

policy report

Office of the New York City Comptroller
Office of Policy Management

**William C. Thompson, Jr.,
Comptroller**

Emergency Room Care: Will It Be There?

Assessing the impact of closing five
emergency rooms in New York City



1 Centre Street
New York, NY 10007
(212) 669-3500

policy report

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William C. Thompson, Jr.,
Comptroller, City of New York

Gayle M. Horwitz,
Deputy Comptroller
Chief of Staff

Glenn von Nostitz,
Director, Office of Policy Management

Susan R. Scheer,
Assistant Director, Office of Policy Management
Health Policy Adviser

Executive Summary

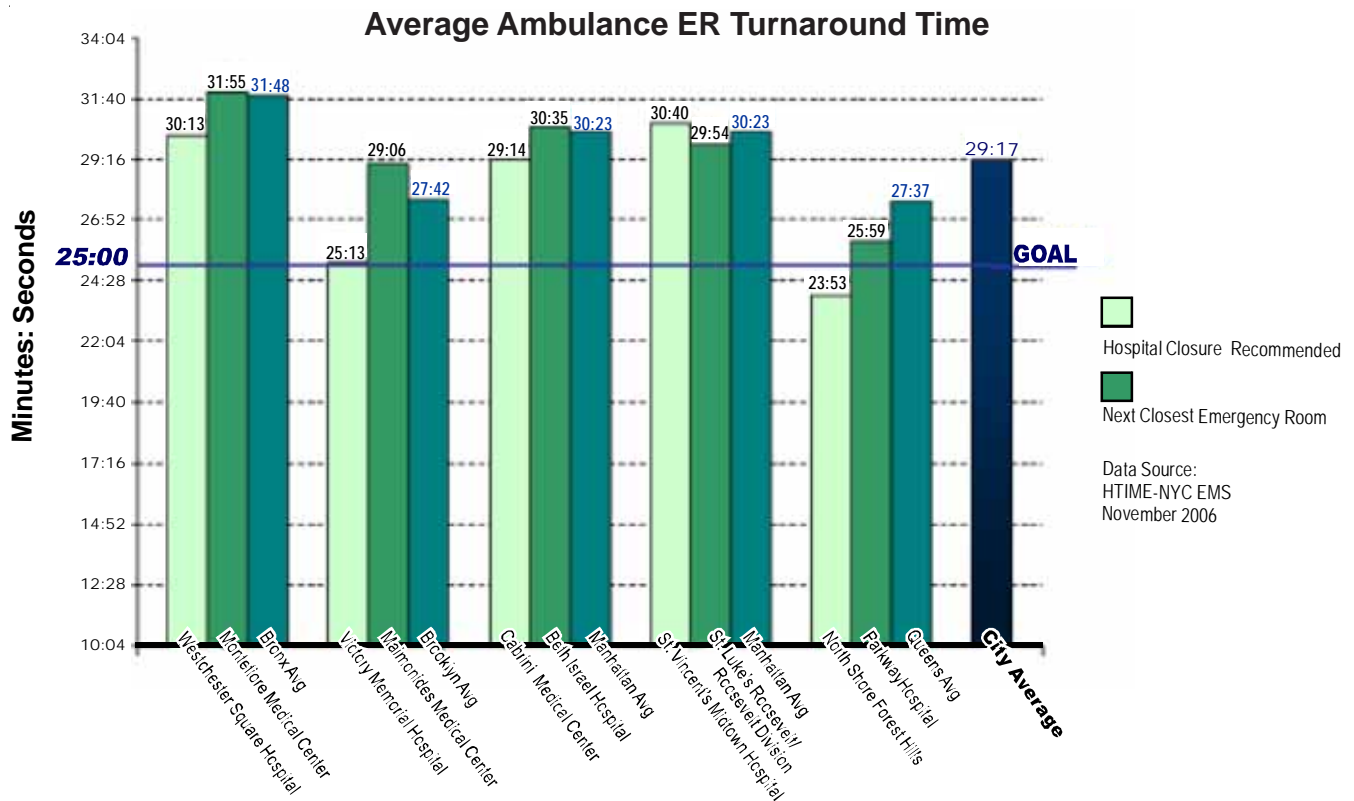
Key Findings

It is widely acknowledged that because many New York City hospitals have faced long term financial distress, hospital closures, mergers and reconfigurations are necessary to reduce excess inpatient bed capacity and to help place the remaining hospitals on a more secure financial footing. In New York City, the New York State Commission on Health Care Facilities in the 21st Century has recommended the closure of New York Westchester Square, Cabrini Medical Center, St. Vincent’s Midtown, Victory Memorial, and Parkway Hospitals and the merger and downsizing of Peninsula Hospital with St. John’s Episcopal Hospital South Shore and New York Methodist Hospital with New York Community Hospital of Brooklyn.

A review by the Office of the New York City Comptroller of hospital utilization and payer data has determined that, together, these hospitals provide significant amounts of unreimbursed care and essential emergency care as well as substantial amounts of primary care to vulnerable populations. Thus, the Commission’s recommendations will have significant repercussions on the finances and operations of neighboring, surviving hospitals, including New York City Health and Hospitals Corporation hospitals, and on the health of area residents.

Emergency services (See Appendix A, Map 1 for emergency room data by hospital)

- **If the five recommended closures are implemented, a total of 14 New York City emergency rooms will have closed since 2002**, a 21 percent reduction in emergency rooms in a City with a population expected to grow to over nine million by 2025.
- **At least three of the recommended closures could lead to large influxes of emergency patients at the nearest remaining hospitals.** If all of the emergency patients at these hospitals switch to the nearest remaining hospital, the closure of Westchester Square Hospital, Parkway Hospital, and St. Vincent’s Midtown Hospital would result in large increases in emergency room volume at the closest remaining hospitals—50 percent at Montefiore Medical Center/Weiler Division, 48 percent at North Shore at Forest Hills Hospital and 46 percent at Roosevelt Hospital. It is particularly troubling that some emergency rooms that would experience large influxes already face capacity constraints.
- **Crowded emergency rooms could leave fewer ambulances available to take calls.** Ambulance crews are required to wait until patients are formally transferred to hospital emergency staff before they can return to the field. While New York City Emergency Medical Service sets a performance goal of 25 minutes for patient turnaround times, these times are in fact longer in overcrowded emergency rooms. Recent tracking showed turnaround times already average 29 minutes at Roosevelt Hospital, which would receive emergency patients from a closed St. Vincent’s Midtown, and 32 minutes at Montefiore, which would accept patients from a closed Westchester Square Hospital, according to EMS’s November 2006 Turnaround Report. Longer turnaround times limit the availability of ambulances for other emergencies.



- **Closure of the five emergency rooms would require some New Yorkers to travel farther in an emergency.** Approximately one-quarter of New York City's trauma cases are treated at community hospital emergency rooms such as those recommended for closure. If the recommended closures proceed, some of the trauma patients who would have gone to these hospitals would spend extra minutes going instead to the nearest remaining hospital—critical minutes that could mean the difference between life and death. This may be a concern particularly in southern Brooklyn where Victory Memorial Hospital is recommended for closure, inasmuch as in 2004 the New York City Emergency Medical Service indicated that another trauma center was needed to reduce response time in this part of the borough.
- **Emergency rooms of several hospitals proposed for closure are heavily used by uninsured ("self-pay") patients who would instead present at nearby hospitals with possible adverse effects on hospital finances.** Some uninsured patients would travel extra distances to hospitals that already treat significant numbers of self-pay patients such as New York City Health and Hospitals Corporation hospitals. For example, some patients who would have gone to the Cabrini Medical Center emergency room (21 percent self-pay) and to St. Vincent's Midtown Hospital's emergency room (36 percent self-pay) would likely present at Bellevue Hospital (37 percent self-pay). Jacobi Medical Center, another HHC hospital (22 percent self-pay), would likely receive some self-pay patients who would have gone to Westchester Square Hospital (10 percent self-pay).

Inpatient and outpatient services (See Appendix A, Map 2 for inpatient and outpatient services data)

- **Although the Commission focused primarily on low hospital inpatient occupancy rates, the overwhelming majority of patient contacts with the hospitals recommended for closure were as outpatients and emergency room visitors, not as inpatients.** In 2004, there were a total of 373,740 inpatient discharges, outpatient visits and emergency visits in the five hospitals recommended for closure. Only slightly more than 11 percent of these were inpatient discharges.

- **Hospitals adjacent to several hospitals recommended for closure currently have high inpatient occupancy rates, raising questions about the ability of these hospitals to absorb additional inpatients.** For example, Maimonides Medical Center, has a 93 percent staffed bed occupancy rate—the number of beds available for inpatients—and is the closest hospital to Victory Memorial Hospital, and Montefiore Medical Center/Weiler Division, has a staffed bed occupancy rate of 87 percent and is the closest hospital to Westchester Square Hospital.
- **Some intensive care units have occupancy rates well in excess of 90 percent, meaning they are often completely full during the day.** St. Luke's-Roosevelt's ICUs average 120 percent, yet Roosevelt would be expected to accept patients from St. Vincent's Midtown.

Treatment of the uninsured

- **All of the hospitals recommended for closure, except St. Vincent's Midtown, are located in communities where a significant share of the adult, non-elderly population—ranging from 22 percent for Victory Memorial to 26 percent for Cabrini Hospital—did not have health insurance at some point from 2002 to 2004.** This strongly suggests an adverse financial impact on the remaining neighboring hospitals that would now serve this population. There could also be an adverse impact on local residents' health; an influential study by Donald Shepherd of Brandeis University found that “30 percent of patients whose hospital closes stop seeking care” and a Boston University public health professor who is an expert on hospital closings has noted that “the most vulnerable patients are made more vulnerable when hospitals close.”

Key Recommendations

If the recommended hospital closures and mergers occur:

- **New York City Emergency Medical Service should report to the public by March 1, 2007 with an evaluation of the impact of the Berger Commission recommendations for closing emergency rooms.** New York City EMS should analyze the impact of the five recommended hospital closures on emergency room services, including whether replacement services would be best provided by NYC EMS and/or under contract, and publicly release its findings.
- **Regardless of whether all of the recommended closures and mergers are completed, New York State should adopt a legal requirement for local EMS agencies to hold a public hearing and issue a written report evaluating the potential community impact of downgrading or closing emergency room services.**
- **The New York State Department of Health should closely monitor emergency room utilization in communities affected by emergency room closures and be prepared to grant emergency approval to increase inpatient capacity.** Increased patient loads will require re-engineering current emergency room operations to reflect best practices. Montefiore Hospital's “fast-track” program to expedite care for non-emergency patients in its emergency room can serve as a model. Montefiore has reduced average arrival-to-discharge time and reduced the walkout rate—the percentage of patients who leave because they are unable to wait any longer.
- **The potential impact of the hospital closings and mergers on HHC facilities should be fully assessed to ensure that HHC does not absorb a disproportionate share of the medically**

displaced uninsured and under-insured. If HHC becomes the medical home for these individuals, savings from the closures should be provided to HHC to fully cover unreimbursed costs related to treating these new patients.

- **A community-based plan should be created, and a substantial portion of any savings from closures and mergers must be reinvested in community health, and, if necessary, additional dedicated funding should be provided for implementation.** Creation of a community-based plan with dedicated funding for primary care must be an early milestone in any plan for implementing the Commission’s recommendations. It must be recognized that closures would permanently eliminate a vital source of already scarce primary care for thousands of people and that this lost capacity must be recreated elsewhere. This can be accomplished in part by restructuring reimbursement formulas to create an incentive to increase primary care capacity.

The Commission’s report encompasses a complex set of policy recommendations with many facets beyond hospital closures. Community members, local government officials and other stakeholders require adequate time to develop implementation plans that acknowledge and address negative impacts to the fullest extent possible. This critically important work should not be rushed.

I. Background

The New York City Hospital Fiscal Crisis

The 67 voluntary and public hospitals and divisions¹ in New York City provide medical care 24 hours per day, 365 days per year to the City's 8.2 million residents² and an anticipated 44.4³ million visitors in 2006. In 2004, its hospitals received a total of 3.5 million emergency room visits,⁴ its inpatient units had approximately 1.2 million discharges,⁵ and its outpatient clinics handled over 15 million visits.⁶ With its rich array of academic medical centers, New York City's hospitals attract patients seeking the highest quality, cutting-edge medical treatment.

Like the patients that seek care inside their doors, New York's hospitals are sick. Financially, many of them are bleeding. Almost a dozen hospitals closed in New York State and nine hospitals or divisions terminated inpatient and emergency services in the City between 2002 and 2005.⁷ Several others, including the St. Vincent's Catholic Medical Center network, Parkway Hospital, and Brooklyn Hospital Center, are presently under court-supervised bankruptcy proceedings.

According to the Healthcare Association of New York, the State's hospitals lost \$2.4 billion over an eight-year period ending in 2005. Nearly nine out of 10 New York State hospitals operated with margins below four percent, the margin recommended by health care economists to allow for adequate patient care.⁸

City hospitals experienced operating losses of \$39 million in 2002, \$190 million in 2003, and \$288 million in 2004, while operating margins fell from -0.2 percent to -1.3 percent. Slightly more than half the hospitals operated at a loss in 2003. This stands in contrast to the national picture where, on average, hospitals are operating profitably.⁹

Many of New York's hospitals are saddled with large amounts of debt, constraining access to capital and making it difficult for these institutions to make the investments necessary to improve efficiency and reduce operating costs.¹⁰ In 2005, New York State's hospitals were carrying \$15 billion in debt, a figure surpassing any other state.¹¹

Reimbursement rates have, in many cases, distorted hospital spending decisions, driving the delivery of profitable services at the expense of needed but non-lucrative primary and preventive care.¹²

There is little doubt that the current level of financial distress is unsustainable and some hospital closures are a necessary form of triage to reduce excess bed capacity and ensure that even more institutions do not fail in the future. To close hospitals without doing harm to the patients who depend upon them requires a comprehensive plan for continuity of care, however. Many hospitals that have the weakest balance sheets provide significant amounts of under- and unreimbursed care to the uninsured and underinsured, contributing to the institutions' financial vulnerability. Their emergency rooms provide significant amounts of primary care in neighborhoods where these services are not readily available. The promised savings associated with the closures could quickly evaporate as patients without neighborhood access to care delay seeking treatment and later present themselves at the remaining hospitals with more serious and costly medical conditions.

While ensuring the financial viability of New York's hospitals is an important and necessary step in restoring the health of the acute care system, closing and downsizing hospitals without first ensuring that necessary replacement medical services are in place is likely to cause great hardship to the City's most vulnerable residents.

The Commission on Health Care Facilities in the 21st Century

Controlling the growth of Medicaid spending in New York has been an ongoing effort of the Executive Branch, the State Legislature and local governments. At \$45 billion, the State’s Medicaid budget is the nation’s largest, and also the single largest component of New York’s budget. The federal government funds 50 percent of Medicaid costs and the State pays 25 percent of New York’s Medicaid costs. New York City contributes 25 percent for non-long term care expenses.¹³

One gubernatorial working group reviewing Medicaid spending recommended eliminating what it described as excess hospital bed capacity. The group estimated the overage at 19,000 to 20,000 beds, or one-third of the total beds statewide, the cost of which, in part, is borne by the State via the Medicaid program.

In response, the New York State Legislature and Governor Pataki created the Commission on Health Care Facilities in the 21st Century to “right size” hospitals and nursing homes statewide. Led by Stephen Berger, who had previously chaired the working group, the Commission’s 18 statewide members and up to six voting representatives per region held 19 public hearings, collected hundreds of pieces of testimony, and conducted hundreds of meetings with stakeholders focused on exploring the need for hospital closures over a period of 18 months.

On November 28, 2006, the Commission issued a report with its recommendations for “right sizing” the State’s hospitals and nursing homes. In New York City, speculation had focused on the future of over one dozen hospitals located in every borough except Staten Island. While the results were not as sweeping as predicted, the Commission recommended the closure of nine hospitals statewide, five of which are located in New York City. Eight other City hospitals are slated for mergers, downsizing or conversion and one is targeted for expansion.

The Commission’s authorizing legislation called for a complex decision-making matrix based on factors such as current capacity and the need for capacity in nursing homes and hospitals, the economic impact of closure, including employment, the facility’s financial status, the availability of other medical services in the area, the potential to convert the facility to a non-medical use, and the degree to which it meets the medical needs of the area, including as a safety net provider. The Commission’s analysis used data supplied by the State Department of Health and the State Dormitory Authority. Despite the requirement to consider multiple factors when determining which hospitals to recommend for closure or merger, both hospitals and community members expressed concern to the Commission during its evaluation process that fiscal status appeared to overshadow other considerations and that hospitals located in medically-underserved, low-income communities would be disproportionately affected.

Closing hospitals can be a costly process. To acquire the financial resources to enact the recommendations, the Governor negotiated and recently announced the approval of a unique waiver (known as F-SH(a)RP) with the federal Centers for Medicare and Medicaid Services (CMMS) that will provide the State with up to \$1.5 billion over five years contingent upon, among other requirements, the full implementation of the Commission’s right-sizing recommendations. By January 31, 2007, the State must certify to CMMS that there are no legal obstacles preventing compliance with the Commission’s recommendations for hospital closures and by July 15, 2008, the State must certify that all of the Commission’s hospital closure recommendations have been acted upon, including an implementation timeline, in order to retain eligibility for the federal funds.¹⁴

The Federal waiver has rigid terms and conditions. The State must meet several important requirements, in addition to the hospital closings, in order to capture the full waiver amount such as providing \$3 billion in State matching funds, meeting specific annual revenue goals for collection of Medicaid fraud and abuse dollars, and reducing expenditures in Family Health Plus, an insurance program for families whose income falls just above Medicaid guidelines.

According to an analysis by the Save Our Safety Net-Campaign, more than 50 percent of the F-SHRP funds appear to be directed towards debt repayment. At least \$875 million is to be used largely to retire/restructure debt and for labor commitments such as severance and pensions. The terms also include \$75 million for primary and ambulatory care.¹⁵

The Healthcare Efficiency and Affordability Law for New York (HEAL-NY) will also provide sizable funding to reshape the health care delivery system. Over 100 facilities statewide, including 32 City hospitals and nursing homes, applied to the HEAL-NY program, which will allocate a total of \$1 billion for costs associated with hospital and nursing home restructuring as well as health information technology.

