Abstract
Accountable Care has emerged as a critical delivery system redesign companion to expanded coverage within federal health reform. Accountable Care calls for providers to organize to provide a full continuum of care to patients and populations, to commit to improving quality while controlling cost, and to be rewarded as they succeed. However, the principles of Accountable Care are based upon demonstrations and lessons learned primarily in Medicare populations served by highly organized and integrated health systems. The Safety Net differs in the patient populations it serves, the structures and relationships between its providers, and its funding, which is mainly concentrated in Medicaid and local government reimbursement. Thus, the federal emphasis on the development of Accountable Care will need to be tailored differently for the Safety Net. Further, California’s Safety Net will face the challenges of building collaborative delivery models earlier than the rest of the nation as the renewal of the State’s 1115 Medicaid Waiver is implemented during the next year. These State and national moves toward integrated care offer both opportunity and challenge to the Safety Net and progress toward Accountable Care will be made only after embarking on an honest and thorough examination of necessary changes in relationships and organization, delivery system design, infrastructure, and revenue distribution. Taking leadership now to create Accountable Care is a strategy that is most likely to secure the ongoing existence of Safety Net providers, assure access for the patients they have historically served, and improve the health status of their communities. It is also a strategy that is likely to gain the support of the federal government as new models are sought to efficiently and effectively deliver care for a population that will soon represent the single largest publically-funded health coverage program.

Introduction
In the post-health reform flurry of speculation and amidst the scramble to prepare for 2014, the Accountable Care Organization (ACO)—which is the focus of the newly created Innovation Center within the Center for Medicaid and Medicare Services (CMS)—is emerging as a centerpiece of federal strategy to implement vast coverage expansions while also assuring and promoting quality of care, improving the health status of defined populations and, at the same time, not bankrupting future generations. It appears that CMS is seriously and quickly moving to assist in the establishment of these new delivery systems.

Further, the focus on integrated health care delivery is being echoed in the renewal of the California Medicaid Waiver,¹ which will precede national reform in its implementation. Both major Waiver
The Centers faced the development of accountable care models that will ultimately be required under federal reform. The Waiver offers a further incentive to California providers that rely on Medicaid reimbursement to start moving toward new accountable care models that will ultimately be required under federal reform.

Why should the Safety Net focus on the development of integrated delivery systems, including ACOs? The ACO concept is still indistinct. Past CMS demonstrations have involved large physician groups with predominantly Medicare and commercially insured patients—not the primary populations served by the Safety Net. The vision of shared responsibility required by an ACO is complicated within the Safety Net which includes entities as disparate as public health and hospital systems, Federally Qualified Health Centers (FQHCs), private community hospitals and physician groups. State Medicaid agencies will need to be involved in ACOs focused on the Safety Net and they are now inundated with budget deficits and faced with staff furloughs. It may seem more prudent, and certainly easier, to wait and see how things fall out as health reform moves toward implementation.

However, there is a compelling case to be made that the Safety Net should not only participate in the development of ACOs and other integrated delivery system models, they should lead. Among the reasons to proceed aggressively now are the following:

- **CMS needs models for ACOs that target the populations cared for by the Safety Net.** Patients covered by Medicaid and the uninsured will be a significant focus for health reform expansion in 2014. Safety Net systems have the opportunity to help shape the evolving concept of ACOs for these groups. Safety Net systems can build collaborations with little active competition from others concentrating on ACOs predominately serving Medicare and commercial patients.

- **The Safety Net would benefit from the support that will be offered by CMS to prepare for the massive change that this transformation will require.** An ACO governance model will need to be built that takes into account the various accountabilities of County systems, FQHCs and private hospitals and physicians. An ACO finance strategy will need to be conceived that transforms the current complexity of Intergovernmental Transfer agreements (IGTs), Disproportionate Share Hospital (DSH) payments and FQHC PPS reimbursement into a “bundled” revenue stream that encourages efficiencies and best practices. Clinical silos will need to be replaced with integrated approaches and shared agreement on approaches to care delivery. This transformation will require an infusion of financial, regulatory, legal and technical assistance.

- **Local community and government support of health care in California is currently an advantage but may change under health reform and new delivery systems will need to be developed that assure access and maximize efficient use of resources.** In California, counties have long been mandated to address the care of the medically indigent and, while this charge has materialized in different forms, the building blocks are there to begin to construct a new model. Further, as health reform moves toward implementation, the role of local government as
both a payor and provider of health care services will, more and more, come into question. This next period of time, with potential for both State and federal support, provides a window of opportunity for the local Safety Net to define and shape its role in the future.

