Resource Guide

Voices From the Field: Insights on Coordinating Health and Community Care in Rural, Frontier and Tribal Communities

A resource guide from USAging's Aging and Disability Business Institute and Center of Excellence to Align Health and Social Care

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Executive Summary

Health care delivery is most effective when coordinated with community care. It is estimated that 80 percent of health care costs come from unaddressed social needs, impacting upstream drivers of health.[i] **Upstream drivers of health** encompass the social, environmental and economic factors that tie back to a person's ability to maintain their health and well-being. These factors include financial stability, access to healthy food, affordable and stable housing and utilities, readily available health care services and accessible transportation.[ii]

In rural, frontier and Tribal communities in the United States, services that address upstream drivers can be scarce. While almost 20 percent of people live in a rural community, 80 percent of rural America is medically underserved. Rural communities typically lack access to things like primary care, experience high rates of poverty and have a higher population of older adults when compared to urban areas.[iii] As of 2024, 75 million people live in a primary care health professional shortage area, maldistributed in rural counties.[iv] Frontier and remote areas often experience limited access to health care services, with a notably high proportion of older adults living in these regions. Geographic isolation obstructs both health care access and social service delivery.[v]

With a large percentage of the population in rural areas being over the age of 65, there is an increased need for organizations that serve older adults to coordinate health and social care.[vi] However, health and social systems are often disconnected in these communities, and according to a recent poll, 60 percent of individuals think their communities need more health and social supports for older adults to remain living independently.[vii] To analyze this dichotomy, in early 2025, USAging conducted a study to assess the needs of rural, frontier and Tribal communities in linking health and community care. In this study, USAging found that:

- Coordination between health and social care in rural areas is often limited however, but community-based organizations (CBOs) are working to establish and build relationships with rural health care partners.
- CBOs in rural areas experience barriers related to capacity, funding, technology and data sharing.

Contracting with health partners through a community care hub (CCH) provides many benefits for communities and health care providers, including, but not limited to, better coordinated care, enhanced service delivery and improved quality.

- CBOs and health partners in rural areas are jointly serving Tribal populations; however, partnerships between Tribal organizations and other health and social care systems are still developing through trust and relationship building. Each Tribal population varies in history, culture, values, geographic spread, practices and utilization of available funding. Education and coordination are needed in this area.
- CBOs and health partners in rural, frontier and Tribal areas need continued training and technical assistance to support contract development, business acumen and sharing of best practices and would value support with implementation of these resources.

Project Background

Since 2013, USAging's Aging and Disability Business Institute (Business Institute) has collected and disseminated information, resources and tools to Area Agencies on Aging (AAAs) and other CBOs to enhance organizational capacity, improve the connection between CBOs and health care entities and support CBOs in effectively contracting with health care providers and payers. USAging maintains a database of resources, case studies, research and assessment tools. Through the Business Institute, USAging has identified numerous initiatives to connect health and social care in rural communities; however, we found that nationally, little has been done to assess, address and support the unique needs of fully integrating health and social care with rural, frontier and Tribal populations up until this point. Starting in 2023, USAging launched the Center of Excellence to Align Health and Social Care (COE), with funding from the U.S. Administration for Community Living, which works to

develop, expand, connect and support sustainable, high-functioning aging and disability CCHs—and the networks of downstream providers that they lead—throughout the country through infrastructure funding and technical assistance. The COE identified leaders in this field, and **75 percent of the CCHs that received infrastructure funding reported that at least part of their service area is considered rural.**[viii] Through these various efforts, USAging aims to provide AAAs and other CBOs and networks with new, focused information and resources to engage local leaders and address the needs of older adults and caregivers in rural areas.

75%

of the CCHs that received infrastructure funding reported that at least part of their service area is considered rural.

CBO health care contracting networks are increasingly led, organized and supported by CCHs, which provide an administrative and operational infrastructure to support member CBOs and serve as what the U.S. Department of Health and Human Services calls the **"connective tissue"** within communities to provide contractual linking between health, public health and social care organizations for enhanced access to services for individuals, families and caregivers.[ix] Some CCHs are stand-alone entities, but a majority of CCHs are affiliated with another organization, including AAAs. CBOs that make up the networks of CCHs include Aging and Disability Resource Centers, Centers for Independent Living, faith-based organizations, public health partners, veteran service organizations, food and nutrition providers, transportation providers, housing providers, Tribal partners and more. These organizations are trusted, local providers of care that address upstream drivers of health by delivering services such as meals, transportation, care management, assessment for social services, evidence-based programs and services, and many more.

