

If you've ever built a house of cards or played a game of Jenga, you know how quickly an ill-timed move can destroy your goal of maintaining equilibrium. The consequence of upsetting one piece of the whole is a common metaphor many safety net providers use to help other healthcare organizations understand their role in the system. The fiscal and physical pressure on just one safety net provider can create a dangerous ripple effect in a community, threatening the stability of other area providers and access to care for the patients they serve. "We have created a complicated tension within our healthcare system," says Stuart H. Altman, Ph.D., HFACHE, professor, National Health Policy, at Brandeis University in Waltham, MA. "If any single major sector of the system is out of balance, the others will be affected in a very negative way." Depending (in part) on geography as well as local and state politics, the fate of "non"-safety net providers can hinge on the success of those organizations whose primary mission is to provide indigent care. "If the safety net fails, the whole healthcare system could potentially collapse because the remaining providers simply cannot handle all of the demand," says C. Duane Dauner, FACHE, president of the California Healthcare Association in Sacramento. The current situations in Washington, D.C., Dallas, and several California counties illustrate this domino effect Dauner describes.

# Strengthening the Safety Net

by Ellen Lanser May

**Washington, D.C.** After struggling to address financial, operational, and facility issues, the District of Columbia closed D.C. General Hospital—the only hospital owned and operated by the District—nearly three years ago. To oversee indigent care for patients who previously relied on D.C. General, city officials created a public-private partnership in 2001 called the D.C. Healthcare Alliance. When five area hospitals voluntarily joined the partnership, Alliance managers assured them that one hospital, Greater Southeast Community Hospital, would develop new services—including a Level I trauma center—in order to treat many of the former D.C. General patients. Within a short time, it became clear that Greater Southeast would be unable to provide the services originally planned for. As a result, displaced patients began crowding into the already overburdened emergency departments at other Alliance hospitals. The situation was exacerbated when the

Alliance's parent company declared bankruptcy and Greater Southeast lost its Joint Commission accreditation; these two events resulted in a further shift of patients to the other four Alliance hospitals.

With the significant increase in uninsured and Medicare/Medicaid patients, Alliance members such as George Washington University Hospital are concerned about their ability to absorb more patients, as well as their financial stability given proposed cuts to the Alliance's 2004 budget and the addition of 9,000 beneficiaries to the program. "When one safety net provider falls, as D.C. General did, and then another slips, as Greater Southeast did, every provider in the District feels the effects. It jeopardizes our ability to provide services to the community at large," says Daniel P. McLean, CHE, chief executive officer of George Washington. "Providers all across the country must understand that no one is

immune from the fact that there is a safety net in place—and that they will become part of it. We are all in this together."

**Dallas.** Although Parkland Health and Hospital System in Dallas is primarily funded by local taxes, its service responsibilities—which include trauma and other high-risk services—are regional. Within Dallas County, Parkland serves a 900-square-mile area and a population of 2.3 million; 700,000 of those individuals live 200 percent below the poverty level. Because Texas is a border state, Parkland also treats many immigrants, many of whom are working but do not receive health benefits. Adding to Parkland's challenges, Texas cut Medicaid reimbursement in its efforts to balance the state budget. Because of the cuts, Parkland has lost \$35 million in revenue but still serves patients who lost their coverage and were turned away by other hospitals. "It's hard to make people feel

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accountable for caring for the uninsured if they have the ability to shift people to the safety net provider down the street,” says Ron J. Anderson, M.D., president and chief executive officer of Parkland. “That kind of thinking will bring the rest of the system crashing down. There is a cost for every episode of care provided, and someone is paying for it implicitly or explicitly.”

