COUNCIL OF THE CITY OF PHILADELPHIA

COMMITTEE ON PUBLIC HEALTH AND HUMAN SERVICES

- - -

Room 400, City Hall
Philadelphia, Pennsylvania
Tuesday, February 2, 2010
10:25 a.m.

- - -

PRESENT:
COUNCILWOMAN MARIAN B. TASCO, CHAIR
COUNCILWOMAN JANNIE BLACKWELL
COUNCILMAN CURTIS JONES, JR.
COUNCILMAN JAMES F. KENNEY
COUNCILWOMAN MARIA QUINONES-SANCHEZ
COUNCILWOMAN BLONDELL REYNOLDS BROWN

RESOLUTION 090915 - Resolution authorizing the Public Health and Human Services Committee to hold hearings on emergency room procedures, and to investigate whether emergency room protocols were followed at the Aria Health care facility on November 28, 2009 in the incident involving Joaquin Rivera.

- - -

COUNCILWOMAN TASCO: Good morning. I'd like to call the Committee on Public Health and Human Services to order and note that we have Councilwoman Maria Quinones-Sanchez, Councilwoman Blondell Reynolds Brown and myself at the table. Other members will join. This is a hearing on an issue. It's not a bill, so we can start without a quorum.

I will also recognize the presence of Councilwoman Jannie Blackwell and Councilman Curtis Jones.

The Clerk will please read the resolution.

THE CLERK: Resolution 090915, authorizing the Public Health and Human Services Committee to hold hearings on emergency room procedures, and to investigate whether emergency room protocols were followed at the Aria Health care facility on November 28, 2009 in the incident involving Joaquin Rivera.

COUNCILWOMAN TASCO: Thank you very much.

2/2/10 - PUBLIC HEALTH - RES. 090915

The Chair recognizes Councilwoman Maria Quinones-Sanchez.

COUNCILWOMAN SANCHEZ: Thank you, Madam Chair.

I want to thank Councilwoman Blondell Reynolds for leading the sponsorship of this resolution.

We are here this morning -- and all that we do here this morning will not bring Joaquin Rivera back, but we are here this morning to attempt to use this opportunity as both my colleagues as educators here would say, as a teaching moment, in what patients and residents should expect around emergency care.

I'd like to go on the record that Aria Hospital, Frankford Division is in my councilmanic district, and since my election in January of 2008, I have worked with them and the Administration. Former Deputy Mayor Andy Altman and Deputy Mayor Schwarz have visited the campus, because I, like many others, are concerned about the closure of small

healthcare facilities in our neighborhoods. And I want to say that I am here as the Councilwoman, understanding that this institution is an important institution in the 7th Councilmanic District. It is an important employer in the District. And so we are not here in any way, shape or form to hurt Aria Hospital, but to use this as an opportunity to see what we can do to improve access to healthcare for everyone. So I wanted to go on the record on that.

Joaquin Rivera was an incredible human being. We have a saying in Spanish, un ama a dios (ph), because he would give you his shirt off his back. He worked tirelessly for 40 years serving at Olney, serving in the community. There is not one signal -- one single event in the Latino community that Joaquin has not been part of. He is one of the reasons why I'm here today serving on City Council.

So this is very personal to me. And these hearings will not bring Joaquin back, but will serve as part of his legacy, because Joaquin would have wanted us to use this opportunity to educate others so that this does not happen to another human being.

So I want to thank all of the folks involved, Blondell Reynolds' office for coordinating the hearings and obviously the Chair for hosting these, and hope that today all of us would leave better informed about what we should expect at hospitals and all of us become advocates to ensure that this national debate, healthcare and healthcare access, this national debate -- it is a national problem -- that we become better advocates to ensure resources and support for those institutions so vital in our communities.

Thank you, Madam Chair.

COUNCILWOMAN TASCO: Thank you.

The Chair recognizes the

presence of Councilman James Kenney.

The Chair now recognizes Councilwoman Blondell Reynolds Brown.

COUNCILWOMAN BROWN: Thank you, Madam Chair.

Good morning. As a member of this Committee and as a co-sponsor of this bill, the beauty of public hearings is that they give all of us a chance to have our say. The beauty of public hearings is that they give all of us a chance, irrespective of position or perspective, they give us all a chance to have our say.

So I am here this morning to listen and learn. We want to hear what happened to Joaquin Rivera on November 28th, 2009 at the Aria Health Center. We fully understand that the Pennsylvania State Department of Health has completed their investigation and will be here to offer a brief summary of their findings.

In this hearing, as in most of the work that we do, I am always deeply

interested in what are the best practices. When you stack this hospital against all of those around the country, what are the best practices. So in the title of this resolution, we wanted to investigate and hear and learn what are the best practices in emergency room procedures and situations.

We're hopeful that having listened to many who have desired to offer testimony that this will move us to a place where we may offer recommendations to the Pennsylvania State Department of Health, because ultimately we also, members of this legislative body, can only have a say in the process. It is our understanding that it is the state who has the ultimate authority to authorize, dictate, demand or expect what changes there should be.

We want again to thank you all for the testimony. I do want to salute and say thank you to Katherine Gilmore, my legislative aide, for being as

thoughtful and inclusive as possible in honoring any and everyone's request who called our office with an interest to participate. Thank you for your attendance.

Madam Chair.

COUNCILWOMAN TASCO: Thank you very much.

The Chair recognizes Panel 1, beginning with Thomas R. Kline, Esquire, to come forth and present his testimony. We will next have Stacey Mitchell, Deputy Secretary for Quality Assurance, Department of Health, State of Pennsylvania. Thank you very much.

(Witness approached witness table.)

COUNCILWOMAN TASCO: Good morning.

MR. KLINE: Good morning, Councilwoman Tasco. Good morning, other Councilmembers.

Every year --

COUNCILWOMAN TASCO: Would you

state your name for the record, please.

MR. KLINE: I sure would. I'm used to doing that actually, but not in City Council.

My name is Thomas R. Kline and I represent the Rivera family. I'm their legal counsel.

Councilmembers, every year in the United States, according to a study by the Institute of Medicine, medical errors cost the lives of approximately 100,000 Americans. Medication errors alone cause 7,000 deaths a year. Hospital-acquired infections cause 90,000 deaths a year. Many of these errors unfortunately occur in emergency rooms.

The sad truth is that most of the catastrophically injured and the dead disappear into a quiet world of agony and grief. I have witnessed this time and time and time again. I've represented many of those families for more than 30 years, from the poorest and most disadvantaged to the families of the very

prominent, including many physicians and other healthcare providers who have actually sued their own colleagues when mistakes have had devastating consequences.

I come before this Committee today as the legal representative of the surviving spouse, Maria Rivera, and adult children Brenda, Inez and Cito. They are the family of one victim of medical negligence, Joaquin Rivera, whose very public death, it is acknowledged by the Department of Health of the Commonwealth of Pennsylvania and the Aria Health System itself, could and should have been avoided had the healthcare providers and the facility at Aria-Frankford provided him the proper emergency diagnosis and treatment.

While this legislative body has no direct regulatory authority over the practice of medicine, it has enormous power of persuasion, as evidenced by the community interest here today and, I

might add, the impressive group of presenters here today before this Council, all of whom are in positions of responsibility and authority and who can assure us that the neglect and the indignity which befell Joaquin Rivera will not happen again in any Philadelphia area hospital.

To assist this effort, and in connection with my responsibility to the Rivera family, my law firm, in consultation with a panel of outside independent medical experts, as well as in collaboration with three of our six physician/attorneys at Kline & Specter led by Mark Hoffman, a prominent surgeon/lawyer, as well as two experienced emergency room physician/lawyers at our firm, have prepared a report to this Council addressing the topic of this resolution, to wit: to determine whether emergency room protocols were followed at Aria Health care facility on November 28 of

2/2/10 - PUBLIC HEALTH - RES. 090915

2009 in the incident involving Joaquin Rivera. We, like the Pennsylvania Department of Health, have unfortunately concluded and tragically concluded that the answer is no, and we are making our report available and part of the public record at this hearing. And I might add I've provided copies to all of the Councilmembers and additional copies are available to those who would like them by simply asking me or my staff here today. The Kline & Specter report on the death of Joaquin Rivera is also posted at www.klinespecter.com.

Members of Council, the focus of the Rivera family goes beyond their grief and goes beyond compensation which they are entitled to through the civil justice system, for which I am responsible to represent them. They have authorized me today here in this very public hearing to embrace the goal of improving emergency room care so that this incident and this kind of incident

can be prevented in the future.

The focus of our report, which you have before you and in your hands, is to critically evaluate all aspects of the systemic breakdown of delivery services at Aria-Frankford on the night of the death of Joaquin Rivera, and to make our own independent recommendations to assist in improvements at Frankford and I am sure will be part of the discussion occurring both locally and nationally over this tragedy. The recommendations, Councilpersons, include having appropriate policies and procedures in effect; making sure in particular that the registrar, those people who we see at the front desk when we first register, that they are recognized to be the vanguard of the interface between the public and the emergency room department, and they must be trained to red flag, as we put it, those patients who present with high-risk complaints.

There must be closer

supervision of the registration desk staff. There must be policies and procedures in effect in every emergency room department that acknowledge the dynamic process of medical illness, especially in the medical department. Someone can come into a medical department, be asked to sit down, but they can get worse, and the doctor who is going to see them is not their primary care doctor. I'm sure this will be a subject of discussion as the morning goes on.

Our recommendations include emergency departments, not only at Aria but throughout the City, have a process for repeating vital signs, for performing initial assessments, for performing ongoing assessments while patients wait in the emergency room, in the waiting area. We all know, I am sure, of sometimes delays in the emergency room, but the key point is prioritizing patients, a patient like Mr. Rivera who

came in with left-sided pain. That might be significantly more important, I would suggest to this panel, than someone who comes in with a runny nose.

And, finally, we have suggested a system in place to account for those patients who don't have their name called or who don't respond to their name being called. That's very important. We can't lose people in the emergency room. We can't forget about people in the emergency room. Someone who comes into the emergency room can't be told, Just please take a seat, we'll be with you. That person is coming seeking help, and the sign on the front door does say "emergency."

I believe our report and our recommendation on behalf of Mr. Rivera's family -- and I might add, Councilmembers, in his name and in his honor -- are consistent with the family's interest, the Rivera family's interest, in having something positive and

constructive come out of something so tragic and terrible. That was after all, that was after all what Mr. Rivera stood for through his lifetime. That is what Mr. Rivera, Joaquin Rivera, would have wanted.

Joaquin Rivera will always be remembered for what he did during his lifetime - a mentor, a musician, a model of citizenship. He was a husband and a father and a grandfather and a man of the community, and I only wish I had got to know him during his lifetime. He was a man who truly led a selfless life.

It is the sincere hope as we begin these hearings of the Rivera family that the findings of our report will be received and reviewed not only by this Committee, not only by City Council, not only by the Department of Health -- and we view our report as a supplement to the Department of Health report, not a substitute, a supplement -- we hope that it will be received and reviewed by the

Committee, Aria and the medical community. I've already had a constructive discussion with representatives from Aria about our intentions and about the Rivera family. We are here to be part of a constructive dialogue and embrace sensible reform in the medical practices, policies and procedures at Aria and elsewhere, with the goal of quality medical emergency care delivery, which so dramatically and obviously was lacking the night Mr. Rivera came to the Frankford Hospital. I know my perspective is shared broadly in the community. I believe it is shared actually in the medical community, and I trust that it will be shared among the many leaders in the medical community, including those from Aria who will be presenting here today.

I thank the Council for the opportunity on behalf of Joaquin Rivera's family to be heard.

COUNCILWOMAN TASCO: Thank you very much. We thank you for your thoughtful testimony.

Are there any questions on behalf of the Committee?

Councilwoman Brown.

COUNCILWOMAN BROWN: Thank you very, very much. Thank you for indeed what is a comprehensive report.

I'm struck by Section C, which speaks to health inspection reports. Briefly, just tell us what -- I see what it means, but for the record and for those who are here, speak briefly to the need for this type of information and this type of report.

MR. KLINE: I'm not sure what you're referring to.

COUNCILWOMAN BROWN: Exhibit C in the document.

MR. KLINE: Exhibit C is the report of the Department of Health. We have summarized the ten key findings of the report of the Department of Health of

the Commonwealth of Pennsylvania on Page 6 of our report.

There were some notable deficiencies which were found by the Department in what is a lengthy report and, frankly, a little bit difficult to slug your way through at first blush, Councilwoman Reynolds Brown. But the bottom line is that the Department of Health -- and I'm sure they'll speak for themselves -- when they conducted an unannounced inspection and asked some tough questions to Aria, they found that there were basic failures at not only the health delivery area level but also at the higher governing body levels.

Finding number one, which I believe is the most important, is that the governing body of the hospital failed to ensure that the facility had sufficient personnel and failed to follow facility policies to meet the needs of patients. That, respectfully to all here today, including Aria, is a pretty

stinging indictment of the failure to deliver healthcare on the most fundamental level. And here, their report, the Department of Health's report, which I also am now privy to, is based on a videotape. The thing that's been so striking and evident and has captured the public imagination, Councilwoman, is the fact that what we have here is an event which is on videotape. So you can actually see a man who came into the emergency room, registered, sought help, and then essentially none of those policies and procedures, frankly, most of which are common sense, were followed. And he was told to take a seat, and he took a seat and he didn't get proper triage, despite having a family history of heart disease, despite being in an age group of high risk and despite having complaints of left-sided pain. And the Department of State has said that the hospital failed to ensure emergency patient safety and

failed to follow policies and procedures which would be expected to meet the medical standard of care.

I might add that the purpose here, my purpose, is not to find fault. There's plenty of, I guess, time potentially to find fault. Here what the Department of State was doing and what our law firm is doing is stepping forward and saying, Here's some constructive suggestions based upon our medical expertise, outside consultants, as well as emergency room and trauma specialists.

COUNCILWOMAN BROWN: My second and final question is, briefly speak to your experience in working with families who have had emergency room circumstances just by way of background, your experience, because that often lends itself to any particular case.

MR. KLINE: I unfortunately have extensive experience representing many families in many circumstances who have had medical errors committed in

emergency rooms. They fall into a number of categories. Some of them not following the proper policies and procedures, some lack of training, some failing to recognize signs and symptoms. And I have one case actually, which I would expect to be public very shortly, involving a violation of a federal statute called EMTALA, where a patient was denied coverage, and it's right there in the medical records, because he didn't have insurance coverage and turned away from a major institution whose name would be well recognized in this room. There are some things that are very troubling about emergency care.

Having said that, Councilwoman, as a citizen of this city and the Commonwealth and the nation, it strikes me that emergency rooms are overworked and understaffed and they have an enormous task in front of them. We can't just wave a magic wand over the fact that too many people show up at emergency

rooms for non-emergent care and emergency rooms are crowded and they face all kinds of difficulties.

Having said that, I don't think you're going to get any disagreement here today by any of the professionals who will speak after me that there are certain standards, certain requirements when you open the door and you put the sign "emergency" out that requires the emergency room to offer high-level care, and that includes registering patients, triaging patients, seeing what their signs and symptoms are, prioritizing patients, making a determination who needs care most quickly, doing the appropriate tests and getting the right treatment. And Mr. Rivera's case symbolizes it, because he went in with what we all recognize by common sense to be a real problem, a pending heart attack, and he had the symptoms of it, and what needed to be done was to get him back quickly, get him oxygen, get him an

EKG, because every minute counts. Every minute, I think the statistics are, that a person who is in his kind of condition, you lose ten percent of the chance of survival. That's really significant, and it tells you that, again, we need to put the "emergency" back in emergency room.

COUNCILWOMAN BROWN: I thank you for your testimony. You indeed answered what my follow-up question was going to be and, that is, state for us the top three priority best practices that are uniform across systems, and you answered that question.

MR. KLINE: I think I've covered it.

COUNCILWOMAN BROWN: Thank you very, very much for your testimony.

MR. KLINE: I'm very grateful to be here and have the opportunity.

COUNCILWOMAN TASCO: Thank you very much for your testimony.

The Chair now recognizes Stacey Mitchell, Deputy Secretary for Quality

Assurance, Department of Health, State of Pennsylvania.

(Witness approached witness table.)

COUNCILWOMAN TASCO: Do you have testimony, Ms. Mitchell?

MS. MITCHELL: No. I don't have any prepared testimony. We've submitted the report of our findings and I would be happy to answer any questions you have or explain anything that I can about the role the Department of Health plays in regulating hospitals.

