HHS Strategic Approach to Addressing Social Determinants of Health to Advance Health Equity

Community Care Hubs: A Promising Model for Health and Social Care Coordination

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the Administration for Community Living (ACL) at the U.S. Department of Health & Human Services

November 2023

The Office of the Assistant Secretary for Planning and Evaluation

The Assistant Secretary for Planning and Evaluation (ASPE) advises the Secretary of the U.S. Department of Health and Human Services (HHS) on policy development in health, disability, human services, data, and science; and provides advice and analysis on economic policy. ASPE leads special initiatives; coordinates the Department's evaluation, research, and demonstration activities; and manages cross-Department planning activities such as strategic planning, legislative planning, and review of regulations. Integral to this role, ASPE conducts research and evaluation studies; develops policy analyses; and estimates the cost and benefits of policy alternatives under consideration by the Department or Congress.

The Administration for Community Living (ACL) was created around the fundamental principle that older adults and people of all ages with disabilities should be able to live where they choose, with the people they choose, and with the ability to participate fully in their communities. By funding services and supports provided primarily by networks of community-based organizations, and with investments in research, education, and innovation, ACL helps make this principle a reality for millions of Americans.

Why We Commissioned This Report

The U.S. Department of Health and Human Services (HHS) envisions a future in which all individuals, regardless of their social circumstances, have access to aligned health and social care systems that achieve equitable outcomes through high-quality, affordable, person-centered care. This vision is based on the recognition, documented through a wide body of research, that unmet social needs can affect a wide range of health, functioning, and quality-of-life outcomes and it is aligned with HHS' Strategic Approach to Addressing Social Determinants of Health to Advance Health Equity. Other documents related to the Strategic Approach can be found here.

This report is being released in tandem with the U.S. Playbook to Address the Social Determinants of Health and an HHS Call to Action intended to catalyze efforts at the community level to address social needs through cross-sector partnerships across health care, social care, public and environmental health, government, and health information technology organizations. The report is the result of a two-year project that ASPE (in partnership with the ACL) commissioned RAND to undertake, to better understand existing approaches to coordinating health and social care services, with a focus on one particular model, community care hubs (Hubs). Hubs are community-focused entities that support a network of community-based organizations (CBOs) providing services to address social needs that can affect health outcomes. These Hubs support their members by centralizing administrative functions in contracting with healthcare organizations.

As part of HHS' approach to addressing social determinants of health,[1] agencies across HHS are implementing policies and programs to support community-led transformation to develop well-coordinated systems of health and social care, to better address unmet social needs. For instance, the Centers for Medicare and Medicaid Services (CMS) is implementing health care program payment policies designed to drive health care professionals toward routine screening for unmet social needs and, in some instances, allow payment programs to cover the cost of certain services to address housing instability, food insecurity, and lack of transportation. Such policies represent critical initial steps to addressing social needs identified in health care settings. However, without an organized system in place to facilitate referrals to social care providers, track if and when social services are delivered, and determine whether an individual's needs have in fact been met, there is a risk of building a potential bridge to nowhere. While well-intentioned, this falls short of achieving the underlying objective of improving the social circumstances that are impacting an individual's health. Backbone organizations that help facilitate coordination between the health and social care sectors, such as Hubs, can serve as the connective tissue within a community to ensure these needs are met.

[1] The U.S. Department of Health and Human Services defines social determinants of health as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."

Through the work of the first phase of this project, we set out to gain insights into the various forms of backbone organizations that exist in the field, including how they are structured, challenges they face, and approaches they apply to overcome these challenges. In the second phase of this project, we focused specifically on Hubs as a promising model with the potential to support CBOs in their interactions with the health care sector. We commissioned RAND to conduct a series of six case studies of a diverse set of Hubs to better understand: (1) how they may be structured, (2) approaches they use to incorporate community input into their decision making, (3) what types of organizations they partner with to achieve their strategic objectives, (4) the information technology infrastructures they employ to manage referrals, track service provision, and monitor outcomes to improve service delivery, (5) financing sources for their operations, and (6) policy changes identified by Hubs that would enhance their ability to operate successfully.

What We Learned from This Report

From the first phase of this project, we learned that there is an array of backbone organizations operating in various locations across the country that can facilitate coordination between health and social care providers. These include organizations that are operated by government entities, health systems, and CBOs stemming, in part, from the unique circumstances and histories of the local environments in which they operate. They vary in the processes by which they are governed, how they are funded and operate, their approach to care coordination, who they serve, and the nature of their interactions and relationships with other partner organizations. Key informants discussed the advantages of CBO-led backbone organizations because of their potential capacity to establish trust with both social service agencies and health care institutions, and their potential to elevate the collective influence of smaller CBOs when interacting with larger health care institutions. Informants noted that their success is dependent on their ability to align themselves with the collaboration needs of other stakeholders.

From the in-depth case studies of Hubs conducted in the second phase of this project, we learned that these Hubs varied significantly along a number of dimensions but shared a similar sense of mission to uplift the people in the communities they serve. Other common themes reported by the Hubs included being able to combine trust from the community with administrative and technological sophistication to interact with health care entities and that they empowered other CBOs to have a “seat at the table” with health care entities.

Among the Hubs included in our study, many of them had their origins in Area Agencies on Aging, which are state-designated agencies that coordinate and offer services, typically through a network of service providers to address the needs of older adults in specific geographic regions to allow them to remain independent in their homes and communities. However, a number of these Hubs have since expanded the types of populations they serve beyond the elderly, the types

of services they coordinate, and the geographic regions they cover. They reported having different types of relationships with the CBOs in their networks, which varied from direct interactions to working through a "network of networks" (i.e., coordinating with other CBO networks operating in different areas or serving different populations). How they identify individuals also varied, from directly identifying patients at partner health care institutions, to using claims data provided by health care partners to identify those who could benefit from their services, to receiving rosters of potentially eligible patients who have been recently hospitalized that might benefit from their services to ensure safe transitions back to their homes and communities. They varied in their governance models with different approaches to incorporating community input. They reported relying on different types of funding sources as they matured, often benefiting from startup funds awarded by foundations and federal grants and transitioning over time to receiving most of their funding from health care partner contracts in addition to ongoing sources of social services funding which enabled them to serve a greater proportion of individuals in need.

A common theme among the Hubs we met with was challenges related to interoperability of their information technology systems with those of their health care partners and member CBOs, often requiring manual data entry to share information across organizations. They reported that health care payers and providers generally have sophisticated information systems, while individual CBOs vary widely in their ability to report and share information. A number of the Hubs also reported not being able to obtain information on the health and health care of the individuals they serve beyond the information they receive for referral purposes, making it challenging for them to assess some of the ultimate impacts of the services they provide.

The Hubs suggested a number of potential actions that could help support their success such as:

- Establishing standardized contractual arrangements;
- Reducing the complexity of data collection and billing operations required by health care contracts;
- Providing funding for data sharing infrastructure;
- Developing guidelines for information sharing between health care entities and Hubs;
- Establishing standardized performance metrics and otherwise improving quality measurement; and
- Promoting alternative payments models that offer flexibility and accountability for the quality of service delivery.

Looking Forward

The conditions in the environments where people are born, live, learn, work, play, worship, and age affect a wide range of health, functioning, and quality-of-life outcomes. At the community-level, these social determinants of health influence a variety of individual social needs such as financial strain, unstable and poor-quality housing, food insecurity, lack of access to health care, and inadequate educational opportunities that can have consequential implications for health outcomes. Addressing these needs is critical to ensuring equitable opportunities exist for all Americans to be able to achieve their optimal health and well-being.

Over the course of the next year, HHS will continue to invest in Hubs through an ACL grant award for a Center of Excellence (COE) to Align Health and Social Care, which will re-grant funding to support the operational infrastructure of approximately 20 Hubs across the country. The COE and its grantees will also participate in an external evaluation of Hubs to further assess impact of this model. A Community Care Hub National Learning Community will launch in December, offering up to 30 organizations the opportunity to gain access to vital peer support, individual and group technical assistance from national experts, and up-to-date information on resources and initiatives aimed at furthering the capacity of Hubs nationwide.

Based on experience to date, community care hubs appear to be a promising model for coordinating health and social care services that has proven to be sustainable in practice and of interest to health care entities and CBOs alike. This model is worthy of further attention and evaluation to better understand the specific characteristics of Hubs that contribute to success based on their goals and within the context of the communities they serve.

Project Report

Approaches to Coordination of Health and Social Care

An Overview of Backbone Organizations and Key Takeaways from Case Studies of Community Care Hubs

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RAND Health Care

PR-A2895-1
September 2023
Prepared for the Office of the Assistant Secretary for Planning and Evaluation

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About This Report

The U.S. Department of Health and Human Services (HHS) is prioritizing efforts to coordinate health and social care services as part of its strategy for addressing social determinants of health. These efforts are aligned with other HHS policies that incentivize health care providers to screen patients for health-related social needs (HRSNs). *HRSNs* are social needs, such as lack of transportation or unstable housing, that can affect health outcomes. For patients screening positive for one or more HRSNs, better coordination between health and social care providers can help facilitate connecting such patients with relevant social care services that can address their needs. To better understand current approaches to health and social care coordination, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) contracted with the RAND Corporation to examine the innovative approaches to coordinating health and social care services. This report presents the findings of a two-phase project examining backbone organizations that coordinate health and social care service sectors. The first phase, performed in fiscal year 2022, involved an environmental scan of alternative models for coordinating health and social care services, whether based in the health system, government, or community. In the second phase, we focused on community-based backbone organizations, particularly an emerging model, known as a Community Care Hub, or Hub. *Hubs* are independent organizations that serve as a single point of contact between health care entities (including payers and health care delivery systems) and a network of community-based organizations that provide social services addressing HRSNs. To study Hubs, we conducted a series of six case studies, outlining similarities and differences in how Hubs address common challenges in coordinating health and social care services.

RAND Health Care

This research was funded by the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services and carried out within the Access and Delivery Program in RAND Health Care.

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Acknowledgments

We are grateful to our sponsor, ASPE, and we thank Amelia Whitman, Bisma Sayed, and Andre Chappel for their support and guidance on this project. We also appreciate the guidance and resources we received from other partners within HHS, including Kristie Kulinski (ACL), Kelly Cronin (ACL), Amanda Cash (ACL), Karen Hacker (CDC), Arleen Bierman (AHRQ/IOD), Aimee Eden (AHRQ), Samantha Meklir (ONC), and Ann Conmy (ASPE). We would also like to acknowledge Jessica Sousa and Sameer Siddiqi for their work on this project in fiscal year 2022. Finally, we would like to thank Len Nichols (Urban Institute) and Melony Sorbero (RAND), Paul Koegel (RAND), and Christine Eibner (RAND) for their review of this report through RAND's quality assurance process.

Summary

Coordination of Health and Social Care

As part of its strategy for addressing the impact of social determinants of health (SDOH), the U.S. Department of Health and Human Services (HHS) is prioritizing the coordination of health and social care services. This strategy is meant to address the historical separation between health care institutions, which provide treatment for medical conditions, and social care, which addresses health-related social needs (HRSNs)—such as access to safe and stable housing, nutritional diets, and transportation—in community settings. In recent years, a variety of policy solutions and interventions have been suggested or implemented to bridge the gap between these two sectors. To explore the landscape of approaches to coordination of health and social care, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) contracted the RAND Corporation to conduct a two-phase project. The first phase, conducted in fiscal year (FY) 2022, examined models of *backbone* organizations (defined here as organizations designed to coordinate care between the health and social care sectors). The second phase, conducted in FY 2023, focused on Community Care Hub (or *Hub*) organizations (a specific type of backbone organization that is of particular interest to ASPE and others in HHS).

Environmental Scan of Backbone Organizations

In the first phase of this study, we performed an environmental scan—which included a literature review and key informant discussions—to explore the variety of backbone organizations that have been implemented or discussed in the policy literature. The literature review covered peer-reviewed literature and grey literature. Key informant discussions were conducted with 14 individuals who either operate backbone organizations or who write about them as policy experts. The backbone organizations examined in the environmental scan can be classified into three groups: government-based, health system–based, or community-based. Government-based backbone organizations, such as the Anne Arundel County Partnership in Maryland, are situated within local government agencies, usually at the county level, from where they coordinate public health activities with health care entities and local communities. Health system–based backbone organizations, such as some Accountable Health Communities and the New York State Health Home model, are situated within health systems or health care payers, from where they identify individuals with HRSNs and coordinate community-based services to address those needs. Community-based backbone organizations, such as AgeSpan in Massachusetts and Partners in Care in California, are situated outside the health care system and act as unified administrative entities for a network of community-based organizations (CBOs) to facilitate care coordination with health care entities.

Across these three types of backbone organizations, four common issues were frequently discussed in the literature as major factors affecting their implementation and success:

- **Planning and governance** (decisionmaking structures of backbone organizations): Initiatives are governed by nonprofit organizations, leadership coalitions, or contractual agreements involving health care providers, payers, government agencies, and community stakeholders. Mandates stem from federal, state, or local priorities.
- **Funding** (the sources of public and private finances available to support the coordination of health and social care services within rules and regulations): Funding sources vary by organization, often combining federal funding from the Centers for Medicare and Medicaid Services (CMS) or the Veterans Health Administration with contributions from local health systems, agencies, and philanthropy.
- **Data infrastructure** (the challenges in sharing management, accountability, and patient care information between health and social care service systems that operate with different levels of resources and data privacy constraints): Lead coordinating organizations typically manage data, including electronic health records, service referrals, and SDOH data. Data-sharing arrangements differ, as does the accessibility of data to health and social care service providers.
- **Scope and populations** (differences in the services provided and the specific patient populations served): Health services that are coordinated include primary care, behavioral health care, dental care, obstetric care, health education, family planning, and more. Social services that are coordinated include housing, nutrition, public assistance enrollment, substance use treatment, and interpersonal violence support. Initiatives were often implemented at city, county, or regional levels, often in partnership with large health systems. They cover such populations as high health care utilizers, older adults, pregnant individuals, veterans, and those experiencing poverty or homelessness.

Six themes were identified from the key informant discussions:

- **Qualities of a good backbone organization:** Key informants highlighted the advantage of CBOs as backbone organizations because of their capacity to establish trust with both social service agencies and health care institutions. The success of CBO-based backbone organizations is contingent on aligning their qualities with the collaboration needs of different stakeholders.
- **Balancing stakeholder interests:** Effective backbone organizations must strike a balance between the requirements of social service agencies and health care institutions. The engagement of social service organizations as equal partners in decisionmaking was emphasized to counter the power imbalance between these entities, ensuring a fair governance structure that promotes coordination.
- **Managing data and standardization:** A significant consideration revolved around data collection and sharing. Challenges emerged in transferring information across varying systems used by health care and social service providers. Standardizing data collection and integration emerged as a key solution to enhance coordination. Discussions underscored the need for uniformity to facilitate program evaluation.
- **Funding challenges and longevity:** Key informants stressed limitations in billing for Medicare, uneven funding distribution between health care and social services, and the

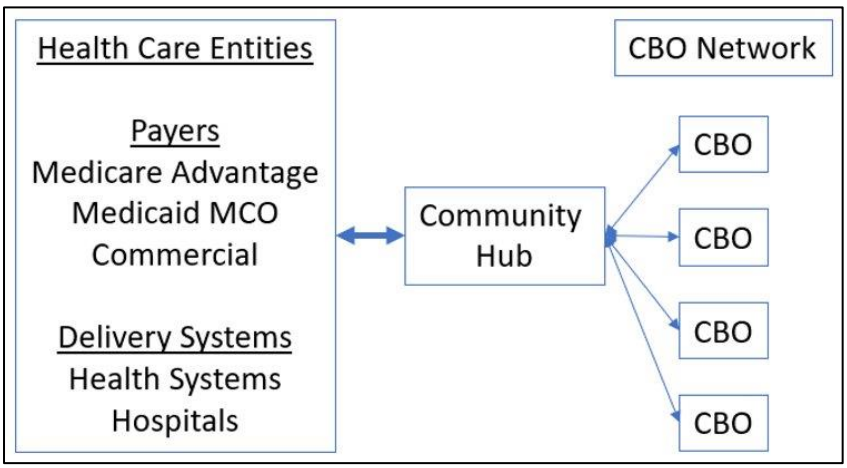
necessity of blending funding from multiple sources. Informants emphasized funding access for social workers and community health workers for their role in coordination.

- **Government support and policy influence:** Informants highlighted such mechanisms as Medicaid section 1115 demonstrations, which offer flexible funding. Leadership support at various government levels was seen as instrumental in fostering a conducive policy environment and garnering financial and administrative backing for backbone organizations.
- **Telehealth's evolving role:** Informants discussed telehealth's potential to enhance access and overcome barriers, especially during the COVID-19 pandemic. Informants noted the benefits that telehealth could have for remote screening and care and called for sustaining regulatory changes that expanded access to these services.

Community Care Hubs

In the second phase of this study, we focused on one type of community-based backbone organization, known as a Hub. *Hubs* are nonprofit organizations that provide a centralized administrative and operational interface between health care institutions and a network of CBOs that provide social services. As shown in Figure S.1, Hubs serve as a single point of contact between health care entities (which might be payers or provider organizations) and a network of CBOs that provide social services. To describe how Hubs are being implemented in practice and the factors that are influencing their operations, we conducted case studies of six Hubs. The case studies were used to compare Hubs with respect to their (1) development and structure; (2) community engagement and governance; (3) community, health care, and government partners; (4) health information systems; and (5) financing. Leadership of each Hub were also asked about potential policy changes that would enhance the Hub's ability to operate successfully.

Figure S.1. The Community Care Hub Model



Development and Structure

Hubs developed from preexisting organizations with experience coordinating health and social care and often had an originating or parent CBO. Five of the six Hubs were developed by Area Agencies on Aging (AAAs).[1] Several Hubs had also participated in CMS's Community-based Care Transitions Program (CCTP).[2] Reflecting this background, the services provided by the Hubs initially focused on coordinating care for older adults during hospital-to-home transitions for patients for a limited geographic area. Over time, however, the Hubs have incrementally expanded the populations they serve, the services they coordinate, and the geographic regions they cover. Although the Hubs share a general structure for linking health care and social services, there are differences in their operations. Some Hubs, such as VAAACares®, operate as a separate program within the organization that also houses the AAA from which it developed, although they remain formally separate from those AAAs. Others, such as Western New York Integrated Care Collaborative (WNYICC), were established as independent organizations. Hubs also differ in the extent to which they work directly with CBOs in their networks: Some Hubs have direct relationships with CBOs, some work through existing AAAs (creating a "network of networks"), and some have a combination of both approaches. Patient identification processes also differ: Some patients are identified by Hub or hospital staff during the patient's hospitalization, while others are identified through claims data or discharge lists received by the Hub from payers. In one Hub, CBOs can make initial referrals into the Hub, which can connect them with other CBOs or health care partners.

Community Engagement and Governance

According to our discussants, Hubs offer potential benefits for communities by providing opportunities to have input into health care priorities and care delivery organization. Hubs build networks of CBOs that are attuned to immediate community needs, especially in underserved communities (such as communities of color and immigrant communities). Governance boards are a key way to ensure community input on policies.

We found three predominant models of governance. In the first, Hubs relied on their parent or originating CBOs for their governance boards, without creating a separate governance board

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[1] AAAs are state-designated agencies that coordinate and offer services to address the needs of older adults in specific geographic regions and allow them to remain in their homes. AAAs can be public, private, nonprofit, or quasi-governmental organizations (Administration for Community Living, 2023). These organizations work to help older adults remain in their homes by helping coordinate their care and services. Many AAAs also run Aging and Disability Resource Centers, which are part of the No Wrong Door model to streamline access to long-term services and supports for key populations, including older adults, people with disabilities, and their families (Administration for Community Living, 2017).

[2] CCTP was launched by CMS in 2012 and aimed to improve quality and patient experience and reduce costs associated with care transitions. The five-year program provided funding to CBOs to establish partnerships with hospitals and other health care providers to improve high-risk Medicare beneficiaries' care transitions. Participants paired existing care transition models with additional social services and supports to reduce readmissions (Ruiz et al., 2017).

for their Hub activities. In the second model, a new governance board was created for the Hub, which included representatives from network CBOs and representatives with health care experience. In the third model, the Hub relied on several boards, with separate boards created for each participating county in which the Hub operates. According to Hub discussants, these models enable them to represent local community perspectives, prioritize needs, and enhance community involvement in decisionmaking processes.

Among the Hubs that we examined, none had a formal community governance board that was specific to the Hub, but all six had structured ways to incorporate community input into Hub policy. Several Hubs predominantly relied on advisory boards that do not have decisionmaking authority to gather feedback from constituents and members of their patient population. In addition, some Hubs had not expanded their community member engagement to the same reach as their Hub activities. Instead, their community member input predominantly came from individuals in the typical service area of their parent or originating CBO.

Community, Health Care, and Government Partners

All the Hubs maintain and support a network or multiple networks of CBOs that can provide a wide variety of social care services across the geographic regions in which the Hub operates. Hubs form membership agreements with member CBOs that authorize the CBOs to participate in network activities (such as training programs and policy meetings) and to provide and be reimbursed for services delivered to individuals covered by contracts that the Hub enters into with health care entities. The Hubs developed these networks starting with the CBOs they had histories of working with prior to becoming a Hub and expanding through recruitment of new CBOs. Hub leadership described the expansion process as following a "friends-of-friends" model, in which new CBOs were recommended by existing network members. Hubs emphasized the importance of vetting potential new CBO partners—through discussions with leadership and site visits—for the CBO's ability to provide and document care.

