Case Study

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Establishing a Coalition to Pursue Accountable Care in the Safety Net: A Case Study of the FQHC Urban Health Network

Karen E. Schoenherr, Aricca D. Van Citters, Kathleen L. Carluzzo, Savannah Bergquist, Elliott S. Fisher, and Valerie A. Lewis

ABSTRACT: The Federally Qualified Health Center Urban Health Network is a coalition of 10 federally qualified health centers (FQHCs) in the Minneapolis–St. Paul area that pursued an accountable care organization (ACO) through a Medicaid demonstration project with Minnesota. Under the ACO model, the coalition has assumed responsibility for the total cost and quality of care delivered for an assigned patient population. This case study explores: the state context under which the ACO contract emerged; origins of the coalition; the members' motivations to participate; strategies and processes established to work toward cost and quality benchmarks; challenges faced in pursuing accountable care; and the organizational strengths that facilitated the health centers' shift from competition to collaboration. The keys to the coalition's success include a committed leadership team focused around a singular purpose; the partnership with its administrative services partner; and the diversity of programs, services, and experiences among the 10 FQHCs.

OVERVIEW

The Federally Qualified Health Center Urban Health Network (FUHN) is a coalition of 10 federally qualified health centers (FQHCs) in the Minneapolis–St. Paul area that came together to pursue an accountable care organization (ACO) contract with the state of Minnesota. Under an ACO contract, the FQHCs will collectively be held accountable for meeting established quality and cost benchmarks for a defined Medicaid patient population, and the coalition will be eligible to share in any savings they achieve during the three-year contract.[1] FUHN's delivery system consists of nearly 40 service sites across seven counties. The clinics provide care to approximately 150,000 patients, of which nearly 23,000 are Medicaid patients that will be served by the ACO.[2]

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For more information about this study, please contact:

Karen E. Schoenherr
Health Policy Fellow
The Dartmouth Institute for Health Policy & Clinical Practice
karen.e.schoenherr@dartmouth.edu

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FUHN is one of the nation's first safety-net ACOs. In forming an ACO, the FQHCs have transitioned (in the words of one FUHN board member) from "fierce competitors to fierce collaborators." The 10 FQHCs view accountable care as a mechanism to leverage resources and foster collaboration in the face of limited funding and a geographically dispersed and diverse network. By participating in accountable care at an early stage, FUHN hopes to demonstrate the capacity of an FQHC-based ACO to deliver high-quality, low-cost care for safety-net patients.

This case study was written as contract negotiations between FUHN and the state of Minnesota were nearing a close; the final contract was executed and the ACO's performance period began in January 2013 (Exhibit 1). The study explores the state context under which the ACO contract emerged; origins of the coalition; the health centers' motivations to participate; strategies and processes established to work toward cost and quality benchmarks; challenges faced in pursuing accountable care; and the organizational strengths that facilitated the FQHCs' shift from competition to collaboration.

The ACO model developed by FUHN may be of interest to organizations pursuing a coalition-based ACO and may provide insights to safety-net organizations considering accountable care. Based on FUHN's model, it appears each of the following may be important to the development of a coalition-based ACO, particularly in the safety net:

- aligning leadership through the identification of a shared vision;
- establishing a strong governance structure tasked with overseeing and driving progress;[3]
- developing a unified strategy for using data to measure progress and identify improvement opportunities; and
- prioritizing the development of care coordination infrastructure.

Exhibit 1. FQHC Urban Health Network (FUHN): Contract Features

Contract feature	
Length of contract	Three years, starting January 1, 2013.
Patients	
Attribution method	Performance year attribution.*
Attributed patients	Approximately 23,000 Medicaid beneficiaries. Covered patients include both fee-for-service and managed care beneficiaries, excluding dual eligibles.
Financial model	
Risk model	Upside shared savings only (no downside risk).
Shared savings rate	Savings achieved are shared equally between FUHN and the state.
Covered services in total cost of care	A range of services including inpatient, ambulatory, pharmacy, laboratory, and mental health services. Excluded services include dental, supplies, transportation, and most long-term supports and services.
Baseline spending calculation	Calculated using fee-for-service claims and managed care encounter data from the base year.
Risk adjustment	Adjusted Clinical Groups (ACG) risk scores weighted to reflect differences in the health risk between attributed and nonattributed populations.
Upfront payments	No upfront payments received from the state.
Quality performance	Year 1: 25% of shared savings contingent on reporting quality and patient experience measures. Year 2: 25% of shared savings tied to relative improvement on clinic-based measures and absolute performance on hospital-based and patient experience measures. Year 3: 50% of shared savings tied to relative improvement on clinic-based measures and absolute performance on hospital-based and patient experience measures.

* V. A. Lewis, A. B. McClurg, J. Smith et al., "Attributing Patients to Accountable Care Organizations: Performance Year Approach Aligns Stakeholders' Interests," *Health Affairs,* March 2013 32(3):587–95.

STATE CONTEXT

Health System Performance and Reforms

Minnesota has one of the most advanced state health care systems in the nation. According to The Commonwealth Fund's 2009 *State Scorecard,* Minnesota leads on many indicators of population health and is ranked third in the country in rates of insurance coverage.[4] The state passed health care reform legislation in 2008 designed to achieve the "triple aim" of improved patient care, improved population health, and reduced per capita costs of care.[5] The law included provisions to develop standard quality measures, establish a statewide health improvement program, increase consumer engagement, and promote the patient-centered medical home model.[6] Despite these factors, Minnesota experiences high levels of racial, ethnic, and socioeconomic health disparities, ranking only 17th nationally on measures of health equity.[7]

Safety-Net Efforts

Seventeen FQHCs in Minnesota serve as safety-net providers for 170,000 patients, 45 percent of whom are enrolled in public health insurance programs and 40 percent of whom are uninsured. The health centers provide care to disadvantaged patients from a range of cultural backgrounds. Ninety-four percent of health center patients have incomes below 200 percent of the federal poverty level, and many of the clinics make efforts to provide culturally competent care to specific populations (e.g., Somali, Native American, Latino, African American, or Hmong).[8] Patients seeking care from the health centers often have complex medical and social needs, including multiple chronic conditions, low health literacy, and hardships such as poverty and homelessness.

