

Santa Clara County Emergency Medical Services Regional Medical Center Specialty Care Services Reduction Impact Assessment

April 2024



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EXECUTIVE SUMMARY

On February 13, 2024, The Hospital Corporation of America (HCA) provided Santa Clara County Emergency Medical Services (SCCEMSA) notification that Regional Medical Center of San Jose (RMC) will be reducing emergency medical services provided at their facility. The notification indicates the hospital is electing to eliminate its Trauma Program and Cardiac Program, and downgrading its Stroke Center designation from Comprehensive Stroke Care to Primary Stroke Care. These service changes will be effective August 12, 2024.

In accordance with California Health and Safety Code an impact assessment and public hearing must be conducted by SCCEMSA within 60 days of notification, then submitted to the California Department of Public Health.

SCCEMSA took the following actions upon receiving the reduction notice from RMC:

- Notified state, county, and health system stakeholders.
- Established a Health Impact Assessment planning team.
- Scheduled a Public Hearing for March 27, 2024.

Current System

SCCEMSA provides regulatory oversight and operational coordination to ensure quality patient care. It involves a network of public and private agencies, including Public Safety Answering Points (PSAPs), fire service agencies, medical transport services, and acute care hospitals. Key components include PSAPs handling emergency calls, fire agencies providing initial medical care, and ambulance services categorized into Basic Life Support (BLS), Advanced Life Support (ALS), Critical Care Transport (CCT), and Air Ambulance. American Medical Response (AMR) is contracted to provide countywide 911 ambulance transportation, and hospitals provide services including specialty care through designated Trauma, STEMI, and Stroke Centers. These hospitals play a pivotal role in the EMS system, serving as essential hubs where patients receive critical medical care and interventions. Specialty programs within the system require close collaboration and coordination with local hospitals to ensure seamless patient care. Any disruption in this interconnected system affects its entire functionality—making it essential to address potential disruptions for effective evaluation, mitigation, and improvement.

The Service Area

Santa Clara County, known for its diversity and economic prosperity, faces challenges related to healthcare access and disparities despite favorable health indicators. The county's population is projected to grow significantly in the coming years, with shifts in demographic composition, emphasizing the need for equitable healthcare services. RMC's service area encompasses a significant portion of the county's population, with a higher concentration of Hispanic residents and lower median household income compared to areas outside the service zone. Additionally, RMC serves a diverse patient population with a significant proportion covered by Medi-Cal and a notable uninsured population.

Specialty Care Summary

Trauma

RMC plays a vital role in trauma patient care, seeing approximately 2,450 trauma patients annually, representing a quarter of all reported trauma cases in the county. Despite RMC's claim of a reduction in trauma volume, SCCEMSA data shows no significant decrease in trending volumes since 2019. RMC primarily attends to adult trauma patients, with a negligible volume of pediatric cases. The majority of trauma injuries treated at RMC occur within five county zip codes. Evaluation of the Injury Severity Score (ISS) distribution among RMC trauma patients indicates a majority exhibit minor scores, with notable variations in lengths of stay based on severity. Changes in trauma services at RMC

will significantly impact Santa Clara Valley Medical Center (SCVMC), the next closest trauma center and increased transport times of at least 15 minutes are expected for trauma patients.

Stroke

As the only Comprehensive Stroke Center (CSC) in the eastern region of the county, RMC receives a substantial portion of stroke patients, providing specialized interventions not offered by Primary Stroke Centers. The transition from a CSC to a Primary Stroke Center (PSC) at RMC will concentrate comprehensive stroke care in the western region of the county—impacting patient access and outcomes, particularly for those outside the benchmark window for timely treatment. The closure of RMC's stroke services will necessitate the redistribution of patients to other stroke centers, potentially leading to delays in care and poorer outcomes for stroke patients. The need for Interfacility transfers (IFTs) are expected to increase and the availability of ICU beds for neuro-critical care will decrease, straining the system at key times.

STEMI

RMC serves a significant volume of patients requiring cardiac catheterization lab services, including ST-Elevation Myocardial Infarctions (STEMI). Closure of RMC's STEMI program will impact patient access to timely care, potentially leading to delays in treatment and worse outcomes. The redistribution of STEMI patients to other hospitals may strain resources, particularly in areas with disproportionate availability of cardiac catheterization lab beds. Increased transport times for patients residing in certain areas will further exacerbate delays in care.

RMC's reduction in specialty services will have significant ramifications for continuity of patient care, especially within the prehospital setting. The closure of these services will necessitate adjustments in patient transport protocols and may lead to longer transport times, increase use of hospital bypass, and availability of inpatient specialty beds.

EMS System Impacts

The changes at RMC are also expected to affect various aspects of EMS operations, including 911 transport times and utilization, interfacility ambulance services, ambulance patient offload times (APOT), and disaster response.

- **911 Transport Times and Utilization:** It is anticipated that 911 patient transport times to other specialty care centers will increase, particularly for incidents located north or east of RMC. Longer transport times may result in ambulances being less available for response due to increased travel time, leading to the loss of several hours of availability.
- **Impact on Interfacility Ambulance Services:** The number of transfers to other acute care hospitals or specialty care centers are expected to increase, and specialty care patients may require higher levels of care during transport, potentially leading to longer response times for IFT units.
- **Ambulance Patient Offload Times (APOT):** Increased volume at the remaining specialty centers in the county will likely lead to delays in offloading patients from ambulances to emergency departments, which can cause resource allocation issues, ED overcrowding, longer wait times, and decreased patient satisfaction.
- **Impacts on Healthcare Providers:** Additional strains will be placed on healthcare providers, including emergency medical personnel, physicians, and nurses. Disrupted care pathways will force patients to seek care at alternative facilities, increasing demand on neighboring hospitals and exacerbating staffing shortages, burnout rates, and compromised patient care.
- **Disaster Response:** The discontinuation of specialty services at RMC may impact disaster response capabilities, particularly for incidents affecting both Santa Clara and Alameda counties. Larger-scale incidents, such as earthquakes or mass casualty events, may further strain the EMS system and require alternative means of medical care.

Overall, the changes at RMC are expected to have significant implications for EMS operations, patient care, hospital services, and disaster response capabilities in the region. Strategies for managing increased transport times, addressing offload delays, and ensuring effective disaster response will be crucial for maintaining the quality and efficiency of the EMS system.

Community Impacts

RMC's reduction of STEMI, Trauma, and Stroke units is expected to have profound effects on health outcomes, access to care, and community well-being. The following key themes emerged from a literature review, highlighting several anticipated impacts on the community:

- **Exacerbation of Healthcare Disparities:** Hospital reductions and closures have been shown to worsen healthcare disparities, particularly affecting seniors and low-income patients who rely on nearby hospitals for care. Increased distance to the closest hospital could lead to higher mortality rates from heart attacks and unintentional injuries, placing an additional burden on already vulnerable populations.
- **Impact on Follow-Up Care:** The closure of specialized hospital units not only disrupts acute care but also hampers follow-up care for patients with chronic conditions. Longer travel distances to healthcare providers may result in missed appointments, medication non-adherence, and delayed interventions, ultimately contributing to worsened health outcomes and increased healthcare costs.
- **Community Education and Outreach:** Closure of hospital specialties diminishes community education and injury prevention programs, jeopardizing public health outcomes. These programs, mandated for trauma center accreditation, aim to reduce injury rates, and promote safety awareness through tailored initiatives and partnerships with local organizations and stakeholders.

Mitigation & Conclusion

To mitigate the impact of these changes, several strategies have been proposed, including maintaining communication with RMC leadership, enhancing public messaging regarding service changes, revising EMS policies and procedures, and reviewing recommendations from the American College of Surgeons to strengthen the trauma system. Furthermore, reassessing funding opportunities for hospitals in low-income areas and implementing policy and regulatory reforms are deemed essential to ensure equitable access to vital healthcare services for all community members.

Ultimately, the closure of specialty services at RMC not only challenges the immediate functionality of the EMS system but also raises concerns about the long-term mortality and morbidity impacts on vulnerable populations. Addressing these challenges necessitates collaborative efforts among stakeholders to strengthen healthcare infrastructure, expand access to specialized services, and promote health equity within the community.

PURPOSE & SCOPE

On February 13, 2024, The Hospital Corporation of America (HCA) provided Santa Clara County Emergency Medical Services (SCCEMSA) the legally required 180-day notification that Regional Medical Center of San Jose (RMC) will be reducing emergency medical services provided at their facility. The notification stated the hospital is electing to eliminate their Trauma Program, Cardiac Program, and downgrading their Stroke Center designation from Comprehensive Stroke Care to Primary Stroke Care. These service changes will be effective August 12, 2024 (Appendix A).

Pursuant to California Health and Safety Code, Division 2.5, Section 1300(b) (Appendix B) (1), the County or the local Emergency Medical Services Agency (LEMSA) is responsible for performing an impact evaluation and conducting at least one public hearing within 60 days of the hospital announcing its intention. In accordance with the statute, SCCEMSA has an established policy (Appendix C) detailing the criteria for performing an impact evaluation of a hospital's planned reduction or elimination of emergency medical services detailing the criteria for performing an impact evaluation of a hospital's planned reduction or elimination of emergency medical services (2).

SCCEMSA is responsible for the oversight of the provision of emergency medical services in Santa Clara County, which includes the administration of Trauma, Stroke, and STEMI (ST-elevation Myocardial Infarction) critical care systems. These systems play a critical role in the provision of immediate, life-saving care. The SCCEMSA coordinates with local hospitals to ensure adherence to regulations, policies, and standards pertaining to these systems of care, also referred to as specialty programs. As such, SCCEMSA is best positioned to conduct a rapid health impact assessment, provide mitigation recommendations, and develop monitoring criteria to evaluate the ongoing impact this change will cause.

This assessment will be shared with the California Department of Public Health (CDPH) and the Emergency Medical Services Authority (EMSA), the Board of Supervisors, all city councils, fire departments, ambulance services, hospitals, and other impacted stakeholders in mid- to late April 2024. The purpose of this report is to detail the effects the reduction of specialty programs will have on emergency medical services and the Emergency Care System, neighboring hospitals, and the community within the service area. Policy actions or EMS System changes implemented as a result of the reduction in services will occur after meeting with system stakeholders and will be detailed in a final report. The final report will be released 90 days after the reduction of services has occurred.

PROCESS

In accordance with California Health and Safety Code Division 2.5, Section 1300(b), SCCEMSA Policy 400 outlines the minimum criteria to include in the impact assessment (2). The World Health Organization (2000) defines, "A health impact assessment (HIA) is a combination of procedures, methods, and tools by which a policy, program, or project may be judged as to its potential effects on the health of a population and the distribution of those effects within the population" (3). The HIA process has been integrated into this rapid assessment to ensure stakeholders are better equipped to make informed decisions amidst the changes to emergency healthcare delivery in Santa Clara County. In reviewing data, every attempt was made to use the most current full year

(2023); however, some data sets are not available until later in the year. In those instances, the most current year available was used and cited, but it is not anticipated to significantly impact this assessment. All mapping for drive times and distances was completed using Google Maps, reviewing different times of day to determine traffic impacts. Service area maps were created using census data and ArcGIS Pro.

Upon receiving notification from Regional Medical Center of San Jose, the following actions were taken:

- The Santa Clara County Board of Supervisors, Santa Clara County Public Health Department, Santa Clara County Counsel, EMS system providers, local hospitals, and other system stakeholders were notified of the planned reduction.
- Notification was provided to the California Emergency Medical Services Authority.
- Coordination began with the Office of the County Executive and the Board of Supervisors to schedule a public hearing within the defined timeline.
- A planning team was formed to conduct the HIA.
- A public hearing was scheduled for March 27, 2024, and public and system stakeholders were encouraged to attend. Public messaging through news, social media, and email notification was utilized to encourage attendance.
- The impact assessment was added to the meeting agenda for the April 16, 2024, Board of Supervisors meeting. A summarized report of this assessment was presented, and additional public comment was received.
- Routine meetings were scheduled with RMC to track transition progress and stay informed of issues that may arise prior to the reduction of services.
- EMS System stakeholder meetings were scheduled to collaborate on mitigation strategies and solicit input for any policy or system changes that may occur. These will occur between April 1, 2024, and June 1, 2024.

CURRENT SYSTEM

The primary function of the SCCEMSA is to provide regulatory oversight and operational coordination of resources to ensure the provision of quality patient care. The Santa Clara County EMS System is comprised of both public and private agencies, each performing an essential role to ensure efficiency of the system.

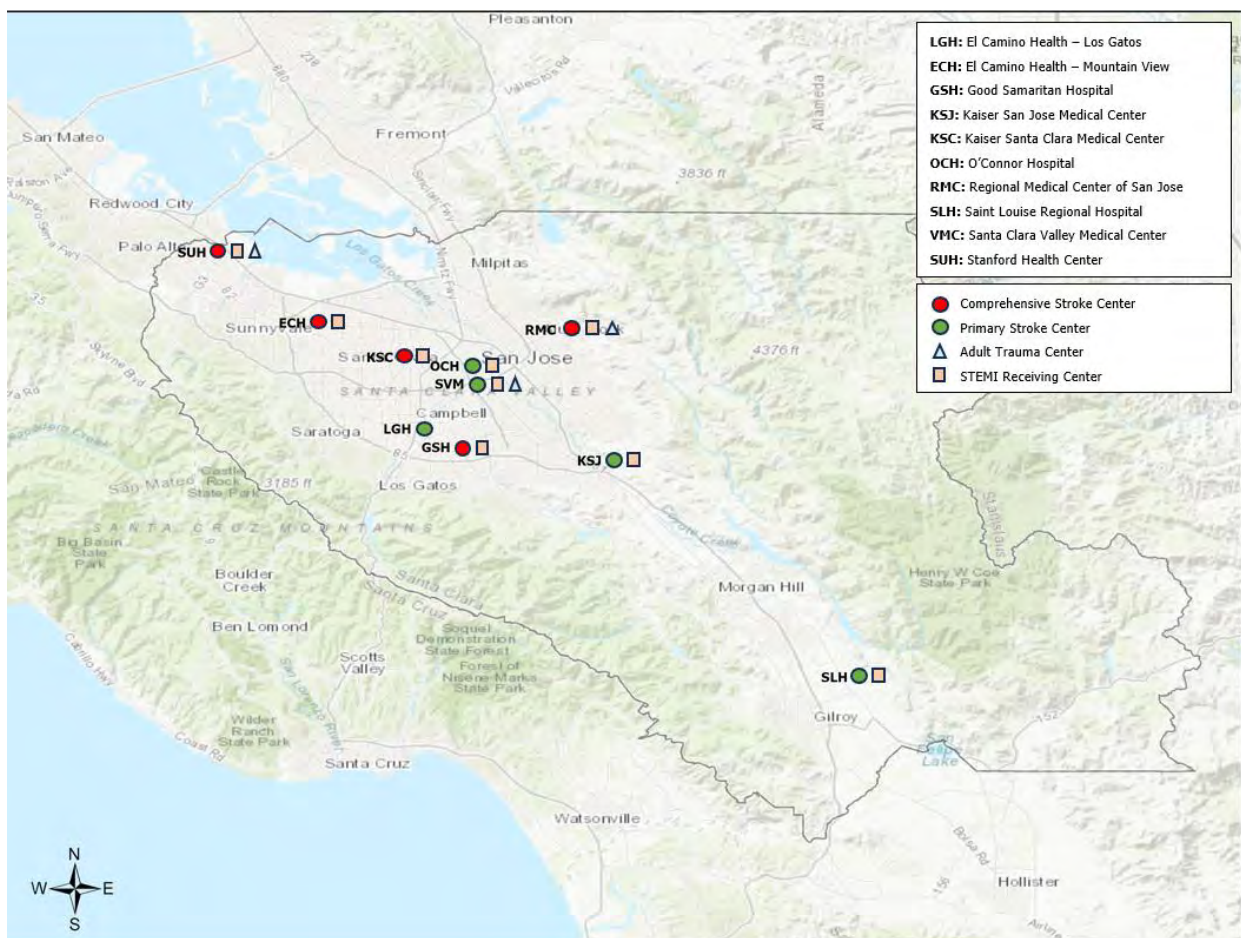
- Public Safety Answering Points (PSAPs) are responsible for answering 911 and other emergency and non-emergency calls, providing information, dispatching resources (including law enforcement, fire, ambulance services, etc.), and referring or transferring callers to the appropriate agency.
- Fire service agencies, or First Responders, not only provide fire and rescue services but also deliver medical care at both Basic and Advanced Life Support levels (BLS or ALS). These agencies usually arrive first to an emergency scene, providing an initial assessment and treatment to patients. Most fire agencies do not transport patients to emergency departments but may provide additional personnel to ride along, assisting with critically ill or injured patients. There are 13 fire service agencies within Santa Clara County, five of which have the ability to transport patients.
- Medical transport (ambulance) services are categorized into four main groups:
 - Basic Life Support (BLS): BLS ambulances are staffed with two Emergency Medical Technicians (EMTs) and primarily handle non-urgent patient transfers between hospitals, medical facilities, and homes. However, they may also be called into service for 911 calls to support the system, often during high call volume periods.
 - Advanced Life Support (ALS): ALS ambulances are staffed with a paramedic and either

an additional paramedic or an EMT. These ambulances mainly serve the 911 system but may also conduct non-life-threatening patient transfers similar to BLS ambulances.