Hubs establish contractual relationships to coordinate social care with health care entities, including payers and health care providers. Payers such as Medicare Advantage plans, Medicaid managed care organizations, and commercial insurance plans were among their partners. In the case of at least one Hub, their contracts initially covered only specific populations, such as a payer's Medicare beneficiaries. Over time, according to our Hub discussants, the payers came to appreciate the value of the Hub's work and expanded their contracts to cover all health plan members. Hubs also discussed establishing formal contracted relationships with hospitals, health systems, and medical practices to coordinate care for high-risk patients. However, relationships with skilled nursing facilities, rehabilitation facilities, and primary care practices tended to be more informal. Some Hubs faced challenges in establishing contracting relationships with health care providers because some providers preferred creating their own internal programs to coordinate health and social care.

Hubs collaborate with government partners at the federal, state, and local levels. At the federal level, CMS and the Administration for Community Living (ACL) were mentioned as sources of funding, networking, and technical assistance. Several Hubs started under CCTP and continued with other CMS programs. Parent CBOs of Hubs interact with their local Medicaid offices, including through their state Medicaid waiver programs, which allow Medicaid to pay for home and community-based services for eligible individuals. Hubs also participate in various initiatives led by ACL (such as ACL's Community Care Hub National Learning Community) and connect with other Hubs through these programs. At the state and local levels, Hubs have formal partnerships or relationships with public health departments, city or county governments, state departments of health, Medicaid agencies, and housing agencies. These partnerships support Hubs by setting standards and providing access to services, but the relationships are often ad hoc without a dedicated office or agency focused on working with Hubs and their networks.

Information Systems

Much of the work of the Hubs involves managing information, providing a connection between non-interoperable information technologies on the health care and CBO sides of their work. Hubs have developed electronic record systems to coordinate and document care provided by the CBO networks. However, the interfaces between the Hubs and their health care partners remain complex and disconnected from the CBO networks, requiring, in many cases, manual data entry for billing or health information. These challenges are magnified by differences across payers' information systems and reporting requirements. Hubs also lack access to information on the health and health care of the individuals that they serve beyond what they gather and the information shared with them for referral purposes, which makes understanding the impact of their work on health outcomes difficult.

Financing

The financing of Hubs follows a common development sequence, starting with external funding for startup from foundations, federal grants during early development, and later transitioning to contract support for ongoing operations. Hub leadership emphasized the importance of transitioning from reliance on grant funding, which is unpredictable, to contract funding, which is more stable. Contracts generally provide for payments from health care entities, which the Hubs pass along to CBO service providers, keeping a percentage to support Hub operations. Most Hubs are paid following a fee-for-service model, but some are being paid through alternative payment models, in which fixed payments are made per patient or intervention. CBOs in the Hub networks receive payments for their services from the Hub, and they can blend and braid that funding with other sources of revenue for additional services they provide to individuals referred through the Hub. Blending and braiding of funding at the CBO level is also used by some Hubs to fund services not covered by the health care contracts held by

the Hub. A few Hubs noted that they were concerned that this practice might indirectly subsidize health care organizations that benefit from the care provided by CBO social care service providers that is not paid for through their contracts.

Policy Challenges and Suggested Opportunities Identified by Hub Leadership

In our discussions with Hub leadership, we asked discussants to identify policy changes that would enable them to operate more effectively and efficiently. Their recommendations address three general topics: information systems, payment systems, and other regulatory changes.

- **Information systems**: Discussants highlighted the need for simplified data collection and billing operations to better manage health care contracts. They suggested that the government should invest in data infrastructure for CBOs to enable direct reporting from service providers and proposed regionwide social care data platforms to standardize methods for referral tracking and increase transparency. Bridging the gap between health care and CBO information systems through guidelines for information-sharing was also recommended. Improved quality measurement using health information systems and standardized performance metrics were seen as beneficial for assessing care and enabling alternative payment models.
- **Payment arrangements**: Overall, Hubs made two financing suggestions: (1) providing startup funds for network development to address information technology (IT) development and initial staff hiring and (2) promoting alternative payment models for Hubs to offer flexibility and accountability for quality and outcomes of social care services. Federal and state policies were seen as catalysts for shifting from fee-for-service to alternative payment models.
- **Other regulatory changes:** Hubs proposed standardizing contractual arrangements and workflow between Hubs and health care entities to bring consistency and predictability to their operations within regions and states. From the Hub perspective, standardized contract arrangements would reduce the burden of developing new contracts with each health care entity with whom they work. The Hubs also raised the idea of setting quotas for minimum referrals from health care entities to Hubs (based on anticipated need) to better predict caseload size. One Hub also raised a concern about a proposed federal rule that would require AAAs to disclose details of contracts with health care entities to State Units on Aging. Because those contracts include proprietary information covered by nondisclosure agreements, this rule would require separation between Hubs and AAAs, which would be a costly and wasteful process, according to our discussant.

Conclusions

The following are our general conclusions across both phases of the project:

- **Alignment, facilitation, and coordination:** Many backbone organizations, including Hubs, aim to fulfill three functions—alignment, facilitation, and coordination. *Alignmen*t involves developing shared knowledge and norms across a group of internal partner organizations. In the case of Hubs, this would involve aligning among CBOs within the network about what kinds of care and assessments are expected, which can improve the

capacity of CBOs to address complex needs. *Facilitation* refers to the development of protocols and pathways to provide concurrent care by multiple providers, while *coordination* involves actively managing complex care at the individual level. The degree of alignment that can be achieved may be affected to a certain extent by the type of entity that is serving as a backbone organization. The strength of Hubs, compared with other types of backbone organizations, is related to alignment (i.e., their ability to organize networks of CBOs and provide the necessary bridging services that enable coordination of care across sectors).

The following are our conclusions specific to Hubs:

- **Challenges of community involvement:** Engaging the communities in which patients live is an important component of addressing HRSNs. Hubs differ from other backbone organizations by being located outside the healthcare system and having strong connections with CBOs. However, even for the Hubs, formalizing governance structures and including community representatives in setting policy priorities remains challenging. Additionally, a one-way referral flow from health care entities through the Hubs to CBOs is common, limiting the ability of CBOs to influence care for individual community members.
- **Hubs face familiar challenges:** The literature on backbone organizations consistently highlights challenges that these organizations face with respect to IT and financing. Challenges related to IT and financing are common in Hub operations. The lack of quality measures hinders accountability and the ability of Hubs to negotiate more flexible payment models.
- **Lessons for future studies**: Further investigation is needed to understand the impact and role of Hubs and other types of backbone organizations in health and social care coordination. Given the focus of Hubs on high-cost, medically complex patients, evaluations of their impact should focus on outcomes with clear relevance to this population. The observations from this study come primarily from six case studies, supplemented by an environmental scan and key informant discussions, so results might not generalize to other organizations and settings.

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Chapter 1. Community Care Hubs and Integration of Health and Social Care Services

As part of its strategy for addressing the impact of social determinants of health (SDOH), the U.S. Department of Health and Human Services (HHS) is prioritizing the coordination of health and social care services (De Lew and Sommers, 2022). The approach recognizes that health care, narrowly conceived, is limited by its focus on treatment of specific medical conditions, while the incidence and prognosis of most medical conditions is powerfully influenced by the social conditions in which people live and work (Gómez et al., 2021). Historically, health care institutions have not had the capabilities or resources to address health-related social needs (HRSNs), such as access to safe and stable housing, nutritional diets, and transportation. Integration of health care institutions with social service agencies, which directly address HRSNs, is seen by HHS as a critical approach to improving population health, particularly for low-income and disadvantaged populations, including Medicare and Medicaid beneficiaries (Chappel et al., 2022)..

The coordination of health and social care services faces numerous challenges (National Academies of Sciences, 2019). The health care industry is increasingly characterized by large-scale payers and delivery systems that operate in multiple states or across large regions. These entities operate in a highly complex regulatory environment using sophisticated administrative systems and information technology (IT) to manage clinical care and business processes. Relative to organizations in the health care industry, the organizations that provide social services tend to be small, community-based organizations (CBOs) oriented toward service to their local area and responsive to its needs. These organizations frequently lack the technological, administrative, and financial means to conduct business in the health sector. Moreover, the social services sector in any given geographic area tends to be fragmented, populated by multiple organizations with diverse constituencies, capabilities, missions, and resources, which challenges health care organizations that require standardized service provision at scale.

Given these challenges, there is great interest in innovative institutional arrangements that can bridge the gap between health and social care services, aligning across organizations to facilitate coordination of care for individual patients. For instance, the Centers for Medicare and Medicaid Services (CMS), through section 1115 demonstrations, Medicare Advantage supplemental benefits, the Merit-Based Incentive Payment System, and other programs, is promoting routine identification of HRSNs in health care settings and, in some cases, providing for coverage for services to address transportation, food insecurity, and housing issues. The Administration for Community Living (ACL) and Centers for Disease Control and Prevention (CDC) are using grant programs to support development of infrastructure to connect health and

social care sectors. ACL will be funding a new Center of Excellence to Align Health and Social Care with up to 20 competitive subawards. To help assess SDOH at a population level, the CDC has provided states with an SDOH module for the Behavioral Risk Factor Surveillance System. The Office of the National Coordinator for Health Information Technology (ONC) is supporting SDOH data standardization, such as the United States Core Data for Interoperability, to facilitate effective cross-sector referrals and person-centered care.

Investigating Backbone Organizations

One of the organizational strategies for bridging health and social care that has developed in recent years involves the use of a *backbone* organization, an independent organization that provides the infrastructure to connect and facilitate interactions between health care entities and social care providers in the community. In the first phase of this project, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) contracted with the RAND Corporation to conduct an environmental scan to identify best practices in implementing and operating health and social care service coordination efforts at the local level. The environmental scan consisted of a literature review and semistructured discussions with key informant practitioners, policymakers, and experts.

The literature review of academic and grey literature provided a high-level summary of initiatives that coordinate health and social care services. Within the literature review, seven categories of highly relevant health care and social service coordination initiatives were identified in consultation with ASPE: (1) Accountable Communities for Health; (2) Medicaid Accountable Care Organizations; (3) Community Integrated Health Networks; (4) shared stewardship for wellbeing, equity, and racial justice; (5) Medicaid care coordination for whole-person care; (6) maternal care coordination; and (7) Pathways Community HUB. Reviewing these categories of health and social care service coordination initiatives revealed a variety of models for backbone organizations based within the health system, government, or community and shared characteristics in the areas of planning and governance, funding, data infrastructure, and scope and populations covered.

Informed by the literature review, we then conducted a series of semistructured discussions with 14 key informants drawn from backbone organizations and academic experts who study how these organizations work. From these key informant discussions, several key themes emerged. One key distinction that emerged from the environmental scan was where the backbone organization was based: government, health system, or community. Key informants described that it was advantageous to have a CBO that has the trust of social service providers serve as the backbone organization instead of an organization based in the government or a health system. Key informants also emphasized the need for CBOs to have an equal voice in the network to address the power differential with health systems. The next key considerations discussed by informants were the importance of data collection, sharing, and standardization, which are key

for coordination and delivery of services. Additionally, key informants described the challenges that backbone organizations face in finding sustainable, sufficient funding. Typically, funding comes from health care payers, compensating for the reduction in health care costs produced by the social services. But because social services represent a limited set of payment mechanisms, backbone organizations are forced to braid and blend these funding across a variety of sources. Relatedly, key informants discussed the role of governments in successful backbone organizations. For instance, several informants stressed the important role that section 1115 demonstrations have played in allowing more flexible use of Medicaid funding. The final key theme from the key informant discussions was the potential for telehealth. Allowing for health and social care to be provided outside in-person visits can increase access to screening and services, as evidenced by the relaxed regulations on telehealth services implemented during the COVID-19 public health emergency.

Overall, the results of the environmental scan describe a variety of models for backbone organizations that coordinate health and social care services and the common issues that affect their implementation and success. The second phase of the project built on the results of the environmental scan to explore select backbone organizations in greater depth through six case studies. Following from the results of the environmental scan, the case studies focused on backbone organizations based in the community that coordinate health and social care services, otherwise known as Community Care Hubs.

Case Studies of Community Care Hubs

In the second phase of this project, we conducted a series of case studies of one type of community-based backbone organization of particular interest to ASPE, known as a Community Care Hub, or Hub. *Hubs* are nonprofit organizations that provide a centralized administrative and operational interface between health care institutions and a network of CBOs that provide social services. As a centralized administrative and operational interface, Hubs offer a promising strategy for coordinating health care institutions and CBOs that provide social services (Chappel et al., 2022; Dutton et al., 2022). The health care institutions that Hubs work with include public payers, such as Medicare Advantage plans or Medicaid managed care organizations (MCOs), commercial insurance companies, health care systems, and hospitals. The CBOs tend to be a diverse set of organizations, each of which that operates within a limited geographic area. Collectively, the network of CBOs provides a wide variety of services, including housing, in-home meal services, and transportation.

Hubs aim to address the misalignment of the health and social care services sectors by providing a single point of contact between the health and social care services sectors. From the health system perspective, the Hub offers a single agency that can provide access to an entire network of CBOs rather than having to manage relationships with each individually. Health systems can thus offer social services to patients who are likely to benefit from them—through

reduced acute care utilization and improved quality of life—without taking on the task of directly providing the services or contracting directly and separately with many CBOs. Moreover, the Hub can be held accountable for reporting on service provision and quality measures (e.g., Were the patient's social needs met?) in ways that meet the contractual obligations of health systems. The reporting process is thus much simpler than it would be if the health care systems were to work individually with each CBO.

From the CBO perspective, the Hub provides a larger and more predictable source of referrals than the CBO would have if it relied exclusively on community-generated referrals. The health care partners are systematically identifying individuals with needs for community-based services and referring them to the Hubs. The Hub also provides a more sustainable source of financing, given that many CBOs rely heavily on grant funding. Through the Hub, the CBOs establish working relationships with health care entities without having to negotiate on an individual basis with much larger institutions or make large investments in their own administrative capacity. Hubs can also take on administrative functions, such as billing, that would stretch the capabilities of CBOs on their own. Importantly, for both health care entities and CBOs, the Hub is a "trusted broker," an independent organization without a competitive financial interest (Nichols and Taylor, 2018).

By facilitating access to a network of social care providers for patients with HRSNs, Hubs have the potential to improve a broad variety of health outcomes. For patients with complex medical conditions, better access to social care services can enable them to live comfortably in their homes and communities, avoiding health crises, visits to emergency departments, and hospitalizations. Community-based social service providers are also in a position to conduct comprehensive assessments of individuals' needs in their home context, giving them the ability to identify and address needs that would not come to the attention of medical providers. These assessments also enable a more tailored approach to addressing an individual's needs, including accounting for the specific barriers that individuals face, such as lack of access to healthy foods or transportation to medical appointments.

To examine how Hubs are currently operating across the United States, we conducted a series of six case studies. The Hubs were selected with input from federal partners from a list of Hubs currently participating in a national learning community supported by ACL. Hubs were selected to include different regions of the country, sizes, and stages of organizational development. One of the selected Hubs is still in its planning stage, two cover specific regions within their states, and three have expanded to include whole states or operate in multiple states.

The case studies were conducted using a combination of document review and semistructured discussions with the leadership of each Hub. Multiple discussions were held with each of the six Hubs. The discussions covered the Hubs' (1) governance and organizational structure; (2) partners in CBOs, health care, and government; (3) IT and financing strategies; and (4) local policy context. In each of these domains, we asked discussants to describe challenges that they face and key policy issues at the local, state, and federal levels that have helped or

hindered their development to date. Information from the document reviews and discussions were synthesized into case study descriptions for each of the Hubs. The six case studies were then compared to highlight similarities and contrasts.

Organization of the Report

In Chapter 2, we present the results from the first phase of the study that examined backbone organizations, conducted during fiscal year (FY) 2022. Results of the case studies conducted during FY 2023 are reported in Chapter 3. In the concluding chapter, we highlight key takeaways from the case studies and emerging policy issues. Our discussion guides from the FY 2022 and FY 2023 projects are presented in Appendixes A and B. Summaries of the case study Hubs are presented in Appendix C.

Chapter 2. Landscape of Health and Social Care Coordination

In FY 2022, ASPE engaged RAND to identify best practices in implementing and operating health and social care service care coordination efforts at the local level. In this first stage, we conducted an environmental scan that included a literature review and semistructured discussions with key informants. The literature review focused on the peer-reviewed and grey literature related to approaches to coordination of health and social care services. The key informant discussions with representatives from backbone organizations and academic experts focused on understanding the structure and finances of backbone organizations, their operations, and policy-related factors that help or hinder their operation. In this chapter, we summarize key findings from the first phase of this work. In addition, we focus on how the prior phase informed the strategy for sampling Hubs and developing the discussion protocols for the second phase of the study.

Literature Review

Methods

The literature review that we conducted as part of the FY 2022 environmental scan provides a high-level summary of the academic and grey literature about community-based approaches to coordinating health and social care services. To conduct the literature review, we developed a narrowly scoped set of search terms, which included care coordination, case management, managed care, social service, and integrated care. A set of Medical Subject Headings (MeSH) terms, which included social work, social support, integrated delivery of health care, and community health services, were also employed. The search terms also included terms related to specific initiatives identified by the project team, including Pathways Community HUB, Accountable Health Communities, and Medicaid section 1115 demonstrations. The approach was refined and implemented by a RAND research librarian using PubMed. The results were limited to articles in English published within the past five years. The search was tested using relevant articles suggested by the project team. The relevance of the initiatives was determined based on ASPE feedback. The final sample of 115 articles were identified after a full text review of 272 articles identified as relevant from a title and abstract screen of 1,172 articles produced by the initial search. From the review, we abstracted the following information: geographic context, coordination model, health services offered, social services offered, coordinating entity, entities involved, populations covered, health conditions covered, funding, planning or governance model, data-sharing approach, and other characteristics.

Findings

Our review of the literature identified seven categories of health and social care service coordination initiatives that were highly relevant given our inclusion and exclusion criteria and through consultation with ASPE: (1) Accountable Communities for Health; (2) Medicaid Accountable Care Organizations; (3) Community Integrated Health Networks; (4) shared stewardship for wellbeing, equity, and racial justice; (5) Medicaid care coordination for whole-person care; (6) maternal care coordination; and (7) Pathways Community HUB.

While all the models examined have backbone organizations that serve as a centralized point of contact for identifying individuals in need of care and sharing information to facilitate coordination, the models are distinguished by being based within the government, health system, or community. An example of a government-based backbone organization is the Anne Arundel County Partnership for Children, Youth and Families in Maryland. This organization is a county-based system of local management boards that work with community organizations, local government agencies, and health care systems to identify and address local health care needs (Rozansky, 2011). Other government-based backbone organizations include Hennepin Health, in which a county government serves as an Accountable Care Organization for its Medicaid population. The second base of backbone organizations is the health system that links health care services with a network of community-based social service agencies. Examples of health system–based backbone organizations include some of the Accountable Health Communities (AHCs) created through a CMS demonstration project (Renaud et al., 2023). AHCs were designed with "bridge organizations" that provided the backbone organization functions. Another example of a health system–based backbone organization is the New York State Health Home model, in which Medicaid payers serve as backbone organizations, connecting patients with complex medical needs to social services through case management organizations (Mayer et al., 2021; Scharf et al., 2014). The final base of backbone organizations is the community, independent from both governmental and health system organizations. Community-based backbone organizations include nonprofit organizations that provide a centralized administrative and operational interface between health care institutions and a network of CBOs that provide social services. Examples include AgeSpan in Massachusetts, which developed out of a local Area Agency on Aging (AAA) serving an elderly population and now has expanded to provide services to individuals with disabilities. Another example of a community-based backbone organization is Partners in Care, which started in 1997 in Southern California but has expanded through contracts with MCOs to provide access to networks of CBOs across California.

These backbone organizations differ in important ways that affect their function and potential impact, such as their engagement with the health care payers. According to the literature review, backbone organizations based in governments, health systems, or communities each share characteristics in the following areas.

Planning and Governance

The initiatives were typically governed by independent purpose-built nonprofit organizations, leadership coalitions consisting of representatives from participating organizations, and/or formal contractual agreements between participating organizations. The individual governing organizations included health care providers or payers (e.g., health systems or federally qualified health centers, Medicaid managed care plans), government agencies (e.g., county departments of health, social service agencies), and community-based stakeholders (e.g., local social service organizations or patient representatives). The underlying mandate for initiatives varied, with some reflecting federal policies (e.g., Veteran Affairs' [VA] national maternity care policy, Medicaid section 1115 demonstration, or a CMS Innovation Center pilot) and others reflecting state or local priorities.

Funding

Funding arrangements for coordination tasks and care varied between projects, but most initiatives relied on federal funding from health care payers (such as Medicare and Medicaid) transmitted to the community-based backbone organizations and then distributed to CBOs. However, because social services represent a limited set of Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes and payment mechanisms, these funding sources are inherently limited. Consequently, community-based backbone organizations supplement these funding sources with combined contributions from local health systems, state or county health agencies, and other philanthropic partners. Detailed information on funding was not available for most of the organizations described in the literature.

