[Music]

Mark Masselli: This is Conversations on Healthcare, I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well, Margaret, we are seeing yet another devastating storm of epic proportions. We haven't even begun to adequately assess the damage of Hurricane Harvey on Texas. And now a week later, we are watching a powerful category five hurricane plow through the Caribbean and the track of the storm that heads straight for Florida and points north.

Margaret Flinter: Well, we are concerned about the effects of such storms on the U.S. we also keep in mind the smaller countries who are far more vulnerable in many respects and will be dealing with the aftermath for years to come.

Mark Masselli: The kind of coordination required with these two back to back storms is impossible to calculate and the health impacts could be enormous.

Margaret Flinter: Well, relief agencies are already stretched the capacity, this new assault on Florida and the East Coast will tax the system and the people who staff them even further as regions brace for the worst. And that brings us to our guest today, Dr. Rebekah Gee is the Secretary of the Louisiana Department of Health.

Mark Masselli: Dr. Gee is a real leader and I am looking forward to that conversation, and she will be talking about lessons learned from Hurricane Katrina as well as subsequent weather events, and how that has helped them plan a storm preparedness protocol that other states might learn from, really looking forward to this timely conversation, Margaret.

Margaret Flinter: And Lori Robertson will be stopping by, the Managing Editor of FactCheck.org.

Mark Masselli: But no matter what the topic, you can hear all of our shows by going to www.chcradio.com. And as always if you have comments, please e-mail us at chcradio@chc1.com or find us on Facebook or Twitter, we love hearing from you.

Margaret Flinter: We'll get to our interview with Dr. Rebekah Gee in just a moment.

Mark Masselli: But first, here is our producer Marianne O'Hare with this week's Headline News.

[Music]

Marianne O'Hare: I am Marianne O'Hare with these Healthcare Headlines. The Senate Health Committee undergoing two days of hearings on Next Steps for Health Reform, several other nation's insurance commissioners and several governors testifying before the bipartisan committee on ways to stabilize the insurance marketplaces. It has been a nascent effort at seeking some bipartisan solutions to the health reform conundrum. Many of those testifying asking for Congress to automatically boast through the cost sharing subsidies which allow insurers to keep premium prices and out-of-pocket costs lower for consumers purchasing insurance on the exchanges. Tennessee Insurance Commissioner Julie McPeak telling the committee the cost sharing reduction payments are not handouts to insurance companies, there are important cost control measures and market stabilizers. The Trump Administration has cut funding for advertising for the insurance marketplaces by 90% over the last year's budget and has shortened the enrollment period in half. There is little time for the Senate to act and it's uncertain if they will in time. The state insurance commissioners have until the end of the month to separates for next year.

It's a known fact when it comes to mental health services many Americans are accustomed to going without or long wait times to see a behavioral specialist, and if you are getting your insurance on the insurance marketplaces, you are having an even tougher time. Apparently, according to an in-depth investigation by Health Affairs the statistics aren't good, on average exchange plans cover just 11% of mental health providers in their states more than half of psychiatrists aren't part of a single exchange plan. And among mental health providers who aren't doctors less than 20% were part of any plans network. I am Marianne O'Hare with these Healthcare Headlines.

[Music]

Mark Masselli: We are speaking today with Dr. Rebekah Gee, the Secretary of Louisiana Department of Health which oversees the State's Public Health Initiatives as well as Medicaid. Dr. Gee is also a practicing obstetrician, gynecologist, having served as Director of the State's Birth Outcomes. She earned her Master's in Public Health from Columbia University, her Medical Degree from Cornell and did her residency at Brigham and Women's Hospital in Boston. Dr. Gee, welcome back to Conversations on Healthcare.

Dr. Rebekah Gee: Thank you, Mark.

Mark Masselli: Well, first of all, we are so pleased to see that Louisiana seems to be out of the direct path of Hurricane Irma and was spared the worst of Hurricane Harvey, but you have some significant experience with the effects of massive storm, with Hurricane Katrina never far from mind, and more recently the 2016 storm that really deluged the Baton Rouge area. And I am wondering if you could share with our listeners, what are the public health steps that you've taken

and what has your state done that other states should learn from in preparing for these incredibly potent storms?

