

Overview of Preparing Community-Based Organizations for Successful Health Care Partnerships

By Victor Tabbush

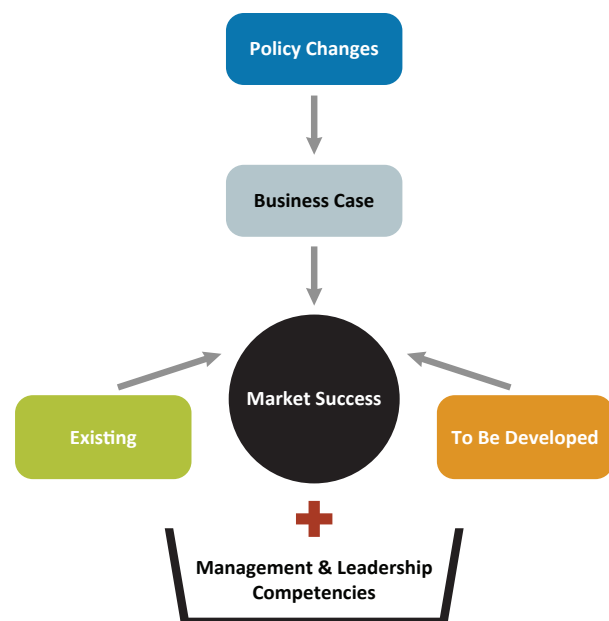
While efforts are underway to improve care transitions and coordination, there is a dearth of information on how best to build partnerships between community-based long-term services and healthcare systems. Both sectors are tackling the issue of care coordination and good care transitions, but have been doing so in silos. To better understand specific opportunities for these partnerships in California, the Foundation developed this series of background briefs.

Successful business strategies are formulated by articulating the strengths of the organization with the opportunities presented to it by the external environment in which it operates. When changes occur in the business environment – such as those in the technological, economic, and policy arenas – new opportunities are created. Organizations that align their existing core competencies, develop others that are needed, and are willing to modify their strategies accordingly can not only sustain themselves, but can thrive in the midst of these shifts. Health care reform generally, and more specifically the Patient Protection and Affordable Care Act (ACA), will continue to dramatically impact organizations in the health sector far into the future. Community-based organizations (CBOs) that can provide support services such as care transitions, chronic disease management, medication management, nutrition, transportation, home and family assessments, health benefits counseling, and caregiver support to the healthcare sector are well-positioned to exploit the opportunities created by health care reform by providing these services in partnerships with the health care sector.¹ In this new environment, CBOs can make a convincing business case that their services create value for their potential clients and partners (hospitals, post-acute care provid-

ers, provider networks, and insurers) in excess of what the clients will be asked to pay for them. Furthermore, CBOs can demonstrate that they are the most cost-effective entities to provide these services. The potential market success stemming from these policy changes when new and existing competencies are deployed to make and execute the business case for CBOs is illustrated in Figure 1.

FIGURE 1

The Factors for Market Success.



The Changing Policy Environment for Healthcare: New Business Opportunities for CBOs

This section describes the major recent, relevant policy developments that are generating attractive new business opportunities for CBOs. It is these developments that are creating an increase in demand for services of the sort offered by the CBOs. The changes chosen for discussion are those aimed at reducing financial and health burdens stemming from flawed transitions. Fortunately, the CBOs possess already, or else can create, the core management and leadership competencies to capitalize on these developments.

Health care Reform and the ACA

There are several provisions, policies and programs within the ACA that have implications for the business models of CBOs; the most significant ones are described here.

Evidence Based Care Transitions Program

The Administration on Aging (which is now part of the Administration on Community Living) and the Centers for Medicare & Medicaid Services (CMS) currently support the Evidence Based Care Transitions Program under the auspices of the Aging & Disability Resource Centers. In 2010, the Administration on Aging issued grants to 16 states, including California, under the program; grantee states are directed to utilize evidence-based models to improve care transitions. Some of these care transitions models are already being implemented in California's hospitals and communities.

