

FINDINGS FROM A COMMUNITY HEALTH CARE DISCUSSION

Hosted by the *Department of Public Administration*
College of Health and Public Affairs, University of Central Florida



Forum Moderated and Report Drafted by:

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Executive Summary

Faculty and staff in the Department of Public Administration, College of Health and Public Affairs, at the University of Central Florida answered the call from President-Elect Obama's Transition Team. Recognizing the need for citizen input into health care policy making, they announced a discussion forum for December 22, 2008, at the university's main campus in Orlando. Expecting a low turnout given the time of year and the university calendar, organizers were taken aback by the overwhelming response from both the university and surrounding community. Media coverage on the local NPR station (WMFE) and a local television station also generated interest and participation from the general public.

Ultimately, nearly 70 discussants came together at noon, three days before Christmas. They came as representatives of nonprofit social service agencies, local government agencies, medical offices, and academic disciplines, including nursing, social work, and public administration. Most came with their representative hat, as well as individuals who have been tested in their efforts to acquire affordable and high quality health care.

Others came as individuals, longing for an opportunity to have their voice heard. For instance, a young mother of two young children spoke of the challenge of finding affordable health care for her and her family. She has a pre-existing condition; with her husband, she was being charged a premium for insurance, but they were unable to qualify for public assistance to get insurance for their children. The intervention of a Florida State representative helped alleviate that distress.



Dr. Thomas Bryer, Assistant Professor in the Department of Public Administration, opened the forum by noting its historic and innovative character. Most efforts by governments to engage citizens begin with the government agency defining the time, place, and agenda for the meeting. In this case, the Obama Transition Team has invited citizens to define their own time, place, and to a large extent, agenda. The costs of participation for many were reduced, particularly knowing that the incoming Administration wanted to hear the words of Americans with diverse experiences in the health care system.



One such American came to the forum with the benefit—and misfortunate—of multiple perspectives. She serves as a nurse, a teacher, and she now is a cancer patient. She understands the supply side and demand side of health care; she has seen waste but understands the patient's need to know. Her experiences enlightened other participants.

Participants engaged the topic at the start of the forum with an exercise. Each person was asked to select an image card from several dozen spread around the room. The card they selected was to be a symbol of what they perceived to be the biggest or one of the biggest problems in the health care system.

Several participants selected images that represented the *fragmentation* of the healthcare system. Others identified *cost* to be a major concern. Still others selected images of children or families and expressed concern regarding their ability to ensure their loved ones will always have *access* to the care they need. One participant selected an image of a machine with cogs, bolts, and wheels. She expressed her concern for the *inefficiency* of the health care system, like a machine that needs some tuning and repair.



Zenaida Gonzalez Kotala captured some of the more poignant stories heard during the forum, including:



The software-engineer, who after working for a company for 35 years, was laid off and now can't find health insurance.

The state employee, who despite working two part-time jobs providing psychiatric care to children, doesn't qualify for health insurance.

The farmer, who is healthy at 55, but can't afford health insurance.

The janitor, who has to call the state every week to make sure his children keep their state-funded insurance because he doesn't make enough to buy it privately. He also does not work enough hours to qualify for coverage through work.

Then there was Cindy Parker Martinez, who stood up to speak. She's married and has two young children. Both she and her husband are college educated. Her husband was injured at work, which began the unraveling of their lives.

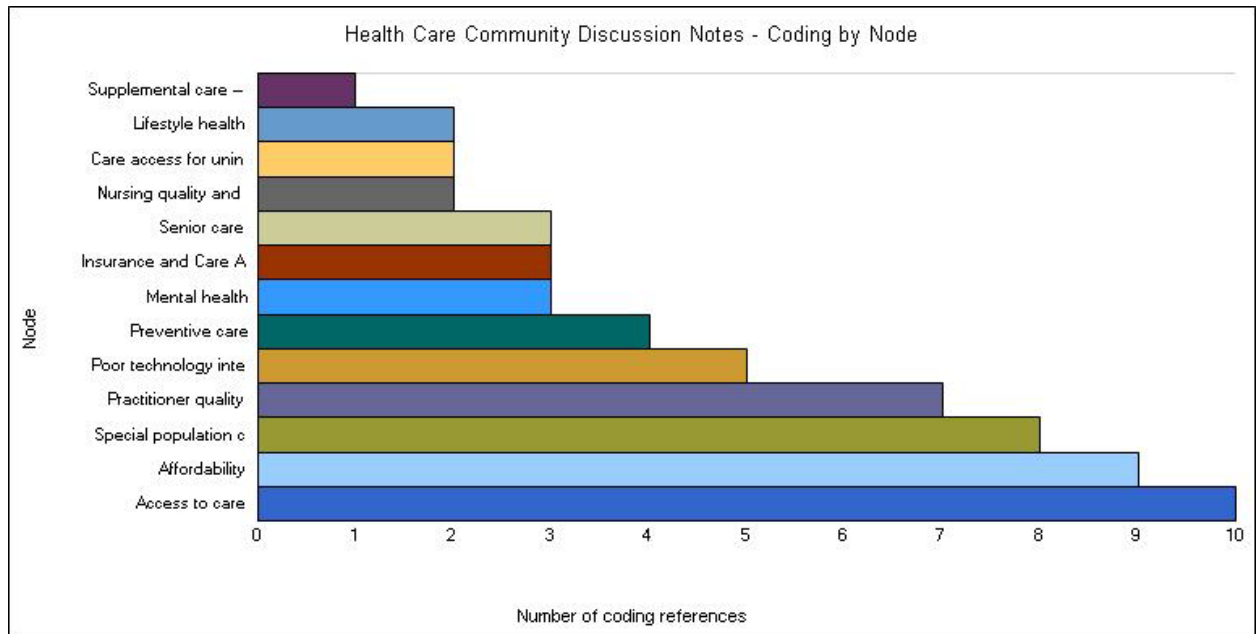
"My husband had group insurance at the time," she said. "Even with this group insurance plan, it was a \$52,000 hospital bill we were stuck negotiating rates with out of net-work doctors visiting him in an in net-work hospital."

The hospital bills alone forced them to cancel their high premium "group" insurance of \$1,200. All were declined "private" insurance due to age or pre-existing conditions. And, the family earned too much to qualify for any public assistance programs.

"My family is the American dream, so we thought..." she said holding her youngest, as her oldest watched from a stroller eating a peanut butter sandwich. "We're college educated. We've always worked hard and now . . . This is what's wrong with our system."

Health Care System—Problem Identification

Participants raised numerous issues in discussing their perception of the biggest problems in the health care system. These problems are summarized below. Some individual stories related to these perceived problems are reported below the summary.



Concern over care *access* was greatest. Participants expressed worry regarding access for the un- and under-insured, for children, and for themselves. Alongside access as a concern is *affordability*. Participants spoke about the disparities in costs of care for different individuals, as well as the personal and family costs of acquiring insurance and/or receiving care—particularly in the case of a pre-existing condition.

Numerous participants spoke about *special populations*, which include here children, those with special needs, homeless, and people in prison. Each of these populations faces unique health challenges and requires potentially unique solutions to their care.

Practitioner quality was considered to be important and a problem area by some participants. For example, a participant expressed concern over quality of care received within the restrictions of his health insurance plan. Numerous other participants considered the quality of care that might be possible, for instance through a country doctor model. This issue went hand-in-hand with the question of affordability, and participants looked to examples from other countries, such as Cuba, Germany, and England for a balance between cost to patient and care.

Some discussion occurred regarding the *integration of technology* to improve efficiencies and patient services. Whereas the potential was seen by participants, some expressed concern about information security and what the possible implications might be when patients are asked to disclose private information.

Participants spoke about the need for *preventive care* to improve overall health and reduce costs of treatment. Alongside this issue is healthy lifestyle promotion, by promoting healthy eating and exercise.

Other problem areas identified are consistent with those already summarized. For instance, *senior care* was seen as significant and requiring special attention. Providing care for the *under- and un-insured*, including some of the special populations identified above, was seen to be an important issue to address in order to reduce overall costs. The role of *nurses* was considered and what steps might be taken in order to enhance the number and quality of nurse-practitioners in order to enhance overall quality of care. Last, other forms of health were addressed, such as *dental, vision, and mental health*.

Karin Letizia offers a story that demonstrates the perceived need for change in the health care system. Her mother required specialized, long-term care. A medical doctor agreed to this, but her insurance denied the request. It took months of complaints to various agencies and officials before some level of required care was covered. Karin's story is detailed in a letter she wrote, found in Appendix B of this report. She calls for a health care czar to oversee agencies to ensure they are responsive to complaints of citizens like her and her mother.

The cost of care is demonstrated by Cindy Parker-Martinez. Cindy, in a letter found in Appendix B, describes how the costs of immunizations for her children prevented her from giving needed treatments to her kids for months.

Robin Hurt demonstrates the need for public policy. He supports S.2278: The Community and Healthcare-Associated Reduction Act of 2007. This act would help prevent the kind of tragedy that claimed his mother's life, as he describes in a letter found in Appendix B. She was admitted to the hospital for a broken arm, became ill from a virus acquired while in the care of hospital staff, and died 48 hours later. Cleanliness and protecting the vulnerable is the inspiration behind Robin's advocacy. In addition to his letter, see his website: [://www.washyourhands.org/](http://www.washyourhands.org/).

