POLICY ALERT

Office of the New York City Comptroller
Office of Policy Management
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# Closures of St. John's and Mary Immaculate Hospitals Are Overwhelming Remaining Emergency Rooms

## Emergence of H1N1 Virus Causing ER Crisis in Queens

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June 2009

**Executive Summary**

Hospital emergency departments in much of the Borough of Queens are in crisis, experiencing many of the problems predicted in a letter by the Comptroller to the New York State Health Commissioner on February 12, 2009. The letter warned that closure of St. John's and Mary Immaculate Hospitals would lead to overcrowded emergency rooms, longer wait times for patients, and longer ambulance turnaround times. Since the two hospitals closed their emergency rooms on February 14th, all of this has come to pass.

The letter also noted that there had been no public or inclusive discussion concerning transition plans or how these closures would affect the health and safety of area residents. The report issued by the Comptroller in December 2006, *Emergency Room Care: Will It Be There?*, raised similar concerns about the impact of the five New York City emergency room closures proposed by the Berger Commission.

The New York State Department of Health (SDOH) and the New York City Department of Health and Mental Hygiene (DOHMH) failed to acknowledge and act in response to the deteriorating financial condition of Mary Immaculate and St. John's Hospitals in a timely fashion. As a result, a critical opportunity to engage in a transparent, inclusive planning process prior to the closures was lost.

Hospitals that intend to cease operations are required to file a closure plan with SDOH. A hospital's closure plan is intended to be the culminating product of a thoughtful planning process. Yet, according to individuals directly involved in the process, SDOH allowed St. John's and Mary Immaculate Hospitals to close without finalizing and approving a closure plan, in violation of the Department's own requirement. Yet the "Final Draft" closure plan prepared by Caritas Health Care Incorporated, the two hospitals' owner, dated February 5, 2009, stated:[1]

> "There is significant proposed impact on the Health and Hospitals Corporation Elmhurst and Queens Hospital Center facilities, projecting an additional 30,000 emergency department visits and 8,000 inpatient admissions. Based on our Monday January 26 meeting with HHC, these *hospitals may not be in a position to absorb this projected demand in the timeframe contemplated herein. Our meeting with senior staff of Medisys [owner of Jamaica Hospital] on Wednesday January 28 provided similar serious reservations with respect to ability of Jamaica Hospital to absorb emergency room volume and inpatient psychiatry admissions.* "[emphasis added]

And:

> "There have been multiple communications with City and State EMS authorities with respect to termination of Caritas ambulance service and emergency rooms.

[1] Caritas Health Care Closure Plan, *Draft Final*, February 5, 2009.

We have yet to determine that alternate resources will be in place upon the closure of Caritas…"

An effective planning process would have been grounded in the realities of healthcare delivery and taken into account the lead time needed to add space and staff at nearby hospitals, to put replacement primary care services into place and to help patients make a successful transition to a new medical provider. With these elements in place, it is likely that fewer people would now be crowding the emergency rooms, and conditions in the emergency rooms would be significantly better for both patients and staff.

What we are seeing now is a crisis in the hospital and healthcare system in much of Queens, particularly for safety net hospitals which tend to treat a higher proportion of uninsured or under-insured patients. A similar scenario may repeat itself if H1N1 virus outbreaks appear in other boroughs. To be sure, while the timing of the H1N1 virus itself was not foreseeable, the likelihood of some event of a similar nature causing a sudden surge in demand was both foreseeable and inevitable. In fact, it is one of the core missions of the City and State Departments of Health, as well as other State and municipal agencies, to prepare for and respond to this type of healthcare emergency.

Yet, as the hospitals and patients struggle in the face of this crisis, they do so alone. Comptroller staff has been told by hospital administrators that no senior State Department of Health officials have come from Albany to see with their own eyes what is happening. They claim that no assistance of any kind has been offered. The same is true of the City Department of Health and Mental Hygiene.