COUNCILWOMAN TASCO: The Chair recognizes Councilwoman Sanchez.

COUNCILWOMAN SANCHEZ: Are you prepared to speak on the state report that was issued?

MS. MITCHELL: On the Department of Health's findings? Yes.

COUNCILWOMAN SANCHEZ: Can you very quickly summarize your findings and what you perceive to be the top two or three things that stuck out at you in

your regulatory role?

MS. MITCHELL: As Mr. Kline pointed out, we found that the governing body failed in its responsibilities for appropriate staffing and resources. What it really largely came down to is that there were policies and procedures in place. Employees did not know of those policies and procedures and the activities that were required of them. One was to maintain awareness and to reassess patients who were in the waiting area. It was clearly in the policy.

The policies also were not as specific as they could have been. It didn't say how to maintain awareness, how often to maintain awareness, and so it could have been left up to interpretation by the employee. So they had policies and procedures that we felt were not as specific as they could have been and they were not followed. Had they been followed -- as you can see from Aria's plan of correction, they've put a lot of

steps in place, and we believe those will correct the deficiencies that we've cited.

COUNCILWOMAN SANCHEZ:

Mr. Kline alluded to a follow-up visit where there were still some areas of non-compliance. Can you speak to those?

MS. MITCHELL: Follow-up visit where there were areas of non-compliance? We've not conducted any follow-up visits yet. What we do when we cite a hospital for deficiencies is, we send the 2567. That's the name of the report as we call it. They submit a plan of correction and they tell us the outside date by which all of the activities on the plan of correction will be completed. After that outside date, when things have been corrected by the facility, we will go out and do an unannounced survey. We will then make sure that all of those activities are in place, and also while we're there, if we see anything else that is a new deficiency, we will begin and

cite for any new deficiencies that we find.

COUNCILWOMAN SANCHEZ: So you've issued a report. You will now do a follow-up inspection. What happens hereafter? I mean, obviously we want to learn some lessons today. What will be the state's role in monitoring the activities at Aria, and in particular this facility, over the course of the next year?

MS. MITCHELL: One of the most important parts of the plan of correction and it's why my area in the Department of Health, which is the regulation of healthcare facilities, is called quality assurance, is that we need to make sure that what we do lasts and that there's sufficient monitoring going on so that any activities, any cures, any remedies that have been put in place are institutionalized and lasting. And so what we see in this plan of correction and what we require from all of the

hospitals is that they have an ongoing monitoring program. Don't just tell us you're going to do something. Tell us how you're going to monitor for it and how often you're going to monitor for it. Those activities and those assurances made to the Department become something that we will continue to check for on an ongoing basis whenever we have cause to be at Aria or any other hospital.

COUNCILWOMAN SANCHEZ: Can you be more specific to that? What is the state's normal oversight and overview of hospitals? Do you conduct a visit every three years? What's your normal oversight?

MS. MITCHELL: Hospitals are licensed on a two-year cycle. So we do a full survey of each hospital, and that generally takes a team of several individuals several days. It is unannounced. And thereafter, healthcare facility regulation is generally complaint driven.

We do get -- there is some mandatory reporting that goes on in Pennsylvania, so we do get reports of events that happen at hospitals. Those can generate an on-site investigation, as well as complaints that come into our hotline.

COUNCILWOMAN SANCHEZ: How are those complaints assessed and what triggers a potential site visit?

MS. MITCHELL: Complaints come into our central office, they are entered into our licensing software service, and they are immediately sent to the field office. The field office is where the surveyors are. Our surveyors are -- they're health facility quality examiners. They're registered nurses in the hospital survey world, and they will assess the complaint and determine whether or not an on-site is required immediately or whether it's something that can happen at the next cycle or the next complaint investigation.

2/2/10 - PUBLIC HEALTH - RES. 090915

COUNCILWOMAN SANCHEZ: Have you had an opportunity to interact with Aria as part of this process?

MS. MITCHELL: I personally have not interacted with Aria. My surveyors have.

COUNCILWOMAN SANCHEZ: Their corrective action plan, how would you rate it? Do you think it's adequate? Do you think that there are more things that could be done?

MS. MITCHELL: I think that the activities they've put in their plan of correction are comprehensive. I think that they are looking at everything from the architectural structure of the building and the layout. Most definitely they have responded to the issue of policies and procedures and visualization of people in the waiting area, the frequency with which they're called. There's also issues concerning documentation. There's software systems that don't talk to each other, so there's

information recorded in one that's not recorded in another. Everything that we've put into our statement of deficiencies they have responded to and they have, I believe, taken it very seriously.

COUNCILWOMAN SANCHEZ: One of the issues that arose as part of this discussion, particularly for hospitals located in communities like Aria Hospital, is the fact that their emergency room is in one physical plant and the clinics are in another, and that when folks come in for something that's non-emergency, they cannot refer them over to the clinic. Can you speak to that regulation and the limitations of that?

MS. MITCHELL: That's actually a very technical law that's called EMTALA that prohibits that. And EMTALA is federal law and I don't -- I regulate it, but I don't purport to be a legal expert in EMTALA, so I'll do my best for you.

2/2/10 - PUBLIC HEALTH - RES. 090915

COUNCILWOMAN BROWN: Spell that.

MS. MITCHELL: It's the Emergency Medical Treatment and Active Labor Act, E-M-T-A-L-A, and it goes back to, I believe, 1986. It was originally anti-dumping, because hospitals were allegedly -- it's a little bit before my time, but not that much -- were refusing to treat patients based on their ability to pay. So EMTALA is the standard that says when a patient presents to the emergency room asking for treatment or appearing to a prudent layperson to need treatment, the hospital must give them a medical screening examination that's appropriate for their condition prior to discharge. And so once they're there -- and it has to be without regard for their ability to pay or their condition or any other factors that might cause a hospital to not want to take a patient. So once you present to the emergency room, they owe you a medical screening exam before

they can send you someplace else.

In the case of a hospital where they have clinics that maybe have evening hours or might be a more appropriate place, once the patient lands in the emergency room, they owe them the medical screening exam in the emergency room. They can't send them someplace else without making sure that they have been able to stabilize the condition. So it was designed for another day, another problem. Most hospitals have found a way to provide after-hour services in other locations, but it does make life complicated.

COUNCILWOMAN SANCHEZ: Can you give us some examples of those?

MS. MITCHELL: There are hospitals who have established urgi-care centers in other locations. I think as long as they're very well advertised and the community understands that they're urgi-care centers, they're separate usually, very distinct from the four

walls of the hospital. When you present in those locations, you're fine, but when you come into the emergency room, that's when EMTALA kicks in.

COUNCILWOMAN SANCHEZ: Could a hospital have an urgent care facility within their campus? Is that appropriate?

MS. MITCHELL: They're certainly able to do that. They're absolutely able to do that. There is another nuance of EMTALA that I think plays a factor in where these are cited and how they're represented, and, that is, that you can't have a percentage of patients who go to the urgi-care who then become ER patients, because then the urgi-care center becomes covered by EMTALA. It is operating and functioning as a mini emergency room.

So the distinction has to be very clear. You want the patient to self-select what you hope is the right avenue of care. You don't want ER-level

patients going to an urgi-care center. That would not be a good solution for anyone.

COUNCILWOMAN SANCHEZ: What would be some of the conditions that you would say fall under urgent care?

MS. MITCHELL: Well, again, I'm not a medical expert, but I've been working in the healthcare field for a while. Urgi-care are -- generally what you see are the conditions that drive people into services after hours when they can't get access to their primary care physician, things like urinary tract infections, colds, flus, bronchitis, headaches. It's generally pain that drives people to seek services after hours. A lot of those things can be treated in urgi-care centers. Some of them cannot. And I think you will find that everyone's worst fear is that something that looks like a headache turns out to be something far, far worse, or indigestion turns in to be something

far, far worse.

So it's important for people to understand themselves where they're going, what their expectations are. Emergency rooms are for emergencies, and urgi-care certainly plays a very important role, but we have to be careful how patients get there.

COUNCILWOMAN SANCHEZ: One of the things -- and this will be my final question. I know Councilwoman Blondell Reynolds.

One of the things that came out in the report, and I want to be real clear, is around training and staff training. And I ask this from a broader scale, not just Aria.

We are now asking pre-registration clerks to make a determination as to what they data entry for triage nurses, and in light of what I've learned leading up to this event, I would not want to be a registration clerk who has to make a determination between a

chest pain and a left shoulder pain and the differences in services within that.

Do you feel that the Aria Hospital training proposal is appropriate? What have you seen in other places as it relates to that? Because we are asking your lower-scaled staff to take a large responsibility. Is this a broader problem that we're not going to be able to address today?

MS. MITCHELL: I'm not sure that I can tell you it's a broader problem. We've not experienced this, I would say, on a universal basis in the emergency rooms in Pennsylvania. It was obviously an area of concern at Aria. I think they have responded by changing some of their questions and their protocols and ensuring that staff is completely and thoroughly trained. The challenge is to maintain that training going forward to make sure that it's comprehensive, that all new employees are trained and that their skills are

maintained. Sometimes if you don't do something for a while or you don't think anyone is paying attention, you might not be as rigorous as you ought to be. And so it's going to be incumbent upon Aria and the supervisors of triage in every ER to make sure that the triage staff know what questions to ask and that they ask them every time that's appropriate.

COUNCILWOMAN SANCHEZ: Thank you.

COUNCILWOMAN TASCO: I just have a couple of questions before I call on Councilwoman.

You are in charge of quality assurance. When was the last inspection of Aria before this inspection?

MS. MITCHELL: I don't know the day of their last annual inspection. I believe it was over a year ago.

COUNCILWOMAN TASCO: Would they have found these deficiencies with their questioning or their protocol would have reached -- found out that these

deficiencies existed at that time?

MS. MITCHELL: It's unlikely that we would have found that on an annual survey. The survey is -- while it is comprehensive and we are there and we do observe patient care, the specificity that you see in this report and that you see in a lot of our other survey activities is generally complaint driven. And obviously the closer in time that complaint is received by us to the time of treatment -- because we'll get a complaint that will be a year after something has been done. So we go in, there's no employees for us to talk to, they've moved on, things have changed. So obviously the closer in time that someone alerts us to a situation, we can go in.

These findings were very specific to this particular situation, and if we had looked at the policies and procedures and they said that the staff is responsible for assessing patients in

the waiting area, we would have said, That's fine, but the proof was in the pudding and the responsibility to do that assessment and to make sure staff is doing those assessments of people in the waiting area is something that they did not do in this situation.

COUNCILWOMAN TASCO: So your questions by your inspectors are, Do you have adequate staff to provide service in the emergency room, and they would respond yes, but on this specific case, you found that they did not have. How can you use the findings of this incident to strengthen the questions or what you look for in future inspections knowing that the deficiencies can exist and do exist? The next facility, not just Aria, but the next facility that you go to, would you assess what has happened in this instance and strengthen your inspection policies to try to reflect and to deflect what might happen later?

MS. MITCHELL: While we expect

quality assurance of the hospitals, we also expect quality assurance of ourselves, and we do learn from every survey that we conduct. We do many EMTALA investigations throughout the year. I would tell you that all the circumstances are unique to whatever that hospital situation was at the time those services were provided, but it is my responsibility and the agency's responsibility to learn as well in every opportunity that we have.

I think what we've seen in this instance is that there were policies and procedures that had they been followed might have given us a different outcome. They were not as specific as they probably could have been, and I think that's an area that we will be on guard for going forward. We don't have a state law, however, that says not only do you have to have a policy and procedure that says people have to check the waiting area, but they must do it on these

intervals and in these manners. Our regulations are not that specific, and they're actually not that specific for a very good reason, because it becomes -- the regulation becomes the minimally accepted level of performance. Regulations are the floor, bare bottom. Best practices is the ceiling. So we're out there to make sure that the bare minimum standards are followed.

If a policy -- if a state regulation said that people need to be checked every five minutes, for most people that would be wonderful. For other patients that's too long. And if the law said that the hospital had five minutes to do it and someone died in two minutes, there's nothing any of us could do about it because the law gave them five minutes.

So the regulations actually have the flexibility to allow the hospital to move as is appropriate for the patients and the conditions and the

circumstances they find themselves in, and we have to hold them responsible for what's going on at that point in time.

COUNCILWOMAN TASCO: Thank you very much.

Councilwoman Brown.

COUNCILWOMAN BROWN: Thank you, Madam Chair.

Follow-up questions to Councilwoman Sanchez. You answered the question on what the standard operating procedure is, two-year cycle, full survey, done on several days, surprise visit. What happens in an instance where, like this one, where we now have a clear violation of standard operating procedures going forward, knowing that there has been a violation of protocols, if you will? What does the Department do in this type of instance?

MS. MITCHELL: In this type of instance, the last completion date, I believe, on the plan of correction is March 1st. So sometime after March

1st -- and I couldn't tell you when even if you asked me. I wouldn't be allowed to -- we will do another unannounced visit and we will check the hospital. It may be during normal business hours. It might be in the evenings. It might be on the weekends. No one knows when our inspectors will show up, and we will make sure that they have implemented this.

We will also monitor it on an ongoing basis. So should we receive any other complaints from the emergency room patients or about emergency care at Aria, that will be triaged and handled with a higher level of priority because we know that there is a plan of correction and things should have been resolved.

Should we be called there for a complaint about a billing issue or any other problem that might send us on site, we will, again, continue to monitor their progress and their commitment to resolving these deficiencies.

COUNCILWOMAN BROWN: You also

stated that best practices are the ceiling, regulations are the bare minimum and are the floor.

MS. MITCHELL: Right.

COUNCILWOMAN BROWN: What corrective action does the state employ when the bare minimum have been violated or simply ignored?

MS. MITCHELL: What you see in the statement of deficiencies are the state laws that they have not been compliant with. We hold the hospital responsible for that.

Generally speaking, what we do is require a plan of correction, because the most important thing to do is get compliance as quickly as possible. There are other fines, penalties and sanctions that we have available to us under the law, and depending on the cooperation of the institution, the thoroughness of their response and their plan of correction, we can up the fines, penalties and sanctions accordingly.

COUNCILWOMAN BROWN: Does that require some time that the Department may have to provide what some may call technical assistance, hand-holding, if you will, to assist institutions to move into compliance?

MS. MITCHELL: We're very clear that we don't tell people how to get into compliance. We tell you what the law is, and it's your responsibility to figure out -- "you" as in the hospital -- to figure out how to be compliant. Obviously people will ask us, Does this satisfy you in our plan of correction, and there are times when we say, No, it does not. We reject the plan of correction, either it wasn't thorough, it wasn't responsive or there's no ongoing monitoring.

COUNCILWOMAN BROWN: And then lastly, there are many of us who like to look at a report card and make judgments about what we do based on that information. Does the state provide to

citizens statewide a report card, for lack of a better word, about where hospitals stand on different types of factors?

MS. MITCHELL: Sure.

COUNCILWOMAN BROWN: And that's public?

MS. MITCHELL: What I meant was, sure, I can answer your question. I'm sorry. No, we do not have a report card. We don't have A hospitals and B hospitals and C hospitals. What we have are hospitals in Pennsylvania who our job is and their job is to make sure they are all equally compliant with the law.

COUNCILWOMAN BROWN: So that is the minimum expectation?

MS. MITCHELL: Correct.

COUNCILWOMAN BROWN: Equally compliant with the law?

MS. MITCHELL: Correct. And our findings for the hospitals and the results of all of our survey investigations and the plans of

correction we do make available to the public on the Department of Health website, and we have an extensive history on pretty much every institution in Pennsylvania.

COUNCILWOMAN BROWN: Okay. Well, thank you for your testimony.

COUNCILWOMAN TASCO: One more question -- two more questions. You mentioned the governing body of this hospital, Frankford Hospital. This system has three hospitals, I believe, in Philadelphia. The governing body you referred to, is it of that hospital or is there an overall governing body that sets policy for all three facilities?

MS. MITCHELL: I do not know the answer to the actual hierarchy structure at Aria. Whether there's a governing body for each hospital or there's an overarching governing body, the ultimate governing body is the one that needs to be responsible for the operations of effective and efficient

healthcare institutions, and so it is the governing body that we are holding responsible.

COUNCILWOMAN TASCO: The overall governing body?

MS. MITCHELL: I don't know the answer to that. I don't know how -- again, I don't know how many layers --

COUNCILWOMAN TASCO: I guess what I'm trying to get to is that if it is -- and we will ask Aria when they come forward what is the structure. If it's the overall governing body, would you look to the other two institutions to see if they're following the procedures in those hospitals if you found deficiencies in this and it was the governing body that seems to be the one that failed to provide the oversight necessary?

