EMBRACING THE SHIFT:

THE IMPACT OF HEALTH CARE CONTRACTING ON COMMUNITY-BASED ORGANIZATIONS

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Suzanne R. Kunkel
Abbe E. Lackmeyer
Isha Karmacharya


MIAMI
UNIVERSITY
SCRIPPS GERONTOLOGY CENTER

100 Bishop Circle, Upham Hall 396, Oxford, OH 45056
MiamiOH.edu/ScrippsAging.org │ 513.529.2914 │ Scripps@MiamiOH.edu

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Suzanne R. Kunkel, PhD

Abbe E. Lackmeyer, MGS

Isha Karmacharya, PhD Candidate

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EXECUTIVE SUMMARY

Growing evidence for the impact of social drivers of health (SDOH) on health outcomes has underscored the value of social care, defined here as community-based programs and services that address health-related social needs such as transportation, food security, and social connection. One model for aligning health and social care is contracting between health care entities (including hospital systems and managed care plans) and community-based organizations (CBOs), such as Area Agencies on Aging (AAAs) and Centers for Independent Living (CILs). The prevalence of these arrangements is increasing, but there is little documentation about the ways in which contracting with health care impacts the organizational operations and culture of a CBO. This qualitative study was designed to add depth to our understanding of these impacts.

A focus group and interviews with 13 individuals representing 10 organizations (all of which were AAAs) yielded the following major findings:

1. Mission alignment was frequently discussed as an important component in the decision to contract, and in communication about the value of the new endeavor with staff, board members, and other stakeholders.

2. There was variability in the extent to which contract-related business practices were kept separate or integrated into existing staffing, funding, and work flow processes. The extremes of that variability were organizations that established a separate business entity (such as a 501c3 or an LLC), to those that blended the new contract-related work into existing staffing and work flow operations. Between those extremes, several organizations described the need to hire new staff to address increased volume and sometimes different skills that were required for the new work.

3. Data infrastructure and processes were often affected by contracting, particularly when data privacy standards meant that the CBO staff did not have access to the data they were entering; in these cases, information about program and staff performance was available only through reports provided by the healthcare partner.

4. The impact of healthcare contracting on the organizational culture of the CBO was partly shaped by the existing culture. Some participants highlighted their long-standing organizational culture of innovation, growth, and change. Others outlined strategies for communicating the mission alignment and sustainability benefits of the new ventures.

5. Valuable lessons learned and advice for other CBOs emerged from this study, including encouragement to embrace this opportunity to strengthen the alignment of social care and health care, and the importance of making a strong business

case that appropriately values the essential role of the work they do and rewards them for the quality of the services they provide.

BACKGROUND

The role of the social drivers of health has never been clearer. An estimated 50% of the variation in health outcomes is attributable to these conditions in which people live, work, play, learn, and grow older.[1] A significant proportion of the improvements that can be made in health outcomes and health equity will come from interventions that address social risks and needs related to unfavorable social drivers of health (SDOH circumstances. Programs and services that address these needs are collectively referred to as social care—community-based interventions that address health-related social needs such as nutrition, transportation, housing, and social connection. To effectively align social care and health care, a growing number of community-based organizations (such as Area Agencies on Aging (AAAs), Centers for Independent Living (CILs) and more) and health care entities (such as managed care plans, insurers, and hospital systems) are entering into contracts to collaborate on and deliver more fully integrated health and social care services. The prevalence of these contracting arrangements have been increasing. Five waves of a national survey tracking community-based organizations (CBOs)-health care contracting show that the percentage of CBOs who report contracting with a health care partner increased significantly from 38% in 2017 to 47% in 2023.[2]

This series of benchmarking national surveys and a previous qualitative study provide a great deal of information about the nature of these contracting arrangements, such as the characteristics of the CBOs who are participating, who the health care partners are, what services are provided, which populations are served, and what some of the challenges have been.[3] As these contracting arrangements continue to be a proven and prevalent method to align health and social care, deeper information about the impact of these partnerships on CBOs will support the replicability and viability of the model. To that end, the Aging and Disability Business Institute (Business Institute) administered by USAging, with funding from The John A Hartford Foundation, partnered with the Scripps Gerontology Center to conduct a qualitative study to hear from contracting CBOs about how the shift to health care contracting has impacted their organizations.

