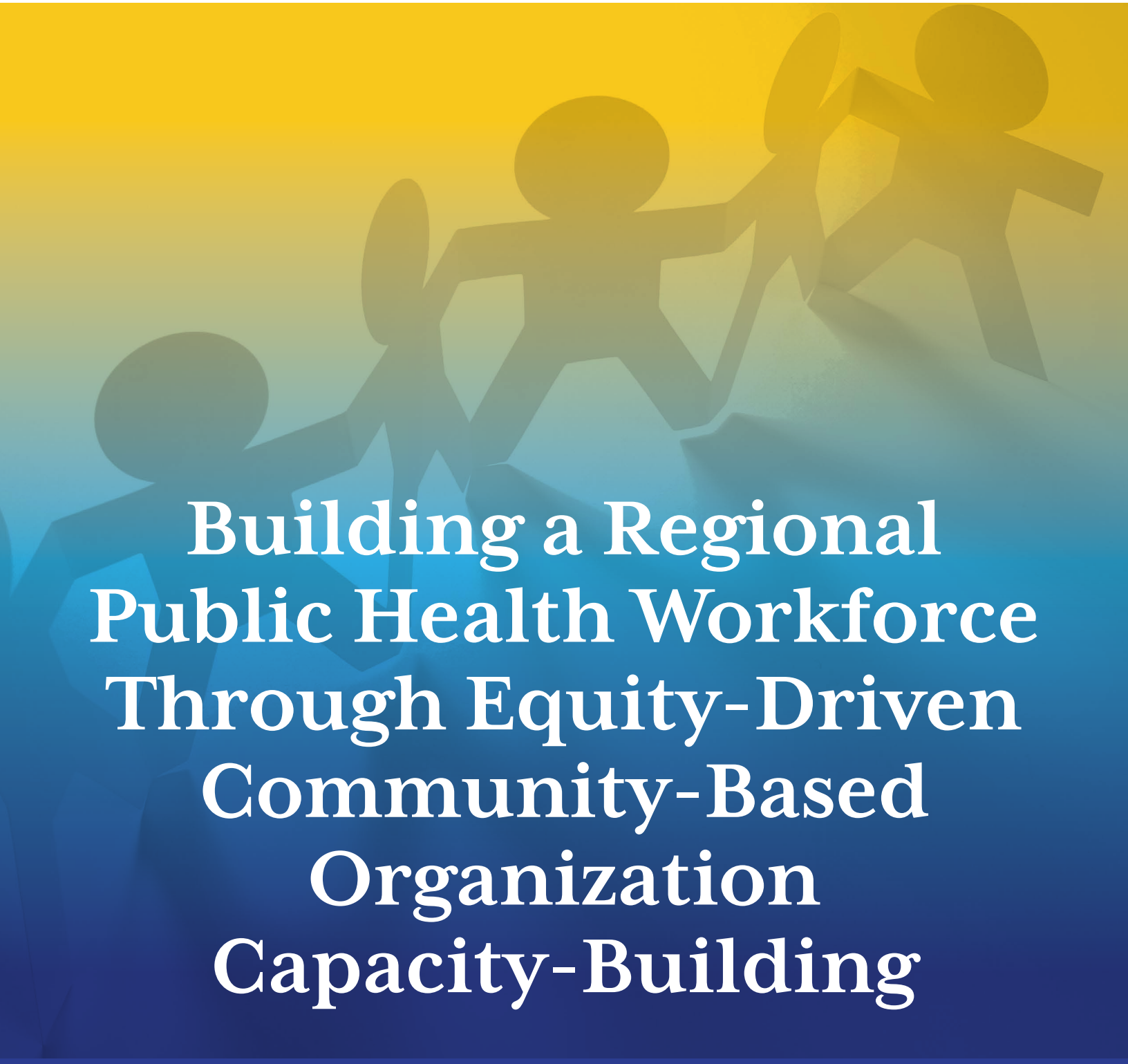
METRO DENVER
PARTNERSHIP FOR HEALTH



Building a Regional Public Health Workforce Through Equity-Driven Community-Based Organization Capacity-Building

A Report of Potential Models and Approaches Based on Literature Review and Key Informant Interviews

MARCH 2024

Contents

Acknowledgments

This report was developed by:

- Fuji Robledo, Consultant, Colorado Health Institute
- Chrissy Esposito, Research and Analysis Manager, Colorado Health Institute
- Kirsti Klaverkamp, Director, Colorado Health Institute

Introduction

Background

The Metro Denver Partnership for Health (MDPH) is a capacity-building, cross-sector collaboration of public health agencies, health systems, and Regional Accountable Entities (RAE) working alongside community-based organizations, health alliances, and human service agencies. MDPH's efforts impact 3 million Coloradans who live in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, and Jefferson counties. The Colorado Health Institute (CHI) is the partnership's administrative and strategic hub for workforce convening, facilitation, and project management.

The COVID-19 pandemic stretched the fabric of Colorado's public health safety net. It also illuminated the key role that community-based organizations (CBOs) play in connecting with community members, sharing trusted, culturally responsive information, and providing services that address the social needs that affect people's overall health, including food, safe housing, transportation, and utility services.

CBOs will continue to be essential partners in the public health workforce. While these organizations have experienced increasing workload and service demands as a result of the pandemic, they have less access to tools and resources for their staff and service capacity when compared to the health care and public health sectors. MDPH recognizes the challenges experienced by CBOs as a critical regional workforce priority. To promote overall health and build resilience to respond to the next public health emergency, health care and public health leaders need to explore existing pathways and innovative solutions to establish more equitable partnerships with CBOs in ways that also support CBO service capacity. This report, based on peer-reviewed and gray literature and key informant interviews, is a summary of potential models and approaches. It was developed for MDPH and its partners to foster equitable and sustainable partnerships with and service capacity within CBOs in the Denver region.

