June 2024

Community Care Hubs

An Innovative Strategy to Deliver the National DPP Lifestyle Change Program and Other Chronic Disease Risk Reduction Services

About this Resource

Innovative strategies are emerging across the United States that support payment models for services that address chronic disease risk reduction. These models bundle coverage and payment for a range of evidence-based chronic disease prevention and management programs (such as the National Diabetes Prevention Program Lifestyle Change Program and Diabetes Self-Management Education and Support) as well as services that address health-related social needs (HRSN). Community Care Hubs (CCH) are one such approach.

Through funding from the Centers for Disease Control and Prevention, NACDD and their partners at the Kem C. Gardner Policy Institute gathered key learnings from CCH organizations engaged in these strategies. This resource provides information on how state health departments can leverage these models to support their efforts to decrease risk for chronic diseases among the communities they serve. Information on the following topics is included in this resource:

1. Introduction to Community Care Hubs (CCHs)
2. Functions of a CCH
3. Benefits of Participating in a CCH
4. Using CCHs to Offer a Suite of Evidence-Based Programs and Address HRSN
5. The Role of State Health Departments in Supporting CCHs
6. Where to Start as a State Health Department?
7. CCHs and the National DPP Lifestyle Change Program: CCH Spotlights
8. Appendix: How is a CCH Different from Other CBO Network Approaches?

For More Information

The Administration for Community Living (ACL) funds community-based organizations (CBOs) in every state with an acute focus on high-cost, high-need populations. A key ACL strategy for sustainable engagement of community-based health integration services is the support and development of CCHs.

ACL has many resources to support health care organizations and CBOs in efforts to develop and maintain CCHs.

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*The **Building Capacity for Public and Private Payer Coverage of the National DPP Lifestyle Change Program** project is supported by the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling **$4.2 million for grant year 6** with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.*

Introduction to Community Care Hubs

It is increasingly common for community-based organizations (CBOs) to contract with a lead organization as part of a broader CBO network. This CBO network approach is based on the premise that the individuals they collectively serve will experience better overall health and health outcomes when the different CBOs and health care organizations are coordinated and well-integrated. One such CBO network approach is the Community Care Hub (CCH).

A CCH is a community-focused entity that organizes and supports a network of CBOs that provide evidence-based chronic disease prevention and management programs and services to address health-related social needs (HRSN). A CCH supports their network members through centralizing administrative functions and operational infrastructure. A CCH has trusted relationships with and understands the capacities of the local CBOs and health care organizations in their network and fosters cross-sector collaborations that incorporate authentic local voices through community-based leadership.

A CCH is a promising approach for how a group of organizations can work together to deliver and increase enrollment in the National Diabetes Prevention Program (National DPP) lifestyle change program.

Functions of a CCH

A CCH centralizes the administrative functions and operational infrastructure of its network members to support a range of evidence-based chronic disease prevention and management program delivery (National DPP lifestyle change program, Diabetes Self-Management Education and Support (DSMES), Diabetes Self-Management Program (DSMP), Medical Nutrition Therapy (MNT), Falls Prevention Program, etc.). Functions of a CCH include, but are not limited to:

- Leadership and governance of network members
- Strategic business development and contracting with health care organizations and health insurance companies
- Payment operations
- Management of referrals
- Service delivery fidelity and compliance
- Technology and information security
- Data collection and reporting

Benefits of Participating in a CCH

There are many ways organizations offering the National DPP lifestyle change program may benefit from participating in a CCH, including:

- **Enhance System Efficiency**: A CCH is essentially a one-stop shop for the delivery of multiple evidence-based programs, interventions, and services. It offers inherent efficiencies to scale contracting opportunities and to integrate health care and social care efforts. It allows health care organizations and health insurance companies to contract with multiple CBOs in a streamlined way and ensure the quality of services delivered.
- **Expand CBO Capacity**: A key element of CCHs is their diverse network of CBOs and health care organizations that cover broad geography, populations, and provide an increased set of services—which expands the capacity to address chronic disease prevention and management and HRSN beyond the capability of a single CBO.
- **Advance Health Equity**: CCHs and their CBO provider network are experts in delivering social care support and services that address HRSN. With the CCH providing administrative and operational support, CBOs in the network have increased capacity to focus their efforts on addressing the needs most prevalent in their communities. For many CBOs and health care organizations, this directly aligns with their organization's health equity goals.
- **Engage Communities**: CCHs are made up of a diverse collection of CBOs who are trusted partners in the communities they serve and act as an important connection between health care and social care sectors. A CCH works with their network to build and/or strengthen trust with community members and gather feedback from a broad range of voices on important matters.
- **Create Financial Benefits:** CBOs participating in a CCH do so in part because they often lack the organizational capacity and resources to contract directly with health care organizations and health insurance companies. CCHs can provide valuable input and support to ensure appropriate and equitable payment rates are in place for CBOs. They can also help identify and/or leverage funding from additional

federal, state, local, and private organizations. Health insurance companies and other payers seeking to reduce emergency department visits, hospital readmissions, and improve clinical outcomes can benefit from having CBOs with existing trusted relationships among community members. The CBOs can help lead payers' efforts to address HRSN, resulting in a return on investment for the payers.