Community Care Hubs[x]

Improving health through efficient coordination of services and supports

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The Business Institute's *CBO–Health Care Contracting Survey* showed that between 2017 and 2023 the proportion of CBOs contracting with health care payers and providers increased from 38 percent in 2017 to 47 percent in 2023. Additionally, the proportion of contracting CBOs that reported contracting as part of a network of CBOs doubled from 20 percent to almost 40 percent. Many of these are statewide or multi-state networks, encompassing rural, urban and suburban areas alike.[xi] **However, only 31 percent of AAAs in rural areas are contracting, compared to 56 percent in non-rural areas.**[xii]

Percentage of Rural vs. Non-Rural AAAs Contracting

56%
of AAAs in non-rural areas are contracting

31%
of AAAs in rural areas are contracting

In 2025, USAging conducted a series of key informant interviews of CBOs and health partners that operate in rural geographies to gain a better understanding of health care contracting in rural areas. In the interviews, USAging sought to discover the general needs that rural CBOs have for supporting health care contracting. USAging also assessed the overall health care landscape in rural communities and if CCHs were being utilized in rural and frontier geographies. During the interview process, USAging's COE released a National Map of CCHs that represents how CCHs are distributed and provides parties with an interactive tool to find and connect with CCHs across the country.[xiii] The overall purpose of the key informant interviews was to connect with local leaders and gain a better understanding of efforts underway to link health and social care in rural, frontier and Tribal areas.

Methodology

Interview Details

A total of 44 individuals representing 24 rural and Tribal organizations were interviewed as part of the key informant study. USAging's Business Institute and COE identified key informants based on their experiences serving rural and Tribal areas and providing services through contracts with health care and through CCHs.

Interviews were semi-structured, and key informants were provided with a list of questions before the interview, which served as a guide throughout the discussion. The guide included open-ended questions asking organizations about the area they serve; the health landscape in their region; contracting efforts; participation in CCHs; and information about the benefits, challenges and needs experienced with contracting in their areas. The interviews were conducted virtually and took place between January 2025 and April 2025.

The interviews were analyzed using Dedoose Software, allowing researchers to code interview transcripts and identify themes and relevant quotes. Researchers coded more than 24 hours of transcripts and identified 516 codes related to the three major areas of interest, including **Benefits** (180), **Challenges** (166) and **Needs** (170).

Key Informants

Key informants represented a variety of CBOs serving in rural and Tribal areas across 20 states. The states that were interviewed span eight of the nine U.S. Census Bureau divisions, encompassing a diverse array of geographic and demographic areas across the country. The organizations included AAAs (half of key informants), stand-alone CCHs, public health departments, agencies that serve individuals with disabilities, clinically integrated networks and agencies that represent or serve Tribal members. One-third of the organizations indicated that they coordinate with Tribal organizations.

The majority (54 percent) organizations that participated in the interviews are leading a CCH, meaning they already run or play a significant role in a CCH in their service area, while another 29 percent are pursuing a CCH, meaning they are actively working on setting up a CCH in their service area. Eight percent of organizations are participating in a CCH as a provider or advisor, and another eight percent are not interested in or able to participate in a CCH currently due to funding, staffing and capacity constraints.

A further breakdown of rurality showed that key informants classified their service area as predominantly rural (29 percent) or rural (29 percent), with the remaining 42 percent stating they served a semi-rural area. Those serving a semi-rural area often described a situation in which they have one county or town with a higher population, but this area is surrounded by rural or geographically isolated areas. More than half (58 percent) provide services with regional coverage (from three to 32 counties), with another 38 percent providing statewide coverage. One organization provided services across multiple states.