The missteps surrounding the closures of Mary Immaculate and St. John's Hospitals can, to some extent, be redeemed if the State and the City learn from this experience. Effectively meeting the healthcare needs of New Yorkers is a fundamental responsibility of government and it is one that can and must be met.

**Recommendations**

New York City has a proud history of pulling together in a crisis. It is time for officials to publicly acknowledge that many hospitals in Queens, especially those serving the most disadvantaged populations, are in crisis primarily as a result of the closures of Mary Immaculate and St. John's Hospitals and exacerbated by the rapid spread of the H1N1 virus. But money alone will not solve this problem.

First and foremost, what is needed is leadership. Patients and hospitals cannot resolve these problems alone. The City and State need to pull key healthcare providers and other stakeholders together immediately to share information, identify problems and develop solutions to address the current surge in demand stemming from the H1N1 virus. As the flu spreads and possibly returns in the fall, other hospitals throughout the city could be pulled into the same downward spiral that Queens is experiencing. It is critical that the lines of communication between government and healthcare providers be open and responsive.

**Short term**

- **Triage individuals with flu symptoms at ambulatory care facilities**. Many of the people currently seeking care in the emergency room either do not actually have the H1N1 virus or have a mild form and do not have other risk factors. By seeking out an initial diagnosis at a community health center, they can be evaluated by doctors and directed to the emergency room if indicated. Reducing the crowding at emergency rooms will allow patients with serious flu-related conditions and others with true medical emergencies to receive better and faster attention.

  For this approach to be successful, two actions are critical. The City must encourage the use of these health centers and widely advertise their locations. In addition, the City must work with the centers to temporarily expand their hours and be open seven days a week. Local medical practices should also be approached.

  Although there are not many in Queens, Federally Qualified Health Centers, known as FQHCs, are located throughout the city. These centers will see all patients regardless of their insurance status and, with expanded hours, could become the backbone of an effective triage system if emergency rooms in other boroughs experience the same surge. Because of the FQHC funding mechanisms, they are in a better position to manage the marginal costs associated with expanded hours. Other clinics may require a small subsidy to cover the extra staff costs.

- **Activate necessary additional resources to deal with the current situation and be ready to provide more resources in other communities as needed.** Hospitals in much of Queens need immediate help to cope with the heightened challenges presented by the two closures and now the H1N1 virus. Just as the City and State sends personnel, equipment and supplies to emergencies throughout the State, such as floods or fires, it may be necessary to ask other New York locales to provide similar assistance in Queens or in other boroughs if similar emergency room overcrowding becomes a concern. With Jamaica Hospital, for example, now handling well over 500 emergency room visits daily, up from 300 to 350 a day before H1N1 and the two hospital closures, this is indeed a crisis.

  SDOH and the City should post staff at the affected hospitals, especially at peak hours, to ensure smooth operations, rather than relying on telephone calls between the Department and hospital administrators.

- **Provide loans and working capital to cover expansion costs**. Because many hospitals are in weak financial positions, it is difficult for them to borrow money. If they hire staff, treat uninsured patients, modify their facility or incur any other expenses associated with expanding capacity to meet a significantly increased patient load, they must wait anywhere from months to a year to recoup that expenditure in form of insurance or government reimbursement and frequently no reimbursement is provided. By asking those hospitals that are financially challenged and that are near the two that closed to spend money they do not have, SDOH is threatening the very

survival of those hospitals. For example, many hospitals are relying heavily on the use of overtime during the H1N1 surge.

- **Provide data on emergency room utilization to the public.** In conjunction with the hospital closures, SDOH agreed to disclose emergency room data like those cited throughout this report. After an initial release in early April, no additional data has been made available, according to press accounts.[2] SDOH has cited the need to focus its staff on managing the H1N1 virus as the reason it has not followed through on the commitment. While it is certainly true that the spike in emergency room utilization caused by H1N1 may make analysis of the impact of the closures alone more difficult, SDOH is undoubtedly still collecting emergency room data as part of its H1N1 monitoring.

