Assembly Committee on Health
Informational Hearing

HOSPITAL SERVICES AND EMERGENCY CARE: AN EMERGING CRISIS

Friday, May 18, 2007
10:00 am
Inglewood City Hall
1 W. Manchester Blvd., Community Room
Inglewood, California

A significant number of hospitals have closed in California in the last decade. According to the California Hospital Association (CHA) from 1996 to 2006 almost 80 hospitals closed in California, including 39 emergency departments. Almost 70% of the closures were located in Southern California. Not quite 20% were located in Central and Northern California and the remaining hospital closures were located in the San Francisco Bay Area. Of the Southern California closures, 32% (25 hospitals) were closed in Los Angeles County alone. These hospitals were in the cities of Artesia, Bellflower, Burbank, Canoga Park, Culver City, Duarte, Granada Hills, Harbor Bay, Hawthorne, Lancaster, Long Beach (2), Los Angeles (4), Monrovia, Newhall, North Hollywood, Palmdale, Pasadena, Redondo Beach, Van Nuys (2), and Westlake Village.

More closures or relocations of hospitals are expected within the next five years as compliance deadlines associated with California seismic safety requirements near. A January 2007 RAND study indicates that total hospital construction could cost $45 billion to $110 billion, in part, because modern hospital design calls for larger facilities.[1] In addition, the report points out that most hospital owners are choosing to rebuild rather than retrofit, and for the highest risk buildings this effectively makes the actual deadline 2008, if extensions are approved, 2013 and 2015, rather than 2030.

WHY ARE HOSPITALS CLOSING?

Studies of the issue reveal a complex mix of potential reasons for the growing number of closures. According to CHA, in a September 2004 letter to Governor Schwarzenegger it has to do with a "convergence of adverse forces, including an unrelenting uninsured population, the lowest in the nation Medicaid payments, unfunded mandates and state regulations that are creating unintended consequences…"

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[1] Meade, Charles and Kulick, Jonathan, SB 1953 and the Challenge of Hospital Seismic Safety in California, prepared for the California HealthCare Foundation, January 2007.

A study of hospital closures between 1995 and 2000 conducted for then-Attorney General Bill Lockyer identified financial hardship present at each hospital's closure.[2] As a group the closed hospitals reported some of the worst financial indicators, such as very low operating margins and high accumulation of debt. There were three main claims associated with closures, the hospital: 1) was losing money, 2) had declining reimbursements, and/or 3) low utilization. A 2001 report prepared for the California HealthCare Foundation (CHCF)[3] confirmed the financial deterioration of California hospitals for the period of 1995 through 1999 citing California's highly competitive market, patients with higher severity of illness, higher wages for full-time hospital employees, the nursing shortage, and a large uninsured population.

The Petris Center report also highlighted the potential impact of rumors on a hospital that is experiencing financial difficulties and may be near closure. Imminent closure prompts health plans and doctors to seek contractual relationships elsewhere and hospital nursing staff and patients to go to other facilities. At the same time, management of larger health care systems may also deprive a hospital facing financial problems of support or capital, drop, downsize, or relocate services to other hospitals in the system. The CHCF 2006 Market Report suggests that in some cases financial losses are not cash or operating losses but could be due to "writing down" the value of assets by the parent company.[4] The report also found that when hospitals are experiencing large financial losses, it can create concern for doctors that practice in the facilities and prompt concerned doctors to increase their admissions to other hospitals.

A study of hospital closures in minority communities attributes such closures to an underfunding of health services for the poor and an inadequate supply of physicians in those communities.[5] The study suggests that closures further exacerbate health care access because physicians relocate when hospitals close. The author states that some hospitals attempt to maximize profits by relocating to more affluent markets, or renovate facilities and expand technological capabilities to attract physicians and a wealthier patient base.

The Petris Center report concludes that private entities closed more hospitals than the government, that more for-profit hospitals closed than non-profit, that hospital chains were the most active closers during the mid to late 1990s, and nearly half of the closed hospitals had changed owners recently prior to closure.

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[2] Scheffler, Richard, California's Closed Hospitals, 1995-2000, Nicholas C. Petris Center on Health Care Markets and Consumer Welfare (Petris Center), University of California, Berkley, School of Public Health, January 2001, Revised April 2001.
[3] Issue Brief: Financial Challenges for California Hospitals, prepared for the California HealthCare Foundation, September 2001.
[4] Baumgarten, Allen, California Health Care Market Report 2006, prepared for the California HealthCare Foundation, February 2007.
[5] Clark, Brietta R., Disentangling Fact From Fiction: The Realities of Unequal Health Care Treatment: Article: Hospital Flight From Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare, DePaul J. Health Care L. 1023, 2005.

HOSPITAL CLOSURES AND THE IMPACT ON EMERGENCY CARE.