MS. MITCHELL: If there is one body responsible for all three institutions, then, yes, they would be held responsible for any deficiencies at any of the other two institutions.

2/2/10 - PUBLIC HEALTH - RES. 090915

COUNCILWOMAN TASCO: Thank you. Councilwoman.

COUNCILWOMAN SANCHEZ: We just wanted to ask you to stay in case any other questions arose after Aria's testimony.

MS. MITCHELL: Sure.

COUNCILWOMAN SANCHEZ: Thank you.

COUNCILWOMAN TASCO: Thank you.

We want all of these witnesses to come forward: Linda Wilson, Chief Operating Officer, Aria; Robert Danoff, family physician and Program Director of Aria; Dr. Julie-Lee Pineiro, Medical Resident, Aria Health; Phyllis Clapier, Registered Nurse; and Elizabeth Maloney, Unit Secretary, Aria Health.

(Witnesses approached witness table.)

COUNCILWOMAN TASCO: Thank you all for coming today. Would you please -- I guess, Dr. Danoff, you're going to testify first? Please --

whoever. I mean, you can decide who goes first. It's up to you.

MS. WILSON: Good morning.

COUNCILWOMAN TASCO: Linda. I'm sorry.

MS. WILSON: Yes. Good morning. My name is Linda Finsrud Wilson. I'm the Chief Operating Officer at Aria Health. I've recently come to Aria Health and I moved here from Colorado, and I've learned to love the people of Philadelphia but, in particular, our staff and our patients that I serve within this institution. Our staff is the salt of the earth. They humbly go about healing and about the process of healing in a way that is very touching.

On behalf of Aria Health, I extend my deepest appreciation to Councilwoman Marian Tasco, Councilwoman Blondell Reynolds Brown, Councilwoman Maria Quinones-Sanchez, members of the Public Health and Human Services

Committee and the Philadelphia City Councilmembers for the invitation to come and speak to you today. Aria welcomes this opportunity to discuss our ongoing enhancement of emergency care delivery in the context of a local healthcare environment that continues to present a number of growing formidable challenges.

Since his death on November 28th, 2009, Mr. Joaquin Rivera has been remembered by many as a respected leader, a strong supporter of the Latino community, a trusted mentor and a good friend. Aria again wishes to express our sincere condolences to the Rivera family. We have taken Mr. Rivera's death very seriously and have implemented a number of proactive steps to ensure continuous improvement of our emergency room processes and to guarantee the safety of the community we serve.

Immediately following Mr. Rivera's death, Aria conducted a comprehensive and thorough examination of

our policies and procedures. In fact, I had been out of town in California visiting my son over the Thanksgiving holiday and I received a call at very early in the morning, in the wee hours, indicating what had happened.

Aria conducted this review in advance of and then in partnership with the Pennsylvania State Department of Health. We sincerely appreciate the Department's review and thank them for their subsequent report and recommendations. In response, Aria developed a comprehensive action plan for its Frankford Campus Emergency Department. Approved by the Department of Health, this plan includes a detailed review of our security staffing model and procedures; examination of our emergency department triage service; reinforced adherence to policies and procedures; enhanced orientation for emergency department registration staff and a detailed review of the process for

patient throughput. Aria then further expanded upon these recommendations, and we started to work with a team of industrial engineers to actually create a process flow for patients and staff that is most effective and efficient and very, very safe. Using industrial engineers is very common in industry, but it is rare in healthcare, and we accepted that opportunity to really improve our services.

Further, we assembled a Lean Six Sigma team to further analyze the processes as well as its connection to the inpatient environment, which is critical. Subsequent to the implementation of these interventions and innovations, we had a visit from The Joint Commission, the accrediting body for hospitals in the United States, who commended our efforts and our action plan and described them actually as "best practice."

In addition, Aria has expanded

its community outreach activities and initiatives, working closely with leaders and representatives in our Frankford Campus service area. We are actively developing a Healthy Community Coalition to share comprehensive input into the development of better health and healthcare in the Frankford community. As a key part of this effort, Aria is partnering with the Consortium for Latino Health to determine how we may better serve the Latino population.

Aria is dedicated to maintaining strong ties with the Frankford community, which it has steadfastly served since the hospital was founded in 1903. At that time, Northeast Philadelphia physicians were having their patients turned away by Center City hospitals that were operating at capacity. To meet patient need, the physicians established a community hospital that would provide convenient high-quality medical care to its

neighbors. More than a century later, Aria has remained true to its mission and is serving new generations of patients in the Frankford community that have experienced the closure of other local hospitals.

Aria recognizes this challenge and embraces the privilege of providing a comprehensive range of healthcare services to a community that is in great need. These efforts are appreciated on a daily basis by our patients as noted in personal thank-you letters that they take time to write and through patient satisfaction surveys. In fact, in the past few months, several nursing units at our Frankford Campus received a rare 100 percent patient satisfaction score, and that means that 100 percent of patients surveyed on these particular units judged their hospital's experience as outstanding and that 100 percent would recommend others to the Frankford Campus.

Aria has continued to provide

high-quality care in the face of a number of economic challenges. In 2009, Aria's Frankford Campus had 70,000 patient visits, 70,000, many of whom were underinsured or uninsured, with an ever-shrinking Medical Assistance budget from the state. In addition, the Frankford community has experienced the closure of five local hospitals in recent years. This includes the closure of Northeastern Hospital, as well as the emergency department at Friends Hospital. As a result, Aria's Frankford Campus is the last hospital with an emergency department serving a community with a total population just under a half of a million people. The closure of Northeastern has resulted in a 30 percent increase in patient volume at our Frankford Campus Emergency Department, all being addressed with a significant investment in additional hours of service, additional staff and additional physicians. To sustain service at the

2/2/10 - PUBLIC HEALTH - RES. 090915

Frankford Campus, Aria experiences annual losses in the millions.

While seeking to meet the healthcare needs of the Frankford community, Aria is also the area's largest employer. More than 800 of Aria's employees work at the Frankford Campus, half of whom live in the immediate community and support the local economy. Our staff has their hair cut at Lorenzo's, eats at Lee Brothers Deli and Raja's and other local institutions and use the local bank. As a dedicated community partner, Aria also leases space at reduced rates to area businesses to maintain and enhance resources for local residents. The Aria School of Nursing, with over 200 students, brings additional revenue into the community. In addition, the School provides space for nurse assistant training for those who need to expand their job skills. An invaluable resource to thousands of uninsured residents, the nearby Aria Health Center

Clinic also provides desperately needed primary healthcare services and routine diagnostic procedures.

While Mr. Rivera's death was a tragic occurrence that Aria has addressed with swift action, I come before you today to respectfully ask that the Frankford Campus not be judged by this one incident.

We heard today from legal counsel for the Rivera family, who has gone on record stating that he is preparing a lawsuit over this occurrence, and he will do much to keep you focused on the single tragic occurrence, but I respectfully ask that you focus on the broader story here and the potential impact of the closure of another hospital. For more than a century, Aria's Frankford Campus has provided high-quality, life-saving emergent and primary healthcare services to a community that needs and deserves them. We have made a commitment to remain in

the community. With the current challenges facing Philadelphia in general and the Frankford community in particular, Aria serves as a significant part of its foundational infrastructure. We have acknowledged all recommendations, instituted improvement plans and been commended for our efforts by a prestigious national organization as we have worked to ensure that nothing like this ever happens again. We also feel a responsibility, however, to use this platform that has been graciously extended to us to educate City Council and the general public about health being everyone's responsibility and how critical it is to access the healthcare system in a way that is most effective.

We look forward to continuing our recognized exemplary service to this historically underserved population, but we need your help and the help of the community to do so. That is the only way that Aria will be able to continue our

proud history of service to the Frankford community in the years to come.

Thank you again for your invitation to participate in these proceedings.

COUNCILWOMAN TASCO: And thank you very much for your testimony.

I think we'll save questions until all of you have testified and we'll come back with questions.

Dr. Danoff.

DR. DANOFF: Hi. My name is Rob Danoff and I'm a family physician and Program Director in the Department of Medical Education at Aria Health, and I thank you for the opportunity to speak with you all today.

For over 100 years, Aria Health has been dedicated to serving the needs of the community in Frankford. While other hospitals have left the area, we have continued to stand by our Frankford neighbors and do our best to take care of their healthcare needs, regardless of

age, ability to pay, racial or ethnic background. In fact, our healthcare team is made up of a diverse population of individuals from many backgrounds, united in one goal - to help people get better. We also have a medical clinic, offer many free educational and medical screening services to the community and have been recognized for our healthcare contributions to the Frankford community.

As Director of several residency programs, I have the privilege of working with residents and healthcare personnel who serve the Frankford community. I too have had the opportunity to work at the Aria Health Center Clinic. Throughout these experiences, one consistent message is clear: The citizens of this community have very important medical needs, as well as a strong need to be educated in how, when and where to access healthcare services and resources.

Our hospital does its best to

help patients in a community environment that has scarce or inadequate resources to address the complex and wide-ranging healthcare needs of its citizens. Our physicians in the Department of Medical Education come from diverse backgrounds. Their commitment is to the individual patient. They want to help. Our mission is to help. And we are always touched by the kindness and appreciation of the patients we serve. Often our physicians and staff leave the patient care experiences feeling fulfilled, but recognize that the needs of the patients are much greater than what they can accommodate in a single patient encounter.

There are many in the community with little or no insurance, many with physical conditions and needs that have not been addressed and have been building up over the years, many who have unaddressed behavioral disabilities and many with social issues that include

inadequate or lack of housing. I constantly hear stories of physicians' difficulties in trying to find the patients they serve their needed medications to keep them healthy and safe or medical equipment for their homes, counseling for their medical health needs and ways to follow up with a primary care or clinic to ensure a continuity of care for their patients upon discharge. It is so important. It is a challenge that all healthcare providers face, and we need cities and communities all over the country to assist in the education and help their community citizens.

Needless to say, our hospital, as well as our colleagues seated beside us and all the hospitals in Philadelphia, do our best to help patients in a community environment that has scarce or inadequate resources to address the complex and wide-ranging medical needs of and psychological needs of its citizens. Many of the health issues that we as a

community experience begin way more than a single visit to the emergency room. They're happening every day, here and now, because people don't have access to primary care. We all need to work together, all of us, all of us, to find solutions to help our community and its citizens. And I thank you.

COUNCILWOMAN TASCO: Thank you very much.

Dr. Pineiro.

DR. PINEIRO: Good morning.

COUNCILWOMAN TASCO: Good morning.

DR. PINEIRO: My name is Dr. Julie-Lee Pineiro. I'm a second-year medical resident at Aria Health in a combined program for emergency medicine and family practice. As a resident physician, I have had the opportunity to spend much time caring for patients at Aria's Frankford Campus both in the emergency department and on the hospital floors. Of all the campuses, I actually

offer to work at Frankford the most, because patients who need you the most are often among the most grateful. Many times they're the sickest and with the least accessibility to healthcare.

I once treated an African American female prisoner who was brought to the emergency department after breaking her arm. She was very upset and worried that her arm would be deformed forever. I reassured her and placed a special splint on her arm that would also withstand the abuse of imprisonment. Later she said to me, Thank you for treating me like a human being.

At Aria Health, we strive each and every day to provide the best care for patients of all ages, ethnicities, races and backgrounds. Several months ago, I created a lecture series called Cross-Cultural Medicine. It helps physicians broaden skills needed to care for patients from cultures different than their own. Someone once asked me, Does

that all really make you a better physician?

My answer? Yes. Being a physician is about caring for patients from all aspects, biologically, socially and psychologically. At Aria it is about understanding and communicating with our patients so that doctors and patients together can achieve optimal health.

Thank you for your time.

COUNCILWOMAN TASCO: Thank you for your testimony.

Ms. Phyllis Clapier.

DR. PACHECO: Good morning, Councilmembers.

DR. DANOFF: Dr. Denny Pacheco also.

COUNCILWOMAN TASCO: Okay.

DR. PACHECO: My name is Denny Pacheco. I'm one of the residents at Aria Health. I'm the Chief Resident of Family Practice and Emergency Medicine. Prior to this, I was a bilingual teacher in New York City and served my country as

an officer in both the Army and the Navy. I've worked in Aria for five years and I've received an excellent education there in preparation to practice as either a doctor in family medicine or emergency medicine. In all that time, I have always seen my attendings treat patients equally, always providing a level of care warranted by the patient irregardless of social, economic or cultural background. The care received at our hospitals is exceptional, and I have not hesitated to take my own family members to be treated there. It's a great place to train, it's a great place to see our mentors provide excellent examples of healthcare. And thank you for your time.

COUNCILWOMAN TASCO: Thank you very much.

MS. CLAPIER: My name is Phyllis Clapier and I'm a registered nurse, having been employed by Aria Health for over 30 years. I, along with

many of my co-workers, also reside in the community I serve. It is not unusual for any of us to encounter our own family members, friends and neighbors in the emergency department and other areas of the hospital. It is our privilege to care for them.

Although I did not know him personally, I mourn the loss of Mr. Joaquin Rivera. It sounds as if he was an absolutely wonderful man, and my heart goes out to all the folks he touched during his life. The circumstances surrounding his loss have been particularly difficult to me, because on a daily basis I witness the life-saving actions of our hospital staff, as well as their benevolent and caring spirit.

As a night-shift worker at Aria's Frankford Campus for many years, it is my opinion that one of the best things about this neighborhood and our staff is the wonderful diversity of

cultures, personality and affluence. My own immediate neighbors include Caucasian, African American, Hispanic and Indian families, many of modest financial means, and we care for and support each other as needs arise. This atmosphere of diversity and support spills over into my work experience as well, and on any given shift, we can locate staff who speak Spanish, Creole, Hindi, Russian, Polish, Vietnamese or Cantonese, and graciously assist our patients and their families in whatever capacity they are needed.

I have witnessed firsthand the vital role that the Frankford Campus plays in providing healthcare services, but also how it serves as an oasis for a community facing a unique set of health and economic challenges. In addition to providing excellent patient care, we have helped improve the overall quality of life in the Frankford community. These efforts include -- and I've been personally asked to donate -- a variety

of charitable endeavors, including hospital-wide drives to collect hundreds of school supplies, toys and food items for annual back-to-school and holiday programs that benefit local children and families, to name just a few. We routinely receive positive feedback and deep appreciation from the organizations with whom we partner on these projects. Aria has delivered holiday presents to children who might not have had any and also put food on the table of many who might have gone hungry otherwise. In this regard, I have personally had the experience of seeing the joy on the faces of children who are also my immediate neighbors after they receive a backpack stuffed with school supplies and a few months later personalized Christmas gifts provided by our emergency department staff.

The tangible improvements in the lives of our patients and area residents brought about through these

projects clearly demonstrates that the Aria Health family is comprised of hard-working, generous and compassionate individuals. It has been a privilege and pleasure to have spent the largest and best part of my career as part of this team.

Thank you.

COUNCILWOMAN TASCO: Thank you very much.

Ms. Maloney.

MS. MALONEY: Good morning.

COUNCILWOMAN TASCO: Good morning.

MS. MALONEY: My name is Elizabeth Maloney. I live in Northeast Philadelphia and I have worked at Aria Health's Frankford Campus Emergency Department as a Unit Clerk since 1993. It has been an honor to work alongside a staff of well-trained and extremely dedicated personnel. In my opinion, I have seen my fellow staff members save lives. It never ceases to amaze me how

much of themselves they give to the job. It has never mattered to them who the patient is or what their history is, medically or otherwise. They give each and every patient their full attention and talent. I so admire and respect this group of professionals because they care and go above and beyond for their patients.

The recent loss of Mr. Joaquin Rivera has been taken personally by each and every one of us. We are here to help our patients and I have frequently witnessed the joyous reaction of the staff when we are fortunate enough to save a life. It is both humbling and exhilarating for the staff. When we are not able to accomplish this and lose a patient, everyone takes it personally. We grieve with each one we are unable to save. That is the inherent challenge of working in the healthcare system.

If and when I have a family member who needs medical care, I will be

sure to bring them to Aria Frankford Campus. I have seen firsthand the care that is excellent and that only dedicated and high-qualified staff are caring for us there.

Thank you for your time.

COUNCILWOMAN TASCO: Thank you very much.

Thank you all for your testimony.

Are there questions for this panel?

Councilwoman Brown.