  SDOH needs to restore public confidence by publishing key daily statistics about emergency room utilization and staffing. These should include the total number of adult and pediatric emergency room visits, the number of hours patients are waiting before actual care begins (not to be triaged), the number of hours admitted patients are waiting to be moved from the emergency room to Intensive Care Units and to a bed on an inpatient floor as well as daily staffing levels and overtime hours worked at affected hospitals.

- **Help hospitals staff-up to meet the increased demand**. SDOH should issue an update on the number and type of additional staff hired at these hospitals, while doing whatever is necessary to expedite hospitals' ability to hire staff, especially in medically-underserved areas where it is difficult to attract physicians and other medical personnel. For example, the federal stimulus package contains funding for a medical school loan-forgiveness program for doctors who work in high need areas.

- **Identify gaps in services created by the closures**. As soon as possible, SDOH should publish an inventory of the quantity and type of all services provided by the two closed hospitals, where those services are now being provided and which services have not been continued by any provider in the area. The lapsed services, if deemed essential, should be the basis for a community healthcare plan.

**Longer term**

In the longer term, the answer is planning, as the Office of the Comptroller has recommended previously. SDOH should be proactive and create a master plan, in dialogue with the community, to begin to restructure the health care delivery system in New York City. SDOH has taken some promising steps in this direction already, especially in its focus on primary care.

At the moment, however, it seems that New York City is losing primary care at an alarming rate. Since hospital outpatient departments represent a significant portion of the

[2] John Lauinger, "Study on impact of closing hosps sidetracked by epidemic scare," *New York Daily News,* May 3, 2009.

City's primary care capacity, the closures of 15 New York City emergency rooms since 2002 has markedly reduced capacity. In addition, outpatient departments can be a drain on hospital finances and some have cut back these services to improve their financial picture.

New York State needs to develop integrated systems that accurately reflect primary care service levels and can be used to assess where shortfalls exist. The Department needs to return to community-based comprehensive health care needs assessments and use the results as the basis for allocating resources in the most efficient, cost-effective manner. If SDOH had undertaken this process beginning in December 2006, as the Office of the Comptroller recommended, it is likely that much of the current impacts in Queens could have been minimized.

The need for such an assessment and allocation process is especially acute in Queens. A 2006 report by the Office of the Queens Borough President found that the borough had only 1.4 hospital beds per 1,000 residents, compared to 7.1 per 1,000 residents in Manhattan, and projected a 1.4 percent increase in Emergency Department visits and 11.1 percent increase in hospital admissions and discharges, from 2004 to 2016.[3]

[3] Office of the Queens Borough President, *Borough President Helen Marshall's Vision for a Comprehensive and Sustainable Healthcare Delivery System in Queens,* November 2006.

## Introduction

On Saturday, February 14, 2009, St. John's Hospital and Mary Immaculate Hospitals' emergency rooms closed their doors for the last time.[4] According to the Doctor's Council, which represents New York City Health and Hospital Corporation (HHC) physicians, and the Council of Interns and Residents (CIR), which represents doctors in training, at least two nearby hospitals, Elmhurst Hospital and Queens Hospital Center already were operating at full capacity and, at times, even turning ambulances away in the weeks leading up to the closure.

Hospitals that intend to cease operations are required to file a closure plan with the New York State Department of Health (SDOH). Among other requirements, closure plans must demonstrate how continuity of care will be ensured for the institution's patients. In its closure plan of February 5, 2009, Caritas Health Care Incorporated, the operator of the two now-closed hospitals, raised concerns that nearby hospitals would not be able to absorb their emergency room visits: "[T]hese hospitals may not be in a position to absorb this projected demand in the timeframe contemplated herein."[5]

Based on analysis of emergency room data, and interviews with community leaders, CIR and Doctor's Council officials, and hospital executives and emergency room physicians at several of the remaining hospitals in Queens, the Office of the Comptroller has found that the concerns raised in the closure plan were well-founded. The specific findings are described below.

