Safety-Net Hospital Systems Transformation in the Era of Health Care Reform

Experiences, Lessons, and Perspectives from 13 Safety-Net Systems Across the Nation

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Introduction

The Affordable Care Act (ACA) of 2010 has committed considerable dollars to help safety-net hospital systems build their capacity, create efficiency, enhance quality, and ultimately transform to improve the health of communities. This commitment reinforces the Triple Aim that the U.S. health care system strives to achieve—to improve population health while simultaneously improving quality and reducing cost.[1] A central driver for moving the country closer to achieving the Triple Aim has been the expansion of health insurance availability, including the operation of health insurance marketplaces and Medicaid expansion in 2014, which has created many new opportunities for hospital systems to see more paying patients, improve bottom lines, and in turn, invest in systems transformations to improve health care delivery.

At the same time, however, many safety-net systems face new challenges—ranging from payment reductions and penalties to intensified competition for newly insured patients and the need to invest in capacity in short order to meet new demand—where in many cases the financial resources may not exist to do so. While many recent studies have documented how leading safety-net systems across the country have adapted and transformed in response to the ACA, few have explicitly focused on what it would take for less prepared or more challenged hospitals to survive, if not prosper, in this new environment. This is especially true of safety-net systems in a leading ACA implementation state like California, where there is growing concern around the gap between the "have" and the "have-not" safety-net systems in terms of the opportunities and challenges they face.

With support from the Blue Shield of California Foundation, this report provides a review of safety-net systems across the country, identifying their experiences, lessons, and successes in adapting and responding to health care reform. The purpose is to capture transformations occurring across systems varying financially, while also caring for a large number of low-income patients, to document their actions and innovations as well as implications and potential considerations for the California safety net. As such, this study intends to build on and add a unique dimension to the existing body of work on safety-net hospital systems transformations nationally and in California. To this end, the objectives of this report are to:

1. Document transformation experiences occurring at safety-net systems across the country, especially following and in response to the major health insurance reforms that were implemented in 2014;

2. Identify promising actions and innovations of safety-net systems as they work to address the Triple Aim; and

3. Identify opportunities for California's health care safety net to draw on experiences from across the country, both in the context of the state's Medicaid 1115 Waiver renewal process as well as to inform individual hospital systems transformation.

To assure relevance of this study to California, we drew explicitly on experiences and lessons from systems located in states expanding Medicaid. And within these states, we selected a subset of hospital systems serving a disproportionately large low-income patient mix. The intent was to capture experiences emerging across not only leading systems, but also those that may be more vulnerable, to identify and highlight strategies they have adopted to reaffirm and potentially inform transformations in California and across the country. A companion issue brief released in January 2015, *Snapshot of Medicaid 1115 Waiver and Other State-Based Delivery System Transformations*, was also developed to offer experiences and lessons from across the country to specifically inform California's Medicaid 1115 Waiver and Delivery System Reform Incentive Payment program.

Setting the Context

Safety-net hospital systems—and in particular public hospital systems—play a central role in providing health care services to uninsured and low-income populations. While approximately 15% of hospitals in the country are defined as "safety-net," over half of low-income and uninsured populations rely on safety-net hospitals as their primary source of care.[23] The full impact of the ACA is still to be felt and seen on these providers, however, early indicators recognize that they will continue to play an important role in providing a range of services, not only to the remaining uninsured, but also to many newly insured who have come to trust and rely on them over time. And yet, how these systems survive or prosper is still to be seen and will largely depend on how well positioned they are to adapt to a transforming health care environment, characterized by growing competition and rising demand, alongside declining federal, state, and local support.

While a safety-net system's "position" prior to reform—including factors such as capacity, size, and financial condition—is a key predictor of its ability to adapt to reform, also important is an institution's commitment and flexibility to reform.[4,5] Many safety-net systems across the country have worked explicitly to build on their position to adapt and respond to the changing health care dynamics. These include investments in health information technology, a focus on developing integrated delivery and payment reform systems, undertaking cost-cutting measures, addressing primary and specialty care capacity, becoming a provider of choice in the community, and achieving common ground in addressing key infrastructural issues such as a system's mission and leadership.[6,7] The scope and extent of such transformations, however, have largely depended on broader factors, such as a system's financial condition, local political environment, and leadership.

California, in many ways, has led the country in conceptualizing and preparing for health care reform, efforts that predated the ACA overall and in certain parts of the state. California's Section 1115 Medicaid Waiver programs—including in particular the Health Care Coverage Initiative, Low Income Health Program, and Delivery System Reform Incentive Payment program—set the state on a path to reform. In addition, whereas the ACA has only recently spurred considerable support around demonstrations for coordinated care, San Francisco embarked on an earlier and expansive version in 2007 as part of its Healthy San Francisco initiative—a comprehensive, coordinated health care coverage program that also incorporated important features for building a robust safety net, such as primary care homes and linkages to specialty care and hospitalization.[8]

California's Health Care Reform Journey: A Precursor to the ACA[9]

While it is well known that Massachusetts undertook extensive reforms prior to the enactment of the Affordable Care Act, it is a lesser known fact that California attempted major initiatives in state-based health reform. The fate of many of these efforts was highly affected by the political turbulence and leadership of the state in the previous 25 years. Though not all of the legislative reform initiatives passed, many served as an early blueprint for national reform efforts.

California's efforts began as early as 1987 through the passing of legislation that penalized patient dumping and provided some funding for physicians who provided care for the uninsured. Single payer proposals were introduced, and failed, in the California legislature in both 1992 and 1994. Nevertheless, in 1992, other important reform proposals passed such as insurance coverage expansion for pregnant women at twice the poverty level. In 1997, the State Child Health Insurance Program (SCHIP) was passed, benefitting low-income and working families in the state. In 2000-2001, new efforts to streamline state programs such as Medi-Cal and Healthy Families were introduced and the health reform debate restarted in California.

In 2005, California obtained its first Section 1115 Medicaid Waiver establishing the Safety Net Care Pool (SNCP) as well as the Health Care Coverage Initiative (HCCI) to expand coverage to childless adults in 10 counties. The year 2006 went on to provide major state-based reform victories through the enactment of bills that provided drug discounts for the uninsured and underinsured. California also became the first state in the nation to prevent hospitals from overcharging the uninsured.

In 2007, Governor Arnold Schwarzenegger pushed for universal health care in California through health coverage expansions and insurance exchanges, which by 2008 had failed to receive statewide support. Nonetheless, San Francisco embarked on a major reform journey in 2007: a mayoral task force was created that led to the passage of Healthy San Francisco, a comprehensive, coordinated health care coverage program for low-income individuals.

In 2008, President Obama was elected into office and in the years that followed, national health reform was enacted. In the interim, California experienced a recession that resulted in state funding cuts to various benefits. But by 2010, with the passage of the ACA, no state was at the forefront of reform and transformation like California. The state took a leadership role in implementation: being the first to establish a health insurance exchange, ensuring access to children with pre-existing conditions, enacting rate reviews, an early expansion of Medicaid, and limits on what physicians could charge uninsured patients. Central to leading reform was the state's second Section 1115 Medicaid Waiver, Bridge to Reform, which established the Low Income Health Program (LIHP) and the first Delivery System Reform Incentive Payment (DSRIP) program in the country.

The section that follows provides a brief primer on California's health care safety-net landscape, focusing in particular on the role and fate of safety-net hospital systems prior to, during, and now following ACA implementation. We note that given the breadth and scope of California's safety net, and the large body of work on its innovations, transformations, as well as the DSRIP program, we do not provide an exhaustive literature review; rather this summary is intended to set the stage for our study and findings. To this end, the following summary intends to capture how providers have prepared and responded to reform, including a discussion of major facilitators that have spurred transformation and innovation, such as the Section 1115 Medicaid Waiver, along with documented challenges and barriers that remain.

California's Health Care Safety Net

California's health care safety net has been described as a "complex web" of programs and providers that serve low-income and uninsured Californians.[10] Primary among programs to assist individuals and families in covering costs of health care are Medi-Cal, Healthy Families, and county programs for uninsured and medically indigent, among other episodic and low-income programs. Key providers in the safety-net system include a range of public, district, and nonprofit hospitals and federally qualified health centers, along with other clinics and private doctors' offices providing charity care.

The state's public hospital systems and health centers in particular are a cornerstone of the safety net—with public hospital systems providing 69% and health centers providing 45% of all care to those uninsured or on Medi-Cal.[11] California's 21 public hospital systems, while comprising only 6% of hospitals statewide, serve 2.85 million Californians each year and provide 40% of hospital care to the state's uninsured.[12] Many of these systems are training grounds for providers in the state (e.g., 57% of doctors in California are trained at public hospitals) and collectively operate major burn and top-level trauma centers, while also operating over 100 outpatient primary and specialty clinics.[13]

California's Section 1115 Medicaid Waivers

Two consecutive Section 1115 Medicaid Waivers have become a central component of California's safety-net support in its transition in the era of health care reform. Section 1115 Medicaid Waivers—granted by the U.S. Department of Health and Human Services to waive certain legal provisions of Medicaid—offer an important policy tool for states to promote and support innovation to improve quality, increase efficiency, and reduce costs.

California's 2005 1115 Waiver. In 2005, the state was approved for a five-year waiver largely focused on providing federal reimbursement for local expenditures for the development and implementation of the Health Care Coverage Initiative (HCCI)—a program to extend coverage to low-income adults (with incomes below 200% of the federal poverty level) who were ineligible for other public programs—as well as to expand and strengthen the safety-net system. Counties participating in the program were charged with establishing provider networks through their existing safety-net providers, expanding those networks, establishing a medical home for each patient, and enhancing infrastructure such as health information technology, among other requirements.[14] In total, 236,541 people were enrolled in this program.[15]

California's 2010 1115 Waiver. The second waiver, the "Bridge to Reform," was approved in 2010 and expires on October 31, 2015. Among the waiver's two cornerstones are the Low-Income Health Program and the Delivery System Reform Incentive Payment program.

The *Low-Income Health Program (LIHP),* through which participating counties provided Medicaid services to two previously uninsured groups of adults—those with income at or below 133% of the Federal Poverty Level (FPL), and adults with incomes between 133% and 200% FPL. The intent of the program was to identify and enroll uninsured individuals in temporary county programs to ease transition and enrollment in Medicaid and the marketplace in 2014.

The *Delivery System Reform Incentive Payment (DSRIP)* program, first created by California, is an unprecedented initiative that provides $3.3 billion in federal incentive payments over five years to public hospital systems in the state to design and implement transformative projects to improve capacity, infrastructure, care delivery, and quality. While California had engaged in many pilot improvement projects in previous years, DSRIP afforded a unique opportunity to expand the scope and scale of these efforts. California's 21 public hospital systems submitted 17 five-year DSRIP plans "rooted in evidence-based medicine and in the lessons learned about successful ways to improve care in order to make [systems] more efficient, coordinated, and patient oriented."[16] Four broad categories of initiatives were addressed by DSRIP plans: (1) infrastructure development, (2) innovation and redesign, (3) population-focused improvement, and (4) urgent improvements in care—with systems on average carrying out 15 projects and 217 milestones across these categories over the five years.[17] An additional fifth category was added in subsequent years concerning HIV Transition Projects.

Four years into the DSRIP, California's public hospital systems have made considerable progress in expanding primary care access and workforce capacity while decreasing unnecessary service utilization. In conjunction with California's LIHP efforts to expand coverage, DSRIP's focus on primary care helped connect LIHP enrollees to teams of primary care providers. Through the 17 DSRIP plans, a total of 11 systems expanded primary care capacity while seven focused on primary care redesign.[18] Efforts included more weekend and evening hours, better panel management, more patients assigned to primary care providers, integration of behavioral health, patient navigation programs to connect patients from the emergency department to primary care, improvements in team-based accountability for patient outcomes, better management of patients with complex medical and social needs, and improvement in patient engagement and experience.[19]

Beyond improving primary care access and patient-centered care, these systems have progressed to implementing a range of health information technologies, from electronic health records to creating disease registries, standardizing data reporting, and capturing race, ethnicity, and language data. These and other innovations have worked to enable, inform, and improve population health management. The DSRIP program has also enabled hospitals to improve inpatient care and reduce adverse events. Specific achievements include a reduction in preventable hospital-acquired conditions, such as a reduction in sepsis and central line associated blood stream infections through training, simulation-based learning, and application of evidence-based practice guidelines, along with more robust data monitoring, use of multidisciplinary teams, and improving bedside nursing techniques, among other actions.[20] Such remarkable progress with DSRIP has set the stage for California to embark even further toward achieving the Triple Aim, building on its many successes and assets, while continuing to

address remaining safety-net complexities, especially faced by systems challenged by limited resources, payer-mix, geography, and population diversity.

California's Public Hospital Preparedness and Response to Reform

Since the enactment of the ACA in 2010, many studies have documented the experience, preparedness, and potential implications of the law on the safety net, and in particular public hospitals. In seminal work commissioned by the California Healthcare Foundation, *Ready or Not: Are Health Care Safety-Net Systems Prepared for Reform*, the authors reported that California's major regions were at varying degrees of preparedness. [21] Regional preparedness for reform was assessed across four dimensions, including (1) strength of local leadership, (2) expansion of outpatient care, (3) implementation of LIHP for the uninsured, and (4) collaboration between county officials and safety-net providers. Based on these criteria, the San Francisco Bay Area and Los Angeles were identified as relatively "well-prepared" for health reform, San Diego and Riverside/San Bernardino were "moderately prepared," and Sacramento and Fresno were lagging in preparation.[22] Even in regions appearing relatively well prepared for health reform, providers and local leaders reported several ongoing concerns that continue to impact safety-net planning, including funding adequacy and life-cycles, workforce capacity limitations, caring for populations that will continue to remain uninsured (including undocumented immigrants), and competition from non-safety-net providers for newly-insured patients.

Other studies from California have documented the range of innovations that safety-net systems are undertaking to transform and adapt to a new, post-reform health care environment. Courtney Lyles and colleagues, for example, conducted interviews between January and April 2012 with a subset of member hospitals of the California Association of Public Hospitals and Health Systems (CAPH) to identify innovations occurring at these systems as well as strategic challenges and barriers to transforming in an era of reform.[23] Systems identified two key challenges and priorities as critical to responding to reform: becoming a "provider of choice" and recognizing the importance of transitioning to new payment structures. The authors also sought to understand how systems conceptualize "innovation," identifying that most defined it as "being open to new ideas by adapting and implementing solutions that already have been shown to work in other health care settings." General consensus was that innovation does not mean "inventing new solutions" but is about "embracing continual change toward improvement by taking incremental steps to gain better results." Respondents identified a set of innovations their systems have recently undertaken to prepare for reform:

- Enhancing patient-centered care, including patient-centered medical homes, given populations' complex medical and social needs;
- Adopting fixed payment structures to encourage coordinated care and team models to maximize staff time and resources;
- Enhancing health information technology, such as electronic referrals and telemedicine; and

- Establishing leadership to align innovation with organizational priority areas (i.e., aligning bottom-up approaches to innovation with top-down leadership).

Identified future directions for public hospitals included a greater understanding and sharing of evidence-based innovations; a need to establish and strengthen health care partnerships especially between hospital systems and clinics; skill-building to support improvement and innovation; and movement to better align payment structures with population health objectives and new modes of care delivery, such as telemedicine and virtual visits.

