

**NWX-HHS-AOA-1**  
**Moderator: Lauren Solkowski**  
**June 19, 2013**  
**1:00 pm CT**

Coordinator: Thank you for standing by. All lines in today's call are in a listen-only mode until the question-and-answer session. At that time for an open line you can press star 1. Today's call is being recorded. If you have any objections, you may disconnect at this time. And I'd now like to introduce Lauren Solkowski, Program Analyst. You may begin.

Lauren Solkowski): Thank you (Michelle). And thank you to everyone for joining us for today's webinar on Personal Stories Moving into a Business Market Approach. As mentioned in the calendar appointment, the purpose of today's webinar is to hear personal stories that other community-based organizations have encountered in developing their business acumen and working with healthcare providers and plans.

Before we get started and into the bulk of our webinar, there are a few housekeeping announcements that I'd like to go through really quickly. If you have not done so already, please use the link included in the calendar appointment to get on the WebEx so that you can not only follow along with the slides as we go through them but also ask your questions when you have them through chat.

If you do not have access to the link we emailed you, you can also go to [www.webex.com](http://www.webex.com) and click the Attend a Meeting button at the top of the page and then enter the meeting number which is 666685392. That was 666685392. If you have any problems with getting into WebEx, please call WebEx technical support at 1-866-569-3239. That's 1-866-569-3239.

As (Michelle) mentioned all participants are in listen-only mode. However we welcome your questions throughout the course of the webinar. There are two ways that you can ask your questions. The first being through the web using the chat function in WebEx. You can enter your questions and we'll sort through them and answer them as best we can and take breaks for questions - small breaks between each person presenting.

In addition after the teams wrap up we will offer another chance for you to ask your questions through the audio line. When that time comes (Michelle) will give you instructions as to how to queue up to ask your questions. If there are any questions that we don't get to answer during the course of the webinar, we will follow up to be sure that we get them answered. If you think of any questions after the webinar, please email them to me at [Lauren.Solkowski@acl.hhs.gov](mailto:Lauren.Solkowski@acl.hhs.gov).

As (Michelle) mentioned we are recording this webinar. I will provide information on accessing the recording after the webinar has concluded. So I think with that I'd like to get started.

Before we hear from our two community-based organizations, I'd like to introduce June Simmons who is the CEO and President of the Partners in Care Foundation that is here to make an announcement on behalf of the John A. Hartford Foundation. June are you there?

Coordinator: June check your mute button please. Just one moment and I'll pull her line to check.

Lauren Solkowski: Thank you.

Coordinator: June Simmons is joined.

Lauren Solkowski: (Hi)...

((Crosstalk))

June Simmons: I'm very sorry. I was on the line, it cut me off, and then when you introduced me I was on the line but you couldn't hear me. So hopefully I'll be worth hearing now that I'm here.

Lauren Solkowski: Right. Thank you, June.

June Simmons: Good morning. Just briefly I bring greetings from the leadership of the John A. Hartford Foundation whom I know you all appreciate, have been fantastic investors in advancing aging and health and bringing support to the Aging Services Network and healthcare for aging.

And they are beginning some new funding investments and so I have the privilege of announcing a new grant that they have just approved that their board called Improving the Health of Older Adults Using Integrated Networks for Medical Care and Social Services.

They're running that grant through Partners in Care Foundation here in Los Angeles and we are working closely with a (sub granted) distinguished site you'll be hearing more from later, Elder Services of the Merrimack Valley

and the grant also is designed to work in close partnership with ACL on this learning collaborative.

The grant in brief is looking at prototyping how we link Coleman Community Services and medicine through building business structures and clinical partnerships so we are prototyping.

In Los Angeles we're prototyping around three service lines evidence-based self-management short-term in home care coordination and support and then longer term services and supports at home. So it's three different kinds of network models and Elder Services of the Merrimack has strength in several of those areas and it's prototyping by building a statewide network for evidence-based self-management workshops and its contracting capability.

And we also are working with the evidence-based leadership council that brings many of those management programs to all of us across the country and that group is working to integrate their efforts and streamline accessing through a shared portal. It's a three-year program. And so I don't know if there's more you'd like to know about it, but I don't want to use too much time except to say it's a major investment by the John A. Hartford Foundation.

And then there's sub funding to Merrimack and the (unintelligible) Foundation is matching that so it's very exciting and a budget is a little bit of money that's been advancing the ACL collaborative that we're on this morning.

Lauren Solkowski: Thank you June. And then also if you could mention that as you just said in advancing our collaborative for ACL that the plan to also host the in person meeting.

June Simmons: That's what our funding is from Hartford that was placed through the Partners project will be used for a variety of efforts and one is to see if we can create support for an in person gathering of the learning collaborative. And also if this learning collaborative should have a shorter rather than a longer life, we are - at Partners will continue to help with supporting it over the three-year period as well so that national learning and dissemination of the local prototyping efforts made this a very natural investment by Hartford to support the ACL initiative with some support for in person gatherings.