On November 29, 2006, one day after the Commission released its final report, and six days before the legal deadline, Governor Pataki, joined by Governor-elect Spitzer, announced their approval of the Commission's recommendations.¹⁶

The New York State Legislature held statewide hearings in early December regarding the Commission's recommendations. The New York State Legislature could have halted the approval process only if a majority of members of both houses voted to adopt a concurrent resolution rejecting the recommendations no later than December 31, 2006, a deadline of merely four weeks following the report's release. As of this writing, the State Senate has adjourned and indicated that it will not return until January 3, 2007, effectively upholding the Governor's approval.

There is still a possibility that the recommendations could be revisited. At least one key legislator has indicated an interest in reviewing the legal and fiscal implications of rejecting or renegotiating the F-SHRP agreement in order to regain the ability to amend the closure recommendations.¹⁷ Some hospitals have indicated that they intend to seek protection from a closure by filing for bankruptcy. This legal strategy could pre-empt or delay any State decision to close a hospital by placing control over its operations with the Court.¹⁸

The Berger Commission report represents a first step in remedying New York State's expensive and inefficient health care system. Yet, it is critical that the tight deadline for reviewing its recommendations and the prospect of significant federal dollars contingent upon its implementation are not the main drivers of the reform process. This report analyzes selected aspects of the services provided by the hospitals slated to close. Others who examine the Commission's recommendations will doubtless raise other valid concerns. All stakeholders—hospital workers, patients, community leaders, and elected officials—must ensure that there is a thorough review of all valid concerns and that these concerns are addressed as part of moving forward with any plan.

Moreover, these recommendations must be incorporated into a comprehensive statewide plan to ensure that all New Yorkers have access to affordable, high quality, culturally appropriate medical care in their own community. Many states and cities, including Massachusetts, Vermont, Florida and San Francisco, are experimenting with innovative approaches to health care reform that could serve as starting points for a

similar effort in New York. The release of the Berger Commission report offers a historic opportunity to “spend smarter” and to create incentives for urgently needed primary and preventive care to meet the needs of our most vulnerable New Yorkers.

II. Discussion and Analysis

The Commission on Health Care Facilities in the 21st Century recommended:

- Closure of five New York City hospitals: New York Westchester Square, Victory Memorial, Cabrini Hospital, St. Vincent’s Midtown Hospital and Parkway Hospital.
- Conversion of New York Eye Ear and Throat from an acute care facility to one serving outpatients only.
- Merger of two sets of hospitals: Peninsula Hospital and St. John’s Episcopal Hospital South Shore and New York Methodist Community Hospital and New York Community Hospital.
- A new passive parent corporate relationship for Mount Sinai Hospital with North General Hospital.
- Conversion of 80 detoxification beds at Beth Israel Medical Center-Petrie Division to psychiatric beds.
- Expansion of the medical-surgical service at Queens Hospital Center by 40 beds.
- Decertification of 78 beds at New York Downtown Hospital.

Of the 15 hospitals directly affected by the Commission’s recommendations, at least 10 could be considered community hospitals. Community hospitals tend to be on the lower end of the range for the number of licensed beds and occupancy rate. Their patients are primarily residents of the area immediately surrounding the facility, and they generally do not focus on specialty care or care requiring the highest levels of technology. Over the last eight to ten years, many New York community hospitals have pursued strategies such as affiliating with a larger hospital system in an attempt to improve their financial status. In 2000, the United Hospital Fund, one of New York State’s most well-regarded health policy institutions, documented the weakened financial condition of the City’s community hospitals.¹⁹ The patient mix has remained disproportionately low-income and uninsured since then, leading to ongoing issues with financial performance.

A table summarizing all of the key recommendations for New York City hospitals with selected operating indicators is included as Appendix B.

While there are many factors to be considered in examining the impact of hospital closures on New Yorkers’ health and communities, the Office of the Comptroller has focused its review on the potential implications of hospital closures and downsizings on emergency room services while also examining certain inpatient and outpatient issues. We have also profiled the rates of poverty and of individuals without health insurance in the neighborhoods surrounding the recommended closures. While the Commission’s recommendations cover hospitals and nursing homes throughout New York State, this analysis addresses New York City hospitals only.

A. Emergency Services

In many communities where routine medical care is not readily available or affordable, the local emergency room serves as a *de facto* primary care doctor. Thus, closing or reducing emergency room services will harm the health not only of those with true medical emergencies, but also individuals who use the emergency room for their outpatient care. Considerable preparation will be needed to address the disruptions and dislocations associated with emergency room closings.

New York City emergency rooms often are overcrowded

City hospital closures will increase demand on nearby emergency rooms which in turn can lead to longer waiting times and more ambulance diversions.²⁰ As indicated by New York City EMS ambulance turnaround times, the City’s emergency rooms already are overcrowded.

Ambulance crews are required to wait until patients are formally turned over to hospital emergency staff before crews can return to the field. While New York City EMS sets a turnaround performance goal of 25 minutes, turnaround times are longer when emergency rooms are overcrowded. According to the EMS November 2006 Turnaround Report, the average turnaround time for the entire City was 29 minutes, which was typical for the full year and indicative of widespread overcrowding in emergency rooms. As discussed below, turnaround time was even longer in several of the hospitals that would receive additional emergency room visits from the hospitals recommended for closure.

The investigation conducted by the Comptroller’s Office included interviews with several emergency medical technicians and supervisors and further established that New York City hospital emergency rooms often are backed up with patients awaiting treatment. On any given day, emergency room operations can be compromised by nursing shortages, multiple ambulances arriving at once, or a patient requiring intervention by most of the emergency room staff, among other reasons. When significant delays occur, EMS supervisors place the emergency room on “diversion,” which means that the next ambulance must travel farther to find an available emergency room. Because ambulance crews have to wait longer before they can return to the field or spend extra time being diverted to another hospital, overcrowded emergency rooms decrease the overall availability of EMS ambulances for calls. Currently, EMS estimates that only 40 percent of ambulances are available at any given time to take calls, while 60 percent are either treating patients or at the emergency room.²¹

The closure of seven New York City emergency rooms from 2002 to 2004 has already impacted the remaining closest emergency rooms.²² During this period there were approximately 3.5 million emergency room visits annually in New York City. Since the number of emergency room visits remained largely unchanged, most of the emergency room visits shifted from the seven closed emergency rooms to the remaining hospitals in the surrounding areas.

This impact was compounded by two additional closures in 2005, St. Mary’s Hospital in Crown Heights, Brooklyn and Bayley Seton Hospital on Staten Island. St. Mary’s handled 35,174 emergency room visits in 2004, of which 86 percent were made by individuals unable to pay or using public health insurance.

Adding staff to handle a surge in patient volume can be difficult and costly. Given the well-documented shortages in the availability of nurses, many medical facilities are scrambling to meet staffing needs. As Wendy Z. Goldstein, the chief executive of Lutheran Medical Center, observed in *Crain’s New York Business*,

the use of overtime and temporary nurses from employment agencies is expensive and means that “[w]hen you’re at 98 or 99 percent occupancy, you’re losing money.”²³

Emergency rooms need surge capacity

Many hospitals and local governments remain inadequately prepared to handle a large-scale catastrophe, such as a natural disaster or terrorist attack, according to a recent report by the National Academy of Sciences, Institute of Medicine. The report found that many emergency departments are “so overcrowded in major cities that they can barely handle a multiple car crash, let alone mass casualties.”²⁴

Emergency rooms that are already operating at full capacity will likely have difficulty meeting sudden increases in patient volumes. In January 2001, nine months before the attack on the World Trade Center drew the public’s attention to the need for surge capacity in emergency rooms, New York State Health Commissioner Antonia Novello sent a letter to all hospitals urging administrators to keep careful watch on emergency room operations, given the potential for overcrowding during peak patient volume periods, such as flu season. The Commissioner noted that: “One of the key factors contributing to emergency department overcrowding is that patients who require hospital admission are being kept in the emergency department waiting for available inpatient beds.”²⁵

1. Selected utilization, payer and EMS statistics for emergency rooms in hospitals recommended for closure or merger and in nearby hospitals

For every hospital that provided Institutional Cost Report statistics to the New York State Department of Health, Map 1 (see Appendix A) shows the number of emergency room visits in 2004 as well as the percentage of those emergency room visits that resulted in admission to the hospital. Three hospitals or hospital divisions shown on the maps, St. Mary’s in Brooklyn, St. Joseph’s in Queens, and Beth Israel North in Manhattan closed or no longer operate emergency rooms. Manhattan Eye, Ear and Throat, which is slated to cease inpatient operations, has no emergency room.

The map also shows the percentage of emergency room visits that were “self-pay or no pay,” a proxy for uninsured patients, or paid by public health insurance, Medicaid and Medicare. Finally the data is laid over neighborhood poverty rates.

It should be noted that the poverty rates shown on Map 1 represent the average for each of 42 broadly defined neighborhoods in New York City as compiled by the New York City Department of Health and Mental Hygiene (DOHMH) using 2000 Census data. As with all averages, the data masks unusually high and low values. For example, for the Canarsie-Flatlands neighborhood in Brooklyn, the map shows a rate of 14 percent to 16 percent living below the federal poverty line. Using data developed by *INFOSHARE.ORG*, which matched census tract level data to the neighborhood boundaries, the Comptroller’s Office identified 13 areas within the Canarsie-Flatlands neighborhood that had poverty rates between 22 percent and 47 percent, representing more than 11,000 residents. Within these high poverty census tracts, 24 percent of those living in poverty were under the age of 18.

Health and Hospital Corporation (HHC) and voluntary hospitals are each marked respectively in red and blue along with each hospital’s status as a 911 receiving hospital and regional trauma center.

As Map 1 illustrates, in 2004 Lincoln Hospital in the Bronx had the City’s busiest emergency room with 144,880 visits, followed by Montefiore Hospital/Moses Division also in the Bronx with 128,052 visits and

Kings County Hospital in Brooklyn with 126,850 visits. Two of the three, Lincoln and Kings County Hospitals, are public hospitals operated by the City's Health and Hospitals Corporation (HHC). HHC hospitals treat many uninsured and underinsured individuals who are able to pay little or nothing for their treatment.

Of the five hospitals the Commission has recommended for closing:

- **The combined closure of both Cabrini Medical Center and St. Vincent's Midtown Hospital, both located west of 5th Avenue and south of Central Park, with a total of 45,627 emergency patients in 2004, could have an especially significant impact on nearby hospitals.** Despite the relatively low poverty rates in their neighborhoods, St. Vincent's Midtown Hospital and Cabrini Hospital treat relatively high proportions of self-pay patients in their emergency rooms. These mostly uninsured patients would instead go to St. Vincent's, Beth Israel, New York Hospital, the Roosevelt Division of St. Luke's-Roosevelt Medical Center, Bellevue Hospital, and possibly New York Presbyterian/Weil Cornell.
- **From 2002 to 2004, the number of emergency room visits was virtually unchanged or slightly increased at three of the five hospitals recommended for closure:** Cabrini, no change; St. Vincent's Midtown, 1.18 percent increase; and Westchester Square, 2.36 percent increase.
- Average New York City ambulance turnaround time—the amount of time before an ambulance is available to take its next call—is approximately 29 minutes, four minutes longer than the 25 minute NYC Emergency Medical Services performance goal. This is a result of emergency room overcrowding and understaffing. **At a number of hospitals that would receive an influx of emergency patients from closed hospitals, the turnaround time already exceeds 29 minutes and would likely increase if all of the recommended closures occur.** There would also be a “ripple effect” on ambulance response times throughout the borough, according to emergency medical technicians and supervisors who were interviewed by the Office of the Comptroller. **Because the current 29 minute average turnaround time is four minutes longer than the EMS performance goal, nearly 60,000 extra hours of ambulance time a year is not currently available to take new calls.**
- **Several hospitals are located in or adjacent to primary care “serious shortage” and/or “stressed” areas as measured by the ratio of Medicaid-enrolled population-to-primary care providers who accept Medicaid.** These include **Westchester Square Hospital, Victory Memorial Hospital and St. Vincent's Midtown.** Medicaid enrollees who depend on these hospitals' emergency rooms for primary care could have difficulty finding a primary care doctor in their community. According to HHC and the New York City Primary Care Development Corporation, although 39 percent of New York City residents are enrolled in Medicaid, they have access to only 25 percent of primary care physicians based in the City.²⁶

Table 1. Emergency room visits and selected payers at hospitals recommended for closure, 2004

	ER visits	% self or no-pay visits	% public insurance payer	% of visits resulting in hospital admission/ borough average	% of population in poverty
New York Westchester Square Hospital	23,187	10	34	27/18	22
Victory Memorial Hospital	23,808	9	46	25/21	16
Cabrini Medical Center	18,674	21	35	37/20	23
St. Vincent's Midtown Hospital (Man)	26,953	36	45	16/20	14
Parkway Hospital	13,973	11	52	46/22	13

Source: ER Visit, Admission and Payer Data (NYS Institutional Cost Report and individual hospitals, 2004); Poverty Rates (NYCDOHMH Epidemiology Service Sortable Statistics)

New York Westchester Square Hospital

- If all of Westchester Square Hospital's emergency room patients were to present at the next closest emergency room, at Montefiore-Weiler Division, **the number of additional emergency visits would constitute 50 percent of Weiler Division's 2004 emergency room volume.** Montefiore ranked seventh in a recent survey of the nation's busiest emergency rooms.²⁷ In November 2006, Weiler Division's emergency room turnaround time was 31 minutes and 55 seconds, five minutes longer than the New York City EMS performance goal.
- Twenty-seven percent of emergency room visits resulted in an admission, the highest rate for the Bronx. **Montefiore Hospital/Weiler Division, the next closest hospital, has a relatively high staffed bed occupancy rate of 87 percent,** which may raise questions about its ability to absorb additional patients that would have been admitted to Westchester Square Hospital.
- **The Northeast Bronx (ZIP code area 10469) and Pelham/Throgs Neck communities (ZIP code area 10465) are primary care provider "serious shortage areas"** as measured by the ratio of Medicaid-enrollees to primary-care providers who accept Medicaid, and Pelham/Throgs Neck (10462) is a "stressed area".²⁸

Alternatively, Crotona-Tremont residents who would have gone to the Westchester Square Hospital emergency room might go to the emergency room at Bronx Lebanon Hospital/Concourse Division; central Crotona-Tremont is about equidistant from Montefiore and Bronx-Lebanon Hospital/Concourse Division. The Concourse Division's 106,213 emergency room visits made it the borough's third busiest, and its ambulance turnaround time was 31 minutes, 33 seconds in November 2006.

Only 10 percent of Westchester Square's emergency room visits were self-pay. As indicated earlier, self-pay usually refers to patients who are able to pay little if any of the cost of treatment. Since only a relatively low ten percent of emergency room visits in 2004 were self-pay, the financial impact on other hospitals absorbing more self-pay visits would be small. Jacobi Hospital, the closest HHC hospital, already had a self-pay rate of 22 percent.

Capacity for inpatient admissions from the emergency room could become a challenge for Montefiore Hospital's Weiler Division. More than 27 percent of Westchester Square's emergency room visitors were subsequently admitted to the hospital, the highest proportion in the Bronx. The Weiler Division of Montefiore Hospital already has a 25 percent admission rate from the emergency room, the borough's second highest inpatient admission rate, and a comparatively high staffed bed occupancy rate of 87 percent. Together,

these relatively high rates raise questions about the ability of the Weiler Division to absorb additional inpatients from Westchester Square.

Victory Memorial Hospital

- If all of Victory Memorial's emergency room patients were to present at the next nearest hospital, Maimonides Medical Center, **the number of additional emergency visits would be 25 percent of Maimonides' 2004 volume.** In November 2006, its emergency room turnaround time was 29 minutes, six seconds, four minutes longer than the New York City EMS goal.
- In 2004, 25 percent of Victory Memorial emergency room visits resulted in an admission. **Maimonides Medical Center, the nearest hospital to Victory, currently has a staffed bed occupancy rate of 93 percent.**
- **Bensonhurst/Bay Ridge (ZIP code area 11214) is a primary care provider "serious shortage area"** and Borough Park (11204) is a "stressed" area as measured by the ratio of Medicaid enrollees to primary care physicians who accept Medicaid.²⁹

Victory Memorial Hospital, located in the Bensonhurst and Bay Ridge neighborhoods of Brooklyn, had 23,808 emergency room visits in 2004, the third fewest of any hospital in the borough. If all of Victory Memorial's emergency room visits shifted to the next closest hospital, Maimonides Medical Center, it would be equal to 25 percent of Maimonides' 2004 volume. Residents to the south of Victory Memorial might also go to Coney Island Hospital and residents to the north might shift to Lutheran Medical Center.

Although the Commission believes that surrounding hospitals will be able to absorb Victory Memorial's inpatients, its report does not specifically discuss the impact of inpatient admissions from the emergency room.³⁰ Managing expanded inpatient admissions from the emergency room can require additional resources, as noted in the preceding discussion of surge capacity.

Sufficient capacity for inpatient admissions from the emergency room could become an issue for Maimonides Medical Center and Lutheran Medical Center. Maimonides had a similar rate of 28 percent while Lutheran and Coney Island hospitals had approximately 20 percent inpatient admission rates. Although its license allows it to add beds, Maimonides Medical Center currently has a staffed bed occupancy rate of 93 percent, suggesting that it could have difficulty absorbing a significant number of additional inpatients through its emergency room. Lutheran Medical Center, with a staffed bed occupancy rate of 92 percent, may be in a similar position. Coney Island Hospital has a staffed occupancy rate of only 77 percent.

