



BRING NEW ORLEANS BACK
HEALTH AND SOCIAL SERVICES COMMITTEE

*REPORT AND RECOMMENDATIONS
TO THE COMMISSION
(JANUARY 18, 2006)*

**BRING NEW ORLEANS BACK (“BNOB”)
HEALTH AND SOCIAL SERVICES COMMITTEE**

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INTRODUCTION

THE NEED TO REBUILD THE HEALTH AND SOCIAL SERVICES INFRASTRUCTURE IN NEW ORLEANS

HURRICANE KATRINA: “THE REAL DEAL”

Fred Johnson, a New Orleanian who rode out Hurricane Katrina on the fourth floor in the New Orleans Hyatt Hotel, described the sound of the 100 plus mile per hour winds, which battered New Orleans for four hours during the height of the storm, “like 40 freight trains coming at you from different directions – all at once!” Dr. Lee Hamm, the Chairman of the Department of Medicine at Tulane University Hospital, said there is no way to verbally describe the power of winds, “The winds were a power of nature that you had to see to believe,” said Dr. Hamm.

The winds of Katrina and the damage they left, however, are minor footnotes on the tragedy of the devastation of New Orleans. The primary cause of catastrophic damage was floodwater, which inundated the City with a tidal surge, estimated at 20 plus feet. The power and force of the floodwaters caused breaches in the City’s poorly built canal system and sent waves of water into St. Bernard Parish, the Lower Ninth Ward and New Orleans East from the Gulf of Mexico. Two-thirds of New Orleans was submerged in floodwaters for more than two weeks, which caused catastrophic damage to the City’s infrastructure. One of the hardest hit areas of critical services was the health care delivery system in New Orleans.

Warned by an urgent phone call from the head of the National Hurricane Center on Saturday, August 26th, Mayor Ray Nagin issued a “mandatory evacuation” of New Orleans. He called Katrina, “The real deal,” in an effort to dispel the cynical and lethargic reaction of many local residents who had ridden out threats of hurricanes for more than 40 years without major flooding or wind damage to New Orleans.

KATRINA WAS THE ONE!

More than one million people in the Greater New Orleans area heeded the order to leave and began an orderly evacuation guided by a recently developed “Contra-Flow” plan put in place by state and local officials following a less than orderly evacuation the previous year when Hurricane Ivan threatened Southeast Louisiana. But thousands of New Orleanians and residents of surrounding parishes did not have the means, the ability, or the will to leave the area. To accommodate those citizens who stayed, the City set-up the Louisiana Superdome as a “shelter of last resort.” It was!

Dr. Stephens says that when the storm hit, conditions in the Dome began to deteriorate rapidly. “We could hear the winds tearing away sections of the roof. It sounded like loud gun shots as the metal tiles, battered by the winds, banged against the Dome’s ceiling. Water began

to flow in torrents through the holes in the roof and conditions worsened as the Dome's carpet began to take on water."

"By midday Monday the power went out and the medical staff had to rely on small generators to provide emergency electrical services in the make-shift medical corridor. By Monday afternoon, there was no running water in the bathroom facilities", according to Dr. Stephens.

But, by late afternoon on that fateful Monday, the winds had calmed and people began to plan their return to some normal life. "The sun broke through the clouds late Monday, and we began to prepare for people to return to their homes and assess their damage. Then the flood waters came Monday night!" said Dr. Stephens.

"By Wednesday, with the stench from the waste of thousands of people without bathroom facilities becoming overwhelming, and with three feet of flood waters surrounding the Dome, we made preparations to move the special needs patients out of the Dome to the Sports Arena which had clean bathrooms and would provide a safe, dry environment for treatment and care," said Dr. Stephens. The special needs patients were moved to the Sports Arena and later to Kendrick Hospital, where eventually, they were evacuated by helicopter in the days that followed.

In addition to the 650 people with special needs who came to the Dome before Katrina hit, scores of people began to arrive at the Dome, the Sports Arena and the Convention Center as they were being rescued from rooftops by boats or by walking through murky floodwaters. The national news media was filled with scenes of dramatic rescues of people being saved by the heroic efforts of military and volunteer boat rescuers and dramatic helicopter rescues as the flood waters began to consume large portions of the City.

Public hospitals in New Orleans also faced daunting efforts to maintain emergency medical services as the floodwaters rose and crippled emergency power sources, many of which were located in the basements of these facilities. Dr. Hamm reports that many people were rescued by helicopter from Tulane Hospital and others from Charity Hospital.

Vice Chancellor Ron Gardner, who chairs the Emergency Management Team at LSU Health Sciences Center, says that 180 people were evacuated from the Health Sciences Center. "We had crisis after crisis including a pregnant patient who had to be transported by boat to University Hospital, an elderly man who needed oxygen and the auxillary power was running out to support the generator, two diabetics running out of insulin, and the challenge of feeding essential personnel, students and their families," said Gardner. All of the area hospitals were challenged by the lack of electrical power and limited food and water supplies.

Private hospitals and nursing homes were severely damaged and experienced extreme and wrenching conditions as power sources failed and sanitation services were overwhelmed in the wake of the most devastating storm ever to impact the continental United States.

Three hospitals in the Greater New Orleans area were able to maintain operations during and following the storm (East and West Jefferson Hospitals and Ochsner Medical Center) – all in Jefferson Parish. An emergency medical facility was set-up at the New Orleans Convention Center, and Touro Hospital opened with limited capacity in Orleans Parish, several weeks after

the storm. Prior to Katrina, there were 2,269 staffed hospital beds in Orleans Parish in eight hospitals. Now there are 388 staffed hospital beds in Orleans Parish in three hospitals. And, in those three hospitals, the staffed beds have dropped from 882 to 388. The Medical Center of Louisiana at New Orleans (MCLNO - Charity and University Hospitals) remain closed.

A STRAINED SYSTEM OF HEALTH CARE – PRE-KATRINA

A Henry J. Kaiser Family Foundation Commission report on the Health Care Delivery System for Low Income People in New Orleans Pre-Katrina says that the devastation which caused the closure of the Medical Center of Louisiana at New Orleans (“MCLNO”) “not only affects the thousands of people who receive regular care at the hospital or at one of the many outpatient clinics, but also disrupts the state’s trauma care system. MCLNO operated the only Level 1 trauma center along the Gulf Coast.”

The Kaiser report indicates that, “Prior to Katrina, the New Orleans area was served by 16 acute care hospitals providing inpatient and outpatient services (In 2004, those hospitals provided nearly 172,000 discharges and over 962,000 inpatient days).” MCLNO (University and Charity Hospitals) was recognized as the “safety net” hospital for the uninsured. It served a largely poor, predominately minority population through inpatient care, a network of outpatient clinics, and the busiest emergency department in the city. Nearly three quarters of its patients were African-American, and 85 percent had annual incomes of less than \$20,000. Over half of the inpatient care provided by MCLNO was for patients without insurance, representing two-thirds of this care to the uninsured in the city.

The Kaiser report details, “When Katrina struck, about 22 percent of Louisiana residents and 23 percent of New Orleans residents were living in poverty (\$16,090 for a family of three). Over 900,000 people or 21 percent of Louisiana residents had no health insurance. Tied to these poverty and uninsured rates, Louisiana had some of the poorest health statistics in the nation with high rates of infant mortality (49th highest in the country), chronic diseases such as heart disease and diabetes, AIDS cases, and lower than average immunization rates. Large disparities in health statuses existed for minorities in the state. African-Americans, who represent one-third of the residents in Louisiana and two-thirds of all residents in New Orleans, are more likely to suffer from heart disease, diabetes, and asthma than their white counterparts.”

Access to primary care for the uninsured in New Orleans was limited. Despite having extremely high rates of poverty, New Orleans was served by only two Federally Qualified Health Clinics. MCLNO was again a major source of primary care providing 350,000 outpatient visits at a number of primary care and specialty clinics.

“Before Katrina hit, the number of uninsured was increasing, but the volume of services provided by MCLNO had been decreasing over time due to shrinking resources. From 1999 to 2003, the number of discharges decreased by 16 percent, outpatient visits declined by 26 percent, and emergency room visits declined by 17 percent. Lack of resources, not reduced demand, explains the decline in volume,” according to the Kaiser report.

“The uncompensated care burden shouldered by MCLNO was crippling. With 50 percent of its total costs uncompensated, the hospital struggled to secure sufficient revenues to simply

sustain operations. It lacked the capital to make much needed infrastructure improvements. In fact, the deterioration of the facility was so severe that the hospital had been threatened with losing its accreditation. Officials, pre-Katrina, had been exploring options to replace the hospital with a smaller inpatient facility and primary care clinics located throughout the City,” according to the Kaiser Commission report.

**THE NEED FOR COURAGEOUS CONVERSATIONS
TO CHANGE THE DELIVERY OF HEALTH
AND SOCIAL SERVICES**

The disparity that previously existed in the delivery of health care in New Orleans is but one of the inequities this community must overcome in the aftermath of the Katrina devastation. On September 15, 2005, President Bush delivered remarks to the entire nation concerning Hurricane Katrina recovery. President Bush made the following important statements in his remarks concerning rebuilding our community. “As all of us saw on television, there is also some deep, persistent poverty in this region That poverty has roots in a history of racial discrimination, which cut off generations from the opportunity of America. We have a duty to confront this poverty with bold action.” In this report, the Social Services Sub-Committee speaks to the need for “Courageous Conversations” during the Katrina Recovery to ensure that public policy changes are implemented to address the serious lack of services for poor people who disproportionately are people of color.

The deliberations of the BNOB Health and Social Services Committee and its five subcommittees over the past three months have been guided by these concerns and the Committee has worked to develop recommendations which speak to a broad vision of health care and social services for all of our citizens.

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EXECUTIVE SUMMARY

COLLABORATION IN THE FACE OF EMERGENCY

In the aftermath of Katrina, there was an immediate recognition for the need for a collaborative effort to address and deal with issues concerning the devastated health and social services infrastructure in the City of New Orleans and surrounding parishes and to develop a detailed plan that could be used by state and federal officials for rebuilding.

Several weeks after Katrina hit New Orleans, the Louisiana Public Health Institute in collaboration with the Centers for Disease Control, the City Health Department, the State Department of Health and Hospitals, the U. S. Department of Health and Human Services, private hospitals, LSU Health Sciences Center and the Medical Center of Louisiana, academic medical centers, schools of public health, and community based organizations and community health clinics convened a meeting of over 100 people to begin developing a plan for the rebuilding of the health care delivery system in Southeast Louisiana. This collaborative effort resulted in the development of a document, "The Framework for a Healthier Greater New Orleans." The "Framework" document was offered and accepted as the core document for development by the Bring New Orleans Back ("BNOB") Health and Social Services Committee and was offered to the Louisiana Recovery Authority. See attached Compendium of Related Information.

BNOB COMMISSION FURTHERS THE COLLABORATION

Consistent with and in an effort to build upon this collaborative planning process, the Health and Social Services Committee of the Bring New Orleans Back Commission met for the first time on November 1, 2005. This initial meeting provided an overview of the purpose of the Committee, and discussed the structure and the composition of the Committee. Specifically, the Health and Social Services Committee of the BNOB Commission was formed to address issues related to the rebuilding and recreation of the health and social services infrastructure in New Orleans, so that all of our citizens can be provided with outstanding health care. Rather than "reinvent the wheel" by starting the collaborative process all over again, the Committee used the structure outlined in the "Framework." Many of the findings and recommendations of the BNOB Committee are guided by the principles enumerated in the Framework. At the first meeting, the following subcommittees were formed to develop recommendations concerning rebuilding the health care and social services sectors: (1) Hospital and Specialty Care; (2) Primary Care; (3) Core Public Health Issues; (4) Human Services Issues; and (5) Core Environmental Health Issues.¹

At this initial Committee meeting, each subcommittee was charged with reviewing the delivery of health care services and social services in New Orleans before Katrina, and

¹ *The members of the Health and Social Services Committee, the subcommittee co-chairs and members are listed in Appendix "A" to this report.*

addressing the following issues before making final recommendations. Specifically, what will it take to rebuild the sector; what are the obstacles/challenges facing the sector and what are the possible solutions; what are the resources needed to rebuild the sector, including, but not limited to, financial and governmental resources; how can the system be redesigned and improved; what assignments and tasks should be proposed to initiate rebuilding and follow-through; and what are the opportunities and possible timelines for a rebuild and redesign of the system? The need for broad-based community input was also addressed at this first committee meeting and at subsequent meetings. The BNOB Health and Social Services Committee represents a broad cross section of health care providers, customers and citizens with a keen interest in rebuilding a better healthcare and social services system for the community.

The second meeting of the Health and Social Services Committee was held on November 15, 2005, and the purpose of this meeting was to provide committee members and the public-at-large with information concerning the status of health services in the City of New Orleans, and to address environmental and public health issues. Presentations were made by Dr. Kevin Stephens, Director of the City of New Orleans Health Department; Dr. Mike McDaniel, Secretary of the Louisiana Department of Environmental Quality; Dr. Jimmy Guidry, Secretary of the Louisiana Department of Health and Hospitals; Dr. Richard E. Green, Regional Administrator, EPA Region VI and Sam Coleman, Director of the Superfund Division, EPA Region VI; and Dr. Howard Frumkin, Director of the National Center for Environmental Health and the Agency for Toxic Substances and Disease Registry at the United States Centers for Disease Control and Prevention. Also, to address some of the financial challenges facing the health care industry after Katrina, Dr. Roxanne Townsend, Medicaid Medical Director for the Louisiana Department of Health and Hospitals, made a presentation concerning funding and reimbursement issues.

The focus upon community input in rebuilding a better healthcare and social services delivery system was addressed at the third meeting of the Health and Social Services Committee on November 29, 2005. This community outreach session provided an opportunity for citizens to ask questions and to voice their opinions about a redesigned healthcare and social services system in New Orleans, with breakout sessions to provide focused discussions on the rebuilding efforts. The comments and questions raised during these breakout sessions assisted in developing this plan for a post-Katrina healthcare and social services system.

The final meeting of the entire Health and Social Services Committee was held on December 20, 2005. Dr. David Satcher, the former Surgeon General of the United States and the President of Morehouse School of Medicine, addressed the members of the Committee about the effects of the storm on our citizens physically, mentally and emotionally, and particularly the toll taken on our children. Moreover, during this meeting, the co-chairs of the five (5) subcommittees made brief presentations concerning their subcommittee recommendations, which were critiqued by Dr. Satcher and audience members.

In addition to these four (4) public meetings of the full Committee, each of the five subcommittees met a number of times to discuss and address issues related to their specific sectors, and finally, to craft specific recommendations for the development of an overall plan for the delivery of health and social services for the metropolitan New Orleans area. The Committee collected input from more than 400 people who participated in some part of the planning process,

and every effort was made to be inclusive of individual and organizational interests throughout this process, to promote public participation, and to encourage open and honest discussion on these very important issues. This report was drafted to identify the challenges facing the New Orleans community in the delivery of quality health care and social services since Katrina, and more importantly, to recommend solutions to those challenges.

