POST-KATRINA RECOVERY: RESTORING HEALTH CARE IN THE NEW ORLEANS REGION

HEARING

BEFORE THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

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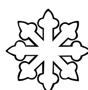

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CONTENTS

	Page
Hearing held on December 3, 2009	1
Statement of:	
Brand, Marcia K., Ph.D., Deputy Administrator, Health Resources and Services Administration, U.S. Department of Health and Human Services; Alan Levine, secretary, Louisiana Department of Health and Hospitals; Joia Crear-Perry, M.D., FACOG, director of clinical services, Health Department, city of New Orleans; and Clayton Williams, MPH, director, Louisiana Public Health Institute	120
Brand, Marcia K.,	120
Crear-Perry, Joia	145
Levine, Alan	131
Williams, Clayton	159
DeSalvo, Karen B., M.D., MPH, MSC, executive director, Tulane University Community Health Centers; Cynthia A. Bascetta, Director, Health Care, U.S. Government Accountability Office; Diane Rowland, executive vice president, the Henry J. Kaiser Family Foundation; Donald T. Erwin, M.D., president and chief executive officer, nephrology, St. Thomas Community Health Center; Michael G. Griffin, president and chief executive officer, Daughters of Charity Services of New Orleans; Alice Craft-Kerney, executive director, Lower Ninth Ward Health Clinic; and Roxane A. Townsend, assistant vice president, health systems, University Hospital, Louisiana State University System	8
Bascetta, Cynthia A.	24
Craft-Kerney, Alice	43
DeSalvo, Karen B.	8
Erwin, Donald T., M.D.	49
Griffin, Michael G.	55
Rowland, Diane	74
Townsend, Roxane A.	63
Letters, statements, etc., submitted for the record by:	
Bascetta, Cynthia A., Director, Health Care, U.S. Government Accountability Office, prepared statement of	26
Brand, Marcia K., Ph.D., Deputy Administrator, Health Resources and Services Administration, U.S. Department of Health and Human Services, prepared statement of	123
Craft-Kerney, Alice, executive director, Lower Ninth Ward Health Clinic, prepared statement of	45
Crear-Perry, Joia, M.D., FACOG, director of clinical services, Health Department, city of New Orleans, prepared statement of	148
DeSalvo, Karen B., M.D., MPH, MSC, executive director, Tulane University Community Health Centers, prepared statement of	12
Erwin, Donald T., M.D., president and chief executive officer, nephrology, St. Thomas Community Health Center, prepared statement of	51
Griffin, Michael G., president and chief executive officer, Daughters of Charity Services of New Orleans, prepared statement of	57
Issa, Hon. Darrell E., a Representative in Congress from the State of California, prepared statement of	7
Kucinich, Hon. Dennis J., a Representative in Congress from the State of Ohio, prepared statement of	107
Levine, Alan, secretary, Louisiana Department of Health and Hospitals, prepared statement of	134
Rowland, Diane, executive vice president, the Henry J. Kaiser Family Foundation, prepared statement of	76

Page

Letters, statements, etc., submitted for the record by—Continued
Towns, Chairman Edolphus, a Representative in Congress from the State of New York:
Letter dated December 2, 2009 118
Prepared statement of 3
Townsend, Roxane A., assistant vice president, health systems, University Hospital, Louisiana State University System, prepared statement of 65
Watson, Hon. Diane E., a Representative in Congress from the State of California, prepared statement of 182
Williams, Clayton, MPH, director, Louisiana Public Health Institute, prepared statement of 162

POST–KATRINA RECOVERY: RESTORING HEALTH CARE IN THE NEW ORLEANS REGION

THURSDAY, DECEMBER 3, 2009

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The committee met, pursuant to notice, at 2 p.m., in room 2247, Rayburn House Office Building, Hon. Edolphus Towns (chairman of the committee) presiding.

Present: Representatives Towns, Cummings, Kucinich, Tierney, Watson, Connolly, Quigley, Kaptur, Kennedy, Lee, Issa, Bilbray, Jordan, Flake, Chaffetz, Luetkemeyer, and Cao.

Staff present: John Arlington, chief counsel—investigations; Jean Gosa, clerk; Adam Hodge, deputy press secretary; Carla Hultberg, chief clerk; Chris Knauer, senior investigator/professional staff member; Phyllis Love, Ryshelle McCadney, and Christopher Sanders, professional staff members; Mike McCarthy, deputy staff director; Leah Perry, senior counsel; Ophelia Rivas, assistant clerk; Jenny Rosenberg, director of communications; Leneal Scott, IT specialist; Ron Stroman, staff director; Gerri Willis, special assistant; Lawrence Brady, minority staff director; John Cuaderes, minority deputy staff director; Rob Borden, minority general counsel; Jennifer Safavian, minority chief counsel for oversight and investigations; Frederick Hill, minority director of communications; Adam Fromm, minority chief clerk and Member liaison; Kurt Bardella, minority press secretary; Ashley Callan, minority counsel; and Molly Boyl, minority professional staff member.

Chairman TOWNS. The committee will come to order.

It has been nearly 4 years since Hurricane Katrina devastated the New Orleans region. Since then, the area has struggled to regain its footing and slowly rebuild its neighborhoods, businesses, and critical services. One area particularly hard-hit by the storm was the region's health care infrastructure. When Katrina flooded the city and surrounding parishes, many important hospitals and outpatient clinics were severely damaged and destroyed.

Before the storm, the low-income population of the region often relied on hospital emergency rooms and outpatient clinics, mostly hospital-based, as its main source of primary care. Charity Hospital, which was the major public hospital and the source of many of these services, particularly for the working poor and uninsured, was flooded and essentially destroyed. It remains shuttered today.

Because this and other critical health care facilities were destroyed, many of the region's residents struggled to obtain health care after the storm. Those facilities that remain open, particularly those willing to take the uninsured or poor, had limited capacity and significant waiting times. While eventually some organizations were able to open some clinics, major health care delivery gaps remained for months and even years after Hurricane Katrina.

In July 2007, the Department of Health and Human Services, with money granted from Congress to restore the Gulf Coast region, provided a $100 million grant to the State of Louisiana. This funding, called the Primary Care Access and Stabilization Grant, was designed to restore and expand critical and primary care services to the region without regard to a patient's ability to pay. The grant was also intended to reduce costly reliance on emergency room use for primary care services for patients who were uninsured, underinsured, or covered by Medicaid.

The good news is that an impressive network of health clinics has emerged which are now providing critical health care services. As of June 22, 2009, over $80 million of the $100 million Federal grant had been distributed and these clinics are now collectively providing care for over 160,000 individuals in the Katrina-affected region, nearly half of whom are uninsured. However, because the region does not have a clear plan on when it will begin breaking ground on a replacement for Charity Hospital, and because there are no clear plans on how to financially sustain these clinics, part of the region's population faces an uncertain future.

I am particularly interested in understanding what needs to be done to ensure that we preserve the critical health services these clinics are currently providing. In addition, it has now been more than 4 years since Hurricane Katrina destroyed Charity Hospital. While a temporary facility is providing critical care to the region, we will hear today that this interim hospital is reaching capacity. Four years is long enough for a plan for a replacement facility to sit in limbo, and I look forward to hearing how and when we can expect a new hospital will be built.

Let me conclude by thanking our witnesses today, particularly those who have traveled from the New Orleans region to be with us today. We really appreciate your being here. Many of you were in the trenches in the hours and days following this storm and provided critical care to those who otherwise would have gone without, and we thank you for that. Your story is an important one and needs to be heard. I applaud your efforts and I am sure all my colleagues remain committed to helping you rebuild the New Orleans region. Today's hearing is one more step toward that end.

I will now recognize the ranking member, Mr. Darrell Issa of California, for his opening statement.

[The prepared statement of Chairman Edolphus Towns follows:]

OPENING STATEMENT

CHAIRMAN EDOLPHUS TOWNS

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

"Post-Katrina Recovery: Restoring Health Care in the New Orleans Region."

December 3rd, 2009

It has been nearly four years since Hurricane Katrina devastated the New Orleans region. Since then, the area has struggled to regain its footing and slowly rebuild its neighborhoods, businesses, and critical services. One area particularly hard hit by the storm was the region's health care infrastructure. When Katrina flooded the city and surrounding parishes, many important hospitals and outpatient clinics were severely damaged or destroyed.

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uninsured or poor, had limited capacity and significant waiting times. While eventually some organizations were able to open some clinics, major health care delivery gaps remained for months and even years after Katrina.

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# # #

Mr. ISSA. Thank you, Mr. Chairman, and thank you for holding this important hearing.

Although the devastation of Hurricane Katrina occurred over 4 years ago, its effects on the New Orleans region is still being felt by its residents today. The health care infrastructure was hit especially hard and has not fully bounced back. The picture of health care in the New Orleans area is still very bleak. Hospitals remain shuttered, physicians are short in supply, and many residents, as you said, nearly half, are uninsured.

A key number of hospitals that served the uninsured population prior to Hurricane Katrina remain closed. As a result of these closures, many New Orleans residents now go to outpatient clinics for care. This change and the causes necessary are our focus here today, and in fact, how to get to a healthier community with a permanent hospital remains a vexing problem that we will hear about.

Receiving early care and proper treatments will reduce overall costs, and certainly reduce the strain on emergency rooms. A primary care focus can reduce overall health care spending by eliminating emergency room costs, room cost shifting. Unfortunately, many clinics are filled to capacity in the region. And as you said, Mr. Chairman, the economic conditions in New Orleans continue to prevent the rebounding of the robust economy that could in fact fund new hospital maintenance on a permanent basis.

The Federal Government has limited resources. It is clear that we have to work together to find a way for the region to be self-sustaining when possible. But today we will hear that is not possible today. Certainly we will also hear that a leading factor in the nationwide physician shortage is the high cost of medical liability insurance and malpractice insurance. As a result, broader health care reform is needed here in Congress. We need to look seriously at tort reform and bring health care costs that make delivery systems so expensive and inefficient down.

Additionally, as the chairman knows, public hospitals today have certain limited immunity from tort. Bills being considered in the Congress here today would strip that immunity, thus raising the cost of public health and their liability insurance.

So I hope in addition to dealing with the devastation of Hurricane Katrina that lingers on in New Orleans, we will recognize that there is not unlimited amounts of money to pay for health care unless health care can be delivered in an efficient and effective fashion. Today we will look at whether or not we can restore New Orleans' ability to have primary health care delivered in a way that is sustainable, cost-effective, and will prevent the citizens from having either poor health or excessive trips to the emergency room.

Mr. Chairman, I thank you for holding this hearing, and I yield back.

[The prepared statement of Hon. Darrell E. Issa follows:]

EDOLPHUS TOWNS, NEW YORK
CHAIRMAN

DARRELL E. ISSA, CALIFORNIA
RANKING MINORITY MEMBER

ONE HUNDRED ELEVENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

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Statement of Rep. Darrell Issa, Ranking Member

"Post-Katrina Recovery: Restoring Health Care in the New Orleans Region"

December 3, 2009

Thank you, Chairman Towns for holding this hearing. Although the devastation of Hurricane Katrina occurred over four years ago, its effects on the New Orleans region are still being felt by residents. The health care infrastructure was hit especially hard and has not fully bounced back. The picture of health care in the New Orleans area is still very bleak: hospitals remain shuttered, physicians are in short supply and many residents are uninsured.

A number of key hospitals that served the uninsured population prior to Hurricane Katrina remain closed.

As a result of closures, many New Orleans residents now go to outpatient clinics for care. This change, caused by necessity, has increased focus on primary care and – if sustained – may ultimately lead to a healthier community. Outpatient clinics are a much better setting in which to administer primary care than hospitals. Many citizens of New Orleans are receiving care earlier, when treatments can be more effective and less costly than if the patient had received care in an emergency room. A primary care focus can reduce overall health care spending, by eliminating emergency room cost shifting.

Unfortunately, many of the clinics which fill the region's primary care needs are in jeopardy of cutting services or closing their doors due to a lack of funding. I hope today we will gain perspective on how the region's primary care and outpatient clinics can be sustained going forward.

Additionally, compounding the effects of damage from Hurricane Katrina is Louisiana's shortage of physicians, especially primary care doctors and neurosurgeons.

A leading factor in the nationwide physician shortage is the high cost of medical liability insurance and malpractice lawsuits. As we discuss broader health care reform here in Congress, we need to look seriously at tort reform, to bring down health care costs and make our health delivery system more efficient.

Again, thank you to our witnesses who have taken time out of their busy schedules to speak with us today; I look forward to hearing from each of you.

Chairman TOWNS. Thank you very much for your statement and also your involvement in this issue over the years.

I would like to introduce our first panel of witnesses that will be testifying today: Ms. Cynthia Bascetta, Director of Health Care, U.S. Government Accountability Office; Dr. Karen B. DeSalvo, vice dean for community affairs and health policy and C. Thorpe Ray Chair in internal medicine at Tulane University School of Medicine. I would also like to introduce Ms. Alice Craft-Kerney, executive director of the Lower Ninth Ward Health Clinic in New Orleans; Dr. Donald T. Erwin, president and CEO of the Saint Thomas Community Health Center in New Orleans; Dr. Michael G. Griffin, president and CEO of Daughters of Charity Services of New Orleans; Dr. Roxane A. Townsend, assistant vice president for health systems for Louisiana State University; and, Dr. Diane Rowland, executive vice president of the Henry J. Kaiser Family Foundation.

Ladies and gentlemen, it is a longstanding policy that all of our witnesses are sworn in. So if you would stand and raise your right hands.

[Witnesses sworn.]

Chairman TOWNS. Let the record reflect that all the witnesses have answered in the affirmative.

Dr. DeSalvo, why don't we start with you. And thank you again for coming.

STATEMENTS OF KAREN B. DeSALVO, M.D., MPH, MSC, EXECUTIVE DIRECTOR, TULANE UNIVERSITY COMMUNITY HEALTH CENTERS; CYNTHIA A. BASCETTA, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; DIANE ROWLAND, EXECUTIVE VICE PRESIDENT, THE HENRY J. KAISER FAMILY FOUNDATION; DONALD T. ERWIN, M.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, NEPHROLOGY, ST. THOMAS COMMUNITY HEALTH CENTER; MICHAEL G. GRIFFIN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, DAUGHTERS OF CHARITY SERVICES OF NEW ORLEANS; ALICE CRAFT-KERNEY, EXECUTIVE DIRECTOR, LOWER NINTH WARD HEALTH CLINIC; AND ROXANE A. TOWNSEND, ASSISTANT VICE PRESIDENT, HEALTH SYSTEMS, UNIVERSITY HOSPITAL, LOUISIANA STATE UNIVERSITY SYSTEM

STATEMENT OF KAREN B. DeSALVO

Dr. DESALVO. Good morning, Mr. Chairman and members of the committee.

My name is Dr. Karen DeSalvo, and I am a practicing primary care physician in New Orleans. I also serve as the director of the Tulane University Community Health Centers.

Thank you for the opportunity to speak on behalf of my team and our patients, and to update you on the progress of health sector recovery in New Orleans, the challenges ahead for sustainability of the community health network, and describe strategies that may help us sustain these gains.

In a now too-familiar story, the failure of the Federal levees in August 2005 resulted in the devastation of the greater New Orleans community, including our health sector. In the face of this crisis, the community realized we had a chance not just to rebuild our

city but to re-make it into one worthy of our historic importance to our Nation, one that could be a model for others. This vision extended to redesigning our health sector into one that would provide all our citizens with access to high quality, affordable health care.

The rationale for re-making our health sector was simple. For decades it had performed amongst the worst in quality, cost, and disparities. Any discussion of a redesigned New Orleans health care sector has to include consideration of the role of the public hospital. The Medical Center of Louisiana at New Orleans, formerly known as Charity Hospital, served as the principal source of care for hundreds of thousands of uninsured and underinsured persons in the region. Yet in spite of good intentions, at the time of the storm the system was overwhelmed and under-funded. Primary care services offered limited hours that reflected the schedules of medical student trainees and other doctors rather than patients. They generally did not see the same doctor on a concurrent visit, and if they missed an appointment, it was a 12-month wait until the next available one.

Most of the uninsured received their care through emergency rooms as a result, and there was also not an alternative network of community care to pick up the slack. When Charity closed because of Katrina-related flooding, its patients lost access to the chief source of care available to them. Into the vacuum created by this closure, a grassroots, largely volunteer effort emerged to provide care. Tulane's part in this was initially led by a handful of our medical residents who set up six urgent care stations on the streets of New Orleans while the city was still under mandatory evacuation and partially flooded.

These trainees realized that people would need care, particularly the low-income and marginalized populations that Tulane had cared for at Charity for the past 170 years. One of these makeshift first aid stations evolved into a permanent primary care site, Covenant House. When the dust had settled, stakeholders set to work to define a vision for our rebuilt health system. We envisioned one founded upon community health care marked by quality and efficiency, because the evidence is clear that this kind of framework leads to better health and it also leads to lower costs. The public hospital needs to be a part of this new model, but it should not be the sole source of the primary care safety net.

In the spring of 2007, I testified, along with others, about the challenges in health care recovery in post-Katrina New Orleans. We were less than 2 years from the disaster at that point, and had much work to do to rebuild. The community was unified in asking for assistance to shore up what had become our new paradigm of health care in our recovering city—community health. The result of that hearing was the awarding of the Primary Care Access and Stabilization Grant [PCASG], a reflection of the bipartisan support for the community-based model of care.

Tulane has used these PCASG funds to expand access to thousands by increasing the capacity at our main site, Covenant House. That once makeshift first-aid station has grown into a robust, comprehensive NCQA-recognized patient-centered medical home. Our team is proud to have built a program that offers primary care for all ages. We have onsite integrated mental health and resiliency

programs. We offer social work and legal aid services. We use an electronic health record. And we have active quality improvement and evidence-based medicine programs.

We are engaged in work force training for physicians, nurses, social workers, public health students, and pharmacists, all in partnership with local universities. We also partner actively with community organizations and members to empower them to become physically, mentally, and economically healthier. Demand for our services has been so high we have outgrown our space and will soon move to a new location in the same neighborhood. Our new site will be a renovated building that has been blighted since Katrina and will serve as a cornerstone of economic development for that neighborhood.

Tulane has also expanded beyond Covenant House due in large part to PCASG funding. We provide high quality, culturally competent care throughout the city from mobile units, school-based health centers, and a new primary care site in collaboration with the Mary Queen of Vietnam Development Corp. in New Orleans East.

The people we serve are mostly the working poor. Their employers do not offer health insurance and they are not poor enough to be eligible for Medicaid. Others have recently lost their insurance when they lost their jobs, like a man I saw recently in New Orleans East. He had been laid off and was newly uninsured. He developed a new problem that caused him to visit the emergency room the night before he had been diagnosed with painful gout. This was a genetic condition he suffers through no fault of his own, and was exacerbated by his compliance with his blood pressure medications. The emergency room knew of our services, sent him to us and now he is integrated into our medical home and has a medical team that will help him manage his care, and he will not need to rely on emergency rooms in the future.

I am quite proud of what we have accomplished as an individual organization, but perhaps more proud of the collective efforts. I believe our experience is a model program for other areas. However, my enthusiasm is tempered by the knowledge that in the fall of 2010, the funding comes to an abrupt halt. The quality network of care for our population of largely uninsured working poor will need to be scaled down dramatically, perhaps as much as 40 percent, leaving some 50,000 citizens or so without access to primary community and community health.

We will lose our gains from this investment and tens of thousands of citizens will have to revert to the old option of using expensive emergency rooms, which the taxpayers ultimately bear the burden of cost. Tulane community health programs will not be immune from these cutbacks.

To prevent the loss of gains from this investment, a set of strategies are needed, and none alone are likely to be sufficient. Some are within the control of the community health providers themselves.

Chairman TOWNS. Dr. DeSalvo, would you wrap up, please? Because you're beyond your 5 minutes.

Dr. DESALVO. Yes, sir. These include improving efficiency and business practices at the center, which we have undertaken. Other

actions are beyond our control and include options such as working with HRSA for community health center programs and creating ongoing funding for uncompensated care, much the same way hospitals are supported in the DSH programs.

We look forward to working with you on the ways in which we can sustain this vital component of New Orleans' recovery. Thank you.

[The prepared statement of Dr. DeSalvo follows:]

TESTIMONY OF KAREN B.DESALVO, MD, MPH, MSc
Executive Director, Tulane University Community Health Centers

United States House of Representatives
Committee on Oversight and Government Reform
Hearing on:
"Post-Katrina Recovery: Restoring Health Care in the New Orleans Region"

December 3, 2009

INTRODUCTION

Good morning Mr. Chairman and members of the Committee. I am Dr. Karen DeSalvo, a practicing primary care physician, currently serving as Executive Director of the Tulane University Community Health Centers, including our flagship, the Community Health Center at Covenant House. Thank you for the opportunity to speak on behalf of my team and our patients, to share my perspectives based upon my experience as a health provider and leader for the past 15 years in Greater New Orleans. I will describe our city's successes and ongoing challenges in health sector recovery in post-Hurricane Katrina New Orleans.

In the Spring of 2007, the Energy and Commerce Committee's Sub-committee on Oversight and Investigations held a hearing on health care recovery in post-Hurricane Katrina New Orleans. In our testimony, we asked for support to sustain our gains in community health and dramatically expand access for our areas' uninsured population and asked that Congress hold us accountable for our commitments. The result of that hearing was support through the Primary Care Access and Stabilization Grant (PCASG), a $100 million investment to support primary care and mental health services delivery in the growing network of community health sites. In addition, then Secretary of Health and Human Services (HHS) Michael O. Leavitt established a primary care

workforce recruitment and retention program to support providers in these community health sites.

The Greater New Orleans provider community was clear about their expectations of outcome from the funding. We would not just provide services, but would build a high quality care network marked by efficiency and accessible to all citizens, irrespective of their ability to pay. We have created jobs, are developing a new workforce and are aiding in the recovery of a great American city. We are quite proud of what we have accomplished as individual organizations and as a collective and believe our experience is a model program for other urban areas.

This enthusiasm is tempered by the knowledge that in the fall of 2010, the funding comes to an abrupt halt and the quality network of care for our population of largely uninsured, working poor will need to be dramatically scaled down, and the health sector will revert to the old one in which patients waiting in lines for care or used expensive alternatives such as emergency rooms.

BACKGROUND

The failure of the federal levees in August 2005 resulted in the devastation of Greater New Orleans and our health sector. This tragedy caused approximately 1500 deaths, billions in damages and disrupted the social fabric for nearly 1,000,000 people. However, was also viewed by the community as a chance not just to rebuild, but revitalize an important American city in to one that could be a model for others. This vision to redesign included our health sector, which was antiquated in structure and financing. We sought to rebuild the system in to one that provides all area residents with access to high quality, neighborhood-based health services.

The rationale for this was that our health sector was not meeting the needs of our population, particularly those most vulnerable. Before the Hurricane, the state had the distinction of being the unhealthiest in the US according to the United Health Foundation rankings. The health care sector was among the worst performing in the nation no matter the payer and the population experienced significant racial/ethnic health disparities.

At the heart of the health sector was the Medical Center of Louisiana at New Orleans (formerly known as Charity Hospital), the primary resource in the safety-net for hundreds of thousands of uninsured and underinsured persons in Greater New Orleans. For generations, low income, uninsured and largely minority citizens of the area relied upon Charity Hospital and its clinics for their care. Unfortunately, in spite of good intentions, the system was overwhelmed and under-funded. Primary care services offered limited hours that reflected the schedules of the medical school trainees rather than patients. They generally did not see the same doctor. Those doctors had limited resources available to them – no onsite mental health social work or care managers to help people with chronic disease navigate their disease and/or the system. If patients missed an appointment for any reason, it was a 12-month wait until the next available appointment. Indeed, most of the patients accessed the system through the emergency room.

The reasons for this dependency on the public hospital system for care of the poor and uninsured are many. We had become reliant on Disproportionate Share Hospital funds to support care of the uninsured, rather than availing ourselves of other programs including Medicaid. The funding supported institutions, rather than patients. Limits on DSH funding did not keep up with the cost

of providing the care, leaving the system under-funded. Additionally, medical practice changed into one that was more outpatient based and DSH funding is not designed to support that kind of care without waivers in place. With few exceptions, the Greater New Orleans health sector landscape that was destroyed was a landscape devoid of community health centers to meet the primary care needs of the population. The result was that when Charity Hospital closed after Katrina, suddenly hundreds of thousands lost access to the chief source of care available to them and no portable financing.

AN UNEXPECTED OPPORTUNITY

It was clear to health care stakeholders as early as October 2005 that we had a once in a lifetime opportunity to remake a health sector from scratch. Instead of rebuilding our old health sector that had produced such dismal results, stakeholders envisioned a redesigned health sector that would be founded upon community health care marked by quality and efficiency. The evidence is clear to support this kind of framework – people with access to such health systems are healthier and the costs are lower. Remarkably, the Greater New Orleans community has nearly achieved this vision through grass roots efforts and with unprecedented support from the community, philanthropy and both state and federal governments. The PCASG largely fueled the development of this community health network. It is an overlooked bright spot in the recovery of New Orleans and a potential model in urban renewal.

TULANE UNIVERSITY'S ROLE IN THE NEW COMMUNITY HEALTH NETWORK

Before the Hurricane, Tulane did not have an historic community health presence, with a few exceptions. However, in the days immediately following the devastation of the storm, a

movement began that has grown and transformed our medical school. A handful of our medical residents and recent program graduates from Tulane University School of Medicine set up urgent care stations at six sites in the streets of New Orleans. This was at a time when the city was still under mandatory evacuation and parts of our city were still flooded. The effort was born of the good will of our trainees who realized immediately that even though the traditional health sector had closed, people would need care - particularly the low income, uninsured and marginalized populations who we had cared for through the Charity Hospital system for 170 years.

They called in faculty for support and soon we had a small army of providers delivering care to some 400 people a day. The "street care" experience not only engendered great satisfaction but changed our paradigm of medical education. It was so clear that providing care in this community based setting was improving our trainee and faculty understanding of the social determinants of health and helping to bridge understanding about barriers to wellness. It is hard not to account for the impact of access to safe quality housing on health when all around you at the makeshift urgent care station you see destroyed homes where those you are serving once lived. There was no doubt in my mind that we could not return to a system where we trained our students in hospital based clinics and miss the opportunity to embed them in the community.

One of these makeshift first aid stations was on the street in front of Covenant House, a social service and residential agency for at risk youth. The residents and staff had fled the city with the approaching storm, and the executive director of Covenant House welcomed Tulane into the building in their absence to make the best use of the facility. We were able to grow our services there and in November 2006 moved into a building on the back of the campus to offer primary

care and mental health services to the people in the surrounding devastated neighborhood returning to rebuild their lives.

CURRENT STATE OF TULANE COMMUNITY HEALTH CENTERS

In the four years since Katrina, that once makeshift first aid station has grown in to a robust comprehensive patient-centered medical home for thousands of residents in the greater New Orleans area. Initially, an ad hoc mixture of public-private support including philanthropy, volunteerism, and Social Services Block Grant funds supported it. Since the summer of 2007, we have been able to use the support of the PCASG and the GNO Workforce Recruitment and Retention Grants, to provide more and higher quality care to thousands.

Our services at the Tulane Community Health Center are comprehensive. Our goal is to become a key resource of patient-centered, quality care for all the residents in the surrounding neighborhoods. Our team is proud to have built a program that offers primary care for all ages, as well as onsite integrated mental health and resiliency services. We are also able to offer critical supportive services for our patients that include social work and legal aid support. Our care is of high quality, recognized by the National Committee for Quality Assurance (NCQA) as a top tier Patient Centered Medical Home. We are using the most modern information systems and have a paperless medical record that enables cutting edge population management and quality improvement programs. We have workforce training programs on site for physicians, nurses, public health, social work and soon pharmacy, aimed at training our new generation of providers in a new paradigm of team-based care that contextualizes patient needs. We actively partner with community organizations and local churches to reach out beyond our walls, and

work with them to empower our local community to be physically, mentally and economically healthier.

Demand for our services has been so high that we have outgrown our space and will soon move to a new location in the same neighborhood. The new facility will allow us to continue our current programs and also permits us to expand the array of services we provide, such as specialty care and enhanced supportive services. Our new site will be a renovated building, blighted since the Katrina flood, and will serve as an economic cornerstone of rebuilding in a devastated neighborhood. We are working closely with the residents and leaders of the neighborhood to ensure that our new facility is not just a health center but a resource for a healthier community.

Tulane's community health programs now expand beyond the site at Covenant House to serve thousands more in the city, due in large part to the PCASG funding. There are now 8 sites directly operated by Tulane University as well as additional locations where Tulane services in partnership (Exhibit A). Our sites provide high quality, culturally competent care to vulnerable populations in Greater New Orleans. These sites range from mobile medical units to school-based health centers to comprehensive primary care providers. Our most recent addition is a collaborative project with the Mary Queen of Vietnam Community Development Corp in New Orleans East. This health center has been open just over a year and serves the largely Vietnamese population that was dramatically underserved until the site opened.

The people we see in our clinics are largely the working poor without access to insurance who are not eligible for Medicaid. Even working more than one job, they would not have access to insurance since few businesses in Louisiana offer health insurance. Our typical patient is characterized in a man I recently saw at our New Orleans east health center a couple of Saturdays ago. The gentleman is in his mid-thirties with hypertension and lives nearby the health center. He had been followed by a private practice primary care physician but had recently been laid off from his job at a chain store and is now uninsured. He had visited the emergency room the night before with a newly painful foot, diagnosed to be gout. He had a family history of gout and was on a medication that can precipitate it as a side effect. The emergency room sent him to our medical home for follow up care. We were able to treat him and now he is connected with a primary care team in the medical home. He will have access to education, become empowered about his health and have access to his team 24 hours a day, 7 days a week. When he is again employed and insured, we hope that his experience will have been so positive in the system that he will stay on as our patient.

Without the PCASG funding, this clinic simply would not have been available to him and he would have no doubt had to visit the emergency room for this relatively simple set of problems that are best managed in the primary care setting. The cost to the taxpayer would have been at least four times higher and/or would have led to a needless, but significant debt burden for the patient.

While Tulane is proud of what we have contributed, we recognize and value the broader network of community health providers that has evolved since the flooding. In unprecedented ways, we

have come together to meet the critical need of providing our recovering city with access to quality health care. This includes sharing best practices on quality and efficiency and coordinating site expansion. We have also worked together to achieve recognition as Patient Centered Medical Homes given that this model of care is known to eliminate disparities across race/ethnicity and insurance status.

CHALLENGES AHEAD

Despite our remarkable progress, we all face a critical challenge in the fall of 2010 when the funding provided by the PCASG mechanism will end, leaving a significant gap in our ability to provide these critical health services and continue the New Orleans recovery. Funding needs to be in place by the fall of 2010 to ensure uninterrupted primary care and community mental health services for the low income, uninsured of the Greater New Orleans area or the network will be forced to significantly scale back services, particularly in the hardest hit inner city.

These cut backs will also be a reality for Tulane's health centers. We will have to decrease our staff size and minimize our hours of operation. We will also have to largely eliminate the supportive and enabling services we can now provide, such as social work and care coordination. We will have to begin this planning for cuts in services in a couple of months when the budget cycle begins.

It would be wasteful to let wane the investment of approximately $150 million by taxpayers, and would also prompt the uninsured to return to emergency rooms for conditions better suited and considerably less expensive to treat in the community health setting. Consider of our patient

treated in our health center for gout. Were we not an option, he would bounce back and forth to the emergency room for a condition highly treatable, and indeed preventable. Ultimately his care is paid for, better he should receive quality care at the right time, in the right place at a fraction of the cost of emergency room care.

POTENTIAL SOLUTIONS

Louisiana has reached agreement that we think the program has value in both providing care and contributing to the recovery of the city. We want it to continue, the question is how. There are a set of potential solutions that would allow continuation of this valuable program and it will likely take a combination of all of them. Some of these strategies are within the control of the community health providers themselves including:

1. Working through traditional channels such as the HRSA Community Health Center program:
    a. The community rallied around St. Thomas Community Health Center and they have received their designation as an FQHC, bringing to 2 the number of full grantee designations in Greater New Orleans.
    b. We have additional applications for Look-alike status, including one for the Tulane Community Health Centers in progress.
    c. However, the business model for FQHCs and Look-alikes calls for no more than 40% uninsured to be sustainable. Unfortunately, Tulane and other PCASG grantees in the New Orleans area have rates of uninsured as high as 70%. More support will be needed to ensure all the patients in the system can continue to receive care.

2. Improvements in efficiency and business practices at the centers:
   a. We have implemented policies and practices that allow us to bill when a payer is available, have actively enrolled eligible patients in Medicaid, charge a sliding scale fee to patients, and are continually undergoing process improvements and training to become more efficient.
   b. A group of fourteen PCASG providers formed 504HealthNet in the spring of 2008, though membership is open to all of the twenty-five potentially eligible organizations in the area. Members work collaboratively to better meet the primary care and behavioral health needs of low-income, uninsured, and underinsured residents. In particular, 504HealthNet has been working to improve quality, reduce cost, and advocate for policies that will improve the health of all citizens, particularly the most vulnerable (www.504healthnet.org).
3. Development of high-quality centers that would make them providers of choice attracting insured patients as well:
   a. PCASG recipients represent the highest density of high quality primary care in the nation – over 40 sites are recognized by the NCQA as Patient Centered Medical Homes.

Other actions that will allow Greater New Orleans to sustain the gains from the PCASG program are beyond our direct control. This includes granting of FQHC sites and a no cost extension of the PCASG program (currently pending with HHS). Coverage expansion through public and private programs will address some of the funding shortfall. Because the vast majority of Louisiana's businesses are small businesses and two-thirds of these do not offer health insurance. This means that the majority of the uninsured, such as those served through PCASG funding are

working but do not have access to health insurance and would not be eligible for Medicaid. Several initiatives aimed at achieving coverage expansion in some form or another have failed in the past few years. Funding for those without coverage will need to be secured. Some of the funding may already be in hand through existing Community Development Block Grants and DSH funds.

CONCLUDING REMARKS

The community health providers in the Greater New Orleans area have met our promise of increasing access to care responsibly. Yet we have not simply used the investment from the PCASG to increase access, but have also built a high quality network that has created jobs, is training the community health workforce of the future, and is innovating new models of care delivery. We are realizing our vision of not just rebuilding what we had, but establishing a new, more patient centered paradigm and revitalizing devastated neighborhoods with new economic engines. As a result, we have enjoyed broad, bipartisan support (Exhibits B, C, D). The program is a model and warrants continuation, and possibly expansion to other urban areas.

This success in building a model community health network would not have been possible without the support of the American people and public leaders such as the members of this committee. We owe it to the citizens of Greater New Orleans to build a community health care infrastructure that can ensure a resilient safety net. We look forward to working with you on the ways in which we can sustain these vital programs.

Thank you and I look forward to your questions.

Chairman TOWNS. Thank you very much. To the other witnesses, because we have so many witnesses today, we want to try to stay within the 5-minutes. We have your written statements. If there are things that you need to add, you can possibly add them during the question and answer period.

Thank you very much.

Ms. Bascetta.

STATEMENT OF CYNTHIA A. BASCETTA

Ms. BASCETTA. Thank you, Mr. Chairman and members of the committee. We appreciate the opportunity to be brought together this morning to discuss the important issues involved in restoring health care services in New Orleans.

The pre-Katrina health care infrastructure was hospital-based, very expensive, and yielded generally poor outcomes. As you know, many low-income and uninsured people traveled downtown to get their care at emergency rooms and clinics at Charity Hospital. A better system would be built on a solid foundation of primary care that would be located closer to people's homes and would be accessible as their health care needs arise, that would provide continuity of care over the long term and that would coordinate care for people with chronic or more serious conditions who need to see specialists.

Health services research indicates that primary care also yields better health outcomes at lower costs. So building primary care in New Orleans became a key priority in the wake of Katrina, especially for those on Medicaid or without adequate insurance. My testimony today is based largely on our July 2009 report on the use of Federal funds to support primary care in the area. The lion's share of the money, as you know, is the $100 million PCASG grant. Lesser amounts of Federal funds were provided through the Social Services Block Grant and the Professional Workforce Supply Grant, as well as more recent American Recovery and Reinvestment Act Funds for enhanced Medicaid payments and additional federally qualified health centers.

The PCASG was intended to restore and expand access to primary care, including mental and dental services, as well as referral to specialty care and ancillary services like transportation. In addition, the organizations must have had the intent to be sustainable, that is, to be able to continue providing primary care after the grant ends in September 2010. So far, the 25 funded health care organizations have provided more than 1 million health encounters to over 250,000 patients.

After the storm, provider shortages were a major reason for disruption in health services. We found that the grant organizations used the funds to hire and retain physicians, nurses, and other providers. They told us that this allowed them to increase access by cutting waiting times and expanding their hours.

Mental health services were especially hard hit. HRSA's area resource file documented a 21 percent decrease in the number of psychiatrists in greater New Orleans between 2004 and 2006, compared to a 3 percent increase in counties nationwide. Ten of the PCASG organizations hired both medical and mental health providers to alleviate service gaps, and 15 of 18 we interviewed for our

report on mental health services for children identified the lack of providers as a significant barrier.

Other funds were used to renovate or relocate physical space so that providers could expand capacity through additional examination rooms and the purchase of new equipment. Despite the progress made, PCASG organizations face challenges in establishing a full continuum of care with referrals to specialists and they are concerned about their long-term sustainability. Most continue to have difficulties hiring and retaining staff due to persistent problems with housing, schools, and the overall community infrastructure in the greater New Orleans area. In fact, HRSA has designated all four parishes as a health professional shortage area for mental health, a designation that none had before Katrina, and most of the parishes as shortage areas for primary care and dental services.

In addition, financing poses serious challenges. Although Medicaid billing has increased and some are able to bill private insurance, at more than half of the organizations, most of the patient population and sometimes 70 percent are uninsured. This is a daunting demographic, given that nearly all the funding is temporary. Many reported that they intended to use health center program funding to improve their sustainability, but with only 16 percent of applicants awarded grants nationwide in fiscal year 2008, it is unlikely they would all be successful in obtaining a grant.

LPHI provided a sustainability strategy guide to help them address a possible $30 million annual shortfall in revenues. Recipients have completed and planned actions to be sustainable, but it is not clear which ones will be successful and how many patients they will be able to serve after the funds are no longer available. With less than 10 months remaining, quickly implementing ways to pay for the large number of uninsured patients will be necessary to prevent disruptions in these vital services and to prevent the erosion of gains made in delivering primary care through this grant.

[The prepared statement of Ms. Bascetta follows:]

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HURRICANE KATRINA

Federal Grants Have Helped Health Care Organizations Provide Primary Care, but Sustaining Services Will Be a Challenge

Statement of Cynthia A. Bascetta
Director, Health Care

GAO-10-273T

Highlights

Highlights of GAO-10-273T, a testimony before the Committee on Oversight and Government Reform, House of Representatives

December 3, 2009

HURRICANE KATRINA

Federal Grants Have Helped Health Care Organizations Provide Primary Care, but Sustaining Services Will Be a Challenge

Why GAO Did This Study

The greater New Orleans area—Jefferson, Orleans, Plaquemines, and St. Bernard parishes—continues to face challenges in restoring health care services disrupted by Hurricane Katrina which made landfall in August 2005. In 2007, the Department of Health and Human Services (HHS) awarded the $100 million Primary Care Access and Stabilization Grant (PCASG) to Louisiana to help restore primary care services to the low-income population. Louisiana gave PCASG funds to 25 outpatient provider organizations in the greater New Orleans area. GAO was asked to testify on (1) how PCASG fund recipients used the PCASG funds, (2) how recipients used and benefited from other federal hurricane relief funds, and (3) challenges recipients faced and recipients' plans for sustaining services after PCASG funds are no longer available.

This statement is based on a recent GAO report, *Hurricane Katrina: Federal Grants Have Helped Health Care Organizations Provide Primary Care, but Challenges Remain* (GAO-09-588), other GAO work, and updated information on services, funding, and sustainability plans, which we shared with HHS officials. For the report, GAO analyzed responses to an October 2008 survey sent to all 25 PCASG fund recipients, to which 23 responded, and analyzed information related to other federal funds received by PCASG fund recipients. GAO also interviewed HHS and Louisiana Department of Health and Hospitals officials and other experts.

View GAO-10-273T or key components. For more information, contact Cynthia A. Bascetta at (202) 512-7114 or bascettac@gao.gov.

What GAO Found

PCASG fund recipients reported in 2008 that they used PCASG funds to hire or retain health care providers and other staff, add primary care services, and open new sites. For example, 20 of the 23 recipients that responded to the GAO survey reported using PCASG funds to hire health care providers, and 17 reported using PCASG funds to retain health care providers. In addition, most of the recipients reported that they used PCASG funds to add primary care services and to add or renovate sites. Recipients also reported that the grant requirements and funding helped them improve service delivery and expand access to care in underserved neighborhoods. As of September 2009, recipients used PCASG funds to support services for almost 252,000 patients, who had over 1 million interactions with a health care provider.