Cabrini Medical Center

- If all of Cabrini's emergency visits were to present at the next nearest hospital, **Beth Israel Medical Center, the number of additional emergency visits to Beth Israel would be 30 percent of the hospital's 2004 volume.** In November 2006, Beth Israel's EMS ambulance turnaround time was 30 minutes, 35 seconds, more than five minutes longer than the New York City EMS goal.
- **A significant portion of emergency room visits, 21 percent, were self or no-pay.** A shift of self-pay emergency patients to Beth Israel or to Bellevue, a nearby HHC hospital, could have an adverse financial impact on both hospitals' finances. Bellevue, where 37 percent of emergency patients already "self-pay," could be especially impacted. Already, Bellevue draws significant numbers of

lower-income patients from outside its immediate community, indicating that these individuals will travel a distance to be treated at an HHC facility.³¹

- **Two Lower East Side zip code areas (10001 and 10009) are “serious shortage areas” as measured by the ratio of Medicaid recipients to primary-care providers who accept Medicaid.**³² Closure would require low-income individuals who rely on the Cabrini emergency room for primary care to seek care elsewhere.
- **Thirty-seven percent of emergency room visits resulted in an admission, the highest rate for a non-specialty hospital in the borough.** However, since Beth Israel Medical Center, the nearest remaining hospital, had a staffed bed occupancy rate of 64 percent in 2004, capacity constraints should not pose a significant problem.

Cabrini, located in the Gramercy Park neighborhood of Manhattan, had 18,674 emergency room visits in 2004. The closest hospitals to Cabrini Medical Center already have busy emergency rooms. If all of Cabrini’s emergency room visits shifted to the next closest hospital, Beth Israel-Petrie Division, it would have 30 percent more emergency visits. At 62,552 visits, only six of 19 other Manhattan hospitals had more emergency room visits in 2004.

Cabrini’s emergency room payer mix would be problematic for Beth Israel and Bellevue. Since 21 percent of Cabrini’s emergency room visits in 2004 were self-pay versus 16 percent for Beth Israel, as the nearest remaining hospital Beth Israel could expect to receive additional self-pay emergency visits. Bellevue, which had a 37 percent self-pay rate, the highest rate in Manhattan, could experience a substantial influx of self-pay patients who would have presented at Cabrini. It should be noted that HHC hospitals account for a disproportionate 45 percent share of self-pay emergency room visits Citywide even though HHC accounts for only 33 percent of total emergency room visits and has only 11 of the City’s 61 emergency rooms, including Coler and Goldwater hospitals, because self-pay emergency room patients are more likely to use public hospitals when they need care.

Cabrini Medical Center has an unusually high inpatient admission rate from its emergency room. Approximately 37 percent of Cabrini’s emergency room patient visits resulted in admission to the hospital, the highest proportion in Manhattan with the exception of Memorial Sloan Kettering, a cancer specialty hospital. Beth Israel admits 26 percent of its emergency room visits while Bellevue admits 19 percent. Capacity for inpatient admissions from the emergency room does not appear to be a major challenge for Beth Israel and Bellevue; Beth Israel and Bellevue Hospital had a staffed bed occupancy rate of 64 percent and 73 percent respectively, leaving ample capacity for additional emergency room admissions. Some Cabrini emergency patients might also shift to St. Vincent’s Hospital, which had an emergency room inpatient admission rate of 22 percent and a staffed bed occupancy rate of 82 percent.

Given Cabrini’s emergency room inpatient admissions rate, further analysis of the patients admitted through Cabrini’s emergency room would provide data to assist Beth Israel and Bellevue in planning for how best to absorb these patients.

St. Vincent’s Midtown Hospital

- If all of St. Vincent’s-Midtown’s emergency visits were to present at the next nearest hospital, the Roosevelt Division of St. Luke’s-Roosevelt, **the number of additional emergency visits to Roosevelt would be 46 percent of this hospital’s 2004 volume.** In November 2006, Roosevelt’s

ambulance turnaround time was 29 minutes, 54 seconds, nearly five minutes slower than the New York City EMS goal.

- **Additional hospitals that could be expected to absorb some of the emergency patients** who would have gone to St. Vincent's-Midtown emergency include St. Vincent's Hospital of New York and Bellevue Hospital and, possibly, New York Presbyterian/Weil Cornell.
- **St. Vincent's Midtown Hospital runs a busy emergency room, and their clientele includes area residents, the homeless, workers** from recently constructed Times Square office towers and growing numbers of tourists. If it remained open, it could become even more heavily utilized as the City's plans for redevelopment of West Midtown take shape. In Fall 2006, the emergency room's EMS turnaround time exceeded 30 minutes, five minutes longer than the 25 minute EMS performance goal and indicative of overcrowding.
- Thirty-six percent of the hospital's emergency visits were self-paid, the second highest rate in Manhattan.³³ **The financial impact of closure on nearby remaining hospitals, such as Roosevelt and St. Vincent's of New York, and from absorbing additional self-pay emergency visits could be significant.** Because Bellevue Hospital serves a patient profile similar to St. Vincent's Midtown and it is the closest HHC hospital to St. Vincent's Midtown, it would also likely attract some of the self-pay patients who would have gone to St. Vincent's Midtown.³⁴
- Sixteen percent of emergency room visits resulted in an admission, a relatively low proportion for the borough. **This low percentage indicates that many of those who visited the emergency room sought non-emergency care.** It also indicates that there would be relatively few admissions from the emergency room when visits switch from St. Vincent's Midtown to Roosevelt or Bellevue for emergency services.
- **Chelsea-Clinton (ZIP code area 10001) is a "serious shortage area" and Chelsea-Clinton (10018 and 10036) is a "stressed area" as measured by the number of Medicaid recipients per primary-care provider who accepts Medicaid.**³⁵ Closure would require Medicaid recipients who rely on the St. Vincent's Midtown emergency room for primary care to seek it elsewhere.

St. Vincent's Midtown Hospital, formerly known as St. Clare's Hospital, is located on 51st Street between Ninth and Tenth Avenues in the Clinton area of Manhattan. The closest hospital is St. Luke's Roosevelt Hospital/Roosevelt Division. Two other hospitals, St. Vincent's Hospital of New York and New York Presbyterian Hospital/Weill Cornell are approximately forty blocks south and slightly less than three miles across town on the Upper East Side, respectively. Cabrini Medical Center, which is also recommended for closure, is approximately the same distance away as St. Vincent's Hospital of New York. St. Vincent's-Midtown Hospital had 26,953 emergency room visits in 2004.

If all of St. Vincent's-Midtown Hospital's emergency room visits shifted to the next closest hospital, the Roosevelt Division of St. Luke's-Roosevelt Medical Center, Roosevelt's emergency room volume would increase by 46 percent to more than 85,000 visits. Roosevelt is currently expanding its emergency room because it is already overcrowded.³⁶ Some St. Vincent's Midtown Hospital patients could be expected to also shift to St. Vincent's Hospital of New York, which handles an emergency room volume similar to Roosevelt's. Consequently, with the simultaneous closing of St. Vincent's Midtown and Cabrini hospitals, the impact on St. Vincent's Hospital of New York and its emergency room could be magnified.

St. Vincent's Midtown's high 36 percent emergency room self-pay rate could have an adverse impact on surrounding hospitals such as Roosevelt and Bellevue. Since only 16 percent of Roosevelt's emergency room visits were self-pay in 2004, the addition of St. Vincent's Midtown's numerous self-pay emergency visits could have a significant adverse impact on the hospital's finances. If St. Vincent's Midtown patients seek care at Bellevue because of its history of accepting large numbers of self-pay patients, Bellevue's proportion of un-reimbursed care could rise even higher than its current high rate of 37 percent.

Capacity for inpatient admissions from the emergency room would not appear to be a significant challenge for nearby hospitals. In 2004, only about 16 percent of St. Vincent's Midtown patients visiting the emergency room were subsequently admitted to the hospital, a relatively low proportion for the borough. Many of St. Vincent's Midtown patients could be expected to shift to St. Vincent's Hospital of New York, which has an emergency room inpatient admission rate of 22 percent and a staffed bed occupancy rate of 82 percent. Roosevelt, which has a 21 percent ER admission rate, and Bellevue Hospitals had staffed bed occupancy rates of 82 percent and 73 percent respectively, indicating the existence of ample inpatient capacity.

Parkway Hospital

- If all of Parkway's emergency visits were to present at the next nearest hospital, North Shore Forest Hills Hospital, **the number of additional emergency visits to Forest Hills Hospital would increase 48 percent above the 2004 level.**
- **A relatively small percentage of emergency room visits, 11 percent, were provided for free or reduced cost,** indicating little adverse financial impact of a closure on the emergency service operations of neighboring hospitals.
- Forty-six percent of emergency room visits resulted in an admission, the highest rate in New York City, except for Memorial Sloan-Kettering. **Forest Hills Hospital, the nearest hospital to Parkway, has a staffed bed occupancy rate of 90 percent, raising a question about the adequacy of the hospital's capacity if Parkway's closure proceeds.**
- Parkway Hospital has the highest percentage of Medicare payers for emergency room visits and a rate of inpatient admissions from its emergency room more than twice the borough-wide average. **This means that it has the highest usage among seniors for the hospitals that are closing and suggests that many of the admissions were age-related illnesses.**

Parkway Hospital, located in Fresh Meadows in Central Queens, had 13,973 emergency room visits in 2004. If all of Parkway's emergency room visits shifted to the next closest hospital, North Shore Forest Hills Hospital, the additional volume would increase Forest Hills' emergency visits by 48 percent above the 2004 level.

Parkway Hospital's emergency room payer mix is comparable to Forest Hills Hospital's, while its impact on Queens Hospital Center, the next nearest hospital, would appear to be mixed depending on the number of self-pay and Medicaid visits that shift from Parkway. In 2004, only 11 percent of Parkway's emergency room visits were self-pay. North Shore Forest Hills Hospital had the lowest self-pay rate in the borough, 8 percent, while Queens Hospital Center, an HHC facility had the borough's highest self-pay rate, 36 percent. Fifty-two percent of Parkway Hospital emergency room visits, a proportion placing it third highest in the borough, and tied with North Shore and Flushing Hospital and Medical Center, used public health insurance as the payer, 13 percent with Medicaid and 39 percent with Medicare. North Shore's split between Medicaid

and Medicare was 21 percent and 31 percent respectively and Queens Hospital reported 41 percent of its visits were paid by Medicaid, while only 6 percent were paid by Medicare.

If Parkway closes, sufficient capacity for inpatient admissions from the emergency room could become a concern for Forest Hills Hospital and Queens Hospital Center, although implementation of the Commission's recommendation to add 40 beds to Queens Hospital Center could reduce the impact on that facility. Approximately 46 percent of Parkway's emergency room patient visits resulted in admission to the hospital, the highest non-specialty hospital inpatient admission rate in the City, and 33 percent of Forest Hill Hospital's emergency room visits produced inpatient admissions. Forest Hills Hospital and Queens Hospital Center had staffed bed occupancy rates of 90 percent and 83 percent respectively.

Given Parkway's high rate of admitting emergency room patients, further analysis of the patients admitted through Parkway's emergency room would provide data needed to assist Forest Hills Hospital and Queens Hospital Center with plans to best absorb these patients.

St. John's Episcopal Hospital-South Shore/ Peninsula Hospital

St. John's Episcopal Hospital and Peninsula Hospital, both located in different communities on the Rockaway Peninsula in Queens, handled 27,898 and 26,430 emergency room visits in 2004, respectively. The Commission recommends that these two hospitals shed a total of 180 beds and, contingent on financing, merge and rebuild a single 400 inpatient bed facility.

The two hospitals are more than 40 blocks apart. If one new hospital is built to replace the two existing hospitals, as the Commission recommends in the long term, it would mean longer travel times to the emergency room for many residents of the Rockaways.

2. Selected payer characteristics of emergency rooms in HHC compared to non-HHC hospitals

Table 2 provides another perspective on self-pay rates as well on the use of Medicaid to pay for emergency room visits by comparing Health and Hospitals Corporation (HHC) and voluntary hospitals. In 2004, HHC handled a disproportionate 33 percent share of the City's emergency room visits even though it had only 11 of the City's 61 emergency rooms. The proportion of the City's self-pay emergency room visits was even more skewed toward HHC, which handled 45 percent of all self-pay emergency visits. This indicates that if the recommended closures proceed, it is likely that a disproportionate share of uninsured, self-pay patients who would have gone to one of the emergency rooms recommended for closure would instead go to an HHC emergency room.

Table 2. ER visit by Medicare, Medicaid and self or no-pay: HHC compared to non-HHC, 2004.

	Medicare	Medicaid	Medicare HMO	Medicaid HMO	Self or no-pay	TOTAL VISITS	Number of NYC ERs
Non-HHC hospitals	326,690	392,806	57,628	468,927	404,960	1,651,011	50
% of Total	86	69	93	65	55	67	82
HHC hospitals	52,206	178,014	4,033	256,109	330,747	821,109	11
% of Total	14	31	7	35	45	33	18
Total #	378,896	570,820	61,661	725,036	735,707	2,472,120	61

Source: *Total ERs, Visit and Payer Data*, NYS Institutional Cost Report and individual hospitals, 2004.

Table 3 compares the rates of self-pay/no-pay and Medicaid use at the HHC hospitals closest to the hospitals recommended for closure. If significant numbers of Medicaid patients shift from closed hospitals to HHC emergency rooms, especially to HHC emergency rooms where Medicaid already accounts for a large share of payers, there could be a significant negative financial impact on the receiving HHC facility because Medicaid pays less than 30 percent of the cost of an emergency visit (\$125 versus \$455). Although all hospitals lose substantially on every Medicaid visit, many non-HHC hospitals make up some of this loss if the emergency room patient is subsequently admitted to the hospital. However, since HHC hospitals have comparatively low rates of admission from the emergency room—ranging from 14 percent for HHC hospitals in the Bronx to 17 percent in Brooklyn—they are less likely to recoup the non-reimbursed costs of emergency visits. The low HHC admission rate from the emergency room reflects the especially heavy use of HHC emergency rooms for primary care.

Table 3 shows that among HHC hospitals, Bellevue would likely experience the most significant financial impact on their emergency services due to an influx of self-pay patients; in 2004, Bellevue already had a 37 percent self-pay rate and nearby Cabrini as well as St. Vincent's Midtown both had high self-pay rates. Coney Island, Jacobi and Bellevue could be especially affected by an increase in emergency room visits paid by Medicaid since Victory Memorial, Westchester Square and St. Vincent's Midtown have substantial Medicaid payment percentages.

Table 3. Emergency visit payers, hospitals recommended for closure and their nearest HHC hospital, 2004.

Hospital recommended for closure	% of self or no-pay at closing hospital	% paid by Medicaid at closing hospital	Nearest HHC hospital to closing hospital	% of self or no-pay at HHC hospital	% paid through Medicaid at HHC hospital	% of area population in poverty
Westchester Square	10	25	Jacobi Medical Center	22	57	22
Victory Memorial	9	24	Coney Island Hospital	28	41	16
Cabrini	21	19	Bellevue Hospital	37	30	23
St. Vincent's Midtown	36	33	Bellevue Hospital	37	30	14
Parkway	11	13	Queens Hospital	22	44	13

Source: *Total ERs, Visit and Payer Data*, NYS Institutional Cost Report and individual hospitals, 2004.

Although it might be assumed that self-pay patients will go to the next nearest emergency room if their closest hospital closes, the emergency room payer statistics in Appendix A clearly indicate that self-payers have a strong preference for HHC emergency rooms. This helps to explain why in 2004, for example:

- Kings County Hospital Center had an emergency room self-pay rate of 53 percent compared to only 13 percent at SUNY Downstate Medical Center, 19 percent at Kingsbrook Medical Center, and 18 percent at St. Mary's Hospital, all of which were located nearby. The next closest hospitals, Interfaith Medical Center, Brookdale Hospital Medical Center, and New York Methodist Hospital, had self-pay rates of 21 percent, 21 percent, and nine percent respectively.
- Similarly, in Manhattan, with the sole exception of St. Vincent's Midtown, the highest self-pay percentages were at the three HHC hospitals — Bellevue, Harlem and Metropolitan.
- In the Bronx, HHC's Lincoln Hospital had the highest self-pay rate, 30 percent, and HHC North Central Bronx Hospital's self-pay rate was 25 percent, exceeding the 18 percent rate at Our Lady of Mercy and 15 percent rate at Montefiore/Moses Division, its two closest hospitals.

- In Queens, the highest self-pay rates were at HHC Queens Hospital Center, 36 percent, and HHC Elmhurst Hospital Center, 33 percent, well in excess of the rates for the next closest hospitals.

3. Impact of recommended closures on ER trauma patients and centers

While a significant share of emergency room visits are for non-emergency purposes, emergency rooms must be prepared to treat the most severe cases 24 hours a day. The New York City region is served by 21 regional trauma centers, the State's highest service level designation, to handle the most demanding emergency room treatments, such as gunshot and stabbing victims. According to the New York State Appropriateness Review Standards:

“[A] regional trauma center is a major tertiary care facility with the ability to provide definitive treatment to the full-range of trauma patients. Such a facility has twenty-four hour availability of specialists in varied surgical and non-surgical fields. A regional trauma center is capable of treating 1,000 severely injured patients per year.”³⁷

All regional trauma centers in the City are also 911 Receiving Hospitals. However, there are additional City hospitals that belong only to the 911 system. To be a 911 receiving hospital, the emergency room must comply with City and State standards and operational requirements. All 911 calls are dispatched to the closest appropriate and available ambulance by the City's Emergency Medical Services, a division of the New York City Fire Department.

According to the 2004 report, *Evaluation of the New York City Trauma System. Final Report to the State Hospital Review and Planning Council*, the most severe trauma cases represented approximately eight percent of New York City emergency visits to trauma centers in 2002.³⁸ Manhattan trauma centers treated the most cases overall and the most severe cases, followed closely by Queens. The number of trauma cases is declining nationwide and in New York City; the decrease is attributable to the lower crime rate in recent years and changes in consumer behavior, such as wearing seat belts. Some patients may also be seeking care at ambulatory surgery centers rather than through the emergency room.³⁹

The report notes that approximately 25 percent of all New York City moderate to severe trauma cases are treated at community hospitals rather than trauma centers.⁴⁰ Under EMS standards, such cases should be transferred to regional trauma centers but very few are. The authors found, however, that care at the community hospitals seemed to be appropriate, and many patients arrived by a method other than EMS. One theory about the reason for the care level may be that New York City community hospitals have better medical and surgical resources on hand compared to community hospitals elsewhere. At least four of the hospitals recommended to close, Cabrini, New York Westchester Square Hospital, Victory Memorial Hospital and Parkway Hospital, could be classified as community hospitals.