METHODOLOGY

A total of 13 individuals representing 10 Area Agencies on Aging participated in this qualitative study. We conducted one in-person focus group with representatives from 5 AAAs followed by individual interviews with 5 additional AAAs. Participants were selected based on having a contracting relationship with health care entities and were from a pool of potential participants suggested by Business Institute leaders. Although

the sample only consisted of AAAs, the insights gained from this study are applicable to a broader range of CBOs.

The focus group and individual interviews were semi-structured, and participants were guided through the discussion by an interview protocol developed by Scripps Gerontology Center and the Business Institute. Participants received a list of the interview questions prior to the focus group or interview. The open-ended questions asked participants about their contracting experiences and the ways that contracting affected their organizational operations, staffing, and culture. The focus group and interviews took place in July and August 2024. The Scripps research team analyzed by coding the transcripts and aligning responses with the interview protocol. Individual and collaborative coding were used to identify important themes and illustrative quotes. Preliminary themes were reviewed with Business Institute research team members and the agreed-upon themes provided the framework for reporting results.

WHO DID WE SPEAK TO?

The ten organizations we spoke to were all identified as Area Agencies on Aging; two of the ten also served as Community Care Hubs (CCH). A CCH is a community-focused entity supporting a network of CBOs providing services that address health-related social needs; the CCH centralizes administrative functions and operations infrastructure on behalf of the contracting CBOs. More than half of the organizations had been contracting between 6-10 years and, with the exception of one organization that has been contracting for over 10 years, the rest had been contracting for 5 or fewer years. On average, these organizations maintain 4 contracts with health care entities (median: 2.5; range: 1-15). The average total number of people served by each of these 10 organizations through their health care contracts was 2,500 (median: 450; range: 93-8,000).

These organizations work with multiple and varied partners through their contracting efforts. Half indicated that they work with Medicare Advantage plans but nearly all were working with multiple partners including commercial or employer-sponsored health insurance plans, Medicaid managed care plans, State Medicaid Agencies, Accountable Care Organizations (ACOs)/Coordinated Care Organizations (CCOs), health care center or clinic, hospital or health system, the Veterans Administration (VA) or Veterans Administration Medical Center (VAMC), primary care entities, Medicare-Medicaid plans, Program of All-Inclusive Care for the Elderly (PACE), and/or provided Medicare Part B Services using Medicare Fee-for-Service codes.

Through their contracts, these organizations provide assessments of health-related social needs (HRSNs) and/or long-term services and supports (LTSS) needs, care management, fiscal intermediary services, and even sending referrals to organizations beyond their area or into other states.

RESULTS

DECIDING TO CONTRACT WITH HEALTH CARE ENTITIES

Contracting with health care partners to meet HRSNs has a range of consequences for a CBO's scope, reach, resources, and infrastructure. All participants in this study described a decision-making process that took into consideration the changing nature of health and social care as well as the capacity and mission of their own organizations. They acknowledged an awareness of the changing health care landscape, an understanding of the implications for their organization, and a vision for the long-term viability of their organization. The decision to enter into a contract was typically made by the CEO and leadership team. All reported that they had involved their boards in making the final decision, and some included their board at earlier stages of creating the business case for entering into contracts.

