Summary of Brainstorming Meetings on Community Hubs

JANUARY 2026

CONVERGENCE

TABLE OF CONTENTS

Background to meetings and their purpose.

The Convergence Brainstorming Meetings on Hubs grew out of an earlier ***Convergence Collaborative on Social Factors of Health***. Members of that Collaborative repeatedly discussed the concept of hubs as organizations playing a key role in helping to coordinate a range of health and social services to benefit households and communities. At the end of the Collaborative project, there was a desire among some members to dig more deeply into the concept of a hub, such as how to define hubs, clarify their functions, and build a network of hubs.

Convergence responded to this interest by gathering approximately 40 thought leaders and practitioners from communities, social service and support agencies, government, academia, and policy organizations for three brainstorming meetings on hubs.

[For a list of attendees of these brainstorming sessions, see Appendix.]

This report is a summary of the three meetings, including areas of agreement as well as topics on which there were sometimes strong differences of opinion. Unlike other Convergence projects, these meetings were not intended to produce a consensus. Rather, the purpose was to explore the concept of a hub, identify the lessons that emerge from the experience of different hub organizations, and to pinpoint issues that still need to be resolved. As such, this report is intended as a resource to encourage further discussion of the role of hubs in the community.

Program Funders

Convergence is grateful to the following funders who make this critical work possible.

CommonSpirit

The John A. Hartford Foundation

About Convergence

Convergence is the leading organization bridging divides to solve critical challenges through collaborative problem solving across ideological, political, and cultural lines. For more than a decade, Convergence has brought together leaders, doers, and experts to build trusting relationships, identify breakthrough solutions, and form unlikely alliances for constructive change on seemingly intractable issues. Our process is improving the lives of Americans and strengthening democracy for a more resilient and collaborative future.

THE QUESTION OF DEFINITION

At the outset of the first meeting, it became clear that there are significantly different views of what the term “hubs” encompasses. Indeed, arguably one of the most important outcomes was a shared recognition that the term “hub” encompasses a variety of models and functions. Understanding this, the feeling was that, going forward, being clear about these descriptions may mitigate confusion and promote more robust discussions about the future directions that hubs can take and the support they need to do so.

Specifically, while there was recognition that the term is, in practice, used loosely to describe a variety of institutions that facilitate bringing together a range of health, housing and other social services for individuals and families, several group members argued that the term most appropriately should be reserved for ***organizing models that generally do not provide services directly to people but instead provide “back-office” functions*** such as contracting, data systems and referrals, and compliance reporting, to networks of community-based organizations (CBOs) that actually deliver services. Some people use the term “backbone organization” for these institutions. In this way, a network of CBOs can work with a single manager of information, supplies, etc. In addition, individuals can gain access through the CBO network to both direct services and to referrals, other programs, and services. One example is Area Agencies on Aging (established under the Older Americans Act to help social service organizations serving older adults and adults with disabilities with planning, coordination, and more). Another is Community Care Hubs, a national model in which the hubs are coordinating and contracting organizations, incorporating financial and data services.

Other group members argued, however, that the back-office/service delivery distinction is not always so clear cut, since ***many sophisticated CBOs that directly provide a service also incorporate certain back-office functions*** that enable them to introduce additional services to the mix that they organize and make available to their clients and communities. Examples that combine some back-office functions with direct services would include certain Federally Qualified Health Centers and Community Schools.

EMERGING THEMES & EXAMPLES

AS THE CONVERSATION PROCEEDED, TWO THEMES BEGAN TO EMERGE.

1. A broadly held view was that the important point is to define "hubs" by ***what functions are provided***, with the focus being on the organizational back-office functions. Some such hubs do not directly provide services themselves butwork with networks of CBOs. Other hubs may be primarily service institutions that have developed at least some back-office skills and capacity that enable them (possibly with partners) to deliver a range of services.

