Lessons Learned from Partnerships Between Networks of Community-Based Organizations and Healthcare Organizations

Building healthy communities and addressing widespread health disparities require that people have access to more than just the healthcare provided within clinical walls. Beyond treatment plans and prescriptions, people need access to safe housing, employment, social services, and much more. Community-based organizations (CBOs) have been working to meet these needs for decades.

We embarked on the Advancing Resilience and Community Health (**ARCH**) initiative in response to growing momentum around the idea that partnerships and contracts between CBOs and healthcare organizations (HCOs) could advance health equity. In order to partner at scale with HCOs to promote community health, CBOs were forming networks and adapting their business models and services so they could form contractual relationships. NFF believed that partnerships like these had the potential to address many of the challenges facing CBOs by providing a viable revenue source for networks and CBOs to deliver existing services, coordinating care across disparate silos of healthcare and community organizations, streamlining data collection and referrals, and providing more equitable services to communities that lacked access to care. The driving hypothesis at the start of the ARCH initiative was that HCOs were looking for scalable models to improve community health, that networks offered a unique value proposition that healthcare was willing to pay for, and that networks would bring greater negotiation power to the table with HCOs.

Over the last two and a half years, NFF partnered with **three networks** – EngageWell IPA of New York (EngageWell), Metropolitan Alliance of Connected Communities of Minnesota (MACC), and Thomas Jefferson Area Coalition for the Homeless of Virginia (TJACH) – to explore what it takes for CBO networks to come together around a shared vision for how to partner with healthcare. (Read more in the blog series on "Setting Strategic Priorities" with **EngageWell**, **MACC**, and **TJACH**.) Each network had a contract opportunity with a healthcare partner and participated in ARCH for support and resources to advance their vision, mission, and partnership objectives. ARCH gave us a firsthand look at the demanding work involved for CBO networks **pursuing contracts and partnerships with HCOs**.

At the start of this engagement, our goal was to help CBO networks close financial contracts with HCOs. ARCH challenged us not only to rethink our hypothesis, but also to look critically at how existing healthcare funding systems hamper efforts to build viable partnerships between CBO networks and HCOs. We hope that the lessons we learned from this project can inform new approaches to advancing community health.

ABOUT NFF

NFF is a nonprofit lender, consultant, and advocate. For more than 40 years, we've worked to strengthen nonprofit organizations and improve the way money flows to social good. We are committed to building a more equitable and just social sector, and helping community-centered organizations led by and serving people of color access the money and resources they need to realize their communities' aspirations.

Contracts have more disadvantages than benefits

Our networks participated in and evaluated a **number of contractual opportunities** over the last two and a half years. While HCOs and our networks at first **expressed similar goals** around advancing health equity and coordinating care, it soon became clear that HCOs' and CBOs' **motivations behind partnerships** were often misaligned. While HCOs focus on treating individuals for health-related needs and reducing total cost of care, CBOs are positioned to influence outcomes across entire communities. These vastly contrasting approaches hindered partnerships that were initially thought to be motivated by shared objectives.

CBO network members want to transform the system by providing coordinated services that improve care. However, coordinating services with HCOs requires significant investments of time and resources. For ARCH's three networks, those investments ultimately weren't profitable for any party. In addition, potential revenue sources for CBO networks didn't always align with network goals around addressing social determinants of health (SDOH). Lastly, existing structures to pay for services offered by CBOs aren't designed to overhaul an inequitable system; an increase in referrals might bring more revenue to a CBO, but it won't fix inequities within the healthcare system or address the underfunded costs associated with CBO service delivery.

Ultimately, the investment in resources, capacity, and time required from the networks was extractive and resulted in unpaid or limited contractual opportunities. Additionally, HCOs lack either the financial resources or the **economic and financial incentive** to make investments that would scale the infrastructure of CBO networks and allow them to deliver aligned health services. Our work at NFF can support the financial health of CBOs and CBO networks, but that is not enough to change the imbalance of power when small CBOs are negotiating with large HCOs.

To improve community health, it's widely recognized that we must address both healthcare inequities and SDOH. However, partnerships between CBO networks and HCOs are resource intensive and not attainable without significant investment from other funders – largely government and private philanthropy – as HCOs often don't cover CBOs' expenses to participate in partnerships or contracts.

Networks redefined success by prioritizing communities over contracts

Over the course of this engagement, networks of CBOs responded with rigor to their communities' needs: they have valiantly **responded to COVID-19** and implemented complex **data systems** to aggregate information across multiple organizations. And they are redesigning processes to address racial disparities in service delivery. Networks recognized the value of offering a platform to amplify voices of those who often go unheard – both individuals and small organizations. As individual CBOs continue to conduct mission-critical work on the ground, networks can advocate, fundraise, fill critical capacity gaps, coordinate services, and collect and analyze data on behalf of their members. They are also helping to redesign systems and push for systemic change.

