Safety-Net Hospital Systems Transformation in the Era of Health Care Reform

Experiences, Lessons, and Perspectives from 13 Safety-Net Systems Across the Nation

EXECUTIVE SUMMARY

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INTRODUCTION

The Affordable Care Act (ACA) of 2010, through its vision, requirements, and incentives, has set the stage for transformation of the health care system, creating many new opportunities for achieving the Triple Aim—to improve population health while simultaneously reducing cost and improving quality of care. Considerable resources have been devoted to assist safety-net hospital systems in the United States in transforming their institutions and improving the health of their patient populations through demonstrations, efforts to assist in building infrastructure and capacity, and most importantly in California, Medi-Cal expansion. While this surge in commitment to the safety net is much needed, these hospitals—many of which face chronic financial, operating, and other challenges in meeting the needs of vulnerable and diverse patients—now confront formidable new challenges regarding payment incentives and reductions, competition for newly insured patients and meeting workforce capacity needs. And while the ACA offers support to meet challenges, the rapidity of change has forced many systems to make difficult decisions to remain viable in this new era. These efforts, in turn, offer significant lessons for California's safety-net settings and those in other states across the country in reaffirming, if not guiding, transformations.

Project Goal

With support from the Blue Shield of California Foundation, this report provides a review of a subset of safety-net systems across the country, identifying their experiences, lessons learned, and successes in adapting and responding to health care reform. The explicit intent is to capture transformations occurring across systems varying financially as well as bearing a considerable burden in caring for low-income patients, documenting actions and steps taken to adapt to a highly dynamic environment and identifying implications and potential considerations for California's safety net.

CALIFORNIA'S SAFETY NET

California's health care safety net has been described as a "complex web" of programs and providers that serve low-income and uninsured Californians. Central to the state's safety net are 21 public hospital systems, which comprise only 6% of hospitals statewide but serve 2.85 million individuals each year, provide 40% of hospital care to the state's uninsured, and train nearly 6 out of 10 doctors in the state. While some are considered among leading hospital systems in the United States, a number have also struggled to keep pace with the changing health care landscape. The state's Delivery System Reform Incentive Payment (DSRIP) program—an unprecedented initiative providing $3.3 billion in federal incentive payments to public hospital systems through California's Section 1115 Medicaid Waiver approved in 2010—has played a pivotal and central role in transitioning systems to vie in this new environment by helping them improve capacity, infrastructure, care delivery, and quality. Four years into the DSRIP, California's public hospitals have made considerable progress from expanding primary care access and patient-centered care to adopting new health information technologies; standardizing reporting measures including racial, ethnic, and language data; and improvements in patient disease management and outcomes, among other achievements. Despite this "overall" success, progress has varied, with financially vulnerable systems and many in more high-need locations facing continued challenges.

METHODOLOGY

Table 1. Study Safety-Net Providers

Hospital Name	State	Provider Type
AEH Member Public Hospitals		
Boston Medical Center	MA	Public Hospital
Cambridge Health Alliance	MA	Public Hospital
Cook County Health & Hospitals System	IL	Public Hospital
Hennepin County Medical Center	MN	Public Hospital
Maricopa Integrated Health System	AZ	Public Hospital
MetroHealth System	OH	Public Hospital
Mount Sinai Hospital of Chicago	IL	Public Hospital
NYCHHC - Elmhurst Hospital	NY	Public Hospital
UK HealthCare Hospital System	KY	Public Hospital
UW Harborview Medical Center	WA	Public Hospital
Other Safety-Net Providers		
Clinica Family Health Services	CO	FQHC
Maui Memorial Hospital	HI	Public Hospital
Yuma District Hospital	CO	Critical Access

The purpose of this review is to identify experiences, innovations, and lessons learned from public hospital systems and other safety-net providers located in states, that, like California, are expanding Medicaid; to offer potential insight for California's public hospitals as they adapt to the changing health care landscape following the ACA; and to provide a broader safety-net perspective in efforts to renew DSRIP plans in 2015. To this end, we first reviewed literature addressing systems transformations that have gained increasing attention and investment nationally and in California, including: integrated delivery systems; value-based payment and delivery reforms; primary care redesign; and initiatives responding to rapid pace of change, such as transitional leadership and cost-cutting strategies. Secondly, and building on the literature review, we identified and interviewed a subset of public hospitals affiliated with America's Essential Hospitals (AEH) located in Medicaid expansion states that had at least a 50% mix of Medicaid and uninsured patients in 2010. Of 15 hospitals that met these criteria, 10 agreed to participate (Table 1). To add additional perspective we interviewed three other safety-net providers: a federally qualified health center, a non-AEH public hospital in a diverse environment, and a critical access hospital. As intended, the study's public hospitals generally resembled California's urban public hospitals in many ways, including average size, discharges, inpatient days, Medicaid discharges, and percent Medicaid Net Revenues, although California's hospitals had a higher proportion of self-pay patient mix.

