Community Care Hub Shared Services Strategy and Implementation Resource

Background

Community care hubs (CCHs) that are operating an advanced community care network may consider scaling through a shared services strategy, as similar infrastructure is required across the network to successfully contract and partner with healthcare. Conversely, CCHs not meeting that definitionhttps://acl.gov/sites/default/files/Prize competitions/cch-core-functions-acl.docx or that have not assessed a healthcare market need for scaling should not yet proceed with shared services.[1]

That said, if a CCH operating an advanced community network has a market need and is ready, shared services allow the CCH to leverage a shared resource or function (e.g., information technology platforms, billing systems) across multiple established networks, which may lower the total cost of administration for each organization. The goal is not for the CCH to fill gaps or weaknesses through new partners, but rather to strengthen and extend the full range of competencies and functions to the entire network. While called "shared services," they are not direct person-facing services; they are shared or centralized infrastructure that:

- leverage economies of scale to reduce operational costs, enhance organizational effectiveness, and improve outcomes and quality of services,
- improve the scalability of community-based services across a community-based organization (CBO) network, and
- facilitate the integration of health and community care in partnership with healthcare organizations.

[1] **It is important that CCHs only pursue a shared services strategy if they are already operating as an advanced community care network—and have conducted a market assessment of service demand and determined that scaling and shared services are appropriate.** Please see ACL's resource, "Required Community Care Hub Functions and Infrastructure for an Advanced Community Care Network" for more information, but a high-level summary is that the CCH, at a minimum:

- Serves a large geographic area with reach that can be regional, statewide, or multistate
- Maintains the capacity to serve large volumes of people across its networks
- Provides a diverse set of community-based services to advance health and well-being
- Maintains a robust infrastructure that supports scaling resources and services while reducing operational costs
- Demonstrates high performance through strong technology and data systems that enable impact measurement and outcomes reporting

The following is a list of services commonly obtained as a shared service (not exhaustive):

- **Business and technology** functions and infrastructure
  - Information technology
  - Revenue cycle management services
  - Credentialing with health plans
  - Contracting support services, including for value-based contracting
  - Population health management
  - Regulatory compliance and data security
  - Direct services/staff augmentation, cross-agency coverage, and shared operations expertise (IT support, financial management, marketing, contract management, legal, etc.)[2]
- **Data, performance, and impact** functions and infrastructure
  - Processes and procedures to increase standardization and incorporate shared learning into best practices
  - Consumer satisfaction survey and analysis
  - CCH/CBO performance management
- **Network management** functions and infrastructure
  - Workforce training, development, and mentorship infrastructure
  - Technical assistance to support CBO service delivery

These anonymized real-world examples show different CCH approaches to share services:

- One CCH negotiated for a group of CCHs in different states to use an integrated electronic medical record, revenue cycle management, and patient engagement platform.
- One CCH established a shared long-term services and supports (LTSS) case management technology platform that enabled all AAAs in their state to enter direct contracts with a Managed LTSS plan for fully-delegated case management services.
- Multiple CCHs utilize a federated model, where AAAs across a geographic area or state create an administrative affiliation or partnership to collectively address the needs of a healthcare contract. Often, one of the more advanced organizations in the group serves as the CCH lead, performing most CCH functions, and determining how to delegate other functions and services. But generally, the group leverages existing operational expertise and capacity within and across the participating AAAs (e.g., one participating AAA may have strong billing and account management capabilities, proprietary software, or other data management and analysis capabilities that could be leveraged by other AAAs). One of the CCHs using this federated model has a statewide shared care management documentation system for the AAAs, helping to streamline service coordination across all health plans, manage beneficiary records, and house assessment data.

[2] CCHs should carefully consider whether to "build" or "buy," and preferably leverage existing expertise within the network before deciding to bring new expertise in-house to the CCH.

Key Concepts for Shared Services Strategy Planning and Implementation

There are many functions that could be shared—and different arrangements for sharing them. Sharing across organizations can be complex, so the adoption of shared services should follow a thoughtful process to prioritize and launch them. CCHs might consider the following seven key concepts in planning for and implementing shared services, either directly performing these steps or hiring outside help to assist.

SHARED SERVICES STRATEGY PLANNING PHASE

1. Conduct a systematic needs assessment

Survey and interview CCH leadership, AAAs, CBOs, and other key partners or subnetworks (e.g., Meals on Wheels providers) that make up the advanced community care network to identify pain points, gaps, and priorities. Identify which administrative burdens consume the most time and resources. This is a recurring process but is especially important before considering a shared services approach.

Data-driven analysis to understand market opportunity and inform approach.

- Review revenue cycle metrics (healthcare contracts, payment denial rates, days in accounts receivable, collection rates) across CCH(s) and network partners
- Analyze quality measure performance gaps, including those used in healthcare (e.g., HEDIS measures), but also those important to CCH and CBO quality
- Assess payer mix and contract performance across CCH(s) and network partners
- Identify patterns in staffing turnover, operational inefficiencies, and technology gaps

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2. Segment new network-based partners by need and capacity

New network-based partners, such as new CCHs or AAAs not in the advanced CCHs' existing network, have different needs. Segmenting allows the CCH to consider tiered service packages rather than a one-size-fits-all shared service model. Segment by:

- **Size of network-based partners**, like other CCHs or AAAs (e.g., segment by network members, geography, population actively receiving services, etc.)
- **Specialty** (e.g., segment by nutrition services, housing navigation, dementia care services, chronic disease self-management, preventive health programs such as the Diabetes Prevention Program, etc.)
- **Maturity of the partner organization** (segment by well-established vs newly-formed)
- **Technology readiness** (e.g., segment by information technology adoption, electronic medical record adoption, data capabilities, population health analytics, etc.)
- **Payer mix** (e.g., segment by Medicare, Medicaid, Medicaid Managed Care Organizations, Medicare Advantage, dual-eligible special needs plans, value-based contracts, etc.)