The closures occurred only two weeks after the hospitals' financial difficulties were made public, affording nearby hospitals little time and no additional funding to prepare for the flood of additional patients that ambulances were now bringing to their doors. While the rapidity with which the decision was made to close the hospitals was unexpected, the possibility of closures should not have been a surprise to the State; the State had spent over $61 million subsidizing the two hospitals' operations in the years leading up to Caritas's bankruptcy.

In December 2006, the Office of the Comptroller released a report, *Emergency Care: Will It Be There*?, raising concerns that New York City hospital emergency rooms were already overcrowded and that the closure of several hospitals as recommended by the Berger Commission would overload the hospitals nearest to those scheduled to close. Among other recommendations, the report urged SDOH to lead an inclusive, transparent community-based planning process to ensure that adequate resources were in place before any closures occurred.

Since that time, the Office of the Comptroller has continued to monitor the situation in New York City's emergency rooms. The severe impact of the closures on the

[4] The two hospitals also ceased accepting elective admissions on February 14th. They closed their doors on February 28th.

[5] Caritas Health Care Closure Plan, *Draft Final*, February 5, 2009, p. 6.

emergency rooms surrounding Mary Immaculate and St. John's Hospitals -- made even worse by the recent appearance of the H1N1 virus -- offers a timely lesson in the consequences of failing to plan ahead. What has happened to the hospitals in Queens in the wake of these two closures could happen to other hospitals in other neighborhoods throughout the city.

This Policy Alert seeks to raise awareness of the crisis in Queens and to highlight the urgent need for leadership at the highest levels of City and State government. A new approach is needed if we are to ensure that the Queens hospitals and all our remaining hospitals and their emergency rooms are able to provide the public with quality care.

### A. The immediate impact of the closures on nearby hospital emergency rooms

While every hospital in Queens is experiencing increased demand as a result of the two closures, we focused primarily on Queens Hospital Center, Jamaica Hospital, North Shore University Hospital-Forest Hills and Elmhurst Hospital, which are closest. The Office of the Comptroller obtained emergency room utilization data for these hospitals compiled by the State Department of Health.[6] The following data provide a sense of the daunting challenges faced by emergency room staff in the remaining hospitals in the six weeks after the two closures but *before* the appearance of the H1N1 virus:

- *Emergency room registrations soared*. Between the mid-February closures of the St. John's and Mary Immaculate emergency rooms through the end of March, Emergency Department patient registrations at the HHC Queens Hospital Center consistently exceeded those of the comparable period one year before. On at least a dozen days, the number of emergency room patient registrations reached 300 or more whereas this occurred on only one day in the same period a year prior. At Jamaica Hospital Center, from mid-February through the end of March there were 20 days on which there were at least 350 registrations, compared to only two such days in 2008.

- *Numbers of patients waiting to be admitted from the Emergency Department also soared*. Between mid-February and the end of March 2009:

    - At Jamaica Hospital, there were nine days where at least 20 or more patients were waiting to be admitted from the emergency department and 25 days when at least 10 patients were waiting. For the comparable period in 2008, there were no days when 20 patients were waiting and only eight days when 10 patients were waiting.

    - At Queens Hospital Center, there were 24 days when at least 10 patients waited for admission compared to eight days in 2008.

    - At Long Island Jewish Hospital, there were seven days when at least 20 patients were waiting for admission compared to no days in 2008 and there were 35 days when at least 10 patients were waiting compared to 19 days in 2008.

[6] The data was self-reported by the hospitals and was, in some cases, incomplete.

Since the appearance of H1N1, the number of persons who present at emergency rooms has only increased.