Data Infrastructure

In most instances, data were managed or housed by the lead coordinating organization. With few exceptions (e.g., Pathways Community HUB), the precise configuration of data-sharing agreements and infrastructure was not captured in the literature. Data elements included electronic health records (EHRs), service referrals, social service encounter records, SDOH data, and other data from CBOs and were typically accessible by social service providers, health care providers, and initiative coordinators.

Scope and Populations Covered

Most highly relevant initiatives were implemented at the city, county, or regional level, often in partnership with a large health system or large health agency. The populations covered by these initiatives include high health care utilizers, older adults, pregnant people, veterans, and people experiencing poverty or homelessness. Although the conditions that are covered varied by initiative, some conditions of focus included pregnancy, severe mental illness, substance use disorder, disability, and other chronic conditions.

Health and Social Care Services Coordinated

Highly relevant initiatives coordinated a variety of health care services, including primary care, behavioral health care, dental care, obstetric or postpartum care, health education, family planning, breastfeeding support, and screening. The social services that are often coordinated by strongly aligned initiatives include housing support, nutrition support, public assistance enrollment support, substance use treatment, smoking or alcohol cessation, and interpersonal and intimate partner violence services.

Key Informant Discussions

Methods

The second component of the FY 2022 environmental scan conducted was a series of semistructured discussions with key informants drawn from a variety of organizations that coordinate health and social care services and with academic experts who study how these organizations work. Using the results of the literature review and leveraging ASPE contacts, we identified a list of potential key informants. Priority was given to individuals associated with initiatives that engaged in a broad scope of coordinating efforts and/or organizations that served a large or scalable population. As a result, 14 individuals/groups were identified, invited, and accepted participation in scheduled, semistructured discussions, as described in Table 2.1.

To facilitate the semistructured discussions with key informants, we developed a discussion guide drawing on the literature review and the interests specified by ASPE. We identified areas that required further clarification or that were missing from the published literature. Additionally, the discussion guide incorporates ASPE interests in (1) contextual factors, (2) planning and governance models, and (3) structural details (e.g., leadership, tracking). The discussion guide was designed to include probes and prompts for more discussion of the ideas raised by the key informants. Appendix A contains the FY 2022 discussion guide.

Table 2.1. Key Informants

Name	Title(s)	Affiliation(s)	Type of Organization
Pam Brown, PhD	Executive Director	Anne Arundel County Partnership for Children, Youth and Families	Health and social care service coordinating initiative
Jeff Levi, PhD	Director	George Washington Funders Forum on Accountable Health	Academic/research institute
Bruce Goldberg, MD	Director	Oregon Accountable Health Communities	Health and social care service coordinating initiative
Robyn Golden, LCSW, and Bonnie Ewald	Associate Vice President, Department Chair; Associate Director	Rush University Medical Center, Center for Health and Social Care Integration	Health services
Jennifer Raymond, JD, MBA, and Joan Hatem Roy, LICSW	Chief Strategy Officer; Chief Executive Officer	AgeSpan	Health and social care service coordinating initiative
Len Nichols, PhD	Director, Center for Health Policy Research and Ethics	Urban Institute	Academic/research institute
Toyin Ajayi, MD, MPhil	Co-founder and Chief Executive Officer, SIREN National Program Leadership	Cityblock Health, SIREN	Health and social care service coordinating initiative
Kate Diaz Vickery, MD, MSc	Physician	Hennepin Health	Health plan and accountable care organization
Connie Benton Wolfe, MA	President and Chief Executive Officer	Aging and In-Home Services of Northeast Indiana, Inc., Ground Game Health	Health and social care service coordinating initiative
Erica Coletti, MBA, and Michele Horan	Chief Executive Officer; Chief Operating Officer	Healthy Alliance	Health and social care service coordinating initiative
Stuart Butler, PhD	Senior Fellow in Economic Studies	Brookings Institution	Academic/research institute
June Simmons, MSW, and Ester Sefilyan	President and Chief Executive Officer; Vice President of Network Services	Partners in Care Foundation	Health and social care service coordinating initiative
Rishi Manchanda, MD, MPH and Sadena Thevarajah, JD	Founder and President, SIREN National Program Leadership; Managing Director	HealthBegins, SIREN	Health and social care service coordinating initiative
Charlene Wong, MD, MSHP	Executive Director	North Carolina Integrated Care for Kids Model	Health and social care service coordinating initiative

Key Themes

Discussions with key informants took place in September 2022, and several key themes emerged.

What Makes a Good Backbone Organization?

Throughout the key informant conversations, participants discussed the qualities that make an organization a good backbone organization, contrasting different types of backbone organizations. The primary advantage of having a CBO serve as a backbone organization, as opposed to a health care or governmental organization, was described as deriving from the trust that CBOs can establish with social service providers on the one hand and health care institutions on the other. The CBO serving as a backbone organization must have the qualities that each type of stakeholder regards as crucial for collaboration. For the social services organizations, CBOs provide a fair and financially disinterested mediator to facilitate negotiation and contracting with health care providers. As one discussant emphasized, social service organizations want a partner that shares their values in serving the community. Developing trust with health care institutions that backbone organizations work with (including public payers, such as Medicare Advantage plans or Medicaid MCOs; commercial insurance companies; health care systems; and hospitals) requires that the backbone organization have a high level of sophistication with respect to managing contracts, collecting and sharing information using standardized formats, and assessing the quantity and quality of services that are provided. One discussant highlighted this tension by saying that the best backbone organizations are those that grow organically from within the community, but for funders to feel safe investing in a backbone organization, they need to see certain credentials.

Backbone organizations aim to address the misalignment of the health and social care services sectors by providing a single point of contact between these sectors. From the health sector perspective, the backbone organization offers a single organization with which they can interact that can provide access to an entire network of social services providers rather than having to manage relationships with each provider individually. Health care organizations can thus offer social services to patients who are likely to benefit from the services through reduced acute care utilization and improved quality of life without taking on the task of directly providing the services or contracting directly and separately with many CBOs. Moreover, the backbone organization can be held accountable for reporting on service provision and quality measures in ways that meet the contractual obligations of health care organizations, while many CBOs would not be prepared for the required reporting.

From the CBO perspective, the backbone organization provides access to health services for the people they serve and a predictable and sustainable source of referrals and revenues. Through the backbone organization, the CBOs have the potential to access health care resources without having to negotiate on an individual basis with much larger institutions or make large investments in their own administrative capacity. Backbone organizations can also take on

administrative functions, such as billing, that would stretch the capabilities of CBOs on their own. Importantly, for both health care entities and CBOs, the backbone organization is a "trusted broker," an independent organization without a competitive financial interest (Nichols and Taylor, 2018). CBOs can trust that the backbone organization will represent their interests in negotiating prices and other contractual issues with health care entities.

Through coordination of health and social care services, backbone organizations have the potential to improve a broad variety of health outcomes. For patients with complex medical conditions, better access to social services can enable them to live independently in their homes and communities, avoiding health crises, visits to emergency departments, and hospitalizations.

Non–Health Care Providers Need a True Seat at the Table

Discussants also emphasized the need to address the enormous power differential between social service organizations and health care providers and payers in the governance and practice of backbone organizations. Without direct support for social service organizations, including technical assistance in many cases, the non–health care organizations could be dominated by health care interests and fail to achieve coordination with CBOs. One discussant emphasized the importance of building a new sort of ecosystem of health, centered on the involvement of social service organizations as true partners. The involvement of social service organizations, according to discussants, should include an equal voice in how priorities are set and how infrastructure for care coordination, such as EHR systems, are designed and implemented.

Data Collection, Sharing, and Standardization

The role of data collection and sharing was also a key consideration discussed by informants. Information transfer can be challenging (particularly across health and social care service providers) because each partner uses different systems, and there are specific requirements and data safeguarding that must be maintained. One discussant underscored that, because billing, workflows, and processes are not currently standardized across health and social care service providers, building stronger data systems with better integration would allow for improved coordination and delivery of services. Data standardization was also an important theme from the discussions, with informants highlighting how the lack of standardization can make it challenging to merge data systems, understand disparities, and evaluate programs. One discussant captured this issue when describing a standardized questionnaire that they created to purposely align with Medicaid, as opposed to other core measures that often do not align with federal measures.

Funding Challenges and Sustainability

Discussion participants brought up challenges that health and social care service coordination initiatives face in terms of finding sustainable, sufficient funding. Generally, CBOs receive funding via health care payers, essentially compensating the CBOs for the reduction in health

care costs produced by their services. However, informants brought up the limitations around what CBOs and social service providers can bill to payers, such as Medicare (including the type of providers who are eligible to bill Medicare); the lopsided funding for health care services over social services; and the importance of braiding and blending funding across a variety of sources. Several discussants mentioned that social workers and community health workers do not have access to many of the HCPCS and CPT codes and payment mechanisms through value-based payment models that physicians and other providers can access, despite being on the front lines of coordinating health and social care services. There was also a call for additional and clear guidance for CBOs on any restrictions on how they are allowed to use federal funding when addressing community needs. As one informant emphasized, fear of differing interpretations of these guidelines by auditors might be a barrier to entering these initiatives for some health care organizations. The challenges surrounding access to consistent and adequate funding was a key consideration for both the initiation and continuation of these coordination initiatives.

Role of Federal, State, and Local Governments

The role that the government plays was also discussed by informants as an important part of how successful initiatives can be. Several informants stressed the important role that section 1115 demonstrations have played in allowing more flexible use of Medicaid funding. Participants underscored how government support, through policies like the Medicaid waivers, signals to potential network participants and the larger community that these initiatives are important. Having buy-in from federal, state, and local policymakers gives credence to these efforts and can foster a policy environment that leads to additional support for backbone organizations, both financially and administratively. As one discussant explained, once there was leadership support from the state, “it was really not hard to get people on board” with their effort. Social service organizations in particular “had been trying to find a way in” to integrating with health care, and the promise of integrated care delivery, data, and a novel payment model was more than enough to bring people to the table.

Potential for Telehealth

Telehealth’s increasing role in the provision of health care and social services was another recurrent theme in discussions. Under the COVD-19 public health emergency, regulations governing how and when telehealth services could be used were relaxed. Allowing for health and social care to be provided outside of in-person visits can increase access to screening and services. As one discussant indicated, the ability to use phone calls to screen for SDOH and arrange for direct services was a benefit of relaxed regulations during the COVID-19 pandemic, and although much work needs to be done in-person, the option to supplement work with phone calls and texting could increase access for people who face transportation barriers and other challenges. Informants pushed for continuation of the recent telehealth flexibilities so that remote access to care can be provided to those who could benefit from it.

Phase Two

The results of the environmental scan informed the second phase of the work and led to the focus on one particular model for coordinating health and social care services—Community Care Hubs (or Hubs)—in FY 2023. The environmental scan also informed the selection of case study Hubs based on important contextual characteristics, such as urbanicity, organization size and coverage area, connection to health care system, and the larger area's health care landscape.

Chapter 3. Community Care Hubs in Practice: Six Case Studies

In this chapter. we present the results from case studies, highlighting similarities and differences in how the Hub model has been implemented and the perspectives of Hub leadership. The results are divided into five areas: (1) the development and structure of the Hubs, including the services they provide and the populations they cover; (2) community engagement and governance; (3) partnerships that Hubs have with CBOs, health care entities, and government agencies; (4) information-sharing; and (5) financing. In the final section of this chapter, we summarize the discussants' recommendations for policy changes that would facilitate the work of the Hubs.

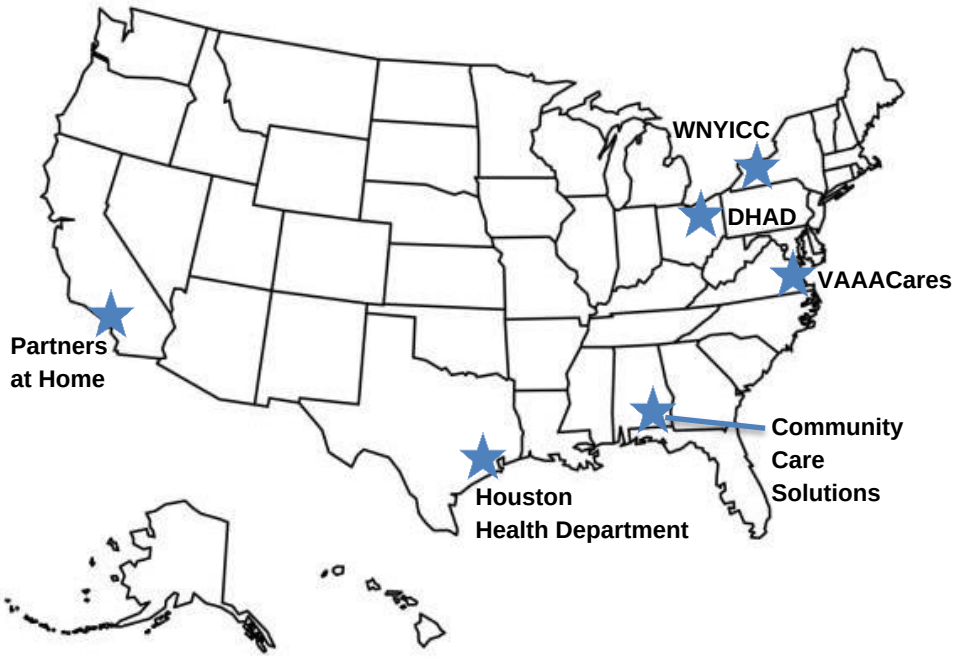
Case Study Methods

We selected six case studies from the 58 organizations participating in the ACL Community Care Hub National Learning Community. The goal was to arrive at a sample of six Hubs that vary with respect to geography, size, and stage of development. One of the initially selected Hubs declined to participate because it did not consider itself a Hub and was replaced by an alternate. Figure 3.1 shows the location of the six Hubs that participated in the study:

- Virginia Area Agencies on Aging—Caring for the Commonwealth (VAAACares®), headquartered in Urbanna, Virginia
- Community Care Solutions, headquartered in Dothan, Alabama
- Direction Home Akron Canton Area Agency on Aging and Disabilities (DHAD), headquartered in Uniontown, Ohio
- Houston Health Department, headquartered in Houston, Texas
- Partners at Home, headquartered in Los Angeles, California
- Western New York Integrated Care Collaborative (WNYICC), headquartered in Buffalo, New York.

Information for the case studies was compiled using documents available online and discussions with Hub leadership. Prior to contacting the Hub, the research team reviewed Hub websites and conducted searches for descriptions of each Hub in published peer-reviewed and grey literature. Discussions were then held with Hub staff, following the discussion guide presented in Appendix B. Initially, contacts were made with the leadership of each Hub to discuss participation in the study. Hub leadership were informed of the topics to be covered and were asked to help arrange discussions with the appropriate staff in their organization with the relevant expertise and experience. Multiple discussions with each Hub were conducted as needed to cover all topics in the discussion guide. For instance, separate discussions were held with staff from DHAD to cover overall structure of the Hub and its services, IT, and financing. Between two and four discussions were held with each Hub.

Figure 3.1. Map of Included Community Care Hubs



A case study template was used to combine the information from the document review and discussions into case study summaries, which are presented in Appendix C. Draft summaries were shared with the Hub leadership for their review, and Hub leadership provided corrections and additional details that were added to the summaries. All members of the team then reviewed the case study summaries and, through discussions, identified the main points of similarities and differences across Hubs within each of the major topic areas.

Development and Structure

The six Hubs in our sample have developed along similar trajectories. Each of them was formed by an originating or parent CBO that had taken on a role as a network backbone organization as part of a state or federal policy initiative focused on social care. Through these programs, these pre-Hub backbone organizations had their first experiences contracting with health care entities to provide linkage between health care and social services, generally focusing on a particular population, most commonly older individuals. Through these early contracts, the organizations developed skills in contracting, organizing community-based services to meet contracting terms, and managing payments from health care entities to their network CBOs. In addition, contracting provided a more stable and sustainable source of financing than the grant-based work that the organizations had previously relied on. Following from that experience, the organizations sought out new contracting opportunities that enabled them to provide services beyond their initial scope of practice. Continuing success in contracting led to expansion of the

health care entities that they contracted with, the services that they coordinated, and the populations and regions that were covered by the contracts. In some cases, the Hub was formed as a distinct program within the existing CBO in which it developed; in others, the Hub was formed as a new independent nonprofit organization with its own administrative and governance structures.

Five of the six Hubs in our sample have roots as AAAs.[3] Of those five, all four of the operational Hubs were nonprofit AAAs; the fifth, the Houston Health Department (which is still in its planning stages), is a AAA located in a local government agency and is now planning to house its Hub outside the government in an affiliated nonprofit agency. Staff at DHAD highlighted the value of having a AAA act as Hub by emphasizing that they have long held "the role of assessing need, providing information, referrals, and support to people across programs," which "helps ensure barriers and gaps are met outside of the patient's transition needs."

Three of the Hubs with roots in AAAs had their first experiences as a backbone organization through the CMS Community-based Care Transitions Program (CCTP).[4] The one Hub that was not a AAA shared with the other Hubs an origin in an innovative policy initiative: Partners at Home had its first experiences as a backbone organization as part of a nursing home diversion program that was part of a Medicaid waiver and that also participated in the CCTP.

Once these organizations had their first experiences as backbone organizations, they expanded incrementally into their current form as Hubs. For instance, the three AAAs that had participated in the CCTP program continued to contract for care transitions with payers and health care providers after the CCTP program ended. Medicare Advantage plans were prominent among their initial contracting partners, although they have since developed more diverse health care partners, including Medicaid payers, commercial health plans, and health care providers. WNYICC, which was formed by two AAAs and did not participate in the CCTP program, began with contracts with Medicare Advantage plans, serving a population similar to the ones they had previously served as AAAs, before expanding to contracts with Medicaid payers. Similarly, Partners at Home's initial local Medicaid contracts led to contracts across the state with Medicaid payers.

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[3] AAAs are state-designated agencies that coordinate and offer services to address the needs of older adults in specific geographic regions and allow them to remain in their homes. AAAs can be public, private, nonprofit, or quasi-governmental organizations (Administration for Community Living, 2023). These organizations work to help older adults remain in their homes by helping to coordinate their care and services. Many AAAs also run Aging and Disability Resource Centers, which are part of the No Wrong Door model to streamline access to long-term services and supports for key populations, including older adults, people with disabilities, and their families (Administration for Community Living, 2017)a.

[4] CCTP was launched by CMS in 2012 and aimed to improve quality and patient experience and reduce costs associated with care transitions. The five-year program provided funding to CBOs to establish partnerships with hospitals and other health care providers to improve high-risk Medicare beneficiaries' care transitions. Participants paired existing care transition models with additional social services and supports to reduce readmissions (Ruiz et al., 2017).

The foundation of these organizations in transitional care for older adults is reflected in the kinds of services that they currently coordinate as Hubs, as shown in Table 3.1. All the Hubs provide hospital-to-home transition services. Most also provide services that address food insecurity, such as prepared meals (including medically tailored meals) or nutritional support. Three of the six Hubs provide transportation and housing services, and two indicated that they provide other services, such as a falls prevention program that includes a home walkthrough and retrofitting of the home to reduce the chance of falls and diabetes education and support classes that support beneficiaries in making better food choices.

Table 3.1. Services Provided by Hubs

Hub	Hospital-to-Home Transition	Meals/Food Security	Transportation	Housing	Other
VAAACares	x	x	x	x	
Community Care Solutions	x	x	x	x	x
WNYICC	x	x			
Houston Health Department	x				
Partners at Home	x	x		x	
DHAD	x	x	x	x	x

The five Hubs in our sample that are currently operational have also expanded geographically as they expanded the breadth of their contracting activities and the populations they serve. Three of the Hubs (VAAACares, DHAD, and Partners at Home) operate statewide in their states of origin, and two of them (VAAACares and Partners at Home) have begun expanding outside those states. Community Care Solutions and WNYICC have also expanded, but both remain more focused on their region of origin. For the Hubs created by AAAs, increased networking with other AAAs in their states has led to subcontracting arrangements and regional growth.

All six Hubs have the same general structure for linking health and social care services, but there are important differences in how they operate. First, there are some slight differences in the extent to which the Hubs interact directly with the CBOs in their networks or indirectly through other AAAs that organize local networks. WNYICC and VAAACares are examples of Hubs that work directly with their member CBOs. For instance, VAAACares vets each individual CBO in its network, often making onsite visits prior to including the CBO in the network. DHAD and Community Care Solutions rely on their network of AAAs to provide services in the regions in which they operate or to identify local CBOs and manage referrals to those CBOs in cases in which the AAA itself does not provide those services.

