REPORT OF THE MEDICAL CARE COMMISSION MEETING
HELD ON JANUARY 24, 2006 @ 9:00 A.M.

I. CALL TO ORDER AND ROLL CALL

The meeting of the Medical Care Commission was called to order by Chairman Michael Dennis at 9:00 a.m. in the Town Council Chambers. All members of the Commission were present. Others present for all or a portion of the meeting were: Mayor Jack McDonald, Town Council President William Brooks, Town Council President Pro Tem Norman Goldblum, Fire-Rescue Chief Edward Moran, Fire-Rescue EMS Coordinator Brian Fuller, and Town Clerk Susan Eichhorn.

II. PLEDGE OF ALLEGIANCE

The Pledge of Allegiance was led by Chair Dennis.

III. APPROVAL OF AGENDA

The Agenda was approved as printed.

Town Manager Elwell introduced Sara-Ellen Blake, as the administrative assistant to the Medical Care Commission.

IV. APPROVAL OF MINUTES OF THE JANUARY 12, 2006, MEETING

Commission Member Stein commented that he had not received a copy of the minutes or the back-up material for this meeting.

Chair Dennis suggested that approval of the minutes for January 12, and for January 19,

2006, be tabled until all members had an opportunity to read them.

V. APPROVAL OF MINUTES OF THE JANUARY 19, 2006, MEETING

[See above.]

VI. ME. RICHARD CAMERON, CONSULTANT TO THE PALM BEACH COUNTY MEDICAL SOCIETY

Chair Dennis introduced Richard Cameron, Consultant to the Palm Beach County Medical Society.

Mr. Cameron addressed the Commission, stating that the group that he was supporting was the Emergency Department Management Group (EDMG), which was sponsored by the Palm Beach Medical Society Services, Inc. At this point of time, the group was focused specifically on issues involving access to on-call physicians who were needed to care for patients that presented themselves at emergency rooms, and the concerns related to the declining number of physicians who were willing to remain on-call in emergency rooms. He noted that many physicians who want to remain on-call also wanted to be paid for being on-call.

The concern of physician availability to cover on-call needs of the emergency rooms in Palm Beach County was a problem that had been faced in many parts of the country. The problem itself was manifested when hospitals, with a full-service 24/7 emergency room, had a responsibility to have availability for certain services for patients who may require skills beyond he skills of the emergency room physicians who were staffing the emergency room. The problem for hospitals was making sure that specific specialities were available for patient care. In the past few years, the problems of physicians not willing to remain on-call, coupled with their desire to be paid for being on-call, had created issues for the hospitals as far as availability of specialists to provide services, as well as the affordability of paying additional monies to help provide on-call pay for physicians.

It appeared that there may be a shortage of certain types of specialities in Palm Beach County, and that may also be a part of the problem in Palm Beach County. He explained that there were a variety of reasons for this: the Federal law - Emergency Medical Treatment an Liability Act (EMTALA), requiring that any hospital that has a 24/7 emergency room must provide service access

to patients who present themselves and ask for treatment, and they must in turn make arrangements for care to be provided, if not in their facility, at some other facility. That requirements puts a lot of responsibility on hospital emergency departments to provide services in a variety of ways for a variety of services. Many patients use the emergency room as a primary care physician.

Malpractice coverage is also an issue of concern. The south Florida medical malpractice environment is extremely poor for physicians – there was either no insurance available, or it was available at a very high price, and many physicians in the County had opted to go bare, and not carry malpractice coverage. That increases their concern for liability for patients coming into the emergency room. There was also a problem with inadequate reimbursement – Florida is known as a state where managed care penetration is quite high – insurance contracts with providers usually end up having reimbursement rates that are fairly aggressive, and in many cases for physicians, the reimbursements are below Medicare.

Emergency department visits are increasing in response to a lack of access and a lack of insurance coverage; the emergency room becomes increasingly a place of first resort for many patients who do not have a physician. In Palm Beach County, there was a perceived aging of the physician work force; the medical climate in the County as so difficult to work in, that it makes it difficult to recruit doctors.

Another activity that impacts the willingness of physicians to remain on call is that they have an increasing number of ways to provide service to patients outside of the hospital, such as ambulatory service centers, and other types of out-patient service sites. Their need to actually use the hospital as a place to take care of their patients is diminishing. Because of that, their desire to remain on call is also diminishing.