RECOMMENDATIONS

To that end, the primary recommendations of the Committee include the following:

- Prepare hospitals, nursing homes and providers for future disasters.
- Involve social services in future disaster plans to help ensure that all people are reached.
- Create a system of care for all segments of the population and neighborhood primary care centers linked to hospitals, with changes in payment models to open up access to care.
- Shift the focus, to the degree possible, toward ambulatory care, wellness and preventive medicine, health promotion and chronic disease prevention and away from institutional care.
- Maintain a university teaching hospital in New Orleans.
- Focus on the individual through such things as electronic medical records.
- Focus on the 10 essential public health services.
- Focus on environmental health.
- Create area-wide healthcare and human services collaboratives that include a critical mass of committed key participants, working toward clearly defined goals, with the necessary leadership and financing, pursuant to written charters.

Although it was a tragedy of unparalleled scope, Katrina provided our community with the opportunity to “get it right” and provide quality healthcare services to all citizens.

* * * * *

SUMMARY OF RECOMMENDATIONS

PRIORITY RECOMMENDATIONS

1. **Emergency Planning for 2006 Hurricane Season:** First, undertake immediate planning and facilities work concerning (a) sustainability of power and services during a storm (including obtaining funding for required upgrading and moving of power generation and distribution equipment) and (b) evacuation, when required. Second, those involved in human services and public health have a unique opportunity to (a) identify people who will need help in evacuating and (b) in disseminating emergency information – hence they should be included in that process. Third, communications within the staffs of emergency healthcare providers and between them and emergency management personnel must be made effective and reliable. Fourth, to the degree possible in the interim before an interoperable electronic medical records system can be put in place, establish a means by which citizens who must evacuate have key pertinent medical information with them or available to providers in the locations to which they evacuate.

2. **System of Care:**

- **Changes in Payment Models to Open Up Access to Care:** It is critical that changes be made in the current payment and reimbursement models which will result in greater access by the entire community to quality healthcare. Thus, universal healthcare payment coverage should be considered by the State of Louisiana. This is an example of a funding mechanism that has been discussed here and elsewhere in the country since well before Katrina. Indeed, in Louisiana, the statutory authority is in place for a demonstration project. The objective is to afford equal access to quality, cost-effective healthcare, thus eliminating the existing two tiered system of delivery of healthcare in this community. Making recommendations on the specifics of how a funding mechanism like this should be implemented goes beyond the scope of this report – it is a complex issue, requiring time and expertise to analyze, and it is an issue where the state and federal professionals in this field have the real expertise and ability to act.

Additional options to be considered include cost-based reimbursement under Medicaid and Medicare to all hospitals in the declared disaster area, adjustments to the Medicare outlier methodology to reflect the decreased capacity in available services in the disaster areas, adjustments to the wage index calculation to reflect current changes in the affected areas, and permanent changes to the Medicaid payment system. The Committee also recommends that the relevant governmental entities revisit efforts for reform directly prior to the storm (e.g. CMS 1115 waiver/Health Pac, Medicare 646 demonstration project, etc.), and re-establish those processes that have merit in the current environment; catalog and evaluate other existing mechanisms (other waivers, SCHIP, FQHC, etc.) and benchmark successful efforts elsewhere for maximizing financing and information exchange among GNO primary care providers; pursue public and private grant funding by local and state leaders; and make recommendations for

both short and long-term solutions to bridge and sustain the primary care infrastructure.

- Community Health Centers: Establish “community health centers” in appropriate locations and configurations for the populations to be served. Include within the delivery of services at these facilities primary care, mental health, behavioral health, dental care, community outreach, pharmacy, immunization and human services. Expand the number of community health centers as the population increases. Separately reestablish specialty clinics for HIV, STD and TB.
 - Distributed Hospital Care: Have hospital and specialty care treatment for the uninsured and underinsured distributed across other hospitals and specialty care facilities in the area and continue to establish cooperative agreements to sustain healthcare services and to build upon public/private partnerships. This should be coupled with: (1) developing a funding mechanism that will reduce the negative financial impact of this recommended change for the impacted facilities; and (2) addressing issues of accessibility and quality.
 - Medical Center of Louisiana: Redefinition of the Mission and Goals
 - Create Academic Medical Centers and rebuild the university teaching hospital as a modern, up-to-date system that does not replicate the previous two-tiered system for health-care delivery (long term).
 - Small hospital established promptly, initially at what was St. Charles General, or a similar facility (short-term).
 - Level 1 trauma center established promptly, and temporary remediation of University Hospital (short-term).
3. **Environmental Health Entity Within the New Orleans Department of Health:** Establish this entity as a coordinating body with regard to environmental health matters. In order to ensure ongoing staffing, establish and encourage educational programs for environmental health workforce employees.
4. **Health Promotion and Chronic Disease Prevention:** Establish the necessary staffing and processes to support an ongoing program of health promotion and chronic disease prevention.
5. **Technology – Electronic Medical Records & Databases:** First, establish electronic medical records as the norm in the region’s healthcare facilities and establish the necessary “interoperability” (i.e., the necessary capability in the facilities to use these records). Second, establish database systems for use with human services and public health in order to coordinate and facilitate the services with those who need them.
6. **Regional Healthcare Collaborative:** Establish a collaborative, including a convenor of stature, clearly defined goals that are as narrow as possible, a committed leader, a written

charter, participation by a critical mass of principals of substance and participation by constructive critics. The name we suggest is *Greater New Orleans Healthcare Taskforce*. We also recommend that there be clearly established coordinating mechanisms with the State and with the regional human services collaborative (*Katrina Community Based Services Network* suggested below for this second collaborative)².

7. **Professional Development of Reliable Census Information**: Develop a reliable and timely professional means of gathering census information concerning the region, including (a) numbers of people, (b) demographics and (c) geographic location within the region. Results to be compiled on a monthly, then quarterly basis. This should be done by an outside contractor. The quality and timeliness of the information must be adequate to inspire confidence in it by the broadest range of key participants in the recommended collaboratives.

SPECIALIZED AREAS RECOMMENDATIONS

Hospital and Specialty Care

Staffed Beds: Increase available beds in accord with accurate ongoing census.

Staff: Take aggressive action to furnish required staffing (in a situation where much staffing has been lost as a consequence of the housing issues).

Primary Care

Staffing in the City: Identify staffing needs in terms of both primary care and subspecialties within the City and create incentives for those professionals who work in Orleans Parish.

System-wide issues: Identify and address issues using a regional approach to developing a primary care system in metropolitan New Orleans.

Workforce Development: Work to build back the necessary subspecialties, the graduate medical education programs and the allied health professional education programs.

System Financing: Explore additional avenues for financing and financial support for the delivery of primary care services.

Public Health

Health Assessment: Establish a long term Katrina-related monitoring system with regard to health effects.

Surveillance: Establish a comprehensive long term system of surveillance with regard to health events, health status and related issues.

² See Human Services section under Report and Recommendations below.

Community Outreach and Integration with Primary Care: Establish and staff an appropriate process for community outreach on public health issues, including an appropriate coordination with primary care providers.

Infrastructure for Essential Public Health Services: Ensure funding and related needs for the public health agencies in the region to deliver on all ten of the essential core public health services.

Maintain Public/Private Partnerships: Continue and strengthen the utilization of public/private partnerships to address core public health issues.

Human Services

Coordinated Service Delivery: Establish a system of collaborative, cross-sector, neighborhood-based wrap-around human service delivery.

Regional Human Services Collaborative: Establish a collaborative, including a convener of stature, clearly defined goals, a committed leader, a written charter, participation by a critical mass of principals of substance and participation by constructive critics. The name we suggest is Katrina Community Based Services Network (“KCBSN”). We also recommend that there be clearly established coordinating mechanisms with the State and with the regional healthcare collaborative (the Greater New Orleans Healthcare Taskforce).

Environmental Health

Repopulating the City: Furnish up-to-date information to those who are moving back to the City or considering moving back to the City concerning any health issues associated with sediments, debris or other storm-related issues in order to facilitate their making individual judgments as to risk.

Surveillance: Establish a long term monitoring and surveillance program to assess the long term impact of environmental factors on health and events and develop the necessary technology support.

Environmental Health Risk Communication Program: Establish a risk communication program that will provide information to the public, allow the public to communicate their concerns and allow for an orderly and thorough consideration of those concerns.

Program to Address Gaps in Knowledge, Science, Policy and Practice: Establish, in collaboration with the environmental health entity established within the New Orleans Department of Health, a capability and process for dealing with gaps in knowledge, science, policy and practice related to environmental health.

RECOMMENDATIONS TO OTHER COMMITTEES

1. **Healthy Neighborhoods (Recommendation to the Land Use Subcommittee of the Urban Planning Committee):** Evaluate the establishment of “healthy neighborhoods”, meaning neighborhoods that are established with biking and walking paths, parks and playgrounds, low numbers of alcohol and tobacco stores, larger numbers of healthy food stores and good lighting/visibility on streets and sidewalks for safety purposes.
2. **Access (Recommendation to the Infrastructure Committee):** The hospitals and specialty care facilities will be in various locations around the City – some specialty care likely will be in adjacent parishes. While the *community health centers* will generally be in the appropriate neighborhoods, even they may be far enough away that transportation is required. It is requested that the Infrastructure Committee continue to develop transportation plans that will ensure that this distributed system of healthcare is, in fact, accessible to all.
3. **Healthcare Needs in Emergency Shelters (Recommendation to the Commission as a Whole):** Ensure that emergency shelters have adequate equipment and facilities to deal with those with healthcare and special needs. Work with the Department of Health in identifying what those needs are.
4. **Emergency Power/Evacuation:** Priority Recommendation No. 1 relates to this topic, which likely is also part of the mission of other Committees. It is requested that those Committees incorporate healthcare facilities in their planning along the lines recommended here.

* * * * *

REPORT AND RECOMMENDATIONS

This Report and Recommendations section puts some flesh on the bones of the recommendations listed in the Summary of Recommendations section above. Additionally, the following helps explain the thinking that went into the recommendations.

Many potential recommendations with merit were developed during the course of this process. They, however, were winnowed down to the most important – those that appear here, whether categorized as “priority”, “specialized areas” or “to other committees.” The point to take from this introduction is that the Committee considers all of the following to be important, whichever of the three categories they are in. All are important for the City in redeveloping the health and social service infrastructures and for the development of “model” regional healthcare and social services systems.

PRIORITY RECOMMENDATIONS

1. ***EMERGENCY PLANNING FOR 2006 HURRICANE SEASON: Sustainability of power and services; evacuation planning; including public health and human services in evacuation planning in order to reach everyone; communications systems; and transportable key healthcare information.***

Sustainability of Power and Services

Ever since Hurricane Georges, hospitals in the GNO region have recognized their vulnerability to losing electrical power from flooding due to the placement of their emergency generators and power switches. Every hospital that has undertaken a major rebuilding effort has incorporated elevating the emergency generators and switches into their new designs. Unfortunately, very few hospitals, particularly in this area, have had the availability of funds to accomplish this needed change. We may never know how many deaths occurred at hospitals as a direct result of failure to the emergency electrical backup systems but we do know that hospitals cannot sustain in place without electrical power. Before the next hurricane season, the emergency generators and switches must be placed above flood level at our reduced number of health care facilities. Since the equipment failed in New Orleans due to flooding, FEMA should be requested to provide the emergency funding to replace these systems.³ In Jefferson Parish, emergency remedial dollars should be immediately requested to assist hospitals there. With working emergency back-up generator systems, area hospitals, in some instances, could successfully do vertical evacuations and/or sustain in place without unnecessary loss of life while awaiting evacuation.

³ During her testimony before Congress on December 14, 2005, Governor Kathleen Blanco expressly requested federal funding to protect generators in hospitals from flooding.

Evacuation Planning

Evacuation plans that are formalized, known and practiced by the region and State of Louisiana are needed. Where they already exist, they need to work better than they did in the face of Katrina. While the plans developed under the Hurricane Pam exercise and through the HRSA Bioterrorism Grant to Hospitals worked fairly well in handling the outward movement and surge of patients into other areas, lack of actual documented systems for taking patients from hospitals and destination identification caused significant problems to patients, caregivers and families. Policies and procedures for hospital evacuations must be finalized with education and drills provided at the local, state and federal levels. These policies and procedures should reflect the extraordinary needs and evacuation complexities of special needs patients apart from the general population. The Committee recommends that planning, education and a drill to establish evacuation methods and surge capacity must be a priority under the 2005-2006 HRSA grant funding.

Public Health and Human Services in Evacuation and Emergency Planning – Reach Everyone

Katrina and its devastating aftermath revealed the desperate need for a fully functioning plan to evacuate New Orleanians who are without access to transportation. As city and state governments continue to develop and refine future emergency and disaster preparation plans, the Committee strongly recommends that the human service agencies, public and private, in the city be an integral part of such planning and be appropriately utilized. They can help us ensure that everyone is included in evacuation plans, evacuations and emergency planning – they have contact with people in need.

Each day, the city's charitable organizations and public health officials have hundreds, if not thousands, of contacts with individuals and families in need. The clients of these organizations are more likely than other groups to be without access to transportation and thus in need of assistance in evacuating when a storm threatens the city. We propose that when a client enters the coordinated network of human service organizations,⁴ information be collected from the client about their specific need for help in evacuating. This would be a highly effective means of approximating the scale of the need for evacuation services, and would also help determine routes and pick up locations based on clients' addresses to ensure that the evacuation plan would be as efficient as possible. Further, we suggest that in interactions with clients, all human services agencies distribute disaster planning information similar to that available from the American Red Cross to educate clients on how they can build a disaster supplies kit, how to evacuate, and what to bring to a public shelter. Incorporating disaster information into human service agencies' interactions can ensure that our citizens who have a critical need for assistance have access to information.

The Committee believes that incorporating these simple, but important, steps into human service agencies' interactions with clients, and also coordinating with the city to create a mass evacuation plan for citizens without access to transportation can reduce the future risk of the

⁴ *This recommendation for a coordinated network is discussed in greater detail in the Human Services section under Report and Recommendations below.*

terrible loss of life and extraordinary suffering that occurred when Hurricane Katrina and its aftermath struck our city. Returning and new citizens of New Orleans deserve assurance that there is a “safety net” in place to evacuate those in need in the event of a disaster and that the relevant human service organizations are involved in this process.

