

How are Massachusetts Community-Based Organizations Responding to the Health Care Sector's Entry into Social Determinants of Health?

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EXECUTIVE SUMMARY

With a growing focus on population health and value-based care nationwide, the health care sector is increasingly recognizing the impact that social and environmental factors have on the health and health care utilization of low-income and other vulnerable populations. In Massachusetts, the state's Medicaid program, MassHealth, is implementing a number of reforms as part of the Delivery System Reform Incentive Payment (DSRIP) program that was approved as part of the state's most recent Medicaid 1115 demonstration waiver extension. MassHealth has also taken steps to address the social determinants of health (SDOH) through its care delivery reform efforts. Accountable care organizations (ACOs) are required to screen for health-related social needs in specified domains and are encouraged to refer patients with positive screens to local resources. The specific role of community-based organizations (CBOs) within the MassHealth ACO program is still in development.

This report aims to address the following question: How are CBOs responding to the health care sector's movement into SDOH programming in Massachusetts? CBOs are defined as nonprofit organizations that work at a local level to improve life for residents through direct service delivery and that are not focused primarily on health care promotion or delivery. The research team employed a key informant interview method to address the research question and conducted 46 interviews with leadership and high-level program staff from a diverse set of CBOs, including ones focused on food, housing, legal services, and more, across Massachusetts between September 2017 and March 2018. In analyzing more than 1,000 pages of resulting data, the research team identified five emergent themes.

1. CBOs perceive significant differences between their organizations and health care organizations in terms of how they conceptualize their work, determine eligibility, refer and receive referrals, measure impact, and the scale of their service delivery, among other operational and cultural distinctions.
2. Despite feeling largely excluded from the policymaking process to date, CBOs regard the implementation of the Medicaid 1115 waiver as providing important financial incentives for health care organizations to address SDOH deficits among patients. CBOs anticipate that health care will do so in partnership with CBOs.
3. CBOs indicate that they view favorably the policy changes that transferred financial risk to health care organizations and spurred new interest in coordination between themselves and health care. In short, this is seen as "movement in the right direction."
4. CBO staff report a number of recent strategies adopted by their organizations that were intended to improve their organization's positioning to partner with newly-formed MassHealth ACOs and gain access to the financial and political resources available to health care organizations.
5. Amid these deliberate efforts to better position themselves in response to health care's movement into SDOH programming, CBOs also report a series of risks and concerns about the impact that partnering with health care could have on their organizations and the social service sector as a whole.

These findings highlight the strategic tensions that Massachusetts CBOs face as they develop strategies to respond to health care's entry into SDOH. While CBOs may reasonably wish to “grow toward the light”—a metaphor used to describe the effort to position themselves favorably to become partners to health care akin to how a plant sprouts unexpectedly sideways to capture resources necessary for its growth—many also want to prevent losing the aspects of their work that they are most proud of and make the CBO sector unique. It is too early to tell whether CBO efforts to position themselves for health care partnerships will ultimately prove successful for the CBOs or beneficial to the communities they serve.

The implications of this work for policymakers are threefold. First, CBOs should be included in the development of SDOH-related policy in order for functional partnerships between the health care and social service sectors to develop. Second, technical assistance (TA) for CBOs is warranted, particularly around issues of data management, but so too may be “reverse TA,” wherein CBOs are given opportunities to share their expertise and scope of work with health care leaders and policymakers. Third, in considering how to support the integration of health care and social services, policymakers may reasonably aim to legitimize the CBO sector as a key resource in addressing SDOH statewide without inappropriately medicalizing these organizations.

The redesign of the MassHealth program remains in the early stages of implementation. Brokering successful relationships between the health care sector and CBOs should be an area of sustained focus as our state faces another opportunity to lead the nation in improving population health.

BACKGROUND

With a growing focus on population health and value-based care, the health care sector is increasingly recognizing the impact that social and environmental factors have on the health and health care utilization of low-income and other vulnerable populations.^{1,2} Payers and policymakers are incentivizing health care systems to develop strategies to address these social determinants of health (SDOH).^{3,4} SDOH, as defined by the World Health Organization, are the conditions in which people are born, grow, live, work, and age, and which influence health.⁵ These circumstances are shaped by the distribution of money, power, and resources, and play a key role in determining health inequities. As health care payers and providers consider programming to address SDOH, there has been an upsurge in literature that describes the benefits of investing in social service delivery for high-need, high-cost populations.⁶ In much of the literature, researchers have focused on the partnership between health care organizations and community-based organizations (CBOs) by highlighting (a) the business case for health care organizations to undertake new ventures with CBOs and (b) aspects of the relationship between health care organizations and CBOs that are likely to determine the success of the partnership.⁷⁻¹¹ Factors such as leadership, communication, data, and accountability are routinely cited as elements essential to successful partnerships. To date, there is limited consideration of the perspectives of CBOs, whose work in communities to address unmet social needs may be impacted by the health care sector's entry into SDOH programming.

Particular attention is owed to Medicaid populations and the various Medicaid redesign efforts that are ongoing in several states.¹² Several states are pursuing delivery system reforms that incentivize providers to reduce health care costs while achieving population health improvements by addressing SDOH.¹³ In Massachusetts, the state's Medicaid program, MassHealth, is implementing a number of reforms as part of its Delivery System Reform Incentive Payment (DSRIP) program approved as part of its most recent Medicaid 1115 demonstration waiver extension. The state seeks to transform the delivery of care for most MassHealth members and change how that care is paid for, with the goals of improved quality, integration, and coordination of care, ultimately resulting in reductions in health care spending. Under the waiver extension MassHealth introduced accountable care organizations (ACOs) for many of its members in 2018. An ACO is "a group of doctors, hospitals, and other health care providers that work together with the goals of delivering better care to members, improving the population's health, and controlling costs."¹⁴ In this new model, MassHealth contracts with ACOs, which are financially responsible for delivering and coordinating physical health care, mental health care, substance use disorder treatment, and long-term services and supports (LTSS) to a defined group of MassHealth members.^{i,ii} ACOs are also required to collaborate with community partners (CPs)—organizations that provide behavioral health services and LTSS, and provide care management and care coordination to certain MassHealth members.¹⁵

i While this report focuses on the recently created MassHealth ACOs, many of the same features and services are provided by MassHealth's existing managed care organizations (MCOs).

ii Until year three of the program, LTSS is not included in the total cost of care for which the ACO is at risk.

MassHealth has also taken steps to address SDOH through its care delivery reform efforts. ACOs are required to screen for health-related social needs in specified domains and are encouraged to refer patients with positive screens to local resources.¹⁶ Senior leadership at health care provider organizations generally, and MassHealth ACOs in particular, are considering whether to build social service programming into their organizations, buy social service programming from CBOs, or pursue a hybrid strategy to secure SDOH services for patients.¹⁷⁻¹⁹ MassHealth has also introduced flexible services as a mechanism to address social needs to members with complex health care needs. Flexible services are intended to address health-related social needs by providing supports not currently paid for by MassHealth (e.g., housing supports and nutritional programs). The state's protocol for allowable flexible services has recently been approved by the Centers for Medicare and Medicaid Services (CMS).

The specific role of CBOs within the MassHealth ACO program is still in development, though the value of the SDOH services they provide is repeatedly underscored. To help inform the effective integration of health-related social services, including implementation of flexible services programs, MassHealth has created a working group to advise state policymakers which includes representation from providers, ACOs, CPs, CBOs, managed care organizations, and advocates.

In light of the new interface between health care and social service delivery fostered by the MassHealth program redesign, it is important to understand how CBOs perceive the entry of health care organizations into their domains of social service delivery. This report aims to inform this discussion by summarizing the findings from a qualitative study that explores the perspectives of CBO leadership on the health care sector's movement into SDOH programming in Massachusetts.

METHODS

This study sought to address the following research question: How are CBOs responding to health care organizations' movement into SDOH programming? For the purposes of this study, health care organizations are defined broadly to include both delivery organizations (health systems, clinics, provider groups, etc.) and payers (commercial insurers, MassHealth managed care organizations, etc.). CBOs are defined as nonprofit organizations that work at a local level to improve life for residents through direct service delivery and are not focused primarily on health care promotion or delivery.

