Evaluating the Community Impact of the Closure of Eugene, Oregon's Only Emergency Department

by

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In December 2023, PeaceHealth Sacred Heart University District hospital closed, leaving the city of Eugene, Oregon without an emergency department within city limits. This project evaluates the closure's impact on access to emergency care, particularly for those with financial and transportation barriers. Answering how the hospital closure impacted local access to and perceptions of local emergency care, this research analyzes eight interviews with those working in and around emergency healthcare, providing firsthand insight. These semi-structured interviews lasted 35 minutes on average, from those working primarily in nonprofits, local government, healthcare, and the University of Oregon. Overall, while the closure has complicated access to care in some regards, interviewees cite staffing shortages, inadequate primary care access, and financial barriers as greater challenges impacting healthcare access for the general public. However, the closure disproportionately affected the unhoused and University of Oregon students, whose proximity to the former hospital and limited transport options create unique barriers. These findings provide insight on the effects of hospital closures on communities amongst a broader trend of closures nationally, with an aim to inform future solutions.

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Introduction

With the closure of the PeaceHealth Sacred Heart Medical Center University District hospital in December 2023, the city of Eugene, Oregon was left without an emergency department. For the roughly 177,000 residents of Eugene (Census.gov), the closest care now lies across the Willamette River in neighboring Springfield. Figure 1 (page 7), highlights the locations of the two remaining hospitals in the region, centralized about 6 miles away from downtown Eugene in an area with a lower proportion of the region's overall population. This closure has the potential to impact access to emergency medical care for many, especially those with limited financial means for an ambulance ride, those without access to a vehicle, and those who live in western areas of the city. In trauma care, the "golden rule" of allotted transport time to medical care is 30 minutes to reduce negative outcomes (Sidibe et al., 2017), and this increased travel distance presents a new barrier to achieving this desired level of access.

The phenomenon of hospital closures is not exclusive to Eugene; cities across the U.S. have seen a reduction in hospital capacity amid a rise in ER attendance (Morganti, 2013), further exacerbating issues surrounding access to healthcare. Within the landscape of hospital closures, Eugene represents a unique case; most constitute reductions in a city's emergency department capacity, but this closure marks a complete elimination of service in favor of a smaller city nearby. With a population of about 61,000, Springfield is much less populated than Eugene, creating a situation unexamined in existing literature. Consequently, the unique impacts of this situation merit their own analysis, for both Eugene, and in the event of a similar closure elsewhere. This project will seek to answer how the closure of Eugene's only emergency department has impacted community access to and perception of emergency care.

In a November 2024 news article, the Oregon Nurses Association raised concerns about the wait times at the largest remaining hospitals in the region, citing patients waiting 8-13 hours for care at PeaceHealth's RiverBend hospital, resulting in complications for those experiencing time-sensitive conditions (James, 2024). The hospital closure is cited as a primary cause of these increased wait times, in addition to staffing and bed shortages, and understanding these impacts will be crucial to mitigating them moving forward. Without intervention, these prolonged wait times and barriers to access care can cause real harm to patients, and this project seeks to inform proposed solutions to remedy these challenges moving forward.

This project offers an in-depth analysis of how this closure has impacted access to emergency care in Eugene, and which communities were particularly affected. This project uses expert interviews with those working in emergency medicine and related fields to shed light on the effects of the closure on local access to care. These individuals have unique, first-hand insight into how the healthcare system functions today, and can speak to challenges they observe on a daily basis in their work. This participant pool offers the advantage of direct experience without asking individual patients about their medical crises. These interviews are supported by a reference map to contextualize and visualize the local landscape of emergency care.

The primary goals of this research are twofold. First, as the city and local hospitals debate about how to bolster emergency care in Eugene, this data identifies which communities are most impacted in the event of a medical emergency. Second, given the current landscape of hospital consolidation and closure across the U.S., this project offers a case study of how these trends are felt within the communities they impact, and which individuals may be particularly affected. Due to the unique nature of Eugene's hospital closure, this research addresses impacts which are unanswered by case studies from other regions.

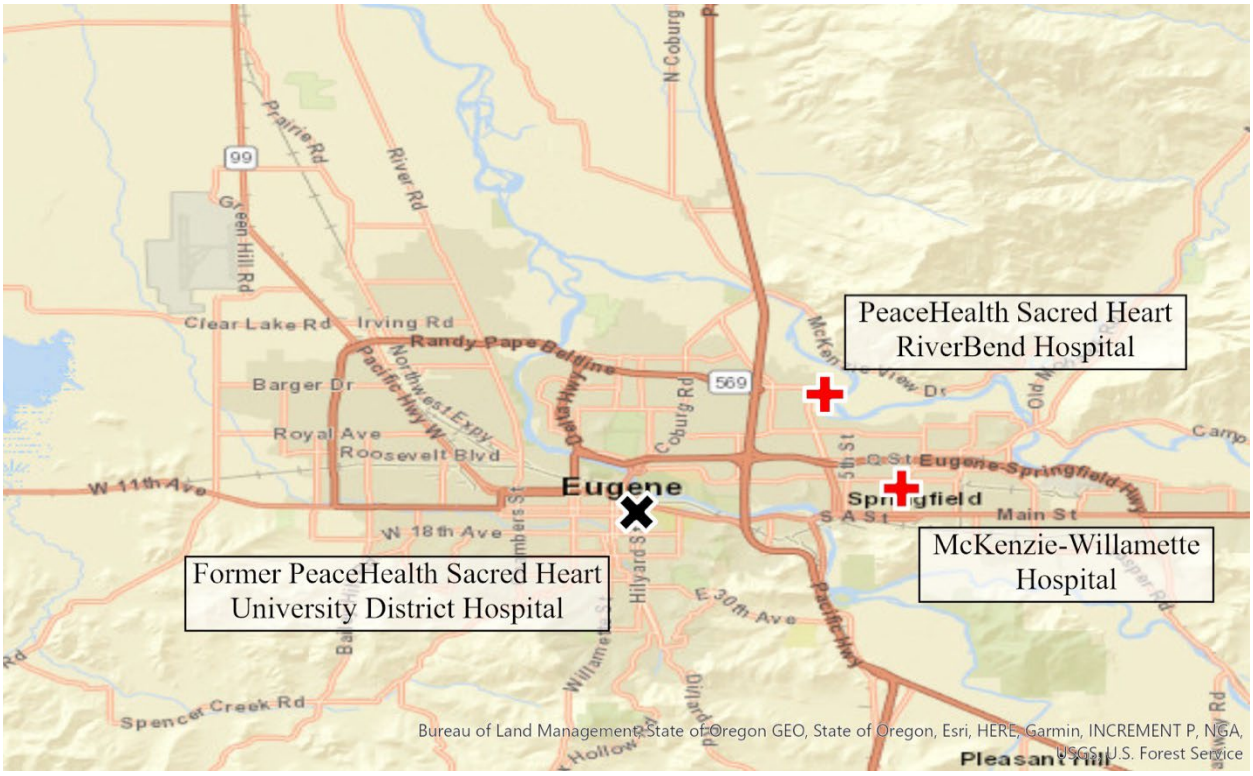

Figure 1: Hospital Reference Map

This map shows the locations of the two remaining hospitals in the Eugene-Springfield region, in addition to the site of the closed University District hospital. This map was generated using ArcGIS Pro software by ESRI.

