TESTIMONY COVER SHEET
FOR

Gary Wiltz, MD

Testifying on behalf of the
Teche Action Clinic
Louisiana Primary Health Care Association
National Association of Community Health Centers

Before the House Energy & Commerce Subcommittee on Oversight and Investigations

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Summary:
The health care infrastructure of Louisiana, which was already broken, was even further decimated by Hurricane Katrina. The loss of facilities and providers has undermined an already fragile system, with the uninsured and even the Medicaid population suffering the most. Steps need to be taken immediately to revitalize the infrastructure of New Orleans, and the surrounding rural parishes of Louisiana if we are to help those in need. Congress should consider an immediate expansion of the Community Health Centers within the state, and also the placement of additional National Health Service Corps staff. In the long-run, both the state and federal government must assist in the rebuilding of the medical capacity of the state, especially the mental health care needs in rural and urban areas.

STATEMENT OF DR. GARY WILTZ

Good Morning Mr. Chairman, and Members of the Committee – and it is a special honor today to appear before my Congressman, Mr. Melancon. Thank you for the opportunity to speak with you today about the very serious and continuing health consequences of Hurricane Katrina and its aftermath. I come before you this morning wearing many hats:

- First and foremost I am a practicing Board Certified Internist in a small rural community 100 miles southwest of New Orleans;
- I am also the CEO and Medical Director of Teche Action Clinic, a Federally Qualified Community Health Center, or FQHC, established in 1974, whose home base is located in Franklin, the seat of St Mary's Parish, with three satellites in Dulac, Houma, and Edgard;
- I serve as Chairman of the Governor's appointed Region 3 Health Care Consortium, which includes seven (7) rural parishes (Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary and Terrebonne) all located immediately outside the New Orleans area (see map of Louisiana);
- I serve on the Board of Directors of the Louisiana Primary Care Association (LPCA), which represents the state's 21 FQHC's that together provide health care to more than 125,000 Louisianans – almost half of them uninsured – in nearly 50 communities throughout the state; and –
- I was just recently elected and now serve as national Secretary of the National Association of Community Health Centers, or NACHC – the national voice for America's community, migrant, and homeless health centers – known together as FQHCs – and the 16 million low-income Americans they serve in more than 5,000 communities across the country.

I would like to begin by telling you a little about my personal history. My roots run deep in New Orleans. I can trace my ancestry back for over 4 generations. I was born at Charity Hospital in 1953 on the 'colored' ward section of the then- segregated hospital. I grew up and attended the public school system in New Orleans, earned a scholarship to Tulane University, and later attended Tulane Medical School where I was fortunate enough to earn a National Health Service Corps (NHSC) scholarship while in medical school. Ironically, I did most of my residency training at the same institution where I was born, Big Charity in New Orleans. Upon completion of my residency, I was assigned to Teche Action Clinic in Franklin, to serve my 3 year service pay-back obligation; 25 years later, I am still practicing medicine at that same site. I gave you this history because it might help to shed light on how it shaped my perspective, as one who was born, raised, and educated in an urban setting, and who for the past quarter century has practiced in a rural environment.

In speaking of the health care realities in my home state today, I must begin by noting the sad reality that Louisiana's health care system was broken pre-Katrina. Louisiana has the dubious distinction of having consistently ranked 49th or 50th among the states in the United Health Care Foundation's annual health status report over the past 10 years. Our health care system has been fragmented, expensive, and ineffective, producing far too many poor health outcomes. Our system epitomizes the classic two-tiered levels of care: one for the "haves" – those with good health insurance that allows them access to all levels of care; and another for the "have-nots" – the uninsured, underinsured, and even most Medicaid recipients, who have at best limited access to only the most basic levels of care.

The original concept behind Charity Hospital was to demonstrate the compassion of the people of our state. It was perfectly named to fulfill its founding purpose – to provide "Charity". The flag-ship of this system, located in New Orleans, fast became known affectionately among locals as "The Big Free". Unfortunately, as we all know, nothing in life is truly free. Its urban location has left the state's rural residents with no choice but to travel great distances to access this care. Pre-Katrina, the residents of the 7 rural parishes in our Consortium depended on Charity hospital – some for primary care and for most, specialty and sub-specialty care including mental health services. Katrina essentially destroyed the health infrastructure for the entire southeast part of Louisiana. It also decimated the healthcare workforce by displacing more than 6,000 healthcare professionals, most of whom have not returned. The true impact of Katrina's devastation can not be understood or explained within a silo. Some summary points about Katrina's aftermath:

- Southeastern Louisiana Healthcare Infrastructure Destroyed
- Healthcare workforce decimated
- Universities unable to provide training sites for medical students, residents, and other healthcare professionals
- Increase in numbers of individuals uninsured or underinsured who require/need health care, even as the overall population shrunk considerably
- Primary care providers no longer have access to a medical facility to refer uninsured patients requiring specialty and sub-specialty services

In the immediate aftermath of Katrina, our surrounding parishes saw evacuees overflowing into our communities. My family personally housed 19 family members for many months after the disaster hit. I am proud to say that Louisiana's health centers

responded to this tragedy securing seven mobile units and dispatching them to emergency shelters and FEMA transitional housing sites to provide care to more than 200,000 evacuees at these sites. Moreover, our state Primary Care Association partnered with Morehouse College and IBM to provide training for over 160 healthcare providers on how to recognize and treat patients suffering from Post-Traumatic Stress Disorder (PTSD) and other behavioral health conditions. Our Association also secured assistance from the federal Health Resources and Services Administration (HRSA), from our National Association (NACHC), and from national and state foundations, to support the placement of 20 temporary medical providers at health centers across the state to provide life-saving health care, plus an additional 14 psychologists and licensed clinical social workers to respond to mental health disparities.