What We Learned

Rural Resiliency

Regardless of where they serve, CBOs face challenges in their efforts to ensure that both the health and social needs of their communities are being met in a coordinated, efficient and effective way. These challenges are only exacerbated for organizations serving in rural, frontier and Tribal areas. The circumstances these organizations face demand an elevated level of resiliency, and they are continuously showing that they meet this demand by finding creative and effective ways to serve individuals through new partnerships, unique delivery models, as well as practical organizational changes. The leaders of these organizations understand the additional challenges they face but also have a deep respect for the value and benefits of living and serving in rural and Tribal areas. As one key informant stated,

> “You know it because we live here and we serve here. What happens in our community is near and dear to our hearts. And so we’ve cultivated a department that doesn’t take no for an answer. I mean, we’re ‘yes’ people.”

In describing the rural and Tribal areas they serve, organizations shared the challenges they face, including a lack of transportation, traveling long distances for work or to see clients, lack of stable internet and modes of communication, lack of housing for clients and providers, high unemployment rates, staffing issues, reliance on multiple funding streams for operations, identifying ways to serve inter- or multi-generational populations, language barriers, health literacy concerns, and serving low-income and uninsured communities and clients. The 2025 AAA survey shows that rural AAAs have about 53 percent less staff than non-rural AAAs. On average, AAAs in rural areas operate with a budget that is approximately $12.1 million less than those in non-rural areas. Organizations shared stories of traveling two or three hours to visit one client, coordinating transportation for a client to see their specialty care doctor that is across state borders and, even far more concerning issues, including a lack of access to clean drinking water.

Organizations noted a shared sense of community and respect for their rural areas.

On the other hand, serving in rural areas comes with unique advantages and opportunities. Organizations noted a **shared sense of community and respect** for their rural areas, which leads to better partnerships with other local organizations, as well as better service delivery because they are trusted by those they serve. In speaking about forming strong partnerships, one key informant shared,

> "And they just seem more collaboration oriented, for whatever reason; I'm from a rural county, and I feel sometimes I'm like, yes, because we're just friendlier. But… that's a thing I've noticed…it seems like there's just a greater willingness to partner potentially because there's less resources. And they don't have any other choice."

In addition to the challenges of serving in rural areas, these organizations are also faced with an ever-changing and unpredictable health care landscape. Nearly all organizations spoke to a lack of access to primary care physicians, specialty care, critical care and long-term-care options.

> "It's not uncommon for someone to have to drive more than an hour one way to go to see their primary physician within our area. And that's just primary. That's not specialty. You're driving to the [city], if you're lucky."

This is just one of several comments made by key informants regarding the struggle to access care locally.

They also spoke of a shortage of health and social care providers, noting a lack of housing and desire or incentive to stay in a rural area. As one key informant shared,

> "... they were unable to get providers to come in, because there was no place for them to live, and so they wound up... taking the office space...and turn[ing] it into temporary housing for providers... And oftentimes the providers that come in are folks that have committed to serving in rural communities for a period of time. I think to offset some of the costs, maybe, of their student loans or whatever. And as soon as that time is up, they're out… so you can't maintain that good relationship, that long-term relationship, with providers."

Additionally, they face local or rural hospitals closing or being absorbed by larger (urban-based) health systems that often do not have the same understanding of the needs of the rural area.

> "I know some of the rural hospitals; there's been a lot of struggling areas. There's been some that have closed. Some have merged with other systems in those more metropolitan areas to try to support the rural centers. But that's certainly an area of dwindling access."

AAAs and other CBOs are often faced with addressing the downstream impact that comes with a shifting health care landscape. They are the organizations that are called upon to help coordinate transportation to doctor and specialty appointments and address the social needs of individuals to reduce the reliance on unnecessary trips to the emergency department or other emergency services.

Despite the challenges of rural service areas and unpredictable health care landscapes, AAAs and other CBOs have found ways to successfully provide programming to their communities and clients. They have become experts in forming unique or unlikely partnerships, expanding the services they provide and the populations they serve, and finding ways to blend and braid funding sources. One organization shared their partnership with the local fire departments to address falls prevention programming with individuals who were frequently calling the fire department to conduct lifts. Another organization spoke of launching their own in-home primary care practice to address the shortage of access to care in their rural area. They have hired staff, including a nurse practitioner, to address the barriers older adults are experiencing with accessing their primary care physician. Some organizations that were previously only serving older adults in home and community-based settings have expanded their services and populations, such as serving youth or incarcerated populations, to continue to meet community needs.

