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ORIGINAL PAPER

Impact of the Closure of a Large Urban Medical Center: A Qualitative Assessment (Part I)

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Abstract This community health needs assessment—the first part of a mixed-methods project—sought to qualitatively examine the impact of the closure of St. Vincent's Catholic Medical Center, a large not-for-profit hospital in NYC, on individuals who used its services. Key informant interviews with organizational leaders and focus groups with residents were conducted to understand hospital utilization, unmet health care needs, health care utilization and experiences post closure, perceptions of the most significant effect of the closing, and recommendations for improving health care in the community. Most respondents spoke positively of the hospital's accessibility, comprehensive, high-quality services, and its close relationship with the community. Conversely, experiences post-closure were largely negative, including decreased access, interrupted care, and loss of emergency and specialty care. Lack of information concerning medical records reflected a larger problem of poor planning and community outreach. Another issue was widespread anxiety in a community now lacking a hospital. Further, while the hospital's closure might cause inconveniences, these effects were described as more daunting to vulnerable groups. Our findings provide a consistent picture of a hospital highly regarded by residents, patients, and leaders of several health and social services organizations. Regardless of whether it should have been permitted to close (as raised by many respondents), the lack of advance planning and outreach to community members and patients remains a major criticism. Coordinated efforts to provide the community with information about health and social services in the area will respond to a clear need while reducing some of the complexity encountered with utilizing local health care services.

Keywords Hospital closure · Community health · Access to care · Vulnerable groups · Qualitative methods

Introduction

After 160 years of providing health care services, St. Vincent's Catholic Medical Center (St. Vincent's) in lower Manhattan, New York City (NYC), closed on April 30, 2010. This resulted in the loss of an emergency room, in-patient hospital facilities, a Level 1 trauma center, several outpatient clinical services, and capacity to address a widespread public health emergency such as a natural disaster or act of terrorism [1, 2]. While health services are available in alternative settings, questions remain as to the gap in health care faced by this community and the entire Lower West Side of Manhattan. Through the efforts of various elected officials' offices and Community Boards, a Steering Committee (SC) was formed in fall 2010 to address these concerns. This paper describes findings from a community health needs assessment undertaken to understand the impact of the closure of St. Vincent's.

Hospital closures have a significant impact on communities. Of the few studies that assessed the impact of the closure of urban hospitals or trauma centers, researchers have found an association between closures (and resulting increases in distance to the nearest hospital) and increases

Human Subjects: This study (Protocol #10-10-295-4471) was approved by the CUNY School of Public Health at Hunter College Institutional Review Board on November 1, 2010.

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in deaths from heart attacks and unintentional injuries and other negative patient outcomes [3, 4]. Additionally, a study of hospitals in Los Angeles County found an association between hospital closures and initial surges in emergency department (ED) crowding and ambulance diversions [5]. Potential overcrowding of area hospitals as a result of another hospital closure may increase workload of hospital staff, cause fatigue and thus compromise quality of care [6, 7]. A recent study of the impact of the closure of St. Vincent's among remaining area hospitals reported patient surges of 10–30% in the ED, causing a variety of challenges, including difficulties maintaining patient privacy, increased workload and decreased staff morale [8]. Another study examining the impact of the closing of a safety-net hospital on primary care physicians also highlighted the strain and burden felt by the local and regional system and poorer patient health outcomes due to challenges navigating the system [9]. For vulnerable populations, such as individuals with severe mental illness, the impact may be greater, as they have greater reliance on ED services and experience increased lengths of stays in EDs, when compared to the general population [10].

Our study sought to understand the impact of the closure of St. Vincent's on the community, and in particular, on former users of St. Vincent's, from both the individual and organizational perspectives approximately 1 year after the hospital closed. An understanding of how the community perceived and utilized St. Vincent's when it was open, and the impact of its closing on access to healthcare, may inform better community outreach and engagement in the event of other hospital closures.

Methods

This study utilized a mixed-methods approach. We first collected qualitative data through key informant interviews (KII) with organizational and community leaders, and focus groups (FG) with community residents and other users of area health-related services, to achieve an in-depth, more contextualized understanding of how the community was experiencing the closing of St. Vincent's. A subsequent quantitative survey was conducted and is reported separately (see accompanying article [11]).

We followed a community-based participatory approach in collaborating with the SC, which included representatives from residents' groups, health care providers, elected officials, and advocates for people with special needs (e.g., HIV/AIDS, seniors, people with disabilities, mental health and substance abuse problems). From the outset, guidance was sought from SC members regarding problem definition, data collection methodologies and instruments, data sources, and dissemination/sampling strategy. Ultimately, the research process benefitted from the knowledge and expertise of the SC. The research plan was approved by the SC prior to submission to and approval by the Hunter College Institutional Review Board.

Sample

The definition of "community" was informed by previous analyses (which specified zip codes surrounding St. Vincent's, referred to as the Primary Service Area [PSA], Secondary Service Area-I [SSA-I], and Secondary Service Area-II [SSA-II]), as well as by SC members who advocated for consideration of those who might not live within these areas but used St. Vincent's services. As such, our sources include individuals who reside within and outside of the primary and secondary service areas. Key informants and focus group participants were from organizations and/or associated with the following populations/groups: underserved, underinsured and uninsured, individuals and families seeking behavioral health services, low- and moderate-income individuals, individuals living with a disability, individuals directly or indirectly affected by HIV/AIDS, and families and individuals of all ages and backgrounds seeking a variety of social and health services.

