HEALTH CARE ADVISORY BOARD

Meeting Summary
January 11, 2010

MEMBERS PRESENT
Marlene Blum, Chairman
Bill Finerfrock, Vice Chairman
Rose Chu, Vice Chairman
Dave West
Francine Jupiter
John Clark
Rosanne Rodilosso
Susan Conrad
J. Martin Lebowitz, MD
Timothy Yarboro, MD
Ellyn Crawford

STAFF
Sherryn Craig

GUESTS
Dr. Gloria Addo-Ayensu, Health Department
Rosalyn Foroobar, Health Department
Deputy Chief Christine Louder, Fire & Rescue, Emergency Medical Services (EMS) Division
Jennifer Siciliano, Inova Health System

The meeting was called to order by Marlene Blum at 7:49 p.m.

Approval of the Minutes

The minutes from the December 14, 2009 HCAB meeting were accepted as submitted.

JoAnne M. Jorgenson

A moment of silence was held to remember JoAnne M. Jorgenson who died on Saturday, January 9, 2010.

EMS Presentation on Quality Measures

Deputy Chief Louder presented data on EMS quality and clinical measures for the third quarter of 2009 (July-August). EMS tracks pre-hospital care for Acute Coronary Syndrome (ACS) ST Segment Elevated Myocardial Infarction (STEMI) patients. EMS responded to 13,414 ACS/STEMI incidents during the third quarter. A 12-Lead EKG was conducted on 2,454 patients. ST segment changes were reported for 46 individuals presenting with ACS (i.e. a primary impression of chest pain/discomfort or cardiac rhythm disturbances) and 17 individuals with symptoms other than ACS. In total, ST changes were noted for 63 patients during the third quarter. Patients exhibiting ST elevation must be transported to a Primary Percutaneous Coronary Intervention (PCI) hospital. Chief Louder reported that Fairfax, Alexandria, Arlington,

and Reston are the four main receiving sites. However, Loudoun Hospital has also recently been certified as a PCI/STEMI Receiving Center.

Chief Louder emphasized the importance of providing timely, critical care for STEMI patients. The recommended timeframe from transport to catheterization is 90 minutes. Ideally, a patient should be transported within 30 minutes of the Advanced Life Support (ALS) Unit's on-scene arrival, but Chief Louder acknowledged traffic congestion and patient/family refusals make compliance a challenge.

55 patients were successfully transported within the recommended timeframe; eight were not (an increase of two patients from prior quarter). EMS will continue its efforts to reduce on-scene response times.

In answer to a question regarding what type of incidents EMS responds to, Chief Louder stated that motor vehicle accidents drive the highest call volume.

Chief Louder described the operational challenges inherent in communicating 12-Lead results. Patient EKGs can be transmitted during transport to the hospital, but according to Chief Louder, Inova has been unable or unwilling to designate a physician in the ER or Cardiovascular Center to receive the report. Currently, EMS will provide a print out of the patient's 12-Lead, which hospital staff will then scan into his/her medical record.

There was some discussion over the advantages of submitting 12-Leads. On the one hand, STEMI patients could bypass the ER; on the other, a more serious medical condition could be overlooked. Chief Louder maintained that the standard of pre-hospital care would remain the same regardless of whether Inova received the EKGs prior to arrival. Once a patient arrives at the hospital, EMS personnel print out the 12-Lead, which hospital staff then scans into the patient's record.

The need to enter each patient's personal medical history into an electronic patient record (EPR) further compounds response times. The County's HIPAA Compliance Manager requires all EMS to delete patient records at the conclusion of each transport. Because paramedics' tablets are vulnerable to being lost, misplaced, or stolen, data cannot be saved. Bill Finerfrock asked if this standard was common practice. Chief Louder said that to her knowledge, paramedics in Arlington and the City of Alexandria must also reenter patient information.

There was some concern among HCAB members that a narrow interpretation of HIPAA and oversensitivity to privacy concerns may impede providers' ability to provide care, especially for patients with a prior history of ACS/STEMI. Susan Conrad also stated that the inability of these systems to interface was a result of implementing different protocols.