Despite sharing the goal of providing high-quality care to low-income and medically underserved populations, the state's FQHCs—particularly the 12 in the Minneapolis–St. Paul region—describe their historical relationship as competitive. The health centers have had to vie for grant funding, service areas, providers, and patients. The Minnesota Association of Community Health Centers has served as a hub for some collaboration, mainly in response to policy issues at the state and national levels. From this association, a subset of urban FQHCs and community clinics met regularly to coordinate efforts around emergency preparedness, billing support, and a limited number of local quality improvement initiatives.

Impact of Market Consolidation and Managed Care

Horizontal and vertical integration in Minnesota's insurance, hospital, and purchasing sectors has resulted in a highly consolidated marketplace, with high levels of managed care and several large, hospital-based systems.[9] The FQHCs have often felt dwarfed in a marketplace dominated by large systems with greater resources and managed care plans, and thus view the ACO demonstration as an opportunity to better represent their collective interests within this consolidated marketplace.

ORIGINS OF FUHN

In May 2010, Minnesota passed legislation mandating the Department of Human Services to develop and implement the Health Care Delivery Systems (HCDS) demonstration to test innovative delivery systems, including accountable care organizations for Medicaid beneficiaries. Later that year, the Minnesota Association of Community Health Centers held a board meeting focused on health reform activities at the state level. This resulted in the formation of a planning committee tasked with investigating the future of ACOs. The committee members—chief executive officers from four of the 10 organizations that would eventually compose FUHN—saw the HCDS demonstration as an opportunity for the health centers to participate in accountable care.[10] They studied the principles and concepts of accountable care and gauged interest among the other FQHCs in pursuing an ACO contract. Resulting from this investigation, the 10 CEOs that would form FUHN's board of directors began meeting

in July 2011 to develop a response to the state's request for proposals for the demonstration program.

Participating FQHCs and Patients Served

FUHN includes 10 of the 12 FQHCs in the Minneapolis–St. Paul area, totaling 40 service sites that provide care to 150,000 patients annually. One member's predecessor clinic was founded in the 1930s, and the newest health center formed in 2008 to serve the Somali and other East African communities. The 10 FQHCs vary greatly in their size and capabilities. For example, the smallest, the Native American Community Clinic, serves just 4,000 patients at one location, whereas the largest, West Side Community Health Services, serves 33,000 patients across 18 locations (Exhibit 2).

FUHN's clinics provide care to patients who may benefit greatly from strong care coordination. The HCDS demonstration's covered beneficiary population includes all Medicaid fee-for-service and managed care beneficiaries, except those who are dually eligible for Medicare and Medicaid. Among FUHN's patient population in the ACO demonstration, 43 percent sought care at the emergency department over a one-year period, often for nonemergent conditions such as respiratory illness, nonpsychotic mental health conditions, and dental pain. FUHN's adult patients (ages 20 to 64) also experience high levels of chronic disease: 36.2 percent have a depressive condition; 17 percent have been diagnosed with asthma; and 11.8 percent are diabetic. The high chronic disease burden and potentially avoidable use of emergency departments represent key cost drivers among FUHN's patient population.

Exhibit 2. Member Organizations of the FQHC Urban Health Network (FUHN)

Clinic	Target population	Number of sites	Number of patients*	Patient insurance status*	Year founded
Axis Medical Center**	Somalis, East Africans, residents of Stevens Square & Loring Heights	1 medical	4,500	9% uninsured 89% public 2% private	2008
Community-University Health Care Center	Children and low-income families in South Minneapolis	1 medical, dental & behavioral health	12,000	28% uninsured 58% public 14% private	1966
Indian Health Board of Minneapolis	American Indian community in Minneapolis	1 medical, dental & behavioral health	5,000	51% uninsured 38% public 11% private	1971
Native American Community Clinic	Native American families in metro area	1 medical, dental & behavioral health	4,000	26% uninsured 53% public 21% private	2003
Neighborhood HealthSource	Community members of North & Northeast Minneapolis	4 medical & behavioral health	10,000	39% uninsured 43% public 18% private	1971
Open Cities Health Center	African Americans, Southeast Asians, immigrants, refugees	2 medical, dental & behavioral health	14,000	38% uninsured 47% public 15% private	1967
People's Center Health Services	Economically disadvantaged and socially disenfranchised	2 medical & behavioral health, 1 dental	10,000	28% uninsured 61% public 11% private	1970
Southside Community Health Services	Low-income women & children from Southside Minneapolis	2 medical, 1 dental & vision	10,000	37% uninsured 50% public 13% private	1971
United Family Medicine**	Medically uninsured, underinsured, underserved residents of St. Paul	1 medical & behavioral health, 1 satellite	15,000	20% uninsured 47% public 33% private	1971
West Side Community Health Services	Latinos, Hmong, adolescents, immigrants, low-income community	18 medical & behavioral health, including 2 dental	34,000	51% uninsured 38% public 11% private	1969

* Data from the Bureau of Primary Health Care's 2011 Uniform Data System, http://bphc.hrsa.gov/uds/view.aspx?q=rlg&year=2011.
** Data from the Bureau of Primary Health Care is unavailable for FQHC Look-Alikes. Patient information based on organization's annual reports.