Data Collection Instruments

Through information gathering via SC meetings, document review, and SC members' suggestions, we developed draft key informant and focus group interview guides. Through an iterative process, all feedback was considered, reconciled and incorporated into final versions approved by the SC. Both the semi-structured interview guide and focus group topic guide covered: perception of health care utilization in the community, access to and quality of health/mental health services, health needs and service gaps before and after the closing of St. Vincent's, most significant effect of the closing, and recommendations to improve health care.

Key Informant Interviews (KIIs)

SC members recommended individuals for KIIs, which obtained information from leaders at community-based organizations (CBO) that serve individuals with specific health needs and/or provide health care-related services. Six KIIs were conducted, each involving between one and three respondents. A seventh "hybrid" group interview comprised of six health care providers was also conducted. All individuals approached agreed to participate, for a total of 16 interviewees. The interviews lasted approximately 1 h and were conducted at the interviewee's office location or at our offices. All but one interview was permitted to be

digitally recorded allowing for verbatim transcription for analysis. The researchers relied on detailed notes taken during the course of the remaining interview.

Focus Groups (FGs)

While the KIIs provided an organizational perspective of the impact of the hospital closure on specific groups, the focus groups (FG) obtained information directly from individuals who personally experienced the closing. Conducting the KIIs before the FGs allowed for further identification of relevant populations and issues that could then be examined with individuals directly affected by the closure. Participants were selected in collaboration with SC members and other community partners. Six FGs were conducted with residents and/or users of community-based health-care services. Standard FG procedures were employed, including description of the research purpose and informed consent; distribution of a brief questionnaire to collect anonymous demographic information; and a moderated group discussion [12]. The FGs were conducted at various CBO sites to facilitate the participation of residents and other users of their services. Our partners recruited 8–10 individuals who were at least 18 years of age, represented their client population, and had previously utilized services at St. Vincent's. Participants received $20 each for their time. The FG discussions were digitally recorded and lasted between 1 and 1.5 h, with an average of seven participants per FG. Notes taken during the discussions were used to assist transcription and guide data analysis.

Analytic Approach

We reviewed all transcripts to identify salient themes, including concordant and discordant experiences before and after the hospital closed. The field research team (DR, AK, JS) participated in all data collection and related activities (i.e., conduct of interviews and focus groups, note-taking, transcription). Transcripts were independently coded by two researchers. Meetings were held to review the meanings attributed to the codes (validity) and ensure consistency across researchers (inter-rater reliability). A similar process was followed for the interpretation of results.

Results

The sample consisted of 60 individuals: 44 focus group participants and 16 key informants. Table 1 describes the demographic characteristics of the FG participants as well as their likelihood of seeking care at St. Vincent's

Table 1 Demographic variables and utilization/importance of St. Vincent's among focus group (FG) participants

Demographic variable	%
Age (mean)	55 years Range: 32–82 years
Gender	
Female	45.0
Male	55.0
Race*	
African-American/Black	46.0
White	42.0
American Indian/Alaskan Native	2.0
Native Hawaiian/Pacific Islander	2.0
Other	10.0
Hispanic/Latino	
Yes	30.3
No	69.7
Primary language*	
English	88.0
Spanish	18.0
Educational attainment	
Less than high school	22.5
High school diploma/GED	22.5
Some college/2 year diploma	30.0
College diploma/bachelors	15.0
Some graduate school or graduate degree	10.0
How long lived in current home (mean)	18.2 years Range: 2 months–51 years
Employment status	
Full-time	10.0
Part-time/per diem	10.0
Retired	20.0
Unemployed	40.0
Unable to work	20.0
Service area	
Primary service area	55.0
SSA-I	2.0
Other	43.0
Likelihood of seeking health care at St. Vincent's, compared to another provider	
Very likely	82.5
Likely	15.0
Very unlikely	2.5
Importance of St. Vincent's when it was open	
Very important or important	100

* Percents may sum to greater than 100 since more than 1 racial group and language could be selected

compared to another provider, and the degree to which St. Vincent's was important to them. The following results report the combined data from the key informant interviews ("informant") and focus groups ("participants"), organized under the five main categories of questions.

Utilization and Perceptions of St. Vincent's Pre-Closure

Informants and participants discussed their relationship with St. Vincent's, including experiences with the hospital and their perception of the quality of services rendered. Almost across the board, participants spoke highly of St. Vincent's with regard to its environment (e.g., "comforting," "homey," "personal"), its relationship with community-based organizations (e.g., "very helpful with our client population," "cooperative"), and the high level of expertise in medical care and treatment (e.g., HIV/AIDS, gerontology). This was in contrast to descriptions of other area hospitals, which included "more impersonal," "large," and "difficult to navigate." While several participants from one FG expressed some dissatisfaction with the hospital, this was a minority opinion. The themes that emerged included: access; local, comprehensive services; relationship with the community; and, quality of care.

Accessible Health Care for All

There was a strong sentiment that St. Vincent's was thoroughly committed to making their facilities and medical services available to all. This "accessibility" was referred to in several ways, including location, accessibility for people with disabilities, and ability to pay. Having a large academic medical center in close proximity meant residents could obtain timely access to care. For example, one informant discussed how the elderly may experience chronic pain or other low-level symptoms of more major conditions which might not warrant emergency ambulance transportation. However, having their provider nearby meant they could more easily seek services and possibly avoid negative health outcomes associated with delaying care.

