

TRANSCRIPTION by Fresno Metro Ministry
OF FRESNO COUNTY BOARD OF SUPERVISORS MEETING NOVEMBER 5, 2002,
ITEM # 7, ANNUAL REPORT OF COMMUNITY MEDICAL CENTERS REGARDING
CONTRACT

CLERK TO THE BOARD: Item number seven under administrative office: Receive annual report on Community Medical Centers in Fresno County agreement for the care of indigent and inmate populations.

DR. J. PHILIP HINTON, CEO, COMMUNITY MEDICAL CENTERS: Good morning. I'm Dr. J. Philip Hinton. I'm the chief executive officer of Community Medical Centers. Dear members of the board, I appreciate the opportunity to stand before you and give the annual report. I've provided you with a written report on the status of our 30-year contractual agreement, and I'd like to take this time to provide a summary of that report, and in addition I will answer the questions that were posed to me by the county administrative officer in a letter dated October 25, 2002. Let me start with some observations on the status of healthcare in our state.

In my role this year as chairman of the California Association of Public Hospitals, it is apparent to me from reports of our membership that this is a challenging time for hospitals statewide to serve the poor. For example, county supervisors in San Luis Obispo have voted to close their county hospital, the only public hospital between Monterey and Ventura counties. UC Irvine Medical Center is refusing to take new needy patients who live more than five miles away from their medical center. In Los Angeles, facing a \$700,000,000 deficit in their healthcare system, the Los Angeles county supervisors have already voted to close eleven of their 16 clinics, and they've delayed until November 19 a final vote on closing two of Los Angeles County's six hospitals. These problems are due to falling government subsidies for the healthcare of poor people, the rising number of medically uninsured people as our country is in recession, and the rapid rise of nursing salaries because of a severe nationwide nursing shortage. On the other hand, we're not facing the same dire conditions, at least not yet here in Fresno.

Community Medical Centers is living up to all the promises in its 1996 contract with the County. Now this contract requires Community to deliver care to the medically indigent covered by Section 17000 of the state codes, and we're delivering that care. Our percentages exceed the amount required. The contract requires Community to serve the rural areas with clinic access, and we're doing that. The contract requires community to build a new burn level 1 trauma center at a cost of at least 65 million, and we're doing much more than that. Those of you who have driven by see that our \$145,000,000 trauma and critical care building is on time, under budget, and scheduled to open in 2004. Clearly the desire on our part is to go beyond the minimum, and in many ways we've done that.

Now in addition to providing details on these key contractual provisions, your staff sent us a request for additional information in a letter dated October 25, 2002, and today I've provided you with a written response to these questions from our legal council because the questions involve detailed legal analysis. Because someone shared the questions with the media before we had the opportunity to answer them, here is a synopsis of those questions and answers.

First, on the question about why we aren't paying for County indigent patients who are treated at other hospitals, we are responsible for caring for the needy of Fresno County, but we are not the County's HMO or an insurance company. When patients are diverted to other hospitals because our beds are full, we are not obligated to reimburse other hospitals for their care any more than the County did when it ran its own hospital and it didn't.

Second, on the question about budget reductions in the University Medical Center Emergency Department, the budget for the University Medical Center Emergency Department has not gone down. It has gone up substantially. The budget went up 27% in 2000-2001 and has gone up another 27% in the current fiscal year. It's gone from 6.3 million to 10.2 million in two years. Running a first-rate burn trauma center is one of community's top priorities.

The third question dealt with tardy submission of data for California healthcare for indigents' claims to the County. Our data submissions to the County have been timely and correct, but there have been follow-up questions that have taken additional time to answer. We would be happy to work with County staff to determine what you're looking for and how to smooth out the time lines.

The fourth question dealt with changes we're making to the Mendota Dental Clinic. In this case our only change involves subcontracting with United Health Centers, a federally qualified health center. This will increase the hours of service and thus increase access to MISIP patients. Because the services are not being reduced and they're not being relocated, this does not affect the County contract.

