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Strengthening essential emergency departments: Transforming the safety net

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Abstract

Safety-net emergency departments (EDs) are a critical component of the US health care system, delivering emergency care for patients in need, including vulnerable populations. EDs provide unscheduled acute care for patients 24 hours a day, 7 days a week, regardless of a person's ability to pay. In addition, EDs have transformed beyond their traditional roles of providing emergency services and being the centers for regionalized trauma, cardiac, and stroke care, to also becoming stewards of public health by leading screening and treatment efforts for nonemergent conditions, such as HIV, hepatitis C, mental health, and opioid use disorder. Many safety-net hospitals and their EDs serve essential roles in urban and rural communities, making the impact of recent closures particularly concerning. In response, we convened clinical, operational, and administrative leaders of key safety-net EDs across the United States in order to develop expert consensus related to critical issues facing safety-net EDs. The goals were to help inform policymakers about current challenges and to offer timely recommendations so that together we can mend the safety net as the country works toward the goal of health equity for all.

Key words: safety net; safety-net hospitals; safety-net emergency departments.

Introduction

In 2000, the National Academy of Medicine report highlighted the tenuous state of our health care safety net, criticizing it as a patchwork of institutions, financing, and programs that vary dramatically across the country as a result of a broad range of economic, political, and structural factors.[1] Yet, to date, more than 2 decades later, very little has changed to significantly reform or reduce our country's reliance on a health safety-net system. Instead, the safety net is now at risk of failing due to uncertain or declining funding on top of a crumbling and fractured public health infrastructure.

Safety-net hospitals are those that see a substantial share of uninsured, Medicaid, or low-income Medicare patients.[2] Other key domains that define a safety-net hospital include the location, its community investment, and the offering of essential services (such as inpatient psychiatric and HIV care) that are typically insufficiently reimbursed.[3] Safety-net hospitals and their emergency departments (EDs) deliver disproportionally more undercompensated and uncompensated care, yet have similar operating costs as other EDs.[3]

Recognizing that safety-net EDs have unique challenges based on their operating and financial environments, and that their served patient populations have more complex needs, we aimed to better understand the specific challenges that safety-net EDs face in today's national health care system. To this end, in June 2023, the Department of Emergency Medicine at Boston Medical Center convened 50 physician, nurse, and administrative content-area leaders representing 15 academic safety-net hospital EDs across the country to engage in a 3-day, facilitated conference designed to identify and develop consensus understanding of barriers to delivering optimal care in safety-net EDs. Participants identified priority areas that must be addressed to ensure the health of our nation's safety-net EDs. The 5 major calls to action specific to safety-net EDs identified by the group of content area experts were as follows: (1) a need for financially aligned incentives, (2) a need for timely access to outpatient primary and behavioral care, (3) a need to optimize our health care system's inpatient and post–acute care capacity, (4) a need to ensure appropriate workforce staffing and workplace safety, and

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(5) a need to uniquely support vulnerable patients impacted by the social drivers of health. Following is a summary of the consensus findings of the convened safety-net ED leaders and experts.

A need for financially aligned incentives to support the financial viability of safety-net institutions and their EDs

Financial stressors facing the safety-net health care infrastructure today are multifactorial. While variation exists in the financial models of safety-net health systems, Medicaid covers a significant portion of patients who seek care at safety-net EDs and hospitals.[3] Expanding Medicaid through the Affordable Care Act (ACA) was monumental in shrinking the gap in coverage. Yet, since passage of the ACA, 10 states still have not adopted the expansion.[4] Despite Medicaid enrollment significantly increasing during the COVID-19 pandemic, the resumption of Medicaid redetermination processes has resulted in the loss of coverage for millions of eligible individuals, which has significantly impacted safety-net hospitals.[5] A large uninsured population also remains, including people ineligible for government-sponsored programs due to income limits or immigration status. These patients are more often cared for in safety-net EDs, resulting in a disproportionate cost burden on these EDs without appropriate compensation. Furthermore, Medicaid payment rates for both hospitals and clinicians are significantly lower than Medicare and private insurance payment rates,[6] again inequitably impacting safety-net hospitals. While federal and state payments through the Disproportionate Share Hospital (DSH) Program try to mitigate these shortfalls in funding, they do not result in appropriately crediting for the varied levels of under- or uncompensated care that safety-net hospitals provide. This program also fails to financially address clinicians delivering the care at the bedside.[3,7]