- **The core principles inherent in ACOs offer a strategy to the Safety Net to improve health outcomes and reduce costs.** The care provided in the Safety Net should be more coordinated, produce better outcomes, result in greater patient satisfaction and cost less. This is an opportunity for providers to be supported to do what they know should be done anyway.

This paper offers a broad analysis of the elements of ACOs and their likely role in the future, the particular challenges faced by the Safety Net in moving toward this new model and basic steps that Safety Net providers need to take to achieve a population-focused, collaborative approach to delivering health care services. While the focus of this paper is on the ACO (because of the emerging federal opportunities), the principles that make up these models are applicable to many different approaches to integrated care delivery that would be of significant benefit to the Safety Net. It is the premise of the authors that the Safety Net must be preserved—not because “it is too big to fail” but because it is likely to continue to be needed and has a responsibility to survive. The lessons of the past have confirmed that “coverage” does not equal “access.” There will always be those that have no other place to go for care and there will always be those that rely on the services that only Safety Net providers have the experience and expertise to provide. The potential failure of Safety Net providers would have a more profound impact than the failure of other providers for whole communities and for their most vulnerable residents.

It will be important, though, not to be like the generals who repeatedly plan to “win the last war;” preparation must be for the emerging challenges ahead. The transition period between the way that care is delivered and funded today to the model for the future will be the most critical time for the Safety Net. Lack of capital and infrastructure, difficult and cumbersome bureaucracies and governing organizations, financial arrangements that reward processes and expenditures rather than quality and outcomes—all of these issues are very real in the Safety Net and will take leadership, collaboration and intensive effort to address. It must be done, however, and it must start now.

**What is “Accountable Care”?**

“Accountable care” is a mechanism that the federal government hopes will address what is widely acknowledged to be poor value for the money spent in the U.S. health system, which is more expensive and inflationary while, at the same time, failing to achieve even comparable health status of other countries. Further, within the borders of the United States, there is wide variability of health care costs and no seeming relation between the cost of care and the outcomes achieved. Health care in this country can be dazzling and dramatic but fails to broadly provide even half of the services

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recommended to achieve and maintain good health, resulting in life spans, infant mortality rates, potential years of life lost, and health-related quality of life that are clearly subpar. In addition, the population is generally dissatisfied with their care and certain populations have shamefully and disproportionately poor health outcomes.

If health care value were improved, it would mean the population would receive more value for what they pay. This could happen if health care quality and outcomes improved while cost remained the same or if costs decreased while quality remained constant. Of course, improving quality and decreasing cost would enhance value the most. Expanding health insurance coverage for the population is necessary but not sufficient to improve value. Coverage might improve outcomes for those who previously had no access to medical care but would also add new cost and would not end the current inflationary spiral. Further, increased coverage might not completely address access problems as providers shift their focus to take advantage of the most profitable “lines of business,” while avoiding “losing services,” leaving already underserved communities with high risk populations served unequally. This complex intersection of cost, quality and health status is the paradigm that ACOs are meant to address.

While the definition of ACOs is still being fully refined and may, in fact, take multiple forms, several elements must be in place. Care must be provided to a distinct population, large enough to be able to show a clear impact of organized care delivery but not too large that such an impact would be impossible to accomplish. The ACO should eventually care for patients covered by all types of payers, public and private. The ACO must be driven by providers, with decisions made that reflect the elements of practice that can deliver higher quality care at lower cost. Among current providers, there are likely to be winners and losers in a successful ACO. Based on previous federal ACO demonstration experience, it is clear that, to achieve its objectives, a new practice model must be adopted that is heavily focused on primary care medical homes, care management and connective health information technology.\(^5\) Progress in meeting cost, quality and improved health status goals must be able to be measured. A new financial model must be established that aligns provider incentives to meet cost, quality and health status improvement objectives rather than basing payment on service volume. Finally, ACO governance must rely on integrated clinical leadership, organized in a way to constantly evaluate medical evidence and health outcomes and, as necessary, alter resources and practice to meet the needs of the population.

