

# Integration of Emerging Healthcare Delivery Systems in South Los Angeles

June 7

2011

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Summary Report of Key Stakeholder Interviews  
*Presented to The California Endowment*



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## EXECUTIVE SUMMARY

The California Endowment (TCE) retained National Health Foundation (NHF) to serve as the lead organization to assist in the development and implementation of a planning effort designed to create a vision with measurable goals, objectives and implementation strategy for an integrated healthcare delivery network (IDN) for South Los Angeles.

NHF has identified four key areas which could facilitate integrating individual efforts being undertaken. These include measuring quality, assuring meaningful use of health information technology, capitalizing on governmental and private financing and identifying innovative demonstration projects. As a result of a commitment from the Watts Health Foundation and the California Endowment, approximately \$20 million dollars is available to assist key stakeholders in accomplishing the goal of developing an integrated delivery network for South Los Angeles.

This report represents the first in a series commissioned by TCE that will provide context for understanding the challenges and opportunities for attempting to create an integrated delivery network of healthcare in South Los Angeles. The purpose of this report is to summarize findings of a survey conducted among key thought leaders. Specifically, it helps illuminate where these healthcare leaders are with individual approaches and prospects for creating a process for enhancing coordination across initiatives being planned or implemented which will effect healthcare delivery in South Los Angeles. Findings from this report have been used to suggest next steps for the California Endowment to consider in order to help define the process used for going forward to accomplish this coordination.

Prior to this effort, funding by TCE in South Los Angeles has either targeted the Building Healthy Communities Initiative (placed based initiative with the goal of creating a place where children are healthy, safe and ready to learn) or individual projects that provide great benefit but lack cohesion or strategy. NHF recommends creating a strategic vision to help integrate healthcare delivery in South Los Angeles with the goal of improving overall community health.

We recognize that TCE has already invested in an emerging South Los Angeles Safety Net ACO specifically in funding the planning stages. In light of lagging Safety Net ACO regulations, TCE could continue to invest in this model as it's striving to represent the entirety of the safety net in South Los Angeles. In particular, it would be wise to focus on quality and health information technology as they have the potential to be the most influential in the success of both an individual ACO and the larger IDN and could be the most difficult to independently finance.

Additionally as part of strengthening the South Los Angeles ACO, TCE could also help finance Martin Luther King Medical Center's (MLK) participation in an ACO after an operator has been identified. Because of its turbulent past, MLK is in need of additional funding and support. Most importantly MLK hospital is at the center of the South Los Angeles Community and could serve as a hub for integrated services within an ACO.

While investment in an emerging integrated system of care such as an ACO, in South Los Angeles is needed an investment in developing an IDN that integrates all systems of care present

in South Los Angeles is a more sound strategy to increase cooperation, health care quality and drive cost down in the entire region.

As this report describes, integrated systems of care are already in place or developing in South Los Angeles. However, interview respondents were most in support of creating opportunity and incentive for integrating all efforts so that any patient seeking care in South Los Angeles is tracked across systems. Based on findings to date, this would entail making greater targeted investment into a region-wide quality scorecard, health information technology system and cross cutting demonstration projects.

Finally, based on the survey results, leadership is lacking in the formation of an IDN. TCE could serve as the catalyst for cohesion around quality, meaningful use of health information technology and demonstration projects. While TCE has been identified as a potential and needed leader in incentivizing the integration of healthcare services in South Los Angeles, they should not work alone. A coordinated effort by multiple funding entities could achieve greater impact on healthcare integration. TCE could leverage the philanthropic activities in South Los Angeles by creating a collaborative among a group of funders who have demonstrated commitment to South Los Angeles. This cooperation between funders could prove powerful in driving measurable change in South Los Angeles.

## INTRODUCTION

The California Endowment (TCE) retained National Health Foundation (NHF) to serve as the lead organization to assist in the development and implementation of a planning effort designed to create a vision with measurable goals, objectives and implementation strategy for an integrated delivery network (IDN) for South Los Angeles.

NHF has identified four key areas which could facilitate integrating the individual efforts being undertaken. These include measuring quality, assuring electronic connectivity, capitalizing on governmental and private financing and identifying innovative demonstration projects. As a result of a commitment from the Watts Health Foundation and the California Endowment, approximately \$20 million dollars is available to assist key stakeholders in accomplishing the goal of developing an integrated delivery system for South Los Angeles.

Starting in November 2010 and over the next 18 months a series of tasks have and will be initiated. These include: 1) a survey of 36 key stakeholders to better understand the goals and objectives of the various Accountable Care Organizations (ACOs) and integrated systems that are currently in development and how an IDN can best be developed and implemented 2) background information on the use of quality measures, health information technology and financing options to help ensure a successful integrated system 3) a convening of the key players involved in developing ACO's in South Los Angeles to create the opportunity to learn what the others are attempting to accomplish 4) a series of quarterly task force meetings designed to identify how best to develop and implement ways to assure inter-operability and meaningful use of health information technology, measure quality, identify what financial assistance could be made available and identify a significant innovative demonstration project(s) that could be implemented. A web-based system which will allow stakeholders in South Los Angeles to pose questions, and receive systematic feedback from the task force work groups has been developed. Prior to each taskforce meeting, stakeholders will have the opportunity to pose questions and/or identify issues they would like the taskforces to address. Results of each task force meeting will also be posted on this project web site. Any interested party will have access to the proceedings of each task force meeting.

NHF will use the information from the interviews and taskforces, not to create an ACO or structured delivery system of healthcare, but rather to design and manage a process with those who are doing so to facilitate "integration" of key components across the various developing ACO's to support a coordinated comprehensive network of care for all of the residents of South Los Angeles.

National Health Foundation is an independent 501(c)3 non-profit organization striving to increase access to healthcare. NHF is not a business stakeholder in South Los Angeles and has no vested interest in the success of specific projects, only to the improvement of health for the South Los Angeles Community.

## *Report Objective*

This report represents the first in a series commissioned by TCE that will provide context for understanding the challenges and opportunities for attempting to create an integrated delivery network of healthcare in South Los Angeles. Specifically, the purpose of this report is to summarize findings of a survey conducted among key thought leaders in South Los Angeles. This report helps illuminate where South Los Angeles leaders are with individual approaches and prospects for creating a process for enhancing coordination across initiatives. Findings from this report will be used to recommend next steps for the California Endowment to consider in order to help define the process used for going forward to accomplish this coordination.

## *Context*

The passage of health care reform (Affordable Care Act) in 2010 has set into motion a number of efforts to create different models and approaches for providing comprehensive, coordinated, and cost effective care<sup>1</sup>. This effort endeavors to expand health insurance coverage, coordination of care and availability of funding opportunities for communities in need. South Los Angeles is in critical need of such an effort with an estimated 270,000 uninsured residents out of 944,000(30%)<sup>2</sup>. ACOs appear to be the most popular model being pursued, first for Medicare patients and second for the safety net followed by commercial patients. The new health care law sets forth some broad goals for what an ACO should accomplish and specific regulations on how ACOs are to work in practice with the Medicare population<sup>3</sup>.

In South Los Angeles a number of different entities exist or are working to develop their individual versions of an integrated system via different mechanisms such as ACOs, Accountable Care Networks or other integrated delivery networks. Clearly, successful development of one or more integrated system could be beneficial to residents of the area. But even greater benefit would be derived if a process could be developed and implemented whereby residents are assured that no matter which system serves them, their medical histories and records would always be available to the appropriate care provider. Historically, fragmentation and shifting provider networks have resulted in duplication of services, tests, procedures and visits when patients are faced with yet another new source of care. Opportunities for efficiencies are evident. Similarly, having an agreed upon set of quality metrics adopted by each individual system could demonstrate how their collective efforts have improved the health status of South Los Angeles residents. Equally exciting is the prospect that some major demonstration project(s) resulting from collaboration among these systems could be developed and potentially serve as models for other major metropolitan areas across the nation.

For purposes of this project, South Los Angeles is defined as Service Planning Area 6 (SPA 6) (Figure 1).

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<sup>1</sup> WhiteHouse.gov. The Affordable Care Act. <http://www.whitehouse.gov/healthreform/healthcare-overview>  
Retrieved May 2011.

<sup>2</sup> California Health Interview Survey. CHIS 2009 All Ages Source File. Los Angeles, CA: UCLA Center for Health Policy Research, April 2011.