The research team employed a key informant interview method to address the research question and conducted 46 interviews with leadership and high-level program staff from a diverse set of CBOs across Massachusetts between September 2017 and March 2018. The final sample included representatives of CBOs offering social services including housing and shelter, nutrition support, domestic violence, community centers,ⁱⁱⁱ multiservice organizations,^{iv} legal services, early education, workforce training and job development, and transportation.^v Organizations that provide behavioral health care and/or LTSS were purposely excluded from the CBO sample because many are serving the role of CPs, described above, and their relationship with health care organizations had been contractually specified in the MassHealth ACO requirements. Virtually all behavioral health and LTSS organizations serving as CPs also have longstanding partnerships with health care organizations and payers.²⁰ CBOs, in contrast, operate largely without longstanding institutional relationships with health care delivery systems and have considerably more variation than CPs in terms of organizational size, structure, services, and geographic range.

The CBO interviewees were asked questions regarding (1) mission, funding structure, and services provided by their organization, (2) perspectives on health care organizations entering into the provision of social services, (3) experiences with health care referrals or partnerships, and (4) potential risks and benefits of health care entering into social service delivery. A series of codes and key themes were developed through an analysis of the qualitative data. See Appendix A for additional details on the study methods and a summary of the CBO interviewee sample demographics.

iii Community centers were defined as physical spaces where people from a geographic area (community) can meet for social, recreational, or educational activities. Many of the community centers in our study also offered health behavior change programs, gyms, or other wellness benefits.

iv Multiservice organizations were defined as nonprofit organizations that do not have a primary set of services or programs in a recognizable SDOH domain (e.g., housing) but rather have been conceived of as offering a comprehensive set of services from their inception.

v To inform the development of the study sample and the CBO semi-structured interview guide, an initial round of interviews was conducted with key health care stakeholders who were actively engaged in the development of MassHealth ACOs. The information collected through these interviews was not included in the study findings but was used to shape the study design.

KEY THEMES

This section summarizes the five key themes that emerged from the analysis of the CBO interviews on their perspectives regarding the health care sector's movement into the SDOH space. Quotations from interviewees are presented in italicized text. These themes may be important to consider as policymakers continue to develop processes and plans to better incorporate SDOH as part of ACO development and delivery system transformation initiatives.

THEME #1: PERCEPTIONS OF ORGANIZATIONAL AND CULTURAL DIFFERENCES BETWEEN HEALTH CARE ORGANIZATIONS AND CBOs

CBOs perceive significant differences between their organizations and health care organizations in terms of how they conceptualize their work, determine eligibility, refer and receive referrals, measure impact, and the scale of their service delivery, among other operational and cultural distinctions. These differences may increase the potential for health care organizations and CBOs to develop partnerships based on complementary skills but could also make it challenging to integrate teams and workflows.

A number of salient organizational and cultural differences exist between CBOs and health care organizations, and these may have consequences if partnerships become a means of providing SDOH supports to ACO members. Generally speaking, these differences seem to suggest the potential value that can be created through partnership. However, too much difference can create tension in partnerships, as both sides struggle to feel that they are working toward enough of a common goal to make the partnership worthwhile for their organization. While all CBO representatives we spoke with recognized the connection between their work and the work of health care providers, individuals in the sample were more actively grappling with what the key differences in approach were and the extent to which these could be overcome in a working relationship. One interviewee summarized this theme as follows: *"I think the hospitals have a view of the world that is very different than I think the community-based organizations have."* At a more practical level, we observed differences in language, for instance, on even the most basic of terms. While health care organizations refer to the people they serve as 'patients,' CBOs use 'clients.' One interviewee, a physician now employed by a CBO, identified such distinctions in language as representative of distinct 'worlds':

I don't know that we've done a really good job on both sides of helping CBOs understand how health care thinks and help [health care] organizations in understanding how community providers think ... We have two separate cultures that exist in the same space but don't speak the same language.

CBOs described differences in scale between their organizations and health care organizations, suggesting that their organizations are generally smaller in size in terms of both number of employees and operating budget. CBOs anticipated that this may become relevant when negotiating the specifics of a contract, because health care organizations would enjoy relatively more negotiating power and carry an expectation that CBOs could provide SDOH services on a scale that matched their own. Interviewees acknowledged differences in available resources as compared with health care organizations, with repeated mention of the imbalance of dollars spent on the health care sector compared with social services. One person mentioned that the CBO sector

“operates in a mind-set of poverty” compared with the relative wealth of health care organizations. Many CBOs mentioned that their smaller organizational size offered managerial advantages inasmuch as they were able to respond more flexibly to the unique needs of individuals and families and focus more squarely on relationships. One respondent noted, “*The ability to be fluid and change and really meet the needs of the community oftentimes comes more easily from a smaller community-based organization.*” This stood in contrast to health care’s perceived interest in large-scale interventions, per one interviewee: “*I think that the one thread that runs through everything we do is relationship, and I think that the idea of scaling and relationships are at odds.*” This CBO representative perceived health care as interested in developing consistent but impersonal operations over large geographic swaths. This struck him as antithetical to his deeply local, multi-decade, and neighborhood-based approach to improving the lives of vulnerable people, making partnering a challenge.

CBOs also placed emphasis on the differences between how health systems and CBOs perceive their target populations. CBOs viewed themselves as having developed specialized expertise over, in many cases, decades of serving exclusively low-income and otherwise vulnerable communities. In their view, health care organizations participating in the MassHealth ACO program were focused primarily on “covered lives” determined by state contracts, meaning not only that the individuals who are cared for are “patients” within the health care organization, but they are specifically patients for whom the system or clinic bears financial risk. This contrasts with many (but not all) CBOs’ interests in allowing people to self-refer to services and keeping eligibility criteria to a minimum in order to serve specific sociocultural communities and geographic neighborhoods. This concern about health care’s interest in predefined “target populations” was particularly important at the time of interviewing (fall 2017 – spring 2018), as MassHealth ACOs were reviewing prospective member assignment and negotiating with the state government over who was, and was not, on their list of assigned members.

Interviewees further remarked on differences in outcomes and metrics used by the two sectors, and the potential for those outcomes to be in tension with one another. One interviewee said: “*The Department of Housing and Urban Development measures the city on the number of new people [entering] into homelessness. I don’t want [hospital 1] or [hospital 2] or anybody sending people here that aren’t genuinely homeless. One of the things we worry about is driving our numbers up inadvertently.*” Here an interviewee is referring to a circumstance in which a health care organization may try to discharge a patient without stable housing to a homeless shelter in order to reduce that individual’s length of stay in a hospital, reduce costs, and what the health care organization may see as unnecessary utilization. A homeless shelter, however, may be less than eager to receive this person if he or she is housing unstable as opposed to homeless. A key Housing and Urban Development (HUD) quality measure for shelters is the total number of individuals living in homelessness in a city. Hence, the hospital’s referral may be perceived by shelter staff as a threat to the shelter’s organizational performance. This highlights the fact that not only are outcomes of interest different between CBOs and health care organizations but also that interventions to improve one organization’s measures may unintentionally worsen the other’s.

Other CBO representatives discussed as another potential source of tension in a partnership the long timelines required for their work to demonstrate impact in contrast to timelines for assessing the value of interventions that health systems rely on. Several interviewees referred to their mission, using words like “intergenerational impact” to describe how CBOs conceptualized time horizons for impact. This far exceeds 90-day readmissions or even year-over-year time horizons common among health care delivery and payer organizations. These differing timelines can be perceived as a hindrance to partnership in the view of some CBO leaders because health care’s interest in improving the SDOH profile is seen as too short term to allow for meaningful interven-

tions to demonstrate impact. For example, several housing CBO representatives with whom we spoke were engaged in community development projects including beautification of blighted spaces and downtown revitalizations, but found that most health care organizations were not in a position to be able to wait three to five years to see a return on their investments.

Interviewees also described differences in the types of accountability structures for the health care and CBO sectors. Health care organizations face a series of government, payer, and professional association regulations, particularly related to cost and quality of services. While CBOs may be subject to federal, state, and municipal regulations depending on their sector of service and sources of funding, interviewees spoke about being primarily accountable to the CBO's mission and values, its board, grantmakers, the local press, and its word-of-mouth reputation among the community it serves. One interviewee noted how this distinguished his organization's approach to accountability from potential health care partners, saying: "*That accountable care organization, ACO, is [jockeying] for how can we do it cheaper? The reason I don't like that ... I love accountability ... but it's [all] about fiscal accountability.*" This quote highlights CBOs' apprehension that the financial concerns of the health care organizations will take priority over other considerations such as community engagement or local reputation.

