HOUSE PROFESSIONAL LICENSURE COMMITTEE
PUBLIC HEARING ON HOUSE BILL 2727

Thursday, October 23, 2008
Drexel University
Paul Peck Alumni Center's Board Room
Philadelphia, Pennsylvania

COMMITTEE MEMBERS PRESENT:

REPRESENTATIVE MICHAEL STURLA, Chairman
REPRESENTATIVE JOHN YUDICHAK
REPRESENTATIVE MARC GERGELY
REPRESENTATIVE WILLIAM ADOLPH
REPRESENTATIVE THOMAS KILLION
REPRESENTATIVE KEITH GILLESPIE
REPRESENTATIVE CHRISTOPHER SAINATO
REPRESENTATIVE NICHOLAS KOTIK
REPRESENTATIVE TIMOTHY SOLOBAY
REPRESENTATIVE RONALD WATERS
REPRESENTATIVE CRAIG DALLY
REPRESENTATIVE THOMAS YEWCIC
REPRESENTATIVE JAMES WANSACZ
REPRESENTATIVE SEAN RAMALEY

REPORTED BY: DEBRA RICE, Court Reporter - Notary Public

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1420 Walnut Street
Suite 1200
Philadelphia, PA 19103
(215) 928-9760

133-H Gaither Drive
Mt. Laurel, NJ 08054
(856) 235-5108

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1 TESTIFIERS:

2 DR. JOHN LASKAS, Dermatologist, Dermatology Limited

3 DR. JAMES GOODYEAR, Pennsylvania

4 Medical Society

5 PANEL from THE HOSPITAL and HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA:

6 MARY MARSHALL, Director for Workforce

7 and Professional Services

8 EUGENE ZEGAR, Vice-President of Human Resources, Crozer-Chester Medical Center

9 DR. BRADLEY FOX, President, Pennsylvania

10 Academy of Family Physicians

11 DR. DAVID PAO, President, Pennsylvania Academy of Ophthalmology

12 DR. THOMAS GAMBA, President,

13 Pennsylvania Dental Association

14 PANEL from PENNSYLVANIA PHYSICAL THERAPISTS ASSOCIATION:

15 IVAN MULLIGAN, PT, President-Elect

16 COLLEEN CHANCLER, PT, MHS, Southeast

17 District Director

18 ANDREA DEVOTI, Public Policy Committee Chair, Pennsylvania Homecare Association

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1 REPRESENTATIVE STURLA: I want to
2 call the House Professional Licensure Committee
3 to order. We are here today for a public hearing
4 on House Bill 2727, introduced by Representative
5 Killion, which deals with uniform standards in
6 health care settings by which patients can
7 identify the credentials of the individuals that
8 are serving them.
9 We will start by having the
10 members introduce themselves. We will start on
11 my right.
12 REPRESENTATIVE YUDICHAK: Good
13 afternoon; Jack Yudichak, representing Lucerne
14 County.
15 REPRESENTATIVE GERGELY:
16 Representative Marc Gergely from Allegheny
17 County.
18 REPRESENTATIVE STURLA: Chairman
19 Mike Sturla from Lancaster County.
20 REPRESENTATIVE ADOLPH: I'm Bill
21 Adolph from Delaware County. I'm the Republican
22 Chairman.
23 REPRESENTATIVE KILLION: Tom
24 Killion, Delaware and Chester Counties.
25 REPRESENTATIVE GILLESPIE: Good

1 afternoon; Keith Gillespie, York County.
2 REPRESENTATIVE SAINATO: Chris
3 Sainato, I represent part of Lawrence and a small
4 section of Beaver Counties.
5 REPRESENTATIVE KOTIK: Nick Kotik,
6 45th Legislative District, Allegheny County.
7 REPRESENTATIVE SOLOBAY: Tim
8 Solobay from Washington County.
9 REPRESENTATIVE STURLA: I would
10 like to note for the record that we have had
11 letters submitted from the Pennsylvania
12 Department of State, Pennsylvania State Nurses
13 Association, the Pennsylvania Optometric
14 Association, the Pennsylvania Osteopathic Medical
15 Association and the Pennsylvania Association of
16 Chain Drug Stores. They all submitted comments
17 on this legislation and will be testifying today.
18 In a second, I'll let
19 Representative Killion make a few comments if he
20 chooses to, but before that, I would like to
21 point out that today that is Representative
22 Adolph's birthday; so, if any of you guys would
23 like to sing Happy Birthday --
24 MR. ADOLPH: Thank you,
25 Mr. Chairman.

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1 MR. KILLION: Thank you, Mr.
2 Chairman; I will be brief. I appreciate your
3 holding this hearing on this piece of
4 legislation. We have done a number of bills
5 recently on the standards and practices, and
6 there are more and more people coming in and
7 treating our constituents, and the issue has
8 actually been brought to me by a constituent of
9 mine, Dr. Laskas, who will be testifying, that it
10 would be a good idea to have a "uniform standard"
11 so that when you're being treated you know
12 exactly what that person's training is and what
13 their field is, so there is no confusion. Thank
14 you.
15 REPRESENTATIVE STURLA: Thank you.
16 I would point out that we have just been joined
17 by Representative Wansacz.
18 The first to testify is Dr. John
19 Laskas, a dermatologist with Dermatology Limited.
20 I will point out to all the people who are
21 testifying today that we are already five minutes
22 behind time; so you don't need to read your
23 testimony. If you want to give us a brief
24 overview of what it is you're presenting, and
25 that way it will allow time for members to ask

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1 questions also. So, Dr. Laskas.
2 DR. LASKAS: Well, thank you,
3 everybody. Good afternoon to everyone and thank
4 you for having this hearing. I'm going to read
5 this, because it won't take long, and I think it
6 lays out the issues, and I won't miss any points
7 that we had wanted to make.
8 I'm in a dermatology practice in
9 Delaware County. I'm the immediate member and
10 past president of the Academy of Dermatology and
11 Dermatologic Surgery and the Chair of the Patient
12 Safety Committee. I'm on the task force of
13 Patient Safety for the American Academy, which is
14 our national organization.
15 So, as you see here, I think it is
16 best if we all just think of ourselves as
17 patients and not legislators and not physicians
18 or whatever our field might be, because this is
19 for patient safety, and we are all patients. So,
20 if we can all kind of think of the patient's
21 perception of this sort of thing, I think it will
22 help everyone to understand this necessity.
23 So, when we're sick, we're
24 privileged to have access to some of the finest
25 medical care on the planet. There are many

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1 people with many different skill sets who serve
2 us as caregivers, including physicians, nurses,
3 physician assistants, physical therapists, social
4 workers, et cetera. The days are past when the
5 only caregiver was the neighborhood doctor. Many
6 people with many different credentials now serve
7 as primary caregivers in individual settings,
8 including private offices, hospitals, emergency
9 rooms, pharmacy clinics and many other venues.
10 So let's figure that your three-
11 year-old child, say your granddaughter or
12 daughter, develops a fever of 103 degrees and a
13 rash. So maybe this is a simple flu-like virus,
14 but could it be meningitis? I mean, that's one
15 of the things you have to rule out. So you take
16 her to the local pharmacy clinic where you are
17 assured by a pleasant individual in a white coat
18 that all is well, and you're given Tylenol; a
19 real thing, it really happens. It will happen
20 when they see a physician too.
21 But what were the credentials of
22 the person in the white coat? Was it a
23 physician, a nurse, physician assistant, a social
24 worker, pharmacist, or what? And would you have
25 chosen further consultation if you knew that in

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1 this particular case it was not a physician? We
2 have no way of knowing the credentials of that
3 individual in the white coat, because an
4 identification badge was absent or obscured or
5 too small to read or of a confusing design.
6 Another example, after your heart
7 attack, you awake 200 miles from home in a
8 hospital unfamiliar to you. At midnight, a
9 person in a scrub suit arrives to inject an
10 unknown substance intravenously. Wouldn't you
11 like to know immediately that this is a nurse and
12 not the medical secretary who is "helping" the
13 nurse, who is too busy elsewhere?
14 So, depending on our illness or
15 other circumstances, we patients may prefer to
16 see a physician or a physician assistant, a nurse
17 practitioner or physical therapist, all people
18 who have demonstrated competency, and we want to
19 see them in various circumstances of our choice.
20 Patients have the absolute right
21 to know the credentials of the person to whom
22 they entrust their lives during each and every
23 medical transaction. So keep in mind that there
24 is a wide spectrum of training and expertise
25 among caregivers. In spite of the fact that some

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1 wear badges, in a clinical setting, it's almost
2 impossible for us to know whether the person
3 offering care is a physician, nurse, physician
4 assistant, pharmacist, dentist, dental hygienist,
5 et cetera.
6 Furthermore, physicians in private
7 outpatient settings are not required to wear any
8 identification at all. This lack of requirement
9 is a throwback to the time when anyone in a white
10 coat was presumed to be a physician. So we
11 patients often have no idea at all of what the
12 alphabet soup of credentialing designations on a
13 badge means. If there is a badge and it says
14 PA-C, MD, CRNP, DO, RN, LPN, what does that mean?
15 So who is the person in the white coat or scrub
16 suit holding our lives in their hands?
17 The problem is, there is no
18 consistent design allowing the patient to read or
19 search the badge for credentials without
20 physically grabbing the badge, if there is a
21 badge. The credentials and most other
22 information on the badge are often too small to
23 read at a conversational distance.
24 If there is a badge, where on the
25 badge should we look for credentials that has

