# Community Integrated Health Networks:

## An Organizing Model Connecting Health Care & Social Services

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Health care and community-based long-term services and supports have historically operated as separate delivery systems, with health care providers addressing individuals' medical needs and community-based organizations (CBOs) addressing functional needs and social determinants of health (SDOH). The lack of coordination between these equally important – but siloed – systems leaves the individuals who use them – older adults, individuals with disabilities, and caregivers – with the burden of navigating different service systems, leading to confusion, stress, and a higher probability of institutional care and related costs.

In this paper, we make the case that integrating these systems into *community integrated health networks* leads to better outcomes and lower costs. In addition, we describe a set of CBO network models, ranging from a local/regional level to a national level. These networks of CBOs operate at different levels and formalize contractual relationships with health care partners according to their size, capacity, population needs, and geographical reach.

## Preamble: The Guiding Principles of the Organizing Model

The goal of the organizing model presented below is to promote a person-centered approach to integrating medical and social care in which the individual's preferences, goals, and interests are embedded across various services and touch points. It draws heavily from input provided by a work group of participants who attended the *Enhancing Community-Based Networks for Nationwide Capacity* Roundtable Meeting at the Washington, DC offices of the Administration for Community Living (ACL) on December 5, 2019. Following the Roundtable meeting, a subset of community leaders who have been developing networks over the last decade agreed to meet on a biweekly basis to further refine an organizing model for connecting health care and social services.

The Roundtable Work Group was guided by the following set of core principles on community integrated health networks:

1. **Trust**: Networks leverage established relationships in the community and in the home to ensure that individuals feel understood and supported.

2. **Leadership**: Social service and health care decision makers share leadership responsibilities in planning and managing social assessments, referrals, service delivery, and team-based, holistic care.
3. **Accountability**: Social service leaders implement a system of accountability and quality improvement at all levels using agreed-upon performance benchmarks, frameworks for data sharing and regular reporting, and data-driven strategies for improvement.
4. **Sustainability**: Networks finance services that address SDOH through multi-payer arrangements that build community capacity. Over time, they transition from a fee-for-service payment model to value-based/risk-based payment models for delivering social services in comprehensive, coordinated care environments.
5. **Innovation**: To maximize efficient delivery of services and health outcomes, networks implement, evaluate, and iterate evidence-based interventions and innovative care models.

# Why Do We Need Community Integrated Health Networks?

A growing body of literature shows that CBOs are more likely to successfully expand their mission to support the diverse needs of individuals and families in the community if they belong to integrated networks with diverse partners. These studies offer crucial insight into why it is important to design and replicate effective approaches for network organization.

In a study of Accountable Care Organizations (ACOs), which have become early adopters of efforts to integrate medical care and SDOH, Murray, Rodriguez, and Lewis (2020) found that ACOs were often hampered by *not* being well-integrated into CBO networks that have already developed the capacity to address SDOH. They concluded that ACOs are more likely to succeed in integrating SDOH into their broader efforts if they implement local and regional networking initiatives that connect them to CBOs. They further concluded that such integration would also be improved by providing sustainable funding and developing standardized data on CBOs' services and their quality.

In one study, Brewster, Brault, Tan, Curry, and Bradley (2018) studied 16 Hospital Service Areas (HSAs) that performed either well or poorly across three key outcomes: ambulatory care-related hospitalizations; readmission rates; and average reimbursements per Medicare beneficiary. Using site visits and in-depth interviews with nearly 250 representatives of health care organizations, social service agencies, and local government bodies, they found that organizations in the high-performing HSAs collaborated more deeply and consistently with CBOs that provided social services than those in the low-performing HSAs.

In a separate study, Brewster, Kunkel, Straker, and Curry (2018) found that counties whose Areas Agencies on Aging (AAAs) maintained informal partnerships with a broad range of organizations in health care and other sectors had significantly lower hospital readmission rates, compared to counties whose AAAs had informal partnerships with fewer types of

organizations. Moreover, counties whose AAAs had programs to divert older adults away from nursing home placement had significantly lower avoidable nursing home use, compared to counties whose AAAs lacked such programs.

