THOMAS L. GARTHWAITE, M.D.
Director and Chief Medical Officer

FRED LEAF
Chief Operating Officer

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
313 N. Figueroa, Los Angeles, CA 90012
(213) 240-8101

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November 12, 2004

The Honorable Board of Supervisors
383 Kenneth Hahn Hall of Administration
500 West Temple Avenue
Los Angeles, CA 90012

Dear Supervisors:

PROPOSED REDUCTION OF TRAUMA SERVICES AT MARTIN LUTHER KING, JR./ CHARLES R. DREW MEDICAL CENTER
(2nd District) (3 Votes)

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve the proposed reduction of trauma services at Martin Luther King, Jr./Charles R. Drew Medical Center.

2. Instruct the Director of Health Services, or his designee, to submit for the Board's consideration, an appropriation adjustment, as necessary, for Harbor-UCLA Medical Center to provide for additional trauma patients resulting from the closure of the Martin Luther King, Jr./Charles R. Drew Medical Center trauma unit.

3. Delegate authority to the Director, or his designee, to amend the trauma services agreement with St. Francis Medical Center, as necessary, to provide for additional trauma patients resulting from the closure of the Martin Luther King, Jr./Charles R. Drew Medical Center trauma unit.

PURPOSE/JUSTIFICATION OF PROPOSED RECOMMENDATION:

The Department of Health Services (DHS) has recommended to your Board that, for purposes associated with patient safety and quality of care, trauma services at Martin Luther King, Jr./Charles R. Drew Medical Center (KDMC) be closed.

FISCAL IMPACT/FINANCING:

There are no expected savings to the County to be realized by the closure of the trauma unit at KDMC because the personnel and resources presently used for trauma patients will be reassigned to the care of other KDMC patients. Additionally, supplemental funds will be expended to support the additional patients absorbed by Harbor-UCLA Medical Center, St. Francis Medical Center, and the newly-designated California Hospital Medical Center as the result of the closure of KDMC's trauma unit. The potential additional costs associated with these patients are expected to exceed any savings associated with the closure of the KDMC trauma unit.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS:

Over the past year, the Department has been examining closely the clinical operations throughout KDMC. Based on its review, as well as the findings by federal, state, and private regulatory and accrediting agencies, it has determined that the high volume of traumatic injuries presented to the hospital threatens the quality and safety of patient care. These agencies and the Department have identified significant weaknesses at KDMC in the provision of basic health services. In light of these issues, the current number of patients requiring complicated, resource-intensive services cannot be assured an acceptable margin of safety and are best not placed in this care environment.

The stress of caring for the most complex patients has inhibited the ability of the hospital to overcome the significant challenges it faces in restructuring and improving the quality of care. The Department has determined that the most effective way to achieve a safer clinical environment is to lower the number of critically-ill patients entering the hospital. The most appropriate way in which to achieve this, while continuing to ensure the broadest continued access to the hospital, is through the closure of the trauma center.

Regulatory and Accreditation Issues

Since January, KDMC has undergone nine surveys by either the federal Centers for Medicare and Medicaid Services (CMS) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). CMS has conducted four reviews, two of which have been full-scope surveys that have examined all areas of the hospital. The result of the May full-scope survey resulted in the hospital being out of compliance with three of the Medicare Conditions of Participation – nursing, patient rights, and physical environment. This led CMS to propose termination of the hospital from participation in federal programs, which could result in the loss of $200 million in funding.

The hospital also has received two "Immediate Jeopardy" citations by CMS in the areas of medication management and management of assaultive behavior (patient rights), which required immediate correction in order to avoid the loss of federal funding.

While CMS has accepted the Plan of Correction and conducted a follow-up full-scope survey in October, it is clear from that resurvey that the hospital has considerable work ahead in order to ensure ongoing full compliance with the Medicare Conditions of Participation.