<sup>3</sup> <http://www.kaiserhealthnews.org/~media/Files/2011/ACO%20Proposed%20Rule.pdf>



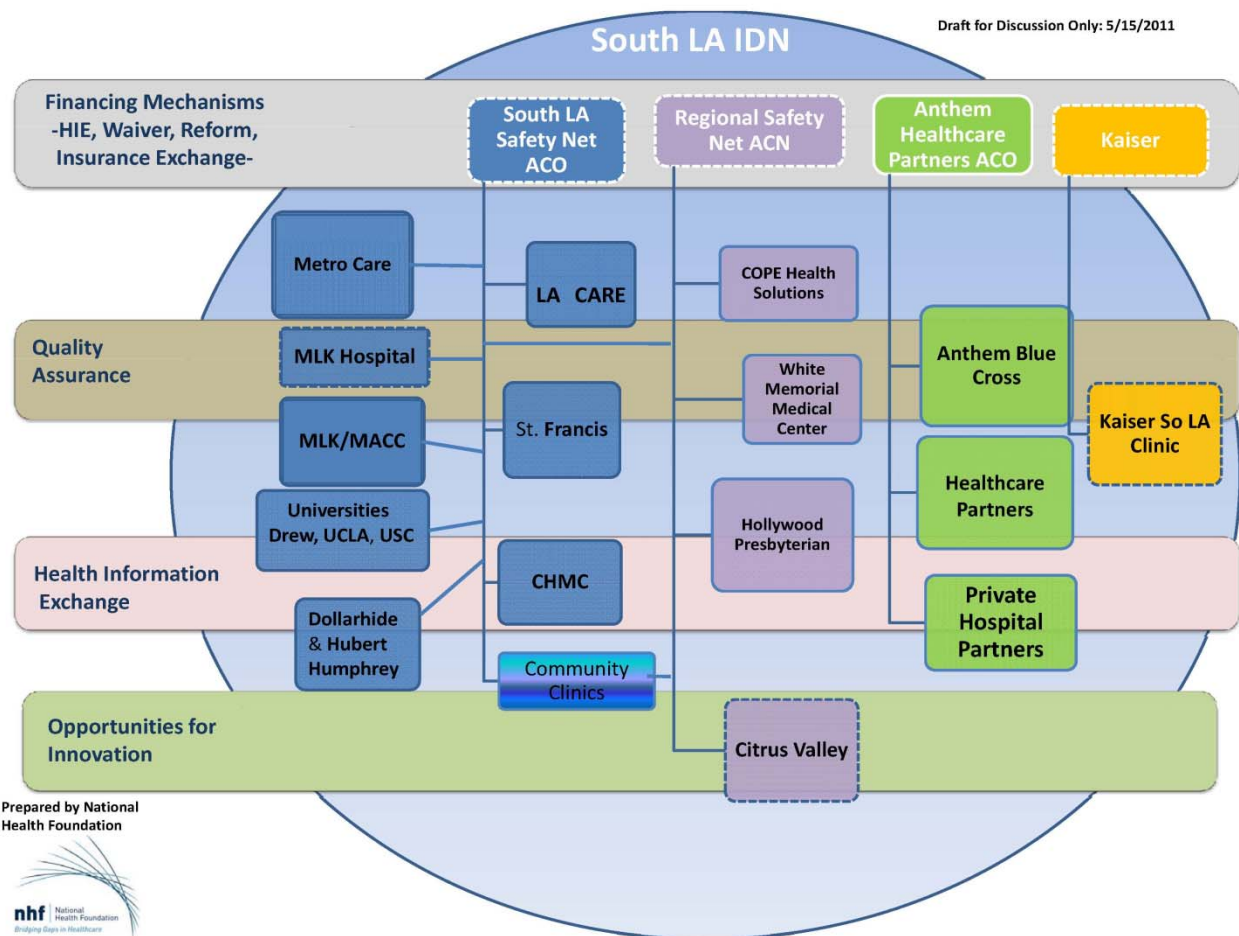
Key themes include:

- Integrated Delivery Networks, ACOs and essential components are perceived differently among stakeholders.
- Quality measurement and meaningful use of health information technology are imperative for improving quality and driving cost of care down in South Los Angeles.
- Health care reform and the preceding 1115 Medicaid Waiver present a financing and incentivized cooperation opportunity for South Los Angeles healthcare delivery.
- A lack of leadership exists in driving integration across competing healthcare systems in South Los Angeles.

## EXISTING AND EMERGING INTEGRATED HEALTHCARE DELIVERY SYSTEMS IN SOUTH LOS ANGELES

Figure 1 depicts NHF’s vision of potential horizontal integration across already existing or developing healthcare delivery systems in South Los Angeles.

**Figure 2. Potential for Horizontal Integration of Healthcare Delivery in South Los Angeles**



The four identified existing and emerging systems include the following;

**1. South Los Angeles Safety Net ACO**

The South LA Safety Net ACO is a public private partnership of critical healthcare providers in South Los Angeles including St. Francis Medical Center, California Hospital Medical Center, Los Angeles County Department of Health Services (LACDHS), Southside Coalition of Community Clinics and other federally qualified health centers (FQHC) serving South LA and LA Care (the largest managed Medicaid managed care plan in the county). The model is based on Health Management Associates' (HMA) framework of integrating care<sup>4</sup>. HMA plans on continuing to work with the ACO during the planning process. Governance will be provided internally by partners in the ACO<sup>5</sup>.

The planning process has various phases (of which Phases I and II have been completed) that analyzed community need and began the process of providers working together in forming an ACO. Phase III is currently being funded by TCE and consists of structural and operational structure development for the pending ACO and securing commitments from participants. MOUs have already been distributed to potential partners. Assuming the Centers for Medicare and Medicaid Services (CMS) will release safety net ACO regulations, the partners of this safety net ACO would be well positioned to apply for certification and hope to be operating as a functioning ACO by 2012. Initial enrollment will start at approximately 5,000 people with a goal of 12,000 by year three of the ACO. While the numbers do not appear substantial, the effects of changes to accommodate the ACO (such as infrastructure for quality measurement and health information technology), will affect the majority of the safety net in South Los Angeles due to indirect consequences of infrastructure development. This number is estimated at approximately 135,000 people based on the population that the Southside Coalition of Community Clinics serve (11.25% of South LA population overall)<sup>6</sup>.

This model is predicated on the hope that CMS will come out with a set of guidelines for a safety net ACO which would be different from the current regulations for Medicare ACOs.

**2. Regional Safety Net Accountable Care Network (ACN)**

The Safety Net ACN is a public private partnership of LACDHS hospitals, FQHCs and Independent Physician Associations (IPA) serving Koreatown, Hollywood, Downtown, East Los Angeles and East San Gabriel Valley. This covers a portion of the northern region of South Los Angeles or SPA 6. Partners for the ACN include AltaMed Health Services Corporation (AltaMed), Citrus Valley Health Partners(CVHP), Hollywood Presbyterian Medical Center (HPMC) and White Memorial Medical Center (WMMC). Additionally, LAC+USC Healthcare Network is engaging as a collaborating entity. COPE Health Solutions serves as the Coordinator and Facilitator of the ACN.

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<sup>4</sup> Health Management Associates, Framework for a Multi-Provider Accountable Care Organization serving the Medically-Vulnerable Populations of South Los Angeles.

<sup>5</sup> The Los Angeles County Department of Health Services is still in talks with the ACO partner on defining their role.

<sup>6</sup> Number provided by Southside Coalition of Community Clinics, 2011

Goals of the ACN include;

- Improve access and quality of care, patient safety and satisfaction, efficiency and cost effectiveness of care delivery.
- Improve long term financial viability of providers within the network
- Provide strong clinical leadership and resources to the network
- Drive advocacy and policy development to improve access to care for the safety net population.

The regional safety net ACN is hoping to develop the necessary level of clinical integration and legal and financial frameworks so that more health plans may be engaged in terms of the safety net population (Medi-Cal, seniors and persons with disabilities (SPD), California Children's Services (CCS), etc.). Essential to the ACN is physician commitment, alignment and leadership. It is unknown whether the ACN will progress to a formal ACO however efforts are being made to make the two compatible.

### **3. Anthem Blue Cross and HealthCare Partners ACO**

HealthCare Partners, a Torrance based Medical Group and IPA, and Monarch HealthCare, an Irvine based Medical Group and IPA, are collaborating with Anthem Blue Cross as part of a pilot project to form an ACO led by the Engleberg Center for Health Care Reform at Brookings and the Dartmouth Institute for Health Policy and Clinical Practice. This will hopefully serve as a demonstration project that will provide a successful model replicable throughout the county for healthcare integration under healthcare reform.

Healthcare Partners serves a limited number of patients residing in South Los Angeles (approximately 35,000 or 2.92%). The ACO pilot will only cover approximately 5,000 people and it is unknown at this time what percent will be in South Los Angeles. While this number is most likely very low, it is still an example of an ACO model for reducing cost and increasing quality that may be relevant to the population of South Los Angeles.

### **4. Kaiser Permanente**

Kaiser Permanente, while always invested in South Los Angeles continues to expand their integrated model of health care delivery and community benefit programs in the region. In the spring of 2011, Kaiser opened a new medical office building in South Los Angeles estimated to serve more than 80,000 Kaiser members. This facility joins already existing medical and vision offices in Lynwood and Inglewood. The facility is the first of its kind for Kaiser in South LA offering primary care, X-rays, lab tests and a pharmacy, and at 15,000 square feet represents a \$10 million dollar investment in the community. The opening of the new facility solidifies Kaiser's place as a key integrated system already operating in South Los Angeles.

Currently Kaiser is a leader in creating a successful health information technology system for members with other healthcare delivery centers looking to them for guidance which is beneficial to other partners in South Los Angeles. Additionally, Kaiser invests a significant amount in Community Benefit Programs unlike other systems including the Watts Counseling and Learning Center, Watts Healthy Farmers Market, Education Theater Program

and a multitude of grants to local organizations including many FQHCs. In addition Kaiser supports a variety of Healthy Eating, Active Living projects in South Los Angeles.

Kaiser has approximately 215, 341 members who reside in South LA, the largest percentage of any group with coverage in the area (approximately 17.92% of the population). Kaiser has an established reputation and can help lead South Los Angeles by example specifically in terms of integrating systems, measuring quality and creating a meaningful health information exchange infrastructure.

