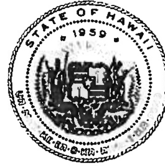
DAVID Y. IGE
GOVERNOR OF HAWAII



VIRGINIA PRESSLER, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. Box 3378
Honolulu, HI 96801-3378
doh.testimony@doh.hawaii.gov

Testimony COMMENTING on HB 1147
Relating To Health

REPRESENTATIVE DELLA AU BELATTI, CHAIR
HOUSE COMMITTEE ON HEALTH
Hearing Date: February 19, 2015 11:10 AM Room Number: 329

1 **Fiscal Implications:** Appropriates an unspecified amount of general funds in fiscal years 2015-
2 2016 and 2016-2017. The Department respectfully defers to the Governor's Executive Budget
3 request for the Department of Health's appropriations and personnel priorities.
4 HB1147 would require the Department of Health to establish a Fail Safe program that
5 provides 24 hours per day, seven days per week, and 365 days per year consultation services to
6 emergency room physicians and nursing staff. It would also require the Department to provide
7 patients and their family members, upon request, an opinion of another physician, including a
8 senior emergency room physician regarding the diagnosis or treatment plan prescribed by an
9 emergency room physician.
10 **Department Testimony:** The Department takes no position on HB1147. The Department
11 respectfully defers to the findings and recommendations of the task force established per the
12 passage of House Concurrent Resolution 112, HD1, SD1: Urging the Director of Health to
13 Convene a Task Force to Assess the Scope and Feasibility of Establishing an Emergency
14 Services Patient Advocate Program during the 2014 legislative session. The report was
15 submitted to the twenty-eight legislature in December, 2014. The report may be viewed
16 electronically at http://co.doh.hawaii.gov/sites/LegRpt/2015/Reports/1/HCR%20122.pdf
17 The Department facilitated meetings of highly qualified and diverse emergency department
18 experts and healthcare consumers. Consensus was reached on recommendations for HCR122,
19 HD1, SD1, including:

1. Emergency Department (ED) care in Hawaii, for the most part, is quite good. It would not be prudent to implement changes that have the potential to disrupt the system currently in place.
2. A nurse practitioner would probably not have sufficient stature to persuade and ED physician to re-evaluate the management plan.
3. Many of the apparent conflicts between patient/families stem from inadequate communication.
4. Because the patient advocate (PA) would not have the benefit of direct contact with the patient or the results of the clinical workup, the value of the "second opinion" would be limited.
5. On occasion, the management plan might be altered for the better, but the ED professionals on the task force could not offer a meaningful estimate of how often this would occur, except to say that it would probably be rare.
6. On the other hand, more tests would be ordered, more consultations would be obtained, and more patients would be placed in observation or admitted to the hospital. Costs would rise and patients would be subjected to increased risk of adverse reactions to tests and procedures.
7. To provide this service 24/7/365 using realistic salary estimates: $1,300,000. per year in salary alone. $850,000. per year in salary, if the service was provided only nights and weekends.

The task force recommended deferring the implementation of a centralized Department of Health program and strongly supported the utilization of existing hospital resources to support the objectives of a statewide patient advocacy program.

Thank you for the opportunity to testify.

THE QUEEN'S HEALTH SYSTEMS

HB 1147, Relating to Health
House Committee on Health
Hearing—February 19, 2015 at 11:10 AM

Dear Chairwoman Belatti and Members of the House Committee on Health:

My name is Tina Donkervoet and I am the Director of Care Coordination and Patient Flow at The Queen's Medical Center-Punchbowl. We would like to offer comments regarding HB 1147, which would establish an emergency services failsafe program. We would ask that you defer this measure because the program could compromise patient care and be expensive to establish and operate.

It seems important to note that for the last year a group of providers, advocates and other stakeholders have been meeting to discuss ways to improve patient advocacy in emergency departments. The Patient Advocate Task Force was established as a result of House Concurrent Resolution 122 from the 2014 legislative session. I was a part of that group that met for many months to find ways to assess the role of patient advocates in our state's hospitals to help patients and families who seek emergency care.

The group came up with a number of conclusions and recommendations. Our first recommendations was to "establish a centralized program that is managed by the State Department of Health" that would provide an appropriate forum for hospitals to share best practices in patient advocacy.