In a third study, Brewster, Yuan, Tan, Tangoren, and Curry (2019) explored the characteristics of effective collaborative networks. They collected survey data on collaborative ties among health care and social service organizations in 20 communities with high or low performance on avoidable health care use and spending by Medicare beneficiaries. They measured six types of ties: collaboration; referrals; information sharing; project cosponsoring; financial contracting; and joint needs assessments. Two features distinguished high-performing networks from low-performing ones: 1) health care organizations occupied more central positions (meaning they had the densest array of connections to other organizations); and 2) subnetworks of co-sponsorship ties were more cohesive (specifically, denser and more centralized around activities such as client referral and needs assessments). AAAs tended to be more central than any other type of organization because they are already positioned as network brokers and can thus serve as anchors for new networks of CBOs within HSAs.

The findings of these studies suggest that efforts to improve medical outcomes and lower costs by addressing SDOH will be more effective if CBOs, health plans, and health systems develop formalized partnerships within collaborative networks.

# How Might Community Integrated Health Be Organized?

How should CBO-led networks be organized? To answer that question, we first define **community integrated health networks** as a coordinated group of visible and trusted CBOs led by a **Network Lead Entity** (NLE) that have entered a formal partnership with a health care organization. Headed by NLEs, community integrated health networks are scalable and can offer one-stop contracting for multiple proven interventions and services. These interventions can be conducted in an individual's home and in a person-centered fashion by a workforce trained in person-centered thinking, planning, and practice. These networks may benefit from using a centralized, coordinated model for service provision, administrative functions, and quality improvement. The NLE, which serves as the hub for coordinating the services of the wider network, provides a unified and consistent approach to program delivery across a geographic area. It can also provide administrative oversight and take the lead in governance responsibilities.

Establishing community integrated health networks led by NLEs gives these networks the capacity to:

- Deliver a broad scope of SDOH services
- Expand and evolve populations served by reaching more diverse consumers and traditionally hard-to-reach populations

- Build stronger administrative infrastructures
- Capitalize on economies of scale
- Provide expanded geographic coverage at various levels – community (within states), statewide, regional (across state lines), and national (multi-state)
- Offer one-stop contracting for multiple services with different payers
- Expand quality improvement initiatives and successes

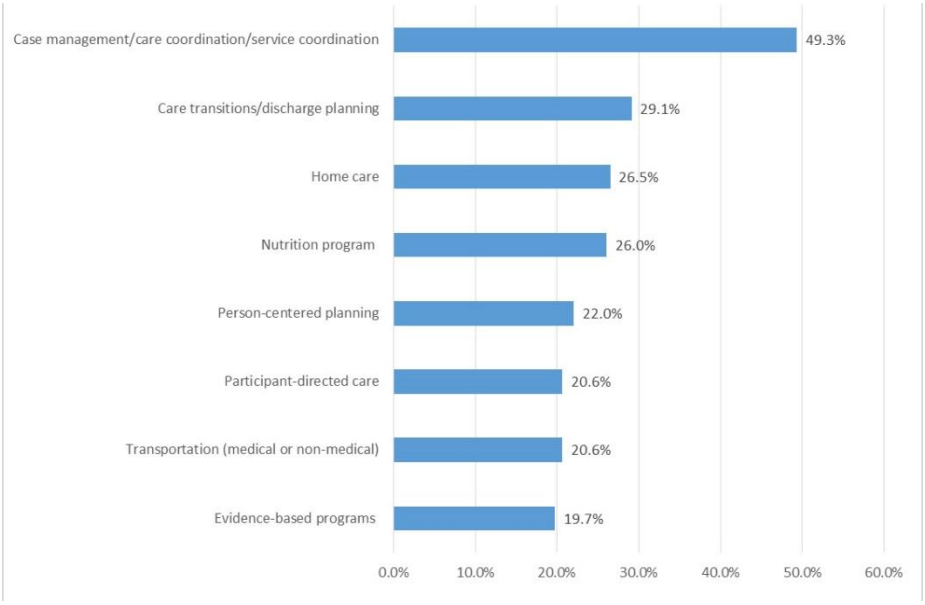
A NLE allows private health care entities to efficiently contract with multiple community-based service organizations in a streamlined way. In response to health care payers across the country, NLEs can leverage existing national aging and disability networks. NLEs are rapidly forming new legal and organizational structures to help streamline and coordinate payments, implement a consistent referral and service delivery process, manage data flows, expand geographic coverage, and improve risk management. A significant advantage of NLE-led networks is their capacity to provide services at different geographic levels, such as 1) community-wide; 2) statewide; 3) regionally across state lines; and 4) national models across multiple states to meet the market demand of health plans' and systems' geographic footprint.