The State review found that trauma care was readily accessible to all trauma victims in New York City, except for a few neighborhoods in southern Kings County. Consequently, Kings County Hospital, Maimonides Medical Center, and Brooklyn Hospital, none of which are designated trauma centers, all handled such cases for southern Brooklyn.⁴¹ It should be noted, however, that representatives of New York City EMS advised the State that they believed an additional trauma center was needed in the south Brooklyn area.

Eastern Queens is also relatively underserved, according to the study, although North Shore Hospital on Long Island also accepts some New York City trauma patients.⁴²

Trauma cases that would have been treated at one of the hospitals recommended for closure would be treated at the next closest hospital or at the nearest trauma center. This would mean extra minutes of travel time. Table 4 lists hospitals recommended for closure and their nearest trauma center. In nearly all instances, traveling to the trauma center adds substantial time when every minute is vital.⁴³ In addition, severe traffic congestion can make a trip even longer; a half-mile trip may take half an hour or longer.

Table 4. Hospitals recommended for closure and their nearest trauma center.

Hospital recommended for closure	Trauma center	Distance
New York Westchester Square Hospital	Jacobi Medical Center	2.06 mi.
Victory Memorial Hospital	Lutheran Medical Center	2.71 mi.
Cabrini Medical Center	Bellevue Hospital	0.75 mi.
St. Vincent's Midtown Hospital	St. Luke's Roosevelt/Roosevelt Division	0.55 mi.
Parkway Hospital	Jamaica Hospital	2.28 mi.

Source for Hospital Closures, *Final Report of the Commission on Health Care Facilities in the 21st Century*. Source for Trauma Centers: New York State EMS. Travel distance: Mapquest.

New York City EMS is not currently required to evaluate the possible impacts on emergency room services when a hospital proposes closing or downsizing its emergency room services. It is common practice, however, for the local EMS to consult with the New York State Department of Health during DOH's review process for evaluating a hospital closure.⁴⁴ Given that New York City EMS indicated in 2004 that another trauma center was needed to reduce response time in Southern Brooklyn, it would be prudent to revisit the issue at this time.⁴⁵

B. Inpatient and Outpatient Services

Assessing the need for a particular hospital based on usage is a complex calculation. Combining inpatient discharges, outpatient visits and total emergency room visits where the patient was treated and released gives a sense of the relative proportions of each activity to the total units of service each hospital delivered. Even if overall volume is low, the impact of closing any one component of the mix, especially if it is a substantial portion of the total, can still dislocate medical care for thousands of people.

Outpatient care is already in short supply

Many hospitals provide much of the primary care available in an area through their outpatient services such as diagnostic tests and clinic visits.⁴⁶ Especially in neighborhoods with high poverty rates and large numbers of uninsured and underinsured individuals, the lack of access to primary care is a significant factor in creating health care disparities. Hospital outpatient services typically are vital safety net providers. Several hospitals recommended for closure are located in or adjacent to primary care "serious shortage" and/or "stressed" areas as measured by the ratio of Medicaid-enrolled population-to-primary care providers who accept Medicaid. As noted above, according to HHC and the New York City Primary Care Development Corporation, although 39 percent of New York City residents are enrolled in Medicaid, they have access to only 25 percent of primary care physicians based in the City.⁴⁷

1. Inpatient, outpatient and emergency room volume of hospitals recommended for closure and nearby hospitals

Map 2, included in Appendix A, shows the number of beds each hospital is licensed to operate, how many inpatients were discharged from the hospital, and how many outpatient visits the hospital handled on site

and at affiliated off-site locations in 2004. Map 2 also shows the inpatient occupancy rate for licensed beds and for the number of beds the hospital is staffed to operate. Finally, Map 2 shows the inpatient service with the highest occupancy rate among psychiatric, medical-surgical, obstetrics, and pediatrics/neonatology services.

Seven hospitals or hospital divisions shown in green on the maps—Our Lady of Mercy D’urso Pavilion and Bronx Lebanon Hospital/Fulton Division, St. Mary’s Hospital and Interfaith Jewish Hospital in Brooklyn, Beth Israel North in Manhattan, St. Joseph’s in Queens and Bayley Seton on Staten Island—no longer operate inpatient facilities. Map 2 includes some hospitals that closed between 2003 and 2005 to illustrate inpatient and outpatient capacity that was lost prior to the current round of closures and downsizing.

The hospital data uses the best available approximation of the borough’s adult, non-elderly uninsured rates using survey data from the New York City Department of Health and Mental Health. Public and voluntary hospitals are each marked respectively in red and blue. The uninsured rate consists of the sum of the people who were uninsured at the time of the survey and of people who had been uninsured at some point during the preceding year.

Table 5 shows that outpatient services constituted 68 percent of the 373,740 units of service in all of the hospitals recommended for closure and emergency room visits accounted for another 28.5% of all units of service. Although the Commission has focused primarily on excess inpatient bed capacity, it is clear that a central function of these five hospitals is to provide outpatient and emergency services.

Table 5. Patient volume, hospitals recommended for closure and their boroughs, 2004.

Hospital and borough	Total inpatient discharges(A)	Total outpatient visits (B)	Total ER visits(C)	ER visits resulting in admission (D)	Total volume (est.) (A+B+C+D)
Victory Memorial Brooklyn	9,251 314,347	76,918 3,851,963	23,808 1,008,070	5,977 216,185	104,000 4,958,195
Westchester Square Bronx	7,297 199,101	17,372 2,595,434	23,187 737,337	6,298 133,180	41,558 3,398,692
Cabrini	9,800	42,473	18,674	6,884	64,063
St. Vincent’s Midtown	7,159	111,562 ⁴⁸	26,953	4,220	141,454
<i>Man Subtotal</i>	<i>16,959</i>	<i>154,035</i>	<i>45,627</i>	<i>11,104</i>	<i>205,517</i>
Manhattan	471,351	6,465,094	944,794	191,839	7,689,400
Parkway Queens	9,365 238,612	5,720 2,338,451	13,973 682,862	6,393 151,730	22,665 3,108,195
ALL CLOSURES	42,872 (11.5%)	254,045 (67.9%)	106,595 (28.5%)	29,772	373,740
4-Borough Total	1,223,411	15,250,942	3,373,063	692,934	19,154,482

Discharges: Commission on Health Care Facilities/NYS Institutional Cost Reports, 2004; Outpatients, United Hospital Fund 2004 Institutional Cost Report database information provided to the NYC Comptroller; ER visits and admissions NYS Institutional Cost Reports, 2004.

- Manhattan’s Cabrini Hospital and St. Vincent’s Midtown Hospital together accounted for just over half of the Citywide volume of combined services that would be displaced if the recommended closings are implemented.

- The five hospitals recommended for closure provided a total of over a quarter of a million outpatient visits. If the primary care provided at these sites is not replaced in close geographic proximity, it is likely that emergency room visits and inpatient admissions will increase at nearby hospitals.⁴⁹

2. Measuring inpatient occupancy rates; licensed bed versus staffed bed utilization rates for hospitals recommended for closure

Inpatient occupancy rate is another element to be considered in assessing a hospital’s volume. However, looking at the official occupancy rate, which is the licensed occupancy rate, rather than the staffed rate may make a relatively well utilized hospital appear to be underutilized.

Each hospital has an approved (licensed) number of beds which is reflected in its operating certificate from the State Department of Health. Licensed bed occupancy rate is a standard indicator for comparing how often the hospital’s total beds are full. Many hospitals intentionally operate with fewer inpatient beds than reflected in its license, however. This is the number of beds the hospital has sufficient staff to operate. The staffed bed occupancy rate provides a truer picture of the hospital’s level of occupancy.

Table 6 shows:

- The closure of all five hospitals would result in a loss of 1,050 staffed beds, of which approximately two-thirds, or 683 beds, were actively in use.
- The two hospitals recommended to close in Manhattan had a combined average staffed occupancy rate of almost 70 percent versus a licensed occupancy rate of a mere 39 percent.
- Westchester Square Hospital’s staffed occupancy rate was 11 percent higher than its licensed rate.
- Cabrini Hospital had a 32 percentage point higher occupancy rate for its staffed beds than for its licensed beds. This was the highest staffed occupancy rate among the hospitals recommended for closing, reflecting a managerial decision to reduce the number of staffed beds in order to improve efficiency.

Table 6. Inpatient utilization rates for hospitals recommended for closure, 2004.

Hospital recommended for closure, all hospitals	Total licensed beds	Average licensed bed utilization and percent	Total staffed beds (est.)	Average staffed bed utilization and percent
Victory Memorial Brooklyn, all	243 7,493	151/62% 5,060/68%	232 5,995	151/65% 5,059/84%
New York Westchester Square Bronx, all	205 4,179	105/51% 3,011/72%	169 2,995	105/62% 2,319/79%
Cabrini St. Vincent's Midtown	474 250	195/41% 86/35%	268 146	195/73% 86/59%
Sub-total	724	281/39%	414	281/68%
Manhattan, all	12,237	8,024/66%	8,909	7,147/80%
Parkway Queens, all	251 4,842	146/58% 4,842/74%	234 3,879	146/62% 3,373/87%
All hospitals recommended for closure	1,423	683/51%	1,050	683/65%
4-Borough Total	28,751	19,668/68%	21,737	17,899/83%

Source: Licensed beds: New York City Department of Planning Facilities Database; Licensed bed and staffed bed utilization: Commission on Health Care Facilities/SPARCS, 2006 and NYS Institutional Cost Reports, 2004.

While a hospital's overall occupancy rates may appear low, the busiest inpatient units, such as psychiatric and obstetrical services, may be operating at or over capacity. Even if the overall hospital occupancy rate suggests excess capacity, if usage in a particular service is high, a closure will have a disproportionate impact on patients using the busiest service. Examples:

- At St. Vincent's Midtown Hospital, the busiest inpatient service was Psychiatric, based on 2004 Institutional Cost Reports. **In 2004, this service used 337 percent of licensed capacity, filling 40 beds rather than the 12 that are currently licensed.** Psychiatric services are also the busiest inpatient service at the closest hospital, St. Luke's Roosevelt/Roosevelt Division. At St. Luke's, the psychiatric service has a licensed occupancy rate of 102 percent.⁵⁰
- Some intensive care units have occupancy rates well in excess of 90 percent, meaning they are often completely full during the day.** St. Luke-Roosevelt's combined intensive care unit occupancy rate was 120 percent, yet Roosevelt Hospital would be expected to accept patients who otherwise would have been patients at St. Vincent's Midtown's ICU. Similarly, Maimonides Medical Center's ICU occupancy rate averaged over 94 percent, which indicates that it is often full during the day, particularly during flu season. Yet Maimonides would be expected to treat patients who would have gone to Victory Memorial Hospital.

C. Impact of recommended actions on the uninsured

A review of the Citywide percentage of individuals without health insurance provides a perspective regarding the financial demands already placed on neighborhood hospitals and how those demands will continue to be a concern for the City's remaining hospitals. Lack of insurance also limits access to health care which often leads to poor health status and expensive treatment in the emergency room or as an inpatient.⁵¹ The cost of providing unreimbursed or under-reimbursed care will be absorbed by the remaining hospitals surrounding those that will close.

Approximately 1.8 million New York City residents do not have health insurance. A recent Urban Institute study found that about one-quarter of all uncompensated inpatient and outpatient care in New York State is provided by HHC, and approximately 72 percent of the New York State total is attributable to New York City. Statewide, one-third of unreimbursed care was for inpatients.⁵²

As the numbers of uninsured have risen, hospitals have provided increasing amounts of uncompensated care which has contributed to their declining financial picture. According to a study by Citizen Action, New York State provides its hospitals with \$847 million annually to cover the medical costs of patients who are unable to pay for their care.⁵³

The Urban Institute, however, estimated that hospitals statewide actually provide \$1.8 billion in uncompensated care annually. Hospitals with large numbers of uninsured patients tend to have relatively small private-pay revenues to make up the shortfall.⁵⁴

When the local hospital that provides medical treatment for an uninsured individual closes, the consequences for their health status may be profound. Professor Alan Sager of the Boston University School of Public Health, citing research by Donald Shepherd, has noted that “30 percent of patients whose hospital closes stop seeking care and the most vulnerable patients are made more vulnerable when hospitals close.”⁵⁵ Certainly, the uninsured should be counted among the “most vulnerable.”

Table 7. Uninsured rates for neighborhoods surrounding hospitals recommended for closure.

	Uninsured rate (ages 18-64)	Self or no-pay rate for ER visits	Poverty rate
Victory Memorial	22%	9%	16%
Westchester Square	24%	10%	22%
Cabrini	26%	21%	23%
St. Vincent's Midtown	16%	36%	14%
Parkway	25%	11%	13%

Uninsured Rates: NYCDOHMH, Community Health Profiles, 2nd Ed., 2006; ER payer data: NYS Institutional Cost Report, 2004); Poverty Rates, NYCDOHMH Epidemiology Service Sortable Statistics.

- All of the hospitals recommended for closure, except for St. Vincent's Midtown, are located in neighborhoods where approximately one in four individuals did not have health insurance at some point in the year.
- The uninsured rate is 6 to 12 percent higher than the poverty rate in the neighborhoods surrounding Victory Memorial and Parkway hospitals, suggesting that more residents in those areas may be working but either do not have access to or cannot afford health insurance through their employer.
- Victory and New York Westchester Square have lower than expected rates of self or no-pay emergency room visits given the uninsured and poverty rates in their areas.
- St. Vincent's Midtown has a higher than expected proportion of self or no-pay visits when compared to the area's poverty and uninsured rates.
- Parkway's self or no-pay visits are consistent with area poverty rates but much lower than the uninsured rates in the area.

III. Recommendations

Nearly one third of United States health care spending is for inpatient hospital care, with more than 60 percent of the bills going to Medicaid and Medicare for payment. As the population ages, national spending on hospital care is expected to grow. At the federal, state and local levels, policymakers are looking closely at the implications of these expenditures and how to formulate a response. Many states and cities, including Massachusetts, Vermont, Florida and San Francisco, are experimenting with innovative approaches to health care reform that could serve as starting points for a similar effort in New York.

New York State has started its own efforts with the work of the Berger Commission. Significant analysis and decision-making is still needed, however, prior to or in combination with implementation of the recommended “right sizing” actions.

For example, part of the right-sizing process must identify the need for additional hospital beds or even new hospitals to accommodate new population and utilization patterns. New York City’s population is expected to grow to nine million by 2025. Many of these newcomers will be living in the outer boroughs. The Health and Hospitals Corporation recently submitted a proposal to the State to increase the number of beds in its hospitals in Queens⁵⁶ and similar expansion may also be needed in other fast-growing areas, such as the Rockaway-Broad Channel neighborhood at the southern edge of Queens which had the third highest level of new building permits among New York City neighborhoods in 2004.

If the recommended hospital closures and mergers occur:

Recommendation: New York City Emergency Medical Service should report to the public by March 1, 2007 with an evaluation of the impact of the Berger Commission recommendations for closing emergency rooms.

This report’s findings included the following for emergency rooms: at least three of the recommended hospital closures could lead to large influxes of emergency patients at the nearest remaining hospitals; emergency rooms of several of the hospitals proposed for closure are heavily utilized by uninsured (“self-pay”) patients, who would likely present at a nearby HHC hospital instead; several of the emergency rooms recommended for closure are heavily utilized for routine primary care treatment; and closure of these emergency rooms will require longer trips to the next nearest emergency room for many people when every minute counts.

Furthermore, although the five emergency rooms recommended for closure are not designated trauma centers, they nonetheless treat substantial numbers of trauma patients. New York City EMS indicated in 2004 that an additional trauma center was needed in Southern Brooklyn.⁵⁷ With the closing of Victory Memorial, the question of whether there is a need for a trauma center in the area should be revisited.

New York State law requires hospitals to file a closure plan with the New York State Department of Health. It is current practice for the State’s EMS division to conduct an analysis of the impact of a closure, usually in consultation with the local EMS agency. New York City’s EMS division should take the lead on this issue and evaluate the impact of the five recommended emergency room closures. California mandates such an evaluation and recommends using evaluation criteria such as geography, travel time and distance to next nearest facility, volume, provision of trauma care, and availability of specialty services.

EMS should prepare such a report and hold a public hearing by March 1, 2007, 60 days after the recommendations for closure become law. This report should then be submitted to the New York State Department of Health, with recommendations for the approval or denial of each emergency room closing. If EMS recommends closing an emergency room, the report should include the steps needed to minimize adverse impact.

Comprehensive performance indicators are necessary to better evaluate emergency room services. For example, the State DOH has ceased publishing statistics on the average waiting time in each hospital's emergency room. The Fire Department collects, but does not release publicly, "turnaround" times, which measure how long an ambulance crew is detained at the emergency room and unavailable to take another call. This data should be available to the public on a regular basis.

Recommendation: New York State should adopt a legal requirement for local EMS agencies to prepare a written report evaluating the potential community impact of downgrading or closing emergency room services. The evaluation should be based upon criteria agreed upon in advance and in consultation with the New York State Department of Health.

Under Section 1300(c) of California's Health and Safety Code, local EMS agencies are required to create and submit a plan to the State specifying the criteria it will use to evaluate a hospital's request to close or downsize emergency room services. Within 60 days of such a request, the local EMS agency must produce an impact evaluation report based upon the previously agreed criteria and hold a public hearing. Enacting this requirement in New York State would create a transparent and objective process for determining how a proposed emergency room closure or downgrade would affect emergency services provided by EMS and any other relevant local entities.

Recommendation: Current emergency room operations should be restructured to better handle increased patient loads.

To minimize the impact of unavoidable emergency room closures, the State Department of Health should:

- Monitor emergency room usage closely and be prepared to grant emergency approval to increase bed capacity under certain conditions as well as take other steps to address high levels of emergency room usage and accompanying concerns about patient safety.
- Assist in the development and implementation of a comprehensive plan to re-engineer emergency room operations to reflect best practices. For example, Montefiore Medical Center's "fast-track" program to expedite care for non-emergency patients in its emergency room can serve as a model for emergency rooms facing increased patient loads as a result of hospital closings.⁵⁸ Montefiore has reduced average arrival-to-discharge time for non-emergent patients from about six hours to two hours and reduced the walkout rate—the percentage of patients who leave because they cannot wait any longer—from about 5 percent to 1.5 percent. The reduction in the walkout rate at Montefiore, the AP/Chronicle notes is "significant because walkout patients often get sicker and show up later in worse shape."

