

**St. Vincent's Catholic Medical Center:  
Community Health Assessment**

Qualitative Data Collection Report  
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*Submitted to:*

The St. Vincent's Hospital Community Health Assessment Steering Committee

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## **EXECUTIVE SUMMARY**

A community health needs assessment was conducted to determine the impact of the closure of St. Vincent's Catholic Medical Center (St. Vincent's) on individuals who used its services, focusing primarily but not exclusively on those from the West Village/Chelsea communities. Following a community-based participatory research (CBPR) approach, the CUNY School of Public Health at Hunter College collaborated with members of the Steering Committee convened by Community Boards 2 and 4 and involving various community-based organizations (CBOs) and elected official's offices. A total of 13 key informant interviews and focus groups were conducted between January and April 2011, involving 60 individuals as well as seven organizations that provide a wide range of health and social services to patients and members of the surrounding community. The data collected sought to address the following issues: how services provided by St. Vincent's were perceived and utilized prior to its closing; identification of any unmet health care needs; health care utilization and related experiences since the hospital closed; the most significant effect of the hospital closure; and, key recommendations for improving health care in the community.

The data collected from both leaders of CBOs that provide health-related services in the community and individuals who used the various services provided by the hospital were highly correlated. Respondents spoke positively of four major characteristics of the hospital that fostered their use of its services: accessible health care; health services which were both comprehensive and of high quality; and, the close relationship that existed between the hospital and the community. The description of experiences subsequent to closure of the hospital was consistently negative. Respondents reported decreased access to health care and interrupted care, particularly lamenting the loss of emergency and specialty care (eg, mental health, gerontologic, HIV/AIDS-related services). Many were disturbed by the lack of information concerning their medical records, which was part of a larger problem of lack of advance planning and outreach to the community in anticipation of the closing of the hospital. This culminated in an issue that consistently emerged, which was a widespread feeling of anxiety in a community "bereft of a hospital," as one resident put it. Both individual and organizational respondents were hard-pressed to identify any unmet health care needs during the time that the hospital was open. Conversely, the two main impacts resulting from closure of St. Vincent's were loss of emergency medical services and readily available access to comprehensive medical care in the West Village/Chelsea area. Going forward, the three main recommendations for improving health care in the community consistently expressed by respondents were (a) to re-establish hospital/emergency services, (b) to provide the community with a comprehensive inventory of available health care services, and (c) to strive for overall reduced complexity of health care systems (eg, pertaining to in/out-of-network providers, covered services, etc).

The results of the qualitative data collected from the in-depth interviews with key informants and focus groups with former patients of St. Vincent's provides a consistent picture of a medical center that was highly regarded by residents, patients from outside the surrounding area, and leaders of several health and social services organizations in the community. Many described the hospital like "family" and, thus, its loss in similar terms. Regardless of whether it should have been permitted to close (which was raised by many respondents), the lack of advance planning and outreach to community members and other patients remains a major criticism of those with whom we spoke. In addition, it appears to be associated with a year-long state of "limbo" and interrupted care described by many with chronic illnesses. 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. The specific health care needs of the community (eg, primary vs. specialty care; ambulatory vs. inpatient hospital services) will need to be determined by examination of the quantitative data analysis (NYS SPARCS database) and the availability of health-related resources.

## **BACKGROUND**

On April 30, 2010, St. Vincent's Catholic Medical Center (St. Vincent's), closed after 160 years of providing health care services to residents of Greenwich Village and the surrounding New York City (NYC) neighborhoods. The loss of the hospital and access to the various services it provided is of special concern to the affected population. Included in the closure of St. Vincent's is 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. Even though health services are available in alternative settings in the community, questions remain as to the gap in the health care available to this community and the entire Lower West Side of Manhattan. In order to better understand the impact of the closing of the hospital, a community health needs assessment was undertaken.

The CUNY School of Public Health at Hunter College (CUNY SPH) was asked to collaborate on a Community Health Needs Assessment in the form of qualitative data collection and analysis of the impact of the closure of St. Vincent's. Subsequently, CUNY SPH was asked to assist with development and fielding of a quantitative survey, which was conducted separately. Thus, only the qualitative primary data collection and analyses are the focus of this report.<sup>1</sup>

## **Process**

Through the efforts of various elected officials' offices, including that of Congressman Nadler, NYC Council Speaker Quinn, NYS Senator Duane, NYS Assembly members Gottfried and Glick, Borough President Stringer, and Community Boards 2 and 4, the Community Health Needs Assessment Steering Committee (the "Steering Committee") was formed in early fall 2010. Steering Committee members include representatives from residents' groups, health care providers, elected officials, and advocates for people with special needs including but not limited to HIV/AIDS, seniors, people with disabilities, mental health and substance abuse problems. Following an evidence-based approach to assessing the health care needs of the Lower West Side communities, it is expected that the findings from the Community Health Assessment will guide the Steering Committee in its recommendations on improving access to health care for community residents in the post-St. Vincent's context.

The CUNY SPH has followed a community-based participatory approach in its collaboration with the Steering Committee. From the outset, we have sought input and guidance from Steering Committee members with regard to the proposed data collection methodologies, the data collection instruments (ie, interview guides; survey), data sources (ie, key informants; focus groups), and dissemination/sampling strategy (specifically pertaining to the survey, which will be addressed in a subsequent report). As a result of the high level of interaction with members of the community represented on the Steering Committee, the research process has benefitted from their knowledge and expertise, including problem definition/issue selection, research design, and conduct of the research. In this report, which summarizes our analysis of the qualitative data results, we invite feedback from both the Steering Committee members and the larger community, including identification of possible omissions and/or corrections. Further, we look forward to deliberations on how the results can best be used for effective public health action.

## **METHODS**

At the time that the CUNY SPH was invited to participate in the Community Health Assessment, quantitative analyses of NYS SPARCS data were underway by the North Shore-Long Island Jewish (NLIJ) Health System. Thus, in order to achieve a deeper, more contextualized understanding of how the community was experiencing the closing of St. Vincent's, we proposed to collect *qualitative* data

through key informant interviews with organizational and community leaders, and focus groups with community residents and other users of area health-related services. Key informant interviews and focus groups go beyond categorical questions and can provide a more in-depth understanding of the factors that affect health care experiences. Conducting the key informant interviews before the focus groups allowed for further identification of relevant populations and issues that could then be examined with individuals directly affected by the hospital closure.

