Establishing and Operating The Los Angeles Surge Hospital

By Marc Futernick, MD, FACEP

As COVID-19 numbers were increasing this spring, California State leaders decided they wanted to prevent the types of overwhelming situations being faced in other areas, where resources were insufficient to offer optimal care to all in need. California leased a hospital in the heart of Los Angeles that had recently closed, St. Vincent's Medical Center. They partnered with Dignity Health and Kaiser to set it up and manage the operations and, subsequently, with VEP Healthcare to provide the staffing, which is how I became involved as a medical director.

The Los Angeles Surge Hospital was designed to accept seriously ill COVID-19 patients from hospitals throughout the area who were at capacity and needed help. Most of the patients were intubated, but some were on high flow oxygen, and some were of lower acuity based on the needs of the requesting hospitals. We had lab, pharmacy, X-ray, and CT, but otherwise resources outside the ICU and step-down unit were minimal, including only tele-consultants for specialized needs.

Fortunately, the overwhelming situations encountered elsewhere did not materialize in Los Angeles, although several hospitals really needed the relief valve that we provided. We opened in mid-April and shut down on the Friday of Memorial Day weekend. Although there was discussion about the potential of a near-term surge, the State decided to close the hospital without plans to re-open. I can only speculate as to the exact reasons, but I suspect it was a combination of factors. Even though there were hospitals who really needed help, community-wide there was plenty of capacity. Nearly all the patients transferred were uninsured or on Medi-Cal. We had to transfer out about 10% of our patients due to lack of proper resources for certain conditions that developed. Considering the total number of patients, and the cost of setting up a functioning hospital, the cost per patient was substantial. My sense is that future surges would be best handled by better coordination and regionalization of care, particularly for under-insured patients who will not be readily accepted by private institutions with capacity.

I had the privilege of working with a dedicated, mission-driven group of administrators, directors, and physicians. We all took time away from our usual jobs, exposed ourselves to increased risk, and came together for a common purpose. Although shorter than expected, it was an experience I will not forget. I believe we provided excellent care to a population in need and provided insurance against the unfathomable situation of rationing ventilators or ICU beds, as has happened elsewhere. We also gave the hospitals some time to prepare for the new reality of multiple surges of critical COVID-19 patients. ■