Emergency room center closures are also of major concern for many communities. In 2003, nationwide, there were 113.9 million emergency department (ED) visits up from 90.3 million a decade earlier. At the same time, the number of facilities available to deal with ED visits has been declining. The total number of hospitals in the U.S. decreased by 703, the number of hospital beds dropped by 198,000, and the number of emergency departments fell by 425.[6] Governor Schwarzenegger also recognized this problem as part of his January 2007 health care reform proposal in which he included the following, "65 emergency rooms in California have closed in the last decade. In Los Angeles County, one fifth of emergency rooms have closed since 1995, leaving only 75 emergency rooms open for the county's 10 million residents."

Emergency room overcrowding is also a very significant problem. Some have suggested that this overcrowding is due to the uninsured. The data tells another story. Increased usage is driven primarily by more frequent visits among those with insurance.[7] Publicly insured patients were found to be overrepresented among ED users in one study.[8] Most of the increase in ED visits is attributable to cases that fail to meet the criteria for emergent or urgent care.[9] Primary care physicians use the ED for access to diagnostic testing and to admit patients to the hospital.[10] Extended delays in care also exist when on-call specialists are not available. Specialists may choose not to be on call for many reasons including difficulty getting paid, additional liability risks, and because of the disruptions call obligations have on private practice and family life.

Overcrowding of hospital beds also leads to delays in the emergency room, with a significant impact on the quality of care provided to patients. Patients stalled in an ED when hospital beds are not available have limited privacy, receive less timely services, and do not have the benefit of expertise and equipment specific to their condition that they would get within the inpatient department.[11] Half a million times each year – an average of once every minute – an ambulance carrying an emergency patient is diverted from an emergency department that is full and sent to one that is farther away.[12] According to the American Hospital Association, nearly half of all hospitals – and nearly 70% of urban hospitals – diverted patients at some point during the year in 2004.

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[6] Report Brief: The Future of Emergency Care in the United States Health System, Institute of Medicine of the National Academies, June 2006.

[7] Cunningham, P. and J. May, Insured Americans Drive Surge in Emergency Department Visits. Center for Studying Health System Change, October 2003.

[8] Zuckerman, S., and Shen, Y., Characteristics of Occasional and Frequent Emergency Department Users: Do Insurance Coverage and Access to Care Matter? February 2004.

[9] U, T., M.R. Sayre, and S. C. Carleton, Emergency Medical Care: Types, Trends and Factors Related to Non urgent Visits. Academic Emergency Medicine. 1999.

[10] HarrisInteractive Poll, Emergency Department Utilization in California: Survey of Consumer Data and Physician Data, conducted for the California HealthCare Foundation, October 2006.

[11] Report Brief: The Future of Emergency Care in the United States Health System, Institute of Medicine of the National Academies, June 2006.

[12] Report Brief: The Future of Emergency Care in the United States Health System, Institute of Medicine of the National Academies, June 2006.

Diversion adds transport time and delays care which can be the difference between life and death and it prevents the ambulance from responding to other emergencies.

HOSPITAL CLOSURES AND ACCESS TO CARE IN LOS ANGELES COUNTY.

According to the CHCF 2006 Market Report, hospital capacity is a major issue in the Los Angeles region. Major new construction or reconstruction projects are underway or in the planning stages. As indicated above, the driving force behind these projects is the need to meet seismic safety standards and also to modernize outmoded facilities, and stay competitive with the new technologies and equipment. Hospital finances have improved for many making investment in new projects possible.

At the same time, Los Angeles County contains the highest concentration of uninsured individuals in California. Over one-third of the residents lack insurance. In some areas over 40% of the residents are uninsured. Los Angeles County is also one of the most diverse in the state. South Los Angeles is confronted by the most difficult realities, such as the highest rates of uninsured children, teen births, obesity, high blood pressure, and mortality from cancer, stroke, diabetes, and coronary heart disease. In 2005, public hospitals in Los Angeles County, including County-USC and Harbor, were closed to ambulances an average of about 20 hours a day. Some private hospitals were closed for 12 hours or more.[13]

PRESERVATION OF SERVICES IN UNDERSERVED COMMUNITIES.

South Los Angeles has limited access to health care services. It has the largest need for additional beds and ED treatment stations, worst densities of available specialty physicians, worst ratios of discharges to available bed, and worst wait times for emergency room visits.[14] The Los Angeles County Medical Association (LACMA) has called health care conditions in South Los Angeles a crisis. In a recent paper LACMA states that a year ago, Memorial Hospital serviced 40,000 patients in its emergency room and Martin Luther King Jr. Hospital (MLK) serviced 60,000. Now Memorial is closed and Martin Luther King Jr. Hospital MLK has been downsized.

