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GIH

Safety Net in the Era of Health Reform: A NEW VISION OF CARE

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FOREWORD

As part of its continuing mission to serve trustees and staff of health foundations and corporate giving programs, Grantmakers In Health (GIH) convened a group of grantmakers and safety net experts on November 3, 2011, to discuss the challenges and opportunities for the safety net system as the Affordable Care Act is implemented.

Very sincere thanks to those presenters who took the time to share their work with their colleagues at the Issue Dialogue. Speakers included: Melinda Abrams, The Commonwealth Fund; Jeff Bontrager, Colorado Health Institute; Tom David, Tides; David Fukuzawa, The Kresge Foundation; Cecilia Echeverria, Blue Shield of California Foundation; Tina Hahn, Pittsburgh Regional Collaborative; Sarah Iselin, Blue Cross Blue Shield of Massachusetts Foundation; Leighton Ku, The George Washington University; Margaret Laws, California HealthCare Foundation; and Bruce Siegel, National Association of Public Hospitals and Health Systems.

Lauren LeRoy, president and CEO of GIH moderated several sessions of the Issue Dialogue. Anna Spencer, senior program associate, planned the program, wrote the background paper, and synthesized key points from the Issue Dialogue into this report. Faith Mitchell, vice president for program and strategy, and Leila Polintan, communications manager, provided editorial assistance.

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EXECUTIVE SUMMARY

Safety Net in the Era of Health Reform:

A NEW VISION OF CARE

Grantmakers In Health (GIH) convened a group of grantmakers and safety net experts on November 3, 2011, for an Issue Dialogue to discuss the challenges and opportunities for the safety net system as the Affordable Care Act is implemented.

The collection of services and providers making up the safety net system plays a crucial role in providing health care to the nearly 50 million uninsured adults and children nationwide (Kaiser Commission on Medicaid and the Uninsured 2011a). Passage of the Patient Protection and Affordable Care Act (ACA) presents both opportunities and significant challenges for this system. The health reform law will extend health insurance coverage to more than 30 million individuals by 2014. At the same time, it will invest significantly in building provider and clinic capacity, as well as in more coordinated and integrated care delivery systems (Summer 2011). This influx of patients will place increased demands on a system that is already experiencing capacity, financial, and workforce stressors.

WHAT IS THE SAFETY NET?

Sometimes referred to as a "patchwork of providers," the health care safety net is an array of primary care and specialty services, hospital-based programs, and emergency services that delivers care in a variety of public and private settings. It is supported by federal, state, and local funding streams. The Institute of Medicine (IOM) defines "core safety net providers" as having two distinguishing characteristics: 1) either by legal mandate or explicitly adopted mission, the provider offers care to patients regardless of their ability to pay for services, and 2) a substantial share of the provider's patient mix consists of uninsured or underinsured people, Medicaid recipients, and other vulnerable populations. Many different types of health care providers meet the IOM criteria, including community health centers (CHCs), emergency departments, public and community hospitals, local health departments, school-based clinics, and private office-based providers.

WHO IS SERVED BY THE HEALTH CARE SAFETY NET?

The safety net primarily serves low-income patients who are uninsured, publicly insured, or underinsured. Data show that in 2007, 70 percent of health care safety net users had family incomes at or below 100 percent of federal poverty level, and more than 90 percent had family incomes at or below twice the federal poverty level (Rosenbaum et al. 2009). In 2009 nearly 40 percent of patients who visited CHCs lacked health insurance coverage, and one in eight were Medicaid beneficiaries (NACHC 2009). One in seven rural residents receives care from safety net providers. Racial and ethnic minorities are disproportionately represented among CHC patients. In 2009, 27 percent of health center patients were African American and 35 percent were Hispanic/Latino (HRSA 2011a). Health centers also provide care to special populations, including migrant and seasonal farm workers and their families, individuals experiencing homelessness, and residents of public housing.

CURRENT CHALLENGES

The safety net system contends with myriad challenges on a regular basis. In addition to caring for the most vulnerable citizens, safety net providers must manage multiple funding sources, each with their own requirements; compensate for staffing shortages; manage complex patient referrals and follow-up care; and continually operate in a countercyclical environment in which economic downturns generate both an increased demand for services and increased attempts to reduce Medicaid expenditures. An added challenge is preparing for changes that will come with the ACA, while continuing to meet the significant increase in

demand for services that has accompanied the recent recession. The decline in employer-sponsored health insurance, exacerbated by the loss of jobs offering health insurance, has swelled the ranks of the uninsured and others who rely on the safety net (Summer 2011). In 2010 almost 50 million people were uninsured (DeNavas-Walt et al. 2011).

A NEW VISION OF CARE

The ACA provides opportunities to re-orient the safety net system to focus on the delivery of prevention and primary care services in a more accessible, patient-centered, and comprehensive fashion. The development and expansion of health, or medical, homes is a centerpiece of the law. The patient-centered medical home is a care delivery model for providing comprehensive preventive and primary care services to children and adults. The approach facilitates partnerships between patients and their providers. Studies demonstrate that this model improves access, increases patient satisfaction, decreases mortality, and lowers health spending, among others (Beal et al. 2007).

RECENT PHILANTHROPIC ACTIVITIES

Foundations and corporate giving programs have dedicated their resources to prepare the safety net for health reform implementation and enhance the performance of the safety net system. These activities include establishing and evaluating patient-centered medical home models; building capacity within CHCs; assessing innovative payment models and delivery system reforms; monitoring the impact of health reform on the safety net; and developing new technologies to improve care delivery and reduce costs.

FUNDER OPPORTUNITIES

The ACA presents an opportunity to make significant improvements to the health care system through incentives that focus on patient-centered care, on reinforcing and building the capacity of CHCs, and on directing dollars to preventive care. There clearly are roles funders can play to help safety net providers take advantage of these opportunities.

- ***Building Bridges*** – While many safety net systems work well together to provide integrated care for patients, in some communities tensions exist. Funders can create neutral forums for safety net providers to come together to find common ground in delivering patient-centered care. In order to achieve the vision of fully integrated care that the ACA embodies, this convergence will need to occur.
- ***Research/Data Collection*** – Philanthropy vigorously supports qualitative and quantitative research on many aspects of the safety net. As health reform unfolds, it will be important to monitor and evaluate the numerous changes that occur. There is also a role for philanthropy to help safety net systems improve the quality of the data used to assess their performance and capacity. Philanthropy can also help communities establish uniform reporting systems.
- ***Training and Fostering the Next Generation*** – Without effective leadership, safety net systems may not make it through what is perhaps both the most critical and the most promising transformation they have ever experienced. Philanthropy can help train and prepare the next generation of safety net system leaders, pave the way for the full range of health care providers to have a role in integrated models of care, and support all levels of the workforce in navigating these uncharted waters.
- ***Understanding the Patient Experience*** – As health reform becomes a reality, many more people with health insurance will flow into CHCs and other safety net settings. As this happens, safety net providers may want to enhance their practices and position themselves as providers of choice. Developing an understanding of patient satisfaction and preferences will be essential. With the support of foundations, providers can use web-based tools and research to truly appreciate the patient experience and hone "the perfect practice."
- ***Building on Successful Models*** – Safety net providers have much to offer the broader health care system,

particularly as it tries to adapt to changes stimulated by the ACA and broader calls for system reform. For years, safety net clinics have been doing more with less, and there are many opportunities to export their models of care and care coordination out into the broader community. It is possible that the safety net could become a model for broader system reform. Philanthropy can help disseminate promising practices both within the safety net system and to the wider health care community.

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INTRODUCTION

The collection of services and providers that making up the safety net system plays a crucial role in providing health care to the nearly 50 million uninsured adults and children nationwide (Kaiser Commission on Medicaid and the Uninsured 2011a). Passage of the Patient Protection and Affordable Care Act (ACA) presents both opportunities and significant challenges for this system. The health reform law will extend health insurance coverage to more than 30 million individuals by 2014. At the same time, it will invest significantly in building provider and clinic capacity, as well as in more coordinated and integrated care delivery systems (Summer 2011). This influx of patients will place increased demands on a system that is already experiencing capacity, financial, and workforce stressors.

> ***For years, the safety net system has been learning how to do more with less. Certainly, I think the safety net needs [philanthropic] support to develop and strengthen new models of care, [but there] is also a huge amount of innovation that needs to be exported and transferred to the rest of the American health system.***
>
> ***– Bruce Siegel, National Association of Public Hospitals and Health Systems***

This issue brief focuses on some of the daily challenges facing the safety net, as well as new challenges and opportunities that will emerge as health reform unfolds. Philanthropy has long supported many aspects of the safety net, including developing the business and clinical structure and infrastructure, such as health information technology and strengthening the primary care and paraprofessional workforce. Philanthropy has also helped increase the capacity of community clinics and other safety net providers and expand the services associated with patient-centered care models to include translation, transportation, health literacy support, and community prevention. This paper highlights some of these efforts, and outlines areas of opportunity for funder investment in the safety net in this era of health reform.

WHAT IS THE SAFETY NET?