Communications Systems

During Hurricane Katrina, the loss of power, coupled with inadequate advance communications planning and training, caused at least two significant areas of failure in healthcare related communications: (a) communications internally within healthcare facilities and shelters; and (b) communications between healthcare/shelter facilities and those in government responsible for emergency management. Accordingly, the necessary steps fall into the following general categories:

- Internal facilities communications: Healthcare and shelter facilities need to have the hardware and software installed that will allow effective internal communications, even in the event that there is a loss of power from the outside. The people who will have to operate those communication systems need to be trained on how to do it.
- Communications with emergency management: The hardware and software that will make it possible for healthcare and shelter facilities to communicate with emergency management personnel outside of their facilities must be put in place. As Senator Barbara Boxer stated at a recent Senate Commerce Committee hearing on Hurricane Katrina, “We didn’t learn our lesson after the ’93 World Trade Center bombing; we didn’t learn our lesson after September 11. We don’t need any more failures.” During her December 14, 2005 testimony before Congress, Governor Blanco also stated that “You can’t coordinate if you can’t communicate. What we experienced in Katrina was not a failure to communicate, but an inability to communicate.” Also, there must be training that involves both people who will be in the facilities and the people in emergency management who will need to communicate with one another to ensure that all of them can do it effectively and on a sustained basis in the event of an emergency.

While recognizing that there is no simple fix because local municipalities and agencies lack the money and radio frequencies to upgrade equipment and federal aid is limited, there are some innovations in other states that could possibly be used to improve the current system. According to a recent article in *USA Today*, about 10 states, including Indiana, Colorado, Michigan, Minnesota and Florida, have built statewide radio systems that city and county agencies may join. Other areas, such as San Diego County, Alabama and Littleton, Colorado, have installed gateways that link an area’s radio systems, which is a less costly approach.

Because of the undisputed importance of workable communications systems in the event of a disaster, the Committee recommends that federal aid be immediately requested to address these issues.

Transportable Key Health Information

Many people who had to evacuate in the face of Hurricane Katrina had healthcare needs that were ongoing during the time they were evacuated. Few took medical information with them, whether medical histories, lists of prescription medications or otherwise. Electronic access to such medical information from remote locations was not possible. Consequently, those who were called upon to give medical treatment, including furnishing prescription medications, had only the memories of the people in need to rely upon. That is not an acceptable situation.

Once a fully operational electronic medical records system is in place and remotely accessible in the event of an emergency, much of this problem may prove to be solved.⁵ However, that is not going to happen between now and the time of the 2006 hurricane season. Accordingly, under the direction of the City Health Department, summary medical information forms/cards should be prepared by healthcare providers and furnished to their patients so that the necessary information can be taken with the patients in the event of an emergency evacuation.

2. ***SYSTEM OF CARE: Review of other health care systems; changes in payment models; community health centers; distributed hospital care; academic medical centers; and a rebuilt university teaching hospital.***

Background

The development of an overall plan for rebuilding and enhancing metropolitan New Orleans must include an understanding and appreciation for the overall “health” of our citizens - physically, mentally and emotionally. The development of an effective system of care model to serve all of our citizens must be a priority as we rebuild New Orleans in the short and long term.

Notwithstanding the devastating tragedy of Hurricane Katrina, it has provided metropolitan New Orleans with a unique opportunity to develop a system of care for our citizens which could serve as a model for metropolitan areas across the country. This recommended system would work through participation, cooperation and partnership between public and private entities, and allow and encourage quality and cost-efficiency of care, and free enterprise and innovation. The critical elements of the recommended system of care should include the following: (1) strong focus on preventative medicine; (2) be community-driven and community-based; (3) utilize information technology to improve quality and reduce cost; (4) utilize a multidisciplinary team approach including mid-level practitioners, with access to behavioral and oral health services; (5) primary care should be integrated with subspecialty care and hospitalization; (6) modifications should be made to existing payment models to open up access to care, including consideration and implementation of a demonstration project for a universal health care payment coverage system; and (7) consistent funding for the system.

Many metropolitan areas throughout the country have effectively functioning primary care systems for their entire populations, or for segments of their populations. All of them have

⁵ This recommendation for a fully operational electronic medical records system is discussed in greater detail below in the Technology - Electronic Medical Records and Databases section under Report and Recommendations.

their strengths and challenges as they serve the primary care needs of their respective populations. A number of healthcare system models were chosen for review because of their documented success in attempting to meet the healthcare needs of their communities. They were evaluated for their strengths and their applicability to metropolitan New Orleans, while recognizing the unique demographics of our population and the opportunity presented by Hurricane Katrina to establish a healthcare system like none other that has ever existed in our community. The recommended system of care would provide integrated lifetime care which is community-oriented, quality-driven and accessible to all, both in terms of location and cost. There must be accountability between the system of care developed and the patients served.

Models Examined and Key Issues

(a) New York Model: The New York Health & Hospital Corporation (“NYHHC”) was found to be the most closely aligned with the Committee’s recommendations for the critical elements of an effective system of care. The basic features of NYHHC are:

- Consideration of population health quality as part of the community planning process
- Preventive care focus
- Community driven and responsive
- Multidisciplinary approach including mid-level providers, behavioral health, and oral health prevention and treatment programs
- Fully-integrated IT system (appointments, administrative information, radiology, laboratory, limited EMR, and referral services)
- Alignment of performance incentives
- Pharmacy benefit
- Integrated into a Subspecialty Network/Hospital
- Flexibility built into system for growth/change
- Universal health coverage
- Consistent source of funding

It is the Committee’s understanding that the NYHHC system has been competitive in the New York marketplace, serving as the provider of choice for patients of varied sociodemographic backgrounds, with demonstrated efficiency and quality, including reduced hospitalizations and length of stay. While the NYHHC system may not be perfect, it is viewed as having an effective primary care system to serve a diverse population, as in metropolitan New Orleans. There are many lessons to be learned from studying this approach. The Committee recommends that public policy officials and state and local leaders consider visiting New York to

view its system first-hand, and likewise consider inviting New York's system's leaders to metropolitan New Orleans to offer their advice and input as we develop our own premier system of care.

(b) Notable components of other systems: In addition to the NYHHC model, there are other healthcare systems with elements that should be considered to develop a system of healthcare which is the most appropriate for metropolitan New Orleans.

For example, in Pittsburgh, the “no wrong door” approach has been used to recognize patients who access community services or primary care services, and trained staff is available to recognize other key indicators of medical conditions or behavioral issues which should be addressed. Regardless of what “door” is entered, the person walks into a network of services and programs which are mobilized and customized for the individual. This model ties in with specific recommendations in the Human Services area, which will be discussed later in this report.

Of particular note, is the healthcare system in Milwaukee, Wisconsin, a model developed after closure of its public hospital. This program emerged from the ashes of a county hospital closure in 1995 which forced the community to reexamine how it cared for its poorest residents. Leaders seized upon the opportunity to develop an integrated, cost-effective healthcare system that would yield better care for more people, particularly single adults, early retirees and undocumented residents who lacked other options. Referred to as the “General Assistance Medical Program,” this is a model which should be considered by New Orleans based upon how Milwaukee responded to a potential massive problem, given the present funding and infrastructure challenges faced by the Medical Center of Louisiana at New Orleans.

(c) Use of Mid-Level Practitioners: In addition to physicians, almost all of the models reviewed included the use of mid-level practitioners to provide necessary services in the primary care setting. An adequately trained and available workforce is key as metropolitan New Orleans is repopulated. Most frequently, advanced practice nurses and physician assistants were used as physician extenders in the primary care setting. Given the displacement of so many physicians, metropolitan New Orleans should consider primary care models which rely upon the use of mid-level health care professionals, e.g., nurse practitioners and physician assistants.

(d) Focus Upon Behavioral and Mental Healthcare: Of the models evaluated, those that stand out as being leaders in the behavioral health care arena were Pittsburgh and Galveston. With Pittsburgh's “no wrong door” approach, behavioral concerns are recognized immediately and appropriate referrals are made. In Galveston, in cooperation with faith-based community leaders, the primary care clinics' IT system provides an interface with social services and behavioral resources. Once a referral is made to any of the social or behavior services from the primary care clinic, vouchers are issued immediately to qualifying patients to cover the cost of the care, so that the patient does not fall through the cracks. The importance of developing a system of care that includes a focus upon behavioral and mental health care is also briefly discussed in the Human Services section of this report.

(e) Access: In most of the models which were evaluated, standard components for community health centers included extended hours, 24/7 accessibility, same day service appointments, mid-level call centers for consults, and educational services at clinic sites.⁶

(f) Preventive Care: Any “model” healthcare system developed in New Orleans must focus upon preventative medicine for our population. Case and disease management are critical in preventative medicine, especially for certain high risk patients, including those with diabetes, HIV, heart failure, and geriatrics. We are all well aware that New Orleans has a high share of high risk patients. Models evaluated that have effective disease management approaches include both Pittsburgh, Pennsylvania and Buncombe County, North Carolina. Through effective case management and provision of preventative medical services, they have been able to reduce the emergency room (“ER”) utilization for the targeted population from 28% to 8%, and more than 80% of the patients have reported improved health status. In Pittsburgh, preventive case management involves stratifying program enrollees according to their level of risk for various health conditions or problems such as domestic abuse that might lead to health risks. Network case managers develop service plans, locate high-risk members and intervene to get them into care before catastrophic medical crisis occurs. Also, electronic claims surveillance is used to identify high-risk patients. Both of these systems count on enhancement of patient educational opportunities, a pharmacy benefit program for their patients, and fully-integrated IT systems to give case managers and physicians early warning signals that help identify high-risk patients. IT systems which fully integrate intake and screening opportunities with referral systems for specialty and hospital care, and community resources are important to overall system success, and particularly in the preventative medicine component. The importance of an integrated IT system in a “model” healthcare and social service system is discussed in more detail in this section of the report as well as in the Human Services section of the report.

(g) Integration with Subspecialty Care and Hospitals: The provision of primary care services is only one piece of the overall “health” formula. Accessibility to subspecialty and hospital services is critical for continuity of care and for enhanced patient outcomes in a “model” system of care. In an effective primary care system, the need for subspecialty and hospital care should actually be reduced as a result of improved preventative care services being administered; however, effective case management may necessitate referrals and hospital inpatient or outpatient services.

In the models reviewed, this integration was made more effective and efficient with the use of a comprehensive web-based referral system. An adequate supply of sub-specialists (physicians), specialty services, and inpatient and outpatient facilities is necessary to provide continuity of care in the “medical home” model.⁷ These services could possibly be included in a network-type design as is done in Indianapolis. In many of the models reviewed, often residents and fellows under the supervision of attending physicians provide staffing in the inpatient and outpatient settings. The Committee recognizes that this element of a health care system model will be a significant challenge in light of the closure of multiple hospitals in the New Orleans

⁶ A more detailed discussion of the necessity of developing excellent community health centers in New Orleans is discussed under Community Health Centers later in this subsection.

⁷ The “medical home” model will be discussed in greater detail in the Primary Care section in Report and Recommendations, later in this report.

area, the displacement of physicians, and the permanent relocation of many sub-specialists. The Committee recommends that consideration be given to incentives as a means of enticing sub-specialty physicians to remain or locate to New Orleans, including the expansion of Health Professional Shortage Area designations.

(h) Strong Emphasis on Information Technology to Improve Quality, Patient Compliance and Reduce Duplication and Cost: Cook County in Chicago and Indianapolis, Indiana represent healthcare systems with superior information technology and applications which result in better coordinated and fully-integrated care. Indianapolis appears to excel in the integration of IT systems of all of its community health centers, hospitals, large multi-specialty clinics, and health plans as well. Components vary by hospital, but basic demographic information, laboratory, radiology and diagnostic results are available to providers throughout the community to enhance coordination of services and patient outcomes. In Cook County, a web-based referral system integrates clinical systems and radiology with appointment systems. The clinic director reviews referrals, and based on patient acuity, can “triage” patients to health and community resources cutting down the wait time for appointments, therefore increasing patient outcomes. There are several software systems which are able to establish similar platforms for integration. The importance of increased utilization of information technology is also addressed in the Human Services Section of this report.

Changes in Payment Models to Open Up Access to Care and Potential Funding Mechanisms

The Institute of Medicine clearly documents the wide-ranging costs of un-insurance to individuals, communities, business and society in general. In a “new” healthcare design, it is important to develop a system which opens up access to care and allows patients choices for health improvement and maintenance.

In cities where successful healthcare systems exist, there is a sound business model. Many are supported through property or sales taxes, and a combination of public, private, or business support. A well designed, planned and executed system of care in metropolitan New Orleans must start with de-politicizing the funding of that care.

In the models reviewed, there were multiple approaches used to guarantee funding, including a combination of Intergovernmental Transfers and state funding, Medicare and Medicaid, including disproportionate share, third-party coverage, donated care, tax revenue (often from property and/or sales tax revenue), and public and private grant sources. Cook County, Denver, Dallas, Indianapolis, Marion County in Indiana, Milwaukee, Muskegon County, New York and Pittsburgh all had consistent funding sources for their primary care program.

Community-Oriented Primary Care in Dallas, Texas was one model which was reviewed which approached the element of universal health care payment coverage. Patient care in this system is financed through a combination of tax dollars, the Medicaid disproportionate share program, third-party reimbursements, and sliding scale copayments. To help maintain financial stability, Parkland has developed three insurance/access products as well: 1) Parkland HEALTHplus - a sliding fee scale payment program which has 60,000 enrollees, Parkland HEALTHfirst (Medicaid managed care insurance (which has 45,000 enrollees), and Parkland

KIDSfirst (Children’s Health Insurance Program), with 30,000 enrollees. They also have in place a managed care package for 7,700 Parkland employees and their dependents.

Other models considered often cover up to 200-250% of the Federal Poverty Level, with sliding scale payments, Medicaid coverage, employer participation and possibly some level of tax support. In New York, financial screening for coverage options is aggressively done to ensure coverage by the third visit. There are other possible coverage options, including “pay or play” models which exist in states like Massachusetts.

As previously discussed in this report, the ultimate objective is to eliminate a two-tiered system of health care delivery. In evaluating options for opening up access to care and possible restructuring of the financing of a health care system with a needed focus on primary care, the Committee recommends that the following be considered, noting the complexity of these issues and the time and expertise required for an appropriate analysis:

1. Universal healthcare payment coverage for Louisiana citizens. State law already exists in Louisiana allowing “**demonstration projects**” to be created in this arena. One such demonstration project which is promoted by the Louisiana State Medical Society and the American Medical Association is a 3-year pilot program. The plan is called, “Expanding Health Insurance: The AMA Proposal for Reform.”⁸
2. Establishment of guiding principles around primary/neighborhood-level healthcare financing for the Greater New Orleans area.
3. A review of challenges that existed prior to Hurricane Katrina resulting from multiple/inadequate funding streams for neighborhood-level primary care.
4. Revisit efforts for reform that existed directly prior to Hurricane Katrina (e.g., CMS 1115 waiver⁹/Health PAC, Medicare 646 demonstration projects, etc.), and reestablish those mechanisms that appear to have merit in the current post-Katrina environment.

