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Safety-Net Emergency Departments: At Look at Current Experiences and Challenges

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Executive Summary

Safety-net hospital emergency departments (EDs) are an important part of our health care system, especially, but not only, for the uninsured and others with low income. With multiple major changes unfolding in our system today, including the development of new health care delivery models, payment reforms, health insurance expansion, and increasing demand for primary care, safety-net EDs are a sort of crucible in which these shifts and transitions can be seen playing out. To understand more about safety-net EDs' current experiences and challenges as the Affordable Care Act (ACA) begins to take hold, we conducted interviews in June and July 2014 with ED directors in a convenience sample of 15 of the 750 safety-net hospitals around the country, and asked them about selected aspects of their ED's experience in January-June 2014 compared to the same period of 2013.

The hospitals in our sample come from all four Census regions and a mix of Medicaid expansion and non-expansion states. Our sample includes primarily large, urban teaching centers with an average of close to 100,000 ED visits per year. Ten of the 15 hospitals are public (non-federal) and five are private non-profits. All are trauma centers, including 11 Level 1 Regional Resource Trauma Centers, three Level 2 Community Trauma Centers, and one Level 3 Rural Trauma Hospital.

Several key themes emerged from our interviews:

- The ED directors we spoke with in hospitals in Medicaid expansion states reported reductions in the share of ED patients without insurance and corresponding increases in the share with Medicaid. However, uninsured rates remained high in all the safety-net EDs.
- The ED directors' expectations regarding trends in ED visit volume over the next few years varied. Some anticipated increased visits, citing pressures on primary care access, remaining large uninsured populations, or expanded ED capacity. Others anticipated flat or declining ED visits due to expanded coverage and access and the impact of new models of health care delivery and payment.
- The ED directors we interviewed were not certain what the net impact of expanded coverage, large remaining uninsured populations, DSH cuts, delivery system reforms, and other ongoing changes will be on ED finances.

- The interviews underscored that EDs play multiple roles in our health care system, not only providing emergency care, but also acting as a primary and specialty care safety-net, a diagnostic and referral center, and a psychiatric treatment site.
- The interviews also spotlighted how EDs have become a critical site of psychiatric treatment due to major strains on access to inpatient psychiatric treatment. The ED directors reported that adult patients needing inpatient psychiatric treatment often have to wait in the ED for 10 hours or more for an inpatient bed, and waits for children are as long as 24 to 48 hours.
- We heard that broader changes in the health care system, such as the emergence of stand-alone EDs, the growing prevalence of high-deductible plans, and delivery system transformation, present safety-net EDs with new challenges and opportunities.

Introduction

Safety-net hospitals, including their emergency departments (EDs), are an essential part of our health care system and a major source of care for millions of Americans, especially (but not only) the uninsured and others with low income. With significant changes affecting nearly every aspect of our health system today, including health care delivery, payment systems, insurance coverage and markets, and capacity to meet rising demand for access, safety-net EDs are a sort of crucible in which these shifts and transitions can be seen playing out. To understand more about safety-net EDs' current experiences and challenges as the Affordable Care Act (ACA) takes hold, we conducted interviews in June and July 2014 with ED directors in a convenience sample of 15 of the 750 safety-net hospitals around the country. We asked the safety-net ED directors about selected aspects of their ED's experience in January-June 2014 and how they compare to their experiences during same period of 2013.

We defined safety-net hospitals as those reporting in the American Hospital Association (AHA) Annual Survey Database that over 25% of their FY 2012 inpatient discharges were Medicaid patients. The 15 hospitals in our sample are located in all four Census regions and in a mix of Medicaid expansion and non-expansion states. Our sample includes primarily large, urban academic centers with an average of close to 100,000 ED visits per year. Ten of the 15 hospitals are public (non-federal) and five are private non-profits. All are trauma centers, including 11 Level 1 Regional Resource Trauma Centers, three Level 2 Community Trauma Centers, and one Level 3 Rural Trauma Hospital.

This issue brief draws out key themes that emerged from our interviews and highlights variation in the experience reported by ED directors in different hospitals and environments. The observations and perspectives of these safety-net ED directors, while not representative in a statistical sense, illuminate important issues and can help to inform assessments of both the opportunities and remaining difficult challenges for safety-net EDs as change accelerates under the ACA.