Lauren Solkowski: Great. Thank you so much June. And now I'd like to turn it to Roseanne DiStefano. She is the Executive Director of the Elder Services of the Merrimack Valley.

Roseanne DiStefano: Hi folks and good afternoon. As opposed to June, we're out in the East Coast. So we're in the afternoon time. All right. So I'm going to - I want to try to go through this quickly. I know I'm talking to a bunch of our really esteemed colleagues who have already pursued some of this work and see if I can enlighten you at all in terms of how we started.

I'll begin with, you know, creating relationships with the healthcare organizations. And what I would say here is that the best place to start obviously is where you have any kind of relationship with either a physician group or any kind of healthcare provider. Use your existing relations to open the door and begin to talk to them about what they're pursuing. And I'm going to talk about two examples and one is an ACO and one is a non-ACO. One has been a success and one I would say is - I won't say a failure, but we haven't been successful yet.

In the case of the non-ACO, we began talking to them a few years ago about the concept of medical homes as it was something that they were interested in. And it led to us going to a conference together down in Washington and that really helped to get to know them even better.

The conference was on medical homes and we were listening with them about what it will take for them to change their very large physician practice into a medical home. So I built some really nice bonds there although as I say this is the example that has not been successful yet.

At the same time we really started working with another physician group that's located in (unintelligible) that had pursued the pioneer ACO funding. And in this case the timing - I think the timing was right. We had had previous relationships with them when they had pursued the managed care contracts.

So some I would say eight to ten years ago we actually had a contract with them early on that was not continued, but not because of us but really largely because the pilot that they were working under in Massachusetts was called a social healthcare managed care organization and that didn't continue. But the point is that we had relationships.

So what I want to say here is that obviously you can't start cold. So you start where you have some connection and you really try to do your homework in terms of what kind of organization are there - are they and what are their incentives. Are they pursuing ACO status, are they pursuing medical homes, are they a hospital that you work with already. So think about all of that and then you have to think about okay what do you bring to them.

And sometimes the most obvious things are confusing to the medical community in that what is an Area Agency on Aging anyway. And we had to

really distinguish ourselves from a home health agency. There is a lot of confusion for whatever reason I think with the medical providers as community base is all one thing and it's there out and this and that when the nurse goes out and takes care of things.

So we had - let me very clear in terms of what we offer and how that's very different from a home health agency and in particular emphasize the fact that we have a neutrality. We don't represent any particular service provider and in fact we're not a service provider.

We can help them in assessing risk, identifying their highest risk clients, and why - what the home looks like by actually doing a home visit, doing a home safety analysis, talking to the elder about, you know, where they're having difficulty in complying with the medical tier plans we can get much deeper into a conversation because as you know oftentimes even if an VNA is going in they may not address issues such as income, being able to afford medications, the housing situation, safety, and others. So being able to differentiate yourself and be clear about what you can offer.

The other thing I would say is you obviously have to stop talking about return on investment with them and by that I mean - well in the early days, I wasn't sure what it meant to be honest with you, but I knew that we could have an effect on how people utilize their physician's visit and how they could better utilize a physician's practice. How we could keep them out of emergency rooms and hospitals by looking at for example some of the evidence-based self-management programs. So all of that was part of our pitch to them on the return on investment.

Also I would also say that in order to getting - being ready, you have to look at your program costs and if you were to provide care coordination there's a

lot involved in terms of what - it's not just the salary and fringe benefits of a particular worker. Obviously you have to really bring in all those services and programs that you offer that you think they may take advantage of.

What we did with the first example that I talked about is that we try to anticipate their need to do the budget on a PMPM - a per member per month basis and they just looked at us kind of crazy and said yes, but what's the cost. So we anticipated that that's how they needed the budget and it turns out that no a monthly cost was fine and they understood that it would be a very inclusive cost. Again not just looking at the salary and fringe of a particular care manager, but rather all the services and programs that we would bring to bear.

Finally I would say on this piece is that for us we've been successful because we've been willing to try it on a demonstration basis or on a pilot basis at no cost. That means there's no contract to sign. Yes, there's a memorandum of agreement and you have to respect confidentiality and such, but by not entering into a contractual agreement at the get go. You really - you're saying look let us prove ourselves to you, let us see what this cost, let's see how you can use it, and then let's - we will sit down and look at what the cost of delivering this long-term would be.

I would caution people to not make the mistake that we did which is, you know, speak about an end date. Is it a six-month pilot? Is it a year pilot? We were willing to do a year pilot, but it took a year and a half even to get to the point where we realized we had to actually stop the pilot to get their attention so that we could begin to negotiate a contract. That's a long story for perhaps another webinar. But I would say that make your pilots time limited, but give yourselves enough time to demonstrate your effectiveness.