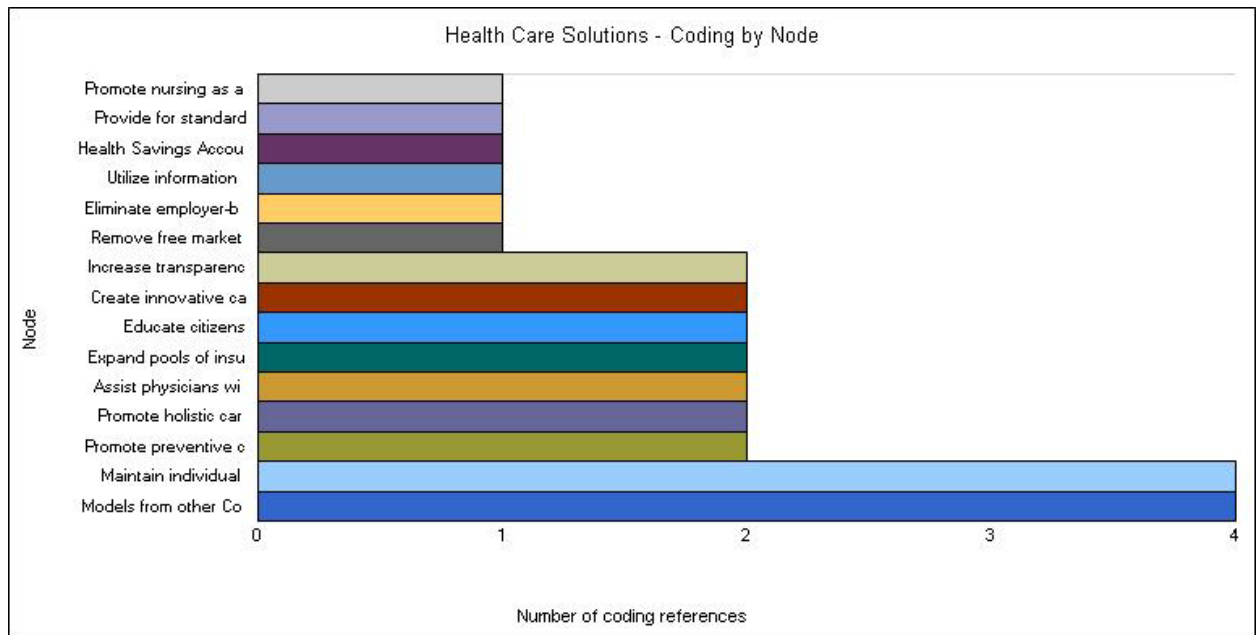
Carl Maultsby offers an example of fragmentation and cost burdens. He was living in New York but visiting Florida often to care for his mother. He had private state-based insurance. During one Florida visit, he suffered a broken toe and required medical care. The hospital in Florida did not accept his state-based insurance; they required that he pay 100% up front and submit the invoice to his insurance for reimbursement. Carl chose to spend less and fly back to New York for his care.

Last Dale Roane demonstrates the need for transparency in public policy and across various health care systems. He feels he is being denied entitlements for which he has

been paying throughout his working life. Uncertain about for what programs he is eligible and why his social security benefits are being taxed to pay for Medicaid, he has sought assistance and guidance from various government officials. His story demonstrates the need for clarity in government programs.

Possible Solutions to Perceived Problems

Participants engaged in lively discussion regarding a variety of alternative solutions to some of the problems identified. There was no attempt to reach consensus on these solutions, nor do all solutions require public policy intervention. The solutions are summarized below.



Several participants identified their experiences with *health care in other countries*, such as Cuba, Argentina, England, and Germany. They urged that future policymaking in the United States look to examples from outside U.S. borders. For instance, Judge Jose Rodriguez described during the forum how he received exceptional care while in Argentina at little cost to him.

Other participants were passionate about maintaining or expanding *individual choice* in the health care system. For instance, and listed separately above, one participant advocated *Health Savings Accounts*. At the same time several participants were *opposed to free market* solutions to problems in the health care system. They considered such innovations to be damaging to the ideals of equity.

Beyond the market vs. state dichotomy, participants considered other variables that might be address. For instance, *promoting holistic and preventive care* through public policy or otherwise can help reduce overall costs burdening the health care system. *Educating citizens* to be more focused on holistic and preventive care was seen by some participants

as a key component of future restructuring of the health care system. Also seen as central in future restructuring is a renewed focus on *innovative care delivery*. For example, one participant described the need for “high tech and high touch.” *Use technology wisely* and provide care like a country doctor would.

These are some of the ideas expressed, or, they are better thought of as principles to pursue as the Obama Administration continues new public policies to enhance the health care system to better serve all Americans.

Appendix A—List of Participants

Lois	Adams
Pamela	Ark
Maria	
Elena	Augustin
Caitlin	Augustin
Akyia	Azula
Fanny	Ballester
Melody	Bennett
Jenna	Benyanes
Meryl	Biszick
William	Bowman
Margaret	Brennan
John	Bricout
Thomas	Bromly
Thomas	Bryer
Bakari	Burns
Laura	Capp
Jenna	Cawley
Drew	Chastain
Rick	Daigneault
Dave	Daly
Carlos	de la Cruz
Judi	Dugre
Nancy	Ellis
Julie	Ellis
Christopher	English
Jennifer	Floyd
Richard	Fox
Michael	Frumkin
Shelly	Gaughan
Bob	Gaughan
Betsy	Guimond
Karen	Guin
Dan	Hector
Rudy	Henkel
Patrick	Howard
Randall	Hunt
Robin	Hurt
Pamela	Ingersoll
Bonnie	Irvine
Emma	Kudrick

Ray	Larsen
Phyllis	Laufer
Jean	Leurner
David	Marshall
Carl	Maultsby
Mary Allen	Meagher
Josephine	Mercado
Judy	Mercer
Hannah	Morse
Jocelyn	Mueller
David	Mushur
Kandis	Natoli
Anne	Norris
	Parker-
Cindy	Martinez
Ken	Peach
Mulva	Pearson
Johnny	Robinson
Judge Jose	Rodriguez
Christelle	Schafer
Mary Lou	Schropp
Judi	Scrack
Mary Lou	Sole
Cat	Somerville
Andrew	Stafford
Cathy	Stankiewicz
Carlos	Travieso
Igor	Volkov
Karen	Willis

Appendix B—Letters and Other Supporting Documents from Participants

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Information Prepared by the College of Nursing for the Dec. 22, 2008 meeting to discuss problems with the US health care system

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INTRODUCTION:

This is a quick report composed in a very short time to capture problems the UCF College of Nursing sees with respect to the US Health Care System. It does not reflect the results of any internal meeting, and is not even representative of all of our faculty. It is instead a product of informal face to face and electronic communications held over the weekend even while our College was on break and many faculty out of town. Individual stories and comments are incorporated into this report and can all be traced to specific people who have provided their contact info and would be happy to elaborate or assist the new administration in designing a health care system that works. Our College is also eager to participate in or organize additional meetings to discuss problems and solutions in 2009 if this would be helpful.

We chose to organize our thoughts around 3 key issues summarized by our Dean (Jean Leuner, jleuner@mail.ucf.edu): Patient Safety, Cost, and Access. We found that these problems were often intertwined. For example, access issues can result in increased cost through delayed care seeking or emergency room (ER) use. Although we spoke of such problems only once, we note the intertwining in our discussion of them.

We recognize that there are no easy fixes for the health care system in this country, and many of the challenges to our current system are a result of problems that extend far beyond the health care system itself (e.g., violent urban neighborhoods with few grocery stores that sell healthy food). However, we are convinced that better use of nurses could produce cost savings. Moreover, as nurses we are accustomed to coming up with creative solutions, often in the face of scarce resources. These solutions are individualized to meet the needs of our patients, evaluated and then revised if needed to increase efficacy. We want to bring our skills and insights to bear on this enormous challenge that our country is facing.

PATIENT SAFETY

No consistent format for health care records and no easy portability

Having medical records that put information in different places or require different information increases likelihood that information is missed. Also, patients are often providing the same information in multiple settings which is then entered into computer systems multiple times increasing health care costs. Steve Heglund ARNP talks about the potential for medical error as well as duplication of work that he sees in his practice in an Emergency Department (ED) because of the current record keeping system that he works with (see his story on page 16).

Electronic medical records like what are now being used across the country in the VA system would allow for seamless transition of patients across various care settings in different parts of the country.