Hospital Readmissions Reduction Program

Under this program, CMS beginning in Fiscal Year (FY) 2013 will reduce Diagnostic Related Group (DRG) payments by up to 3 percent for hospitals with higher than expected readmissions for specified conditions.² The ACA's readmissions reduction program, by establishing financial incentives for hospitals to limit readmissions - a key indicator of poor transitions - creates an opening for CBOs to market care transition services to hospitals.

National Pilot Program on Payment Bundling

Under the bundled payment pilot, participating organizations (most likely hospitals and post-acute care providers) will receive a single payment covering all care provided during the 30 days following discharge. Organizations participating in this pilot could gain financially by reducing expensive and often preventable readmissions and, in general, by keeping combined acute and post-acute care costs down. Consequently, these organizations should be potential customers for care-transition services delivered by CBOs and other providers. These services can reduce readmissions, emergency room visits and improve health outcomes while enhancing the patient experience.

Medicare Shared Savings Program & Accountable Care Organization (ACO) Demonstration Program

The ACA, through the Medicare Shared Savings (Demonstration) Program creates economic incentives for provider organizations to amalgamate in order to improve their service delivery models. Primarily, these accountable care organizations (ACO) will be combinations of previously-independent

organizations; the likely composition will include a local health care organization, a related set of service providers including primary care physicians, specialists, hospitals, and nonmedical supportive services. The intent behind encouraging the formation of ACOs is to hold the collective entity accountable for quality health outcomes while incentivizing cost containment. Under this program, ACOs will be eligible to share in any resulting cost savings that the Medicare program will enjoy, provided quality of care targets are met. Community-based supportive services could be part of an ACO service portfolio, as these services have the potential to avert preventable emergency room visits, hospital admissions and readmissions. Avoiding these episodes of care reduces costs, avoids undesirable patient experiences, and improves health outcomes. Therefore, the decision of an ACO to incorporate a CBO within its partnership team can be economically wise.

Community-Based Care Transitions Program (CCTP)

Another ACA initiative is intended to improve care transitions more broadly, through direct program funding rather than offering payment and reimbursement incentives. The ACA establishes the Community-based Care Transitions Program (CCTP), a five-year, \$500 million program under which CMS will provide reimbursement to communities seeking to improve Medicare beneficiaries' experiences of returning home after a hospital or rehabilitative stay and reduce the likelihood of their readmission. Applicants for funding must include a consortium of community-based service providers working collaboratively with clinical providers to execute an effective care transitions intervention. CBOs will be crucial in providing the required comprehensive medication review

and management, assistance in interactions between providers, self-management support, and other services. Grantees that provide care transition interventions in conjunction with multiple hospitals and practitioners and/or entities that provide services to medically-underserved populations, small communities, and rural areas will be especially well-positioned to participate as the ACA requires that they be given a preferred status.

Dual Eligible Demonstration

The Medicare-Medicaid Coordination Office, established through the ACA, serves people who are enrolled in both Medicare and Medicaid, also known as dual eligibles. The Office seeks to provide dual eligibles with access to seamless, high quality health care and to make the system as cost-effective as possible. The Office works with the Medicaid and Medicare programs, across federal agencies, states, and stakeholders to align and coordinate benefits between the two programs effectively and efficiently.

In 2011, California was one of 15 states awarded a \$1 million planning contract from CMS to develop this Demonstration that is "intended to alleviate fragmentation and improve coordination of services for Medicare/Medicaid enrollees, enhance quality of care, and reduce costs for the State and the Federal government."^{3,4} Under the Demonstration, Medi-Cal managed care plans will receive a blended payment of federal, state, and county funds to deliver a range of Medicare and Medi-Cal-covered medical services and long-term services and supports. The state continues to prepare for implementation of the demonstration, which is slated to begin in 2013.

