LIFTING THE VEIL: HOW NETWORKS FORM, OPERATE, STRUGGLE, AND SUCCEED

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EXECUTIVE SUMMARY

Organizational networks have become an increasingly prominent approach to the provision of services for complex, multi-dimensional needs such as behavioral and mental health needs, HIV/AIDS, substance use disorders, and services for people who are unhoused. This model is also taking hold among community-based organizations (CBOs) seeking to work with each other and to contract with health care entities to improve coordination, reduce fragmentation, and increase the efficacious integration of health and social support services for older adults and people with disabilities. There are very few studies that document how networks form, operate, and succeed in these cross-sectoral collaborations. This qualitative study was designed to fill that gap.

Interviews with 23 representatives of 8 distinct CBO networks (including network hubs and network members) yielded the following major findings:

1. The formation of CBO networks for contracting with health care entity partners is an evolving and expanding approach. The perceived values of a network include the opportunity to collaborate, to build a more integrated system, to centralize administrative functions, and to better serve clients. Networks emerge in response to context-based opportunity, necessity, or both.

2. The level of formality in network roles, relationships, and governance structure varies, sometimes related to the newness of the network and the legal structure of the network hub.

3. A very common challenge for networks is the efficiency, functionality, and accessibility of the data ecosystem. Many networks build their data infrastructure on existing systems used by the CBO members and/or the network hub, which does not always map well to the needs of the entire network (health care entity, hub, and members).

4. Important tips for network success emerged from this study, including the need for value propositions and cost-benefit analyses for the network hub and members; the importance of transparency and accountability in all network operations such as referral volume and process, and contract negotiations; and the need for data systems that create data channels that are efficient and accessible for all organizational participants.

The rich information shared by the participants in this study also pointed to best practices and to technical assistance and resource needs that require further study and action.

BACKGROUND

Over the last decade, networks of community-based organizations (CBOs) have emerged in response to the changing landscape of integrated care and the changing relationships between CBOs and health care entities (HCEs). The primary purpose of these networks is to negotiate, implement, and manage contracts between health care entities and multiple CBOs that coordinate and provide social care to support positive health and quality of life outcomes for clients. Networks are typically comprised of multiple CBOs with a central organization (the network hub) providing administrative functions and operational infrastructure. Networks are gaining traction as a strategic and collaborative means to improve care integration and to better meet social needs for clients. Network-level contracting introduces greater efficiency and broader reach–both geographically and population-wise–than can typically be accomplished by individual CBOs. The growing role of networks in effective and efficient community-based, multi-sector health systems is receiving attention from funders, from health care entities, and in the health services literature. Due to this attention, there has been increased investment in supporting CBO networks. As the Administration for Community Living (ACL) states, "ACL's emphasis has evolved from improving the business practices of individual CBOs to supporting the development – and enhancing the capacity – of CBO networks."[1] Further testimony to the importance of networks in the evolving health care landscape, Robertson and Chernof[2] argue for "scaling the CBO network model across the country, organized to correspond to markets for health care delivery and payment." As CBO networks continue to grow in number, and as the models become more refined, good data about network operations will help to shape the path forward.

Since 2017, USAging's Aging and Disability Business Institute[3] (Business Institute), together with their partners at Scripps Gerontology Center at Miami University, have administered four national Request for Information (RFI) surveys on CBO and health care contracting. The purpose of the RFI is to track and understand the contracting efforts between CBOs and health care entities. Over the past several RFIs, participants have been asked about whether they have been entering into contracts with health care entities as part of a network. The proportion of CBOs who are contracting as part of a network doubled between 2017 and 2021. The 2021 RFI included questions about the structure of networks and services provided, but the primary purpose of the surveys is to understand contracting in general. It was clear that a national survey could not provide the depth of understanding of how networks operate that would be most useful at this juncture. To deepen our understanding, the Business Institute and Scripps Gerontology Center invested in a qualitative study to take a deeper look at the world of contracting through networks, with a focus on how networks emerge, how they operate, and factors that contribute to the success of these models.

NETWORK TERMINOLOGY

Amidst the growth of the network model to improve integrated care systems, the term 'network' has become ubiquitous; it is broad, can be very inclusive, and is currently used to describe collaborative models for service delivery in several health and social care sectors, including mental health, HIV/AIDS, and services for people who are

unhoused. The simplest and broadest dictionary definition of a network is "a closely connected group of people, companies, etc. that exchange information".[4] To tailor the concept of a network to the circumstance of CBOs contracting with health care entities, the Aging and Disability Business Institute (Business Institute) has defined a network of CBOs as "a coordinated group of CBOs that pursue a regional or statewide contract with a health care entity". Throughout our work on this study and on our RFI surveys, we learned that even with that specific definition, the term 'network' can cause confusion. Organizations who participated in this study were sometimes part of more than one network, including health care contracting networks, networks of affinity groups of community-based organizations, and multi-sector collaborations convened to provide services to specific client populations.

We acknowledge the complexity of the concept of networks as well as the terms used to define all the components of a network. As networks have evolved, so has the language used to describe and define networks. For the purposes of this report and to remain consistent with the language currently being used in the field, we will be using three major terms and definitions provided in Exhibit 1 below.

