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## **NOTES OF COMMUNITY HEALTH CARE ROUNDTABLE**

Thursday, August 18, 2005

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*The purpose of our Community Healthcare Roundtables and of our healthcare projects is to increase healthcare access that is appropriate medically, geographically, linguistically, and culturally and to improve public health. The Community Healthcare Roundtables are funded by individual donors, local congregations, event and activity sponsors, The California Health Care Foundation, The California Wellness Foundation, Vitamin Cases Consumer Settlement, Hewlett Foundation, USDA, MAZON: A Jewish Response to Hunger, Kaiser Permanente, Health Net, Children's Hospital Central California, Alliance for Family Farmers, and the California Nutrition Network.*

### **Dr. Edward Moreno – Potential Reorganization of Medi-Cal Managed Care**

Today I'm talking about the state Medi-Cal Medicaid Demonstration Project under the Social Security Act Section 1115 to redesign Medi-Cal. Our current waiver with the federal government is expiring and the state needs to come up with another agreement with the Centers for Medicare and Medicaid Services. Specifically representing the State of California is the California Health and Human Services Agency, Department of Health Services. The purpose of the waiver is to reduce Medicaid expenditures but maintain levels of healthcare.

***The California Medi-Cal Hospital/Uninsured Care Demonstration Project recently released the special terms and conditions, which include general program requirements, general reporting requirements, and general financial requirements***

To simplify it for myself I look at it as two components. One is the hospital component, which includes private and public hospitals, and the other is the expansion of Managed Care Medi-Cal or redesign of Medi-Cal here in the state. It's important to keep these two in mind because

they're both related in that the total funds that are made available under this contract for hospital services is dependent upon the state's successful expansion of Managed Care Medi-Cal through certain regions of the state and counties in the state. This is called the California Medi-Cal Hospital/Uninsured Care Demonstration Project, and just a couple days ago the state released the special terms and conditions. It's broken down into three components: the general program requirements, the general reporting requirements, and the general financial requirements.

***The general program requirements allow for a phase-in period and a phase-out period***

The general program requirements state that the period of this new waiver and agreement is from September 1, 2005, through August 31, 2010. The agreement requires that the state is compliant with federal nondiscrimination statutes and Medicaid laws. There is a demonstration phase-in and a demonstration phase-out. The demonstration phase-in allows the current providers to work with the current SPCP, which is Selective Provider Contracting Program, and they can continue to see patients, provide services, and bill through August 31, 2005. The contract states that the nonfederal share of payments to the private hospitals will be made through state general fund appropriations, but in other parts of this contract it does refer to the possibility that local funds can be used for the nonfederal match. There is a demonstration phase-out at the end of the five years. There are also suspension and termination clauses, the provision for adequate infrastructure that the state will demonstrate and provide to carry out the terms of the contract, provision of funding and reimbursement protocols, and procedures for determining cost eligible for federal matching through the Certified Public Expenditures, or CPE. Certified Public Expenditures is the method which the federal government and Department of Health Services have agreed upon. Basically, the public hospitals have to justify the cost of providing healthcare to get reimbursed.

***The general reporting agreement requires monthly calls, quarterly reports, annual reports, and a final evaluation report***

The second component of this agreement is the general reporting requirements. Very simply, there are monthly calls with Centers for Medicaid and Medicare Services, quarterly reports, annual reports, and a final evaluation report which is due before the termination of the five-year agreement. The state will operate with certain accounting procedures.

***Private hospitals may receive supplemental payments under the graduate medical education funds or emergency services supplemental payments***

I want to talk about the general financial requirements of the terms and conditions. First of all, as I mentioned, the payment for Medicaid-eligible patients must be made through a Selective Provider Contracting Program, or SPCP, which is referred to as the inpatient hospital component. There are private hospitals and government hospitals. The private hospitals, as mentioned earlier, will receive per diem payments and they may receive supplemental payments. An example of that would be the graduate medical education fund, which Community Medical Centers and University Medical Center participate in. There are also emergency services supplemental payments. As far as the government hospitals, payments will be based on allowable Medicaid hospital costs and they will continue to receive DSH funding, which can

include Federal Financial Participation, or FFP. The hospitals must retain the full amount of any payments involving intergovernmental transfers. In the past some of the hospitals were in receipt of money for Medi-Cal services. I was hearing that the government was not pleased with the fact that hospitals in association with other government agencies were moving money around, and they wanted to reassure that the money coming to the hospitals was being spent on healthcare, so there is that stipulation that the money cannot be transferred. Any money that is received can be used in subsequent years by those hospitals, but they cannot, again, receive funding in excess of the cost of services. They're basing it on Certified Public Expenditures. What it costs is what you get. The state may redistribute the federal portion of DSH funds that it receives among government hospitals, so what I'm seeing from this is that a hospital submitting money for a federal match may not be surprised to find out that they're not getting the full federal appropriation that they were expecting.