### B. The immediate impact of the closures on EMS activity

The closures of Mary Immaculate and St. John's Hospitals eliminated a total of 28 daily ambulance tours that were operated by the two hospitals. St. John's former territory attracted interest from local voluntary hospitals, and New York Hospital of Queens, Wyckoff Heights Medical Center and North Shore picked up a total of 11 tours. However, an official of one hospital told Comptroller staff that no hospitals were interested in assuming Mary Immaculate's runs, and the New York City Fire Department EMS, as the provider of last resort, took them over. The long-term sustainability of the 28 tours is not assured, however. The Mayor's Executive Budget cuts the FDNY EMS budget by $3 million, which would result in the elimination of 30 ambulance tours citywide. This is in addition to the substantially greater number of tours that are expected to be eliminated because of an anticipated $60 million Medicaid reimbursement reduction. In 2007, there was an average of slightly more than 900 New York City EMS tours a day.

According to EMS data reported to the New York State Department of Health and obtained by the Office of the Comptroller, the number of transports to the affected hospitals has risen dramatically. In the first week following the closures, the number of EMS transports to Jamaica Hospital increased by 197 compared to the same period a year earlier, an increase of 39 percent, and transports to North Shore University Hospital-Forest Hills almost doubled to 203 from 111 during same week in the prior year.

A PowerPoint presentation by New York City EMS to the Office of the Queens Borough President on the impact of the two closures focused on four hospitals -- Jamaica Hospital Medical Center, Queens Hospital Center, Elmhurst Hospital Center and North Shore University Hospital-Forest Hills. According to the presentation,[7] which the Borough President's office provided the Office of the Comptroller:

- *Ambulance transports went up.* Comparing January 2009 to March 2009, the number of patients brought by ambulance to Queens Hospital Center increased by 51 percent, North Shore-Forest Hills had a 40 percent increase, and Jamaica Hospital and Elmhurst Hospitals saw transports rise by 24 percent and 13 percent respectively.

- *Ambulance turnaround times increased.* Turnaround time -- the amount of time from EMS's arrival at the emergency room until the ambulance is free to take the next call -- can be a proxy for overcrowding. The more crowded the emergency room, the longer EMS must wait until medical personnel are available for a safe hand-off. Turnaround time at Jamaica Hospital grew from 27:51 minutes prior to the February

[7] FDNY EMS - Division 4 Hospital Closure Presentation, Chief Robert P. Browne, EMS Division 4 Commander.

14th emergency room closures to 30:36 minutes during March 2009; at Queens Hospital Center turnaround time increased from 22:49 minutes to 24:39 minutes; and at North Shore University-Forest Hills Hospital turnaround rose from 27:16 minutes to 28:21 minutes.

A letter from a Queens mother to her local newspaper suggests that too few ambulances have been left in some locations. She wrote that after her son had a seizure, a first responder from the Fire Department arrived in four minutes but that the ambulance took another 21 minutes to reach her home. She subsequently learned that there was a nine-minute delay in assigning the first ambulance. A second ambulance was dispatched 16 minutes after the first call. The medics told her they had come from Erskine Street and the Belt Parkway near Spring Creek in Brooklyn to her home in Ridgewood, Queens -- a distance of nearly six miles.[8]

### C. The impact of increased patient loads, according to healthcare workers

Doctors, nurses, paraprofessionals and other staff at the hospitals most directly affected by the St. John's and Mary Immaculate closures are now facing extraordinary challenges in delivering healthcare to their patients. A number of them told Comptroller staff that overcrowded emergency rooms conditions were already negatively affecting the quality of patient care before the H1N1 virus appeared and that the situation has markedly deteriorated since then.

With Queens as the epicenter of the illness, hospital emergency rooms in the vicinity of the closures are seeing unprecedented numbers of patients. According to one recent newspaper article, "The emergency room at Jamaica Hospital Medical Center hit a record high of 478 patients [on April 27, 2009.] At least an extra 100 patients a day poured into ERs at Elmhurst Hospital, Queens Hospital Center and New York Hospital Queens."[9] The increased patient load continued to grow through the Memorial Day weekend. Jamaica Hospital was up to 663 emergency room visits on May 27th, more than double the average daily volume in 2008. As discussed above, these sharp flu-related increases come on top of the additional patients due to the closures.