The definition of “community” was informed both by the NLIJ analyses as described in their third report<sup>2</sup> (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 members of the Steering Committee who advocated for consideration of individuals and groups that might not live within these zip codes but used St. Vincent’s services nonetheless. The zip codes in the PSA include 10001, 10011, 10012, 10014; the SSA-I zip codes include 10003 and 10013; and, the SSA-II zip codes include 10002, 10009, and 10038. In following suggestions from Steering Committee members, our data sources include individuals who reside both within and outside of the primary and secondary service areas.

### **Data Collection Instruments**

Through the process of initial information gathering via the Steering Committee meeting discussions, document review (including previous NLIJ reports), and direct requests for Steering Committee members’ suggestions, we developed an initial draft of the key informant and focus group interview guides, respectively. These documents were shared with the Steering Committee for additional feedback, both in person at the public meetings, as well as electronically allowing for more individual and detailed input. Through an iterative process, all sources of feedback were considered, reconciled and incorporated into final versions that were again shared with the Steering Committee for final approval. Upon approval by the Steering Committee, the research plan was submitted to the Hunter College Institutional Review Board (IRB); the research protocol (#10-10-295-4471) was approved on November 1, 2010.

### **Key Informant Interviews (KIIs)**

In planning the first component of data collection, we turned to the Steering Committee for suggestions as to which leaders of community organizations should be considered “key informants,” with regard to the role that St. Vincent’s played in the provision of health care and the current status of health care need. After receiving such input, we combined it with groups identified as in particular need of health care, to determine the list of individuals to be approached for key informant interviews. These interviews were intended to obtain information on the impact of the hospital closure from individual leaders at community-based organizations that serve residents and/or individuals with specific health needs.

Six key informant interviews were conducted with representatives in leadership positions at community-based organizations representing residents, patients, and/or providing health care-related services. All key informants were recommended by members of the Steering Committee. Three interviews involved one respondent, two interviews involved two respondents, and one involved three respondents. A seventh “hybrid” group interview comprised of six key informants (health care providers) was also conducted. All individuals whom we approached for a key informant interview agreed to participate, for a total of 16 interviewees. In accordance with the IRB-approved research protocol, the names of these interviewees are kept confidential.

The interviews, which lasted approximately 1 hour, were conducted either at the office location of the interviewee(s) or at the CUNY SPH. All but one of the interviews was permitted to be digitally recorded

allowing for a verbatim transcription for analysis. (The two respondents who participated in one key informant interview did not consent to audio recording; thus, the researchers had to rely on detailed notes taken during the course of the interview.) The semi-structured interview guide (see Appendix 1: Interview Guide) was used to conduct the discussion in a consistent manner across interviews, while allowing for open-ended responses that would likely vary across interviewees. Questions covered topics including: perception of health care utilization in the community, access to health/mental health services and quality of services, health needs and service gaps prior to and since the closing of St. Vincent's, most significant effect of the closing, and recommendations going forward.

### **Focus Groups (FGs)**

Data gathered from the key informants helped to inform the next step of data collection through focus groups. As opposed to key informant interviews, which provided an organizational perspective of the impact of the hospital closure on specific groups (as reported by a leader or expert), the focus groups were intended to obtain information directly from individuals who had personally experienced the closing of the hospital.

The participants were selected in collaboration with Steering Committee members and other community partners. In total, six focus groups were conducted with residents and/or users of community-based health-care services. Standard focus-group procedures were employed,<sup>3</sup> including description of the research purpose and informed consent process; distribution of a brief questionnaire (see Appendix 2: Focus Group Background Questions) to collect anonymous demographic information from individual participants; and a moderated group discussion guided by questions from a topic guide (see Appendix 3: Focus Group Topic Guide). The topic guide questions were open-ended and covered themes pertaining to health care utilization, access to and quality of health services, health needs and service gaps before and after the closing of St. Vincent's, the most significant effect of the closing, and recommendations to improve health care.

The focus groups were conducted at various community-based organization (CBO) sites in order to facilitate the participation of community residents and other users of their services. Our CBO partners handled recruitment of approximately 8 to 10 individuals who were at least 18 years of age, represented their client population, and had previously utilized services at St. Vincent's. Light refreshments were provided and each participant was given nominal compensation (\$20) for their time. The focus group discussions lasted between 1 and 1.5 hours, with an average of seven participants per focus group (total number of participants was 44). A digital audio recorder was used to record the discussion. Project staff took notes during the group discussions, which were used to assist with questions that might arise during transcription of the digital audio files and to guide data analysis. The focus group transcripts did not contain personal identifying information of any of the participants, in accordance with the IRB-approved protocol guaranteeing participant confidentiality.

### **Sample Description**

Data were collected from the key informants and focus group participants who were from organizations and/or associated with the following populations/groups:

- Underserved, underinsured, and uninsured individuals, including non-US citizens seeking primary care and preventive care, including health, oral, and mental health/substance abuse services. Most of these individuals reside in lower Manhattan, including the Primary and Secondary Service Areas. The majority of patients represent racial/ethnic minority populations, have incomes below 200% of the federal poverty line, and almost half have no health insurance.

- Individuals and families seeking behavioral health services for emotional problems and mental illness, including outpatient mental health services, psychiatric rehabilitation, case management, consumer self-help, family support, and residential services generally located within Secondary Service Areas. The population includes individuals who have been incarcerated, those with developmental disabilities in addition to emotional and/or psychiatric disabilities, persons who are abusing substances in conjunction with their emotional difficulties, and those who are deaf, deaf-blind, or hard of hearing and who also have emotional and/or psychiatric disabilities.
- Low- and moderate-income individuals living in the Primary Service Area. These persons are differentiated solely on their income status and have no defining health care issues. Constituents can be individuals, couples or families of all ages and demographic characteristics.
- Individuals living with a disability, whether it came at birth, by injury, disease, or during the process of aging and seek services in the Secondary Service Area.
- Individuals whose lives are either directly or indirectly affected by HIV/AIDS in the PSA. This includes a large population of gay individuals.
- Families and individuals of all ages and backgrounds in the PSA seeking a wide variety of social and health services, including early childhood education, drug and alcohol abuse, mental health, services for people living with HIV/AIDS, arts and cultural enrichment, elder care and senior social activities.

### **ANALYTIC APPROACH**

Following standard qualitative data analysis procedures,<sup>4</sup> we reviewed the interview and focus group 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 of the data collection and related activities (ie, conduct of key informant interviews, focus groups, and note-taking; audio file transcription). Transcripts were then assigned such that each was independently coded for salient themes by two different researchers. Regular group 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 the results. The analytic process continued as the results were summarized in written form, and direct quotes (data) from the informants and participants were included to illustrate or support the findings.