Dr. Rebekah Gee: Sure. Well, Mark, for those who live through Hurricane Katrina, their lives will always be punctuated by before the storm and after the storm. You know there were many mistakes made, some of them were just because no city of that size had endured a hurricane disaster of that proportion. 25,000 individuals had to be evacuated post storm, almost 2,000 people lost their lives. Since then what we have done is a number of things, first and foremost, developed a network. In Katrina, there was a lot of communication going in different directions, but there was not the ability to confirm, there was not an ability to coordinate, we didn't have a disaster response network. We now do. We have a central command. I have what we call our EOC Operations Center where we coordinate all of the healthcare activities for the State. We are able to far and advance of the storm assist facilities with evacuation plans, make sure that they have their generators, what they need to weather the storm or to leave for the storm, we are able to coordinate. And we also focus on pre-storm evacuation. So prior to Katrina, folks hadn't experienced that level of devastation, take the evacuation orders as seriously now. We really insisted everyone leave and we have a very robust medical institution evacuation plans that includes making sure that every facility has the ability to evacuate. So we now have Medical Special Needs Shelters.

So prior to the storm, we would have medical staff that would show up and assist in the general shelters so what we learned was that you have a lot of vulnerable individuals those who are getting common community based services, some of them need a higher level of care, a nurse to care for them during the day and so we setup Special Needs Shelters. We have a mega-shelter now in Alexandria and we also one in Baton Rouge that we can setup and maintain and staff. And so we now plan for that. We also have people who are assigned to sheltering duties, assigned to medically fragile. And we also finally have a much more robust command of the data. We use our data to know where people are on before the storm who are fragile, we make sure that they have an evacuation plan, we have a much better handle on where people are.

Margaret Flinter: Well, Dr. Gee, we have issues related to people having gone without prescriptions, we cannot ignore the mental health issues. Maybe you could talk with us a little bit about what health issues you expect will affect the victims of Hurricane Harvey, and how are State Health Departments helping each other really rise to the challenges that we think we're obviously going to be seeing more of?

Dr. Rebekah Gee: So I just got off the phone my Secretary Philip, Florida's Department of Health, and we spoke about the need to help each other out because unfortunately with the climate changing in our globe, we expect these events to happen. We have to expect that these things may happen with more

regularity and unfortunately on the coasts, we are all in the same boat. We were very fortunate with Harvey that the storm did not hit Louisiana so we were in a very good position to help our brothers and sisters in neighboring Texas. Around 95% of the people who came into our shelters are Texas residents and we had about 1,900 Texas residents in Alexandria, 60 of those with medical needs. So when we look at folks the most common thing that happens and we saw this in the flooding in the Baton Rouge area last August is that individuals leave quickly, they leave without their prescriptions, without durable medical equipment and so we have now plans in place to make sure that they are able to resale their prescriptions even if they are not due. And we workout the ability to cross state lines in terms of providing medical care. So those things are fairly seamless. Unfortunately, we get to dust off these plans a little bit more regularly than we would like.

Mark Masselli: You know, I am wondering is really the sort of this focusing on providing health services and have you seen any technology assisters out there that might be helpful to managing populations and keeping track of them as anything new in terms of technology that might also give some assistance in disasters like Hurricane Harvey?

Dr. Rebekah Gee: Sure. So we've seen significant advances in healthcare technology and purely with record keeping because the most important thing in a storm is knowing where your vulnerable population is and having confirmation of whether they have been able to evacuate. So we now have a single point of entry to report medical assets and also to report medical needs. We have a registry that identifies where every vulnerable individual is in areas that are high risks. And so the advances in IT structure with the single data point of entry allow us to know where people are, what their needs are. And it also allows hospitals to report their capacities whether their generators are up and running, how many beds are filled with that particular hospital so that we can plan in the condition of an evacuation, grant management system, post-storm so that we know where the moneys are coming in and how to distribute them. So we are much more prepared from a data standpoint.

