My Drift

Title: ERs & Hospitals in Crisis

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America's Emergency Rooms (ER) and Hospitals are in crisis!!

Please let me relate to you a story about a homeless alcoholic bouncing in and out of the ER. This is a true story told by the head ER doctor at a Providence, RI hospital.

The sun rose as the overnight shift at my emergency room came to an end. Mr. P had been with us all evening. He had arrived in an ambulance hours earlier after wandering into a homeless shelter, intoxicated. According to the information the ambulance staff delivered to us with Mr. P, he had been disruptive and argumentative at the shelter. According to Mr. P, the shelter staff members had been unreasonable, and he had just been minding his own business.

I performed a brief physical exam, describing in my notes a frail man, 56 years old and probably Caucasian, who had a thick gray beard and blue eyes dulled from alcohol, with subtle icterus (a yellowing of the eyes). His nose had been flattened from previous falls, and his skin was deeply sunburned, almost purple. The city's dirt had merged with his epithelial layer, giving it a rough, Velcro-like appearance.

He had unremarkable vital signs, with no new trauma and no specific medical complaints. He blew a 310 on the breathalyzer. The textbooks would tell us that at that level, Mr. P — whom I'm identifying only by his initial for privacy reasons — was in

serious danger of alcohol poisoning, but as we already knew, he lived at this rarefied level and stumbled and slurred only moderately.

From that point on, we both knew our roles. I would ignore him until the morning, and he would be given a sandwich and have the opportunity to sleep in a room with three other people in similar conditions. Before the development of our modern health-care system, churches and shelters would have provided similar services.

Mr. P

The next morning, Mr. P wanted to leave the ER — and so did I. I printed out his discharge papers, which included a list of detoxification centers, and watched as he tossed them into the trash. As he walked out, he said a pleasant goodbye to the security guards and nurses, calling them by their first names. We knew we would see him again later that day.

Providence, R.I., where I work, has adopted a medical response to public intoxication like Mr. P's that involves an ambulance ride and a stay at the hospital. State laws specifically mandate this policy. If he were in another state, Mr. P might be arrested and taken to jail for the same behavior. But if he were in the same condition behind closed doors, he would be neither a patient nor a criminal. How the care for patients such as Mr. P varies from community to community exposes the paradoxical policies and philosophies behind the way alcoholism and public intoxication is treated in the United States — if it is treated at all.

At times, I felt used by Mr. P. Last year, after we discharged him late one afternoon, he complained that we were not letting him spend the night. (Mr. P did not use our hospital's formal system for lodging complaints; instead he preferred the expletive-laden diatribe.) I explained to him that he was no longer intoxicated, and I had to discharge him. He promised that he would return later that night, drunker, and I'd be forced to keep him until the morning. He kept his word.

Mr. P's care in our ER had been routinized to a large extent. We would use a history and physical exam to screen him for acute medical and traumatic issues. Given how frequently he came to the ER, we did not routinely document his chronic liver disease, gastritis, poorly controlled seizures and chronic obstructive pulmonary disease, and blood work for these chronic conditions was not indicated.

Acute issues, such as when Mr. P fell, was assaulted or had low oxygen levels, required a more thorough work-up. We had ordered hundreds of computed tomography (CT) scans of his brain (almost always with normal results) and had often admitted him to the

hospital for pneumonia and other infections. But most often, his diagnosis was what we call uncomplicated intoxication, and our ER was there to ensure his safety when he could not.

Despite the challenges of caring for him, including his intoxicated outbursts, Mr. P had become beloved by most of our staff members. The nurses and technicians had spent hours dressing his wounds, caring for his hygiene, helping him to the bathroom and listening to his stories.

He could be remarkably kind when he was not too drunk. He often asked the nurses about their families. Occasionally he gave out hugs and thanked us earnestly for caring for him. He could also be deftly funny. Like alcohol, his humor was warm and soothing, blunting the sharp edges of his personality and alleviating our frustrations in caring for him.

We learned from him, too. Dark humor became our own preferred elixir to quell the unpleasantness of Mr. P's inevitable health trajectory and our complicity in it. When he left the ER, we often said to each other, "We'll see him later today, unless he dies." It was a fatalistic tonic for our guilt.

