Executive Summary

The Safety Net is a collection of health care providers and institutes that serve the uninsured and underinsured. Safety Net providers come in a variety of forms, including free health clinics, federally qualified health clinics, also known as Community Health Centers, Community Mental Health Centers, hospitals that see a high percentage of Medicaid and uninsured patients, and the other agencies that facilitate the care of these patients.

These organizations are supported by highly diverse sources of funding, including patient contributions, private donations, grants, and in some cases government funding.

Challenges Facing Safety Net Providers

Workforce Capacity | In a changing health care environment, Safety Net Clinics work to recruit and retain high quality providers to maximize continuity of care, address the complex needs of patients, and maintain up-to-date clinical training and computer skills. This need for qualified staff means that increasingly, Safety Net Clinics must be competitive in their ability to attract and keep highly skilled workers.

The ability of Safety Net providers to continue to deliver quality services to clients is jeopardized without sufficient funding to stabilize and increase workforce capacity.

Information and Data Systems | Safety Net Clinics will need additional financial resources to address increased costs related to electronic health records and consequent lowered productivity during the implementation.

Organizational Capacity | Safety Net capacity will require continued investments in the physical layout as well as the essential support services needed to serve the diverse needs of this network’s clientele.

Affordable Care Act | The recent Supreme Court decision puts the future expansion of Medicaid in an indeterminate state. While the Supreme Court upheld the constitutionality of the expansion, state legislatures may not choose to participate. The expansion of Medicaid to cover low-income adults would include 255,000 uninsured residents in Missouri and 151,000 Kansans. While the status of the Medicaid expansion is unknown, other sources of support for Safety Net organizations will begin to decline, including Disproportionate Share Hospital Funding and potentially the funding of current Medicaid from the state.
INTRODUCTION TO THE SAFETY NET

The medical Safety Net is composed of a network of free health clinics, charitable clinics, Community Health Centers (FQHCs), safety net hospitals and local public health institutions. The diversity of the Safety Net is one of its greatest strengths. This diversity allows patients to be served in the locations that they choose, allows the institutions to adapt to local needs and allows different providers to develop areas of special focus or expertise.

Safety Net agencies work with a range of private and nonprofit organizations to serve the many needs of low-income patients. These partnerships include service agencies that provide adjunctive services at the local level, advocacy groups working on behalf of the under and uninsured, the research community, academia, and an array of faith, civic, and voluntary groups.

IMPACT | The Safety Net has addressed the needs of low-income, high need patients for the last 50 years. Their services have provided medical, mental health, dental health and social services to many thousands of people. These providers help patients manage complex health conditions in the setting of intense social challenges. The Safety Net provides critical access for early childhood screening. It has also reduced the need for emergency services and decreased hospital readmission rates. These sites provide direct care, screening, and care coordination for young and old alike.

GROWING NEED | Over the last two decades, the need for access to safety net services has grown. As of 2010, statewide rates have increased to 13.2 percent in Missouri and 13.9 percent in Kansas for the uninsured, with the most dramatic local increases in Jackson County, Mo. (up to 17.0 percent) and Wyandotte County, Kan. (up to 26.4 percent). (Source: 2010 American Community Survey) In that time, the Safety Net community addressed an across-the-board increase in both the number of patient visits as well as a more diverse, complex and sicker population of patients.

CHANGING ROLES | In many communities, issues such as diabetes, obesity, smoking, immunizations, racial disparities in health outcomes, mental health needs and HIV/AIDS are viewed not only as public health issues but as political and social issues on which opinions differ and a consensus on solutions is elusive. In these situations, Safety Net organizations must draw not only on their direct skills in disease treatment and prevention but also on talents for participating in collaborative efforts, building trust in communities, and providing objective data on health and access to policy makers and community members.