- Critical Care Transport (CCT): CCT ambulances specialize in transfers between acute care hospitals. A CCT ambulance crew consists of at least one Registered Nurse (RN) and one EMT. On a case-by-case basis, additional paramedics, doctors, and respiratory therapists may aid in transport, depending on the needs of the patient.
- Air (helicopter and/or fixed-wing aircraft): Air ambulances, particularly helicopters, respond to 911 calls when ground transport to a hospital is not feasible. They also handle specialized transfers similar to CCT ambulances and are staffed with specialized flight nurses and/or additional flight nurses or paramedics. In poor weather, the crew from the air ambulances may transport patients via ground utilizing a BLS or ALS ambulance from the system.
- American Medical Response (AMR) is the contracted ambulance provider, responsible for countywide transportation of 911 patients with the exception of the City of Palo Alto, which manages ambulance transportation services within its jurisdiction. There are [seven private ambulance provider](#) companies and two air ambulance companies that provide the services listed above, augmenting the system (2).
- Acute care hospitals deliver medical services to patients requiring emergency, intensive, or in-patient medical care. Currently, Santa Clara County has [11 hospitals](#) equipped to receive patients from the 911-ambulance system (2).
 - Specialty care services are provided at acute care hospitals that offer unique medical and surgical patient care services, such as Trauma Centers, STEMI, Stroke, and Burn Centers. SCCEMSA is responsible for ensuring that hospitals meet the standards for each of these specialty programs, as defined in EMS Policy, and issues the EMS designation status that permits ambulances to transport patients meeting specific criteria to these facilities.

Hospitals play a pivotal role in an EMS system, serving as essential hubs where patients receive critical medical care and interventions. As the ultimate destination for EMS transports, hospitals provide a spectrum of services ranging from emergency care to specialized treatments, ensuring the continuity of patient care. Additionally, hospitals serve as crucial partners in the coordination and collaboration with EMS agencies, contributing to the seamless delivery of emergency medical services within communities. Their expertise, resources, and commitment to patient well-being make hospitals indispensable components of the EMS system, ultimately saving lives and improving outcomes for those in need of urgent medical attention.

Figure 1: Specialty Hospitals in Santa Clara County



With Santa Clara County being the sixth most populous county in California (4), EMS volume often surpasses

250 transports per day, and over the past four years, the number of transports has consistently increased by 5% - 7% each year (5). In 2023, there were 139,726 EMS responses, with 94,207 resulting in transport to one of the 11 hospitals in the county (5). Based on field triage and [EMS destination](#) policies, a patient will be transported to the closest facility most equipped to provide the care needed (2). Under the California EMS Authority, SCCEMSA is charged with implementation of specialty care plans and oversight of the programs. Hospitals with specialty care services will receive patients specific to the level of designation granted by the SCCEMSA (2). There are four types of specialty designations within the EMS System: Trauma Centers, Stroke Receiving Centers, STEMI Receiving Centers, and Pediatric Receiving Centers. For the purposes of this report, the Pediatric Receiving Center designation will not be detailed, as Regional Medical Center will not be changing the status for this program. Please refer to Figure 1 for a map detailing the location of specialty services within Santa Clara County.

TRAUMA CENTERS

Santa Clara County operates an exclusive trauma system, in which the care of acutely injured patients is focused on delivering major trauma victims, defined by [specific criteria](#), to one of three designated Trauma Centers within the county (2). Each of these trauma centers provides appropriate geographic coverage relative to the population, and the county has defined [catchment zones](#) intended to evenly distribute trauma patients to the appropriate facility while also ensuring short EMS transport times (2). The Regional Medical Center catchment zone covers the eastern and most of the southern portion of the county, Santa Clara Valley Medical Center's catchment zone covers mostly the central portion of the county and areas to the southwest, while the Stanford Health catchment zone covers the north and northwest portion of the county. Pediatric patients (under 15 years old) meeting trauma criteria are to be transported to Stanford Health or Santa Clara Valley Medical Center, which are the only designated pediatric trauma centers. Patients suffering from major burn injuries are transported to Santa Clara Valley Medical Center, one of only three burn centers in the region. All three trauma centers receive trauma patient transfers from non-designated acute care facilities within the county and from adjacent counties, such as Alameda County, San Mateo County, San Benito County, Santa Cruz County, and Monterey County. The three trauma centers in Santa Clara County collectively treat around 25 patients each day, amounting to approximately 9,000 trauma patients annually (6).

STEMI CENTERS

STEMI Receiving Centers are equipped to provide timely and advanced care to patients experiencing a heart attack caused by a complete blockage of blood flow to the heart muscle. These centers have a cardiologist available 24 hours a day, seven days a week, to rapidly diagnose and treat STEMI cases, typically through procedures such as percutaneous coronary intervention (PCI) or thrombolytic therapy. PCIs are minimally invasive procedures performed in a cardiac catheterization lab. The target benchmark is for this procedure to be performed within 90 minutes of arrival to the emergency department (referred to as door to balloon time or DTB). The EMS destination policy directs patients meeting [STEMI criteria](#) to the closest STEMI Receiving Center based on total transport time. All but two hospitals, Saint Louise Regional Hospital and El Camino Health - Los Gatos Hospital, are [designated as STEMI Receiving Centers](#) (2). There are a total of 29 cardiac catheterization labs between all STEMI Receiving Centers (7). Patients residing in Gilroy and further south will experience transport times of 25 minutes, with ideal traffic conditions, to reach the closest STEMI Receiving Center. Patients residing in Los Gatos would bypass the El Camino Health - Los Gatos to the next closest facility, approximately 7 minutes further away (8). The Department of Veterans Affairs Hospital-Palo Alto also has cardiac catheterization lab capabilities, but as a federal facility, it does not fall under the authority of SCCEMSA or EMSA. While the EMS System focuses on triaging STEMI patients to receive priority care, cardiac catheterization labs provide a variety of additional procedures, often on an outpatient basis. There are more than 13,000 cardiac catheterization lab visits annually, including over 400 PCIs for STEMI care. STEMI Receiving Centers receive 57% of patients via 911 ambulance, while 39% arrive by private vehicle or walk-ins, and 4% are received as transfers (5).

STROKE CENTERS

Stroke Receiving Centers are equipped to provide timely and comprehensive care to patients experiencing a

stroke, which occurs when blood flow to the brain is disrupted, leading to brain cell damage. These centers are designated to rapidly diagnose and treat stroke cases, often utilizing advanced imaging techniques and specialized treatments. Stroke Receiving Centers adhere to established protocols and guidelines aimed at minimizing treatment delays and optimizing patient outcomes. There are four different levels of [stroke designation](#) based on the facilities' diagnostic and treatment capabilities (2). All ten¹ hospitals in Santa Clara County meet the standards for Primary Stroke Center (PSC), which includes medical staff trained and available to rapidly assess, diagnose, and provide thrombolytic therapy when warranted (2). Kaiser Permanente - Santa Clara and El Camino Health- Mountain View meet the standards for a Thrombectomy-Capable Stroke Center (TSC), that has the resources to perform an additional treatment using endovascular intervention. Good Samaritan Hospital, Stanford Health, and Regional Medical Center are designated as Comprehensive Stroke Centers (CSC), which provide advanced treatment for all types of strokes, as well as surgical interventions and rehabilitative services. EMS Policy directs patients meeting [Comprehensive Stroke Receiving Center Criteria](#) to the closest CSC if transport time is less than 30 minutes, thus bypassing a PSC (2). If the closest CSC is greater than a 30-minute transport time, then EMS shall transport to the closest PSC. For clarity, the field stroke screening tool utilized in the EMS System is intended to identify a large vessel occlusion (LVO), a type of stroke best treated by endovascular therapy. Therefore, both TSCs and CSC are considered a Comprehensive Receiving Center per EMS policy. In 2023, there were nearly 4,100 stroke patients, 43% arriving via 911 ambulance (9). The five Comprehensive Stroke Centers receive 70% of all stroke patient volume and a larger proportion of EMS volume, 70% vs 30% (9). Ischemic strokes account for 67% of patients, followed by intracerebral hemorrhage (15%), transient ischemic attacks (14%), and subarachnoid hemorrhage (4.5%) (9)².

The Specialty Programs are a vital component of the EMS System. Each portion of the EMS System plays a vital role in the ability to provide effective, efficient quality care that extends through the patient care continuum. The specialty programs require collaboration and coordination with local hospitals to ensure the immediate needs of the patient are met, and the EMS care provided transitions adequately to the standards- of care set forth in these programs. This system is an interdependent structure and any disruption to any part of it affects the entire system. It is this potential disruption that serves as the focal point of this evaluation.

CHARACTERISTICS OF SERVICE AREA

COUNTY DEMOGRAPHICS

Santa Clara County, nestled in the southern portion of the San Francisco Bay Area in Northern California, boasts a population of approximately 1.9 million residents, making it one of the most densely populated counties in the state and the nation (2). Cities such as San Jose, Mountain View, Milpitas, and Gilroy make up much of the population. The county shares its borders with San Mateo County to the northwest, Alameda County to the north, Stanislaus County to the east, Santa Cruz County to the south, and San Benito County to the southeast.

San Jose, with approximately 1,000,000 residents is the 10th most populous city in the United States.

¹ The Department of Veterans Affairs Hospital Palo Alto is a federal facility under the authority of the Division of Veterans Health Administration and is exempt from local emergency medical services authority in regard to administration of specialty programs and therefore does not receive 911 ambulance transports for stroke or STEMI care. Patients may elect to be transported to the VA per policy or facilities may initiate IFT transfers for health plan repatriation.

² An ischemic stroke occurs when a blood clot, known as a thrombus, blocks or plugs an artery leading to the brain, it is the most common cause of strokes. Intracerebral hemorrhage (ICH), a subtype of stroke, in which instead of a clot, a ruptured blood vessel causes bleeding inside the brain. A subarachnoid hemorrhage (SAH) is when the bleeding occurs in the space between the brain and the tissue covering the brain, often referred to as an aneurysm. Transient Ischemic Attacks (TIA), is a brief blockage of blood flow in the brain, often causing stroke-like symptoms to appear but resolve.

Demographically, Santa Clara County epitomizes diversity, with various ethnic groups contributing to its rich cultural fabric. The Asian American community, including individuals of Chinese (accounting for 25% of the population), Indian (20%), Vietnamese (10%), and Filipino (5%) descent, constitutes a significant portion of the population. Hispanics/Latinos represent approximately 30% of the population, while Whites make up about 35%, and African Americans account for around 3% (4).

In terms of age breakdown, Santa Clara County has a diverse population distribution. Approximately 15% of the population is under the age of 18, while the working-age population (18-64) comprises the majority, constituting around 65% of the total. The elderly population (65 and older) makes up the remaining 20% (4).

Economically, Santa Clara County thrives as a global technology hub, boasting a robust job market and a historically low unemployment rate. The region's economy is driven by the presence of technology companies, such as Apple, Google, and Facebook, among others.

Health outcomes in Santa Clara County rank favorably compared to statewide metrics (10), owing in part to comprehensive public health initiatives and access to high-quality medical care. Notably, the county is home to world-class medical institutions, including Stanford Healthcare and the Santa Clara Valley Healthcare, which provide cutting-edge healthcare services to residents.

Despite its economic prosperity and favorable health indicators, Santa Clara County faces challenges related to equitable access to healthcare services and addressing health disparities among underserved populations. Efforts to bridge these gaps are ongoing, with initiatives aimed at increasing healthcare access for low income and vulnerable residents and promoting safety and wellness for all county residents and visitors.

The geographical distribution of healthcare institutions in Santa Clara County heavily favors the western regions, leaving communities on the eastern side, which includes San Jose, underserved. This situation is highlighted by the fact that Regional Medical Center is the only hospital serving the eastern part of the county, making it a crucial resource for healthcare in that area.

The county population is expected to increase by 3.7% in ten years (2034) and an additional 4.5% in 20 years (2044), with the percentage of Asian/Pacific Islander and Hispanic residents also increasing by 3.9% and 4.8%, respectively. There will be a 60% increase in the population age 65 years or older by 2044 and 80% by 2060 (11).

REGIONAL MEDICAL CENTER OF SAN JOSE SERVICE AREA

METHODOLOGY

To establish a service area for RMC, Santa Clara County was partitioned into 109 smaller areas or neighborhoods based on their geographic locations. A neighborhood is recognized as being within the service area if a patient from that locality was transported to RMC for any specialty services during calendar year 2023.

SERVICE AREA CHARACTERISTICS

RMC's service area encompasses 46 out of the 109 small areas/neighborhoods identified in the county, with 47% of the total population residing there. The subsequent maps, as illustrated in Figures 5-7, offer detailed insight into these neighborhoods. Darker shaded regions signify a higher concentration of patients treated at RMC compared to the lighter shaded areas, which indicate fewer patients originating from those locales.

Demographic characteristics reveal much of the Hispanic population (63%) of Santa Clara County resides within RMC's service area, along with nearly half of the Asian and African American populations (4). In contrast, only

30% of the county's White population resides in this area (4). The age demographics were similar in the RMC

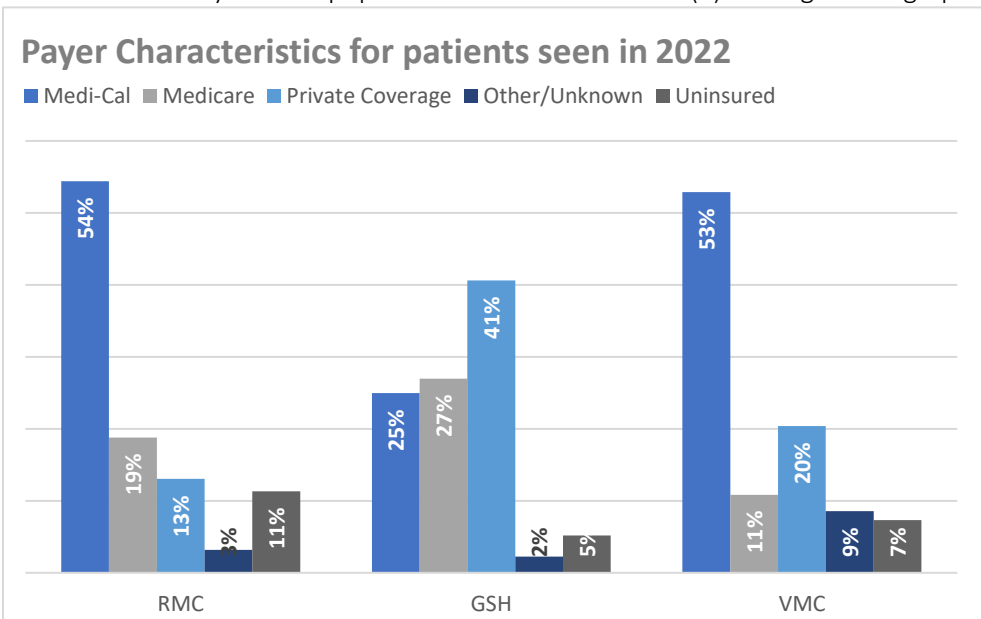


Figure 2: Payer Characteristics for patients seen at RMC, GSH, and VMC in 2022

service area when compared to the county population as a whole.

Socioeconomic characteristics indicate that the median household income for the service area is \$124,940, which is lower than the median income of \$158,419 for the population residing outside the service area (4). Additionally, 22% of the neighborhoods within the service area have at least a quarter of families living below the 200% poverty line (4).

