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Which Way to Turn? Options for Rebuilding the Gulf Region's Health Infrastructure
Alliance for Health Reform and Robert Wood Johnson Foundation
May 11, 2007

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ED HOWARD, J.D.: I want to welcome you to this briefing. My name is Ed Howard at the Alliance for Health Reform, on behalf of J. Rockefeller and Susan Collins, our chair and co-chairman respectively, and the other members of our board welcome you to this briefing on rebuilding the health infrastructure in the Gulf region, particularly in Louisiana in the wake of Hurricane Katrina. Our partner today and co-sponsor is the Robert Wood Johnson Foundation, the country's largest health and health care centered philanthropy. You can hear from the foundations John Lumpkin in just a moment. We will soon approach the two year anniversary of the disaster and, sadly, too many of the elements of that disaster effecting the delivery of health care in the region still linger today. You're going to hear a lot about that from our panelists and we hope to give you some idea of the next steps that need to be taken and the role for federal policy in all of this. You'll note the particular emphasis on mental health questions today, that is not accidental, it's a part of the debate that too often gets neglected and we want to make sure that that doesn't happen today.

As I mentioned, the Robert Wood Johnson Foundation is co-sponsoring this briefing. Representing the foundation today and sharing moderator duties is Senior Vice President of the

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Foundation and Director of its health care group, Dr. John Lumpkin. John is no stranger to the kinds of problems we'll be discussing today, having come from the foundation, what, about four years ago, from heading the Illinois Department of Health. So John, thank you for coming and thanks to the foundation for its interest in this topic.

JOHN LUMPKIN: Thank you; I thank you for the kind introduction and also for hosting this very important panel. The events of early September 2005 have left few of us untouched. All of us remember the drama, the horror, the shock, as the events of that week unfolded. As a nation, we've seen the results of neglect of the infrastructure and we've also seen the results of vulnerable populations when they're not protected. The question is, have we learned the lessons?

Since the storm, I've been to the Gulf region seven times. As a state health official, who weathered the Mississippi floods, the great floods of 1993, and an emergency physician, I thought I pretty much knew what I was going to see. I thought I was hardened. But I was shocked by the extent of the devastation across the Gulf. I was dismayed in my trips subsequently at the painstakingly slow progress that was made across the Gulf because of the magnitude of this disaster. For the people who lived there, day to day, however, what for me was dismay, for them is day to day experience.

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It's an experience that takes a toll on the spirit and becomes a force in and of itself. It is into this breach that philanthropy and community, the philanthropic community, must step. For years, many of us, including the Robert Wood Johnson Foundation have worked in this region of the country. We've worked in the Gulf because of the key problems that existed there and because the need was so great. Even before the hurricanes hit, 12-percent of all children in Louisiana were uninsured. That's 140,000 kids, three quarter of a million adults. Louisiana ranked last in the nation in overall health indicators, last in the nation in access to primary care. Mississippi leads the nation in obesity and infant mortality. And the entire region has pockets of crushing poverty.

There is an old African proverb that goes, the best time to plant a tree is 20 years ago. The second best time to plant a tree is today. Is it acceptable for this nation to rebuild in a way, to plant our trees in a way that brings this area back to pre-Katrina levels? We must demand a better future for the entire Gulf coast. We must use our collective resources, expertise, and efforts to lift the entire region up to where it ought to be, to help build a stronger, healthier, and more equitable Gulf coast.

Of course the resources of our foundation, one of the largest foundations in this country, pale beside the enormity

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of the task at hand. The monetary contribution of philanthropy is dwarfed by the needs, dwarfed by the federal, state, and local contributions. Yet we believe that philanthropy has much to offer. Not only do we bring expertise to this issue, but perhaps more importantly, we can act as a connector.

Let me give an example of some of the things that have been done and can be done. First, technical assistance. You'll hear some about the big considerations that are going on about whether or not to replace big charity. And we know that that issue is still being discussed. But as Louisiana State University is exploring that issue, we have funded them to link them with the Georgia Center for Health Design so that they can have expertise on how best to rebuild a hospital if that, in fact, is going to be what they are going to do. Evidence based, let me give an example. If you put a window in an intensive care unit, the length of the stay in that intensive care unit will drop by an average of one day. There are other kinds of things that have been determined as part of the evidence base that ought to be used when we look to rebuild areas of New Orleans. We've also funded school nurses as part of the core to help them learn better to identify kids with mental health problems and to best refer them. All these are examples of the kinds of things we have done and other philanthropies are doing in New Orleans.

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This panel will discuss the current situation. It will discuss the crisis, what is needed to be done, and some areas of hope and directions in the future. And I am sure, as many of you look forward to the expertise of those who are here in this room, who have contributed to that effort.

ED HOWARD, J.D.: Thank you, John. Let me just do a little bit of a logistical business if I can before we get started. First, if there's anybody who has not yet turned their cell phone on to vibrate, I would appreciate it if they would do that now. In your package, you're going to find a lot of information, background, substantive background and biographical information about our speakers, to which I commend your attention, much more extensive then I'm going to have time to give them. Tomorrow, thanks to the far sightedness of the Kaiser Family Foundation, we will have available a webcast of this briefing on Kaisernetwork.org and a transcript not long thereafter, along with both on that website and ours at allhealth.org, copies of the materials that you will find in the packets that you have will let you know when that transcript is available, send you an email. So you may be able to make use of that. You'll find some microphones that you can use to ask questions at the conclusion of the formal presentations. There are green cards in your packets that you can write a question on and have it brought up front and I

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would urge you to do that and, particularly, before I introduce our speakers, I'm particularly anxious to encourage a vigorous dialogue with the people who represent a variety of views in the audience, as well. We tried, I think about as hard as we have ever tried, to get an administration representative on this panel because we know there have been minor differences between the state and federal government about the general direction in which to proceed. And despite their best efforts, and I assure you our best efforts, it didn't quite work out. We've tried to include some materials that would make sure that, to the extent that we understood their views, they were represented, and I would urge those of you who have questions about that aspect of this, to raise them when we get to the Q&A.

Nonetheless, we're blessed with a very distinguished lineup of speakers, so I want to get those presentations going without any further delay.

We're going to start with Diane Rowland, of the aforementioned Kaiser Family Foundation, she is not here as a philanthropic entity as much today as the nationally known health policy expert that she is. She's the Executive Vice President of the Kaiser Family Foundation and the Director of its Commission on Medicaid and the Uninsured. You probably know all that. You may not know that she served for two years,

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beginning before Katrina on Louisiana's Health Care Reform Task Force, and yesterday, the foundation released its study of how Katrina affected the daily lives of Gulf residents, and I commend that to you. It's incredibly rich and very disturbing. And so Diane, thank you for joining us to share some of the perspective of what was going on in the Gulf beforehand, and how it's been affected by the events that have happened since then.

DIANE ROWLAND, SC.D.: Thank you, Ed, and thank you John, and the Robert Wood Johnson Foundation for sponsoring this briefing today. We all believe that we need to remain committed to keeping a focus on the challenges facing Louisiana and the residents of New Orleans in terms of their struggle to return to their homes and to their lives after Katrina. I think John's opening remarks about the devastation there are something that no one who hasn't been there can even comprehend, and that what we try to do in the report we put out was at least capture some of that, but it really is something that you have to see it on the ground to understand what devastation occurred and how even one, almost two years later, the rebuilding process continues.

