May 17 – Health Equity: Partnering with Community-Based Organizations

Fiona Giblin (00:00:02):

Now, without further ado. Please welcome Karen Dale to begin!

Karen Dale, HEAT Co-Chair (00:00:07):

Thank you. I'm immensely pleased that each of you has taken time to join us today for our panel: Fostering Collaborative Communities, Empowering Partners in Alternative Payment Models and Value-Based Care programs. My name is Karen Dale, and I'm the co-chair of the LAN's Health Equity Advisory Team. also known as HEAT. Next slide, please.

Karen Dale, HEAT Co-Chair (00:00:36):

Let's review our agenda and objectives for today's call. We will hear from several community-based organizations and representatives of community-based organizations, or CBOs, to learn more about how payers, providers, and other health care organizations can better collaborate and engage CBOs in alternative payment models and value-based care.

CBOs play such an important role in addressing health disparities and inequities. And while CBOs are not representative of the entire communities that they serve, they are valuable partners and conduits for action on behalf of and provider engagement with, the community. We further wish to recognize that important work is already done. Lots of good work happening across our nation. For instance, CBOs and managed care organizations have been partnered for a while now, with the goal of improving quality and community care hubs have become more prevalent with the intent of convening CBOs in support of value-based care.

It is the HEAT's intent to build on this great work already being done and to create momentum by further emphasizing the role of CBOs and highlighting critical elements that make for equitable partnerships in the context of payment reform that will ultimately help to address health disparities in a more holistic way.

Karen Dale, HEAT Co-Chair (00:02:04):

So, we're going to start off with a little audience participation and a quick poll. You should see a polling question coming up, and the question is simple: Has your organization partnered with a CBO? Yes or no?

Karen Dale, HEAT Co-Chair (00:02:42):

You should start to see the results in a few more seconds.

Karen Dale, HEAT Co-Chair (00:02:53):

There we go. Oh, that's a good number. 67% of you answered yes, you have partnered with a CBO. So, that is awesome. That should make for really wonderful discussion today. So, thank you, and we're hoping today's event will be informative for you as you continue with your existing CBO partnerships. And hopefully, if you are in the percentage that answered no, you'll be listening carefully to learn more about how to develop new ones. Next slide, please.

Karen Dale, HEAT Co-Chair (00:03:27):

So, before we jump into the panel discussion, I would like to share a little more about the work of LAN and the HEAT, in terms of our choice to focus on community engagement and community-based organizations in 2023. So, the Health Payment Learning and Action Network, or LAN, recognizes that Alternate Payment Models, or APMs, have an important role to play in supporting, incentivizing, and holding health care organizations accountable for achieving health equity. The LAN established the Health Equity Advisory Team to help identify and prioritize opportunities to advance health equity through APMs, and to influence the design principles, and to inform LAN's priorities and initiatives. The HEAT's goal is pretty simple. Pretty direct. It's person-centered, right? We want to figure out how we leverage APMs, to help make needed care more accessible, drive better patient outcomes, and reduce disparities. We also want to be sure that the experiences of patients, priorities, and perceptions are critical in the work that we do.

The HEAT believes that intentional APM design can help mitigate the negative impact that health-harming biases and structural racism have on historically marginalized communities and the providers that serve them. And that APMs can definitely serve as a tool to help advance health equity. So, through our work, the HEAT has developed a theory of change focused on how APMs advance health equity. A key driver of change and the focus area of the HEAT for this year is partnership with community-based organizations providing local health-related social needs services. So, when you look at this theory of change, up there in the right where the orange box is highlighting, right? There's that. This is the focus: partnering with community-based organizations. Now we know partnership with CBOs is directly tied to person-centered work. And we know that to change outcomes for people, we need to ensure all their needs and challenges, even those that are happening outside of the formal health care system, are accounted for.

Karen Dale, HEAT Co-Chair (00:05:44):

We know that the knowledge and ability required to effectively achieve this holistic approach is the stuff that happens outside of providers' office or a hospital. It's all those things that help people in their everyday lives. Then there are secondary drivers in the HEAT theory of change which are interrelated, and they are also highlighted on the screen with the orange boxes. And this is to point out that these enablers are important in the effective partnership with CBOs and social service agencies in pursuit of achieving more equitable outcomes.

One last comment before we move on to the next slide. The HEAT recognizes that partnerships with CBOs - it's one component of broader community engagement. So, there are other things that certainly

must be considered and explored around how there's deeper engagement with the community as well. Next slide, please.

Karen Dale, HEAT Co-Chair (00:06:42):

The HEAT is now uniquely poised, building on much of the work we've been doing over the last two years to build on this theory of change. We know that limited community engagement in payment and delivery system reform limits the potential for these interventions to effectively address multi-dimensional disparities. And we're taking this to heart as we focus on partnerships with CBOs.

The HEAT is hoping to achieve the following through our work this year: provide opportunities for meaningful engagement with CBOs and CBO partners to share varying experiences and perspectives on participating in APMs, amplify the existing work being done in this space, and bridge notable gaps through further guidance and development, collaborate with CBOs to understand the lived experiences of their communities, and bring this into our design and implementation of APMs. We want to also understand the best pathways for CBOs to engage in innovative payment and delivery models, and then promote those pathways. So, without further ado let's get started. Next slide, please.

Karen Dale, HEAT Co-Chair (00:07:54):

So, with that grounding that I just provided, I'd like to give our panelists a chance to introduce themselves. Panelists, when I call your name, please introduce yourself, your organization, [it'd] be great to know where you are located and tell us about the population of focus. Also, share any experience your organization has with value-based care or alternative payment models. I'm going to begin with Tim.

Tim McNeill, Partnership to Align Social Care (00:08:24):

Thank you. My name's Tim McNeill. I'm with a Partnership to Align Social Care and based in Washington, DC. And we are an organization that's supporting, is a collaborative of health plans, health systems, and CBOs working to identify best practices, to align social care with health care, to achieve outcomes, particularly as it relates to health-related social needs.

Part of that work includes providing intensive technical assistance to organizations that are engaging in a value-based payment model, with a pair, and a CBO. And I could, okay, later on, will provide examples of that work.

Karen Dale, HEAT Co-Chair (00:09:04):

Thank you, Tim. Sam, will you go next, please?

Sam Hoeffler, Reinvestment Partners (00:09:08):

Hi, everyone. My name is Sam Hoeffler. I'm the director of Food Programs at Reinvestment Partners. We are based in Durham, North Carolina. We're an anti-poverty organization that partners with health care payers, providers, and clinics. We run a program called Eat Well, and it is the Nation's largest produce prescription program, and produce prescriptions connect people with the money that they

need to buy healthy food. And so, we basically send people a prepaid debit card that's restricted to the purchase of fruits and vegetables. And they can shop at Walmart, they can shop at Kroger, Albertson, Dollar General, and we served more than 90,000 people over five years. And currently, we're serving 30,000 people, and our participants are spending a million dollars a month on fruits and vegetables, using their Eat Well card in partnership with the health care sector.

Karen Dale, HEAT Co-Chair (00:10:05):

Thank you, Sam. Aza. Please share.

Aza Nedhari, Mamatoto Village (00:10:10):

Hello! My name is Aza Nedhari. I am the co-founding executive director at Mamatoto Village. I am also a practicing midwife and family therapist. Our population of focus is in Black maternal health and perinatal workforce development, and we are also DC-based. We have been working with the Medicaid managed care organizations here in the district since 2015, and we started in a fee-for-service model before moving to capitation with one of our payers.