2. The organizations and structures that might be referred to as "hubs," as well as the general use of the term, ***are evolving***. Ten years or so ago, a "hub" would sometimes be thought of as a neutral convener. Now, a community hub is also considered to be an organization that provides multiple administrative and support functions but may also deliver direct services to some people and communities. Ten years from now, other institutions may emerge that are referred to as hubs. The changing nature of institutions referred to as hubs caused some group members to push back against such ideas as accrediting hubs (see below).

EXAMPLES OF STRUCTURES WHICH PARTICIPANTS DESCRIBED AS FORMS OF HUB

Reflecting the discussion and debate among group members about what constitutes a hub and what versions should be supported, certain broad categories of hub emerged during the conversations.

Community Care Hubs.

The specific term "community care hub" emerged in the early 2020s as an institution to help link together and support CBOs that provide health and social services in communities. The model was developed by the Partnership to Align Social Care and **the federal** Administration for Community Living with the purpose of developing the infrastructure of contracting, evaluation, and other back-office services needed for a network of CBOs to deliver integrated and coordinated services to address the health and social needs of a community. USAging's Center for Excellence to Align Health and Social Care provides technical assistance, funding, and other support to strengthen and scale community care hubs.

SUMMARY OF THE DISCUSSIONS

A **Pathways Community HUB** (PCH) is another Community Care Hub model and is the central administrator of a network of local CBOs employing community health workers (CHWs) who provide community-based care coordination through the Pathways Community Hub Institute (PCHI) Model of home visiting that addresses all the social drivers of health. A PCH has a license from PCHI to utilize the Model and enters outcome-based contracts with payers. The PCH manages data and other operational needs for partner organizations. Importantly, there is only one PCH per region, and different types of nonprofit organizations, including community action agencies and health care associations, such as the Dayton Regional Pathways HUB in Ohio, can be PCHs, as long as they are not clinical providers or employ CHWs in their network, in order to maintain neutrality. Unlike some other forms of Community Care Hub, PCHs are more focused on health improvement by addressing health-related social needs and access to care. They also make extensive use of CHWs, use the outcome data generated to address community resource gaps, and contract with payment tied to outcomes, which are tracked through engagement and address risk factors tracked in a set of 21 standardized "pathways" to better health, such as housing stability, food security, and obtaining a medical home. Multiple PCHs may work together in a state to develop statewide networks.

State-sponsored and statewide hubs.

Some states have taken steps to identify organizations to function as "official" hubs in areas of the state. These hubs interact more closely with state departments, while working with networks of CBOs. For example, **legislation enacted in New Jersey in 2020 created four regional health hubs.** The **Camden Coalition** is one of the hubs. The Camden Coalition is a multisector, community-based organization focused on improving care for people with complex health and social needs in Camden and neighboring areas of New Jersey.

Similarly, the state of Maryland passed legislation in 1990 (revised in 2005) to create county-level organizations called **Local Management Boards.** While not called hubs, and consisting of a variety of nonprofit organizations and government bodies depending on the county, these Boards essentially function as hubs within each county. Some say the quasi-public nonprofit Maryland Local Management Boards function as "community quarterbacks," coordinating health and social services for children and families. For example, the **Family League of Baltimore** operates as Baltimore's Local Management Board. It contracts with CBOs, monitors performance, and provides technical assistance, but it does not provide services to families.

SUMMARY OF THE DISCUSSIONS

Some hubs have evolved into statewide or regional hubs. For example, the **Iowa Community Hub** started from scratch and differs from New Jersey's state-designated hubs in that legislation was not involved and **the hub covers the entire state.** The hub provides referral and navigation assistance for people needing health and social care. It also provides program coordination, technical support, compliance services, effectiveness research,and other services to CBOs and clinics throughout the state.

We see some hubs serving a statewide or even a multi-state area, yet they may or may not be state-sponsored. The Iowa Community Hub covers an entire state, but it is not a state-sponsored organization. Meanwhile, **Washington State's Accountable Communities of Health** was created by the state and undertakes some, but not other, services associated with hubs. The same is true of **North Carolina's Healthy Opportunity Pilots;** both of these state-created organizations were established under state Medicaid waivers.

Local CBOs and other service institutions expanding their services and back-office functions.