Existing Literature on U.S. Emergency Care

The Current State of Emergency Care in the U.S.

Within the complex landscape of American healthcare, the emergency department (ED) play a unique role. Emerging in the years following World War II, EDs began as part-time operations staffed by "community physicians, rotating house officers, or moonlighters" (Morganti 2013, P. 1). Beginning in the 1970s, they began to resemble the 24/7 enterprises known today, with specialized physicians and complex diagnostic equipment. This shift increased in the role EDs play within U.S. healthcare, compounded by their legal obligation to offer access to emergency services to all. Enshrined in federal law in 1986, the Emergency Medical Treatment & Labor Act requires hospitals to offer emergency medical treatment to all, regardless of their ability to pay, in order to receive critical Medicare funds (CMS.gov). As a result, hospitals, and the EDs within, earned the title of "the safety net of the safety net" for those in need of medical care, and "are disproportionately used by low-income and uninsured patients who cannot reliably get care in other settings" (Morganti 2013, p. 2-3). This study estimates that the population most reliant on the ED for care includes "approximately 60 million low-income or uninsured Americans and many undocumented immigrants" (Morganti 2013, P. 49).

Consequently, recent trends within hospital access and availability may appear counterintuitive. From 2001-2008, ED visits nationwide grew at about double the rate of population growth, while hospitals closed roughly 198,000 beds over that same time period (Morganti 2013, P. 2). This trend has disproportionately impacted marginalized or disadvantaged groups – over that time period, hospital closures were 1.32 times more likely to cause a 30 minute or greater increase in commute time to the ED for high-poverty areas, and 1.5-1.6 times for communities with medium and high shares of uninsured residents (Hsia & Shen 2011, P.

1916). These trends have led to issues with overcrowding, as more people attempt to access care from a shrinking number of facilities and available beds. ED overcrowding can be detrimental to patients, potentially threatening the lives and wellbeing of patients, in addition to the general discomfort of a long wait to receive care. In a study of select California hospitals in 2007, patients admitted on days when EDs were experiencing high levels of crowding "experienced 5% greater odds of inpatient death… 0.8% longer hospital length of stay… and 1% increased costs per admission" (Sun et al. 2013, P. 2). High ED crowding was attributed to 300 inpatient deaths for the year in the hospitals studied, offering insight into the consequences of reduced hospital capacity and overcrowding across the U.S. medical system (Sun et al. 2013, P. 5).

Case Studies of Hospital Closures across the U.S.

Three key case studies on hospital closures across the U.S. provide relevant information for Eugene's closure. These articles examine the impacts of closures in L.A. County, New York state, and Rhode Island, all providing insight on urban hospital closures relevant to this study. In L.A. County, researchers obtained data from government sources and long-term hospital data on patient outcomes to determine how a series of hospital closures impacted care for urban residents. They found those impacted by the closures were statistically more likely to be white, hold U.S. citizenship, and have private health insurance, due to the neighborhoods of these closed hospitals being relatively affluent for the area (Buchmiller et al 2004, P. 11). Regarding perceptions of care, these closures resulted in a perceived decrease in "ease of obtaining healthcare" particularly for seniors, low-income individuals without a regular source of care, and those without insurance, despite a minimal overall perceived impact across all residents. Additionally, for certain conditions, a one-mile increase in distance to the hospital was found to increase mortality, reporting a 3-6% increase in deaths from heart attacks, and 4-6% for deaths

due to unintentional injury, while less time-sensitive conditions, such as chronic heart disease or cancer, saw no increase in mortality due to the closures (Buchmiller et al 2004, P. 20-21). These closures marked a reduction in regional hospital capacity between 3-4%, to reach potential cost-savings as more efficient hospitals took on a greater role in the system (Buchmiller et al 2004, P. 22). Overall, they estimated that these closures resulted in 30.5 additional deaths per year, which when evaluated using "standard value of life estimates" between $1 and $5 million per person in 2004, was less than reported gains in operating efficiency, despite the additional negative impacts not included in a financial approximation of human worth. This is a similar justification to the one offered in the case of Eugene's University District hospital closure, with poor financial performance and weak utilization numbers cited as the reasons for the closure, in order to shift capacity to more efficient facilities (PeaceHealth, 2023). However, given the fewer number of nearby hospitals, these negative impacts may be amplified in the case of Eugene.

In the case study on New York state, researchers evaluated how patient volumes were redistributed to other facilities in the wake of closures using state data on hospital visits. From 2004-2010, 15 hospitals closed, while 192 remained open across the state, with closures more likely in counties with higher uninsured populations, and more competition from other hospitals (Lee et al. 2015, P. 461). Hospitals nearby those that closed saw an increase in admissions, but at levels 20% lower than they estimated, attributed to some seeking alternative means of care rather than commuting the additional distance required (Lee et al. 2015, P. 464). These insights are useful in this case to estimate impacts to remaining emergency departments in the region, with differences due to their focus on state-wide impacts and long-term admissions data.

Finally, the most similar case to Eugene's situation is the closure of the Memorial Hospital of Rhode Island, serving the city of Pawtucket in the Providence, RI metro area.

Closing in 2018, studies on this closure are the most recent, and their focus on a single closure offers the greatest parallels to the closure of University District hospital. One study on the impact to remaining nearby hospitals due to the closure, found an 18% increase in monthly ED volume, a 24% increase in length of stay, and a 123% increase in patients leaving without being seen at the nearest remaining hospital (Lawrence et al. 2019, P. 38). Less significant impacts were found at the second closest facility, with both hospitals experiencing an increased proportion of Hispanic, Medicaid, and self-pay patients. A second study focused on the different narratives surrounding the reasons behind the closure. They utilized interviews to gain an understanding of what the community felt caused the closure, with themes centering on financial troubles, corporate mismanagement, and overall realignment of resources within the healthcare system (Savage et al. 2024). Another study on the same closure focused on the impacts to adjacent hospitals, and the impact to homeless patients in particular, both of which are particularly useful insights in the case of Eugene's own closure. The two nearest remaining facilities in Providence experienced increases in visits from unhoused patients, with those patients facing higher rates of discharge, higher rates of repeat visits, and significantly longer wait times than housed patients (Gummerson et al. 2022, P. 368). Overall, homeless patients were found to be disproportionately affected by the closure, who rely on ED services as a "critical access point" to care (Gummerson et al. 2022, P. 371). The closed hospital was identified as serving patients that were "more chronically ill, more impoverished, less educated, more likely to be a racial minority, more likely to use ED services, and more likely to be uninsured than patients in the rest of the state", with lower rates of car ownership and less access to transportation (Gummerson et al. 2022, P. 369).