**What are Challenges for Safety Net Participation in Accountable Care?**

The Safety Net has been determined to be “those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients.”\(^6\) These providers typically include public health care systems, FQHCs, community hospitals that serve vulnerable populations (because of either mission or geography), and private practitioners located in underserved areas. Health care delivered by the Safety Net is financed predominantly by Medicaid, local government funds, out-of-pocket payments by patients, Medicare, and a small percentage of commercial health insurance.\(^7\) A significant, but undetermined amount of care is completely uncompensated. Patients served by the Safety Net have generally lower health status than that of the broader population in their communities, whether measured by health outcomes or self-reported, and
tend to have a higher prevalence of chronic illness, suffer from a higher incidence of catastrophic occurrences, and have a higher prevalence of serious and persistent mental illness, substance abuse, and co-morbid chronic conditions. Safety Net patients are expensive.

The Safety Net is not currently, in most communities, a system of care. It is, rather, a fragmented and unsystematic collection of hospitals and doctors and clinics that deliver care to complex patients in a way that can be episodic and reactive, though often heroic. As the name implies, the Safety Net has focused much of its energy and resources on catching those who already are “falling” due to lack of prevention or complications of uncontrolled illness. Safety Net institutions are generally characterized by poor data generation with resulting scanty information on cost of care or health outcome measurements. Particularly for public Safety Net providers (local government-operated hospitals and health systems), the main business strategy has historically focused on increasing revenues, not controlling costs. One of the unique features of many Safety Net institutions is that they are reimbursed by Medicaid based on the costs they generate. These institutions may be adept at calculating the total overall costs used for reimbursement, but have a poor sense of the specific distribution and reasons for cost that might be helpful to generate cost-reducing interventions.

While Safety Net providers often have unique and distinctive expertise in caring for complex patients, they have limited tradition of collaboration or formal partnering with each other. There is often no history of prospective joint planning to improve the health of the population, to secure revenue, or to share in savings. Even within public health systems, primary care and behavioral health services are often disconnected from emergent and inpatient care. These institutions have usually developed their information systems separately and communicate inadequately to improve patient care or to fill gaps and eliminate costly duplications in service delivery. Complex and difficult patients are often sent without adequate coordination of care to other providers within the Safety Net, causing them to fall through the “cracks” in the system, suffer adverse health consequences, and ultimately incur higher health care costs.

Central to the ACO model (and all effectively managed integrated delivery systems) is a Patient Centered Medical Home (PCMH) for each patient. The PCMH is the starting point for all health care coordination and offers prevention, management of chronic illness, and access for acute problems. The PCMH initiates and coordinates referrals for subspecialty consultation and diagnostics and receives recommendations, shares in the development of the patient’s care plan and is the point in the health system that brings together all the patients health needs and treatments. The PCMH, however, is not simply a conventional primary care practice. It is expected to supply team-based care where staff roles are optimized and defined to meet the needs of patients in a planned, rather than a reactive, manner. It manages transitions between levels of care as, for example, in post-hospital discharge back to primary care.
care. While many Safety Net providers are attempting to move toward the PCMH model, it is not yet widely implemented. The Safety Net is characterized by lack of reserves to meet the financial challenges that even well-funded systems met during the transition to PCMH. Safety Net providers are less likely to have invested in the information technology that is necessary to support the implementation of the PCMH. "Patient-Centeredness" is a fundamental attribute of the PCMH but Safety Net providers developed originally as services of "last resort" without incentives or direction to become "patient-centered." The participation of FQHCs, many of which have greater experience in Medical Home conversions than other providers serving similar populations, could be an asset in the development of ACOs in the Safety Net. Further, some of the California Counties that have participated in the State's "Coverage Initiative" over the past several years have experimented with converting old forms of episodic care delivery to Medical Home models and could serve as the basis for building integrated delivery systems.

The Safety Net shares in the national crisis of an inadequate supply of primary care practitioners, as fewer and fewer medical students enter primary care careers. However, unlike the commercially-insured health care system which has an overabundance of specialists, the Safety Net strains to provide minimum access to specialists and diagnostics for its patients and the lack of access to these services may contribute to the less than optimal health outcomes of its patients. Further, poor communication between providers of specialty care and primary care in the Safety Net often squanders scarce resources by causing a repetition of treatment and testing or "churning" of patients in specialty settings who could have been returned to primary care. Lack of common information systems between specialty and primary care practitioners, the insular culture of training clinics at public academic medical centers, and little financial incentive to communicate with primary care all conspire to decrease the effectiveness of specialty care when it can be obtained. The role of both public hospital systems and private doctors in the development of specialty care panels tied to the ACO (and the assurance of their connection to primary care) will be a critical feature in an effective integrated ACO model, as will exploring the potential expansion of specialty care in innovative collaborations between specialists and FQHCs. The involvement in Medicaid managed care plans (in particular, California’s Local Initiatives and County Organized Health Systems, plans with a mandate to preserve the Safety Net) can provide assistance in identifying those specialty providers who have traditionally served Safety Net populations, often in isolation from each other.