Karen Dale, HEAT Co-Chair (00:10:51):

Thank you, Aza. And Joe, please go ahead.

Joe Strickland, SARCOA (00:10:55):

Hello! My name is Joseph Strickland. I work with the SARCO AAA Regional Council on Aging in Southeast Alabama. I am the director of Home and Community Medicaid Waiver programs, as well as the system administrator for our case management software for all the 13 AAAs operating in the HCBS world in the State of Alabama. Of course, as a AAA, we focus on providing services to our community predominantly to frail, elderly, and disabled individuals through multiple business lines. And I have been doing that for a number of decades. About five years ago, we were, we emerged as a new organization in managed care, and we are completing our fifth year in a managed care environment and working through procurement for the next five-year contract cycle. So, we're excited.

Karen Dale, HEAT Co-Chair (00:11:47):

Awesome. Thank you, Joe. So, after hearing those introductions, I'm sure our audience agrees that we've got a great lineup. There'll be a lot to learn. So, thank you, each of you panelists, for being here today, and we're going to look forward to a great discussion.

A quick reminder to our audience. Please feel free to submit questions as we go along, in the chat. And then at the end when we have audience Q&A, we will be going through and trying to get to as many of those questions as we can. I don't want you to forget your questions, though, so you can certainly put them in the chat. We will be reviewing those and getting to as many of them as possible. Next slide, please.

Karen Dale, HEAT Co-Chair (00:12:32):

So, we're going to jump in with our questions. So, the first question is one that I'd love for each panelist to weigh in on. And that is, can you provide an example of a successful partnership between a community-based organization and a health care organization that you've observed or one in which you have participated?

Karen Dale, HEAT Co-Chair (00:12:55):

And, Sam, would you like to start?

Sam Hoeffler, Reinvestment Partners (00:12:59):

Sure! We actually partnered with Blue Cross Blue Shield, North Carolina in March of 2021, and we contracted with them to offer our produce prescription to hypertensive Blue Cross ACA members who are receiving a 100% subsidy. We enrolled 5,000 people in a month, and those folks were enrolled for more than a year.

So, this contract, just as the CBO, led to additional contracts with Blue Cross as far as additional lines of business, including Student Blue. So, we served 6,000 college students across North Carolina, which was really cool and kind of novel. And then we also offered this program to their federal employee program. And so, in total we served about 12,000 people with Blue Cross.

Sam Hoeffler, Reinvestment Partners (00:13:52):

I just want to share two components that I think are really important. The first is that we did something new, which is leverage existing data for outreach and enrollment. So Blue Cross knew who they wanted to target, and they had information on those folks. So, they basically developed a list of people who had hypertension, like I said, and they were ACA members, and then they had that subsidy. And we'd worked with them to send those folks an email. And we sent them an email telling them that they were eligible and developed an online enrollment process so that people could basically receive an email, see that they're eligible - without having to find us, prove anything, pay for anything, or jump through any hoops to get enrolled - and then they get involved themselves online, and they had access to funds every month for a year.

So, I think that is important to share because it felt like we were actually operationalizing a commitment to centering the experience of our participants and Blue Cross members, and kind of valuing their time and making sure that they weren't having to do a ton of work to get enrolled.

Sam Hoeffler, Reinvestment Partners (00:15:04):

And then the other piece, that I think is important just to share, is that we're really doing this work, as, with the goal of food, healthy food, being a covered benefit. So, everything that we're doing, program-wise or evaluation and research wise, we're trying to lay that path to that result. So, with Blue Cross, they included us, I think, in a meaningful way, in their research and in their evaluation. So, they're studying these programs and we're working together to make sure that we're asking the right questions, and that we're ultimately kind of informing this path toward covered benefit and this path towards strengthening the possibility for CBOs to meaningfully integrate into the health care sector.

So, this research and evaluation was really rooted in mutual learning, and I think that is a key component of our success, and it allows kind of this work to be a part of a bigger systems change.

Karen Dale, HEAT Co-Chair (00:16:03):

Oh, a lot of things there. Mutual benefit, partnership, making things easier for who is being served, rigorous evaluation, looking at what policy and structural things can be addressed. Awesome. Thank you. Aza, would you like to share about any successful partnerships that you've either been involved in or observed?

Aza Nedhari, Mamatoto Village (00:16:27):

Yes, so I will speak to our partnership with AmeriHealth. So back in 2015, Mamatoto started a relationship with AmeriHealth Carita in DC. And that relationship eventually led to us being able to contract with all of our Medicaid managed care organizations in the district to provide a funding source for our perinatal home visiting program.

At the time, back in 2015, maternal health, obviously- it's those of us who work in the in the MCH field- this has always been a point of discussion for us. But, it was not a part of the national conversation as it is right now. And so, Mamatoto was really a bit of a unicorn in this space, especially having a contract with a Medicaid managed care provider to deliver fully our home visiting.

Aza Nedhari, Mamatoto Village (00:17:28):

At the time, that NCO contract was actually our primary source of funding for being able to deliver this program. That looks very different almost 10 years later. But at that time, it was the catalyst that allowed us to cultivate a workforce from within the community, and then deliver care to our most vulnerable and historically marginalized members in the district. Over the last couple of years, we've been working directly with the AmeriHealth to evaluate our perinatal home visiting program where we cross-analyzed people who were participants in our program and who were multips, meaning they had had a subsequent pregnancy, and who were AmeriHealth members. We use them as their own control, looking at those who had a baby inside while they were with us, and had a baby without being a part of the program.

And then we compare that also to AmeriHealth members with a similar profile, both health and demographic, and assess those outcomes. And what we found was that our home visiting program had significant evidence in supporting and preventing pre-term birth outcomes.

And so, this for us allowed us to cultivate an evidence base which we are using towards a national replication of our home visiting model. And over the years of developing this relationship with AmeriHealth, it’s supported our clients in being able to ensure that their maternal health outcomes are being optimized. Our team has monthly case meetings with the care managers at AmeriHealth. There's enhanced communication, and so we see the difference in those members who are able to have that complete rap support. It makes it difficult to lose someone to care when you have the community-based organization who is on the ground addressing social needs. And you have that insurance

provider who has been feeding and getting the information that they may not get through telephonic support.

Karen Dale, HEAT Co-Chair (00:19:33):

Thank you, Aza. Lots of good things I heard there too. That the collaboration, the communication pathway, is important. And again, the theme of rigorously evaluating to understand what works. But thank you for sharing. Joe, may I go to you next?

Joe Strickland, SARCOA (00:19:50):

Certainly. Thank you. So, our experience here at SARCOA AAA is somewhat similar to many smaller CBOs as we were pressed into the competitive market for the work we've been doing for a number of years. In 2015-2016 legislative cycle, the state of Alabama legislature enacted law and requirements that the AAAs be allowed the privilege of continuing our business line with the HCBS waivers in an upcoming procurement with our Medicaid Agency and a managed care organization. The award was made in 2018, and we've been able to successfully leverage our experience over the multiple decades to continue the work we do. The fact is, in Alabama we saw the need to prepare in advance of the initial procurement, and we did use our experience and our skill sets within each of the 13 AAAs to do a deep dive into policy process, so forth and so on, and we determined we needed to provide a standardized business solution or case management solution statewide, in order to appeal to a managed care organization.

