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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well, Margaret, I know we're in hurricane season, but we're already up to N.

Margaret Flinter: Well, it is just astonishing to have this many back to back storms, Mark, and this latest storm, Hurricane Nate, hit the coast of Alabama and the good news is it was far less devastating than the previous storms to hit the U.S. and American territories this season.

Mark Masselli: The greater Houston area, Puerto Rico, and U.S. Virgin Islands were all hit by category four storms or higher complete destruction in some cases.

Margaret Flinter: Well, in Puerto Rico, we're seeing emergency evacuations of vulnerable patients to nearby hospital ships as a strategy to take care of those people. These kinds of interventions and disaster areas are all too familiar to our guest today. Michael Nyenhuis is the CEO of the nonprofit relief agency, Americares, and right now, they're on the ground in Puerto Rico, in Texas, in the Caribbean, all places that have been hard hit by the summer's hurricanes.

Mark Masselli: Really looking forward to hearing from our guest today.

Margaret Flinter: And Lori Robertson will stop by. She is the managing editor of FactCheck.org. But remember, no matter what the topic, you can hear all of our shows by going to CHCRadio.com.

Mark Masselli: And as always, if you have questions or comments, please email 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 Michael Nyenhuis in just a moment.

Mark Masselli: But first, here's our producer, Marianne O'Hare with this week's headline news.

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Marianne O'Hare: I'm Marianne O'Hare with these Healthcare Headlines. The Trump administration released rules that paved the way for broad restrictions of the Affordable Care Act's contraception mandate, allowing for exceptions based

on religious beliefs. The mandate required all employers providing insurance coverage to make birth control and other contraceptives available to all women with no copay. A number of religious institutions filed suit against the Obama administration over that mandate. Accommodations were made for such institutions to outsource providing contraceptive services, but this new angle gives much broader reach for organizations to refuse to provide the benefit. The broader scope includes nonprofit organizations, for profit colleges, and other institutes of higher learning that provide health benefits for students. The American Civil Liberties Union and spade [PH] of attorneys general around the country are vowing about legal challenges against the lifting of the contraception mandate. Advocates for women's health say this move could affect possibly millions of American women who get their coverage through their employers.

California Governor, Jerry Brown, considering a bill that would require drug companies to give the state 60 days' notice before raising the cost of a drug by more than 16%. The Drug and Price Transparency Bill would also force pharmaceutical companies to explain why the increases were necessary. In recent years, a handful of commonly prescribed drugs have seen price hikes from hundreds of times to much higher in some cases.

November 1st is opening day for open enrollment on the insurance exchanges. The Trump White House has cut the marketing budget this year by 90% and cut the length of time Americans can sign up for health coverage from three months to six weeks, due to many uncertainties being left by the current administration. There are likely going to be many insurance rate hikes and higher out of pocket costs for consumers next year.

Veteran soldier turned mental health advocate, Britain's Prince Harry, has turned his sights on mental health in the military. The Prince, who served for ten years in the military, including two tours of duty in Afghanistan, said the military establishment needs to do more to prepare soldiers for the rigors of war and the devastating toll it can take on mental health. Prince Harry, his brother, Prince William and his wife, Kate, have all made mental health a platform for their advocacy.

I'm Marianne O'Hare with these Healthcare Headlines.

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Mark Masselli: We're speaking today with Michael J. Nyenhuis, President and CEO of Americares, a nonprofit global health and relief organization offering support to over 90 countries around the world. Mr. Nyenhuis oversees a half a billion dollar budget and manages offices in multiple continents. He has an extensive background in global health, having previously served as CEO of MAP International, which provides lifesaving medicines and health supplies to people

in need. He earned his Bachelors of Arts at the University of Wisconsin, and his MBA from Emory University. Michael, welcome to Conversations on Healthcare.

Michael Nyenhuis: Thank you so much for having me.

Mark Masselli: Yeah, you know it's dizzying, the number of disasters worldwide. I'm not sure how you all manage this, but they seem to be tapping the resources of disaster relief community to its limits. And fortunately, your team in Americares is not alone in this space of delivering aid to areas grappling disasters. We've had leaders from Doctors without Borders, International Rescue Committee, and Save the Children on our show, talking about the work they do in this space. I understand Americares' primary focus is getting medical supplies and drugs to areas hard hit by disaster and war, and I'm wondering if you could share with our listeners more about your mission, the work you do around the world, and where your teams are handling some of the most critical challenges right now.