For both the unhoused community and nearby hospitals, the impact of this closure was significant. The longer, repeated nature of visits from the unhoused placed an increased strain on

the hospitals, and the increased commute adding difficulty in accessing care for unhoused patients. These factors are relevant to the case of Eugene's closure; estimates vary, but the most recent Point-In-Time count from Lane County in 2024 reported over 3,000 people in the region were experiencing homelessness, increasing by 200 from the year prior, and by nearly 900 since 2019 (Wilk 2024). Reporting from 2019 placed the per capita homelessness rate in Eugene as the highest in the country (Adams 2019). The potential impact on such a large unhoused population as a result of the closure is high, given the resulting impacts in other regions on these individuals.

Defining Access and Inequality of Access to Healthcare

To evaluate how this hospital closure impacted access to emergency care in Eugene, it is crucial to define what access entails. One study breaks the concept of access to healthcare into five "dimensions of access": 1) availability, 2) accessibility, 3) accommodation, 4) affordability, and 5) acceptability (Penchansky & Thomas 1981, P. 128). These categories are interconnected and offer a useful set of definitions to discuss accessibility. The most relevant dimension of access to this study is general accessibility, defined as "the relationship between the location of supply and the location of clients, taking account of client transportation resources and travel time, distance and cost" (Penchansky & Thomas 1981, P. 128). Availability, or "the relationship of the volume and type of existing services… to the clients' volume and types of needs" (Penchansky & Thomas 1981, P. 128), in addition to the affordability of care, are also crucial dimensions of access to consider. Understanding how each of these five factors work together to facilitate or complicate access overall provides crucial insight to alleviating barriers to care.

Across the U.S. healthcare system, inequitable access due to affordability is pervasive. In 2017, Americans spent an estimated $10,209 per capita on healthcare, roughly double what other developed nations pay (Reinhardt 2019, P. 14). The reasons for these high costs are complex, but

its impacts are fairly straightforward; “a higher proportion of Americans than people in other developed nations deny themselves access to needed health care over out-of-pocket costs or have serious problems paying their medical bills” (Reinhardt 2019, P. 70). This situation is particularly relevant in the context of emergency care, where bills can be very expensive, and include the results of deferred medical care once issues become critical.

A study on Canadian EDs reported patient experiences of discrimination at the ED at a rate of 21.5%, with the top five factors being “substance use, appearance, mental health, [being] suspected of drug seeking, and age.” (Varcoe et al. 2022, P. 252). They identify how these factors intersect to make certain individuals feel less welcome at the ED. This study offers relevant insight into factors that may make care feel less accessible for certain patients.

Ambulance Access to Emergency Care

An important factor shaping ED accessibility is the role of ambulance services, and the crucial role they play for low-income individuals. In 2011, emergency medical services (EMS) transported over 15% of ED visits, with Medicaid coverage or a lack of insurance identified as factors that increase the odds of ambulance use (Meisel et al. 2011, P 1036). The role that ambulance services play for low-income is highly relevant to this case due to the increased travel distance required for ambulances to reach an ED. After the closure, ambulances reported an increase in time spent waiting at the two remaining Springfield hospitals for patients to receive medical care. The cumulative time that ambulances spent waiting at an ED increased about 13% after the closure (Thomas, 2024). Deputy Chief of Eugene-Springfield Fire Chris Heppel highlighted these impacts in an interview with local media, saying that increased travel distance and wait times due to the closure added “about 27 to 30 minutes per patient total unit time”

(DiCarlo 2024). Across the emergency care system, these increases add up, impacting the entire community, but especially low-income patients who rely on these EMS services to access care.

The Growth and Limitations of Urgent Care

In recent decades, the availability of urgent care has grown significantly, with a 7% average increase in urgent care centers annually (Urgent Care Association, 2023). Eugene is no exception to this trend; upon the closure of the University District hospital in December 2023, PeaceHealth relocated an urgent care facility from West Eugene to the University District campus (Richards, 2023). These clinics serve a role between primary care and the ED, valuable for conditions that are pressing, but less diagnostically complex or time sensitive. Despite these benefits, limitations within their services prevent them from perfectly replacing ED services. Having an urgent care in a given ZIP code was found to reduce the total number of ED visits for residents by 17.2%, often offering relatively lower wait times and costs for nonemergent conditions (Allen et al. 2021). These benefits are substantial; however, urgent care is limited in its ability to replace ED services, primarily due to limited service hours, reduced complexity, and no requirement to provide care regardless of financial means. Additionally, a 2016 study described them as "selective about their payer mix, [providing] a lower share of their care to Medicaid and uninsured patients than do emergency departments" (Le & Hsia 2016), with the availability of urgent care disproportionately distributed based on socioeconomic factors. On average, urgent care services are more common in younger, urban communities with higher incomes, and greater levels of private insurance (Le & Hsia 2016). These clinics represent a useful way to access care, with real benefits to patients in certain situations; however, they are not a direct substitute for ED services due to their limited scope and limited benefit for low-income patients.

Methods

This project centers on eight expert interviews with those working in emergency medicine in the Eugene-Springfield area, and relevant adjacent fields. Due to the sensitive nature of a visit to the ED, this focus offers a composite view of how access to emergency care functions today without prying into individual visits. Additionally, those routinely working in local emergency medical care have unique insight into how it operates, and what issues are most pressing in their work. These interviews generally fall into four categories, from groups with proximity to and insight into the closure, including 1) healthcare staff; 2) city employees, such as EMS operators; 3) nonprofit workers facilitating access to emergency care; and 4) University of Oregon employees working in healthcare. These participants were identified using purposive sampling and 'snowball' sampling, which involved participants identifying additional candidates for future interviews. While these methods of sampling introduce selection bias, they offer the critical benefit of the selecting individuals with relevant experience. Additionally, these methods allowed for the selection of participants across a broad range of positions.

The duration of these interviews ranged from 20 to 60 minutes, with an average duration of 35 minutes. All of these interviews took place remotely via Zoom or Microsoft Teams, although the option of in-person interviews was offered to all participants. Interview protocol and participant data privacy were reviewed and approved by the University of Oregon's Institutional Review Board. Grant funding was awarded by the University's Undergraduate Research Opportunity Program to provide compensation of $25 for each participant. While these funds were offered to five of the participants once funding was approved, only one participant accepted the money. These interviews were recorded using Apple's Voice Memos and transcribed using Microsoft Word's automatic transcription. Demographic information such as

age, race, occupation, and gender was collected using a pre-interview Qualtrics online survey, where participants also received informed consent information. All identifiable participant information remained confidential and has been omitted from this document. General information about how these individuals relate to the field of emergency healthcare will be included, and each participant was assigned a pseudonym to protect their identity. Participants received a brief introduction of this project before the interviews began in earnest, to orient participants and make sure they understood what their answers were being used for.

