[The Pointer Sisters'
"Yes We Can Can" plays]
>> Help each man be a better man
With the kindness that we give
>> I know we can make it
>> I know that we can
>> I know darn well
We can work it out
Yes, we can
I know we can, can
Yes, we can, can
Why can't we?
If we wanna, yes, we can, can
>> I know we can make it work
I know that we can make it if
we try
>> Oh, yes, we can
I know we can, can
Yes, we can
>> Great gosh
>> This is your local agencies,
and we'll be working with
families, as well.
Call 774-7477 to make an
appointment.
So far, it's my understanding
they've got about 90 families
enrolled to participate in this
screening.
So whenever there's an
opportunity to get some kind of
medical attention at no cost, I
suggest you take advantage of
that.
So that's the Health Brigade
activity, which is gonna be,
again, March 19th through the
23rd in St. Thomas, St. John, at
Elaine Co., the MCH -- Maternal
Child Health building that's
across from Nisky Center and
the Moravian School, and it's on
March 24th in St. Croix at the
Maternal Child Health Clinic,
and that's at the
Charles Harwood Complex.
So we are privileged today.
We have a guest, and boy, we
have a lot of questions for you.
>> Good morning, good morning.
>> We're welcoming Wanda Ruben
who is the new Chief Executive
Officer at the Juan F. Luis
Hospital.

Good morning. How are you?
>> Good morning, and thank you so much for having me on your show.
Very honored to be here.
>> A very busy person!
>> Yes, my goodness!
[Laughter]
>> First, tell us about yourself, who you are and your role at CEO of the hospital, especially given that you jumped in from being a Chief Nursing Officer to a Chief Executive Officer, which are two distinct roles and how you're faring, how you're doing with that.
I mean, you must have a lot of sleepless nights in Seattle.
[Laughter]
>> Yes.
Well, thank you so much for asking that question because I want the audience and people to see who the CEO is.
I think it's very important for them to know and to understand the role of the CEO within the hospital.
First of all, if I may take the opportunity, I'd like to say "Happy Birthday" to my mom.
Today's her birthday, and I want to say "Happy Birthday, Mommy!"
She's 84, God bless her.
And she's the main reason for why Ms. Ruben moved here.
I was born and raised here in the Virgin Islands.
Got, I went to Charles Emanuel Elementary School, which I was told is no longer Charles Emanuel Elementary School.
But I'm so happy to be back home.
like I said, I was born and raised here.
I am a mother of six kids.
Five of those are boys and they were all born here in St. Croix, one in St. Thomas.
So I have a St. Thomean.
[Laughter]
And then I have my little girl

who is the only California girl.
I left St. Croix in 1989 because of Hurricane Hugo.
I have, I should say, the honor of experiencing the first hurricane that I as a resident of the Virgin Islands experienced, and because of the hurricane, I had to move, and I had small kids, and that's why my heart goes out to the mothers who have kids and went through this Hurricane Maria with small ones because it's a very, very challenging time to have kids, very young kids, and go through a hurricane like that.
I moved there in 1989 and had the opportunity to grow within healthcare.
In 1997, I graduated from Loma Linda, worked at the Emergency Department and loved it.
Wanted to do more for my patients, so I decided to become a nurse practitioner and accomplished that in 2003.
I carried many hats during my career in nursing.
From nursing, I went into a director and then CNO, and then also administrator of many facilities.
I actually had two hospitals under my care, my supervision as an administrator and CNO.
>> Tell us what a CNO is.
>> Oh!
It's a Chief Nursing Officer.
A Chief Nursing Officer is usually a person that's responsible for all the clinical or anything pertaining to patient care.
The reason I say that is because you might have a lab under a CNO.
Reason, because in some facilities and some institutions, they see that as involvement in patient care.
Respiratory is another one.
So it's not just nursing that is

under the Chief Nursing Officer.
There could be a lot of other
units that the facility feels
that pertain to patients and
they can place it under the
Chief Nursing Officer.
But the Chief Nursing Officer,
actually, her responsibility is
patient care and nursing.
I also did administrative.
An administrator is another
title that could be given.
Let's say it's a most
cost-effective title that can
be given to a CEO.
Basically, you already --
>> They do the real work.
Is that what you're saying?
[Laughter]
>> It's more about
cost-effectiveness.
It's all in the title.
>> Right.
>> So, as an administrator, you
carry the same responsibility as
the CEO, but you have a
different title.
But their responsibilities are
the same.
I did that out in California for
two facilities and decided at
that time, and many times,
because I wanted the public to
know that I tried many times to
come back home.
I tried in 2004 to return home
as a Nurse Practitioner, but at
that time, I believe it was a
little too early.
It was too soon to add.
Nurse Practitioner roles were
not that popular in the Islands,
and so I decided I had to go
back to California.
>> What does a Nurse
Practitioner do?
How is that new or not as
present here?
>> In 2004, when I came back
home -- let me say, the role of
a Nurse Practitioner is more
advanced.
They also call it an advanced
nursing position.