> [Regarding] the elderly, why don't they call 911?…those operators are sort of single-track… 'Well, is this an emergency?' 'Well, it's not an emergency really but I've been having nagging pain in my left side of my chest but I wouldn't call it an emergency.' 'Well, if it's not an emergency, I'm not really programmed to send…' [So] that's the end of that. [Yet, if the hospital was still open]…to the perception of the elderly, it's not in 'Europe.' It's not somewhere downtown in that welter. It's one stop on the 7th Avenue line. Or it's $5 or $6 in a cab, you know? It's that building that we passed for so many years. It's our neighborhood hospital. And in New York City, a neighborhood is huge. (600 FG)

The local presence of the hospital also engendered a sense of security. The knowledge that St. Vincent's was in the neighborhood was extremely comforting and reassuring to people, particularly in emergency cases—many residents shared personal or familial accounts of asthmatic or heart attacks, accidental overdoses, being hit by a car, and the positive outcomes that they attributed to being in such close proximity to a hospital.

Another aspect of accessibility at St. Vincent's pertained to individuals with special physical and other needs, such as the existence of wide doors, adjustable exam tables, and availability of information in languages other than English, including American Sign Language and Braille. Such accessibility especially benefitted the disabled and elderly, who found the hospital to be particularly manageable. Experiences were described which illustrated how hospitals tend to be in greater compliance with regulations concerning accessibility for people with disabilities, and are therefore superior to less accessible, albeit local, ambulatory settings. Other groups such as patients with HIV/AIDS and the cognitively impaired also found St. Vincent's to be a more manageable health care facility compared to private physicians' offices. As stated by one informant:

> For people with psychiatric disabilities, St Vincent's played a really vital role. We would often be working with people with severe psychiatric disabilities who would come here in a crisis, and not be able to, on their own, access assistance…We would walk somebody over, because we knew that with the urgent care for psychiatric needs, with the clinics that they had, somebody would be seen…within a much more reasonable amount of time. (100 KII)

Numerous participants also referred to the "welcoming" environment of St. Vincent's, in that they found the medical center to sincerely accept all people, regardless of background or ability to pay. The patient perspective of a local resident that was representative of many was that "they took care of you, even if you didn't have any paperwork." (300 FG)

> Going to the doctor is put off now…being a carpenter between jobs you don't have coverage. And if you go to a new physician they want you to fill out your life history and then you get to the point you don't have coverage…[and] you're like in between. You made too much, you don't even make the hours for coverage, you're gonna end up paying and you just say well I'm not gonna go to the doctor. In 'St. Vincent's

day' we could have went there and talked about it [the payment] later. (300 FG)

This view was matched by that of health care providers who worked at the hospital: "So St. Vincent's—both ER and hospital—in fact never turned patients away. Basically invited with open arms all patients: indigent, uninsured, illegal, Medicaid, etc., drug user, alcohol, whatever." (700 FG) This type of service was unparalleled, according to several informants and participants, and has been part of the mission since its inception [13].

Local, Comprehensive Health Care Services

The notion of "one roof" or "one-stop shopping" was repeatedly emphasized among the majority of informants and participants. Many of the residents received multiple services at St. Vincent's—mental health services, care for arthritis, asthma, diabetes, etc. Thus, the closing of the hospital meant a loss of *all* of their doctors, simultaneously.

I was a St. Vincent's patient…going there helped me out a lot because I'm a sick person with many, many types of illness. I have pain management [that] I was going for at St. Vincent's. I was going for depression. I was going for my arthritis, my asthma. And them not being there is trouble for me to get to where I need to go, to find somewhere that was perfect or good, that I'm happy with. And it's hard because my doctors were all at St. Vincent's. (300 FG)

Many informants also stressed the level of expertise found at St. Vincent's, with one informant stating that no one hospital has the same specialty levels that it had. According to an informant, St. Vincent's was known for its experience in the treatment of people living with HIV/AIDS and offered quality comprehensive HIV/AIDS care through their inpatient and outpatient services. Further, they had expertise not just in HIV/AIDS but also in the dozens of related secondary illnesses—"they knew what to do with it all…as they saw new and emerging issues, they became experts in them." (400 KII).

Close Relationship with the Community

The frequently expressed message from all but one FG was that individuals had developed close, positive, family-like relationships with St. Vincent's hospital and staff. Most described a friendly environment where they personally knew their providers, which gave them a sense of security when seeking services at the hospital.

All I know is, every time I used to go to St. Vincent they used to treat me with love. They care about you. They know that you was there and they wanted to help you. You know, that's one thing I always look upon them, just that love and that care that they used to give us…I used to say "Wow, I'm already healing." There was a lot of love there. (300 FG)

The few FG participants who did not express the same level of closeness and dependence on the hospital were disproportionately from other parts of NYC. By contrast, according to one key informant, the "relationship" with St. Vincent's that so many from the community spoke of seemed to enhance their connection with other primary-care health services:

So, as much as people think a hospital is only for emergency services, it creates a relationship with communities [that] then broadens [their use of other] health facilities where they're seeing a doctor once a month for [their] sugar or anything. (300 KII)

We also found that St. Vincent's had strong, positive relationships with other health and social services organizations. One informant of a multi-service organization spoke about the informal and formal ties the organization had with St. Vincent's, and the importance of this relationship for referrals, especially for seniors. Geographically, it was very easy to bring clients to the hospital, which also made for more accessible follow-up care and greater ability for friends and family to visit in the case of hospitalizations.

