



Catholic Healthcare West

July 15, 2008

HAND DELIVERED

Rob Reid, Chairman of the Board
San Luis Obispo Emergency Management Services Agency, Inc.
712 Fiero Lane #29
San Luis Obispo, CA 93401

Dear Mr. Reid:

This letter is respectfully submitted for the record by the undersigned and represents the culmination of our review and analysis of the Assessment and Recommendation for Trauma System Development Report submitted by Diane Akers (consultant) and released June 12, 2008. After a thorough review, we want to take this opportunity to provide a detailed account of our issues and concerns. It is our strong belief that this report lacks a comprehensive view of the present trauma care system and contains unreliable statistical information. We fundamentally disagree with its conclusions and recommendations.

As reflected in the beginning of the document, the stated purpose of the report is: *"To have an objective and detailed assessment of the SLOEMSA trauma system and to propose practical next steps in the development and implementation of the trauma system."*

We firmly believe that this purpose was not carried out and that there is considerable bias toward designating a trauma center rather than enhancing a trauma system. The validity and motive for the report's conclusions are called into question because the recommendation is for sweeping changes to an established system that works. Unfortunately, the report failed by any measure to assess the current level of trauma care provided to our community as stated in the objectives. Of great concern is a failure to recognize the valuable systems already in place to manage the specific type of trauma our community experiences. Our concern is that these recommendations would likely dismantle the current system and place the community at risk for a lower standard of care.

From the outset, we were supportive of the objective to provide an assessment of the current level of trauma care provided and to propose practical next steps in the development and implementation of an enhanced trauma system. However, we do not feel a trauma system was ever the focus of the report, but rather the designation of a trauma center. We are concerned that the report utilizes comparisons with other states and counties that clearly do not mirror our county's unique patient population, demographics and the extremely high level of expertise already present by our Emergency Medicine Physicians and other Medical Staff involved in the care of the trauma patient. We believe that the recommendation would have been much different if the report addressed the fact that our local hospitals are all staffed exclusively by Board Certified Emergency Physicians who can effectively triage and treat trauma patients and have access to Board Certified Surgeons capable of treating multiple trauma patients.

French Hospital Medical Center
1911 Johnson Avenue
San Luis Obispo, CA 93401
805.543.5353 telephone
805.543.5708 fax

Arroyo Grande Community Hospital
345 South Halcyon
Arroyo Grande, CA 93420
805.489.4261 telephone
805.473.7603 fax

To be more specific, we have identified several sections of the consultant's report that we dispute.

1. Lack of an Updated Trauma System Plan

It is stated in the report that the SLOEMSA was requested to revise areas of the trauma system plan in March 2007 before moving forward. To our knowledge, this update has never been completed. Therefore the question arises, how can the report make any educated recommendations for a trauma system or center, if the plan has never been updated? Additionally, in 2004, a trauma designation of a Level III was the only option recognized by all the hospitals in the county. However, in 2007, Level II surprisingly became an option even though the 2004 SLOEMSA Trauma Plan has yet to be updated. Our county's current trauma plan does not have the capacity to support a Level II trauma center. It appears that the logical sequence of events that should have occurred never did. We believe that there needs to be a complete level of understanding with regard to the level of care provided by the various facilities in the community in order to make a viable appraisal of how to change the system of care in our community.

2. Methodology and Use of Data is Flawed

We have serious concerns regarding the methodology of the report. The OSHPD data used is outdated, from 2006, and it is based on outdated DRG discharge data. Meanwhile, it is unclear why the consultant determined that 2007 PCR data was unusable and we question any reason behind such determination: *lack of confidence in the PCR data* (Page 4). Instead, the report incorporates standard statistics, ACS data, rather than our actual community experience to create Critical Trauma Patient data. This is illogical because the ACS data is based on a theoretical algorithm. We expected to be provided with recommendations based upon data that reflects our unique community. Even with the use of this flawed data, the report shows that the facility asking for a Level II designation is actually the provider of the least trauma care of the three facilities that see the majority of the trauma.

