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**UNITED STATES HOUSE OF REPRESENTATIVES  
COMMITTEE ON ENERGY AND COMMERCE  
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Hearing on:  
**“Post Katrina Health Care:  
Continuing Concerns and Immediate Needs in the New Orleans Region”  
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**I. INTRODUCTION**

Mr. Chairman and members of the Subcommittee: Thank you for the opportunity to speak today about post-Hurricane Katrina health care recovery in New Orleans.

I am Dr. Karen DeSalvo, the Executive Director of the Tulane University Community Health Center at Covenant House, a clinic formed in the aftermath of the storm to meet the urgent needs of the population of city. Since September 2005, I have been active in efforts to restore immediate health care services and in planning groups focused on the longer term vision of a redesigned health system.

Before I begin my testimony, I want to thank all the Members of the Committee for the opportunity to review the progress we have made. Health care is not a partisan topic and many have contributed to our progress, including the city, state and federal officials you will speak with later. All deserve recognition for working earnestly towards resolution of a uniquely difficult situation for our nation. Your assistance is needed now to help health care recovery efforts in New Orleans continue to progress so that people who are currently uninsured, and without access to essential primary and preventive care receive the care they need.

Today I will share with you my perspective as a primary care physician trying to care for the uninsured patients on our city. I hope to give you a snapshot of what it is like to practice medicine in that environment, the challenges we face, what would help improve access to care in the short run, and how we might go forward to ensure that we provide support for the New Orleans safety-net primary care system while deciding the larger policy issues.

## **II. PRIMARY CARE RECOVERY: WHAT WE HAVE ACCOMPLISHED**

We have come a long way towards restoring health care services in the 18 months since the flood waters receded. Much has been made of the divisions in New Orleans, of our struggles in surviving the storm and its aftermath, and in beginning the process of rebuilding from it. A much overlooked bright spot in those efforts has been the progress we have made as a community in building a care network for our most vulnerable citizens. The community has pulled together in unprecedented ways to overcome overwhelming challenges to restore services and define a better health system.

We described this Louisiana vision for our re-engineered health system through the reports of several planning groups. Health and Human Services provided critical support for much of this work beginning with the United States Public Health Service support of the “Framework for a Healthier New Orleans” and culminating in the Louisiana Health Care Redesign Collaborative Concept Paper (Concept Paper). While we have been planning the future, we have been living in the present, all the while trying to keep within the vision of a distributed ambulatory care system that can make primary care more accessible.

Historically, our safety-net system has been the Charity hospital and associated clinics which were staffed by physicians from both Louisiana State University and Tulane University.

An estimated 250,000 people received care, including primary care, through that system. Before the storms, smaller, community-based providers were increasingly working in concert with the Charity system, but their share of safety-net care provision was small.

The flooding caused by Hurricane Katrina destroyed much of the bricks and mortar of the safety-net system in New Orleans and the surrounding area. Affected institutions included the Charity system and all other safety-net providers. Even though we had a successful evacuation of New Orleans, many of the sickest and poorest patients remained behind and needed care. These people were those being pulled out of flood homes where they had been for many days without access to their medications or health care. First responders and others coming to reconstitute our city were also in need of care.

In response to that need, Tulane University resident physicians came to New Orleans in the second week of September 2005 when the waters in most of the city had receded and there were dry places to set up temporary care sites. These physicians-in-training partnered with the police to establish first aid stations and provide general primary care at 6 makeshift sites around town. Most of these clinics were started with meager provisions: a willing physician, a stethoscope, and a few donated, portable supplies. The providers generally worked without power, potable water, or sanitary systems. Some of these health sites were on the sidewalk under tents, some in hotel ballrooms, and others in police station dispatch rooms.

In addition to providing much needed care for patients, these makeshift operations stimulated a culture change in our primary care community. As academic physicians working at Charity, we had provided a major portion of the safety net care for the city through the Charity Hospital based clinics. For those patients who could get an appointment with us, the quality was

good. However, we also knew that 12 month waiting periods for new patients to get in to see us, and the lack of sufficient after hours access was preventing us from reaching many.