### **RESULTS**

#### **Demographic Description of Focus Group Participants**

Overall, 44 individuals participated in the six focus groups with an average age of 55 years (range = 32 to 82 years). A slight majority was male (55%). Among those who provided their ethnicity (n=33), one third were Hispanic/Latino and many (n=17) provided a mix of other ethnic backgrounds. Of the 41 who identified with a specific racial group, 46% identified as Black/African American, 42% White, 2% American Indian or Alaskan Native, 2% Native Hawaiian or Other Pacific Islander, and 10% "Other." The majority reported English as being their primary language (88%), with 18% reporting Spanish.\*

On average, participants lived in their current home for 18.2 years (range = 2 months to 51 years). Of the 40 participants who provided their home zip code, slightly more than half (55%) lived in the PSA and just under half (43%) lived in other parts of Manhattan and the outer boroughs; only one respondent was

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\* The percents may sum to greater than 100 since respondents could select more than one racial group and language.

from SSA-I. With regard to educational attainment, about one fifth each reported less than high school (22.5%) and a high school diploma/GED (22.5%), 30% had some college or a 2-year diploma, 15% had a college diploma (Bachelors), and 10% had either some graduate school or earned a graduate degree (Masters or higher). As for employment, 10% were working full time, 10% part time/per diem, 20% were retired, 40% were unemployed, and 20% were unable to work.

In response to whether or not they would have sought care at St. Vincent's when it was open compared to another provider, over 80% of the respondents (n=40) said it was 'very likely' and 15% said it was 'likely.' Only one person (2.5%) said it would be 'very unlikely' they would have sought care at St. Vincent's. Finally, 100% (n=40) of participants said St. Vincent's was either 'important' or 'very important' to them when it was open.

### **Key Informant Interview and Focus Group Findings**

Although we were able to obtain a "snapshot" description of the focus group participants from the 10 close-ended background questions (summarized above), the crux of the findings from the key informant interviews and focus groups come from the qualitative data we collected via open-ended questions. Thus, the results reported here combine data from the key informant interviews ("informant") and focus group participants ("participants"). The findings are organized under the five main categories of questions that were asked.

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

Key informants and focus group participants discussed their relationship with St. Vincent's prior to its closure. This included any experiences with the hospital or related outpatient facilities and their perception of the quality of services rendered. Overall, the majority of participants expressed a very positive relationship with St. Vincent's. Almost across the board, participants spoke highly of St. Vincent's with regard to the environment at the medical center (eg, "comforting," "homey," "personal"), its relationship with community-based organizations (eg, "very helpful with our client population," "cooperative"), and the high level of expertise in medical care and treatment (eg, HIV/AIDS, gerontology). This was in contrast to words used to describe other area hospitals, such as Bellevue Hospital Center and Beth Israel Medical Center, which included "more impersonal," "large," and "difficult to navigate." While there were several participants of one focus group who expressed some dissatisfaction with the hospital, this was clearly a minority opinion. The four specific themes that emerged from the data pertained to access; local, comprehensive services; relationship with the community; and, quality of care.

### *A) Accessible Health Care for All*

1. **Accessibility:** 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 different ways. One aspect pertained to its location. Having a large academic medical center in close proximity meant area residents could obtain timely access to care. For example, one key 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 located nearby meant such individuals 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 7<sup>th</sup> 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, in particular to community residents. This was most relevant in emergency cases – many residents shared personal or familial accounts of asthmatic attacks, accidental overdoses, heart attacks, being hit by a car, and the positive outcomes that they attributed to being in such close proximity to a hospital. A key informant also echoed this sentiment, highlighting the importance of geography in determining where else to seek services, particularly for resident seniors who were very dependent on St. Vincent's:

*[St. Vincent's] gave many people a great feeling of security when they thought about, 'Where should I go in case something happens?' (600 FG)*

Another aspect of patient 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. Specific 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. Because the medical center was accessible, 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. Several key informants and focus group participants spoke of the special kinds of "access" that St. Vincent's provided:

*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)*

*We would see people with triple co-morbid conditions – psychiatric disability, chemical dependency, and cognitive disability...You want to try to get somebody as directly and as simply, and as non-bureaucratically, into a place where they can get help. And that was possible to do. (100 KII)*

2. Ability to pay: Numerous participants referred to the "welcoming" environment of St. Vincent's. 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, you know, mainly, 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 don't really... 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)*

*Whenever we called emergency, St. Vincent's ambulances came. Not fire department. Not Beth Israel. [It was] St. Vincent's....[Regarding paying for ambulance service] That never happened with St. Vincent's. We have to pay now when ambulance services comes. (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 focus group participants, and has been part of the mission since its inception (see Appendix 4: Area Hospital Mission Statements).

#### B) *Local, Comprehensive Health Care Services*

The notion of “one roof” or “one-stop shopping” was repeatedly emphasized among the majority of informants and focus group participants. Many of the community residents received multiple services at St. Vincent’s – mental health services, care for arthritis, asthma, diabetes, etc. As a result, the closing of the hospital meant a loss of *all* of their doctors, simultaneously.

*I was a St. Vincent's patient, at the clinic since I was widowed and 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 that was found at St. Vincent’s, with one key informant (JW) 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)

Another key informant highlighted the exceptional gerontology program at St. Vincent’s, among other excellent outpatient programs:

*...there was a pool of expertise in St. Vincent's - both in their outpatient and their inpatient - that's just not there anymore. I mean they had good drug treatment programs at St. Vincent's, which meant if we had a client with a drug problem who went to St. Vincent's we knew that they were going to know how to take care of that person, and treat them with respect, and all of that kind of thing, and that's gone. Which is not to say that wouldn't happen - that good treatment wouldn't happen at the other hospitals, but it's not going to happen in the neighborhood where the person actually lives. (600 KII)*

#### C) *Close Relationship with the Community*

Respondents consistently expressed a family-like connection to St. Vincent’s, which appeared to have been engendered among patients, residents, leaders of community-based organizations, and providers alike. The term “family” was repeatedly used with specific anecdotes to describe the close, positive relationship that many key informants and focus group participants had with the hospital. A focus group

participant who was currently seeking health care services at an area community health center described it like this:

*I knew my doctors personally. We were like family. Wasn't doctor-patient relationship. We was like family. My doctor knew everything about me. I'm sure it was held confidentially. He knew me as a person, not a number or a tag or something. He knew me personally. (200 FG)*

1. Individual residents: The consistent message from all but one focus group was that individuals had developed close relationships with St. Vincent's hospital and its 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.

