

The NEWSSTAND



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New York Times – February 10, 2008

Two Cities, Two Besieged Hospitals, Two Startlingly Different Results

By Richard G. Jones

It wasn't until Peter Betts came to Barnert Hospital in Paterson in July — as its interim and, ultimately, last chief executive — that he realized just how dire the financial straits were at his hospital, one of the two main medical centers in this struggling city.

“We were \$45 million in debt and we had \$200,000 in the bank,” Mr. Betts, said in an interview on Feb. 1, hours after he announced that the hospital would close. “It's been a roller coaster since then.”

On the same day, Bayonne Medical Center, 25 miles away, mired in \$29 million in debt and in the middle of its own bankruptcy, completed an agreement for its sale to a limited liability corporation that would assume the bulk of its debt. “We looked at everything we could to turn this thing around,” said Dan Kane, the medical center's chief executive.

Two cities, two struggling hospitals, two wildly different outcomes. What has happened in Paterson and Bayonne paints a vivid picture of the distressed situation of New Jersey's hospital industry. It also underscores the findings of a commission appointed by Gov. Jon S. Corzine that the state toughen its criteria for deciding which troubled hospitals to save from going out of business.

For years, financially ailing hospitals have routinely appealed to state officials for emergency grants and other measures to help them stay afloat. In the past year, eight hospitals — including Barnert and Bayonne — have received such grants, totaling about \$38 million. But the report issued last month recommended that the state reserve such fiscal parachutes for hospitals deemed to be essential, a determination made by weighing factors like the number of poor patients and the proximity of other hospitals.

Nonessential hospitals, the commission said, should “be subjected to market forces and to potentially close.” Mr. Corzine has not set a timetable for acting on the recommendations.

The report does not go as far as a similar review undertaken by the New York State Legislature, which recommended in 2006 that at least nine hospitals be closed down, including five in New York City.

Nevertheless, the commission's findings have sent a tremor of insecurity through the 78 acute care hospitals in New Jersey at a time when federal statistics show that hospitals here are in worse financial condition than their counterparts nationwide.

Five New Jersey hospitals — including Barnert and Bayonne — have filed for bankruptcy since July 2006. According to the report, 38 of the 80 hospitals reviewed by the commission scored below the statewide average on prime measures of financial viability, including profitability and liquidity. Nearly 60 percent of those hospitals are in the Newark and Hackensack areas. And Barnert will become the 16th acute care hospital in the state to close in the last decade.

At the same time, the report found a glut of hospital beds in the state, particularly in northern New Jersey, where occupancy rates average around 75 percent; roughly 85 percent occupancy rate is considered the benchmark for a hospital to be viable.

The report has sent hospital officials around the state scurrying to explain how the situation got to this point and whose fault it is.

Betsy Ryan, president-elect of the New Jersey Hospital Association, said that her group is finalizing its response to commission recommendations like forcing hospitals to be more transparent about their finances and linking some aid to efficient management.

But she called on state officials to address what she said were chronic underpayments to reimburse

hospitals by public insurance programs like Medicaid and the state's Charity Care program.

New Jersey and Washington are the only states that require hospitals to provide Charity Care, or to treat patients regardless of their ability to pay. Under the Charity Care program, hospitals can draw from a state-financed pool of money — this year about \$715 million — to reimburse costs associated with caring for the poor. But the report found that public insurance reimbursements cover only about 70 cents of every dollar spent by the hospital, and sometimes as low as 22 cents to the dollar, Ms. Ryan said.

Those reimbursements are particularly significant in New Jersey where about 1.3 million of the state's 8 million residents are without health insurance, including 250,000 children.

“Until the state addresses that hospitals are losing money on every Medicaid and Charity Care patient we treat, hospitals will continue to struggle,” she said.

The report predicted that more hospitals are likely to close in the coming years if the state does not establish a system for rescuing financially troubled hospitals or, at the very least, an early warning system, an idea Ms. Ryan said her association welcomed.

Heather Howard, the New Jersey health commissioner, said officials were already working on creation of such an early warning system.

“Unfortunately, a hospital will sometimes come in on Friday and say, ‘We can't meet payroll; can you help us out?’ ” Ms. Howard said. “I want to move from a culture of crisis management to one of strategic planning.”

Currently, the most common way the state helps ailing hospitals is with grants in the form of an advance on Charity Care funds, the same grants that helped Barnert and Bayonne, though to little avail.