What we always have to remind ourselves of and summarize in the first one, is that Louisiana started out as a poor state with a high share of its population living in

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poverty, with a substantial profile of health needs in terms of the health status of its population, a very large percent, it's not an elderly population, uninsured, many also on Medicaid, but primarily children, and a high percent of their population, almost one third, African American. What we also, though, have to remind ourselves of is that there were a lot of issues on the table in terms of how the Louisiana Health Care System and the system in New Orleans in particular, functioned pre-Katrina. I think it's important to note that we think of health care coverage through Medicaid and through the SCHIP program, which is known as La Chip in Louisiana, as a major source of coverage for the low income population. But in Louisiana, it primarily covered children and pregnant women up to 200-percent of poverty, which was about 34,000 dollars for a family of three, but in comparison left other adults, especially working parents and childless adults uncovered, working parents only covered at about 3,500 dollars a year for a family of three, so extremely low eligibility and the Medicaid program care for the uninsured then, with a large uninsured population, was primarily being financed through disproportionate share hospital payments under Medicaid and concentrated through the charity hospital system, which was known as big Charity in Louisiana's New Orleans area. It also was an area in which Louisiana was quite different from the

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rest of the nation in that 19-percent of its Medicaid money was flown through the Dish program as opposed to six percent nationally. These were some of the issues on the table when the Governor's Task Force began to look at how to reform health care services at Louisiana and what to do about the concentration of care for the uninsured and the charity hospital system.

Hurricane Katrina kind of wiped the slate more or less. In the New Orleans area you see these statistics which you can't forget about lives lost, people displaced, people living in trailers, jobs lost, businesses destroyed, and much of the health care infrastructure, especially in New Orleans itself, destroyed. What we set out to do in the survey that we conducted from September through November of last year, was to find out who was back in New Orleans, what their situation had been pre-Katrina, how they were faring now, what their priorities were, and we will be doing more follow-up on both their health care situation and, in another year or two years, tracking the progress. But what we see overwhelmingly in the report that Ed mentioned, is the impact of Hurricane Katrina was pervasive. It didn't just affect a few people, it affected virtually everyone living in the area. Eighty one percent of the population that we surveyed, and this was a household interview survey, door to door, interviewing adults, said that

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they had been affected in one way or another by Katrina. A majority said their financial situation was worse, a third said their housing costs had gone up, many experienced a significant disruption in terms of their housing, their social network, 14-percent overall told us that a close friend or family member had died as a result of Katrina.

So while this is now known as a general measure of mental health, you can think about what this has done to the stability and the needs of the population in terms of their coping. Over a third told us their access to care had been compromised, a quarter said stress had taken some personal toll, including temper flare-ups, increased alcohol use, tension in their marriage, dissolution of their marriages, and more reported physical health worsening, mental health worsening, 16-percent said their mental health was substantially worse after Katrina.

And then what that tells us is that the quality of life of the people in New Orleans today has declined substantially. Pre-Katrina, 65-percent of the people that we interviewed said they were very satisfied with their lives, and that's dropped to only 34-percent today. When we look at the problems they are facing, nearly half say that they have a health care coverage or access problem today, 27-percent have no usual source of care, which we know is a strong indicator of

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getting the continuity of care people need. A lot go to the ER, 25-percent of the non-elderly adults are uninsured. Their physical health is challenged, 41-percent say they have a chronic condition, 13-percent rate their health as fair or poor. There are problems with jobs and inadequate wages that make affordability of the health care that is available, difficult to meet. And the share that say they have mental health challenges, eight percent of those rate their mental health as fair or poor, another eight percent are taking new medications for mental health since Katrina, six percent report they are depressed, five percent with post traumatic stress disorder, four percent reported as mentally ill. So altogether, 77-percent of the population is facing one of these challenges today in terms of being able to cope and live and rebuild their lives in New Orleans. And when you ask them what some of their biggest needs are, the majority say that they need more hospitals, clinics, and medical facilities, that there are not enough currently operating, and that the health care services available for people without health insurance are severely compromised, especially given the closure of the Charity Hospital System.

This is a year after Katrina. When we asked them what their priorities were in terms of rebuilding, you see here that reopening hospitals in the community is one of the top, or very

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important to an overwhelming share of the population. Obviously, one of the challenges is that they've lost their doctors, they've lost nurses, they've lost other health care workers, and bringing them back remains a high priority. Opening more emergency services, these are the numbers behind the faces and the anecdotes you've heard about people waiting in ambulances to be able to get into a hospital. And especially one of the priorities that was pre-Katrina, getting more community clinics up and operating and running, and making mental health counseling and services more available, are all highly ranked by the population.

When we asked them how they would rebuild, we see that they just want the system rebuilt. Overwhelming numbers strongly favored, or somewhat favored, rebuilding charity hospital and having it open, and play the role it previously played, and their strong support for building more clinics that would provide basic medical care, and their strong support for expanding the public programs to provide broader coverage for the low income population so that the uninsured rate can finally come down.

So I think what we see from these results, and we'll have more in depth analysis of the health issues, is that there is a big challenge ahead for rebuilding health care services, bringing back a substantial health care work force to meet the

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needs, especially mental health care is a priority, which I know you'll hear more about, really trying to diversify the availability of health care services to more community based primary care, and rebuilding some of the capacity, at least in New Orleans parish for hospital and specialty services. It all goes along with being able to finance the changes, to financing issues are also on the table, as they always have been, Medicaid and La Chip have been about how to expand them, how to maintain them, how to get broadened health insurance coverage, and finally, recognizing that even with some of the improvements in public coverage, there is still likely to be an uninsured population. There is a new Hispanic worker population coming in, that is largely uninsured, how to fund uncompensated care in the area. So it is a system in need of immediate attention, not just long range plans, and a system where the population places high priority on getting their health care services back after levees. It's one of their biggest challenges, and we're surprised to see how high the public ranked health care services and returning health care services to the area against all of the other priorities we asked them to measure.

So I look forward to working with the other members of the panel and to hearing from you about how, in fact, we can get those services back so we do make good on the promise to

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restore New Orleans to where it was before and the health services of the population it needed. Thank you.

ED HOWARD, J.D.: Thank you, Diane. Next we're going to hear from Dr. Fred Cerise, who has headed the Louisiana Department of Health and Hospitals for more than three years. He's a New Orleans native. One of his first tasks was to come up with and implement a reform plan for the Louisiana health care system, which as Diane and John both pointed out, had some very serious difficulties before Katrina. He didn't know he'd have to replace so many parts of system that had been wiped clean as a result of the disaster before any reforms could be put in place. So he's a man with a very big agenda and we're very pleased that you've taken the time to share some of the difficulties you've wrestled with and the directions that you're trying to go in with us today. Fred?

FREDERICK CERISE: Thanks for the interest of the Alliance in this topic and for inviting me to just speak today. Whenever I see a group like this, I always feel like I must, we're going to talk about a lot of problems we have in the state and things we continue to be challenged with. We've gotten a lot of help over the last couple of years and we're grateful for the support that we've gotten from around the country, John Lumpkin and RWJ certainly, and Diane and Kaiser have been incredible resources for the state as well as others,

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Len Nickles and Fish Brown and Kaiser, that we spent two days there learning from them as we were trying to put pieces back together, so we got a lot of assistance. There's a lot of work to be done.

I'm going to give a very high level overview and then I understand we'll have a fair amount of time to get into some detail with question and answer. I share this quote because this is one of the things that we've tried to be guided by as we try to put the pieces back together, this is from the Institute of Medicine. It says the challenge before us, this has nothing to do with Katrina, the challenge before us is to move from today's highly decentralized cottage industry to one that is capable of providing primary preventive care, caring for chronically ill, and coping with acute and catastrophic events. To meet this challenge there must be a commitment to organizing services around common patient needs and applying information technology and engineering concepts to the design of care processes. I show this because it's one of the things, it's how we have tried to direct our rebuilding work, and that is recognizing that, not only in Louisiana, but in the country, we've got a very fragmented system, both from the delivery side, from the reimbursement side, from a lot of different angles, and that results in some of the issues that we're dealing with, with increasing costs and lack of accountability

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and in terms of getting the kinds of outcomes that we need. And so as we look at the pooling state and federal resources into fixing, filling the void that's been created as a result of Katrina, we're trying to do it in a way that makes sense in the long term. So the challenge for us is to meet the immediate needs that we have, while ensuring that in the process, we support a better system overall that comes back.