So in terms of barriers - by the way I'm just, you know, just move the slides as you want - in terms of barriers as I say some physician groups are not going to be ready. If they're not at risk and they don't plan to be at risk in the near future, you might not catch their ear.

The idea of becoming a medical home is appealing I think to a lot of physician groups, but then they realize what that means and that it might cost them some money and again some of them are simply not ready. They may have some payers that are incentivizing them based on how they address high-risk patients, but that may not be enough for them to really think more broadly about how they can use a community-based organization.

Again I think the - when you pursue - when you get to the point of actually developing that pilot or if you're lucky a contractual relationship from the get go, you know, be clear about what you're going to be able to define as your outcomes. Sometimes there's an expectation that, you know, we can do a lot more than what we can actually do and some things are difficult to define.

For example oftentimes as you empower a consumer to use healthcare more effectively, they may actually use the physician more in the beginning because they have more questions, they are more engaged. So that it may not simply be, you know, a reduction in costs in the office visit. In the beginning it may actually be a more comprehensive visit, but long-term what we hope to do is reduced costs.

I would say that one of the other things is you need buy in from all levels of the practice. This is easier said than done. We had some excellent buy in with the physician group that has not yet been successful, but we had buy in with a very small group of physicians. They understood that they were part of the pilot and part of the demo, but it never spread. So because it didn't spread and

because it was so narrow, I think that made it hard for us to prove our value down the road.

Okay let's see. I'm going to go culture change. The trick is a lot of work I think administratively as well as your agency as a whole to be ready for the contractual work with private payers. It's very different than like most of our funding for years had been from the state and federal government through, you know, through legislature and this is very, very different. So obviously I think again I'm speaking to people that understand and know the difference. But understand that your customer now is not just your elder and making sure that the elder or the older adult gets better care, but it's also the payer and tuning into what the payer needs and wants.

In looking at your costs, it's really for many of us who grew up in the early days of funding from the Old Americans Act we really didn't have a sense of individual cost for different - for individual services. And I think that takes some time and energy to really begin to look at the labor hours that are involved. For example with one person receiving money management counseling or one person from a (shine) counselor which is on health insurance, but also how long does it take to do an assessment. What level of person do you need and how quickly can they do the documentation.

I would say that there's a lot of I guess they call it the business acumen because it's really a way of looking at your - how you do the work that you do differently I think through a different lens. The work doesn't change, but you're looking at it I think differently.

I think you're aligning your goals with theirs, but for this contract not for everything that you do. Built in this contract you have to identify that your goals are their goals and it's certainly reducing costs, but also improving

quality and I would say patient satisfaction. While patient satisfaction doesn't reduce costs, it does build loyalty and that is another thing that I think helped tier systems (and) very, very concerned with about whether they're an ACO or a physician group or whatever, they want the patients that are enrollees to be loyal to them.

I would say also the other culture change is really looking in house as to how your care managers used to working. It's important that they're used to working as part of a team and to be a part of a team not only of other colleagues such as themselves, but an interdisciplinary team to understand the concept of sharing a case.

That I think for us it was one of the bigger changes of case managers feeling they own, this is my case load and I'm responsible for these 100 people to a point where no there are going to be a lot of people that are concerned for those 100 people. And you might be the lead tier manager trying to coordinate different members, but you're going to have a nurse, you're going to - and in this case you're going to have outside folks that absolutely have to feel that they're part of your team and you're part of their team.

I think where we've been successful, the physician practice has really embraced us and that we are part of a regular rotation or rounds, whatever they call it, so that we're reviewing with them the high-risk patients or enrollees that they have and brainstorming with them about what we need to do. So that's where it works best.

So the big picture, changes for success. I would say that again that, you know, thinking about interdisciplinary approach, think about a pilot. Be willing to move quickly to make changes in the pilot because oftentimes they don't know what to expect and you're not sure exactly what to expect both in the

amount of time each referral will take. But also to some extent where do you start.

I mean in some cases you might have to define a maximum amount of hours that you would spend per case just because there's going to be very challenging cases that may refer to you and you may want then to refer out of this pilot to other systems and other community programs that you know exist.

I would also say in terms of big picture that it's important - it's always been important to us to share the vision with all our staff not just the staff that are working on a particular demo. It's important to me that everybody understands what we're doing and why we're doing it and what's down the road.

Why the bridge between community-based organizations and the medical community is so important. And I would say that same talk is also something that I emphasize with our board members. It's important as every CEO knows not to get too far out in front of your board and make sure that they understand where you're going, why you're going down that road because it's so different. And I think there's always a little bit of concern is this taking us away from our mission. And when you can explain how this is absolutely enhances your ability to be successful in your mission because you're impacting the healthcare of older adults, I think you get the buy in that you need.

And then finally I would also that just being excited about these opportunities is contagious and it's something that I think it's good to share and for everybody to feel part of it. Okay.

