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How Five Leading Safety-Net Hospitals Are Preparing For The Challenges And Opportunities Of Health Care Reform

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ABSTRACT **Safety-net hospitals will continue to play a critical role in the US health care system, as they will need to care for the more than twenty-three million people who are estimated to remain uninsured after the Affordable Care Act is implemented. Yet such hospitals will probably have less federal and state support for uncompensated care. At the same time, safety-net hospitals will need to reposition themselves in the marketplace to compete effectively for newly insured people who will have a choice of providers. We examine how five leading safety-net hospitals have begun preparing for reform. Building upon strong organizational attributes such as health information technology and system integration, the study hospitals' preparations include improving the efficiency and quality of care delivery, retaining current and attracting new patients, and expanding the medical home model.**

The Affordable Care Act calls for overhauling the nation's health care system to achieve near-universal health insurance coverage, including a major expansion of the Medicaid program. By 2016 as many as thirty-two million Americans are expected to gain coverage, assuming that most states move ahead with Medicaid expansion even in the wake of the Supreme Court decision that effectively makes the expansion optional for states.[1] Reform adds substantial new federal money to Medicaid and to states to allow them to make substantial changes in their health delivery systems.

Yet despite the Affordable Care Act's many reforms, the nation's health system will continue to struggle with serious challenges. This reality is particularly true for safety-net hospitals, which will be competing in a new marketplace with limited financial resources while caring for the residual uninsured people.

More than twenty-three million people will probably remain uninsured in 2019, including those eligible for Medicaid but not enrolled, those for whom private insurance is unaffordable (including those in states that decide not to implement the Medicaid expansion), and undocumented immigrants and some legal immigrants not eligible for Medicaid coverage.[1] Safety-net hospitals will be a major source of care for many of these people.[2]

With their history of providing care to low-income populations, safety-net hospitals will also continue to be sought out by many newly insured people. Indeed, in Massachusetts, which implemented health reform and a major coverage expansion in 2006, demand for safety-net facilities' services increased.[3]

Demand for safety-net hospitals will persist and possibly even expand after the implementation of reform. Yet these hospitals face many challenges. The most serious may be the severe budget shortfalls confronting most states and localities, which have put considerable financial pressure on safety-net hospitals.[4–6] Over the long term, safety-net hospitals need to reposition themselves to compete effectively in the post-reform marketplace.

In this article, we describe strategies used by five leading, nationally recognized safety-net hospital systems preparing for reform. The five hospitals are Bellevue Hospital Center, in New York City; Denver Health Medical Center, in Colorado; Parkland Health and Hospital System, in Dallas, Texas; San Francisco General Hospital, in California; and Virginia Commonwealth University Health System, in Richmond.

Opportunities And Challenges Resulting From Reform

For safety-net hospitals, health reform presents substantial opportunities.[7] When many currently uninsured Americans gain coverage, safety-net hospitals may receive additional reimbursement from those previously unable to pay for care. These hospitals also will be able to participate in demonstration projects aimed at reducing costs and improving care delivery. By providing an infusion of federal funding to states, including the funds associated with the Medicaid expansion, reform may also ease state health budget difficulties, freeing up state funding to continue supporting the safety net.

Yet reform also presents safety-net hospitals with considerable challenges. Chief among these are the planned reduction in Medicaid disproportionate-share-hospital payments, which provide financial support to hospitals rendering care to high numbers of Medicaid and uninsured patients. The rationale behind reducing this funding is the expectation that after reform, the need for these payments will be lower because more people will be insured.

Yet it is uncertain whether the reimbursement that safety-net hospitals will receive from Medicaid and health insurance exchange plans will be sufficient to compensate for the reductions in federal funds. Also uncertain is whether residual disproportionate-share-hospital payments will cover the costs of caring for the remaining uninsured people. A related concern is whether states and localities will reduce their funding for safety-net hospitals.

Underinsurance is another concern for safety-net hospitals after reform. Although many people will gain coverage when the Affordable Care Act is fully implemented, Medicaid reimbursements—both fee-for-service and managed care—may remain too low to enable real access to care. Benefits provided through health insurance exchange plans may also be insufficient or cost sharing too high, which could push underinsured people to seek care at safety-net hospitals. Underinsurance is especially problematic for safety-net hospitals, given that most of their patients are lower income.

Safety-net hospitals will also face the challenge of increased competition with private hospitals for newly insured patients. This intensified competition will be difficult for safety-net hospitals because of their compromised financial health. In 2010 safety-net hospitals' margins averaged 2.3 percent, while the average among all hospitals was 7.2 percent.[8] With fewer resources, safety-net hospitals face greater difficulty than other hospitals in investing in new health care technologies and innovations.