⁸ *This proposal revolves around four basic principles:*

1. *Expanded consumer choices;*
2. *Individual selection and ownership (still allowing through employer, if chosen);*
3. *Defined contribution (by employer or government); and*
4. *Expanding insurance coverage to ensure universal coverage through tax credits (or vouchers for the poor), HSAs for the working poor & market enhancements – perhaps modeled after the Federal Employees Benefit Program.*

⁹ *The federal inter-agency transfer of at least \$150 million from FEMA to CMS to pay the cost of the approved Section 1115 waiver which permits all Medicaid providers to recover uncompensated care costs incurred for providing care to hurricane evacuees is basically a budgetary neutral step.*

5. Catalogue and evaluate other existing mechanisms, such as other waivers, SCHIP, FQHCs (which will be discussed in the next section of this report), and benchmark successful efforts in other communities for maximizing financing and information exchange among Greater New Orleans primary care providers.
6. Public and private grant funding must be explored and pursued by the appropriate local and state leaders.
7. Explore short and long term solutions and then pursue them in order to bridge and sustain the primary care infrastructure.

The methodology for such waivers and funding exists and other demonstration projects have been initiated, including both Medicare and Medicaid demonstration projects, in other states. Some of Louisiana's existing waiver programs for our working poor citizens might be used as a basis for expanding necessary coverage.¹⁰

Additional options that should be immediately considered to open up access to care are: cost-based reimbursement under Medicaid and Medicare to all hospitals in the declared disaster area; adjustments to the Medicare outlier methodology to reflect the decreased capacity in available services in the disaster areas;¹¹ adjustments to the wage index calculation to reflect current changes in the affected areas;¹² and permanent changes to the Medicaid payment system.

Community Health Centers

Public and private health services capacity development in the region will be based on a shared principle of a community approach to quality, and accessible and affordable care in a systematic way for all residents. The foundation for this community approach is access to continuous preventative and primary care services with timely referrals and back-referrals for all necessary specialty, diagnostic, therapeutic, hospital-based and other institutional-linked care. Complimented by a healthy environment, this primary and preventative approach will assure a much healthier and thriving community while assuring better return on the investment in health care.

New York City is again a model to be considered for a community-driven and community-designed approach. Through community advisory boards and community outreach, NYC has been able to create community health centers which are a reflection of the needs of that particular community. Hospital services are also driven by community input and are tied to the

¹⁰ According to an article in the *Times-Picayune* on January 9, 2006, "the Louisiana State Medical Society wants the state to seek a waiver from Congress that would let federal Medicaid money administered by the state be spent purchasing private insurance policies for uninsured residents, rather than reimbursing hospitals and doctors directly for services." Basically, this would allow for a funding mechanism for uncompensated care whereby the "dollars would follow the patient."

¹¹ The reimbursement system assumes that a hospital has the ability to discharge patients expeditiously and to the appropriate level of care. However, metropolitan New Orleans does not have that ability as a result of the absence of a significant amount of long term care facilities, home care, etc.

¹² The current reimbursement system adjusts payments according to the comparative cost of normal labor markets.

needs of the population, as well as needs related to graduate medical education training. These models often include partnerships with payers, business and other community interests to build success.

Another innovative approach to responding to community need is in Jackson, Mississippi. In response to community input, a “medical mall” was developed in an existing retail center where patients have access to every type of primary and specialty care, as well as community resources and medical products. This “one-stop-shop” approach to care has been very effective in that area, and while it is not a part of one of the models the Committee reviewed in depth, it is a component that should be closely studied and might be relatively easy to replicate in New Orleans given the retail-type space which is available in many areas in our community.

One of the things that makes New Orleans unique is racial and cultural diversity within our community. A “one size fits all” approach to the design of the primary care system will not take this diversity into consideration. However, insistence upon community involvement in the assessment of the types of services needed in community care centers in metropolitan New Orleans will result in a customized approach to the provision of primary care services.¹³

It is important to note that there were a number of increasingly effective efforts within the metropolitan New Orleans community to strengthen the primary care system prior to Hurricane Katrina. In addition, there was an increasing effort, especially via the safety-net provider community providers, such as EXCELth, LSU and the Daughters of Charity, to coordinate care services for the indigent population through the development of the Partnership for Access To Healthcare (PATH) which was convened by the Louisiana Public Health Institute (“LPHI”). These efforts should be applauded and continued within the transitional system, and as a part of the process toward implementing a new primary care system for ALL New Orleanians, not just those who fall through the cracks.

One such community-driven, community-based model that could be considered by New Orleans for expansion is that of the Federally Qualified Health Center (“FQHC”). Presently, EXCELth, Inc. has been a leader in the development of FQHCs, which are a mix of public and private interests. Likewise, Cook County in Chicago is successful in the development of FQHCs. The FQHC and FQHC “look-alike” models present an opportunity for private practice physicians and other health care professionals to be integrated into a public-private partnership to deliver care in a local health center which is designed by and for the population it is serving.

The Committee also recommends that consideration be given to school-based health centers either located on or near school property. This design element encourages a “family approach” to seeking and providing primary care services, and may tie in with the school model

¹³ For example, according to the local newspaper, a clinic created in Algiers in the aftermath of Katrina was one of the first places in New Orleans to offer free medical assistance after the hurricane. Since the storm, the clinic has served more than 8000 patients in the New Orleans area. Operating as a non-profit, the clinic’s current staff consists of about 35 volunteers, including nurses, massage therapists, herbalists, social workers and several local doctors. Although it was created as a temporary measure, it is now working on incorporating as a 501(c)(3) non profit organization and is seeking grants and long-term financing to provide local jobs so that the facility continues after the volunteers leave. As one patient stated, “They don’t just treat the medical problem – they listen to you as a person.” See *Times-Picayune*, January 9, 2006.

recommended by the Education Committee of the BNOB Commission. Louisiana has made strides in the development of effective school-based health centers which enhance preventative medicine outcomes as the health care professionals are able to identify children and adults who may be high-risk.

In New Orleans, both the McFarland Institute and the Step Together New Orleans (STEPS) program have made strides in this area as well. Importantly, the STEPS program represents a public-private partnership focused on evidence driven preventive promotion.

In finalizing a plan for the development and rebuilding of community health centers in our community, it is important to recognize that the New Orleans area has existing facilities that can be used after repairs and renovations, and that we must look at all existing resources – capital and human – so that any funding is used in the most efficient and quality driven manner.¹⁴ Consistent with the Committee’s recommendations concerning possible changes in payment models to open up access to care, it is critical to have a strategic planning process involving policy makers and experts. Moreover, monitoring and evaluation are critical to ensure that the appropriate action items are implemented by key stakeholders and that all funding is spent as intended. Accountability is paramount.

Against this background, the Committee recommends that funding be requested for the building of at least fifteen (15) new clinics at the present time in Orleans Parish at an approximate cost of \$950,000 to \$1 million per site for construction and operations, which operation costs would presumably diminish during subsequent years as available financing and payment options stabilized. However, as stated, these funding issues are complex and require extensive expert review and analysis.

Distributed Hospital Care

The National Association of Public Hospitals and Health Systems (NAPH) lists 59 corporate provider members. These hospitals exist in 25 states plus Washington DC and the Virgin Islands. Louisiana’s “Charity” system is included. These are the “safety net” hospitals which promise to take care of any patient regardless of payment source.¹⁵ These “safety net” hospitals can do this because they receive supplemental state and local funding. In the recommended “model” healthcare system for the metropolitan New Orleans area, hospital and specialty care treatment for the uninsured must be distributed across other hospitals and specialty care facilities in the area. This must be coupled with the development of a funding mechanism to reduce and minimize the negative financial impact of the recommended change for the impacted facilities. The hospitals that fall within this category represent 2% of the nation’s hospitals. According to a recent study by NAPH, 21% of the care they deliver is uncompensated by any insurer or private source.

¹⁴ *Since Katrina, the City of New Orleans is currently operating three clinics: the Ida Hymel Clinic; the Algiers Community Clinic; and the Pillsbury Clinic.*

¹⁵ *According to Dr. Michael Ellis, a former president of the Louisiana State Medical Society, “as part of the process of redefining Charity, special attention is being paid to its longtime role as the principal treatment center for people without insurance, a figure that has jumped statewide since Katrina from 900,000 to about 1.2 million.” See Times-Picayune, January 9, 2006.*

Again, according to NAPH, 25% of uncompensated care (UCC) in the nation is delivered through these “safety net” hospitals. The remaining 75% of care is delivered through private not-for-profit or for-profit hospitals. Many communities choose to serve the uninsured and underinsured this way. If any hospital treats an undue proportion of uninsured patients extra funds are often available through Medicaid, Medicare and special state funding pools.

Given the uncertainty of the demographics of the New Orleans population over the next several years, providing indigent care in all hospitals throughout the region creates a more efficient delivery system, proximate to all populated neighborhoods. Enhancements of the pre-Katrina public/private partnerships with academic physicians, residents, and medical students caring for patients, including the uninsured, in private hospitals should also be encouraged. Special fund pools, however, may need to be established so that regional hospitals, already suffering from additional expenses and loss of revenue, are not crushed under this additional financial burden.¹⁶

Alternatively, the state could decide to expand funding to Medicaid/LACHIP to allow care to be delivered in the private sector. This unfortunately does not cover all groups that may fall into the current expensive and inefficient healthcare safety net.

The state of Maryland addressed the problem three decades ago by a mandatory state regulated hospital payment system that incorporates the uninsured. All monies from insurance, Medicaid, and Medicare are pooled. Hospitals are paid for all care in a predictable manner that prevents cost shifting and does not discriminate among payers. This makes payments to the hospital system more equitable and ensures that all indigent care is compensated. This system would require all payers to participate and a Medicare waiver would be needed.

Another model, used in Massachusetts, requires all hospitals to perform a certain amount of uncompensated care with the largest portion going to an academic medical center, which acts as a safety net. Thus, not-for-profit hospitals meet their public duty in treating the uninsured and Medicaid in order to maintain their tax-exempt status. Those hospitals failing to meet their uncompensated care goal must pay money back to the safety net hospital equal to the share of the uncompensated care the hospital failed to meet. This ensures that the safety net hospital has adequate resources to meet its capital plan and maintain quality care, in spite of a disproportionate amount of uncompensated patients. Changes in legislation and state regulations would obviously be required for this plan. Other models should be identified and explored by the appropriate policy-makers before a final decision is reached.

In the development of a “model” healthcare system in the metropolitan New Orleans area, in which hospital and specialty care treatment for the uninsured is distributed across other hospitals and specialty care facilities across the area, it is critical that the cooperation that began

¹⁶ As noted in a recent article in the *Times-Picayune*, in Charity’s absence, other area hospitals have seen marked increases in the number of uninsured patients they have treated, and they complain that their tight budgets are being stretched further. For example, according to this article which quotes Dr. Mark Peters, CEO of East Jefferson General Hospital in Metairie, the proportion of uninsured patients visiting the emergency room has jumped from 5% to 18% and patients without insurance coverage are filling about 9% of the hospital’s general-care beds, compared with 3% pre-Katrina.

in the aftermath of Katrina be continued. Specifically, the Committee recognizes and recommends the following:

- The sharing of services between hospitals that began immediately after Katrina continues unabated today. Facilities in Jefferson Parish that sustained much less damage and loss of patient population than those in Orleans Parish continue to provide full support of some services such as blood banking and partial support for a variety of operational elements including indigent care and trauma services.
- Today, cooperative agreements are the only viable option to sustain health care services in much of the region. These initial short-term, cooperative agreements, such as the one for trauma care, can become the prototype for more rational, effective healthcare planning in the longer term. Market forces, which may not operate efficiently for health care in the best of conditions, should not be expected to completely guide recovery of health services to a devastated community. The short-term and long-term model must remain that of cooperation, not competition.
- Cooperative agreements would not have been considered in the extraordinarily competitive pre-Katrina milieu, structured over time in the absence of health services planning in the face of stagnant population growth, economic weakness, and decaying infrastructure. Changes in the abilities of the healthcare delivery sector and the reduced population of Orleans, St. Bernard and Plaquemines Parishes provide an opportunity to develop a planned framework for recovery based upon public-private partnerships.
- The smaller population that remains and the decreased healthcare dollars available cannot support duplicative and unnecessarily expensive, organizationally focused efforts.
- Therefore, regional cooperative healthcare planning that was started by the Greater New Orleans Healthcare Taskforce should be continued in a formal planning organization whose members are representatives of all hospitals, healthcare training institutions, EMS, human services agencies, and parish representatives in the GNO region.

Medical Center of Louisiana: Redefinition of the Mission and Goals

For 270 years, Charity Hospital, and later as part of the Medical Center of Louisiana (“MCL”), was the primary provider of care for the indigent and under-insured population of New Orleans. It must be recognized that Charity Hospital performed an important service to our region and state. “For most of New Orleans’ history, Charity Hospital was at the epicenter of the city’s medical community, as a center for treating victims of trauma and grave disease – especially the poor and uninsured – and as the training ground for most of Louisiana’s doctors.” Times-Picayune, January 9, 2006. The majority of Louisiana physicians (70%) received some form of training at Charity Hospital, which also serviced our region as the Level One Trauma

Center. Charity Hospital's tradition ended in August with Hurricane Katrina. "Post-Katrina floods inundated the basement, wrecked wiring and plumbing and trashed medical equipment, much of which was so old that replacement parts aren't made anymore." Times-Picayune, January 9, 2006.

Over the past two decades healthcare services and the delivery of health have changed significantly. In the past, healthcare served only to treat the infirm. Now, it not only encompasses the infirm, but healthcare must provide chronic disease management and disease prevention. New technologies and web-based tracking in an electronic health record change the face of healthcare. Notwithstanding the devastation brought by Hurricane Katrina, it has provided our community with the opportunity to model healthcare for the 21st Century – to bring indigent and poorly compensated care to the forefront, and to emphasize quality, research, and efficiency (the best care at the least cost). The new MCL should work in concert with the other regional academic healthcare centers to provide a network of specialty care to the citizens of the region.

(a) Academic Medical Centers: The role of an Academic Medical Center ("AMC") is to define and to deliver quality healthcare through its patient centered use of basic science, translational and clinical research. By re-establishing some AMC(s) (LSU-MCL and Tulane) in a cooperative network with Ochsner Foundation Hospital, Xavier University and other hospitals and universities committed to providing training sites and research for the community, we would continue the efforts to prevent, manage, and treat the diseases that afflict the citizens of the greater New Orleans region. AMC(s) serve as the focal point for numerous centers of excellence, including but not limited to, a Center of Excellence in Healthcare Disaster Management and a Center of Excellence in Black/Afro-American Healthcare.¹⁷ AMCs provide published research in peer-reviewed journals which contribute to improving both community and worldwide healthcare. Clinically, the care provided is a source of graduate medical education for health care providers who are desperately needed throughout the state. AMCs collaborate within the university spheres locally and nationally to reach across disciplines in associated departments, schools, and disciplines assuring that health care dollars will be effectively and efficiently spent. Finally, the AMC(s) will serve as a key economic driver in rebuilding this area through partnerships with the pharmaceutical industry, healthcare technology and health informatics.