Recommendation: The potential impact of the hospital closings and mergers on HHC facilities should be fully assessed to ensure that HHC does not absorb a disproportionate share of the medically displaced uninsured and under-insured.

If HHC becomes the medical home for these individuals, savings from the closures should be provided to HHC to fully cover un-reimbursed costs related to taking on these new patients.

Recommendation: A community-based plan should be created, and a substantial portion of any savings from closures and mergers must be reinvested in community health, and, if necessary, additional dedicated funding should be provided for implementation.

Governor-elect Spitzer has stated that there should be more emphasis on providing routine preventive and primary care in outpatient settings rather than through emergency rooms or as inpatients, an approach for which there is virtually unanimous support.⁵⁹ The Primary Care Development Corporation (PCDC) has found that two out of five emergency room visits in New York are for conditions that should have been prevented or treated in a primary care setting and at a lower cost.⁶⁰ Use of emergency rooms for non-emergency treatment is particularly prevalent in the City's low-income communities.⁶¹ Moreover, lack of access to primary care contributes to health care disparities and poor health status, especially among individuals with chronic illnesses.

PCDC has used innovative methods over the last twelve years to finance capital projects at fifty-six primary care sites. As they note in their recent report, *Laying the Foundation: Health System Reform in New York State and the Primary Care Imperative*, the need for more community health centers remains high. Bronx County, for example, ranks first among the State's 62 counties in terms of need for primary care investment. There is also a shortfall in the number of primary care physicians serving low-income New Yorkers.⁶²

There is no State plan to replace and expand primary care capacity in neighborhoods where hospitals will close or to create additional primary care in shortage areas. Until such a plan is prepared, and implemented, the impact of the closings will fall on those least able to afford the consequences, both financially and medically.

Recommendation: The current reimbursement system for medical care should be restructured and strong incentives for the provision of preventive and primary care created.

This should be an early and critical milestone in any implementation plan for the Commission's recommendations.

Governor-elect Spitzer has indicated his support for a restructuring of reimbursement rates.⁶³ The Berger Commission has noted in its final Policy Recommendations report, a non-binding series of issues which the Commission believes need further study, that the current structure of reimbursement rates is creating a "medical arms race." High profits for medical services such as cardiac catheterization, cancer centers and cardiac and orthopedic surgery centers have led hospitals to expand capacity in these areas. While some of these profits are used to cross-subsidize unprofitable services such as primary care, the reimbursement rate structure, starting with Medicaid, will need a radical overhaul to shift incentives away from specialty care and towards preventive and primary care, including the management of chronic diseases

This realignment can be the basis for real and meaningful reductions in health care spending, while also improving outcomes. According to a state study cited by Elizabeth Swain and Ronda Kotelchuck in an opinion article in the *Albany Times Union*,⁶⁴ costs for Medicaid beneficiaries who used community-based health centers were 22 percent less than those who did not have a regular source of health care; health center patients had 41 percent lower costs overall.

Any significant lag in creating and implementing new reimbursement rates, will not allow sufficient time to incentivize hospitals and other medical providers to put needed primary and preventive care in place before the current hospital-based services are downsized or eliminated.

Hospitals save lives every day of the year. Once a hospital closure is even recommended, staff and patients leave, leading to the curtailment of service and a downward spiral. The Greater New York Hospital Association has reported that for New York City hospitals that have been closed, “their patient volume drops, their physicians leave and their workforce grows restless as word of their financial situation became public.”⁶⁵ With the release of the Commission’s recommendations, the clock has started ticking for the hospitals on its closure list. The findings of this report are an alarm alerting interested parties that any hospital closing has both foreseeable and unforeseeable consequences. While we must heed the warning to protect the most vulnerable among us at all costs, we can also use this wake-up call as a catalyst to reform New York’s health care system.

Acknowledgements

In preparing this report, we drew on data from multiple sources. We would like to thank everyone who assisted in this process, especially the New York State Department of Health, individual hospitals, United Hospital Fund, the Save our Safety Net Campaign, Judy Wessler, Nancy Lager, Linda Green and Sharon Salit.

Footnote data sources

In some cases, the data used in this report differs from what was published in the Commission’s final report. The discrepancies are partially attributable to when the data was collected, updated and provided to the Commission and to the Comptroller’s Office as well as whether the data came from Institutional Cost Reports or SPARCS, two sets of information maintained by the State Department of Health and submitted by all hospitals statewide.

The poverty rates used in this report are understated because they are based upon 2000 census data, and apply only to individuals with incomes below 100 percent of the Federal Poverty Level. They also represent averages over a neighborhood, which masks pockets of high poverty. The locations of the hospitals are based upon the geo-coded coordinates in the Department of City Planning’s facility database.

The uninsured rates for each neighborhood were taken from the New York City Department of Health and Mental Hygiene Community Health Profiles published in 2006. To insure the validity of this particular statistic, the DOH combined 2 or 3 years, depending on the neighborhood, of data from the Community Health Survey so the data reflects the average for the period 2002 to 2004 for adults 18 to 64. The last survey included was taken from March to November 2005 and reflected information for 2004.

Map sources

Licensed Beds: New York City Planning Facilities Database.

Total Discharges: Berger Commission/New York State Institutional Cost Report, 2004.

Total Outpatient Visits (O-P): (United Hospital Fund 2004 ICR database information provided to the New York City Office of the Comptroller). Total visits includes affiliated free-standing facilities.

Discharge and Outpatient Visit Data for: Montefiore campuses reported under Moses Division; New York Presbyterian Columbia Center, Allen Pavilion, and Weil Cornell reported under Columbia Center; St. Luke’s Roosevelt locations under St. Luke’s Division; Staten Island University Hospital divisions under Staten Island Hospital North; SVCMC Mary Immaculate, St. John’s and St. Joseph’s under Mary Immaculate; Our Lady of Mercy D’urso Pavilion under Our Lady of Mercy; St. Vincent’s Staten Island and Bayley Seton under St. Vincent’s Staten Island; and Bronx-Lebanon Concourse and Fulton Divisions reported under Concourse Division

Occupancy Rate: Licensed Beds - (Berger Commission, Maps, New York City Hospitals and Critical Access Hospitals, <http://www.nyhealthcarecommission.org/docs/hospmap.pdf>, SPARCS, January 15, 2006); Staffed Beds - (Berger Commission, Hospital Data, Institutional Cost Reports, http://www.nyhealthcarecommission.org/docs/2004_icr_commission_data.pdf, pps. 29-31, 2004) Staffed Beds for: Montefiore campuses reported under Weiler Division; Columbia Center, Allen Pavilion, and Weil Cornell under Columbia Center; SVCMC Mary Immaculate and St. John’s reported under Mary Immaculate

Busiest Inpatient Service (Berger Commission, "Region 2: Summary of Regional Utilization by Major Service Categories," SPARCS, 2004)

Uninsured Rates (NYCDOHMH, Community Health Profiles, 2nd. Ed., 2006-survey

In Table 5, The Commission's report included outpatient data for St. Vincent's Midtown, Cabrini and Victory that differed from the data used here. The Commission did not provide outpatient visit data for Parkway or for Westchester Square. The net difference for the three hospitals was 20,777 visits. The only substantial difference was at St. Vincent's Midtown where the Commission reported 41,438 fewer visits than this report. This report includes visits for methadone treatment, which fully accounts for the difference. The Comptroller's Office drew its figures from a database provided by United Hospital Fund that used NYS DOH 2004 Institutional Cost Reports.

Endnotes

¹ New York State Department of Health. <http://hospitals.nyhealth.gov/>. Includes HHC's Coler and Goldwater Hospitals and excludes hospitals listed on the NYSDOH website that are not operating as full hospitals or have closed: St. Vincent's Catholic Medical Center Bayley Seton Hospital, St. Mary's Hospital, Staten Island University Hospital Concord Division, and Bronx-Lebanon Hospital Fulton Division.

² <http://www.nyc.gov/html/dcp/html/census/popcur.shtml>.

³ NYC & Company, Telephone interview, December 4, 2006. Based on 2006 forecast for domestic and international visitors.

⁴ New York State Institutional Cost Report, 2004. Data includes hospitals that closed after 2004.

⁵ Total discharges, Berger Commission/New York State Institutional Cost Report, 2004.

⁶ Total outpatient visits: United Hospital Fund 2004 ICR database information provided to the New York City Office of the Comptroller. Total visits includes affiliated free-standing facilities.

⁷ These were: Beth Israel Singer Division, Brooklyn Hospital Caledonian Division, Interfaith Brooklyn Jewish and St. John's Division, Our Lady of Mercy D'urso Division, St. Vincent's Catholic Medical Center Bayley Seton, and St. Joseph's hospitals, St. Mary's Hospital, and Staten Island University's Concord Division. Source: United Hospital Fund, *Hospital Watch*, November 2004, Vol. 15, No. 3.

⁸ http://www.hanys.org/communications/pr/2006/upload/11_15_06_EightYearsFinancial.pdf

⁹ Richard Perez-Pena, "Hospital Business in New York, Once Prized, Braces for a Crisis," *New York Times*, April 11, 2005; UHF *Hospital Watch*, July 2005, Vol. 16, No. 2; http://www.hanys.org/communications/pr/11505_pr.cfm. Source: Hospital 2004 Financial Statements, Note: 213 Hospitals Reporting.

¹⁰ http://www.hanys.org/communications/pr/2006/upload/11_15_06_EightYearsFinancial.pdf

¹¹ Richard Perez-Pena, op. cit.

¹² A Plan to Stabilize and Strengthen New York's Health Care System: Final Report of the Commission on Health Care Facilities in the 21st Century, December 2006, p.5.

¹³ The City pays 25 percent of all non-long term care costs and 10 percent of long term care costs, bringing the overall share to approximately 18 to 19 percent.

¹⁴ Save Our Safety Net Campaign, *What is F-SHRP?* pps. 2-3.

¹⁵ Ibid.

¹⁶ Richard Perez-Pena, "Pataki and Spitzer Back Downsizing of Hospitals," *New York Times*, November 30, 2006.

¹⁷ Assemblyman Richard Gottfried, New York State Assembly Hearing, December 11, 2006.

¹⁸ "Hospitals Ready Court Push," *Crain's New York Business*, November 13, 2006.

¹⁹ United Hospital Fund, *Hospital Watch*, October 2000, Vol. 11, No 2.

²⁰ Peter Cunningham, "What Accounts for Differences in the Use of Hospital Emergency Departments Across U.S. Communities," *Health Affairs* 25(2006):w324-2336;10.1377/hlthaff.25.w324.

²¹ Meeting with New York City Emergency Medical Service, October 23, 2006.

²²United Hospital Fund, *Hospital Watch*, November 2004, Vol. 15, No.3.

²³ Samantha Marshall, "Revamped ERs Focus on Efficiency" *Crain's New York Business*, July 4, 2005.

²⁴ "Hospitals, Local Governments Have More Work To Do To Prepare for Disasters, Experts Say," *Medical News Today*, quoting *Wall Street Journal* article on the Institute of Medicine Report, *Hospital-Based Emergency Care: At the Breaking Point*, June 14, 2006.

²⁵ State of New York Department of Health, press release, "Health Commissioner Directs Hospitals to Take Immediate Steps to Avert Hospital Emergency Room Overcrowding," <http://www.health.state.ny.us/press/releases/2001/erover.htm>).

²⁶ Nancy Lager, et al., *Primary Care Capacity Shortage in New York City and The Potential Impact of Hospital Closures*, New York City HHC and PCDC, September 2006, p. 5.

²⁷ Sondra Wolfer, "Montefiore 7th in Nation in ER Visits" *New York Daily News*, June 27, 2005

²⁸ Source: Center for Health Workforce Studies, SUNY at Albany, NYS Physician Re-Registration Survey, 2004-2006.

²⁹ Source: Center for Health Workforce Studies, SUNY at Albany, NYS Physician Re-Registration Survey, 2004-2006.

³⁰ *A Plan to Strengthen and Stabilize New York's Health Care System*, p. 152.

³¹ According to New York City Department of Health and Mental Health *Community Health Profiles*, Bellevue's cachement area of Gramercy Park and Murray Hill has only an eight percent poverty rate. According to the New York City Department of City Planning, there were only 4,969 Medicaid recipients in this community in 2005. Yet 37 percent of Bellevue's emergency room visits in 2004 were self-pay and 30 percent were Medicaid enrollees. At Beth Israel, the next closest hospital to Bellevue, only 16 percent of emergency room visits were self-paid.

³² Source: Center for Health Workforce Studies, SUNY at Albany, NYS Physician Re-Registration Survey, 2004-2006.

³³ Adults in this community are nearly twice as likely as adults in New York City overall to binge drink, and hospitalizations due to alcohol and drug abuse are also higher in this community according to the New York City Department of Health and Mental Hygiene Community Profile.

³⁴ As discussed later in this report, HHC hospitals treat a disproportionately large share of self-pay patients and account for most of the highest self-pay rates in the City. In the case of Bellevue, although only eight percent of the households in the hospital's neighborhood (Gramercy Park and Murray Hill) are in poverty, 37 percent of Bellevue's emergency patients were self-payers in 2004, indicating that the hospital draws large numbers of emergency patients from beyond its affluent cachement area. Although Bellevue Hospital is located at 1st Avenue and 27th Street, across town from St. Vincent's-Midtown Hospital, its status as a municipal hospital means that it would likely treat some of the self-pay patients who would have gone to the St. Vincent's Midtown.

³⁶ *A Plan to Stabilize and Strengthen New York's Health Care System*, pps. 168-169.

³⁷ New York State Appropriateness Review Standards for Trauma Centers, Section 708.2(b)(9)(ii).

³⁸ *Evaluation of the New York City Trauma System: Final Report to the State Hospital Review and Planning Council*, August 2004. p.6.

³⁹ *Ibid.* p. 5.

⁴⁰ *Ibid.* p. 7.

⁴¹ *Ibid.* p.10.

⁴² Ibid. p. 13.

⁴³ <http://www.mapquest.com/directions/main.adp?bCTsettings=>

⁴⁴ Telephone conversation with Edward Wronski, Director, Bureau of Emergency Medical Services, New York State Department of Health, December 8, 2006.

⁴⁵ Op. cit., *Evaluation of the New York City Trauma System*, p. 16.

⁴⁶ Nancy Lager, et al. *Primary Care Capacity Shortage in New York City*, p. 2.

⁴⁷ Ibid., p. 5.

⁴⁸ Includes methadone treatment visits. For more details, see Map Sources.

⁴⁹ Nancy Lager, et al., *Primary Care Capacity Shortage in New York City*, p. 2.

⁵⁰ Since St. Vincent's Midtown is using 28 additional beds and Cabrini is using 24 psychiatric beds, it is essential that the Commission's recommendation to convert 80 beds at Beth Israel for psychiatric patients be implemented, although this represents the bare minimum needed given the high inpatient psychiatric unit occupancy rates in Manhattan. Busiest inpatient service data (SPARCS, 2004).

⁵¹ Nancy Lager, et al., *Primary Care Capacity Shortage*, pp.1-2.

⁵² Randall Bovbjerg, et. al., *Caring for the Uninsured in New York*, Urban Institute, October 2006, p. 7.

⁵⁴ Randall Bovbjerg, et al., *Caring for the Uninsured in New York*, pp. 1-3.

⁵⁵ Donald S. Sheperd, "Estimating the Effect of Hospital Closure on Areawide Inpatient Hospital Costs: A Preliminary Model and Application," *Health Services Research*, Vol. 18, No. 4 (Winter 1983), pp. 513-549. Sager, Alan "Testimony before the District of Columbia City Council, September 22, 2000, retrieved from <http://www.dcwatch.com/issues/pbc000918g.htm#23>

⁵⁶ Carl Campanile, "City Boosts Qns. Hosps," *New York Post*, October 5, 2006

⁵⁷ Telephone conversation with Edward Wronski, Director, Bureau of Emergency Medical Services, New York State Department of Health, December 8, 2006.

⁵⁸ "Hospitals Aim To Reduce Emergency Department Wait Times as Part of Effort To Address Medical Errors, Improve Patient Care", Daily Health Policy Report, [kaisernetwork.org](http://www.kaisernetwork.org), November 6, 2006. Retrieved from http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=5&DR_ID=40893

⁵⁹ Errol A. Cockfield, Jr., "Spitzer vows to cut" *Newsday*, September 8, 2006.

⁶⁰ Nancy Lager, et. al. *Primary Care Capacity Shortage*, p. 7.

⁶¹ Ibid., p. 2.

⁶² Ibid., p. 2.