It is well documented that lack of access to primary care often leads to overuse of the emergency room, further contributing to overcrowding. In 2008, Mary Immaculate and St. John's Hospital together had 119,883 outpatient department visits. With the exception of Mary Immaculate's family health center that was transferred to a new operator, little of the two hospitals' primary care capacity remains. Comptroller staff was told by hospital personnel that this has led to overcrowding in outpatient clinics at the nearby hospitals due to the closures, and increased reliance on the local emergency rooms as an alternative place to seek care.

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[8] Letter to the Editor, *Ridgewood Times*, April 16, 2009.

[9] Ginger Adams Otis and Melissa Klein, "'Room' Emergency at Bursting Qns. Hosps," *New York Post,* May 3, 2009.

In some cases, patients are actually "bouncing" from one local hospital to another, making multiple visits over a short period of time, according to a Queens Hospital Center emergency room physician. For example, after finding the outpatient clinic at Jamaica Hospital too crowded, patients left without being seen by a doctor and sought care in its emergency room instead. When the emergency room at Jamaica Hospital grew too crowded, patients then presented at Queens Hospital Center's emergency room.

Some patients reported being seen in several emergency rooms because they had been discharged without understanding how to follow-up on their condition. In the rush to see the next patient, some doctors and nurses may not have the time or the resources -- such as translation services--to properly explain what the patient needs to do upon discharge, and the medical condition worsens as a result. Other patients, unable or unwilling to cope with the long waits to be seen are leaving the emergency room without getting care at all. As Dr. Toni Lewis, President of CIR, stated, "Because the ERs are full, everyone is waiting longer and coming in sicker. This is only going to snowball."

Doctors, nurses and other healthcare professionals told Comptroller staff that they are reluctant to make public their concerns about delivering quality care in overcrowded emergency rooms because they do not want to frighten patients. Instead, many stated that they just work harder and longer. But the consequences could be serious. As one doctor stated, "Patients feel like they're not getting good care and the doctors feel like they're not giving it." In the wake of the closures, doctors working in the emergency rooms at Queens Hospital Center, Elmhurst, and Flushing Hospitals have stated that they feel overwhelmed.

It is clear that their all-out effort cannot be sustained indefinitely. For example, to accommodate the extra patients from the closures and now from H1N1, hospitals have been forced to quickly make additional space available in their emergency rooms. Medical professionals are providing care in temporary converted spaces such as former offices or waiting areas that lack essential supplies, provide little or no privacy for patients, and make merely moving around difficult.

Doctors working at Flushing Hospital and Queens Hospital Center told Comptroller staff that administrators have given temporary permission for patients to be admitted to the hospital but remain in the hallways or in the emergency room. Patients have remained in corridors for 24 to 48 hours at times of peak overcrowding, and a resident said that procedures such as blood transfusions are administered in the halls, without proper privacy, infection control or access to oxygen in case of an adverse reaction. The resident added that the situation was "dangerous" and [s]he worried about the welfare of the patients.

A Queens Hospital Center emergency room doctor with over two decades of experience described conditions at the hospital to Comptroller staff as a "living nightmare," and added that "the state of emergency medicine in the borough of Queens is the worst I've seen it in my career." He expressed a deep concern that the level of care has deteriorated because there is pressure to "move the patients" -- either admit them or

get them out of the emergency room. He noted that he leaves his shift worried that he has "missed something" in treating a patient because of the volume and time pressure. He estimated that he now sees 35 patients per shift compared to 20 before the closures. To meet the increased demand, he works at least two hours extra for every eight hour shift plus 10 hours a week of mandatory overtime.

With only a few weeks' notice before the closures and the onset of the H1N1 virus soon after, many of the affected hospitals did not have time or, as discussed below, the financial resources to hire additional staff to meet the demands of an increased patient load. Consequently, in order to keep the emergency room at appropriate staffing levels, administrators are forced to rely on having their personnel work overtime and/or shifts other than those for which they are regularly scheduled. Both approaches are costly, both financially and in terms of staff morale and performance. All of the staff and administrators interviewed by Comptroller staff noted that staffing levels are wholly inadequate, not just in the emergency room, but also in laboratories, x-ray areas and other ancillary service areas needed to diagnose emergency room patients.

