young children and families in the target neighborhoods." A small number of partnerships are also collecting data on partnership efficacy itself, in some cases using established tools such as "Working Together" to evaluate their level of integration.[13]

How Data is Shared

Data is important to measure a partnership's effectiveness as well as to align partners, serve as a shared language, and maintain engagement around collective goals. Nearly 70% of respondents reported having shared indicators that measure the partnership's success. Over 80% of respondents reported having data-sharing systems in place, with data being shared on three distinct levels.

> *"Regular data sharing… allows for understanding of cost and utilization trends at the member and aggregate level, and fosters healthy competition on performance metrics."*
> *- Respondent from partnership based in Massachusetts*

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10   Youssra Marjoua and Kevin J. Bozic, "Brief history of quality movement in US healthcare," *National Center for Biotechnology Information*. Last modified December 2012, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3702754/

11   Wendy Gerhardt, Leslie Korenda, Mitchell Morris, MD, Gaurav Vadnerkar, "The road to value-based care," *Deloitte University Press*, last modified March 20, 2015, https://dupress.deloitte.com/dup-us-en/industry/life-sciences/value-based-care-market-shift.html.

12   "Data-Driven Funders: In Search of Insights" *GuideStar*, accessed May 12, 2017, https://learn.guidestar.org/hubfs/docs/Data-Driven-Funders2016-04-11.pdf

13   "Working Together Framework," *Novia Scotia Health Authority*, accessed May 12, 2017. http://www.cdha.nshealth.ca/primary-health-care/working-together-framework

Most commonly, partners share patient-level data as part of service delivery, for instance, sharing real-time data through electronic systems linking patient health records with case management information. Partners also share data with each other on an aggregate level to regularly observe and assess progress toward agreed-upon goals, for example, through regular quantitative reports, face-to-face meetings, or dashboards. Finally, though reported less frequently, partners share data externally, for instance, through regular reporting to the community or funders via web communications or in-person events.

Like funding models, data and outcomes emerged as an area of continued evolution for partnerships. Nearly one-third of respondents have developed goals for the next five years related to outcomes, data-sharing, and evaluation. Nearly 20% cited challenges related to data collection or data-sharing as inhibiting the effectiveness of the partnership. With an increasing focus on outcomes-based approaches, and as priorities of the national healthcare landscape shift from volume to value, demonstrating results will continue to be essential for partnerships, with data existing as an ever-critical tool to understanding and articulating these results.

Relationships: The Key Ingredient

Partner Alignment

RFI results provide an understanding of the core components of partnership between healthcare organizations and CBOs: two or more parties, partner integration, clinical or population-health goals, a funding model, data and data-sharing systems, shared indicators, and adaptability. Asked directly what practices have led to effective partnership, the overwhelming majority of respondents didn't cite any one of these components; rather, respondents cited trust and alignment – "cultural" or "relational" elements – as the thread weaving core components into effective partnership. In the words of one respondent: "Our work moves at the speed of trust. We cannot simply put more resources to a strategy to guarantee success in a short timeframe. Instead, we must cultivate strong relationships which serve as [the] strong foundation for work."

> *"What I have found to be the most important factor, across the board, [are] relationships. Building a trust-worthy, honest, transparent, and compassionate relationship where people feel respected, listened to, valued, appreciated, and empowered is what moves people to action."*
> *- Respondent from partnership based in Michigan*

These cultural or relational elements may be less discrete or quantifiable than a funding model, a shared data system, or a memorandum of understanding, but the quality of partner relationships appears central to a partnership's performance. Over 130 respondents cited practices related to relationship-building as key to partnership effectiveness; more than 50 identified challenges related to cultural differences – differences in priorities, language, or decision-making processes, for example – as inhibiting effective partnership. For these partnerships, territorialism, inflexibility, and pushback – or, as one respondent noted, "not understanding each other's worlds, mandates, priorities" – were cited as barriers.