It is unclear whether an emergency fund for distressed hospitals would have helped Bayonne and Barnert, but without it their fates were left to the whims of the market and the appetites of potential buyers.

Mr. Kane, who became the chief executive a year ago, said that the forces that allowed the 278-bed medical center to survive stemmed from hard work and good fortune — hard work in establishing an active campaign to find a buyer and the good fortune to locate one.

Vivek Garipalli, who leads the company that bought the hospital, I.J.K.G., said that despite the fiscal condition of the health industry in New Jersey, he is confident about

his company's \$33 million investment in the hospital.

“Bayonne is a very vibrant community where the payer-mix is good,” Mr. Garipalli said in an interview. With Bayonne situated on a peninsula where — in the teeth of northern New Jersey traffic — the nearest hospital is roughly a half-hour's drive away, “There's a built-in market here of 62,000 people,” he said.

At Barnert Hospital in Paterson, the problems proved more intractable. After staving off closing for months through a series of intense negotiations with creditors, the hospital was forced to shut down after a deal with a potential buyer fell through.

Its demise leaves Paterson — New Jersey's third-largest city with 150,000 residents — with just one acute care hospital, St. Joseph's Regional Medical Center, which does not provide residents with some services offered at Barnert.

But as he prepared to close the hospital earlier this week, Mr. Betts bemoaned the death of what he felt was an important local institution and the loss of more than 300 jobs.

“These are people who have never worked anywhere else in 20 years,” he said. “And they're coming up to me saying, ‘How are you holding up?’ ”

St. Louis Post-Dispatch – February 13, 2008

St. John's shifts the way nurses fill its shifts

By Chris Birk

The days of phone calls and paper pushing are over.

Now, from the comfort of her couch, Becky Allen hops online to sort through and pick up extra nursing shifts at St. John's Mercy Medical Center. The hospital recently became the first in the St.

Louis area to implement a Web-based work force management system created by San Diego-based firm Bidshift, Inc.

The scheduling program gives the medical center's more than 2,000 nurses greater flexibility in identifying extra shifts and linking

the vacancies to their expertise and interests.

“You can do it on your own time, at one in the morning — whatever your preference,” said Allen, 31, a nurse who's worked for 10 years in the center's neonatal intensive care

unit. "It's a great way to get people to know all these shifts are open."

In the past, individual medical units posted vacancies at their respective stations. Nurses interested in picking up extra work would have to walk by each unit or work the phone to compete for a good fit. Vacancies occur for a number of reasons, from nurses on leaves of absence to sickness and bad weather.

Spurred in part by growing interest throughout the industry, hospital executives sought a more up-to-date method of communicating open nursing shifts and attracting qualified workers.

St. John's officials met with Bidshift representatives last year to examine the technology and evaluate the facility's needs. Dubbed "MShift," the portal rolled out in mid-January.

More than 150 hospitals nationwide have implemented the six-year-old company's scheduling program, said Bidshift chief executive officer Graham Barnes.

Nurses can sort through all available shifts that match their skill set and availability. Allen, for example, is certified to work in the pediatric intensive care unit as well as the NICU. The program also allows

unit managers to assess the skills and schedules of applicants before awarding an open shift, all through a secure Internet site.

"The manager can focus on being out on the unit with the patients and co-workers, not sitting in an office making telephone calls," said Bruce Weinberg, executive director of nursing, business operations, at St. John's. "Already, we've seen a tremendous increase in workers working on different units."

More than 1,850 nurses have enrolled in MShift so far, and nursing managers have filled 822 shifts through Feb. 23, said Weinberg.

To encourage the use of MShift, the hospital offers incentives. Nurses earn points for requesting extra shifts as well as for working them. They can then redeem these points for things such as parking spots, meal vouchers and consumer goods through an online catalog. Weinberg said that a nurse recently redeemed her points for an MP3 player.

The Web-based program is quite helpful to Allen, who prefers flexible hours rather than a fixed schedule. She used the program the day after its rollout, bidding on about a half-dozen shifts from her home computer. She received a confirmation or denial in real-time

from nursing managers monitoring the site.

For Allen, managing the drop-down bars and navigation buttons presents little challenge. The hospital has also provided informal training for nurses who want it.

"I like that we're online. It's easy to click and drag your shifts, get awarded it and put it on the calendar," Allen said. "I think it's going to be more efficient."