For organizations looking to strengthen their delivery of the National DPP lifestyle change program, participating in a CCH can increase their capacity to focus on the unique needs facing their priority populations, opening time and resources to implement strategies to increase enrollment and retention in the program.

Using CCHs to Offer a Suite of Evidence-Based Programs and Address HRSN

A CCH centralizes the delivery of multiple evidence-based programs and services. By engaging with a diverse network of CBOs, CCHs can provide individuals with access to an increased set of programs. This expands the CCH's capacity to address chronic disease prevention and management beyond the capability of a single CBO.

Barriers to participating in these evidence-based programs, including the National DPP lifestyle change program, are often the result of HRSN. HRSN are an individual's or family's unmet, adverse social conditions that can lead to decreased health and a lower quality of life (e.g., lack of transportation, housing instability, food insecurity). Social determinants of health (SDOH) are the conditions in the environment where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. While everyone has socially determined factors of health, some populations and individuals may have HRSN stemming from these factors. Because HRSN can influence whether an individual enrolls, engages, and remains in programs like the National DPP lifestyle change program, CCHs highlight a promising opportunity to address these HRSN.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) issued a Call to Action in November 2023 that encourages partnerships across health care, social services, public and environmental health, government, and health information technology sectors to improve the health and well-being of every individual. It highlights the importance of CCHs in managing these partnerships and improving coordination between health and social care providers.

Research finds that CCHs improve the ability of CBOs to address HRSN. CCHs provide the vital connection within a community to ensure a coordinated approach to health and social care is working equitably to meet an individual's needs. Through the establishment of a diverse network of CBOs providing multiple evidence-based chronic disease prevention and management programs, CCHs increase the efficiency and effectiveness of individual CBOs to address HRSN by expanding their geography, populations served, and the services they provide. The CBOs that make up a CCH have trusted relationships with the individuals and communities they serve and are experts in delivering social care services that address HRSN.

The National DPP lifestyle change program, for example, is uniquely positioned to address unmet HRSN among program participants. Visit the Addressing HRSN Through the National DPP Lifestyle Change Program page for more information on how the National DPP lifestyle change program teaches valuable skills that address HRSN, as well as learn more about opportunities to address HRSN to support participants' success in the program.

The Role of State Health Departments in Supporting CCHs

CCHs are important partners as State Health Departments (SHDs) increasingly seek to decrease risk for chronic diseases and expand access to services that address HRSN. The CCH model holds promise for supporting SHDs to more effectively and sustainably offer chronic disease prevention and management programs and address priority populations' HRSN. There are several ways SHDs can support CCHs in their state, including:

- **Foster CCH and State Medicaid relationships.** A strong relationship between state Medicaid and CCHs can support efforts to fund and scale the National DPP lifestyle change program, other evidence-based programs, and social services that address HRSN. CCHs can work with state Medicaid to effectively deliver evidence-based chronic disease prevention and management programs to Medicaid beneficiaries and ensure network adequacy. SHDs can serve as convenors of CCHs, their service delivery subsidiaries, state Medicaid, and Medicaid managed care organizations (MCOs) to build the necessary shared understanding and trust for MCO contracting with CCHs. SHDs can help cultivate these relationships, which benefits both state Medicaid and the CCH.

- **Educate on beneficial policy opportunities**. SHDs can educate policymakers, state Medicaid, and health care organizations on the importance of policies and strategies to support CCHs. Such strategies may include 1115 waivers that provide a structure and funding to expand and sustain CCHs, state plan amendments (SPA) to cover evidence-based programs and services in Medicaid, and other enabling state legislation to address specific issues that can support CCH and CBO efforts to effectively deliver evidence-based programs and address HRSN (e.g., reimbursement for community health workers, CHWs).
- **Connect partners to CCHs.** SHDs can support CCHs by connecting them with National DPP lifestyle change program providers, identify other CBOs to participate in the CCH network, and connect CCHs to available funding opportunities within the SHD. SHDs can also work with CCHs to identify and recruit CBOs that work with priority populations to improve these populations' access to evidence-based programs and HRSN services.
- **Educate CCHs on emerging Medicare reimbursement opportunities through the 2024 Physician Fee Schedule (2024 PFS).** The 2024 PFS provides new pathways to reimburse a range of activities to address Medicare beneficiaries' HRSN, creating a new opportunity for CCHs to access sustainable reimbursement. SHDs can educate CCHs on the 2024 PFS and promote the adoption of the new billing codes.
- **Startup funding to support long-term sustainability.** Startup funding can support CCHs in moving towards sustainability. Having sufficient funding in the early stages of CCH development is essential to establishing the infrastructure needed to support a system that can successfully contract and secure reimbursement.
- **Provide training and technical assistance (T/TA) to CCHs, their CBO network, and partnering health care organizations.** SHDs play a critical role in convening and training CBOs and health care organizations. SHDs can facilitate shared learnings and support TA that drives collaborative system development to advance care delivery and payment.
- **Communicate the Return on Investment (ROI)/ Return on Value (ROV).** SHDs can partner with CCHs to elevate the ROI and ROV of CCHs to policymakers, health care organizations, health insurance companies, CBOs, and other state agencies.