Early Indicators of Hospital Utilization Following First Enrollment

While it is still relatively early to determine the impact of health insurance expansion on health service utilization, findings from an evaluation of two of California's 1115 Waiver programs—LIHP and HCCI—offer some early indications suggesting there is likely to be a temporary "pent-up demand" or spike in utilization given that many newly insured populations will have unmet needs. Nigel Lo and colleagues published a study in October 2014 that examined enrollment and claims data for 182,443 individuals in their first year of enrollment in the LIHP program in eight counties that implemented both HCCI and LIHP (Alameda, Orange, San Diego, San Francisco, San Mateo, Ventura, Contra Costa and Kern).[24] The intent was to identify pent-up demand for outpatient, emergency, and inpatient services during the first two years of LIHP. Findings suggested that rates of emergency room visits and hospitalizations, while high in the first quarter, declined rapidly into the second year and remained relatively constant among those with the highest unmet need. They found that rates of outpatient visits remained relatively constant among all enrollees during the first two years of enrollment. These trends generally mirror the surge followed by the rapid decline in demand for hospital services observed in Massachusetts after that state expanded coverage to near-universal levels in 2006.[25]

Based on these points of comparison and early trends, there is some sense that California may face a similar phenomenon following the ACA's insurance expansions—i.e., an initial spike followed by decline in utilization of expensive inpatient and emergency services. However, one potentially important distinction worth noting is given California's 1115 waiver initiatives, many of the newly insured through Med-Cal expansion and the marketplace were "pre-enrolled" in HCCI or LIHP, and thus may have witnessed a significant amount of their pent-up demand for emergency room and hospital care prior to this expansion. In addition, HCCI and LIHP required counties to adopt many systems transformations, such as mandatory assignment of enrollees to a medical home, care coordination, health risk assessments to stratify enrollees based on disease, improved access to specialty services, and culturally competent disease management.[26] These mandates and state experience to date may at least serve to better transition and position providers to care for incoming, "newly" ACA-insured patients, some with considerable unmet need, whereas others who may already have been assigned to a medical home.

Methodology

We adopted a two-pronged approach. First, we conducted ***a review of the literature*** (including peer-reviewed articles, grey and white papers, and information available on Web sites) to distill common and distinct themes around how safety-net systems are positioning themselves in response to the changes brought on by the ACA, including lessons learned and outcomes, both in California and nationally. This review resulted in the extraction of a common set of safety-net transformation priorities and themes that formed the basis of the interviews.

Secondly, to more fully document the experiences of safety-net systems in states generally resembling California in health care reform dynamics, we ***interviewed hospital executives*** (mainly Chief Executive Officers) at a subset of safety-net hospital systems. Public hospitals were selected in our study based on a review of financial and utilization data publicly available from America's Essential Hospitals (AEH), formerly the National Association of Public Hospitals and Health Systems, for 2010. Our criteria for inclusion included (1) public hospitals located in a state, like California, that is expanding Medicaid; and (2) public hospitals with at least a 50% mix of Medicaid and uninsured patients. We identified a set of 15 hospitals that met these criteria. We then followed with requests to their Chief Executive Officers to conduct telephone-based, semi-structured interviews, of which 10 agreed to participate.

To add perspective particularly around rural priorities, diversity, and community-centric initiatives, we interviewed three safety-net providers beyond AEH hospitals: a critical access hospital, a federally qualified health center, and a non-AEH public hospital. While the primary focus of this study is to reflect on and inform public hospitals, our findings also aggregate information from these settings to offer perspective on dynamics not captured through the public hospitals in our review. All institutions interviewed in this study are listed in Table 1. Interviews were conducted between July and October 2014.

We asked hospital executives about their strategies, decisions, experiences, and plans for positioning their hospitals following implementation of the ACA related to payment and delivery reform, integrated systems of care, primary care redesign and capacity priorities. We also asked them to comment on opportunities and barriers they faced in carrying out this transition. Interviews were qualitatively analyzed, utilizing a stepwise approach to distill common and distinct themes, followed by sub-themes capturing specific patterns and emerging models and strategies. Where possible, we followed up on programs mentioned in the interviews to further document processes, lessons, and outcomes.

Table 1. List of 13 Safety-Net Providers in Medicaid Expansion States Interviewed for the Study

Hospital Name	State	Provider Type
AEH Member Public Hospitals		
Boston Medical Center	MA	Public Hospital
Cambridge Health Alliance	MA	Public Hospital
Cook County Health & Hospitals System	IL	Public Hospital
Hennepin County Medical Center	MN	Public Hospital
Maricopa Integrated Health System	AZ	Public Hospital
MetroHealth System	OH	Public Hospital
Mount Sinai Hospital of Chicago	IL	Public Hospital
NYCHHC - Elmhurst Hospital Center	NY	Public Hospital
UK HealthCare Hospital System	KY	Public Hospital
UW Harborview Medical Center	WA	Public Hospital
Other Safety-Net Providers		
Clinica Family Health Services	CO	Federally Qualified Health Center
Maui Memorial Hospital	HI	Public Hospital
Yuma District Hospital	CO	Critical Access Hospital

Study Public Hospitals and Characteristics

Table 2 provides a summary of characteristics and financial data for the 10 AEH public hospitals included in this study, comparing averages from public hospitals nationally and in California.

Large urban hospitals, many with academic center affiliations, comprised the majority of settings. Medicaid is a major player at many of these systems (42% on average), representing between one-fourth and nearly three-fourths of net revenues (with the exception of Harborview, which is less reliant on Medicaid). The hospitals generally have high volumes of both Medicaid and uninsured patients for both outpatient and inpatient services. On average at these hospitals, Medicaid and uninsured patients accounted for nearly 57% of all inpatient visits, with hospitals in Chicago seeing an even higher proportion (nearly 80% at both facilities included in our study). Over 60% of outpatient visits are attributed to Medicaid and uninsured patients, with Chicago-based systems and Maricopa Integrated Health System in Arizona seeing nearly 80%.

Table 2. Selected Utilization and Financial Data for 10 Public Hospitals in Medicaid Expansion States included in the Study, in Comparison to National and California Public Hospitals, 2010

Hospital Name (State)	Beds	Total Dis-charges	Inpatient Days	% ED Visits	% Medicaid Dis-charges	% Uninsured Dis-charges	% Medicaid Out-patient	% Uninsured Out-patient	% Medicaid Net Revenues
Boston Medical Center (MA)	511	28,876	136,779	13%	42%	6%	40%	11%	28%
Cambridge Health Alliance (MA)	165	11,084	61,284	16%	37%	7%	40%	13%	38%
Cook County Health & Hospitals (IL)	619	54,667	147,116	20%	31%	50%	19%	66%	53%
Hennepin County Medical Center (MN)	469	21,973	120,317	23%	47%	12%	41%	23%	38%
Maricopa Integrated Health System (AZ)	534	18,573	139,057	12%	39%	24%	66%	13%	47%
MetroHealth System (OH)	545	24,867	127,856	11%	38%	14%	32%	26%	35%
Mount Sinai Hospital of Chicago (IL)	291	21,714	82,995	13%	66%	12%	39%	21%	64%
NYCHHC- Elmhurst Hospital Center (NY)	551	25,507	172,155	18%	60%	6%	50%	32%	71%
UK HealthCare Hospital System (KY)	644	32,355	185,593	18%	28%	12%	17%	12%	25%
UW Harborview Medical Center (WA)	413	19,578	135,124	19%	26%	16%	29%	23%	17%
Average for:									
Study Public Hospitals	474	25,919	130,828	16%	41%	16%	37%	24%	42%
Large Urban CA Public Hospitals (>200 beds)	451	21,795	128,450	14%	42%	25%	31%	35%	41%
Small CA Public Hospitals (<200 beds)	124	9,201	40,233	17%	54%	20%	46%	26%	60%
America's Essential Hospitals Average	440	20,799	120,730	14%	36%	18%	27%	30%	35%

How Study Public Hospitals Compare to California Public Hospitals

As intended, the selected study hospitals generally resemble California's large urban public hospitals in several important ways:

- On average, these public hospitals were of similar size, although our subset of hospitals were slightly larger (474 vs. 451 staffed beds, respectively);
- Total discharges and inpatient days were also similar for both sets, although slightly higher for our subset of hospitals, likely given their larger capacity;
- Percent Medicaid discharges were nearly identical for both sets of hospitals (41% for our subset vs. 42% for California), although percent Medicaid outpatient visits were slightly higher for the study subset (37% vs. 31%, respectively); and
- Percent Medicaid Net Revenues were also nearly identical for both sets of public hospitals (42% for our subset vs. 41% for California).

A primary distinction between the study hospitals and large urban public hospitals in California was the proportion of uninsured or self-pay inpatient and outpatient visits, which in both cases were considerably higher for California's large public hospitals, as compared to our subset. Also important to note were the differing characteristics and dynamics occurring at smaller public hospitals in California, a number of which are located in smaller, more suburban localities. These systems have largely depended on Medicaid, as is evidenced by the considerably higher proportion of Medicaid inpatient and outpatient visits, and importantly by the proportion of net revenues attributable to Medicaid.

Emerging Safety-Net Delivery and Payment Reforms

We reviewed literature on systems transformations occurring at safety-net settings nationally and in California following the implementation of the ACA. In this section, we provide an overview of emerging concepts and programs to address two broad priorities that have gained increasing momentum in terms of attention, investment, and action at safety-net settings:

- ***Delivery Reform***, including a movement toward more coordinated or integrated systems of care that incorporate principles of team-based and patient-centered care; and
- ***Payment Reform***, including shifting payment mechanisms that increasingly reward value (i.e., quality and efficiency) over volume of services.

Our selective summary is intended to set the context and provide a background for our study overall as well as the interviews with safety-net executives, and offer points of comparison to California's safety-net dynamics and experience related to delivery and payment reform.

Delivery Reform: Toward Coordinated and Integrated Systems of Care

Integrated delivery systems can help to better coordinate care, reduce waste and duplication of services, and improve overall health outcomes.[27] While many concepts, scopes, and frameworks exist for defining integrated delivery systems, there is a common understanding that "integrated care should coordinate patient care in a way that improves patient experience and the quality of care received."[28] An expansive approach to an integrated delivery system is characterized as "a single integrated entity that is responsible for providing all services and has financial and clinical accountability for the health of a defined patient population."[29]

While achieving a single integrated entity (such as Kaiser Permanente or Geisinger Health System) may not be realistic for many safety-net providers, working to achieve the elements that comprise such an entity may be more feasible to moving toward integrated systems of care. As seminal work by Alain Enthoven describes, successful systems integration is comprised of eight key elements: [30]

1. Leadership, commitment, and a coherent organizational structure;
2. Patient-centered approach;
3. Culture of teamwork among clinical providers;
4. Coordinated care across all settings (inpatient, outpatient, physician's office, and home);
5. Financial incentives that are aligned with patient interests;
6. Quality improvement through the use of evidence-based guidelines;
7. Implementation of health information technology; and
8. Sufficient primary and specialty capacity.

The Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA) recently proposed a framework for levels of integrated care to help health systems understand where they are on a continuum and what

actions may be required to move them toward a more integrated system (Table 3). The framework proposes three levels of integrated care:

- ***Coordinated***, with minimal collaboration or basic collaboration at a distance;
- ***Co-located***, with basic or close onsite collaboration; and
- ***Integrated,*** with close collaboration approaching an integrated practice or full collaboration in a transformed/merged integrated practice.

These and other frameworks offer model structure and context, and identify many of the elements central to safety-net transformation occurring in California as well as in other parts of the country.

Table 3. SAMHSA-HRSA Standard Framework for Levels of Integrated Healthcare

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet ill-defined team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

In California, the first Medicaid 1115 Waiver, approved in 2005, supported the development of safety-net-based coverage initiatives that afforded a unique opportunity for select counties to advance on a path to systemic integration.[31] While adopting integrated systems of care was not a part of waiver requirements, counties receiving support through the waiver for the Health Care Coverage Initiative worked to adopt many aspects of integration—including referral management, care coordination, patient disease management and health promotion programs, monitoring quality (e.g., provider performance in relation to evidence-based clinical guidelines), and adopting electronic health records and other health

information technology.[32] Although counties made notable progress, challenges still remained, as a 2012 report indicated:

> *California counties have made uneven progress in the five key areas of integrated delivery systems…They have moved toward developing a single integrated entity and have had the most success in providing better access to appropriate care and improving the quality of care. Their efforts toward care coordination, availability of patient information, and alignment of financial incentives were less fruitful or more difficult to assess.*[33]

As this study suggested, one of the most challenging aspects of integrated delivery was aligning safety net and financial incentives. Counties faced continuous declines in funding, limiting their ability to implement or sustain systems transformation.

* * *

The sub-sections that follow further examine key elements outlined in Alain Enthoven's framework for successful systems coordination and integration, focusing on patient-centered care, team-based care models, and the importance of leadership and organizational structure overall, and for California. We acknowledge that a more in-depth discussion of elements such as health information technology and quality are beyond the scope of this paper; however, the advancement of both of these elements in conjunction with what is discussed here is important for advancing and moving closer to developing more efficient, coordinated, and integrated systems of care. The next section on payment reform addresses emerging literature and models for better aligning financial incentives with population health.

Patient-Centered Medical Homes

There is growing recognition that primary care must be structured around "the patient" to be more efficiently organized to have maximum reach and produce quality outcomes. For example, Michael Porter and colleagues presented a framework in 2013 in *Health Affairs* reinforcing this theme, citing: "the fundamental goal of primary care should be improving value for patients. This goal must transcend the traditional management focus on optimizing financial performance of primary care practices under fee-for-service payments…In value-based delivery, care is organized around the patient and meeting a defined set of patient needs over the full care cycle."[34] Achieving such a redesign in systems requires a multi-pronged approach that addresses both supply and demand-side dynamics and transforms primary care into a value-based delivery system.

Since Patient-Centered Medical Homes (PCMHs) were first recommended in 1996 by the Institute of Medicine, they have grown and evolved in focus and scope from traditional primary-care based medical homes to initiatives targeting disease-specific populations in "health homes" to more community-wide efforts often called "medical home neighborhoods."[35] PCMHs have also become an important means for integrating behavioral

health services. The growth in PCMHs is largely spurred by evidence that documents their many benefits, including better quality, patient experience, continuity of care, prevention, and disease management. A large body of work also documents lower costs from reduced emergency department visits and hospital admissions as well as reduced income-based disparities in care.[36]

Among leading systems with PCMHs, key features have included integrated primary and behavioral health services; shared medical records; single system for appointments, follow-ups, and referrals; co-location of primary, behavioral, and specialty care in one site; and involvement of ancillary staff, care coordinators, and case managers as members of care teams.[37,38]

The National Committee for Quality Assurance (NCQA) has the nation's largest PCMH program, designating 10% or nearly 7,000 U.S. primary care practices as "medical homes." Among NCQA's primary criteria for defining PCMHs are enhanced access after-hours and online, long-term patient and provider relationships, shared decision making, patient engagement on health and health care, team-based care, better quality and experience of care, and lower cost from reduced emergency and hospital use.