The influx of uninsured patients has forced Parkland to put off elective surgeries for up to five months. To make its own budget, Parkland has embarked on 50 different projects since the Balanced Budget Act of 1997, including staff and benefit reductions. “We were able to get by this year, but it is not a sustainable effort. You cannot cut your way to prosperity,” Anderson says. While non-safety net providers in Texas have not experienced these challenges to the extent that Parkland has, they are beginning to feel the effects. “In our community, other hospitals appreciate that through the indigent care we provide, we shoulder some of the burden for them,” Anderson says. “And in turn, they have helped us with trauma work. Baylor Hospital, for example, budgeted 6 percent for charity care for 2003. But today they’re at 13 percent because of the assistance they provide for indigent care. At some point, they won’t be able to absorb this kind of stress without jeopardizing their own viability. While we have good collaborative relationships

with providers in the area, the more the economy becomes strained, the more strained these relationships and the local system can become.”

There is no single, quick fix for the complicated situation in which providers like George Washington and Parkland are mired. But increased attention to several key factors can strengthen safety net providers—factors that require the support of the American healthcare provider community as a whole.

## Public Policy

Like all private sector healthcare organizations, safety net providers are up against enormous challenges with fiscal planning. But unlike their colleagues in the private sector, hospitals serving a higher proportion of underinsured or uninsured patients rely more heavily on Medicaid revenues and other government and grant support to fulfill their mission. Adequate funding is *the* defining characteristic of a strong safety net provider—and that funding depends on the ever-shifting political climate at local, state, and federal levels. While the degree to which safety net providers are struggling varies widely across the country, the national economic slowdown of the past two years—which includes higher unemployment rates, an increasing number of uninsured people, and deepening healthcare cuts by state and local governments—could create challenges for more hospitals nationwide

in the near future. In other words, every provider will likely feel the impact.

“We need advocates at every level of government who understand the complexities of healthcare financing and reimbursement, as well as the role our safety net hospitals play in our respective communities,” says John W. Bluford III, CHE, president and chief executive officer of Truman Medical Center in Kansas City, MO, a nonprofit hospital that fulfills many safety net responsibilities in the Kansas City metropolitan area. “Our fiscal success hinges totally on public policy. That’s our bottom line.” In California where all healthcare providers must comply with several major unfunded government mandates, organizations like the California Healthcare Association voice concern about regulatory burdens for safety net hospitals in the state. “We work to help remedy the unintended consequences of mandates such as seismic-safety legislation and nurse-patient ratios. Much of this legislation cannot realistically be achieved under the current structures and time frames,” says CHA’s Dauner. “The CHA urges policymakers to be more flexible with and make adjustments for safety net hospitals. But *all* healthcare providers need to become stronger advocates. Organizations that are not safety net hospitals must support public policies that create mechanisms to ensure the viability of the safety net. Across the

## Practicing Effective Business Strategies: Findings from The Center for Studying Health System Change

There has been more recognition over the last few years that commitment to a mission is not enough to develop a stable safety net, and the often-heard mantra is “No margin, no mission.” Similar to what is seen in thriving businesses, the leaders of safety net organizations have developed into or been replaced by entrepreneurial business managers who are more effective at day-to-day operations and ensuring long-term organizational viability. Through our eight-year study of 12 nationally representative communities across the United States, we identified strategies common among safety net hospitals and community health centers in each location:

- Streamline operations and improve productivity by, for example, increasing use of clinical support staff and nonphysician clinicians, upgrading information technology, and transitioning to same-day patient scheduling.
- Improve payment collection from insurers and patients.
- Leverage economies of scale and share technical expertise with other safety net providers.
- Enroll uninsured patients in public insurance coverage at the provider site.
- Attract more privately and publicly insured patients to improve payer mix.
- Raise funds and apply for grants, such as federal CHC expansion grants, particularly to develop mental and dental health services.

In the northern New Jersey community we studied, managers at a struggling public hospital improved the hospital’s financial accounting and reporting information systems to demonstrate the need for additional state charity care funds—monies that helped to stabilize the hospital’s finances and generate positive margins. In Syracuse, NY, a community with historically low uninsurance and a stable safety net, significant increases in demand for services prompted the sole community health center to create a foundation to raise money for equipment and capital projects and to form partnerships with main-stream providers to improve access to care. Overall, we found that while funding is vitally important to strengthening the safety net, providers can learn to leverage limited dollars through capable management and effective business strategies.