Where to Start as a State Health Department?

SHDs may consider the following steps to better understand CCHs and support CCH development and sustainability in their state.

- **Learn CCH Basics.** Explore and understand the benefits of CCHs to address HRSN and expand chronic disease prevention and management programs such as the National DPP lifestyle change program.
  - Office of Assistant Secretary for Planning and Evaluation's HHS Call to Action: Addressing Health-Related Social Needs in Communities Across the Nation.
  - Office of Assistant Secretary for Planning and Evaluation's Community Care Hubs: A Promising Model for Health and Social Care Coordination.
  - ACL Technical Assistance page and FAQ page.
  - Partnerships to Align Social Care's Community Care Hub Resources page and CCH Primer.
- **Understand the Medicaid coverage benefit landscape in your state.** Covered Medicaid benefits vary state by state. Learning more about what chronic disease prevention and management programs and social services are covered in your state can be helpful when considering opportunities for CCHs. To learn more about the Medicaid coverage benefit landscape in your state, see:
  - The State Overviews page at Medicaid.gov, which provides key characteristics of each states' Medicaid program.
  - To learn more about what benefits are covered by Medicaid, talk to your state Medicaid agency or see the Medicaid State Plan Amendments page at Medicaid.gov.
  - For information related to the National DPP lifestyle change program, review the NACDD Coverage Toolkit including:
    - The Medicaid page.
    - The Medicaid Coverage Landscape page.
    - For detailed accounts of how states attained Medicaid Coverage for the National DPP lifestyle change program, see state stories for: California, Illinois, Maryland, Michigan, Minnesota, Montana, New York, Ohio, Oregon, Pennsylvania, and Wisconsin

- **Understand where there could be policy opportunities (e.g., waivers, state plan amendments, or new initiatives) to support a CCH model in your state.** CCH work can be accelerated by Medicaid state policies such as 1115 waivers and In Lieu of Services. Such policies provide a mechanism for the reimbursement of chronic disease prevention and management programs as well as services related to HRSN. To learn more about different policy opportunities being used by states across the U.S., see:
  - Working with Community Care Hubs to Address Social Drivers of Health, Medicaid Authorities to Support Financing of CCHs (Appendix A) and North Carolina Healthy Opportunities Pilot (page 34).
  - State examples addressing HRSN in the Coverage Toolkit.
  - ACL's State Support for Community Care Hubs and Networks, Leverage Policy Levers (page 5).
- **Help cultivate the CCH and State Medicaid relationship.** SHDs can be a bridge between the state Medicaid agency, CCHs, and CBOs, helping to foster communication and shared learning.
  - For more information on incorporating CBOs in Medicaid, see: Center for Health Care Strategies' Key State Considerations.
- **Support CCHs working with MCOs.** SHDs can collaborate with state Medicaid to provide CCH's with MCO contract guidance, including contracting considerations and suggested rates for HRSN services. For example:
  - The Engaging MCOs to Attain Coverage page describes the dynamic and flexible role MCOs can play in promoting coverage for the National DPP lifestyle change program in Medicaid.
  - The MCO Contracting page provides general guidance and key considerations around MCO contracting.
- **Connect CBOs to a CCH.** SHDs can help CCHs build their network of CBOs to deliver chronic disease prevention and management programs and services to address HRSN. To learn more about potential ways to support relationship-building among CBOs and CCHs, see:
  - Working with Community Care Hubs to Address Social Drivers of Health, States Strategies to Engage Communities via CCHs (page 14).
  - Engaging Community-Based Organizations page in the Coverage Toolkit.
- **Providing technical assistance and infrastructure support.** SHDs can establish dedicated funding to help CCH development and strengthen capacity. To learn more about how states are supporting CCH capacity with funding and technical assistance, see:
  - Working with Community Care Hubs to Address Social Drivers of Health, Strategies to Expand Community Capacity via CCHs (page 16).
  - ACL's State Support for Community Care Hubs and Networks, Create Opportunities for Seed Funding (page 3).
- **Learn about the 2024 PFS and educate CCHs on reimbursement opportunities.** SHDs can learn about the reimbursement opportunities available through the 2024 PFS and connect CCHs with resources to understand and implement the 2024 PFS billing codes. These codes reimburse activities addressing Medicare beneficiaries' HRSN. For more information see:
  - Partnership to Align Social Care Understanding the Medicare Physician Fee Schedule Billing Codes for: Community Health Integration (CHI), Principal Illness Navigation (PIN), Principle Illness Navigation – Peer Support (PIN-PS) Services.