So the last picture - the last slide is really something that we've used in several different presentations to look at kind of overlaying the Wagner model for chronic disease self-management or chronic care model, I'm sorry. Looking at the Wagner model and then using the name of organizations.

In this case you'll see we put Elder Services. Yes, firmly rooted where the community programs are, but then looking at the care transitions work that we're doing with the CMS and the medical care coordination as a bridge to the healthcare systems as well as and you'll see the Healthy Living Center of Excellence which is our infrastructure. Our center to really expand and build upon the capacity across the state of evidence-based programs and wellness programs such as the (Prime) Disease Self-Management model.

These are some of the things that we bring to the healthcare systems because oftentimes opens doors. They are very - might be very interested in these wellness programs before you even can talk about care coordination. And other times they'll talk about care coordination for us and then you bring in the wellness programs after that. But absolutely they are part of the bridge. So I'll stop there. I think my time (unintelligible), but (unintelligible).

Lauren Solkowski: Great. Thank you so much Roseanne. I'm currently not showing any questions in chat so I think with the interest of time we'll go ahead and move on with our next presenter and then we'll do questions at the end. So up next we have Sharon Fusco. She is the Director of Business Results and Innovation at the Council on Aging of Southwestern Ohio. Sharon?

Sharon Fusco: Good afternoon everybody. Thanks for having me and it's always tough to follow a really good act. So I hope I can do this some justice. So I think you're bringing up my presentation. I'm not seeing it up on the screen.

Lauren Solkowski: Yes, I'm pulling it up right now.

Sharon Fusco: Okay. All right. So, you know, obviously we were asked to talk to you on what are the big picture changes and sort of how did we get there and talk some about our relationships that we built with the healthcare system and so forth. So I will try to do that by really telling you kind of our story from COAs perspectives sort of what happened to us and to do that I'm going to have to take a time machine back to about 2006, but I want to start by just giving you sort of a sense of who we are. So if you want to advance a couple of slides that would be good.

The Council on Aging is - the next slide - yes, we've been around for about 41 years. We were the, you know, very AAA. We've got a fairly large region. Five counties in Southwest Ohio. And if you could advance to slide 5. Our core functions, you know, we administer tax levy funding, Medicaid waiver funding. We do services like pre-admission review, care management, care coordination, care transitions. All of the other functions that go with being in Area Agency on Aging.

We are one of the largest non-profits in our area and have a pretty good network and about \$100 million coming in annually that we are working with to serve our clients. And we serve I think on the next slide, you'll see that we serve about 20,000 clients a year and you can see some of the statistics. So this is who we are in terms of an agency. But as I said our story really starts in 2006 when we really started seeing some changes in our system. And if you go to slide number - I'm going to skip a couple of slides in the interest of time and you can't see my son's little picture but okay. Let's - yes.

So what I want talk to you about is today is how did we move from sort of this scared Lucy picture to where we are today. And I wouldn't say we've quite

achieved this free-wheeling picture of driving the road and life is easy, but we are certainly closer to that than we were when we began this quest.

So our current situation - next slide - is that it does feel a little bit like this picture from Lucy and we're sort of scared to death, but we aren't really standing still and waiting to see what happens. It's more like trying to catch a bullet train and we feel like we're just one step of what that bullet is. And that bullet really is how things are changing in the medical world really impacting us as COA. And we saw this bullet coming back in 2006. So if you'll go to the next slide.

And in 2006 our organization is pretty much what I would describe sort of a sleeping giant. We have very much a family orientation. We thought we were number 1, but when you ask us what we were number 1 in we really couldn't say. We really didn't have the data to back that up. It was just something that we felt that we were.

And we were more about advocacy and heart in terms of how we viewed our role than we really were about budget and business operations. And this culture really permeated throughout our organization. So we were very much a business as usual. We're just going to do what we've always done for the last 40 years. And when our new CEO came on board she took a look around and she saw some things that were pretty scary in our network. Next slide please.

The environment that we were in in 2006 was that we saw managed care taking its first run at our passport funding which is our Medicaid waiver funding and represents about half of our budget. And there was a huge, huge desire for us to also at the same time reduce our Medicaid spending so that was coming down from the state level. And there was an increased

competition just across the board not only in our industry, but in other industries for scarce resources.

We found that, you know, traditional fundraising, you look around and you see how these resources are tight. That, you know, we saw that happening. We saw more and more competitors in our market who wanted to do what we can do and believe that they could do it better and so forth. And this theme continued.

If I go back even just a couple of years those themes continue where the state is taking big budget cuts at our program and there was a lot of advocacy work that we had to do to maintain our funding. And the state at that time also became approved to do a dual (demonstration) looking at Medicare/Medicaid waiver services and turning our role over to managed care companies. And so we looked at this environment and said this is pretty scary stuff. We've got to change and so those things were happening. Next slide please.