FUNDING UNCERTAINTIES | Because of their various organizational structures, Safety Net entities are funded in a variety of ways — through government funds, fees for service, grants, donations, and fundraising efforts. Many of these sources of income are subject to change or are intermittent in nature. There is uncertainty as health reform moves forward in how the payment and various means of governmental support will change. Grant funding has up-and-down cycles which can make long-term budgeting and organizational investment difficult.

CONCLUSION | Clinics are faced with rapidly increasing demand for services due to the poor economy. At the same time, funding has, at best, remained level. Organizations have continued to stretch budgets to their limits, doing more with the same level of funding. This leaves very little room for new program development or expansion, capital investment and threatens the ability to maintain a stable workforce. Clinics are at the point of seeing demand for services far exceed their budgetary ability to provide care.
WORKFORCE CAPACITY

Safety Net workforce capacity and competency encompasses the expertise and experience of the professionals who work in the free clinics, community health clinics, community health centers and safety net hospitals to provide essential health care services to the underserved and uninsured.

A UNIQUE WORKFORCE | The Safety Net workforce is comprised of a talented staff of direct care providers and the crucial support staff to care for vulnerable populations. In order to fully meet patient and community needs while controlling costs, many clinics also utilize a network of volunteers and volunteer health providers, including physician specialists. Many Safety Net Clinics also serve as training locations for medical residents, social workers, pharmacists, chiropractors and other students.

Workers in the Safety Net system are often specifically drawn to mission-based care and are specialized in the care of vulnerable populations. As the overall U.S. population has diversified over the last 40 years, Safety Net workers must continue to ensure that health care is delivered in culturally and economically sensitive ways.

COMPLEX NEEDS | Safety Net clinic patients often exhibit chronic conditions and require a breadth of services and more appointment time with providers than patients in a standard medical practice. Safety Net Clinics focus on the social determinates of health, which add to the complexity of patient care and require special services such as medical interpreters, social workers, child development specialists and health educators. The availability of skilled mental health and dental health professionals remain areas of additional need in the Safety Net workforce. Access to affordable medication and education about prescribed medicines is a critical component of Safety Net care.

QUALITY IMPROVEMENT | As the entire health care industry works to improve access, health outcomes, reduce hospitalizations and manage costs of care, Safety Net Clinics are also investing in IT and in quality improvement. This requires additional training of the workforce, which sometimes affects the productivity of current providers. Medical practices, including some Safety Net Clinics, are applying to become recognized as Patient Centered Medical Homes (PCMH). Safety Net providers often operate with health care teams to emphasize active management of wellness and disease to ensure better health outcomes, improved health and reduced health care costs. Safety Net Clinics incur costs to form and enhance provider and medical care teams, develop and formalize additional processes and procedures, train their staffs, and educate patients.

All Safety Net Clinics are assessing how to ensure increased patient access in an environment of growing community need, while also working on continuous improvement of health outcomes. The number of patients is projected to increase substantially with implementation of the Affordable Care Act because of the role Safety Net Clinics will play as the starting point for quality health care access for newly insured people.

CONCLUSION | In a changing health care environment, Safety Net Clinics work to recruit and retain high quality providers to maximize continuity of care, to address the complex needs of patients, and to maintain up-to-date clinical training and computer skills. This need for qualified staff means that increasingly, Safety Net Clinics must be competitive in their ability to attract and keep highly skilled workers. The ability of Safety Net providers to continue to deliver quality services to clients is jeopardized without sufficient funding to stabilize and increase workforce capacity.
INFORMATION AND DATA SYSTEMS

As health care reform, information technology and electronic health records (EHR) advance, safety net clinics will face both significant opportunities for enhanced patient services and outcomes, and greater challenges. Electronic health records represent a “sea change” for clinic functions, especially for medical providers during patient interactions and communication.