Organizational Formation

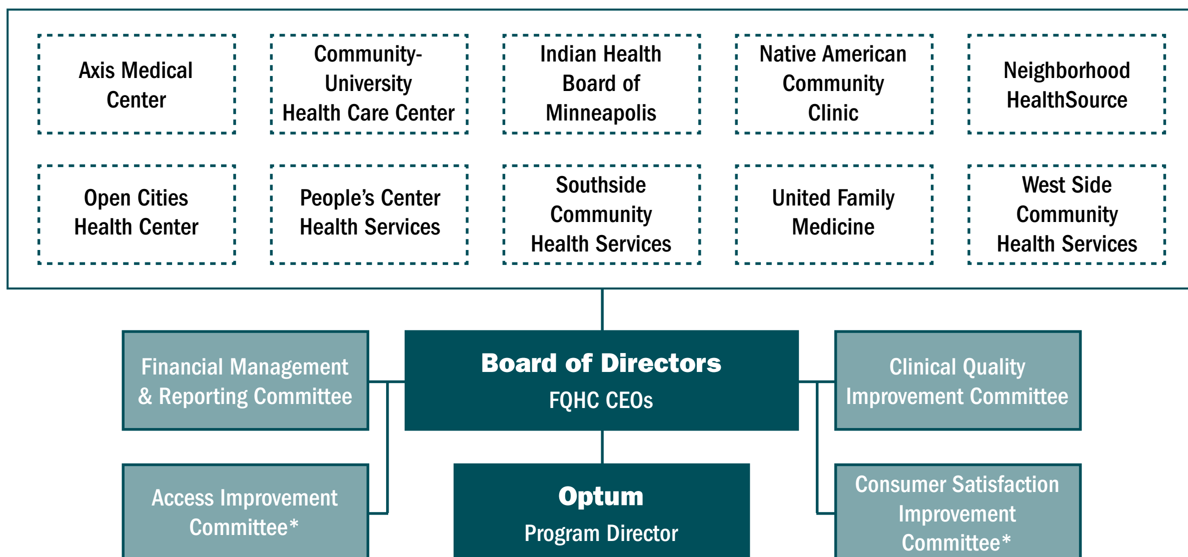
The FQHCs' proposed ACO was selected for contract negotiations under the HCDS demonstration in December 2011.[11] The group identified early on that lack of data would be a significant barrier to implementation of a new care delivery model, particularly given the absence of integrated electronic medical records to connect the FQHCs. To overcome this, FUHN pursued a partnership with an administrative services organization for data management and population health analysis. FUHN interviewed four organizations before contracting with Optum (a subsidiary of UnitedHealth Group) to provide data tools, strategic and operational insight, and other administrative services to support clinic-level improvements and network-wide infrastructure.

The FQHCs worked with Optum to develop a care delivery model that includes performance improvement coaching, quality analysis and monitoring, and information technology infrastructure. Because of the limited funding available among the FQHCs, Optum has taken on significant financial risk for the ACO's infrastructure investments. FUHN's leaders considered the investment from Optum as necessary to pursuing the ACO contract because the state did not provide any upfront or advance funding for the demonstration, such as advances on shared savings or upfront care management payments. Neither Optum nor the member FQHCs went into the demonstration blindly: they worked with a nonprofit health plan in Minnesota to analyze data on 9,000 patients served by the FQHCs and concluded there was potential for significant shared savings under an ACO contract. Optum advised the FQHCs on the development of FUHN's proposal to the state and is providing an array of expertise, services, and technology to support FUHN in meeting cost and quality benchmarks.

Governance and Leadership

The democratic and collaborative nature of the FUHN coalition is firmly rooted in its governance structure (Exhibit 3). FUHN's board of directors consists of the executive director or CEO from each of the 10 FQHCs. Board members convene weekly with Optum to discuss program development and implementation. According to FUHN's members, the coalition's success has come in large part from the fact that its leaders have devoted significant time to the effort. An Optum-employed program director supports the executives, working closely with them to establish a program development office charged with documenting policies and processes, and creating reporting templates, data reports, and job descriptions for new care coordination and analytic staff.

Exhibit 3. Governance Structure of the FQHC Urban Health Network (FUHN)



* Committee outlined in FUHN's "Response to Request for Proposals," but not yet established.
Source: West Side Community Health Services, Inc., "Response to Request for Proposal," Letter to Minnesota Department of Human Services Health Care Administration, Nov. 4, 2011, St. Paul, Minnesota.

FUHN's Financial Management and Reporting Committee, consisting of the chief financial officers or finance directors from each of the health centers, is tasked with forecasting operational needs and establishing the coalition's policy on the distribution of shared savings across sites. The Clinical Quality Improvement Committee, which includes medical directors, senior physicians, and quality personnel, is working to share best practices, determine standard treatment protocols for common chronic conditions, set performance targets for improvement, and monitor quality results achieved by FUHN and the member FQHCs. Both committees are supported by the Optum-employed FUHN program director.

MOTIVATIONS TO PARTICIPATE IN THE ACO INITIATIVE

The health center executives view the move toward value-based payment as inevitable and believe the formation of a coalition (with its increased patient volume and strengthened political voice) is the best way to ensure the health centers' survival and success in an evolving health care system. Within this context, three main motivations drove the FQHC's pursuit of an ACO: the opportunity to demonstrate the effectiveness of the FQHC model, the desire to lead health reform, and the ability to leverage scarce resources and participate in shared learning. The relative importance of these motivations varied for each FQHC, often because of the size and capabilities of the organization.