We also understand that the report was based on the SLOEMSA EMS System Plan (2006) and the SLOEMSA Trauma System update (2007). As aforementioned, we challenge if the EMS Plan has ever been updated. If so, we have never seen it. Nor have we ever seen the System Update. We also question the decision to use the other documents reviewed: Title 22, the Trauma Plan Development Guidelines (EMSA #151), and Resources for Optimal Care of the Injured Patient. While these documents serve a purpose for many communities, they do not apply to our county's unique health care system characteristics. For example, our county, unlike others who benefit from the Trauma Guidelines, has four highly functioning hospitals with diverse on-call panels serving a relatively small community.

In reference to the data presented on page 5, we categorically dispute that 100% of the trauma patients were transferred to Sierra Vista Regional Medical Center and we request a review of any data that would suggest as much. On that same page, please note that the report uses OSHPD numbers which completely contradict the ACS predictions that were used earlier on page 3.

3. Use of Outdated Trauma Center Protocols

We take considerable issue with the section titled Trauma Systems and Trauma Centers (Page 3). The trauma center protocol and guidelines used in the report is outdated and not relevant for our community. As aforementioned, the use of the Trauma Plan Development Guidelines (EMSA #151), and

Resources for Optimal Care of the Injured Patient are documents from 1979 and 2006. These models do not apply to today's Emergency Department protocols to effectively assess and treat a patient. More recent literature questions the value of trauma centers unless there is a high incidence of "penetrating" trauma, which this county sees very rarely. This model was best served in the 1980's and 1990's in large metropolitan areas with multiple stabbings and gunshot wounds, and in the absence of current technology, such as cutting-edge CT scans. The majority of our county trauma is blunt trauma, not penetrating trauma.

The report states that trauma is a 'surgical disease' and the patient needs to be evaluated by a "surgeon". Since the scope of practice has changed dramatically in recent years, a trauma program that is led by a surgeon in the Emergency Department is being debated.

We believe included in the methodology should have been research and comparison to counties of our size with a Level II trauma center. To reach a conclusion that this county should pursue a Level II trauma center without investigating comparable-sized communities is further evidence of a flawed recommendation.

4. Lack of Understanding of Our Community

We believe the report clearly reveals a lack of understanding, education and investigation. Most specifically, we consider Table 2 and Table 3 in the report to include flawed information, methodology and much discrepancy. Again, neither table takes into account the unique patient population of San Luis Obispo County. Furthermore, the data does not reflect the doubling populations at the beaches, lakes and dunes that our county experiences each summer. We had hoped the report would reflect both existing and emerging demographics that would drive the need for trauma services.

The report also states that only one hospital has the resources to meet the Level II requirements. This statement appears to be based on "assumptions" rather than fact. For some reason, the report indicates the inability to confirm the other facilities' provision of care at a Level III capacity. Before recommending a shift in the system that is in place to care for our critically injured patients, it would be imperative to confirm the level of services that are currently provided. Statistics also show that a large majority of our county's trauma comes from the Oceano Dunes, the Los Berros interchange, Highways 41 and 46, Lake San Antonio and Lake Nacimiento. This would suggest that trauma resources be directed to the North and South County instead of the city of San Luis Obispo. Additionally, the report states that the closest trauma center is in Los Angeles and Santa Clara, while in fact Fresno has a Level I trauma center. A simple survey of our hospitals would have shown that a significant number of our trauma transfers are to University Medical Center Fresno rather than the 100% to Sierra Vista Regional Medical Center as the report suggests. This lack of thoroughness and objectivity once again leads us to have serious concerns as to the level of research and understanding the consultant has with respect to our community.