It's a nurse that returns back to school and has an advance on many areas and can now perform some of the roles of a physician.
>> To get my prescriptions, for example.
>> Yes. Yes.
I practiced in the Emergency Department, and that's probably why the Nurse Practitioner I'm not actually defined as, but it is an advanced role, and you basically see the patient, diagnose the patient, and you prescribe.
You can prescribe drugs.
It depends in what facility and the role, again, that facility would allow you.
What they call it, they credential you and the privilege that they provide you.
In the Emergency Department that I practiced at in California, I'd admit patients, I was involved in Trauma.
I basically did the role of the physician.
When I came to admitting, they I collaborate with the physician.
There's two different things between a PA and Nurse Practitioner.
A Nurse Practitioner can practice in collaboration with the physician but doesn't necessarily need the physician to be present at that facility to be able to practice.
Physician Assistant collaborates with the physician, but they need to have physician present in that facility in order for them to practice.
So we have a little bit more autonomy than a Physician Assistant.
But as a Nurse Practitioner, you can prescribe.
Like I said, you can assess, you can diagnose, and prescribe medication.
>> So, technically, you're not

just a nurse.
>> No.
No, but you know what, and I have to say that I was surprised when I hear that I was called "just a nurse."
But I'm very proud of my background in nursing, and it has prepared me to see the hospital in a different way -- not just as a business but the patient care.
And I think I had to learn the business.
In nursing, you have to learn the business of the hospital because if you ask a nurse insurances, we don't talk about the business.
We talk about patient care and quality of care.
And I had to learn the business part once I became a Nurse Practitioner because if you're gonna run your business, you have to know how the business is run in healthcare.
But, yes, I am not just a nurse.
I have also been a Nurse Practitioner and I practiced for probably about 7, 8 years.
And I love it.
I wish I can go back to that.
I try still to maintain my education, and I take CMEs and still try to stay up with the drugs that we have out there because it's always good to learn.
And if I can help in any way as NP, I will jump in and do that.
>> And you came along with someone else.
Could you introduce?
>> Yes! I apologize, I have my Executive Administrative Assistant Eugenie Williams, who accompanies me to many activities.
And she is my right hand, my left hand.
She is actually my boss.
She keeps me straight and in line, and I appreciate very much

that I have Eugenie working
with me.
But, like I said, I decided to
come back home for two reasons.
Being in California, I learned a
lot, and people might say, "Oh,
she comes from the outside.
She's been out too long.
It's 28 years.
She doesn't know the changes
of the Islands."
No, I never forgot my people,
and I used to come the Islands
almost once or twice a year,
more frequently once my father
passed away because now I have
my mom.
But not being in the Islands
doesn't mean that I didn't know
about the healthcare in the
Islands.
Like I said, I had 13 aunts and
uncles who were born and raised
here.
Only one, I believe, was born in
Vieques, Puerto Rico.
All the others are from the
Islands.
So this is where my family is.
This was my mom's family.
My mom is a Croixian.
She was born and raised here,
and she would not leave the
Islands, believe me.
Because many times I've tried,
and she is like, "No, I'm
staying back home."
Even my dad, when I took him to
San Diego to have his therapy
for cancer, at the end, he says,
"I want to go."
>> Mm, sure.
>> "I want to go home.
That's where I want to --
If I'm gonna die, that's where I
want to die."
And he did.
He came home and he passed away
here in the Island to fight the
cancer.
He didn't succeed that one.
But my mom always, and that was
something that I always had in
my mind.