Other federal hurricane relief funds helped PCASG fund recipients pay staff, purchase equipment, and expand mental health services to help restore primary care. According to data from the Louisiana Department of Health and Hospitals, 11 recipients received HHS Social Services Block Grant (SSBG) supplemental funds designated by Louisiana for primary care, and 2 received SSBG supplemental funds designated by Louisiana specifically for mental health care. The funds designated for primary care were used to pay staff and purchase equipment, and the funds designated for mental health care were used to provide a range of services including crisis intervention and substance abuse prevention and treatment. Most of the PCASG fund recipients benefited from the Professional Workforce Supply Grant incentives. These recipients hired or retained 69 health care providers who received incentives totaling over $4 million to work in the greater New Orleans area.

PCASG fund recipients face multiple challenges and have various plans for sustainability. Recipients face significant challenges in hiring and retaining staff, as well as in referring patients outside of their organizations, and these challenges have grown since Hurricane Katrina. For example, 20 of 23 recipients that responded to the 2008 GAO survey reported hiring health care providers was a great or moderate challenge, and over three-quarters of these 20 recipients reported that this challenge had grown since Hurricane Katrina. PCASG fund recipients also reported challenges in referring patients outside their organization for mental health, dental, and specialty care services. Although all PCASG fund recipients have completed or planned actions to increase their ability to be sustainable, recipients are concerned about what will happen when PCASG funds are no longer available. Officials of the Louisiana Public Health Institute, which administers the PCASG locally, expect that some recipients might have to close and others could be forced to scale back capacity by as much as 30 or 40 percent. They have suggested strategies to decrease what they estimate would be a $30 million gap in annual revenues when PCASG funds are no longer available. With the availability of PCASG funds scheduled to end in less than 10 months, preventing disruptions in the delivery of primary care services could depend on quickly identifying and implementing workable sustainability strategies.

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss primary health care services in the greater New Orleans area. My testimony is based primarily on our July 2009 report entitled *Hurricane Katrina: Federal Grants Have Helped Health Care Organizations Provide Primary Care, but Challenges Remain.*[1] More than 4 years after Hurricane Katrina made landfall on August 29, 2005, the greater New Orleans area continues to face challenges in restoring health care services disrupted by the storm. Before the hurricane, most health care for the low-income and uninsured population in the area was provided in emergency rooms and outpatient clinics at Charity and University hospitals, which were part of the statewide Louisiana State University (LSU) public hospital system. About half of the hospitals' patients were uninsured, and about one-third were covered by Medicaid. Following the hurricane and the subsequent flooding, the hospitals and clinics closed because of the significant damage they had sustained. In November 2006, LSU reopened University Hospital under its new, temporary name, Interim LSU Public Hospital, which is operating at a lower capacity than Charity's and University's pre-Katrina capacity; Charity Hospital remains closed. While health care provider organizations in the area were able to reopen some health care clinics, gaps in the availability of primary care services[2] in the greater New Orleans area remained.

To help address the continuing health care needs of low-income area residents, the Department of Health and Human Services (HHS) awarded the $100 million Primary Care Access and Stabilization Grant (PCASG) to the Louisiana Department of Health and Hospitals (LDHH) in July 2007.[3]

[1]See GAO, *Hurricane Katrina: Federal Grants Have Helped Health Care Organizations Provide Primary Care, but Challenges Remain*, GAO-09-588 (Washington, D.C.: July 13, 2009). In this statement we follow the Centers for Medicare & Medicaid Services' definition of the greater New Orleans area—Jefferson, Orleans, Plaquemines, and St. Bernard parishes—which is used by the program at the center of this statement, the Primary Care Access and Stabilization Grant.

[2]In this statement, we define primary care as basic medical care that is generally provided in an outpatient setting such as a clinic or general practitioner's office, as opposed to in a hospital.

[3]This grant was made under a provision of the Deficit Reduction Act of 2005 authorizing payments to restore access to health care in communities affected by Hurricane Katrina. Pub. L. No. 109-171, § 6201(a)(4), 120 Stat. 4, 133 (2006). Notice of Single Source Grant Award, 72 *Fed. Reg.* 51,230 (Sept. 6, 2007).

The grant is administered at the federal level by HHS's Centers for Medicare & Medicaid Services (CMS) and at the local level by the Louisiana Public Health Institute (LPHI), the local partner of LDHH. The PCASG is intended to restore and expand access to primary care services, including mental health care services[4] and dental care services, without regard to a patient's ability to pay, and to decrease costly reliance on emergency room use for primary care services for patients who are uninsured, underinsured, or covered by Medicaid.[5] In addition to primary care services, PCASG fund recipients can use grant funds to provide specialty care, such as cardiology and podiatry services, and ancillary services, including supporting services such as translation, transportation, and outreach. LDHH provided funds to 25 outpatient provider organizations, which we refer to as PCASG fund recipients. As of March 20, 2008, the recipients were operating 75 sites that were eligible to use PCASG funds.[6] For an organization to be eligible for PCASG funding, it must have been a public or private nonprofit organization serving patients in the greater New Orleans area at the time that Louisiana's grant proposal was submitted. It must also have had the intent to be sustainable, that is, able to continue providing primary care after PCASG funds are no longer available.[7] The PCASG was given only to the state of Louisiana. PCASG funds were made available to Louisiana for a 3-year period, from July 23, 2007, through September 30, 2010. As of June 22, 2009, PCASG fund recipients had received more than $80 million in PCASG funds.

Since the disruption to the health care system caused by the hurricane, several HHS agencies have awarded other grants that facilitate access to primary care. However, like the PCASG funding, much of the funding is temporary. HHS's Administration for Children and Families provided Social Services Block Grant (SSBG) supplemental funds to Louisiana,

[4]In this statement, we define mental health care services to include substance abuse prevention and treatment services.

[5]Medicaid is a federal-state health insurance program for certain low-income individuals.

[6]March 20, 2008, was the end date of the first period for which recipients of PCASG funds reported data on their activities to LPHI. In this statement, we describe the data for this period at the recipient level. As of September 20, 2009, the 25 PCASG fund recipients were operating 93 sites that were eligible to use those funds.

[7]For the PCASG, CMS defines sustainability as the ability to continue to provide primary care to all patients (regardless of their ability to pay) through some funding mechanism other than the PCASG funds, such as enrolling as a provider in Medicaid or another public or private insurer.

which subsequently dedicated a portion specifically for health care services, including mental health care.[8] The Secretary of HHS awarded Professional Workforce Supply Grant funds to reduce shortages in the professional health care workforce. The funds were distributed as financial incentives to eligible health care providers; eligibility requirements included agreeing to serve Medicare, Medicaid, and uninsured patients.[9] Grants from the Health Center Program of HHS's Health Resources and Services Administration (HRSA) were also available during this time to certain organizations providing primary care services. Under Section 330 of the Public Health Service Act, HRSA provides grants to health centers nationwide to increase access to primary care, using a competitive process to award grants. All health center grantees are Federally Qualified Health Centers (FQHC), which enjoy certain federal benefits such as enhanced Medicare and Medicaid payment rates. However, not all FQHCs receive Health Center Program grants, and those that do not are sometimes referred to as having an FQHC Look-Alike designation. Four health center grantees served the greater New Orleans area at the time HHS awarded the PCASG in July 2007.

My statement today is based primarily on our July 2009 report on the PCASG, in which we examined (1) how PCASG fund recipients used the PCASG funds to support the provision of primary care services in the greater New Orleans area, (2) how PCASG fund recipients used and benefited from other federal hurricane relief funds that support the restoration of primary care services in the greater New Orleans area, and (3) challenges the PCASG fund recipients continued to face in providing primary care services, and recipients' plans for sustaining services after PCASG funds are no longer available. In addition, we updated selected information from our 2009 PCASG report and relied on other related GAO work.

[8]To help respond to the short-term crisis counseling needs, the greater New Orleans area also received federal Crisis Counseling Assistance and Training Program funds. See GAO, *Catastrophic Disasters: Federal Efforts Help States Prepare for and Respond to Psychological Consequences, but FEMA's Crisis Counseling Program Needs Improvements*, GAO-08-22 (Washington, D.C.: Feb. 29, 2008).

[9]Financial incentive payments could be given to health care providers who remained in their qualifying job or to newly hired health care providers; individuals may receive only one financial incentive payment.

To do the work for our July 2009 report on how federal grants helped support primary care, we conducted site visits at 8 of the 25 PCASG fund recipients during April 2008, during which we collected documents and interviewed PCASG fund recipient, state, and local officials. Based in part on information we gathered during the site visits, we developed a Web-based survey that focused on how recipients used PCASG funds, the challenges they continued to face, and their plans for sustainability. We administered the survey in October 2008. We received responses from 23 of the 25 recipients, a response rate of 92 percent. We also reviewed and analyzed data from LDHH on expenditures related to the supplemental SSBG and on awards made under CMS's Professional Workforce Supply Grant Program, reviewed the recipients' applications for PCASG funding and their plans for sustainability, and interviewed officials at LDHH and PCASG fund recipients about how the recipients used PCASG and other federal funds. We conducted the work for our July 2009 report from February 2008 through June 2009. To update the work on the PCASG, we interviewed state, LPHI, and PCASG fund recipient officials about sustainability plans and reviewed and analyzed more recent data from these officials about program funding and services. We conducted this new work in October and November 2009 and shared the information we obtained with HHS officials. In addition, we incorporated findings from another July 2009 report, which examined barriers to mental health services for children in the greater New Orleans area.[10] We conducted the original and updated work in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions in this product. A detailed explanation of our methodology for each of the 2009 reports is included in the respective reports.

[10]GAO, *Hurricane Katrina: Barriers to Mental Health Services for Children Persist in Greater New Orleans, Although Federal Grants Are Helping to Address Them*, GAO-09-563 (Washington, D.C.: July 13, 2009).

PCASG Fund Recipients Used PCASG Funds to Support Primary Care Services by Hiring Health Care Providers and Other Staff and Adding Services and Sites

PCASG fund recipients that responded to our October 2008 survey reported that they used PCASG funds to hire or retain health care providers and other staff, add primary care services, and open new sites. (See table 1.) Recipients also said that the PCASG funds helped them improve service delivery and access to care for the patients they served. As of September 20, 2009, PCASG recipients reported to LPHI that they had used PCASG funds—in conjunction with other funds, such as other federal grants and Medicaid reimbursement—to support services provided to almost 252,000 patients. These patients had over 1 million encounters with a health care provider, two-thirds of which were for medical and dental care and one-third of which were for mental health care.[11] A small number of encounters were for specialty care. The patients served by the PCASG fund recipients were typically uninsured or enrolled in Medicaid. We reported in July 2009 that for the first several months during which PCASG funds were available, at more than half of the PCASG fund recipients, at least half—and at times over 70 percent—of the patient population was uninsured.

Table 1: Number of Primary Care Access and Stabilization Grant (PCASG) Fund Recipients That Used PCASG Funds to Hire or Retain Staff, Expand Services, or Open or Renovate Sites, as of October 28, 2008

Actions taken with PCASG funds	Number of PCASG fund recipients taking action
Hired health care providers	20
Hired other staff	18
Retained health care providers	17
Retained other staff	15
Added or expanded primary care services	19
Opened new or relocated sites	15
Renovated existing sites	10

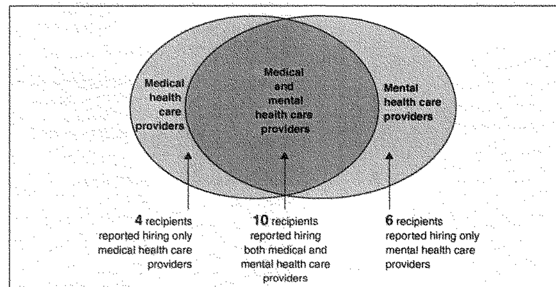
Source: GAO analysis of PCASG fund recipients' responses to GAO's Web-based survey.

Note: The data in the table are based on the responses of the 23 recipients that responded to GAO's Web-based survey. Recipients may have hired or retained more than one type of staff and added or expanded more than one type of service.

[11] An encounter is an interaction between a patient and a provider for the purposes of meeting a health care need. It can occur by telephone or in person.

Of the 20 recipients that reported in our October 2008 survey that they used PCASG funds to hire health care providers, half hired both medical and mental health providers. (See fig. 1.) One recipient reported that by hiring one psychiatrist, it could significantly increase clients' access to services by cutting down a clinic's waiting list and by providing clients with a "same-day" psychiatric consultation or evaluation. Another recipient reported that it hired 23 medical care providers, some of whom were staffed at its new sites. Some recipients reported that hiring additional providers enabled them to expand the hours some of their sites were open.

Figure 1: Number of Primary Care Access and Stabilization Grant (PCASG) Fund Recipients That Used PCASG Funds to Hire Health Care Providers, as of October 28, 2008



Source: GAO analysis of PCASG fund recipients' responses to GAO's Web-based survey.

Note: The data in the figure are based on the responses of the 23 recipients that responded to GAO's Web-based survey.

Of the 23 recipients that responded to our survey, 17 reported they used PCASG funds to retain health care providers, and 15 of these reported that they also used grant funds to retain other staff. For example, one recipient reported that PCASG funds were used to stabilize positions that were previously supported by disaster relief funds and donated services.

Nineteen of the 23 PCASG fund recipients that responded to our survey reported using PCASG funds to add or expand medical, mental health, or dental care services, and more than half of these added or expanded more than one type of service. Specifically, 11 added or expanded medical care,

15 added or expanded mental health care, and 4 added or expanded dental care services. In addition, PCASG fund recipients also reported using grant funds to add or expand specialty care or ancillary services. One recipient reported that it used PCASG funds to create a television commercial announcing that a clinic was open and that psychiatric services were available there, including free care for those who qualified financially.

Almost all of the PCASG fund recipients that responded to our survey reported they used PCASG funds for their physical space. Ten recipients that responded to our survey reported using grant funds to renovate existing sites, such as expanding a waiting room, adding a registration window, and adding patient restrooms, to accommodate more patients. Officials from one PCASG fund recipient reported that relocating to a larger site allowed providers to have additional examination rooms.

PCASG fund recipients that responded to our survey reported that certain program requirements—such as developing a network of local specialists and hospitals for patient referrals and establishing a quality assurance and improvement program that includes clinical guidelines or evidence-based standards of care—have had a positive effect on their delivery of primary care services. In addition, they reported that the PCASG funds helped them improve access to health care services for residents of the greater New Orleans area. For example, one PCASG fund recipient reported that the PCASG funds have helped it to expand services beyond residents in shelter and housing programs to include community residents who were not homeless but previously lacked access to health care services. Representatives of other PCASG fund recipients have reported that their organization improved access to care by expanding services in medically underserved neighborhoods or to people who were uninsured or underinsured. Representatives of local organizations also told us the PCASG provided an opportunity to rebuild the health care system and shift the provision of primary care from hospitals to community-based primary care clinics.

Other Federal Hurricane Relief Funds Helped PCASG Fund Recipients to Pay Staff, Purchase Equipment, and Expand Mental Health Services to Help Restore Primary Care

PCASG fund recipients also used other federal hurricane relief funds to help support the restoration of primary care services. According to LDHH data, as of August 2008, 11 PCASG fund recipients expended $12.9 million of the SSBG supplemental funds that were awarded to Louisiana and that the state designated for primary care.[12] They used these funds to pay for staff salaries, purchase medical equipment, and support operations. For example, one recipient used SSBG supplemental funds to hire new medical and support staff and, as a result, expanded its services for mammography, cardiology, and mental health. The two PCASG fund recipients that received a total of almost $12 million in SSBG supplemental funds designated for mental health care used those funds to provide crisis intervention, substance abuse, and other mental health services, mostly through contracts to other organizations and providers.[13] The majority of funds were expended on the categories LDHH identified as "substance abuse treatment and prevention services," "immediate intervention and crisis response services," and "behavioral health services for children and adolescents."[14]

As of August 2008, most of the 25 PCASG fund recipients had retained or hired a health care provider who had received a Professional Workforce Supply Grant incentive payment to continue or begin working in the greater New Orleans area.[15] Among the health care providers working for PCASG fund recipients, 69 received incentives that totaled $4.5 million. The number of those health care providers who were employed by individual PCASG fund recipients ranged from 1 or 2 at 7 recipient organizations to 10 at 2 recipient organizations. Three-quarters of recipients of incentive payments were existing employees who were retained, while one-quarter were newly hired.

[12]The SSBG supplemental funds were distributed before organizations received PCASG funds. Dollar amounts reflect funds expended by PCASG fund recipients at sites where they later used PCASG funds.

[13]None of the contracts were awarded to other PCASG fund recipients.

[14]Behavioral health is a term often used to refer to mental health and substance abuse services.

[15]In discussing the incentive payments made from Professional Workforce Supply Grant funds, the information we provide about the 25 PCASG fund recipients is based on the more than 80 sites that were also eligible to use PCASG funds as of August 2008. Additional health care providers who have received incentives may be employed by PCASG fund recipients, but not at sites eligible to use PCASG funds.

PCASG Fund Recipients Face Multiple Challenges and Have Various Plans for Sustainability

PCASG fund recipients face significant challenges in hiring and retaining staff, as well as in referring patients outside of their organizations, and these challenges have grown since Hurricane Katrina. Recipients are taking actions to address the challenge of sustainability, but are concerned about what will happen when PCASG funds are no longer available.

PCASG Fund Recipients Face Significant Staffing and Referral Challenges, and These Challenges Have Grown Since Hurricane Katrina

Although most of the 23 PCASG fund recipients that responded to our October 2008 survey hired or retained staff with grant funds, most have continued to face significant challenges in hiring and retaining staff. Twenty of the 23 recipients reported the hiring of health care providers to be either a great or moderate challenge. Among those, over three-quarters responded that this challenge had grown since Hurricane Katrina. For example, in discussing challenges, officials from one recipient organization told us that after Hurricane Katrina they had greater difficulty hiring licensed nurses than before the hurricane and that most nurses were being recruited by hospitals, where the pay was higher. Moreover, officials we interviewed from several recipient organizations said that the problems with housing, schools, and overall community infrastructure that developed after Hurricane Katrina made it difficult to attract health care providers and other staff. In addition, 16 of the 23 recipients reported that retaining health care providers was a great or moderate challenge. Among those, about three-quarters also reported that this challenge had grown since Hurricane Katrina.

An additional indication of the limited availability of primary care providers in the area is HRSA's designation of much of the greater New Orleans area as health professional shortage areas (HPSA) for primary care, mental health care, and dental care.[16] Specifically, HRSA designated all of Orleans, Plaquemines, and St. Bernard parishes, and much of Jefferson Parish, as HPSAs for primary care. While some portions of the greater New Orleans area had this HPSA designation before Hurricane Katrina, additional portions of the area received that designation after the hurricane. Similarly, HRSA designated all four parishes of the greater New Orleans area as HPSAs for mental health in late 2005 and early 2006;

[16]HPSAs are used to identify geographic areas, population groups, or facilities facing a shortage of primary care, dental, or mental health providers.

before Hurricane Katrina, none of the four parishes had this designation for mental health. In addition, HRSA has designated all of Orleans, St. Bernard, and Plaquemines parishes and part of Jefferson Parish as HPSAs for dental care; before Katrina, only parts of Orleans and Jefferson parishes had this designation.

The PCASG fund recipients that primarily provide mental health services in particular faced challenges both in hiring and in retaining providers. Six of the seven that responded to our October 2008 survey reported that both hiring and retaining providers were either a great or moderate challenge. Officials we interviewed from one recipient told us that while the Greater New Orleans Service Corps, which was funded through the Professional Workforce Supply Grant, had been helpful for recruiting and retaining physicians, it had not helped fill the need for social workers. Furthermore, officials we interviewed from two recipients told us that some staff had experienced depression and trauma themselves and found it difficult to work in mental health settings. Beyond challenges in hiring and retaining their own providers and other staff, PCASG fund recipients that responded to our survey reported significant challenges in referring their patients to other organizations for mental health, dental, and specialty care services.

We also reported on a lack of mental health providers in our July 2009 report that examined barriers to mental health services for children in the greater New Orleans area.[17] Specifically, 15 of the 18 organizations we interviewed for that work identified a lack of mental health providers—including challenges recruiting and retaining child psychiatrists, psychologists, and nurses—as a barrier to providing mental health services for children. In addition, we reported that HRSA's Area Resource File (ARF)—a county-based health resources database that contains data from many sources including the U.S. Census Bureau and the American Medical Association—indicated that the greater New Orleans area has experienced more of a decrease in mental health providers than some other parts of the country. For example, we found that ARF data documented a 21 percent decrease in the number of psychiatrists in the greater New Orleans area from 2004 to 2006, during which time there was a 1 percent decrease in Wayne County, Michigan (which includes Detroit and which had pre-Katrina poverty and demographic characteristics similar to those of the greater New Orleans area) and a 3 percent increase in counties nationwide.

[17]GAO-09-563.

PCASG Fund Recipients Are Taking Actions to Address the Challenge of Sustainability, but Are Concerned About What Will Happen When PCASG Funds Are No Longer Available

In our July 2009 report on the PCASG, we found that an additional challenge that the PCASG fund recipients face is to be sustainable after PCASG funds are no longer available in September 2010.[18] All 23 recipients that responded to our October 2008 survey reported that they had taken or planned to take at least one type of action to increase their ability to be sustainable—that is, to be able to serve patients regardless of the patients' ability to pay after PCASG funds are no longer available. For example, all responding recipients reported that they had taken action—such as screening patients for eligibility—to facilitate their ability to receive reimbursement for services they provided to Medicaid or LaCHIP[19] beneficiaries.[20] Furthermore, 16 recipients that responded to our October 2008 survey reported that they were billing private insurance, with an additional 5 recipients reporting they planned to do so. However, obtaining reimbursement for all patients who are insured may not be sufficient to ensure a recipient's sustainability, because at about half of the PCASG fund recipients, over 50 percent of the patients were uninsured.

Many PCASG fund recipients reported that they intended to use Health Center Program funding or FQHC Look-Alike designation—which allows for enhanced Medicare and Medicaid payment rates—as one of their sustainability strategies. Four recipients were participating in the Health Center Program at the time they received the initial disbursement of PCASG funds. One of these recipients had received a Health Center New Access Point[21] grant to open an additional site after Hurricane Katrina and had also received an Expanded Medical Capacity[22] grant to increase service capacity, which it used in part to hire additional staff and buy equipment. Another of these recipients received a New Access Point grant to open an additional site after receiving PCASG funds. Beyond these four

[18]GAO-09-588.

[19]LaCHIP is the name of Louisiana's Children's Health Insurance Program. The Children's Health Insurance Program is a federal-state health insurance program that offers insurance to certain children under age 19 whose family income is too high for Medicaid eligibility and who are not enrolled under other health insurance.

[20]From September 2007 to September 2009, there was a 20 percent increase in the number of PCASG recipients' clinics that billed Medicaid, according to data from LPHI.

[21]New Access Point grants are for new grantees or for existing grantees to establish additional sites.

[22]Expanded Medical Capacity grants support increased service capacity, such as by expanding operating hours.

recipients, one additional recipient received an FQHC Look-Alike designation in July 2008.

HRSA made additional grants from appropriations made available by the American Recovery and Reinvestment Act of 2009, awarding five PCASG fund recipients with additional Health Center Program grants totaling $7.4 million as of October 19, 2009.[23] Specifically, three PCASG fund recipients were awarded New Access Point grants totaling $3.9 million,[24] five received Capital Improvement Program grants totaling more than $2.4 million,[25] and five received Increased Demand for Services grants totaling nearly $1.1 million.[26]

Of the remaining 18 recipients that responded to our survey, 6 said they planned to apply for both a Health Center Program grant and an FQHC Look-Alike designation. In addition, one planned to apply for a grant only and another planned to apply for an FQHC Look-Alike designation only. Although many recipients indicated that they intended to use Health Center Program funding as a sustainability strategy, it is unlikely that they would all be successful in obtaining a grant. For example, in fiscal year 2008 only about 16 percent of all applications for New Access Point grants resulted in grant awards.

About three-quarters of PCASG fund recipients reported that as one of their sustainability strategies they had applied or planned to apply for additional federal funding, such as Ryan White HIV/AIDS Program grants,[27]

[23]The American Recovery and Reinvestment Act of 2009 provided HRSA with $2 billion for the Health Center Program (Pub. L. No. 111-5, div. A, title VIII, 123 Stat. 115, 175).

[24]One of the three PCASG fund recipients that were awarded New Access Point grants was the one that received Look-Alike designation in 2008; the other two were existing grantees.

[25]Capital Improvement Program grants are limited-competition awards designed to address capital improvement needs in health centers, such as construction, repairs, renovation, and equipment purchase, including health information technology.

[26]Increased Demand for Services grants are formula allocation awards designed to help health centers increase the number of total patients and uninsured patients served, such as by extending hours of operation, expanding existing services, adding staff, or retaining staff.

[27]Through the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 and subsequent legislation, HRSA provides federal funds to metropolitan areas, states, and others to assist with the cost of core medical and support services for individuals and families infected and affected by HIV/AIDS. See 42 U.S.C. §§ 300ff through 300ff-121.

or for state funding. In addition, a few reported that they had applied or planned to apply for private grants, such as grants from foundations.

In our fall 2009 interviews, LPHI and PCASG recipient officials told us that there is uncertainty and concern among the PCASG fund recipients as the time approaches when PCASG funding will no longer be available. LPHI officials told us that they expect that some PCASG fund recipients might have to close, and others could be forced to scale back their current capacity by as much as 30 or 40 percent. For example, one PCASG fund recipient official we spoke with in November 2009 told us that the organization's mobile medical units may not be sustainable without PCASG funding; services provided by mobile units are not eligible for Medicaid funding without a referral and collecting cash from patients could make the units targets for crime. LPHI officials said they expect that the loss of PCASG funds would most affect PCASG fund recipients that serve the largest number of uninsured patients.

To help PCASG fund recipients achieve sustainability, the LPHI developed a sustainability strategy guide in April 2009. This guide suggests actions that the recipients could take to become sustainable entities, such as maximizing revenues by improving their ability to screen patients for eligibility for Medicaid and other third party payers, enroll eligible patients, electronically bill the insurers, and collect payment from insurers.

LPHI and a PCASG fund recipient have identified additional potential approaches for securing revenues to decrease what LPHI estimated would be a $30 million gap in the PCASG fund recipients' annual revenues when PCASG funds are no longer available. The LPHI sustainability strategy guide proposed that expanding Medicaid eligibility through a proposed Medicaid demonstration project that HHS is reviewing could result in a decrease in the number of uninsured people; these are the patients for whom PCASG fund recipients are most dependent on federal subsidies.[28] The LPHI guide also suggested that it could be helpful if Louisiana

[28]States operate and administer their Medicaid programs independently within federal requirements established in statute and regulations, and the federal government shares in the cost of each state's program by paying an established share of states' reported expenditures. Under section 1115 of the Social Security Act, however, the Secretary of HHS may waive certain federal requirements for demonstrations the Secretary deems likely to promote Medicaid objectives, allowing states to apply to test and evaluate new approaches for delivering Medicaid services.

received greater flexibility to use Medicaid disproportionate share dollars for outpatient primary care not provided by hospitals.[29] In addition, a PCASG fund recipient official told us in November 2009 that a no-cost extension for PCASG funds might help some PCASG fund recipients if they are able to stretch their PCASG dollars beyond September 30, 2010.

Although PCASG fund recipients have completed or planned actions to increase their ability to be sustainable and have received guidance from LPHI, it is unclear which recipients' sustainability strategies will be successful and how many patients recipients will be able to continue to serve. With the availability of PCASG funds scheduled to end in less than 10 months, preventing disruption in the delivery of primary care services could depend on quickly identifying and implementing workable sustainability strategies.

Mr. Chairman, this completes my prepared remarks. I would be happy to respond to any questions you or other members of the committee may have at this time.

Contacts and Acknowledgments

For further information about this statement, please contact Cynthia A. Bascetta at (202) 512-7114 or bascettac@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Key contributors to this statement were Helene F. Toiv, Assistant Director; Carolyn Feis Korman; Deitra Lee; Coy J. Nesbitt; Roseanne Price; and Jennifer Whitworth.

[29]Medicaid disproportionate share hospital payments provide financial assistance to hospitals that serve a large number of low-income patients, such as people with Medicaid and the uninsured. Medicaid disproportionate share hospital payments are the largest source of federal funding for uncompensated hospital care.

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Chairman TOWNS. Thank you very much.
Ms. Craft-Kerney.

STATEMENT OF ALICE CRAFT-KERNEY

Ms. CRAFT-KERNEY. Good morning Chairman Towns and members of the committee. I am Alice Craft-Kerney, and I am the executive director of the Lower Ninth Ward Health Clinic in New Orleans, LA. I appreciate the opportunity to be here to discuss the successful partnership of government and community to deliver health care services to the citizens of the New Orleans region.

I want to first express my appreciation for the Primary Care Access and Stabilization Grant, which has been a lifeline for the uninsured and under-insured residents of the greater New Orleans area. The grant has enabled the Lower Ninth Ward Health Clinic, as well as other health clinics, to employ medical staff and provide health care services in New Orleans which has been designated, as we said, as a medically under-served area. It is my hope that Congress will recognize the critical need for our health clinics and take action to continue this fruitful collaboration which contributed significantly to the recovery of the greater New Orleans region.

Before Hurricane Katrina, I worked as a nursing supervisor at Charity Hospital in the trauma surgery wards. During that time, I observed many patients that were not insured. And the reason why they were there is that they did not have access to primary health care services. These were unnecessary hospitalizations. But to understand fully what is going on, you have to understand that community, which was most impacted by Katrina. You have to understand that this population was very vulnerable and they had poor health outcomes because there were large numbers of New Orleans residents living at the poverty level. There was low education levels and high illiteracy rates. There was a high dependence on the public sector for health care needs. There were high rates of chronic illnesses, high numbers of, as I said, uninsured residents. And the use of the emergency room was substituted for primary health care.

And there was an inadequate emergency preparedness. And on August 29, 2005, these factors collided with the worst natural and man-made disaster in the history of the United States, creating a public health crisis of enormous proportions.

Ms. Patricia Berryhill, a registered nurse, and my colleague, and I decided to confront the crisis head-on by opening the Lower Ninth Ward Health Clinic on February 27, 2007. This was a humanitarian mission that we have undertaken at the Lower Ninth Ward Health Clinic and it is informed by the United Nations Guiding Principles of Internally Displaced People, a standard of care that is supported by the U.S. Government to ensure the recovery of people around the world who have become displaced by a disaster.

Principle 19 of the Guiding Principles calls for comprehensive medical care and special attention to the health needs of displaced persons. For displaced New Orleaneans, these health needs involved the traumatic experience of the disaster and being uprooted from homes, as well as the physical impacts of not having access to life-sustaining medications and treatment. As time passed, no one came to the Lower Ninth Ward, a community separated from

the rest of the city by a waterway called the Industrial Canal, and historically the Lower Ninth Ward was the last to obtain any services.

With that knowledge, we opened the Lower Ninth Ward Health Clinic in order to improve medical care needed by internally displaced people returning to New Orleans, many of whom have a history of inadequate medical attention.

Initially, the clinic was staffed by volunteer medical providers at a time when many medical professionals who lived in the city were physically displaced by the disaster. It was largely through the Primary Care Access and Stabilization Grant that we were able to access the funds to employ and stabilize the medical staff, purchase medications, medical equipment and supplies, and contract services for laboratory tests. The grant also provided us with the capacity to raise funds from other sources.

Today, the Lower Ninth Ward Health Clinic is proud to report that it employs two part-time physicians with significant medical experience, two medical assistants, one clinical director, and one executive director. We serve more than 2,200 patients on an ongoing basis and over 5,000 patients through initial medical visits. We are grateful to provide a service that has not only contributed to the medical progress and positive health outcomes of our patients, but also to their recovery and to the recovery of New Orleans.

While we have made incremental progress, there is still much work to be done in the areas of quality improvement and disparity reduction. With the adversity of this disaster, there was also an opportunity to discard ineffective treatments and try new and innovative therapies to improve quality of care and reduce disparities. The positive health care outcomes to date have been realized in large part because of the funding of the Primary Care Access and Stabilization Grant.

We are eternally grateful to all Members of Congress and commend past Secretary of Health and Human Services Michael Leavitt for his service and his leadership as well as his insightful actions, which aided the New Orleans region in receiving much-needed funding for health care services. We are looking forward with great anticipation to future public-private collaborations which enhance and sustain the health care status of citizens of our region.

We are at a pivotal moment in the evolution of providing excellent health care services. We must not forget we have an opportunity to change the trajectory of internally displaced people. We are now positioned to do phenomenal things to improve the health and welfare of the people of New Orleans and the Gulf Coast region.

Thank you.

[The prepared statement of Ms. Craft-Kerney follows:]

From Disaster to Wellness: The Need to Build on the Success of the Lower 9th Ward Health Clinic in Post-Katrina New Orleans

Statement of
Alice Craft-Kerney, RN, BSN
Executive Director of the Lower 9th Ward Health Clinic
New Orleans, LA

Before the Oversight and Reform Committee
U.S. House of Representatives
"Post Katrina Recovery: Restoring Health Care in the New Orleans Region"
Congressional Hearing

December 3, 2009

Chairman Towns and members of the Committee, I am Alice Craft-Kerney, Executive Director of the Lower 9th Ward Health Clinic in New Orleans, Louisiana. I appreciate the opportunity to be here today to discuss the successful partnership of government and community to deliver health care services to the citizens of the New Orleans region.

I first want to express my appreciation for the Primary Care Access and Stabilization Grant, which has been a lifeline for the uninsured and underinsured residents of the Greater New Orleans area. The grant program enabled the Lower 9th Ward Health Clinic, as well as, other health clinics to employ medical staff and provide health care services in New Orleans, which has been designated as a medically underserved area. It is our hope that Congress will recognize the critical need for our health clinics and take action to continue this fruitful collaboration, which contributed significantly to the recovery of the New Orleans region.

Before Hurricane Katrina, I worked as a nursing supervisor of trauma surgery wards and the confined care unit at Charity Hospital (Medical Center of Louisiana), which is part of the LSU Health Care Services Division. Charity Hospital was a level one trauma center that served as the safety net provider for patients who either had no health insurance or were underinsured. During my nineteen and a half years at the Medical Center of Louisiana, I served many patients who were hospitalized because they were not able to access primary care services that could have prevented their need for hospitalization. There are significant factors that contribute to people in the New Orleans region being vulnerable to poor health outcomes, which include:

- Large numbers of New Orleans residents living at or below the poverty level
- Low education levels and high illiteracy rates among residents
- High dependence on the public sector for health care needs
- High rates of chronic illness
- High number of uninsured residents
- Use of emergency rooms as a substitute for primary care

- Inadequate emergency preparedness

On August 29, 2005, these factors collided with the worst natural and man-made disaster in the history of the United States, creating a public health crisis of enormous proportions. Ms. Patricia Berryhill, a registered nurse and my colleague at the Medical Center, and I decided to confront this crisis by opening the Lower 9th Ward Health Clinic on February 27, 2007.

THE LOWER 9TH WARD HEALTH CLINIC: A MEDICAL HOME

The humanitarian mission we have undertaken at the Lower 9th Ward Health Clinic is informed by the *United Nations Guiding Principles of Internal Displacement*, a standard of care that is supported by the U.S. Government to ensure the recovery of people around the world who become displaced by a disaster. Principle 19 of the *Guiding Principles* calls for comprehensive medical care and special attention to the health needs of displaced persons. For displaced New Orleanians, these health needs involved the traumatic experience of the disaster and being uprooted from home as well as the physical impacts of not having access to life-sustaining medications and treatments.

As time passed, no one came to the lower ninth ward—a community separated from the rest of the city by a waterway called the Industrial Canal. Historically, the lower ninth ward was last to obtain any services. With that knowledge, we opened the Lower 9th Ward Health Clinic in order to provide the medical care needed by internally displaced people returning to New Orleans, many of whom have a history of inadequate medical attention.

The necessity for the Lower 9th Ward Clinic was borne by the on-the-ground conditions in New Orleans. In the immediate aftermath of Hurricane Katrina, Charity Hospital, the medical safety net provider, was closed indefinitely. Some of the re-opened private health care facilities were ill equipped and without the capacity to care for the host of needs among the patient population. There was also the question of who would provide care for the uninsured? Scarce medical resources led to the roll-out of health care service buses that passed through various neighborhoods and temporary tent clinics which drew long lines of people.

In the lower ninth ward, residents struggling to restore their lives demanded a health care clinic. Ms. Berryhill and I committed ourselves to finding a way to meet this urgent demand. Ms. Berryhill allowed use of her home on St. Claude Avenue in the Lower 9th Ward to be converted into a health clinic. With the assistance of residents, advocacy organizations, and volunteers, we planned, designed, and built the Lower 9th Health Clinic with a clear focus on making it a real home for healthcare regardless of ability to pay. By "home," I mean a place where people feel welcomed and comfortable with staff who support them in taking the necessary steps to wellness and prevention.

Initially, the clinic was staffed by volunteer medical providers at a time when many medical professionals who lived in the city were physically displaced by the disaster. It was largely through the Primary Access and Stabilization Grant that we were able to access the funds to employ and stabilize medical staff, purchase medications, medical equipment and supplies, and

contract services for laboratory tests. The grant also provided us with the capacity to raise funds from other sources.

Today, the Lower 9th Ward Health Clinic is proud to report that it employs two part-time physicians with significant medical experience, two medical assistants, one clinical director, and one executive director. We serve more than 2,200 patients on an on-going basis and over 5,000 patients through initial medical visits. We are grateful to provide a service that has not only contributed to the medical progress and positive health outcomes of our patients, but also to their recovery and the recovery of New Orleans.

HEALING & EMPOWERING PATIENTS

As we continue to move forward, the Lower 9th Ward Health Clinic has made tremendous strides in health promotion and disease prevention. Our overarching goal continues to be prevention of premature deaths and avoidance of unnecessary disabilities due to chronic illnesses. We embrace a model of care that is patient-centered and provides a conduit to a continuum of health care services. We are patient navigators who empower our patients to effectively care for themselves through highly individualized patient education, consistent medical follow-up, preventive screenings, and a unique aftercare program. The Lower 9th Ward Health Clinic has implemented programs that utilize and promote best practices in disease management among high risk, underserved populations and institutes extremely innovative therapies. At each and every visit, we question and document the patient's responses to recent hospitalizations and
Like all of New Orleans, but particularly in New Orleans East, data has shown significant population shifts and demographic changes post-hurricane. Each month that the New Orleans East Clinic has been open, we have seen a 15% increase in patient volume. We currently offer Gynecological, Pediatric, Adult Primary Care services, WIC, and Healthy Start. We have collaborations with LSU and Tulane Schools of Medicine for specialty care, diagnostic procedures, and inpatient management.

There are 65% of our patients who are uninsured. Our typical patient is a working mother who comes in for WIC services, brings her children in for a pediatric visit, participates in Healthy Start parenting class with the father of the children, gets her pap smear and birth control and makes her brother come in to get his blood pressure checked. She can get all of this accomplished in her neighborhood because of the New Orleans East Clinic. For a growing population that is geographically isolated, the PCASG funding has allowed us to provide convenient compassionate services, because even four years later, there is no hospital within 20 miles, and very limited private medical care and services, and virtually no free or reduced fee primary medical care and services.
we are most proud of our accomplishments in reducing emergency room visits, decreasing hospitalizations, and reducing absenteeism from work which translates into increased productivity and a better quality of life. With every patient we serve, we know that we are reducing the factors that have led to poor health among residents before and after Hurricane Katrina.

ONGOING PARTNERSHIP

While we have made incremental progress, there is still much work to be done in the areas of quality improvement and disparity reduction. With the adversity of this disaster there was also an opportunity to discard ineffective treatments and try new and innovative therapies to improve

quality of care and reduce disparities. The positive health care outcomes to date have been realized in large part because of funding from the Primary Care Access and Stabilization Grant. We are eternally grateful to all members of congress and commend past Secretary of Health and Human Services, Michael Leavitt, for his service and his leadership, as well as, his insightful actions which aided the New Orleans region in receiving much needed funding for health care services. We are also looking forward with great anticipation to future public-private collaborations which enhance and sustain the health care status of the citizens of our region. On behalf of the 2,200 patients of the Lower 9th Ward Health Clinic, we ask for the support of this Committee to continue the Primary Care Access and Stabilization Grant in order to save lives and enhance the health care status of the citizens of our region.

Thank you.

Chairman TOWNS. Thank you very much for your statement.
Dr. Erwin.

STATEMENT OF DONALD T. ERWIN, M.D.

Dr. ERWIN. Good morning. I would like to thank the chairman and members of the committee for their continued interest in the health care situation of post-Katrina New Orleans and for the opportunity to appear here today.

I am Don Erwin, CEO of St. Thomas Clinic, which is No. 54 on the map that you have. It was started in 1987 as a community-based clinic in one of the country's oldest housing developments. Prior to Hurricane Katrina, the focus was its neighborhood and our programs were defined by the availability of public and private grants. The budgets were small, services were limited. After Hurricane Katrina, through the generosity of many, the clinic reopened to provide health care for returning citizens and has since become one of the community's largest and most comprehensive primary care centers.

With the PCASG funds, St. Thomas has gone from 2.4 FTE providers to 8 primary care and mental health care providers. We now have a staff of 45 people and an annual operating budget of $4.5 million. We have a patient base of 14,000 patients and provide over 22,000 patient visits per year. Although we use an open access appointment model, we are still not able to meet the need. Prior to Katrina, we saw patients from three to five local zip codes. Last year, we saw patients from 251 zip codes in three States.