It is critical to develop incentives for both clinicians and hospitals to align with patient-centered health. With a rise in inflation, decreasing clinician reimbursement rates, and increased denial rates by insurers, clinicians must see more patients in a shorter amount of time in order to remain financially stable.[8-10] For safety-net ED clinicians, who receive lower baseline reimbursement rates, the pressure to do this is even greater. Failure to do so puts EDs at risk for closure. Unless safety-net EDs receive significant additional support from their already financially strained hospitals, they will have difficulty maintaining adequate clinician and nurse staffing. Without additional sources of financial support, the current clinician reimbursement model will only continue to drive safety-net EDs towards a fee-for-service (FFS) model, placing undue pressure on providers to spend less time with patients in order to increase volume.

While shifting from a primarily FFS payment model to a value-based care (VBC) model will likely benefit our nation's health care system, current alternative payment models (APMs) appear to consider ED presentations as failures rather than to view them as an opportunity to meet a patient need that is too difficult or complex to care for effectively outside the ED. While reducing unnecessary ED visits is an important objective for the nation's health care system, APMs typically fail to acknowledge that EDs can often be best positioned to help deliver value-based care with the appropriate resources at the right time.

In order for APMs to be successful, they must create reimbursement models for safety-net EDs to appropriately manage and coordinate complex patient encounters without bearing the cost of the extra time involved. Alternative payment models require emergency clinicians to spend considerable time and effort connecting with primary care clinicians and coordinating multidisciplinary teams comprising nurses, pharmacists, case managers, social workers, and physical and occupational therapists to safely discharge a patient. This care coordination often leads to many more hours in the ED for patients in order to safely decrease admissions. For example, a patient with Parkinson's disease who suffers a fall down the stairs receives an evaluation in an ED. After assessment and management, emergency clinicians discover that, in addition to the patient's chronic disease, the person is also experiencing an acute injury that may prohibit them from having a safe discharge plan to home. Only after time-intensive discussions with the patient and family members, along with collaborative dialogue among multidisciplinary health care staff, can the ED discharge the patient to a safe and appropriate alternative to a hospital (eg, sending them home with physical therapy or to a rehab facility).

A potential payment model that should be piloted due to its potential to provide financial stability and align incentives for ED clinicians, hospitals, health care systems, and payors is an inflation-adjusted global budget for ED clinicians.[11] The ED provides a service that benefits the public, the same as fire departments.[11] Instead of supporting emergency care by charging patients who experience emergencies, Pines et al[11] describe global budgets for hospital-based care that could finance the delivery of acute unscheduled care, incentivize development of programs to reduce avoidable ED visits, and provide financial stability for ED clinicians. This payment model, administered by a state government agency and funded by insurers, would also have a bonus pool, which could incentivize hospitals to reduce ED boarding, encourage clinicians and hospitals to partner on population health initiatives, and align clinicians, hospitals, and payors around value-based care.

In summary, current reimbursement policies significantly strain the financial health of safety-net institutions and their EDs. Financial incentive alignment between clinicians and hospitals, along with payment rate parity from all payors for both clinicians and hospitals, are needed in order to achieve the financial viability and sustainability our nation's safety-net health system requires.