*I used them for a lot of years for a lot of different things. I knew the doctors. I knew the hospital. I knew different people by name. (400 FG)*

*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. That's what I needed of them. I used to get...to feel better...especially when I got triaged. I used to love that. They used to treat me so good. I used to say "Wow, I'm already healing." There was a lot of love there. (300 FG)*

*Above [all], you know, I was familiar with it and some of the doctors and nurses and staff. And you know, you form a trust and it's not there anymore and you don't know where you're going to go if an emergency happens now. You don't know where to go. (100 FG)*

*I felt when I [went] to see my doctors and my therapist and the receptionist, I felt like that was family when I went to St. Vincent's. I felt like that was home. You know, they have workers there, even though they're not doctors or nothing like that they would listen to you and talk to you and I used to... I told my father once that when I go to St. Vincent's I feel more happier there. Sometimes I'm finished with all my appointments and I'm still there you know, just talking and hanging out because I felt at home there. I felt they understood all my needs. I was like family there. So I mean, it really... it was like a family broken up for me, that's how it felt. You know with the psychiatric side and the medical side, I really felt that that was it. (500 FG)*

It is important to note that the few focus group participants who did not express the same level of closeness and dependence on the hospital were disproportionately from other parts of New York City (ie, less likely to be residents of the West Village/Chelsea area). 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)*

2. Community-based organizations: Our findings also indicated that St. Vincent's had strong, positive relationships with other health and social services organizations. One informant (600 KII) of a multi-service organization spoke about the informal and formal ties the organization had with St. Vincent's, and the importance of their relationship with the medical center for referrals, especially for seniors. Geographically (for the organizations in the neighborhood), it was very easy to bring

clients to the hospital when necessary, which also made for more accessible follow-up care as well as 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, they would 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 kind of 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).

3. 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)*

The hospital's commitment to primary care and the community was also evident in discussions about its distinctive origins and mission. The following statements from several health care providers previously associated with St. Vincent's provide an "insider's" perspective that is complementary to the "family" terminology voiced by many patients who utilized the hospital's services.

*I would assume that there was a mission statement associated with the Sisters of Charity. So, what you had at St. Vincent's was something 'in the air.' But it was rooted in what had been founded by the Sisters of Charity. (700 FG)*

*You're certainly not going to find any hospital who says their mission is to turn away patients. They... legally they have to take patients. Now the nuns are gone...but that unspoken mission was in the air. It was in the water we drank and it became the way we talked to each other. Even as the visible presence of the nuns disappeared, that spirit...the hospital didn't change at all. (700 FG)*

*So to a degree...it wasn't the physical bricks and mortars that created this ethos, this culture; it's the staff. And if that staff is going to come back and it's going to be local... you know, there is a belief that it could be [recreated]. (700 FG)*

#### D) Quality of Care

Popular opinion regarding the quality of services at St. Vincent's prior to closure 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 focus group

participants had utilized St. Vincent's for multiple generations and literally credited the medical center with extending or saving their life or that of a family member. Many also spoke of strong patient advocate services that would take care of most patient care issues. Overall, 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)*

Reports of the high quality of care provided at St. Vincent's came from focus group participants and key informants alike. And in several areas it was also regarded as a leader in field, as is conveyed in the following comment from 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, it is noteworthy that over half of the participants in a focus group 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. Several felt that hospital staff members were more concerned with their employment prospects than the quality of patient care at that point.

*As a patient of using all their services, emergency services, or in the O'Toole building, or even just the HIV clinic that they had around the corner, they were going downhill a long time before they finally closed. (400 FG)*

*I was just asking questions and every time I got a answer it was with a negative attitude. And that discouraged me from going back. (400 FG)*

## **II Unmet Health Care Needs in the Community: Pre- and Post-Closure**

The second category of questions we asked participants was about whether they knew of or experienced any unmet health care needs while St. Vincent's was open. The majority were not able to identify 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. One health care provider summed up the availability of health care in the following way:

*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 and lung 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)*

Across focus groups and key informant interviews the sentiment was fairly consistent—respondents were hard-pressed to identify any health care needs they or their organizations had that were not met by services provided by St. Vincent's. Taken together with the extensive ways described in which the hospital provided health care services, it is clear that the majority felt that St. Vincent's provided comprehensive services to individuals from within and outside the community.

### **III 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 we interviewed felt they had lost a close-proximity provider capable of accommodating the many health care needs of the community. Some participants expressed initial panic and a "state of shock" over the closing of the hospital while others used words such as "fearful" and "scared" in describing the uncertainty of seeking services at new locations and the difficulty of navigating the health care system to locate new providers. The main trends that emerged included: decreased access and continuity of care; lost specialty care and medical records; lack of planning; and, widespread anxiety.

#### *A) Decreased Access to and Continuity of Care*

1. Lack of information: Participants' reports of success or difficulty accessing health care in the wake of the hospital's closure was to some extent correlated with whether or not they received information about alternative health care services at the time the hospital closed. Some reported having received mailings from *Continuum Health Partners*, their own health insurer (eg, *Fidelis*), their private doctor or information from the hospital about their medical records. (See "Lack of Community Planning and Outreach" below.) But numerous participants said that they did not receive notice as to where their physician was relocating and/or the appropriate hospital to go to (eg, that would accept their health insurance or accommodate lack of health insurance). According to one informant from the community, "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 focus group participants with respect to the amount of information they received in preparation for the closing of the hospital. 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.

*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. (100 KII)*

This “hiatus in care” was explicitly reported by several key informants and focus group participants, who described different actual scenarios that made clear the limbo that many people currently find themselves in with regard to their health care.

*So, it's just going to deteriorate their health conditions. I mean, diabetes, for example, you know, 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)*

In response to the question of what one might do if s/he needed medical attention for chest pain, for example, one elderly resident answered, “That’s why I’m waiting to call tomorrow with the group insurance, or whatever they call, to find out what I’m going to do. Which hospital [it] has to be, what doctor I have to see.” Another elderly focus group participant from the area added, “I still have a medical doctor [but] I don’t know what hospital he’s connected with. I have to ask him.” (600 FG)

A focus group discussion with several lower-income residents from the community revealed a strong connection between lack of information concerning several aspects of the hospital closure—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. I have this really bad cough that I don't know where it's coming from. And I have 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/mental illness who described a feeling of hopelessness 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 focus group participant asked, “You can’t find Dr. X? He’s in Beth Israel!” (300 FG) This instance of “information discovery” between participants was not unique to this particular focus group and served to reiterate the situation of confusion and inconsistent information among many who relied on health care services from St. Vincent’s hospital, its clinics, and affiliated medical staff. It is noteworthy that this was the situation almost one year since the hospital had closed.