Second, for all the Hubs, a majority of the patients they serve are identified by the health care entity that they are contracting with, but there are differences in how this process works. For

some, such as VAAACares, patients are identified while hospitalized so that a transition coach affiliated with VAAACares can meet with them prior to discharge for an evaluation. The coach then follows up with the patient at home for a home-based assessment to identify additional needs. DHAD has a similar process to VAAACares: Their contracted health plan sends regular rosters of potentially eligible patients who have had recent hospitalizations and that could benefit from the Hub's acute care transition program, in which it conducts needs assessments and helps coordinate any services that could address the patient's potential HRSNs. Additional patients are also found through the DHAD's participation in hospital Ground Rounds, in which the Hub's registered nurses (RNs) who serve as health coaches can learn about other high-risk individuals who might benefit from the Hub's work and are eligible for services based on their contract. The system at Community Care Solutions is slightly different in that the Hub receives claims data from its health care partners (either from the regional health plan or the local independent medical practice that it contracts with) that the Hub uses to proactively identify high-risk individuals who could potentially benefit from the Hub's services. The Hub then performs a home visit in which it conducts a needs assessment and identifies any health and social care service needs. In the case of Partners at Home, the payer refers patients to the Hub, and then the Hub contacts the referred patient to conduct an assessment in person or by phone. Partners at Home then makes referrals to CBOs in the network to address identified needs. There was only one Hub, WNYICC, in which CBOs were able to make cross referrals into the Hub (i.e., refer for other services offered by the Hub while receiving their referred services) rather than solely the other way around.

Community Engagement and Governance

One of the potential benefits that the Hub model offers is to provide a structure through which communities can have input into health care priorities and the organization of care delivery. In many communities, health care payers and systems are distrusted and seen as large and distant organizations with their own financial and administrative priorities. In contrast, the CBOs that form the provider network for Hubs tend to be oriented toward immediate community needs. Specifically, communities of color and immigrant communities that have historically been underserved by health care institutions rely on CBOs to understand and respond to their health care and social service needs. By building a network of CBOs in a region, a Hub can provide a mechanism for local community organizations to have a role in determining how the social needs of community members are addressed.

There are a variety of mechanisms that Hubs can use to ensure that their policies reflect the priorities, goals, and culture of the communities they serve. The most formal mechanism is to have a community governance board, which can be used to formalize the relationship with the local community. In such a structure, community members and organizations can have a direct role setting policy and ensuring financial sustainability. A community governance board

provides a formal structure for accountability to a community, but there are other, less formal ways that Hubs can give community members a "seat at the table." For instance, advisory groups that meet regularly can offer CBOs a forum in which to discuss organizational policies and priorities.

Among the Hubs that we examined, none had a formal community governance board that was specific to the Hub, but all six had structured ways to incorporate community input into Hub policy. Three models of community input were identified, each with different strengths and limitations. First, three of the Hubs in our sample were formed by organizations that were already community-based social service agencies that served as nonprofit AAAs: VAAACares, Community Care Solutions, and DHAD. In two of these three cases, the Hub does not have a governing board that is separate from the governing board of the parent CBO (Bay Aging for VAAACares and DHAD for DHAD). In these cases, the parent CBO has a governing board that is designed to have representation from the community in which it is located. For example, the Bay Aging board consists of volunteers from the counties that the agency serves: ten appointed by their county's board of supervisors and five chosen by citizens of the region. While the parent organization for the Hubs have boards with community representation, the Hubs cover larger areas than their parent organization and do not have boards that reflect the entire area of operations. In addition, the board of the parent CBO might not have the same interests as a board devoted exclusively to the Hub.

Although these Hubs do not have a community governing board, they all have advisory groups with diverse community representation that is focused specifically on the Hub operations. For example, VAAACares, which operates statewide in Virginia, has an advisory board that includes members of CBOs from across the state, state government officials, and policy experts with experience in the Virginia Medicaid system. These advisory groups provide input on community needs and on agency strategy and policy from an expert perspective. VAAACares has been considering giving this advisory board a more formal governance function but has not yet done so. DHAD, on the other hand, has community members who participate on its governing board in addition to its advisory group.

The second model is exemplified by both WNYICC, a Hub that was formed as a new independent organization by several AAAs in the western New York region, and Community Care Solutions. Without a single existing board to fall back on, WNYICC created a new governance board that consists of all the CBOs in the Hub network. Although this board includes community input through the CBOs, it does not include representatives from other segments of the community. The board meets regularly to discuss networking and policy issues, such as development of a response to the state's plans for a section 1115 demonstration. According to Hub leadership, the goal for the organization is to have all member CBOs participate in board meetings and to participate on at least one board working group. However, according to the Hub discussants, the ability of CBOs to participate on the board varies widely; many CBOs do not have the capacity. Consequently, some organizations participate more in leadership and advisory

roles than others. The leadership of the Hub recognizes that there is a balance between their expectation that CBOs participate in leadership and the burden that that responsibility places on them. CBOs do not face any restrictions on their participation in the network if they do not participate in the advisory group. In the case of Community Care Solutions, the Hub has a board of directors that is separate from its parent CBO (Southern Alabama Regional Council on Aging [SARCOA]). For input from community members, the Hub relies on its two partner AAAs (SARCOA and Central Alabama Aging Consortium [CAAC]). SARCOA and CAAC have advisory councils that consist of program participants, service providers, caregivers, and community members who give feedback to the AAA about their operations and provide information about the current and future needs of the elderly community. This information also informs Community Care Solutions' work as a Hub.

Partners at Home exemplifies a third model, in which a Hub that has expanded across a large geographic area (in this case, the entire state of California), builds a standard mechanism for enabling the CBOs in each area to participate in Hub decisionmaking. In each county of California, Partners at Home creates an advisory board that consists of the CBOs in that county. The board meets regularly to discuss local issues, such as cost of living and pay, drive times, and other local factors that might differentially affect the CBOs in that county. This information is fed to the staff at the Hub to inform future contract negotiations. For example, CBOs in the Bay Area noted the high cost of living and need for additional payment for competitive salaries in the area. This information was used by the Hub to discuss payment and case rates with local payers. The organization of the advisory boards at the county level fits well within the Medicaid system in California because Medicaid managed care is also organized at the county level. These boards also act as a place in which network members can network and exchange best practices or share information informing their work in the county. Partners at Home noted that it is working on formalizing the structure of sharing information from the county level up for larger Hub awareness.

Community, Health Care, and Government Partners

Relationship-building and creating partnerships with other CBOs, health care entities, and government agencies is one of the key roles that Hubs play in coordinating health and social care services.

Community Partners

In several of the case studies, we found that Hubs were often entities that grew out of an original parent CBO, several of which were originally AAAs (Community Care Solutions, VAAACares, DHAD, WNYICC, Houston Health Department). As AAAs, these parent CBOs already offered clients in their region a wide variety of social services and had an existing network of CBOs that they could turn to for social services that were not directly provided by the

parent CBO. The parent CBO and its existing network can then act as the initial set of partner CBOs for the Hub. In addition, as AAAs, there is a built-in network of other AAAs across the state that could be used to facilitate expansion into new geographic regions. One Hub highlighted that "the value in just sticking with the AAAs is we know each other. We have worked with each other for years. We openly share best practices with one another. We're better together as an organization." Because the needs of populations might vary by geographic region, Hubs also highlighted that the network of CBOs and the services they provide might differ by locality. This can also be related to the population density or rurality of an area: More-rural regions require patients or health coaches to travel farther to access or supply the needed services.

Finding and expanding the network of community partners was described as often happening through a "friends-of-friends" model, in which the Hub would add new partners that were recommended by or were similar to existing partners but that provided different services or were in different geographic areas. Hubs highlighted the importance of having discussions with potential new CBO partners about their capacity, data systems, ability to assess quality, cost of services, and other capabilities that are required to participate in the Hub network. At least one Hub, VAAACares, discussed making site visits to CBOs and vetting them before bringing new organizations into the network. Hubs also emphasized the importance of training new CBO partners to make sure their addition to the network is smooth and that it maintains necessary compliance standards.

Once the network is established, Hubs provide a variety of services to keep the CBOs engaged, strengthen links between member CBOs, and increase their capacity to provide services and participate in the network. Some of the Hubs have regular training sessions, focusing on such topics as IT, quality measurement, and business acumen. Regular meetings of network members are used to provide information on policy changes that are likely to affect CBOs and on opportunities for which they may have to develop new lines of service.

Health Care Partners

Hubs' partnerships with health care entities generally were with payers and providers of health care services. Payers included Medicare Advantage plans, Medicaid MCOs, and commercial insurance plans. In some cases, these relationships grew from initial contracts for the Hub to provide services and support only to the payer's Medicare population to eventually—after the Hub demonstrated the value of the work it was doing for that population—cover all the health plan's members.

Relationships with health care providers could be either formal contracted relationships or more informal partnerships. The contracted relationships were most often with hospitals and health systems that partner with the Hub to coordinate the health and social care of their high-risk patients. In one case, the Hub also contracted with an independent medical practice that was part of an Accountable Care Organization (ACO) to help coordinate care for its patients to meet

the quality standards of the ACO.[5] Several case study participants pointed to their participation in CMS' CCTP as being their first foray into the role of Hubs and including care coordination in their portfolio of work. Even when CCTP ended, the partnerships they had built with hospitals and health systems remained strong and continued into other contracts and programs managed by the Hub.

Relationships with skilled nursing facilities (SNFs), rehabilitation facilities, and primary care practices generally seemed more informal. At least one Hub described having open communication with SNFs and rehabilitation facilities so that it could plan for when clients might be discharged or return home, but that, for the most part, the facilities did care coordination and needs assessments themselves (rather than partnering with the Hub to provide those services) while the patient was at the facility.

None of the Hubs included in our case studies specifically discussed partnering with federally qualified health centers (FQHCs). Relationships with FQHCs are likely to exist but might be more informal and in need of more development. The Veterans Health Administration (VHA) was another health care entity that some of the Hubs we spoke with included as a partner.

Some of the Hubs we spoke with expressed struggling to establish contracting relationships with health care providers, suggesting that the providers would rather create their own internal program than to contract out to existing organizations like the Hub. Others also found it challenging to identify the right health providers to partner with, finding that many health care partners thought they could do the work themselves rather than contracting it out to the Hub.

Government Partners

All the Hubs we spoke with work in some way with government partners, but these relationships were at times more informal than other partnerships. Hubs' parent CBOs often have direct contracts for services with local and state governments; however, the relationships with the Hubs were limited to consultation and advice. At the federal level, CMS and ACL were both mentioned as government partners. As previously discussed, several Hubs got their start under CCTP and continued with other CMS programs, such as the Medicare Diabetes Prevention Program. In addition to setting standards and requirements for these programs, CMS has also acted as a payer for the work that Hubs and their network conduct. Additionally, parent CBOs of the Hub are often the lead entity for managing Medicaid waivers in their region. Hubs also discussed participating in various initiatives led by ACL and connecting with other Hubs through these initiatives. At the state and local level, several Hubs discussed having either formal

[5] *ACOs* are groups of health care providers that voluntarily come together to coordinate care. ACOs that are successful in delivering high-quality care and producing cost savings for Medicare share in these savings. In some cases, ACOs also take on downside risk in which they also share in any additional costs that Medicare takes on (should there be any). Medicare beneficiaries are assigned to an ACO based on their use of services. This assignment determines which patients are included in evaluations of the ACO in terms of savings and costs.

partnerships or close relationships with their public health departments, city or county governments, state health departments, Medicaid agencies, and housing agencies.

All these partnerships at the local, state, and federal levels help to support the work that Hubs do by setting standards, initiating new programs, and providing access to subsidized services. However, the relationships between Hubs and government agencies were often not formalized, and there was no specific office or agency that the Hubs discussed as being their dominant regulatory agency.

The Hub that is being developed by the Houston Health Department is unique among our cases because the department is itself part of the city government. Also, in contrast with the other Hubs we examined, the AAA that is involved in development of the Hub sits within city government and not within a nonprofit organization. In this case, the relationship between the Hub and the government agency is stronger than in other Hubs we examined. However, there were also factors that, according to our discussants, were leading them to situate the Hub outside city government. On the one hand, the Houston Health Department has experience contracting with community-based social service providers across the city and ways of identifying areas with low geographic access to specific types of health resources. In this regard, the department is well situated to operate a Hub. On the other hand, being part of city government would make it very difficult to contract with health care payers and health care systems, which is the department's primary goal in developing the Hub. As one of the discussants said, "We are a local government, and with local government comes a lot of the bureaucracy that you have to, you know, deal with." For this reason, the emerging plan would situate the Hub outside the city government, in a nonprofit organization that has a long history of working with the department. That organization would be able to contract with health care entities more easily and take advantage of existing resources and relationships that the department has in building out its network of CBOs.

Information-Sharing

To provide their services, Hubs need data systems and infrastructure in place to accept referrals, assign and track referrals, track service delivery, prepare reports for contract requirements, and transmit information to and from CBOs, payers, and health care providers. Health care payers and providers generally have sophisticated information systems to meet their operational and regulatory demands, while CBOs vary widely in their ability to report and share information. One of the goals of the Hubs is to reduce the barriers that CBOs face in coordinating care with health care entities.

Five of the six Hubs already have established data systems created over time and developed in conjunction with contracting relationships. The Houston Health Department has not started as a Hub yet but is already thinking through the type of system it will need and is currently discussing the use of an off-the-shelf commercial electronic health system with which the department has experience. The other five Hubs noted their ability to accept referrals and that

they have a system to assign referrals to partner agencies. Often, the health care systems and CBO network systems are completely separate, requiring manual data entry to track a referral through the process of care.

Among Hubs with an existing information system, data is collected by care managers and Hub member agencies related to service delivery. Care managers input information related to assessments before enrollment and after completion of programs, and Hub members collect and transmit data relevant to payer contracts, including several process measures, such as service delivery status, time from referral to completion of service delivery, and patient or client satisfaction. This information is stored in the internal systems of the Hub and can be shared with other entities (e.g., payers) through structured reports. Reports can also be shared with partner CBOs. Partners at Home, for example, noted that it shares aggregated information about service delivery to partner agencies to show how well partners were performing.

Hubs that are further along in their development and infrastructure—WNYICC, Partners at Home, DHAD, and Community Care Solutions—have more-mature data systems for referral management and data-sharing. WNYICC, Partners at Home, and Community Care Solutions have both a single, streamlined internal data system that they use to track all the services provided by their partnered providers and a separate system for assigning and tracking referrals, while DHAD has multiple internal systems for data collection. Each considers its internal system to be a gold standard. These systems have been built over time and act as their sources of truth for service delivery and referral status. Because DHAD uses multiple internal systems, it discussed the challenges that come with combining and consolidating information across systems and programs. Even with internally integrated systems, Hubs can still struggle to create reports and share information outside the network because reporting requirements vary considerably from contract to contract.

One limitation noted by the more mature Hubs was the lack of integration and interoperability between the data from the health care system to the Hub and the data coming from the CBOs to the Hub. In some cases, such as DHAD, the Hub is using multiple systems to pull information into the organization, none of which are interoperable. Data extraction and transmission of data from the CBOs and from health care to the other is often done manually and with a large amount of labor. Data exchange is done through a secure file transfer portal (SFTP) because it contains protected health information (PHI). Community Care Solutions uses National Committee for Quality Assurance (NCQA) standards and minimum access standards to determine which users can see what information.[6] WNYICC representatives noted that all CBOs are trained in proper data transmission protocols.

[6] NCQA establishes standards and accreditations for organizations working across the health care system, including organizations like Hubs. These standards can include an accreditation for case management or long term and social support services.

Some Hubs, such as VAAACares (which has a data system used internally to record care provided by CBO partners), emphasized the challenges of having separate data systems for reporting to each of their major stakeholders: the federal government, including reporting required by grants from ACL; state governments; and federal agencies on aging, transportation, and housing. Although Community Care Solutions has a single data system, it segments data such that information relevant only to its parent CBO (SARCOA) or to the Hub network are kept separate. Emerging Hubs, such as the Houston Health Department, are considering their data system and whether there needs to be different systems for the Hub entity and the service provider to ensure the proper firewalling of information between the service delivery and the Hub entity.

Partners at Home in particular noted issues with receiving outcomes data from its payer and provider partners. Similarly, VAAACares noted that it lacked access to information on utilization of acute care and costs of care. Payers and providers hold this data (i.e., claims and health status change), and Hubs are either not provided this data or have significant delays in receiving it. Without information on claims and other health outcomes, Hubs cannot determine the impact of their programs on health outcomes and must rely on process measures (e.g., whether referrals were sent on time) and internal program measures (e.g., assessment data on social needs before enrollment and after completion of the program) to judge efficacy. In addition, Hubs noted that each CBO might have its own system, or no system at all, so training CBOs on reporting often took time. Some CBOs do have experience reporting for grants, which was helpful in reporting data to the Hub. In contrast, health care organizations, payers, and providers alike have established capabilities for sending and receiving information based on the contracts negotiated with the Hubs. The information-sharing challenges with these entities is that they each have their own system that the Hubs need to learn to interact with. In addition, performance metrics for the contracts varied, adding to the reporting burden held by the Hub.

Financing

Several common themes emerged across case studies regarding the financing of Hubs. First, the Hubs share a common sequence of financial development over time, starting with external sources of funding for their initial startup (such as grants from foundations or savings from their originating CBO), federal and other grant support during early development, and contract support via health care payers, such as Medicare, for their ongoing operations. In two cases, the initial startup funds came directly from within the CBOs that decided to invest in Hub development. In two other cases, startup funds were provided by foundation grants: one from a local foundation focused on the region's health and one from a national foundation focused on improving the care for older adults. Notably, even organizations that had been AAAs required additional investments to develop into Hub organizations that work with a larger network of CBOs to address a wider variety of needs for a broader population.

External funding played an important developmental role in all the Hubs we examined. In some cases, a grant program preceded the organization becoming a Hub. For example, funding for the CCTP program enabled VAAACares to develop expertise and capacity in delivering hospital-to-home transition care and to develop a network of home care providers to implement the evidence-based model they were delivering. The skills and organizational infrastructure developed with federal support for that program enabled it to apply for further federal support through ACL to further build out its work as a Hub. Over time, grants came to play a smaller role in financing the Hubs and were replaced by contracts for services with health care payers and other health care entities. In several cases, contracts make up 100 percent of Hub revenue, while some other Hubs continue to receive a mix of contracts, grants, and donations from local philanthropies.

Second, most Hubs are financed using a fee-for-service model, but some alternative payment models are also being used. In the fee-for-service model, CBOs provide services and submit the claims to the Hub. The Hub submits the claims to the health care entity, receives the payment, and passes the payment to the CBO, taking a percentage for Hub operations. In the alternative payment models, which are being used by some of the Hubs we spoke with, including Partners at Home, Community Care Solutions, and DHAD, the Hub is paid a fixed amount per month or per intervention for each patient in its assigned caseload (either per person served or per member covered). In each of these cases, the Hub is the contracting partner and then subcontracts to other CBOs in the network for the services they provide. The Hub has the potential to make money if the costs are lower than the monthly payment, but is at risk of losing money if the costs are higher than the monthly payment. One Hub we spoke with has an additional performance-based risk component to its contract such that if it does not meet certain quality standards (e.g., on 30-day hospital readmission rates, patient satisfaction, or member engagement) its payment is reduced. One Hub that has only fee-for-service arrangements has been trying to convince the payers with which it contracts to switch to alternative models. The leader of this Hub told us, "I offered [the payers] to do a risk-based [payment], value-based [payment], you name it, and nobody wanted to." This Hub leader believes that, given the chance, the Hub can demonstrate that the CBOs in its network are delivering high-quality care with positive outcomes on health and care utilization.

Third, braiding and blending of funds to meet the social needs of patients served by the Hubs was described as a common practice. Braiding and blending can be done by the Hub, but it was more commonly described at the CBO level, in which CBOs provide services to Hub clients that go beyond their contracted services, using funds from other sources. Consistently, the service for which external resources are used to supplement health care contracts is housing, in which CBOs receive support from federal and local government sources, as well as donations. There was also some concern that services that CBOs provide beyond those being paid for by the health care partner, which may be an expectation among some health care entities and policymakers, would serve as a form of subsidy for the health care partner that derives from volunteer efforts,

donations, or other public funding sources. Additionally, Hubs discussed braiding and blending funding to cover the salaries of key staff during times of transition between contracts: for example, with CCTP ended and before new contracts with health care payers or providers officially began.

Policy Issues

In discussions with Hubs, we asked about policies that, from the Hubs' perspective, could improve their ability to be successful in their business activities and their coordination of health and social care services. The recommendations fall into three groups: (1) those related to information systems (including quality measurement and billing), (2) arrangements for paying for services provided or coordinated by the Hubs, and (3) other regulatory changes that would enable Hubs to be more effective and efficient.

Information Systems

Discussants focused on methods for reducing the complexity of data collection and billing operations required by health care contracts, which remain challenging for Hubs and their CBO network partners. Some Hub staff suggested investing government funds into infrastructure for CBOs to enable data collection and quality measure reporting directly from service providers. In this vein, one discussant suggested investing in regionwide social care data platforms, which could provide a common platform for an entire network (enabling broader reach and capacity), standardize methods for referral tracking, and increase the transparency of network operations. However, discussants also noted that some population referral platforms are not able to document referral outcomes, care delivered by CBOs, or quality of CBO delivered care, all of which are essential for Hub operations. Currently, even within CBO networks, individual CBOs often use different information system platforms, which makes information-sharing challenging. Trying to get all CBOs within the network to use the same platform is challenging because switching platforms requires significant investments of staff time and funds. Some discussants also focused on the gap between information systems on the health care side and those on the CBO side, calling for guidelines to facilitate direct sharing of information. Guidelines for how to provide access to health information while also observing relevant laws regarding personal health information would, according to our discussant, address a major barrier to efficient functioning of the Hub. Another participating Hub suggested that a strategy similar to what was used in the health care sector to establish and reach meaningful use of EHR systems would be useful for CBOs and those providing long-term services and supports.[7]

[7] In the 2010s, CMS established a meaningful use program in which it provided incentives to health care entities to accelerate the adoption of EHRs that met certain requirements.