COUNCILWOMAN BROWN: Dr. Julie-Lee Pineiro, if you would, elaborate more on the cross-cultural experience you are involved with there at the hospital and does it cut across all sectors both wide and deep.

DR. PINEIRO: I'm sorry. Could you just repeat the last part.

COUNCILWOMAN BROWN: Does what you do cut across all sectors of the hospital, both wide and down to the

clerks?

DR. PINEIRO: The Cross-Cultural Medicine program that I have developed is dedicated towards physicians. Everyone is welcome to sit in, but my audience is generally residents, attendings, students, better-trained physicians.

The whole point of the program is to provide them with the knowledge of multiple cultures, all races, backgrounds, ethnicities, both on a biological level, because every race is different, but also on a social level and a cultural level so that physicians can not only have an understanding of where their patient is coming from but be able to better communicate with their patients --

COUNCILWOMAN BROWN: How old is that program?

DR. PINEIRO: -- and ultimately result in better patient compliance.

COUNCILWOMAN BROWN: How old is

that program?

DR. PINEIRO: We started it in September, October of this year, maybe a little bit before that.

DR. DANOFF: That's for the physicians --

COUNCILWOMAN BROWN: State your name for the record just for our --

DR. DANOFF: I'm sorry. Dr. Rob Danoff. I'm actually her Program Director.

We started the cultural competency training for physicians in September of 2009, but we have had cultural competency training for our employees, for our nurses, for many years, I believe at least 12 to 15 years. I can't tell you the exact date. It consists of computer-based training where they learn by a module prior to beginning their tenure at the Aria Health System. Also, they have yearly reviews and tests, both written and oral, to ensure that their competency-based training is up to

date, that they are sensitive to the needs of the multiple ethnicities that we help, and that we are attuned to communicating and understanding their medical needs. So that, combined with the physician training, we felt would enhance our ability to serve our community.

I had asked Dr. Pineiro to be in charge of the physician component, as she had had experience prior to joining our hospital system, and I've seen her ability to communicate. And our staff is so multi-cultural that we have involved other physicians and healthcare personnel in helping us understand where they're coming from, understand the needs, understand the unique communication, the barriers to healthcare, and also help us implement plans to be more effective providers.

COUNCILWOMAN BROWN:

Ms. Wilson, could you please speak to on Page 2 of your testimony? You speak to,

and I quote, "We have acknowledged all recommendations, instituted improvement plans, and been commended for our efforts by a prestigious national organization."

Cite for us at least three of each, three recommendations that you've acknowledged. Acknowledgment is one step. Action becomes the follow-up. And then speak to instituted improvement plans that you've already exercised in the agency.

MS. WILSON: Certainly. I'll start by saying that our improvement plans actually started immediately, within 24 hours, following Mr. Rivera's death and prior to even the Health Department coming on site. But some of the things that we've implemented, first and foremost, as far as the staffing issue that was discussed with some of the prior testimony, we understand that the community is changing a lot faster than we anticipated, and as a result of that, we needed to beef up our staffing and

security. So within 24 hours afterwards, we changed our staffing model within our security area to include two security guards on either end of our emergency room that stand there 24/7. And to give you an idea of how extensive that is, our emergency room only has 25 chairs in it, our emergency waiting room. And so we now have two security guards that basically are watching over only 25 chairs.

The other related security issue that we've had to implement, much to some of the dismay of some of the community, is we have a no sleeping rule in our emergency waiting room. If we have people asleep, we really cannot tell whether they are sleeping, whether they are in more of a significant situation from a clinical standpoint. And so we now have to wake up all of our waiting patients, even in the wee hours of the morning, but it does keep us safe and keeps the patients safe.

As far as security, in addition to that, we've increased our security campus-wide as well. And so that was our security staffing issue, and that was our major staffing issue that was identified with the Department of Health.

Moving on to the triage program -- and this is an area that we were really commended on because of the simplicity, yet effectiveness of this intervention. The first thing we did was, we actually put tape on the floor of where the triage nurse needs to come out of the triage space, which is a more confidential space where a patient can speak to that triage nurse more confidentially, come out into the waiting room, call that patient's name. If the patient does not respond to that name, she actually moves to the other end of the waiting room to another tape on the floor, and while she's moving, she's to survey the entire waiting room, which isn't difficult. It's a relatively small

waiting room.

When she reaches that other tape and she again calls the patient's name and there isn't a response, then she takes a poll of the waiting room folks.

Now, because of the neighborhood in which we serve, it is not unusual or hasn't been in the past unusual for people to come in to our emergency room to get out of the cold if they are homeless.

The other issue that we have experienced in the past is that people will understand how to, for lack of a better term, game the system. They're able to come in, and as you heard prior, our EMTALA issues preclude us from ever letting anybody leave who wants to have a medical exam. So they'll come, they'll register, they'll wait to be triaged, and then just prior to triage, they'll leave. So they'll have enough time to stay there, get warm and then leave. We have since abandoned that ability and are very

strict about the number of people that can accompany a patient as well as anybody who is coming in that we can't determine that they have an issue that needs to be seen by a medical professional or they desire to see a medical professional.

The triage time, we reviewed all the policies and procedures with our triage staffing and our registration personnel and made sure that they were well aware of our policy and procedure to go out into the waiting room and take vital signs on a regular basis if there is a delay. Now, that delay can never occur between registration and triage and, in fact, did not occur within that night to a large extent. So what I am telling you is that the average time -- and it's tough to talk about average flow and time when you're talking about a gentleman that has died, but yet this is how we need to address this to make sure that we are providing the most efficient

and effective environment.

The average time in Pennsylvania from when a patient comes in the door to triage is about 17 minutes. On that particular night, Mr. Rivera died at about 11 minutes after entering the emergency room and was called at 14 minutes. So even though we were below the state average and well within the guidelines, we still determined that we needed to relook at our policies and procedures so that we assure that everybody is adhering to those policies and procedures and sustaining that, as was previously mentioned as well.

Our leadership - our managers, our charge nurses - are all responsible to assure that those policies and procedures are adhered to and that the patient flow is effective. I myself have been in the emergency room numerous times since this occurrence to assure that we are in fact addressing the policies and procedures. In fact, we had one night

that was particularly busy about a week ago where we had to get excess people in to take vital signs to be sure that we were adhering to that policy and procedure. We don't want anything to happen to anyone while they're waiting for care. And as far --

COUNCILWOMAN BROWN: What --

MS. WILSON: Did you want me to go on with the registration folks?

COUNCILWOMAN BROWN: Registration?

MS. WILSON: You said three examples.

COUNCILWOMAN BROWN: Yes, I would like to hear that.

MS. WILSON: For our registration people, we have always had a system in place where there are specific complaints that come in - chest pain, shortness of breath, those types of things - where the registration clerk immediately sends the patient back. And by the way, if a patient comes by

ambulance, they immediately go to the back as well.

We have since trained the registration staff to look for additional information. Now, they are not clinicians. However, they will be able to dig deeper with a patient. And there is a window in between the registration desk and the triage nurse, so they can communicate effectively through that window as well as through the software, and they use both of those specific areas.

Our registration staff is very attentive to our patients in the emergency room. However, one thing just to be sure that they had an adequate line of sight, we had our registration desk -- and if you can picture our registration desk with a window in the front, we had them take down every single piece of paper on that window that had previously been for the patient's convenience, talking about various requirements and

various regulations, as well as what their rights are within the emergency room. We had them take them all down and put them toward the back of the registration area and in the emergency waiting room, just to be sure that the registration clerk also has complete line of sight.

The one thing I'm most proud of, though, is that we brought in a group of industrial engineers to look at our flow, identify any potential areas that may pose a threat to safety or any lapses or gaps and then look at the most effective way to flow the patients through.

Our emergency room is like many emergency rooms, it has been expanded and expanded and expanded. And so in the case of a brand new emergency room, the flow can be established architecturally. We don't have that luxury within this facility, and so we're also wanting to look at architectural improvements that

can be made as well.

We did have an unannounced survey, as I indicated, from The Joint Commission, the accrediting body for hospitals across the United States. They were very, very impressed with our action plan and actually said to us, You have best practices here and you should publish what you've done.

COUNCILWOMAN BROWN: So that visit happened post the passing, correct?

MS. WILSON: Yes. It is typical for all of our accrediting and governing agencies and regulatory agencies when an event like this occurs and it has such media attention, it is typical for them to come unannounced and inspect our facilities. And we are under one provider number for our facilities, and so not only did they inspect the Frankford Campus but they inspected all three of our campuses.

COUNCILWOMAN BROWN: You stated, and I quote, that your staff are

very attentive. Please speak to briefly what type of training really does happen for emergency room personnel and what changes have you made in training since this tragic incident.

MS. WILSON: First of all, we have a requirement when they come on the job. So a registered nurse obviously has to be in good standing, has to have sufficient recommendations and references and certainly has to be liked --

COUNCILWOMAN BROWN: Forgive me for cutting you off. I'm talking specifically for the emergency room.

MS. WILSON: Yes.

COUNCILWOMAN BROWN: Okay.

MS. WILSON: In addition to that, we provide an annual EMTALA training to assure that everybody in the emergency room, not just clinical staff, everyone understands that every single person that presents to the emergency room has the right to receive a medical examination regardless of their ability

to pay, their medical status, their race, their ethnicity, anything. And, in fact, anyone who comes to our campus, any part of the campus, including the parking lot, has the ability to receive a medical exam should they request that. And that training is given to our staff every single year to make sure that they understand that.

COUNCILWOMAN BROWN: With that said, then tell us what happened. If the training is as you just stipulated and you indicated that the staff are very, very attentive, where, in your view, did the breakdown happen?

MS. WILSON: Mr. Rivera was treated with no respect to his situation economically, his insurance, his background, his race, ethnicity, anything like that, and that occurred and it occurs with all of our patients, and we are strictly regulated by that. And, in fact, we often have patients come in that really don't want to go to any other

hospital, they want to stay there, and many times we have to tell them, Your condition warrants you being transferred to a coronary care center or an academic center such as the University of Pennsylvania. But we often have patients that say, I don't want to leave here.

With that aside, the triage nurse was unaware of the policy that she needed to go into the waiting room and take vital signs on a regular basis. The policy was in place. However, the policy was not adhered to.

In addition, I believe that increased staffing and security would have prevented this robbery from occurring, which, in my mind, was a heinous act.

COUNCILWOMAN BROWN: So the change that has been instituted is? Complete the sentence for me. The change that has been instituted post this tragic incident is?

MS. WILSON: Multi-faceted.

And that change includes over a dozen assurances. And I won't say -- they're all improvements and we haven't been cited on all of them, but we decided to take this opportunity to improve emergency care globally and not just for the areas that the state cited us on.

COUNCILWOMAN BROWN: Okay. I would rest, because colleagues have questions as well.

Thank you, Madam Chair.

COUNCILWOMAN SANCHEZ: Thank you, and I do want to thank Aria Hospital for coming forward and providing this opportunity for the public to hear from you. I know when these incidents happen, it's very difficult to always respond to all of the press situations. So this is an opportunity for you to, as Blondell Reynolds said earlier, state your case and what happened.

I'm a little concerned because the report was quite serious, the state report, and I'm concerned because

according to our Deputy Secretary, regulations are the floor. In light of what we saw in that video and clearly your acknowledgment that certain protocols were not followed, where are you now? Do you find yourself in the middle or really -- you mentioned that the national organization said best practices, but in light of this report, where do you see yourself on the Frankford Campus?

MS. WILSON: I can answer that by saying that if anyone in this room ever needs emergency care, I would go to the Frankford Campus at any time, day or night, for a variety of reasons. Number one, our care is so tender and our healers are true healers.

Number two, we are so involved in being vigilant as a result of this event that occurred that you will have much less of a concern about anything that would occur at this point in time.

And certainly, number three,

our clinical staff is outstanding and our staffing levels are outstanding as well.

And just one other area that certainly bears mentioning. I focused on the security staffing because on that particular night, we actually had more staff than would have been advised or indicated by state staffing requirements, and it was -- we were certainly clinically adequately staffed. However, our security staff was lacking.

COUNCILWOMAN SANCHEZ: It's really hard when these situations happen, and I'm happy to see some of the staff here. This is not a discussion around laying the blame on staff. I know staff is overworked, and having had family members stay at Frankford, I can attest to their care when folks are at Frankford on the campus. So this, by no means, is -- and that's why you're here, because as the COO, the buck stops with you. Ultimately one of the things that we want to ensure is that all staff is trained

adequately, that that training is continuous and that when we are at dangerous staffing levels in terms of the care, that you make that decision around additional staffing. Unfortunately, the state report and the video presents a different case in terms of Aria Hospital. So my question to you is, what are you going to be doing now in terms of outreaching to the community and to the public to ensure them that all of these changes have taken place and that they will get improved care? What are some of the things that you're doing?

MS. WILSON: First of all, from your comment regarding the videotape, the majority of any emergency room staffing is in the back, and so our nurses, physicians -- and that's very appropriate certainly, because that's where the patients are treated. So if you're looking at staffing from a video in a waiting room, you're not going to see a lot of -- you're not going to see nurses

and physicians roaming around. You will see security, and hopefully you will see a lot of security.

As far as our commitment to the community, through our outreach efforts as well as through our community campaigns, we will continue to educate the community not only on the improvements that have been made, but we feel it is partially our responsibility, and certainly in partnering with the City Council and other leaders within the community, to help the community understand how do we access healthcare, where do we access healthcare, how do we improve our health so that when you come to the emergency room, you understand what your own healthcare is about, you understand that you've exercised, you've eaten properly. These are issues that are prevalent across the United States, but in particular in Pennsylvania. And so all of those things are extremely critical.

In addition to that, we just started a medical home process where we assign a medical home to patients so that they have that continuum of care. Some patients do not want that medical home, but we're doing our best to assign that, and that has been a very effective practice, and thanks to Governor Rendell and his real support of the medical home process, we're getting involved as well.

So those continuous efforts. We continually express to the community our improvements in what's happening.

COUNCILWOMAN SANCHEZ: I had a question to the medical education director. In addition to the training, the cross-cultural training, what are some of the lessons you've learned and how are you looking to improve your training to your medical team on site?

DR. DANOFF: Well, enhance our ability to help the community, right now we network extensively with case managers --

COUNCILWOMAN SANCHEZ: You have to speak into the microphone.

DR. DANOFF: I'm sorry.

COUNCILWOMAN TASCO: Identify yourself again for the record.

DR. DANOFF: Dr. Rob Danoff, Medical Director at Aria.

We have case managers and social service personnel who help us identify resources, medical resources, for the community. So, for example, if someone comes in and does not have a place to live, they help identify safe shelters. If someone needs medications, we help identify resources or even provide them with the medications. We just need a safe place for them to receive them.

Our residents in education consistently work with case managers and social workers to try to enhance the continuity of care.

When a person arrives at the hospital, like we talked about, their

health status has been going on for a long time. So we network with the family docs in the area, which there is a shortage, and in the clinics. Many people don't have primary care. So we're trying to outreach more, as Linda mentioned, with the medical home, which we are beginning that process, trying to ensure continuity of care, because by the time they come to the hospital, many processes have gone on that sometimes can lead to bad occurrences.

So what we're doing in medical education is training our physicians, one, not only to just treat the patient at this point in time, but it's preventive medicine, trying to prevent events from happening, and that's the basic. Everyone talks about getting their cholesterol, but before that, safe areas, identify safe areas for activity, better food for them, healthier food. I mean, that's all primary prevention. And we hopefully will be able to network

better with our community leaders. I have two of my residents here today, because they want to be involved, to help work with you all to help our community, to network, to partner, and that's what we're trying to do. We've very involved with community health education, and to me, that's the ultimate in prevention, try to keep people healthy, not come in when it's the last resort.

So that's what we're doing in medical education, working with our case managers to try to provide people their needs, whether it's home equipment, oxygen. People who live by themselves, you know, a lot of times we're discharging patients and that's what the insurance companies want, but we have to ensure that they have someone at home to help them, and that's where our case managers and social workers come in, arrange home healthcare. And our residents are very aware of that. So it's ensuring a continuity of care, not

just for when they arrive, but for when they go home, and the whole idea is to try to keep them as healthy as we can.

COUNCILWOMAN SANCHEZ: Thank you.

I again want to personally thank you, Linda, and all your team. I know immediately after the incident, we had communication. You guys were available, have always been available, have been taking the advice and the suggestions. So I want to thank you and pledge my continued support to working with you in improving the healthcare in Frankford.

Thank you.

MS. WILSON: Thank you very much.

