Safety net hospital

A safety net hospital (SNH) is one of the medical centers in the United States that has a legal obligation to provide healthcare for individuals regardless of their insurance status (the United States does not have a policy of universal health care) and regardless of their ability to pay.

Because of this legal mandate to serve all populations, safety net hospitals typically serve a proportionately higher number of uninsured, Medicaid, Medicare, Children's Health Insurance Program (CHIP), low-income, and other vulnerable individuals than their non-safety net hospital counterpart.

Safety-net hospitals are disproportionately impacted by hospital payment reform policies. Complex elective procedures performed at safety-net facilities are associated with worse outcomes and higher costs. The effects of hospital safety-net burden on highly specialized, emergent, and resource-intensive conditions are poorly understood.

Lopez Ramos et al., examined the effects of hospital safety-net burden on outcomes and costs after emergent neurosurgical intervention for ruptured cerebral aneurysms.

They conducted a retrospective analysis of the Nationwide Inpatient Sample (NIS) from 2002 to 2011. Patients ≥ 18 years old who underwent emergent surgical clipping and endovascular coiling for aneurysmal subarachnoid hemorrhage (SAH) were included. Safety-net burden was defined as the proportion of Medicaid and uninsured patients treated at each hospital included in the NIS database. Hospitals that performed clipping and coiling were stratified as low-burden (LBH), medium-burden (MBH), and high-burden (HBH) hospitals.

A total of 34,647 patients with ruptured cerebral aneurysms underwent clipping and 23,687 underwent coiling. Compared to LBHs, HBHs were more likely to treat black, Hispanic, Medicaid, and uninsured patients (p < 0.001). HBHs were also more likely to be associated with teaching hospitals (p < 0.001). No significant differences were observed among the burden groups in the severity of subarachnoid hemorrhage. After adjusting for patient demographics and hospital characteristics, treatment at an HBH did not predict in-hospital mortality, poor outcome, length of stay, costs, or likelihood of a hospital-acquired condition.

Despite their financial burden, safety-net hospitals provide equitable care after surgical clipping and endovascular coiling for ruptured cerebral aneurysms and do not incur higher hospital costs. Safety-net hospitals may have the capacity to provide equitable surgical care for highly specialized emergent neurosurgical conditions.

SNH patients with brain metastases treated with SRS alone had fewer follow-up neuroimaging studies and were at higher risk for neurologic symptoms, hospitalization for brain metastases, and salvage neurosurgery in comparison with private hospital (PH) patients. Clinicians should consider the practice setting and patient access to follow-up care when they are deciding on the optimal strategy for the
Prior studies have identified poor outcomes, increased costs, and reduced access to certain complex, elective surgeries at Safety net hospitals (SNHs). However, it is unknown whether similar patterns exist for the Glioblastoma treatment (GBM). Brandel et al., sought to determine if patients treated at HBHs receive equitable care for GBM, and if safety-net burden status impacts post-treatment survival.

The National Cancer Database was queried for GBM patients diagnosed between 2010 and 2015. Safety-net burden was defined as the proportion of Medicaid and uninsured patients treated at each hospital, and stratified as low (LBH), medium (MBH), and high-burden (HBH) hospitals. The impact of safety-net burden on the receipt of any treatment, trimodality therapy, gross total resection (GTR), radiation, or chemotherapy was investigated. Secondary outcomes included post-treatment 30-day mortality, 90-day mortality, and overall survival. Univariate and multivariate analyses were utilized.

Overall, 40,082 GBM patients at 1202 hospitals (352 LBHs, 553 MBHs, and 297 HBHs) were identified. Patients treated at HBHs were significantly less likely to receive trimodality therapy (OR = 0.75, p < 0.001), GTR (OR = 0.84, p < 0.001), radiation (OR = 0.73, p < 0.001), and chemotherapy (OR = 0.78, p < 0.001) than those treated at LBHs. Patients treated at HBHs had significantly increased 30-day (OR = 1.25, p = 0.031) and 90-day mortality (OR = 1.24, p = 0.001), and reduced overall survival (HR = 1.05, p = 0.039).

GBM patients treated at SNHs are less likely to receive standard-of-care therapies and have increased short- and long-term mortality. Additional research is needed to evaluate barriers to providing equitable care for GBM patients at SNHs.

References