[If] somebody came here and they were running fever and they looked bad, we would literally walk somebody to St. Vincent's. We would have case worker take them in…sit with them until…they would get seen by their doctor, they would get admitted, they would get treated; we would be able to follow them very easily. They would get outpatient appointments, we would follow up with them…and all of that could happen because [several] blocks away is not a sacrifice for us to get to. (400 KII)

This was in contrast to a case worker having to travel, for example, to a community hospital in the Bronx or Brooklyn. In that scenario, getting someone into a new system with a new doctor at a new hospital is much more challenging for both patient and case worker (400 KII).

Another aspect of community relations that was referenced was the community medicine focus and hospital "mission." The Department of Community Medicine at St. Vincent's was cited as a key draw for health care providers when deciding where to do their residency training and subsequent primary care practice. One provider's statement captured the sentiments of several:

Its focus is on clinical care and reaching out to underserved communities in a pragmatic and genuine

way. Rather than some other institutions' departments of community medicine that are more interested in teaching people how to do epidemiologic studies (of course an important foundation to how we deliver care). But the roll-up-your-sleeves and go to the men's shelter, you know, go to the Chelsea Clinic and deal with that, with who you're going meet there, that's something that is…I haven't [found] anywhere. (700 FG)

Quality of Care

Popular opinion regarding the quality of services at St. Vincent's was that the medical center offered superior care with excellent outcomes. There were numerous stories of patients who had successfully recovered from major surgeries and emergency medical situations. Some FG participants utilized St. Vincent's for multiple generations and literally credited the medical center with extending or saving their or a family member's life. Many also spoke of strong patient advocate services that would take care of most patient care issues. The consensus was that the staff was caring, with frequent comments like "they really listened to me" and "handled me great." From two seniors and long-term residents of the community:

I used to belong to St. Vincent's Hospital for a long, long time since I lived around here. I had a few operations over there and I really miss the hospital. And I need it so badly. (600 FG)

I can only say, whenever I've had to be at St. Vincent's, I was taken care of and I mean, they followed up and I had no problems. (600 FG)

In several areas it was also regarded as a leader in the field, as conveyed by an executive at a health and social services organization:

But, St. Vincent's was the HIV hospital. It was the AIDS hospital in New York. And I'm not talking the Village, I'm not talking about Manhattan, I'm not talking about lower Manhattan, I'm not talking about the West Side. I'm not talking about the East Side. I'm talking about New York City! (400 KII)

Although a minority opinion overall, over half of the participants in a FG consisting mainly of gay men with HIV expressed negative views toward St. Vincent's. Some cited long lines and excessive overcrowding going back decades. According to one participant, such experiences "kind of rubbed me a wrong way and [I] wanted to leave St. Vincent's." One referred to medical errors and lack of privacy. Others did not like the complexity of St. Vincent's and, instead, sought medical care at smaller, more intimate clinical settings. They felt that St. Vincent's was "overpopulated" and only utilized the hospital in emergency situations. There was a general feeling that by the time the hospital was almost closed, the staff "couldn't care less" about the patients, with one participant stating "they were going downhill a long time before they finally closed." Several felt that hospital staff members were more concerned with their employment prospects than the quality of patient care at that point.

Unmet Health Care Needs in the Community: Pre-Closure

Regarding unmet health care needs, across FGs and KIIs the sentiment was fairly consistent—respondents were hard-pressed to identify any unmet health care needs or barriers to accessing care at St. Vincent's. According to an executive of one multi-faceted health and social services organization:

I don't think there were any. We had excellent relations with St. Vincent's; I really don't think there were any barriers. They were always extremely cooperative and very helpful, and with our client population…our HIV population, we're talking about a lot of people with drug addiction issues and they were excellent, they were just really very good. (600 KII)

Although several health care providers indicated that St. Vincent's did not have 24-hour MRI scan or EEG availability, that was not considered to be of great concern. As stated by one provider:

I think all medical needs were met and met very well, with the exception of really tertiary and quaternary care. So we didn't do kidney transplants and heart transplants…nor should we have done them. But, you know, there were the incredibly really good things and critical care comes right to the top. I can't think of any form of medical service that was not adequately provided there. (700 FG)

Health Care Utilization and Related Experiences Post-Closure

The closure of St. Vincent's was almost unanimously reported as a very negative and detrimental event. The vast majority of those interviewed felt they lost a close-proximity provider capable of accommodating the many health care needs of the community. Some expressed initial panic and a "state of shock" over the closing while others used words such as "fearful" and "scared" in describing the uncertainty of seeking services and finding new providers at new locations and the difficulty of navigating the health

care system. The main trends that emerged included: decreased access and continuity of care; lost specialty care and medical records; lack of planning; and, widespread anxiety.