—*The Center for Studying Health System Change, Washington, D.C.*

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country, we need unanimous support—whether you are in the private or public sector—and strong political leadership from all providers to keep this part of our system in place.”

Based on recently reported results on a study of community safety nets, the Center for Studying Health System Change found that resilient safety net providers are often supported by local political leaders who focus public attention on these providers and initiate ways to fund and manage the local safety net. “Miami-Dade County’s mayor established a healthcare task force as a forum to improve the existing delivery system and expand insurance coverage options for the uninsured and, with the county council, is considering establishing a county entity to conduct more formal safety net planning,” says Paul B. Ginsburg, president of the Center. If your local government isn’t doing this, urge them to become involved.

## Collaboration

Partnerships among various community organizations can help safety net providers increase their capacity and help coordinate indigent care. The Center’s study also showed that collaboration among public and private health and business organizations along with private foundations can coordinate new clinic-based and private physicians services for low-income people in underserved areas. In its study, the Center also found that a “virtual” managed care model

works particularly well. “This type of collaboration between policy-makers and providers coordinates care for uninsured individuals as if they had insurance coverage by distributing a membership card to assist access to primary, specialty, and often inpatient care within an established network of providers,” says Ginsburg.

While the D.C. Alliance did not function as well as anticipated, leaders of Alliance member hospitals still believe that public-private partnerships can succeed. “If you look at the concept on paper and the way it was constructed in principle, the D.C. Alliance could have been an extremely viable option,” says George Washington’s McLean. “And such partnerships can flourish—as they do in Los Angeles, for example—and do a good job for everybody. The concept is sound, but as with most things, the devil is in the details.” Based on his experience, McLean urges organizations to be sure that due diligence and purposeful planning are conducted up front.

## Quality Focus

Many safety net hospitals are providing the most high-risk and specialized services in their area at the highest quality levels—and their leaders are proud of that. Despite the myriad challenges safety net providers face, quality remains a focus. “Whether you’re fulfilling a specific mission for a safety net hospital or not, quality is still quality,” says George Washington’s

McLean. “Your organization won’t stand the test of time without it. Quality of service provision has to be the focus, regardless of who you are providing it to.”

Maintaining this focus helped Truman Medical Center’s Bluford turn the organization around. When Bluford took the organization’s helm in 1999, the hospital was suffering from poor communication among staff and leaders, a lack of trust between physicians and management, and general instability. In the past three years, the organization has reduced turnover by 32 percent, increased net patient revenue by \$75 million between 1999 and 2002, and reduced accounts receivable to fewer than 80 days, as opposed to 100. “Yes, public policy is critical, and we engage and monitor it constantly,” Bluford says. “While providing indigent care is a big part of what we do, we don’t define ourselves as a safety net hospital—we see ourselves as simply a damn good hospital. Psychologically, that is a very key premise for our organization. It’s an attitudinal adjustment that sets up the culture of our organization and our focus. Two things have been repeated for the past five years: excellent clinical outcomes and excellent customer service. Everything we do should be contributing to those two ends. My advice to leaders of other safety net hospitals is to first ensure that your services are the best they can be and then roll out your marketing plan

and public policy initiatives. But take care of the fundamental blocking and tackling at home first.”

For these reasons, effective management strategies are increasingly important for safety net providers. Along those lines, in the study conducted by the Center for Studying Health System Change, business acumen was identified as one of several key factors of safety net resilience (see sidebar on page 13).

### A Dynamic Equilibrium

Perhaps the sometimes unrealistic expectations placed on our safety net providers stem from the misnomer that's been given to them. “We've never created a true, complete safety net—or it's a net with many gaping holes,” says Brandeis University's Altman. Although every part of the healthcare system is under pressure, private sector hospitals have a role to play in preserving the nation's delicate safety net. Altman adds, “The populace needs to be educated about the importance of the safety net and the ramifications of policy on its ability to provide services. Community hospitals should share resources with safety net hospitals and work with them economically and politically so that they can keep their doors open and serve their communities. All providers need to work together to create a dynamic equilibrium within our healthcare system.”

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