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Emergency!

Mid City Closure
Symptom of Bigger Issue

One on One
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The American College of Emergency Physicians makes no bones about it: uncompensated care has contributed to the closure of hundreds of emergency departments across America. As the only healthcare entities required to provide care to all patients, regardless of their ability to pay, most emergency rooms cost more to run than payments from patients can cover. This loss of revenue varies widely with location, and in areas with high numbers of uninsured patients—who tend to be patients who cannot pay for their care—emergency departments operate at much higher losses than those in areas with lower numbers of uninsured patients. Many have buckled under the pressure and closed down, putting even more strain on the remaining emergency rooms in the area. This domino effect has happened across the country, and now, it appears to be happening in Baton Rouge.

EmeRgency!

Mid City closure latest symptom of growing issue

By **Claudia S. Copeland, PhD**

IN APRIL OF 2013, THE LSU EARL K. Long Medical Center (EKL) in north Baton Rouge closed its doors, removing a major emergency room from an area with a high proportion of poor and uninsured patients. At the time, critics such as state Rep. Bodi White expressed concern that more uninsured patients would be showing up at nearby hospitals, including Baton Rouge General-Mid City and Lane Memorial Regional Medical Center, the two ERs closest to the Earl K. Long facility. If EKL closed, some feared that these nearby hospitals could be at risk of going bankrupt if they did not receive compensatory funding from other sources.

In hindsight, these concerns were remarkably astute. Mid City was the next closest ER to the largely uninsured North Baton Rouge patient population that was previously serviced by EKL. No provisions were made, however, for Mid City to take on EKL's emergency patients; the federal funds previously used to offset the cost of uninsured North Baton Rouge emergency patients went to Our Lady of the Lake Regional Medical Center. Local patients with non-life-threatening conditions were to be treated in a new, nearby 24/7 urgent care clinic, and patients with illnesses or injuries beyond the scope of an urgent care clinic were supposed to be redirected to the Lake. However, very ill or injured patients tend to choose a nearby emergency room over one across town, and after EKL closed, that meant Mid City.

Uninsured patients visiting the Mid City ER rose by 30%, and psychiatric patients by almost 70%. The Mid City ER had already been losing money before the closure of EKL—annual losses had risen from $6 million to $8 million from 2009 to 2012. In 2013, though, the year EKL closed, they shot up to $12.5 million, then soared to a staggering $23.8 million in 2014. While the state stepped in with supplemental funding for one year, it was a temporary fix—no long-term provision of funds to keep Mid City open had been made during the planning process for the EKL closure and move to the Lake. With losses at that level,

c. 2615 BC

An ancient Egyptian papyrus penned by Imhotep applies diagnostic methods to disease.

Ancient Mesopotamian healers are tasked with discovering what god or demon had produced an illness and how to appease that entity so that the symptoms might ease. They are also believed to have used observation, palpation, and auscultation in their diagnoses.

c. 1800 BC

Baton Rouge General Mid City ER staff pauses for reflection on the day of closure.

Mid City had no choice but to close the ER to stop the hemorrhaging and save the rest of the hospital.

As pointed out in a *Bloomberg News* analysis, the acceptance of Medicaid expansion in Louisiana would have helped, but could not by itself have saved Mid City's ER. (In addition, a study of a lottery-based Medicaid expansion in Oregon published in *Science* last year found that ER use actually increased when patients were enrolled in Medicaid. So, while Medicaid expansion may have provided extra funding, it might also have swelled the number of ER patients, contributing to overcrowding.) However, Medicaid-based federal funds for charity hospitals are slated to be cut in 2016, as the plan was that uninsured patients would enroll in Medicaid. Therefore, in effect, refusing to accept Medicaid expansion will essentially be equivalent to cutting funding, not just refusing an offer of extra help.

Baton Rouge is far from unique in the phenomenon of ER closures. Across the United States, a pattern of steady closure of emergency departments in urban areas has been emerging. Researchers Hsia et al., in a 2011 report in *JAMA*, calculated that from 1990 to 2009, the number of non-rural emergency departments had decreased by 27%. Further, the hospitals that had closed their doors tended to be in "safety net" hospitals, in areas with a higher proportion of the population in poverty and a higher proportion of uninsured patients. Particularly striking was the observed influence of market forces on ER closures, calling into question the wisdom of relying on market forces in caring for patients' needs in urban areas.