COUNCILWOMAN TASCO: I just want to follow up on the question that I asked earlier about your overall system. Are you looking at best practices and the prevention of anything like this in the other hospitals under yours? I assume

you're a supervision.

MS. WILSON: Our entire healthcare system is under one provider number. We have one governing Board of Directors. We do have a centralized management team, of which I'm a part of, and then we have a de-centralized management team at each campus. Whenever we have a best practice at one campus, we transfer that best practice to another campus. And we also don't live in isolation. We understand that there are best practices across the nation that we can glean from, and we look for those on a regular basis. And, in fact, immediately after this event occurred, I called two of my former colleagues who are at Dartmouth and they are emergency room experts, and one of them is a trauma surgeon, the other is an industrial engineer, and asked for some of their advice and some of the best practices they've seen in their consulting business across the nation.

So we're not going to insulate ourselves and say, Well, we know best within Aria. We certainly do not, and we take our advice from various parts of the country to benefit the community that we serve.

The other thing that I do want to mention is, it really matters not whether you're in the Bucks County community, whether you're in the Torresdale community or you're in the Frankford community. We give our best practices in all three of our campuses, and as I mentioned, we strongly financially support the Frankford Campus from the work at our other campuses.

COUNCILWOMAN TASCO: Thank you very much.

Councilwoman Brown.

COUNCILWOMAN BROWN: My final question, the purpose of this gathering again was to look at best practices and to learn from what they are. What is your number one takeaway? What's your

number one lesson learned as an institution? We've heard of the very specific recommendations you are implementing, but what's the biggest takeaway for you and a lesson learned for other professionals in leadership positions in hospitals around the City?

MS. WILSON: Well, with all due respect, our biggest lesson was that the City is changing in a far rapid rate than we anticipated and that the need for security and the need for us to realize that our security has to be tight as a drum was really a significant eye-opening experience.

If you walk into the Aria Frankford Campus, you're walking into an oasis of people and love and attention, and you don't really realize what's happening on the outside -- in the outside communities. And so that was probably the biggest eye-opening experience, was the significant need for security, something that we have tried to

address in other ways and now have to address, as many inner cities hospitals have to address. But as far as internal process -- and I'm sure that's really what you were getting at.

COUNCILWOMAN BROWN: Well, it can be either. It could be external or internal, because both of them have bearing on the operations.

MS. WILSON: Yes. Yes. So our most -- my most significant eye-opening experience certainly was the need for security. But I'll also comment on the internal piece as well.

Our eye-opening experience internally is that we need to -- and we constantly look at our flow and we constantly flex. When Northeastern closed and we saw a 30 percent increase in patients, we increased our staff, we looked at additional hours, we reacted very, very well. And we've looked at our data over time and you can see on the graph where Northeastern announced their

closure and when they closed. The impact on our hospital was direct. However, one of the eye-opening experiences that -- the flow is also a critical area as well -- is that we need to attend not just to the increase/decrease in staffing and services and hours, but we also need to look at the flow.

And, finally, the other eye-opening experience is that sometimes the requirements that we are under from a regulatory standpoint, while they protect us and protect our patients, sometimes inhibit that flow, and how do we address that as an organization. It takes incredible creativity and incredible attention to quality always as number one, and I can tell you that the staff at all three of our campuses, we do have -- someone mentioned a report card earlier. We have probably a dozen internal report cards that we consult on a regular basis, I myself on a daily basis, and we are constantly attending to quality. But we

need help. That was probably another eye-opening experience, we need the community, we need the federal government, we need our state government. We need a constant attention to what the challenges are within emergency medicine.

COUNCILWOMAN BROWN: I thank you all for your testimony. Thank you very much.

DR. DANOFF: Thank you.

MS. WILSON: Thank you.

COUNCILWOMAN TASCO: Thank you all very much for your testimony.

The next panel will be Pamela Clarke, Delaware Valley Healthcare Council; Dr. Nicholas Tsarouhas, Children's Hospital; Al Black, University of Pennsylvania Health System; Dr. Carl Chudnofsky, Albert Einstein; Larry Foster, City of Philadelphia Fire Department.

(Witnesses approached witness table.)

COUNCILWOMAN TASCO: Thank you

very much. Okay, Ms. Clarke.

MS. CLARKE: Good morning, Chairwoman Tasco. I am Pam Clarke. I'm the Vice-President of Healthcare Finance and Managed Care for the Delaware Valley Healthcare Council of HAP. DVHC represents and advocates for more than a hundred acute care, pediatric, rehabilitation, behavioral health and specialty-care health systems, hospitals and facilities and the patients here in Southeastern Pennsylvania. DVHC is part of the State Hospital Association that represents more than 250 acute and specialty-care hospitals and health systems across the state.

I'm a Philadelphia resident. I work here in Center City. And I appreciate the opportunity to testify today about Philadelphia hospitals' commitment to providing the best possible healthcare for their patients and communities. I realize you have a copy of the full testimony that we have

submitted in writing. I will abbreviate my testimony and highlight aspects of it, and I trust that my esteemed panel will also illustrate for you the best practices at their individual institutions.

COUNCILWOMAN TASCO: Thank you.

MS. CLARKE: My testimony will provide an overview of guidelines and regulations pertaining to hospital emergency care, the patients and communities served here in Philadelphia emergency departments, the wide array of services and high level of care provided, challenges hospitals encounter and innovations hospitals have employed to ensure that the patients are treated to the best of the hospitals' ability.

Hospital-based emergency departments represent a crucial and essential component of Pennsylvania's healthcare system. Each day an average of 2,500 people seek medical care in Philadelphia's 15 emergency departments,

the only healthcare resources in the City staffed 24 hours, seven days a week and equipped to respond to patients with widely differing types and severity of medical conditions and injuries. About 20 percent of these ED visits result in hospitalizations. What does that mean? Many Philadelphians rely upon emergency departments as their primary or sole medical care providers due to economic constraints and/or limited access to primary care, psychiatric and other specialty physicians. Emergency departments truly represent the safety net for medical care here in our city.

As part of their mission and what has already been described by those who testified previously, hospitals are under federal law called EMTALA, Emergency Medical Treatment and Labor Act, in which they are required to screen and stabilize all patients regardless of their ability to pay. Philadelphia hospitals embrace this responsibility.

2/2/10 - PUBLIC HEALTH - RES. 090915

In addition to caring for all who turn to them, hospitals devote additional resources, such as financial counselors and social workers, to help patients as needed with insurance options, financial assistance and social services. As you already heard from Stacey Mitchell of the Pennsylvania Department of Health, that is the entity that governs the licensing and regulation of Philadelphia hospitals, including their emergency departments. Hospitals must have established procedures whereby the ill or injured person can be assessed and either treated, referred to an appropriate facility or discharged as indicated. The Department evaluates hospitals every two years through their surveying process, and their surveys include surveying emergency departments for compliance with their regulations.

Hospitals in Philadelphia have voluntarily sought and achieved accreditation by The Joint Commission.

2/2/10 - PUBLIC HEALTH - RES. 090915

This independent, not-for-profit organization certifies more than 17,000 healthcare organizations and programs in the U.S. Joint Commission accreditation and certification is recognized as a symbol of quality and safety that reflects a hospital's commitment to meeting certain performance standards. We are proud that Philadelphia hospitals have achieved this certification.

But beyond meeting the stringent licensing and certification requirements, emergency department physicians, nurses and administrators in their quest for excellence review and adopt guidelines developed by highly respected organizations such as the American College of Emergency Physicians and the Emergency Nurses Association. In 2003, these organizations endorsed triage scale standardization, stating that based on expert consensus of currently available evidence, quality of patient care would benefit from implementing a

2/2/10 - PUBLIC HEALTH - RES. 090915

standardized emergency department triage scale and acuity categorization process. Philadelphia hospitals have adopted this five-stage scale, and some of the physicians on the panel can talk about their triage process in more detail.

We have eight hospitals here in the City that have emergency departments but also are trauma centers. These facilities must adhere to requirements and standards set forth by the Pennsylvania Trauma Systems Foundation. The average Pennsylvania trauma center spends 1.35 million a year on equipment, staff, training and education to meet the standard for compliance for accreditation.

Who are the patients served by Philadelphia's 15 emergency departments? As you're aware, Philadelphia has a racially and ethnically diverse population of nearly 1.5 million. Close to 1 million of these individuals are on public assistance, which means that they

are covered by either Medical Assistance or Medicare. About 335,000 have commercial insurance. Nearly 160,000 adults and children have no health insurance.

Why is this important? Nationwide, visits to the ED by Medicaid and uninsured is increasing twice the rate as commercially insured populations. Philadelphia's population is aging. Among the nation's ten largest cities, Philadelphia has the highest proportion of residents more than 65 years old. Older adults use far more healthcare than other groups.

From cut fingers and earaches to Level I traumas and full-scale disasters, the City's network of emergency rooms and trauma facilities must be ready to care for anyone and anything. According to the American Hospital Association, a typical urban emergency department can expect to see and must be prepared to treat well over

1,500 conditions. Respiratory infections, viral infections, asthma, stomach pain, alcohol abuse and pneumonia are among the most common conditions treated. Behavioral health visits are on the rise. Nationally, about 70 percent of all ED visits are emergent, urgent or semi-urgent. About 15 percent are non-urgent and 15 percent are uncategorized. According to the Centers for Disease Control and Prevention, recommended times to treatment range from within 15 minutes for the most emergent to 24 hours for non-urgent conditions.

In addition to the fundamental role of being ready and capable of treating virtually any health emergency, hospitals and their emergency department must meet two other key needs. On the one hand, for Philadelphians, emergency departments function as the access point for healthcare and even social services, providing basic primary care, chronic care and other assistance. On the other

hand, especially since the tragic events of 9/11, hospitals play a key role as first or near first responders in case of large-scale accidents, natural disasters, epidemics and terrorist actions.

To fulfill their mission of caring for all who come through their doors, hospitals have invested in innovative ways to provide the right care at the right time in the right setting. Most Philadelphia emergency departments have or are creating "fast-track" or urgi-center type facilities within or near their emergency departments to provide the appropriate care for health needs judged less urgent or less complex during triage. And other members of the panel will talk more about "fast-track" systems.

Pennsylvania does not have public hospitals that receive direct financial support from government such as exist in other municipalities and other states. As a result, much of the

responsibility for providing healthcare service to un and underinsured Philadelphians falls on the City's emergency departments.

The particular challenges are: The demand for emergency care is rising. The number of emergency departments is decreasing. And in addition to that, many aspects of emergency care are underfunded.

Here in Philadelphia, from 1997 to 2007, ED visits increased nearly 25 percent, while the number of EDs decreased by more than 40 percent. In the five-county region, visits increased nearly 25 percent, while the number of EDs decreased by nearly a third. One factor driving this increased utilization is the growing shortage of access to primary care services.

The other challenge faced by hospital EDs is chronic underfunding. As safety nets for the un and underinsured, emergency departments often provide care

free of charge or, in the case of Medicaid, at below cost. On average, Pennsylvania hospitals are reimbursed 82 percent of the cost of services provided to Medicaid patients. In other words, hospitals lose 18 cents on every dollar of care provided.

These funding challenges contribute to the thin profit margins of Philadelphia hospitals. In Fiscal Year 2008, three out of four Philadelphia hospitals had negative total margins. In contrast, the Pennsylvania ambulatory surgical centers on average enjoy total margins of more than 26 percent. These facilities specialize in providing good-paying elective diagnostic and surgical care and cater to patients with commercial insurance, but depend upon hospitals' emergency departments to provide emergency care if complications develop.

Finally, I just want to say that hospitals constantly strive to

improve the health and healthcare of their communities, finding new ways to deploy their resources more effectively, with the goal of providing the best possible healthcare for their patients. For hospital emergency departments, this has meant investing in innovative technology, programs and services to develop the capacity to serve more patients and provide patient education and preventive healthcare to avoid unnecessary health emergencies.

The EDs of Philadelphia are committed to providing the best care possible for all who come through their doors. Thousands of physicians, nurses and other healthcare professionals dedicate themselves to providing excellent, efficient emergency care 24 hours a day, every day of the year.

Thank you.

COUNCILWOMAN TASCO: Thank you very much.

Dr. Nicholas --

2/2/10 - PUBLIC HEALTH - RES. 090915

DR. TSAROUHAS: Tsarouhas.

COUNCILWOMAN TASCO: -- Tsarouhas.

DR. TSAROUHAS: Hello. My name is Dr. Nicholas Tsarouhas. I'm the Associate Medical Director at the Children's Hospital of Philadelphia Emergency Department. Thank you very much for giving me the opportunity to speak this afternoon.

What I just want to do over the next few moments is just review some of the best practices that we've identified at our institution for the optimal care of patients presenting to the emergency department, specifically at the front end and those patients who actually come to the emergency department to be triaged initially and their waiting times.

I actually worked yesterday evening and witnessed some of these myself. I actually told the nurse just go ahead and do her thing. I wanted to watch them actually do that, and I saw

many of these practices in action.

The first and most important thing is, as soon as a patient presents to the emergency department, they go up to a desk and literally ask -- they're giving their name. There's a new position that we've created, a patient access coordinator, who is a nurse, who actually watches the whole process of registration, and she literally is as the patient is presenting their name and some very brief demographics to a registration clerk, the nurse is immediately assessing the patient, and simultaneous with that registration, she is assigning a triage level.

We employ, as was previously mentioned, the five-level triage. That includes critical, acute, two levels of urgent and then one non-urgent category that I can discuss later, if need be. But immediately, that first quick triage nurse is identifying a patient's acuity simultaneous with the registration.

And also extremely importantly, even in that very brief demographic collection of information, the parents are immediately told that you've been assigned this particular category. If anything changes at any point, if you feel the need at any point to have your child reassessed, please come right back and we'll repeat this procedure again. So everyone is told multiple times by the staff members that if you feel that your child has changed in any way, please come on right back to the desk and we'll have a nurse reassess your child.

So after that very initial quick triage by the patient access coordinator and that brief demographic information is collected, the patients go into the waiting area. Then by level of that very initial five-point triage assessment, they're called into the more formal triage assessment, and this is, I think, what we're more conventionally used to where the family and the patient

come, they sit in a booth and the nurse will go through and she'll do their vital signs, she'll do their general assessment, she'll ask a series of questions and then she will assign the formal triage assessment, again, using that five-level scale that we talked about. And she may upgrade the patient, she may downgrade the patient, she may leave it the same. But, again, the most important thing is, after that assessment - critical, acute, urgent or non-urgent - the patient is again told, the mother or the father told, Please go on back to the waiting room, we're going to call you in the level of -- based on your acuity, but, most importantly, should you feel that your child has changed in any way or needs to be reassessed, please come on right back to me. And the nurses have really stressed that. They'd like for the families to come back to the nurses that have formed that relationship so they can say, Oh,

yeah, I remember you, I saw you five minutes ago, what's changed, how can I reassess your child particularly.

Very important too, I'll add that we've instituted a language line that we have in triage and actually in all of our patient care rooms now. There's a line where any family can be spoken to regardless of whatever the language is. We have these very special two receiver phones where you can request any particular language and immediately we can get a trained professional translator to communicate with any family again, and that's in triage as well as in the regular patient care areas.

We do have a very systematic approach to reassessment. I know that's been brought up many times this morning, where patients will in fact be reassessed at standard intervals, and that's, again, depending on their triage category, but there is a nurse who is constantly circulating in our emergency department

waiting area who is very cognizant of the different levels of triage that have been assigned and they will do those periodic reassessments. As I say, there's a continual reassessment that's going on all the time, because she's visually walking through the emergency department waiting area, but then we have very strict protocols that mandate the more formal triage, vital signs, et cetera, at certain periods depending on their level of acuity again.

Once they are triaged, called through, we have several different layers of emergency department care. I think we've talked about urgent care already this morning. We do have an on-site urgent care area in our emergency department, and about 25 percent of patients overall who present to CHOP over the course of a year are seen by our urgent care physicians, usually staffed by pediatricians, but in some cases pediatric emergency medical physicians as

well. But you'll be ultimately placed in one of four or five different medical teams that simultaneously function depending on the time of day, but, again, one of those is in fact an urgent care area.

We also have, especially now in response to the H1N1 epidemic that we just went through, we created yet another new team that is a different acuity team that is managing slightly lower acuity patients but, again, on site in response to the increased volumes. And it was so successful during the H1N1 epidemic that we have chosen to keep that practice and we've actually reached out to our primary care physicians to help us staff that, and now we have a very nice joint partnership between the pediatric emergency medicine physicians and the pediatricians throughout the hospital, as well as our primary care physicians offsite, and we jointly staff this lower acuity onsite, I would say, urgent care

area even though we're not in the H1N1 epidemic.