CCHs and the National DPP Lifestyle Change Program: CCH Spotlights

The National DPP lifestyle change program played a significant role in the development of CCHs. In 2014, the Centers for Medicare and Medicaid Innovation (CMMI) funded a demonstration for the National DPP lifestyle change program in which the YMCA of the USA served as a lead organization to a delivery system of local YMCAs across the country that delivered the program. The outcome showed increased effectiveness of individual CBOs organized as a network under a single managing organization, improved health outcomes, and reduced costs.

As a result of the demonstration, Medicare established coverage for the MDPP, allowing CBOs to deliver the program as a new Medicare benefit. The history and evidence demonstrating the effectiveness of the National DPP lifestyle change program makes it a promising starting place for CCHs.

There are many examples across the country of organizations that use the CCH model to support a network of CBOs. Below are three examples of CCHs that support providers in offering the National DPP lifestyle change program among other evidence-based programs.

Western New York Integrated Care Collaborative (WNYICC)

Background and description

Western New York Integrated Care Collaborative (WNYICC) is a community care hub serving the communities of western and central New York. WNYICC includes a network of more than 70 CBOs, nine county Area Agencies on Aging (AAA), two county Departments of Health, and a Center for Independent Living (CIL) with 15 affiliate offices throughout the region.

In 2017, WNYICC received funding from the Health Foundation of Western and Central New York to develop the hub's infrastructure and grow its network. WNYICC used this funding to hire a full-time Director of Business Development who operationalized the program by developing a network of CBOs, acquiring contracts, establishing referral pathways, and building a training academy for network partners.

From 2016-2019, WNYICC operated solely through grant funding. By early 2024, approximately 25% of WNYICC's budget was funded through grants and the remaining 75% through contracts (55% are contracts with payers and 45% are consulting and technical assistance contracts). WNYICC primarily contracts with Medicare Advantage (MA) plans. Other payer contracts include Medicaid managed care organizations (MCOs), Medicaid long-term care plans, and commercial health insurance plans.

Service delivery model

WNYICC subcontracts service delivery to a network of CBOs. They use Welld Health, a centralized documentation system, to record services and bill health plans via submitted claims. CBO staff document services for their assigned clients using this system.

WNYICC's menu of service offerings has expanded over time to include Healthy IDEAS (a social isolation intervention), post-discharge meals delivery, medical nutrition therapy, a community health coaching program (CHC), a caregiver support program, and other evidence-based programs (i.e., National DPP lifestyle change program, DSMES, and Falls Prevention).

WNYICC uses a coaching model to provide CHC, Falls Prevention, and caregiver support services. When an individual is referred to WNYICC, a WNYICC-trained health coach is assigned to the member and conducts a SDOH screening. WNYICC coaches work with members for up to 12 months to address needs identified through the screening process and assist members in setting goals, linking to HRSN services (i.e., food, housing, transportation, community supports, SNAP), and coordinating their health care. The health coach then helps the member enroll in evidence-based community programs such as the National DPP lifestyle change program, Chronic Disease Self-Management Programs, Matter of Balance, Tai Chi, Enhance Fitness, Walk with Ease, Powerful Tools for Caregivers, and Exhale Caregiver Respite Programs.

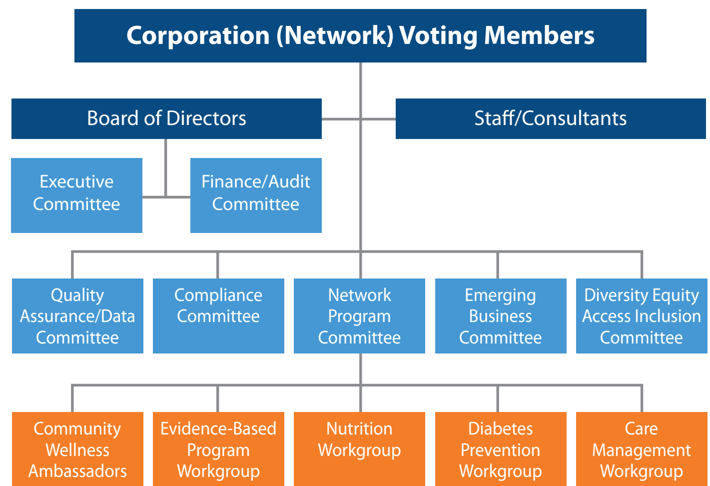
Governance model

WNYICC's governance model consists of a Board of Directors and six committees (Figure 1). The board includes 11 members from the hub's network partners (CBOs) serving 3-year terms and acting as committee chairs. The six committees focus on (1) finance and audits; (2) network programs; (3) compliance; (4) quality assurance and data; (5) diversity, equity, and inclusion (DEI); and (6) emerging business. The committees and Board of Directors guide the development and operations of the hub.

