

Testimony by Dawn Myers Purkey, Program Director, Yolo Adult Day Health Center  
Assembly Aging and Long Term Care Committee  
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Chair, Assemblymember Mariko Yamada

Good afternoon, my name is Dawn Myers Purkey. I am the program director at Yolo Adult Day Health Center and have been for the past 15 years. We, like most adult day health centers have developed expertise to work successfully with a diverse population.

As you know the adhc population is very frail; a fragile population struggling to stay out of hospitals and nursing facilities. This is not a population that is suitable for a senior center. Just to give you a sense, at center the clients average 6 chronic medical diagnosis. I have patients with as many as 19. The average number of daily medications is 10. But this is only an average (25% of take over 15) 15! I have one patient with over 21 rx's to manage.

I want you to imagine the skills needed to successfully manage that many medications. As a matter of fact, medication issues are the #1 reason we get calls from IHSS workers. WHY? Because they are untrained, unfamiliar and scared of making a mistake. Any definition of medication management that you will find will include an MD or nurse doing the management. Med management is not organizing pills only and the belief that IHSS workers take on this role is unrealistic.

Yolo County, like many Californian counties, is rural. Rural counties are service poor: plain and simple. When your population is geographically spread out, it's expensive for providers to do business so we have fewer options.

ALSO rural communities come with a unique set of challenges primarily related to isolation. Geographically as well as personally as many immediate and extended family are geographically distanced. The bottom line is people can't get to services and services struggle to get to the person (with ADHC being the exception).

There are five rural counties covered by three non-profit ADHCs where there is no managed care (Butte, Glenn, Tehama, Humboldt, and Shasta). For these patients, an out-of-state for-profit publicly traded contractor, APS, Inc, with headquarters in New York, will perform care coordination.

Today, my options are the same options for a vendorized telephonic nurse or a managed care provider; very limited. It seems more rational for the state to contract with the non-profit ADHC where the patients are well-cared for, safe and in a familiar setting with familiar staff who know them and the community resources well.

Eventually APS is for all patients, statewide, who opt out of managed care plans. Is APS prepared to handle the needs of the expanded population, take care of them in their native language and track them if they move or change telephone numbers?

And the DHCS assertion is that a person can receive outpatient therapy and home health nurses in an ongoing manner to maintain stability in the community sounds great

on paper but it is counter current Medicare law and is untested by DHCS. I, however, have had extensive conversations with these providers in my community and they are quite clear about the extreme limitations they have based on Medicare and Medicaid restrictions.

I also learned from local IHSS Director that they cannot add hours to replace adhc services just because ADHC goes away. They are not capable of providing skilled services therefore they are quite limited in their ability to backfill the loss of adhc. The transition plan however implies that these services are available and accessible.

So since Medicare and FFS Medi-Cal won't pay, who will? Does the State really think at \$60 extra per month that managed care will purchase these services?? It was mentioned in this room today that the State is willing to spend "whatever it takes" (Toby Douglas, Medi-Cal Director, DHCS). If that is the case given the cost effectiveness and service effectiveness of adhc why are we eliminating it?

The 22 page transition plan only makes sense to non-practitioners. To someone who has never studied this population, been out to a center or completed actual field research.

It's doomed from the start. We are simply sacrificing the safety and well-being of tens of thousands of disabled Californians with a half baked plan. This is all smoke and mirrors theater to try and win the court case in November. From then on it's every frail disable old sick Californian for themselves.

We all know that adult day health care is unique from all other models of care and is specifically designed for a specific population. I know from my conversation with our managed care plan that they recognize our cost effectiveness and realize it is beyond anything they are experienced at providing. They would like partner with us and are clearly a key to the future reimbursement structure of adhc but the transition cannot occur overnight as proposed here.

AND

Please know that when the telephonic nurse calls to see how a patient is doing she will likely never be aware of the fact that the patient has been sitting in their own urine without taking their meds because their IHSS worker doesn't come until 3 pm.