## **SURVEY OF KEY STAKEHOLDERS**

In order to better understand key healthcare thought leaders' strategies for responding to healthcare reform and to obtain their views on the importance of coordinating or "integrating" across potential competing integrated systems, NHF, with assistance from TCE, identified a list of over 45 key leaders and stakeholders in South Los Angeles to provide input into planning an Integrated Delivery System (IDS). Out of this list of stakeholders, 36 were interviewed. The rationale for selecting these individuals was that they have a vested interest in healthcare delivery in Service Planning Area 6 (SPA 6) that could be influential in either supporting or dissuading participation in a process to create an Integrated Delivery Network (IDN) (See Figure 2 for map). NHF sent letters, a brief summary of the project and a letter of support from TCE via mail and e-mail to all potential respondents (Appendices 1-2).

NHF created an interview protocol (Appendix 3) with input from TCE. Interviewees consisted of stakeholders in already existing integrated systems referenced previously in South Los Angeles, academic institutions, consultants and community leaders (Appendix 4). Once the interview protocol was finalized and approved senior staff at NHF conducted interviews in person and by telephone. Interviews were transcribed into an excel database and analyzed for purposes of this report.

## **RESULTS**

The interview protocol consisted of many open ended questions that allowed respondents to illuminate their views on systems they are involved with and how to better integrate across all healthcare delivery systems to improve health care quality and health status of residents in South Los Angeles. After analyzing data, common themes emerged and are presented in this section via summary and quotes.

### **1. Integrated Delivery Networks, ACOs and essential components are perceived differently among stakeholders.**

While there is a depth of knowledge regarding individual and developing systems by those involved there is little if no understanding of what others are doing in regards to healthcare delivery in SPA 6. Current efforts are operating in silos and can benefit from sharing knowledge across systems in hopes to increase healthcare quality and access in South Los Angeles. Additionally knowledge of opportunities through Health Care Reform including ACOs is varied across respondents. Key thought leaders interviewed have different ideas on

who should be involved and how a successful integrated system should look. Additionally, respondents were appreciative of the interview itself and took advantage to understand more about other efforts in South Los Angeles and opportunities through Health Care Reform and potential partnerships with other agencies.

***Respondents identified additional players necessary in the formation of an integrated system.***

Respondents had a broader view of who should be included in creating an integrated system of care both geographically and in terms of types of services. Other hospitals within SPA6, such as Centinela Hospital Medical Center, were mentioned repeatedly as needing to be at the table. Hospitals outside of SPA 6 were mentioned as these hospitals do see residents from SPA 6 such as Cedar-Sinai Medical Center. There are other community clinics in South Los Angeles and while not FQHCs are still important to include such as the Compton Community Health Centers. The inclusion of private physicians within SPA 6 and labor represented by Service Employees International Union (SIEU) were both emphasized.

***There is confusion over what population an ACO can serve.***

The majority of respondents knew that an ACO was defined by the federal government with the purpose of increasing quality and decreasing cost of healthcare, however there was confusion over what population an ACO might cover. While ACO regulations have been defined for the medicare population by CMS, regulations for the Medicaid population have not. There is optimism in the safety net community that safety net regulations will be instituted shortly. This is especially important as the South Los Angeles Safety Net ACO is predicated on the creation of these Medicaid safety net regulations.

***AN ACO .....***

***“ is a cop out and term used only by policy wonks. The ban on the corporate practice of medicine in California makes alignment difficult. Since you can’t explain an ACO in 30 seconds it doesn’t make sense”***

***“is Aligning Incentives for outcomes that targets an entire geography, the community and everyone”***

***“stands for Amazing Consulting Opportunity!”***

***“is whatever you want it to be. If you take a step backward , isn’t this conceptually a HMO that is supposed to be an integrated system with aligned incentives, care coordination, financial alignment and population health management. I guess I am cynical “***

***“is more structured. There are more resources and really targets the medical home and chronic care management. It will embrace senior population first and then move up to the community.”***

***“Is an ACO designed to get around the fact that managed care is socialized medicine? Is this a kinder way of saying same thing? Why not just stick everyone in managed care? Why create a whole new system? Why reinvent the wheel? There are very few medicare patients that will be part of the ACO to begin with, will this spill over to medi-cal eventually?”***

***“should also be based on Geography. To improve health you need to be transcend payer categories.”***

***There is no known plan to horizontally integrate ACOs and Integrated Delivery Systems.***

As discussed previously, developing ACOs and existing healthcare delivery systems are operating in silos. While vertical integration of ACOs and systems like Kaiser are already in process, there has been little discussion on horizontal integration to allow for communication across all healthcare delivery systems in South Los Angeles. Respondents identified a need for such horizontal integration as to successfully track patients throughout SPA 6.

***A working system of reimbursement is essential in ensuring a sustainable integrated system or network.***

Respondents agreed that government and foundation money will be required over the next few years to help finance infrastructure of integrated systems that will hopefully increase access to care/coverage and quality while decreasing costs. However, sustainability of integration was questioned. Once initial investments are made, many question how systems will sustain themselves while increasing quality and decreasing or maintaining cost. Some respondents did express the view that the success of ACOs will be dependent upon their intrinsic financing models. This also begs the question of how involved the private physicians should be.

Additionally, in order for any system to be sustainable it must be profitable, or at least cover costs. Therefore it is important to enroll patients who are healthy and will improve overall quality scores while not draining resources. Thus, it is imperative that the low risk health insurance pool also be enrolled in any sort of system as to help make it more self sustaining.

***Medical Homes should lie with Primary Care Physicians and FQHCs and should be the point of access to an integrated system.***

Most respondents agreed that medical homes are a necessary piece of integration and that in the safety net this medical home should reside in the FQHCs or community clinics while in the non safety net population, with primary care physicians. Intrinsic to an ACO is a medical home where care can be managed. Specifically in the case of the forming South Los Angeles ACO, medical homes will lie with community clinics.

This is significant as the drivers of integration in South Los Angeles tend to be hospitals. Considering that respondents see care coordination taking place at the physician and clinic level, it's important they are part of the conversation.

***Physician championship is lacking in South Los Angeles***

While the majority of respondents expressed the necessity of physician alignment in integration and the importance of physicians in providing a medical home, it was noted that there is little if no perceived physician championship for integrating healthcare in South Los Angeles. This coupled with certain

***“What you want in a medical home is some entity or hospital clinic that manages an individual care in such a ways that they know that that’s the place to go to get what they need as a starting point. That starting point will manage them both internally and externally if they will be sent out for specialty care.”***

***“It takes more than a medical home, it takes a medical village.”***

restrictions such as the ban on the corporate practice of medicine in California, make it extremely difficult for hospitals to partner or align with physicians. This is significant in the context of creating an integrated system of care as it is very difficult and without physician champions, and very well may be impossible.

*The healthcare workforce may not be adequate to support integrated delivery systems in South Los Angeles.*

Once the Medi-Cal Waiver 1115 takes effect in 2011 and Health Care Reform takes effect in 2014, there will be more eligible patients in South Los Angeles, however the number of primary care physicians is expected to stay the same or decrease. Additionally as MLK is opening there has been little talk of opening a physician building adjacent to the new facility which could help attract both primary care physicians and specialists.

However it was noted that with an integrated system or formation of an ACO, primary care physicians might not be the sole provider of care but rather allied health professionals such as physician assistants or nurse practitioners would take on a more important role. Therefore both physician shortages and allied healthcare shortages need to be recognized.

*Substance abuse and mental health services need to be at the table.*

The population of South Los Angeles suffers disproportionately from substance abuse and mental health issues. Thus the creation or integration of any system without addressing these two morbidities will hinder possible positive outcomes of an ACO or IDN.

*IDN or ACO governance, operations and financing is a challenge.*

*“Governance will be tough depending on how formalized things get. Many at county will not relinquish control. It might be best to look like LA Care governance- public, private, industry etc. “*

ACO governance regulations makes it difficult for the county to play. ACO’s will have separate financing and governance structures that might make it very difficult for the county to be a major player.

*MLK Hospital is critical but their role is unknown.*

The reopening of MLK hospital is essential to the community health of South LA. The board of MLK is currently focusing on choosing an operator and how to operate day to day as a hospital. Thoughts on integration with ACOs and other delivery systems in the area have been limited. Concern has been expressed that the MLK

*“MLK is like Humpty Dumpty” Don’t know if we can put it back together again*

*“MLK must be a fundamental piece of an integrated network in South Los Angeles. MLK will be a campus, doing primary, specialty and social support and could be the hub of the IDN. They can set pattern of moving forward.”*

board needs to enter into these conversations simultaneously with the re-opening in order to stay connected with integration efforts currently underway in South Los Angeles.

Additionally, even though MLK will primarily serve the safety net, it will not be operated by Los Angeles County Department of Health Services. Therefore it is unknown how a private operator will work with the County to ensure that the safety net is covered.