Study Data And Methods

The hospitals in this study were selected based on input from industry observers and national experts and after reviewing financial data from the National Association of Public Hospitals and Health Systems. We focused on academic safety-net hospitals that we judged financially sound as of summer 2010. We also pursued diversity along several dimensions, including geography, size, and system affiliation.

Using a semistructured protocol, we conducted site visits and interviews between September 2010 and January 2011 with hospital leaders and staff, including chief executive officers, chief technology officers, chief financial officers, and hospital medical directors.

Study Results

HOSPITALS AND CHARACTERISTICS Exhibit 1 provides a summary of the study hospitals' characteristics. They are all large, urban, academic medical centers that are nationally recognized for their health care delivery.[9,10] They also share similar utilization patterns and financial characteristics, including high volumes of uninsured and Medicaid patients for both inpatient and outpatient services (Exhibit 2). At each hospital, Medicaid is a major payer, accounting for one-third to nearly two-thirds of net revenues.

PREPARING BUILDING BLOCKS FOR REFORM As we noted above, we interviewed key management and medical staff at each of the five hospitals in this study. There were common themes in the factors they reported as important to preparing for health reform: strong and stable leadership and a long-term commitment to improving care and care delivery through investing in health information technology (IT); developing integrated systems of care; and aligning safety-net and academic missions.

▶**HEALTH INFORMATION TECHNOLOGY:** The hospital leaders we interviewed cited health IT as being critical to their systems' performance, with Parkland, Virginia Commonwealth, and Denver Health having a long history of health

EXHIBIT 1

Selected Characteristics Of Five Hospitals In The Study Of Safety-Net Hospitals After Health Reform, 2010

Hospital organization	Associated facilities and services	Physician staffing
Bellevue Hospital Center: flagship hospital for the New York City Health and Hospitals Corporation	11 hospitals, 6 diagnostic and treatment centers, 80 community clinics, 4 long-term care facilities, a managed care plan	Staffed through an affiliation agreement with New York University School of Medicine
Denver Health Medical Center: fully integrated health care system organized as an independent public authority within the city of Denver, Colorado	911 system, 8 community health centers, 12 school-based health centers, poison and drug center, 100-bed detoxification facility, correctional health, public health, a managed care plan	Physicians are employed by Denver Health Medical Center, but also have faculty appointments at the University of Colorado, School of Medicine
Parkland Health and Hospital System: organized as a hospital district within Dallas County, Texas, giving it independent taxing authority	11 community-oriented primary care clinics, 8 women's clinics, 11 youth and family health centers, 28 homeless shelters throughout Dallas County	Primary teaching facility for the University of Texas-Southwestern Medical School
San Francisco General Hospital: owned and operated by City of San Francisco, California; part of San Francisco Community Health Network, Department of Public Health	Numerous primary care health centers, including 6 that are hospital based; other community and mental health services	Staffed through an affiliation agreement with the University of California, San Francisco, School of Medicine
Virginia Commonwealth University Health System: academic health center	Medical College of Virginia hospitals, physicians; Virginia Premier Medicaid managed care plan; schools of dentistry, medicine, nursing, pharmacy; operates Virginia Coordinated Care program	Physicians employed by Virginia Commonwealth University Medical Center

SOURCE Authors' compilation.

EXHIBIT 2

Selected Utilization And Financial Data Of Five Hospitals In The Study Of Safety-Net Hospitals After Reform, 2010

Data type	Bellevue Hospital Center	Denver Health	Parkland Health and Hospital System	San Francisco General Hospital	VCU Health System
Staffed beds	809	404	798	507	719
Discharges	28,764	20,562	41,294	15,403	32,244
Percent Medicaid	57	44	28	35	28
Percent uninsured	8	25	56	25	15
Outpatient visits (number)	649,302	1,038,724	1,330,066	790,269	929,125
Percent Medicaid	45	26	30	28	18
Percent uninsured	31	33	54	35	21
Percent emergency department	18	6	14	7	9
Net revenues					
Percent Medicaid	59	58	46	31	31
Percent Medicare	19	13	21	11	23
Percent commercial	5	21	14	16	37
Percent uninsured	1	3	11	<1	2
Percent other	4	1	7	3	8
Percent state/local payments	12	5	0	39	0

SOURCE National Association of Public Hospitals and Health Systems 2010 hospital characteristics survey (Note 8 in text). **NOTE** VCU is Virginia Commonwealth University.

IT investment.