Joe Strickland, SARCOA (00:21:01):

Initially, we believed the managed care organization would prefer to have one contract with one CBO, or mega CBO perhaps, for statewide coverage. In fact, we eventually moved to 13 individual contracts with a managed organization. However, the appeal to the managed care organization was that we were able to attain NCQA accreditation for our case management program, CML TSS, which was a very time-consuming and laborious process, took approximately 18 months to do, but it's been very successful for us. In pre-MCO worlds, we weren't necessarily fully aligned with the person-centered approach to case management or care coordination. However, our experience in doing a deep dive on our policies and processes, as well as the standards for CML TSS, proved to us that we needed to increase our awareness to provide a more person-centered approach, and really, really go deep in ensuring the program we provide meet the needs of the individuals, as well as the purchaser, to improve outcomes and experience in general. And contract began October of 2018, and as I mentioned a moment ago, we are completing the fifth year of our contract in the midst of procurement for the next five-year contract and we feel confident we will continue to be able to work in this area for a number of years, and do so very successfully, and supportive of the frail, elderly, disabled population through our HCBS waivers. All in all, we see this is a very, very strong win for the AAAs. Strong win for the state of Alabama and the consumers or the members we provide services to.

Karen Dale, HEAT Co-Chair (00:22:47):

Thank you. I love that path of growth and improvement, you know, that's awesome.

All right, Tim, I'd love to hear from you as well, and if you could also share examples from your work at the partnership in terms of your role of a convener of CBOs.

Tim McNeill, Partnership to Align Social Care (00:23:04):

Absolutely, So, I supported a community care hub in Western New York, which is the hub with multiple community-based organizations organized into a social care delivery system. They successfully contracted with two Medicaid managed care plans and a Medicare Advantage Plan initially for an intervention for depression and social isolation amongst those members. So, they adopted an evidence-based program called Healthy Ideas and with Healthy Ideas they identified members within those plans who had an elevated PHQ-9 or had a diagnosis of depression. We set up a referral process, engaged those persons, and that was our first quality measure that we had to meet, and was initially engagement. But then, we then deployed this evidence-based intervention with weekly PHQ-9s where we also had to show an improvement in PHQ-9, or depression scores over time. We also, since they are also referring persons to have been identified as socially isolated, we also included the UCLA loneliness score, as our other quality metric.

Tim McNeill, Partnership to Align Social Care (00:24:18):

The value-based payment model was a 10% quality withhold where we then were paid that additional 10% after a retrospective review of the quality data showing improvement in PHQ- 9 and UCLA loneliness data. And that was very successful and has now led to additional contracts with those payers and other arrangements. One key hallmark of the intervention was a screening for health-related social needs, deploying interventions to address those health-related social needs in addition to the evidence-based intervention. And now one of the measures you're looking at is the percentage of the population that have remission from their depression within 12 months of identifying that they have that diagnosis.

Karen Dale, HEAT Co-Chair (00:25:09):

Thank you. So glad to hear this work happening in the behavioral health space as well, right? We know how important that is, and heard that continued theme of growing, improving, scaling, yeah, and measuring and evaluating so awesome work. Thank you.

My next question is, so, we've heard some great things in terms of the work you've done, what do you think limits CBOs from engaging in this work in payment? You know, working with payment models and delivery system reform. If you could share some examples of what you believe stands in the way of CBO partnership. I'll go in reverse order. Since you were just speaking, Tim, would you like to begin?

Tim McNeill, Partnership to Align Social Care (00:25:55):

Sure. So, I was specifically supporting a network in Maryland, another community care hub model, engaging in a discussion around a value-based payment model design that was not successful. And one of the challenges was that the community-based organizations were going to deploy an intervention

that's preventive in nature. And the payer wanted something that would have an immediate impact on claims. And with many of these preventive interventions there won't be an immediate impact on claims data. And so, they needed to find other measures to document performance and quality, and that becomes a challenge where there needs to be a matching between the community-based organization strengths, how that will have an impact, and also realization that many interventions, particularly those addressing health-related social needs of the most vulnerable, won't have an immediate impact on claims and utilization, but will definitely have a projected improvement in other quality measures, and eventually claims and utilization, but not always immediate. So, I think that's one challenge, and just to say one more, is access to the data. So, the CBOs having access to the data so that they can understand what the baseline level is, and what the performance measure they need to achieve, and tracking their performance over time, that also is a barrier to CBO's participating in value-based payment model design.

Karen Dale, HEAT Co-Chair (00:27:30):

Thank you. Definitely heard two things, that high bar and expectation for immediate change, and then the importance of that mutual goal of sharing information and data that helps with all the planning.

Thank you. Joe, please tell us about what your thoughts are about what causes limitations and challenges.

Joe Strickland, SARCOA (00:27:52):

Perfect, thank you. From a smaller CBOs' perspective, one of the greatest challenges we experienced as we began the discussions a number of years ago was trying to determine what we had available, translating our work into a reimbursable deliverable for a managed care organization, and in doing so, allowing that data, that information, to support whatever measures and improvements that managed care organization wanted to realize. You know, as a small CBO, we tend to be rooted in our language or vernacular that we've been utilizing for a number of years and decades, and learning the new language, the new speak, from the managed care organization's perspective was very important for us. We're constantly translating what we do into meaningful language from the purchaser's perspective. So, that was a significant challenge - identifying something we were doing and showing value, and then establishing some sort of deliverable, measurable outcome to keep our purchaser comfortable with the relationship.

Joe Strickland, SARCOA (00:28:57):

An additional barrier was economy of scale, the cost of doing business. Tim mentioned data and information and entering. For us a lot of the work we had performed for a number of decades in Alabama was pen and paper assessments and work. You have no meaningful data to extract and measure and utilize if you utilize a pen and paper process. So, we actually undertook a process to identify a case management software solution to act as the network, the data network, for our AAA network. In doing so, we established about two years of data, a warehouse, that we could use to measure extrapolate metric, so we could show outcomes historically and moving forward to be able to leverage that in conversations with the managed care organization. You know, a number of years ago

at a regional conference, we were advised that the managed care organization didn't really care how they received the data, as long as they received the data. To a certain degree that's true, but I can tell you the large managed organization wants the data and a meaningful way, so that they don't have to spend a very, very, a lot of time, working and managing and ensuring that it's its integrity is high, and its usefulness is there. So, software is a solution for deliverables was very important for us. I could go on and on from a small CBOs perspective, but I think that's enough to start with.

Karen Dale, HEAT Co-Chair (00:30:35):

Yeah, so I hear that there's infrastructure investment and then there's a whole piece of the learning curve. Yeah, so that's it. It takes time right for the CBOs to make space and commit staff to that process of change. So, thank you for sharing that. Aza, tell us, what are your thoughts on the challenges?

Aza Nedhari, Mamatoto Village (00:30:56):

Yeah, I'm going to use this acronym like C.R.A.P., because it's like you got to cut through all the crap to get through all these barriers. And so, I would say the first one is capacity, and that's personal and organizational capacity. That's the resources. The talent, you know, that's needed to even be able to take something like this on. R being resources. You know, a lot of organizations are surviving, not thriving, and they need to have people power. They need to have the financial reserves to be able to put towards developing a relationship like this in the first place. I know I'm speaking, you know, in our experience as well, even to be able to engage in a payment reform conversation, can be, can feel like a luxury when all of your advocacy efforts, or all of your attention, maybe on direct service. Knowing how to cut through red tape and get to those relationships and cultivate those relationships in a way that they are not transactional, but transformative, and they are truly value aligned. And then you know something that Joe mentioned, even being able to have the relationship within the community that will amplify your work to the exposure or to the visibility of a MCO.

