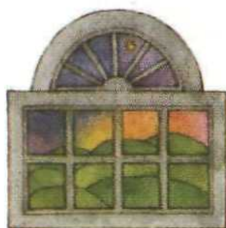


BUILDING TRUE COLLABORATIONS

A Senior Support Network Illustrates a Successful Partnership of Healthcare and Social Service Providers

BY BARBARA KILBOURNE & NANCY GIGUERE

In 1997 Catholic Social Services (CSS) of the Diocese of Scranton and Mercy Health Partners–Northeast Region joined forces to develop a senior support network for residents in the city of Wilkes-Barre and the Borough of Kingston, PA. This project is one of four sites of the Neighborhood-Based Senior Care National Initiative (see **Box**, p. 40). With funding for the first year from the Retirement Research Foundation of Chicago, the initiative is working to develop collaborations between Catholic health systems and Catholic Charities agencies. Its goal is to help poor communities meet the needs of at-risk and chronically ill older adults, while developing a model for use by social service agencies and healthcare systems nationwide. The initiative creates collaborations that supplement formal health and welfare systems and help older people continue to live in their communities.

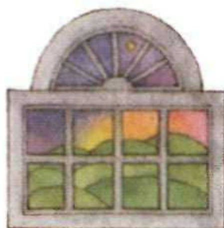
Collaboration involves the melding of different styles and languages, and there exists tremendous potential for misunderstanding. For example, when healthcare and Catholic Charities aging program administrators first met to discuss how they might serve older adults, each group was wary of the other. But through regular meetings, they learned about their organizations'

Summary The relationship between Catholic Social Services (CSS) of the Diocese of Scranton and Mercy Health Partners–Northeast Region, which joined forces last year to develop a senior support network for residents of Wilkes-Barre and the Borough of Kingston, PA, illustrates how collaboration grows out of cooperation and coordination of services. The network is a project of the Neighborhood-Based Senior Care National Initiative, which works to develop collaborations between Catholic health systems and Catholic Charities agencies to help poor communities meet the needs of aging persons.

Barriers to successful collaboration may stem from cultural misunderstandings, differences in organizational stability and decision-making processes, attitudes toward money, and even professional vocabularies. Organizations that trust and respect each other can overcome these barriers. The Wilkes-Barre project began simply, but its success established a pattern of cooperation between CSS and Mercy Health Partners, which led to further coordination of referral programs, development of community health profiles, and cross-organizational training. After nine months on the Wilkes-Barre project, CSS and Mercy Health Partners are now developing a Program of All-Inclusive Care for the Elderly (PACE).

Effective collaboration between healthcare providers and social service agencies is a long, sometimes difficult, process that requires organizational commitments of time and resources. Organizations must not yield to the temptation to take shortcuts to achieve short-term gains.

Barbara Kilbourne is the national project director of the Neighborhood-Based Senior Care National Initiative and president of Barbara Kilbourne, Ltd., a healthcare consulting company in Minneapolis. She is executive director of the Catholic Health Association of Minnesota. Nancy Giguere is a freelance writer based in St. Paul.