My mom always wanted to leave
for her care.
She would not want to go to the
hospital here.
She didn't trust it.
"Take me."
Any little thing, she'd call me
right away.
"You need to come and get me."
Even when she had a stroke, she
asked me, "Please, take me."
And I called the hospital.
All I wanted to know is when
she's gonna be discharged so I
can take her home.
And I know that there's a lot of
families here that feel that
way, that they don't trust the
healthcare that is being
provided at our facility.
And as a Virgin Islander, I
couldn't accept that.
I was like, "No.
People deserve more.
I want to come down.
I want to help.
I want to take care of my mom,
and I also want to help in the
healthcare.
It didn't matter where, but
of course my field of healthcare
has been in the hospitals.
So I look at that, and I was
very blessed that there was the
position available for CNO.
It took me a while, believe it
or not.
I started in June of 2016, and
finally on April of 2017, I
accomplished the role.
Ms. Iris Bermudez was actually
the last person that interviewed
me, and after that, I was able
to come home.
And I'm here to help the
community, to help my people, to
get that care, to get that trust
back on the healthcare.
>> That's gonna a tough row to
hoe, so to speak.
>> Yes.
>> And so what I'd like to do
during the course of this
broadcast is to find out exactly

what is going at the hospital,
what units are open, how is it
staffed?
Outwardly, you pass by and there
seems to be a structure, but,
you know, I just don't know
what's going on on the inside.
So we'd like to know a lot more
about what's going on at the
hospital because you're in the
seat of, you know, where people
are most vulnerable.
>> Yes. Yes.
>> And so it does take a lot of
trust.
>> It does, it does.
>> To surrender yourself to
care.
So it's good to know of your
background.
That helps. [Laughs]
Your skills and experience.
That helps a lot.
And that you have a personal
stake in this.
>> Yes.
>> It does. I do.
And Juan Luis Hospital --
Let me start by saying
Juan Luis Hospital is open.
We are still providing the
services with the exception --
and I will start with the
exception -- of the Outpatient
Dialysis.
The Outpatient Dialysis Unit
suffered the most damage from
Maria, and a lot of water
intrusion is what happened in
Juan Luis Hospital, and I want
people to understand that
because they still -- I don't
know, 'cause the building is
still there and it looks
beautiful.
And everybody that comes in
looks around and says, "Well,
what is she talking about?"
But what happened to Juan Luis
Hospital was the intrusion of
water.
It was a lot of water running
down those walls.
I was there, and because of

water, then here comes the mold that is created by that due to the moisture, and it's not a safe environment for patients. But the services are still available except for the Outpatient Dialysis, which we had to transfer, and I think that's been very well talked to around the Islands, about our Dialysis patients that were evacuated to Atlanta, Georgia.
>> Is that the only place they were evacuated to?
>> For the most part, yes. There were a few, I believe about 7, that are located in Florida, but most of our patients went to Atlanta, and then from Atlanta, if they had any relatives, whether it was Florida or California, and they felt that they wanted to go there, FEMA would transfer them there.
So I think that's how we have some of them in different places.
But most of our patients, a total of 79 of them -- are from St. Croix.
That's just St. Croix 'cause I don't have the number for St. Thomas.
But from St. Croix, there are 79 patients in Atlanta, Georgia.
So that is a unit that we had to evacuate our patients.
And the reason is, we don't have dialysis.
We only provide emergency dialysis for any emergency that walks in.
But also our OR, our Surgery Department was also severely damaged by water, and we went from six suites to one suite right after the hurricane, and then we were able to restore one room, and now we only have two rooms for surgeries.
So we conduct, for the most part, emergency, and then any other case that is presented to

our CMO and he feels that it's
something that is gonna lead to
deterioration of that patient,
of course, we provide that
surgery.
But for the most part, we do it
in emergency cases.
>> Now, a CMO is a...?
Chief Medical Officer?
>> Chief Medical Officer.
>> Okay.
>> And he's the one that
supervises all the physicians.
So they will discuss the cases
with the Chief Medical Officer,
and then they determine if the
case needs to be done or needs
to be thrown out of the Islands.
So the surgery is also -- we
have it, but it's not for
elective surgery, I should say
that.
Then we also have the Cardiac
Lab that is also closed.
In lieu of the movement of
patients from our hospital to
the VICC.
The VICC was the only building
that survived the Hurricane
Maria.
So our second floor --
Our third floor is totally
damaged.
We were able to transfer our
patients prior to Maria because
we knew that if the third floor,
in the case of the roof --
So we move our patients all the
way to the second floor.
The third floor is closed
completely.
The second floor consists of
Labor & Delivery, Postpartum,
NICU, ICU, Pediatrics, and then
it had a department that we
called PCU, which is
Progressive Care Unit.
It's kind of a step-down unit
where we hold our tele patients
or any patients that require
trained care.
It's a low service.
It doesn't require ICU, but it's
also a little bit higher than a