And then, lastly, I would say like those power dynamics between health care systems and CBOs that sometimes are not a part of the conversation that can sometimes feel inequitable or extractive, which again, can sometimes feel like a deterrent for a CBO to want to come to the table, to have to code switch, to have to change your language, to change the way in which you are presenting yourselves are showing up can be all things that that can present themselves as levels of barriers to CBOs and wanting to engage with the payment system, especially when you're in communities where there's historic harm that has happened in relationship to health care that there can sometimes be a hesitance to even take those steps in the first place.

Karen Dale, HEAT Co-Chair (00:33:11):

So, there's something about the alignment, the ability to bring who you are as an organization to the table and not be asked to materially change who you are and the benefit that you bring. Thank you. Sam, what are your thoughts about challenges?

Sam Hoeffler, Reinvestment Partners (00:33:29):

I think you all did a really good job summing it up. You hit all the high points, I really like that acronym C.R.A.P., it really encapsulates a lot of the things that we've kind of gone through as well. So, yeah, everything that you all have shared has really resonated with me.

And I think I was just going to say something similar, which is to say it is a high bar for a CBO to meet health care needs and requirements. And so, I think, you know, I'm thinking of tangible things like a SOC 2 certification, or HIPAA compliance, or making sure your model works at scale, and a customer service team that can meet demand once you do scale. And I think about the idea that CBOs really need startup funds and without a contract the investment might not lead to a return or make any sense, but it's hard to get the contract without making the investment. And so, I think that we're kind of in a chicken and egg situation because we need to have these startup funds to get going for a contract, but without the promise of that contract we're not really going anywhere. So, I think there is just a general lack of existing infrastructure to really meet, match up reality, and what CBOs need. And I think for us what we kind of how we structured it, I don't know if this is helpful at all, but I was thinking through like how did we manage that? Because it is chicken and egg, and like I said, so we really got grant funding for a while, and it sounds like it's similar with the y'all's work as well. But we got grant funding for a while for operational and program costs, and at the same time we're kind of building our capacity so that we could transition to PMPM without kind of operating at a loss. So, we really overlapped some of those things. But again, it was kind of like betting on ourselves, a little bit, where it was like we didn't really know where we were going but we were hopeful that this investment was going to play out for organization. So, I think it was a little bit of like a steppingstone model, and I think some more that we can integrate or make that accessible to CBOs lay a path there that I think that's helpful.

Karen Dale, HEAT Co-Chair (00:35:49):

Thank you. Yeah, that upfront investment and how do you get started, even when you're interested is a challenge, and something that certainly has to be contemplated because you don't want to harm your organization by stepping out, even though you believe this is going to be good. What if it doesn't work out? Then your organization might suffer. But thank you all for those responses.

I'll add, from a payer perspective, a few things, some of which I think I've heard versions of. The first is that there is often this lack of understanding of the payer priorities. You know, we have the alphabet soup of things. We've got HEDIS. We've got, you know, we may have a whole host of pay-for-performance things to align around. And so, if time isn't taken to have those conversations and lay those priorities out, so it's not just about what the CBO is offering, I think it's important that the MCOs are pretty transparent about what their pain points are and their priorities are. And you have that conversation, right, about where alignment is or is not, and so that the CBO has a better understanding of expectations.

Karen Dale, HEAT Co-Chair (00:37:04):

In addition to upfront investments, I think ensuring that there is agreement that the MCO will provide tailored technical assistance that it's not, "okay, so here's what we want. We need you to do it." It's

important to be there throughout the journey, as in any good relationship or partnership, you're helping each other. And so, having frequent enough conversations to understand where the CBO might be experiencing challenges, even though they agreed to do something, but they may need some help understanding the how and some patients, right, of how they worked it out. And I think it was Joe that was talking about kind of that whole learning process. So, the MCO has to agree to be patient, invest the time, and support, in terms of technical assistance for that growth and change to happen.

Karen Dale, HEAT Co-Chair (00:37:56):

I think maybe even Joe that mentioned, or Tim, that mentioned the insufficient time to have that path of change happen, or that pace of change to happen. I think the most successful relationships, it's about three years. That first year, it's learning, learning, learning. The second year, you know, process improvement. And that third year, you've got the learning, the process improvement, the payment process. You know the confluence of things, I think things then start to pick up, and you can re-commit, scale, and grow.

We mentioned CBOs being asked to change and fit into the MCOs' way of doing things. It just, it doesn't work, it really doesn't. And it doesn't help a relationship when you know you're just going to dominate by saying, "you must do these things", versus saying, "so, where do we meet in the middle?" to strike that right balance for collaboration, partnership, and I believe Aza I mentioned it, and that sharing of power. What the CBOs do matters. It's valuable work. They have community trust, and very often the MCOs are exerting a lot of resources to try to get that. And so, we could spend a lot of time trying, trying, trying, however, when you have CBOs that already have figured that out, now we've got the right ingredients to have a great partnership, right? Where you come together as partners exchanging, aligning around mutual benefits so that good things can happen. And then something that we've been talking about, as the HEAT too, is humility.

Karen Dale, HEAT Co-Chair (00:39:29):

We've got to come with humility, recognizing and elevating what the CBO does well, and continuing that process of being humble enough to learn from the CBOs because one of the things I often learn is how we, as a MCOs, have made some things more difficult. Right?

I'm always like, "Oh, no, I wish I had known", but unless you're in that place to listen and work on making change, right, and then going back and asking the question again, "Did we get it right?", things don't work as well. So being humble enough to ask for feedback, listen to feedback, acknowledge when we're wrong, and create that path to even better change in a collaborative way.

So, we know the challenges, and they're probably some that we forgot to mention. I'm wondering, what support could partners offer to overcome these challenges? What have you experienced, or what ideas do you have about how do partners do more to help overcome these challenges? I can start with you, Sam.

Sam Hoeffler, Reinvestment Partners (00:40:42):

Thanks. I think what comes to mind for me is kind of, it feels, at least in the food as medicine space where we're working, it really feels like we need more information from payers, especially as we're thinking of moving into value-based care. I think quantifying and identifying the value is actually really helpful. And so that's some of the work that we're doing with research and evaluation is trying to say, "What is the value of this, and compared to what?", and like, we don't have enough information to make that case ourselves. And so, we rely on the payer for that information. And so, it's not enough to just lower someone's A1C, for example, if they have diabetes, right? Like, that's part of a bigger story that I think the payer needs to tell kind of themselves, as far as like priorities, how these things translate into whether it's their bottom line that they're focused on, whether it's member of retention, or things like that. So, I think we're learning more about how we fit in, and we sometimes have trouble knowing what case to make because we're not the payer. And so, I think we- that's kind of what comes to mind for me, is this sort of like research and evaluation component that I hope that the payers and other groups, whether it's academics, can engage in kind of like operationalizing these things as it relates to generating value.

Karen Dale, HEAT Co-Chair (00:42:22):

Yeah, that's a key part of the relationship - that transparency about data because the payer is paying the claims. And so, they know what's happening from a trend perspective and sharing that so that the program can make pivots or changes as necessary to keep on a path to improvement is super important. Joe, what thoughts do you have? What should payers be doing to help address these challenges?