King/Drew also has come under significant scrutiny by JCAHO for lapses in patient care. JCAHO has conducted five surveys of the hospital, one triennial review and four in response to adverse clinical events. As a result of the August 13 and 14 unannounced survey, which identified deficiencies in a range of patient care issues, JCAHO issued the preliminary denial of the hospital's accreditation. The Department appeared before JCAHO in October to appeal this determination and the full Commission will meet in December to issue a ruling. If JCAHO votes to disaccredit the hospital, DHS will have one more appeal option before a final determination is rendered in February 2005.

JCAHO accreditation is a requirement for designation as a trauma center and is expected for accreditation as an academic training site. As such, if KDMC ultimately loses its JCAHO accreditation, it would no longer qualify for designation as a trauma center and could lose its ability to operate resident training programs.

KDMC's trauma center also has been without accreditation by the American College of Surgeons (ACS) since 1999. In denying its approval, ACS cited a number of problems with the hospital's performance improvement process, insufficient continuing medical education for physicians, lack of reimplantation services, and resident physicians performing procedures without appropriate supervision.

Finally, the resident training programs at KDMC also have been the subject of adverse regulatory actions over the past year. In May, the hospital received its second unfavorable institutional accreditation by the Accreditation Council on Graduate Medical Education (ACGME). If the deficiencies identified are not corrected by the next survey in 2006, the hospital will lose its ability to operate any resident training programs. In addition, effective June 30, 2004, ACGME withdrew accreditation for the surgery and radiology training programs. The loss of surgery residents makes it extremely difficult to sustain adequate surgical coverage for the trauma unit. Further, the ACGME's withdrawal of the surgery training program's accreditation resulted in hospital being downgraded from a Level I to a Level II trauma center, effective July 1, 2004.

While other than the surveys conducted by ACS, outside regulators have not singled out the trauma service for specific criticism, the general problems identified in such areas as documentation, medication management, and patient assessment, exist throughout the facility. The trauma unit is inextricably tied to the rest of the hospital and its resources. Trauma patients are served by the same ancillary service departments as patients elsewhere in the hospital and once a patient leaves the trauma unit and is admitted to an inpatient bed, the individual's outcomes are equally dependent upon the consistent delivery of high quality care.

Patient Flow

The majority of KDMC patients enter the hospital through the emergency room or trauma unit, either transported by ambulance or brought in by a family member or friend. Some of these patients are treated and discharged the same day, as their medical condition is not critical or life-threatening. This is true of patients in both the emergency room and the trauma unit. Eighty-one percent of the hospital's admissions come through the emergency room, as compared to nine percent through the trauma unit.

The most serious of these patients require care in an Intensive Care Unit (ICU). If there is no capacity in the ICU, patients remain in the emergency room or trauma bay. Neither the emergency room nor the trauma unit is staffed or equipped to handle the level of care required by an ICU patient over a long period of time. These areas are not structured or staffed to accommodate long-term patients. Emergency and trauma units are designed for short-tem patients who are moved into a longer-term, more managed care setting. For example, the dietary and pharmacy services are not organized to manage long-term patients in these temporary settings. This less than optimal placement of patients makes it more difficult to manage their care and does not provide for the best opportunity for improving their health status.

The increased acuity of ICU-level patients strains the resources of the emergency room and the trauma unit, leading to potentially unsafe conditions. Similarly, some patients who require surgery as a result of their injury or illness are taken to the operating room and remain in the post-anesthesia care unit for a lengthy period of time until an ICU bed becomes available, straining the resources in that unit.

Over the past three weeks, KDMC's trauma unit has increasingly been placed on diversion because the hospital could not safely accommodate additional critically-ill patients. In recent weeks, multiple patients have waited an extended period of time in the trauma bay or emergency department for an ICU bed.

On any given day, between seven and nine patients in the trauma unit, Emergency Department, or Post-Anesthesia Care Unit, are awaiting transfer to an ICU bed. Recently, the hospital had 15 patients in need of an ICU bed and no ability to place them. This situation does not serve the patients well and is unacceptable.

One of the critical components of ensuring a safe clinical environment is the ability to recruit qualified permanent nursing staff to provide patient care. Due to a number of factors – which include the national nursing shortage, negative perceptions of the hospital work environment, and problems with skills competence – KDMC has been unable to hire sufficient nursing staff to staff the fully budgeted number of ICU beds, which leads to long patient wait times for an ICU bed.