Patient-Centered Medical Homes in California

California, and its public hospitals in particular, have been at the forefront of transforming primary care into patient-centered medical homes. Supporting and leveraging this transformation have been two key safety-net entities—California Association of Public Hospitals and Health Systems (CAPH) and California Health Care Safety Net Institute—that have launched a series of pilots and programs for medical homes. CAPH, in particular, has issued eight core components for defining a medical home in an effort to establish a standard set of expectations and benchmarks.[39] These eight components include:

- Care is tailored to patient's health needs.
- A team of providers is responsible for a patient's care.
- Patients are involved in their own planned, whole-person care.
- Care is continuous, comprehensive, and coordinated
- Care is driven by measures and supported by technology.
- The patient has access to care.
- The patient and care team engage in open and effective communication.
- Reimbursement should adequately reflect cost and value of medical homes.

A review of public hospital medical homes across the state found that many are undertaking common strategies to advance medical homes, such as:[40]

- Integrating behavioral and physical health.
- Connecting patients with community resources, such as housing and transportation.
- Monitoring health through disease registries.
- Working with *promotoras* to promote prevention and patient wellness.
- Focusing on reducing patient wait times.
- Improving patient safety through review and reconciliation of patient medication lists.

New resources have recently emerged to assist safety-net systems in assessing their level of "medical homeness" and identifying opportunities for improvement. Among them is a new tool—*Patient-Centered Medical Home Assessment (PCMH-A)*—issued in September 2014 and developed by the MacColl Center for Health Care Innovation and Qualis Health for The Commonwealth Fund's Safety Net Medical Home Initiative.[41] The tool assesses the extent to which PCMHs have taken specific actions across the following eight priorities: engaged leadership, quality improvement strategies, empanelment, continuous and team-based healing relationships, evidence-based care, patient-centered interactions, care coordination, and enhanced access initiatives. The Agency for Healthcare Research and Quality (AHRQ) has also been a breeding ground for supporting and advancing PCMH efforts. Its Patient Centered Medical Home Resource Center, in particular, offers a range of resources such as emerging research and evidence related to PCMH implementation, evaluation tools, policy briefs, and other resources.[42]

Medical homes are increasingly morphing into larger, more community-wide arrangements. The medical home neighborhood was conceived as an extension of the PCMH, designed to address its potential limitations in capacity and care collaboration.[43] Medical home neighborhoods consist of a core PCMH linked to an array of other local clinicians, non-medical community and social service organizations, hospitals, nursing homes, and state and local public health agencies.[44] Many linked providers operate in close proximity to the PCMH, but the neighborhood can also include providers outside the core geographic area that serve a needed specialty or with whom the PCMH has an efficient working relationship.[45] Core to the medical home neighborhood is a "collaborative care agreement," which defines roles for neighbors in the system and sets mutual expectations for timely referrals, information sharing, and care coordination activities.[46] Early outcomes from medical home neighborhoods show promise, but achieving high-volume care coordination remains contingent upon the development of more sophisticated electronic health IT platforms and alternative reimbursement strategies.[47]

Team-Based Care

Team-based care has grown largely out of a need to better coordinate health care services, increase access, enable continuity of care, reduce inefficiencies, and serve as an antidote for primary care physician shortages that are being experienced all over the country, and often most acutely in safety-net settings. A care team is a small group of clinical and non-clinical staff who, together with a provider, are responsible for the health and well-being of a panel of patients. Who is on the care team and their specific roles generally varies based on patient needs and practice organization.[48]

Generally, care teams are led by a physician but also include various other health care providers such as nurses, physician assistants, nutritionists, pharmacists, social and community health workers, and behavioral health providers. Members of care teams work together and coordinate services to address the range of health-related needs of patients. Critical to team-based care (and arguably a strength) is the ability of all health professionals and ancillary staff

to perform to the fullest capacity of their training. This is optimized when state licensing laws allow practitioners to practice at the full scope of their license and training.[49]

Recognizing the importance of a range of health professionals working in concert with a physician to provide care, the American Medical Association adopted the following definition of team-based care: “The consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of training, experience and qualifications needed to help patients achieve their goals, and to supervise the application of these skills."[50]

Team-based approaches have afforded a unique opportunity to expand the role of advance practice clinicians (such as physician assistants and nurse practitioners) to provide acute, non-urgent, and routine care, sometimes working with supervising physicians and in other cases having their own designated patient panels. As experience from San Francisco General Hospitals' team-based care efforts suggest, "the nurse's role is particularly important in implementing team-based care in an academic setting, in which a team may include some physicians who are only in the clinic for one day a week because they also teach and do research. Having nurses on the team helps provide critical consistency of care."[51] In this way, the team-based care approach allows existing primary care physicians to see more patients and increase access through interdisciplinary care.

While some settings may be employing a looser version of team-based care, emerging experience with implementation of more successful models suggest that a common set of elements frame and influence actions to develop well-coordinated, interdisciplinary team care: [52,53,54,55]

- Good leadership and organizational policies that are supportive of team care;
- Defining broad goals as well as specific, measurable operational objectives of team care;
- Clearly delineating division of labor and roles, and how each member can work to advance goals and objectives;
- Training team members in their roles and in team functioning;
- Building trust among team members;
- Ongoing and routine communication through paper, health information technology, verbal interactions, and team meetings; and
- Monitoring of processes and outcomes for improvement of provider and patient experience and outcomes.

In addition to these elements, successful team-based care has evolved from solely addressing a patient's clinical needs to more broadly addressing the underlying factors which may influence a patient's health and well-being. This more expansive approach has led to a recognition of the importance of engaging non-clinical, culturally representative and competent members of the community to serve as “care coordinators.”[56] Non-clinical team members can help address the factors that lead to the patient’s health issues, connect them with resources in their community and assist in navigating the health system to better ensure regular and preventive care.

Team-Based Care Approaches in California

California's shift to increasingly utilizing interdisciplinary and team-based models of care has been driven in large part by its 1115 waiver.[57] This shift has served as an important enabler for care collaboration among providers who previously had little interaction, as well as shared accountability for patient outcomes.[58] Examples of successful team-based care approaches at California public hospitals include:

- San Francisco General Hospital's Pediatric Asthma Clinic has been utilizing the team-based model for over 10 years and found it very helpful in addressing the whole child. Many patients at the clinic live in environments that contribute to their health condition. Teams consist of not only clinicians but also social workers that assist in connecting children's families with programs that can provide housing support to remove patients from home environments with excessive mold that exacerbate their asthma. Through team consultations, or "huddles," between team members, providers are able to treat the health condition, assist in more effective management and address the social determinants that contribute to the illness.[59]

- San Mateo Medical Center took on an initiative to better address the behavioral health issues experienced by patients with chronic medical conditions. Of its 780 diabetic patients screened for depression, 23% were determined to be positive and received immediate referrals to behavioral health providers on the care team. In this way, they were able to receive care not only for their chronic health condition but also for some of the behavioral factors that contributed to that condition.[60]

A growing body of research documents the many advantages of team-based care from addressing provider shortages and access to care issues to improving patient satisfaction, outcomes, and continuity of care to lowering costs.[61] For example, a recent 2014 study found that team-based care decreased health care costs by about 60%, in large part by reducing the number of emergency visits.[62]

Other innovations, grounded in patient-centeredness and team-based care, have emerged to reform and redesign primary care. Leading these efforts is the Centers for Medicare and Medicaid Services Innovation (CMMI). For example, CMMI is supporting a demonstration on the Comprehensive Care Physician (CCP) Model which has its centerpiece in "a single physician providing inpatient and outpatient care" for patients at increased risk for hospitalization.[63] Approved for funding as a CMMI Health Care Innovation Award in July 2012, the University of Chicago Medical Center is testing the CCP model among Medicare beneficiaries. The program has established panel size of patients that each physician can manage with the support of an interdisciplinary team. Eligible Medicare beneficiaries for the program are defined as Medicare patients who have been admitted to the hospital at least once in the past year. The program is built around a care team—intentionally limited to about five care members—including a CCP, a clinic coordinator, a social worker, a registered nurse, and an advanced-practice nurse. Outcomes from this demonstration are expected in 2016, however, there is optimism that the CCP model will be able to achieve better care and cost-savings in coordinating more efficiently inpatient and outpatient services for complex patients.

Leadership and Organizational Structure

In many cases, the movement toward better coordinated, patient-centered, and integrated care across safety-net systems has been spurred by strong, championing leadership and a facilitative organizational structure. A growing body of work on safety-net systems highlights the important role that strong leadership plays in the ability to respond to changing circumstances. Many studies also reflect on the role that governance structure plays in influencing key aspects of public hospitals, from financing and capital, to operations, staffing, strategic planning and other actions. Findings from research, however, have been mixed in what constitutes "effective" leadership and governance for change.

A 2014 study by Teresa Coughlin and colleagues highlights the important role that leadership and governance across four safety-net hospital systems—Cook County Health & Hospitals System (Chicago, IL), Harris Health System (Houston, TX), Santa Clara Valley Medical Center (San Jose, CA), and University Medical Center of Southern Nevada (Las Vegas, NV)—have played in positioning systems for reform.[64] As the study shares, Cook County Health and Hospital System underwent a significant organizational transformation, with its management structure evolving from being very hierarchical to one that is flat, to accommodate rapid and shared decision-making (versus the traditional crisis management model). In the midst of a $250 million shortfall, following late 2010, Santa Clara Valley Medical Center reorganized and streamlined its leadership and management structure, hired new executive leadership, strengthened its county oversight with leadership from the Office of the County Executive, and established a range of new policies and systems to hold hospital administrators accountable for meeting performance and financial goals.[65,66] University Medical Center of Southern Nevada's leadership transformation has also been focused on lifting the system from financial turmoil, focusing on cost-cutting financial and operational priorities. Key to this hospital's efforts has been a change in governance structure from county (which historically thwarted timely decision-making) to an independent board.

A 2012 study by Laurie Felland and Lucy Stark also reflected on how an independent governance structure can facilitate systems to be better positioned for fast changing circumstances. Their review focused on five public hospital systems—Cambridge Health Alliance (Boston, MA), MetroHealth System (Cleveland, OH), Wishard Health Services (Indianapolis, IN), Jackson Health System (Miami, FL), and Maricopa Integrated Health Services (Phoenix, AZ). As with other recent studies, this research also confirmed that an independent board offers greater flexibility to allow systems to respond swiftly to change, as is reflected in the study's findings:

> *Four of the five public hospitals now have a governance structure removed from local government but remain publicly owned. While direct public control might provide more short-term protection of staff and services, a more independent board can provide more flexibility in developing strategies and reducing costs in ways that may be unpopular with the community but could make the hospital more efficient and preserve ongoing viability. Independent governance structures*

have allowed public hospitals to retain or even increase access to public funds and helped separate strategic and operational decision making from the changing priorities and politics of local elected officials. Public boards that are independent from local government have fewer constraints than hospitals under direct local control. The more independent hospitals typically face less political influence over labor decisions—for example, hiring, layoffs, benefits, salaries and raises—and fewer civil service rules and requirements, such as needing to hold meetings in public. Independent boards also have greater flexibility to attract board members with strong management experience in health care financing and delivery.[67]

Governance of Public Hospitals in California

A 2009 study commissioned by the California Health Care Foundation, *Governance Models among California Public Hospitals*, assessed whether California public hospitals' governance structure facilitated or hindered their ability to respond to a changing health care landscape.[68] The study found no apparent relationship between a public hospital's governance structure and key institutional characteristics, such as its size, patient volumes (discharges and visits), or operating margin.

They suggested that there is no "optimal" model of governance for public hospitals, but that effective models depend on the environment in which the hospital operates and the abilities of key leadership. At the same time, they found that "restructuring provides opportunities for increased nimbleness and the ability to influence four key factors including management oversight, board composition, level of public involvement, and hospital bylaws."[69]

Payment Reform: From Rewarding Volume to Value

The U.S. health care system has long been characterized as fragmented, inefficient, costly, and delivering variable quality of care. A focal point of the ACA is to rid the system of such inefficiencies by supporting programs and demonstrations to advance delivery system and payment reforms that are well-aligned. Payment reform has especially gained momentum in recent years in efforts to curb rising health care costs associated with the fee-for-service model, as it reimburses providers for each discrete service provided—often encouraging unnecessary service volume—and does not account for quality or outcomes in service delivery. In recognition of these growing inefficiencies in the fee-for-service system, the federal government, states, philanthropies and others are exploring new payment strategies for rewarding value in achieving better outcomes at a lower cost.

The federal government, prompted in large part by the ACA, is providing considerable support to test new payment models that reward "value"—i.e., improving quality and outcomes while containing costs. By 2017, Medicare expects that 10% of its reimbursement to hospitals will be risk-based, or dependent on hospital performance on quality and safety measures.[70] Catalyst for Payment Reform established the ***National Scorecard on Payment Reform*** to track national

progress in transitions from volume to value-oriented payment structures.[71] Findings from their second annual report card released in fall 2014 revealed that "40% of all commercial in-network payments are value-oriented—either tied to performance or designed to cut waste. Traditional fee-for-service, bundled, capitated and partially capitated payments without quality incentives, make up the remaining 60%."[72] Of value-oriented payments, just over half (53%) place providers at financial risk for their performance, whereas 47% do not place providers at risk, but may instead offer financial incentives to improve quality.

The ***California Scorecard on Payment Reform*** suggests that the state may be largely ahead of the national curve in transforming toward value-based systems.[73] Results from the 2014 *Scorecard* show that over 55% of all commercial in-network payments are value-oriented in the state (as compared to 40% nationally). Of these value-oriented payments, 86% are "at risk," again much higher than the national average of 53%.

While the movement toward more value-oriented systems has in many cases focused exclusively on payment reform, other demonstrations align payment reform with delivery transformation, such as through Accountable Care Organizations which transform both how care is organized and delivered, as well as how it is paid for. In addition, whereas some models place "risk" on providers, others work to "incentivize" or utilize both as a way to improve quality, efficiency, and outcomes. The approach taken largely hinges on specific market characteristics and dynamics that a system is located in, among other factors.

In the next sections, we describe three payment reform strategies that have recently gained traction in the safety-net realm: Accountable Care Organizations (i.e., shared savings programs), bundled episode payments, and global capitation payments. For each of these, we reflect on both national and California-based experiences.

Accountable Care Organizations

Accountable Care Organizations (ACOs) have gained a considerable foothold throughout the country as a means for reorganizing care delivery and reimbursement, and rewarding quality and outcomes over quantity and volume. Prompted in large part by the ACA, the main aim of ACOs is to incentivize health care providers to become accountable for a patient population and to invest in infrastructure and redesigned care processes that provide for coordinated care, high quality, and efficient service delivery. While ACOs are more prominent in settings serving Medicare or commercial populations, they have more recently emerged at many safety-net settings serving predominantly Medicaid and uninsured populations.

Early research on ACOs, especially in the early years of the ACA, found that financially stable or thriving hospital and health care systems were more sought-after collaborators with whom to enter into an ACO. In contrast, hospitals with fewer resources, and especially those not frequently participating in demonstration projects, requiring high start-up costs, and serving high proportions of uninsured and low-income populations were deemed as having reduced ability to implement initiatives targeting quality improvement and cost reduction.[74] Safety-net

hospitals, especially those in more vulnerable financial conditions, were often cited among those entities that would face added challenges to forming an ACO due to limited financial capital, lacking infrastructure such as integrated health information technology systems or not having sufficient volume to create an ACO.