Decreased Access to and Continuity of Care

Within this theme, three sub-themes emerged, including lack of information, location of alternative facilities, and over-capacity and poor quality at other health care facilities. With regard to information, or lack thereof, participants' reports of success or difficulty accessing health care in the wake of the closure was to some extent correlated with whether they received information about alternative health care services. Some reported receiving mailings from *Continuum Health Partners*, their own health insurer, their private doctor or information from the hospital about their medical records. But many reported not receiving notice as to where their physician was relocating and/or the appropriate hospital to go to. One informant stated, "There really is no information going out there on what to do. We got more information on how to fight for a hospital than what to do [to get health care]." (300 KII)

Overall, there was wide variation among participants regarding the amount of information they received in preparation for the closing. These comments substantiated several key informants' fears that the burden and difficulties of finding a new provider could, in turn, cause a lapse in care for many individuals. Several respondents described scenarios highlighting the limbo in health care that many people currently find themselves. One informant said, "People whose care is disrupted, it can take a long time to get it all in place again. So there may be a hiatus in care."

> So, it's just going to deteriorate their health conditions…diabetes, for example…if you're not seeing your doctor any more, it's going to affect you in all kind of ways. And I know for a fact, even myself…I just recently started going back to the doctor to get medication and to see how I was doing. I know the other ones…they're just not really taking mind to their health because of the closure of the hospital. It's like a child…you get used to something and then when it's not there no more…you don't know what to do. (300 KII)

A FG discussion with several lower-income residents from the community revealed a strong connection between lack of information concerning access to medical records, whereabouts of previous doctors, process for obtaining new doctors, and difficulty maintaining continuity of care.

> Well right now I've been sick for over three months and I still haven't got to a doctor because I was always with St. Vincent's. I have high blood pressure…this really bad cough…allergies. And I still haven't seen a doctor…because St. Vincent's was so close. It's easier for me to get there. I don't wanna see another doctor. I wanna see the doctor that was in there. (300 FG)

Another example involves a woman with a history of depression who described feeling hopeless when the hospital closed. She was currently in need of mental health services but still hadn't found a psychiatrist. According to her husband, "she wants her old psychiatrist, Dr. [X]." Coincidentally, another FG participant asked, "You can't find Dr. [X]? He's in [X hospital]!" (300 FG) This instance of "information discovery" between participants was not unique to this group and reiterated the situation of confusion and inconsistent information among many who relied on health care services from St. Vincent's. Further, this was the situation almost 1 year after the hospital closed.

Several CBO leaders also spoke of their own uncertainty regarding whether patients were able to access care post closure. One informant who expected an increase in enrollment in their mental health programs said that the organization actually hired former St. Vincent's staff with this in mind. Yet, the increase was not as high as expected. The informant stated, "This begs the question of where did these patients go? Are their needs being met elsewhere–or are they not accessing treatment?" (600 KII) Some organizations have gone to great lengths to ensure continuity of care for their clients, such as increasing case management efforts. However, this is more challenging with populations such as those in drug treatment, as these clients tend to be less consistent with their care and thus less likely to have been steadily followed by a physician or other health care provider.

There was also substantial evidence that the lack of a nearby hospital influenced perceived access to services, especially in more vulnerable individuals. Seniors, persons with disabilities, and lower-income individuals spoke of great reliance on the hospital and, consequently, reported more difficulty accessing care after the hospital closed. These individuals now had to either travel farther to find another hospital or obtain services in more private practice, ambulatory settings which may not be as accessible as a large medical center.

Additionally, those who knew their physician's new location said it was further away and/or required a greater expense (e.g., cab fare). Such changes often resulted in a break of a long-term doctor-patient relationship with providers affiliated with St. Vincent's.

> I think it has had a serious effect on our seniors because if you're a senior and you're living in the Village and you need to be hospitalized, and it's an

> emergency situation, you have to go quite some distance. The ambulances have to take you [a greater] distance… that's a serious gap I believe. (600 KII)

Proximity was also noted as important for visiting hospitalized family and friends or, for example, finding someone "in a pinch" to take care of children if one has to go to the hospital.

> One of my concerns as far as not having St. Vincent's is…God forbid, something should happen to me, ok? And I'm hospitalized for a long period of time. You know, how are your friends or family going to know where or how to come to see you if necessary? Or bring you anything that's necessary or go speak to your doctors or medical staff if necessary…? (100 FG)

Finally, there were several references to over-crowding and long waits at health care facilities that individuals had turned to since the hospital closed. A key informant spoke of how, for example, a specific ambulatory care health facility was making efforts to accommodate displaced St. Vincent's patients but was already beyond capacity with months-long waits for an appointment. This was confirmed by a FG participant who spoke about confusion regarding other health care facilities. He was told that a local community health center was an urgent care center that could take on additional patients. However, when he tried to go, he learned he needed an appointment and that the earliest was in 6 months. This was compounded by the experience of misinformation described by a FG participant as to how prior to the hospital's closing residents were told that area health clinics received additional funding and then were *not* going to provide emergency care:

> …they had come to our meetings when St. Vincent's was closing… and said this is where you could come. They were funded millions of dollars to help. And we told all our tenants, 'this is where you go because it's right across the street.' Well, I went in and I discussed it with them and we had meetings, we had people that came and told us this and they said it's not true. You're not going to be helped in that type of facility. It has to be an appointment. (300 FG)

Another example came from a health care provider who described obtaining emergency care for a knife-cut in the hand 3 weeks post closure.

> [I] go to [a local hospital]. Mobbed. I think I need stitches…[so I] go over to [an urgent care center] on 23rd street…the place is packed. On top of that, I happened to be there after eight o'clock at night which is the change of shift. After eight…there's a physician assistant and an LPN. The physician assistant…looks at me and says 'Wow, you're really bleeding there.' And I got the pressure dropping and he says, 'Isn't that freaking you out a little bit?' So I said, just give me like a couple stitches. 'Oh no it's after eight o'clock at night. We don't do stitches…but I can give you Dermabond®.' I went up to [another hospital] at 4 in the morning to get eight stitches in my finger. (700 FG)

A local health care provider described another patient's experience, 1 year post closure.

