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HOUSE DEMOCRATIC POLICY COMMITTEE
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House of Representatives
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

HOUSE DEMOCRATIC POLICY COMMITTEE HEARING

Topic: Health Care Access

Good Shepherd Rehabilitation Network – Allentown, PA

January 10, 2018

AGENDA

2:00 p.m. Welcome and Opening Remarks
- John Kristel, President & CEO, Good Shepherd Rehabilitation Network

2:10 p.m. Panel One:
- Dr. David Burmeister, Chair of Department of Emergency & Hospital Medicine, Lehigh Valley Health Network
- Alan Jennings, Executive Director, Community Action Committee of the Lehigh Valley, Inc. (CACLV)

2:25 p.m. *Questions from Committee Members*

2:40 p.m. Panel Two:
- Melissa Miranda, Executive Director, Neighborhood Health Centers of the Lehigh Valley
- Deb Gilbert, Director of the Parish Nursing/Community Outreach Department, Sacred Heart Healthcare System
- Kelly Berk, Network Director of Maternal Child Health Initiatives for Nurse-Family Partnership, St. Luke's University Health Network

3:00 p.m. *Questions from Committee Members*

3:20 p.m. Panel Three:
- Maggie Murphy, Director, NAMI Lehigh Valley
- Dr. Michelle Wasno, Dentist, Wasno Dental
- Dr. Mark Dalton, Optometrist, Allentown Vision Care

3:40 p.m. *Questions from Committee Members*

4:00 p.m. Closing Remarks

Lehigh Valley Health Network

Statement by Lehigh Valley Health Network

Presented by David B. Burmeister, DO
Chair, Department of Emergency & Hospital Medicine
Emergency Medical Services/Emergency Medicine/Hospital Medicine

Pennsylvania House of Representatives
Democratic Policy Committee
January 10, 2018

Contact: Mary L. Tirrell
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Government & Legislative Affairs
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Good afternoon, Chairman Sturla, and members of the Democratic Policy Committee. I appreciate the opportunity to speak with you today and want to thank Representative Schweyer for inviting me to speak on this important topic of improving access to healthcare.

I am David Burmeister, Chair, Department of Emergency and Hospital Medicine at Lehigh Valley Health Network, where I have worked for the past 15 years. I grew up in a small town in central Pennsylvania, attended undergraduate at Clarion University of Pennsylvania, medical school at the Philadelphia College of Osteopathic Medicine and did my residency training at Einstein Medical Center in North Philadelphia. I have either lived in, spent time in or traveled in virtually every corner of this great state. In Emergency and Hospital Medicine we feel we are a vital part of our community's safety net. We all have the same challenges regardless of what corner or what county we live in.

Lehigh Valley Health Network (LVHN) includes eight hospital campuses - three in Allentown, one in Bethlehem, one in Hazleton, two in Pottsville, and one in East Stroudsburg. We have 7 Emergency Departments where we treat approximately 314,000 patients per year. As a not for profit organization and as emergency departments- we take all comers regardless of their ability to pay. Additionally, since the passage of the The Emergency Medical Treatment and Active Labor Act, (EMTALA) in 1986, hospital- based emergency care is the only medical treatment to which Americans have a legal right to obtain. (1) This, of course, is "the right thing to do" but continues to be an unfunded mandate. It's a topic in emergency medicine we are very proud of, yet challenged with every day.

It's been said that the quickest way to understand a community's access to appropriate care is to understand what brings patients to the emergency departments across the country. Studies have shown that direct clinical care provided by hospitals and physicians only accounts for about 20% of the influence on a person's health. 40% can be attributed to social and environmental factors, 30% to one's own personal behaviors and the last 10% by your physical environment. The point to this is that there are many factors outside the hospital system that determine a patient's health and access to healthcare.