Contrary to this belief, however, over the last couple of years, unique ACO arrangements, particularly those taking more holistic, community-wide approaches, have emerged at safety-net settings across the country. Through interviews with 66 safety-net ACO leaders and state officials across 14 states, a recent study by James Maxwell and colleagues identified a set of factors that have facilitated ACO formation in safety-net settings:[75]

- ***State policy and support, such as legislation or agency-initiated efforts.*** For example, Massachusetts mandates that 80% of its Medicaid population be enrolled in risk-based contracts by 2015, and Oregon has made a similar commitment through its 1115 Medicaid Waiver's Coordinated Care Organizations (CCOs). In contrast, in California, despite the absence of ACO-related state policy, the state's safety-net, recognizing its importance for future patient care, has made developing ACOs one of its priorities.

- ***Adopting a common set of building blocks,*** including building health homes that are patient-centered, coordinated, and employ team care; prioritizing high-cost case management; and integrating behavioral health with primary care.

- ***Upfront capital and financing are necessary for ACO startup***, especially for building blocks such as high-cost case management strategies, IT infrastructure, and meeting workforce needs. The National ACO Survey conducted in 2013 found that organizations on average require $4 million in capital for ACO startup.[76] While some safety-net systems are able to invest reserve capital or fundraise to collect such funds, others have had to obtain such funding through other means such as grants or global capitation payments to a risk-bearing partner in an ACO.

- ***Adopting payment and delivery system transformations incrementally***, in some cases starting with commercial and Medicare patients in ACO arrangements and expanding to the Medicaid population. In other cases, systems are starting with developing patient-centered medical homes and moving incrementally into risk-based contracts.

- ***Building on the recognition that safety-net ACOs will be serving populations with complex and often unmet social and economic needs***. Many systems are addressing social determinants of health by taking a two-pronged approach: (1) screening patients through risk assessments for their underlying social and economic needs; and (2) coordinating care with a wide group of community and social service organizations.

Early ACO Experience in California

In California, the Hill Physicians Medical Group—Northern California's largest independent practice association (IPA)—joined local hospitals and commercial health plans in forming four separate accountable care organizations (ACOs) aimed at improving quality, reducing fragmentation, and lowering the cost of care as a means of retaining business. The first and largest ACO was established in January 2010 to reduce premiums for 41,000 public sector employees and retirees covered by the California Public Employees' Retirement System (CalPERS). Early findings suggest that this ACO has decreased hospital use and per-member per-month spending in its first three years, resulting in $59 million in savings to CalPERS, or $480 per member per year. Leaders credit success to developing a mutual understanding of one another's strengths and challenges, which was a prerequisite for improving care coordination, increasing patient education, and reducing unwarranted variations in care.

Bundled Episode Payments of Care

Under bundled episode payments of care (referred to as "bundled payments" from here on), a group of health care providers receives a fixed payment—often a per-member per-month (PMPM) fee—that covers the average cost of a bundle of services. Payments for services delivered by multiple providers for an episode can be combined to form a single payment, which is then divided among providers. Fixing the price that providers will receive for a bundle of services gives them an incentive to reduce the number and cost of services contained in the bundle.

While neither the concept of episode-based payments or bundled payments are new, the combination of the two is a novel experiment that offers new ground for incentivizing greater coordination and efficiency in care delivery.[77] The history of episode-based payments can be traced to Medicare's diagnosis-related group (DRG) payments which are pre-set, lump-sum payments for diagnoses or procedures. And the concept of bundling has been used by HMOs for years to pay provider organizations a lump sum to cover costs of care delivered by a group of providers. Under the ACA, CMS is investing considerably to experiment with bundled payments through the Bundled Payments for Care Improvement initiative.[78] While there is still little conclusive evidence on the outcomes of bundled payments in terms of improving quality of care, reducing costs, or both, early lessons are emerging from across the country.

Early Learnings from the Bundled Payment Acute Care Episode Demonstration Project describes lessons learned from a CMS pilot project, the CMS Acute Care Episode (ACE) Demonstration Project, which is testing the effects of bundling Medicare Part A and B payments for episodes of care on the coordination, quality, and efficiency of care.[79] The report offers several lessons learned to date for bundled payment initiatives, such as recognizing the importance of constructing a framework from the beginning, working to increase market share with vendors, engaging physicians from the start and throughout the process, and recognizing the importance

of working with a full-time case manager, community health worker, or other to address the range of social determinant-related needs of patients.

Early Bundled Payments Experience in California

In 2010, the Integrated Healthcare Association (IHA) and the RAND Corporation received a three-year, $2.9 million demonstration and evaluation grant from AHRQ for their project called the IHA Bundled Episode Payment and Gainsharing Demonstration.[80] The purpose of the grant was to implement and evaluate bundled payments for orthopedic surgery for commercially insured Californians under the age of 65 years. Findings from its evaluation suggested that the program did not achieve its intended objectives. Among challenges that emerged were (1) Difficulty in developing consensus around a bundled definition, including potential exclusions—such as preexisting conditions or high body mass index—for bundling. Applying a potentially narrow definition of what is to be bundled resulted in an inadequate number of procedures to make bundled payments viable. Volume of procedures was also found to be important to bundling. (2) Competing interests and lack of trust particularly between providers and health plans. (3) Lack of technical infrastructure for processing and paying claims for bundled payments, which initially had to be done manually.

Among recommendations that came from this study were (1) Ensure sufficient volume, which can be increased by focusing on common conditions and procedures, including multiple large payers and providers, and limiting exclusions; (2) Assure shared-decision making by patient-provider is a part of decisions for any procedures included in bundled payments to limit inappropriate utilization; (3) Ideally, incentivize providers based on performance risk (factors within their control) and adjust or control for insurance risk (factors outside of provider control); (4) Keep bundle definition simple; and (5) Assure technical capacity such as ability to electronically process claims data for bundle payments.[81]

In Minnesota, the implementation of a new bundled cancer care payment model demonstrated reduced health care costs while maintaining outcomes.[82] The model is designed to reward physicians for focusing on best treatment practices and health outcomes as opposed to the number of drugs prescribed. The three-year study, conducted between October 2009 and December 2012 by UnitedHealthcare and five medical oncology groups around the country, covered 810 patients with breast, colon, and lung cancer, assessing the difference in cost of care before and after payment reform.[83] The pilot demonstrated that the new cancer care payment model resulted in a 34% reduction in medical costs.[84] Central to the approach was that oncologists were paid the same amount regardless of drugs administered to the patient in efforts to separate income of oncologists from drug sales.

Global Capitation Payments

Global payments, also referred to as "global capitation," differ from bundled payments in that they are usually paid to a single health care organization to cover a wider range of services for a larger patient population over a designated time period (such as a month or year).[85] Global payments are currently used by many private HMOs, including publicly financed products such

as Medicare Advantage and Medicaid managed care plans. As profits are linked with cost savings generated from lower utilization or more coordinated, efficient care delivery, plans include measures of quality and utilization to assure providers do not withhold needed care. Global payment determinants can be based on "normative standards (e.g., the average risk-adjusted payment for the population in the community) or based on historical spending for the population cared for by the capitated organization, tended forward." [86]

Capitation: Not a New Phenomenon in California

California presents a unique context for payment reform nationally as capitation has a strong foothold in the state. While in the late 1990s, many providers across the country moved away from capitation to fee-for-service, in California, nearly one-third of residents continued in health plans—through employer-based coverage, Medicare, and Medi-Cal—under capitation arrangements. Kaiser Permanente, in particular, was at the forefront of capitation payment initiatives.[87] Generally, there have been two key approaches to capitation in California: (1) physicians participate in formal, multi-specialty group practices in which they share facilities and are salaried, such as the Palo Alto Medical Foundation—a large multi-site clinic which also has integrated with other clinics in northern California to contract with health plans jointly; or (2) physicians practice solo or in small, single-specialty groups and join networks of independent practitioners or independent practice associations (IPAs) such as Hill Physicians—a northern California network of 3,000 physicians and other providers.[88]

* * *

Our review of the literature offers an overview of models, experiences, and lessons that have emerged around payment and delivery reform, both in California and across the United States. While there is considerable common ground in addressing delivery reform, especially to redesign primary care around medical homes, through team care and integration of services, experiences with payment reform have been mixed though there is general consensus of the need to align payment with population health. As is often the case, we found that there is no one-size-fits-all approach; rather success with transformation may well depend on factors internal and external to systems. As such, in the next section we reflect on "realities from the field" uncovered through interviews with safety-net executives across the country to learn first-hand about their common and unique paths and experiences in transforming care delivery and payment in these new times.

Realities from the Field:
Safety-Net Systems Transformation in the Era of Reform

Hospital executives in our study discussed a range of actions they have undertaken in anticipation and preparation for reform, as well as their experiences and response strategies in the aftermath of the first year of implementation of the ACA's health insurance expansion. In this section, we summarize emerging transformative actions, lessons, and challenges discussed by hospital executives in the context of five key themes. Many of these themes reinforce what we found through our literature review as key elements for moving toward better coordinated and integrated systems of care, especially in a post-reform health care landscape:

- Value-based payment and delivery reforms;
- Primary care redesign;
- Responding to competition;
- Embracing change through strong and flexible leadership; and
- Implementing cost-cutting strategies.

Value-Based Payment and Delivery Reforms

An overwhelming majority of hospital executives cited that they were indeed "turning the dial," transitioning from a fee-for-service payment structure to more capitated approaches that reward population health and value over volume. Most systems acknowledged that while they are currently "in that in-between time," they are taking explicit steps to transition away from fee-for-service. While no interviewed system is taking draconian measures to entirely transform their payment structures, we learned that most are taking iterative steps, recognizing that in this "transitioning period" they will like be in a "two-canoe situation" where fee-for-service and capitated approaches may need to run side-by-side. Following are identified initiatives that many safety-net systems discussed undertaking in efforts to move toward a more value-based delivery and payment system.

Accountable Care Organizations

At least six of the systems we spoke with said that they were part of an Accountable Care Organization (ACO). Two hospitals cited that they made a conscious decision to forgo participation in CMS-funded pilot ACO programs to instead focus their efforts to strengthen their financial situation and build infrastructure to establish their own ACO. As one of these hospitals shared, "Our ultimate goal is to leave fee-for-service medicine; an all-payer ACO would be the direction we're moving towards," but the provider recognized that to move in this direction would require taking on significant risk, and thus considerable financial and infrastructural foundation. Among systems with ACOs, such as Harborview, Hennepin, MetroHealth, and others, we came to find that even within our subset of hospitals, approaches to ACOs varied in partnerships, scope, and patients (e.g., Medicare, Medicaid). For example, whereas some are more traditional in their partnerships between health plans and providers, others are taking more expansive approaches to partner with social service organizations to

provide a more holistic approach to care delivery, and one system is directly partnering with an employer (taking the insurance company out of the network altogether).

UW Medicine Accountable Care Network

Harborview is part of the ***UW Medicine Accountable Care Network (ACN),*** launched in June 2014, spanning 46 cities and neighborhoods and including over 700 primary care providers, 4000 specialists, 573 clinics, 24 urgent care locations, 20 hospitals, and 21 emergency departments in the state of Washington.[89]

The ACN was built on UW Medicine's foundational framework—***Patients Are First***—which places the patient's needs at the center of all care delivery, and as such seeks to assure patient safety and satisfaction, quality outcomes, cost controls, and employee satisfaction. An important prerequisite to the ACN development was the systems' efforts to meeting federal Meaningful Use goals to use certified EHR technology to improve quality, safety, efficiency, and reduce disparities; engage patients and families; improve care coordination; and maintain privacy and security of health information. Other technological advancements, such as deployment of the Epic medical record system to specialty clinics, have also served as important steps to launch the ACN to better coordinate care.

Unique to the UW Medicine ACN is its partnership with Boeing resulting in an employer-driven ACO arrangement, with no insurance company involved—thus believed to be among the first in the nation to use this approach.[90] Called the ***"Preferred Partnership"*** option, and launched as of January 1, 2015, the arrangement has been described as follows:

In the deal with Boeing, the contracts set goals for the employees' medical costs. If the costs are higher or lower, the provider either foots the bill or reaps the savings. The contracts also include quality goals that matter to patients, such as the ability to schedule appointments in a timely manner and maintaining patient safety and satisfaction. There are additional benchmarks tied to costs, including reducing readmissions to hospitals after treatments and effectively managing chronic conditions such as diabetes and heart disease.[91]

In efforts to implement an ACO coinciding with the expansion of Medicaid, Hennepin Health established a ***Minnesota-based Social Accountable Care Organization***. Taking on more risk, the ACO partnered with social service organizations to especially target and ensure appropriate care for its vulnerable populations, including those with high rates of mental illness, unstable housing, chemical dependence, and two or more chronic conditions. Built on the foundation of patient-centered medical homes with a strong continuum of care coordination, this ACO is also addressing the social determinants of health, such as housing, substance abuse, and joblessness, among other priorities.[92]

Whereas some ACOs have been in existence for several years, others have only recently emerged. ***MetroHealth Care Partners Accountable Care Organization***, for example, was selected as one of the 123 Medicare ACOs and was formally established in January 2014, with 500 primary care physicians and specialists, covering nearly 1.5 million Medicare beneficiaries. Shared savings from the initiative are intended to be reinvested in the ACO itself, as well as among individual physician practices within the ACO.[93] Among the ACO's identified

infrastructural needs were to enhance clinical integration, especially by adding care coordinators and care navigators, and building technology for reporting and analytical support. The ACO intends to reinvest its shared savings in the ACO infrastructure as well as across the ACO partners, including primary care professionals, specialists, and the hospitals, with the first year investing more heavily in infrastructure (70%, vs. 30% for partners) and by the third year, both infrastructure and partners receiving 50% of savings.[94]

Hennepin Health: A Social Accountable Care Organization

Hennepin Health, a county-based safety-net ACO in Minneapolis, Minnesota, and its surrounding suburbs, was created in 2011 in partnership with four organizations:

- Hennepin County Human Services and Public Health Department;
- A Level I trauma center and medium-size public hospital and safety-net system;
- A federally qualified health center; and
- A nonprofit county-run, state certified health maintenance organization serving Medicaid and Medicare enrollees.

Unique to Hennepin Health ACO is a recognition that moving toward "population health" approaches requires explicitly addressing the social determinants of health, and thus the ACO partners with the human services and public health sectors—a partnership most ACOs across the country have not explored. "All partners signed a business agreement to share full financial risk for newly enrolled Medicaid beneficiaries. The partners were motivated by the fact that working together under global capitation, with all parties at financial risk, would enable a more coordinated, comprehensive model."[95]

Hennepin Health's ACO payment model combines both capitation and fee-for-service arrangements. Hennepin Health receives a per-member per-month capitation payment from the state to cover the cost of services for the Medicaid-enrolled population. The medical providers are in turn reimbursed through fee-for-service payments from Hennepin Health. Social services provided by the county human services and public health department are paid for with human service funds and supplemented by the health plan's per member per month payments. [96]

Over 9,000 Medicaid beneficiaries are enrolled in the ACO; 70% are racially and ethnically diverse. A large proportion of beneficiaries have a mental health diagnosis and many report a range of social challenges, including lack of social support, housing needs, transportation, and others.

