

News from Maternal and Child Health Access



The “Year of the Woman” in the 2018 Elections – *so can we have our health care back?*

The mid-term elections were HUGE in so many ways: The sheer numbers of women who ran and were elected and the “firsts” for women, people of color and LGBTQ candidates. Many people who ran – and won – did so out of personal experiences that made them want to change policy. Unbelievably, there are states that have never before sent women or people of color to Washington. Texas will for the first time send TWO Latina representatives. The first Native American and Muslim women won election to Congress. The first female senator from Arizona is also the first openly bisexual senator

Some of the victories were just...poetic justice. California’s first openly bisexual congressperson, Katie Hill, beat incumbent Steve Knight, the son of the man who wrote California’s ban on same-sex marriage, later overturned by the state Supreme Court.

Lucy McBath, whose son was killed in Georgia, campaigned openly on gun control in the deep South – and won. Colorado, where the United States Supreme Court upheld the right to refuse to bake a cake for a gay couple, elected a gay governor. North Dakota elected Ruth Buffalo its first Native American woman state legislator. She beat the Republican sponsor of the famed voter ID law that disenfranchised Native Americans for having P.O. boxes.

California, trail-blazers that we are, elected 53 women – 28 members of our legislature, 19 members of Congress and three statewide officers – Lt. Governor-elect Eleni Kounalakis, Treasure-elect Fiona Ma and incumbent state Controller Betty Yee. Across the US, even with two races yet to be called, it appears 35 new Democratic women have been elected to the House, with just one woman elected by Republicans.

It feels good. Now, let’s get to work.

We have marched and protested against bad policies and for better services and have campaigned for people we think would help make change happen. We know that women, at least when we are holding them accountable, can and do change policy. According to the Brookings Institute, *women candidates for office spend more time than men speaking about health care, education, climate*

change, and minimum wage. Women lawmakers bring in nine percent more federal spending to their districts than do males, and women lawmakers sponsor more bills.

And there is a lot to be changed, in funding slashed for health and human services for women and families (\$1 trillion cut in Medicaid over the next 10 years) and the restrictions placed on funding for women’s health. Changes to the Title X family planning regulations would,

if successful, allow providers to restrict the kinds of contraception they offer women and whether they would even mention abortion. The regulations would even require all pregnant women to be referred to prenatal care, regardless of stated wishes. Any discussion of abortion would become prohibited. These rules are inconsistent with the standard of care under the Center for Disease Control’s Quality Family Planning Guidelines.



The Administration has also finalized regulations allowing certain employers with religious or moral objections to opt out of providing birth control as part of health care. For many women, birth control will no longer be covered. In addition, short-term health plans the feds allowed earlier this year do not have to comply with the ACA; under these plans women can be charged more than men, pre-existing conditions can be used as an excuse to charge women more, and the ACA’s essential and preventive health benefits do not have to be covered. This is a slippery slope for changes the Administration would like to make in all health coverage.

Imposing work requirements, cutting funding for teen pregnancy prevention, making women pay more for birth control if their employers object to it, allowing states to defund clinics that offer abortion care – all of this may be challenged as the Democratic House Majority takes office next year. Presumptive House Speaker Nancy Pelosi has said that health care will be at the top of the agenda – defending the ACA, which she had a huge role in passing, protecting against pre-existing condition discrimination and making health care more affordable.

It is through organizing – that raised issues, turned out the vote and elected these women – that change can be made. So yes, let’s get to work – and get our health care back.

NO MÁS BEBÉS



Fabiola Sandoval and Virginia Espino

now serves as President and Chief Executive Officer of the California Community Foundation.

No Más Bebés is the story of Mexican immigrant mothers who sued Los Angeles County, the State of California, and the U.S. government for being sterilized in the 1970s without their consent after giving birth at the LAC+USC Medical Center. In the film, "a young Chicana lawyer armed with hospital records secretly gathered by a whistle-blowing doctor" took up the cause. That lawyer was none other than Antonia Hernandez, who went on to lead the Mexican American Legal Defense and Education Fund and who

MCHA's Fabiola Sandoval, Community Associate and co-chair of the Boyle Heights Building Healthy Communities, Health Happens with Prevention workgroup, created an event in November to show the film in the very community in which the injustice took place.