Creating primary health care from scratch in the post-Katrina environment, gave us first hand experience with a new paradigm of care and an unexpected opportunity to rebuild a better system. Included in this health care culture change was an understanding of the essential role of teams and partnerships, the synergistic value of collaboration, and the benefits a multi-disciplinary approach to care. Also included in this paradigm shift was attention to developing patient-centered models of care. The makeshift clinics were established in response to where the patients were. For example, we identified new sites of care based upon scouting the streets of recently opened zip codes. We then set up our clinics as near to the patients as we could. We worked side-by-side with volunteers from all disciplines. To access care, patients only had to walk up to the card table and ask to be seen.

Over the course of the ensuing weeks, open tent structures were replaced by mobile vans and a few clinics landed space in available buildings such as empty store fronts and dormitories. Eventually, the restoration of utilities moved us back in to these more traditional venues which we generally welcomed. However, we wanted to retain some of the elements of our new paradigm from our “street based” primary care as we moved ahead.

### **From a care table to a neighborhood-based medical home: Tulane Community Health Center at Covenant House**

One of the early temporary care sites opened in early September 2005 when Tulane trainees and faculty set up a card table as temporary care site on the sidewalk in front of the community center. At the height of need, we served 150 patients a day. Desiring to maintain

this new neighborhood health clinic, Tulane partnered with Covenant House and Johnson & Johnson to develop a permanent neighborhood clinic nested within a community center ([www.tucovenanthealthcenter.org](http://www.tucovenanthealthcenter.org)). We had, by default, become a medical home for many in the city, particularly those in the neighborhoods near us and were committed to continuing to that public service.

The Tulane Community Health Center at Covenant House started as a makeshift, post-Katrina first aid station that developed into a permanent primary care clinic. Since transitioning from a card table to a permanent primary care clinic, we have become a source of primary care for hundreds of patients and have seen over 12,000 since opening our doors 18 months ago. This medical home is able to provide basic primary care for adults including care through a multi-disciplinary health care team. We have access to basic laboratory and diagnostic studies. We also serve as a training site for house staff and medical students and other health professionals so that the next generation of clinicians are exposed to a patient-centric model of primary care. We have a sophisticated electronic health record that allows us to manage our population of patients proactively and provide decision-support for clinicians to improve the quality and cost-effectiveness of care.

We developed a fragile patchwork of referral patterns for laboratory, diagnostic and specialty services. We have a sophisticated electronic health record that allows us to manage our population of patients proactively and provide decision-support for clinicians to improve the cost effectiveness of care.

To support the ongoing delivery of primary care from clinic, we have been aggressively seeking funding so that we can expand our ability to provide health care to this uninsured population. We have strung together our funding from an array of entities including the

government, corporations, individual donors, and foreign nations. Specifically, we are supported through the Social Services Block Grant, foundation support from the Avon Foundation, Americares, the American Refugee Committee and a generous gift from the People of Qatar.

If we adhere to our budget and expectations, we could provide basic care to 4200 patients at a cost of \$360 per year per person for the next 3 years. In the near future, we are implementing business processes to collect reimbursement from available sources and plan to secure a more stable funding stream. We may request the subcommittee's support as we move forward.

### **The Partnership for Access to Healthcare (PATH): A Collaborative Prototype for Medical Home System of Care**

Though we are focused on meeting the immediate health care needs of the population we serve, we are also working towards creating a neighborhood based-medical home that can not only serve as a potentially replicable model but help to transform the New Orleans health care system. The concept of a medical home has been well described by national groups and our Louisiana Health Care Redesign Collaborative Concept Paper. It emphasizes health promotion, preventive health and primary care, supplemented by peer education and support. The health team is multi-disciplinary and includes social services and mental health support.

Our clinic is one in a newly developed, broader system of care that has emerged since the storm to fill a void left when the traditional safety net was displaced by the flooding. This network of safety net clinics represent service, called the Partnership for Access to Health Care (PATH) ([www.pathla.org](http://www.pathla.org)), represents a broad group of clinics working cooperatively to provide access to

care for the uninsured and under-insured. These partnerships bring together public and private entities, academia, consumer groups and corporations into a common goal of filling the need. In the aggregate, these clinics serve 900 patients a day, an estimated 50,000 covered lives. An estimated 90% are uninsured and represent the rich racial, ethnic and cultural diversity of post-Katrina New Orleans. Inclusion in the group is open to providers willing to share in the core values of quality and cost-effectiveness. Current participating PATH clinical entities include:

<b>Clinical Providers participating in the Partnership for Access to Healthcare</b>
Algiers Community Health Clinic ( <i>New Orleans Health Department/EXCELth Inc</i> )
Common Ground Health Clinic
St. Cecilia Clinic ( <i>Daughters of Charity Services of New Orleans/EXCELth, Inc.</i> )
DCSNO at Causeway Clinic ( <i>Daughters of Charity Services of New Orleans</i> )
Jefferson Community Health Centers, Inc Marrero ( <i>Jefferson Parish</i> )
Jefferson Community Health Centers, Inc, Avondale ( <i>Jefferson Parish</i> )
University Hospital ( <i>Medical Center of Louisiana at New Orleans</i> )
Hutchinson Clinic ( <i>Medical Center of Louisiana at New Orleans</i> )
Ida Hymel Health Clinic ( <i>New Orleans Health Department/EXCELth, Inc.</i> )
Edna Pilsbury Health Clinic ( <i>New Orleans Health Department</i> )
Healthcare for the Homeless ( <i>New Orleans Health Department</i> )
McDonough 35 High ( <i>New Orleans Health Department</i> )
St. Charles Community Health Center
St. Charles Community Health Center ( <i>Lulling</i> )
St. Thomas Community Health Center
Tulane Community Health Center at Covenant House
Tulane University Pediatric Clinic and Adolescent Drop in Center at Covenant House
New Orleans Science & Math High ( <i>LSU HSC Adolescent School Health Initiative</i> )
Eleanor McMain High ( <i>LSU HSC Adolescent School Health Initiative</i> )

These providers have deliberately set out to create a distributed system of neighborhood based clinics that will provide more accessible care for the returning New Orleans population.

These partners have worked collaboratively to identify and fill gaps in primary care services, develop the model of the medical home, and find ways to link their patients into

specialty care and other services. With continued support and additional resources, PATH could serve as the core of a future model medical home system of care that could transform medical care in Louisiana.

### **III. PRIMARY CARE DELIVERY: THE CHALLENGES**

The primary care community struggling to provide care for a growing number of uninsured and underinsured individuals faces many challenges. The health system's "short term" needs, which we presumed would be long behind us, continue to dominate our minds, conversations, and energies. The generous support of corporations, foundations and citizens has been a critical bridge, but will be insufficient to rebuild and sustain the primary care safety-net system.

For our part, the major limitations involved poor access to specialty care and diagnostic services. On a daily basis, this means my ability to provide evidence-based care for a typical patient is limited. For example, we do not have access to colon cancer screening and diabetes eye care. We also do not have access to urgent diagnostic studies such as brain imaging or endoscopy. As a result, we sometimes need to rely on sending patients to emergency rooms for such tests. Worse, patients sometimes go without arriving at the hospital with significant or long term health consequences that prevent him from being a productive member of our community.

Like many other clinics in the city, we have an insufficient number of clinical providers at our site. For our part, if we could have more staff, we have the bricks and mortar capacity to expand services and hours. However, as you might imagine, finding physicians and other clinical personnel willing to move to New Orleans is a challenge. There are concerns about long term job security and frustrations about trying to maintain a high standard of practice in a broken

environment. One of my physicians has been so frustrated with the difficulties of providing basic care for his patients that he has considered returning to Liberia to practice.

Complicating matters is the high burden of chronic disease for the uninsured, low literacy and the rapidly expanding population of Spanish-speaking immigrants. Adoption of best practices, the use of care management and health information technology will help with the care of those with chronic disease. A strong social services infrastructure can help support those with extensive social service needs. The immigrant population poses its own unique set of challenges for us. The low income workers in this group are likely to not be eligible for coverage if they are undocumented immigrants. We will eventually also need to leverage existing federal programs to care for these populations.

Congress and the Administration can play a major role in expanding and sustaining access to primary care for our community. We are still in desperate need of additional assistance. Our short term problems are largely not those of bricks and mortar. Instead we are under-resourced and have a short time window until the existing resources we do have will end.

#### **IV. PRIMARY CARE: THE OPPORTUNITIES AND NEEDS**

New Orleans and its surrounding region *cannot* recover without adequate health care services. Sufficient infrastructure and accessibility are essential if we are to retain and attract business and industry, tourism, and have a productive workforce. The most cost-effective means of rebuilding focuses resources on the primary care infrastructure. A robust system of primary care is also critical to unclog an overwhelmed hospital system. If we build a highly functional and accessible system, people will need to use emergency rooms less. Good primary care

prevents hospital admissions for illnesses such as asthma, heart failure and diabetes. Patients would be better served prevention, proactive care management and empowering themselves.