The last question dealt with access to the University Medical Center Diabetes Clinic. We are certainly not curtailing the UMC Diabetes Clinic. We are moving patients through more quickly using group education sessions, which reduced the waiting period and increased access. Individual counseling and treatment sessions are still available.

Now moving to another part of the report, you're entitled to know a bit about the strength of Community's operations. We are setting records in the number of patients we're treating. Last year our emergency room visits topped 129,000. We delivered a record 9,400 babies, and the average daily census at our three facilities was 532, an all-time high. We continue to provide the best in medical science. For example, we now have the da Vinci surgical robot to help with precision surgery under magnification, and we're doing neurosurgery with no incisions using stereotactic radiosurgery. We're partnering with all the other hospitals in our region in the Paradigm Program at Fresno City College. It's one way in which we're growing our own nurses to meet this severe nationwide nursing shortage. Our care continues to earn high marks from patients. In surveys 92% of respondents rated the overall quality of care they receive with us as excellent, and 98% of patients at our facilities stated they would return and would recommend Community Medical Centers to their family and friends.

I'm proud of these efforts of our doctors and employees, but as I said at the outset, these are tough times in healthcare. Finances are not good for many hospitals in California, and other counties are not doing as well as we are here, and we're doing our best to maintain access and

provide excellent care in an era of diminishing resources and increasing expenses. I look forward to making our unique public/private partnership as good as it can be and to addressing items not covered by the contract. We'll have to work cooperatively to accomplish that, and I commit our organization to working with you to do just that.

SUPERVISOR SUSAN ANDERSON : I have a question, Dr. Hinton, on the Mendota Dental Clinic. Will that clinic still provide the teaching opportunities that it has provided in the past under the new contract?

DR. HINTON : I do not believe that it will provide the same teaching opportunities for dental residents. We have about 190 total medical and other residents that are working with us mainly under an agreement with the University of California San Francisco. Our dental program is a one-year postgraduate training program that is not approved by University of California San Francisco right now, I don't believe. I don't know the details on that, Susan, but it's a one-year extra training after the person finishes dental school and is licensed, so it's my understanding that the clinic will be operated by fully licensed and qualified dentists, but I'm not sure that it includes the training program. I simply don't know the exact answer to that.

SUPERVISOR ANDERSON: Can you get back to us on that, because I think that is an important service for the community to have, I believe, two slots for dentists in training to work there.

DR. HINTON : I know that we're training approximately ten postgraduate dentists all the time. There is room for them to be trained at the University Medical Center clinics, and my understanding is that there is not a shortage of dentists in this area. Our primary focus is on training medical people where there is a shortage in the Central Valley, so our residencies focus on bringing doctors to the Valley where there's a shortage. That's the mission of the University of California programs. I'll be happy to get back to you on that.

SUPERVISOR JUDY CASE: Just a couple of questions, and I'm one who really believes Community provides a very important service to our community at large, and the care tends to be excellent with a few areas that people have had concerns. On the letter you initially sent us you stated the disproportionate hospital share supplemental funding was \$10 million below the previous year. That was in your letter to us. What is the current level that you receive in assistance support?

DR. HINTON: In the previous years we were receiving about \$54 million in 855 DSH. In the current year we received about \$42 million. Those numbers are decreasing nationwide because of the balanced budget act and the, it's called the DSH cliff. The actual amount of money available is dropping rapidly.

SUPERVISOR CASE: And this is money that represents support to hospitals that carry a significant load of Medi-Cal patients relative to their general population?

DR. HINTON: Yes. The way it gets its name, disproportionate share, is that the hospitals that take care of the most needy people, defined as those which take care of a lot of Medi-Cal patients

in addition to their other loads of patient, indigent and paying patients, if the percentage of Medi-Cal patients is high enough it makes you eligible for supplemental payments under a program of state law called 855. I must point out to you though, that even with the DSH payments added in, if you take the actual cost that it costs us to provide care to Medi-Cal patients, now not charges but actual costs of caring for Medi-Cal patients, and then you subtract from that what we get paid by the state and the managed care companies and subtract the entire amount of 855 DSH, we're still \$17 million short in covering the costs of those Medi-Cal patients. So it's not like we're making money on DSH. It helps to make up the shortfall between what we get paid originally and what it actually costs us, but it doesn't really make it up.