A need for timely access to outpatient primary and behavioral care for society's most vulnerable members

The safety-net ED is often the only gateway for vulnerable patients to access health care. For uninsured patients, they are less likely to access outpatient care due to financial barriers, leading to worsening health outcomes.[12] Unfortunately, even after obtaining insurance, there continue to be issues related to timely access to primary care and specialty care, including behavioral health. While Medicaid expansion through the ACA has improved this access, patients continue to face entrenched barriers in accessing high-quality care. Primary care physicians are required to see more patients per day, which strains their capacity to accommodate patients who need timely follow-up care after an ED visit. Other barriers include smaller numbers of clinicians in low-income communities

due to workforce shortages, largely from lower participation in Medicaid compared with other insurances, especially in behavioral health.[6]

Lack of access to timely primary care or post-ED follow-up care continues to be a challenge in reducing avoidable ED presentations. As a result of these delays and challenges, patients' medical conditions and risk of adverse outcomes often worsen, such as the increased risk of stroke when chronic hypertension remains uncontrolled due to inadequate monitoring or the increased risk of suicide when depression goes untreated. Patients with new-onset diabetes without timely access to primary care for care initiation and monitoring often end up back in the ED for diabetic emergencies that could have been avoided. While care coordination in the ED can help avoid unnecessary return visits, this can only occur if outpatient access to needed services is available in a timely manner. Policymakers and lawmakers should consider methods to increase reimbursement for primary care–related services and specialty care payments.[13] This stands to make primary care more attractive to clinicians-in-training, which would help organizations recruit and increase the proportion of primary care clinicians in their community.[13]

While overall access to health care for vulnerable patients remains a challenge, a potential innovation in improving access to mental health care is the development of Certified Community Behavioral Health Clinics (CCBHCs). For Medicaid enrollees experiencing behavioral health disorders, CCBHCs can help address the gap in accessing outpatient mental health care. Certified Community Behavioral Health Clinics are required to provide behavioral health services and coordination 24 hours a day, 7 days a week, regardless of a patient's ability to pay.[14] Supported through the Centers for Medicare and Medicaid Services' Medicaid Demonstration and other independent state programs, CCBHCs may serve as a potential model that improves outpatient access and follow-up ED care. In summary, to reduce unnecessary ED visits, policymakers and lawmakers must financially incentivize easy access to high-quality, coordinated outpatient services.

A need to optimize our safety-net health care system's inpatient and post–acute care capacity

Safety-net hospitals and their EDs espouse a mission related to caring for vulnerable patients, regardless of their ability to pay. When their mission is combined with the federal government's unfunded mandate outlined in the Emergency Medical Treatment and Labor Act of 1986 (EMTALA)—which requires all patients to receive an appropriate medical screening exam—patients presenting to safety-net EDs can find themselves facing significant waiting-room delays and ED crowding.

Emergency department crowding worsens health care inequity and causes preventable patient morbidity and mortality.[15,16] For patients seeking care at safety-net EDs, they are more likely to leave-without-being-seen (LWBS), which is a marker of crowding, or they may be forced to wait longer for a hospital bed.[17] The cause of ED crowding often stems from misaligned health care incentives that favor higher-margin patients with elective procedures.[16] Safety-net hospitals receive lower reimbursement rates for the same procedures compared with non–safety-net hospitals, while also providing essential services with lower operating margins, such as inpatient psychiatric care.[18] Due to this financial risk, safety-net hospitals are at the highest threat for closure. More than 70 safety-net hospitals and their EDs in the United States have closed during the last 5 years.[19] This disproportionately impacts the most vulnerable patients, including those who are underinsured or uninsured.[17] As a result, vulnerable patients are often forced to travel farther in order to access basic care in the remaining safety-net EDs. This creates significant barriers to sustaining health, while at the same time further contributing to crowding in these remaining EDs.