Objectives

This report summarizes four primary findings that outline challenges and associated recommendations to build and sustain CBO service capacity through cross-sector partnerships and shared investments. MDPH leaders and CHI will use this report to develop an action plan for the partnership to develop consensus on potential approaches, next steps, and resources to pursue. The long-term goal of investing in CBO partnerships and capacity is to build and maintain a holistic, regional public health workforce that supports whole-person and whole-family health and well-being through strong, mutually beneficial, cross-sector collaboration.

Overall findings in the literature focused on ways health care organizations can better partner with and support CBO capacity-building. However, MDPH intends to extend these findings and associated recommendations for consideration by its health care, public health, and RAE member organizations.

DEFINITIONS

This report uses the following definitions:[1,2]

Community-based organization (CBO) or service provider: A private, nonprofit organization, which may include faith-based organizations, that provides direct services and/or advocates for a certain population in the community. Direct services may include nutrition or food pantry services, home-delivered meals, transportation, utility assistance, housing navigation assistance, temporary housing or shelter, or other services that address an individual or family's health-related social needs.

Community-based organization (CBO) capacity-building: The investment of time and resources to develop and maintain:

- **Infrastructure** (e.g., formalized partnerships) that facilitates trust, shared missions, and best practices for collaboration among CBO service providers, health care providers, public health partners, RAEs, and other relevant partners.
- **Capability** to participate in cross-sector partnerships to promote whole-person and whole-family care delivery, including having the necessary administrative tools and systems, data collection, and technology to communicate and coordinate services effectively.
- **Sustainable funding models and arrangements** that appropriately compensate and sustain CBOs to provide the types and volume of services to people in need and in search of community-based resources and services.

This definition creates a framework for understanding different approaches to CBO partnership and capacity-building. CHI developed this definition based on the **Metro Denver Connected Community of Care Community Engagement** and **Sustainability plans**, which were designed collaboratively with MDPH partners and community leaders. It is imperative that CBO capacity-building approaches and solutions continue to be driven and informed by community partners. CBOs know their programs, services, and community priorities best.

Health organization: A general term used to describe health care systems, clinics, or hospitals, and public health agencies or organizations.

Health-related social needs: Social needs such as healthy food, safe housing, utilities, transportation, and interpersonal safety. Unmet health-related social needs contribute to poor health outcomes and are a result of underlying social determinants of health.[3]

Social determinants of health: **Conditions** in the environments where people live, work, and play that impact their health and quality of life outcomes.[4]

Whole-person and whole-family care: An approach to promote and maintain overall health and well-being by providing care, services, and resources to address people's physical, mental, and behavioral health and social needs.

Methods

CHI conducted the following qualitative research to develop and outline the findings in this report:

Key informant interviews. Conducted five key informant interviews with CBO service providers, a safety-net health care provider, and a nonprofit consulting and technical assistance provider that focuses on upstream, social factors that impact health. Interviews explored approaches to CBO capacity-building, including models or payment arrangements that the organizations or providers participated in through past partnerships to address health-related social needs, successes and challenges of these models, payment arrangements or partnerships, and recommendations for sustainability.

Literature review. Reviewed 61 journal articles, peer reviewed sources, and gray literature to synthesize findings related to successes and barriers for CBOs to engage in health care or public health partnerships, existing and emerging payment models and arrangements for CBO services, and best practices to support CBO capacity-building and sustainability.

Findings and Recommendations

Infrastructure for Trusted, Mutually Beneficial Partnerships

When health and community-based organizations work together, they can provide holistic care that addresses people's physical and social needs in ways that support overall health and well-being.[5,6] Working together means aligning on shared missions and best practices for coordination to serve individuals and families effectively. Because the literature focused on partnerships between health care and community-based organizations, this section explores challenges to and recommendations for developing partnerships between health care and CBO service providers. However, the public health field is also exploring ways to strengthen its partnerships with CBOs, as evidenced by recent efforts led by the CDC Foundation, supported by Human Impact Partners and the Kaiser Permanente National Community Benefit Fund.

CHI identified two key challenges and related recommendations to building and strengthening partnerships among CBOs and health care organizations. These findings may be applied to other organizations within MDPH as well.

FINDING 1

Community-based organizations and health care organizations approach health and well-being differently.

Health care organizations and CBOs operate through different business and service models, which influences how partnerships between them are developed.

Challenge: Individual versus population-level prevention and care. Health care organizations tend to approach business operations and treatment to support individual health outcomes. Similar to public health organizations, CBOs typically focus on prevention and promotion services among populations, providing community- and policy-level services that support overall health outcomes in communities. Population-level interventions are more effective for addressing social determinants of health because they address systemic barriers linked to health disparities. While health care providers offer essential care for individuals, those interventions do not create the systemic changes needed to improve health outcomes across populations.[5,7,8] One key informant interviewee described this dynamic and related incentives for the differing business and service models, stating that in their experience, "The health care system is built on 'sick care,' while community-based organizations focus on 'creating health,' which means the incentives for each system are different."

On the other hand, when health care and CBOs work together, they create an integrated model of care for individuals, families, and communities that can improve overall health outcomes by linking a person's physical health with their social needs.[5,6]

RECOMMENDATION

Recommendation 1a. MDPH member organizations define shared goals and outcomes with CBOs to establish equitable, mutually beneficial partnerships in capacity-building efforts.

Health care and public health organizations may consider the following best practices to develop partnerships with CBOs:[9]

- **Build trust** by developing relationships in the community and being open to community feedback. Integrate that feedback in decision-making to ensure that the community's needs and priorities are being represented.
- **Establish shared leadership practices** to ensure that power and decision-making is evenly distributed and that each partner has the ability to contribute and be heard.
- **Establish accountability practices** by agreeing on shared outcome measures, data-sharing practices, and the strategic use of data and community input to ensure that community and partner needs are met.
- **Foster sustainability** by diversifying funding and considering innovative funding models. See Finding 4 for more detailed recommendations related to sustainability.