SUPERVISOR CASE : I guess the other question and concern I have, and I'm not sure where this is all going to go, it's not unique to Community Medical Centers, but in the last probably two, possibly three years every hospital in this area has found themselves in the position that all their beds are full, and they're diverting patients away from their emergency rooms with the exception of those who are able to walk through the front door. I do understand that even University Medical Center, which has kind of been the catch all for everybody, has been known on occasion to also divert patients from your door because you're full, and I guess maybe County Council needs to get back to us in terms of how that impacts our contract. If we have a contract for patients to go to a certain place, they're supposed to go to UMC and UMC diverts them to another facility, is that an implied approval because you're not accepting them and you're sending them somewhere else? But in the broader scope, what's your crystal ball on how this diversion issue gets addressed? I've had some first-hand experience when my own family member got diverted away from her provider of choice, ended up in another location, and what happened was the family pulled together and paid the cost of the ambulance to get her over to the hospital where her doctor was located, so we had an out-of-pocket cost close to a thousand dollars just because she was diverted in the system. How many other families does that happen to, and how do we fix that problem?

DR. HINTON: What you're really referring to is a nationwide problem, and the basic foundation of this problem, the underlying difficulty, is that the United States has no healthcare policy. Our only healthcare right in America is the right to emergency room care, and it was established by a budget act, the Balanced Budget Act of 1986, which said that if you go to an emergency room, any hospital with an emergency room, they're obligated by law to treat you until you are stable, even well, regardless of your ability to pay. Now that's the right kind of a decision for the government to make to require you to do that, but it came with absolutely no money. Now as the number of uninsured people rises in this country, and because we have absolutely no healthcare policy in the United States other than this unfunded mandate that if you show up at a hospital with an emergency room they must take care of you until you're stable, the number of uninsured people is rising, they have figured out that they can get their primary care at no cost at their hospital with an emergency room, and they come, and the healthcare system nationwide is flooded with people doing exactly this. It's a nationwide problem and one that I believe needs a nationwide solution to address. The president's plan is to address it with tax credits for people to buy insurance. I think that's a good idea. Another part of the president's plan is to encourage these federally qualified health centers, the community clinics, and we encourage that as well so people have a place to go to get their primary care that isn't just the

emergency department. But I predict that eventually we have to have some more fundamental solution.

I'd like to return specifically to that question about diversion from emergency departments. All emergency departments across the country are being swamped by this unprecedented demand for services, and it's not necessarily emergencies because when people come in it might just be for a cold, but the law says you have to examine them and do whatever tests are necessary to prove it is or isn't an emergency. So there are lots of people there that need to be there, there are lots of people there that don't need to be there. And so there will be times when University Medical Center is on diversion, there are going to be times when Kaiser and Saint Agnes and everyplace else that has an emergency room is on diversion, and our obligation at University Medical Center is to make sure that we have enough capacity from the standpoint of beds and physicians and nurses to take care of level 1 trauma and burn. We serve as the only level 1 trauma and burn unit all the way from the L.A. area clear up to Sacramento. We have that burden, and so we try hard not to go on diversion, but we also try to keep enough capacity that when people are really badly injured we have room to put them in there.

There is one more thing about the federal mandate for emergency rooms to take care of patients that seems to me completely unfair. I understand I'm facing a terrible lobby, and as a physician I'm stepping on toes of my brothers, but here's the truth. That mandate says that hospitals with emergency departments must take all comers, and there is no payment for it, but the law does not obligate doctors to show up. They don't have to. And so nationwide they're demanding payment for showing up, and the hospitals, even with diminishing resources, are having to pay the price to get them to come. It's not fair.

SUPERVISOR CASE : So you're saying the hospitals are having to contract with physicians to be able to be available when they come to emergency rooms?