Medical Surgical floor.
So that department consisted of 12 beds.
We were able to convert it into 22 beds and transfer our Medical Surgical patients down there.
And remember, the Medical Surgical Department consisted of 41 beds.
So we had to take those patients -- not all 42, but whatever numbers we had -- and transfer them into the 22-bed unit.
That department regardless suffered a lot of water damage also during the hurricane.
Once the third floor became a rainforest...
>> Mm.
>> ...and it was raining on the third floor, it all trickled down to the second floor.
So we had to move our patients from that department into the VICC.
The VICC consisted of 15 beds.
We converted that into a 23-bed, and now we have our patients there.
>> Now, the VICC is the Cardiac Center?
>> The Virgin Islands Cardiac Center.
>> Okay.
>> Mm-hmm.
And our bed capacity has gone from a census of 63.
The hospital is licensed for 188 beds.
We are now down to for the acute adult 23.
Our census is usually on a normal -- before Maria -- 63.
We're down to 39, 40.
It all depends.
If we go higher than actually the 23, we already are on a bed capacity situation.
So most of our patients, unfortunately, are held down in the ER.
Just a couple of weeks ago, we

had to call a Code Yellow, and a Code Yellow is called in a hospital when there is an internal disaster or an external disaster.
And an internal disaster can be something like this -- a huge surge of patients that now we have to sign up.
We have to work out what we are gonna do with these patients because we don't have the bed capacity.
So that's a reason for calling a Code Yellow.
A Code Yellow then will bring everybody from housekeeping to physicians to discuss "What are we going to do about this, and how are we going to resolve it?"
So our patients can continue having that quality of care.
So that was called.
Physicians start looking at what patients we can transfer.
If a patient is gonna be there for more than five days, then we really need to transfer this patient because we can't hold a patient that long because of the capacity of beds that we have.
So we start talking about who we can discharge home, who are we going to transfer out of the Emergency Department, and if there's any surgery that is not emergency, that the patient can wait.
Then we will cancel those because there's no bed capacity, not even in Postpartum at that time.
So we look at all that and we make a decision and we do what we call a "decompress."
Once that is accomplished, then we clear the Code Yellow.
So there's a lot of innovations and things that we have to do, but, again, let me quickly say we have emergency services provided, we have all outpatients -- Lab, Radiology, Ultrasound -- services, as well

as inpatient services for Lab, Radiology, and Ultrasound.
We have mammography.
It's still being offered.
Then all the acute areas we have.
We have surgery for emergencies, we have Mother-Baby.
>> Labor & Delivery.
>> That is open.
Those services are open.
That was a unit that was able to survive.
We have a few areas that we had to close down, but for the most part, the Postpartum, Labor & Delivery, and NICU are still open.
Like I said, only the Outpatient Dialysis and the Cath Lab has been closed.
>> Ms. Ruben, after the hurricane passed and you were evacuating the patients on a very important basis, there was a lot of concern from the community that they didn't know where their relatives were, nobody was tracking them.
Could you explain the national registry that was available to track these patients to the listening audience?
>> I can explain the process when it happened.
Once the hurricane hit, we were -- and I want the community to understand this.
This was a decision that was made through the Department of Health, through FEMA because the hospital was damaged.
Once we alert the government that the hospital was severely damaged by water, then of course we started the evacuation of patients.
We were told we had to start evacuating patients, and that's the norm.
That is nothing that wasn't supposed to be done.
It was.
Once we started evacuating our

patients, the Incident Command Center, which I have Ms. Eugenie here who was the one --
We had a spreadsheet, and every single patient that we transferred out, we documented it on our tracker.
We had a spreadsheet where we had all our dialysis patients that left, and we had all the medical patients that left all the way up to December 31st.
Then when we take those patients to the airport, then the military will take over those patients.
They have national database that they will then place the patients there.
Those patients -- That data belongs to the military.
It doesn't belong to the Juan Luis Hospital.
So they will then have this database where they will, if the family needs any information --
Let's say we had to transfer a patient that only communicated with one relative, and that's the one that left, and now another relative wants to come and know where their patient went, we will provide them with a number that was given to the hospital of a representative in those particular states where these patients went.
Let's say, for example, we sent patients to Atlanta.
The patient then went directly to a hospital.
When the military took the patient, they took them to a base.
>> Mm-hmm.
>> Then from that base, they allocated the patients to different facilities.
So there's one representative for the Atlanta region that can give the family the information of where this patient went once they arrive.
So the role of Juan Luis was to

