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Hurricane Katrina: Lessons Learned for Primary Health Care Society of Primary Care Policy Fellows and University of Miami Miller School of Medicine February 27, 2007

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GARY COLANGELO, D.D.S.: I want to welcome everyone to the Society of Primary Care Policy Fellows Capital Hill Round Table, "Katrina: Lessons Learned for Primary Health Care". I'm Gary Colangelo, I'm the current President of the Society, and let me give you a little background about the Society. Members of the Society of Primary Care Policy Fellows are graduates of the United States Health Service Primary Care Policy Fellowship. The activities of the Society allow us to continue our interest in healthcare policy. Our mission is to affect primary care policy, education, research and service at the local, state, national, and international levels. And this round table is an activity in support of that mission.

Let me acknowledge a few people for the efforts they put into getting the round table going, Kirsten, she's out in the hall being the marshal of our—. All right, Kitty, Kitty Werner [misspelled?], well let me just tell you about them. [Laughter] Kirsten is the energy behind the round table, she did one other round table for the Society on rural health, she's at the George Washington University School of Medicine and Health Sciences in the physicians assistance program. So she, I think we all need to thank her for her efforts, and she's out still working.

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Kitty, Kitty? You back there? Kitty Werner is our Executive Director and she did an awful lot, Kitty say hi, an awful lot on the logistics of the round table.

Finally, I want to thank Bob Schwartz who was unable to be with us, Bob is the chair of the Department of Family Medicine and Community Health at the University of Miami. His department helped to support the cost of the round table.

The structure of the round table is pretty simple, we'll have three presentations, each about 15 minutes, and then we'll have a 30 minute discussion. And as I said, we want you to be energized and do more than just listen because the round table is meant to be a dialogue, a discussion of the presenters with the audience. So save up your questions, think of your ideas, these are topics that are important to all of us.

Hurricane Katrina was the costliest and one of the most deadliest hurricanes in the history of the United States. It was the sixth strongest Atlantic hurricane ever recorded. And the third strongest hurricane on record that ever made landfall. The aftermath of Hurricane Katrina continues to challenge our nation's critical thinking on meeting the basic healthcare needs of not only the victims of Katrina, but of all Americans.

Today we will explore the issues raised by Katrina, to try to gleam some direction for future disasters, for health

disparities, and care access solutions, and ultimately for healthcare system reform. Primary healthcare clinicians address a majority of personal healthcare needs by providing community based integrated and accessible care that is sustained over time. Primary healthcare clinicians are often the first to respond to people's needs after a disaster. Essential to preparing for future disasters, and solving the current issues of health disparities, and healthcare access, is the need for effective primary healthcare policy. Our expert panel today will provide you with an assessment of issues from the Hurricane Katrina experience and direction and answers to those important issues.

So I'd like to present our, or introduce our first presenter, and that's Bob Philips. Bob is, and I see that Dr. Gloria is joining us, do you need to, do you need to take a rest break? {Laughter] Are you ready to go?

GLORIA WILDER-BRATHWAITE, M.D., M.P.H.: I had my rest while we were parking. [Laughter]

GARY COLANGELO, D.D.S.: Oh, okay, all right. Well we had, we had Dr. Gloria first on the agenda, so, are you want to, you ready, catch your breath, good. Okay, Bob, excuse me, I'll get back to you. I will give you a little breather and I'm going to give you an introduction here.

GLORIA WILDER-BRATHWAITE, M.D., M.P.H.: Okay.

GARY COLANGELO, D.D.S.: All right. Dr. Gloria Wilder-Brathwaite, also known as Dr. Gloria, is a pediatrician and advocate for children's healthcare. She is the founder and CEO of Core Health, an healthcare solutions company dedicated to assisting providers to underserve populations in improving the quality of care given to the underserved through enhanced business efficiency. She volunteers as a pediatrician at Safety Net Clinics and provided three years of service to the National Health Service Core. She serves as advisor to numerous foundations and NCO's that specialize in community programs. For her efforts, on behalf of the underserved, she has received many awards including the 2005 Caring Award, joining Jimmy Carter and Mother Theresa, who were past recipients of this award. Her work has been featured on the Oprah Winfrey Show, CBC's 48 Hours and NBC's Dateline.

I've had a couple of phone conversations with Dr. Gloria and just in the phone conversations I became inspired. So I am really looking forward to your presentation and welcome to our round table.

GLORIA WILDER-BRATHWAITE, M.D., M.P.H.: Thank you. Thank you guys so much and remind me never to drive here. [Laughter] I live in Demfreeze [misspelled?] Virginia, so I've been on the road since 6:00 am, but I'm so happy to join you guys. You know when this invitation came and I thought about

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the topic, I thought about all the experiences that we've had over the last year and a half, and not in New Orleans but Houston and Atlanta and a lot of different places and meeting a lot of different folks, and so I made some notes for myself, just the things that I wanted to kind of generate a discussion amongst us all about.

I think so many providers who responded to this disaster, we were struck of course by the enormity of the disaster for the first part of it, just like with September 11th, we don't talk that much about September 11th anymore, but I was actually in New York on midnight on September 12th because my mother had a stroke, and had to be taken to a hospital after she closed the buildings in Manhattan of the Supreme Court. And the connection for me, between those two disasters is the fact that those with the least got the least and, of course, we're able to, unable to access quality care but also very basic kinds of services. And so, I think we need to discuss that and when Gary and I and the group here spoke over the phone, I did not want us to, and none of us did, wanted us to miss the point of connection on concentrated poverty and social injustice and the economic segregation that we see in every one of our major cities now. Every one. And I can say that, I've been to 31 states in the last two years and there is economic segregation across our country and it is just as destructive as

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the racial segregation that we still see in some counties, but that we saw universally in the United States in the 1950s and 1960s, and before that of course. But we don't like to talk about it because it makes us all uncomfortable.

When it comes to preparing any city for a disaster, and really what that means is, deciding on one day, whatever that element is that triggers the disaster, whether that is a natural disaster or whether it's a terrorist attack, or whether it's your neighbor deciding to get silly and blow up the block, whatever the disaster is, at that moment that it strikes, there is an assumption of equality and equity that I think every citizen expects. Whether that person is homeless when that moment hits, or whether that person is in a 50 million dollar mansion at the moment that it hits, I think we all expect that that incident has leveled the playing field. And one of the things that I saw with the Katrina aftermath, is that it did not. And that there were no real resources in place and not a lot of good intent to level that playing field. And so we now see 18 to 20 months after this disaster that those who had the least, still have the least, and have less than they had when they started out, and that those who have been able to recover where the ones who had resources in the first place. And I know I'm preaching to the choir when I tell you all this but I don't think we should forget that.