The definition of hub became even less distinct when looking at local organizations delivering a range of services in the community. While typically described as CBOs, some CBOs have developed internal management functions to enable them to deliver additional types of services, or to partner with other CBOs supplying these additional services. In so doing, they have established at least some of the back-office functions generally associated with the term "hub." Meanwhile, some other types of service institutions in communities that might typically be called CBOs, including health clinics, schools, and even some nursing homes and churches, have edged towards acting, at least to a degree, as hubs. The Camden Coalition is such an example. The organization began as a group of multidisciplinary and multisector care providers exploring ways to work together to improve care. It evolved into a hub as the coalition of service providers began working on multisector issues and improving collaboration.

Not all group members were comfortable with categorizing these CBOs and other local institutions with expanded functions as hubs, given that their primary focus is supplying services to community members. But some group members maintained that the core organizing and networking activities are consistent with the functions of a hub, and it is important to explore their potential. On the other hand, several group members argued that few such organizations have the skills and capacity to carry out the core hub function of networking and supporting CBOs to achieve shared goals. Nevertheless, during the three convenings and in other discussions, group members talked through these issues, and there was openness to the idea of examining the potential of such local forms of hub and piloting models.

SUMMARY OF THE DISCUSSIONS

Example: Repurposing underutilized hospitals and nursing homes. For example, Sisters of Charity Health System in Cleveland is converting a hospital into a "**health and healing hub**" to address Central Neighborhood's health and social challenges. The plan has been to close the organization's acute care hospital and pivot to a "hub and spoke" range of service providers that address such needs as behavioral health, meals, educational and family supports, and other services. In essence, it could be viewed as almost a condominium network of service providers, with the Sisters of Charity Foundation as the organizational enterprise responsible for financial and planning management.

In another meeting, group members reviewed examples of transforming underutilized hospital buildings into community-centric "healthy villages" that integrate town planning and community health. These villages often include long-term care facilities, addressing the needs of aging populations in underserved areas.

Meanwhile, there was discussion of some financially challenged or underutilized nursing homes utilizing their space differently, expanding their activities and range of services to become service hubs in their community. Some group members were skeptical that many nursing homes had the potential to develop extensive back-office functions to manage a range of service supply functions, but others saw possibility in repurposing some nursing homes as the hub and spoke of services for older adults in a community.

Example: FQHCs as hubs. Federally Qualified Health Centers (FQHCs) were another example examined by the group as service hubs that might, in the future, play a more prominent role as service network coordinators,while also providing back-office services to partner organizations. FQHCs receive some federal support and have flexibility to address community needs. While several group members pointed out that federal budget uncertainties, Medicaid changes, and other constraints mean few FQHCs currently are looking at expanding their functions, some more sophisticated FQHCs have been developing hub-like functions.

For example, **Mary's Center** is a multi-facility FQHC in the District of Columbia and bordering Maryland counties that services each year over 65,000 patients, most of who receive Medicaid or are uninsured.1 But Mary's Center also provides social services to families, and, in four sites, is collocated with a D.C. public charter school that provides both pre-school and adult education services. Moreover, Mary's Center handles human resources services and shares data management for the school. It also maintains approximately one hundred partnerships with other institutions in the community, including immigration law firms and housing organizations. It has many of the coordination and back-office **functions of a hub**, while its main focus is delivering integrated health and social services.

SUMMARY OF THE DISCUSSIONS

Note: Several group members noted a difference between these examples and a Community Care Hub: a CCH organizes groups that serve the community, or, in other words, employs a network approach. The FQHCexamples, they said, are mainly individual organizations adding new services and partnerships. The goal is similar: a form of one-stop shopping. However, a CCH primarily utilizes existing resources more effectively, rather than adding services.

Regardless of the hub form and function, group members identified several common challenges: workforce, data systems, proving value, and sustainable funding.