For example, Virginia Commonwealth initiated such investments thirty years ago, when there were many skeptics. Seven years ago it moved away from its legacy system, adding patient-friendly electronic health records. More than a decade ago, Parkland boosted its investment in health IT, which is now a core piece of its delivery system. Parkland already has a fully integrated electronic health record system, and it plans to join Virginia Commonwealth as one of the first public hospitals to offer patients access to that system.

Similarly, Denver Health initiated investments in health IT years ago. It built a system that links operations and care delivery across its entire operation, including inpatient services, ambulatory care, the emergency department, and school-based clinics. It was named a "Top 100 Most Wired Hospital" in 2011.[11]

Health information technology has played a key role in helping these hospitals improve performance and respond to market and regulatory demands for increased efficiency and accountability. It has also yielded other advances.

For example, it has helped improve the delivery of care, including better decision support for evidence-based medicine and chronic disease management systems; centralized tracking of medical tests, prescriptions, and appointments; and physician reminder systems to ensure the provision of timely and appropriate care. One Parkland initiative reduced readmission rates by 50 percent among patients with chronic obstructive pulmonary disease by using new technology to pull information from electronic health records to identify high-risk patients.

Health IT has also improved financial management, including automated applications for Medicaid and self-pay patients. The results have been more patients with public coverage; automated systems for supply-chain management; consistent service coding to ensure that the hospitals are billing for all of the care they provide; and timely and accurate billing to improve cash flow and reduce write-offs. Denver Health noted that expanded efforts to establish Medicaid eligibility have generated an additional $5 million in revenue per year.

And health IT has helped strengthen management and increase accountability. These improvements have taken the form of support for continuous feedback on care delivery and care outcomes, real-time performance monitoring, and systematic tracking of quality improvement initiatives. Leaders at Denver Health, Parkland, and Virginia Commonwealth whom we interviewed said that they viewed such support systems as critical to improving efficiency, saving millions of dollars every year.

San Francisco General and Bellevue have moved more slowly on health IT. One estimate indicates that a hospital requires, on average, five to ten years of experience before it can fully capture the advantages of health IT to improve care delivery.[12] Thus, these two organizations will probably experience a sizable lag before being able to put health IT to full use in response to reform.

▶**INTEGRATED SYSTEMS OF CARE:** Hospital leaders consistently identified system integration as a critical ingredient to successfully responding to reform, because it provides for a rapid, systemwide ability to react to changing circumstances.

Each of the five hospitals studied for this article has already established some degree of integration, with Denver Health leading the way. Denver Health is a fully integrated health system spanning acute care hospitals; primary care; community health centers; and public health operations such as immunizations, infectious disease tracking, prevention, treatment, and health promotion. Hospital leaders report that integration has been their most important asset in dealing with recent challenges because it allows for rapid deployment of change, whether in care systems, staffing, or resource allocation.

Leaders at all of the hospitals in this study reported that integration has expanded their capacity for primary care and subspecialty services, which will increase their ability to care for the increased volume of patients expected after the full implementation of health reform. The leaders whom we interviewed emphasized that integration reinforces financial stability by allowing hospitals to diversify clinical service lines and cross-subsidize unprofitable services.

Bellevue and San Francisco General, for example, use inpatient care revenues to help finance their community clinics, which have struggled with deficits. San Francisco General officials also noted that their hospital's close alliance with the San Francisco Department of Health helps it absorb the many financial ups and downs it faces by providing supplemental sources of revenue.

Integration also provides the hospitals with economies of scale and increased purchasing power to support more efficient operations. Bellevue's parent institution, the New York City Health and Hospitals Corporation, for example, has centralized administrative functions and uses its large size to renegotiate contracts with vendors and drive down costs.

Integration has also increased the hospitals' ability to improve community health through disease prevention and other strategies. Parkland has been recognized for its innovative

community outreach efforts. It uses its large network of community-oriented primary care health centers, women's clinics, youth and family health centers, and homeless shelters to provide not only acute care for Dallas County residents but also health education and disease surveillance. San Francisco General, Bellevue, and Denver Health have similar capabilities, which should only be more valuable under reform as delivery systems are increasingly expected to care for defined populations.

Integration eases the way toward large-scale delivery system reform and the development of systems for achieving universal access. San Francisco General is perhaps the best illustration of this phenomenon. Close integration with the San Francisco Department of Health has enabled the hospital to coordinate care across providers, organize health information, and provide long-term disease management—essential building blocks to implementing coverage expansion. It was this tight integration that provided the foundation from which to launch Healthy San Francisco, which provides access to health care for uninsured city residents, in 2007.[13]

▶**ALIGNING SAFETY-NET AND ACADEMIC MISSIONS:** Many safety-net hospitals are affiliated with medical schools. Such affiliations confer strengths but also create competing agendas.