Chief Louder returned to the 63 ACS/STEMI patients, of whom 98% received oxygen, 62% aspirin, 56% nitroglycerin, and 19% morphine. Prior medical histories were assessed for 98.4% of these patients. In response to whether these outcomes are converted into ICD-9 and ICD-10 codes, Chief Louder stated that the ER and EMS billing collect this information from the electronic patient record.

Dr. Yarboro asked if EMS had access to ACS/STEMI data post hospital admission. Chief Louder stated that the Northern Virginia EMS Council presents outcome data for all patients that the county transports. Dr. Yarboro asked if the information was disaggregated by race and sex, given the differences in cardiac care and treatment for minorities and women. Chief Louder said that it is not. Dr. Yarboro stressed that this data should be collected as part of ACS/STEMI outcome measures.

Chief Louder concluded by presenting data on advanced airways and vascular access. When asked to describe the King LT Airway, Chief Louder said that this device had been widely used among paramedics in the Iraq and Afghanistan Wars. The King LT Airway uses a balloon inflation design, allowing for the blind insertion of the device into a patient's airway. She said the device is unique because of its ease of use and its potential as a backup for a difficult or failed endotracheal intubation (ETI). During the third quarter, EMS attempted to insert an advanced airway in 86 patients. ETI was chosen as the first method to secure the airway in 59 patients; the King LT was chosen as the first method in 27 patients. King LTs were used subsequent to failed intubation attempts in 16 patients. EMS successfully intubated 63% of these patients.

Dr. Lebowitz endorsed the use of new and improved technologies, but cautioned that skill levels be maintained for ETI.

Chief Louder also reported on the two modalities used for vascular access—intravenous (IV) and intraosseous (IO). The insertion site for an IV is the vein. The insertion site for an IO is the bone. During the third quarter, EMS initiated IO access in 34 patients. IO infusions were used as the initial method for securing access in 22 patients with 3 IVs being placed as a secondary access site. IO access was used in 12 patients after an IV attempt.

Mr. Finerfrock asked Chief Louder what three things would make the biggest improvement in survivability or quality among the people EMS serves. Chief Louder responded that EMS was looking into doing a time study at the ER so that it could improve its efficiency and increase its productivity. She mentioned the purchase of power cots which reduce injuries, but are prohibitively expensive. Finally, the FY11 budget may recommend the elimination of four transport units, which could reverse the agency's gains in reducing overall response times.

Dr. Yarboro asked Chief Louder to comment on the agency's use of air support. Chief Louder briefly described the agency's change in protocols, which only allows for air transport when a patient is experiencing a physiological change. Fairfax used to Medevac 15-20 patients a month. Since changing its protocols, this number has dropped to 8-10 patients a month. The National Transportation Safety Board (NTSB) is considering Fairfax's protocols for a national model.

Follow Up on Federally Qualified Health Centers (FQHC)

Rosalyn Foroobar clarified the status of the Medically Underserved Populations (MUP) and the Federally Qualified Health Center (FQHC) projects currently being explored as part of the Beeman Commission recommendations.

MUPs are areas or populations designated by the Health Resources and Services Administration (HRSA) as having too few primary care providers, high infant mortality, high poverty, and/or a high elderly population. Ms. Foroobar reported that Fairfax County, in collaboration with Alexandria and parts of Arlington, first applied for an MUP designation in 2003. The County's request was denied. Since that time, the County has contracted with a private consultant to secure a Governor's MUP designation.

An MUP designation is key to obtaining eligibility for an FQHC and accessing Federal Community Health Center Grants. The goal of an FQHC, or FQHC Look Alike, is to maintain, expand and improve availability and accessibility of essential primary and preventative health care services and enabling services.