CBOs in rural and Tribal communities **rarely take "no" for an answer.** They find solutions every day to continue to serve the people in their own communities. As one key informant stated,

> "We're doing the work on a smaller scale here in our rural community. Just because it's the right thing to do, regardless of what it's called. And so I think for us, we're used to being nimble and flexible and taking time, like knowing that some of this progress just takes time."

Tribal Coordination

Compounding the barriers to coordinating health and social care for older American Indian and Alaska Native (AI/AN) populations are centuries of societal stigma and prejudice in institutional structures and policies. However, certain high-impact interventions are being delivered in these areas, through Tribal partnerships, that are not found elsewhere. Although most AI/ANs reside in non-rural areas, the proportion of AI/ANs who are age 50+ living in rural communities and/or Tribal lands is growing.[xiv] In key informant interviews, researchers collected needs, barriers and innovations that were unique to organizations that serve AI/AN elders. There is a wide variation in health care, social services and cultural traditions. One key informant shared,

> "[Tribal members] are very proud people, very resilient and innovative in the way they find solutions for their problems…

Navigating federal recognition, trust and treaty obligations, and the Indian Health Service (IHS) are common themes that key informants discussed. There are some health and social services that are available for Tribal members only, such as services provided at local clinics. Many of these clinics also offer services not traditionally seen in similar community health centers, such as dental care and housing services and supports. Publicly funded services, including programs offered under Medicaid and IHS, are underused because of the barriers to enrolling in these programs and the lack of availability of services. According to USAging's *2023 Title VI Native American Aging Program Survey,* approximately 13 percent of Title VI programs are currently billing Medicaid either directly or in partnership with IHS or Tribal clinics.[xv]

Overcoming these barriers for generations has created innovative and interwoven solutions. Medical care, social care, behavioral health, and long-term care are all offered under the same roof in many Tribal communities. This holistic approach limits gaps between health and social care. Unlike many health systems that rely on short-term planning cycles, Tribal communities build on Indigenous knowledge, lived experience and cultural traditions that have been sustained across generations. Drawing on the guidance of Elders, the Tribal Health approach naturally integrates the social, environmental and spiritual factors that support overall health and wellness of their members.[xvi] There is also growing coordination with Older Americans Act (OAA) services and programs. In the latest Title VI survey, 72 percent of respondents shared that the Title VI program and the AAA coordinate in one or more ways. A key informant shared,

> "When you talk with Tribes, we think of seven generations back and seven generations forward. Imagine how much value that brings to the table? Imagine how much that value brings to the health care dollar. And guess what? We've been outperforming managed care organizations, publicly traded organizations for years because of the way we've had to deal with the funding, and they've taken care of the people. The people have been resilient. They're still here, you know."

Data sovereignty and external coordination were common challenges that key informants shared. One key informant mentioned,

> "It almost could be a full-time job just cultivating [Tribal] relationships"

proving the complicated nature of building partnerships between health and social care with organizations that jointly serve AI/AN elders. Another key informant shared, "That whole data piece can also be somewhat of a barrier, because Tribal communities would like to keep their own data"

Federally recognized Tribes often face significant barriers to accessing timely public health data held by state and federal systems, limiting their ability to track outcomes and coordinate care. As sovereign territories, Tribal communities struggle with getting access to data to track health outcomes and better coordinate care; some delays last over one year, according to recent reports.[xvii]

To close these gaps, key informants recommended focusing on relationship building, fostering trust between CBOs and health care providers to assist with the full integration of health and social care in Tribal communities. One key informant said,

> "Autonomy is obviously the principle that you need to engage with Tribal groups. Effective partnerships must be grounded in respect for Tribal sovereignty and self-determination. And so, when it's clear that what we're bringing forward is not something that is going to align with their values, I'm not the kind of person to keep pushing it. Instead, I will leave them with the resources, the information, and then let them know we want to partner with them, regardless of this particular thing when we have an opportunity, where it aligns more closely with their priorities."

This drives home the importance of recognizing, uplifting and educating organizations on the needs of AI/AN populations to improve access.