The lack of information was not limited to community members. As leaders of community-based service organizations, several key informants spoke of their own uncertainty regarding whether patients were able to access care post closure. One informant who expected an increase in enrollment in certain of their programs—in particular mental health services—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 following comment from one key informant summed up a persistent concern:

*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.

2. Alternative facilities further away: There was also substantial evidence that the lack of a nearby hospital influenced perceived access to services, especially in more vulnerable individuals. Specifically, 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 distances to find another hospital or obtain services in more private practice, ambulatory settings which may not be as accessible as a large medical center.

In addition, a number of those who knew their physician's new location said it was in a distant, hard-to-reach location and/or required a greater expense (eg, cab fare). For example, some participants received notice that their provider was now seeing patients on the Upper East Side or in Connecticut despite the participants' Lower West Side residence. Such change in service location 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)*

*...if we have to have a psychiatric hospitalization...which of course is not unusual in a mental health treatment program, you can't go to St. Vincent's because it doesn't exist. So you know, if you have a client with suicidal ideation...needing hospitalization...St. Vincent's closing is a big deal in terms of how far people have to go in order to be seen in the emergency room. (600 FG)*

Proximity was noted as not only extremely important for individuals in need of emergency health care services but also 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.

*So for an ambulance or any type of emergency service to get here, it takes over an hour or so to get down 10th avenue or 9th avenue [with all the clubs in the area] and we don't have an hour when it comes to any emergency never mind when it's a health emergency...For visiting reasons also we had our hospital in a location where we [could] get back and forth. Now we don't have that. (300 FG)*

*One of my concerns as far as not having St. Vincent's is, you know, 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)*

3. Over-capacity and poor quality care at other health care facilities: There were several references to over-crowding and long waits at various health care facilities that individuals had turned to since the hospital closed. A key informant spoke of how one area health care center (ie, Callen-Lorde Community Health Center) 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 focus group participant who spoke about confusion regarding other health care facilities. He was told that Callen-Lorde was an urgent care center that had resources to take on additional patients and that he should go there. However, when he tried to, he found out that an appointment was



indeed needed and that the earliest appointment was in 6 months. This was compounded by the experience of misinformation described by a focus group 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 focus group participant, who is also a health care provider, described multiple attempts at obtaining emergency care for a knife-cut in the hand three weeks post closure of the hospital.

*[I] go to Beth Israel. Mobbed. I think I need stitches or something [so I] go over to the Urgent Care Center on 23<sup>rd</sup> street. Walk in there, 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 o'clock at night, there's a physician assistant and an LPN. The physician assistant comes and 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 Roosevelt at 4 in the morning to get eight stitches in my finger. (700 FG)*

In contrast to the previous anecdote which was shortly after the hospital closed, a local health care provider described a patient's recent experience (ie, approximately 1 year post closure) with a similar type of injury.

*She cuts her finger. She goes to the NYU emergency room. She's there 6-7 hours, 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)*

Two other recent patient experiences were described by a health care provider, which involved different health care issues and medical centers but point to similar concerns with respect to the time to receipt of care and nature of the service. In one case, the doctor sent his/her patient from the Mt. Sinai HIV Center (formerly St. Vincent's) to the Mt. Sinai Hospital emergency room after speaking with an ER doctor and providing all relevant 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 nine hours to first be seen by a physician and was likely going to take an additional 12 hours before getting a bed.

The other case involved a patient of a local doctor who presented at Beth Israel Medical Center on a Saturday. Yet, the patient's primary care physician was not contacted until three days later when the patient was "half dead, no blood pressure, septic...really sick." Although the primary care physician had been caring for the patient there for several months and documenting his/her contact information on all patient notes, they claimed to not know who the patient's doctor was. As such, the patient was admitted to a doctor who did not know him. "They called three consults of physicians...none of whom were the doctors who consulted there while [I] was there for four months." (700 FG)

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)

#### B) *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. Those with HIV/AIDS, mental health issues and the disabled shared this viewpoint. According to the 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 was not simply knowledgeable in HIV care, but that *specialized* in these 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 within walking distance, and the uncertainty of finding care in unfamiliar locations. The comments that follow provide some insight to the special health care needs of many in the community.

*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)*

*I’m struggling with the methadone, which I’m addicted on, as we speak. You know, yesterday was my last visit. (100 FG)*

*I’m in deep depression since my mother-in-law and my father passed away. I was depressed for three years. I locked myself in a room. I only came out to cook, take a shower, and go back to sleep. I used to be everywhere in the streets, everywhere. I did everything. You know and seeing the psychiatrist helped me and I don’t have one yet. (300 FG)*

#### C) *Missing Medical Records*

Knowledge about and experience with accessing medical records from the hospital varied for both focus group participants and key informants. 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 for patient services.

*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, you know, if we had those medical records. (200 KII)*

*We talk about the patients being informed and provided with information; I don’t know how well the information flow was directly to the patients. When we would help the patients with case*

*management, if we were having difficulties with getting medical records, we would sometimes say to the patient, 'go to this location, at this address, and see if you can literally go get a copy of your medical record then and there.' Sometimes it worked, sometimes it didn't work. (200 KII)*

On the individual level, the majority of focus group participants said they were not always successful at tracking down their own records. And many patients said their new physicians still had no prior record of their medical history.

*The medical records... I have 8 people in my family that all the medical records were at St. Vincent's. It's very important to us to find out and 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. And to my knowledge, that information is supposed to be confidential between me and my physician and whoever that maybe at St. Vincent's...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 focus group (300 FG) participant said she was told that another clinic (ie, Raymond Naftali Center) had a significant portion of the medical records, and that she was notified about it by her insurance company. While 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 (or had them transferred to a new provider) generously offered such information and assistance to fellow focus group members. What was clear was that almost one year later there remained a lack of official, organized, consistent information regarding patients' medical records and many we spoke with were still trying to "figure it out."