THEME #2: CBOs' PERSPECTIVES ON THE PROCESS AND IMPACT OF MASSHEALTH'S NEW SDOH-RELATED POLICIES

Despite feeling largely excluded from the policymaking process to date, CBOs regard the implementation of the Medicaid 1115 waiver as providing important financial incentives for health care organizations to address SDOH deficits among patients. CBOs anticipate that health care organizations will address these deficits through a partnership model, wherein CBOs will become partners (alternatively, grantees, suppliers, vendors, or contractors) to MassHealth ACOs.

When asked about what CBOs saw as motivating health care's intensified interest in SDOH, virtually all interviewees described changes in health policy by which financial incentives were being put in place to encourage health systems to focus on population health and to reduce health care utilization by addressing SDOH. CBO staff suggested that health systems had long ignored the need to provide basic social supports until new financing arrangements made this impossible to ignore. An interviewee recalled: "*We thought five to 10 years ago that it was time to talk to health care institutions, and it was way too early. They weren't ready. Nor was it really in their financial interest. Now it's starting to be.*" Some interviewees expressed more skepticism in the financial motivations for health care's interest in social service programming, as they felt that until a financial incentive was presented, health care expressed little interest in partnering with CBOs. Per one interviewee:

I think it's always felt to us that they come in when they feel like maybe their Medicare, Medicaid funds are threatened if they don't work with us, as opposed to it coming from a point of, how do we work together to solve a problem?... But it doesn't seem to be a common conversation until it comes to a head for them, where it feels like they're maybe being told to go do more in order to get the reimbursement.

The perception that the MassHealth ACOs had a financial interest in attending to patients' SDOH needs was rooted in the recognition that the providers will now be at financial risk for patients' total cost of care.

While interviewees discussed the financial incentives as motivation for health care's interest in SDOH, they were nearly unanimous in describing exclusion from policymaking at the state and organizational levels. Per one

interviewee: “Honestly, my fear right now, we are so late as a community. Like, quality metrics at MassHealth are being finalized right now. We were not invited to the party.” What’s more, several CBO leaders related that they were told about being included in an ACO contract by health care organizations without their knowledge. One said: “I know [health system] has written us into their ACO agreements, but we’re still trying to know and understand what that is specifically. You know, they’re like, ‘Ah, we wrote you in.’ But they haven’t really shared the details of what they want from us yet. Or invited us to the table to discuss those things.” Exclusion from the policymaking process and the sense that health care organizations were interested in partnership with CBOs primarily for financial reasons contributed to a sense of skepticism about the policymaking process.

All the same, the majority of interviewees anticipated that the financial incentives would lead health care organizations to seek out partnerships with local CBOs. One interviewee argued that the need to partner was virtually self-evident by saying: “There is just no way that they can be a hospital but also then become a food bank. It’s an incredibly huge operation, with food logistics and acquisition.”^{vi} The health policy literature to date has also encouraged ACOs to take a partnership or “buy” approach over a “build” strategy, although few policies in Massachusetts have gone so far as to require it.²¹⁻²⁶ (One example of a Massachusetts investment program requiring partnerships between hospitals and community resources is the Health Policy Commission’s SHIFT-Care Challenge, announced in 2018.) When probing interviewees’ assumption by suggesting that health care organizations could also build capabilities in-house, many anticipated that health care would be uninterested in building their own SDOH programming, frequently citing the complexity of their services and CBOs’ specialized community-focused workforce as a barrier to health care developing their own in-house social services.

THEME #3: POLICY MOVEMENT IN THE RIGHT DIRECTION

CBOs indicate that they view favorably the policy changes that transfer financial risk to health care organizations and have spurred new interest in coordination between themselves and health care. In short, it is seen as “movement in the right direction.” New policies have facilitated more patientcentered, whole-person care and created new opportunities for CBOs to access political and financial resources.

Interviewees were asked whether the attention that health care was paying to SDOH indicated policy movement in the right or wrong direction, and there was near unanimity that the shifts under way represented policy movement in the right direction. Three rationales were commonly offered to support the thinking that the movement is in the right direction.

First, many described the change as welcome because it encouraged health and social service delivery systems to more closely mirror the reality of patients’ interdependent health and social needs. Even with ambiguity about how health and social services would relate to one another or work together, interviewees were optimistic that the changes represented a move away from fragmentation and toward a whole-person orien-

vi While the interviewee was referring to a large scale food bank, we recognize that there are hospitals that have food pantries on site, often for specific populations. For example, Boston Medical Center has maintained a Preventive Food Pantry since 2001 to assist low-income individuals with accessing food to meet their special nutritional needs.

tation. An interviewee supported the notion that policy is heading in the right direction by saying: *“This idea of fracturing a person into medical care and social care is ridiculous. It doesn’t make common sense, and it’s not working. People need this . . . service, and it should be just a part of holistic patient-centered care.”*

Second, CBOs indicated that health care’s movement into SDOH represented a financial opportunity for their organizations. Health care organizations were viewed as wealthy institutions, with a great deal of discretion about how they use their large annual budgets and endowments. More straightforwardly, one CBO leader described the financial opportunity inherent in health care’s new attention on SDOH: *“[We] see the health care organization as having a lot of money, and [we] want those dollars.”* Here, a CBO representative is using “we want those dollars” as a shorthand way of communicating an interest in developing grants or paid contracts with MassHealth ACOs for social services rendered to enrolled members.

Third, CBO leaders viewed the policy shifts as an opportunity for their organizations to gain a kind of social and political capital that had previously been inaccessible to them. Interviewees expressed a sense of gratitude that “finally” their work was being taken seriously by the health care sector. One interviewee highlighted the potential for the CBO’s organizational profile to be raised: *“I think that [partnering with health care] legitimizes what can sometimes be viewed as ‘Oh, that’s just basic needs.’ It may be basic needs, but it is crucial to really big issues like health care.”* Interviewees saw these policy shifts—and the focus on SDOH—as an opportunity to solicit support from health care organizations to lobby state policymakers on their behalf for additional investment in communities and CBOs. One interviewee referred to the powerful political voice that health care organizations could bring to social issues: *“Hospitals [should] be able to say [housing] is impacting our entire workforce from the lowest income to the highest income—this is impacting our patients. That’s just another voice that’s giving validity to what housing people have been saying.”* This CBO leader was hopeful that health care organizations would recognize the impact that the widespread housing crisis in Massachusetts was having not only on patients but also on the health care workforce, many of whom have low- or minimum-wage jobs and may face affordable housing concerns of their own.

THEME #4: CBOs’ EFFORTS TO POSITION THEMSELVES AS PARTNERS TO HEALTH CARE ORGANIZATIONS

CBO staff report that their organizations have adopted a number of recent strategies to signal their alignment with health care. These strategies are geared toward improving the organizations’ positioning to partner with newly formed MassHealth ACOs and gain access to the financial and political resources available to health care organizations.

In asking interviewees about their responses to health care’s inclusion of SDOH, the research team found substantial evidence that CBOs were taking concrete steps to become more attractive “partners” (a term used to describe both unpaid collaborators and paid contractors and vendors) to health care organizations. One interviewee reflected self-critically on the CBO sector in Massachusetts, suggesting it had historically been so complicated that there should have been no reasonable expectation that health care would be willing to venture into the fray: *“Our business has got to get neater. It’s got to make more sense [to health care]. Otherwise, how can you ask people to put their profitability at risk trying to work with them?”* Another interviewee summarized the sense that CBOs would need to change in order to secure substantive partnerships with health care organizations: *“There has been a more deliberate effort to market, and to try to develop relationships for referrals, specifically for health care providers.”*

CBOs identified steps they were taking to better position themselves in response to MassHealth's new emphasis on SDOH as a priority for Medicaid ACOs. These include:

1. CBOs ARE HIRING HEALTH CARE STAFF AND ADOPTING HEALTH CARE ORGANIZATIONS' LANGUAGE.

CBO representatives mentioned an effort to hire health care staff and attract health care board members based on a recognition that the health and CBO sectors would be more closely linked in the future. Health care staff included physicians as well as nurse managers, dieticians, and clinically trained social workers. This step is in keeping with a national trend of physicians taking the helm at social service organizations,²⁷ most notably at nutrition-related organizations. In fact, several interviewees indicated that they were hired for their current CBO post from an administrative role at a health care organization in part because of the professional networks that they were able to bring with them. Some CBOs also noted that they were interested in adopting certain medical language and service processes into their organizational routines. A representative of one homeless shelter, for instance, described its intake program: *"We call it a triage program, because we really try to mimic an emergency room at a hospital, with the idea that not every person actually needs the same level of response."* Nutrition-related organizations underscored that they were relying heavily on the "food as medicine" concept to make their case to health care organizations. These organizational choices are one piece of a larger strategy to help health care organizations recognize that CBO personnel and processes can be trusted as potential partners.