Hennepin Health's care model is built on interdisciplinary care coordination teams located at primary care clinics, with patients stratified by "risk categories" to tailor care. Teams are comprised of registered nurse care coordinators, clinical social workers, and community health workers. Core to the care model is access to nonclinical and social services.

Early outcomes from Hennepin Health have shown promise, with ED visits declining from the first year of implementation to the next by 9.1%, and outpatient visits increasing by 3.3%. Quality outcomes have also improved, with percentage of patients receiving optimal diabetes care, vascular care, and asthma care. Patient satisfaction has also increased with 87% of members saying they are "satisfied" with their care. Over $1 million in savings has been re-invested in services such as behavioral health, employment counselors, and other community-oriented efforts.[97]

Primary Care Redesign

Hospital executives reflected on a range of actions their systems have undertaken to transform how primary care is delivered—including patient-centered medical homes, team-based care models, and other approaches to address primary care provider shortages as well as efforts to better coordinate and integrate primary and behavioral health services.

Patient-Centered Medical Homes

Virtually all of the interviewed hospitals have shifted to providing primary care through patient-centered medical homes (PCMHs), citing that it has expanded their ability to see more patients—both existing and new. Executives also overwhelmingly suggested that PCMHs are an important precursor to adopting delivery and payment reforms built on coordinated care, population health, and capitation.

A range of approaches have been adopted to establishing PCMHs, and as one executive reaffirmed, "PCMH doesn't mean the same thing in all markets," recognizing that approaches vary from more expansive with a population or community focus (e.g., medical home neighborhoods) to more disease- or population-specific (e.g., health homes for chronically ill). One executive also suggested that "not all patients need a PCMH," and thus discussed the need for systems to recognize that "multiple strategies" may need to be adopted to address the needs of patients with varying risks and circumstances. In this section, we reflect on different experiences and models of interviewed systems in coordinating care around "patients" and establishing medical homes.

Medical home consolidation and co-location. At least two interviewed systems are investing in consolidating and renovating their facilities to create medical homes for patients that are integrated and accessible in one versus multiple sites. Boston Medical Center is undergoing construction to bring all its services under one structure to further facilitate the medical home mission. The project will cost $270 million and will consolidate the hospital's two South End campuses and eliminate 60 beds while maintaining the same level of services. While the hospitals have integrated departments over the past 18 years and closed one of the two emergency rooms in 2010, they have continued to offer medical care at both campuses, often shuttling patients admitted at one to specialists at the other—a two-block ambulance ride.[98] As Dr. Ravin Davidoff, chief medical officer at Boston Medical Center has stated, "we're positioning ourselves for the next phase of health care…We're creating a ***patient-centered clinical campus***."[99] The consolidation is expected to save at least $25 million per year through energy efficiencies, elimination of "workarounds," and better care coordination.[100]

Similarly, MetroHealth (Ohio) is proposing a $400 million project to renovate or rebuild nearly 75% of the facility to create a "smaller, more accessible campus" that would facilitate and advance the medical home model.[101] The renovation is part of a larger community-wide effort to build a revitalized ***West 25th Street Corridor***: "Our job, really, is to connect MetroHealth and

help foster its relationship with the community and to connect the hospital to economic development opportunities."[102] In efforts to newly design an "evidence-based" hospital system that is conducive to the medical home and related systems reform models, MetroHealth has "built life-sized, cardboard hospital-room mock-ups where patients and families can interact with doctors and nurses to see what designs work best."[103]

Medical homes for complex patients. Many systems identified the need to establish a medical home for patients with complex medical as well as non-medical social needs (e.g., homelessness, lack of social support, transportation) that may contribute to high utilization of emergency and inpatient care. Hennepin County Medical Center, for example, has established a ***Coordinated Care Center***—a patient-centered, multidisciplinary, team-based care clinic—that caters to complex patients with a history of frequent hospitalizations.[104]

Hennepin County Medical Center's Coordinated Care Center[105]

Hennepin County Medical Center recognized that 3% of its patient population represented 50% of the cost of care. This prompted Hennepin to create the Coordinated Care Center (CCC)—a patient-centered, multidisciplinary, team-based clinic—to improve patient health, reduce cost, and avoid preventable readmissions of complex patients. CCC services include walk-in access for new issues, medical follow-up after hospitalization, oversight by clinic pharmacists, and attention to a patient's behavioral health and social needs.

The clinic is available to patients by referral only and new patients typically have three or more hospitalizations before they are referred on. Clinic-based Nurse Care Coordinators and Social Workers organized and facilitate care within the health system and the community.

In 2013, the CCC won a NAPH Gage Award for population health improvement as the initiative significantly reduced emergency department visits (by 37%) and inpatient stays (by 25%) following one year of implementation.

Medical home in rural facility. Yuma District Hospital (Colorado), a 12-bed inpatient facility serving a predominantly rural population, in collaboration with safety-net clinics in the state participated in a five year demonstration project to transform into a patient-centered medical home. This movement was largely prompted by longstanding challenges the facility faced in recruiting and retaining healthcare providers given its rural location.[106] Through incremental changes—including a movement toward part-time, long-term employment as a way to attract physicians, the implementation of team-based care to smooth care transitions, and the addition of care navigators—the facility set on a path to become a medical home.[107]

Selected by the Colorado Health Network, and initiated and funded by Qualis Health in Washington State, the Commonwealth Fund, and the MacColl Center for Health Care Innovation at the Group Health Research Institute, the five-year demonstration is intended to assist Yuma and its clinics to transform into a certified PCMH, following which Yuma Hospital District was also invited to participate in the ***Medicaid Regional Care Coordination***

Organization, an ACO initiative.[108] Participating members of the PCMHs receive $2 per-member per-month, along with $1 per-member per-month for achieving the following goals: reducing 30-day readmissions, reducing ED visits, and reducing high-cost imaging. As recently shared through the Hospitals in Pursuit of Excellence initiative of the American Hospital Association, Yuma has experienced some initial success:

> *Introducing the medical home process helped in developing communication systems to improve patient hand-offs and data access. A huge advantage of being part of the PCMH is access to the wealth of data available to help with patient care management. After reviewing the data, Yuma identified a pool of high-risk people who could benefit from patient care management.*[109]

In addition, Yuma's CEO recently shared that "patient satisfaction is up and hospital admissions are down" but there are worries about "how Yuma will fare in the shift to value-based reimbursements and how long the hospital will be able to remain independent."[110]

Among challenges for Yuma in implementing the medical home model has been some community dissatisfaction with interruptions in traditional patient-provider relationships—i.e., moving from a traditional model of physician service (where patients often see the same provider) to one where a patient may see multiple physicians and other providers. Yuma learned several lessons along the way, including the need to help educate and transition patients to foster understanding of the benefits and value of this new model of care. They also learned that everything cannot be achieved at once, but that there is a need to "take baby steps" to achieve PCMH goals.[111]

Integrating private practice principles in safety-net medical homes. Elmhurst Hospital in Queens, New York, was recently recertified as a Level 3 PCMH, the highest level possible by the National Committee for Quality Assurance.[112] The hospital has uniquely worked to integrate promising aspects of private practice to expand access and better coordinate care.

Elmhurst Hospital's "Private-Practice" Approach to PCMHs[113]

Elmhurst Hospital, a hospital of the New York City Health and Hospitals Corporation, was recertified as a "Level 3" Patient-Centered Medical Home, the highest accreditation possible by NCQA. Part of Elmhurst's success with PCMHs has been building on what it calls the "best elements of private practice" to better coordinate care, including: "implementing an on-call system where patients reach their doctor if situations arise that could affect their care; new care-management procedures to identify high-risk patients; referral tracking and follow-up; supporting safe-care; and the ability to document and measure performance in meeting goals."[114] Other initiatives that the hospital has undertaken to achieve the Level 3 designation includes: extended hours of operation; greater availability of same day appointments for outpatient care; establishing patient care teams; patient monitoring through spectrum of pre- to post-care; and collaborating with patients for disease self-management.

Team-Based Care Models

The majority of hospital systems in our study have adopted team-based care approaches, especially in the context of providing primary care through PCMHs. While the size and scope of teams may vary, the end goal for all systems is largely the same: to deliver higher quality, better coordinated and efficient care. Urban systems such as Cambridge Health Alliance and Hennepin County Medical Center are using health care teams in an effort to increase access, ease flow, and reduce costs. Rural hospitals, such as Yuma District Hospital, as well as health centers such as Clinica, are using the approach to help ease the burden of a physician shortage.

Cambridge Health Alliance has been testing and implementing a range of processes over the last decade to improve population health through team models of care.[115] Their journey began with a team model of care to manage diabetes and asthma more effectively as part of the Robert Wood Johnson Foundation's *Pursuing Perfection Initiative*. Among other positive outcomes, results indicated dramatic improvements in pediatric asthma outcomes (with over 90% reduction in emergency room visits and inpatient admissions).[116] More recently, the system has been working to improve complex care management for its Medicaid managed care population.

Cambridge Health Alliance Model of Team-Based Care Implementation Guide and Toolkit[117]

Cambridge Health Alliance issued an implementation guide and toolkit on their team-based care approach, lessons, and strategies. The guide walks through the different kinds of teams that systems ought to consider forming (e.g., session team, patient's "go to" team, coverage team or pod, and complex care management team); the steps to building a patient-centered care team; and the different roles and responsibilities of team members on each team and through the continuum of care. Core to their model of team care are four key principles:

- Every patient is assigned to a care team that, at the very least, includes a primary care provider, a nurse, medical assistant, and receptionist.
- The team huddles daily to care for patients in a proactive way.
- The teams meet at least monthly to proactively manage population health and to discuss high-risk patients.
- The usual care team interfaces seamlessly with the complex care management team.

Cambridge Health Alliance has learned several lessons in implementing team-based care approaches, which largely reinforce lessons from other parts of the country including California: (1) clearly defining and communicating roles, responsibilities, and workflows, as well as training team members to function at the "top of their license"; (2) engaging unlicensed but trained culturally competent members from communities to serve as patient navigators, care coordinators, and health educators especially to overcome health literacy, cultural, and linguistic barriers as well as establish trust; and (3) assuring teams have capacity to address mental, social, and other complex needs of patients that affect their health and well-being.

Clinica Family Health Services' in Colorado is among the leaders in the country in implementing team-based care models at primary care clinics. Their teams are comprised using a pod structure which includes a physician, nurse, physician assistant, pharmacy tech, medical records staff, and behavioral health practitioner.[118] Each member of the team works to the "top of their license," to afford licensed health practitioners and other allied health professionals greater autonomy in the types of functions they are allowed to take on.

Clinica's primary care teams are set up around a central bullpen area with an open line of communication and sight to patient rooms. Each team member is given his or her own patient panel, which improves accountability and continuity of care. In an effort to improve efficiency and coordination, team members take on functions of other personnel as needed. For example, team nurses also manage the schedule, front desk staff perform clinical outreach, and behavioral health professionals receive hand offs from primary care. Each team also has a case manager for clinical goal setting (e.g., for diet and exercise) that helps patients access other resources in the community, refer needs for specialty care, navigate medical records, connect with a hygienist, and access clinical pharmacy services.

Clinica treatment providers and patients are on color teams. When a patient leaves, they are given a colored appointment card to help them coordinate future treatment-related visits. Aside from improving the patient experience, Clinica care teams are also encouraged to join in "friendly competition" for the benefit of patients, as teams can view and compare each other's outcomes. Also, as part of its team-based care approach, Clinica Family Health Services has innovated a timed patient hand-off called a "flip visit." ***Flip visits*** are intended for patients who arrive at the clinic with minor acute illnesses or require relatively routine care for non-chronic conditions.[119] They allow nurses to play a greater role in care and see more patients, potentially yielding greater cost effectiveness.

Clinica Family Health Services' Flip Visit[120]

To improve access to care, create efficiencies, and contain costs, Clinica Family Health Services has innovated "flip visits" to hand off minor acute, routine, and non-chronic disease patients to nurses or other allied health professional for care. "In a flip visit, a nurse or other assistant provider does the bulk of the work on a visit, and then hands the patient off to a provider, who briefly checks and adjusts the nurse's diagnosis and care plan. This converts the nurse's visit into a billable provider visit. A provider doing flip visits should schedule their day in hour-long cycles: two standard twenty-minute visits, followed by a twenty-minute segment devoted to charting and paperwork and picking up the 'hand off' of a flip visit."[121]

Early lessons are emerging from Clinica's flip visit program. First, they have found that flip visits have facilitated greater communication between nurses and physicians, especially to discuss greater detail about individual patients. To drive such communication, Clinica has also been working to accommodate and set up appropriate physical workspaces. Clinica has also felt that staff encouragement and enthusiasm are key to success and has thus created badges and materials with the slogan "Ninja Nurses FLIP IT!"

Integrated Behavioral Health

Executives from at least five hospital systems spoke about a commitment to, yet difficulty in, integrating behavioral health services with primary care. An underlying theme among them was recognition for the need for greater communication and collaboration between primary care and mental health providers. One hospital executive shared that a concerted effort had to be made to connect providers of primary care and mental health: "We have had to introduce primary and mental health doctors to each other because they literally didn't know who each other were. Now they are starting to coordinate." Another executive pointed to the importance of explicitly addressing and establishing a medical home for patients with mental health needs.

Cambridge Health Alliance launched a pilot effort in 2012 to better integrate medical care with mental health care in an outpatient mental health setting.[122] This initiative builds on the system's initial success with ***Recovery U***, a weekly group program that provides care in one familiar location to improve the health and lives of patients with mental illness. Termed "clubhouse care" the program strives to integrate medical care on-site where psychiatric patients feel most comfortable receiving care.[123]

Cambridge Health Alliance's Mental Health Medical Home[124]

In an effort to better care for patients that co-present with needs for medical services as well as mental health care, Cambridge Health Alliance is in the process of developing a true mental health medical home. A pilot program has begun to integrate medical care with mental health care through an outpatient mental health venue. The pilot is an extension of a weekly group program (Recovery U), providing care in one familiar location to improve the health and lives of individuals with mental illness.

As is cited on its Web page, the program has incorporated the following elements:[125]

- Evidence-based clinical services, including a clozapine program, groups promoting social functioning and physical wellness, individual psychotherapy, and medication management.
- Emphasis on engaging individuals reluctant to participate in traditional services.
- Close coordination with service providers throughout the continuum of care.
- Monthly coordination with local Community-Based "Flexible Support" teams.
- Opportunities to participate in research interventions.
- Early psychosis program in planning phases.

The program's Web page also describes the following as its initial phase of work:[126]

- Weekly groups targeting nutrition, smoking cessation, other aspects of health and wellness; young adults' particular needs; and social isolation.
- Seasonal social gatherings with food, music, and entertainment.
- Individual psychopharmacology and psychotherapy
- Close coordination with community providers.
- Opportunities for participation in innovative research.

