The future of healthcare is here: Partnerships with community-based organizations

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"The poor man who enters into a partnership with one who is rich makes a risky venture."

-Titus Maccius Plautus

In 2009, YMCA of the USA (Y) and UnitedHealth Group (UHG) formed what would turn out to be a historic partnership. Under the terms of this agreement, UHG would reimburse the Y for each of its eligible insured customers who successfully participated in the YMCA's Diabetes Prevention Program (YMCA's DPP). This program targets individuals with prediabetes—the precursor to the disease—and aims to help them lose at least 5% of their body weight. Research has shown that participants who achieve this goal reduce their risk of developing type 2 diabetes by almost 60% (Diabetes Prevention Program Research Group 2002).

Over the past few years, UHG has invested millions of dollars in its partnership with the Y. To my knowledge, this partnership represents one of the first times that a

commercial health insurance payer has contracted with a social service community-based organization (CBO) to offer a chronic disease prevention program on a true pay-for-performance basis. Partnerships like these represent the future of healthcare. This article explores what is driving the formation of these partnerships and what it will take for them to be successful over the long term.

Background on YMCA's Diabetes Prevention Program and partnership with UnitedHealth Group

As described more fully in "Using National Networks to Tackle Chronic Disease" (Hussein and Kerrissey 2013), the YMCA's DPP is a yearlong program. Participants meet for one hour per week for the first 16 weeks and then monthly for another 8 months. The sessions are conducted in a small group format, usually with anywhere from 8-15 participants, and are led by trained Lifestyle Coaches. At each session, participants learn about healthy eating habits and discuss their own impediments to changing their eating and physical activity behaviors. Starting around the fifth week, participants are also encouraged to start incorporating 150 minutes per week of physical activity into their lives. The YMCA's DPP is considered an evidence-based intervention and was adapted from a similar program developed through extensive research by academics funded by the National Institutes of Health ((Ackerman and Marrero 2007).

YMCA of the USA is the national office that supports a federated network of approximately 900 independent, local Y associations across the country. UHG is an $80+ billion diversified health and well-being company that, among other businesses, provides health insurance to tens of millions. UHG entered into this partnership, in part, because it was attracted by the Y's ability to achieve the same weight-loss results as clinical providers, but at much lower costs. With thousands of sites located across the country, the Y also offered the benefit of being a service provider with tremendous scale. Importantly, however, UHG could develop this partnership through negotiations with one national office rather than up to 900 legally separate entities.

Forces driving the formation of partnerships between CBOs and healthcare providers or payers

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Tectonic shifts are underway in the field of healthcare. The decades-old paradigm of "more"—more hospitals, more specialists and surgeons, more (and usually more expensive) treatments and more access to high-end technology—is giving way to a renewed emphasis on maintaining health, preventing disease and getting

primary care. The rationale for these shifts is clear: by almost all measures, the US spends more on healthcare than any other developed country and yet our citizens are sicker than most and have shorter life expectancies (Institute of Medicine 2013).

We've arrived at this point, in large measure, as a result of how we finance healthcare. The healthcare system has been incentivized to treat sickness rather than maintain health. The results are well known: healthcare expenditures now account for almost 18% of GDP, and Medicare and Medicaid, which consume an ever larger share of state and federal budgets, crowd out other worthwhile investments in education and infrastructure. And many of us feel the pain as our healthcare premiums and out-of-pocket costs increase by double-digits each year.

With the Affordable Care Act (ACA) now firmly the law of the land and any meaningful debt-reduction package likely to include changes in entitlement programs, healthcare financing mechanisms are changing rapidly. Commercial insurers, and even Medicaid, are experimenting again with global payment schemes: paying healthcare providers a fixed amount annually to take care of a group of insured customers or covered beneficiaries. At the heart of all these initiatives is an attempt to promote improved health outcomes at a lower cost.

Attempts to put the nation on sounder financial footing for the long term are also causing tremors in the world of community-based organizations (CBOs) that provide social services. A vast array of nonprofits that provide substance abuse, mental health, housing and a host of other critical services to some of our nation's most vulnerable populations has historically operated alongside, but largely at the periphery of, our healthcare system. Massive cuts in public funding, the primary source of financial support for most of these organizations, have already pushed some of these nonprofits to close their doors and are pushing many others to pursue mergers and other types of strategic collaborations.