2. CBOs ARE SHIFTING METRICS.

Some CBOs mentioned changing their metrics to make them more focused on health. In the case of one food bank, an interviewee described the organization's shift away from measuring success in terms of pounds of food: *"We are now actually transitioning to thinking about a new metric, which is healthy meals We really recognize that food insecurity is so tied to one's health. And there's been a lot of research that has been emerging on that."* Others are considering the ways in which they might be able to demonstrate their interventions' impact on metrics that are relevant to health care, including most notably readmission rates and emergency department utilization. On this point, one interviewee referred to readmission rates as a "health recidivism rate," which could be reduced if community supports were strengthened: *"If the community-care aspects are strong when somebody's been released from the care of a physician the return rate it's almost as if there were a health recidivism rate that dropped down."* More generally, it was noted that CBOs are considering their value proposition in terms of the returns that could be offered to health care, referencing both financial and utilization outcomes.

3. CBOs ARE EXPRESSING ENTHUSIASM FOR RESEARCH AND DATA.

Interviewees shared an enthusiasm for data, research, and development of an evidence base for their work. The majority of CBOs described having participated in some kind of research, most often initiated by academic physicians or university researchers. A small number of interviewees referenced recently published randomized control trials (RCT) that supported the effectiveness of their work. These studies were viewed by CBOs as evidence of credibility. In one case, a CBO leader talked about the influence of the RCT on how her organization designed a social intervention by saying *"What our RCT told us we needed was ..."* Similar to health care's emphasis on evidence-based medicine, CBOs exhibited an interest in relying on peer-reviewed literature and gold-standard scientific methods to support how they work and determine which services to add or change.

Many interviewees saw participating in research projects as a way into potentially more enduring relationships with health care. Among the CBO leaders interviewed who had experience partnering with health care organizations to provide SDOH services, the great majority had begun their organizational relationships through a research project. Many CBO leaders described experiences of being asked to sign a letter of intent or provide other supporting materials for a grant being led by a researcher at a hospital or clinic. Although CBO leaders frequently felt as if their organization was providing a research site rather than being a research partner, many CBOs tolerated these episodic engagements with health care repeatedly as a way to gain initial entry to health care institutions, and cited their research experience as important validation of their work. Recognizing that MassHealth ACOs placed political priority on making investments in services with demonstrated efficacy, some CBOs saw this kind of research as a necessary step to partnering long term with health care organizations.

4. CBOs ARE PRESENTING MENUS OF SERVICE OPTIONS.

A handful of interviewees shared that they were endeavoring to think about their services in terms of a menu of options from which health care organizations could select to purchase on behalf of their patients. Doing so was part of a strategy to make the complex work of CBOs more immediately intelligible for ACO staff and was most common among the CBOs with the greatest experience working with health care. Importantly, these were primarily CBOs with physicians or lawyers in leadership positions who perceived that MassHealth ACOs would want to develop a customized program of supports for enrolled members but would have little time to devote to learning the CBO landscape. One interviewee who led a legal services organization said: *“It has been useful to be able to market ourselves with a suite of services. It’s almost like a menu. . . . There’s usually something for everyone.”* Another CBO leader shared a similar strategy: *“We know that every single community health center is absolutely unique and they all have different perspectives. . . . So when we offer this three-prong program, we do it as a menu of options. We say, ‘Hey, these are the three things that we can offer you. What’s important to you?’ And they can feel free to take one prong, two, or all three aspects.”*

5. CBOs ARE CONSIDERING CREATING HUBS.

CBO leaders described an interest in forming coalitions and collaborative hubs with other social service providers in order to be able to match the scale at which they anticipated health care organizations would wish to contract for social services. The creation of these novel organizational structures would have the added benefit of making the purchase of SDOH services a more streamlined process for health care organizations. CBO staff with previous experience interfacing with the health care sector were particularly strong champions of this idea, having heard from health care organizations about their unwillingness to create multiple contracts within the same SDOH domain in a single city or even region. (The research team’s initial interviews with health care stakeholders confirmed this preference.) One interviewee we spoke with described the need for greater collaboration among CBOs as follows:

I think [there is] added benefit from partnering with human-service providers [and] rationalizing human services themselves, to make them easier to work with, easier to reach, easier to create a unified package of client supports. If that doesn’t happen, there’ll be every good reason for health care providers to want to [provide the social services] themselves.

In an effort to respond to health care’s desire for scale, CBO leaders in both Boston and Worcester discussed the potential to create what they termed a hub, which would function as a shell organization that could handle large-volume contracting with health systems and subcontract the service delivery obligations to existing CBOs.

One CBO leader described the impetus as follows:

One of the ways that the smaller and less stable organizations . . . could sustain themselves more effectively would be by working within larger collaboratives that provided some level of administrative control and reduction in some of the kinds of carrying costs that are difficult for a small outfit.

The idea of a hub may also allow small CBOs to outsource or consolidate back-office operations (human resources, development, etc.) and reduce their overhead rates, improving their ability to put discretionary dollars directly into service offerings.

THEME #5: RISKS AND CONCERNS

Amid these deliberate efforts to better position themselves in response to the health care sector's movement into SDOH programming, CBOs also report a series of risks and concerns about the impact that partnering with health care could have on them and the social service sector as a whole. We have organized these risks and concerns into five categories summarized below.

1. FUNDS WILL BE "TRAPPED AND VAPORIZED."

Several interviewees noted a fear that the funding health care organizations receive from government entities to conduct SDOH-related work would not be distributed to partnering CBOs for social service delivery. The research team characterized this as a fear that resources would be trapped and vaporized inside the four walls of the hospital or clinic. One interviewee described this as follows: *"My concern is that it's a money grab . . . That there won't be dollars for the services people on the ground need to have positive lived experiences . . . The medical industry will absorb the resources."* This CBO leader felt that if health care absorbed dollars that were meant for improving SDOH, individuals and communities would not benefit from increased investment that would materially improve local conditions. Similarly, another interviewee underscored the potentially competitive dynamics that could emerge between health care organizations and CBOs in relation to new funding from state government: *"We're trying to capture resources to bring to bear to serve in our community, and they're trying to keep them to favor their bottom line."* These fears were based on a combination of past experience and reputation. One interviewee described a past experience of working to create an educational and professional pipeline for low-income people to prepare them for careers in community-based home health care settings. A large hospital system entered the field and hired away a wide swath of these home care staff to work for a hospital-owned home health division. Other interviewees cited past experiences in which grants that were ostensibly meant to be shared between clinical and community resources had been absorbed primarily by hospitals.

2. CBOs WILL BE FLOODED WITH REFERRALS (OR NOT).

Interviewees expressed concerns regarding the requirement to perform health-related social needs screenings that MassHealth has established for all ACOs. While there was neither a prescribed screening tool nor recommended screening questions, MassHealth requires ACOs to ask enrollees about pre-specified SDOH domains.^{vii} While details of the flexible services parameters remained uncertain through the study period, CBO

vii MassHealth requires ACOs to screen for housing insecurity, utilities, physical activity, food insecurity, experiences of violence, transportation, and employment.

leaders felt more confident that universal screening would be implemented, and therefore focused substantial energy on trying to ascertain the impact this policy change would have on their organizations. Interviewees in our sample offered different perspectives on how the mandated screening might or might not impact the number of referrals to their organizations.²⁸

A minority view among CBOs was that the universal screening requirement would not lead to any new referrals. The representatives of these CBOs felt they were wholly engaged in their communities, and therefore it was unlikely that the required health-related social needs screening was going to identify new patients who were not already receiving social services. The majority of CBOs anticipated that universal screening would turn up substantially more need for services than most health care leaders or policymakers would expect. They worried that these referrals would come with no additional funding, effectively creating an unfunded mandate for CBOs to provide services to a population that was previously unknown to the social service sector. When the research team described the “make or buy dilemma” that health care may be facing in relation to developing social service capacities, interviewees added that referring, for instance, ACO enrollees for services without additional funding constituted a third option: “take.”