Strategy 7.2 in the Beeman Commission Report recommended that the County explore modification of the Affordable Health Care System to an FQHC Look Alike to interface between primary and mental health care. The Commission and its organizing staff suggested establishing a group to explore strategy implementation. The HCAB was identified as the convener of this group. Ms. Foroobar reported that no progress had been made on implementing this recommendation.

It was Ms. Foroobar's suggestion that the HCAB establish an ad hoc committee with the purpose of:

- Benchmarking and reviewing the FQHC/FQHC Look Alike (e.g. Arlandria);
- Examining pros and cons of an FQHC/FQHC Look Alike and evaluating its affect on access, operations, quality, population, funding, and oversight;
- Assessing the impact on current and future access to primary care;
- Considering options that maintain or improve access, quality and scope of services currently available in Fairfax County; and
- Making a recommendation on an FQHC/FQHC Look Alike.

Marlene Blum reviewed the HCAB's bylaws governing the formation of standing and ad hoc committees: "The HCAB maintains committees as needed. Generally, committees consist of two to three HCAB members and may include interested citizens and service providers. Committees may be ad hoc or standing, depending on their function and need." It was recommended that an ad hoc committee be convened in May 2010, allowing the HCAB and the Health Department to devote March and April to the County's FY11 budget.

Dr. Lebowitz commended the County's Affordable Health Care System and asked what the value added would be in pursuing an FQHC designation. Bill Finerfrock replied that FQHCs are organized as nonprofits, governed by a Board of Directors, and funded with federal dollars. In exchange, FQHCs must provide primary, mental health and dental care to low income individuals who do not have health insurance; FQHCs cannot deny care or treatment. The distinctions between an FQHC or FQHC Look Alike and the County's Affordable Health Care System are the funding source and the scope of services provided. In other words, the county's taxpayers support the Affordable Health Care System while in other communities, that support is provided by the federal government. Moreover, an FQHC would allow a jurisdiction to provide

additional services to more people (i.e. mental health and dental care). Mr. Finerfrock explained that an FQHC Look Alike maintained the same organizational and service delivery criteria, but instead of Community Health Center Grants, the facility would receive specialized Medicare and Medicaid payments. The immediate benefit of qualifying for an FQHC Look-Unlike was unclear. However, Mr. Finerfrock mentioned that the County could pursue a Look Alike designation and then transition to a full FQHC.

Ms. Blum explained that the Community Services Board (CSB) may not be as interested in the funding distinction as it is in the scope of services. CSB clients who receive Medicaid for their mental health treatment do not have access to primary health care as the Affordable Health Care System only serves individuals who have no source of health insurance—private or public.

Given the provider shortage, Ellyn Crawford asked if the County could qualify as a National Health Service Corp site. Mr. Finerfrock stated that NHSC eligibility would be dependent on the MUP designation. However, even after a facility is designated, there is no guarantee that it would qualify for the NHSC, as there is a separate prioritization process which must be completed. Mr. Finerfrock speculated that the county would receive a low ranking in that process, making it difficult to secure an NHSC obligee.

Ms. Blum also suggested that the HCAB start thinking about the future of the Affordable Health Care System in light of national health care reform. Specifically, what will happen to the population that is currently being served and will the county need to make a policy change to serve people who have insurance but no health care provider?

Mr. Finerfrock volunteered to contact an individual to assess the county's likelihood of qualifying for an MUP designation.

The HCAB deferred a decision on convening an ad hoc committee until its February 8 meeting when Mr. Finerfrock will report out his findings. Ms. Foroobar will also talk with George Braunstein, Executive Director of the Fairfax-Falls Church CSB, to assess his understanding of the MUP as well as his timeframe for implementing the Beeman Commission recommendations.

Other Business

Sherryn Craig will survey members' meeting availability in March to begin work on reviewing the County Executive's FY 11 Fiscal Plan. Bill Finerfrock agreed to serve as the budget chair, and while historically the HCAB has used three meetings to conduct its work on the budget, if the HCAB can accomplish its review with fewer meetings, it will do so.

There being no further business, the meeting adjourned at 9:50 pm.