Information technology (IT) is an essential tool for care coordination and disease management; it improves quality and may help to control costs. Safety Net investment in IT, however, has lagged behind the broader health care community. The establishment of an Electronic Health Record (EHR) is the focus for integrated delivery systems and the inclusion of a chronic disease registry is a necessity in effective disease management. Further, EHRs need to be connected to all providers that make up the ACO as efficient care in one sector (primary care, for example) is limited if it is not connected to other parts of the continuum of care, such as hospitals and outpatient specialty consultation. All levels of care in an ACO need to share a common patient care plan, be able to refer and gain advice from specialists, access diagnostics easily and appropriately, and manage the transition of patients between institutions and toward lower levels of care. Information systems that do exist within Safety Net institutions are
rarely connected or consistent with each other and their potential to support an ACO is limited by their isolation. Solutions such as Health Information Exchanges are needed and have been developed in Safety Nets, as have other creative approaches that have emanated from the Safety Net and are available, less expensive and readily implementable that can: provide registry functions short of a complete EHR (i2h disease registries initiated in the Bay Area); assure accessible but efficient links between primary care and specialists for referral and communication (the IRIS clinical rules-based specialty referral system conceived in the Cook County system in Chicago); and connect hospitals and EDs to Medical Homes in near real time (Safety Net Connect that links all of the hospitals in the community with physician practices and clinics caring for the uninsured supported by Orange County).

Beyond the need for using information technology to manage and coordinate the care for individual patients, the ACO must be accountable for cost and quality and must be able to measure both in a reasonable time. Ultimately, revenue will depend upon these factors and the successful ACO must know the status of quality and cost of care of its population. Safety Net systems are weak in this regard as data often cannot be generated in real time and its accuracy may be suspect because, historically, Safety Net systems have not needed to closely tie expenditures to utilization. The change in orientation of the Safety Net to generate and use valid and timely utilization, cost and quality data is critical. Further, ACOs may ultimately be held responsible to demonstrate improvement in the health status outcomes of the whole geography its serves, not simply those enrolled in the ACO itself. In that case, the Safety Net ACO must be connected to data that currently resides in the public health realm. In some local communities within the United States, these linkages already exist.

ACOs must be formed by provider collaborations of practitioners and institutions willing to be held responsible for the quality and cost of patient care and health outcomes. They also must agree to be reimbursed in new ways. The ACO will be a new organization with a legal structure that must accommodate an abundance of complicated existing regulations and laws (and politics). The agreements that establish and organize the Safety Net ACO are likely to be even more complex than those that will be utilized in the private health care system, as most will include local government health systems and FQHCs and private hospitals—all with their own governance structures. The participation of a public system in an ACO will involve internal policies, such as human resource rules, that extend beyond the health care sector. The high percentage of unionization of public systems (compounded further by civil service) may heighten resistance to change. On the other hand, organized labor may serve as an agent that helps this restructuring proceed if brought to the table early in the process. In Santa Clara County, for example, Local 521 of the Service Employees International Union (SEIU) was instrumental in both developing a broad analysis of the challenges facing the County in light of the California Waiver renewal and national health reform and in providing the catalyst to bring together all components of the local Safety Net—public and private—to begin to discuss the potential for forming an ACO focused on the meeting the health care needs of the most vulnerable residents of the County.