Among those interviewees who believed that the health-related social needs screening would identify people needing services who were, in effect, new to the CBO landscape, the second-order question was whether there would be sufficient capacity among CBOs to meet the revealed demand. A number of CBO leaders expressed concern that their organizations would not have the capacity to keep up with the demand for social services that may be generated when health care organizations begin to systematically screen patients for social needs. One multiservice CBO leader captured this challenge as follows: *“If all of a sudden these partnerships took off and the [hospital] ramped up their referrals. . . how much more capacity do you think [the CBO] has to serve more patients through referral?”*

Alternatively, some interviewees suggested that their organizations would be able to scale up operations to meet newly revealed demand but that there were a variety of sector-level constraints that might keep Mass-Health ACO members from actually receiving services. This was particularly true among housing CBOs, where interviewees were confident that they either had or could hire sufficient housing navigation staff to absorb ACO referrals on their client roster but noted that most housing CBOs do not have the ability to generate a new supply of low-income housing. This would mean that referred clients would likely be added to already long waitlists for scarce available units. For example, one interviewee said: *“You can screen everybody, but if people are homeless, they need a house, right? That’s step one. Well, I hear that. What’s the hospital doing? Is the hospital gonna build housing?”*

Similarly, some early education CBOs were reliant on government allocations of classroom spots that they could not control or adjust on short notice. These CBOs functioned largely as “front doors” or gateways into government-funded services (e.g., public housing, Head Start). Several interviewees were concerned that the influx of referrals, combined with fixed supply at the sector level, would make it impossible for CBOs to deliver on the outcomes that health care might be most interested in as a condition of the partnership. For instance, if health care was interested in measuring what proportion of people referred to a housing organization were successfully housed, CBOs cautioned that they would not have control over this outcome given system-level constraints.

3. CBOs MAY FACE ETHICAL DILEMMAS.

Several CBOs with comparatively more experience working closely with health care organizations on projects that required a contract or formal agreement expressed fears about the potential for ethical dilemmas between their organizations and health care organizations. These concerns about potential ethical dilemmas were partly rooted in a more general understanding that health care and CBOs were serving imperfectly overlapping populations. CBOs may consider themselves more anchored to geographically or culturally defined communities, while health care organizations provide care for patients rather than communities. For instance, within a particular zip code in Boston, MassHealth ACOs may feel responsible to improve the health status of assigned enrollees, while CBOs may feel a sense of responsibility for anyone living in the neighborhood where they operate. Beyond residents of their neighborhood or zip code, a CBO may see little obligation to improve health outcomes, while the ACO is responsible for its assigned members statewide.

The potential for conflicts was described by CBO leaders across housing, legal services, and community center organizations, who often felt their professional standards were pitted against those in the health care sector. One respondent anticipated health systems wanting access to low-income housing for their highest-cost MassHealth enrollees. The interviewee feared that to do this, health systems would attempt to purchase or otherwise gain preferred status in relation to what is currently a 38,000-person waiting list in Boston for low-income housing. This potential request by health care would put the CBO in a challenging position given their obligations to abide by federal fair housing laws.

One thing that we're trying to get a handle on is if hospitals really have to serve their patients only, and they need to also have access to housing [for people on the citywide waiting list]... we start to run up against fair housing laws. We have to ensure that affordable homes are open to anybody who needs them. There's just this challenge where I can see it coming.

Among legal services, the concern about ethical dilemmas took a different form. Representatives of legal aid programs reported ambiguities about to whom they were ultimately responsible if a clinic were paying for legal services on behalf of patients. One interviewee imagined aloud a scenario in which her expertise on immigration law was requested by the health care institution, but the patient later disclosed misgivings about the quality of the health care he or she received at the clinic. In that case, who would the legal aid lawyer have an ultimate duty to protect? The answer is not clear.

4. CBOs WILL FACE UNFAVORABLE CONTRACTS.

Based both on past experience and on anticipation of how their relationship with health care might evolve, CBOs expressed concerns that their organizations would be faced with contracts that were disadvantageous. Perceived disparities in size, resources, and negotiating power between CBOs and health care organizations were at the heart of this concern. Additionally, several of the CBO leaders interviewed reported having had previous experiences in which they had been asked to do work (e.g., collaborate on grant applications) that would benefit a health care organization without financial compensation to the CBO. This was a particular concern for CBOs as they envisioned referrals from health care scaling up without additional funds to support the increased demand. One interviewee shared the following experience:

Yeah, we've had situations where the major hospital asked us to undertake a project at no cost to them. We said, 'Why would we do that?' We had a major hospital say, 'Can

you provide us with your curriculum in this training area?’ We said, ‘No. You’d have to pay us for it. We run a business just like you do.’ Sometimes people make requests of us, or engage in ... I don’t know what people think. That maybe nonprofits don’t need to pay their employees? I don’t really know.

Several other CBOs reported that they had little way of assessing or asserting their own value in negotiations with larger organizations. This lack of resources and/or infrastructure to assess their own value, as well as persistent shortfalls in funding, drove some CBOs to accept suboptimal contracts. In the view of one legal aid advocate: *“My concern, and I have seen this happen ... is that there is a structural bias for legal aid to sort of tolerate and stretch more than it should [in contracting with health care]. And that’s not okay. They shouldn’t be in that position.”* More specifically, some CBOs pointed to specific instances wherein health care organizations paid them below-market rates for the services provided. This was particularly true among smaller CBOs and those with little previous experience interfacing with health care. One interviewee from a community center described renting space to a local health care entity from a position of weakness:

My understanding of the contract was at the time when my CEO took over the building... she was kind of desperate to fill the space and have the money come in, which a lot of times [community centers] do when they’re not a fiscally strong... So she made the agreement with [health care provider]. What they pay monthly I’m going to say is lower than market value for the space.

The most commonly cited concern regarding contracting was that CBOs would be required to enter into exclusive contracts with a single MassHealth ACO or health system. This concern was rooted in what CBOs perceived to be other health care providers’ experience, in particular specialty medical practices that had been locked into exclusive agreements or purchased outright. On this point, there appeared to be some confusion as to how likely an exclusivity requirement might be for the CBO landscape. Several interviewees suggested that the CPs (as defined by MassHealth) were also locked into exclusive contracts with MassHealth ACOs, which they are not.^{viii} One respondent described:

I think it raises some really interesting questions about whether in 10 years there are going to be exclusivity expectations of social service providers the way that there currently are with these other community partners, and what that means.

This misunderstanding underscores the need for more in the way of clear and consistent communication between health policymakers and CBOs in order to ensure that the best available information is available to all relevant parties.

viii MassHealth ACOs are required to contract with all behavioral health CPs and at least two LTSS CPs. For more information, please see the following contractual requirements: Accountable Care Partnership Plan Model Contract, Section 2.5 (F) & (G); Primary Care ACO Model Contract, Section 2.3 (F) & (G); and MCO-Administered ACO Model Contract, Section 2.8 (A) & (B).

5. CBOs WILL BE MEDICALIZED.

CBOs expressed concern that their work will be medicalized, and in some sense corrupted, through the process of partnering with health care organizations and securing additional resources. More specifically, interviewees described a process by which their work would be commodified into specific products and services. One interviewee who worked on behalf of community centers described this risk:

I'm concerned that health care will want to make [addressing SDOH] into tight compartments that make sense, and the social spectrum does not work that way. But they'll want to define it, encapsulate it, put borders and boundaries around it, and [it] will no longer be a social determinant. It will be a new service line. That would be, I think, a tremendous detriment, because social determinants have to be fluid to the needs of individuals.

CBO leaders additionally worried that partnership with health care would require a shift in focus from whole communities and neighborhoods to specific ACO-designated, high-risk or disease-defined subsets of patients. Given scarce resources, targeting pre-specified patient populations could come at the expense of other equally or more vulnerable individuals who may not be identified as “high need” or “high cost” by the health care system. Referencing the difficulties in finding affordable housing for people without costly interactions with the health care sector, one interviewee said:

People would develop housing, say it's for [complex care], and then a provider writes a letter saying, 'Oh yeah, they're [complex care],' and therefore they get in. Well, you're not putting in [to housing] the ones who are really the neediest and the most difficult to work with.

Several interviewees were concerned that the social service sector would become distracted from its core functions in order to produce outcomes that are in line with health care's timelines and priorities. Thinking well into the future, one advisory board member^{ix} feared that if CBOs were to shift their focus entirely onto patient populations with a demonstrated need that were referred by MassHealth ACOs, “*It would amount to the potential for a loss of all primary prevention in the system.*” In the public health literature, primary prevention refers to interventions that are applied before there is evidence of disease or injury and aims to limit incidence of risk and illness.

