

Profile:

Name: Frank LaVallee; Sarah “Sally” LaVallee

Age: 57 (born 1957); 56 (born 1958)

Occupation: Lobsterman; Family Day care Provider

Marital Status/Family: Married (son: Marc, 34; daughter: Elisa, 33)

Living Arrangement/City: Thomaston, Maine – The LaVallees live in their own home, which they purchased in 1986. They have two ten-year mortgages, which are paid monthly.

Patient/Client Background:

Frank LaVallee is a sternman on a lobster boat owned by his uncle. Lobster fishing is hard and rigorous work that has taken a toll on Frank’s body. He grew up and still lives in Thomaston, Maine where he met his wife, Sally, in high school. Sally runs a home-based family day care, which she started when their youngest child was 3-years-old. Frank has a high school diploma and Sally has an associate’s degree in childcare from Kennebec Valley Community College. Their first child, Marc, was born in 1980. Their second child, Elisa, was born in 1981. Both adult children are married with children of their own and live in New Hampshire and Massachusetts respectively. Mr. LaVallee’s 78-year-old mother Giselle has lived with the couple for the last 5 years following the death of her second husband. The LaVallee’s also have a 29 year-old nephew, Nick, who began living with them at age 9 after the death of his mother.

Patient and Family Concerns:

Frank LaVallee: Frank believes in the values of hard work, self-sufficiency, and family. He has always been a good provider and at the same time, appreciates Sally’s contributions to the household finances. He is self-contained – a man of few words. He loves his family but could be described as uncomfortable with displays of affection. His marriage to Sally is strong but not without its hardships especially perpetual financial worries, concerns about his mother’s health, and conflicts with his nephew Nick.

Sally LaVallee: Sally is an efficient woman who derives pleasure and satisfaction from managing her home and business. She is pleased to have raised her children well and enjoys caring for others’ youngsters. Unlike her own mother who stayed at home raising 9 children, Sally places great value on her economic contributions to the family. Like Frank, she is fiercely independent and does not always agree with her husband’s views on family matters and social issues. For the most part, she avoids marital conflict focusing instead on managing their household. Sally has become increasingly concerned about Frank’s health in the last 4 years, and has repeatedly found herself unsuccessfully trying to encourage him to seek medical help. She is also quietly worried about her own health. Since Elisa was born Sally has steadily gained weight.

She's at her highest weight now since quitting smoking 18 months ago. At her last yearly check-up, Sally learned that she has diabetes and high blood pressure.

Socioeconomic Status:

The LaVallee's have never depended on social services, but they have always struggled with finances. They own their home in Thomaston, but because both are self-employed and income is unpredictable, they've had to make difficult choices about which bills to pay. They have never carried health insurance for themselves because other expenses were prioritized. Both Frank and Sally are concerned that their physical symptoms could cause them to slow down and/or retire early. They have no savings, life insurance or retirement plan. Should they be unable to work, Social Security will be their only income.

Patients' Medical Histories**Family History**

Frank's family has a history of lung and heart disease. He has no knowledge of his paternal medical history. His maternal uncle Jack, 77, has Chronic Obstructive Pulmonary Disease (COPD) and diabetes and lives in a nursing home. His mother Giselle, 78, is relatively healthy with mild dementia.

Lifestyle

Frank has a 60-pack year tobacco addiction (1 ½ packs per day x 40 years). He describes an unremitting cough and increasingly feeling breathless. He considers himself a moderate drinker (1-3 beers a night and occasionally more when watching sports with friends) and has never used illegal drugs. Frank's work has always been very physical, he is lean (Body Mass Index, BMI = 20), and views himself as very active. He leaves work exhausted every day and has recently taken unpaid sick days as a result of fatigue and increasing body pain. He suffers with chronic neck and mid- to lower back pain, which he attributes to the repetitive motions of hoisting and hauling heavy ropes and traps. He consumes mostly meat, fish, and potatoes and stays away from soda and sweets. He drinks 5-6 cups of coffee a day and recently added high-energy drinks (e. g. Red Bull) to manage his fatigue. He takes 2 – 4 OTC (over the counter) Ibuprofen 200mg daily and sometimes a No-Doz tablet in the morning or afternoon. He does not believe in taking vitamins. His leisure activities include watching sports, darts, and ice and smelt fishing.