It might also prove cost-effective.

Weinberg hopes that Mshift ultimately lessens the hospital's reliance on temporary agency nurses, whose hiring remains a drain on resources. A temporary agency nurse can cost double or triple the hourly rate of St. John's nurses.

"We prefer to have our own co-workers taking care of patients here," Weinberg said. "Nothing replaces your own co-worker." Hospital patients also stand to gain because of a more streamlined scheduling process, said Barnes, the Bidshift chief executive.

"Ultimately, we expect to be able to see improvement in patient outcomes for people visiting that hospital," he said.

USA Today – February 15, 2008

Medicine meets a culture gap

By Joy Buchanan

Thelma Hyman is 90 years old, and she expects to be called Mrs. Hyman when she visits the doctor's office. But when the black woman recently visited the office of a white physician, he called her Thelma.

"I'm not sure I'm going back to him," says the resident of Washington, D.C. "It's very important. Everyone has their own

feelings about how you need to address them."

The exchange may seem inconsequential, but a growing amount of research is investigating whether these small cultural differences — most of them between white, male doctors and their diverse patients — could be a

big reason for the nation's persistent health care disparities.

In 2005, New Jersey became the first state to require cultural-competence education for physicians to get licenses. California requires continuing medical education for doctors to include cultural and linguistic competency training.

The federal government is financing studies examining whether the training can help health care workers get diverse groups to comply better with doctors' orders.

But no study has proven cultural competency training works, either by improving doctor-patient relationships, increasing patient compliance or reducing disparities.

But examining the question is the first step to addressing the problem, says Ramon Jimenez, chairman of the diversity advisory board of the American Academy of Orthopaedic Surgeons. "Cultural competency will have to be on everybody's radar screen for generations to come. When the day comes that the melting pot is truly a melting pot, then we won't need this, but that day isn't here yet."

About six years ago, the academy gathered information for a culturally competent care guidebook and accompanying DVD for doctors with chapters on African-Americans, Asian-Americans, Native Americans, Latinos, women and religions including Islam.

The academy compiled interviews with patients of different races and cultural backgrounds with doctors familiar with diverse patients and a plethora of research. For example, the guidebook encourages doctors with Native American patients to "ask if patients may seek a healer or medicine man." It also recommends that doctors with Latino patients break the ice by asking them their country of origin.

Hyman, a retired physical education teacher and former high school athlete, had knee pain so severe that she missed family events and wouldn't leave her house without a cane.

"When I found I couldn't walk a block, that disturbed me," she says. But, like many black patients, according to the guidebook, she was reluctant to have her knees replaced or to have any other kind of surgery.

It is common for black patients to distrust doctors and hospitals for many reasons, including a general distrust of hospitals, fear that doctors may recommend surgery when it isn't necessary and concern they may suffer bad outcomes, says Tony Rankin, an orthopedist in Washington and the first black president-elect of the Orthopaedic academy.

Hyman was referred to Rankin for surgery at Providence Hospital. He replaced both her knees, and she was pleased with him. "He was very understanding," she says. "He explained what he was going to do. He allayed all my fears."

He also called her "Mrs. Hyman" and arranged meetings with her three children to answer their questions. "Just little things like that," Rankin says. "Though it seems insignificant, it makes a big difference."

Not all doctors are as keen on cultural competency training, especially if it's mandatory. Joseph Zebley III is a white male and a family doctor in Baltimore. His

patients are mostly African-American and Southeast Asian, and he also sees many Haitians because he speaks French, the language of his mother.

"Just because I happen to be a white male doesn't mean I'm not comfortable with African-American culture in Baltimore city," Zebley says.

Some doctors may be uncomfortable with unfamiliar cultures, but courses in cultural sensitivity aren't the answer, he says. "You can't really teach that. You have to bond one-on-one with the patients. Otherwise, you can do all the cultural competency training in the world, and it's not going to make a difference."

The guidelines aren't meant to apply to every person in every case, Rankin says. Indeed, the guidebook carries a disclaimer: "Never assume that an individual who comes from an ethnic culture shares the traits of that ethnicity or culture."

For example, Jimenez says he might ask recent Latin immigrants if they have used a curandero, or folk healer, but he may not ask that question of a second- or third-generation Latino.

Part of knowing when and whom to ask these questions takes experience, he says: "You don't go through four years of college, four years of medical school, six more years of training and thousands of patient interviews without learning something."

