TESTIMONY OF

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COMMITTEE ON HEALTH, EDUCATION, LABOR AND PENSIONS

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Mr. Chairman and members of the committee, I'm Don Smithburg, CEO of the LSU Hospital & Clinic System in Louisiana. I thank you for your interest in health care and in Louisiana after Katrina and Rita. I also thank you for your invitation to appear today and the opportunity to answer any questions you may have about Louisiana's state public hospital system, about what we have learned from catastrophe, and about how we are preparing for the future.

I represent 9 of the 11 state public hospitals and over 350 clinics that traditionally have been called the "charity hospital system" in Louisiana. I would like to describe this system briefly.

Our hospitals and their clinics constitute the health care safety net for the state's uninsured and underinsured, particularly the working uninsured – 2/3 of our patients are hard-working Americans. In your states, this role is generally a local government function, but in Louisiana it is the responsibility of a state-run and statewide hospital and clinic system under the aegis of LSU. Every individual in the state is eligible to receive services in any of our facilities regardless of where they live or their ability to pay. Louisiana has one of the highest rates of uninsurance in the nation; over 20 percent of the population and estimated to include over 900,000 individuals. Another 21 percent of the citizenry is on Medicaid. So 41 percent of Louisiana's population is without private health insurance. That was before Katrina and Rita. Blue Cross of Louisiana has recently projected a 120,000 person increase in the ranks of the

uninsured as businesses fail because of the storms' destruction. In New Orleans alone, the uninsurance rate is 41 percent since Katrina.

The LSU hospitals also have played an integral role in supporting the education programs of our medical schools and training institutions, and that includes not only LSU but also Tulane and the Ochsner Clinic Foundation. Our LSU system flagship is in New Orleans, commonly known as "Big Charity," is actually two facilities, Charity Hospital and University Hospital, operated under one medical center umbrella. At our New Orleans facility alone, there were over 1,000 Tulane and LSU medical students and residents in training, and many more nursing & allied health students, when Katrina struck and the multiple levee failures devastated our institution.

Some of these same students at Big Charity had rotations at the V. A. hospital in New Orleans as well. The VA facility sits a stone's throw from Big Charity and was also devastated by the flooding. In recent months, LSU and the Department of Veterans Affairs have been engaged in an historic and collaborative effort that we hope will result in rebuilding one plant that will support two hurricane-hardened hospitals, both able to better serve their respective patient populations and conserve federal and state resources at the same time.

I know you will understand that the destruction of Charity Hospital is felt especially deeply here. "Big Charity" was the second oldest continuing hospital in the nation and has endured as one of the most significant medical institutions in the nation over the 270 years. It

was established in 1736. The hospital was destroyed once before by a hurricane, in 1779, but rebuilt just five years later; without FEMA, by the way. Today, it sits in ruins.

Emergency Preparedness

Having created both a **statewide** and a **public** hospital system, it is natural and appropriate that Louisiana would turn to this system in times of emergency. Under state emergency preparedness plans, our hospitals are designated as the lead facilities in each region to accept patients who have special acute needs that may become emergent in a crisis or catastrophe. We have regarded it as our hospitals' obligation to gear up for potential disasters and to continue to operate when others may not be able to. We have the capacity as a system to transfer patients to our facilities in other parts of the state, if necessary. And since Louisiana's only Level I trauma and specialty care centers – in New Orleans and Shreveport – are operated by LSU, special medical needs generally could be accommodated internally.

Louisiana's emergency preparedness plans, and our role in them, were fundamentally sound up to a point. Clearly, that point was surpassed by the magnitude of Katrina in the New Orleans area. Our hospitals were prepared to help the victims of disaster, but not to be a victim ourselves.

The Reality of Disaster and the Paucity of Response

What happened at Charity and University Hospitals when the levees failed? In brief, the city streets and hospital basements flooded. Power in the city was lost and hospital emergency

generators were able to operate for only a short time because of lack of fuel. Supplies of essentials, such as food and water, were not allowed to be brought in despite our attempt to deliver such basic supplies and provisions. Restrooms did not work and maintaining sanitary conditions was difficult. External communications were exceedingly limited since telephones generally did not work. The sentinel result was that patient care and safety was compromised, especially for such critically ill patients as those on ventilators. Conditions didn't meet the standards we would expect of Third World countries. Staff in the hospitals worked heroically to care for patients, manually ventilating some for hours and then days. In a few instances staff administered intravenous nutrition to one another. In sum, it became imperative to evacuate both patients and staff. But the hospital itself had no means to do so.

You are looking for the lessons from this disaster with an eye toward improving not only Louisiana's future emergency preparedness, but also that of a vulnerable nation. From our perspective, there were several general lessons and many others at the hospital operational level.

Evacuation. First, as this committee is aware, there proved to be inadequate ability – or insufficient priority – to evacuate patients and staff at Charity and University Hospitals within a reasonable period of time. In the future we will not again assume that agencies that are physically and bureaucratically remote from our hospitals will come to our rescue. Instead, we have developed the means to transport patients and staff should the need arise. Quite simply, a trauma center is designed to stand in place in order to take in casualties after a disaster. This season, we are prepared to evacuate without reliance on the government.