### D. Lack of additional funding combined with recent budget cuts are impeding some hospitals' ability to respond.

The affected hospitals have received a total of $14.5 million from the State to expand capacity needed to absorb the additional patients they are seeing as a result of the closures. The availability of this money was announced by the Department of Health on February 17, 2009, two days after the emergency rooms at the two Caritas hospitals closed.

One hospital official told Comptroller staff that "the funds are too little, too late." Some hospitals have yet to receive their full allotment, and, according to hospital administrators, the funds will not fully cover construction costs. Some hospitals cannot afford to start construction of new emergency room and inpatient space until the monies are in hand, which means that space to relieve overcrowding may not be completed for at least another year or more. More significantly, the State has not announced any program to provide the hospitals with additional loans or grants to cover the costs of their expanded operations. Without this assistance, some hospitals are finding it difficult to afford more staff or to purchase new equipment. Instead, as discussed previously, they are relying on current staff working overtime to meet the demand. Unbudgeted overtime costs, however, will not be financially sustainable over the long term if there is no prospect of recouping the expenditure.

Hospitals also report that no funding has been advanced to the affected hospitals to cover the increase in patients who are unable to pay for their care. St. John's Hospital and Mary Immaculate Hospital both served a mostly low-income population, many of whom were uninsured or underinsured and unable to pay some or all of their medical bills. This reimbursement shortfall was a significant contributing factor to Caritas' bankruptcy. With these patients now receiving care at nearby hospitals, some of which were already in a financially precarious position, the long term financial viability of some of the remaining hospitals may be in question.

As if the impact from the closures and the upsurge in patients from the H1N1 virus were not enough, hospitals are now facing lowered Medicaid reimbursement and increased assessments under New York State's FY 2009-2010 budget. For HHC hospitals, in particular, which serve as a safety net, the loss of Medicaid revenue combined with the increase in uninsured and underinsured patients is likely to result in a financial "perfect storm."

## E. Recommendations

New York City has a proud history of pulling together in a crisis. It is time for officials to publicly acknowledge that many hospitals in Queens, especially those serving the most disadvantaged populations, are in crisis primarily as a result of the closures of Mary Immaculate and St. John's Hospitals and exacerbated by the rapid spread of the H1N1 virus.

Money alone will not solve this problem. First and foremost, what is needed is leadership. Patients and hospitals cannot resolve these problems alone. The City and State need to pull key healthcare providers and other stakeholders together immediately to share information, identify problems and develop solutions to address the current surge in demand stemming from the H1N1 virus. As the flu spreads and possibly returns in the fall, other hospitals throughout the city could be pulled into the same downward spiral that Queens is experiencing. It is critical that the lines of communication between government and healthcare providers be open and responsive.

**Short term**

- **Activate the necessary resources to deal with emergencies.** Hospitals in much of Queens need immediate help to cope with the heightened challenges presented by the two closures and now the H1N1 virus. Just as the City and State sends personnel, equipment and supplies to emergencies throughout the State, such as floods or fires, it may be necessary to ask other New York locales to provide similar assistance in Queens. With Jamaica Hospital, for example, now handling well over 500 emergency room visits daily, up from 300 to 350 a day before H1N1 and the two hospital closures, this is indeed a crisis.

  SDOH and the City should post staff at the affected hospitals, especially at peak hours, to ensure smooth operations, rather than relying on telephone calls between the Department and hospital administrators.

- **Triage individuals with flu symptoms at ambulatory care facilities**. Many of the people currently seeking care in the emergency room either do not actually have the H1N1 virus, have a mild form, and do not have other risk factors. By seeking out an initial diagnosis at a community health center, they can be evaluated by doctors and directed to the emergency room if indicated. Reducing the crowding at emergency rooms will allow patients with serious flu-related conditions and others with true medical emergencies to receive better and faster attention.