In addition to primary care, collaborations have been made to provide our patients with specialty care in seven major medical specialties. This specialty care, offered in a primary care setting, provides coordinated patient-centered care in a cost-effective way. We are also a training site for medical students, residents, and nurse practitioners.

As part of a CDC-sponsored national breast and cervical early detection program, administered by the LSU School of Public Health, St. Thomas provides breast cancer early detection with digital mammography and ultrasound. For over a year after Katrina, we were the only mammography site for uninsured women and we continue to be one of only two in the region. Through a unique collaboration with Ochsner Clinic Foundation and the Association of Black Cardiologists, St. Thomas offers interventional cardiovascular care for the prevention of heart attacks, stroke, and sudden death. For uninsured patients, this cardiovascular care is generally unavailable or delayed for months.

Included in my written testimony is a copy of a cardiac tracing that shows an implantable defibrillator operating to serve the life of a 52-year-old working man who has a wife and two children. He was at work when he had an episode of silent ventricular fibrillation and the defibrillator saved his life.

Although these defibrillators cost $50,000 each, we have installed 14 of them in uninsured patients, with both the defibrillators and the cardiologists' time being donated to St. Thomas. I would like for you to understand that this man is just one of the many thousands of lives that have been saved by this grant and the services provided.

All of the specialty services that we have available at St. Thomas are offered to any patient of any of the safety net clinics in the New Orleans community. As a result of the infrastructure made possible by the Primary Care Access and Stabilization Grants, St. Thomas has become a federally qualified health center and also a level 3 patient-centered medical home, recognized by the National Committee for Quality Assurance.

We were recently notified that St. Thomas would be honored by the National College of Physicians, the second largest physician group in the United States, which is this year awarding St. Thomas its Rosenthal Award for the original approach to the delivery of health care in a way which will increase its clinical and/or economic effectiveness.

Although St. Thomas has become a federally qualified center, the annual FQHC grant of $650,000 makes up only 14 percent of our annual $4.5 million budget. We are unable to take full advantage of the augmented FQHC Medicaid rates, since only 14 percent of our patients have Medicaid; 72 percent of our patients remain uninsured. Although the percentage of Medicaid-eligible patients will increase in the future, we think this will take at least 2 years.

Without the funds provided through the Primary Care Access and Stabilization Grant, it is difficult to project continued viability for St. Thomas. Although we are steadily moving toward sustainability, with 72 percent uninsured patients, we do not expect to have replacement revenue to support our operations until there is expanded Medicaid eligibility. Certainly an early consequence will be the loss of the infrastructure necessary to support the policy and procedure requirements to remain a federally qualified health center and a patient-centered medical home.

In our business plan, for 3 years, we project that in the beginning of year three, we could replace the revenues lost by the Primary Care Access and Stabilization Grant. In the intervening 2 years, however, we cannot identify any source of adequate support, nor do we see any other safety net site in our region which would absorb our patients. As you have heard, Hurricane Katrina created a new population of uninsured patients when the storm took people's homes, jobs and health insurance. The PCASG has enabled us to begin the restructuring of the delivery system in our State.

We are optimistic about the sustainability of clinics like St. Thomas, if we are given another 2 or 3 years for the recovery to continue. But for the present, if there is no bridge funding, we anticipate that our patients will find themselves in the same situation they found themselves immediately post-Katrina, where the only source of primary care was the crowded emergency rooms.

Thank you very much for the opportunity to speak with you this morning and for your continued support of our community.

[The prepared statement of Dr. Erwin follows:]

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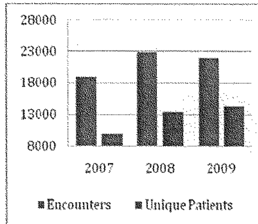
4 December 2009

Testimony before the House Oversight Committee

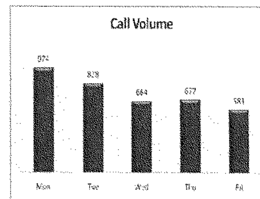
I would like to thank the Chairman and the members of the committee for your continued interest in the health care situation in post Katrina New Orleans, and for the opportunity to appear before this committee.

St. Thomas Community Health Center was started in 1987 as a community based health center in one of the country's oldest housing developments. For the 18 years prior to Hurricane Katrina, its focus was the Irish Channel neighborhood, and its programs were structured by the availability of private and public grants. The budget was small and services were limited. After Hurricane Katrina, through the generosity of many, the clinic reopened to provide health care for returning citizens, as the large safety net State Charity Hospital and its clinics were still closed. With the funding from the Primary Care Access and Stabilization Grant, St. Thomas has become one of the community's largest, and most comprehensive primary care centers.



St. Thomas CHC now has a staff of 45 people including 2 primary care physicians, 3 nurse practitioners, and 3 Licensed clinical social workers. It has an annual operating budget of $4.5 million dollars, and serves an annual patient base of over 14,000 patients. For each of the last two years, St. Thomas has provided over 22,000 patient visits per year.

We use an open access appointment model, but are still not able to see everyone who would like to be seen. Prior to Katrina we saw patients from 3-5 zip codes. Last year, we saw patients from 252 zip codes and 3 states. When the daily phone calls to the clinic were measure, on a Monday, there were 972 phone calls between 7:30 AM and 11:30 AM.



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In addition to Primary Care, collaborations have been made with specialty providers so that St Thomas provides Cardiology, Rheumatology, Nephrology, Gynecology, Optometry, Mammography and Mental Health. Providing specialty care in a primary care setting has enhanced the clinic's ability to provide coordinated, patient centered care in a cost effective way. We are also a training site for medical students, residents and nurse practitioners.

As part of the CDC National Breast and Cervical Early Detection Program, administered by the LSU School of Public Health, St. Thomas provides breast cancer early detection with digital mammography and ultrasound. After Katrina, the clinic was the only mammography site for uninsured women for over a year, and it continues to be one of only two sites in the region for uninsured women.

Through a unique collaboration with the Ochsner Clinic Foundation, the Association of Black Cardiologists, Astra Zeneca pharmaceutical Company, and others, St. Thomas provides interventional cardiovascular care for the prevention and treatment of health attacks and strokes for patients with no health insurance. We receive referrals from the other safety net clinics in New Orleans, as well as local emergency rooms and private providers for this cardiovascular care that would otherwise be unavailable or delayed for months for the uninsured. Included in my written testimony is a copy of a tracing showing an implantable defibrillator functioning to save the life of a 52 year old working family man with 2 children (see appendix). We have installed 14 such implantable defibrillators, usually costing $50,000 each, in our uninsured patients with both the units and the Cardiologist's time, being donated to St. Thomas.

Through collaboration with the Eye Ear Nose and Throat foundation, St. Thomas provides screening and treatment for diabetic retinopathy and glaucoma, and treatment for ear nose and throat cancer. Patients are also provided eye exams and glasses at low cost.

All of the specialty care services available at St. Thomas are also offered to all patients of any of other safety net clinics in the New Orleans community.

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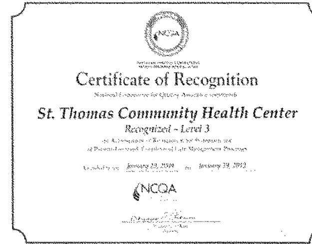
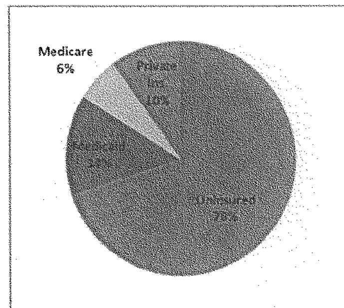
As a result of the infrastructure made possible by the Primary Care access and Stabilization Grant, St. Thomas received a New Grant Award to become a Federally Qualified Health Center. St. Thomas has also been recognized by the National Committee for Quality Assurance as a Level 3 Patient Centered Medical Home. Considerable system support and expertise was also provided to St Thomas by the Institute for Healthcare Improvement.



We were recently notified that St. Thomas will be recognized at the upcoming annual meeting of the American College of Physicians, a national organization of physicians who specialize in the prevention, detection and treatment of illnesses in adults. ACP is the largest medical-specialty organization and second-largest physician group in the United States, This year St. Thomas is receiving the ACP Annual Rosenthal Award for the "original approach to the delivery of health care which will increase its clinical and/or economic effectiveness".



Although St. Thomas has become Federally Qualified Health Center, the annual FQHC grant of $650,000 makes up only 14% of our annual $4.5 million dollar budget. One of the main ways that being an FQHC helps provide financial stability is through its augmented re-imbursement for Medicaid and Medicare patients. Nationally, for most FQHCs, the patient demographics are 45% uninsured and 45 % Medicaid. At St. Thomas, we cannot capitalize on this augmented re-imbursement since only 14 % of our population is Medicaid, with 72 % being uninsured. Although the percentage of Medicaid eligible patients will likely increase in Louisiana, this will not take place for another 2 years.

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Without the funds provided by the Primary Care Access and Stabilization Grant, which makes up 66% of our operating revenue, St. Thomas will revert to a shell of our present status. We would be able to support at the most, 1.8 to 2.0 providers, and none of the comprehensive care we currently offer. Most importantly, we would not be able to provide the infrastructure that would allow us to continue to meet the policy and procedure requirements to remain either a Federally Qualified Health Center or a Patient Centered Medical Home.

In the 3 year business plan, a copy of which is submitted to this committee, we expect that beginning in year 3, St. Thomas will have the increased patient revenues, including the increased Medicaid population, which could replace the funds lost from the Primary Care Access and Stabilization Grant.

In the interim, we cannot identify any other source of revenue that will allow St. Thomas Community Health Center to remain a vital health care resource in the community. We similarly do not see any other safety net site in the region which would be able to absorb the patients and provide the care they need.

Hurricane Katrina created a whole new population of uninsured patients when the storm took away people's homes jobs and health insurance. The PCASG grant has allowed us to begin to restructure the health care delivery system in the state. We feel optimistic about the sustainability of clinics like St. Thomas if we have another 2-3 years for the recovery to continue, especially with the anticipated increase in Medicaid eligible patients. But for the present, if there is no funding to bridge the gap for the next 2-3 years, many of our patients will revert to essentially the same situation they found themselves in immediately post Katrina, and that is the only source of primary care to be delivered in the hospital emergency rooms.

Donald T. Erwin, M.D.
CEO
St. Thomas Community Health Center

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Chairman TOWNS. Thank you very much for your statement.
Mr. Griffin.

STATEMENT OF MICHAEL GRIFFIN

Mr. GRIFFIN. Good morning Chairman Towns, Congressman Cao, and other distinguished members of the Committee on Oversight and Government Reform. I would like to thank you for allowing me to offer testimony in this public formum on ongoing health care concerns and challenges facing the New Orleans region post-Hurricane Katrina.

My name is Michael Griffin. I am the chief executive officer of Daughters of Charity Services of New Orleans, a primary health care provider whose organization has roots in New Orleans for 175 years, with services to the poor and vulnerable. The Daughters of Charity Services of New Orleans [DCSNO], is sponsored by Ascension Health. Ascension Health was founded in 1999 with the Daughters of Charity and the Sisters of St. Joseph joining their health ministries into one organization.

DCSNO's mission is to improve the health and well-being of our community. We are dedicated to providing primary and preventive health care services which address the needs of the total individual—body, mind and spirit. I welcome this opportunity to inform you on how the Primary Care Access and Stabilization Grant program has assisted us in restoring and improving the health delivery system in New Orleans and what challenges are still before us.

When Hurricane Katrina struck the city of New Orleans on August 29, 2005, it severely impaired the health care delivery system. Medical and other support personnel were displaced and the city lost several hospitals and numerous primary care providers. DCSNO was not sheltered from the impact of Hurricane Katrina. We lost our one and only health center site to flooding in the aftermath of the storm. Yet as our history demonstrates, the DCSNO board and Ascension Health would remain steadfast and committed to serving the poor and vulnerable in New Orleans. Within 45 days after the storm, we opened a new health center in the Metairie area, next door to the Department of Health. However, the diminished capacity of the overall health care infrastructure in new Orleans severely compromised continuity of care for low-income and minority populations who were attempting to remain or return to the area.

Katrina resulted in the loss of five hospitals, one of which served the vast majority of the medically under-served and poor. The aftermath of Hurricane Katrina was the litmus test which challenged DCSNO to improve access to health care services at additional locations throughout the metropolitan area with the goal of meeting the primary care needs of the community at large. It was because of the Primary Care Access and Stabilization Grant awarded by the U.S. Department of Health and Human Services and authorized by Congress that DCSNO was able to rapidly expand from one to three primary health care centers in the area. Today, these health care centers are current in providing primary care services to the under-served populations in the Carrollton area, the Upper Ninth Ward, and Metairie.

As a direct result of PCASG funding, DCSNO has been able this past year to provide affordable or free care to 20,034 patients, totaling 65,509 patient visits. Seventy-two percent of those patients are uninsured. Let me repeat that: 72 percent of the 20,000 patients are uninsured. Fifteen percent are on Medicaid, 5 percent are on Medicare, 7 percent are on other insurance. DCSNO has experienced unanticipated growth in this last year of a 49 percent increase in our patient population since last July.

The Primary Care Access Stabilization grant funding allowed us to retain and hire new doctors. We are offering free pharmacy services and have expanded access to mental health providers for both children and adults. We have plans to expand dental care and optometry. In addition, we have leveraged the PCASG funding to encourage partners like the Unity Foundation and the March of Dimes to help fund mobile primary care units, two of which are mobile prenatal units and the other is one that treats the homeless, and to restore our Seton Resource Center for Adolescent and Mental Health Development that offers behavioral health and counseling services at 10 public and parochial schools.

Let me quickly tell you this story. An uninsured mother, who didn't have a regular physician, recently attended a health fair staffed by DCSNO's mobile unit. She had a history of hypertension, cholesterol, and glucose issues. While having her testing done, the woman expressed concerns to her medical provider about her daughter complaining of not feeling well. She was constantly drinking water and going to the rest room. She wondered if we could just take a quick look at her daughter. We gave the 9-year-old a glucose test and found that the glucose level was above 300, which was extremely dangerous. Our clinician recommended that the mother immediately take her child to Children's Hospital for further treatment. The child was in fact admitted to Children's Hospital, where the emergency room doctors informed the mother that any prolonged high blood sugar could have resulted in a stroke, coma or even death.

I tell this story because it demonstrates the type of community that we are doing at Daughters of Charity Services of New Orleans to help those who do not have health insurance and/or a family physician to call when a child gets sick.

I thank you, Chairman Towns, for this opportunity to testify before Congress, and thank you for your support of New Orleans.

[The prepared statement of Mr. Griffin follows:]

Post Katrina Recovery: Restoring Healthcare in the New Orleans Region

Statement by
Michael Griffin
Chief Executive Officer
Daughters of Charity Services of New Orleans
Before the
House Oversight and Government Reform Committee
Washington, D.C.
December 3, 2009

Good Morning, Chairman Towns and other distinguished members of the Committee on Oversight and Government Reform. I would like to thank you for allowing me to offer testimony in this public forum on the ongoing healthcare concerns and challenges facing the New Orleans region post-Hurricane Katrina.

My name is Michael Griffin, and I am the Chief Executive Officer of Daughters of Charity Services of New Orleans, a primary healthcare provider whose organization has its roots in New Orleans for 175 years with service to the poor and vulnerable. The Daughters of Charity Services of New Orleans, or DCSNO, is sponsored by Ascension Health. Ascension Health was formed in 1999 when the Daughters of Charity and the Sisters of St. Joseph joined their health ministries into one organization.

DCSNO's mission is to improve the health and well-being of our community, and we are dedicated to providing primary and preventive healthcare services which address the needs of the total individual – body, mind and spirit. I welcome this opportunity to inform you on how the Primary Care Access and Stabilization Grant (PCASG) program has assisted in restoring and improving the healthcare delivery system in New Orleans and what challenges are still before us.

When Hurricane Katrina struck the City of New Orleans on August 29, 2005, it severely impaired the healthcare delivery system. Medical and other support personnel were displaced and the city lost several hospitals and numerous primary care providers. DCSNO was not sheltered from the impact of Katrina. We lost our one and only healthcare center site to flooding in the aftermath of the storm. Yet as our history demonstrates, the DCSNO Board and Ascension Health would remain steadfastly committed to serving the poor and vulnerable in New Orleans. Within 45 days after the storm, we opened a new health center in the Metairie area, next door to the Department of Health. However, the diminished capacity of the overall heathcare infrastructure in New Orleans severely compromised continuity of care for low income and minority populations who were attempting to remain or return to the area.

Katrina resulted in the loss of five hospitals -- one of which served the vast majority of the medically underserved and poor. The aftermath of Hurricane Katrina was the litmus test which

challenged DCSNO to improve access to healthcare services at additional locations throughout the metropolitan area with the goal of meeting the primary care needs of the community at large. It was because of the Primary Care Access and Stabilization Grant (PCASG) grant awarded by the U.S. Department of Health and Human Services and authorized by Congress that DCSNO was able to rapidly expand from one to three primary healthcare centers. Today these health centers are currently providing primary care services to the underserved communities of Carrollton, St. Cecilia and Metairie.

As a direct result of PCASG funding, DCSNO has been able to provide affordable or free primary care to 20,034 patients, totaling 65,509 patient visits. Seventy two percent of our patients are uninsured, 15 percent are on Medicaid, 5 percent are on Medicare and 7 percent have other forms of insurance. DCSNO has experienced unanticipated growth, with a 49 percent increase in our patient population just since last year.

PCASG funding allowed us to retain and hire new doctors. We are offering free pharmacy services, have expanded access to our mental health providers to both children and adults, and have plans to provide dental care and optometry. In addition, we have leveraged PCASG funding to encourage partners like the Unity Foundation and United Way to help fund a mobile primary care unit, two mobile pre-natal Mom & Baby units, and to restore our Seton Resource Center for Adolescent and Mental Health Development that offers behavioral health and counseling services at 10 public and parochial schools.

Our medical providers focus on "primary care prevention" and integral to our delivery system is the use of electronic health records. These records enable center providers to stay abreast of our patients' needs for chronic care management. The integrated patient-centered medical home model of care provided to all of our patients reduces the amount of time our patients must wait to be seen and treated; enhancing the quality of care a patient receives from our health centers. All three of DCSNO's healthcare centers have received the National Committee for Quality Assurance's Level Three Recognition -- their highest level of recognition -- for our patient-centered, medical homes. This achievement was made possible by funding received through the PCASG grant.

Additional outcomes linked to PCASG grant funding include a significant and documented increase in the use of primary care providers and improved health status for community residents served by our centers. PCASG funding has, in fact, enhanced and fundamentally altered the way medical care is delivered in New Orleans, forever.

Let me share a brief story with you. An uninsured mother, who didn't have a regular physician, recently attended a health fair staffed by DCSNO's primary care mobile unit that was offering free testing for hypertension, cholesterol and glucose. While having her testing done, the woman expressed concerns to our medical provider that her daughter had been complaining of not feeling well, that she was constantly drinking water and going to the restroom. She wondered if we could just take a quick look at her. We gave the 9-year-old girl a glucose test and found her glucose level to be above 300, which is extremely dangerous. Our clinician recommended that the mother immediately take her child to Children's Hospital for further treatment. The child was, in fact, admitted to Children's Hospital where the emergency room doctors informed the mother that had she prolonged getting her daughter to the hospital any longer, the child would have probably died or slipped into a coma.

I tell this story because it demonstrates the type of community outreach that we are doing at DCSNO to help those who do not have insurance or a family physician to call when a child gets sick.

Daunting challenges still confront New Orleans. The largest hospital in our region, Charity Hospital, has not reopened and many of the area's poor are still lost without the care it provided. However, DCSNO and the other PCASG grantees have stepped up in a significant way to provide a more appropriate way for the uninsured to receive healthcare services in lieu of queuing up for care in Charity's ER. As a native of New Orleans, I can attest that many of our patients are now seeing the advantages of receiving care at a primary care clinic rather than waiting long hours in the ER to get treated for a sore throat or, worse, to manage a chronic condition such as diabetes, asthma or high blood pressure.

Our budget is comprised of 50 percent of the funds received through the PCASG program. Should PCASG funding disappear, who and what will fill the void? We are looking at various scenarios right now, none of them good. We would likely have to cut out most, if not all, of our community outreach activities. I worry about what will happen to the homeless population that is presently being served by our mobile health unit. Where will the new Latino worker population go to secure healthcare? Who will make the effort to bring healthcare facilities to impoverished areas and how long will it take to see that brought to fruition?

I believe that in the years to come, the foresight that Congress had in providing funding for primary care services post-Katrina will be credited with fundamentally changing the way that New Orleans residents seek access to medical care. I believe that one major reason for the success of PCASG funding was that it was made available to all nonprofit safety net providers in the community and eligibility was not limited to entities already participating in other federal primary care programs, such as the federal CHC or FQHC programs. Under current law, health centers that are owned and operated by another entity, such as the Daughters of Charity, are not eligible to participate in those federal programs.

One option that many of us in New Orleans have considered, and that GAO cited in its report, is to convert our organizations to FQHC Look Alike status or to try to qualify for Public Health Service funding through the Community Health Center program. Unfortunately, funding under the federal CHC program is extremely limited. It is my understanding that new grantees may not be able to receive funding as new access points for several years. The bulk of the $2 billion that Congress authorized in the stimulus bill went to existing CHC grantees and only $200 million was made available for new access points.

I would like to be able to say that the sustainability of DCSNO is assured and that we will be able to continue to expand along the lines that we have been able to over the past few years in partnership with the federal government. But I cannot. It is hard for me to imagine that we will be able to continue or even sustain our current patient load because of the high rate of uninsured people we serve and our inability to qualify for existing federal programs aimed at improving access to primary care to the medically underserved.

We look forward to a continued dialogue with Congress to ensure that we continue to work together to achieve Ascension Health's goal of 100% access and 100% coverage for all by 2020.

Thank you, Chairman Towns, for this opportunity to testify before Congress and thank you for your support of New Orleans.

Chairman TOWNS. Thank you very much, Mr. Griffin.
Dr. Townsend.

STATEMENT OF ROXANE A. TOWNSEND, M.D.

Dr. TOWNSEND. Thank you Mr. Chairman and members of the committee for the opportunity to address you today regarding the status of health care in New Orleans on behalf of the Louisiana State University health system.

In addition to my role at the health system, I also have the privilege right now of serving as the interim CEO to the public hospital in New Orleans.

When Hurricane Katrina forced the closure of the Medical Center of Louisiana at New Orleans, we did lose critical infrastructure for health care. We lost 550 inpatient beds. At that time, we were doing 23,000 patient admissions a year, we had 120,000 emergency department visits. But something that is not often recognized and is really important, we did more than 260,000 outpatient clinic visits in our hospital-based clinics. That included primary care as well as specialty care.

We had over 640 medical residents and fellows from Louisiana State University and Tulane University training at that hospital, along with thousands of other students, dental, nursing, and allied health, and pharmacy. It was a critical area for teaching for Louisiana, for the work force, for the future. We lost all of that in Katrina. And when you look at that, the role of that facility, it wasn't simply for the New Orleans region. It was a Statewide resource, where people who were uninsured could go to get specialty care. Oftentimes the specialty care isn't available to these folks, even if they have a Medicaid card in the rest of the State. We lost all of that from Katrina.

Knowing the important role that this facility played, I consider these people who stayed there during the storm and reconstituted services after as really true heroes. They went from constructing tents in a parking lot where they continued to provide services; they moved those tents into the convention center because it didn't flood. So they at least had a roof over their head.

Then they moved those tents into a former department store in a mall adjacent to the Superdome once the flooding subsided. And we continue to do specialty care and primary care clinics there today, because it wasn't until November 2006 that the former University Hospital campus was able to be transformed and reconstituted into an inpatient facility. That was through the work and collaboration of FEMA and LSU, as well as Louisiana's Office of Facility Planning and Control. Today we are operating 275 beds, about half of what we had before the storm. With that, we are running close to 85 percent occupancy. If you look at hospitals across the country, 85 percent occupancy is full. In our ICU, we have 36 beds. They stay full all the time. We have 38 inpatient acute psychiatric beds for adults. They are always full.

We also provide the only Level I trauma center in Louisiana, serving a nine-parish area. We have 11 operating rooms, less than half of what we had before the storm. One of those always has to be on standby for trauma, since we are Level I. So we are cram-

ming all of our operating room cases into 10 operating rooms in that facility.

And as a well-respected physician in the community, someone who was there during the storm and after the storm said, we really are gaining stability but we are still pretty fragile. We are probably one big bus wreck away from just crippling the entire system down there. So we still have a way to go.

One of the really exciting things that did happen was through the generous funding of Congress we got the Primary Care Access and Stabilization Grant. So we were able to bring six community clinics up after the storm associated with in the interim hospital. And this was different from before the storm where everything was pretty well located on campus. Now these six clinics are allowing quality patient care to happen close to where people live. And the quality is evidenced by the NCQA actually giving us recognition status as patient-centered medical homes in those community clinics.

The grant funding was flexible enough that we were also able to provide some specialty care services. As we look at this funding coming to a close, we recognize that our role as an academic medical center is to support these primary care clinics. So we are looking at consolidating some of those clinics into bricks and mortar, rather than the temporary buildings that they are in now. But we see that access to the specialty care and inpatient care is extremely important. So we are trying to partner with the community clinics that are still there that will hopefully survive after the primary care grant goes away, so that we can give important services to those folks. We don't just treat, we also educate. And we have to do both of those together.

So I thank you for the opportunity to address the committee today.

[The prepared statement of Dr. Townsend follows:]

The Committee on Oversight and Government Reform
"Post-Katrina Recovery: Restoring Health Care in the New Orleans Region"
Outline of Testimony for
Roxane A. Townsend, M.D.
Assistant Vice President for Health Systems
Louisiana State University Health System
December 3, 2009

I. Brief introduction and overview of the LSU Health System and the impact of Hurricane Katrina on the services provided by the LSU public hospital operating in New Orleans including pre Katrina volume statistics.

II. Actions of LSU following Hurricane Katrina to restore hospital and clinic services to the region including current capacity.

III. Overview of current outpatient activity including establishment of community based primary care clinics as result of the Primary Care Access and Stabilization Grant (PCASG) including volume statistics.

IV. Analysis of financial and programmatic impact of loss of PCASG funds on future operations of LSU community clinics

V. Concluding comments on future commitment of LSU to delivery of health care in the New Orleans region.

Attachments:

(1) PCASG community clinic trend data
(2) Map reflecting PCASG patients by zip code
(3) Total Interim LSU Public Hospital clinic and hospital trend data
(4) Residency programs operating at Interim LSU Public Hospital

The Committee on Oversight and Government Reform
"Post-Katrina Recovery: Restoring Health Care in the New Orleans Region"
Testimony of

Roxane A. Townsend, M.D.
Assistant Vice President for Health Systems
Louisiana State University Health System

December 3, 2009

Thank you, Mr. Chairman and members for the opportunity to address the Committee regarding the status of primary health care in New Orleans on behalf of the Louisiana State University Health System. The LSU Health System is comprised of 2 health sciences centers and 10 public hospitals across the state including the Interim LSU Public Hospital (ILH) in New Orleans that is striving to provide the care that was formerly provided at the Medical Center of Louisiana at New Orleans (MCLNO).

The Impact of Hurricane Katrina

Until August of 2005 when Hurricane Katrina forced the closure of the Medical Center of Louisiana at New Orleans (MCLNO), the facilities served as the major site for teaching medical students and residents for both LSU and Tulane Schools of Medicine in New Orleans. As would be expected, the hospital and clinics of MCLNO also served as the region's safety net providing care to a large volume of uninsured patients in both the inpatient and outpatient settings. In the academic year that ended June 30, 2005, just 2 months before Hurricane Katrina made landfall, MCLNO had 23,337 admissions, 264,800 outpatient visits, 119,815 emergency department visits and more than 640 medical residents and fellows training there.

The Current State of Public Health Care in New Orleans

In November of 2006, through the collaboration of Louisiana Office of Facility Planning and Control, FEMA and LSU, the Interim LSU Public Hospital opened its doors in the building formerly operated as University Hospital. University Hospital along with Charity Hospital (the Reverend Avery C. Alexander Medical Center) comprised the MCLNO. ILH initially opened with 60 beds and today has grown to 275 regularly staffed beds including 36 ICU beds, 38 acute adult inpatient psychiatric beds, and 20 medical substance abuse detoxification (detox) beds. The occupancy rate at the hospital today is consistently between 75% and 85%. The ILH also operates the region's only Level 1 Trauma Center serving the 9 parish area.

The extensive outpatient clinic activity of the hospital is provided in multiple venues as opposed to the hospital-based centralization of clinic services prior to Katrina. These outpatient clinic

sites include a former Lord and Taylor department store that serves as a primary care and multi-specialty clinic; another off-site clinic for specialty care including HIV treatment and hospital-based specialty clinics that are provided on transformed inpatient wards within ILH. With the recent opening of the University Medical Office Building, some of these clinics will move to more appropriate outpatient space.

One of the exciting opportunities to emerge from the challenges of Katrina was the placement of six community-based clinics located throughout New Orleans instead of located adjacent to the hospital. The ability of LSU to establish and operate these six clinics is a direct result of the Primary Care Access and Stabilization Grant (PCASG) made possible through generous funding from Congress for the New Orleans area. Since their inception, these six community clinics have provided over 29,000 encounters serving an average of 7,800 individual patients each year.

The PCASG funds have also provided assistance for LSU to operate multiple specialized services that support primary care. The specialty services include behavioral health, dental, ophthalmology for patients with diabetes and HIV treatment. The services to patients infected with HIV include both primary care and dental services. These specialized services occur in multiple locations including the Lord and Taylor multi-specialty clinic, the Mental Health Emergency Room Extension, and in the HIV Outpatient (HOP) clinic. In addition to the services provided in the community clinics, these specialized clinics have provided over 112,000 encounters for an average of 18,000 patients annually. The overall outpatient clinic volume at ILH is now approximately 228,000 visits per year; 86% of pre-storm volumes.

With more than 66% of the clinic visits for patients who are uninsured and the limited flexibility of DSH funds available for their outpatient care, the PCASG funds provided critical capital and operating funds for these uninsured patients to be seen in the appropriate outpatient setting. As a result of the PCASG, quality primary care is being delivered closer to patients' homes. All six of the LSU community clinics are Level 1 NCQA certified as Patient Centered Medical Homes. In these Medical Homes, our patients are assigned to doctors who know the patients, coordinate their care and participate in our extensive system-wide disease management programs.

Another important outcome of the ability to provide primary care in multiple settings is the opportunity to partner for behavioral health services which are integrated into the care provided at our clinics. Contracts have been executed between ILH and Metropolitan Human Services District (the local entity responsible for outpatient behavioral health services) to fund Licensed Clinical Social Workers for three of the community clinics. Social workers provide services at Murray Henderson, Martin Behrman Elementary School and Douglas Elementary. The latter two are school-based health centers. All children registered in these clinics are screened by the Social Workers. Decision support for behavioral health and addictive disorders

is provided to adults and children and referrals and linkages to services are facilitated. In addition, a psychiatrist provides services upon referral from the ILH Community Clinics. The psychiatrist's services are provided through the Metropolitan Human Services District and when appropriate, fees are paid by PCASG funds. The entire process is well coordinated between agencies and affords improved care to the patients with physical and behavioral health issues.

ILH participated in the Collaborative to Improve Behavioral Health Access (CIBHA), an LPHI-Robert Wood Johnson initiative. This learning collaborative is designed to improve behavioral health access and has been made available to all PCASG participants. Through this effort, all patients who entered our community clinics were screened for depression. A toolkit was made available and used to stratify and treat patients.

Sustainability of Clinics Funded by PCASG

The funding from the PCASG has allowed the community clinics to be sustained despite significant budgetary constraints for the Interim Hospital. These clinics are run by staff level practitioners and are not used for resident or student education. The cost of the services provided by physicians that are not engaged in medical education is a non-allowable expense and is not eligible for federal matching funds. Without PCASG funding, the total costs of all of these services would have to be covered by scarce state general fund dollars.

Sustainability of Community Clinics

Recognizing that the funding for the PCASG would end in September of 2010, LSU took on a detailed analysis of the expenses of the clinics in order to determine sustainability post grant. Total expenses of the six community clinics on an annual basis are approximately $3.7 million and expected to increase to $4.1 million by 2013. The clinics receive approximately $1.1 million from patient revenues, DSH reimbursement for allowable costs, and state funds from the Office of Public Health (for school-based health clinics). The PCASG has provided another approximately $1 million dollars in reimbursement annually to support the clinics. However, to support the ongoing operation of the clinics, there remains a state fund obligation of over $1.5 million this year alone. As the state of Louisiana faces a budget crisis like most states across the country, it is clear that they will not be able to fund the clinics at full operation given the gap in revenue and the loss of the $1 million PCASG grant. With inflationary and volume increases that are expected, the amount of state general funds needed would increase to $2.6 million by 2013. As occurred this past year, we expect our state fund support to decrease, not increase next year. Therefore, our analysis is indentifying other non-LSU safety net clinics operating in the vicinity of LSU clinics that have the capacity to accept the patients we are currently serving in our clinics. Conversations with these other PCASG clinics are continuing and partnerships are likely. LSU expects to maintain two clinics in New Orleans; one on the East Bank and one the

West Bank of the Mississippi River. Given our access to specialists, LSU will also focus on providing specialty care access to patients being seen at all of the PCASG clinics. This would appear to be a prudent use of state resources; to allow community partners to focus on primary care while the Academic Centers focus on supporting the necessary access to specialists for the patients of these clinics.

We have historical experience working with our partner clinics - even before Katina - through the PATH program (Partnership for Access to Health Care). This effort allows non-ILH physicians to order outpatient diagnostic and lab testing at the hospital and provides electronic access to test results for PATH clinic providers. This type of primary care-specialist support will be the emerging role of LSU in contemplation of a loss of the PCASG funds.

Ongoing Health Care Recovery in New Orleans

Ideally, a network of quality health care providers offering a continuum of coordinated care will [illegible] to operate in New Orleans and LSU is committed to being an integral part of that network. As the primary training site for medical professionals in South Louisiana, the ILH is focused on establishing and maintaining the best clinical experience for our residents and students. The LSU Interim Public Hospital and its affiliated specialty and primary care sites support two medical schools in 55 residency programs and thousands of students from seven different schools of medicine, nursing, allied health, pharmacy, and dentistry. The model of linking patient care and training provides important benefits not only to the patients we serve but for the communities that rely on us to supply their medical workforce. Ninety-seven percent of Louisiana is designated a HPSA medical professional shortage area. Given this great need, we will continue to focus our recovery on bringing back needed services for patients but also on restoring our education and training capacity. We don't feel we can accomplish one without the other.

Attachments:

(1) PCASG community clinic trend data
(2) Map reflecting PCASG patients by zip code
(3) Total Interim LSU Public Hospital clinic and hospital trend data
(4) Residency program operating at LSU Interim Public Hospital

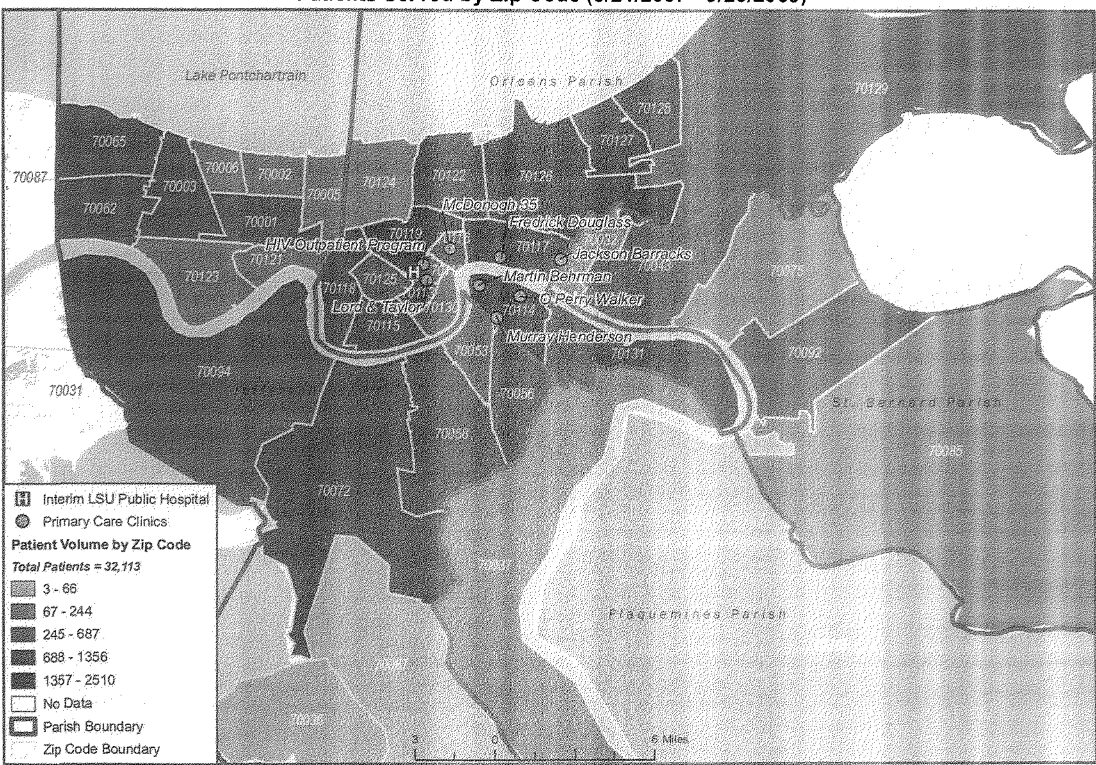
ATTACHMENT 1

LSU PCASG COMMUNITY CLINIC VISITS	FY 05 (Pre-K)	9/07-9/08	9/08-9/09
MCLNO Primary Care Clinics		0	0
Jackson Barracks (opened 1/24/08)	0	2,289	4,922
Martin Behrman (opened 2/25/08)	0	973	4,725
Federick Douglas Sr High (opened 1/24/08)	0	2,285	3,359
Murray Henderson (opened 3/3/08)	0	909	1,128
O. Perry Walker School-based Clinic (opened 10/22/07)	0	1,214	1,188
New Orleans East (4/28/08)*	0	2,591	3,502
TOTAL:		10,261	18,824
*Closes clinic due to loss of lease			
Other LSU clinics supported by PCSAG			
Lord & Taylor Clinic	-	16,285	20,164
MHERE	-	1,537	1,624
HOP		9,621	9,224
HOP Dental		2,981	3,348
Dental		35,685	9,294
Ophthalmology			2,985
Grand Total		76,370	65,463

LSU PCASG COMMUINTY CLINIC UNIQUE PATIENTS	FY 05 (Pre-K)	9/07-9/08	9/08-9/09
MCLNO Primary Care Clinics			
Jackson Barracks (opened 1/24/08)	0	1,010	2,621
Martin Behrman (opened 2/25/08)	0	545	2,069
Frederick Douglas Sr. High (opened 1/24/08)	0	1,252	2,064
Murray Henderson (opened 3/3/08)	0	464	1,095
O. Perry Walker School-based Clinic (opened 10/22/07)	0	642	706
New Orleans East (4/28/08)*	0	1,364	1,772
Total:		5,277	10,327
*Closed clinic due to loss of lease			
Other clinics supported by PCSAG			
Lord & Taylor Clinic	-	8,179	9,554
MHERE	-	1,288	1,332
HOP		2,615	2,758
HOP Dental		577	641
Dental		3,841	4,622
Ophthalmology		-	1,000
Grand Total		21,777	30,234

ATTACHMENT 2

Interim LSU Public Hospital Ambulatory Primary Care Clinics
Patients Served by Zip Code (9/21/2007 - 9/20/2009)



Sources: Louisiana Public Health Institute; ESRI (other features and boundaries).