In a nutshell the bottom line for us was that we could see our funding streams changing. In the past it was all cost reimbursement. Every contract that we had whether it was for our tax levy - we had property tax levies to support Elder Services here and we managed those and those are all cost reimbursement. Likewise our Medicaid waiver, all cost reimbursement. And we knew that that was - we could see that that was changing.

Presently we are starting to see Fee-for-Service is here in our marketplace. We do have a care transition grant that we are paid Fee-for-Service. When duals project goes live, we will be paid on a per client basis to provide services and we will be paid by a managed care company. So that's a big change for us. And we know in the future that in order for us to survive we will be selling our services on a per unit basis.

It is very likely that our payments may also include outcome and performance based incentives and that it will be to private payers, to managed care companies, to hospitals, to any wide variety of customers. So we know that that's where we're headed.

And so our biggest question - next slide please - is can we compete. We have that question in 2006 and we have it in 2011 and we have it today. And, you know, when you have a history of being a monopoly in terms of providing these services can we change fast enough. If we even had a, you know, I said we were a sleeping giant. We have that entitlement mindset that we of course will be the ones who will receive the funding and that we're very quickly learning that no we have to compete for the privilege of providing the services that we provide.

And our competitors are changing where they used to be maybe other non-profits or other home care providers or who thought that they could also do care management.

What we realized is that no it's actually companies like managed care companies in the united healthcare world and the (Millenias) and so forth. And so we need to be thinking about what are the right products. How should we be positioned in the marketplace? What relationships should we have. And it was great to hear Roseanne talk about, you know, thinking about those relationships and thinking about your products and services and so forth so we had those same questions.

And - next slide please - other things, you know, and the short story for us was that we had to prepare for the future and as part of that that we want to answer

- we needed to know that we could offer the highest quality services at a competitive price and maintain our market share and profit margin. Next slide.

So this is a question I often get from our staff which is profit margin. Really? You're really going to talk to me, I thought I joined a non-profit and we told them yes absolutely. If there's no margin, there's no mission. And so when we - moving forward we have to really understand how much our services cost and how much additional funding we have so that we can grow them and improve them.

And we had to dispel the myth that it's illegal for a non-profit to make profits. The bottom line and I try and make it really, really simple which is that non-profits can earn revenue as long as you're turning that back into your programs and services to provide better services to more clients, you're on the right side of the law with regards to that.

And I always put my little disclaimer on here just to make the CFOs happy because there's a lot more to it than that, but the bottom line for me is that. And you're hearing - off to the margin you'll see, you know, social entrepreneurship is really a new name for that mentality that says non-profits are going to find non-traditional sources of revenue.

They're going to move away from philanthropic to selling services, but there are non-profits that have been doing that for literally over 100 years. If you look at Goodwill and Girls Scouts and Boy Scouts and those are just examples of ways that non-profits play in the for profit market and are successful at deriving from that unrestricted revenue which is always our best friend. Next slide.

And there is more. There are other reasons to be thinking more about being competitive and thinking about market share and margin. The market that we're in is a hot market. I never knew that when I joined this market, but it was going to be the market to be in and there's going to be a high demand for services but also a low supply of them. So there is some significant profit potential in that.

But as I indicated earlier there are many people who believe that they can do it better than we can do it. That they can do it at a lower cost and guess what? They can. They can do it better and they can make money on it. And so what we had to help people realize - next slide - was the bottom line was we needed to start playing to win. And it meant for us that we could - if we can do that we can continue to provide a high level of services to our clients and be innovative and really deliver the most for the least amount of money. Next slide please.

So when I think about the big picture changes that we've made since 2006, they really focus in four different areas sort of a traditional organizational development model - structure, people, systems, culture. And I also included in there relationships because some of what you asked today that it is the external part, the part outside of our organization that we needed to focus on. So there's a real strategic emphasis from our strategic plan. If you go to the next slide.

We had a focus area that said to strengthen and position the organization and under that you can see what we put in for some of the strategies that we would employ to begin to align our strategic plan with what we needed to do to maintain competitiveness. And so - next slide, I'll go kind of through those four areas with you and give you some real tactical things that we did from our organization.

And the first one was to really think about our organizational structure. We did a massive restructuring about three years ago, four years ago and removed some extra layers if you will of supervision. We did a high focus on making sure that the departments that we had were giving us some true value in the things that we would need.

And one area was the area that I currently manage was birthed out of this reorganization and it was the business results and innovation where we really focus on - we have teams focusing on analytics, and quality, and project management, business development. Really making sure that that's a part of our structure.

We also put in a very innovative human resources team. Our human resources director actually assisted the executive level and that's really important for us because we need that person to be driving the culture and also be working making sure that we're structuring the organization and always keeping that human element at the forefront of our strategic planning. So we put it at that executive level for that reason. And she has done just an awesome job of coming up with some innovative ways for us to be thinking.