Workforce Issues

Group members emphasized the importance of recruiting the appropriate workforce for hub functions, recognizing that coordination and support roles require specific skills. In cases where a hub institution directly provides services, members emphasized the importance of staff who know the community, can command local trust, and work smoothly with service partners and government departments. As one group member put it, they not only have to win the trust of the community, but they also need to have sufficient status to "have their calls returned" by different agencies. Many group members with a focus on service hubs **saw community health workers as the primarystaff for community-based care coordination**, although others argued for being open-minded about using other professionals, e.g., social workers, as core staff in this form of hub.

Those group members viewing hubs as coordinating and supporting networks of CBOs delivering services generally saw staff needs differently. For them, the reason for creating a hub is for CBOs delivering services to have professionals with administrative and support service expertise, such as marketing, data management, sales, contract management, and funding/revenue management. They argued that bringing that expertise together and sharing it through the hub is a major source of value these hubs deliver. Thus, when service hubs attempt to expand their range of services and networking functions, they need to add staff with these skill sets – often finding that the full cost of such staff cannot be included in the funding on which they rely.

In general, group members felt that hub functions and needed staff skills are not well recognized and financed through existing social service and health programs and that the cost of coordination needs to be accepted as an integral part of funding by government and philanthropy. Some argued that the need for proper training and professional development for such workers should be recognized in federal and state programs.

SUMMARY OF THE DISCUSSIONS

Data, evaluation, and technology needs

Group members discussed the importance of data and data systems for a) effective and coordinated operations, including referrals, financial management, tracking care coordination and client progress, needs, and outcomes, and b) the evaluation of hub performance.

Several group members emphasized that these data needs often limit the potential of smaller organizations to carry out their functions and make the case for funding their hub activities, whether as local multiple service coordinators hubs or as more sophisticated community care hubs focused on administrative support and coordination. Group members emphasized the importance of recognizing and investing in data systems. They also raised the challenge of ensuring the access of service organizations to common client data systems, while assuring appropriate privacy and data protection.

In addition, they pointed out a common dilemma: many large health systems either develop their own proprietary data management systems or contract with a supplier of data services to manage referrals and other activity when dealing with networks of CBOs. That means CBOs working with several health systems must often navigate several data departments that may have very different requirements.

Return on Investment. The challenge of measuring effectiveness of all forms of "hub" was raised in every meeting. The shortcomings or inadequacies of data collection capacity and analysis – especially in smaller administrative and service hubs – was a particular area of concern. But another concern often raised was even more fundamental: the task of identifying the system-wide impact of an intervention and hence deriving the full "social return on investment" as an indication of impact. Many participants said funders need clarity on the value of collaborating and funding hubs before making commitments, but the full value-added is difficult, or perhaps impossible, to measure. They added that technical weaknesses in methods of measuring impact may in some cases account for lackluster evaluations and highlight the need for investments in better evaluation tools.

Financing and sustainability

Participants often returned during the discussions to the challenges of financing and sustaining all forms of hub. Several pointed to progress in funding, however. It was noted, for instance, that in addition to funding support, the federal government's Administration for Community Living is engaged with the Centers for Medicare and Medicaid Innovation (CMMI) in exploring better ways to recognize hub functions and developing scaling strategies. The CMMI **Accountable Health Communities demonstration** included funding for hub support, which enabled several hubs to be launched – with several now supported by states. In addition, agencies are helping with efforts to align the roles of philanthropy, federal agencies and states, and programs like the Older Americans Act, to strengthen hub infrastructure.

SUMMARY OF THE DISCUSSIONS

Despite such developments, many participants expressed concern that both private and public payment systems do not appropriately recognize the value of coordination and shortchange workforce and infrastructure costs that would improve outcomes. Still, some have been able to use TANF and other funds to help build hubs.

Several group members also emphasized the importance of federal (chiefly Medicaid) and state waivers, and pilots, in fostering experiments with forms of hub, and called for greater use of these tools. Others described experimentsin which trusted brokers raise investor bonds for defined populations and outcomes as stimulating interest in funding hubs as tools. The important role of philanthropy in supporting hubs was also noted.