Demonstrating the Effectiveness of the FQHC Model

Many members chose to participate in FUHN in hopes of demonstrating that FQHCs can provide high-quality, low-cost care. With increased numbers of newly insured individuals coming under the Affordable Care Act, the FQHCs saw the formation of an ACO as a way to transition (in the words of its board chair) from "default provider to preferred provider."

In particular, the FQHCs viewed their participation as a defensive move to more permanently secure their relationship with their Medicaid patients. Many clinic leaders thought the state might eventually move the majority of Medicaid patients into value-based contracts should the HCDS demonstration prove successful. A number of executives also expressed concern for the overall future of the FQHCs, fearing that failure to participate in the demonstration would result in either absorption by a larger hospital-based system or marginalization. Of the six projects selected to participate in the first phase of the HCDS demonstration, FUHN is the only participant in the HCDS demonstration that is not an integrated delivery system but is instead coalition-based.[12] FUHN sought to demonstrate the effectiveness of an alternate model that was "primary care–led and community-based, rather than hospital-led and system-based."[13]

> *"We saw the opportunity to demonstrate that we can manage care as effectively, or in fact maybe more effectively, than some of the big health systems in our market here."*
>
> Financial Management and Reporting Committee

Leading Health Reform

Some health centers also wanted to play a leading role in health reform. FUHN's leaders believe that as a coalition they have been able to exert much greater influence on the state's health reform process than any one of the FQHCs would have been able to do on its own.

The HCDS demonstration marked the first time the health centers felt they had an opportunity to guide state-level policies affecting a large proportion of their patient population. Their ability to take part in contract negotiations and shape the ACO model to the benefit of the FQHCs was a significant departure from past payment arrangements with the state. Previously, the health centers negotiated primarily with managed care organizations that were under contract with the state. For the HCDS demonstration, they have instead been able to negotiate directly with Minnesota's Department of Human Services. FUHN hopes its participation in the demonstration will serve as a model, providing lessons for other states and health centers considering Medicaid ACO initiatives.

Leveraging Scarce Resources and Participating in Shared Learning

Finally, the opportunity to leverage scarce resources and participate in shared learning motivated some of the health centers to participate. Executives and clinical staff saw FUHN as a vehicle for sharing resources (e.g., after-hours care, transportation, and administrative and psychiatric services), standardizing policies and procedures, and sharing best practices for the treatment of common chronic conditions. Regular meetings among clinic leaders provided opportunities for mentorship and guidance around issues such as performance measurement, risk-management, workforce planning, and health information technology support. Additionally, some executives were eager to take advantage of the added resources and business expertise they felt Optum could provide. The ability to leverage scarce resources and participate in shared learning held greater importance for some of the smaller and less established organizations, while the desire to lead health reform served as a greater motivation for the larger FQHCs. The executives of the larger FQHCs often saw shared learning as more of a byproduct of the collaboration and less as a primary motivation for participating in FUHN.

ACCOUNTABLE CARE DELIVERY MODEL

In addition to forming a strong governance structure, FUHN's leaders identified three interdependent elements of their accountable care delivery model: 1) data analytics, 2) performance improvement coaching, and 3) patient-centered medical home certification.

Data Analytics

FUHN is working with Optum to implement an analytic tool called ImpactPro, which is designed to improve the utility of administrative claims data by monitoring cost, utilization, and quality trends for individual patients, as well as for providers and clinics. It will produce four types of reports: 1) patient follow-up reports will identify opportunities for preventive services and follow-up care; 2) panel view reports will give physicians information on their patients' historical utilization of care and relative risk; 3) high-risk patient management reports will use quality measures, evidence-based care protocols, and predictive analyses to identify opportunities to help patients at highest risk of hospitalization; and 4) clinic-specific performance reports will track each FQHC's progress in meeting overall cost and quality benchmarks. The reports aim to drive continuous improvement activities and measure their impact in reducing utilization and improving the quality of care.

Performance Improvement Coaching

To enable effective use of the data available through ImpactPro, FUHN plans to place performance improvement advisors at each of the FQHCs. Performance improvement advisors and medical directors will work directly with staff to analyze clinic performance, identify improvement strategies, and monitor their implementation. In particular, they will help design care coordination processes aimed at reducing emergency department and inpatient utilization, in particular for high-risk populations and patients with high hospital utilization. Additionally, performance improvement advisors will study high-performing clinics and bring recommendations to the governance committees for spreading effective practices across the network.

Patient-Centered Medical Home Certification

FUHN strives to strengthen primary care by having each of its members attain Health Care Home certification, Minnesota's version of patient-centered medical homes. Introduced by the state's 2008 health care reform legislation, health care home certification is a rigorous process that requires the use of effective team care delivery, patient registries to identify gaps in care, previsit planning, care plans to track patients' progress over time, patient experience surveys, and ongoing partnerships with community resources.[14] The FQHCs in the network are at varying stages of becoming health care homes, with four having already obtained certification.

CHALLENGES IN PURSUING ACCOUNTABLE CARE

In developing and implementing its new care delivery model, FUHN's leaders have identified three internal challenges: 1) providing significant upfront investment of time and resources; 2) establishing a means for effective communication, decision-making, and standardization among coalition members; and 3) managing performance variation among member organizations. FUHN hopes to address these challenges through the careful design of its care delivery model, the terms reached in its contract negotiations with the state, and the strength of its governance structure.[15]

Investment of Time and Resources

FUHN's leaders have made significant upfront investments, both in terms of time and money, in order to launch the ACO initiative. The CEOs devoted substantial time to gain expertise in accountable care. In addition, the subset of CEOs that served as the FUHN negotiating team invested significant time during the negotiation process with the state. FUHN's workgroup and committee meetings demand hours of time from the CEOs, financial directors, and medical directors of member organizations. This investment of time presents a particular challenge for the smaller FQHCs, whose leaders often have a hard time balancing the needs of their own clinics with those of FUHN.