Michael Nyenhuis: Yeah, so thank you for that, and you're right, it does take a lot of different organizations with different areas of focus to sort of complement one another to get everything that needs to be done, done in a situation like a disaster. Just to broaden a little bit, sort of the sense of -- sort of the core of our mission, we're really focused on supporting local health infrastructure before disaster, in the midst of it, afterwards in recovery, and then sort of ongoing in a longer term way. We focus on local health centers, building their capacity to serve the health needs in their community. And one critical way that we do that is making sure they have access to medicines and medical supplies. So we do have a large logistical operation that distributes medicines and supplies, and then our work goes beyond that to build the capacity of these local health centers that are really the backbone of health service for people in communities of poverty or communities affected by disaster. So that's where we go. That's where we work first, right alongside the health workers and others that are manning those health centers.

Margaret Flinter: Michael, I agree with Mark, it seems logistically very daunting to meet the needs of so many communities simultaneously. And I don't ever recall something like Hurricanes Harvey, Irma, and Maria causing such devastation, along with an earthquake in Mexico, and then of course we have not natural disasters, but manmade, such as what we've just seen in Las Vegas. But we've been reading about your three pronged approach, this three pronged approach of prepare, respond, and recover as a way of addressing a variety of emerging disasters, as well as the humanitarian crises that just seem to go on and on. Maybe talk with us just a little bit more about what that prepare, respond, recovery approach is and are you using that now in the deployment of the recently hard hit areas?

Michael Nyenhuis: Yes, certainly and I'll give you maybe a real tangible example of how that might work in a disaster situation like this. So as I mentioned, we focus on and work alongside local health centers that serve people affected by these sorts of things, and then Texas, we have a network of charitable clinics that have been there before these hurricanes hit certainly and will be there afterwards. We come alongside them and make sure they get -- they can respond effectively to the disaster and then get back up on their feet. So we've been doing that. We responded with them. Many of them need recovery from the disaster and we're helping them do that. And then another part of our programing is to help them prepare for the next disaster. These are great moments for people who have been affected to think carefully about, "Do we have a good disaster plan? Do we know what we're going to do next time there's a hurricane come through? What are the steps we want to take? What are the policies, procedures we need in place?" And so we will help them do that. So it's a complete cycle. There are other places where we start with the prepare work in disaster prone areas to help health centers and communities think through how they can best be prepared and then respond. But it is a complete cycle and we're not one of those relief agencies that jumps in, does a little bit of relief work, and leaves and goes home. But we typically stay for a longer period of time to do that recovery and then bring the circle back around to preparedness.

Mark Masselli: Well, I really like the accentuation on the preparation and obviously there have been far too many opportunities of late to see what happens when an entire region is brought to its knees after a disaster. And as we look at the devastation in Puerto Rico, for instance, you realize that until the infrastructure is made functional again, it's nearly impossible to bring aid to all those affected by the hurricane, and ensuing devastation. And I wonder if you could talk with us about the ways you've managed to bring your important lifesaving medicines and medical support to these hard to reach areas. Just sort of how the logistics of that obviously require a whole team of people working together, but how do you overcome these barriers? And maybe Puerto Rico is a great example to use.

Michael Nyenhuis: Yeah, I think it is a great example. So we sent a team there immediately. Actually, we had a team in Puerto Rico before Hurricane Irma came through and Hurricane Irma hit more of the islands a little bit to the north and east of Puerto Rico. So it didn't take quite as much of a hit. And then, of course, Maria came right behind it and hit Puerto Rico really hard. So we were already stationed there and ready to go. And how we operate is to immediately go out and do assessments of health centers that have been impacted by the storm, and of course, we outfit our team with satellite phones and put in place the logistics for them to get around. With no communications on the island, they were going from place to place, health center to health center, looking for what the needs might be and were able to communicate that back to us and to other officials with satellite phones that they were using. We do a really quick

assessment and work with the Department of Health there and these health centers develop a needs list, like what do they really need in terms of medicines and supplies immediately? And then we build shipments based on that needs list. We want to make sure that we're only sending in the things that are actually called for, asked for, and needed. So we have put thousands of pounds of medicines and supplies into Puerto Rico already. We landed an airlift there over the weekend with eight tons of material on it to distribute to the centers and lined up the logistics to make that happen. But the key thing is being there early, being on the ground, having communication tools to make sure that you can communicate with the team and with the officials in the country, and then to build and use needs lists to make sure that the exact kinds of materials get where they're needed to go.