Exhibit 1. Network Terminology

Network Terms & Definitions	How we will reference in this report:
Network of Community-Based Organizations (CBOs): **A coordinated group of CBOs that pursue a regional or statewide contract with a health care entity.**	− Networks of CBOs − CBO Networks − Networks
Community Care Hubs (CCH)[5]: **Community-focused entities supporting a network of CBOs providing services addressing health-related social needs—which centralize administrative functions and operational infrastructure. *Community Care Hub/Hubs is often referred to as Hub/Hubs or CCH and replaces the former term Network Lead Entity (NLE). Throughout the majority of this report, we will be using CCH to identify the community care hub.***	− Community Care Hubs − CCH − Hub/Hubs − Network hub(s)
Network Members: **community-based entities that are in a partnership, collaboration and/or have a contractual relationship with the community care hub.**	− Network member(s) − Member(s)

QUALITATIVE STUDY: METHODS AND INTERVIEW PROCESS

Individuals from eight CBO networks, representing the hubs and members, agreed to participate in the qualitative study. The eight networks invited to participate, based on suggestions from Business Institute leaders, ranged from those that were just forming to those that have been operating for several years; the participant group was also inclusive of different network structures and geography. We conducted interviews with network hub representatives from the eight networks. Each network hub was then asked to provide the names of at least two network members to be interviewed as well. In addition to the eight network hub interviews, 15 interviews were conducted with network members for a total of 23 interviews. Each interviewee was asked to complete a short pre-survey regarding details of their networks and services and each was provided a list of interview questions in advance to serve as a guide. The interviews were semi-structured; they were guided by an interview protocol developed by Scripps Gerontology Center and the Business Institute; the open-ended questions covered topics related to the evolution of the network, building relationships, services program and quality and network operations. All interviews took place between August and October 2022.

The Scripps research team began the analysis process by coding the transcripts from every interview and aligning responses with the interview protocol. There were two additional rounds of coding and collaboration to identify areas of overlap in the information received in answer to the interview questions, and to identify important themes that emerged from those conversations. During the latter stages of coding, illustrative quotes were identified. Preliminary themes were reviewed with Business Institute research team members and then used to build the results section of this report.

RESULTS

The following sections summarize the experiences of the eight network hubs and 15 network members interviewed. Their perceptions and lessons learned provide an invaluable, one-of-a-kind, deep look into how networks are structured, how they operate, the goals they seek to achieve, the vision that they share, and the challenges they face.

ORIGIN STORIES: HOW AND WHY ARE NETWORKS FORMED?

Based on the experiences of our participants, the general story was that networks were primarily born out of a response to the environment in which they operate. This could be a response to a funding opportunity, a response to a perceived threat to their business practices such as changing legislation or the demands of the health care community, or a combination of these two driving forces.

Funding Opportunities

Funding opportunities, sometimes with health care entity partners, have played a major role in the formation of networks. Many networks began as the result of a grant or contract which created the opportunity to develop partnerships among community-based organizations, particularly the Centers for Medicare & Medicaid Services' Community-based Care Transitions Program (CCTP). CCTP, which launched in 2012 and concluded in 2017, provided the opportunity for CBOs to come together as networks (either formally or informally) with the goal of improving the transition of individuals from the hospital to home while reducing readmission rates. These programs not only served to positively impact patients and hospital systems, they also helped to showcase the success of collaboration among CBOs partnering with health care entities. Since the days of CCTP, federal agencies and national organizations such as the Business Institute have offered funding and technical assistance opportunities to help build or support the infrastructure, capacity, and operations of networks.

There are networks that still rely on grant or other funding, especially newer networks. Others, however, have been able to build the network infrastructure using grant funding but over time, have found ways to sustain operations and expand their services through partnerships and contracts.

Perceived Threats and Opportunities: Changing Legislation and Demands of Health Care

Other networks have developed in response to changes at the local, state, or national levels that created a unique opportunity and/or a perceived threat to Area Agencies on Aging (AAAs) and other community-based organizations. Community-based organizations are acutely aware of the impact of legislative changes at every level and some networks formed to ensure that CBOs remain competitive, at the table, and able to continue to do what they do best in their communities. One such example of a perceived threat and opportunity that fostered the formation of networks was when managed long-term services and supports (MLTSS) started to roll out in a state. Developing networks of CBOs made sense as a way to come together around value-based payment opportunities, meet the requirements of states and health plans, and remain central and competitive in the changing environment.

What Do Networks Look Like?

While no two networks we spoke with were exactly alike, they all function to better serve older adults and people with disabilities across the country. The networks in this study have been in operation between a few months and 13 years. They operate statewide or within a designated region in their state. Through their contracts with state agencies, health plans, hospitals, and other health systems, they serve all populations including older adults; adults age 18 to 65 without a disability, impairment, or chronic illness; children; caregivers; individuals with a disability of any age; individuals with chronic illness any age; and Veterans. While there are a variety of services being provided

through their health care contracts the most common services provided by the networks we spoke with, were evidence-based programs (e.g., Chronic Disease Self-Management Programs, A Matter of Balance), transitions from hospital to home, assessments or screenings for health-related social needs and/or Long-term Services and Supports (LTSS) eligibility, and caregiver support/training/engagement.

Every network is comprised of a **Community Care Hub (CCH)**, (formerly referred to as a Network Lead Entity (NLE)) and **network members**. The following sections describe these two kinds of entities and l how they function individually and with each other.

Community Care Hubs

As highlighted above in Table 1, the Community Care Hub is defined as a community-focused entity supporting a network of CBOs providing services addressing health-related social needs which centralize administrative functions and operational infrastructure.