Benefits

A majority (35 percent) of key informants shared the benefits of linking health and social care for the community they serve. Since AAAs and other CBOs work to address conditions and environments that people live in, a wide variety of benefits can be garnered from contracting with health partners. AAAs and other CBOs are very well-equipped to deploy preventive and chronic condition management services and supports that address upstream drivers of health. Twenty-three percent of key informants said that coordination of health and social care was the most significant benefit of health care contracting and network development. By linking individuals to social care from a clinical setting, CBOs address upstream drivers of health, providing more person-centered, whole-person care. One key informant stated,

> "We've kept the clients at the front and center of everything we do around these changes, and how we can leverage our strengths together to really build capacity for the future. This is a long-term solution, not just a flash in the pan, so it will take time, and there will be huge benefits to our communities and the people we serve, especially in rural spaces. As access to care gets a little tougher, if we can help to connect the dots with the health care systems through different means, we'll do better by our clients."

Benefits to the Community

By working with a CCH, key informants felt that they could offer better coordinated care, enhanced health system delivery and improved quality of services and supports to the population they serve. Seventeen percent of key informants discussed these benefits. Many described that by working with a CCH, CBOs can do what is best for the shared clients they serve in coordination with health partners. Contracting through a CCH also provides cost savings to the health providers. This return on investment comes from addressing health system pain points. Rural CBOs are an excellent place for health providers to focus on risk stratification, or identifying and targeting high-risk individuals in rural, frontier and Tribal communities, allowing them to receive care that they would not otherwise

be aware of. Risk stratification can also provide significant cost savings to health providers. CCHs offer a centralized point for the streamlined evaluation of CBOs in their network. By working with a CCH, CBOs can measure and track outcomes, allowing for better consistency of service delivery across CBOs and improved performance over time. Key informants described working with a CCH as a "one-stop shop" for CBOs and health partners, providing a single point of contact for closed-loop referrals and contract deliverables. One key informant described this concept:

> "For health care, a one-stop shop or an 'easy button' philosophy is a benefit."

Benefits to CBOs

A significant benefit that was highlighted in key informant interviews is that the CCH model can offer rural CBOs increased reach, additional funding sources and administrative support with building health care partnerships. Seventeen percent of key informants discussed the benefits to small rural CBOs. CCHs provide CBOs with additional geographic reach by coordinating and collaborating with other CBOs to increase the territory where participating organizations can provide services. By working with a CCH, rural CBOs can expand the population that health partners serve, such as reaching **remote or geographically isolated individuals.** Health care partnerships also benefit rural CBOs by diversifying the types of services they provide, such as expanding the age of the population they serve. A key informant shared,

> "[The CCH] doesn't have geographic restrictions like some of our partners do. So we're able to bring those dollars to areas that are in need that may not have been eligible before because of geographic restrictions. We're also able to serve a variety of different areas and do different programming because of that as well."

Rural CBOs typically have a low number of incoming referrals, so working with a CCH can help overcome the barrier of limited referral flow to their individual agency by facilitating expanded reach. Nine percent of key informants shared that CCHs introduce rural CBOs to new lines of business and additional revenue sources, diversifying funding streams and decreasing reliance on limited, traditional funding sources, increasing the sustainability of their organization.

CCHs provide CBOs with shared administrative functions, which support rural CBOs with enhanced negotiation power, shared legal expertise, centralized data collection processes, ongoing training and technical assistance, and shared purchasing. CBOs can benefit from significant cost savings when working through a CCH for shared purchasing of things, such as technology, supplies, systems and sharing staff. CCHs can assist CBOs with building relationships with health care partners, finding champions and facilitating the culture change that needs to take place to execute a health care contract, which are things that rural CBOs report they do not have the time or resources to do. One of the key informants said,

> "There's strength in numbers. There are opportunities where, if you're a standalone agency, you might not be able to apply, because if you don't cover the whole region, you're not able to contract with that health plan."

Challenges

Many key informants (32 percent) shared challenges and barriers that they face in forming and maintaining health and social partnerships and in service delivery in rural areas. CCHs, CBOs and health partners experience challenges with establishing and building relationships and many are limited by federal, state or local restrictions.

Service Delivery Challenges

Capacity was the primary challenge that key informants discussed. Seven percent of key informants shared this as a challenge, and 23 percent of those key informants believe capacity is the biggest challenge they face with health and social care integration in rural, frontier and Tribal communities. Most of the key informants discussed the lack of available staff among CBOs and health partners in rural communities. This was described by one key informant, who said,

> “Not everyone appreciates nor gravitates to a rural lifestyle… I think that’s part of the challenge, is getting workforce to work in communities. These are typically communities that have a different belief and value or political leaning than maybe urban areas. And so I think that’s why I don’t think, I know that’s also a challenge, as is, you know… There isn’t a lot of childcare. There’s not a lot of housing.”