1 meaning which we can immediately understand?
2 More often than not, one cannot know the
3 licensure credentials and thereby the level of
4 expertise of the health care professional right
5 in front of us.
6 So here is the obvious question:
7 Why don't patients just ask, "What are you?"
8 Well, think of it as a patient or think of it as
9 a parent or a son or daughter of the patient. By
10 doing so, naturally we're afraid of insulting the
11 caregiver who is in front of us by questioning
12 her credentials right at the beginning of this
13 medical transaction. We're afraid of this, but
14 they often will literally hold our lives in their
15 hands or the lives of our loved ones. And so we
16 don't naturally as a person want to incite anger
17 or resentment in the caregiver; so you don't ask.
18 You're scared, and you don't ask.
19 So this is a simple solution
20 proposed by House Bill 2727. It requires that
21 all caregivers in Pennsylvania wear an
22 identification badge with some standardized
23 feature in each and every face-to-face encounter
24 with every patient in Pennsylvania. The most
25 important information for patients to know is

1 shown as the most prominent feature on the bottom
2 of the badge, and you all have badges in front of
3 you. And you see, as with this, you can read
4 this at a conversational distance. It's right up
5 front, and if you knew in Pennsylvania that
6 everybody had one of these on, you would know
7 exactly where to look and there wouldn't be any
8 questions. You then make your decision, I'm
9 going to continue with this or, you know what,
10 maybe I want to take this with whatever
11 appropriate grain of salt you may choose.
12 But your safety, we are all much
13 more dependent on ourselves as participants in
14 our care than we used to be, and we need this
15 information. So this is a simple badge. All
16 this says, all this thing really says is, it
17 gives identification in a stripe across the
18 bottom and a picture and the name of the person.
19 But everything else on the badge can be used by
20 hospitals or whomever to incorporate their own
21 particular needs.
22 Our friends in the Hospital
23 Association have led the way on this for 20 years
24 now. They have been identifying themselves. But
25 because of the varying designs from one

1 institution to another, we patients don't know
2 where to look on the badge for the licensing
3 credential. Some hospitals' ID badges have the
4 institutional logo and photograph or picture of
5 the hospital taking up most of the badge, with
6 the name of the caregiver and their license
7 credential too small to read.
8 Under this bill, that credential
9 will be prominently displayed on the bottom of
10 the ID badge in every hospital, nursing home,
11 physician office, pharmacy or other health care
12 facility in the state. Thus we patients will be
13 completely informed every time.
14 This bill and its badge design
15 provide plenty of space for hospitals to provide
16 any institutional information they require. We
17 recommend grandfathering in their existing
18 hospital badge and giving them perhaps a year to
19 retire the old designs.
20 So we patients make complicated
21 decisions regarding our own health care and that
22 of our loved ones each and every day. We need
23 for our safety every piece of information we can
24 get, starting with the nature of the education
25 and training of the persons to whom we entrust

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1 our lives.
2 Thank you for listening.
3 REPRESENTATIVE STURLA: Thank you.
4 Questions from members?
5 REPRESENTATIVE GERGELY: Doctor,
6 the proposal that you have put forth to us, have
7 you looked at other states that may have already
8 implemented this program with identification
9 badges and have implemented some of the
10 legislation associated with Representative
11 Killion from the states that have implemented
12 some of these things?
13 DR. LASKAS: Yes, I have looked at
14 it, and I looked at it when we first brought this
15 up before the Pennsylvania Medical Society about
16 two years ago. And I apologize; I thought on the
17 way down I should bring it, but there are other
18 states that have efforts in this; they've brought
19 it up in their badges, identified difficulties
20 and solutions to it, and this bill incorporates
21 their designs.
22 REPRESENTATIVE GERGELY: Any
23 specific states that you have found?
24 DR. LASKAS: That's my problem;
25 I'm sorry, I will have to provide that, but there

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1 were at least six states that had something.
2 REPRESENTATIVE GERGELY: That
3 would be helpful to look back from the
4 committee's perspective.
5 DR. LASKAS: Yes, I will provide
6 that for you.
7 REPRESENTATIVE GERGELY: Thank
8 you, Chairman.
9 REPRESENTATIVE STURLA: Thank you.
10 Other members?
11 REPRESENTATIVE ADOLPH: Thank you,
12 Chairman Sturla.
13 Doctor, thank you for your
14 testimony. One question: I see where you're the
15 Immediate Past Chair of the Patient Safety
16 Committee.
17 A. Present Chair.
18 Q. Nice to see you back. Do you have
19 any personal experience of identification being a
20 problem in any of our local hospitals?
21 A. I think the hospitals do quite
22 well. I'm most familiar with Crozer, and they
23 have good badges. The problem is the statement
24 of the credentials is about the same size as the
25 name of the individual. If you're familiar with

1 the badge and you know where to look, it's great.
2 If you don't know where to look, it's a little
3 confusing, as are most of them.
4 I know of many situations where
5 patients have gone to a physician's office for
6 serious dermatologic problems, and believe it or
7 not, there are life-threatening ones. And
8 they've been there five times and get referred to
9 the Chair of the University of Pennsylvania and
10 have never seen a physician. And they have a
11 severe life-threatening situation, and they're
12 seeing a physician assistant, which is great, but
13 at some point, they should know that they have
14 not yet seen a physician, let alone someone who
15 works in dermatology, just a trivial example.
16 But these things that we're
17 talking about as an example, a pharmacy, that
18 happens all the time. It's bad enough that you
19 have a physician who doesn't care or doesn't take
20 good care. We all make a decision on whether or
21 not this is the right person for us. Besides
22 trying to figure out whether or not they are a
23 really interested person or a competent person,
24 you want to know their credentials.
25 REPRESENTATIVE ADOLPH: Thank you

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1 very much.
2 DR. LASKAS: And if I could
3 respond to Representative Gergely one more time,
4 the thought as we look at the other states and
5 what they have done, it should be, I think, that
6 this state is the leader in patient safety
7 regulations in the United States. We need the
8 best, and we can look at other people and see
9 what they've done and we see that they've noticed
10 a need for it, and we can take from them, but we
11 want to have, I think, in our state the best
12 patient safety regulations possible.
13 REPRESENTATIVE STURLA: Thank you.
14 Any other members?
15 Next on the agenda is Dr. James
16 Goodyear, Vice-President of the Pennsylvania
17 Medical Society.
18 I would like to point out that we
19 have been joined by Representative Yewcic.
20 DR. GOODYEAR: Good afternoon,
21 Chairman Sturla, members of the Committee. I'm
22 Dr. James Goodyear, a physician and current
23 Vice-President of the Pennsylvania Medical
24 Society. I'm here today to discuss and support
25 House Bill 2727, also known as the Health Care

1 Practitioner Identification Badge Act.
2 First, I also want to thank
3 Representative Killion for introducing this
4 important legislation and commend my colleague,
5 John Laskas, M.D., also a physician, who is
6 essentially the father of this legislative
7 proposal. He did speak to legislators,
8 Representative Killion about this concept and
9 brought it to the Medical Society, especially
10 leadership, for our internal consideration.
11 House Bill 2727 would provide a
12 uniform standard in health care settings by which
13 patients can be apprised of the identity and
14 licensure credentials of individuals who provide
15 health care services to them. When treating a
16 patient working in a health care facility or when
17 engaged in face-to-face contact with the public
18 in a professional capacity, the health care
19 practitioner would be required to wear an
20 identification badge displaying the
21 practitioner's name, photograph, along with
22 license, certification or registration held by
23 that person. By doing this, the patient can
24 confirm whether or not Dr. Smith is a medical
25 doctor, specifically a physician, or not, even if

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1 the health care professional does not indicate
2 that verbally.
3 In the past, the provisions in
4 this bill were probably not necessary. Patients
5 knew that when someone walked into an exam or
6 hospital room and said they were Dr. Goodyear,
7 for example, the patient presumed that was a
8 doctor of medicine or osteopathy, a physician.
9 This has been generally accepted by the public
10 for many, many years.
11 However, with time, advanced
12 degree granting programs for other health care
13 professions gained momentum and have admittedly
14 helped to advance health care. Those finishing
15 with these programs sometimes earn a Ph.D., which
16 in academic settings is called a "doctorate." As
17 such, there are several types of doctorate
18 degrees other than MD and DO. This has led to
19 some concern as it relates to the hospital
20 environment.
21 Individuals other than MDs and DOs
22 may include Doctors of Nursing, Doctors of
23 Psychology, Doctors of Pharmacology, who may all
24 play a role in patient care in and out of the
25 hospital. We are certainly thankful for all

1 those academic enhancements, because ultimately
2 it benefits patients' care by increasing the
3 qualifications of health care professionals.
4 And let me just say as an aside at
5 this point, the Pennsylvania Medical Society
6 recognizes and supports the concept a health care
7 team as professionals that have strengthened the
8 health care environment in our state. It does
9 provide adequate and more efficient and safe
10 patient care. But this is an issue about
11 identity which has to do with patient
12 confidentiality and patient safety.
13 If used in the appropriate
14 setting, the use of the term "doctor" is not a
15 problem. If you're on a college campus, for
16 example, and someone introduces themselves as
17 "Dr. Smith," you could appropriately assume that
18 that person is a professor or dean or the
19 president of the university. This legislation,
20 however, is necessary for our patients, because
21 when the title "doctor" crosses into health care,
22 you start a game of confusion, particularly in a
23 patient setting.
24 Due to the various types of
25 doctors, there is mounting concern for the