Participants described several drivers for the decision. Organizational benefits that they mentioned included enhanced opportunities for growth and viability, enhanced revenue streams, and maintaining their important role of serving their communities. They also welcomed the opportunity to serve new populations (such as younger people with disabilities and veterans) with an expanded portfolio of services. Several participants discussed the transformation of health care in which the centrality of community-based social care has never been stronger, presenting unique opportunities for CBOs. While there was acknowledgement of the "growing pains" that can accompany contractual relationships with health care, there were clear messages about the importance of remaining relevant, and the need to think creatively about financial viability and sustainability. On this latter point, one participant commented that reliance solely on traditional governmental funding streams (such as Older Americans Act) is not viable, warning that *"It's a leaky canoe."*

Alignment with mission was an important variable in the decision to contract, and an essential component of the case to be made to board and staff members. Illustrating this mission alignment for their organization, one participant stated:

> *You know, I've always said …we want to serve people when they need us most and they often need us most after an acute health care incident, when they have multiple chronic conditions. And so, when we can marry social service support and other supports, we offer when people need us most and do that with the health care system then I think that's really, that's really positive.*

Many participants saw health care contracting as an acknowledgement of two important points: 1) AAAs and other CBOs hold a unique position that is essential for the integration of social and health care, and 2) it represents an important recognition that

health care and social care organizations each have distinct and equally important roles to play in meeting the needs of people in their communities. Illustrating the first point, one participant said, "*We try to be the eyes and the ears on the ground for [health care partners], about what's going on in these people's lives, in their homes and communities."* On the second point, a participant commented, "*I cannot tell you… how refreshing it is to actually have the medical profession identify that they are not in control of everything that's health care-related…"*

Impact on Business Operations

Taking on the work of contracting, whether it be adding new services or programs, expanding to new populations, or serving more clients, required all organizations to evaluate how such changes will impact their business operations. Identifying the extent to which their structure, workflow, policies, and procedures need to be modified is key to integrating new activities into day-to-day operations. Participants also discussed the importance of establishing with health care partners how their performance will be measured, developing strategies to anticipate and manage increased work volume, and cultivating strong relationships and open communication with their partners. There was some variability in how early and how thoroughly organizations addressed changes to business operations at the beginning of their contracts, but there was agreement about the value of working out these details very early on. Often, the amount of change to an organization's operations depends upon the nature and complexity of the new work related to contracting.

Braiding & Blending

The following provides definitions of braiding and blending as noted in an issue brief from Trust for America's Health:

- Braiding: coordinating funding and financing from several sources to support a single initiative or portfolio of interventions (usually at the community level).
- Blending: combining different streams into one pool, under a single set of reporting and other requirements, which makes streams indistinguishable from one another as they are combined to meet needs on the ground that are unexpected or unmet by other sources.

An overarching theme that emerged from participants' discussion of integrating contract-based operations into existing work was the extent to which functions were integrated or kept separate. These discussions touched on two major topics: 1) the extent to which contract-related business processes and client-facing services were blended into existing work flows or kept separate, and 2) the extent to which funding streams could be brought together and coordinated to support specific programs, or whether funding sources could be pooled more generally to most effectively meet

unexpected and unmet needs. While only one of the participants used the terms “blending” and “braiding”, many of them talked about the general strategies.[4] The text box to the right provides a definition of these approaches, which are gaining traction as methods to support CBO capacity, flexibility, and effectiveness in meeting HRSNs.

Three major components of business operations that can be affected by contracting relationships are: organizational structure, data infrastructure, and staffing.

Organizational Structure

A consideration for contracting organizations was whether changes needed to be made to their existing organizational structure. Many organizations had the structural agility to easily and seamlessly incorporate contract-based activities into their existing systems and would house the work within existing departments or programs.

Whether it be the structure of the organization prior to contracting or the requirements of a particular contract or contract partner, some organizations found it necessary or advantageous to separate the work of the contracts from their existing operations. This could be done by creating a new department or program to separate activities or maintaining a separate board of directors or advisory council. Beyond this, on a much larger scale, developing an entirely separate legal entity such as an LLC or 501(c)(3) was necessary. For example, after a health care partner expressed concern with contracting with a quasi-governmental organization, that organization established a separate 501(c)(3); this new entity allowed for flexibility in contracting efforts and removed some of the barriers experienced in negotiating and acquiring contracts.

