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Transcribed Speech of Dr. Jennifer Cutrer

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Transcribed Speech of Dr. Jennifer Cutrer

DR. CUTRER: I teach health policy at the University of North Texas Dallas, and one of the things I try to tell my students is remember that many Latinos didn't cross the border. The border crossed them. And when you look at 1848 and the Treaty of Guadalupe Hidalgo, a great amount of land, over 500,000 acres of land of Mexico, was lost and that culture, which has close ties to its homeland, is still interacting. My family emigrated from Sicily. We don't have that kind of interaction, because of the Atlantic Ocean. We're still discriminated against, as you saw, the mafia got arrested again yesterday. God only knows why. We're just doing business. You know? We all have different definite business ethics, but this whole complication of the sociopolitical environment in addition to the economic environment really makes for an extremely complex situation. So I try to sometimes explain it from a sociologist perceptive and I get very blank stares but I keep going because I think it's a dimension that needs to be covered. So that crossing back and forth of the cultures and the maintaining of the culture is separated by a small and winding river that is easily crossed and easily breached. Unlike the Mexican culture, my culture has lost its history and customs through the years because we don't have that same contact with the Italians. So you're seeing a lot of the values that are still contained and maintained. And Brietta [Clark], you made so many good comments that I['d like to reiterate] the commitment of the Latinos, the pride in working, and we see the pride in coming to the hospital to pay.

But let me just go ahead and not deviate from my presentation and try to be as concise as possible. I'd like to start off with something that makes a very powerful argument for immigration reform. Talking about the confluence between the uninsured and access and immigration. I want to introduce you to Parkland as I know it. There was a segment that ran about three weeks ago on "World News Tonight" narrated by Charles Gibson. Their crew came to Parkland and spent twenty-four hours in our emergency room. What I need to tell you [is] that this is [un]scripted and it was just what they pulled out and what they gave us back. So if you don't mind it's about a five minute segment on Parkland.

Robert and I were just talking that we're both delighted to be here and one of the things that you're going to find is that Robert is about thirty-five miles down the road from me and he represents [John Peter Smith ("JPS")], the Tarrant County Hospital District. Oh, you can smile Prof. Yearby. One day I said, you know, I need to call and find out who's on our panel. And I

called Prof. Yearby and I said who's on our panel? And she said, Robert Earley from JPS. Well, we are constantly pitted against one another because we have very different policies and philosophies based on the political arena, our environments, and our cities, and we take a very different approach to the undocumented. Robert will tell you about his and I'll tell you about ours and I want you to know that I have immense respect for the hospital, for JPS, for what they do; and we work very well and very carefully so this is not going to be acrimonious and there will not be any debate, but there may be a spirited discussion. Right, Robert?

But let me introduce you to Parkland and I'm going to go through some of these slides quickly as my colleagues did because I don't want to bore you with a lot of details. But the topic of our discussion is the cost. What does it cost for access? And let me define what we are and what we're proud of and the fact that we stand on these tenets of Parkland of what we represent. As a safety net hospital, the key words at the bottom of this definition [are] "[w]e deliver a significant level of health care to the uninsured, Medicaid, and indigent patients." So nowhere in there do you see anything about documented or undocumented, legal or illegal.

We're a nationally recognized safety hospital and we have been listed among the top 100 hospitals for over 10 years. We constantly have news organizations wanting to come in to see our operation mainly because of the way we do things and because of the size of our operation, which is pretty incredible and I'll go through some of those numbers with you.

We serve as the primary teaching hospital for the University of Texas Southwestern Medical School. We have more than 2000 faculty residents and fellow positions in sixty-six different fields. More than half of the doctors in the Dallas area have undergone formal training at Parkland, and they remember it and they remember it well because . . . we work in numbers. We have large numbers of people; we have large numbers of people who come in who are acutely sick and present diagnoses that they would never see at some of the other hospitals.

Parkland serves as a regional referral center for burn and trauma. We are a Level I Trauma Center, and if you know anything about trauma centers, the stand-ready cost[s] alone on a trauma center are just incredible. So we spend a lot of money on trauma and it's utilized considerably. Governance structure—we report to the taxpayers who are very, very conflicted on this issue, and I will go into that a little bit and the issues which assail our County Commissioner's Court. The Commissioners then appoints a Board of Managers that sets policy for the hospital district, which does business [as] Parkland Health & Hospital System.

Let me tell you the size of the system. On our main campus, we are certified for 968 beds. We can staff about 750 of those beds because of the staffing problems at this point in time and because of facility restrictions.