Challenges With Network Formation and Development

When it comes to getting involved in a CCH, key informants described that they struggle with committing time, staff and resources to a project without financial investment. Many CBOs shared that building relationships with health partners takes a lot of staff time and effort that is typically unpaid or provided through in-kind support. Agencies only begin to break even when the partnership starts to bring in additional revenue, offsetting the initial investment in building a CCH. The work that goes into building or participating in a CCH includes setting up the appropriate technology necessary for data sharing and billing services, setting rates, analyzing service packages and collecting outcomes data to prove the value of CBO services. One key informant described the initial investment, saying,

> “Everyone thinks it’s a good idea in practice. But then getting over the hump to actually being in operation has been a challenge because we get our health care partners on board and interested, and then something happens, like there’s a shakeup in leadership, or there’s a big grant that gets ended, or something that just kind of forces us to. By the time we’ve lined up the money to do it, the partners have changed. We’ve got the partners in place, and then the money changes, and so that’s why we’ve gone the route we’ve gone, where we’re not relying on a contract with a health care partner to fund it.”

Challenges With Coordinating Health and Community Care

Thirteen percent of key informants shared barriers they face with technology, information exchange, billing, coding and proving value. Key informants appreciate the ability to bill Medicare for social care under the Physician Fee Schedule, but the uptake of these codes among health and social providers is very limited in rural areas. According to the *2025 National AAA Survey,* 96 percent of rural AAAs said they do not provide Medicare Fee-For-Service benefits. Only one percent of AAAs are providing Community Health Integration services under the Medicare Physician Fee Schedule. The software needed to exchange health and social care data and engage in these billing codes is very expensive and requires a lot of research and expertise, which is unattainable for small local CBOs to invest in. One key informant said,

> “What we’re finding is that each agency may be using up to four to five different software systems, and there are huge interoperability issues. There are variances between the agencies, although we’re doing the same work.”

Overall, CBOs face significant challenges setting up bidirectional information exchange with health partners, and when data sharing is taking place, rural CBOs report needing to document in multiple platforms. In the *2023 CBO-Health Care Contracting Survey,* approximately 17 percent of CBOs that are contracting say that the “willingness of health care partners to share data” continues to be a challenge.

Social health referral platforms are being adopted widely but are being used as a workaround for closed-loop referrals. One key informant shared,

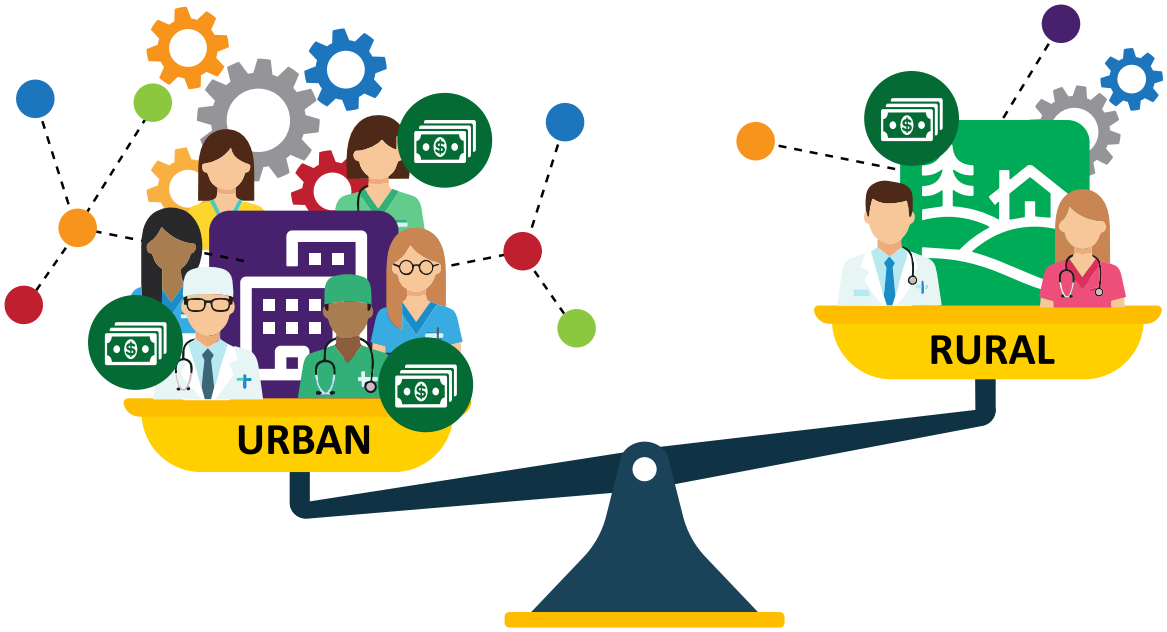
> “I think…this approach to episodic referral-based payment is just way too volatile for a community that’s on the edge.”