*A Successful Integrated System/Network may be measured using various levels of outcomes.*

Respondents had a variety of answers in response to measurement. Many focused on hospital specific indicators while others focused on community level indicators. Additionally there was a distinction between short term and long term indicators. Specific indicators may include;

- Community Indicators such as unemployment, workforce productivity, crime and those living below the federal poverty level.
- Overall Population Health such as rates of obesity, diabetes and other chronic disease.
- Hospital Indicators such as quality metrics and decrease in hospital patient days.
- Financial Indicators
- The institution of a meaningful health information exchange

***“It is necessary to measure change in overall cost of the system including all payers including commercial and medi-cal. Overall cost must go down. Cost shifting is not enough.”***

*There are many perceived barriers that must be overcome.*

Healthcare delivery in California has enough barriers to overcome without the additional stress that this geography puts upon it. Specific barriers mentioned by respondents include;

- The nature of a fragmented healthcare delivery system
- Different reimbursement mechanisms for providers
- Lack of leadership to promote an integrated approach to healthcare delivery
- Money in an impoverished area
- Large undocumented population living and seeking care in South LA not covered under the waiver or ACA.
- Ban on corporate practice of medicine making physician alignment difficult
- Lack of a substantial workforce

***“The challenge is that an ACO must be a mix of all parties and focus must be shifted from hospitals to practitioners. But many ACOs that are being developed now are still centered on hospitals. Maybe CMS doesn’t understand?”***

***“People in Los Angeles don’t collaborate unless it’s in their best interest (of the partners not the community). “***

## 2. Measuring quality with a standard scorecard is imperative for improving quality and driving cost of care down in South Los Angeles.

### *Quality metrics do not need to be reinvented.*

All respondents found quality to be an integral part of a successful IDN or ACO. The majority agreed that new measures need not be created and that both population health and more traditional quality measures are needed.

*“The challenge is that the safety net is way behind in terms of quality. Where do you start? I would start with the most high risk populations such as those living with diabetes or other chronic diseases. “*

*“As FORD says, ‘quality is job one’, quality of care has to drive what we are doing, ie these underlying requirements to be part of system. As a non physician, I think the world of health quality measurement as depicted by HEDIS, medical science has already defined what we are looking at based on quality for conditions. But we are behind on other issues..ie obesity, social indicators”*

*“We need a formalized way of measuring community health since care has been so fragmented and uncoordinated. First thing we need is to come up with a standardized matrix of measurement.”*

The creation of a community wide quality scorecard was highly recommended by respondents. Publicly reporting health care quality data both creates transparency between the public and providers and also drives change<sup>7</sup>. It is imperative that a quality scorecard incorporating both clinical and behavioral indicators is developed as part of integrating care in South LA. While currently, organization’s commitment to quality in South Los Angeles is high, there is a disparity between what is planned and underway. This is especially true in community clinics and primary care providers which are both understandably lagging behind hospitals.

Currently, the Community Clinic Association of LA County is the only non-governmental public health entity to openly report quality data to its members, but do so for only 4 chronic disease measures. Additionally, California does not mandate specific quality reporting for specific metrics at the clinic or individual physician level. While some reporting requirements do exist they are limited. Additionally quality metrics that have been collected suggest that overall, healthcare quality in South LA is below the state and national average. Both the lack of transparency and lagging health care quality, call for a community wide adherence to a quality scorecard<sup>8</sup>.

<sup>7</sup> Madison, Kristen. “The Law and Policy of Health Care Quality Reporting.” Campbell Law Review Campbell University. <http://law.campbell.edu/lawreview/articles/31-2-215.pdf>.

<sup>8</sup> National Health Foundation Integration of Health Care Delivery Systems in South LA- Background Analysis, 2011, Report was provided with assistance of Price Waterhouse Coopers

### 3. Electronic Health Records and Health Information Exchange

#### *Electronic Health Records (EHR) and Health Information Exchange (HIE) are Essential.*

All respondents agreed that both EHR and HIE are key components in integrating healthcare. There was some disagreement, however, on the urgency of implementation. Additionally, some infrastructure is currently being developed for both EHR and HIE through a federated system using Cal-E Connect, Health-E LA and LANES powered by WHIN. Whether this evolving model is the best fit for South Los Angeles is still unanswered. Specifically, the lack of meaningful use of health information technology suggests the need for the creation of such a system to integrate care<sup>9</sup>.

*“ We are trying to keep an eye on health IT. Clinics are finally doing something for themselves. We would be missing the boat if we do not think about implementing a structure for all the parties. This is difficult because many are at different organizational development. The interface between the public and private are important to county and we need to track a patient through the system and overutilization as well as under utilization.”*

*“Optimistic, HIT is critical, it allows one to decompress the emergency rooms, access care appropriately and measure quality”*

*“Need to manage care of both individuals and populations. We need this so directors can manage populations and develop primary care registries, lists of patients, who has diabetes, etc. This has to be done!”*

*“It is necessary to understand what is needed and what our overall goal is before you can address the IT question.”*

*“ Should be careful how much money is being put into health IT. The issue is that everything is shared by everyone. You can build a bridge to anything if you want to pay for it. But you should really focus on making sure everyone is receiving health care services.”*

All stakeholders are at different stages of adoption, with hospitals more likely to have implemented an electronic health record system with any type of meaningful use. Within clinics and physician groups adoption is not as mature. LANES powered by WHIN does have a presence and support of stakeholders in South Los Angeles, however their approach has limitations. Specifically, LANES powered by WHIN will not provide physicians with contextualized patient data within a timely manner. This is not insurmountable as additional HIE technology could be layered over the WHIN infrastructure to provide the query capabilities. WHIN would continue to provide the backbone. This would allow for the current momentum to continue.

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<sup>9</sup> National Health Foundation Integration of Health Care Delivery Systems in South LA- Background Analysis, 2011, Report was provided with assistance of Price Waterhouse Coopers

There are still additional issues that need to be understood prior to moving forward with implementing or recommending any system such as data security, governance (where is data housed), insufficient funding and overall interoperability.

#### 4. Health Care Reform Presents Opportunity

*Health Care Reform and the waiver present an opportunity for South Los Angeles.*

The California Section 1115 Medicaid Waiver and Affordable Care Act present a unique and timely opportunity to address questions of quality, integration and cost. Most respondents agreed that the waiver will prepare South Los Angeles for the implementation of healthcare reform in regards to the safety net population and in particular the county. Background analysis supported interview results.

In Los Angeles County, it is estimated that in 2014, over 900,000 out of the 2 million uninsured are expected to be eligible for Medicaid (currently eligible and not enrolled or Medicaid expansion to childless adults up to 133% poverty level). Another 23% may be eligible for subsidies to purchase insurance however approximately 20% of the uninsured will not be eligible for any of the new coverage due to citizenship status. In South Los Angeles specifically, it is estimated that coverage could be facilitated for approximately 150,000 to 279,000 through Medi-Cal expansion or through the exchange<sup>10</sup>.

*“You need a big dog to get people to the table. TCE could make this happen and should run it. TCE has established themselves as caring for the community. I think they have the structure to make it work. The challenge is to get everyone to work together and TCE could be the force and teeth behind that happening.”*

*“Health Care Reform is a lot like Disneyland. There is great promise until you wait all day for one ride.”*

#### 5. Lack of Leadership

*The California Endowment has a crucial role.*

Many respondents expressed the need for a non-stakeholder leader to incentivize and lead a process to integrate systems in South Los Angeles. TCE was suggested as the best candidate based on past work with South Los Angeles and collaboration with Watts Health Foundation. TCE’s role could focus on funding or governance, but a more effective use could be to exercise their influence and good will to bring divergent parties together in order to create an integrated healthcare delivery strategy for South Los Angeles.

In addition to federal funding and state funding opportunities to support greater coverage, private foundations are another viable option. However, in order for these philanthropic organizations to increase their impact in South Los Angeles, the development of a joint funding effort should be

<sup>10</sup> National Health Foundation Integration of Health Care Delivery Systems in South LA- Background Analysis, 2011, Report was provided with assistance of Price Waterhouse Coopers

explored. This coordinated effort would allow these foundations to share common goals and to maximize their resources, rather than continuing to fund in silos.

## UNANSWERED QUESTIONS

While respondents had set ideas on their own operations and general ideas on how to best integrate healthcare delivery and improve quality in South Los Angeles, there were themes that were conspicuously absent and warrant further discussion.

- The integrated systems are either stand alone (Kaiser, ACN and Healthcare Partners) or are involved in the creation of a new closed partnership through an ACO (South Los Angeles ACO). While these systems will represent a large proportion of the South Los Angeles population, it is not all inclusive. Private physicians and groups are not all represented by these systems. Should this be addressed to have a wholly operational integrated system in South Los Angeles?
- There are many players conspicuous in their absence including health plans, pharmacies, SNIFs, school based clinics and other community services that are essential for an integrated and effective healthcare landscape. Should efforts made to include these players into the healthcare landscape?
- While a lot of attention is being paid to integrating healthcare services, there is little talk of integrating community services as part of a larger system including nursing homes, home health services, dentists and pharmacies. Should community services be integrated into healthcare delivery services and what impact will it have on community health if they are not?
- A scorecard approach to measuring quality is supported by the majority of respondents and a preliminary draft of a scorecard has been developed. How easy will it be to get data and will all stakeholders sign on? Is additional work on incentivizing participation necessary?
- Having a standardized health information exchange and compatible electronic health record systems via the exchange is recommended by the majority of respondents. However, respondents are focused on their own systems and getting EHR to work before thinking of the exchange. Additionally they are unaware of what others are doing and how to make things compatible. How much additional communication and work will be necessary to align health information systems to make the exchange and data use meaningful in South Los Angeles?

## CONCLUSION

Prior to this effort, funding by TCE in South Los Angeles has either been targeted at the Building Healthy Communities Initiative (placed based initiative with the goal of creating a place where children are healthy, safe and ready to learn) or on individual projects that provide great benefit, but lack cohesion or strategy. NHF recommends creating a strategic vision to help integrate healthcare delivery in South Los Angeles with the goal of improving overall community health.