Fragmented care

- a) Insurance issues: surgeon removing skin lesion won't take off another skin lesion because won't be paid for unless it is treated as separate procedure.
- b) Transitioning from one setting or one provider to another puts people at risk
- c) Employer Plans change. Medicaid Plans change. Then doctors won't take you because the reimbursement rate changes. (See Dale Roane's story, pg. 19)
- d) Being forced to seek out multiple providers to solve a single health care problem (See Kandis Natoli's story for one example, pg. 17)

Not enough nurses: Nurses are critical to patient safety (IOM, 2004). The American Association of Colleges of Nursing (AACN) notes in their White Paper: Nurses are much more likely than any other health professional to recognize, interrupt and correct errors that are often life threatening (Rothschild et al., 2006). Higher levels of baccalaureate-prepared nurses in hospital settings reduce mortality and failure to rescue rates (Aiken, et al, 2004). Inadequate nurse staffing levels may lead to a higher incidence of complications and inadequate care (Aiken et al., 2002, JCAHO, 2002; Needleman et al., 2002). See Jenna Benyounes, SN story #2 (page 13) for an example of what happens when there are not enough nurses.

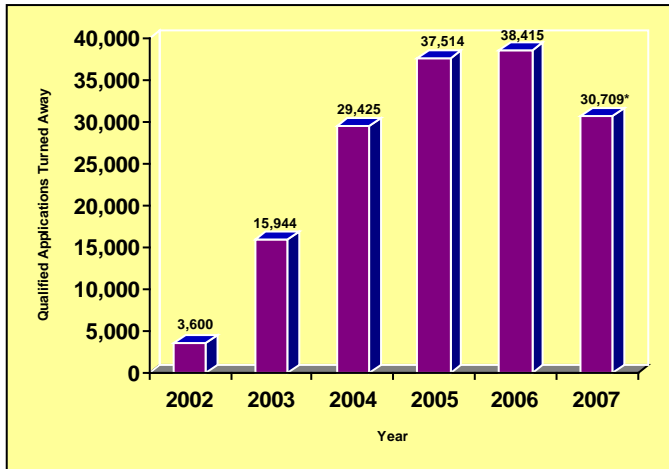
As Dan Hector ([@mail.ucf.](mailto:dan@ucf.edu)) says: "It doesn't matter who pays. There has to be someone to deliver the care."

Not enough nursing doctorally prepared faculty to meet the interest of students who want to be nurses.

This means that people that want to become nurses can't because there are not enough faculty trained to teach them and so schools and colleges of nursing must limit their enrollment. So someone like Cara Arsenault, SN who has wanted to be a nurse since high school, but financial struggles during her college years forced her to take a job to pay tuition costs and lowered her

GPA. This and the large numbers of people applying for a limited number of seats in undergraduate nursing programs resulted in her being refused admission when she initially applied. Fortunately she persisted and is now enrolled in UCF's College of Nursing program (see Cara Arsenault's story, pg. 11). However, Jenna Benyounes, SN tells a different tale of three women interested in nursing, only one of which persisted in the face of these barriers, the other two changed majors (See Jenna Benyounes, SN story #1, pg. 12 about Qualified applicants not being accepted to nursing school).

Number of Qualified Applications Turned Away from Entry-Level Baccalaureate Nursing Programs: 2002-2007 (Research and Data Center, 2002-2007)



Medication Safety:

Funding of medication trials by pharmaceutical industry.

- a) Many studies finding the medicines ineffective were not published in medical journals. (House, 2008)
- b) No systematic funded monitoring of patient responses to medication once a medication has been approved.

COST

Industries involvement in health care

Medicare pay for performance (P4P) is being dictated by 3rd party payers guided by short term cost incentives. Outcome standards are not patient centered or necessarily evidence based as a result patients suffer and health care costs are needlessly increased.

The problem is that the people who are making care decisions who are not health care providers or are not at the health care setting and they do not take into account the individual's patients unique co-morbidities and illness context. Outcomes are evaluated based on statistically generated not clinically based outcomes. The process is called scientific but in actuality it undermines the provider's ability to individual patient care.

A very different example is the marketing of formula to new Mom's which undermines breast feeding, a healthier and cheaper alternative that has been shown to improve infant outcomes. See Ruthy Wilson's story, page 20)

ER use for primary care (an access issue that increases cost)

Patients without insurance and those without good access to care use the ER when they become ill. The ER has become the health care safety net, but it is an expensive safety net. One option is to create primary care centers connected to ER's can triage patients who need primary care there. This would preserve our ERs for those who need it most.

This is a problem for even those who have good insurance because of doctor's limited access due to the restraints on their time being created by reimbursement rates. For example, Anne Norris, PhD, RN had a very bad case of poison ivy and was forced to go to the ER because her primary care physician could not take or return her phone calls. (See Anne Norris' story, pg. 18). She saw her primary care physician but the medicine that was prescribed did not seem to be working (or was making the poison ivy worse). She could not sleep, was taking Benadryl every 4 hours without relief, was using icepacks, etc. She called and called but her primary care physician could not take or return her phone calls. Finally she went to the ER, was given a different medication and 6 weeks later was symptom free and able to return to work.

Expensive problems – let's prevent them:

- a) Mental illness: promoting healthy parenting (Debbie Gross's Chicago Parenting Program, summary pg. 15 – full story in attached PDF or go to <http://www.chicagoparentprogram.org/>)
- b) Chronic illness management: Using primary care to reduce exacerbations with chronic illnesses is effective (e.g., HIV patients, Ding, et al, 2008).

Children who are prenatally infected with HIV must learn to live with and manage this illness. However, doing so is complicated by their family circumstances and their reliance on the Medicaid system. Patricia Robinson is a nurse practitioner with an effective program (HUG ME) that closed in December 2008 due to lack of funding. Now these children's care is even more fragmented and the safety net that protected them is gone. Without support and without medication there is also the risk that their viral levels

will increase and they may not practice safer sex as they become older (Call Patricia Robinson for her story 352-514-3100).

c) Obesity, Diabetes, Hypertension:

1. Increase school subsidies to provide only healthy food in our childrens' school breakfasts and lunches. Appleton, WI found that providing health foods in a school for kids with behavior problems resulted in improved learning and decreased behavior problems. Why not take the Appleton, WI story and bring it to Florida? (see A Different Kind of School Lunch, The Appleton Wisconsin Story, pg. 9)
2. Perinatal stress increases risk for diabetes (Entringer, et al, 2008; Weinstock, 2008)
3. Racism/Discrimination is a stressor linked with insulin resistance, a factor in diabetes (Chambers, et al 2004)
4. Violence in the neighborhood is a stressor that can be linked to hypertension (Wilson, Kliewer, & Sica, 2004)

ACCESS

Health Literacy

Patients don't always know enough to get the care they need, but a nurse can help them navigate. For example, Karen Aroian (a nurse and a professor) benefitted from having an HMO provided nurse to guide her through the initial breast cancer treatment phases (see Aroian's story, pg. 10).

Insurance business practices can be a barrier to care. For example, Karen Aroian had to delay radiation treatment for breast cancer and risk a re-occurrence because she did not have an insurance card in her possession to verify that her coverage had already started.

Dale Roane and his family have been struggling to cope with state related changes in Medicare and Medicaid. For example his daughter is suppose to have dental care under Florida's "Healthy Kids" but when he talks to United Health Care (insurer for Healthy Kids in Flagler County he is told he does not have dental care for her. Dale's task of obtaining health care for his two sons, daughter and wife is complicated because they are all on different plans despite all being covered by Medicare or Medicaid (see Dale Roane's story, page19).

Cobra for employees who have lost their jobs is often not affordable. Debbie Chandler, ARNP notes that she has had so many patients who have lost their jobs and now can't afford the Cobra. Worse yet, if they don't continue with Cobra they now have a pre-existing health condition that no one will cover for the first 1-2 years they're employed with the new company.

Lower reimbursement rates for Medicaid result in fewer places to go and feeling like you're being sent to the back of the bus

Few specialty clinics in Florida accept Medicaid so Dale Roan has trouble finding providers to treat his two sons with ADHD. Effective treatment of ADHD reduces problems in school and increases likelihood that kids will not engage in substance use when they are teenagers (ADHD treatment is protective). One of these sons also has asthma. Effective management of asthma would decrease costly ER use.

Debbie Chandler's Neurology Clinic is one of the few clinics that accept Medicaid, but she has had several occasions in which her patients have had urinary problems, but there are no urologists in the Orlando area that take Medicaid. The closest urologist that takes Medicaid is in Tampa. In addition, there are no Pain Mangement providers in Orlando that take Medicaid either.

Restrictions on Nurse Practitioner's Scope of Practice (also impact quality of care and cost) Although 48 states allow nurse practitioners to prescribe controlled substances, Florida is not one of them. So a nurse practitioner like Debbie Chandler, ARNP who works in neurology, in partnership with neurologists (physicians), cannot prescribe or write refill prescriptions for medications commonly used in the practice even though doing so is consistent with nationally recognized practice guidelines (based on the American Academy of Neurology guidelines). This is particularly ironic because one of the advantages a nurse practitioner brings to a practice is the potential to increase access. Nurse Practitioners are particularly useful for seeing those

patients who may take more time or could benefit from nursing's expertise in helping patients manage their illness rather than have the illness managing them. However, the laws in Florida limit the potential increase in access she could provide by interrupting both her practice and Dr. Rosenberg's practice (see Chandler's story, pg. 14).