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1 misunderstanding that this title may cause in the
2 hospital or similar health care settings. This
3 could result in unintended disclosure of personal
4 or confidential information to wrong parties,
5 increased patient safety concerns and risks and
6 compromise the quality of care provided.
7 In particular, I have significant
8 personal concern in the case of a patient
9 relaying a current symptom of her past history to
10 someone who calls himself or herself a doctor,
11 but who is not a physician. The result could be
12 the later misdiagnosis or an unintended
13 disclosure of personal health information to
14 those that don't have a realistic need to know.
15 The worst case scenario would be if critically
16 important information were unwittingly
17 communicated to a non-physician doctor who is
18 unable to process or advance that potentially
19 critical information so as to ensure safe and
20 quality care. This error can be avoided and
21 patient safety and confidentiality assured by
22 enactment of House Bill 2727.
23 Some who disagree with this
24 legislation would paint this as a turf battle,
25 but the reality is different, and the public

1 doesn't see it that way. According to a
2 September 2007 study by the Institute of Good
3 Medicine of the Pennsylvania Medical Society, the
4 public has concerns. Only 3.7 percent of
5 Pennsylvanians polled feel that it's okay for a
6 nurse practitioner to say they are "Dr. Smith,"
7 for example, without clarifying that they are not
8 a physician.
9 In other words, overwhelmingly,
10 the public wants clarification. They want to
11 know just who walked into their exam or hospital
12 room. With an ever increasing number of
13 individuals with doctorate degrees involved in
14 the expanded health care team, it is only just
15 and right that patients know from the start who
16 actually are their physicians and who are the
17 non-physicians in their midst, and they need to
18 know that this information is accurate.
19 Those with advanced degrees, as I
20 said, deserve to take academic credit for their
21 hard work, but they should not be allowed to fool
22 the public in a hospital setting. Full
23 transparency is necessary for the safety of
24 patient and quality care. Due to the importance
25 of providing patients with the best care, it is

1 crucial that there is no confusion on the part of
2 the patient, the family or the staff when
3 communications or other interactions occur.
4 Both the Pennsylvania Medical
5 Society and AMA policy have specific approaches
6 concerning the title and identification of
7 doctors in a hospital environment.
8 In addition, the Joint Commission
9 of the national organization that accredits and
10 certifies more than 15,000 health care
11 organizations and programs across the United
12 States and is recognized nationwide as a symbol
13 of quality and safety in health care has specific
14 standards to ensure that patients are given
15 specific information regarding their health care
16 provider. The Joint Commission's standards
17 mandate that a person receives information about
18 the person providing them care.
19 Patient safety, quality of care,
20 patients' rights and confidentiality are the
21 foundation of these policies and standards. Most
22 importantly, patients are demanding this
23 transparency.
24 If there are concerns about the
25 size of the badge, the size of the print, the

1 availability of badges or anything of this
2 nature, the Pennsylvania Medical Society is
3 certainly happy to work with the sponsor and this
4 Committee to make this proposal workable. What
5 we will not compromise is our position on patient
6 safety.
7 Again, the Pennsylvania Medical
8 Society supports House Bill 2727. It helps
9 patients understand who is treating them in the
10 health care setting and helps to ensure their
11 safety and quality of care.
12 Thank you. I will be happy to
13 take any questions.
14 REPRESENTATIVE STURLA: Thanks.
15 Representative Wansacz?
16 REPRESENTATIVE WANSACZ: Thank
17 you, Mr. Chairman. Thank you, Dr. Goodyear, for
18 your testimony. My question is -- I understand
19 the intent of the legislation, but are we seeing
20 a big problem in hospital patients being
21 mistreated by someone who is not a doctor and is
22 calling himself a doctor?
23 DR. GOODYEAR: I don't think as
24 yet we are seeing a big problem, but I think you
25 need to recognize that there is an expanding

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1 presence of individuals with doctorate degrees
2 entering into the health care team who are seeing
3 patients primarily within their specialty in a
4 health care environment. I think it's
5 appropriate for us to be proactive and prevent
6 that confusion, maintain the confidentiality and
7 patient safety and quality of care before there
8 is a problem, and not be reactive, seeing that
9 this problem has occurred and patients are
10 compromised in any way. This is an attempt to be
11 proactive and prevent that.
12 REPRESENTATIVE WANSACZ: So,
13 currently, you're not seeing a big problem with
14 it, but you're just trying to identify it before
15 it becomes a problem; am I correct?
16 DR. GOODYEAR: I do believe it
17 exists. If I may give you an anecdotal story,
18 Sarah Goodyear -- the name sounds familiar
19 because it's my daughter -- she happens to work
20 at Fox Chase Hospital and was in seeing a patient
21 and tried to get information from the patient and
22 was having a lot of difficulty. Then the patient
23 said, "If you don't mind, I'd rather talk to a
24 doctor." Well, Sarah Goodyear is a doctor. If
25 she would have had a name tag and hadn't given

1 that information to some other individual, maybe
2 it would have been a lot easier and the patient
3 care would have been a lot more efficient; so
4 it's a reverse, but it's still the same
5 situation. Patients are confused. They need to
6 know that information up front. It needs to be
7 accurate. The Pennsylvania Medical Society
8 believes we should be proactive on this.
9 REPRESENTATIVE STURLA: Okay;
10 thank you very much.
11 Next we have a panel from the
12 Hospital & Health Care System Association: Mary
13 Marshall, Director of Workforce and Professional
14 Services, and Eugene Zegar, Vice-President of
15 Human Resources at Crozer-Chester Medical Center.
16 MS. MARSHALL: Good afternoon; as
17 you indicated, I'm Mary Marshall, Director of
18 Workforce and Professional Services with the
19 Hospital & Healthsystem Association of
20 Pennsylvania. We represent and advocate for more
21 than 250 hospitals and health systems in the
22 Commonwealth.
23 We appreciate the opportunity to
24 express our view regarding House Bill 2727, the
25 proposed legislation that seeks to provide a

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1 uniform standard in health care settings by which
2 patients can identify their health care
3 professionals.
4 I would like to note that in order
5 enable the public to recognize and understand the
6 qualifications of the health care professionals
7 providing their care, the Department of Health
8 enacted regulations during 1998 which require all
9 Pennsylvania hospitals to properly identify
10 personnel. Adherence to these regulations is
11 enforced by the Department of Health through its
12 survey process.
13 HAP does not support this
14 legislation since there already are uniform
15 requirements for hospitals through the Department
16 of Health. This legislation, while well
17 intended, will duplicate a process already in
18 place and could lead to conflicting
19 identification processes. The accountability of
20 identifying health care practitioners in a
21 hospital appropriately rests with the hospital
22 under the purview of the Department of Health.
23 To illustrate how hospitals
24 fulfill this accountability, we've asked one of
25 our member hospitals to join us today so that

1 they can share with you how they meet the current
2 requirements in their facility.
3 I would like to turn the testimony
4 over now to Mr. Eugene Zegar.
5 MR. ZEGAR: Good afternoon. I am
6 the Vice-President of Human Resources at the
7 Crozer-Keystone Health System. By way of
8 background, Crozer-Keystone Health System is a
9 health system composed of five hospitals:
10 Crozer-Chester Medical Center, Delaware County
11 Memorial Hospital, Taylor Hospital, Springfield
12 Hospital and Community Hospital, all located in
13 Delaware County. As a health system, we
14 currently employ 7,100 people and are the largest
15 employer in Delaware County. In addition, we
16 have over 1,100 physicians on our medical staff.
17 I am pleased to offer a few
18 comments regarding House Bill 2727, also known as
19 the Health Care Practitioner Identification Badge
20 Act. For many years, the hospitals in the
21 Commonwealth have been in compliance with the
22 Department of Health regulations that require an
23 identification badge which displays the person's
24 name and professional designation. The Joint
25 Commission on the Accreditation of Health Care

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1 Organizations also has requirements for patient
2 and staff identification which we must comply
3 with. I would like to explain the system that is
4 currently used at Crozer-Keystone Health System,
5 and I suspect at many hospitals across the
6 Commonwealth, to meet these long-standing
7 requirements.
8 Our identification policy has been
9 in place with various provisions since 1983, over
10 25 years ago. No employee can begin work without
11 an identification badge, and our policy in part
12 provides:
13 The identification badge is the
14 property of the Crozer-Keystone Health System and
15 must be returned upon completion of employment.
16 An employee identification badge
17 bearing the employee's photograph, name and job
18 title will be issued to each new employee during
19 orientation before they set foot on the hospital
20 floor.
21 Department managers will send
22 transferred employees or employees with new
23 titles or name changes to the Security Department
24 for issuance of an updated identification badge
25 at the earliest possible opportunity, and this

1 happens on a regular basis, where there's changes
2 in names, changes in department, changes in
3 professional responsibilities.
4 Employee identification badges
5 must be worn as close to "eye-level" as possible
6 so that they can easily be seen by patients,
7 visitors, co-workers and others.
8 I believe the intent of House Bill
9 2727 models the Department of Health regulations
10 and models at least this health system's
11 policies, but there are several differences that
12 I would like to highlight. First of all, we
13 currently require identification for all
14 employees, not just those professions falling
15 under a licensing board and all 1,100 physicians.
16 If someone from the dietary department or the
17 housekeeping department goes in the patient's
18 room, that patient has the right to know who they
19 are. Under the current House Bill, those
20 employees would be excluded. Everyone who works
21 for a health system must have proper and current
22 identification, including agency or temporary
23 employees, as well as outside contractors. They
24 are also given a badge before they enter our
25 premises.

