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A matter of mindset: CBOs must master “outside-in” thinking to partner up and deliver quality, cost-efficient care

By **Victor Tabbush**

Recent healthcare policy and payment reforms, such as Medicare’s Bundled Payments for Care Improvement (BPCI) initiative, the Hospital Readmissions Reduction Program and the Value-Based Purchasing Program, among others, share a common feature: each reform incentivizes financial and performance accountability on the part of medical providers.

Home- and community-based service providers (CBO) are well-positioned to partner with the medical care sector in these integration efforts. In this new payment environment, CBOs can reduce medical costs and improve health outcomes for potential clients and partners (hospitals, post-acute care providers, provider networks and insurers). Success in forming and implementing these partnerships requires CBOs to adopt an outside-in business mindset.

The Business Mindset: Adopting An Outside-In Orientation

To be an attractive partner to the medical sector, the CBO must become an “outside-in” organization, adopting an external orientation in its thinking and actions. The outside-in approach is driven by the belief that creating value for the partner is key to its success.

The “inside-out” approach, in contrast, is driven by the belief that the organization’s strengths are the foundation for a sustainable future. If organizations intend to be successful in marketing their services to the medical sector, they will need to shed the inside-out mindset. This prescription stems from recent work The SCAN Foundation has undertaken to build the business acumen of a dozen CBOs. The four symptoms of an “inside-outside” organization are described below.

1. Using terms that the organization itself understands, but are unfamiliar to the potential partner.

If CBOs are to be invited by medical partners to integrate service delivery, they first must avoid terms that, while standard in the LTSS lexicon, may be poorly understood and confusing to the medical sector partner. Acronyms used mainly within the LTSS sector, such as home- and community-based services (HCBS), community-based adult services (CBAS) and multipurpose senior service program (MSSP) may need to be avoided. Potential partners are not going to invest in learning the CBO language; theirs must be learned and spoken by the CBO. CBOs must

adopt and be fluent in the language spoken by partners. They must learn what is meant by return on investment (ROI), and why this metric is crucial from a medical partner's perspective.

2. Promoting their services and features rather than their benefits—and why these exist.

In its marketing efforts to potential partners, the CBO must communicate the anticipated outcomes of its services. It should not focus on the features of the service, or on the output from them. For example, for a CBO to cite to a health plan the large number of clients it has served is almost meaningless: persuasive power stems from providing evidence on the number of hospital readmissions that have been avoided. A CBO must adopt the customer perspective—identifying its problems and finding solutions. It must stress outcomes and benefits that are meaningful from the external perspective. In short, CBOs need to emphasize the “why” and not the “how” and “what” dimensions of its services.

3. Failing to see their organization the way others do.

CBOs generally will have a strong sense of their mission, their identity and how it is transforming. But that sense may not be shared effectively with external constituencies; perceptions held by others may be inaccurate and rooted in the past. A CBO will know its history and why it carries the name it does, but it may be a name that misleads and confuses the potential partner. For example, some CBOs' names have references to ethnic and religious groups and affiliations, but do not limit services to them.

A CBO may now regard itself as a business offering its services on a commercial basis. However, the prospective medical partner may still regard the CBO as a traditional social services agency providing free services. The CBO's communications, especially its website, must be up-to-date and provide accurate information to its constituencies. It may need to rethink and restate its mission statement, and even consider a name change to accurately convey its identity.

4. Pricing its services on the basis of its own costs rather than on the value created for partners.

A common and financially harmful symptom of an inside-outside organization is its tendency to base its price on its costs. After all, cost information is easily available internally, and costs should be covered. But cost-plus pricing generally is not recommended. The partner does not care what the CBO's costs are; they care about their own. Instead of cost-based pricing, the CBO should set price based on value (see sidebar on how this might work, below).

Unlike the ease with which cost can be determined, value is difficult to establish. The outside-in organization must look to the partner's goals and convert its success in achieving them into a dollar measure of value. Clearly, the CBO needs to understand the outcomes that drive value for the partner, must monetize these outcomes and set prices accordingly. The chief source of value creation is most likely the medical cost avoidance that the long-term services and supports achieve.

Summing Up the Outside-In Approach

Payment and policy reform have created many business opportunities for CBOs to partner with the medical sector. A crucial success factor is developing the right business mindset: an outside-in approach to its thinking and actions. This mindset is the foundation for business acumen.

An outside-in CBO adopts the language of its partners, identifies and addresses their problems, emphasizes benefits over features, ensures its external image and identity match to its evolving strategic intent, and prices its services based on the value they create. ■

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An Example of Demonstrated Value

The following example is from a program to transition discharged patients from the hospital to home. The motivation is to reduce 30-day hospital readmissions, for which it is assumed the hospital bears the full financial responsibility, averaging \$10,000 per readmission.

The CBO incurs a direct cost of \$200 per transition and, using a cost-plus pricing method, might charge the hospital \$250, with the extra \$50 to cover indirect expenses. If the program is successful in demonstrating the desired outcome—meaning a reduction in readmissions—this inside-out mindset method may leave money on the table.

Suppose, for example, that the service reduced the probability of a readmission by 10 percent. Then the value to the hospital of each transition would be 10 percent of \$10,000, or \$1,000. Conceivably, the CBO with an outside-in orientation could charge a fee in excess of \$250, one closer to the value its service creates.

—*Victor Tabbush*