On days when Mr. P didn't show up at the ER, we were concerned. He had become our neighbor, a sort of distant relative, subject to the same sort of worry and gossip that we would bestow upon such people. Yet for all of our worrying, we repeatedly discharged Mr. P to the street in the morning, teetering on the edge of alcohol withdrawal, a condition that could worsen and lead to tremors, hallucinations, seizures or death. Luckily, the corner liquor store opened at 7 a.m.

When is someone like Mr. P no longer a patient? When his blood alcohol concentration is zero, or when it reaches the legal driving limit of 0.08 percent? When he can walk steadily? When he decides to leave? What if it is cold outside? What if someone shows up and wants to take him home?

The problem was that Mr. P was intoxicated all the time: His alcohol level never reached zero while he was in our care. And no one ever showed up to take him home. In routine practice, we considered the right time to discharge him to be the "sweet spot" after his period of significant intoxication ended and before withdrawal began. If we missed this sweet spot, we might have to admit him to the hospital for alcohol withdrawal. It was a paradox and a vicious cycle: Discharging Mr. P on the verge of alcohol withdrawal essentially guaranteed that he would start drinking immediately and would end up back in the ER later that day.

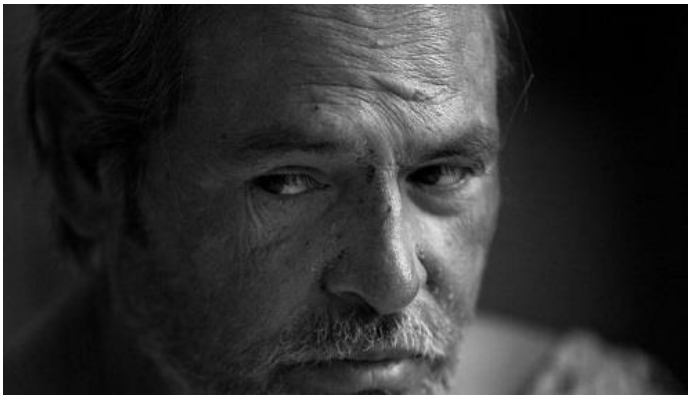
But what other options did we have? At 6:30 a.m., the answer was: Not many. In theory, there were alcohol detox programs that we could offer our patients. But these are small programs, run by community nonprofits, with a limited number of "state beds" for the uninsured. Additionally, the patient must be willing to enter the program. Mr. P had been offered detox countless times and never accepted it.

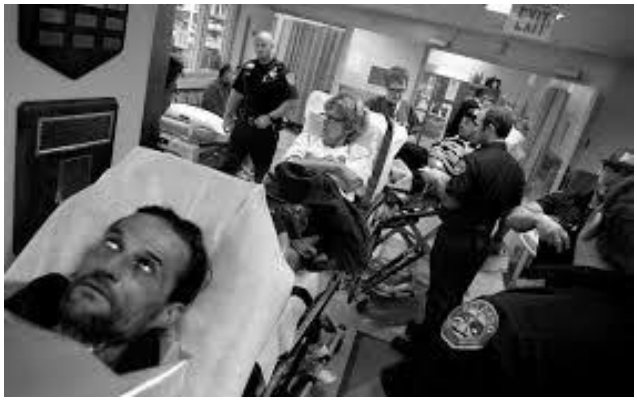
Police departments and jails were more than willing to punt homeless alcoholics back to the health-care system for treatment. Soon, many states were struggling to fund the large number of detox beds they needed. At the same time, private hospitals were generally not willing to admit patients for alcoholism.

Large detox programs funded by states or cities were replaced by ones run by smaller nonprofit community organizations. With Providence having no centralized detoxification program and a robust modern ER, it was no surprise that Mr. P wound up with my colleagues and me.

Mr. P died last autumn, having collapsed at a bus stop not long after being discharged from my ER. He was in cardiac arrest when help arrived, and he was brought to us, intoxicated and dead. It was unclear whether he had aspirated vomit into his lungs, had had a heart attack, or both. Rest in peace Mr. P.

Okay, that was a little long but I think by reading these stories you will have a better understanding of what is going on at almost every hospital ER in the United States. Here is a story about a former U.S. Marine named Raohl Hursh who lives on the streets of San Diego, CA.