For this approach to be successful, two actions are critical. The City must encourage the use of these health centers and widely advertise their locations. In addition, the City must work with the centers to temporarily expand their hours and be open seven days a week. Local medical practices should also be approached.

Although there are not many in Queens, Federally Qualified Health Centers, known as FQHCs, are located throughout the city. These centers will see all patients regardless of their insurance status and, with expanded hours, could become the backbone of an effective triage system if emergency rooms in other boroughs experience the same surge. Because of the FQHC funding mechanisms, they are in a better position to manage the marginal costs associated with expanded hours. Other clinics may require a small subsidy to cover staff costs associated with expanded hours.

- **Provide loans and working capital to cover expansion costs**. Because many hospitals are in weak financial positions, it is difficult for them to borrow money. If they hire staff, treat uninsured patients, modify their facility or incur any other expenses associated with expanding capacity to meet a significantly increased patient load, they must wait anywhere from months to a year to recoup that expenditure in form of insurance or government reimbursement and frequently no reimbursement is provided. By asking hospitals near the two that closed to spend money they do not have, SDOH is threatening the very survival of those hospitals. For example, many hospitals are relying heavily on the use of overtime during the H1N1 surge.

- **Provide data on emergency room utilization to the public.** In conjunction with the hospital closures, SDOH agreed to disclose emergency room data like those cited throughout this report. After an initial release in early April, no additional data has been made available, according to press accounts. SDOH has cited the need to focus its staff on managing the H1N1 virus as the reason it has not followed through on the commitment. While it is certainly true that the spike in emergency room utilization caused by H1N1 may make analysis of the impact of the closures alone more difficult, SDOH is undoubtedly still collecting emergency room data as part of its H1N1 monitoring.

  SDOH needs to restore public confidence by publishing key daily statistics about emergency room utilization and staffing. These should include the total number of adult and pediatric emergency room visits, the number of hours patients are waiting before actual care begins (not to be triaged), the number of hours admitted patients are waiting to be moved from the emergency room to Intensive Care Units and to a bed on an inpatient floor as well as daily staffing levels and overtime hours worked at affected hospitals.

- **Help hospitals staff-up to meet the increased demand**. SDOH should issue an update on the number and type of additional staff hired at these hospitals, while doing whatever is necessary to expedite hospitals' ability to hire staff, especially in

medically-underserved areas where it is difficult to attract physicians and other medical personnel. For example, the federal stimulus package contains funding for a medical school loan-forgiveness program for doctors who work in high need areas.

- **Identify gaps in services created by the closures**. As soon as possible, SDOH should publish an inventory of the quantity and type of all services provided by the two closed hospitals, where those services are now being provided and which services have not been continued by any provider in the area. The lapsed services, if deemed essential, should be the basis for a community healthcare plan.

**Longer term**

In the longer term, the answer is planning, as the Office of the Comptroller has recommended previously. SDOH should be proactive and create a master plan, in dialogue with the community, to begin to restructure the health care delivery system in New York City. SDOH has taken some promising steps in this direction already, especially in its focus on primary care.

At the moment, however, it seems that New York City is losing primary care at an alarming rate. Since hospital outpatient department represent a significant portion of the City's primary care capacity, the closures of 15 New York City emergency rooms since 2002 has markedly reduced capacity. In addition, outpatient departments can be a drain on hospital finances and some have cut back these services to improve their financial picture.

The State needs to develop integrated systems that accurately reflect primary care service levels and can be used to assess where shortfalls exist. With a comparatively high ratio of 592 residents per hospital bed in Queens, the Department needs to return to community-based comprehensive health care needs assessments and use the results as the basis for allocating resources in the most efficient, cost-effective manner.

If SDOH had undertaken this process in December 2006, as the Office of the Comptroller recommended, it is likely that much of the current impacts in Queens could have been minimized or avoided entirely.

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