The state projects that savings will be

generated from providing the right care at the right time through care coordination and increased access to home and community-based services. It is anticipated that fiscal savings will result from overall reductions in inpatient hospital settings and skilled nursing facility utilization. Establishing an integrated service delivery model that incorporates long-term care services and supports will be a necessary component to realizing these savings. CBOs that can provide care transition, coordination, and other related services would be well-positioned to partner with health plans. This creates yet another business opportunity for those CBOs providing care coordination and other long-term services and supports

Concluding Thoughts about the Changing Environment and the Business Case for CBO Services

The array of recent health care policy and program changes, both at the federal and at state levels, has radically alerted the landscape in which CBOs operate. Providing effective care transitions that reduce preventable emergency room visits, hospital admissions and readmissions are central to their aims. Several initiatives seek to provide patient-centered, coordinated, and cost-effective care. These initiatives mean that the services that CBOs traditionally supply are of increasing value to the health care sector that stands to gain more than ever from their use. There is now an increasing focus on facilitating successful transitions from a higher to a lower level-of-care but also to avert transitions in the opposite direction. CBOs have the capacity to respond to this higher demand and seize upon this opportunity and play a major role in these initiatives. The potential demand for the services CBOs provide is substantial; there are over 500 general acute care hospitals in California. Another indicator

of this potential is the number of hospital discharges of Medicare patients in California - about 1.2 million annually.⁵ Upon discharge a large majority of patients are sent home – making adequate care transitions to home care essential. CBOs that provide care transition and related services are well-positioned to play a crucial role in this heretofore-neglected component in the continuum of care. They possess the needed experience, the presence, and connections in the community. They also possess most of the requisite competencies enabling them to revise their business models and to adapt to the changing business environment; those competencies that are lacking can be built - as will be argued in the following section.

Leadership & Management Competencies Required for Successfully Presenting and Executing the Business Case for Care Transitions

For CBOs to compete in this market, their top management teams must possess certain key competencies. Key competencies are technical and behavioral skills, knowledge, and abilities crucial for business success. Competencies can be divided into behavioral/emotive and technical/cognitive. Often the term “leadership” capacity is applied to the set of behavioral/emotive competencies and the term “management” capacity is applied to the set of technical/cognitive ones.

The **Leadership** competencies in this context are mostly generic and are similar to those in any setting where organizations must adapt to changing external environments. Foremost in this area are the following that require little elaboration:

- Strategic orientation
- Innovative thinking
- Relationship building and maintenance
- Building effective teams
- Change: Building enthusiasm for it and overcoming resistance to it
- Achievement & Performance Orientation
- Analytical, data-driven decision-making
- Communication skills
- Negotiation skills

The requisite competencies in the **Management** domain tend to be more skill and knowledge oriented than those in the Leadership domain. The latter tend to fall more neatly into the category of abilities. For CBOs intending to enter into or expand on an already-existing presence in the care transitions market, the required management competencies are less general than the leadership ones. The next section will describe these core and specific competencies. Each falls within one of three distinct stages:

Stage One: Planning and promoting the services and making the business case

Stage Two: Delivering the services successfully and profitably

Stage Three: Evaluating the services

Stage One: Planning and promoting the services and making the business case

A strategic planning system is one that effectively articulates the unique capacities and values of an organization with the external environment in which it operates. Such a planning system is essential for the CBO; it must assess the business opportunities presented by health

care reform, other policy and regulatory changes, demographic shifts, economic trends, and technological advancements. The CBO must assess its internal strengths and weaknesses, consider its mission and core values in order to align its strategy with this external landscape. It must be adaptable to changing circumstances and even be willing to reformulate its mission in light of new marketplace developments. This planning process should incorporate a competitor analysis and yield the identification of service offerings, specific markets, market segments and customers where the CBO has a competitive advantage. Attention also needs to be paid in the strategic planning process to the possibility of developing new innovative services and new combinations of existing ones to meet client and partner needs.

Making the business case to potential clients/partners for CBO services involves three steps:

1. Calculating the magnitude of the economic burden from the status quo

2. Providing evidence of the extent of the mitigation of the burden that would result from the CBO intervention; and

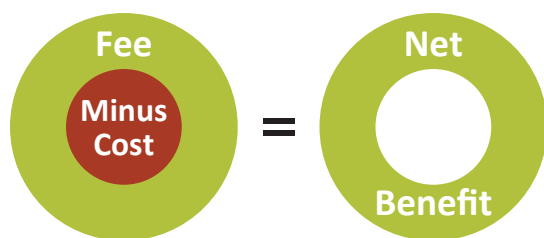
3. Pricing the service so that the economic value of the burden mitigation to the client/partner exceeds the fees paid to the CBO.