Raohl Hursh sits up in his hospital bed in the intensive care unit at UCSD Medical Center-Hillcrest. Hursh was taken by ambulance in critical condition when an alcohol-related assault left him with bruising and bleeding in his brain. The month before, Hursh had been to the ICU with a similar injury, also alcohol-related. Hursh has used the emergency medical system at least 70 times since July 1, 2011

'Frequent fliers' strain emergency medical system in San Diego. With an ambulance gurney cradling his defeated body, Raohl Hursh sought peace with his past inside the frenzied emergency room of the UC San Diego Medical Center in Hillcrest. It was his 74th visit in six years, his 12th in a month, his second in four hours.

"I've already tried to kill myself," the former serviceman with a history of mental illness said, vodka-addled and occupying a room where a beehive of doctors and nurses would soon hover over a heart attack patient. "I've killed others. ... So, I'm being punished for all this. It hurts. It hurts."

Hursh is a frequent emergency services user, or as some emergency workers cynically call them, a "frequent flier" — a group of mostly homeless patients who use the 911 system and hospital emergency rooms in great disproportion to their small numbers.

Hursh is part of the top 1 percent of health care users nationwide who account for 22 percent of health costs, according to a federal health agency report released in January, which included the elderly and those with chronic illnesses. Repeated calls to 911 from patients like Hursh are among the most frustrating entry points to the medical system, and a burden to local taxpayers.

In San Diego, according to the city medical director's office, 1,136 frequent users are on course to use the EMS system at least six times this year, and to generate more than $20 million in ambulance and paramedic charges alone. They represent a minuscule eight-hundredths of a percent of the city's population yet account for more than 17 percent of paramedic and ambulance calls in the city.

Hospitals and emergency rooms are losing money and closing at an alarming rate. You might be wondering how hospitals could be losing money when the average cost per inpatient day is $2289. A week in the hospital could cost you more than $16,000. The average cost of a visit to the ER across the U.S. was $2,168. And on top of all this, the average cost for the Emergency Medical Services (EMS) ambulance to transport you to the hospital is a little over $1,000 dollars.

If hospital received all the money that was billed, there would be no problem. If all patients had high-option health insurance or Medicare, there would be less of a problem. Hospitals and medical providers, historically, received 90 percent of the reimbursement from insurers. However, for every patient dollar being billed, hospitals have failed to collect 65 cents.

Let's look at some hospital statistics for the years 2010 and 2016

Item	2010	2016
U.S. Population	309 Million	323 Million
Number of Hospitals	5,754	5,564
Number of Beds	942,000	897,961
Number of Admissions	36,915,331	35,061,292
Average Cost per inpatient Day	$2,025	$2,289
Average Cost of Hospital Stay	$9,700	$10,000
Aggregate Hospital Costs	$376 Billion	$382 Billion

In the past 10 years, the number of emergency department (ER) visits increased by 40%, but the number of ERs decreased by 27%. The closure of an ER can have a profound effect on a community because patients have to drive farther to obtain care, and the remaining ERs have to bear the extra patient volume.

Why in the world does our government allow this to happen? Well, for one thing, our government caused the problem and they don't seem to be in any hurry to correct the current conditions at the ERs and hospitals.

Are you familiar with The Emergency Medical Treatment and Active Labor Act (EMTALA) that was passed by our Federal Government in 1986?

Basically, this act says all U.S. hospital Emergency Rooms (ER) must provide an appropriate medical screening examination (MSE) to all individuals seeking treatment for a medical condition, regardless of age, race, religion, nationality, ethnicity, residence, citizenship, legal status, or ability to pay.

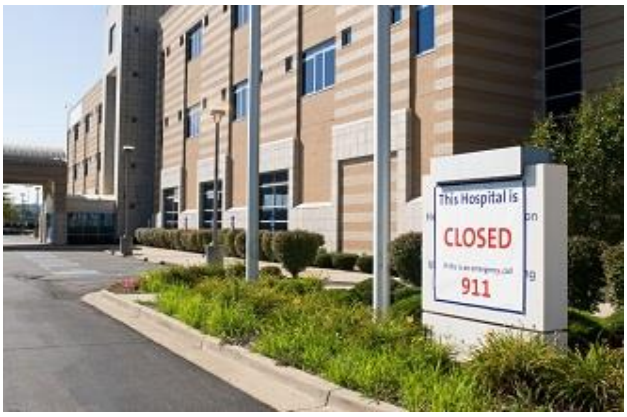
If the ER determines an individual has an emergency medical condition (EMC), the hospital must provide further treatment and examination until the EMC is resolved or stabilized and the patient is able to provide self-care following discharge, or if unable, can receive needed continual care. Inpatient care provided must be at an equal level for all patients, regardless of ability to pay. Hospitals may not discharge a patient prior to stabilization.

