SHORING UP THE Safety Net:

Grantmakers Act to Strengthen Providers Serving the Underserved

Much of the debate on improving health care access has focused on how to expand insurance coverage. While significant progress has been made in expanding public coverage for children, the economic downturn, state budget crises, and political stalemate in Washington suggest that, at least in the short term, universal coverage will be more of a rallying cry than a reality. As advocates continue to pressure local, state, and federal decisionmakers for coverage expansions, attention is also being focused on how to strengthen the safety net – the fragmented and fragile system of care that now serves the underserved.

The term "safety net" is misleading because there is no fail-safe system to catch those with no other source of medical care. Rather, it is used to refer to a collection of institutional and individual providers who happen to take care of the poor and underserved. The Institute of Medicine (IOM) has defined safety net providers as those that "organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients." The IOM further distinguishes what it terms "core safety net providers" as those that maintain open-door policies (that is, a commitment to serve all patients regardless of their ability to pay) and serve a substantial share of their community's uninsured, Medicaid, and otherwise vulnerable populations (IOM 2000). In many communities, these providers include public hospital systems; local health departments; and federal, state, and community-supported clinics. In some localities, academic medical centers are an important component of the safety net; in others, private practitioners play a more prominent role.

Despite local variation in their composition, local safety nets tend to have some commonalities. Growing competition in the health care marketplace has resulted in both a smaller subset of institutions willing to take on care of the underserved and less ability on the part of those remaining to cross-subsidize services from other revenue sources (Bovbjerg et al. 2000). In addition, the heavy reliance of providers on Medicaid dollars makes these institutions vulnerable when state funds are tight. For example, in 2001, over one-third of health center operating revenues came from Medicaid (Rosenbaum and Shin 2003).

HOW DO YOU DEFINE STRESS?

- In 2000, almost half of public hospitals belonging to the National Association of Public Hospitals and Health Systems experienced negative margins, as compared with less than one-third with negative margins five years previously. The average margin was -1.0 percent (Singer 2002).
- Between 1990 and 2001, the number of uninsured Americans grew by 19 percent. The number of uninsured persons served by health centers grew by 82 percent (Rosenbaum and Shin 2003).

WHAT GRANTMAKERS CAN DO

Health grantmakers are working to shore up the safety net in various ways. Virtually every health funder working at the state and local level provides funding for direct services. Others provide funding for capital equipment or construction and renovation of facilities.

➤ **Strengthening organizational capacity**. Many safety-net organizations are consumed by the day-to-day stress of serving vulnerable populations and lack the resources that other organizations invest in infrastructure and planning. Health funders are providing critical support to help hospitals and clinics improve efficiency, engage in strategic planning, and invest in systems to manage patient flow, track clinical indicators, and monitor and analyze financial data. For example, in May 2003, the first grants were made under *UrgentMatters*, a $4.6 million initiative of The Robert Wood Johnson Foundation to help hospitals eliminate crowding in their emergency departments. The initiative has three goals: helping safety net hospitals respond to demand for emergency department services, analyzing the state of local safety nets in select communities, and making the program's findings accessible to local and national audiences. In the first round of grants, 10 hospitals were selected to receive funding up to $125,000 through a collaborative learning network designed to streamline emergency department procedures and reduce overcrowding. Four of these hospitals received an additional $250,000 for demonstration projects. Local health foundations are formal partners with two grantees: St. Luke's Health Initiatives with St. Joseph's Hospital and Medical Center in Phoenix, Arizona, and the Community Health Endowment of Lincoln with BryanLGH Medical Center in Lincoln, Nebraska.

The California Endowment and The California Wellness Foundation have made major investments to strengthen the capacity of their state's community clinics, but their strategies have different emphases. The *Community Clinics Initiative*, funded by The California Endowment and operated by the Tides Foundation, began in 1999 as an effort to help both

individual clinics and collaboratives of clinics make technological changes in anticipation of the year 2000. Since then, it has grown into a multimillion dollar long-term effort to strengthen the internal systems of community clinics, bringing as many as possible up to a minimum level of technical capacity, as well as supporting connectivity both internally and across clinic sites. Most recently, the initiative has partnered with an e-health firm to develop a software certification process to encourage developers to create products that best meet clinic needs and that offer strong technical support.