Boston Globe – February 14, 2008

1 in 10 patients gets drug error

By Patricia Wen

One in every 10 patients admitted to six Massachusetts community hospitals suffered serious and avoidable medication mistakes,

according to a report being released today by two nonprofit groups that are urging all hospitals in the state

to install a computerized prescription ordering system.

The report is the first large-scale study of preventable prescription errors in community hospitals, and its author, Dr. David Bates of Brigham and Women's Hospital in Boston, said he was surprised that these mistakes were so frequent in these community hospitals. Previous studies in large academic hospitals that also lacked computerized systems found such medication errors occurred less than half as often, he said.

Researchers declined to release the names of the six Massachusetts hospitals, which participated in the \$5 million study voluntarily on condition that they would remain unnamed.

Of 73 hospitals in the state, only 10, almost all of them large teaching hospitals in Boston, have adopted the computerized physician order entry system, which requires doctors to type into a central database every medical order, including prescriptions, diagnostic tests, and blood work. The doctors' orders are matched against the patient's medical history, triggering red flags to prevent problems related to drug allergies, overdoses, and dangerous interactions with other drugs.

Bates said that after this system was put in place at Brigham and Women's Hospital in 1995, preventable medication errors declined by 55 percent over the next two years.

The researchers could not explain the higher rate of preventable errors in the community hospitals but cautioned against patients assuming that these hospitals overall are less safe than academic teaching hospitals. They said this is one of only a small number of studies nationwide that have analyzed prescription error rates at hospitals, and comparisons are difficult because each study varied slightly in its scope and definitions.

Donald Thieme, head of the Massachusetts Council of Community Hospitals, said studies show that many community hospitals offer the same, if not better, care for patients with some serious illnesses. He said community hospitals struggle to adopt the computerized prescription systems because of cost, but they are committed to improvements because they want "errors down to zero." Thieme said he could not comment on the specifics of today's study because he had not seen it.

Community hospitals in Massachusetts may not have a choice but to implement such computerized systems, based on increasing pressure from insurers who see the systems enhancing patient safety and saving money. Gerald Greeley, director of information services at Winchester Hospital, said Blue Cross Blue Shield of Massachusetts and Harvard Pilgrim Health Care, over the last year, have demanded the gradual introduction of the computerized physician order entry system as a condition of reimbursement contracts with Winchester Hospital.

"The technology is there - we must adopt it," said Wendy Everett, president of the New England Healthcare Institute, a nonprofit health policy research organization that is one of the two groups releasing the study.

The report argued, based on a financial analysis by PricewaterhouseCoopers, that it makes financial sense for all hospitals to install a computerized ordering system, despite the \$2.1 million up-front costs and more than \$400,000 annual operating costs. The study estimated that the average victim of a medication error stays in the hospital at least four extra days. The researchers also looked at how often doctors at the six community hospitals ordered more expensive

drugs when a cheaper, generic drug would do, or when they ordered an intravenous delivery of a medication when a less expensive oral pill would have been just as effective. Redundant lab tests were also documented.

The study concluded that by eliminating these extra expenses, a computerized system could save each of the community hospitals an average of \$2.7 million a year, said Mitchell Adams, executive director of the Massachusetts Technology Collaborative, a nonprofit organization focused on the state's high-tech economy and the other group involved in the study. Adams said any hospital putting the system in place would recoup its cost in about two years. The two nonprofits called on hospitals to install the computerized systems within three years.

The researchers reviewed a total of 4,200 randomly selected patient medical charts at the six community hospitals, covering stays from January 2005 to August 2006. An average of 10.4 percent of patients suffered a preventable "adverse drug event" - defined as a case in which the patient was given a drug even though the medical records noted that the medication could trigger a drug allergy or that the dose given would exacerbate a medical condition. Medication errors were counted only when patients suffered serious reactions, including going into shock or suffering kidney failure. In nearly every instance, the patients remained in the hospital longer to recover from the mistake. Nobody died from any of the mistakes, researchers said.

Everett said the study's findings can be "generalized to all hospitals" without such computerized systems, and indicate that prescription errors are often made in the rushed hospital atmosphere. She recommended that patients inquire

about a hospital's patient-safety systems, and ask medical staff to double-check dosages and names of all medications given.

"I'd demand it," she said.