If the hospital does not have the capability to treat the condition, the hospital must make an "appropriate" transfer of the patient to another hospital with such capability. This includes a long-term care or rehabilitation facilities for patients unable to provide self-care. Hospitals with specialized capabilities must accept such transfers and may not

discharge a patient until the condition is resolved and the patient is able to provide self-care or is transferred to another facility.

This act has remained an unfunded mandate since 1986 (31 years at this writing) and means hospitals must "eat" much of these enormous costs for treating people who cannot pay. Either that or pass these costs on to insurance companies or to patients who can pay their bill. This is not always possible so the other option is to close the ER and/or the hospital. This is another example of our government not doing their job.

The number of ERs at U.S. hospitals has gone down by 27 percent in the past 10 years.



In California, hundreds of medical clinics and at least 84 hospitals have closed in past 5 years due mostly to unpaid bills by illegal immigrants.

After 85 years of serving patients in the islands, the Hawaii Medical Center announced it has closed its last remaining hospitals - Hawaii Medical Center East in Liliha and Hawaii Medical Center West in Ewa.

Wahiawa General Hospital is in danger of closing. The hospital has lost $9 million over the last three years. Built in 1944, Wahiawa General Hospital has served the people of Central Oahu and the North Shore for 72 years.

Here is the real problem

Illegal immigrants and most homeless people use America's emergency rooms and hospital services for every medical issue and pay nothing. Not a cent. Uninsured people in the U.S. have very few options when it comes to getting medical attention. However, the current system helps the uninsured but penalizes hardworking U.S. citizens who have insurance and pay their bills. It really penalizes the ERs and hospitals who are forced to treat everybody even if it means going out of business.

There are about 12 million unauthorized immigrants living in the United States. The state with the most illegal immigrants is California with 2.4 million. Obamacare bans non-US citizens from obtaining health insurance even if they wanted to buy it. California sued the Federal Government and demanded that the Federal Government pay the hospital bills for the illegal immigrants. The Federal Government refuses and they now have what might be called a "Mexican standoff". In the meantime, more hospitals in California are closing their doors.

U.S. hospital emergency rooms and hospitals are overflowing with sick homeless people who have no health insurance and no money to pay their hospital bills. Did you know that there are more than 600,000 homeless people in the U.S.? Most of these people don't have health insurance and use hospital ERs for all medical needs including being drunk and needing a place to sleep.

ERs are overcrowded – Up to 20% of these people are uninsured homeless

Hospitals are forced to put patients in the hallways

Did you know that chronically homeless individuals have an average life expectancy of 51 years? Living on the street or under a freeway bridge shooting drugs and drinking cheap wine all day is not a very healthy lifestyle. About 50% of homeless people abuse alcohol and/or drugs. About 25% of the chronic homeless are mentally

ill. These people get sick frequently and have a lot of chronic health issues. When things get too bad, they call 911 for an ambulance to come take them to the nearest ER.

25% of the chronic homeless are single women

Homeless man living under the H1 Freeway bridge in Honolulu

There has been an explosion of homeless people in Hawaii and most of them have learned that they can get "free" health care at hospital ERs. And if they have a severe health problem, they will be admitted into the hospital where they will have a room, a bed, three meals a day, and a nursing staff to serve their every need. All for free!!

Queens Medical Center is Hawaii's largest hospital and it is cracking under the strain of the homeless crisis

Here is a HawaiiNewsNow story by Reporter, Allyson Blair:

The Queens Medical Center

HONOLULU (HawaiiNewsNow) –

Alberto Rodrigues

Life on the streets has taken a toll on Alberto Rodrigues. For years, he's bounced in and out of the Queen's Medical Center. Outreach workers say he's there about a dozen times a year. He's gone in for everything from alcohol withdrawal to heart problems to serious wounds on his feet.