Academic activities that are rewarded by medical schools, such as research and teaching, often differ from the improved efficiency, productivity, and customer service sought by safety-net hospitals. Given this situation, there is the potential at these institutions for conflict in balancing the roles of care delivery, medical education, and research.

In some of the study hospitals, physicians were reported to struggle with "serving two masters" as they provide clinical care at the hospital while meeting the education and research requirements demanded by their academic affiliation. Among the five study hospitals, San Francisco General, Denver Health, and Virginia Commonwealth exemplify closer alignment with the hospital mission.

San Francisco General physicians are effectively "based" at this hospital, which has its own dedicated, freestanding academic departments and chief of medicine. This arrangement differs from those at many other academic safety-net hospitals, which share leadership with other teaching hospitals. Although San Francisco General staff physicians hold faculty appointments at the University of California, San Francisco, medical school, the majority have no responsibilities to university departments.

At Denver Health and Virginia Commonwealth, physicians are directly employed by the hospital rather than the medical school. Because these physicians have no responsibilities to other departments or hospitals, they are more focused on supporting their hospital's mission.

In contrast, physicians at Bellevue and Parkland are employed by the New York University and University of Texas–Southwestern medical schools, respectively, rather than the hospitals themselves. This arrangement reportedly creates challenges for those hospitals in care delivery and operations. At the time of our visit, Bellevue's parent, the New York Health and Hospitals Corporation, was working to overhaul its affiliation agreements with the medical schools it contracts with, so as to motivate physicians to "keep their eye on the prize." Rather than academic pursuits, the corporation views this "prize" as the delivery of higher volume and more cost-effective patient care.

Similarly, at the time of our visit, Parkland management was not satisfied with its long-standing physician practice model, believing that many physicians have focused on their academic careers instead of supporting Parkland's safety-net mission. Parkland was reported to be working to establish a "dedicated medical staff model" that would require more "accountability" and "productivity" from faculty physicians.

Key Reform Strategies

To prepare for the full implementation of the Affordable Care Act, the hospitals in this study are building on their existing health IT, systems integration, and academic and safety-net alignment described above to improve efficiency and quality, retain and attract new patients, and expand the medical home model.

IMPROVING EFFICIENCY AND QUALITY Because safety-net hospitals typically operate under narrow financial margins, increasing efficiency, reducing costs, and improving quality have long been core strategies. The hospitals in this study have renewed their focus on these efforts after recognizing the very real possibility of increased demand for services, uncertain reimbursement, and intensified competition under reform.

Denver Health, Bellevue, and Parkland have each implemented variations of Lean performance improvement strategies. Based on the Toyota Production System, Lean is a set of tools and principles for identifying and eliminating waste and improving efficiency.[14]

Denver Health is the leader in this regard among the study hospitals, having implemented Lean approaches throughout its system—from core business functions to its operating rooms—and having generated both tens of millions of dollars in savings and improvements in

quality of care. The latter includes both broad reductions in hospitalizations and readmissions as well as gains from very targeted initiatives, such as reductions in deep venous thrombosis after surgery.

San Francisco General and Virginia Commonwealth have developed their own strategies for improving efficiency, which, they argue, better reflect their environment. San Francisco General—paid mostly by capitation, or a fixed amount per patient—has achieved efficiencies in care delivery without being tied to the restrictions of a fee-for-service system.

Not needing to be paid for the volume of services delivered has enabled the hospital to invest in new delivery practices to increase specialty care capacity. These have included the use of specially trained nurse practitioners to care for patients with chronic conditions and the introduction of innovative telemedicine technology.

Virginia Commonwealth has a long-run focus on developing an efficient, high-quality care delivery system, although this may require more investment in the short run. For example, Virginia Commonwealth recently invested in specialized hospital beds designed to reduce pressure ulcers. Although the beds are more costly initially, their use has reduced the incidence of bedsores and, as a result, brought about shorter lengths-of-stay, which has reduced long-run costs and improved health outcomes.

RETAINING AND ATTRACTING PATIENTS Each hospital is keenly aware that reform will present the challenge of retaining current patients as well as attracting newly insured patients, who will have a choice of providers. The hospitals are confident that they will be prepared. They already have much experience working with Medicaid and low-income uninsured patients, many of whom will be gaining coverage.

For example, San Francisco General, with its experience serving a diverse socioeconomic population under Healthy San Francisco, is already caring for many of the people who will become insured after reform. Serving these patients, including those with higher incomes, has alerted staff members that they will need to meet diverse care and service needs and expectations.