Payment in the ACO will be different than conventional medical revenue generation, particularly for the public sector but also for private Safety Net provider participants. Revenue will not be based on volume of service delivered but rather on the number of persons served by the ACO and meeting benchmarks for the quality of their care and its cost. Reimbursement will include sharing of savings through a system
of incentives that emphasize the most effective and lowest cost care. This is in direct opposition to the current focus of investment in and reimbursement of care within the United States where the highest cost, highest utilizing areas of the country often demonstrate worse health outcomes than areas of lower cost and utilization\textsuperscript{20}. A single ACO financial model does not exist and will have to be tested and refined based on the principles of cost and quality tied to reimbursement. A starting point might be chosen from the experience of the CMS Physician Group Practice (PGP) Demonstrations\textsuperscript{21, 22} or evaluations of practice incentives such as the Pay for Performance (P4P) initiatives.\textsuperscript{23} The PGP experience is helpful but was focused entirely on Medicare populations and tested in settings of established and successful, highly structured physician group practices that most resembled integrated delivery systems. Even with guidance from evaluations of P4P initiatives, unique models will have to be fashioned for a Safety Net ACO, since many of the evaluations of models existing today are from the commercial insurance market. When P4P in the Safety Net has been examined, concerns about comparability have arisen due to differences in the patient population, data sources, and the type and employment status of physicians who practice in the Safety Net.\textsuperscript{24, 25} But new Safety Net financing models are starting to emerge. In Chicago, for example, a group of FQHCs, private hospitals and the Cook County Health and Hospital System, spurred by foundation support, have come together to develop an integrated delivery model, first targeting Medicaid patients, and are working with the State of Illinois to test a new “gain-share” payment methodology that would allow cost-savings to be returned to the new entity to improve quality and access. Lessons learned from efforts like these will be important in making the transition from current Safety Net payment mechanisms that incentivize cost and volume.

The makeup, coverage and nature of the patient population cared for by the Safety Net will require additional consideration in an ACO, which assumes not only patient cooperation but increased patient-centeredness and empowerment. The Safety Net’s patients are, by definition, poor and have had little political, individual or market force strength. Health services available to them have been episodic and reactive so it is not surprising that their health-seeking behavior reflects this pattern. The patient population within the Safety Net is not only socially complex and disadvantaged; they are sicker. Health disparities are a recognized fact in the United States\textsuperscript{26} and an ACO within the Safety Net must be prepared to address these disparities. The population suffers and dies mainly from poorly-controlled chronic illness and experiences a higher level of serious and persistent mental illness and substance abuse.\textsuperscript{27} Services available to these persons may be inadequate but do exist within the current Safety Net, although they are often organized separately from the rest of the health care delivery system. Integration of medical, mental health and behavioral health will have to be a priority but the mere availability of these services can be a tremendous advantage to effective care for a Safety Net ACO. These models are also starting to be explored in places like Los Angeles, where an integration is being implemented between FQHCs, the County’s medical system and its mental health services, all focused on the highest utilizing and most complex patients in the skid row area of the city.

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The Safety Net may be unique in its attention to the uninsured, including persons who are not legal residents or otherwise are not likely to be covered under health reform. Formation of ACOs will not change this commitment but practitioners and institutions within the Safety Net are concerned that the uninsured are not discussed in proposed models or evaluations of past initiatives and worry that they may be overlooked or crowded-out by ACO planning. This is another reason to step up and influence the process now as Safety Net ACOs offer a unique laboratory for building effective approaches to these populations. In Orange County, for example, the leaders of all of the private hospitals have begun to collaborate with the Orange County Health Care Agency and CalOptima (the County Organized Health System Medicaid managed care plan) to help expand the County’s current approach to meeting the needs of the nearly half million uninsured by finding new ways to expand the pool of dollars available and to develop a more coordinated delivery system that includes the hospitals, clinics and private physicians. By starting with those patients with few options, a better system can be developed to meet the needs of those who have coverage.

What Steps Must the Safety Net Take to Participate in or Direct the Development of Approaches to Accountable Care?

As Safety Net leaders move their own institutions toward more integrated approaches to care delivery, they will first need to accept the inevitability of the change that health reform presents and reach the conclusion that there won’t be a “magic bullet” reprieve for the Safety Net, as there has been in the past. When the management of Safety Net institutions is so often dominated by moving from one crisis to the next, it is difficult to focus—and be supported in that focus—on planning for the future. As the country approaches 2014—and as California approaches the implementation of its Medicaid Waiver next year—there will need to be a resolve on the part of the leadership of Safety Net institutions (as well as their governing boards) that they are going to help to shape the transformation in how health care is delivered, not to wait for change to be imposed upon them. It is critical to move before policies are set in stone. There is enough fluidity now—and apparent openness to trying new things—that the Safety Net can be in the forefront of developing models that make sense for its providers and, even more important, its patients and communities.

