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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

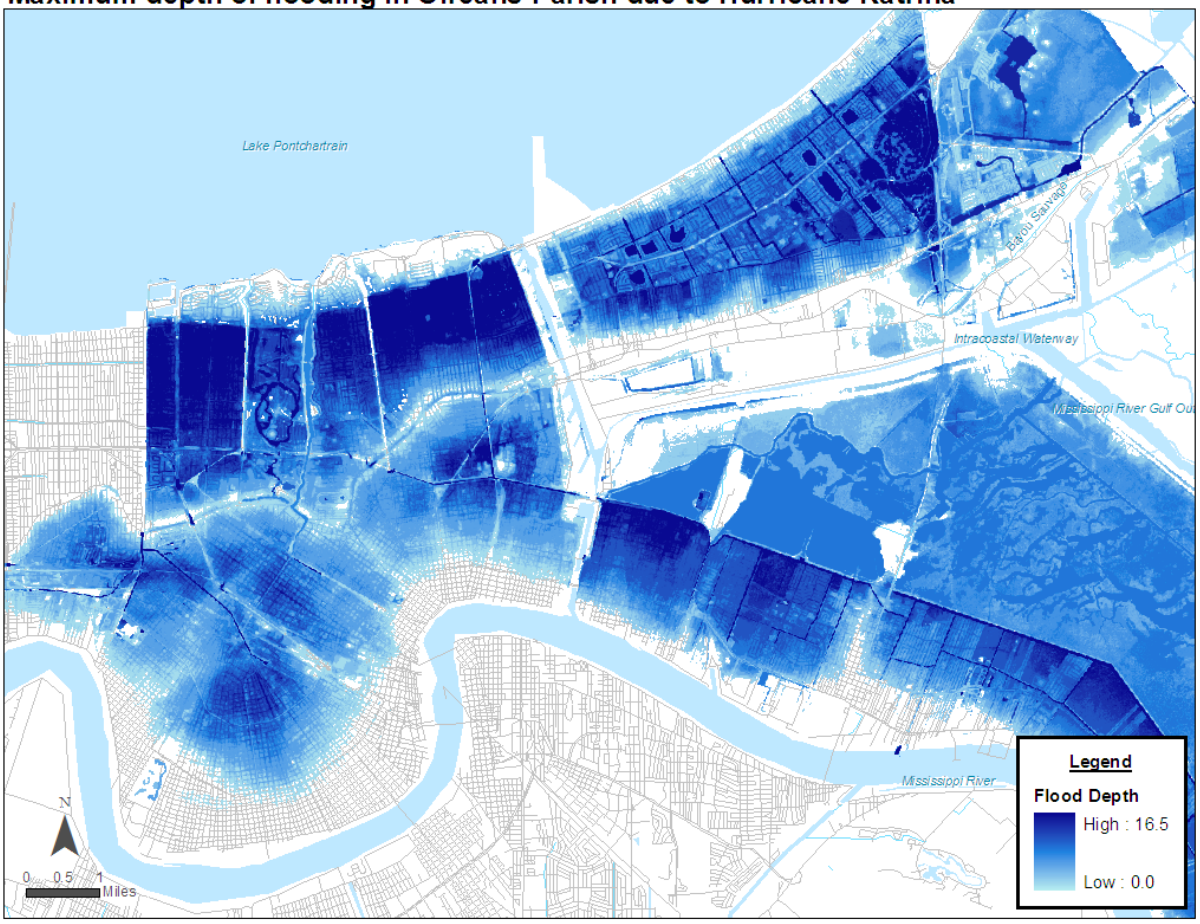
A desirable result of this hearing would be that all parties involved will redouble efforts to identify and implement a set of solutions to address these threats immediately. These solutions could include:

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.