provide them with that
information, that
representative's phone number so
the family can then call them
and find out where their family
was.
>> Okay.
This is a call-in show.
So if you are so inclined, you
can certainly call and ask
questions of the Juan Luis CEO.
The number here is 713-1079.
That's 713-1079.
And if you've missed any portion
of this broadcast, this
broadcast will be posted on our
website, which is located at
drcvi.org.
We're gonna take a quick break,
and we'll be right back.
>> Now's the time for all good
men to get together with one
another
We got to iron out our problems
and iron out our quarrels
and try to live as brothers
And try to find a piece of land
without stepping on one another
And do respect the women of the
world
Remember you all have mothers
We got to make
>> We're back.
You're listening to Ability
Radio, You and Your Life.
My name is Amelia Headley LaMont
and I'm joined this morning by
my co-host Iris Bermudez, and
our special guest this morning
is Wanda Ruben, CEO of the
Juan Francisco Luis Hospital
with a lot of information, just
bringing us up to speed as to
what has transpired in the wake
of Hurricanes Irma and Maria and
the patients that had to be
flown off the island because
they were in need of urgent
care.
And there was some conversation
during the break.
Can you share that with the
audience as far as, again, some
were flown at the direction of

FEMA, correct?
And you had to keep, in essence, a spreadsheet of who went where, under whose care, from FEMA to the military planes, from the military planes to the military bases.
And then what happens after that?
How do we trace this?
>> And then from the military bases, they are allocated to different hospital in the state that their base is located, and they do not give us that information.
And this is one thing that I wanted to share with the committee so they can understand the HIPAA Laws.
>> And HIPAA is...?
I know it's hard.
It has to do with privacy.
>> Yes, privacy.
>> Anyone?
>> Yes, it's the laws that protect the privacy of information of a patient.
And so once we -- and I'll tell you, this is an area for improvement because I discussed that with FEMA and I told them we need to be able to follow our patient.
>> Right.
>> And I agree with the community.
Juan Luis Hospital, or any hospital, should be able to follow the patient.
I feel once the patient leaves, once you allocate that patient to a hospital, it should be some process where the hospital can know where their patients are.
I think it would be a lot easier.
So there's area for improvement on the transfer and evacuation of our patient that we have discussed already.
And I want the community to know that.
I think if we had a perfect

process, I mean, I would be rich because we wouldn't have this. But we are humans and we try our best in a situation like this with patients in mind, and I want the community to understand that this is not to hurt no one or done with an malintention or no caring for where these patients are going.
But at that moment, we think about what is the right thing for these patients.
>> Right.
>> And so we work the process. It is not a perfect process. We saw that.
I saw that, and I expressed it to some of the FEMA personnel that sat with us throughout this process and I told them, "We need to know where these patients are going, regardless."
At least a hospital.
Not just a representative because first of all, I think it's better when the patient calls you at Juan Luis Hospital here in the island and we can tell them "Your family is at such-and-such hospital."
I think as far as that, it's not a HIPAA violation because you can know where the patient is and even you can be told that the patient is stable.
And I want the community to hear that because even if you call for a patient at Juan Luis Hospital, they just came to the Emergency Department and you are not next of kin -- and that means the person that actually has the authorization to know about this patient -- all the nurse can tell you is that the patient is stable if it's an emergency and a disaster.
Because they have to know that they're there somewhere, right?
"My father came to the ER.
He is stable.
She can then -- because I want

the community also to know that if there's a family at the bedside, she can go to the family at the bedside and say, "There's somebody on the phone that claims to be the sister or the uncle or the aunt and would like information on your relative."
Either she can take the phone call and give that permission, or she can tell the nurse that she can tell them that, "Yes, my dad is here," and whatever information she wants the nurse to give.
Or most of the time, we pass it onto the family member and let them be the one to give the information.
So I want the community to also know that.
>> Yeah.
>> Because I think it's fair. And I tell my staff I am honest with them, and I have to be also transparent with the community so they can learn and know that when you call, you can ask if there's a family at the bedside. "Can I speak to them?"
And that's perfectly okay.
But we cannot give you that information unless that patient gives us permission to do that.
So you can be told that the patient is stable, but that's all we can do because of the HIPAA Laws.
Oh! They gave me what HIPAA stands for.
It's Health Information Portability and Accountability Act.
And, again, we'll be like, "Huh?"
That means, in our language, just between us, it means that it's a law that protects the information of the patient.
So when this patient goes to the States via FEMA, then they are allocated to the hospital, and the only information that the