UNRESOLVED QUESTIONS

SOME IMPORTANT UNRESOLVED QUESTIONS

The three brainstorming sessions indicated strong and broad agreement on the importance of hubs as key organizations to achieve the coordination of health and social services that influence household and community health. The sessions also revealed, as might be expected, disagreements on what one might call the “engineering” aspects of hubs, such as the appropriate workforce, financing, etc.; these disagreements likely can be resolved through experimentation/evaluation and developing and testing new models. Some areas of disagreement on hub engineering involved differences of vision and general approach, and three were discussed often during the meetings.

How broad should the definition (and related functions) be for an entity to be a hub? Do we need only one definition?

There were strong views, but no consensus over one definition. Group members generally agreed, however, that, to avoid confusion, it is important to emphasize the difference between the service delivery functions and administrative/coordination functions in anything referred to as a “hub” and that these different functions require different skills and capacities.

UNRESOLVED QUESTIONS

Should a hub, especially a network manager form of hub, have exclusive jurisdiction in a geographic area, or can/should hubs compete?

There remained differences of opinion over whether hubs should be awarded some form of exclusivity to serve a geographic area. For those group members who were more open to hubs as service providers, or who felt hubs are an evolving institution, there was a greater desire to allow different organizations to offer hub services in an area to spur innovation. Meanwhile, within such states as New Jersey and Maryland, an official designation includes geographic exclusivity. And some hub models, such as the Pathways Community Hub Institute (PCHI) system of hubs, only certifies one organization to be a PCHI hub in a defined service area, usually defined by county or region. A PCHI hub must be connected to the community it serves; it may not be statewide.

Several group members also emphasized the importance of federal (chiefly Medicaid) and state waivers, and pilots, in fostering experiments with forms of hub, and called for greater use of these tools. Others described experimentsin which trusted brokers raise investor bonds for defined populations and outcomes as stimulating interest in funding hubs as tools. The important role of philanthropy in supporting hubs was also noted.

Should a hub, especially a network manager form of hub, have exclusive jurisdiction in a geographic area, or can/should hubs compete?

Government or private/philanthropic sector financing of hubs would be easier to arrange, if there were official standards of competency and capacity in certain key functional areas. Funders currently require information about capacities in defining who qualifies for support as a hub.

Some group members worried about accreditations as requirements to qualify for public or private financing. They argued that hubs are still at a relatively early state and models are evolving, and, thus, setting clear standards now would likely slow or freeze innovation. They felt that, with so much innovation happening, and so many versions of “hub” being explored, it would be premature to use one vision of a hub to set standards and requirements for funding.

That said, some group members declared that they have been seeing a merging of definitions over the last few years. For example, Pathway Hubs and Umbrella Hubs are types of hubs that fall under the broader Community Care Hub model, with both becoming either USAging/COE grantees or active participants in learning collaboratives. This merging of definitions, it was said, has been occurring over the last few years and appears to be accelerating.

CONCLUDING OBSERVATIONS

CONCLUDING OBSERVATIONS BY CONVERGENCE PROJECT DIRECTORS CARYN HEDERMAN AND STUART BUTLER

The role of trusted institutions in communities proved to be an important element of the discussions during the 2024 ***Convergence Collaborative on Social Factors of Health*****.** In particular, it was agreed that institutions involved in coordinating a range of services to address social factors of health – generally referred to as "hubs" – play a critical and essential role in improving community and household health. Thus, it was agreed during the project that public policy must, among other things, recognize the importance ofhubs, help strengthen them, and foster the evolution of these institutions. However, it also became clear that perceptions of what hubs are and could (or should) be differedsignificantly among Collaborative members.

The purpose of our work in 2025 was to delve further into the notion of a hub. The aim was not to resolve competing visions of hubs, but to identify different existing models, as well as to explore the issues and questions that will need to be resolved for hubs to reach their potential to help improve health in their communities. To do this, we sought to bring together experts and practitioners who likely would disagree on several points but would work together constructively to achieve the project's objective.

This publication summarizes the highlights of the three discussion sessions we held on hubs.