Safety-net hospitals and their EDs disproportionately treat more socially complex patients with medical or psychiatric issues, which can lead to longer ED and hospital lengths of stay to ensure a safe discharge plan.[20] Following the COVID-19 pandemic, post–acute care sites, such as skilled nursing and rehabilitation facilities, have experienced significant capacity issues due to staffing shortages and facility closures. This has especially impacted safety-net hospitals, due to the high social needs of the patient populations they serve. As a result, uninsured patients who require post–acute care often stay in hospitals considerably longer than is medically necessary, which further worsens ED crowding.[21] Patients who are dual eligible (those who qualify for both Medicare and Medicaid), and have a substance use disorder or a behavioral health diagnosis, or both, are more likely to be denied entry into post–acute care facilities or discharged to lower quality post–acute care facilities.[22,23] Patients who are uninsured, have Medicaid, or are dual eligible and waiting for a publicly funded psychiatric facility, all stay significantly longer in the ED than those with insurance or those going to private psychiatric facilities.[24,25] As ED and inpatient lengths of stay go up, safety-net ED crowding levels also increase, putting vulnerable patients at risk for worse outcomes.[25]

In summary, policymakers, lawmakers, and payors should increase reimbursement rates to post–acute care facilities for patients on Medicaid, which would facilitate expansion of these key resources. To ensure accountability for optimal use of the additional financial resources, regulatory agencies should consider critically reviewing patient-screening and acceptance practices by post–acute care facilities and ensure there is no discrimination towards socially complex patients.

A need to ensure appropriate workforce staffing and workplace safety

Nursing staff shortages negatively impact the ED and inpatient care by increasing morbidity and mortality rates in patients, and by adversely affecting clinical operations, leading to increased ED LWBS rates and increased patient length of stays.[26] It is important to note that the current ED nursing staff shortage is not believed to be due to a lack of personnel (ie, supply),[27,28] but rather stems from high turnover rates resulting from burnout, with turnover rates approaching 30% in many hospitals post–COVID-19 pandemic.[28] In addition, staffing cuts due to financial constraints or budgetary reasons have only exacerbated the issue.[29]

Due to crowding and boarding, it can lead to patients lashing out at ED staff.[30] This is made worse with staffing shortages, causing ED staff to feel they are not able to provide the best level of attention and care for their patients. With high levels of boarding, bedside ED nurses are forced to provide inpatient level of care, which decreases the time they would spend assessing and caring for the diagnostically undifferentiated or acutely ill patients.

Table 1. Potential solutions to address the main concerns of the safety-net ED.

Recommendations	Potential solutions
Support the financial viability of safety-net institutions and their EDs	• Provide EDs an opportunity to participate and be rewarded in alternative payment models • Pilot inflation-adjusted global payment models in emergency care
Increase outpatient primary and behavioral access for society's most vulnerable members	• Rebalance primary care and specialty care payments to help increase recruitment of primary care physicians • Continue to invest in and study CCBHC models of care
Optimize our safety-net health care system's inpatient and post–acute care capacity	• Improve reimbursement rates to post–acute care facilities for patients on Medicaid • Provide additional enforcement tools for regulatory agencies to ensure nondiscriminatory acceptance practices
Assure appropriate workforce staffing and workplace safety	• Reduce ED crowding by aligning payment incentives, such as through a global payment model • Promulgate regulations to support the safety of health care providers
Support vulnerable patients impacted by the social drivers of health	• Fund population health efforts by the ED • Expand Medicaid coverage to undocumented immigrants

Abbreviations: CCBHC, Certified Community Behavioral Health Clinic; ED, emergency department.

The level of workplace violence in the ED is also on the rise, making the work environment even more stressful and dissatisfying for nurses and other ED staff.[31] The ED is the area of the hospital with the highest incidence of verbal and physical abuse towards staff by patients and visitors due to staffing issues, crowding, and lack of privacy, with nurses disproportionately the target of this violence. In the past, this was accepted as "part of the job" in the ED.[30,32] While staff training in de-escalation skills is important, increased screening by, and presence of, security in the ED has become a needed reality. Reducing ED crowding may help to reduce some of the violence, since many episodes stem from patients experiencing frustration related to long waiting times.[33] Real mitigation strategies that address crowding in addition to preventing workplace violence must be developed and implemented at the federal, state, and institutional levels.

