

Alameda County Board of Supervisors Health Committee's Community Dialogue on Preparing for Health Reform

Session 12: The Patient Experience

December 10, 2012

This session examined how health reform policies promote improving the patient's care experience. This was part of a [13-month series](#) on how the Patient Protection and Affordable Care Act (ACA) could impact Alameda County. This session examined new policies and incentives created by health reform and how local entities are responding to them. The speakers for this session included:

- Overview of the ACA's major impacts on consumers by **Julie Silas**, Senior Policy Analyst, Consumers Union
- ACMC's efforts to improve the patient experience in response to the ACA by **Kimberly Horton**, Chief Nurse Executive at Alameda County Medical Center
- Consumer's perspective: **Patsy Jackson** and **Rasesh Parikh**, patients at the Alameda Health Consortium
- Overview of lessons learned about communicating the Medi-Cal managed care transition to seniors and people with disabilities and its application to upcoming transitions, **Wendy Peterson**, Director of the Seniors Services Coalition of Alameda County

The ACA's major impacts on consumers

Several aspects of the ACA focus on improving consumer protections and patients' experience of care, said Julie Silas. Some of the new rules have already taken effect in California, and others will start in January 2014. In some places, California has gone even further than the federal law in being protective of consumers.

The Patient Bill of Rights is focused on helping Americans get needed coverage. It prohibits denying insurance due to pre-existing conditions. California has implemented this for children, and it will take effect for adults in January 2014. The ACA also prohibits insurance companies from capping spending. There are no longer lifetime limits allowed, annual dollar limits are being phased out, and rescinding coverage is no longer allowed. Also, the new law guarantees a consumer's right to appeal a decision made by an insurance company.

Children now can stay on their parents' health insurance up to age 26. The ACA also requires that insurance companies spend 80 percent to 85 percent of premiums on health coverage. They must provide rebates to employers or individuals if the amount was lower.

The coverage expansions through the health benefits exchange – Covered California – is also a key benefit to consumers. Significantly more people will have health insurance as a result of the law's increasing tax credits and subsidies for purchasing coverage along with expanding the eligibility limits for Medicaid. The ACA also created new rules around standardizing insurance products to make it easier to shop for coverage. For the first time, Silas said, consumers will be able to compare apples to apples when buying insurance. This is especially true in California, which has gone above and beyond the federal law in requiring standardized benefits and cost sharing of all the insurance products available through Covered California.

Many aspects of the health reform law are just now taking shape, Silas said. Alameda County leaders can weigh in on the development of these rules. Alameda County also can work with the Exchange outreach and education efforts on enrollment. California counties play a critical role in enrollment and this is an essential part of the process to make sure California takes advantage of all the new federal funds available.

Efforts at ACMC to improve the patient experience

Like many safety-net institutions, the Alameda County Medical Center (ACMC) is focused on efforts that will help retain patients who gain health coverage in 2014. The hospital also is responding to new financial incentives in the ACA, such as value-based purchasing that ties payment to patient experience.

ACMC is first and foremost focused on providing safe care, said Kimberly Horton. The hospital has several quality improvement initiatives running that focus on safety and effectiveness. Additionally, ACMC is focused on increasing access to care for patients in its clinics to relieve pressure on the emergency department (ED) and promote appropriate use of the ED.

ACMC also has a strategy around improving the patient experience. ACMC recently created its Institute of Patient and Family-Centered Care Practices and started a patient and family advisory council. An equity council also advises the Board of Trustees on how to ensure patients from all backgrounds receive culturally competent and appropriate care. There is a new Patient and Family Centered Care Department within ACMC that is focused on ensuring the patient and family care experience is optimal. ACMC has hired a director for this department, marking its commitment to increasing patient and family involvement in the care process.

Several audience participants commented that they were pleased to hear ACMC was focused on improving the patient experience. They noted that cooperation with

community-based organizations (CBOs) could support this effort. CBOs particularly could support linkages to follow-up care for patients after they leave the hospital.