At the conclusion of the data collection and analysis period, the research team convened a group of 40 CBO representatives (roughly half of whom had been included in the original study sample) to solicit feedback on the preliminary study findings. (See Appendix A for more detail on the session.) During the session, attendees were asked to work in small groups to rate the various risks and concerns on a scale of 1 to 5 based on the likelihood that the risk would come to fruition and the potential danger to the organization if the risk did come to fruition. While disparate sets of risks had been mentioned over the course of the one-on-one interviews, this process allowed the CBO representatives to have a within-group conversation and reach some degree of convergence regarding which risks and concerns were most well founded. For policymakers, this exercise lends insight into the unintended consequences that may be most deserving of policy mitigation. The top three risks identified through this exercise were “unfavorable contracts,” “funds will be trapped and vaporized inside health care,” and “CBO work will be medicalized.” See Appendix B for a detailed breakdown of scores from the risk-rating exercise. The participating CBOs noted that the rating of risks would vary depending on the size of the organization. Specifically, the size characteristics that seemed most pertinent to attendees when rating the different risks were service area, number of employees, annual budget, and number of clients served.

ix To ensure valid representation of perspectives from CBOs, the study team empaneled an advisory group comprising representatives from CBOs and public health and health care organizations. The advisory group was convened twice during the study period to review and provide feedback and validation checks on the sampling frame, interview guide, initial emergent themes, and final interpretation of the data. See Appendix A for more information.

More broadly, some CBOs suggested that the sector's efforts to position themselves favorably with regard to health care may result in further entrenchment of a broken health care system. To the extent that CBOs allowed themselves to be modified in the image of health care's operations, metrics, and cultures, interviewees feared, they would become part of the problem rather than a solution to the challenges facing vulnerable communities. For example, tracking health care outcomes and developing additional "service lines" for specific patient groups were viewed as ways of buying into—and in a sense, contributing to—the existing system that has failed to deliver health improvements for vulnerable communities over many decades. Several noted that the system was broken and needed substantial rethinking, including a clearer sense of how health care and social services could optimally work together. *"There has to be a guiding structure,"* one interviewee said.

DISCUSSION AND NEXT STEPS

GROWING TOWARD THE LIGHT

In communicating these findings, and particularly those presented in Theme #4 (CBOs' efforts to position themselves as partners to health care organizations), the metaphor of a plant growing toward the light has proven useful. CBO leaders reported a range of adaptations their organizations were making to position themselves favorably to become partners to health care organizations. Doing so increased the potential to garner resources from health care, including money and social and political capital. In this sense, the CBO sector is akin to the plant that sprouts unexpectedly sideways to capture resources necessary for further growth. This metaphor carries no normative implication, meaning it is not yet clear whether the changes that CBOs are undertaking in pursuit of health care partnerships will ultimately prove to be positive or negative for CBOs or the communities they serve. In attempting to position themselves favorably for health care partnerships and contracts, it may be that CBOs become more scientifically managed and data-oriented, which might improve the efficiency and efficacy of the social services they provide. On the other hand, mimicry of health care organizations might cost CBOs some of their focus on long-term outcomes and cultural concordance, which allows for trust and positive reception in some of Massachusetts' most vulnerable communities. It is worth unpacking the implications of CBOs growing toward the light, inasmuch as it may impact health care organizations, CBOs themselves, and the communities they serve. While we recognize that some version of this behavior may have been a longstanding feature of the two sectors' relationship, our data suggest that CBOs' efforts on this front have intensified following health policy shifts that prioritize attention to SDOH. These organizational changes undertaken by CBOs may be important for policymakers to consider as they continue to grapple with how best to align the goals and needs of health care organizations and CBOs.



IMPLICATIONS FOR THE MASSACHUSETTS CBO SECTOR

Massachusetts CBOs face a strategic tension as they decide how to respond to health care's entry into SDOH. The strategies organizational leaders described in Theme #4 (CBOs' effort to position themselves as partners to health care organizations) involve substantial potential upside. Many CBO interviewees outlined an intentional strategy to vie for health care attention as a means of bolstering their legitimacy and access to resources. To the extent that CBOs are successful in their efforts to attract new resources from partnering with health care organizations, CBO leadership and staff may look back at the risks outlined above as having been worth taking on behalf of their organization. Moreover, if CBOs achieve the kinds of organizational and service delivery standards that health care organizations are seeking in partners—that is, if they succeed in making their work “neater” and their outcomes more discernible to health care—health care organizations may welcome outsourcing social service delivery as an alternative to building radically new capabilities internally.

While CBOs may reasonably wish to grow toward the light to seek additional resources from health care, many also want to prevent losing the aspects of their work that they are most proud of and make the CBO sector unique. What makes the CBO sector unique is difficult to articulate given its inherent diversity, but the interviewees appeared aligned around a few shared commitments, including an interest in being responsive to the particular needs of individuals or families; serving the most vulnerable groups, including those without English language proficiency, health insurance, and residency or citizenship documentation; focusing on community mobilizing and organizing; incorporating peer as opposed to professional supports; and ensuring that people receive services concordant with their linguistic and cultural backgrounds. We hypothesize that these attributes were part of, though perhaps not all of, what interviewees had in mind when they used the terms “intrinsic value” or “special sauce” of community-based work. The pursuit of closer alignment, if not partnership, with health care may force a reconsideration of these commitments, given health care's emphasis on protocols and checklists as hallmarks of good management; focus on covered lives and identified patients; interest in demonstrating intervention effects over short time horizons; preference for standardized, licensed professionals as care providers; and commitment to “scalable” solutions that are widely applicable regardless of language and culture.

The shift in focus from the standard CBO commitments to those that more closely resemble health care's may be what one interviewee was thinking of when she noted that the changes afoot could amount to a system-level loss of primary prevention. Her comment highlights a key subtlety embedded in this work, which is that it may be entirely in a single CBO's self-interest to change its ways of working in pursuit of health care partnerships. It may do so under the assumption either that this is the only way to survive as an organization or that other CBOs will continue fighting the good fight and abiding by traditional CBO commitments. However, if all CBOs pursue this strategy and are successful, the sector-level implications may be profound.

INCLUSION OF CBOS IN THE POLICYMAKING PROCESS

Substantial research and health policy discussions have focused on the potential for partnerships between health care and CBOs to transform care delivery for Medicaid and other vulnerable populations.²⁹⁻³³ CBOs perceive themselves as having specialized expertise when it comes to serving low-income and vulnerable populations. This sense of expertise drives their staffs' disappointment in feeling that they have not been included in the policymaking process around SDOH, as indicated by repeated references to “not being at the [policymaking] table” and “not being at the [policymaking] party” in our data.

Including CBOs in the development of SDOH-related policy is an essential step in developing functional partnerships between the health care and social service sectors. While the study findings evidenced a sense of enthusiasm for such partnerships among CBOs, it also bore out a skepticism about health care’s motives, which may be exacerbated if CBOs are not included in the discussions about the goals of new partnerships from the start. As we have outlined, health care–CBO relationships will have plenty of barriers to overcome in terms of bridging distinct ways of working and values, without adding further sources of mistrust on the basis of having been excluded from the policymaking process. Going forward, CBOs should be invited into state-level policy discussions as well as organizational-level planning by MassHealth ACOs as soon as possible. Incorporating CBOs in policymaking may feel to state and ACO policymakers like it lengthens the time to reach key decisions, but doing so will provide a much-needed opportunity for bidirectional education between health care and social service providers, shortening the startup time required within each ACO-CBO relationship and increasing the success rate of these partnerships. And CBOs would benefit from inclusion in policymaking by giving them access to information necessary to begin the work of developing new strategic plans, hiring additional staff, or investing in infrastructure that accommodates the needs of health care organizations.

LEGITIMIZING BUT NOT MEDICALIZING THE CBO SECTOR

As policymakers consider how to support the integration of health care and social services, a reasonable aim would be to legitimize the CBO sector without medicalizing it. By “legitimize,” we mean taking steps that would increase the visibility, role, and bargaining power of the CBO sector. By “medicalize,” we mean taking steps taken to hold CBOs accountable for managerial styles, ways of working, and using metrics that are common in the health care sector. No doubt various stakeholders will have disparate views on where the line between these functions lies. For instance, one person may see a state requirement that all staff working in a food pantry be licensed as a “legitimation of that line of work,” while another may argue it is undue medicalization. Nevertheless, we believe there are a number of easier cases where most of the parties involved can agree on positive steps forward. Such a framing may lead to more productive conversations than simply whether or not CBOs are “ready” to partner and how they can be readied quickly for health care reforms or left out of them.

