REPORT OF THE MEDICAL CARE COMMISSION MEETING
HELD ON JUNE 16, 2006

I. CALL TO ORDER AND ROLL CALL

Chairman Dennis called the meeting to order on Friday, June 16, 2006, at 9:00 a.m., in the Town Council Chambers. On roll call, the following members of the Commission were found to be present: Chairman Michael Dennis, M. D., Vice Chairman Robert Friedman, Commission Member Norman Goldblum, and Commission Member Norman Traverse, M. D. Absent from the meeting were Commission Members Richard Furlaud and Michael Stein.

II. PLEDGE OF ALLEGIANCE

The Pledge of Allegiance was led by Chairman Dennis.

III. APPROVAL OF AGENDA

The Agenda was approved as printed.

IV. COMMENTS FROM THE PUBLIC

There were none.

V. NEXT MEETING: JUNE 21, 2006, 9:30 A.M. IN THE EMERGENCY OPERATIONS CENTER (EOC)

VI. ANY OTHER MATTERS

There were none.

VII. SITE VISIT- PALM BEACH GARDENS MEDICAL CENTER (ATTENDEES WILL ASSEMBLE IN THE MAIN LOBBY AT PALM BEACH GARDENS)

The meeting was temporarily adjourned, to be reconvened at Palm Beach Gardens Medical Center. Thereafter, at 4:00 p.m., the meeting would reconvene in order to hear the comments of Bruce Moskowitz, M. D.

The meeting was reconvened at Palm Beach Gardens Hospital at 10:00 a.m., on Friday, June 16, 2006. Palm Beach Gardens Hospital Chief Executive Officer Mary Jo Gregory, and Chief Operating Officer Wayne Jones greeted the Commission. Ms. Gregory provided a presentation including the following points of interest:

- The hospital had a very busy heart program; they had the third highest acuity in the State of Florida; they were trying to blend preventative medicine through a partnership with the FACT Foundation; they were working with community services and first responders.

- The hospital was owned by Tenet Healthcare, and was a for profit hospital, with 199 beds, 850 employees, 425 affiliate physicians, and 150 volunteers. Here were 11,260 admissions per year, 37,227 outpatient visits per year, 23,709 emergency room visits per year. This year, there had been 5,843 diagnostic cardiac catherization procedures, and 2,569 interventional cardiac catherization procedures.

- Patient flow is monitored throughout the year, not only on a seasonal basis.

- An 8-bed Clinical Decision Unit has been instituted for those patients entering the emergency room, but who may require many diagnostic tests in order to assure a more comfortable environment for the patient.

- Staffing consisted of 94.7% registered nurses, and 5.3% licensed practical nurses. Registered nurse turnover was decreased by 6.3% in 2005.

- National statistics were pointed out, such as the number of physicians over 55 (30%), and that more physicians were attending non-U.S. medical schools. A nursing shortfall was

projected by 2010, as the average age of a nurse was 46.8 years.

- The Intensive Care Unit (ICU) had a ratio of 2 patients to 1 nurse, or 1 patient to 1 nurse, depending upon the acuity of the patient.

- The diversion protocol was discussed, and it was pointed out that a cardiac patient would never be diverted. If a patient in Jupiter Hospital ER needed a cardiac catherization, that patient may go to JFK Hospital, if all Palm Beach Garden catherization labs were full.

- Palm Beach Gardens hospital did not have a relationship with any medical schools currently, but did have agreements for training with nurses and pharmacy schools.

- Palm Beach Gardens Hospital was well within the national norms for infection. The hospital tried to increase patient confidence by being very open and transparent, and explaining things to patients. The hospital had an infection control practitioner; in service was done on a consistent basis; there as an ongoing initiative of hand washing, and the hospital was taking every kind of non-invasive approach that they could when treating patients.

The tour of the hospital included the Emergency Room, the Cardiac ICU, the Cardiac Recovery Center, and the Clinical Decision Unit.

VIII. TEMPORARY ADJOURNMENT - TO BE RECONVENED AT 4:00 P.M. IN TOWN COUNCIL CHAMBERS TO HEAR PRESENTATION FROM DR. BRUCE MOSKOWITZ

Dr. Bruce Moskowitz addressed the Commission, stating that he had come to the community in 1977, and at that time he was absolutely taken aback by the great quality of care at Good Samaritan Hospital. A summarization of his comments follows:

It was inconceivable, knowing all of the talent in the room today, and the talent in the community, that the quality of care cannot be restored to what it was before, and even be made better. Good care could not be delivered if patients had to be concerned that they were having a heart or neurological problem, and may have to by-pass Good Samaritan for another hospital.

There was no reason why there could not be full treatment for cardiac emergency at Good Samaritan Hospital, including stent placement. Stent placement had been done without open heart back-up successfully at Exeter Hospital in New Hampshire. A top notch catherization team from JFK was already coming to Good Samaritan, bringing their own nurses. There was no health risk,

but there would be a health risk if the service was not offered. It was inexcusable when a patient was having an elective procedure and developed chest pain, and then had to wait for a transfer to another hospital. If a patient had to be transferred to another hospital, a lot of time was wasted.

The community was too small to maintain a stroke program by themselves, however, there was no reason why it could not partner with the University of Miami, or the Cleveland Clinic in Ft. Lauderdale, and add a physician to their team that could rotate to Good Samaritan to be available for stroke emergencies. Both organizations were willing to lend their support to make that happen.