CBOs are not yet seeing benefits from these systems. Some rural health providers are using less sophisticated systems for referrals and commonly send referrals to CBOs through fax. Very few organizations were connected to a health information exchange. As a result of the challenges with sharing data, CBOs lack information that shows the outcomes of delivering social care and proves the business case for contracting and network development. One of the key informants stated,

> “It’s more difficult to continue to get data out of the health system. So you know, now, we’re a couple of years past that data. And we still want to be able to say, ‘Okay, and we’ve had this much greater impact or that.’ It continues to show over time. This isn’t just a blip, and accessing that data is very challenging.”

Key informants shared that they experience various levels of resistance to coordinating health and social care in rural areas. Due to many **health care partners operating out of urban centers,** rural providers find it harder to develop a value proposition for contracting and network development that resonates with health care leadership. For instance, one key informant said,

> [Local health providers] are all tied to bigger hospital systems that are in the city. So that's where it's a referral to go to the city for the specialist.



Rural CBOs must work very hard to get a seat at the table, but rural health care partners are not adopting social care collaboration, despite existing incentives to do so; they need more significant support. Rural areas typically receive lower rates due to population and cost-of-living estimates from federal programs being lower than their urban counterparts. One key informant shared,

> We're such a small agency on aging. I have less than 20 employees, and I'll tell you, over half of them are in my transit department, so as far as administering the Older Americans Act and the state program... there's eight of us. That's it.

Smaller aging organizations rely on federal funding as their primary source of revenue, outside of health care contracts. According to the *2025 National AAA Survey,* 30 percent of AAAs report that OAA is 51 percent or more of their total budget. This makes negotiating a reasonable price to deliver social care in clinical settings complex for both CBOs and health partners.

Lastly, five percent of key informants shared that they cannot engage in health care contracts because of external forces. Some organizations shared that the interpretation of the OAA guidance limits health care contracting in their state. In some areas, CBOs are not included in managed care efforts at the state level, limiting partnerships. As of 2025, 56 percent of AAAs are government based (i.e., part of a city or county government or a council of governments/regional planning and development agency). A few organizations shared that being a government-based CBO can make it harder to participate in health care contracts.

Needs

To overcome the challenges and bolster the benefits, 33 percent of key informants shared the needs they have in health care contracting and network development. Key informants would like to see continued training and technical assistance to support things like contract development, business acumen and sharing of best practices, but would like assistance with the implementation of these resources. Many CBOs shared that they do not have the staff, capacity or funding to commit to this work. They would like to see ongoing support from USAging and other national partners with things like infrastructure, standards development and communications. CBOs want to see continued federal support for CCH development efforts and additional funding for infrastructure development projects, such as the COE. A key informant stated this succinctly and said,

> “If I could bring aboard any resource, it would be someone who knows us, who could go out and sell these contracts. I do it right now. I’ve got some good team members that help out with the management of all of that. I’m so busy, it’s so hard to find the time. But you need somebody with expertise in this line of business. We’ve advertised in the past. We haven’t been able to find anyone, or we did find one or two people, but we couldn’t afford it.”

Key informants shared that they like having a centralized, accessible place for resources, training, technical assistance, peer-to-peer learning and sharing of best practices. CBOs need to be aware of federal updates and have opportunities to interpret and understand the impact on their organization but need support with data collection and claims data to describe the value that their network can bring to health care partnerships.