Other systems are working to build patients with mental health needs into their existing coordinated care efforts. For example, Hennepin County Medical Center's ***Coordinated Care***

Center focuses on complex patients with a history of frequent hospitalizations, including those that may have behavioral health needs.[127] Furthermore, recognizing shortages in behavioral health providers, one hospital stated that it is using telepsychiatry—a form of telemedicine that allows psychiatrists to see and communicate with patients in remote locations using video or audio-conferencing technology.

Addressing Provider Shortages

When asked about provider shortages, safety-net systems generally in more constrained financial situations or in less desirable geographic localities cited major challenges with recruiting and retaining providers, whereas others, especially those affiliated with academic medical centers, felt it was not as big an issue. As one hospital executive struggling with this priority shared, "Our biggest challenge is recruiting physicians overall to the area. We need enough physicians to just cover call, and we are challenged by our limited capital."

Another system spoke about their success in retaining practitioners, despite being in a rural location. The executive suggested that central to the success of hiring and retaining providers was a two-pronged approach: (1) the system serves as a family practice rotation site for medical residents, offering exposure to a unique community-based experience; and (2) the system provides stipends in the last year of medical training. This system noted that nearly two-thirds of physicians were recruited through this process. As the executive suggested, "key is to get physicians in training and give them opportunities to see what kind of experience they would get from practicing here."

Some hospitals reported that while they were experiencing challenges in recruiting and retaining primary care providers, initiatives, especially state-led, have been helpful in shoring up primary care capacity for their expanding patient populations. Providers we interviewed in Colorado, for example, spoke about two promising initiatives aimed at addressing primary care provider shortages: loan payments and scholarships.

Addressing Primary Care Shortage in Colorado

Two initiatives in Colorado incentivize practice in primary care settings serving predominantly underserved populations.

First, the Colorado Health Service Corps pays up to $150,000 of a graduating medical student's educational loan in exchange for serving three years in an underserved area—i.e., primarily serving uninsured or publicly insured patient populations.

The program has shown that 77.6% of program alumni are retained at an eligible clinical site and 44% of providers anticipate continuing to work in underserved settings for 16 or more years.[128]

Secondly, the Heart of the Rockies Regional Medical Center Foundation offers $2,500 annual scholarships for college students from underserved areas who plan health care as a career plan.[129]

Responding to Competition

There was a strong sense of uncertainty among interviewed executives around the fate, role, and direction of safety-net providers. The common sentiment was that while they will continue to be a primary source of care for remaining uninsured, low-income, and vulnerable populations, their survival will depend on their ability to compete for paying patients. Given the challenging financial situation many are in, especially with the looming threat of declining payments and growing requirements and penalties, many felt that to survive they would need to actively respond to rising competitive pressures. Otherwise, they felt they would be left with a "disproportionate burden" of unhealthy, high-risk, low-income, and uninsured patients. One executive summed up her hospital's experience: "We now have nearby nonprofit or private hospitals with neuroscience institutes, robotic surgery, and other highly reimbursed services and they're taking business away. How do we keep up with these systems?" Several strategies were discussed to countering competition including collaboration, partnering with community clinics, addressing social determinants and community priorities, active outreach and enrollment, and expanding scope to providing health plans.

Collaboration

Many of the initiatives we have cited represent the importance of and have featured new or expanded efforts to collaborate with and beyond the safety net. At least four hospital executives reinforced this priority noting, in particular, the direction of systems adaptation, especially with the proliferation of population health and value-based payment programs; ACOs and other shared savings arrangements; as well as primary care redesign emphasizing more ambulatory-based care. Common sentiments around collaboration included:

> *The language of care delivery is changing because capacity is being tested. We are learning to collaborate out of necessity; we are caring for the same populations. It just makes more sense to collaborate.*
>
> *I don't believe in competition, I believe in collaboration. It would be crazy in this landscape to think differently.*
>
> *Consolidation is the natural direction in health care now but our hospital is not the most attractive partner to other systems because we're 50% Medicaid.*
>
> *We are creating collaborations to offer certain service enhancing actions so that other hospitals start bundling patients and generate referrals to us.*

Building and Strengthening Relationships with Community Clinics

A majority of health executives stressed the role community clinics play, recognizing the importance in some communities of "taking care" to where people live, work, and pray. Such an approach is working to fulfill critical gaps in access to care and health education, as well as offer

trusted venues for often reluctant patients from diverse socioeconomic, cultural, and linguistic heritage.

As one executive discussed, his system is recognizing the necessity of investing in community-based clinics given evolving population dynamics, in particular what he cited as the "suburbanization of poverty" where in suburbs, services—including enabling and social support—for poor and low-income populations are largely lacking. In his city, historically, 60% of the poor lived in urban areas, but now that number is less than half.[130] As such, this system and others have realized the strategic need to partner with organizations and clinics in the areas where vulnerable patients live if they are to improve access to and quality of preventive and primary care services (e.g., attending community events such as fairs and festivals to provide free health screenings and preventive care).[131]

While some hospital systems are investing in building and operating their own community clinics, others have explored partnerships with existing providers. For example, University of Kentucky Health is contracting with primary care health sites through which hospitals refer primary care patients to the clinics, and in turn, the clinics refer specialty and more complex care to the hospitals. This has been an important measure to leverage limited resources and more efficiently coordinate limited services within the community. A summarized by one hospital executive:

> *We need to capture patients for destination services, not by building hospitals but by supporting existing hospitals in those areas so they can survive and manage care and refer specialized patients to us.*

University of Kentucky Health's Community Clinic Partnerships

While many hospitals have invested in opening their own clinics, the University of Kentucky Health has taken a unique approach that does not require capital investments in external clinics, yet increases access to primary health care for their patients. The health system has partnered with existing, and previously unaffiliated, primary care clinics around the state. The existing primary care centers are well positioned to provide targeted and competent care to their communities and refer specialty care needs to the University of Kentucky Health.

The clinics receive benefits from the University of Kentucky Health that would otherwise be difficult or out of their reach such as extensive IT support, marketing, and others. The University of Kentucky benefits by expanding its service area, developing an ingrained referral base and maintaining the ability to focus on specialized care. The benefit for patients in the state is the ability to access a system of health care in which their primary care is handled at a local community clinic, while maintaining a seamless connection to specialty care.[132]

Addressing Social Determinants of Health

Nearly half of the hospital executives discussed that their strategy to continue to compete for patients was grounded in their mission, and for many, in their strength to provide a range of enabling services, such as transportation, case management, social support, and language assistance. As one executive reinforced, "the health care system is the end of the line and we

need to move upstream if we want to really serve our population." Another hospital executive shared how her hospital was investing in services beyond health care: "Many of our patients are in low-income situations and health is affected by the stresses in their lives. So adding social workers has been very helpful to help reduce those stresses."

Boston Medical Center, in particular, shared its many unique programs grounded in a more holistic approach to providing patient care. For example, the hospital's new pediatric residents undergo ***Poverty Simulation*** to better understand the lives and circumstances of families they treat. The hospital provides a prescription food pantry program to address episodic hunger and improve the nutrition of some of its most vulnerable patients. It also offers the Medical Legal Partnership program to assist patients who face legal issues that may be contributing to poor health access, affordability, or care.

Boston Medical Center's Poverty Simulation

Boston Medical Center's (BMC) new pediatric residents undergo Poverty Simulation to better understand the lives and circumstances of families they treat. The simulation was designed to spread awareness about the struggles many patients face. "During four, 15-minute intervals, the residents were asked to go about a typical month in the life of a family living below the poverty line—some as children, some as parents, some as grandparents."[133] The residents were organized into various family situations simulating the very real situations of some of BMC's patients. "Walking in the shoes of these families, the residents had to make hard decisions quickly—choosing between picking up their paychecks or picking up their child at school, paying for food or paying for their rent…Though the residents were lucky enough to be able to end the simulation and return to their lives, they were made aware that many of their patients could not walk away from these situations as easily. They will be interacting with patients over the next few years who will be just as frustrated as they were during the simulation because of the inability to make ends meet, patients who will have more pressing issues than their health sometimes."[134]

Others, such as Hennepin County Medical Center, have invested in cultural and linguistic competence programs given the growing diversity of their patient population. The hospital has a ***Diversity and Inclusion Strategy*** with diversity training for employees, diversity actions identified for departments, and creation of policies, procedures, and practices that are sensitive to the diversity of employees and patients. The hospital also has a ***Native American Program*** with dedicated staff members to oversee encounters with Native American patients, with advocacy and training for staff provided on specific cultural issues. The ***Interpreter Services Department***, one of the largest hospital interpreter programs in the country, provides professional, culturally competent language interpretation and cultural brokering/advocacy to establish clear communication and improve mutual understanding between providers and patients.

A Focus on Outreach and Enrollment

Outreach and enrollment for Medicaid and the health insurance marketplace have been critical actions undertaken by safety-net systems in adapting to health care reform. Hospital executives were somewhat optimistic that if they invested in enrolling uninsured patients generally loyal to their facility, by investing in outreach and enrollment efforts, it may yield a long-term return on investment. Many efforts have emerged such as requiring frontline staff to become certified application counselors, supporting community health fairs for enrollment, establishing enrollment vans, and others. Hospital executives also recognized the importance of in-person assistance and the opportunity it offers to potentially build trust with individuals and their families. As one executive summarized:

> *Newer immigrants, even those documented, are wary of giving information to government institutions. There is a lot of misinformation in their communities. We are working on outreach that can be integrated into health mission and that builds community trust.*

One hospital executive shared an example of "mobile" enrollment efforts his institution has initiated to proactively reach, educate, and enroll potentially eligible individuals within communities. As he stated:

> *We have invested in community outreach that is uncompensated but we think serves our mission and will bring more of the eligible or newly insured patients to us. An example is the **Enrollment Outreach Mobile Unit** (i.e. "enrollment van") which goes to the community and enrolls people on site to a variety of public programs they qualify for.[135] There are dedicated enrollers that can serve three people at a time. A WIC van was repurposed for this initiative and so far it's been effective in enrolling our existing population into coverage as well as attracting new patients.*

MetroHealth's Enrollment on Wheels[136]

MetroHealth launched "Enrollment on Wheels" to help individuals sign up for coverage where they live and work. The Enrollment Outreach RV, a 38-foot vehicle, travels to various locations around Cuyahoga County, Ohio. Staffed with certified application counselors, this effort is intended to help individuals enroll in Medicare, Medicaid, and other public programs. Individuals also have an opportunity to schedule a future appointment at MetroHealth before leaving. The mobile unit has numerous work stations and is staffed by counselors that have been certified by the Centers for Medicare & Medicaid Services. The counselors help community members understand their options through the health insurance marketplace and other public programs and assist in applications. All assistance is provided in private sections of the mobile unit and applicants are also given an opportunity to schedule an appointment with MetroHealth and setting up an electronic medical records chart before finishing. In this way, community members can quickly and seamlessly enroll in insurance and be connected to care in one meeting.

Hennepin County Medical Center in Minneapolis is actively engaging and educating patients about insurance opportunities through its marketplace, MNsure. Approximately two out of three uninsured patients at Hennepin are eligible for coverage. MNsure is playing an active role in assuring these patients are directed to the Center's financial counseling office. Approximately 30 Hennepin financial counselors have completed training to become certified application counselors for MNsure. For those patients who are not eligible for coverage through MNsure, Hennepin is maintaining a financial assistance program. [137] Maricopa Integrated Health Services has adopted a similar initiative entitled ***"culture of coverage,"*** with a focus on vulnerable, diverse and other populations less likely to participate in care.

Maricopa Integrated Health Services "Culture of Coverage"

Maricopa Integrated Health System embraced an active "Culture of Coverage." With the ACA enrollment deadline looming, paired with the implementation of Medicaid expansion, an urgent need to communicate with consumers regarding the changing healthcare landscape in Arizona was established. Key messages were designed to resonate with the community. In-reach and outreach activities were implemented to identify vulnerable and hard-to-reach populations. Targeted efforts were launched to reach special populations such as Persons Living with HIV/AIDS, Latinos, refugees and those on health plans due to sunset. Multi-cultural marketing promotions, mass mailings, calling campaigns and Secret Shopper programs were designed to be innovative and serve multiple purposes.[138]

Offering Own Health Plan

At least three hospital systems in our study have moved to adopting their own health plans as a way to recruit newly insured patients, provide them with a medical home, and ultimately retain patients within the system. One hospital executive shared their initial success with offering a health plan:

> *For the last six months, our hospital has more insured than uninsured patients. This is the first time in the long history of the hospital. We are at 54% insured and it used to be 70% uninsured. There's no way that would've happened if we didn't have our own health plan.*

Health and Hospitals Corporation in NYC created ***Metroplus*** (a health plan offered on the exchange) and sees this as a "powerful opportunity to attract a different class of patients—somewhat higher income, more educated, more stable—to a system whose historic mission has been to serve the poor, and whose finances have been straining."[139] The plan offers coverage for comparatively lower prices by keeping its network narrow and limited to a core set of safety-net providers, and does not cover care in other hospitals.

Cook County Health & Hospitals System introduced a Medicaid managed care program, ***CountyCare***, in 2014. While the program spent more money than it brought during the first six months of fiscal year 2014, the health system gained $137.2 million during this period because

many of the newly insured patients sought care at the system's various hospital and clinic settings.[140] In building on the success and promise of this initiative, the CEO of Cook County Health & Hospitals System, Jay Shannon, recently stated, "Before CountyCare, this organization historically had been spending $500 million to $600 million a year for uncompensated care. This was an opportunity for us to bring in resources to offset those significant dollars…The fact is that CountyCare brought in more than $100 million in payments that this health system would not have received without it."[141]

Cook County Health & Hospitals Systems' "CountyCare" Program

Through Medicaid 1115 Waiver support, the State of Illinois and Cook County Health & Hospitals System rolled out a Medicaid program for uninsured adults in Cook County called CountyCare preceding the ACA's 2014 Medicaid expansion. Individuals enrolled in CountyCare received medical care from providers in Cook County Health & Hospitals System and select community providers. CountyCare was created on a medical home model in which patients were assigned to a team comprised of a doctor, nurse, social worker, and medical assistant. In an effort to reach all the residents eligible for Medicaid, Cook County sent letters to each eligible persons in the county on its books, approximately 115,000 individuals.[142] It listed their options for coverage, including CountyCare. The county health plan residents were required to go to a provider within the county's network of hospitals and affiliated Federally Qualified Health Centers.[143] Enrollees of state Medicaid could go to any doctor that accepted Medicaid. After the state expansion in 2014, eligible individuals were able to leave CountyCare and enroll in Medicaid through the State of Illinois.[144] Cook County Health & Hospitals System has reported the connection with their own health plan as a major advantage to recruiting newly insured patients, providing medical homes, reducing costs for caring for those patients and increasing care coordination.

Branding

A few systems cited the importance of "branding" their safety-net system to be more attractive to patients. For systems with affiliations with reputable academic partners, they have cited intentionally expanding on their branding to highlight institutional ties. As one executive shared, "As we do our marketing and branding, we lead with [the academic institution], and this was a lesson learned because before there was a misconception that it was a county hospital. So branding has been linked to [the academic institution] and marketed for people of all walks of life." This executive shared that following this branding, the community has come to see the institution as "the best care" out there and not as a site exclusively serving low-income, "but one for everyone who needs complex health care."