> *"The hub has trusted relationships with, and understands the capacities of, local CBOs and health care organizations; they also foster cross-sector collaborations…that engage CBOs and the individuals they serve."*
> - [Administration for Community Living](#) *(ACL)[6]*

For the most part, the role of the CCH is to assume primary responsibilities for ensuring that all aspects of managing and administering contracts are fulfilled. From the CCHs we spoke with, this included contract negotiation and management, workforce training, member and provider credentialing, legal counsel necessary for contractual activities, purchasing, information and technology, billing systems, service referrals, and human resource functions. It should be noted that the roles and functions of the CCH vary based on intra-network relationships and agreements and by the type of contract(s) in which they are engaged. There are some networks in which the CCH is also a direct service provider.

The CBO that takes on the role as the CCH in a network may be the agency that submits the grant proposal or contractual agreement on behalf of a group. The network may also decide upon which network member has the capacity to take on this role.

Types of Community Care Hubs

Given the different circumstances of their inception and the contexts within which they operate, it was not surprising to learn about the different ways in which a CCH takes shape. Three basic types of CCHs were described by our participants and align with previous research into network models by [Cantrell and Ross](#).[7] These CCH types vary partly by the level of independence, level of formality, requirements of contracts, and/or existing organizational structures, and relationships among the CCH and member

organizations. The three major types include: central authority, lead agency, and federated model.

Central Authority

Some networks started as an informal group of organizations coming together for a grant or other common goal or project. During the process of pursuing those opportunities, they collectively decided that the best option was to create the CCH as a stand-alone entity (independent nonprofit or for-profit organization) forming an LLC or 501c3. As one CCH participant explained:

> *… [CBO leaders] did research through that year, while they were in the [learning] collaborative to figure out what would be the best way for our region's nonprofits, to position themselves to be ready when health plans [were] ready to reimburse for the programs and services that they already do. And they really decided that a stand-alone 501c3 nonprofit… was the best they wanted to do. And no one really wanted to be the lead agency, and everybody wanted to have an equal say in how it was run.*

Lead Agency

This was the most common type of CCH among interviewees. In most cases, the CCH becomes a separate division or arm of an existing or umbrella organization. An example of this would be an Area Agency on Aging (AAA) that responds to a funding opportunity to build a CCH which then exists as a division within the AAA. The CCH may have a different name than the umbrella organization and operate as a separate entity with a separate board or it may just be separated in terms of staffing and job roles but retains the same governance as the organization in which it resides.

Federated Model

Under this less common model, the CCH is formed by a group of community-based organizations, and the functions of the CCH are the responsibility of the network members or contracted vendors. An example of this is a state association of AAAs that proactively built a network to advocate for, and position its members to participate in, a proposed managed care initiative. The CCH maintains overall responsibility for ensuring that all the functions of the network are fulfilled but some of the specific functions are contracted out to network members or outside vendors.

Network Members

Network members are community-based entities that are in a partnership, collaboration, or a contractual relationship with the CCH organization. The CCHs we interviewed have between 11 and 70 network members. Network membership is often shaped by the service requirements of a funding opportunity and/or existing partnerships. Members could be a collaborating organization, an organization that serves a particular population, or an organization that provides a particular service. The members we

spoke to identified their organizations as: Area Agencies on Aging (AAAs), Centers for Independent Living (CILs), Supportive Service Providers (home delivered meals, home care, housing, transportation) or other nonprofit organizations (YMCA, faith-based, university departments, multicultural alliance).

Initial Engagement and Formalizing Partnerships

In most cases, the process for identifying and bringing on network members was described as organic, relying on existing partnerships across communities and/or within the state and built on shared interest in contracting with health care entities. In other cases, members were recruited or joined because they were well-suited to fill the role laid out by a funding opportunity or contract.

Some networks have a much more formal process for bringing in members; prospective members complete an application which is reviewed and approved by committee or board members. Once approved, the new member organization goes through a formal onboarding process. In some cases, before the network welcomes new members, the CCH will go through the process of ensuring that the mission of the CBO aligns with the network's mission, and that the member organization has the capacity to take on the required work of the contract.

Other networks have a very informal approach for bringing on members. This informal process could be as simple as vetting an organization and adding them to their website as a resource in the area, and including them on calls and meetings as needed.

While many networks may have existing informal or formal relationships with and among their members, the majority formalize their contracting-related relationships through a written contract, Memorandum of Understanding (MOU) or Non-Disclosure Agreement (NDA). This has become a standard practice that is shaped by the nature of the contract and working relationship. Many CCHs have standard contracts that they tailor to individual network members or update as needed given the requirements of a contract with a health care entity. There are existing resources to assist networks in developing an MOU, NDA or contract, but often this responsibility lies with the CCH, and they will seek legal guidance when developing contracting documents.

Member Involvement in Contracts

Most members of a network have contracts with the CCH to provide services to clients of a health care entity. However, we did learn that there are times in which a network will include members that are not necessarily providing services under an existing contract. These organizations are very much considered a member of the network, but the relationship is not governed by a contract, MOU, or NDA. Most often, they have become members with the intention of contracting or building a partnership when the opportunity arises. Until that time, these members are part of the communications within the network, and they participate in sharing information and resources. CCHs find it

important to maintain these relationships in the event that a more formal or contracted partnership could be built in the future.

Sustaining Partnerships with Members

Participants described two primary methods used by networks to engage and sustain connections with members: **communication** and **joint activities**. The level of **communication** between a CCH and its members can vary based on the formality of the relationship and the requirements of a contract. Some CCHs will communicate with their members daily as they exchange information about services, billing, or contract needs while others will meet monthly or quarterly.

