Community Healthcare Suffers From Budget Cuts

David Lavine

Writer's Comment: Mr. Stephen Magagnini's UWP 111B advanced journalism course was a fast-paced, hands-on workshop in investigative research methods and narrative techniques. From examining court reports, medical records, and the federal Freedom of Information Act, to learning the effective use of characters, dialogue, and story structure, we were taught to think and write like reporters. And our final assignments—one investigative and one narrative—were to exemplify that tutelage. "Community Healthcare Suffers From Budget Cuts," the combination of those two assignments, is a story told through the eyes of two patients and a physician in order to illuminate some of the many obstacles in the way of effective community health care. I'd like to thank Mr. Magagnini for the fantastic class, as well as Professor Debora Paterniti for her thought-provoking and inspiring sociology of health care course and the initial lead for the story.

—David Lavine

Instructor's Comment: When David Lavine told our advanced journalism class he wanted to investigate a broken Sacramento County health system that had idealistic young doctors questioning their Hypocratic oaths, the story sounded overwhelming, requiring clearances from patients, doctors, and administrators, and interviews with elected officials. David hit a lot of closed doors and left a lot of messages that weren't returned. But he never gave up, because he understood that this story was of critical importance to all Californians. All great stories begin with people. David found and talked to patients caught in "health care limbo," as he put it, and he made us care. He combined the best elements of narrative writing and investigative reporting—the two skills our class was all about—to deliver a powerful, well-balanced, clear, graceful story. The future of journalism is all about investigative stories in the public interest, and nothing matters more to people than their health. I expect David Lavine to lead the next generation of investigative health reporters battling to keep us alive and well—especially the poorest Americans who can't negotiate the health maze or fight for themselves.

—Stephen Magagnini, University Writing Program and The Sacramento Bee

She took a deep breath.

Immediately overcome by pain, she clenched her jaw and stiffened her shoulders. Gasping, she struggled to exhale. It felt like a sharp kick to the middle of her back. The piercing sting penetrated into her stomach.

Alison, 28, sat atop an exam table in a patient room at Sacramento County's Primary Care Clinic on February 23. Standing in front of her was Dr Milin Ratanasen, a third-year UC Davis resident.

"Try once more," he said, lightly placing his right hand to her tense shoulder.

Again, she took a deep breath.

Arching, she quickly pulled away from his touch. Her blonde ponytail swung with her body. The white paper lining the green table crinkled with the sudden movement.

Alison froze. Ratanasen paused. Only time competed with their brief silence.

Tick. Tick. Tick.

The look in her drained eyes told a story—one not of surprise or shock, but of frustration and disappointment. The pain was familiar.

After several seconds passed, she continued to describe her extreme discomfort.

"It feels like electric needles and little bugs going up and down," she said, tenderly lifting her arms to further explain her symptoms. "It goes from nothing to where I want to rip my arms out to make it stop." Quickly, she collapsed them back to her side.

He nodded and readjusted the blue stethoscope draped about the collar of his white physician's coat. "That's new?" he asked.

"It's not new, it's just more severe." Anxiously, she toyed with the rhinestones lining her blue jean pockets. "I'm not getting nerve blocks anymore. I'm not getting anything anymore."

Puzzled, Ratanasen placed his hand to his cheek, scratching the point at which several days' worth of scruff met several months' worth of goatee.

"I'm confused," he said.

"I'm confused too!"

Suffering from rare, chronic, and painful neurological conditions, Alison's health is anything but common. But her story—one devoid of

primary health care due to a broken and inefficient health system—very much is.

And ongoing, nearsighted county budget cuts are making these stories increasingly more common, according to a group of concerned UC Davis resident physicians, the members of a unique primary care training program.

Called Transforming Education and Community Health, or TEACH, the program is a partnership between the County of Sacramento Department of Health and Human Services and the UC Davis Health System. Its primary aim is to reduce health disparities and increase the quality and access of primary care in disadvantaged communities. To that end, TEACH residents split their work hours between the county clinic and the UC Davis Medical Center.

Ratanasen is one of those dedicated few. "We try to take care of the underserved," he said. "But the system definitely isn't set up in a way to optimally do that."

The TEACH residents are now worried more than ever about the well-being and safety of an already underprivileged population. It's an apprehension that stems not from numbers they see on paper, but from real situations they encounter first-hand throughout their shifts in the Sacramento community clinics and the UC Davis Medical Center.

Alison, a member of that population, is in health care limbo.