Key Findings

Who is Coming through the ED Door

The ED directors' assessments of recent changes in visit volume were mixed. Visit volume in some EDs was flat in the first six months of 2014 relative to 2013. One director explained that no increase in visits was possible because the ED was already at its saturation point. Directors who said ED visit volume was higher in 2014 than 2013 posited a variety of explanations, including continuation of recent upward trends in ED visits, higher patient through-put due to improved ED operations, new utilization due to expanded coverage, and strained access to outpatient primary care. ED directors who reported declines in visits also offered differing explanations. For example, one suggested that his county hospital, which is known for seeing indigent patients, might not be the first choice for patients who have a choice, including those who gained coverage in 2014. Another mused that high-

"…I think education, both for physicians and for mostly the patient population, to understand the value of seeing a primary care doctor, how to utilize health care resources appropriately, what the appropriate use of a sub-specialist and an emergency department are – I think, hopefully, those things will occur. As people understand how to do those things …our system becomes more efficient, more resource saving."

deductible plans might have contributed to reduced ED visits because they impose high financial barriers to expensive care.

The ED directors' expectations regarding ED visit volume in the next few years varied, too. Many of the directors we interviewed anticipated higher visit volume in the next three to five years. The reason they cited most often was their expectation of rising strains on outpatient primary care capacity as coverage expands. Also, the ED directors widely emphasized that it will take time for many newly insured patients to learn how to use their coverage, establish relationships with primary care providers, and seek care appropriately. Several interviewees indicated that capacity and use of their EDs is increasing due to new ED programs, new construction, and efficiency improvements.

"As the ACA matures and patients without primary care physicians hopefully have developed relationships, the number of visits at ERs is going to plateau…I hope and then I trust there will be certain dividends to maturity of the ACA."

The directors who expected visit volume to remain stable or decline were more optimistic that newly covered patients will be able to establish relationships with primary care physicians. One pointed to the fact that more patients now have a choice about where they seek emergency care. Another observed that because his hospital was operating on a global budget for all its patients, there was increased emphasis on outpatient management of conditions that previously triggered admissions to the hospital.

The ED directors in Medicaid expansion states reported lower uninsured rates among ED patients in the first six months of 2014. With one exception, all the ED directors in Medicaid expansion states reported that the uninsured rate among their patients had fallen in the first six months of 2014 compared to the first six months of 2013 or a somewhat longer look-back period. They attributed the reductions in uninsurance almost entirely to the Medicaid expansion, pointing to closely corresponding increases in the share of their ED patients with Medicaid coverage. In some cases, they reported that private coverage had increased, too. One of the five ED directors in Medicaid non-expansion states also reported a drop in the uninsured rate among ED patients, citing increases in Medicare, Medicaid, and private coverage.

Notably, uninsured rates remain high across the board. Notwithstanding higher rates of insurance coverage in some EDs, uninsured rates in safety-net EDs remain high in both Medicaid expansion and non-expansion states, ranging from 20% to 25% at the low end (except for one outlier, reporting about 8%), to 70% or more at the high end. The ED directors said that, regardless of coverage expansion, they will continue to see a large population that remains uninsured.

Safety-Net ED Finances

ED directors are not certain how all the changes that are occurring – including but not limited to ACA-related reforms – will affect their EDs' bottom lines. In the immediate post-ACA implementation period we asked about, it was not yet clear to the ED directors what impact the law would have on their institutions' finances. Those in Medicaid expansion states generally saw measurable reductions in the uninsured rate among their patients and increases in Medicaid coverage and patient revenues. At the same time, along with the other directors, they pointed to an array of other factors also in play – anticipated reductions in Medicaid DSH payments; low Medicaid reimbursement rates; large populations who remain

uninsured, including undocumented immigrants and low-income adults in non-expansion states; increased patient choice among the newly insured; and payment reforms underway in some states and hospitals. In addition, a number of ED directors mentioned that neighboring hospitals and urgent care clinics had well-established methods to attract and retain insured patients while routing uninsured patients to safety-net hospitals. The directors said they were uncertain about what the net effect of all these changes on their bottom lines will be.

"The concern would be that the few patients who do get insurance,… if they choose to go someplace else, if they choose to go down the block to the urgent care center, then we're going to have a greater percentage of non-paying patients, which is going to strap the hospital even further."

EDs Have Multiple Roles Beyond Emergency Care

In addition to providing traditional emergency services, safety-net EDs play numerous other roles in their communities. They are rapid diagnostic and treatment centers for overwhelmed primary care clinics. They are a source of access to specialty care and act as referral centers for patients with limited outpatient treatment options. And they are a key source of information and assistance for people new to health insurance and the health care system who are trying to navigate this unfamiliar and complex terrain. These additional roles have become integral to the operations as well as the community expectations of safety-net EDs across the country. Some of these activities are described in greater detail below.