ATTACHMENT 3

All LSU Interim Public Hospital (ILH) Outpatient Clinics*	FY 05 (Pre-K)	7/07-6/08	7/08-7/09
Allergy (opened 11/29/07)	5,097	49	191
Cardiology (L&T) - Heart Failure (opened 10/27/08)	n/a	0	447
Cardiology (opened 5/8/06)	4,120	2,877	3,489
Dental (opened 10/17/05)	16,163	6,186	8,851
Dental HOP (opened 11/6/06)	n/a	2,191	3,134
Dermatology (opened 2/3/06)	11,898	4,839	6,337
Diagnostics and Treatment (opened 1/3/07)**	n/a	2,046	4,263
Endocrine (opened 1/3/07)	3,681	901	744
ENT (opened 6/1/09)	6,255	0	54
General Surgery (opened 1/29/07)	12,889	2,991	3,760
Gastrointestinal/Hepatology (1/25/07)**	n/a	2,211	2,125
HOP (HIV Outpatient Program) (opened 4/24/06)	17,267	7,720	9,405
Hyperbarics (10/2/06)**	n/a	6,780	8,890
Medicine (11/2/05)	25,127	10,970	12,051
Neurosurgery (2/14/07)**	n/a	777	2,141
Neurology (opened 2/2/06)	10,237	2,596	2,874
OB/Gyn (opened 7/27/06)	37,204	17,641	22,343
Oncology (opened 8/13/07)	13,649	1,828	5,291
Orthopedics (opened 2/22/07)	14,452	4,210	7,022
Plastic Surgery (opened 1/5/07)**	n/a	1,329	1,751
Pulmonary (opened 1/5/07)	2,180	895	1,190
Renal (opened 8/23/06)**	n/a	1,465	1,100
Rheumatology (opened 10/11/06)**	n/a	573	1,060
Urology (opened 2/26/07 temporarily closed 8/07-1/08)	9,248	1,006	3,374
Breast and Cervical (opened 6/2/08)**	n/a	16	997
Ophthalmology (opened 8/18/08)	14,144	0	4,640
PM&R-Physical Medicine and Rehab (opened 7/22/08)	4,871	0	1,911
Surgical Oncology (opened 10/14/08)**	n/a	0	251
Vascular Surgery (opened 4/1/08)**	n/a	58	891

*all pre-Katrina outpatient clinics are operational although inpatient services may not be.
**Statistics tracked together prior to 2005

LSU Interim Public Hospital (ILH) Services	2005 - MCLNO	2006-ILH	2007-ILH	2008-ILH	2009-ILH	2010 YTD ILH	2010 Proj ILH
Total Admissions	23337	3897	5043	11941	12921	4881	14643
Total inpatient days	137771	25253	28082	64026	75494	27914	83742
Staffed beds	465	90	93	211	244	275	275

ATTACHMENT 4

RESIDENCY PROGRAMS AT
LSU INTERIM PUBLIC HOSPITAL

LSU RESIDENCY PROGRAMS
Dermatology
Emergency Medicine
Family Medicine
Internal Medicine
Medicine/Pediatrics
Med-Allergy & Immunology
Med-Cardiology
Med-Gastroenterology
Med-Infectious Disease
Med-Nephrology
Med-Pulmonary/Critical Care
Neurology
Neurosurgery
OB/GYN
Ophthalmology
Orthopedic Surgery
Otolaryngology
Pathology
Pediatrics
Ped-Neonatology
Phys. Med & Rehab
Psychiatry
General Surgery
Plastic Surgery
General Dentistry
Oral Surgery
Radiology

TULANE RESIDENCY PROGRAMS
Anesthesiology
Dermatology
Medicine
Cardiology
Endocrinology
Gastroenterology
Hematology/Oncology
Infectious Dieases
Nephrology
Otolaryngology
Pediatrics
Pulmonary/Critical Care
Neurology
Neurosurgery
OB/GYN
Orthopedic Surgery
General Surgery
Urology
Medicine-Neurology
Medicine-Pediatrics
Medicine-Allergy & Immunology
Ophthalmology
Pathology
Hemopathology
Psychiatry
Psychiatry-Child
Psychiatry-Forensic
Surgery-Plastic Triple Board

The following programs closed because of Katrina
Pediatric Radiology
Neuroradiology
Intervential radiology
Musculoskeletal radiology
Abdominal Imaging
Geriatrics
Hematology Oncology
Intervential Cardiology
Endocrinology
Rheumatology
Cyptopathology

Chairman TOWNS. Thank you very much.
Dr. Rowland.

STATEMENT OF DIANE ROWLAND

Ms. ROWLAND. Thank you Mr. Chairman and members of the committee. I am Diane Rowland, executive vice president of the Kaiser Family Foundation, and since Hurricane Katrina I have helped lead the Foundation's efforts to document the needs and monitor the progress in New Orleans through two city-wide surveys of New Orleans residents in 2006 and again in 2008. We are also planning our third survey in 2010, just to be able to assess how the progress has been going.

All of our work underscores the importance of building a strong health care system to meet the needs of all the residents of New Orleans as part of making New Orleans again a vital and dynamic system. You have heard from all of our witnesses of the fact that New Orleans did not have a fully operating system even before Katrina. And you have heard about the devastation that Katrina wrought on the city and on its health care system.

But the devastation was so widespread that it also brought an opportunity to establish and design a better system, with community-based services and integrated services for the poor and uninsured, instead of a system based on a hospital and disproportionate share Medicare payments to help sustain it. The public returning to New Orleans had many of the same problems of the public that left New Orleans. Many were poor and uninsured and many with chronic health problems. So Katrina did not wipe away the problems of the residents of New Orleans.

Adequate medical care, rebuilding medical capacity, and the Charity Hospital system establishing care in clinics and neighborhoods were high priorities of the residents that we surveyed, and came in next after rebuilding the levees which as you might imagine would have been their major concern. And as we look at a redesigned health care system we need to look at the major elements that need to be put in place. First and foremost, health care coverage provides the means for people to access health care services and the financing to support a health care system. For children in New Orleans, there is a success story. Today, only 8 percent of New Orleans' children are uninsured, lower than the national average. This is due largely to the expansion of coverage through Medicaid and the LaCHIP program. Today in the city of New Orleans, over half of the children have Medicaid as their source of coverage, which helps account for the lack of a large uninsured population.

But for adults in New Orleans, the story is very different. Louisiana, among the poorest States in our Nation, one in four living in poverty, has one of the most meager programs in terms of eligibility for adults. In fact, a working parent cannot qualify for the Medicaid program if their income is over $5,513 a year, or 25 percent of the Federal poverty level. No coverage is available for childless adults and those who are in the city now. We account that 29 percent of non-elderly adults are uninsured. These are the same levels of lack of insurance for adults as before Katrina, and these are the very individuals who are now seeking care through the community clinics that have been developed, and will need care in

an ongoing manner until insurance coverage is made available. Attempts to improve coverage have been stymied, leaving these developing health systems to care for the largely uninsured adult population. Seventy-two percent uninsured is an unsustainable level of care to be delivered in even a grant-supported clinic.

And the good news, though, is that the community-based system of clinics for primary care has been able to at least develop with the support of the Federal grant funds. It is decentralized, it is in the neighborhoods where people live. A forthcoming Commonwealth Fund study that is evaluating these clinics has found that the patient experiences show very promising results on quality, on access and on efficiency for these clinics. The investment in these clinics has helped to move a new model of care to the city of New Orleans, and appears to be bringing much-needed care to the city's still substantial uninsured population.

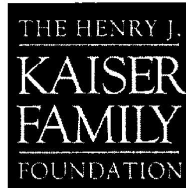
But the bad news is that the future sustainability of these clinics is in jeopardy, largely due to the lack of coverage. And while we all talk today about national health insurance and universal coverage as part of the health reform efforts, those efforts are still not going to be phased in if enacted until 2013 or 2014, leaving a huge gap right now for these clinics to be able to continue. In order to provide them with the support they need, coverage needs to be expanded, many need to be able to become federally qualified health centers, and there needs to be continued support for the uncompensated care that they provide to individuals who are uninsured.

Even in the models of community health centers around the country, we see that the mix of revenues that support them is grant funding from the Federal Government combined with the payments for their insured patients through the Medicaid program. And finally, a fully integrated health care system requires specialty care and tertiary care capacity, as you have just heard. So reestablishing a teaching hospital with multi-specialty care to back up the clinics is equally essential.

Without improved coverage of adults, combined with financial coverage for the uninsured, the neighborhood primary care model will falter, not in the care it delivers, but in its ability to sustain operations. Yet this is a critical building block for the future of New Orleans' health care and a critical building block as we look toward national reform. I hope this hearing will help to shed light on the needs of these clinics and the ability to provide services to the uninsured and the low-income population of New Orleans.

Thank you for this opportunity.

[The prepared statement of Ms. Rowland follows:]



HEALTH CARE IN NEW ORLEANS:

PROGRESS AND REMAINING CHALLENGES

Testimony of Diane Rowland, Sc.D.
Executive Vice President, Henry J. Kaiser Family Foundation
Executive Director, Kaiser Commission on Medicaid and the Uninsured

Before the U.S. House of Representatives
Committee on Oversight and Government Reform

"Post-Katrina Recovery: Restoring Health Care in the New Orleans Region"
December 3, 2009

Introduction

Mr. Chairman and members of the Committee, I want to thank you for the opportunity to testify today on the progress and challenges that remain in addressing the health care needs in New Orleans in the aftermath of Hurricane Katrina and the devastating levee breaches that followed in its wake. I am Diane Rowland, Executive Vice President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured. From 2004 to 2006, I served as a member of Louisiana's Health Care Reform Task Force that endeavored to develop a plan for improving health and long-term care services in Louisiana.

I am pleased the Committee recognizes the importance of continuing to monitor the restoration and development of health care services and is examining the efforts and progress made in rebuilding health care coverage and capacity in New Orleans. I am honored to participate in this hearing today with so many local leaders and health care providers who have worked tirelessly to provide and improve health care services in Louisiana since Katrina struck and New Orleans flooded in 2005.

The devastation in the wake of Katrina left New Orleans with a challenged population and a crippled health care system needing broad scale reform. Post-Katrina, to assist the people of New Orleans and its health care system in their rebuilding efforts, the Kaiser Family Foundation has tried to use its resources to give voice to the concerns and needs of the people of New Orleans, to keep attention on the recovery efforts, and to raise national awareness. We have monitored the progress and challenges that remain for the people of New Orleans as they continue to recover and rebuild after Katrina, including a series of surveys of adult residents of New Orleans one year and three years later to determine how the storm has impacted their lives – from their financial and employment situations to their access to needed health care. The third survey of this series will be fielded in early spring of next year in order to determine the progress that has been made as well as the challenges that remain for the residents of New Orleans five years after the storm.

My comments today will draw on our studies and analysis of health care in Louisiana before and after Katrina to provide an overview of the health care system in New Orleans, assess the impact of the steps taken immediately after the storm to address the population's

needs, and offer some perspectives on the progress and the remaining challenges of continuing to recover and rebuild the health care system in New Orleans.

Health Care in Louisiana Pre-Katrina

Hurricane Katrina devastated a health care system that was already straining to provide necessary health services to its population. Louisiana is one of the nation's poorest states and ranks near the bottom of all 50 states on most measures of the health of its residents. When the storm struck in 2005, Louisiana had high rates of chronic diseases and ranked among the worst in the nation for infant mortality, AIDS cases, and diabetes mortality (Figure 1). Nearly one in four (23%) Louisiana residents lived in families with incomes below the federal poverty level ($16,600 for a family of 3 in 2006), including nearly a third of Louisiana's children (Figure 2).

Prior to the storm, over 20% of individuals in each of the Greater New Orleans parishes (Orleans, Jefferson, Plaquemines, and St. Bernard Parishes) lacked health insurance. The people of Greater New Orleans, particularly the low-income uninsured (the majority of whom came from working families), faced many challenges in accessing necessary healthcare services (both physical and behavioral). Partly due to deeply rooted cultural norms and Louisiana's unique system of state-run public hospitals for the poor and uninsured, the low-income uninsured tended to rely on emergency departments and hospital clinics as a regular source of ambulatory care. Nearly ninety percent of the healthcare delivered to the uninsured in the Greater New Orleans area was delivered by the state-run public hospital, Medical Center of Louisiana at New Orleans (MCLNO), which consisted of two hospitals on the MCLNO campus, Charity and University Hospitals.

Together, Charity and University Hospitals served a largely poor, uninsured, and African-American population and accounted for 83% of inpatient and 88% of outpatient uncompensated care costs in the New Orleans area in 2003.[1] It was also the dominant provider of psychiatric, substance abuse, and HIV/AIDS care in the region, and housed the lion's share of the region's inpatient mental health beds with nearly 100 mental health beds and a 40-bed crisis intervention

[1] Rudowitz, R., Rowland, D. and A. Shartzer, "Health Care in New Orleans Before and After Hurricane Katrina," Health Affairs, August 29, 2006.

unit. Further, Charity Hospital was home to the Gulf Coast's only Level One trauma center and the busiest emergency department in the city, and served as the major teaching hospital for both the Tulane and LSU medical schools.

With only two federally qualified community health centers in the New Orleans area, a lack of private providers willing to treat the uninsured, and the state's use of Medicaid disproportionate share hospital (DSH) funds to finance inpatient and outpatient care primarily at the state-run hospitals, the clinics at Charity Hospital were a dominant source of ambulatory care for the low-income largely uninsured population, providing 350,000 outpatient visits and operating more than 150 primary and specialty care clinics. [2] Charity Hospital was the mainstay of health care for the poor. Yet, despite this substantial role, Charity Hospital was severely strained and faced shrinking public resources, a high burden of uncompensated care, and a lack of capital to make much-needed infrastructure improvements; the public hospital system and care for the poor was in need of much reform and improved financing even before Katrina.

The two-tiered and institutionally-based system of providing care to the uninsured in Louisiana was largely driven by the way in which it was financed. Medicaid represented not only a system of health care coverage for low-income people in Louisiana but also a mechanism of financing health care for the uninsured. Louisiana was a major user of Medicaid DSH funding; in 2005, Louisiana's $1 billion in DSH funds accounted for nearly 20% of all Medicaid spending in the state (compared with about 6% nationwide).[3] DSH payments are made by a state's Medicaid program to hospitals that the state designates as serving a "disproportionate share" of low-income or uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing inpatient care to Medicaid beneficiaries. In Louisiana, the state channeled most of its Medicaid DSH payments to the LSU system to finance care for the uninsured. Louisiana's use of Medicaid DSH funds in this way created a dependence on institutional hospital care for the poor, rather than outpatient or ambulatory care settings, because states generate DSH dollars through inpatient use.

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[2] Ibid.
[3] Ibid.

Katrina's Devastation

As we all know, the damage wrought by Hurricane Katrina and the levee breaches on Louisiana was staggering—over 1,400 lives lost and 900,000 people displaced, 18,750 businesses destroyed, over 200,000 homes damaged or destroyed, and over 220,000 jobs lost.[4] The immediate impact of Katrina on the health system was the destruction of health care services in New Orleans as hospitals flooded and patients were evacuated. Most notable among the irreparably damaged facilities was Charity Hospital, the primary source of care for the low-income uninsured, as well as the closure of University Hospital. In the weeks and months that ensued, the area's community hospitals, several community safety net clinics (some of which were part of the landscape prior to Katrina as well as some that had been established in direct response to the urgent needs post-Katrina), and doctors in private practice attempted to fill the void.

By the time of the our first Kaiser Family Foundation survey in the fall of 2006, MCLNO's Charity and University Hospitals remained closed, with former hospital staff providing limited urgent care services out of a converted Lord and Taylor department store in downtown New Orleans and a trauma center in rented hospital space in Jefferson Parish. With the monolithic Charity Hospital building out of service and a severely reduced medical workforce, only 48 percent of the 4,083 pre-storm hospital beds were staffed within the region. Consequently, for specialty and inpatient services, the uninsured were most often forced to travel to public hospitals located in Houma, Baton Rouge, or further out of the Region or state.

A related and critical situation up to and during the time the survey was a severe lack of inpatient mental health services. With MCLNO's 120 pre-storm inpatient mental health and medical detoxification beds not operational, a mere 190 of the region's 462 pre-storm mental health beds were in service. This led to local emergency departments clogged with acutely mentally ill individuals waiting for days on end for availability of inpatient beds or transfer to other areas of the state for treatment.

The destruction of the health care system in New Orleans and the displacement of hundreds of thousands of individuals made it extremely difficult for people to obtain health care after the storm. The Kaiser Family Foundation conducted a series of structured interviews with

[4] Louisiana Recovery Authority, "Hurricane Katrina Anniversary Data for Louisiana," August 2006.

Katrina survivors living in New Orleans, Baton Rouge, and Houston about six months after the storm to learn more about their health care experiences following the storm.[5] These interviews revealed that although survivors often experienced health problems before Katrina, they were now facing even more daunting challenges in obtaining needed health care. Despite suffering emotional and mental trauma from the storm, with many experiencing anxiety, depression, and trouble sleeping and eating, almost none had received formal counseling services for themselves or their children.

Rebuilding After Katrina

The health challenges for coverage and access to care for the poor and uninsured long pre-dated Katrina's devastation, but the impact of the hurricane and the subsequent flooding further compromised their access to care and also affected the health services available to all New Orleans residents. Rebuilding health care capacity has been a critical component to bringing back New Orleans as a viable and desirable city for those who live there and to encourage former residents to return.

Health Needs of the Population

The findings from our follow-up surveys in the fall of 2006 and spring of 2008 of adults in New Orleans highlighted some of the major health needs that the people living in the New Orleans area faced, reflecting the high levels of health concerns that had continued from before the storm. In 2008, 61 percent of residents reported some sort of chronic illness (Figure 3). Overall, hypertension was the most commonly reported condition, experienced by 37 percent of adults, which was higher than the 28 percent of Americans reporting high blood pressure nationally.[6] Our survey results also found that 15 percent of adults reported a serious mental illness such as depression. The health needs among the residents of New Orleans are often also exacerbated by the challenges in coverage and access. While fewer residents reported having no usual source of care in 2008 compared to 2006, a quarter of adults still continued to depend on a hospital emergency room as their primary source of care (Figure 4). Overall, more

[5] Perry, M. et al, "Voices of the Storm: Health Experiences of Low-Income Katrina Survivors," Kaiser Family Foundation, August 2006, http://www.kff.org/uninsured/7538.cfm.
[6] Centers for Disease Control and Prevention, *Chronic Disease Indicators Report*, 2007.

than half the city's adult population reported some sort of coverage or access problem, and a third had two or more problems.

Coverage Issues

Health care coverage provides the means for people to access health care services and financing to support the health care system. When Katrina struck, Louisiana already had one of the highest percentage of its population uninsured—20% statewide and 28% in New Orleans. Following Katrina, more people undoubtedly became uninsured as they lost their jobs and their health insurance. Some low-income Katrina survivors were able to turn to Medicaid for assistance, but because the eligibility standards for Louisiana Medicaid were not changed after the storm, many others were not able to access this coverage. The income eligibility level for working parents in Louisiana is 25% FPL ($5,513 a year for a family of four in 2009) and only 12% FPL ($2,646 a year for a family of four in 2009) for non-working parents. Uninsured rates among the nonelderly in Louisiana and New Orleans continue to be higher than the national average – 20% statewide and 25% in New Orleans compared to 17% nationally (Figure 5). Adults under the age of 65 comprise the bulk of Louisiana's and New Orleans' uninsured population. In 2008, a quarter of nonelderly adults in Louisiana and 29% in New Orleans were uninsured, substantially higher than the national average of 20% for this group and at roughly the same level as pre-Katrina.[7]

However, the story is quite different for children due to the availability of coverage through Medicaid and LaCHIP. While eligibility for adults is extremely limited, Louisiana has been successful in reaching out and providing coverage to low-income children by expanding health coverage through LaCHIP for children in families with incomes up to 250% of the federal poverty level ($55,125 for a family of four in 2009). In 2008, 8 percent of children were uninsured in Louisiana compared to 10% in the country overall in 2008. Children in New Orleans have slightly higher rates at 13% uninsured in 2008. Public coverage through the Medicaid and LaCHIP programs has helped to close the coverage gap for Louisiana's children with 44% of children in Louisiana and 53% in New Orleans covered through Medicaid or LaCHIP. The extensive reach of these programs and lower level of uninsurance for children highlights the importance of these programs in maintaining coverage for low-income children

[7] KCMU and Urban Institute Analysis of the 2008 American Community Survey (ACS).

and helping to provide access to the preventive services and medical care they need to have a healthy start in life.

Beyond the importance of providing coverage for children is the critical fact that by covering the majority of children and leaving few uninsured, the providers of care to those children are compensated for their services. Thus, the expansions in coverage for children have also helped to restore provider capacity. However, coverage for the three in ten nonelderly adults who are uninsured in New Orleans remains a challenge. Lower eligibility levels mean that most of the New Orleans' low-income adults are uninsured and depend on ERs and public clinics, which treat them as uncompensated care.

Restoring Health Services

Over a year after the storm, the Brookings Institution's Katrina Index reported that only 52% of state-licensed hospital beds were in operation. Further, the number of physicians filing claims for medical services had fallen by roughly half, the number of safety-net community clinics in the region has dropped from 90 to 19, and a large share of the region's long-term care capacity remained destroyed.[8] There were severe shortages in the health care workforce at all levels —physicians, nurses, attendants, laboratory technicians, dieticians, and housekeeping staff—that are essential to patient care, as many had relocated elsewhere in the state or out-of-state.

As part of Congressional authorization of assistance to the region post-Katrina, funding was allocated to both help pay for coverage of Medicaid for those individuals who sought health care services in other states as well as provide direct support to restoring health care services in New Orleans. To help address primary care and workforce shortages, the Department of Health and Human Services released $100 million in funds for the Gulf Region authorized in the Deficit Reduction Act. These funds were used to help support public and non-profit clinics that provide primary care to low-income and uninsured residents in the area and assist with recruiting much-needed health workers back to the area through the Greater New Orleans Health Services Corps.

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[8] Rudowitz, R., Rowland, D., and A. Shartzer, op. cit.

With this support, progress in restoring health care capacity in the New Orleans area has slowly been made. After operating clinics out of tents in the Convention Center and then in an abandoned department store, LSU refurbished and reopened parts of University Hospital in November 2006. In February 2007, trauma care was transferred from a rented space at Elmwood Hospital to the reopened University Hospital. However, the capacity of the reopened University Hospital was considerably smaller than the former combination of Charity Hospital with University Hospital, with only approximately 140 staffed beds. Furthermore, services provided at University Hospital have been much more limited than were offered before the storm, especially for specialty care such as mental health services.

The efforts to rebuild and reform the health care infrastructure in New Orleans have focused on decentralizing health care services throughout the community as well as rebuilding Charity Hospital. With the delay in the rebuilding of Charity Hospital, a number of community health clinics have opened to help provide the community with primary and preventive health care services. These clinics have provided an invaluable source of care for returning residents who previously depended on Charity for health care services. By the fall of 2006, 22 primary care community clinics of varying size and scope in the Greater New Orleans region were established to provide healthcare to people regardless of their ability to pay. Most of these facilities were a part of the Regional Ambulatory Planning Committee of the Partnership for Access to Healthcare (PATH), which became a vehicle to coordinate services and disburse supplemental Social Services Block Grant dollars to support the recovery and expansion of neighborhood-level primary care services in the region.

Further support for community clinics came from the Primary Care Access and Stabilization Grant (PCASG). These funds continue to support public and non-profit clinics that provide primary care to low-income and uninsured residents in the area. This support for primary care services has provided an important foundation for building a community-based system in New Orleans, including providing services to nearly 80,000 of the region's uninsured population each year. The 25 participating organizations have expanded the number of service delivery sites from 67 pre-grant to 93 today. The sites vary in scope and scale, including primary and behavioral health care clinics, school-based health centers, dental and mobile clinics. As a result of this support, the total number of individuals served has steadily increased by 15% every six-month period starting March 2007 for outpatient primary and behavioral health care.

Our survey findings indicate that when it comes to the health care system, the residents of New Orleans place a high priority on a number of possible methods to expand access to health care services. While four in ten listed building a new hospital to replace Charity as their most important priority, nearly as many focused on expanding health coverage or bringing in more medical personnel (Figure 6).

Next Steps

Recovery in New Orleans is not complete and many challenges remain in the efforts to restore capacity in the health system and provide for adequate access to health care services for the people of New Orleans. The rebuilding effort is aimed toward the goal of building a health services network that is integrated and provides preventive and primary care throughout the city with specialty and inpatient services when needed. It is a vision of a modern medical care system that links patients to the care they need and replaces the hospital-centered two-tier system of the past.

However, if this vision of medical care in New Orleans is to be realized, current efforts need to be sustained and additional steps need to be put in place. Among the options to consider in strengthening coverage and access to care in New Orleans:

- Maintain health insurance coverage and the critical role that Medicaid/LaCHIP play for Louisiana's children to improve and promote access to care for the children of New Orleans, where over half (53%) are now covered through Medicaid or LaCHIP, and provide a financing base for the providers and clinics that care for them.

- Extend coverage through Medicaid to low-income adults by raising the eligibility levels for parents and extending coverage to childless adults to enable basic primary care services to be made available for this population and reduce uncompensated care costs for the hospitals and providers that treat them. Health reform legislation now pending would provide coverage through Medicaid for low-income adults, but implementation would be several years out. State action now to increase eligibility levels for parents could offer immediate assistance and provide federally-matched Medicaid dollars to help pay providers.

- Sustain the network of community-based clinics to provide frontline primary care services in the community to broaden access and deter reliance on emergency departments for care. Priority needs to be given to certification of additional federally qualified health centers and securing financing for clinics that are caring for the uninsured.

- Develop additional community-health centers and integrate existing centers with inpatient facilities and the region's broader delivery system. More primary care services throughout the community, and especially in neighborhoods that are being rebuilt, would both provide access to care for residents as well as a stable practice setting for returning doctors and health workers.

- Provide back-up resources for the community clinics by increasing both inpatient and outpatient capacity for tertiary care and for mental health services to supplement the care now provided through the interim University Hospital. Extending mental health capacity is particularly important with the recent closure of the New Orleans Adolescent Hospital, which had provided mental health beds for adults after the closure of Charity Hospital post-Katrina. It has been almost five years since the storm, and construction of a new teaching hospital to replace Charity Hospital has yet to begin. A fully integrated health system will require establishing a full range of specialists and hospital services that provide the full continuum of services for patients --- from primary to tertiary care.

Important steps are being taken to achieve this vision of an integrated health system for the people of New Orleans, but the progress is always slower than desired. Much has been achieved in building new capacity among the community-based clinics, but other pieces like the expansion of coverage for adults have been on a slower track making sustainability over time difficult for the clinics. Moving forward --- and in anticipation of health care reform --- maintaining coverage for children and broadening coverage for some of their parents can help provide needed resources to the providers of care, but until more universal coverage is achieved, many of the community providers may need additional funds to help cover the uncompensated care from the uninsured population.

This Oversight Hearing today provides an opportunity to assess the progress to date and look ahead to how the recovery process can be completed. Making sure the progress achieved

thus far is not rolled back is essential to restoring health care services in New Orleans and building a strong base for a reformed health care system.

Thank you for the opportunity to testify today. I welcome any questions.

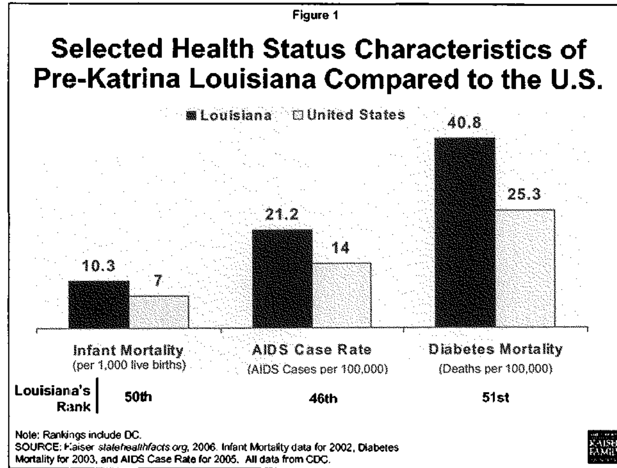
Figure 1
Selected Health Status Characteristics of Pre-Katrina Louisiana Compared to the U.S.
Louisiana
United States
10.3
7
21.2
14
40.8
25.3
Infant Mortality
(per 1,000 live births)
AIDS Case Rate
(AIDS Cases per 100,000)
Diabetes Mortality
(Deaths per 100,000)
Louisiana's Rank
50th
46th
51st
Note: Rankings include DC.
SOURCE: Kaiser statehealthfacts.org, 2006. Infant Mortality data for 2002, Diabetes Mortality for 2003, and AIDS Case Rate for 2005. All data from CDC.

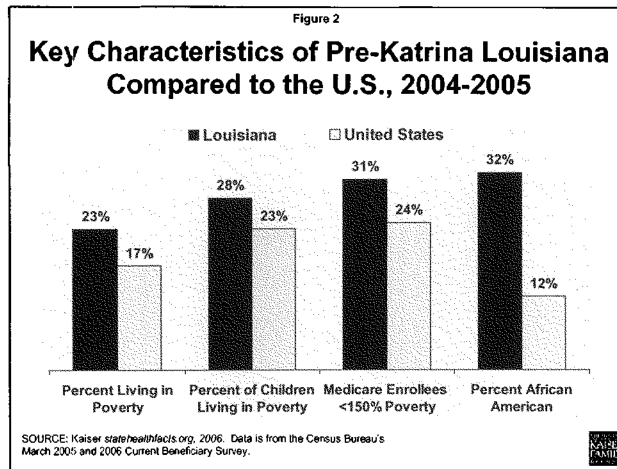
Figure 2
Key Characteristics of Pre-Katrina Louisiana Compared to the U.S., 2004-2005
Louisiana
United States
23%
17%
28%
23%
31%
24%
32%
12%
Percent Living in Poverty
Percent of Children Living in Poverty
Medicare Enrollees <150% Poverty
Percent African American
SOURCE: Kaiser statehealthfacts.org, 2006. Data is from the Census Bureau's March 2005 and 2006 Current Beneficiary Survey.

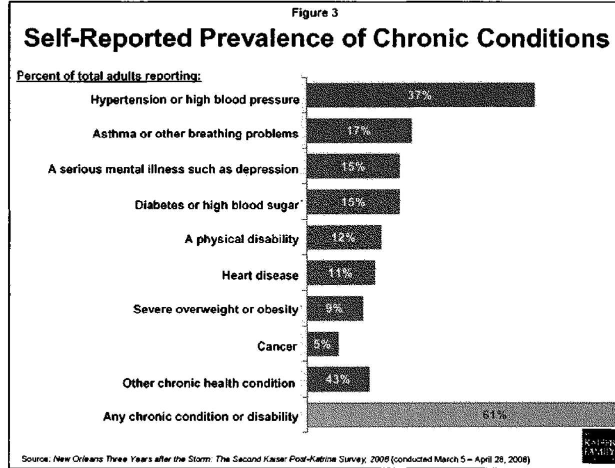
Figure 3
Self-Reported Prevalence of Chronic Conditions
Percent of total adults reporting:
Hypertension or high blood pressure
37%
Asthma or other breathing problems
17%
A serious mental illness such as depression
15%
Diabetes or high blood sugar
15%
A physical disability
12%
Heart disease
11%
Severe overweight or obesity
9%
Cancer
5%
Other chronic health condition
43%
Any chronic condition or disability
61%
Source: New Orleans Three Years after the Storm: The Second Kaiser Post-Katrina Survey, 2008 (conducted March 5 – April 28, 2008)

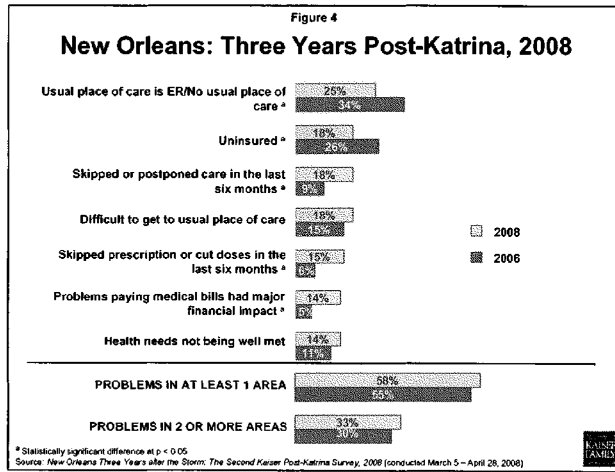
Figure 4
New Orleans: Three Years Post-Katrina, 2008
Usual place of care is ER/No usual place of care a
25%
34%
Uninsured a
18%
26%
Skipped or postponed care in the last six months a
18%
9%
Difficult to get to usual place of care
18%
15%
Skipped prescription or cut doses in the last six months a
15%
6%
Problems paying medical bills had major financial impact a
14%
5%
Health needs not being well met
14%
11%
2008
2006
PROBLEMS IN AT LEAST 1 AREA
58%
55%
PROBLEMS IN 2 OR MORE AREAS
33%
30%
a Statistically significant difference at p < 0.05
Source: New Orleans Three Years after the Storm: The Second Kaiser Post-Katrina Survey, 2008 (conducted March 5 – April 28, 2008)

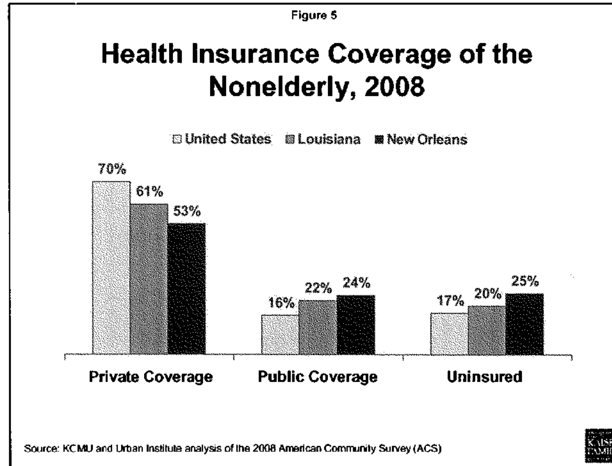
Figure 5
Health Insurance Coverage of the Nonelderly, 2008
United States
Louisiana
New Orleans
70%
61%
53%
16%
22%
24%
17%
20%
25%
Private Coverage
Public Coverage
Uninsured
Source: KCMU and Urban Institute analysis of the 2008 American Community Survey (ACS)

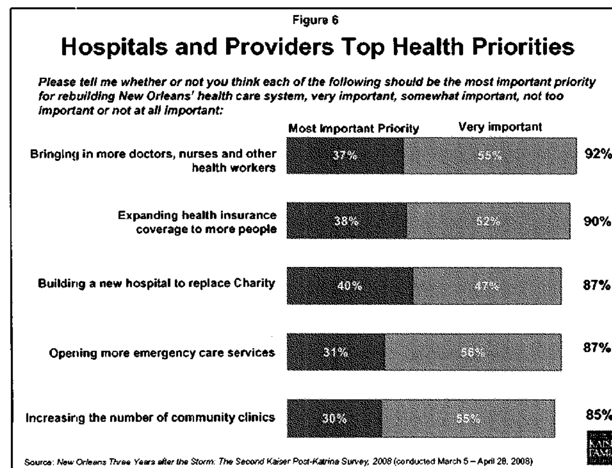
Figure 6
Hospitals and Providers Top Health Priorities
Please tell me whether or not you think each of the following should be the most important priority for rebuilding New Orleans' health care system, very important, somewhat important, not too important or not at all important:
Most Important Priority
Very important
Bringing in more doctors, nurses and other health workers
37%
55%
92%
Expanding health insurance coverage to more people
38%
52%
90%
Building a new hospital to replace Charity
40%
47%
87%
Opening more emergency care services
31%
56%
87%
Increasing the number of community clinics
30%
55%
85%

Chairman TOWNS. Thank you very, very much. Let me thank all of you for your testimony. You have been very helpful.

Now we are going to the question and answer period. I will start by first asking you, Ms. Bascetta and Dr. Rowland, what would it mean toward the region's overall recovery to lose these services that have been described so eloquently here this morning?

Ms. BASCETTA. I think that most importantly, the threat of backsliding on the progress that has been made so far in the primary care foundation is something that we would not want to see. These clinics now and this primary care foundation that has been built is in an expanding mode. It is in a growth mode. And reverting back to a less effective system where people would have to seek care in an emergency room would be more expensive and would yield poorer outcomes, as you have heard.

In addition, like emergency rooms throughout the country, they are already at capacity. So it would be very dire to lose these primary care clinics.

Chairman TOWNS. Dr. Rowland.

Ms. ROWLAND. Mr. Chairman, I know your concern is for the people of New Orleans. I think what these clinics have demonstrated is that they need access to care. There are severe gaps in their ability to get the care they need. We know that uninsured people get less care than those with insurance and that they live sicker and die quicker. So I think it is an investment not only in the clinics themselves but especially in improving the health care of the people of New Orleans. And many of the low-income population there suffer from multiple chronic conditions that are not readily available to emergency room care. So I think you really need to have in place a good primary care network and to sustain it.

Chairman TOWNS. Right. Thank you very much.

Let me raise this question with you, Dr. DeSalvo, Ms. Craft-Kerney, Dr. Erwin, and of course, Mr. Griffin. As you know, the grant ends next year. What Federal assistance are you now seeking to be able to keep it going, just sort of run down the line real fast as to what you're doing to keep this alive. What are you doing?

Dr. DESALVO. What we have done is work toward improving efficiency, quality, so that we are providers of choice for communities, irrespective of ability to pay. We work collaboratively with organizations like 504 Health Net to ensure that we are sharing best practices, billing when appropriate, etc. So we are doing our best to be efficient operations.

The reality is, as you heard, that can only go so far, including when patients contribute to their care, which they do. We charge sliding scale fees at these sites. And so the gap will need to be filled in much the ways that hospitals have a gap filled for uncompensated care. It is just the DSH program doesn't support primary care federally in the way that it supports the hospital systems.

So in terms of gap, it may be additional appropriation, it may also be just thinking about ways that we can use existing funds that we have, for example, CDBG funds that we got for recovery are now at the LRA to, that are for urban renewal, principally for housing, but thinking about the fact that without health care, it doesn't make a lot of sense to just build housing, you have to have the fabric. So that is one opportunity for bridge funding, and then

to think about whether we want to use a waiver for disproportionate share money to support the clinics going forward, until it is not needed, because there is coverage for everyone.

Chairman TOWNS. And right down the line.

Ms. CRAFT-KERNEY. The Lower Ninth Ward Health Clinic is moving toward sustainability by first, making sure that we are Medicaid providers, Medicare providers, and private insurance providers. We came up a little bit differently, because we came up post-Katrina, truly a grassroots effort. So we are putting those different things in place, so that we can become more sustainable. Also, we are looking to the philanthropic community to assist us.

Chairman TOWNS. Dr. Erwin.

Dr. ERWIN. St. Thomas is a federally qualified health center, and as such, get Federal funds from that. As I mentioned in my testimony, the financial base that is required to maintain the infrastructure, so that you can comply with the policies and procedures and the 24 hour coverage and that sort of thing, we are working hard to try to maintain it.

We have a sliding scale, we have increased our patient revenue money, funds from patient revenue, from zero 2 years ago, 3 years ago, to an estimated $420,000 this year. The mayor of New Orleans has also granted us $850,000 for CDBG funds. But this is a one time only thing.

We have a $2 million allocation from the State, but that is for capital improvements only. So we have to stay viable in order to be able to capitalize on that. Our staff meets weekly and we go over ways that we can improve our sustainability, not only with grants but by watching our costs as carefully as we can. And we have unfortunately with the 72 percent uninsured population, it is just very hard for us to find any kind of viable revenue that could replace this money until there is some expansion of Medicaid.

We are told that there will be a substantial increase in patients eligible for Medicaid, but this will likely take 2 years. That is why in our sustainability projections we estimate that beginning year three, should this occur, the beginning of year three St. Thomas will actually be able to replace the $3 million that we would lose from the Primary Care Access and Stabilization Grant.

We expect to be self-sufficient in year three on the business plan. As I say, we charge everyone that can pay. There is a sliding scale and we ask the patients to take responsibility for helping us be viable. But when we are dealing with a demographic of 72 percent uninsured, it is really hard.

Chairman TOWNS. Right. Mr. Griffin, briefly, because my time has expired.

Mr. GRIFFIN. Daughters of Charity is focused on the growing uninsured population, as we are 72 percent uninsured. Since Katrina, we have blindly accepted all who come. And that has been majority adults who do not qualify for Medicaid or uninsured. So we are 72 percent uninsured, we are focused on growing our Medicaid, Medicare, and insured populations. We also are evaluating our expenses and looking at our care management model, which is pretty comprehensive, seeing how we could be more efficient. And also looking at fundraising.

Chairman TOWNS. Thank you very much. My time is expired. I now yield 5 minutes to the ranking member, Congressman Issa, from the great State of California.

Mr. ISSA. Thank you, Mr. Chairman. The great State of California is $140 billion or whatever, upside down at any given time, actually it is $47 billion right now, they have narrowed it. We are a State that taxes at a rate more than 25 percent higher than Louisiana, and we have overspent. We provide a lot more public health assistance in California in many areas than Louisiana does. And I guess, Mr. Cao, who of course is one of your representatives, will probably look more specifically into a lot of what can be done and what can be delivered from the Federal Government. But my questions are going to have to be a little more tough love, not just because I am personally a conservative, but because I have an obligation to California, in addition to the Constitution.

Louisiana's top tax rate is 8.4 percent, California is 10.4 percent. You have a 4 percent sales tax, we have an 8.25 percent sales tax. I know you are all health care professionals. But in spite of this, is everyone so poor in Louisiana that in fact the State cannot do more for you? Are you going to be a permanent ward of the Federal Government? Because when I hear sustainability counting on Medicaid increases, when I hear Mr. Griffin saying, "well, we take everyone, including those who are not poor enough to qualify for Medicaid," then I am extending Medicaid past what we define as the poor.

So let me ask you much more the other part that I didn't hear. What is your State, and we will have a second panel from your State, but what is your State doing to bring all the powers to be of the State, including finding funding sources for you besides simply the Federal Government? Because obviously the direct effects of the levees breaking, even if we put them all on the Federal Government, at some point that is paid out. Then we ask the question of what is going to make you a sovereign State, meeting your own obligations.

And Dr. DeSalvo, only because I can see that you are saying, how is this guy asking a doctor this question, would you help me with this? Because I know that all of you look to all sources of revenue. You are doing a lot to build better doctors and better health care. But I have to ask in the long run, what are you doing besides coming to us? And don't get me wrong, Mr. Cao is absolutely dedicated to making sure we do everything we can do. But if I could ask each of you that same question, it is really my only question for the panel. Because I see all of you as doing the right things within the structure that exists. You are getting money from all revenue that you can find, you are building great solutions for people who come to you. And I don't have any quibble with that. I totally see that.