Two months after her twenty-first birthday, she was diagnosed with complex regional pain syndrome, or RSD—a chronic and excruciating neurological condition with an incidence of one in every 18,000 patients per year, according to data from the Mayo Clinic. She was also previously diagnosed with fibromyalgia, another chronic and painful condition, which is present in about 2 percent of the population in the United States, also according to the Mayo Clinic.

"I hit the lottery," she said.

For five years she sought treatment at UC Davis Medical Center's Division of Pain Medicine. There she received nerve blocks and treatment for her conditions. Not covered by state disability, but still unable to work due to her pain, Alison qualified for the County Medically Indigent Services Program, or CMISP.

By law, according to California's Welfare and Institutions Code, counties must provide and pay for medical care for their indigent population. CMISP is that last resort "safety net" care.

But in a letter sent on September 2, 2009, the county notified its indigent patients, effective September 1, 2009, "the CMIS program is not responsible for payment of any type of medical services to CMIS participants at UC Davis Medical Center."

For monetary reasons, and contract disputes, the county dropped its coverage with UC Davis. In November, the UC Davis Health System, which alleges the county owes $125 million for unpaid medical claims for its indigent patients, filed a lawsuit against the county. A hearing is scheduled for April.

"The patients are getting lost in all of this," said Dr. Tonya Fancher, a co-director of TEACH with the UC Davis Department of Internal Medicine, in an interview.

Alison did not receive any type of primary care for six months due to various bureaucratic hurdles. As a result, she resorted to the emergency room for treatment and medication in response to her acute bouts of severe pain.

"I feel guilty every time I go to the emergency room because they're like, 'Oh, you're here again,'" she said. "I can't keep doing it. They just inject me and send me out. And in a few days I'm back in. It's bad when everyone knows you in an emergency room."

Bad, not only in terms of human suffering, but bad because it's expensive—the very thing the county has tried to prevent with their cuts.

"That's thousands and thousands of dollars worth of ER workup," said Ratanasen.

Such visits could be prevented if patients had better access to primary care.

"It's ass backwards," said Dr. Zach Holt, UC Davis chief medical resident of internal medicine, in an interview. "There's so much throughput in this county machine. It's overloaded, like a plastic bag ready to pop."

At the same time as Alison and Ratanasen's clinic visit, in a boardroom just northeast from them—ten minutes by car, or thirty minutes by bus—the first day of Sacramento County's two-day midyear financial hearing convened to discuss the $10 million shortfall for the 2009–2010 fiscal year budget.

Many members of the public attended the two-day hearing to speak on behalf of the programs they desperately needed.

The supervisors may have been sympathetic, but, due to the recession, drops in property tax, sales tax, and state revenue, the situation left them no choice but to reduce county services even further. The board approved, among other things, 100 more layoffs, cuts to welfare payments, and the elimination of the Behavioral Health Services Department. These cuts total about $14 million in reductions, according to county budget documents.

Before the mid-year hearing, the county had already made about $180 million in reductions, a significant proportion of those cuts coming from Child Protective Services, The Public Health Department, and primary and mental health care.

"Dollars have come into direct conflict with the well-being of the patients," Holt said.

But the board's hands are tied.

"The revenue to the county has dropped enormously," said Dr. Joy Melnikow, director of the UC Davis Center for Healthcare Policy and Research, in an interview. "There are really no good guys or bad guys here. They don't have the money they had before. They have to take it from something."

The supervisors also addressed the projected $150 million shortfall for next fiscal year at the hearings. But to fill that massive deficit, the county may have no choice but to take from programs that don't have any more to give.

"This is something that hits you in the mind, the heart, and the gut, all three at the same time," said Don Nottoli, District 5 supervisor, during the second day of the hearings.

Still, the supervisors say they are dedicated to finding a way to prevent further cuts to an already slashed community.

"This is a time that obviously calls for all of us to be as creative and original in thought as possible," said Roger Dickinson, District 1 supervisor. "This staff is committed to doing whatever we possibly can . . . making sure we help the most vulnerable in the community."

Regardless, members of the TEACH program—Milin Ratanasen, Christopher Giedt, Gemma O'Keefe, and Zach Holt—have expressed their frustration with the cuts in a letter jointly addressed to the people of Sacramento County and the Board of Supervisors.

In Sacramento, county clinics are the largest local providers of medical care and services for the poor. But due to ongoing reductions, there are now what they call "major holes" in the "safety net."

Several county clinics have been closed or significantly limited, forcing indigent patients to go to the main clinic on Stockton and Broadway. These patients may have to take several hours worth of public transit to get there, causing them to potentially miss meals and spots at shelters.

Accordingly, further limited access means further limited care for the city's poor.