Joe Strickland, SARCOA (00:42:49):

I think, both Sam and Karen, you mentioned briefly a moment ago - communication. You know, speak effectively, know how to effectively share your knowledge experience at the CBO level with your managed care organization. Communicate regularly, talk it through, you know. Be very candid about what you can do and what you're willing to do, and understand what the pain points from the managed care organization may be. Whether it's a HEDIS measure that you need to assist with, support with, or whether it's something, you know, unrelated to HEDIS. Something that they just want to kind of pilot or demonstrate. Know where you can bring your value to the table for negotiation purposes and for contracting purposes. You know, a number of years ago we were not necessarily focused at the CBO level in the state of Alabama with 30-day readmissions to skilled or acute care setting. We weren't necessarily as detailed in our transitions of care, case management care coordination. We learn, we evolved, based on the needs of the purchaser and we continue to grow in our sophistication and our abilities.

Joe Strickland, SARCOA (00:43:55):

Humility, obviously, plays an important role in the relationship. Thank you for mentioning that. Be humble and challenge yourself at the CBO level to step slightly away from your comfort zone or your preferred scope or practice. Be willing to grow what you're able to offer to the individuals that are willing to purchase your services and support. Don't restrict yourself to only those things you do and

do well. Know that as our industry expands and grows, our population needs become more and more complex. The business line, and the supports you provide, will need to evolve with the population and the needs of the purchaser. So, all of that, it's a lot to keep your mind wrapped around, but it's very important. And if you're successful in doing that, you're probably not sleeping as well at night as some people do, but it's very rewarding. And if you can continue to challenge yourself, I think it'll be successful in this business, in this industry.

Karen Dale, HEAT Co-Chair (00:44:59):

Thank you. Aza, what are your thoughts about how to address the challenges?

Aza Nedhari, Mamatoto Village (00:45:05):

Yes, you all have definitely brought up some things that I think can be done well. Additional things I would say is that those partners can really seek out those people in the community that may not be as visible, but that do you have something valuable to offer.

Ensuring that when establishing relationships, and those APM models, that the risk doesn't fall on the CBO. And so, putting in frameworks for that, for the risk to be on the payer, especially because the CBO, again, usually doesn't have a lot in which they can bear all of that risk. That the payer or the partner can open up their network to CBOs again, elevating their work beyond that contract. Whether that's through expansion through other payers, whether that is introducing them to funders, thinking about the ways in which they can see power with that CBO beyond just that initial transaction between the two entities. And then, as Karen you have mentioned, providing that technical assistance. And I also say capacity building assistance so that organizations can really move successfully along that life course towards sustainability, and towards longevity, and being a stable resource within the community.

Karen Dale, HEAT Co-Chair (00:46:29):

Thank you. Tim, please share your thoughts.

Tim McNeill, Partnership to Align Social Care (00:46:33):

Yes. So often, community-based organizations and community care hubs operate with razor-thin margins, so they don't have a lot of additional capital to invest in the infrastructure. So, we have to realize that infrastructure investment is required to participate fully in a value-based payment model. And so, hopefully health plans will think creatively on how to address the infrastructure needs of community-based organizations to fully support them. Some of the models I've seen, I successfully worked with a Medicare Advantage Plan in Western New York that really wanted to work with a large community-based organization but recognize an infrastructure need. So, they decided they would pre-fund a certain amount that then that CBO would bill against, that gave them the necessary startup capital to then engage with the pair. And the other challenge I often see is we go through all this work to get the contract, and then there's no volume. And so, me, as a small CBO, I can't invest in staff and resources to serve five people. And so, in that same arrangement where the health plan pre-fund a certain amount that we essentially build against that pre-payment, they also guaranteed a certain

volume. And then we met on a monthly basis to discuss how the health plan could help us engage their members to fully participate to meet the volume goals that we mutually decided upon. So those were creative ways that they help support the infrastructure need that the CBO needed in order to fully participate in that value-based payment model design.

Karen Dale, HEAT Co-Chair (00:48:19):

Yeah, I like that - mutual investment, right, to make things happen. Awesome. So, I'm thinking that we probably have some community-based organizations on the phone. So, the answer to this question hopefully will help them. I'm going to ask our panelists to please share, based on your experience, what are some key lessons learned and takeaways that if we have a CBO on the phone that's really interested in getting engaged with APMs and VBCs that, you know, this is the thing that might get them off the line and, you know, jumping in right to say, “Yep, I'm going to get started working on this”. I'll start with you, Tim, since you're right there.

Tim McNeill, Partnership to Align Social Care (00:49:02):

Great, thanks. So, one thing that could, to, address the infrastructure challenges we are finding success when community-based organizations with like interest band together within a certain market to establish a hub. Then they're able to leverage economies of scale, and through that economies of scale, they mutually invest themselves, and they can establish the infrastructure, and they can also fill in gaps that others may have so then they have a seamless delivery system. So, I would advise CBOs to look to your sister organizations within your market, discuss how we could band together to realize these opportunities, particularly as health care and because of NCQA and joint commission, all the requirements are really recognizing the impact of health-related social needs and a health-related social needs delivery system could be enticing to a payer or a health system, and through a community care hub model they can create that.

Karen Dale, HEAT Co-Chair (00:50:08):

Absolutely. Thank you. Joe? What are you thinking? What are some key lessons learned?

Joe Strickland, SARCOA (00:50:15):

So, I agree with Tim. Shared resources amongst small CBOs that may be able to band together in form, for instance, a statewide network. Those shared resources make the buildup process, or the visionary through the buildup process, more appealing to the smaller CB[O]. They may have limited resources, limited funding. Of course, startup cash is very important, and it's very difficult for a smaller CBA to invest the resource, time, and dollars into the possibility of obtaining a contract in the near future. The near future could be 6 months. It could be 18 months. It could be longer, and many CBOs don't have the ability to sustain cash flow without reimbursement for that length of time. So, pooled resources are shared resources [and] are very important.

Secondly, there's a high likelihood a small CBO doesn't possess within their organization the knowledge, skill, and ability within their pay staff, C-level staff, or mid-level staff to have the vision or the ability to move into the managed care CBO contract relationship. So, don't be afraid to go outside

your organization and find talent, identify a consultant, someone that can guide you through the process because the process that you're going to undertake is multi-layered and complicated even on the best of days, and it takes someone that has a little experience to help guide you through the process. You will make mistakes. Hopefully not big mistakes, but you will make mistakes, or you will misinterpret ideology, or thoughts, or processes, and it's okay. But having someone to lean on to guide you through the process will improve your experience and then lessen the likelihood of making those mistakes. Mistakes are inevitable though. You have to have vision.

Karen Dale, HEAT Co-Chair (00:52:11):

Thank you, Joe. Sam, what are your thoughts?

Sam Hoeffler, Reinvestment Partners (00:52:17):

I was just vigorously head nodding to that because I feel like that is really, that's like, summarizing all the things that I think I would say as well. I think for us a strength was having a really well-established program before we entered into the health care space. So, we had already, kind of, tested certain things. Proof of concept, as far as technology, like can we get people money from food also? Do they like it? Is it working? Are they using it? All of these questions you're answering about our own program. And then once we did that, that was a five-year process, and then, finally, I think we were able to just put that kind of aside and focus on the integration in the health care sector rather than doing both of those things at the same time. But my answer is pretty much everything Joe said.