Bates said some doctors have worried that the computerized system requires them to spend

precious time entering data - one study put it at 20 minutes a day, but also found that, over the long haul, doctors saved time through the centralization of records. He said the system has many benefits for nurses and pharmacists who can easily find all the information in one place.

Adams said he hopes the study's results will spur more medical insurers, government officials, and healthcare providers to pressure the state's hospitals to adopt the computerized system. "We must speed up the adoption of this technology in every hospital in Massachusetts," he said.

USA Today – February 14, 2007

Senior benefit costs rise 24% since 2000

By Dennis Cauchon

The cost of government benefits for seniors soared to a record \$27,289 per senior in 2007, according to a USA TODAY analysis.

That's a 24% increase above the inflation rate since 2000. Medical costs are the biggest reason. Last year, for the first time, health care and nursing homes cost the government more than Social Security payments for seniors age 65 and older. The average Social Security benefit per senior in 2007 was \$13,184.

"We have a health care crisis. We don't have an entitlement crisis," says David Certner, legislative policy director of the AARP, which represents seniors.

He says seniors shouldn't be blamed for the growing cost of government retirement programs.

The federal government spent \$952 billion in 2007 on elderly benefits, up from \$601 billion in 2000. It's the biggest function of the federal government. States chipped in another \$27 billion in 2007, mostly for nursing homes.

All three major senior programs — Social Security, Medicare and Medicaid — experienced dramatically escalating costs that outstripped inflation and the growth in the senior population.

Benefits per senior are soaring at a time when the senior population is not. The portion of the U.S. population age 65 and older has been constant at 12% since 2000.

The senior boom, however, starts big time in 2011 when the first baby boomers — 79 million people born between 1946 and 1964 — turn 65 and qualify for Medicare health insurance. The oldest baby boomers turn 62 this year and qualify for Social Security at reduced benefits.

USA TODAY used a variety of government data to calculate the cost of providing Social Security, medical benefits and long-term care to an aging population. Billions of dollars paid to non-seniors — the disabled, children and others in the programs — were removed to create an estimate that focuses exclusively on seniors.

Findings include:

- Medicare experienced the most explosive growth from 2000 to 2007. The Medicare prescription drug benefit, started in 2006, accounts for about one-fourth of the increase in Medicare, which provides health benefits for people 65 and older.

- Long-term care costs per senior have declined slightly in the last

three years because of a move away from nursing homes to less-expensive home care.

- The cost of senior benefits is equal to \$10,673 for every non-senior household.

- About 35% of the federal budget is spent on senior benefits, up from 32% in 2004.

Eugene Steuerle, a senior fellow at the non-partisan Urban Institute, notes that the full cost of senior benefits goes beyond Social Security, Medicare and Medicaid. A complete estimate would include other programs for retirees, such as military and civil servant pensions and medical benefits, he says.

The Urban Institute estimates that kids receive an average of about \$4,000 per child in benefits, including the child tax credit and other indirect assistance.

Economist Dean Baker calls it "granny bashing" to focus on the cost of senior benefits. The elderly paid a designated tax for Social Security and Medicare taxes during their decades of working to support these programs when they retired, says Baker, co-director of the liberal Center for Economic Policy and Research.

ERs fail as the nation's safety net

By Mary Engel and Rong-Gong Lin II

The long waits that government inspectors say endanger emergency room patients at Harbor-UCLA Medical Center can also be found in backlogged hospitals across the country, according to emergency care experts who have been trying for years to draw attention to the nation's overloaded safety net.

"Overcrowding in our emergency departments is a national crisis," said Dr. Linda Lawrence, president of the American College of Emergency Physicians, an advocacy group based in Washington D.C. "We no longer have the capacity to serve as the safety net for society."

The group surveyed 1,000 emergency care physicians in September and found that one in five knew of a patient who had died because of having to wait too long for care, Lawrence said.

The death of an emergency room patient in December at Harbor-UCLA prompted California health officials, acting on behalf of the U.S. Centers for Medicare and Medicaid Services, to inspect the L.A. County hospital. William Harold Jones Jr., 56, was admitted to the emergency room on Dec. 22 but left the hospital before treatment was finished. His absence went unnoticed for hours before he was found dead on a sidewalk across the street.

County officials released a statement earlier this week that said they expected Harbor-UCLA to be cited for placing patients in "immediate jeopardy."

Harbor-UCLA is the third hospital owned by Los Angeles County to undergo federal scrutiny in recent months for emergency room deaths.