Margaret Flinter: Dr. Gee, we had former Louisiana Health Official, Dr. Karen DeSalvo on this show, she talked about one the casualties of Katrina and how the state rebounded from what was the loss of certainly millions of paper and health records, and says that it [inaudible 00:09:54] dramatic shift in your state to the use of electronic health records. And others talked about the impetus that Katrina gave to really developing a more robust primary care system really implementing a stronger primary care structure. I mean if you like to share with us a little bit about some of the progress in that area that your state undertook.

Dr. Rebekah Gee: So in the wake of Katrina, we developed new and robust primary care facilities in the New Orleans area and I think more importantly was the decision that Governor Edwards made which is to expand Medicaid. Here in

Louisiana, we have a large number of working poor folks who one of four of them were uninsured, no way to access primary care except for if they went to charity facility or an emergency room. Now nearly 440,000 adults many for the first time in their live have access to primary care and we know that over a 100,000 of them have received preventive health services, tens of thousands have gotten colonoscopy, 19,000 women have gotten diagnostic breast imaging, 3,000 adults being treated for diabetes, over 30,000 were treated for depression or mental illness and that's something that we realize post-storm when they have lose their home, lose everything they have worked for. That sometimes potentiates mental illness and stress and so having a whole system of care where they have insurance, can go to a federally qualified health center, have a medical home and has been a real [inaudible 00:11:19] for Louisiana.

Mark Masselli: We are speaking today with Dr. Rebekah Gee, the Secretary of the Louisiana Department of Health which oversees the State's Public Health Initiative. Dr. Gee, another storm is brewing in the arena of health policy in this country. We watched just the congressional leaders and the White House attempted to repeal and replace the Affordable Care Act, other backing session looking hopefully for a new approach. I am wondering what your thoughts about that and as you mentioned Governor Edwards really stands out as a real leader in making the expansion you talked about. Tell us about the state's infrastructure to manage 400,000, what strains have that have put on the system?

Dr. Rebekah Gee: So we have had actually very excellent results in terms of primary care visits in the first year and half of our program. We've made sure that our managed care companies assign every members to a primary care practitioner. We've done education and to make sure that people know that they have an opportunity to receive primary care. We are in the middle of working on a system of care we designed that focused on primary care, we are looking at hospital rates and things that would potentiate our ability to incentivize primary care including looking at Accountable Care models. On the legislative front, I do think this is a good time for bipartisanship. We are seeing that the federal overhaul legislation has failed, we have seen the 11 governors including my own John Bel Edwards who assigned bipartisan letter talking about the fundamental principles for health reform. And I am very optimistic that that the bipartisan spirit will continue. What we've seen out of the federal proposals so far is very disappointing, what they don't address are the fundamental drivers of cost what I see as the biggest challenge is the overall cost of care. We spend double what other countries that are developed spend on healthcare and we don't have as good as the outcome, we have poor diabetes, and we have poor obesity numbers and our behavioral health problems are more robust.

So we are failing to deliver prevention care and we are failing to deliver health so we need to deal with some of the fundamental cost drivers. One of the major ones is pharmaceutical cost who right now the taxpayer has to shoulder the burden of whatever pharmaceutical industry wants to charge for their drugs, that

results frankly in lack of treatment and/or higher cost to the healthcare system, and because these pharmaceutical prices are just so high. So we are addressing that, we are working with the National Governors Association on some works that would lead to some different proposals. For some of these drugs that are really common, a good example is Hepatitis C where you have in our state 70,000 people with Hepatitis C and in the Medicaid program, we only treated 320 of them last year. People also spend a lot of money at the end of life and for care that they might not even want. People tend to want to die at home, but we do all sorts of very intensive things to them at the end of their life. And so what we really need is the very robust discussion about what we can do to get the cost of healthcare down. What happened in the Congress this year was a really discussion about block granting and other mechanisms that would fundamentally result in decreased coverage and then millions of people losing their healthcare. Let's focus on the things that will bring greater value to this discussion like how do you cover these people and cover them at a lower cost, how do you promote healthy behaviors, and so those are all really important discussions that I really look forward to having over the upcoming year.