We conducted semi-structured, telephone-based key informant interviews with hospital executives from the 13 study sites and asked them to reflect on a range of questions on positioning their systems to transform following the ACA. Specific questions sought to elicit their strategies, experiences, decisions, and directions on payment and delivery reform, integrated systems of care, primary care redesign, and capacity priorities along with what they have found to be facilitators or barriers to transformation. Where possible, we followed up on specific models and programs mentioned in the interviews with a review of the literature to identify details on related processes, lessons, and outcomes.

REALITIES FROM THE FIELD

Adaptation and Transformation Actions

It was clear from the executive-level interviews that these systems were without exception actively engaged in a broad range of initiatives and programs to take advantage of opportunities to position their settings in the aftermath of the first year of implementation of the ACA's health

insurance expansion. The results of these discussions were distilled across what were identified as five primary themes, largely reflecting what emerged from our review of the literature as the focus and direction of safety-net providers in these new times.

- ***"Turning the dial" to transition from fee-for-service delivery and payments toward capitated approaches that reward population health outcomes***. Almost all executives cited either an intention or action to move away from fee-for-service to capitated models of payment and delivery, with most moving cautiously and taking incremental steps recognizing that in this "transitioning period" they may have to vie in a "two-canoe situation." At least half of the systems are part of Accountable Care Organizations (ACOs). While some have adopted the model through federally-funded demonstrations, others have invested in their own ACO initiatives, creating more "out-of-the-box" models, such as Hennepin Health's Social ACO that takes on additional risk by partnering with social service organizations to be accountable for a much broader spectrum of health and social services. Other identified models such as the University of Washington Medical Center's Accountable Care Network created a unique partnership with the private sector, Boeing, to establish an employer-driven ACO (eliminating the insurance company from more traditional arrangements).

- ***Redesigning primary care to be better coordinated, patient-centered, and grounded in multidisciplinary, team-based approaches***. Virtually all interviewed executives discussed how they are improving or redesigning the delivery of primary care to meet new and growing demand following ACA implementation. Most have shifted to or are in the process of achieving patient-centered medical homes (PCMHs), with some making institution-wide investments—such as Boston Medical Center's consolidation and co-location of two medical sites into one to create a "patient-centered clinical campus." Cleveland's MetroHealth System is undergoing a campus transformation in collaboration with other sectors to create a "health corridor" focused on connectivity and coordination between health, housing, and transit across five west-side neighborhoods.

  Others are taking more strategic approaches to target complex patients. Hennepin County Medical Center's Coordinated Care Center provides a patient-centered, multidisciplinary, team-based care clinic for patients with a history of frequent hospitalizations. Among other efforts, Cambridge Health Alliance launched a pilot medical home initiative for mental health patients, Yuma District Hospital has been working to achieve PCMH designation in partnership with other rural providers, and Elmhurst Hospital has built on successes of private practices in delivering patient-centered care.

  In conjunction with medical homes, most systems have adopted team-based models of care that generally employ a range of health professionals at the "top of their license," engaging them to more proactively manage a patient population. Some have developed innovative approaches to effectively manage these team approaches to assure visits can be reimbursed. For example, Clinica Family Health Services' "flip visits" have afforded nurses a greater role in caring for minor acute, routine, and non-chronic disease patients in a more timely and cost-effective way. While nurses provide the bulk of time and care for these

visits, a physician will review, check, and if needed adjust the nurse's diagnosis and care plan, converting the nurse's visit into a billable provider visit.

- ***Responding to competition in efforts to retain patients***. Most interviewed safety-net executives felt that their survival depended in large part on their ability to compete to attract and retain patients. Ironically, "collaboration" was cited as a key response to competition. As one executive shared, "we are learning to collaborate out of necessity," and another reiterated this point by stating that "it would be crazy in this landscape to think differently." To this end, many systems are working to build new or strengthen existing collaborations with other health care providers, such as health centers or clinics, as well as organizations in other sectors. University of Kentucky Health contracts with unaffiliated primary care clinics to link their patients to primary care in community settings; in turn, the clinics refer their patients for specialty and inpatient services to the hospital system resulting in mutual benefit such as expanded service area and referral base as well as a strategic focus on services they provide best.

