



The Children's Clinic, "Serving Children & Their Families"

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Re: Joint Oversight Hearing of Senate and Assembly Health Committees on Seniors and People with Disabilities in managed care.

Honorable Ladies and Gentlemen of the Legislature,

I thank you for allowing me to address you concerning the recent rollover of seniors and people with disabilities into managed care. I am a physician with training in public health and CEO of The Children's Clinic, "Serving Children and Their Families", a system of health centers one of which serves the homeless. Despite our name, over 1/3 of our 27,000 patients are adults. Last year we provided over 70,000 visits, 60% to Medi-Cal and Healthy Families patients, and 40% to the uninsured from the greater Long Beach area.

I also am the mother of a 23 year old with physical and intellectual disabilities who if it were not for my private insurance would be in this new program. I received at my home the same literature as our patients. In addition, I served for 9 years on the LA Care Health plan board and have tremendous respect for the leadership of that organization.

This is an issue that I feel personally connected with. As CEO of a large nonprofit, I understand the financial and administrative issues surrounding patient care. I have cared for and continue to care for children, adolescents and young adults with disabilities for over 25 years and I have seen the issues that arise when changing the reimbursement streams and systems. I am here to speak not only from the patient's perspective but also from the perspective of those of us that are on the ground on a daily basis doing the best we can to serve a very complex and populations in need.

Since the inception of this program we have received over 1,000 SPD patients. Well over half of whom are new patients to us. Only 24% of these patients chose us. Also, many of our own SPD patients were assigned to other primary care providers without their knowledge. Having seen the literature that arrived at my home for my son I can understand why more did not enroll. It was challenging for me to understand and I was aware of the changes coming forward. Over 30% of the patients have significant mental health issues i.e. schizophrenia and bipolar, many have cognitive challenges and motor challenges. Almost all have some sort of chronic disease. Some of our patients are blind with diabetes and others are in the middle of their cancer treatment. The psychosocial challenges they face on a daily basis in addition to their medical challenges are hard for many of us to understand. Add to that the

fact the those on SSI have had their monthly support checks cut over \$100 a month (more than 10%) since the downturn and you may understand why they may have not filled out their forms for this transition.

I want to paint a picture for you as we see it on the ground level, the point where the patient actually presents for needed care, refill or equipment. I will try to give you solutions that can help those patients and allow all to get the care they need and deserve.

In a nutshell, as one of my physicians said about the new program, **“This new program is insurance centered care not patient centered care.”**

Now our already busy clinics are even more crowded with anxious, sick and many times mentally ill patients, in crisis needing urgent refills, durable medical equipment or surgical procedures. Our staff is asked to sort out the complex maze of their previous care and our doctors to assess their medical status without any prior records. Only 11% have had their Health Risk Assessment completed and when it can be found, it is woefully inadequate and will sometimes merely say that “PCP and Case Manager to coordinate ongoing PCP visits” and the “member will schedule, complete and maintain regularly schedule PCP visits”. This is for a patient with schizophrenia on multiple antipsychotic meds, unable to care for himself, living in a board and care. This assessment is done by phone without personal contact and no contact is made with the PCP i.e. my doctors. This not only impacts the patients but our already stressed staff struggling to manage multiple forms and processes for programs such as Healthy Way LA, SPD transition and HRSA programs. The many layers of bureaucracy and administrative complications are layered upon each other taking away from our primary task of caring for patients.

Allow me to touch on some specific situations.

Patients with HIV

We are not an HIV center and do not receive Ryan White dollars. We are fortunate to have excellent HIV programs for children and adults in Long Beach who have provided primary and specialty care for this population for decades serving as their true “medical home”. That has been disrupted. We now have over 20 new patients with HIV who have been assigned to us and have not been able to maintain their relationship with the HIV center for all their care. Their care is fragmented and disrupted and we must sort out what is HIV-related and what is not. The CARE Center at St. Mary Medical Center is more than happy to be their medical home, but they are not receiving assignment as a primary care provider.

Patients with Psychiatric Disorders

As I mentioned, over 30% of the patients assigned to us have mental illness and are the patients most frequently presenting in crisis, needing their medications urgently. Their relationship with their psychiatrist has been disrupted as they are not on the plans and the patients must access care at the Department of Mental Health (DMH) clinics. Although we have a good relationship with these clinics, they have a three month waiting list and have

told us that if the patient is in crisis they can come on the same day early in the morning and try and access an appointment. This is unfair to the patient and to us. Reestablishing trust and a therapeutic relationship is challenging in many of these patients. One of my very compassionate doctors described a recent case to me, emailed to me at 10:45 pm last night; "I saw a patient today who is now 60 years old, who was physically abused as a child, with some type of seizure disorder due to the abuse. He has had a life full of crime and substance abuse and was in and out of homelessness. He became sober 7 years ago and, though homeless, attends AA and NA meetings. He had a stroke approximately 3 years ago with persistent dysphagia and weakness. It is obvious speaking to him that he has mental illness as well, does not like to sleep inside and is happy sleeping in a tent. He finally got linked to a primary care provider a few months ago and has been seeing a mental health practitioner and was making progress. Now coming in today he had to adjust to our clinic, and meet a new doctor and was claustrophobic. Considering everything, it went pretty well but I have no records and he had recently established care and should be getting other benefits than what he has now. I felt very bad for him having to make all these "adjustments."