Based on findings from this report and a better understanding of key thought leaders approaches towards developing a process for creating a strategic vision capable of enhancing coordination

across initiatives, we visualize different ways to move forward to operationalize the creation of an IDN in South Los Angeles.

We recognize that TCE has already invested in the emerging South Los Angeles Safety Net ACO specifically in funding the planning stages. In light of lagging Safety Net ACO regulations, TCE could continue to invest in this model as it's striving to represent the entirety of the safety net in South Los Angeles. Specifically, it would be wise to focus specifically on Quality and Health Information Technology as they have the potential to be the most influential in the success of both the individual ACO and larger IDN and could be the most difficult to independently finance.

Additionally as part of strengthening the South LA ACO, TCE could also help finance MLK's participation in the ACO after an operator has been identified. Because of its turbulent past MLK is in need of additional funding and support. Most importantly MLK hospital is at the center of the South Los Angeles Community and could serve as a hub for integrated services within an ACO.

While investment in an emerging integrated system of care in South Los Angeles is needed, a greater investment in integrating all systems of care present in South Los Angeles is a more sound strategy to increase cooperation, health care quality and drive cost down in the region. As this report suggests, integrated systems of care are already in place or developing in South Los Angeles. However, respondents were most in support of creating opportunity and incentive for integrating efforts so that any patient seeking care in South Los Angeles is tracked across systems. Based on findings to date, this would entail making greater targeted investment into a region wide Quality Scorecard, Health Information Technology System and cross cutting demonstration projects.

Recommendations for a quality scorecard are already developed however incentives to participate in collecting data for that scorecard is lacking. There have also been suggestions on what health information exchange systems would be best for South Los Angeles, but little incentive to come together and commit to a common system. Additionally, demonstration projects within singular systems are forming to take advantage of health care reform however participation among different systems is not being explored. TCE could serve as the catalyst for cohesion around both quality, meaningful use of health information technology and demonstration projects.

Finally, based on results leadership is lacking in the formation of an IDN. While TCE has been identified as a potential and needed leader in incentivizing the integration of healthcare services in South Los Angeles, they should not work alone. TCE could convene additional funders such as California Community Foundation through their Centinela Fund to create greater impact by coordinating a giving collaborative in support of the aforementioned recommendations for next steps. This cooperation between funders could prove powerful in driving measurable change in South Los Angeles.

Resolution of how TCE would like to move forward will help determine the taskforces' participants, structures and goals in order to create more specific recommendations for progress

in the creation of an IDN for South Los Angeles. Additionally, a key objective of the taskforces is to address unanswered questions previously identified in this report.

# Appendices

## Appendix A. Key Stakeholder Interviewees

Organization	Name	Title
California Hospital Medical Center	Jerry Clute	President & CEO
County of Los Angeles	William Fujioka	CEO
Eisner	Carl Coan, MS MPH	President & CEO
Keck School of Medicine	Carmen A. Puliafito, M.D	Dean
LA Care	Elaine Batchlor, M.D.	Chief Medical Officer
LA Care	Howard Kahn	President, CEO
LACDHS	Mitch Katz, MD	Chief
LACDPH	Jon Fielding, MD	Chief
Metro Care, Harbor UCLA	Miguel Ortiz-Marroquin	CEO
MLK-MACC	Cynthia Moore-Oliver	CEO
Southside Coalition of Community Health Centers	Nina Vacarro	Executive Director
St. Francis Medical Center	Gerald Kozi	President & CEO
St. John's	Jim Mangia	President/CEO
THE Clinic	Risë K. Phillips MPH, MBA	CEO
UMMA	Yasser Aman	President/CEO
Watts	William B Hobson	President/CEO
COPE	Alen Miller	CEO
Healthcare Partners	Bob Margolis, MD	Managing Partner
Healthcare Partners	Chris Wing	EVP, COO
Kaiser So Los Angeles Clinic	Diana Bontá, RN, DrPH,	VP, Public Affairs Southern California
Kaiser	Benjamin Chu, MD MPH	President, Southern California
UniHealth Foundation	Mary O'Dell	Executive Director
California Community Foundation	Alvertha Penny	Sr VP Programs
DHHS	Herb Schultz	Regional Director, Region IX
LACDHS	Kimberly McKenzie	Director, QI/Patient Safety
Community Health Councils	Lark Gilloway-Gallium	Executive Director
Los Angeles Country	Yolanda Vera	Health Deputy
Building Healthy Communities, TCE	Charles Fields	Program Officer
Community Health Councils	Robert Tranquada, MD	Former Dean, USC School of Medicine
CAP-G	Don Crane	President
HASC	Jim Lott	EVP
SEIU	Kathy Ochoa	SEIU Local 721
Cedars-Sinai Medical Center	Tom Priselac, MPH	President & CEO
Los Angeles Chamber of Commerce	Gary Tobben	President & CEO
USC Center for Community Health Studies	Michael Cousineau	Director
Healthcare Management Associates	Terry Conway	Managing Principal

## **Appendix B. Interview Protocol**

### **Interview Questions- South LA Integrated Delivery System**

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- The California Endowment has retained the National Health Foundation (NHF) to serve as the lead organization to assist in the development and implementation of a planning effort designed to create a vision with measurable goals, objectives and implementation strategy for an integrated delivery system (IDS) for South Los Angeles commensurate with re-opening of Martin Luther King Jr. Medical Center.

As part of this process we have identified you as a key stakeholder and invaluable participant in this process. Your participation is essential to help define what will be the most effective means of integrating healthcare delivery in South Los Angeles.

While a script will be followed for this interview, please note that it is likely we will veer from the format and any additional input you have to offer is appreciated. The interview should take approximately an hour and any information collected during the interview process will be strictly confidential and no individual results will be reported.

#### **GENERAL QUESTIONS:**

- The first set of questions refers to general concepts not specific to South Los Angeles.
1. How do you define an Accountable Care Organization?
  
  
  
  
  
  
  
  
  
  
  2. How is an ACO different from an Integrated Delivery Network?
  
  
  
  
  
  
  
  
  
  
  3. Can you have one without the other?



6. IF QUALITY OF CARE AND HEALTH STATUS ***IS*** MENTIONED.....You mentioned the role of quality of care and health status in your ideal IDN or ACO for South Los Angeles.....(go to a)

- a. Who do you see as key persons or organizations to best address quality of care and health status in the creation of an IDN or ACO for South Los Angeles?

IF QUALITY CARE AND HEALTH STATUS IS ***NOT*** MENTIONED.....What role, if any, do you feel quality of care and health status will play in the creation of an IDN or ACO in South Los Angeles? If a role is identified (go to a).

7. IF HEALTH INFORMATION TECHNOLOGY ***IS*** MENTIONED.....You mentioned the role of health information technology in your ideal IDN or ACO for South Los Angeles....(go to a)

- a. Who do you see as a key persons or organizations to best address health information technology in the creation of an IDN or ACO for South Los Angeles?

IF HEALTH INFORMATION TECHNOLOGY IS ***NOT*** MENTIONED....What role, if any, do you feel health information technology will play in the creation of an IDN or ACO in South Los Angeles? (If a role is identified go to a)

8. IF FINANCING MECHANISMS **ARE** MENTIONED.....You mentioned the role of financing mechanisms in your ideal IDN or ACO for South Los Angeles.....(go to a)
  - a. Who do you see as key persons or organizations to best address financing mechanisms in the creation of the IDN or ACO for South Los Angeles?

IF FINANCING MECHANISMS ARE **NOT** MENTIONED....What role, if any, do you feel financing mechanisms play in the creation of an IDN or ACO in South Los Angeles? If a role is identified (go to a).

9. Identify current funding streams that you are aware of that would support the creation of an IDN or ACO in South Los Angeles. What potential future funding do you think may be on the horizon?
  - a. IF HEALTH CARE REFORM IS NOT MENTIONED..... How can Health Care Reform foster or hinder the creation of funding streams for an IDN or ACO in South Los Angeles?
  - b. IF MEDICAID WAIVER IS NOT MENTIONED..... How do you think the Medicaid Waiver will foster the creation of funding streams for an IDN or ACO in South Los Angeles?

10. What specific indicators would you use to determine the success of an IDN or ACO in South Los Angeles?

11. (If not mentioned previously) What do you see as the role of medical homes in the creation of an IDN or ACO in South Los Angeles?

12. Some say that physician alignment with hospitals is critical for a successful ACO/IDN. What is your view? What will it take to bring about this alignment?

13. What role are you or your organization playing in the development of an ACO/IDN for South Los Angeles?



15. What do you think it will take to get the above mentioned persons or organizations to cooperate in trying to develop a coordinated Integrated Delivery System for South Los Angeles?

16. Do you think it is possible to coordinate care given the different ACOs/IDNs being created? If yes, how? If no, why?

**FINAL QUESTIONS:**

17. Is there anything else about the development of a coordinated Integrated Delivery System in South Los Angeles that you would like to comment on that we have not covered?

18. Would you be willing to serve on a working group to develop a coordinated Integrated Delivery System for South Los Angeles?

19. Is there anyone you can think of that we should speak to regarding the creation of the Integrated Delivery System?

Thank you very much for your participation and we look forward to working with you in the future. If you have an additional comments or questions, please feel free to email or call me at (insert your info here).

## Appendix C. Summary of Project



### **Integration of Healthcare Delivery Systems in South Los Angeles**

#### ***Background***

The passage of health care reform has set into motion a number of efforts to create different models and approaches for providing comprehensive, coordinated, and cost effective care. Accountable Care Organizations (ACO's) appear to be the most popular model being pursued. While the new health care law sets forth some broad goals for what an ACO should accomplish, specific regulations on how ACO's are to work in practice have yet to be developed.