We have a series of initiatives that we have, again, worked through our primary care people to try and introduce some initiatives outside of the emergency department itself, and we're working with our primary care people to increase their ability to have expanded telephone hours and expanded services at their remote sites as well. So we're trying to help serve the population in the areas where they're used to seeking care, as well as in the emergency department at CHOP.

We also have a full capacity protocol. Matter of fact, I was just paged two hours ago, that we have invoked it once again because our volumes have gone up, and that's in conjunction with the Department of Health, and that is a very formal process by which we now, on an emergent basis, will temporarily use non-traditional places to care for patients as an inpatient setting, and

it's very clear where patients can be cared for and who may care for those patients, and the Department of Health has given us very specific guidelines on how many beds we may open. And very importantly I think, especially to emergency department providers like myself, it's tied to several different features, but, most importantly, one of them is in fact the number of patients presenting to the emergency department per hour. So if it's a situation where we have a huge deluge of patients presenting at the same time and the waits are backing up, we can in fact invoke this full capacity protocol to decompress the patients who are waiting, as we call boarders, in the emergency department to be admitted to the inpatient area. So that's tied to emergency department flow as well as hospital census. So there are several triggers that actually will allow the teams upstairs to increase their bed capacity as well as staff capacity as

well. And our residency program has instituted a series of protocols where they too will increase their staffing to open up emergency teams with nursing components to go along with that.

I think the last thing that I'll highlight is that at the administrative level, we can have nothing but praise for our staff. I'm actually one of the leaders for our patient flow initiatives at the hospital as well, and administration has been hugely behind all of these safety initiatives, and patient flow is a very important feature that the hospital looks at. And specifically, we have our institutional safety dashboard. That is reviewed at the very highest level by our CO and our COO and our Board, and we now have our patient flow metrics, as well as things like "left without being seen," which are national measures of quality for emergency departments, that are held in very high importance by our administrative staff.

So as we who work on the front lines always say, Nothing that we do can't be really successful without strong administrative support, and I think that we're very fortunate at our institution at the Children's Hospital of Philadelphia to have a really good backing by the administration to help us keep our patients safe.

COUNCILWOMAN TASCO: Thank you very much.

Mr. Black, would you like to come to the table, please.

MR. BLACK: Thank you, Chairwoman Tasco and members of the Public Health and Human Services Committee for inviting Penn Medicine to testify today at this hearing on emergency medical services. My name is Al Black and I'm the Chief Operating Officer for the Hospital of the University of Pennsylvania, HUP. HUP is one of three Penn Medicine hospitals located within the City of Philadelphia.

2/2/10 - PUBLIC HEALTH - RES. 090915

My comments today will focus specifically on our triage protocols, as well as steps that we have taken to deal with the ever-increasing volume of patients that we see in our emergency department. Collectively, Penn Medicine hospitals provide over 116,000 emergency patient visits each year. At HUP, we see about 59,000 of these patients.

Let me start by saying that there is no doubt that all hospitals across the country are facing tremendous challenges related to the growing utilization of our emergency services. HUP provides emergency care for a vast array of patients, and we're also a Level I trauma center caring for major victims of trauma.

Unlike your typical doctor's office, there are no appointments and there's no real way to predict who will walk through the door on any given day. As a result, our emergency department must triage patients based on the

severity of their medical condition at the time they arrive. This is our only standard.

All patients are treated regardless of their ability to pay, insurance status, citizenship or socioeconomic factors. A patient's prioritization is only related to how sick or injured they are when they arrive.

Please give me an opportunity to talk about specifically how we triage patients at HUP.

When patients arrive at our emergency department, they are first met by a trained intake staff who enters the patient's name, date of birth and chief complaint into an electronic system. Triage nurses review and continually monitor the electronic log-in in realtime and can quickly identify and prioritize patients who have high risk complaints such as chest pain.

Patients are then evaluated by

a trained triage nurse who assesses patient vital signs, symptoms and the reason they came into the emergency department.

All of our ED nurses are trained in emergency care, and additional training is provided to those who work in triage.

During times of high volume, we also have the capacity to initiate additional diagnostic tests in the triage area itself. This could include things like EKGs and basic lab work.

The HUP Emergency Department also uses the Emergency Severity Index, ESI, which has already been mentioned here previously. In this categorization, highest priority patients, Class 1, who need immediate intervention are seen first, and this constitutes about one to two percent of the visits at HUP. The next largest categories are 2 and 3, which represents about 64 percent of our patients. Patients with less complex

medical conditions such as ankle sprains or lacerations are seen by our medical professionals in our "Fast Track" Department, which is adjacent to our ED and has a capacity of eight rooms. Last year we saw approximately 10,000 patients in this area.

The patient waiting room is continually monitored by our nurses who have direct visualization of the area. Additional nurses are assigned to help monitor patients in the waiting room during times of high patient volume. If a patient is called and we have pagers for a patient and they do not respond, our protocol is to ask security or the ED intake for assistance in locating the patient. The security officers are also trained to look for signs of patients in distress and to alert the triage nurses in such cases.

Recognizing the growing demand for emergency services, Penn Medicine has taken a number of steps to reduce

crowding in our emergency department, and this is a particular challenge for us because on most days, our occupancy is well above 95 percent. Some of the things that we've done is that we've created within the emergency department an eight-bed Clinical Decision Unit, and this unit is located within the emergency department 24 hours a day, seven days a week to manage patients that may need a bed, but we don't have an available bed upstairs.

We also have what we call flex beds, and these are other locations in the hospital that we've worked with the State of Pennsylvania on to use in those situations where beds are not generally available, but we can create them as beds when we get overcrowded.

And most recently, in the fall of this year, we opened a 17-bed Transition Unit, and this is like an inpatient unit, except that it's located next to our emergency department, and we

open and close this unit based upon demand in our emergency department.

In addition to what we've done at HUP, both Pennsylvania Hospital and Penn Presbyterian Medical Center have recently remodeled their emergency departments as well. Even with these improvements, however, we continue to face challenges related to emergency department overcrowding, principally because there is insufficient availability of primary care physicians. Patients might express concerns about the wait times they encounter, but it is important to know that the protocols and practices that we employ are there for a reason, and, that is, to ensure that those patients needing life-saving care are seen first.

On behalf of HUP, I want to thank you for holding this hearing, because I think it's important to make the general public aware of hospital triage practices so that when they're

waiting in the emergency care, they have a better understanding of the process.

Thank you.

COUNCILWOMAN TASCO: Thank you very much for taking time, all of you, for taking time to come over and share what your process is at the various hospitals.

Now Dr. Carl Chudnofsky.

DR. CHUDNOFSKY: Good morning.

With humanity, humility and honor, to heal by providing exceptionally intelligent and responsive healthcare and education for as many as we can reach, this is the mission of the Albert Einstein Healthcare Network, a mission that every employee strives to realize every day.

COUNCILWOMAN TASCO: Would you identify yourself for the record.

DR. CHUDNOFSKY: My name is Carl Chudnofsky and I am the Chairman of the Department of Emergency Medicine at Albert Einstein Medical Center. I would

like to thank the City Council of Philadelphia, especially Chair Marian Tasco, Vice-Chair Donna Reed Miller and Councilmember Maria Quinones-Sanchez, who represents the districts serviced by Albert Einstein Medical Center, for giving us the opportunity to testify this morning and to share with you some of the innovative programs and extraordinary care that's provided in our emergency department every day.

The ED at Albert Einstein Medical Center cares for almost 90,000 patients per year. We are very proud to serve such a diverse and culturally rich community.

We have a staff of highly trained and experienced Board-certified physicians, nurses and technicians that provide care 24 hours a day, seven days a week. The use of high-tech equipment and technologically advanced systems such as our patient tracking system helps us to provide high quality care and service.

The tracking system uses infrared technology to passively track both patient and staff movements throughout the ED, time-stamping all interactions and important time intervals. This system provides extremely accurate data that allows us to critically appraise patient flow processes and important operational activities.

Let me share with you some examples of how Einstein team work and the ability to think outside the box has made us one of the top providers of emergency care in the Commonwealth.

When patients arrive in the ED, they are greeted by a member of our Protective Services Department. These hand-picked officers receive special training to work in the ED setting. There are two officers stationed in the ED 24 hours a day. In addition to these officers, the waiting area is under constant surveillance by way of strategically placed security cameras.

2/2/10 - PUBLIC HEALTH - RES. 090915

After patients sign in for care, they are triaged by a highly trained and experienced ED nurse. We also use the five-level ESI system to help prioritize care. The triage area is directly across from the waiting room, giving the triage nurse rapid access to all patients waiting to be placed in an exam room. Last year the time from patient arrival to evaluation by the triage nurse averaged only 12 minutes. Our efficient triage process has also resulted in timelier physician evaluations. Last year, the time from patient arrival to evaluation by one of our emergency physicians averaged less than 50 minutes.

Like many EDs in Pennsylvania and across the country, we have found that the leading cause of emergency department crowding is boarding of admitted patients in the ED due to a lack of readily available inpatient beds. Length of stay; that is, the length of

time a patient remains admitted to the hospital, is a critical determinant of inpatient bed availability. Several years ago a hospital-wide initiative was begun to help reduce the length of stay at Einstein. This initiative resulted in a significant reduction in our length of stay and helped reduce ambulance diversion to less than ten hours per month last year.

Let me also describe a recent example of how Einstein uses non-traditional approaches to save lives. It is well known that quickly opening a clogged coronary artery in the cardiac cath lab is the optimal treatment for patients having a severe heart attack. Prognosis in these patients is directly related to the Door to Balloon time, which is the time from patient arrival in the ED until a cardiologist threads a catheter into the clogged artery to restore blood flow to the heart. The national Door to Balloon time goal is 90

minutes.

At Einstein, we have instituted a number of successful strategies to meet this goal. Most recently, we created a "Stat EKG Room" at the walk-in entrance to the ED. When an appropriate patient presents with chest pain, an ED tech does an immediate EKG and walks that EKG directly to one of our attending physicians for review. This saves precious minutes. Over the past eight months, we have met the Door to Balloon time goal of 90 minutes or less in over 95 percent of our patients.

At Einstein, we also do our very best to provide services to those individuals in our community with less acute medical problems, as well as those with social problems who may not be able to access care or services elsewhere.

We have a separate Fast-Track area that provides care to patients with lower acuity problems so that they do not have to wait to be evaluated in the main

ED, where most patients require more intensive and time-consuming treatment. A major goal of our Fast Track is to evaluate patients in 90 minutes or less, a goal that we consistently achieve.

For those patients with more chronic problems and difficult social issues, we have both care managers and social workers available to help. Care managers are nurses who help patients manage chronic medical problems. They assist with home care needs, medications and follow-up care. Social workers provide a myriad of services to our patients and their families. From prescription medications or a ride home to arranging counseling for a troubled youth, our ED social workers are always there to help.

In the last few minutes, I've tried to demonstrate how team work and innovative thinking has made Einstein Medical Center a premier provider of healthcare in our region. I am

particularly proud of the men and women providing care in our emergency department, who work tirelessly every day, often under difficult and stressful conditions, to meet the needs of the community we serve. These individuals are the true heroes in healthcare. They emulate our namesake, Albert Einstein, and the vision of our network: "Einstein brilliance and compassion in all we touch."

Thank you.

COUNCILWOMAN TASCO: Thank you very much for your testimony. I usually don't like to make personal references to these hearings, but I will say that I had the use of your emergency department once and I thought I was getting special treatment. Now I know you do it for everybody.

DR. CHUDNOFSKY: I'm glad to hear that. Thank you.

COUNCILWOMAN TASCO: They had hardly finished registering me before I

was in the room. So it was really good. So thank you very much. We appreciate you. You are in my district, but I have a respect for all of the hospitals in the City of Philadelphia. Thank them for providing services to the residents, our citizens in this city, and we certainly understand the challenges that you all have in the current health environment. So we thank you all for your services.

I only have one question. You might not want to answer this. When we have this national debate on healthcare, national healthcare bill reform, where were you all in terms of that legislation or where are you? Because during the course of the testimony today, we heard a lot about cost, lack of funding and certainly a number of uninsured patients.

MS. CLARKE: Certainly. The Hospital Association is in support of healthcare reform and have advocated to the extent, particularly supporting the extended coverage for citizens across the

United States, because we think it's critical that all Americans have health insurance. We do believe that coverage will improve access, particularly to preventative care services, as has been testified to here this morning and early this afternoon, that unfortunately sometimes patients who don't have insurance or citizens who don't have insurance will not seek care that they need on a preventative level, and so then unfortunately they might end up needing more serious services because complications develop. And so we are in support of extended coverage.

COUNCILWOMAN TASCO: Thank you very much. Thank you for your testimony and taking time to stay and to listen. Thank you.

Next we'll have Philadelphia's finest, Mr. Foster and Lieutenant Ackerman from the Fire Department.

(Witnesses approached witness table.)

2/2/10 - PUBLIC HEALTH - RES. 090915

COUNCILWOMAN BROWN: Good afternoon, gentlemen. Good afternoon. If you would please state your name for the record and --

MR. FOSTER: Yes. Good afternoon, Madam Chair Tasco and members of the Committee on Public Health and Human Services. My name is Larry B. Foster. I'm the Emergency Medical Services Administrative Chief and I am here to testify on behalf of Commissioner Lloyd Ayers regarding Resolution 090915, which was introduced by Councilwomen Reynolds Brown and Quinones-Sanchez. With me is Paramedic Lieutenant Brian Ackerman.

This resolution authorizes Council to hold hearings on emergency room procedures and protocols, and as such, I have been asked to outline the Fire Department's procedures utilized in transporting patients to a medical facility. The Fire Department's protocol is as follows:

2/2/10 - PUBLIC HEALTH - RES. 090915

A call is received by a 9-1-1 call taker located in the Fire Communications Center. The call taker elicits the necessary information such as the address, nature of the call and provides instructions to the caller, if needed. The information is then sent to the dispatcher simultaneously to ready EMS for immediate response.

The dispatcher analyzes the system for available resources and dispatches the appropriate units, including medic units and first responder companies.

Upon receiving the dispatch from the Fire Communications Center, the units respond to a designated address to render assistance while maintaining communication availability with the Fire Communications Center to receive updates and instructions.

Upon arrival to the location, the EMS personnel locate the patient and begin to assess and consider appropriate

interventions based on PA state protocols and Fire Department procedures.

EMS personnel, based on patient assessment and a hospital capability list, determine which hospital the patient will be transported to, which would be the closest appropriate hospital.

Upon arrival to the hospital, the patient is taken into the emergency department. The EMS employee provides an oral report to a nurse, who makes the decision on where the patient is placed. Most hospitals use a charge nurse to make the decision and some hospitals use the triage nurse for this determination.

The patient is then transferred from our care to the hospital's care. We then receive a signature from the nurse on our Mobile Data Terminal to complete the transfer.

After the patient is transferred to the hospital personnel, the EMS employee completes a Patient Care

Report electronically, and the unit is made ready for service. The medic unit either returns to the station or responds to another call.

Every hospital has a user name and password specific to their facility to access a secured website to obtain the completed Patient Care Report.

I'd be happy at this time to answer any questions, if there be.

COUNCILWOMAN TASCO: Councilwoman Sanchez.

COUNCILWOMAN SANCHEZ: Thank you.

In light of the situation we're talking about, Mr. Rivera, had Mr. Rivera called 9-1-1 and had been picked up, what would have happened between the time you picked him up in the hospital?

MR. FOSTER: Well, according to the testimony that I've heard to date from the hospital at Aria, they would have went right back to the treatment area, would not have been in the triage.

2/2/10 - PUBLIC HEALTH - RES. 090915

COUNCILWOMAN SANCHEZ: What type of assessment do you do en route to the hospital?

MR. FOSTER: The assessment that we do starts immediately upon the arrival of the patient. We take a general impression, then we take the vital signs. Also the first thing is, we ask the patient or a bystander just what the chief complaint is and what the patient called us for, and then we have protocols that govern all of our action depending on what we find.

COUNCILWOMAN SANCHEZ: So you would have taken his pulse, his vital signs, all of that?

MR. FOSTER: That's absolutely correct.

COUNCILWOMAN SANCHEZ: During the trip to the hospital?

MR. FOSTER: And reassess, depending how long the trip to the hospital would take.

COUNCILWOMAN SANCHEZ: Thank

you.