The Consumer's Experience

The next section of the hearing focused on testimony from patients who described their experience with the safety-net health care system. Patsy Jackson, a 35-year-old Oakland resident, spoke first. Jackson described the numerous times that her employment or Medi-Cal status changed, causing shifts in her health care coverage. She is HIV-positive and takes several medications daily. Disruptions in care are frightening, and the risk for disruptions is high during transitions between health care coverage. She relies on good referrals for information and services from case managers.

She implored health care workers in attendance to learn where to send people with HIV for help. Have a list of clinics and providers or social workers who can help connect people to care, she said. She also said it was critical for doctors to spend time getting to know their patients and understanding their needs. One doctor helped her reduce her medications from 22 a day to only seven after patiently working with her. "That was huge for me," she said.

Rashesh Parokh, a 55-year-old Fremont resident, came to the Bay Area in 2010 from India. After losing his job last year, he was under significant stress and experienced health problems. He had trouble seeing. A caseworker at the employment office recommended he go to the Tri-City Community Health Center for care. At his first appointment, Parokh learned that he was diabetic and his blood sugar levels were too high. The clinic provided him free medicine and taught him the importance of eating healthy and exercising. His blood sugars now are within normal range. Parokh recommended that there be more neighborhood clinics. More clinics spread throughout the county could help people avoid going to the Highland Hospital ED for care, he said.

Preparing for California's Coordinated Care Initiative: Lessons learned from previous transitions to managed care

Under its "Bridge to Reform" Medi-Cal waiver, California shifted hundreds of thousands of Medi-Cal beneficiaries into managed care between 2011 and 2012. This commonly is referred to as the "Medi-Cal SPD transition" because it involved seniors and persons with disabilities, who historically were not required to enroll in Medi-Cal managed care. They were enrolled on a mandatory basis into managed care in 2011 and 2012. This affected about 23,000 Alameda County residents.

Wendy Peterson described lessons learned from that transition and how they relate to the upcoming planned transition under the state's Coordinated Care Initiative. The transition was a challenging process, she said. State training for CBOs was meager and

there was no funding to support enrollment assistors. Additionally, this was a new population for the health plans and the State's enrollment broker. This group of beneficiaries had significantly more needs than the populations traditionally in Medi-Cal managed care. Only a portion of the target population received, read and understood the state's letters and packets. This resulted in a default plan assignment of about 60 percent. When beneficiaries enrolled, the health plans received poor quality data making it difficult to find the beneficiaries to do health assessments and ensure continuity of care. Peterson hoped the upcoming transition would be smoother.

Peterson also spoke about the launch of Medicare Part D in 2006 as an experience to learn from when planning for the Coordinated Care Initiative transition. About 30,000 Alameda County residents were affected by passive enrollment into a Part D plan because they had both Medicare and Medi-Cal, people known as "dual eligibles." The Part D launch had too many options for people, she said, but a major advantage was that the HICAP program provided one-on-one counseling to help people make their choices. "People who didn't have someone proactively working with them to understand their options suffered," Peterson said.

Peterson next described the upcoming transition planned for the Coordinated Care Initiative. The CCI includes two parts: 1) requiring all Medi-Cal beneficiaries to receive their long-term services and supports through a health plan; and 2) launching new integrated Medicare and Medi-Cal health plans under a federal demonstration. Enrollment into the demonstration plans will be voluntary but conducted via passive enrollment. If an individual does not opt out, the State will automatically enroll them into the demonstration.

All the system changes required under this new policy are incredibly complex and will be complicated for beneficiaries to understand, she said. Significant training of CBOs, advocacy organizations and other trusted places where beneficiaries already seek help will be needed. Beneficiaries will need more than just education. They will need personal help figuring out their options and making a choice. HICAP counselors will be invaluable, but so will information from doctors, pharmacists and other providers.