Data Infrastructure

Another key impact of contracting was the degree to which new contracting specifications required changes to an organization’s data infrastructure including separate operations as related to data privacy, collection, and reporting. Some contracting allowed for information and data to be transmitted by way of shared but protected files (through a shared platform or drive or via email). In other cases, firewalls had to be established to keep information separate and protected. Some organizations had to adapt to systems and platforms designed and maintained by their health care partners while others developed new IT platforms to ensure that contract-based information was entirely separate from the rest of their CBO data. For example, employees working on a contract with an insurance plan had to have separate computers which allowed them to be tied into health care systems. However, the rest of the staff did not have access. In one particular case, to maintain the highest level of confidentiality, the employees were not allowed to share with other employees any information about the work, including the plan for whom they are providing services.

Using systems maintained by health care partners can also create a situation in which the CBO does not have access to some types of data, including client information and

program performance reports. One respondent described the way this health care partner-centered system works in the case of employee performance data: *“They [the health care partner] have access to [the system] that we use. They have access to that at more of an administrative level. We don't. But they can run reports specifically on each individual employee we have. They can run reports on our block of employees that we have.”*

Staffing

The potential impact on staff of any major change to business practices was something that all participants had considered. How will contracting change the roles and workload of staff members? Are there enough staff members to do the work? Are additional staff members needed? Are the right people in the right positions? Who needs to be hired? What skill sets are needed? How do those skill sets differ from existing staff? These are the types of important questions considered by organizations when acquiring new contract work. All organizations had to step back to see what could be done ‘in house’ with existing resources and what made sense to be outsourced or staffed with new positions and new people.

> *We operate pretty leanly so everybody's plate is already full and anytime you're going to think about doing something new, who's actually going to do the thinking, who's going to do the learning, who's going to take those first steps, beyond those first steps, do we need to hire somebody, do we need to look at maybe bringing on a consultant, do we have the resources to do that.*

Their approaches to managing new work varied across organizations and across contracts. Some organizations wrapped the contract work into existing positions and roles, with staff members assuming new duties and responsibilities. Other organizations kept the contract-based work entirely separate and created positions solely dedicated to working on duties associated with the contract. These blended versus separate staffing and workload decisions were made for staff who are directly involved in serving clients, and for administrative staff, such as accounting. Again, this was often dependent on the requirements of a contract and the nature of the work. Leadership had to determine how much of their staff, as well as their own time, would be devoted to new activities, and where they needed to add, streamline or separate work. The following quote provides insight into the process one organization took in identifying the right individuals, skill sets, and positions needed to successfully staff contracting work.

> *So, it was finding somebody who had the right balance of skills and then figuring out where we developed elsewhere in the organization [the] skills [needed] to help support [the contract] like in accounting. Our accounting department started out very, very small and so [we thought], who has expertise to really work in Excel and do all of this billing and who's really good at quality assurance and monitoring case notes and [see if] they [are] meeting ABCD so it's allowable as a billable service. So, we did a lot of just that internal work of who has the right skills. And then as we grew it, then we figured out, okay, we're gonna section off this program from this person. We're gonna give that to this other person so they can focus on these programs because that's where their skill set is.*

The requirements and expectations of a new contract with a health care provider or payer may look very different from the traditional services the organization has been providing. For example, an organization that has traditionally provided ongoing care management may now also be providing a service to a health plan in which they conduct a quick assessment, provide resources or a referral, and then their contact with the individual ends. Providing new and different services led many organizational leaders to re-think who they were hiring and the types of skill sets needed to be successful in their contracting role. They often had to consider whether someone within their own organization would be a good fit and could make an easy transition, or if it was in their best interest to hire someone new with a different set of skills. In the case of the organization that began providing short-term information and referral contacts with clients, they found it advisable to hire separate individuals for that work compared to hiring staff with a history of working in ongoing case management. Given the nature of the work, one participant described the individual they needed to and eventually hired. *“We needed a person who could use a complex computer system, ask a lot of really personal questions for a high-volume number of people, and not everybody can do that.”*

Participants also noted that for many of their contracts with health care entities, they would benefit from hiring individuals with experience within the health or medical systems and could ‘speak’ health care.