MDPH will be more effective in pursuing ensuing recommendations in this report by exploring this foundational recommendation. The following tools and resources explore how to implement these best practices to build trusted, mutually beneficial cross-sector partnerships:

- Partnership Assessment Tool for Health (PATH) tool
- ReThink Health, a Rippel Initiative and corresponding integrative activities governance model
- Collective Impact model and corresponding readiness assessment

Equity at the Center

Due to historical and pervasive structural racism, the U.S. health care system still often benefits white people more than people from racially and ethnically diverse communities. For example, Black and Latino patients are less likely to receive diagnostic screenings, timely treatment for cancer and stroke, mental health care, and adequate pain management, compared with white patients.[10] They are also more likely to have insufficient or no insurance coverage. Unless health care organizations critically consider and address systemic biases and inequities, adopting their practices and payment models in cross-sector partnerships may continue to cause harm.[8] Furthermore, CBO stakeholders who participated in key informant interviews expressed concerns that adapting to health care processes to enable financial payment for CBOs could lead to unintended consequences. One potential unintended consequence found in the literature included cost increases for CBO services.[5]

MDPH cannot solve issues related to structural racism alone. Root causes of health inequity, including racism and discrimination, must be addressed collectively through policy and systemic changes across all sectors and types of organizations. However, MDPH is committed to its role in being part of solutions through its CBO partnerships, capacity-building, and related efforts. Key informant interviewees mentioned the importance of buy-in from both health care providers and CBO service providers, indicating how crucial it is for successful, long-term partnership. **Key Lessons on Structural Racism and Health Equity** provides additional context.

FINDING 2

Community-based organizations and health care organizations assess the net value of partnerships differently.

CHI identified a challenge to developing cross-sector partnerships related to differences among sectors in defining and communicating the value of partnership.

Challenge: Shortcomings of return-on-investment assessments. Health care organizations and CBOs are not aligned in how they measure the net financial value of their partnerships. Health care organizations often use tools to measure the financial return on investment (ROI) to gauge the types of services or partnerships that will be a value-add to their operations. HealthBegins developed an ROI tool to help bridge the gap and facilitate support for CBO and health care partnerships. The ROI tool can anticipate health care savings from social service investments provided through CBO partnerships.[11] The results of ROI assessments can inform whether and how health care organizations pursue partnerships with CBOs, including financial investments. However, the challenge remains that current ROI calculation methods, when used as the only form of measurement, do not adequately capture the total value that CBOs bring to partnerships.[12]

The wrong pocket problem may or may not help explain this. The wrong pocket problem occurs when one organization or sector carries the expense of tackling a specific problem but another reaps the benefit of the investment. For example, if a community-based organization provides medically tailored meals to help a person manage their diabetes or heart disease, a hospital may see a reduction in the person's preventable hospital visits. This can create a cycle where health care and community-based partners share the costs and benefits of investments inequitably and can lead to challenges in accurately measuring ROI. [11,12]

Regardless, the resources needed to calculate a ROI — especially in the short-term — often

exceed the resource bandwidth that many CBOs have.[8,12] Key informant interviewees expressed frustration about the challenge of communicating the benefits of cross-sector partnership using traditional ROI assessments. Other innovative models, such as value of investment (VOI) frameworks and pilot programs, may more accurately capture the overall benefits of such partnerships.

RECOMMENDATIONS

Recommendation 2a. MDPH member organizations adopt VOI frameworks to assess the overall value of partnerships with CBOs and associated community-based services.

A VOI framework measures the benefits of a partnership in three ways, including through:[12]

- Financial returns (traditional ROI measures)
- Economic returns (tangible and intangible benefits such as staff productivity, service capacity, and goodwill)
- Social returns (a broader set of benefits to the organizations, related partners, and the community)

VOI frameworks facilitate a more comprehensive assessment of the value of health care and CBO partnerships by including traditional ROI measures and other benefits such as staff retention, overall health outcomes, and the quality of a patient or client's experience. Shifting the focus toward calculating the VOI may address common ROI barriers.[12] A key informant interviewee also recommended a VOI framework to better measure the overall benefits of investing in CBO organizations and partnerships.

Calculating and applying a VOI requires rethinking priorities and approaches within and across organizations. A VOI framework can help health organizations better understand CBO missions, the services they provide, the current capacity of their services, and opportunities to streamline coordination of care and services across organizations.[12] Tools and resources to implement this recommendation include:

- The One-Stop Shop for Healthcare and Community Partnerships, HealthBegins
- Value Proposition Tool: Articulating Value within Community-Based and Health Organization Partnerships, the Nonprofit Fund
- Partnership Impact Evaluation Guide, Mickel and Goldberg

Recommendation 2b. MDPH member organizations collaborate with state agencies, other partners, and funders to explore and invest in pilot programs that demonstrate the impact of cross-sector partnerships to make more informed investments in community-based services.

Innovative models and demonstration projects, including those supported through the Center for Medicare and Medicaid Innovation (CMS Innovation Center), fund pilot programs that evaluate and demonstrate the benefits of addressing health-related social needs through health care and CBO partnerships. Once a business case is made, this funding can then transition to a fee-for-service, insurance reimbursement, or contract-based funding model between organizations, facilitating a mechanism for CBO service capacity and sustainability.[13]

A couple of promising innovative models demonstrate the value of CBO and health care partnerships. For example, the Accountable Health Communities Model, funded by the CMS Innovation Center, connected clinical and community-based organizations to collaboratively screen, refer, and provide services to address people's health-related social needs. The Model demonstrated a reduction in emergency department visits for Medicare and Medicaid beneficiaries. The Model did not increase people's connection to community-based services, which may be in part due to gaps in community resource availability.[14] Financial sustainability models to support community resource availability are further addressed in Finding 4.