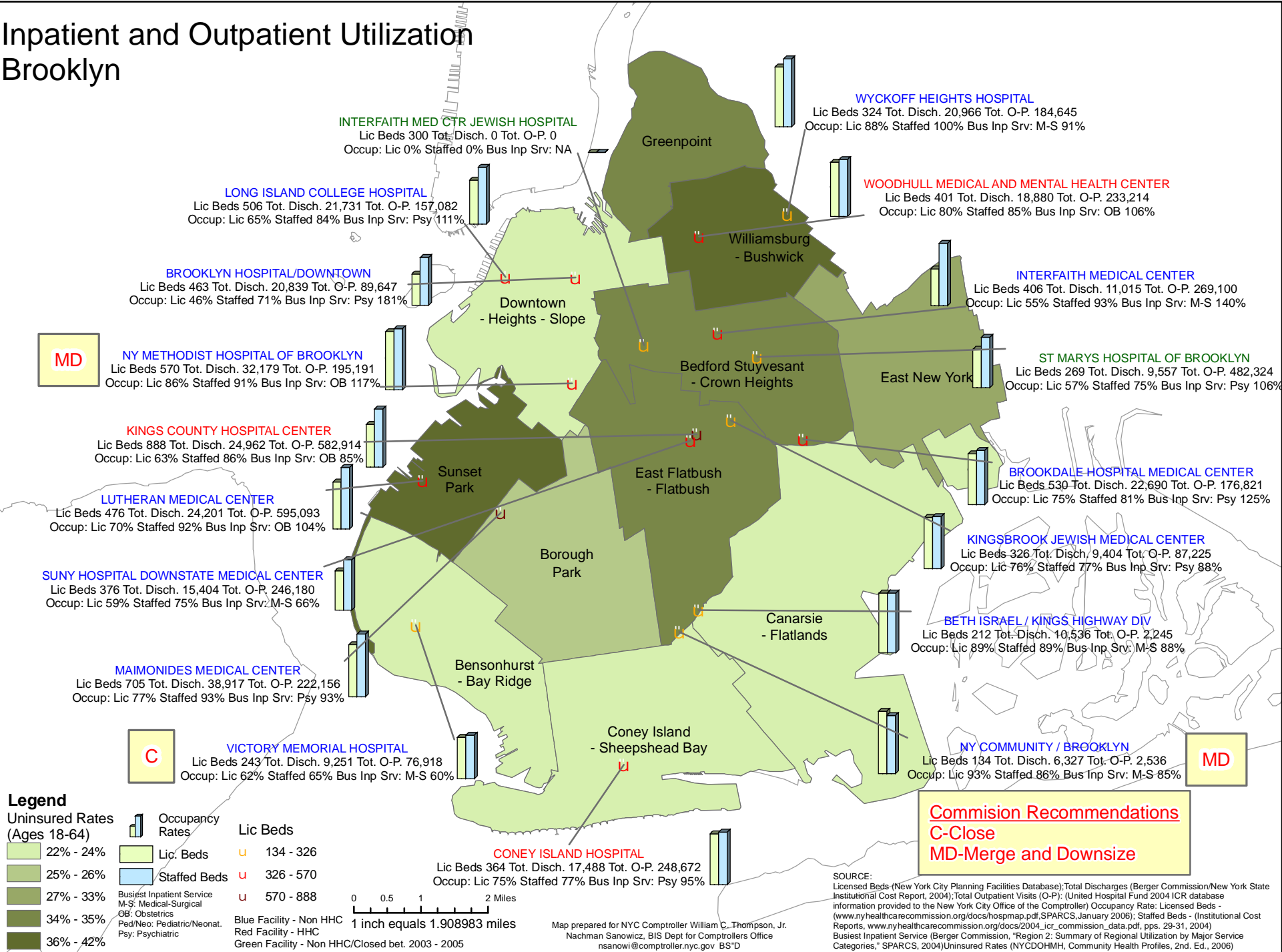
⁶³ Danny Hakim "Spitzer Says He's Willing to Close Hospitals to Trim Medical Costs," *New York Times*, September 8, 2006.

⁶⁴ Elizabeth Swain and Ronda Kotelchuck, "Make primary, preventive care a priority," *Albany Times Union*, July 25, 2006.

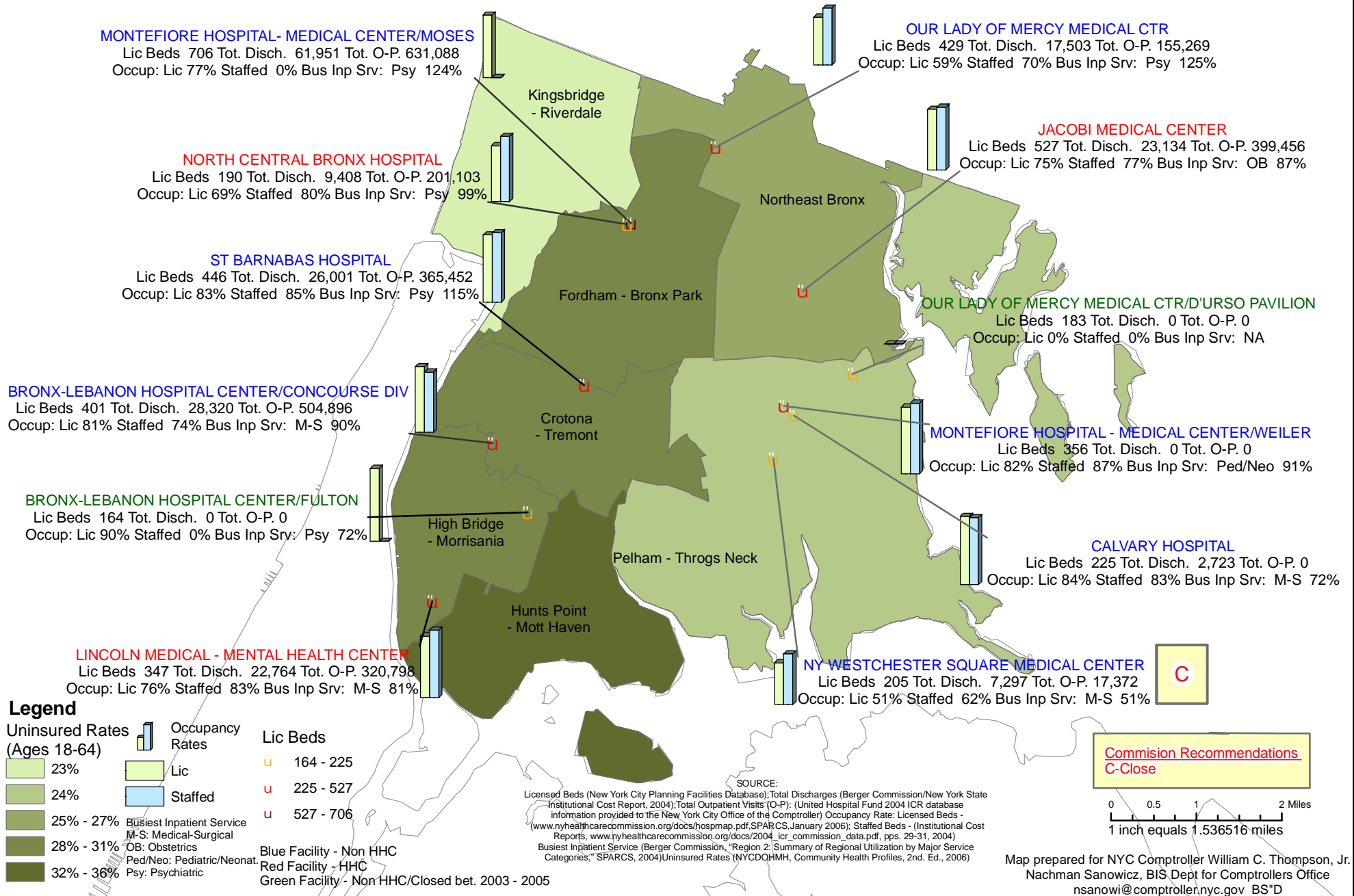
⁶⁵ Testimony of Greater New York Hospital Association before the New York City Council Committee on Health, June 15, 2005.

APPENDIX A

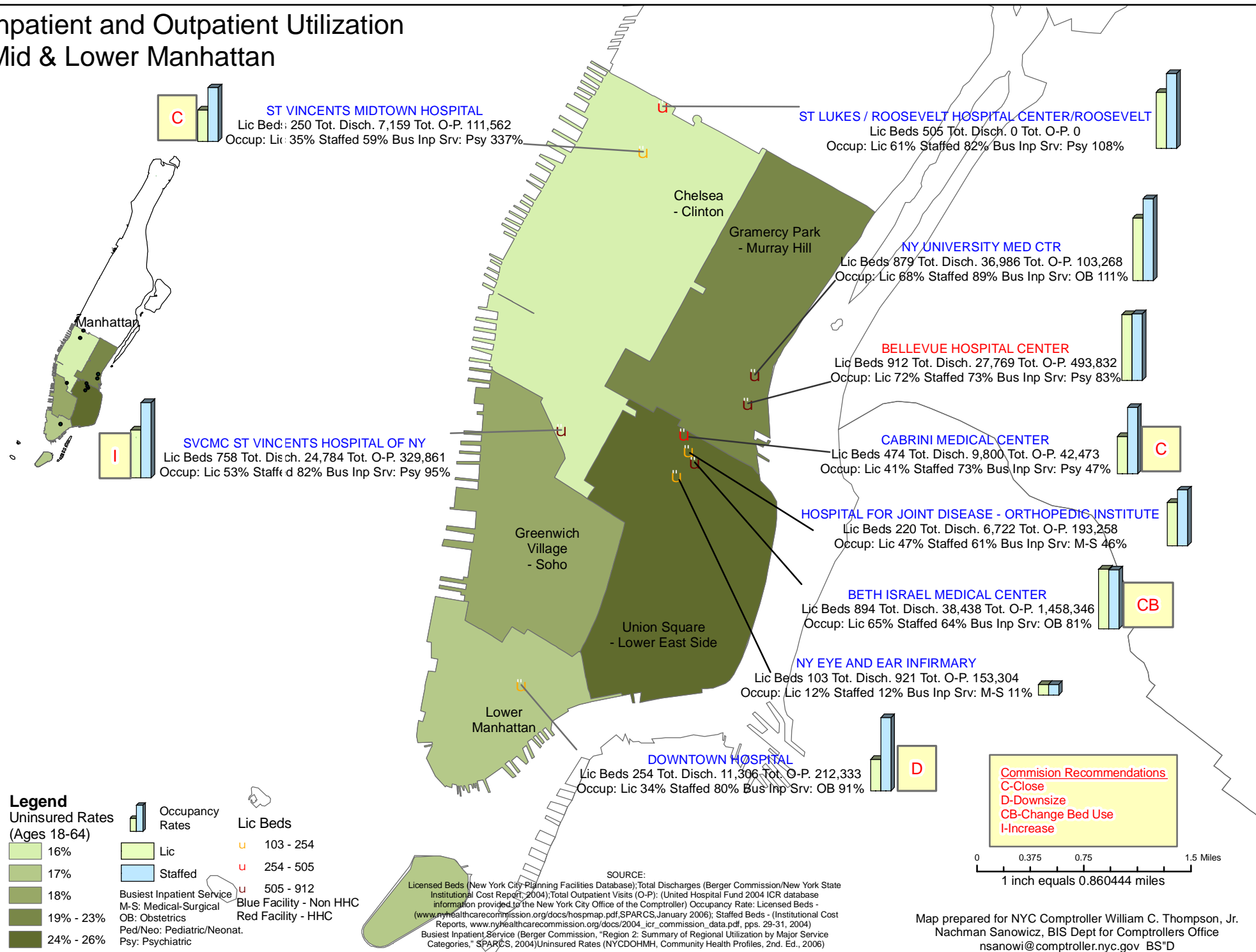
Inpatient and Outpatient Utilization Brooklyn



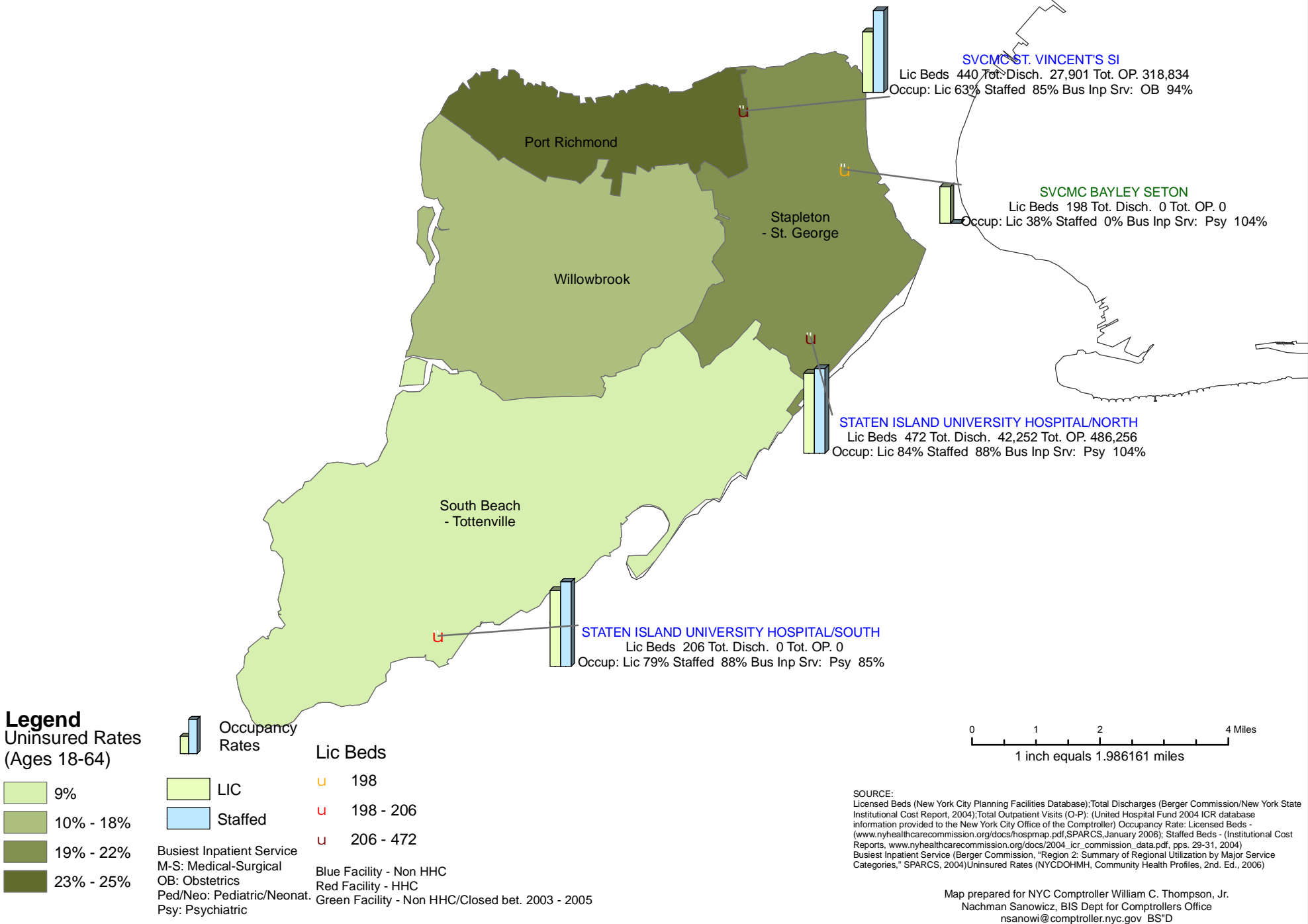
Inpatient and Outpatient Utilization Bronx



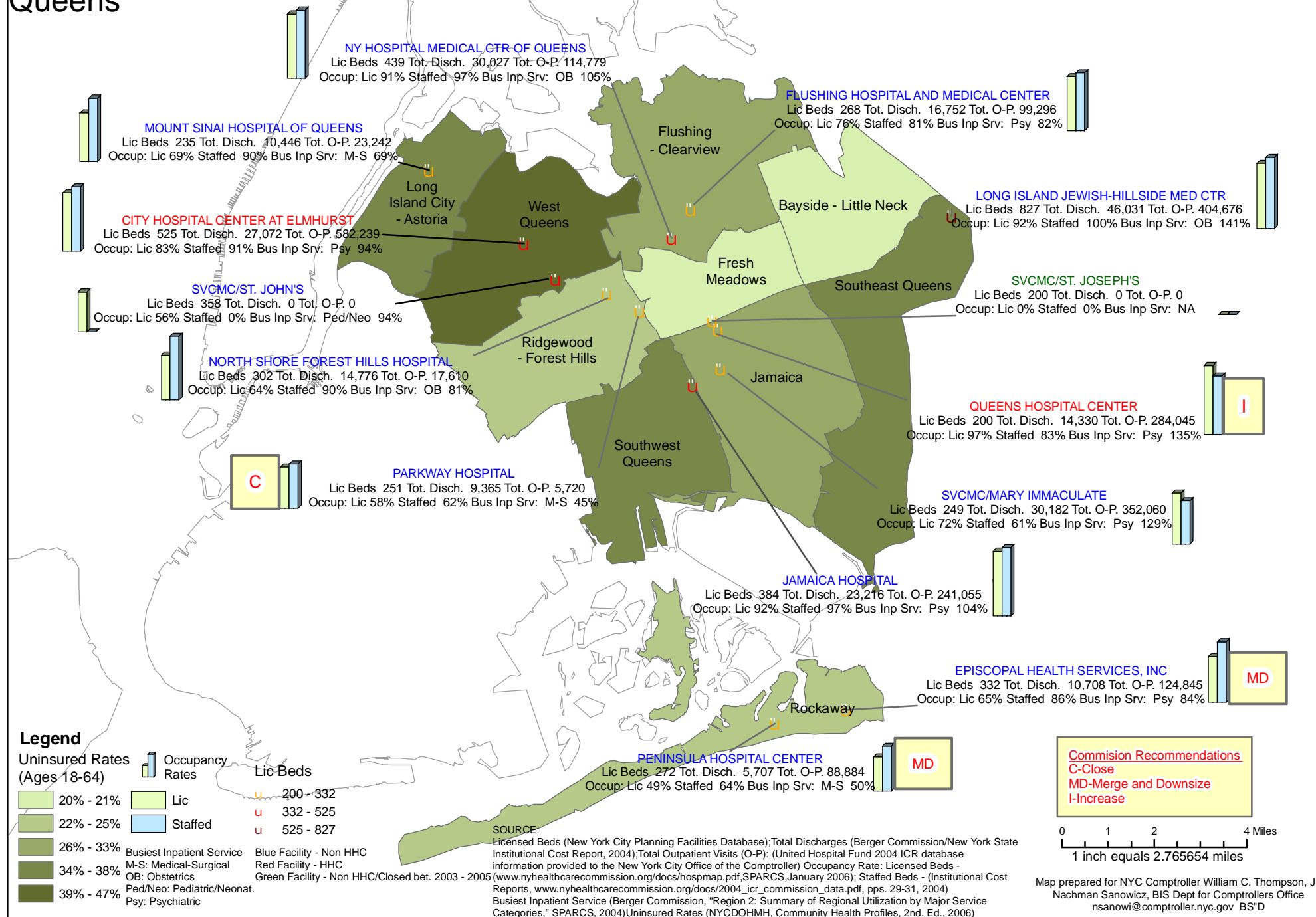
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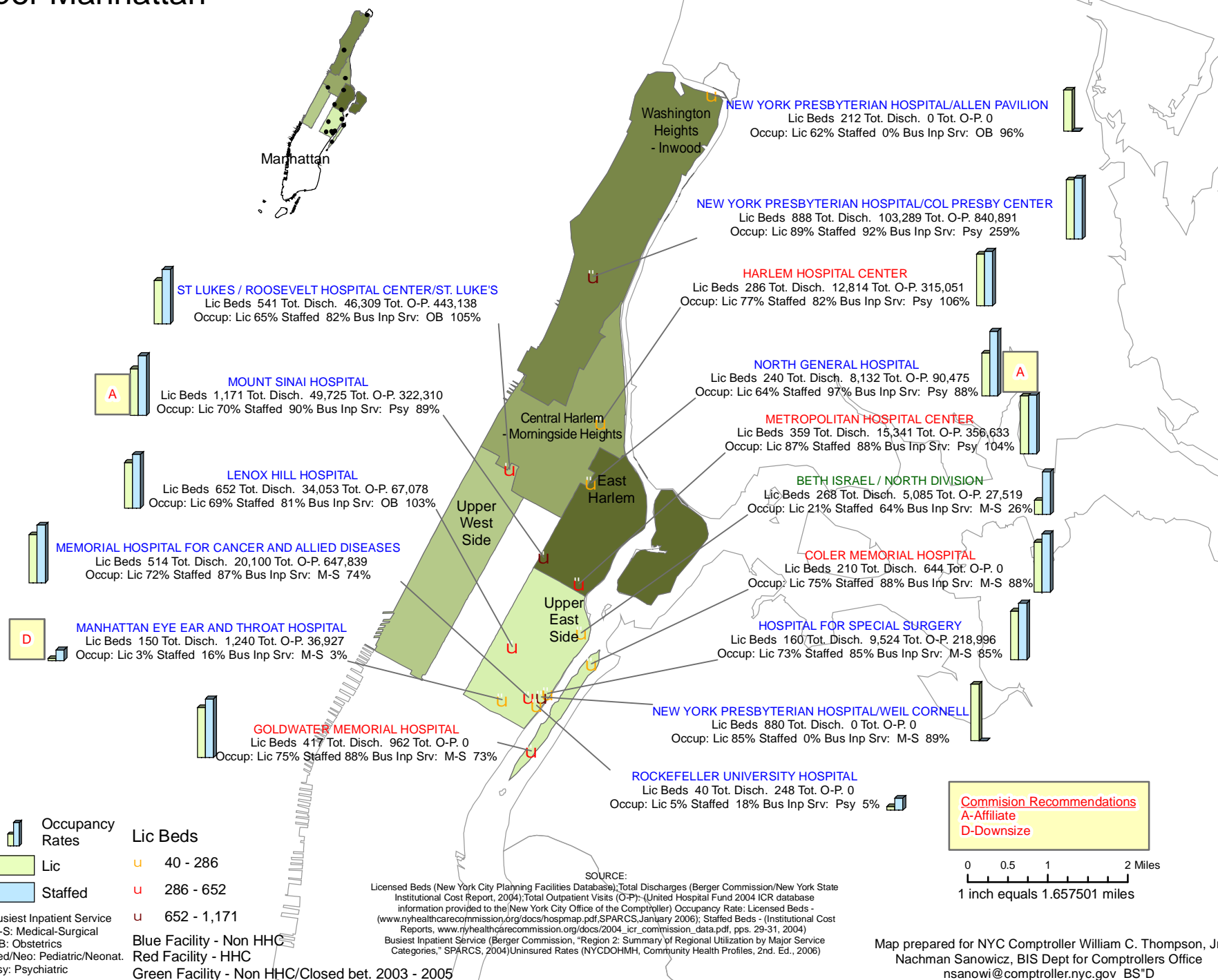
Inpatient and Outpatient Utilization Staten Island