There were also some life style and choice issues involved – physicians make decisions every day about size and scope of their practice, and how much time they want to devote to their families and to their profession.

Mr. Cameron addressed actions that have taken place to respond to the problem: About two years ago, a coalition of hospitals and physicians started meeting, and authorized a survey to be done by a medical consulting firm. The report was finalized about one year ago, and there were eight recommendations: formation of the EDMG, consisting of approximately fifteen people, half of them physicians, half of them hospital CEOs. They had been meeting to better understand what they could do as a group to address many of the on-call issues. This volunteer group asked another group, the Institute of Medicine (IOM), to take a look at their report and to provide some additional perspective.. IOM provided a review and a report, basically affirmed the recommendations that had

been proposed, and added a few additional recommendations. One key recommendation was for a project manager to help provide support.

ME. Cameron advised that he was identified and retained in December 2005, as the project manager. His goal, on behalf of the EDMG, was to implement the recommendations that were approved and supported by the EDMG. After the next meeting, he stated that he would be in a better position as to the intent of addressing some of these issues. He noted that the general areas of concern would include the on-call funding mechanisms, clustering on-call specialities at several hospitals within the County, the physician supply issue, risk management issues, and quality assurance.

Mr. Cameron remarked that he would be happy to come back in the future to provide a further update, and offered to respond to questions.

Commission Member Friedman requested that Mr. Cameron keep in touch with Ms. Blake on an ongoing basis.

Commission Member Stein requested a bullet point summary of the points made by Mr. Cameron. In response to his question regarding the percentage of doctors belonging to medical societies, Mr. Cameron replied that it was fairly typical to have one-third to one-half of the doctors in the community belonging. In response to the question of Commission Member Stein regarding an analysis of emergency cases presented to the different hospitals – which were treated in the hospital, which had to be transferred, and for what reason, and would that lead to a better understanding of what medical specialities are deficient, Mr. Cameron replied that there was not a study per se of that question. It was his expectation that the EDMG would want to set up a more formal mechanism with all of the hospitals to capture some of that information, and use that information to help monitor the quality of care and accessibility.

In response to Chair Dennis, as to interaction with the American College of Emergency Physicians (ACEP), and a state Health Task Force, Mr. Cameron replied that there were several physicians in the EDMG that were emergency room physicians, and they were bringing the emergency room physician perspective. He noted that he had not talked to the state ACEP representative as yet.

Mr. Cameron noted that the local hospitals continue to be very concerned about on-call access as it related to service specialties, and dealing with funding for on-call physicians. The potential sources for funding would include asking managed care companies to increase reimbursements, looking for alternate sources of funding, increase of Medicare rates and public

funding dollars, private support. He referred to an article from the St. Louis Post Dispatch related to health care issues, as an example of the issues facing everyone.

Chair Dennis asked Mr. Cameron if he was familiar with mechanisms used in other parts of the country related to the improvement of recruitment of physicians?

Mr. Cameron replied that he was aware of a few instances where communities had put some money together to help build a clinic for a doctor of a certain speciality to get that doctor started in the community. That occurred mostly in rural locations, and he was not aware of any larger communities where that had been done.

Commission Member Stein commented that many communities had raised money to build hospitals, and to recruit physicians to staff the hospitals. He suggested that the possibility existed that the community may have to raise certain sums of money to provide certain levels of care, in combination with the people who are already in the hospital business, but do not seem able to do it.

Mr. Cameron stated that there were many examples around the country where hospitals employed doctors as employees, and that employment relationship was a well understood area. The question for hospitals was always one of can we keep the employee physician motivated to continue to do good work and to see patients as an employee, versus being an independent business person.

Commission Member Traverse commented that the key was to create an environment for someone to want to come into the area; in addition, doctors in the community may be alienated.

Commission Member Stein noted that academic centers all over the country had full-time medical staff on salary, and there were usually formulas whereby the full-time staff were compensated by regular salary, plus a percentage of their income on patient billing. There was always a tension, varying to some degree, between full-time staff and voluntary staff, as to who gets the patients that come into the hospital. He suggested that was a low level consideration compared with having a competent, full-time staff; a blend of the two concepts may be something that could work out very well.

Commission Member Traverse replied hat 95% of patients were treated at community hospitals, where doctors were independent contractors.

Chair Dennis commented that there was no lack of academic centers that had an interest in the community.