***Safety net care pool funds ensure continued government support  
for healthcare to the uninsured***

The safety net care pool funds were established to ensure continued government support for healthcare to the uninsured. My understanding when I read it was it may be used for DSH funds, but I need to get some clarification on that because in years three, four, and five it appears that it's required to be used for something else. It does include 22 governmental hospitals, but this agreement says that the state may decide to add other agencies, state, city, private, or public. The pool of money is capped at \$766 million a year in federal funds. This amounts to \$3.83 billion over three years. The unexpended funds may not be carried over to the next year with one exception, and that is to pay claims, for example, that were submitted in year one and paid in year two. Other than that, the hospitals cannot carry over the federal portion of the funds for Medicaid payments from one year to the next. For the first two years of the Medicaid redesign, \$180 million of the safety net care pool funds will be conditioned upon meeting the deadlines for Medi-Cal redesign. In demonstration year one of the five-year agreement, of that \$180 million, \$90 million is available to the state if managed care legislation is enacted by September 30, 2005. The legislation is to expand the number of counties covered by Medi-Cal Managed Care and to enroll Medi-Cal-only seniors and individuals with disabilities into Managed Care Medi-Cal. The other \$90 million is available to the state if it submits Medicaid state plan amendments by May 31, 2006. Each time a deadline passes and we don't meet the deadline, a portion of the \$90 million is prorated to the state, so if we go past the September 30 or May 31 deadlines the state loses out on money. If no legislation is passed in demonstration year one, then the \$180 million is lost all together. In demonstration year two, the \$180 million is broken up into three \$60 million portions. The first \$60 million of safety net care pool funds is tied to state completion of Medicaid state plan amendments and waiver requests for managed care expansion. The next \$60 million is tied to successful contract of managed care and rate submissions. Another \$60 million is tied to beginning enrollment in Managed Care Medi-Cal by 2007. If Managed Care legislation is not passed by August 31, 2007, year-two safety net care funds are lost. The \$180 million in each of years three, four, and five is to be used to fund a healthcare coverage initiative to expand coverage options for individuals currently uninsured.

***Fresno County does not have a state-recognized Managed Care Medi-Cal system***

As you know, the Fresno County Health Department is no longer providing healthcare. The healthcare that we were obligated to provide by statute to the medically indigent inmates was signed through a contract with Community Medical Centers in the late 90s, but we still feel we have an obligation to follow this and determine what role we have, if any, to play. The state has proposed an expansion of Managed Care Medi-Cal in certain counties. Basically, they pick the counties most likely to have success in expanding Managed Care Medi-Cal. However, we've been told by the state that they are willing to discuss and accept requests in the form of letters from county officials who propose alternatives to the state-proposed expansion plans. Fresno, Madera, Merced, and Kings currently do not have a state-recognized Managed Care Medi-Cal system. We have two plans here in Fresno County, but state looks at us as not having one of the recognized plans. The options that we were offered years ago and that are still on the table are, first of all, a county-organized health system. It's an option for some counties. It was recommended by the state for certain counties to adopt this plan. The requirements to adopt this plan in the county are, again, that you don't have a recognized managed care system in place but that you are a neighbor to a current county with a system that would basically take you in. If you don't have one it would cost several million dollars, from my understanding, and a lot of effort to develop such a system in a county. The other plans, which counties like Kern and Tulare currently have, are the two plan models that include a local initiative, which is local government participation in at least one private plan. The newest model is the Geographic Managed Care Medi-Cal model. Under this system, any health plan that submits a proposal to the state to provide Medi-Cal Managed Care that also meets the criteria that the state has established can participate in that county. The plan just needs to meet the minimum criteria, so that could be anywhere from a handful to five, six, or seven plans. I haven't heard from anyone that can reassure me of any accurate predictions of how many plans would be interested in applying here in the County of Fresno.

***Drastically increasing the number of health plans in Fresno County may prove very challenging to both patients and providers***

There are two more options which the state didn't propose but they're listening to from counties. One is limited Geographic Managed Care Medi-Cal. If a county was interested in limited Geographic Managed Care Medi-Cal plans the state would entertain that possibility. The reason that I asked them about this was because in the opinions that were shared by some of our local folks at the Central Valley Health Policy Institute when the state came down, some people felt that drastically increasing the number of health plans in this county, which still has a large rural component to it, may prove exceedingly challenging to not only the patients who are utilizing Managed Care Medi-Cal system but also the providers, so this is something that would need to be discussed. The other option would be no Managed Care Medi-Cal, and that's the least desirable to the state. They have already selected which counties they want to expand Managed Care Medi-Cal. There is at least one county that is interested in telling the state they're not interested for various reasons, and I believe they may move forward and make their case. The state is expecting about 27 total counties to participate in Managed Care Medi-Cal by the end of this, and if even just one county says they're not participating and it's approved, what that means for the state in terms of their agreement with CMS in expanding Managed Care Medi-Cal is

unclear. From what I'm told, the state must be supported by county leaders, providers, and the community for it to be convinced, and then a feasible plan must be offered. If we don't take action then my understanding is that Geographic Managed Care will begin in this county and applications will be accepted by the state for any plan that is interested in participating.