In 2022, Medi-Cal accounted for 54% of RMC's payor mix, followed by Medicare (18%), Private coverage (13%), and Uninsured (11%) (12). In comparing payor mix to Santa Clara Valley Medical Center, the county's public healthcare safety net, and Good Samaritan Hospital (an HCA operated facility), Valley Medical Center reports Medi-Cal (52%), Private coverage (20%), Medicare (11%), and Uninsured (7%), while Good Samaritan reports Medi-Cal (25%), Private coverage (40%), Medicare (27%), and Uninsured (5%) (12). RMC serves more uninsured and Medi-Cal patients, while Good Samaritan sees more Medicare patients.

HOSPITAL SERVICES

Regional Medical Center of San Jose is licensed as a general acute care hospital with 258 licensed beds, 34 of which are designated as Intensive Care Unit (ICU) beds and 42 as ED beds. RMC has seven operating rooms, and four rooms capable of performing cardiac catheterizations. Below is a table detailing RMC patient volume for 2022 (13). In 2022, there were a total of 70,455 visits to RMC's Emergency Department (ED). Among these visits, 14,416 patients were transported by EMS, while the remaining cases involved self-transport. Of the ED visitors, 13% were admitted to an inpatient unit

RMC Patient Volume, 2022							
		Number of Patients		Percent of Volume		Percent of all County	
Total ED Visits		70,455		83%		39%	
EMS	Walk-in	14,416	56,039	20%	80%	14.5%	
Total Admitted to hospital from ED		10,941		13%		11.9%	
Inpatient Only		624		1%		0.7%	
Ambulatory Services		2,785		3%		2%	

Figure 3: Regional Medical Center 2022 Patient Volume (13).

(13). A minority of patients, constituting 1%, were directly admitted to the hospital, while 3% received care in ambulatory service departments, such as outpatient surgery or same-day procedures. RMC's ED accounted for 14.5% of all EMS transports to hospitals in Santa Clara County, positioning it as the second busiest ED in the county for receiving EMS patients.

RMC is designated by SCCEMSA as an Adult Trauma Center, STEMI Receiving Center, Comprehensive Stroke Receiving Center, and General Pediatric Receiving Center. RMC is verified by the American College of Surgeons as a Level II Adult Trauma Center; the last verification visit was December 2022, in which SCCEMSA staff participated. RMC has Joint Commission certification as a Comprehensive Stroke Center; the last certification visit with renewal occurred July 2023. The last site verification visit by SCCEMSA for stroke designation was December 5, 2022, in which no deficiencies were identified. The last site visit by SCCEMSA for STEMI verification was February 22, 2023. During this visit, several deficiencies were identified, which included lack of cardiology coverage for the catheterization lab, resulting in frequent requests for STEMI bypass. It was determined that RMC would be provided a provisional re-designation, with a request to submit a written corrective action plan followed by 90 days of program monitoring. RMC was able to address the concerns identified and was cooperative in the monitoring process; full designation was granted on August 30, 2023.

With RMC eliminating its Trauma and STEMI specialty programs and downgrading its stroke center designation to Primary Stroke Center, it was determined that the service area and impacts for each program should be analyzed separately. It is expected that the total ED volume received at RMC may decrease; however, with the planned expansion of RMC's ED and the year-over-year increases in ED utilization, it is unlikely that this impact will be noticeable. RMC will likely experience an approximately 13% decrease in 911 ambulance transports and a 2% decrease in Interfacility Transport (IFT) arrivals, with an increase in the need for IFT transports from the facility. As with ED utilization, EMS volume has been steadily increasing in the last four years; therefore, the impact will initially be noticeable but will be less discernable over time (5). There will be shifts in the volume of patients admitted from the ED, as 95% of patients treated for stroke, STEMI, and major traumatic injuries tend to be admitted for ongoing care and often are initially admitted to ICU. As a result, the hospitals now tasked with absorbing these specialty patients will experience increased admissions and utilization of ICU beds. RMC plans to maintain the licensed number ICU beds converting them to medical-surgical ICU beds. ICU bed availability will continue to be an issue affecting hospitals, especially for specialty care and seasonal variations. While it is predicted that EMS patients will mostly be absorbed by the next closest specialty center, patient transfers for ICU care may necessitate transport to facilities located at greater distances, potentially out of the county.

BYPASS IMPACTS

EMS [Policy 603](#) defines hospital bypass as “the diversion of 911 EMS patients from the affected emergency department and all associated EMS Agency designated specialty receiving centers at that hospital other than major trauma patients transported to designated, ACS-verified trauma centers” (2). The intended use is for hospitals to gain better patient volume management, as they have deemed it unsafe to continue to receive patients. The bypass status applies to ambulance traffic, as the hospital would remain open to walk-in

<u>North Bypass Zone</u>
Stanford University Hospital
El Camino Hospital of Mountain View
Kaiser Santa Clara
<u>Central Bypass Zone</u>
Santa Clara Valley Medical Center
O'Connor Hospital
Good Samaritan Medical Center
<u>South Bypass Zone</u>
Kaiser San Jose Medical Center
Regional Medical Center of San Jose
St. Louise Regional Hospital
<u>Other (no zone)</u>
El Camino Hospital of Los Gatos
Palo Alto Veterans Administration Hospital

Figure 4: Santa Clara County EMS Hospital Diversion Zones (EMS Policy 603)

patients. The policy also details criteria for specialty bypass that can be requested separately from ED bypass. This is often used when diagnostic equipment or specialized staff are unavailable to offer that service. For example, CT imaging equipment may not be operating, requiring the request for Stroke bypass. Specialty bypass is monitored routinely to ensure hospitals are offering specialty services, and frequent use of specialty bypass could indicate that the hospitals are not meeting established SCCEMSA standards. A hospital shall not remain on ED bypass for more than 60 minutes and must remain open for 60 minutes before requesting bypass again. Trauma bypass has more specific criteria since there are only three trauma centers in the county. If a hospital requests bypass for more than 60 minutes, they will also then be required to go on bypass for their specialty services (2). SCCEMSA established bypass zones to ensure adequate ED services are available; only one hospital may be on bypass at a time in each zone. The established zones are detailed in the adjacent table. This structure is based on geographic location, trauma catchment zones, and advanced stroke care. The changes at RMC will impact bypass distribution based on the current zones. The South Zone will no longer have a Trauma Center or a Comprehensive Stroke Center, and only one STEMI Center. The North Zone has an unequal concentration of Comprehensive Stroke Centers. If Good Samaritan Hospital were to request Stroke bypass, then there would be no Comprehensive Stroke Center for the South or Central Zone. Trauma Bypass allows only one center to be on bypass at a time. If this requirement were to remain unchanged, only one Trauma Center would be available for the entire county. In considering allowable bypass hours, it is difficult to predict the possible number of bypass hours for hospitals impacted by the increased volume of patients and determine an acceptable amount. One study examining ED ambulance diversion after hospital closures in Los Angeles County found the monthly diversion hours increased over time, with an average of 56 hours for four months at the nearest ED and hospital with trauma centers utilized diversion more (14).

SPECIALTY SERVICES

TRAUMA

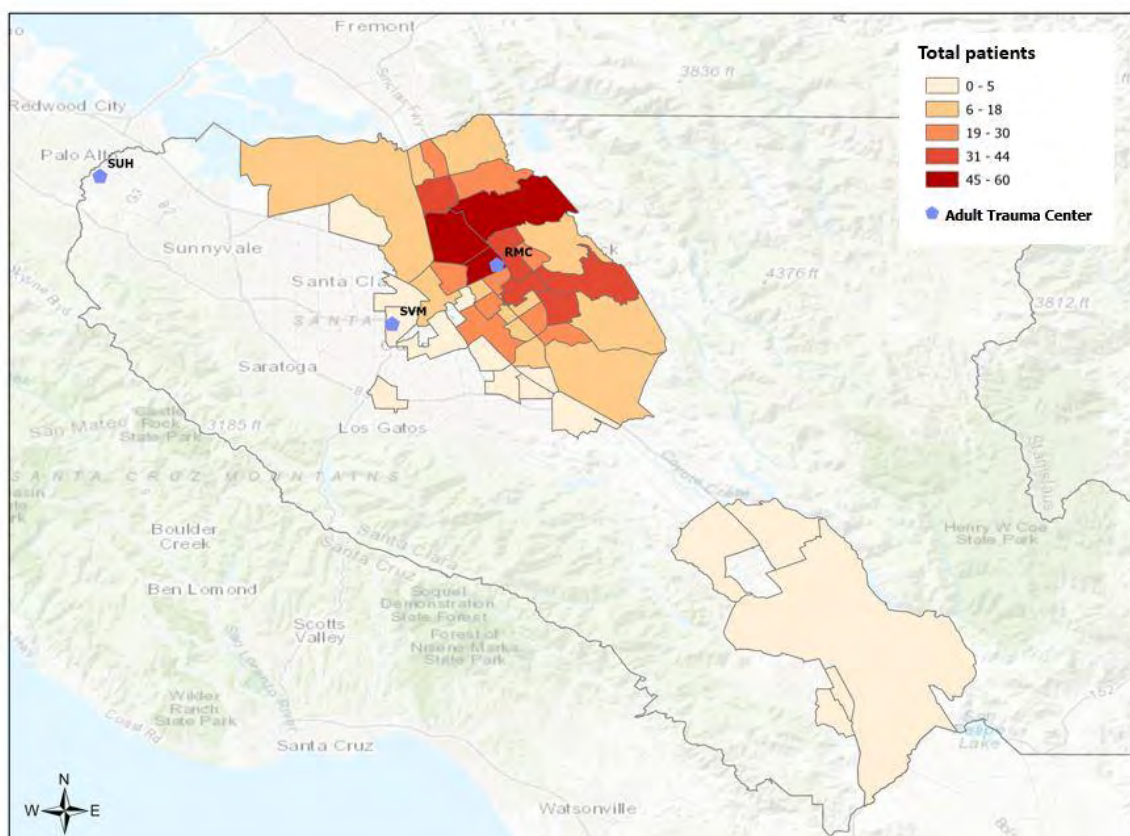


Figure 5: Map of RMC Service Area with Trauma Receiving Centers in Santa Clara County (2023)

All the three Adult Trauma Centers in the county are required to submit patient data to a Regional Trauma Registry that is managed by SCCEMSA (2). Unless otherwise cited, all data presented in this section is derived from that registry (6). As one of three Adult Trauma Centers in the county, RMC assumes a substantial role in trauma patient care, seeing on average 2,450 trauma patients annually, accounting for a quarter of all reported trauma cases for the trauma system. While the reduction notification letter referenced a reduction of trauma volume at the facility, there was no significant reduction seen when trending volumes since 2019 (6). RMC is not designated as a Pediatric Trauma Center, yet it receives a negligible volume of walk-in pediatric trauma patients. Conversely, the hospital attends to approximately 30% of adult trauma patients. The location of RMC is significant, given that half of the county's population aged 15 years and older resides within RMC's service area (4). Of the trauma cases seen at RMC in 2023, 12% were walk-ins and 15.5% were received from neighboring counties or as an out of county IFT. The zip code in which the injury occurred is reported, showing that 30% of trauma injuries treated at RMC occurred in the zip codes of 95122, 95116, 95112, and 95127. In reviewing trauma patients in the RMC catchment area relative to transport times, less than 5% originated in the city of Milpitas (furthest north), less than 4% originated in Gilroy (furthest South), and 5% originated in the Alum Rock area (Eastern foothills).

The Injury Severity Score (ISS) is a calculation tool used to assess the severity of a trauma injury, predict morbidity and mortality, and is widely used to define a major trauma (15). The scoring is divided into four categories: Minor, Moderate, Severe, and Profound. Traumas categorized as Severe or Profound (major traumas) have the highest probability of death and morbidity. The EMS field triage system is designed to identify the major trauma patients requiring rapid transport to the highest-level trauma center available, with scene plus transport time being less than 30 minutes. Whereas patient cases in the Mild and Moderate category could benefit from being seen at a trauma center, if available, patients meeting the Mild criteria should be reviewed as potentially over-triaged, either from field triage categories or ED activation policies. Examining the ISS distribution among RMC trauma patients reveals that the majority (61%) exhibit Minor scores, 20% scored in the Moderate category, 6% were classified as Severe, and 5% were seen as Profound. Notably, patients classified as Severe and Profound have significantly longer average lengths of stay at 10.2 days and 13.3 days, respectively, compared to 3.32 days for Minor scores and 5.2 days for Moderate scores. In reviewing the Minor and Moderate categories further, 56% were discharged from the ED after receiving care. The average amount of time a Trauma patient spends in the ED, either before discharging home or transferring to inpatient, is 5 hours, 35 minutes. Patients with a profound score tend to spend the least amount of time, averaging 3 hours and 50 minutes (this time is similar to other Trauma Centers).

On January 1, 2024, SCCEMSA implemented new field trauma triage criteria based on the [2021 National Guidelines for the Field Triage of Injured Patients](#) (2). The changes to the field criteria may have impacts on trauma volume; however, at this time, there is not data to compare the impacts of these changes.

The impact of RMC eliminating its trauma services will be most significant to Santa Clara Valley Medical Center (SCVMC), the next closest trauma center, located 7.5 miles west of RMC. The next closest trauma center is Stanford Health (SHC), 21 miles northwest of RMC. There are limited options for regional trauma centers when factoring in distance and drive time. Highland Hospital, in Alameda County is 45 miles north of RMC, in peak commute traffic drive times are greater than 1.5 hours. Natividad Medical Center, located in Monterey County, is 28 miles south of Gilroy, CA, which would be a near equal drive time to VMC. In peak commute traffic, Natividad Hospital may offer a shorter drive time for patients south of Gilroy. All data points in this section on distance and duration were derived from Google Maps (8). If the trauma system and EMS policy were unchanged, except to remove RMC, and continue with transporting to the closest trauma center, the estimated volume impact would be 48 additional patients a week, with seven of those being a Major Trauma. The Trauma Centers currently can anticipate 26 admissions per week, on average, and of those, seven initially needing ICU beds. It is possible that the walk-in volume will remain at RMC, necessitating IFT to the other trauma centers. The higher volumes expected at SCVMC and the longer transport time to SHC could delay care and worsen outcomes for major trauma patients.

Research indicates a rise in 30-day mortality rates at a nearby hospital subsequent to its closure. Although it isn't a full-scale shutdown, the cessation of specialty services could yield comparable effects, given that these services attend to time-sensitive and life-threatening emergencies (16). The IFTs and transports received from out of county will have to be absorbed at other trauma centers. Hopefully efforts can be made to direct these patients to other trauma centers not in Santa Clara County, thereby preserving trauma beds in Santa Clara County.

STROKE

Comprehensive Stroke Centers (CSC) and Primary Stroke Centers (PSC) follow evidenced based standard and are focused on providing quality patient care; however, a CSC has additional equipment and trained staff to diagnose and treat stroke patients who require a high intensity of medical and surgical care, specialized tests, or interventional therapies (18). All data presented in this section was derived from the Get with the Guidelines Registry maintained by American Heart Association.

RMC, as the only CSC on the northeast, east, and southeast side of the county, receives the highest concentration of stroke patients among all hospitals, with 20% of all stroke cases presenting there. RMC is the primary destination for one in four stroke patients transported by ambulance, and it serves a



**RMC is the primary destination
for 1 in 4 stroke patients.**

considerable portion (65%) of stroke patients in the county with no insurance. Currently as a CSC, RMC receives the second highest volume of transfers, approximately 100-150 patient annually, providing post-management of IV thrombolytics, evaluation for Endovascular Thrombectomy (EVT), surgical intervention, and rehabilitative services. 61% of patients transferred to RMC were from healthcare

facilities located outside the county of Santa Clara. When RMC reduces its services to PSC, all the comprehensive stroke care will be concentrated in the western side of the county. Good Samaritan Hospital that is the next closest CSC, is 14 miles away, and Kaiser Santa Clara, being a TCSC is 11 miles away; both have nearly equal drive times (8). In a Stroke System of Care consensus statement, for communities with more than one destination option, patients with a suspected LVO should be transported directly to a CSC, bypassing a TSC or PSC if the additional transport of 30 minutes is not exceeded, however if total travel time is greater than 45 minutes patients then EMS should transport to the closest PSC (19). Approximately 15% of patients being triaged by EMS meet the criteria to be transported directly to a TSC or CSC, prioritizing the availability of time sensitive resources to provide first line treatment, such as a mechanical thrombectomy for LVO ischemic strokes. For most of RMC's service area, patients experiencing strokes can still access a CSC following the reduction in services within the benchmark window of 30 minutes; however, patients originating from the city of Gilroy and further south will be outside of that window, even in the most ideal traffic conditions. For patients originating in the northern or far eastern portions of RMC's service area, in Milpitas or the Alum Rock area, traffic

conditions during peak commute hours will likely impact the ability of EMS to transport directly to a CSC.