The capacity to plan systematically is essential to Stage One; so is the technical competence of CBOs to present and promote the care transition services to the healthcare sector. This might be termed “Making the Business Case.” Making the business case means that the CBO presents compelling arguments, backed by evidence, that their services will be financially beneficial to their purchasers: that the benefits conferred exceed the fees paid as illustrated in Figure 2. A compelling marketing message

to promote new or existing service offerings to potential new clients must be crafted. It is one that must highlight in a convincing way the attractive value proposition that CBOs are tendering to the healthcare sector. The value proposition is simply the difference between the value (benefits) of the offering to the client and the fees they must pay to receive them. CBOs must adopt a client perspective, be client-driven and focus on those benefits that that are meaningful from the client perspective. CBOs must recognize that not only are the patients their clients, but so too are their health care sector partners.

FIGURE 2

The net benefits to the health care sector client from the CBOs service.



For the health care sector, while the benefits to the patients from improved health outcomes continue to be important, enhanced reimbursements and lower expenses from averting preventable re-hospitalizations and emergency room visits are an increasingly important source of value creation. Making the business case in this discussion focuses on cost avoidance. There is, however, another source of benefits that CBOs can create for hospitals: improved quality of care. In addition to being important to patients, quality care benefit hospitals directly through new financing arrangements tied to quality. In addition, im-

proved care quality provides indirect financial and other benefits from enhanced reputation via ratings such as the CMS Star System. The impact of improved quality of care that CBOs could facilitate might also lead to increased health care provider and staff satisfaction.

It will be imperative for a CBO to have the technical competence to estimate the value created by their activities, and employ such a calculation in its marketing. Communicating value convincingly will require the CBO to create a financial model that identifies the economic burden to the client (health care sector provider or payor) from preventable re-hospitalizations, and possibly from emergency room visits and nursing facility stays. (A starting point in such a model is the cost of a hospital stay - upwards of \$15,000.⁶)

The business case must include an accurate estimate of the degree to which the CBOs services can mitigate this burden. A useful datum in this calculation would be the proportion of re-hospitalizations that is preventable. The extent of the financial burden multiplied by the CBOs probability of reducing it with its offering results in a measure of the financial value that the CBO confers. Helpful in this regard are studies that show that effective transitional care processes, linked with strong home care programs can reduce re-hospitalization by a third in some less intensive models, and by half or more in some more intensive models.⁷ (Similar calculations can be made for preventable emergency room visits to the extent the CBO is potentially able to reduce utilization there.)

In presenting the business case, the CBO needs to utilize the language of business. That might include the correct use of the term “return on investment” (RoI) that clients and partners will enjoy from the services provided by the CBO. Essentially, RoI is comparable to the value

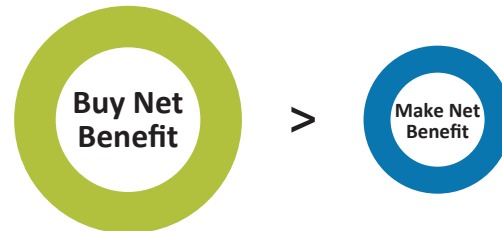
proposition except that in the former calculation net benefits are normally expressed as a percentage of the investment or cost. CBOs must be capable of making individualized estimates of the RoI for each potential acute care facility, and even for individual DRGs, because the value delivered will vary with these and with other circumstances. The more attractive market segments (where cost mitigation is more dramatic) might also be revealed by this approach.