- To end homelessness in Charlottesville, Virginia, TJACH is purchasing a hotel and repurposing it into transitional and permanent housing. With the support of Corporation for Supportive Housing, they mapped the system of services for people experiencing homelessness in the region and

are part of a US Department of Housing and Urban Development (HUD) Equity Demonstration Project to assess racial disparities in their process for measuring adequate housing needs.

- To integrate disparate care management databases and electronic medical records across the network, EngageWell invested in a "proof of concept" data repository that matched health data (Medicaid claims) with social service data (grant-funded programs). While this project represents an important first step towards understanding more holistically how clients move through the network and health system, a more sophisticated and comprehensive analytics project will require significantly more capital. Although it has also been instrumental in identifying new contract opportunities for all its CBO members, EngageWell has not found a way to sustainably fund ongoing services beyond the current financial year. As such, EngageWell may operate in a smaller capacity to provide services to its members while it waits for momentum behind contracting to re-emerge.

- To manage the referrals, reporting, and outcomes necessary for healthcare partnership, MACC implemented a data integration pilot between their member CBOs and two local healthcare partners. MACC already operates an enterprise client data management system (ClientTrack) on behalf of 38 member CBOs. This pilot was an opportunity for several members to explore a technical solution for sharing referral data with healthcare partners. Recognizing the challenging power dynamics and economics of these partnerships, MACC will continue to work towards a more equitable redesign of how resources are distributed across the community.

Given that the financial opportunity CBO networks first saw in HCO partnerships is not realistic without government or philanthropic support, CBOs may instead want to focus on how networks can create efficiencies among the involved organizations (e.g., referrals, data-sharing, etc.) and better health outcomes for the communities they serve.

Addressing health equity means centering racial equity

ARCH was not originally designed with a focus on racial equity. We created parameters at the start of the initiative prioritizing network applicants that already had potential health contracts, which granted more opportunities for white-led organizations with access to resources and pathways to partner with healthcare. In part because of this, all of the networks and many of the organizations that participated in ARCH were white-led.

If we were to redesign this work today, we would change the selection criteria to prioritize organizations led by people of color that are deeply connected to their communities, have their community's trust, and set up regular feedback loops to understand the hopes and burdens of community members. Similarly, we would encourage other funders and supporters to prioritize organizations with community connections, as those organizations are best positioned to deliver strong community health outcomes. **We also observed other racist practices** that are perpetuated in healthcare – such as prioritizing short-term profits over longer-term health outcomes and expecting CBOs to conform to HCOs' way of operating.

As the ARCH networks continue to prioritize community need, they are also examining various intersections between health and racial equity:

- When TJACH identified that white participants scored higher on vulnerability assessments than

black participants – and were therefore more often prioritized for housing assistance – they questioned why. Now, they are re-examining their intake system to redesign how they engage with their constituents.

- The MACC network is exploring how members might identify needs within their communities and bring them to healthcare partners – instead of the healthcare partner always determining the direction of an intervention.

- EngageWell is actively integrating a peer workforce in all of its interventions to address healthcare mistrust and the discrimination and stigma that patients of color often experience in healthcare settings. HCOs often seek to support a "professional" or "credentialed" workforce for service delivery and reimbursement; in contrast, EngageWell believes a care team is most effective when comprised of community members with lived experiences similar to those of their patients.

Advancing health equity requires more investment in organizations that are community led – especially those led by and serving people of color that have been most impacted by a legacy of racist, systemic underfunding.

It's time to invest in community-led solutions

An ideal partnership between CBO networks and HCOs builds on the strengths of each entity rather than prioritizing the needs and demands of HCOs. Furthermore, NFF has found that the potential of a networked approach is greatest when CBO networks lean into their strengths instead of prioritizing partnerships. These strengths include:

- Advocating for network members and community needs

- Leading with what's best for the community (not just what healthcare institutions are willing to pay for)

- Co-designing solutions with communities that are impacted by inequities in healthcare

- Amplifying community voices in new ways

NFF's exploration of partnerships and contracts between CBO networks and HCOs ultimately revealed that policy- and systems-level change is necessary – both to influence and to pay for addressing SDOH. **While CBOs and networks should be leading voices as ambassadors of their communities, they currently don't have the power to redesign systems or change the structural inequities that result in limited access to care.**

While we applaud the spirit of the effort that initially led to this pursuit, we no longer believe that partnerships between CBO networks and HCOs are the first right step for the systems change needed to achieve true health equity. Rather, we believe that CBO leaders – especially those led by and serving people of color – understand their communities' aspirations and challenges and have the clearest insights about how to drive healthier outcomes. Getting behind community priorities and following the lead of those closest to the work is where we see the greatest potential for advancing health equity.

Robert Wood Johnson Foundation