

# Breaking Down Barriers to Creating Safety Net Accountable Care Organizations

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# Introduction

Blue Shield of California Foundation funded an interdisciplinary study to:

1. develop, assess and pilot a safety net ACO ***readiness assessment instrument*** in two California counties, and
2. ***examine the legal and regulatory issues*** associated with safety net ACO formation.

The project work has four primary components: the creation of the *instrument*, the *pilot testing* of the instrument, a series of *three policy briefs*, and this conference.

# Our Team

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# Defining Terms

We define the *safety net* broadly as:

- More than just government-funded insurance and county hospitals
- From a patient perspective, incorporating providers who accept sliding scale payments, or no payment at all (bad debt) for patients who cannot pay

We define an *ACO* as a group of health care providers that:

- Are collectively responsible for, and held accountable to measures of, the health of a population they serve, and
- Have an organizational structure permitting encouragement of improvements in quality and lower costs through payment incentives.

# The Burden for Safety Net ACOs

Both *patients* and *providers* in the safety net have a lot to gain from the coordinated care strategies and financial incentives offered by ACOs

During preliminary interviews, safety net providers expressed concerns about issues including:

- Scarce capital,
- The complicated health issues of safety net patients, and
- The lack of information technology and infrastructure.

# Methodology

- Literature review of the current ACO readiness assessment tools
  - AMGA ACO Readiness Assessment
  - Brookings-Dartmouth ACO Learning Collaborative Toolkit
  - CAPG Standards of Excellence
  - The Dartmouth Institute's Survey for Providers about ACO Implementation
  - Group Health Cooperative of Puget Sound Survey
  - Health Research and Educational Trust's Integration and Care Coordination Survey (AHA)
  - MGMA Survey
  - NCQA Draft ACO Criteria
  - Premier Hospital Alliance Survey
- Outreach interviews to the CA safety net provider community
  - AltaMed Health Services
  - California Association of Public Hospitals
  - California Department of Managed Health Care
  - California Primary Care Association
  - CAP Management Systems, MedPOINT Management, and SynerMed
  - Catholic Healthcare West
  - Community Family Care IPA
  - Daughters of Charity Health System
  - Department of Health Care Services
  - Eisner Pediatric & Family Medical Center
  - Family HealthCare Network
  - Hospital Council of Northern & Central CA
  - Medical Services Initiative, Orange County Health Care Agency
  - Mission Neighborhood Health Center
  - Natividad Medical Center
  - Open Door Community Health Centers
  - Redwood Community Health Coalition
  - Safety Net Financing Division, Department of Health Care Services
  - Santa Cruz County Health Services Agency
  - Santa Rosa Community Health Centers
  - UCSD Health Services
  - West County Health Centers, Inc.

# Instrument Logistics

- Qualtrics survey tool was used
- *90 questions\**
- Written to be completed in *30 minutes*
- *Multiple individuals* from across each organization were surveyed
- Survey takers record their responses on a *scale of 1 to 9*, where the meaning of each rating is explained separately for each question
- In the pilot phase, the survey was administered to two California counties

\*Built with internal skip logic, so survey takers were not asked to answer all 90 questions.



### A. ORGANIZATIONAL MISSION/POPULATION SERVED

A1. To what extent would becoming an ACO require your organization to make changes in its mission to serve the underserved in your community?

Will require significant change in our mission and might cause us to lose focus on the underserved.	Will require some change in our mission but is largely consistent with our historical mission to provide care to the underserved.	Consistent with our mission, will require no change. May actually enhance our ability to provide care to the underserved.	Don't Know
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1 2 3 4 5 6 7 8 9

Please drag the bar to where you are on the scale.



A2. How well do you feel you "know" the population your organization is currently serving with regard to **socio-demographic characteristics, health care utilization, and costs of care**?

We have very little knowledge of the above data on the population we serve.	We have some data on the above characteristics but need to collect further data.	We have very good, complete data on the above characteristics for the population we serve.	Don't Know
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1 2 3 4 5 6 7 8 9

Please drag the bar to where you are on the scale.