Role of National DPP lifestyle change program

The National DPP lifestyle change program created new contract opportunities for WNYICC. As a CDC-Plus Recognized National DPP program, all network partners deliver the National DPP lifestyle change program under WNYICC's DPRP code. CMS' requirement that Medicare Advantage (MA) plans provide the National DPP lifestyle change program (or MDPP) created a pathway for WNYICC to expand its contract portfolio. WNYICC serves as a centralized hub for MA plans, allowing them to contract with multiple MDPP suppliers. This created additional opportunities for WYNICC to work with these MA plans to promote coverage for other evidence-based programs.

Figure 1: WNYICC Organizational Chart



It is important to note that the MDPP and National DPP lifestyle change program do not alone support the financial sustainability of CCHs, requiring hubs like WNYICC to develop a diversified menu of service offerings to build financial sustainability. To support sustainability and promote the hub's offerings, WNYICC educates providers on the hub's programs and encourages referrals.

Community Integrated Network of Oregon (CINO)

Background and description

The Community Integrated Network of Oregon (CINO) is a network of diverse partners focused on building the statewide infrastructure to deliver and sustain evidence-based health education programs and interventions to all adults in Oregon. The goals of the network are to increase access to evidence-based health education and care navigation to address HRSN, implement closed-loop referral systems, and establish billing infrastructures. CINO is supported by two network lead organizations: Comagine Health and Oregon Wellness Network (OWN) (Figure 2). Early investments in CINO laid the foundation for the network, but its formal launch came with a 3-year (2021-2024) cooperative agreement from ACL. Other funding includes CDC 1705 and 2320 grants.

Comagine Health serves as the backbone entity for CINO, leading activities related to convening and coordinating network partners; providing technical assistance to support infrastructure development and quality improvement activities; consultant management; and administering the centralized data system. CINO's centralized data system streamlines data collection and enables network delivery partners to easily access reports for quality improvement, submission to CDC and other program licensing entities, and to support components of required claims documentation.

OWN is the network CCH and leads program delivery, billing and reimbursement, care navigation, and closed-loop referrals (Figure 3). To accomplish this body of work, Comagine Health and OWN have strong, supportive partnerships with key stakeholders across the state of Oregon (Figure 4).

Figure 2: Community Integrated Network of Oregon Operational Model

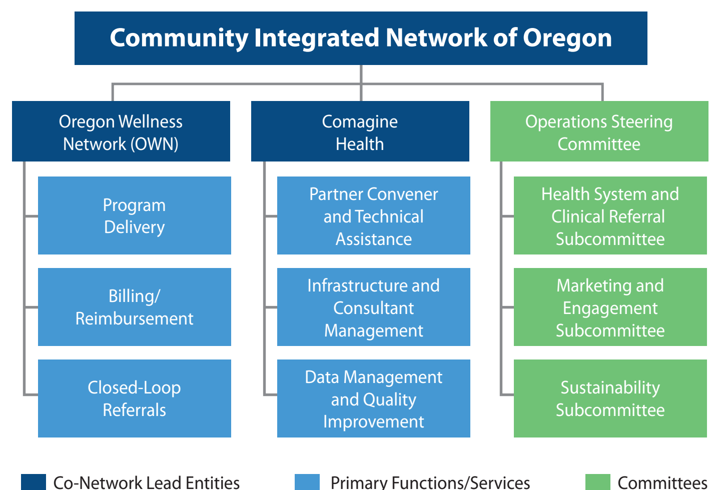


Figure 3: Oregon Wellness Network Hub Model

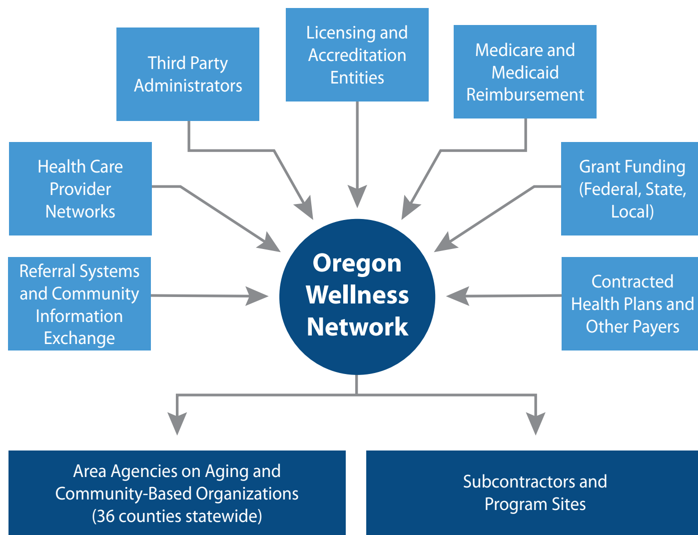


Figure 4: CINO Statewide Partnerships

- Oregon Health Authority (OHA; State Public Health Department and State Medicaid)
- Oregon Area Agencies on Aging
- Oregon's Health Information Exchange (Reliance eHealth Collaborative)
- Oregon State University Cooperative Extension
- Oregon Health & Science University
- CareOregon
- Oregon Primary Care Organization
- Oregon Medical Association
- Oregon Diabetes Prevention Alignment Workgroup (DPAW) comprised of organizations seeking to align efforts and resources around diabetes prevention in Oregon.