hospital is given is the representative of that state and the number.
But I do not know, honestly what information that this representative is able to give the family members.
But I know there was a lot of, you know, information and concerns and anger going around.
"I don't know about my family. I don't know where they are."
And unfortunately, that's the information that was given to the hospital.
>> Okay.
>> And we're looking to improve on that with FEMA.
Hopefully we do not have to use it again, we get no hurricane.
But unfortunately, it can happen, and so we're looking at all that for improvement.
>> Yeah, there was a question and, again, you may have responded to it before, but again, people have in their minds -- Why were folks flown out of here?
Was it because we didn't have doctors with the necessary skills, or was it because the hospital couldn't handle it or wasn't equipped to handle it?
How would you respond to that?
>> When it came to the Dialysis patient, we don't have the equipment.
We couldn't provide the Dialysis to these patients.
So we had to transfer them to where the service is provided.
Also, if these patients, because they say, "Well, if you can give emergency, you can take care of all of the other patients.
That means you have a chair somewhere that you can do dialysis."
And there also was a question about the kidney center that was open.
"Why can't they come in?
Why can't they take patients and

you can't?"
And I tried to explain to the community, it's not just giving dialysis.
If that dialysis patient is a patient that has a port-a-cath, and if anybody can educate me on what the name is, please do 'cause I always even as a nurse couldn't remember what the name of the cath is.
But there's a cath that is placed the end of patients and invasive.
>> It's a tube that's inserted, right?
>> Yeah, it's sort of a tube with two lines -- one that goes to the vein and one to go to the arteries to return blood.
So if this gets infected, it requires for the patient to go into surgery and have it cleaned.
The same thing if we're gonna place one, it requires also that service.
We do not have that service.
If a patient becomes an emergency case, we do not have the dialysis equipment to be able to provide that.
So also what FEMA is looking at, the emergency -- I'm sorry that I'm saying FEMA -- the whole team.
The Department of Health, the hospitals, the Human Services, and FEMA is look at, also, is the damage caused by Hurricane Maria.
>> Right.
>> These people need to have a home, a clean home, clean water to prevent any kind of infection.
So it's a more sensitive area.
So we're looking at it as a whole instead of just dialysis.
>> Right.
>> And I think the community just look at it as, "Well, the kidney center is doing dialysis."

Yes, but there's more to it than
just the dialysis.
Also, the supply.
When the hurricane hit, the
tropical ports, the shipments
are damaged.
The airplanes, you know, landed.
So these are supplies that the
hospital cannot receive, and it
requires supplies to be able to
give a dialysis.
Dialysis is not just a chair and
the equipment.
It's also the supplies.
So if you don't have the
supplies and the medication to
be able to give these patients,
then you can't provide that
service.
That's what we mean with
"service."
It's everything, not just the
dialysis.
>> Wow.
You know what, early on during
the conversation, you talked
about trust facility.
We have a lot of patients that
go off-island seeking medical
care because what comes from
them is that they don't trust
the hospital.
They don't trust certain
providers, and this has been
going on for years and years and
years.
It's nothing that just sprung up
after the hurricane.
What can we do to build up that
trust again so that our
insurance dollars don't go
off-island?
Because that's a big pot of
money going off-island.
>> Yes. Yes.
And I want to keep those
patients here.
I want to keep our residents
here, that they can come to Juan
Luis, and I'll tell you, the
first thing that we need to do,
and I always say this --
We need to educate the community
on what is the role of acute

care hospital.
>> Yes.
>> We need to let them know what boundaries -- how far can a hospital go?
Because I have --
The collaboration of the community, also.
>> Yeah.
>> And I think it's more we have to educate them.
I always feel as a leader, it's my responsibility to make sure that they trust us.
It's my responsibility to make sure that they are educated on the role of a hospital.
The hospital has boundaries.
The hospital has limits of care.
You come to the hospital under an emergency condition.
You come to the hospital, to the ER.
And that's our biggest challenges.
I'll be the first to say it.
I know my Emergency Department have a lot of areas they need to improve, like length of stays in the Emergency Department, the quality of care in my Emergency Department.
They have to be looked at, and we're working on that.
But let's say you walk through the Emergency Department.
You are considered to have an emergency condition even if you come in with a toothache.
Because I don't know if you have an abscess, which could be more of a bacteria than just a simple toothache.
You can lose your life.
>> Mm-hmm.
>> So anybody that comes through the Emergency Department is considered an emergency condition.
You need to be seen by a physician in order to be considered out of that emergency condition.
Once the physician sees you and