#### D) *Lack of Planning and Outreach*

Many organizations and former patients felt that the closing of St. Vincent's happened too suddenly, without adequate community planning or outreach. Individuals found themselves displaced and in immediate need of new care arrangements. The common view held by many was that poor communication on the part of the hospital left patients, community residents, and organizations without knowledge of where to seek replacement services or how to coordinate care. Some participants spoke of patients being auto-assigned to new providers by certain insurance companies. Other people 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 not universally implemented which led to an increased case management burden for community-based organizations 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 focus group 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 was instructed to call his/her insurance company to find alternative physicians; yet, this individual did not recall receiving a mailing from the provider (ie, FEGS) that was taking over the St. Vincent's adult mental health clinic. The spouse of a second 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 (ie, Raymond Naftali Center). 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)

#### E) *Widespread and Persistent Anxiety*

A consistent theme from key informants and focus group participants was a very high level of anxiety with the lack of a hospital in the community in the event of an emergency. This included fear of not finding good doctor (ie, lack of information), feelings of anxiety and fear around seeking services at different 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 ambulance to arrive in event of emergency and possibly being hospitalized in an unfamiliar place with an unfamiliar system was expressed repeatedly. Ultimately, many respondents said that 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 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 resident from the community put it:

*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)*

*Beth Israel, Bellevue—we've tried both. And you know, we're not going to 59<sup>th</sup> street because we already see what happened at Beth Israel, we saw what happened at Bellevue. They just don't want to treat us. That's the attitude. So, that keeps us from going as often as we should. (300 FG)*

These sentiments were echoed by an executive at a local community-based organization:

*...you know 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)*

#### **IV 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 went on to describe that by losing St. Vincent's, the community was losing a trusted hospital in close proximity 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 two main themes identified as the most significant effects of the closure of St. Vincent's were the loss of emergency services and accessible, comprehensive health care.

##### **A) Loss of Emergency Services**

Across the key informant interviews and focus groups 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, as well as 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. The series of comments that follows is illustrative of many others voiced by informants and focus group participants alike.

*...it's really very frightening to not be able to go locally to an emergency room... I've heard they [other hospitals] are very over crowded in their emergency rooms, so I'm just praying I don't have any emergencies because of this. (100 KII)*

*I'm fearful of the time when something may have to happen, which is an emergency, and we don't have a hospital nearby. (600 FG)*

*...my number one health issue is that now that my doctors and the hospital is gone, if I had an emergency situation, where do I go? (400 FG)*

*I suffer from depression and I have also used their mental health clinic. And I often wonder, God forbid, if I should have a breakdown or something, which I have had in the past. You know, it was so convenient for me to just go over to the hospital, to St. Vincent's. I could walk there. Someone could drag me there, depending on how, you know, what was going on with me. And I worry that...if I should get really sick, timing is so important. (100 FG)*

##### **B) Loss of Readily Available Access to Comprehensive Care**

Many informants and focus group participants cited the loss of an easily accessible all-in-one ("under one roof") source of medical care in close proximity to be the most significant effect of the closing of St. Vincent's. Many 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 disjointed and many in the community 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 thus been experienced as a major disruption in health care. As summed up by one informant:

*I want you to be thinking about the level of complexity of establishing care relationships when an entity like St. Vincent's with its accessibility is disrupted. (100 KII)*

One of several focus group 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, you know, 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)*

*The most significant [effect] is the multiple services that they had. That's no longer there and the same services elsewhere, it's going to take longer for you to get there because you're going to have to wait with others that no longer have anywhere to go, either. (100 FG)*

## **V Key Recommendations for Improving Health Care in the Community**

A final question asked of all informants and participants 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.

### **A) Hospital/Emergency Services**

There was agreement from many key informants and focus group participants that the closing of St. Vincent's resulted in the need to increase community-based health services capacity. However, there were often varied suggestions as to what kind of services this meant. 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 string of comments from an elderly community resident, leader of a community-based health and social services organization, former St. Vincent's health care provider, resident with mental health needs, and person living with HIV/AIDS, respectively, are illustrative of the priority given to a local hospital and emergency services.

*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)*

*A new hospital on the previous St. Vincent's site could attract back the physicians with HIV expertise. (400 KII)*

*... 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)*

*That they at least open the emergency [room], in the least, that's what they could do. (600 FG)*

*[We need] the security of the emergency services, because health goes up and down. (400 FG)*

#### B) *Community Health Services Inventory*

Many participants recommended that an inventory of all available health care services within the community be developed. Such a directory would provide detailed information on which services were available, where they are located, and other relevant information such as hours of operation, insurance plans accepted, fees. This was suggested as a way to potentially serve both members of the community as well as CBOs, facilitating these organizations' ability to make referrals and better coordinate their services.

*Imagine how much emergency room utilization we could reduce by having people simply know where the walk-in or urgent care capacity is...that's accessible. Imagine! It's so simple. (400 KII)*

*...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)*

*You know, when you talk about an inventory—a comprehensive inventory—of what services are available in the neighborhood, and what aren't, such an inventory could then inform discussions of the essential benefits package, which is currently being discussed in health reform. (400 KII)*

#### C) *Decreased Complexity*

One of the other most cited recommendations for improving the health care delivery and services for the community was to reduce the overall complexity of the health care system. Some advocated for a single-payer system while others wished for an arrangement where everyone would have access without the confusion and uncertainty 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.

*Have 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)*

Creation of an integrated medical system that is easily accessible and helps to alleviate the challenges that patients encounter in navigating a complex healthcare system was strongly recommended by another key 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 like this:*

*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**

The purpose of this community health needs assessment was to better understand the impact of the closure of St. Vincent's via in-depth, qualitative data. A deeper examination of the results reveal several overarching issues that cut across individual themes reported above (eg, reduced access and loss of emergency services). These cross-cutting issues are discussed below.

Overall, the data collected from key informants and focus group respondents 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, the majority of respondents could not identify any unmet health care needs while the hospital was open. Conversely, experiences since the hospital closed 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 particularly *vulnerable groups*. While the loss of a medical center might be expected to cause inconveniences, such as interrupted care, additional travel to alternative facilities, and identification of new providers, 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 some this was experienced in terms of reduced physical or financial accessibility, for others it was manifest in the loss of specialty services or a setting that offered comprehensive care. 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 associated with health facilities that 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 that appeared to permeate much of the feedback we received from respondents 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 study 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 focus group participants, they demonstrated a relatively high level of resourcefulness and agency in securing health services.