In another example, the state of California leveraged a 1115 Medicaid waiver to implement a five-year experiment (2016-2021) to integrate medical care, mental health services, housing supports, and other social supports including navigation to other available benefits and services in the community to address people's

complex needs. Local public health departments led most of the pilot programs and shared data with CBOs to collaboratively serve people who might have otherwise been left with unmet needs. Results included improved rates of patient follow-up after hospitalizations, timely care planning, and engagement in behavioral health treatment and services. Based on these positive results, California implemented of a statewide Enhanced Care Management and Community Supports benefit for California Medicaid (Medi-Cal) recipients in 2022, creating a pathway for long-term sustainability.[15]

Concerns about pilot programs also exist. For example, the Metropolitan Alliance of Connected Communities obtained funding for a pilot program to determine the effectiveness of an integrated referral process between CBOs and various health care organizations. While the program demonstrated that integrated systems can work, the program did not run for long enough to show its impacts on health outcomes. The program also required more time and resources than health care and CBO partners expected.[16] Key informant stakeholders voiced a similar challenge: pilot programs require significant work up front and may not lead to future funding. To address these challenges, funders of pilot programs need to consider appropriate duration of implementation and more extensive coverage of CBO-associated program and service costs to participate.

Overall, CBOs appreciate holistic, person-centered care provided through regional partnerships and see benefits in expanding their networks and capacity to serve people. However, CBOs also highlight the need for equitable policies that prioritize and incentivize mutually beneficial and sustainable partnerships with health care organizations.[5,16] Further recommendations in support of this priority are described in Findings 3 and 4.

Investment in the Capabilities of Community-Based Organizations

CBOs have strong ties to their communities and often understand the best ways to address their communities' priorities. While collaborations between CBOs and health care organizations are increasingly used as mechanisms to address unmet health-related social needs, CBOs have not been offered the same opportunities as health organizations to invest in their administrative tools and systems, data collection, and technology capabilities in ways that serve them or their communities.[14]

Health organizations can better support the capacity of CBOs by considering changes to their own data and system requirements and exploring workforce training to ensure health care staff are prepared on how to best refer and connect people to CBO resources.[14,17] CHI identified two challenges and associated recommendations related to these efforts.

FINDING 3

Lack of standardized data sharing processes, systems, and limited staff training inhibit effective cross-sector partnerships.

Data sharing is a vital part of how CBOs and health organizations can coordinate the care and services they provide to individuals and across communities. Data are needed to evaluate program effectiveness, identify challenges and gaps, and determine where additional investment is needed.[18,19,20] Despite its importance, bidirectional, secure, and standardized data-sharing across organizations and sectors is a challenge.

Challenge: Lack of standardized data collection processes and systems. CBOs and health organizations in Colorado have no standardized data-collection and sharing processes.[17,21] Each sector requires different data to perform its services, and a lack of consistency around when and how data is collected, stored, and shared can inhibit collaboration across organizations.[22] Due to power differentials, CBOs are often asked to

adapt to health care organization processes, including data collection requirements, billing practices, and processes to measure and report the value of their services, when developing partnerships. Funders typically dictate reporting and compliance requirements that do not always align with the needs of CBOs or the communities they serve.[23] For example, health care organizations often prefer contracts that emphasize shorter-term, quantifiable outcomes because of their business models and associated reporting requirements.

Health care organizations received significant funding from the Health Information Technology for Economic and Clinical Health (HITECH) Act in 2009 to speed their transition to electronic health record (EHR) systems. The Affordable Care Act further encouraged health care providers to coordinate care and services, relying on advances in EHRs.[24] CBOs have not received similar investments or financial incentives to adopt new systems or advance their technology capabilities. Accordingly, not all CBOs have the capacity to adapt to data-driven processes and systems to report program and service outcomes that are desired in contracts and partnerships with health care organizations. These adaptations can be costly and time-consuming, require technical know-how, necessitate privacy and ethical considerations to share sensitive, individual-level patient or client information, and buy-in to do so.[23,25] CBO stakeholders from key informant interviews also said that new contracts with health care organizations did not necessarily correlate with sustainable funding beyond the contract. These situations may disincentivize CBOs from engaging in partnerships with health organizations that may otherwise support service capacity for patients or clients who are referred to their services.

Challenge: Limited staff training and resources. Key informant interviewees highlighted the importance of appropriately capturing and using data to inform care for people but also emphasized that these processes are time-consuming and require staff resources. In order for data sharing to facilitate effective coordination across health and CBO service providers, staff from both sectors must be trained on how to appropriately collect and act on the data being collected. For example, health care providers identify social needs through health risks screenings and assessments in clinical settings but are not always adequately trained on how to follow up on this information for their patients or clients. This can create challenges for CBO staff to accommodate service demands for patients and clients who are referred to them. On the other end, if CBOs have new reporting requirements with a health care partner, staff need resources to be appropriately trained to follow these requirements.[16,23,25]

RECOMMENDATIONS

Recommendation 3a. MDPH member organizations develop methods to co-create and align data metrics and reporting processes with CBO service providers to support shared goals and outcomes.

Health and CBO partners can co-create and align data metrics by considering three practices:

- **Right sizing.** Ensure that reporting requirements meet the needs of all partners, rather than trying to capture every data point. Each partner should determine what data are needed to measure outcomes, further the organization's mission, and comply with reporting requirements.[26]
- **Goal setting.** Identify partnership goals, such as the best mechanism for referrals, roles, and responsibilities among organizations. This will ensure partners know who is responsible for what data.[16]
- **Staff training.** Invest in staff training to manage and address data-related issues as well as to train other staff (i.e., data infrastructure requires human infrastructure).[27]

CASE STUDY

Hunger Free Colorado Demonstrates the Impact of Communication and Collaboration to Build Successful Data-Sharing Activities Across Clinical and Community Organizations[28]

Hunger Free Colorado is a statewide nonprofit organization that provides resources for people in need of food and advocates for policy reforms to end hunger.[29] Hunger Free Colorado formed a partnership with Kaiser Permanente Colorado, Children's Hospital Colorado, Denver Health, and other health care organizations to better connect people to nutritious food and benefit programs through a streamlined referral system. This partnership increased Hunger Free Colorado's service uptake from 5% to 75% because the referral process was more efficient for all involved. For example, the partnership established processes so that providers obtained consent to share screening information with Hunger Free Colorado, which then contacted patients directly within 48 hours of the referral.