A3. How well do you feel you "know" the population your organization is currently serving with regard to the **quality, outcome, and health status of the population**?

We have very little knowledge of the above data on the population we serve.	We have some data on the above characteristics but need to collect further data.	We have very good to complete data on the above characteristics of the population we serve.	Don't Know
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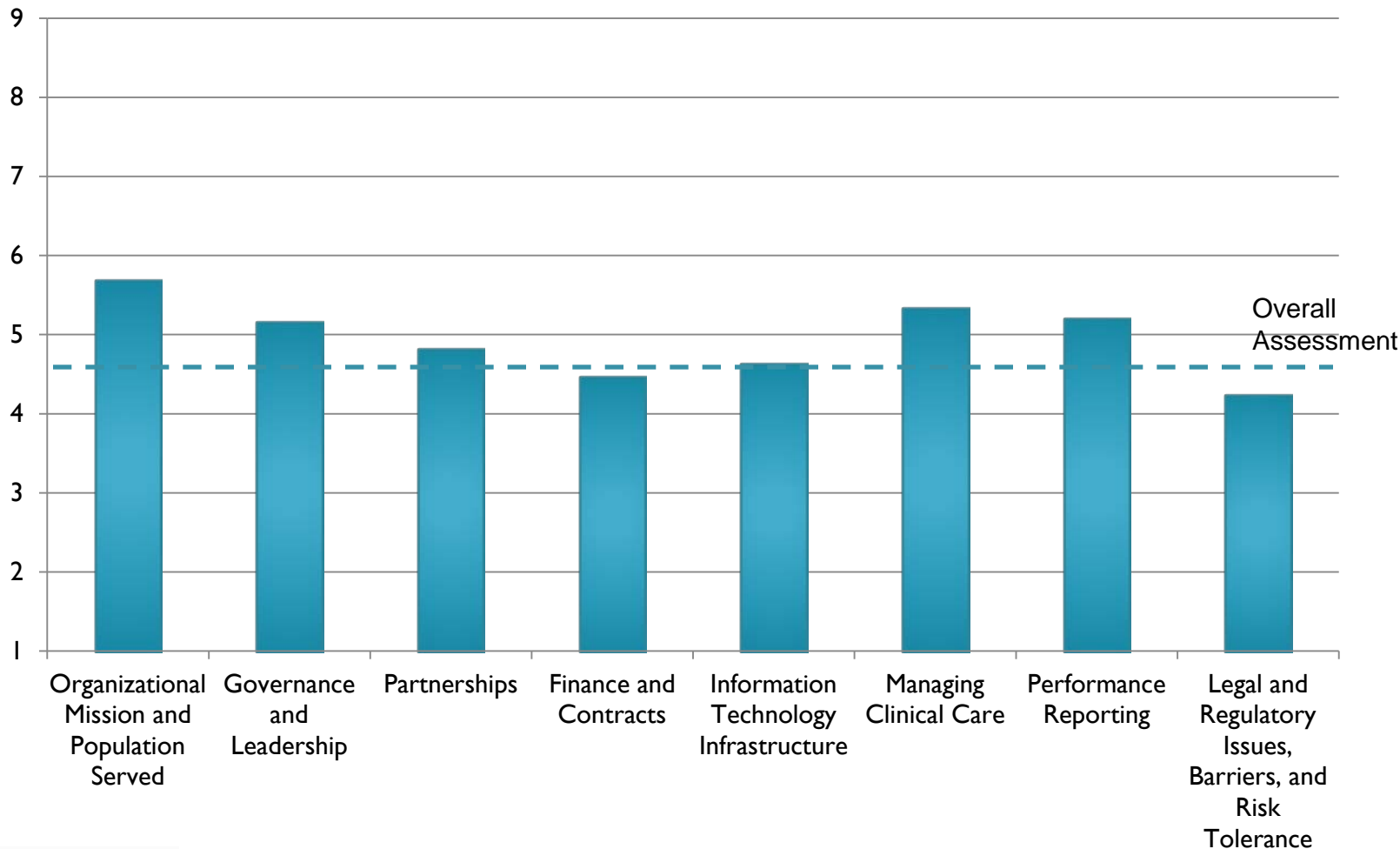
# Pilot Instrument: 9 Categories Defined