> *So, we need to hire specific skills. Often, we're looking for people who've worked in health care settings. And when I think about the kinds of people that work in our health care portfolio, I won't call it that. You know, we've got compliance, data privacy officer, we have a network director, we've got community health workers that do some direct assessment. We have a program; we have provider relationship managers. But we're often again looking for people who have had some experience working in a health care setting.*

Many discussed the need to explore hiring individuals outside of the traditional care management role, with an eye to the specific skills needed for specific jobs. Some have hired community health workers, registered nurses, or therapists because of their clinical skills; some hired former teachers because of their expertise in client engagement, education, and communication; some hired former food service workers because of their customer focus and their ability to engage with all kinds of clients. In addition, many organizations found that they needed to add staff within their finance, quality assurance, and data departments.

IMPACT ON CULTURE

The shift towards health care contracting introduced cultural changes within the organizations involved. There were varied levels of initial acceptance and adaptation among staff, board members, and partners, with both support and resistance to the change. Many participants explained that their board members and staff readily embraced the shift, recognizing health care contracting as an opportunity to continually support individuals in their service area and expand to and serve more or different populations. Some organizations acknowledged the value of hiring a communications professional to frame the contracting initiative positively.

In organizations where a culture of change had already been established, the transition to health care contracting was more straightforward. One participant remarked on the legacy left by a long-standing predecessor who had instilled a culture of change within the organization: *"She did this amazing job of developing and nurturing a culture of change. There is no person who works at our agency who thinks things aren't going to change… it's even in our staff orientation, like, don't get too comfortable with what's happening right now… at least culturally, it's an expectation."* Another participant described their organization as agile, emphasizing a culture of adaptability driven by health care contracting. One participant highlighted their organization's culture of abundance, which refers to an organizational mindset focused on opportunities, growth, and potential rather than on limitations, scarcity, or constraints. They viewed health care contracting as a valuable source of new opportunities for organizational growth and expanding services.

However, some participants experienced reservations within their organizations, explaining that staff and board adhere to a more conservative approach and are less ready to embrace innovation. Participants noted that effectively communicating the financial implications of health care contracting posed a significant challenge because not all staff think in terms of revenue and balance sheets. In addition, some staff expressed concerns that collaborating with health care organizations could undermine the organization's mission. For example, staff were initially uneasy about the organization's involvement in health care contracting, assuming it was the work of a for-profit entity and too business driven. It took considerable time and effort to explain to their staff that the contracts were aligned with their nonprofit mission to serve and meet the needs of individuals in their communities. For mission-driven organizations focused on social services, reconciling their commitment to altruistic goals with the sometimes-transactional nature of health care contracting posed a significant challenge. Staff expressed discomfort when the nature of health care contracting activities was more structured and goal oriented. As one respondent reflected,

> *I think people who tend to work in nonprofits who have very specific missions like serving the elderly or serving children have this, "Oh, we've got to save everyone." So, the fact that this service is doing assessment, getting them the information, and we're done, is a little uncomfortable for some staff who feel like we're not doing the best service we can [for] the public.*