As Project Directors for this project and having served similar roles in other Convergence health and wellbeing projects, we would like to add three observations which we feel may enhance the prospects for hubs to evolve in important ways. **NOTE: These are our views and not those of project participants.**

- Information technology infrastructure, including integrated artificial intelligence and readily adaptable cloud computing, is quickly improving the ability of organizations to coordinate services and client referrals. In a sister Convergence project on data sharing, evaluation, and innovation, Unlocking American Health through Social Factors, teams shared their (Republican and Democratic) states' fast-paced efforts to develop innovative integrated data systems to link departments and clients. In our view, this trend likely will accelerate the evolution of community hubs.

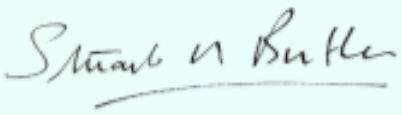
- The role of trusted institutions in communities proved to be an important element of the discussions during the 2024 Convergence Collaborative on Social Factors of Health. In particular, it was agreed that institutions involved in coordinating a range of services to address social factors of health – generally referred to as "hubs" – play a critical and essential role in improving community and household health. Thus, it was agreed during the project that public policy must, among other things, recognize the importance ofhubs, help strengthen them, and foster the evolution of these institutions. However, it also became clear that perceptions of what hubs are and could (or should) be differedsignificantly among Collaborative members.

CONCLUDING OBSERVATIONS

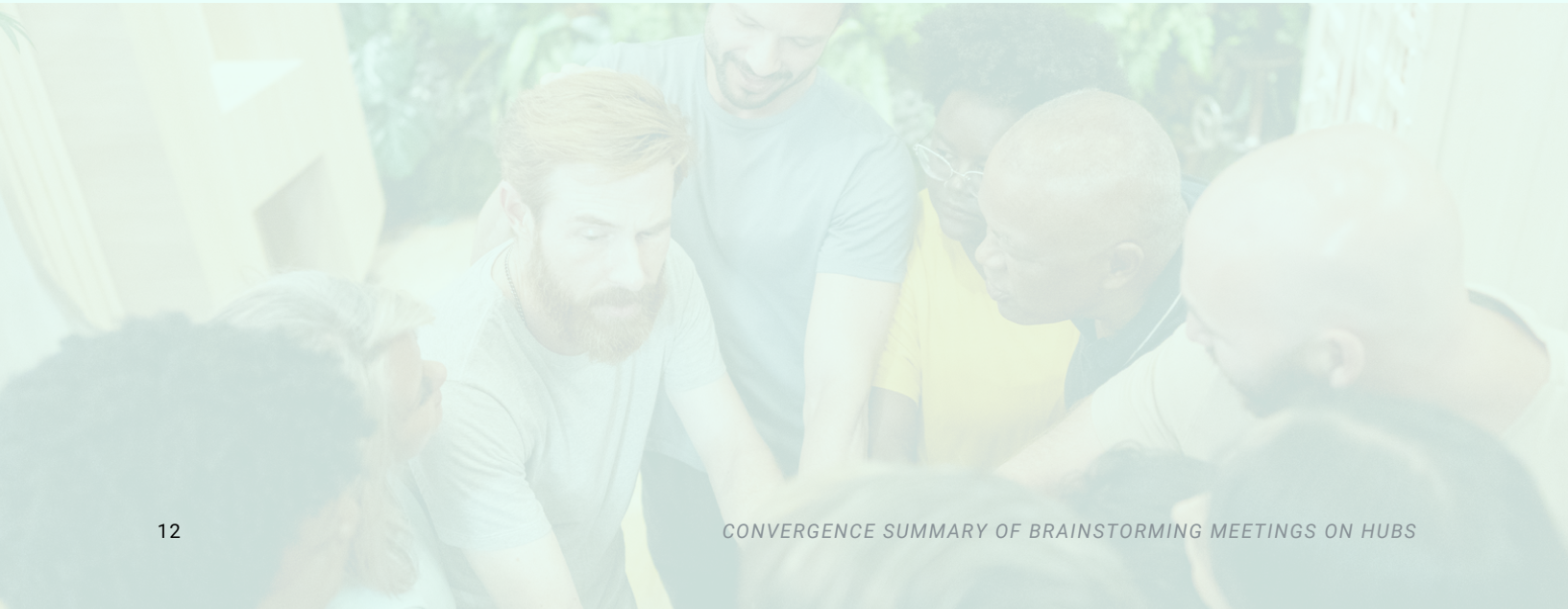
Significant demographic trends, including the aging of America, will increase pressure on communities, local institutions, and government to explore new forms of housing arrangements and new ways to coordinate and deliver health and social services. These patterns also seem likely to influence the future role and nature of community hubs. ***In our view, American demographic trends will spur further exploration of means for local service organizations to coordinate health and social services and the formation of regional hubs and support networks of local organizations to deliver services.***