Sally's family history is significant for diabetes, depression, and domestic violence. Her mother and sister take insulin injections daily. Sally assumed getting diabetes was inevitable so her recent diagnosis of Type II diabetes came as no surprise. Sally does not drink alcohol and gave up smoking 18 months ago (with a 20-pack year addiction, 40 years x 1/2 pack per day). She is a self-described stress eater and drinks diet Pepsi throughout the day. She is approximately 30 pounds overweight for her height of 5'4" (BMI = 32). She considers her work running around

after the children in her daycare and cleaning the house her form of exercise. Sally takes Metformin for diabetes, occasional Xanax for stress, OTC Ibuprofen for headaches, and a daily multivitamin for women. She enjoys knitting, cross-stitching, card playing, cooking, cleaning the house, visiting with her children and grandchildren, and baking.

Current Situation

Frank has had an increasingly complex set of health problems, which started in his early 50s. He did not have a primary care doctor (PCP) or medical home where he could receive regular check-ups or health care, largely because he didn't have health insurance did not perceive it at the time as necessary. In the last year Frank has missed 15 days of work because of increasing neck and back pain. He assumes the pain is muscular-skeletal, though it may emanate from other sources. His cough has worsened and keeps him up at night. He's also experiencing tooth pain for which he takes OTC aspirin. In the last month Sally has lobbied for him to go to the community health center for a comprehensive check-up. Frank has agreed it's time especially given the lost days at work and the impact his health is having on their finances.

Like Frank, since turning 50 Sally's health has become more complicated. The migraines, night sweats, anxiety and frequent urination that she previously exclusively attributed to menopause she learned from the physician assistant in her yearly check-up were in fact symptoms of diabetes and hypertension (BP = 160/88). The PA suggested that Sally lose 30 lbs. and join nutrition and exercise programs offered at the community center for people with diabetes. Sally also confided to the PA who she's known for years that her anxiety and feelings of depression are worsening. She describes using sleep as a method to escape from stress.

The LaVallee family seems to have reached a significant turning point in thinking about healthcare. Frank's condition isn't getting any better and there are plenty of young people in line for his job. The LaVallee's know they need insurance coverage but worry if their pre-existing conditions and limited finances might make health coverage beyond their reach. Additionally, both Frank and Sally worry about how much longer they can care for Giselle. They do not believe in putting elder family members in nursing facilities – it goes against their cultural and intergenerational customs.

The family does not know what to do, and are struggling with the question: “What is it that we really want?” What do they need?