Infant Mortality – An example of how access issues contribute to a national scandal. The United States has one of the highest infant mortality rates compared to other industrialized nations. With all of our resources, why is this such a problem? Much of this is due to decreased access to health care. It is shown that socioeconomic status and race are correlated to increased infant mortality. It makes sense, if a parent barely has money to put food on the table how are they going to be able to take themselves or their child to those much needed doctor's appointments? If we had more prenatal access to healthcare we could make sure the mother is getting proper nutrition and education. After the baby is born is just as important. In New Zealand, nurses make home visits to new mothers to check on the mother and baby and provide any education deemed necessary. In France, they have nurses who perform the same duties. They even have doctors and nurses who make house calls. New Zealand and France both have lower infant mortality rates than the United States. In the BSN program for nurses community health care is a key component. By performing home visits it can help the parents prepare for the baby and visiting after creates continuity of care and prepares the parents for the infant. In the United States we are very good and focus on the setting of acute care such as NICU and PICU but we wouldn't have as many babies in the NICU/PICU or high infant mortality rates if we started in the community with preventative health care. Preventative health care can prevent a multitude of problems and can increase access to health care since it is cost effective. For example, if a mother waits until her child is extremely ill, she may take him to the ER, their primary source of care which is extremely expensive and then, a simple infection may have turned into something worse since she needed to wait, which then cost even more money to treat and in the worst case scenario, she waits too long and the child passes. If we had increased preventative health care, less people would be using ERs as primary care settings which would save money, we could find and treat illness earlier and we could help prevent and decrease the astounding infant mortality rate in the United States. It is so much more cost effective and it increases the access to health care for so many people if we improved our preventative health care in the United States.

References

AACN White papers:

- Hallmarks of Quality & Patient Safety (included at the end of this report)
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THE APPLETON WISCONSIN SCHOOL LUNCH STORY



from *PURE FACTS* October 2002

A different kind of school lunch

Students in one midwestern community are enjoying fresh, delicious food plus a big change in their learning environment.

Walk down the hallways of the Appleton, Wisconsin, Central Alternative High School and you will see students focused on their education, interacting successfully with each other and with their teachers. Notice the calmness and purposefulness that sets these teens apart from others.

You will notice that the hallways are different in another respect. They aren't lined with soft drink and junk food machines. Then check out the cafeteria. There is no smell of grease. Burgers, fries and burritos have been replaced with salads, meats prepared with old fashioned recipes, and whole grain breads. Fresh fruits and vegetables are offered and the students drink water.

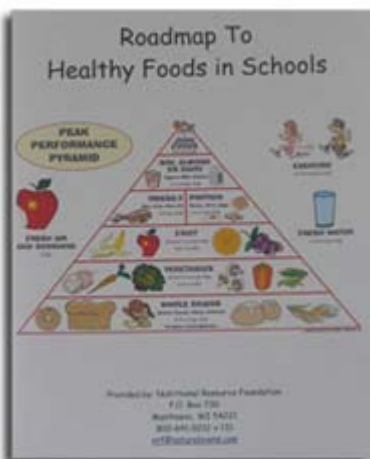
Grades are up, truancy is no longer a problem, arguments are rare, and teachers are able to spend their time teaching. What's going on in Appleton Wisconsin?



In 1997 of Manitowoc, WI initiated a five-year project to bring healthy food into area schools. The goal was to show that fresh, nutritious food can make a real difference in the student's behavior, learning and health.

Just prior to the beginning of the program, Greg Bretthauer was offered the job of dean of students at the school. What he saw were teens who were "rude, obnoxious, and ill mannered" and he turned the job down. Because the school had so many problems with discipline and weapons violations a police officer was recruited to be on the staff. He found a school that was out of control.

Today Greg is the dean of students in an atmosphere that is vastly different from what he saw in 1997.



The story of the Appleton project has been documented on a short DVD, *Impact of Fresh, Healthy Foods on Learning and Behavior*. It is also part of their *Roadmap to Healthy Foods in School*, and both are available from www.naturalpress.com, 1-877-629-8398.



Principal LuAnn Coenen is amazed at the change she has seen in her school. Each year principals are required to file a report with the state of Wisconsin, detailing the number of students who have: dropped out, been expelled, been found using drugs, carrying weapons or who have committed suicide. Since the start of the program, she reported, the numbers in every category have been "zero."

Mary Bruyette, a teacher at the high school, believes "If you've been guzzling Mountain Dew and eating chips and you're flying all over the place I don't think you're going to pick up a whole lot in class." She reports that the students are now calm and well behaved. "I don't have to deal with the daily discipline issues; that just isn't an issue here."

Mary goes on to say, "Our biggest problems now at the school are parking in the parking lot and student tardiness. I don't have the disruptions in class or the difficulties with student behavior that I experienced before we started the food program."

Students who previously had been headed for trouble have turned their lives around, according to Dr. Thomas Scullen, Superintendent of the Appleton Area School District. He told the interviewer, "We have kids who have had a lot of problems and got through the whole last year without an expulsion. Drop-outs dropped to non-existent. Kids came to school. They have learned that with healthier foods it's going to make them a better person. It keeps them more focused and makes them happier."

Dr. Scullen had expected that the healthy diet would improve behavior, but he was pleasantly surprised that it has had such an impact on academic performance.

Mary Bruyette can demand more, academically, from the students than she previously had. Now she can use all of the class period for instruction.

The high school's counselor, Deb Larson, says, "I don't have the angry outbursts so instead we get to deal with the real issues that are underlying and causing some of the problems in the kid's lives."

Why don't other schools try this approach?

Typically, while school dietitians want children to eat healthier food, they are convinced such efforts will be futile, and if students cannot get their fast food in the cafeteria they will buy it off campus. This does not appear to have been a problem in Appleton, where the food is not only natural, it is prepared with care; Natural Ovens made sure of this by hiring and training the cooks for the school.

Like children on the Feingold Program, once these teens have made the connection between food, behavior and learning, they tend to prefer to enjoy the benefits. One student said, "I really like the food. It tastes good, it's hot, it's fresh."

One girl commented, "Now that I concentrate I think it is easier to get along with people 'cause now I'm paying attention to what they have to say and not just worrying about what I have to say to them." Another student said, "If you're going for a big test you want to eat great."

The on-campus policeman, Dan Tauber, is able to be a role model now, instead of a disciplinarian. Students are interested in how he eats to keep in such good physical shape, and have noticed their athletic abilities have a lot to do with their diet.

"Returning students are now the advocates for the program. The kids encourage each other," according to Mary Bruyette. "They set the example for the new kids. It works great."

Many of the changes are being phased in to Appleton's middle and elementary schools. Candy machines are gone and pop machines are being replaced with juice machines or water coolers. There is a district-wide commitment to healthier eating and lifestyle in general.

Even in schools where more modest changes have been made, there are some real differences. Gary Van Lankvelt, principal of the Einstein Middle School, has seen "more calmness and less bouncy activity. Students seem to be more alert and focused."

Madison Middle School's principal, Fred Ginnochio says the students are buying the healthier a la carte items and more are using the salad bar. He has found when the kids are in the halls "we have not had one incident all year that I have had to get involved in with shoving, a fight, aggressive behavior."

"I've taught here almost 30 years. I see the kids this year as calmer, easier to talk to. They just seem more rational. I had thought about retiring this year and basically I've decided to teach another year -- I'm having too much fun!"

- Dennis Abraham,
middle school science teacher

Dr. Scullen sees an eventual switchover in all of Appleton's schools. "It can take several years to make the transition. The program will sell itself on its own merits, given the time. I think instead of looking at the food program as a "break-even" we have to take a look at what do we have to put in to make it really good for the kids."

What about increased cost?

"One child arrested would cost the schools more."

- Dr. Barbara Reed Stitt,
Natural Ovens President

Natural Ovens underwrote the cost for their 5 year study that will eventually impact 200 Wisconsin schools. The price to turn the problem around was \$20,000 a year. Natural Ovens President, Dr. Barbara Reed Stitt, noted that "one child arrested would cost the schools more."

Dr. Scullen believes, "if it results in a happier kid, improved learning, and ultimately a better community then it's a cost we cannot avoid. It's something we must do."

Says Dan Tauber "Let's invest in the kids now, financially, with food versus invest in them later, financially, with 'how do we correct the problems we have because they are not eating healthy?'"

"Nutrition for students should be part of the general operating budget" according to Mary Bruyette. "We're concerned about everything else. We're concerned about new band uniforms. We're concerned about the football team. We're concerned about text books. Why not be concerned about nutrition? That seems to me the basis in many cases for creating a positive learning environment."

LuAnn Coenen says "I can't buy the argument that it's too costly for schools to provide good nutrition for their students. I found that one cost will reduce another. I don't have the vandalism. I don't have the litter. I don't have the need for high security." "We've got to stop using our most precious commodity -- our kids -- to make extra money."