Karen Dale, HEAT Co-Chair (00:53:05):

Thank you. Aza, what would you want the CBOs on the call to know?

Aza Nedhari, Mamatoto Village (00:53:11):

Yeah, Sam took mine. But I was going to say, just be clear on your value proposition like, what are you offering? Like, is it already working? How do you know? Being clear on mission creep. It's easy when you have something new and shiny in front of you to be like, “Oh, we can do all these new things”, that's kind of outside of maybe even your organization's expertise. Also, being clear on what you have the capacity to take on at the time of that contract, and that may look different two years or three years out, and this is where you keep communication open with that partner. But just be really clear about what you can do in that moment, how many people you can actually serve, and serve those people really well. That may be 100 people when you start out, but it may be 400 in two or three years as you build capacity.

Karen Dale, HEAT Co-Chair (00:54:03):

Thank you. So, I'll add a few things. This is an “and” to everything that I've heard that I completely agree with. I often say to my team “no” is a complete sentence. I don't want any CBO with whom we work to be harmed by the relationship. And so sometimes I see that, you know, that we're the MCO, we’re the payer. And so, we're asking something, and it's like they feel like they have to say yes, and it's okay to say no, right? If we really built a trusting relationship where there's mutual benefit and

alignment about what is to be achieved, there shouldn't be harm. And so, I want the CBOs to know that you should be sitting at the table as an equal partner, and you should expect that and talk about that upfront so you're not agreeing to things that you don't really agree with that, that you're very concerned about your capability to execute on, right, or whether you have enough support funds, whatever. So, it's, you know, go into this being very clear, like Aza said, about what you can do, what you can't do, and what you will say no to, because it'll hurt your organization. If you don't have that level of clarity. I think you can end up sideways in ways that you didn't, you know, you didn't intend, right?

The other thing that's really important is being willing to bring things to light. It's a trust issue, right? So, if you know something isn't working in the process you should, you know, be willing to come forward and say, you know, hopefully there are frequent enough communication and meetings, but you bring it forward, right? You bring it forward and be ready to say, "Here's where we have a challenge. We need to sit down together and figure this out". If you're not resourced enough to be able to spend the time in that level of communication, ideation, and problem solving and change, then, you know, get yourselves kind of ready for that. Because what we do hear sometimes is, "Well, we're trying to do all the work. We are patient consumer", you know, "Member facing, and you're asking us", because sometimes the thing to be solved cannot just be solved with the MCOs' perspective, right? The payer's perspective. And so, having the ability to have enough team members or consultants and supports to be able to work through things is important to keeping the program holistic and getting things improving. It's already been mentioned about the infrastructure piece.

Karen Dale, HEAT Co-Chair (00:56:42):

It's really hard to figure out the value of a program that you are spending a lot of your team's time actually manually doing data. And so, even though that may not be a day one accomplishment, like, knowing that you have a path to automation and some other ways of either billing or documenting. The nuts and bolts of what a payer is often going to need and request. You've got to at least know that you have a path to getting there because not having that path, I think, is going to cause things to get lopsided later on when it comes to talking about value and outcomes and, you know, many of the things that are going to be on the payers' priority list.

All right. So, any final thoughts you want to share about, you know, your organization or any other value-based partnership opportunities that you've seen? If you don't have any, it's okay. Just giving one, giving you, the last word on that question. If there's anything else.

Tim McNeill, Partnership to Align Social Care (00:57:56):

I think the opportunities for community-based organizations to engage in the value-based payment model is, I think, the biggest opportunity ever is now before us. And I think that there's a formal recognition of the impact on health-related social needs. And so as much as possible, I want CBOs to not be afraid. Don't shy away to take this head on. There really is opportunity, you know, some folks have said that before, but this is real this time, and if you put in the work, I mean, there's real examples of success. The organizations that you see on the screen, they didn't start off with a fully operational

great models, bringing in all kind of revenue. They started at day one and perfected their craft and then engaged with the pair, and I encourage other CBOs to do that.

Karen Dale, HEAT Co-Chair (00:58:51):

Thank you. Anyone else? All right. Well, thank you all so much for sharing your valuable insights and experiences. I'm hoping that everyone takes away, right, from this all the possibilities, like you said Tim, it is a great time. CMS is very focused on this. Many states and jurisdictions are focused as well recognizing the benefit that CBOs bring, and really the potential to dramatically improve care delivery and create equity, so great things and takeaways from all that you've shared.

Karen Dale, HEAT Co-Chair (00:59:27):

I now like to give our audience an opportunity to ask questions, so hopefully there are things in the chat. And we will, let me look to see what we have here as questions. Let's see. Okay. Wow, there are a lot! All right. Let's see.

How are organizations funding the services? It looks like the question, maybe, was initially for Sam. How are organizations funding the services?

Sam Hoeffler, Reinvestment Partners (01:00:08):

That's a good question. The biggest, by far, expense that we have is the money for food. So, we started with our initial grant was through a USDA Grant, and then we layered on additional grants, and ultimately got contracts with payers. But I would say, in general, we worked with public grants, private grants, initially to, kind of, prove the concept.

Karen Dale, HEAT Co-Chair (01:00:41):

Thank you. Here's a fun one. Someone wants to know what is the A in the acronym C.R.A.P. Aza?

Aza Nedhari, Mamatoto Village (01:00:51):

Yes, it's accessibility.

Karen Dale, HEAT Co-Chair (01:00:55):

Ah, thank you. Let's see, another question for all panelists. Do you have examples of improving data sharing communication across the care continuum in rural or underserved areas?

Karen Dale, HEAT Co-Chair (01:01:21):

Anybody worked in a rural? Tim, I'm wondering when you were in New York, was that, is any part of that rural?

Tim McNeill, Partnership to Align Social Care (01:01:27):

It is. So, that work, and it covers the entire Western New York market. And so, if you're familiar with Western New York, and Buffalo is kind of the center, but the rest of the Western New York is very rural. And a perfect example is that the MCO was very concerned about food insecurity for persons in

rural areas, particularly minorities in rural areas in Western New York. And so that community care hub engaged with smaller CBOs that had niche services for specific pockets and populations. And then through that community care hub, we empowered them with the technology tools to participate in data sharing. So, a best practice that we continue to highlight, and the plan applauds was: there's a African American community in rural Western New York and to address food and security, we engage with a church that had a kitchen in the basement, and now they're part of a food and security delivery system, and how we're tying that to what's important to the payer. The payer identified that they are frequent hospitalizations and readmissions from that population. So, we set up a food and security intervention, post-discharge, as part of a follow-up intervention and then provided this church with the technology tools and online data system access to capture the data and feed it back, and through that community care hub model that was very successful. So great success there at the rural market in Western New York.

Karen Dale, HEAT Co-Chair (01:03:09): Thank you. I'm thinking maybe Sam or Aza. A question is, how are beneficiaries involved in defining the desired services and outcome goals for your program? Also, how are beneficiaries that are not online/email supported, if relevant, when you're thinking about the program and looking at participation?