But I will start with Dr. DeSalvo, because this is a question that a California Member has an obligation to ask, in addition to a Louisiana Member, who is obviously going to say, we have to do more. Please.

Dr. DESALVO. Thank you for the question. I will begin with the concept that, when the Federal levees failed and our city was destroyed we began very early to work together to think about how

we would rebuild this. And in education, for example, there has been creative thinking, just like there has been in health care.

We did not as a community of stakeholders and health care providers think that there was going to be some manna from heaven that was going to fall to make it happen. And indeed, as Alice describes, and I tried to as well, and others, it is very grassroots, this clinic system.

Mr. ISSA. I am totally supporting that.

Dr. DESALVO. I am going to get there.

Mr. ISSA. Where is Louisiana coming in and how are they going to help New Orleans? Because you are a State first. Cities are not actually directly recognized by the Federal Government. We recognize States. We are the United States of America, and in a sense, only States come to us. And when the next panel is up, I am going to be asking them that same series of tough questions, what is the State doing to be equal in its support of its people to other States.

Dr. DESALVO. Yes, sir. So I will skip the tax policy, because I really cannot answer the question. But what I wanted to tell you is that the past 4 years, the community has come together at policy tables, Democrats, Republicans, maybe Independents, who knows, to think about ways that we could finance this kind of system. We have developed at least three discrete plans: one, the redesigned collaborative that was a mix of private coverage; another which was an affordable health insurance plan through private coverage solely, called COLA; and another one that was a waiver that went in about a year ago to the Feds to use disproportionate share to recover to shift the funds. Money we already get, but use it in a different way that requires Federal support.

So I will just say that we have been working incredibly hard in Louisiana, across party lines, through two Governors, and have always come up with the same idea as a State: this is what we want to see happen. We need to figure out how to finance it. At this point, I can't speak on behalf of the State, but there are some things that do need to happen federally to allow us to move forward as a State, i.e., waivers for how we use disproportionate share money, how we might use the existing recovery authority money that we got for urban renewal that might require some congressional action to allow it to be for urban rebuilding.

Mr. ISSA. Anyone else that can answer as to just what you see your State doing? Because Bobby Jindal was a colleague of ours, a friend of mine, and I want this committee and all the committees to work hand-in-hand with your Governor, to enable those things. But we are going to have to ask them the same tough question I am asking you. So if any of you have an answer to that narrow question of how Louisiana is working to meet this sustainability requirement that you all talked about. Yes, Dr. Townsend.

Dr. TOWNSEND. I obviously can't answer for the State, I don't sit in that role. But I think when you look at how health care is funded, there are really only three pots of money. And perhaps it is only two. I mean, there is Federal money, there is State money, or there is private sector money. So I think one of the things that the State is trying to do is economic development. Because if you have an employer who offers an insurance plan, then you have access to insurance that the Federal Government doesn't really have to par-

ticipate in, nor does the State. So I think that is one of the ways. We have to improve our education, we have to improve our employment, so that people have access to health care programs that don't necessarily have to be funded by tax dollars. So I think that is one of the things that is happening.

And then I think Dr. DeSalvo talked very eloquently about the other kinds of waivers and ideas for current funding, not to increase it but to have more flexibility in current funding.

Mr. ISSA. And I know we would like to do that. Mr. Chairman, I thank you for your indulgence. I am sorry we can't continue this, but I assure you, we will be trying to work together with Mr. Cao to make those waivers happen as your State sees fit. Thank you.

Chairman TOWNS. I now call on a very active member of this committee, of course, Mr. Cummings from the great State of Maryland.

Mr. CUMMINGS. Thank you very much, Mr. Chairman, and I want to thank all of you for what you do every day to address the needs of so many people. You don't have to say it, I will say it, I have listened to your testimony, these folks have been left behind. Let's not kid ourselves. You all are doing the best you can with what you have. And in answer to Mr. Issa's inquiry about tough love, you can have tough love and die. And you have not provided the testimony yet, but we have just spent a lot of time in the House addressing this issue of health care overall. And the statistics show, and the research shows, that some 45,000 Americans die every year because they don't have insurance. Other research has shown that 1,000 children die every year because of no insurance.

So the question is, where does the tough love, how far do you go with the tough love if people are dead? So let me ask you this. This committee, Mr. Chairman, we had some testimony a while back, and the Members will remember this, where we were talking about formaldehyde in trailers, where folks were living in trailers getting sick, big time. And this was a while back. This committee pushed hard to get the folks out of trailers.

I just wondered if any of you all can comment on that. Where is that? Because a lot of your work would be made even harder. When they told us about the ailments that resulted from folks breathing those fumes, it was quite devastating and we were very upset. I just wonder, where does that stand? Can one person just tell me about that? Just one. Somebody please, my time is running out.

Dr. ERWIN. I will just take a stab at it. We still see patients who are living in trailers, and we still see patients who are exposed to formaldehyde. The problem as we perceive it is there is just not adequate housing for them to get out of the trailers.

Mr. CUMMINGS. So housing is still not adequate, is that what you are saying?

Dr. ERWIN. No, sir, it is not.

Mr. CUMMINGS. And I think going back to what you said, Dr. Townsend, you were talking about, when you were answering Mr. Issa's question, you talked about the whole issue of people living, being able to have jobs and so forth and so on. What I said from the beginning was a lot of people have been left behind. I don't know how many people on this panel have visited the Ninth Ward,

probably all of us, and visited New Orleans to see even to this day areas that have not seemingly been touched that were destroyed.

And I am just wondering, you all talked about the three different areas that funds could come from. First of all, do you think that you are doing the best that you can with the funds that you have? Dr. Townsend, don't be shy.

Dr. TOWNSEND. Yes, sir, thank you. I do think that everyone is making a concerted effort to wisely use these dollars to make sure that we provide the best care for the most people in the most efficient way. I think that is happening right now.

Mr. CUMMINGS. And you said something about you have one half of the beds but 85 percent capacity, is that what you said?

Dr. TOWNSEND. No, sir. I have about 50 percent of the beds, but capacity——

Mr. CUMMINGS. Fifty percent of the beds that you had before Katrina?

Dr. TOWNSEND. That we had before the storm. But we are providing about 60 percent of the inpatient services. So even in the inpatient setting, we have become more efficient and cost-effective. And in the outpatient setting, we are about 80 percent of the outpatient capacity that we were before the storm. We are doing about 80 percent of the visits that we were doing before the storm.

Mr. CUMMINGS. An area that I am very interested in is dental care for children. We had a little boy in my State who died, Deomonte Driver. He was on Medicaid, but he died at 12 years old because the tooth infection that would have cost $80 to repair went to his brain and he died at 12. I am wondering, Ms. Rowland, you talked about children, only 8 percent of children are uninsured, but how are we handling our children with regard to dental care? What is going on there?

Ms. ROWLAND. Well, as you know from the case in Maryland, dental care is very limited, even under the Medicaid program. It is a covered benefit, but very few dentists participate. So I think that is one of the areas that really has to be supplemented and helped in all the States, as well as Louisiana.

Mr. CUMMINGS. How are we doing in your State? That is what I want to know?

Ms. ROWLAND. I think that dental care speaks to the broader issue of how this community of health providers is working together to cover the territory. So for example, some of the dental care is provided in mobile medical units by some of the organizations in this. They have created a Web site with a map and a grid that will tell providers where people can go for dental care on any given day. Charity Hospital has reopened its dental care services. Daughters of Charity will have dental care services.

But we are not going to replicate that if we are just a couple of miles apart. We are trying to be very responsible with the funding to make sure that there is access to services.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. I see my time has run out.

Chairman TOWNS. Thank you very much.

I now call on the gentleman from Louisiana, Congressman Cao.

Mr. CAO. Thank you, Mr. Chairman, for this extremely important hearing. I know fully the health care needs of the district. But be-

fore I begin addressing those questions, I would like to ask Ms. Bascetta, do you see any instances of waste, abuse, or fraud from the Federal money that was channeled down to the area for rebuilding purposes, especially in regard to the health care system?

Ms. BASCETTA. We have not specifically scoped our work to look at fraud, waste, and abuse. But in the course of our work, we did not see any of that ourselves and we didn't hear about that from any other organizations, the IG, or anyone else.

Mr. CAO. So based on the information that you have received so far, they have used the money responsibly?

Ms. BASCETTA. That is right.

Mr. CAO. Dr. DeSalvo, I know that you are in charge of Tulane community-based health clinics. How have you seen the increase in clinics help address the issue of the uninsured, and whether or not this is a model that we should be looking at as a Nation in order to cut down the health care costs that we are struggling with, trying to address?

Dr. DESALVO. The goal is to get people to go to the right place at the right time for the right care, because that is not only better quality, but it is more cost-effective. And primary care is usually the best place for people to go. Clearly, emergency rooms and hospitals are a necessary part of the continuum. But all things considered, like the man I described in my testimony, he is better suited, with his high blood pressure and his gout, to be treated in primary care where it is about a quarter of the cost than the emergency room.

And there is a fair number of people in Louisiana who fall into this gap. They would not qualify for Medicaid, even being quite poor. If they don't have children, they wouldn't qualify. But most insurers in Louisiana don't offer health insurance that is not affordable. So this is an interesting model, PCASG, where we have actually taken funds and though they are still distributed institutionally, we are paid not based on some sort of, it is a given, we are going to give you the funds, we are actually paid as organizations to take care of a set population. There is a high expectation that we are going to be available for those patients, provide quality care, do it in a very cost-effective way. We are mystery-shopped, we have satisfaction surveys, so there is pretty intensive oversight of our programs.

But I think the PCASG is a really interesting bridge model for urban markets, in particular that want to move away from hospital-based funding of care for the uninsured. There is a gap until there can be universal coverage. But you want to make sure that you have distributed the funds so that all of your money is not in one financially consolidated institution or place.

What we have also learned is that if you pay providers for quality and value and you give us the opportunity to take care of populations instead of just paying us for volume, it naturally leads to team-based care and opportunities for innovation that I have never experienced before in 20 years of health care.

Mr. CAO. Dr. DeSalvo and also Dr. Townsend, do you have a system where patients who show up in your emergency rooms, to direct them to community-based health clinics?

Dr. TOWNSEND. Yes, we do. At the interim LSU public hospital, when patients arrive at the emergency room, whether the care is actually emergency room appropriate or not, if they are not assigned to a primary care clinic and particularly if they are uninsured, then we are able to direct them to a primary care provider in one of the community clinics where they can access care. We work with them to try to make sure that they understand how to appropriately access the clinic and the emergency room when necessary.

Dr. DESALVO. Tulane Hospital has been touched in a fashion, of course, by us because we have clinics in the system, but touched by the leadership of PCASG meaning very specifically going out and targeting and talking to the emergency room leadership, the hospital leadership to be certain they are aware of the program. We update them with flyers and information about availability. And there is a Web site they can go to, which I think you have information on, G&O Community, which will tell you in a zip code what is available, what the hours are, what languages they speak, and what services they offer. We have been really aggressive about trying to get people directed from emergency rooms, when appropriate, into medical homes so that they don't continue using that other system.

Mr. CAO. How many more medical community-based clinics do you see that we will need in the future, in order to address the needs of the people of the Second District? Another question to you here is, how, what steps do we need to take when the Primary Care Access Stability Grants end? What plans do we have to continue these community-based clinics and to provide primary care to those who are uninsured?

Dr. DESALVO. In terms of the number of providers, types and sites, I think that is a really great technical question that HRSA can help us with. They have been thinking about that with some of the providers already. The 91 access points that we have are really varied in scope and size. Some of them are small, school-based clinics or mobile units. I certainly don't want the committee to walk away thinking we have 91 community health care centers, because we are not there yet. And I don't know if that is the right number. But it is an important planning issue we do have to decide. The community certainly wants to work together to right-size it.

Mr. CAO. What plan do you have in order to continue these projects once the Primary Care Access grant runs out or ends?

Dr. TOWNSEND. I think what you have heard today is that as long as about 72 percent of the patients who have to access those community clinics remain uninsured, then the sustainability of those clinics I think is really impossible without an alternate funding source identified. Like I said, there are really essentially two pots of money. There are tax dollars and then there is private sector. Other than grants and philanthropy and things like that, I am not really sure that anyone is able to identify how we are going to keep this going.

Chairman TOWNS. The gentleman's time has expired. Now we will yield, as you know, we have just been called for votes. So we will try to get at least two more in.

Congressman Tierney from Massachusetts.

Mr. TIERNEY. Thank you very much. I just want to ask one particular question. We know that sending children to school in a healthy State is a good thing. Have you had any examples of creative use of the educational funds and system, and cooperation or coordination with the health care system that have helped you at all?

Mr. GRIFFIN. There have been discussions and work that has been done. As I mentioned in my presentation, we actually do behavioral health in 10 schools. We are actively having discussions with a school system about expanding that. There also have been numerous efforts and expansion in school-based health centers throughout the State as well as in the New Orleans area. That is a more comprehensive provider model that has medical behavorial health and other services included in those locations.

So there are, I think approximately nine school-based health centers in New Orleans and several more in the metropolitan area. So those efforts are ongoing in collaborating and coordinating with the school systems.

Mr. TIERNEY. Thank you. Ms. Bascetta.

Ms. BASCETTA. We had a companion report in July of this year that we issued on the mental health needs of children in New Orleans. We noted in that report, which I can provide for the record, that school-based health centers were an important model in the area.

Mr. TIERNEY. Thank you. If nobody else wants to comment on that, I'd like to yield to Mr. Kennedy, who I know has some pertinent questions he would like to ask.

Mr. KENNEDY. Thank you, I thank the gentleman from Massachusetts.

I would like to ask, for those of you who would answer, what percentage of those coming into the emergency rooms exhibit mental health issues and addiction issues? And to what extent do you attribute any of the PTSD, obviously to the natural disaster? And if you could, address the issue of the trauma that was exhibited as a result of the hurricane and to what extent there was a lack of proper mental health services available to address the needs of folks. From what I understand, clearly, trying to get people's mental health needs met has been an endemic problem. Clearly, the enormous crime rate in the area now, I kind of feel like our criminal justice system is a substitute in kind of the last sense for our mental health system that isn't there.

So I would ask you to comment on the lack of a mental health system and also what you see as the consequences of that today in terms of the number of people showing up with mental health issues in our health care system as a primary source of issues, and whether you can reimburse for that, given the exclusion that many insurers have, if people come in with an accident, that you can't reimburse for it if they have alcoholism; if they have been drinking alcohol or ingested, as a result of drugs, that many insurers say they won't insure, because that is "a deliberate thing" and they won't allow you to get reimbursement for it. If you could comment on any of those issues.

Ms. CRAFT-KERNEY. Mr. Kennedy, at the Lower Ninth Ward Health Clinic, we have seen many come in with mental health problems. We had a young man who was known to us who said, "I just want to slit my wrists." We had to get him some help immediately. But we just want you to know that many of the mental health problems that are taking place, what is happening is because there was a lack of services initially, and there is still ongoing problems with the mental health piece, we are at a point where we are actually diverting and sending people to the correct places. But initially, there was a big impact and people are suffering from depression, this underlying depression. I might be OK today, but tomorrow I might not be.

So you are seeing people who are just very, very fragile. And we don't know what is going to be the breaking point for them. So there is ongoing assessment of that depression.

And what I did want to say is that the criminal justice system comes into place because many times people are below the radar. I am OK today, but you don't know what is going to happen tomorrow. So what happens is they become entangled with the criminal justice system, and what happens is right now our biggest provider of mental health services, inpatient, is the Orleans Parish Prison, unfortunately.

Ms. ROWLAND. Mr. Kennedy, in our surveys of the residents of New Orleans in 2006 and 2008, the need for mental health services was quite apparent. But one of the striking things we found was in 2006, 1 year after the hurricane, people reported that their mental health status was fairly good, I think because so much was going on in their lives they didn't really focus on it. But by the time we came back in 2008, we saw much higher contact with the health care system, much more frustration over inability to get the medications they needed, and today saw that 15 percent of those in New Orleans reported that they had a severe mental illness, such as depression or other things. So I think you are pointing out an area where the population has severe needs. We will be going back in 2010, and hopefully find better access than we did in 2008.

Mr. KENNEDY. Are you integrating mental health to the "white coat docs?"

Dr. ERWIN. I would like to address that, if I could, Representative. One of the other recipients of the PCASG money is the Metropolitan Human Service District in New Orleans, which is the public entity responsible for most of the mental health funds. Working with the State, Secretary Levine, Governor Jindal, they address the fact that immediately afterwards about the only place for mental health service was jail.

So we have put into place forensic assertive community teams, adolescent community teams. I think there has been a remarkable improvement in the coordination of care with the Metropolitan Human Service District, which had some problems prior to Katrina. It has a new executive director, a new medical director, and is implementing, last week actually, a very coordinated call center where if a patient shows up either in a hospital or jail, something like that, then it is very, very close to being coordinated, so that the case manager will know that the next day and they can followup on that.

Also ways of following up when people don't get their prescriptions filled where they should. So I think that they are not represented here except for me, I am on the board. It does represent a real success for the Primary Care Access and Stabilization Grant. I am really happy to get a chance to help you understand that has made a huge difference in a very dysfunctional problem that we had.

Dr. DESALVO. In answer to your question, we have integrated at almost all of the sites mental health services into primary care. One of the benefits of this program is we can have warm handoffs, if I identify somebody who seems depressed or anxious, I have services right onsite. I don't have to send them home or refer them out. The flexibility in funding has allowed that through this program.

Chairman TOWNS. The gentleman's time has expired. We have four votes, so we will reconvene at 12:30. Of course, I would like to ask unanimous consent that Representative Barbara Lee, the Chairperson of the Congressional Black Caucus, be allowed to sit and be allowed to ask questions. Without objection, so ordered.

We will reconvene at 12:30. The vote is on now and we have 4 minutes left on the vote.

[Recess.]

Chairman TOWNS. The committee will reconvene.

The gentlewoman from California will be recognized for 5 minutes.

Ms. WATSON. I want to thank our chairman for holding this most necessary hearing. I want to commend all of our special guests on the panel for coming today. I have been on special delegations to New Orleans, and I was appalled at the promises that were made and unkept. There were too many pieces of vacant property, there were too many trailers with formaldehyde. I am a victim of formaldehyde, too, and I know how you can suffer.

There were too few medical institutions. Catholic Charities, I must give them credit, came in and they set up temporary facilities to serve. But so many of our schools were destroyed, so many of our universities were destroyed. My grandmother was born in Louisiana, so I have a very personal, personal affection for Louisiana. She was in a convent for 18 years. Obviously she came out. [Laughter.]

So I am very much a part of that particular State and the French Quarter.

You are not to blame. We failed you, and we watched while you were being failed. I was getting a call from the stadium about how the buses were passing up the people and wouldn't stop to pick them up. I had 14 relatives that we could not find. We dispatched someone from my capitol, Sacramento, to go to Baton Rouge. We finally saw one of the relatives hoisted up and taken to a hospital. So I was very much a part of that.

So I say all that to say, I want to commend you for what you have done, I want you to tell me now what we need to do in health care reform, how we can plug up the holes. And this was the biggest natural and national disaster we have ever had, and the world viewed it. When the dikes broke and that water flowed in like would flow into a bowl, we were all so tearful. So I know what you went through. And I want you to tell us what we need to do in

health care reform that will plug up those holes, and what we need to do in our system so never again will we have to go through those levels.

I was not one to support Homeland Security to come and take all the agencies. Because I thought FEMA should be separate and apart so it could move on a dime. So in terms of health delivery, what can we do, Dr. Townsend, Dr. Rowland, all of you? Give us the input. Because we want to, before the end of the year, come out with a bill that will cover all Americans the right way, affordable, sustainable, accessible and with all pre-existing conditions.

I just really appreciate Congressman Kennedy, who put a particular emphasis on health care. I had a family in my home whose son had a breakdown when he went back home and found out they didn't have insurance, they lost everything. And so I know the need for mental health services.

So let's just go down the line, starting with Dr. DeSalvo. Why don't you give me the input on how we can make sure that health delivery is sustainable and what we should do?

Dr. DESALVO. Well, Congresswoman, thank you for remembering and recognizing all that pain. We really do appreciate it.

Ms. WATSON. I shared it.

Dr. DESALVO. I just wanted to thank you. And what can we do? We have done a lot with very little. And we are not asking for much. I think what——

Ms. WATSON. By the way, I am from California, the largest State in the Union and the first State to be a majority of minorities. So don't think that every Californian feels the way I do, but you know how I feel. Go ahead.

Dr. DESALVO. I think what we have built is really valuable. It is an investment by the taxpayers, post-Katrina. It is helping recover our city. It is building jobs. It is building work force development, new opportunity for people. It is not just about health care.

To continue it, the gap is somewhere in the neighborhood of $30 million a year. It means that we can continue this until there are other options, until finding special mechanisms to pay for the uninsured aren't really needed because there are no uninsured. And it would be really a shame to disassemble this investment, which is really what we are facing in the fall.

So finding those funds could be really as straightforward as allowing the Louisiana Recovery Authority [LRA] perhaps to use some CDBG funds they have in a more urban renewal fashion instead of just for housing. We don't want to not give people housing. But if we think that we have access and we can give them the fabric of community around their house, i.e., health care, that would be helpful.

And there are some other opportunities, perhaps, with the disproportionate share funds, to redirect it from using it only for hospital-based care but also for community-based care.

Ms. WATSON. Thank you.

Ms. CRAFT-KERNEY. Thank you Congresswoman, and I appreciate the feeling of just knowing that you care. So many people showed that to us, and it just means so much.

I am not a policy person. I am a person who sees people on the front lines. I am at ground zero in the Lower Ninth Ward. But I

can tell you what the impact should feel like. It should feel like a person should be able to come to the clinic and not worry about whether I can pay for it or not. It should feel like, I can get the services that I need, whether it is primary health care or specialty services. And I just want to say that this has been a wonderful collaboration, because of the Primary Care Access and Stabilization Grant, we have been able to work together, something that I don't think we really did prior to Katrina as much, but we were forced to. Necessity is the mother of invention they say. And I am telling you, we definitely forged a lot of friendships, invaluable friendships and relationships, so that we could give the care to the people that so desperately needed it.

And when we move forward, when the next catastrophe should happen, we should definitely keep the people who have been on the ground, who have built what we have today. They should be the ones really to give you guidance. It shouldn't come from the top down. It should come from the bottom up. Because we have already shown that we have been very, very effective in what we have been able to do. And with meager, meager resources, we have given a lot of care. I have to commend all of the people who are at this table who have a commitment and who have been mission-driven to bring about these great results that we have seen today. And that partnership with government has been invaluable. We wouldn't have been able to do it without you guys.

But the people who have been doing the work need to guide the work. Thank you.

Dr. ERWIN. Thank you very much, Congresswoman. I would like to reinforce what has already been said. I think first and foremost, we would like to maintain what we have accomplished and maintain what we have. We all, I think most of us at this table, realize that health insurance for everyone is a must. When we are dealing with 72 percent uninsured, we see the ravages of that.

But I would really like to make sure that we understand that we, and other cities in California and everywhere else, are having financial plights. That is very clear. What we would like to encourage you to think about is that with the PCASG money, you took a blank slate and you helped us build a health care delivery system that has a good start. It doesn't take massive amounts of money now to nudge it on to where we really could become sustainable and we could become permanent and we could grow. Because as you already heard, we are coordinating mental health and primary care in ways that we had not been able to do before.

So we really feel like that, we understand what it must look like for us to be asking for money for just one particular part of the country. But you have really helped, with the PCASG money, you have really helped rebuild a health care system better than it was before. Without a little bit of money now, I think, relatively speaking, we will slip back. We will go back to where there isn't the primary care, there are not the community clinics, there are not the alternatives to the emergency room care.

So we really do, first, I think, and foremost, want you to understand the money you have spent has really made a difference. You have really saved a lot of lives. We have really built, starting with the Governor, Secretary Levine, we have all worked together to

build a better health care system. I have been there for 30 years and this is the first time I have seen the kind of collaboration and the input that we have had both at the city and the State level and the community clinics.

Ms. WATSON. Doctor, can I just request of the Chair 3 more minutes, so that we can finish up your panel?

Chairman TOWNS. Well, I would love to do that, but we sort of——

Ms. WATSON. A minute and a half?

Chairman TOWNS. A minute and a half.

Ms. WATSON. Thank you. Mr. Griffin. You use the half, and then we'll have the other two ladies split the minute.

Mr. GRIFFIN. Thank you for the question. I think 100 percent access and 100 percent coverage should be, you asked about reform, that is hopefully where everything is going. And as it relates to the PCASG grant and what has been accomplished in New Orleans, I do think there has been a tremendous accomplishment of changing a system from hospital to primary care. And when you talk about coverage, excuse me, when you talk about access, nationally there will be a need for more access to primary care. You could be looking at a model that could be replicated nationally.

The vehicle for primary care development through the Federal Government in the past has been through federally qualified health centers. Most of the people sitting at these table, only one of these entities qualifies as a federally qualified health center. So this has expanded the opportunity for, through this crisis, other entities to actually have more dollars going to primary care and having more primary care delivered in a community. We are changing the lifestyle and the behavior of our population in New Orleans, which in the long run will reduce costs to the health care system.

Dr. TOWNSEND. I will echo a lot of what you have heard, and that is, we have the beginnings of a network of care, which I think is part of the answer for health care reform in the future. And the other piece that is extremely important in health care reform is going to be coverage. And we don't have that piece yet. So I think what you are hearing is we would like to see a bridge of funding, whether it is flexibility in the Community Development Block Grant funds, or whether it is a waiver for the disproportionate share hospital funding, to help support these clinics that are an integral part of a network of care.

Dr. ROWLAND. I would just echo those comments that the coverage promised in the health care reform legislation passed by the House would, of course, help many of these clinics to be sustainable. But the implementation date there is 2013, maybe 2014, depending on the Senate action. And you really do need to think about how to bridge us from where we are today to where we would want to have these clinics be and the peoples' coverage be in 2013. I think that involves both phasing in better coverage for some of the low-income people, as well as providing for support to these clinics during the bridge or transition period, and recognizing that maybe one of the best steps would be to try and develop a plan for how to turn the clinics from freestanding clinics into those that can participate in the federally qualified health center program, which

undoubtedly will have to remain a strong part of our health reform efforts for medically under-served areas.

Chairman TOWNS. The gentlewoman's time has long expired.

Ms. WATSON. Thank you, Mr. Chairman.

Chairman TOWNS. But I really felt that the information that we were getting was just so important that we could not interrupt. I think the timing of it means so much to us right now here in Washington. So thank you very, very much.

I now yield 5 minutes to the gentleman from Ohio, Congressman Kucinich.

Mr. KUCINICH. Thank you, Mr. Chairman, for holding this important hearing on the state of health care in the New Orleans region.

One thing is clear, we must ensure that the clinics and public hospitals in the area remain as strong as possible. The need is unusually great there. As someone who believes that health care is a human right, I think the people deserve help from the Federal Government that will help them to fulfill that need.

In the short term, we must shore up the Primary Care Access and Stabilization Grant funds before they run out. And we must build a new public hospital that is financially sustainable, attracts world class providers, researchers, and students. If such a hospital provides a little competition for more profitable hospitals with a lower charity care patient mix, then we should embrace that.

But this situation needs long-term fixes. A strong public hospital and set of clinics in affected areas are part of that. But New Orleans has for-profit hospitals, Mr. Chairman, around the periphery of the city, who collectively take less than 15 percent of the charity care, leaving the rest to go to public hospitals. It is called cherry-picking. It is not profitable to provide health care to those who need it the most.

So the for-profit health care industry goes out of their way to avoid it. The result is we are constantly fighting to provide adequate publicly funded health care for the disadvantaged. Now, if we are going to provide sustainable health care for New Orleans, we need to make sure the hospitals that are making big profits are pulling their weight. The failure of profitable hospitals to provide adequate levels of charity care is not simply a New Orleans problem. Indeed, in Cleveland, Metro Hospital has a steadily growing patient mix of charity care cases, which presents a growing financial burden that strains their budget, the budget of the county and, of course, the budget of patients and providers.

So I look forward to working with this committee to address the role of private hospitals and clinics in bringing health care to New Orleans and affected communities all over the Nation. I have read the testimony of the witnesses. And I have heard comments by my colleagues. I have heard one of my colleagues refer to New Orleans as a ward of the Federal Government. It is interesting, Mr. Chairman, this discussion occurs 2 days after the President announced an escalation of a war. We have money for war here, we don't have money for health care. We have money for war and Wall Street, we don't have money for health care.

You have a $100 million grant, as though you are supposed to stretch that into the next year, you are running out of money, to maintain a health infrastructure that was weak before the storm

hit. New Orleans was already in dire economic straits before the storm hit. If there has been a hearing that puts in bold relief more clearly about the distorted priorities of America, I would like to know what it is, other than this one. We are trying to keep alive a health infrastructure to assist people, and we are getting ready to spend $160 billion next year on a stupid war in Afghanistan. Billions.

I read the Kaiser report here which spells out the statistics, the great health care problems that still exist, the infant mortality that was high even before Katrina, the number of AIDS cases, diabetes mortality, comparing Louisiana to the rest of the United States. If we can't see that New Orleans is still suffering, if we can't see that New Orleans has a health care infrastructure that is not adequate to meet the needs of people who are still recovering from this hurricane, if New Orleans has to come here with a tin cup to beg for money for clinics to—you have to fight FEMA to try to get the money that you should have gotten, they are going to arbitration, Mr. Chairman. The new hospital is going to cost over $1 billion, and FEMA is nickel and diming New Orleans in an arbitration as to whether they are going to get $100 million, $150 million, or the $492 million that New Orleans wants.

This is a disgrace, really. It is good that you are here to remind us. But really, our country is falling apart. And what is happening in New Orleans is a signal condition of where America's priorities are totally fouled up. You should not be here begging, essentially, for recognition.

Thank you, Mr. Chairman, for holding this. But I will tell you, the more I hear the drum beats for war and we are going to go bomb poor people in Afghanistan and put a war into Pakistan, we can't even take care of our own people here at home, how disgraceful.

Thank you for being here. You have supporters in the Congress who understand that the fate of America is going to be linked to how we are able to take care of communities like New Orleans that are still struggling to survive. And just know that there are people right here who are standing right with you on it. Thank you.

[The prepared statement of Hon. Dennis J. Kucinich follows:]

Statement of Rep. Dennis J. Kucinich
U.S. House of Representatives
Oversight and Government Reform Committee

Hearing on "Post-Katrina Recovery: Restoring Health Care in the New Orleans Region"

December 3, 2009

Thank you, Mr. Chairman, for holding this important hearing on the state of health care in the New Orleans region. One thing is clear; we must ensure that the clinics and the public hospital in the area remain as strong as possible. The need is unusually dire there. As someone that believes that health care is a human right, I think they deserve the help from the federal government that will enable them to fill that need. In the short term, we must shore up the Primary Care Access and Stabilization Grant funds before they run out next year. And we must build a new public hospital that is financially sustainable, attracts world class providers, researchers, and students. If such a hospital provides competition for the more profitable hospitals with a lower charity care patient mix, then we should embrace that.

But this situation needs long term fixes. A strong public hospital and set of clinics in affected areas are part of that. But New Orleans has for-profit hospitals around the periphery of the city who collectively take less than 15% of the charity care, leaving the rest to go to public hospitals. This is called cherry picking. It is not profitable to provide health care to those who need it the most. So the for-profit health care industry goes out of their way to avoid it. The result is that we are constantly fighting to provide adequate public funding for health care for the disadvantaged. If we are going to provide sustainable health care for New Orleans, we need to make sure the hospitals that are making handsome profits are pulling their weight.

The failure of profitable hospitals to provide adequate levels of charity care is not a problem that is specific to New Orleans. Indeed, in Cleveland, Metro hospital has a steadily growing patient mix of charity care cases, which presents a growing financial burden that strains their budget, the budget of the County, and of course the budget of the patients and providers. I look forward to working with the committee to address the role of private hospitals and clinics in bringing health care to New Orleans and affected communities all over the nation.

Chairman TOWNS. Thank you very much. I would like to thank the gentleman from Ohio for his statement.

Congressman Luetkemeyer from the State of Missouri.

Mr. LUETKEMEYER. Thank you, Mr. Chairman.

Because of the specificity of the issue that we are dealing with here today and its importance to Representative Cao, I would, Mr. Chairman, yield my time to Mr. Cao. I feel he has more direct impact and probably has more knowledge and a lot more concerns about this issue than what I would have. But I would certainly be supportive of him using all my time.

Thank you, Mr. Chairman.

Chairman TOWNS. The gentleman from Louisiana.

Mr. CAO. Thank you, Mr. Chairman.

I would like to thank Mr. Luetkemeyer for yielding me time. First of all, I would like to thank Congressman Kucinich for his passion and for his understanding of the situation in New Orleans. I believe that he is clear on point with respect to the needs of our people down there. We have been struggling for 4 years to rebuild the Lower Ninth Ward. New Orleans East, right now there is a population of approximately 80,000 people in New Orleans East and no hospitals to address the needs of people there. So the needs are tremendous. And we will continue to require Federal assistance to help us move forward in our recovery. And in talking about recovery, I note that the new Charity LSU VA system, or at least the hospitals that we are planning to build will serve as an economic center for the city. Dr. Townsend, if you don't mind, could you please elaborate more on the plans for the VA LSU hospitals and where are we with respect to that particular project?

Dr. TOWNSEND. Certainly, Congressman, thank you.

We are in the process of doing the planning for the new academic medical center. But I think it is important to note that we recognize that the Charity model is not the model of the future. It is not what we want to see going into health care reform. It is not the best way to take care of patients.

So what we are building is a new academic medical center. So LSU, in partnership with Tulane, can train our residents and fellows and other health care professionals in that setting. And as someone said, we can attract world class physicians, researchers, do things there like you see in the Birminghams and the Houstons, where many people in New Orleans go for care today. We are exporting patients for health care, when we should be able to provide that at home.

So what we are doing is, we are staying on track with the planning process. We are waiting for a resolution from FEMA and once we get that, we are going to move forward into this new model. We are on track today to be in that new facility in the beginning of 2014.

So at this point, without knowing the FEMA number, we are still on track. We have not lost any time. But we have an exciting project that we are hoping to move forward on.

Mr. CAO. Thank you, Dr. Townsend. Mr. Chairman, the issue with FEMA is an issue that we have been battling for 4 years now and Congressman Kucinich is absolutely right, the cherry system

is so integral for New Orleans. And FEMA is still nickel and diming the city in order for us to get the system back online.

I would really appreciate if we could have a hearing in which we could invite FEMA to explain their position and to see how we can try to overcome some of this impasse that we are experiencing down there in the district. But I know that the numbers between the State and the city, there is a difference of around $300 million. Can you please tell the committee, how important is it that we should receive the full $492 million to rebuild the system?

Dr. TOWNSEND. Someone mentioned the price tag for the project. The hospital itself is about a $441 million construction. But the entire complex, so it includes a clinic building so that you can do outpatient, particularly specialty services there on campus. So that $1.2 billion price tag, the State has already committed $300 million to that project. And the remainder of the $1.2 billion will have to be financed. And a new entity is being created that will manage that new academic medical center.

So they are going to be responsible for some sort of bond issuance or some way to raise that money. So the difference between raising $800 million or $400 million is significant. So yes, we are hopeful that through the arbitration process that is going on right now, that the State will get a favorable declaration from FEMA and the number that the State has submitted reimbursement for is $492.

Mr. CAO. Thank you very much. I see that my time has expired.

Chairman TOWNS. Yes, thank you very much. Let me say that we really tried to have this hearing in New Orleans. But the schedule just got so messed up that we could not do that. And of course, I am sure if we had had it in New Orleans that we would have had others involved as well.

But the point is that we felt it was just too important not to do it. And also, to commend you on the great work that you have done, we wanted to do that as well. We think that you have done an outstanding job in terms of and in spite of the difficult conditions and circumstances.

Now I would like to yield to the gentlewoman from Ohio, Congresswoman Kaptur.

Ms. KAPTUR. Thank you, Mr. Chairman. I want to compliment you for holding this important hearing, and for your leadership. I know how much you care, as a health care expert yourself, about what needs to be done in New Orleans and Louisiana and many of the coastal areas that were so damaged by Katrina.

I was fortunate to be able to travel to New Orleans and to Mississippi with the Majority Whip, Mr. Clyburn, and with our Speaker and others almost 2 years ago, now, I think it was. That was very, very instructive. I guess I wanted to say to all those who traveled here today from Louisiana, it is a gift of the Christmas season that we get to meet angels who are on this side of eternity and who are working and doing God's work. I just want to compliment you for, you could be doing many other things in your life and you have chosen to do this. The people of my region, I know, admire it and view it as a very noble effort. So let me compliment you for what you do and through my remarks help to give you strength to continue to help those who need it so much.

My question, I have a question and then a comment. Ms. Bascetta, in your testimony you talk about an adequate sustainability strategy to help these clinics in the future. Hopefully, we will be able to get them additional funding. But we would be interested in your suggestions on sustainability. And Dr. Erwin, in your testimony you say if there is not funding to bridge the gap after the public clinic, primary clinic funding ends, many of your patients will revert essentially to the same situation they found themselves in immediately post-Katrina. I think it would be important for you to state for the record what that would be.

Finally, before you answer, let me just say that when I was down there as a member of the Agriculture Committee, along with my other duties here, I was struck by the unmet opportunities to use additional space that is available in New Orleans. I am interested in having you submit for the record or comment here today on how the added strength of food power and nutrition in your region is being implemented. With all those open swaths of land, with the possibility that primary health care clinics could also become food stamp redemption sites for people who grow food in the area, I can tell you in the community that I represent, one of the eight poorest areas in the country now, we get over $100 million a year of food stamps in the region. I had a great epiphany a few years ago saying, "hey, wait a minute, we can turn these into economic development dollars if we can get the people who live in these areas to actually produce the food and turn them into food stamp redemption sites." It is a no brainer. So we are about that task.

And I am just curious about these efforts perhaps being made by your associates that could help your health clinics also become nutrition clinics, and to deal with some of the related health problems that you face. I am curious about your progress on those. But in terms of my first question, which is sustainability, Ms. Bascetta and Dr. Erwin, could you comment? And then if anyone wants to say anything on agriculture, I would be most grateful.

Ms. BASCETTA. I would be happy to. We have heard that where the rubber hits the road is the uninsurance problem. There simply aren't revenues by definition from that population. And it is a very large population in New Orleans, well above the national average.

Ms. KAPTUR. Could you pull your mic closer? I don't think I heard you properly.

Ms. BASCETTA. The uninsurance problem in New Orleans is much more severe than the national average. That is where the rubber hits the road in terms of sustainability. By definition, that population doesn't provide any revenues to the providers. They are uncompensated care. Historically, the only, the funding streams that have provided reimbursement for those people are either the DSH payments that we have heard about, which are typically to institutions, to hospitals, unless there is a way to redirect them through a waiver, and the HRSA health centers also provide funding for people who are, for health centers to take care of people who are uninsured.

Our view is that CMS and HRSA have already made a significant investment in the area to try to do this model demonstration of doing health care the right way, primary care first, as the most important building block of the continuum. It really would be a

shame to have erosion in the progress that has been made so far if the funds can't be made available to shore up these clinics at this point.

And since the grant ends in September, we really don't have 10 months. It is pretty urgent now, in January, to make sure that plans are in place. Because what happens if they are not, providers begin to worry about their job security, they need to know that there is going to be an infrastructure in place. Patients begin to become anxious about where they are going to get their care.

So it is important to expeditiously make a decision about whether we are going to continue this investment that has made this progress so far.

Ms. KAPTUR. Thank you. Dr. Erwin.

Dr. ERWIN. Yes, thank you very much. I would like to make a comment about both the sustainability and the nutrition, if I could. As I mentioned earlier, we have tried in a very systematic way to deal with the issue of sustainability since the grant came out. That is part of it. We have appreciated that.

Our revenues, the patient care revenues that we generated the first year, were around $238,000. This year it is going to be right around $420,000. We have a pretty detailed process where we try to help, we have representatives in the community who work as our partners explaining to people that it is really important for everybody to pay what they can to help us be sustainable. And so we are dealing with the fact that almost everybody pays at least $20, but the fact is, with a 72 percent uninsured population, which is why we get out of bed every morning, we are not going to try to get private pay until we find some way for these patients to get their care met.

We are very hopeful about the expanded eligibility that Secretary Levine can probably tell you about for Medicaid. But that will be 2 years away. In our budget, we are pretty conservatively working with our CPA. We really do think that by year three, if we get a nudge and can continue on, by year three we can be pretty well sustainable. We really do.

If I could just make a comment about the nutrition, too. We have had, as part of our "mental health program," an issue, a program for community health and resilience, to try to encourage healthy neighborhoods. We are a small clinic. We don't kid ourselves about how broad our impact is. But we have partnerships with one of the churches, the Sixth Baptist Church. And we have a coffee shop that is part of our clinic, that is run by the youth group at the church. There is 8 weeks training to begin working there, after the first 8 weeks, when they work in the coffee shop then they move to the kitchen, where they make pralines. We are beginning to sell them on the Internet. We have pepper sauce from a community garden that we are selling.