High quality for basic diagnostic procedures should be available 24/7 – for example, almost all x-rays are read by teleradiology, and the images are sent to places such as Australia for the images to be read. The Cleveland Clinic was ready to do teleradiology, as was the Brigham and Women's Hospital in Boston. Complicated films should be looked at by a neuroradiologist, and other specialists. All of this was readily achievable. The medical centers were willing to do it. Getting that done would be a big step towards restoring the quality of care in the community.

The medical staff must be re-built as well – there were more primary care people, and more sub-specialists, more intensive care unit people, etc. A doctor was needed in the intensive care unit 24 hours per day taking care of critical care patients.

Dr. Moskowitz commented that Town Council Member Allen Wyett had worked on the improvement of care in the community. He stated that the City of West Palm Beach also needed to be involved.

Dr. Dennis asked Dr. Moskowitz what he thought had led to the decline at Good Samaritan, and what prevented some of the improvements from happening today?

Dr. Moskowitz replied that when the eyes are taken off of the patient, and the patient's needs, things erode quickly. Nurses took other positions, x-ray services were diminished to five days per week, highly qualified physicians left. The erosion was probably due to an organization in transition, and a company that was based outside of the geographic area.

In response to Commission Member Friedman, Dr. Moskowitz replied that a lot of good physicians were moving into the area; they were not leaving the state; they were happy with their lifestyle. However, physicians would not want to go to a hospital that could not offer full services; they would want radiology 24/7. The Medical Care Commission would need to go to Tenet and set up a meeting to move forward to bring up specific points to accomplish and a specific time frame in which to accomplish them. The City of West Palm Beach also needed to get in tune with the efforts of the Medical Care Commission. Dr. Moskowitz suggested that teleradiology should be

turned on as quickly as possible; a board certified neurology trained stroke physician would also be needed. He pointed out that if the University of Miami was offered payment for another fellow in their program, they would gladly take the money, and it would be money well spent. The officers of Tenet would have to give the green light for a cardiac program. Dr. Midwall's group from JFK would be more than happy to come to Good Samaritan to do catherizations, stents, and take them to JFK when necessary. They would need backing from a major medical center saying that there was agreement that this should be done; it would also take legislative action. He also suggested a specific person, a consultant, who knew medicine, to survey what was needed at Good Samaritan Hospital to make it work properly.

Chair Dennis commented that the technology was in place for a teleradiology program, and asked where the roadblocks were?

Dr. Moskowitz replied that the roadblock was a matter of sitting down to make the phone calls to make it happen, and to make sure that the appropriate people come into contact with each other. He suggested that the Medical Care Commission needed to appoint someone to sit down in Mr. Echelard's office at Good Samaritan and make the calls. He commented that he always looked at how he would want to be treated or his patients want to be treated, and there were no guarantees when one hospital had to be bypassed safely to send someone to another facility. Patients were taken away from a doctor they knew to a doctor they had never met; their support system may then be taken away as well.

As far as stroke programs, Dr. Moskowitz gave an example: there are intravenous medicines for acute strokes which could be used only some of the time; other times a neuroradiologist who could extract a clot was needed — if a patient needed a neuroradiologist it could be that those specialists were not available locally, and the patient would need to be transferred to another location. He pointed out that a doctor needed to know that a patient could be protected for a basic stroke, before shipping the patient somewhere else. Sometimes a specific patient would need to be transferred to another location, but that would be a minuscule amount of the time. He commented that he wanted even a better program than those currently available at JFK or Jupiter. It was preposterous to think that any of those small programs could satisfy the needs of Palm Beach County. It was necessary to know that physicians were always available both in neurology and radiology, with a stroke program to fall back on.

Dr. Moskowitz advised that he would assist the Commission in any way that he was asked. He pointed out that with the talent in this community there was no doubt in his mind that the situation could be made better.

Mr. William Diamond commented that the corporate structure, with a corporate entity that was not based locally had other thoughts on their minds other than the delivery of medicine, and that seemed to be the structural problem that was in place.

Dr. Moskowitz replied that all of the equipment was in place to force their hand; if they did not respond, then the legislature would need to be approached.

Commission Member Traverse noted that a site visit had been made today to Palm Beach Gardens Hospital, and it seemed to be very well run; a holding area had been developed for the emergency room; the intensive care unit was monitored with a nurse/patient ratio of 1:2; there was a 93% retention of nurses. That indicated that it was possible to improve within the Tenet system.

Dr. Moskowitz noted that this community had built Good Samaritan, and that needed to be recognized.

Mr. Diamond suggested that an important site visit to make would be to the national headquarters of Tenet and address the situation with them.

Dr. Moskowitz commented that the CEO of Tenet in Texas, Reynold Jennings was very easy to talk to, and would listen.

Chairman Dennis noted that he had contacted Mr. Jennings to invite him to address the Commission.

Mayor McDonald commented that Dr. Moskowitz had come in with a degree of optimism that had been missing from many of the previous speakers that had come before the Commission, and that Dr. Moskowitz had simplified his suggestions so that the Commission could see that it was not as much as an obstacle that had been perceived.

IX. ADJOURNMENT

There being no further business, the Medical Care Commission meeting of June 16, 2006, was adjourned at 5:35 p.m.

APPROVED:

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Michael Dennis, M. D., Chairman