In South Los Angeles a number of different entities are working to develop their individual versions of an ACO. Clearly, successful development of one or more ACO's could be beneficial to residents of the area. But even greater benefit could be derived if a process could be developed and implemented whereby residents could be assured that no matter which ACO serves them, their medical histories and records would always be available to the appropriate care provider. Historically, fragmentation and shifting provider systems have resulted in duplication of services, tests, procedures and visits when patients are faced with yet another new source of care. Opportunities for efficiencies are evident. Similarly, having an agreed upon set of quality metrics adopted by each individual ACO could demonstrate how their collective efforts have improved the health status of South central residents. Equally exciting is the prospect that some major demonstration project(s) resulting from collaboration among ACO's could be developed and potentially serve as models for other major metropolitan areas across the nation.

#### ***Overview of project***

The California Endowment has retained the National Health Foundation (NHF) to serve as the lead organization to assist in the development and implementation of a planning effort designed to create a vision with measurable goals, objectives and implementation strategy for an integrated delivery system (IDS) for South Los Angeles.

NHF has identified three key areas which could facilitate "integrating" the individual efforts being undertaken. These include measuring quality, assuring electronic connectivity, and identifying innovative demonstration projects. As a result of a commitment from the Watts Health Foundation and the California Endowment, approximately \$20 million dollars is available

to assist key stakeholders in accomplishing the goal of developing an integrated delivery system for South Los Angeles.

### ***Timeline***

Over the next 18 months a series of tasks will be initiated. These include: 1) a survey completed via in-person interviews of 20-30 key stakeholders to better understand the goals and objectives of the various ACO's currently in development and how an integrated delivery network can best be implemented 2) a convening of the key players involved in developing ACO's in South Los Angeles to create the opportunity to learn what the others are attempting to accomplish 3) a series of quarterly task force meetings designed to identify how best to develop and implement ways to assure inter-operability (e.g. electronic connectivity), measure quality, identify what financial assistance could be made available and identify a significant innovative demonstration project(s) that could be implemented. A web-based system which will allow stakeholders in South Los Angeles to pose questions, and receive systematic feedback from the task force work groups has been developed. Prior to each work group, stakeholders will have the opportunity to pose questions and/or identify issues they would like the task forces to address. Results of each task force meeting will be posted on a project web site. Any interested party will have access to the proceedings of each task force meeting.

### ***How is this different than other projects?***

NHF's task is not to create an ACO or structured delivery system of healthcare but rather to design a process with those who are doing so to facilitate "integration" of key components across the various developing ACO's to support coordinated comprehensive system of care for all of the residents of South Los Angeles.

### ***Why National Health Foundation?***

National Health Foundation is an independent 501(c)3 non-profit organization striving to increase access to healthcare. NHF is not a business stakeholder in South Los Angeles and has no loyalties to the success of specific projects, only to the improvement of health for the South Los Angeles Community.

**Appendix D. TCE Letter of Support for South Los Angeles IDN**



Dear \_\_\_\_\_:

The California Endowment has retained the National Health Foundation (NHF) to serve as the lead organization to assist in the information gathering and analysis of how South Los Angeles can take advantage of the federal Affordable Care Act to advance improved health and development of integrated health delivery in the community. One of the first tasks NHF will undertake is to interview stakeholders with a vested interest in seeing that a successful coordinated health care delivery system designed to serve the residents of South Los Angeles is created. You have been identified as one of the key individuals whose thoughts and suggestions will be invaluable to the planning effort. After the receipt of this letter you will be contacted by a staff member of NHF to schedule an interview. Information collected during the interview process will be strictly confidential and no individual results will be reported.

Our primary objective is to assure that while multiple regional efforts may unfold between now and 2014, The California Endowment and key stakeholders keep our eyes on the prize for South Los Angeles: improved access, improved health outcomes, and a high quality health system for the community. In addition, please be aware that we will keep Supervisor Mark Ridley-Thomas and County officials apprised of our work and findings on this front.

If you have any questions about this project, please feel free to contact me or Dr. Beatriz Solis at The California Endowment (213) 928-8736. We want to personally thank you in advance for helping us with this most important endeavor.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert K. Ross".

ROBERT K. ROSS, M.D.  
President and CEO

cc: Supervisor Mark Ridley-Thomas

## Appendix E. Glossary of Terms

### Glossary of Health Care Terms

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#### [A](#) [B](#) [C](#) [D](#) [E](#) [F](#) [G](#) [H](#) [I](#) [J](#) [K](#) [L](#) [M](#) [N](#) [O](#) [P](#) [Q](#) [R](#) [S](#) [T](#) [U](#) [V](#) [W](#) [X](#) [Y](#) [Z](#)

**Accountable Care Organization (ACO):** A network of health care providers that band together to provide the full continuum of health care services for patients. The ACO would receive a payment for all care provided to a patient, and would be held responsible for the quality and cost of care. Proposed pilot programs in Medicare and Medicaid would provide financial incentives for these organizations to improve quality and reduce costs by allowing them to share in any savings achieved as a result of these efforts.

**Age-rating:** A method for setting premium rates for health insurance plans under which policy holders premiums are determined based on their age.

**American Recovery and Reinvestment Act (ARRA):** A federal law enacted in February 2009 as a direct response to the economic crisis intended to create new jobs and save existing ones; spur economic activity and invest in long-term growth; and foster unprecedented levels of accountability and transparency in government spending.

**Archer Medical Savings Account (Archer MSA):** A tax-exempt trust or custodial account set up with a U.S. financial institution (such as a bank or an insurance company) in which money is saved exclusively for future medical expenses.

**Benefit Package:** The set of services, such as physician visits, hospitalizations, prescription drugs, that are covered by an insurance policy or health plan. The benefit package will specify any cost-sharing requirements for services, limits on particular services, and annual or lifetime spending limits.

**Bundled Payment:** A payment structure in which different health care providers who are treating a patient for the same or related conditions are paid an overall sum for taking care of that condition rather than being paid for each individual treatment, test, or procedure. In doing so, providers are rewarded for coordinating care, preventing complications and errors, and reducing unnecessary or duplicative tests and treatments.

**California Confidentiality of Medical Information Act (CMIA):** A State law that protects patient privacy by prohibiting health care providers from disclosing medical information without obtaining appropriate authorization.

**Capitation:** A method of paying for health care services under which providers receive a set payment for each person or “covered life” instead of receiving payment based on the number of services provided or the costs of the services rendered. These payments can be adjusted based on the demographic characteristics, such as age and gender, or the expected costs of the members.

**Care Coordination: The organization of treatment across several health care providers. Medical homes and Accountable Care Organizations are two common ways to coordinate care.**

**Case Management:** The process of coordinating medical care provided to patients with specific diagnoses or those with high health care needs. These functions are performed by case managers who can be physicians, nurses, or social workers.

**Catastrophic Coverage:** a health plan intended to provide coverage in the event of a catastrophic health event. These plans have lower premiums but higher cost-sharing and deductibles.

**Children’s Health Insurance Program (CHIP):** Enacted in 1997, CHIP is a federal-state program that provides health care coverage for uninsured low-income children who are not eligible for Medicaid. States have the option of administering CHIP through their Medicaid programs or through a separate program (or a combination of both). The federal government matches state spending for CHIP but federal CHIP funds are capped.

**Chronic Care Management:** The coordination of both health care and supportive services to improve the health status of patients with chronic conditions, such as diabetes and asthma. These programs focus on evidence-based interventions and rely on patient education to improve patients’ self-management skills. The goals of these programs are to improve the quality of health care provided to these patients and to reduce costs.

**COBRA:** When employees lose their jobs, they are able to continue their employer-sponsored coverage for up to 18 months through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under the original legislation, individuals were required to pay the full premium to continue their insurance through COBRA. The American Recovery and Reinvestment Act (ARRA) provides a temporary subsidy of 65% of the premium cost for the purchase of COBRA coverage to people who have lost their job between September 1, 2008 and December 31, 2009.

**Coinsurance:** A method of cost-sharing in health insurance plans in which the plan member is required to pay a defined percentage of their medical costs after the deductible has been met.

**Community Rating:** A method for setting premium rates for health insurance plans under which all policy holders are charged the same premium for the same coverage. “Modified community rating “ generally refers to a rating method under which health insuring organizations are permitted to vary premiums based on specified demographic characteristics (e.g. age, gender, location), but cannot vary premiums based on the health status or claims history of policy holders.

**Comparative Effectiveness Research:** A field of research that analyzes the impact of different options for treating a given condition in a particular group of patients. These analyses may focus only on the medical risks and benefits of each treatment or may also consider the costs and benefits of particular treatment options.

**Consumer-Directed Health Plans:** Consumer-directed health plans seek to increase consumer awareness about health care costs and provide incentives for consumers to consider costs when making health care decisions. These health plans usually have a high deductible accompanied by a consumer-controlled savings account for health care services. There are two types of savings accounts: Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs).

**Co-payment:** A fixed dollar amount paid by an individual at the time of receiving a covered health care service from a participating provider. The required fee varies by the service provided and by the health plan.

**Cost Containment:** A set of strategies aimed at controlling the level or rate of growth of health care costs. These measures encompass a myriad of activities that focus on reducing

overutilization of health services, addressing provider reimbursement issues, eliminating waste, and increasing efficiency in the health care system.

