

California's Healthcare Safety Net: Moving Toward the Future

Blue Shield of California Foundation

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On November 30, 2010, the Blue Shield of California Foundation (BSCF) convened a group of 45 providers, funders, advocates and other health care leaders to discuss the future of California's Healthcare Safety Net.

The meeting began with a presentation by Ian Morrison, Futurist, who discussed the Safety Net as it currently exists and key forces that will drive change in the safety net structure and practice in the era of health care reform, and presented four scenarios for the future reflecting different levels of service competitiveness and of integration. In smaller groups, meeting participants universally agreed that the preferred outcome would be a more integrated, collaborative system, but also identified numerous barriers to such integration and began to brainstorm solutions.

Meeting participants subsequently discussed specific leadership skills that will be needed to move toward the desired future scenarios, identified specific steps to be taken, and created a list of projects and areas in which they feel that they need external support.

Throughout the day's discussions, participants deemed a number of elements essential to the future success of the Safety Net. Among these were population-based strategies; practice redesign; transformational leadership; investments in data systems and the importance of measurement and reporting; realignment of financial incentives (from payment for procedure to payment for outcomes); and inclusion of a broader provider group than public hospitals and community clinics to serve the population effectively.

Setting the Stage

Peter Long, PhD., President and CEO of the Blue Shield of California Foundation (BSCF) described the challenge that the Safety Net faces as it turns to implementation of federal health care reform. Given the heterogeneity in the field and the tremendous local and regional variation the state, how should California's Safety Net prepare for health reform implementation? What should the sequence of activities be? Should the approach be based on issues, provider types, geography, or some other categories? Defining goals and measuring progress toward them will be critical.

The Institute for Healthcare Improvement (IHI)'s "Triple Aim" provides a useful template. The Triple Aim states that an Optimized Healthcare System achieves the following goals: Improving the Experience of Care; Improving the Health of Populations; and Reducing Per

Capita Costs of Health Care. The Accountable Care Organization (ACO) is one strategy to achieve this, though Mr. Long challenged participants to focus more on strategies that achieve the aims and less on the organizational structure and partners of the ACO discussions.

Among the areas that the Safety Net needs to address in preparing for ACA implementation are the expanded need for primary care, including provider supply; the necessity of improving contracting and financial systems, data systems, and health information technology in the context of health insurance expansions; changes in the delivery system including accountable care, behavioral health integration and health homes; and planning for the care populations who will remain uninsured past 2014.

Looking Ahead at the California Safety Net

Ian Morrison, Author, Consultant and Futurist discussed the “Safety Net Conundrum:” some providers (including community clinics) care exclusively for Safety Net populations, but non-Safety Net providers (e.g. non-profit hospitals and community-based physicians) provide a significant proportion of services to the Safety Net population. Uninsured patients do not make up the majority of visits for community clinics; in fact, the community clinic market share of uninsured is approximately 14%. Two-thirds of physicians in California see Medi-Cal patients, and while 80% of Medi-Cal patient visits are seen by 25% of physicians, the concentration is not exclusively in community clinics or public hospitals. Thus, safety net providers need to think broadly about new alliances as they move forward to continue toward their mission.

Mr. Morrison said that the future of health care reform is far from certain, but argued that the way that the Safety Net delivers care requires changing regardless of what happens with the ACA. Health care reform will mean a massive coverage expansion in 2014, and a consequent increase in demand for health services. Even with efforts to increase the supply of primary care providers, there will not be enough to meet the demand absent fundamental and rapid change in the ways that the Safety Net delivers care. Health Insurance Exchanges could be good or bad for the Safety Net, depending in part on whether Safety Net providers can compete for patients who will have a choice of provider.

Ian Morrison then introduced four scenarios for the future of the California Safety Net under the ACA. The four are arranged along two axes, one representing the level of integration and the other the level of service competitiveness.

Scenario #1: Local Access Only (High Service Competitiveness/Low Integration) in which Safety Net Providers prove to be expert and competitive in serving local communities in terms of primary care services and FQHCs expand service and offerings to new communities in need, but providers have less interest in partnership and consolidation with acute care providers. On balance, clinics thrive, even though the health status of the populations served show less improvement than expected.

Scenario #2: Integrated Community Care (High Service Competitiveness/High Integration) in which local or regional entities lead efforts to rationalize Safety Net public health and healthcare delivery models using a wide range of Integrated Care models as a strategy, Virtual Capitation is created by combining funding streams, and there is significant consolidation of both Safety Net providers and non-Safety Net providers into organized and integrated systems of care.

Scenario #3: Left Behind (Low Service Competitiveness/Low Integration) in which Community Clinics and Safety Net Providers do not prove to be competitive with non-profit exchange based offerings for the most actuarially attractive segments of the newly covered (young workers, recent graduates, and the healthy uninsured), and although funding streams are sustained to support FQHCs serving local communities, the population mix served becomes disproportionately the undocumented, the very poor, geographically immobile population, the chronically ill in poverty, and those with significant mental health and substance abuse issues.

Scenario #4: Inverse Field of Dreams (Low Service Competitiveness/High Integration) in which Safety Net providers make a significant effort to rationalize and integrate offerings, but, as in Scenario #3, do not prove to be competitive with non-profit exchange based offerings for the most attractive segments of the newly covered. The integrated delivery system that the Safety Net builds is overly hospital-centric, and lower-cost, higher-performing offerings are available for most of the Safety Net-population from other managed care organizations.