While the data infrastructure was important, Hunger Free Colorado also needed to invest heavily in provider training. It partnered with the Colorado Prevention Alliance to develop a web-based module to teach providers how to administer the screenings, educate them about the impacts of health and social outcomes (like food insecurity), and provide sensitivity training.

Recommendation 3b. MDPH member organizations collaborate with state, regional, and local partners to explore, implement, and participate in interoperable technology to facilitate compatible data ecosystems that support shared goals and outcomes with CBO service providers.

Health organizations and CBOs should use interoperable technology to facilitate appropriate data sharing across their organizations to coordinate care and services for people. Interoperable technology allows organizations to continue using their own systems while still communicating and sharing relevant data and information appropriately within a larger ecosystem.[30] By creating an ecosystem of care, CBOs and health providers can have the capacity to securely share physical, behavioral, and social health information to provide whole-person care.[31] This approach may help overcome challenges and inequitable requests experienced by CBOs to develop new processes, systems, or technologies that do not serve them or their communities.

COLORADO SPOTLIGHT

The Colorado Office of eHealth Innovation is collaborating with other state agencies, partners, and stakeholders to develop a unifying social-health information exchange architecture, which would be the first data ecosystem of its kind for the state. This interoperable system will allow health care, behavioral health, and social service providers to securely share data, and connect people to resources and services to meet their physical, behavioral health, and social needs. More information can be found **here**.

Sustainable Funding Models and Arrangements

A strong, regional public health workforce will require trusted, mutually beneficial partnerships that include more equitable and effective funding models and arrangements to increase and sustain CBO service capacity. CHI identified three challenges and associated recommendations related to funding models for CBO sustainability.

FINDING 4

Community-based organizations have inequitable access to sustainable funding streams.

CBOs provide a variety of essential services and operate differently depending on the community and geographic area they are serving. CBOs are seen as trusted, reliable entities in their communities, yet they frequently operate through unreliable or limited funding streams.

Challenge: Funding restrictions. CBOs often take on the financial burden for supplies, travel costs, and extra time required for community outreach when these operations are not directly covered by their funders.[32,33] Key stakeholders mentioned having to be creative to get funding for essential operating costs that were not covered by their funding streams that only allowed payment for direct services to individuals or families.

Due to legislation, government agencies, such as the Centers for Medicare and Medicaid Services (CMS), further restrict how funds may be spent, directing the types of services or specific populations that grantees may serve through their reimbursed programs.[33,34,35] Key informant interviewees reported that they are unable to serve certain populations in the community because the government funding they receive is allocated for a specific age group. Some CBO stakeholders also reported challenges with being paid on time and having to find alternative funding sources while they wait for or are not fully covered by anticipated CMS reimbursements.[34]

Challenge: Lack of transparency and autonomy in funding allocations. Due to existing infrastructure and policies, CBOs do not have the same agency as other organizations to direct how funding is spent in their communities. For example, some state government funding flows directly to health care organizations that determine when and how to pass dollars through to CBOs for designated priorities. This process can limit the autonomy of and restricts CBOs in participating in funding decisions.[33] Having health care organizations mediate funds can also create less transparency around how funds are allocated and spent in communities. Health care organizations are more likely to partner with organizations they are familiar with or those to which they have a personal connection.[36] Furthermore, with no formal vetting process, even well-intentioned health care organizations may unintentionally leave out potential contracting partners that are led by or that serve disproportionally impacted communities.[37]

Challenge: Complexity of contracting policies and managed care plans. Key informant interviewees shared how much time and "insider knowledge" of the health care system each contract takes to develop and process. This burden is compounded when CBOs must create a different contract with each health care partner. One CBO key informant credited their previous experience in health care as a major reason their organization was able to enter into a contract with a health care organization.

Some CBOs enter contracts with Medicaid managed care plans. Through these plans, Medicaid creates relationships with third party organizations, like CBOs, to provide care and services to its members.[38] These contracts are often complex and involve policies that would not otherwise be part of CBO operations. For example, when deciding on resources or services to invest in, managed care organizations typically consider what is called the medical loss ratio. This ratio is meant to ensure that 85% of expenses go toward medical claims as opposed to other costs. However, payments to CBOs are usually classified as administrative costs, which means that distributing funds for CBO services may make it appear that these organizations are spending more on administrative costs than they are allowed. This creates a challenge to able to partner with and distribute funding for CBO services.[39] Additionally, because these contracts are often small-scale, CBOs may not receive enough reimbursement for their direct services to make it worth the time invested in the partnership or contract.[39]

RECOMMENDATIONS

Recommendation 4a. MDPH member organizations collaborate with one another and other government and philanthropic partners to develop and expand more inclusive payment models for CBO services.

Health care, public health organizations, and other governmental and philanthropic funders should consider how to streamline and simplify

application processes as much as possible to avoid undue burden on CBOs.[36, 40] When expanding payment models to be more inclusive, these entities should also consider the following practices:[36]

- **Design multi-year federal funding opportunities.** Implement longer funding periods, which are especially important for CBOs with limited administrative staff to apply for or reapply for grants on a frequent basis.
- **Ensure that funding is sufficient to cover all costs necessary for service delivery.** Work with CBOs to better understand and determine their overall program costs, including materials or equipment needed for service delivery, funds for outreach and advertising programs, and associated transportation costs, so that funding allocations may be more representative and inclusive of the resources needed to achieve desired outcomes.
- **Provide funding up front instead of through cost reimbursable arrangements.** Paying CBOs for their upfront costs to set up and prepare for service delivery can reduce unnecessary risks for these organizations and create more equitable pathways for CBOs to take on new contracts.
- **Develop a tiered funding system based on CBO size and program scale.** Use a tiered funding system to appropriately scale compliance and reporting requirements that match CBOs' organizational goals and program scale, creating more equitable opportunities for CBOs of all sizes to participate in different funding models.