DR. HINTON: Or they simply refuse to come because they do not have a legal obligation to show up. Only the hospital, not the insurance companies, no one except the hospitals with emergency departments are obligated by this.

SUPERVISOR CASE: Well, in the past there was no diversion. That just wasn't done, and it's been more of a phenomenon those past few years, I think, because of lack of capacity. With your new trauma center, how many additional emergency room beds do you anticipate?

DR. HINTON: That's a really great question. We'll be open in 2004, and if you took the current emergency room space at Community Medical Center Fresno and you took the current emergency room space at University Medical Center and added those two together in terms of square footage, the new Community Regional Medical Center Emergency Room is more than twice as big, so we're adding a lot of room. We're adding a lot more services. Now will that really help? I don't know. When you're already completely full maybe that will simply fill up very rapidly too, but at least we're doing our best to provide the space and the facilities.

SUPERVISOR CASE : Thank you. That's my last comment. When we wonder where the growth of our community is coming from you said your facilities delivered 9,400 new citizens to Fresno County?

DR. HINTON: Yes.

SUPERVISOR CASE: That's a lot, and there are still other hospitals that are delivering babies, so right there is a lot of our local growth.

SUPERVISOR JUAN ARAMBULA: Just one question, Dr. Hinton. On the issue of diabetes education, I think all of us recognize that that's a growing problem in our community and nationwide. Can you elaborate a little bit on the change in the manner in which patients are educated about the disease and how that compares to best practices in the field.

DR. HINTON: The diabetes education and treatment that was being done through our University Medical Center Clinic and our other clinic system and by our physicians was largely individual meetings, an hour-long visit or so initially and then multiple individual patient visits. And this caused a backlog of people waiting to get in. It provided a situation where as the number of people with diabetes increases it was difficult to actually handle that load. Our physicians looked at what we call best practices. We encourage our doctors to do clinically based medicine. You go to the literature, you go to other physicians, you go to conferences and you ask other doctors what works the best to get the most service you can for a reasonable amount of income. You're always balancing resources and service because you have to. I've already told you the amount of money coming in is going down, and so you're trying to find the most efficient way to deliver the services. And it turns out that as we looked at the literature, as we looked at practice nationwide, we can do the education parts of the visit in groups of 10 or 20 people, so you're educating people. You get a group of 10 or 20 people that speak the same language and have the same basic level of diabetes, and you can teach them together. You can do the same thing with people that are Spanish speakers, and then when it comes down to their individual treatment that needs to be different from someone else then you move them into an individual visit. It turns out that this is becoming the practice nationwide. It's even becoming the practice in doctor's offices. Group visits in your private physician's office are proving to be very useful. If you're in with another group of people that have the same condition you have you trade stories and you talk about what works for you, and it's become a nationwide phenomenon. We are attempting to use those best practices in how we design our diabetes services, and we're starting with the educational group so that people get an understanding of the disease right up front, and it's lessening the waiting time to get in. Now we think that's a good idea, the literature says it's probably a good idea, but not everybody agrees with us.

SUPERVISOR ARAMBULA: And I assume that as you get more experience with this you'll re-evaluate it and see if in fact it does show the kinds of benefits that best practices in the Bay Area have shown.

DR. HINTON: That's what evidence-based medicine is supposed to do. You do the best you can, you measure and see if it's working.

SUPERVISOR ANDERSON: I have one more question, Dr. Hinton. What is Community Medical Center's plan as far as the use of the UMC facility that the County owns?

DR. HINTON: That's a very good question. As we complete the Community Regional Medical Center and move acute care services to the Regional Medical Center we will be vacating the University Medical Center buildings. It is possible that it would be advantageous both to us and the County to plan alternative medical uses for that that wouldn't have to do with the actual acute care hospital services, and we would be happy to entertain discussions with respect to that.

SUPERVISOR ANDERSON: So about when do you expect to be vacating the building?

DR. HINTON: Our current approximate date is summer 2004.

SUPERVISOR ANDERSON Thank you.