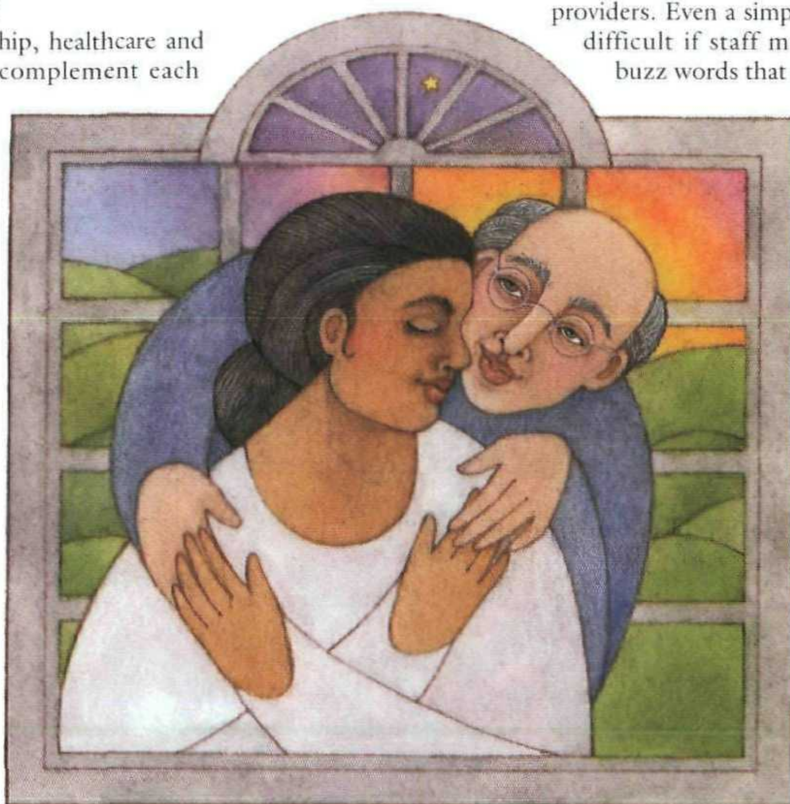


different working contexts and incentives. They realized that their missions were similar, and they began to discuss how to blend resources.

Collaboration goes beyond cooperating or coordinating with other organizations to achieve the goals of one's own agency or group. To achieve a true collaboration, participants must develop mutual goals, authority, and accountability for success, and share responsibility for risk and reward (see **Box**, p. 50)

BARRIERS TO COLLABORATION

In a cooperative relationship, healthcare and social service programs complement each other. Healthcare workers refer patients to the social service agency for nonmedical services such as housing, food pantries, in-home counseling, transportation, light chore services, or telephone support. Social service workers refer clients to healthcare screening and assessment programs, clinical support groups, prevention classes, health information and counseling programs, physician referral services, and, in the case of Wilkes-Barre, pastoral outreach and spiritual guidance from Mercy's Pastoral Care Department.



But social service agencies and healthcare systems operate very differently. Healthcare systems are in a constant state of change, and this affects collaborative work. First, working with an organization undergoing internal change can be confusing to members of social service agencies accustomed to operational stability. Second, the two agencies may make and implement decisions at different rates of speed.

Other barriers exist in the areas of funding and even vocabulary. Healthcare systems fund programs and start-ups primarily out of earned income, while social service agencies, which derive much of their funding from grants or government contracts, have little earned income. These differences lead to different attitudes toward money and spending. Social service agencies may see healthcare systems as "rich" organizations, but in reality these systems must follow rigidly prescribed guidelines in spending decisions.

Social service and healthcare personnel also speak different languages. The vocabulary of regulation and financing are different for each. Managed care terms such as "capitation" or "covered lives" may be unclear to social service providers. Even a simple conversation may prove difficult if staff members use acronyms or buzz words that are unfamiliar to their colleagues in the other organization.

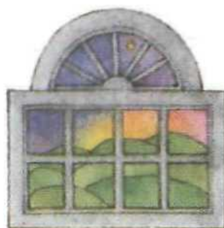
COLLABORATIVE BEGINNINGS

Luzerne County, PA, where Wilkes-Barre and Kingston are located, is second only to Dade County, FL, in percentage of adults aged 65 and over. Over one-third report limitations in mobility and self care; 30 percent do not own cars; nearly 70 percent of older adult households have incomes of less than $25,000, and per capita income for the county is $12,000.

The Wilkes-Barre project began very simply by recruiting volunteers as "friendly visitors" to older individuals who were at risk of institutionalization because of poor health.

Volunteers call on clients weekly and telephone them once or twice a week. Clients are also visited by a CSS case manager several times a year. Both clients and visitors fill out periodic questionnaires and clients who need additional services are referred to the Luzerne/Wyoming County Bureau for the Aging.

The success of the program enabled CSS and Mercy Health Partners to establish a pattern of cooperation. A friendship that developed between two members of the CSS and Mercy executive staffs facilitated the exchange of infor-



mation, and the fact that the two organizations shared several board members ensured that policy decisions included perspectives from both agencies.