Coping with Breast Cancer
Karen J. Aroian, PhD, RN
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SOMETIMES YOU NEED A NURSE TO INCREASE QUALITY AND DECREASE COST (EVEN IF YOU ARE NURSE)

I am a doctorally prepared nurse. I recently had a reoccurrence of breast cancer. Immediately after the pathology report from the needle biopsy confirmed breast cancer, a nurse escorted me into her office and kindly made the appointments for the next level of contact with health professionals. Although I am very capable of negotiating patient care systems on my own (compared with older people, people with language barriers, people with less education, for example), it was a relief to have someone make the appointments on my behalf. I then underwent a number of surgeries, test results, and consultation with a team of physicians, namely surgeons, radiation specialists and oncologists. At this time, I was introduced to a nurse who said she was available to help me navigate the system. My husband accompanied me during these consultations. He is also doctorally prepared, a scientist, and used to making sense of large amounts of information. Nonetheless, both he and I had trouble remembering all of the details of the consultations, despite having been given a very comprehensive set of patient education literature. I underwent more surgery and my surgeon told me to contact the radiation specialist to schedule radiation. I was relieved to receive this recommendation rather than being told that chemotherapy was the next, intermediary step before starting chemotherapy. Chemotherapy has plenty of unpleasant side effects and long term health consequences over and above the unpleasant side effects and long term health consequences of radiation. My relief was short lived, however. The nurse navigator reviewed my record and noted that my case was not as straightforward as the surgeon assumed. Characteristics of my tumor made chemotherapy a consideration. She coordinated my receiving more diagnostic tests, a highly individualized test called oncotype DX, to determine if chemotherapy was indicated. Thankfully, the oncologist determined that the results of the oncotype dx test confirmed that chemotherapy was not needed. Nonetheless, I was reassured that I had not skipped an important step in cancer treatment. This is a perfect example of the importance of coordinating patient care and the usefulness of having a knowledgeable and trained professional, namely a nurse, assist patients in navigating a complex medical system. Had I really needed chemotherapy but slipped through the cracks, I would undoubtedly suffered more ill health from cancer reoccurring and in turn, my health status would have incurred more financial costs. Thus, the nurse's efforts on my behalf can also be seen as preventative.

INSURANCE BUSINESS PRACTICES CAN IMPEDE ACCESS AND CREATE RISK FOR INCREASED COST

A rather unfortunate aspect of my cancer experience, however, was that I was changing jobs, had sold my home, and was moving to another geographic location. I was insured by a HMO that was not in my new geographical area. I had to delay radiation, a delay that is documented to be less effective in eradicating cancer, until my new job began and I had local insurance. Getting prompt insurance coverage was very stressful. My new insurance started January 1 and health professionals refused to book appointments with me until I had an insurance card. This resulted in my treatment being delayed for weeks after I was technically insured in the new geographic

location. This fragmented aspect of third party reimbursement is not cost effective and it is very stressful.

A nursing student's difficulty of getting into limited access nursing school programs
Cara Arsenault's Story
305-766-6247

Since sophomore year of high school Cara has been interested in becoming involved in the health care field. In addition to taking courses which included honors and advanced placement courses she was able to take a set of three classes in allied health as well as participating in various school sports, afterschool clubs and a part time job at a local tourist store. She has been working since the age of 15 and only took a yearlong break when she was a freshman in college. She graduated from high school in Spring 2004 with a 3.8 GPA and several scholarships to help offset the costs of four years of college.

Once in college began Cara became more and more interested in the field of Nursing and declared her major midway through freshman year. In her sophomore year she took on a job due to the costs of school and her families' inability to offset the costs not covered by scholarships or loans. She has been working at the UCF Student Union since Fall 2006 as an Event Services Associate and also a Information Desk Associate. The people and organizational skills she is acquiring will only enhance her skill as a nurse, but the work limited her time for study and slowed her academic progress towards her goal of studying nursing.

During her junior year she finally met all the requirements for the limited access nursing program at UCF except for the grade point average (GPA) from the difficulties she met in the general education courses and difficulty balancing work and school. She had a 3.1 UCF GPA and the program required a 3.2 UCF GPA. Since there is not an interview process or any other considerations due to budget and an insufficient faculty to teach a greater number of students she was turned down. The limited access program only allows 120 students into the regular baccalaureate program a year. Forced to offset another year she pursued another minor in Health Services Administration and focused on simply getting her UCF GPA up to the required amount. She reapplied in December 2007 and continued to work and try to save money for impending costs. She was accepted in February 2008. In the meantime, she was offered and accepted the position of Information Desk Supervisor at her job and was in charge of seven other associates again demonstrating people skills and a management potential that would be extremely beneficial in a nurse.

Since dealing with the frustrations of getting into the program, the first semester of the Nursing program has been a success and Cara finished the first semester of the program with a 3.1 semester GPA even after having several difficult hurdles to overcome and eagerly anticipates beginning the next semester which will be the hardest for nursing students at UCF. Due to this next semester's difficulty in course load Cara has decided in her best interest to stop working and focus solely on school so she can be successful. Her teachers are pleased that she will have additional time to focus on her studies and develop her true potential. However, Cara is greatly concerned about the costs she is going to face as her baccalaureate scholarships are ending along with the decreased availability of overall scholarships and increased difficulty in attaining student loans. Her total years spent in school will now total six once she graduates due to the impediments to continue classes in her chosen major but she will continue to work towards reaching her goal of becoming a Nurse even with the economic crisis at hand or until she is no longer able to pay for school. Cara is determined to be a nurse!

Qualified applicants not being accepted to nursing school (Story 1)

Jenna Benyounes, SN

President of the UCF Student Nurses Association

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Applying to nursing school can be one of the most exciting times of your life. You dedicate yourself to your studies for all of your prerequisites to ensure that you do well to have the best chance of getting in, however, many of these students are not accepted. It is not that they did poorly in academics but simply because there isn't enough room. My friend Amanda Maurer has always wanted to be a nurse and was so excited to declare it as her major when she first got into college. She tediously worked for two years on her prerequisites, attending all of her classes, going to tutoring sessions and study groups. All of the time she spent was to do well in her classes, gain a solid foundation and to get into nursing school. When the time came to apply, she knew nursing had high standards, but she felt she met them through doing well in her previous classes. Amanda turned in her application and awaited a response. A few months later she found out that she did not get in. It was not due to poor academics or behavioral issues, there just wasn't enough room in the program. She was a well qualified applicant with a passion for nursing but was turned away. She then had the option to wait a year or to choose a different major. She decided to stick with nursing and take up a minor for the year she had to wait. Others may not be as enthusiastic as Amanda was to stay a whole extra year to become a nurse. That whole extra year meant more money on tuition, books, room and board and less time with a full time job.

Many students, while wanting to be nurses, may not be able to make the sacrifices Amanda did to obtain a degree in nursing. Now not only did we lose many qualified applicants that could have become nurses that year but they may not even apply to the program the next year since they would change their major to graduate in time. Two students I knew that applied, who were very qualified, but were not accepted and were unable to wait that extra year, they changed their majors. In order to decrease the nursing shortage we need to make nursing school more accessible to those who are qualified to attend, and when there is not room, we need to find suitable alternatives so these students are not waiting an entire year to apply to the program which they, again, may not even get into so we do not lose even more potential nurses.

When there aren't enough nurses (Story 2)
Jenna Benyounes, SN
President of the UCF Student Nurses Association
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My boyfriend's uncle, Sam, underwent a coronary bypass about 7 months ago. After the surgery it seemed to be a rushed feeling of get him in and get him out. He returned home, on multiple medications but was doing alright. He went on for several months and appeared to be doing well although his heart was still weak. On Friday, December 19, he went outside to shovel snow. He died that night of a massive heart attack. Our first day of learning about cardiac in our adult 2 class, our professor Dr. Demarias told us that people who have cardiac issues shouldn't shovel snow since their heart is weak and the activity can cause a heart attack, which is exactly what happened to Sam. In the hospital or even at his doctor's appointments it should have been stressed to him the changes he would need to make in his lifestyle, what he would need to watch out for and that he shouldn't be shoveling snow. The system failed in many ways. The nurses were busy and overworked and didn't appear to have time to educate him. The doctors did not appear to look at the whole life style and solely explained to him what was going on with his heart. If a student nurse, such as myself, can look at the big picture why couldn't these professionals? The nursing shortage is causing nurses to not have enough time to perform their tasks and educate. If we had more nurses they could spend more time with patients talking to them, learning about them and educating them. Even if we had more autonomous nurse practitioners, who tend to look at the whole person, we would have more cost effective and well rounded health care. Also, if we improve the use of nurse practitioners and their autonomy, it would give doctors more time to be with patients so they as well can begin to look at the whole person and not just their pathophysiology. If Sam had been given the simple education of not to shovel snow, he would still be here today. We need more nurses and more autonomous nurse practitioners to provide the best and complete patient care that is possible to prevent this from happening to other families.

A nurse practitioner trying to enhance access and provide cost-effective quality care
Debbie Chandler's Story
407-461-4402

Debbie Chandler ARNP is a nurse practitioner who works in a neurology clinic in Florida where nurse practitioners are not allowed to prescribe controlled substances. She sees about 10-12 patients per day. At least half of them are on some form of controlled substance because medications like Ritalin, Lyrica, and Klonopin are used to manage illness and symptoms in patients with chronic neurological illnesses. The use of these medications is consistent with practice guidelines. When Debbie needs to write a prescription for a controlled substance, even it is a refill for an on-going medication and the patient has had no change in symptoms, she has to leave the room, find Dr. Rosenberg, the physician she works with. Then she has to wait for him to finish with his patient or conversation with another provider, etc. Then she has to describe what's going on and wait while he writes the prescription before she can go back and give it to the patient. This takes an average of 5-15 minutes per patient, or 25-90 minutes a day which translates into anywhere from 2 hours and five minutes to 7 and 1/5 half hours a week that could be better used seeing patients. And that's just considering the burden on her time, not Dr. Rosenberg's.