Imagine how the patient feels and how stressful this is for him and this caring physician. Also imagine how long a visit like this takes and the toll it takes on the other patients who are waiting to be seen.

Patients with Cancer

We have had numerous patients with cancer come to us as new patients in the middle of their cancer treatment and their current specialists are not on the IPA or health plan. One such patient was awaiting a bone marrow transplant that had to be delayed several weeks while new contracts were drawn up. Another patient presented with a port-a-cath in the neck requesting us to remove it. However, this indwelling catheter must be removed by a surgeon. Authorization was submitted but by the time it was authorized the patient somehow was switched to another primary care doctor and therefore the authorization was voided. We called the State Ombudsman (888-452-8609) and received a recorded message to navigate through. After 30 minutes my staff was told to leave a message. We still have not received a call back. This patient must now try to navigate yet another system.

Durable Medical Equipment

Numerous patients have presented in the middle of obtaining their wheelchairs or scooters. All efforts prior to being placed in managed care become null and void and the process must be started anew with another orthopedic and physical therapy assessment. It took over 6 months to get one patient's new scooter and the effort of doctors, front office staff and even the Chief Operating Officer and the Associate Medical Director. Hours and hours of frustration were suffered not only by the patient but also for our staff.

Another case was a blind patient with diabetes who was new to us and needed a talking glucometer. It was not clear who was responsible for this piece of equipment, the HMO or the IPA. The request bounced back and forth until finally the Associate Medical Director

called one of the medical directors at LA Care with whom she had a personal relationship and then got the equipment.

Medication

As mentioned, many of the patients presenting are on long lists of medication and we get no records. They present urgently for refills down to their last pill and ask us to refill them. They try and contact their own doctors but they will not refill them if they are signed up with another practice. If we do determine the medication many times the IPA or HMO will not authorize it as we have not tried previous medications which were reportedly already tried. So we have to have them fail another meds i.e. inhaled corticosteroids before we can put them back on Advair. This is not quality care.

General Issues

The complexity of the patients from a physical, mental health, and psychosocial standpoint is further complicated by a system that sometimes appears to be focusing on restriction of care rather than supportive of care and the patient. Patients whose relationships with their medical homes, be it HIV Center or PCP, is disrupted will suffer. Those new PCP and trying to care for them are being overwhelmed. We already have a critical shortage of primary care doctors wanting to serve the low income populations. These added stressors are threatening this fragile safety net.

Add to that the disruption of their specialty care and inability to get needed medication, treatment and equipment and you have a perfect storm for bad outcomes. It is the sense of our doctors that many patients are getting hospitalized because of these disruptions.

Solutions


- ❖ **Link patients** who have not chosen a primary care MD to their last primary care doctor. Give this information to the HMOs so they can facilitate in a timely fashion **before** the assignment is made.
- ❖ Allow patients in specialty care centers such as HIV and Cystic Fibrosis centers to maintain those centers as medical homes for those patients that address not only specialty care but also primary care.
- ❖ For those primary care providers or practices who have received over 250 SPD patients, fund care coordinators at the RN or LVN level for every 250 patients. These **care coordinators** should be **embedded on-site** to meet and get to know the patients and allow for improved care and management of the patients.
- ❖ Ensure network adequacy especially for the **specialty network** as well as the primary care network.
- ❖ **Administrative simplification** is critical. We are trying to transform into efficient providers of choice in the new health care environment. We are striving to provide efficient, quality, customer-friendly care. To do this we cannot work under such administratively burdensome circumstances.

- ❖ Reassess the Health Risk Assessment process. It is costly and offers little help to the provider or the patient. The money would be better spent on care coordinators embedded at the primary care provider site.
- ❖ Make the **medical exemption process** transparent, effective, timely and simple.
- ❖ Improve the ombudsmen line services so that the needs of patients and providers are met.
- ❖ Allow patients to be able to automatically refill their medications for several months until they have a well-established relationship with a PCP.
- ❖ Assure that centers of excellence are available in the plans and IPA for those patients that need them.
- ❖ Seriously consider slowing down the process so we can adequately care for those patients that have been enrolled up to now.

I thank you for this opportunity to speak. This is a very complex patient population to serve and that is why they were carved out for so many years. Please let's make this a "patient centered care program not an insurance centered care program". I and my dedicated staff are more than happy to help in any way we can to better serve this population successfully.

Thank you.

Sincerely,

A handwritten signature in cursive script that reads "Elisa A. Nicholas".

Elisa A. Nicholas, MD, MSPH
Chief Executive Officer
The Children's Clinic, "Serving Children and Their Families"