- **Organizational Mission / Population Served**
  - a) Extent to which meeting requirements might require adjustments to the organization's mission and/or changes in the population served, and b) Adequacy of health workforce to serve the target population
- **Governance and Leadership**
  - Adequacy of the organization's governance structure and leadership
- **Partnerships**
  - a) Readiness of partner organizations to provide accountable care, and b) Partners' willingness to add or delete services to meet target population needs
- **Finance and Contracts**
  - Ability to a) bear risk, b) manage contractual relationships, c) distribute shared savings, and d) afford the potential upfront costs of becoming an ACO
- **Information Technology Infrastructure**
  - Electronic health record functionality, covering many of the "meaningful use" EHR criteria

# Pilot Instrument: 9 Categories Defined

- **Managing Clinical Care**
  - a) Cultural competence of providers, b) care management processes, c) the integration of behavioral health services, and d) the overall ability to provide more cost-effective care
- **Performance Reporting**
  - Ability of the organization to report on the 65 metrics initially listed in the preliminary draft ACO regulations
- **Legal / Regulatory Issues, Barriers, and Risk Tolerance**
  - Organization's awareness of the legal or regulatory issues and barriers that they might face, including: a) the corporate practice of medicine doctrine, b) the involvement of tax-exempt healthcare providers, and c) issues of compliance
- **Overall Assessment**
  - How ready the organization was on the whole to assume the responsibilities of providing more accountable care

# Response Summary: 51 Respondents



# Section-Level Summary

	Mean	Median	Standard Deviation	Range
Organizational Mission and Population Served	5.69	5.75	1.03	[2.86, 7.75]
Governance and Leadership	5.16	5.00	1.91	[1.20, 9.00]
Partnerships	4.82	4.93	1.60	[1.00, 8.33]
Finance and Contracts	4.47	4.25	1.90	[1.00, 8.67]
Information Technology Infrastructure	4.63	4.64	1.77	[1.00, 9.00]
Managing Clinical Care	5.33	5.36	0.82	[3.55, 7.25]
Performance Reporting	5.20	5.00	1.93	[1.33, 8.67]
Legal and Regulatory Issues, Barriers, and Risk Tolerance	4.23	4.33	1.78	[1.13, 8.67]
Overall Assessment	4.80	5.00	1.81	[1.00, 9.00]