Recommendation 4b. MDPH member organizations develop co-designed, participatory funding models with CBO service providers.

CBOs and health organizations can use participatory models to co-design contracts and payment arrangements.[41] Participatory models require all partners to come together to use their expertise to identify shared challenges and to co-develop solutions. This ensures that both CBOs and health organizations can share their ideas and perspectives on how contracts or payment arrangements may be structured, what information is needed for negotiation, and the roles and responsibilities of each partner. The final contract or payment arrangement should reflect the needs of both sectors.

One example of an innovative, participatory funding model is Rhode Island's Health Equity Zone Initiative. The Initiative is a place-based approach that works to strengthen community leadership in planning and budgeting decisions and create new partnerships to collaboratively address mental and behavioral health, and health-related social needs in the community. The Rhode Island Department of Health provides initial seed investments over a few years, allowing these funds to be used flexibly and without restrictions so that the CBOs can identify community needs and determine where to dedicate funds to address those needs appropriately.[42, 43]

Another opportunity to adopt a participatory funding approach may be through nonprofit hospital community benefit programming. Nonprofit hospitals can use community benefit funds to cover a full range of activities and services that address the cause and impact of health-related social needs.[44] MDPH and its partners may consider developing partnerships and payment models similar to Oregon's C3 Community Assistance Program (C3CAP). Project Access NOW is a local CBO that administers the C3CAP to connect low-income and uninsured community members with health care and community resources to make their transitions from the emergency department and inpatient hospital settings back home more successful. Participating health systems and coordinated care organizations fund the program mostly through community benefit funds and do not monitor use of the funds at the patient level. The partnership collectively covers all program costs for the CBO's service delivery, including staffing, training, operations, overhead costs, and a per transaction fee to cover the program's software system.

CASE STUDY

COVID-19 Pandemic Illuminates the Potential for More Flexible, Community-Centered Funding Models.

Organizations experienced significant stress and uncertainties during the pandemic in ways that shifted how health care, community-based services, and associated funding were delivered. Several health care organizations relaxed their application and compliance requirements in response to the COVID-19 public health emergency — allocating emergency funding to ensure that CBOs and health care organizations could respond appropriately and collectively. For example, health care organizations created partnerships with local CBOs, that were trusted in their communities, to distribute vaccines and deliver other much-needed services. Health care organizations invested in CBOs by providing more grants and direct donations that were flexible for CBOs to increase their own capacities to adapt and successfully meet the needs of their communities. In turn, these partnerships also reduced the burden on the health care system to carry out vaccine distribution.[45]

Recommendation 4c. MDPH member organizations connect with CBO service providers to explore interest and readiness to develop funding hubs to increase the time and resources CBOs can spend on their own service delivery and reduce their time spent on administrative and contracting requirements.

Funding hubs are organizations that act as trusted intermediaries for CBOs to consolidate, manage, and complete required reporting for the different funding sources that a CBO may receive. This consolidated approach also allows for CBOs to have a streamlined process for applying to diverse funding sources at the local, state, and federal level.[46] Funding hubs reduce administrative time for CBOs and allow their staff to allocate more resources to providing and overseeing their primary services. Ideally, the hub model provides an opportunity for CBOs of all sizes to partner to exchange information with peers and to increase opportunities for funding and partnership. Hubs can be financed through government grants, philanthropic contributions, individual donations, donations from participating stakeholders, captured savings from agreed-upon interventions, and other joint ventures that bridge health care services with efforts to address the social determinants of health.[47]

As one example, the U.S. Administration for Community Living, in collaboration with the Centers for Disease Control and Prevention, provided grants to encourage opportunities for CBOs to work together to establish community care hubs. Community care hubs are an evolving model, but their purpose is to serve as a centralized contracting entity for payers (e.g., health insurers and health systems) and CBO service providers to partner and contract with one another. While community care hubs can vary by region and state, the Aging and Disability Business Institute has reported an increasing trend of CBOs contracting with health care organizations via these types of networks versus contracting individually.[48,49,50] Some hubs can be regional and statewide. For example, the Virginia Area Agencies on Aging — Caring for the Commonwealth (VAAACares) network is made up of 20 area agencies on aging, four health systems, and five large insurance companies. The network provides a statewide, one-stop hub for referrals, billing, data work, training, and partnership contract compliance.[36] Funding hubs could be an innovative, community-led approach that MDPH member organizations could pursue with community partners to address all three pillars for cross-sector partnerships and sustainable CBO service capacity identified in this report: infrastructure, capabilities, and sustainable funding models and arrangements.

Conclusion

For the last 10 years, MDPH has been advancing population health regionally through cross-sector collaboration. With an increasing emphasis on addressing health-related social needs, especially in the wake of the COVID-19 pandemic, CBOs have experienced growing demands for their services across the region. As the partnership enters the next decade, MDPH is committed to exploring and investing in ways its member organizations can better support the infrastructure, capabilities, and sustainable funding pathways necessary for more equitable, mutually beneficial partnerships and capacity-building with CBOs. MDPH envisions a holistic, regional workforce that supports the overall health and resilience of people and sees the future with CBOs as shared leaders and partners in these efforts.