5. Impact to Other Hospitals is Ignored

We believe the report incorrectly states the impact of a proposed trauma center on the other hospitals in the county. The numbers used are, as previously stated, too theoretical and, therefore, not considered the best approach. The report has failed to recognize and take into consideration the huge potential loss to the other county hospitals if one Level II trauma center is designated. The other hospitals, who typically treat most of the current trauma patients, would suffer immensely but, most importantly, the

patient would lose critical and potential life saving minutes by being driven past capable hospitals to get to the designated trauma center.


Summary

In summary, we are very disappointed in the methodology used to gather the data, analyze the data, and report the findings as submitted. We do agree that an enhanced trauma system should be developed, but this report is at best a weak starting point. The report is generic, inaccurate, out of date and reflective of political biases that are rapidly becoming recognized in medical circles as tactics to increase market share rather than address and improve patient care. Unfortunately, the report has not met the stated objective - an assessment of the current system and practical next steps in the development of a trauma system. Unfortunately, this report has led the SLOEMSA staff to become public advocates for a "Trauma Center" rather than a "Trauma Plan". Furthermore, during this interval, the agency has been unable to move forward with issues that are also under its purview.


We are also troubled to learn that this consultant is seeking employment to construct a complete trauma system plan. Based on this report, we would wholeheartedly object to such employment and not contribute to cover any associated costs. We strongly want to reiterate our belief that this recommendation to move forward with a single trauma center would paralyze the viability of our county health care system. Much more investigation and consideration needs to be given before the county should even consider moving forward. The SLOEMSA needs to have appropriate staffing and expertise in place to provide acceptable oversight of a trauma system, if one is implemented. Only when and if the SLOEMSA updates its trauma plan and develops appropriate policies and procedures should the agency begin assessing a trauma system. If anything is implemented, it should be a collaborative, coordinated trauma system which transports patients to the appropriate facility. It is important to note that the recommended changes may benefit less than 1% of our Emergency Department encounters and may adversely affect approximately 99%.

Thank you for this opportunity to submit our comments. We greatly appreciate your willingness to consider our viewpoints. Please accept our efforts to prepare sound, thoughtful and substantial arguments. We understand the difficulty of this process but sometimes it is necessary to take a step back and assess the situation before moving forward. While we are all deeply committed to improving the health systems and the health care provided in SLO County, this is too important an issue to hastily embrace this consultant's recommendations. We look forward to the opportunity to work together to create a Trauma System Plan that will more adequately reflect our current community experience and embrace the future of trauma care for San Luis Obispo County.

Sincerely,



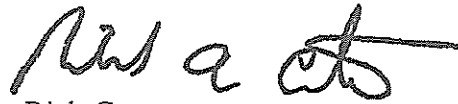
John Ronca, Jr., Esq., Chair
Community Board of Directors
French Hospital Medical Center



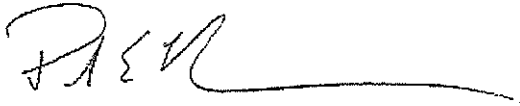
Ernest Jones, MD, Chair
Community Board of Directors
Arroyo Grande Community Hospital



Alan Ifiniuk
President
French Hospital Medical Center



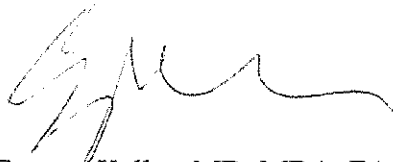
Rick Castro
President
Arroyo Grande Community Hospital



Paul Christensen, MD, FACEP
Chief of Medical Staff
French Hospital Medical Center



Carsten Zieger, DO, FACEP
Chief of Medical Staff
Arroyo Grande Community Hospital



Eugene Keller, MD, MBA, FACEP, FAAP
Vice President of Medical Affairs
French Hospital Medical Center



Larry Foreman, DO, FACEP
Vice President of Medical Affairs
Arroyo Grande Community Hospital

cc: Mr. Jeff Hamm
Director
Health Agency Services

San Luis Obispo County Board of Supervisors

Sandra Duerr
Executive Editor
The Tribune