A few months ago, he sought care after a pit bull ripped off his ear. "One dog got this," he said, pointing to his left ear lobe.

When asked why he went to the ER earlier this month, he replied, "Pain in my body. Pain, pain, pain."

As Hawaii's homeless crisis continues, Hawaii's largest private hospital is cracking under the strain of helping chronically homeless people like Rodrigues, who have no access to primary care and so turn to ERs for both urgent and non-urgent health needs.

The Queen's Medical Center says it's seen ER visits surge in recent years. And the greatest spike is among the homeless population.

In fiscal year 2013, homeless people accounted for nearly 6,958 ER visits to Queen's. At the end of the 2016 fiscal year, the figure hit nearly 11,000.

The cost of caring for the those high-needs homeless patients is astronomical -- about $90 million a year for Queen's alone. And because Medicaid doesn't cover all of the costs, the hospital has been forced to eat almost $40 million in health care expenses over the last four years.

"Without the financial support that this mission-driven hospital has, it would bankrupt a hospital," said Dr. Daniel Cheng, assistant chief of the ER at Queen's.

The problem is multi-pronged, but one of the biggest issues is that only about 10 percent come into the ER with a true emergency, Cheng said. Most just need to be cleaned up and given some prescription medications.

"What they really need is good access to primary care," Cheng said.

The strain on the hospital's ER was noticeable on a recent Thursday afternoon, when all 36 beds were full. With 60 people in need of immediate care, nurses were stashing patients anywhere there was room.

The issue of 911 and emergency room "super-users" isn't a new one in Honolulu, but the problem has grown more acute as the number of chronically homeless people in the islands has grown and as the cost of their health care grows.

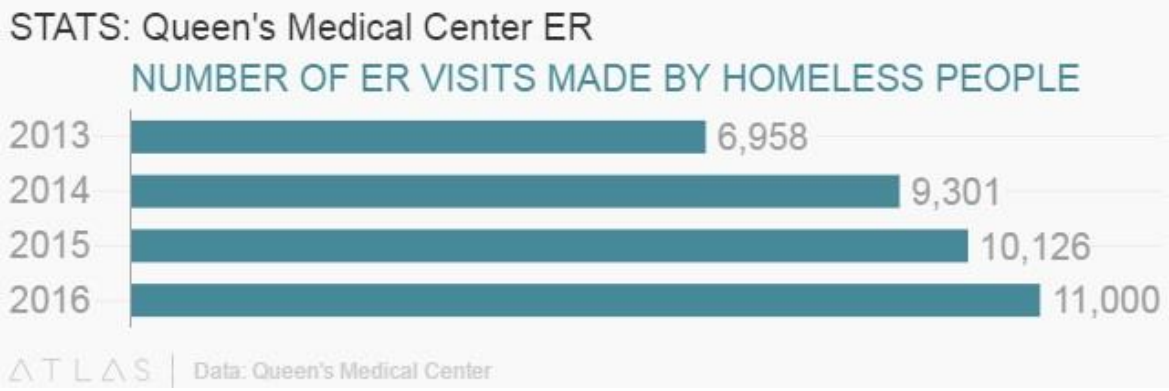
Queen's Medical Center records show that from Sept. 1 to Nov. 30, some 39 homeless people accounted for at least 734 ER visits. Half arrived by ambulance or were brought in by police. And one person went into the Queen's ER 60 times in those 90 days.

"The cost is so great right now," Cheng said. "What we're paying as a community in terms of not being able to access 911. Paying in terms of actual cost. Paying in terms of not being able to be seen timely when we do have life-threatening emergencies."

State Sen. Josh Green, chairman of the Senate's Human Services Committee, has been working on a plan to help shoulder some of the burden. He's proposed building a new facility in Downtown Honolulu where patients could go for basic health care needs.

The senator is working with Queen's and local businesses to generate funding, and hopes to have a facility up and running in six months. He's hoping the state and city will chip in to help cover some of the costs. He estimates the cost of launching a new facility will likely cost $30 million to $50 million dollars.

"Right now, it's just a crazy system," Green said, "to have a hospital being occupied by individuals for $4,000 and $5,000 visits when they need $30 worth of care and a roof over their head."