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And so I wanted to talk about a couple of things. One; the assumption of do no harm. Everyone assumes that folks within the medical profession believe fully in the oath of do no harm. First, let me remind you only some of us take the oath, and even fewer believe in it fully. And the oath of do no harm does not mean to do good, all right? It's not the same thing. That's the oath of non-malevolence and not benevolence. And what disaster relief requires is benevolence. It requires that provider, or group of providers, to be willing to run in when everybody else is running out. And every one of our major cities has a disaster plan that is premised around the fact that we believe the healthcare providers and safety net providers will stay and serve, but the truth is that these providers have families that they care about and they want to save their families in addition to saving yours. And so I think we need to do more work in helping providers to get ready for a disaster and helping them to prepare their families, much like we do with the military. That work is not done in emergency preparedness as far as healthcare providers are concerned.

The next thing I wanted to mention is what I call the non-profit hypocrisy. You all will see I'm a little spicy. [Laughter] I just say it like it is. [Laughter] The non-profit hypocrisy is what some of us saw in New Orleans, in

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particular, but also in Mississippi, where the non-profit community from around the nation, that rushed in to help and did remarkable work in the first few months, and raised millions and millions, perhaps billions of dollars on behalf of this tragedy, failed at the point when they were supposed to switch over the resources back to the local non-profits. Some of our largest national non-profits, instead of supporting local providers, displaced them and hired providers from all across the country, and I say hired, right? Not everybody was a volunteer. Providers from all across the country to come in and serve on behalf of that non-profit, but did not, and in some cases, would not hire the local providers. I was struck by the number of nurses and doctors who I met in Atlanta and Houston, who could not get back because, not only were their houses gone, but the opportunity for employment was gone, and they had no way, or a very difficult way of finding out about all these jobs that all of us heard about in our lives and in our circles. So larger non-profits, some of them, forced smaller non-profits out of business and surrounding states with larger non-profit headquarters actually got an economic boost from the dollars that were raised because these national headquarters were able to strengthen their selves and grow in order to respond to the disaster.

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Some healthcare workers decided to take advantage of a good opportunity and permanently move to the area, causing some permanent displacement of their colleagues. Again, we don't talk about that. Right? Because we're supposed to be sitting on the right hand side of God so we don't want to say that there was some incentive to maybe not be benevolent, but just to sit in non-malevolence.

I mentioned down here that minority providers, who for the most part, not always, but for the most part had less resources than their non-minority counterparts. Were the last to come back, and still aren't back in many of the communities where they served, and there are African-American and Hispanic, Latino physicians and nurse practitioners who still are struggling to find a way back. But again, when you don't have family resources, and a lot of minority physicians, not exclusively but a lot, who have served in the national health service core and who have traditionally served these communities, struggling communities, were raised in struggling communities. And so, there was no extra family to go to, who had another house, or who could bail you out, or pay your bills for a while for you. So those providers took a personal hit, and are still in recovery.

The next thing I wanted to mention is the need to restore medical homes rapidly within communities that are

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responding in a disaster. Medical homes, we all know what those are, but the importance of primary care and preventive healthcare cannot be ignored in a disaster. Yes, there is an immediate response to trauma and emergency that we have to do, but then quickly we have to be able to manage chronic diseases, quickly we have to get appropriate and consistent sources of medications for folks within a community. And we also play a very big role in reducing the impact of trauma and stress by providing a familiar environment of service delivery.

One of the things that I was struck by, just a couple of months ago at the FEMA camps, amongst some of the elderly, we all know how many elderly folks have died subsequent to the recovery phase of this disaster in New Orleans. But one of the things that I was struck by is the number of seniors who want their doctors back, want their nurses back, want their way of getting things back, "I knew how to go get this, Ms. Anne at the front desk would tell me to take this pill", and all of that is gone. So not only is family gone, but the community of folks supporting these seniors is gone and so we see higher levels of depression and other acts.

And then lastly, I had in my notes here, what I call the social justice paradigm, and again going back to the issue of concentrated poverty and the acknowledgement that condition existing before the flood continues to affect families post

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flood. The health impact of poverty put tens of thousands of residence, just in New Orleans, at increased risk of negative health outcomes from any disaster, let alone a huge disaster, but increase risk of heart attack, consequences of missed medications for families who had cancer patients, HIV/AIDS, alcoholism, suicide and homicide, there's no coincidence that right now we're seeing an increase in the crime rate, in particular in the homicide rate, in New Orleans. Homicide is the black man's suicide. That's what it is, this is not rocket science, this is what we see in Washington DC, in some of our neighborhoods. This is an offset of an offshoot of depression, neglect and hopelessness, when you have young men who will take that kind of risk with their lives and who are looking for a cop to take them out, that's suicide and we need to make sure that we check these young lives off on both lists. Yes it was a homicide, but it was also a suicide.

Without basic economic health and legal literacy within these communities, once they are disconnected from the sources of support and social services that existed prior to any disaster, what happens is eventually a community begins to implode. It begins to turn on itself and that's what we're seeing and we're allowing it to happen. And we're allowing it to happen in all of our major cities; the only thing that's unique about New Orleans now, is that we blame it on water.

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There are five keys to social justice, and this is my last point. Quality healthcare, access to a quality education, quality housing, fair economic opportunity, and environmental justice, which is a clean nurturing community free from violence and toxins. Weakness in any of these five keys to social justice will weaken all of them within a community. In New Orleans, right now, all five are broken and what is even more remarkable is that all five were broken before the levies ever broke.

So, I'm going to end there. My wish for all of us is, I'm glad we have an opportunity to talk and dialogue and figure out a way to prepare our own communities for such a disaster, but my wish for all of us is that we would not ignore the very huge, huge red flag that sits in front of all of us. And that is the flag of poverty, and the fact that in the United States, poverty is a choice that the middle class and upper-middle class make for those who are not in our conditions, and that we can choose to do something different whenever we want. It will cost 124 billion dollars to end poverty in the United States, we have spent more than ten times that amount on our war. Thank you.