SUPERVISOR BOB WATERSTON: Dr. Hinton, I won't put you on the spot. I have teased you, and we go back a long way together. I just can't hardly imagine how life goes on with a doctor and a nurse down here and a fireman all involved in politics now when we used to work together at the hospital. The question I had of all of this though, because I don't know the answer to this, and that's when we pay for the indigents and they go to another hospital, how is the hospital supposed to get paid for that? Say they go to Saint Agnes. How does that work? I think that's been, at least some of the stuff I've read about, that seems to have been a rub a little bit with things.

DR. HINTON: According to the contract we're a service provider, not an HMO and not an insurance company, so our obligations as Community are exactly the same as the obligations the County had when it ran University Medical Center as Valley Medical Center, and in those days I was at Community Hospital and I was at Saint Agnes, and if I got a county indigent patient at one of those hospitals who came to my office and I took them to a hospital that was not Valley Medical Center, I did not get paid and that hospital did not get paid by the County because that's the way the rules are set up. So I've provided you in the letter with a detailed explanation by our attorneys going through the contract details, but that's the basic thing. The obligation we have is exactly the same obligation the County had before, and that's what we're doing.

SUPERVISOR WATERSTON: The thing that's confusing to me. The County, we no longer are taking care of the indigents. We've turned that over to Community Hospitals. Is that correct?

DR. HINTON: Yes you have, but for physical health, not mental health. Physical health.

SUPERVISOR WATERSTON: Now I have to ask the County Council here and Bart, how does this work? I thought that Community Hospital had the contract to take care of indigents. Now if you're loaded up I understand that, my gosh, if you have to divert, and then we've got the same people that you normally would have taken in had you not had to divert that are now at another hospital, and I guess they're asking to be reimbursed for taking on that person through

the County, and I don't know how come the County has to pay for that if you're responsible for it.

DR. HINTON: We're responsible for it if they come to our hospitals just like the County was responsible for it if they came to the County hospital. If they choose to go to another hospital they're making up their own mind. If they get taken there because of diversion it is still a situation where we're a service provider. We are not an insurance company. When we negotiated this contract with the County we were very careful and the County was very careful to make sure that the wording was exactly so that we had exactly the same obligation as the County of Fresno did when it owned the hospital.

SUPERVISOR WATERSTON: Is this something the County has to pay for then, Phil?

COUNTY COUNSEL PHIL CRONIN: First of all, this issue first came to our attention, I think, Friday. We weren't consulted in the letter that went out to Community Hospital, so we would need time to...and I just received Mr. Bob Ward's, Community Hospital's attorney, analyses. In all fairness to our office we would need time to look at the issues, to look at the facts, and to look at the contract. The contract is the size of the New York telephone directory. It has multiple parts to it, it's very complex, and our office put it together and we would need adequate time to look at this and then respond to your question.

COUNTY ADMINISTRATOR BART BOHN: Let me give one comment just to explain the situation as I understand it. What we have now is if a diverted indigent patient goes to another hospital there is no mechanism, and the hospital is not reimbursed in any way, shape, or form if it's not CMC or UMC.

DR. HINTON: Or unless we had given prior authorization.

ADMINISTRATOR BOHN: Which is probably problematic in the case of an emergency. I guess my question to Dr. Hinton is in terms of what has changed. Is it a fact that perhaps diversion was not as frequent in the earlier years back when the County operated the hospital and that diversion is much more frequent now, and that's why the problem comes to our attention more often? I don't know.

SUPERVISOR CASE: You know, it might be helpful to have Gary Carozza just kind of explain where he sees it. In my recollection and experience within the healthcare field, diversion was something that just didn't happen in the past, and it's only been really most recent years, and we're seeing patients that are being moved away from hospitals that feel that they can't safely take one more critical patient in regards to having the support to be able to do that. Maybe Mr. Carozza could talk a little bit, because I think when this contract went in place, and Gary maybe you can help us with that, I don't recall there being any diversions at that time, so I'm not sure it was even something that was discussed or expected that one hospital that we contracted with – and that's really our focus today – would be in a position to have to divert patients to another facility that we had thought would come there. And I'm not saying this is a Community Medical Center problem. This is a system-wide problem, but I think it does reflect on patients we did not anticipate would be diverted to another location.