COUNCILWOMAN TASCO: Thank you so much for your testimony. Thank you for coming.

MR. FOSTER: Thank you. It's a pleasure.

COUNCILWOMAN BROWN: Excuse me, sir. Do you have testimony?

LIEUTENANT ACKERMAN: No. My name is Lieutenant Brian Ackerman. I was here to answer any questions you may have.

COUNCILWOMAN BROWN: All right, then. Thank you both.

MR. FOSTER: Thank you.

COUNCILWOMAN TASCO: The next panel would be Dr. Karen Sarpolis, Margaret Robinson, Lisa McGarrigle Vanderwoude.

(Witnesses approached witness table.)

COUNCILWOMAN TASCO: She's going to make her presentation first.

DR. SARPOLIS: Hi. My name is

2/2/10 - PUBLIC HEALTH - RES. 090915

Dr. Karen Sarpolis. I'm a former ER physician and a women's health advocate, but today I'm mostly here as a mother, because my daughter died after a 9-1-1 call when I was living in the Philadelphia area while I was pregnant. And I'm going to talk about what's supposed to happen when somebody walks into an emergency room.

First thing is supposed to happen is triage, and I'm kind of surprised to hear some of the comments here, because in the rest of the country -- I'm a transplant from the midwest -- that's supposed to take place within zero to two minutes. It's supposed to be almost immediate as you hit the door. You get registered, very minimal information, and you go right to triage.

What triage is is a short history and physical that's sufficient to determine the maximum amount of time that a patient can safely wait to see the

physician. It is done by a nurse, but a physician in the hospital is ultimately responsible for that exam and for anything that happens out of it.

Most ERs implement one of the standard methods for triage, and I know you've heard about them several times, ESI, the Canadian system, things like that. And that method is usually bolstered by prompts and more detailed protocols that are embedded into the electronic medical records. So as you're pulling up, putting in the patient's chief complaint, you can be prompted and reminded to take certain assessments.

But the most important thing to triage is to put your best and most experienced nurses in those positions. There really aren't any cookbook methods that are going to help you if you're not really familiar with emergency medicine.

And according to law, pregnant women and their babies have to be triaged in the ER if they present there. It has

to cover routine labor, it has to cover problems with the pregnancy, it has to cover any non-pregnancy-related problems. And mom and baby both have to be treated in the same timeframe as other patients according to their level.

At the end of the initial triage, the patient is assigned on a five-point scale, which is no longer there, but I'll talk about it, and that level corresponds to the maximum wait time. As people have said before, there's five levels. It corresponds to the maximum ideal wait time for the patient to see the doctor. And if the wait time ends up exceeding these, which it shouldn't unless you're on one of the lower levels, the patient needs to be re-triaged.

Level I's, those are people who need immediate resuscitation, and we all know who those people are. You don't have to have a medical degree. They're patients coming in by ambulance, they are

people who are being dragged in by their family members, they're staggering in by themselves. This is not rocket science.

The second level is emergent. This is really the highest level that the triager actually deals with in actual practice. And being at risk for rapid deterioration is one of the main criteria that gets you put into Level II. They wait for the doctor back in an ER bed with a nurse. That nurse is supposed to start working on them, taking more history, slapping electrodes on them, putting IVs into them, those kind of things. When they say "time to nurse" on these levels, when they say "time to nurse," they're talking about the nurse in the back. They're not talking about the triage nurse. And what that means is, if they code on you, if they do tend to rapidly deteriorate, if they do actually do that, then a nurse is right there and you start resuscitating them, you defibrillate them, all those kind of

things. So I was really shocked to hear all these comments where they seem to think that registration is some kind of a process where you can safely delay triage. Triage is an immediate process to help you gauge you can safely delay seeing the doctor.

Like I said, I'm from out of this state. This is where I practiced and this is where most of my experience is from. This is what they do in the rest of the country.

So your waiting room is really supposed to be composed of Level III's, IV's and V's. Those are urgent, less urgent and non-critical patients. I mean, I can't believe they're putting tape on the floor to go look for people who are going to code. If I had to put tape on my floor of my ER, it would be in front of the patient bed. You know, that's where the nurse is supposed to be that's looking for the patient who might code soon. People aren't supposed to be

coding out in your waiting room.

And I know a lot of people have mentioned EMTALA, the Emergency Medical Treatment and Labor Act. That requires a medical screening exam. This is very different than triage, and probably one of the biggest mistakes in emergency medicine is confusing these two things. A medical screening exam is an exam by a physician. It's done in the back. It's got to be sufficient to determine that emergency medical condition, whether there is one or isn't one. And the reason we do that is so you can treat them and stabilize them before the patient deteriorates.

So triage really isn't mentioned specifically in the law, but if it isn't done correctly, you don't get the patient to that required, legally required, medical screening exam and stabilization before they deteriorate.

And it is a law. It's not just a guideline or a standard of care or

anything like that. In other parts of the country, the consequences for death by waiting, which is what this is called, and other serious ER violations are $50,000 fines per incident, $1.2 million community restitution programs, court-supervised protocols, criminal charges, murder indictments, threatened or actual expulsion from the Medicare program. So elsewhere in the country not only -- maybe they're tied together. Maybe the reason we're so much more attuned to these restrictions in other parts of the country is because the fines and the penalties are so much worse.

In Pennsylvania, it seems like there's really no consequences. I mean, again, from what I've heard here, they let the hospitals write their own rules, they let the hospitals decide their own punishments, and they put out these safety bulletins that are endorsing actually questionable practices. And I think people in Philadelphia expect more.

They expect much more done. And if the state and federal authorities really can't do it, then perhaps the District Attorney in Philadelphia needs to emulate those in Los Angeles and Chicago and file some kind charges to get these problems under control.

Thank you.

COUNCILWOMAN TASCO: Thank you very much.

Councilwoman Brown.

COUNCILWOMAN BROWN: Please speak to and elaborate on the Chicago -- did you say Chicago and Los Angeles?

DR. SARPOLIS: Chicago and Los Angeles. There was a very famous case like a couple of years ago where Los Angeles hospitals were dumping patients from the ER on skid row. You probably heard about it in the news. The district attorney went in and charged them with things like elder abuse, dependent care person abuse. They had like $2 million worth of fines. They weren't really

fines; they were kind of mandated donations to community organizations to take care of homeless and to take care of indigent people. It was very severe.

In Chicago area, they've used -- they've had murder indictments for death by waiting.

I understand, the state is supposed to be the one that's regulating these laws and enforcing them. Unfortunately, the penalties are about 25 years old. They go back to the beginning of the law. So the maximum fine per incident is $50,000, but when you investigate, you can find more than one incident. And so if you look -- I think I included a link of enforcements throughout the country. They go in for one incident, they may come out with $250,000 worth of fines, because they find a bunch more. And the state and local authorities can also take other action. I'm not a lawyer. I don't know exactly how they do this, but talk to

these people, you know.

COUNCILWOMAN BROWN: Thank you for your testimony.

COUNCILWOMAN TASCO: Thank you very much.

Our next witness is Margaret Robinson.

MS. ROBINSON: Excuse me. Hello.

COUNCILWOMAN TASCO: Pull the microphone to you.

MS. ROBINSON: Hello. Greetings, Chairperson and members of Council.

I lost a loved one in emergency too.

COUNCILWOMAN TASCO: What is your name?

MS. ROBINSON: Thank you for allowing me to speak to you. My name is Margaret Robinson and I have come before you today to testify on behalf of my deceased sister, Diane Robinson. On June the 27th, 2008, my sister called 9-1-1

because she was having difficulty breathing and she had a history of asthma and congestive heart failure. When the paramedic arrived to transport my sister from her home at 5th and Lawrence Street, my sister was able to walk to the ambulance. None of my family members were able to go to the hospital.

It is my understanding that when my sister arrived at Temple University Emergency Room, she was told to wait in the triage room, despite the fact that she couldn't breathe. After about 15 to 20 minutes, my sister stood up and insisted she receive some immediate assistance because she could not breathe. By that time she was escorted to the patient treatment area and she passed away.

My family agreed that an autopsy would be necessary to determine the cause of death, because we were concerned that my sister died after being in the emergency room for such a short

amount of time. Today, our family still questions whether or not my sister would have survived had she received immediate attention when the paramedic brought her in.

The autopsy report and other hospital records do not contain any documents from the EMT report nor did they have any notes from the triage nurse explaining her passing.

I am requesting that the City Council investigate the circumstances surrounding my sister's death. I am concerned that the procedures -- excuse me. I'm so nervous -- be followed when it comes to emergencies similar to my sister.

Anyhow, I have something here stated that when the EMT -- the autopsy from Temple Hospital, when the EMT brought my sister into the hospital, they did not escort my sister in. They dropped my sister off at the emergency door. My sister walked into the

emergency, sat in the triage room and waited there. No one assisted my sister. She had four kids and one grandchild, and all we do is cry, because she was only 52 years old. And I'm trying to find out how did my sister just die like that. Nobody wanted to hear my case, but it took this other guy to pass away and I came here to let y'all know this is what happened to my sister and somebody need to find out what happened to my sister, too.

Thank you.

COUNCILWOMAN TASCO: Thank you very much. Would you stay once the testimony is over. We'll have a chat with you.

Next is Ms. Lisa McGarrigle.

MS. VANDERWOUDE: Yes; Lisa McGarrigle Vanderwoude.

One thing not noted in my written statement is, our experience came out of Aria Bucks County Emergency Room.

Good morning, members of City

2/2/10 - PUBLIC HEALTH - RES. 090915

Council and everyone here. I am here to support Resolution 090915.

The following is our experience during a medical emergency involving my 73-year-old mother who was ambulanced to Aria in critical condition. Sadly, she laid in the emergency bed for over an hour and a half before even an IV line was started on her.

I witnessed one emergency room nurse, Rick, torn between two dying patients. A second nurse with authority over Rick flew through and ordered Rick to prioritize. She flew through a few minutes later and bellowed, "Rick, fallen protocol." I asked Rick what that meant. Disappointedly he replied, Leave the 73-year-old, treat the 20-year-old overdose first.

When Rick was able to scurry from bed to bed, in disbelief, we then worked as a team tandemly. I assisted Rick by locating targeted sites for blood draws, so if Rick could return, we could

utilize what little time he was allowed to spend with her as effectively as possible. By then, her blood was hemolyzed. I now know that means too thick to use for tests.

Rick had to run over to the overdose victim, who was vomiting while on the ventilator. As mom declined, I analyzed what was unfolding, and I yelled, Rick, dehydration?

Rick yelled out to the hall, We need an IV line stat.

Staff ran it in and left it on the counter. Rick briefly returned to redraw blood. Still too thick to use. Rick found the IV task not completed, let alone started. Rick yelled, I need assistance. One nurse returned, hung the IV, inserted it and hurried off.

The third time Rick ran back to draw, it was still unusable. Rick noted the nurse didn't open the IV drip. Aria also missed three breathing treatments in ICU in one day.

2/2/10 - PUBLIC HEALTH - RES. 090915

Aware of obvious staff shortage, we didn't leave her alone. The longer we stayed, the more transparent staff shortage became. Aria is staffed short from professionals to housekeeping.

I witnessed extremely stressed staff run from patient to patient, to the point of confusion and physical exhaustion.

I believe to remedy not only Aria's reputation, but to restore the public confidence, Aria needs to increase staffing.

The only other thing I can say is, I found inexperienced nurses. When I asked Rick what "hemolyzed" meant, he told me he wasn't sure.

Not only that, when she was, first of all, in ICU for four days, they handed her her own suction with a BiPap mask on. What she was suffering from was carbon monoxide poisoning as a result of being a COPD patient on oxygen at home. She had gotten a cold. It turned into

bronchial pneumonia. She was not able to expel the carbon from her body. It took over an hour and a half to get blood that they could draw to find her carbon levels. They put a BiPap mask on her that blows air into your face at 65 miles an hour, put her in an ICU bed. The nurses that came in were dripping with sweat, and in the meantime, she was bringing up phlegm. They handed her her own suction to hold through the mask to be able to suck the phlegm out of her mouth and left. From then on, we stayed.

On the fourth day in ICU, I asked the nurse to please dispose of the original suction tube and the canister in which the debris was left. They never cleaned her face. When we mentioned the fact that there was phlegm all over, they handed us the brush to open and wash her face down. No one ever touched her hair. Regardless of that fact, in less than 24 hours, they stepped her down on a BiPap machine from ICU into a regular bed and

had a social worker that was looking for a rehabilitation center for her. They gave us a list of about four. One of them that was on the top that they were recommending was brand new.

I started going to these nursing homes to see what they were, to see how rehabilitated they were. The first one that I went to, I found out the one they highly recommended had no respiratory therapist on staff.

So in the meantime, my brother was over with the nursing supervisor. When this woman came in, she was the color of a statue. My brother called me. I went to the apartment. They let me in. The police then came. The ambulance came, and she was in such a dehydrated state, they weren't even able to start an IV in the ambulance. I had left with my children with no shoes. We ran out the door to her house. From her apartment -- we all live in the same town -- I went and got my children's shoes, got them

stuff to occupy them at the hospital, went to the hospital, went back into the ER room to find her still laying there on oxygen with nothing else done. I said to my brother, What did they say?

He said that they said that they're going to do tests. And that was it. There was no other staff member that came in to assist that man. Luckily, the overdose victim who had vomited had his girlfriend with him. As Rick is trying to catheterize my mother, trying to get any relief for her, he's screaming to her, Tilt him on his side and he'll be there as soon as he can. Through all of this confusion, no one came in to assist him.

So we kept vigilant, and even in the ICU room, the respiratory therapist would come in, write down her stuff and be called stat to leave. That's how the treatments were missed. As a matter of fact, I believe two of them were even logged, but since my other

brother was there and had witnessed them come in, write it up and be called out, we knew they were not done.

Once we went to the third nursing home, which was the oldest of the few that we were given, that's when I found out they were one of the only rehabilitation places in the area that staffed two respiratory therapists 24 hours a day.

They were sending a woman in desperate respiratory distress, recommending a step-down rehabilitation place that had no respiratory staff.

Luckily, she's still alive to this day, but had not there been family intervention and someone with her almost continuously, I can guarantee you that would not have happened.

They told him to follow protocol, to leave her. There was one nurse between two critically ill patients in an emergency room and it was -- I just couldn't believe. Then when we went into

the regular rooms, they were never dusted. The beds were never cleaned. Housekeeping wasn't done. The same bag of trash stayed in her room for four days until we requested that they come and take it out.

All I can say is, it's been my experience and I can also testify that a friend of mine went to Aria Torresdale in an accident, 25 miles an hour. He hit a tree. They gave him 35 stitches in his mouth, never cleaned his face. He was left basically unattended for three days until they discharged him. Again, family had to stay with him, wash the blood off his face, wash his hair.

It just -- it seemed like in either of the two hospitals if you didn't have family, you didn't stand a chance.

That was my personal experience with Aria.

COUNCILWOMAN TASCO: Thank you very much for your time.

Any comments or questions?

MS. VANDERWOUDE: And thank you for inviting me to testify, because I'll tell you, going through it, it was really hard, and to try and complain and to follow steps and to get supervisors and to keep your track of mind, it was horrendous. It was the most horrendous experience I can recall.

COUNCILWOMAN TASCO: Well, you have the leadership here of the hospital listening to your testimony. I'm certainly sure they would certainly pay attention to your comments and backtrack and try to see what happened.

MS. VANDERWOUDE: Thank you. Again, when I was there, they asked me if I was a nurse, and the only experience I had was as an avid blood donor and first aid CPR and stuff like that that pertained to children, being a caregiver myself.

COUNCILWOMAN TASCO: Thank you.

MS. VANDERWOUDE: Thank you again for the invitation.

COUNCILWOMAN TASCO: Thank you.

MS. VANDERWOUDE: And I can't express how grateful I am that this has come to court. And that's it.

COUNCILWOMAN TASCO: Is there anyone else here to testify on this bill?

Yes. Would you come forward, please.

Thank you all for your testimony.

(Witnesses approached witness table.)

COUNCILWOMAN TASCO: Good afternoon. Thank you so much for staying, and certainly we appreciate your coming in to share with us your testimony. And so would you please identify yourself for the record. Each of you who plan to speak, identify yourself and proceed with your testimony.

MS. GAST: Hi. I'm Susan Gast. I'm a concerned citizen from Philadelphia and I've been on both sides of the coin. I'm sorry for the loss of Mr. Rivera. I

know he was an activist well known in the community, and it's a real loss. And I worked in healthcare as a unit secretary. First the title was Ward Clerk in the emergency room at Nazareth for 23 years, some part time, mainly full time. I was on the floors for a short time as well. And I've also been a patient in the hospital, and I've also lost loved ones in hospitals, my father at Frankford-Torresdale. I don't blame the hospital for that. I do understand how hospitals are.