The mission of emergency medicine is exactly what it sounds like. We take care of the emergencies, we stabilize and treat the patient and then refer for ongoing care if necessary. Acute care hospitals rely on our communities to also address patient's needs after our emergency and acute care is complete. If there are not support services available, we end up taking care of patients for extended periods of time due to the lack of ability to discharge to the next appropriate level of care.

Let me give you an example:

As we speak, there is a 16 year old boy who has mental illness and has been abandoned by his parents in our emergency department for 23 days due to a lack of community resources to appropriately disposition this patient. Unfortunately, this is not an isolated event, there are multiple occasions every week where we have patients that wait for extended periods of time (20, 30, 40 and even 50 hour lengths of stays) in our emergency department before they can access appropriate care in facilities outside LVHN. Although we work closely with county departments of human services, who are often responsible for finding appropriate placements, they too are frustrated by the lack of options.

I can tell you that when we can't discharge a patient who needs ongoing, long term care or follow up services, not only does the patient suffer, but the cost of healthcare increases for everyone. Without an appropriate disposition out of the hospital, hospitals become an extremely expensive "hotel room" for the very vulnerable populations of patients that can't find access to continuing care. This often includes aggressive and difficult to handle behavioral health or intellectually disabled patients, homeless patients, the patient in need of long term addiction services and the chronic, medically ill aging population. All of these patients are at risk. This will continue to be a problem as the nation struggles with the opioid crisis and as state governments get out of providing long term placements for a unique subset of patients who may never be able to live independently.

To compound everything, the cost of basic housing continues to be out of reach for many people in our state. As a not for profit organization, LVHN has been a very strong supporter of our community with an internationally recognized street medicine program to help care for the homeless, mental health treatment programs treating over 20,000 patients in about 120,000 visits per year often starting with psychiatric evaluation and treatment in our Emergency Departments. We have 140 inpatient behavior health beds across our Network. We've worked closely with our County Drug and Alcohol Departments and we have developed a comprehensive toxicology program with 4 toxicologists and hired an addiction recovery liaison to create a warm hand off process to help assist our addicted patients into timely treatment after discharge. We have developed a comprehensive psychiatric emergency services team covering all of our campuses. We have developed Continuum of Care teams consisting of physicians, nurses and support staff to manage "at risk" patient populations in our community. Many other healthcare providers across our state are attempting to build the same infrastructure.

However, I'm sorry to say the access to care outside of the hospital walls is otherwise often lacking. I'm reminded of a quote in a local newspaper from the PA Acting Secretary of Welfare regarding the closing of Allentown State Hospital, saying "As facilities close, we open doors to

opportunities for residents to live their lives to the fullest by returning to their homes and communities. The Department plans to reinvest the millions of dollars saved by closing the hospital to develop and sustain clinically based, recovery oriented services."

Certainly, we all share that vision but we need to ask; have millions of dollars truly been reinvested in the community to create the services promised? From our perspective in our Emergency Departments and Inpatient units, we believe there's much more investment needed as we are experiencing dwindling options for placement outside the walls of our health systems. We think state government needs to take a look at what capacity was generated for community based care after the closing of state hospitals, reevaluate the needs of our community and determine what funding and support is needed to begin to close these gaps in care.

It is not just the vulnerable patient population that suffers when these resources aren't available: Any patient who attempts to access care in Emergency Departments across this state is affected. The patient flow in to, and out of, an emergency department is what keeps access to care available to all who need it. The patient who presents with a stroke, a patient who presents with a heart attack, the patient who presents after a motor vehicle collision; the capacity to take care of all these patients can be compromised by the inability to discharge patients who no longer need our care.

In Emergency and Hospital Medicine, we will continue to provide great care to anyone who comes through our doors. Providers ask lawmakers to strongly consider the following:

1. Study and consider the impact recent and future government decisions have on these significant challenges;
2. Re-evaluate the low Medicaid reimbursement rate for behavioral health services. It will become increasingly difficult for health systems to continue to reinvest money into behavioral health if this doesn't take place;
3. Evaluate the outcomes from closing the state hospitals and how the behavioral health dollars were reinvested into the community;
4. Evaluate the restrictions for reimbursing the use of advanced practice clinicians to provide psychiatric services for which they are licensed.