COUNTY COUNSEL CRONIN: Well, also the discussion kind of begs the question because the issue is what constitutes authorization. And again, if we were given the time to look at this prior to coming to your board we would have been prepared for this, but I think we will be glad to look at this and to confer with staff, find out all the facts and then look at the contract and see under the contract and under case law and statutes what the obligations are and what constitutes authorization. So it's not just as simple as it's been made to appear.

SUPERVISOR WATERSTON: What I'd like to do, because I don't think we're going to solve anything here at all today, I'd like Gary to go ahead and speak and then I really think this needs to be taken back if it's okay with the other board members and brought back where we can discuss it with other things, because it kind of hit us at the last, and stuff got leaked out to the paper, the paper calls. There are a lot of things that I didn't even know how to answer and I still don't. So Gary, go ahead, and then if it's okay with the other board members I think we'll turn this back over to our staff. Is that okay? Okay, go ahead Gary.

DIRECTOR OF FRESNO COUNTY COMMUNITY HEALTH GARY CAROZZA: I would defer that question to Council. And I thank the supervisor. Gary Carrosa for the record, Human Services, Community Health Department. The issue of diversion is one that's been growing for the last four or five years. As shortages appear in critical care areas both in staffing patterns and now with the changing in nursing ratios, we anticipate that there are going to be more and more types of processes that are starting in a motion. As to the question of the diversion of indigents, I have to defer to Council as it regards to contract, but to answer your question, our EMS system now is on call 24 hours a day. We evaluate all diversions at all facilities and dispatch individuals to evaluate and then reopen as soon as possible or as soon as practical working with the hospitals in terms of safety and security of the patients.

SUPERVISOR WATERSTON: All right, Gary, thank you. Is that okay with the board if we turn this back over? I don't know what else we're going to accomplish here today unless one of the board members has some other questions. Anything?

SUPERVISOR ANDERSON: I just want to express my appreciation to Dr. Hinton for being here today, and I do want to encourage the staff to talk to Dr. Hinton and the folks at Community Hospital and maybe create a more open communication, open environment for better communication, and we need to make an attempt to do that too.

SUPERVISOR ARAMBULA: I would concur, and I just want to point out that there may be some public input, but I would feel comfortable directing our staff to review the response and do an analysis of the contract and the issues that have been raised, and certainly we have an ongoing long-term relationship with the hospital system, and I think it's to our advantage to make sure we have a full understanding of the issues and keep working on the relationship.

SUPERVISOR WATERSTON: I really do appreciate you coming, Dr. Hinton, and what your answers did is make me scratch my head more, because I really don't understand. You know, again, when I was in the streets for a lot of years we didn't have a lot of diversions, and towards the end of my career I saw more and more, but now I just read in the paper and talking to people like Gary, it's quite a bit now. You know what I'm going to do, though. I'm going to open this

up to the public. If you're asking for us to answer a question, as you can see now I don't think we're prepared to give you an answer to things. But if you'd like to express yourself, feel free to come up forward.

REV. WALT PARRY: Good morning. I'm Walt Parry with Local Health Care Coalition and Fresno Metro Ministry. I've got several comments and one question, and the question may have to be answered later, but I do have one question.

I wanted to commend the County for the questions and issues. Many of the issues that were in that letter we were not aware of, and I think it's extremely appropriate that the County monitor the contract as closely as possible.

Secondly, I want to commend Community Medical Centers for a number of issues, and a primary one is that progress is being made, maybe even ahead of schedule, related to the level 1 trauma and burn clinic. My understanding is that a major difference between level 1 and level 2 is that with level 1 you have all the specialists on site. That is essential, and it's essential that that be continued, and I wanted to commend Community Medical Centers for that as well as a number of efforts that they have made to have their staff be more culturally competent and appropriate with people from many different languages and many different cultures. There is always more to do there, but I think they've been making quite a bit of progress in that area.