1 I would like to point out that
2 today most identification systems are
3 computerized programmable systems that encompass
4 much more than identification. At
5 Crozer-Keystone, the badges are programmed to
6 provide entrance into specific parking lots. The
7 badges are used to record time and attendance in
8 an automated payroll system and are utilized to
9 provide access to a limited number of employees
10 in those areas that are access controlled, for
11 example, the operating room, maternity
12 department, cashier's office or the pharmacy.
13 They're all controlled by access control.
14 These systems automatically record
15 the time and identification of all people
16 accessing the payroll system or the entrance
17 point into the medical facility. Identification
18 badges are also utilized to record attendance at
19 specific meetings or training sessions.
20 In addition, the programmable
21 video system provides a permanent database for
22 identification purposes throughout the health
23 system. Upon termination of employment, badges
24 of department employees are returned and
25 deactivated, denying access, yet maintaining a

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1 permanent picture record in our database.
2 The employer is currently charged
3 with the responsibility of ensuring compliance
4 with internal policies and state regulations. I
5 don't understand how the licensing board of 15
6 different disciplines can invoke discipline at
7 each hospital or health care facility as required
8 in the proposed legislation. This discipline and
9 removal from work is currently being handled by
10 the health care organization that has the current
11 responsibility of enforcing employee
12 identification regulations.
13 If an employee forgets or loses
14 his or her badge, the employee can be issued a
15 new badge at the workplace upon proving proper
16 identification, and the work schedule can be
17 maintained. If the state boards are responsible
18 for issuing badges, productive time will be lost
19 while waiting for a replacement badge.
20 Our badges cost between $5 and $10
21 to process, and we currently have badges for over
22 9,000 individuals. Project this cost over
23 200-plus hospitals in the Commonwealth. It's a
24 staggering figure. To replicate this effort
25 would be a huge financial burden to provide an

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1 identification system that is currently mandated
2 by the Department of Health and the Joint
3 Commission. The purpose of the current
4 identification regulations are to provide an
5 opportunity for patients to identify the
6 credentials and classifications of individuals
7 whom they connect with during their hospital
8 stay, and it appears to be meeting its purpose.
9 The proposed legislation would duplicate current
10 practices, add significant cost to an
11 overburdened system and potentially slow down the
12 employment process. If there are problems with
13 the current requirements, let's fix them, but
14 let's not duplicate what all hospitals are
15 currently doing and spread this responsibility to
16 15 or 20 different boards that are ill-equipped
17 to handle this mandate.
18 Thank you.
19 REPRESENTATIVE STURLA: Questions
20 from members?
21 REPRESENTATIVE KILLION: Thanks
22 for your testimony. As you may know, I'm a big
23 fan of Crozer-Keystone Health System.
24 DR. GOODYEAR: And we appreciate
25 your support.

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1 REPRESENTATIVE KILLION: You
2 mentioned that everyone who works in your health
3 care system must have a badge. Is that a
4 statutory requirement, or is that just something
5 that's --
6 DR. GOODYEAR: It's in our system,
7 but it is required by the Department of Health
8 regulations.
9 REPRESENTATIVE KILLION: And you
10 feel this would change that?
11 DR. GOODYEAR: I think it would
12 add a complexity that's currently not necessary.
13 For example, we have the responsibility; if we
14 had to wait for 15 different boards to issue
15 identification badges, which may not be in sync
16 with what our requirements are, it would take a
17 significant amount of time to adjust it, if you
18 will.
19 REPRESENTATIVE KILLION: My
20 interpretation of the legislation is just to make
21 it uniform so that when someone comes into the
22 patient's room, they know where to look, the
23 print is big enough so they can see it, and
24 they're not put in that awkward position of
25 having to ask for a doctor who can help them

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1 instead of an LPN. So it's clear, if you were to
2 issue your own badges and have control within
3 your own organization, however, it would be
4 standardized like this along the bottom, medical
5 doctor, would that make it more palatable
6 (indicating)?
7 DR. GOODYEAR: We can currently
8 program our current badges to meet any standards
9 that you set up; the font could be a different
10 size; we could put different colors in. But is
11 that our responsibility under the Department of
12 Health regulations, or does that become the
13 responsibility of 15 different boards that have
14 different standards? That's the part that causes
15 some concern.
16 REPRESENTATIVE KILLION: And
17 that's the purpose of a hearing like this, to see
18 if we all can come to some level of agreement.
19 My feeling would be that I would just like to
20 see, first of all, having it done as efficiently
21 as possible, but at the same time have a standard
22 set that makes it more comfortable for the
23 patients that they can see exactly who it is that
24 is treating them.
25 DR. GOODYEAR: We're in agreement

1 on that.
2 REPRESENTATIVE STURLA: Questions
3 from other members?
4 REPRESENTATIVE GERGELY: If I'm
5 following your line of thinking, if instead of
6 going to the board we went to the Department of
7 Health to then have this oversight of uniformity,
8 that would make more sense for you; is that
9 correct?
10 DR. GOODYEAR: That's correct.
11 Based on what I heard with the prior testimony,
12 it seems that the issue is not with the hospitals
13 per se. It may be with outside settings,
14 clinics, drugstores, things like that. This
15 legislation covers everything, and I think we
16 have legislation in place that currently covers
17 hospitals.
18 REPRESENTATIVE GERGELY: As it was
19 identified, as a result, it's also very general
20 in terms of non-uniformity in terms of the
21 hospital in Pittsburgh having replicated what the
22 hospital in Philadelphia does. I think we're
23 just in a flux. I know everyone is provided with
24 identification. You also pointed out a good
25 aspect, that this only requires that health care

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1 wear badges, not the security personnel. The
2 doctor has the security on his badge, but it
3 would have been required in the legislation. So
4 I think this is a transition to the next session,
5 and we should look at all that as we implement
6 this.
7 REPRESENTATIVE STURLA: Thank you.
8 I know in some cases where the different
9 professional boards have requirements that also
10 allow for equivalents, they were approved also.
11 It may be the case here where something would
12 happen with the Department of Health when they
13 say, "We're already requiring you do something."
14 You might be able to produce your own badges, and
15 they would have to produce at the state -- this
16 is, I guess, the tough part we're going to run
17 into when we get to the small facility that might
18 have two or three employees. Do they have the
19 wherewithal to produce their own badges, or
20 should we allow them to get them produced at the
21 local hospitals and how that might occur? But
22 those are some of the details we need to work out
23 on this.
24 Any other questions from any other
25 members?

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1 Next on the agenda we have Dr.
2 Bradley Fox.
3 DR. FOX: Good afternoon, Chairman
4 Sturla and members of the House Professional
5 Licensure Committee. My name is Dr. Brad Fox.
6 I'm a practicing family physician in Erie,
7 Pennsylvania, and I'm also President currently of
8 the Pennsylvania Academy of Family Physicians.
9 It is on behalf of the 4,700 members of the PAFP
10 that I speak with you here today in support of
11 House Bill 2727, the Health Care Practitioner
12 Identification Badge Act, introduced by
13 Representative Thomas Killion.
14 As a way of background, in August
15 of this year, the PAFP submitted written
16 testimony to this Committee in support of House
17 Bills 2715 and 2716, introduced by Representative
18 John Siptroth. That package of legislation would
19 amend Pennsylvania's Practical Nursing Law and
20 Professional Nursing Law respectively to add
21 statutory protection for the general term
22 "nurse." And to reiterate, the PAFP does support
23 those bills. The policy reasoning used to
24 support House Bills 2715 and 2716 was that some
25 health care technicians and assistants, either

1 explicitly or implicitly, were representing to
2 patients that they were "nurses." Our Family
3 Physician members certainly understand that this
4 could easily pose a threat to the public health
5 and safety when a patient may follow the clinical
6 advice of a person who is not educated, trained
7 and licensed to dispense that advice.
8 Particularly in my own office, I
9 have a roamer who is either a nurse's aide or
10 medical assistant who puts the patients in a
11 room, asks what they're there for that day, takes
12 a little bit of pertinent information along with
13 the vitals. When I go in the room, I reiterate,
14 "Hi, what can I do for you today?" They will
15 usually on many occasions say, "I already told
16 the nurse." In my office, we make sure that
17 people are identified as "medical assistants" or
18 "nurse's aides," and I try to educate my patients
19 that it was not the nurse they told; it was the
20 nurse's aide or a medical assistant.
21 Fast forward to our hearing today,
22 and our Family Physician members use identical
23 policy reasoning to assert their support for
24 House Bill 2727, the Health Care Practitioner
25 Identification Badge Act. House Bill 2727 would

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1 require that health care practitioners wear name
2 badges which identify and differentiate one
3 another so that a patient under can understand
4 who is treating them, what their level of
5 training and education may be, and, directly
6 corresponding to that, what type of advice they
7 are able to dispense to the patient. The PAFP
8 believes that House Bill 2727, the Health Care
9 Practitioner Identification Badge Act, would
10 provide additional and needed patient protections
11 using identical policy reasoning.
12 Now, this is not a physician-only
13 issue. This is a transparency issue, whether it
14 be medical assistants or nurse's aides versus
15 nurse, whether it be physician's assistant, nurse
16 practitioner versus doctor, whether it be a Ph.D.
17 versus an M.D. or D.O., or, quite honestly,
18 whether it be a family physician versus a
19 gastroenterologist or cardiologist. Right now
20 it's required to say "medical doctor." I'm proud
21 to say that that I'm a family physician, and if
22 my name tag said "Family Physician" versus
23 "Cardiologist," "Gastroenterologist" or other
24 sub-specialist, I would be perfectly proud to
25 wear that.