These interviews utilized a semi-structured format, incorporating both a set of pre-written interview questions, and further questions based on the answers offered. Each participant was asked a set of general questions, and an additional set based on their field of expertise; these were categorized using the four aforementioned groups of interest.

Participant	**Age**	**Occupation**
Addison	21	Student; Action Project Leader, Student Health Advisory Committee
David	36	911 Communications Supervisor
George	n/a	CAHOOTS First Responder
Janet	49	Board Member, PeaceHealth Sacred Heart Medical Center Foundation
John	67	Physician
Lana	50	Registered Nurse, formerly at PeaceHealth
Samantha	63	University Health Services, Public Health
Ray	48	University Health Services, Counseling Services Former Member of Lane County Forensic Intensive Treatment Team

Table 1: List of Participants, with Age and Occupation

Perspectives on the University District Hospital Closure

Over the course of eight interviews, participants spoke to a range of barriers to emergency medical care access that they observe in their work, with a varied and complex impact due to the hospital closure. Key themes included how the closure interacted with larger problems within the healthcare system, limitations of the University District (UD) facility, and disproportionate impacts for university students and the unhoused. Overall, participants reported a decrease overall in accessibility to care as a result of the closure but emphasized how the closure may be a less significant barrier than issues such as limited primary care access and financial influence on healthcare for the general public. Participants emphasized the disproportionate impact of the closure on certain populations, primarily University of Oregon students, and the local unhoused community, due to a variety of factors unique to these groups. Excerpts from interviews have been edited for length and clarity.

Interactions between the Closure & Underlying Issues within Healthcare

When asked about how the closure has impacted the local emergency medical system, participants offered a variety of responses, ranging from minimal to substantial impacts depending on their position and perspective. One constant across a majority of the interviews was the discussion of how other factors within healthcare act as barriers to care. The closure of the University District hospital exists within the wider context of local healthcare and interacts with these underlying factors to impact patient access in several respects. Issues that have been reported in local news coverage, primarily long wait times at remaining local hospitals, are multi-faceted, and the following factors were cited by participants as primary drivers of these issues.

Nursing Shortages and High Turnover

Five participants spoke to the impact that nursing shortages and high nurse turnover at the hospital level has had on the operations of local EDs. Staffing woes for physicians and other healthcare staff were mentioned, but nursing challenges were most commonly mentioned. John, who works as a hospital physician as well as with local non-profits to provide free community medical services, highlighted how staffing challenges limit overall capacity. He stated that "in order to see patients in the ER, you have to have a place to put them… so whether that's just physically there aren't enough beds, or there aren't enough beds because there aren't enough staff… it just kind of dams itself." George, who worked as a first responder with CAHOOTS crisis response, spoke to the issue of nurse burnout that he observed in his experiences at the ED:

> Part of the issue is not that UD closed, and part of the issue is just the number of nurses they have working and how many beds they can have open at one time. So, seeing PeaceHealth and McKenzie Willamette take better care of their nurses and give them more pay opportunities and do more for retention would be really cool because… the nurses get so burnt out working… and the turnover rate can be pretty high, which just affects the number of beds that they can have open. There are definitely days at RiverBend, I can mostly speak to the ER, but I know it's true for other floors, they have empty beds, but they don't have enough nurses to have the correct nurse to patient ratio.

These limitations regarding nurse staffing at remaining local hospitals leads to a decrease in overall ED capacity, contributing to longer wait times for patients. Factors that contribute to this shortage are complex, and present across healthcare nationwide, but participants cited it as one of the most pressing challenges regarding access to emergency care in Eugene.

Janet, a board member of PeaceHealth's charitable foundation, spoke to their efforts to address these issues with nursing retention and shortages. Known as the nursing excellence initiative, this program was intended to help ease disruptions within nursing staff that stemmed from the COVID-19 pandemic, namely an increase in the use of traveling nurses in place of local nurses:

> We had a lot of travelling nurses, especially during COVID, so the hospitals are really trying to get those numbers down, because while traveling nurses obviously fill a gigantic need… there's no connection really to the community, so wanting to build and retain and keep nurses that are here living as part of our community. That nursing excellence initiative was really to support and retain nurses here in Lane County at PeaceHealth and build them the support system… really working to get that turnover number down, which it has.

These efforts to reduce turnover rates and increase local nursing staff at the PeaceHealth facility in Springfield have helped, but other participants highlighted the continued impact of these staffing challenges. The issue of nurse pays, mentioned by two participants as a key factor in the burnout, turnover, and overall workplace dissatisfaction for nurses, remains pervasive.

Staff Morale

Four participants mentioned the impact that the closure had on overall healthcare staff morale, in addition to the impact from numerous other stressors experienced by those working in the industry. Ray, who currently works for University of Oregon's Counseling Services and formerly worked with Lane County as a frontline mental health crisis responder, spoke to these impacts across the healthcare landscape:

> Whether it's practitioners, so medical staff, psychiatric staff, people who work in all kinds of stuff, from group homes to treatment facilities to mental health facilities to physical health, it just feels like things just are a little bit funky. And because everybody has their story, anybody that works in this field and is trying to help people has some kind of a story about the impact of not having a local emergency department. And I've never heard a positive one since the ED closed. I think the impact is felt not only on the kind of dramatic street level stuff that I've been describing, but just the fundamental stuff… it's made a lot of my colleagues more bitter, and bitter honestly towards PeaceHealth, even though I don't think we all truly know the depth of the why, and don't understand necessarily some of their business needs of doing this.

This reflects the impacts on staff morale that can be difficult to quantify due to a hospital closure. He gave an example of somebody who may manage a group home for having to arrange an ambulance for a patient with chest pain, which places strain on providers to arrange

transportation, in addition to a “life saving timeline dilemma” due to the added transport time. These factors increase the strain places on healthcare providers in already stressful situations like a medical crisis, in addition to potentially worse patient outcomes.

These impacts on morale were reflected in an interview with Lana, who worked as a nurse at both the University District and RiverBend hospitals but left the organization before the closure was announced. She spoke to the impact that she observed amongst the nursing staff who worked the hospital when the closure was made public:

> I was already gone, but I still have friends that work there, I'm still on social media groups where nurses can go and vent and voice their opinion. And, yeah, definitely people were really upset. There was a lot of uncertainty about where… these people who've potentially been with PeaceHealth for a long time, where is their job going to be now? Are they gonna have to go work with the other emergency room? Are they going to be absorbed in some other floor, another unit? There was definitely similar concerns about the patient population that they saw with the unhoused, how are those patients now going to make it there when you're so many miles away, and what if there's a natural disaster and the only way to get there is over a bridge? So yeah, I definitely heard a lot of concern from the nursing staff.