"When somebody dies or somebody walks out the door and drops dead or a kid dies in the back of an ambulance, the typical press reaction is find the nurse, find the doctor, and crucify them," said Dr. Arthur Kellermann, professor and chairman of emergency medicine at Emory University School of Medicine in Atlanta. "UCLA-Harbor . . . [has] been operating right on the edge in terms of volume of care for years. There's just not any room left. This is the death spiral of American medicine, if we don't figure out what to do."

Report after report has laid out the crisis.

A review of 90,000 emergency room visits nationwide from 1997 to 2004 found that one in four heart attack patients waited almost an hour after arriving in a hospital emergency room before receiving care. Heart attack patients waited 150% longer for care by the end of the study period, or 20 minutes on average, up from eight minutes in 1997, according to the Harvard Medical School study published last month in the journal *Health Affairs*.

The National Institute of Medicine, an arm of the National Academies of Science, warned in a 2006 report that hospital-based emergency care was at a breaking point because of increasing demand and dwindling numbers of both emergency rooms and hospital beds.

The declining number of inpatient beds matters because emergency patients who need to be admitted for further treatment end up "boarding" in the emergency room -- often on gurneys in hallways -- until a hospital bed becomes available. Indeed, boarding is the key driver of the emergency room crowding

crisis, the report said, taking up space and attention needed to treat the next emergency and leading to backlogged waiting rooms.

The gridlock is exacerbated by a chronic, nationwide nursing shortage and a dearth of specialists willing to be on call for emergencies, as well as by an aging population with increasingly serious medical needs.

The growing number of people without medical insurance also contributes because the lack of reimbursement, along with ever-shrinking payments from both public and private insurers, has turned many emergency rooms into money-losers and driven some hospitals out of the emergency-care business. Federal law requires hospital emergency rooms to treat patients regardless of their ability to pay.

The crisis is especially acute in Los Angeles County. In the South Los Angeles area alone, six emergency rooms -- which accounted for 100,000 emergency room visits a year -- have closed since 2003. Five were at private hospitals and one was at the county-owned Martin Luther King Jr.-Harbor Hospital in Willowbrook, which was cited last year in the death of a woman who writhed in pain for 45 minutes on the floor of the emergency room lobby without receiving medical attention. The county closed all but the outpatient clinics and urgent care center at King-Harbor in August after the hospital failed multiple inspections and lost federal funding.

"What we have is a persistent erosion of ER services, predominantly private, and that creates increasing pressure on every

other hospital that runs an emergency room," said Dr. Bruce Chernof, L.A. County's director of county health services. Although his department "can do some things to mitigate the problem," he said, "this is part of a larger issue across the county."

County health officials are expected to report on Harbor-UCLA's waiting times and triage system to county supervisors Tuesday and propose a plan to correct any weaknesses.

Lark Galloway-Gilliam, executive director of Community Health Councils, a health advocacy group, agrees that all hospitals are strained but believes that there's more to the county's problems than that.

"A lot of it has to do with management and oversight," she said, echoing critics who have long advocated that the county hand off hospital oversight to an independent authority. County supervisors "do not have the skills or the time to protect patient care when resources are so scarce."

She also said that the county brought on much of the current overcrowding, first by closing county-run clinics and more recently by shuttering King-Drew.

"We now see patients getting sicker and going to ERs, and the ERs don't have the capacity to deal with this volume and level of illness," she said. "People get overlooked, and people die."

The county has not yet offered a plan to reopen Martin Luther King Jr.-Harbor Hospital. Chernof said Friday that negotiations with private operators are "active."

Meanwhile, federal regulators have threatened to pull funding from the county-owned Olive View-UCLA Medical Center in Sylmar after government inspectors said the center failed to provide prompt medical screening for three emergency room patients last October. One of the patients, a 33-year-old man, had arrived at the emergency room experiencing chest pains. He never received a test to check if his heart was functioning properly. More than three hours after he came in, he collapsed and died of a heart attack.

The overcrowding is not expected to get better in the short term, even as the county prepares to move its flagship hospital, Los Angeles County-USC Medical Center, to a new facility in Boyle Heights as early as June. In 2002, the hospital was staffed to handle 750 beds; nursing shortages have reduced that to 650 beds. The new hospital is licensed for 600 beds.

"It's going to reduce our flexibility," said Dr. Stephanie Hall, chief medical officer of the Los Angeles County-USC Healthcare Network. "It will be a challenge for the system to provide care."