MLK and Charles R. Drew University of Medicine and Science (Drew University) were created out of the Watts riots in 1965 where 32 people died and 1,000 people were injured. In December 1965, Central Intelligence Agency Director McCone issued a report citing the lack of adequate health care facilities as a contributing factor to the civil unrest. This prompted city and state officials to put in motion plans to build a medical school and teaching hospital in the Watts community.

Drew University opened in 1970, and MLK, a public hospital, opened in 1972. According to the California Wellness Foundation, more than one-third of all underrepresented minority doctors practicing medicine in Los Angeles County received training at Drew University. Drew University has graduated more than 2,500 specialist

[13] Los Angeles Times, October 15, 2006
[14] LA Health Action

physicians, 400 medical doctors, and more than 2,000 physician assistants, as well as many other health professionals, and ranks in the top 10% of institutions for research funding from the National Institutes of Health and among the top 50 private universities.

In 2004, the Los Angeles Times began reporting on widespread neglect and mismanagement at MLK. After the federal Centers for Medicare and Medicaid Services (CMS) threatened decertification of the hospital to serve Medicare and Medicaid patients, Los Angeles County terminated the medical residency program, as part of a restructuring of the hospital referred to as "Metro Care Plan." Under the Metro Care Plan, the hospital's name was changed to MLK-Harbor Hospital. The plan eliminates the Pediatric Intensive Care Unit, Inpatient Pediatrics, Neonatal Intensive Care Units and the general/medical surgical ward at MLK-Harbor. Administrators from Harbor-UCLA were also asked to take over management of the hospital.

On March 6, 2007, Drew University officials served Los Angeles County a 45-day notice of intent to file a lawsuit of more than $125 million against the county for breach of contract with the medical school and the impact of the decision to terminate the residency program on 1.7 million poor and medically underserved residents of South Los Angeles.

At the end of March, an agreement was reached between CMS, the state and the county to extend the Medicare contract for MLK-Harbor until August 15, 2007. As part of the agreement, the county agreed not to bill for non-emergency Medicare and Medi-Cal services from May 1 through August 15. No further extensions of the agreement will be provided, and the hospital must meet all CMS standards prior to the August 15 expiration date.

On May 15, 2007 the Los Angeles Times reported the death of a patient at MLK-Harbor who reportedly had been complaining of additional pain after treatment and release from the facility. The patient died at the facility. An investigation into the patient's death and treatment is underway.

In 2004 the Centinela Freeman HealthSystem formed after three Los Angeles hospitals were purchased from Tenet. The newly formed system announced: 1) continued operation of the 24/7 EDs at all three hospitals (Centinela Freeman Regional Medical Center: Centinela Campus; Memorial Campus; and Marina Campus), 2) the Airport Clinic had been approved to accept paramedic ambulances to reduce the burden on hospital emergency rooms, and 3) plans to update the emergency departments at the Marina and Memorial Campuses, and to refurbish the emergency room at the Centinela Campus. Expansions were planned for the obstetrics and delivery services at the Centinela Campus, and four new neonatal intensive care beds at the Memorial Campus.

By October of 2006 the Centinela Freeman system announced a restructuring of its operations at Memorial and Centinela campuses, including closing the emergency department at Memorial and adding two new urgent care facilities with extended hours. The system commissioned a report by the Camden Group which showed that nearly two-thirds of emergency department patients at the Inglewood hospitals are treated for

non-emergency and non-life threatening conditions.[15] Under an agreement between Tenet and the Attorney General, which the system is obligated to carryout, the ED had to remain open for five years (until December 2006). Another study by Navigant Consulting found Inglewood needs an additional 160 family and general practice physicians, and 103 internal medicine physicians to meet the community needs.[16] In response to the announcement about the closure of Memorial's ED, the former director of county Emergency Medical Services said the closure could be devastating to the area.

These are just two examples of hospitals (both public and private) in a significantly underserved community in California that are in trouble. How long will it be before these facilities close? What can the State Legislature do to preserve these important community institutions and others like them in other areas of California?

RECOMMENDATIONS FOR LEGISLATIVE REVIEW AND CONSIDERATION.

A number of proposals have been introduced in the Legislature over the years to try to prevent hospitals, such as these from closing (see below for a description of these bills). This legislative hearing is intended to gather recommendations from community leaders and health care professionals who serve on the front lines of the health care system. Some additional recommendations for Legislators to consider include the following:

- Promote expanded urgent care clinic options. Promote education of patients about the availability of urgent care clinics.
- Require improvements in hospital efficiency and patient flow. Redesigning hospital patient admissions has the potential to improve bottlenecks, reduce crowding, improve patient care, and reduce costs. A clinical decision unit, or 23-hour observation unit, can help ED staff determine whether certain patients require admission.
- Increase use of Information Technology such as dashboard systems that track and coordinate patient flow and communications systems that enable ED physicians to link to patient's records or providers.
- Require a better coordinated emergency care system. Make the system accountable through performance measurement and public reporting.
- Prevent gaps in hospital access in underserved communities as hospitals rebuild and relocate to meet seismic requirements, modernize and upgrade.
- Consider public financing of facility upgrades with explicit public benefits for taxpayers, such as requirements to maintain emergency rooms.