We use self-directed teams. We have very few managers. We have team educators. We have very creative staffing structures. Additional duty and contract employees and things like that that allow us to keep our costs low. And the quality of our service is high.

So the picture off to the left of the funky little bus is all about making sure that we are creating the right bus to carry the people that we need. And so that leads us right into having the right people on the bus. If you'll turn to the next slide.

And the issue here again it's do you have the right people. Do they have the right knowledge, skills, and ability to do what you need them to do? And so we have a lot of focus on making sure (1) we have a fairly, you know, robust HR process whereby we make sure we bring the right people in. We screen them well. We develop them. We have certain organizational capabilities that we focus heavily on and make sure that people are in the right seats on the bus. It's kind of a common theme that you hear over and over, but it certainly was a part of our strategy. Next slide please.

We also wanted to make sure that we have the right systems in place to maximize the resources that we had. And you heard Roseanne talk a little bit about making sure you understand your costs and I couldn't agree more. And I will say that this understanding of costs really drove a huge cultural change for us and I'll show you some of the ways that we did that in a minute.

But we needed to - (1) we need to fully understand how each position in our organization is paid for. We had to have conversations between program people and finance people to say this is the work that needs to be done. This is how it's designed, but here's all the things that go into making that work happen. Here's all the people that go into it, here's all the other resources that go into so we could really understand on a per unit basis what that cost looked like.

And that's been actually work that has spread from our organization across our state because our whole AAA network in Ohio has been doing a lot of work understanding pricing and costs and that kind of thing and we trained everybody. We trained the directors, we trained our staff, everybody so that they understood it and that's been a big factor in driving our culture change.

We also have a pay performance system here and all of us have major work objectives and we are paid according to our achievement of those objectives. And then there's been a huge emphasis on technology and I would say this is the area that we continue to struggle with, but we have put in a fairly robust business intelligence system.

(SASS) Business Enterprise Guide does a lot of our analytics and makes them very accessible to our managers and to individual staff people so that they can see what their performance is. We can see what it looks like at a department and an organizational level.

We also have, you know, a very robust electronic care management system to help us track information and then that information actually gets into our business intelligence system so that we can analyze the data that we can capture from that. So those things work in tandem with one another. And then we do - we have other systems in place. Just as an example like (VPN) being able to work from home making ourselves very mobile, very agile as an organization has worked really well for us. Next slide please.

And I can't emphasize enough and I think if I made any under estimation in terms of the change, one that needed to be made, and how difficult it would be would probably be the culture area. It's the one area that keeps kind of sneaking up and catching me.

And so if I were to give any advice to anybody, it would be to focus on creating the culture. Don't let the culture evolve on its own. Be intentional about how you go about creating the culture. And some of the things that worked really well for us were (1) we drove home the idea that you don't make decisions if you don't have the data to support it.

So back in 2006 when we said we're number 1, we didn't know why. Today if we say we're number 1, we got the data to prove it. And so we make decisions and we always are very intentional about going out and getting data. Right now our big focus is on positioning. How are we going to position our organization for the future and what products and services do we need to have.

We just invested a lot of money in market research to help us understand what it is our clients want from us and they want it packaged and what our customers need from us. So we made an intentional investment in that.

This focus on outcomes and getting it down to quality results and that kind of thing has been, you know, we had started with pay for performance and it continues and so even all of our chart reviews and things like that are more focused on the outcome and on the quality improvement we can get from that. That's all cultural stuff that we're still in the throes of changing that culture, but it's starting to happen.

And then the use of these cost models and price models I have alluded to before making sure that - that can actually drive a lot of your culture change. If you go to the next slide I'll give you a really good example of that. We developed this list - I give full credit to my accountant (Carl) who developed (Carl)'s grocery store model - back when we were trying to talk to staff about why it was important that they hit as many care transitions interventions as they could in a month. Why it was important that they hit their target of having a full case load of that.

And so we actually took our costs model - our price model and we flipped it over and said okay if you want a new - a telephone or a cell phone this is how many - this is what it cost and this is how many interventions it takes to

support that phone call. And that was a huge - that was an eye opening day for our staff. It started to click with them that our world had changed.

And what we recognized as leadership was that the message it had to be presented in that kind of a way. It had to be made very, very tangible for our staff in order for them to start realizing that geezers I play a really, you know, my volume matters. In the past we had brought in our best care manager into our care transitions program.

Our care transitions program was the first program that we had where we were paid on a Fee-for-Service basis and we thought using our best care managers would make it automatically successful. What we didn't anticipate was this culture thing because they came in with this mindset of I need to spend time, I need to build lots of long-term relationships with my clients, and so forth.

But in the care transitions program that's not what you need. You need a 30-day intervention that's a short-term relationship. You need to sell the program because people aren't automatically going to want it. And so there was an element of selling.

And so the people that were high performing in their traditional role when it got flipped over to a Fee-for-Service struggled and it was because of these kinds of issues. Not understanding the connection between I got to hit my monthly target and our ability to make operations run. So hopefully that's a little bit of a help.