Service delivery model

OWN and Comagine Health have a history of working together to promote and deliver the National DPP lifestyle change program, MDPP, Diabetes Self-Management Training (DSMT), and Chronic Disease Self-Management Program. With the formalization of the statewide network CINO, OWN and Comagine Health continue to expand service offerings. Current evidence-based health education programs include Living Well with Chronic Conditions, Living Well with Diabetes (DSMP), Program de Manejo Personal de la Diabetes, Tomando Control de su Salud, the National DPP lifestyle change program, MDPP, and Walk with Ease.

Oregon's 1115 Medicaid waiver created a pathway for funding specific HRSN. Network partners are working to integrate the approved HRSN services into their offerings. CINO is also in the process of mapping the HRSN landscape in Oregon and exploring expanded partnerships that will be needed in the network.

To support the implementation of programs in new communities or by new delivery partners, CINO offers orientation and onboarding support to new program delivery coordinators and organizations. For organizations with existing infrastructure, program delivery support through CINO includes (1) centralized scheduling for programs across the state; (2) participant engagement, enrollment, and roster management; (3) facilitator, peer leader, and lifestyle coach training and certification; (4) advanced skills training for leaders and lifestyle coaches; (5) participation in communities of practice; (6) program licensure or recognition; (7) fidelity monitoring and quality assurance; and (8) direct contracting with coaches and leaders for program delivery.

Governance model

CINO's governance model consists of the CINO Operations Steering Committee and three collaborative subcommittees (Marketing and Engagement, Health System and Clinical Referrals, and Sustainability). The Steering Committee guides the development of CINO's business plan, activities critical to sustainability, and provides overall guidance on its strategies and activities. The three subcommittees focus on strategies and activities to increase enrollment, increase referrals from health care providers, establish billing infrastructures, and develop relationships with health plans and providers.

Role of National DPP lifestyle change program

The National DPP lifestyle change program is a Medicaid covered benefit in Oregon under the state's 1115 waiver. This policy opportunity positioned OWN to be able to contract with Medicaid coordinated care organizations (CCOs), which led to conversations about providing other evidence-based programs and services as a network hub to the CCOs' members.

Iowa Community HUB

Background and description

The Iowa Community HUB (HUB), established in 2020, is a statewide nonprofit CCH dedicated to reducing health disparities among priority populations through centralizing support for its partners and connecting Iowans to evidence-based programs. The HUB collaborates with partners to maximize resources and support community initiatives by:

- Strengthening clinic-to-community partnerships
- Building support for evidence-based programs
- Advancing navigation to community resources
- Operationalizing lived experience feedback

The HUB supports initiating, expanding, and sustaining health and wellness programs through centralizing and coordinating administrative functions on behalf of its CBO partners (Figure 5).

The HUB is working to add billing and contracting as a centralized administrative function to further enable CBO partners to focus on program delivery and relationship building. The HUB aims to expand its network and study the model's impact by collaborating with Iowa State University (ISU) as its translational research partner.

Funding for the HUB comes from various sources and is braided to maximize support for HUB efforts. Funding partners include:

- Initial contract support from NACDD for statewide program expansion of Walk with Ease (WWE) and the National DPP lifestyle change program
- CDC grants for WWE, Falls Prevention, and Arthritis (AAEBIs) in partnership with ISU
- Contracts with the Iowa Department of Health and Human Services through CDC 2320 and the Association of State and Territorial Health Officials (ASTHO)
- USAing Center of Excellence to Align Health and Social Care CCH grant
- Data Across Sectors of Health (DASH) Incubator
- ACL Falls Prevention grant with the University of Iowa

As of April 2024, contracts funded approximately 55% of the HUB's budget, with grants covering the remaining 45%.

Service delivery model

The HUB provides services through HUB Navigators that process referrals and work to enhance enrollment and retention in evidence-based programs. Navigators are trained CHWs.