Affordable Care Act Overview

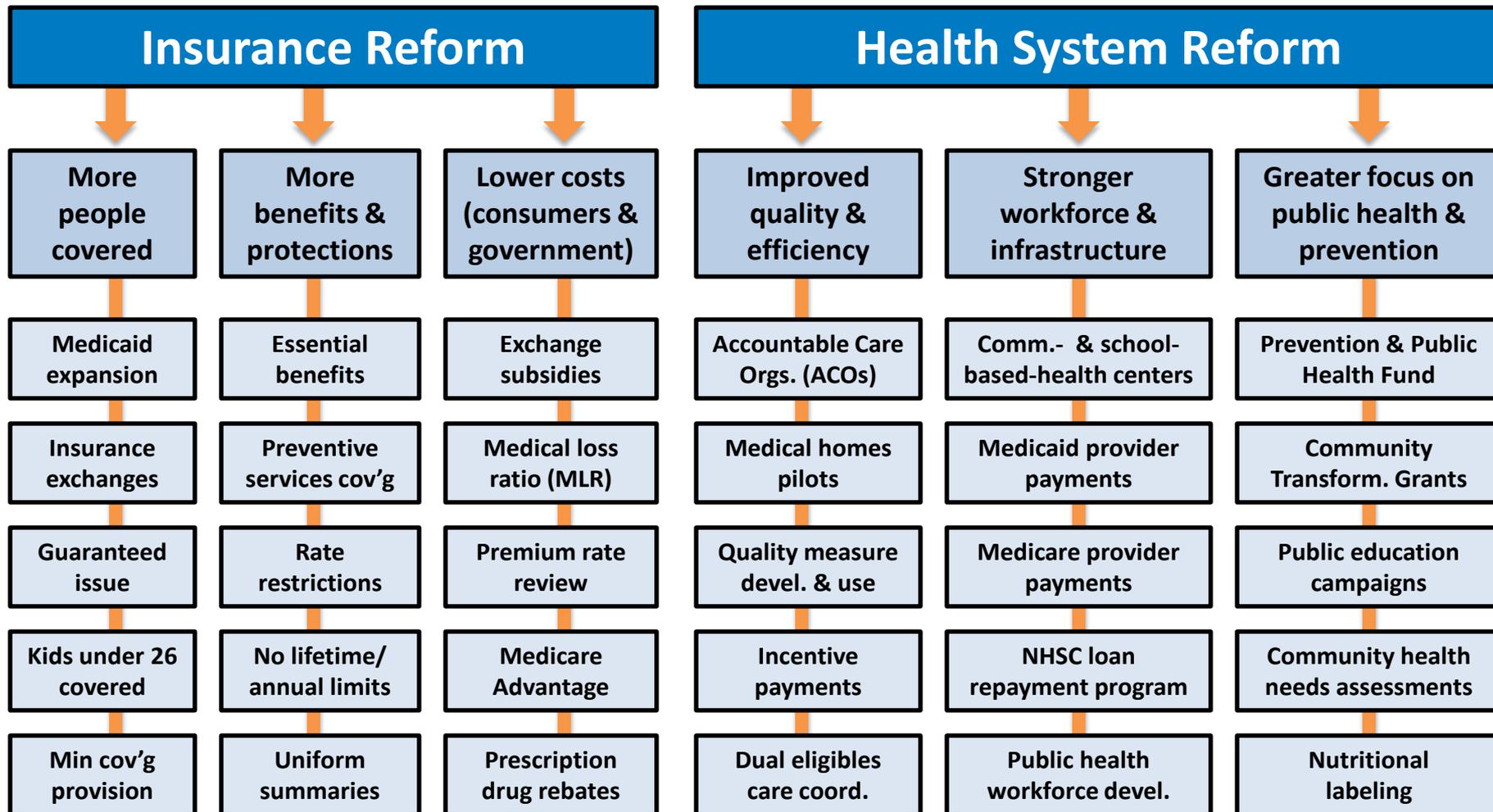
Selected Provisions

August 2012



American
Public Health
Association

This chart provides a broad overview of the structure of the Affordable Care Act (ACA), the health reform law enacted in 2010. It does not address all provisions in the law. See next page for brief explanations of these provisions. Visit www.healthcare.gov for a full list of provisions and more detailed explanations. Visit <http://www.apha.org/advocacy/Health+Reform/> for more ACA resources.



Affordable Care Act Overview

Summaries of Selected Provisions

August 2012



The chart on the previous page provides a broad overview of the structure of the Affordable Care Act (ACA), the health reform law enacted in 2010. It does not address all provisions in the law. This table provides a brief explanation of the provisions in the chart, and the year each is effective (in parentheses). Visit www.healthcare.gov for a full list of provisions and more detailed explanations. Visit <http://www.apha.org/advocacy/Health+Reform/> for more ACA resources.