Because community integrated health networks can include public and private health systems and health plans, they have the power to serve individuals with complex medical, social, and functional needs, independent of the health plan in which they are enrolled or the health system through which they typically receive their medical services. In addition, as a majority of payers shift to value-based care, a NLE can contract with all willing and interested payers and providers in a given market that can share in the investment needed to evolve and sustain the community integrated health network. These networks can also evolve their approach to targeting populations in need based upon individual assessments and population level analytics and grow network capacity and service delivery to meet these needs accordingly.

An example of an existing community integrated health network appears in Appendix A. It illustrates how one network, VAAACares, has used the NLE model to bring together CBOs and health partners to improve outcomes for the individuals they serve while adhering to the key principles listed in the preamble of this paper.

# Which Services Do Community Integrated Health Networks Offer?

According to a recent national request for information (RFI) survey by the Aging and Disability Business Institute (Kunkel, Wilson, Lackmeyer, and Straker, 2019), the most common health care contracting partners for CBOs (AAAs, CILs, and others) are Medicaid managed care organizations (MCOs), followed by state Medicaid plans and hospitals and hospital systems, respectively. Through a recent shift in the CHRONIC Care Act, CBOs are also beginning to partner with Medicare Advantage plans with such partnerships continuing to grow. The same survey revealed that nearly 250,000 individuals were served through contracts with health care partners, and 85 percent of respondents indicated that their contracts targeted high-risk or high-need groups. Finally, the RFI survey also found that the most common services provided under contracts were community home-based case management, care coordination, and service coordination.




*Citation: 1 Kunkel, Stracker, Kelly, and Lackmeyer (2017)*

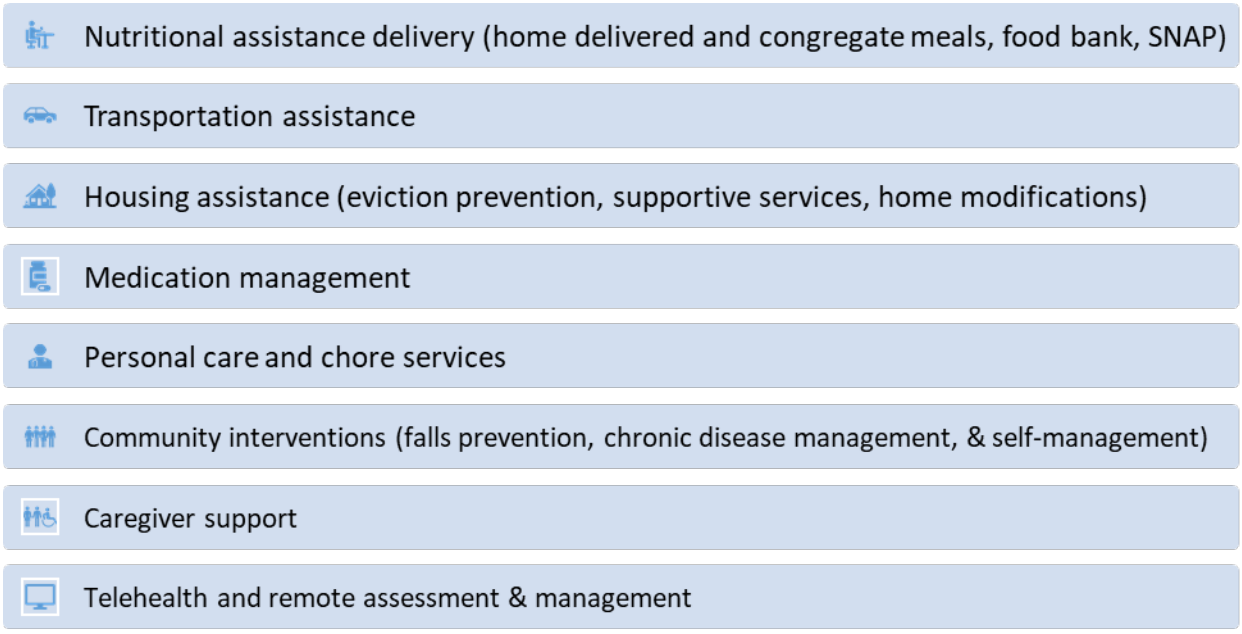
Community integrated health networks may offer a basic set of services. These commonly offered services could include those listed in the graphic below.