Cultivating and Maintaining Trust

The RFI results share insight into tactics partners are using to cultivate and maintain trust and alignment. Many respondents acknowledged the upfront time and energy partners spent learning the distinct language, skills, motivation, and bottom-lines of each partner. In several cases, partnerships formed out of a previous relationship or a history of collaboration. For instance, in New York, a partnership designed to increase access to healthy food grew out of a "long-standing coalition…consisting of about

> *"[We operate] as one team with mutually shared goals regardless of the organization that writes the paycheck."*
> *- Respondent from partnership based in Ohio*

70 healthcare and community service providers, CBOs, local government agencies, and local foundations." Others have highlighted the value of in-person meetings and outside facilitation in fostering partner alignment. As one health coalition noted: "We put a high value on traveling the state and meeting Network members in their communities. This has continued to pay dividends as we're able to listen to their needs first hand and

equalize the power dynamic between our organizations." For many partnerships, it is the upfront, often deep relationship-building that respondents identified as critical to effective implementation of the partnership over time.

While the value of partner trust and alignment is apparent, the often time-consuming and resource-intensive relationship-building process can present a challenge. How, then, do partners stay engaged and committed over long planning or implementation periods? Some respondents focused first on easy wins, for example, "celebrating quick wins to build trust and generate momentum" and "bright spotting for program development and design." Several highlighted the importance of clarity and efficiency in communication – "finding methods of engaging partners in an ongoing manner without asking for too much time commitment." Partnerships also stressed the need for project champions, buy-in from partner organization leadership, and an individual from each partnering organization with responsibility and accountability for driving the effort forward. As one respondent cautioned, however, trust must reside across the partnership, not just among a group of champions or project managers: "[Partnership] is fundamentally based in relationships, and transferring these established relationships to new staff has proven challenging and delayed some work. When one person…who has championed active engagement in the [partnership] leaves, it can be challenging to get the same level of participation."

The Community as a Partner

In addition to internal relationship-building, many partnerships highlighted the value of external relationship-building, and in particular, relationship-building with the community served by the partnership. The effectiveness of a partnership, and its ability to achieve clinical or financial goals, often depends on community members understanding and trusting the partnership. Respondents highlighted a commitment to community engagement: "active listening…and humility to defer to community expertise," "approaching things with a community-first mentality," "ensuring the partnership remains community owned," "community engagement as the center of our work." Often, community engagement is a primary strength that the CBO brings to a partnership.

> "Community-driven work is a long-term commitment that requires patience, adaptation and flexibility. It takes time and intentionality to create trusted space where community members can sit as equals alongside healthcare and other systems partners and guide what will make a difference in their community... It is measurable, it is actionable, it is powerful for community transformation and for healthcare systems transformation. When the spirit and intentions are right, magic can happen." - Respondent from partnership based in Colorado

In many partnerships, relationship-building in the community has enabled effectiveness. Simply launching a new or changed service in a community doesn't guarantee its uptake; rather, respondents highlighted the events, creative outreach, and strategizing that go into cultivating community trust. Some partners work with community advocates, for example, using a "participatory framework of developing strategies with community leaders and churches in marketing programs to the community." Others have actively engaged client populations in partnership development and implementation, for example, "acknowledging residents and youth as experts and inviting them into the process through personal invitations." And for some partnerships, strategies to gain and maintain community trust have included involving the community – not only the partners – in partnership monitoring and improvement, for example, "using a public-facing dashboard…as a navigational tool, which puts everyone in the community in the driver's seat of shared responsibility for the greater common good."