So the next slide is really on building those right relationships and the right partnerships and I liked Roseanne's start where you know people. That's huge. I would also say start with the partners who are the influencers.

In Cincinnati for us we needed to build a bridge to the healthcare community. We went to our local hospital association. They were the influencers in our community. We do the same things though in other areas. For example we need to build relationships in our counties and so for each county we sort of have a map of who are the influencers. Who are the people that can bring the other people to the table? And we've pinpointed them and strategically figured out how to build relationships with them.

So for example in Clermont County, it needs to be with Clermont Senior Services. In Warren County, we need to be with - they've got a business association that everybody attends. That's where we need to be. And so it's understanding who those people are and how to put yourself around them.

Other things that have helped with that as we moved forward with our role with the health council, it was defining those rules and responsibilities. What are you going to do versus what are we going to do and making sure that we're not stepping on each other, but rather working in tandem.

And I loved the example that Roseanne gave about starting small and starting with a pilot and being willing to invest something in that. That is exactly how we got our care transitions program up and running. It's how we're building partnerships and care coordination in the city. We're piloting them, showing that it works, investing our own funds in that with the idea that we'll get that back because we're going to be able to price this product at a margin that is going to cover our startup, our research costs, and move us forward and be able to grow and spread it.

And always working towards integration. That was just a lesson that we learned that, you know, it's one thing to put something on paper and a flow

chart that says this is how we're going to work together. It's something entirely different to get it truly integrated and that's where the real work is.

You know, having quality improvement teams where they're cross functional and they can talk about issues and really talk about what - how to get this - whatever this new service is integrated into the bigger healthcare system. That's where our work really needs to be focused once we figure out what the partnership is. And again its lots of TLC, lots of communication, and lots of time and energy spent on the relationship itself. So with that I think I've got one more slide which is just any questions or anything like that and as my husband said that tape is always (unintelligible) any question.

Lauren Solkowski: Thank you so much Sharon. I think - I know we're right about 3:00, but I think we do want to take in a couple of questions so I'm going to turn it over to (Michelle) to open up the lines and queue up a few questions. In the meantime while she is doing that we had a few come in through chat. The first being have either of you seen integrative or holistic health type services showing often any of these programs such as acupuncture, herbology, etcetera?

Roseanne DiStefano: This is Roseanne. I really haven't. I think the only thing that in terms of evidence-based programs that we offer that touches on that is the Tai Chi which teaches both balance and wellness. But there's not been too much evidence-based done with those programs to my knowledge and so it's hard to bring the data or to show the return on investment.

Lauren Solkowski: Okay great. Oh go ahead.

June Simmons: My experience would be go to the (unintelligible). I haven't seen it with this particular population. I've seen it in others, but not in this particular one.

Lauren Solkowski: Okay and then...

((Crosstalk))

Coordinator: I'm sorry to interrupt. I just wanted to let people know if they would like an open line they can press star 1 on their touch tone phone and make sure they're unmuted and then record their name when prompted. Thank you.

Lauren Solkowski: Thanks (Michelle). And then we have another question here for Sharon. It sounds like you are using some of the good to great strategies for non-profits. Do you think this is a good research for the group?

Sharon Fusco: Oh absolutely. It was actually - I wasn't a part of the actual original restructuring, but it was required reading as I understand as they went through this so I do believe that was one of the resources. And yes I do think it's a very good resource.

Another book that I think is an excellent - actually there's two other books that I would recommend, they are both by (Lafian) and one of them is called Play to Win and the other one is called the Non-Profit Strategy Revolution. I've got it in my desk, I'm just double checking that that's the name. Yes the Non-Profit Strategy Revolution and it's by (David Lafian). And both of those books I think have really good - for non-profits who are entering the for profit market and can give you some really good information.

Lauren Solkowski: Excellent. Thank you. And then (Michelle) have we had any questions come in?

Coordinator: You do have two questions. Art your line is open.

Art De Loreto: Yes, hi folks. This is Art De Loreto from the Pennsylvania Association of Area Agencies on Aging. It's good to be with you all. And Sharon it's very interesting to hear your presentation. We had an opportunity as you might know to hear from your CEO Suzanne Burke last week at our membership meeting and it's really insightful to gain both of your perspectives.

We hear a lot as we look at business capacities and business acumen about, you know, the change of culture and you touched on a couple of things for that. I'm just wondering one of the things that we understand when an organization goes through cultural is that there is some down side and the downside becomes what typically is called casualties. You know, certain staff either are unable to perform or maybe realize that their work is not what they originally signed on for.

From your experience how did you continue to affect your cultural change while being able to give the staff that were affected some sense of stability and security and if you will confidence in them dealing with the personal sides or organizational change - the fears, the worries, the doubts, the defiance? What did you - what do you recall were some of the things you were able to do?