The film's producer, Dra. Virginia Espino, was present alongside community leaders and residents, including three sisters and their daughters whose mother was sterilized at the hospital, unbeknownst to her. Attendees engaged in a gratitude ceremony to honor women impacted, and discussed future plans to commemorate this time in history. Maestra Ofelia Esparza and artists Rosanna Esparza Ahrens and Luz Marlene Cordero coordinated honoring and healing activities. As noted on the film's website (<http://www.pbs.org/independentlens/films/no-mas-bebes/>), and given today's contentious debate over immigration, we must make sure that patients fully understand the treatments they are offered, and move from the language of "choice" to the framework of reproductive justice.

Poison Control Workshops

Poison can be anything that causes harm when swallowed, breathed in, or spilled on skin. Most accidental poisonings happen in the home and for children under five, swallowing medicines is the biggest cause of accidental poisonings. MCHA has partnered with the California Poison Control System since 2010 with grants for outreach and education about poison control. For us, this includes one-to-one education in Parent Child Workshops at LA County public libraries with parents, grandparents and caregivers who attend with their toddlers.

MCHA provides simple tips for saving children's lives with safe placement and storage of medicines, cleaning supplies and personal hygiene products, and knowing whether a houseplant is dangerous. It is a big shock to most parents that the Calla Lily and Peace Lily are poisonous! A display shows how easily medicines may be mistaken for candy.

Calpoison.org provides many helpful, free materials in TWELVE languages, including phone stickers and magnets with the Poison Control Center phone number (1-800-222-1222) flyers and brochures. Parents and social service providers alike appreciate the Poisonous Plants Poster, pretty enough to display on a wall and handy to check for questions about plants in or around homes. It's exciting to see the parents so engaged while learning new ways to protect their kids from accidental poisonings!



Family with Carmina at Weaver Library, South Gate

SPOTLIGHT ON STAFF – Celia Valdez, Director, Health Outreach and Enrollment

Celia has that rare combination of empathy for individual clients and ability to see the policy changes needed to help the people who don't come in our door – the embodiment of MCHA's mission and vision. She was the second person hired at MCHA, for our then brand new health insurance outreach and enrollment program for working poor families under welfare reform. During the 22 years that followed, Celia has built an amazing team of eight people and made MCHA the go-to for difficult cases, not only for the clients we reach but also for individuals referred by the county as being too complicated for eligibility workers to handle, and even for family members of county health and social services agency staff.



It has not been easy. The funding for this program has always been a patchwork of federal, state, local and foundation funding sources – the joint federal-state Healthy Families program, Long Term Family Self-Sufficiency through our local Department of Public Social Services, First 5 LA's Healthy Kids program for pregnant women and kids to age 5 ineligible for Medi-Cal, and, at present, local Department of Public Health funding. Through it all, Celia has testified at public hearings, presented case stories to policymakers and the media, and helped clients speak out not only about health coverage but also health coverage that **works** for people. She has shone a bright light on the fact that success is not just about how many people you help enroll but also whether each individual is in the best program for them, that enrollment continues despite the many barriers to retention that come up, and that the person gets access

to the care they need on a timely basis. The importance of this approach is now supported by data and widely accepted by funders and administrators. Earlier this year, Celia led a statewide coalition and flew to Sacramento to testify about the critical importance of maintaining funding in the state budget for outreach and enrollment in this broader sense. As with many other health measures, the Legislature decided in the final hours of the budget process to postpone the decision for the new Governor and administration. Luckily, our LA County Department of Public Health stepped in to fund the effort, recognizing the value of this work to good health. But other counties were not so lucky.

Every year, Celia and a group of high school friends provide Christmas – for a family in need – toys for the children and a meal. At her daughters' school, Celia is known as the one to ask for any health coverage-related question or need. She has untangled a web of issues for a friend of a friend not-yet-diagnosed, but suspected, with ALS. Celia is the one who can tell hilarious stories in the lunchroom about her family's and her own exploits, but whose eyes will well up at the indignities and hardships faced by clients. She recently sat with a client for over an hour shortly after his hospital discharge, sharing with him her own experience with the medical issue he now faced as a single father. Would he be able to work? What could and should he eat? What about medications? She assured him that as bad as he may be feeling now, post-discharge, she too had felt it and he would come out of it and feel better. Such empathy and support is, as they say, "priceless."

MCHA Advocacy Gets Results!