Insurance: More people covered	Insurance: More benefits & protections	Insurance: Lower costs for consumers, gov't	System: Improved quality & efficiency	System: Stronger workforce, infrastructure	System: greater focus on public health, prevention
Medicaid expansion: Nearly all Americans under 65 with incomes under 133% of the federal poverty line will now be eligible, in states that choose to expand. (2014)	Essential health benefits: In order for a plan to qualify to be sold through the exchanges, it will have to offer a minimum set of benefits. (2014)	Exchange subsidies: Many individuals and small businesses buying exchange plans will receive subsidies or tax credits to help them afford coverage. (2014)	Accountable Care Orgs. (ACOs): Medicare incentives to providers to work together to coordinate care, improve quality of care, and reduce costs. (pilot 2012)	Community- & school-based health center funding: New funding for community health centers (CHCs) and school-based health centers (SBHCs). (2010)	Prevention & Public Health Fund (PPHF): New funding for state and local prevention efforts, bolstering public health capacity, & prevention research and tracking. (2010)
Insurance exchanges: New virtual marketplaces will help consumers and small businesses comparison-shop for insurance. Also see "exchange subsidies." (2014)	Preventive service coverage: Insurers must cover certain preventive services at no cost to enrollees. (2010 most services; 2012 additional women's services)	Medical loss ratio (MLR): Insurers must spend at least 80-85% of premium dollars on health care (instead of profits, marketing costs, etc), or refund enrollees. (2011)	Medical homes: New options under Medicaid to test and implement medical home models of coordinating care and integrating community-based services (2010, 2011)	Medicaid provider payments: Medicaid primary care provider payments are increased so they are equal to Medicare provider payments. (2013-2014)	Community Transformation Grants (CTG): PPHF funding (see above) focused on community-level efforts to address preventable chronic conditions. (2010)
Guaranteed issue: Insurers can no longer deny coverage due to pre-existing conditions. Until it's effective for adults in 2014, there is a temporary Pre-Existing Condition Plan for adults. (kids 2010; adults 2014)	Rate restrictions: Insurers can't charge higher premiums based on gender or health status; other limitations also apply. (2014)	Premium rate review: Insurers must justify proposed premium increases of 10% or more; states or the federal government will review and publish the info for the public. (2011)	Quality measure devel. & use: New quality measures for M'care/M'caid providers, incl. patient-centeredness, health disparities, meaningful use of electronic records, and more. (2011)	Medicare provider payments: 10% bonus payments for Medicare primary care services, and for general surgeons serving communities in need. (2011-2015)	Public education campaigns: New funding for large-scale outreach activities focused on nutrition and exercise, tobacco cessation, oral health, and more. (2010)
Kids under 26 covered: Young adults can stay on their parents' plans until age 26. (2010)	No lifetime/annual limits: Insurers are banned or restricted from imposing lifetime or annual coverage limits on essential benefits. (2010; 2014)	Medicare Advantage reform: Excessive payments to insurers via this program will be curbed, to lower government and consumer costs. (2011)	Incentive payments: M'care payments will be based on quality measures, not number of patients served. Payments reduced for hosp.-acquired infections or excessive readmissions. (2012, 2014)	Loan repayments: The National Health Service Corps program (loan repayments while serving communities in need) is permanently authorized, and funding is increased. (2010)	Community health needs assessments (CHNAs): Tax-exempt hospitals must assess and address community needs, and include public health stakeholders in the process. (2012)
Minimum coverage provision ("individual mandate"): Most Americans will have to obtain coverage or pay a small penalty, in order to keep the system balanced. (2014)	Uniform summaries: Insurers must provide standardized summaries of benefits and coverage so consumers can easily understand and compare plans. (2012)	Prescription drug rebates: Medicare enrollees who reach the drug coverage "donut hole" get rebates while the hole is slowly closed. (2011)	Dual eligibles care: New efforts to coordinate care for Medicare/Medicaid dual eligibles, often the sickest and most costly enrollees. (2010)	Public health workforce development: PPHF funding (see above) for graduate and post-graduate training in public health and preventive medicine. (2010)	Nutritional labeling: Chain restaurants & vending machines must display nutritional info. (2011, but implementation delayed)