Sometimes referred to as a "patchwork of providers," the health care safety net is an array of primary care and specialty services, hospital-based programs, and emergency services that delivers care in a variety of public and private settings. It is supported by several federal, state, and local funding streams (Redlener and Grant 2009). The Institute of Medicine (IOM) defines "core safety net providers" as having two distinguishing characteristics: 1) either by legal mandate or explicitly adopted mission, the provider offers care to patients regardless of their ability to pay for services, and 2) a substantial share of the provider's patient mix consists of uninsured or underinsured people, Medicaid recipients, and other vulnerable populations (IOM 2000). Many different types of health care providers meet the IOM criteria, including community health centers (CHCs), emergency departments, public and community hospitals, local health departments, HIV/AIDS and school-based clinics, community mental health and oral health clinics, and private office-based providers (see "A Patchwork of Providers").

Begun as a small demonstration program in 1965 as part of the "War on Poverty," CHCs have proliferated over the years and are now an essential component of the safety net (David and Stafford 2010; Rosenbaum et al. 2009). As defined by the Health Resources and Services Administration (HRSA), they are "community-based and patient-directed organizations that serve populations with limited access to health care." The success of CHCs hinges largely on their ability to provide comprehensive, culturally competent, quality primary health care services to vulnerable populations, including low-income individuals, the uninsured, those with limited-English proficiency, migrant and seasonal farm workers, individuals and families experiencing homelessness, and residents of public housing (HRSA 2011a; Hoffman and Sered 2005). In addition to primary care, CHCs provide dental care; mental health and substance abuse treatment; pharmacy services; and other services that facilitate care such as translation, transportation, and case management. In 2009, community clinics provided primary care to more than 21 million patients in over 8,000 communities across the country (Direct Relief International 2011).

Free clinics offer health care on a free or very low-cost basis to nearly 2 million low-income uninsured or underinsured individuals annually (Darnell 2010). In 2010 approximately 3.5 million medical and dental visits were made to free clinics (Darnell 2010). Almost all free clinics provide care for acute, non-emergent conditions. Many also provide a full range of primary care (including preventive care) and care for chronic conditions, while some include licensed pharmacies and dental services. Free and community clinics provide many similar services, with the difference that free clinics offer health care primarily through the services of volunteer health professionals and community volunteers, along with partnerships with other health services providers (National Association of Free and Charitable Clinics 2011).

Safety net hospitals are a subset of public and not-for-profit hospitals that provide a disproportionate amount of care to low-income and uninsured patients. They serve more than 10 million people each year, nearly two-thirds of whom are either uninsured or covered by Medicaid (Regenstein and Huang 2005). The majority of safety net hospitals (56 percent) are located in large urban areas and serve an ethnically diverse population (65 percent of individuals receiving inpatient care in 2002 were classified as black, Hispanic, Asian/Pacific Islander, or other nonwhite races) (Regenstein and Huang 2005). Safety net hospitals also

Critical Access Hospitals (CAHs) are small, generally geographically remote facilities that provide outpatient and inpatient hospital services in rural areas. The designation was established by the federal Balanced Budget Act of 1997. CAHs represent a separate provider type with their own Medicare conditions of participation, as well as a separate payment structure. CAHs must:

- be located in a rural area,
- provide 24-hour emergency services,
- have an average length-of-stay of 96 hours or less for its patients,
- be located more than 35 miles (or more than 15 miles in areas with mountainous terrain) from the nearest hospital or be designated by its State as a "necessary provider," and
- have no more than 25 beds.

Source: CMS 2010

offer critical public health and specialty services to the entire community, including trauma, emergency psychiatric, and burn care (Hoffman and Sered 2005).

In some communities, the relationship between community clinics and safety net hospitals is strained. The tensions between the two entities stem from the independent governance structure that is at the very heart of CHCs, competition for patients, and the dynamics of funding streams that are so different between hospitals and clinics. This often creates a "reluctance to play," resulting in very separate safety net silos that end up working against the concept of coordinated care for patients (Siegel 2011).

A PATCHWORK OF PROVIDERS

Emergency departments of community and public hospitals offer emergency medical care, regardless of ability to pay or insurance status. Many hospitals, particularly teaching hospitals, also provide basic primary care and specialty care services for people without other health care options.

Community health centers (CHCs), also known as federally qualified health centers (FQHCs), provide primary care, including preventive physical, dental, behavioral, and substance abuse services, to low-income populations. FQHCs are located in medically underserved areas and must meet certain criteria under Medicare and Medicaid (respectively, Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act). All clinics funded under the Health Center Program (Section 330 of the Public Health Service Act) are FQHCs, though not all FQHCs are guaranteed Section 330 funding (which confers preferential payment under Medicare and Medicaid).

FQHC look-alikes are health centers that have been identified by the Health Resources and Services Administration and certified by the Centers for Medicare and Medicaid Services as meeting the definition of "health center" under Section 330 of the Public Health Service Act, although they do not receive grant funding under the federal Health Center Program.

Local public health departments and public nursing services offer limited primary care services, which vary by community. Services may include health assessments and screenings for Medicaid children, immunizations, family planning, oral health, cancer screenings, and testing for sexually transmitted diseases and HIV.

Community-funded clinics provide free, low-cost, or sliding-fee primary care services to low-income and uninsured families and individuals. These clinics can include faith-based clinics, those staffed by volunteer clinicians, and family practice residency clinics.

Free Clinics provide many similar services as CHCs, with the difference that free clinics offer health care primarily through the services of volunteer health professionals and community volunteers, along with partnerships with other health providers.

Federally designated rural health clinics offer basic primary care services. Rural clinics are located in non-urbanized areas with documented shortages of health care providers and/or medically underserved populations.

School-based health centers (SBHCs) provide primary health care services, including immunizations, well-child checks, sports physicals, chronic care management for conditions such as asthma and diabetes, and acute medical care, in schools with many low-income children. SBHCs may also offer mental and dental care, substance abuse treatment, and violence prevention.

Community mental health centers provide outpatient, emergency, day treatment, and partial hospitalization mental health services to low-income individuals residing in a designated geographic service area.

Community-based low-income dental clinics provide dental services to low-income uninsured individuals or those who, despite being enrolled in a public coverage program, cannot find a dental provider to accept them.

Source: Colorado Health Institute 2011; HRSA 2011a; National Association of Free and Charitable Clinics 2011

WHO IS SERVED BY THE HEALTH CARE SAFETY NET?

The safety net primarily serves low-income patients who are uninsured, publicly insured, or underinsured. Data from CHCs show that in 2007, 70 percent of CHC patients had family incomes at or below 100 percent of federal poverty level ($22,350 for a family of four in 2011), and more than 90 percent had family incomes at or below twice the federal poverty level ($44,700 for a family of four in 2011) (Rosenbaum et al. 2009). In 2009 nearly 40 percent of patients who visited CHCs lacked health insurance coverage, and one in eight were Medicaid beneficiaries (NACHC 2009). One in seven rural residents receives care from safety net providers. Racial and ethnic minorities are disproportionately represented among CHC patients. In 2009, 27 percent of health center patients were African American and 35 percent were Hispanic/Latino—more than twice the proportion of African Americans and Hispanics/Latinos reported in the overall U.S. population (Hing and Hooker 2011). Health centers also provide care to special populations, including 865,000 migrant and seasonal farm workers and their families; more than 1 million individuals experiencing homelessness; and more than 165,000 residents of public housing (HRSA 2011a).

REPEAL OR REPLACE: WHAT DOES IT MEAN?

Since passage of the Affordable Care Act in March 2010, the law has been under attack. Twenty-six states have joined a multistate lawsuit, which challenges the constitutionality of the health care overhaul. In mid-November 2011 the Supreme Court agreed to hear oral arguments (set for March 26, 2012) on whether Congress was acting within its constitutional powers to require all Americans to have health insurance, or to require individuals who elect not to obtain coverage to pay a penalty on their tax returns (Barnes 2011). The Supreme Court will also consider:

- Whether other parts of the law can go forward if the "individual mandate" is found unconstitutional. Lower courts have differed on this question. The administration says the law's more popular features cannot work financially without the mandate that all Americans join the system.
- Whether Congress is improperly coercing states to expand Medicaid.
- Whether the issue is even ripe for deciding. Some lower-court judges have said that the penalty paid for not having insurance is the same as a tax and, under the federal Anti-Injunction Act, cannot be challenged until someone has to pay it in 2015.

Though the uncertainty over the higher court's ruling has many in a wait-and-see mode, states and foundations are forging ahead with implementation. Regardless of the Supreme Court's decision, many aspects of the health reform law—paying for quality, improving patient outcomes, reducing patient errors, lowering health care costs—are "here to stay, and people need to be ready for that no matter what" (Siegel 2011).

CURRENT CHALLENGES

The safety net system contends with challenges on a regular basis. In addition to caring for the most vulnerable citizens, safety net providers must manage multiple funding sources, each with their own requirements; compensate for staffing shortages; manage complex patient referrals and follow-up care; and continually operate in a countercyclical environment in which economic downturns generate both an increased demand for services and increased attempts by states to reduce Medicaid expenditures.

An added challenge for the safety net system is that it must prepare for changes that will come with the ACA, while continuing to meet the significant increase in demand for services that has accompanied the recent recession. The decline in employer-sponsored health insurance, exacerbated by the loss of jobs offering health insurance, has swelled the ranks of the uninsured and others who rely on the safety net (Summer 2011). In 2010 almost 50 million people were uninsured (DeNavas-Walt et al. 2011). From 2009 to 2010, the nation's poor increased by 2.6 million, to 46.2 million (the highest number in the 52 years for which such estimates have been published) and the number of those without health insurance grew by nearly 1 million people (DeNavas-Walt et al. 2011).