For example, Debbie cannot give her patients with multiple sclerosis a refill prescription for Ritalin when they need one. Ritalin is currently the only Medicaid approved drug for MS Fatigue. However, because Ritalin is a controlled substance, it can only be prescribed one month at a time. Therefore, monthly visits are necessary for patients to obtain a prescription refill.

MS patients have terrible fatigue. They frequently describe this as waking up with an empty gas tank. Without the Ritalin, they don't have enough energy to work, or if they go, they're exhausted and not able to function well. One of Debbie's patients with MS who lived several miles away, couldn't drive and depended on the local bus system or his mother to get to her office. No physician was available when he was seen at her office. So this patient had no alternative but to go back home, wait for 3 days, take the bus back to the office to get the prescription, unless he wanted to wait at home for an additional 2-3 days for the prescription to be mailed to him. During those 3 days he was unable to do anything but lay in bed until he was able to get the medication.

Another of Debbie's patients with MS needed a MRI but the woman was claustrophobic and needed sedation prior to the MRI. However, Debbie could not give her a one-time dose of Ativan for the procedure because Ativan is considered "dangerous" because of the risk of addiction. Ironically, Debbie can prescribe chemotherapy medications for worsening MS and these medications are much more dangerous.

Debbie Chandler, like many health care providers, is convinced that allowing nurse practitioners to prescribe controlled substances will reduce costs to the office practices, patients, Medicare and Medicaid, reduce time to care for the patient, improve patient care, and reduce the liability to the physician, by having the provider taking care of the patient write all prescriptions needed. For more information, you are invited to contact Debbie Chandler and set up a visit at her office with herself and Dr. Rosenberg to discuss her story in more detail.

Empowering Parents
Debbie Gross's Story
Debbie Gross, PhD, RN
Johns Hopkins University
dgross17@son.jhmi.edu

Debbie gross's story is a story about developing a parenting program in partnership with low income and ethnic minority parents. It is a parenting program that empowers parents under stress who live in low income communities. Through her program she has been able to improve parenting skills, reducing parents' reliance on harsh discipline techniques for gaining their children's cooperation. As a result behavior problems in young children have decreased. The program is relatively inexpensive to deliver, costing as little as \$292/child with a 900 percent return on investment and can be built into existing Head Start programs.

A PDF WHICH COULD NOT BE INTEGRATED INTO THIS DOCUMENT ACCOMPANIES IT AS AN ATTACHMENT.

Her story can also be found using the following link

http://www.aannet.org/files/public/Chicago%20Parent_template.pdf

A Case for a Uniform Electronic Medical Record & Tales from a Nurse Practitioner in an ED
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I work in an ED that uses two methods of documentation (one electronic and the other on paper) that do not "talk" to one another. As a result, patient information that I record is not readily available to subsequent providers unless they track down the hand written portion. And while I have access to the computerized records, information does not flow from that record onto my forms unless I transcribe it (which is an opportunity for errors of omission). To add to this disconnect, the computerized record ONLY has information gleaned while the patient has been under care in our facility. My county (Indian River) has only 2 hospitals and it is beyond common for patients to seek care from both. They often call both ERs to see who is more or less busy each is and make that the deciding factor for where they seek PRIMARY care. So, this situation often results in less than perfect information and always requires a complete review of the records that we do have access to, thus raising costs in oversight time.

I would be more than happy to serve as a contact person for the Obama team. I actively work in a rural ED that serves many persons without Health Insurance, inadequate insurance, SCHIP coverage, Medicaid and Medicare. I also see a fairly significant number of Hispanic (Mexican) immigrants (some with undocumented status) that are primarily Farm and Labor workers.

Kandis Natoli

December 21, 2008

kandis.natoli@gmail.com

Young mothers have taken to journaling their birth, breastfeeding and early mothering stories on the internet. An excerpt from one such story is presented here to illustrate fragmentation of health care delivery. Despite this mother's obvious high level of health literacy, she needed to consult three different healthcare providers for this simple and common breastfeeding problem.

...After a while I noticed a white coating on the cracked part of the nipples. Coupled with the severe pain, this seemed like a classic case of thrush, a nasty yeast infection that is passed from the baby's mouth to the breast. But Izzy showed no real signs of oral thrush...her tongue was a little white in the back, but the rest of her mouth was clean, and I assumed her tongue was simply stained with milk. In the mother, thrush can be characterized by cracked, red, and burning nipples, intense nipple pain from birth or during the entire feeding process, shooting pains in the breast after nursing, and nipple pain with the correct use of an electric breast pump. I called a lactation consultant at the hospital where I delivered and explained that I seemed to be experiencing all of these symptoms to the EXTREME. She urged me to call Izzy's pediatrician for treatment and to make an appointment for myself ASAP at the women's health center.

What was actually required was a script for a topical antifungal medicine; an ointment for the mother and an oral suspension for the baby, instructions for how to apply them, and follow-up if things don't significantly improve in 48 hours. If the hospital billed this mother for the telephone consult, the pediatrician charged for the office visit and the obstetrical provider also charged for that office visit, the time and money for this intervention was needlessly exorbitant.

Speegle, T. (September 19, 2008). Breastfeeding Blues in Life with Izzy, (September 19, 2008).

Retrieved on December 20, 2008 from website:

[://izzylynn.blogspot.com/2008/09/breastfeeding-blues.](http://izzylynn.blogspot.com/2008/09/breastfeeding-blues)

An Insured Patient Uses the ER Because Primary Care MD is Unable to take Calls
Anne Norris, PhD RN's story
anorris@mail.ucf.edu

In August, Anne developed a bad case of poison ivy which does not seem like a big deal but it can be. She was given a steroid medication but taking it seemed to make things worse (or at least not better). She called and called her physician but the physician was unable to take her calls. This is a very responsible physician who is currently frustrated with the reimbursement rates that force her to see many patients in a day to pay her overhead costs.

Anne felt like she was going to lose her mind from the itching. She was unable to sleep, taking Benadryl and using icepacks around the clock, controlling her irritability by withdrawing and isolating herself from her family, and unable to work. As a nurse she assessed the extent of the rash and could see that it was increasing in severity, so she went to the ER. After waiting 4 hours, she was finally seen and told she was given the wrong dose of steroids which had made the poison ivy worse. If things had progressed she would have been admitted to the hospital. She was given a different steroid dose and 6 weeks later was symptom free.

Dale Roane's Story
A Family Man Struggling to Obtain Health Care for His Family
386-585-4453

Dale Roane is trying to do the right thing, but he is disabled and cannot work. His wife is retired and on Medicare. His children from a previous marriage are now living with him. When their mother died, the children were living in New Jersey but he went to get them and bring them home so he could raise them. The children came with "Medicaid Gold," but after a year they were put into the "Florida Health Kids" program and then into another program and then another. He cannot keep up with the coverage changes, the program miscommunications, or the challenge of finding providers. For example, his daughter is suppose to have dental care but when he tries to obtain it, the insurance provider says it is not covered. When he goes back to Healthy Kids, they say she is covered for dental. He cannot get through to the right people to get this done. He struggles first hand with trying to get his kids seen and providers refusing because they don't take Medicaid because the reimbursement rate is so low. In addition, he is asked to pay \$100 dollars a year plus a 20% of the cost co-pay that he cannot afford.

Dale Roane's sons are in a separate plan from his daughter because they need the "chronic illness plan" due to their asthma and ADHD. However, he cannot find providers for them either.

There are a lot more details to this story that captured in this brief summary. Some of them are outlined in the attached documents. However, Dale Roane would be happy to give more details to anyone who wants to listen. He feels the current complex web of Medicaid and Medicare funded programs disenfranchise him and his family and are used to disqualify them from the basic health care services they need. He argues that one state wide or national program is the answer rather than counties in a state being able to have different programs based on size of population and other factors, including politics.

Discharging new moms from the hospital with formula packs

Ruthy Wilson MSN C-PNP IBCLC (321-453-1717)

Allowed in Florida, banned in Massachusetts

I am a PNP UCF and FN certificate candidate and though I am unable to attend and contribute, I would like speak out as a perinatal advocate regarding the distribution of formula packs that are distributed to all parents except those who deliver in Baby Friendly USA designated hospitals. Research indicates direct marketing of formula to consumers discourages breastfeeding and hospitals that distribute them are tacitly endorsing formula as the preferred method of infant feeding.

The American Medical Association and the American academy of Pediatrics discourages the industry distribution of "Gifts" to professionals and to consumer under the guidelines that these are in-ethical practices and add to the burden of consumer's individual health care costs.

There are state and national policy makers that are working tirelessly to raise the bar for women's and children's health care policy and take action to remove this isolated marketing tactic from all health care systems. No other industry direct markets to the patients in hospitals, orthotics are not distributed at discharge from an ortho unit nor are cardiac monitors "given away" to every patient leaving a telemetry unit.