[Applause]

GARY COLANGELO, D.D.S.: Okay folks, Dr. Gloria, very articulately laid out the issue, big problems and we know that,

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but hearing it from someone who has been on the front line for so long, I think it drives it home and what we want to do with the rest of the morning is to explore some of these issues, collectively, and of course, we're centering our thoughts and discussion on primary care. Bob Phillips is a family physician and Director of the Robert Graham Center, policy studies and practice and primary care. The Robert Graham Center functions as a division of the American Academy of Family Physicians and focuses on primary care and family practice policy issues.

Dr. Phillips has faculty appointments at Georgetown University and George Washington University, as the President of the National Residency Matching Program. He is also Vice Chair on the council on Graduate Medical Education. So, Bob.

ROBERT PHILLIPS, M.D., M.S.P.H.: Thank you Gary. I'm not from New Orleans, I'm not a New Orleans expert, but I share Dr. Gloria's concerns, not only about what is in New Orleans, but what is in many cities around the country because the situation, the setup for disasters is there. I liked the analogy of the water, in New Orleans, because it works. We saw what happened there and we saw not only what it did in terms of physical damage, but what it did in damaging the people who live there. And the water there was high before the hurricane ever struck, there was an erosion of the shoreline that had set

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it up so that a class three storm could push it over, destroying levees and populations, and homes.

That water level is high in many of the cities around the country and that water is people, the people who live in poverty, the people who live in the situations of social injustice that Dr. Gloria was mentioning. And that water is high, it's right up against the top of a levee, a very fragile system of levees that are the primary care physicians, nurses, nurse practitioners, PA's, community health centers around this country that form the safety net. That take care of those people and hold the water at bay. But it won't take much to push the water over those levees all over this country, we're very close in fact.

So, I want to continue that analogy, but I want to start off with a quote that I found very disheartening. A quote from a forum we held about 15 months ago here in DC, not very long after the hurricanes had hit, and that quote was by Dr. Karen Disolvo [misspelled?], who is the chief of general internal medicine at Tulane, who said, "The policy makers would do well to finish the storms destruction of the medical infrastructure in the area." The medical system in New Orleans was not designed to take care of the people who were living there at the time, except for a very important safety net that relied heavily on just a few providers, one of whom, Charity

Hospital, is gone. So I want to start there, to think that this storm offered an opportunity to wipe the slate clean and start over, that may actually reveal a missed opportunity when we sit here, gosh, a year and half later and that has not been fixed.

But prior to the storms, there were two fairly qualified health centers and a network of clinics sponsored by Charity Hospital, that provided the bulk of the care, in fact most of Charities Hospitals inpatient service was either uninsured, impoverished, or on public health assistance. There was also a system of residency clinics that took care of people, so relying on trainees in the pipeline, trainees who are only there by virtue of the fact that there are hospital beds that receive funding to support those trainees, and over half of those hospital beds are now gone.

Last fall, Gene Lambrue [misspelled?] and Donna Sholalutz [misspelled?] told us the hurricanes reduced the hospital capacity by 80 percent and the safety net clinics by 75 percent. It did 65 million dollars in damage to the community health centers in those areas. Sixty-five million dollars and there were no appropriations to make up for that damage. In health affairs just this year, Dr. Rudowitz [misspelled?], Rollin [misspelled?], and Schwartz said, the aftermath of Katrina devastated New Orleans healthcare safety

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net, entirely changing the cities healthcare landscape and leaving many without access without care a year after the storm. But the story actually starts before the storm, the story is that there had been a 20 year decline in primary care production, in southern Louisiana surely, but in the entire state of Louisiana, and in the last decade 20 percent of Louisiana family medicine programs had closed. In fact, just within the last, the year and a half before the storm, an important family medicine wrote program in Baton Rouge closed, a program that had graduated a 122 residents, 78 percent of who stayed in Louisiana, and 91 percent of whom practiced in health profession shortage areas. And it was closed.

If you look at the map of the footprint of that residency program, it covers the parishes of New Orleans and Jefferson and a lot of southern Louisiana, and that program is gone. It has not been rebuilt. You lost 45 hundred active patient care physicians from New Orleans and the surrounding areas, about 12 hundred who had gone back as of a year ago, but we have no real way to measure how many of those folks have come back, or how many will come back at all. And as Dr. Gloria said, it affected many of the people who were living on margins, surviving on margins, that kept them there but don’t allow them to go back and rebuild.

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I want to talk about the water too, because prior to the hurricanes Louisiana had some interesting statistics, it was forty-ninth in healthcare outcomes. It ranked fiftieth in health risks and fiftieth in qualities, despite being in the top quartile of Medicare spending per capita. In 2004, again before the storms, 89 percent of Louisiana's, or I should say New Orleans parishes were health profession shortage areas, and since then 97 percent. Half the population lived below 200 percent of poverty and more than 20 percent were uninsured and 29 percent were on Medicaid, or some other form of public assistance.

The water was deep. And we are sitting in a town where the water is similarly deep. Detroit faces similar problems. There are cities in Southern California, we can point to cities all over the country where the water is deep in that regard. And then the congressional budget office says that more than two million people from the affected areas where receiving, or became eligible, for Medicaid and many, many more became uninsured. So the water not only became deeper, it became indelude [misspelled?] and it's still flowing.

So what are the options? People have articulated these better than me, there are many options, the most basic is let's get the levees back. Let's rebuild the federally qualified health centers and build them better than they were. Let's

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avoid hospital centric care, which is what was there before. Let's provide support for primary care services and practices, bring them back, help them locate where they're needed, help those people from rural or minority ethnic, or racial backgrounds and contributing to those areas, get them back. Those are the people that those populations trust. Create some residency training flexibility, if it's tied to hospital beds and we've cut them in half, then we'll cut the residence in half. You will cut the opportunity for residence, not only to care for those populations, but to learn how to care for those populations and develop compassion for caring for those populations. We need to increase support for primary care residency training in other ways, especially in underserving outpatient settings. And we need, maybe even more fundamentally, to change the ways that we select people to become physicians or to become nurse practitioners or PA's. There's good evidence that when we choose people from rural backgrounds, when you choose people from intercity backgrounds, they go back and serve those populations at a much higher proportion than people we're taking into medical school now. And LSU and Tulane have programs, to their credit, to do that and those could be expanded.