The value proposition equation is defined as benefit minus cost; that is, the net benefit to the client is the difference between the value the CBO creates from its service and the fee charged for performing it. Consequently, beside the extent of the benefit, it is necessary to know the fee charged by the CBO in order to calculate the magnitude of the value proposition to the health care sector client or partner. While it is obvious that this CBO fee must be less than the value (benefit) created for the client, there is yet another condition that must be met for the value proposition to be attractive from the perspective of the hospital client or partner. The CBO must offer this service at a fee to the hospital beneath the hospital's cost of producing it itself and beneath that the hospital would pay from acquiring a comparable service from another source as illustrated in Figure 3.

Hospitals or health plans have a “make” as well as a “buy” option. Thus, the value proposition from buying the service from the CBO must be bigger and therefore more attractive to the health care sector than from making it itself. Otherwise, the CBO will not succeed in selling its services; it will not be competitive. Thus, assuming the CBO delivers comparable value to that of the health care sector, it must set a fee beneath the cost at which that sector can produce it itself and beneath the

FIGURE 3

The buy versus make option.



fee charged by non-CBO vendors.⁸ Otherwise, even if care transitions services can be shown to be cost-beneficial, CBOs may not be the most cost-effective entity to provide them. Thus, it is imperative that CBOs possess a competitive advantage in providing these services. In that way, CBOs can make the business case that not only are such services economically wise to provision, but also that CBOs are the most cost-effective suppliers. The competitive advantage of CBOs can result from either lower costs, from greater effectiveness, or both, in comparison to the “make” option and the option of buying the services from non-CBO sources.

Thus, the management ability to set price at appropriate levels is a core competence that the CBOs must develop. Optimal fee setting will rely for its actualization on the CBOs ability to understand not only its own costs, but also the staffing levels and pay structure of the health care sector associated with its optional “make” decision. In short, considerable financial acumen will need to be possessed by the CBO sector in this initial stage - both in planning and even more so in the presentation of the business case. Indeed, this financial orientation is even more pivotal for success when we consider its role in Stage Two - delivering the services profitably and successfully.

Stage Two: Delivering the services profitably and successfully

While an attractive value proposition tendered to a health care sector partner is an essential condition for making the business case, it does not guarantee that the CBO will benefit financially from the partnership. The CBO must (in the long run) receive fees from their services that exceed their “true” cost of providing them, a necessary relationship that is shown in Figure 4. The services must be profitable. For profitability, the CBO must possess and use certain key competencies.

Cost accounting & fee setting

For profitability, the CBO must have an accurate understanding of its own costs of providing its array of services – the cost drivers, their magnitudes, which categories

FIGURE 4

The CBO services must result in profit.



are relevant for each specific business line, and how they vary with scale. That is, the CBO must be competent in managerial cost accounting.

Fee setting becomes even more complicated if and when CBOs decide to assume risk by engaging in pay-for performance and capitated schemes with their partners from the health care sector. Accordingly, the sophistication

of the needed financial skills increases. Calculating and then managing risk requires actuarial skills found in insurance settings. (It is advisable for CBOs to begin with fee-for-service contracting and gather their resulting utilization and cost data before embarking on at-risk contracting.) Accurate cost forecasting is certainly a technical competence required by CBO management for successful market entry or further penetration.

But several other challenges in delivering services successfully and profitability remain for CBOs. With each challenges come a set of required competencies. Some competencies are leadership - and others managerially-oriented. Three major challenges will be discussed here. No doubt there are others, but these appear to be particularly significant to overcome.

Access to capital

First, a significant challenge for the CBO to overcome is having access to sufficient capital for expansion - either internally from its cash flow, or externally from borrowing. The ability to expand must be present, as large partners from the health care sector will likely place capacity demands on CBOs. Due to the differential timing of reimbursements and costs, there will already be a strain on the working capital of the CBO, a strain worsened in a context of expansion when costs rise faster than revenues. Therefore, CBOs must have access to capital. Grants, including those from a renewable loan fund, might be available for that purpose. Nevertheless, some reliance on bank financing is likely. That means demonstrating credit worthiness to lenders, which in turn requires a demonstration that the organization is business oriented and professionally managed. Those same organizational traits will also be demanded by close health care sector partners that might be

approached to invest in CBO infrastructure. Thus, in addition to the inherent need to have good governance, a clear business strategy, marketing expertise, and sound financial controls to successfully plan and operate its business, the CBO will be required to demonstrate these competencies to potential lenders and investors.