In response, San Francisco General is forming more patient advisory committees and involving patients in hospital decisions, such as redesigning the outpatient lobby. In addition, unlike the uninsured and most Medicaid beneficiaries, who have formed the core of the hospital's patients, Healthy San Francisco patients make copayments. Thus, a major new area for San Francisco General is patient billing and handling billing complaints—something that the hospital will need to handle after reform.

EXPANDING THE MEDICAL HOME MODEL Hospitals in this study have already used their health IT resources and system integration to provide coordinated and cost-effective care for patients, including those with high-cost chronic diseases. This approach serves as a foundation on which to establish patient-centered medical homes and accountable care organizations.

For example, building on years of work to integrate care for Bellevue patients, primary care clinics at Bellevue have received patient-centered medical home designation from the National Center for Quality Assurance. And since 2000 Virginia Commonwealth has operated its Virginia Coordinated Care program, which provides a medical home for indigent patients. Parkland also provides medical homes to uninsured patients through its extensive network of community-based clinics, which offer primary and acute care services and care coordination.

San Francisco General already provides a medical home to patients enrolled in Healthy San Francisco by coordinating their care from primary care to inpatient admission. Taking the medical home concept further, the hospital envisions developing a "medical home neighborhood" that would be a seamless integrated delivery system, involving not just primary care providers but also hospitals and specialists.

Parkland is also exploring the neighborhood approach, including strategies such as rotating specialists through primary care clinics and developing multispecialty clinics. The clinics are intended to increase the availability of specialty care in the community and improve coordination across the care continuum, from primary care physicians to specialists and inpatient care.

Finally, Denver Health is part of a large, multipayer, multistate patient-centered medical home pilot project that includes public and private payers and providers. This initiative, which began in 2009, is evaluating innovative care delivery strategies and technologies that offer the potential for advances in the medical home model under the Affordable Care Act.[15]

MOVING TOWARD GLOBAL PAYMENT Leaders at each hospital are cautiously optimistic about new payment systems, especially global payment systems that provide a set payment to manage care for conditions across the care spectrum. Global payment systems associated with accountable care organizations are an important component of reform and are expected to improve quality while lowering costs.

Although the hospitals recognize that under such systems they could be at risk for costs incurred across the care cycle, they are interested in having control over provider payment amounts and allocation. Hospital leaders stated

that their chronic disease management capabilities enabled by health IT and system integration will allow them to focus on patient outcomes, leading to improvements in prevention of and care for high-cost chronic conditions. They also expect that these new payment systems will enable them to develop a strong business case for the further expansion of primary care and urgent care services, better coordination of primary and specialty services, and investment in pay-for-performance initiatives that will drive improvements in the quality and efficiency of care.

Conclusion

This study has reviewed how five leading safety-net hospitals are preparing for the major changes expected to result from full implementation of the Affordable Care Act. The capacity of these hospitals to respond to the challenges presented by reform is strongly supported by underlying organizational attributes, including health information technology and system integration.

Building upon these attributes, the study hospitals' preparations for reform include improving the efficiency and quality of care delivery; investing in the systems, staffing, and physical environment needed to retain current patients and attract newly insured patients; and laying the groundwork for accountable care organizations and new payment systems.

Because the study hospitals are among the nation's leading safety-net hospitals, their experiences are not fully generalizable to all other safety-net hospitals. Yet there is value in studying how they have become leaders among their peers. The findings highlight some of the major investments and strategies that these hospitals have pursued to help them succeed. Their experiences and innovations provide valuable lessons for other safety-net hospitals as they respond to the challenges presented by health reform. ■

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In this month's *Health Affairs*, Teresa Coughlin and coauthors report on their study of how five leading safety-net hospitals have begun preparing for the full implementation of health care reform. They note that each of these institutions has built on strong organizational attributes, such as health information technology, the use of Lean and other approaches to improve the efficiency and quality of care delivery, and expansion of the medical home model. The authors write that these changes will stand these organizations in good stead as they contemplate future challenges, such as competing effectively for newly insured people, who will have a choice of providers as of 2014.

Coughlin is a senior fellow in the Health Policy Center at the Urban Institute. For more than twenty-five years, she has studied issues related to Medicaid, state health policy, and the health care safety net. Her current work includes analyses of "dual eligibles"—people who qualify for both Medicare and Medicaid—as well as safety-net hospital financing, geographic variation in Medicaid health spending, and health care access and use. Coughlin holds a master's degree in public health from the University of California, Berkeley.

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