And so I'll just give you a couple of examples of three areas where we've tried to meet the immediate needs and also with an eye towards the future. First, in terms of primary care, we've had great difficulty just meeting the needs of the population, we've got emergency rooms that are crowded, more so than before Katrina, and we've lost a lot of access points, certainly Charity Hospital and the clinics associated with that. A lot of people don't realize that it's not just the hospital moving, it's a huge volume of clinics that went with that facility, that regular points in contact of care that was lost with Katrina, has been slow in coming back. We did receive some block grant funds, significant block grant funds to support those primary care services. We had a series of community clinics spring up, some that were pre-existing, others new, and we've been able to use those funds to support those sites. And one of the things that we've tried to do in the process is to get them to work together in collaboration,

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to try to have some degree of order to match delivery of services with needs in the community, and put some expectations on there as well, one of which is as we fund clinics that come back up to rebuild infrastructure, we said we want you to implement electronic records in the process because we lost so many paper records, it was such a critical issue and it was one of the expectations we put and these clinics are adopting that. So not to kind of pile on work while people are just trying to get their heads above water, but to say as we provide infrastructure support, we want to do that with an eye to the future in recognizing all the value that having electronic records will provide, not only in terms of emergency preparedness, but also in terms of long term issues with quality, safety, and efficiency, and those types of things.

In the area of behavioral health, I'm going to touch on it real quickly because Dr. Osofsky is going to talk about this, but immediately we did get crisis counseling grant funds to do immediate behavioral first aid, if you will. We also received block grant funds that we were able to use to at least begin some of these programs and initiatives that we know that we have been lacking in the state for some time. Better community based services, crisis response services, we realize we are low objectively on the number of mental health beds, not only in New Orleans, but in the state. It's worse in New

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Orleans than anywhere else in the state right now, but with block grant funds we were able to put in place throughout the state, and this is still coming on line and I know Howard is going to talk about it's not as fast as we would like, but to get crisis response services in place, diversionary programs so that people don't end up in the emergency rooms, but assertive community treatment teams to provide intensive services to people on the outpatient side, to keep them out of the emergency rooms, support of independent living and with some of the initial funding we've gotten through block grants, realizing that there is an end date to that, we are in our state session right now, we have had a significant commitment in the executive budget to continue those services that we were able to get up and running and demonstrate the effectiveness of. And as I said, we've actually in some of the areas outside of New Orleans, had a lot greater success, mainly because it's just easier to find work force and put some of these programs in place, but certainly in the New Orleans area it's one of the areas that we know that we need to do more outside of the emergency department. So we've been able to start some things with block grant funds, consistent with our plan for long term behavioral health services and improvements, and then able to supplant that with some state funds. It's not the ultimate answer, but it's part of it.

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And then in terms of IT, we realize we lost a lot of records with Katrina, and as people disbursed around the state and around the country. That medical information didn't travel with them, there were a couple of examples where it did, our immunization registry for kids, that link system, was accessed from across the country. Harrison County in Houston estimates they save 1.6 million in immunizations by being able to tap into this, as kids were displaced and being enrolled in new schools, being able to tap that information was a significant benefit. And importantly, it provided the forum in the post hurricane days, for competitors to sit around the table and talk about these issues now. We were able to develop a health information exchange among major providers in Baton Rouge and New Orleans regions. There is a prototype that is operable today. We have made great strides in this area of being able to implement health information exchange as a baseline for the future growth of electronic records, again, as we rebuild this system.

There are a number of areas where immediate needs remain. And these are the highlights. Primary care for the uninsured, we estimate in the region one, which is the four parish region around Orleans, that we are roughly 50 FTE's short in terms of primary care for the uninsured. Specialty services are tougher to quantitate, but we know not only for

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the uninsured, but for others we have a shortage in many of those areas as well. Behavioral health services, certainly, workforce recruitment and retention, all these other three areas kind of fall under this, but also nurses and techs and dentists and social workers, and just the whole spectrum, we've got work to do in terms of recruiting people back into the area. We've been able to do some of that with some grant funding, but we've got a long way to go, and then graduate medical education, as you can imagine, was severely disrupted with the loss of Charity Hospital and so much of the work that went on there in the dispersion of residents. And there are some issues that go along with being able to rapidly respond to that and maintain those training programs.

How can these needs be addressed? Well, we have initiated with 15 million dollars in federal grant funding, it's a down payment on what we think is a much bigger needs, the greater New Orleans Health Services Corp, which is a recruitment and retention program, we just administered the first grants associated with that this week, flexibility with using our dish funds, these are the funds that traditionally have supported the public delivery system. In order to get some of that care out into the community clinics and to pay doctors for services, we need to be able to have some flexibility with that, increasing primary care capacity through

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what we call community health centers and medical homes, which is a more coordinated system of care, that we have described in some detail in our planning. Support for the states behavioral health plan, which is a multi faceted plan, again, Howard is going to go through some of the immediate needs, but this deals with psychiatrists and acute beds and crisis intervention units and these assertive community treatment teams and rent subsidies and supported independent living, the whole spectrum, where we've got gaps in the New Orleans area. And then continued support for our information exchange and our graduate medical education issues.

So let me just conclude by saying that meeting these immediate needs will help us to, not only put services on the ground today, but also do so in a way that builds the better system for the future, a more coordinated system for the future as well as dealing with some of the immediate issues we have with emergency room crowding, some of the behavioral health system problems we have and the overall work force shortages that we are experiencing. So that's it, that's our challenge, meeting the immediate needs and doing so in a way that works for us in the future.

ED HOWARD, J.D.: Thank you very much. Let me pass this down if I can. Thanks very much, Fred. Our final panelist is Dr. Howard Osofsky. He's both a professor in, and

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chair of, the department of psychiatry at LSU Health Sciences Center, and he's an active psychoanalyst. He has helped develop training programs for first responders and others in New Orleans and statewide. In the wake of Katrina, he has had to deal with everything from a lack of medications to the shortage of psychiatric treatment beds, as Fred referred to, which was a big problem even before the hurricane, and of course, the shortages of trained personnel that you've heard about. Diane pointed out that one in 12 New Orleans residents in the survey that Kaiser just released, said they were taking a new prescription drug because of a mental health problem that developed after Katrina. This is a massive problem and we're very pleased to have Howard Osofsky here to help us go through it. Howard?

HOWARD OSOFSKY: Thank you very much. I am going to divert from what I've had on the briefer power point presentation given my own role. As Fred was saying, we've worked very collaboratively with the state since the hurricane, working together with OMH and DHH. I was made the clinical director of the Louisiana Spirit, the crisis response program. Actually, my wife oversees the programs for children and adolescents. I've also worked on the Governor's Panel as we've worked through the new directions in health care and my role in the department. And following the hurricane, the mayor of New

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Orleans and then St. Bernard Parish said, please, will your department help provide the services for first responders and families? And we were here on the flooded streets, but also then lived with the police and the firefighters and EMTs on the crew ships for the next four months, restoring lives for their families. Then we began first with St. Bernard parish, remarkable parish, where we've screened every child returning to the parish, together with the school system. Now in New Orleans and in [inaudible] parish, the most devastated schools, and we've done evidence based assessments on over 12,000 children and adolescents, trying to provide services. I'll just mention briefly, amidst incredible resilience and wonderful people and new relationships, yet 45-percent of kids, this past fall, returning to the devastated areas, could quality for mental health services. Twelve percent, these are fourth grade and beyond, especially in high school, themselves asked for counseling. With younger children, over 30-percent of parents requested counseling for themselves and their children. Among first responders, where we would find shortly after the hurricane, and it's still going on, 25-percent had significant symptoms of depression and at least 10-percent of post traumatic symptoms. What we saw in our surveys had increased use of alcohol, considerable marital problems, 40-percent said that if we could provide services, and we do it at

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no cost, for themselves and their families, they would avail themselves of it. And we're actually blessed that the Robert Wood Johnson Foundation is working with us in learning collaboratives to train professionals throughout our state and Texas, and I believe Mississippi.

