From: Court Petros
To: DPH.HFSRB.PublicHearings
Subject: Re: FW: [External] Personal Statement: Mercy Hospital and Medical Center Closing
Date: Friday, October 30, 2020 4:04:24 PM

Received!

On Fri, Oct 30, 2020 at 3:49 PM DPH.HFSRB.PublicHearings <DPH.HFSRB.PublicHearings@illinois.gov> wrote:

> **From:** Erika Romeus
> **Sent:** Friday, October 30, 2020 12:41 PM
> **To:** DPH.HFSRB.PublicHearings <DPH.HFSRB.PublicHearings@Illinois.gov>
> **Subject:** [External] Personal Statement: Mercy Hospital and Medical Center Closing
>
> Good afternoon, my name is Erika Romeus, and I am a former employee at Mercy Hospital and Medical Center. I am a licensed pharmacist in the state of Illinois, and since I became a pharmacist nearly a decade ago, I have become a board certified ambulatory care pharmacist and have earned specialized certifications to treat patients with HIV and Diabetes. When I relocated to Chicago in 2018, I specifically chose to work at Mercy because of its commitment to improve access to quality healthcare to medically underserved populations. Many others have already referred to this topic as reason to keep Mercy's doors open, and I would like to offer additional details to describe how truly pervasive the effects will be if Mercy closes its doors.
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> Ill start by explaining a bit about my responsibilities while at Mercy. Again, I am a pharmacist by training, but I was never within the walls of a pharmacy when I worked there. Rather, via permissions and authorities granted by collaborative practice agreements, I was able to schedule one-on-one appointments with hundreds of patients who needed intensive anticoagulation or blood-thinning medication monitoring, or intensive diabetic control, or patients who wanted to quit smoking but needed assistance along the way. These protocol agreements that allow pharmacists to provide direct patient care in this capacity may still not be common knowledge among the public however are quite common among many health systems.
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> The patients at Mercy who needed intensive monitoring of their blood-thinning medication, which is known better by its brand name Coumadin, were often in that position because Illinois funded medication plans prefer coverage of this medication over other medications. Coumadin is an old and trusted medication; however it requires close and frequent monitoring, and is notorious for its dietary restrictions, which include avoidance of spinach, kale, broccoli, and a number of other foods that are known to provide essential nutrients. To be clear, this medication requires patients with known higher rates of heart disease, obesity, and diabetes to avoid spinach, kale, and broccoli. If you are wondering, there are multiple alternative medications that are free of any dietary restrictions, however these medications are not preferred options under Illinois funded pharmacy benefits plans. Coumadin does not have one standard dose, rather each individual's dose is specific to the person, so patients must be seen every few weeks to monitor drug levels, rendering these patients more and more vulnerable to COVID19 exposure and transmission. If you are wondering, the alternative medications that exist that are free of dietary restrictions, are also free of any monitoring requirements, because they have standardized doses. Many patients who are treated in this capacity at Mercy come to the facility because transportation is not a privilege

that they have access to. So they either utilize Mercy transportation, or take multiple CTA busses, or walk, because it is located within their community. Closing Mercy's doors will ensure that these hundreds of patients will be left on a needed blood-thinning medication but without realistic access to ensure safe and effective use. If you recall what I mentioned earlier, many of these patients are left with Coumadin as their only choice due to Illinois Department of Healthcare preferred drug list. I implore you to understand the depths of the multiple levels of healthcare structures that are set up to ensure medically underserved patients remain this way. Keep this in mind when making the decision to close Mercy.

It was common for the patients who needed intensive diabetic control to have an A1c upon entry into care of 14, 15, even 16. These were numbers that I was used to seeing. For reference, a normal A1c for someone without diabetes is around 5, and an A1c for a person with controlled diabetes is around 7. It is commonplace that patients of Mercy present to care for diabetes with a number more than double this amount, due to the lifelong barriers to quality healthcare with which they have lived. In a majority of cases that I saw, patients A1c values could easily drop to 9 within 1-2 months with simple non-insulin medication adjustments and disease state education that focused on proper nutrition. For example, seemingly simple nutrition recommendations such as, spaghetti is not an optimal choice for breakfast, or limit yourself to one-half of one banana per serving instead of 3 bananas per serving, were real-life examples of nutrition recommendations that needed to be made, but once made, had a tangible and quick impact on A1c values. Again, I implore you to realize that this again is a result of lifelong systematic barriers to care, and closing Mercy's doors will only enhance these systematic barriers. All who are involved in this decision have the potential to stop a deadly trend that this community has faced its entire existence.

Scientific evidence shows that tobacco company advertising targets members of racial and ethnic minority communities. So it's no wonder that many patients at Mercy have smoked cigarettes for over 40 years. Many patients don't feel the negative effects of cigarette smoking until after they have their first heart attack or stroke. By then, nicotine has done its addictive damage, and quitting is not as easy as just stopping. When I saw patients who were motivated to quit smoking, I would provide seemingly simple background education about how damaging smoking is to our heart and cardiovascular system. I was almost always met with the response of, 'wow, no one has ever told me that before'. Instead, what many patients are used to, are messages that promote smoking for stress relief or for socializing. Walking a patient through the journey of quitting smoking provides feelings of joy, but these feelings are overshadowed by shame for the systems that were set up to lead these patients to smoke in the first place. Make no mistake, Mercy continues to help decade-long smokers reach cessation, but this is yet another essential service that will no longer be accessible to vulnerable patients in need if you choose to close Mercy.

As I reach the end of my statement, I would like to remind you of the medical teaching that happens at Mercy. Mercy has trained hundreds of physicians, pharmacists, and many other members of the healthcare team every year since it was opened. Each one person trained leaves Mercy with the capacity to impact an infinite number of patients. So if you choose to close Mercy, you are truly generating a nationwide ripple effect. There will be far less healthcare providers with quality background training that focuses on the medically underserved population. There will be far less healthcare providers that look the same as these patients in need. If you choose to close Mercy the effect will be insidious. Let Chicago be a role model to other cities in or nation to lead the change to preserve and value our Black and Brown communities.

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Erika Romeus