Margaret Flinter: Well, I'm imagining you have an incredible playbook for people to follow that's been developed from your years of experience. You know, I want to pick up on something you said and just ask you to talk about a little more. You referred to health centers, and my guess is you're being inclusive of all kinds of healthcare facilities, and that from free clinics to perhaps Americare clinics, to community health centers, to maybe hospitals and independent, private provider practices. Tell me what you mean by health centers, who you really reach out to and maybe you could also, if you would, just talk a little bit about -- between getting medications to a place and then dealing with the fact that the infrastructure around refrigeration and clean water is down. We've heard such stories about diabetics, people have lost their ability to refrigerate their insulin or the vaccine and immunization supply. How do you bring those health centers together to address these big issues?

Michael Nyenhuis: So just yeah, maybe a clarification on the health centers, so you're right, it could be a small health post, it could be a community clinic, it could be a hospital. We're certainly targeting those that serve the communities most in need. So our ongoing work, sort of everyday, which actually is about 80% of our work is non-disaster related, is working with those health posts, hospitals, clinics that serve communities of poverty. So that's what our mission is focused on, trying to bring good health to people who are underserved. So those are our targets, the health centers that serve that population. So even in a disaster, that's the first places we'll go, though certainly main hospitals that serve a broader population are part of that as well. And when we make our assessments, we're looking for where's the neediest place? Where's the place that's sort of been left off the grid, the place that is not getting assistance, and how can we help there the most? There are all kinds of complications, and you pointed to a couple of them, electricity, cold chain, all of that is really important. You don't want to send materials that need refrigeration to a health center that doesn't have electricity, either by regular means or a generator, until it's ready for that. So that's why we have people on the ground, why we do assessments to, again, make sure the right things are going to the right places, at the right time.

Michael Nyenhuis CEO Americares

Mark Masselli: We're speaking today with Michael Nyenhuis, President and CEO of Americares, a nonprofit global health organization. You know, I was thinking as you were talking about your real focus on populations living in poverty, that this is not just outside of the United States. But Americares has built health clinics here in the United States, really again focusing on that underserved population and it aligns with your mission statement that every person deserves access to quality care. I wonder if you could talk to us about this primary care delivery arm of Americares and its core mission and how are you providing access to primary care in underserved communities?

Michael Nyenhuis: So we actually own and operate four charitable clinics here in our home state of Connecticut and they serve uninsured patients. So people that are falling all the way through the cracks, they don't have health insurance from employers, Medicaid, typically these are working poor who are day laborers. They don't have health insurance from an employer, and frankly, they don't get sick days from employers either. If they're not healthy, they're not working. If they're not working, they're not making progress for their families. So our job is to help keep them healthy. And then, we have a broad program across the U.S. where we work with a network of more than a thousand similar clinics that are run by other nonprofits, usually community nonprofits that run off charitable clinic, and this is all 50 states, and we provide them medicines and medical supplies that they would not normally have access to and other kinds of programing to increase their ability to do chronic disease care well, to do mental health services, to do improvements in their inventory management and control. So, we believe effective primary care at the community level is really the basis for good health in a community. If you have what we like to call a thriving local health center, it will keep people in their community healthy, and if those people are healthy, they have a shot at all kinds of opportunity that they would otherwise not.

Margaret Flinter: Well Michael, one thing that we can be certain of in the wake of disasters like the hurricanes, earthquakes, refugee crisis, massacres that we've seen, is that it takes a huge toll on the behavioral health of the people in these communities, and that underpins all other health issues. And at Americares, I know that you have a program that specifically targets emotional health for those who have been through a trauma. Can you talk with us about your mental health initiative?

Michael Nyenhuis: Yeah, I'll give you an example from Nepal and our response to the earthquake there a couple of years ago. It was a big disaster and caused a lot of traumas for people, and what we found out is when there's not good mental health services available, people who are traumatized tend to go to a primary care clinic. And what you find is that the health professionals, or the community health volunteers that man those primary care clinics are completely ill-equipped to be able to deal with mental health and psychosocial issues. And the work that we've done there is twofold. One is to provide training to the community health workers and the medical staff at a number of clinics so that

they have at least the ability to recognize, diagnose to a simple level, and do basic treatment and referral for people who are coming to them but don't have physical ailments, but really have mental or psychosocial issues. So that's that first line of care, taking them from ill-equipped to deal with this, to equipped to deal with this, which we think is making a big difference there. And then secondly, we've done a lot of community sensitization about mental health issues through a theater program that we've done in many communities, where we're just putting out on the table the issues, trying to put stigma down and help people in the community to recognize that they have a place to go to deal with these sorts of issues. So community sensitization of it and then equipping of the health professionals to be able to manage it, at least at a basic, level. And right now in Texas, we are looking at launching a similar kind of program on people who were affected there and frankly, in every major disaster that we respond to now, this will be a key part of it. We have a completely unmet need and something that's real, and if not dealt with, can have long term negative impacts for people and their communities.