he determines that you're in stable place after he does the X-rays or he does the lab, he comes back to your room and he says, "Hey, you just have the flu."
>> Mm-hmm.
>> Now you're stable, which means he did his medical screening examination.
Now you are a stable patient.
You're either gonna be admitted, you're either gonna be transferred, or you're gonna go home.
>> Right.
>> So once you get admitted, that means that you have a condition that needs to be further stabilized, which means you're, let's say, Med Surg.
You are kind of urgent stable patient.
So they admit you so you can get antibiotic for five days.
Now you are clear.
They give you the medication, the lab comes.
Now you don't have a fever.
Now they're gonna send you home.
That means that is it.
Your medical necessities were taken care of.
>> Okay.
>> We have elderly patients that now need to be sent home, and we have nowhere to send them.
Some because I believe that's the only nursing home we have here, Herbert Grigg, is full.
>> Mm.
>> Others because family members do not want them back.
>> Mm.
>> And unfortunately, that is something that the community needs to know.
Either because they don't have services or they can't care for the family members anymore.
Or they leave on vacation and we can't locate them.
So the community feels that you need to take care of that

patient until I figure out my problems, until I solve them. And, believe me, when I came here as a CNO and I saw the amount of work that the Case Management, Human Services, even Senators have done, that have gone out of their way to help those family members, I was impressed because this isn't something that you will do in the States at all.
>> No.
>> In the States, you're no longer need a medical necessity.
>> In the States, they'll put you out in the street with your hospital gown on in the cold. There were stories of that. That's happened quite a bit.
>> Yes. In L.A.!
So I was impressed in how much the hospital and Case Management and everybody gets involved to try and resolve those issues. But it's not supposed to.
I want the community to know that is way beyond what the hospitals are supposed to do. And I think they need to also understand that.
So I think the community needs to understand the care, how far a hospital can go.
They also need to learned and educated on the EMTALA Laws, and I believe a lot of people in the community don't know what the EMTALA Laws stands for.
>> Thank you.
How about an explanation, please?
[Laughter]
>> Eugenie's gonna find it. Emergency Medical Treatment and Labor Act.
She's gonna look for the word, but what EMTALA is --
EMTALA was created, I believe, in the '80s because if you remember, there was a pregnant mom, active labor, that was going to be taken to a facility and they diverted that ambulance

because she didn't have any
insurance.
>> Oh.
>> Oh, wow.
>> And I'll be quick on this,
because I believe the community
needs to know this.
When you walk into that
Emergency Department, you have a
right to be seen by a doctor no
matter what.
No matter what.
You should not be sent home.
If anybody comes out and says,
"Uh, we don't have a bed so you
have to go home," call the CEO.
Because you should not be sent
home.
>> That's a violation.
>> That's a violation of EMTALA
Laws.
>> Mm-hmm.
>> It is a hospital problem, not
a patient problem.
So who they should be calling is
the CEO to say, "Hey!
We need to get beds."
>> Yes, all these miracles that
you'll have to perform.
[Laughter]
We're gonna take a quick break.
You're listening to Ability
Radio.
We'll be right back.
>> We got to make this land a
better land
than the world in which we live
And we got to help each man be a
better man
with the kindness that we give
I know we can make it
>> I know that we can
>> I know darn well
We can work it out
Yes, we can
I know we can, can
Yes, we can, can
Why can't we?
If we wanna, yes, we can, can
>> I know we can make it work
I know that we can make it if
we try
>> Oh, yes, we can
I know we can, can

Yes, we can
>> Great gosh
Now's the time for all good men
to get together with one
another
We got to iron out our problems
and iron out our quarrels
and try to live as brothers
>> We're back.
You're listening to Ability
Radio, You and Your Life.
And our special guest this
morning is Wanda Ruben, CEO
for Juan Luis Hospital in
St. Croix.
>> We have a caller.
Good morning.
>> Good morning!
>> Hi, good morning.
How are you?
>> All right.
We kept power on for a full hour
this week.
>> Good.
[Laughter]
>> So, it's good to hear from
Ms. Ruben, and I do agree with
her, the community needs
education so we can understand
the role of the hospital, but I
also want to point out that
beside the EMTALA Laws, there's
another one for caretakers and
the breakdowns of discharge
plans.
It's my understanding in the
other, EMTALA, if a patient
comes in and they're seen, they
should definitely have a
discharge plan, and I'm not
certain that always happens,
especially with those with
mental illness.
>> Mm-hmm.
>> For the Psych patients, you
mean?
Mental illness?
>> Mm-hmm.
>> Well, no, they're only coming
into the Emergency Room in St.
Croix, is that correct?
>> The mental health?
>> Right.
>> Yes, and unfortunately, due