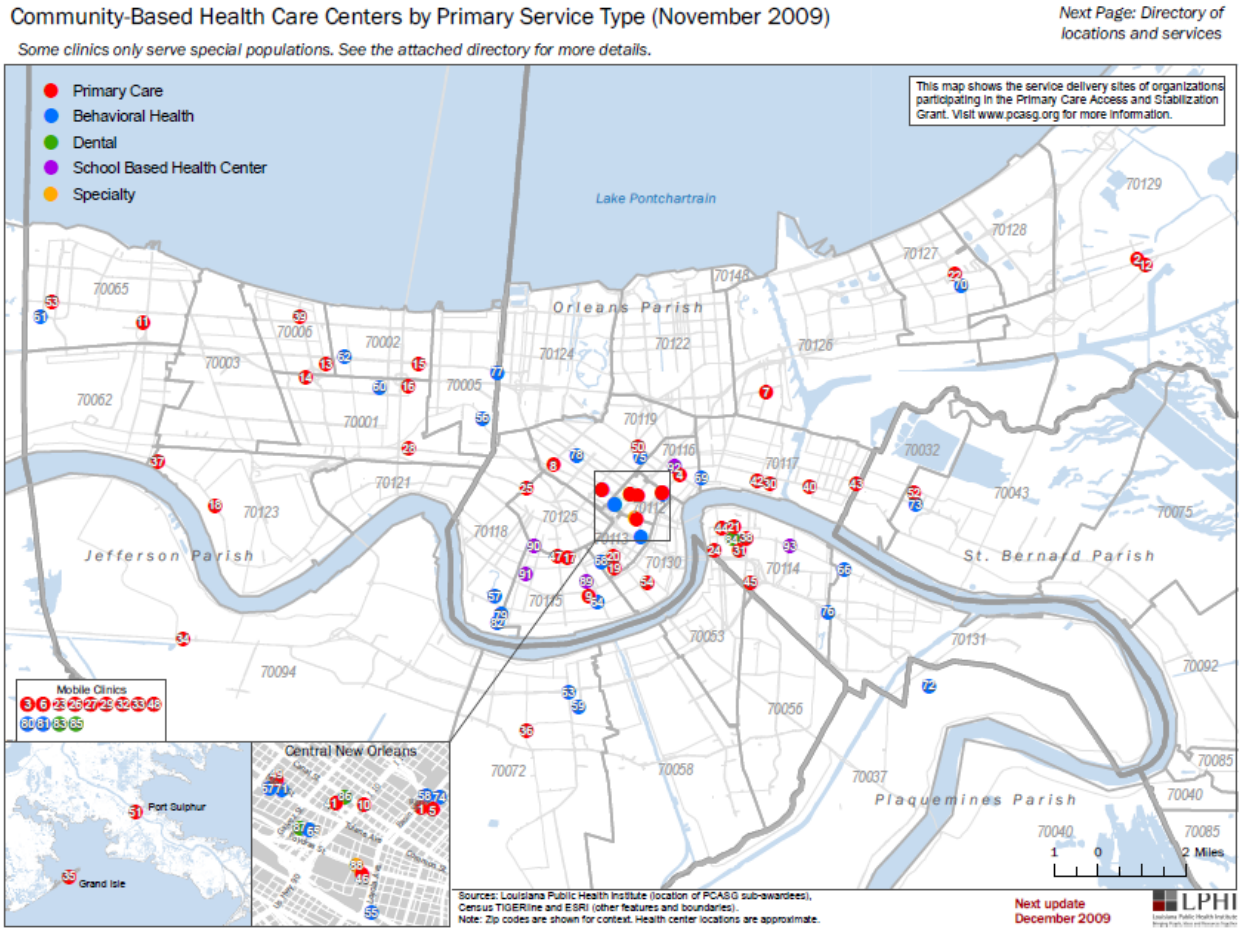
LPHI Exhibit 1

Maximum depth of flooding in Orleans Parish due to Hurricane Katrina



Source: FEMA

LPHI Exhibit 2



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