PATIENT CARE | A major benefit of new information systems in safety net clinics is the potential for enhanced sharing of patient information. EHRs, as the broader information infrastructure is developed, will allow for more timely, complete and efficient sharing of patient records among primary providers (medical homes), hospitals and their emergency departments, specialists, laboratories and the patients themselves, leading to better coordination of care. Patient engagement in health maintenance and treatment plans may be enhanced by providing patients with direct and same-moment access to their health records and more options for timely communication with clinic staff. Preventive care, patient wellness and disease management education may be enhanced. Health data, outcomes and trends will be easier to capture and track for individual patients and clinics as well as for the broader community.

OPPORTUNITIES | Public health systems will benefit by more rapid and reliable shared information, especially around epidemic threats like the recent H1N1 outbreak. Disaster preparedness and response will also benefit. The challenge of delivering both primary and specialty care in rural and underserved communities may be mitigated by telemedicine, and made more accessible and robust with EHRs. Incentive payments from Medicaid and Medicare may provide some financial benefit to those clinics able to adopt EHR technology and use it to achieve specific objectives.

CHALLENGES | Significant start-up costs (e.g., purchase of EHR, hardware, training) and additional ongoing operating costs (licensing, greater IT and other EHR-related staff support) present a fundraising challenge to individual clinics. It is vitally important that charitable foundations and other financial supporters recognize and address these additional funding issues. Lessened productivity (certainly during the start-up period and possibly beyond) will occur, resulting in fewer patient encounters and a reduction of patient revenue. Perhaps more significant is the potential negative effect EHRs may have on the workforce. Older (less computer-adept) providers, both employed and volunteer, may not be able to transition to EHRs. At the least, their productivity will be negatively affected. Clinics that educate interns and residents will be challenged by training these transient providers on new systems.

CONCLUSION | Safety Net Clinics will need additional financial resources to address increased costs related to electronic health records and consequent lowered productivity.

TOP ISSUES:
- Improved data and information sharing
- Illness prevention and improved health outcomes
- Additional financial costs to safety net clinics and lessened productivity
ORGANIZATIONAL CAPACITY

The Safety Net infrastructure consists of a network of local organizations, their physical locations, workforce and other assets.

It is easy to define the workforce as those who provide direct care, those who provide ancillary and support services to clients, and the administrative workforce to support operations. It is, however, harder to describe the numerous organizational supports needed to provide high service quality and high performing organizations. Some of these are as mundane as paying for malpractice insurance and utilities. Others are more fluid, such as data management, quality control, outcomes evaluation, staff education and training. All are key components of the various functions inside of these organizations.

PATIENT COMPLEXITY | The daily needs of existing clients may challenge the capacity of Safety Net organizations to respond quickly to patient’s complex needs. The workforce is well versed in the range of medical and behavioral health, economic and social issues affecting patients. However, the ability of providers to address them can be hampered by budget constraints, high staff turnover and outmoded information systems. The rate of chronic disease across the country has grown requiring more investment in patient education, self-management and an increased array of medications and therapies.

CHANGING NEEDS | As with all health care settings, the physical layouts are in need of support — repairs, expansion, and modification to support a change in service needs, sometimes meaning relocation or adding satellite services for areas of emerging needs. The infrastructure associated with information technology has required re-evaluation of physical layouts and installation of new equipment.

STRAINED BUDGETS | Core operating support is imperative, not only to sustain operations at individual clinics but also to maintain a strong safety net system. In the Kansas City area, safety net organizations receive significant operational support from philanthropic sources. Providers are able to use these funds to leverage considerable other assets including volunteers, business support and additional donations of goods and services. Safety Net providers operate with very lean budgets. When cuts to funding occur, there is very little margin before there is a significant impact on services. As clinics reduce services or are forced to stop accepting new patients, this impacts all clinics as individuals seeking care go to other clinics in the area to meet their needs, placing a further strain on the safety net system.