The National Association of Community Health Centers reported a 14 percent increase in visits between June 2008 and June 2009, compared to a 6 percent increase for a comparable period before the recession. Hospitals also felt the effects of the recession. The demand for services increased from 2000 to 2009 for all hospitals, but the increase was significantly greater for public hospitals compared to all acute care hospitals. The cost to provide such care is staggering. In 2008 the cost of uncompensated care was $57.4 billion and will likely continue to rise if health reform is not realized (Holahan and Bowen 2010).

THE FUTURE OF FUNDING FOR SAFETY NET HOSPITALS

The ACA reduces Medicaid payments to hospitals that serve a disproportionate share of indigent patients under the assumption that there will be fewer uninsured individuals relying on public hospitals for care. At this point, methods for calculating the reductions in disproportionate share hospital funding are unknown and, as such, it is unclear whether the reductions will match increases in Medicaid payments (Hart 2010).

While there are new gains for safety net providers in the form of ACA grants to expand clinic capacity, build the health care workforce, and implement technological advancements in safety net settings, there is new spending on state Medicaid programs and there remains uncertainty about safety net financing, particularly for safety net hospitals (Katz 2010).

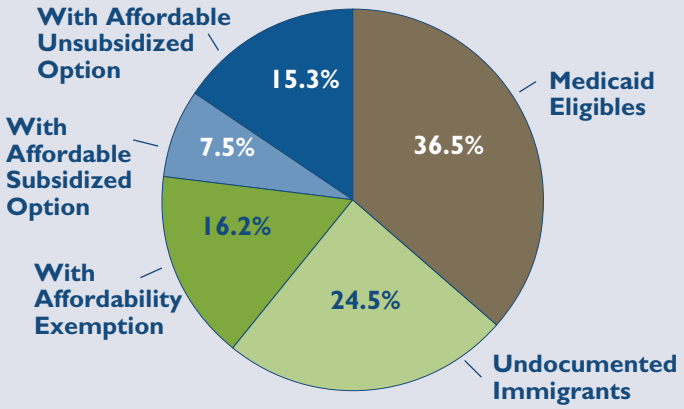
Despite the coverage expansions that will occur because of the ACA, millions of individuals will remain uninsured after the implementation of health reform. According to Congressional Budget Office (2011) projections, more than 23 million individuals will still be uninsured in 2014 when the law is fully implemented. The Urban Institute predicts that roughly 37 percent of the uninsured will be eligible for Medicaid and the Children's Health Insurance Program but not enrolled; 24.5 percent will be undocumented immigrants, who are ineligible for public coverage; 16 percent will be subject to the mandate but choose not to purchase coverage; and over 23 percent will be offered a subsidized or unsubsidized option in the state health insurance exchange but will choose not to participate (referred to as "With Affordable Unsubsidized Option" and "With Affordable Subsidized Option" in Figure 1)(Buettgens and Hall 2011).

Findings from a recent *Health Affairs* study show that undocumented immigrants—a population that has grown considerably in the last decade—will continue to rely on the safety net for much-needed care (Zuckerman et al. 2011). Between 1999 and 2007, the number of undocumented immigrants increased from 8.5 million to 11.8 million. Under the ACA, undocumented immigrants will be ineligible for public insurance or any type of private insurance coverage offered through the state health insurance exchanges. Barring a change in an individual's immigration status or policy amendments that allow undocumented

immigrants to access health insurance coverage, members of this group will become an increasing percentage of the remaining pool of uninsured people after 2014.

Many analysts have turned to Massachusetts for lessons learned from the implementation of health reform in 2006. The Massachusetts experience suggests that, as national reform rolls out, insurance expansions may lead to a surge in demand for primary health care, particularly among new Medicaid beneficiaries and medically underserved low-income communities; that investments to expand the capacity of the primary care system are essential; and that a continuing need for sources of care for individuals without health insurance coverage will remain (Ku et al. 2011a).

FIGURE 1. PROJECTED DISTRIBUTION OF THE UNINSURED UNDER THE AFFORDABLE CARE ACT (2011)



Source: Buettgens and Hall 2011

The experience in Massachusetts underscores the importance of the safety net, which, despite health insurance expansions, continues to be a much-needed source of care. In the five years since implementation began, the number of people in Massachusetts without health insurance coverage has declined over 15 percent, yet the number of individuals accessing safety net clinics—CHCs and safety net hospitals—has risen by nearly 31 percent (Ku et al. 2011b). In addition, about 11 percent of the Massachusetts population is still

CONNECTING THE HEAD TO THE REST OF THE BODY

The integration of oral health services into primary care is often tenuous, especially within the safety net. In 2006 only one in three children in Medicaid had received a dental service within the past year (Borchgrevink et al. 2008). Among the reasons dental providers cite for their low participation rates in Medicaid are: low reimbursement rates, burdensome administrative requirements, and problematic patient behaviors.

To expand access to dental services for low-income people, the Nokomis Foundation is working with the University of Michigan School of Social Work to certify, and set standards for, midlevel dental providers (MDP) in Michigan, who will perform basic preventive and restorative dental procedures under the direct, indirect, or general supervision of a dentist. Despite opposition from the American Dental Association, dental schools in Michigan are considering creating an MDP curriculum.

Cavity Free Kids, funded by the Community Health Foundation of Western and Central New York, in collaboration with Washington Dental Service Foundation and the State of Washington, teaches oral health preventive lessons to low-income children and families, with a focus on the prevention of dental disease among children aged zero to five. Children learn through hands-on, play-based activities, while parents learn through positive, proactive messages.

To promote integration of services, the National Interprofessional Initiative on Oral Health (NIIOH), a consortium of funders and health professionals, engages primary care clinicians to be alert to their patients' oral health needs, ready and willing to deliver oral health preventive services to patients of all ages, and to partner with dental specialists. By focusing on service delivery at the primary care level—engaging family physicians, pediatricians, nurses, physician assistants, and pharmacists—NIIOH is working to expand access to oral health prevention services without creating any new professionals.

without health insurance coverage. These people tend to be young, single, male, nonelderly, low-income adults, and/or of Hispanic ethnicity. Forty-three percent are young adults (18-25 years of age), 65 percent are male, more than half have never been married, and more than 75 percent have incomes less than three times the federal poverty level (Raymond 2011).

THE WORKFORCE CHALLENGE

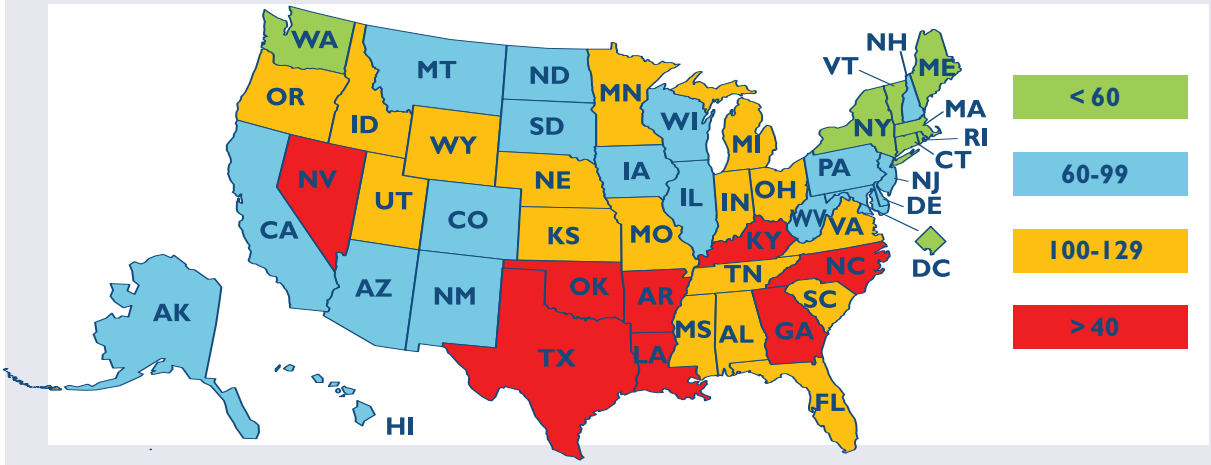
Health care workforce shortages are pervasive across the country, especially in rural and inner city communities. As of March 2009, 80 million Americans lived in 3,132 mental health professional shortage areas (HPSAs); 65 million Americans lived in 6,080 primary care HPSAs; and 49 million Americans lived in 4,091 dental HPSAs (HRSA 2011b). Researchers estimate that policies to expand coverage to all Americans will increase demand for physician services by 25 percent, exacerbating the shortage of providers resulting from the 78 million baby boomers who are beginning to reach retirement age.

> *There really is an important need to expand primary care clinicians, and in a hurry.*
>
> – *Leighton Ku, The George Washington University*

The expansion of coverage to newly Medicaid-eligible patients and low-income patients in the state health insurance exchanges, and in the safety net generally, will place substantial demands on health care providers. While gaps in access to care are a concern system-wide, problems within Medicaid will be amplified because of low physician participation in fee-for-service Medicaid, the disproportionate representation of Medicaid beneficiaries in federally designated HPSAs, higher rates of multiple chronic conditions among program beneficiaries, and other factors related to poverty (Kaiser Commission on Medicaid and the Uninsured 2011b). In addition, many of the newly eligible low-income adults entering Medicaid are expected to be in fair or poor health, heightening the need for primary care services.