I recommend a new national policy that ALL hospitals cease and desist marketing discharge "Gift bags" from Formula companies to parents.

12/23/08

Patient

Gloria Pierson
601 Wren Ave
Miami Springs, Fl 33166
305-887-8593
78 years young

Complaint made by:
Daughter – Karin Letizia
6 Cedarwood Court
Palm Coast, Fl 32137
386-864-8334
[@cfl.rr.](mailto:karin.letizia@cfl.rr.com)

I heard on the news this weekend of the Forum that you are having regarding complaints or what is wrong with our Health Care. I am sorry that I am unable to come and speak in person – but I hope my letter will be included as a complaint.

My mother suffered a fall and broke her left ankle in March 2007. This injury required surgery to repair with screws and bolts. Her right ankle was extremely sprained in the fall as well. After the surgery – the Doctor attending to her at the hospital stated that she would be placed in a skilled nursing facility to recover from the injury and get the rehab she needed to be able to walk again – he stated we will take good care of your mother. All of a sudden things changed after her HMO/VISTA got involved – the Doctor stated that yes she does need to be in a Skilled Nursing Facility but his hands are tied because the Medical Director for VISTA said she has to go home. This Medical Director never came in to see my mother and her condition at all. I was calling them left and right trying to understand what is going on – I could not speak to a Medical Director myself to understand why – they would send in Representatives and they would cause my mother to cry – she had a cast that was bleeding through, she was diabetic and she is Obese. Now she has not been into a medical facility for years except in the late 1990's for a knee operation – it did not work – and from that she was confined to a wheel chair – she was not overweight before the knee surgery – but being confined to a wheel chair caused her to have to limit her exercise and the weight came on through the years. She was able before the accident to walk using her walker about 10 steps at a time. So she had not been a burden on this HMO at all with illnesses and injuries. These Representatives would come in and scream at my mother that she had to get out and go home and slam down clipboards next to her – they treated her so mean. After letters and many phone calls by me– she was placed in a Skilled Nursing Facility for a week – Vista wanted her out from there as soon as those days were up – and I fought and fought again – and they said that the facility was not equipped for her and transferred her to another facility. I was not told that they were not covering it and her Insurance coverage was dropped by the second SNF because they thought she was coming in for good – no-one in my family ever stated this to be done. Nor did we receive notice. She wanted to get rehab and return to her home where she was independently living after my father's death. The Health Insurance would not reinstate her after this error. I made again phone calls to many different departments of the HMO

and Senior citizen watch groups - Medicare. After two months of complaints – they finally re-instated her. Every day she was getting rehab at this facility for hours at a time – but the HMO decided to label it as a custodial visit – which made them not have to cover her – that is there most famous saying throughout the year of recovery by the HMO– she is a “Custodial” patient. Besides denying, and denying services for her which were listed in her health guide manual from the HMO. I would have to write letter after letter to this VISTA and appeal and appeal for services she was suppose to receive according to her Health Plan. I visited Vista Headquarters twice living 5 hours away and demanded that my mom get the services she deserves during this injury.

They wanted to send her home and send Rehab there – we had tried this – and they were the most disorganized group of rehab persons – they would say they are coming at a certain time – like 10:00 am and come to her house – like late at night...or they would not come at all when they say they would be...my mom would wait in her wheelchair for hours for them – while her leg laid low and would swell tremendously. They would also only approve a couple of visits or no visits. It was a joke that they thought this kind of care was ok. If I did not fight tooth and nail for my mother from this healthcare – she would have a stump of a leg. They don’t care. I am not sure how many other patients are being treated like this – but I was not going to let this happen to my mom.

Places that I complained to:

FMQAI, AHCA, Medicare, Governor’s Office, Inspector General’s Office, Florida Medic, AARP, Shine, Local Senators from my mom’s district. Committee on Health Quality and Healthcare Council, and the Patient Advocate Foundation.

No-one seemed to have control over this HMO. I would like to see someone be a Health Care Czar to oversee these companies and oversee complaints.

I would love to see a Universal Health Plan in our Country.

Also the medicine costs needs to be reviewed – patients are overcharged so much for drugs. I feel like the Pharmacy companies are running the industry when our Government should have a say in these matters. Pharmacy Representatives come into Doctors offices and take away our time – by visiting the Doctors and making us wait longer.

I could go into more detail about my mom’s situation but I have tried to condense these matters. I have a plastic file folder container full of paperwork – I can barely carry. If my mom did not have me to represent her – she would not have wanted to live in her condition – Therapy helped her regain her independence – but at the costs of writing letters of complaints, time away from my family, etc. it was a nightmare. We changed her Insurance this past year to ARRP supplemental plan – I have not had one thing denied, or had to appeal a thing. I have not had to write one letter.

Please call me if you have any questions. I thank you for taking the time to listen to my concerns regarding HMO’s and Healthcare.

Obama Transition Team;

The Transition Team Community Health Forum- held on campus at the University of Central Florida- proved to be a wonderful opportunity for me to hear the perspectives of a diverse group of my community members. It was of particular value since I am a graduate student seeking a Masters degree in Health Services Administration. Moreover, a firefighter/EMT for over six years now, who has seen problems associated with moral hazard, quality, access, and cost. Of the many views expressed, the most salient that everyone agreed on was that of our fundamentally broken health care system. In short, it does not make us healthy, does not care for us, and bears little resemblance to an efficient system. However, I feel strongly that our current model has significant value, and should not be tossed out of the equation.

Empirical review, both within our nations borders and abroad, will be the key to our health care system success in the years to come. This would ensure that we expand access, control costs, and gain higher levels of quality. Additionally, we have some great minds in all fields that have already proposed excellent ideas. For example, managed competition, which would make strong demand side alliances, break the job tie to health care, and ensure access. Also, a health care annuity established by the government for its citizens that would also break the current job tie to health care while ensuring access.

In closing, I have observed that a significant portion of health care reform debate stems from a question regarding health as a right or a responsibility. It is fair to say that we, as Americans looking for health care reform, will not soon come to an agreement. We should concentrate our efforts on making our current system better, and not tossing it out in the name of universal health care.

Respectfully,

Carlos Travieso
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407-929-2225
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Oviedo, Fl 32765

Dear Thomas Bryer:

I'm writing to expand on the statements that were made by me at the UCF Healthcare forum. Due to my kids, I was offered the opportunity to speak much earlier than anticipated and some of my prepared notes were not discussed. Below, are some points that you may consider for your Obama Healthcare report.

1) We cancelled our \$1,200 per month "group" healthcare plan when my husband was placed in the hospital for pneumonia. He had a cold which turned into the flu and turned into pneumonia. His 6 day visit monthly bills cost us more than we could pay without eliminating our "group" health insurance plan. We believed the whole purpose of paying for insurance is to be protected during emergencies.

2) We attempted to locate individual healthcare plans. I had a preexisting. My son was being considered for tubes in his ears at the time. My daughter was under 1 years old and could not receive healthcare without an adult on the plan. And, my husband was declined insurance for 124/90 blood pressure being outside of the "normal range". Therefore, my daughter and my husband were declined. Can you believe a baby is unable to receive healthcare until they are age 1? This is true through the individual United Healthcare plan and the Florida Kidcare Medicaid plans with our \$48,000 income level.

3) Infants need regular shots which usually consist of 2-4 shots at one time. Are you aware that shots cost over \$125 each? This was costing us \$500 to keep up with the required immunization. Therefore, we went for months without these shots until I located a clinic. It's hard to believe that we live in America and struggle with basic medical necessities for our children.

4) My husband's employer provides healthcare coverage, but we cannot afford the \$1,200 monthly premiums. His \$48,000 salary did not qualify us for Medicaid. We do not consider ourselves poor and we are conservatives living within our means. I believe all Americans should receive basic coverage and medically necessary medications. American citizens should be able to visit their own doctor or locate a doctor where they do not have to pass the welfare line to be treated. True.

5) My anti-epileptic medication costs \$330 per month. Why does a 10 year old medication cost \$5.50 per pill? The generic is the same price. Of note, ORMC charged us \$14 for an ibuprofen for my husband too.

As you can see I am very passionate about the horrible situation we have been through in 2008 and I want to represent every family who wears our shoes throughout the United States. As a stay at home mom with a college degree, I have interviewed for employers who do not offer healthcare. If I were to accept employment, childcare costs are \$1,200 per month and healthcare costs would be \$1,200 per month. This totals \$28,800 per year. These employers were only offering \$35,000. I met a stay at home mom who was a self-pay for her pregnancy delivery. She refused the recommended epidural because it would cost her \$2,000 more than her means. Very responsible citizen...

I am considering moving to Germany or England if things don't change for the better with our healthcare. I believe our current healthcare, hospitals, mortgage crisis and credit card crisis to come are all struggling because they have one thing in common...they have been charging consumers too much money. The fees and the terms are unsustainable. Thank you very much for transferring this message to the new Presidential transition team, Dr. Bryer. I look forward to a positive outcome.