Let me go on after that and talk to you about, I was asked actually by the Louisiana Public Health Institute, also by our first responders, would I talk the way it is currently in New Orleans. That is much of what I will do with the remaining time that I have left. As Dr. Cerise mentioned, at the moment, there are 20 in-patient adult public psychiatry beds. Charity Hospital had 99 adult beds and 40 crisis intervention unit beds, [inaudible] infirmary had 50, DePaul had over 60, this is prior to the hurricane, and for all the questions that are raised about charity and what was its crumbling structure, the care I could say in psychiatry was actually good. There were clear benchmarks each step along the way, including the crisis intervention unit, where the timetable began at one hour and ended at the end of 24 hours with services. But if one had a heart attack or stroke in New Orleans, in spite of it being an old and somewhat neglected hospital, your chances of immediate survival were better at Charity Hospital than in any of the private or not for profit

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hospitals in the community. I think this is something that tends to get forgotten and is part of the loyalty.

Last spring the Office of Mental Health received funding from the state and at New Orleans Adolescent Hospital, it should have been cleared six months earlier. Fifteen of the 30 child and adolescent beds were open and for the first time, there was a unit for 20 adults beds, and the Office of Mental Health is trying to add another small unit by this summer. But this is the extent of the beds at the present time.

Let me say what there aren't because I think we would be unfair if we didn't say it. At the present time, the system of care remains very fragmented both in adult and child mental health, and especially in adult mental health. There are very limited alcohol and substance abuse services, almost no geriatric services, in spite of the fact that we're seeing so many problems of the elderly. There are no emergency crisis services that convert problems at the present time. In other words, one of the things we proposed is 24/7 availability of counselors, of walk-in clinics, of an urgent care or primary care type of combination, and mobile units. This still is not up and running.

We truly do need the restoration of a crisis unit and this is something that should be provided. I know the Office of Mental Health is dropping a modular unit, but the

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responsibility, it's not the LSU Health Sciences Center where I am, but the LSU Health Care Services Division, the Charity Hospital Division, that operates out of Baton Rouge. And that truly needs to be reestablished, we need emergency services and crisis unit and a 72 hour stabilization unit so that there can be the effort to get people back in homes, but get them into treatment and also provide medication, provide 24 hour access to services.

You've seen some of these figures already stated, there certainly is an increase in mental illness. Part of this is people with prior medical illness without treatment, worsening of symptoms, part of the people did not have problems before. And part of what we've been seeing is people who feel they can't get services because they can't afford them. I've mentioned the police calls relative to the population, police calls for serious mental illness, for gravely ill people, suicidal, homicidal, are all proportionately. And the police will talk and we have the instances, at least of episodes of violence, of suicide, of homicide, related to people not receiving care.

I've got the figures up here for the emergency medical system. This is a small system, and yet, at least approximately once a day, they are getting calls for people again, who are bizarre, they get calls for people who have made

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a suicide attempt, and the smaller one on the right is for people who actually, by the time they got there, had completed a suicide. And then there are the real problems that the police and the EMS have, and two weeks ago, the CO of University Hospital, a chair to the Charity Hospital System, talked about the mental health, mental illness, clogging the emergency room. These people that couldn't go on, other people weren't getting treatment. And as much as I appreciated his statement on one hand, in a way again, it was taking the victims and making them the problem. The problem is everyone who has an illness, whether it's mental or physical, deserves the care, and that we should be respectful. And what this does to the perception of nurses, of patients, of residents, of people who are working to do this. We're in a situation now where the Office of Mental Health is trying hard, transporting people around the state, this means that very often, parents are not part of their children's treatment, that people aren't getting the continuity that they need, and the other problems that exist along with it. And I do mention what's happening with Orleans Parish imprisonment began before the hurricane, but the police told me how before the hurricane, they would try and use excuses to divert people with minor problems to Charity, now they may divert them to the parish prison, because at least they know they'll get medication and some mental

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health treatment. Obviously, terribly to criminalize mental illness and get people record.

Okay, with that, I don't mean to end on a discouraging note, and yet this is something we deal with every day and trying to see how resources can be better coordinated, how they can be rebuilt, how there can be more available to the people, and we are all working together on a state and local level with our district in trying to rebuild these services. Thank you.

ED HOWARD, J.D.: Thank you very much, Dr. Osofsky. We've heard some sobering assessments of both what was going on before and what the situation is now. You get a chance to weight in now with questions about any aspect of this, once again, you have green question cards, and there are microphones at either end and in the middle that you can use. And let me start, we've got somebody at the microphone. I ask our questioners to identify themselves and keep the questions as brief as they can so that we can get as many of them in as we possibly can. Yes sir?

AL GUIDA: My name is Al Guida and I represent the National Council for Community Behavioral Health Care. They represent the nation's community mental health centers. I have a question for Dr. Cerise. I'm just holding in my hand an April 22 Times article that goes over much of the same ground that Dr. Osofsky just described. It indicates that the city of

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New Orleans lost 300 psychiatric beds, you lost 19 community mental health centers. That's most of the outpatient psychiatric capacity in the city, and most of the emergency psychiatric beds. According to this article, the largest inpatient psychiatric facility is the Orleans parish prison. Dr. Cerise, on behalf of my client, we approached Senator Landrew regarding additional monies in the Supplemental Appropriations Bill, to provide for additional mental health services on the ground there in New Orleans beyond the social security, the SSBG monies, there are about seven million dollars in that for mental health services. By the way, the wait to see a community psychiatrist in New Orleans in a community based facility is four weeks. So I understand from the House Oversight Investigations staff that people with mental illness in emergency rooms in New Orleans are held for the rest of the population by ropes, and they are under armed guard. So when we approached Senator Landrew's office in an effort to generate additional appropriations beyond the SSBG money, we were told that Governor Blanko had not requested any mental health monies beyond the SSBG extension, so therefore the request was denied. So I have two questions for you, sir, and I recognize you are in a very, very difficult situation. You have my great sympathy trying to stand up an entire system in a very difficult set of circumstances, obviously with very

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limited federal support. Can you help the staff take us through how you help Governor Blanko shape her FY 2008 appropriations request, can you help us understand what your constraints were? Can you help us understand how it was that the only additional federal discretionary monies you requested are the SSBG money? And secondly, can this be appealed? The appropriations committee's are actually well under way to marking their bills up. But on behalf of my client, I am sincerely hoping that some kind of a supplemental request might be put in to address the dire situation that Dr. Osofsky described a few moments ago, that frankly seven million dollars barely scratches the surface.

FREDERICK CERISE: A couple of things, first the funding for behavioral health is much more than seven million dollars. It was 80 million dollars in that SSBG, that is a statewide number. The majority of that though, is in the New Orleans region so it's much more than the seven million. The biggest priority for us, back in the time that you are talking about, was getting an extension period for all the SSBG funds. That was the largest priority because we knew that we weren't going to spend those dollars in the limited time period that we had to spend them. And the reason for that, in a nutshell, is it's a lot of money in a short period of time to spend on a complicated problem. And when we talk about lack of mental

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health beds in the city, we lost about over 400 behavioral health beds in the city before, we have about 150 now. The 97 beds at Charity that were lost, the others that Dr. Osofsky talked about. Now we've gone to every provider in the city, in the region, and said, look, if we can pay you to open up psychiatric beds, will you open psychiatric beds for us? Every hospital that's open in the region and we have one taker that said they'll do 12 beds for us, and it'll take a year to do the renovations and to get the beds up. So we have done, the state does operate some facilities. The Adolescent Hospital in New Orleans, we have changed from that mix, we've added 20 adult beds there, we are renovating a section now, and this summer we'll add 20 more adult beds there, which is that's a big deal to put adult beds there, and we've gone through that, as you can imagine, but it's a temporizing measure. We've brought up beds in the surrounding area in Baton Rouge and north of the lake, and Hammond we've been able to bring up almost 50 beds in those surrounding areas. It's by no means ideal, but it's where we have space and we have work force that it's much easier to turn on. And so I guess the answer is we do have requests, in fact we have budget associated with a behavioral health plan that we have put forward, but the priority at the time you were talking about was not to reach this endpoint where we had millions of dollars of social service block grant

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funds unspent that we knew we needed, but that we weren't going to be able to spend because of constraints on work force and buildings. I'll tell you one other thing just very quickly. I was at Jefferson parish, the human service district there which runs their community services, I walked into a meeting that they were having with about 50 social workers in a room training them in post traumatic stress, and you just don't have the volume of people who are poised and ready to go into the field to do these services, so it's taken awhile to get some of them in place.