1 Throughout the Commonwealth, in
2 hospitals and in family medicine offices, family
3 physicians work collaboratively with all types of
4 very skilled allied health care professionals and
5 providers and attest to their skills in helping
6 to provide quality care to their collective
7 patient base. Quite honestly, right now the
8 Pennsylvania Academy and the American Academy of
9 Family Physicians is pushing forth the idea of
10 the patient-centered medical home, where a family
11 physician or primary care physician would oversee
12 all of the care of the patient, in collaboration
13 with other health care providers, nurse
14 practitioners, physician assistants, nurses,
15 medical assistants, and in doing so would take
16 care of the health of the patient not in an
17 illness-care model but in a well-care model.
18 This actually incorporates the whole idea of the
19 patient-centered medical home, allowing people to
20 practice to the full extent of their training
21 within a collaborative environment.
22 Once again, key to that is
23 transparency as to who's doing what and how. In
24 fact, many of these practitioners that I have
25 just mentioned just now have attained advance

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1 degrees, and some have even completed doctorate
2 programs. And the first boarding for the
3 advanced Doctorate of Nursing, the BNP, is going
4 to be November 23rd. This is hopefully going to
5 increase the positive impact on patient care,
6 and, quite honestly, I'm all for increased
7 education. Family physicians have to re-certify
8 every seven years or every ten years. We go
9 through the CNB process. We have required
10 credits. Advanced education can only help in
11 patient care.
12 However, the PAFP believes that a
13 patient can be misled when, either explicitly or
14 implicitly, the patient is led to believe that
15 the person treating them is a medical physician
16 or a medical doctor. House Bill 2727 would be
17 one attempt to provide patient disclosure as to
18 who is treating them and, again, what
19 qualifications they may have when dispensing
20 medical advice.
21 Each legislative session, the
22 House Professional Licensure Committee and the
23 General Assembly see many bills introduced, and
24 some are enacted that seek to amend the laws and
25 regulations of the Commonwealth to establish or

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1 increase the various scopes of practice that
2 professional advocacy groups argue are warranted.
3 While the merits of these proposals from the
4 patient and policy perspectives are debatable,
5 the fact that they are perpetually present is
6 not. And, as we work to keep our laws and
7 regulations on par with the practices that match
8 the education and training levels of each person,
9 we should also work to simultaneously keep the
10 patient informed and safe. The Health Care
11 Practitioner Identification Badge Act would work
12 toward both of those outcomes.
13 I opened this testimony with, "Hi,
14 I'm Dr. Brad Fox, a practicing family physician
15 from Erie, Pennsylvania." What if I had opened
16 it with "Hi, I'm Dr. Fox"?
17 The PAFP pledges to work with this
18 Committee, the Pennsylvania Medical Society and
19 others in administering this legislation should
20 it be enacted.
21 I thank you for the opportunity to
22 provide this testimony this afternoon. I will do
23 my best to answer your questions at this time.
24 REPRESENTATIVE STURLA: Thank you.
25 Any questions from members?

1 REPRESENTATIVE WANSACZ: Thank
2 you, Chairman Sturla. My question is where I can
3 see some of my local family physicians maybe
4 having a problem; if I go to my family physician,
5 there is one doctor, one nurse. I know who the
6 doctor is; I've been going to him the whole time.
7 If he forgets to wear his identification badge or
8 something, can he practice treating patients that
9 day, or if someone reports him, does he get in
10 trouble?
11 DR. FOX: One of the ways to look
12 at this is, how are you identifying what you're
13 doing. In my own particular office, we have a
14 photograph up in the waiting room of who the
15 players are and what their training is, with
16 identification underneath them. I don't
17 personally wear a badge at the moment. However,
18 were the law to go through, I would. The idea is
19 transparency. If a person can show that they're
20 making the effort to be transparent in what
21 they're doing, I think that's the goal.
22 How you actually enact the
23 process, the legislation itself speaks to badges.
24 The intent is good. It's making the transparency
25 come out that we'd like to see. And I'll work

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1 with you to make it work. In an office with one
2 doctor, one nurse and one front office person, I
3 would argue that a badge may not be necessary,
4 and there could be a way to do that, as long as
5 transparency is upheld.
6 REPRESENTATIVE WANSACZ: Well,
7 that would be my concern then, knowing that so
8 many people are busy. If they leave home and
9 forget their badge or they take it home that
10 night -- I can see that happening -- forgetting
11 they have it home, and they come in the next day
12 and somebody can report them. I can see people
13 would have problems.
14 DR. FOX: At my hospital right
15 now --
16 REPRESENTATIVE WANSACZ: I'm not
17 talking about hospitals right now. Hospital
18 status, as it was stated, most hospitals already
19 do have those procedures.
20 DR. FOX: But process why; if I
21 forget my badge and I walk into my hospital, I
22 don't practice. So it becomes a learned process,
23 or you leave a badge in the office and you leave
24 a badge in the hospital, or you leave a badge at
25 home in a locked place. I mean, there are ways

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1 to operationalize it. I can't argue how to
2 operationalize it or how even to legislate it.
3 The key is transparency. The key is the patient
4 safety. And I'm arguing for transparency and
5 identification.
6 How we accomplish it, the badges
7 right now make the easiest operational sense.
8 The question becomes do we get bogged down in the
9 process or do we make transparency happen.
10 REPRESENTATIVE WANSACZ: In your
11 office now, is every employee required to have
12 badges with their ID?
13 DR. FOX: Every single person in
14 the office but me wears a badge at the moment,
15 and I will put one on should the law go through.
16 REPRESENTATIVE WANSACZ: So what
17 I'm really concerned about -- I understand the
18 intent, and I've listened to the argument, and it
19 sounds good. The only thing I'm a little bit
20 concerned about is that this could be done now
21 currently if you wanted it to be done in your
22 practice --
23 DR. FOX: Correct --
24 REPRESENTATIVE WANSACZ: -- and
25 you turn around where some doctors may say, "Hey,

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1 I'm in here by myself. This is going to become
2 more of a hassle." That's what I'm concerned
3 about.
4 DR. FOX: In the office that
5 you're talking about where it's one doctor, one
6 nurse and one front office person, there is no
7 question of transparency. When you're working
8 with a doctor, a nurse practitioner, a
9 physician's assistant -- in my office, I'm a
10 physician; I currently have two physician's
11 assistants. My physician's assistants identify
12 themselves as physician's assistants. When
13 someone calls my senior physician's assistant
14 "Dr. Lisa," she corrects them, and she actually
15 corrects them repeatedly if she has to. She
16 doesn't want to be called "Dr. Lisa."
17 The way things work, however, is,
18 once again, my office has a feeling of
19 transparency. I'm on the forefront of this.
20 There are places where transparency may or not be
21 wanted, and there are ways to protect against
22 that as well.
23 Once again, it's not just a
24 physician issue. It's all levels. My medical
25 assistants need to be medical assistants. My

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1 nurse's aides need to be nurse's aides. And
2 people need to know who's taking care of them and
3 whom they're giving information to. If you have
4 someone taking your vitals who isn't trained to
5 take your vitals, you need to know that.
6 In my field -- and this is not
7 speaking for my specialty, and this is not
8 speaking for the group I am personally
9 representing; this is my own personal opinion --
10 I think we need to identify ourselves for what we
11 do. Too many patients come from the hospital,
12 and I ask them, "What did the gastroenterologist
13 tell you? You saw one while you were in there."
14 "Which one was he?" So, from my standpoint, I
15 think our badge should say "Family Physician" or
16 "Gastroenterologist" or "Cardiologist," but
17 that's me personally. I think transparency
18 should go that far, and I'm proud to call myself
19 a "family physician."
20 But the bottom line is patient
21 safety, patient education, patient understanding,
22 and it's getting blurry, and it's getting more
23 and more blurry, and, quite honestly, I think
24 it's becoming dangerous.
25 REPRESENTATIVE WANSACZ: Again, I

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1 understand your intent. I'm just saying maybe
2 there are certain ways that we can look at this;
3 maybe instead of requiring it for every practice,
4 maybe just for a practice that is so big. If
5 they want to voluntarily do it, fine; if they
6 don't --
7 DR. FOX: I take it a separate
8 way. If there are different levels of practicing
9 in the office, you need badge identification.
10 Once again, I tell you, in my office, my MAs say
11 "MA;" my nurses say "RN" or "LPN;" my medical
12 office manager, who is a certified CMOM, her name
13 tag in large letters says "CMOM." People ask,
14 "What's a MOM?" And my PAs say "Physician's
15 Assistant." I'm known to be a doctor, because
16 I'm the only doctor in the building. However, if
17 I would have a partner, I would probably put on a
18 tag so people would know I'm Dr. Fox versus Dr.
19 Whatever. I'm also the only male in the
20 building, which makes it a little bit easier for
21 me.
22 Once again, if you wanted to do
23 something -- we're getting bogged down in how to
24 enact stuff -- if you said there are different
25 levels, you need to identify who is at what

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1 level, period. If it's one physician, it's going
2 to be painfully obvious who that is. If you
3 start talking two physicians, one nurse
4 practitioner, one physician's assistant, a couple
5 of MAs and a nurse, yes, you need to identify who
6 is what and what they're doing.
7 REPRESENTATIVE WANSACZ: Thank
8 you.
9 DR. FOX: Absolutely.
10 REPRESENTATIVE STURLA: Any other
11 members with questions? Representative Waters,
12 who has joined us?
13 REPRESENTATIVE WATERS: Thank you,
14 Mr. Chairman. Thank you, Dr. Fox. I'm sorry; I
15 missed some of your testimony, but this law will
16 correct what problems that have already occurred?
17 DR. FOX: I'm going to go two
18 levels on that. The problems that are occurring
19 currently are people are being thought of as
20 nurses when they're medical assistants,
21 especially in hospital settings. They're being
22 thought of as physicians when they're nurse
23 practitioners or physician's assistants.
24 There's also the future that is
25 coming, which there are going to be five to seven