Donnisha LaFlor and Baby Admiré Lewis

Medi-Cal's New Non-Medical Transportation (NMT) Benefit

This new benefit is transforming medical access in California by providing round-trip transportation to Medi-Cal-covered services, including to get to a doctor, to pick up a prescription or durable

medical equipment such as a wheelchair, or to attend to a sick baby in the NICU. Although we started providing community education materials about Medi-Cal transportation in early 2013, our work on this issue really took off this year, with a flyer explaining the benefit, a webinar for advocates and service providers, and lots of technical assistance to groups trying to ensure access to transportation for their clients. Last year we surveyed Medi-Cal plans to note each plan's instructions, help correct misinformation, and list phone numbers on our flyer. Unfortunately, the NMT process for people in fee-for-service Medi-Cal (not in a health plan) is an interim and temporary process until an official list of NMT providers is ready for posting to the DHCS website (due long ago, but still not available as of press time). A consumer-friendly flyer for beneficiaries will be posted once the transportation list for fee-for-service beneficiaries is posted on the state's website.

We are spreading the news about this benefit as well to groups now paying for transportation for their clients, so their scarce grant and fundraised dollars may be used in other parts of their programs, as well as with media in response to articles about the role transportation plays in access to care.

Untangling Overlapping Eligibility That Blocks Access To Prenatal Care – The Case Of Medi-Cal Access Program (MCAP) And Medi-Cal

Ms. Lopez's pregnancy is considered high risk due to her diabetes and age. She applied for health coverage in April 2018. An MCAP approval notice was issued in May, stating that her eligibility would not begin until May 13, instead of May 1 as it should have said. In addition, her MCAP eligibility did not appear in the computer system providers use to look up eligibility until May 30. In the meantime, the system had blanks everywhere that a Medi-Cal aid code should have been and showed a "Share of Cost" of \$5,207! Share of Cost (SOC) is an amount that a patient must pay (generally) or a provider agrees to bill before a provider will see a patient. Ms. Lopez contacted MCHA in mid-May because she could not access prenatal care with this enormous SOC.

Although the MCAP aid code designation has since been added, the SOC still showed in the provider computer system. In June, Ms. Lopez went to the hospital Emergency Room because of vomiting and dizziness. ER staff told her she would be billed because of the SOC. She has access to prenatal care now only because MCH Access and the LA County Department of Public Social Services communicated with the provider while attempts were made to have the SOC removed from the case. But this is hardly a solution for each provider Ms. Lopez will see, much less the thousands of MCAP-eligible women potentially in this situation.

MCHA has been the leading voice on health coverage enrollment for pregnant women and transitions among programs. We assumed that

role early on, when Access for Infants and Mothers (now the Medi-Cal Access Program, MCAP), which provides comprehensive medical benefits, including for undocumented women, was repeatedly left out of the state's Obamacare enrollment system and mindset about programs for low-income people. MCHA has also succeeded in getting the state to comply with its responsibility to include coverage for dental, vision, mental health and substance use disorder services for women in MCAP. Starting in July 2017, women with MCAP are enrolled in Medi-Cal plans and receive full-scope Medi-Cal benefits.

MCHA began seeing issues with our own clients and getting technical assistance calls about women who had both MCAP and Share of Cost (SOC) Medi-Cal, for people with higher incomes than the limit for no-cost Medi-Cal. Dual coverage in MCAP and SOC Medi-Cal is problematic for a number of reasons. Like commercial insurance, MCAP does not begin until the first day of the month in which eligibility is approved, which can take weeks or longer and/or run into the following month. There is no retroactive coverage for services received before that date (only up to \$125 in pregnancy-related care may be reimbursed in limited circumstances). In addition, until the woman is enrolled into a Medi-Cal plan, which can take an additional 30 days or more, her MCAP coverage is in fee-for-service, not in a managed care plan, but this is not explained to providers, resulting in women being turned away from medical care by non-plan providers. Worse, providers are led to believe in coverage explanations that the SOC applies to MCAP, not just Medi-Cal. In our painstaking research with cases, we have seen many variations in how the access barriers come about.

MCHA has sent the state several letters with case illustrations and participated in several conference calls. The state now agrees there are a number of systemic problems and has committed to instructing the counties on interim workarounds during the up to two-year period it will take to re-program the eligibility computers for MCAP. Our goals are to speed up immediate relief, simplify the process so that the woman has coverage and access to health care in the program best for her, and make MCAP more like Medi-Cal – with the ability to access services immediately (presumptive eligibility) and continuously if transitions take place to lower-cost Medi-Cal.