**Cost-Sharing:** A feature of health plans where beneficiaries are required to pay a portion of the costs of their care. Examples of costs include co-payments, coinsurance and annual deductibles.

**Cost Shifting:** Increasing revenues from some payers to offset losses or lower reimbursement from other payers, such as government payers and the uninsured.

**Consumer Operated and Oriented Plan (CO-OP) Program:** A federal program to assist in the establishment and operation of nonprofit, member-run health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans.

**Credible Coverage:** Health insurance coverage under any of the following: a group health plan; individual health insurance; student health insurance; Medicare; Medicaid; CHAMPUS and TRICARE; the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country); Children's Health Insurance Program (CHIP) or a state health insurance high risk pool. If an individual has prior creditable coverage, it will reduce the length of a pre-existing condition exclusion period under new job-based coverage.

**Deductible:** A feature of health plans in which consumers are responsible for health care costs up to a specified dollar amount. After the deductible has been paid, the health insurance plan begins to pay for health care services.

**Dependent Coverage:** Insurance coverage for family members of the policyholder, such as spouse, children, or partner.

**Disproportionate Share Hospital (DSH) Payments:** Payments made by a state's Medicaid program to hospitals that the state designates as serving a "disproportionate share" of low-income or uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing inpatient care to Medicaid beneficiaries. States have some discretion in determining how much eligible hospitals receive. The amount of federal matching funds that a state can use to make payments to DSH hospitals in any given year is capped at an amount specified in the federal Medicaid statute.

**Dual Eligibles:** A term used to describe an individual who is eligible for Medicare and for some level of Medicaid benefits. Most dual eligibles qualify for full Medicaid benefits including nursing home services, and Medicaid pays their Medicare premiums and cost sharing. For other duals Medicaid provides the "Medicare Savings Programs" through which enrollees receive assistance with Medicare premiums, deductibles, and other cost sharing requirements. These beneficiaries are often referred to as "Medi-Medis."

**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services:** One of the services that states are required to include in their basic benefits package for all Medicaid-eligible children under age 21. EPSDT services include periodic screenings to identify physical and mental conditions, as well as vision, hearing, and dental problems. Services also include follow-up diagnostic and treatment services to correct conditions identified during a screening, without regard to whether the state Medicaid plan covers those services for adult beneficiaries.

**Electronic Health Record/Electronic Medical Records:** Computerized records of a patient's health information including medical, demographic, and administrative data. This record can be created and stored within one health care organization or it can be shared across health care organizations and delivery sites.

**Employer Mandate:** An approach that would require all employers, or at least all employers meeting size or revenue thresholds, to offer health benefits that meet a defined standard, and pay a set portion of the cost of those benefits on behalf of their employees.

**Essential Health Benefits Package:** A set of health care service categories that must be covered by certain plans, starting in 2014. These include doctor office visits, hospitalizations, and prescriptions. Insurance policies must cover these benefits to be certified and offered in Exchanges, and all Medicaid plans must cover these services by 2014.

**Experience Rating:** A method of setting premiums for health insurance policies based on the claims history of an individual or group.

**Federal Medical Assistance Percentage (FMAP):** The statutory term for the federal Medicaid matching rate—i.e., the share of the costs of Medicaid services or administration that the federal government bears. In the case of covered services, FMAP varies from 50 to 76 percent depending upon a state's per capita income; on average, across all states, the federal government pays 57 percent of the costs of Medicaid. The American Recovery and Reinvestment Act (ARRA) provides a temporary increase in the FMAP through December 31, 2010.

**Federally Qualified Health Center (FQHC):** Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of patient's ability to pay. Services are provided on a sliding scale fee based on patient's ability to pay.

**Federally Qualified Health Center (FQHC) Look-Alike:** Nonprofit health centers or clinics that serve medically underserved areas and populations. Like FQHCs, FQHC Look-Alikes provide primary care services regardless of patient's ability to pay; and services are provided on a sliding scale fee based on patient's ability to pay. While FQHC Look-Alikes must meet the same program requirements as FQHCs and receive many of the same benefits, Look-Alikes do not receive section 330 federal funding.

**Fee-for-Service (FFS):** A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient, who then submits them to the insurance company, or are submitted by the provider to the patient's insurance carrier for reimbursement.

**Free Choice Voucher:** An amount equivalent to what the employer would have contributed to the firm's plan on behalf of such an employee, but which would allow the employee to apply that amount toward the purchase of coverage through a nongroup insurance exchange. Employers in all size groups will be required to provide free choice vouchers if they offer coverage to their employees outside of the exchanges in which the lowest cost policy option would require an employee contribution of 8-9.8% of an employee's income.

**Group Health Insurance:** Health insurance that is offered to a group of people, such as employees of a company. The majority of Americans have group health insurance through their employer or their spouse's employer.

**Guarantee Issue/Renewal:** Requires insurers to offer and renew coverage, without regard to health status, use of services, or pre-existing conditions. This requirement ensures that no one will be denied coverage for any reason.

**Health Care Cooperative (CO-OP):** A non-profit, member-run health insurance organization, governed by a board of directors elected by its members. Co-ops provide insurance coverage to individuals and small businesses and can operate at state, regional, and national levels.

**Health Flexible Spending Account (Health FSA):** An arrangement that allows employees to be reimbursed for medical expenses. FSAs are usually funded through voluntary salary reduction agreements with your employer. No employment or federal income taxes are deducted from the employee contribution, and the employer may also contribute.

**Health Information Technology (HIT):** Systems and technologies that enable health care organizations and providers to gather, store, and share information electronically.

**Health Information Technology for Economic and Clinical Health Act (HITECH):** A federal law, enacted as part of the American Recovery and Reinvestment Act, that seeks to encourage the adoption of electronic health records and other health information technology

**Health Insurance Exchange/Connector:** A purchasing arrangement through which insurers offer and smaller employers and individuals purchase health insurance. State, regional, or national exchanges could be established to set standards for what benefits would be covered, how much insurers could charge, and the rules insurers must follow in order to participate in the insurance market. Individuals and small employers would select their coverage within this organized arrangement. An example of this arrangement is the Commonwealth Connector, created in Massachusetts in 2006.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA):** Through The Health Insurance Portability and Accountability Act of 1996, individuals in many states who lose group health coverage after a loss of employment have access to coverage through high-risk pools, with no pre-existing condition exclusion periods. HIPAA also sets standards that address the security and privacy of personal health data.

**Health Maintenance Organization (HMO):** A type of health insurance plan that usually limits care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require that an individual live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

**Health Reimbursement Account (HRA):** A tax-exempt account that can be used to pay for current or future qualified health expenses. HRAs are established benefit plans funded solely by employer contributions, with no limits on the amount an employer can contribute. HRAs are often paired with a high-deductible health plan, but are not required to do so.

**Health Savings Account (HSA):** A tax-exempt savings account that can be used to pay for current or future qualified medical expenses. Employers may make HSAs available to their employees or individuals can obtain HSAs from most financial institutions. In order to open an HSA, an individual must have health coverage under an HSA-qualified high-deductible health plan. These HSA-qualified high-deductible health plans must have deductibles of at least \$1,150 for an individual and \$2,300 for a family in 2009.

**High-Deductible Health Plan:** Health insurance plans that have higher deductibles (the amount of health care costs that must be paid for by the consumer before the insurance plan begins to pay for services), but lower premiums than traditional plans. Qualified high-deductible plans that may be combined with a health savings account must have a deductible of at least \$1,150 for single coverage and \$2,300 for family coverage in 2009.

**High-Risk Pool:** State programs designed to provide health insurance to residents who are considered medically uninsurable and are unable to buy coverage in the individual market. As of early 2009, high-risk pools operate in 34 states but vary by who is eligible, cost sharing requirements, availability of premium subsidies, and funding sources.

**Individual Insurance Market:** The market where individuals who do not have group (usually employer-based) coverage purchase private health insurance. This market is also referred to as the non-group market.

**Individual Mandate:** A requirement that all individuals obtain health insurance. A mandate could apply to the entire population, just to children, and/or could exempt specified individuals. Massachusetts was the first state to impose an individual mandate that all adults have health insurance.

**Lifetime Benefit Maximum:** A cap on the amount of money insurers will pay toward the cost of health care services over the lifetime of the insurance policy.

**Lifetime Limit:** A cap on the total lifetime benefits an insured person may get from his/her insurance company. An insurance company may impose a total lifetime dollar limit on benefits (like a \$1 million lifetime cap) or limits on specific benefits (like a \$200,000 lifetime cap on organ transplants or one gastric bypass per lifetime) or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services.

**Long-Term Care:** Services that include those needed by people to live independently in the community, such as home health and personal care, as well as services provided in institutional settings such as nursing homes. Medicaid is the primary payer for long-term care. Many of these services are not covered by Medicare or private insurance.

**Managed Care:** A health delivery system that seeks to control access to and utilization of health care services both to limit health care costs and to improve the quality of the care provided. Managed care arrangements typically rely on primary care physicians to act as “gatekeepers” and manage the care their patients receive.

**Mandatory Benefits:** Certain benefits or services, such as mental health services, substance abuse treatment, and breast reconstruction following a mastectomy, that state-licensed health insuring organizations are required to cover in their health insurance plans. The number and type of these mandatory benefits vary across states.