Aza Nedhari, Mamatoto Village (01:03:36):

I can go first. So, our workforce development model, which is like the other part of our mission, is set up in such that we actually hire our client, so they have an opportunity to go through our training and then be either employed with us or employed at other community-based organizations, or supported in whatever their career goals are. But our goal in doing that is to diversify the perinatal workforce. The other ways in which we do that is through evaluation. And so, we do have qualitative focus groups, interviews, we do a discharge survey with all of our clients where we ask them about their experience of care. Every year, as we are thinking about programming, we do engage our clients and asking them: What do they want to see new? What do they really love? Where do we see the most participation? And we make modifications or adjustments to our services based on the feedback from our clients, as well as our home visitors, who are on the front lines. In terms of our program participation, so about 70% of our clients actually complete our full program up until 12 weeks postpartum. And so, we do have a high level of overall participation for those people who are not fully engaged. We don't have people who are exclusively email-supported, or just telehealth only, that's not our model. We're actually, kind of, trying to get our staff away from that right now. In moving back into fully in person with the option for telehealth with those very, very specific cases. So that's what we're currently doing right now.

Karen Dale, HEAT Co-Chair (01:05:26):

Thank you. What would you like to share, Sam?

Sam Hoeffler, Reinvestment Partners (01:05:31):

I would just say that we, in the beginning, did a lot of, kind of like, focus groups and everything. We kept it very small so we could be interactive with folks to understand what works best for them. I think

one of the things in our work that has been something that we're still figuring out is how much money to give people. Initially, it was $40. You can do different math as far as like what one serving of food costs multiplied out. So, I think right now we're at $80. We're seeing that folks in general are spending about 3/4s of that every month, but then some folks are spending all of it. And lately we've been kind of thinking through whether or not it needs to be scaled to household, and how that looks, especially in the insurance or health care sector, when maybe only one person actually is being covered. So, I know there's a lot of conversation around that right now. And I think in general, our main goal is to just have a sustainable, kind of like, long-term source of funding for this for folks so that they can stay on these programs for as long as they need. That's the main thing that we hear from folks is that we try to do a minimum of a year. Some funding requires us to do about six months, but every time we just hear from people like, please keep this going, I really need this. So, I think that's why we're so focused on trying to find long-term sustainable funding for this.

Karen Dale, HEAT Co-Chair (01:07:12):

Thank you. There are wonderful questions coming in. How do you see this need for partnerships as evolving from previous managed care efforts in terms of case management, etc., particularly those with Medicare Advantage? It seems that with the attachment to MCOs has continued to elicit those with risks leading to less than optimal outcomes. I don't know, is that you, maybe, Joe?

Joe Strickland, SARCOA (01:07:44):

Gosh, that's a big question.

Karen Dale, HEAT Co-Chair (01:07:45):

Yeah.

Joe Strickland, SARCOA (01:07:51):

So, I think as we envision and build out a solution to the needs of the managed care organization. We start with the idea that we're going to satisfy a certain need, and that need evolves over time. One of the panelists mentioned a moment ago, I'm going to call it scope creep, or, you know, contract creep. You obviously don't want to get into a situation as a CBO, even a small CBO, that you're providing more than you're paid for, generally speaking, but you want to have a collaborative opportunity to work with your managed care organization to ensure that all of your deliverables' requirements are met. With that said, I don't necessarily see less than optimal outcomes with individuals enrolled in our programs as we engaged with the MCO, high-level MCO, in the contract relationship. I actually see - mainly because we have data now, but also we have certain required deliverables and thresholds, performance goals, and expectations - we have a more defined understanding of what we need to do to satisfy the needs, improve outcome experience, and so forth and so on. I see it as a win-win from the CBOs' perspective, as well as the MCOs' perspective. But that's a huge question.

I would say that in our particular situation, in the state of Alabama, our case management program exceeds the requirements established by our state Medicaid agency. We do go much deeper in what we do, what we provide, because we are in NCQA accredited for CML TSS. And so, we're very particular

in making sure we assess the individuals and provide support where needed to improve outcomes, improve experience, reduce risk, so forth and so on. So, a lot happening in that question, and I think it's very CBO specific. And of course, the size of the CBO will have some impact on what you're able to do.

Karen Dale, HEAT Co-Chair (01:10:11):

Did anyone else want to weigh in on that before I go to another question? So, this next one is really a thought provoking one. It says: overall, do you think the interest in your services from health care organizations, payers, is helpful or harmful for your organization and sector?

Tim McNeill, Partnership to Align Social Care (01:10:38):

I'd like to jump in, and so it, we have seen particularly with more and more organizations engaging with social care referral platforms where CBO's have expressed that they've been harmed because there's been a significant increase in referrals for addressing social means without payment. And so, I may be at a small CBO where I have a wait list for my services and now I have this influx in new people asking for services that I'm turning away. And so, that has been harmful. However, in instances where there's a realization of the value of the community care hub and the CBO, and we find a way to monetize those efforts, there's the opportunity to for additional revenue for the CBO to expand their mission to serve people they hadn't served before. And so, this partnership with health care could definitely be valuable but both have to recognize we can't just blood referrals to CBOs and hope people get what they need. There's a cost associated with that. And so, if we find models to monetize it, to provide sustainability for the CBO then, just as Sam said, then there's a long-term sustainability and both goals could be achieved.

Karen Dale, HEAT Co-Chair (01:12:07):

Yeah, excellent, excellent response and points there, yeah. Now that we've all, so many people, you know, they see how important addressing health related social needs. So now, okay, let's get people what they need. However, someone has to deliver that service, deliver it with quality, make sure people get an opportunity to navigate all the way through the process. And payers are also saying they want, you know, closed-end referrals. They want to know that the person got what they needed, and all of that requires the CBOs to do more. So, thank you so much for that answer. Anyone want to weigh in on it, with anything else, to that point?

Sam Hoeffler, Reinvestment Partners (01:12:47):

Yeah, I was going to say it makes me think of in North Carolina we have an 1115 demonstration waiver and, kind of, on that, the side of harm, I think, when you do see especially small CBOs pivoting fully into something like this to meet the needs of a very specific time-limited waiver for example, it's a big risk, and if that doesn't come through in the end, then that means that they've taken their time away from fundraising, their time away from all of these other things to focus on this betting that it'll come through. So, I think that in North Carolina, it's like what we're seeing is like we got to make this matter, especially for the super small CBOs, and I think that's a big risk that can lead to real harm because these organizations are essentially shifting their entire orientation toward very specific outcomes,

billing mechanisms, and all these things that may or may not be guaranteed in the long-term. So, I think there's a real risk there. And I also think that we talk a lot about value sharing. So, I think exactly what we were talking about earlier about CBOs not knowing their full value, I think that can be another risk to CBOs where the payer is actually gaining a lot of value from an intervention whether it's tangible, quantifiable, or not. And so, how do we, as a CBO, ensure that not only that we're being properly compensated for the value that we're offering, but also talking about things like value sharing and like how can we reinvest this money in a partnership, for example, and not have it necessarily go to places that, like, we can't control or see. So, I think we've been having conversations around, not just quantifying the value, but ensuring that it's kind of going to places that are being reinvested into the participants that we serve as well.

Karen Dale, HEAT Co-Chair (01:14:41):

Absolutely**.** Another question we have is: how does the panel think about some of the intermediary entities in the private sector, or this idea of community hubs to try and overcome the power imbalance between CBOs and health plans?

Tim McNeill, Partnership to Align Social Care (01:15:07):

So, I'm partial to the hub concept, because we've seen so much success of it. I mean Joe in Alabama, they have created a statewide network, and you know Alabama is a rural state. There are small CBOs in Alabama that would not be able to do this if they did not create this hub concept. And so, I think that a hub, or someone called it an intermediary, that can aggregate CBOs and then create a social care delivery system is very akin to a health care delivery system for social needs. And if they're able to do that, then they can make the case for compensation in a world that's moving to value-based care with the recognition of the impact of health-related social needs on those outcomes.