For patients experiencing a stroke, faster treatment times are associated with improved outcomes. Several studies have indicated transport delays, to include transfers from a PSC are more likely to have worse outcomes and higher 90-day and one year mortality rates (20; 21; 22). In a 2019, comparative analysis of PSCs and CSC in the United States, researchers found transferred patients had higher mortality rates and lower discharge home rates that ED admissions for both CSCs and PSC, additionally, the time from symptom onset to arrival was almost three hours longer for transferred patients compared to those admitted directly to the ED. For patients who may be EVT candidates, this delay could disqualify them from receiving the therapy (20; 21; 22). Receiving prompt treatment significantly diminishes the severity of stroke, minimizing its impact. For certain patients, undergoing thrombolytic and/or EVT procedures within the treatment window enables them to return home with minimal to no functional impairments. Prompt access to advanced treatment is crucial in reducing morbidity among patients.

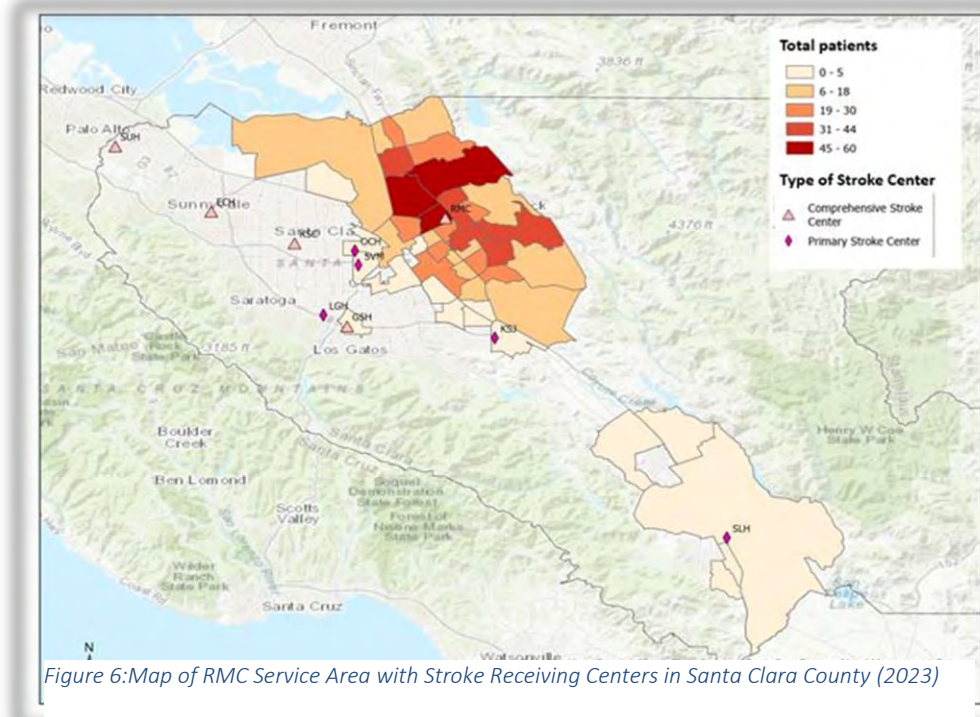


Figure 6: Map of RMC Service Area with Stroke Receiving Centers in Santa Clara County (2023)

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It is anticipated that approximately 3.75% of patients in the RMC catchment will be transported to GSH or KSC from the EMS triage practice to identify LVO strokes has indicated that it has established arrangements with GSH to automatically accept stroke patients, which will help absorb the proportion of RMC's walk-in volume and in-patient strokes that would require CSC care. However, this arrangement could have impacts on GSH's ability to accept transfers from the other PSC hospitals. A conservative estimate on volume impacts would indicate 42 patients per quarter will need to be absorbed by the other CSCs, 16 of which will be through 911 EMS transports.

In evaluating stroke patient admissions and Length of Stay (LOS), 94.7% of patients evaluated in the ED at RMC were transferred to in-patient care. In general, patients requiring CSC capabilities are more acute and can have much longer lengths of stay. They require admission to Neuro-ICU or ICU units until their conditions improve. The average length of stay at RMC for severe stroke patients (as measured by NIHSS³) is 8.78 days. In comparison, the average LOS at RMC is equally comparable to other CSC across the nation but is 2-3 days longer than three of the four CSCs in Santa Clara County. LOS is important to consider when determining impacts on ICU bed utilization, general hospital census, and patients' and families' social needs.

³National Institute of Health Stroke Scale (NIHSS) is a tool used by healthcare providers to objectively assess stroke symptoms and impairment. It was developed by Dr. P. Lyden and colleagues for acute stroke trials in 2001. It has become the gold standard for research trials and has been proliferated by the NIH as the performed tool for measuring outcomes. The scale has 11 items that are scored. 0=no stroke symptoms, 1-4=minor stroke, 5-15=moderate stroke, 16-20=moderate to severe stroke, 21-42=severe stroke (34).

STEMI

The impacts of closing a STEMI program, or more specifically cardiac catheterization lab services, are difficult to assess. ST-Elevation Myocardial Infarctions, although the most severe and highest risk for complications and death, are not the only type of heart attack requiring a heart catheterization and admission to the hospital for treatment. The EMS system focuses on the triage and prioritization of STEMI positive patients, as the gold standard for treatment is to evaluate the patient, activate the cardiac catheterization lab, and perform a Percutaneous Coronary Intervention (PCI) within 90 minutes of first medical contact (by EMS or ED staff, whichever occurs first) and 120 minutes for patients initially transported to a non-STEMI Center (23) ST elevations are difficult to diagnose from EMS ECGs, and the algorithms for cardiac monitors are not always accurate. A patient's symptoms and medical history may still warrant the need for a cardiac catheterization, even if a STEMI is not present, which creates the potential for both under and over triage of patients to STEMI Receiving Centers.

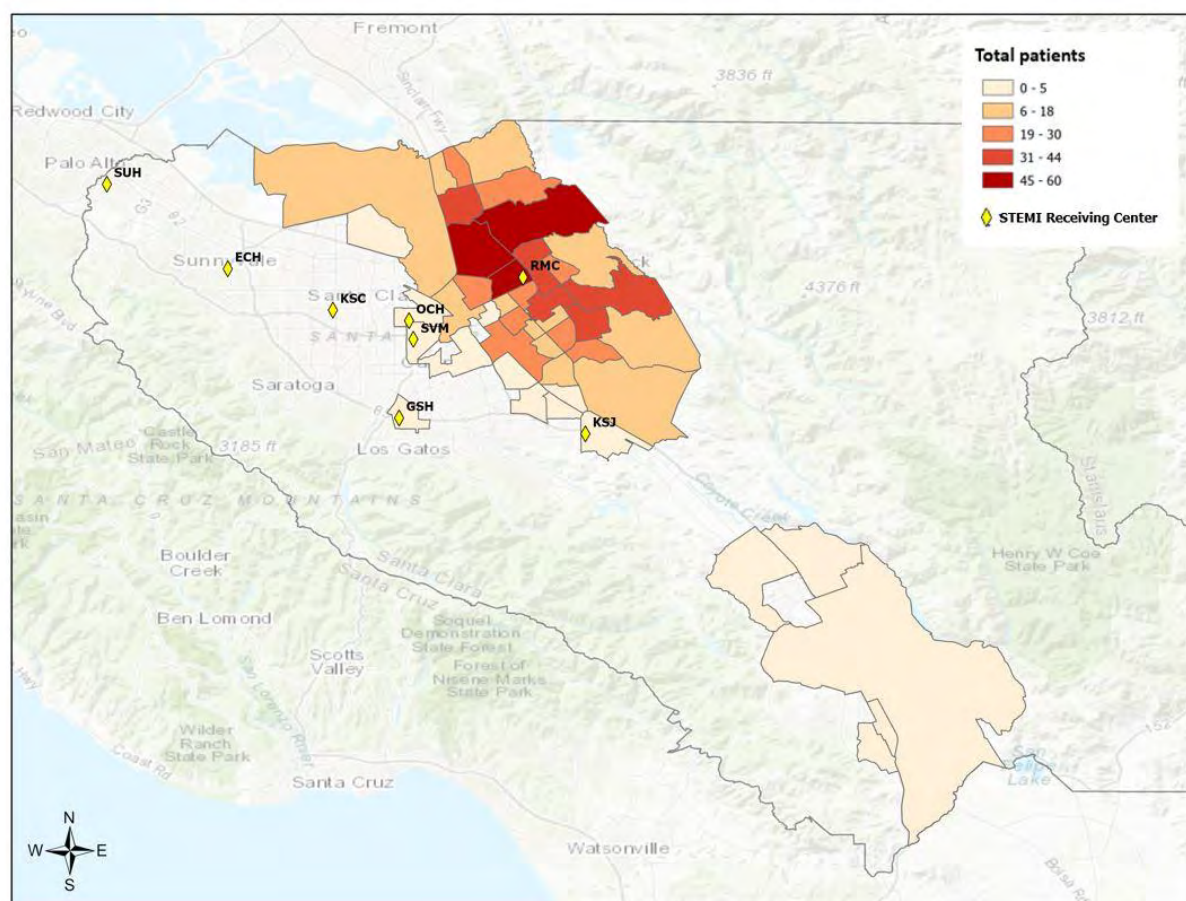


Figure 7: Map of RMC Service Area with STEMI Receiving Centers in Santa Clara County (2023)

The 2023 STEMI registry data indicate RMC received 12% (82) of all reported cases. Among these cases, 78% underwent percutaneous coronary intervention (PCI) at RMC. Notably, most STEMI cases arrived at the hospital via ambulance (61%), while the remaining cases (39%) presented as walk-ins. Furthermore, the average length of stay for STEMI patients at RMC was observed to be 4.05 days for cases treated with PCI. Interestingly, the average length of stay remained consistent irrespective of the mode of arrival, with 4.05 days for EMS arrivals and 4.16 days for walk-ins (9).

Since the STEMI registry data is exclusively comprised of confirmed STEMI cases, 2019-2021 data from the California Department of Health Care Access and Information (HCAI) was examined for ED ICD-10 diagnosis codes pertaining to unstable angina, Non-STEMI, and STEMI patients treated at RMC to gain a deeper understanding of the volume and demographics of patients requiring ED evaluation for chest pain,

with the objective of confirming or ruling out a myocardial infarction and assessing the potential necessity for a catheterization lab intervention. RMC averaged 2,969 visits for unstable angina annually, approximately 69.4% of which were transfers from the ED to the inpatient setting (9). Asian/Pacific Islander (56%) and Latino (49%) were the most predominant race of patients, and 60.5% were males. Non-STEMI patients accounted for a smaller volume, with roughly 500 ED visits annually; however, 97.6% were transferred to the inpatient setting for further care. As with unstable angina, the demographic breakdown was similar: Asian/Pacific Islander (44%), Latino (31.9%), and 61.5% male. The STEMI data was comparable to that of the registry for volume; 93.5% were transferred to inpatient care. Asian/Pacific Islanders accounted for 45.7%, while Latinos made up 29.6% and Whites were 28.7%; however, the number of males treated was slightly higher at 76.5%. The percentage of these patients that were walk-in versus EMS was unable to be verified. The reported number of cardiac catheterization lab visits for RMC in 2022 was 621, with 251 being for PCI intervention, and 61 of those being for a STEMI. That would indicate 24% of RMC's catheterization lab PCI volume is related to a different diagnosis, potentially NSTEMI or unstable angina.

Again, conservatively estimating the volume impacts, almost all patients diagnosed with a STEMI or an NSTEMI are admitted to the hospital (approximately 600 patients annually), and of those diagnosed with unstable angina, there is potentially an additional 2,000 patients annually. Without any cardiac services remaining at RMC, this would be a significant volume for the other hospitals to absorb. The next closest STEMI Centers, Kaiser San Jose, O'Connor Hospital, and Santa Clara Valley Medical Center could anticipate seven patients a day needing evaluation for chest pain, with approximately four patients each day needing a cardiac catheterization procedure. The volume of confirmed STEMI patients arriving by EMS would be one patient every three days, but over-triage numbers support one patient per day. In breaking down the

With the reduction of RMC's STEMI services, the number of beds per 1,000 individuals in this service area will decrease to 5.

volume this way, it seems manageable, however, the western region of the county exhibits a disproportionate availability of cardiac catheterization lab beds relative to the geographical service areas. Presently, the eastern and southern sectors of the county possess 9 cardiac catheterization lab beds per 1,000 individuals, whereas the northern and western sectors boast 20 beds per 1,000 individuals. With the reduction of RMC's STEMI services, the number of beds per 1,000 individuals in this service area will decrease to 5.

For STEMI patients, the adage "time equals muscle" is often used to emphasize the importance of time when initiating care for a person experiencing chest pain who might be experiencing a heart attack. This is because the more time a patient goes without proper treatment and blood flow restored in the heart, more muscle will die, potentially being life-threatening. Interhospital transfers delays are associated with delays in reperfusion and worse patient outcomes. Wang et al, found with a 5.5% in-hospital mortality rate, mortality increased among patients with a DIDO time greater than 30 minutes (5.9%) compared with patients who had a DIDO time of 30 minutes or less (2.7%; $P < .001$) and difference in associated mortality was greater with incremental increases in DIDO time (24)⁴.

The drive time to the next closest STEMI Center from RMC ranges from 13 to 18 minutes under ideal traffic conditions (8). While drive times will remain unchanged for patients originating from west of RMC or the southern portion of the county, they will increase for those residing in the northern or eastern areas, such as Milpitas and Alum Rock, who will now need to bypass RMC. Upon reviewing the catchment map, it becomes evident that the majority of patients accessing RMC for chest pain are situated directly north of the facility. Therefore, they should anticipate at least a 5 to 15-minute increase in transport

⁴ DIDO or Door-in to door-out, is defined as the duration of time from arrival to discharge at the first hospital.

times (8).

EMS SYSTEM IMPACTS

911 TRANSPORT TIMES AND UTILIZATION

With the elimination and downgrading of specialty services at RMC, it should be expected that 911 patient transport times to other specialty care centers will increase. It is expected that approximately nine patients a day who normally would have utilized RMC's specialty care services (Trauma, STEMI, and Comprehensive stroke) through the 911 system will now be transported to other specialty care centers. Dependent on the location of the initial incident, incidents located north or east of RMC will have longer transport times. With ideal traffic conditions, the closest trauma center by travel time is approximately 15 minutes from the RMC

service area. Travel time from areas north or east of RMC will likely encounter transport times up to 20 to 25 minutes to the closest trauma center. With ideal traffic conditions, the closest STEMI center by travel time is approximately 13 minutes from RMC. Travel time from areas north or east of RMC will likely encounter transport times up to 20 to 25 minutes to the closest STEMI center. With ideal traffic conditions, the closest comprehensive stroke center by travel time is approximately 18 minutes from RMC. Travel time from areas north or east of RMC will likely encounter transport times up to 30 minutes to the closest Comprehensive Stroke Center. These longer transport times essentially make ambulances less available for response due to the added travel time. It is anticipated that several hours of availability will be lost due to the increased travel time. This includes the redeployment of ambulance coverage lost to ambulances traveling outside of their area of operations. (All transport times were calculated from Google Maps)

IMPACT ON INTERFACILITY AMBULANCE SERVICES

Regional Medical Center currently contracts with Royal Ambulance to provide interfacility ambulance services. Royal Ambulance is currently permitted to provide three levels of ambulance services (BLS, ALS, or CCT). BLS level transport accounts for 87% of requests, while CCT accounts for 9.7%, and ALS accounts for 3.3% of

Table 2. Distance between RMC and other specialty hospitals in Santa Clara		
Hospitals	Miles from RMC	Travel Time
O'Connor Hospital	8	13
Valley Medical Center	8	15
Kaiser-San Jose	11	17
Kaiser-Santa Clara	12	18
El Camino-Los Gatos	13	18
Good Samaritan	14	18
El Camino-Mountain View	15	22
Stanford Medical Center	27	33
Veterans Affairs Palo Alto	25	28
Saint Louise	30	32
*Shortest Route Rounded Up to Whole Mile		
**Under Ideal Traffic Situations ⁵		

Figure 8: Table of travel distance and time from RMC to other SCC hospitals. (Google Maps 2023)

⁵ *Ideal Traffic Conditions*: The ability of an emergency ambulance to travel posted speed limits during daylight hours, utilizing the shortest travel routes, unimpeded by traffic congestion, road construction, and/or inclement weather.

requests (25). Of these transfers, 46% are related to patients being transported back to skilled nursing facilities (SNFs), assisted living facilities, or rehabilitation services, while 34% are patients being transferred to another acute care hospital (25). It's estimated that 6% of the patients being transferred are health plan repatriation⁶ (25). An estimated 28% are being transferred directly from the RMC ED to another acute care hospital, likely for services not offered at RMC (25).