Mark Masselli: As an international organization, raising money largely through charitable donations, I would imagine that with so much going on in the world right now, there's probably a bit of disaster fatigue. Could you tell our listeners what your greatest need is and for those who want to help, and I know there are so many wanting to help out the disasters that are close to home and around the globe, what's the best way for people to help?

Michael Nyenhuis: Well, certainly the best way for people to help is to donate funds to reputable organizations that they trust, that are doing good work in a disaster zone. This work requires professionals who know what they're doing and there are organizations like ours that can do that with the resources that are provided to us. Often time, people have felt need to gather up clothing and bottled water and try to ship it down to these disaster zones, but I've been in too many disaster zones where uncoordinated relief aid arriving actually creates more problems than well-coordinated relief aid can even solve. We need to do to this in a way that's really professional and well-executed and there are groups like Americares that can do that. I will say, having so many of these in a row, gratefully we have not really seen kind of a fatigue yet among donors. We continue to see donors giving resources for us for Hurricane Harvey, and that was the first of the three. So we're really grateful for that support and it's going to allow us to do a lot of really great work.

Margaret Flinter: We've been speaking today with Michael Nyenhuis, President and CEO of Americares. You can learn more about their important work by going to Americares.org, or follow them on Twitter @americares.org. Michael, thank you so much for joining us on Conversations on Healthcare today and best wishes to you and all of your teams across the globe working to make things better.

Michael Nyenhuis: Thank you very much and appreciate the attention you bring to these sorts of issues.

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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 nonpartisan, 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 weekend?

Lori Robertson: In early October, the Trump administration broadened an exemption to the Affordable Care Act's requirement that health insurance plans cover birth control with no cost sharing. The new rule would allow any business or nonprofit organization to exclude such coverage on religious or moral grounds. The ACA required that all private, non-grandfathered insurance plans cover contraceptives approved by the FDA for women without cost sharing starting in 2012. The plans must cover without cost sharing, at least one form of the 18 FDA approved contraceptive methods. That includes IUDs, the pills, diaphragm, emergency contraception, and more. But if a doctor recommended a specific product for a patient, that must be covered cost free too. The requirement prompted litigation from those citing religious reasons for their opposition. The Obama administration allowed houses of worship to claim an exemption from the requirement, but nonprofits and closely held for profit businesses could only get an accommodation, allowing the employer to not pay for coverage of birth control, but the insurer would then cover the cost. It's unknown how many employers will now opt for an exemption and how many women will lose birth control coverage with no cost sharing. The Trump administration said the change could only affect 200 organizations, the ones that filed lawsuits. But the original requirement did save women money, to the tune of an estimated $1.4 billion per year just on the pill according to a study by the University of Pennsylvania researchers. Before the requirement, birth control costs had been 30% to 44% of women's out of pocket health spending. Before the ACA, 85% of large firms covered birth control, though cost sharing may have been involved, according to the Kaiser Family Foundation report. Eight states have some requirements for no cost sharing contraception coverage. And that's my fact check for this week. I'm Lori Robertson, managing editor of FactCheck.org.

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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.

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Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Of the 6.6 million births per year in this country, over half are unintended. Colorado has been conducting an experiment for several years to examine what might happen if sexually active teens and poor women were offered the option of long term birth control, such as IUDs or implants.

Dr. Larry Wolk: What was so striking was the word of mouth amongst these young women to each other and the network of support that was built to access this program to help the tens of thousands of women, really did then result in these significant decreases in unintended pregnancies and abortions.

Mark Masselli: Dr. Larry Wolk, Medical Director of the Colorado Department of Health and Environment.

Dr. Larry Wolk: The result in decrease is 40% plus or minus in both categories, pregnancy and abortion. When you extend this out over an additional year, even approaching 60% reduction.

Mark Masselli: There was a significant economic benefit to the state as well.

Dr. Larry Wolk: We have seen a significant decrease in the number of young moms and kids needing public assistance, whether that's public insurance, the WIC program.

Mark Masselli: A free long term contraception program offered to at-risk teens and women, trying to avoid the economic hardship of unplanned pregnancies, leading to a number of positive health and economic outcomes for all involved. Now, that's a bright idea.

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

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

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.