So it is sort of a "light a candle" rather than "curse the darkness." But it has created a really positive mind set with a lot of the youth, particularly. There are an awful lot of kids who have nothing else to do. And so we feel like that this type of thing is well worth our expenditure. We hope that it is the kind of thing that we can continue to do.

Thank you very much.

Dr. DESALVO. I think what Don is speaking to is this concept that health is more than getting people to a doctor. And it is an underpinning for all of us and what we do. We think of our sites as centers, places where people can come not only to become empowered, to get regular medical care, to learn about their health, but almost all of us have programs that reach out into the community and engage and empower them to build economic opportunity, work force training, as Don is describing, to help develop community gardens, to make it part of the healthier foods in schools. The model here is really going beyond just the idea of a clinic delivering medical care. We feel an obligation to address the social determinants of health as well.

Ms. KAPTUR. Thank you, Mr. Chairman. Thank you all.

Chairman TOWNS. I now yield to the gentleman from Utah, Congressman Chaffetz.

Mr. CHAFFETZ. Thank you, Mr. Chairman, and thank you all for being here.

I would actually like to yield the time to Mr. Cao from Louisiana.

Mr. CAO. I would like to thank the gentleman for yielding. I would like to ask this question to either members of the panel, maybe to Dr. Townsend, Dr. Erwin, Dr. DeSalvo. How does the lack of a flagship hospital affect recruitment? And how does this lack of recruitment affect the quality of care of the people, especially for the poor people in New Orleans?

Dr. DESALVO. I am happy to start. I think for the university's part, the Charity Hospital system has been a really important site for work force training for us for generations. And it is the reason I came to New Orleans to train at Charity. It is where I did my National Health Service Corps payback. It is part of the fabric of how we develop new physicians, nurses, etc. So there is the element of developing the new work force to work in the community and to stay there to take care of the population. That is important.

We are also realizing that if you are going to train folks to work in community health centers or expect them to when they complete, they need to have that opportunity. I think that is really important, to shift that educational paradigm as well.

For our patients, especially for those patients of ours who are uninsured, they are by necessity financially triaged. So the State hospital system has been really critical in providing specialty services and inpatient services for those folks. As has been described, it is probably beginning to bulge at the seams a little bit. So we need to think about how we improve efficiencies of referrals and communication between the system so we don't overwhelm them needlessly.

Mr. CAO. Dr. Townsend.

Dr. TOWNSEND. I would say that actually, some of our recruitment has been very good post-Katrina. But it is because of the promise of a new academic medical center, a promise of new labs for research. So if you are going to have those kinds of, if those pieces of the infrastructure are going to be present and are going to stay, we are going to need that new medical center. We need a flagship hospital. As far as recruitment for residents, I think it becomes a little more difficult because we can't support the number of residents. Today, we are supporting about 200 Tulane residents

and fellows at the hospital, because we just simply don't have the volume. The 640 that were there before, they have to be in different places. That education is not as attractive to residents and fellows. So it makes it a little more difficult to recruit. Our medical school recruitment is still going well.

I am happy to say, for the dean of the medical school at LSU, his recruitment, like I said, with the promise of a new academic medical center, our NIH funding now is actually higher than it was before the storm. But that hospital is critical. And Dr. DeSalvo is right, we need the clinics. Because that is part of the training that is very important. But we have to have that flagship hospital, we have to have those tertiary and even quaternary care kinds of services that you simply can't get in the outpatient setting.

Mr. CAO. Dr. Erwin.

Dr. ERWIN. Thank you. It is particular pertinent to me, because I have a son that is a medical student and we are trying to recruit him to stay in town. And certainly, the training that you have heard both of them describe that comes with a flagship hospital that has academic excellence as well as clinical care is critical. We also feel that one benefit from recruitment has been the altruism of the country. We have seen a lot of people come down who really want to help.

But it is very important, we feel, for people who are going to work in community clinics, to train in community clinics. They don't get that training in the hospital. It is a different type of practice. So the residents, the students who come to town who come out to our clinics, they make a difference for us. They make a difference in the number of patients we can see, they make a difference in the quality of services that we offer. So that the higher quality that comes in, they don't come for us. They are lured by the flagship hospital. We benefit from it.

Mr. CAO. Now, there are areas in the second district, as well as in Chairman Melancon's district, that lack hospital care. And the statement from Mr. Issa saying that, what the State is doing, in order to help those people there, my question to you here is, I have spoken with the State and there might be some issues with respect to how much the State can contribute. Can LSU and Tulane, can you all come together in order to address the hospital, maybe the acute care needs of the people in Northeast and St. Bernard, and how can the Federal Government assist you all in that endeavor?

Dr. TOWNSEND. I think today, with the hospital that we have, the public hospital that we have, for citizens in New Orleans East who are uninsured, I think we are serving them today. As far as being able to serve them in the area, I think it is really important to have primary care, a bigger presence there. And there are some conversations going on right now with the city of New Orleans about the ability to use the medical office building that was at the former Methodist Hospital to be able to expand primary care services that would be a natural link then into the inpatient care.

As far as inpatient services, without the hospital in New Orleans East, obviously, I can't speak for Tulane, but I know that there are always contractual relationships that can be formed in order to have providers provide services at different hospitals. Because we do that today in the New Orleans region with other hospitals.

Chairman TOWNS. The gentleman from Utah's time has expired.

Mr. CAO. Thank you very much.

Chairman TOWNS. I now yield to the gentleman from California who is the Chair of the Congressional Black Caucus, who has been very involved and supportive of getting resources into the Louisiana area, Congresswoman Barbara Lee.

Ms. LEE. Thank you very much, Mr. Chairman.

Let me thank you for your very consistent leadership on this committee, and just as a Member of Congress and as a human being with regard to your concern and commitment to ensure that those living in New Orleans actually benefit from what our Government has tried to do in the past. It is unfortunate that this natural disaster was turned into a human disaster. Your leadership and this committee's leadership makes us believe that we will be able to do the right thing. But we have to do it now. And I thank you again for inviting me to participate.

As Chair of the Congressional Black Caucus, let me just welcome all of you, greet you and just say, thank you for being here. Most members of the CBC have been to New Orleans many, many, many times. And each time we go, we want to come back. We believe we are not doing enough yet and we have to do more. So this is an important step in the right direction.

I hope, Mr. Chairman, that in the future, this committee could lead a delegation to visit New Orleans once again, but look specifically at the primary care clinics and community care clinics. If that request hasn't been made formally, I request that, because I think it is time we come back. And especially now during this health care reform debate, and part of what we have been insisting on in at least in the House bill was an expansion of community clinics. So some of us would like to see how that would work, post-Katrina. Because we think if it can work, if it is working in New Orleans, it can work anywhere because of all of the issues, the tough issue that you are dealing with.

Let me ask you, a couple of things about medical records. On a couple of occasions, I visited and went to the hospitals and talked to some of the personnel and was concerned, they were concerned, like many of us, and I know you are, about the medical records and how you retrieve medical information from people who are coming back. Do you have medical records in terms of the computerization and the technology necessary for retaining, now, medical records, or how did all of that happen with regard to those who lost their homes and had to leave and are now coming back? How do you recapture medical histories?

Mr. GRIFFIN. I would like to respond to that. We have, I think since Katrina, developed a fairly robust system with electronic medical records. At Daughters of Charity Services of New Orleans, we have a paperless system for the most part. It is backed up out of town so that there is no jeopardy of losing the information. And our providers are able to access the records remotely. So that has been a, there are multiple vendors that entities are using. But it has been, of course, helped by this grant because of the operational assistance and infrastructure that this grant has provided. So that has been a true evolution and something that has worked very well.

I would just like to thank you for all of your, from the Congressional Black Caucus' Chair, for all the work you have done and all you all have done to look at New Orleans and assist New Orleans. And also I would like to express your sentiment with the chairman. Mardi Gras is coming up, so you all can have a visit or come down in 2 months if you like for your site visit. [Laughter.]

Ms. LEE. Thank you very much. And thank you for that invitation.

Dr. DESALVO. I just want to add to what Mike's saying, that the opportunity from the loss of our paper records was to rebuild it better. We have done that. We felt as a group of community providers that we wanted to move toward a paperless system. We think it has better safety parameters. It is more accessible for providers, if it is after-hours calls that we take on patients, we have the information at our fingertips to help make care decisions, to let them decide whether the emergency room is the right place or the clinic.

It has also really helped to advance our programs in quality and quality improvement and helped us to share information to think about how we are going to treat chronic disease like diabetes better.

Ms. LEE. But I have to ask you though, for those who lost everything, and I say this as the daughter of an 85-year-old mother who walks around with a briefcase full of medical notes and records, because where she lives they still aren't computerized, and there is no technology. So to remember, for a person who left during the storm, came back, lost everything, how do you reconstruct a record? I can't remember everything that, for instance, every medication that my mother takes or every diagnosis. How did you do that and how do people put all that together again?

Dr. DESALVO. It is a lesson learned from this tragedy, really, because we didn't have a lot of that information. So we did not want to go back to that situation, if it were to ever happen again. And we think, for disaster and every day, it makes sense to have the information available, not just to providers, by the way. The step we are not at yet is the portal for patients. Because really, they own that information and should be able to see it any time that they need to have access to it.

But what it took in the beginning was, honestly, we had records in the Charity system. That system, some of the dictator boards and labs were available, some of the hospitals had their inpatient electronic systems. So we pieced it together, painstakingly with folks. And it does take quite a long time when you are getting folks re-entry, over an hour or more, just to find out what happened to them in their lives and make sure it is not lost again.

Ms. LEE. Yes, and what medications, for example, understanding the health disparities in the African American community, diabetes, hypertension, lung cancer, breast cancer. How do you reconstruct the medications?

Dr. TOWNSEND. One of the advantages that we had was that the collaboration through an HCAP grant, there was the PATH partners that many of these folks belong to, including us, we had developed a retrieval system for electronic information. And so that piece of information, that history was available electronically, even after the storm. In addition to that, the pharmacies across the Na-

tion, if you use a retail pharmacy, you could retrieve that information of filled prescriptions. And then for our patients, most of them don't have a pharmacy benefit. So we access patient assistance programs and they get free medications. But there is an electronic system within the safety net that keeps track of what medications they have received.

That is important information. We were able to reconstitute that information very quickly.

Ms. LEE. That is great. Let me ask you one more question, Mr. Chairman, to this panel, as it relates to HIV and AIDS. How are you faring, and how are the rates in New Orleans as it relates to HIV and AIDS, and are people able—I remember earlier, right after the storm, accessing medications and getting people back on their meds at the right time and what have you was a difficult task. Are the rates now leveled off in New Orleans, are they going up, going down? Do we need to look at New Orleans and see what we need to do and do it better? How are things going?

Dr. TOWNSEND. HIV care in New Orleans, the public hospitals, clinics, it is called the HOC clinic, the HIV Outpatient Clinic, that clinic has been reconstituted. People are back in care. They are able to receive medicines. We have always had a really high diagnosis rate in New Orleans. I actually am not sure what that is today. My guess is that perhaps because the population is down, the rates may not be as high as they were. Because we have diagnosed so many of those people. But there are still people who are not in care. And we are still trying to get those people to the appropriate level of care. This is one place where we have made such great strides that you can really manage that disease on an outpatient basis.

Ms. LEE. Are you able to do testing initiatives, testing drives?

Dr. DESALVO. We are, and I think Diane can tell—I believe we have the second highest rate in the Nation of HIV after D.C. It is a major problem. There are programs in place for screening, education, identification, triaging people to care. One of the recipients of PCASG is the NO/AIDS Task Force, which has benefited and been able to grow its programs. So it is on the front of our minds. We know it is a major problem for the population and quite frankly, the community is very conscious of it. Of the things that we get requested as a health center to go do screenings on, it is HIV more than diabetes now.

Chairman TOWNS. Thank you very much. Let me thank the panel for being here. We really appreciate your coming and sharing with us, because we see it as being very, very important. And of course, we want you to know that you do have a lot of support on this side. We just hope to be able to move some of these things a lot quicker. But again, your coming here has been extremely beneficial.

Also I would like to just say that I also have a letter that is addressed to both Congressman Issa and myself from Mr. Melancon regarding this hearing. As you know, he represents several of the most affected regions recovering from Hurricane Katrina, including St. Bernard Parish, of course, and Plaquemines Parish as well, which are just east of the city and still recovering. He has been a leader on recovery, particularly in the areas of restoring and build-

ing the region's health care infrastructure. I would like to put this letter in the record.

[The information referred to follows:]

CHARLIE MELANCON
3RD DISTRICT, LOUISIANA

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AND COMMERCE

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December 2, 2009

Representative Edolphus Towns
Chairman, Committee on Oversight
and Government Relations
2157 Rayburn House Office Building
Washington, DC 20515

Representative Darrell Issa
Ranking Member, Committee on Oversight
and Government Relations
2157 Rayburn House Office Building
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Dear Chairman Towns and Ranking Member Issa:

I would like to take this opportunity to thank you for holding the hearing "Post-Katrina Recovery: Restoring Health Care in the New Orleans Region." I appreciate your leadership in raising awareness of this important health care access issue and for taking time to highlight the necessary role the Primary Care Access and Stabilization Grants (PCASG) play in supporting medical clinics in the parishes of Jefferson, Orleans, Plaquemines, and St. Bernard.

As you know, Hurricane Katrina devastated the medical facilities and health care delivery infrastructure in the greater New Orleans area. Further exacerbating the situation, the area lost numerous healthcare workers and practitioners due to the loss of their homes and livelihoods. St. Bernard Parish, in my district, lost its only hospital after it was destroyed by Hurricane Katrina. The remaining local doctors and health care practitioners opened the St. Bernard Health Center to provide basic health care to the people in the area. I was pleased to host a bi-partisan Congressional delegation in August of 2007 where 15 House members, including Speaker Pelosi, were able to see first hand the need for additional federal funding for health care services.

Through the effort and support of the Administration and the House Leadership, the U.S. Department of Health and Human Services (HHS) provided a $100 million grant to the State of Louisiana to support community health clinics through the Louisiana Public Health Institute (LPHI). These funds have provided support for 25 organizations which operate 93 clinics and provide care for more than 251,000 individuals, 40 percent of whom are uninsured. The St. Bernard clinic received over $700,000 in a PCASG grant and continues to operate today providing necessary health services to a population that would have otherwise had to go without.

PCASG grantees have been good stewards of their funding. Forty sites have been recognized by the National Committee on Quality Assurance (NCQA) as Patient Centered Medical Homes. Additionally, the entire program will have remaining grant funds at the end of fiscal year 2010

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due to their operational efficiencies. I have supported, along with the Louisiana delegation, a no-cost extension to allow PCASG grantees to be able to continue to use this remaining funding and have communicated this support to Secretary Kathleen Sebelius.

Again, I thank you for holding this hearing and for highlighting the positive work that is being done in the greater New Orleans area. These clinics are a model for the future of health care delivery. I look forward to continue working with you as we search for funding to continue the operation of these clinics beyond fiscal year 2010.

Sincerely,

CHARLIE MELANCON
MEMBER OF CONGRESS

CM:vg

Chairman TOWNS. Let me again thank you so much. Now we move to our second panel. I apologize for the delay because of votes. But in the meantime, we have to vote around here. If not, they talk about you. [Laughter.]

So we will now move to our second panel.

Will all the witnesses come forward, please.

Let me just indicate before we start, we swear all of our witnesses in. What we will do is we will allow you to start, but we will have to have another break to go and vote. I really apologize. They make an issue of it if you don't vote around here. So please stand and raise your right hands.

[Witnesses sworn.]

Chairman TOWNS. Let the record reflect that the witnesses answered in the affirmative.

Let us begin with you, Dr. Brand. Thank you so much for being here. I really appreciate your being here all day, too. Thank you so much.

STATEMENTS OF MARCIA K. BRAND, PH.D., DEPUTY ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ALAN LEVINE, SECRETARY, LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS; JOIA CREAR-PERRY, M.D., FACOG, DIRECTOR OF CLINICAL SERVICES, HEALTH DEPARTMENT, CITY OF NEW ORLEANS; AND CLAYTON WILLIAMS, MPH, DIRECTOR, LOUISIANA PUBLIC HEALTH INSTITUTE

STATEMENT OF MARCIA K. BRAND

Ms. BRAND. Mr. Chairman, members of the committee, thank you for the opportunity to testify today on behalf of the Secretary of the Department of Health and Human Services [HHS] and the Administrator of the Health Resources and Services Administration [HRSA]. We appreciate your interest and support of primary care in New Orleans and welcome the opportunity to work with you to strengthen HHS and HRSA programs in the region.

I appreciate the remarks of the previous panel and I applaud their fine efforts to provide access to care for the people of New Orleans.

HRSA also helps the most vulnerable Americans receive quality primary care without regard to their ability to pay. HRSA works to expand health care for millions of Americans, the uninsured, mothers and their children, those living with HIV and AIDS, and residents of rural areas. HRSA recognizes that people need access to primary health care and through its programs and activities, it seeks to meet those needs.

My testimony will briefly describe the Centers for Medicare and Medicaid Services [CMS] Primary Care Access and Stabilization Grant and ways that HRSA is working with its partners to provide access to primary care services in Louisiana. In July 2007, CMS awarded Louisiana the Primary Care Access and Stabilization Grant, a 3-year grant of $100 million to assist public and not-for-profit clinics in the greater New Orleans area to expand access to primary care, including primary mental health care, to all residents, low-income and uninsured residents. The grant was de-

signed to support the long-term sustainability of primary care in New Orleans. The grant required sustainability plans within the grant application and tapered funds over the life of the 3-year grant. The Louisiana Department of Health and Hospitals made provisions with the Louisiana Public Health Institute to help the State administer and oversee this grant's day-to-day operations.

As we have heard from the previous panel, the organizations receiving PCASG operates 91 primary care and behavioral health clinic sites across the region, including fixed and mobile facilities. As of September 2009, these clinics have served approximately 252,000 patients. The Department is pleased with the improvements in primary care access that has resulted form this grant. HHS looks forward to continuing our close partnership with the State and local health care organizations to meet the primary care needs of residents in the Gulf Coast.

HRSA's efforts to support primary care in post-Katrina New Orleans includes support for health centers, the primary care work force and infrastructure. Health centers are community-based and consumer-driven organizations that serve populations with limited access to health care. These include low-income populations, the uninsured, those with limited English proficiency, individuals and families experiencing homelessness, and those living in public housing. These centers are designed to provide accessible, dignified, health services to low-income families.

In 2004, prior to Hurricane Katrina, HRSA funded two health center grantees that supported 10 sites in New Orleans, serving 17,500 people. Since 2006, HRSA has funded seven additional applications. HRSA provides grant support to five health center grantees in the greater New Orleans area. This includes four existing health center grantees that received $7.1 million in 2009 to operate 18 sites and service 34,000 people.

The fifth health center is a new grantee that received funding under the Recovery Act. New Orleans has additionally benefited from Recovery Act funding and has received 13 awards that support new health center access points, increased demand for services and capital improvement awards. The Recovery Act funding will allow these primary care providers to see an additional 35,000 patients at more than 20 clinics across the area over a 2-year period. Two of the health centers are using these funds to provide additional mental and behavioral health services, which we know from our discussions today are critical to this region.

In addition to providing direct patient care, HRSA strengthens primary care by placing health care providers in communities where they are needed most. The National Health Service Corps, through scholarship and loan repayment programs, helps health professional shortage areas in the United States obtain primary care. And Dr. DeSalvo, who was on the previous panel, is an excellent example of the National Health Service Corps loan repayment program.

In addition to supporting a National Health Service Corps, we directly support health professions programs that provide infrastructure for training and education. This includes the Southwest Area Health Education Grant.

We also provide resources to address particular patient population challenges, including women and children. And as of this summer, we had another grant that would support care for people living with HIV and AIDS. HRSA provides Ryan White care funds to the New Orleans AIDS task force. And they provide comprehensive HIV care for about 800 people living with HIV and AIDS.

We are extremely proud of our programs and look forward to continuing to work with you, Mr. Chairman, and members of the committee, to provide quality primary care for all. HHS has invested a great deal of time and resources in assisting the recovery of New Orleans, and there is much more work to be done. We are looking forward to collaborating with you in that effort.

[The prepared statement of Ms. Brand follows:]

Statement of

Marcia K. Brand, Ph.D.

Deputy Administrator
Health Resources and Services Administration
U.S. Department of Health and Human Services

Before the
Committee on Oversight and Government Reform
U.S. House of Representatives

Washington, D.C.
December 3, 2009

Mr. Chairman, Members of the Committee, thank you for the opportunity to testify today on behalf of the Secretary for Health and Human Services and the Administrator of the Health Resources and Services Administration (HRSA), to discuss Post-Katrina Recovery: Restoring Health Care in the New Orleans Region. We appreciate your interest and support of primary health care in New Orleans and welcome the opportunity to work with you, Mr. Chairman, and the Committee to strengthen HHS and HRSA programs in New Orleans.

Introduction

The Health Resources and Services Administration helps the most vulnerable Americans receive quality health care without regard to their ability to pay. HRSA works to expand the health care of millions of Americans—the uninsured, mothers and their children, those living with HIV/AIDS, and residents of rural areas. HRSA recognizes that people need to have access to primary health care. Through its programs and activities, it seeks to address the country's need for primary care. HRSA takes seriously its obligation to diligently and skillfully implement laws that address primary care access. HRSA helps to train future nurses, doctors, and other clinicians, placing them in areas of the country where health resources are scarce. HRSA seeks cross-cutting alliances across its Bureaus and Offices to bring about quality integrated services. The Agency collaborates with government at the Federal, State, and local levels, and also with community-based organizations, to seek solutions to primary health care problems.

We at HRSA believe that primary care is more than having a place to go when you are sick. We view primary care as the Institute of Medicine (IOM) does: the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of the family and the community.

My testimony will briefly describe the Center for Medicare & Medicaid Services' (CMS) Primary Care Access and Stabilization Grant, HRSA's role in helping to support that activity, and other ways that HRSA is working to improve access to primary care services in Louisiana. In addition, I will outline current and future programs of HRSA that will be helpful in closing remaining gaps in health care access there.

Primary Care Access and Stabilization Grant

On July 23, 2007, CMS awarded Louisiana the Primary Care Access and Stabilization Grant (PCASG), a three-year grant of $100 million to assist public and not-for-profit clinics in the greater New Orleans area to expand access to primary care, including primary mental health care, to all residents, including low-income and uninsured residents. By design, PCASG funding provided a larger boost of initial support in order to expedite the infusion of funds into the distressed area and help facilitate a sustainable New Orleans primary care safety-net system. The PCASG grants were designed to support the long-term sustainability of primary care in New Orleans, requiring sustainability plans within the grant application and tapering funds over the life of the three-year grant.

For an organization to be eligible for PCASG funding, it must have been a public or private non-profit organization serving patients in the greater New Orleans area—which CMS defined as Jefferson, Orleans, Plaquemines, and St. Bernard parishes—at the time that Louisiana's grant proposal was submitted. It must also have had the intent to be sustainable, that is, able to continue providing primary care after PCASG funds are no longer available. For the PCASG, CMS defines sustainability as the ability to continue to provide primary care to all patients (regardless of their ability to pay) through some funding mechanism other than the PCASG, such as enrolling as a provider in Medicaid or another public or private insurer, and reviewed sustainability plans included by applicants in their applications for PCASG funding.

The Louisiana Department of Health and Hospitals (LDHH) made provisions with the Louisiana Public Health Institute (LPHI) to help the State administer and oversee this grant's day-to-day operations. The 25 sub-awardees received $16.7 million initially, with supplemental payments allocated on a biannual basis. As of September 30, 2009, a total of approximately $61 million has been disbursed by CMS through the LPHI, with

specific allocations based on the State's CMS-approved payment methodology. The funds have been allocated as follows: $12.6 million in December 2007, $16.64 million in June 2008, $17.66 million in December 2008, and $16.62 million in June 2009. In addition, $15.02 million is projected to be allocated in December 2009. Approximately $3.85 million of the total grant funds will be withheld from the global distribution pool for payment of performance incentives. The State is given discretionary authority to design these incentives. The goal of the Quality Incentive Payment (QIP) is to offer financial incentive for PCASG grantees to adopt nationally recognized quality standards modeled after the National Committee for Quality Assurance (NCQA) Physician Practice Connections – Patient Centered Medical Home framework. Although voluntary, grantees are encouraged to participate in the incentive payment program. Disbursements were made in February and June 2009, with a third incentive payment scheduled for December 2009. Clinic sub-awardees are eligible for these payments as of December 2008. If a grantee does not utilize all of its allotment within the budget period, unspent amounts are put back into a general pool that is subsequently redistributed among all 25 sub-awardees.

The organizations receiving PCASG operate 91 primary and behavioral health care sites across the region, including fixed and mobile facilities. Fifty-six percent are primary care centers, 30 percent are behavioral health only sites, and 14 provide a combination of services. Fourteen percent of these locations are mobile sites, and 86 percent fixed. As of September 2009, PCASG clinics have served approximately 252,000 patients.

The grant has also been used to leverage additional external support. For example, the Robert Wood Johnson Foundation is now supporting technical assistance for PCASG recipients on integration of behavioral health and primary care. In addition, a quality improvement incentive program for PCASG recipients was established via a partnership between LPHI and the National Committee on Quality Assurance.

Four million dollars of PCASG funding was explicitly allocated to the City of New Orleans Health Department to increase clinical services, recruit health professionals for two new public health care sites, and staff dental and vision care mobile vans.

The Department is pleased with the improvements in primary care access that has resulted from this CMS grant program and looks forward to continuing our close partnership with local health care organizations to meet the primary care needs of residents in the Gulf Coast.

HRSA's Role

After Hurricane Katrina devastated the area, HRSA worked with CMS on an HHS planning team to create the PCASG program and ensure its coordination with existing HHS initiatives. More specifically, HRSA assisted in writing the PCASG grant guidance with CMS; advised on how to fund primary care systems and services; helped CMS to set the pool of eligible applicants in the Greater New Orleans area and provided ongoing technical assistance to CMS, the State of Louisiana, and the LPHI; ensured all safety net organizations connected to HRSA or Substance Abuse and Mental Health Services Administration (SAMHSA) were eligible for the funding; and developed the reporting requirements and quality improvement standards for the PCASG program and conditions of its grant award.

Background on HRSA's work in New Orleans

Health centers are community-based and consumer-directed organizations that serve populations with limited access to health care. These include low-income populations, the uninsured, those with limited English proficiency, individuals and families experiencing homelessness, and those living in public housing. These centers are designed to provide accessible, dignified health services to low-income families. Community and consumer participation in the organization and a patient majority governing board were and continue to be the hallmark of the health center model.

In 2004, prior to Hurricane Katrina, HRSA funded two health center grantees that supported 10 sites in New Orleans, serving almost 17,500 people. HRSA has funded 7 applications for the New Orleans area since

2006—1 EMC grant, 5 NAP grants, and 1 PL grant. Three of the five NAP grants were funded under the American Reinvestment and Recovery Act (ARRA). In addition to the ongoing support for the two pre-Katrina health center grantees, the following new awards were made in 2007 and 2008:

Year	*Type*	*Organization*	*City*	*State*	*Area*	*Award*
2007	EMC	Excelth, Inc.	New Orleans	LA	Orleans Parish	$354,013
2007	NAP	Jefferson Community Health Care Centers, Inc.	Avondale	LA	Jefferson Parish	$433,333
2007	NAP	Excelth, Inc.	New Orleans	LA	Orleans Parish	$920,833
2007	PL	Broadmoor Improvement Association	New Orleans	LA	Orleans Parish	$80,000

HRSA also awarded the Louisiana Primary Care Association with a grant for $666,665 to establish an emergency communications network, linking Louisiana health centers with the state Department of Health and Hygiene and with major medical centers. The Louisiana Primary Care Association is working to establish a comprehensive, interoperable, and flexible emergency communications system, including a training and exercise program. In conjunction with the development of the emergency communications network, the Louisiana Primary Care Association is working to integrate policy, procedures, and plans with state, regional, and local emergency preparedness agencies.

Currently, HRSA provides grant support to five health center grantees in the greater New Orleans area. This includes four existing health center grantees that received almost $7.1 million in FY 2009 grant support to operate 18 sites serving approximately 33,680 people (including patients served in neighboring St. Charles Parish). The fifth health center is a new grantee that received funding under the American Reinvestment and Recovery Act (ARRA).

Number of Health Centers, Patients and Sites, Current (2009)				
Name of Health Center	*Parish*	*FY 09 Health Center Funding*	*# of Patients Served in 2008*	*# of Sites*
Excelth, Inc.	Orleans	$3,556,765	12,506	9 (including 6 mobile clinics)
City of New Orleans Health Department, Health Care for the Homeless	Orleans	$1,235,554	2,187	3
Jefferson Community Health Care Center, Inc.	Jefferson	$1,587,505	6,887	3
St. Charles Community Health Center, Inc (Kenner sites)	Jefferson	$ 719,424	12,101*	2
St. Thomas Community Health Center, Inc. (ARRA New Access Point with 3 service delivery sites)	Orleans	(See below)	NA	
	TOTAL	$7,099,248	33,681	17

* Includes patients served in St. Charles Parish.

The American Reinvestment and Recovery Act
On February 17, 2009, President Barak Obama signed the American Reinvestment and Recovery Act to jumpstart our economy, save and create millions of jobs, and put a down payment on addressing long-neglected challenges so that our country can thrive in the 21st century. In New Orleans, ARRA funding has supported three Health Center New Access Point (NAP) awards, five ARRA Health Center Increased Demand for Services (IDS) awards, and five ARRA Health Center Capital Improvement Program (CIP) awards.

		American Reinvestment and Recovery Act			
Health Center	*Parish*	*NAP*	*IDS*	*CIP*	*Total*
Excelth, Inc.	Orleans Parish		$346,264	$687,710	$1,033,974
City of New Orleans Health Department, Health Care for the Homeless	Orleans Parish		$143,351	$326,545	$469,896
Jefferson Community Health Care Centers, Inc.	Jefferson Parish	$1,300,000	$238,355	$491,045	$2,029,400
St. Charles Community Health Center, Inc.	Jefferson Parish	$1,300,000	$247,732	$673,535	$2,221,267
St. Thomas Community Health Center, Inc.	Orleans Parish	$1,300,000	$100,000	$250,000	$1,650,000
	TOTAL	**$3,900,000**	**$1,075,702**	**$2,428,835**	**$7,404,537**

This Recovery Act funding, which totals to date about $7.4 million to the New Orleans area, will allow these health centers to provide needed primary care services to an additional 35,000 patients at more than 20 clinics across the area over a two year period. Two of the health centers are using these funds to provide additional mental and behavioral health services—care that is much needed in New Orleans.

This recent influx of funds has been a welcome addition to the support HRSA has already been providing to primary care initiatives in the New Orleans area since Katrina. Now, I would like to review some of these programs and the essential work that they have been doing.

Excelth, Inc.
Excelth, Inc. began as a joint collaborative with the City of New Orleans Health Department but is now an independent organization. It has been federally funded since 1992. Prior to Hurricane Katrina, Excelth was the largest health center in Louisiana, with nine sites located throughout New Orleans. Since Katrina, Excelth has focused its service delivery in the downtown and northern sections of New Orleans and concentrated its efforts in three areas: (1) providing access to health care services, (2) rebuilding service delivery capacity, and (3) responding to special needs of the population.

City of New Orleans Health Department (Healthcare for the Homeless)
The Healthcare for the Homeless program, operated by the City of New Orleans Health Department, has provided services to homeless individuals and families in Orleans, Jefferson, Plaquemine, and St. Bernard Parishes since 1988. The health center provides preventive and acute medical, dental, podiatric, mental, and substance/abuse services at two sites. One of the sites targets homeless adolescents and is operated by the Tulane School of Medicine through a contractual agreement. The demographics of the homeless population have changed dramatically since Katrina from primarily adult males to young single mothers. The health center is planning to relocate its main service delivery site, has identified a new location, and is currently working with the City of New Orleans for approval of the relocation.

Jefferson Community Health Care Centers, Inc.
Jefferson Community Health Care Centers, Inc. received its first Federal funding in 2006. It serves the West Bank of Jefferson Parish with a population of 363,000. Jefferson Community currently has three service sites. Two are located on the west bank of the greater New Orleans area in Avondale and Marrero. The third site is located on the east bank in River Ridge. Hurricane Katrina had little impact on Jefferson's operations and facilities.

St. Thomas Community Health Center, Inc.
St. Thomas Community Health Center has been providing comprehensive health services to the low-income, uninsured, and working poor since 1987. It received its first Federal funding in March 2009 as an ARRA New Access Point. The target population of this health center is 133,229 low-income individuals in New Orleans. St. Thomas Community Health Center was one of the first sites that opened its doors to the impoverished population of New Orleans soon after Hurricane Katrina. St. Thomas provides access to health care to those most in need in the New Orleans service area and to persons of all ages.

Since its inception, St. Thomas Community Health Center has been an independent, not-for-profit clinic. The majority of patients have little or no insurance. The new access point at St. Thomas Community Health Center will serve approximately 11,900 individuals (33,680 are being served by existing primary care facilities). The clinic's independence has enabled it to be flexible and respond quickly to community direction and needs. Independence has also meant ongoing challenges to financial security and sustainability. Revenue generation, grants, and donor contributions remain critical. Cost effectiveness and efficiencies are constantly reviewed. The revenue that St. Thomas generates by being a Federally Qualified Health Center is crucial, and ongoing grant support is also needed in order for services to continue.

National Health Service Corps
In addition to providing direct patient care, HRSA seeks to strengthen primary care by placing health care providers in communities where they are needed most. For example, the National Health Service Corps (NHSC), through scholarship and loan repayment programs, helps Health Professional Shortage Areas (HPSAs) in the U.S. obtain medical, dental, and mental health providers in order to meet the area's need for health care.

Since its inception in 1970, more than 30,000 primary care physicians, nurse practitioners, certified nurse midwives, physician assistants, dentists, dental hygienists, and mental health professionals have served in the NHSC, expanding access to health services and improving the health of people who live in urban and rural areas where health care is scarce. About 80 percent of NHSC clinicians continue to work in a HPSA beyond their initial commitments, 70 percent stay at least five years, and about 50 percent make caring for underserved people their career. Finally, there are more than 8,000 job vacancies in NHSC-approved sites today—and more are added everyday.

About half of all NHSC clinicians work in HRSA-supported health centers, which deliver preventive and primary care services to patients regardless of their ability to pay. About 40 percent of health center patients have no health insurance.

The FY 2008 Field Strength Report (NHSC clinicians in service as of September 30, 2008) for the State of Louisiana shows a total of 83 clinicians across the State, which break down as follows: 33 physicians (40 percent), 15 dentists (18 percent), 13 nurse practitioners (16 percent), eight physician assistants (10 percent), and 14 behavioral and mental health clinicians (16 percent). The Recovery Act will double the NHSC and bring additional NHSC clinicians to New Orleans.

In addition to directly assisting in the placement of primary care providers, HRSA supports the health profession programs that provide the infrastructure for their education and training.

Health Professions
HRSA funds Area Health Education Centers (AHECs), which are academic and community partnerships that provide health career recruitment programs for K-12 students and also increase access to health care in medically underserved areas. AHECs address health care workforce issues by exposing students to health care career opportunities that they otherwise would not have encountered, establishing community-based training sites for students in service-learning and clinical capacities, providing continuing education programs for health care professionals, and evaluating the needs of underserved communities.

The Southeast Louisiana AHEC in New Orleans was started in 1988 through a grant written by Louisiana State University Medical Center. This AHEC serves as a bridge between schools of health professions, health providers, and communities. The Southeast Louisiana AHEC conducts needs assessments to determine health care workforce needs, recruits and retains health care professionals for rural and underserved areas, and sponsors adult and student health career fairs.

After Katrina devastated the Mississippi Delta, the Southeast Louisiana AHEC worked tirelessly to help out any way they could. Its 6,500 square foot office building sustained limited damage and remained open 24 hours a day during the early stages of recovery.

One of the AHEC's projects since Katrina has been the establishment of a rural loan fund as a component of a grant from the Robert Wood Johnson (RWJ) Foundation. The AHEC was able to leverage HRSA support to work with RWJ, which sent $1.25 million for use by the loan fund to support reestablishment of primary care clinics and other facilities damaged by the hurricane. RWJ required that each of the five most affected parishes be given a $50,000 grant to use to hire grant writers or other staff to help restore needed health services. Southeast AHEC staff facilitated that activity and made grant distributions to St. Bernard, Orleans, Plaquamines, Jefferson, and Cameron Parishes. The remaining $1 million was provided to support loan requests to repair or support primary care clinics and facilities damaged by the hurricane.

Maternal and Child Health (MCH) Provisions
HRSA also administers the Title V Maternal and Child Health (MCH) Services Block Grant program, which is the Nation's oldest Federal-State health care partnership. For over 70 years, the MCH Block Grant has provided a foundation for ensuring the health of the Nation's mothers and children. Today, State MCH agencies, which are located within a State health department, apply for and receive a formula grant each year.

Every $4 of Federal Title V money received must be matched by at least $3 of State and/or local money. This "match" results in there being more than $5 billion annually available for MCH programs at the State and local level. At least 30 percent of Title V Federal funds are earmarked for preventive and primary care services for children and at least 30 percent are earmarked for services for children with special health care needs.

The purpose of the Title V MCH Block Grant is to improve the health of all mothers and children consistent with the applicable health status goals and national objectives, and to provide and assure mothers and children (in particular those with low income or with limited availability of health services) access to quality maternal and child health services.

The MCH Block grant also funds Special Projects of Regional and National Significance, one of which is the MCH Schools of Public Health Training Grant at Tulane University. HRSA's MCH Schools of Public Health Training Grant at Tulane University was first supported by HRSA's Maternal and Child Health Bureau in 2005. The grantee has a close working relationship with the State Title V Program. The program is particularly strong in recruiting diverse students.

Another program that I would like to highlight is Healthy Start New Orleans (HSNO). HSNO was one of the first programs to resume services in New Orleans after Hurricane Katrina, mobilizing scarce resources in the

city to serve women and children. It has grown from the immediate post-Katrina staff of four FTEs to the current level of 28 FTEs. Serving 750 families annually, it has had to be creative in order to increase clinical and case management services because many providers have not returned to the city. In addition to providing needed obstetrical, pediatric, and dental services, the grantee has focused on the growing needs of this population for services to address perinatal depression, post-traumatic stress, and domestic violence. Case management services are provided to first-time mothers through the Nurse Family Partnership (NFP) Program and to pregnant and parenting non-first-time mothers by the Healthy Start staff. The NFP Program works through an agreement with LSU.

HIV/AIDS

And finally, HRSA provides Ryan White grant funds to the New Orleans AIDS Task Force. This task force is a new Ryan White grantee as of July 1, 2009, and provides primary comprehensive HIV care to approximately 800 people living with HIV/AIDS (PLWHA). Services available in the clinic include primary care, phlebotomy, pain management, psychiatric care, pharmacy, and support services.

CONCLUSION

We are extremely proud of our programs and look forward to continuing to work with you, Mr. Chairman and Members of the Committee, to provide quality primary health care for all. The Department of Health and Human Services has invested a great deal of time and resources in assisting the recovery of New Orleans. There is more work to be done, but we are pleased with the progress we have made. Our goal is to continue and expand our partnerships with local primary care providers and develop new National Health Service Corps sites. I truly appreciate the opportunity to testify today, and I would be pleased to answer any questions at this time.

Chairman TOWNS. Thank you very much, Dr. Brand.

Just before we start with Mr. Levine, we are going to break until 2:15. We hate to do this, but we have to make these votes. And then we will start again. And of course, hope that we won't have any more votes until we finish. Thank you, and we hope you understand. So we will actually recess until 2:15.

[Recess.]

Chairman TOWNS. The committee will reconvene.

Mr. Levine, you may begin.

STATEMENT OF ALAN LEVINE

Mr. LEVINE. Thank you, Mr. Chairman. It is an honor to be here today.

I had prepared some comments, I am going to depart a little from my prepared comments and sort of get to the crux of what some of our financial challenges are going forward. You have heard good stories this morning about the good things that were done as a result of this grant. There were other grants as well. And Congress and the executive branch have done a lot for the State of Louisiana and New Orleans. For that, we are grateful.

We are also grateful for the selection of Craig Fugate to be the Administrator of FEMA. I worked with him during the eight hurricanes that Florida faced during 2004 and 2005, and I don't know a more capable person in the country to lead FEMA.

I just want to get to some of the real financing challenges that we have that really trump all of this. Because all of this will become very difficult for us to sustain, if we can't solve these specific issues. First, our State faces the largest reduction in Federal match in Medicaid in the history of the Medicaid program. January 2011, our Federal match will decrease by 18 percentage points from an 81 percent match under the stimulus to 63 percent. That is an annualized loss of $900 million per year that Louisiana will either have to, will have to reduce from the expenditures in the program. That is one-sixth of our Medicaid program.

On top of that, we face a reduction in our DSH program. You have heard a lot about the low eligibility, the 12 percent eligibility for adults in Louisiana. Part of the reason for that is we have historically used this public hospital system to provide access for people that were low income. You heard that nearly 95 percent of our children have insurance coverage and we have a very low eligibility for adults. That is true, because we have this public system.