**Medicaid:** Enacted in 1965 under Title XIX of the Social Security Act, Medicaid is a federal entitlement program that provides health and long-term care coverage to certain categories of low-income Americans. States design their own Medicaid programs within broad federal guidelines. Medicaid plays a key role in the U.S. health care system, filling large gaps in the health insurance system, financing long-term care coverage, and helping to sustain the safety-net providers that serve the uninsured. Medi-Cal is California’s Medicaid program, administered by the Department of Health Care Services (DHCS).

**Medicaid Waivers:** Authority granted by the Secretary of Health and Human Services to allow a state to continue receiving federal Medicaid matching funds even though it is no longer in compliance with certain requirements of the Medicaid statute. States can use waivers to implement home and community-based services programs, managed care, and to expand coverage to populations, such as adults without dependent children, who are not otherwise eligible for Medicaid.

**Medical Home:** A health care setting where patients receive comprehensive primary care services; have an ongoing relationship with a primary care provider who directs and coordinates their care; have enhanced access to nonemergent primary, secondary, and tertiary care; and have access to linguistically and culturally appropriate care.

**Medical Loss Ratio (MLR):** The percentage of premium dollars an insurance company spends on medical care, as opposed to administrative costs or profits.

**Medical Underwriting:** The process of determining whether or not to accept an applicant for health care coverage based on their medical history. This process determines what the terms of coverage will be, including the premium cost, and any pre-existing condition exclusions.

**Medicare:** Enacted in 1965 under Title XVII of the Social Security Act, Medicare is a federal entitlement program that provides health insurance coverage to 45 million people, including people age 65 and older, and younger people with permanent disabilities, end-stage renal disease, and Lou Gehrig's disease.

**Medicare Advantage (Medicare Part C):** A type of Medicare health plan offered by a private company that contracts with Medicare to provide all Medicare Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. When enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

**Medicare Part A (hospital insurance):** Part A helps cover inpatient care in hospitals, inpatient care in a skilled nursing facility, hospice care services, home health care services, and inpatient care in a religious nonmedical health care institution. People with Medicare usually don't pay a monthly premium for Part A coverage if they or their spouse paid Medicare taxes while working ("premium-free Part A"). Individuals not eligible for premium-free Part A may be able to buy Part A. In most cases, people who choose to buy Part A must also have Part B and pay monthly premiums for both.

**Medicare Part B (medical insurance):** Part B helps cover medically-necessary services like doctors' services, outpatient care, home health services, and other medical services. Part B also covers some preventive services. Most people pay the standard premium amount; however some people pay more if their adjusted gross income is above a certain amount.

**Medicare Part D:** A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.

**Out-of-Pocket Costs:** Health care costs, such as deductibles, co-payments, and co-insurance that are not covered by insurance. Out-of-pocket costs do not include premium costs.

**Out-of-Pocket Maximum:** A yearly cap on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding the premium cost.

**Patient Protection and Affordable Care Act (PPACA):** Legislation signed into law by President Obama on March 23, 2010, putting in place comprehensive health insurance reforms. Commonly referred to as the Affordable Care Act (ACA) the law includes provisions to expand coverage, control health care costs, and improve health care delivery systems.

**Pay for Performance:** A health care payment system in which providers receive incentives for meeting or exceeding quality, and sometimes cost benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay for performance programs is to improve the quality of care over time.

**Payment Bundling:** A mechanism of provider payment where providers or hospitals receive a single payment for all of the care provided for an episode of illness, rather than per service. Total care provided for an episode of illness may include both acute and post-acute care.

**Portability of Coverage:** Rules allowing people to obtain coverage as they move from job to job or in and out of employment. Individuals changing jobs are guaranteed coverage with the new employer without a waiting period. In addition, insurers must waive any pre-existing condition exclusions for individuals who were previously covered within a specified time period. Portable coverage can also be health coverage that is not connected to an employer, allowing individuals to keep their coverage when they have a change in employment.

**Pre-existing Condition Exclusions:** An illness or medical condition for which a person received a diagnosis or treatment within a specified period of time prior to becoming insured. Health care providers can exclude benefits for a defined period of time for the treatment of medical conditions that they determine to have existed within a specific period prior to the beginning of coverage.

**Preferred Provider Organization (PPO):** A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Cost-sharing is lower when using providers that belong to the plan's network. Doctors, hospitals, and providers outside of the network can be used for an additional cost.

**Premium:** The amount paid, often on a monthly basis, for health insurance. The cost of the premium may be shared between employers or government purchasers and individuals.

**Premium rate review:** A process that allows state insurance departments to review rate increases before insurance companies can apply them.

**Premium rating area:** An area used for determining premium rates, usually by zip code. The premium rate is based on the average health care costs and physician/hospital discounts in that area.

**Premium Subsidies:** A fixed amount of money or a designated percentage of the premium cost that is provided to help people purchase health coverage. Premium subsidies are usually provided on a sliding scale based on an individual's or family's income.

**Prevention:** Activities to reduce risk and avoid health problems such as routine check-ups, immunizations, patient counseling, education and screening.

**Preventive Care:** Health care that emphasizes the early detection and treatment of diseases. The focus on prevention is intended to keep people healthier for longer, thus reducing health care costs over the long term. Preventive services typically include screenings, check-ups, and patient counseling to prevent illness, disease, or other health problems.

**Primary Care:** Health services that cover a range of prevention, wellness, and treatment for common illnesses.

**Primary Care Provider:** A provider, usually a physician specializing in internal medicine, family practice, or pediatrics (but can also be a nurse practitioner, physician assistant or even a health care clinic), who is responsible for providing primary care and coordinating other necessary health care services for patients.

**Prospective Payment System (PPS):** A payment system whereby a provider's payment rate for a service before the service is delivered based on the average costs incurred in furnishing the services by all participating providers of that type. PPS is used for Medicare, Medicaid, and CHIP.

**Protected Health Information (PHI):** Any individually identifiable health information that is protected under the Health Insurance Portability and Accountability Act, which includes any information related to an individual's health condition, the provision of health care, or payments for health care.

**Provider Payment Rates:** The total payment a provider, hospital, or community health center receives when they provide medical services to a patient. Providers are compensated for patient care using a set of defined rates based on illness category and the type of service administered.

**Public Plan Option:** A proposal to create a new insurance plan administered and funded by federal or state government that would be offered along with private plans in a newly-created health insurance exchange.

**Public-Private Partnership Clinics (PPP):** An organized system comprised of private, community primary health care clinics in Los Angeles County and the Los Angeles County Department of Health Services to provide quality health services in a culturally and linguistically appropriate environment to low income and uninsured communities. Primary, specialty and dental care services are available to Los Angeles County residents of all ages whose net family income is at or below 133⅓% FPL. Started in 1997, the PPP program was originally funded through a Medicaid 1115 waiver and subsequently funded by the county at a lower overall funding level in 2005 when the waiver terminated.

**Purchasing Pool:** Health insurance providers pool the health care risks of a group of people in order to make the individual costs predictable and manageable. For health coverage arrangements to perform well, the risk pooling should balance low and high risk individuals such that expected costs for the pool are reasonably predictable for the insurer and relatively stable over time.

**Reinsurance:** Reinsurance is insurance for insurance companies and employers that self-insure their employees' medical costs. Through government-funded reinsurance programs, federal or state governments pay for a portion of the high costs experienced by insurers. By limiting

insurers' exposure to very high health costs, reinsurance programs enable insurers to lower the premiums they charge to employers and individuals. This type of program is a form of subsidy to the insurer that lowers the premium cost for all purchasers. The Healthy New York program and the Healthcare Group of Arizona are examples of state reinsurance programs.

**Rescission:** The retroactive cancellation of a health insurance policy. Insurance companies will sometimes retroactively cancel an entire policy if the policyholder made a mistake on his/her initial application when purchasing an individual market insurance policy. Under the Affordable Care Act, rescission is illegal except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

**Risk Adjustment:** The process of increasing or reducing payments to health plans to reflect higher or lower than expected spending. Risk adjusting is designed to compensate health plans that enroll an older and sicker population as a way to discourage plans from selecting only healthier enrollees.

**Safety Net:** Health care providers who deliver health care services to patients regardless of their ability to pay. These providers may consist of public hospital systems, community health centers, local health departments, and other providers who serve a disproportionate share of uninsured and low-income patients.

**Section 125 Plan:** A section 125 plan allows employees to receive specified benefits, including health benefits, on a pre-tax basis. Section 125 plans enable employees to pay for health insurance premiums on a pre-tax basis, whether the insurance is provided by the employer or purchased directly in the individual market.

**Self-Insured Plan:** A plan where the employer assumes direct financial responsibility for the costs of enrollees' medical claims. Employer sponsored self-insured plans typically contract with a third-party administrator or insurer to provide administrative services for the plan.

**Single-Payer System:** A health care system in which a single entity pays for health care services. This entity collects health care fees and pays for all health care costs, but is not involved in the delivery of health care.

**Small Business Health Options Program (SHOP) Exchange:** An exchange in which small businesses with generally fewer than 100 employees can shop for insurance, providing similar purchasing power as large businesses and offering more choices of high-quality coverage and lower prices.

**Small Group Market:** Firms with 2-50 employees can purchase health insurance for their employees through this market, which is regulated by states.

**Uncompensated Care:** Health care or services provided by hospitals or health care providers that don't get reimbursed. Often uncompensated care arises when people don't have insurance and cannot afford to pay the cost of care.

**Underinsured:** People who have health insurance but who face out-of-pocket health care costs or limits on benefits that may affect their ability to access or pay for health care services.

**Value-based purchasing:** Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

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