CURRENT AND PREVIOUS LEGISLATION.

- AB 113 (Beall), which is pending in the Assembly Appropriations Committee, establishes a process for counties to designate hospitals as “essential community facilities” or “ECFs.” This bill requires an ECF to furnish a performance bond, in an amount determined by the county board of supervisors, and in the event

[15] Lab Business Week, October 1, 2006
[16] 2006 City News Services, Inc., September 19, 2006.

the facility fails to provide 180 days notice prior to closure or elimination of emergency services, requires the bond to provide for the immediate release of funds to the county in order to be used to mitigate the impact of the hospital's closure on the community.

- ❖ AB 1384 (Price), which is pending in the Assembly Health Committee, requires every general acute care hospital or acute psychiatric hospitals to provide public notice at least 60 days prior to the planned date of the closure of the facility, the reduction or elimination of the level of health services provided by the facility, or the lease, sale, or transfer of management of the facility.

- ❖ AB 717 (Gordon) of 2005 would have required the Centinela Airport Clinic to receive private and government reimbursement rates equivalent to that of a contiguous emergency department of a general acute care hospital if it met certain specified requirements; would have authorized the Centinela Airport Clinic to receive 911 telephone system transports of basic life-support patients at the rate applicable in October, 2004; and would have required the Los Angeles County Emergency Medical Services Agency to report to the Legislature by May 1, 2008 on the effect the clinic had on the quality of emergency health care services provided by the clinic. This bill failed passage in the Senate Health Committee.

- ❖ SB 1540 (Margett) of 2004, which was vetoed by Governor Schwarzenegger, would have included local emergency medical service agencies among those entities to be notified when a hospital closes or downgrades its emergency department, and would have placed a moratorium on a hospital licensee when the Department of Health Services (DHS) finds that the licensee has not complied with hospital notification requirements. The Governor's veto message stated that emergency room closures pose a threat to the health of all Californians and this serious issue should be addressed. Although the Governor indicated support for the author's intention to require hospitals to notify the regional emergency services agency when they plan to close an emergency room, he felt the minimum one year moratorium prohibiting a licensee from expanding services in other areas of the community and state was excessive and would further decrease access to care.

- ❖ AB 2874 (Diaz) of 2004, which was vetoed by Governor Schwarzenegger, would have required an entity planning to close a general acute care hospital to give the county an opportunity to establish a local health care district or increase the tax of an existing district in order to purchase the hospital if there are not plans to sell the hospital to another entity, as specified. The Governor's veto message contained, in relevant part, the following:

  > I am concerned about hospitals and emergency rooms closing, but DHS cannot mandate hospitals, who are likely struggling financially, to stay open for up to nine months to allow the local governments to form local health care districts. Furthermore, requiring insolvent private hospitals to remain open, without county financial assistance

during that time, could result in lower patient care standards due to rapid attrition of medical staff, hospital staff and suppliers during that time.

This bill addresses the symptom of hospital closures and not the illness: the cost of providing care in California. Instead, the Legislature should focus on measures that foster success and solvency such as improving the regulatory environment, reducing the number of unfunded mandates that divert resources away from care and making health insurance premiums more affordable for our uninsured patients.

- AB 910 (Diaz) of 2003, which was held in the Assembly Appropriations Committee, would have established the Hospital Protection Review process for downgrades or closures of private hospitals, and would have prohibited any person from owning more than one private hospital within a county or a specified area without entering into a Community Responsibility Contract with the Attorney General.

- AB 421 (Aroner) of 2000, which was held in the Senate Appropriations Committee, would have required counties to designate hospitals as "essential community facilities" based on a number of factors including, but not limited to, geographic isolation, volume of ambulance transportation, total volume of emergency visits, and other special services. AB 421 would have created an "Emergency Department Supplemental Fund" to be administered by the California Medical Assistance Commission, under which hospitals could apply for enhanced Medi-Cal reimbursement rates if supported by the county. The bill would have required hospitals that receive the enhancement to commit to keeping their emergency rooms open.

- AB 2103 (Gallegos), Chapter 995, Statutes of 1998, requires hospitals to notify DHS and the public 90 days in advance of closing or downgrading emergency services, and requires a county or its designated local emergency medical services agency to complete an impact evaluation of a proposed emergency services downgrade or closure. AB 2103 also requires DHS to receive the community impact evaluation prior to "approving" the downgrade or closure of emergency services.