### **Mathew Abraham – Self-introduction and Saint Agnes Medical Center update**

I came here in January from Antelope Valley Healthcare System, which is in Lancaster. The hospital I came from is almost identical to Saint Agnes, 358 beds and an emergency room that's always busy. We used to see about 108,000 visits a year compared to Saint Agnes, which is about 58,000. We used to deliver about 5,000 babies a year. Saint Agnes does about 2,600 or 2,700. We had a budget of about \$200 million. Saint Agnes has a budget of \$360 million. So in many ways it's a similar facility to what I came from.

#### ***Saint Agnes Medical Center is a leader in California in many ways***

In my 22 years of healthcare experience in California I've always heard great things about the Saint Agnes Hospital and about Fresno. It is the leading hospital in many ways. It's also the only faith-based hospital in the area. The Sisters of the Holy Cross who started the hospital started with a vision and a mission and to this day the hospital lives up to that. Five years ago Saint Agnes became part of Trinity Health. Trinity Health was formed as a merger between Holy Cross and Sisters of Mercy. It's based in Novi, Michigan. They've got 42 hospitals in the system. It's the third largest Catholic healthcare system in the country with \$6 billion in revenue, 40,000-plus employees, and something like 20,000 doctors associated with the hospital system. Trinity is a fabulous organization. With its clout of 42 hospitals and the number of beds that we have we can do better in terms of purchasing, designing and building facilities, hiring doctors, implementing new and emerging technologies, and hiring the best people that we can afford.

#### ***Saint Agnes has state-of-the-art technology making it one of the most advanced hospitals in the nation***

Five years ago the hospital started this new building program. It is indeed an impressive facility. It takes five or six years to build a hospital in California from the day that you submit your plans to OSHPD, or Office of Statewide Health Planning and Development. The cost today in California to build a hospital is a million dollars a bed. The most expensive building cost in the country is for hospital care for a variety of reasons. Five years ago they started this project. It's about \$143 million. We doubled the size of the hospital in terms of square footage, expanded the cardiology services, and doubled the size of the emergency room, which has drastically cut down on the wait time. We're now down to less than two hours wait on any busy day. It used to be up to five or six hours. The cardiac facility is second to none. Today doctors can watch a surgery being done in the surgical suite in one of our conference rooms. We can also transmit that surgical procedure digitally to any place in the world, so if you have an expert in cardiology in Boston, they can literally watch that procedure being done at Saint Agnes. That's truly an impressive advance in technology, and we have it here. In addition to cardiology and doubling the size of the emergency room, we also doubled the size of the x-ray and imaging department,

state-of-the-art digital x-ray facilities. Again, like cardiology, we can beam any x-ray image to any doctor, any hospital, anybody anywhere in the world through the computer. These are advances that have not been seen in very many other places, so Fresno is truly on the map, and we're proud to be part of that. In addition to all that, we have an expanded outpatient center with better seating, more seating, more spaces, and it's easier in terms of admitting and registration. Lastly, on the sixth floor we have shelled space for an additional hundred beds if we ever have to expand again, so hopefully the costs that we incurred today will be far less than the cost in five or six years when we may have to expand again. So we're poised for growth, we're poised for providing comprehensive and quality healthcare to all of Fresno and the Central Valley, and I'm really glad to be here and be part of that.

**Participant question:** The ability to record the x-rays or the surgeries and send them anywhere, what will that be used for?

**Mathew Abraham:** It will be used for any medical expert that we may not have in Fresno. Let's say you may have a patient who is visiting here from New York. Their personal doctor may be in New York. It's easy for that physician sitting in New York to watch the image of the patient that's here in Fresno. It really provides the continuity of care between your personal doctor who may be miles away and a patient who may be hospitalized in Fresno.

**Participant question:** At one time Saint Agnes refused to accept Medi-Cal anymore. Do you have any plans to change that and make it accessible to people who have Medi-Cal.

**Mathew Abraham:** I'm not sure what happened in the past, but today we do have a Medi-Cal contract. As a matter of fact, right now we're involved in the negotiation of the new contract for next year.

### **Daniela Simunovic – Pollution 101 Power Point**

#### ***Traffic, industry, urban sprawl, and the inversion layer all contribute to air pollution in the Central Valley***

Good morning, everybody. The presentation that I'm going to give to you right now is a basic, simple review of what the problem is that we're facing here in the valley. Why is our air so bad? Right smack in the middle of our great state is our even greater valley, the Central Valley. We're surrounded by mountains on both sides. We have two very important things that dissect our valley, which are I5 and Highway 99. These are huge factors in our air pollution problem. We see thousands and thousands of cars and trucks running through our valley on a daily basis. Most of the trucks are grossly polluting with their diesel engines, and the majority of them don't even stop in our valley. Other thing that we have in the valley that is contributing to contamination is industry. In the south valley we have the oil industry. The other industry that we have that, unfortunately, contaminates a lot is agriculture. Until about last year with the state legislation that was passed, agriculture had been exempt from the Clean Air Act, so they were getting away with various types of pollution that they were contributing such as ag burns in the fall, the machinery that they use, the irrigation pumps that run on diesel engines, pesticides, and now we're even finding the issue of mega-dairies. Dairy cows are contributing more to this