CSS and Mercy Health Partners formed a Collaboration Advisory Committee with representatives from both organizations, including the latter's outreach coordinator. Other participants included the Luzerne/Wyoming County Bureau for the Aging, Mercy Home Care, and the Friendly Care Givers Program, which provides supportive services not funded by the Bureau for the Aging program. Project coordinator Aileen Ward established relationships that resulted in referrals from the parish nurse program in Shavertown and the pastoral outreach program in Wilkes-Barre. Ward recruited volunteers at local colleges, a Retired Senior Volunteer Program volunteer fair, and through the local American Association of Retired Persons office. She also met with residents of local subsidized housing to acquaint them with the program.

The two organizations shared several board members.

Ward asked local Catholic parishes to refer members who could benefit from the project and in return recruit volunteers and fund part of the program through social justice grants. So far, 11 parishes have joined the program.

PROJECTS OF THE NEIGHBORHOOD-BASED SENIOR CARE NATIONAL INITIATIVE

The Wilkes-Barre collaboration is one of four projects of the Neighborhood-Based Senior Care National Initiative funded for the first year by the Retirement Research Foundation of Chicago.

The New Orleans project brings together the Daughters of Charity, Catholic Charities, and the Office of the Social Apostolate of the Archdiocese. They will create a volunteer outreach program to identify isolated, at-risk older adults in the predominantly African-American neighborhood of Carrollton/Gert Town. The target population includes more than 4,000 people over the age of 65. Nearly one-third live below the poverty level; an equal number are without a telephone or a car in an area where public transportation is poor.

In Houston, Catholic Charities is partnering with the Sisters of Charity Health System to identify and prioritize health and social service needs and coordinate services for a primarily Hispanic and black population in a 42-square-mile area of inner-city Houston.

Catholic Charities of the East Bay and Catholic Healthcare West's Mercy Retirement and Care Center are working with local leaders to develop a seniors-helping-seniors program in the ethnically diverse Fruitvale district of Oakland, CA. The area includes 25 percent of the city's Supplemental Security Income recipients. Trained senior volunteers, supported by an integrated network of services, will identify needs in their immediate neighborhoods and work with project staff to find solutions.

The Neighborhood-Based Senior Care National Initiative was developed by the Aging Committee of Catholic Charities USA (CCUSA) and the Systems Directors of Aging Services network of the Catholic Health Association (CHA). Staff from both organizations provide assistance to the project. A room on the CCUSA website will be open to CHA and CCUSA members this fall with information about the project. CHA is the fiscal intermediary for the project. Both organizations will provide venues for information dissemination.

FROM COOPERATION TO COORDINATION

Once a pattern of active cooperation has been established, the partners are ready to embark on the second phase of collaboration: program coordination. This involves sharing the planning for specific projects and establishing formal communication channels between the two organizations. Each organization must be frank about the resources it will commit to a project and willing to make those resources available to staff of the partnering organization.

In Wilkes-Barre, Mercy Health Partners began to establish a community health profile from surveys of older people. The profile was shared with all participants and establishes a baseline against which to measure future changes in community health status. CSS, Mercy Health Partners, and the Luzerne/Wyoming Bureau for the Aging studied the possibility of developing a common assessment tool, but differences in tools and the legal requirements for the Bureau of Aging made this effort unfeasible.

However, the coordination of referral sources helped identify individuals who could benefit from programs such as the Friendly Care Givers and the Friendly Visitor program. Participants were referred from parish pastoral care programs, the Bureau for the Aging, the pastoral outreach program in senior highrises, and HealthSPAN, Mercy Health Partners' neighborhood-based program to assess the healthcare needs of families and assure access to services.

Other efforts fostered cross-organizational training. Ward attended a six-day training seminar given by Mercy Caring Partners to learn how to use its older adult assessment tool. Plans were developed for using this assessment by the CSS case manager. Mercy paid for a member of the CSS staff to attend, with a Mercy executive, three United Way conferences and learn more about managed care. CSS added community

Continued on page 50

LONG-TERM CARE ALLIANCES

Continued from page 49

into an agreement to operate as a "care system" in Scott County, one of the seven counties participating in the state's MSHO program. The Access Alliance will be accepting global risk for the total healthcare needs of its enrolled population, and expects to accept its first enrollee in the summer of 1998. The Access Alliance is currently planning its priorities over the next three years and seeking ways to raise the necessary capital from its organizations.