Most commonly, we found that the CCH will, at a minimum, hold bi-monthly or monthly calls or meetings with all members and will send out communication in the form of a newsletter at least monthly. Some of these meetings are very well-structured, which was reported as ideal for both the CCH and the members, as shared by one participant:

> *We've got lots of different monthly meetings, and then weekly emails and, phone calls and meetings as well. So, there's a lot of collaboration that goes on, which is why I think it's been so successful, you know, good communication.*

The value of regular well-organized meetings was emphasized by many participants. Monthly meetings were described as serving two major purposes: an opportunity to discuss the work of the network and specifics of the contract, and as a way for all members to connect and to troubleshoot or find ways to better serve clients. For example, if a CBO that is well versed in providing evidence-based programming has a client that needs meals or transportation, they can connect with other CBOs to help fill in gaps for the client.

Another mechanism that strengthens the ties among CCHs and members is **joint activities**. Most joint activities stem from the requirements of a contract and the business relationship between the members and the CCH. Network members may serve as members of the advisory council or different committees established by the CCH (such as financial, emerging business, strategy, planning). Members may also be participants or speakers on network calls and be included in conferences and meetings. Some networks also provide training opportunities and share widely resources and best practices. While not as common, some networks hold annual meetings or networking conferences.

Network Governance

Governance and the roles of the CCH and the network members varied from network to network. For some, (common under the central authority type of CCH), the network has

its own board of directors or advisory board. In other cases, (common under the lead agency type), the network is governed by the existing board of directors or advisory board of the organization in which the CCH is housed.

In some networks, the network members serve on the board or on advisory committees; in others, the members have an ownership stake in the network. In addition, there are other networks in which the members do not play any role in the governance of the network but maintain more of contractor/contractee type of relationship.

We found that many networks have experienced growing pains around finding the right structure and governance for their network and identifying the roles and responsibilities of the CCH and of each network member and what each organization contributes. One network with a lead agency type CCH noted that they have had recent discussions on whether it makes the most sense for the network to be housed as a separate division within a larger organization or whether they should consider becoming a separate, central authority entity. Another interviewee explained, "We are struggling to bootstrap the network into something bigger that works for all AAAs."

What Resources Are Needed to Start a Network?

There are several resources needed to build a network, and even more to sustain it. The rest of this report provides details about essential infrastructure necessary for effective operation of a network. In this section, we summarize comments from participants about what was required to get the network off the ground.

Financial Resources

As mentioned above, most networks are formed following the receipt of funding which allows the CCH the capacity to build infrastructure, bring in partners, establish contracts, and manage administrative roles. In some situations, networks were formed following monetary contributions from network members, which may vary in size. For example, a CCH may front specific costs, such as IT systems, or members that had access to larger funds may contribute more than other members to get the network off the ground.

The CCH organization often assumed much of the cost and the risk of starting a network. As one CCH noted, "We could tolerate that risk, we have a contingency…we can take the hit. The other area agencies and partners, they can't take that hit."

Human Resources/Leadership

The resources that go into starting a network are not solely monetary. The amount of 'sweat equity' should not be overlooked. Many networks have taken shape due to the often-unpaid work of champions or organizational leaders that are working on the development of their network while also managing full-time jobs. For example, as one (central authority) network was being formed, there was not yet funding in place to pay the work of the few CBO leaders that were working to build partnerships, infrastructure, and develop the network. They were working as directors and CEOs of their own

organizations while making calls, setting up meetings, writing grants, building connections, and making decisions on the best way to move forward. These champions fought to build relationships not only with other CBOs but with health care partners as well.

DATA ECOSYSTEM

A key component of any contract and a major responsibility of CCHs and members is to collect, analyze, share, and use data about the services being offered and the clients being served. Managing data allows networks and their members to show value, improve services, and measure outcomes. Being able to collect, store, protect, access, and analyze relevant data are essential aspects of network data systems. All these functions require some level of data infrastructure within the network.

Data infrastructure can include things such as hardware systems, software systems, and data transfer pathways (e.g., bandwidth, data migration tools to allow data to move from one system to another, etc.), as well as trained personnel to support the data infrastructure. Even a well-designed and fully-featured system is not sufficient to accomplish these essential aspects without accompanying agreements (including legal and regulatory protections where applicable), policies (who has access and for what purposes), processes for getting data into the system reliably and accurately, and processes for getting information out of the system as easily as possible. Taken together, the data infrastructure and agreements, policies, and procedures for managing the flow of information within the network constitute a data ecosystem. Ideally, data are entered into the ecosystem accurately and easily once, after which they are shared within the network with those entities that should have access, they are stored safely and protected, and they are available for providing care, documenting services provided, improving services, making sound business decisions, making sure that providers are paid, ensuring quality, and measuring performance by each part of the network.

Data Pathways

Exhibit 2 is a simplified diagram of the data pathways of a network data ecosystem; it was created to summarize what we heard from CCHs and members. This data ecosystem supports two major functions: data input and data output. Implicit in this ecosystem are the hardware, software, people, processes, and policies necessary for these two functions. Data inputs include processes and agreements for entering data into the data ecosystem. Data outputs include protections and agreements for accessing and retrieving data from the ecosystem.