But fundamentally, just like New Orleans has had their levee shored up but the shoreline problem remains. You can't

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get away from the fact that there's nothing buffering the ability of the water to flow over those levees again. So, just as Dr. Gloria said, we've got to try and think about how we're going to tackle the issues of social disparity and social injustice, because that water is becoming deeper for whatever, we can point to all kind of policies that have been in place, not just in the last two to three years, but in the last 20 that have allowed the gaps in income to grow and allowed the disparities to grow, to erode our social cohesion of things that we should fall back on when we have emergencies, but it's just not there anymore.

So, the breech remains in terms of healthcare in New Orleans, I only tried to articulate a few of the options we have for repairing that breech, but really just as New Orleans has to deal with the more fundamental problem of it's shoreline, we really should think of things to deal with that shoreline and the water that is creating the disaster, the potential disaster to begin with. I'll stop there, thanks.

[Applause]

GARY COLANGELO, D.D.S.: Thank you Bob. Sara Rosenbaum is Chair of the Department of Health Policy and Herald and Jane Hirsh Professor of Health Law and Policy at George Washington University. Professor Rosenbaum has dedicated her career to promoting more equitable and effective healthcare policies in

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this country, particularly in the areas of Medicaid and Medicare, Managed Care, employee health benefits, and civil rights and the healthcare systems. She has been named one of the nations five hundred most influential health policy makers by McGraw Hill and has received the Investigator Award in health policy from the Robert Wood Johnson Foundation. As a member of the White House Domestic Policy Council under President Clinton, she directed the drafting of the Health Security Act. So, Sara.

SARA ROSENBAUM, J.D.: Thank you. Good morning everybody, it's really a pleasure to be here today and to be on this wonderful panel. I'm going to focus my remarks, actually, on sort of the dry underbelly of what Dr. Gloria and Bob Phillips were talking about, which is the societal and moral response to a crisis, how we see community and sit down and deliberately think about what a community needs and then go about building what the community both needs and desires. I'm going to focus on the larger question of financing, on the government's role in financing and really therefore the government's role in helping a community have a healthcare system at all. And whose vision values out to be the most influential as government thinks about how to structure it's financing arrangements.

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Katrina is a very unusual situation for a lot of reasons, all of the societal and ethical reasons we've heard expressed this morning on this panel, but it's also unusual as a study of public policy because you essentially go right back to nothingness and you have to think about going from nothing to something. And sort of the fundamentals of how you would finance that journey become very important to shaping the journey itself. If an entire healthcare system gets wiped out, as was the case in the area hit by Katrina, a couple of things become very apparent, especially when that region was one that had in some ways, a tenuous grasp on healthcare anyway, it had a remarkable group of people who were very hardy and very enduring and loved their communities and were there but, as others hade mentioned, millions of people lacked any insurance coverage. Many, many communities were medically underserved and had very serious health professional shortages. It was not an area where people's connection to the healthcare system could really be described as going beyond fragile and whatever was there got leveled, and a few things became very apparent right away, just sort of basic economic sense.

One was, that in a recovery that is this big, where literally you're having to restore a regional healthcare infrastructure, everything from the medical home you walk into, to tertiary emergency services, to serve entire regions of the

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country, long term care services for people with very, very serious physical and mental disabilities, you can't do it by covering only some people. Everybody has to be in, everybody has to be covered, everybody has to have a way to pay. Not just because that's the just thing to do, but from a basic dollars and sense point of view, it's very hard to get a healthcare system which is vast and you suddenly see how it interacts with all of us, whether or not we happen to be well insured at any given moment. To get something that fast back on it's feet everybody's got to be able to buy into what's going to be available because it's very hard to attract the human and financial capital that's needed to rebuild a region if you have only a small part of the region able to pay for the care.

Now, the kind of financing that one has to think about is not just the coverage though, coverage is of course a major feature of this kind of intervention, but it doesn't stop there because there are certain kinds of investments that have to be made on a jumpstart basis. You may be able to go to private lenders and get that investment, if your strong, if you look at here in Washington, Children's National Medical Center, The Washington Hospital Center, my own medical center wants to build new facilities. They have the tremendous strength to get up credit rating, issue of bond, raise money in the private

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capital markets, that's not true for providers in services that serve areas that don't yield much in the way of revenue. They need public capital. It's that simple.

Now 60 years ago we used to do this, we did this with the Hal Burton Program, that's what Hal Burton was, it was just public capital and that era we did it so that soldiers who were returning from a war could go home. Certainly the population needed hospitals, but the precipitating event was the return of veterans who needed ongoing care with no health systems in their communities. In this case, we have a combination of capital, we have the primary care the community health centers program, that's just capital. It's capital to get a clinic off the ground and then to give it an operational subsidy for when it's up and running. We could of course have reinvested in the Hal Burton Program, it's still on the books. And we could have, of course done much more to expand loan guarantees in order to allow people who might be able to move into private capital markets to do so with some backstopping from the government. And in that capital investment we really needed to do a bunch of things, we needed to rebuild buildings, we needed to get equipment back, we needed, of course now that we know so much more, we needed to make the latest health information technology available. If you're going to rebuild an entire health system in the 21st century, you would deal with health

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information technology needs and as Bob points out, you need to build with an eye toward a strong teaching component because teaching grows a new generation of community healthcare leaders and teaching also attracts back to the region people who want to be involved in the teaching and educational enterprise. And it, of course, measurably expands the resources, the capability of a healthcare system.

So, it was pretty clear what had to happen. There had to be healthcare financing that would cover everybody for some period of time to let the financial engines start going again, and then you needed a combination of direct public financing and loan guarantees, and possible other kinds of capital interventions to give the tools, to put the tools into place to let people move the system back in and turn on the engine again. Would have taken years but we knew what was needed, we've been down this road before.