As identified in previous sections, some patients meeting STEMI, stroke, or trauma criteria self-transport to RMC. While a small portion of these patients can be cared for at RMC, those needing higher care will need to be transferred to other specialty centers. Ideally, these patients will be transported by IFT ambulances staffed with ALS or CCT level of care, thus increasing the number of these transports. Often, specialty care patients have specialized medical equipment or continuous IV infusions that are not within a paramedic's scope of practice, requiring a clinical staff member from the hospital to accompany the patient for transport. A Registered Nurse, Respiratory Therapist or Physician can join the EMS crew of a CCT, ALS transport unit, or air ambulance to complete the transfer. Based on availability of the appropriate resource, an IFT transport unit can take greater than thirty (30) minutes to respond to RMC to pick up the patient. In the event a patient's condition warrants needing [immediate](#) transfer, a hospital may request the use of a 911 ALS unit (2). We anticipate an increase in requests for the use of 911 resources to assist with these transfers, thus increasing the total estimated volume impact on EMS.

AMBULANCE PATIENT OFFLOAD TIMES (APOT)

Ambulances Patient Offload Times refers to the duration it takes for EMS crews to transfer a patient's care from the ambulance to the hospital's emergency department (ED) staff. Adequate times are essential for maintaining the effectiveness, efficiency, and overall performance of EMS systems, ultimately ensuring timely access to life-saving medical care for all patients. SCCEMSA has established the benchmark of a 20-minute APOT for 90% of the patients arriving by 911 ambulance (2). Ambulance Patient Offload Delays (APOD) will impact resource allocation by reducing the ability of the EMS crew to respond to other calls in the system, resulting in longer scene wait times for both fire first responders and the patient, ultimately creating a backlog for 911 dispatch. They also contribute to ED overcrowding, creating longer wait times not just for patients arriving by ambulance but also for those arriving by self-transport. This can disrupt the flow throughout the healthcare system, increasing the risk for adverse events. Overcrowding in Emergency Departments is linked to various clinical outcomes, including mortality, and also impacts crucial aspects of patient care, such as the time taken to provide treatment for individuals with time-sensitive conditions (26). Lastly, patient continuity and satisfaction are decreased with prolonged APOD. It's imperative that patients receive prompt and continuous medical care as they transition from pre-hospital to ED care, especially for time-sensitive conditions such as stroke and STEMI.

SCCEMSA conducts continuous quality improvement monitoring for APOT. Reports are shared with hospital administrators for continuous monitoring. If any APODs are identified for specialty services, they are addressed with the appropriate program managers. Current aggregate 90th percentile APOT for all hospitals is 18:15, while the three specialty programs are 12:24 for Trauma patients, 25:30 for STEMI patients, and 15:33 for Stroke patients (5). Some hospitals face challenges in maintaining APOT below the benchmark, especially during the winter months. These APODs may force an ED to request bypass or specialty bypass, thus perpetuating delays in the system.

Ambulances provide a ringdown notification to the hospital expected to receive the patient meeting STEMI, Stroke, or Trauma criteria. With adherence to the ED policies and procedures to rapidly offload these patients, it is not anticipated that the APOT for the specialty services will increase drastically. However, the hospitals

⁶ Health plans such as Kaiser Permanente or Veterans Affairs may request a patient to be transferred to their facility for continued care when stable.

anticipated to receive the highest volume of patients from these service changes will likely experience overall APOD due to the increase in volume. These delays have the potential of creating a serial impact on the system. Ambulances waiting to offload patients with lower acuity and patients triaged in the ED waiting room may experience longer wait times. Limited hospital bed availability or delays in the admission process can lead to ED overcrowding, prolonged wait times, and ED boarding, which is when a patient remains in the ED after the decision has been made to admit them to the hospital. These conditions perpetuate APOD by reducing throughput and impacting the quality of care and have the potential for adverse outcomes. The average length of stay (LOS) outlined in preceding sections for each specialty indicates that the decrease in specialty beds within the county will pose challenges to ED throughput, particularly during the winter months.

IMPACTS ON HEALTHCARE PROVIDERS

Finally, it's essential to take into account the ripple effects of hospital closures on neighboring areas. When a local hospital shuts down and patients seek care elsewhere, the remaining hospitals may experience shifts in demand, patient demographics, and payment sources, which can impact their care delivery methods (27). Recent research indicates that this phenomenon extends to hospitals when a nearby hospital or Emergency Department closes. In response to heightened demand stemming from such closures, the remaining hospitals in the market often exhibit a behavior known as "speed-up": they increase the pace of their services and allocate less time per patient, rather than reducing the time their beds remain idle to accommodate the increased demand (16). While this speed-up approach may enhance overall system efficiency, it can come at the expense of care quality. Omitting steps in the care process can also compromise patient safety.

The closure of hospital specialties places additional strain on healthcare providers, including emergency medical personnel, physicians, and nurses. These specialized units are often regional hubs for emergency care, receiving patients from surrounding areas in need of specialized treatment. The closure disrupts established emergency care pathways, forcing patients to seek care at alternative facilities, often farther away. This not only prolongs the time to receive critical care but also strains the resources of neighboring hospitals ill-equipped to handle the sudden influx of patients with complex medical needs. As a result, the entire emergency care system experiences cascading effects, leading to delays, overcrowding, and compromised patient outcomes.

The loss of specialized units exacerbates the burden on already overworked healthcare professionals, leading to increased burnout rates, decreased job satisfaction, and diminished quality of care. The departure of experienced healthcare professionals further exacerbates staffing shortages and undermines the overall capacity of the healthcare system to respond to emergencies effectively. Healthcare providers, including emergency medical personnel, physicians, and nurses, bear the brunt of hospital specialty closures.

DISASTER RESPONSE

The occurrence of any incident that becomes a significant patient generator and/or medical surge event can strain the Santa Clara County Emergency Medical Services System and will be affected by the reduction of specialty services at RMC. Assessing the impact of this reduction is challenging, as incident impacts on the EMS system depend on factors such as size, nature, transport time, and total patient transportation volume.

Due to the geographic location of this facility, the discontinuation of specialty services will not only affect the Santa Clara County EMS system but also that of Alameda County, which utilizes the facility routinely. This discontinuation of specialty services may also cause larger adverse impacts on the Regional Disaster Medical-Health System and State Disaster Medical-Health System, should a significant incident tax other

operational areas throughout the Region and State.

When incidents are smaller in scale, such as multi-casualty incidents, they can be handled through existing patient distribution plans (Multiple Casualty Incident Plan) that focus on the equitable and timely distribution of patients to hospitals throughout the county. These destination decisions consider all services provided by each facility based on the patient's acuity. These types of incidents currently cause an increase in hospital bypass and frequently increase ambulance turn-around times.

Larger scale incidents, such as a significant earthquake, a vehicle accident involving public transportation, or active shooter incidents, historically result in a large number of "walking-wounded" rather than critically injured persons. In these cases, alternate means of medical care would be required even if RMC were to continue all levels of service. However, if RMC were to reduce its current services and disaster struck the operational area, the ability of the county's Medical-Health System to provide an invaluable service to the ill and/or injured would be drastically affected.

If Regional Medical Center of San Jose were to reduce its current services and disaster struck our operational area this would drastically affect the ability of the County's Medical-Health System to provide an invaluable service to the ill and/or injured.

During a significant disaster, many roadways may be affected, which can lead to extended ambulance transports and transports conducted by private vehicles.

It is important to note that during a significant incident, disaster medical care (austere care) will be the priority. In these incidents, medical care will be provided first to those who are most treatable, the walking-wounded will not be a priority for care, nor will the most critically injured. In extreme circumstances, the differentiation of a trauma center from an emergency department may not be relevant. However, those facilities or persons able to provide the most basic medical care (basic bleeding control, splinting, etc.) will be the most beneficial.

COMMUNITY IMPACT

The closure of essential hospital specialties like STEMI, Trauma, and Stroke units has far-reaching effects on individuals, families, and the healthcare system, significantly impacting health outcomes, access to care, and community well-being. In conducting a literature review, several recurring themes surfaced that can be anticipated for the San Jose community.

Exacerbation of Healthcare Disparities:

Hospital closures might affect distance to care, which can lead to negative patient outcomes, especially for time-sensitive conditions. Increased distance to closest hospital increases deaths from heart attacks and unintentional injury. This effect is expected to be greatest on seniors, who tend to travel shorter distances to the hospital, and low-income patients, who are both less likely to travel far and more likely to use the hospital as their "regular" source of care (28).

More than half of the RMC service area has more 15% of the families living below the poverty line. Low-income communities already contend with significant healthcare disparities, including limited access to quality care, higher rates of chronic illnesses, and socioeconomic barriers to healthcare utilization (29). The closure of essential hospital specialties exacerbates these disparities, as residents are forced to travel longer distances or seek care in overcrowded emergency rooms, further straining an already overburdened healthcare system.

Transportation costs, including public transit fares or gas expenses, can quickly accumulate, placing an

additional burden on already stretched household budgets. Low-income families are less likely to have reliable transportation (30). This leads to a lower likelihood of maintaining regular checkups with a primary care provider and regular refills of prescribed medication, leading to untreated illnesses and exacerbated health conditions. Four in ten low-income Californians say someone in their household skipped dental care or checkups, 28 percent say they or a household member put off or postponed getting health care, and about a quarter say someone in their household skipped a recommended test or treatment (24 percent) or did not fill a prescription (24 percent) because of cost (31).

Impact on Follow-Up Care:

The closure of specialized hospital units not only affects acute care but also disrupts follow-up care for patients with chronic conditions or those requiring ongoing medical management. Patients who previously accessed regular follow-up appointments at the hospital now face longer travel distances to reach their healthcare providers, posing logistical challenges and barriers to continuity of care. The increased burden of travel may lead to missed appointments, medication non-adherence, and delayed interventions, resulting in worsened health outcomes and increased healthcare costs in the long run.

Missed follow-up appointments due to the closure of hospital specialties have profound consequences on patient health and well-being. Patients with chronic conditions such as diabetes, hypertension, or heart disease rely on regular monitoring and interventions to manage their conditions effectively and prevent complications. However, the inability to access timely follow-up care increases the risk of disease progression, uncontrolled symptoms, and avoidable hospitalizations. For some patients, new health morbidities exacerbate financial hardships due to miss work or loss of employment, potentially leading to further socioeconomic challenges. Missed appointments represent a significant risk for all-cause mortality (32), disrupts the patient-provider relationship, impeding communication and shared decision-making, which are vital components of quality healthcare delivery.

A qualitative review after the closure of a Bay Area hospital with similar population demographics found that residents and patients experienced increased fear and stress in not knowing where or how they would access care. Patients without access to private transportation rely on friends, family, and public transportation to obtain care. The closure meant residents would need to spend more than an hour commuting to the next closest facility. Some also felt unsure of where they should go knowing insurance and ability to pay are barriers to accessing private clinics for follow-up appointment when referred. Lastly the community felt left out, forgotten, and perceived as a burden to the rest of the county and health system. The care shifted from neighborhoods with higher proportions of violence, poverty, and chronic diseases to well-resourced communities with higher income. This left community members feeling, health care providers would no longer be present to promote health and well-being in the community thus worsening their health status (33).

Community Education and Outreach:

The American College of Surgeons (ACS) has established specific requirements for trauma center accreditation, which include comprehensive injury prevention programs. These requirements aim to bolster community outreach and educational endeavors, ultimately reducing injury rates and fostering safety awareness. Each trauma center is mandated to conduct a thorough community needs assessment, identifying the top three causes of injury within its locality. They are expected to develop tailored programs and partners with schools, local organizations, and community stakeholders to disseminate educational materials and presentations promoting injury prevention initiatives. For instance, Regional Medical Center (RMC) offers a range of educational programs targeting various areas such as fall prevention, safe teen driving, intentional violence, and pedestrian safety. These initiatives are bolstered by collaborative efforts with numerous community organizations and local governments, leveraging collective expertise and resources.

Furthermore, RMC conducts community education campaigns focused on cardiovascular health to mitigate the risk of strokes and heart attacks. These efforts include organizing health fairs featuring blood

pressure and glucose screenings, as well as organizing events like 5K walks during February Heart Month and Stroke Awareness Month. The loss of such community health education and injury prevention programs would significantly impact the community, potentially leading to increased incidence of preventable injuries and diminished awareness of safety measures, ultimately jeopardizing public health outcomes.

PUBLIC HEARING SYNOPSIS

A public hearing was held on March 27, 2024, regarding the proposed reduction of trauma, STEMI, and stroke services at the Regional Medical Center of San Jose (RMC) showcased a spectrum of perspectives.

A representative for RMC, expressed the hospital's commitment to understanding the community's perspective on potential service changes. She outlined RMC's plan to continue evaluating, treating, and stabilizing stroke and serious heart attack patients. Moreover, she addressed the rationale behind downsizing the trauma designation and emphasized the hospital's dedication to maintaining patient care standards by investing \$10 million to expand the emergency department.

Following RMC's presentation, the Santa Clara Valley Healthcare (SCVH) physician leader panel underscored the substantial repercussions of the proposed closures on patient care, hospital operations, and public safety. Public comments echoed these concerns, with community members and healthcare professionals sharing personal anecdotes and emphasizing the importance of equitable access to healthcare resources.

The comments from various stakeholders during the public hearing highlighted several overarching themes concerning the proposed closure of RMC's Trauma, STEMI, and Comprehensive Stroke Services:

- **Patient Safety and Outcomes:** Many speakers expressed concerns about the direct and indirect effects of closure on patient safety and outcomes within the community. They emphasized that delayed access to essential services could lead to longer transport times, delayed care, and potentially increased morbidity and mortality rates. Closure was seen as posing a significant risk to public safety, particularly for vulnerable populations who rely on timely medical interventions during emergencies.
- **Cascade Effect on Healthcare System:** There was consensus among speakers that closure would have a profound impact on the broader healthcare system. The anticipated cascade effect on other hospitals, including increased demand for transfers, ambulance services, and specialty care, raised concerns about the system's capacity to absorb additional patients and maintain quality of care. The strain on emergency departments, in particular, was highlighted with concerns about overburdening resources and compromising patient care.
- **Disproportionate Effect on Vulnerable Communities:** Several speakers emphasized the disproportionate impact of closure on vulnerable communities, particularly during the critical "golden hour" following traumatic events. They highlighted the potential exacerbation of existing healthcare disparities and stressed the importance of ensuring equitable access to essential medical services for all members of the community.
- **Sustainability of Expanded Emergency Services:** Concerns were raised about the feasibility and sustainability of expanding emergency department (ED) services without concurrent investments in other critical areas of healthcare. Speakers highlighted the need for comprehensive follow-up care and specialty services to ensure continuity of care for patients, particularly those with complex medical needs.

- **Community Awareness and Engagement:** Many speakers expressed concerns about the lack of awareness within the community regarding the proposed closure and its potential implications. They emphasized the importance of community engagement in healthcare planning and decision-making processes, highlighting the need for transparent communication and collaboration between healthcare providers, policymakers, and community stakeholders.
- **Need for Sustainable Solutions:** Across the comments, there was a recurring call for innovative and sustainable solutions to address the underlying challenges facing healthcare delivery. Speakers stressed the importance of investing in resources, infrastructure, and staffing to meet the evolving needs of the community while advocating for the preservation of essential services to ensure equitable access to quality healthcare for all residents.