At present, New Orleans has baseline resources to establish a multi-facility, academic medical center. The loss of several facilities throughout the area has left us with a critical hospital bed shortage and today hinders our rebuilding efforts. Now, more than ever, New Orleans needs the Schools of Public Health that assist in providing disease prevention and epidemiological resources. The Allied Health, Nursing, Medical Schools and School of Public

¹⁷ For example, the National Cancer Institute recently awarded Tulane University and Xavier University \$1.4 million to develop biomedical research and education programs to address the disparities in statistics between Caucasians and African-Americans in the incidence of cancers and overall death rates from cancer. Researchers plan to develop collaborative cancer-research initiatives and grant submissions; recruit more African-American students into cancer research, education and policy development; and develop a course on cultural competence and diversity to train faculty, researchers and students. See Gambit Weekly, January 3, 2006.

Health provide health care providers and expertise throughout the state while the Graduate Studies program provided research bases that are key to any program.

As discussed earlier in this report, Louisiana has one of the highest uninsured and Medicaid-based systems per capita in the country, and a rebuilt healthcare system for metropolitan New Orleans should include care for the indigent that equals, at a minimum, private care access, quality and outcomes. In addition to other options discussed earlier in this report, one solution to address this problem is the AMCs and their corresponding centers of excellence. The AMCs would continue the mission of Charity and MCL by maintaining the almost three-century tradition of caring for the citizens of Louisiana, and would also position New Orleans as a leader in healthcare while providing care to our client base. Moreover, the AMCs would provide economic incentives in rebuilding an industry that brings jobs and revenues back into the community. Specifically, by developing Centers of Excellence for cancer, Alzheimer's, coronary vascular disease, infectious disease and other population-based programs, the AMCs would be at the forefront of medicine. The Greater New Orleans area would be in a better position to accommodate the changing healthcare needs of our citizens, while significantly increasing the attractiveness of this area to incoming businesses as a vibrant atmosphere for the development of scientifically based, progressive healthcare programs.

To accomplish this mission, the MCL portion of the academic medical center must have a viable capital plan with sufficient resources to set standards of quality, excellence and efficiency. In the past, MCLNO equipment was obsolete and MCLNO was hampered by an infrastructure and legislated expenditure cap that prevented the acquisition and developing of new technology, such as medical informatics. As everyone is aware, technology grows at an exponential rate that is daunting at best. Pair this with the challenge of providing uncompensated care without adequate financing and the original operational mission becomes overwhelming to the institution and its stakeholders. To ignore the need for a viable capital plan operating on sound business principles would be to ignore the health care needs of this area.

There are several ways to address having sufficient resources to support this recommendation. First, the Committee recognizes that the state alone does not have the resources to completely fund an AMC. Constitutional restrictions and budgetary cuts led to the financial instability of the public hospitals prior to Katrina, such that alternative funding must be sought. It is recommended that the appropriate entities and individuals on a state and federal level explore and examine how other states or facilities have solved this difficult problem, including an evaluation of the operation of the LSU Hospital and Health Sciences Center at Shreveport.

In light of already depleted state resources, the Committee also recommends changes to the governmental payment systems, and that different governance models such as an independent public benefit corporation, a hospital service district and others be explored to manage a new academic medical center. As discussed earlier in this report, this could be augmented by an enhancement of the pre Katrina public/private partnerships with academic physicians, residents, and medical students caring for patients, including the uninsured, in private hospitals as well as collaborating in research and healthcare policy.

(b) **University Teaching Hospital:** The Committee recommends that a modern, up-to-date university teaching hospital be rebuilt to accommodate LSU, Tulane and possibly the VA, and provide quality healthcare services to all citizens, and that this replace the deteriorated, antiquated facilities damaged by Katrina, which provided a two-tiered system of healthcare. As Dr. Larry Hollier, Dean and Chancellor of the LSUHSC stated, “[Charity] was a wonderful training ground, and I think many people have difficulty letting go of what was there, but a lot of people have tried to cling to a vision in New Orleans that was not there,” alluding to the hospital’s decline in recent years. “What’s more important is that we assess the situation and see what opportunities there might be and build something better for the future.” Times-Picayune, January 9, 2006.

(c) **Trauma Center:** The Level 1 Trauma Center has always been a cooperative effort of both LSU and Tulane. The skill sets for the treatment of trauma patients, from the time they enter the ER through the immediate recovery phase must be available for our citizens, workers, local and other, and our visitors. While on the surface, trauma centers are cost losers, we must not overlook the indirect dollars that accrue to the City because citizens, workers and visitors know that a Level 1 trauma center exists, if they need it. Successful Level 1 Trauma Centers, both national and international, should be studied structurally, operationally and financially as plans for the new Level 1 Trauma Center are developed. A Level 1 Trauma Center must be part of the AMC to provide tertiary services for trauma victims in the greater New Orleans area and surrounding parishes. The Committee recognizes that University Hospital is being remediated and may provide a Trauma Center, and that major trauma care may be transferred to Elmwood Medical Center as early as March 1, 2006. While utilization of a remediated University Hospital is critical to the immediate and short-term delivery of necessary healthcare services to our citizenry, the Committee believes that this is not a long-term solution to the issues discussed above.

(d) **St. Charles General:** To further offload the private hospitals of the acute care hospital needs, Touro Infirmary recently announced the purchase of St. Charles General Hospital to meet the growing demand for services.

3. ***ENVIRONMENTAL HEALTH: Environmental health entity within Department of Health; and workforce development.***

Entity Within City Health Department

It is recommended that a core environmental health entity be established within the New Orleans Department of Health to serve as a coordinating body, charged with facilitating collaboration on environmental health issues among City health, environmental, planning and economic agencies or organizational entities. This entity would also serve as a central point of coordination with State and federal counterparts to ensure a safe environment (i.e. safe drinking water; food safety; air quality), as well as a “one-stop-shop” for environmental health information for communities. The Committee believes that this entity can be established within a 6-12 month timeframe, and the initial resources will require operating funds for staffing and program support.

Workforce Development

It is recommended that a comprehensive environmental health workforce development program be implemented to educate, train and hire environmental public health professionals. Activities would include short-term training of a cadre of current City Health Department professional staff in environmental health areas of greatest need (air, soils etc); graduate student internship and rotation placement in environmental health at the City and State level; as well as identifying possible scholarships for graduate education in environmental health. The Committee believes that this can be implemented over a period of six months to three years and that outside grants and funding can be explored for operational expenses. This would also continue the public-private partnerships that have been operating in the health care and social services areas in the aftermath of Katrina.

4. HEALTH PROMOTION AND CHRONIC DISEASE PREVENTION: Establish staff and an ongoing program.

Prior to and certainly after Katrina, the need to promote good and healthy living and work to prevent chronic diseases was recognized in the New Orleans Community. Too many of our citizens are ill or die from unhealthy diets and lifestyles as well as the failure to address a number of chronic diseases that plague our community. This must change and therefore the Committee strongly recommends health promotion and prevention of chronic disease.

Health Promotion

It is recommended that public health agencies deliver health promotion messages that address the leading underlying causes of morbidity and mortality, particularly chronic diseases, injuries, and the behaviors that lead to them. Messages should be delivered through both the mass media and community outreach, with enough reach and frequency to have a population-level impact.

Chronic Disease Prevention

As discussed earlier in this report, public health agencies should work with primary care providers to promote screening and early detection of chronic diseases.

5. TECHNOLOGY – ELECTRONIC MEDICAL RECORDS AND DATABASES: Interoperable electronic medical records as the norm in the region. Databases supporting public health and human services.

Interoperable Electronic Medical Records

Comprehensive “holistic” type information systems which maximize opportunities to coordinate patient care and community resources are critical to being able to maximize efficiency, reduce duplication, improve health outcomes and increase cost savings to the system. We are persuaded that such system redesign should include the integration of health information technology consistent with the national health information infrastructure strategy and that:

- Informs clinical practice,

- Interconnects clinicians,
- Personalizes health care, and
- Improve population health.

We would expect that a significant component of major system redesign would be the adoption and use of health information technology within practice settings and the promotion of clinical data exchange across and among practices within a community, prototypes for a national health information network.

President George W. Bush in his 2004 State of the Union address announced, “By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care.” President Bush maintained an ambitious goal of assuring that most Americans have electronic health records within the next 10 years. The Institute of Medicine report expressed concern that our highly fragmented healthcare delivery system largely lacks even rudimentary clinical information capabilities which result in poorly designed care processes characterized by unnecessary duplication of services and long waiting times and delays. This fragmented system results in medical errors which produce a need for additional health care services to treat patients who have been harmed (Institute of Medicine, 2000b). For healthcare to be delivered safely and efficiently, an interoperable electronic health record (EHR) is necessary. This is an opportunity for the city of New Orleans and the state of Louisiana to turn the Katrina disaster into a healthcare success by instituting an interoperable EHR. The EHR is simply the set of healthcare data that is stored or transmitted to other locations. Interoperability is the ability to interconnect health providers to each other and to hospitals, laboratories, radiology centers, pharmacies, and payers instantaneously and seamlessly exchange healthcare information.

An interoperable EHR has important clinical and financial ramifications. Clinically, the EHR provides improved documentation, enhances access to patient data, and increases patient safety. Notes are typed and legible. Templates lead to more complete documentation. Providers seamlessly access all of a patient’s records whether seen in a hospital, a specialist’s office, or in the provider’s clinic. Information from all sources is collated. Links to the literature or clinical pathways make decision-making easier, assuring that the latest in evidence-based medicine is used. Patient safety is enhanced by eliminating mistakes. Because medical providers are aware of all the patient’s medications, duplication and medication interaction are avoided because integrated decision support system advises providers of potential medication interactions. The computer physician order entry system in the EHR has been shown to reduce errors in drug prescribing and dosing. The provider is notified of critical laboratories or x-ray findings. These EHR features promote safe and efficient quality care.

Financially, cost savings are seen from improved workflow, more efficient care and improved charge capture and billing. Improved data acquisition saves time, which improves workflow. Repeating recent lab work or expensive radiologic studies can be avoided because patient records are readily accessible. This improves workflow thereby diminishing duplicate costs. Prescription refills are done at the touch of a button, saving time and money and filling costs are reduced. Additionally, the EHR encourages appropriate documentation for improved charge capture. This promotes efficient billing of payers.

Public Health and Human Services Databases

In addition to an interoperable EHR related to medical records, the Committee recommends that coordinated technology be utilized in the public health and human services areas, which will provide equitable and easy access to integrated health and human service information through a centralized call-in and web-based system. Building upon pre-existing community work and resources, a coordinated, regional, continuously updated central database can be used to collect accurate information about human service needs and available resources.

As discussed in greater detail in the Human Services section of this report, it is recommended by the Committee that a human service collaborative, the Katrina Community Based Services Network (“KCBSN”), be established to serve as a new independent umbrella organization, whose role is to:

- Bring separately functioning major nonprofit human services agencies together;
- Make their services easier to access for people in need by coordinating their management;
- Ensure that information about benefits and programs are widely known;
- Jointly train agency staffs on services and needs; and
- Identify and resolve operational issues to assure efficient and proper management of resources.

Similar to the Committee’s recommendation concerning the development of a system for interoperable electronic medical records, one of the specific, recommended operational components of the KCBSN is the maximization of technology. Specifically, use of technology will strengthen the efficiency of both the coordinated intake and service coordination systems.¹⁸ Computerized information systems will support and facilitate an intake process that eliminates the submission of documents to multiple front-line workers and enables information to be easily accessed on-line at any time in the future. Most importantly, technological applications will maintain and inform the network of service providers to improve communications and service to service recipients. The technology applications will be as follows:

- A searchable, centralized directory of benefits and services information will enable Service Coordinators to quickly locate the latest benefits and services information for individuals and families affected by the disaster. This directory will also be available on-line as a Community Web Site and Online Assistance Guide for public use, to directly inform citizens about the various kinds of help for which they may be eligible and can access.

¹⁸ *These systems are discussed in the Human Services section of this report.*

- An electronic intake system will support front-line workers conducting initial client data gathering. This electronic system will include the scanning and saving of critical documentation, streamlining the process of information provisions for individuals and families.
- A confidential database will be used to enter client data from initial intake. Service coordinators will update client information throughout the recovery process via their respective agencies' client information systems. The database will act as an information repository and valuable reference tool, enabling all service coordinators to better understand the specific circumstances of the individual and/or family they are working to help.

6. REGIONAL HEALTHCARE COLLABORATIVE: *Establish a collaborative regional group focused on coordinated cooperative efforts in healthcare.*

Background

The extraordinarily competitive pre-Katrina milieu, structured over time in an almost total absence of health services planning and in the face of stagnant population growth, economic weakness and decaying infrastructure, left the City in a vulnerable and poorly served situation. Immediately after Katrina, the Greater New Orleans Healthcare Taskforce was assembled in order to begin a process of coordinated regional thought and planning – albeit on an emergency basis.

As noted earlier in the report, the sharing of services between hospitals that began immediately after Katrina continues unabated today, and cooperative agreements are necessary to sustain health care services in much of the region.

The Bring New Orleans Back Commission (“BNOB”) formed the Health and Social Services Committee. That Committee has brought together an extraordinary combination of public and private participants in the region’s healthcare and human services fields. We should not lose that initiative, coordination and cooperation. Instead, we should perpetuate it and make it more regional.

Recommendation

It is recommended that a collaborative regional organization be formed, utilizing the name “Greater New Orleans Healthcare Taskforce”. In order to achieve a sustainable functioning collaborative effort of this nature, the following components of such a collaborative effort must be put in place:

- Identify a convener of stature. We recommend that Secretary Leavitt of the U.S. Department of Health and Human Services appoint a top official at DHHS to serve in this role.
- Clearly and narrowly define the problems to be addressed.
- Identify a committed leader – the manager of the collaborative.

- Prepare a written charter for the collaborative organization, specifying such things as:
 - The clear definition of the problems to be addressed.
 - How such issues will be addressed and concluded.
 - Financing of the collaborative organization.
 - Governance structure for the collaborative organization.
- Establish a critical mass of key participants from the region.
- Ensure that principals of substance are those at the table for the participants.
- Ensure that constructive critics are also at the table.

The collaborative effort must be established in such a way that participation is voluntary, but where the participants wish to continue to participate because of a recognition that they are better off participating than not. The collaborative organization must function in an atmosphere that can produce success and an atmosphere of decision making, not merely conversation.

In order for the collaborative to be effective, it will be necessary to develop the necessary statistical information, population data, demographic information and other critical background upon which such a collaborative organization must rely. That must be done professionally, and financing for such an effort must be identified. See Priority Recommendation No. 7.

7. ORDERLY DEVELOPMENT OF RELIABLE CENSUS AND OTHER STATISTICAL INFORMATION: *Retain a professional organization to provide statistical information with regard to the population in the region being served, with a particular focus on Orleans Parish as its population and the related demographics change.*

The healthcare system serves the region, not simply the City of New Orleans. Prior to Katrina, the Greater New Orleans area had a population of approximately 1.3 million, with approximately 485,000 of those people living in the City of New Orleans. Current projections suggest that one year after Katrina, the population of the Greater New Orleans area may be at 1.2 million, with approximately 200,000 to 250,000 living in the City of New Orleans. Whether those predictions prove to be precisely accurate or not, they certainly illustrate the fluid nature of the dynamics of population in the region.