Since rural communities are tight-knit, key informants would like support with ensuring that local, community-based efforts are leading the charge. Rural CBOs understand the history and culture of their communities better than external organizations and need assistance with describing this value to potential partners.

Resources Requested

Most key informants described funding as a need, and 17 percent felt it is the most pressing need they have. A key informant stated, “I think capacity and funding. There are a lot of competing priorities right now… I think those are some of the big things and barriers to this work.” CCHs need support navigating multiple funding streams and understanding how to maximize the limited funding available to support CCH development. Many would like to see more grants and pilot opportunities to kickstart health and social care partnerships.

CCHs appreciate having a place to learn from each other and need an outlet for shared learning, networking and collaborative learning. A large part is sharing how various organizations are setting up technology infrastructure across networks. Fourteen percent of key informants felt technology is their most significant need. CCHs need support with documentation, workflows, information exchange, selecting the right platforms and electronic referral management. This was highlighted by a key informant who said,

> “If you talk to any CCH, the things, resources that you need are…an integrated or a centralized data system that will integrate with health care so that you can have that bidirectional communication. You need to be able to document all the different services, whether it’s your evidence-based classes, or it’s more clinical billing like diabetes self-management or medical nutrition therapy.”

Resources and Next Steps

Suggestions Based on Interview Findings

Understanding the needs described by key informants helped to identify a variety of resources that will serve to support rural and Tribal organizations in developing relationships, coordinating services and contracting with health care organizations serving in rural areas and areas impacted by an ever-shifting health care landscape. These resources include:

- Capacity support
- Funding
- Technical assistance
- Resource libraries
- Learning collaboratives
- Affinity groups
- Standards development
- Data collection
- Storytelling resources
- Technology support

USAging's Business Institute and COE are committed to providing ongoing support to organizations in this work by developing ready-to-use tools and guides and providing mechanisms for peer-to-peer learning for rural organizations and partners. One key informant summarized the sentiment,

> "Anything that we can do to help rural America, sign us up for it, because folks do not understand that there is a disconnect. Folks do not understand the reality of service delivery in rural America, and how hard it is, and how much more it costs…"

Where to Find Existing and Future Resources

- **Aging and Disability Business Institute**
- **Center of Excellence to Align Health and Social Care**
- **Partnership to Align Community Care**
- **U.S. Administration for Community Living**
  - **Advancing Partnerships to Align Health Care and Human Services**
  - **Services for Native Americans (OAA Title VI)**

USAging

Leaders in Aging Well at Home

About USAging

USAging is the national association representing and supporting the network of Area Agencies on Aging and advocating for the Title VI Native American Aging Programs. Our members help older adults, people with disabilities and family caregivers throughout the United States live with optimal health, well-being, independence and dignity in their homes and communities. For more information, visit the **USAging website** and follow @theUSAging on Facebook, X and Instagram.

Aging and Disability BUSINESS INSTITUTE

Connecting Communities and Health Care

About the Aging and Disability Business Institute

The mission of the Aging and Disability Business Institute (Business Institute) is to build and strengthen partnerships and contracting between Area Agencies on Aging, aging and disability community-based organizations (CBOs), community care hubs (CCHs) and their networks, and health care entities. Led by USAging, the Business Institute helps these organizations adapt to a changing health care environment and strengthen their organizational capacity to capitalize on emerging opportunities for sustainable funding. The Business Institute is home to the Center of Excellence to Align Health and Social Care, which funds and supports CCHs and the networks they lead.

Learn more at the **Aging and Disability Business Institute website**.

CENTER OF Excellence

to Align Health and Social Care

About Center of Excellence to Align Health and Social Care

The Center of Excellence to Align Health and Social Care (COE), part of the Aging and Disability Business Institute at USAging, is supported by the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) through a cooperative agreement totaling approximately $12 million over a three-year period with 100 percent funding by ACL/HHS.

The purpose of the COE is to develop, expand, connect and support sustainable, high functioning aging and disability community care hubs (CCHs) – and the networks of downstream providers that they lead – throughout the country through infrastructure funding and technical assistance.

The contents of this [article/report/resource guide/webinar] are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, ACL/HHS or the U.S. Government.

Learn more at the **Center for Excellence website**.

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Endnotes

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