The need for primary care providers will vary greatly depending on geographic region. When health insurance reforms are implemented, some states will see as much as a 70 percent decline in the number of uninsured. In these same states, however, there is relatively low primary care capacity (see Figure 2; Ku 2011). As the demand for care goes up in states, the pool of primary care providers will need to be expanded. It will also be important to tap into the broader pool of providers, including doctors of osteopathy, nurse practitioners, physician assistants, as well as other medical staff. The challenge for the safety net system is to meet the current demands for care, while ramping up workforce capacity to receive the newly insured.

FIGURE 1. LEVEL OF STATE PRIMARY CARE CHALLENGES: RATIO OF MEDICAID EXPANSION TO PRIMARY CARE CAPACITY



Source: Ku 2011

A NEW VISION OF CARE

> *You can't fix everyone's problems today, but you can avoid a lot of them with prevention.*
>
> – *Amber Slichta, Community Health Foundation of Western and Central New York*

The ACA provides myriad opportunities to re-orient the safety net system—and the health care system in general—to one that focuses on the delivery of prevention and primary care services in a more accessible, patient-centered, and comprehensive fashion. Among the many provisions included in the ACA was $11 billion over five years dedicated to CHCs, including $9.5 billion for new health center construction for communities in need and for the expansion of capacity at existing health centers (HHS 2011a). Another $1.5 million was earmarked for capital funding to all health centers to help modernize their facilities and serve more patients. The ACA also made financial incentives available through Medicaid and Medicare to encourage the adoption of health information technology and to implement other service delivery and quality measures to improve patient care and health outcomes. The Prevention and Public Health Fund, created by the law and administered by the U.S. Department of Health and Human Services, allocated an additional $15 billion for workforce development, community disease prevention and health improvement initiatives, and infrastructure development (Prevention Institute 2011).

CHC FUNDING IN JEOPARDY

ACA funds earmarked for CHC development and workforce expansion are in jeopardy. Under a federal budget compromise reached in March 2011, the Obama Administration diverted some of the $11 billion set aside in the ACA to expand health centers and instead used it to keep CHCs operating at current levels (Galewitz 2011). Advocates and health centers are concerned that further cuts might occur as Congress tries to limit federal spending. For example, the House Appropriations Committee released a draft 2012 appropriations bill in October 2011 that cut $1.2 billion for health center expansion, precluding future growth for the Health Center Program. As a result, over 700 communities in need throughout the country remain on a wait list for a health center and an additional 1,100 communities with existing health centers are unable to expand service capacity to meet increased demand (NACHC 2011).

THE MEDICAL HOME

Along with expanding coverage, the ACA initiates several efforts to change how health care is paid for and delivered within the United States (Ku 2011). It offers a number of incentives to safety net providers to provide high-quality, patient-focused care; make meaningful use of health information technology (namely electronic health records); and expand services to accommodate the many newly insured Americans (Eslan and Preheim 2011). It also creates new payment policies and demonstrations in Medicare and Medicaid, and offers technical assistance grants to support the development of new health centers within the community and the expansion of current health centers (Berenson et al. 2011).

The development and expansion of health, or medical, homes is a centerpiece of the new law (see "What Is a Medical Home?"). The patient-centered medical home is a care delivery model for providing comprehensive preventive and primary care services to children and adults. The approach facilitates partnerships between individual patients and their personal providers and, when appropriate, the patient's family (Patient Center Primary Care Collaborative 2011). Multiple studies demonstrate that patient-centered primary care improves access, increases patient satisfaction, decreases mortality, prevents hospital admissions for patients with chronic diseases, lowers utilization, improves patient compliance with

recommended care, and lowers health spending (Beal et al. 2007).

There is evidence that having a patient-centered model in place has a positive impact on providers as well. An analysis from Group Health Cooperative in Seattle, Washington, showed that physicians who were engaged in practices that employed a patient-centered medical home model reported more joy in their work and less emotional exhaustion (Porterfield 2010). This translates into greater professional satisfaction, higher staff morale, and lower rates of turnover. Improving physician job satisfaction (along with other clinic staff), may in fact help address the health care workforce shortage problem (Abrams 2011).

> ***While there are challenges ahead, when you start talking about medical homes and safety net and primary care, it is exciting when you think about what is going on across the country. There is reason to be enthusiastic [because] there is a lot that is promising, and there is an enormous role for foundations to play to help continue to build that momentum.***
>
> *– Melinda Abrams, The Commonwealth Fund*

Public hospitals and clinics, federally qualified health centers (FQHCs), rural health centers, and free clinics already employ many dimensions of the patient-centered care model. Many safety net providers have developed effective community partnerships to provide needed care such as behavioral health and substance abuse services; dental health; and other supportive services, including housing and culturally competent care (Coleman and Phillips 2010). In addition, health centers have a culture that emphasizes patient input (FQHCs are required to have past users on their boards), and many CHCs provide care during off-hours or are co-located within public housing or at schools.

> ***Safety net providers can take advantage of the momentum created by health reform to improve clinical outcomes, place patients at the center of their care, and eliminate waste*** **(CHCF 2011a).**

Safety net providers, however, face significant challenges in becoming true patient-centered medical homes. Several factors may inhibit the ability of safety net providers to move to desired levels of patient-centered care delivery as outlined in the ACA; they include the financial demands of care coordination, workforce shortages, accessing referrals to specialty networks, high demand for services (because of both the recession and the soon-to-be influx of newly Medicaid eligible patients), and limited health information technology systems.

A survey of FQHCs by The Commonwealth Fund found that health centers can provide timely access to on-site care, but many centers face barriers in providing off-site specialty care services, even for patients who have insurance (Doty et al. 2010). Forty percent of centers have electronic medical records, but their capacity for more advanced health information technology, such as electronically ordered prescriptions and tests, patient registries, and tracking patients and tests, is highly variable. The survey also found that although many FQHCs are capable of functioning as patient-centered medical homes, few report capacity in all of the National Committee for Quality Assurance (NCQA) domains (see box). These findings demonstrate that CHCs have the necessary infrastructure in place, but work and resources are required to improve patient outcomes and achieve high performance (Doty et al. 2010).

A 2011 study about the transformation of 36 physician practices into medical homes showed that adopting

NCQA's **Patient-Centered Medical Home 2011** is a set of standards that provides clear and specific criteria, and gives practices information about organizing care around patients, working in teams, and coordinating and tracking care over time. For details, go to www.ncqa.org.

a patient-centered approach improves the quality of care and can rein in health care costs. One of the biggest hurdles, however, is time—the transition to a new model can take years (Nutting 2011).

Another challenge to the proliferation of patient-centered medical care is reimbursement. The ACA encourages state Medicaid programs to develop medical homes for patients with chronic diseases, and more broadly calls on federal and state governments to consider other methods to transform health care delivery,

WHAT IS A MEDICAL HOME?

There are several working definitions of the patient-centered medical home, also referred to as health home or medical home. The most widely endorsed definition was articulated in 2007 (and refined in 2011) by the American Academy for Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association. These physician groups define medical homes as:

Enhanced access to care: The practice offers same-day appointments, expanded hours, and new options for communicating with clinicians (such as e-mail).

Care continuity: Patients see the same personal physician each time they visit.

Practice-based team care: A team of individuals at the practice level, including non-physicians, works together to manage patients' care.

Comprehensive care: The practice provides or arranges for all of a patient's health care needs (such as acute and chronic care, preventive screening, end-of-life care).

Coordinated care: The practice monitors all other care received by their patients (such as from specialists, hospitals, home health agencies, nursing homes).

Population management: The practice proactively reaches out to patients with chronic diseases to make sure symptoms are under control.

Patient self-management: The practice teaches patients techniques to manage their chronic conditions on a day-to-day basis.

Health information technology: The practice generates and exchanges electronic health information to deliver care, measure performance, and communicate with providers and patients.

Evidence-based: Evidence-based best practices and clinical decision support tools guide decisionmaking.

Care plans: The practice strives to help patients reach goals defined in partnership with patients and their families.

Patient-centered care: Care is based on the needs and preferences of patients and their families.

Shared decisionmaking: Patients actively participate in selecting treatment options.

Cultural competency: The practice ensures that information is conveyed to patients in a language and method they understand, taking cultural differences into account.

Quality measurement and improvement: The physician is held accountable for performance.

Patient feedback: The practice solicits feedback from patients to ensure that expectations are being met and to facilitate practice quality improvement.

New payment systems: The practice receives enhanced reimbursement.

Source: Berenson et al. 2011

including strategies such as creating accountable care organizations (ACOs) and bundling episodes of care. ACOs are provider groups that actively manage and coordinate care for their Medicare fee-for-service beneficiaries, and in return are eligible to share in any savings generated by keeping patients healthy (that is, reducing outpatient and inpatient use).

A recent Commonwealth Fund report examines how changes in the financing of FQHCs could support the transformation of these critical safety net providers into high-performing patient-centered medical homes. Recommendations include: establishing standards for patient- and community-centered medical homes that apply to FQHCs, such as offering nonmedical services like behavioral, dental, or enabling services (for example, case management, health education, and translation), and conducting community needs assessments and other prevention-oriented projects. Other recommendations are to structure payment incentives to promote medical homes; include FQHCs in Medicaid health home projects; adapt payment approaches, including adding monthly case management fees; and encourage HRSA to use quality-of-care measures in making funding decisions (Ku 2011).