It is not possible to do effective healthcare planning without clear information – information as to population and the demographics of that population that is reliable and generally accepted by key participants in any collaborative effort. That cannot be accomplished on an informal basis. Instead, it must be done by professionals, something that will not occur at a useful level without substantial financing that can be counted on over a sustained period of time.

It is also going to be important for that information to be updated in relatively short intervals of time (perhaps quarterly, if not monthly), as the population base in the region – and more particularly in the City of New Orleans – is likely to be changing fairly rapidly, at least over the next two years. Doing such population and demographic surveys with that frequency obviously will add to the cost and the challenge.

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HOSPITALS AND SPECIALTY CARE

INTRODUCTION

As discussed in the Priority Recommendations section of this report, the Committee recommends that emphasis be placed on developing a continuum of care with an ambulatory care system of preventative medicine and diagnostic screening services based on the needs of the population at risk and having strong ties to community hospitals and specialty care. Strong ties to community hospitals are developed by referral systems for diagnostic services and specialty care, enhanced by interoperability and exchange of information by using an electronic medical record containing an essential data set able of being accessed at each patient encounter.

Of critical importance is the availability of hospital beds to support the emerging population. Availability of beds should include medical surgical beds and critical beds complemented by specialty beds in the area of trauma, long term acute care (LTAC), rehabilitation and behavioral health.

BACKGROUND

Prior to Hurricane Katrina, the Greater New Orleans area had fifteen (15) acute care hospitals with 5063 licensed beds. While eighty per cent (80%) of the beds were staffed on a daily basis, problems still existed with inadequate critical care and behavioral health beds.

Hurricane Katrina and the resulting levee breaches caused the closure of all New Orleans and St. Bernard hospitals plus some Jefferson Parish hospitals. The Medical Center of Louisiana's closure brought about the loss of both the "safety net" hospital for the poor and the Level 1 Trauma Center. Since August 29th, most of the trauma services and indigent care have been provided by three (3) Jefferson Parish Hospitals, namely West Jefferson Medical Center, East Jefferson General Hospital and Ochsner Foundation Hospital. As of December, 2005, 1,697 hospital beds were staffed and open. Cooperation between the public and private sectors through the work of the Greater New Orleans Healthcare Taskforce have contributed to the local healthcare community with the assistance of the National Defense Medical System being able to provide the necessary medical services during the immediate aftermath of the storms and during the recovery period.

The changes in the capabilities of the healthcare delivery sector and the reduced population provide an opportunity for positive change. The development of a framework for recovery and healthcare excellence should continue over time and as the population returns to the area. As discussed throughout this report, a private-public partnership is key in designing the new framework. This framework should not seek to rebuild what was but rather develop what will be needed for the future, what we should and must have for all our citizens. This effort

requires two parts: one for maintenance during recovery and a second part for planning the future of health care in the greater New Orleans area.

RECOMMENDATIONS

Staffed Beds

In order to plan for sufficient beds for the returning population, accurate census numbers must be tracked continuously on a monthly basis over at least the next year and then at intervals determined by the twelve months distribution pattern.¹⁹ Predicting numbers of population correctly is a major concern for the provision of health care services in the area. At present, the numbers for the basis of this recommendation have been gathered from many sources both colloquial and scientifically determined.

Based upon an estimate of sixty-five per cent (65%) of the regional population returning by July 1, 2006, it is estimated that seven hundred beds (700) are needed in Orleans Parish by July 1, 2006. As seen in the chart below, it is predicted that at least seven hundred seventy (770) beds should be available by that time. But, be careful with those predictions. As of early January there are only 388 staffed beds in Orleans Parish, and all facilities in the region are facing severe staffing problems. For the GNO region as a whole, it is predicted that fifty-eight (58%) of the pre-Katrina staffed beds will be available by July 1, 2006.²⁰

While these numbers represent a very rough estimate of the beds needed, they do provide a tool to use to gauge whether appropriate progress is being made towards having the beds available for the returning population.

Here are projections we have been given for the longer term:

Parish By Parish Statistics

Parish	2004 Census	Estimate of Returning Population	% of Population
Orleans	484,673	250,000	54%
Jefferson	455,467	362,872	80%
St. Bernard	67,230	16,338	25%
Plaquemines	26,760	23,175	80%
Totals	1,034,130	652,385	65%

Furthermore, as the population returns, the need for a different selection of beds may emerge. Flexibility must be present in the delivery system to adjust to possible new and changing demands for healthcare services. It is not just a question of how much of the population will return but also what segments of the population will return. How many children will return and

¹⁹ The necessity of having accurate census numbers is Priority Recommendation No. 7, discussed earlier in this report.

²⁰ These numbers represent a predicted moment in time (July 1, 2006) in order to illustrate the large points. At the 54% return rate for Orleans Parish over a longer term (see below), the estimated bed count rises to 2,269.

at what time interval? How many of the elderly and special needs population will return? What will be the need for rehabilitation, behavioral and mental health and inpatient prisoner designated beds. What will be the need for patients with addictive disorders as well as the HIV and Aids populations? Provisions must be made to facilitate adjustments as we recognize the human and financial needs of the returning population.

HOSPITAL BEDS

Hospitals	Licensed Beds	Pre-Katrina Staffed Beds	December 2005 Staffed Beds	Beds Needed by July 1	Increase
Thalmette General	194	138	0	0	
Children's	201	175	115	150	+35
EJ	444	444	444	444	
Kenner	203	162	60	100	+40
Lakeside	102	102	71	102	+31
Lindy Boggs	187	168	0	0	
Meadowcrest	207	179	60	150	+90
MCLNO	914	500	0	200	+200
Memorial	318	252	0	0	
Methodist	350	261	0	0	
Ochsner	472	472	472	472	
Touro	504	345	145	200	+55
Tulane	362	362	0	120	+120
VA	354	206	0	100	+100
West Jefferson	451	317	330	350	+20
Totals	5063	4083	1697	2388	+691

Staffing

There is a second, though certainly not “secondary”, issue of concern in providing adequate access to hospital beds in the region. As of December 2005, Orleans Parish had two hundred and sixty (260) staffed beds. In order to triple the number of staffed beds within 6 months, extraordinary expense will be incurred for temporary housing of staff, day care services for staff, facility improvements and repairs, and premium pay to attract staff on short notice. If 510 beds are added to accommodate a population of 250,000, approximately 2,550 staff will be needed (5 FTEs per occupied bed). Hiring this many healthcare workers within 6 months is a huge challenge and many will have to be hired on a temporary basis at premium rates. Hospitals are locked into preset reimbursement arrangements which will not reflect these extraordinary expenses. Besides assistance from FEMA for housing and facility repair, some short term supplemental funding must be identified to assist hospitals with the burden of providing premium pay and non-traditional assistance such as day care.

Additionally, not only Graduate Medical Education for physicians, but also nursing and allied health education were brought to a halt in New Orleans by Hurricane Katrina. As our schools and universities return, program assessments must be made to meet our immediate and future needs. Possible items for consideration are an increase in the number of associate degree registered nurse and LPN to RN programs. Hospitals that previously didn't serve as program training sites may need to open their doors. Pay scale adjustments and better working conditions may need to be planned. And, while we practice the Disney plan of customer service, the Burger

King plan for wages and benefits (bonuses in this market) must be considered in order to have sufficient non-professional labor for our hospitals.

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PRIMARY CARE

INTRODUCTION

The tragic destruction of Hurricane Katrina has provided the Greater New Orleans Metropolitan area with the unique opportunity to develop a primary care system which is the envy of metropolitan areas across the country. By learning from other effective primary care models in the country, and building on the foundation of a number of efforts which were underway, we can take full advantage of that opportunity.

Our ultimate vision for the post-Katrina health system of New Orleans is one in which every citizen has a “medical home” that provides high quality, cost-effective care that is responsive to their needs and perspectives. This “medical home” should be supported by a world class health information technology system with decision support and innovative financing that drives patients into primary care.²¹ The described system would be formed as a public-private partnership and serve the needs of all citizens, irrespective of age, race/ethnicity or insurance status.

The Committee believes that a well designed primary care system has the following characteristics:

- Increase in the effectiveness of the health care delivered, minimizing the over and under-utilization of services through the use of best practice guidelines and other measures.
- Patient-centeredness in the delivery of care is a priority with primary focus on patients’ needs and comfort, including increased emphasis on patient education and development of self-care skills.
- Improvement in the timeliness of care, significantly reducing delay in the delivery of needed health care services.
- Emphasis on ways of improving efficiency in care delivery and thus improving quality.
- Assurance of equity of care for all persons.

²¹ *The necessity of establishing a health information technology system and exploring various options for innovative financing were discussed, in detail, in the Priority Recommendations section of this report.*

BACKGROUND

(a) Key Statistics

Primary care provider needs:

- 1 full-time equivalent primary care physician per 3000 residents.
- 1 mid-level provider per 5,000 residents.

Greater Metropolitan Area Repopulation Estimates

	Baseline	Current (%)		6 months (%)		1 year (%)		3 years (%)		5 years (%)	
Orleans Parish	484,673	101,781	21%	242,337	50%	266,570	55%	290,804	60%	363,505	75%
Jefferson Parish	455,467	400,811	88%	455,467	100%	501,014	110%	546,560	120%	546,560	120%
St. Bernard Parish	67,230	6,723	10%	16,808	25%	26,892	40%	43,700	65%	43,700	65%
Plaquemines Parish	26,760	2,676	10%	6,690	25%	9,366	35%	12,042	45%	16,056	60%
Total	1,034,130									969,821	80%

Based on the described assumptions of the population, for Orleans Parish it is estimated that we will need 121 primary care physicians at the end of 5 years, along with the enabling and support services. For the Greater New Orleans Metropolitan Area, it is estimated that we will require 323 PCPs. In the described community-based models, mid-level providers play an integral role in primary care. We estimate that 73 mid-level providers will be needed for Orleans Parish in 5 years, with 194 needed in the Greater New Orleans Metropolitan Area.

Estimated Primary Care Physician Needs

	Baseline	Current	PCP	6 months	PCP	1 year	PCP	3 years	PCP	5 years	PCP
Orleans Parish	484,673	101,781	34	242,337	81	266,570	89	290,804	97	363,505	121
Jefferson Parish	455,467	400,811	134	455,467	152	501,014	167	546,560	182	546,560	182
St. Bernard Parish	67,230	6,723	2	16,808	6	26,892	9	43,700	15	43,700	15
Plaquemines Parish	26,760	2,676	1	6,690	2	9,366	3	12,042	4	16,056	5
Total			171		240		268		298		323

*PCP: Primary Care Physician

Estimated Mid-Level Provider Needs

	Baseline	Current	MLP	6 months	MLP	1 year	MLP	3 years	MLP	5 years	MLP
Orleans Parish	484,673	101,781	20	242,337	48	266,570	53	290,804	58	363,505	73
Jefferson Parish	455,467	400,811	80	455,467	91	501,014	100	546,560	109	546,560	109
St. Bernard Parish	67,230	6,723	1	16,808	3	26,892	5	43,700	9	43,700	9
Plaquemines Parish	26,760	2,676	1	6,690	1	9,366	2	12,042	2	16,056	3
Total			102		144		161		179		194

*MLP: Mid-level Provider

(b) Damage to Louisiana's Health Care Infrastructure

The Louisiana Department of Health and Hospitals – Bureau of Primary Care and Rural health, quantified acute care and small rural hospitals, primary care, public health, addictive disorders, community mental health and developmental disability facilities that were either closed indefinitely due to hurricane damage, closed temporarily with plans to reopen, or partially functioning as a result of Hurricanes Katrina and Rita as of October 10, 2005. A total of 63 of these facilities are closed indefinitely, 45 closed temporarily and 13 currently only partially functioning. Of critical impact to our community, 68% of the facilities that are indefinitely closed are located in Orleans and Jefferson parishes, while less than 14% of all affected facilities are located in rural parishes.

(c) **Displacement and Immediate Response**

The University of North Carolina at Chapel Hill's recent study on medical manpower in Hurricane Katrina affected areas shows that almost 6,000 active, patient-care physicians have been displaced by the storm. Over two-thirds – 4,486—of those were in the three central New Orleans parishes that were evacuated. This constitutes the largest single displacement of doctors in U.S. history. The study also estimates that over 35% of the displaced physicians in the three central New Orleans parishes are primary care physicians.

In the immediate aftermath of the hurricane, physicians created make-shift clinic sites to provide care to first responders and the citizens of the city. This care was and is being delivered in a variety of locations across the metropolitan area, generally in facilities that were not part of the established infrastructure prior to the storm.

This is particularly true of the safety net facilities. Currently, 7 safety net clinics are operating in metropolitan area, staffed by approximately 20 full-time physician equivalents. These services currently rely upon support from federal resources such as the USPHS for equipment and care delivery.

RECOMMENDATIONS

Staffing Recommendations

Identify staffing needs in terms of both primary care and subspecialties within the City and create incentives for those professionals who work in Orleans Parish. Incentives to consider include:

- Expanding Health Professionals Shortage Area Designations.
- Restructure graduate medical education (GME) financing to ensure that payments for residency training are not predicated on in-patient metrics.
- Loan repayment through the National Health Service Corp and other mechanisms.
- Bridging grants.

System-wide Recommendations

While several of these recommendations have already been addressed in the report, it is important that they be restated because of their impact on the development of an effective regional primary care system in the metropolitan New Orleans area.

- Use a regional approach to developing a primary care system in metropolitan New Orleans
- Develop a strong, sustainable and effective healthcare collaborative to enable ongoing planning and evaluation of the metropolitan health system.

- The system should be evidence-based, high quality and cost-effective.
- The system should be supported by a clinical information system with decision support, a standards based electronic health record, and capability for health information exchange.
- Health promotion and preventive care should be the key elements in the system.

Workforce recommendations

- Recognizing the importance of integration of subspecialty care and hospital care in an effective primary care system, assess the number of subspecialists in the area and the number and type of hospital facilities. Consider offering incentives to subspecialists to relocate to New Orleans in specialties deemed to be diminished beyond the population needs.
- Advocate for continuation of graduate medical education programs and allied health professional education programs in the New Orleans area.
- Restructure graduate medical education (GME) financing to ensure that payments for residency training are not predicated on inpatient metrics.

System financing recommendations

- Provide financial incentives for primary care providers to remain or relocate into the New Orleans metropolitan area including loan forgiveness, loan repayment through the National Health Service Corps and other mechanisms, and bridging grants.
- Allow liberal allocation of disproportionate share money and uncompensated care dollars outside of the health care services division.
- Encourage relaxation of requirements about the structure of FQHCs to encourage the expansion of the existing FQHC network and the development of new licenses.
- Provide fiscal support for grant writing, including for demonstration projects, so as to maximize the federal and other opportunities for financial support.
- Support a group of stakeholders to work collaboratively with national experts and state and federal officials to recommend redesign of the financing system to adequately support primary care for all citizens and to measure and monitor the effect of the new health system on the returning population of the Greater New Orleans area.