VII. REVIEW OF PALM BEACH FIRE RESCUE'S "SPECIAL REPORT" WITH BRIAN FULLER, EMS DIVISION CHIEF

..... Brian Fuller addressed the Commission in regard to the data requested by the Commission at its January 12, 2006, meeting with respect to area hospitals that patients were transported to, how many transports were made to each hospital, and what Fire-Rescue personnel thought was wrong with the patient, and what speciality treatments the hospitals provided. He provided a spreadsheet of the data requested, and reviewed it with the Commission.

Mr. Fuller responded to the following questions from the Commission:

- Travel time from center of the Island to Palm Beach Gardens and to JFK:

  Response: Approximately ten to fourteen minutes. If Good Samaritan was a cardiac catherization hospital, the travel time would much improve; currently, those two hospitals are the only two available that offer those services.

In trauma alert patients, if paramedics do not believe that by the time they get the patient to a trauma center within twenty minutes, they will call the medivac helicopter. The goal is to have the patient on the operating table within one hour. If patients met cardiac alert criteria, they would go to JFK or Palm Beach Gardens. If they did not meet cardiac alert criteria, they would be strongly encouraged to go to the closest hospital. Patients in cardiac or respiratory arrest, meaning no pulses or breathing, were priority one patients, and protocol called for them to go to the nearest facility. All hospitals were capable of caring for a patient in cardiac arrest or respiratory arrest. He noted that paramedics were required to stay with the patient until they were transferred to an appropriate recipient, however,

Mr. Fuller noted that the Fire-Rescue personnel liked to stay with the patient to ensure that the advanced care that was already provided would not be downgraded in any way. The Fire-Rescue personnel would seek out those personnel in the hospital who are qualified to continue the advanced care. For an example, when pre-hospital continuous positive airway pressure (CPAC) was provided, the Fire-Rescue personnel would not leave the patient just with a nurse; the hospital would be contacted to tell them that a patient was arriving that was hooked up to the special respiratory equipment, and that we need respiratory response staff. The Fire-Rescue personnel would then stay with that patient until a registered respiratory therapist or a physician saw the patient.

Mr. Fuller explained that a respiratory patient who had been provided CPAC may also have life-saving diuretic drugs to relieve pulmonary edema, however, it was not working, and the patient was not being stabilized. That patient would be a priority two – those patients should go the nearest appropriate facility for caring for that patient, and most hospitals could appropriately care for those patients. "Should" comes into play when the immediate family strongly encourages the patient to go to another facility, be it their primary care physician belonging to a certain hospital, or they were seen for the same or similar circumstances recently in a certain hospital, or they feel more comfortable with a certain hospital. The patient would be taken to the preferred facility, within reason. If, for any reason during care, the Fire-Rescue personnel had agreed to go to a certain hospital that was further away from the nearest facility, the patient must sign a refusal or hospital by-pass release. If the patient's condition worsens, the rescue would then go to the nearest facility.

The priority three patient was a stable patient with no life threatening conditions. Those patients could go to whatever facility they suggested. Most often it was the closest facility; the closest facility being Good Samaritan Hospital, which was closest to two-thirds of the population of Palm Beach.

Mr. Fuller explained the dynamic process: the patient would call 9-1-1; the dispatcher must quickly assess the patient based upon the caller's remarks, and a pre-designated response would be selected. Most often it was an engine company and a rescue company, which would contain six personnel. If it was a serious cardiac, trauma, respiratory, stabbing, ob-gyn, a Battalion Chief also responds, who is recognized as the most senior, experienced paramedic in the department. The Palm Beach Fire Rescue Department had the quickest response time in Palm Beach County, which is just under four minutes. The average response time for the past two months was three minutes and twenty seconds, from the time the 9-1-1 dispatcher alerted, until the time personnel arrived on scene. The only municipality that did better was Palm Springs, who had a dual capability with police officers also responding, and because they were out on the road and could respond quicker.

Mr. Fuller explained that often the patient's remarks, or the patient's spouse's remarks painted a different picture than what the Fire-Rescue personnel saw when they arrived. Therefore, a treatment plan was developed – there was a 134 page protocol manual with delegated practices. Sometimes the nature of call at scene becomes what is believed to be occurring with the patient. The paramedics and team decide the criteria and treatment modalities provided, with the goal to render the patient in a better condition than when the Fire-Rescue personnel responded.

Dr. Traverse commented that people should be made aware of the advances in early management of strokes, and was a need of the community that should be addressed.

