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

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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.