to the hurricanes that hit the island, they damaged the only Psych facility that was here, handled by the Department of Health, I know that.
So we don't have any.
>> Yeah, it was taken apart even before the hurricane.
>> Yes, we transferred our patient to St. Thomas.
But it's been a problem way before Maria.
We're not unique to that.
Even in the United States, mental health is a huge topic, and I think we need to really work on that, on mental patients here because, again, we have a psychiatrist.
And let me give you the process of a Psych patient.
A Psych patient comes to the Emergency Department, the first thing we're going to do is medically clear him.
By saying that, it's any medical condition.
We can do labs if the patient is a patient that has a chronic condition, and unfortunately, most of our mental health patients do have history of high blood pressure or diabetes or congestive heart failure, and because they come with that history, is the responsibility of the physician in the ER to clear the patient medically.
Okay?
And I want the community to understand, a mental health patient comes with two emergencies -- medical emergency condition and then the psychiatric emergency condition.
Once a patient gets cleared by the physician, now we have to address the psychotic emergency condition of that patient.
For that, we need the psychiatrist to come in.
In the Islands that I know, we used to have two in the Juan Luis Hospital.

Now we only have one psychiatrist, and my heart goes out to that psychiatrist. I love her a lot, and she's very dedicated to her patients. But there's only one. So when she comes in and she clears the patient, we're working with the psychiatrist in trying to get them also, the more psychotic ones, to another area where she wants these patients to go so she can continue the care. But we don't have that continuation of care, and the gentleman is right. That continuation of care is lacking in the whole Virgin Islands, more on St. Croix, and we need to do something about it. And I know that the Department of Health is really working on that, and I volunteer myself and I always do to sit on these kind of committees and bring some of the knowledge and processes that have been done in this state that I know that we can implement here and hopefully can work. But, most definitely, we need more psychiatrists and we also need a Psych Unit for these patients. We were in the process. We had just opened our Psych Unit for four rooms, and here comes Hurricane Maria within, I believe, two or three weeks and destroyed the Psych Unit, the little cycle that we had prepared for our ER. And, believe me, it's a big concern for me. Just this week, we had a patient, a mental health patient, that went psychotic. The nurses were going in there to provide some vitals, and it was not a good thing that happened. My nurses were not injured, but

they got hit by this patient, even though the security was there.
I know parts of the community where we have some retired police officers or active police officers that work in our Emergency Department.
They were involved, but it was too much, this patient, and actually caused some harm.
They got to hit my nurses, and they were concerned for their safety, and we're working on that with them.
But these are the things that can happen in an Emergency Department.
That patient was not there, had just arrived.
She was there for, I believe, one or two days, and then all of a sudden she was psychotic.
These patients are not to be in the Emergency Department because the Emergency Department is a very loud unit because we're constantly getting patients and traumas and things, and for a Psych patient, this actually --
>> It's very agitating. Yeah.
>> It can agitate them more and confuse them.
They're hearing voices, and also by hearing voices, they're witnessing all of this chaos, which for them is chaos, and they become psychotic.
>> Does that answer your question?
>> I guess so.
[Laughter]
I just want to state again, all I'm pointing is the discharge plan both for the mental health as well as under EMTALA and the Caretaker Act.
But thank you for your service, and hopefully your great efforts will bring changes for the better for the hospital in St. Croix.
>> Thank you so much for calling, and thank you for your

questions.
That's why we're here.
Juan Luis is working and we'll continue working for improvement and leading the hospital to provide the quality of care that the community thinks is most-needed.
>> Well, I'd like to thank you for taking the time with us this morning, and I certainly think we'll need to have you come back soon.
Very soon.
Again, this broadcast was brought to you by Ability Radio, You and Your Life.
It is a program of the Disability Rights Center of the Virgin Islands.
What are we doing next week, Iris?
>> Oh, next week is St. Thomas' turn where we'll be interviewing the CEO of the St. Thomas Hospital.
>> Excellent. Excellent.
Again, wanted to announce that there will be a Health Brigade during the week of March 19th to the 23rd.
St. Thomas, St. John at Elaine Co. MCH Health building, and March 24th, St. Croix MCH Clinic at Charles Harwood.
Thank you so much, everyone, and have a great Saturday.
>> Remember you all have mothers
We got to make this land a better land