Sharon Fusco: Well first I hope the perspectives were aligned. I have to say that. And you might have seen some similar wording here which is good because I think I stole some of her presentation for this. It's a really great question and it's not to be taken lightly. There is a down side in terms of - and I wouldn't say a down side, it's just as you shift your focus there are people whose personal value systems no longer are aligned with the organization's values.

And so they are placed - they're in a situation where they have to make a choice either they are going to change their value system or they're going to go to another position somewhere else. And we also saw that of course in our restructuring.

And I think the biggest think that helped particularly it started maybe with our restructuring, but it's continued as we've gone into a huge area of uncertainty. Our market is just changing so fast that it changes daily. So the biggest thing that we could do to help with fear is transparency so. And we were and have continued to be I should say very, very strategic about our employee communications. So when we went into our restructuring for example everybody heard the same message at the same time. That message was also transparent.

And as we continued to deal with the uncertainty that we have in the marketplace which is right now our biggest driver of fear, we are transparent. This is what we know, this is what we don't know. And we're not withholding anything so that they are always hearing kind of a consistent message from all of us as our whole senior leadership team were always on the same page or always on message.

And so - and we have meetings where we sit down and say to prep for meetings to say what is our message. What is our common message? What are the things that everybody, you know, that we need to share. What is happening, you know, and how do we best communicate this. So those would be the things that I would say.

And the other thing is you have to be okay and you have to make your management staff okay with the idea that they may lose some of their people along this path, but that attrition is necessary. I liken it to I've had to trim off a

bunch of vines off of my grapes this past week so that I could get a good grape crop to come out. That's part of - it's part of the process and it's not the most pleasant part, but it is part of it.

Art De Loreto: Very good. Thank you.

Coordinator: You have one more question from Leah. Your line is open.

Leah Eskenazi: Thank you. Roseanne and Sharon thank you so much for your presentations. They've been very informative. I'm Leah Eskenazi from San Francisco with Family Caregiver Alliance. And I was curious if you in any of the business models that or dealings that you had did you propose doing services directed to informal caregivers? And because often it's not part of the common discussion by healthcare providers.

Roseanne DiStefano: This is Roseanne, I'll jump in. Yes absolutely. I think working with the physicians around their patients. One of the things we do when we do an assessment they may identify somebody at risk, but they don't know why. And part of our assessing the whole situation is assessing the informal support, the strength or in some cases the problems around that. So it's very much part of the picture that the physician doesn't normally see and doesn't normally understand.

I would say in addition to that some of the evidence-based programs that we offer are focused on the caregiver to strengthen their resources and skills and that the physicians can be - are and again I'm talking physician groups, but it can be any healthcare provider - are very interested in empowering the informal support givers as well.

Sharon Fusco: I would echo all of that. But the addition that I would have is a little bit more of a business perspective on it. And the difficulty that I see is that everybody agrees that it's necessary, but nobody wants to pay for it.

Leah Eskenazi: Right.

Sharon Fusco: And that's the biggest challenge. I mean we, you know, we had for example we have a manual - a caregiver manual that we developed and published. But is there a market actually out there to pay for it. And getting that manual out to the people who need it and are they willing to pay for those kinds of things, you know, that's just not been something we - we tested that market and haven't been able to find it.

We tested with - in our marketing stuff we went out and we tested the concept of caregiver support and just couldn't get anybody (and) clients themselves necessarily interested in figuring out, you know, was there something that somebody would pay for or to get employers.

We several years ago approached employers about it and said hey you really need to think about this caregiver thing because guess what? In the State of Ohio \$17 billion a year you're losing in productivity hours because people are home taking care of their older adults. That's a huge profit issue - bottom line issue. And still couldn't get anybody interested in it in paying for it. So it's one of those things where I think if we can figure out how to package it in a way, you know, to make it profitable for us that would be awesome. But who's going to pay for it?

Lauren Solkowski: Great.

Sharon Fusco: And (I mean) and it's not that we don't do it. I mean we do caregivers assessments and we do education, but we figure out to fund those from the extra funding that we have. So, you know, it's something we're investing in even though there isn't anybody paying for it.

June Simmons: Yes, I agree. We've run into some of the similar issues. Thank you so much.

((Crosstalk))

Lauren Solkowski: I'm sorry. What was that (Michelle)?

Coordinator: I just wanted to let you know there were no more questions on the phone.

Lauren Solkowski: Okay. Thank you. And I think with that we are a little bit over our time so I do want to thank - many thanks to both Roseanne and Sharon for presenting on today's webinar.

This was very informative and I hope that our sites were - this is helpful for them. And also a big thanks to June and as well as the Hartford Foundation for sharing their announcement and we're thrilled to be working with them on this grant.

If there are questions that you did not get answered today, please feel free to email them to me and I will make sure that we follow up with you. And I think with that we're done. So thank you again to everyone for joining us today.

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