problem than cars. We have 2.5 million cows that live in the Central Valley. Each cow poops about 100 pounds a day, and we're finding that the gasses that are being emitted from these dairies are a significant amount of our pollution. The other thing that we have a lot of in this valley is cities. We have the huge cities of Fresno, Modesto, and Stockton, and if we've lived here long enough we know that we're growing at an exorbitant rate. The valley's population is expected to double within the next twenty years. Are we growing up or are we growing out? We're growing out. We have this horrible phenomenon of urban sprawl that's occurring here in our valley. When things are farther away you have to drive half an hour to an hour to get anywhere in the city, as opposed to cities like San Francisco, which grow up and have parks and spaces for walking and mass transit. On top of all the other issues that we've talked about we have a phenomenon here in the valley called the inversion layer. The inversion layer in simple terms is a layer of cold air that sits on top of our valley blocking the hot air from rising. It functions as a lid on the valley keeping in all the contaminants. All of these factors together give us all this pollution that on most days is so bad we can't even see the mountains.

***Ozone forms when heat and sunlight combine with pollutants in the air***

What are the major pollutants that make our air unhealthy? The first one is ozone and the second one is particulate matter. Most people know ozone as smog. When we talk about ozone it's really important that we don't confuse it with the ozone layer. Ozone is a great thing when it's way up high in the stratosphere far away from here. The ozone layer up there protects us from the sun's rays that can cause skin cancer. When ozone starts to form down here at the ground level it becomes damaging to our health. Ozone forms with sunlight and heat. Our valley is an oven that has the special ingredients ready to cook up some ozone. What exactly are the ingredients? Chemicals from cars, power plants, trucks, ag engines and all other engines, pesticides, paints, lawn mowers, and spray cans. When these chemicals combine with our heat and sunlight, ozone starts to form. Dairy cows emit VOCs, or volatile organic compounds. These compounds themselves aren't dangerous to our health, but when they put them into this equation with the heat and the sunlight we start getting ozone, and so that's why dairy cows are such a big problem. One lawn mower running for one hour pollutes as much as 40 running cars. If you have the means, buy an electric lawn mower. It's an easy way to help contribute to the solution. When we start breathing in ozone it starts to produce something like a sunburn in our lungs. Studies that have been done in Los Angeles on active youth that are participating in sports have shown diminished lung capacity in kids who participated in two or more athletics in places with extreme levels of ozone. We're seeing it here in our valley with our kids. One in six kids in Fresno County has asthma. For the whole valley it's one in three kids. One phenomenon that we're seeing now in the valley is that asthma in the adult population is growing. That's something that is very specific to the valley. There are more than enough studies to prove that ozone exposure can produce asthma attacks and aggravate those symptoms.

***Diesel particulate matter is very dangerous to our health, and children who ride school buses are being exposed to it at dangerous levels every day***

The second pollutant that I'm going to talk about is particulate matter. Particulate matter is a technical way of saying tiny particles of dust, soot, chemicals, and tiny particles from engine exhaust. Particulate matter comes from diesel engines, trucks, buses, trains, fires, oil refineries,

cars, farming, and dairies. All these little particles are floating in the air and they're so, so small that normally you can't see them. One piece of particulate matter can be 10 to 100 times smaller than the width of a human hair. Particulate matter is measured in microns, PM 10 and PM 2.5. The smaller that particulate matter gets, the more threat it poses to our health. Different types of particulate matter can be more hazardous to our health. In particular, diesel particulate is extremely dangerous for us. We're being exposed to dangerous levels of this in terms of our public health. In 1999 eighteen premature deaths were estimated in that year due to diesel exposure asthma attacks. Our kids are being exposed to four times the amount of diesel pollution by sitting on the bus than if they were sitting outside by the engine or riding in a car next to it. Here in the valley we have some of the dirtiest polluting buses. The buses manufactured before 1977 and 1987 are the dirtiest buses because they were produced when there were fewer regulations on the engines and the types of safety standards, so unfortunately, I think we're second only to L.A. in the number of dirty buses we have. We are getting \$25 million to help clean our buses here in the valley. Half of that is going to go to buying new buses and the other half is going to go to retrofitting the old ones.

***Particulate matter is so small that it penetrates our natural defenses and gets into our bloodstream causing health problems such as respiratory problems and heart attack***

Ozone is more of a problem when it's hot, in the spring and summertime, whereas particulate matter by its nature is something that we have to be more concerned with in the fall and winter. Particulate matter comes from burning fireplaces, agriculture harvesting, and also the weather. Cold weather with the moisture in it promotes the production of particulate matter, and the inversion layer also functions as a way to help strengthen particulate matter's effect on us. When we take in a deep breath, all of these tiny particles are coming into our lungs and they're getting to the deepest part of our lungs and they're just sitting there and growing and harvesting and causing damage to our lungs. Studies now are coming out to show that this isn't just causing respiratory problems, but because PM 2.5 is so small, it's penetrating all of our body's natural immune defenses. What they're seeing now is the 2.5 is so tiny that it's actually passing through into our blood vessels, and as we all know, blood flow goes to the heart. They're showing direct links of particulate matter to heart disease and increased incidences of heart attacks due to particulate matter exposure. They estimate that 1,300 people die prematurely in the San Joaquin Valley due to particulate matter.