Discussants also suggested that improvement in quality measurement using health information systems would also enhance their work. Standardized performance metrics would enable Hubs and their health care partners to better monitor and assess the care provided by CBOs. Measures that combine information from health and social care services sectors, such as measures of follow-up after a hospitalization, are of particular interest because they can be used to incentivize coordination across sectors. Improving the ability of Hubs to measure quality of care could also enable development of alternative payment models, as discussed below. Finally, one discussant emphasized that matching services provided by CBOs to fee-for-service billing codes is overly complicated. Better alignment of fee schedules with these services or alternative payment models would reduce the administrative burden on the Hub.

Payment Arrangements

Discussants had two suggestions regarding the financing of Hubs. First, discussants suggested that federal or state government could provide startup funds to support network development. Startup funds could be used to address the IT issues discussed above and for other expenditures not covered by contracts, such as initial hiring and training of staff, organizing CBOs into a network, and coordinating Hub activities with AAAs and local government agencies. Second, some discussants from Hubs that operate on a fee-for-service basis would prefer to be financed through alternative payment models, in which they would be given more flexibility in providing services and be held accountable for quality and outcomes of care. Federal and state policies could encourage a shift from fee-for-service to alternative payment models in contracts with Hubs.

Other Regulatory Changes

Discussants offered suggestions for regulatory changes that could improve their ability to operate effectively. One set of suggestions related to contracting between Hubs and health care entities. Discussants suggested that developing standards for contractual arrangements and workflow would provide consistency in their work across entities and across the regions or states in which they operate. Having a standard contract model would make the operations of the Hub more predictable and sustainable. One discussant suggested that guidelines should require quotas for a minimum number of referrals from the health care entity to the Hub, based on predicted level of need in the covered population, so that Hubs could more reliably predict their caseload size.

Another issue raised by one of the discussants relates to a proposed federal rule to require State Units on Aging to give prior approval of AAA contracts with nongovernment agencies. This rule would make it difficult (or impossible) for Hubs that sit within organizations that also have AAAs to contract with health care payers. Those contracts contain proprietary information about business practices that Hubs are not able to share or make public. This rule would

effectively require the AAAs and the Hubs to form separate organizations—a process that, according to our discussant, would be expensive and wasteful.

Summary

Table 3.2 summarizes the key information discussed above for the five active Hubs included as case studies.

Table 3.2. Summary of Community Care Hub Case Studies

Hub Characteristic	Community Care Solutions	DHAD	Partners at Home	VAAACares	WNYICC
Development	• Started by AAA • Initial work as Hub under CCTP	• Started by AAA • Initial work as Hub under CCTP	• Started as independent CBO, formed Hub for contracting across state	• Started by AAA	• Started by two AAAs
Geographic scope	• Sub-state region of Alabama	• Statewide in OH	• Statewide in CA	• Statewide in VA; some operations in other states	• Sub-state region of NY
Governance	• Board of directors specific to Hub • Relies on advisory boards from CBOs in network	• Relies on parent CBO's board of directors and advisory board	• County-level boards that report up to the organization	• Relies on parent CBO's board of directors • Has statewide advisory board	• Organization board of 11 voted on every three years with all CBOs as voting members • Members encouraged to join one of six committees on the board
Client identification	• Proactive identification via claims data and hospitalization lists received from health care partners	• Daily census of potential clients received from health care partner • Grand Rounds at hospitals	• Receives referrals from health care partners	• Receives referrals from health care partners	• Referrals through website, fax, health information exchange, or self-referral through another program
Services	• Health coaches conduct needs assessments and connect clients to social services	• Transitional care program that includes screening and assessment, medication reconciliation	• Care coordination services, including transitional care, personal care, homemaking, nonmedical respite, and meals	• Transitional care program, screening and assessment, care coordination	• Discharge meal delivery, coaching programs, falls prevention, diabetes programs

Hub Characteristic	Community Care Solutions	DHAD	Partners at Home	VAAACares	WNYICC
Community partners	• Parent CBO covers 11 counties • Second AAA covers seven counties	• All AAAs in the state	• Identify partners in the counties based on contracts in the county • Mostly focused on in-home care and care management and care coordination	• About 100 CBOs regularly and an additional 400 occasionally • Includes most AAAs in state	• Partnered with 54 CBOs in 15 counties • Includes eight AAAs and one CIL
Health care partners	• Contracts with regional health plan and local independent health care practice	• Contracts with regional health plan	• Medicare and Medicaid plans • Health systems and hospitals	• Medicare and Medicaid plans • Health systems and hospitals • VHA	• Medicare Advantage and Medicaid plans, some regional and commercial plans
Government partners	• Alabama Department of Senior Services • CMS	• Ohio Departments on Aging and of Medicaid • CMS	• California Medicaid	• Advocacy with Virginia Department of Health • Advisory group includes state official	• Two departments of health in the region
Information-sharing	• Developed own IT system • CBO EHR not interoperable with health care partners	• Uses multiple systems, including a statewide health information exchange • CBO EHR not interoperable with health care partners	• Commercial software for referral management, shares reported with payers and service providers • CBO EHR not interoperable with health care partners	• Developed EHR for CBO network • CBO EHR not interoperable with health care partners	• Uses a centralized electronic client record that was built to track and manage referrals, document program delivery, and submit claims • Not interoperable with health care partners
Financing	• Per-member per-month payment for contracts with health care entities • Blending and braiding funding from other sources	• Per-intervention payment with risk component based on quality goals for contract	• Case rate payments from contracts that sustain operations • Grants for startup funding	• Fee-for-service contracts • Blending and braiding funding from other sources	• Payments dictated by contracts with payers • Blending and braiding funding from other sources

NOTES: CIL = Center for Independent Living. The Houston Health Department Hub has not been included in this table because that Hub is still in development.

Chapter 4. Conclusions

The first phase of this study examined the broad range of backbone organizations that have developed in recent years, all with a common aim of better addressing HRSNs by actively coordinating the work of health care providers and social services agencies located in the communities in which patients live. The backbone organizations differ from each other in many ways but first and foremost in where they are located institutionally: Some are located within health care entities, some within governmental organizations, and some in community organizations separate from both health care and government. Other key features that distinguish backbone organizations, according to the literature and our key informant discussions, relate to how they collect and share information, how they are financed, and the extent to which they give social services providers and other community stakeholders a role in how HRSNs are met.

The second phase of the study examined community-based backbone organizations, also known as *Hubs*. The Hubs that we examined—five in operation and one in development—are addressing some of the barriers to linking health care and social services sectors that have been described in the literature. The Hubs' growth over time and continued operational success in contracting with payers and health care systems suggests that they are successful in achieving outcomes desired by their health care partners. In addition, their continued success in contracting suggests that they are providing a sustainable source of referrals and revenues to their CBO networks while also sustaining their own operation. However, according to our discussants, the issues of information-sharing and financing remain ongoing points of concern that could be addressed through policy changes. In this concluding chapter, we provide some observations regarding how the Hubs are addressing the challenges that other organizations that attempt to coordinate health and social care services also face, and we highlight potential strategies for future studies to examine the impact of the Hub model.

Limitations

Findings from this series of case studies should be interpreted in light of its limitations. First, the operational success of the Hubs that we describe (i.e., their growth in contract partners and geographic reach) cannot be interpreted as evidence of their impact on outcomes or costs of care. We were not able to identify any carefully controlled independent studies of Hub outcomes in the literature search. Second, we were able to include only six Hubs in this study. The six were selected from the 58 organizations that are participating in ACL's national learning collaborative, which is the best available listing of such organizations. Given the role of ACL in supporting Hubs, it is likely that a majority of the Hubs in operation in the country are

participating in one of the ACL learning collaboratives. However, sampling from organizations participating in the learning collaboratives might have made it more likely that we selected organizations with stronger ties to ACL. The six Hubs that were included vary in their size, in the region of the country in which they are located, and in the ways that they developed out of preexisting organizations. Moreover, the consistency of the issues that arose in the case studies suggests that similar issues would have arisen with a different sample. Third, data collection was limited to semistructured discussions with Hub staff. We were not able to conduct detailed audits of Hubs to examine contracts, to discuss Hub operations with CBOs or service users, or to independently assess processes or outcomes.

Alignment, Facilitation, and Coordination

Our Hub discussants described the Hubs as fulfilling three important functions related to the connection between health and social care services: alignment, facilitation, and coordination.

Alignment refers to the development of shared knowledge of operational capacities and goals; expectations regarding workflow, documentation, and outcomes; and norms for communication between partners. Much of what the discussants described as the Hub's ongoing work of organizing networks of CBOs, including providing training on business acumen, IT, and quality measurement, contributes to alignment of the CBO sector to the requirements of the health sector partners. The descriptions by the Hub leaders suggest that these efforts might have significant positive effects on the capacity of local social service agencies to deliver services and to address complex needs of individuals in their communities living with functional impairments because of medical conditions. However, without direct studies of the impact of Hubs on social services systems in the communities in which they operate, we cannot draw firm conclusions on this point.

Facilitation refers to the development of actual protocols and pathways, tested through repeated practice, through which patient care can be concurrently provided and managed by multiple provider organizations. Hubs are facilitating care by filling in the information processing gaps between CBO and health care information systems, managing payments from payers to CBOs, and distributing referrals across the CBO network.

Coordination refers to the active management of complex care provided by multiple agencies at the individual level. Hubs are coordinating care by providing comprehensive assessments to identify needs and arranging for the full range of available services to address those needs. Although each of these functions is compellingly described, evidence from this study is not sufficient to determine the extent to which Hubs are the most effective means of accomplishing these goals. Moreover, we did not find studies to address this question empirically in our literature review.

Combining these three functions, Hubs might be capable of addressing some limitations that have been identified in studies of other models for coordinating health and social care services.

An example is the recent evaluation of the AHC model, which focuses on identifying individuals with HRSNs in health care settings and connecting them with social services (Renaud et al., 2023). The evaluation found that the AHCs were successful in identifying large numbers of individuals with HRSNs. However, the evaluation also found that the navigation services provided to these individuals did not increase their connections to community services, because of low capacity and mismatch between identified needs and available community services. The ability of Hubs to align CBOs and develop pathways for coordinating care might address the barriers identified in the AHC evaluation.

Hubs Still Face Challenges with Information Technology and Financing

Although the Hubs are connecting health and social care service sectors, they still face the challenges identified in the environmental scan. Two challenges identified in prior literature regarding IT and financing were also two of the most commonly discussed challenges to Hub operations in our case studies. Some discussants also highlighted the lack of accepted quality measures for their work even though there are quality measures for some of the work that Hubs do, such as transition care. More work is needed to identify specific gaps in measurement and potential barriers to use of existing measures.

It is important to note that the challenges described by our discussants are interrelated. IT limitations make the work of Hubs less efficient and precise—thereby raising costs—and hinders measurement of the quality of care. Lack of accepted quality of care measures, as described by our discussants, hinders the ability of the Hubs to demonstrate accountability to contractors or the community and to make targeted efforts to make improvements. Without accepted measurement and quality improvement, payers are more likely to insist on fee-for-service payment arrangements and less likely to offer more-flexible, less burdensome payment models.

Hubs and Community Engagement

One of the major motivations behind the Hub model is the connection between Hubs and the communities in which they are located. CBOs that provide social services to a community tend to be trusted and respected by that community, partially because of their efforts to represent community interests. One of the potential advantages noted of the Hub model is that it provides representatives of underserved communities a seat at the table in discussions of how patients' HRSNs should be met. In practice—as evidenced by the Hubs we examined—Hubs are, in fact, relatively well-connected to their communities compared with the health care entities that they contract with. Many of the Hubs have historical roots in organizations, such as AAAs, that were primarily focused on local community-based services. However, structural connections with communities remains challenging for Hubs in many respects. First, with respect to Hub governance, connections between communities and Hubs are not generally formalized in governance structures that would provide legal accountability to community representatives. All

the Hubs we examined have advisory roles for their CBOs, and some have advisory groups that include community representatives. However, none of the Hubs we examined give these organizations a formal role in setting organizational policy priorities the way that a governing board of a nonprofit organization does. Inclusion of community representatives becomes more challenging as the Hubs grow to cover more communities across larger geographic areas. Second, among the Hubs we examined, there was a tendency for patients to be identified primarily or exclusively by the health care entity (i.e., a one-way referral flow from the health care entity into the CBO network). Movement in the other direction (i.e., people with needs identified in the community being referred to the Hub for coordinated health and social care), was much less common. In the Hubs we examined, the health care entity effectively serves as a gatekeeper to Hub services.

The extent of community engagement and governance is one of the ways that Hub models for coordinating health and social care services vary. Some models envision the backbone organization broadly as a structure for communitywide investment in health and well-being, bringing diverse stakeholders together for public health planning (Mittmann, Heinrich, and Levi, 2022). A model for this type of backbone organization was proposed by Nichols and Taylor (2018) and suggests that communitywide interests in improving health outcomes can motivate collaborative integration efforts across diverse stakeholders. Other models are more narrowly focused on targeted services for a smaller population with higher levels of medical need (Blumenthal et al., 2016). The Pathways Community HUB Institute model, which emphasizes that each member should receive a specific set of services defined by a standard "pathway," is an example of a more narrowly focused approach (Zeigler et al., 2014). Although there was variation across case studies, the Hubs we examined are closer to the latter, narrow model than to the former, broad model.

Lessons for Future Studies

The Community Care Hub model is a promising model for coordinating health and social care services that has proven to be sustainable in practice and of interest to health care entities and CBOs alike. Further investigation of Hubs' role in health and social care service provision and their impact on population health is clearly warranted. Future studies would benefit from investigating the perspectives of CBOs participating in Hub networks and payers that contract with or are considering contracting with Hubs. To advance understanding of Hubs and their impacts, it will be important to clarify the goals that Hubs are meant to address and to evaluate their impact on those goals relative to other approaches to coordination of health and social care. Most importantly, it will be important to determine whether Hubs are seen broadly as communitywide collective responses to health and HRSNs for vulnerable individuals and populations or seen narrowly as facilitators of health care efforts to lower costs and improve outcomes by addressing HRSNs for high-cost beneficiaries. Determining the goals of Hubs is

critical for defining the outcomes of evaluation studies that can provide evidence on their impact. Research that clearly defines these goals and assesses the ability of Hubs to achieve them can provide policymakers with the information needed to support their role in addressing HRSNs.

Appendix A. Discussion Guide for Fiscal Year 2022 Project on Hub Organizations

Oral Consent Statement

The RAND Corporation, a nonprofit research organization, has been contracted by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to identify approaches to health and social service coordination and successful models of planning and governance to meet the health and social service needs of communities.

As a part of this effort, we are convening groups of key informants that have experience or insights regarding the implementation of innovative approaches to coordinating health and social services like Community Care Hubs and other similar initiatives. We have invited ASPE staff members to join this discussion. We are particularly interested in hearing how changes to federal, state, or local policies could improve the ability of these efforts to address health-related social needs. For instance, we hope to understand where there are challenges and what solutions have been implemented—or what could be done—to address them? Additionally, what are actionable things at the federal level that could help with community-based governance, information-sharing, sustainability, and other aspects of the coordination of health and social services?

We anticipate this discussion will last approximately one hour. Your participation is voluntary, and there are no benefits to you to participating. You can choose not to participate, or to stop participating at any time.

If you choose to participate, the information you share will NOT be kept confidential from ASPE staff members. ASPE staff may be joining this conversation, and we will summarize the information you share with us with ASPE staff. However, the information shared by specific individuals or organizations will not be attributed by name in summary reports or in other materials that may be made public. Would you still like to participate in this discussion? **[YES/NO]**

Additionally, we would like to record this conversation so that we can be sure to capture your comments accurately. This recording will be used to facilitate our notetaking and will be deleted after the project is completed. Do you consent to recording? **[YES/NO]**

Do you have any questions before we begin? **[YES/NO]**

Discussion Questions: Individuals with Knowledge of Specific Initiatives

1. To begin, can you tell us a bit about [health and social service coordinating initiative name] and your role(s) there?

a. Can you please tell us more about how your role specifically related to the coordination of health and social services (either individually or as part of a broader network)?

2. Could you please briefly describe [initiative name] in terms of . . .

    a. How and when did the initiative come to be?
    b. Does the initiative have a formal governance structure or operate under a broader governance structure?
    c. What types of organizations are you partnering with?
    d. Does the initiative have formal governmental partners?
    e. What are the initiative's key functions?
    f. What is the initiative's geographic reach?
    g. Please specify each of the services/programs that are coordinated.
    h. Describe the population(s) served? What indicators determine the population(s) served?

3. How are federal and state policies or programs currently supporting this initiative?

    a. What are the limitations of these policies or programs?
    b. How could these or other policies/programs better support this initiative?
    c. How does the initiative address health-related social needs?
    d. How does the initiative screen for social determinants of health and/or health-related social needs?
    e. How does the initiative address social determinants of health and/or health-related social needs?
    f. How does the initiative coordinate service provision across partner organizations (including health care providers)?
    g. Are there [state; federal] policies that could help the initiative better identify social health-related social needs and/or coordinate service provision across partner agencies?
    h. **[LOWER PRIORITY, IF TIME PERMITS]** How did the initiative function during the height of the COVID-19 pandemic?

4. While this project is particularly focused on initiatives like [initiative name], we are also interested in learning about governance efforts established to identify and coordinate broader efforts to address social determinants of health and/or health-related social needs within a community. Such efforts can take multiple forms and incorporate input from various sources.

    a. Is there an entity in your community that engages in broader planning efforts to identify and coordinate efforts to address broader social determinants of health and/or health-related social needs? Can you please describe how this entity functions and how your organization interacts with it?

        i. What was the impetus of the organization?
        ii. Who are the initiative's leaders and what are their responsibilities?
        iii. Are local/state government agencies involved and how?
        iv. In your opinion, what kinds of activities should the community governance entity undertake in the next year or so to further efforts related to health and social needs care?

v. Is there anything you would ideally change about how the initiative operates?

b. **[IF COMMUNITY GOVERNANCE OR OTHER ENTITY DOES NOT EXIST]**
   i. Without a broader community governance/planning effort in your community, how do you foster collaboration across your network to identify and address health-related social needs?

c. **[LOWER PRIORITY, IF TIME PERMITS]**
   i. Who are the stakeholders, including community members, involved in the governance organization? What are their respective roles and responsibilities?
   ii. Do participating initiatives have formal contractual arrangements with the community governance organization, or is participation voluntary?
   iii. How does the initiative assess community needs?
   iv. Are there any federal, state, or local policies that you think could be helpful to advance community governance?

5. Can you describe data sharing between the organizations involved in [initiative name]?
   a. What kind of data do you collect or have access to related to social determinants of health or health-related social needs and service provision? Does the data identify resource needs?
   b. Is data shared across partner organizations, both health and social care providers?
   c. What technologies or solutions do you use to facilitate data sharing?
   d. Based on your experience, what kinds of state or federal policies or resources would help to improve data sharing efforts for this initiative?
   e. How is success, both short and long term, defined (e.g., key health and social service outcomes)?
   f. **[LOWER PRIORITY, IF TIME PERMITS]** What challenges do you face in collecting data that could help inform the operations of your network?

6. How do you ensure quality service delivery?
7. How is the initiative funded?
   a. How is the core infrastructure of the network funded?
   b. How are the initiative's operational coordinating activities and care and social service activities funded?
   c. Many organizations combine funds from multiple sources to finance their programs. Does the initiative rely on combining funds from different sources to support its efforts?
      i. **[PROBE-IMPORTANT]:** What challenges have you faced in trying to combine funds? How have you addressed these challenges?
         1. [IF UNKNOWN] Would you be willing/able to share additional details with us via email about the specific challenges in combining funds?
   d. How could state or federal policy changes and guidance improve the financing of the initiative?
   e. How do you plan to sustain operations of this initiative moving forward?

8. What is the initiative doing to improve health equity?

a. What underserved groups does this initiative reach?
b. **[LOWER PRIORITY, IF TIME PERMITS]** What does the initiative do to make sure it is reaching underserved communities and individuals with the greatest needs?

9. What makes this initiative successful? What do you view as the next steps in improving the work of [initiative name] moving forward? Beyond providing additional direct funding, if there were one or two things you think that the federal government or your state government could do to advance your efforts, what would they be?

    a. What are two or three actions or policies that you think would help to increase social service provider capacity and service provision for health-related social needs?
    b. What would make this initiative replicable and/or scalable to other communities, populations, or settings (clinical, geographic, etc.)?

10. FINAL QUESTIONS, LOWER PRIORITY, IF TIME PERMITS

    a. Is there anything else we haven't asked that would better help us to understand [initiative name]?
    b. Are you aware of other successful health and social service coordination efforts?
    c. Are there any thought leaders in the field or other individuals that you would recommend we speak to?