Finally, something is being done to help fix this growing problem. The Queen's Medical Center and Hawaii Medical Service Association have teamed up with the City of Honolulu to turn a four-story city building in Iwilei into an epicenter for homeless services that will include a 24-hour urgent care center with primary and mental health services.

This is great!! Other cities in the U.S. need to do the same thing.

Here is the story that recently appeared in the Honolulu Star Advertiser newspaper:

Care providers to create Iwilei Medical Service Hub for the homeless

By Kristen Consillio
August 28, 2017

The city plans to turn this four-story industrial building at 431 Kuwili St. in Iwilei into the first all-in-one space to help the homeless.

Homeless Health Care Center

Floor 1: City and County Hygiene Center
Floor 2: Health Floor, Crisis Health and Complex Urgent Care (teams from medical providers)
Floor 3: 21 units for housing for those who require complex medical care, and hospital discharges
Floor 4: 21 units reserved for longer-term homeless with complex medical and behavioral health needs pending longer-term placement

The Homeless Health Care Center will provide a hygiene center, bathrooms, showers, laundry machines, management for mental and physical health care, counseling, substance abuse treatment, job training and placement and supportive housing units.

Hawaii's growing homeless problem has prompted the state's largest health care companies to join forces with the city to provide medical services, respite and housing to some of Oahu's most needy residents.

A group composed mostly of private-sector leaders, including Hawaii Medical Service Association and The Queen's Medical Center, is moving forward with a plan to turn a four-story city building in Iwilei into an epicenter for homeless services that will include a 24-hour urgent care center with primary and mental health services; a rapid detox and wound care center; and a place for the most critical patients to stay for up to 30 days while being treated for chronic diseases, mental illness and other serious health conditions.

"Homelessness is a humanitarian crisis and a health economic crisis," said state Sen. Josh Green (D, Naalehu-Kailua-Kona), a Hawaii island emergency room physician, who is heading the project. "Homeless individuals live to an average age of 51, three decades shorter than average in Hawaii, so it's objectively a health condition. The surge in chronic homelessness and its crushing impact on our best hospitals on Oahu … make it a statewide public health and economic emergency that has to be addressed. These hospitals' survival depends on action."

HOMELESS HEALTH ECONOMIC CRISIS

- ***The average spent per high-utilizer patient is $92,000 per year.***
- ***About $1.2 billion of the state's annual Medicaid spending goes to just 3.61 percent (13,000 people) of Hawaii's beneficiaries, including chronically homeless people.***
- ***The Queen's Medical Center provides an estimated $10.5 million per year in uncompensated care to the chronic homeless community.***
- ***The H4 program has the potential to save $30 million to $50 million in health costs per year statewide.***

In 2016, state hospitals billed $214 million — or $29,862 per patient — in charges for caring for the homeless, compared with $70.5 million in 2010, according to the Hawaii Health Information Corp., a nonprofit health data company. There were 20,323 homeless hospital visits statewide last year versus 11,619 in 2010.

Christina Wang, who has a doctorate in nursing, gave medical care to the homeless people along the River Street canal in Honolulu Chinatown

"I see the ambulance down here more than I see the people that live around here," Loren Hammond, a homeless man who lives at Aala Park, said Friday while being treated by a community health nurse for multiple leg wounds. "If I feel I need them, I'll call them. It works out for the homeless people. A lot of these guys don't have insurance. If you got insurance, (they'll) take care of you. If you don't have insurance, you got the shortest stay in history: 'We're going to bandage you up and put you back on the streets.'"

The project, known as "H4" — hygiene, health, housing and humanitarian — targets the highest users of services at Hawaii's hospitals in hopes of diverting them to more appropriate and less expensive treatment. The group plans to raise $5 million from the private sector to open the facility in 2018.

"It's almost like we're reaching down to the hardest, most challenging patients who are suffering the most," said Dr. Scott Miscovich, who designed the project. "The problem is that … the majority of homeless that are unsheltered in our state are not only socially homeless, they're also being crushed by severe complex conditions. You can't fix those with social services."

Miscovich and Green, chairman of the Senate Human Services Committee, argue that the state is not doing enough to address the health aspect of homelessness.