We've done neither. We very quickly lost the political will in the United States to do meaningful insurance coverage. After the World Trade Center disaster, of course, some of you may recall that the city of New York, with the full support of the Bush administration did something very, very important. As it turned out, because of the unique nature of that disaster the immediate need for the service that was introduced was not obvious, but the long term need was. And that was they got

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special permission from the federal government to cover everybody in the city who needed insurance with Medicaid. And they literally, just on the basis of neural affirmation of income and lack of coverage, got a Medicaid card and people got what they needed. And that case the special emergency program went on for six months, there were early calls for the use of Medicaid again, the creation of an emergency authority and the statute. Medicaid is a wonderfully flexible statute despite it's bad rap, it's a wonderfully flexible statute and the perception was, "Look, this is a statute, we can literally build in an emergency care provision, put 100 percent financing down into the region so that these total destroyed economies don't have to worry about coming up with a non-federal share." And get the engine started again, get people a year's worth of coverage, two years worth of coverage, whatever it might take to get people up and going, and as the state is able to recover, it's state's share would go up to support this.

And of course, as Bob pointed out, you could have done the same thing by pushing and extra hundred million dollars in money through the health interest program, through existing statutes relating to facility capitalization and loan guarantees, FHA, and other statutory authorities done the same thing. Absolute opposition did it in.

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Now what I've just recited is not rocket science, we know how to build healthcare systems, we've done it very well all over the United States. We know what it took here and it was the opposition to the rebuilding that stopped everybody dead in their tracks. The other thing that came very clear in the opposition was it was not just, it was not just spending of the money, it was the vision of what the healthcare system would look like. The community that was hit, I'm a firm believer as somebody who's done federal policy work almost all of my professional career, I am a firm believer that issues relating to healthcare are totally local. There are many things that have to be set or established as national standards, but some of the most vital decisions about healthcare looks are totally local. And what has become evident is that there's more than money going on here. There's also ideology. There is an ideological overlay on the question of how big the role of government should be in healthcare itself. Should everybody just get a voucher to operate and anatomized world, go by individual insurance policy with high deductibles and high cost sharing, and go try and buy care from whoever might be available, which is pretty much nobody if you're trying to jump start the existence of a system. Or, should the government officially intervene in the rebuilding of charity, the reinvigoration of a community primary care

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network, the supply of medical personnel to jumpstart a problem.

We have perfected in the United States the notion that somehow you can use government in an emergency as long as the emergency period is kept until about 30 days and the workers are brought in from all over the country so they can't stay there. They're deployed for short periods of time and then go home. The notion that government would have an ongoing duty to help a community figure out how to rebuild a health system in it's vision, has frankly not be on the table. And so, in finding the will to not ever have to live through a repeat of Katrina, or, God willing, change the course of government response even now, I think we have to think at both levels, one is the resources and the other is the relationship of government to communities.

[Applause]

GARY COLANGELO, D.D.S.: Thank you Sara. Now it's your turn. We've laid out issues, problems, suggestions, I think my feelings at this point is we are on that precipice, it wouldn't take much in this country to have another disaster, bio-terrorism, pandemic flow, water, whatever. But even greater than that issue, are the underlying causes for the dysfunction that we see when there is an incident within our society. So, as I said, now it's your turn. So are there questions,

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comments, that you would have on the remarks of our panelists. We're being recorded, so I will repeat your question, we don't have a portable microphone, so I'll repeat your question, so we can make sure we record it. Heather? Well, you can use one of these microphones.

HEATHER: Thank you all for doing the presentation and articulating so well the issues that I think are innate to us and to help us starting to problem solve. I just have a comment, I loved your articulation of the components for social justice and to appreciate [inaudible] in those communities and to hope for economic viability and help for accomplishing anything. So many times I get very angry when I think about the fact that we have war on terrorism and when the war on poverty was instituted on the Johnson administration that that got abducted by the money, the resources that should have been available to deal with the problems and it was recognized as a need, somehow got through to two other wars that this action were destructed by a fatal cause overall. I want us to relate for, emphasis again, that war on poverty, look at some of the programs that were there. Yes, there were some problems, but [inaudible] and most federal programs at some levels, but using that framework was really start to grapple with, stop putting mandates on problems as they rise and really look at the poverty that really, I think, is integral and pervasive, and is

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more destructive than simply other wars that we, that we talk about [inaudible]. It’s not under the physical attack of people [inaudible], the physical death is an emotional and mental death that is perpetuated when people have to be silent in poverty. And so I would ask us to look at some of those programs that were so important that could possibly make a difference. And look at people outside of that [inaudible].

GLORIA WILDER-BRATHWAITE, M.D., M.P.H.: Well thank you, thank you so much for saying that. I’ve got to tell you guys, everybody who knows me knows I say this all the time, I’m just a street doctor. I take care of folks in mobile units and homeless shelters or whatever it is like that, but I think all of us who are on the ground all the time, we do place band-aids constantly. Decades and decades, layers and layers of band-aids and I get frustrated by programs, because programs alone don’t solve the problem and neither does when the healthcare community only talks about health. I think the challenge for us in the healthcare community, and on this community is to talk about social justice. I’ll ring that bell as many times as I have to but I think we do have a special place in this country, we are a privileged class where when physicians, and nurse practitioners, and physicians assistants, all the other providers in health, when we speak out people listen. When we write and we publish and we put into our journals the impacts

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of health on society, folks start to listen. When we sit on the Today Show and we talk about heart disease and all those types of things, I want us to connect all the dots for the rest of the citizens of our country so that they realize why we see some of the numbers that we see in health.

The other thing that I would remind us is when we talk about primary care, we have to include oral health care and mental health care. That's primary care like that, and one of the most destructive things that I saw is when folks were putting up tents and providing services, all the services were in these silos. I thought one of the funniest things that I saw was, I went to a FEMA camp and there is women with their children in these tiny little FEMA trailers and things, and elderly folks, and they did not have, it's all in mud, so there's little planks of wood in between the trailers, but hundreds and hundreds of trailers, and the kids, kids want to play, and we, we, us, we would not allow tents to be built. Because the feeling was that if you made it too much of a community, people wouldn't leave. Right. People in public housing with some of the seniors who had been in public housing for thirty or forty years, and had been in the same apartment, paying rent, may not have been a lot, maybe 50 dollars a month, 70 dollars a month, but they paid it. They were not allowed to sign up for their housing. They were told that they would have

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to reapply with everybody else, instead of saying, "I want my apartment back, let me sign, I'm here, so that I can get back." That's healthcare right there. And it is this feeling that pervaded that, and some of our public officials came out and said very publicly, "We want to help everybody, but we don't believe that anybody should improve their status in life as a result of the aid that we will be providing." It shocked me.