COPC clinics—and this is very important because these are Community Oriented Primary Care centers which focus on community medicine. Right now there are twelve sites located throughout the county in areas where access is very needy. This model was based upon a model that was established by Dr. Sidney Kark in South Africa. I'll tell you a little bit more about that model and what these clinics do. We have greater than 8800 employees. We house the North Texas Regional Poison Center, Victim Intervention Program, Crisis Recovery Center; victims of torture come to Parkland and are counseled and worked with. We have our own [Health Maintenance Organization (“HMO”)] and this is one of the programs that has helped us be as successful as we have in terms of our bottom line. You're hearing about what's going on at Cook County, you're hearing about what's going on at Grady in Atlanta, and people are saying wait a minute. You serve the undocumented; you take people who can't pay. Why is your bottom line healthy at this point in time? Well, I will attempt to explain that. Homeless Outreach Medical Services (HOMES). We have four vans that travel throughout the county and provide services at twenty-six different homeless shelters and poor women's battered or abused shelters.

The size of our workload is pretty incredible. When you add all those numbers up, we see over a million people a year. And one of the things that [is] constantly baffling people or just impressing people or probably shocking them is that we deliver small villages every year. A total number of 16,252 babies were delivered at Parkland, and I'm going to tell you a little bit about the financing of that. We see over half a million in our outpatient clinics, and there are other clinics located on campus. Our COPC clinics see about 413,000 annually. There are 142,000 ER visits a year, so that demonstrates the magnitude of the demand on that system.

Forty-five babies will be born each day. This is a typical day at Parkland. One in every 260 babies born in the United States is born at Parkland. One in every twenty-four born in Texas is at Parkland. And four out of every ten in Dallas County are born at Parkland. We see 500 inpatients or we treat over 500 inpatients a day. Remember 700 plus beds where you have patients rotating in and out so about 500 people are treated on the inpatient side. We see 3,300 people in a primary care clinic [or] specialty care clinics daily. More than 400 people will be seen in the ER and we write approximately, or fill approximately, 14,800 prescriptions a day.

A little about our revenue, and I'm not going to spend too much [time] on that. Our major revenue sources obviously are Medicare/Medicaid, commercial insurance, self-pay, and what we call charity. Charity programs are the programs that we have in place. We have our own HMO so if you don't qualify for Medicaid, if you are not on Medicare for some

reason and you need to be, say a [Supplemental Security Income] patient [who] hasn't been diagnosed for five years, then we have our own HMO where we can qualify you.

The government [pays us] \$142 million annually. Those are direct provider payments from of Medicare/Medicaid. The other \$94 million we receive is DSH, monies given to hospitals that see a disproportionate share of the indigent. I don't know if I'm using terminology, do people understand DSH hospitals? Some do and some don't. But we see an inordinate amount of people who can't pay for their care so we backfill that or the federal government helps backfill that for us to help us make our bottom line.

Our payor mix is interesting. Medicare is only 15%, Medicaid is 39%. Charity, which is considered Dallas County residents who qualify for our HMO plan, and self-pay is 12.4%, and that's generally not much of what we treat overall given the fact that most people have some source of payment, and of course commercial insurance is almost negligible in terms of the whole scheme of things.

Female Speaker: I'm sorry to interrupt but what was that big property tax number on the previous slide? It looked like \$408 million property tax.

This is our tax dollars. That is the county hospital district tax. The county is the taxing entity that supports this big hospital system. So of that \$480 million it only covers 39.8% of our total cost and the rest is covered by the other pieces of the pie. So we are tax-supported by the Dallas County citizens and this is where great consternation comes in and I will deal with a little bit of that.

Let's look at our demographics. Parkland's demographics, when you look at the distribution of population, we only have 13% of Anglos come to Parkland where the county is comprised of 35% Anglo. African-Americans make up 29% of Dallas county whereas only 20% of that population comes to Parkland. Fifty-one percent of Parkland's patients are Hispanic; the county's makeup is 37% Latino. Asian and other [populations] are considerably smaller.

I'm not going to go through the mission and vision statement but let me tell you about our legal standing, and this is where we are adamant, and no one has really challenged us because it is such a political football. Title IV of the Civil Rights Act of 1964—this is what we consider our legal standing, "Simple justice requires that public funds, to which all taxpayers of all races, colors, and national origins contribute, not be spent in any fashion which encourages, entrenches, subsidizes, or results [in] racial color or national origin discrimination." We see nothing in here about the undocumented, and it is our belief that the undocumented pay taxes. The Social Security expense funds—which totals into the billions are monies collected where the federal government cannot tie these dollars to social

security numbers. The undocumented pay county taxes, real estate taxes whether . . . they're leasing or purchasing a house, and they pay sales tax.