Discussion Questions: Individuals with Broader Knowledge

1. To begin, can you tell me a bit about your professional background, particularly with respect to health and social service initiatives?

    a. We are particularly interested in efforts/initiatives that coordinate services for a broad population or community.

2. Based on your experience, can you describe the top two or three community-based organizations (CBOs) that you think have been particularly successful in coordinating health and social services at a community level to address social needs?

    a. What makes them so successful?
    b. **[LOWER PRIORITY, IF TIME PERMITS]**
        i. What are their key functions?
        ii. What are their geographic reach?
        iii. How have they been funded?
        iv. What types of health and social services are coordinated?
        v. What populations do they serve?
        vi. How do they coordinate services between health and social service providers?
        vii. What data is collected and shared?
        viii. How are community health and/or health-related social needs identified?
        ix. How are the impacts of the initiatives evaluated?

3. While this project is focusing on CBOs in which a lead entity coordinates network operations (e.g., Community Care Hubs, other bridge organizations), we are also interested in learning about broader community coordination efforts that identify and coordinate efforts to address health and/or health-related social needs. Such efforts are

sometimes referred to as community governance and can take multiple forms and incorporate input from various sources.

   a. Based on your experience, what would you say are the top two or three most successful community governance organizations involved in coordinating health and social services to address social needs?
      i. What makes them so successful?
      ii. **[PROBE]:** How are they structured? What types of organizations are involved? How is community input incorporated?
      iii. **[PROBE]:** Is there a particular model of community governance that performs well?
      iv. **[PROBE]:** How are community needs assessed?
      v. **[PROBE]:** How is data shared between organizations?
      vi. **[PROBE]:** How are they funded? How is funding sustained?

4. What innovative approaches have communities used to implement these governance structures? How have they been able to overcome the existing barriers and challenges?
5. Based on your experience, do you have recommendations to increase community capacity to provide and coordinate social services?
6. Given where the field is at, what do you think are the next steps to move this work forward

   a. What do you think needs to happen to move this work forward in the next 2–5 years?

7. How could health and social service coordinating initiatives be better supported by federal or state policies or programs?

   a. How can policy levers be improved to increase community capacity to address health related social needs?
   b. What are two – three action items that you would recommend to the federal government to increase progress in social and health care coordination efforts?

8. What can be done to more successfully implement health and social service coordinating initiatives?

   a. What can be done to increase social service provider capacity and service provision for health-related social needs?
   b. What can be done to help replicate and scale successful initiatives in other communities, populations, or settings (clinical, geographic, etc.)?
   c. Other potential solutions?

9. Based on your experience, how could health and social service coordinating initiatives better address issues of health equity? [**FINAL QUESTIONS, LOWER PRIORITY, IF TIME PERMITS**]

   a. Is there anything else we haven't asked that would better help us to understand health and social service coordination initiatives?
   b. Are there any thought leaders in the field or other individuals that you would recommend we speak to?

Appendix B. Discussion Guide for Hub Case Studies

Overview of the Hub Organization

1. To begin, can you tell us a bit about [Hub name] and your role(s) there?
    a. Can you please tell us more about how your role specifically relates to the coordination of health and social services (either individually or as part of a broader network)?
2. How and when did [Hub name] come to be?
    a. Did the Hub grow out of a previous organization, such as an AAA?
    b. Has the organization been part of other initiatives, such as AHC or ACO?
    c. How did the network of CBOs develop?
3. Does [Hub name] have a formal community governance structure? Can you describe that structure?
    a. How are the CBO network partners involved in the governance structure?
    b. How are consumers or people with lived experiences involved?
4. What kinds of staff does [Hub name] employ?
    a. Community health workers?
    b. Social workers?
    c. Other social service providers?
    d. Administrative staff?
    e. Grant-writing or fundraising staff?
    f. Quality and compliance staff?
    g. Technology support staff?
    h. Health care providers or clinicians?
    i. Others?
5. What is [Hub name's] geographic reach?
    a. PROBE: How has the geographic reach changed since the start of [Hub name]?
6. Describe the population(s) served?
    a. What indicators determine the population(s) served?
    b. How are individuals eligible for the services [Hub name] provides identified?

Partners

7. Who are the community-based organizations (CBOs) that are part of [Hub name]?
    a. About how many CBOs are in the network?
    b. What types of CBOs are in the network?
    c. What are the main kinds of staff that work at these CBOs?
        i. Community health workers?

ii. Social workers?
iii. Primary care clinicians?
iv. Behavioral health clinicians?
v. Others?

d. How does [Hub name] build and manage relationships with CBOs?
e. Are there challenges that [Hub name] faces in managing the network of CBOs?
    i. Limited provider capacity in some communities?
    ii. Technological capabilities of CBOs with respect to billing, reporting, and sharing data?

8. What about on the health care side? Who are your <u>health care partners</u>?

f. Do you partner with health systems? Which ones?
g. Health care payers or health plans?
    i. Probe on Medicare, Medicare Advantage, Medicaid, Medicaid MCOs
h. Do you partner with other providers or provider agencies?
    i. Private primary care practices
    ii. FQHCs?
    iii. Others?
i. How are those relationships established and maintained? What are the main challenges in working with payers and health systems?

9. Does [Hub name] have government partners? If so, who are they?

j. Probe for:
    i. Do you partner with public health agencies?
    ii. Social or human services agencies?
    iii. State Medicaid office?
    iv. Housing agencies (e.g., HUD)?
    v. Any other government partners?
k. What level of government—federal, state, county, other?
l. How do you work with your government partners?

10. Are there any other partners in [Hub name]?

Services

11. The next questions are about the services that the network provides. What are the main services that [Hub name] provides?

a. Probe for:
    i. Transportation, housing, food security, home-based health care, behavioral health care, care coordination, care transitions, evidence-based programs.
    ii. Does the Hub agency provide any of these services itself, or are all the services provided by partner agencies?
b. How does [Hub name] determine which types of services to include in the network?
c. Are there challenges in providing certain types of services that you would otherwise like to provide? Has [Hub name] expanded range of services in its network?

d. Do you anticipate [Hub name] facilitating access to additional services and for other population groups over time?
e. Do you screen for social determinants of health/health-related social needs?
f. Do you screen for medical or behavioral health needs?

12. Can you describe the ways that people access services through [Hub name]?
    a. Are individuals identified by CBOs?
        i. Do CBOs conduct screenings for Hub service needs? Or how do they identify potential patients or clients?
    b. Do you reach out to people identified by providers or payers?
        i. Do health care partners conduct screenings for Hub service needs?
    c. Can people directly access services through [Hub name]?
13. Once someone has accessed services through [Hub name], how do they interact with it over time?

Information Technology

14. Can you describe data sharing and referral management between the organizations involved in [Hub name]?
    a. How is data on individual service recipients shared to facilitate care coordination?
        i. What technologies or solutions do you use to facilitate referrals and data sharing?
        ii. Who shares data in this way—which partners?
            1. Probe about CBOs on the one hand and health care partners on the other.
            2. Are there challenges in sharing information in this way?
            3. What successes have you had in information-sharing?
        iii. How do you manage referrals? Do you monitor for closed-loop referrals, and if so, what do you do if you find out that patients are not receiving services they appear to need?
    b. How is data collected on the quality or impact of [Hub name's] services?
        i. How is this data collected on Hub care coordination activities?
        ii. How is this data collected on CBO services?
        iii. How is this data collected on health care services?
        iv. Are there challenges in collecting and analyzing these data?
        v. Do you monitor or report the quality of services that are provided?
    c. What sources of information does [Hub name] use to and assess population needs or impact?
        i. What kind of data do you collect or have access to related to social determinants of health or health-related social needs and service provision? Does the data identify resource needs?
    d. How is success, both short and long term, defined (e.g., key health and social service outcomes)?
    e. How could policies improve data-sharing efforts for this initiative?

f. What challenges do you face in collecting data that could help inform the operations of your network?

Funding Sources

15. How is [Hub name] funded?
    a. How is the core infrastructure of the network funded? Probe for:
        i. Medicare (MA plans/traditional Medicare)
        ii. Medicaid (MCOs/state)
        iii. Other health systems
        iv. Governmental—federal, state, local
            1. Grants support?
            2. Other monetary support?
            3. In-kind or non-monetary support, such as a part-time employee, data analysis, or other support?
    b. How are the CBO-provided services funded? Probe for:
        i. Medicare (MA plans/traditional Medicare)
        ii. Medicaid (MCOs/state)
        iii. Other health systems
        iv. Governmental—federal, state, local
            1. Grants support?
            2. Other monetary support?
            3. In-kind support?
    c. Many organizations combine funds from multiple sources to finance their programs. Does the initiative rely on combining funds from different sources to support its efforts?
        i. Does reimbursement and financing from contracts cover full costs of the Hub services?
            1. If no: How do you cover the additional costs not covered from reimbursement or contract financing?
                a. Probe: volunteers, donations, endowment
    d. How could policy changes improve the financing of the initiative? How are the initiative's operational coordinating activities and care and social service activities funded?

Policy

16. What current policies enable [Hub] to partner with health care organizations?
    a. Probe: federal, state, and local policy
    b. Are there specific policy changes that have contributed to the success of [Hub name]?
17. How could policy changes reduce the challenges that [Hub name] faces in addressing patients' needs?

a. Probe: federal, state, and local policy
b. What do you view as the next steps in improving the work of [Hub name] moving forward?
c. What can be done to increase social service provider capacity and service provision for health-related social needs?
d. What would make this initiative replicable and/or scalable to other communities, populations, or settings (clinical, geographic, etc.)?

Appendix C. Detailed Case Study Summaries

VAAACares

Virginia Area Agencies on Aging—Caring for the Commonwealth (VAAACares) is a Hub operating statewide in Virginia. The Hub grew out of a nonprofit AAA known as Bay Aging, which has operated since 1978 in the largely rural Middle Peninsula and Northern Neck region of the state. The origins of VAAACares date to 2012, when Bay Aging received funding from the CMS Innovation Center's CCTP (Vesley-Massey, 2019). The CCTP provided support services for Medicare beneficiaries during their transition from hospital or nursing homes to their own homes, with the goal of avoiding readmissions. In 2013, Bay Aging expanded the CCTP program to include five health systems, 69 skilled nursing facilities, and four AAAs covering 20 percent of the state. The new program, called the Eastern Virginia Care Transitions Partnership (EVCTP), followed the Care Transitions Intervention model, in which coaches provide in-home assessments and care coordination in addition to fall-prevention and chronic disease self-management counseling using motivational interviewing techniques. Building on the experience and infrastructure of the EVCTP, Bay Aging led an expansion of the service network by partnering with AAAs across the state and forming VAAACares. The Hub remains headquartered at Bay Aging but now covers the entire state and has begun to work outside Virginia, providing financial management contracts and hub-and-spoke model networks in other states.

Community Governance

VAAACares does not have a separate governance board from Bay Aging. The board of directors for Bay Aging is composed of elected public officials, representatives of low-income persons in the areas served, and members of businesses or organizations in the community. VAAACares is currently considering developing its own community governance board. The Hub has an advisory group, which includes diverse community members and has a cochair in the governor's office; the Hub is thinking of formalizing this group into an official advisory or governance body for the organization. VAAACares holds stakeholder meetings for its CBO network, which are attended by about 150 organizations.

Relationships with Community-Based Provider Organizations

VAAACares's parent organization, Bay Aging, is a AAA, which has a history of direct service provision and contracting with local provider agencies. The Hub maintains these relationships locally while developing new relationships with provider agencies in other areas in which it operates. In some cases, relationships with provider agencies are mediated through other

local AAAs; in other cases, the Hub connects directly with community providers. Relationships with provider organizations are established on a one-by-one basis, starting with discussions of the CBO's capacity, data systems, ability to assess quality and cost of services, and other capabilities that are required to participate in the Hub network. After initial discussions, VAAACares staff often make site visits to CBOs to see the facilities and their operations in person. As one discussant described this process, "It's just like dating. Do we have anything in common? What are your interests?" The CBOs are vetted formally using readiness assessments, similar to those used by payers to assess Bay Aging. VAAACares also provides training in business acumen to CBO provider organizations that is designed to strengthen these organizations' administrative capabilities so that they can continue to operate independently, without being absorbed into a larger organization that would be less tied to its local community. The Hub refers to about 100 CBOs on a daily basis and can draw on an additional group of about 400 organizations for more occasional referrals.

Health Care Partners

VAAACares has contracts with Medicare and Medicaid managed care plans, health systems and hospitals, and the VHA. The contracts generally involve serving as a single contracting entity for a network of CBOs to provide post-acute care for designated lists of payer or health system beneficiaries or patients. The services are generally financed on a fee-for-service basis, with a small percentage of billing allocated to VAAACares to support its role as the Hub. According to the Hub leadership, the Hub has advocated for value-based payments, in which it would be held accountable for performance on quality metrics, but the payers have not agreed to these arrangements.

Government Partners

VAAACares interacts with the Virginia Department of Health (VDoH) in activities related to certification and training of staff, which the department regulates as requirements for reimbursement. The Hub has had the health coaches be trained and certified as community health workers. From the Hub's perspective, the certification enhances the capacity of the coaches and enables the Hub to provide a broader variety of services, for which it also provides training, such as evidence-based behavioral health and fall prevention programs. VAAACares also routinely works closely with the state secretary for health and human resources on issues, such as certification and health information exchanges. However, the VDoH is not aligned with the goals of the Hub in all respects. For instance, VDoH has contracted with a for-profit company to develop referral software using a commercial platform, which does not fit well with the Hub model because it simply announces referrals without tracking subsequent service provision and quality of care.

Hub Services and Operations

The primary focus of VAAACares, in line with its origins in the CCTP, is on care coordination and navigation linking acute care with home-based care. Some of the programs continue to use a coaching model, in which a coach meets with a beneficiary in the hospital prior to discharge, assesses their home-based health care needs, and follows up with the beneficiary post-discharge to directly assess the at-home conditions and arrange for services to address ongoing needs. In addition to the care transitions services, VAAACares also provides access to home and community-based care coordination to address transportation, food insecurity, housing, social isolation, chronic disease, and fall prevention; comprehensive needs assessments for MCO beneficiaries; and home and community-based models of care for chronic disease self-management, depression and anxiety, mental health first aid, motivational interviewing, and fall prevention.

Informants emphasized that the most difficult HRSN to address is housing: "We can't make promises on housing." The Hub can connect beneficiaries to housing support services, but these services tend to have long wait times and not result in immediate housing placement. The difficulty in addressing housing insecurity is simply the high cost of housing: "It is so expensive that MCO's do not want to reimburse us what it would cost to house someone."

Individuals access Hub services exclusively through referrals from the health system or payer that they contract with; there are no self-referrals. The Hub receives files with names and contact information from the health system or payer. The Hub then sorts the contacts and fields them out to the appropriate CBOs. If the contract is for coaching services, the CBO will select the coach, who will meet with the beneficiary in the hospital and begin preparing for the move home. In other cases, depending on the contract terms, an assessment may be made over the phone, or the referral may come in after an assessment has been made. Some contracts are for care coordination for beneficiaries who are already in the community. For these contracts, the Hub will receive names and contact info from the provider and pass them to a CBO to make cold calls; a CBO might make 50 to 70 calls in a day, resulting in new connections with ten beneficiaries. The exact nature of the services and the path into the Hub will depend on the contract under which the beneficiary is covered.

The CBO provides the specified services, along with services to address newly identified needs, and reports to the Hub on what they have provided. The Hub collects this information and manages billing the health system or payer.

Information-Sharing

IT systems have been developed for sharing information both between the Hub and the health systems and payers and between the Hub and the CBO organizations, but the systems have yet to link these two sides of the Hub's operations. Information comes to the Hub from the health care systems or payers, and the Hub distributes it to CBOs. The CBOs share information on their

services with the Hub, and the Hub then shares this information with the health system partners. This last phase in the information-sharing process is time consuming because information from the CBOs has to be manually entered into the health system EHRs. (In a limited number of cases, the CBOs can directly enter information into the health system EHR, but they must also share this information with the Hub, not avoiding the need for double entry.) The Hub can specify the system that is used to share information with CBOs, but the health system partners use a variety of systems, requiring the Hub to learn each system to share information.

Billing information is sent from the Hub to the health system partners using a separate system. The Hub receives information from the CBOs on the services they have provided and Hub staff translate this information into billing codes, which are entered manually into the health care partners' billing systems. They are currently working with a software vendor to develop a new product that will facilitate this process so that the billing data do not have to be manually entered. Developing this system has been challenging because of the difficulty managing billing for care coordination and care management. Simplifying the billing codes for the kinds of services that the Hub manages would greatly reduce the administrative burden of billing.

The VAAACares staff contrasted their system with other referral systems that simply send out referral information to a list of provider organizations. Those systems track whether a referral was made and, at most, whether an organization responded to the referral. A referral is considered successful for the originating organization when a receiving organization responds. However, the system does not collect any information on the services that were actually provided to the referred beneficiary or on the quality of those services. The system that VAAACares uses to share information with its service provider network collects this deeper level of data, enabling monitoring at a deeper level. If a health system or payer contracts with the Hub, they can have a higher level of assurance that services are provided with fidelity than if they used one of the referral platforms.

The Hub has invested in systems to capture data on care transitions. As one informant explained:

> We purchased technology specifically for that so we can track [care transitions]. We have the technology where we capture the data, we have some background on the patient or the member and then we capture what our intervention was. And then we can track it and tell you we know the previous hospitalizations and such. We can tell you subsequently what happened after our interventions.

There are also separate information systems for sharing information with the federal government, including reporting required by grants from ACL and separate systems for reporting to state and federal agencies on aging, transportation, and housing: "We have four different housing databases." Finally, the Hub lacks access to information on utilization of acute care and costs of care, which limits its ability to assess its impact on total costs of care and the success of individual CBO providers in keeping beneficiaries out of EDs and hospitals. These data eventually become available through the Medicaid claims, but the lag makes it unactionable.

Financing

Sixty-five percent of Bay Aging's revenues come from VAAACares contracts. Braiding and blending of revenues from multiple sources occurs when additional HRSNs are identified and addressed using alternative resources, such as financing for housing or meals. Housing in particular requires alternative financing because the costs are too high to be paid solely by the health care partners. To date, the Hub has been successful in part because of its nonprofit status. As an informant put it:

> We're a nonprofit, and I think that that is significant, that we can operate on a little bit slimmer margin. So we don't have to gouge in our pricing, but we have been very successful at Bay Aging in selling to health plans, health systems, other health providers and . . . of course the VA is a big contractor with us also.

Policy Issues

VAAACares staff identified two policy issues of concern. First, there is a concern that the state auditing requirements might make it difficult to continue operating as a Hub located within a nonprofit provider organization, as VAAACares is located within Bay Aging. If the state requires that the organization open the books of the Hub in the same way as is required of Bay Aging, the Hub will be pressured to split into two organizations. This is because the contracts with health care partners have nondisclosure elements that can't be made public. Those organizations will not contract with the Hub if the contract terms will be public because of their concern over proprietary information. The steady revenue from the contracts is essential to the model, but the auditing requirement is a potential threat. The process of splitting the organization would be complicated and wasteful.

Second, as noted above, the fee-for-service billing process is unnecessarily complex for the Hub because of the effort required to translate service delivery information from the CBOs into billing codes used by each health system partner. These codes are complex and variable across systems for the kinds of services that Hubs manage, such as care coordination. Simplification of the billing codes for these services would reduce the administrative burden on the Hub. Alternately, financing arrangements that require less fee-for-service billing, such as value-based payment models, would be desirable from the Hub's perspective because it is already able to collect quality measure data from the service providers.

Community Care Solutions

Community Care Solutions is a Hub operating in 18 counties in Alabama that have a significant rural and elderly population. Community Care Solutions grew out of a local quasi-governmental AAA, Southern Alabama Regional Council on Aging (SARCOA). Established in 1986, SARCOA has a history of direct service provision and contracting with local provider agencies. The decision to create Community Care Solutions grew out of SARCOA's decision to

participate in CCTP in 2013. The CCTP was to be SARCOA's first entrance into the health care services arena. SARCOA's director at the time saw a need for the creation of a separate entity outside the quasi-governmental structure of a AAA to act as "lead entity" for the CCTP contract and other emerging programs that married health and social care services, many of which would likely require the organization to have a provider identification number. Through its work with CCTP, Community Care Solutions also began serving patients outside its traditional region, including those in other counties in Alabama, as well as neighboring areas in Georgia and Florida. When CCTP ended, Community Care Solutions looked to continue its work by establishing additional contracts, which again put them into contact with patients in new counties in Alabama. Through its contract with a regional health plan that wanted coverage for its consumers in 18 counties in Alabama, Community Care Solutions established a formal relationship with another AAA, Central Alabama Aging Consortium (CAAC), to provide and organize services for those living in seven counties well outside SARCOA's traditional service area. Today, SARCOA health coaches provide services in 11 of the 18 counties where Community Care Solutions functions, and CAAC provides services in the other seven counties.

Community Governance

Community Care Solutions was formed with its own board of directors. In addition, the Hub draws on the community advisory input from both SARCOA and CAAC. Each of these AAAs has its own advisory council that consists of program participants, service providers, caregivers, and community members. The councils give feedback to the AAAs and the Hub on their operations and provide information about the current and future needs of the elderly community.