Despite the challenges, the spread of the patient-centered medical home model across the country is substantial. The Medical Group Management Association (MGMA) released a study in April 2011 that captured the views of 341 primary care and multispecialty practices nationwide. Almost 70 percent of respondents were already in the process of transforming or interested in becoming a patient-centered medical home, while more than 20 percent were accredited or recognized as a patient-centered medical home by a national organization. MGMA's study also found that the majority of practices interested in becoming a patient-centered medical home were family medicine (nearly 36 percent), followed closely by multispecialty practices with primary and specialty care (more than 30 percent), and pediatrics (more than 10 percent).

PARTNERSHIP FOR PATIENTS: BETTER CARE, LOWER COSTS

In April 2011 the Centers for Medicare and Medicaid Services (CMS) launched Partnership for Patients, a public-private partnership aiming to improve the quality, safety, and affordability of health care for all Americans. The partnership brings together leaders of major hospitals, employers, physicians, nurses, and patient advocates along with state and federal governments in a shared effort to make hospital care safer, more reliable, and less costly. The primary goals of this partnership are, by 2013, to:

- reduce by 40 percent the number of preventable hospital-acquired conditions, and
- decrease by 20 percent the number of preventable complications during a transition from one care setting to another.

In December 2011 CMS awarded a Hospital Engagement Contract to the National Public Health and Hospital Institute (the research arm of the National Association of Public Hospitals and Health Systems), as part of the Partnership for Patients initiative. More than 66 public hospitals signed onto the initiative, making it the first national safety net quality collaborative for safety net hospitals. The initiative will provide training, technical assistance, and tracking to support hospitals in the improvement of up to 10 patient safety and readmission measures.

RECENT PHILANTHROPIC ACTIVITIES

There are several ways foundations and corporate giving programs have dedicated their resources to prepare the safety net for health reform implementation and enhance the performance of the safety net system. These activities include establishing and evaluating patient-centered medical home models; building capacity within CHCs; assessing innovative payment models and delivery system reforms; monitoring the impact of health reform on the safety net; and developing new technologies to improve care delivery and reduce costs.

PATIENT-CENTERED MEDICAL CARE

- ***The Safety Net Medical Home Initiative*** – In 2008 The Commonwealth Fund, Qualis Health, and the MacColl Institute for Healthcare Innovation of the Group Health Research Institute initiated the Safety Net Medical Home Initiative (SNMHI) to help safety net primary care clinics "become high-performing patient-centered medical homes" (Coleman and Phillips 2010). The goal of the project is to develop and demonstrate a replicable and sustainable implementation model for medical home transformation (Long and Bailit 2010). The initiative is cosponsored by The Colorado Health Foundation; Jewish Healthcare Foundation; Northwest Healthcare Foundation; The Boston Foundation; Blue Cross Blue Shield of Massachusetts Foundation; Partners Community Benefit Fund; Blue Cross of Idaho; and the Beth Israel Deaconess Medicaid Center.

  SNMHI calls for safety net providers and community stakeholders to work together to develop a new model of primary care. Five regional coordinating centers were selected to participate in the initiative, and each partnered with 12-15 safety net clinics in their respective states. For example, the Pittsburgh Regional Health Initiative is exploring ways to integrate behavioral health services and related patient information into primary care systems in the safety net without violating current patient privacy regulations. All partners in the initiative are expected to participate in Medicaid and other policy reform efforts in their respective regions. The provider-community partnerships will receive technical assistance on enhanced access, care coordination, and improving the patient experience. They will also receive funding to support a medical home facilitator (who will lead clinic-based quality improvement projects). The work of the regional coordinating centers began in April 2009, and the initiative will continue through April 2013.

  The regional coordinating centers include: The Colorado Community Health Network; The Executive Office of Health and Human Services and Massachusetts League of Community Health Centers; The Idaho Primary Care Association; The Oregon Primary Care Association and CareOregon; and the Pittsburgh Regional Health Initiative.

- ***Community Health Center Innovation Fund*** – The Community Clinics Initiative (CCI) began as a collaboration between Tides and The California Endowment in 1999 to provide resources, evidence-based programming, training, and evaluation to build the capacity of CHCs and clinics in California. This year, CCI/Tides and The California Endowment developed the Health Home Innovation Fund to encourage partnerships among safety net institutions to build integrated systems of care. Seven regional efforts received $500,000 over two years and an additional three developmental projects received $200,000 over the same period. Rather than propose a standard definition of "health home," the project has elected to support the definitions and models that are emerging at the local level. Although certification may be a goal for many of the participants, the Health Home Innovation Fund is more concerned with providing flexible funding to attract local resources and with encouraging experimentation with alternative payment models that might sustain these model programs over time. Local Medicaid managed care plans and county organized health systems are key partners in these efforts, often contributing their own funds and in-kind staff time to support the work.

  With funding from the Blue Shield of California Foundation, CCI/Tides recently announced the

Community Health Center Innovation Challenge. California clinics have been encouraged to apply for grants of $35,000 for one year to support innovative programs consonant with the Institute for Health Care Improvement (IHI) Triple Aim objectives of improving the health of the population, enhancing the patient's care experience, and controlling costs (IHI 2012). As many as 22 clinics are expected to receive funding under this program, and IHI staff will help provide technical assistance in the form of webinars and in-person gatherings to strengthen the implementation of the innovations and promote the development of a statewide learning community.

- ***Patient-Centered Medical Home Initiative: Missouri Foundation for Health*** – Developing patient-centered medical homes in Missouri was one of the 2011 strategic goals of the Missouri Foundation for Health (MFH). The foundation started the process by convening the Missouri Medical Home Collaborative Council, which includes representatives from the payer, provider, employer, and consumer communities. The foundation was successful in bringing Medicaid to the table, making the collaborative truly multipayer (Barker 2011). MFH hired consultants to assist the state in crafting a plan amendment for the Section 2703 Waiver. Section 2703 of the ACA, the State Option to Provide Health Homes for Enrollees with Chronic Conditions, allows states to apply for a State Plan Amendment to obtain, if approved by the Centers for Medicare and Medicaid Services, 90 percent federal Medicaid matching funds for eight consecutive quarters to reimburse health home services. Services covered include comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; support for patients, their families, and their authorized representatives; referral to community and social support services when needed; and the use of health information technology to link services, as feasible and appropriate.

  In February 2011 the council developed a framework for a patient-centered medical home collaborative and in July 2011 invited proposals from primary care practices and other health care professionals. These clinical settings are expected to redesign their care delivery approaches by, for example, creating internal practice teams that meet regularly to discuss patient care, implementing patient registries, implementing care coordination services, and obtaining National Committee for Quality Assurance recognition (MFH 2011). Selected practices will also participate in a learning collaborative, which will provide technical assistance to primary care practices, and an evaluation of the collaborative's success in improving health care quality and containing costs.

MONITORING AND EVALUATING THE HEALTH CARE SAFETY NET: PREPARING FOR THE FUTURE

Given the tremendous changes facing the safety net system, monitoring its changing structure, capacity, and financial stability on a continuing basis is crucial. The Institute of Medicine has recommended that there be an effort to improve the nation's "capacity and ability to monitor the changing structure, capacity, and financial stability of the safety net" (Blewett and Beebe 2004). Monitoring is somewhat problematic given both the absence of a precise definition of what constitutes the safety net and the complexity of the funding streams that support it (Blewett and Beebe 2004). Nevertheless, foundations are supporting several efforts to evaluate the performance and structure of the safety net in the context of health reform.

- ***National Workgroup*** – In May 2011 the National Academy for State Health Policy (NASHP), with support from The Commonwealth Fund, established the National Workgroup on Integrating the Safety Net into Health Care Reform Implementation. The overarching goal of the workgroup is to inform state and federal policymakers on how actions to expand coverage may affect the health care safety net, and to help the safety net "survive and thrive as part of a new system" (Grossman 2011). The workgroup has broad representation, including national membership organizations (National Association of Public Hospitals and Health Systems, National Association of Community Health Centers, Association of State and Territorial Health Officials, and National Association of Rural Health Care), the Centers for Medicare and Medicaid Services, Health Resources and Services Administration, and leadership from medical centers across the country (Grossman 2011).

The workgroup identified a number of key issues and priorities for policymakers to consider in order to integrate the safety net into a reformed health care landscape, including:

- how safety net providers will fit into new models of care, such as ACOs;
- safety net providers' roles in the state health insurance exchanges' Qualified Health Plans;
- the role that safety net providers will play in outreach and enrollment for their patients and other vulnerable populations;
- what the federal essential benefits package will be for vulnerable populations and the safety net;
- workforce capacity to meet the increased demand for care;
- reporting and measurement requirements for safety net providers, as well as across the health care delivery system;
- collaboration among state and community agencies to ensure full integration of services (including public health, oral health, social services);
- integration among primary care, mental health, and specialty care providers to accommodate the complex comorbidities of safety net systems users;
- how safety net providers will serve as patient-centered medical homes and how reimbursement will work within medical home models; and
- adequate safety net funding and developing appropriate strategies to maintain access to care for the remaining uninsured.

Looking ahead, the workgroup will concentrate on issues where "forging possible paths forward is promising," including developing integrated delivery system models, optimizing the workforce, and developing financing options for the safety net (Grossman 2011).