I also wanted to note from Dr. Hinton's letter that one of the major barriers that they are facing is rural transportation, that people cannot get to the services that are provided, and I think this is something we need to remember as we look both at Measure C and other issues over the future. We need to have a better system of rural transportation than we currently have.

Community Medical Centers over the years because of the contract has had significant DSH dollars and other government funding that has been allowed them to provide a wide variety of services. Now that is decreasing because of both some prior legislative efforts on the federal level and also because of this Washington administration's perspective, and some of that money is drying up, and I think that we as a community need to work with them and others in trying to increase rather than decrease the amount of money that comes from the federal government for those hospitals and other providers that provide services to low-income people and people who have no other means.

I have one question and then a few more comments. The question is we have in Dr. Hinton's report showing patient visits of MISP patients that shows kind of an upward trend. What I have submitted to the board is the Medically Indigent County Report data that has been approved over the past few years that shows a different trend, and I would like some clarification a bit. It probably won't happen now. Both of these relate to patient visits of MISP, medically indigent patients, and it shows two different trends, one that shows a lot more people have been seen and the other one that shows that fewer people have been seen. So as you prepare the other information if you could also address that issue to clarify are these apples and oranges or are these all apples, as to why the difference, because the numbers are significant different.

The Diabetes Clinic issue may or may not be related to the contract. It depends on what services continue for MISP patients. Also it determines whether or not overall the level of service will be above or below what it was at the time of the contract. But I wanted to just emphasize that diabetes is one of our major issues as well as asthma being another that is increasing dramatically in Fresno County. Now even among the Hmong population there is a major increase in diabetes and other issues, and this is an area that in serving this community we want to have as many services as possible, and it does appear to me that some treatment services are going to be decreased. Even our education is going to be done in a different way. The treatment has to remain there because when people are seen, different doses at different times need to be changed, and that treatment element needs to not be decreased, and I hope it will not be. It's true they see very few MISP patients, but they do have a lot of Medi-Cal patients that we're very concerned about, and of course they are one of the major providers of services to people with Medi-Cal, MISP, and to people who have absolutely no reimbursement whatsoever.

I just wanted to point out too that we have an essential need for public/private planning related to meeting all the needs of Fresno County related to health care. As it is now every unit, every provider kind of does their own thing, the County does it's own thing, and I just wanted to recommend, and I hope that with a new public health officer this can happen in the future when we have someone full time, but that we engage in public/private planning beyond the contract. Not just what's in the contract, but as to how all of our providers can best meet the increased need that we have here in Fresno County and to do what we can to have the revenue streams that are needed. Unfortunately, one thing that's happening in health care is there is more revenue when people are urgently sick than preventive measures and maintaining people's health. That makes absolutely no sense financially. It makes no sense as far as health care. I just would conclude by agreeing with Dr. Hinton regarding one thing about our healthcare. There is no healthcare system in the United States other than emergency care. But I disagree related to the president's credits. Basically, we need a large risk pool. That's how you save money. Our country desperately needs a national insurance program of some sort that then has a provider network of private and public providers within that. Our system, I think, is falling apart particularly on the preventive measures and on maintaining people's health so that people don't have to get really sick in order for hospitals to be reimbursed and for people to get the care they need. Thank you.

SUPERVISOR WATERSTON: The things that you have asked for, we'll certainly put those in and get those back because I'd like to know what those answers are. One thing I can answer for you is that we're going to see even more and more that the county here is going to get very much proactive in a transportation system that's going to cover the entire county. Through the Great Valley, we met the other day, and through the Great Valley they're helping with putting on a full-time person that will be working on this all the time. A transportation system, one of them, is to get people to the medical facility. That's very important, like you said, and its also to get people jobs. And it will be a clean-burning system, and that's one thing I can tell you that we're working on as we speak now.