Dr. Brian Johnston, an emergency room physician who has been practicing in Los Angeles for more than 30 years, criticized county

supervisors for the decision to license fewer beds.

"I understand they don't have a budget for it, but I also know they have a legal obligation to provide the services," Johnston said. "The system is stretched beyond belief."

Long-term solutions are years away. A long-awaited expansion of the Harbor-UCLA emergency room won't be completed until 2011 at the earliest, said Carol Meyer, director of governmental affairs at the county's Health Services Department. And building new facilities is expensive, costing \$2 million per bed, Meyer said.

Recent attempts to raise revenue for emergency departments and health services have failed. In 2006, California voters rejected a \$2.60-per-pack tax hike on cigarettes that would have funded expanded health services.

And in January, state senators killed a \$14.9-billion healthcare reform package that would have arranged for medical insurance for nearly all Californians. If that effort had passed, Meyer said, Los Angeles County health services could have received an additional \$200 million a year for its healthcare system, which would have been an 8% boost to its budget.

"The ER crisis has been going on for years," said Emory University's Kellermann. "What does it take to get our society and our government, state and federal, to focus on this?"

New York Times – February 12, 2008

City Hospitals Reinvent Role of Emergency

By Sarah Kershaw

The New York City emergency room — overcrowded, exhausting, sometimes terrifying — has long been a legendary circle of medical hell.

But now hospitals — public and private, large and small — are spending hundreds of millions of dollars renovating, rebuilding and expanding their emergency rooms.

They are dividing them into treatment areas for the sickest patients with the most dire injuries and using quieter corners for the growing number of patients using

emergency rooms for routine medical care.

And an increasing number are taking steps to bring civility and even hospitality to the emergency room, in part because, for all their turmoil, they remain vital points of entry for paying patients whose eventual admission accounts for needed revenue.

Montefiore Medical Center in the Bronx, the city's busiest emergency department, has in recent years built two new emergency rooms, one of them for children, and renovated another. In August, the hospital announced that it was adding another 7,000 square feet, more doctors and nurses, and "comfort rounds," which feature customer service representatives who offer patients extra pillows, free snacks and child care.

At St. Vincent's Hospital Manhattan, officials recently spent \$7.6 million to create what they call a "fast-track" option to speed the treatment of patients with more minor injuries. St. Luke's-Roosevelt Hospital Center recently embarked on a \$15 million project to double its capacity at the Roosevelt campus.

And the city's public hospital system is projecting that it will have spent more than \$100 million by 2011 to upgrade emergency rooms at six of its 11 hospitals.

"The amount of emergency room use in New York has always been a source of criticism," said Kenneth E. Raske, president of the Greater New York Hospital Association, an industry group. "But you can't say to eight million people, 'Don't do this anymore.'"

The familiar root causes of the crisis for the city's emergency rooms have only worsened: the flood of uninsured patients, rapid population growth in the neighborhoods where

the centers are located, a crippling shortage of primary care doctors and bankrupt hospitals closing their emergency rooms.

The situation is not exclusive to New York. Hospitals in cities from Sacramento to Minneapolis to Boston are starting their own efforts to meet the problem, with the national rate of emergency room visits soaring.

Governors and lawmakers from a number of states are also trying to find ways to get capital construction dollars for bigger hospitals and emergency rooms, even as the nation's hospitals brace for potentially stinging cuts to their financial mainstays, Medicare and Medicaid, contained in President Bush's 2008 proposed budget.

But the efforts in New York City — often termed the nation's hospital capital — are striking, as officials rush to keep pace with demand, squeezing capital out of overstretched budgets and appealing for more private donations.

"We are all seeing enormous pressure at the emergency room door," said Alan D. Aviles, president of the city's Health and Hospitals Corporation, which operates 11 public hospitals with two million visits to the emergency rooms annually.

Mr. Aviles said that even with the planned upgrades for the city hospitals, he feared "we still cannot meet all the need."

All told, emergency rooms in New York City handled more than 3.6 million visits in 2005, an increase of 6 percent over 2000. The rising number of visits — the citywide data from 2005 are the most recent available — have been strangling some of the hardest-struck hospitals.