Emergency Care

The defining purpose of EDs is to provide emergency care, frequently including life-saving treatment. Often, it is clear that an individual who presents to the ED is having a medical emergency. But the ED directors stated that it is also often unclear to individuals who seek attention in EDs whether their conditions or symptoms, which may be painful or frightening, indeed require emergency attention. They go to the ED because they need a health professional to make this clinical assessment, and the ED directors saw making these assessments as part and parcel of the job of EDs. They underscored that a visit to the ED to seek care for a perceived emergency, even if it turns out not to be an emergency, should not be considered inappropriate or unnecessary ED use, or confused with avoidable ED visits for primary care. They said that when patients fear that they are experiencing a life-threatening health event, the decision to go the ED is rational, particularly if they are likely to encounter delays in care or inadequate diagnostic testing and treatment if they seek medical attention in other settings.

"If you have chest pain, should you go to your primary care doctor? Should you go to the ER? …It's sort of a blurred line… If the patient's having chest pain and they're 50 years old, can they wait two weeks? Actually, a lot of people probably could wait two weeks, but a few can't. They don't know until they get their EKGs and their heart checked out. It's hard to tell sometimes.

Most of our heart attacks walk in the door. They're not brought in by ambulance, so it's hard sometimes to tell what can wait or what can't wait."

Primary Care

Interviewees characterized safety-net EDs as a primary care backstop in our system. Use of the ED as a primary care safety-net emerged as a major theme in our interviews. When we asked the 15 ED directors how frequently they see patients who visit the ED because they lack access to timely primary care, responses like "extremely often" and "every single minute of every hour of every single day" were typical, although a small number described robust primary care networks in their communities. Nearly all the directors estimated that fewer than half of their patients had a primary care doctor or clinic.

The ED directors suggested that many factors lead people to seek primary care in EDs, including limited outpatient primary care capacity in the community; increased pressure on primary care physicians (PCPs) to see more patients per day, which strains their capacity to accept patients with involved needs; limited PCP participation in both public and private insurance; and lack of after-hours access and long waits for appointments with office-based PCPs. The directors said that, in addition to keeping health care costs lower, increased access to outpatient primary care would help reduce crowding and long wait-times for care in EDs.

"Having a primary care physician and having access to them are two different things… Somebody they can identify and say 'this is my primary care doctor' – that's gone up pretty dramatically, but then you say, well, when was the last time you saw that person or can we get follow-up for that person, and the answers can vary but its commonly 'well, they can't get us in for six months.'"

Weak patient connections to PCPs were also cited. Another issue that some directors raised is that insured ED patients who, according to administrative records, have an assigned PCP often appear not to know it, indicating a need for increased patient outreach and engagement, particularly for newly insured populations who may have limited health insurance literacy and experience with the health system. It was suggested that other safety-net patients have a weak connection to primary care because they make infrequent primary care visits due to travel distances, low income, and other barriers to access. These gaps undermine patients' ability to experience the value of continuity of care, which helps to reinforce patient-PCP relationship.

"[T]hey don't have access. Either they're not familiar with their plan, or they didn't know they had a primary care doctor… "

Many ED directors took the view that improved access to primary care under the ACA will take time to materialize. The ED directors in our sample generally reported that the supply of primary care in their communities remained relatively unchanged in the early period following the ACA coverage expansions. However, many said they expected progress under health reform to take place in a step-wise fashion, beginning with expanded coverage and, over time, leading to improved access to care.

"The challenge of the change is really to connect people to this grand goal of primary care and you have to start somewhere. They started with getting people coverage, but there's a lot more pieces that have to fall into place to make it work, but you've got to start with one piece, right?"

Diagnostic and Referral Center

Patients are often referred to the ED from a primary care provider's office. The ED directors said that PCPs or other clinicians may make the referrals if they lack resources they believe might be required for patients, or for other reasons. They also pointed out that referrals are often initiated by non-clinical staff because the office has limited same- or next-day appointments available. This dynamic has itself influenced both provider and patient behavior to some extent. Some safety-net hospitals have increased the accessibility of their primary care clinics by adding same-day and after-hours appointments, but have subsequently found that many patients once turned away from an office-based PCP and referred to the ED will continue to seek care in the ED because of that initial experience.