Margaret Flinter: I want to look at something that I think has been a success and cause for optimism in Louisiana and that's the very successful public health initiative that you've overseen as Director of the Birth Outcomes Initiative with a goal to decrease infant mortality rates statewide, and we would be really interested in hearing from you on some of the strategy and tactics that you deploy to address birth outcomes.

Dr. Rebekah Gee: I am an obstetrician and continue to see patients and so I would have to come up with some things that would the state out of the 50th grade that we got and save baby's life, and to help deal with health disparities and help deal with infant mortality. So we sat on a very strategic course for things that would work to reduce prematurity and to reduce infant mortality or the number of babies who die before year one. And we said about statewide by educating hospitals, nurses, primary care clinics about what they could do, we spearheaded healthy babies are worth a weight along with the March of Dimes which ended – effectively ended the practice of elective inductions before 39 weeks in Louisiana. We have worked on getting women progesterone, women who are high risk who have had a preterm baby before we were doing horrible at that. We have quadrupled the number of women who get progesterone. We also focused on women would have be healthy going into the pregnancy and the women would time their pregnancies for when they were ready. We had a 25% drop in infant mortality in Louisiana last year that is much higher than the national average of 15% drop over that time.

Margaret Flinter: Yeah congratulations.

Dr. Rebekah Gee: We made progress. There were 92 fewer, fewer African-American babies who died if that's just the continued in that way and a 160

overall fewer babies who died during that period. So we are really proud of those results.

Mark Masselli: I know certainly the country as a whole is looking at the devastating impact that the opioid crisis has had causing so many accidental deaths in this country and that coupled with the obesity epidemic which is impacting the third of the nation's children. And I believe obesity numbers maybe somewhat higher in the south, but I wonder if you can just talk a little bit about how you are thinking about these two chronic and complex health problems and any strategies that you might have cross-walked over from the greater results that you were just discussing?

Dr. Rebekah Gee: Sure. Well, let me start with the hard one which is obesity. We are the most obese state in the nation. The number of obese people in our state I feel are [inaudible 00:17:20] over 16 times. It's also – we have also some of the best food in this country and in the world. People come here to eat our food. So this is a behavior and behaviors that's tough to change. So our well ahead program was recently awarded one of the National Awards for Best Prevention Programs of any State Health Department in the country and this designates well spots and community organizations, businesses that were like to be encouraged and recognized for healthy behaviors and promoting healthy behaviors, get a well spot designation. So that's been a great success. Another big challenge is smoking frankly, and the cost of caring for adults who smoke is tremendously high and we still need to do a better job getting smoking rates down. So in opioids we have had tremendous success with legislative session because this has come to such ahead we first started to see at a couple of years ago with increasing rates of what we called Neonatal Abstinence Syndrome. And the real crisis has really just been mounting and last year for example in East Baton Rouge we saw more overdose deaths and all motor vehicle deaths and homicide deaths combined.

And so our legislature, our medical association and our Medicaid program along with Blue Cross Blue Shield have partnered to do some very powerful things. One is that we set seven-day limit. We know that 80% of the people who are addicted to heroin start on an opioid. So part of it is just decreasing the number of people that ever get a long-term opioid prescription and have a chance to get addicted. And we also had created a 13-member advisory council in heroin and opioid prevention, we strengthened our Prescription Monitoring Program, we also made mandatory medical training for docs so that they know the impact of the opioid epidemic and have more education on addiction. You know when I went to medical school we didn't get any training on addiction, addiction treatments, you know painless that fits vital signs, which hold the treat pain. We didn't think a lot about the ramifications of our actions. We prescribed opioids. So this is a really a see change in terms of mandatory education and I think this will result in much better outcome to the people of our state.