Endnotes

1. Metro Denver Partnership for Health. Community Engagement Plan. (2023) https://www.coloradohealthinstitute.org/sites/default/files/2023-11/Community%20Engagement%20Plan.pdf
2. Metro Denver Partnership for Health. Sustainability Plan. (2023) https://www.coloradohealthinstitute.org/sites/default/files/2023-11/Sustainability%20Plan.pdf
3. Hinton E. A Look at Recent Medicaid Guidance to Address Social Determinants of Health and Health-Related Social Needs. (2023) KFF. https://www.kff.org/policy-watch/a-look-at-recent-medicaid-guidance-to-address-social-determinants-of-health-and-health-related-social-needs/
4. U.S Department of Human Services. Healthy People 2030. Social Determinants of Health. https://health.gov/healthypeople/priority-areas/social-determinants-health
5. Fichtenberg, C., Delva, J., Minyard., K., and Gottlieb, L.M. Health and Human Services Integration: Generating Sustained Health And Equity Improvements. (2020) Health Affairs. 39, (4) https://doi.org/10.1377/hlthaff.2019.01594
6. Goodwin N. Understanding Integrated Care. (2016). International Journal of Integrated Care. 16, (4) https://doi.org/10.5334/ijic.2530
7. What is Public Health? CDC Foundation. (2024) Retrieved February 19, 2024 from https://www.cdcfoundation.org/what-public-health?gad_source=1&gclid=CjwKCAiAlcyuBhBnEiwAOGZ2S1cjvLJiigJWKgrTJJNuUDIDsfZESFzk_TnNZqz_N_4deFqqZg0P9hoCNCQQAvD_BwE
8. Flynn D. Achieving Health Equity: Community-Led Alternatives to Healthcare-CBO Partnerships. (2021) Nonprofit Finance Fund. https://nff.org/blog/achieving-health-equity-community-led-alternatives-healthcare-cbo-partnerships
9. ACL Business Acumen Roundtable Work Group. Community Integrated Health Networks: An Organizing Model Connecting Health Care and Social Services. (2020) Administration for Community Living. https://acl.gov/sites/default/files/common/BA_roundtable_workgroup_paper_2020-03-01-v3.pdf
10. Yearby R., Clark B., and Figueroa J.F. Structural Racism in Historical and Modern U.S. Health Care Policy. (2022) Health Affairs. 41, (2) https://doi.org/10.1377/hlthaff.2021.01466
11. HealthBegins. The Return on Investment (ROI) Calculator for Healthcare Partnerships to Address Social Needs. https://roi.healthbegins.org/welcome?_gl=1*q1dbuf*_ga*MTUyNTIyNjcwLjE3MDU5NDk0NDE.*_ga_BR7HF8KLV6*MTcwNTk0OTQ0MS4xLjAuMTcwNTk0OTQ0MS4wLjAuMA..&_ga=2.20402168.1762757483.1705949442-152522670.1705949441
12. Jantz K. and Batalla-Mann E. Beyond ROI: Understanding Value on Investment in Social-Needs Partnerships. (2023) HealthBegins. https://healthbegins.org/beyond-roi-understanding-value-on-investment-in-social-needs-partnerships/
13. Bachrach D., Guyer J., and Levin A. Medicaid Coverage of Social Interventions: A Road Map for States. (2016) Milbank Memorial Fund. https://www.milbank.org/wp-content/uploads/2016/09/MMF-NYS-Health-Issue-Brief-FINAL.pdf
14. Agonafer E., Carson S.L., Nunez V., et al. Community-based organizations' perspectives on improving health and social service integration. BMC Public Health. 21, https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-021-10449-w
15. Simon M. Whole Person Care Pilots Set the Stage for CalAIM. (2021) California Health Care Foundation. https://www.chcf.org/blog/whole-person-care-pilots-set-stage-calaim/#:~:text=The%20pilot%20projects%20will%20end,%25%20of%20Medi%2DCal%20participants
16. Nonprofit Finance Fund. ing Resilience & Community Health (ARCH) Advancing Resilience and Community Health Partnership and Contract Overview. (2021). https://nff.org/advancing-resilience-community-health
17. Kunkel S.R., Wilson T.L., Lackmeyer A.E., and Straker J.K. Strengthening Ties: Contracting Between Community-Based Organizations and Health Care Entities. (2020) Scripps Gerontology Center. https://sc.lib.miamioh.edu/bitstream/handle/2374.MIA/6675/strengthening-ties-contracting-between-CBOs-health-care-entities.pdf?sequence=4&isAllowed=y&_ga=2.193737578.655587200.1659300241-596318827.1659300241
18. Blueprint for Health Plans: Integration of Community-Based Organizations to Provide Social Services and Supports. (2019). The SCAN Foundation. https://www.thescanfoundation.org/publications/blueprint-for-health-plans-integration-of-cbos-to-provide-social-services-and-supports-full-report/
19. Gottlieb, L.M., Quiñones-Rivera, A., Manchanda, R., Wing, H., and Ackerman, S. States' Influences on Medicaid Investments to Address Patients' Social Needs. (2016). American Journal of Preventive Medicine. 52, (1) 31-37. https://doi.org/10.1016/j.amepre.2016.07.028
20. Waddill K. The State of Payer, CBO Social Determinants of Health Contracting. (2021) HealthPayerIntelligence. https://healthpayerintelligence.com/news/the-state-of-ma-cbo-social-determinants-of-health-contracting

[21] Making Care Primary (MCP) Model. (2023). Centers for Medicare and Medicaid Services. Retrieved January 23, 2024 from https://www.cms.gov/priorities/innovation/innovation-models/making-care-primary.

[22] Miller, E., Nath, T., and Line, L. Partnership for Healthy Outcomes: Bridging Community-Based Human Services and Health. (2017). Nonprofit Finance Fund, Center for Health Care Strategies, Alliance for Strong Families and Communities.