CALIFORNIA'S BRIDGE TO REFORM

On November 2, 2010, the Centers for Medicare and Medicaid Services approved California's Section 1115 waiver entitled "Bridge to Reform." The $10 billion waiver will support the state's preparation for and transition to the requirements of the ACA. Among other things, the waiver expands coverage to 500,000 low-income uninsured adults not currently eligible for Medicaid. It also expands the Safety Net Care Pool, providing additional support to both safety net hospitals and other services that are paid for through the pool; improves care coordination for vulnerable populations by automatically enrolling seniors and persons with disabilities into managed care; tests four health care delivery models for improving care coordination for children with special health care needs; and promotes public hospital delivery system transformation (California Department of Health Care Services 2011). While there is no specific evaluation component as part of the Section 1115 waiver, the University of California, Los Angeles will monitor coverage expansion, evaluate delivery models for children with special health care needs, and examine the effect on emergency department usage of the expansion of coverage for low-income adults.

➤ ***A State Monitoring Effort*** – Long recognizing the importance of Colorado's safety net, The Colorado Health Foundation provided a grant to the Colorado Health Institute (CHI) in 2005 to establish a Safety Net Indicators and Monitoring System (SNIMS) for the state. The goal of SNIMS is to inform communities, health care providers, foundations, advocates, and state policymakers about the nature and changing dynamics of the state's health care safety net. Specific objectives include describing and monitoring the characteristics of current and future safety net users—particularly as health reform rolls out—and understanding the financial viability of safety net providers and the workforce challenges they face (CHI 2009).

In 2009 CHI released its first SNIMS report, looking at measures such as types of providers in the state, user demographics, workforce characteristics, funding sources, and estimates of unmet need. CHI continues to monitor various aspects of the safety net, including the reach of school-based health centers, hospital emergency department use, and health insurance coverage. In March 2011 CHI, with support from Kaiser Permanente Colorado, released a study documenting how difficult it can be for Coloradoans within the safety net to utilize specialty care services.

Since 2006 CHI has convened the Safety Net Advisory Committee (SNAC) to provide guidance on CHIs safety net monitoring activities, and to serve as a forum for discussion of policy issues pertinent to Colorado's safety net. SNAC members include foundations, advocacy organizations (representing consumers; hospitals; the primary care association; and, mental health, oral health, non-FQHCs, FQHCs, and rural providers), state agencies, and payers. CHI's mission is to provide credible and objective health care information to inform sound policy decisions. To that end, CHI serves an important function as a neutral convener and facilitator of discussions on health-related issues that can be somewhat contentious among the diverse safety net stakeholders. On topics such as the health insurance exchange, the role of the health care safety net, and the needs for the primary care workforce, for example, CHI identifies policy options, analyzes their implications, and helps move the discussion forward (Bontrager 2011).

➤ ***Asking Patients What They Want*** – In California, it is estimated that as many as 1.7 million additional low-income state residents will enroll in Medi-Cal (the state's Medicaid program) in 2014, with another 4 million individuals expected to obtain health insurance through the newly created Health Benefits Exchange (Langer Research Associates 2011). While the federal government continues to develop and update major policies, and states work to incorporate this guidance into their programs, little is known about the expectations of the intended beneficiaries of these reforms.

Blue Shield of California Foundation commissioned Langer Research Associates to ask current users of the California safety net system about their experiences and future expectations of health reform. This project grew out of the foundation's long history of support for California's community health clinics through its Community Clinic Core Support Initiative and the Clinic Leadership Institute. The research takes a new direction for the foundation, "one that reflects the precepts of the movement toward 'patient-centered care' by rigorously measuring the attitudes, experiences, expectations, and desires of key users of California's CHCs" (Langer Research Associates 2011).

Langer Research Associates conducted a statewide survey of 1,000 low-income adults earning less than 200 percent of the federal poverty level about their current health care experiences and their preferences for future care. Findings showed that the majority of respondents were dissatisfied with their current care and, given the option, would seek care elsewhere (Langer Research Associates 2011).

Other results showed that:

- Forty-four percent of low-income Californians currently had no choice of care providers, and about as many lacked a regular personal doctor.
- Forty-eight percent rated their care as excellent or very good, with lower levels of satisfaction fueling desire for change.
- The strongest predictors of interest in changing facilities included the desire to have a regular personal doctor, wanting to have a choice of facilities, and concern about the current facility's quality-of-care rating.
- When considering a new place for care, prospective patients made decisions based on factors such as cost, being able to see the same doctor, convenience, and the availability of continuing care services.

The foundation also examined on-line comments about community health clinics and health centers. This analysis demonstrated the importance of the internet—particularly as consumers increasingly turn to it for health care information—and how community clinics can use it as a tool to improve performance. *California's Community Clinic and Health Centers: The Online Conversation* looked at over 1,250 com-

ments that were posted on review websites such as Yelp, Emily's List, and Yahoo Local. Roughly one-third of the comments were patient reviews, and the remaining comments were promotional or informational material posted by the health centers.

The comments revealed that three factors were most important in patients' satisfaction with a clinic:

- respect and courtesy of clinic staff;
- that the clinic offered high-quality and efficient service; and
- the perception that the clinic not only provided good individual care, but also was involved in the overall health and well-being of the community (for example, supporting community gardens and farmers markets, or sponsoring health fairs).

Patient reviews were distilled into word clouds based on actual on-line comments, with the size of each word in the word cloud being proportional to the frequency with which it occurred in the comments (see Figure 3).

From this analysis, the foundation concluded that the Web is a tool that safety net providers can use to monitor patient satisfaction and make accommodations to their facilities accordingly. Safety net providers can also use the Web as a vehicle for being more connected with their communities. As more patients have access to care through expanded coverage, it will be important for clinics to be aware of these opportunities.

FIGURE 3

RESPECT: GOOD SERVICE

RESPECT: BAD SERVICE

Source: adapted from Echeverria 2011

HEALTH INFORMATION TECHNOLOGY

The promise of health information technology (HIT)—especially electronic health records (EHRs)—is that it can improve the quality, safety, and efficiency of health care delivery (Shields et al. 2011). HIT, including patient registries, can potentially reduce health disparities by improving the delivery of primary care services, patient tracking, and care management; creating linkages between the traditional realms of health and social services; and helping safety net providers develop a better understanding of the population health needs of their communities (HHS 2011b).

The level of HIT penetration within the health care safety net is modest but increasing as technology becomes more established (GIH 2008). Between 2000 and 2006, the number of health centers and clinics that had or were planning to implement EHRs jumped from 12 percent to 50 percent (Shields et al. 2011). Safety net providers face many challenges incorporating technology into their practices, including the high

cost of hardware and software; the need to customize off-the-shelf software products to reflect the health center's patient population; restricted budgets; and limited knowledge among staff about hardware and software options, as well as the inability of some safety net providers to maintain their software systems (Shields et al. 2011).

Foundations can support safety net providers with the adoption of HIT in several unique ways, including providing funds for capital investment; providing ongoing technical support and HIT maintenance; and convening safety net providers, local or state health department representatives, and even vendors together to lay the groundwork for interoperable information exchange across clinical sites (GIH 2008).

- ***Infrastructure Support*** – The California HealthCare Foundation recently launched Small Practice eDesign, a two-year, $1.5 million initiative to develop a prototype infrastructure and tools that support the adoption, integration, and meaningful use of EHRs in small practices (CHCF 2011b). The project developed, tested, and refined a model to support EHR implementation in 14 primary care practices in Tulare County, one of the poorest counties in the nation and a federally designated primary care shortage area. The effort combined Web-hosted software, centralized implementation, and technical support with the medical practices working through a local trusted intermediary, the Foundation for Medical Care of Tulare and Kings Counties. Small practices that participated in the initial pilot received subsidies from the foundation to purchase software and test the curriculum. The software combined practice billing and revenue management with an EHR and a patient portal. The initiative is now working with other communities to replicate these approaches and develop sustainable delivery and business models (CHCF 2011b).

  The Maine Health Access Foundation (MeHAF) sees HIT tools as a way of "dramatically improving health in Maine, particularly for [its] most vulnerable residents" (MeHAF 2006). MeHAF has invested significant resources over the last several years to improve the diffusion of HIT throughout the state, specifically through the statewide implementation of electronic medical records (EMRs). In March 2011 MeHAF sought to broaden the reach of EMRs by incorporating behavioral health information into HealthInfoNet, a statewide health information exchange used by hospitals and primary care providers. MeHAF provided support to convene state policy leaders, consumers, and technology experts to address the challenges in adopting EMRs in behavioral health settings. The goal of the meetings is to accelerate the sharing of clinical information among behavioral health providers and with primary care providers, and to develop strategies related to staff education; consumer engagement; clinical information and integration; and legal, policy, and financial barriers (MeHAF 2011).

FEDERAL SUPPORT

In September 2011 the Health Resources and Services Administration, the U.S. Department of Health and Human Services, and the Office of the National Coordinator jointly announced $8.5 million in awards to 85 health centers to improve quality of care and electronic reporting capabilities. The funds, awarded to 15 so-called Beacon Communities throughout the country, are intended to help these CHCs build and strengthen their HIT infrastructure and exchange capabilities to improve care coordination, increase the quality of care, and slow the growth of health care spending (HHS 2011c).

INVESTING DIFFERENTLY

In the last decade, foundations have increasingly used impact investing to leverage their resources to the fullest extent to help shape and accelerate their organizational missions (GIH 2011). Broadly defined, impact investing is a strategy whereby an investor places capital in businesses that can generate financial returns, as well as achieve an intentional social and/or environmental goal. Impact investing is characterized as an "emerging hybrid of philanthropy and private equity." These investments generally provide social or environmental impact at a scale that purely philanthropic interventions cannot achieve (Monitor Institute

2009). A number of foundations are employing impact investment strategies to support and improve the safety net.