ED HOWARD, J.D.: I should say, as we move to the next questioner, I didn't mention that there are some evaluation forms in your package that, as we move through the questions and answers, I would appreciate it if you would keep it in mind and fill out at the appropriate time. Yes?

NORA SUPER: I'm Nora Super with AARP, but my question is really more personal one, as a New Orleans native, and also my father was chief of psychiatry at Charity Hospital for over two decades, and I know that the governor's task force had looked at whether or not to keep the Charity system in place before they were sidetracked by Katrina, and the Kaiser Family Foundation survey indicated that New Orleans residents were still very supportive of the Charity system, and I know was always viewed as a place for uninsured residents to go to, and

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I wonder now where that whole system is viewed, Fred, if you could just look at that now since Katrina, share your view on that?

FREDERICK CERISE: I think, as you said, there is great comfort there for people that have gotten care in the system over the years, so there continues to be great support for that system. The work that's being done now and looking to replace Charity, is looking at that in a much different way. The work is focusing around an academic medical center that LSU and Tulane and the VA will partner with, with a smaller central campus for those services with a more dispersed network of clinics across the city, coordinated with other clinic providers. So I don't think that the region is interested in, and if you look at Diane's data, not having anything there. But the people that are responsible for rebuilding are looking at it in a much different way than it has functioned in the past.

RUTH PEREAU: Yes, good afternoon. My name is Ruth Pereau, I'm the Executive Director of Summit Health Institute. At the end of February, I had the opportunity to be in New Orleans at the Health Information Management Systems Society Conference, I had the honor to meet a number of very, very brave people. One of them was a [inaudible] who was a nurse practitioner, and she was able to escape the floods with a few

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belongings and her palm pilot. And thanks to her foresight she was able to reserve and preserve the records of the people she cared for, elderly citizens who she visited in their own homes. She saved the records of 50 people. She now serves 400 people by herself, in consultation with a physician and a pharmacist, who often provides medications for free. If she were here, she would say, help. But she would also suggest that there are some creative ways to deal with the situation right now and I'd like to get your comments from the panel. One is serving people in their own homes is a way of providing not only medical benefits, but mental health benefits. The personal touch means a lot. She sees people in seven or eight senior citizens in one home sharing medication. Secondly, using health information technology as a way to augment and supplement the personal touch and expand the numbers served. She is also finding that seniors are very pleased to know that their records are being preserved in this way. And thirdly, she would like to say that she needs more help with nurse practitioners and consulting physicians so that they can augment and stretch the resources that are currently available. These seem to be creative solutions to the problem now and I'd like to know if the panel has other creative solutions to the problem right now.

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MALE SPEAKER: I can start. I think that those are very good ideas, and in fact, as we've looked at trying to fill the gap to rebuild, one of the things that we recognize is that here is an opportunity, because before Katrina, in fact not only in Louisiana, but in a lot of places, for someone to be in business and to survive and get reimbursed, it's all driven by the visit, right? Come to the office, generate a visit, and that's how you get paid. And we realize that there's much more to it than that and this medical home network that we've described is something that takes into account the kinds of things you are talking about, and that is having a site that is an access point for people that is driven by primary care providers, that doesn't necessarily have to have a physician visit for every exchange. In fact, nurse practitioners and others knew what to expect to be participating in this, using IT not only for, as you said kind of preserving those records, but to the extent that it works, depending on the population, email visits, and using telemedicine to do consultation with specialists. There is actually a clinic in St. Bernard, the only clinic in St. Bernard now that, as they look for specialty support, that is liable to be an option for them as well as what we traditionally think of in our rural areas, so I think the concepts are there, and as we support systems and coming back, that's one of the things that we are looking to do, is

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also redesign how those providers actually participate in the system in terms of structuring organizing services, and getting reimbursed for those services.

ED HOWARD, J.D.: Diane?

DIANE ROWLAND, SC.D.: You know, I also think that as you look at the survey that we did, you have to recognize that we deal in the health care area, but the population is facing challenges across a multitude of every aspect of their lives, from schools to housing to safety in their neighborhood, and I think one of the other areas where one can be innovative is to try and use the schools as they come back up, as a base for both community care as well as for school based care and that that is one of the areas that may be able to help both support the children, but also help with their families. And I think there are ways to rebuild that that should be looked at as well.

HOWARD OSOFSKY: Could I make a comment or two also? Because I think this question and the other question are both pertinent that under the Stafford Act, obviously there are no clinical services that are about to be provided. I don't believe that we do much good with the crisis counseling and now the specialized services counseling program. I'm not knocking it for what it is and we've been working at constantly improving and building in quality. However, I think everyone

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recognizes it's not enough. And certainly when we're talking 21 months after a hurricane, even much earlier, one recognizes that the restrictions of the Stafford Act also are problematic and probably really should be looked at. We are working, I've been fortunate in retaining such incredible loyalty, I hope we keep it, I even have a waiting list of new professionals who want to join our department, but for example, with children and adolescents, we work mostly within the schools. And this makes it much easier for them and for their families, and this week I have a meeting, we offered it a year ago, but to work with the reestablishing school based health clinics. When we get to the elderly, there is really still another problem, and Dr. Kevin Stevens just documented an article, that's a disproportionate death rate, if we take a look, and we know that it's a combination of physical and emotional, and we take a look at elderly who don't have the supports that they had previously and how this tips them into being less able to function adequately, and the need for a much broader array of services. We have been working with Metropolitan Human Services District, encouraging the idea of mobile outreach programs, and we certainly do believe in telemedicine. I think we've got to be at least a little careful that there does need to be the human interaction too, I think especially if one takes very disturbed people who come into emergency rooms, it's helpful for people

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to see them, or to see them for their first contact, and to try and blend all of these, and having services where they are accessible, where they make sense to families, and to build this continuum, but to build it in an accessible manner.

MALE SPEAKER: Could I just ask, I may be the only one in the room, but is it the Stafford Act that you made reference to? Could you sort of explain what the impact of that act is on the aspects of this that you were describing? And what it is.

HOWARD OSOFSKY: Okay, the Stafford Act, in my understanding, has actually changed several years ago. At one time, it could provide more clinically oriented services and then—

MALE SPEAKER: This is services in schools?

HOWARD OSOFSKY: No, this is the federal act that allows for crisis response after a disaster. And it specifically prohibits clinical services. In other words, it allows for counseling, it allows for brief sessions, and some of it is helpful. One can have up to five sessions, there are no medical records kept, they are not medical sessions. They are trying to help people understand what their problems are, to get them connected with other services, to help them in rebuilding, and I'm not saying that it's not therapeutic, but in other words, one can't provide mental health treatment, one

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can't provide medication, one can't provide what most of us would call clinical intervention. It's forbidden by the act. And that's the bulk monies that are coming in for programs like Louisiana Spirit or Project Liberty, or what went on in Florida after the hurricanes. Florida was able to get some other enhanced services funds, but these are the limitations of the realities of the act.

MALE SPEAKER: That's very helpful. Yes, John?

JOHN LUMPKIN: The Stafford Act is actually a much broader act in that it deals with all kinds of emergency responses. Even from my years in the state of Illinois, we always struggled against that act, understanding that the purpose of those provisions were to not encourage communities that were recovering from a disaster, to use those funds to build new malls and things like that that weren't what was destroyed, sort of hazard replacement, but I think Katrina is a perfect example of some of the failures of that act. Charity Hospital is perhaps a very good example because the Stafford Act only funds restoration to the state, you have a hospital that was build roughly to 1935 specifications. The 1935 specifications would say that the generators, which were in the basement at Charity, if they were going to rebuild Charity and are funded by the Stafford Act, then the generators would have to be placed in the basement, which makes no sense whatsoever.