ME. Fuller replied that educational awareness programs were being instituted. When any resident went to the Fire Stations for blood pressure checks, which they could do at any time, there were stroke screening questions that were asked.

Chair Dennis commented that the Fire-Rescue Department deserves applause for its excellent emergency medical service program.

In response to Chair Dennis, regarding any improvements that may be desirable, ME. Fuller replied that if there were more speciality care options at Good Samaritan Hospital, it would certainly improve things. He explained that years ago, pre-hospital medicine was a hearse; now their were highly advanced people and highly advanced skills. Although there were not that many more lives saved than in the beginning, the huge difference was the quality of life once the patient came out of the hospital. The recognition of the medical emergency as it was occurring and immediate treatment can make the difference – the key was the continuation of that advanced care, and the hospital being capable of definitive treatment. Anyone could start an IV and give oxygen and treat that emergency, but not everyone has the capability to do balloon angioplasty or open heart surgery, or have the qualified physicians to perform that care.

ME. Fuller noted that a utopia would be a large, educational hospital, with the draw of qualified, energetic physicians, with speciality treatments that could offer a wide range of speciality care.

In response to Commission Member Stein, ME. Fuller replied that there was always better equipment, and things that would make his job easier, and the Fire-Rescue Department aggressively sought grant funds to meet those goals. He noted that the Palm Beach Fire-Rescue Department was ahead of any agency in Palm Beach County, because of the grant funds that were aggressively sought, and because of the community that has stood behind the Department. He stated that a wish list would include new EKG monitor/defibrillators.

Chair Dennis requested that ME. Fuller present the Commission with a wish list.

ME. Fuller concluded with the Fire-Rescue Department mission statement, and the measurement of its objectives.

Commission Member Friedman made a personal endorsement of the care given by the Fire-Rescue Department in a situation that was life threatening; he commented that he was here today because the Fire-Rescue Department had saved his life.

VIII. FURTHER CONSIDERATION OF COMMUNITY SURVEY

Chair Dennis noted that he had invited one of the statisticians of the Planning and Community Health Placement Participation Program, Dr. Dodge, from the Palm Beach County Health Department to appear today. He noted that time was of the essence in getting the survey together, and Dr. Dodge would discuss some of the methodology. He suggested that a Request for Proposal (RFP) be drafted to go out to a number of interested parties in the area that could do surveys. Ideally, the survey should be together and mailed by the last part of March, early part of April. In order to improve the response to the survey, he suggested a short article in the local newspaper could indicate its arrival, as well as the importance of residents returning the survey.

Commission Member Furlaud moved approval of the drafting of an RFP. The motion was seconded by Commission Member Traverse. On call of the Chair, the motion carried unanimously.

Chair Dennis stated that he would prepare the RFP.

Town Manager Elwell advised that a review of the RFP before it was put out, it would have to be done at a public meeting.

Commission Member Furlaud clarified that his motion was to give Chair Dennis the authority to develop the RFP.

Town Manager Elwell stated that it could then be provided as information to the Commission, however, it would be promulgated under the authority of Chair Dennis.

Dr. Karen Dodge, Planner for the Palm Beach County Department of Health, and faculty of the medical school at the University of Miami School of Epidemiology and Public Health. She explained that the County was currently in the planning process called Mobilizing for Action through Planning and Partnerships (MAPP), which was a national initiative developed by the Centers for Disease Control and the National Association of City and County Health Officials. The Health Department was engaging in a four years process, to first take a pulse on Palm Beach County to compile a health profile through data that already exists in Tallahassee, to include 150 health variables. The variables would also include air quality, water quality, green space. Four different assessments had been developed on the survey; also Town Hall meetings, focus groups, and key informant interviews were also being conducted. The health profile was a quantitative data analysis across the 150 variables, and it could be unique to Palm Beach. The Forces of Change Analysis would identify strengths and weaknesses of the Town of Palm Beach, through the individualization

of a survey. The initiative was a total County initiative, and she urged that the voice of the Town of Palm Beach be heard and be made known, and that the Health Department would like to work with them.

In response to Chair Dennis regarding health care for indigent people, Dr. Dodge advised that 100,000 unduplicated individuals were provided with health care at the County Department of Health. There were five clinic sites, doing primary care. The County worked in concert with several independent clinics, and also worked in tandem with the Health Care District, which offered six options for payments for people who were employed, but did not have the ability to pay for health care.