Exhibit 2. Data Ecosystem: Hardware, Software, People, Processes, and Policies
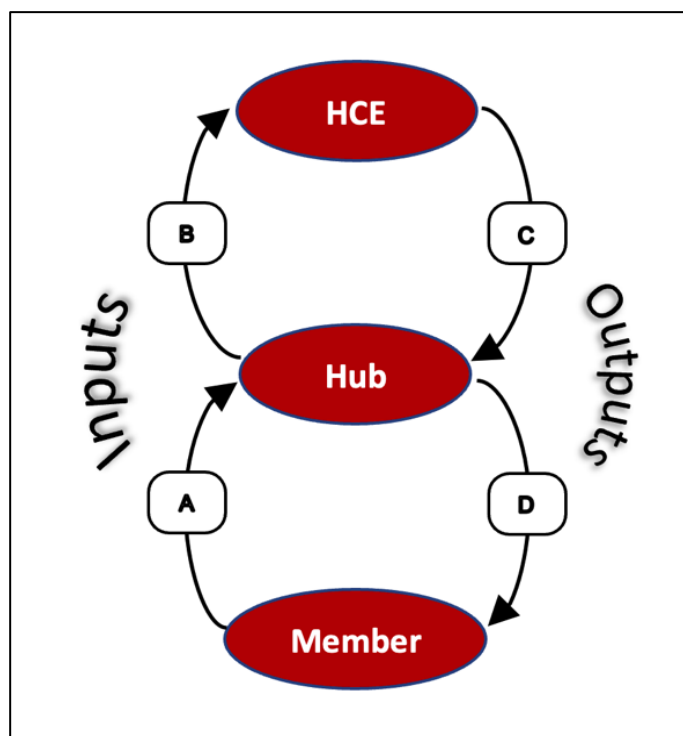
Data about services provided, people served, and other relevant information are collected and aggregated up, from members to the CCH, and from the CCH to the health care entity (HCE). These data inputs are represented in Exhibit 2 by arrows A and B. Data from the members to the CCH (A) allow the CCH to know who is being served, what services are provided, and by which member. For example, this may be used within the network as the mechanism for member reimbursement. Similarly, data from the CCH to the HCE (B) can help the HCE to know what services were provided to whom and by which member.

Likewise, the data output pathway (represented by arrows C and D), shows how data may be shared from the HCE to the CCH, and from the CCH to members. Both the inputs and outputs serve vital functions for all organizations in the network.

The real world is significantly more complicated than the abstract idea of a data ecosystem just described. Still, even though the methods may differ, the principles hold. How do actual organizations meet these essential data-related functions? We heard from each respondent how a data ecosystem looks and functions within their network, including what seems to be working well and what might be improved.

What did we hear?

Respondents provided insights about how data is collected, shared, and used by whom and for what purposes. They noted successes and continued challenges on both the input side (arrows A and B) and on the output side (arrows C and D). The four major topics that emerged were related to what members are required to provide, who has access to data, how their data systems currently function, and what changes might be built into an improved data ecosystem.

Data Requirements of Members

The data requirements (i.e., what needs to be shared with the CCH) of members are determined based on the services and programs being provided under contract. For some contracts that offer services such as evidence-based health promotion programs, the information that needs to be collected could include the number and list of class attendees along with satisfaction surveys. For other contracts, members may need to submit information about clients, their needs, dates of service, dates of follow up, and case notes.

Access to Data and Data Sharing

While data collection is a key piece to running a network and fulfilling the requirements of contracts, the ways in which data are accessed and shared varies greatly – from having complete access to the data to only being given performance reports when requested.

Some members reported that once they enter data into the system used by the CCH (arrow A), they are unable to access the data due to obstacles with pathway (arrow) C or D. As a result, they are forced to enter data a second time, once for the network system, and again for their own records. They enter the data into the network system and enter it again into their own system. This double entry is required when there is no accessible pathway within the data ecosystem for the member to get the data that they need from the system. When members do not have access to the data because of infrastructure limitations or privacy, training requirements, licensing, HIPAA, regulations, etc., sometimes the CCH will develop reports to share with the members.

Current Data Infrastructure

There are many ways to share information, and what works for one network may not work for another. We heard of some networks that have worked with software companies or consultants to invest in building their own data collection systems; others have piggy-backed on existing systems within an organization. Yet another approach mentioned by participants was using the front end of a system used by the health care entity. Some organizations share spreadsheets of information collected or share de-identified information by email. Some respondents mentioned that their network has several different contracts that are then required to use multiple different systems or platforms that do not work together. Each contract may have its own platform or data system that contract partners must use. This can be a real challenge.

Data ecosystems may reflect the stage of development of the network. Newer networks may have a developing ecosystem with the expectation that more capability may be forthcoming as the network matures. For example, one member of a network that is in the very early stages of development reported, "There haven't been discussions about technology or data infrastructure yet."

Sometimes even established networks continue to use pieced-together data systems. It is difficult to do the work of the network (e.g., providing services that people need) *and* to invest in data ecosystem capabilities, even if that capacity would likely yield improvements and efficiencies to the network. For example, in one more established network, a member said that they email de-identified information to the CCH (arrow A) but maintain their own data to ensure their own access. In turn, the CCH shares data/reports with members (arrow D) as needed. Each part of the network reports independently based on the information that they have.

Several respondents noted that their network used SharePoint, Google Drive, or another password protected file sharing application. Many have found this type of solution to be a cost-effective first step to improve data ecosystems. In general, networks may start with only the data infrastructure and tools that each member brings to the network, they find a way to make it work, and then build it as they go. Indeed, most, if not all, networks have adapted and innovated as they are able to become more efficient and extend their data capabilities. All expressed interest in continuing to improve this component of their operations.