***We all need to be aware, protect ourselves, and try to pollute less***

So what can we do? There are various things. Protect yourself, try to pollute less, and take action. How do we protect ourselves? The air quality index tells you what segment of the population will be affected on certain days, when air quality will damage you the most. We like to point out to people that when the index is orange it says that the air is unhealthy only for sensitive groups of people, but most of us are probably going to fall into the category of sensitive groups. A sensitive person for the air quality index is somebody who is over the age of 50, under the age of 18, or if you're an active adult between the ages of 18 and 50, so I don't know anybody here that doesn't fall into that category. Another way that we can protect ourselves is by polluting less. If you're coming to the healthcare roundtable next month and you know five people that are coming, get a car pool together. Car pool to work. Ride your bike or walk,

which I know is hard here in Fresno, especially with the heat, but try to diminish the use of your car. Keep your car well maintained. Keep up with your smog checks. Use an electric lawn mower. Take the bus. When you barbecue try not to use charcoal or lighter fluid. Don't use your fireplace in the winter. There is actually money coming through the air district next year to help people who like to use their fireplace to convert to natural gas. Those are things that you can be aware of.

***We need to take action at the air district and in Sacramento to fight air pollution***

Lastly, take action. Teach others what you've learned today. Educate people and tell them stories. Talk about how this affects us. Take action at the air district, which is the governing board. Unfortunately, the agriculture and oil industries are huge players at the air district and have been guiding the decisions made there for a really long time. One of the things at Metro that we pride ourselves on is being a present voice for the community and for the people for public health at the air district. Public health is always the last issue raised when they're considering any rule or regulation, so we try to get people to these meetings. The governing board meets every third Thursday of the month, so be there. Today the dairy industry is going to ask the governing board to make the air district change the emission factor because they want a lower factor, and the science supports a much higher number that is much more protective of public health. The other place I already mentioned is Sacramento. Metro has been for the past two years sponsoring Clean Air Action Day where we take bus loads of people to Sacramento to knock on legislators' doors and tell them that we want clean air. Our lobby day was crucial in getting the SB 700 series passed, which were the rules for ag under the Clean Air Act, and this year we've been pushing SB 999, which will be up on the Assembly floor next week. This bill will add public health experts, a scientist and a medical doctor, who both have experience in air qualities issues, to the governing board of the air district. In addition, it will give the cities of Stockton, Fresno, and Bakersfield permanent representatives on the board. Currently we're the biggest cities in the valley and we don't have anybody on the governing board. Susan Anderson is the rotating Fresno County supervisor who is on the board, but she is the only voice that Fresno has in these decisions. We can write letters. SB 999 is coming up for an Assembly floor vote next week, so it would really help to get pressure on our valley politicians. Our valley politicians, unfortunately, are really economically tied to industry. A lot of them, I'm finding, are really good guys, but they need that community push to make these votes. It's really hard to get their votes, unfortunately.

**Dan Lynch, Director of Emergency Medical Services Division – Challenges and Achievements**

Good morning. Today I wanted to give you an update on what's happening with Emergency Medical Services. We have one of the best systems around. However, that does delve into healthcare, and healthcare is an issue throughout our entire community. Let's take, for example, that you're riding your bike one afternoon and you're hit by a car. Your friend that is with you sees you get hit, they check you, they see that you're unconscious, you're bleeding profusely, so they run to a phone to call 9-1-1. At that point in time the 9-1-1 operator from the law enforcement agency answers the phone, they ask you what the problem is, they transfer you to the ambulance dispatch center. At that time fire department and police department are being