One frequent misconception has been that the hospital lost nurses in the cascade conducted last year. There was no reduction in nursing staff at KDMC as the result of the cascade nor has any hiring freeze been imposed for these critical positions. In fact, the hospital's budget was increased last year to accommodate the additional nursing staff required to comply with the nurse staffing ratios that went into effect on January 1, 2004. Further, the facility has enhanced its contracts with private registry and traveling nurses to encourage their acceptance of positions at KDMC.

While they constitute only nine percent of the hospital's admissions, the highly acute condition of trauma patients, their treatment requirements both in the trauma unit and upon admission into the hospital, places extraordinary demands on numerous hospital systems. These demands are immediate and often must be given priority, forcing other patients to wait, not only for an inpatient bed, but for surgical and ancillary services as well. This results in the disruption in the efficient flow of patients through the hospital and in the management of patient care. These stresses place

greater demands on the hospital and inhibit the correction of the underlying structural problems in its operation. Until or unless this demand is reduced, timely and successful resolution of these problems is compromised.

Considering Other Options

One suggestion that has been raised by some in the community is the possibility of limiting, rather than completely eliminating, trauma services at KDMC. This is not feasible for a number of reasons.

In February 2004, the County's Emergency Medical Services (EMS) agency altered the trauma catchment area surrounding the hospital in order to relieve some the trauma volume, particularly in light of the temporary closure of the telemetry unit as a result of unexpected patient deaths. Since that time, the number of trauma patients treated at KDMC has been reduced from over 2,700 to approximately 1,800 annually. There has been no evidence that this alteration of KDMC's trauma catchment area, and the resulting decrease in its trauma caseload, has had a negative impact on the community's overall access to trauma care.

Despite the reduction in trauma volume, the demand at KDMC for ICU beds and high level ancillary services continues to exceed its capability and the hospital continues to have problems in the management of critically ill patients admitted to its ICUs. Trauma patients have a higher likelihood than others to require an ICU bed and the intensive services that support their care.

Additionally, reducing trauma volume would not only fail to support efforts address the underlying problems that exist at the hospital, but could lead to other deficiencies. Even if the trauma volume were to be reduced further, the regulatory requirements for physician coverage would remain the same. KDMC would continue to be required to maintain 24 hour a day/seven days per week surgical and sub-specialty coverage, even if the number of patients coming into the trauma unit is minimal. As physicians perform fewer surgeries and other procedures, their proficiency decreases. The most clinically capable physicians are those who regularly practice their craft. Additionally, if the hospital desired to seek ACS verification again in the future, it would be required to have a minimum of 1,200 trauma cases per year for accreditation.

Emergency Services

The hospital and its emergency department will not be closed as a result of this action. The emergency room and urgent care will remain open and will continue to provide the same level and scope of services as are available today. Further, the hospital's ability to transfer patients to inpatient beds without excessive waits in the emergency department will be enhanced. The hospital presently treats approximately 47,000 patients annually in its emergency room.

DHS specifically did not make a recommendation to close the emergency room because it recognizes the much broader impact of the emergency room on the community's access to health services. This concern has been echoed by emergency services providers in the County who have consistently stated that closing the emergency room would have a more devastating impact on the emergency services network and the community than shuttering the trauma center.

Measure B

With regard to the requirements associated with passage of Measure B to support trauma services in Los Angeles County, all Measure B funds will continue to be expended in accordance with the requirements of the law. Measure B requires that the funds raised by the increased property tax revenue will be used, in part, to maintain all aspects of the Countywide trauma network; to expand the trauma system to cover all areas of the County; to provide financial incentives to keep existing trauma centers within the system; to pay for the costs of trauma centers, including physician and other personnel costs; and to defray administrative expenses incurred by DHS in administering this program. There is no requirement under Measure B that the current configuration of the trauma network remain status quo. As the Department has repeatedly noted, this recommendation is based on concerns about patient safety, not financial considerations.