FUHN also has had to overcome significant resource constraints among its members. For example, FUHN determined early on that it would be unaffordable for the FQHCs to develop a health information exchange to connect their disparate electronic medical records. Although FUHN's partnership with Optum may address some resource constraints through the provision of analytic tools and performance improvement advisors, FUHN must continue to work with the limited resources available to safety-net organizations.

Cross-Site Communication, Decision-Making, and Standardization

FUHN faces a number of logistical issues in trying to work effectively as a coalition. A strong governance structure has been established to facilitate coordination across the 10 independent organizations, but this requires time and effort. The board operates by consensus to facilitate full inclusion of all members. Despite the benefits of this approach, decision-making at the board level is often time-consuming and slow.

In addition, FUHN must decide when to standardize across the FQHCs and when to foster clinic-specific strategies and programming. To date, efforts have centered on identifying protocols to be standardized, such as policies for emergency preparedness and for patients seeking pain medication. Going forward, FUHN's leaders will need to think about broader strategies, including the standardization of provider and patient engagement efforts. Care management approaches will likely remain site-specific, adapted by performance improvement advisors to address local needs. For example, Community-University Health Care Center anticipates making more extensive use of case managers for serious and persistent mental illness because of its higher prevalence of patients with behavioral health needs.

Managing Performance Variation

FUHN's member organizations vary widely with respect to their size and staffing, relationships with hospitals, implementation of electronic medical records, provider engagement in care delivery reform efforts, and progress toward health care home certification. These differences will likely affect each health center's ability to meet cost and quality benchmarks. FUHN's leaders must address fundamental questions about how to achieve equity among the 10 organizations, including how to help underperforming sites improve and how to distribute shared savings.

The Financial Management and Reporting Committee is designing a formula to distribute shared savings among the FQHCs while accounting for variance in their size and performance. Thus far, the CFOs have developed a conceptual framework that includes three levels of distribution: 1) a lump-sum payment, equally shared among the FQHCs; 2) a payment tied to each health center's performance; and 3) a payment

indexed to the number of attributed patients at each health center. The committee still needs to develop and implement a specific formula for distributing savings.

ORGANIZATIONAL STRENGTHS

FUHN intends to rely on a number of the coalition's strengths to overcome challenges and facilitate the transition to accountable care. These strengths include a committed leadership team focused on a singular purpose; the partnership with Optum; and the diversity of programs, services, and experiences among the 10 FQHCs.

Committed Leadership Team with a Singular Purpose

FUHN has been a CEO-led initiative since its onset, and members say that their CEOs' commitment and creativity has been critical to the coalition's development. FUHN's leaders feel their singular purpose—to succeed under the ACO model—has enabled unprecedented levels of collaboration. This collaboration has depended on strong governance, including a clearly designed board and committee structure and the active and regular engagement of clinic leaders. The board of directors and each committee has a charter that defines its purpose, outlines key responsibilities, and establishes membership representative of all 10 FQHCs. Clear delineation of roles and responsibilities has fostered the enthusiastic and sustained participation of clinic leadership. The active engagement of a number of leaders from each FQHC (CEOs, medical and finance directors, and quality personnel) differentiates the FUHN initiative from the FQHCs' past efforts to work together.

The health center executives believe their devotion of significant time each week has been essential for successful collaboration. Through weekly board meetings, for example, clinics' CEOs and executive directors have established informal relationships and a level of trust that they hope will facilitate the sharing of resources and insights. Similarly, clinics' quality and medical leaders have built stronger ties through the Clinical Quality Improvement meetings. Members have started connecting outside of committee meetings to discuss progress and share materials, such as previsit checklists.

> *"Optum's participation with us is critical, because they are going to provide some of the infrastructure that we need to be able to positively influence utilization. And that's a whole set of tools and tasks that none of us, individually or collectively, could bring to bear."*
>
> Financial Management and Reporting Committee

Partnership with Optum

According to clinic leaders, Optum played a key role in supporting the development of FUHN's care delivery model. Through this innovative partnership, Optum has provided critically important data analytics software, staff, and business expertise. Additionally, Optum and its program director have set up the pathways for communication by facilitating committee meetings. For example, the program director is responsible for coordinating agenda items with FUHN's leaders as well as distributing notes and reminders for meetings.

Optum is taking on significant financial risk for the resources it provides to FUHN.[16] Over the course of the three-year demonstration, Optum will invest in both upfront and implementation costs, including costs for hiring new staff members (e.g., the program director and performance improvement advisors), analytic tools, and data warehouse infrastructure and maintenance. FUHN must meet cost and quality benchmarks and achieve shared savings in order for Optum and the 10 FQHCs to recoup their investments. Without this financial investment, FUHN's leaders believe it would not have been possible for them to pursue the ACO contract.

Diversity of Programs, Services, and Experiences

The diversity of FUHN's member organizations may strengthen opportunities for collaboration. The 10 FQHCs have tailored their services to be responsive to the unique needs of the underserved, low-income

communities they serve.[17] With each FQHC providing care to different subsets of the population, the coalition hopes to benefit from sharing best practices among FQHCs. For example, Neighborhood HealthSource requested culturally tailored information on diabetes and nutrition for its Latino patients from West Side Community Health Services, the member organization that serves the largest number of Latino patients in the network. Similarly, when United Family Medicine opened its first dental clinic, they lacked the expertise to hire dental staff. The dental director from Open Cities Health Center assisted in the hiring process and helped United Family Medicine establish dental procedures and protocols. Although the integration of 10 disparate organizations will prove challenging, the diversity among the FQHCs means the coalition has a large pool of experience, resources, and knowledge to draw upon.