Embracing Change through Leadership

At least four of the hospital systems spoke about undergoing leadership change, with new leaders credited with significantly "turning around" the financial viability of their hospitals. For example, Cook County Health & Hospitals System's leadership shift has been described as transformational:

Perhaps most striking has been the leadership shift at Cook County HHS, which introduced a wholesale reorganization of the hospital's management structure from one that was very hierarchical to one that is flat, which is intended to facilitate more rapid decision-making. This leadership change took place at the system level, affecting not only Cook County HHS, but also the system's extensive ambulatory care network. Respondents from both inside and outside of Cook County HHS also noted an important move away from the hospital's traditional crisis management model to one of a shared vision for system change.[145]

One hospital executive spoke about being focused on assuring the financial viability of the system in the long-run, stressing the importance of consolidation and co-location for efficient coordination of services: "We need to get a little more real. We are spending money on creating a 'real' medical home and taking away money by making the hospital a little smaller. Reducing costs also builds credibility with those you are trying to convince." Other executives have stood as champions behind the safety-net mission, working to further advance the image, importance, and unique role of the safety net.

Undertaking Cost-Cutting Strategies

Many safety-net system executives we interviewed recognize that in order to survive and prosper in these evolving times they must undertake cost-cutting measures to ensure solvency and support adaptation. While most reflected on the promises of coordinated and integrated delivery systems—including moving to providing patient-centered care through teams of providers—in creating efficiencies and cutting costs, several also mentioned other ways they are working to reduce costs. While some of these initiatives have required significant upfront investments—such as consolidation or renovation—others have been more targeted and specific such as improving patient billing, price transparency, and offering discounted prices so that uninsured patients can pay at least a portion of bills that would otherwise go unpaid.

Consolidation

Two key informants also cited consolidation as a way to streamline costs incurred by multiple sites and facilities. As mentioned, Boston Medical Center is currently undergoing a costly consolidation and building project to co-locate its two campuses. This action will both improve its ability to serve as a medical home and save an estimated $25 million annually in operating costs in the future as they will no longer operate two different facilities.

Improving Patient Billing

At least two informants discussed the importance of streamlining administrative processes, including identifying and eliminating redundancies. Recently, Cook County Health & Hospitals System, for example, has overhauled its billing process to assure a more coordinated process: "Previously, billing was spread across three different billing and medical records offices, while now it is consolidated into a single office and system. Related to improving their billing

practices, the hospitals have also been educating physicians and other hospital staff to record all services that they provide to each patient to support the billing process. Management explained that this sounds easier than it actually is because many hospital staff have never been required to do this and, in some cases, are philosophically opposed to billing poor people for health care. Due to increases in coverage under the ACA, these improvements in patient billing are critical to operations."[146]

Price Transparency and Discounted Prices

A strategy used by Maricopa Integrated Health System to remain competitive in a crowded health market was to publish discounted prices for the 10 most common inpatient and outpatient services on its website. Since rolling out a self-pay discount program and publishing its prices, the hospital has experienced a meaningful reduction in uncompensated care. The discounted pricing is expected to reduce gross income by $30 million in 2014, though net income will only fall by about $5 million. Discounted pricing and transparency programs can help self-pay patients to estimate their out-of-pocket expenses, while also enabling systems to recover at least some of their uncompensated health care costs.

Realities from the Field:
Barriers and Challenges to Safety-Net Systems Transformation

We asked hospital executives to tell us "what keeps them up at night" in efforts to identify challenges or uncertainties they face in a new and evolving era. Following are top responses that executives shared around their anxieties following reform.

Uncertainty of the Safety Net in this New Era

The overwhelming majority discussed the uncertain role and relevance of the safety net in these new times, as reflected in this executive's statement:

> *We are searching for what is going to be our relevancy down the road. If all of that [social, enabling, and community services] went to the private sector what would happen? These are the questions that need to be discussed and answered.*

Other sentiments such as "Where do we fit in the puzzle?" and "What is going to define us?" were common among hospital executives. Many questioned whether public hospitals can continue to survive purely based on their mission-oriented services. But as one executive recognized, "there is a necessity for safety-net organizations to recognize that we really can't limit ourselves to be just a safety net." Many safety-net systems are also grappling with sentiments in their community that their services will no longer be needed, especially as more and more individuals obtain health care coverage. In sharing this sentiment, one executive stated:

> *There is great misperception that the ACA will be the savior to access to health care and as a result of that everyone will have perfect access and you won't need safety-net hospitals, but that is not the case.*

Others continue to struggle with their image as "provider of last resort" or a system that only serves lower-income segments of the population.

Shifting to Population Health Focus: Necessary but Daunting

In addition to the overall feeling of needing to redefine and understand their existence in this new health care world, safety-net executives discussed the challenges of undertaking sweeping reforms—such as shifting payment structures from fee-for-service to a more value-based and capitated arrangement—citing that given their already vulnerable financial situation, taking on more risk, such as with accountable care organizations, was unrealistic. As one executive summed it:

> *We are in a two-canoe situation. We want to move forward with more population health focus, but we are so financially constrained to take more risk.*

In the same vein, however, public hospitals recognized that payment reform should take on a more holistic approach, especially to reward safety-net providers for the unique niche they fill in terms of populations and services provided. Many described the unique role that safety-net providers are playing in providing a full spectrum of services—from public transportation, social support, and language assistance to basic food, shelter, and other needs. They recognize that this "community" and "population" focus is what sets them apart from others, and likely a mission and niche they will need to continue to fulfill moving forward, but they questioned how they will do so with declining federal and state support and rising competitive pressures. If this is truly the role safety-net providers will play, mechanisms to incentivize and reward providers for these enabling and holistic services must also be a part of emerging payment and delivery systems reforms. As one provider questioned, "how do you reward safety-net providers playing such an integral community role?"

Continued Financial Fears and Challenges

Financial viability was cited by all safety-net executives as a key challenge, especially with looming with federal Disproportionate Hospital Share (DSH) payment reductions, state and local budget cuts, new penalties, and costly and complex patients all serving as sources of financial concern. One hospital shared their story and the imminent threat they face from payment reductions:

> *For safety-net hospitals, and in our case, we started with a 60% Medicaid payer mix load, so the incremental impact from Medicaid expansion didn't help us that much. We started out with 30% self-pay, and have seen some reduction in that, but we lost supplemental funding. And while there was an assumption that the need for supplemental funding would be eliminated with more insured patients, nothing could be further than the truth. We are in a big hole right now. We need some form of supplemental funding.*

For one hospital, the DSH payment reductions in 2012 did not seem like a challenge, as at that time they said they felt the cuts were "very back-ended in terms of their size, and in the short term if we are able to get the uninsured into Medicaid and the exchange, it is conceivable that there would be a benefit"—but today they feel the "DSH payment reduction creates a big problem for us." This hospital acknowledged that "while the state has done a great job with Medicaid expansion, our safety-net dollars have been dwindling." The result of declining federal and state support has had devastating consequences for this hospital that once had confidence in its ability to thrive in this new environment. The executive shared that the system took an $84 million cut in the past year, and described the situation as:

> *People don't understand that Medicaid is not the solution. You can't cover people with Medicaid and then take away all these funds to cover services for low-income, uninsured, undocumented, etc. Medicaid expansion is a good thing,*

people having that coverage makes people seek care sooner, but the economics of it are really challenging. And we still have many physicians in the community that don't take Medicaid.

Competition from other providers was another source of financial concern. As summarized by one executive, "competitors will poach healthier patients and keep sending the unhealthy patients to [his system]."

Challenges with Transitioning Staff

At least two safety-net systems spoke extensively about their challenges with embracing team-based and coordinated systems of care. Perhaps nowhere is this more evident than among unionized staff at some of the safety net hospitals we interviewed. For example, settings noted the challenges they have encountered in their efforts to improve patient care by creating medical teams and patient-centered medical homes due to union regulations strictly defining staff responsibilities:

It's hard to do team-based care with union staff. Medical assistants on those teams should be able to take medical history, blood, and schedule patients. Labor unions said this is a clerical function so they can't schedule. Patients have to wait hours to get scheduled as a result of waiting for another staff member to schedule them. Yet, scheduling was in the original job description we all agreed to.

Others have reported that due to state regulation, all staff need to become certified enrollment counselors. Union staff members were the most resistant to this requirement and some were not able to pass their certification requirements, yet the hospital felt they could not fire them. In one setting, the hospital re-purposed the union staff members or re-trained them until certification was achieved.

Discussion and Policy Implications

The Affordable Care Act has prompted an evolution in the health care landscape unlike any seen in the United States in at least the last half century. After just one year of implementation, the number of uninsured individuals in the country has declined by 26%.[147] Projections from the U.S. Department of Health and Human Services and the Congressional Budget Office suggest that in 2015, nationally between 9 and 13 million individuals, respectively, will enroll through the insurance marketplaces, including those renewing coverage as well as those enrolling for the first time.[148] In California, it is projected that by the end of open enrollment in 2015, nearly 1.7 million will gain marketplace coverage (subsidized and unsubsidized), with a net gain of about 510,000 new enrollees.[149] Medicaid expansion is also expected significantly reduce the uninsured rate, with the opportunity to cover more than 1.4 million in California.[150] However, health insurance does not guarantee access to care. And while the ACA has invested considerably in ramping up health care delivery access points and innovations, the fate of safety-net hospital systems, especially those financially vulnerable, remains perhaps the most uncertain in these changing times.

Safety-net hospitals systems have much to gain from the expansion of health insurance as new paying patients enter their systems for care. However, the reality facing these systems extends far beyond this dynamic as both our interviews and latest policy reports suggest. First, these systems will continue to be the primary source of care for over 30 million uninsured nationally,[151] including three to four million in California,[152] following many years of implementation of the law; and secondly, they will continue to serve the uninsured while facing dramatic reductions in federal support to care for these very patients.

While the Protecting Access to Medicare Act of 2014 delayed the start of Disproportionate Share Hospital payment reductions to safety-net hospital systems from 2014 to 2017, it dramatically increased these reductions. Whereas previously, total DSH payment reductions would have totaled $18 billion in 2014-2020, they are now set to total $35 billion in 2017-2024,[153] with some of the greatest impacts being felt by states like California. For example, whereas in 2014 California would have received a nearly 3% reduction in DSH funding, in 2017 the state will face a 10% decline, rising to over 26% by 2018.[154] This increasing shift in cost to serving some of the most vulnerable patients from the federal government to safety-net systems could erode an important lifeline in the country's health care system. As Evan Cole and colleagues recently reiterated, "policy makers should realize that many hospitals that will be affected by the cuts in Medicaid DSH payments are already financially weak and reductions in revenue may affect their ability to provide vulnerable populations with access to care."[155]

Positioning safety-net systems to survive and thrive in these evolving times has perhaps never been more important to the health and wellbeing of this country, especially in regions where communities are reliant on the safety net as the sole source of primary, specialty, and tertiary care. Part of their positioning and adaptation, as intimated through this study, will require systems to vie in what was termed "a two-canoe situation"—on the one hand, still earning per

procedure, and on the other rewarding patient health in a more holistic way, with positive health outcomes being an important measure of systems performance.

Our review and interviews with safety-net systems located in states resembling California in its health care reform climate have revealed at least four points for consideration moving forward as systems continue to position themselves within the new health care environment:

- Adopting delivery and payment reforms with a population health focus;
- Managing transformation through a unified vision, leadership, and collaboration;
- Actively positioning to become competitive providers of choice; and
- Transitioning and supporting the health care workforce.

These considerations, while intended to serve as a reference point and resource for California and its safety-net providers—especially as the state works to renew its Medicaid 1115 Waiver to support systems transformations—are also intended to offer directions for other states and systems across the country.

1. Adopting Delivery and Payment Reforms with a Population Health Focus

Safety-net systems across the U.S. are increasingly realizing the need to find both a balance and a way to integrate population health into their health care delivery and payment initiatives. This shift is being driven in significant part by the ACA, as hospitals have commented that "the ACA focus was supposed to be on population health." Virtually all systems interviewed in this study cited an intention to shift to a "population health" or "whole-person care" delivery system. Whether it be through accountable care communities, accountable health communities, medical home neighborhoods, medical villages, or a variation on the theme—a few common threads tie these varying initiatives together: a recognition that patients and families must be at the heart of care delivery; coordination and collaboration must occur across sectors, providers, and practitioners; and health and medical care must be addressed in the context of broader social determinants of health.

Both our literature review and interviews have revealed various forms and scopes of initiatives and movements to integrate population health, some focused exclusively on redesigning care delivery, others taking on greater risk and tying payment incentives to redesign; all realize that change will not come overnight, but incrementally over time. As safety-net hospital systems in California increasingly embrace population health—recognizing that some have already embarked on this journey whereas others are just getting started—there are emerging frameworks, models, and outcomes that could inform this process.

Conceptualizing Population Health or "Whole-Person Care." Perspectives we captured through interviews on defining and conceptualizing population health or whole-person care generally reinforce what is emerging in California. The John Snow Institute, in collaboration with the California Association of Public Hospitals and Health Systems and California Health Care Safety

Net Institute, issued a series of reports on whole-person care in the safety net, offering a framework grounded in six dimensions as depicted in Figure 1. Our review considerably confirmed the importance of these six dimensions—collaborative leadership, designating a target population, an emphasis on patient-centered care, coordination of services across sectors (within and beyond health), shared data, and financial flexibility—in transitioning systems toward achieving the Triple Aim of improving quality, reducing costs, and improving population health outcomes.

Integrating social determinants of health into care redesign. Building on the whole-person care approach, we found that systems are making intentional decisions to increasingly invest in and support services that address social determinants of health among their patient populations. While some see such strategies in the context of sweeping delivery reforms such as patient-centered medical home neighborhoods and villages and accountable care communities, others view these as "small investments" with potentially large "return on investment." To that end, several systems spoke about offering support services ranging from housing, employment, and transportation assistance to addressing hunger and food deserts to medical-legal support. This realization has also led many systems to rethink their health care teams, adding social workers ("to reduce stress in patients' lives"). As one executive noted, "we're focusing on behavior and lifestyle, which is 80% of the problem—this is a big deal and this is transformational."

Figure 1. Dimensions of Whole-Person Care

Source: John Snow Institute. Opportunities for Whole Person Care in California, September 2014.

These contentions are supported by emerging research, especially evidenced-based outcomes from systems showing declines in emergency department utilization, readmissions, and hospitalizations associated with a range of services that intend to address the root socioeconomic cause of high utilization of costly services by a few. For example a recent report concluded that relatively small but carefully designed and tailored investments can help achieve better overall health outcomes.[156] This may include and involve what safety-net systems have known and developed for years, but have found financial support to be far less sustaining—such as taking care and services to where people live, work, and pray (e.g., maternal and child home visitation programs, preventive screenings in low-income neighborhoods, and mobile services). To this end, philanthropy and the private sector may have an important role to play to support and leverage federal and state funding. Also facilitating this transition to increasingly address social determinants is the "will" of providers. Deborah Bachrach and colleagues

recently reported that 80% of physicians conclude that addressing patients' social needs is as important as addressing their medical needs.[157]

Regional collaborative care. As safety-net systems consider new collaborative and coordinated approaches to care delivery, the geographic spread of services and resources is likely to play an important role—as is the case in California. As such, "regional" approaches to collaborative care with a range of government, nonprofit, and private sector providers in a defined region may offer an opportunity to enhance access points, more effectively coordinate services, and reduce costs. For example, in 2010, New York Presbyterian Hospital launched a "regional collaborative care model," an integrated network of patient-centered medical homes linked to other providers and community-based resources to provide a more holistic delivery system.[158] The model is built around medical homes that incorporate patient-centered processes and are connected through information systems and service collaborations to hospitals, specialty practices, and community-based organizations.[159] Unique to the model are collaborations across independent providers and service organizations in the region as opposed to providers under the same umbrella or governance structure. Three years following the implementation of the collaborative, New York Presbyterian Hospital witnessed decreases in ED visits by 29.7%, hospitalizations by 28.5%, and 30-day readmissions by 36.7% among patients with diabetes, asthma, and congestive heart failure.[160] Patient satisfaction also reportedly improved and the system achieved a short-term return on investment of 11%.