When asked about how those concerns have changed since the closure, she said “I feel like people have just adapted, unfortunately. You can only fight for so long before you feel like you're just losing, and what's the point anymore?”. This sentiment reflects a lack of resolution to the concerns voices by nurses, and the resulting impact on overall morale. These repercussions exist alongside other stressors placed on nursing staff, especially in the stressful environment of a frequently crowded ED. George spoke to how these stressors trickle down to all parties involved in emergency care:

> Nurses at RiverBend, they're working their ***** off with crammed beds. I don't know if you've ever been in the RiverBend lobby on a Saturday night, but there's only room to sit on the floor. The sweet triage nurse- or maybe there's two nurses that have, like 9 patients that they're still waiting to triage, and then they're having people come in with acute symptoms that are jumping the line anyway… So, they just get ******* tired. And then the medics have the same thing. They're getting

> stuck waiting on the wall with patients for a really long time. They're getting treated a little poorly by the nurses, that in turn then is getting transferred to the patients… the poor support that providers are getting then trickles down into patient care and leads to patients just getting worse care – not because it's their fault necessarily. When you look at it on a more systemic lens, it's just everybody's tired.

This quote is a striking example of how stress on nursing staff leads to worse experiences for all parties involved in the ED. While the closure may not be the sole cause of the strain reported by medical providers, it added additional stress to an already demanding job.

When asked about staffing morale, John spoke to the issue of burnout amongst medical providers from a different angle:

> I have had emergency room docs from RiverBend who I know well use the term 'every time I have to go to work in the ED, it is soul crushing.' Because of all the problems we've talked about. Not just the closure of the other hospital, but all the things that I have mentioned here... You're probably familiar with the concept of physician burnout, physicians burning out at a much higher rate now than in the past. And there's actually a subset of that, that I'm not burned out -- burned out implies that it's more a personal issue, but it's this concept of moral injury. I can't provide the care I need to provide because of the system. And that's why I'm burning out. It's not my problem, that I can't handle it. Burn out seems to imply to many people more of a personal thing, while many physicians would say, no, I want to do this, but the system is just so bankrupt and broken that I can't.

This perspective demonstrates how challenges within healthcare coalesce to place strain on those working within it. Similar to the systemic lens mentioned in the prior quote, his use of moral injury to describe working in healthcare highlights the strain on providers due to structural challenges. The closure of University District hospital within this context is yet another stressor for employees who already experience immense strain in their work, impacting both their wellbeing, and the patient experience as a result.

Commercialization of Healthcare

Another consistent theme mentioned by participants is how financial aspects of healthcare impact patient access to care. Mentioned in seven of the eight interviews, the impact

from these factors is directly tied into many issues within healthcare that participants discussed. These range from how providers view their role and the services they provide, to the reasons behind the closure of the University District hospital. When asked about changes he would like to see to improve healthcare access, John emphasized the importance of primary care, and the impact of selective financial incentivization on his work:

> It has to be solving all these larger issues, more primary care. Why don't we have primary care? Well, I can spend 15, 20 minutes talking to a patient about stopping smoking, which ultimately might have a huge impact on them having a heart attack or a stroke 20 years from now. And our healthcare reimburses that for 15 bucks for counseling. I could be an ophthalmologist and take out a cataract in 15 minutes and get paid $2,000 bucks. So, there's a lot of disincentives in our medical system to really address what's important, you know, prevention, lifestyle choices, et cetera.

The financial valuation of certain medical services has an immense impact on which services are prioritized, and how patients are able to access care. John frequently emphasized the importance of access to primary care, and how consequences from inadequate access to primary care manifest into long ED wait times. He stated that “there's still far too many people using the emergency room for what could be more properly addressed in primary care. That's only getting worse with time, and the ED closure had little to do with that”. Issues around primary care compensation, affordability, and availability complicate access to care overall, with consequences for ED operations and wait times as a result of these financial factors.

Lana mentioned the financial state and motivations of PeaceHealth as a factor in both her decision to leave the organization. She said that “it just felt like when they built the new hospital [RiverBend], they couldn't afford it, and patient care suffered… when it was the old PeaceHealth and it was owned by the nuns, I loved working there.” She mentioned pressure from the company to reduce time spent with each patient, and restrictions on their ability to offer services, such as “snacks for your diabetic patient” as examples of how corporatization reduced her ability

to provide care. This pressure ties into other stressors that hospital staff experience, combining to increase strain on nurses. Later, when asked about how people perceive the local healthcare system, she discussed how PeaceHealth's increasing financial focus impacted their reputation:

> I think for years people have looked at Sacred Heart in kind of a negative light – you know, they call it 'sacred wallet' because it is more about the money, and I think that's just increased that feeling since closing the downtown hospital and ER.

This quote points to how increasing financial motivations have changed public perception of PeaceHealth. While generating enough revenue to continue operating is vital for a healthcare organization, participants cited the increased focus on financial performance as hampering their relationship with both employees and patients. The financial justification for the closure served to reinforce these negative sentiments amongst both healthcare providers, and the community.

Issues surrounding not only the growing influence of monetary factors in healthcare, but many of the aforementioned issues are not unique to Eugene; Samantha, who works for the University of Oregon's Health Services team, stated that "we are in an unwieldy, bureaucratic and fundamentally broken system here in the US, and it's no worse or better here in Eugene than anywhere else in the country". Many participants spoke to how underlying factors within U.S. healthcare intertwine to create the challenges that patients experience when accessing care; Samantha emphasized that emergency care is where that dysfunction is most apparent. Some of these factors were further complicated by the University District closure, while others are more structural. To summarize, participants described the impact from the closure on access to emergency care for the general public as negative, yet nuanced, interacting with fundamental issues within American healthcare overall to complicate an already-challenging system.

Limitations of University District and Minimal Impact from its Closure

In contrast to the impacts that the closure had in areas such as healthcare staff morale or local perception of PeaceHealth, some participants also highlighted the flaws of the facility, and two spoke to minimal impacts due to its closure. These sentiments were less common but offer insight into the role the former hospital played, and the reduction in service due to its closure.

Six participants discussed negative aspects of the University District facility that limited the services they were able to provide. One factor was the hospital's age – the complex was originally built in 1941, with extensive additions and renovations in the following decades (Cyr, 2023). As a result, the facility faced challenges not present at the newer RiverBend building. Lana praised the newer equipment at RiverBend, in addition to the elimination of shared double rooms at University District, "which could be really awkward for certain patients".

Other participants spoke to the limited services offered at University District, which saw many services and specialists shift to RiverBend following its construction. George described University District as "kind of like a glorified urgent care" due to the limited services offered, emphasizing its value for "minor to medium medical stuff". In her work with the University's Health Services team, Samantha stated that often times, trauma patients would be sent to RiverBend immediately despite the proximity of University District, due to the higher level of trauma care offered. John described the disparity between the two facilities in greater depth:

> They were admitting very, very few patients into the hospital at University District. None of the specialists went there. So, the only inpatient stuff that University District had was the Behavioral Health unit, which is still open, and they had a very small acute care of the elderly. It's been that way ever since RiverBend opened back in 2008. They weren't doing surgeries…everything was at RiverBend for the most part.