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1 different types of doctors practicing in a
2 hospital setting. You'll have the medical
3 doctor, the MD; the doctor of osteopathy, the DO.
4 You'll have the pharmacist doctor, the Pharm.D,
5 which is practicing in the pharmacy but also
6 seeing patients and working on charts. You will
7 have the Psy.D, or the psychology doctor, who is
8 a Doctor of Psychology but is not necessarily a
9 physician. You'll also have the Ph.D, where you
10 have psychologists and other allied health care
11 professionals.
12 In some hospitals in larger
13 settings, you can have the D.C, which is a Doctor
14 of Chiropractic. And coming up as of November
15 23rd, as I mentioned earlier, there will be the
16 DNP, or the Doctor of Nursing Practice.
17 So, if someone walks in the room
18 and says "I'm Dr. Fox," what are you being
19 treated by? If someone walks in the room and
20 takes your vitals, and you say, "You know what,
21 my stomach really hurts; I'm having a lot of
22 pain," is that a medical assistant who's doing
23 your vitals, or is it a nurse who can actually do
24 something? The mistakes that have happened so
25 far is when people tell a medical assistant that

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1 they're having abdominal pain or that they're
2 having a problem that needs to be enacted upon,
3 the medical assistant is not in a position to be
4 able to do that.
5 The problem that's coming in the
6 future is when a doctor walks in the room and you
7 don't know what you're talking to. And the
8 protection is for the patient, because they need
9 to know whom they're addressing, at what level of
10 education they're addressing and at what level of
11 response they can get. It's really a
12 transparency issue and a patient safety issue.
13 Does that answer what you're
14 asking?
15 REPRESENTATIVE WATERS: Well, you
16 answered my question, I guess, but my concern
17 will be how informed will the patient be to know
18 who they should be talking to. When a person is
19 sick or in an emergency situation, I think if a
20 white coat comes in there, they're going to be
21 happy and trust that the person is not imitating
22 a line of work that they're not qualified to
23 handle. Are you saying that some medical people
24 might come in there and misrepresent themselves?
25 DR. FOX: Absolutely, whether

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1 implicitly or explicitly. It happens now, and,
2 quite honestly, if a badge says "Medical
3 Assistant" on it or says "Physician's Assistant"
4 on it or says "Medical Doctor" or "Nurse
5 Practitioner" on it, and that engages
6 conversation with the patient, then, quite
7 honestly, I think that really serves the purpose
8 of educating a patient, whether they have to read
9 up on what it is ahead of time or whether it
10 stimulates them to say, "Oh, what is a medical
11 assistant?"
12 You know, everyone -- not
13 everyone; let me back up. Patients assume
14 they're being treated by nurses and doctors.
15 They usually blur the other letters that were
16 mentioned in previous testimony, that several
17 different people are involved in their care. The
18 best way to educate is to be up front and forward
19 about what's happening as opposed to just
20 assuming whoever gets in there is going to be
21 good. And, quite honestly, I think that's the
22 way to do it, to be proactive.
23 REPRESENTATIVE WATERS: So this
24 would help the medical profession, the board or
25 the people in charge of overseeing enforcement,

1 that they would be able to easily go after
2 pretenders. I mean, what is the consequence for
3 a person if they have this medical badge
4 identification requirement in place and a person
5 still misrepresents their profession? Then what
6 would you do?
7 DR. FOX: Well, currently there's
8 statutes in place that a nurse practitioner or a
9 physician assistant needs to identify themselves
10 for what they are, and if someone calls them a
11 "physician" or "doctor," they have to say they're
12 not. There are professional advocacy groups out
13 there who are trying to get this legislation
14 removed currently. So right now there's already
15 legislation that you can't do that.
16 The biggest thing we're trying to
17 prevent is people assuming they're getting
18 different care than they're getting. And on the
19 other side of it, once again, proactively, people
20 should understand and they should know who's
21 taking care of them. They should be in the loop.
22 They shouldn't just assume whoever walks in the
23 room is someone who needs to be there for
24 whatever reason.
25 In my office, once again, I like

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1 the patients to know when they're being treated
2 by an LPN, when they're being treated by a
3 medical assistant, when the physician's assistant
4 is treating them and when they're seeing the
5 doctor. You know, my patient always says,
6 "You're the doctor; you're the boss;" not today,
7 not in 2008. In 2008, it's a partnership. It's
8 a health care environment where every person is a
9 player, and the more up front you are with the
10 patient, the more honest you are with the
11 patient, the more you bring them into the loop,
12 the better their care is going to be, and that's
13 my goal.
14 REPRESENTATIVE WATERS: And my
15 final question -- thank you for your tolerance
16 -- if this becomes law, what will be the practice
17 or the method that we use to make sure that these
18 badges can't be duplicated or these badges can't
19 be counterfeited?
20 DR. FOX: That's actually a great
21 question. As the representatives before from the
22 Hospital Association stated, this is a process
23 that has been going on for years. All hospitals
24 for the most part, as far as I know, do have a
25 system in place for having their badges and using

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1 them. And, quite honestly, the question came up,
2 how do we replace all these? It's a big
3 expenditure. Well, it's a one-time expenditure
4 that you just add on people in the future. I've
5 known hospitals that have changed all their
6 badges because they've changed their colors for
7 brand-name purpose. So it's an interesting
8 argument.
9 How you go against counterfeiting?
10 The same way that the hospitals are currently
11 doing it now, whether it be a bar code, whether
12 it be with holographs, hologram technology, as
13 some hospitals do. When you're talking about in
14 an office, quite honestly, in an office setting,
15 there shouldn't be an issue. And the only place
16 it would be an issue is if someone is opening
17 their own office, and then it comes under all the
18 other laws. So I don't think for the most part
19 it's really a problem that would come up, because
20 unlike representing yourself as an officer of the
21 law or representing yourself as a member of the
22 military -- which is against the law, but you
23 could do that -- representing yourself as a
24 physician, a nurse practitioner, a PA, a nurse,
25 et cetera, is not something that you can really

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1 go out and do outside of an office or a hospital
2 setting where you would have a badge where it
3 would come up. So I'm not sure the issue really
4 becomes an issue.
5 REPRESENTATIVE WATERS: Thank you.
6 I'm not opposed to people being properly
7 identified, but I don't want them to feel too
8 comfortable with an ID where maybe they shouldn't
9 be as comfortable. So that's something I'm a
10 little bit uncomfortable with.
11 REPRESENTATIVE STURLA: Thank you.
12 Questions from other members?
13 DR. FOX: Thank you very much. I
14 regret I can't stay for the rest of the
15 testimony. I have another meeting in Hershey in
16 about two and a half hours.
17 REPRESENTATIVE STURLA: Okay.
18 Next on the agenda is Dr. David Pao, President of
19 the American Academy of Ophthalmology.
20 DR. PAO: I wish to express my
21 appreciation to the Committee on Professional
22 Licensure to allow me to testify regarding Bill
23 2727. I am David S.C. Pao, M.D., an
24 ophthalmologist in private practice in Bucks
25 County for 30 years. I'm on the staff of Wills

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1 Eye Institute, and I'm also the President of the
2 Pennsylvania Academy of Ophthalmology; the
3 acronym is PAO, coincidental. PAO has been
4 working to preserve and protect vision and eye
5 health for Pennsylvania citizens since 1943.
6 This testimony is on behalf of our members.
7 Ophthalmologists have always
8 needed to contend with the definition of the
9 three O's: Ophthalmology, optometry and
10 optician. Opticians make eyeglasses.
11 Ophthalmologists are medical doctors who have
12 gone to medical school or an osteopathic medical
13 school. They then complete one year of
14 internship and three years of residency to
15 practice ophthalmology. Optometrists attend
16 optometry school after college.
17 Thirty years ago, there was a
18 marked distinction between our two professions.
19 Ophthalmologists took care of patients medically
20 and surgically. Optometrists dealt mostly with
21 eyeglasses or contact lenses. In the past 30
22 years, optometry has increased its scope of
23 practice to allow treatment of most medical eye
24 diseases; although there are some limitations in
25 Pennsylvania. They are not allowed to practice

1 ophthalmic surgery. However, New Mexico and
2 Oklahoma do allow laser surgery and limited
3 eyelid conjunctiva surgery.
4 There is no objection to the use
5 of non-physician health professionals to treat
6 patients. We definitely need them. Most doctors
7 employ nurse practitioners in their offices
8 because of this need. The crux of the issue is
9 supervision. Each new patient is seen by the
10 physician first to make sure that there is
11 nothing urgent that only he or she with a medical
12 education can tell. Once this is done, the
13 physician maps out a treatment plan, and then the
14 patient can see the nurse practitioner on
15 subsequent visits. This is the best medical
16 care.
17 Under the Pennsylvania Medical
18 Practice Act of 1985, a physician is defined as
19 one who has gone to medical school or osteopathic
20 medical school. The federal registry defines a
21 physician as one who is licensed to practice
22 medicine and surgery by the individual state's
23 board of medicine. This is an important
24 clarification to make. The physician has the
25 ultimate responsibility, and the nurse