Establishing a failsafe program at the Department of Health was <u>not</u> one of the recommendations made by the task force. Indeed, this legislation does not include any of the conclusions or recommendations from the task force. The group did touch on the fail safe policy, but noted that this program was specifically "for cases where [physicians] are not following a clinical practice policy." The fail-safe program "provides the opportunity to have a real-time conversation with a senior emergency medicine physician in a high-risk clinical scenario." The failsafe program is more appropriate for these high-risk scenarios, not for every case that comes into an emergency department.

We have serious concerns about the impact that this program could have on patient care and outcomes. There is nothing in this bill that could guarantee that consultation services will be "convenient or expeditious." Any delay in the provision of emergency care could have serious repercussions. We also have a number of questions about how this legislation would be operationalized and how much the establishment and maintenance of this program would cost.

We ask that you defer this measure. Thank you for your time and consideration of this matter.

KAISER PERMANENTE. Government Relations

Testimony of Phyllis Dendle
Director, Government Relations

Before:
The House Committee on Health
The Honorable Della Au Belatti, Chair
The Honorable Richard P. Creagan, Vice Chair

February 19, 2015
11:10 am
Conference Room 329

HB1147 RELATING TO HEALTH

Chair Belatti and committee members thank you for the opportunity to provide testimony on this bill to establish the emergency services failsafe program to provide a second medical opinion regarding diagnosis and treatment in emergency rooms.

Kaiser Permanente Hawaii has serious concerns about this bill.

Kaiser staff participated on the task force that reviewed possible ways to provide advocacy to patients in the emergency room and their families who were not in agreement with the emergency room staff. We understand the circumstances that caused the need for this discussion and we appreciate the efforts of all the participants.

Nonetheless we have concerns about what is proposed in this bill. A program of this type needs to be available 24 hours a day because emergencies can happen at any time. While the intent is for this contact to happen quickly it is essential that emergency room operations not be delayed if this system is not available in an expeditious manner.

More importantly--will providers be required to take the advice given to them by providers not present and not directly involved in the patients care? Who will take responsibility for the outcomes if the recommendations made by a non-present provider result in unfavorable outcomes? Who will take on any additional expense incurred based on the recommendations of the non-present provider? Patients are always free to seek other opinions about what care is correct for them. They are also free to refuse care they do not want. However, they cannot force providers to provide care not deemed by the provider to be appropriate.

We are also concerned that rules made after this bill is passed could mandate the use of such a program even though the law has it available for voluntary use. Because there are many unanswered questions we urge this committee to defer this measure. Thank you for your consideration.

711 Kapiolani Blvd
Honolulu, Hawaii 96813
Telephone: 808-432-5210
Facsimile: 808-432-5906
Mobile: 808-754-7007
E-mail: phyllis.dendle@kp.org

From: **Fred** opaski@aol.com
Subject:
Date: February 18, 2015 at 5:33 PM
To:

LATE TESTIMONY

My name is Fred Rohlfing. I served as a state Senator. I speak for myself and a committee of my wife Pattys loyal supporters seeking to honor her by better processing of patients in Hawaii's ER's.Pat ty died in 2010 after prematurely being discharged from Kapiolani Hospital.
This hearing was very good news, I wish to thank the chair and several of you, REP Creagon and REP Kobayashi in particular for you r op en-mindedness on the specific aspects of the proposal for a fail-safe proposition - a chance for a 2nd opinion in ER , Yes, a patient in ER should have a process available for review by another physician preferably at another institution via telemedicine.

Unlike many approaches to the undelying communications problem , funding would be minimal
.compared with prior proposals for a corps of patient advocates statewide.. this would be a bargain basin proposition, It could be tested as a pilot project according to Creagan an d Kobayashii

We concur

We urge you to report HB 1147 to Finance for further review. and passage.

George S. Massengale
4300 Waialae Avenue, Apt. A803
Honolulu, HI 96816
808-271-9296
honolulujd@gmail.com

February 18, 2015

House Committee on Health
Rep. Della Au Belatti, Chair
Rep. Richard Cregan, M.D., Vice Chair

Re: HB1147, Relating to Health
Date: Thursday, February 19, 2015
Time: 11:10 a.m.
Place: Conference Room 329

Testimony in Support

Chair Belatti, Vice Chair Cregan and members of the Committee on Health. I am writing this testimony as an individual who is very familiar with many of the issues surrounding HB1147, which if enacted would establish an emergency services failsafe program to assist both emergency room physician as well as patients and their family members in accessing a second opinion where there is a difference of opinion regarding diagnosis and treatment.