The transition to health care contracting also necessitated changes in operational culture, including the nature of the work and job expectations. Participants emphasized the challenges of aligning health care contracting with their organization's vision and mission, noting that it often seemed bureaucratic to some staff. One participant highlighted a shift from predefined caseloads to actively building their own and engaging with potential clients: **"***We went from staff members that…your position is paid for, and you have your caseload and that's the work you do, versus I have to go and develop the caseload, and I have to engage with people."* Participants also discussed how the staff were concerned about job security due to the goal-oriented nature of health care contracting activities. Thus, these operational culture changes and concerns appeared to be driven by the need to align with health care contracts, which often come with specific performance requirements tied to funding. However, participants emphasized the importance of clear communication about the rationale for the change. Effective communication—such as keeping the board and staff informed throughout the contracting process, framing its value and social care aspects, providing a clear rationale for the change, and emphasizing meaningful outcomes—were crucial for anticipating and managing cultural resistance.

Participants also pointed out that factors such as their organization type, geographic location, composition of the board, staff, and the population they serve play a significant role in how team members accept and adapt to health care contracting. For example, one participant mentioned, "*it's nice to be able to make a program work the way it fits best for your area…As an Area Agency on Aging, we have [number] counties that we cover, and we're mostly a rural district. So, what works for us probably would not work for our counterparts, and [AAAs that] are more urban and structured differently with their delivery systems.*" Another participant explained that organizations with veterans on their boards experienced strong support and smooth adaptation to the new line of business to expand their focus on serving veterans. The response and acceptance from the board, staff, and partners were overwhelmingly positive, with many fully backing the initiative, as the contract aligned well with their mission and values.

> *We saw the opportunity to start this program in our area in an effort to serve veterans… It's just a very important part of who we are, and where we are. And so that's a great honor for us as an agency. We have veterans who are on our board, we have veterans who are on staff. We have military spouses who work in our departments. So, it's just a big part of our community.*

While not common, some organizations indicated that their staff already saw themselves as an important part of health care, making the transition relatively seamless. One participant noted, *"AAAs thought they were health care providers. For them to embrace contracting with hospitals and doctor's practices, that was not a problem."*

The cultural impact of health care contracting on organizations varied depending on the pre-existing organizational culture, the effectiveness of communication, and the alignment of the health care contracting model with the organization's mission. Resistance was often rooted in concerns about maintaining nonprofit values and balancing mission-driven work with the sometimes-transactional nature of health care contracting activities. Factors that mitigated these concerns included open communication across the organization that directly addresses concerns, a focus on opportunities and revenue generation, and a vision for long-term sustainability. These strategies helped organizations overcome resistance from the board and staff, fostering a culture that embraced the change.

Lessons Learned & Advice

In the process of describing their experiences with health care contracting and its impacts on their organization, participants shared many lessons learned. At the end of the interview, they were also specifically asked if they had any advice for CBOs that are considering or in the midst of contracting. Some of their most succinct advice about

moving forward with contracting was: *"Just do it"*, "*It's the right thing to do*", *"Don't let what you've always done stand in the way of what's possible.",* and *"Don't be afraid to step outside the box. You have to be able to recognize opportunity."* They also provided more detailed advice in their responses to this direct request for advice, as well as their responses to the questions on the interview protocol. Those responses revealed four major categories of lessons learned and advice: Align Opportunity with Mission, Build the Business Case, Negotiate Good Contracts, and Anticipate and Manage Change.

Align Opportunity and Mission

All of the participants in this study spoke about the potential value of contracting with health care. They were equally uniform in their attentiveness to the importance of aligning contract work with the mission of their organization. Three specific messages emerged around this theme:

1. Embrace the focus on social drivers of health. Many participants discussed the opportunities that were opening up to them (such as new revenue streams, and expanded opportunities to serve more clients with a wider range of services) through health care contracting. In general, our participants had a shared view about the rise of social care, and the role of CBOs in fuller and more effective integration of health and social care. They were clear about the unique and equally important role of both sets of partners. The following quotes from participants speak to these realizations:

   - *"We can do things that health care does not and cannot."*
   - "*Their [health care partners'] issues are our opportunities."*
   - "*...social care is not just a bunch of feel good…. Older adults say how devalued they feel in the traditional health care system…and I'm not sure how great the outcomes are."*