[23] Bopp C., Harmon E., and Voida A. Disempowered by Data: Nonprofits, Social Enterprises, and the Consequences of Data-Driven Work. (2017) Conference on Human Factors in Computing Systems https://doi.org/10.1145/3025453.3025694

[24] Boone, E. ACA at 10 Years: Innovation in Data. (2023) Colorado Health Institute. https://www.coloradohealthinstitute.org/research/aca-10-years-innovation-data

[25] Nonprofit Finance Fund and Center for Health Care Strategies. Advancing Community-Based Organization and Health Care Partnerships to Address Social Determinants of Health. (2018). Nonprofit Finance Fund. https://nff.org/report/advancing-community-based-organization-health-care-partnerships-address-social-determinants

[26] Institute for Accountable Care. Establishing Sustainable Partnerships with Community Based Organizations: Considerations for ACOs. (2001). https://www.institute4ac.org/wp-content/uploads/2022/09/Brief-5_Establishing-ACO-Partnerships-with-CBOs.V6_LH.pdf

[27] Accountable Health Communities. Cross-Sector Data Sharing to Address Health-Related Social Needs: Lessons Learned from the Accountable Health Communities Model. (2022). Centers for Medicare and Medicaid Services. https://www.cms.gov/priorities/innovation/media/document/ahcm-cross-sector-data-sharing

[28] Center for Health Care Strategies and Nonprofit Finance Fund. Hunger Free Colorado: Connecting Vulnerable Patients to Food and Nutrition Resources. (2018) Nonprofit Finance Fund. https://nff.org/report/advancing-community-based-organization-health-care-partnerships-address-social-determinants

[29] Hunger Free Colorado. https://hungerfreecolorado.org/

[30] Data Interoperability. National Library of Medicine. https://www.nnlm.gov/guides/data-glossary/data-interoperability

[31] Social Health Information Exchange (SHIE). Office of eHealth Innovation. Retrieved February 16, 2024 from https://oehi.colorado.gov/SHIE

[32] Jaramillo E.T., Wilging, C.E., Green, A., et al. "Creative Financing": Funding Evidence-Based Interventions in Human Service Systems. (2019) Journal of Behavioral Health Services and Research. 46, (3). 366-383. https://doi.org/10.1007/s11414-018-9644-5

[33] Tsering D., Stauffer C.M., Gittzus J.A., et al. "More than just checking the box": community-based organizations on their role in Medicaid redesigns. (2023). Health Affairs Scholar. 1, (5) https://doi.org/10.1093/haschl/qxad060

[34] Bernstein A. and Smith-Ramakrishnan V. How the Federal Government Can Make Funding Accessible to Maternal Health Community-Based Organizations. (2023). The Century Foundation. https://tcf.org/content/report/how-the-federal-government-can-make-funding-accessible-to-maternal-health-community-based-organizations/#:~:text=These%20CBOs%20receive%20funding%20from,either%20directly%20or%20as%20subgrantees

[35] Evans D. and Lewis R.P. Community-Based Organizations on the Front Lines of the COVID-19 Public Health Response. (2022) CDC Foundation. https://www.cdcfoundation.org/blog/community-based-organizations-front-lines-covid-19-public-health-response

[36] Strong, Prosperous, and Resilient Community Challenge (SPARCC). Elevating the Role of Community Based Organizations in Federal Funding. (2022) https://www.sparcchub.org/2022/03/24/elevating-the-role-of-community-based-organizations-in-federal-funding/

[37] Kunreuther F. and Thomas-Breitfeld S. Meeting the Need: Building the Capacity of Community-Based Organizations. (2022) Building Movement Project. https://buildingmovement.org/wp-content/uploads/2022/12/BMP_Infrastructure-Report_MTNFinal.pdf

[38] Hinton E., Raphael J., and Tolbert J. Understanding the Role of Medicaid Managed Care Plans in Unwinding Pandemic-Era Continuous Enrollment: Perspectives from Safety-Net Plans. KFF. (2023) https://www.kff.org/medicaid/issue-brief/understanding-the-role-of-medicaid-managed-care-plans-in-unwinding-pandemic-era-continuous-enrollment-perspectives-from-safety-net-plans/

[39] Crumley D., Lloyd J. Pucciarello, M., et al. Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstrations. (2018). Center for Health Care Strategies. https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf

[40] Strong Prosperous and Resilient Communities Challenge (SPARCC). Increasing Federal Funding to Community-Based Organizations. (2022) Enterprise. https://www.sparcchub.org/wp-content/uploads/2022/03/Final-CBO-Memo-March-2022.pdf

[41] Fajardo A., Quinn A., White A., et al. Blog: Addressing Systemic Inequities and Racism in Community-Based Organization Funding. (2021) Vaccine Equity Cooperative. https://vaccineequitycooperative.org/news/blog_cbo_funding/

[42] Rhode Island's Health Equity Zone (HEZ) Initiative. State of Rhode Island Department of Health. Retrieved January 24, 2024 from https://health.ri.gov/programs/detail.php?pgm_id=1108

[43] Health Equity Zones: Building healthy and resilient communities across Rhode Island. Rhode Island Department of Health. https://health.ri.gov/publications/brochures/HealthEquityZones.pdf

[44] Colorado Health Institute. Hospital Community Benefit: Accounting for Impact. (2023) https://www.coloradohealthinstitute.org/research/hospital-community-benefit-accounting-impact

[45] Evans D. and Lewis R.P. Community-Based Organizations on the Front Lines of the COVID-19 Public Health Response. (2022). CDC Foundation. https://www.cdcfoundation.org/blog/community-based-organizations-front-lines-covid-19-public-health-response

[46] Kohli J. and Biasi A.D. Supporting healthy communities: How rethinking the funding approach can break down silos and promote health and health equity. (2017) Deloitte Insights. https://www2.deloitte.com/us/en/insights/industry/health-care/building-and-funding-healthy-communities.html

[47] Accountable Communities for Health. (2015) ChangeLabSolutions. https://communitypartners.org/files/documents/cachi/reports/ChangeLab%20Solutions_TCE_ACH_Report_FINAL_20151217.pdf

[48] Pferr, L. Community Care Hubs: What Evidence-Based Program Providers Need to Know. (2023) National Council on Aging. https://www.ncoa.org/article/community-care-hubs-what-evidence-based-program-providers-need-to-know

[49] Advancing Partnerships to Align Health Care and Human Services. (2023) Administration for Community Living. https://acl.gov/programs/strengthening-aging-and-disability-networks/improving-business-practices

[50] Community Care Hubs: Making Social Care Happen. Partnership to Align Social Care. A National Learning and Action Network. https://www.partnershipp2asc.org/cch-resources/


METRO DENVER
PARTNERSHIP FOR HEALTH