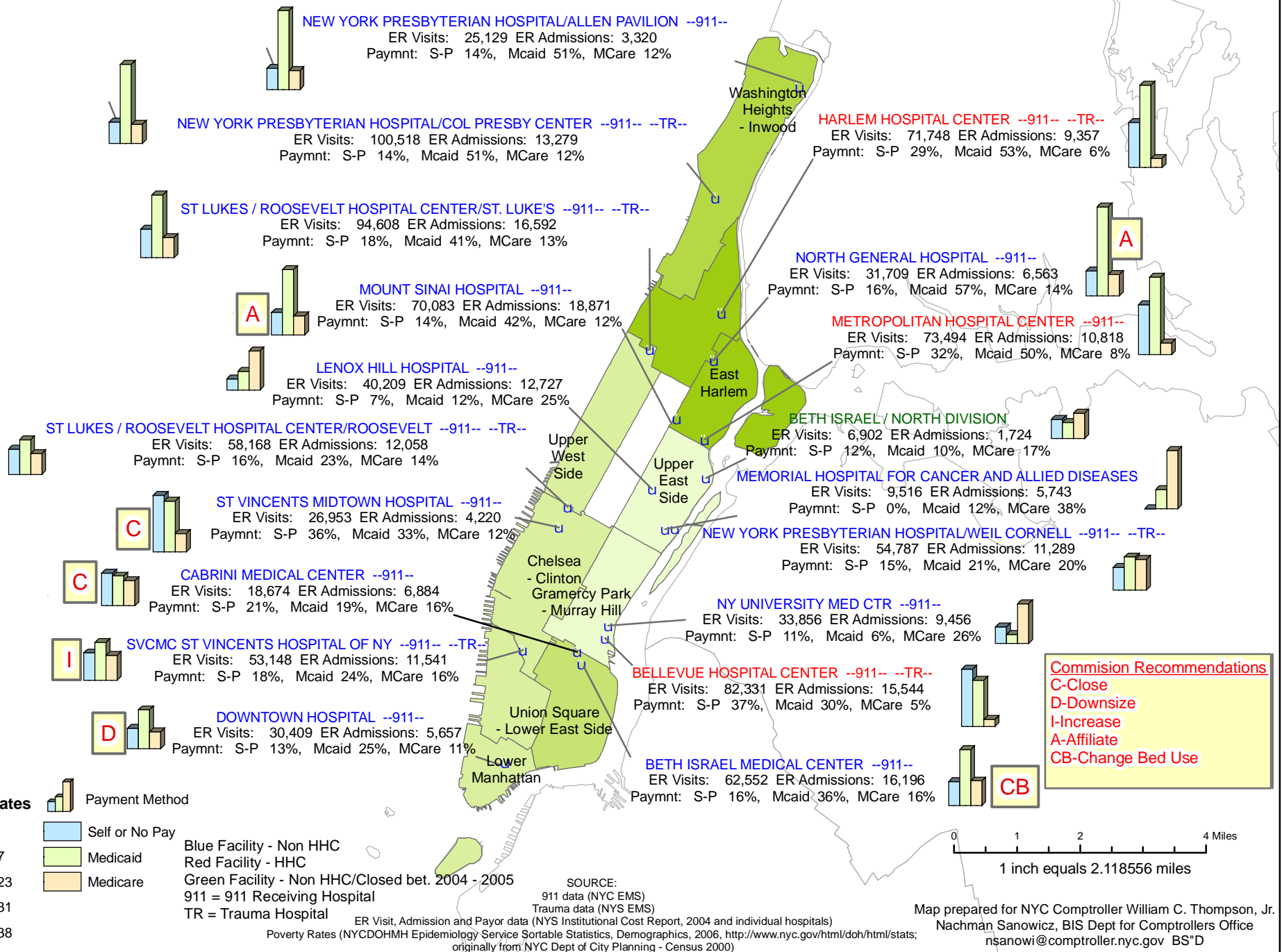
Inpatient and Outpatient Utilization Queens



Inpatient and Outpatient Utilization Mid & Upper Manhattan



Emergency Room Utilization and Selected Payors Manhattan



Emergency Room Utilization and Selected Payors

Brooklyn

WOODHULL MEDICAL AND MENTAL HEALTH CENTER --911--
 ER Visits: 94,031 ER Admissions: 14,489
 Paymnt: S-P 34%, Mcaid 51%, MCare 6%

WYCKOFF HEIGHTS HOSPITAL --911--
 ER Visits: 70,887 ER Admissions: 17,692
 Paymnt: S-P 12%, Mcaid 56%, MCare 11%

BROOKLYN HOSPITAL/DOWNTOWN --911--
 ER Visits: 65,975 ER Admissions: 14,095
 Paymnt: S-P 18%, Mcaid 45%, MCare 9%

INTERFAITH MEDICAL CENTER --911--
 ER Visits: 34,425 ER Admissions: 5,420
 Paymnt: S-P 21%, Mcaid 24%, MCare 8%

LONG ISLAND COLLEGE HOSPITAL --911--
 ER Visits: 63,318 ER Admissions: 12,873
 Paymnt: S-P 10%, Mcaid 32%, MCare 14%

ST MARYS HOSPITAL OF BROOKLYN
 ER Visits: 35,174 ER Admissions: 7,580
 Paymnt: S-P 18%, Mcaid 56%, MCare 12%

MD NY METHODIST HOSPITAL OF BROOKLYN --911--
 ER Visits: 66,216 ER Admissions: 18,657
 Paymnt: S-P 9%, Mcaid 31%, MCare 21%

KINGSBROOK JEWISH MEDICAL CENTER --911--
 ER Visits: 19,719 ER Admissions: 6,051
 Paymnt: S-P 19%, Mcaid 22%, MCare 26%

BROOKDALE HOSPITAL MEDICAL CENTER --911-- --TR--
 ER Visits: 97,441 ER Admissions: 16,648
 Paymnt: S-P 21%, Mcaid 42%, MCare 10%

LUTHERAN MEDICAL CENTER --911-- --TR--
 ER Visits: 49,608 ER Admissions: 11,706
 Paymnt: S-P 18%, Mcaid 43%, MCare 16%

KINGS COUNTY HOSPITAL CENTER --911-- --TR--
 ER Visits: 126,850 ER Admissions: 19,907
 Paymnt: S-P 53%, Mcaid 18%, MCare 3%

MAIMONIDES MEDICAL CENTER --911--
 ER Visits: 91,195 ER Admissions: 25,289
 Paymnt: S-P 11%, Mcaid 43%, MCare 20%

STATE UNIVERSITY HOSPITAL DOWNSTATE MEDICAL CENTER --911--
 ER Visits: 54,190 ER Admissions: 10,431
 Paymnt: S-P 13%, Mcaid 37%, MCare 13%

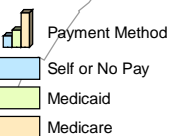
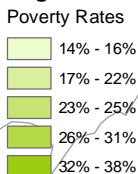
C VICTORY MEMORIAL HOSPITAL --911--
 ER Visits: 23,808 ER Admissions: 5,977
 Paymnt: S-P 9%, Mcaid 24%, MCare 22%

BETH ISRAEL / KINGS HIGHWAY DIV --911--
 ER Visits: 31,626 ER Admissions: 10,044
 Paymnt: S-P 11%, Mcaid 19%, MCare 21%

NY COMMUNITY / BROOKLYN --911--
 ER Visits: 15,783 ER Admissions: 5,478
 Paymnt: S-P 9%, Mcaid 25%, MCare 36%

CONEY ISLAND HOSPITAL --911--
 ER Visits: 67,824 ER Admissions: 13,848
 Paymnt: S-P 28%, Mcaid 41%, MCare 11%

Legend

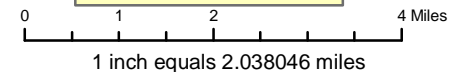


Blue Facility - Non HHC
 Red Facility - HHC
 Green Facility - Non HHC/Closed bet. 2004- 2005
 911 = 911 Receiving Hospital
 TR = Trauma Hospital

SOURCE:
 911 data (NYC EMS)
 Trauma data (NYS EMS)

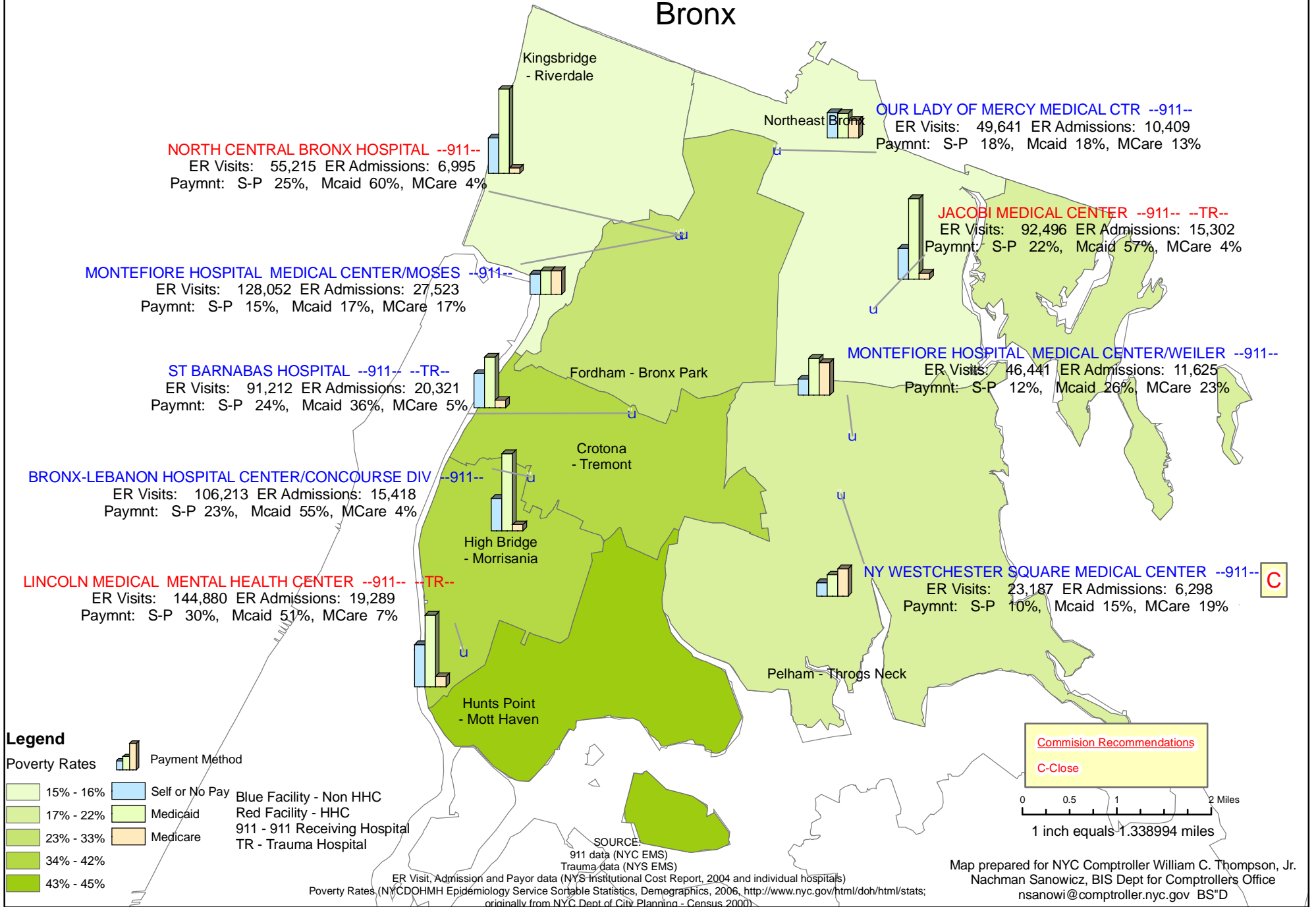
ER Visit, Admission and Payor data (NYS Institutional Cost Report, 2004 and individual hospitals)
 Poverty Rates (NYCDOHMH Epidemiology Service Sortable Statistics, Demographics, 2006, <http://www.nyc.gov/html/doh/html/stats/>;
 originally from NYC Dept of City Planning - Census 2000)

Commission Recommendations
 C-Close
 MD-Merge and Downsize



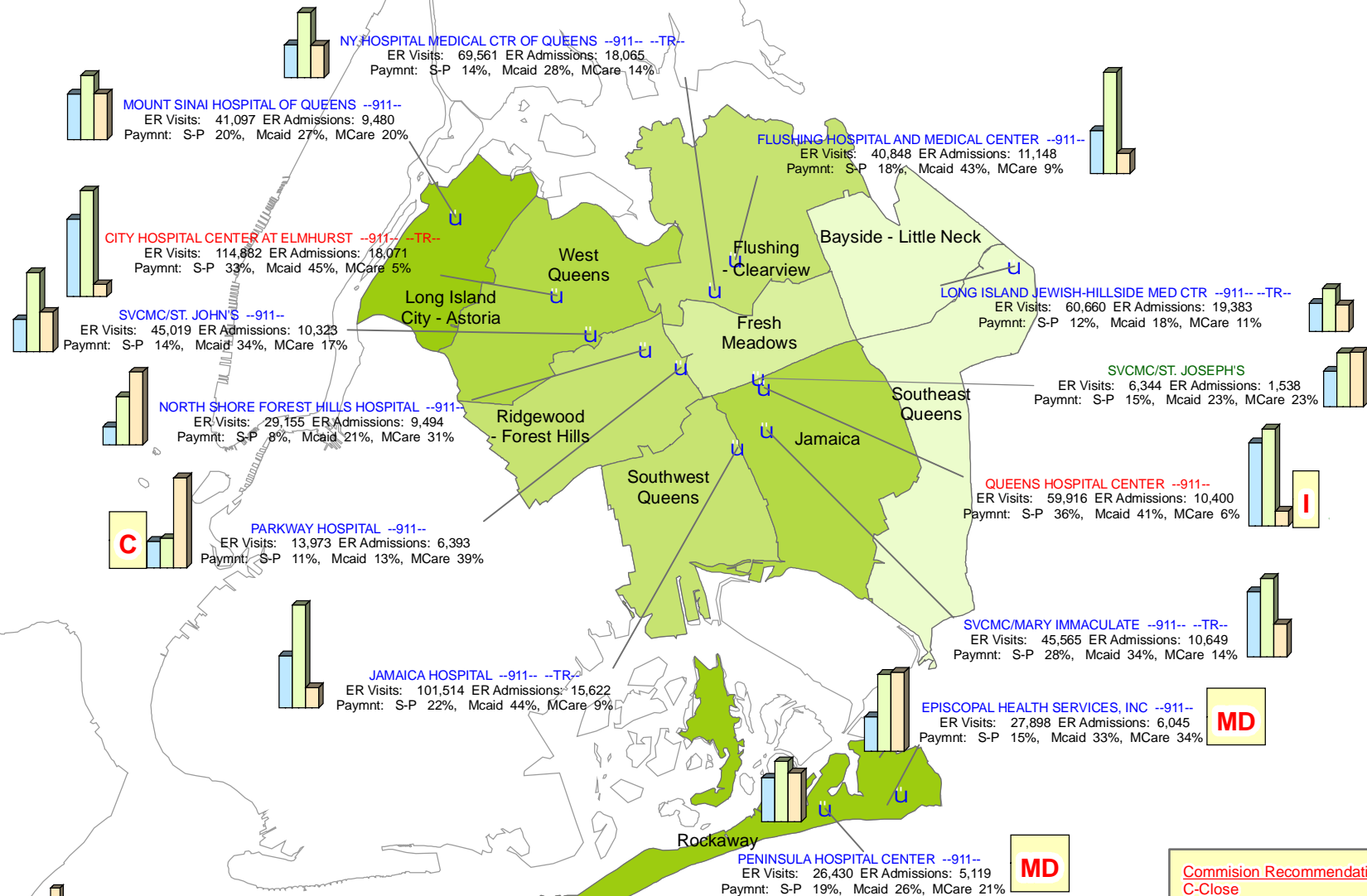
Map prepared for NYC Comptroller William C. Thompson, Jr.
 Nachman Sanowicz, BIS Dept for Comptrollers Office
 nsanowi@comptroller.nyc.gov BS"D