2. "Know your strengths". This succinct piece of advice speaks to the balance between expanding in new directions and remaining true to core strengths and values. The speaker emphasized that mission alignment is tied to recognizing and leading to organizational strengths, rather than taking on new commitments that could not be effectively fulfilled within the expertise of the organization and its intended future directions. Some of the specific strengths mentioned by participants included the kinds of services they provide and their capacity for reaching underserved populations. They also discussed partnerships that were already in place as a strong foundation for a contracting relationship. For example, several participants mentioned existing relationships they had with health care partners around initiatives such as care transitions and evidence-based health programs. Those partnerships, and the AAA's known expertise in providing specific kinds of services, facilitated the contracting relationship.

3. Communicate the alignment. For many participants, preserving their mission while providing services to health care entities was a priority. One participant noted that it is necessary to be "business-minded and mission-driven", and that it is important to understand hesitancy and concerns. In some cases, staff and board members were concerned that the priorities, values, work flow, and performance metrics of the partner organization might undermine the current climate of their organization. However, the majority of participants in this study had been successful in communicating how the work being done under the contract supported rather than undermined their mission. All agreed that acknowledging staff and board concerns, proactive communication, and providing factual information (such as a business plan and revenue projections for the contract work) to address those concerns is essential.

Build the Business Case

Based on information from the participants, making a case for the value of a contracting relationship happens at two levels: a cost-benefit analysis within the CBO, and a business case or value proposition to the health care partner. Participants stressed the importance of an internal cost-benefit assessment as part of the decision about whether and how to move forward with contracting. They discussed the importance of considering necessary investments such as start-up costs, and opportunity costs. One participant was very open about her struggle with the costs and challenges of making such a move, even though she thought it was the right thing to do. She stated, *"…for me these are great opportunities…and yet I think about the time and energy it will take…and about what happens if we don't [take advantage of this opportunity]…Is it worth the investment or the changes?"* Participants also mentioned how helpful it was to present a financially advantageous business case as part of internal communications about the decision to enter into contracts.

A strong externally facing value proposition (to health care partners) is another component of building the business case for contracting. As noted above, awareness of the impact of social care on health outcomes and of the unique expertise and services that CBOs bring to the table is an essential ingredient in an effective value proposition. But participants also emphasized that CBOs have to make a compelling case for the economic value of what they do because, "*Health care doesn't always appropriately acknowledge the value of what we do*". Others celebrated the value-based payment model used in their contracts. *"We do it well, and we get paid for quality efforts. I wish all of our contracts could be quality-based, and we get rewarded for that."* Participants advised that CBOs need to get comfortable with monetizing costs and benefits for their programs, as illustrated by these two quotes: *"We have to show them [health care*

partners] in monetary terms the value we bring, and" "There is value in the work—don't be afraid to put a number on that."

Negotiate Good Contracts

Some participants offered advice about how to establish a good contract—one in which expectations are shared and clear, and rates are fair. They emphasized the importance of learning the language and implications of different payment models. One participant mentioned specifically that USAging's Business Institute *"has done a really good job of helping to prepare [us] for moving forward into this new world."* Becoming familiar with these payment models is a first step in ensuring that an organization can follow the advice to *"Get paid for results.*"

Negotiating payment rates is obviously an important component of successful contracting. An earlier study revealed variability in this element of the contracting relationship.[5] In that study, some CBOs had very positive experiences in working out these rates collaboratively with health care partners; others felt less involved and less empowered in the process, with some noting that it seemed that the health care partner *"held all the cards*" and played a much bigger role in setting rates than the CBO. In this current study, participants focused on the ways in which the CBO can play a role, primarily through the ability to monetize their costs and results, as noted above.