More recent hospital records from St. Luke's-Roosevelt Hospital

Center on Manhattan's West Side, for example, show that there were 105,000 visits to the emergency room last year, up from 59,000 in 1999. "I can't foresee how we can keep up that pace," said Dr. Dan E. Wiener, chairman of the hospital's department of emergency medicine. "The overcrowding is just there — it's the background noise of life. Some days things are O.K., it's tolerable. Some days it's over the top."

Many New York hospitals are also contending with yet another new influx of patients who normally would have sought care at nearby hospitals that have closed, merged with other hospitals or will soon close. A state commission in 2006 ordered almost two dozen mergers or closings in an effort to shrink the state's enormous hospital industry, because beds at some of them were going unused.

Other hospitals across the nation, sustaining big losses in their emergency rooms and depleting their charity care funding for the uninsured, have shut down their emergency rooms or even closed completely.

And so the city's remaining hospitals are milking every inch of coveted real estate to expand and rebuild their emergency rooms. For instance, New York Downtown Hospital, a small hospital near Wall Street that handled more than 1,500 injured victims on Sept. 11, recently spent about \$25 million to build a new emergency room with twice the capacity.

Beyond expansions and renovations, hospitals across the city are also trying to reorganize their emergency departments, with the intention of turning the mayhem into, at minimum, a more organized kind of chaos.

To that end, some hospitals have added private rooms with flat-

screen televisions; others have actually retained art therapists to entertain and comfort the children waiting in their rooms.

Some hospitals now have “navigators,” staff members assigned solely to the uninsured to handle the cumbersome paperwork required for registering them. And an increasing number have also instituted the fast-track systems, which Beth Israel Medical Center in Manhattan — now constructing an emergency room that will be twice the size of its current one — is calling “fast-food McDonald’s-type in-and-out service.”

The fast-track systems divide emergency rooms into areas for patients with minor injuries for those with more acute problems, so that someone with a sprained ankle is not lumped together with a patient who is bleeding profusely from the head.

But if one were to identify a hospital living out every aspect of the reimagining of the troubled New York emergency room, it might well be at Montefiore, which statistics show has the city’s busiest emergency department. Visits there have increased by 30 percent in the last five years to more than 211,000 in 2007. That has meant that the emergency room often operates between 50 and 100 percent above capacity, with stretchers filling almost every square foot of space on most days.

“We are overwhelmed without a doubt,” said Dr. Peter Semczuk,

vice president for clinical services at Montefiore.

So far, Montefiore has added 25 new beds, for a total of 100, falling far short of what is needed. Still, some of the work going on is actually aimed at what might seem a counterproductive goal: increasing the flow of patients to the emergency room.

While hospitals typically lose money on emergency room visits, largely because of the rising numbers of uninsured patients, the insured patients who do come through the same doors and who wind up being admitted for surgery and other care are their economic lifeblood. In fact, a majority of inpatient admissions at New York hospitals come through the emergency room.

So, many hospitals are now aggressively marketing the virtues of their remodeled and expanded emergency rooms. Some are conducting expensive direct mail campaigns; others are beginning advertising campaigns trumpeting their faster service and new amenities like private rooms, telephones and flat-screen televisions.

“It’s about putting yourself in the patient’s shoes,” said Carleigh Gustafson, director of emergency nursing at Lenox Hill Hospital, which recently expanded its emergency room and added individual flat-screen televisions and telephones for patients. “It’s making sure that we’re

communicating very well — it’s both an art and a skill.”

Dr. Semczuk of Montefiore said, “We want to become the Ritz-Carlton of emergency rooms.”

Montefiore may not feel much like a five-star hotel, but patients there said they were pleasantly surprised by some of the new services, which include a child care specialist who plays with the children, handing out stickers, apple juice, Teddy Grahams, Play-Doh and coloring books.

An art therapist is on call as well, helping children express their fears in drawings and paintings, and the child care staff also engages in “medical play,” helping to explain procedures to young patients and sending them off to see the doctor with a “day surgery buddy doll” to accompany them for potentially scary treatments.

“I’ve been here before for 12 or 13 hours, and I couldn’t even get a cup of water,” said Edwin Flores, a construction worker who recently took his 9-year-old son, who was having severe abdominal pain, to the emergency room. “This surprised the heck out of me.”

As Mr. Flores and his family were served lunch from the hospital cafeteria in a private room, one of Montefiore’s customer service representatives, Enid Diaz, stopped by.

“Hello! I’m Mrs. Diaz,” she said. “Can I help you with something?”