Joe Strickland, SARCOA (01:16:02):

I agree, and to speak more to what Tim mentioned about the State of Alabama in general, you know, having that network lead, or that lead entity, brings a lot of value because that lead entity serving as the manager of the hub, or the primary organizer of the hub, the person or the organization that pulls the members together, or the plans connector, so forth and so on to the hub. I think that has a lot of value, and it enables the participants or the organizations answering or participating in the hub to provide a consistent product. And to work together to put the pieces together to answer the needs of the managed care organization, the plan so forth and so on, you know, there's a chance, I as a relatively small CBO working in a rural community may want to connect with someone like Sam working in food or nutrition insufficiency. You know, some sort of specialty that she does quite well that I would prefer not to get so deeply involved in because she would be my expert, for example. Or an IT provider, technology, software, so forth and so on. So, I do see this as a way to bring value, and consistency, and voice to the industry, and allow the smaller CBOs with less capacity or resources to emerge to participate in the in the industry.

Sam Hoeffler, Reinvestment Partners (01:17:43):

That's, kind of, my question because we have a hub, or we more have an intermediary, in North Carolina for our 1115 waivers. That's my question for you, Tim, it's like, how is that paid for in the long-term like? How does that look for value-based care? Is it funneling, kind of, siphoning off some money? But then it's getting past the CBOs, or like, how do you envision that?

Tim McNeill, Partnership to Align Social Care (01:18:05):

Absolutely. So, the vision is that through a community care hub you can create scale, and leverage that economies of scale, which then increases your capacity to serve more people, increase the volume of referrals, and expand the contract model. So, there's more flow, there's more input of revenue, to support all of the organizations that are participating. And yes, some percentage of that has to go to support the hub but it's a percentage of a larger pool of money that we can deliver as a group. And just to give one example of the potential clinical outcome, the accountable health community model was one of the CMMI initiative that looked at screening for health-related social needs. And the CMMI evaluation report for that data showed that over 50% of the people's screen had four, up to five, needs. And so, if someone has multiple needs, a delivery system to address whole-person care will have more potential to have success. And if we could serve more people, it's also the more likelihood of financial sustainability as a group than as an individual.

Karen Dale, HEAT Co-Chair (01:19:29):

Thank you. All right. I'm going to go to our last question. Says, what is the CBOs' competitive edge when competing with actual startups that can offer similar services for often lower price and in multiple markets?

Aza Nedhari, Mamatoto Village (01:19:49):

I'll take a stab at this one. I would say that the competitive edge of the CBO is that they're hyperlocal, and they know the people in the community. They know what those needs are, and that is very different than having what I call transplants, that's people coming in not knowing the community, not really speaking to that community, and bringing services that may not actually be what people want. And I think you see this a lot in the tech market where people come in, they kind of converge on a community. They're like, we have this, everybody wants this, and, you know, it's there for a little bit, it's shiny and new, and it, kind of, moves on. But there is nothing like that hyperlocal, right? It's just like when we buy our food, right? That local farmer that you like. I go to the farmers market, and I know this person, they know what I like, they know what I need. It's a very different experience when you see the people who are serving you, and who are part of your care in the community. It's a very different experience.

Karen Dale, HEAT Co-Chair (01:20:57):

Thank you. Anyone want to weigh in with one last comment?

Joe Strickland, SARCOA (01:21:02):

I'd like to. I agree completely. We know our communities as a CBO. We know the back roads. And we've generally, in even the smaller CBOs' perspective, we've done this for a while. We know our people. We generally know what their needs are. We've generally got a data warehouse, even if it's pen and paper that's converted into spreadsheets, we have a data warehouse of information that we can use. We have a history, and we are already trusted in our community. So, we bring a lot of value. There's nothing wrong with being a startup. There's nothing wrong with wanting to emerge or move into the marketplace, but as an existing CBO with a boost on the ground workforce, we have a lot of value, and we do certainly have that competitive edge.

Karen Dale, HEAT Co-Chair (01:21:55):

Thank you.

Aza Nedhari, Mamatoto Village (01:21:56):

And I just that one more thing, Karen.

Karen Dale, HEAT Co-Chair (01:21:59):

Oh, yes, absolutely.

Aza Nedhari, Mamatoto Village (01:22:00):

Just to, kind of, wrap up, like, Joe's point, like, that can encapsulate both of us. I think that one thing about, like, CBOs too is, like, we're the historians. We are a part of being the historians of a community. And so, I just think that's, like, critically important when people are thinking about, like, where to put the dots. Startups can be great, but I think they also need to come and consult, and work alongside that CBO, as opposed to trying to replace them or move them over.

Karen Dale, HEAT Co-Chair (01:22:31):

Yeah. Excellent point, that historian piece, because sometimes in communities, the trust has been broken. So, there's a lack of trust for a reason, and if you jump in and make the exact same mistakes it can be harming, and it certainly will prevent something new from taking hold. So, thank you. Let's see. So, next slide.

We are coming to a close. I want to express my deepest appreciation to Tim, Sam, Aza, and Joe, and to the audience, because we got lots of questions. We didn't get to all of them, but we will try to get answers out. And there was a question about whether the slides or recording will be available, and it will be on the HCP-LAN site, so that'll probably get dropped into the chat.

Karen Dale, HEAT Co-Chair (01:23:19):

We heard such wonderful things today. We heard insights, challenges, actionable steps about how CBOs and hubs are helping to accelerate movement toward value-based care with a health equity lens. You know, good acknowledgment about the dynamics of power, trust, and humility, and how key those are, right, to getting value-based care programs and APMs off the ground. So, we really want to encourage everyone to continue this conversation. Certainly, beyond this session. Be curious. Go to the

website. Do your own reading to learn more because these meaningful partnerships can absolutely transform our health care system with an eye to equity. And we want that for all the communities being served. You know, I often say equity matters and leadership is a verb, right, which requires deliberate action to create positive impact. So, I'm believing that on this session we had lots of leaders who believe that equity matters and are actively focused on creating the change and the, kind of, wonderful ecosystem that will have the positive impact to happen. So, I look forward to how you will each accelerate progress. Next slide.

So please reach out with any questions that you may have. I'm hoping that each of you will also stay involved with future HEAT and LAN events because we do have more coming on this topic. So, please look out for information that will send around upcoming events. This is the first of three in our LAN Spring/Summer event series.

Karen Dale, HEAT Co-Chair (01:25:00):

Our next event is scheduled for Wednesday, June 8th, and will be focused on advancing high-quality accountable care. We expect to have some guest speakers from CMS be present, so put a hold on your calendar. We are also encouraging all of you to explore the LAN Health Equity Advisory Team website, so you can learn more about some of the guidance we've already put out, and the list of resources. And we're planning to continue to work with CBOs to gain various perspective and insight and develop related material. So, a lot more things to come.

Last thing. When you close the meeting window, a survey will pop up. We ask that before you jump to your next call, because, you know, we're all booked, booked, booked, that you take a minute to fill out the survey. It'll take less than one minute. It's helpful for us, so, that we get your feedback and input as we plan for future events. So, I want to express my thanks once again to our panelists. Thank you all for joining us, and I do hope you have a wonderful afternoon.

Karen Dale, HEAT Co-Chair (01:26:06):

Please do the survey.