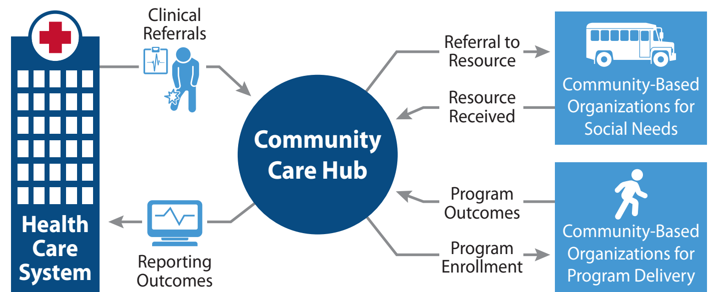
Once an individual is referred to the HUB, a navigator contacts the individual, screens for HRSN, enrolls the participant in the appropriate evidence-based programs (i.e., the National DPP lifestyle change program), and connects the participant to resources to address HRSN that may present as barriers to program participation (i.e., childcare, transportation, nutritious food) (Figure 6).

The HUB is partnering with a Medicaid MCO to pilot a payment approach that bundles the National DPP lifestyle change program with other social care services that address HRSN for Medicaid beneficiaries.

Figure 5: Iowa Community HUB Administrative Functions

- Management of referrals
- Bidirectional feedback with referral sources
- Screening for and addressing HRSN
- Program enrollment
- Program locator and marketing
- Fidelity and compliance
- Data management and security
- Reporting

Figure 6: Iowa Community HUB Referral Pathways

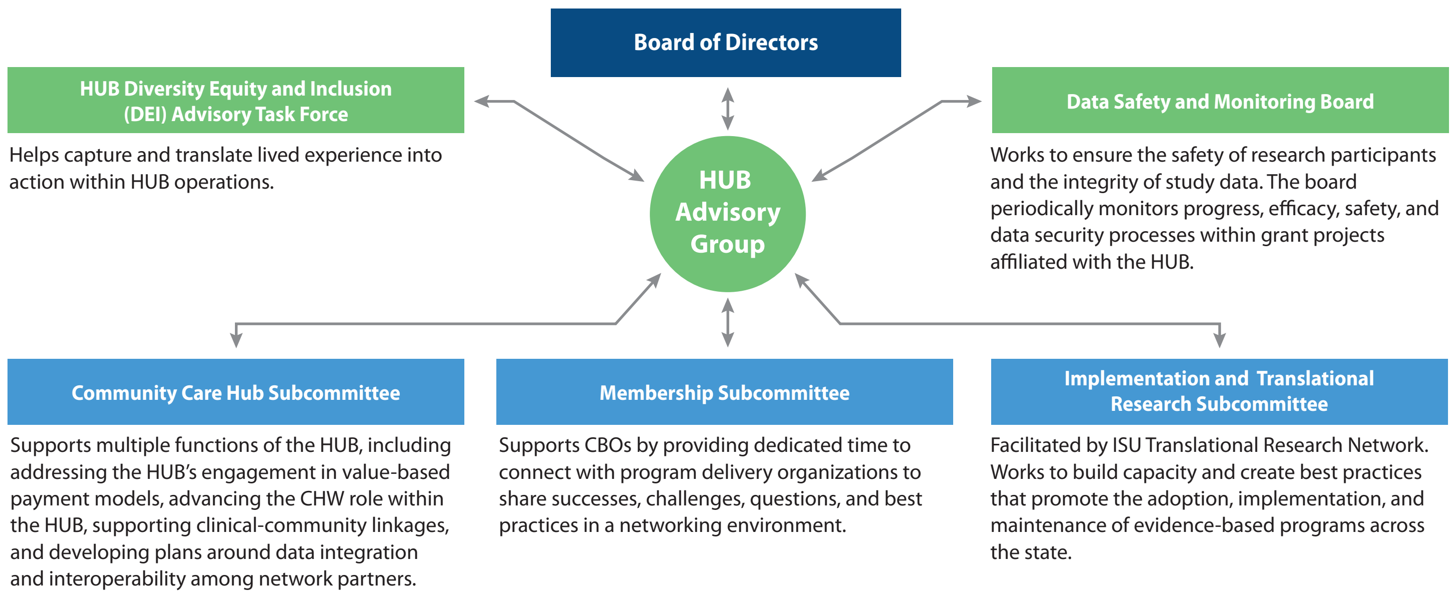


Governance model

The HUB governance model consists of an 85+ member HUB Advisory Group comprised of CBOs. Advisory Group members engage in a learning forum focused on the CCH model and work to advance the HUB's efforts statewide. The HUB Advisory Group includes three subcommittees, a Diversity, Equity, and Inclusion (DEI) Advisory Task Force, and a Data Safety and Monitoring Board (Figure 7).

The HUB Advisory Group's collaborative and participatory nature facilitates a welcoming environment for members to communicate openly about challenges, barriers, and successes in their work to bridge health and social care.

Figure 7: Iowa Community HUB Organizational Chart



Role of National DPP lifestyle change program

The HUB was established to support the delivery of all evidence-based programming. Through opportunities with NACDD, the HUB expanded to become an Umbrella Hub Organization as a strategy to facilitate access to sustainable funding to CBOs delivering the National DPP lifestyle change program and DSMES (more information on umbrella hub organizations and how CCHs differ from other CBO network approaches is in the Appendix). As of June 2024, the HUB has preliminary recognition status from DPRP, soon to achieve full recognition.