Another aspect of payment rates is clarity about performance metrics. There was some variability among the AAAs in this study about the extent to which those metrics are clear, but there was agreement that this is an important step in the process. One participant described provided a successful example. They said that those performance metrics are included in their scope of work, and included specifics such as contract rates, increased client contact, and improved compliance as performance indicators.

Another factor in contract negotiations was the quality and nature of relationships with the health care partners. Many participants mentioned the overarching importance of open communication and collaborative relationships with their counterparts within the health care partner organizations.

Anticipate and Manage Change

There were clear and generally universal messages about the fact that contracting brings about change for a CBO, and that it is useful to anticipate those changes and potential challenges. An overarching message was about expecting uncertainty, bumps in the road, and potentially lean financial times as contracting efforts ramp up. They recommended planning for the long term and dealing with challenges with the end goal in mind. Participants also offered specific advice about managing those changes relative to culture and staffing.

Their advice about culture change echoed themes related to the impact on culture, and aligning mission with opportunity. One participant provided this perspective on how to proactively manage culture change:

> *[Think about] … what do staff want to know, what are they worried about; [this change is] an opportunity to talk about how health care contracting fits our vision and mission and the things we hold dear… This is how we are going to better serve people…. This is what it means for people. These are the outcomes we hope people are going to have.*

Also reflected above, planning for staffing changes was a big issue. Personnel needs may change in terms of specific skills needed, increased staffing, and decisions about feasible and desirable staffing models that keep contract work separate from ongoing work or not. Participants advocated for developing staffing plans early in the process.

In summary, contracting with health care entities reflected a positive collaborative shift for CBOs that impacted their business operations and organizational culture and secured necessary new revenue streams. CBO participants in this study saw contracting as valuable and necessary to move their organizations forward; they were also committed to this approach for improved integration of health and social care and better outcomes for individuals. Meeting health-related social needs also aligned with their organizational missions. The continued growth and success of this model depends on strategic and financial decisions for CBOs and for health care partners. Its success will also benefit from continued investments such as USAging's ACL-funded Center of Excellence to Align Health and Social Care (administered by USAging) which funds and provides technical assistance to 20 CCHs around the country, as well as investments from health care into CBO partner infrastructure.

REFERENCES

[1] U.S. Department of Health and Human Services. (2023, November). *HHS call to action: Addressing health-related social needs ...* ASPE | Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/sites/default/files/documents/3e2f6140d0087435cc6832bf8cf32618/hhs-call-to-action-health-related-social-needs.pdf

[2] Kunkel, S. R. and Lackmeyer A. E., (2024, July). *At The Nexus of Social Care: Successful Contracting Between CBOs and Health Care Entities*. Scripps Gerontology Center. https://sc.lib.miamioh.edu/bitstream/handle/2374.MIA/6998/24-07-30_At-the-Nexus-of-Social-Care_1-13%20.pdf

[3] Kunkel, S. R., Lackmeyer, A. E., & Graham, R. J. (2023, April). *Lifting the Veil: How Networks Form, Operate, Struggle, and Succeed*. Scripps Gerontology Center at Miami University. https://sc.lib.miamioh.edu/bitstream/handle/2374.MIA/6903/Lifting-the-veil-how%20networks-form-operate-struggle-and-succeed-FINAL-5-9-23.pdf

[4] Trust for America's Health. (2018, Sept.). *Braiding and Blending Funds to Support Community Health Improvement: A Compendium of Resources and Examples*. https://www.tfah.org/wp-content/uploads/2018/01/TFAH-Braiding-Blending-Compendium-FINAL.pdf

[5] Kunkel, S. R., Lackmeyer, A. E., & Graham, R. J. (2023, April). *Lifting the Veil: How Networks Form, Operate, Struggle, and Succeed*. Scripps Gerontology Center at Miami University. https://sc.lib.miamioh.edu/bitstream/handle/2374.MIA/6903/Lifting-the-veil-how%20networks-form-operate-struggle-and-succeed-FINAL-5-9-23.pdf