LESSONS LEARNED

Experience in creating alliances shows that developing a long-term care alliance is a sound strategy in the right circumstances. However, as these two case studies demonstrate, the structure of the alliance will differ depending on the vision of its members and the reality of the marketplace. Providers in Connecticut, where there is moderate penetration of managed care, opted for a more measured approach, while providers in Minnesota, comfortable with managed care approaches, pursued a more comprehensive and proactive approach to take advantage of immediate opportunities.

Several common lessons emerge:

- The trust that emerges from a similar sense of mission and values is essential to forming an alliance.
- Substantial development time is necessary to agree on common goals and gain comfort with the risk and uncertainty of such a major undertaking.
- Leadership rather than consensus is necessary to move an alliance from concept to reality.

Although long-term care alliances are a "work in progress," Catholic sponsored long-term care providers might consider partnering with other values-based organizations as a means of flourishing during these times of transition. □

BUILDING TRUE COLLABORATION

Continued from page 40

social service resource information to the Mercy Health Partners database, and Mercy Health Partners supplied a laptop computer so CSS case workers could connect to the database during home visits.

AN ONGOING PROCESS

As organizations reach this point on their journey to collaboration, one or both partners often begins to ask, "Where is the payoff?" In projects such as the Wilkes-Barre effort, the healthcare partner may wonder when it will begin to see the additions to its database reflected in its revenues. All four Neighborhood-Based Senior Care Initiative projects feel financial pressure. Since grant monies from the Retirement Research Foundation underwrite only the study of interagency collaboration, program funds for the actual project must be found locally.

If organizations give in to these performance pressures and cut back on their resource contributions too soon, they put their collaboration in jeopardy. Collaboration is a process to which organizations must commit time and resources. Above all, they must resist pressure to leapfrog the process in order to produce an immediate "product" before they establish a strong working relationship that can support the product.

Nine months into the Wilkes-Barre project, Mercy Health Partners and CSS decided to develop a Program of All-Inclusive Care for the Elderly (PACE). The partners are currently working through the regulatory approval process.

The PACE model was first developed to meet the financing and care needs of elderly residents of San Francisco's Chinatown (see "PACE: Innovative Care for the Frail Elderly," p. 41). It focuses exclusively on the frail elderly, emphasizing their independence and dignity. An interdisciplinary team of providers manages a comprehensive package of services. Financing is based on capitation rather than fee-for-service.

The PACE model fits well with the mission of both CSS and Mercy Health Partners, who are committed to serving frail at-risk elderly persons through community-based programs. PACE is also congruent with managed care efforts within the community because financing is based on capitation.

Collaboration does not occur overnight, but develops gradually as organizations move along the continuum from cooperation to collaboration. The Wilkes-Barre site has, in fact, developed at a relatively rapid pace compared with other collaborations of the initiative. Once the partners in the Wilkes-Barre project succeed in creating a viable PACE site, they will have achieved a true collaboration, because they will have created a new entity which draws from all partners, but belongs to none. □

WHAT MAKES COLLABORATION WORK?

Researchers at the Amherst H. Wilder Foundation in St. Paul have determined that organizations most likely to succeed as collaborative partners are part of a community with existing models of successful collaboration; have a shared vision; trust and respect their partners; see the proposed collaboration as in their self-interest; share a stake in both the process and the outcome; communicate openly and frequently among themselves and with people outside the group; are willing to commit to concrete, attainable goals and objectives; and have an adequate, consistent financing base that supports their operations.

For more information, see *Collaboration: What Makes It Work: A Review of Research Literature on Factors Influencing Successful Collaboration,* by Paul W. Mattessich and Barbara R. Monsey, Amherst H. Wilder Foundation, 1992.