MOVING FORWARD IN THE PURSUIT OF ACCOUNTABLE CARE

FUHN hopes to improve population health and achieve shared savings by increasing preventive health care services, reducing the number of hospital admissions and readmissions, and reducing emergency department use. As they move forward in the performance period, the coalition expects to encounter a variety of emerging challenges. Their experiences may provide lessons for community health centers and other groups pursuing accountable care.

Emerging Challenges

FUHN anticipates a new set of challenges will emerge as it implements its care delivery model and is held accountable for the overall care and cost of its clinics' underserved patient population. For example, the performance improvement advisors will need to be effectively integrated into the clinic workflow. FUHN must develop a standardized process for accurately collecting and reporting data on clinical quality and patient experiences.[18] The FQHCs also must improve their relationships with local hospitals and specialists to better coordinate care across settings. While some have established formal referral relationships with tertiary care centers, the majority make referrals on an ad hoc basis. Given the geographic spread of the FQHCs, FUHN does not plan to standardize these relationships, but instead will look to each clinic to develop its own activities for engaging hospitals and accessing timely admissions and discharge information.[19] Perhaps most important, FUHN must finalize how shared savings will be distributed among the member organizations. Its leaders anticipate considerable performance variation across clinics and are developing strategies to help underperforming sites improve.

Along with these implementation barriers, FUHN faces additional challenges in serving a highly vulnerable patient population. The long-term success of FUHN will hinge in part on the clinics' ability to meet the behavioral health and social service needs of their patients. FUHN clinics plan to collaborate in order to optimize increasingly scarce resources and to learn from each other how to better integrate physical health, behavioral health, and social services.

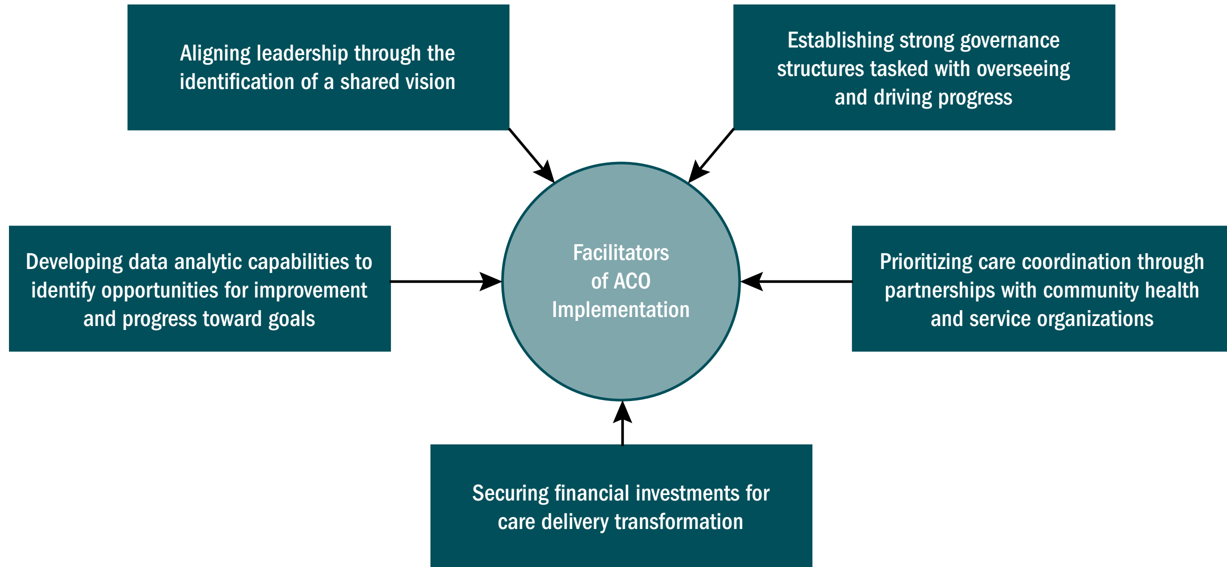
> *"I'm excited about the opportunity to collaborate with the other clinicians. As you can see, we're all trying to reach the same goals, but we all have a different set of resources, we all have a different set of skills and ideas, and we should be bringing those together to improve quality."*
>
> Neighborhood HealthSource

Lessons for the Field

FUHN's transition to accountable care may be of interest to other FQHCs as well as organizations outside of the safety net that are pursuing coalition-based ACOs in a fragmented system of care. Despite serving disadvantaged patients, FUHN faces many of the same challenges as does any organization seeking to pursue accountable care.

Based on FUHN's experience, it appears the following approaches may be important to the development of a coalition-based ACO (Exhibit 4):

Exhibit 4. FQHC Urban Health Network (FUHN) ACO Implementation Facilitators



- aligning leadership through the identification of a shared vision;
- establishing a strong governance structure tasked with overseeing and driving progress;[20]
- developing a unified strategy for using data to routinely measure progress and identify improvement opportunities;
- prioritizing the development of care coordination infrastructure, which may involve community partnerships to overcome size and resource limitations or collaboration with an administrative services group such as Optum; and
- securing financial investments for care delivery transformation.