So you are to say to me, if I'm HIV positive and I have not been able to get my medicines prior to Katrina, that I have no right to get them post-Katrina if that is an improvement of my condition. That's not what we guarantee. And I just think that more of us in our positions of safety and comfort and who every once in a while get to stand in front of a microphone and things, and who can write, and who can publish, and who folks read, I think we need to stop pussyfooting around, as we used to say in Brooklyn, New York and just call it what it is. Now we've got real social issues in our country and it is those of us who sit in the middle and don't speak that are allowing the conditions to continue.

GARY COLANGELO, D.D.S.: Yes.

CINDY: Good morning. Thank you all. I'm Cindy [inaudible] with the American Academy of Pediatrics and I think a lot of the problems that you describe are really crystallized in pediatrics for a number of reasons. First, you have a

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highly vulnerable population. Second, children need their medical home, they need preventive care and well child visits and immunizations, but as Dr. Rosenbaum here explained, most of the financing isn't coming right down for things like medication and health centers, it's coming through Medicare. And our pediatricians don't treat Medicare patients, so what scanty aide there is, isn't coming to children's hospitals, pediatric offices, to pediatric specialty clinics. And in talking to our numbers down on the Gulf Coast, I am very afraid that we are about to see a second wave of an exodus in providers because they held on now for almost two years and things are not improving. They're not getting better, they're not getting any help. They've got tens of tens of thousands of dollars in SDA loans, student loans for their families or whatever to help their practices back up, some patients are back, but not nearly what they had before this to support their practice and I'm struggling on behalf of the AAP to figure out what kind of aide we can either direct them towards, or try and persuade the federal government to provide to keep this crucial segment of the healthcare system functioning at least at the most basic level on the Gulf Coast. So if you have any insights on the issue, I would love to hear them.

SARA ROSENBAUM, J.D.: You raise a, it's such an enormous issue and again, it underscores the systemic nature of

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the problem, if the practices move away, they're going to move away for everybody. And so it doesn't matter that you might be in somewhat better shape in your recovery than neighbors ten miles away. What would make great, first of all, another aspect of your remarks also brings out an important point, it's one thing to have 20 percent of the population uninsured and underserved when you have say 600 thousand people, that's terrible, but the numbers sort of overcome the proportion uninsured. When you've now lost what they lost, half or more of the population, you can't afford to have anybody uninsured, there's no more room for 20 percent of the population to be uninsured because now were into critical mass. Now there's either a market for healthcare, or there's not a market for healthcare. And that's why the absolute critical thing is to make sure that every child left, in Louisiana, obviously has a way to pay for the care that is needed and the obvious thing, of course, for the payer to do is to pay essentially an enhanced charge. Because the enhanced charge would allow the repayment of the loans, the rebuilding of services, the bringing back of associates, if an office visit were normally a hundred dollars or so, for some period of time, you pay a hundred and fifty dollars for the visit and make sure everybody can pay, and sooner or later we have essentially pushed enough resources back into the hands of the practitioners to be able

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to reestablish their practice and with a stronger practice, along with other basic services of the type that Dr. Gloria outlined, you'd be begin to have all the anchors of society to bring people back.

But if we're not willing to invest in the anchors that stayed behind, and we so busy talking about the emergency workers who went down there for a few weeks at a time and went home then we've missed the whole point of what it means to have an emergency. The emergency is to keep the infrastructure that has somehow survived and it's, it of course, you just have to, you're breath is taken away, it's another version of the same remark that you made, Dr. Gloria, which is that somehow you can't put tents up where the trailers are because you might make a society. You can't give people an overage on their charges a couple of years to let them get back on their feet because somehow this would make them dependent on government financing. This kind of use of overage on charges is how this healthcare system has built itself, it's why we have graduate medical education. It's why we have capital repayment. It's how we, during World War II, how the farmer's home administration helped rural areas build a healthcare system and it's such an obvious sort of turnkey engine issue and you are just stopped dead in your tracks when the response is, "Well, we can't do those things anymore."

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I was struck the other night during the interminable Oscar show, which we watched two-thirds of, actually by thing that, of course, Vice President Gore said in accepting his award, and he said it in the film as well, which is that, "Will is a renewable resource and we've just absolutely lost it in this country." and that's the saddest part of all.

ROBERT PHILLIPS, M.D., M.S.P.H.: If I can follow up on that, Sara, since you know the flex points in public policy law, if you can't increase the political will in terms of subsidizing the population and using payments to stroke the engine and payments to overages to keep the infrastructure in tact, is there an opportunity to expand subsidies for the providers, subsidies for the infrastructure. Can you expand the national health service core for three years and create a special subsidy loan for loan repayment for infrastructure support, could you, are there other flex points—

SARA ROSENBAUM, J.D.: Sure.

ROBERT PHILLIPS, M.D., M.S.P.H.: —to support those providers.

SARA ROSENBAUM, J.D.: One of the things that you, borrowing from a model tried in Wisconsin, Marshfield Clinic, how many of you are familiar with, maybe even somebody here worked in the Marshfield Clinic. Big, rurally based, sort of wonderful health system that has some brick and mortar but also

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affiliated practice sites that are private practice sites that are affiliated with the clinic. So, a really innovative way to deal with the entire primary care infrastructure, would have been to declare the whole state a federally qualified health center. Okay. Pop capital into every practice site is a contractual site, have a home, and that’s how Marshfield works. Marshfield does not have a brick and mortar health center, instead the 330 grant actually goes to the Marshfield intermediary, which then uses it’s money to help lower income families enroll with their medical care home in their community. They may come to the main clinic, they may see a doctor, obviously in his or her own office which is under contract to the clinic, but essentially it’s one giant federally qualified health center. If you had done that, so you pumped grant money in for uninsured patients and capital improvements and then given everybody in that a Medicaid card without enhanced payment rate. It would have stabilized the whole region and it could have been done probably within a year. It would have taken a while to pass the legislation and then push the money out, and you obviously could set some value, your sun set on it and then come back with an interim report and revisit whether you need to keep going for a while more. It would have been cheap. We’re talking really about a few billion dollars. This is not monstrous levels of

investment here. It's enough so that the handful of children, relatively speaking, or adults, who are left, compared to what was, become able to buy healthcare and hold the system in place.

GARY COLANGELO, D.D.S.: Yes, Eileen.