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3. Build a governance structure[3] that includes representation from members included in the shared services strategy, potentially including new network-based partners

- Establish a CCH Advisory Committee or CCH Operations Committee to guide shared service development/customization
- Create feedback loops so CCHs can continuously report on service effectiveness
- Ensure governance represents diverse CCH types and sizes

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4. Prioritize shared services using a value framework

Evaluate potential shared services against two axes:

Impact on CCH operations

- Does the shared service meaningfully reduce administrative burden?
- Does the shared service increase revenue or reduce costs?
- Does the shared service improve quality outcomes or patient experience?

Scalability potential

- Can the shared service be standardized across multiple network-based partners?
- Does the shared service become more cost-effective as volume grows?
- Does the shared service support the CCH to achieve value-based care goals?

High impact and highly-scalable services should be prioritized first, especially those with a population health management lens and that align with value-based contract metrics. Once priority shared services have been identified, start with the functions that have the highest return-on-investment and lowest complexity to implement (e.g., those that require minimal workflow disruption). Services that may be more likely to fit this rating include:

- Shared revenue cycle management platforms
- Shared electronic medical records
- Centralized credentialing
- Risk stratification tools and shared data analytics that identify high-need persons across all network-based partners and identify cost drivers and utilization patterns
- Care coordination staff augmentation or implementation of IT technology tools to help network-based partners manage chronic disease populations or expand the volume of people served
- Shared quality reporting infrastructure that helps network-based partners hit HEDIS measures / Star rating improvement targets
- Preventive care outreach (re-calls, gaps in care alerts) to increase patient engagement
- Telehealth infrastructure to extend capacity without adding physical space
- Dashboard attribution and panel management support so CCHs can identify and monitor clients at a population level
- Patient engagement platforms that support adherence and follow-up (such as a patient portal)

[3] Read about Effective Governance for Community Care Hubs for additional information on CCH governance, committee charters, bylaws, legal and contracting structures, etc.

5. Design for scalability from the start

Standardize workflows

- Develop standardized operating procedures for each shared service (for example, for shared infrastructure related to falls prevention, the development of a standard STEADI algorithm implementation process that is embedded in a shared service electronic medical record system used by network-based partners)
- Use common templates, forms, and reporting frameworks across network-based partners
- Avoid custom one-off solutions that are difficult to scale. An anonymized real-world example is one CBO's custom IT solution for a project with a health plan to provide case management for people with a substance-use disorder. The IT solution was hard configured to the specifications defined by the particular health plan, which made it difficult to scale outside of that plan and contract.

Invest in technology infrastructure[4]

- Implement a centralized data platform that aggregates clinical and financial data across network-based partners
- Use cloud-based, interoperable tools that can onboard new network-based partners
- Prioritize medical health record integration to reduce manual data entry and errors
- Take stock of what technology infrastructure already exists in the network and among new network partners and consider existing infrastructure when making decisions about new technology infrastructure to facilitate shared services
- Develop a plan for how to integrate new technology across a CBO network and with healthcare partner health IT applications, as necessary

Build a scalable staffing model

- Hire staff roles aimed at serving multiple CCHs or partner organizations (e.g., evidence-based program trainers and implementation staff/coaches, personnel conducting fidelity assessment and quality assurance across multiple implementation sites)[5]
- Cross-train staff to provide consistent coverage and service levels across service lines and network partners. For example, Medicare Diabetes Prevention Program lifestyle coaches and other evidence-based program leaders can be cross-trained as community health workers to enable staff to also provide Medicare's Community Health Integration services.
- Work with the network to collaboratively develop parameters for shared staff around revenue sharing, service areas, caseloads, credentialing, supervision, etc., to allow shared staff to work across geographies, network organizations, and contracts

[4] When possible, CCHs should avoid investing in or using technology solutions that are proprietary to a particular health partner or contract, as this impedes use of the investment in other scenarios (and thus, scaling). Ideally, technology infrastructure should allow integration of data from other partners, and partners should have secure access to those data. One way to facilitate this is ensuring that the CCH, its CBOs, and other partners adopt HITECH-certified technology.
[5] CCHs should carefully consider whether to "build" or "buy," and preferably leverage existing expertise within the network before deciding to bring new expertise in-house to the CCH.

6. Measure, iterate, and report back to member CCHs

- Define key performance indicators for each shared service (e.g., claims submission volume, denial rate reduction, credentialing turnaround time, quality score improvement)
- Publish quarterly performance scorecards at both the individual implementation partner level and the group level
- Use data to show network-based partners the tangible return-on-investment of shared services
- Continuously retire underperforming services and invest in high-value ones

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7. Develop a formal onboarding process for new network-based partners

As the group of participating network-based partners grows, a repeatable onboarding process ensures consistency by:

- Standardizing network-based partner assessment upon joining
- Phasing service activation based on organizational readiness
- Dedicating onboarding support staff or coordinators
- Using clear service level agreements for each shared service