> She cuts her finger…goes to the [area] emergency room. She's there 6-7 h, some ridiculous time. She says the place was disgusting; there was no privacy. It was outrageous. And the doctor that took care of her said, 'This is like practicing Third World medicine.' (700 FG)

Another recent patient experience described by a provider points to similar concerns regarding time to receipt of care and nature of the service. In this case, the doctor sent his/her patient from the Mt. Sinai HIV Center (formerly St. Vincent's) to a local ER after speaking with an ER doctor and providing all patient information electronically. The ER doctor never followed up with the referring doctor regarding the patient's status. The patient's blood work came back positive yet the ER did not know the patient's whereabouts. The referring doctor ultimately located the patient, who had decided against being admitted because it took 9 h to first be seen by a physician and was likely going to take another 12 h before getting a bed.

Providers at different area hospitals spoke directly to the issue of over-crowding from an institutional perspective. In one case, responding to a "Code Red"—or being over-capacity—was described as an almost daily event requiring discharge of patients to make room for new admissions. The appearance of overcrowding in one hospital emergency room was minimized "because they've knocked out the walls into the clinics and the minute you step in there you're immediately triaged to a nurse behind the wall [who] takes all the information." (700 FG) Similarly, another hospital "expanded the size of the emergency room; the occupancy is about 110% all the time. And the residents are down in the emergency room…I was just on call this weekend…about a quarter of the emergency room were my new patients that I was going over with the residents." (700 FG)

Lost Local Specialty Care

Due to the complexity of finding specialists knowledgeable in certain conditions, there was concern over new providers not knowing how to care for specific health needs.

According to informants representing the disabled, removing hospital capacity for outpatient services essentially replaced accessible facilities with inaccessible ones. HIV patients were concerned with finding a new hospital that *specialized* in HIV services and associated secondary illnesses. For those with mental illness and chemical dependency, it meant the loss of trusted, capable therapists who knew their cases, a welcoming clinic nearby, and the uncertainty of finding care in unfamiliar locations. One participant accounted, "I've been in and out of therapy pretty much since I was a teenager. It took me, I don't know how many years to find a therapist that I clicked [with], and I'd been through a lot of them. I haven't seen a therapist since it closed." (100 FG)

Missing Medical Records

Knowledge about and experience with accessing medical records from the hospital varied for all respondents. For example, despite proactive efforts by the head of a health services provider in the community to coordinate access to medical records, this was not successful and they had to rely on paper copy transfers instead of electronic access. Though the paper copies were eventually received, delays proved to be problematic.

> And we, even to this day, are now getting medical records of patients that have been here several times, and we're just getting those medical records. But, and unfortunately what happens as a consequence is, our doctors are going to put patients through some diagnostic tests that may be unnecessary…if we had those medical records. (200 KII)

On the individual level, most FG participants were not always successful at locating their own records. Many said their new physicians still had no prior record of their medical history.

> …I have 8 people in my family…all the medical records were at St. Vincent's. It's very important to us to…know, where are our medical records, and what rights do we have to obtain them? We don't feel comfortable with them floating around…So because I don't know where they are and because I feel we're entitled to our privacy for whatever treatment we got and for whatever we went in there for, I'm concerned. (300 FG)

Another participant said she was told by her insurance company that another clinic had a significant portion of the medical records. Another said her family's records followed their physician so they have them all. Yet, when the entire group was polled, only 4 out of 12 people knew where their medical records were. The delay in getting one's medical records was associated with delays in getting health care and/or finding a doctor.

In a clear example of the uncoordinated provision of information that many informants and participants complained about, we observed first-hand as the minority of participants who had successfully obtained their medical records generously assisted fellow FG members. What was clear was that almost 1 year later there remained a lack of official, organized, consistent information regarding medical records and many were still trying to "figure it out."

Lack of Planning and Outreach

The commonly held view was that poor communication by the hospital left patients, community residents, and organizations displaced and without knowledge of where to seek replacement services or how to coordinate care. Some spoke of patients being auto-assigned to new providers by certain insurance companies. Others received letters notifying them of where to seek new services such as mental health care. However, the larger view was that this type of coordination was too sudden and not universally implemented which led to an increased case management burden for CBOs and increased confusion for individuals.

Many former St. Vincent's patients had received all of their multidimensional health needs in one location for an extended period of time. Therefore, even almost a full year after closing, there remained patients who had yet to find a new medical home.