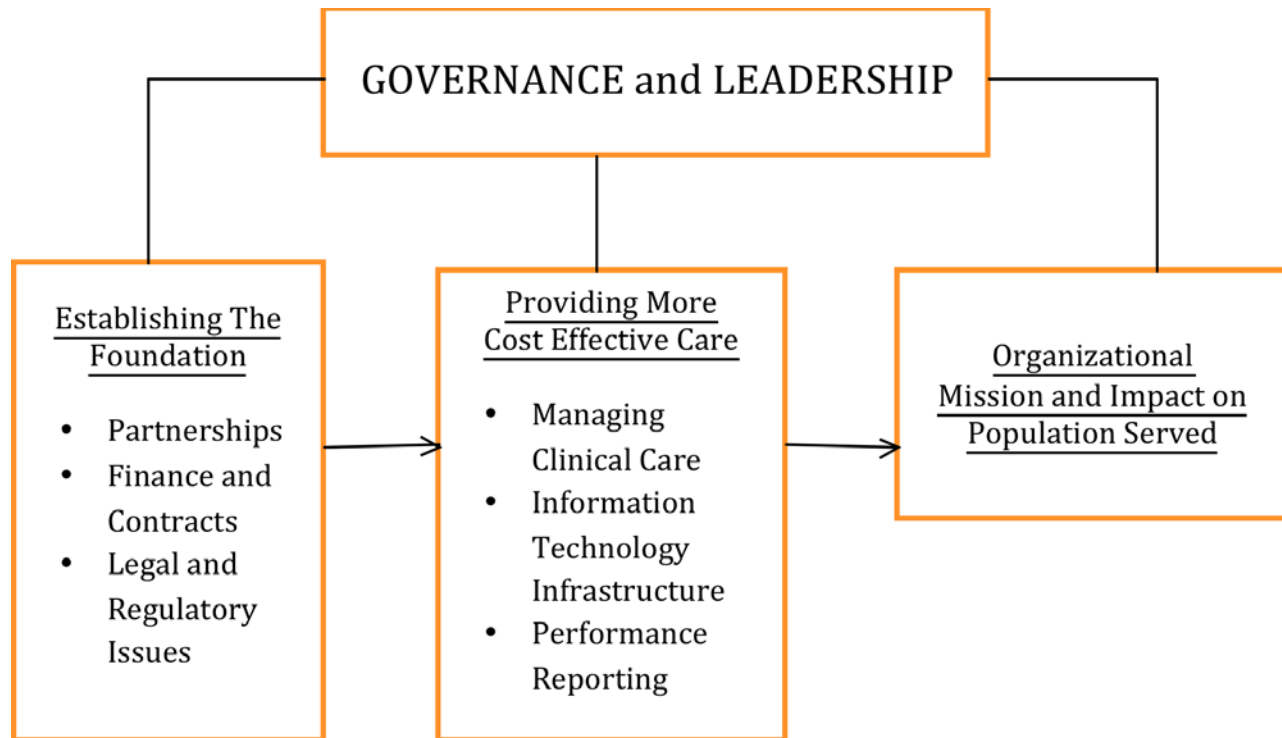
# Areas to Work On

- *Shortage of providers and resources*, especially around primary care; need for new forms of community health workers
- *Information systems* to track utilization, cost, and quality under risk-bearing contracts
- Mechanisms for *distributing shared savings*
- *Electronic health record (EHR) functionality*, including: registries, guidelines, patient communication and engagement tools
- *Integrating behavioral health* into primary care

# Areas to Work On (cont'd)

- Improving *continuity of care* and care transitions
- Increasing *quality improvement capabilities*
- Establishing hospital and physician specialist *partners*
- Protecting the *tax-exempt status* of participating organizations
- Influence of the *corporate practice of medicine* on relationships with new partners
- Greater *ability to meet quality targets than expenditure / cost targets*

# Framework for Assessing Capabilities





# Recommendations

1. Organizational Mission and Population Served: a) *reexamine current scope of practice laws and regulations* to encourage the broadest possible use of non-physician health professionals, b) *consider legislation to train new categories of health workers (i.e., community health workers)*, and c) *pay specific attention to the need for language translation, health education, and transportation services*
2. Governance and Leadership: any ACO providing care to safety net populations should *include safety net provider organizations in its governance structure* and ensure adequate physician involvement in key planning conversations
3. Partnerships: the state Medi-Cal program should consider “*bonus payments*” to safety net providers who concentrate their referrals to high-quality / low-cost specialists

# Recommendations (cont'd)

4. Finance and Contracts: Medi-Cal and other payers should use *financial incentives* similar to the CMS “Advance Payment” mechanisms for rural safety net providers and others who establish a relationship with needed private sector partners
5. Information Technology Infrastructure: the California Department of Health Services should provide *assistance to safety net provider organizations* to allow them to take full advantage of the financial incentive to adopt and implement electronic health records and to participate in Health Information Exchanges
6. Managing Clinical Care: consideration should be given to paying an additional “*coordination bonus*” to safety net providers who integrate behavioral healthcare into overall primary care

# Recommendations (cont'd)

7. Managing Clinical Care: the state and private sector organizations should develop a *statewide safety net quality improvement collaborative* focused on providing more cost-effective care to high-cost, high-risk patients
8. Performance Reporting: ensure that the metrics used for performance reporting for ACOs serving safety net populations *take into account the socio-demographic characteristics of the populations served*
9. Legal and Regulatory Issues and Barriers: give serious consideration to *eliminating or greatly modifying California's corporate practice of medicine doctrine* to permit new arrangements between hospitals and physicians designed to promote clinical integration and more cost-effective care

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# Thank You!

## “Healthier Lives In A Safer World”