Additionally, there were mentions of accessibility and transportation concerns, personal and professional experiences related to RMC, and worries about the potential loss of critical services and the strain it would place on healthcare providers and facilities.

Overall, the comments reflected a shared commitment to preserving access to essential medical services and ensuring patient safety and well-being within the community. Their impassioned pleas underscored the urgency of finding comprehensive solutions that address the diverse needs of the community while ensuring the preservation of essential medical services. They underscored the complexity of the issues surrounding the proposed closure and the importance of collaborative efforts to address the challenges facing the healthcare system effectively.

MITIGATION

Current mitigation strategies taken by SCCEMSA include:

- Continue a meeting cadence with RMC leadership to stay informed of the current reduction process and to develop contingencies if needed should hospital staffing destabilize and the need to reduce services occurs prior to August 12, 2024.
- Ensure RMC reduction plan includes community education and outreach regarding service changes and enhance public messaging to reassure the community their health needs will still be met.
- Develop a contingency plan within the EMS Agency and with stakeholders should reduction of services need to occur prior to August 12, 2024.
- At least eight SCCEMSA Policies and Procedures have been identified as needing review and revision.
- Establish meetings with stakeholders impacted by these changes to receive input on EMS Policies and Procedures changes.
- Develop an education plan for EMS Providers, ensuring they are aware of the service reduction timeline and policy changes.
- Establish monitoring and evaluation criteria to assess impacts leading up to and after the reduction of services has occurred.
- In 2016, the American College of Surgeons (ACS) evaluated the Santa Clara Trauma System, making a series of recommendations to improve and strengthen the system. Now, is the opportune time to

review those recommendations and establish a pathway for implementing any of those recommendations that were not implemented and still remain relevant. Trauma stakeholder collaboration and buy-in will be necessary to accomplish this.

- Consider evaluating the viability of out-of-county trauma resources for both daily system management and to expand capacity during surge events, such as MCI.
- Evaluate the capabilities of other hospitals near east San Jose to increase stroke services to either a Thrombectomy Capable Stroke Center or Comprehensive Stroke Center.
- Conduct a review of cardiac catheterization lab capabilities for east county to identify any potential gaps that may further reduce availability while also considering ability to increase capacity.
- Review PSC transfer agreements and develop mitigation strategies to ensure the increase of IFTs to the remaining CSCs does not impact capacity and perpetuate APOD and bypass.

CONCLUSION

It is clear from the details of this HIA that the reduction of specialty services at RMC will have a significant impact on the ability of the EMS System to function in an efficient and effective manner that provides high quality care to the community. The changes at RMC ultimately place the burden on hospitals that lie on the borders of the community that RMC serves, which forces patients to leave their medical home and travel greater distances to receive specialty care as it relates to STEMI, Stroke, and Trauma services. While this assessment is heavily focused on the immediate impacts to the health system and the community, it is the long-term impacts that will be reflected in the mortality and morbidity of key health demographics in the community. This disparity in access to emergency care disproportionately impacts vulnerable populations, including older adults and persons of color, who may face greater challenges in navigating transportation and mobility issues.

The reduction of Stroke, STEMI, and Trauma Services at RMC also raises concerns about the overall adequacy and sustainability of healthcare infrastructure in the community, particularly considering projected population growth and demographic shifts towards an aging population. As the population ages and healthcare needs evolve, it becomes increasingly important to invest in healthcare systems that are equipped to meet the diverse and complex needs of residents across the lifespan. This may involve strategic planning, resource allocation, and collaboration among stakeholders to strengthen healthcare delivery networks, expand access to specialized services, and improve health outcomes for all members of the community.

It's important to note that while there are no state or local mandates requiring acute care hospitals to provide specialty services or maintain such programs once established, recommendations to the state remain critical. While these services are voluntary, the inability to take regulatory action underscores the need for revisiting policies and regulations to ensure the preservation of community hospitals in underserved communities. Additionally, there is a pressing need to reassess funding opportunities for particularly for hospitals in low-income areas not designated as safety-net hospitals, to safeguard specialty resources for communities most in need of such services. This is particularly important for population dense areas to be able to maintain trauma services.

In light of these considerations, policy and regulatory reforms are essential to address the evolving healthcare landscape, safeguard community hospitals, and ensure equitable access to vital healthcare services for all members of the community.

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APPENDICES

Appendix A – Closure Notice

Appendix B – California Health & Safety Code

Appendix C – EMS Policy 400

Appendix D –Response to Closure Notice

Appendix E – Public Hearing Notice

Appendix F –Public Hearing Agenda

Appendix G – Letters submitted by Stakeholders and
Community Members

Appendix H – Public Hearing Presentations

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Appendix A – Closure Notice



February 13, 2024

VIA HAND DELIVERY

Kenneth Miller, MD, PhD, Medical Director
Jackie Lowther, RN, MSN, MBA, EMS Director
Emergency Medical Services Agency Director
County of Santa Clara
700 Empey Way
San Jose, CA 95128

Re: Termination of Hospital Designation Agreement By and Between The County of Santa Clara and Regional Medical Center of San Jose

Dear Ms. Lowther:

Regional Medical Center of San Jose ("Regional" or the "Hospital") hereby provides 180 days prior written notice of the termination of the Hospital Designation Agreement for Trauma, STEMI, and Stroke ("Designation Agreement") by and between The County of Santa Clara (the "County") and Regional Medical Center entered in to and effective January 1, 2020. This termination will go in to effect on August 12, 2024.

Unfortunately, the Hospital is unable to sustain its Trauma Center, STEMI and Stroke designations and to maintain this current arrangement with the County. Over the last several years, we have witnessed a decline in the utilization of our Level II Trauma Center, with annual utilization showing a consistent decrease. With the planned opening of an additional trauma center in the area, we anticipate further declines in our volumes in trauma, cardiovascular surgery, neurosurgery and other subspecialty service lines. Furthermore, adhering to the rigorous standards set by Santa Clara County and the American College of Surgeons for specialty services has proven to be increasingly challenging. The recruitment and retention of qualified personnel in the market is becoming more and more difficult, making it unsustainable for us to continue providing these services.

The Hospital recognizes the impact that closing these service lines will have on Santa Clara County and its residents. We are working closely with other healthcare providers, first-responders and our regulatory and oversight agencies in an effort to minimize the impact on the closure of these service lines.

225 N Jackson Avenue, San Jose, CA 95116

408-259-5000

Even as Regional adopts and responds to changing conditions and headwinds, we remain dedicated to providing outstanding care to our patients. I want to assure you personally of Regional's continued dedication to serving the healthcare needs of the Santa Clara County community as a designated 911 receiving center. We appreciate the opportunity to partner with you over the next 180 days to effectuate the orderly wind-down of these services.

Please feel free to contact me if you have any questions or would like to discuss this further. I can be reached at 408-347-4042 or by email at Cris.Rivera@hcahealthcare.com.

Sincerely,



Cristina Rivera, CEO
Regional Medical Center of San Jose

cc: Manling Louie, RN, BSN, PHN
California Department of Public Health
(via email)

Appendix B – California Health & Safety Code

APPENDIX A – CALIFORNIA HEALTH & SAFETY CODE

1255.1. (a) Any hospital that provides emergency medical services under Section 1255 shall, as soon as possible, but not later than 90 days prior to a planned reduction or elimination of the level of emergency medical services, provide notice of the intended change to the state department, the local government entity in charge of the provision of health services and all health care service plans or other entities under contract with the hospital to provide services to enrollees of the plan or other entity.

(b) In addition to the notice required by subdivision (a), the hospital shall, within the time limits specified in subdivision (a), provide public notice of the intended change in a manner that is likely to reach a significant number of residents of the community serviced by that facility.

(c) A hospital shall not be subject to this section or Section 1255.2 if the state department does either of the following:

(1) Determines that the use of resources to keep the emergency **center** open substantially threatens the stability of the hospital as a whole.

(2) Cites the emergency **center** for unsafe staffing practices.

1300. (a) Any licensee or holder of a special permit may, with the approval of the state department, surrender his or her license or special permit for suspension or cancellation by the state department. Any license or special permit suspended or canceled pursuant to this section may be reinstated by the state department on receipt of an application showing compliance with the requirements of Section 1265.

(b) Before approving a downgrade or closure of emergency services pursuant to subdivision (a), the state department shall receive a copy of the impact evaluation of the county to determine impacts, including, but not limited to, an impact evaluation of the downgrade or closure upon the community, including community access to emergency care and how that downgrade or closure will affect emergency services provided by other entities. Development of the impact evaluation shall incorporate at least one public hearing. The county in which the proposed downgrade or closure will occur shall ensure the completion of the impact evaluation and shall notify the state department of results of an impact evaluation within three days of the completion of that evaluation. The county may designate the local emergency medical services agency as the appropriate agency to conduct the impact evaluation. The impact evaluation and hearing shall be completed within 60 days of the county receiving notification of intent to downgrade or close emergency services. The county or designated local emergency medical services agency shall ensure that all hospital and prehospital health care providers in the geographic area impacted by the service closure or change are consulted with and that local emergency service agencies and planning or zoning authorities are notified, prior to completing an impact evaluation as required by this section. This subdivision shall be implemented on and after the date that the county in which the proposed downgrade or closure will occur, or its designated local emergency medical services agency, has developed a policy specifying the criteria it will consider in conducting an impact evaluation, as required by subdivision (c).

(c) The Emergency Medical Services Authority shall develop guidelines for development of impact evaluation policies. On or before June 30, 1999, each county or its designated local emergency medical services agency shall develop a policy specifying the criteria it will consider in conducting an impact evaluation pursuant to subdivision (b). Each county or its designated local emergency medical services agency shall submit its impact evaluation policy to the state department and the Emergency Medical Services Authority within three days of completion of the policy. The Emergency Medical Services Authority shall provide technical assistance upon request to a county or its designated local emergency medical services agency.

Appendix C – EMS Policy 400



County of Santa Clara
Emergency Medical Services System

POLICY # 400

HOSPITAL EMERGENCY SERVICES REDUCTION IMPACT ASSESSMENT

Effective: March 13, 2018
Replaces: September 12, 2014
Review: March 13, 2021

I. Purpose

The purpose of this policy is to establish the criteria for performing an impact evaluation of a hospital's planned reduction or elimination of emergency medical services.

Hospitals with a basic or comprehensive emergency department certificate provide a unique service and an important link to the community in which they are located and the reduction or elimination of those services may have a profound impact on the emergency medical services available in their area and to the community at large.

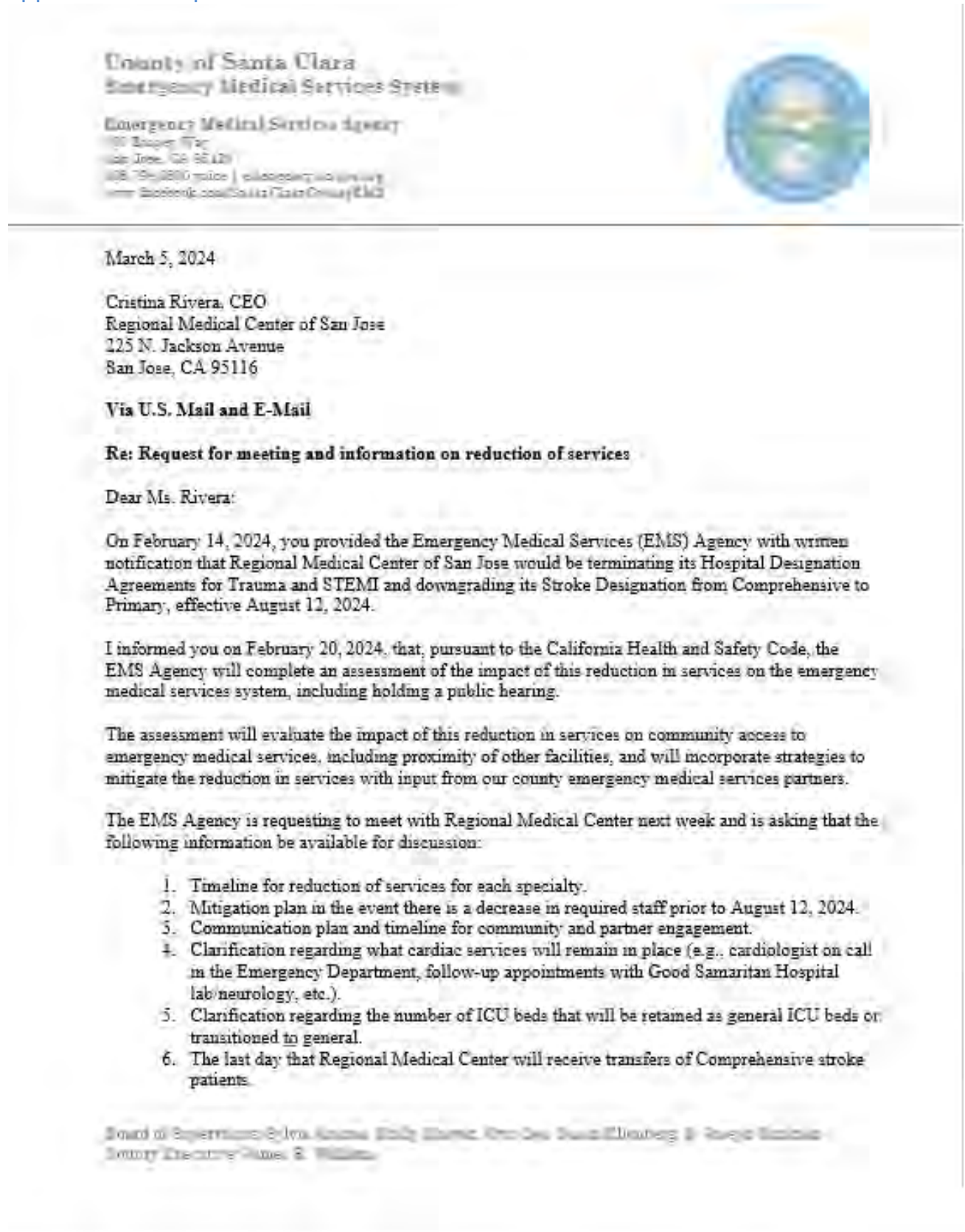
II. Evaluation Process

- A. Upon receiving notification of a planned reduction or elimination of emergency medical services by a hospital or the California Department of Health Services, the Agency will notify the Board of Supervisors, Santa Clara County Public Health Department, all local hospitals, fire departments, ambulance providers, and all local planning and/or zoning authorities.
- B. Within thirty (30) days of reduction/elimination notification, the Agency, in consultation with emergency service providers and planning/zoning authorities, will complete and distribute a draft EMS Impact Evaluation utilizing the Impact Evaluation Instrument.
- C. Within forty-five (45) days of reduction/elimination notification, the Agency will conduct at least one (1) public hearing, and incorporate the results of the hearing(s) in the final Impact Evaluation. The public hearing(s) may be incorporated with other public meetings held by the Health and Hospital Joint Conference Committee, the Board of Supervisors, and/or other government agencies, commissions, or committees.
- D. Within sixty (60) days of receiving reduction/elimination notice, and not more than three (3) days after completing the Impact Evaluation, the Agency will prepare the final Impact Evaluation and submit those findings to the California Department of Health Services, the Board of Supervisors, all city councils, fire departments, ambulance services, hospitals, planning/zoning authorities, affected committees and commissions, and other interested parties.

III. Evaluation Content

- A. At a minimum, the Impact Evaluation shall contain the following:
1. Assessments of community access to emergency medical care, including proximity of other facilities
 2. The effect on emergency services provided by other entities, including any changes in the number of licensed and staffed beds, and/or additional resource requirements
 3. The impact on the local EMS system, including patient transport time, resource utilization, operational procedures, and patient care practices
 4. Strategies taken or planned by the emergency services community for accommodating the reduction or loss of emergency services
 5. Public and emergency service provider comments
 6. Potential options to reduce the anticipated impact, if known

Appendix D –Response to Closure Notice



7. Information regarding the status of the Primary stroke center, The Joint Commission survey, and transfer agreements.
8. Clarification regarding the submission of all final data for all programs areas, including Trauma and STEMI, and the continuation of Stroke data submission.

The EMS Agency will require frequent meetings and ongoing communication until the transition to the reduced level of service and will discuss metrics that will be required from Regional Medical Center following the reduction in service.