EILEEN: Hi, I'm Eileen, I'm a [inaudible] nurse practitioner. I didn't actually know that [inaudible] extended their Medicaid to a group that needed it, and I wondered what happened in March when things ran out?

SARA ROSENBAUM, J.D.: Interesting question. Actually I wrote an article in Jamma [misspelled?] about the New York experiment at the time that congress was considering doing something like this for the Gulf Coast, and then threw in the towel. What people found, and again, of course New York is so different in it's tragedy from this in terms of the, both the affect of the tragedy on the displacement of families. Families weren't displaced in the same way, they were terribly injured but they weren't so much displaced, and they were able, because families remained in the region they were able to reestablish jobs, some of them recovered their employee benefits. New York has a serious uninsured problem, so when the temporary coverage ran out there were people who'd had coverage for some time who didn't have it anymore, but what the coverage did do was let everybody deal, for some period of

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time, with the aftermath, particularly the mental health problems, and other healthcare needs that arose as a result of the attacks and it's not as if things were perfect when the benefits ran out and there were a lot of people who would have liked to have kept the full coverage under liberalized rules, obviously, in place, including me, but the important thing about it was, it was compared to, again, deploying some doctors from one part of the country to another for a few days. It was a way to let the system to begin to get hold of itself.

FEMALE SPEAKER: [Inaudible]

SARA ROSENBAUM, J.D.: I think now, well, I would say now in some ways, and I say this in some goods ways, the countries appreciation of the healthcare crisis is once again reaching the point where we may not even need the horror of Katrina to get the next couple of congresses maybe to start dealing. I think everybody understands the points that have been made up here, which is that we are very close to, anything can push a whole region like this into a health system crisis and we're going to start seeing, I believe, because if you look at the numbers you can't help but reach this conclusion, we're going to see whole regions of the country where the uninsured numbers are so high that even though it doesn't happen in one cataclysmic event, you just can't hold a health system anymore. Because there's not enough paying customers any longer to make

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specialization possible, to make a well funded primary care system possible. So whether it's revisited in the form of emergency aide until the Gulf Coast, or just broader stabilizing reform, I don't know.

I do think that one of the things that we are endanger of again, in health reform, is that we will be limited in our discussion to coverage. And I think that for those of us who really focus on systemic needs, we have to act as reminders that you can't just insure people. You can use insurance to help push a system forward, but when you make an investment in healthcare for people, it has to be in the infrastructure investments needed to jumpstart the improvement and then you come back behind with the financing.

GARY COLANGELO, D.D.S.: Yes.

OSHANK QUIMAR: Hi, my name is Oshank Quimar [misspelled?], [inaudible] and I was saying that what happened in Louisiana just highlight of failure, the whole system failure and they're still not doing the right thing [inaudible] of staffers and everything, everybody be concerned and moved, or maybe think about providing [inaudible] and what I would like you to tell us, what would you like to see happen [inaudible].

SARA ROSENBAUM, J.D.: Well, I think as Bob has pointed out, it's never too late. You could introduce legislation that

would include, especially this year when the health center legislation in the core being considered for reauthorization. You could certainly reauthorize them to include a special provision that for the next five years, will pump a vast overage of both core scholarship and loan repayment funds and health center money into the Gulf Coast. And that combined with, I think, a more, a broader view of how the states Medicaid demonstration in, Louisiana's Medicaid demonstration unfolds, it probably would be helpful. I know the state has been negotiating with the administration about it's Medicaid demonstration and what you want to do is align demonstration with your, with efforts to make primary care investments.

FEMALE SPEAKER: [Inaudible] again, even though we're focused here on primary healthcare, I think we cannot forget the other components that are so critical for families to get back to New Orleans, to reestablish their housing, now that the conundrum right now relative to the funding that's been at the critical level, billions of dollars that have been focused on given to the state relief to develop and help homeowners reestablish themselves, that's not really been done very efficiently or very effectively and so, somehow, there has to be some special mechanism in that legislation or somehow that families can access resources like the FEMA trailers. They were there but they weren't being used or given to the people

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who needed them. There's got to be less bureaucracy, but oversight yes, of how things get distributed to the people at the ground level who need it to reestablish their lives. So, providing health infrastructure I think is very important, but unless we get people back into their homes and there is [inaudible] healthy environmental help, molds, etc., getting people there is just not, again, another band-aid. It's got to be a more comprehensive focus to meet all, or at least most of those needs if we're going to improve the overall health of the people.

ROBERT PHILLIPS, M.D., M.S.P.H.: Can I answer a question real quick, I want to focus on the levees again for a minute, one of them is that it has to do with residency training. We know residency training is probably the most, highest return on investment in terms of building a workforce for a local area. When you train people, they tend to stay within two hundred, three hundred miles of where they trained, particularly in primary care training, and when you just lost a lot of the GME support, the residency training support by cutting the beds in half. One of the perverse things that happened after Katrina is that the residents and the residency directors moved in the community and were providing care out in the community, but there was need to pull them back into the hospitals because it was only when they did work in the

hospitals that funding flowed to the hospitals for their training, and they needed it to care for people in the emergency rooms. But it completely disrupted a social contract, an emergency response, of that residency training. Which I think speaks to the larger issue of residents training out in the community, because if we can create flexibility in the GME funding streams, whether that's on the Medicaid side, or the Medicare side, if we can really support moving residents out to train in communities where they work with those populations and learn that that's a place that they might want to build their career, that's a very good use of that funding. And right now we don't have the kind of flexibility we need for GME funding and in fact, I know that the Medicaid funding for residency training has just been threatened, they've just talked about completely cutting it off. So, we're poised to do a lot of damage to the residency training pipeline, when we really should be focusing on how that pipeline can support communities like Jefferson Parish, or New Orleans Parish.

GARY COLANGELO, D.D.S.: Yes.

RENEE HART: Thank you. Renee Hart, [inaudible]. I actually have two questions, one was for Professor Rosenbaum, when you were talking about your remarks and everything, you're mostly referring to the federal governments, and I think the issue at hand is that this administration really believes in

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states rights so they're looking to the states to deal with a lot of its work and it sounds like your probably saying that this is beyond the state's ability to take care of this healthcare crisis that's going on in that region. And to Dr. Phillips, I'm glad you kind of ended up with what you were saying because located in that same vein, as far as increasing graduate medical education funding, do you also think we're at the point where maybe we should have some sort of funding that physicians who are first graduating now, to be able to come into [inaudible] and get some sort of subsidy to stay there and practice for two, three, four years and some way to pay down there loans and things like that, do you think we're at that point that that will help the situation?