Emergency Room Utilization and Selected Payors Bronx



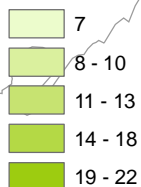
Map prepared for NYC Comptroller William C. Thompson, Jr.
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nsanowi@comptroller.nyc.gov BS"D

Emergency Room Utilization and Selected Payors Queens

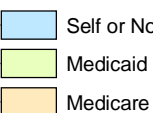


Legend

Poverty Rates



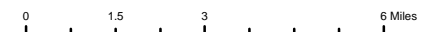
Payment Method



Blue Facility - Non HHC
Red Facility - HHC
Green Facility - Non HHC/Closed bet. 2004 - 2005
911 = 911 Receiving Hospital
TR = Trauma Hospital

SOURCE:

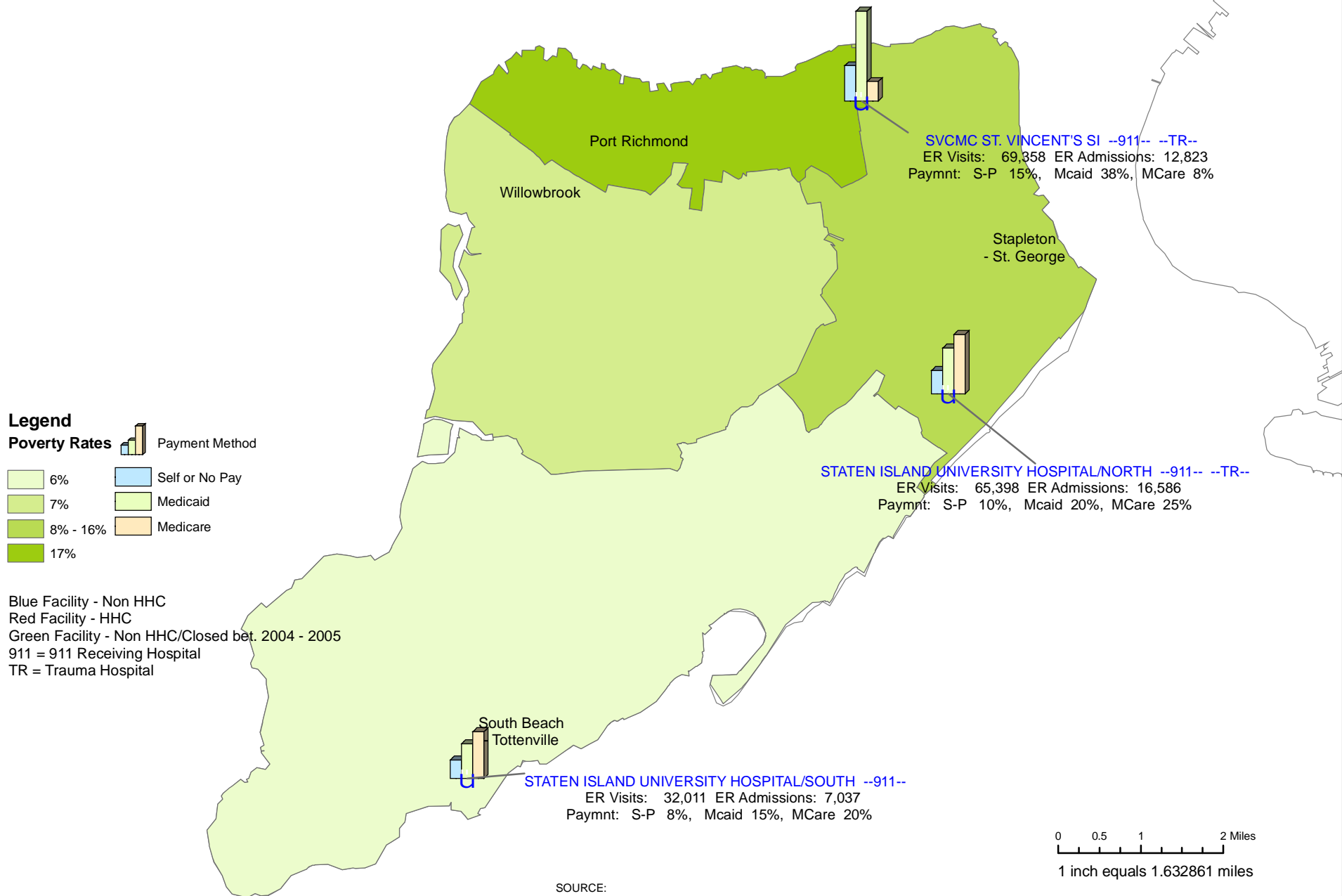
911 data (NYC EMS)
Trauma data (NYS EMS)
ER Visit, Admission and Payor data (NYS Institutional Cost Report, 2004 and individual hospitals)
Poverty Rates (NYCDOHMH Epidemiology Service Sortable Statistics, Demographics, 2006, <http://www.nyc.gov/html/doh/html/stats/>;
originally from NYC Dept of City Planning - Census 2000)



1 inch equals 3.223454 miles

Map prepared for NYC Comptroller William C. Thompson, Jr.
Nachman Sanowicz, BIS Dept for Comptrollers Office
nsanowi@comptroller.nyc.gov BS"D

Emergency Room Utilization and Selected Payors Staten Island



SOURCE:
 911 data (NYC EMS)
 Trauma data (NYS EMS)
 ER Visit, Admission and Payor data (NYS Institutional Cost Report, 2004 and individual hospitals)
 Poverty Rates (NYCDOHMH Epidemiology Service Sortable Statistics, Demographics, 2006, <http://www.nyc.gov/html/doh/html/stats>;
 originally from NYC Dept of City Planning - Census 2000)

Map prepared for NYC Comptroller William C. Thompson, Jr.
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APPENDIX B

Hospital	Commission recommendation	Number of beds ^[1]	ER visits/year ^[2]	Areas of specialty -NYS designated	Selected extension clinics	% uninsured in community, recommended closures ^[3]	Nearest hospital	Other issues
Bronx								
NY Westchester Square Medical Center 2475 St Raymond Avenue Bronx, NY 10461 Tel: 718-430-7300 Web: www.nywsmc.org PFI: 1185 Operating certificate #7000025H New York Presbyterian Healthcare Network	Close	205 (185 medical/surgical)	16,076	Stroke Center	N/A	24%	Calvary Hospital/ (no ER), Montefiore Medical Center-Weiler Division	
Brooklyn								
New York Methodist Hospital 506 Sixth Street Brooklyn, NY 11215 Tel: 718-780-3000 Web: www.nym.org PFI: 1306 Operating certificate #7001021H This hospital is a teaching hospital affiliated with Weill Medical College of Cornell University. New York Presbyterian Healthcare System.	Merge with New York Community Hospital of Brooklyn; maintain two separate campuses Downsize by 60 beds to 510	570 (35 Maternity, 50 Psych)	66,216	Level 3 Perinatal, Stroke	Family Health Centers (4); mental health clinic; sports medicine		Brooklyn Hospital Center - Downtown Campus; Long Island College Hospital	
New York Community Hospital of Brooklyn, Inc 2525 Kings Highway	Merge with New York Methodist	134	15,783	Stroke Center			Beth Israel-Kings	

^[1] All data from NYS DOH website unless otherwise indicated.

^[2] New York Institutional Cost Reports, 2004.

^[3] NYC DOH Community Health Profiles, 2006.

Brooklyn, NY 11229 Tel: 718-692-5300 Web: www.nych.com PFI: 1293 Operating certificate #7001008H New York Presbyterian Healthcare System.	Hospital; maintain two separate campuses Downsize by 40 beds to 90 Add ambulatory services						Highway Division	
Victory Memorial Hospital 9036 7th Avenue Brooklyn, NY 11228 Tel: 718-567-1234 Web: www.vmhny.org/ PFI: 1314 Operating certificate #7001032H	Close Explore options for conversion to a diagnostic and treatment center and/or a long term care services facility	243 (24 Maternity)	23,808	Level 1 Perinatal; Stroke Center	Brighton Beach Family Health Center; Victory Memorial 8 th Avenue Site	22%	Maimonides Medical Center	Filed for bankruptcy in November 2006
Manhattan								
Cabrini Medical Center 227 East 19th Street New York, NY 10003 Tel: 212-995-6156 Web: www.cabrininy.org PFI: 1440 Operating certificate #7002003H This hospital is a teaching hospital affiliated with Mount Sinai School of Medicine Mount Sinai Medical Center Health System.	Close	474 (52 AIDS, 20 Alcohol Detox, 30 Psychiatric-Mental Health)	18,674	AIDS Center	Cabrini East Village Family Medicine Practice; Cabrini Eye Care Center; Haven Family Practice; Wound Center	21%	Beth Israel Hospital-Petrie Division	
North General Hospital 1879 Madison Avenue New York, NY 10035	Enter into a passive parent corporate	200 (24 AIDS,	12,432	AIDS Center	PS 57		Metropolitan Hospital	

<p>Tel: 212-423-4000</p> <p>Web: www.northgeneral.org/</p> <p>PFI: 2968</p> <p>Operating certificate #7002052H</p>	relationship with Mt. Sinai Medical Center	24 Alcohol Detox, 42 psychiatric)					Center	
<p>Mount Sinai Hospital One Gustave L Levy Place New York, NY 10029</p> <p>Tel: 212-241-7005</p> <p>PFI: 1456</p> <p>Operating certificate #7002024H</p> <p>This hospital is a member of the Mount Sinai Medical Center Health System.</p>	Enter into a passive parent corporate relationship with North General Hospital	1,171 (25 Neonatal; 80 pediatric, 103 psychiatric, 12 traumatic brain injury)	70,083	AIDS Center ; Regional Perinatal Center ; Stroke Center	Ambulatory Care Center; JHS 117; Joseph Hazan Ambulatory Cardiac Care Center; Julia Richman HS; Manhattan Center for Math and Science; Mt. Sinai Adolescent Health Center; Dialysis Center; Primary Care Center and Building; PS 108; PS 83; Psychiatric Outpatient; Physical Therapy at Asphalt Green; Senior Health Care Center		North General Hospital	
Manhattan Eye Ear and Throat Hospital 210 East 64th Street	Downsize all 150 inpatient beds	150 (all medical/	4,026	No Designation			New York Presbyt	Current average

<p>New York, NY 10021</p> <p>Tel: 2126053770 PFI: 1452 Operating certificate #7002019H</p> <p>Lenox Hill Hospital</p>	and maintain ambulatory surgery and outpatient clinics	surgical, only 30 are in service)					erian/ Weill Cornell	ge daily inpatient census is 3. Primarily provides outpatient surgery
<p>St. Vincent's Midtown Hospital 415 West 51st Street New York, NY 10019</p> <p>Tel: 2124598400 PFI: 1467 Operating certificate #7002033H</p> <p>St. Vincent's Catholic Medical Centers of New York.</p>	Close Move 12 psychiatric beds to St. Vincent's Manhattan or another Manhattan-based hospital Maintain current ambulatory care services through SVCMC or another sponsor	250 (79 AIDS, 12 Psychiatric) St. Vincent's Manhattan: 727 beds (79 Psychiatric)	20,362	AIDS Center, Stroke Center	St. Vincent's Midtown Hospital Family Care Center	16%	St. Luke's-Roosevelt Hospital-Roosevelt Division	
<p>Beth Israel Medical Center/Petrie Campus First Ave at 16th Street New York, NY 10003</p> <p>Tel: 212-420-2000 Web: www.wehealnewyork.org PFI: 1439 Operating certificate #7002002H</p> <p>This hospital is a teaching hospital affiliated with Albert Einstein College of Medicine</p> <p>Member of Continuum Health Partners, Inc. hospital system</p>	<p>Convert 80 detoxification beds to</p> <p>approximately 80 psychiatric beds</p>	899 (30 Alcohol Detox, 205 Drug Detox, 92 Psychiatric)	62,552	AIDS Center; Level 3 Perinatal; SAFE Center; Stroke Center			Cabrini Hospital (closing); next closest Bellevue Hospital	
<p>New York Downtown Hospital 170 William Street New York, NY 10038</p>	Downsize by 70 medical/surgical beds and 4	254	30,409	Level 2 Perinatal Center	Downtown Family Care		Beth Israel-Petrie Division; St.	Opened a \$25 million ER

<p>Tel: 2123125175 PFI: 1437 Operating certificate #7002000H</p> <p>New York Presbyterian Healthcare Network</p>	<p>pediatrics beds to 180 beds Discontinue inpatient pediatric services and transfer to another facility Reorganize outpatient clinics under new sponsorship</p>				Center		Vincent's Hospital	<p>renovation in 9/2006.</p> <p>Only hospital serving lower Manhattan</p>
Queens								
<p>Parkway Hospital 70-35 113th Street Forest Hills, NY 11375</p> <p>Tel: 7189904131 PFI: 1644 Operating certificate #7003020H</p>	Close	251	4,884	Stroke Center		25%	North Shore Forest Hills	Filed for bankruptcy in June 2005
<p>Peninsula Hospital Center 51-15 Beach Channel Drive Far Rockaway, NY 11691</p> <p>Tel: 718-734-2000 PFI: 1632 Operating certificate #7003006H</p> <p>Clinical affiliation with North Shore LIJ Health System.</p>	<p>Downsize by 99 beds to 173 Merge with St. John's Episcopal Hospital South Shore and rebuild a single facility with 400 beds and comprehensive emergency, inpatient, ambulatory, and psychiatric services</p>	272	18,324	Stroke Center	No Data Available		Episcopal Health Services-St. John's	
<p>St Johns Episcopal Hospital So Shore 327 Beach 19th Street Far Rockaway, NY 11691</p> <p>Tel: 718-869-7000 Web: www.ehs.org PFI: 1635 Operating certificate #7001024H</p> <p>This hospital is a teaching hospital affiliated with: SUNY</p>	<p>Downsize 81 beds to approximately 251 Merge with Peninsula Hospital Center and rebuild a single facility with 400 beds and comprehensive emergency,</p>	332 (20 Alcohol Detox, 14 Drug Detox, 43 Psychiatric; 10 Pediatric, 25 Maternity)	27,898	Level 2 Perinatal	Alcoholism Outpatient Clinic; Brookdale Village Care Facility; Community Mental		Peninsula Hospital Center	

Downstate Medical Center; Touro University Medical Education Consortium (Osteopathic); PCOM (Philadelphia College of Osteopathic Medicine) MEDNET; Ross University. Member of Episcopal Health Services, Inc. hospital system.	inpatient, ambulatory, and psychiatric services				I Health Center; Psychiatric Day Treatment Clinic			
Queens Hospital Center 82-68 164th Street Jamaica, NY 11432 Tel: 718-883-3000 Web: www.ci.nyc.ny.us/html/hhc/html/queens.html PFI: 1633 Operating certificate #7003007H This hospital is a teaching hospital affiliated with: Mount Sinai School of Medicine This hospital is a member of the following hospital system(s): New York City Health and Hospitals Corporation	Add 40 Medical/Surgical Beds	243 (115 Medical Surgical, 12 Alcohol Detox, 20 Maternity, 18 Neonatal/Pediatric, 53 Psychiatric)	59,916	AIDS Center; Level 3 Perinatal; SAFE			Mary Immaculate Hospital	

^[1] All data from NYS DOH website unless otherwise indicated.

^[2] New York Institutional Cost Reports, 2004.

^[3] NYC DOH Community Health Profiles, 2006.

APPENDIX C

**Emergency services statistics for hospitals
recommended for closure and next closest
hospitals, 2004.**

Hospital recommended for closure	No. of ER visits	<i>Closest</i> and next closest hospitals	Increase in ER visits, nearest hospital *	Ambulance turnaround time, nearest hospital**
St. Vincent's Midtown	26,953	<i>Roosevelt</i> St. Vincent's NY	46%	29:54
Victory Memorial Hospital	23,808	<i>Maimonides</i> Coney Island	25%	29:06
New York Westchester Square Hospital	23,187	<i>Montefiore/Weiler</i> Jacobi	50%	31:55
Cabrini Medical Center	18,674	<i>Beth Israel</i> St. Vincent's NY	30%	30:35
Parkway Hospital	13,973	<i>North Shore</i> <i>Forest Hills</i> Queens Hosp Ctr.	48%	25:59

*Assuming that all patients who would have gone to the closing hospital go instead to the next nearest hospital.

**Minutes and seconds, November 2006.