In terms of next steps to support the legitimization and rationalization of CBOs, Massachusetts could consider providing technical assistance (TA) for and by CBOs (see the table below); exploring novel ways for health care organizations and CBOs to share in health care savings resulting from collaborative work; and encouraging and financially supporting regional sector-wide collaborations. Discussion of hubs that could span an array of social

POLICY STEPS TO LEGITIMIZE BUT NOT MEDICALIZE CBOs

STEPS TO LEGITIMIZE CBOs	STEPS TO AVOID MEDICALIZING CBOs
Foster and support stronger intra-CBO collaboration along both geographic and sector-specific lines	Develop “rules of the road” for health care and CBO contracting (around exclusivity, pay-for-performance, etc.)
Provide technical assistance for and by CBOs	Provide more grant and policy flexibility so that the health care sector can be less constrained in what SDOH supports it offers
Develop models for potential savings to be shared	Create a set of common measures for health care and CBO sectors to work toward jointly (with no financial ramifications)

services (housing, transportation, nutrition, etc.) has been one early, concrete manifestation of a grassroots effort from Massachusetts CBOs to rationalize their operations within specific geographic areas. One goal of such collaboratives may be for everyone to be able to bring a list of active clients and compare notes on a regular basis to determine how the social service system can best be leveraged in support of an individual or family. If representatives of local health care organizations were to join this kind of meeting, the coordination of services that could be achieved might improve substantially, providing an additional benefit to health care unrelated to the hub's ability to ease contracting.

In an effort to avoid medicalization, MassHealth may consider developing ground rules for health care–CBO contracting. This could be done in consultation with representatives from CBOs, who may be able to offer examples of de-identified expired or mocked-up contracts that were especially problematic for or conducive to the underlying relationship. The Massachusetts Executive Office of Health and Human Services (EOHHS) could also consider creating a common dashboard of 3 to 5 outcome measures that bear relevance to both the health care and social service sectors and could be publicly tracked over time. A dashboard of common measures is likely to be an unpopular idea with a health care sector that feels constantly barraged by new metrics. The rationale for developing a small set of common measures is to create one or more boundary objects³⁴ or targets relevant to both CBOs and health care. No financial rewards or penalties should be attached to such a dashboard, but the measures could be tracked in public view.

TECHNICAL ASSISTANCE

Both CBOs and health care organizations have indicated a need for MassHealth or other well-informed entities to provide TA to CBOs. Health care organizations that are seeking partners are particularly hoping that the state will create opportunities or requirements for TA for CBOs in preparation for partnerships or collaborations between the sectors. This research, as well as forthcoming research from the Public Health Institute of Western Massachusetts, suggests that some forms of TA to CBOs are warranted and would be welcome, including information sharing sessions about the MassHealth redesign processes, patient privacy (HIPAA) standards, and development of technological capacity to enable bidirectional referrals. Recent findings from a national survey by the consulting firm Oliver Wyman indicated that it's common for social service organizations to operate in dire financial straits.³⁵ Our interviews indicated that the situation in Massachusetts is no different, with most CBOs unable to identify sufficient discretionary resources to invest in TA capabilities themselves.³⁶ This leaves MassHealth or other EOHHS agencies, ACOs, and/or local philanthropies in the position of needing to invest in TA for CBOs.

Government entities and philanthropies could also broker a form of “reverse TA,” wherein CBOs are given the opportunity to describe their own work and the outstanding needs of the community they serve to an audience of policymakers and health care professionals. This study's preliminary interviews with health care stakeholders, in particular, revealed a series of misgivings and concerns about partnering with the CBO sector—including the sector's lack of regulation and contracting capabilities—which may be unwarranted. Additionally, CBOs reported an interest in discussing collaboration with health care but a lack of understanding as to whom within a health care system to approach. The opportunity for reverse TA would allow CBOs to share the scope of their work, existing capacity and constraints, and interests in collaboration with an audience of decision makers in health care.

FURTHER RESEARCH

Further research is needed to better understand the potential role for CBOs, given the growing shift in health care toward value-based care and a greater focus on population health. First, further research is needed to understand the ways in which sectors within the CBO landscape differ from one another. While this study sought to have representation from a variety of sectors (see Appendix A), the research question and methodology were not designed to be comparative in nature. Nevertheless, much of the preliminary feedback on this study from policymakers and health care leaders indicates interest in understanding strengths and weaknesses among CBO sectors—housing, nutrition support, transportation, etc.—that may be relevant for partnering with health care.

Second, additional research is needed to better understand the flow of referrals from health care organization to CBOs. This flow has always been relevant but is made substantially more so by MassHealth ACOs requirement to screen for health-related social needs. The question of whether universal screening for social needs by MassHealth ACOs will overwhelm existing CBO capacity is of particular interest, and data from this study suggests that CBO leaders have a wide range of views on the potential impact on CBO capacity. Quantitative analyses of where MassHealth ACOs are referring patients and why will be valuable information in attempting to help the CBO sector plan strategically and become more efficiently organized.

Third, future research should explore how CBOs conceptualize high-quality social services, what quality measurements currently exist, and where there are gaps in measures. This research may require a combination of qualitative and quantitative analyses. Developing a clearer articulation of quality, if not workable process and outcome metrics, will help the CBO sector to identify existing and develop new quality-improvement processes. It will also assist health care in understanding which CBOs are best meeting patients' needs upon referral.

CONCLUSION

This study sought to better understand CBOs' responses to the health care sector's movement into SDOH programming. Qualitative data was collected through key informant interviews with CBOs representing a range of social service sectors. A series of themes emerged from the data analysis that highlight key perspectives among CBOs regarding health care's growing focus on SDOH. The structure of this research presented opportunities for CBO leaders to convene and discuss study findings and their broader implications. Feedback proved interesting in and of itself, including discussion of the need for more time to organize and strategize as a collective CBO sector. Few professional times and spaces appear to exist for CBOs from across the various SDOH domains and geographies of the state to dialogue amongst themselves.^x In an effort to address the perceived limited availability for group dialogue, CBOs may wish to self-organize to identify ways to share best practices and mitigate the risks and concerns outlined in this report. Some outside funding would likely be necessary, but the return on investment from this kind of organizing could be substantial.

Massachusetts is once again leading the nation with its innovative policies aimed at improving the health of its residents. To the extent that the state's 1115 waiver prioritizes addressing health-related social needs, referrals to community linkages, and provision of flexible services, the waiver's success relies not only on the quality and efficiency of the state's renowned health care providers but also on the state's historic and robust social service providers. As such, CBO perspectives on health care organizations generally and these policy changes in particular serve as a key source of information about interests and concerns that are likely to bear on waiver implementation. CBOs appear cautiously optimistic about becoming partners to newly formed MassHealth ACOs. But a great deal more relationship-building work is likely necessary before CBOs can be meaningfully incorporated into MassHealth ACOs' strategy development, contracts, and workflows. The redesign of the MassHealth program is still in the early stages of implementation, and the flexible services protocol has only recently been finalized. Brokering successful relationships between health care and CBOs should be an area of sustained focus as the state faces another opportunity to lead the nation in improving population health.

x The Alliance for Community Health Improvement (ACHI) emerged over the course of our research with the goal of serving this purpose.

APPENDIX A

This appendix includes a summary of the study's qualitative data collection methods and sample demographics. The research team used key informant interviews to collect data on the responses of CBOs on health care's movement into social service programming.

INTERVIEW GUIDE DEVELOPMENT

To ensure that the CBO interview guide was developed based on a sound understanding of the MassHealth ACO environment, the study team first interviewed key stakeholders from Massachusetts health care systems that were in the process of entering ACO contracts with the state. These ACO contracts included language and potential funds to incentivize addressing SDOH. Health care interviewees were asked "Which social determinants are you prioritizing?" "How are you thinking about whether to build new programs in-house or contract for SDOH services?" and "What are you looking for in a community-based partner?" Thematic saturation was reached after seven interviews. Responses and themes from these interviews, along with a review of the available literature and informal conversations with consumer advocates and academics from across the state were used to develop the semi-structured interview guide for the CBO participants. As such, we did not include these health care interviews as part of our resulting sample or include the data from those interviews in the presentation of results.

SAMPLING FRAME

The sample population included leadership and high-level program staff from a diverse set of CBOs across Massachusetts, including one government organization that was repeatedly mentioned by several interviewees in the health care and CBO sample (n=46).