  Other executives shared that while collaboration and consolidation are "natural directions" in this environment, they may not be seen as "the most attractive partner." To this end, many systems are undertaking multiple strategies to build on their strengths and unique niches, while also taking explicit steps to improve their "public image." Hennepin County Medical Center created a Staff Diversity and Inclusion Strategy, a Native American program, and one of the largest hospital interpreter programs in the country, among other efforts. Boston Medical Center has recognized that many of its "frequent flyer" and complex patients have underlying social and economic needs, and thus continues to invest in social services—such as food pantries, legal aide, and housing transitions. In addition, the system has invested in a unique Poverty Simulation Program to expose medical students and residents to gain more hands-on, scenario-based experience and understanding of the complex role that social determinants play in shaping access, behavior, adherence, and utilization of services.

  Finally, many systems are investing in health insurance enrollment to expand the insured patient population that will use their services. For example, Maricopa Integrated Health System has embraced a system-wide "culture of coverage" with specific cross-cultural "inreach and outreach" strategies. Similarly, MetroHealth launched "Enrollment on Wheels" to educate and help individuals sign up for coverage where they live and work.

- ***Embracing change through strong leadership.*** At least four hospital systems spoke about undergoing leadership change, with new leaders credited with significantly "turning around" the financial condition of their systems especially by championing and embracing "change." In some cases, this has meant "looking at the bigger picture" and taking on additional "risk," such as through investments in medical homes and accountable care arrangements, or as Boston Medical Center stressed in describing their campus consolidation, to create a medical home that will achieve cost-savings in the long run. Others, such as Cook County Health & Hospitals System, reorganized its management

structure from predominantly hierarchical to one that is flat to facilitate rapid and more timely decision-making.

- ***Undertaking cost-cutting strategies***. Beyond embracing comprehensive payment and delivery reforms, systems are also undertaking specific and strategic steps to cut unnecessary costs. For example, two informants discussed the importance of streamlining administrative processes, including identifying and eliminating redundancies. Others, such as Maricopa Integrated Health System, have adopted efforts to create greater transparency in pricing by publishing discounted prices for the 10 most common inpatient and outpatient services on their website. This initiative has enabled the hospital to achieve a meaningful reduction in uncompensated care, as individuals without coverage can more clearly understand costs in determining their ability to pay for services.

Challenges to Adaptation and Transformation

We asked hospital executives to tell us "what keeps them up at night" in efforts to identify challenges or uncertainties they face in a new and evolving era. Following are top responses that executives shared around their anxieties following reform:

- ***Uncertain role and relevance of safety-net institutions*** in the emerging health care landscape, with common sentiments of "where do we fit in the puzzle" and "what is going to define us."

- ***Challenges associated with shifting delivery and payment structures*** from fee-for-service toward more value-based and capitated models, especially for already struggling institutions that may not have the capital or resources to take on added "risk."

- ***Financial viability***, especially with looming federal Disproportionate Share Hospital payment reductions (expected to be larger in magnitude than originally estimated), state and local budget constraints, new penalties associated with health outcomes, and continuing to be a primary provider of uninsured, costly, and complex patients.

- ***Challenges with transitioning staff*** toward reform models and initiatives such as team-based and coordinated systems of care, especially given resistance to change from some systems that are highly unionized, and in some cases from physicians and other staff.

DISCUSSION AND POLICY IMPLICATIONS

Initial results since the implementation of the ACA have been encouraging, especially as they relate to safety-net populations. For example, after just one year of implementation, the number of uninsured individuals in the United States has declined by 26%. With the expansion of Medicaid in many states, including California, the Medicaid population is only set to grow. Yet, we know that coverage does not equal access.

Our study affirms that without doubt, safety-net systems will continue to be the primary source of care for millions—including newly insured, vulnerable individuals as well as the approximately 30 million remaining uninsured nationally (including 3 to 4 million in California). However, given the current and in particular projected financial scenarios, they will strive to do so while facing dramatic reductions in federal and possibly other support. Given these realities policymakers will need to take into consideration that any reductions to payment support may very well threaten the stability of many of these hospitals, while potentially undermining the capacity of those facing greater challenges to provide essential services and meet growing demand.