In response to Commission Member Friedman, Dr. Dodge advised that the County Department of Health tried to approach all of the CEOs of the hospitals in the area; St. Mary's was usually the hospital that received the people that did have the ability to pay for their health care; there was not that kind of relationship with Good Samaritan Hospital, however, the Department of Health would like to have one with them. Emergency room care was one of the biggest issues in the County – there were not adequate resources for adequate care.

Dr. Dodge explained that the University of Miami had started a medical school conjointly with Florida Atlantic University (FAU); also, on the grounds of A.G. Holley Hospital, in Lantana, the Florida Institute of Public Health would be opened, which would be a teaching hospital in affiliation with the school of medicine at the University of Miami and Nova. Right now, at the Department of Health, the only residency program in the State of Florida in preventative medicine was in place; the residents receive their residency training as well as an MDH – a Masters in Public Health. The planning budget for the building on the grounds of A.G. Holley Hospital was $12,000,000 from the State budget; there were 150 beds planned, with 50 beds designated for tuberculosis patients.

Dr. Dodge explained that many people seen at the clinics would rather go to the emergency room, because they did not want to be identified, since many were immigrant populations. At the emergency room, the identification and eligibility process was not as specific.

Dr. Dodge explained that the survey could be made relevant to the Town of Palm Beach, with the Medical Care Commission coming up with its own questions. She stated that she would be willing to work with them to develop the questions, put them on a response sheet, administer them, and then provide the Commission with the results.

IX REVIEW OF TRANSITION IN STAFFING AND ADMINISTRATIVE SUPPORT

Town Manager Elwell advised that Sara Blake had been hired as the Administrative Assistant to the Medical Care Commission, and would be their right hand as they move through the process. He noted that Ms. Blake came with established connections with the medical community, and knew the kind of information that the Commission would be requesting. Her resume had been included in the back-up packet provided today, and each Commissioner could contact her individually without violating the Sunshine Law, as they had been doing with himself and his office. Ms. Blake would now be the primary resource for the Medical Care Commission.

ME. Elwell commented that he would sometimes be attending the Medical Care Commission meetings, and sometimes would not. If at any time in the ongoing work of the Commission, there was a need for his personal attention, he welcomed it, either through the Commission, or through Ms. Blake. He noted that coordinating efforts would take place between Town staff and Ms. Blake.

X. REQUEST FOR AUTHORIZATION TO RETAIN A RECORDING SECRETARY

Town Manager Elwell commented that the Commission meetings would take place very regularly, on a weekly basis at least, and with that in mind, current staff was not able to provide weekly support for the meetings and produce the minutes each week. He proposed that the Commission authorize the retention of a recording secretary to ensure that there would be a prompt turn around in the minutes.

Commission Member Furlaud moved approval of retention of a recording secretary for the Medical Care Commission.

Town Manager Elwell estimated that the recording secretary services would approximate $5,000 per year, and the prior appropriation of $20,000 from the Town Council to the Medical Care Commission would be drawn on for that. At some point, in the future, a review could be held and an additional request could be made, if necessary, to the Town Council. When the Town Council had approved the initial $20,000, there was the clear understanding that while it should be considered more than simple seed money, it was also the expectation that, at some point, in the Commission's two years of work, there would be a request for more funding. By that time, the scope of the Commission's work, and the use of resources, would become much clearer.

The motion was seconded by Commission Member Traverse. On call of the Chair, the

motion carried unanimously.

In response to Commission Member Friedman, Town Manager Elwell replied that he was impressed and pleased by the offer of Dr. Dodge to tailor the kind of survey tool they already use, to be very specific to Palm Beach. He did not know how flexible their system was, or how the questions were written; he suggested that those things were items that the Commission would look at to satisfy themselves that the right kind of data would be collected to be meaningful analyzed. At the same time, options could be considered as to contracting with a survey professional independently; at that point the costs and benefits could be weighed. He suggested that the Commission consider targeting early March, rather than late March, because more residents would be available.

Chair Dennis noted that he usually met with each person that presented to the Commission before the came to the meeting, just to give them an idea of the mission of the Commission. Both Richard Cameron and Dr. Dodge believed that, given the proper core questions from the Commission, a survey could be put together within two or three weeks time. He noted out that the budget was approximately $2 - $2.50 per door step.

Town Manager Elwell advised that there were approximately 10,000 door steps, and costs would then approximately $20,000 to $25,000.