In summary, addressing staff burnout and workplace staffing issues in safety-net institutions and their EDs, realigning incentives to discourage boarding through a global payment model, and developing regulations focusing on workplace safety can strengthen the workforce.

A need to uniquely support vulnerable patients impacted by the social drivers of health

As patients enter our safety-net ED's front door, we are confronted by, and must address, growing health disparities due to the social and political determinants of health. As income inequality grows, we see how our patients' life expectancy falls.[34] Climate change is accelerating the suffering from diseases that disproportionately affect our vulnerable patients, such as reactive airway disease from smog, vector-borne illnesses, severe weather–related illnesses, and interpersonal violence.[35] Emergency clinicians are already integrated into population health efforts to address these and other pressing problems with screening, brief intervention, and referral for treatment, including coordinating care with community-based social workers and case managers. However, intensive care coordination programs alone are inadequate to successfully address these complex upstream factors that drive our patients' health decisions and outcomes.[36]

In recent years, EDs, especially those attached to safety-net hospitals, have seen a rise in demand from undocumented immigrants seeking emergency and chronic care. While immigrants tend to be mentally and physically healthier and have fewer chronic medical problems than native-born homeless individuals, those with illness exposures or injuries have little or no access to health care.[37] As of 2023, half of undocumented immigrant adults are uninsured compared to 8% of US-born citizens.[38] Undocumented immigrants are excluded from most publicly funded health insurance programs and from many social safety-net services,[37,39] leading to them getting a majority of their care in EDs. While emergency Medicaid is available, significant variation from state to state exists and, ultimately, does not cover the cost of care.[39] Therefore, expanding health care coverage and access (emergency, primary, and preventive care) to immigrants, as California did through its Medi-Cal Medicaid program, is critical for a healthy community.[40]

In summary, health care funding mechanisms should help health care systems create and invest in innovative ways to proactively address the social drivers of health facing the most vulnerable populations in our local communities.

Key calls to action

Immediate action by local, state, and federal government agencies is urgently needed to help address the public health system challenges outlined above and the disproportionate impacts they are having on safety-net EDs (Table 1).

By consensus, the conference participants identified these specific key calls to action:

- Adjustment of state and federal payment models to provide equity for safety-net hospitals compared to non–safety-net hospitals
- Expansion of health care coverage for undocumented immigrants
- Implementation of measures to align value-based care incentives among safety-net clinicians and hospitals
- Investment in primary care and community behavioral health clinic models to address critically needed outpatient services
- Realignment of incentives to discourage boarding in the ED
- Creation of policies and practices that effectively address workforce staffing and workplace safety

- Incentivization of health systems to create innovative mechanisms to address the social drivers of health facing their local communities

Conclusion

Safety-net EDs and the patients they serve are threatened in the current health care system. Safety-net hospitals and their EDs provide disproportionately more care for the poor, uninsured, underinsured, and other vulnerable populations in our communities. In addition, safety-net EDs provide services that support large-scale public health initiatives. With ongoing safety-net hospital closures, health disparities among vulnerable populations in communities will continue to grow, and city, state, and federal government agencies will bear increasingly larger financial burdens due to inadequately addressed community health needs. While the participants from our consensus conference represented 15 diverse safety-net EDs from across the country, all identified similar priorities and developed a consensus on broad tactics of how best to address them. The 5 recommendations they developed offer a clear and compelling roadmap to treat our ailing health care system through the development of new payment models and health care delivery systems that acknowledge the value that safety-net EDs and hospitals bring to our community. Adoption of these consensus tactics will be essential to being able to continue to deliver effective, safe, and comprehensive emergency care—not only today but also well into the future.

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Supplementary material

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Conflicts of interest

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Notes

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