The public hearing will be noticed as soon as relevant details are available. The impact assessment report will be shared with all stakeholders in mid-April. Please don't hesitate to contact me at 408-794-0610 if you have any questions or concerns.

Sincerely,



Jackie Lowther, RN, MSN, MBA
Director, Emergency Medical Services

**County of Santa Clara
Emergency Medical Services System**

Emergency Medical Services Agency
700 Empey Way
San Jose, CA 95128
408.794.0600 voice | emsagency.sccgov.org
www.facebook.com/SantaClaraCountyEMS



March 14, 2024

Cristina Rivera, CEO
Regional Medical Center of San Jose
225 N. Jackson Avenue
San Jose, CA 95116

Via U.S. Mail and E-Mail

Re: Request for written plan and response relating to reduction in services

Dear Ms. Rivera:

On February 14, 2024, you provided the Emergency Medical Services (EMS) Agency with written notification that Regional Medical Center of San Jose would be terminating its Hospital Designation Agreements for Trauma and STEMI and downgrading its Stroke Designation from Comprehensive to Primary, effective August 12, 2024.

I informed you on February 20, 2024, that, pursuant to the California Health and Safety Code, the EMS Agency will complete an assessment of the impact of this reduction in services on the emergency medical services system, including conducting a public hearing, which will be held on March 27, 2024, 3:00 p.m.-5:00 p.m. in the Board of Supervisors Chambers, 70 West Hedding Street, San Jose, CA 95110.

The assessment will evaluate the impact of this reduction in services on community access to emergency medical services, including proximity of other facilities, and will incorporate strategies to mitigate the reduction in services with input from our county emergency medical services partners.

The EMS Agency had a virtual meeting with you on March 11, 2024, and asked that the following information be available for discussion:

1. Timeline for reduction of services for each specialty.
2. Mitigation plan in the event there is a decrease in required staff prior to August 12, 2024.
3. Communication plan and timeline for community and partner engagement.
4. Clarification regarding what cardiac services will remain in place (e.g., cardiologist on call in the Emergency Department, follow-up appointments with Good Samaritan Hospital lab/neurology, etc.).
5. Clarification regarding the number of ICU beds that will be retained as general ICU beds or transitioned to general.

Board of Supervisors: Sylvia Arenas, Cindy Chavez, Otto Lee, Susan Ellenberg, S. Joseph Simitian
County Executive: James R. Williams

6. The last day that Regional Medical Center will receive transfers of Comprehensive stroke patients.
7. Information regarding the status of the Primary stroke center, The Joint Commission survey, and transfer agreements.
8. Clarification regarding the submission of all final data for all program areas, including Trauma and STEMI, and the continuation of Stroke data submission.

That meeting yielded little clarity regarding Regional Medical Center's planned mitigation strategies to accomplish a successful reduction in services.

We have a follow-up meeting scheduled for Monday, March 18, 2024, at 1:00 p.m. and request that your full team attend to speak to each aspect of the transition plan. In addition, for the purposes of the State-mandated impact assessment, we require a response to the above information requests in writing by March 20, 2024.

Frequent meetings and ongoing communication between the EMS Agency and Regional Medical Center will be necessary until the effective date of the transition to the reduced level of service and beyond. Furthermore, we will need to discuss the metrics for ongoing data submission that will be required from Regional Medical Center following the reduction in service.

The impact assessment report will be shared with all stakeholders in mid-April. Please don't hesitate to contact me at 408-794-0610 if you have any questions or concerns.

Sincerely,



Jackie Lowther, RN, MSN, MBA
Director, Emergency Medical Services

cc: Jackie Van Blaricum, President
Far West Division

Appendix E – Public Hearing Notice

County of Santa Clara

Emergency Medical Services Agency

700 Empey Way

San Jose, CA 95128

408.794.0600 voice | emsagency.sccgov.org

www.facebook.com/SantaClaraCountyEMS



NOTICE OF PUBLIC HEARING FOR THE SANTA CLARA COUNTY EMERGENCY MEDICAL SERVICES AGENCY FOR THE REDUCTION OF TRAUMA, STEMI, AND STROKE SERVICES AT REGIONAL MEDICAL CENTER OF SAN JOSE

NOTICE IS HEREBY GIVEN that the Santa Clara County Emergency Medical Services Agency intends to conduct a public hearing related to the reduction of trauma, STEMI, and stroke services at Regional Medical Center of San Jose.

On February 13, 2024, Regional Medical Center of San Jose informed the County of their intent to terminate their Hospital Designation Agreement for Trauma, STEMI, and Stroke services, effective August 12, 2024. Consistent with the California Health and Safety Code, a hearing shall be held, so that the public may have the opportunity to provide comment on the intended action.

Members of the public are invited to provide comment at the hearing, which will be conducted by the Santa Clara County Emergency Medical Services Agency as follows:

Date: March 27, 2024

Time: 3:00 p.m. – 5:00 p.m.

Location: Board of Supervisors Chambers, 70 West Hedding Street, San Jose, CA 95110

Members of the public may also participate in the hearing remotely via video conference or telephone.

Video conference: <https://sccgov-org.zoom.us/j/95059868490>

Telephone: +1 669 219 2599, Webinar ID: 950 5986 8490

Telephone callers press *9 to request to speak, and *6 to unmute when prompted. In the event that there are technical problems or disruptions that prevent remote public participation, the hearing may continue without remote public participation options.

Public comment shall be limited to three (3) minutes per speaker and shall conclude at 5:00 p.m. Those unable to provide comment at the public hearing may do so in writing so long as such communication is received by the Santa Clara County Emergency Medical Services Agency on or before March 27, 2024 at 5:00 p.m. Written communication is to be addressed as follows:

Hearing Officer – Hospital Reduction in Services

Santa Clara County EMS Agency

700 Empey Way

San Jose, CA 95128

Email: emsagency@ems.sccgov.org

Board of Supervisors: Sylvia Arenas, Cindy Chavez, Otto Lee, Susan Ellenberg, S. Joseph Simitian
County Executive: James R. Williams

Appendix F –Public Hearing Agenda

County of Santa Clara
Emergency Medical Services Division

Emergency Medical Services Agency
700 West 1st St.
San Jose, CA 95103
408.298.4777 ext. 411 | www.sccasos.org
www.SantaClaraCounty.org/EMSDivision



**Santa Clara County Emergency Medical Services
Public Hearing
for the Reduction of Trauma, STEMI, and Stroke Services
at Regional Medical Center of San Jose**

March 27, 2024

3:00 p.m.-5:00 p.m.

**Board of Supervisors Chambers
70 West Hedding Street, San Jose, CA 95110**

Agenda

1. Opening Remarks
2. Emergency Medical Services Presentation
3. Regional Medical Center Presentation
4. System Stakeholders Comments
5. Public Comments
6. Closing Remarks

www.sccasos.org
www.SantaClaraCounty.org

Appendix G – Letters Submitted by Stakeholders and Community Members

March 12th, 2024

Susan Ellenberg
Board President
Board of Supervisors
County of Santa Clara
supervisor.ellenberg@bos.sccgov.org

cc: Sara Cody, MD
Health Officer
and Public Health
Director
Santa Clara
County
sara.cody@shda.sccgov.org

cc: The Honorable
Matt Mahan
Mayor of the City
of San Jose
200 E. Santa Clara
St.
San Jose, CA
95133
Mayor@sanjoseca.gov

cc: Ash Kalra
California State
Assemblymember
District 25
111 W. St. John
Street, Suite 1150
San Jose, CA
95133
408-286-2535

cc: Dave Cortese
California State
Senator, District
15
2150 S. Bascom
Ave, Suite 154
Campbell, CA
95008
408-558-129

cc: Cris Rivera
Interim CEO
Regional Medical
Center of San
Jose
225 N Jackson
Ave,
San Jose, CA
95136

Cc: Dr. Gloria Wu
President SCCMA
700 Emery Way
San Jose, CA
95128

Dear Supervisor Ellenberg,

We, the Super Majority of the Medical Executive Committee (MEC) of Regional Medical Center of San Jose (RMC-SJ), are writing to express our deep concern regarding the recent announcement to discontinue this hospital's status as a Level 2 Trauma Center, Comprehensive Stroke Center, and ST-elevation Myocardial Infarction (STEMI) Receiving Center. We strongly believe that maintaining RMC-SJ's high acuity trauma, STEMI, and Stroke designations are crucial for our community's health, safety, and access to equitable care. We urge you to consider the implications of the decision to discontinue these vital services to our community. Our hospital serves the community as a crucial economic and healthcare partner in access to emergency care, public health and safety, health equity, continuity of care, and community trust and engagement. The significance of these services to our community's health and welfare cannot be overstated—they are essential and should be preserved and expanded. This expansion may necessitate broader access to resources and possibly a reconfiguration of the hospital's catchment area. Maintaining these crucial lifesaving programs aligns with the best interests of the health, safety, and well-being of the East San Jose community. The removal of these key services could detrimentally impact the remaining service offerings at the hospital and compromise both the safety and quality of healthcare provided.

The Medical Executive Committee of the Regional Medical Center of San Jose is dedicated to engaging in collaborative efforts with your office, the county health department, the hospital's administrative leadership, and other relevant parties to devise sustainable strategies that will ensure the continued availability of these vital health services. We appreciate your consideration of this pressing matter and eagerly anticipate your support in maintaining access to these indispensable care services for our community.

Below, we outline why RMC-SJ should continue to serve our community as a vital trauma, stroke, and cardiac care provider with continued and additional support from the City of San Jose, the County of Santa Clara, and the State of California:

Importance of RMC-SJ Stroke, Trauma, and STEMI Services to the Local Community:

- Vital access to emergency care for severe and life-threatening injuries
- Crucial role in public health and safety, especially during mass casualty incidents
- Support for health equity in a diverse and underserved community
- Ensuring continuity of care from emergency treatment through rehabilitation
- Economic impact on the community through job creation and professional training

Community Impact If/When Trauma, Stroke, and STEMI Services Close:

- Potential increase in mortality rates due to longer travel times to alternative centers
- Loss of immediate, specialized care for trauma and stroke victims
- Negative impact on underserved populations, exacerbating health inequities
- Fragmentation of the healthcare system and undermining quality of care
- Economic and academic opportunities lost with the closure of specialized services
- Loss of community trust and engagement
- Loss of RMC-SJ's fostering a culture of health and wellness
- Potential endangerment of community health and safety with the service discontinuation

Detailed Explanation:

Vital Access to Emergency Care: High-acuity specialized medical centers provide time-sensitive expert care for severe and life-threatening injuries. In cases of severe trauma, every second counts, and longer travel times can significantly impact patient outcomes. A local trauma center ensures rapid access to critical care. Studies have shown that the closure of a trauma center increases the mortality of critical patients by 29% in the first two years after closure. Moreover, an increased distance to a trauma center increases mortality rates for severely injured patients.

RMC-SJ's trauma services are a critical component of the emergency medical services system, providing immediate, life-saving care to more than 2,400 patients per year with severe injuries in Santa Clara County, East San Jose and from 84 referral hospitals. The hospital is surrounded by busy roads and highways that experience higher vehicular accident rates than in rural areas. Given its location, RMC-SJ provides emergency trauma care to critically injured patients in East San Jose and beyond. The hospital's trauma service is in the top 10% of all trauma hospitals nationwide. Without this access to RMCs critical care, residents may have to travel significant distances to reach the nearest trauma centers at Santa Clara Valley or Stanford Medical Centers to receive treatment for potentially life and limb-threatening injuries. This delay increases the chances that they will have preventable adverse outcomes. The residents in East San Jose already face limited access to care, and the loss of RMC-SJ's trauma services further endangers their critical access to emergency medical services.

Like trauma, when a patient has a stroke, every second counts. RMC-SJ is among the top 5 % of hospitals in the USA with a Comprehensive Stroke Center. It has the largest volume of stroke patients in the Bay Area. The majority of stroke and STEMI patients come to our emergency room through the front doors without ambulance use. These critically ill patients will have to be transferred to another facility, losing precious treatment time that can increase unfavorable outcomes. Studies have shown that an untreated patient can lose 1.9 million neurons every minute during a stroke.

Public Health and Safety: Not only do trauma centers play a vital role in individuals' injury care, but they also belong to a greater network of trauma hospitals available to treat victims of mass casualty incidents and natural disasters. Their presence ensures that the community has immediate access to highly specialized trauma and disaster care during large-scale injury events. These services are also critical in underserved areas lacking the resources to handle such events effectively. RMC-SJ is a Level 2 Trauma Center equipped to handle such events and provide rapid, multispecialty, acute specialized treatment for those in the South Bay and East San Jose. Without the RMC-SJ trauma center, the community will be at greater health risk.

Health Equity: RMC-SJ Level 2 Trauma Center, Comprehensive Stroke Center, and STEMI Receiving Center are crucial for addressing health disparities by providing high-quality, specialized care to all segments of

the local population, including underserved communities. East San Jose is characterized by its dense and culturally diverse population, with many immigrant and low-income families. This diversity necessitates healthcare services that are culturally sensitive and accessible to people from various backgrounds, including those who might face barriers to accessing care. Eliminating the RMC-SJ's trauma, stroke, and STEMI services would disproportionately affect those with already limited access to healthcare, further exacerbating health inequities in our community.

Continuity of Care: RMC-SJ's Level 2 Trauma Center, Comprehensive Stroke Center, and STEMI Receiving Center are integral to a comprehensive healthcare system, ensuring continuity of care from emergency treatment through rehabilitation. Closing these services would fragment this system, undermining patient outcomes and the overall quality of care. These services are particularly important in underserved communities, where patients may face challenges navigating the healthcare system or accessing follow-up care.

Economic Impact: RMC-SJ's Level 2 Trauma Center, Comprehensive Stroke Center, and ST-elevation Myocardial Infarction (STEMI) Receiving Center benefit an underserved community economically. The hospital creates jobs, attracts healthcare professionals, and can stimulate improvements in local infrastructure. Further, by providing immediate and specialized care, RMC-SJ can help reduce long-term healthcare costs associated with delayed treatment or the need to seek care outside the community. Closing these pivotal programs at RMC-SJ will significantly negatively impact the already economically challenged community. Additionally, these services bring some of the country's best medical professionals into the community. The multiple medical services supporting trauma care contribute to training medical professionals like medical students, physician assistants, nurses, and fellows. Many of these trained professionals remain in the community and improve the local quality of care. Trauma and stroke care physicians have performed medical research published in highly regarded peer-reviewed journals such as the New England Journal of Medicine. Such opportunities can be particularly beneficial in East San Jose by promoting local talent and enabling career healthcare opportunities in healthcare. Suppose the RMC-SJ Level 2 Trauma Center, Comprehensive Stroke Center, and STEMI Receiving Center are closed. In that case, all the economic, educational, and academic opportunities that come with that function will be lost to the community.

Community Trust and Engagement: Level 2 Trauma Center, Comprehensive Stroke Center, and STEMI Receiving Center have enhanced community trust in the local healthcare system. These programs have promoted injury prevention, stroke awareness, disaster preparedness, and health education initiatives, which have fostered a culture of health and wellness in East San Jose. Both physicians and their patients continually rely on the hospitals' ability to handle complex injuries and medical issues, with no other entity in the area that can treat these conditions.

In sum, RMC-SJ is vital for providing essential trauma, stroke, and cardiac care to an underserved community, acting as a lifeline for East San Jose's health, safety, and economic stability. The loss of these services not only endangers those injured in the East San Jose area but also mass casualty events in the greater South Bay region. Further, the closure of the trauma center disproportionately places those who live in the East San Jose area, with its already underserved populations, at significantly greater risk following traumatic injury.

Considering the above points, we respectfully request the reconsideration of the plan to discontinue RMC-SJ's Level 2 Trauma Center, Comprehensive Stroke Center, and ST-elevation Myocardial Infarction (STEMI) Receiving Center. These services are critical to the well-being of our community and need to be

maintained and then grown, requiring increased access to resources, which may include restructuring the hospital's catchment area. Preserving the hospital's critical life-saving programs is in the best interest of the East San Jose community's health, safety, and well-being. Selectively eliminating these vital services will negatively affect all remaining service lines in the hospital and the safety and quality of medical care.