Only about one-third of breast and cervical cancer screenings are being performed as compared to prior years, they say. STD screenings, psychiatric services, and public health positions have been drastically cut. Many nurse practitioners have been laid off. These reductions in preventative care will no doubt result in not only a significant increase in human suffering, but also in much more expensive emergency care down the road.

The "current clinic closures and layoffs are only rearranging the burden, which in the short term may appear to save money," they wrote, but will later result in a much more expensive public health predicament.

The TEACH physicians took an oath, an oath to live and practice medicine to the best of their ability, to use their knowledge and skills in the prevention and diagnosis of medical diseases—for people, rather than for things.

The ongoing budget cuts, however, are "devastating" to their ability to provide that standard of care.

For instance, if an uninsured patient reports to the UC Davis Medical Center with an inflamed gallbladder, doctors aren't able to operate unless the condition is deemed "life threatening." A gallstone could have been stuck in the patient's gallbladder just hours before the visit, but if one isn't jammed at that moment of the visit, the patient's condition isn't "life threatening." He will be sent away until it is—even if the hospital has the equipment and physicians available to perform the operation, explained Ratanasen.

Similarly, as mentioned before, if a patient is covered under the county CMISP, a visit to UC Davis won't be covered by the safety net; the patient will be monetarily responsible for it—even though he may not be aware of the recent dropped contract. And a visit to Sutter General

Medical Center, a hospital under county contract, just five minutes north, would be much cheaper, if not free.

"It's ridiculous," said Dr. Gemma O'Keefe, a resident member of TEACH, during one of her rounds at the UC Davis Medical Center. "We all took that oath, but we all feel that we're struggling with it now."

The county is in a very difficult situation, said Colin Cameron, UC Davis health economist and professor of health care economics. "They have to cut. The only solution is raising taxes at the state and county level, or waiting for the federal government to step in."

Melnikow agrees. "We need health care reform," she said. "That's number one. These kinds of cuts affect real people in their everyday lives."

With health care reform, patients will have much better access to preventative care, which will save money on costly emergency room visits in the future—not to mention reduce human suffering, she explained.

For example, a patient at risk for diabetes will be able to get the assistance she needs to better manage her blood sugar levels, as opposed to being unaware of the risk, then ending up in the ER with a bill totaling thousands of dollars resulting from treatment for a preventable diabetic coma.

Back in the clinic February 23, Dr. Ratanasen continued with the rest of his appointments. After Alison, he saw three more patients.

Kenneth, 43, was one of those.

Ratanasen walked into the patient room carrying at his side a folder full of multi-colored medical charts, then took a seat on the green stool at the desk just opposite the door. Kenneth was sitting in the light brown side-chair kitty-corner to the entrance next to the desk.

Ratanasen reached for the ballpoint pen in the beaker labeled "Strep Culture Cup." Paper and pen in hand, he questioned Kenneth for several minutes about his medical history.

"Ever done any street drugs, shot up drugs?" Ratanasen asked routinely, scribbling notes on a card he later shoved into his already bursting coat pocket.

"No, no, I'm a fat boy," Kenneth said. "I like to eat."

For almost a year Kenneth hadn't been able to perform general physical activity, like walking up a flight of stairs. He complained of difficulty breathing at night and cycles of severe to moderate chest pain throughout the day.

"It feels like I'm dying," he said.

At 348 pounds, it wasn't an easy task for him to climb up onto the exam table for his physical—the same green table on which Alison had sat just an hour before him. But he managed.

After his assessment, Ratanasen told Kenneth he exhibited symptoms of congestive heart failure and sleep apnea. He needed two blood pressure medications and several more tests.

Although disabled since 1999 from an ankle injury, Kenneth hadn't seen a doctor in over three years. He tried throughout that period, however.

"It's like a cat and mouse game," he said. "Go see this person; go see this person; fill this out; go see that person; and by the time you get through all the paperwork, you've got another ailment."

And the county's cuts to health care are making those games increasingly more difficult.

A health services poster tacked on the wall directly across from him, entitled "Power Clinic," read "Don't let your medical care become a complex puzzle." The "O" in the word, "Power," was a cartooned bright yellow smiley face. "Patient Empowerment" was also written there, in the shape of a puzzle piece.

Ironically, Kenneth's story was that very puzzle.

"It feels like you're a nomad roaming in the desert," he said. "It's like no one cares. You just get lost in the system."

Kenneth sees change as the only solution.

"We need reform, someone at the top who's in touch with the people, someone who knows what it's like to be in our shoes," he said, tilting his head down to look at his white New Balance sneakers.

"Because these shoes hurt."