There are both limitations and strengths associated with the qualitative nature of this study. The extensive amount of text-based data collected from approximately 20 hours of discussions necessarily limits the total sample size of the study—in this case, to 60 respondents. As a result, 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. Moreover, the statements made in this report with regard to the effects or impact of the hospital closure on the community is from the perspective of the study participants and cannot be extrapolated to the larger population that used the hospital. The rich, in-depth information gathered through the interviews and focus groups, however, provides insight into individuals’ and groups’ experiences with this dramatic event in a way that more population-based methods, such as surveys, do not. This strength is accompanied by a purposeful sampling strategy that sought to include perspectives from a range of community residents and other hospital constituents, as well as key health-related organizations that interfaced with the hospital. This permitted for a multi-level analysis with data from the individual and organizational levels. While the sample is not statistically *representative* of the larger population, that is not the purpose of qualitative studies. Instead, we are able to better understand people’s perceptions of events and the mechanisms through which they occur (eg, “why” or “how” access to health care providers has been affected and not just whether one has seen their doctor recently). With this research approach we are most concerned with achieving the point of *saturation* in data collection, which is when no additional interviews and focus groups appear to generate information different from that already collected in previous discussions. In this way we can distinguish salient themes (given concordance across groups) from those that are exceptional (ie, appear to be discordant), with confidence that important issues were not missed. In that regard, we believe we were successful.

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 from outside the surrounding area, and leaders of several health and social services organizations in the community. The three 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. The specific health care needs of the community will need to be determined by further examination of separate quantitative data analysis (eg, NYS SPARCS database) and the availability of health-related resources.

## **Appendix 1: Key Informant Interview Guide**

### **1. Can you tell me a little about what you do?**

- What organization do you work for?
- What community do you serve?
  - i. Does it have any special health care needs (e.g. disability, deaf, etc.)?
  - ii. Do the clients/patients have travel problems in getting to health care services?

### **2. When St. Vincent's was open, what was the relationship like between the community and St. Vincent's?**

- How important was the hospital to the community? Were there particular groups of the population you serve that relied on St. Vincent's more than others?
- What services did people primarily seek at St. Vincent's?
- Where else did people seek healthcare, including mental health care?
- What **were** some of the unmet healthcare needs (physical and mental) of the community?
  - i. What were the barriers to care when St. V's was open?

### **3. Can you talk about what it's been like *now* for the community you serve, in terms of health care (physical and mental) access and utilization?**

- How has the closing of St. Vincent's affected healthcare services? To what extent?
- How has it affected the community you serve? Since the hospital has closed are there particular population groups that you worry about? Are there particular services that you worry about?
- What **are** some of the unmet health care (physical and mental) needs of the community?
  - i. If so, what are the barriers to care? What would make it better?

### **4. Where do people go *now* for healthcare services?**

- For primary care? Specialty care?
- Emergency care?
- Hospitalization?
- Mental health care?

### **5. How do people's *current* "healthcare experiences" compare to when St. Vincent's was open?**

- What is your sense of their satisfaction and/or assessment of the quality of healthcare services they have obtained?

### **6. What would you say has been the *most significant* effect of the closing of St. Vincent's on your organization/the clients you serve?**

- If there was one thing you could do to improve health care delivery in this community what would it be?

**Appendix 2: Focus Group Background Questions**

**Community Health Assessment Study: Focus Group Background Questions**

As part of your participation in this focus group, we ask that you please fill out this brief questionnaire.  
Thanks!

1. What is your gender?

- Male..... 1
- Female ..... 2
- Other..... 3 

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 Years

2. What is your age?

3. How do you define your ethnicity?

- Latino or Hispanic ..... 1
- Other (Specify: \_\_\_\_\_ ) ..... 2

3. How do you define your race? (Please select the one you most identify with)

- American Indian or Alaskan Native ..... 1
- Asian..... 2
- Black or African American..... 3
- Native Hawaiian or Other Pacific Islander ..... 4
- White ..... 5
- Other (Specify: \_\_\_\_\_ ) ..... 6 

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4. What is your home zip code?

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 Years

5. How long have you lived in your current home?

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 Months

6. What is the highest level of education you've completed?

- Less than high school ..... 1
- High school diploma/GED ..... 2
- Some college/2 year diploma ..... 3
- College diploma (Bachelors) ..... 4
- Some graduate school..... 5
- Graduate school diploma (Masters or higher) ..... 6

7. What is the primary language spoken at home?

- Spanish ..... 1
- English..... 2
- Chinese (Cantonese or Mandarin) ..... 3
- Other (Specify: \_\_\_\_\_) ..... 4

8. What is your current employment status?

- Full-time ..... 1
- Part-time ..... 2
- Retired ..... 3
- Unemployed ..... 4
- Unable to work ..... 5
- Other (Specify: \_\_\_\_\_)..... 6

9. When St. Vincent's Medical Center was open, how likely was it that you would have sought health care there, compared to another provider?

- Very likely ..... 1
- Likely..... 2
- Unlikely ..... 3
- Very unlikely ..... 4

10. How important was St. Vincent's Medical Center to you when it was open?

- Very important..... 1
- Important ..... 2
- Moderately important ..... 3
- Of little importance..... 4
- Not at all important..... 5

### **Appendix 3: Focus Group Topic Guide**

#### **Introduction**

1. Introduce yourself by telling us (a) what neighborhood you live in, (b) how long you've lived there, (c) what you do, and (d) what, in your opinion, is the #1 health care issue in your community

*First, we'd like to start by getting a sense of how people make health care decisions. Along those lines...*

2. What factors influence your decision to choose one hospital or provider over another?
  - Convenience/location? Word of mouth? Reputation? Insurance? Race? Language spoken? Insurance coverage, if not, a sliding fee scale based on family size and income?

#### **Health Care Utilization and Service Gaps: Pre SVMC Closure**

*Now, we're interested in the specific "relationship" that members of this community had with SVMC.*

3. Can you tell us about the services you used at St. Vincent's when it was open?
  - Services related to primary care? Emergency care? Mental health services? Other svcs?
  - How long had you been obtaining health care services at St. Vincent's?
  - Where there any services that you needed that *weren't* available at St. Vincent's?
4. Did you go to *other* places for some of your care even when St. Vincent's was open?
  - Where did you go? For what kinds of services?
  - What about other members of your family?

#### **Health Care Utilization and Service Gaps: Post SVMC Closure**

*Flipping it around, now we'd like to know what it's been like obtaining health care since SVMC closed.*

5. Where do you all go now, for medical and/or mental health care services?
  - Have you had a problem accessing care since the hospital closed? What were the barriers/issues?
  - Are you still able to see the same doctor you had when St. V's was open?
  - What about access to your medical records?