Our review and interviews with safety-net hospital systems located in states resembling California in its health care reform climate have revealed and reaffirmed at least four points for consideration moving forward as systems continue to position themselves for the new health care environment:

- ***Adopting new delivery and payment reforms with a population health focus***. Central to redesigning and reforming delivery and payment systems is a need to assure these efforts take on a "whole-person care" approach, especially recognizing that some of the costliest patients are those with not only complex medical needs but those that may also have a range of behavioral, cultural, and socioeconomic needs. While there is no "one-size-fits-all" approach to achieving this goal, systems are investing in a range of efforts that have shown promise, from more comprehensive, resource-intensive—such as ACO, bundled, and global payment models—to relatively smaller, but carefully designed investments that center around the "whole person," such as programs that take care and assistance to where people live, work, play, and pray (e.g., maternal and child home visitations, neighborhood preventive screenings, and mobile services). At the same time, systems should look not to "reinvent the wheel" or "duplicate services," but should seek out collaborative opportunities both within and beyond health care that can leverage limited capacity and resources, especially in regions where providers may be in a shortage or areas inundated with demand.

- ***Managing transformation through a unified vision, leadership, and collaboration***. Given the rapid pace of change in the health care system, managing transformation within the institution is critical to success, including assuring that systems have a unified vision, strong and championing leadership, ties with other health providers and community organizations, and aligned incentives across key players. Part of managing the transformation may require revisiting the system's strategic plans, including vision, mission, and objectives and assuring their relevance in these evolving times. Perhaps most important will be the ability to maintain flexibility to take advantage of new opportunities—for example, establishing new and mutually beneficial partnerships with other hospitals, federally qualified health centers, and clinics; working with sectors outside of health care, including the social service sector, but also reaching into the business and private sectors; and identifying unique strengths of the safety net that may "position" them to be "attractive" partners, such as their unique resources and ability to serve racially and ethnically diverse populations.

- ***Actively positioning to become competitive providers of choice***. Safety-net systems can no longer be seen as providers of "last resort" but must transition to becoming "hospitals of choice" if they are to attract and retain paying patients in this new highly competitive time. Investing in integrated health information technology, patient-centered medical homes, more coordinated and team-based care, as well as new payment and delivery reforms are all key ways in which systems are working to improve health care delivery and quality, while adding to their attractiveness in being "designated" or "certified" providers in this new environment. At the same time, however, systems that may be financially more vulnerable, and thus finding this "transition period" to be potentially longer, are also considering other targeted initiatives to become more attractive. This includes building and expanding on their strengths in providing a spectrum of enabling, social, and community-centric services (e.g., food pantries, sheltering, language support, and others); embracing a "culture of coverage" that proactively seeks and enrolls patients in accessible community settings in efforts to retain them; and rebranding to play-up academic ties and medical home designations, among others. To this end, philanthropy may have an important role to play in supporting these more strategic and specific safety-net transformations in the transition period.

- ***Transitioning and supporting the health care workforce***. Finally, there is a need to acknowledge and address that "the whole will only be as good as the sum of its parts"—in other words, critical to systems transformation success is the successful buy-in and transition of health care leadership and staff involved. With the rapid movement to adopting team-based care models, physicians, nurses, and allied health professionals will need to receive relevant education and training to understand "why" the need to reform and "how" they fit into these transformations, including new and renewed roles and responsibilities. Core to such education is the integration of "social determinants of health" and principles of "whole-person care" provided through innovative didactic and hands-on venues. Also critical is buy-in from unions and unionized staff and finding common ground, as identified by executives and others, in the benefits of transforming to more accountable, value-based, team, and coordinated arrangements of care.

  Finally, as systems continue to expand team-based care, including employing more health educators, community health workers, *promotores*, and other lay members from communities, this movement may not only better integrate social determinants into the care model, but could serve as a modest economic driver in communities fraught with high unemployment rates. To this end, philanthropy, the private sector, and community colleges may have important roles to play in supporting the proliferation of these relatively lower-skilled health care jobs and related trainings.

CONCLUSION

The California safety net, like those in other states across the country, has entered into a period of transformation with its "eyes wide open," recognizing and where possible taking advantage of opportunities to move beyond the usual ways of doing business, monitoring the bottom line, working to compete in traditional and potentially new markets, and becoming fully aware of the

historical and new challenges they face. Notwithstanding these and other dynamics of the day and times, their core mission and the strengths that ally with it—a history of caring for vulnerable, diverse individuals and neighborhoods and offering services essential to communities—align critically with this era and its focus on population health in all its dimensions. As such, these settings offer the opportunity for health care reform in California to transition more fully to address racial, ethnic, geographic, gender, and other disparities in access to care, with new partners, collaborations, and models that address the "whole person."

Monitoring outcomes for these populations and the providers who care for them thus becomes paramount, especially given that payment to recast services and care for the sake of population health has yet to be aligned with the dollar incentives of traditional fee-for-service medicine. But most importantly, federal, state, and local governments and the private sector will need to give these systems sufficient resources to survive and contribute significantly to creating more equitable, high-quality care and health throughout California and its communities.