"…in many instances – and this happens in our own clinic – they're being sent over by their primary care doctor for something that they felt they couldn't handle in the clinic…"

Referrals to the ED also occur because of limited access to timely specialty care. Numerous ED directors noted that it can be more challenging to obtain appointments for some specialties than for primary care. Shortages of some specialists, low participation in Medicaid by certain types of specialists, including orthopedists, limited managed care provider networks, and lack of coverage for and access to oral health care were all cited. One interviewee mentioned that some patients who receive specialist care in the ED will first seek follow-up care with the specialist on call in the ED because geographic and financial barriers make it extremely difficult for them to access office-based specialists, or because they face months-long waits to see an oncologist, for example. One ED director stated that the specialist groups on contract to his ED specialty care clinics are considered to be the best in the field and attract patients from considerable distances. The directors reported difficulty arranging follow-up for patients suffering from advanced cancer and neurosurgical diagnoses, while noting that some of these problems were more memorable than common.

Psychiatric Treatment

Safety-net EDs are increasingly an important source of psychiatric care. Several ED directors spoke about the role their EDs are playing as a safety-net for psychiatric treatment, citing severe gaps in access to both outpatient and inpatient psychiatric care. One director highlighted a sharp increase in psychiatric visits in the first six months of 2014, including many patients with both medical and psychiatric problems. He noted that his psychiatric emergency center is the only one in his large city due to several closures of psychiatric facilities and general hospitals with psychiatric facilities, and also that funding for psychiatric resources had been declining slowly but steadily over the last two years.

Virtually all EDs reported significant difficulty obtaining inpatient treatment for patients suffering from psychiatric illness. Federal law ("EMTALA") requires emergency providers and capable hospitals to provide stabilizing treatment for patients in need of emergency care, regardless of their insurance status. However, the ED directors we interviewed reported that, once they have stabilized psychiatric ED patients, they have difficulty securing inpatient psychiatric treatment for them. Their safety-net hospitals have limited capacity for inpatient psychiatric care and must often transfer psychiatric patients to another hospital. The EMTALA prohibition against considering patients' insurance status does not apply in the case of stable patients, and many ED directors we spoke with reported that their ability to obtain inpatient care for psychiatric patients varied dramatically based on the patient's insurance status, with Medicaid and uninsured patients facing much longer waits for inpatient treatment. The directors noted that access to inpatient treatment was even more limited for patients with co-morbid illnesses, such as substance abuse and its related medical problems. Psychiatric patients often remain in the ED for prolonged periods, awaiting admission to the hospital's inpatient psychiatric unit or transfer to another inpatient facility – a phenomenon known as "boarding." Prolonged periods of patient boarding have been linked with worse health outcomes.

Four of 10 ED directors reported typical boarding time of at least 10 hours for adult psychiatric patients. Ten ED directors provided estimates of typical boarding time for adult psychiatric patients seen in the ED. Of the 10, nine gave estimates of six hours or more, including four who said the typical wait was at least 10 hours. It is noteworthy that three of the hospitals have separate psychiatric EDs or treatment areas, which should reduce boarding times. Several ED directors pointed out that "typical" boarding time concealed important disparities and variation in psychiatric patient experiences. For example, one director reported that boarding time averaged 18 hours for Medicaid patients, but three days for the uninsured.

Another said that, while typical boarding time for psychiatric patients in his ED is 8 to 10 hours, some patients have waited 36 to 40 hours to be admitted for inpatient psychiatric treatment. Some ED directors spoke of especially long wait times for children with psychiatric emergencies – 24 to 48 hours, or even longer – due to the sharp lack of adolescent psychiatric care and pediatric psychiatric beds, made worse in some areas by hospital closures.

Some ED directors cited positive changes in access to inpatient and outpatient psychiatric care. One director mentioned that, because more patients now have insurance, the ED is now able to transfer psychiatric patients to additional inpatient facilities besides the state psychiatric hospital, easing boarding times. Others mentioned ongoing efforts to mitigate gaps in access to emergency psychiatric care, including expansions of outpatient psychiatric care in their hospitals.

Broader Health System Developments

In addition to the central themes and issues that emerged from our interviews, a number of other topics raised by individual ED directors also warrant discussion because they shed light on dynamics in the health care market and our health care system at large.

- ***Stand-alone EDs.*** Emerging first in Texas several years ago, stand-alone EDs currently exist in nearly all states. They may be indistinguishable from traditional EDs from the patient perspective, but their capabilities and licensing requirements appear to vary considerably. Interviewees noted that stand-alone EDs, which are generally located in areas with high rates of private health insurance coverage, may have contractual agreements with nearby hospitals under which the hospitals give priority for inpatient admission to the stand-alone ED's patients – who are more likely to be insured – over its own Medicaid and uninsured ED patients who are waiting for an inpatient bed. While these arrangements may improve the payer mix of the hospitals involved, uninsured or "underinsured" patients in these hospitals' EDs may face delays for inpatient care based on their ability to pay. In addition, stand-alone EDs compete with safety-net EDs for emergency physician staff.