Transforming the Safety Net: Building Scenarios for the Future

Small groups of participants then discussed the following questions regarding each scenario:

- Which scenario is **most likely** and what are its key elements?
- Which scenario is **most desired** and what are its key elements?
- What would it take to move the field from the **most likely** to **most desired** scenario?
- What are the **barriers** to moving forward?
- What are the **attributes** of the new system that needs to be created?

Across all four discussion groups, Scenario #2 (Integrated Community Care) was almost universally named as the **most desired** scenario. Participants felt that this scenario was the one most clearly population-based and focused on community health. At the same time, participants raised concerns about the feasibility of some aspects of this scenario, particularly the consolidation of Safety Net and non-Safety Net providers into organized and integrated systems of care. Payment incentives for hospitals were seen as a particularly difficult challenge to consolidation.

Barriers to achieving the most desired scenario (Scenario #2) were many, and included aspects of the Safety Net culture (institutional competition, a history of mistrust and the difficulty of collaboration) as well as current financing structures; lack of capacity; lack of capital; labor issues; workforce issues; and real and perceived legal barriers. Service competitiveness will be a struggle for the Safety Net; adverse selection is a serious risk and the Safety Net is not skilled in risk adjustment. Many participants said that a lack of leadership was the biggest barrier to achieving the desired scenario, and lack of time to plan for the changes was also mentioned.

Steps to move from the **most likely to most desired** scenario included leadership development; capacity development; realignment of financing; and investment in IT systems, among others. One group discussed strategies to encourage greater cooperation and alignment between hospitals and community clinics, noting that some hospitals are already reaching out to clinics as they seek to reduce their readmission rates. Another group focused on remaking the practice model, saying that this provides the best opportunity for transforming care delivery, even more than changing the architecture of system relationships (plans/doctors/clinics/hospitals). The path toward Scenario #2 will require community-driven leadership at the local (county, regional) level.

Representatives of various sectors had their own answers to the question of what the biggest risk and biggest opportunity are. **County** representatives said that they fear that, given a choice, patients might choose community providers or new private models, leaving the counties with clients who have no payment source. Political support for county systems that serve only undocumented or other uninsured individuals would erode. County representatives also recognized that their systems are not the most nimble when it comes to future planning. Key opportunities include formalizing partnerships with FQHCs, using health care reform to bring the Safety Net and other providers together.

Local public health plans said that maintaining the existing funding stream and capturing greater share of future funding streams will be a challenge for local health plans, whose provider networks are essentially the Safety Net. A related risk is the identity crisis that local health plans will face as they decide whether to continue as Safety Net plans or to compete more directly with commercial plans on the Exchange. Health plans have the opportunity to use their expertise care management and other areas to act as facilitators in their counties.

Private hospitals and physicians noted that the disappearance of DSH is a huge challenge for private hospitals, which must now compete under new rules. More generally, traditional financial models have rewarded inefficiency, and adapting to a new culture of transparency and focus on outcomes is difficult. Integration is attractive, as is the opportunity to provide a full spectrum of services.

Community Clinic representatives were concerned that adverse risk selection could drive up community clinics' costs and jeopardize their cost-based model, but said that community clinics have the opportunity to lead this transformation because they're street-smart, logical,

and relatively nimble. The challenge as well as the opportunity is finding a better way to reinvent the PCMH from a health center site with a population-based approach.

Working Together in New and Different Ways: Approaches and Relationships

Taking as a starting point the need for strong leadership to transform the Safety Net, participants said that the particular **leadership skills** essential to this work transforming the Safety Net included the ability to transcend self-interest and convince others to do so as well; the ability to create and work in partnership at the operational and advocacy levels; and change management, risk-taking, and decisiveness (including knowing when there is sufficient information to act). Participants said that leadership should be defined to include not only the CEO and CMO, but also clinical leadership.

Asked to identify specific steps to move the Safety Net forward, participants discussed their need for technical assistance of many kinds, including economic modeling, legal assistance, health services research, readiness assessment, quality measurement, health technology and exchange and information about best practices. This information should be available in a common repository, to encourage sharing data and strategies and to promote efficiency. Each community needs a convener or catalyst to focus discussion and common methods of readiness assessment, including clinical leadership readiness, incentivizing leaders of individual institutions, and predictors of success, among others.

Participants said that foundations and other outside entities could help by providing some of this technical assistance, particularly in the areas of ACO development, benchmarking and data, legal issues, risk adjustment and risk assessment, and realignment of financial incentives. Foundations could also help perform the convening function, and could provide technical assistance to private physicians and hospitals who need help with infrastructure. Other areas of concrete support include development of a common readiness assessment vehicle and e-referral systems and other technical solutions geared toward the Safety Net. Finally, participants suggested a venture capital fund available to Safety Net entities at various points in the process.

Moving Forward: Observations on the Day and Moving Forward

Summarizing the day's discussions, **Ian Morrison** identified the following five issues as paramount for the immediate future:

1. Realigning financial incentives. The Safety Net must understand the coming changes and build a financial curve for the future.
2. Fact-finding. Data about the current care patterns of the people who are currently served is essential, as is information about how that care should be delivered.
3. Readiness and capacity. The Safety Net needs a neutral place in which to have challenging conversations about these issues.
4. Care redesign.
5. Local action.

Peter Long closed the stimulating discussion by describing BSCF's Safety Net commitments, which include developing baseline metrics and targets for clinic performance, building financial acumen, reinvention of clinics as providers of choice, and innovations in health care delivery that are cost-effective and result in improved health outcomes.