Thank you for your time and attention. It's been my privilege to share these ideas with you today.

1. Kellermann AL, Martinez R. The ER, 50 years on. *N Engl J Med 2011;364:2278-9*

David B. Burmeister, DO, CPE, FACEP is the Chair of the Department of Emergency and Hospital Medicine at Lehigh Valley Health Network. He has direct oversight and responsibility for approximately 200 physicians and residents, 130 advanced practice clinicians, and indirect oversight for 160+ other staff. In addition, Dr. Burmeister is Clinical Associate Professor of Medicine at the University of South Florida Morsani College of Medicine.

Prior to joining LVHN in 2003, Dr. Burmeister was an emergency medicine attending physician at The Western Pennsylvania Hospital in Pittsburgh, Pennsylvania. In this capacity, he was a clinical instructor for the University of Pittsburgh Affiliated Residency in Emergency Medicine.

His passion revolves around improving the efficiency of emergency and hospital medicine and its connection to the overall hospital system with the goal of maximizing the patient care experience. Throughout his career, Dr. Burmeister has been actively involved with clinical quality improvement, education and clinical research initiatives.

DAVID BRIAN BURMEISTER, DO, CPE, FACEP

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EDUCATION

Aug 1988 - May 1992	**CLARION UNIVERSITY OF PENNSYLVANIA** Bachelor of Science, Biology Clarion, PA
Aug 1992 - Jun 1996	**PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE** Doctor of Osteopathic Medicine Philadelphia, PA
Jul 1996 - Jun 2000	**ALBERT EINSTEIN MEDICAL CENTER** Osteopathic Internship Emergency Medicine Residency Philadelphia, PA

ACADEMIC APPOINTMENTS

April 2011 - present	Clinical Associate Professor of Internal Medicine/Emergency Medicine, University of South Florida Tampa, FL
Aug. 2003 – present	Clinical Associate Professor in the Department of Emergency Medicine, Philadelphia College of Osteopathic Medicine Philadelphia, PA
Aug. 2003 – present	Clinical Professor, DeSales University Allentown, PA
Aug. 2000 – July 2013	Clinical Instructor, Temple University School of Medicine Philadelphia, PA
Aug. 2003 – July 2013	Clinical Assistant Professor of Emergency Medicine The Pennsylvania State University College of Medicine Allentown, PA

PROFESSIONAL EXPERIENCE

	LEHIGH VALLEY HEALTH NETWORK **Department of Emergency and Hospital Medicine**
Jan 2012 - present	Chairman
April 2011 – Jan 2012	Interim Chairman
Aug 2003 - present	Attending Physician Allentown, PA
Jul 2006 – present	**LEHIGH VALLEY HOSPITAL - HAZLETON** Department of Emergency Medicine, Attending Physician Hazleton, PA

Jul 2000 - Jul 2003	**THE WESTERN PENNSYLVANIA HOSPITAL** Department of Emergency Medicine, Attending Physician Assistant Clinical Instructor Univ. of Pitt., Affiliated Residency in Emergency Medicine University of Pittsburgh School of Medicine Temple University School of Medicine Pittsburgh, PA
Aug 1998 - Jun 2000	**DELAWARE COUNTY MEMORIAL HOSPITAL** Department of Emergency Medicine, Fast Track Drexel Hill, PA
Sept 1999 - Jun 2000	**ROXBOROUGH MEMORIAL HOSPITAL** Department of Emergency Medicine, Attending Physician Philadelphia, PA