- ***New models of care.*** A number of the ED directors we interviewed said that their institutions were experimenting with new care models aimed either at increasing ED capacity through efficiency measures or at decreasing ED visits. Some had implemented new care processes to reduce ED wait times, improve patient throughput, and provide a "value experience" for patients, in order to attract and retain newly insured patients in particular. Others were participating in accountable care organizations (ACOs) or other population health management programs with global payments, or were operating under a global budget that introduced new pressures and incentives to reduce ED visits.

High-deductible plans. Several of the 15 ED directors we interviewed observed the increasing prevalence of high-deductible health plans. One ED director we spoke to believes that high-deductible plans – which are designed to encourage more prudent consumer use of health care, including ED services – empower consumers because individuals paying out of pocket for expensive medical care are more likely to demand high quality and providers will therefore invest more effort in providing high-value care. Mostly, though, ED directors expressed concern that high-deductible plans effectively render insured individuals uninsured, reproducing the same financial barriers to care that expanded coverage was intended to lower. By the same token, they said, high

deductibles diminish the increase in patient revenues that safety-net providers expected from expanded coverage, as many in the low-income population they serve may be unable to pay these deductibles.

Conclusion

Safety-net EDs play multiple vital roles in our health care system, evolving continually to fill emerging or widening gaps in access to services. In addition to providing emergency care needed by Americans from all walks of life, they also provide a safety-net of primary care and specialty care, serve as diagnostic and referral centers, and, increasingly, act as psychiatric treatment facilities, particularly for the uninsured and others with low income. Even as health insurance coverage expands widely under the ACA, the uninsured rate among safety-net ED patients is likely to remain high and safety-net EDs will continue to be a linchpin of access to care that is not otherwise available to many in our system.

Widespread and far-reaching initiatives to transform health care delivery and payment, along with expanded coverage, expected changes in payment to safety-net hospitals, and other reforms accelerated or set in motion by the ACA, mean that safety-net EDs are operating in a changing environment that presents both new opportunities and new challenges. It will be important to understand how safety-net EDs in this transitional setting participate in and respond to the changes, how they are affected, and what the implications are for access to care in communities across the nation.

Appendix

Methods

We conducted semi-structured interviews with ED directors in a convenience sample of 15 safety-net hospitals around the country, to learn how selected aspects of their ED's experience in the six months immediately following full implementation of the ACA (January-June 2014) compared with their experience in the same six-month period in the year before ACA implementation (January-June 2013). Among those we interviewed were ED medical directors, chairpersons, and chief medical officers. The hospitals included in our sample are located in a mix of Medicaid expansion and non-expansion states and are drawn from all four Census regions. Although we sought to recruit diverse hospitals with respect to urban/suburban/rural location, ownership, and other factors, our sample includes primarily large, urban academic centers with an average of close to 100,000 ED visits per year. On average, the Medicaid share of total inpatient discharges was 42% in the sample hospitals.

Interview Questionnaire

1. Thinking about the period since January 1, 2014, when the ACA-related coverage expansions took effect, has the visit volume in your emergency department changed compared to the first six months of 2013? What do you think is the primary reason for the observed change? What do you anticipate will happen to your visit volume over the next 3-5 years?
2. What is the current insurance (or payor) mix of your ED patients? In other words, roughly what share of patient visits (not revenue or charges) are attributable to Medicaid, Medicare, privately insured, and self-pay/uninsured patients, respectively? Has this insurance mix changed compared to the first six months of 2013? If so, how?
3. Compared to the first six months of 2013, has patient acuity in your emergency department changed since January 1, 2014? If yes, please elaborate – for example, have you seen a change in fast-track volume, admission rates, or triage acuity categories?
4. Approximately what share of your emergency department patients would you say currently have a primary care doctor or a clinic they usually go to? Is this share about the same as it was in the first six months of 2013, or is it different?
5. How often does your emergency department see patients who are visiting the emergency department because they do not have other access to *timely* primary care? Specialty care?
6. What is the typical "boarding time" for an admitted psychiatric patient in your emergency department (i.e., disposition decision to emergency department departure)? Is this about the same compared to the first six months of 2013 or is it different?
7. How, if at all, have the changes in the ACA affected your ED's finances?
8. What do you see as the chief opportunities and challenges presented by the ACA?
9. Is there anything we haven't covered that you'd like to observe or share?