dispatched as first responders to the scene, the ambulance dispatch center gets the call, they get the location of the accident, the ambulance is dispatched, they stay on the phone to give you pre-arrival instructions to explain to you that you're not to move the patient, tell you how to help stop bleeding, those types of things to protect the patient. While they're talking to you everybody is already responding, so there's no delay in the system. As time progresses the fire department arrives on scene as first responders to begin stabilizing you because you're pretty hurt. The police and the ambulance arrive on scene. The police start directing traffic and they start taking reports to figure out what's going on. The paramedics begin taking over the care of you because you're unconscious and badly hurt. They put you in spinal immobilization, which is a spine board. They strap you down to a board and they quickly get you into the back of the ambulance because you're what we're going to call stat trauma. You are in very critical condition. So now they get you in the back of the ambulance and they're en route to the trauma center. There are two trauma centers in our area. One is University Medical Center, which is a level one trauma center, and then we have also Children's Hospital Central California, which is a level two pediatric trauma center. We're fortunate to have both of these in our area because University Medical Center is the only level one trauma center between Los Angeles and San Francisco. Children's Hospital Central California is the only pediatric trauma center between the Bay Area and Los Angeles. So you're placed on a gurney and you're placed in the back of the ambulance. En route to the hospital they start IVs on you to replace some blood and fluid that you've lost and they contact the trauma center to let them know you're coming in. They want to let them know that they've got stat trauma coming so they can activate their system. You arrive at University Medical Center. They bring you in, they turn you immediately over to the hospital staff, the emergency room physician takes a report, and the ambulance crew basically takes their stuff, puts it all back together, gets back in their ambulance, and goes back out to go find somebody else that's been hit on their bicycle. But in the emergency department they find that you do have some very life-threatening injuries. They activate their trauma system. The trauma team from upstairs, which is a surgical team, comes immediately downstairs to evaluate you because, again, you are very seriously injured. They evaluate you and figure you need to go directly to surgery right now. They've done a belly tap on you, you're bleeding inside, you've got some serious problems, so they get you upstairs to surgery, they open you up, they fix your liver that you've lacerated, and they also fix your severely broken leg. Once that's over they get you into ICU. The neurosurgeon and neuro staff come to evaluate you because you've got a pretty good head conk from being knocked unconscious, and so they work with you. You spend about two to three days in the ICU and you're transferred over to the floor. You spend a few days in there. All in all, you spend about eight days in the hospital. Now you start your rehabilitation, so you spend quite a bit of time in your rehab, but over the course of about 30 days you're back in the swing of things and you're back out there getting ready to ride your bike again.

***Emergency Medical Services is well planned medical care  
which starts immediately when someone dials 9-1-1***

What I have just explained to you is our system. The injury that you got was caused by an accident, but the care you were just given was not an accident. We've planned for that. This system has planned for those types of incidents, and that's the Emergency Medical Services system from the pre-hospital setting all the way into the hospital. Really, it's a very complex

healthcare system. When we talk about healthcare, a lot of folks think about hospitals. They think about what's going on in hospital care or outpatient care, but really, healthcare is beginning at the street when someone dials 9-1-1 because we have a medically trained dispatcher on the phone teaching people how to stop bleeding, how to deliver babies, and how to do CPR right over the phone, so healthcare begins from the time the person dials 9-1-1. Our goal with our entire community is that when an incident occurs it doesn't matter what color shirt they're wearing or what type of vehicle they're driving, whether fire, Emergency Medical Services, or police, the idea is that when somebody is in an accident or needs help everybody is doing one thing. The goal is to treat the patient and to give good quality care, and I think we've been extremely successful with that in our area. All of that is under the responsibility of the Emergency Medical Services Agency.

***The Emergency Medical Services system is overseen by Fresno County  
Department of Community Health***

The oversight of the Emergency Medical Services system comes from the Department of Community Health in Fresno. The EMS Agency is the overseer of Emergency Medical Services in Fresno County, and we have a number of responsibilities which are mainly statutory and also enforcement. We basically enforce the state Title 22, the rules and regulations of the state, but also our local policies and procedures. We are the ones that oversee American Ambulance and the other seven ambulance providers in the county of Fresno. We're the ones who certify paramedics and EMTs. We're the ones that will take the certification away from paramedics that decide that they don't want to provide quality care anymore. We're the ones who watch the system, and I think a lot of people don't understand that that actually exists out there. We have a very aggressive quality assurance program that oversees that to make sure that paramedics and EMTs are staying trained and continuing education is kept up. It's very, very important to us and to the community.

***The Emergency Medical Services Agency is a regional agency***

As EMS Agency for Fresno County, we're unique in the fact that we're a regional EMS Agency. Not only are we responsible for the County of Fresno, we are also responsible for the County of Kings, the County of Madera, and just recently, the County of Tulare. Many years ago back in 1987 the counties of Kings and Madera decided that they wanted to contract with Fresno to have Fresno manage and oversee their Emergency Medical Services, which was the idea of regionalization, bringing things together. They didn't want to create their own bureaucracy, so they joined with us and we basically oversee those two counties. A year ago in March, Tulare County decided to do the same thing. They decided that they wanted to join the three-county region and come aboard with us because we're pretty progressive in what we do. Tulare was an incredible challenge for us because at that time when we took over a year ago Tulare County was the only county in California that still did not have paramedics. That's incredible in this day and age. All the other counties had switched over probably 20 years ago. EMS administration in Tulare was almost nonexistent, so when the contract with Fresno County came in, we walked down there with three people, which was about 300% more than they had before. Starting last April, Tulare County began providing paramedic services. The benefit of being a regional EMS Agency is that we make things consistent from border to border. In fact, essentially we erase

borderlines between counties so we are able to implement the same policies and procedures throughout the region. We really have an excellent relationship with those providers and we really couldn't orchestrate this without getting the cooperation from the ambulance providers, fire departments, and hospitals, so it is a huge collaboration of efforts to get this thing done. It's refreshing, it's fun, it's exciting, and it really gives us something to grab onto because we're making a difference.