Ray offered a nuanced perspective on the capabilities of the facility. In his experience, "they seemed under-staffed [and] under-resourced", yet "a lot better than the current state" with the

hospital being closed completely. Overall, the facility faced challenges, both fundamental, and introduced with the relocation of services and staff after the construction of RiverBend. However, participants still saw the facility as beneficial to the accessibility of emergency care.

Two participants spoke to an overall minimal impact due to their closure. David, who works in the local 911 dispatch center, described their operations as staying largely the same after the closure. When asked about the impact of the closure on his work, he said that while there may be slight increases in commute and turnaround times for the ambulances due to an increase in travel distances, there was no "big noticeable difference for us in the center". He highlighted how the choice of which facility a patient is brought to is between them and the medic operating the ambulance, so their work remained unaffected in that regard.

Janet, who works with the local charitable wing of PeaceHealth, reported the least overall impact as a result of the closure. When asked about which communities may have been particularly affected, she stated:

> It is obvious that there are definitely pockets of the community that were very concerned when it was announced, and are probably still concerned regarding the closure of the University District emergency room… I think there are also a lot of nonprofit services in Eugene that do also help offset some of those emergency needs, like White Bird where… it's not an emergency room, but they are providing emergency services. So, I definitely understand maybe the fear around not having a dedicated hospital emergency room in Eugene, but personally, I don't see the difference between Eugene and Springfield.

These perspectives represent a counterbalance to the impacts mentioned by other participants regarding how the closure has affected local access to emergency care. The impact of the closure is highly dependent upon the context and experience of each participant, and these viewpoints reflect that for some, the services offered by the local emergency medical system remain largely unchanged due to the closure.

Disproportionately Impacted Groups

Many participants spoke to how the closure had an outsized impact on certain subsets of the local community. Unique characteristics of both the University of Oregon (UO) student body and the unhoused lead to a greater impact on access to care due to the hospital closure. These two groups share certain traits, such as their close proximity to the former University District hospital but differ greatly in areas such as the nature of their visits to the hospital, and what support services they have available to minimize the impact of the closure.

Impact on University Students

The impact of the closure on UO students was mentioned by four participants, with the greatest emphasis amongst participants who work for the school. One of the greatest impacts as a result of the closure on this population was the increased barriers to access mental health services, particularly during crises that require hospitalization, due to the increased distance to the ED. Samantha spoke to the additional challenges she has observed following the closure:

> One of the greatest impacts has been to mental health services... it's very difficult now to handle students who need hospitalization for mental health issues. Our staff, when this would happen, used to walk a student to University District. They have a Behavioral Health Center there on the premises, and it's still open, but it is managed through RiverBend. So, they have to go to Riverbend first now, they can't just go straight over. And so basically, now it's a heavier lift for us. We have to arrange for transportation for a student to go there. The return trip is difficult. After, if they are stabilized- if they are sent to University District behavioral health, they are likely transported, but getting them home if they're not, or getting them back to campus, is challenging.

Despite the proximity of the Behavioral Health Unit at the UD site, the required visit to RiverBend before a patient can access their services creates a functional barrier to access. Later, she further emphasized the value of walking a student over to the hospital in the event of a mental health crisis, which was echoed by her colleague, Ray. He described how the transport process for a student during a mental health crisis now looks with the increased distance:

> If a student needs to get to the hospital for a psychiatric reason, we have to make a judgment call. Like, is it a taxi ride? Is it a police transport by UOPD without handcuffs? If it's an involuntary thing where somebody has to go, and they don't want to go, then there's a whole involuntary process where police officer can put a hold, but they usually have to handcuff somebody and transport them – not arrested, but it's traumatizing, typically, for students and anybody going through that… now it's all these logistics. And we're dealing with populations of folks who aren't like I was describing on the street and stuff, not the extreme scenarios. But it's still equally complicated. What happens to that student that makes their way over to Springfield, but then gets discharged at 3:00 AM? What do they do? Whereas before they could just walk home to the dorms or whatever. [It would] be a rough night, but it wouldn't be how do I get from the outskirts of Springfield back home?

These logistical complications as a result of the increased distance to reach the hospital represent a stark decrease in accessibility due to the closure. Ray offered examples such as students who may be experiencing psychosis, major depression, or be suicidal, where walking a student over to the hospital was much preferred to arranging transport. During serious mental health crises, the added distance to reach medical care reduces accessibility for the student body.

On the other hand, participants highlighted the medical services offered by the university as effective and comprehensive, helping to mitigate the impact from the closure. Later in the interview, Ray went on to highlight the wide range of services offered by University Health services in both emergency and nonemergent situations. He cited services like mental health services, x-rays, sports medicine, urgent care, and sexual assault evaluation nurses as addressing many medical needs that students may face, and that "the ability to do really comprehensive care here is high". He emphasized that many of these services may prevent the need for students to go to the hospital, in addition to their ability to "catch things before they're a real problem" which may require hospital-level care. These services help address issues of primary care accessibility and misuse of the emergency department mentioned by other participants, which both benefits students and reduces strain on the remaining local hospitals. In the event that a student does require an ED visit, he praised their clear guidelines for addressing the situation, adding that "if

you had to get transported to the hospital from here, it's pretty fast… even though it's a bummer that the hospital is in Springfield". In short, he felt that University Health Services could address most medical needs of the student body despite the closure, a sentiment was that was echoed in the other two university-focused interviews.

Additional efforts launched by the university following the closure help to mitigate transportation barriers posed by the increased distance. Two participants highlighted the recent introduction of Uber vouchers to pay for students to reach the emergency room, easing the financial burden of arranging for transportation. These efforts, in addition to the range of medical services offered by the university, help reduce the overall impact for the student population as a result of the closure. Despite the acute negative impact on students accessing mental health care during crises, participants viewed these institutional resources as generally effective in addressing the additional geographic barriers to medical care introduced by the closure.

Impact on the Unhoused

Five participants spoke to the impact that the closure had on the local unhoused community. Relative to other subsets of the population, those without stable housing face the greatest impact from the closure due to a variety of factors. As established in the literature on hospital access, low-income individuals tend to rely disproportionately on ED care in lieu of traditional sources like primary care, and the unhoused in particular are most impacted by a hospital closure (Morganti 2013, p. 2-3; Gummerson et al. 2022, P. 371). Participants spoke to similar challenges in the case of Eugene's homeless population, in addition to barriers to care that are unique to the local healthcare landscape.