We will continue to seek your help in our ongoing efforts to revive the primary care services in the city and region. I understand that Congress faces many issues related to Gulf Coast recovery, and that spending must be done wisely and with an eye toward what will offer the greatest benefit to the most people. Preventing and intervening early in the process of chronic disease saves money. Nothing is more critical to the renewal of New Orleans than health care.

There are 3 ways that the Sub-committee can help us provide immediate access to health care and prevent us from reverting back to relying on emergency rooms for care.

**1. Increase access to primary care in New Orleans for the uninsured through extending the SSBG deadline and providing further resources through the Deficit Reduction Act funding**

We need to move forward with implementing core components a medical home system of care model that will provide access to care immediately to the nearly 180,000 estimated low income uninsured in our area. The most cost-effective and patient-centered means for doing this is to support and sustain existing primary care resources and add new services to fill gaps until longer term policy decisions can be made.

While our community debates the best way to expand health insurance coverage for our uninsured population, we need to support the continued development of the medical homes and a supportive delivery system of care. This is essential to ensure continued progress rather than returning to a reliance on emergency rooms for care. The PATH network has all the makings of

a medical home system of care but it is a fragile system that could dissipate without sufficient support to provide a bridge to the future health system.

Most of these primary care clinics, now medical homes, have been sustained on cobbled together funding from a variety of sources including public funds, such as the Social Services Block Grant (SSBG) funds. On July 31, 2007, the SSBG funding is scheduled to end. For a variety of reasons, there were delays in getting the SSBG funds available to the providers. Fearing that their expenses wouldn't qualify for reimbursement, many clinics have avoided using the SSBG funding instead relying on other resources and on limiting services to their patients. We are now scrambling to spend the money by the deadline for spending all the allocated money. If we do not, the funding will be returned to the federal government. Providers in our community have repeatedly requested an extension of the deadline so that we can more effectively use the federal dollars we've been granted.

An additional option for transitional financial support would be to allocate the discretionary Deficit Reduction Act funds could be used for just such a purpose. It could fund a pilot to assess the impact of a medical home system of care on improving patient health, care quality and lowering overall cost. If successful, we could transfer these best practices to the rest of our state and potentially the nation.

## **2. Provide financial support for clinicians to help with retention and recruitment**

The need for health care professionals and other staff is acute. Staff shortages cause many clinics to turn away patients. Increasingly, recruitment is hampered by care professionals' rational concerns about the long term financial viability of the health care system in New Orleans and the lack of mechanisms to reimburse them for services. To recruit and retain health care

professionals, resources are needed that will pay qualified providers for services, support educational loan repayment and defray malpractice costs. HHS and DHH have been working towards this goal, but the allocated resources are not likely to be enough. Additionally, application processes are complex and time consuming. The busy clinicians in this system need streamlined and accessible mechanisms through which they can apply for the financial support. Payment for services rendered could be accomplished through expansion of coverage and though uncompensated care payments directed at physicians.

### **3. Assist us as we progress and hold us accountable for our commitments**

The Sub-Committee would do this effort a great service by providing assistance and guidance as we move ahead. This hearing has been quite a catalyst for us locally. We have had better communication and coordination than in months. All of us have been forced to stop and clearly articulate what would improve access to care immediately. Such future hearings would help hold us accountable for our promises and allow us to inform the committee members of ongoing success and continuing needs.

## **VI. CONCLUDING REMARKS**

While we work towards agreement on the long term financing structure of our health care system, we need your help right now to ensure access to primary care for our citizens. With the support of the American people and through our public leaders such as those of you on this Sub-committee, we can restore, expand and sustain primary care services to our population – particularly those who are uninsured.

New Orleans survived the hurricanes and the subsequent flood. But survival, alone, is not the goal of our citizens and is not a suitable objective for the nation. To thrive, to be anything close to the city that it was, New Orleans needs a health care system that all of its citizens can rely upon. The storm has given us a great opportunity to demonstrate the health system of the future – one built around the needs of patients, one readily accessible to all citizens and one that promotes health rather than simply treating illness.

Thank you.