Forging and maintaining effective partnerships

A second challenge is to possess the willingness and ability to form and participate in effective, multi-disciplinary partnerships and integrated networks with the health care sector. Assuming accountability for performance, adopting a broad partnership rather than a narrow CBO perspective, and possessing expert negotiating skills are just some of the emotive or leadership competences required for successful relationships with the health care sector. But just as importantly, CBOs must be willing and able to forge partnerships, collaborations, alliance and even mergers with other CBOs that provide related services. The relationship can be one of complementarity, whereby different but related CBO services are provided in order to offer a broader range to the health care sector. Such partnerships will be driven by the desire to achieve economies of scale. Broad scopes of services offerings are likely to be viewed more favorably by a customer base anxious to simplify contracting and to engage in “one-stop-shopping.” In contrast with complementarity, sought-after relationships may stem from substitutability, whereby organizations that offer the same or similar services combine or merge in order to offer sufficient scale to the client base and to achieve scale economies.

Regardless of the nature of the potential

relationships, CBOs and their leaders will need to be willing to consider relinquishing some degree of control in order to achieve the transformation of the sector and to deliver the services demanded by the health care sector. They will, in addition, need to understand and appeal to the motivations of the individual members of multi-disciplinary partnerships in which they participate.

Assembling, managing and coordinating the resources

A third challenge is assembling, managing, and coordinating the resources for a successful service delivery model. Since care transitions and coordination is a service business where variability in service quality can be large, the quality and duration of people’s lives are at stake, and regulatory oversight is keen, it is crucial for CBOs to have a sound human resource system where direct service providers are methodically screened and hired, suitably trained, appropriately evaluated and compensated, and highly motivated. An administrative team must be competent at supporting, controlling and coordinating direct service providers. Management competencies here would also include legal, regulatory, and compliance knowledge. However, not all administrative capacities need to be possessed in-house; some specialized administrative functions may be candidates for contracting out to vendors.

Information Systems

In addition to the human (and financial) resources, there needs to be adequate physical and information systems infrastructure to deliver the services. Care transition covers not just the physical transfer of the patient, but also includes conveying the clinical information required to coordinate care. Especially important here is creating

information systems and channels to and from individual primary care physicians and institutions that refer patients to the CBO. The information system needs to have a robust financial component for client billing, a process in which CBOs do not now normally engage. Finally, heavy information demands likely to be placed on CBOs by their health care sector partners and regulatory bodies for medical record keeping and data analysis mean that the investment in modern health information technology could be substantial – depending on the CBOs chosen service line. A timely and accurate information system will also be critical for success in Stage Three - Evaluation.

Stage Three: Evaluating the services

While effectively making the business case for transition services is crucial for the CBOs marketing efforts, it is not sufficient for longer-term success. ACO's and other groups with which CBOs may partner will be under keener scrutiny and stronger pressure in the evolving health care environment to demonstrate outcomes on which their financial well-being increasingly depend. CBOs will need to exhibit accountability, and to provide data and other evidence that they are doing their part in delivering the positive health and economic outcomes that stem from their services – and in amounts that warrant their expense. CBOs must therefore possess strong monitoring and evaluation competencies and develop information systems to collect, organize, and communicate data about those outcomes that are meaningful from the perspectives of the health care sector with which it partners. Monitoring and evaluation systems of CBOs should also be robust enough to assess the performance of their ongoing program activities and, if necessary, serve as the basis to implement mid-course corrective actions.