Best regards,

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12/31/2008

Dr. Thomas A. Bryer
Department of Public Administration
College of Health and Public Affairs
University of Central Florida

Dr. Bryer,

Congratulations on your initiative and success in presenting the Obama transition team with an accurate and balanced report outlining the concerns and solutions expressed by all the various stakeholders in the Central Florida region.



My mother, Marjorie Parker Hurt, was admitted to a Central Florida hospital in October 2005 after suffering a broken arm from a fall in her home. While in the hospital, she was administered a sulfa-class drug even though her records-- and a bright red armband around her wrist,-- warned of her allergies to sulfonamides.

Her severe allergic reaction, and delay in diagnosis, caused a rapid deterioration and a drastic suppression of her immune system.

Sometime during this period her body was invaded by a hospital-acquired virus that within days had entered her bloodstream and turned into sepsis. Forty-eight hours later she died.

This unfortunate situation is an all-too-familiar scenario that occurs every five minutes in hospitals and health-care facilities across America. According to the Centers for Disease Control and Prevention and the National Institutes of Health, hospital-acquired infections are the fourth-leading cause of preventable deaths and cost U.S. taxpayers billions of unnecessary dollars annually.

[://www.nichd.nih.gov/news/resources/discovery/2004/staph.](http://www.nichd.nih.gov/news/resources/discovery/2004/staph)
[://www.cdc.gov/od/oc/media/pressrel/r2k0306b.](http://www.cdc.gov/od/oc/media/pressrel/r2k0306b)

Fortunately, President-elect Barack Obama and Senator Hillary Clinton cosponsored Senate bill S.2278: The Community and Healthcare-Associated Reduction Act of 2007. They are aware that with new electronic medication protections (E-MEDS), and implementation of new mandated safe hand hygiene best practices, with surveillance, the number of unnecessary deaths would be reduced dramatically and immediately.

In conclusion, every American should feel comfortable and safe whenever a loved one enters a hospital or healthcare facility. Simple shifts in public policy, enthusiastically endorsed by everyone from patients to caregivers, can save thousands of lives per year and save U.S. taxpayer billions of dollars that can be reallocated more effectively.

Patient safety should be a top priority as the new administration shapes a new health-care system that serves all Americans equally regardless of class or amount of insurance coverage.

Respectfully,
Robin Hurt
[@washyourhands.](https://twitter.com/washyourhands)

*Affordable Health Care
Begins with Breastfeeding*



Affordable Health Care Begins with Breastfeeding

- Breastfeeding is the natural biological mode of infant feeding and breast-milk is irrefutably superior to any artificially prepared substitute.
- Breastfeeding is an important health indicator and a cost efficient method to help prevent or ameliorate a range of diseases from a common earache to cancer.
- Breastfeeding is a complex combination of biopsychosocial factors.

Achieving national health goals for breastfeeding will require overcoming formidable structural barriers and implementing evidence-based solutions.

<u>Problems</u>	<u>Solutions</u>	<u>Examples</u>
Unavailability of skilled lactation support	Levels of care: International Board Certified Lactation Consultants. Develop an Advanced Registered Nurse Practitioner - Lactation specialty area	Follow-up visit to evaluate breastfeeding and related concerns 48 to 72 hours after hospital discharge
Inappropriate interruptions of breastfeeding directed by health care providers	Baby Friendly Hospital requirements as the national standard of care	Help mothers initiate breastfeeding within one hour of birth
Free formula and pervasive promotion of formula use	Develop legislation to implement, and mechanisms to enforce, the World Health Organization's Code of Marketing of Breast-milk Substitutes	Print crib cards, growth charts and tape measures for birthing hospitals. These are things we currently "rely" on formula companies to provide

Lack of family and community support	Loving Support social marketing campaign The Business Case for Breastfeeding Research health disparity issues and develop initiatives targeted to specific at risk populations	Employees need an accessible, clean, private, and safe space (other than a toilet stall) where they can collect breast-milk for their babies
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Young mothers have taken to journaling their breastfeeding stories on the internet. Excerpts from their breastfeeding stories are presented here to illustrate some of the barriers they confronted and some of the solutions they found. The difficulties included lack of skilled support, pervasive formula promotion and use, and inadequate breast pumps.

With my first child, I had every intent to breastfeed, but when she was born and wouldn't latch on, I had no support system and no lactation consultant to teach me how to latch my baby on properly. I pumped a few times and then gave up.

[://www.breastfeedingonline.com/stories](http://www.breastfeedingonline.com/stories).

...I found the nurses at my hospital to be rather unsupportive of my choice ... no one really wanted to take the time to show me what to do so I pretty much taught myself how to feed him based on what I had read. It was very important to me to give my son this great start in life because we have a history of diabetes and Crohn's Disease in our family and I really want to protect Ryan from that. I also enjoy the bonding experience it has provided us with ... I can't think of a better place to be than with my son. I've received a lot of unwanted advice meant to scare me into changing my ideas and ways from giving him water to make sure he doesn't get dehydrated to putting him on cereal to help him sleep through the night. My fears were put to rest recently when at his 4 month check up I was told that 17 lbs. 6ozs. Ryan is "the picture perfect example of a healthy breast-fed baby"!

[://www.angelfire.com/nc2/bfstories/bf64](http://www.angelfire.com/nc2/bfstories/bf64).

I nursed Christopher from my breast for 3 weeks, then I started pumping twice a day, and having my husband feed Chris my pumped milk from a bottle. It was very hard pumping my milk with the electric Evenflo pump. Luckily, at my six week check-up, I read a magazine article about breast pumps. The article talked about the hospital grade electric rental pumps and how good they were. I called around the next day and located a rental station for the Amenda pumps, and boy that a difference that pump made. I could get 6 oz of milk, in 6 – 8 minutes.

[://www.angelfire.com/nc2/bfstories/bf01](http://www.angelfire.com/nc2/bfstories/bf01).

I went back to work when Brennan was 13 weeks old. My company has these industrial strength pumps -- if the milk is in there, these things will get it out!! They give each mom their own sterile kit and you just bring that with you each time you go over to pump. They have nice quiet rooms with the cushioned glider rockers and tons of stuff to read. I went twice a day and it worked out great. I was never embarrassed about what I was leaving to do because I knew that this was the best thing for my child.

[://www.angelfire.com/nc2/bfstories/bf69](http://www.angelfire.com/nc2/bfstories/bf69).

I breastfed both my children but with dd (#1) it only lasted 4 months. I was supplementing with formula and didn't pump as often as I needed to. Pretty soon my supply dropped and it was a downward spiral. I got very discouraged and quit nursing. I still recall nursing dd for the last time (sob). When ds was born, I think that my experience with dd really helped me to realize the importance of safeguarding my milk supply. Ds is 23 months and we are still nursing. I'm not pumping anymore during the day but I nurse before I go to work in the morning and when I get home at night. I stopped pumping just before ds turned 2 years old.

[://www.storknet.com/cubbies/breast/2ndtimearound-patti.](http://www.storknet.com/cubbies/breast/2ndtimearound-patti)

International Board Certified Lactation Consultant

An International Board Certified Lactation Consultant (IBCLC) is a health care professional who specializes in the clinical management of breastfeeding. IBCLCs are certified by the International Board of Lactation Consultant Examiners, Inc. (www.iblce.org) under the direction of the U.S. National Commission for Certifying Agencies. IBCLCs work in a wide variety of health care settings, including hospitals, pediatric offices, public health clinics, and private practice.

Baby Friendly Hospital Initiative

The Baby-friendly Hospital Initiative (BFHI) was launched by WHO and UNICEF in 1991, following the Innocenti Declaration of 1990. The initiative is a global effort for improving the role of maternity services to enable mothers to breastfeed babies for the best start in life. It aims at improving the care of pregnant women, mothers and newborns at health facilities that provide maternity services for protecting, promoting and supporting breastfeeding. BFHI has a simple but thorough approach. Hospitals are awarded "baby-friendly" status only when trained independent evaluators have verified that all hospital practices are consistent with the rigorous standards, including the *"Ten Steps to Successful Breastfeeding."*⁴ The Ten Steps promote exclusive breastfeeding through practices such as rooming in and helping mothers initiate breastfeeding within 30 minutes of birth. In addition, hospitals must agree not to accept free or low-cost supplies of breastmilk substitutes, feeding bottles, or pacifiers.

International Code of Marketing of Breast-milk Substitutes

The Code of Marketing of Breast-milk Substitutes was adopted by the World Health Organization as a set of recommendations that regulate marketing so that mothers were able to make infant feeding decisions free from commercial persuasion. Every nation is encouraged to create, legislate, implement, and enforce protective laws to ensure that families can base their infant feeding decisions not on advertising claims, but on the evidence of science. The WHO Code addresses the primary underlying reason that many women opt not to breastfeed or try and "fail" to breastfeed in the early weeks—they have been swayed by formula marketing tactics which both subvert and mislead the public. Aggressive formula marketing reduces the rate of successful breastfeeding in two ways. 1. Samples and bottles confuse the baby's ability to suck correctly at the breast and reduce a woman's milk supply. 2. Marketing through doctors and hospitals mislead women to see formula as healthy and/or medically necessary.