Should assistance be available, we will gladly accept it, and certainly we will work cooperatively with agencies at any level to create an effective means to deal with all aspects of

emergencies such as Katrina and Rita. But we will also exercise our capacity to take care of our own people within our system.

In fact, when Rita threatened Southwest Louisiana a few short weeks after Katrina, we did evacuate threatened patients and staff from Lake Charles, Lafayette and Houma to facilities in Baton Rouge and Alexandria. We didn't wait for the established cavalry as we did after Katrina's floods. We became our own cavalry and took care of ourselves without asking or expecting help. And it worked.

Since the storms, we have developed contracts with out-of-state ambulance companies to be available to transport patients in the event of emergency. These contracts stipulate that the companies' capacity must be devoted exclusively to our hospitals for the particular emergency. We hope that FEMA would reimburse our system should a future catastrophe require the activation of these transportation services. At this point, our 2006 evacuation costs are unbudgeted, but are estimated at $2.5 million this season for evacuations affecting New Orleans, Houma and Lafayette.

Communications. One major lesson from this crisis was the need for reliable communications. Both in New Orleans and Bogalusa (along the Louisiana-Mississippi border, where our hospital received serious wind damage, communications with our central office, the State Office of Emergency Preparedness and others were exceedingly difficult. In the case of Bogalusa, there was silence for two days. Our police radios worked in New Orleans, but only intermittently in about 45 second intervals. Ham radio was most reliable, and it is a technology we will continue to invest in – but it is slow. Interestingly, cell phone text-messaging worked

in a number of cases even though cell phone conversations often did not. Satellite phones were generally useless for us. Although several different technologies failed or were of very limited use, the communications problem undoubtedly has a technological solution. We need to determine the best way to stay in touch in emergencies, and put the appropriate equipment into the right hands.

It is not enough to have disaster plans. We must understand what they call for and be prepared to implement them unless unforeseen and overriding factors arise. To give you one concrete example, despite the designated role of our hospitals to receive evacuated patients, we received far fewer than we had capacity for. I personally worked at the state Office of Emergency Preparedness headquarters to help move both the patients and the staff from Charity and University to other LSU hospitals that were prepared to accept them, but this approach – the ***planned*** approach – was overruled by FEMA. Instead, patients from Charity and University Hospital were taken to the N.O. airport, ultimately put on military transports and scattered across the country. Only medical records, but no staff, accompanied them. To our knowledge, no record was kept of who was on what plane, where they came from or where they were taken.

Immediately after the evacuation, it was as if our patients had disappeared, and when the calls from families came asking about those in our care, we could not tell them where they were. Staff spent literally weeks calling hospitals across the country asking if any of our patients had been transferred there. Despite these efforts and those of the Louisiana Hospital Association, we never did find out where all our patients were taken.

In a time of major emergency, it became clear that our hospital is imbedded in an

extended, multi-level, multi-agency, multi-government bureaucratic structure, no one part of which was responsible for our rescue. We do not have a single "parent" organization to act on our behalf, such as the VA or hospital companies, but instead are dependent upon the coordination and the jelling of an exceedingly diverse set of scattered entities that work together only intermittently and in some cases with contract employees brought on for a particular disaster.

Hopefully, something can be done to tighten this structure. But its deficiencies are the reason that we must establish contingency plans to take care of ourselves.

Other Lessons. We learned many other lessons and have developed ongoing plans and processes to take the actions that these lessons taught. Identified needs include:

- A stockpile of supplies for a longer period than previously thought, at least two weeks. Supplies should include food, water, medications, generators, gasoline, flashlights, and red bags and buckets with lids.
- Receiving facilities able to accommodate evacuated patients. Includes developing surge capacity in our own hospitals and making other arrangements such as temporary housing as well.
- A system to provide a continuing flow of information on evacuated patients and staff, including clinical information, location, and family contacts. This involves creating backup capacity for clinical IS systems and protection of medical records from potential damage.
- Temporary housing for staff whose homes were destroyed or damaged but who

were able to work.

- Security to protect our people and our assets.

We have also come to understand that we must help shape the capabilities and expectations of the outside world. We cannot afford for emergency preparedness entities and health care providers to maintain unrealistic expectations of what our hospitals can do in the event of a disaster that overwhelms us all. Coping with disaster is our problem, and we hope it is on the way toward resolution. All providers and agencies must craft realistic contingency plans of their own.

We know now that it is essential to plan for the worst case, not just something approaching it, and to prepare for the aftermath of a crisis not just the immediate crisis period itself. As was quoted in the *New York Times* two weeks ago, a New Orleanian said as she reflected on depression and suicide: "I thought I could weather the storm, and I did. It's the aftermath that is killing me."

Thank you again for your interest and for the opportunity to share LSU's perspectives on these critical matters.

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