CBOs: An Assessment of Their Current Strengths

Clearly, there will be major disparities in the management and leadership competencies and overall strengths of individual CBOs in the care transitions sector. Some will be in greater state of readiness than will others to make the adjustments in their business models to realign with the growing momentum towards care transitions. Nevertheless, the CBO sector as a whole is well positioned to exploit the new market opportunities created by the ACA and other policy development that are targeted towards achieving patient-centered, coordinated and lower cost care. Many of these developments are aimed towards Medicare and Medi-Cal populations served by CBOs. Many CBOs possess the certification, experience, care-delivery models, the linkages to the community, and the trained (line) staff. Furthermore, CBOs in the aging network specialize in serving precisely those groups most at-risk for re-hospitalizations.

The health care sector has limited expertise in delivering home-based and long-term supportive services that are essential complements to the medical care that it provides. Indeed, the Long-Term Services and Supports sector is considered the trusted source for the expertise and assistance required to meet the varied and sometimes complex support needs of older adults and persons with disabilities. There are no guarantees that hospitals and health plans will not start providing these services themselves. However, it is likely that they will seriously investigate the option of contracting with specialized organizations that possess the core competencies that they themselves lack. CBOs have a clear advantage here: they are more closely linked with a whole set of community services and providers, which the health care

sector could not easily replicate. The competitive threat may be more likely to come, instead, from commercial enterprises that are launched or expanded to take advantage of the new market opportunities.

Another compelling reason for CBOs to move more deeply into the commercial marketplace, partner with the health care sector, and charge fees for their services is that traditional revenue sources may become more difficult to tap. Contracts and grant funding for non-profit organizations have become more difficult to acquire in recent years. One major reason is that income that foundations generate from the investments in their corpus has been declining due to low interest rates and poorly performing equity markets over the past several years.

CBOs are not only well suited to enter or further penetrate into the commercial arena by forging partnerships with the health care sector, it may be a core strategy for their long-term financial sustainability. To do this successfully will require the further strengthening of already-exhibited skills, knowledge, and abilities of the CBO management team. Other competencies will need to be developed. Fortunately, management and leadership capacity can be built. There are ample examples of management and leadership programs, when well designed and grounded in the context relevant to the business context of the audience, have contributed to successful organizational transformations. Added impact of these training programs can be achieved through technical assistance and coaching of key management team members.

Author Bio

Victor Tabbush, PhD, is Professor Emeritus at the UCLA Anderson School of Management. He has been director of the Office of Executive Education Programs and has served as Senior Associate Dean and Director of the School's Fully Employed MBA and the Executive MBA programs. He specializes in healthcare economics and in healthcare leadership and management capacity building. He is the program director and founder of the UCLA Management Development Institute that builds management and leadership capacity of health systems in sub Saharan Africa and of the Johnson & Johnson Health Care Executive program that serves U.S. community clinics and AIDS service organizations. He has been a core faculty member in both the Blue Shield Foundation Clinic Leadership Institute Program and the California Health Care Foundation Leadership Program since the inception of both programs. He has won Outstanding Teaching Awards in all three of UCLA's MBA programs -- in the Full-Time MBA Program (2000), the UCLA Executive MBA program (1998), and the Fully-Employed MBA program (1996).

References

1. The CBOs referred to in this paper are those non-profit organizations that provide long-term services and supports to older adults in the community. The healthcare care sector is a term used here to refer to three segments that will have a stake in improving care transitions: hospitals, medical groups, and Medicare Advantage (MA) plans.
2. Initially, those conditions are acute myocardial infarction (AMI, or heart attack), pneumonia, and congestive heart failure (CHF). CMS is required to subsequently expand the readmission reduction program to encompass other conditions.
3. <http://www.dhcs.ca.gov/provgovpart/Documents/Demonstration%20Overview%2010%2020%2011.pdf> and http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.
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5. California Healthcare Foundation, California Hospital Facts and Figures, April 2010.
6. International Federation of Health Plans: 2011 Comparative Price Report: http://ifhp.com/documents/2011iFHPPriceReportGraphs_version3.pdf.
7. Boling, P.A., Clinics in Geriatric Medicine, Volume 25, Issue 1, February 2009, Pages 135-148.
8. If the CBO can deliver superior and not just comparable outcomes, it can charge higher fees and still be competitive with the other options. This is known as "service differentiation" and can be considered by CBOs as a possible positioning strategy.

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