ADMINISTRATIVE APPOINTMENTS

	LEHIGH VALLEY HEALTH NETWORK **Department of Emergency and Hospital Medicine**
Jan 2012 - present	Chairman
April 2011 – Jan 2012	Interim Chairman
July 2010 – April 2011	Vice Chair, Operations /Efficiency
Jul 2007 – April 2011	Director, Emergency Department – LVHN – Muhlenberg
Jul 2006 – June 2010	Director of Express Care Units and Advanced Practice Clinicians
Jul 2008 – June 2011	LVHN Network Case Management Physician Advisor
Jul 2006 – Jun 2007	Emergency Medicine Residency Associate Director of Osteopathic Internship
Jul 2006 - present	Emergency Medicine Residency Core Faculty
	GREATER LEHIGH VALLEY INDEPENDENT PHYSICIANS ASSOCIATION, INC.
Dec 2006 - present	Member, Board of Trustees
	POCONO RACEWAY /NASCAR EVENTS
June 2004 – present	Co-Medical Director

PENNSYLVANIA HOUSE OF REPRESENTATIVES
DEMOCRATIC POLICY COMMITTEE

HEARING ON HEALTH CARE
10 January 2018

Testimony of
Alan L. Jennings
Executive Director
Community Action Committee of the Lehigh Valley

First, I think it is important for me to say that we need to proudly and unequivocally demonstrate political courage on healthcare by stating support for a single-payer, universal healthcare system like every other civilized country in the world has. Access to basic healthcare services should be declared a fundamental human right and we should abandon policy that places responsibility for the provision of the cost of such care on our employers. It is nonsensical that companies compete with each other by offering the cheapest (read: inadequate) health insurance to their employees.

There is plenty of good news in healthcare these days: advances in technology are overcoming a wide range of medical problems; the healthcare industry leads the way in job creation and the creation of wealth that often comes with those jobs; the quality of care is improving.

Perhaps most welcome is that insurers, driven by the Affordable Care Act, are moving rapidly to a new regime that rewards providers for outcomes rather than procedures. In the process, providers have learned that the most vulnerable among us - the poor, the uninsured and low income seniors - are driving costs: 80% of healthcare costs are attributable to 20% of the population; almost half are attributable to a 5% sliver of the population.

Providers have been whacked upside the head by the realization that they can provide the best care on the planet but, if their patient goes home to another dose of opioids, that care is unlikely to succeed with no fault attributable to the provider. So, it pays for providers to complement their quality care with basic human services designed to educate and incentivize at-risk populations on prevention and healthy lifestyles. The concept, called "population health," is one big, whopping "I could have had a V-8!"

Reaching out, identifying the most vulnerable and providing special attention on lifestyle choices will dramatically reduce the cost of care. Given that Americans spend $3.4 trillion a year on healthcare, the potential for a transformative impact on every Pennsylvanian, sick or well, rich or poor, white or black, young or old, is significant.

Amazingly, though, hospitals can't get access to Medicare and Medicaid data that will help them proactively identify, seek and serve those who are left out. Lehigh Valley Health Network, for example, has been chasing the reimbursement system in order to start the revolution to no avail. If policymakers did nothing else but require those in state government who administer Medicare and Medicaid to make critical data that can be treated confidentially available to providers in our communities, substantial amounts of funding could be saved or reinvested in our endless socio-economic problems. For example, a hospital-employed community health worker who knows of the young mother who is struggling to manage parenthood and poverty, might be able to make sure the kids are getting to school. Or that community health worker might point out that the chipped paint is likely to be lead paint, and report that to the city's code enforcement office. Or, that worker might recognize the paraphernalia on the kitchen table as the tools of a heroin addiction. As obscure a recommendation as this might be, I am convinced it could have a major impact. And it would not cost the Commonwealth one dime.

This committee should also know that there is an entrepreneur in the Lehigh Valley, the former chair of surgery at St. Luke's University Health Network, who has developed software that can analyze the quality of surgeons. Imagine the impact such data could have on both the quality and cost of health care. The committee should talk to Dr. Marc Granson, whose heroic work has the potential to dramatically improve outcomes while reducing costs at the same time.