We're just at the beginning of a new wave of partnerships

Given the changes buffeting the worlds of healthcare and social service CBOs, we are seeing more serious discussions of partnerships between CBOs and the healthcare sector than ever before. We're not referring here to short-term arrangements between a clinical provider and a social service nonprofit to collaboratively offer a program in response to a specially funded initiative, but rather to healthcare providers formally integrating networks of CBOs into their care delivery systems, and payers viewing social service CBOs as reimbursable providers of services that were previously

the sole purview of highly degreed clinicians.

Examples of these partnership discussions and constructs, while all still generally at early stages, are beginning to proliferate. A few months ago, I participated in a meeting organized by the Administration on Community Living and the SCAN Foundation, which focused explicitly on the kinds of technical assistance needed to support aging and disability service networks in becoming more effective partners with healthcare organizations. Leaders from the participating nonprofits were eager to understand how they could position their organizations to establish formal partnerships with healthcare entities. In a similar vein, the Alliance for Children and Families—an international membership association representing 350 human service agencies—is very actively promoting to healthcare providers and payers the role that its member agencies can play in addressing the needs of the "5/50" population (i.e., the 5% of Medicaid beneficiaries that account for 50% of Medicaid's total expenditures).

What will it take for these partnerships to be successful over the long term?

Partnerships can be tricky business. For partnerships between CBOs and healthcare providers or payers to be successful over the long term, both parties must be clear about their own interests, their assessment of what the other party brings to the table, and why working together

is better than going it alone.

Consider the partnership between the Y and UHG. The 160-year-old Y is a mission-driven organization that seeks, among other things, to help individuals and families improve their health. It tries to reach as many people as it can with proven programs like the YMCA's DPP. Prior to joining forces with UHG, the Y had relied primarily on government funding to support the roll-out of the program. The Y had been able to use those funds to roll the program out to about 30 locations. The public funding, while critical to getting the program off the ground, will never be enough to help it achieve meaningful scale. Besides direct financial support, UHG offered the Y access to a large pool of potential program participants and the ability to develop critical program infrastructure, including a system that allows the Y to monitor results of program participants across the country in real time, and to collect reimbursement from any third-party payer.

UHG provides health insurance coverage to tens of millions of people. It collects premiums from its insured customers, both individuals and companies, and agrees to pay for medical costs incurred by those customers. For every one of its insured customers who develops a disease like diabetes, UHG must pay for treatment, which often costs thousands of dollars annually. For UHG, the diabetes prevention program offered a way to prevent or delay the onset of an expensive and debilitating disease among its customers. In the Y, UHG found a partner that

could offer a high-quality version of this intervention practically everywhere UHG had customers. And not insignificantly, UHG could form this partnership by negotiating with a small number of people in the Y's national office rather than representatives from several hundred independent legal entities.

Clearly, there are many reasons to recommend the development of mutually-beneficial partnerships between CBOs and healthcare providers or payers. The devil is in the details. CBOs considering these types of partnerships should start by asking themselves if they can:

- Quantify and communicate the value their services will bring to a healthcare provider or payer in terms that matter to them (i.e., cost avoidance or additional revenue generation)
- Price their services such that the value they provide exceeds what is charged
- Develop a sustainable operating structure for their services such that variable costs are less than price charged
- Secure funding to build the infrastructure to deliver high-quality services
- Effectively monitor delivery of service to ensure it is of the highest quality and complies with appropriate regulations (e.g., HIPPA, the Health Insurance Portability and Accountability Act)

While the initial impetus for many of these partnership discussions may be the big environmental shifts noted

earlier, the best of the partnerships that ultimately form will be much less about a path to survival for the partnering organizations and more about a way for them to better serve their target beneficiaries. For healthcare providers and payers, these partnerships offer an opportunity to actually improve the health of the individuals and families they serve rather than just treating them when sick, and to do so with a cost-effective approach. For CBOs, these partnerships may allow them to secure more sustainable sources of funding for their work and to scale up and serve far more beneficiaries than they might have previously imagined possible

Resources

Resources

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Author Bio

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