There have certainly been many recent changes in federal activities and funding for efforts to integrate social factors into health strategies. Building upon federal actions, including Medicaid 1115 waivers, previous federal grants to establish hubs and other innovations, new federal funding for rural health transformation and workforce development, and partnerships with the private sector, states are creating forward momentum, despite growing financial pressures. ***In our view, there will continue to be fertile ground for the ideas, strategies, and proposals discussed in this Convergence project.***

Stuart M Butler PhD, Project Co-Director



Caryn Hederman JD, Project Co-Director



APPENDIX

The following individuals took part in one or more of the Convergence discussions on hubs. **NOTE: Inclusion in this list of participants does not mean an individual agreed with any particular observation in this summary. Participants also took part as individuals, and thus project summary points do not necessarily represent the position of their organization.**

Christina Bastida
United Way of San Joaquin County

Kristen Birtwhistle
United Way of San Joaquin County

Will Bleser
HHS Administration for Community Living

Amanda Brewster
University of California Berkeley

Pam Brown
Anne Arundel County (MD) Partnership for Children, Youth & Families

Paul Cantrell
US Aging Center of Excellence to Align Health and Social Care

Jane Carmody
The John A. Hartford Foundation

Tracy Carver
Project Access Now

Julia Chevan
National Association of Chronic Disease Directors

Paul Chapman
Restore Hope

Brian Corbin
Catholic Charities USA

Kelly Cronin
HHS Administration for Community Living

Aanya Datta
NYC Department for the Aging

Adam Davis
OneHealthPort

Ansley Fiorito
John A. Hartford Foundation

Wendy Fox-Grage
National Academy for State Health Policy

Brian Frank
Oregon Health & Science University

Molly French
USAging

Michael Goar
Sisters of Charity Health System

Lauran Hardin
HC2 Strategies

Ji Im
CommonSpirit Health

Arhima Jacobs
WholeYouNYC

Ruth Katz
Association of Jewish Aging Services

APPENDIX

Dara Koppelman
formerly Mary's Center

Nancy Lim
Catholic Health Association of the United States

Marcella Maguire
Corporation for Supportive Housing

Ben Money
National Association of Comm Health Clinics

Anne Montgomery
Health Analyst

Len Nichols
Urban Institute

Kathleen Noonan
Camden Coalition

Sue Polis
Lutheran Services in America

Dr. Sarah Redding
Pathways Community HUB Institute

Trina Radske-Suchan
Iowa Community Care HUB

Jan Ruma
PCHI Pathways

Marisa Scala-Foley
USAging

Alexandra Schweitzer
Harvard Business School

Meghan Shineman
NYC Department for the Aging

Anna Spencer
Center for Health Care Strategies

Ipyana Spencer
Meals on Wheels America

Nalani Tarrant
National Association of Comm Health Clinics

Aileen Tinney
Keswick Nursing Home

Kathy Vesley
BayAging

Sandra Wilkniss
National Academy for State Health Policy

Mary Wiemann
Aging & In-Home Services of Northeast Indiana, Inc.

Connie Wolfe
Aging & In-Home Services of Northeast Indiana, Inc.

Ben Wortham
Catholic Charities USA

Sunia Zaterman
Council of Large Public Housing Authorities

Convergence Center for Policy Resolution
1775 Eye Street NW, Suite 1150-287
Washington, DC 20006

(202) 830-2310
ConvergencePolicy.org
@ConvergenceCtr

CONVERGENCE