Finally, perhaps the most pressing problem today is the inadequacy of behavioral health care. Alcoholism, drug abuse and mental illness are pervasive; the inadequacy of care is immoral and our failure to aggressively right the wrong is negligent at best, criminal at worst. It affects workplace productivity, life expectancy, the cost of care, public health, family cohesion – really, just about every aspect of our lives. And, while it affects us all, regardless of class, color, gender or place, it remains stigmatized and without champions in our culture. I believe behavioral health is the unaddressed human rights issue of our time.

I appreciate your invitation to be here and hope you can bust through the usual obstructions to addressing the challenges of our times.

Plan4PA Healthcare Access

Panel 1-10-18

Deborah R. Gilbert, RN, FCN

1. **Introduction and role in community**: Director of the Parish Nursing/Community Outreach Department of Sacred Heart Hospital. Primary role is to support and educate the urban core parish nurses that we have in Allentown in 4 churches and 5 outreach sites. Our clients consist of mostly impoverished and uninsured residents of PA; some are homeless. One of our foundational attitudes is that each person has value, undeniable dignity and intrinsic beauty. When you start with that fundamental premise, the why is apparent.
2. **Social Issues= Health Issues:** In my experience the researchers are correct in that social issues manifest in health issues. Social issue encompass food insecurity, lack of education, transportation, jobs, housing, and health insurance all possibly leading to the formation of mental and/or physical health issues or an exacerbation of those health issues.
3. **Everyone has a story:** our job as nurses and advocates is to uncover that story and offer options to meet their healthcare and wellness goals; not to judge how they got to where they are now. We work with each person as an individual to help them create their goals, then walk beside them as they allow, to meet those goals by offering community resources that help them overcome barriers to their care.
4. **And there are barriers:**
   - **a)** Biases of any system or the employees of that system;
   - **b)** Boundaries and criteria of every system;
   - **c)** Lack of education;
   - **d)** Identification: expired; out of state ID; lost or stolen documents; undocumented status;
   - **e)** Learned helplessness and hopelessness;
   - **f)** Financial challenges to see a specialist.
5. **Our Department Goals:**
   - a) Build relationship with each client to gain understanding of them and their need(s);
   - b) Offer opportunities that allow for the creation and meeting their self-determined health and wellness goals through community resources;
   - c) Walk beside them to support and guide them not fix them; " teach them to fish";
   - d) Assist in overcoming barriers and advocate for the clients.
6. **Biggest challenges and what is next:**
   - a) Overcoming **some** clients' ingrained attitude of helplessness: "take care of me" attitude;
   - **b)** Need for job training and expectation while on federal funding, i.e.MA and MC disability;
   - **c)** Overcoming the social issues and the barriers;
   - d) Storage of personal property; and ID acquisition especially for those without a "real address;"
   - e) See each person as the valuable human being that they are.

f) Mental Health concerns- connection for all individuals, of every socio-economic level, the incarcerated, the homeless to have immediate on-going treatment as they exit acute care. Legislation is needed to be able to utilize improved civil commitments to require treatment to the many chemistry imbalanced persons that are homeless/in jail or refuse treatment for their out of control behavior. The quality of life for them -their families and the safety for the community has been out of control for over 40 years. 50% of the mentally ill are homeless or in jail. (Doris Farrar) We work extensively with those who come out of jail, or from other areas of the country/ another county who have no way to get their meds even if they are willing to get them because of the length of time in which it takes to get to see a prescribing provider.

NAMI Lehigh Valley
National Alliance on Mental Illness

PA House Democratic Policy Committee Hearing
Plan4PA
January 10, 2018
Good Shepherd Rehabilitation Hospital, Allentown, PA
Remarks by Margaret Murphy, Executive Director, NAMI Lehigh Valley

Thank you Chairman Sturla for bringing the Democratic Policy Committee to Allentown, thank you Rep. Schweyer for hosting this hearing and to all the members of the House Democratic Policy Committee here today for taking time to discuss how to improve access to healthcare.