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PUBLIC HEALTH

RECOMMENDATIONS

The Committee makes the following recommendations concerning public health. Specifically, in the area of health assessment, it is recommended that long-term environmental monitoring and human health surveillance systems should be established to monitor the impact of the changed environment on health, and that special studies be done to measure expected health effects, identify unexpected health effects, and address residents' concerns about health risks related to the disaster. This health assessment should be initiated within six (6) months.

Similarly, public health agencies in the greater New Orleans area should have a comprehensive package of surveillance systems that add syndromic, risk factor, injury surveillance, mental health/substance abuse surveillance, and environmental tracking to existing etiologic disease surveillance systems. As discussed earlier in the Priority Recommendations section of this report concerning community health clinics, it is recommended that specialized clinics for treatment of HIV infection and tuberculosis be reestablished. Further, basic STD diagnosis and treatment should be integrated into primary care systems to protect confidentiality and prevent stigmatization, and such treatment should continue to be without costs and without barriers to access.

In the aftermath of Katrina, it is also recommended that comprehensive communicable disease control programs include the following: oversight systems to assure the delivery of high quality clinical services for HIV, STD and TB; screening and treatment of high-risk populations such as jails, homeless shelters and others; contact tracing; and condom distribution programs and other risk-reduction programs. Also, it is recommended that the necessary infrastructure be established to provide immunizations to the city's general population, particularly, but not limited to, immunization against pandemic influenza.

A system of community outreach should be established for persons and populations at high risk. This system should be integrated and holistic rather than disease-specific, and should be linked to neighborhood-based primary care services.

The New Orleans Health Department, the Region 1 Health office and the Office of Public Health should assure that all of the 10 essential core public health services are fully and adequately conducted with no gaps and minimal overlap. These services are:

- Monitor health status and understand health issues facing the community.
- Protect people from health problems and health hazards.
- Give people information they need to make healthy choices.
- Engage the community to identify and solve health problems.

- Develop public health policies and plans.
- Enforce public health laws and regulations.
- Help people receive health services.
- Maintain a competent public health workforce.
- Evaluate and improve programs and interventions.
- Contribute to the evidence base of public health.

As part of its assurance role, the New Orleans Health Department, the Region 1 Health office, and the Office of Public Health should assure that high quality clinical services are available for all members of the population, and governmental public health entities should work with other organizations (e.g. universities, nonprofit organizations) to take advantage of the strengths and resources of these organizations in promoting the public's health.

In addressing these core public health recommendations, the Committee recognizes that additional resources and personnel are needed, as listed below:

- Staff and laboratory testing to monitor health effects; funding for special studies on long-term assessment of effect of hurricane on health.
- Computers, software, information technology support, and related resources.
- Staff for an epidemiology unit at the New Orleans Health Department.
- Funding to contract for public health expertise not available within government agencies.
- Construction/repair and staff to re-establish HIV and TB clinics.
- Staff to oversee STD care in primary care clinics, funding for STD screening and treatment in various sites, and conducting other communicable disease control activities.
- Staff and other infrastructure to provide immunizations to the general population.
- Staff for health promotion unit(s) and funding for message production and placement.
- Staff to work with primary care providers to enhance prevention services in primary care.
- Community outreach staff.

- Staff to work with city planners and public works department to help design and develop health-promoting neighborhoods.
- Increased public health staff and funding for contracts to address other essential services not currently addressed.

**PUBLIC/PRIVATE PARTNERSHIPS
AND USE OF FEDERAL FUNDS**

Because they address the entire population and have statutory responsibilities, core public health activities are best directed by governmental public health agencies. Additionally, there is currently some duplication of efforts and resources with the New Orleans Health Department and the Region One Public Health Department. Neither department is adequately funded or staffed, creating problems in adequately serving the population. The Committee recommends that consideration be given to consolidating these public health services into the New Orleans Health Department, while maintaining some functions such as laboratory functions and vital records with the Office of Public Health. Moreover, the appropriate resources must be properly directed to ensure that all public health functions and services are maintained for the public's benefit. Public health must be funded properly by a combination of local, state and federal resources, and it is imperative that the New Orleans Health Department be adequately funded prior to the next hurricane season to provide services to the population. Local control is important to maximize efficiencies and efforts to enhance the services rendered to the desired population.

Also, specific activities can often be implemented through contractual arrangements or cooperative endeavor agreements by non-governmental organizations, particularly schools of public health and nonprofit organizations. These arrangements were specifically recommended by the Framework and that recommendation is included here also.

Funding for core public health services nearly always comes from government sources. Because the hurricane has dealt a severe financial blow to the city and state governments, federal funds are needed for all or nearly all of the resources described above. Contributions can be sought from foundations and corporations, but because philanthropies are likely to put a higher priority on immediate relief of displaced hurricane victims than on building a solid public health infrastructure in New Orleans, these contributions are not likely to provide much of the funding needed. It is believed that federal funds will be needed in order to pay for construction, equipment, and supplies in the first year and personnel and other costs for 3-5 years, after which local and state government sources should be able to pay these continued costs.

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HUMAN SERVICES

INTRODUCTION

It is essential to put the proper supports in place so that the population of returned citizens can be fully functional. Human services are one of the key components for the (re)creation of our city. Human services must be viewed as more than a sector; these services are an essential layer of the urban environment and help tie all other layers together.

In addition to being responsive to the needs of the populace, we also recognize an unprecedented opportunity created by Katrina. For many years, public policy has set goals for the improvement of health (Healthy People 2010), education (No Child Left Behind), and economic self-sufficiency (welfare reform and workforce development). Human services are vital to the achievement of all of these goals. By funding a new, improved, and responsive human services delivery system, we will have the opportunity to not only rebuild New Orleans as a stronger and healthier city, we will also have the opportunity to learn valuable lessons and create an urban service model for the rest of the nation.

The Human Services Sector plays a vital role in creating and maintaining healthy and productive communities. Without a healthy and well-cared for community, New Orleans will not recover. While all cities have populations of need, this catastrophe has created a level of need never experienced in the modern history of the United States. We recognize that physical recovery and rebuilding is essential for repopulation, but we also recognize that these efforts will be unsuccessful if the community's human service needs are not strongly and properly addressed. We aim to create a system that will serve as the foundation for social and civic recovery. This is best accomplished by creating a broad range of comprehensively developed and integrated services that support and sustain our most valuable resource: the citizens of New Orleans.

The services and programs which must be provided by this sector are essential to the successful development of every other major sector. These services encompass (but are not limited to) programs emphasizing: mental health; addictive disorders; developmental disabilities; positive youth development; child care; care and services for the elderly and disabled; supportive and long term housing; job training and workforce development; educational and vocational programs; and enrichment through cultural activities. These services clearly support all other sectors by removing and/or minimizing those barriers which prevent individual participation in the growth of each sector.

These essential program services have traditionally been provided by an array of both public/governmental and community and faith based not-for-profit organizations. Included agencies are the Metropolitan Human Services District; City of New Orleans Department of Human Services; Office of Community Services; Office of Family Services and numerous other privately-operated social and human services entities. However, these agencies were overburdened and under-funded pre-Katrina, and must be comprehensively supported in order to meet the pre-existing and emerging needs of our city. The not-for-profit role in this sector is vital to our recovery. These organizations have traditionally worked hand-in-hand with governmental

entities and have carried a heavy burden in meeting the needs of our citizenry. According to the Urban Institute:

83 charities – with \$2.6 billion in annual expenditures...[with] more than 15,000 employees [have] provide[d] direct health and mental health services to New Orleans residents [each year]. Additionally, 385 organizations with \$389 million in annual expenditures [have traditionally provided] human services and community improvement programs to New Orleans residents.

Our own post-Katrina experience shows us that this sector has been severely impacted, leaving many previously vital human service agencies (both public and private) literally homeless and with a limited ability to provide essential services. Furthermore, much of the human service agency staff have also lost their homes and are not capable of functioning at full capacity without human services for themselves.

Based upon the information provided by the Urban Institute, the economic impact of these circumstances could reach as much as \$3 billion annually. The potential financial impact of a poorly developed or poorly supported not-for-profit sector may be characterized in this manner:

...just imagine, for instance, how your city.....would look if every building [and human service organization] funded by individual donors [and operated by the not-for-profit sector] were to disappear ...sucked out of the system and no longer available for society's benefit (Gaudiani, 2003).

Without a fully operational human services sector, much of the demand for assistance and financial responsibility for meeting these needs will inherently fall upon already over-stretched medical facilities, emergency rooms, and even police departments. Such circumstances will collaterally and negatively impact the functioning of our school system, prison system, public health network, and ability of the citizens to fully function and participate in the economic, social, and cultural life of their community. This could lead to an untold financial burden which could cripple development in all other sectors.

Additionally, given our pre-Katrina record of under-funding and under-supporting vital human services, we now face the danger of repeating the same mistake at this critical juncture. These services are essential to support the needs of a traumatized population, as well as a population which has endured decades of negative social planning outcomes. If care is not taken to ensure that proper resources and supports are allocated, and that new and innovative approaches to effective service delivery are explored, we will have failed before we have begun. We will have rendered ourselves incapable of supporting the needs of our population as they return to rebuild their lives and our city.

The planners who converged for the Louisiana Recovery and Rebuilding Conference developed goals and principles for action, including the desire to build neighborhoods with accessibility to health and human services and to pursue policies that promote a healthy population. This extends beyond healthy lifestyles, a safe environment, and financial access to health care. This also includes access to high quality child care and education, adult education

and workforce training, basic dietary needs, and appropriately targeted socio-psychological interventions and supports, to name a few. We do not attempt to address each and every component of these, but we do argue that a well-designed human service delivery system is key to building a more successful and healthier New Orleans. Not only do we need to continue to meet the population needs that existed pre-Katrina, we seek to improve service delivery and take advantage of the new planning design to do so. Additionally, we seek support to rebuild the human service sector's infrastructure and expand services to specifically address the post-Katrina needs of our current and returning population.

MAJOR CHALLENGES/OBSTACLES FACING SOCIAL SERVICES SECTOR PRIOR TO KATRINA

The world of human services in this region and City was far from perfect before Katrina struck. Here are some illustrations:

1. Lack of or shortage of available and accessible facilities, services, supportive, proactive care and available service information for at risk populations:
 - persons with developmental disabilities;
 - infants, children, and adolescents;
 - indigent persons;
 - uninsured persons;
 - working poor;
 - emergency placement options for all ages;
 - long-term inpatient care for all ages;
 - community-based/home-based long-term care alternatives to institutional placement for all ages;
 - age appropriate placement;
 - mental health/substance abuse treatment options; and
 - inpatient detoxification treatment for children/adolescents.

2. Not enough collaboration between health and social service providers; lack of integration of primary care with social services (untreated mental and physical illnesses or follow-up supports); lack of affordable neighborhood-based community health and well-being centers.

3. Lack of evidence-based performance standards and outcome measurement for non-regulated services with mandated quality programs.

4. Lack of safe, affordable housing (general population) and supportive housing – meaning housing with services (seniors, homeless people and others with disabilities).
5. No coherent social/human services disaster preparation and response plan.
6. NIMBY-ism (not in my back yard) regarding community-based facilities.
7. Accessibility of services due to transportation network and physical allocation decisions.
8. Shortage of an employee assistance program model available to everyone in the community.
9. No long-term wellness program available for medical/first responders.

PRIORITY AREAS

Now it is apparent that some key priorities are:

- Community-based service delivery model is necessary to address a myriad of community needs with the following components.
 - multi-disciplinary (including integration of health/social services)
 - single point of entry (for easement of access and appropriate referrals)
 - cultural competence and responsiveness
 - flexibility to respond to evolving needs of the community
- Cross sector collaboration/integration between public/private/nonprofit health, mental health, behavioral health, social and human services
- Technical assistance needed on primary care/social services integration, state/national certification/accreditation issues, and relationship to larger social policy agenda items
- Central information service (this could serve as entry point) for:
 - health
 - mental health
 - behavioral health
 - social services
 - pharmaceutical assistance programs
 - case management

- consumer literacy/education on health issues
- special needs housing
 - On-going population estimates and data collection to inform service planning
 - Comprehensive health/social service disaster plan developed by the Office of Emergency Preparedness with input from the HHS provider community

IMPORTANT NEEDS

- Funding (strategically spent), including bridge loans for existing social/human service organizations and capacity funding for startups
- “Outside” perspective/assessment of sector for improvement based on other city models
- Guiding principles for service development/provision/funding with commitment from all stakeholders
- Courageous conversations on issues of social justice, equity, and race
- Recognition that the social services sector is a major employer and component of the New Orleans economy
- Regular updates on the status of service facilities
- Coordination of information and discussion of emerging needs and needed infrastructure

RECOMMENDATIONS

Coordinated Service Delivery

Develop a system of collaborative, cross-sector, neighborhood-based, wrap-around human service delivery. This will be included in the charge of the coordinating entity.

Regional Human Services Collaborative

(a) **Background and Purpose**: Due to the scope and scale of the physical and social destruction wrought by Katrina, we have few models to work from and immediately implement. The September 11 attack on the World Trade Center affected tens of thousands of people, including the nation’s core financial center, and is perhaps the closest national level comparison to the devastation caused by Hurricane Katrina, but is certainly a different tragedy in scale and long-term impact on the community. With no appropriate historic paradigms available to guide New York in its response to the unprecedented 9/11 disaster, the success of that city’s public, private and nonprofit sectors in meeting the momentous challenges required a more formalized coordination to ensure that those affected by the large-scale disaster received both the immediate

and long-term help they needed as quickly and effectively as possible. The unprecedented organized and coordinated response of New York City's nonprofit agencies and charities to the crisis, with the support of public and private entities, ensured that the continuing needs of those affected, directly and indirectly, by the World Trade Center attack were met compassionately and efficiently.

The August 29 attack on the Gulf Coast by Hurricane Katrina resulted in another unprecedented level of trauma and devastation to not only the region but to one of America's premier cities - New Orleans. We need to follow the lessons learned from the highly successful social and human services response to September 11, by establishing a strong and sustainable human services collaborative, which we would name the *Katrina Community Based Services Network* ("KCBSN") to serve as a new independent umbrella organization. As previously stated, the role of the KCBSN is to:

- Bring separately functioning major nonprofit human services agencies together.
- Make their services easier to access for people in need by coordinating their management.
- Ensure that information about benefits and programs are widely known.
- Jointly train agency staffs on services and needs.
- Identify and resolve operational issues to assure efficient and proper management of resources.

It is important to note that many of the nonprofit agencies that will comprise the KCBSN have suffered major operational losses in personnel, facilities and funding. It is estimated that 80% of employees in the nonprofit sector have lost their homes. Approximately 85% of agencies have had significant damage to their physical space. A preliminary survey, currently underway, estimates that only 12-20% of the pre-Katrina agencies are currently operating in their existing or new locations. The City of New Orleans will be counted on to seek and acquire the funding necessary to quickly and effectively aid the rebuilding of this sector so that the required human services response can be readily implemented. It is ideal that certain services be proactive and in place before repopulation numbers overwhelm the system and claim additional lives.