The Medical Executive Committee of Regional Medical Center of San Jose is committed to working collaboratively with you and your office, the county's health department, the administrative leadership of the hospital, and other stakeholders to find sustainable solutions that will support the ongoing operation of these essential medical services. Thank you for your attention to this urgent issue, and we look forward to your support in ensuring that our community continues to have access to these critical care services.

Sincerely,

A handwritten signature in black ink, appearing to read 'A. Matityahu', written in a cursive style.

Amir Matityahu, MD
The President of the Medical Staff
Representing the Majority of the
Medical Executive Committee
Regional Medical Center of San Jose

March 22nd, 2024

Hearing officer

Hospital Reduction in Services

Santa Clara County EMS Agency

700 Empey Way

San Jose CA 95128

Subject: Opposition to proposed cancellation of Regional Medical Center of San Jose (RMC-SJ) status as a Level 2 Trauma Center, Comprehensive Stroke Center, and ST- elevation Myocardial Infarction (STEMI) Receiving Center

Dear Hearing Officer,

I want to express my strong opposition to the HCA decision to close Regional Medical Center of San Jose (RMC-SJ) status as a Level 2 Trauma Center, Comprehensive Stroke Center, and ST- elevation Myocardial Infarction (STEMI) Receiving Center. The importance of these services cannot be overstated, and I wish to underscore several critical points:

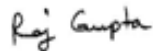
- 1. Essential Trauma Services:** RMC-SJ's role in our emergency medical services system is indispensable, offering immediate, life-saving interventions. The proximity of trauma care significantly influences patient survival rates; studies indicate a 29% increase in mortality for critically injured patients following the closure of nearby trauma centers. Our data reveals a notable volume of trauma cases, with a concerning drop in 2023 linked to reduced service offerings and leadership changes, exacerbating the risk to our community.
- 2. Stroke and Cardiac Care Excellence:** Our Comprehensive Stroke Center has demonstrated remarkable growth, with patient volumes increased by 22% in 2023. This growth highlights our critical role in the region's healthcare landscape, particularly in administering advanced treatments for stroke and cardiac emergencies.
- 3. Impact on Underserved Populations:** Termination of these programs at RMC would severely impact the underserved community of East San Jose. Imagine transporting critically sick patients to sister facility Good Samaritan Hospital which is 14.7 miles away with unpredictable traffic conditions would be a decision between life and death. In the pandemic times, when this community had highest number of Covid 19 patients in the county, Good Samaritan Hospital didn't accept patients despite several efforts. It took 37 years for trauma program, and 20 years for stroke and cardiology to reach this level. It would be a huge loss to the local community. Adjoining hospitals will be put under tremendous pressure to meet the demand. Lots of experienced physicians would be forced to leave the local area.
- 4. Historical Precedents and Health Equity:** In the past about 10 years ago, RMC closed down pediatrics. About 4 years ago, RMC terminated Ob/Gyn, Labor/Delivery and Neonatal Units causing

tremendous hardship to local population. If we let them to close down these programs also, health equity and diversity would be impacted severely. Health entity should not selectively choose which essential services they should provide and which one they shouldn't. There was a reason and need for these programs to be built in the first place, and there is no change in ground realities.

5. Lack of Inclusive Decision-Making: Medical Executive Committee and Board of Trustee of Regional Medical Center are not part of this decision. In fact, they were kept in the dark. There was a retreat done on 11/07/23 where ideas were asked to improve the services at RMC in the presence of corporate leaders, including President Far West Division Jacki VanBlaricum . All the discussions and ideas were duly noted but not acted on. Neither MEC nor BOT get monthly feedback about financial health of the hospital and any efforts to improve it. BOT at RMC is entrusted only with credentialing and quality maintenance. Real Board with functions of major decisions for the hospital including termination of services is done at corporate level to which we have no local representation. All vital decisions regarding RMC-SJ are being taken without any local representation.

I strongly believe that county shouldn't let HCA close these vital services compromising health and wellbeing of a vulnerable population. This is against the principles of Health Equity and Diversity. We should encourage HCA to work with MEC and BOT at RMC-SJ to improve the financial health of the hospital. There is no short cut to success and if you don't learn from history, history repeats. Tomorrow HCA may come back after a few years to ask for more cuts/reductions to a community hospital which has already been made dysmorphic with no pediatric/ob/Gynae /GI/Nephrology services. There is no more room to disfigure it further.

Sincerely,

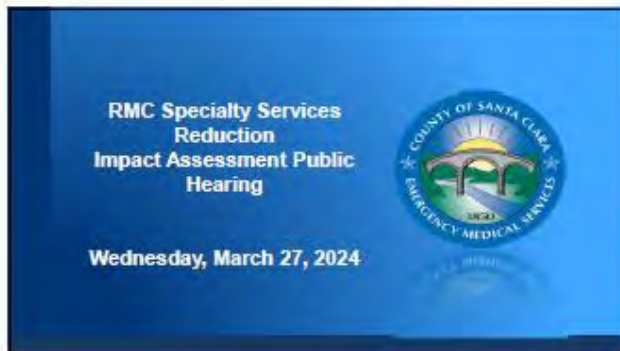


Raj Gupta MD

Ex President Medical staff RMC

Director Stroke and Neurosciences RMC

Appendix H – Public Hearing Presentations



1



2



3



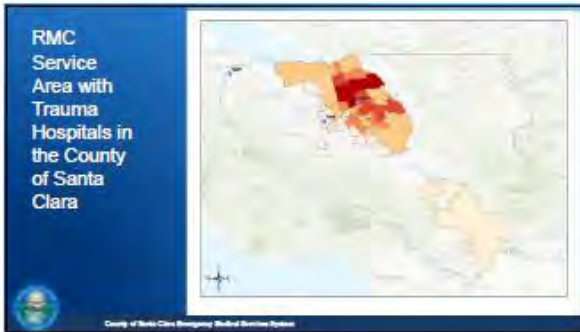
4



5



6



7

RMC Service Area Characteristics

Neighborhoods		
RMC Service Area	46	42%
Non-RMC Service Area	63	58%
Total	109	

Population		
RMC Service Area	907,811	47%
Non-RMC Service Area	1,024,211	53%
Total	1,932,022	

County of Santa Clara Emergency Medical Services System

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RMC Service Area Characteristics

Race/Ethnicity		
	RMC Service Area	Non-RMC Service Area
Hispanic	63%	37%
Asian	50%	50%
White	30%	70%
African-American	55%	45%

Age Range (in years)		
	RMC Service Area	Non-RMC Service Area
<15	46%	54%
15-64	48%	52%
65+	45%	55%

County of Santa Clara Emergency Medical Services System

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RMC Service Area Characteristics

Families living below 200% Poverty Line		
	RMC Service Area	Non-RMC Service Area
<5%	7%	14%
5-14%	39%	73%
15-24%	33%	11%
25%+	22%	2%

Median Household Income		
RMC Service Area	\$124,940	
Non-RMC Service Area	\$158,419	

County of Santa Clara Emergency Medical Services System

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Hospital	Miles from Regional (Shortest Route Rounded Up to Whole Miles)	Travel Time (Under Ideal Traffic Situations)
O'Connor	9	34
Valley Medical Center	10	36
Kaiser-Santa Clara	13	38
Kaiser-San Jose	14	38
El Camino-Los Gatos	14	39
Good Samaritan	15	38
El Camino-Mountain View	15	34
Stanford Medical Center	21	33
Palo Alto Veterans	25	28
Saint Lucile	31	32

County of Santa Clara Emergency Medical Services System

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Experiencing Symptoms of a Heart Attack?

1. Call 911 immediately!
2. Say: "I am having a heart attack!" Be prepared to answer the dispatcher's questions.
3. Do NOT drive yourself to the hospital.
4. Remember, every second counts. Do not delay calling 911.

County of Santa Clara Emergency Medical Services System

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Physician Leader Panel

To Address Closure of Critical Services
at Regional Medical Center of San Jose




**SANTA CLARA VALLEY
HEALTHCARE**

March 27, 2024

Key points

- RMC's Trauma, STEMI and Comprehensive Stroke Services are critical to the community and closure will directly and indirectly affect patient safety and outcomes
- Delayed access to trauma services will affect care for those patients, with longer transport times, delay in definitive care and potential increased morbidity and mortality
- Closure of services will cause an immediate cascade of negative effects to other hospitals in the area, with predicted increased demand for transfers out of RMC – resulting in increased need for ambulances, longer ED wait times related to congestion and prolonged waits for more limited specialty care
- Our shared community and its most vulnerable members will be disproportionately affected by these closures



SCVH Physician Leader Panel

- Brian McBeth, MD – Chief Quality Officer, SCVH
- Dan Nelson, MD – Chair of Department of Emergency Medicine, SCVMC
- Praveen Anchala, MD – Medical Director of Radiology, SCVH; Chair of Radiology, SCVMC
- Adella Garland, MD – Trauma Medical Director, SCVMC
- Tiffany Castillo, MD – Chair of Orthopedic Surgery, SCVMC
- Patricia Salmon, MD – President Elect, Medical Leadership Council, SCVMC; Chief of Adult Endocrinology, SCVMC




Brian McBeth, MD – Chief Quality Officer, SCVH



RMC vs. SCVH Patient Mix

- RMC Trauma Closure Will Directly Impact SCVH



Compromise of Trauma Care

- "Golden hour" of trauma represents an opportunity for early intervention, hemorrhage control and definitive care
- Delays and longer transport times have been associated with increased mortality, especially with hemorrhagic shock

Hsia RY, Srebotnjak T, Maselli J, Crandall M, McCulloch C, Kallermann AL. The association of trauma center closures with increased inpatient mortality for injured patients. *J Trauma Acute Care Surg.* 2014 Apr;76(4):1048-54.

Okada K, Matsumoto H, Saito N, Yagi T, Lee M. Revision of 'golden hour' for hemodynamically unstable trauma patients: an analysis of nationwide hospital-based registry in Japan. *Trauma Surg Acute Care open.* 2020 Mar 10;5(1):e000405.

© 2005 Blackwell Publishing Ltd *Journal of Internal Medicine* 258: 105–112

Stacy ABA, Systolic A, Citric C, Maciowski R, Swain DM, Billerica KY, Crandall AB.
Describing the density of high-level nature centers in the 15 largest US cities.
Thruway State Academe Care Group. 2020 Oct 9 (SI) 1e000560.

	Age	Population (Bosnia and Herzegovina)	High-level income countries	High-level income (population density) (persons/km ²)	High-level income (per-capita GDP) (USD)
East Asia	1994-1995	405.1	17	541512	401
East Europe	1994-1995	459.1	14	205454	404
East Europe	1995-2000	464.6	14	275006	404
Europe	1995-2000	1423.0	3 ^a	171096	234.5 ^b
Europe	1995-2000	311.6	9	150007	400
EU countries	1995-2000	223.9	9	225493	400
East Africa	1995-2000	741.1	7	144441	177.8
East Africa	1995-2000	504.1	5	106765	154.1
East Asia	1995-2000	546.5	2	108405	70.8
East Asia	1995-2000	205.7	3	942119	404
East Asia	2001-2003	303.1	9	1219338	403
East Asia	2004-2005	302.8	9	1219777	399.4
East Asia	2006-2007	301.9	2	895044	393
East Asia	2008-2009	301.3	4	1306087	400
East Asia	2010-2011	301.6	3	1505878	399.3

- Minimum: 40% of RMC cases to SCV/h (30% increase in SCV/h volume)
- Mid: 73% of RMC cases to SCV/h (50% increase in SCV/h volume)
- Max: 100% of RMC cases to SCV/h (70% increase in SCV/h volume)
- Estimated impact for direct trauma cases only and does not include subsequent, downstream care and/or volume

EST. TRAUMA IMPACT TO SCVH	Min (30% Inc.)	Mid (50% Inc.)	Max (70% Inc.)
Trauma Cases	1,280	1,900	2,600
Cases/Day	3.5	5.2	7.1
Patient Days (ICU)*	2,544	4,000	5,779
Patient Days (Med/Surg)	580	1,001	1,576
ADC	8.6	13.7	20.1
OR Cases	205	314	473
OR Cases/Day	0.6	0.9	1.3

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- Lack of access to specialties will reduce RMC's ability to care for patients in their ED, increasing need for acute transfers
- RMC's proposed plan to increase their ED facility space to churn through ED patients is flawed and creates significant patient safety concerns:
 - Total admissions to RMC will increase as ED volume increases
 - In the setting of reduced specialty services at RMC, transfers to other facilities for a level of care will increase
 - Patients will quickly fill RMC ED and inpatient beds, waiting for care and transfers
- For RMC discharged patients, follow up with specialists will also be reduced, leading to longer wait times for clinic appointments and potentially compromising care.
- This impact will be disproportionately felt by the most vulnerable communities while SCVH works to increase access to care for these populations.

- Significant increase in EMS transfer requests out of RMC ED should be anticipated due to lack of specialists' availability
- Demand on the EMS system will directly increase, with anticipated prolonged waits for ambulance availability and significant increase in Ambulance Patient Offload Times (APOT)
- Anticipate a cascade effect that could affect community access to EMS response times across Santa Clara County

- We are the safety net, public hospital system
- As such, we are committed to providing safe, quality care to any and all patients
- The abrupt closure of RMC's critical services poses an unacceptable risk to public safety, and disproportionately to the most vulnerable members of our communities
- This timeline does not allow adequate time for SCVH to expand our capacity to accommodate this significantly increased demand
- SCVH will need to secure additional resources to invest in facilities, staff and infrastructure



**Praveen Anchala, MD –
Medical Director of
Radiology, SCVH;
Chair of Radiology,
SCVMC**




**Adella Garland, MD –
Trauma Medical Director,
SCVMC**




**Tiffany Castillo, MD –
Chair of Orthopedic
Surgery, SCVMC**




**Patricia Salmon, MD –
President Elect, Medical
Leadership Council, SCVMC;
Chief of Adult
Endocrinology, SCVMC**



Specialty Impact

- RMC already has limited specialty care coverage in multiple medical specialties. Closure of the STEMI, comprehensive stroke, and trauma programs will further exacerbate this problem.
- The loss of specialty services at RMC has already had an impact on SCVH, particularly in Gastroenterology and Nephrology.
- In 2023, coinciding with RMC's loss of GI coverage, VMC experienced:
 - 40% increase in the number of inpatient GI consults
 - 40% increase in the number of GI procedures requiring assistance of anesthesiologists

Specialty Impact

- The increased demand for inpatient services requires SCVH to shift resources from the outpatient to the inpatient setting. Until increased capacity can be built, outpatient access will be reduced across multiple specialties.
 - Currently, 1/3rd of VMC specialty clinics have limited access for new patients and are redirecting care outside of SCVH to ensure timely access to care.
- Immediate impact will be seen in Cardiology, Neurology, and surgical specialties, resulting in reduced outpatient services.
 - Patients seen for hospital care will likely require outpatient follow-up, for which access may be limited.
 - Anticipate increased volume in other medical specialties to address comorbidities associated with cardiovascular disease and trauma-related injuries.
- To minimize delays in patient care, VMC will likely need to redirect more patients outside of the system for outpatient specialty services, which will increase outside medical costs and further fragment care.

Lack of access to timely cardiac care

- Cardiovascular disease is the leading cause of death for adults in the US
- Closure of RMC's STEMI receiving capability will directly affect cardiac care for the surrounding community
 - Many STEMI patients self-present to emergency rooms
- Early revascularization saves lives! Time is critical for intervention in STEMI's, with national benchmarks (ACC/AHA) of 90 minutes or less for door-to-balloon time for revascularization
- With added transport times and reduced access, we can expect increased morbidity and mortality
- Non-STEMI care also will be affected by limited RMC cardiac catheterization lab availability, which will reduce RMC's ability to admit and treat cardiac patients, leading to increasing transfer burden

Oliver JC, Hahn KY. Association between Emergency Department Closure and Treatment, Access, and Health Outcomes Among Patients with Acute Myocardial Infarction. Circulation. 2016; Nov 15;134(22):1584-1597

Closure of Comprehensive Stroke Center

- Closure of RMC's Comprehensive Stroke Center will limit access for complex stroke patients across Santa Clara County – including those with an urgent need for endovascular thrombectomy, neurocritical care services and neurosurgical treatment of intracranial aneurysms
- Time-sensitive therapies such as endovascular intervention are expected to see longer wait times that can lead to increased morbidity
- Burden of these complex stroke patients will be born by remaining Comprehensive Stroke Centers at Stanford and Good Samaritan Hospital