- ***Innovation Funds*** – Recently The Kresge Foundation launched the Community Health Hub Investment Initiative, to equip CHCs with adequate capital resources to undertake expansion while continuing to provide high-quality, community-based primary and preventive care (The Kresge Foundation 2011). Funds offered through the initiative support FQHCs that are advancing new methods for reaching vulnerable populations, including better management of risk factors and disease.

  The initiative uses an investment strategy that couples grantmaking with below-market-rate loans, loan guarantees, and other alternative financing tools to spur the growth and sustainability of CHCs. The strategy has four dimensions: provide technical support to lenders so that they can better understand how to underwrite CHCs; provide technical assistance to FQHCs to facilitate capital expansion projects using debt financing techniques; develop policies that will attract other sources of private sector investment; and develop metrics to track the performance of these investments.

  Another innovation fund has been launched by the California HealthCare Foundation, which is looking to entrepreneurs and corporations to develop products and systems that have the potential to improve access to care and decrease costs for the underserved. Through its Innovation Fund, the foundation plans to invest approximately $10 million over three years in up to eight organizations that are developing applications, care protocols, and technologies. These innovations must hold the promise to transform the way health care is organized and delivered within the safety net system, with an eye toward lowering health care system costs and improving access for the underserved (CHCF 2011b). Funded projects include Sirum, a technology-based social venture that redirects usable surplus drugs to those in need; Asthmapolis, which uses global positioning system (GPS) sensors and mobile application devices to help patients map and track asthma symptoms, triggers, and inhaler usage; and Direct Dermatology, a telemedicine group that provides remote dermatology consultation to expand access and reduce specialty care costs.

  Through these and other grants, the foundation has successfully exposed safety net providers and users to innovative financing and technology ideas, and has been able to further develop products and strategies for the benefit of those providers, from the perspective of both price and features.

FUNDER OPPORTUNITIES

The ACA presents an opportunity to make significant improvements to the health care system through incentives that focus on patient-centered care, on reinforcing and building the capacity of CHCs, and on directing dollars to preventive care. There clearly are roles funders can play to help safety net providers take advantage of these opportunities.

BUILDING BRIDGES

While many safety net systems work well together to provide integrated care for patients, in some communities tensions exist among various safety net providers. Funders can create neutral forums for safety net systems, hospitals, CHCs, and free clinics to come together to find common ground in delivering patient-centered care. In order to achieve the vision of fully integrated care that the ACA embodies, this convergence will need to occur.

RESEARCH/DATA COLLECTION

Already, philanthropy vigorously supports qualitative and quantitative research on many aspects of the safety net, including payment reform, the impact of federal and state regulatory and policy decisions, financial sustainability, and promulgating best practices of care. As health reform unfolds, it will be important to monitor and evaluate the numerous changes that occur. Are new systems of care working? How are the state health insurance exchanges functioning? How do the remaining uninsured access care? Are hospitals adequately financed? Does the change in insurance coverage for low-income populations offer new opportunities for safety net? What features of the patient-centered medical home work best in safety net settings? These are some of the many questions that will require exploration and will benefit from funder support.

There is also a role for philanthropy to help safety net systems improve the quality of the data used to assess their performance and capacity. Despite the proliferation of electronic health records and data repositories, safety net hospitals, CHCs, and other safety net providers often do not collect data in a standardized way. Philanthropy can help communities establish uniform reporting systems to better understand the health needs of safety net users, assess the quality of care individuals are receiving, and remain cognizant of who remains ineligible for health care coverage.

TRAINING AND FOSTERING THE NEXT GENERATION

Without effective leadership, safety net systems may not make it through what is perhaps both the most critical and the most promising transformation they have ever experienced. Philanthropy can help train and prepare the next generation of safety net system leaders, pave the way for the full range of health care providers to have a role in integrated models of care, and support all levels of the workforce in navigating these uncharted waters.

UNDERSTANDING THE PATIENT EXPERIENCE

As health reform becomes a reality, many more people with health insurance, including Medicaid beneficiaries, will flow into CHCs and other safety net settings. As this happens, safety net providers may want to enhance their practices and position themselves as providers of choice. Developing an understanding of patient satisfaction and preferences will be essential. With the support of foundations, safety net providers can use Web-based tools and research to truly appreciate the patient experience and hone the “the perfect practice.”

BUILDING ON SUCCESSFUL MODELS

Despite the challenges they face, safety net providers have much to offer the broader health care system, particularly as it tries to adapt to changes stimulated by the ACA and broader calls for system reform. For

years, safety net clinics have been doing more with less, and there are many opportunities to export their models of care and care coordination to the broader community. To achieve this goal, safety net providers need to be better able to collect data, rigorously research best practices, and continuously monitor patient outcomes and preferences. It is possible that the safety net could become a model for broader system reform, and that safety net providers could become "providers of choice." Philanthropy can help disseminate promising practices both within the safety net system and to the wider health care community.

BLUE SHIELD OF CALIFORNIA FOUNDATION: LEADERSHIP TRAINING PROGRAMS

The Clinic Leadership Institute (CLI) prepares emerging leaders of California community clinics and health centers to be effective agents of change in an evolving health care environment. Participants go through an 18-month, part-time program to build their skills in areas such as decisionmaking, financial management, and strategic planning. The program provides participants with career planning, seminars, professional coaching, and peer networking experiences. The institute's program and course content are administered by the Center for the Health Professions at University of California, San Francisco, a nationally recognized resource on the health workforce, organizational change, and leadership development and training.

In December 2011 the Board of Trustees of the Blue Shield of California Foundation approved a new program focused on the training of executive teams of community clinics and health centers. The new program, to be run by University of California, Los Angeles' Anderson School of Management, will train CHC executives to improve their understanding of performance measurement and data management

REFERENCES

Abrams, Melinda, The Commonwealth Fund, remarks at the Grantmakers In Health Issue Dialogue, *Safety Net in the Era of Health Reform: A New Vision of Care*, Washington, DC, November 3, 2011.

Barker, Ryan, Missouri Foundation for Health, remarks at the Grantmakers In Health Issue Dialogue, *Safety Net in the Era of Health Reform: A New Vision of Care*, Washington, DC, November 3, 2011.

Beal, Anne C., Michelle M. Doty, Susan E. Hernandez, et al., *Closing the Divide: How Medical Homes Promote Equity in Health Care* (New York, NY: The Commonwealth Fund, June 2007).

Berenson, Robert A., Kelly J. Devers, and Rachel Burton, *Will Patient-Centered Medical Homes Transform the Delivery of Health Care?* (Washington, DC: Urban Institute, August 2011).

Blewett, Lynn A., and Timothy J. Beebe, "State Efforts to Measure the Health Care Safety Net," *Public Health Reports* 119:125-135, March/April 2004.

Bontrager, Jeff, Colorado Health Institute, remarks at the Grantmakers In Health Issue Dialogue, *Safety Net in the Era of Health Reform: A New Vision of Care*, Washington, DC, November 3, 2011.

Buettgens, Matthew, and Mark A. Hall, *Who Will Be Uninsured after Health Insurance Reform?* (Washington, DC: Urban Institute, September 2011).

California Department of Health Care Services, *California Bridge to Reform: A Section 1115 Waiver Fact Sheet*, <http://www.dredf.org/healthcare/20100610-A_Bridge_to_Reform_6-10-2010.pdf>, accessed December 2011.

California Health Care Foundation (CHCF), *Better and Faster: How Safety-Net Providers Are Redesigning Care*, <http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BetterFaster SafetyNetProvidersRedesigningCare.pdf>, January 2011a.

California Health Care Foundation (CHCF), "Small Practice eDesign," <http://www.chcf.org/projects/2009/small-practice-edesign#ixzz1Yb8m2RC6>, accessed September 2011b.

Centers for Medicare and Medicaid Services (CMS), *Critical Access Hospital Fact Sheet* (Baltimore, MD: September 2010).

Coleman, Katie, and Kathryn Phillips, *Providing Underserved Patients with Medicaid Homes: Assessing the Readiness of Safety Net Health Centers* (New York, NY: The Commonwealth Fund, May 2010).

Colorado Health Institute (CHI), *Primer: Colorado's Health Care Safety Net* (Denver, CO: August 2011).

Colorado Health Institute (CHI), *The State of Colorado's Health Care Safety Net: Safety Net Indicators and Monitoring System (SNIMS) 2009 Progress Report* (Denver, CO: May 2009).

Congressional Budget Office (CBO), "Health Care: Estimates for March 2010 Health Care Legislation," <http://www.cbo.gov/publications/collections/health.cfm>, accessed September 2011.

Darnell, Julie S., "Free Clinics in the United States," *Archives of Internal Medicine* 170(11):946-953, June 2010.

David, Tom, and Jane Stafford, "New Challenges for Community Health Clinics," *Yes Magazine*, <http://www.yesmagazine.org/people-power/new-challenges-for-community-clinics>, May 4, 2010.

DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith, "Income, Poverty and Health Insurance Coverage in the United States in 2010," *U.S. Census Bureau, Current Population Reports* (Washington, DC: U.S. Census Bureau, 2011).

Direct Relief International, *The State of the Safety Net: A Snapshot of America's Nonprofit Community Clinics, Free Clinics, and Community Clinics* (Santa Barbara, CA: 2011).

Doty, Michelle M., Melinda K. Abrams, Susan E. Hernandez, et al., *Enhancing the Capacity of Community Health Centers to Achieve High Performance: Findings from the 2009 Commonwealth Fund National Survey of Federally Qualified Health Centers* (New York, NY: The Commonwealth Fund, May 2010).