*Figure 1: Services That Community Integrated Health Networks Might Commonly Offer*


Note that the services listed above do not represent an exhaustive list.

Community integrated health networks may also offer other types of services. The set of such services could depend on network capacity, the needs of the communities they serve, and demand from payers (including the willingness to pay a reasonable price). These other services could include those listed on page 6.

*Figure 2: Services that Community Integrated Health Networks Might Offer Depending on Local Need and Demand*




Again, the services listed above do not represent an exhaustive list.

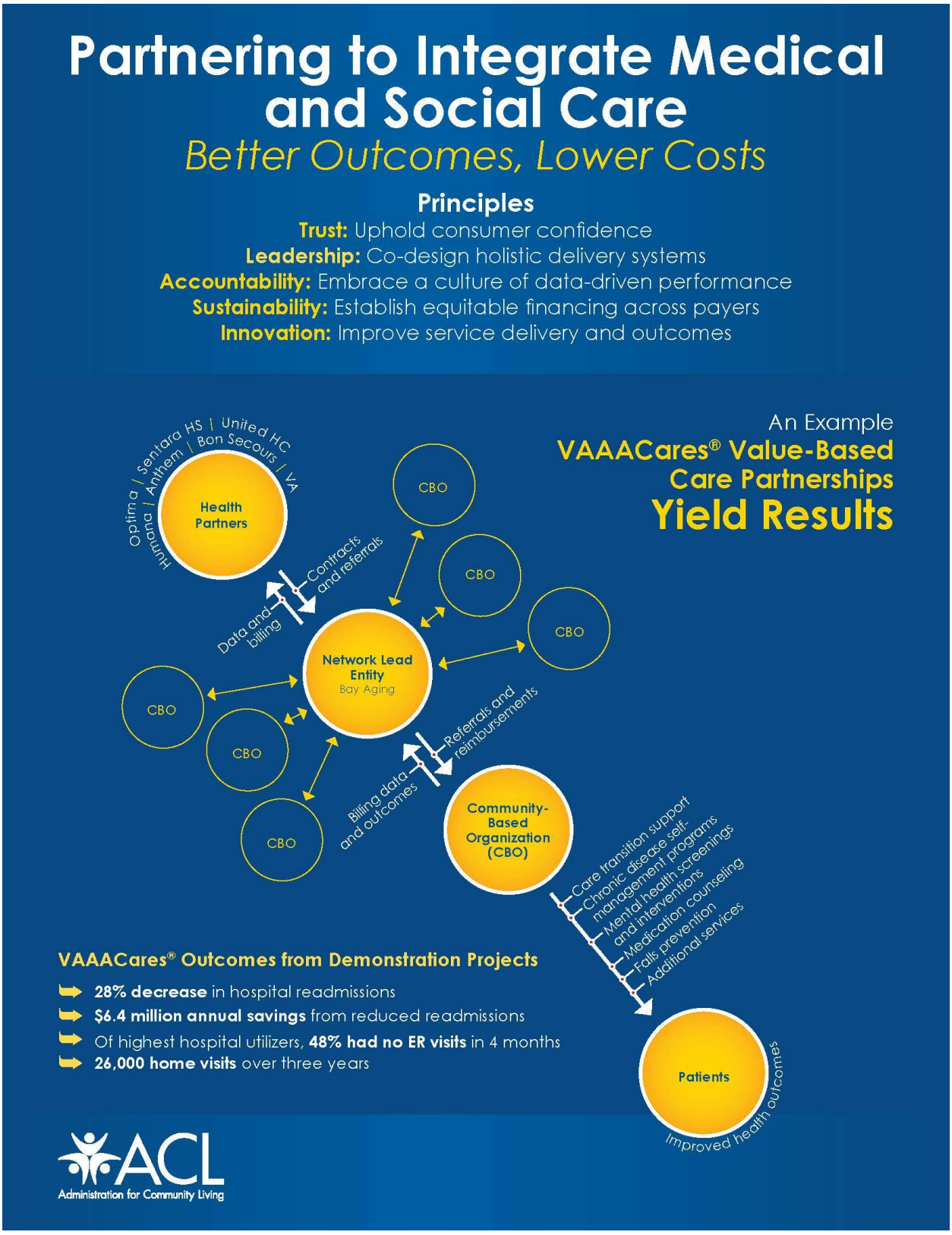
# Conclusion

We have presented a brief review of the benefits of network integration and suggested ways that community integrated health networks led by network lead entities might be organized at different geographic scales. We have also enumerated services that we believe community integrated health networks may commonly offer, along with services that such networks may offer less commonly, depending on capacity, the needs of the community, and demand from payers.