CONCLUSION

FUHN's performance period began on January 1, 2013. As the ACO evolves, its members will continue to address the challenges of: procuring sufficient resources; communicating, decision-making, and standardizing across sites; and managing cross-site variation. To address these challenges and advance toward the provision of lower-cost, higher-quality care, FUHN plans to rely on the strength of its leaders; its partnership with Optum; the diversity of its member organizations; and the growing ability of the health centers to learn from one another and jointly problem-solve. Success in the HCDS demonstration could lead FUHN to pursue additional ACO contracts with payers other than the state, though for now FUHN remains focused on its Medicaid contract.[21] FUHN looks forward to full implementation of its new care delivery model and sees accountable care as a pathway to providing high-quality, low-cost care in the safety net.

About This Study

In late September 2012, a team from The Dartmouth Institute for Health Policy & Clinical Practice conducted a five-day site visit with each of the 10 members of the Federally Qualified Health Center Urban Health Network (FUHN) in Minneapolis–St. Paul, Minnesota. Information in this case study was collected through in-person interviews with the CEOs, medical and finance directors, and quality personnel at the 10 FQHCs. The site evaluation team also attended meetings with FUHN's Clinical Quality Improvement Committee; Financial Management and Reporting Committee; board of directors; and administrative services partner, Optum. Additional information was derived from a review of internal and external documents, including FUHN's response to the Minnesota Department of Human Service's request for proposals, press releases, relevant presentation slides, annual reports, job descriptions, and committee charters.

Notes

1. FUHN is participating in an upside-only risk arrangement with the state; therefore the coalition is not liable for costs that exceed the established cost benchmark.

2. Under the Health Care Delivery Systems (HCDS) demonstration, patients who receive the plurality of their primary care services at one of FUHN's member clinics will be attributed to the ACO. FUHN is responsible for the overall cost and quality of its attributed patients' care, regardless of whether the ACO delivers the services. Attributed patients face no network restrictions and are free to receive care outside of FUHN's member clinics. The demonstration's covered beneficiary population includes all Medicaid fee-for-service and managed care beneficiaries, except those who are dually eligible for Medicare and Medicaid.

3. Strong governance refers to the design and commitment of FUHN's board of directors and committees. Each committee has a charter that defines its purpose, outlines key responsibilities, and establishes committee membership representative of all 10 FQHCs. In addition to clear roles and responsibilities, FUHN's governance has active commitment and engagement of participants, including regular meeting attendance and active participation from committee members.

4. D. McCarthy, S. K. How, C. Schoen, J. C. Cantor, and D. Belloff, *Aiming Higher: Results from a State Scorecard on Health System Performance, 2009* (New York: The Commonwealth Fund, Oct. 2009). In Minnesota, 91.6 percent of the adult population is insured, owing to the state's strong base of employer-provided insurance and large, state-sponsored programs that subsidize coverage for the poor and near-poor, including Medical Assistance (its Medicaid program) and MinnesotaCare (the state's public insurance program for the near-poor).

5. D. M. Berwick, T. Nolan, and J. Whittington, "The Triple Aim: Care, Health, and Costs," *Health Affairs,* May/June 2008 27(3):759–69.

6. Laws of Minnesota 2008, Ch. 358, Art. 2.

7. McCarthy, How, Schoen et al., *Aiming Higher,* 2009.

8. R. Degelau, *Minnesota's Federally Qualified Health Centers* (Minneapolis: Minnesota Association of Community Health Centers). Available at http://www.health.state.mn.us/healthreform/ship/events/degelauppt.pdf. The FQHCs have tailored their workforce and services to be responsive to the unique characteristics of the communities and cultures they serve. For example, 60 percent of the 250 employees at West Side Community Health Center are bilingual and bicultural. Similarly, at United Family Medicine all clinic signs are posted in English, Spanish, Russian, Hmong, and Somali.

9. In the Minneapolis–St. Paul area, four insurance plans (Blue Cross Blue Shield, HealthPartners, Medica, and UCare) and three multihospital systems (Allina, Fairview, and HealthEast) dominate the market. The January 2013 merger of HealthPartners and Park Nicollet is the most recent indication of Minnesota's consolidated marketplace and marks a growing trend of strategic partnerships between different types of health care organizations. The new organization, which goes by the name HealthPartners, is both a health insurer and a health care delivery system that includes five hospitals. See http://www.healthpartners.com/public/newsroom/newsroom-article-list/1-1-2013.html for HealthPartners January 2013 press release. Among the more than 50,000 Medicaid beneficiaries served by the 10 member organizations of FUHN, approximately 70 percent are enrolled in managed care plans.

[10] The four-person planning committee has since evolved into FUHN's Executive Committee, a subset of the board of directors that led contract negotiations with the state.

[11] FUHN became a legal entity later that month through the repurposing of the Neighborhood Health Care Network, the subset of urban FQHCs and community clinics that met regularly to coordinate efforts around emergency preparedness, billing support, and a limited number of local quality improvement initiatives. Eight of FUHN's 10 member organizations were already members of the Neighborhood Health Care Network. The organization submitted a Doing Business As (DBA) application in order to repurpose the Neighborhood Health Care Network to support the activities of the demonstration project. FUHN was approved as a legal entity by the state of Minnesota after the FQHCs not participating in the FUHN initiative resigned and the two FQHC Look-Alikes (Axis Medical Center and United Family Medicine) joined the repurposed organization.

[12] FUHN is classified as a virtual delivery system under the HCDS demonstration. In the demonstration's request for proposals, the Minnesota Department of Human Services defines a virtual delivery system as "primary care providers and/or multispecialty provider groups that are not formally integrated with a hospital or integrated system via aligned financial arrangements and common clinical and information systems."

[13] West Side Community Health Services, Inc., "Response to Request for Proposal," Letter to Minnesota Department of Human Services Health Care Administration, Nov. 4, 2011, St. Paul, Minnesota.