However, the funding for that public system is in jeopardy right now because beginning in July, we face what we estimate will be up to a $150 million reduction in our DSH program, a 20 percent reduction that begins July 1st. So those two issues combined are more than a $1 billion reduction to our safety net programs this coming year. We also are facing obviously the loss in the Primary Care Access and Stabilization Grant funding.

I just want to tell you a story. My first week on the job, there was a young police officer named Nikola Cotton who was murdered on the job. She was murdered by somebody who had been treated in our institutions, in our mental health institutions in New Orleans and had just been released from a mental health institution.

We found that the mental health system in New Orleans and throughout the State of Louisiana has been neglected for 20 years.

So the Governor and I set out, along with the legislature, and some of them are here today, to establish some major reforms in our mental health system. We passed several laws, one of them that we refer to as Nikola's law, that allows for involuntary outpatient treatment for people who don't take the medications when they are determined to be at harm or risk to themselves or others. We increased funding for mental health by $89 million. We implemented forensic assertive community teams, assertive community teams, multi-systemic therapy, functional therapy, services that had never been offered in New Orleans before that today are being offered.

And because we are doing it and because we have tried to move the standard from institutional care to a community-based model, we are serving three times the number of people that have mental health needs.

I want to say, there was a question earlier about what is Louisiana doing. Let me tell you some of the things that we are doing. First of all, I mentioned we have increased our funding for mental health by $89 million last year, even facing economic challenges that we are facing. The Department of Health and Human Services just put out a press release a couple of weeks ago, or put out a statement a couple of weeks ago, saying that Louisiana is one of the most efficiently operated Medicaid programs, and it is the model for how to retain coverage for children.

We went from 44th in the Nation for child immunizations to just a month ago CDC announcing that we are now second in the Nation in child immunizations, pushing our overall health care rankings to 47th in the Nation. Still very low, but the highest we have ever had since the rankings have been done.

So there is forward progress being made. But if we do not solve these challenges, these financial challenges, if the FMAP problem does not get resolved, the consequences will be extremely devastating for our State and many of the gains that you have seen, particularly the investments that have been made by the Federal Government will be, we think, in peril. To be clear, the reason that the Federal match is dropping in Medicaid is because of the very things you have done to help us. It is an ironic twist in the formula. The Medicaid matching formula was never designed for States that had major disasters. So what happens is, tremendous investments are made, billions of dollars of investment are made in our State, economic activity occurs, we have a temporary increase in our per capita income. Our per capita income went up 42 percent from 2005 to 2007. But yet we still have the second highest rate of poverty and our Medicaid enrollment is the highest it has ever been.

And yet, 3 years later, because of the Federal formula in law, our match in Medicaid drops as a direct correlation to the increase in the per capita income resulting from the recovery.

Mr. Chairman, I know my time is up. I will say that this is something that only Congress can resolve. We literally are asking for Congress to take a good, hard look at this to help us with this fi-

nancing challenge that no State in the history of our Union has faced in the Medicaid program's history.

[The prepared statement of Mr. Levine follows:]

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana
Department of Health and Hospitals
Office of the Secretary

TESTIMONY

Hearing on

Post-*Katrina Recovery: Restoring Health Care in the New Orleans Region*

December 3, 2009

Statement of
Alan Levine
Secretary, Louisiana Department of Health and Hospitals

Before the
Committee on Oversight and Government Reform
U.S. House of Representatives

Chairman Towns, Ranking Minority Member Issa, committee members, thank you for the opportunity today to testify about my state's health care challenges and how they will impact the ongoing recovery of the Greater New Orleans region, southeast Louisiana and our entire state. I'm also glad to be here to share with you some of the successes and challenges we have experienced in strengthening health care access through the Primary Care Access Stabilization Grant program.

New Orleans, our state, and, indeed the Gulf Coast Region, have made progress in the recovery since Hurricane Katrina made landfall. Approximately 65 percent of businesses have reopened, and the population is about 78 percent of pre-storm and growing. The health care workforce initially experienced significant losses, but has since exceeded national averages. This is due to the innovative programs that provided financial incentives for providers to return or remain in the region. The supply of medical services continues to transition to the new population levels, with various components of the system facing challenges, such as geographic disparities and other barriers that may limit access to health care to meet the needs of the residents. For example, the majority of the health care delivery sites are located in Jefferson Parish (66 percent) with only one-third (33 percent) in Orleans parish and less than 2 percent in Plaquemines and St. Bernard Parishes. The health care delivery sites ratio for St. Bernard Parish is 3,715 people to every clinic, while Jefferson Parish ratios are at 547 people per clinic in 2007. While the overall physician-to-population ratios for the overall region are better than the national average, we cannot ignore the geographic disparities that are not as well defined or measured.

Louisiana's health care system was ailing for years prior to the 2005 hurricanes, and many of these challenges have only intensified in the aftermath. Thanks to the support of the federal government, some of these issues were mitigated, although we have deep concerns about the sustainability of the gains we have made.

Throughout its history, much of Louisiana's care for the poor has been provided in the public hospital system. With many of the policy changes being contemplated in Washington, including the new rules affecting the funding mechanism for the public hospitals, the Disproportionate Share Hospital (DSH) Audit Rule, as well as the possible expansions of Medicaid, Louisiana must hasten its efforts to prepare its infrastructure for these changes. Next year alone, we face the loss of what could be more than $140 million in DSH payments from the federal government, in addition to substantial reductions in the federal participation in Medicaid. Both of these changes are occurring

at the very moment of a possible expansion of the Medicaid program, which currently covers more than 26 percent of our population. Given this possibility and the funding challenges, the reforms we need to make become even more critical. Overall, Louisiana's Medicaid program has significant challenges, led most importantly by the chronically poor outcomes produced despite the best efforts of our providers—who struggle because they offer services in a fragmented system with little coordination of care. Our rates of avoidable hospitalization have been shown to be among the highest in the nation, and our quality metrics are poor by most measures. When compared to other states, Louisiana spends a great deal of money on health care with a very low return. Louisiana has ranked 50th on many measures of our health system's performance for 16 of the last 19 years, according to the United Health Foundation.

But, progress is being made. Because of our state's commitment to improving child immunizations, for example, our ranking this year has improved from 44th in the nation to 2nd in the CDC rankings. We are proud of this improvement, and it is one of the contributing factors to the most recent report by the United Health Foundation's overall rankings, which ranked Louisiana 47th overall. While this is still too low, *it is the highest ranking Louisiana has received in the 19 years since this ranking has been done.* While this is a step forward, one that we hope to replicate each year, 47th clearly shows that we have tremendous work still ahead of us.

Extensive studies and analyses of Louisiana's health care infrastructure have been performed—all with the same observation. Our state-operated Medicaid program suffers from poor coordination and extensive fragmentation. Governor Bobby Jindal and I have proposed a sweeping reform of the Medicaid funded system, which would provide networks of coordinated care, consumer choice and a focus on transparent quality measures tied to performance – with a goal of moving away from the fragmented, volume incentivized model. We must move toward a system that incentivizes improvement in metrics we know improve health, rather than simply rewarding higher levels of utilization.

I cannot overstate the importance of implementing this model, as our current fee-for-service system cannot manage a Medicaid expansion of the magnitude being debated by Congress without fundamental reforms to our structure. Even today, we struggle to find providers to serve our most vulnerable citizens, and when we do find the providers, we have significant challenges coordinating the care. On top of this, in the next 20 years, the number of people over the age of 55 will nearly

double, placing a huge strain on the demand side of our health care system at the very same time a shortage of more than 125,000 physicians is expected. As utilization demands increase, we must find ways to better manage conditions in the lowest-cost setting or we will find ourselves with unmanageable rates of hospitalization and costs we cannot sustain.

As we develop our new model, we are in the process of deploying a disease management initiative focused on managing chronic asthma, congestive heart failure and diabetes, with the goal of reducing ambulatory sensitive hospitalizations. All of our new Coordinated Care Networks will be required to provide these services, which will also include Chronic Obstructive Pulmonary Disease, Sickle Cell and other chronic conditions at high risk of avoidable hospitalization.

The financial challenges we face over the next several years are profound, and without significant structural changes to our program, the state is not in a position to manage this challenge. To put it in perspective, the state is currently facing a shortfall in Medicaid with an annualized impact of $1.2 billion beginning in July 2011. In the state fiscal year that begins July 2010, the shortfall is expected to exceed $700 million.

Louisiana's people are grateful for the federal assistance provided by Congress and our other federal partners to restore and expand access to primary care and mental health services. In addition to the funds made available to the state through the Primary Care Access Stabilization Grant, the state effectively utilized funding available through the Professional Workforce Supply Grant, Social Services Block Grant (SSBG) and Crisis Counseling Assistance and Training Program (CCP) Grant.

In 2005, under the Deficit Reduction Act, $15 million was provided to recruit and retain primary care, mental health, dental and pharmacy professionals to health professional shortage areas in the Greater New Orleans area. An additional $35 million was awarded in 2007 to continue the successful work of the Greater New Orleans Health Service Corps. Today, the program has made awards to 1,228 professionals. Specifically, we've kept more than 150 primary care physicians, 24 specialists, 560 nurses, 50 pharmacists and more than 130 mental health professionals, as well as many others, in the New Orleans area. The state has work closely with the Human Resources and Services Administration, a division of the U.S. Department of Health and Human Services, to expedite the contracting process, recruit needed medical professionals and address issues that impact retention. My department just received a no cost extension to provide contract oversight of professional health care grantees until September 2012. In addition to assuring

contract compliance, we will expand data collection on recruitment and retention to assist us as we determine what strategies were most effective and can be successfully replicated. Despite these efforts, and similar to our sister states, we are still experiencing varying levels of professional health care shortages within the region—a problem likely to get much worse.

While the Administration for Children and Families administers the Social Services Block Grant funding to assist states in delivering *social services*, an exception was made in the 2006 appropriation to include the provision of health care services. This allowed the state the flexibility to provide services based on the needs of the individual rather than the rules of the bureaucracy. The state received more than $220 million in SSBG funding, and the Louisiana Department of Social Services served as the administrator, working with the Governor's office and the Louisiana Department of Health and Hospitals to identify needs and fund the services.

LDHH received $101.7 million and designated $80 million for mental health services, including substance abuse programs and services for people with developmental disabilities, to help these individuals address what was clearly an emerging mental health crisis. For adults, the funding was utilized for Assertive Community Treatment (ACT) teams, intensive case management, mobile crisis intervention teams, transitional housing and crisis triage services. For children and adolescents, school-based mental health, case management, family preservation, in-home crisis stabilization, after-school mentoring, multi-systemic therapy and crisis housing services were funded. Most of these community-based services did not exist prior to the storms. Even today, we continue to offer many of these services, which the state has funded as the grants have expired. Last year, the state increased the mental health budget by more than $89 million, with much of that funding being used to continue programs begun with the federal grants.

As an example of the weakness in Louisiana's health care system prior to the storm—a weakness exacerbated and revealed by the storm—I point to the history of our mental health services. Whereas in most states, at least 60 percent of the mental health budgets are spent on community-based services, we face the opposite in Louisiana. More than 65 percent of our mental health funding has paid for institutional care. This is not the model proven to be most effective, and we have taken steps to change this approach. With the increased funding for community-based services, and our efforts to integrate care in the setting closest to where people actually live, we believe the quality and availability of mental health services will improve.

The state designated $21.7 million of the SSBG for primary care. Each local parish was encouraged to develop proposals for restoring services according to its unique needs. Seven parishes received funding to address primary care challenges in their area with funds allocated to more than 39 facilities. Contracts were administered by local government entities to provide oversight at the parish and/or regional level as needs crossed parish lines. The funds were awarded based on the needs outlined in the application process—to fill the gap in operational costs for the clinic or facility for the year. Awards were made to replace lost equipment, destroyed supplies and/or increased demand due to need, salaries and benefits to assure access, operational expenses and professional services to stabilize care delivery. While this funding was critical, the sustainability becomes a challenge when it is used for reoccurring expenses, which was done.

Another critical piece in addressing the mental health crisis post-Katrina and Rita was the crisis counseling program, Louisiana Spirit, made possible by CCP grants from the Substance Abuse Mental Health Services Administration (SAMHSA). The grant award of $29 million was intended to meet the short-term mental health needs of people affected by the disasters. In all cases, Louisiana Spirit was either able to de-escalate crises related to storm trauma or refer those in need of greater crisis intervention services to the appropriate resources in the public and private sector. Louisiana Spirit completed 1.9 million face-to-face contacts with affected individuals through individual crisis counseling, group sessions or brief contacts in the New Orleans area alone. These services were extended in the aftermath of Hurricanes Gustav and Ike through an award of an additional $2.8 million, adding more than 200,000 additional contacts with affected individuals in the New Orleans area. More than 4.7 million contacts were made statewide with individuals impacted by Katrina, Rita, Gustav and Ike through individual or group counseling, or supportive or educational sessions.

There are three critical issues that will have a tremendous impact on the success or failure of the recovery of the Greater New Orleans region's health care infrastructure and system. I would also like to offer my recommendations on how we address these issues.

First, the Primary Care Access and Stabilization Grant program has been a critical element in preserving access to services in the region. While many hospitals and clinics were damaged or destroyed during the storm and its aftermath—and some remain closed today—the PCASG grant currently funds more than 90 clinic sites, providing primary and behavioral health care to more than 175,000 individuals in the New Orleans area annually and providing community-based access to

more than 74,000 of the region's uninsured. The Louisiana Department of Health and Hospitals was awarded the $100 million PCASG grant in July 2007 to support the restoration of primary care services and develop a community-based care network focused on primary care and integrated behavioral health care for low-income populations. This grant has been in place for two years, and significant, measurable improvements in quality have been made.

Consider the St. Bernard Health Center, made possible by the PCASG program, and over four years after the storm, the only multi-specialty health care facility currently open in St. Bernard Parish. With more than 50 employees providing services, including doctors, nurses and other staff, parish residents do not need to drive to Orleans or Jefferson Parish to get primary care services—services we know they would likely do without if it was not available in their community. Even more critical, the facility also effectively acts as an urgent care facility with a 24-hour call center and ambulance service when necessary. The St. Bernard Health Center reports that they receive between 3,500 and 4,000 patient visits each month. Without PCASG funding, many of these individuals receiving primary care services would have had nowhere else to go but to an emergency department to receive their care.

We awarded the PCASG funds to twenty-five public and private not-for-profit organizations providing primary and behavioral health care in Orleans, Jefferson, St. Bernard and Plaquemines parishes. Today, 91 clinic sites vary in scope and scale and include primary and behavioral health care clinics, school-based health centers, dental and mobile clinics. The total system volume (number of individuals served) has increased by 15 percent every six-month period starting March 2007. We did not simply want to use the money to pay for the services without implementing performance criteria to improve quality and the system. As evidence of our commitment to using these dollars to transform our system, we point to the fact that thirteen of the 25 organizations have since achieved recognition by the National Committee on Quality Assurance (NCQA) as Patient Centered Medical Homes at 36 clinic locations. Even more clinics are expected to achieve the recognition this year. This is a significant success story—one that is difficult to do even in the best of circumstances.

According to a recent release by the Bureau of Labor Statistics, the Current Population Survey showed Louisiana's poverty rate increasing. In 2007, 20.6 percent of New Orleans residents (47,487 people) were living in poverty. More than 40 percent of New Orleans residents report a chronic health condition or disability, highlighting the importance of primary care. The Louisiana Public

Health Institute estimates that, without a continued source of funding, the participating providers would be forced to scale back 30 to 40 percent of current capacity. The clinics serving high numbers of uninsured individuals in urban areas would bear the brunt of the loss. As a result, many of the most vulnerable patients would lose access to the care they need to stay healthy and help avoid reliance on costly, episodic emergency department care.

We must preserve and sustain these 91 clinics in the region and expand access to primary care and related services statewide. All estimates around national health care reform point to a substantial expansion of eligibility for Medicaid. Louisiana's current eligibility levels for adults are at 12 percent of the Federal Poverty Level (FPL). With the expansions proposed by Congress, eligibility would increase to up to 150 percent of the FPL. I strongly urge Congress to consider the continued federal funding annually to sustain these clinics until health reform is implemented or the debate is resolved. The expansion of Medicaid without sustaining access to primary care would be a terrible combination of events for the people we are trying to preserve access for.

Another funding solution currently being evaluated is through the process of an 1115 waiver, which would propose to permit the state to redirect Disproportionate Share Hospital (DSH) funds used in the hospital setting to the clinic setting. The waiver would provide a coverage model statewide for primary care services, limited diagnostics and pharmacy, as well as the ability to create networks of providers to serve as an individual's medical home. PCSAG clinics, Louisiana State University (LSU) clinics, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), community clinics and private providers would have the ability to participate using the existing successful model. While this potential model has promise, the challenge will be that the state must fund the state match portion of the DSH funding—something that today we may not be in a position to do, particularly with the massive federal reductions we are facing in the Medicaid and DSH programs. We have asked about the possibility of Congress permitting unused Community Development Block Grant (CDBG) funding to be redirected for other purposes, with this being one of the potential uses.

The second critical issue facing our state is one I have previously mentioned related to our funding challenges in Medicaid. Louisiana, a state with traditionally low per-capita personal income and the second highest percentage of people living in chronic poverty, will face an unprecedented drop in Federal Medical Assistance Percentage (FMAP). This substantial loss

in federal support for the Medicaid program is due to the dramatic and temporary inflation in the state's per capita personal income resulting from public and private recovery dollars infused into the state after the 2005 storms. The federal match formula was not designed to recognize the short-lived nature of sudden and temporary economic activity resulting from a natural disaster, and Congress never intended for major disasters to result in lost federal match for Medicaid. Historically, Louisiana's federal match has ranged from approximately 70 percent to 73 percent, with small fluctuations from year to year. In January 2011, upon the expiration of the American Recovery and Reinvestment Act of 2009 ARRA), our federal match will drop from our ARRA enhanced rate of over 81 percent to 63.16 percent. The disaster-related loss from our prior match rate of 72.47 percent to 63.16 percent will cost the state more than $500 million per year. This comes on top of the $450 million per year in lost funding due to the expiration of ARRA. Add to this the loss of $140 million in federal match for the DSH program, and we are facing a total annualized loss of more than $1 billion.

The impact to our state cannot be overstated. A revenue loss of this magnitude would necessitate deep cuts in the Medicaid program, which serves the health care needs of nearly 27 percent of Louisiana's population, mostly children and people with disabilities. In the five parishes most impacted by Hurricane Katrina (Jefferson, Orleans, Plaquemines, St. Bernard, and St. Tammany) there are 267,848 Medicaid or CHIP recipients as of October 2009 who would likely be affected by program reductions and access barriers.

As a condition of accepting the enhanced match, ARRA placed maintenance of efforts requirements on the states. Language in the Act explicitly prohibits a state from adopting any "standards, methodologies, or procedures" in their Medicaid program that are "more restrictive" than those in effect on July 1, 2008. Additionally, every major health reform proposal also includes some form of continued maintenance of effort beyond the expiration of ARRA. This places limits on each state's ability to address shortfalls other than provider rate reductions. Rate reductions of this magnitude will most certainly impair access.

If we are required to make cuts of this magnitude to providers, it will have a significant impact on the 27 hospitals and 3,529 physician's offices that currently accept Medicaid in the Katrina-affected parishes and seriously cut access for more than 250,000 people. Many of these individuals with chronic conditions would seek more costly care in emergency rooms—thus impairing the progress

we have already made, and frankly, causing the unintended consequence of costs increasing at an even faster rate. Some hospitals and physician practices may not survive the deep cuts that would be necessary to the Medicaid program.

To solve this rare and devastating problem, we are seeking a policy that looks to a state's historic pre-disaster per capita personal income growth rate or federal medical assistance percentage (FMAP) as the method for providing relief to Louisiana, and potentially relief to other states that experience major natural disasters. The solution we seek provides nothing more than what we would have received had we not been hit by four major hurricanes.

A third critical issue facing New Orleans and our state is the fact that we must produce our own physicians and allied health personnel to address the supply challenges, and in doing so, we must have a viable teaching hospital to help retain post medical students for residency and help us compete nationally for residents from out of state. The public hospital in New Orleans, known as Big Charity, was severely damaged during Katrina, and today, still has not been rebuilt due in part to lack of payment from FEMA for the cost of the hospital, its plant and equipment. In Louisiana, the system of charity hospitals plays two major roles: providing care to the uninsured and training medical students, residents and allied health professionals. Louisiana's statewide shortage of health care professionals is well established: 97 percent of the state's parishes are designated primary care Health Care Professional Shortage Areas. A strong predictor of where physicians eventually establish their practice is where they complete their residency program. But, according to the American Association of Medical Colleges, Louisiana is one of only six states that actually saw a *decline* in the number of residents entering the state—a 12.6 percent decrease from 1997-2006. Given that 24 percent of practicing physicians in Louisiana are 60 years of age or older (the 11th highest percentage in the nation), our state has been working on a system of graduate medical education that will not only retain or attract a sufficient number of residents, but residents of the highest quality in the specialties we need most.

Three months ago, Gov. Bobby Jindal announced a major step forward in building a new medical center in New Orleans with Louisiana State University and Tulane University signing a governance agreement that departs from the long history of operating the hospital as a government agency. A new private, non-profit board with representatives from LSU, Tulane and other expert stakeholders will operate the new teaching hospital—a model familiar to the nation's most successful academic

teaching hospitals. Louisiana's focus is now on financing the new $1.2 billion hospital. The state has already set aside $300 million and maintains that FEMA owes the state $492 million for the full replacement value of Big Charity because it was more than 50 percent damaged by Katrina. It is expected the balance of funding will be provided through the debt markets.

The proposed hospital will serve as an important training center for Louisiana's medical students, post-graduate residents and other health care professionals. The approved governance structure will allow the new center to compete nationally for the best residents, faculty and researchers; and invest in new equipment and technology, new lines of service and cutting-edge research.

We have begun the process of preparing to build this hospital, but cannot complete the funding until we know the result of the dispute with FEMA. The issue is currently in arbitration, and the results of that are critical to the potential success or failure of our ability to finance this hospital.

Mr. Chairman and members of the committee, state government and hundreds of community-based, health care and nonprofit organizations have made tremendous progress in the recovery over the last few years. But, we face some unparalleled and seemingly insurmountable challenges. We stand ready to work with you and be helpful in every way possible to address these challenges head on. Thank you for inviting me to speak today and I look forward to answering any questions you may have.

Chairman TOWNS. Thank you very much, Mr. Levine.

Dr. Crear-Perry.

STATEMENT OF JOIA CREAR-PERRY

Dr. PERRY. Hello, thank you for having me. I am Dr. Joia Crear-Perry. I am the director of clinical services of the city of New Orleans Health Department and I am an OB-GYN. I would like to thank the House Committee on Oversight and Government Reform for giving the city of New Orleans an opportunity to speak today and for providing us funding for primary care access and stabilization.

This vital funding helps support the city to re-establish a health system of care, along with providing critically needed medical and mental health services to the greater New Orleans community and areas post-Hurricane Katrina.

The causes for our historical social health disparities as a State, and more specifically in New Orleans, are complex and far-reaching and not easily counteracted. When Katrina made landfall, 28 percent of New Orleans' citizens lived in poverty, 25 percent had never finished high school, 50 percent lived in a single parent home and 25 percent had no health insurance. Hurricane Katrina has only exacerbated what was already a fragile health infrastructure and medical service delivery system. The current lack of access to both primary medical care and mental health services for such a large portion of our parish is perhaps the strongest correlation to our repeatedly poor health outcomes.

The goal of the New Orleans Health Department is to provide direct medical care and services and help to build a sustainable and long-term infrastructure along with the opportunity for collaboration and coordination in creating an equitable and accessible health care system for all residents. Therefore, I would like to focus on five things: the lack of access to primary medical care services by our citizens most in need; the professional medical and mental health provider shortages; a profound lack of mental health services; health disparities; and the need for continued support to finish the rebuilding of the city's health infrastructure.

Today, with the population of New Orleans having reached an estimated 350,000 people, close to 75 percent of its pre-Katrina numbers, the services offered by the New Orleans Health Department are much less. The city operates only three primary care clinics: one homeless clinic, one fixed dental site, and two mobile dental sites. The geographic coverage is limited. One of the primary care clinics is located on the west bank, and we have the map up there. One is located in Central City and one is in New Orleans East, across the large Industrial Canal. If you look to the right of the map, where there only a couple little dots in the far right corner, that is New Orleans East, where our clinic is.

There has been a significant decrease in the number of medical, mental health, and dental providers seen in Orleans Parish. According to a 2007 Blue Cross/Blue Shield report, only 28 percent of their original medical professionals returned to practice in Orleans Parish. Last year, the Louisiana Department of Health and Hospitals reported that less than 25 percent of those providers accepted Medicaid patients.

There has never been an adequate mental health infrastructure in New Orleans. And today, the need for care and treatment has only increased exponentially since Katrina made landfall. During the last 4 years, the availability of psychiatric beds has been dramatically reduced, combined with a large number of mental health care providers never returning, which has left the citizens most in need with the most obstacles in receiving care, needed care and treatment. And beyond that, being able to meet the mental health needs of our citizens, it has created a cross-cutting effect on families, communities, work sites, and the broader health care delivery system—from the hospital emergency rooms to the primary care physicians to the local jail facilities—which today houses the most psychiatric beds in the parish.

Just as behaviors and lifestyle choices are the causes of most chronic and infectious diseases, access to primary, preventive, and treatment care is what improves health outcomes and decreases disparities gaps. What research has shown is that health disparities in Louisiana are often found in populations which are poor, minority, high school dropouts, low incomes, uninsured, and lack transportation.

The New Orleans Health Department identified an extremely high need in under-served and under-staffed sites in New Orleans Parish and responded by establishing a clinic site with PCASG funding. As you can see on the map, it was New Orleans East. New Orleans East represented approximately 35 percent of total parish land area and 15 percent of overall population. Yet 4 years later, there is still no hospital. So I just wanted to put up my little Methodist picture. Can't have a New Orleans conversation without talking about Methodist Hospital.

Yet separated by the large Industrial Canal, New Orleans East is considered a suburb of the city, with the fastest-growing part of the parish in terms of population, business and industry, with a strong, increasing middle-upper class Black population and Vietnamese population. Like all of New Orleans, but particularly New Orleans East, data has shown a significant population shift. Each month that the New Orleans clinic has been open, we have seen a 15 percent increase in patient volume. We currently offer gynecologic, pediatric, adult primary care services, WIC and Healthy Start. We have collaborations with LSU and Tulane Schools of Medicine for specialty care, diagnostic procedures, and inpatient management. Sixty-five percent of our patients are uninsured. Our typical patient is a working mother who comes in for WIC services, brings in her children for pediatric services, participates in Healthy Start parenting classes, gets her PAP smear and birth control, and has her brother to come in for a blood pressure check. She can get all of this done at this one site in New Orleans East.

For a growing population that is geographically isolated, the PCASG funding has allowed us to provide convenient, compassionate services, because even 4 years later, there is still very limited care in the area.

Since Katrina, there has also been a severe shortage of dental services. The PCASG funding has allowed us to fill in the gap by staffing two mobile dental units. One goes to the senior centers,

and one goes to the school-based health units. On these units we provided dental exams, prophys, deep scalings, amalgam, bonding, removable partial dentures, complete dentures, crowns, and bridges. We have an oral surgeon who can help with more difficult cases. We have begun oral health education programs with the schools as well. So you can see one of our vans we are very excited about.

We are hopeful that the availability of services plus the student education will span out to beyond the schools and the senior centers in the future. Right now, it is filling a significant need.

So in closing, I know I am over, below are a couple of recommendations from the city of New Orleans. No. 1, to increase Medicaid eligibility, to increase the number of individuals who qualify for coverage and are insured. Two, use flexibility within the Section 1115 waiver for Medicaid for expansion to support the PCASG funding; expand the number of federally Qualified Health centers in the region; and to alleviate the disparities in mental health reimbursement. That is it.

[The prepared statement of Dr. Crear-Perry follows:]

United States House of Representatives
Committee on Oversight and Government Reform

Post-Katrina Recovery: Restoring Healthcare in the New Orleans Region

C. Ray Nagin, Mayor
City of New Orleans

Presented by: Joia Crear-Perry, M.D.
Director of Clinical Services of the City of New Orleans

Testimony

Joia Crear-Perry, M.D.
Director of Clinical Services of the City of New Orleans

Before the
United States House of Representatives
Committee on Oversight and Government Reform
"Post-Katrina Recovery: Restoring Health Care in the New Orleans Region"

December 3, 2009
10:00 a.m.
2154 Rayburn House Office Building

I am Dr, Joia Crear-Perry, Director of Clinical Services of the City of New Orleans. I would like to thank the House Committee on Oversight and Government Reform for giving the City of New Orleans an opportunity to speak today, and for funding the ***Primary Care Access and Stabilization Grant***. This vital funding helped support the City to re-establish a health system of care infrastructure, along with providing critically needed medical and mental health services to the Greater New Orleans Area communities, post Hurricane Katrina.

It is well known, and research continues to substantiate, that Louisiana has historically had some of the poorest health and socio-economic statistics in the country. For the past 20-years, Louisiana has ranked 49th or 50th in the *United Health Foundation's* annual state rankings across most risk factors and outcomes. Economic and social circumstances consistently define significant barriers to achieving health care goals, health equity and the ability to provide access to services for Louisianans who on the average are poorer, less well educated, and unhealthier than the rest of the nation.

The causes for our historical social and health disparities as a state and more specifically in New Orleans are complex, far reaching, and not easily counteracted. When Katrina made landfall, 28% of New Orleans citizens lived in poverty, 25% had never finished high school, 50% lived in a single parent home, and 25% had no health insurance. Hurricane Katrina has only exasperated what was already a fragile health infrastructure and medical service delivery system. The current lack of access to both primary medical care and mental health services for such a larger portion of our parish citizens is perhaps the strongest correlate to our repeatedly poor health outcomes.

The goal of the New Orleans Health Department is to provide direct medical care and services – while helping to build a sustainable and long term infrastructure along with the opportunity for collaboration and coordination in creating an "equitable" and "accessible" health care system for all residents. Therefore, this testimony will focus on five critical areas:

1.) The lack of access to primary medical care services by our citizens most in need,
2.) Professional medical and mental health provider shortages
3.) A profound lack of mental health services
4.) Health disparities

5.) The need for continued support to finish rebuilding the city's health system infrastructure.

I. Primary Medical Care in New Orleans

Hurricane Katina severely impacted the New Orleans Health Department (NOHD), which provided critically needed primary health services before the storm and subsequent levee breach flooding. For the pre-Katrina population estimated at 470,000, the Health Department operated 20 health center sites 7 full-service primary medical care clinics, 3 specialty clinics for Tuberculosis, Sexually Transmitted Diseases and Immunizations, 4 dental clinic sites, 2 mobile van dental clinics, and 4 School Based Health Center (SBHC) sites (Table 1). NOHD was also a PHS Section 330 (h) Healthcare for the Homeless grantee, which received additional funding for Expanded Medical Capacity in 2004. Through these collective networked service sites dispersed to those communities most in need, NOHD provided more than 75,000 client visits annually.

Today with the population of New Orleans having reached an estimated 350,000 - close to 75% of its pre-Katrina numbers – the services offered by the NOHD are much less (Table 1). The city operates only 3 primary care clinics, 1 homeless clinic, 1 fixed dental clinic site and 2 mobile dental sites. The geographic coverage is limited. One of the primary care clinics is located on the *West Bank* of the city, across the Mississippi River one is located in the heart of New Orleans known as *Central City*, and the third is located in New Orleans East, across a large industrial canal bordering Lake Pontchatrain.

Louisiana has fewer Federally Qualified Health Center (FQHC) sites than any other state. In 2006, there were 49 sites across the state, and despite documented high rates of poverty, medical unmet needs and barriers, provider shortages, Orleans Parish only had two of these FQHC sites. According to BPMC, 63 of Louisiana's 64 parishes either completely or partially were classified as "medically underserved, and 57 were designated as primary care health professional shortage areas.

II. Health Provider Shortages

There has been a significant decrease in the number of medical, mental health and dental providers seeing patients in Orleans Parish. According to a 2007 Blue Cross/Blue Shield report, only 28% of their original medical professionals returned to practice in Orleans Parish. Last year, the Louisiana Department of Health and Hospitals reported less than 25% of their providers accepting Medicaid patients in Orleans Parish.

Table I: New Orleans Health Department Service Sites

	2005	2009
Primary Medical Care Clinic	10	3
Dental Sites	6	1
School Based Health Centers	4	0
TOTAL	20	4

New Orleans had 2,258 hospital beds before Katrina. Two years later, it reported 625 staffed beds – still a 75% reduction from pre-Katrina levels. Of the 10 public and private hospitals available to residents within Orleans Parish only 4 have re-opened. Some hospitals were bought and sold, and others were never reopened, and those that are operating are primarily private, and impaired by the overwhelming volume of patients seeking care through emergency departments.

Since New Orleans public health care system was already fragile and inefficient before the storm – with more than 25% of all residents considering the Medical Center of Louisiana a.k.a "Big Charity" Emergency Room – as their primary medical provider, the reduction in neighborhood clinical services and the closure of the Charity hospital have left huge gaps in health care services for many residents, especially for indigent, low income and uninsured.

As of 2008, Louisiana had a total of 120 state Healthcare Professional Shortage Area (HPSA) sites, and ranked 15th nationally overall in provider shortages. In data recently released from the Kaiser State Health Facts (2008), Louisiana had the highest percentage (34%) of estimated underserved population living in primary care health shortage areas - literally 3 times the national average of 11% - a significant increase post hurricane Katrina.[i] Louisiana ranks 4th in unmet need for mental health professional providers at 48%, compared to the national average of 19%. Similarly, unmet need for dental services nationally is 10% compared to Louisiana where unmet need is 32% - ranking 1st nationally.

III. Mental Health Care

Two of the greatest legacies from Katrina are **depression** and **stress**. And most experts agree that even after four years – the general mental health of residents in the community – is only getting worse. Traditionally and still today, in the "medical world" mental health services are severely neglected. Post-Katrina, survivors with mental disorders receive far less attention and care than those with other acute medical conditions, despite the fact that the widespread experience of trauma triggered numerous new cases – while exasperating pre-existing mental disorders. Although federal money has addressed some mental health services in New Orleans, it has been disjointed and sporadic, focusing primarily on provider reimbursements, and dealing with mental health emergencies and crises - as opposed to prevention, intervention and treatments to stabilize, support and keep people in the community as productive and healthy citizens.

For the first two years after the storm, not one of the major hospitals had Psychiatric beds established in their facility, despite the fact that mental illnesses, depression, anxiety and Post Trauma Stress Disorders (PTSD) were both rampant and evident in the city. Today, only University Hospital (part of the Charity Hospital public care system) has set up a Mental Health Emergency Room extension in which 20 mental health patients can at least have a bed while the psychiatrist determines if they can be released or moved into a longer term hospital which often means transporting individuals to another facility, where there is an available bed, and most of these are several hours away from New Orleans. One out of every four of these transports involves a patient that has been seen repeatedly. It is not uncommon to pick up a suicidal patient and they still have their armband on from a recent discharge from a hospital. The three largest hospitals in Orleans Parish, Tulane, Touro and Ochsner Baptist, still do not provide any mental health beds in their facilities.

Psychiatric beds were expected to gradually increase in the city overtime, but as of the end of 2009, the actual capacity for inpatient psychiatric beds remains well below even pre-Katrina levels in the New Orleans metropolitan area more than four years later. The recent closing of 3 additional inpatient facilities in 2009, including the New Orleans Adolescent Hospital, has further decreased available beds.

As of today, New Orleans has fewer than 50 hospital beds for inpatient psychiatric services - 17% of pre Katrina capacity of 345 beds. Of the more than 200 psychiatrist who worked in New Orleans before the storm – just over 10% have returned to continue their practices.

Uninsured adults with mental illnesses, have been found to have the fewest resources available, and are at the greatest risk for developing mental health conditions. For too many individuals, basic physical, mental and emotional health conditions have never been addressed. The data shows the doubling of substance abuse and mental health needs and services post Katrina. Study after study has shown the rates of both mental health conditions and substance abuse – doubling. Today, most residents feel forgotten by the nation and its leaders, and cite health care as one of the three critical issues to rebuilding where they have seen little or no progress. New Orleanians are sicker today – both mentally and physically with more than half saying there are fewer resources available to help and treat people. And 90% - said their mental health is just as important as their physical health, but that the current health care systems give more attention and importance – to physical health issues only. One out of 4 said that general residents feel ashamed and embarrassed about mental health problems, and often avoid care and treatment. Perhaps one of the best studies looking at the impacts of Hurricane Katrina on substance use and mental health was conducted by SAMHSA through their National Survey on Drug Use and health (NSDUH). This study interviewed residents from the hurricane hit gulf south region, and found significant difference related to length of displacement. Interestingly, the NSDUH study done with New York City residents before and after the events on September 11, 2001, found virtually no differences in substance use and mental health conditions pre and post the disaster.

Comparatively, what was reported was the incredible spike in mental health and substance abuse problems in residents who had been displaced for 2 weeks or more post hurricane were 2-3x more likely to engage in substance abuse, and 2-3x more likely to report mental health issues and needs.[ii] Research shows that the number of persons diagnosed with a serious mental illness is estimated at 6% of the general population. Studies in 2009 reported that 11% of New Orleans residents have a serious mental illness and that mild-moderate mental illnesses have doubled from 10% to 20% in people heavily affected by Katrina areas. And some research suggests that half of this region's population has an anxiety or mood disorder, and 1 of every 3 residents – is dealing with post-traumatic stress today.

Put simply, there has never been an adequate mental health infrastructure in New Orleans, and today, the needs for care and treatment have only increased exponentially since Katrina made landfall. And during the past four years, the availability of psychiatric beds has been dramatically reduced, combined with the a large number of mental health providers never returning, which has left those citizens most in need – with the most obstacles in receiving needed care and treatment. And beyond not being able to meet the mental health needs of our citizens, it has created a cross-cutting effect on families, communities, work sites and the broader health care delivery systems – from the hospital emergency rooms, to the primary care physicians to the local jail facility which today houses the most psychiatric beds in the parish.

But perhaps the most compelling data is related to suicide trends post Katrina (Table 2). In the four years since the hurricane, three times more New Orleanians committed suicide in 2009 (N=53) than in 2006 (N=14). Historically, suicide rates in white men were 3x that of black men (22/100,000 vs. 7/100,000) and equally white women 3x that of black women (6/100,000 vs. 2/100,000). However, since Katrina, research has identified "serious psychological stress" in 31% of black – compared to 6% in their white counterparts.

Table 3: New Orleans Post-Katrina Suicides and Attempts

	Attempts	Suicides
2006	179	14
2007	286	21
2008	277	42
2009	244	53

IV. Health Disparities

For centuries, New Orleans has faced racial, ethnic, social and health disparities, which have collectively contributed to the City ranking first nationally in adverse indicators like infant mortality, cancer and heart disease death rates. Inequalities have dominated much of American development; racial and socio-economic differences used to separate, divide and discriminate against population subsets, historically impacting and felt more in the South than other parts of the United States. And although the acceptance and merging of differences is the nation's greater assets and the foundation in being a powerhouse of opportunity throughout history, the result has created ever-increasing socio-demographic and economic gaps and divisions. Today's ethnic and health disparities are attributed to many different causes – but socio-demographic factors underscore the most powerful determinants of health. And although many sub-populations are impacted by limited access to health care-there are populations that are disproportionately affected.

As experienced by New Orleans – the poor are exposed to natural disasters two times more than the general population. Despite the billions of dollars donated and allocated towards this parish over the past four-years, the recovery has been disorganized, disjointed, inequitable, and painfully slow.[iii iv] Our collective goal, is to expand and improve the availability and accessibility of essential primary and preventive health care services and related support services for low income, medically underserved and vulnerable populations that have had limited access to affordable services and face the greatest barriers to care. Provide a comprehensive system of care reflective of the community's needs and available to all persons residing within the geographic service area, regardless of a person's ability to pay for services.

Just as behaviors and lifestyle choices are the causes of most chronic and infectious diseases – access to primary, preventative and treatment care is what improves health outcomes and decreases disparity gaps. What research has shown is that health disparities in Louisiana are often found in populations which are: Poor, minority, high school drop-outs, low-income, uninsured and lack transportation.[v vi]

Significant racial disparities are seen across many health indicators. For example, in 2005, the birth rate for black teenagers aged 15-19 (66) was nearly twice than that of white teenagers (36) as well as the infant mortality rate in black women (15) compared to white women (7).