To recruit an initial cohort of interviewees, we contacted CBO leadership and staff that had attended local public events to discuss integration of health care and social services within Massachusetts, including the open meetings held by MassHealth during the 2016-2017 Medicaid redesign process and the Blue Cross Blue Shield of Massachusetts Foundation's participant list from a Social Equity Convening in 2014. Subsequent recruitment of eligible CBO leadership was done using snowball sampling techniques, wherein each interviewee is asked whether he or she knows of other people who might have relevant perspectives on the research question. Roughly halfway through sampling, we began to ask interviewees whether they were able to recommend people in specific domains of social services in order to achieve an appropriate balance of representation. Transportation, domestic violence, and legal services were the sectors in which we found it most challenging to recruit.

All interviews were conducted between September 2017 and March 2018, lasted between 40 and 75 minutes, and were audio recorded with consent and professionally transcribed verbatim. Interviewees were asked questions regarding (1) mission, funding structure, and services provided by their organization, (2) perspectives on health care organizations entering into social services provision (3) experiences with health care referrals or partnerships, and (4) potential risks and benefits of health care entering into social service delivery (see Figure A1). Interviews were conducted until the research team agreed that thematic saturation had been reached. This study was deemed exempt by the Tufts Medical Center Institutional Review Board.

FIGURE A1: CBO INTERVIEW GUIDE

1. Tell us about your role and organization.
2. What is the organization's mission? Has it change at all recently?
3. What kind of services does your organization provide to whom? Are there strict inclusion or exclusion criteria?
4. How do clients/patients typically find you? What other organizations, if any, refer to you?
5. In broad strokes, can you tell me a bit about how your organization is funded?
6. What kinds of health care providers do your patients/clients typically see? What is your impression of the quality of care that these providers deliver?
7. There is increasing incentivization for health care organizations to include social determinants of health under the umbrella of what they do. Does this sound to you like movement in the right or wrong direction? Why or why not?
8. Have you ever partnered with a doctor's office, hospital, or community health center?
9. How has the interest/emphasis on health system partnership complemented or detracted from CBOs other "core" work or clientele? What are the spillover effects of a partnership with health care?
10. How does the potential of partnering with a health system change CBO's relationships with one another?
11. Do you think there are any for-profit organizations that could do the work you do for health care?
12. How much of a factor, if at all, has Medicaid ACO creation been in your organization's discussions to date?

DATA ANALYSIS

Two coders (EB and LT) used grounded theory and constant comparative method of qualitative coding.^{37,38} Using this methodology, both team members independently analyzed transcripts, generating common codes from the data to summarize key ideas. The team reviewed the initial codes, discussed and re-evaluated codes, and combined them into larger concepts and coherent themes. Both coders iteratively reviewed all transcripts in this manner, lumping and splitting concepts and themes, then adding and combining new codes as needed through a series of weekly three-hour consensus meetings over three months. Analysis then progressed from description of the data to explanation or interpretation of the patterns and their broader meanings and implications. All final codes and themes were agreed upon and applied systematically across transcripts.

ADVISORY PANEL

To ensure valid representation of perspectives from CBOs, the study team empaneled an advisory group comprised of representatives from CBOs, public health, and health care (n=7). Individuals were invited to join the advisory group based on their enthusiasm for the project and depth of knowledge of the MassHealth redesign process. The content of interviewees' perceptions of health care's movement into social determinants was not considered in inviting people to join the group. The advisory group was convened twice during the study period to review and provide feedback and validation checks on the sampling frame, interview guide, initial emergent themes, and final interpretation of the data.

CBO FEEDBACK SESSION

After completion of data collection, coding, and analysis, the study team worked with the Blue Cross Blue Shield of Massachusetts Foundation to convene a larger set of CBOs (n=40) from across Massachusetts for a two-hour presentation and feedback session in June 2018. Roughly equal numbers of people in attendance had and had not participated in our study interviews, offering us a nice cross-section of people who had previous exposure to our work and those to whom it was entirely new. Many of the participants came from within the Greater Boston area, but at some traveled substantial distances from other parts of the state, including the North Shore. This convening provided the study team an opportunity to describe the data collection process and emerging themes and to solicit feedback from a broad set of CBOs.

We presented our preliminary findings, including the five key themes and the codes attached to each theme, and policy recommendations. Throughout, we emphasized that we remained open to CBO feedback and were eager to hear the extent to which our findings resonated with the experiences of people in the room.^{xi} We organized an exercise by which attendees were asked to classify the various risks and concerns by likelihood. We did this by handing out a worksheet to each table of participants and asking them to work collaboratively, in groups of two to six, to rank each risk on a scale of 1 to 5 based on the likelihood that the risk would come to fruition and the danger to participants' organizations if the risk did come to fruition (see Appendix B, Table B1 for a detailed breakdown of scores from the risk-rating exercise).

The top three risks identified through this exercise were “unfavorable contracts,” “funds will be trapped and vaporized inside health care,” and “CBO work will be medicalized.” The fear that CBOs would be distracted from their community (or place-based work) and be forced to focus more squarely on the patients identified by MassHealth ACOs was ranked fourth. Several groups were not able to complete the worksheet in its entirety, leaving us with less data to assess some of the risks than others. We took this as an indication that the conversations the CBO participants were having were valuable and the risks were not easy to dismiss.

LIMITATIONS

Several limitations deserve note. First, the study sample was limited to CBO leadership and senior staff in one state and may not be generalizable to other states. Second, while nine sectors of social services were represented in the final sample, housing was more heavily represented than other sectors. This may limit the generalizability of the data but is representative of the policy environment in Massachusetts, as there has been a concerted movement toward a “housing first” approach to health care and social service partnership.³⁹ Third, the study question was not comparative in nature, and the sample strategy was not designed to solicit differences in perspectives between CBO sectors. Finally, in most cases, the study team interviewed only one senior staff member from each CBO. In larger organizations, these representatives' perspectives may not accurately represent the perspectives of all staff, particularly those working at the front lines. The study team felt that leadership would be able to provide a more holistic perspective of strategy and direction for their organization.

^{xi} During the question and answer session, we were asked for more specific information about why certain kinds of organizations were not seemingly in the sample. Questioners were concerned about whether we had overlooked homeless shelters (we had not), LTSS and behavioral health providers (we had, intentionally), and juvenile justice organizations (we had, unintentionally). Attendees also wanted to know more specifically how many of our sample organizations primarily served racial or other minorities. Several people said thank you for paying attention to CBOs at all. One questioner asked about how our work intersected with health disparities and systemic bias, suggesting that we frame the work not only in an effort to close existing disparities but also with some attention to how systemic bias and racism could influence the delivery of health care and social services.

RESULTS: SAMPLE DEMOGRAPHICS

Our sample included representatives of CBOs offering a range of social services, with a greater emphasis on the services that health care interviewees had shared were a priority, including housing and food. Sectors represented in the final sample included housing and shelter, nutrition support, domestic violence, community centers, multiservice organizations, legal services, early education, workforce training and job development, and transportation.

Following an initial interview, all participants received a survey asking them to describe their organization's size and scope of service delivery. We received survey responses from 40 (85 percent) of all interviewees. Respondent CBOs came from 22 Massachusetts zip codes, representing 8 of the 14 counties in the state. Of those, 75 percent (30) had headquarters located in greater Boston, 18 percent (7) in western Massachusetts, and 8 percent (3) elsewhere in eastern Massachusetts.

APPENDIX B

TABLE B1: RISK RATING BY CBO CONVENING PARTICIPANTS (6/18/2018)

CLASS OF RISK	RISK	LIKELIHOOD THAT THIS WOULD COME TO FRUITION (1-5)	LIKELY DAMAGE TO YOUR ORGANIZATION (1-5)	TOTAL RISK SCORE	RANK
Financial Risks	CBOs will be forced into unfavorable contracts	5	4.83	9.8	1
	Funds will be “trapped and vaporized” inside health care	4.4	4	8.4	2
Service-related Risks	CBOs’ work will be medicalized	4	3.8	7.8	3
	CBOs will be made to focus on covered lives rather than communities	4	3.75	7.75	4
	CBO capacity will not be able to keep up with referrals from health care	3.4	3.6	7	5
Ethical Risks	CBOs will face ethical dilemmas	3.5	2.37	5.3	6 (tie)
	Health care will attempt to jump the line for CBO services on behalf of its patients	2.5	2.75	5.3	6 (tie)

Note: In presenting the risks in our final reporting above, we have collapsed the risk described here as “Community versus covered lives” into our discussion of medicalization.

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