(b) Operational Objectives: The KCBSN should be guided by the following objectives:

- A coordinated intake of client information to expedite and ease victims' immediate and long-term access to the help they need. A central element of this approach must be a centralized helpline to field requests, as well as a mental health hotline to address trauma, bereavement and other disaster-related mental health issues.

- Utilization of a network of Service Coordinators well-versed and trained in the assistance available across the range of private nonprofit and public agencies.
- Technology to centralize information regarding people served and available benefits and services.²²
- Consistent communication with key stakeholders through multiple channels, including those receiving services, other city residents, public governmental entities, private foundations and the business sector.

(c) **Guiding Principles:** Several fundamental philosophies underscore the operational components. In order to facilitate the development and execution of the components, the following principles should guide participating governmental, nonprofit, and private sector organizations and agencies:

- Human services are essential to the quality of life of our community.
- Comprehensive human services must be readily and easily accessible to all members of the community. Information on available human services – including how and from whom to access them – should be communicated clearly, regularly and in a coordinated fashion to the public.
- Successful human services are client-driven and based on best practices.
- Community needs data should drive decisions about service provision, including what, where, when, and how much.
- Standards of care and organizational integrity are important to safeguard the well-being of the community.
- Community members deserve to have all of their service needs met through a coordinated service delivery system.
- The human services sector is an important community resource and should be integrated fully in disaster planning and response.
- Human service delivery should be defined by clarity, consistency, transparency, equity, inclusiveness, and cultural competency.

(d) **Coordinated Intake:** The coordinated intake system incorporates the following elements:

- Common intake procedures, forms and agreements. Technology will be used to facilitate a process allowing victims to submit their information and

²² *This specific recommendation has already been discussed, in detail, above – See Priority Recommendation No. 5.*

documentation only once to a front-line worker, which will then be stored in a centralized database system and downloadable by any agency which may be helping the service recipient. The KCBSN will use a common intake form, a universal client release form, and data sharing and confidentiality agreements among agencies. Client information will be protected with the highest level of security.

- The universal client release form will include the client's consent for the frontline agency to collect and share personal and benefit information with other charities involved in the recovery effort. The form will commit agencies to sharing information for the purpose of improving services for clients.
- Strategically placed community outreach centers will be the main locations for common intake.
- A centralized helpline will field requests from victims and connect them with the help they need, including health, mental health, crisis counseling, and the full array of social and human services available, including child care, activities for youth, services for those with disabilities, homeless assistance, and senior care. The hotline will provide skilled clinicians to assess and refer individuals to appropriate counseling and/or services, as needed.

(e) **Service Coordination**: Service coordination will involve the independent agencies of the KCBSN cooperating to ensure that service delivery is “client-centric,” effective and efficient throughout the social services system. Important immediate and long-term elements of service coordination will include:

- Determining which organizations will be responsible for providing each necessary service or program in both the immediate and long-term. A coordinated effort to adjust for service and geographic gaps will be ongoing. Based upon the 9/11 United Services Group experience, it is anticipated that as immediate governmental and private financial supports and cash assistance provided to individuals and families are reduced or terminated, the burden of assistance will shift to the ongoing social services and mental health systems in the City. Reliance on the ongoing public and private nonprofit social services organizations will become the norm for help. Concrete services will be increasingly needed, including employment and training, mental health services, health insurance, child care, camp opportunities, legal assistance, and other support services. Service Coordinators will, therefore, help individuals and families access these resources.
- A personal, one-on-one service coordination model will provide a human touch to help families manage the complexities of navigating through the sea of available help. The KCBSN will create a network of Service Coordinators – case workers from social service agencies who are cross-trained in the assistance available from all participating network agencies. One Service Coordinator will help guide individuals and/or families through the range of

programs, services and benefits they are eligible for. The quality assurance and staff support procedures, based on learnings from the 9/11 United Services Group, will be developed.

(f) Communications and Outreach Strategies: These strategies should include:

- A multi-channel, coordinated system for disseminating timely, continuous, and accurate information to service recipients; service providers, the media and the general public will be used to clarify what services are available, to whom, and where to access them.
- Internal communications among and within KCBSN agency partners will ensure that accurate information is distributed simultaneously to help ensure that individuals and families receive the most informed, high quality help possible. This system will include key members of government staff involved in human services response.

(g) Recommended Steps:

It is recommended that a collaborative regional organization be formed, utilizing the name “Katrina Community Based Services Network”. In order to achieve a sustainable functioning collaborative of this nature, the following components of such a collaborative effort must be put in place:

- Identify a convener of stature.
- Clearly and narrowly define the problems to be addressed.
- Identify a committed leader – the manager of the collaborative.
- Prepare a written charter for the collaborative organization, specifying such things as:
 - The clear definition of the problems to be addressed.
 - How such issues will be addressed and concluded.
 - Financing of the collaborative organization.²³
 - Governance structure for the collaborative organization.
- Establish a critical mass of key participants from the region.

²³ There is some solid information already available on this topic from two sources. First, much of this can be modeled off of the 9/11 United Services Group in New York. They have actual experience, albeit in a somewhat different setting, on this. In New Orleans, there is in place a multi-agency approach to post-Katrina issues named the “Community Based Services Network.” Though privately funded for a short period of time and a narrow scope of people to be served (2,250), this will generate good cost information. They are a subgrantee of the Louisiana Family Recovery Corps.

- Ensure that principals of substance are those at the table for the participants.
- Ensure that constructive critics are also at the table.

The collaborative effort must be established in such a way that participation is voluntary, but where the participants wish to continue to participate because of a recognition that they are better off participating than not. The collaborative organization must function in an atmosphere that can produce success and an atmosphere of decision making, not merely conversation.

In order for the collaborative to be effective, it will be necessary to develop the necessary statistical information, population data, demographic information and other critical background upon which such a collaborative organization must rely. That must be done professionally, and financing for such an effort must be identified. See Priority Recommendation No. 7.

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ENVIRONMENTAL HEALTH

INTRODUCTION

Environmental health has traditionally been one of the most challenging public health issues facing the City of New Orleans and Louisiana. Strategic priorities at this point include:

- Building the core environmental health infrastructure, including creating a competent and robust environmental health workforce;
- Implementing long term surveillance to monitor the environment and community health;
- Establishing and executing a comprehensive, community-based environmental health risk communication program; and
- Addressing key information and knowledge gaps in science, policy, and practice to assist communities in returning to a safe and healthy environment.

While it is imperative that at this point in the history of New Orleans and in the aftermath of Katrina we forge ahead in a new direction for the development of a structure that fully supports an improvement in the quality of environmental health for our citizens, it is just as important, if not imperative, that at this time, our decisions ensure an environmentally safe environment for citizens who choose to return to New Orleans. This effort will require both the intellect and resources of the professional community (i.e., health departments, university and community colleges, other professionals) as well as local, state and federal support. It is important that at this time and in this place we “get it right.”

Getting it right will entail the expedient release of scientific data to all stakeholders, and the dissemination of the data with culturally sensitive interpretations of the science. It is important to note that the results of environmental sampling conducted by the Environmental Protection Agency (“EPA”), the Natural Resources Defenses Council (“NRDC”), and the American Chemical Association (“ACA”) are all within the same range, but there is disagreement in the application of the science. While the reporting of the data should be truthful and objective, the policy implications for the use of the data are wide and varied, and resultant policy decisions will be made not just on the basis of science. As the Katrina catastrophe has already shown, social, political and economic factors will also influence policy decisions, and it is critical that the appropriate governing bodies make the best decisions for the health of all of its citizenry.

(a) Flood waters and its effect on surface water: Flood water sampling in the early stages following the hurricane showed elevated levels of bacterial contamination associated with untreated sewage. Extensive chemical testing did not reveal contamination at levels of public health concern. Results from fish and shellfish sampling to date did not warrant a ban on seafood

consumption as confirmed by the U.S. Food and Drug Administration. Flood waters have been removed and no longer serve as a source of potential human exposure. Safe drinking water has been restored after the municipal water plants were back on line.

(b) Soils and Sediments: Multiple rounds of soil and sediment sampling occurred to determine concentration levels of fecal coli-form bacteria and chemical compounds. To increase the likelihood of finding contamination, more samples were taken in flooded areas than in those neighborhoods that were not flooded. The results indicate that in general, the sediments do not pose a public health risk to returning residents and current levels are unlikely to pose adverse health effects. However, there are some localized areas where contamination was found in the sediment at levels of concern for long-term residential use. Pending the results of further investigations currently under way to better characterize the nature and extent of the contamination in these areas, it is important to take proper protective measures to prevent exposure, including using personal protective equipment and practicing good personal hygiene. The results of soil sampling reflected historic levels pre-hurricane Katrina and are similar to other urban areas within the US.

(c) Air: Ambient air sampling results do not show levels of public health concern at present. Fine particulate matter (PM 2.5) levels also appear to be below levels of health concern. Ongoing monitoring of ambient air quality is important and will be strengthened by efforts to replace lost monitoring stations as a result of Hurricane Katrina.

(d) Mold: Mold formation in flooded buildings and homes may well be the single most extensive environmental health issue. Mold removal is the only proven action to assure safe living and work environments.

(e) Debris: The flooding and wind damage resulted in creation of debris unprecedented in size and composition. Debris removal and environmentally safe disposal from all affected neighborhoods and areas in the city remains an important action.

(f) Sampling on private properties: Environmental sampling and assessment efforts were instrumental in ascertaining potential public health concerns. All sampling occurred in public areas and not on private properties based on the fact that agencies charged with environmental assessments, such as the EPA, lack the regulatory authority to extend mandates associated with sampling and removal to private homes and properties. If authorized by property owners, environmental sampling should take place on a regular basis.

RECOMMENDATIONS

Repopulating the City

The Committee recommends that up-to-date information be furnished to those who are moving back to the City or considering moving back to the City concerning any health issues associated with sediments, debris or other storm-related issues in order to facilitate their making individual judgments as to risk. Further, it is recommended that protective gear be used where necessary, and clean-up directives be issued based upon EPA clean-up standards for residential areas in neighborhoods. Also, where there are contaminated sediments, the Committee requests

that the EPA continue to conduct comprehensive environmental assessments and sampling, and that remediation take place if necessary.

Surveillance

Implement long term surveillance to monitor the environment and community health, including consideration of such features as:

- Establishing the capacity for contractual services with EPA/LDEQ to conduct selected critical neighborhood-specific environmental sampling.
- Expanding the current public health and GIS tracking system capacity to provide critical assessments of hazardous materials for neighborhoods and other non-traditional units of analysis.
- Strengthening IT infrastructure to expand and, where needed, develop comprehensive, searchable environmental and health outcome databases to facilitate the conduct of long-term environmental monitoring.
- Conducting environmental health surveillance to assess the impact of the environment on health, evaluate the effectiveness of targeted interventions; and periodically ascertain the environmental health status of the city. To bridge the current lack of electronically available health outcome data, initial activities would focus on “pencil and paper”/ shoe leather data collection strategies.

Environmental Risk Communication Program

Establish a risk communication program that will get information out to the public, allow the public to communicate their concerns and allow for an orderly and thorough consideration of those concerns. Include within that consideration such features as:

- Developing a robust risk communication program capable of developing, delivering and evaluating just-in-time and just-in-case messages to reach a geographically scattered audience during and after emergencies.
- Placing emphasis on developing and disseminating neighborhood-specific information in a manner that is clear and responsive to community’s concerns.

Program to Address Gaps in Knowledge, Science, Policy and Practice

Establish, in collaboration with the environmental health entity established within the New Orleans Department of Health, a capability and process for dealing with gaps in knowledge, science, policy and practice related to environmental health. Consider such things as:

- Explore the susceptibilities in specific populations, including vulnerable life stages and pre-existing and newly developed health disparities before or following Katrina.

- Identify innovative markers of exposure, susceptibility and effect associated with hazardous substances present in the environment in the aftermath of Hurricane Katrina;
- Determine the relative role of outdoor and indoor air quality, including mold, on respiratory and cardiovascular effects in people with existing disease;
- Develop new methods to treat solid waste byproducts unique to storm situations such as mold-contaminated building materials.

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CONCLUSION

A conclusion to this report – yet just a start to a process that can mark a new beginning for healthcare and human services in New Orleans.

Just a “start” because these are complex issues. This report sets forth several recommendations and the reasoning behind each. Much remains to be done in terms of analysis, thoughtful planning and funding in order to achieve those objectives, steps that cannot be taken solely at a local level. Instead, they will require strong and sustained regional, state and federal collaboration.

A new “beginning” because beginning over again is the only course anyone could want or envision. A two tiered system of healthcare that materially disadvantaged the poor and uninsured; a focus on institutional care, not wellness and prevention; human services chronically under-funded; and a fractured governmental process for addressing those problems – that is what we were pre-Katrina. It is not something anyone would recreate intentionally. Instead, our vision is of a region characterized by first rate healthcare and human services delivery to all on an equal footing, a focus on wellness and prevention, effective and coordinated human services, and a firmly established collaboration to sustain that situation. That will be a truly new beginning.

But, can we have that new beginning and sustain its promise if we remain as we were pre-Katrina? Race, class, parish to parish competitiveness and jealousy, the decades old tension between New Orleans and the state it is part of, private vs. public, for profit vs. non-profit – all are forces that have been important in driving us to where we were in many aspects of our lives together, markedly so in healthcare and human services. Where have those forces taken us? One of our subcommittees captured the essence of the answer in its report:

The extraordinarily competitive pre-Katrina milieu, structured over time in an almost total absence of health services planning and in the face of stagnant population growth, economic weakness and decaying infrastructure, left the City in a vulnerable and poorly served situation.

But, in healthcare and human services since Katrina we have shown what we can and should be as people, what we are made of. We have pulled together, often with few resources but consistently together. This report is but one example; its many parents are from this immediate region, men and women, white and African-American, old and young, from the public and private sectors, for profit and non-profit. We have already proved to ourselves that we can work in common cause. Now we need to prove to ourselves, and to the world, that we can stick with it, allowing us to take meaningful steps with others.

For the next steps are not steps that can be taken alone. They are steps to be taken by us in a new collaboration with our region, our state and the federal government. These must be genuine and sustained relationships, not temporary alliances of convenience.

Out of extraordinary adversity has arisen extraordinary opportunity. When we succeed in the steps set out in this report, we will have seized the opportunity, lived up to our own potential and dreams, and made the region better, as it should be, for ourselves and generations yet unborn.

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APPENDIX

“A” BNOB Subcommittee Members, Health and Social Services Committee, Members and Meeting Participants

COMPENDIUM OF RELATED INFORMATION (on CD)

Framework for Rebuilding the Health Sector of Metropolitan New Orleans, Greater New Orleans Health Planning Group (2005)

New Orleans After the Storm: Lessons From the Past, A Plan for the Future, The Brookings Institution, Metropolitan Policy Program (October, 2005)

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