Relationships with Community-Based Provider Organizations

Community Care Solutions' parent organization, SARCOA, is a AAA and contracts with 55 home and community-service providers. In addition, Community Care Solutions partners with CAAC to provide and organize services for those living in counties outside the 11 counties that SARCOA serves for Community Care Solutions. Both AAAs provide social services directly themselves and have longstanding relationships with other CBOs in their communities that they can connect their clients to for necessary services. These AAAs also work outside their traditional service areas in the work they do for Community Care Solutions. In our conversations with Community Care Solutions, staff stated that they hope to be a statewide Hub at some point but that there can be challenges in expanding into some counties in Alabama because of low population density.

Health Care Partners

Community Care Solutions has two main care management contracts with health care partners: one with a health care provider serving the counties in which it operates and one with a health insurer. The health care provider contracts with Community Care Solutions to meet the

necessary performance metrics and outcomes for its patient population that are expected as part of its participation in an ACO. The contract with the health insurer extends beyond SARCOA's traditional service region, which led Community Care Solutions to partner with CAAC because CAAC was already working in other counties and had existing connections to home and community-service providers in those areas.

Government Partners

Community Care Solutions does not have any significant relationships with government agencies beyond SARCOA's role as a AAA, its participation in CMS programs, and its treatment of Medicare and Medicaid beneficiaries.

Hub Services and Operations

Health coaches are at the core of Community Care Solutions' work. Health coaches are directly employed through SARCOA and CAAC, but their salaries are covered by the contracts that Community Care Solutions has established with its health care partners. When new clients are identified, Community Care Solutions sends health coaches to connect with patients and conduct an initial needs assessment. The health coaches will then help identify the social services needs of the patients and connect them to the appropriate programs, either those that exist within SARCOA and CAAC or to other CBOs. New clients are identified proactively through claims data from its contracted health plan and health provider and through referrals from its contracted health provider, case managers, and from its health coaches based in a local hospital.

Information-Sharing

After reviewing the available software for case management and data sharing, SARCOA decided to work with a vendor to develop its own IT system. The software incorporates all case management activities and acts as a system of record for all activities. The software that SARCOA developed has now been adopted by all the other Alabama AAAs (as well as Community Care Solutions), and SARCOA administers the platform for the network of AAAs.

Health coaches are one of the key sources of data for Community Care Solutions' information system. The coaches conduct needs assessments with clients and input that data along with their narrative notes and information about the services they provide or connect clients with into the system. Using tablets in the field and a cloud-based system, this information is available immediately to all approved users.

To maintain data safety, Community Care Solutions' IT system uses NCQA standards and minimum access standards to determine which users can see what information. Community Care Solutions also has a segmented data system to keep information that is relevant only to SARCOA or Community Care Solutions separate and not unnecessarily mingle the data.

In interacting with health care partners, Community Care Solutions' information system does not include a two-way interface that allows its data system to connect with a health care

provider's or health plan's system. This means that Community Care Solutions must duplicate some of its data entry, first inputting it into its own system and then inputting it directly into the health plan or health care provider's health system. Community Care Solutions also receives claims information from its health care partners, although these are delivered as a separate monthly file transfer. Community Care Solutions highlighted that becoming an integrated part of its health care partners' IT systems was likely not high on its partners' to-do lists because Community Care Solutions is only a small part of their larger portfolio of work, although that is a goal of Community Care Solutions for the future.

In addition to its discussion of duplicate data entry and not being fully integrated into its health care partners' systems, Community Care Solutions highlighted some additional challenges it faces with its information system. Because data comes from multiple sources, variation in data quality was one issue. To address this, Community Care Solutions has implemented processes to clean and translate data as it comes in. It also discussed a need for more data analysts because it is currently not able to maximize the data it has. More staff focused on analyzing and understanding the data could help to improve its workflows and allow it to present more results around quality improvement and return on investment than it currently is able to.

Financing

At its start, Community Care Solutions was created using funds that SARCOA had built up through its work as a AAA. These startup funds were necessary for getting Community Care Solutions off the ground because there was little to no external funding available to create a Hub in the early 2010s. In addition, funding stability would have been challenging in the early years of developing the Hub without the funds from SARCOA that Community Care Solutions was able to use. CCTP was Community Care Solutions' first major activity and was followed by CCTP II, as well as evidence-based diabetes management and nutritional management programs. Today, Community Care Solutions blends and braids funding from a variety of sources, including grants, contracts, and donations. Its key contracts are with two health care partners that include a state health plan and an independent medical practice that is part of an ACO.

Policy Issues

Community Care Solutions also discussed several policy issues that it has faced. When it comes to funding, it discussed the importance of finding funding to pay for hiring, training, and building up a well-prepared staff with appropriate expertise and ability to understand the Hub's practices, policies, and information systems. This funding is needed both before a Hub can really get off the ground and to sustain it moving forward. Although it reported seeing increases in these funding opportunities for newer Hubs since Community Care Solutions began, it highlighted the importance of sustainable funding and getting the timeline right for receiving the initial funding and getting staff hired and trained before a new program or project begins.

Another policy area that Community Care Solutions discussed was the growing emphasis from CMS on screening for SDOH. In addition to expressing support for this policy shift, Community Care Solutions also highlighted a desire for CBOs to get credit for the work involved with screening for SDOH, for referring patients to resources to address their SDOH or HRSNs, and for following up with patients to make sure that the referral is successful.

Finally, Community Care Solutions expressed a desire for more consistent standards for programs so that the services provided and the expectations for what a Hub does is similar across both the state and the country. Community Care Solutions also felt that policies supporting this work should be aligned with the standards. However, it did highlight that, although structure through standards could be beneficial for improving consistency, allowing for flexibility is important so that CBOs and Hubs can figure out how best to organize, staff, and run their Hub and networks.

Direction Home Akron Canton Area Agency on Aging and Disabilities

Direction Home Akron Canton Area Agency on Aging and Disabilities (DHAD) is a AAA operating in four counties in Ohio. It is part of Direction Home LLC, a network that includes all 12 of the state's AAAs. A key program that the Direction Home LLC network provides is to support acute care transitions. DHAD acts as the Hub for this program. The acute care transitions program originally began in response to CCTP in 2012. After that program ended in 2017, DHAD began exploring alternative contracts to continue providing acute care transition support and began formally contracting with a state health plan in 2018. Initially, the contract was specifically for the health plan's Medicare Advantage population in a few counties in the state but eventually grew to include all the plan's enrollees throughout the state's 88 counties.

Community Governance

DHAD does not have a community governance structure that is specific to its Hub work. However, as a AAA, DHAD does have a board of directors that consists of 22 members representing health care and business professionals and community members. All members of the board have experience in health, long-term care, and community services. In addition, DHAD receives input from community members through an areawide advisory board. The board consists of approximately 35 representatives from the four counties that DHAD serves as a AAA, and half of the members are over the age of 59. The group meets on a quarterly basis and discusses such topics as provider allocations and area plan recommendations, advocacy training, agency updates, and other topics that relate to older adults in the area. The president of the areawide advisory board also serves as a member of DHAD's board of directors.

DHAD staff highlighted the value of having a AAA act as Hub by emphasizing that they have long held "the role of assessing need, providing information, referrals, and support to

people across programs," which "helps ensure barriers and gaps are met outside of the patient's transition needs."

Relationships with Community-Based Provider Organizations

The network of CBOs that participate in DHAD's acute care transition program include all 12 AAAs in Ohio, allowing the network to provide coverage to members of their contracted health plan in all counties in the state. The health plan contracts directly with DHAD, and the other AAAs act as subcontractors. In discussions with DHAD, it highlighted that it "[has] a very strong state association within Ohio across the AAAs" and that "the value in just sticking with the AAAs is we know each other. We have worked with each other for years. We openly share best practices with one another. We're better together as an organization." Although DHAD does refer individuals to other CBOs in cases in which individuals need services that the AAAs do not directly provide themselves, DHAD does not formally subcontract with these CBOs for this program. DHAD does see potential future partnership opportunities with other CBOs in behavioral health and addiction medicine because it does not currently have as much expertise or experience addressing these needs.

Health Care Partners

DHAD has health care partnerships as a Hub with a state health plan and with nearly all hospitals and health systems throughout the state. In many hospitals, RNs participate regularly in Ground Rounds to identify potential patients who could benefit from the acute care transition support that is provided by the network. The health coaches also interact with the patients' primary care practices. As was explained during our discussions with DHAD staff, "the registered nurse [who acts as health coaches to participating patients] can call physicians directly if needed, but at a minimum, the primary care physician receives an outcome-based summary on our interaction with their patient," as well as the detailed medication reconciliation that was completed by the health coach in the patient's home.

Government Partners

For the overall work that DHAD does as a AAA, it partners closely with the Ohio Department on Aging, the Ohio Department of Medicaid, CMS, and ACL. These partnerships benefit the patients who participate in the Hub's acute care transition intervention because the health coaches are able to refer eligible patients to other programs supported by government funding and partnerships.

Hub Services and Operations

Under the current iteration of the network's acute care transition intervention, a health coach (who is an RN) works with patients that could benefit from additional support as the patients

transition from a hospital or SNF stay back to their homes. Patients are identified either by the health plan or through attendance at hospital Ground Rounds. The health plan's referrals for the intervention come in the form of a daily list of patients with an inpatient stay or an upcoming scheduled procedure or surgery. Additional participants are also identified by staff who are a part of the network attending virtual Ground Rounds with hospitals throughout the state to hear about potential patients who could benefit from acute care transition support. These patients still must be enrolled in the health plan to be eligible for the intervention, but they are sometimes not on the list that DHAD receives from the health plan because they do not fall into the categories that the health plan looks for to identify potential participants.

Once a referral to the intervention has been made, staff try to connect with the patient before they leave the hospital, SNF, or rehabilitation facility, either through an in-person or telephonic visit. For patients in SNFs or rehabilitation facilities, the health coach will stay in contact with the facility to receive updates on the patient and identify the likely discharge date. Once a patient is discharged, the health coach conducts a home visit within one to three days of discharge. During this home visit, which lasts between 60 and 90 minutes, the health coach will review discharge instructions with the patient, confirm follow-up appointments, discuss potential red flags or symptoms of decline they want to watch out for, conduct a medication reconciliation, evaluate for any social service needs, make referrals, and conduct a fall risk assessment. As part of the intervention, DHAD is also starting to pilot a caregiver support program in which the health coach identifies if there are any needs of the patient's caregiver that are not being met. The home visit is then typically followed by two phone calls between the health coach and the patient over the next 30 days, in which the health coach will tie up loose ends on any referrals that were made, identify any new areas of concern since the previous interaction, and reinforce any education or information that was given during the visit. The intervention ends at 30 days post-discharge.

Information-Sharing

Across DHAD, several systems are used to collect, track, and analyze patient data and the services that the AAA provides. The data from these systems are used to produce regular reports for a wide variety of partners and needs. In addition, the Hub collects weekly satisfaction surveys from clients using the AAA and Hub's services.

For its Hub program, DHAD has a specific data system that gathers information from health coaches across the state on the services they provide in the acute care transitions intervention. This system is not interoperable or integrated with the health systems or the health plan with whom DHAD partners. Data from the health plan about potentially eligible patients for the intervention are based on the health plan's claims data and is delivered to DHAD on a regular basis. The Hub also uses a statewide health information exchange, which allows DHAD to quickly obtain information about patients and program participants. Overall, across both the Hub

and DHAD's larger portfolio of programs, staff expressed a desire for a more integrated, interoperable system.

Financing

The Hub's work was initially financed through CCTP and did not require significant additional startup funds. By braiding and blending DHAD's overall funding sources for its programs, it was then able to cover the gap between the end of CCTP and the start of its contract with the state health plan so that it could keep key staff onboard and not lose the institutional expertise it held from implementing and running the network's CCTP work. The current contract for the Hub's work is based on a per-intervention payment. Recently, this payment was renegotiated to incorporate support for some of the work done outside the direct services provided through the intervention, including finding and updating patient contact information, collecting additional information for the health plan about patients' health and social needs, conducting the fall risk assessment (which was more recently added to the intervention), and an administrative fee for DHAD. In addition, there is a risk component to DHAD's payment should the network not meet quality goals regarding 30-day readmission rates and patient satisfaction.

DHAD's larger portfolio of work is funded through Medicaid, the Older Americans Act, and other government funding, nongovernment contracts, state and local funding, and other sources. DHAD also discussed a useful cost model framework that it created that helps it quickly cost out potential programs.

Policy Issues

DHAD staff highlighted two main policy issues in which they thought additional guidance or future policies could help to better support Hub work. First, staff discussed the need for improved interoperability and integration of IT systems used across service providers and partners. They pointed to the support given within health care for providers to improve their health information systems to reach meaningful use standards and suggested that there is a need for "that investment in long-term care, long-term services and supports providers" as well so that they are "able to really scale up" their systems.

Another policy area that DHAD staff highlighted was around accreditation requirements. Specifically, staff questioned whether all partners involved in a contract need accreditation or whether it is appropriate and sufficient for the Hub to have that accreditation without requiring it of those who are acting farther downstream in the process. As staff explained, one of the benefits that Hubs provide is their ability to keep overhead low and ease the contracting and partnership process across health and social care providers while ensuring security expectations and standards are met. However, when all partners are required to reach a certain level of accreditation, that increases costs and burden. As DHAD staff said during our conversations, "the role of the Community Care Hub [is] to streamline infrastructure and keep costs low, but

provid[e] that standard oversight that we've already built." This role and value can be diminished if accreditation requirements become overly applied and burdensome.

Houston Health Department

Unlike the other case studies in this report, the Houston Health Department Hub is still being developed and has not yet begun to operate as a Hub. Planning for the Hub is currently being conducted by three partners: (1) the Houston Health Department itself, (2) a group of population health researchers at the University of Texas, and (3) the Houston Health Foundation, an independent nonprofit organization that creates public-private partnerships to advance public health in the Houston region. The three organizations have been meeting regularly to develop detailed plans for implementing a Hub model. In this summary, we focus on factors that have influenced decisionmaking by the group developing the Hub during the planning process.

Within the Houston Health Department, the group working on the Hub is the local AAA. The Houston AAA is the largest of the 28 AAAs in Texas, and it has already been acting like a backbone organization in some respects. Although the AAA does not contract with payers, it contracts out 98 percent of its services to community-based providers. The only services that are not contracted out are care coordination and caregiver support coordination. The university-based group has experience as principal investigators on an AHC grant from CMS, which supported integrating efforts to screen for and address SDOH across multiple health care systems and hospitals in the Houston region. With that experience, the university-based team brings expertise in identifying HRSNs in health care settings and the challenges of addressing those needs in the community. The third partner, Houston Health Foundation, works closely with Houston Health Department to administer public health programs in the community, such as a community food security initiative, a youth violence prevention program, and a diabetes awareness and wellness network.

Community Governance

Each of the three organizations developing the Hub has a different governance structure. As part of the city government, the Houston Health Department is accountable to the city administration and the voters. Being located in a governmental agency also means that the Houston Health Department is accountable to the complex bureaucracy of city government. The university-based team did not have a community governance board for the AHC that they created. Houston Health Foundation has a governing board that is responsible for the entire organization but is not designed to represent the Hub network or the community served by the Hub. In planning discussions, the three organizations have discussed creating a community governance board using a community engagement approach, but that process has not yet been initiated.

One of the major issues to be decided in the planning process, which concerns the varying governance structures of the organizations, is where the Hub would be housed. Initially, the Houston Health Department was considered the appropriate home for the Hub because it houses the AAA and has the most extensive connections with CBOs. However, the bureaucratic processes that are required to operate within a city government, such as the contracting issues discussed below, were found to be overly burdensome. Consequently, the current plan is for the Hub to be housed within the Houston Health Foundation.

Relationships with Community-Based Provider Organizations

The network of CBOs that have a history of providing services under contract with the Houston Health Department would serve as the core of the CBO network for the Hub. There are about 40 such agencies, and they tend to be large for CBOs. For most of these organizations, the Houston Health Department is not their only contractor. The AHC also has a history of working with CBOs that provide services to address HRSNs, though not through contractual relationships. As part of the planning process, the AHC inventoried the existing programs and identified 150 CBOs that could be part of the network. The organizations in the AHC network provide a broad variety of services, including home food delivery, access to community meals, diabetes prevention, education, housing, housing navigation, travel vouchers, home improvement vouchers, and services for adults to combat loneliness. Some of the organizations are quite small.

Health Care Partners

It is not yet clear who the main health care partners would be, and all the possibilities remain under consideration: local hospitals and health systems, Medicare Advantage plans, and Medicaid Managed Care plans. The Houston Health Department has a history of partnering with local health care systems on care transition projects, so there is a basis on which to build those relationships for the Hub. The department also has a history of working with United Healthcare to provide care to hard-to-reach populations. The health systems that partnered in the AHC model would also be natural partners for the Hub.

Government Partners

The Houston Health Department regularly works with other arms of the city government, such as work it does with the housing authority to provide housing vouchers to people at risk for homelessness. However, within Harris County, where Houston is located, there are many municipalities. Part of the planning for the Hub has been strategic thinking about how to include more of these municipalities. The planning group has also had discussions with the state Medicaid office about how they might work with Medicaid payers.

Hub Services and Operations

Multiple models for Hub operations are being considered. The strategy is to start on a small scale by contracting for a clearly defined set of services with which they are familiar, such as post-hospital transition care. The scope of services could be expanded if those initial contracts were successful. However, the Hub would function differently from how the Houston Health Department has worked with hospitals in the past. The department used to embed a staff person within the hospital and then start the transition process from the hospital prior to discharge. The embedded staff were able to review the census every day to identify patients; they may have been looking for patients with specific conditions, such as CHF. In the Hub model, the department expects that the referral would come from outside the Hub (e.g., from an MCO) and that the Hub would then need to identify the appropriate CBOs to provide needed services. The Hub might identify more needs than were initially identified, and it might make referrals beyond those initially requested by the referral source.

There is also discussion about how best to use what was learned from the AHC model for developing the Hub. The AHC model was based around screening patients for SDOH. Using the results of the screening, AHC would then provide navigation related to SDOH needs for one year. However, the Hub model does not have clear guidelines about how these operations should be structured. Having to work with each payer and meet their needs for social services is more challenging. In addition, the Hub involves direct contracting with the CBOs and monitoring of the services, which was not part of the AHC model. Ideally, according to one discussant, a person would be referred following screening to the Hub and the Hub would have the decisionmaking ability to route the person to the right CBO to get the services they need, and this would be an integrated system.

Information-Sharing

The Houston Health Department is currently considering using a commercially available platform for its Hub EHR because it has used it in the past, and several of its CBO and health system partners already use it. However, it is not completely clear that the platform will be able to do everything that is needed for the Hub, including sending referrals across systems. The department is currently investigating how other Hubs have set up their EHR systems. They told us: "So that's where we are also looking at some other Community Care Hubs and different states to determine how they work that [data-sharing] process out so that we can . . . purchase a new type of system that works, that's compatible with [the system], and that is accessible by the community-based organizations." The information systems for the AHC model did not require sharing information with CBOs electronically because the system only made referrals. No health-related information was shared, and closed loop referrals were not tracked.

Several other challenges related to information systems were mentioned. There is a need for information security, which the selected system provides, but it needs to be strengthened when

CBOs get involved. There has to be consideration of where the information will reside. In the AHC model, the university was able to store information because they are a CMS entity. The cost for IT is considerable, and it involves upfront investments that need to be paid for. To use the selected system, the Hub would need an IT team, a quality improvement team, and the hardware infrastructure. The CBOs need training in the technology and reliable internet service in their area, which might be beyond anyone's control. Working with the CBOs around technical skills is challenging because so many of their staff are volunteers, and they have high turnover.

Financing

The Hub planners anticipate that the financing for the Hub will come primarily from contracts with Medicaid managed care companies. There might be some other sources, such as the state fund for care for the uninsured and local care systems. The Hub planners hope to get some grant support to help launch but would rely on contracts for sustainability. They have been learning about strategies involving blending and braiding sources of financing, but they are wary of being put in a position in which they have to provide financing for services outside their contracts. In the past, the department has had the experience in which they provided services for a health system and demonstrated good outcomes, but the health system nonetheless stopped providing the service as soon as the external funding ended. In some cases, there are services that can be billed to Medicaid, but they are currently provided by the Houston Health Department for free. In these cases, the payers will not be interested in contracting to pay for what they are currently receiving for no cost. As one discussant said, "So there's all these models that we're trying to, you know, work through, but at the same time not undervalue what we what we offer and what we can bring to the table."

Policy Issues

Discussants expressed concern that the incentives for payers to work with Hubs are not strong enough. As one discussant said, "We are putting money into the sick care system where we don't want this work to reside, and then rely on that system to be benevolent and contract with Hubs." It might be important, therefore, for CMS to have requirements regarding how money flows to Hubs and CBOs. Another concern is with duplication of care coordination efforts, with care coordination happening within health systems (often in multiple locations) and within the Hub. It would be more efficient to figure out one location from which to coordinate care. Finally, establishing the Hub would be facilitated by expanding Medicaid.