Chair Dennis pointed out that the Civic Association had offered to help with funding, as well as some individuals.

In response to Commission Member Stein, Town Manager Elwell advised that he believed it was important for the Commission to do a written survey, because of the importance of offering the opportunity for direct participation to every resident and business. The survey done by the Town last year yielded excellent information that was very helpful to both the Mayor and Town Council and the staff. That telephone survey allowed the collection of information from about 400 households, representing a cross section of the opinions of the people of the Town. He noted that there were people in the community who disputed the validity of the results, and felt uncomfortable with the entire process because they personally were not called. In order to avoid that potential outcome in this process, and in order for people to share anecdotal experiences, the written survey may be more appropriate.

Town Council President Pro Tem Goldblum commented that Good Samaritan was the hospital to be targeted. He noted that years ago, he had been appointed by John Brogan, who was on the board of Good Samaritan, as an advocate in the emergency room, checking what was going

on and reporting back to the hospital board. He also noted that at Morse Geriatric, there was a physician as an advocate for the residents that go to all of the hospitals, and good results had been obtained from that.

Commission Member Friedman suggested the possibility of an ombudsman program to oversee the quality and services of the hospital.

Town Manager Elwell advised that could be amongst the array of recommendations made by the Commission; intervening on behalf of a resident in a medical situation would be a situation that would need to have the pros and cons weighed carefully. He suggested that the Commission was already shining a bright light on a number of issues, just from the fact that the Commission was paying attention to these issues.

Commission Member Stein suggested that it may be possible to reach an agreement with Good Samaritan regarding some voluntary method of providing a patient care ombudsman.

XI. COMMENTS FROM THE PUBLIC

Mrs. Yvelyne Marix, 1570 North Ocean Blvd., commented that the emergency room was being used as clinic for many people, and she wondered if any research was being done with the percentage of people who were using it as a first top medical treatment facility. She also referred to the concierge medicine concept, with the yearly fee paid to doctors by patients, and that she had heard that this would make the availability of doctors even more restrictive. She suggested that it was something new that should be looked at.

Mrs. Marix also suggested that the issue of more intense training for nurses was a consideration, to take up some of the burden that now falls on the doctors; perhaps the immigration problem could be used to benefit the medical community in that anyone who was trained as a nurse in their own country could come to the U.S. on a special immigration visa, to be valid as long as the continued the nursing career. She also suggested a tax on each plastic bag of snacks would be enough to cover basic insurance for a great many people who could not afford it now.

Town Councilman Wyett commented that Good Samaritan had always practiced triage, and was presently trying to improve that through a system called "Fast Track." Also, they were interviewing a new director of emergency care. He stated that surveying 10,000 households, and then interpreting it would take a lot of time; he suggested that if a survey were taken of the 681

people that were taken to Good Samaritan by the Fire-Rescue Department, as well as the 271 people that were taken to JFK, and compared notes, there would be a survey of almost 1,000 people. That information may be able to be interpreted much quicker than the larger survey.

Commission Member Stein suggested that the patients who were serviced by the Fire-Rescue could be followed up as to their experience at the hospitals.

ME. Fuller replied that due to the HIPPA laws, he was not sure that was possible.

Ms. Blake commented that a survey could be left on a desk, or put on a table, and a patient could chose to pick it up and fill it out, however, the patient could not be asked to fill it out. The HIPPA and the confidentiality laws prohibit someone identifying patients and asking them their opinion of services.

XII. NEXT MEETING JANUARY 31, 2006

[This meeting was subsequently cancelled and rescheduled for Tuesday, February 7, 2006].

Town Manager Elwell commented that the Town Council Chambers was now reserved for every Tuesday morning throughout the year, with only three dates when the room was already booked for a Tuesday morning, other than the second Tuesday of the month when the Town Council met in the Chambers.

XIII. ANY OTHER MATTERS

Councilman Wyett referred to the financial losses reportedly experienced by the hospitals, and questioned how long they would be able to remain opened. He suggested that those questions be asked of the hospital representatives.

Commission Member Traverse requested that the study of the American College of Emergency Physicians be added to the Agenda for discussion at the next meeting.

XIV. ADJOURNMENT

There being no further business, the Medical Care Commission Meeting of January 24, 2006, was adjourned at 12:05 p.m.

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Michael Dennis
Chairman

Prepared by:
Susan A. Eichhorn
Town Clerk