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1 practitioner or other ancillary personnel
2 practices under his auspices.
3 If you have a minor problem and
4 you go to your physician's office, the nurse
5 practitioner may see you and take care of you,
6 but most importantly, they already have your
7 medical history, and you have already been
8 evaluated by a physician. If you go to a retail
9 medical clinic or medical spa, no one has seen
10 you before, and there is no medical history on
11 record. You may have only a minor respiratory
12 infection, and you may want to receive some
13 antibiotics. In the case of children, they may
14 appear to have minor respiratory infection one
15 day, and the next day it turns out to be
16 meningitis.
17 This was shown at the University
18 of Pennsylvania Emergency Room about a month ago;
19 a person went to the emergency room, and three
20 days later it was meningitis. And here he was
21 seen by a physician. So we can't find them all.
22 But that was a subspecialty. He went through all
23 the tests, and it was negative.
24 It is still your right to go to
25 these clinics, but you have the right to be

1 informed of the education of the practitioner.
2 The nurse practitioner and the
3 physician assistant do receive good training
4 under the current educational guidelines, and
5 their scope of practice reflects this. However,
6 the depth and duration of their education and
7 training are not equivalent to those physicians
8 undergo. With his or her education, the
9 physician is better able to diagnose conditions
10 in their early stages. Once you have seen a
11 fire, anyone knows it's a fire. You need someone
12 with training to suspect smoke or that something
13 is not just right. That is where the physician's
14 four years of medical school, one year of
15 internship and three to five years of residency
16 make the difference.
17 As long as the patient knows the
18 experience and the education of the practitioner,
19 he or she can decide whom to consult. I have no
20 qualms about a patient seeing anyone. They can
21 see an herbalist or an alternative medicine or
22 naturopathic practitioner. They can see an
23 acupuncturist, as long as they know whom they are
24 consulting. The danger is that half the
25 population sees a person with a white coat and

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1 stethoscope and assumes that they are fully
2 trained physicians and medical school graduates.
3 This bill will give to patients the information
4 they need to make informed decisions about health
5 providers.
6 However, I also recommend the
7 posting of signs in waiting rooms and reception
8 areas that explain the differences in educational
9 backgrounds of various health providers. When I
10 go to a hospital waiting room, there is a huge
11 sign that says, "This is your patients' rights.
12 This is your HIPPA rights." I go to the break
13 room of the hospital, and there's a big sign that
14 says, "Here's your federal employees' rights."
15 But I don't see any sign that says "This is the
16 educational background of your practitioner."
17 Patients deserve information on their
18 practitioner's training. I hope this can be
19 included.
20 While the patient deserves to know
21 the truth, we must be careful in the amount of
22 cost of more regulations. Regulations have cost
23 medicine, I estimate, 30 percent additional.
24 They have necessitated a lot more paperwork.
25 They have driven my colleagues away from medical

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1 practice and have deterred them from encouraging
2 their children to go to medical school. That is
3 a shame.
4 The government and the insurance
5 companies are not helping the patient sort out
6 the different professional titles of health
7 providers. Twenty-five years ago, Medicare
8 listed optometrists, podiatrists and
9 chiropractors as physicians under the Medicare
10 payment system. As a result, they have expanded
11 their scope of practice, and patients do not
12 understand the differences in their training.
13 Even many legislators do not know the
14 differences.
15 For example, our coroner in Bucks
16 County is a podiatrist, although I learned upon
17 inquiry that the county does have a contract with
18 a pathologist in Philadelphia should an autopsy
19 ever be needed. So my impression is our coroner
20 pronounces them dead on their feet; sorry, I had
21 to put that in there.
22 We hope the definition of a
23 physician does not change as it is stated in the
24 Medical Practice Act of Pennsylvania. An
25 additional problem is the title of "doctor" in

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1 front of the name. Dr. Fox alluded to this in
2 the previous testimony. As stated, many people
3 use the title "doctor" but never went to medical
4 school: Dr. Phil, Dr. Joyce Brothers, Dr. Desert
5 Dry, Dr. J. Even now, there's a two-year program
6 for nurse practitioners to receive a doctorate in
7 nursing. The question is, do we now call the
8 person "doctor doctor," or do we call them
9 "doctor nurse"? Many professional degrees award
10 a doctorate. As stated, there is a "Doctor of
11 Nursing," Doctor of Chiropractic," "Doctor of
12 Podiatry" and "Doctor of Optometry." Hopefully,
13 proper designation under this law will clarify to
14 the patient that these "doctors" did not go to
15 medical school. Also, as on your agenda, you
16 have listed five of us as doctors without
17 designating whether we're MDs or DOs or ODs, et
18 cetera. So even your person who makes up the
19 agenda did not differentiate us, but fortunately
20 I think we're all MDs. But that's an assumption
21 by the members.
22 I'm not saying that patients
23 should not be treated by them. They are a vital
24 part of our health provider network and are
25 needed to provide health care for all our

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1 citizens. I just want patients to know the
2 qualifications of their providers, in my case,
3 physician.
4 In conclusion, I want to make a
5 recommendation about name badges. These badges
6 already exist and are provided by the hospitals
7 across the states. Extending the requirement for
8 badges to all will be beneficial. If the
9 existing badges conform to HR 2727, then there is
10 no need for additional duplication by the state
11 with additional costs.
12 You have asked about the cost.
13 I'm a single solo practitioner with an associate.
14 These cost $6. I think we can afford it
15 (indicating).
16 The other two things I wanted to
17 add after hearing the testimony is that
18 transparency is important. It's not just
19 proactive right now. It's action that's needed.
20 It's not a question of the honest people saying
21 who they are. It's those who are outrightly
22 dishonest or those who are "misrepresenting"
23 themselves but don't know it. This is the main
24 problem. I just received a card from the Mina
25 (ph.) Clinic, and on it, it says "Your provider

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1 is a board certified health practitioner."
2 The other thing is, I can imagine
3 if we didn't have some of this transparency in
4 the military; it would really be a problem,
5 because we all know who's a non-commissioned
6 officer. We also know who's an officer, who's a
7 general, what detail they're in, whether they're
8 medical or they're in artillery or armory. The
9 military has identified things must easier than
10 we have.
11 That was my main comments I had,
12 and that's not in the written statement. Thank
13 you for allowing me this opportunity to testify.
14 REPRESENTATIVE STURLA: Thank you.
15 Questions from members?
16 REPRESENTATIVE WATERS: Two quick
17 comments: I would have wished you would have
18 added Dr. Dre in here, but please leave Dr. J
19 alone. I think he earned his title. That really
20 comes from him, "mean dude" for MD. That's how
21 he got to be Dr. J.
22 DR. PAO: I think the Pennsylvania
23 Medical Society can grant him an honorary
24 doctorate.
25 REPRESENTATIVE STURLA: Questions

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1 from other members? All right; thank you.
2 Next on the agenda is Dr. Gamba,
3 President of the Pennsylvania Dental Association.
4 I'll also point out that
5 Representative Petrarca has joined us.
6 DR. GAMBA: Good afternoon,
7 Chairman Sturla, Representative Killion,
8 distinguished members of the Committee. I am Dr.
9 Thomas Gamba, and just for your clarification, my
10 doctorate is a Doctor of Dental Surgery, nothing
11 else. I'm a general dentist practicing in
12 Philadelphia, and I'm also President of the
13 Pennsylvania Dental Association. We appreciate
14 the opportunity to testify today on behalf of my
15 constituents, more than 5,500 members who are
16 licensed to practice dentistry in Pennsylvania,
17 concerning HB 2727.
18 We appreciate the legislature's
19 overriding concern to protect patients by
20 ensuring that only qualified individuals licensed
21 or certified by the state are providing
22 treatment. We certainly do not condone the
23 actions of unqualified individuals falsifying
24 their identities and placing patients' health and
25 lives at risk. We understand that this bill was

1 introduced to prevent the occurrence of such
2 incidents as baby kidnapping or inappropriate
3 dispensing of medication. However, the
4 Pennsylvania Dental Association is concerned
5 about the practical application of requiring
6 identification badges for those individuals in
7 the dental profession.
8 We understand that the genesis of
9 this legislation is to prevent identity fraud in
10 larger clinical or hospital settings. However,
11 the preponderance of dentists are small business
12 owners and solo practitioners. They usually have
13 a small number of staff and work in more confined
14 areas than hospitals or other larger health care
15 facilities. Most dentists have less than ten
16 employees. I personally have two. The PDA
17 believes that an identification badge would not
18 be necessary in this type of a setting, where it
19 is virtually impossible for individuals to
20 fraudulently work as a dental professional. PDA
21 urges the Committee to consider amending HB 2727
22 to include language similar to that found in a
23 parallel North Carolina statute, and I will quote
24 that: "The badge or other form of identification
25 is not required to be worn if the patient is in

1 the health care practitioner's office and the
2 name and the license of the practitioner can be
3 determined by the patient on a posted license, a
4 sign in the office or a brochure provided to the
5 patients, or otherwise." This provision could be
6 made specific to the dental profession, of
7 course.
8 There are two other points that we
9 would like the Committee to consider: Most
10 importantly, we are concerned about the potential
11 risks of cross-contamination between the
12 patients. The patients are often laying prone in
13 dental chairs with a dentist or other team member
14 leaning over them to provide treatment. Because
15 of the close contact, it is feasible that a
16 patient's saliva or blood containing
17 microorganisms could transfer to the name badge
18 and then to another patient. The name badge will
19 not be sterilized like the dental instruments
20 used during treatment.
21 We also have a small concern as to
22 whether the Bureau of Professional and
23 Occupational Affairs currently has the capacity
24 to handle the issuance of identification badges
25 to all health care professionals or if additional