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Otherwise, they would not be able to be funded, so I think that there are a lot of lessons that can be learned from Katrina of how the federal government can help communities, particularly as it relates to the health response, respond to those disasters that completely overwhelm the capabilities, at the same time design it in such a way that the federal government plays an appropriate role without the states taking advantage of them.

ED HOWARD, J.D.: Yes, go ahead.

ART KELLERMAN: Art Kellerman, I'm a Health Policy Fellow with the Oversight Committee in the House. I have a statement and then a question. The statement is to point out to you on the panel and to the people in this room, a number of statements were made over the course of the discussion that would lead one to believe that the emergency care system in New Orleans is indifferent, sometimes hostile, and clearly inadequate. And I do think it's important for historical record for people to know that the doctors and nurses, who comprise that system and the medics were absolutely the backbone of the response after Katrina, were the last doctors and nurses to leave Charity when Charity was evacuated. It didn't leave until the final patients were taken out, having taken them up and down 13 and 14 floors of stairwells. They then staffed a tent emergency department in a parking lot for

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months, while everybody wrangled about physical facilities. Those tents were then moved into a downtown department store, where they continued to provide care 24 hours a day, seven days a week, 365 days a year, and I have heard many panels and presentations, and I never see them here because they are always back in New Orleans taking care of patients, 24 hours a day, seven days a week. As an emergency physician you might be surprised, or else why would I be this partisan, it's very difficult to provide care to acutely psychotic individuals when you have stretchers in a hallway, inadequate exam rooms, no place to admit the critically ill and injured, and no primary care or outpatient care system to refer your patients out of the ER once they have been stabilized. That's the statement, here's the question. Like everyone in this room, I heard the President of the United States stand in Jackson Square and promise that this great country was going to come to the aid of our brothers and sisters in the Gulf 21 months ago. I'm sick and tired of hearing panels like this one, with superb, committed, idealistic people, leave me nothing but depressed, almost in despair, for the fact that you all are trying with band aids and spit to resurrect a functioning health care system in New Orleans and in the Gulf. What is it going to take to get beyond this kind of retail level discussion of what we're going to do and really come at this with the major

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commitments that have to be made to not rebuild a 1930's system, but construct a 21st century system, that will not only serve as a system in the Gulf, but be a lesson for the rest of us in this country. Surely we have the capacity to do that.

ED HOWARD, J.D.: By the way, there's a question, maybe you wrote this on the card. No, actually it is a congressional staffer, but it is somebody from a Louisiana member of Congress who wants to know, in respect to workforce issues, but certainly more generally is the context in which you raise it, what can we as policy makers in this room and the people you work for, do to help the state come to grips with work force issues, with Medicaid and Medicare issues? What is it that's on the agenda that we ought to be able to let people know they ought to be working on it? Big answers and small answers.

MALE SPEAKER: I can start. First off, let me say I appreciate your comments because those are my friends at Charity and I walked down those 13 flights on the outside corridor with them. And so I know the group you're talking about and Peter W. and company, those are committed individuals and, as you can imagine, frustrated individuals as well. They were pleased to finally get University Hospital back opened and the emergency room there back open. But it's just not enough. And so when you say, what is needed, there certainly is a long term look and a long term look is looking at capacity and

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replacing capacity and that has generated a lot of debate and discussion, because there's this tension, this disagreement on, should there be a Charity Hospital in New Orleans or not? And people split ideologically on that, and think if you build the building, then you're committing to warehousing people at one place, and it's got all kinds of negative connotations and that's not all what's on the drawing board. But because of that, there is resistance to even that long term solution that we're still trying to work through. But that's a longer term issue. In the short term, our biggest challenge continues to be work force, work force. And you talk to hospitals in the area, including University that's now open, and with the people they could open up more space and more beds. It's not all of the space that we need, but it's certainly a big part of the solution. We had put forward some requests in this regard in our discussion with HHS in terms of the issues we need to meet immediately, in terms of a significant investment in a work force initiative to recruit people into the area, to get people to commit to three years in the area. What we have right now in hospitals is they are all sort of up in the ante against each other trying to get nurses into the area, and the contract companies are just doing great, they're loving the competition because the price just keeps going up and up. What you need is something to be able to get those nurses to commit to work for

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a hospital and not for a contract company, and commit to be there for three years. We've got a package that describes that. But I think that's probably our biggest need. There are a number of other things that we need, but the most critical thing right now is work force. Can I also say, and again, as somebody who I wasn't in Charity, even though it was my department, I was in New York consulting on disasters when the hurricane hit, I got right back and have been working since in the streets, with Charity, with Memorial, with what people went through at various hospitals and continue to go through themselves, wonderful people. We worked very closely with the emergency room doctors, at times the state will say to me when they said to wear a shirt and tie, we need the heart and the brains, but we need to do it this way too. But I do want to mention we could look at it on every level and I think the emergency room doctors would say the same thing that I am. We do have the work force problems but there are hospitals in the city that could likely be doing more. Or the metropolitan service district is still somewhat fragmented in its services and its staff and what it's able to provide and really needs to be taking a more holistic look in working together and I know [inaudible] was working with them yesterday. They are trying, the CEO, the original CEO lost her position and there was a five month search, there is now another CEO who has his own

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plans. I can also say on the state level, we truly need to recognize the importance of people getting care in their communities and the importance of that in the health care services division, which is part of LSU, really is trying but there needs to be timetables to reopening in a variety of ways, the continuity of services that would be provided. And by the way, the emergency room doctors would agree with me that we would be pleased to open an urgent care center, and we talked about the Lord and Taylor's there, but one that's safe and secure could be providing diversion in primary care as well, so I don't really know how that's going to go.

ED HOWARD, J.D.: Diane?

DIANE ROWLAND, SC.D.: I think we also know that while there are these immediate needs, what Katrina showed us in New Orleans is that we're totally unprepared as a nation to respond quickly and effectively to a major catastrophic event like this, and that while we've got all our FEMA and our other tools, we don't have a way where Medicaid can step in immediately, where some of the resources can be there, where mental health services can be provided, not just as a result of the trauma, but to those with mental health services, and I think it does call for really looking again at the federal response and at what the federal government needs to have in place to deal with this or a dirty bomb or some other

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catastrophe. We don't seem to have learned a very good lesson yet from Katrina.

HOWARD OSOFSKY: Could I also mention that the public health service and FEMA were wonderful, we worked very closely together. But if you take a look in the early response, one wasn't allowed to utilize Louisiana psychiatrists, psychologist, and social workers, and at a time where, if anything, we were trying to utilize the best talent we have, this was not part of the provision of the federal response and this eventually changed. I think going along with the comments, we really do need to look at the overall planning for health care, but also for the disaster responses, especially when it's going to be long term responses.

DAN VOCK: Hi there, I'm Dan Vock, I'm a reporter with stateline.org. I was just hoping you could bring us up to speed as to what exactly is going on between the Bush administration and the state, as far as the primary care versus Charity. I mean, it's come up a couple times in passing, but if you could just bring us up to speed, and also give us an understanding, within the state of Louisiana, whether there's that same debate going on, or whether it's just kind of a cultural thing that people in New Orleans are for the Charity care regardless, or across the state, regardless.