# If You Have Feedback on This Paper

If you have feedback on this draft of the paper or wish to connect with a community network, you may email the Administration for Community Living at CommunityNetworks@acl.hhs.gov.

# Appendix A: Example of Community Integrated Health Network, VAAACares



# Appendix B: Glossary of Abbreviations

| Acronym | Meaning |
|---|---|
| AAA | Areas Agency on Aging |
| ACL | Administration for Community Living |
| ACO | Accountable Care Organizations |
| CBO | Community-Based Organizations |
| CIL | Center for Independent Living |
| HSA | Hospital Service Areas |
| MA | Medicare Advantage |
| MCO | Managed Care Organizations |
| NLE | Network Lead Entity |
| RFI | Request for Information |
| SDOH | Social Determinants of Health |

# References


Brewster, A. L., Brault, M. A., Tan, A. X., Curry, L. A., & Bradley, E. H. (2018). Patterns of collaboration among health care and social services providers in communities with lower health care utilization and costs. *Health Services Research*, *53*, 2892–2909. https://doi.org/10.1111/1475-6773.12775

Brewster, A. L., Kunkel, S., Straker, J., & Curry, L. A. (2018). Cross-sectoral partnerships by area agencies on aging: Associations with health care use and spending. *Health Affairs, 37*(1), 15-21. doi:10.1377/hlthaff.2017.1346

Brewster, A. L., Yuan, C. T., Tan, A. X., Tangoren, C. G., & Curry, L. A. (2019). Collaboration in health care and social service networks for older adults: Association with health care utilization measures. *Med Care, 57*(5), 327-333. doi:10.1097/MLR.0000000000001097

Kunkel, S.R., Lackmeyer, A.E., Stracker, J.K., Wilson, T.L., (2019) Aging and disability business institute: Final evaluation report. *Scripps Gerontology Center.* Retrieved from https://sc.lib.miamioh.edu/bitstream/handle/2374.MIA/6400/kunkel-aging-disability-business-institute-report-5-23-19-bt.pdf

Kunkel, S. R., Straker, J. K., Kelly, E. M., & Lackmeyer, A. E. (2017). Community-based organizations and health care contracting. *Scripps Gerontology Center*. Retrieved from http://bit.ly/2iW6mQL

Murray, G. F., Rodriguez, H. P., & Lewis, V. A. (2020). Upstream with a small paddle: How ACOs are working against the current to meet patients' social needs. *Health Affairs (Millwood), 39*(2), 199-206. doi:10.1377/hlthaff.2019.01266


# Further Reading on Social Determinants of Health


Abraham, T. (2018). 1 in 5 patients at high risk of socioeconomic health problem, survey finds. *Healthcare Dive.* Retrieved from https://www.healthcaredive.com/news/1-in-5-patients-at-high-risk-of-socioeconomic-health-problem-survey-finds/544233/

Artiga, S., & Hinton, E. (2018). Beyond health care: The role of social determinants of health in promoting health and health equity (p. 13). *Kaiser Commission on Medicaid and the Uninsured.* Retrieved from http://files.kff.org/attachment/issue-brief-beyond-health-care

Compelling Reason, LLC. (2018). The business case for Oregon's ADRC. *Oregon Aging and Disability Resource Connection.* Retrieved from https://www.oregon.gov/dhs/seniors-disabilities/sua/adrcdocuments/dhs-adrc-business-case-overview-2018-06.pdf

Culhane, D. P., Metraux, S., & Hadley, T. (2002). Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate, 13*(1), 107-163. doi:10.1080/10511482.2002.9521437

Lavelle, B., Mancuso, D., Huber, A., & Felver, B. E. M. (2014). Expanding eligibility for the family caregiver support program in fy 2012. *Washington State Department of Social and Health Services, Research and Data Analysis Division.* Retrieved from https://www.dshs.wa.gov/sites/default/files/rda/reports/research-8-31.pdf

Simmons, J. (2020). The simplicity of one partner with the resources of many*. Partners in Care Foundation.* Retrieved from https://www.picf.org/partners-at-home-network/