The Iowa Department of Health and Human Services contracts with the HUB to help support, expand, and sustain the National DPP lifestyle change program, DSMES, and the Chronic Disease Self-Management Program statewide. The contract includes HUB efforts to address program participants' HRSN, including coupling participation with monthly, home-delivered boxes of fresh produce.

How is a CCH Different from Other CBO Network Approaches?

CCHs are one approach to building a CBO network. Two other CBO network approaches are umbrella hub arrangements (UHA) and the partner network. While these models also provide an overarching infrastructure aimed at centralizing administrative and operational functions for a collective group of CBOs, there are some differences worth noting. For example, a key differentiating factor of CCHs when compared to UHAs and partner networks is their focus on supporting CBOs in the delivery of multiple evidence-based programs compared to the delivery of only the National DPP lifestyle change program.

It is important to note that an organization can participate in more than one CBO network approach. For example, Trellis serves as an umbrella hub organization to support organizations in delivering the National DPP lifestyle change program and is also recognized as a CCH providing a package of evidence-based programs and HRSN supports. The summary table below describes key components of CCHs, UHAs, and the partner network approach.

UHAs

UHAs connect CBOs with health care payment systems to pursue sustainable reimbursement for the National DPP lifestyle change program. Umbrella hub organizations (UHOs) administer and lead the arrangement. Startup funding for UHAs almost exclusively comes from CDC's Division of Diabetes Translation (DDT). Submitting claims, and subsequently receiving health insurance reimbursement, is a critical component to sustaining any UHA.

Benefits unique to UHAs include the following:

Operate as one Medicare Diabetes Prevention Program (MDPP) Supplier: In a UHA, the UHO is the MDPP enrolled supplier and subsidiary organizations do not separately enroll as MDPP suppliers.

Share CDC-Recognition Status: To join a UHA, each subsidiary organization must have pending, preliminary, or full recognition; however, while participating in the arrangement, all subsidiary organizations assume the recognition status of the UHO. This shared recognition allows subsidiary organizations to leverage the UHO's collective recognition status.

Streamline billing, claims, and administrative support: A key element of a UHA is a single billing and claims submission platform used by all subsidiary organizations.

Historically, the key differentiating factor of UHAs compared to CCHs and partner networks is UHAs solely focus on the National DPP lifestyle change program. However, some UHAs, such as the YMCA of Metropolitan Milwaukee, have subsequently become CCHs and begun to include other chronic disease programs in their network in addition to the National DPP lifestyle change program. The YMCA of Metropolitan Milwaukee's other chronic disease programs include blood pressure self-monitoring, group exercise for older adults, support for cancer survivors, falls prevention, and weight loss and management.

See the UHA Overview page of the Coverage Toolkit for more information on UHAs.

Partner Networks

A partner network is a group of organizations and representatives from different communities that team up to advance a common goal or vision. Partners leverage each other's expertise and reach to maximize their capacity and capabilities.

An example of a partner network in the context of type 2 diabetes prevention is the Bright Spot Initiative (BSI), which applies the principles of collective impact with the goal of dramatically increasing enrollment in the National DPP lifestyle change program. Collective impact is an engagement approach which consists of a multisectoral collaboration of organizations and community members that advance equity through shared learnings and integrated actions to achieve population and systems-level change. At its helm is a backbone organization that manages and coordinates the networks' efforts towards successful implementation of collective impact. Similar to CCHs and UHAs, partner networks advance health equity by centering health equity strategies in all their activities.

A key differentiating factor of partner networks when compared to CCHs and UHAs is the partner networks' efforts to leverage each partner's unique expertise and reach to **maximize their collective capacity to achieve the same agreed upon goal(s)** (as opposed to the lead organization supporting the needs and goals of individual partner organizations). Another key difference is that partner networks could be formed in any industry. See the Partner Networks page of the Coverage Toolkit for more information.

CCHs	UHAs	Partner Networks
• Consists of lead organization, CBOs, health care organizations (HCOs), and social service providers • Includes **multiple** evidence-based programs • Centralizes administrative and operational functions, including payer contracting and billing • Receives funding through multiple blended and braided funding streams, including payer reimbursement • Advances access to social services to resolve HRSN	• Consists of lead organization (UHO) and subsidiary partners, including CBOs • Focuses on the National DPP lifestyle change program • Allows the UHA to operate as a single MDPP supplier and share CDC-recognition status with subsidiaries • Centralizes administrative and operational functions, including payer contracting and billing • Pursues sustainability through payer reimbursement for subsidiary organizations, including CBOs • Advances health equity-related goals for National DPP UHA priority populations	• Consists of lead organization (backbone organization), CBOs, and HCOs • Focuses on organizations working together to achieve a common goal or vision • Convenes cross-sector partners, inclusive of diverse industries (employers, HCOs, CBOs) • Centers health equity strategies in all activities