Echeverria, Cecilia, Blue Shield of California Foundation, "Consumer Perspectives on the Healthcare Safety Net," presentation at the Grantmakers In Health Issue Dialogue *Safety Net in the Era of Health Reform: A New Vision of Care,* Washington, DC, November 3, 2011.

Eslan, Alexia, and Callie Preheim, *Better and Faster How Safety-Net Providers Are Redesigning Care* (Oakland, CA: California Health Care Foundation, January 2011).

Galewitz, Phil, "Local Health Centers Hit by Deficit Cuts," *The Washington Post*, <http://www.washingtonpost.com/national/health-science/community-health-centers-hit-hard-by-washington-deficit-cuts/2011/09/23/gIQA9l0DPL_story.html>, October 6, 2011.

Grantmakers In Health (GIH), *Guide to Impact Investing* (Washington, DC: 2011).

Grantmakers In Health (GIH), "Health Information Technology: Increasing Quality and Access within Safety Net Providers," Issue Focus, *GIH Bulletin* (Washington, DC: May 5, 2008).

Grossman, Laura, Katharine Witgert, and Catherine Hess, *Toward Meeting the Needs of Vulnerable Populations: Issues for Policymakers' Consideration in Integrating a Safety Net into Health Care Reform Implementation* (Washington, DC: National Academy for State Health Policy, November 2011).

Hart, Andrew, *Medicaid, CHIP and the Health Care Safety Net* (Waltham, MA: Brandeis University, The Heller School for Social Policy and Management, July 2010).

Health Resources and Services Administration (HRSA), Bureau of Primary Health Care, "What Is a Health Center?", <http://bphc.hrsa.gov/about/whatishealthcenter/index.html>, accessed September 2011a.

Health Resources and Services Administration (HRSA), "Shortage Designation: HPSAs, MUAs, and MUPs," <http://bhpr.hrsa.gov/shortage/>, accessed September 2011b.

Hing, Esther, and Roderick Hooker, *Community Health Centers: Providers, Patients, and Content of Care*, National Center for Health Statistics Data Brief, 65 (Hyattsville, MD: July 2011).

Hoffman, Catherine, and Susan Starr Sered, *Threadbare: Holes in America's Health Care Safety Net* (Washington, DC: The Henry J. Kaiser Family Foundation, May 2005).

Holahan, John, and Garrett Bowen, *The Cost of Uncompensated Care with and without Health Reform* (Washington, DC: Urban Institute, March 2010).

Institute for Healthcare Improvement (IHI), "The IHI Triple Aim," <http://www.ihi.org/offerings/initiatives/tripleaim/pages/default.aspx>, accessed January 2012.

Institute of Medicine (IOM), *America's Health Care Safety Net: Intact but Endangered* (Washington DC: The National Academies Press, 2000).

Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer, Key Facts about Americans without Health Insurance* (Washington, DC: The Henry J. Kaiser Family Foundation, October 2011a).

Kaiser Commission on Medicaid and the Uninsured, *Ensuring Access to Care in Medicaid under Health Reform* (Washington, DC: The Henry J. Kaiser Family Foundation, May 2011b).

Katz, Mitchell, "Future of the Safety Net under Health Reform," *The New England Journal of Medicine* 304(6):679-680, August 2010.

Ku, Leighton, Center for Health Policy Research, The George Washington University, "The Safety Net Landscape: An Evolving World," presentation at the Grantmakers In Health Issue Dialogue *Safety Net in the Era of Health Reform: A New Vision of Care,* Washington, DC, November 3, 2011.

Ku, Leighton, Emily Jones, Peter Shin, et al., "Safety-Net Providers after Health Care Reform: Lessons from Massachusetts," *Archives of Internal Medicine* 171(15):1379-1384, August 2011b.

Ku, Leighton, Peter Shin, Emily Jones, et al., *Transforming Community Health Centers into Patient-Centered Medical Homes: The Role of Payment Reform* (New York, NY: The Commonwealth Fund, September 2011a).

The Kresge Foundation, "Health and Caring Communities," <http://www.kresge.org/programs/health/caring-communities>, accessed August 2011.

Langer Research Associates, *On the Cusp: The Healthcare Preferences of Low-income Californians* (San Francisco, CA: Blue Shield of California Foundation, June 2011).

Long, A., and M. Bailit, *Health Reform and the Patient-Centered Medical Home: Policy Provisions and Expectations of the Patient Protection and Affordable Care Act* (Seattle, WA: Qualis Health and Bailit Health Purchasing, October 2010).

Maine Health Access Foundation (MeHAF), *Innovative Statewide Health Information Project Receives $1 Million Challenge Grant and New Leadership*, press release (Augusta, ME: May 2006).

Maine Health Access Foundation (MeHAF), "Fast Tracking Behavioral Health Information Sharing," *Access Points eNewsletter*, <http://www.mehaf.org/media/docs/resources/2011/07/05/Access_Points_June_2011.pdf>, June 2011.

Medical Group Management Association (MGMA), "MGMA Study Finds Many Practices Are Interested in Becoming a Patient-Centered Medical Home," <http://www.mgma.com/press/default.aspx?id=1366853>, July 19, 2011.

Missouri Foundation for Health (MFH), "Patient-Centered Medical Home Request for Proposals," <http://www.mffh.org/content/516/patient-centered-medical-home.aspx>, accessed September 2011.

Monitor Institute, *Investing for Social and Environmental Impact: A Design for Catalyzing and Emerging Industry* (Cambridge, MA: January 2009).

National Association of Community Health Centers (NACHC), *A Sketch of Community Health Centers: Chart Book 2009,* <http://www.nachc.com/client/documents/Chartbook%20FINAL%202009.pdf>, May 2009.

National Association of Community Health Centers (NACHC), *NACHC Statement on House Labor-HHS Appropriations*, press release (Washington, DC: October 3, 2011).

National Association of Free and Charitable Clinics, "What is a Free Clinic?", <http://www.nafcclinics.org/about-us/what-free-clinic>, accessed December 2011.

Nutting, P.A., B.F. Crabtree, W.L. Miller, et al., "Transforming Physician Practices to Patient-Centered Medical Homes: Lessons from the National Demonstration Project," *Health Affairs* 30(3):439-4545, March 2011.

Patient Center Primary Care Collaborative, "Patient-Centered Medical Home," <http://www.pcpcc.net/patient-centered-medical-home>, accessed August 2011.

Porterfield, Elaine, "What's up in the Doctor's Office?", *Northwest Health*, <https://www.ghc.org/features/feature.jhtml?reposid=%2fcommon%2ffeatures%2fstory%2f20101001-medicalhome.jhtml>, Fall 2010.

Prevention Institute, "Federal Prevention and Community Health Initiatives," <http://www.preventioninsti-

tute.org/focus-areas/reforming-our-health-system/projects/591-federal-prevention-and-community-health-initiatives.html>, accessed August 2011.

Raymond, Alan J., *Lessons from the Implementation of Massachusetts Health Reform* (Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation, March 2011).

Redlener, Irwin, and Roy Grant, "America's Safety Net and Health Care Reform: What Lies Ahead?" *The New England Journal of Medicine* 361(23):1178, December 2009.

Regenstein, Marsha, and Jennifer Huang, *Stresses to the Safety Net: The Public Hospital Perspective* (Washington, DC: The Henry J. Kaiser Family Foundation, June 2005).

Rosenbaum, Sara, Brad Finnegan, and Peter Shin, *Community Health Centers in an Era of Health System Reform and Economic Downturn: Prospects and Challenges* (Washington, DC: The Henry J. Kaiser Family Foundation, March 2009).

Shields, Alexandra E., Peter Shin, Michael G. Leu, et al., "Adoption of Health Information Technology in Community Health Centers: Results of a National Survey," *Health Affairs* 26(5):1373-1383, September 2011.

Siegel, Bruce, National Association of Public Hospitals and Health Systems, remarks at the Grantmakers In Health Issue Dialogue, *Safety Net in the Era of Health Reform: A New Vision of Care,* Washington, DC, November 3, 2011.

Slichta, Amber, Community Health Foundation of Western and Central New York, remarks at the Grantmakers In Health Issue Dialogue, *Safety Net in the Era of Reform: A New Vision of Care*, Washington, DC, November 3, 2011.

Summer, Laura, *The Impact of the Affordable Care Act on the Safety Net*, Academy Health Meeting Proceedings (Washington, DC: April 2011).

U.S. Department of Health and Human Services (HHS), "Community Health Centers and the Affordable Care Act: Increasing Access to Affordable, Cost Effective, High Quality Care," <http://www.healthcare.gov/news/factsheets/2010/08/increasing-access.html>, accessed August 2011a.

U.S. Department of Health and Human Services (HHS), *HHS Action Plan to Reduce Racial and Ethnic Disparities: A Nation Free of Disparities and Health and Health Care*, <http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf>, 2011b.

U.S. Department of Health and Human Services (HHS), *HHS Awards Affordable Care Act Funds to Improve Quality of Care and Electronic Reporting Capabilities in Beacon Communities*, press release (Rockville, MD: September 12, 2011c).

Zuckerman, Stephen, Timothy Waidman, and Emily Lawton, "Undocumented Immigrants, Left Out of Health Reform, Likely to Continue to Grow as Share of the Uninsured," *Health Affairs* 30(10):1997-2004, October 2011.