Community engagement is a component of nearly all current partnerships. All but three respondents indicated having one or multiple mechanisms in place to engage community members and collect feedback. Over 60% of respondents conduct surveys with community members, while just over half reported holding community meetings. About one-third of respondents engage community members in a governance role, for example through advisory boards or designated community liaisons, or through community advisory councils.
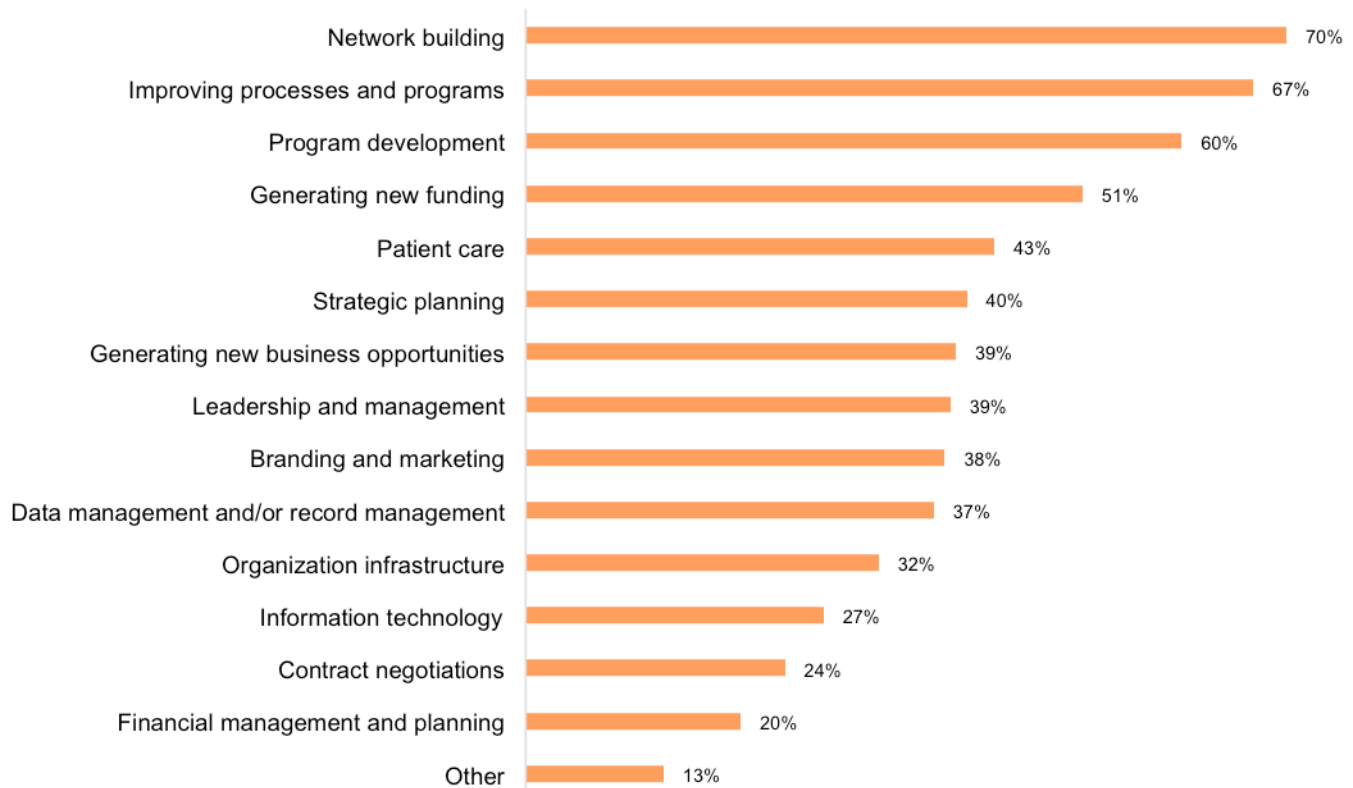
Shared Goals, Changed Organizations

In most partnerships, organizations have come together to achieve goals related to short- or long-term health improvement. These direct benefits have driven organizations to develop new relationships, serve new populations, incorporate new systems, or enter into an entirely new sector. For some CBOs, partnership has required implementing an electronic health record system or learning new insurance billing codes; for some healthcare organizations, it has required building the cultural competence to serve a new population.

Healthcare organization and CBO respondents alike identified ways in which participating in a partnership has built or expanded organizational capacities. Over half of respondents indicated that their organization's capacity expanded in network-building, improving processes and programs, program development, and generating new funding as result of partnership. On average, partnerships that were established earlier tended to report more expanded capacities. In addition to health outcomes and cost savings, partnership has contributed toward an expanded set of skills for both healthcare organizations and CBOs, skills that can strengthen individual organizations beyond the context of partnership. As noted by one California-based respondent, "The partnership has helped [CBO] execute strategic changes to better position itself in this rapidly evolving healthcare marketplace, and [develop] quality improvement and assurance systems, allowing measurement of quantifiable outcomes for the first time. This has positioned the organization to better serve its client population."