Steps to Ensure Continued, Timely Access to Trauma Services

The Department has taken a number of steps to ensure residents of the community have continued access to trauma services. The acuity of trauma patients taken to KDMC and the associated transport time has been closely evaluated in an attempt to ensure that patients are not placed at significant risk as a result of the closure of the trauma unit.

Most significantly, the Department is recommending entering into an agreement with California Hospital Medical Center to become a trauma hospital, effective December 1, 2004. This contract has been filed for consideration by your Board on the November 16, 2004, agenda. Under this agreement, California Hospital would ultimately accept 1,200 trauma patients annually. This patient caseload will be phased in over the next seven months, with the initial trauma catchment area providing approximately 600 patients. The second phase, which will occur in early 2005 will increase the trauma boundaries to provide an additional 600 patients to California Hospital.

Additionally, DHS will be amending its trauma contract with St. Francis Medical Center to enhance funding to offset the increase in trauma patient volume. DHS estimates that St. Francis Medical Center will experience an increase of between 200 and 300 trauma patients annually as a result of the closure of the KDMC trauma unit.

Harbor-UCLA Medical Center also will receive an additional estimated 400 to 500 patients as the result of the redrawn trauma boundaries. The Department will be returning to your Board to the Board with a budget adjustment to increase funding for Harbor-UCLA Medical Center to accommodate this increased caseload.

LAC+USC Medical Center will not receive additional patients as a result of the closure of KDMC's trauma unit.

Transport Distance

DHS also has analyzed the acuity and transport distance of patients taken to KDMC's trauma unit. During the six-month period of October 1, 2003 through March 31, 2004, 862 patients were treated in the trauma unit. Ninety-two percent arrived by ambulance and the remaining eight percent were

brought in by private vehicles. Of these patients, 59 percent, or 509, required hospitalization. The remaining 41 percent were either treated and released the same day (33 percent) or died in transport or subsequent to arrival (eight percent) in the trauma unit. Attached is a flow-chart that summarizes this information.

It is inevitable that some patients suffering from a traumatic injury may continue to be delivered to the hospital by private vehicles, similar to other urban, non-trauma designated emergency rooms. KDMC would triage and treat these individuals in the emergency room and, to the extent the patient required a higher level of care, would initiate a transfer to another trauma facility. Based on a review of medical records, the majority of these "drop-off" patients were either treated and released or did not experience time-critical injuries that would be compromised by a longer travel distance to a trauma center.

An analysis of the medical records of trauma patients admitted to the hospital during this period indicates that fewer than 15 percent (133) suffered from potentially time-critical injuries. For the largest segment of these patients (43) the travel distance to an alternative trauma hospital will be within two miles of the current distance under the revised trauma boundaries, which have been adjusted to take into account the addition of California Hospital to the trauma network. Forty-one of these patients will have to travel two or more miles farther. A review of patient medical records indicates that less than one percent overall, or three to six patients with a time-critical injury, would have had to travel farther under the new trauma boundaries. Nine percent of all patients would travel at least three miles shorter to get to a trauma hospital.

The potential increase in travel time for this small, but important, segment of critical trauma patients must be balanced with the demonstrated delays in care and operating room access time that frequently occur at KDMC due to the many factors that have been discussed. Ultimately, getting the patient to a hospital staffed and capable of providing immediate definitive care, as defined by the American College of Surgeons, is the ultimate goal of a trauma system.

Please let me know if you have any questions.