My name is Maggie Murphy, I am the Executive Director of NAMI Lehigh Valley, a local affiliate of the National Alliance on Mental Illness, the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

Mental illness cuts across race, ethnicity, gender, sexual orientation, age, and socio-economic status. One in five American adults experience an episode of mental illness in a given year. Yet more than one-quarter of those with serious mental illness, including schizophrenia, major depressive disorder, and bipolar disorder reported an unmet need for mental health care in the prior year. Untreated mental illness has a tremendous impact on quality of life for individuals living with mental illness and their family members. For example:

- 40% of those with a substance use disorder have a co-occurring mental health disorder, and the number is thought to be higher as many individuals haven't received treatment, and therefore do not have a diagnosis.
- 26% of homeless adults living in shelters have a serious mental health disorder.
- 24% of state prisoners have a recent history of mental illness. Those with un-or under-treated mental illness are three times more likely to be incarcerated than those without.
- 90% of those who die by suicide have an underlying mental illness.

And, of course, the financial costs of addressing these results of untreated mental illness are almost incalculable.

At NAMI, we see three significant barriers to access to mental health care: 1. affordability of mental health care; 2. a shortage of mental health providers, particularly psychiatrists, and, 3. the stigma surrounding mental illness.

First, affordability. According to one study inability to afford treatment was cited as the primary reason for not receiving mental health care. This is not limited to individuals without health insurance coverage, 40% of those with private insurance couldn't afford mental health care. It is difficult for Medicaid recipients to access psychiatric care due to low reimbursement rates. We must achieve true parity between mental health insurance and other coverage. Several measures, like the Mental Health Parity and Addiction Equity Act, are in place to assure parity, however, these need to be enforced, protected, and if possible, expanded to make sure much needed insurance coverage is available.

Second, the shortage of mental health providers. My office receives calls almost daily from individuals and families seeking help in finding a psychiatrist. They are being told by the psychiatrists' offices that the wait for an appointment for a new patient is approximately six months. A recent search of psychiatrists within one of the region's major health system indicated only three providers within 25 miles of Allentown are currently accepting new patients at all. Tragically, many receive treatment for the first time when a life-threatening event triggers an emergency room visit and subsequent hospital admission. Low reimbursement rates, aging of practicing psychiatrists with fewer new physicians entering psychiatry, burdensome documentation requirements and regulatory restrictions around coordinating care have been cited by a US Department of Health and Human Services study as reasons for the shortage. A variety of solutions have been offered, among them telepsychiatry and the increased use of physician extenders—nurse practitioners and physician assistants who are trained in psychiatry. While not a replacement for psychiatrists, well-educated and supervised NPs and PAs can assess and treat patients, including prescribing needed

medications. We hope will consider supporting proposals to expand the use of physician extenders.

In 2016 Human Services rolled out a new PA HealthChoices program: Telephonic Psychiatric Consultation Service Program, also known as TIPS. This allows pediatricians and other primary care providers who treat youth up to age 21 to have phone consultations with psychiatrists. This will at least provide a stop-gap until the patients can be seen and makes pediatricians more knowledgeable about prescribing, or offering other therapeutic modalities when appropriate. Evidence supports the benefits of these telephone consultations. We encourage you to support expanding this service to include adults.

And finally, the continuing stigma around mental illness keeps many people from seeking treatment for fear of being labeled, as "different" or "crazy." Because of the lack of discussion or awareness, many do not realize that mental illness, like other illnesses, is treatable. I would ask you, as you talk with your colleagues and constituents, to do everything possible to help remove the stigma. NAMI Lehigh Valley, along with other NAMI affiliates, has a wealth of resources to help with this. We have print, audio visual materials, and expert speakers available to present to any audience to decrease the perception of mental illness as a personal weakness, soften the ground for interventions, increase compassion for those with mental illness diagnosis, increase mental health referrals and increase the number of people who report mental illness as a treatable condition for which there is hope.