> Patients were…felt displaced and that they had to individually figure out some new care arrangement or healthcare arrangement, and I think the information and the communication could have been handled so much better (not that this is a word)…in a "planful"[way]. And I just feel that there was a dearth of planning…there's a void, there just wasn't planning. (200 KII)
>
> …it's not so easy for that population to say, oh I've been coming to this clinic for the last few years, now let me just research and transition to this other one. (200 KII)

One FG provided insight to the range of experiences with planning (or lack thereof) around the hospital closure. A participant with mental health issues described receiving notice that the hospital was closing and instructions to call his/her insurance company to find alternative physicians; yet, this individual did not recall receiving a mailing from the provider that was taking over the St. Vincent's adult mental health clinic. The spouse of another individual in need of mental health services said that "they told her that they were moving elsewhere but they didn't like notify her [of] the address." Yet, another participant received

information about the closing and was recommended to seek health care services at a nearby clinic. According to this participant, "I go there. I'm happy with them. But it's not emergency care and that's what we really need here." (300 FG)

Widespread and Persistent Anxiety

A consistent theme from informants and participants was a very high level of anxiety with the lack of a hospital in the community in case of emergency. This included fear of not finding a good doctor (i.e., lack of information), feelings of anxiety and fear around seeking services at hospitals that are further away and with unknown quality of care. Of particular concern was HIV-related care, travel distances for seniors and persons with disabilities, and insurance/prescription coverage. Anxiety over having to wait a long time for an ambulance and possibly being hospitalized in an unfamiliar place with an unfamiliar system was expressed repeatedly. Ultimately, many respondents said the need for a hospital eventually comes ("it's just a matter of time") and now there isn't one close by.

> Well I'm just fearful of, if it comes to the point where I have to go to the hospital again and there is an element of choice, I don't know where I would go. I don't know which… If I were faced with being able to choose, I don't know which hospital to choose to go to. (500 FG)

Some voiced a "fear of rejection" associated with going to other hospitals. Prior experiences that were perceived as discriminatory—being treated like outsiders—created concern among some with regard to seeking future services. As one community resident said:

> Fear of rejection because these other hospitals have been overburdened with overcrowdedness and they don't want us and they make that clear…. All you gotta do is walk in there like my family has… and say 'Yeah, you know we from St. Vincent's.' That's all you gotta say. We see the whole attitude of the hospital staff there. (300 FG)

These sentiments were echoed by an executive at a local CBO:

> …it's regardless of where the patient is coming from, that's their medical home they're coming from. So they come with a sense of anxiety, and anxiousness…and it just makes a world of difference if someone says, here's a really good provider, they're a qualified provider, they're a good entity, they're going to take care of you. And patients felt like they were just left hanging and in a void. (200 KII)

Most Significant Effect/Impact of Closing of St. Vincent's

When asked to describe the most significant effect of the closing of the hospital on their clients, one informant referred to it as "splintered," in that no one hospital is doing it all, "so there's a splinter here and a splinter there, but the wood is shattered and if you touch it, you're going to get little pieces, but you're not going to get the whole." (400 KII) The informant further described that by losing St. Vincent's, the community was losing a nearby trusted hospital with comprehensive expertise in HIV/AIDS and all its subspecialty areas. Ultimately, St. Vincent's was highly regarded for its reliability in the community and acceptance of people of all race/ethnicities, sexualities, immigration statuses, insurance statuses, and financial situations. The main themes identified as the most significant effects of the closure were the loss of emergency services and accessible, comprehensive health care.

Loss of Emergency Services

Across the board there was a strong, universal feeling that it is now "very frightening" not to be able to go locally for emergency services. There was much anxiety over the uncertainty of where residents would be taken in the event of an emergency, and the quality of the care that would be received. This was compounded by anxiety concerning overcrowding at other emergency facilities, including an emergency psychiatric clinic.

Loss of Readily Available Access to Comprehensive Care

Many also cited the loss of an easily accessible all-in-one ("under one roof") source of care in close proximity as the most significant effect. The majority considered the hospital to be an exemplar of community access to the kind of comprehensive health services needed for myriad conditions. Upon closure, primary care, emergency services and specialty care were all suddenly disjoined and many have found the logistics of finding and seeing multiple providers in different locations very problematic. Replacing such nearby capacity with distant medical centers, unfamiliar settings, and potentially less accessible private practices has been experienced as a major disruption in health care. One of several FG participants who is visually impaired described the main impact of the hospital closure related to her health needs:

> I used to go there for my eye problem but…now that I have an asthmatic condition I would have needed a hospital more often…and would have liked to have a steady doctor to see—a pulmonary doctor or

whatever. And I think that's how it has impacted me, I have [had] to travel all over the place while I was not able to breathe. I had to run all over the place looking for a doctor instead of just going to St. Vincent's. (100 FG)

Key Recommendations for Improving Health Care in the Community

A final question asked of everyone was what their main recommendation would be to improve health care delivery and services in the community. Three main themes emerged: re-establishment of a hospital/emergency services; inventory of community health services; and, a less complex, more integrated health care system.

There was agreement from many informants and participants that the closing of St. Vincent's resulted in the need to increase community-based health services capacity. However, some recommended that an entirely new, full service hospital be established in the building space vacated by St. Vincent's. Others said that at least emergency services would fill some of the medical care vacuum created by the hospital closure and address some of the anxiety that many in the community are experiencing. The following comments from an elderly community resident and former St. Vincent's health care provider are illustrative of the priority given to a local hospital.

I wish they'd get more aggressive, not just by showing big hootenannies, but I wish they'd sent letters to Congress to have our hospital back…. You know we're not making it as big an issue as it should be…But we should have a hospital back in this neighborhood. I mean, we're bereft of a hospital (600 FG)

… when all is said and done we have this huge community with no hospital. There's no local health care anymore. There's local doctors… but the primary care doctors, a lot of the office-based consultants, have not left this community and they'd be in that hospital in a minute. (700 FG)

Many participants recommended the development of an inventory of all available health care services within the community. Such a directory would provide detailed information on services available, location, hours of operation, insurance plans accepted, fees, etc. This was suggested as a way to potentially serve community members as well as CBOs, facilitating these organizations' ability to make referrals and coordinate services.