Building Better Data Ecosystems

Regardless of the maturity of the network, each CCH and member spoke to the challenges they have experienced related to data systems, data collection, and data sharing. This was the most commonly mentioned challenge faced by networks and there was universal interest in finding better solutions. As one CCH noted, they are working across 25 different platforms, and are currently seeking a single front end platform that then disburses appropriate data to specific platforms for programs, funders, service providers, etc. While many have adapted to what they have access to, no one had a perfect system in place. Specific goals include:

Building the Right System:

Many CCHs spoke to the challenge of finding and building a data system that would work exactly as needed for the goals of their contract. As one CCH described:

> *We're still getting to that place [of putting usable data in the hands of network members]. We're not fully there. But hopefully, through our IT assessment and our repositioning, you're looking at integrators, and what we need to do to provide more dashboards for our providers. I think we could get to a better place. But we've really come a long way.*

Dedicated Staff (at both the CCH and member level):

Some networks may be too small or lean to have staff members dedicated to learning and using comprehensive data systems, which can be a capacity issue that affects the data ecosystem. This was a concern raised by some network members; they fully understand the importance of data but are not positioned to build that capacity at this time. One CCH stated:

> *Just in general, I found that they [members] don't really have data people; they have regular project coordinators, or supervisors trying to do data. That's where I think it's kind of a disadvantage for them because they don't have that access. I mean, everything's done manually, and by hand almost like not brought up to this time frame. I think our [hub's] data infrastructure and process right now is pretty nice. I mean, we have a whole data team. These are people that specialize in this role, so it's working*

Improving Access to Make Better Use of Data:

There were some CCHs that indicated that they would like to do more to put more useful data into the hands of their partners, and they continue the work of providing accurate and helpful data. One CCH noted:

> *I think the biggest surprise was, and it's a challenge no doubt, is the information technology system, the scope of it, and what is required, and what's available currently in the market … [It] kind of surprised me; I thought it would be ... more appropriate integrated systems out there, but we're finding, and we're not the only ones, it's just a real challenge to put together an IT system that we can afford, and that will meet our needs.*

In summary, it is clear that developing a comprehensive and integrated data ecosystem is a complex project that requires significant time, expertise, and money. There was strong consensus among our interviewees that a data ecosystem that meets the needs of each network entity is a crucial step for effective and sustainable network operations. There was also a clear message that the shared and sometimes competing priorities for CCHs and members (i.e., building CBO capacity, serving clients, and continuing to build the network) add to the challenge of building these systems.

SERVICE AND PROGRAM QUALITY

When asked about service and program quality within a network, most CCHs and members referred to the standards and requirements outlined in their respective

contracts (contacts between the CCH and member and the CCH and health care entity) as the ways in which they are able to monitor the quality of their services. Membership agreements typically detail the responsibilities of the members, and the contracts will include specifics for quality, compliance, data, and financial standards. These standards help set service and performance expectations for the members which can improve service quality.

The ways in which quality is managed within the networks we interviewed include:

- extensive documentation about quality standards,
- developing quality and fidelity measures,
- programming certifications,
- reviewing and monitoring data (chart reviews, etc.), and
- reporting on and providing actionable feedback about the performance of programs and members.

A crucial piece identified by CCHs and members to ensuring quality is **consistency** – consistency in member training, consistency in data collection expectations and processes, and consistency in program and service delivery. As one member noted about a CCH:

> *Consistency is very important. One thing I really appreciate is they [Hub] have set the standard for what are the data that the whole network needs to collect, what are the post and pre surveys that we need to do? I think that will help the whole network to actually be more consistent, ... and the data being collected will be the same throughout the whole network. At least … when we want to have any charts or any data, we'll be able to get it from either from [the Hub] or we can collect it from our own as well.*

Having access to a data ecosystem that works well for the network members allows the network to have the data necessary to assess and improve service and program quality for the network. It also allows each member to assess their own service and program quality. Data ecosystems develop in a particular context that looks different for each network. Each network must balance the network resources available with the network's need for collecting information and sharing information. Those data ecosystems that are best adapted to meet the needs of each member that is part of the network can benefit the whole network and the people it serves.

FINANCIAL OPERATIONS AND MANAGEMENT

Network financial operations encompass a wide range of functions for both CCHs and members, including rate negotiation and rate setting, referrals, invoicing, payment, and managing all aspects of contract-related finances. The general financial management flow described by interview participants starts with the CCH sending out referrals to their

members. Each member agency follows up on these referrals and keeps track of services provided. Providers reconcile their billing sheet with units-of-service reports generated by the CCH system, then file their verified claims with the CCH. When the CCH receives payment from the health care entity, reimbursement for claims filed is sent to the member agencies that provided service. There are some variations in the flow of some of these steps and where they are housed. For example, one participant described a system in which a AAA receives lump-sum funding from the health care entity as agreed upon in the contract, then disburses funds to providers using their existing invoicing, reconciliation, and billing system. To support decentralized financial management as described by this participant, the CCH sometimes provides templates for invoices, monitoring, and reconciliation.

The degree to which these processes are standardized and managed by the CCH depends on the extent to which any or all of these functions are integrated into a single system. The section of this report on data infrastructure addresses the different kinds of data systems used within networks.

Referrals

Client referrals are at the heart of financial operations for CCHs and their members. Some aspects of the referral process were often mentioned as concerns or confusions. The single most common concern was about low levels and unpredictability of referral volume. Appropriate referral volumes help ensure sufficient revenue to sustain operations of the network member. One speculation about the root of the problem, mentioned by several network members, is a lack of specificity about projected referrals in contract negotiations and in written contracts. They wondered how much of a role the CCH can reasonably have in assuring a predictable and transparent referral process. Their concern is that the health care entity partners do not have models to predict or assure referral volume and, as a result, the CCH and members have no choice but to live with the uncertainty if they choose to enter into the contract.