Do you want me to continue or let everyone else introduce themselves? Continue my testimony now?

COUNCILWOMAN BROWN: You've started, so you can certainly proceed with your testimony.

MS. GAST: Okay. So I can see from both sides of the coin what it's like being a patient. I had good care. And I know how important fire rescue is to get to the scene when someone is

injured or having a heart attack, myocardial infarction, as family members, my mother and father had had, or someone having an overdose.

The hospital that I worked at, I no longer work at. I was trained as a paralegal. I don't work in that field. I don't enjoy working with attorneys. I'm out of work right now, but -- and I also have no health insurance at 51 after my grandparents coming from a foreign country, my grandfather living in a barn when he arrived here.

We still have the same problems going on today. A lot of people coming over from foreign countries for a better life.

We had five people in New York City die from Guatemala. I don't know if they were illegal aliens, green card people or special invitation card members. Fourteen firefighters in New York City critically injured, a baby of two critically injured, a head injury,

with a mother having to throw her out the window of a tenement in New York City, little baby, who may die. Fire rescue there, but unfortunately layoffs there and here as well. And also hospitals closing throughout the country, starting in California, where a lady was left in the waiting room of a hospital there and I think she may have been someone from Mexico with no insurance. I'm not sure. I know she had no insurance and there was a problem with that. She may have been born here. But there was no insurance and there was a problem.

And I know how hard the staff works. When the bigwigs at the hospital, the CEOs that are making six figures or more, are home with their families on the holidays, the staff is there in the emergency room. It's a different breed. Most people in the hospital don't want to work there. Even though they're registered nurses and physicians, they don't -- and nurses aides or even the

ward clerks, they don't want to go to the emergency room. You don't know what you're going to see.

A girl that's pregnant from the prison in active labor, three overdoses on Christmas day with teenagers dragged in. Me, not a nurse, and the nursing staff and the nurses aides having to run out with three stretchers because somebody that I guess got them high drove them to the hospital instead of calling 9-1-1. We had to drag three people out, three teenagers out of a car and their parents don't want to come in.

You know, myocardial infarctions, heart attacks, CVAs, strokes.

We at Nazareth took care of the oldest population in the country. Rhawnhurst with all the nursing homes and the age per capita is the oldest -- was when I worked there for 23 years, I left around 2003 -- the oldest population in the country per capita. Some people live

to 105. A lot of people are do not resuscitate, some the family wants everything done for them, meaning mechanical means of keeping someone alive even if they have cancer throughout their body. They need to be put on a respirator.

Sometimes RNs and physicians and nurses aides are taking care of five people at a time on a respirator, and then they have an overdose, a young person that needs help. A girl from the prison in active labor, you know, this is where she's going to go to have her baby. The maternity ward is closed.

We've lost many hospitals throughout the country, starting in California. Here in this city we lost Philadelphia General Hospital, which was the hospital for the police and firefighters and also for the indigent community. I knew people that worked there that were LPNs at my hospital, now deceased unfortunately, and they worked

there and loved working there.

I know people that worked at Nazareth that work at the VA. I know she started as an LPN and became an RN. All the nurses work all different hospitals, call an agency. They don't just work at one place. A lot of them work all over the City. They work at Jefferson, they work at Penn, they work at Frankford-Torresdale or Frankford-Frankford. I grew up in an area where Frankford-Torresdale is now. It wasn't always there. Nazareth was the closest hospital.

If you collapse, you could have a subdural hemorrhage or a heart attack, if you don't have oxygen to the brain in seven minutes to 15 minutes, I think, brain damage sets in, unless you have a miracle, like some people in Haiti are getting.

Nazareth was too far, but still people had to make due with it. Now we've had -- we've seen so many close:

Parkview; PGH; Kensington; St. Mary's in Fishtown, not in Langhorne where there's more money; Episcopal, other than ER and Rape Crisis Center; Lawndale; St. Agnes with the Burn Center; Misericordia; Women's Medical. I could go on and on. There's more than that, I'm sure. And, of course, Northeastern, where Governor Rendell didn't bother to show up, neither did two senators, one who calls himself a democrat now, named Arlen Specter, who the President, who I campaigned for, is running around the City and State campaigning for, when he did nothing to stop Northeastern Hospital from closing.

And I feel that people, called attorneys, that continue to blame hospital staff when it's the people at the top, not the ER physicians, unless they're truly negligent, and not the nurses. And the LPN schools even closed. One program in the City that was a success was James Martin Public School, LPN School, closed, turned down, put out

of business. A lot of our RN schools closed. St. Mary's in Fishtown, their LPN school closed. Jefferson's LPN school closed. We have CNA programs.

Governor Rendell was supposed to work on the shortage of nurses in this state. We have RN programs that closed. There's an article I have here from yesterday's paper, is it? Sunday, January 31st, "An Ailing Field for Jobs." Many people went to nursing school to get a better job because their companies, maybe their unions, folded. How many companies has this city lost?

When you work in a hospital, it's like a city. There's so many people employed there. It's not just doctors and nurses. There are medical records people, there are billers, there are gift shops, there are dieticians, nutritionists, physical therapists, orderlies, all kind of people, secretaries, of course, the CEO. And we now have at Aria things like massage.

And Nazareth --

COUNCILWOMAN TASCO: Ms. Gast, we have two other people to testify. Could you please try to bring your testimony to a conclusion.

MS. GAST: Okay.

COUNCILWOMAN TASCO: Thank you.

MS. GAST: My conclusion is this: We have legislators who are attorneys. They start out as attorneys mainly, and they've allowed hospitals to close in a city where we were attacked on September 11th, two in Queens, now a third, St. Vincent's, to be overtaken by corporations. And, you know, our country is not corporate America, and Ruding (ph) Corporation wants $300 million to erect a Congo complex that is probably a tax abatement, and, you know, the Continuum Health Partners wants to take this over.

Everything has become corporate in America, and it needs to stop and people can continue to put money in their pockets. People have put money out for

programs for nursing school. We don't have enough physicians trained that are Americans. We don't have enough nurses at all. And any of us at any time could be attacked. We're at war. We have things like Triumph Strollers that when I went to paralegal school at Manor Junior College were supposed to be put out of business.

COUNCILWOMAN TASCO: Ms. Gast?

MS. GAST: They're back to destroy a child's fingers, amputation.

When you work in an ER, if you volunteer there, you can get to see exactly what goes on.

And I just want to end with one thing. One thing I want to say is, 107-year hospital there, 125 at Northeastern. We have a woman at Temple University named Ann Weaver, who I don't see you bringing a suit against her, because the direct cause -- Ann Weaver Hart is the direct cause of killing Mr. Rivera and other countless unknown

individuals, because Northeastern closed. There wasn't enough -- and in LA, we have a man named Bill Cosby who came from the City, who grew up in a project in North Philadelphia --

COUNCILWOMAN TASCO: Ms. Gast?

MS. GAST: -- who went to LA who had --

COUNCILWOMAN TASCO: Ms. Gast, please.

MS. GAST: -- a son named Ennis, and if he was found on the street, if there wasn't enough fire rescue in LA because of cuts and there wasn't a hospital, if he was shot by someone from a foreign country, who probably had a DPA card, unlike millions of Americans don't, then Mr. Ennis Cosby would have lived if he had gotten to a hospital and everyone knew who he was. Regardless of his color, he would have lived if they had gotten him to a hospital in time, and everyone would have been pleased to save his life because he was Bill Cosby's kid,

who grew up from a project.

How many people today who grow up from subsidized projects are going to make it in America with people making everything corporate?

COUNCILWOMAN TASCO: Thank you very much.

MS. GAST: That's all I have to say.

COUNCILWOMAN TASCO: Thank you.

Good afternoon.

MS. SUSAN RIVERA: Good afternoon, Councilwomen Reynolds and Tasco and Quinones. My name is Susan Rivera and I'm a resident in the North Philadelphia area and I'm here because the death of Joaquin Rivera really, really upset me. He was a family friend. I remember when I was about 18 or 16 years old, I went out, it was like caroling, but in Spanish we say parang giando (ph), with them for Christmas, and everywhere I went, he always was there. A month before his death we were at a

conference and he was playing his guitar.

When he died in Aria Health, it was very shocking, and to call my father-in-law and say, Look, your best friend up here in Philadelphia passed away, to hear the choking in his voice, you know, just realized how shocking it was to lose him. And, like I said, he's a family friend and it was horrible the way he died. And to add insult to injury, being robbed in the emergency room also.

The reason why I'm here also is because two years ago, my brother also passed away and we feel that if we would have gotten the proper care at the emergency room, my brother would have been alive today also. So it's just like -- it's not just Aria Health Emergency Room. It's every emergency room need to check their policy and check the patient.

My brother was brought in. He was dehydrated. We're not doctors, but

we saw he was dehydrated. He wasn't talking. He wasn't eating. He wasn't drinking. We took turns as a family to go with him to his medical doctor, take him to the hospital, take him where he needed to go to get care. And at the time, my sister, Maria, here, she went with my other sister to a certain hospital emergency room and we brought him in and we told him exactly what was going on. We're the family. We knew how he was, who he was and what was going on. They just basically told them to just have his seat and someone would be with them. A few minutes later, an hour later, it seemed like days later, no one was seeing him.

I really can't get too much into his case because it's still an ongoing case, but the anger that I feel about how Joaquin Rivera as a family friend just brought up the anger with my brother, you know, when he passed away. His name was Jose Fontanez.

Like I said, we took him to this hospital. They didn't treat him. My sister took the initiative and they said, You know what, you're not going to care for my brother in the emergency room, you're not going to take care of him, you're going to make him get up from his wheelchair when he couldn't even get in the wheelchair. They basically had to walk him in there. They made him get out of the wheelchair and sit in a chair, because they needed the wheelchair for somebody else.

So they made the decision to leave that hospital and take him to another hospital, where there they coded him. They gave him a yellow sticker. We don't know what that meant, but I'm sure it didn't mean he was in emergency. He waited there for a while, a long while. By 9 o'clock at night -- and this all had started early in the morning. By 9 o'clock at night at this certain other hospital, my brother was finally admitted

for dehydration, and within the next day, he was in ICU. Two days after that to three days after that, my brother died. There was no reason for this 31-year-old to die a couple of weeks before his birthday, and this was all -- this I say would have been prevented had in the emergency room they would have took the initiative to say, Listen, we're going to bring him right back.

Just because we didn't bring him in in an ambulance doesn't mean that it was not an emergency. My brother is just, I guess, a case number, but to us he was our brother. This is Jose Fontanez. This is all we have besides our memory of him to live with, to hold on to. Why? Because someone in the emergency room was either too tired to come out and say, Okay, we're going to bring him in, or they thought someone had a bigger issue or bigger problem.

We're not doctors. We don't know how they code people, but I know

that it's not an isolated incident. Joaquin Rivera would have been alive with us today had he been taken care of. My brother would have been alive today. Everyone that testified here with a lost family member would have been alive today if someone in that ER would have just came up to them the time they were sitting or even when we as a family member came up to them and said, Listen, we've been waiting here a half an hour, he's not getting any better, he's practically passed out on the chair, and they would tell us, Someone would be there in a few minutes to help him. And as family members, we decided that we're not going to allow that anymore. Now there's always going to be a family member to go into the triage room with our loved one, to go into the MRI room with our loved one, to go into the x-ray and wait outside. They tell us at the hospital you can't do that. Two years ago I lost my brother, and two years ago

I vowed that even now that my father is in the hospital and we're constantly for the last two weeks fighting doctors who know more than us and tell us, You can't come in, we're fighting with them and saying, Oh, no, we're going to come in, because when we're here, you treat our family member with respect and you treat him as a person. When they're here by them self, you ignore them, and that's never going to happen again.

So I support this bill, and I hope that anybody else that has suffered a loss of a family member because they don't know what to do in the emergency room take the chance to listen to your heart and say, This is my family, I'm not going to let them down. Just because it's not your mother, your father, your brother, you're not going to let this happen to mine.

I'm in the medical field. I'm a dental assistant. I treat all my patients like they were my mother, my

father, my brother. I stand up and fight for those who can't fight for themselves.

My brother is not here. Joaquin Rivera is not here. His family, if they're not here, it's because the grief. I wish somebody would have came up here and fought for my brother when I was grieving his loss.

And now I thank you for allowing me to speak today.

COUNCILWOMAN TASCO: Thank you very much. We appreciate your testimony.

MS. MARIA RIVERA: Hi. Good afternoon. My name is Maria Rivera. I am the sibling of Susan Rivera, and just as she said, yes, we did lose a family member, but it was more hard and more shock. More windows opened, more light came in when I saw this man die the way he did. He was my high school music teacher, and we're talking about plus 30 years ago. To know that this happened in an ER and know that there were people sitting there while it was happening, no

one came to even say, Are you okay, sir, they just went about their business, it's really hurting not only to me. I am also an advocate. I am a surgical technologist. I'm also a medical assistant, and I deal with patients all the time, and I have where you come in and I will triage you in a minute and then take it to the doctor and say, This patient is really doing this, you need to see this patient.

It's not happening anymore. It's not like back in the old school. This is what we do. Not anymore.

So I understand and I grieve with the family as well, because he was a well-known person to our community. He was always in Concilio, in Centro Pedro Claver. We always met up with him there when we had auditions or any kind of stuff. We were always there with Joaquin. Always. And on behalf of the church on 6th and Venango and on behalf of Centro Pedro Claver and everyone else,

we all want to thank you guys for letting us speak up on him, because it's not just about the immediate family, it's about those who grew up around him, and we do miss him dearly.

Thank you.

COUNCILWOMAN TASCO: Thank you very much. Thank you for coming in to testify.

Is there anyone else here to testify on this resolution?

(No response.)

COUNCILWOMAN TASCO: Councilwoman Sanchez, you have any closing remarks?

COUNCILWOMAN SANCHEZ: I'll be brief.

Thank you, Susanna and Maria, and for all the folks in Hunting Park and San Ambrosio where Joaquin spent most of his life sharing.

I hope that today's hearing has enlightened many of us as to the serious issues that emergency rooms face given

the fact that they are critical care centers. I'm encouraged by some of the best practices that were shared by some of the medical professionals who were here around procedures and what patients should be asking for and looking for as they enter our emergency rooms.

I will recommit myself to working with Aria Hospital to ensure that they strive for those best practices and provide the best medical care to the community of Frankford and to the City as a whole.

So I want to thank Chairwoman Tasco and Blondell Reynolds, my colleague, for co-sponsoring this hearing, and I think that what I'd like to be able to do is go visit some of these emergency rooms and look at some of these practices and definitely talk with our state colleagues around what other things we could be putting into play as it relates to regulation but, more importantly, support for training and

ongoing training of medical personnel, especially in underserved communities.

So I want to thank Aria Hospital officials and all the folks that came today and testified, and as I said in the beginning of this, this is exactly what Joaquin would have wanted us to do. It is part of his legacy. He continues to provide advocacy even from where he is today.

Thank you.

COUNCILWOMAN TASCO: Councilwoman Brown.

COUNCILWOMAN BROWN: Thank you, Madam Chair.

I will only add and suggest and urge the panelist Margaret Robinson, we will be having a conversation with you sidebar, but I need to get the name right of -- please, is it Lisa McGarrigle?

MS. VANDERWOUDE: Yes.

COUNCILWOMAN BROWN: I would urge you to seize the moment and have a conversation with the leadership here at

Aria Health on your particular matter, and go on the record to say that Councilwoman Sanchez and I will present a formal letter with recommendations based on this hearing to our colleagues at the state and at the state Department of Health.

So, again, we thank you all for your important testimony. You can put a comma at the end of this hearing, not a period.

Thank you very, very much.

COUNCILWOMAN TASCO: Thank you. This Committee is adjourned.

Thank you.

(Committee on Public Health and Human Services adjourned at 1:40 p.m.)

- - -

CERTIFICATE

I HEREBY CERTIFY that the proceedings, evidence and objections are contained fully and accurately in the stenographic notes taken by me upon the foregoing matter on February 2, 2010, and that this is a true and correct transcript of same.

_____

MICHELE L. MURPHY

RPR-Notary Public

(The foregoing certification of this transcript does not apply to any reproduction of the same by any means, unless under the direct control and/or supervision of the certifying reporter.)