Partners at Home

Partners at Home is a Hub located in California, providing services in all 58 counties in the state. Partners at Home is the name of the Hub network that is a division of the larger Partners in Care Foundation (Partners) organization. The Hub grew out of work done in the Los Angeles

County area as a part of the Nursing Home Diversion Program under California's Medicaid Waiver. That led to a statewide contract with Blue Shield. Partners in Care also participated in CCTP. Partners recently hired a new senior director and director for the Hub to support ongoing Hub activities now that the core infrastructure has been built out. The Hub uses a centralized approach to organizing its different partners and types of programs. All financing, billing, and compliance is centralized in the Hub and disseminated to partners. Leadership in the Hub is active nationally in the Partnership to Align Social Care, in which they participate in creating a core set of functions for Hubs.

Community Governance

Partners at Home uses a member agency model for governance. The board does not have a bylaw structure. Most members are CEOs or their designates at partner organizations. Information from the Hub is shared at the member agency level. All members are invited to regular monthly meetings for briefings and for input and to identify issues. Partners is a direct service provider as well. The Hub works to provide feedback on information from member agencies to the payers and other partners. The Hub is working to formalize the process of collecting information from the member agencies, which is then fed back to the payers to inform future programs and contracts. One mechanism that has been used to elicit information on programs is the Net Promoter Score through patient satisfaction surveys, which is required for all beneficiaries served under its Blue Shield contract.

Relationships with Community-Based Provider Organizations

The majority of CBO partners specialize in home care and in care management and care coordination and include local organizations, such as adult day health care centers, senior centers, home care agencies, aging and disability serving organizations, Meals on Wheels, and family services organizations. Service providers vary based on the counties and the contracts that Partners at Home has in a given area. The Hub looks at it primarily from a county-level perspective, identifying community organizations in that county and their ability and capacity to meet the projected volume expectations from the payer's side. The Hub uses a "friends-of-friends" model—or organizations that look like Partners—to identify new partners, particularly those that operate statewide. The value of organizing into the Hub is both that health care organizations do not need to have hundreds of contracts with service providers and to provide the Health Insurance Portability and Accountability Act (HIPAA) and compliance training to partners so they are trained to provide services for health care organizations. The Hub model allows member agencies to focus on what they do best (beneficiary social care and well-being) while the Hub focuses on the administrative services of health care contracts.

Health Care Partners

Through the larger Partners organization, Partners at Home holds contracts with health systems, hospitals, medical groups, and health plans, including Medicare and Medicaid but often with all business lines, which are negotiated individually and vary in scope. The contracts are based on the health care partner's needs, the target population, and the types of providers available in the area(s) of operation.

Government Partners

Partners at Home did not note any government partners for service delivery through its Hub. However, Partners at Home has engaged the state Medicaid agency in the CalAIM rollout and has received funding through government agencies, such as ACL, for infrastructure development.

Hub Services and Operations

The Hub function is to first identify the needs and to then identify the solutions, codesign them, and implement them. Care coordination is the primary service provided by the Hub and its partners. It can be provided through short-term engagements (30 to 90 days) or longer-term engagements. Within the care management model, there are a variety of services provided. One service is supporting transitional care from the hospital for Medicare and Medicaid beneficiaries. Another set of services revolves around personal care, homemaking, nonmedical respite services, and meals, including medically tailored meals. In 13 counties, the Hub has a self-management program under the Older Americans Act. These are evidence-based programs to help people adopt better behaviors to achieve better health outcomes.

The Hub plans to add more services over time that align with the organization's mission. The Hub added private duty care, nonmedical home care, and personal care respite services because these services aligned well with the mission of supporting people in the community.

Services begin with a telephone visit or encounter that triggers the case rate. Each service starts with an assessment of the beneficiary and receipt of services for 30 days. The payers identify beneficiaries and initiate the referral. The Hub reviews the referral to ensure all the necessary information was delivered to the Hub. Then, based on the coverage area, the capacity of network members, and the members' ability to take on additional cases, the beneficiary gets assigned to a network member. Service delivery is driven by the scope of work with the health care partner, although a screening is done with each beneficiary. The Hub leverages its resources to provide additional support, such as buying mattresses or other equipment to support beneficiary needs. The Hub has an urgent needs fund that is used to address pressing issues that are not covered by the payer.

Information-Sharing

Partners at Home uses Salesforce as its EHR for many of its health care contracts. Referrals come into the Hub, which moves referrals to partners based on capacity, scope of the member agency, demographics of the beneficiary and the organization, and geography of the beneficiary and the organization. The Hub also manages a call center that receive referrals. Because the main service provided is care management activity, the Hub tracks whether referrals are completed (closed loop) and whether services are provided in a timely manner. Quality is measured through the net promoter score and several process measures, including timeliness of outreach and timeliness of service delivery. In addition, each contract has its own metrics that are tracked as a part of service delivery.

The Hub creates reports and shares data regularly with payers and service providers. For service providers, the Hub creates benchmarks as a mechanism to motivate its network. For payers, reports are contractually agreed on in the scope of work. These reports are shared over a SFTP or secure email because it includes PHI.

Partners at Home reported that it struggles to get outcome data, such as claims and health outcomes, from payers and providers. Defining the outcome in contracts has also been a struggle because social care is a piece of the larger health and utilization of a patient. Another area that is a struggle is the lack of consistent terminology used between medical care and social care. The Hub noted a conversation with a local IT vendor who recommended that there should be work done between the plans, social care, and medical care to collaborate on common information standards for the SDOH marketplace. Right now, there is complexity and inefficiency in the system. The California Department of Health Care Services is flexible and innovative with its programs, leading to many programs with differing requirements. Even within a county, there are several programs operated by plans that vary in their requirements.

Equally challenging is the diverse set of approaches that each health plan or provider can set out as a scope of work to achieve the same result of keeping people independent and well in the community. This multitude of care "roadmaps"—each ending in the same destination but built on its own unique requirement of assessments, IT documentation, and other varied requirements—leads to greater cost and inefficiencies for CBOs and Hubs. An agreed to, uniform roadmap to a care plan would lead to greater efficiency, lower cost, and better outcomes for those under care.

Financing

Partners at Home received startup funding from The John A. Hartford Foundation in 2012–2013. From there, the Hub developed contracts to sustain itself on service delivery activities. At this point, the Hub can sustain itself with the case rate for services provided as the Hub. Although grants are helpful to start, they can be "mercurial." To become sustainable, organizations need to shift to contracts. Grants can continue to be useful in energizing or

expanding the operations of the Hub. Some contracts are per-member per-month payments that function similarly to case rate payments. One service that is typically not covered in the case rate is outreach, which is uncompensated.

According to Partners, CBOs do not struggle with the braided and blended financing model because that is how they have traditionally operated. Payments to the partner organizations in the network are passed through the Hub to the partner organization. The Hub negotiates an administrative fee in each of its contracts with payers and has separate contracts with partners to pay them for the services provided.

Policy Issues

Partners at Home identified a few issues that might require policy interventions. First, the Hub noted that there needs to be policies recognizing how social care operates. Specifically, it noted that health care operates using claims and encounter data, whereas social care does not use that model to track its work. There need to be policies recognizing how social care operates and how that framework can be used in conjunction with the health care framework for care. Second, the Hub noted that licensure issues might be problematic for social care. They noted that social care uses an alternative workforce that should have different standards because they are not facility-based and do a lot of their work during home visits and tracking down beneficiaries where they are. Third, the Hub noted that there needs to be consistency in the services and contracts available to social care organizations. In many cases, social care providers receive lists of patients and are tasked with outreach without payment, or they receive an overwhelming number of referrals at once and then receive none for extended periods of time. Finally, to promote Hub activity, the Hub advocated for increased support from organizations—such as America's Health Insurance Plans (AHIP), American Hospital Association, American College of Emergency Physicians, and government agencies, such as CMS, the Office of the National Coordinator for Health Information Technology, and the CDC—to promote the integration of social care.

Western New York Integrated Care Collaborative, Inc.

Western New York Integrative Care Collaborative, Inc. (WNYICC) is a Hub operating in the 15 westernmost counties in New York, with most of its services focused on the eight counties including and surrounding Buffalo. WNYICC grew out of the efforts of two county-based AAAs and their nonprofit partner agencies in the area who wanted to capitalize on the increased attention that health care institutions were paying to addressing SDOH. The AAAs leveraged their networks to create WNYICC as a separate standalone 501(c)(3) entity to act as a contracting backbone organization in 2014. Because of its start with AAAs, the first few contracts that the WNYICC had were with Medicare Advantage organizations, focusing on the over age 65 population. The Hub currently consists of 54 partner organizations, including two

departments of health, one Center for Independent Living (CIL), eight AAAs, and 43 social care agencies. The Hub is expanding its network of providers to include supports for children and families, as it is preparing to apply to be the lead entity Social Care Network for Western New York under New York state's Medicaid section 1115 demonstration renewal.

Community Governance

The WNYICC board consists of 11 members. All members of the board are either leaders of the member CBOs or former leaders of the CBOs. Board members are elected to three-year terms that may be renewed annually. The four officers of the board make up the executive committee, which has the authority to make decisions on behalf of the full board. The 54 network member agencies are all voting members. Each network member agency is represented by a network agent who has the authority to vote on behalf of the agency. The voting network member agents meet annually to review an annual report and vote to approve the slate of the board. Additionally, network members are encouraged to join one or more of the six committees on the board, all of which are chaired by a WNYICC board member and coordinated by the WNYICC team: (1) Finance/Audit; (2) Network Program; (3) Compliance; (4) Quality Assurance/Data; (5) Diversity, Equity, and Inclusion; and (6) Emerging Business. Some network members are more engaged than others, which is their option. WNYICC's work is informed by the feedback received in the committees.

Many CBOs are very busy or have small staffs, with some consisting of one employee and many volunteers. Thus, the Hub has, in practice, been flexible with respect to its expectations, and CBOs are not excluded if they are not able to participate on the committees. In addition, the Hub works to actively engage network members by providing monthly lunch and learn opportunities; providing updates on national, state, and local policy issues, such as New York state's upcoming Medicaid section 1115 demonstration; publishing quarterly newsletters; sharing information through social media; and holding an in-person meeting every June.

Relationships with Community-Based Provider Organizations

WNYICC has a network of partner CBOs that has expanded from the base of the CBO networks of the two AAAs that originated the Hub. The current network includes a wide variety of CBOs that provide food delivery services (e.g., Meals on Wheels) for people with intellectual and developmental disabilities, temporary and emergency housing, care coordination, and services for criminal justice system–involved individuals. As new needs emerge from either a contract or from external events, the Hub works to add more agencies to its network. For example, in 2023, the Hub focused on bringing in agencies in inner city Buffalo because there was a significant racially motivated shooting that rocked the region. Typically, the Hub uses "friends of friends" (i.e., CBOs that are recommended by existing CBO partners) to build the network. According to the Hub, it is an easy choice for the CBOs to decide whether to join the network because there's no cost to the CBO. CBOs get all the benefits of being in the network—

including advocacy on their behalf and the potential contracting opportunities—and the CBO can be as engaged or not engaged as it wants. All contracted partners are provided training through WNYICC's Training Academy on compliance, program workflows, documentation, how to receive and handle referrals, and invoicing WNYICC for the services they deliver.

WNYICC also has partnerships with eight AAAs all at the county level in its region. In addition, there is one CIL with affiliate offices in all 15 counties that WNYICC serves.

Health Care Partners

The majority of the WNYICC's current contracts are with Medicare Advantage plans. The Hub also has several contracts with Medicaid plans for the Diabetes Prevention Program (because it is a billable Medicaid service in New York state) and several value-based contracts with Medicaid long-term care plans. The Hub also has a few contracts with commercial plans. With the Hub's biggest health plan contracts, they meet weekly to talk through all the different programs included in the contract and take a partnered approach to care delivery. The focus of the weekly meetings is on co-developing processes and procedures, setting up referral pathways, and developing minimum referral guidelines. With other health plans, the Hub might sign a contract and not receive many referrals. The most successful partnerships, from WNYICC's perspective, have been those with regional health plans, particularly those that try to engage and partner with local agencies.

In contrast to health plan contracting, the Hub has struggled with contracting with health systems and providers. As a part of the ACO REACH Model, the Hub was close to having a contract with a system to implement its Health Equity plan, but the system decided to contract elsewhere. According to the Hub, provider budgets are slim, so they may prefer to build supports rather than buy them from (or contract with) outside organizations. In contrast, health plans can bill for services, so they are less reluctant to engage.

Government Partners

WNYICC has partnerships with two departments of health in its region. Although there is mostly benefit for partner agencies, the Hub continuously works through challenges for some partners to sign contracts, particularly health departments and other government agencies or small agencies who do not have adequate insurance. The contracting process with governmental entities can be protracted and take multiple rounds of legal review. WNYICC works with its network members to help reduce the barriers to contracting. It has also received funding through ACL for infrastructure development.

Hub Services and Operations

WNYICC coordinates a variety of services for health plans and is constantly asset mapping, with the goal of expanding the services available to health plans. WNYICC's goal is to not provide services themselves but rather contract with CBO service providers based on contract

stipulations with payers. However, WNYICC's community nutrition program manager, who is a registered dietitian (RD), does deliver the medical nutrition therapy program because of a lack of RDs in the network. The Hub is starting to contract with independent contractor RDs to fill this gap.

The most common service provided is the post-discharge meal delivery program. The service includes two weeks of meals after at least one overnight stay. In any month, there are 80 to 100 members using the service. The Hub also offers multiple coaching programs. Members are assigned a coach and screened for SDOH needs, and then the coach works with them for up to 12 months to address the concerns that came up during screening. Coaches have the option to enroll the beneficiary into one or more evidence-based programs. The coach helps the member get necessary resources needed to address the needs in their care plan, helps fill out applications, and assists the member in setting goals. The Hub also offers a fall prevention program. A service provider does a walkthrough of the beneficiary's home (looking for loose rugs, grab bars, light switches, etc.), helps the beneficiary get a personal emergency response system, creates a mobility plan, and enrolls the member in an evidence-based fall prevention workshop, such as Tai Chi, delivered by a network member. Similar to the fall prevention program, the Hub offers a caregiver support program that includes the beneficiary and their caregiver. The plan pays for the caregiver to receive support and coordination of services from the health coach (even though the caregiver is not the beneficiary), knowing that it is going to benefit the beneficiary. The Hub also has a program called Healthy IDEAS, which is an evidence-based program modeled as a community emotional wellness program. The program provides education on what depression is and where to find resources and treatment and then focuses on behavioral activation to start setting small goals to help the member begin feeling better and reduce stress. Finally, the Hub offers two diabetes programs: the Diabetes Prevention program, which is a CDC-recognized, yearlong group class, and the Diabetes Self-Management program. For the Diabetes Self-Management program, there are some issues with credentialing because the program requires dietitians that are not normally employed by CBOs.

Information-Sharing

WNYICC uses a centralized electronic client record that was built to track and manage referrals, document program delivery, and submit claims. The goal of the system is to reduce the burden on the CBOs, who may use one platform, and payers and providers, who may have another system that they want their contractors to use. Every referral is entered into the system's referral management section by the WNYICC administrative team, who verifies the referral by checking that the members have the proper eligibility requirements. Once the referral is verified for eligibility, it is assigned from the referral management queue to the program delivery partner. Each program has a documentation center. Referrals are assigned based on the contract, the service providers in the area of the referral, and the capacity of the CBO to accept the referral.

The Hub can receive referrals in one of four ways: (1) through a HIPAA secure link on its website; (2) through a fax; (3) through the regional health information exchange's direct messaging from a provider, plan, or health plan's case managers; or (4) through self-referral for enrollees in another WNYICC program. WNYICC delivery partner coaches and RDs are encouraged to cross-refer to additional programs that might benefit their clients. WNYICC's outreach coordinator engages with providers in the region to educate them on WNYICC programs and the referral process.

As a part of the programs offered by the Hub, WNYICC's contracted delivery partner staff perform an SDOH screening with enrollees. Their responses are tracked to show changes in need and whether enrollees achieved their goals through the coaching programs. A key metric that the Hub uses to measure the programs' efficacy is whether SDOH concerns are addressed. Other metrics are program-specific and include such metrics as PHQ-9 score changes from the Healthy IDEAS program; changes in weight, vegetable intake, and malnutrition scores for the Medical Nutrition Therapy program; and satisfaction with services for the meals programs.

WNYICC would ultimately like to build an integrated data system to reduce the amount of data entry and allow providers to see social care information in their clinical record. The Hub is in process of starting a project with a data integrator to reduce the manual data entry and report generation process time. Currently, the Hub does not have the bandwidth to complete individual reports for all programs because of the time required to generate reports manually. However, providers and plans may request individual client reports, as needed.

Program reports are tailored to the contract and program. Reported metrics are negotiated with the health plans. If the program is referred by a doctor, there is a report sent to the referring provider as well. In addition to sharing reports externally with health plans, reports are also generated and shared as a part of the quality assurance program within the Hub. Data is reviewed in committees on the board. The Hub tracks several metrics overall on its programs, including the number of enrollees per program, how many enrollees stay in the program, how many complete the program, and whether there were improvements in metrics for those who complete the program. These data are used as benchmarks to track performance over time.

Financing

In 2017, the Health Foundation of Western and Central New York provided grant funding to WNYICC to develop its infrastructure and network. One of the participating AAAs, Erie County Department of Senior Services, had developed a diabetes self-management program that was used to show the ability for WNYICC to create programs, become accredited, and use them to gain contract funding. The funding from the Health Foundation of Western and Central New York was used to hire a full-time director of business development to operationalize the program by developing a network, acquiring contracts, developing referral pathways, and developing a training academy.

Once the initial funding was in place and the network was established, WNYICC began contracting with Medicare Advantage plans in its region. Approximately half of the budget of WNYICC comes from grants, while the remaining half comes from contracts. Most contracts relate to service delivery, but there are a few related to technical assistance and training. All the money from the contracts comes to WNYICC, and then WNYICC pays its partners through individual subcontracts. CBOs submit an invoice, and the Hub pays them for their services. Contracts with CBOs are negotiated individually for each agency and program. Approximately 65 percent of payments go directly to a CBO partner, and the remaining 35 percent cover the administrative costs for the Hub. Administrative funds go toward staff time to do referrals; toward contracting, marketing, and operational staff; toward paying for a third-party biller; and toward developing and supporting the IT system.

WNYICC tracks funds at the program level. WNYICC noted several challenges to financing that make it difficult to expand its work. The first issue mentioned was low reimbursement rates from Medicare and Medicaid for certain programs, particularly the Diabetes Prevention program. Another issue was the lack of minimum referral guarantees in contracts. Without these guarantees, CBOs have a hard time staffing up to meet a potential contract demand. In addition, there are few dedicated funding sources for CBO capacity-building. WNYICC is hoping that funding for capacity-building with CBOs will be included in the New York state Medicaid section 1115 demonstration amendment when it is approved because post-pandemic, CBOs lost staff (and they already had a high rate of turnover). Funding was available for other institutions, such as nursing homes, but similar funds were not available to CBOs. Finally, WNYICC noted the need for additional support explaining and supporting braiding and blending funding sources among its partners. Similarly, CBOs are less comfortable with contracted work because most of their work has been grant funded, in which funds pay for a project over time, as opposed to a service to be completed.

Policy Issues

WNYICC identified three policy areas that would be beneficial to its work. The first is dedicated funding to support social care data platforms. Health care organizations received funding to adopt electronic medical records, but social care has not been provided with dedicated funding for these efforts. Second, WNYICC advocated for the development of standard metrics. There are regional, state, and contract-level differences in metrics, as well as metrics that vary by population (i.e., different metrics for Medicaid versus Medicare patients receiving the same services). These differences create administrative burden for the Hub and are challenging to CBOs who often provide services regardless of payer. Finally, the Hub advocated for policies to increase the visibility of backbone organizations and support engagement. WNYICC noted that it sometimes struggles to get engagement with plans or health care providers despite its best efforts to communicate the efficacy and cost-savings of its programs. As new policies and requirements are developed for addressing HRSNs on both the state and federal levels, WNYICC advocates

for mandates for health plans and providers to partner with social care experts at local CBOs or Hubs.

Abbreviations

AAA	Area Agency on Aging
ACL	Administration for Community Living
ACO	Accountable Care Organization
AHC	Accountable Health Community
ASPE	Office of the Assistant Secretary for Planning and Evaluation
CAAC	Central Alabama Aging Consortium
CBO	community-based organization
CCTP	Community-based Care Transition Program
CDC	Centers for Disease Control and Prevention
CIL	Center for Independent Living
CMS	Centers for Medicare and Medicaid Services
COVID-19	coronavirus disease 2019
CPT	Current Procedural Terminology
DHAD	Direction Home Akron Canton Area Agency on Aging and Disabilities
EHR	electronic health record
FQHC	federally qualified health center
FY	fiscal year
HCPCS	Healthcare Common Procedure Coding System
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HRSN	health-related social need
IT	information technology
MCO	managed care organization
NCQA	National Committee for Quality Assurance
PHI	protected health information
RD	registered dietician
RN	registered nurse
SARCOA	Southern Alabama Regional Council on Aging
SDOH	social determinants of health
SFTP	secure file transfer portal
SNF	skilled nursing facility
VA	Veteran Affairs
VHA	Veterans Health Administration
WNYICC	Western New York Integrated Care Collaborative

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