Sincerely,

Thomas L. Garthwaite, MD
Director and Chief Medical Officer

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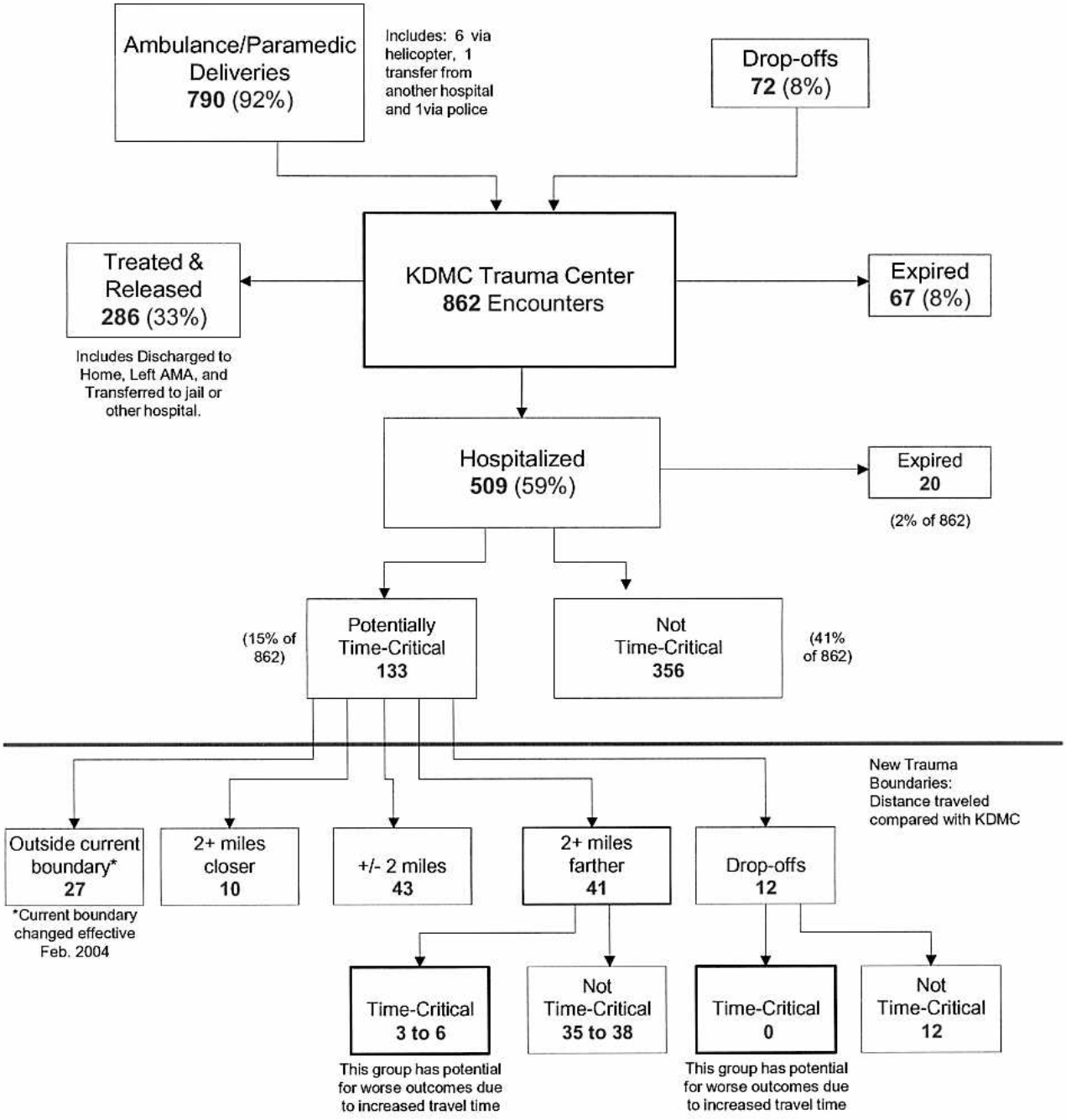
Attachment

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors

KDMC Trauma Patients
Oct. 2003 - Mar. 2004



Notes:
1) "Potentially Time-Critical" group includes those with penetrating trauma and Injury Severity Score >15, plus those who went to the operating room for neurological, vascular, abdominal, thoracic, or pelvic injuries.
2) "Time-Critical" and "Not Time-Critical" groups defined using medical record review and medical expert consultation. Ranges are based on range of medical opinion.

Sources: TEMIS EMS and Trauma databases, 10/1/03 - 3/31/04;
DHS Enterprise Data Repository, 10/1/03- 4/17/04; and
Medical chart reviews conducted by QIP staff and medical personnel.

LAC DHS Office of Planning, Data Quality and Analysis, 11/10/04