Initiatives to incentivize management of complex patients. Understanding who the most high-risk, costly patients are in systems—in terms of clinical diagnoses as well as demographics, cultural and linguistic heritage, socioeconomic status, and behavioral needs—has served as an important starting point for many systems in our review shifting to population health as these patients require the most "holistic" of approaches to effective care. Hennepin County Medical Center's Coordinated Care Center offers an award-winning approach based on establishing a patient-centered, multidisciplinary, team-based clinic exclusively for patients referred to it due to their excessive hospitalizations and related complex medical conditions. The inclusion of nurse care coordinators and social workers with the explicit intent to connect complex patients with health, community, and social services offers yet another means for addressing these patients in a "whole-person care" context. Cambridge Health Alliance's mental health medical home model also offers additional insight and opportunity for building a medical home for patients facing significant mental/behavioral challenges, bringing primary care and social support to outpatient mental health settings where such patients are most comfortable, familiar, and likely receptive in receiving services and support.

Recognition of no "one-size-fits-all" approach and the need to track the effects of systems transition. A primary finding in our study was that while systems realize the need to shift to population health, this realization among several systems has presented financial challenges in particular as they seek to identify funding streams to support such services and outreach. And while demonstration projects and some other incentives may offer opportunities, a number of these settings feel they are far from firm financial footing. As one CEO stated, "…if you go too far [in redirecting to population health]…you will end up with our financial issues. For anyone to

organize the way the ACA says you should can lead to serious financial woes."As such, many executives voiced the need to more "incrementally" address and embrace this shift to population health, recognizing that systems will be in the "two-canoe" situation in the near term at the very least.

2. Managing Transformation through a Unified Vision, Leadership, and Collaboration

The incentives, requirements, and overall vision of the ACA are leading health systems across the country to reassess their role, approach to care, patients, and their needs and relationships with other health care providers and communities. Overlaying these issues are questions fueled by concerns—and opportunities—around health care financing and revenue streams. These and other points of focus have become central to safety-net hospitals as they work to manage their adaptation and transformation in this era of reform.

Our review has found both positive and promising actions as well as fundamental questions among safety-net systems—both of which are likely to significantly influence the nature and substance of systems adaptation. Among those identified by these systems are issues concerning their "raison d'être" or mission and the challenges for leadership in managing if not embracing change, the importance of collaboration and working with new partners, and managing payment and incentive transformation.

Mission. A number of settings are revisiting their safety-net role. This reassessment is especially important given the uncertainties around reform as it affords staff and administration the occasion to reinforce their primary mission. But at the same time the changes occurring have led some to ask where they fit in an evolving safety-net landscape. While the core concept may remain resolute for the vast majority, what it means moving forward is more open to question. For some California systems, especially those whose margins pose significant challenges—and with potential DSH reductions pending—they may be forced to assess the feasibility of offering the services they have historically provided. Such actions, already being considered by similar settings in other parts of the country, may provide a measure of financial relief but at an uncertain cost to the overall ability to meet need.[161]

Some in California may revisit what many formerly traditional public hospitals have done to transition to other ownership structures. Models—mostly successful compared with their previous status such as Truman Medical Center, Denver Health, and Regional Medical Center of Memphis—have opened new doors for partnering, developing service models, and offering more flexibility in staffing. These and other advantages may encourage weighing the value of such alternative structures given the new incentives and requirements under health care reform.

Collaboration and working with new partners. The ACA and its patient care incentives, measures to increase efficiency, strong emphasis on care coordination, and a focus on improving quality of care—as well as potential and actual competitive pressures—have raised

the importance of developing effective collaboration and networks of care among safety-net systems. Previously uninsured populations seen primarily as the responsibility of these hospitals now, with Medicaid expansion, have greater opportunities for care. Moreover, for some systems, health care reform offers potentially new avenues to expand their payer base. As succinctly put by one executive "I believe in collaboration. It would be crazy in this landscape to think differently."

These new and significantly enhanced collaborations are playing out according to priorities and realities facing these settings. Some recognize that they are "not the most attractive partner to other systems" due to their patient populations. Nonetheless, the services offered, history, and knowledge of the community represent value to other providers, especially as they seek to offer care to patients traditionally served by the safety net. With cost-effectiveness, competition, and quality at the forefront of health care reform these partnerships offer considerable if not vital promise. As noted by one executive:

> *The language of care delivery is changing because capacity is being tested. We are learning to collaborate out of necessity as we are caring for the same populations. It just makes more sense to collaborate.*

Collaborations are playing out according to needs. Some are using DSRIP programs—as they encourage if not mandate cooperation—by creating integrated teams from multiple hospitals outside the safety-net system. A number of interviewed systems expressed that the ACA and current financial environment was requiring that they identify new health care partners likely to be caring for their patients and communities. Some safety-net hospitals, such as Elmhurst, have entered into discussions with non-affiliate systems who share a similar patient mix. In recognizing common patient and population concerns, the goal in collaborating is to improve coordination and sharing of patient information and medical/health care. University of Kentucky Health is also entering into unique partnerships with external clinics that do not require capital investments, but rather collaborations built to leverage limited resources and assets to mutually benefit all players, while enhancing capacity and access to care for patients.

A potentially significant initiative, supported by Kaiser Permanente, is working to bring together safety-net hospitals and community health centers, through their respective organizations, to develop collaborations that strengthen efforts to integrate these providers. As summarized in the 2013 announcement, "A key project goal will be to identify safety-net collaborations that successfully integrate care to ensure seamless transitions from enrollment to participation in medical homes and referrals to other safety net providers."[162] Should this project be successful, it would align together two major sectors that share similar missions at a level and focus not as yet seen which could, in turn, offer models and model elements for these settings in California and across the U.S.

As these new arrangements evolve, safety-net settings, especially those less familiar with such partnerships, will need to proceed with caution to assure that there is significant *mutual* benefit. Concerns around equality in these collaborations and sharing of not only services and

innovations with marginal financial value but that generate revenue for all settings must remain paramount.

Managing the pace of payment and incentive transformation. A number of large urban systems in particular are struggling with the rapid pace, complexity, and lack of clarity at this time. As expressed by one executive, "Payment system reforms and other dynamics are exciting but it is all happening so quickly we don't know if we can keep up with the pace of change." At the same time, longstanding impediments have led some to resist the pull to change without addressing fundamental concerns:

> *I am reticent to put real effort to change the image of the hospital until I'm confident it [the hospital] has changed. There are real structural impediments that restrict access to the excellent services the hospital offers such as a lousy scheduling system, call routing system, and a health plan portal with lots of errors. We don't want to bring new patients in and have them experience the same problems here as always.*

These sentiments from safety-net executives capture some of the anxiety around the changes occurring in systems across the country, and are likely to mirror those in California. They pose or imply circumstantial if not fundamental questions around timing, pacing, resources, and changing traditional "ways of doing business" as well as infrastructure needs. There is no neat solution that easily allays such challenges and the anxieties they may bring, as we learned in asking "what keeps you up at night." Nonetheless, given the value of the "real time" experience these systems are going through, they offer insights that may assist in helping their peers in navigating through these transitions.

3. Actively Positioning to Become Competitive Providers of Choice

Safety-net systems are increasingly recognizing the importance of shifting from being a hospital of "last resort" to a "hospital of choice" as a means to not only survive in these unpredictable times, but ultimately to prosper. Many safety-net hospitals in California and across the country are well aware that the ACA is likely to, if not already, create unprecedented competitive pressures for patients that, for the most part, they had assumed were their "market." However, as Medicaid expansion takes hold and continues, they fear being left with a disproportionate burden caring for unhealthy low-income or uninsured patients, especially as for-profit, nonprofit, and other providers draw on their ability to access revenues to enhance their position, and/or feature their specialty care to attract patients.

In response to this new environment, many have focused on recasting their profile in their communities and "rebranding" to feature their strengths in care, community knowledge, and centers of excellence. Some are seeking to become part of networks to care for those newly insured through the exchanges, working to appeal to private employers by offering reduced premiums for families, with the intention that if successful they can market directly to these businesses. Others are weighing options around intensifying their community health efforts or

developing health panels. Still, some feel that Medicaid's lower reimbursement rates will act as a disincentive to other providers. Finally, many expressed optimism that their new patient care redesign initiatives will offer considerable opportunity to reach and retain populations they have historically served.

Building on safety-net strengths. A source of strength and hope among many safety-net systems in adapting to these fast-changing times has been their niche and unique role in serving low-income and culturally and linguistically diverse patients. With an increasing shift to population health, safety-net systems may be able to leverage their historic role and ties with communities to become valuable and attractive partners in various new models of care delivery, because without them such initiatives may not have the "soul" they need to survive and prosper. To this end, federal and state government, the private sector, and nonprofit philanthropies may be able to play an important role in continuing to support and enhance community-centric initiatives at these facilities.

Active involvement in outreach and enrollment. The safety net's growing role in outreach and enrollment, as well as "inreach" among its existing patient population, will likely be central to maintaining critical mass. For example, as described, Maricopa Integrated Health Systems has embraced a "culture of coverage" and has invested considerable resources in providing culturally and linguistically appropriate marketing, outreach/inreach, education, and enrollment assistance to attract and retain potentially eligible Medicaid and marketplace enrollees. Many systems are working to educate and enroll communities "where they are" as opposed to waiting for them to enter the system. These efforts have ranged from enrollment vans that drive through neighborhoods such as MetroHealth's Enrollment on Wheels, as well as outreach and enrollment being integrated into existing community programs such as home visitations, neighborhood-based prevention and screenings, and community health fairs, among others.

4. Building and Transitioning Health Care Workforce

Safety-net systems without question have become sensitized to the need for innovation and adaptation driven by the ACA. However, for many systems successful implementation will require a cultural shift among personnel, including employing new or reassigning duties to staff as they increasingly shift to more patient-centered care. Our review revealed that systems are increasingly building capacity through support for team-based care and other strategies that employ significant and growing numbers of frontline personnel, such as medical assistants, patient registrants, social workers, case managers, community health workers, and lay health educators.

Team models taken to new dimensions. With a growing number of insured individuals expected to seek care, especially in the early years of ACA implementation, the need for personnel to support ongoing management and counseling of patients is extremely critical—especially as research suggests that "the average primary care physician does not have enough hours in a day to adequately attend to the needs of a patient population that is aging and facing

increasingly complex health conditions."[163] Many innovative staffing models have emerged to address this dynamic, especially employing more frontline and pre-baccalaureate health care workers. A recent Brookings report, *Part of the Solution: Pre-Baccalaureate Healthcare Workers in a Time of Health System Change*, for example, highlights the evolving and expanding role of medical assistants who are being trained to move beyond rooming patients and taking their vital signs to working as health coaches, helping patients with chronic disease management, serving as interpreters, and making home visits to perform risk assessments, among many other roles.[164] Models such as Clinica's flip visits, identified in this study, also offer an example of expanding scope of practice, especially for nurses to increase billable time and offer new opportunities for creating efficiencies in care delivery.

Transitioning providers and practitioners through education. Transitioning staff to serve in evolving practice arrangements requires training and education, not only to enhance knowledge and skills, but also to better align practitioner goals and incentives with hospital systems. However, as the recent Brookings report found, health care training programs, while growing, are not keeping up with the actual skills needed to work in evolving team-based roles. To this end, the report shared the importance for systems, leveraged by private sector, philanthropic, and government funding, to support career development as a means to not only build skills and capacity, but also to drive the economy:[165]

> *In order to reward and retain highly trained staff, many sites are offering career development as a part of their practice change model, providing career ladders with promotions both within and beyond the MA [medical assistant] job category, wage increases, quality bonuses, educational reimbursement and other means of recognition for the value added by their MAs. Career development for frontline workers may provide a broader benefit, enabling local health care organizations to serve as "economic engines" for the communities they serve, providing not only culturally competent health care to patients, but economic opportunity and upward mobility to the health care workers who often originate from those same communities.*[166]

Building this workforce may offer considerable opportunities in communities in California that are grappling with high unemployment rates as well as high utilization of high-cost services. Beyond medical assistants, these communities may draw on and train community-based individuals to serve as lay health educators and community health workers, among other roles that more fully engage communities in shifting to whole-person care.

Finally, health professionals—such as physicians, nurses, and mental health providers—are likely to require more formal education and training on the role and influence of social determinants especially as the care delivery system transitions to organizing around and rewarding population health over volume. Boston Medical Center's Poverty Simulation program, among others, may offer some direction especially as systems work to obtain buy-in and better align physician and practice incentives to achieve population health improvement.

Transitioning unionized personnel. The challenge of embracing the shift to more coordinated and integrated systems of care is perhaps nowhere more evident than among unionized staff at some of the safety-net hospitals. For example, settings in this study have noted the challenges they have encountered in their efforts to improve patient care by creating medical teams and patient-centered medical homes due to union regulations strictly defining staff responsibilities, inhibiting staff from sharing or taking on additional roles and responsibilities that could potentially add to efficiency. Systems such as Cambridge Health Alliance have explicitly addressed this challenge by negotiating for job changes. For example, the Cambridge Health Alliance formally updated their ambulatory registered nurse job description to align with American Academy of Ambulatory Nursing's competencies, working with unions to vet the process.[167] The system also worked to negotiate and add new competencies to other staff roles, including registration clerks and medical assistants.

Conclusion

The California safety net, like those in other states across the country, has entered into a period of transformation with its "eyes wide open," recognizing and where possible taking advantage of opportunities to move beyond the usual ways of doing business, monitoring the bottom line, working to compete in traditional and potentially new markets, and fully aware of the traditional and new challenges they face. Notwithstanding these and other dynamics of the day and times, their core mission and the strengths that ally with it—a history of caring for vulnerable, diverse individuals and neighborhoods and offering services essential to communities—potentially align critically with this era and its focus on population health in all its dimensions. As such, these settings offer the opportunity for health care reform in California to transition more fully to address racial, ethnic, geographic, gender, and other disparities in access to care, with new partners, collaborations, and models that address the "whole person."

Monitoring outcomes for these populations and the providers who care for them thus becomes paramount, especially given that payment to recast services and care for the sake of population health has yet to be aligned with the dollar incentives of traditional fee-for-service medicine. But most importantly, federal, state, and local governments and the private sector will need to give these systems sufficient resources to survive and contribute significantly to creating more equitable, high-quality care and health throughout California and its communities.

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