[14] "Health Care Homes Certification Assessment Tool," Minnesota Department of Health, http://www.health.state.mn.us/healthreform/homes/index.html.

[15] FUHN's contract negotiations with the state ended in January 2013. The exact terms of the final contract (including the performance measures used to determine eligibility for shared savings) have not been released.

[16] Three administrative services organizations other than Optum expressed interest in partnering for the demonstration. One of these was willing to take on similar financial risk.

[17] For example, People's Center Health Services is located within five blocks of a high-density housing complex that is home to over 10,000 Somali refugees and immigrants. The FQHC operates disease-specific programs targeting the needs of its Somali patients, including programs for hepatitis and post-traumatic stress disorder.

[18] To become accountable for the quality of its patients' care, FUHN must overcome technical challenges in collecting performance measures specific to the HCDS demonstration. Although FQHCs have long reported on performance as required by the Bureau of Primary Care, the demonstration uses measures from Minnesota's Statewide Quality Reporting and Measurement System (Minnesota Statutes 62U.02; MN Rules, Chapter 4654). Performance measurement and reporting may present greater difficulty for the less-resourced FQHCs.

[19] Although the coalition does not include a hospital partner, FUHN's total cost of care will include inpatient and emergency care services. Because of this, FUHN is working to improve care transition management and hopes to reduce preventable readmissions and emergency department visits through strengthened community partnerships with local hospitals and specialists. Medical directors and performance improvement advisors plan to work with clinic staff to implement methods for ensuring that primary care physician designations are understood by hospitals caring for FUHN's patients.

[20] Strong governance refers to the design and commitment of FUHN's board of directors and committees. Each committee has a charter that defines its purpose, outlines key responsibilities, and establishes committee membership representative of all 10 FQHCs. In addition to clear roles and responsibilities, FUHN's governance has active commitment and engagement of participants, including regular meeting attendance and active participation from committee members.

[21] Because the core of the clinics' patient population is uninsured or enrolled in Medicaid, FUHN does not anticipate pursuing additional ACO contracts in the immediate future. Currently, the commercial payer mix varies widely at each FQHC, and only United Family Medicine sees a significant number of Medicare beneficiaries (approximately 13 percent of their overall patient population). With upcoming Medicaid expansion and the opening of state insurance exchanges under the Affordable Care Act, however, the payer mix at the FQHCs could change significantly. This may affect FUHN's decision to participate in additional ACO contracts. FUHN will do so only if regulatory concerns, such as antitrust laws, can be overcome.

About the Authors

Karen E. Schoenherr is a health policy fellow at The Dartmouth Institute for Health Policy & Clinical Practice. Her research examines the formation and development of Accountable Care Organizations and the impact they may have on vulnerable populations and the safety net. Previously, Ms. Schoenherr worked in the social services sector as a caseworker for homeless families and individuals. She holds a bachelor's degree in social epidemiology from Harvard University. During her undergraduate career, Ms. Schoenherr worked extensively with patients at community health centers to connect them to community resources.

Aricca D. Van Citters, M.S., has more than 14 years of experience conducting qualitative and quantitative process and outcomes evaluations in a variety of health care settings. Her recent research projects focus on understanding the formation and performance of accountable care organizations; developing an integrated care pathway for hip and knee arthroplasty that considers safety, efficacy, efficiency, and the patient experience of care; and understanding factors that contribute to rapid improvement in hospital quality, costs, and mortality. She has provided coaching to hospitals around methods to improve the patient experience of care and has provided technical assistance to numerous organizations in implementing evidence-based interventions. Ms. Van Citters received a master of science degree in evaluative clinical science from Dartmouth College.

Kathleen L. Carluzzo is research manager for Patient Reported Measures at The Dartmouth Institute for Health Policy & Clinical Practice, where she is also pursuing a master of science degree in health services research. Her research is focused on population health, including evaluation of accountable care organizations and patient-reported outcome measures. She has experience performing qualitative and quantitative data collection and analysis.

Savannah Bergquist, M.S., is a health policy fellow at The Dartmouth Institute for Health Policy & Clinical Practice. In this role, Ms. Bergquist contributes to implementation and analysis of the National Survey of Accountable Care Organizations (NSACO), including tracking the growth and spread of accountable care organizations and analyzing issue areas such as physician compensation and post-acute care. Prior to joining The Dartmouth Institute, Ms. Berguist received her master of science degree in health and population studies from the London School of Economics and her bachelor's degree in political economy from Georgetown University.

Elliott S. Fisher, M.D., M.P.H., is director at The Dartmouth Institute for Health Policy & Clinical Practice and the James W. Squires Professor of Medicine and Community and Family Medicine at the Geisel School of Medicine at Dartmouth. He is also codirector of the Dartmouth Atlas of Health Care and a member of the Institute of Medicine of the National Academy of Sciences. Dr. Fisher's early research focused on exploring the causes and consequences of the twofold differences in spending observed across U.S. regions and on the development and testing of approaches to performance measurement and payment reform that can support improvement. His current policy work focuses on exploring the determinants of successful formation and development of accountable care organizations. Dr. Fisher received his undergraduate and medical degrees from Harvard University and completed his internal medicine residency and public health training at the University of Washington.

Valerie A. Lewis, is an assistant professor at The Dartmouth Institute for Health Policy & Clinical Practice. Her work focuses on evaluating the impact of delivery system and payment reform on disadvantaged groups. Dr. Lewis earned doctoral and master's degrees in sociology from Princeton University. She completed postdoctoral training at the Kennedy School of Government at Harvard University.

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