***Fresno County EMS has a joint communication center that all calls are routed through***

I want to talk about some of the great things that EMS system has in our area. One is what we call the Fresno County Emergency Medical Services Communication Center. Every ambulance requesting the County of Fresno goes through one communication center. When there is a request for ambulance the request comes to one communication center and they dispatch every ambulance, whether it's American Ambulance, Selma Fire Department, Sanger Fire Department, Coalinga, Kingsburg, Sequoia Safety Council, the CHP helicopter, or Skylight Helicopter. They all carry our pagers. We dispatch them. That is a huge benefit because we have immediate access to resources. We essentially erase boundary lines. If Sequoia Safety Council that covers the Reedley area is not available then we page Sanger or Selma Ambulance to go to the call. There are no questions asked. That fire department from the city gets in their ambulance and goes all the way to Hume Lake if they have to. It's a pretty powerful system, and the EMS Communication Center directs that.

***Performance agreements guarantee that providers will meet performance standards***

The other crown for our area is performance agreements. We have a performance agreement with, for example, American Ambulance that covers the Fresno/Clovis metropolitan area but extends all the way up into Shaver Lake and the Sierras all the way down into Mendota and south into Riverdale. It's called an exclusive operating agreement. They have the agreement until the end of December 2007, and it was competitively bid. The reason it was done like that was to get one provider who could perform to the expectations that the community gave them. When American Ambulance came aboard we were able to put in performance standards that must be met. I think American Ambulance does an excellent job for this community. They have to be to every call within ten minutes 95 percent of the time. If they are late by one minute on any given call they're charged \$15 for every minute they're late. If they drop below that 95<sup>th</sup> percentile we charge them \$100 for every tenth of a percentage that they drop below the 95<sup>th</sup> percentile. We could be 99 percent good, and in anybody's book 99 percent is excellent, but what that 99 percent really means is that one percent may not be happy with the system, which is about 1,200 people. If there are 1,200 very vocal people that want to complain, they could actually give the idea that the system runs poorly. But if we put it in perspective, the system runs very, very well.

***So many facets of the healthcare system are failing at the same time that it is creating "the perfect storm"***

Let me talk about some challenges. Some of the challenges here are very significant. One of the issues we're having today is hospital overcrowding. Hospital overcrowding is by far the biggest

issue that is in our community today and will stay in our community for a long, long time. Let me explain what's happening. Somebody else has coined the phrase "the perfect storm." I like the phrase, but I'm not going to take credit for making it. This healthcare issue is the perfect storm because so many facets of healthcare are failing at the same time that it's almost an unresolvable issue. It's not one problem. You can't put your finger on it. It's across the board. It's everything. Because hospital capacity hasn't really grown with the community, with incredible access of the emergency departments because people don't have primary care physicians or maybe their primary care physicians have referred them because they're busy, there are a myriad of issues, but people end up at the emergency department. The emergency department gets a huge number of people and the hospital admits a lot of people, so they basically fill up their hoops. It's July and August and the hospitals are all full right now, so the capacity to keep admitting patients is not there. When it's full they start keeping them in the emergency department, so a 36-bed emergency department that normally sees waiting room patients and ambulance patients with all 36 of their beds is now decreasing capacity because now they start admitting patients to the hospital. They don't have a bed upstairs so they leave patients in the emergency room until a bed becomes available. There are people that come into the hospital that are admitted to the hospital and are discharged and have never left the emergency department and they've spent two or three days there. It happens all the time. The other problem that's it's causing is that it backs everything up in the waiting room. Now you get not just two-hour waits. You're getting 10-hour waits, 12-hour waits, and some people are waiting 18 hours to get to see a doctor in the emergency department. Ambulances are showing up with patients and standing with patients on their gurneys and waiting two hours to get patients from their gurney to somewhere else. In some instances they're actually continuing to treat their patients on the gurney while standing in the emergency department. I could sit here and talk about the horror stories of this thing because it is an incredible issue. We have rural communities that transport patients down like the Sierra Ambulance in Oakhurst. Their ambulance stands around in a hospital for two to three hours trying to turn a patient over and there is no coverage back in their communities, so now they've got to hire people to cover their communities, so the cost is even higher. It's a huge domino effect. The community has no idea that we have a crisis of this level right now, and that's why it's the perfect storm. It's a dirty little secret. Jim Boren put out a very good article last Sunday in the newspaper about this situation and UMC's problem with overcrowding at this time. I thought it was a very good outline of the situation. It's not a local problem anymore. This is a statewide issue. It's happening everywhere. I bring this up because this is what plagues our system now, and when we talk about technologies of hospitals, technology is only good as long as you have access to it, and right now we don't. We need to get the community talking. We need to get our legislative folks involved. This is not a winning deal for them. A politician doesn't want to step in the middle of this because it doesn't have a solution. They're not going to win on this one, so nobody is touching it. We need folks like us to push this issue, and we also need to look as a community to find out what we're going to do in the short run because we have some problems coming.

**Laurie Primavera:** How do we actually get our emergency rooms in our area to cooperate given the payer source factor?

**Dan Lynch:** This is happening at UMC, Fresno Community, Saint Agnes, and Kaiser. They all have the same problem, so it seems like we have a common issue. We need to bring those administrations together and start talking about what we can do as a local group, and we have done that with Tim Curley and the Hospital Association's work over the last three years. We've brought hospitals in to talk about the problem. The issue is that the problem is so large, but this year, I think, is going to be different from the others in the fact that the issue has been compounded more this year in what we're seeing now. I think there's an education piece for the community to know what's happening so that maybe we can reduce some of the impact on emergency departments but also find other creative ways to start dealing with healthcare.