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MALE SPEAKER: I guess in terms of, I'm not quite sure on your question about whether it's a debate just in the city of New Orleans and what's the feeling there, I think before Katrina, there was this debate in the state about how we should deliver health care, should we be doing it through a public delivery system or should we have another model where people have insurance or were using private sector services and reimbursing that way for care. So that was an ongoing discussion. There's not agreement within the state. Louisiana, I don't think is unique, that discussion happens in a lot of states and a lot of major metropolitan areas with big public hospitals. I would bet Grady that you probably talk about that, I know in Chicago they talk about that. We have raised it to another level in Louisiana because we do have a state wide system, but the model is the same. Just to bring you up to date on the discussions and give a little bit of history there, shortly after Katrina, Secretary Levitt came to New Orleans and said, we want to help you guys, we realize that there is a void here, and we will work with the state to develop waivers, to develop changes to the way we administer and pay for services, if you'll work with us and agree to this process, and it was a process that was set in place. A 40 member collaborative, broad representation, and that collaborative put forward a set of recommendations on October

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20th, and I'll tell you, we did that with an understanding that the concept that we put forward, at least from the state's perspective, was going to come with a significant price tag because if we are to, it involves insuring the entire population or the majority of the population. Right now the uninsured in the state and around the country use fewer services than the insured, they cost less, and they're not getting services. To insure them it going to come with a price tag. We made that very clear in our discussions and we're actually put in a bit of a position, I felt, that there were several, it was a gradation of what we could request here, but there was a clear desire on the part of the administration for us to put forward a model where people are receiving an insurance product and essentially use the disproportionate share of funding to purchase insurance for the population. And so that's what we put forth, not because, and I say I hesitate, not because we didn't want to insure the entire population, we would love to be in that position, but we know not only were we dealing with a federal budget neutrality, but also state affordability issues, because we still were going to have to come up with match for this. And so anyway, we put that forward with the understanding that there's a significant price tag associated with that, and we would need significant additional federal funds that we don't have today to make this

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work. We did get a series of discussions with HHS, afterwards we got a response, ultimately, and the response was one that the state was uncomfortable with. And I say the state, the state leadership, certainly the governor and legislative leadership, was uncomfortable with, and that is it transferred 770 million dollars in disproportionate share of funds, essentially the funds for public hospital and clinic system, for the purchase of insurance for about 319,000 people, which is less than half of our uninsured population in the state. We think the 319,000 is an optimistic number, it's based on things like per member, per month of 157 dollars, and without a safety net system, we felt like that was highly discounted, there were things that the collaborative said that the reimbursement would have to be at least Medicare for providers and this was modeled at Medicaid, and so there were a number of things like that. So long story short, that statewide mission that we put forward, we are not pursuing right now, we are looking at can we do something on a regional level in New Orleans and Lake Charles, the other region that was affected by hurricane Rita, and can we craft a model that incorporates the principals of this delivery system that the collaborative put forward, but on a much more limited scale that doesn't eliminate the safety net in the process.

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ED HOWARD, J.D.: Anybody else want to take a crack at that?

MALE SPEAKER: Can I just ask a quick follow-up, Fred, one of the pieces that are in the materials is about a new estimate by an LSU research unit of the number of uninsured people in the state. Do you and the federal government now agree on how many there are?

FREDERICK CERISE: Yes, and that's an interesting piece too, because the way this came out, we worked close together throughout a lot of the process and then there was a gap when we didn't work together, and then there was a federal proposal that was made very publicly, and we were in a position to react to that. And one of the things we were not in full agreement about at the time was the number of uninsured, and that became an issue. It's really not a tipping point kind of issue for us, because we're so far off, but we do have agreement on an estimate of the uninsured. It doesn't substantially change the position that we're in.

ED HOWARD, J.D.: Okay, thank you. Go ahead.

MALE SPEAKER: Before we go, there is a question about could you address what Katrina did to the long term care facilities? And what are the plans in place to do evacuation, based upon the lessons learned in Katrina?

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FREDERICK CERISE: Diane, do you want to start? I'll start and give some specifics on what we are doing.

DIANE ROWLAND, SC.D.: We did one study of the long term care facilities, obviously one of the big challenges there was how to evacuate them and when to evacuate them and what one learns about evacuations for frail, elderly people is that they can sometimes be more harmed by the process of evacuation that by staying in place, staying in a place that is safe. However, many of the facilities ended up expecting to be able to just house their population in place, and had to evacuate them with unfortunately a loss of life associated with that. And now Fred has evacuation plan.

FREDERICK CERISE: Traditionally, in Louisiana, the long term care facilities have had to have an emergency response plan on file with the local office of emergency preparedness. And that was the extent of it. We, as the surveying agency, had to make sure they had that on file, but it was up to the local OAP to coordinate that. And it became clear to us that that was just not sufficient, there were issues where they may have all been pointing to the same transportation company, that you would never connect the dots, and so there's no way in the world that everybody was going to get out because they were all pointing to the same resources. Things like that that just requires a higher level of

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coordination. We have addressed this through several laws in the interim now dealing with building code requirements where there are standards that we will be bringing very shortly on new construction. Also, kind of a grid matrix that deals with location, elevation, current construction, and what you're able to withstand to be able to make some decision matrix on staying or getting out, because like Diane said, obviously, if you can stay put, that's the best thing because fragile people don't do well with long evacuations. But we realize that that's a balance that we've got to hit. And so we have done, in the interim, planning with those facilities, individualized planning, they know that they are responsible for transportation, securing those assets ahead of time, we go in and check to see if they have legitimate contracts in place, we also recognize that at the eleventh hour, those things may not hold true. And so we've got buses that we've secured from out of state that will be on standby that will be able to come in as backup. So we certainly were deficient in that level of planning before, but feel much more prepared now.

SARAH: Hi, my name is Sarah [inaudible] and I actually work here in D.C., but I am from Baton Rouge. I represent the coalition of leaders for Louisiana Health Care, which is a new group of business and health care leaders in Louisiana that have formed to, I think their goal is to really take the next

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step in what the health care redesign collaborative was talking about, in terms of medical homes and health care reform generally, with the focus on region one because I think that you're correct Dr. Cerise, that it's a lot easier to focus on region one than it is to really look statewide, at least in terms of trying to find consensus. One thing that concerns me a little bit is that there hasn't been a whole lot of emphasis, and it happens I think persistently in these kinds of panels, on the reaction of the private sector taking care of folk's post-Katrina, and a lot of the hospitals and the clinics and the community physicians that really did step up to the plate. One of the big priorities of this coalition is that in any system moving forward, and I think the state has done a wonderful job of really raising the medical home system of care model, bringing it to the state legislature and trying to move it forward. But the big question becomes what is the private sector's ability going to be to participate in that system? Are they going to be able to provide the care that they are providing now? The unfortunate part now is that the reimbursement structure in Louisiana is such that a lot of times they're not getting paid for providing good care and I think a lot of the folks, especially the path network and the community physicians and hospitals that are private and non-profit based, we really would like to see a system where they

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can participate and they can provide care, and I think ultimately we knew pre-Katrina that the Charity system was a problem in terms of low health outcomes and moving toward some system where the private sector can participate, I think does potentially raise quality as well as access to care, which is something that the Kaiser survey noted. I was very interested to see that the Kaiser survey noted that in New Orleans, a lot of folks do want to rebuilt Charity, that being said, I think that a lot of folks also, because they don't feel like they have access to care, probably don't know that there are other options. And so the question becomes then, how do we educate people, how do we outreach to people to inform them that there are other options outside of the Charity system? How do we fold in the private sector and then let people know that those private sector providers are other options that they can turn to for care?

DIANE ROWLAND, SC.D.: One point about the survey, most people answered that question did not have Charity as their usual source of care before, or after the storm obviously, but were using the private hospitals. So we did get, and you can find in the cross text, where everyone said they were going for health care before, and now go for health care afterwards, in the statistics.