Within the region, the unhoused population is predominately centered in Eugene, and the majority utilized the University District hospital for care before the closure. John detailed the reasons for this imbalance as follows:

> For a long time, Springfield has been much more homeless unfriendly than Eugene has. You don't see near the number of homeless people in downtown Springfield as you do in downtown Eugene and it's been that way for a long time, and so very few of the homeless were using either McKenzie Willamette or Riverbend because that's not where they were, and now there are only two options are over there, not where they tend to be living or staying.

George mentioned a similar trend in his work with CAHOOTS, noting that the closure represented an immediate jump in the distance required to reach care. This increase was coupled with transportation barriers that make accessing remaining local hospitals in Springfield difficult. John noted that CAHOOTS was an option for medical transport for the unhoused (prior to its elimination in Eugene), in addition to ambulance service, while George mentioned the role bus service played. RiverBend is served by the EMX bus line, a bus rapid transit line connecting the region, which is useful for some, but he noted that “a lot of folks that we see are not allowed on the bus.”, and for those who are, “You could go to the hospital at 4:00 PM and the buses run until 11, but you don't actually get discharged till two or three and you're in a pickle because you're way out in northern Springfield and there's not much out there”. These factors have led them to discourage ED visits for “minor to moderate stuff” due to a “high likelihood that they'll get stranded out there.” While these nonemergent conditions have been cited by other participants as negatively impacting ED operations and increasing wait times, these individuals may lack alternative options for treatment, potentially leaving conditions to worsen until they do constitute an emergency. These transport limitations represent a large barrier for the unhoused in accessing the ED, leaving those in medical crisis with few options to access necessary care.

Another factor which poses unique challenges for those without stable housing is the availability of discharge options for patients after their hospital visit. John described a gap in the "middle level of medical recovery" for patients, with particular difficulty for those living on the street, which complicates the healing process immensely. He highlighted a lack of discharge options in particular for the elderly, who "maybe don't need a nursing home level of care, but they need adult foster care" and face challenges like fall risks while living unassisted at home, in addition to the unhoused:

> There are multiple patients sitting in the hospital, in-patients that are ready to be discharged from the hospital, they don't need hospital level of care anymore, but there's no place to discharge them to. They're homeless and we can't really send them back to their camp, but they don't qualify for a nursing home and so we're looking for where can we discharge them to that it's a safe discharge? So, every day at the hospital, we have patients sitting in the hospital that don't really need to be there, but we don't know where to send them. And that just backs up to the ED.

This lack of discharge options represents a challenge not only to their medical recovery, but to hospital operations overall, contributing to long wait times observed at local EDs. He spoke to efforts made by PeaceHealth to create more supportive discharge options for patients, which have seen some success. One initiative involved renting beds in local nursing homes, which allowed RiverBend to override their ability to decline admittance on the grounds of issues like "a history of drug abuse and mental health [challenges]". Despite these efforts, he cited "strict standards to have Medicaid pay for nursing home placement" which may leave some unable to afford this care, regardless of its availability. Another, known as the "pallet program", gave patients a single-occupancy shelter to recover for one to two weeks after discharge from the hospital, and receive resources like meals and home health services. However, this program requires that patients be "totally independent of activities of daily living – able to walk, bathe, feed yourself, [and] walk across the street to get a meal", which excludes some patients. The challenges of finding adequate levels of care for patients after discharge from the hospital leaves

some unable to access the support they need. John went on to offer an example of a patient who may find themselves lacking the necessary support to recover upon discharge from the hospital:

> We're finding an increasing number of elderly patients homeless for the first time – [a] prime example would be a couple in their 60s, not married, they both have social security. One dies, and now that single income is not enough to pay for the apartment they had, and that person's now out on the street with significant medical issues for the first time at age 62.

For a variety of confounding factors, the issue of finding appropriate care for certain patients upon discharge from the hospital remains, despite these efforts to address the problem. This challenge is felt not only by unhoused patients who may struggle to access the necessary support upon leaving the hospital, but the extended boarding of patients in the hospital as a result.

An additional complicating factor for the unhoused in accessing care is the complexity of their medical conditions, which participants mentioned often include a range of mental and physical components. Ray spoke to the difficulties this posed as a mental health crisis responder:

> There's the whole psychiatric piece, [and] we can handle quite a bit on the street level for psychosis and things, but there's a ton of medical problems that people have. You know, they've been under supported, under resourced, under treated for sometimes decades. But even a few years of running kind of hard on the streets and doing a lot of drugs and not tending to health stuff, a lot of our clients would have schizophrenia or bipolar or major depression, PTSD as the mental health diagnosis. They'd be unhoused, poor nutrition because they [lack] access to good food, but would always almost always have a serious medical condition, and most of those medical conditions were related to just being on the streets and having like a wound that got untreated…There's all of that, so having access to emergency room level of care, or urgent care style, emergency department level care or whatever you call it for health was really important.

He went on to describe the difficulties imposed by the added travel distance to the hospital after the closure of University District:

> We [had to] figure out again how to transport, and usually those chronic conditions or acute injuries that were undertreated or never treated, they don't rise to the level of an ambulance ride, and then White Bird would typically maybe help us, but they were usually 3 or 4 hours out, so that wouldn't necessarily be for CAHOOTS to help us as a backup. So, I remember times where we'd have to

> figure out and make judgment calls – sometimes you think, that looks like MRSA or something really contagious, and the staff would be like, I don't really want to bring that person in our vehicle. But sometimes you just have to decide, go out and expose myself to something contagious, just to get this person to the Springfield side of town. We had a situation where we did one of these things and afterwards, we found out that it was highly contagious, so one of two vehicles that we had had to get taken offline and get super cleaned. It took like a month for us to get our vehicle back because they had to completely clean it, decontaminate it.

This example highlights how a variety of challenges, including the complexity of medical needs, transportation difficulties, and strain on support services represented challenges in providing care for the unhoused, which were all amplified due to the closure, echoed by other participants as well. Ray went on to praise the nursing staff at University District, who had the experience and institutional knowledge to effectively address the conditions facing many unhoused patients:

> When I had individuals, either in the clinic setting or in the street setting that needed hospital level care, whether it's medical or psychiatric, we would bring them down to the ED at University District all the time, and it was super easy, super convenient… If we were calling ahead and letting them know, the nurses often knew us and knew their clients, so there'd also be potential for care coordination ahead of time, so when they received us, they wouldn't be surprised who we were with or what we needed... And then, because the behavioral health unit was right there too, there was a synergy from outpatient street work to handing off to the emergency department… It was really obvious when Springfield took over that they weren't prepared to deal with our clients in the way that the University District was. They didn't have the full-scale psychiatric setup, so then there was this kind of awkwardness.

He cited a "legacy of being the urban kind of gritty hospital that could just handle whatever" amongst their staff, which did not necessarily translate to RiverBend after the closure, leaving unhoused patients without the support they used to receive at the facility. George described the treatment of the unhoused at University District in a less positive light, while still highlighting the relative benefit, stating that "it's not to say that they were ever treated particularly well, but now it's pretty dismal." These two perspectives reflect a worse experience for unhoused patients at the ED as a result of the closure, and a disruption of the institutional knowledge and synergy in treating this population, despite varying levels of praise for experiences at the former facility.