To begin, we need to go back to 1986 when Congress passed the Emergency Medical Treatment & Labor Act or EMTALA, which mandated that ER departments in Hospitals to provide an "appropriate" medical screening examination (MSE) for all that show up in the emergency department. In 1998 the U.S. Advisory Commission Protection and Quality in the Health Care Industry adopted the Patient's Bill of Rights. A key provision of the act is, it gives patients a way to address any problems they may have. In reality "failsafe" is the prodigy of these two afforded protections.

Today as part of an ER department's risk management program, many hospitals have adopted a "failsafe" program to minimize that risk. So what is "failsafe"? Failsafe provides ER physicians with 24/7 phone access to an experienced, senior EM physician for discussion of high-risk cases or situations which may arise. Needless to say this program has saved many lives, and hospitals have avoided litigation cost because of it. I'm sure that if a "failsafe" program had been in place several years Senator Rohlfing's wife Patty would be with us today.

I would also note for the committee that in 2009 the 6th Circuit Court of Appeals in Moses v. Providence Hospital expanded EMTALA by ruling that EMTALA, has an obligation to affirmatively provide care "until the patient's emergency condition is stabilize...and no

further deterioration is likely." Clearly ER departments are on notice that their obligation to the patient does not end at the doors to the emergency room, see attached excerpt, Journal of Health and Medical Law.

Establishing a failsafe program in all our hospital's is a cost effective and prudent thing to do. It will save lives, while at the same time reducing liability exposure. Because risk management concerns HPH has now adopted a failsafe program. Hopefully this committee today will make a requirement for all of our hospitals. Let's err on the side of caution, it can't hurt, and it will prevent tragic occurrences.

In closing I would also point out that HB1147 has no Senate companion, thus it would be in everyone's interest that this measure be passed to continue its journey to the Senate for further discussion and consideration.

Respectfully submitted,

George S. Massengale

In *Moses v. Providence Hosp. & Med. Ctrs., Inc.,* the court considered whether a non-patient has standing to sue under EMTALA and what a hospital's obligations are upon discovering an emergency medical condition. 8 The court held that any individual, including non-patients, who suffered direct personal harm from a hospital's violation of the EMTALA provisions, has standing to sue. 59 Additionally, the court ruled that them requirement to stabilize a patient's condition before discharging or transferring the patient is not satisfied by merely admitting a patient to an inpatient unit and then releasing the patient. 60 Rather, appropriate treatment must be rendered such that the patient's condition has *actually* been stabilized prior to discharge, regardless of whether treatment occurs in the emergency department or elsewhere in the hospital. 61 Though susceptible to criticism for expanding the law and creating compliance ambiguity, the court appropriately and logically looked to the plain language of the EMTALA statute where no cases on point existed regarding standing, as well as ruled according to precedent on the issue of stabilization. 62 With precedent now established, other appellate courts should feel comfortable following the Sixth Circuit's lead in ruling that injured non-patients have standing to sue, particularly in cases like *Moses* where the facts precisely fit the plain language and meaning of EMTALA.63

Journal of Health & Biomedical Law, Vol. V (2009): ***345-360 0*** *2009 Journal of Health & Biomedical LawSuffolk University Law School, p.360.*

LATE TESTIMONY

BARBARA MARUMOTO

1438 Ihiloa Loop

Honolulu, HI 96821

Date : Feb. 19, 2015

To : Hon. Della Belatti, Chair

Hon. Richard P. Creagan, Vice Chair &

Members of the House Committee on Health

From : Barbara Marumoto

Re : HB 1147 – FAILSAFE PROGRAM – IN FAVOR

Patients, when not comfortable with one doctor's opinion, frequently seek out a second opinion. If a second physician were available in emergency rooms, patients and their families might be reassured by the first doctor's diagnosis and treatment or have an option to pursue another course of action.

Such a service would bring us closer to better "patient-centered care", a stated goal in medical care. A failsafe program, if instituted in our larger hospital emergency rooms, would be a good start.

For the sake of better health care, we need more discussion on HB 1147. Thank you for your consideration.