Racial Comparisons in Disease Rates: Per 100,000

	Black Male	White Male	Black Female	White Female
Teenage Mother Rate			66	36
Infant Mortality Rate			15	7
Heart Disease Rate	335	297	223	191
Cancer Rate	329	240	186	159
Diabetes Rate	62	35	63	25
Homicide Rate	50	5	7	3
Suicide Rate	7	22	2	6
Accidents	101	87	41	42

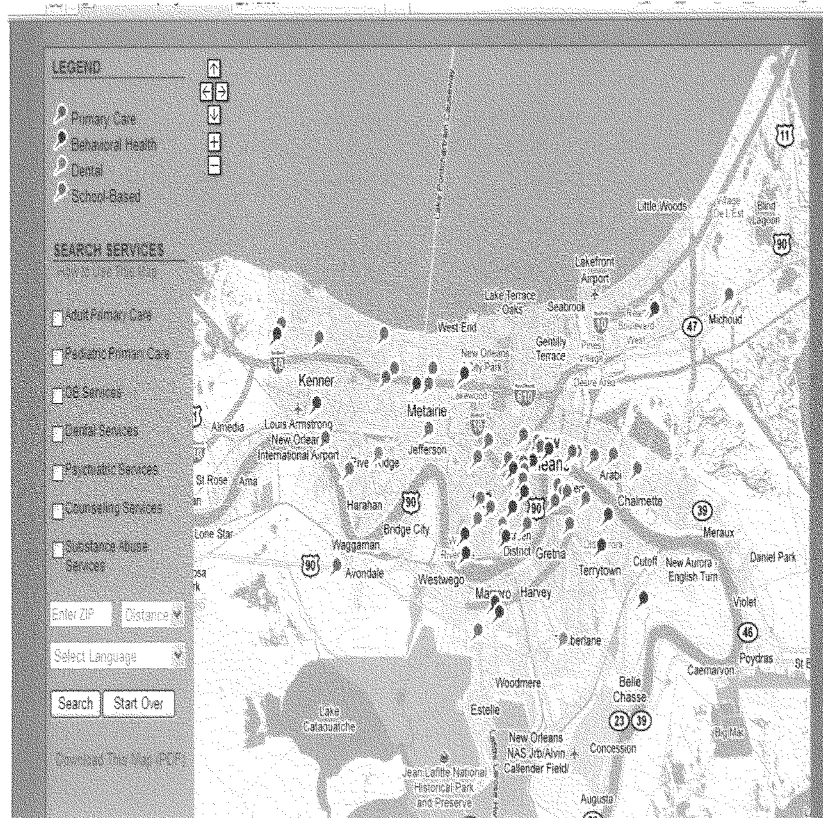
NOHD Highlight:

The New Orleans East Family Health Center and Mobile Dental Units

The New Orleans Health Department identified an extremely high need, underserved and understaffed site within Orleans Parish and responded by establishing a clinic site in the geographically remote area of the parish in New Orleans East, in 2008. As shown on the Orleans Parish map, New Orleans East represents approximately 35% of total parish land area, and over 15% of overall population. Yet, four years later there is still no hospital. Separated by a large industrial canal bridge, New Orleans East is considered a suburb of the city, and was the fastest growing part of the parish in terms of population, business and industry, with a strong and increasing middle-upper class Black population.

Like all of New Orleans, but particularly in New Orleans East, data has shown significant population shifts and demographic changes post-hurricane. Each month that the New Orleans East Clinic has been open, we have seen a 15% increase in patient volume. We currently offer Gynecological, Pediatric, Adult Primary Care services, WIC, and Healthy Start. We have collaborations with LSU and Tulane Schools of Medicine for specialty care, diagnostic procedures, and inpatient management.

There are 65% of our patients who are uninsured. Our typical patient is a working mother who comes in for WIC services, brings her children in for a pediatric visit, participates in Healthy Start parenting class with the father of the children, gets her pap smear and birth control and makes her brother come in to get his blood pressure checked. She can get all of this accomplished in her neighborhood because of the New Orleans East Clinic. For a growing population that is geographically isolated, the PCASG funding has allowed us to provide convenient compassionate services, because even four years later, there is no hospital within 20 miles, and very limited private medical care and services, and virtually no free or reduced fee primary medical care and services.



Since Katrina there has been a severe shortage of Dental Services. The PCASG funding has allowed up to help fill in that gap with staffing for two mobile dental units. One goes to the Senior Centers and the other goes to School Based Health. On these units we provide dental exams, prophy, deep scaling, amalgam fillings, bonding, removable partial dentures, complete dentures, crowns and bridges. We have an oral surgeon who we can bring in for more difficult cases. We have begun an oral health

education program with the schools as well. We are hopeful that the availability of services plus the student education will span out to beyond the Senior Centers and the Schools in the future. But, as for now it is filling a significant need.

V. Primary Care Access and Stabilization Grant

In 2007, Congress authorized funding for a Primary Care Access and Stabilization Grant. The goal was to expand and improve the availability and accessibility of essential primary and preventive health care services and related support services for low income, medically underserved and vulnerable populations that have had limited access to affordable services and face the greatest barriers to care. As a result of this funding, 25 public and private health agencies and community nonprofits have come together, for the first time in the City's history, to serve as a diverse group of both traditional and nontraditional leaders, to build collectively a system of care reflective of the community's needs and available to all persons residing within the geographic service area, regardless of a person's ability to pay for services. In addition to the extensive planning and organizing efforts this grant has afforded the City of New Orleans, it has also paid for the direct provision of health care services so desperately needed in this city.

These funds allow the city of New Orleans to provide direct medical care and services – while helping to build a sustainable and long term infrastructure along with the opportunity for collaboration and coordination in health care provision. Additionally, this will provide for increased data collection on high risk and hard to reach populations. It can continue to serve as best practice model nationwide to areas with similar demographics and hardships with access to quality wellness care. Below is a summary of the top 5 grant accomplishments, as well as the top 5 remaining challenges, for the New Orleans Health Department.

Table 1. New Orleans Primary Care Access and Stabilization Grant	
Funding Accomplishments	**Remaining Challenges**
Care to Geographically Isolated Communities	Access to Residents Most in Need of Services
Providing Accessible Dental Services and Care	Need for Dental, Medical and Mental Health Providers
Implementation of Electronic Data Collection Systems	Funding to Sustain and Expand these Systems
Tracking of Service Demographics and Disease Data	Data Sharing/Coordination Between Service Providers
New Collaborations Among Untraditional Partners	Lack of a Public Charity Hospital System
Expanded WIC and Other Children's Programs	Ending of PCASG Grant in September 2010
311 City Assisted Emergency Evacuation Program	Increase and Expand Emergency Planning/Services

Below are some recommendations from the City of New Orleans:

1) Mandate a Medicaid eligibility expansion to increase the number of individuals who qualify for coverage and are insured.

2) Flexibility in the use of Medicaid Disproportionate Share (DSH) dollars as outlined in LAs 1115 Medicaid waiver request so it can be used to support outpatient primary care

3) Expansion of the Federally Qualified Health Center program in the New Orleans Region and the State to bring it in line with levels of funding received by states/ regions with similar needs

4) Alleviate disparity in Mental health reimbursement

We again thank you for allowing us this opportunity to share our successes, suggestions and current needs.

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[i] Office of Shortage Designation, Bureau of Health Professions, Health Resources and Services Administration, Special Data Request, April 2009.

[ii] Sabstance Abuse and Mental Helath Services Administration, Office of Applied Studies. *The NISDUH Report: Impact of Hurricanes Katrina and Rita on Substance use and Mental Health,* Rockville, MD. January 31, 2008.

[iii] Louisiana Economic Development. Economic Impact of Hurricanes on Louisiana, September 18, 2008.

[iv] Dupre, Reggie. State of Louisiana Senate. Ad Hoc Subcommittee on disaster Recovery, Committee on Homeland Security and governmental Affairs, U.S. Senate. September 19, 2008.

[v] Morgan, K.O. and Morgan, S (Eds). 2006. *Health Care State Rankings 2006.*

[vi] Blanchard, Troy. Paterson, Karen. The Growing Hispanic Population in Louisiana: New Evidence from the July 1, 2008 Population Estimates by Race and Ethnicity, CAPER, Louisiana State University. Fact Sheet #11, May 2009.

Chairman TOWNS. Thank you very much.
Mr. Williams.

STATEMENT OF CLAYTON WILLIAMS

Mr. WILLIAMS. Mr. Chairman, thank you and members of the committee, thank you for the opportunity to address this important topic today.

I am employed by the Louisiana Public Health Institute,a non-profit organization that works State-wide to improve health through public-private partnering. LPHI was chosen as the State's local partner in administering the Primary Care Access and Stabilization Grant. I serve as the director of that program.

Today my testimony will, in my 5 minutes, hopefully summarize how the grant has been used over the past year, 2 years, toward the grant goals, and discuss the challenges we face in maintaining the gains we have achieved. The catastrophic flooding throughout the New Orleans region following Hurricane Katrina wiped out the health care safety net, as you have heard about today. There is a map showing the relative flood depths that you could look at in relation to the location of the clinics, which is overlapping.

Also, as you have heard today, the clinic representatives here today were among those who spent the first couple of years after Katrina cobbling together resources and trying to get the growing health care needs met in the region. Then in July 2007, we received the $100 million Primary Care Access and Stabilization Grant from HHS to stabilize and expand the clinics that were on the brink of failure at that time. We want to thank you and HHS very much for making that possible and making it possible under terms that allowed for the use of those funds in a flexible way, so that we could be effective toward the goals of the grant.

We strive for a health care system with a public-private network of primary care clinics as its foundation to facilitate access to the right care delivered in the right place at the right time. And four fundamental goals have guided our efforts to use this grant to advance toward this vision. No. 1, increase access to care on a population basis. No. 2, deliver high quality, evidence-based health care. No. 3, create an organized system of care. And No. 4, develop sustainable business entities: access, systemness and sustainability have been our mantra.

Twenty-five public and non-profit organizations in the New Orleans region were eligible to participate in the grant program. The first award of $16.7 million was distributed to the organizations within 2 months after the issuance of the notice of grant award. Supplemental awards have been made every 6 months since then to all 25 entities. And so far, $80,275,000 has been distributed.

The remaining grant funds will be distributed in December of this year, and the grant funds will be substantially exhausted by September 30th of next year. However, we expect a no-cost extension will be approved by CMS shortly to help the grantees stretch these dollars as far as possible. About 80 percent of the funds have been spent on personnel and contracts for the provision of direct patient care services and the remainder on equipment and supplies, facility renovations, and other expenses that support care delivery.

Now, I will summarize the status and progress made toward our priority goal, to increase access to care on a population basis. The outstanding performance of the 25 participating organizations in this priority goal area has led to an increase in the number of service delivery sites in the region from 67 per-grant to 93 today. There is a map you have seen that shows the distribution of all those sites across the region. In addition, they have increased the size of the delivery system by almost 50 percent in 2 years in terms of patients served. You can look at the next exhibit, which is a graph that shows the increase in patient volume by a 6-month period since the beginning of the grant. It is a dramatic, dramatic growth in a system in such a short period of time.

In the past year, they have provided primary and mental health care services to nearly 175,000 individuals and to a total of 250,000 since the grant began. In the past year, 42 percent were uninsured, representing about half of the uninsured in the region, and 25 percent had Medicaid. More importantly, over 40 percent of the conditions cared for in the primary care clinics are conditions that would likely require expensive emergency room care if not effectively managed in the outpatient setting.

Now on goal No. 2, which is to deliver high quality evidence-based health care, as a condition of receiving grant funds, all participating clinics met minimum quality improvement benchmarks, such as providing same day appointments for urgent care. In addition, $3.8 million was set aside for a voluntary quality improvement incentive program in partnership with the National Committee on Quality Assurance [NCQA]. This incentive program rewards clinics that achieve standards set by NCQA in their patient-centered medical home framework.

Significantly, 40 of the clinics received NCQA recognition through the incentive program. This is the highest concentration of such recognized clinics anywhere in the country. And just 2 days ago, we heard that this impressive cross-sector quality improvement will receive a national award from NCQA in March of next year.

I have 1 more minute here. I am going to skip down to goal No. 4, sustainability, which I think is the focus of the hearing here. Substantial improvements in billing practices among the participating organizations have been achieved. For example, 82 percent of the primary care organizations are now billing Medicaid, Medicare, and/or private insurance.

Despite the progress that has been made in this goal area, we estimate the participating provider organizations would face a $30 million annual operating deficit if they were to maintain their current capacity without the help of this grant or some other such source. The projected deficit stems from their mission to serve people who are not covered by any insurance and hence from whom the clinics receive little or no revenue. Over half the participating organizations depend on grant funds for more than 50 percent of their operating expenses. And several rely on grant funds for more than 75 percent of their operating expenses.

Organizations caring for the highest portions of uninsured individuals are most at risk, and some of the highest volume and highest quality clinics that you have heard from today have patient

populations that include upwards of 70 percent uninsured individuals. This program was envisioned as a bridge to a more favorable policy environment. However, it is clear that those conditions are still years away. Unless we work together now to devise and implement solutions to span the gap, the progress that has been made will quickly erode, and the health system recovery in the New Orleans area will take a giant step backward, resulting in an estimated 30 to 40 percent reduction in services overall among these organizations.

Most organizations will be forced to cut back severely. Several will likely fail altogether. Many people who currently rely on these clinics will go without care or end up in the emergency room. Meanwhile, if and when relief comes down the road in the form of coverage expansion, the expensive exercise of expanding the health care delivery system to handle the new demand will have to be repeated. Wouldn't it be more effective and efficient overall to keep this network intact than to let that happen?

The desirable result of this hearing would be that all parties involved will redouble their efforts to immediately identify and implement a set of solutions to address these threats. These could include allocation of existing unobligated community block grant recovery funds for this purpose, granting permission for the State to use Medicaid disproportionate share funds for outpatient primary care and physician services, and exportation of additional sustainable options for funding.

It has been an honor today to participate in the hearing, and thank you for your continued support of our efforts to rebuild a healthier, greater New Orleans. I would welcome your questions.

[The prepared statement of Mr. Williams follows:]

Testimony of Clayton Williams, Director of Health Systems Development

Louisiana Public Health Institute (LPHI)

Before the US House of Representatives Committee on

Oversight and Government Reform

Post-Katrina Recovery: Restoring Health Care in the New Orleans Region

December 3, 2009

Mr. Chairman and members of the Committee, thank you for this opportunity to address how the Greater New Orleans Primary Care Access and Stabilization Grant program has been used to assist in restoring health care in the post-Katrina New Orleans area, and what future challenges remain for restoring health care infrastructure to the region.

My testimony will:

1. Provide a brief overview of the context and events leading up to the award of the $100 million Primary Care Access and Stabilization Grant;
2. Describe how the grant has been used over the past two years to help transform primary and mental health care services throughout the New Orleans area for everyone, without regard for ability to pay; and
3. Discuss the challenges we face to maintain the gains made and strive for additional growth and improvement.

I. Introduction and Overview of the Louisiana Public Health Institute (LPHI)

The Louisiana Public Health Institute (LPHI) was established in 1997 and is one of over 25 public health institutes nationally. LPHI is a private not-for-profit organization with a mission to promote and improve the health and quality of life in Louisiana through public-private partnering at the community, parish and state levels.

LPHI maintains a population-level focus on health improvement, and recognizes the relative importance of addressing the broad determinants of health through its programming—from social, to environmental, to the influences that can be realized through the healthcare delivery system. LPHI places an emphasis on promoting equity and reducing racial and economic disparities in health outcomes.

By responding to a public announcement, the Louisiana Public Health Institute was chosen as the State's local partner in administering the Primary Care Access and Stabilization Grant, and I serve as the director of this program for LPHI. This grant program serves as a model for how all levels of government and the not-for-profit sector can work together effectively to address a pressing public policy challenge.

II. Context: Events leading up to the award of the Primary Care Access and Stabilization Grant

There are two important points to be made in terms of historical context:

1. *The health care system was in bad shape before Hurricane Katrina.* For decades, people with limited means in need of health care have had to make their way downtown to visit Charity Hospital's emergency room. They have lacked options for affordable, high-quality, continuous primary/ preventive care in their neighborhoods.

2. *The people you have heard from in today's hearing have seized the opportunity to get it right this time.* If all components of the health system were rebuilt as they were prior to Hurricane Katrina, the people of Greater New Orleans would likely be doomed to the same poor health outcomes that have been experienced historically—nearly the worst in the country. Now is the time to get it right, at least for those components that are under our control, and in so doing glean some lessons that will be of value to the rest of the country.

The breaches in the levy system that caused catastrophic flooding throughout the New Orleans region following Hurricane Katrina wiped out the health care safety net in the New Orleans area (see Exhibit 1 for a map showing relative flood depths). The public hospital was closed, and outpatient facilities were essentially nonexistent. In the weeks and months that followed, community residents, volunteers from outside the area, and individuals from community organizations took it upon themselves to begin to fill gaps in health care and other services. You have heard from some of those very people today who spent the first couple of years after Katrina cobbling together scant resources in trying to get the job done. Then on July 23rd, 2007 the Louisiana

Department of Health and Hospitals (DHH) received $100 million from the US Centers for Medicare and Medicaid Services (CMS) to stabilize and expand the primary care clinics and behavioral health services in Greater New Orleans that were on the brink of failure.

The people of Greater New Orleans sincerely thank the Congress and the Department of Health and Human Services for making the Primary Care Access and Stabilization Grant available. Thanks to your staff, officials from CMS, the Health Resources and Services Administration, and the Substance Abuse and Mental Health Services Administration for so capably assisting in addressing this pressing need of the people of Greater New Orleans as this program was conceived and rolled out.

III. How the Primary Care Access and Stabilization Grant has been used to restore health care services to the New Orleans region after Hurricane Katrina

We strive for a healthcare system with a public/private network of neighborhood-based primary care clinics as its foundation to facilitate access to the right care, delivered in the right place at the right time to advance quality and reduce the cost of care at all levels. These neighborhood clinics should be portals to diagnostic, specialty, and acute care, be linked to other supportive services through a coordinated system, and be under-girded by robust information systems. Advancing this vision is central to our approach to rebuilding.

Four fundamental goals based on this vision have guided our efforts since then:

1. Increase **access** to care on a population basis;

2. Deliver **high quality**, evidence-based health care;

3. Create an **organized** system of care; and

4. Develop **sustainable** business entities.

Twenty-five public and private not-for-profit providers of primary and mental health care in the region (including Orleans, Jefferson, Saint Bernard and Plaquemines parishes) were eligible to participate in the grant program. With the support from the Commonwealth Fund, several panels of expert advisors and local stakeholders were convened to inform the development of an effective payment methodology, a leading edge quality improvement program, and a program evaluation strategy to measure our progress and impact. What follows is an update of current status and accomplishments in terms of grant administration and the four grant goals. While analyses are still underway, most of the results have been validated by independent investigators from the Government Accountability Office, the Commonwealth Fund, and the University of California at San Francisco.

Administrative status and accomplishments

The first payment of $12.7 million across 24 eligible primary and mental health care entities—plus a one-time lump sum payment of $4 million to the City of New Orleans

Health Department—was distributed less than two months after the issuance of the Notice of Grant Award. Supplemental awards have been made every six months since then to all 25 eligible entities. So far $80,275,000 has been distributed to participating organizations, and 71% of that has been expended to date. The remaining grant funds will be distributed in December of this year, and it is anticipated that all grant funds will be substantially exhausted by September 30th, 2010.

Approximately 80% of the funds have been spent on personnel and contracts (for provision of direct patient care services), with the remainder having been spent on equipment, supplies, facility renovations and other expenses. LPHI successfully underwent a recipient capability audit from the HHS Office of the Inspector General (OIG) prior to receiving the funds, and robust program integrity procedures and fiscal controls to ensure the grant funds are used appropriately are in place. To date, all 25 organizations remain eligible and compliant with grant terms and conditions.

Status and progress towards Goal 1: Increase access to care on a population basis

The progress towards achieving this priority goal has been impressive due to the outstanding performance of the 25 participating health care organizations. For example, they have increased the number of service delivery sites from 67 pre-grant to 93 today (see Exhibit 2 for a map of participating clinic locations); increased the size of the delivery system by almost 50% in 2 years in terms of patients served (see Exhibit 3 for a

graph showing increase in patient volume in the first 2 years of the grant program); and expanded hours of operation available in the region by 20.2% (642 hours of operation per week have been added since the grant began). In the one-year period between September 2008 and October 2009, they collectively provided primary and mental health care services to nearly 175,000 individuals in the region, and have served 251,972 individuals total in the first two years of the grant. Forty-two percent were uninsured—representing approximately half of all of the uninsured in the region—and 25% had Medicaid. Patients are predominantly African American, adult and female. Over 40% of the conditions cared for in primary care settings were *Ambulatory Care Sensitive Conditions*—conditions that would likely require emergency room care if not effectively managed in the outpatient setting.

Status and progress towards Goal 2: Deliver high quality, evidence-based health care

As a condition of receiving grant funds, all participating clinics met minimum quality improvement benchmarks such as providing same day appointments for urgent care, and providing 24/7 access to a clinician by phone. $3.8 million was set aside for quality improvement incentive payments to those organizations that exceeded minimum standards. In partnership with the National Committee on Quality Assurance (NCQA), this incentive program was established to reward clinics that achieved recognition by NCQA as Patient-Centered Medical Homes. Significantly, forty clinics received NCQA

recognition through the incentive program—the highest concentration of so-recognized clinics in the country at the time.

With grant funding from the Robert Wood Johnson Foundation and in partnership with Columbia University, a learning-collaborative to improve access to mental health services was established to train primary care providers in the management of mild to moderate conditions such as depression and anxiety in the primary care setting, and develop more efficient linkages between mental health providers and primary care clinics in the region. Finally, survey results show patients are better equipped to take responsibility for their own care with 96% of adult primary care clinic patients in New Orleans either very (72%) or somewhat (24%) confident they can control and manage their own health problems.[1]

Status and progress towards Goal 3: Create an organized system of care

Effective primary care cannot be delivered without timely access to specialty and diagnostic services. This is particularly challenging to achieve for people without health insurance coverage. They must rely primarily on the services of the public hospital—the entity with the funding (albeit limited) and mandate to provide services to these individuals. Therefore, agreements were brokered among the clinics and the Interim LSU Public Hospital (ILH) to facilitate access to specialty and diagnostic services, and

[1] Source: Preliminary findings from a 2009 Commonwealth Fund survey of New Orleans primary care clinic patients.

provide referring clinicians access to a web-based information system (called *CLIQ*) that provides access to results and reports in the community clinics.

In addition, a centralized, searchable, web-based clinic services database (visit www.GNOCommunity.org) and information and referral hotline were developed and made available to all participating clinics and the public facilitate referrals among participating clinics. This was made possible with the help of grant funding from Baptist Community Ministries (BCM).

Finally, a provider-governed, horizontal network called *504Healthnet* has been established by a majority subset of grant recipients to formalize relationships and maximize efficiencies among community clinics through shared services activities, such as group purchasing and other mutual support. The creation of this entity bridges goal areas three and four.

Status and progress towards Goal 4: Develop sustainable business entities

Substantial improvements in billing practices among participating organizations have been achieved, with 82% of the primary care organizations now billing Medicaid, Medicare and/ or private insurance. Despite the progress that has been made, in order to maintain current capacity without the help of Primary Care Access and Stabilization Grant funds or some other source, the program would face a $30 million annual operating deficit. The deficit stems from their community mission to serve so many persons who are not covered by any insurance or Medicaid or Medicare, and hence

from whom the clinics receive little or no revenue. As I have described, the evidence-based review of these clinics shows that, as a group, they provide high quality care (NCQA recognized) with significant efficiency.

Over half of the participating organizations depend on grant funds for more than 50% of their total operating expenses associated with the provision of primary and mental health care services, and several rely on grant funds for more than 75% of their total operating expenses associated with these services. Organizations caring for the highest proportions of non-elderly adult uninsured individuals are most at risk. Some of the highest volume and highest quality clinics have patient populations that are upwards of 70% uninsured.

This program was originally envisioned as a bridge to more a favorable policy environment, including health insurance coverage expansion; however, it is clear that those conditions are still years away. Unless we work together across the local, state and federal levels to devise and implement solutions in the interim, the progress that has been made will quickly erode and health system recovery in the New Orleans area will take a dramatic step backwards—resulting in an estimated 30-40% reduction in services overall. Most organizations will be forced to reduce staff, limit hours of operation, and close service delivery sites. Several will likely fail all together. Many people who currently rely on these clinics will then go without care until they are forced to go to the emergency room. The still-fragile Interim LSU Public Hospital system, including its emergency department, will be quickly overwhelmed, and people will spill

over to the private hospitals. Meanwhile, if and when relief comes in the form of increased health insurance coverage, the expensive exercise of rebuilding the health care delivery system's capacity to handle the new demand will have to be repeated. Wouldn't it be more efficient overall to keep this network intact than to let that happen?

Conclusion

A desirable result of this hearing would be that all parties involved will redouble efforts to identify and implement a set of solutions to address these threats immediately. These solutions could include:

1. Allocation of existing, unobligated Community Development Block Grant recovery funds for this purpose;
2. Granting permission for the State to use Medicaid Disproportionate Share (DSH) funds for outpatient primary care and physician services; and
3. Exploration of additional funding options and policy solutions.

It has been an honor and privilege to participate in today's hearing. Thank you for your continued support of our efforts to rebuild a healthier Greater New Orleans. I welcome your questions.

LPHI Exhibit 1

Maximum depth of flooding in Olreans Parish due to Hurricane Katrina

Legend

Flood Depth

High : 16.5

Low : 0.0

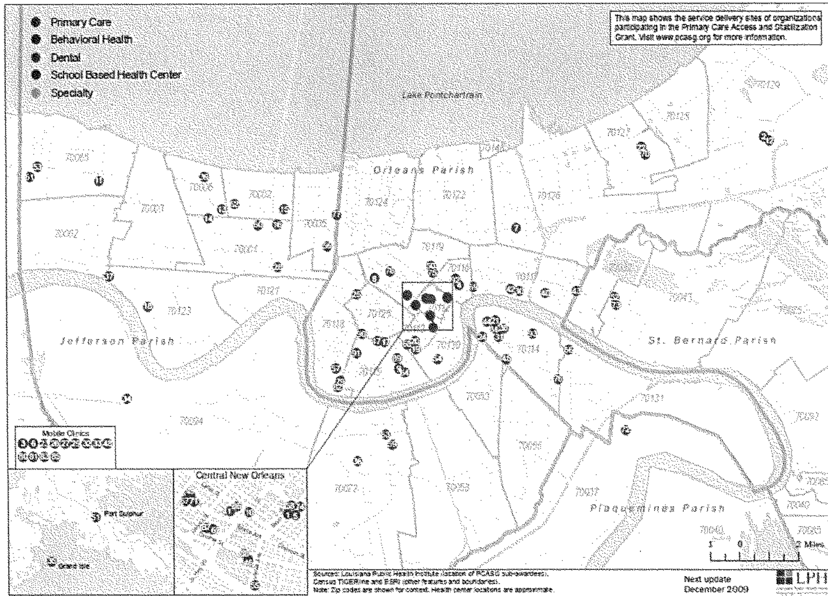
Source: FEMA

LPHI Exhibit 2

Community-Based Health Care Centers by Primary Service Type (November 2009)

Next Page: Directory of locations and services

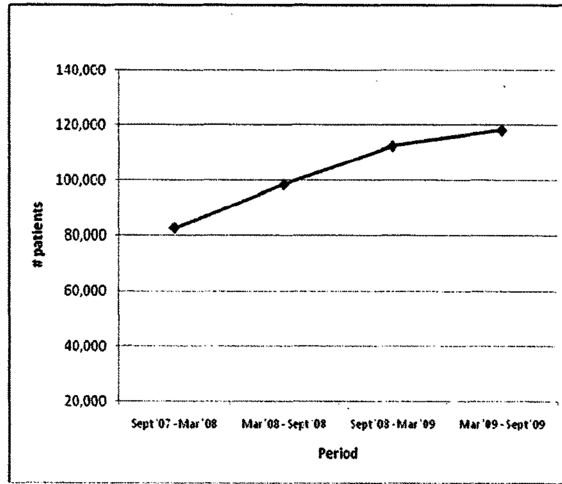
Some clinics only serve special populations. See the attached directory for more details.



Testimony of Clayton Williams, Louisiana Public Health Institute
Before the US House of Representatives Committee on Oversight and Government Reform
December 3, 2009

LPHI Exhibit 3

Growth in patient volume by six-month period for clinics participating in the Greater New Orleans Primary Care Access and Stabilization Grant



Chairman TOWNS. Thank you very much. Let me thank all of you for your testimony.

Let me begin with you, Dr. Crear-Perry. I am interested in that van. How does that work? Do you go to the same area once a week, twice a week? How does that work?

Dr. CREAR-PERRY. We actually have an MOU with the school-based health clinics. The one that you saw with the children on the van, that one goes to the schools. They make a schedule, so the school nurses at the schools will find out which kids need dental services. They send home a packet with all the kids and their parents fill it out. Then they make a schedule and they let us know that if we are going to have, say, 10 kids the next day, and we usually have a schedule for the week. We right now are rotating between two different schools. We go to one school 1 week and then one school the next week.

Each week, we get requests from other schools. Everybody wants it, because there is such a need for dental services in the city. So some of the hardest part is just getting through the bureaucracy to make sure that we can get it there and get the services to them. But the kids really do enjoy being able to get the services. Because a lot of times we have kids who haven't been to the dentist since the storm. And we have been able to take care of them on the dental units.

Now, for the senior centers, it goes to four different senior centers in the city. It also has a schedule that it changes every day from one senior center to the other. So the senior centers are more consistent. They know their schedule. They come in, and so it is a lot easier to get the senior on the dental van than it is sometimes to get the children.

Chairman TOWNS. Dr. Brand, and first of all, I want to thank you for staying all day and listening to the testimony earlier and then coming and testifying later. I want you to know that when I became Subcommittee Chair back some years ago, I was going to change the procedure, because I wanted agency people to hear in terms of what was being said. Because we always had the agency people first, and then after that we would bring others in. After the agency people would testify, everybody would get up and walk out. And then when the people that had the problems, when they testified, nobody from the agency was around to hear it.

So I was the one who said, from now on, we have the people talk first and then have the agencies come in afterwards. But I want you to know that your being here all day today has made me sort of rethink this thing, because you have been here and you have listened to the testimony. I want to ask you, you have heard what was said. Do you think it is possible that maybe the agency would think about, let's look at sort of establishing or sort of group a task force, I don't like the word task force, but a group to work together to see in terms of how we might be able to move some of these efforts along? I know you might not be able to make the decision sitting at the table today. But can you take this back to request that we would like to establish a committee to explore ways to continue restoring health care services to the post-Katrina region?

I think there is still a lot that needs to be done. I know you can't right away say. But the point is, if you could take that back and

let us know if there is any real interest in this. There are many Members of Congress, along with the representatives from the area, that would like to see what more we might be able to do. Sometimes it is not money, it is just getting things coordinated. I want to get your views on it and recognize that it is not something you can bang the table and say you will do. But will you take that back and think about it?

Ms. BRAND. Yes, sir. And it has been very helpful and interesting to have spent the day listening to my colleagues talk about New Orleans and access to primary health care as it is at this time, and how it has changed compared to immediately before and after Katrina.

HRSA and the rest of the Department I think have worked collaboratively to address these challenges. CMS certainly is the part of the enterprise that looks at payment. But HRSA is concerned about access through health centers, work force. Our colleagues in SAHMSA would be very interested to hear the challenges that the city still faces in providing access to adequate mental health services. So certainly, sir, I will take your challenge and your charge back to the Department and see what we might do.

We have been working together collaboratively. But this might be an opportunity to look at that and see what the next phase might most appropriately be.

Chairman TOWNS. Thank you very much, Dr. Brand.

Mr. Levine, can you give me a broad outline of your administration's plan to build a replacement facility for the now-shuttered Charity Hospital? When will construction begin? How will it be financed and what scope and size? Is there anything that the Congress can do to facilitate this?

Mr. LEVINE. Thank you, Mr. Chairman. We have taken several steps to move the process along to the extent that we can. Obviously, the financing is the big piece of this that hasn't been resolved. We are still, unfortunately, in the arbitration phase with FEMA at the moment. We believe that the State has made adequate, has provided adequate evidence that the State is owed $492 million under the Stafford Act. FEMA's last offer was $150 million, up from the original offer of $26 million or so.

We are in the process of acquiring the property. The architects are doing the design planning phase of the project. So all the things that can be done while we work out the financing piece of this is critical.

The other thing that we have done is we have completely changed the model from the old Charity Public Hospital model. We have actually looked at what happened in Atlanta with Grady, we have looked at Tampa General, we looked at others—Shands Hospital in Gainesville with the University of Florida. We have looked at models of teaching hospitals that used to be public but have converted to the non-profit model. And that is what we have done. We entered a memorandum of understanding between Tulane, LSU, and the State that was signed about 2 or 3 months ago.

So all of those pieces have been put in place. The one piece that has not been put in place is the FEMA piece of this, which is substantial. The way the financing is supposed to work is, the State has committed $300 million. We had estimated the $492 million

from FEMA. And then the difference between that and the $1.1 billion and $1.2 billion was going to be financed through the debt markets. If FEMA doesn't come through with the significant amount of money, if the arbitration doesn't go our way, that could really imperil our ability to finance this hospital, given the situation. We would have to finance more than the estimated $400 million that we had planned on.

So irrespective of whether somebody believes we should rebuild the old hospital or build a new one, it is all academic if we can't get the money from FEMA. So the question about what Congress can do, to the extent that FEMA falls short due to the arbitration process, if it doesn't go our way, certainly Congress can step in and provide funding that would bridge that gap. We aren't asking for that at this point. That is certainly in the purview of Congress. But we are trying to work within the scope that has been laid out by FEMA.

Chairman TOWNS. On that note, I yield to the representative from the area.

Mr. CAO. Thank you, Mr. Chairman. And Mr. Chairman, I am very glad to hear today from the GAO that we have been using the money responsibly. Because traditionally, we have had some negative images with respect to how money is being spent.

With that being said, I was a little bit disappointed, Dr. Crear-Perry, to hear that there are $4 million for mental health that is left unspent by the city. And you come here to testify of mental health needs. Can you explain with respect to that discrepancy?

Dr. CREAR-PERRY. We don't have money for mental health in the city.

Mr. CAO. I am sorry?

Dr. CREAR-PERRY. We don't have a mental health grant for the city.

Mr. CAO. I received information from very secure sources that the city does have $4 million in mental health money left unspent.

Dr. CREAR-PERRY. I am not sure.

Mr. CAO. Can you look into that, if you don't mind?

Dr. CREAR-PERRY. Yes.

Mr. CAO. And Mr. Williams, do you have any comments with respect to that?

Mr. WILLIAMS. I believe it would be a strange coincidence if it wasn't the, if this wasn't the $4 million carve-out from the Primary Care Access and Stabilization Grant that was specifically earmarked for the city of New Orleans Health Department to address not just mental health, although that is an allowable expenditure of the primary care grant funds, but also to address health care needs in particularly under-served areas and to provide the dental services, which are up and running. They got off to a slow start spending that money, but they are well underway to make good use of it at this point, as far as I know today. We can get you more information on that.

Mr. CAO. So of the $4 million, which portion of it was spent on mental health, which portion of it was spent on the dental trucks?

Dr. CREAR-PERRY. When we applied, we didn't apply specifically for mental health. We could use it for dental and the New Orleans East Clinic. So we have spent it on dental and New Orleans East

Clinic. So we are on track to spend all of our allocation by the end of the grant. We will have no money left.

Mr. CAO. OK. Dr. Brand, I was looking at some of the grant allocations that HRSA has granted to the area. I have noticed that a large portion of it was concentrated in the downtown and uptown area, where, the areas around the fringes, the northeast areas, St. Bernard, those areas in Waggaman and Westwego, there have been very little being done for those areas. Can you address that, please?

Ms. BRAND. Certainly. I believe that Administrator Wakefield has begun talking, dialoguing with you and your staff about the fact that those areas do not have ready access to federally qualified health centers. We continue to work with the Primary Care Association to look at those areas where we might, should resources be made available to do a new expansion or provide a new access point. There will not be resources available for a cycle in 2010. We don't know what the situation will be for 2011, because that budget is still being developed. But certainly, we will work with folks in that community. We will work with the Primary Care Association to help, an organization that is ready to stand up and be prepared to either be an FQHC or lookalike, be prepared.

The other opportunity, should resources be available, is something called a planning grant that helps a community organize and be prepared to apply, and perhaps be more successful in that application process.

Mr. CAO. Mr. Levine, I know that the State has a terrible FMAP problem. Can you please explain to us how would the FMAP problem affect the issue of the poor in the district, and also I would like to know whether or not the State has an audit system with respect to how money is being spent by the city as it comes down from the State.

Mr. LEVINE. Thank you, Congressman Cao. The FMAP problem is the single biggest problem our State faces right now, with financing for the poor. We can't sustain nearly a $1 billion a year reduction in our funding for Medicaid. It would trump everything, all the progress that has been made here. Whether we talk about the expansion, I know there is a potential expansion of Medicaid in the reforms. In the House bill, it was 133 percent, in the Senate, it is 150 percent.

For us to go from where we are today, where currently we have a $275 million deficit in our Medicaid program this year, into a situation next year where we face a $900 million shortfall, and then go into a period where we then have to do an expansion of Medicaid, it couldn't be done. The maintenance of effort requirements under the stimulus, and then in both of the House and Senate bills, would really put a lot of pressure on provider rates and really, I think effectively make our program insolvent.

So we really need a solution to this FMAP problem. All of the good work that has been done, what we talked about earlier about potential solutions to the PCASG grant, for instance, allowing us to use CDBG money that is unspent, or applying for a DSH waiver that would allow us to use disproportionate share funding for community-based clinics, we can do those things. But we also have to provide State match.

With the decrease in Federal match that we are facing, we are not capable of doing that. So I think that the fundamental problems here are: (a), fixing the FMAP problem, (b), acknowledging this DSH audit rule and the quarter of a billion dollar per-year impact it is going to have on our State, in addition to the FMAP problem, and then (c), the $30 million problem we are going to have when this grant runs out in less than a year. These are three converging factors that any one of which would be devastating. But all three of them are virtually impossible for the State to be able to overcome on our own.

Mr. CAO. Does the State have an audit system to ensure that money is being spent by the city?

Mr. LEVINE. As it relates to funds that come through the Department, we do. And we have an internal audit function. We also have the ability through our contract to review all such expenditures, as does the legislative auditor, I believe, have the authority to audit any grant funds that come through our department.

Mr. CAO. Could you provide us with a copy of the audit?

Mr. LEVINE. Sure. I won't say that—have we done any audits at this point? Yes. The answer is yes.

Mr. CAO. Mr. Chairman, if you will allow me one more question.

Chairman TOWNS. Sure. I will extend the gentleman's time for another minute.

Mr. CAO. Thank you very much.

I know Dr. Crear-Perry has addressed the issue of the New Orleans East and the lack of hospitals out there for New Orleans East and St. Bernard. Dr. Brand and Mr. Levine, is there any way both of you or both of your organizations can sit down and discuss the problem and come up with some kind of solution in connection with Tulane and LSU to see how we can address that particular need out there, for approximately 120,000 people? 120,000 people right now do not have access to a hospital.

I know, I live out there in New Orleans East. About 2 years ago, I had to drive my father close to 40 minutes to get him to the nearest emergency room. He is a diabetic and he has some complications. We had to fight traffic, drive over the high rise, which for the people of New Orleans East, almost serves as a psychological block for many of them. So if you could do that, I would really appreciate it.

Ms. BRAND. I think the administration stands ready to work with the Congress, the State, and the local partners to address all service gaps. Certainly we would be happy to meet with them.

Mr. CAO. Thank you very much. That is all I have, Mr. Chairman.

Chairman TOWNS. Thank you very, very much. Let me thank all of you for your testimony. You have been very, very helpful and we look forward to working with you in the days and months ahead, and to move some of these things forward. I think under very difficult circumstances and conditions that you have been able to do some amazing things. I want you to know we really salute you for that.

Again, thank you so much for your testimony. This hearing is adjourned.

[Whereupon, at 3:20 p.m., the committee was adjourned.]

[The prepared statement of Hon. Diane E. Watson follows:]

Opening Statement

Congresswoman Diane E. Watson

"Post- Katrina Recovery: Restoring Health Care in the New Orleans Region"

Full Committee on Oversight and Government Reform
Thursday, December 3, 2009
2154 Rayburn HOB
10:00 A.M.

Good morning Mr. Chairman, and thank you for holding this exceedingly important hearing on the restoration of health care in New Orleans post Hurricane Katrina. When the levees broke, streets, homes, and lives were flooded with seemingly insurmountable devastation that continues to this day for far too many. Over four years later it is critical that we continue to hold hearings such as today's to assess what has been done so far and where to go from here.

Today we will hear from a select panel of individuals who have taken action to improve the lives of those affected by Hurricane Katrina. It is a testament to what President Obama would refer to as "the character of our nation." In the face of the largest natural disaster in our history, individuals and communities have come together to rebuild the infrastructure of the region's health care system despite numerous challenges.

Through various public and private partnerships over 90 primary care clinics now operate to fill the void left by the closure of the state-run Charity Hospital. However, their future remains unclear as the funding from the Primary Care Access Stabilization Grants many rely on will no longer be available in about nine

months. As we confront this deadline it is crucial that all the stakeholders work together to develop a strategy that will ensure New Orleans has a medical system that is effective, affordable, and sustainable.

I would like to thank all of today's witnesses for their testimony, and the work they have done to provide health care to the people of New Orleans. Hurricane Katrina threatened our faith in our nation's ability to live up to its own standards and provide for its citizens basic human rights, but we have the ability now to ensure we do not perpetuate past failures into the future.

Thank you Mr. Chairman. I hope this Committee will continue to aggressively pursue these issues, and I yield back.