GROWING DEMAND | Clinics are faced with rapidly increasing demand for services due to the poor economy. Organizations have continued to stretch budgets to their limits, doing more with the same level of funding. This leaves very little room for new program development or expansion, or capital investment and threatens the ability to maintain a stable workforce. Clinics are at the point of seeing demand for services far exceed their budgetary ability to provide care. The newest challenge faced by the Safety Net system is the rapidly changing health care environment and regulatory uncertainty making it necessary for institutional adaptations. This pace will only accelerate as health care reform brings thousands of newly insured into the existing Safety Net with its current infrastructure.

TOP ISSUES:
- Invest in physical location upgrades or redevelopment, including IT, to address emerging needs.
- Maintain the broad array of support systems needed to serve the diverse needs of this clientele.
- The rapidly changing health care environment and regulatory uncertainty will continue to provide unique challenges to the Safety Net that will require continued organizational adaptations to meet.

CONCLUSION | Safety Net capacity will require continued investments in the physical layout as well as the essential support services needed to serve the diverse needs of this network’s clientele.
IMPACT OF THE AFFORDABLE CARE ACT

The Affordable Care Act (ACA) is expected to reduce the total number of uninsured people and increase the numbers covered by Medicaid. However, there will remain a substantial number of people, mostly non-elderly adults, who will lack insurance. In addition, there will likely also be a large number who, despite having insurance, will continue to have difficulty accessing services. Projections are that the Safety Net Clinics in the Kansas City metro area will continue to serve thousands of low-income uninsured and underinsured persons. The Robert Wood Johnson Foundation’s brief on the ACA states “Safety net programs and providers that serve the uninsured … (may) adjust their policies and structures to best serve the needs of the many millions who remain uninsured even after the ACA is fully implemented.”

EXPANDED COVERAGE | In 2009, the major Kansas City area Safety Net Clinics provided 267,000 visits to up to 30 percent of the vulnerable population, or about 120,000 people. Projections are that the ACA will expand insurance coverage to many vulnerable KC metropolitan residents:

1) Increased Medicaid coverage for adults up to 138 percent of the federal poverty level (FPL), conservatively estimated to be about 95,000 individuals in the Kansas City metro area.
2) Increased coverage to about 43,000 through private insurance paid through employer mandates.
3) Increased coverage through private insurance subsidies for about 20,000. (The types of insurance coverage available for the poor with subsidies may carry higher co-pays and deductibles, thus rendering these insurance plans ineffective for covering the outpatient care for the poor that is provided through Safety Net Clinics.)

Insurance coverage is necessary but not sufficient to guarantee access. Despite the anticipated increase in covered individuals with Medicaid and other insurance, key issues remain.

1) Up to 85,000 people in the Kansas City area would remain uninsured.
2) It is critical to engage enough willing medical professionals to provide services
3) It is important to make insurance more stable so that gaps in coverage can be reduced
4) It is important to protect patients from high out-of-pocket health care costs

INCENTIVES | Incentives are provided for implementation of electronic medical records through Medicaid or Medicare for those providers with high Medicaid and Medicare ratios in their practices and to Federally Qualified Health Centers (FQHC). Complexities of the law make it such that most free and charitable clinics will not qualify for those incentives.

BILLING | Safety net systems may require changes to business plans and revenue streams to adjust to the new landscape. Shifting billing procedures and policies to serve the underinsured and remaining uninsured will be a challenge for some Safety Net Clinics.

DONORS | Analysts’ concerns are that the Safety Net supports may be prematurely reduced due to donor over-confidence in ACA coverage for vulnerable populations. It is important for Safety Net providers to highlight the importance of continued funding for Safety Net services because most of the growth in coverage will come from Medicaid, a weak source of revenue.

SERVICES | Populations served through the Safety Net Clinics are not simply vulnerable due to lack of insurance or poverty alone, but carry a higher burden of social issues. Safety Net Clinics provide a spectrum of supportive services in addition to direct health services. These services are not generally “billable” through insurance sources and will require continued subsidies from donors.