For-profit hospitals were more likely to close their ERs than not-for-profit and government hospitals, and closed hospitals were twice as likely to be in the lowest quartile of profit margins. The probability of a hospital ER remaining open was 50% for for-profit hospitals vs. 75% for non-profit or government hospitals, and 50% for hospitals in the lowest quartile profit margin vs. 75% for those in the other three quartiles. This suggests that, to keep an emergency department open, a hospital should either be (1) profitable or (2) run as a non-profit/government facility. In areas with high percentages of uninsured and poor patients, option 1 may not be viable. This certainly seems to have been the case at Mid City. Realistically, based on the pattern across the United States, hospitals serving the demographic that Mid City did cannot rely on profits to fund their ERs; if they are not provided with other funding, they will be at risk of closing.

"Realistically, based on the pattern across the United States, hospitals serving the demographic that Mid-City did cannot rely on profits to fund their ERs; if they are not provided with other funding, they will be at risk of closing."

The roots of the problem date back to 1986, when the Emergency Medical Treatment and Labor Act (EMTALA) was passed as an unfunded mandate. This law requires emergency departments to screen and stabilize all patients, regardless of their insurance status or ability to pay. The problem is, without putting into place any structure to compensate emergency departments for treating patients who can not pay, EMTALA put the burden of paying for uncompensated treatment solely on the shoulders of hospitals.

Over half of all emergency care goes uncompensated, a staggering amount made worse by the fact that it is unevenly distributed. While those hospitals with mainly insured patients can absorb the cost of uncompensated treatment as an operating expense, hospitals treating

c. 1050 BC

Esagil-kin-apli pens the Diagnostic Handbook, a Babylonian medical textbook that utilizes diagnostic techniques along with observation of symptoms when treating illness.

c. 300 BC

Greek physician Hippocrates promotes observation and the use of the senses in making diagnoses, but also conducts diagnostic tests on urine, sometimes by tasting it. He believes that disease is related to imbalances in the body's fluids or humors.

largely poor and uninsured patient populations face hurdles that can be insurmountable. If they cannot obtain the resources they need to keep their emergency departments open, they must close, leading to the supreme irony that a law designed to assure access to care for everyone ends up doing the exact opposite: poor patients are facing ever more limited access to emergency care.

Researchers are just now beginning to analyze the consequences of ER closures on the wider community. In a 2014 report in *Health Affairs*, Liu and colleagues conducted an analysis of the effect of emergency department closures in California on inpatient mortality at nearby hospitals. They point out that emergency departments are under increasing strain: between 1996 and 2009, the number of ER visits in the U.S. increased by 51 percent, from 90.3 million to 136.1 million. During the same period, the number of ERs decreased by 6 percent. This has resulted in overcrowding, long wait times, and strained resources, leaving hospitals with little capacity to take on yet more patients when a nearby ER closes. Liu et al. found that patients admitted to hospitals in the vicinity of a closed ER experienced a 5% greater risk of inpatient mortality than patients admitted to hospitals not near a closed ER. The adverse association persisted even when they limited the time frame to within two years of the ER closure. This sobering finding suggests a ripple effect that goes far beyond the inconvenience of patients having to go farther or wait longer for emergency care, as daunting as that can be when in fragile condition. ER closures significantly affect the quality of care at nearby hospitals, and therefore impact the wider community, not just their own patients.

BETWEEN 1996 AND 2009, THE NUMBER OF ER VISITS IN THE U.S. INCREASED BY 51 PERCENT

In the case of Baton Rouge, these ripple effects are slated to grow even stronger next year, when the billions in federal cuts to charity hospitals go through. That alone is reason for pause and careful deliberation when considering closure in any city. Perhaps it is time to rethink the paradigm of emergency care as a patchwork system that relies on individual hospitals to work out how to compensate for their ER losses. A paradigm based on the reality of emergency care would consider all patients in need, all revenues that patients and insurance (private and government) generate, and how to divide up the responsibility for making up the difference between the two. At its root, this would mean moving the responsibility for funding uncompensated care from individual hospitals to the community at large, including hospitals in more affluent areas and taxpayers. Without such a paradigm shift, the hospitals charged with serving the most difficult populations will continue to bend, and break, under the pressure. ■

c. 100 BC

The ancient Chinese text, Yellow Emperor's Inner Canon, explains how to make diagnoses based on the relation between humans, their environment, and the cosmos, on the contents of the body, on human vitality and pathology, and on the symptoms of illness. Diagnostic techniques include inspection, listening, smelling, inquiry, palpation.

Galen believes all disease can be identified through a system that ties Hippocrates' humors to the four elements (earth, air, fire, water). Diagnosis entails working out which area is out of balance.

c. 180 AD