Access to mental health care matters because treatment works. Thank you again for your interest in assuring access to care for every individual living with mental health issues in Pennsylvania.

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01/10/18

Good afternoon. My name is Dr. Mark Dalton, and I am an Optometrist with 20 years of experience treating patients here in Pennsylvania. But before I begin, I would first like to thank representative Peter Schweyer for inviting me to participate in today's hearing. As a doctor, health care access is a subject of great importance to me. As a Father of a teenage daughter who is also childhood cancer survivor, access to affordable, quality healthcare in Pennsylvania literally meant life or death for her.

For the past 19 years, I have been the owner of the Allentown Vision Center in downtown Allentown, PA. I am a current member of the Pennsylvania Optometric Association (POA), the American Optometric Association (AOA), and the immediate past president of the Lehigh Valley Optometric Association (LVOS).

I was born and raised in Southern California. In 1993 I graduated with a Bachelors of Science in Biochemistry from California Polytechnic State University. From there I moved north to the University of California at Berkeley, were I studied, in addition to everything about the eye and visual system, physiology, anatomy, neuroanatomy, biochemistry, microbiology, psychophysics, optics, calculus, statistics, physics, pathology, pharmacology, pediatrics and gerontology. An of course, hours and hours of clinic time, including off site rotations at the VA hospital and an indian reservation in Pine Ridge South Dakota. At Berkeley, I received a second Bachelor's degree in Vision Science and then my Doctorate in Optometry in 1997. After 8 years of college, and within a month after graduation, my wife Kathy and I moved to sunny Eastern Pennsylvania, our home for the past 20 years.

I have been an Optometrist and a business owner in the City of Allentown since 1998. I originally started with three employees, growing steadily over the years to become a large, busy practice with as many as 3 doctors and 14 hourly employees, seeing approximately 12,000 patients per year.

Our practice has always provided primary eyecare to a wide range of patient types and we take many different types of Vision Plans and Medical Insurances. We have a mostly urban patient population and we see a lot of Medicaid and Medicare patients. In fact, I would estimate that roughly 60-70% of our patients have Medicaid as their primary insurance.

During my time as a Pennsylvania Optometrist, I have enjoyed some positive changes to my mode of practice, the numbers of patients I am able to help, the types of

conditions I am able to manage and treat, and patient access to my care. All possible from a broadening scope of practice for Pennsylvania Optometrists.

When I first moved east in 1997, optometrists in Pennsylvania had been largely left behind most of the country in scope of practice. While many of my colleagues in other states were treating common eye infections, allergies, injuries, glaucoma, and a whole host of other ocular conditions, in Pennsylvania our hands were tied due to a practice act that had not been updated to reflect our extensive training in ocular disease detection, diagnosis and treatment. During this time, I would routinely have to refer relatively simple conditions to a specialist. Even more concerning were the more serious eye diseases such as glaucoma or diabetic retinopathy which were going unmanaged and untreated due to difficulties in access to care. Problems with finding the right provider, getting insurance coverage, getting an appointment, and finding transportation to the specialist prevented many of my patients from following up as directed, leading to higher rates of morbidity, irreversible vision loss and blindness.

Thankfully, due to the very hard work of many volunteer optometrists, working with state legislators, our scope was expanded twice, once in 1998 and again in 2002, to include many of the procedures and treatment options we were all trained for but up until then unable to provide.

Since 85% of patients receive their primary eyecare through an optometrist, and optometry as a profession is more cost effective than a visit to the ophthalmologist, these changes immediately helped increase Pennsylvania citizen's access to affordable, high quality eye care in a timely manner.