MCHA Encourages LAHSA To Change Housing Criteria

Five percent of women living without shelter on the streets report that they are pregnant, according to LA's Economic Roundtable. The percentage is highest among young women 18 to 24 years of age with 15 percent reporting being pregnant.



The extent of homelessness in LA is shocking. Our Welcome Baby outreach team has witnessed firsthand the increase in homeless prenatal clients that express a need for housing referrals. Measure HHH passed in November of 2016 to provide housing to homeless people and Measure H in March of 2017 to fund programs for supportive housing for Los Angeles County. Regardless, the need is overwhelming.

Through our Resource and Outreach program, headed by Ana Leiva, MCHA learned how pregnant women were treated in the new system for homeless housing; over the next year, led by Ana, we worked to improve it.

Families have priority over single adults for housing services. Before our intervention, pregnant women were eligible to receive housing services as a family, but only from the second trimester or if the pregnancy was considered "high-risk."

MCHA knew, however, that being homeless in and of itself constitutes high risk. Requiring a woman to either get certification of high risk from a provider during her first trimester or making her wait until the second trimester of her pregnancy, was a barrier to housing for this most vulnerable population. MCHA's raised questions at public meetings and made other requests for information from the county. LAHSA staff themselves noted that no other major city homeless program they contacted had a similar housing policy for pregnant women, except San Francisco, which was in the process of changing as well. Ana's work bore results, and this last spring, the restrictions were removed, and pregnant women will now be listed in the highest priority category for housing along with other families.

Comments On State Standards For Midwifery Services

MCHA commented in October on standards proposed by the state for Medi-Cal managed care plans to include midwifery services. In particular, we emphasized the need to comply with state geographic and timeliness standards for access. Geographic access means that Certified Nurse Midwives and Licensed Midwives must be available without women having to travel more than 10 miles or 30 minutes from their homes. Timely access means specified timelines for getting into care, based on the level of care needed. Our recommendations contrasted sharply with the state's proposed standard of only one midwife per plan, as set forth in federal guidance. But since California law and regulations impose stricter access standards, they must be followed for midwifery services, too.

We will know what the state has decided when it's final All Plan Letter, which provides guidance for managed care plans, is released.

MCHA Submits Comments On Federal Title X Changes

Title X is federal family planning funding annually appropriated by Congress. It supports family planning and other preventive health services for low-income, under- and un-insured individuals. Along with our colleagues at a number of reproductive rights and family planning organizations, MCHA commented on the federal government's proposed changes to regulations on how Title X funding may be used. These dangerous changes would emphasize non-medical services, such as abstinence and natural family planning, over the most effective means of pregnancy prevention and would no longer require each provider funded by Title X funds to offer all family planning methods and services. The rule would also impose difficult administrative separation on Title X providers who also provide abortion services with other funds in the same facility. Most strikingly, the rules would prohibit clinics and providers from presenting abortion as an option or providing referrals,



interfering with medical practice and sometimes potentially life-saving information.

In addition to addressing reproductive health issues, MCHA also addressed the impact of the proposed changes birth spacing and healthy birth outcomes. Access to contraception is associated with adequate birth spacing and reduced risk of adverse birth outcomes, including preterm birth and low birth weight.

Public Charge – Proposed Changes In Rules To Federal Regulations

Ms. M. was very depressed and anxiety ridden, expressing severe financial problems. A couple of months back she had been advised by her immigration attorney to cancel any and all public benefits she received, including Medi-Cal for her family and SSI benefits for her disabled U.S citizen child. She followed his advice and then weeks later found herself in the hospital and now has a medical debt as a result of having dropped her Medi-Cal and been left completely uncovered. I encouraged her to re-apply for Medi-Cal. She was clearly eligible for it. She hesitated but acknowledged she needed to, as she could not afford the medical bills.

She was in tears as she talked about how she struggles as a single mother of three children. She talked about how difficult it is to put food on the table, pay the rent, and provide for kids. She recently took on a second job as an Uber driver but still was making ends meet. I told her the family is eligible for CalFresh but she refused to apply, again stating that her attorney advised her not to. After completing the Medi-Cal application, I referred her to a legal advocate for further clarification on what is and what is not a "Public Charge" currently, and also referred her to mental health services. I told her we'd follow her case to ensure her bills get covered and would be here for her should she decide to apply for CalFresh or simply for support. She was very grateful, but two months later, still is too fearful to get CalFresh benefits.