Over the past seven years, The California Wellness Foundation has provided more than $20 million in general operating support grants to 14 clinic consortia, which then pass along 50 percent of each grant to member clinics. These funds may be used to support existing services, but about 65 percent of the grantees have used the funds to strengthen their infrastructure. Examples include developing business plans and hiring development staff or consultants to assist with applications for federal, state, and private grants (Holton 2003).

The New York Community Trust has been working with community health centers to help them cope with the data requirements associated with Medicaid managed care. Since the late 1990s, this community foundation has been funding the Primary Care Development Corporation to help health centers track different aspects of patient encounters and associated financial data. These data are then compared to industry norms to inform decisions about scheduling and staff work assignments that are cost effective in a capitated payment environment.

- **Supporting community-based health plans**. Another area of activity is supporting community-based health plans that bring together local providers to offer a core set of health benefits. Although these programs vary across communities, they typically provide a medical home and some form of case management, offer incentives for providers to serve the underserved, and act to promote the dignity of enrollees (Silow-Carroll et al. 2001). Several grantees under the W.K. Kellogg Foundation's *Community Voices* initiative are pursuing this approach. For example, in Albuquerque, the University of New Mexico Health Sciences Center created the UNM Care Plan. Pooling county indigent care funds with other local resources, the plan links uninsured enrollees with private providers in neighborhood clinics. The Ingham Health Plan provides a defined set of outpatient services to uninsured residents in Ingham County, Michigan, including connection to a regular source of primary care and referrals for specialty and diagnostic services (Silow-Carroll et al. 2001).

  Other funders are supporting integration of services across safety net sites. For example, the Blue Cross Blue Shield of Massachusetts Foundation provided $50,000 to Holyoke Health Center to continue efforts to aggressively decrease emergency department utilization for primary care; improve referral processes at the emergency department; and continue to provide comprehensive case management, coordination, outreach, and follow-up services for low-income and uninsured community residents. The foundation provided similar funding for a project serving year-round residents of Martha's Vineyard, including expanding access to coordinated care at facilities off the island.

  A particularly dramatic step to stabilize the safety net was taken by The Rhode Island Foundation in December 2000 when it purchased a Boston-based managed care plan that was the major source of coverage for Rhode Islanders receiving public coverage. Executing a program-related investment, the foundation purchased $2 million of the company's preferred stock and immediately converted this interest into a long-term loan. At the same time, the health plan converted from for-profit to nonprofit status. The state's 14 community health centers are now owners of the new Neighborhood Health Plan of Rhode Island.

- **Educating policymakers**. Health grantmakers are supporting efforts to educate policymakers about the state of the safety net, making the case at the local, state, and federal levels about the need for systemic change in health care financing and delivery. For example, the California HealthCare Foundation funded a study to look at the safety net's performance in providing chronic care services, with a focus on asthma in children, congestive heart failure, diabetes, and hypertension. Policy recommendations included those focused on payment policy, training, and systems changes within provider organizations. Community Voices Miami, a grantee of the W.K. Kellogg Foundation, created a multiagency consortium of community stakeholders whose work eventually led to the creation of a health care task force by the mayor of Miami. In California, Oakland Community Voices, a grantee of both the Kellogg Foundation and The Robert Wood Johnson Foundation, conducted the first comprehensive multilanguage county-specific survey of its kind to focus on uninsured adults and a much-needed supplement to existing data on children.

SOURCES

Bovbjerg, Randall R., Jill A. Marsteller, and Frank C. Ullman, *Health Care for the Poor and Uninsured after a Public Hospital's Closure or Conversion* (Washington, DC: Urban Institute, 2000).

Holton, Ruth, *Reflections on the Safety Net: The Case for Core Support* (Woodland Hills, CA: The California Wellness Foundation, 2003).

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

Silow-Carroll, Sharon, Stephanie E. Anthony, Paul A. Seltman, and Jack A. Meyer, *Community-Based Health Plans for the Uninsured: Expanding Access, Enhancing Dignity* (Battle Creek, MI: W.K. Kellogg Foundation, 2001).

Singer, Ingrid, *Annual Survey Results Reveal Extraordinary Financial Strains on Nation's Public Hospitals and Health Systems* (Washington, DC: National Association of Public Hospitals and Health Systems, 2002).

Rosenbaum, Sara, and Peter Shin, *Health Centers as Safety Net Providers: An Overview and Assessment of Medicaid's Role* (Washington, DC: The Henry J. Kaiser Family Foundation, 2003).