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MALE SPEAKER: We've tried not to make this a public/private discussion, we tend to get that attention nevertheless, and we're looking at how do you best provide care for people that don't have access today? Because we look at the inner city, there generally is access for people with insurance today. It's not 100-percent, you've got some gaps there, but largely we're talking about the Medicaid and uninsured population there, and we're looking at, what we'd like to see is a system of care that provides adequate access to those individuals at a price that the state can afford, because obviously, again, when we've done the math on taking each one of those individuals and providing them with an insurance product, like most states in the country, is not in a position to afford that. And we hear a lot about two tiers and we don't want to have a charity tier and another tier of care, but if you look at the insurance proposal put forth to the state by HHS at 157 dollars a month, I would contend, that's a lower tier of insurance coverage for the uninsured, and we're more comfortable with that. So we tend in the state, we tend to fight over this pool of funds that go into the public delivery system, and when Price Waterhouse did a report after Katrina that showed in the state that we had 19.4 billion dollars of spending in the state, and using all sources of spending on the uninsured, it was about 1.3 billion for the

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uninsured. And if you looked at just the spending in that public delivery system for the uninsured, it was about 600 million or so. So about three percent of the spending in the state on 17 or 18-percent of the population, I tell people that's not where we're going to go fix our health care problems in the state, in focusing on that component clearly there's a role there and there are things that need to be done to improve there, but we need to look at what are the expectations in order to provide access to people in a coordinated way that the state can afford, and then there are a number of entities that are not public entities that are providing those services in the city today that we would expect to participate in this system of care. What we're trying to do is match capacity with the need for services, but not have it wide open, you send in a claim and the state pays it because we know we would not be able to afford that.

ED HOWARD, J.D.: We have only about 10 more minutes, so we have some folks who are already in line and you get a chance to ask your question, please.

MARY GILIBERTI: Hi, I'm Mary Giliberti, with the National Alliance on Mental Illness, which is an organization representing family members and individuals with mental illness. And my question, I recently was in the New Orleans area, and I spent some time with the ACT teams and mobile

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crisis people and the police, unfortunately. And I noticed two things, one was there was a very small percentage of people, smaller than I would expect, who are actually on Medicaid, that were seriously mentally ill, and secondly and maybe more importantly, a lot of the services weren't being billed to Medicaid, they were using other funding sources to pay for those, and so that's my question, I know that there have been some proposals to the legislature to get more people onto Medicaid, but could you talk a little bit about those plans and particularly with respect to the state plan, any changes in state plan and timelines that people might expect. What I heard from a lot of people was a big worry about sustainability over time and that Medicaid might be a helpful sustainable force for that, but I'm concerned about a timeline for moving forward, given that some of the other funding sources may be very time limited.

MALE SPEAKER: A couple of things on that, you're right, when we look at our mental health clinics, less than half of the individuals there are on Medicaid, we get very restrictive financial criteria for parents, as Diane showed in the state. We have just recently changed our disability determination process, we've through state plan so that now we do that within the Medicaid agency, we were relying on SSI and deeming that as eligibility for disability purposes, we've just

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recently taken that in and we hope that we are going to be able to get more people enrolled in Medicaid through that process, and there's actually a state appropriation in this year's executive budget that goes along with that to show support for that. We have asked in our process of discussions, with CMS about this issue, and can we qualify as a Medicaid eligibility category in this region, people with serious mental illness, because of the circumstances, and have not gotten a favorable answer on that. So we're looking at it from, and I know that that's not the norm, you would need waivers to do that, but we've tried to do it through the disability process but we will still pursue that issue of trying to get Medicaid eligibility for that population because, like you said, there's a great need there.

ED HOWARD, J.D.: Yes, go ahead.

STEPHANIE: Hi, how are you all doing, I'm Stephanie from Senator Landers office and I just wanted to thank you guys for coming up here to try to put this information out here and thank you for everything that you have done to try to pull things together. I know that everybody is in a difficult position down there and the work that you guys are doing to try to work with our offices and everybody up here to address work force issues and mental health issues, and appreciate it. What can we do to try to help you, as we work to rebuild the health

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system infrastructure, set it up so that we will build into the system that addresses some of the primary preventive care needs that could help bring down some of the health care costs, and the outcomes that the state has had to sort through?

MALE SPEAKER: Thanks, Stephanie. Well, the gaps that we have, again behavioral health is a big gap, we've heard about that and certainly primary care. If you look in emergency rooms and walk through emergency rooms in the city, there are always people waiting for beds upstairs, it's not just a behavioral health problem, it's a capacity problem all around as well, work force would help address that, and the way we've tried to look at this is can we add work force? And that's complicated by the fact that there's limited housing, there's other infrastructure things that complicate that, but certainly having some funds to recruit people into the area, incentives to recruit people into the area, is going to be a big issue. And then, what we'd hoped to do in terms of the primary care component, use that recruitment as a way to pull them into a coordinated system of care, the medical home system that Sarah was referring to, that I had talked about before, so the biggest single issue on there is recruiting people back into the area. It's just an odd situation because you've got a city that is coming back in piecemeal, you've lost so much in terms of both infrastructure and population, and as that comes

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back, and it just doesn't come back in order. And so you've got people before you've got some of the other essential infrastructure pieces, and to get those infrastructure pieces in place, you need more people. But housing continues to be a challenge. But recruiting folks back is our biggest issue and the health care work.

HOWARD OSOFSKY: First of all, I'd like to say we appreciate what you're doing and what the senator is doing. There are so many pieces we could focus on because there is the issue of mental illness and severe mental illness, which is very important. There are other people, as Fred was pointing out, who are newly mentally ill, who didn't have problems before. But we also have the people, I hate to call them mentally ill because they are way out there under a great deal of stress, we see a lot of depression, we see other types of symptoms, family problems. We really look at prevention and when we take a look at the next generation of people, the importance of doing things not only with school age students and their families, it's all familiar from even living with their families and overcrowded situations, that very young children, where we see the impact on them and their families and what we can do in a preventive type of way. In addition, what we can do in trying to turn risk into even greater resilience and strength. There are so many areas, but getting

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away from our area today, but I think they are all parts of the same piece in trying to rebuild the city and give people their future.

FEMALE SPEAKER: And I guess I would just say that as SCHIP legislation comes forward, obviously it's been a very important building block in providing health care coverage in Louisiana and across the country, and as we saw in our survey, children, there are still uninsured children in Louisiana, fewer than there used to be, but there are a lot and they have a lot of health needs that are going unmet, so clearly making sure that we don't move backward on coverage of children is a priority that can be on the table and ought to be on the table.

ED HOWARD, J.D.: Yes, I believe you're going to have the last question.

LISA ERICKSON: Okay, my name is Lisa Erickson, I'm with the Association of American Medical Colleges, and I have a little bit more micro level question that I thought might be appropriate. I was wondering if there are any people that are moving towards using group visits for medical care. As it seems like an effective way to use limited personnel and medical staff to treat larger groups of people. It's been an effective care model in diabetes and other chronic care diseases and might provide an opportunity to address some of the mental health issues as well for this population.

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HOWARD OSOFSKY: In our field, some of the models we're introducing are group models. They are group models that, for example, you were just talking about children and adolescents. A number of the models that we are utilizing are group models that can incorporate this. We do group supervision in addition to the models of intervention, so we're trying to look across the life span at different types of models that can be addressing these types of needs, but also then, the ongoing supervision of people to implement these models in a quality manner.

ED HOWARD, J.D.: Got a comment, Fred?

FREDERICK CERISE: Yes, I actually worked with Karen DeSalvo from Tulane on an Ark Grant several years ago and to recruit visits was the project she was looking at there, and so I would be surprised if for clinic covenant house is not using group visits in this. And again, it's one of those things, as we look at reimbursement structure for practices that come back as part of this network, we want to give them the flexibility to do that and not have to have single visits to generate their revenue.

ED HOWARD, J.D.: Okay, this has been discussion from which I learned a lot. John, do you have any closing comments? If not, let me just ask you if I can, remind you, that it would be very helpful to us if you would fill out that blue

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evaluation form that's in your packets so that we can try to make these programs better the next time around. I want to thank the Robert Wood Johnson Foundation, and particularly, John Lumpkin for their active participation and his active participation in this program. Thank you for your very active and lively participation in the discussion and I want to thank the panel, and you can join me in that, if you would, in congratulating them on dealing with a very—

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