Access to emergency care for the unhoused following of the closure has also been impacted by reduced availability of support services. Participants pointed to local non-profit and government-run services as critical reducing barriers to care introduced by the closure, with three naming CAHOOTS as especially important. However, a termination of their services in Eugene in April 2025 eliminated this critical support, when the city did not renew their contract (Hansen-White & Lehman, 2025). George, who worked as a CAHOOTS first responder but recently received the news of his termination prior to the interview, discussed the gap left behind in the absence of CAHOOTS. He highlighted their ability to divert people from the emergency room, reducing ED operational strain and improving patient access to care, and emphasized that proposed solutions, primarily the expansion of the Lane County Mobile Crisis program to replace CAHOOTS, fail to replace these benefits. He described the disparity as follows:

> I'm biased a little bit, admittedly, but we really pride ourselves on our integrated health model, which means we have the mental health and the medical worker, because we recognize that people's crises do not exist in a bubble. Folks can have a mental health crisis, but also a host of medical issues. Folks can have medical emergencies that present as mental health crises.

Other participants echoed the value of treating these issues together, due to their interconnected nature. The elimination of CAHOOTS service in Eugene, in conjunction with the impacts for the unhoused from the closure of University District hospital, serve to further increase barriers to accessing emergency care for the unhoused. Lacking the support of an institution like the University of Oregon, which eased the impact of the closure for their student body, the elimination of critical services offered by CAHOOTS only serve to make emergency medical care more inaccessible for the unhoused. The closure of the University District hospital and the reduction in emergency medical support services, together with the variety of barriers already facing unhoused individuals while accessing medical care, coalesce to create a major reduction in access to critical medical care for some of the city's most vulnerable residents.

Conclusion

The closure of Eugene's PeaceHealth University District hospital has reshaped the region's landscape of emergency care, with a complex impact related to a host of challenges within healthcare, both local and nationwide. Long wait times and overcrowding at the remaining local EDs, which can increase mortality, duration of hospital stays, and cost of admission, are a result of both the closure, and other structural problems within healthcare (Sun et al. 2013, P. 2). Participants identified primary challenges such as nursing and physician shortages, financial motivations within healthcare, and inadequate access to primary care as most pressing factors reducing accessibility of care and causing operational issues at remaining EDs. The closure worsened some of these; participants cited impacts to staff morale across the local healthcare ecosystem, and a worsened local perception of the hospital's operator, PeaceHealth. Other factors that impact ED operations and access, like limited primary care access and discharge options for some patients, go beyond the scope of the closure. Taken together, the closure reduced access to care for the general public, primarily due to increased travel distance; however, long wait times may be more attributable to factors like staffing challenges rather than the closure. The magnitude of the closure's impact ranged from minimal to substantial depending on the participant but was perceived overall as reducing accessibility of emergency care for most local residents.

Participants identified two key groups as disproportionately impacted by the closure, relative to the general public: University of Oregon students, and the local unhoused community. While both enjoyed close proximity to University District hospital and saw a large increase in travel distance to the ED, differences in support services and resources creates very different outcomes for the two groups. Participants cited a major impact on students during mental health

crises, who now faced greater transportation barriers to reach care. However, the expansion of services such as travel vouchers to reach the hospital, and comprehensive care offered at the campus health center, limited the impact of the closure in most other cases. Unhoused residents, on the other hand, are disproportionately reliant on the emergency room for medical care and often the most impacted in the event of a closure (Morganti 2013; Gummerson et al. 2022). Fundamental challenges like complex physical and mental health challenges, in conjunction with limited access to alternative care options and financial resources leave unhoused individuals most vulnerable following the loss of ED services nearby. The elimination of CAHOOTS, the most critical support service for the unhoused, represents a further reduction in access to care that is unique to Eugene. Combined with the complexity of their medical needs and limitations in adequate discharge options upon release from the hospital, this population faces a number of barriers in accessing necessary care. As a result, access to emergency care for the unhoused has been greatly reduced following the hospital closure, impacting the city's most vulnerable residents at a much greater level than that experienced by the general public.

These findings are in line with similar case studies of hospital closures in other regions, which reflected impacts to nearby ED operations, and disproportionate impacts on low-income and unhoused individuals (Lee et al. 2015; Gummerson et al. 2022). However, this research reflects unique impacts resulting from underlying factors within healthcare on access to emergency care, which are heighted due to the closure, but not necessarily a direct result of it. Additionally, the unique impact to a student population due to the closure was not echoed in prior case studies and represents a group that is uniquely impacted in the case of Eugene's hospital closure, despite the availability of institutional support to ease the impact of the closure.

Limitations & Further Research

This research included participants with a diverse range of experience, including emergency room expertise, street-level first response, 911 dispatch, and university health services. However, the limited number of interviews, and key groups that were not represented in this subject pool represent areas for improvement. Specific challenges included reaching participants who work at PeaceHealth, despite numerous attempts to reach those working in the remaining Springfield hospitals. Attempts were made to contact potential participants through personal connections, online leads, and networking at a local healthcare event; however, each request was either denied or received no response. In one instance, someone working at a local hospital stated that they were unable to speak on the subject of the hospital closure, which was likely an unspoken factor for many more. Further research that is able to incorporate perspectives from those working in remaining facilities on hospital closures would provide useful insight. Additional challenges were encountered when contacting those working for the government of Eugene, in which prospective participants did not respond to requests for interviews or stopped responding during the interview scheduling process. The primary impact from this missing perspective is limited information on the closure's impact to local EMS operations. While local reporting cited the closure as negatively impacting their operations (e.g. DiCarlo 2024, Thomas 2024), this study lacked participants who could speak to these impacts, and future research would benefit from the inclusion of this perspective.

This research was conducted over the span of a few months and provides an exploratory look into the state of emergency healthcare in Eugene today. Future research on this subject may be able to shed additional light on this subject through a more extensive study scope, and a longer research period. Interviews with a wider range of participants could shed additional light

on the impacts of the closure on their work and incorporate a greater range of perspectives. Additional information may be found through interviewing individuals about their personal experiences accessing care at the two Springfield hospitals, which was not feasible for the scope of this project. Due to the exploratory nature of this research, there is not a large concentration of perspectives from any single field within emergency healthcare. Further research focusing on a specific subset of that field to create an in-depth analysis of their perspectives on healthcare would offer a greater depth of information. A geospatial analysis of the closure studying the impact of the closure on drive times to the remaining hospitals, with an emphasis on socioeconomic factors of those most affected, would offer a useful perspective into this closure at a geographic level. Finally, further research on issues that participants identified as barriers to care beyond the closure, like difficulties with primary care, limited discharge options for some patients upon leaving the hospital, and the impact from the elimination of CAHOOTS service merit investigations of their own.

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