It is important to understand that there is still a great deal of ambiguity about the specifics of ACO development and implementation. This uncertainty is likely to cause ambivalence, a lack of urgency and even hostility to change within the Safety Net. However, the massive expansion of coverage will clearly require new models to both assure access and contain costs. The focus on the core principles of ACOs (management of a population, direction by a coordinated set of providers, financial incentives aligned with clinical goals, containment of cost, enhancement of quality and the patient experience, improvement of overall health status) will benefit the Safety Net institutions and all of its patient populations, whether ultimately covered by health reform or not, or whether the adoption of these principles results in the formation of an ACO or not.

The steps that the Safety Net should take to prepare for the likely movement into integrated systems of care through ACOs are detailed below.
1. **Someone has to step up and lead.** The key to forming an approach to accountable care is to find a leader or leaders who can look beyond the self interest of any one provider. In Chicago, that leader was a foundation that committed both start-up and long term support to the effort that is resulting in an integrated system of care for Medicaid patients on the south side of the city. In North Carolina, private physicians directed the development of integrated networks that eventually formed the basis for service delivery for Medicaid patients throughout the state. In South Los Angeles, a private hospital system served as the convener of a group that now includes FQHCs, the public health and hospital system, other private hospitals and the Local Initiative Medicaid managed care plan to take on the development of an integrated approach to the care of vulnerable populations in that community. In San Mateo, the County government initiated a process that has resulted in collaboration between the public health system, private hospitals, large physician groups and FQHCs in the care of traditional Safety Net populations. FQHCs, public hospitals, local business groups concerned about access for their employees, unions, foundations, private hospitals—the impetus for change, and the tenacity and skill to keep all of the players at the table, can come from many quarters.

2. **Determine the geographic area to be covered by a Safety Net ACO.** The area should be large enough to demonstrate the impact of the ACO on cost, quality and health status but not too large to be impossible to manage effectively. For example, some California counties would likely represent a plausible target area while others would need to be divided into rational subdivisions. Within the geographic target area, while understanding that all populations would ultimately be included, a plan for an incremental approach to population inclusion will need to be developed, likely starting with Safety Net populations (i.e., Medi-Cal, uninsured, dually Medicare and Medicaid eligible).

3. **Thoroughly understand the target populations and communities.** A Safety Net ACO will need to identify vulnerable populations, their current utilization patterns (ED use, connection to primary care, hospital readmission rates), and their health problems. This analysis will then need to be compared with what care *should be* provided and what health status goals *should be* achieved. It is not enough to identify, for example, how many outpatient specialty visits were generated by a given population; it must be compared to objective criteria for what should be occurring in a managed approach for a comparable group of patients. Other information to be identified should include: gaps in care (i.e., too few specialty visits compared to what is indicated for the care of certain chronic illnesses), duplication of services (i.e., diagnostics at multiple institutions) and inappropriate use of certain levels of care (i.e., excessive Emergency Department visits for ambulatory sensitive conditions). This process of assessing the population is a critical step in allocating resources and setting goals in an integrated delivery system that will effectively care for the population. All available data should be thoroughly examined: County health utilization, FQHC federal reports, state Medicaid data. Medicaid managed care plans, particularly those that have a commitment to preserve the Safety Net, can be invaluable partners in assessing current utilization patterns and identifying trends, gaps and duplications.
4. **Begin to build a framework for how different providers could fit into an integrated delivery system.** It is important to identify the providers to whom target populations have traditionally gone for their care. These clinicians and institutions (public and private) should form the first critical mass of those who will come together to begin to plan for this new and integrated approach to care delivery through an ACO. Developing an ACO made up of providers with little history of collaboration and joint planning for a population is a delicate endeavor. Conversations must start between individual leaders to build relationships, to demonstrate a clear willingness to “put everything on the table” and to build on the assets of individual providers, sharing what one does best and giving up other services when there are better options. In some areas it may become clear, for example, that certain providers are better suited to become the primary care Medical Homes for some patients, while another provider may develop “Enhanced Medical Homes” for those patients that require greater access to specialty, behavioral health and diagnostic support. One hospital provider may be seen as the primary resource for cancer care for the ACO and another may develop cardiac services. Still another provider participant may have the most effective model for care management that can be disseminated throughout the ACO. FQHCs will need to coordinate with each other and with the large number—in many communities—of private physicians who are caring for Safety Net populations, building on each other’s strengths in the development of Medical Homes and specialty panels. These preliminary discussions are vital to assembling this inventory and engaging in creative thinking among provider participants.