1 staff would need to be hired. We have a
2 weakening economy, and we caution against raising
3 licensing and certification fees to process
4 identification badges and possibly even hire
5 additional staff to do that.
6 So I thank you for the opportunity
7 to speak with you here today about this bill. We
8 appreciate your careful consideration of our
9 request to exempt individual dental
10 practitioners' offices from this bill, and I
11 would be happy to answer any questions you have.
12 REPRESENTATIVE STURLA: Thank you.
13 Questions from members?
14 I'll just make one comment: I saw
15 a study a few years ago that claimed that the
16 most contaminated thing in a hospital was the
17 neck ties that doctors wore, because they would
18 flop into each patient, and they would carry the
19 bacteria from patient to patient as they went and
20 did rounds in the hospital. I think, and I don't
21 know whether it's in the bill or not, but I
22 remember one incarnation where there was concern
23 about particularly doctors in operating rooms,
24 and then they would be embroidered in on their
25 uniforms and things like that so that you could

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1 prevent the need for the badge that would flop
2 around or carry microorganisms. Would that be
3 something that you would think would perhaps make
4 sense?
5 DR. GAMBA: In a dental practice?
6 REPRESENTATIVE STURLA: Yes.
7 DR. GAMBA: It would be better
8 than the badge, yes. Of course, many of us use
9 scrubs that we change frequently or the
10 traditional white coat that is also laundered
11 properly. But our main objection is really just
12 that it would be unnecessary in a dental
13 practice, we think.
14 REPRESENTATIVE STURLA: Questions
15 from other members? Thank you.
16 DR. GAMBA: Thank you, sir.
17 REPRESENTATIVE STURLA: Next on
18 the agenda, we have a panel from the Pennsylvania
19 Physical Therapists Association: Ivan Mulligan,
20 President-Elect; and Colleen Chancler, Southeast
21 District Director.
22 MS. CHANCLER: Mr. Chairman,
23 members of the Committee, invited guests, good
24 afternoon, and thank you for the opportunity to
25 testify regarding House Bill 2727.

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1 Unfortunately, we do not have copies of our
2 written statement, but those will be
3 electronically sent and are being sent as we
4 speak. My name is Colleen Chancler, and I'm a
5 licensed physical therapist and the Director of
6 the Pennsylvania Physical Therapy Association.
7 I'm employed at the University of Pennsylvania
8 Health System as a site manager for occupational
9 and physical therapy. I'm joined today by Ivan
10 Mulligan, who is also a licensed physical
11 therapist and is President-Elect of the
12 Pennsylvania Physical Therapy Association. Ivan
13 is a faculty member at St. Francis University and
14 is Director of Sports and Orthopedic Physical
15 Therapy. We are here today to represent the
16 Pennsylvania Physical Therapy Association.
17 The Pennsylvania Physical Therapy
18 Association supports the concept behind House
19 Bill 2727 that health care practitioners be
20 required to wear an identification badge so that
21 patients can be apprised of the identity and
22 licensure credentials of the individuals who are
23 providing them with health care services. In
24 fact, this is a concept consistent with the
25 American Physical Therapy Association's policies

1 and positions designed to ensure that the patient
2 is aware of the training and education of the
3 person providing the health care services.
4 The PPTA, however, does have some
5 concerns with House Bill 2727 in its current
6 form. First, the PPTA believes that it is
7 important that there are some qualifications
8 placed around the disciplinary actions to be
9 taken against the health care practitioner for
10 violating the requirements of House Bill 2727.
11 For example, as mentioned previously, if a
12 licensee forgets his or her identification badge
13 but utilizes a temporary identification badge
14 that is not in strict compliance with the current
15 House Bill 2727, the PPTA does not believe that a
16 disciplinary action is appropriate.
17 Also, the facility may require
18 that an employee wear a badge that has a
19 particular style, and that badge may not be
20 provided by the licensure board. In such a
21 situation, it appears that there should be some
22 obligation of the facility in addition to the
23 licensee, as the facility would have no control
24 over the design and the distribution of that
25 identification badge.

1 Secondly, PPTA is concerned how
2 House Bill 2727 would affect physical therapist
3 students and physical therapist assistant
4 students. If a facility elects to utilize the
5 identification badge issued by the board, a
6 mechanism should be in place to account for
7 students who will not be directly covered by the
8 board and therefore would not be eligible to
9 receive a board-issued identification. Otherwise
10 facilities would be required to adopt independent
11 identification badges and have them approved by
12 the board for the sole purpose of use by
13 students. Depending on the interpretation of
14 House Bill 2727, this also may be an issue for
15 physical therapists and physical therapist
16 assistants functioning under a temporary license.
17 Finally, PPTA believes that it is
18 important that adequate lead time be included
19 with the legislation to allow the licensee to be
20 issued an identification badge. For example, if
21 House Bill 2727 should pass, it will likely take
22 large facilities like I work in a number of
23 months to issue identification badges to each of
24 their employees. Also, on the issue of private
25 enforcement, PPTA has concerns with individuals

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1 who begin work prior to receiving a badge and
2 whether or not a grace period for compliance
3 could and should be included.
4 Should legislation similar to
5 House Bill 2727 be introduced and passed into law
6 in the future, we respectfully ask that the
7 Committee and the Bureau of Professional and
8 Occupational Affairs consider PPTA's comments in
9 developing regulations and any additional
10 exceptions.
11 On behalf of PPTA, we thank you
12 for providing the association with this
13 opportunity to testify before the Committee, and
14 we welcome any questions.
15 REPRESENTATIVE STURLA: Questions
16 from members? The luck of the draw also, it's
17 later in the day.
18 MS. CHANCLER: Absolutely; thank
19 you.
20 REPRESENTATIVE STURLA: Thank you.
21 I'll point out also that we've been joined by
22 Representative Ramaley. And we will call the
23 last person to testify, Andrea Devoti, the Public
24 Policy Committee Chair for the Pennsylvania
25 Homecare Association.

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1 MS. DEVOTI: Good afternoon; my
2 name is Andrea Devoti, as you've already heard.
3 I'm the Executive Director of Neighborhood Health
4 Agencies, which is a homecare and hospice in
5 Westchester, Pennsylvania. I'm also the Chair of
6 the Public Policy Committee for Pennsylvania
7 Homecare Association. You have my testimony in
8 front of you. I'm not going to read it to you.
9 What I would like to do is just point out a few
10 things that I think are important.
11 One, as the Hospital Association
12 already has pointed out, homecare, hospice and
13 personal care facilities are already under the
14 Pennsylvania Department of Health Licensure Act,
15 and under that, we are required to provide
16 identification badges that display a person's
17 name, professional designation, license. We also
18 include their picture, and have done so for over
19 ten years. They mirror what's in House Bill
20 2727. So I feel that in a way it's duplicative
21 for those of us who are under those legislative
22 acts.
23 What I would like to really point
24 out is perhaps we could add to the bill or
25 something near about identifying essential

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1 employees. For those of us who don't practice in
2 a hospital or a physician's office but that drive
3 over three million miles a year to see people in
4 their own homes, when there's times of crisis in
5 our state, on the back of our ID badge, courtesy
6 of our county, we have a statement that we are
7 essential employees. So those people who are on
8 medical devices at home in a crisis, a flood, a
9 blizzard, we can get to them to assist them in
10 their homes so that there's not a crisis
11 requiring them. So I'd really like to suggest
12 that become part of the ID badge, as well as to
13 clarify what a health care facility is. Does
14 that include only facilities licensed under the
15 Health Care Facility Act, or does it include
16 other things, such as personal care homes and
17 licensed assisted living, boarding homes or other
18 places licensed by DPW? Can they apply for
19 alternative badges, and also what is the criteria
20 for an alternative badge? If our badges meet all
21 the criteria -- and, again, ours are $5.60
22 apiece -- could we provide them so that our
23 people have them, they can go into the home and
24 not delay patient care?
25 So I thank you for the

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1 opportunity. I commend the legislation and
2 welcome any questions.
3 REPRESENTATIVE STURLA: Thank you.
4 Questions from members?
5 I'll just make one comment: I
6 appreciate the suggestions you have made here.
7 One of the things that we go through as
8 legislators, we are in most cases jacks-of-all
9 trades and experts of none. But as we look at
10 these pieces of legislation, it's always good to
11 get the feedback as we have today about what is
12 right and what is wrong, how it can be made
13 better. This is the kind of stuff that makes for
14 good legislation in the end, and I think it's
15 well worth taking the time that we have today to
16 get to that point. So I just want to thank you
17 for your testimony and the other people who
18 testified also.
19 Representative Killion?
20 REPRESENTATIVE KILLION: I would
21 just like to thank the Chairman for holding the
22 hearing today and thank everybody for their
23 testimony. As I said a little earlier, this is a
24 process we want to move forward. We can make it
25 a better bill, and the testimony we had today is

1 what we need in order to do that. Thank you.
2 REPRESENTATIVE STURLA: Thank you.
3 Any other comments from members? With that, we
4 will adjourn this hearing. Thank you.
5 (The hearing was concluded at 4:15
6 p.m.)
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1 C E R T I F I C A T E

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3 I hereby certify that the

4 proceedings are contained fully and

5 accurately in the stenographic notes taken

6 by me on the Hearing of the within cause

7 and that this is a correct transcript of

8 the same.

9

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DEBRA RICE

11 PROFESSIONAL COURT REPORTER

12 DATED: November 12, 2008

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