Another concern is that there may be competing priorities for CCHs and members. CCHs must build a strong network of members that conveys to their partners the ability to serve the number and geographic spread of clients that will meet the payers' needs. At the same time, member CBOs must make their decisions about participating in a contract based on a risk calculation that is hampered by inadequate information regarding expected revenue. One participant summarized these shared concerns about the volume and transparency of the referral process, stating:

> *When [the CCH] brings in more members, I think … that's cutting into my piece of the pie? I need to support full-time staff … Are we continuing to add members when we don't have the referrals yet to even support the members that we have?*

The actual referral process was generally described in three ways. As a flow from the health care entity to the CCH, from the CCH to members, and from members to service providers within their own agency or contracted though their agency. Geographic service areas typically played a major role in referrals from the CCH to the members. However, we learned that geographic service areas were not as relevant for virtually-offered services such as evidence-based health and socialization programming. Beyond geographic service areas the details of the referral process were not clear for some network members in this study.

From the descriptions provided by CCHs and members, several issues emerged related to how rates are set and by whom. Sometimes the CCH may reach out to network members during contract negotiations to get an estimate of service costs. Some organizations described in detail a collaborative "workshop" processes in which members, direct service providers, and the CCH review data together and discuss costs of delivering services and rates. But the formality and level of involvement of members varies. For example, in some cases there is no involvement of members, in others the members are no aware of how rates were set, and in one case members set their own rate based on costs and the CCH serves as an intermediary to negotiate with the health plan partner.

The extent to which rate negotiation with health care entities is possible was raised by many participants. They conveyed skepticism about how much power the CCH and members have to successfully negotiate rates. Some said that the rate is dictated by the payer up front, others said that there didn't seem to be much room for negotiation, and several commented that currently the health care entities are able "to call the shots" on pricing. A few described collegial and inclusive negotiations with the health care partner.

Perhaps reflecting the newness of some of the networks we learned about, there was some lack of clarity about how, when, and why rates may vary. A few participants mentioned variation by rural v. urban area served, which was seen as necessary and appropriate. Others raised questions about whether rates vary by contract and payer.

Overall, while there are clear challenges in establishing robust financial systems for this new model of care integration, there is a shared focus on overcoming these barriers. The interviews revealed some best practices regarding financial operations including:

- standardized processes for service delivery verification, invoicing, and reimbursement;

- responsiveness of the CCH to their member's questions about referrals, billing, and payments;

- up-front clarity about referral processes and volume; and

- commitment to collaboratively working out billing and payment issues.

POTENTIAL VALUE OF HAVING A NETWORK

CCHs and members provided their perspectives on the potential and realized value of a network. A number of overarching themes emerged from these discussions about the intangible and tangible merits of a contracting network, in general, and for network members specifically.

Reach and Strength

Many participants commented that a network makes it possible to serve more people and new populations. Some also mentioned *statewide reach* as an added value because it is appealing to (and sometimes a requirement of) health care entities. As one participant said, "We were willing to work with [Agency X] and allow them to be the CCH agency, to sign contracts, because everybody realized that the insurers didn't want to sign 25 separate contracts to cover [our state]". A few participants also discussed the potential for statewide contracts to help build a more seamless system for consumers.

Some interviewees mentioned that state-wideness and serving new and more clients could also be a challenge, since not every CBO has the capacity to do more; some do not have the risk-tolerance, payment models, or financial agility to enter into contracts at this time. Financial agility refers to the level of access to discretionary funds that can be used by a CBO to build adequate capacity to participate in anticipation of a new contract. For some respondents, the opportunity to serve more clients was outweighed by the costs, and risks, of hiring new staff to handle them without some discretionary funds at their disposal, and they were reluctant to increase their volume prior to receiving any revenue from the new contract. Several participants saw this as particularly problematic when it exacerbated existing differences among CBOs within the same state: those with more diverse funding sources and more staff might have the flexibility to participate in contracts, while smaller and less financially diversified organizations might not.

The capacity of a network to offer statewide coverage to a health care entity is hampered by these CBO constraints. At least one network dealt with the state-wideness challenge by allowing AAAs to provide services outside of their official planning and service area when the agency for that area chose not to participate in the contract. This was a good solution for that state, but other participants raised concerns about the unintended negative consequences in their state, due to the "haves and have-nots" tension that already existed, and the possibility that boundary-crossing might seem like a threat rather than an incentive to get CBOs to participate in the contract.

Strength and expertise for advocacy for CBOs and older adults was also frequently mentioned as a value of networks. Because of the focus and length of the interviews, there was limited opportunity to explore this topic more deeply. It would be helpful to learn more specifically what the advocacy role for a CCH might look like (e.g., with health care entity partners, with state policymakers and state office, with federal

decision-makers), and whether the advocacy role was explicitly an expectation of members for the CCH.

Collaboration, Cooperation, and Learning from Each Other

Networks with good communication processes and meaningful interconnections among members create collaborative opportunities such as learning from each other, building internal strength, and cooperation rather than competition. Several network members talked about learning how to calculate service costs and rates because of their network involvement. Some noted that being part of a network encourages and sometimes requires looking at steps and potential breakdowns in client flow, monitoring, billing, and payment systems.

Opportunity to build stronger collaborations rather than competition was mentioned as another value of a network. Participants noted that being involved in a network allows each organization to learn what other organizations do, ideally leading to roles in network contracts that that allow each CBO to do what it does best (i.e., serving their client population, developing new programs).