**Participant question:** What are the plans for surge capacity?

**Dan Lynch:** Several years ago during Thanksgiving when we had the I5 dust storm and we had a terrific accident out on the west side of Fresno with over 100 victims and 17 dead, the hospitals took it in stride. Most of the hospitals didn't even have to go to a disaster type capacity issue because we had capacity to deal with such an incident. Today I worry about when my pager goes off and we find out that there's a multi-casualty accident with five patients. We don't have the capacity to deal with five major trauma patients today. We don't have the best answer in the world because we have to depend on hospitals to help us solve the problem of surge capacity. If we have an incident occur like an epidemic or something like that, which we know is going to overwhelm the system, we've got to figure out what to do with people. Right now in the Department of Community Health we're creating casualty trailers that can deal with 125 patients under tents. We can build a tent city to deal with housing folks or utilize other areas like the convention center. Someone is going to say, "Great, so you can house them. Where are you going to get the staff to take care of them?" We don't have the staff. This is a work in progress. We don't have an answer for surge capacity. This is a problem that plagues every community right now because capacity is just not there.

**Ray Ensher:** The solution to this is passing SB 840, universal healthcare, and then you wouldn't have all these parents bringing their kids into emergency rooms and we'd have preventative care. Why aren't some of the HMOs and these people being entrepreneurs and establishing facilities of emergency wards, in other words, an attach to a hospital? It would seem to me this is very profitable. If everybody is going to emergency rooms, have a separate building for emergency people and then they can send them out to whatever hospital they need to go to.

**Dan Lynch:** I agree. I think there has to be a legislative solution to this. The problem has gotten too large. We don't have a lot of specialty services anymore in our area simply because the pay is not there for them or it doesn't pay them to do on call for hospitals or the liability to be that type of a doctor in California just isn't worth it so they've moved or don't do the service any more. Like I said, there are so many fingers to the problem, and that's one of them.

**Gloria Grijalva:** I don't want to add to your burdens, but a couple of years ago I did an observation. I was coming from Kerman and I had my comadre with me and we witnessed an accident with a bunch of farm workers. The CHP got there and then the ambulance showed up and I admired the efficiency. I ended up translating, but one of the things that really saddened me was the attitude of some of the ambulance workers towards the farm workers who had been

involved in the accident. I felt there was a lack of cultural competency and understanding that these people are human beings. The language barrier is also a problem.

**Dan Lynch:** You're absolutely right. That is one of the biggest hurdles for most pre-hospital care. There are interpreter services available to us that we use. Unfortunately, it's not available right there on the highway. We do have cultural training for all of our agencies to touch on all the cultures. If there are some incidents that occur then it's probably more of an individual issue than it is an agency issue because I think most of the folks out there are very compassionate. You've got to be a different sort of person to get into this business.

**Participant question:** Is there a committee or some type of organization that's set up for all the emergency room directors to discuss distributing patients and how that system works?

**Dan Lynch:** Not unless the Hospital Council is doing something I'm not aware of one. Each year we try to get the hospitals all into one room and we do that several times each year to talk about current issues and problems, but it's not the most productive group. Nothing really comes out of that. We eliminated diversion two years ago simply because we found that we were just rotating patients around. It really wasn't changing the number of patients everybody got and it was not really solving the problem.

**Laurie Primavera:** Is there a first step that could happen? Where do we start?

**Dan Lynch:** Jim Boren has a powerful voice when he puts it in the Fresno Bee, and it's in the Fresno Bee. If people want to read it, it's there, but nobody is picking up the problem. If we want to create an issue of it and make it a problem to where maybe this is one of the issues that Dean Flores wants to come and deal with, which nobody is touching this, then it's got to be something where we create the crisis. Unfortunately, the only time something is fixed is when a legislator's loved one dies because of a situation. We don't want that to happen, but it's going to happen because other people are already dead because of the situation. Nobody wants to pick up the gauntlet. We've got to raise it.

**Tim Curley:** I work for a group called the Hospital Council and we work with about 200 hospitals and health systems from Kern and San Luis Obispo counties north to the Oregon border. We work primarily with Hospital CEOs, but depending on the issue we get into the emergency department and work with our emergency department managers or work with our nurse executives or chief financial officers. I'm based in our Fresno office and work primarily with our hospitals in the Central Valley. They are as much aware if not more aware of a lot of the problems that Dan mentioned. They live it and see it every day. We have had a good partnership with EMS and we're going to continue to have a good partnership with EMS. We do need to have a conversation around capacity. We've talked about it previously. They are difficult issues to find solutions to. There just isn't an easy answer. Notwithstanding that, we are committed to working with these issues. We're committed to finding a solution, to finding an answer. We're very open to suggestions and ideas. Right now we don't have the answers, but we're going work with all of you to find them.