"Public Charge" is a term used by U.S. immigration officials to refer to a person who is considered primarily dependent on the government for subsistence, as demonstrated by either receipt of public cash assistance for income maintenance or institutionalization for long-term care at government expense. A proposed new federal rule would broaden the definition to include immigrants who use one or more specified government programs. Lost in all the media reports and inaccurate advice given by often-trusted street "notarios", or notaries public, is that the proposed rule is STILL only a proposal, its content may change, and it will not go into effect for some time, assuming it survives litigation. Benefits used would only be "counted" if used after that time. Not all immigrants are affected – only those non-citizens applying for a visa to enter the country, or to obtain legal permanent resident status (a "green card").

MCHA is working to try to convince families at an individual level that now is not the time to be giving up much-needed benefits that help keep themselves or their children healthy and even alive in many cases. We have circulated draft comments and, at our September monthly meeting, provided an expert who explained the public comment process.

Of course, just the topic in the media strikes fear in the hearts of families of mixed or undocumented status. Immigration and Customs Enforcement (ICE) raids and the reality from the border, of children being taken from their parents, having to stand trial and represent themselves at age five or younger, strikes at the heart of immigrants who are already vulnerable to exploitation and poverty. MCHA is part of an Immigrant Health Taskforce convened by the California Community Foundation to strategize and share information about the issue. And we will submit our own comments by the deadline, December 10th.

Thanks to Our Generous Contributors:

Our apologies for any misspellings or omissions. Please call (213) 749-4261 ext. 110 or info@mchaccess.org with corrections.

- Amazon Smile
- Asian Americans Advancing Justice
- Baby2Baby
- CBS, Inc.
- Berke Family Foundation
- Bloom Again Foundation
- California Association of Food Banks
- California Poison Control System – UCSF
- Center for Biological Diversity
- CPEHN
- Facebook/Gates Foundation Giving Tuesday 2017
- First 5 Los Angeles
- Health Net
- International Institute of Los Angeles
- LA Care Health Plan
- LA Shares
- Live Nation
- Los Angeles County Department of Public Health
- March of Dimes Birth Defects Foundation
- Morrison & Foerster Foundation
- Planned Parenthood
- Ten Thousand Villages – Pasadena
- The California Endowment
- The California Wellness Foundation

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MCHA AND APHA

MCHA had the opportunity to present two papers and a roundtable presentation at the American Public Health Association, held Nov. 10-14 in San Diego. Sandra Hoffman, Lili McGuinness and Amber Villa submitted about the Welcome Baby (WB) program and Lynn Kersey and Lucy Quacinella submitted about policy work in which MCHA is engaged. The WB paper, "Promoting health equity by increasing health care literacy among underserved mothers and infants through a short-term, universal home visitation program" explained the Welcome Baby program, its objectives and evaluation efforts. The paper focused on improvement found in women's "health care literacy" – or the degree to which individuals have the capacity to obtain, process and understand

basic health information and services needed to make appropriate health decisions. Understandably, this literacy affects a person's ability to navigate the health care system and can be a source of disparities associated with poor health outcomes. Despite the Welcome Baby program's relative "low intensity," i.e., nine points of contact with the



Lili McGuinness (middle) and Sandra Hoffman (right)

pregnant/ postpartum woman, the increase in health care literacy was significant between 28 weeks of pregnancy and either two weeks or nine months postpartum. Health care literacy has an impact on accessing health care, with MCHA's Welcome Baby achieving 91% return to provider for postpartum visits. This is much higher than Medi-Cal or even commercial insurance achieves.

The second Welcome Baby presentation was a more informal Roundtable on Adverse Childhood Experiences (ACES) and Trauma-Informed Interventions, explaining Welcome Baby's multidisciplinary and holistic approach. Lynn Kersey also presented a paper on MCHA's work to improve the monitoring and data collection for the state's Comprehensive Perinatal Services Program. The presentation was entitled, "Maximizing Comprehensive Perinatal Services to Improve Health Equity in California."

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For Hanukkah, orders must be placed by December 7th to arrive by the last night of Hanukkah (December 10) and after December 21st, the card or gift may not arrive by Christmas.

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