Centralization and Standardization

A commonly mentioned benefit of networks was the centralization of expertise and administrative services for outreach to health care entity partners, contract negotiations, quality and performance standards, and program monitoring. These functions performed by the CCH were cited as a benefit that allowed organizations that were coordinating or providing services to focus on their core strengths. Most network members mentioned the importance of the administrative infrastructure provided by the CCH, including shared management, and centralized business operations. Some mentioned proactive outreach and contract negotiations as a strength they wanted to see shored up in their CCH agency. However, there was also common acknowledgement that, in the early stages of network operations, network members and CCH agency staff are still clarifying expectations for who does what with what level of expertise.

Vision and Innovation

Several participants talked about ways in which network involvement encouraged system-level thinking, with a focus on identifying and addressing system-wide gaps. Formal and informal conversations about network development, collective responses to contracting opportunities, and sharing best practices regarding value-based payment models were all cited as occasions when network involvement encouraged big-picture and future-oriented thinking. Some noted that being part of a network allowed them to position themselves in a new way, as a statewide or regional CCH for some specialized services.

COST-BENEFIT ANALYSIS

There were many persuasive illustrations of the ways in which a network is perceived as valuable. However, this topic also generated conversation about some of the costs and challenges of operating as a network. One participant from a network member organization summed up the sentiments of quite a few others: "We believe in what the network is trying to do, and the philosophy behind it, but we are running a business." Specific challenges included referral volumes and pricing that are not adequate to generate excess revenue, making it a cost rather than a benefit. Some participants were not convinced that the CCH had the capacity to accomplish effectively and efficiently all that will be necessary for the network to be successful. Several noted that CCHs have not made the business case to existing and potential members for why they should become/remain a part of the network. Many agreed that network leads need a clear value proposition. One network member simply stated that, "There is no benefit (of network membership) to us at this time."

These conversations about network value generated deeper discussion of the need for systematic and data-driven cost-benefit analyses for network members and for the CCH. There was widespread agreement that this is an important step for a successful network and its members. Interview participants provided a lot of insights about the importance of estimating real costs, and about some factors that need to be considered for a cost-benefit analysis such as: ramp-up time during which there is no revenue from the contract, costs related to administrative infrastructure, low payment rates set by the CCH agency and/or health care partners, and opportunity costs. On the last point, several respondents commented that network involvement might limit their capacity to pursue other innovations that might be more financially valuable for their organization. They did not think they had the bandwidth to pursue multiple new ventures at the same time, especially in the absence of evidence for the risk-reward outcomes of contracting with health care entities.

Several respondents noted that the amount of revenue was unpredictable, late in coming in, and even merely "a dribble", and perhaps not financially viable. On the other hand, the intangible, non-monetary benefits (as noted above) were also mentioned as a counterbalance to the financial challenges. Other notable points included the importance of conducting a cost-benefit or ROI analysis before signing on or continuing with a contract, the desire for guidance on how to do so, and the necessity of including opportunity costs in these analyses. There were consistent messages about the need for agreed-upon benchmarks and metrics for success that should be built into such an analysis.

CONCLUSION: FEATURES OF A SUCCESSFUL NETWORK

The participants in this study were generous with their time, their insights, and their honesty. They highlighted centralization and standardization of administrative functions, opportunities for collaboration and innovation, and expanded reach as some of the

benefits of being part of a contracting network. Data infrastructure limitations, uncertain referral volume, need for cost-benefit data and practices, and "growing pains" in clarifying roles and expectations emerged as some of the challenges. The successes and pain points they described all contributed to a list of tips for building and maintaining strong and successful networks. Those tips include:

1. Build networks upon existing structures, strengths and, most importantly, existing partnerships. Most contracting relationships were built with organizations with which the CCH already had a strong working relationship. Trust, mutual respect, and interdependence are important building blocks.

2. Identify champion organizations and people to move the model forward. Participants in this study talked about drive, attention to unmet needs, imagination in pursuing solutions, attentiveness to opportunities, and willingness to take risks as elements of the vision necessary for network success.

3. Have as many elements of network operations in place as possible before entering into a contract, such as data expectations and uses; performance expectations and MOUs and NDAs for CCH and members, and well-documented processes for referrals, billing, and monitoring.

4. Nurture healthy relationships among CCHs and members through ongoing communications, transparency, and a clear sense of shared goals. Develop explicit guidelines for communication timelines and strategies that all members of the network agree to.

5. Create convincing value propositions from CCHs to network CBOs and to health care entity partners about the benefits of, and returns on investment from, network involvement.

6. Build cost-benefit analyses into standard practice for the CCH and CBO members. Establish standards for timelines, benchmarks, performance expectations, monitoring, and measures of success for the CCH and for individual member organizations.

7. Invest in the effectiveness and sustainability of the CCH to ensure that the expected and necessary centralized (or subcontracted) administrative functions and skills can be maintained.

8. Invest in a data ecosystem that is beneficial to CCH and members, and create channels where data is easily accessible for all organizational participants in the network.

In conclusion, there is not a "one-size fits all" model for how networks emerge and how they operate, but there is an evolving wealth of knowledge about what works. While there appears to be a collective sense that they are "building a plane while it is in the air", the insights and candid reflections from the participants in this study can refine the instrument panels and flight paths for future networks.

To continue to move this work forward, it would be useful to build more breadth and depth about a network-based approach to integrating health and social care. We need to learn more detail from more networks about best practices in major areas of network function such as referral processes, billing and payment systems, internal relationships among CCH and CBO members, data systems, cost-benefit analyses, and performance expectations for the CCH and members. Resources based on deeper investigation of these best practices could be made available to CCHs, members, and health care entities.

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