*Given that it's been about 1 year since SVMC closed...*

6. What medical and/or mental health care needs are *still not being met* (in your communities)?

#### **Impact of Closure of SVMC**

7. What would you say has been the *most significant* effect of the closing of St. Vincent's on you?
8. What one thing would make the biggest difference to you?

#### **Wrap-Up**

9. Is there anything that we didn't ask that we should have? Do any of you have questions for us?

## **Appendix 4: Area-Hospital Mission Statements**

### **Saint Vincent's Medical Center:**

[http://en.wikipedia.org/wiki/Saint\\_Vincent%27s\\_Catholic\\_Medical\\_Center#Mission](http://en.wikipedia.org/wiki/Saint_Vincent%27s_Catholic_Medical_Center#Mission)

“Drawing on its Roman Catholic heritage, SVCMC's emphasis was on patient-focused healthcare, with a special mission to provide care for the poor and disenfranchised. While medical technology has changed dramatically over our 150 years of serving the medical needs of the community, our original mission of caring for all those in need has never wavered. “

#### Mission:

*Respect:* The basic dignity of the human person is the guiding principal in all our interactions, policies and procedures.

*Integrity:* Integrity is the consistency between the Catholic identity we profess and the ways in which we act it is that quality of truthfulness, which fosters trust.

*Compassion:* Compassion is the way we share deep concern, love and care toward each person.

*Excellence:* Excellence is our way of demonstrating that we can always be more, always be better.

### **Bellevue Hospital Center:**

<http://www.volunteermatch.org/search/org30632.jsp>

Mission: Bellevue Hospital Center provides high quality, respectful and accessible health care services to the people of our neighboring community and throughout New York City. Care is provided to all who require clinical and social support, regardless of ability to pay. Our tradition of public health, education and research continues as our guiding principle.

### **NYU Langone Medical Center:**

<http://www.med.nyu.edu/about-us/who-we-are/our-mission>

Mission: To Serve. To Teach. To Discover. We are committed to making world-class contributions that place service to human health at the center of an academic culture devoted to excellence in research, patient care, and education.

Patient Care that is: Patient-centered, Collaborative, Safe, Best Practice, Ethical, Respectful of individual dignity, Based on standards of excellence, Focused on improvement of individual and system outcomes, Available to our extended community

Medical Education: Redesigning medical education by developing a new Curriculum for the 21st Century that is patient-centered and disease-focused based on “spiraling” topics to enhance the intellectual link between the classroom and patient care.

Research: We will bring together outstanding basic scientists and clinical researchers, to foster highly collaborative, multidisciplinary investigation, inspiring new ideas and discoveries; and translating scientific advances more swiftly into new ways of diagnosing and treating patients and preventing disease.

**Beth Israel Medical Center**

<http://www.volunteermatch.org/search/org11213.jsp>

Mission: We pledge to provide quality patient care delivered and supported by a staff that promises a healing environment. We will treat each individual with dignity and respect, while working to restore and maintain the health of your mind, body and spirit.

**New York Downtown**

<http://www.downtownhospital.org/pages/3050/index.htm>

Mission: Downtown Hospital is a community teaching hospital committed to meeting the healthcare needs of the people who live in, work in, or visit Lower Manhattan.

As a community hospital, Downtown Hospital offers healthcare to meet the specific needs of the community with an emphasis on outreach and ambulatory services.

The Hospital also provides ready access to the most sophisticated medical technology and procedures through affiliation with the NewYork-Presbyterian Healthcare System.

As a teaching hospital, Downtown Hospital conducts graduate and undergraduate educational programs, continuing medical education programs, and provides clinical experience for physicians, medical students, nurses, and other health professionals.

Downtown Hospital offers its patients, medical staff, and employees a caring environment that emphasizes patient dignity and professional pride.

**Roosevelt Hospital (58<sup>th</sup> Street & 10<sup>th</sup> Avenue; 114<sup>th</sup> Street & Amsterdam):**

<http://www.volunteermatch.org/search/org22180.jsp>

Mission:

- Provide Outstanding Health Care to Our Community
- Provide Quality Education for Health Care Professionals
- Conduct Research to Advance Medical Knowledge

**St. Luke's Hospital (Morningside Heights):**

[http://www.chpnyc.org/patients/stl\\_home/aboutStl.html](http://www.chpnyc.org/patients/stl_home/aboutStl.html)

St. Luke's-Roosevelt Hospital Center, an Academic Affiliate of Columbia University College of Physicians and Surgeons, is a 1,076-bed, full-service community and tertiary care hospital. St. Luke's-Roosevelt was formed in 1979 by a merger of St. Luke's Hospital, adjacent to the campus of Columbia University, and The Roosevelt Hospital, located two blocks west of Columbus Circle. The St. Luke's and Roosevelt Hospitals, established in 1846 and 1871, respectively, brought to their merger extraordinary records of medical "firsts" and commitment to their patients.

### Commitment to Community

Throughout our history, St. Luke's-Roosevelt has placed a strong emphasis on responding with compassion and sensitivity to the unique needs of the communities we serve, including areas whose residents have multiple social and economic challenges.

The Hospital Center's ability to serve these populations is enhanced through relationships with groups including the William F. Ryan Community Health Center and the Council Health Center, as well as through school-based clinics at area high schools.

St. Luke's-Roosevelt initiates and supports a wide range of community health-focused activities and maintains an extensive network of relationships with churches and community groups throughout the West Side and Upper Manhattan.



## **REFERENCES**

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<sup>1</sup> A separate quantitative component, involving SPARCS data from the NYS health department, is being conducted separately by North Shore-Long Island Jewish (NLIJ) Health System and is independent of the research conducted by CUNY SPH faculty and reported herein.

<sup>2</sup> North Shore-Long Island Jewish Health System. (December 3, 2010) *Community Health Assessment Discussion Paper #3: Socio-demographic Description of the Service Area and Overview of Health Status Indicators*. Report to Community Health Assessment Steering Committee (presented by J. Kraut).

<sup>3</sup> Morgan DL. (1997) *Focus Groups as Qualitative Research*. 2<sup>nd</sup> ed. Thousand Oaks, CA: Sage Publications.

<sup>4</sup> Coffee A, Atkinson P. (1996) *Making Sense of Qualitative Data*. Thousand Oaks, CA: Sage Publications; Ritchie J, Lewis J, eds. *Qualitative Research Practice*. London: Sage Publications.