SARA ROSENBAUM, J.D.: I was definitely saying that the precise shaping of a solution needs to be at a community level, but what government can do, whether it's for healthcare or housing relocation and recovery, or whatever, what federal government can do, is push money and loan backing down. That's really what we're very good at, and you want to be sure as you shape the terms and conditions of financing, whether it's for health or healthcare, that you are building in enough flexibility so that the community can then begin to adapt the solution to it's own needs. If they wants to rebuild Charity Hospital, it should be able to do that, if they decide that

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they don't need a scale down in patient facility with a whole cluster of outpatients, that they're going to use whatever inpatient is available and just bill that patient, that's fine, but it should be their choice.

ROBERT PHILLIPS, M.D., M.S.P.H.: In terms of the subsidies, yes. The issue that Sara brought up earlier about healthcares as an economic engine, not just an economic engine for the community, but an economic engine for support of the infrastructure in the healthcare system, giving subsidize, loan repayment, creating a way that physicians, especially those coming out of training, who already have the passion and want to work with that community, to allow them to build and build in a way that doesn't put them in financial jeopardy for the next decade, would be very nice. Allowing those primary care trainees who are coming out, and we've got to build that pipeline back up, because it just, twenty percent of it's gone, and it's been lost for the last decade. But if you could also tell them, "And when you come out, we're going to subsidize your practice, we're going to give you tax incentives, we're going incorporate you in a statewide FQHC", but something to shore up that infrastructure would be amazingly helpful in specific, specific to the area and getting people to relocate or come back.

GARY COLANGELO, D.D.S.: Yes.

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FEMALE SPEAKER: [Inaudible] needing to subsidize, I agree with that because I think that the physicians are, physicians alone can't provide the health system that's needed, and so we have to, and I'm thinking really brought it in terms of how do we get the workforce that we need into the area, and I think that there's, it's much more complicated then if I could just look at subsidies for physicians, and I think we may need those kind—

SARA ROSENBAUM, J.D.: Well the point that you raise, which I think would be at the, actually, if I were going to set any conditions for any of the Gulf Coast states on a much broaden day package, one of the issues is an overhaul of their licensure laws, their scope of practice acts, you want to absolutely make it possible for every potentially qualified professional who can furnish care of any kind at any level to be able to relocate into the state and establish a good practice. And I, of course, don't, it's been years and years since I looked at the practice acts in the Gulf Coast regions states, I used to do a lot of practice act work, but it's a very interesting issue because it brings up the question of whether these acts are antiquated and need to be overhauled.

ROBERT PHILLIPS, M.D., M.S.P.H.: Gene, I am what I am, so I apologize. [Laughter] We need, the other thing is that the environment that we live in right now, the states are

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spending billions of dollars to expand medical schools right now, build new ones or expand them. When that's probably the place we have the least return on our investment, in terms of the local workforce. Opportunities to build out residencies and then to subsidize practice location, probably has a much higher return on investments, so that's where my head is. We need healthcare teams to relocate. We need teams that include many people, but particularly mental health providers, within the primary care context, we need to be able to put teams into the communities that can take care of all the healthcare needs, because we know that is the only medical solution to helping reduce disparities brought by social disparities. So, we need effective teams to locate.

GLORIA WILDER-BRATHWAITE, M.D., M.P.H.: I want to say one thing that hasn't been brought up yet, and this is about our role in the larger kind of global concerns about poverty and healthcare disparity. One of the things that I said in a forum in New Orleans and then again a town hall meeting in Houston, is that we need to call on the international community to monitor what our countries is doing with this recovery effort. We also need to apply for foreign aide for New Orleans, and the lower ninth ward, and some parts of Mississippi Gulf Region. We need to call on the UN to hold a session on the impact of US poverty and it's effects on global

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poverty. When we start to do those things, we start to awaken in our country the reality that we are part of a world. That we don't live in silos, that it's not just about whether the United States is healthy, but honestly, the health of our nation affects the rest of the world. And we do currently provide the rest of the world with some of the most highly trained doctors, nurses, nurse practitioners, physicians assistants, healthcare providers in the world. Right? A lot of folks who train here don't stay here. And that's a beautiful thing, that folks get to come and have some training. But when our system begins to fail, it affects the rest of the world and I hope that we will see ourselves in our true role as global citizens and call on foreign aide and ask for international monitors to come and report on how we are rebuilding our US healthcare system.

GARY COLANGELO, D.D.S.: Any other questions or comments? Yes. We have one more, yes?

MALE SPEAKER: [Inaudible] I really appreciate this panel this morning, although I must admit that it's reawakened in me both a sense of despair as well as a energy to do something. What we really, what I really learned, a lesson learned to take away from this, is that I asked myself whether or not what really needs to be done in New Orleans is to rebuild what was there to begin with, or to take advantage of

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this disaster and build something new out of the ashes, if you will, or whether the third option, which is more likely is going to take place, which is we are going to do neither of this. We are not going to have the wherewithal, or the resources to build something new, we're not even going to have the wherewithal and resources to rebuild what we had, and so we're essentially going to ignore mostly what's taking place in New Orleans and let it dissolve out of our consciousness. And recognition for me reminds me that if we had a functional system to begin with, part of that functional system would be the ability to repair itself and renew itself. Lacking that it just reminds me, once again, that we didn't have a functional system to begin with. New Orleans is a perfect example of the fact that we had providers there, we had stuff going on and when you wipe out the providers and the safety net, there is no system to rebuild whatsoever. And that's a lesson for the rest of us to learn in other communities. We have some other disasters in some other communities and we need to remind ourselves that there is no functional system to rebuild and that's a huge challenge for us.

GARY COLANGELO, D.D.S.: I think that articulates the challenge for all of us, although I have in my way of thinking an optimistic outlook because we have people like Dr. Gloria and Bob and Sara, who are not only thinking the right thoughts,

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but are taking the action to, in their own way, to push the change, and I think that's the challenge for all of us in this room.

I want to thank you all for joining us this morning and I hope that you were inspired, I hope that you learned a little bit, but I think the most important thing is that you will do something once you leave this room.

Thank you very much.

[Applause]

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