Margaret Flinter: We have been speaking to Dr. Rebekah Gee, Secretary of the Louisiana Department of Health. You can learn more about the department's work by going to their website www.ldh.la.gov or you can follow Dr. Gee on Twitter @rebekahgeemd. Dr. Gee, thank you so much for the incredible work that you are doing and for joining us on Conversations on Healthcare today.

Dr. Rebekah Gee: Thank you Mark and Margaret.

[Music]

Mark Masselli: At Conversations on Healthcare, we want our audience to be truly in the know when it comes to the facts about healthcare reform and policy, Lori Robertson is an award-winning journalist and Managing Editor of FactCheck.org, a non-partisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. politics. Lori, what have you got for us this week?

Lori Robertson: Many readers have asked us whether the herbicide glyphosate causes cancer. The short answer is that there is evidence to suggest it may cause cancer at very high doses, but not at the low doses typically found in food. Our readers often sighted an article on www.foodbabe.com which outlines the reports that found "alarming" levels of glyphosate the most used herbicide by volume in 2015 in various brands of cereal, cookies, chips and crackers. In 2015, the International Agency for Research on Cancer did classify glyphosate as "probably carcinogenic to humans". But in 2016, a group of pesticide residue experts at WHO and the United Nation also concluded that glyphosate is "unlikely to post a carcinogenic risk to humans through their diet". Those conclusions aren't as contradictory as they seem. The 2015 conclusion aims at identifying any potential cancer hazard. But the 2016 assessment looked at actual cancer risk of the herbicide at a specific level of exposure. Using a strict standard from the European Food Safety Authority, a 175-pound adult could ingest nearly 40 mg of glyphosate a day without a risk of developing cancer. Alternatively, a child of half that weight could ingest 20 mg of glyphosate a day, how does that compare to the amount of glyphosate the report highlighted by Food Babe found in cereal and other foods. In order to max out an acceptable daily intake a 175-pound adult would have to eat more than 1,270 servings of cheerios a day. So yes, glyphosate is found in some food, but experts believe those doses of the herbicide don't pose a cancer risk to humans. There is more information about several studies on glyphosate on our website at FactCheck.org. I am Lori Robertson, FactCheck's Managing Editor.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you would like checked, email us at www.chcradio.com, we will have FactCheck.org's, Lori Robertson, check it out for you, here on Conversations on Healthcare.

[Music]

Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives. It's a known fact that the current generation of American children is more obese than any previous generation. And at a Washington D.C. Community Health Center Unity Health Care, a pediatrician was in a quandary over how to tackle this growing health scourge. He began with the unique solution targeted to a teen patient whose body mass index had already landed her in the obese category. What he did was write a prescription for getting off the bus one stop earlier on a way to school which made her walk the equivalent of one mile a day. Dr. Robert Zarr of Unity Community Health Center understood that without motivation to move more kids just might not do it. The patient complied with the prescription and has moved from the obese down to the overweight category. He then decided to expand this program by working with the D.C. Parks Department mapping out all the potential walks and play area kids have within the city's parks.

Dr. Robert Zarr: How to get their parking? Is parking available if someone is going to drive? Bike racks, there is a section on pets park safety.

Margaret Flinter: Dr. Zarr writes park prescriptions on a special prescription pad in English and Spanish with the words Rx for outdoor activity and a schedule slot to ask when and where will you play outside this week?

Dr. Robert Zarr: I like to listen and find out what it is my patients like to do and then gage the parks I prescribed based on their interests, based on the things they are willing to do.

Margaret Flinter: With some 40% of his patient population grappling with overweight or obesity, he wants to make the prescription for outdoor activity adaptable for all of his patients and adaptable for pediatricians around the country. And one day, he liked to be able to track his patients' activities in the parks. Rx for outdoor activity, partnering clinicians, park administrators, patients and families to move more yielding fitter, healthier, young people. Now, that's a bright idea.

[Music]

Margaret Flinter: This is Conversations on Healthcare, I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

Dr. Rebekah Gee – Louisiana State Health Commissioner

Conversations on Healthcare broadcast from the campus of WESU at Wesleyan University, streaming live at www.wesufm.org and brought to you by the Community Health Center.