Due to this new, easier access for our patients, I started monitoring and treating more and more people with various ocular diseases, including glaucoma, a blinding eye disease if untreated. For many of these patients, due to a prior lack of access, my treatment was their first.

As time went on, I was able to purchase valuable diagnostic equipment, and hire more staff, which again allowed me to provide even better care to all of my patients. In addition, diabetic retinopathy, the leading cause of new blindness cases in the United States, could now be managed from our office. The patient would only need a referral if surgical intervention was indicated, saving valuable resources and money for those that truly needed it.

Access to care is also a big problem in rural Pennsylvania. In many areas an optometrist is the only eyecare provider available within a several hour drive. Increasing our scope of practice helps to increase the availability of care to these rural patients.

Approximately 250 systemic diseases can manifest in the eye. This includes diabetes, hypertension, elevated cholesterol, anemia, and even cancer. As primary eyecare providers, we are oftentimes the only interaction a patient may have with any kind of doctor on a regular basis. I check blood pressure on every patient - many of whom have never seen a PCP. I review a patient's medications in detail, as well as diet, exercise and lifestyle habits. We also coordinate care and send reports to their primary care provider or other specialist as needed. In many cases, I will convince a patient who hasn't been to see a primary care physician for a decade or longer to make an appointment because of what I have discovered during a comprehensive eye examination. I have even sent several patients to the emergency room who simply presented for a pair of glasses, only to learn the cause of their blurry vision is a serious medical condition.

Access to affordable, quality health insurance is paramount to the long term success of the individual, and our state. As an employer, I have made it my goal to offer health insurance to my full time employees. As a consumer, I have spent hours upon hours trying to balance cost of care and quality of care. For a family of four I pay approximately $10 per hour worked for decent coverage. For a single employee, I am paying $3 to $4 dollars per hour worked for each of their coverage, depending on age. So as you easily see, someone making even TWICE the minimum wage would still be spending up to 28% of his or her GROSS PAY just for health coverage.

Most of my Medicaid patients are either small children, students, or single parents who work. Most of these families would never be able to afford healthcare on their own. This is why it is so critical to create a bridge between low wage earners and medical insurance coverage. Health insurance is so important that some employees will forgo raises or promotions in fear of making too much money to qualify for medicaid, since they cannot afford it on their own. This has the perverse effect of preventing hard working employees from moving up the economic ladder.

A few ways the legislature can improve access the healthcare in PA would be to:

1. Streamline the process allowing non-MD healthcare professionals the opportunity to expand their scope of practice when proper education and training is provided.

2. Allow low income patient's the chance to excel in the workplace without fear of completely losing his or her health coverage, instead allowing for a gradual decrease in benefits as income increases. For example, an increasing level of copays as income levels increase.

3. For medicaid patients, increase the access to primary care providers by increasing reimbursements for services, and decreasing unreasonable requirements for providers. . For example, in the past 20 years the reimbursement for a routine eye exam via medicaid vision providers has not increased at all, and other reimbursements have steadily *decreased* with time, despite the steady rise in medical costs. Also, some medicaid plans require the optometrist to accept their vision plan in order to be a provider for medical services. I currently spend about half my day dealing with medical issues, primarily glaucoma and diabetic eye disease, as well as many other types of infections, illnesses and injuries. In order to do that, I was forced to be credentialed by a third party Vision Plan. I cannot opt out of the vision plan if I want to continue treating my medical patients, regardless of how poor the vision plan may be for my practice or my patients. For these reasons, many of my colleagues refuse to credential with PA medicaid plans.

In summary, I would again like to thank Representative Schweyer for inviting me to joing my esteemed colleagues for today's hearing. Our commonwealth cannot reach its true potential without a healthy, educated population to lead the way. I hope today's hearing is a small step in that direction. Thank you.

Respectfully Submitted,

Mark Dalton, OD
President, Allentown Vision Center