> *"Building a large multi-agency partnership has created learning opportunities with all organizations involved. They appreciate the peer learning and the ability to start implementing a new initiative a few steps ahead, thanks to shared advice, protocols, and workflows." - Respondent from partnership based in Massachusetts*

In what areas has your organization's capacity expanded as a result of participating in the partnership? (n=198)

Area	Percentage
Network building	70%
Improving processes and programs	67%
Program development	60%
Generating new funding	51%
Patient care	43%
Strategic planning	40%
Generating new business opportunities	39%
Leadership and management	39%
Branding and marketing	38%
Data management and/or record management	37%
Organization infrastructure	32%
Information technology	27%
Contract negotiations	24%
Financial management and planning	20%
Other	13%

What's Next?

Amidst policy change, new research, and a drive toward innovation, partnerships between healthcare organizations and CBOs are becoming more common. As the number of partnerships grows, so too does the number of partnership models. While there is no "one-size-fits-all" approach, RFI results highlight several themes of how partnership is being implemented. Our scan of the partnership landscape has also pointed to several ideas of what steps are needed – by partnerships and those funding partnerships – for the field to progress:

Invest in building partner relationships: Partnerships are fundamentally built on relationships, with trust, values alignment, clear processes, and robust communications as key contributors to effectiveness. Thoughtfulness in relationship-building upfront can foster more effective partnership implementation in the long-run, though it's important to recognize that strong relationships can be time-consuming and costly to build and to maintain.

Partnerships: Plan for added time to establish clear goals, roles, communications, and expectations to ensure alignment over time.

Funders: Consider various ways to invest. Seed funding, which is distinct from ongoing, operating funds, can support the upfront costs of relationship-building critical to ensuring effective partnership.

Consider the range of stakeholders influencing partnership effectiveness: Partnerships between healthcare organizations and CBOs often involve additional stakeholders. Public health departments, funders, health plans – among others – have been involved as key partners, and in some cases as the partnership initiator or lead. Community members are also important stakeholders, and many partnerships integrate their engagement directly into operations.

Partnerships: Think creatively about who should be involved, including within partner organizations – and to what extent – to best achieve partnership goals.

Funders: Recognize your role as a partner. In addition to financial support, funders can provide critical support through networks and expertise.

Understand the full cost of partnership: Regular partner communications, the integration of data systems, the solicitation of community feedback, and more can add to a partnership's expenses. The cost of partnership may be greater than the direct cost to provide a service.

Partnerships: Gain a clear sense of the effort's full cost – including those costs covered in-kind and those costs beyond day-to-day operating expenses – to develop a viable, sustaining funding model.

Funders: To make effective decisions around seed and ongoing support, recognize that a partnership's costs – including the cost of building and maintaining the relationship – often extend beyond direct, operating expenses.

Embrace change and adaptability: For many partnerships, change is the only constant. Changes in external forces – shifting policies and funding practices – and internal forces – staff turnover or a new strategic direction – have meant the need for funding model evolution, new partners, added services, or revised data collection protocols. Even the strongest partner relationships don't shield against change.

Partnerships: Approach the effort with a learning orientation and the open-mindedness to pivot. In navigating change, ensure that partner communications are open and transparent.

Funders: Keep funding flexible to foster a partnership's capacity to adapt. Maintain open dialogue with partners to understand changing needs as the effort evolves.

Across stakeholders – partnerships, funders, researchers, policymakers – advancing the field will also require clarity in language and greater precision in the meaning of the term "partnership." A common and clear understanding of various partnership goals and typologies can ensure that strategies and support – peer-learning, capacity-building, and funding, for example – are appropriate, targeted, and efficacious.

While there is little certainty as to how healthcare in the US may evolve, partnerships are poised to play a critical role in improving care and reducing costs. More than half of RFI respondents cited goals related to partnership expansion, strengthening, or dissemination over the next five years: "expand outreach through satellite locations," "triple the number of consented clients," "increase the number of health sites," "improve the quality of services delivered." Partnerships have ambitions not only to serve more individuals, but to serve them better. As efforts emerge, evolve, and expand, a deeper understanding of specific financial, operational, cultural, and strategic ingredients can help partnerships thrive, increasing their positive impact on the health and wellbeing of people and communities across the US.