"(State Homeless Coordinator Scott) Morishige and the governor's team has failed to acknowledge this, and until programs like H4 get launched, the statewide health care safety net and the Medicaid budget will be gravely threatened," Green said.

The state so far is "just not making any progress" in its efforts to solve homelessness and stem the bleeding among the private medical community, Miscovich added.

"They're affecting tourism, our local residents, our neighborhoods," he said. "More importantly, these people are suffering. These people are dying in the streets."

The state has focused its efforts to address homelessness largely on affordable housing, including expanding programs that provide permanent supportive housing for the chronically homeless population.

"The state is supportive of efforts by the City & County of Honolulu and others to bring online new programs that align with this framework and address the needs of the unsheltered homeless population, including individuals with chronic medical needs," Morishige said in an email.

Honolulu Mayor Kirk Caldwell met with health leaders Thursday to discuss the H4 proposal as a way to alleviate the significant impacts of homeless health care on hospitals and primary care providers. The city had originally planned to use the proposed location at 431 Kuwili St. to create a hygiene center, as well as space for social services and permanent supportive housing, according to the mayor's spokesman, Jesse Broder Van Dyke.

"In concept, Mayor Caldwell is supportive of the proposal and looks forward to receiving this operational commitment from the private health care providers because it would certainly be a game changer on how we deal with the high cost of homeless health care," Broder Van Dyke said. "Mayor Caldwell would like to first see a specific operations and management plan and the specific funding commitments before making any change. It's not a done deal but it's making progress."

Queen's estimates it handles 64 percent of the state's homeless hospital encounters, mostly through the ER, resulting in unreimbursed costs of about $10.5 million annually. Nearly 80 percent of the 10,100 homeless patients who went to Queen's in 2015 were diagnosed with behavioral or substance abuse issues.

"Our motivation is that there is a need that seems yet to be filled," said Queen's President Art Ushijima. "I don't think there is anything in our community that seems to provide that level of support to the homeless, particularly the substance abuse and behavioral issues that these individuals have. I don't know if there is this holy grail that solves the homeless issue. I don't know if we will ever be without homeless, but at the same time at least we can reduce that number."

Some closing comments:

(Wait a second ------ I need to get my Soapbox)

Hard working American citizens who pay for health insurance and pay our doctor and hospital bills need to get our hospital emergency rooms (ER) and hospitals back!

The uninsured homeless and illegal immigrants have taken over an important part of America's health care system – the hospital ERs.

Hospital Emergency Rooms should be for emergencies only. Period!! 9 out of 10 visits to the ER by homeless people are not emergencies. Half of the beds in the ER should not be taken up by loud belligerent drunken homeless people.

The Federal Government must modify the Emergency Medical Treatment and Active Labor Act (EMTALA) immediately. Hospitals should not be forced to treat the homeless and illegal immigrants for free and then "eat" most of the charges.

There are even some "bleeding heart" liberals out there that say the homeless should be allowed to stay in hospitals until housing can be found for them. WHAT? It is not the hospital's responsibility to baby sit the homeless while critically ill Americans with health insurance are forced to stay in the hallways. Besides that, most chronic homeless don't want a home.

Here is what I recommend

Cities that have not already done so should have a designated "Homeless Health Care Center" similar to the one being remodeled in Honolulu. All homeless people must use this center. If a homeless person calls "911" for an emergency, the EMS (ambulance) driver will take this person to the Homeless Health Care Center. If for some reason a homeless person ends up in a hospital ER or in the hospital, the government must reimburse the hospital for all unpaid ER and hospital bills. The government also needs to reimburse EMS for transporting the homeless to the health care center or the hospital ER.

America cannot afford to have any more ERs and hospitals closedown! The population is increasing – we need more ERs and hospitals. What if America has another terrorist attack like 9/11 or more hurricanes like Harvey in Texas and Irma

in Florida? What if a hurricane or a tsunami hits the island of Oahu in Hawaii? What if that idiot in North Korea fires a missile that hits Guam or Hawaii? What if that "BIG" earthquake hits Los Angeles? There will not be enough medical establishments to handle all of the injured people.

Hurricanes

Earthquakes

Terrorist Attacks

Tsunamis or Tidal Waves

Missile Attacks

It is about time our Federal and State governments "stood up" and did something to correct these critical problems. Don't you think?

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