WALT PARRY : One other concern we would have is that at this point it is our understanding there is no funding for a new ambulatory care unit on the new campus, and we think there needs to be that ambulatory care unit. It's planned, but there is no funding for it at this point. So from

my perspective we all need to work together to find some way for funding a new ambulatory care unit on the Regional Medical Center campus. Otherwise there is going to be a lot of back and forth. I don't know all the other options, but that is also a concern.

CHAIRMAN WATERSTON: Thank you. And I also thank you for all you do for this community.

WALT PARRY: Thank you.

SUPERVISOR WATERSTON: We appreciate it. You're very much respected. Anybody else like to speak?

ROGER SIMONIAN: Mr. Chairman, supervisors, my name is Roger Simonian, and I'm the current dental director at the Mendota Dental Care Clinic. I'd like to pass out some information that can better illustrate some of the programs that we have out at the dental clinic, and can I give those to your clerk?

SUPERVISOR WATERSTON: The clerk, yeah, please. Thank you.

ROGER SIMONIAN: My main purpose of being here today is to answer any questions that anyone may have, and I believe Supervisor Anderson you had a question regarding the residency program and whether they would continue out there. When this plan was first presented to us, the takeover at the clinic by the United Health Centers, it was presented in such a way that we thought that the residency program and the teaching program would continue. As it progressed we found out that United Health Centers did not want anything to do with any of the residency or teaching programs, so they therefore would just have their private dentists working in the clinic. So to answer your question, no, there will not be any residents at the new center. The primary purpose of that rural healthcare clinic is to train and give residents experience in rural healthcare. I believe we are the only clinic situation within the whole state of California and the whole GPR programs in California that has such as aspect to it. There is no definite training in dental school for rural areas. There is no definite training unless somebody makes a specific intention of going to a rural area. So we believe that our clinic is the only healthcare clinic that gives the residents the experience in rural dentistry. There have been a number of our residents that have elected to stay in rural dentistry. We have them in Kerman, we have them in Dos Palos, we have them in Huron, we have them in Exeter, and they've gotten their experience with rural dentistry and access to care or situation through that Mendota Clinic. Are there any other questions or any other information that I can give you? Most of the information will be in those letters in the packet that you receive, and you can read those at your leisure, if you have any leisure time.

SUPERVISOR ANDERSON: I guess my question would be maybe for our County Council to answer at a later time as to whether or not that issue is something that the board can address. Is that something that we have control over under the contract? I do think that's important, and I did have my own dentist call me about this and was concerned that we were eliminating this training program and that it would in the long run be a problem for our rural communities, and so I'm concerned about that. I'm not sure that we have control over that under the contract. So we'll check that out.

ROGER SIMONIAN: One of the other aspects that Dr. Hinton brought up was that yes, the residents could be brought back into the clinic at University Medical Center. The only problem we have there is we don't have the backup personnel or the support staff to assist those new residents. All the support staff is going to stay out in the Mendota area. Another thing, too, that you may consider is that while there is going to be some sort of continuity of care with United Health Services, the Mendota Clinic has been there for 25 years and in its current location since the early 1990s when supervisor Koligian helped us procure that. But what's happened in the past is we've been there for 25 years on a continual basis. There have been dentists that moved in and out, and if you look at some of the track record of United Health Centers they sometimes have problems finding and filling positions for maybe years at a time or they have to shuffle people around. So I don't know if the continuity of care will stay the same with them as it did with the residency program.

SUPERVISOR ANDERSON: My other concern about this is just the fact that we don't have a Supervisor here in that district right now. I'm just a little sensitive to that issue because we don't have a board member really representing Mendota at this point, and I'm concerned that something might sort of fall through the cracks because we don't have anybody there now.

ROGER SIMONIAN: We will by tonight.

SUPERVISOR ANDERSON: Yeah, hopefully by tonight we will have somebody there.

ROGER SIMONIAN: Okay, any other questions? Thank you very much.

SUPERVISOR WATERSTON : Anybody else in the public would like to make any comments on this issue. If not, I close the public portion and bring back to the Board. Did we talk about just letting Phil take this now and give us some answers, just turning it back over to staff. Is that what we agreed upon?