…if there was some kind of repository or some kind of 'geographic information system' that identified what all the different community-based organizations are in the area…if there was some mechanism for us to have that information, I think it would go a long ways towards helping the service providers to meet those needs. (200 KII)

Another most cited recommendation was to reduce the overall complexity of the health care system. Some advocated for a single-payer system "that all doctors are part of, and the doctor and patient makes the decisions as to what care is going to be approved" (100 KII) while others wished that everyone would have access without the confusion of whether their health care provider is accepted by their insurance company. This more broad-based recommendation appeared to be indicative of the day-to-day health care realities that both individuals and community-based health services organizations face, as well as a recognition that the arrival of a St. Vincent's-like provider in the community was unlikely. Creation of an integrated, easily accessible medical system that helps to alleviate the challenges of navigating a complex healthcare system was strongly recommended by another informant:

"keep building a network, so that we have something for our clients without making [them] work so hard that they give up. And, figuring out what to do with that client who does have frequent hospitalization- in and out, in and out- and does have substance use or mental health issues, and making sure that it's all coordinated." (400 KII)

Ultimately, another organizational leader summed it up in that "Complexity…is the enemy of access to care and is an ever present feature for people with [special health care needs]." (100 KII)

Discussion and Conclusions

This community health needs assessment aimed to understand the impact of the closure of St. Vincent's via in-depth, qualitative data. Overall, the data from key informants and focus group participants were highly correlated. Respondents spoke positively of the hospital's accessibility, comprehensive, high-quality services, and the close relationship that it had with the community. In addition, few could identify any unmet health care needs while the hospital was open. Conversely, experiences since the closure were largely negative, including decreased access, interrupted care, and loss of emergency and specialty care, which appears to be associated with a year-long state of "limbo" and interrupted care described by many with chronic illnesses. Lack of information concerning their medical records was part of a larger problem of poor planning and outreach to the community.

A key cross-cutting issue was the concern for and potential impact of the hospital's closure on *vulnerable groups*. While the loss of a medical center might be expected to cause inconveniences (e.g., interrupted care, additional travel), these and other effects were described as more daunting to the elderly, individuals with multiple health problems and/or disabilities, and those with fewer resources, such as lower-income individuals. For example, for individuals living with disabilities, finding a provider with the appropriate expertise, in an accessible setting and in the community presents challenges that are several-fold greater than for people without these difficulties. Similarly, lower-income persons have fewer resources to successfully locate providers, support the additional time and travel when health facilities are further away, and to access multiple providers in different locations. It is not clear to what extent these vulnerable groups may have been disproportionately affected by the hospital closure.

Another issue consistently raised was anxiety associated with the unknown in the event of an emergency. This was influenced by negative experiences at other hospitals, not having been to a doctor recently for a chronic condition, as well as recollection of "close calls" when St. Vincent's was open. This anxiety also appeared to be related to other consequences of the hospital closure, including lack of information (attributed to poor planning and outreach), uncertainty regarding the whereabouts of patients' medical records, and loss of a long-term "member" of the community, given that so many respondents referred to St. Vincent's and the staff there as "family." Thus, in its absence, a keen sense of loss and anxiousness was expressed by most respondents.

In a noteworthy exception to the overall findings, several participants in one focus group stood out in comparison to the larger study sample in their less favorable depiction of the services they received at St. Vincent's. These participants were persons living with HIV/AIDS (PLWHA) who described dissatisfaction with their interpersonal relations with some St. Vincent's staff members and the large patient volume and complexity associated with receiving care there. As a result, they indicated that their medical providers and preferred hospitals were in various other areas of NYC, even if it required more effort on their part to receive regular care. Given the chronic health care needs of PLWHA and the fact that this group of respondents was connected to a CBO in the service of such clients, it was not surprising that they were more critical of the hospital and were less likely to rely on local services. Compared to other participants, they demonstrated a relatively high level of resourcefulness and agency in securing health services.

There are limitations and strengths associated with this study. The extensive amount of text-based data collected necessarily limits the total sample size of the study, thus no claims of the "representativeness" of this sample to the populations in the primary and secondary service areas surrounding St. Vincent's can be made. The rich, in-depth information gathered, however, provides insight into individuals' and groups' experiences with and perceptions of this dramatic event in a way that more population-based methods (e.g., surveys) do not. Further, our purposeful sampling strategy sought to include perspectives from community residents and other hospital constituents, as well as key health-related organizations that interfaced with the hospital. This permitted for analysis with data from the individual and organizational levels. With this research approach we are most concerned with achieving the point of saturation in data collection. In this way we can distinguish salient themes from those that are exceptional or discordant, with confidence that important issues were not missed.

From this study, it is clear that many organizations and individuals considered St. Vincent's to be more than just a hospital. It was highly regarded by residents, patients, and leaders of several health and social services organizations in the community. The main recommendations for improving health care in the community expressed by respondents were to re-establish hospital/emergency services, provide the community with a comprehensive inventory of available health care services, and strive for overall reduced complexity of health care systems. In our view, a coordinated effort to provide the community with specific information about physical health, mental health, and related social services in the area will respond to a clear need identified by various community stakeholders, while possibly reducing some of the complexity encountered with *local* health care services.

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