5. **Bring a critical mass of providers into discussions about an ACO.** Once it is clear that there is the potential for an integrated approach to the delivery of care to a defined population, those providers should be convened and start meeting together to plan for the development of an ACO. It will be important that the CEOs and other senior administrators—including clinical leaders—of these provider organizations compose the planning group so that commitments can be made for the individual institutions. Eventually, this body will need to further expand to include other key stakeholders (schools, mental/behavioral health, business, etc.). Local Initiatives and County Organized Health Systems can provide expertise in both identifying key private physician groups that have traditionally been major providers for Safety Net populations and offer resources in the development and implementation of infrastructure in managing the integrated delivery system.
6. **Agree to move together in phases but with a clear timeline.** The issues that will require scrutiny and decision once there is a determination of the target area and the initial component of providers will be daunting. These issues must be developed in a “forced march” of timelines and clear deliverables. Each area will appear overwhelming and must be pushed through, often with incremental solutions.

   The list includes, but is certainly not limited to:
   
   - setting priorities and a schedule for *patient inclusion* (who will be cared for when will impact the scope of the provider network, the financial strategies, the infrastructure and the shape of the organization):
   
   - establishing a model or models for an *organizational structure for the ACO* which will likely include public health and hospital systems, FQHCs, private hospitals and even private practitioners—all with their own constraints and all required to be represented;
   
   - determining an approach to *integrated clinical leadership and goal setting* that will assure provider inclusion in the operation of the ACO;
   
   - setting a plan for *patient management infrastructure*, including connective information technology, targeted care management, utilization review; and
   
   - establishing *financial strategies* that incent best practices, fill gaps in the continuum of care, minimize duplication or inappropriate use of resources, identify the potential use of shared savings.

7. **Involve the major payers of the Safety Net, including State and local governments that reimburse for the care of the Medicaid population and the uninsured.** It is important that these entities are included and, perhaps through CMS, supported to partner with Safety Net ACOs as they attempt to build integrated delivery systems to provide higher quality, better coordinated and more cost-efficient care for vulnerable populations.

8. **Start by starting: begin to act as a “virtual ACO” as the real one is being developed.** Even before the final structures are in place, the provider participants in the ACO should start to find ways to operationally and clinically collaborate or expand coordinated activities already in place. Further, health care institutions (whether they are large academic medical centers or community-based FQHCs or faith-based community hospitals or two-physician private practice offices) all have employees and systems and cultures. They may have limited experience with working collaboratively with other providers. The understanding of new ways of operating, of working and openly communicating with partners, is a new lesson to be learned and is counter-intuitive on many levels. The ability to make this concept real will be contingent on developing and doing real work together.

9. **Get help to build the infrastructure that will make the ACO a reality.** The transition period will be a very difficult one. It is projected that there will be support available from the Center for
Innovation in CMS and that Safety Net ACOs will be viewed as attractive partners as the federal government moves to cover tens of millions of patients who have traditionally relied on Safety Net providers for their care. Other sources of support should be mined, however. Foundations could play an important role in seeding real and ultimately sustainable infrastructure elements (IT, legal assistance as governance is being developed, medical home readiness training, etc.) and sponsoring formal interactions between Safety Net ACO efforts to share best practices as learning from each other will likely be more helpful than drawing lessons from traditional ACO models.

What is the Conclusion about Accountable Care and the Safety Net?

The Safety Net, like the rest of the country, is about to experience the greatest change in health care delivery in several generations. As its patients move from uninsurance to coverage, as payment mechanisms transition from subsidizing providers who care for underserved populations to incentivizing quality and cost-controls and as new clinical models emerge that demand integration and best practice, the Safety Net must be prepared. These institutions are critical resources in their communities and waiting for changes to be imposed without influencing how they impact the Safety Net, and those patients who have traditionally relied upon it, is a bankrupt strategy. There is a window of opportunity to lead and the Safety Net has an obligation to be in the forefront of change, not resistant or ambivalent to it. Across the country, small groups of hospitals, FQHCs, physician groups, and public health systems are beginning to talk about the populations that they all serve and how to serve them more effectively and efficiently. These efforts should be incubated and brought to fruition. The entire US health system will be better for it.

7 Ibid
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