Our country’s safety-net health system, including public hospitals and community health centers that are often the singular lifeline for many of the 100 million patients who have Medicaid or no insurance, is doubly hit by the coronavirus disease 2019 (COVID-19) pandemic. In just 2 months, US jobless claims have exceeded 30 million, and the coronavirus has proven to be a disproportionate burden in low-income neighborhoods and communities of color. These realities imply that the safety net must rapidly scale to absorb new patients and attend to needs directly and indirectly associated with COVID-19.

These are sobering facts, particularly when considering the financially tenuous position of most safety-net systems. However, the structure of these essential health systems may prove to be particularly well primed to rise to the challenges of COVID-19, with sufficient resources. Three features of the US safety net allow it to be resilient and prepared for this turbulent time.

First, both because of their financial capacity and their mission-driven culture, safety-net health systems are built to deliver care more aligned with modern, value-based models rather than follow traditional fee-for-service incentives. Financially, safety-net systems operate with narrow to negative margins and rely heavily on capitated payments. Culturally, clinicians are more used to working with limited resources and attuned to avoiding unnecessary care and prioritizing high-value, patient-centered interventions. Consequently, safety-net systems aim to shift patient care to the least expensive site of care, compared with peer institutions, which seek high volumes and expensive procedures.

One visible example borne from this ethos is the safety-net system’s early foray into using technology to bridge gaps in access to specialty care. The eReferral or eConsult systems use simple technology to asynchronously access specialist expertise, attenuating the wait for a consult from months to days. These systems, pioneered at San Francisco General Hospital, proliferated even when no billing codes existed for such visits. During this pandemic, safety-net health systems, such as the Los Angeles County Department of Health Services and NYC Health + Hospitals, that adopted eConsult systems early have been able to build on such existing infrastructure with greater agility than their peers.

Second, safety-net health systems have historically shown a greater orientation to sharing innovation, rather than viewing these as sources of competitive advantage. Many health systems around the country, for example, have been focused on identifying patients with high needs and high costs, often relying on risk prediction models based on claims data. However, safety-net systems often do not have the resources for such expensive, commercial risk models. NYC Health + Hospitals’ leadership discovered an added challenge: patients without insurance do not generate claims data, meaning they would be excluded from existing models. Embracing the notion that necessity is the mother of invention, they developed their own payer-agnostic predictive model—one not reliant on claims data—and made it publicly available. Peer safety-net health systems, including Los Angeles County and Denver Health, have now incorporated this methodology into the development of similar models for their populations.

A similar spirit of collaboration exists across public health departments and community-based organizations. California forged countywide collaboratives through the Whole Person Care initiative (either led by county health departments or hospitals and clinics) to address medical and social needs of Medicaid beneficiaries with the greatest vulnerabilities, such as people experiencing...
homelessness. During the pandemic, several counties found this interagency infrastructure vital to COVID-19 response. For instance, Whole Person Care partnerships helped provide operational support for isolation hotels and stood up temporary housing for individuals who have recently been incarcerated.4

Third, safety-net health systems’ reliance on public financing to offset uncompensated care generally presents major challenges to their financial viability. Initial stages of innovation are often dependent on grant funding because of a paucity of capital available for investment. For example, analyses have found that telehealth adoption at federally qualified health centers was contingent on public and private grants, hindering long-term planning and scalability. Despite its uncertainty, public financing offers one important silver lining: funding flexibility.

Most health systems are reliant on traditional fee-for-service payments and operate with decentralized budgetary systems, impeding their ability to make global investments. In contrast, when sufficient resources are made available, safety-net health systems may be more likely to invest in population health programs that pay long-term dividends across departments and care settings. For example, while national adoption of community health worker programs, which have repeatedly shown a positive return on investment, has been slow, the safety-net system has taken to these with greater enthusiasm.5 The Indian Health Service has relied on the community health worker model for decades to reach patients in marginalized groups and connect them with care.6 These programs are increasingly viewed as a viable structure on which to build contact-tracing initiatives necessary to suppress transmission of COVID-19 and ensure a safe reopening of the US.

The COVID-19 pandemic has been a devastating crisis and unmasked the fragility of the US health care system in several ways. While safety-net health systems are naturally well positioned to contribute to this response, they require greater support. In the near term, the health care safety net would benefit from a fairer allocation of stimulus dollars from disaster relief funds designated for hospitals. The formulae used by the Trump administration to determine relief money allocations from the Coronavirus Aid, Relief, and Economic Security (CARES) Act left safety-net hospitals shorthanded, favoring hospitals with greater private insurance revenue. Thankfully, this imbalance is being addressed in the latest tranches of funding, with a recent announcement from the US Department of Health and Human Services about an additional $15 billion in relief monies earmarked to eligible Medicaid physicians, dentists, behavioral health providers, and assisted living facilities and home services providers and a further $10 billion to safety-net hospitals.

In the longer term, safety-net health systems could be at the vanguard of a broader trajectory of transformation that prioritizes population health over rent-seeking behavior in health care. This pandemic has upended traditional health-system strategies that rely on maximizing patient volume and prioritizing in-person care. Going forward, systems could be oriented around flexible budgets that allow for multiple modalities of service delivery and further extending care into patients’ neighborhoods and homes. Braiding and blending public funds could further cinch collaboration across sectors, particularly with public health departments and community-based organizations, around the common goal of improving the health of US residents with low incomes.

Public financing helps ensure that safety-net health systems serve the patients with the greatest vulnerabilities. Yet the COVID-19 era has shown how this mission has spillover benefits for the rest of society. Uncontrolled outbreaks in vulnerable neighborhoods can easily spread beyond them. The essential workers underpinning the economy rely on clinics and hospitals that accept Medicaid or serve patients with no insurance. Safety-net health systems provide financial protection not only to such patients but also neighboring hospitals that would otherwise take on their uncompensated care burden. For all of these reasons, shoring up our safety-net system should be seen less as charity and more as an investment in health for all.
ARTICLE INFORMATION

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Corresponding Author: Dave A. Chokshi, MD, MSc, Department of Medicine, New York University Grossman School of Medicine, 550 First Ave, New York, NY 10016 (Dave.chokshi@alumni.duke.edu).

Author Affiliations: Department of Population Health Sciences, Weill Cornell Medicine, New York, New York (Mullangi); Department of Medicine, New York-Presbyterian Hospital, New York (Mullangi); Department of Medicine, New York University Grossman School of Medicine, New York (Knudsen, Chokshi); NYC Health + Hospitals, New York, New York (Knudsen); Department of Population Health, New York University Grossman School of Medicine, New York (Chokshi).

Conflict of Interest Disclosures: Dr Chokshi reported personal fees from Institute for Healthcare Improvement, Aspen Institute, RubiconMD, and ASAPP Inc outside the submitted work and has served in leadership roles at NYC Health + Hospitals from 2014 to 2020. No other disclosures were reported.

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