You know about [the Emergency Medical Treatment and Active Labor Act ("EMTALA")]. So we are in compliance with EMTALA and with our emergency room volume, how much time do you think we have to go over what your legal status is, treating those kinds of crisis, and those kinds of acuties that come to Parkland? Because, remember, as a Level I Trauma Center, we have to take, if we have the capability, we have to take traumas from Level II and Level III because if [other hospitals] cannot handle the acuity of that illness, we are required to take their patients.

Under the state mandate, once the county establishes a hospital district, the district provides for the establishment of a hospital. The County Commissioners and Board of Managers have determined that if you reside in the district you're entitled and you will receive care and you will receive discounted care if you cannot afford it.

I pretty much covered the first two points. The bottom line is that as health care professionals—and this is a very strong point with Dr. Anderson, who is our CEO and who feels extremely committed to this—as professionals we are trained to and took an oath to provide care to those in need and therefore there are no illegitimate patients.

In the fiscal year 2007, we had \$511,983,592 in uncompensated care. One of our big areas of uncompensated care results from people coming in from other counties who don't want to support hospital districts, even though they have the resources to provide hospital districts. Without a county hospital district, these counties are mandated by the state to have county indigent health programs, but the state doesn't enforce this policy and the requirements for payment are negligible. So we have numerous costs from out of district patients—over \$18 million of that alone [is] just from the seven surrounding counties. Plus, people are flown in from Oklahoma and other areas of the country because of our burn level status and we have to take burn patients. It would not surprise me if [we treated] some of the people from [the] Georgia [sugar fire]; we usually end up with patients like those who were critically injured because there are not that many critical burn units like ours who can sustain those kinds of extensive burns.

According to a local economist, [Parkland Hospital generates] \$3 billion in business activity to Dallas County. The numbers I'm going to give you are not our numbers. We don't release numbers; we don't believe in counting people by documented and undocumented. The state comptroller in 2006 reported that the undocumented cost the state a total of \$58 million in Medicaid expenditures alone, \$38.7 million in Emergency Medicaid, and the public health system \$33.9 million. Now, that's compared to the \$957 million that's spent on public education, and higher education is estimated

to cost the state \$11.2 million. Now, I'm getting tired of people talking to us about socialized medicine when we have socialized education. I don't like the concept of socialized medicine. I think what it does is it puts it in an arena where it demonizes it; it makes it sound like it's forced down your throat and that you have no options and no ability to control it. We do have a strong commitment to public education. We know the importance of public education to a healthy economy and workforce Why not have a commitment to the healthcare of our workforce, to our children, and to our elderly—not only to those who are most vulnerable, but to those who help make American great.

One more thing; there are certain data points where we feel it is fiscally responsible for us to count the undocumented and we do so by using proxy variables. We do not ask people "are you here legally?" People will volunteer that. There are Emergency Medicaid monies provided by the federal government and we are urged to count the undocumented when feasible. About 40% of the women coming in to give birth cannot prove that they are residents so they are covered under again under EMTALA. We have state/federal perinatal SCHIP funds, which is an interesting thing with the religious right because we argue if this child is an American citizen and you believe that all children have the right to be born, why can't a child have prenatal care so that this baby is healthy?

I can give you some statistics as to what prenatal care does. For every dollar you spend on prenatal care, you save upwards of \$3.83 dollars, and the cost of putting a baby in a neonatal intensive care unit is \$2500 a day to \$3000 a day and they average stay of an unhealthy baby is twenty-one days. Do you want to foot that bill? Or would you like to do prenatal care at \$585 for one visit per month for nine months. That's our cost.

We have the [Medicare Prescription Drug Improvement and Modernization Act ("MMA")] Section 1011 monies. You know about those—a five-year program to help us with our emergency room care. So these are the data points that we look at because we do feel we need to be fiscally responsible to our county tax-payers. These monies are there so we do everything we can to capture that data without putting people in a position to discourage them from getting health care.

I can tell you one thing about Parkland. We are a community organization. We work with the community, the community respects us. The undocumented are not afraid to come to us. We don't turn people in to immigration. We don't do anything to jeopardize their standing in the community. We respect all people. I think it's something that's incredibly important and it's something that I have immense respect [for]; because if [it] wasn't for Ron Anderson I think we would probably not [be] doing this.