Now fast-forward 18 months and where are we today? To borrow a line from the play, *The Music Man*, "Oh, we've got troubles right here in river city." Those of us who continue the struggle to provide care in the outlying parishes are seeing a number of serious health concerns that need immediate attention. In particular, we are seeing more and more patients suffering from depression, PTSD, suicide, substance abuse, acute psychosis, and domestic violence. In the wake of these ever-worsening mental health care needs, we face an enormous lack of mental health workers – particularly psychiatrists – as well as social workers and psychiatric nurse practitioners. There are no pediatric psychiatrists in our seven parish region. But our greatest problem is the lack of in-patient psychiatric services. We simply have no beds available for patients seeking detoxification treatments. Patients with acute psychiatric problems are having to be boarded in hospital emergency rooms. Those patients with dual diagnoses – those with

both medical and psychiatric health problems – have even fewer options. To underscore how serious these problems are, I give you several **true case studies**:

- A 38 year old male with a diagnosis of bi-polar disorder is brought to the hospital emergency room by a Sheriff's Deputy. Family members say that he has not seen a psychiatrist in 18 months because of Katrina. He is suicidal and homicidal, not for the first time – in fact, his last episode required in-patient treatment at Big Charity. A physician emergency commitment, or PEC, is completed, but he lacks health insurance – so we spend the next 10 hours attempting to find a facility willing to accept him, only to be told repeatedly "all beds are full with a waiting list." He remains in the hospital emergency room for 72 hours, being sedated for his own and everyone else's protection, only to be finally released to his family when no other recourse can be found. In the succeeding month, he arrives several times at the same emergency room in the same condition, before a bed is miraculously found for him.

- Our regions only pediatric psychiatrist has left the area. The hundreds of children who were under his care are referred back to their primary care pediatricians' to manage their mental health issues. The pediatricians refuse to manage their psychotropic medications and refer them to the local psychiatric nurse practitioners (PNP). Our PNP alone has a two month waiting list so he is now seeing children who because this delay are now unmedicated and have now decompensated.
- A 57 year old female complains of chronic neck pain that is now worsening, with numbness in both arms and hands, associated weakness, and decreased motor

strength. She has Medicaid so an MRI can be obtained, which confirms that she needs neurosurgery; however, there are no private neurosurgeons who will accept Medicaid. Previously she would have been referred to Charity Hospital in New Orleans, 70 miles from her home town. Currently the only neurosurgeons accepting Medicaid are located at LSU charity hospital in Shreveport, a 6-hour drive from her home – if only she had transportation.

- A 40 year old resident of St John Parish, approximately 30 minutes from New Orleans, with a long history of hypertension and abnormal kidney function, urgently needs to be seen by a nephrologist. We are able to get him an appointment at Chabert Medical Center in Houma, about an hour away – but his wait time for the appointment is 3 months.

There have been numerous reports and other panelists will delineate the extent of the problem of people using the emergency room for basic primary medical care. This inappropriate use of these facilities has resulted in exorbitant costs.

So now that we see what the current landscape looks like, might I suggest some solutions? Let me say that, while the scope of the problems we face in our communities are so great that they will require the kind of money that only the federal government – or the state – can provide, the best solutions are not likely to be crafted out of Washington or Baton Rouge. Let me add one more point – that simply providing "health care insurance" to the many uninsured, while that is a crucial step to make health care *affordable*, will do little or nothing to make health care *available* or *accessible*, if there are no – or not enough – providers around to furnish that care. We need a model that

works, that is proven, that's cost effective, culturally competent and that can serve as a medical home – a *health care* home, in fact – and the beauty of it is that such a model already exists, in our nation's community health centers. This is not to suggest that they are the panacea to all our healthcare problems – but they certainly can play a large part in the solution.

Health centers bring good health to needy communities, and have compiled a remarkable record of achievement in providing care of superior quality, with exceptional cost-effectiveness and efficiency. Their costs of care rank among the lowest, and they reduce the need for more expensive in-patient and specialty care, saving billions for taxpayers and society. That helps to explain why the program has been ranked one of the 10 most effective federal programs by the Office of Management and Budget, and the top competitive grant program within HHS.

An expansion of health centers would quickly address the needs of the underserved across our nation, and be a critical step in transforming our health care system. Health centers improve the health of the patients and communities they serve by providing cost-effective, regular primary and preventive care that translates into reduced hospitalizations, lower use of emergency rooms, and fewer referrals to costly specialists, reducing overall health care spending significantly and producing far better health care outcomes. As a result, pressure on local emergency rooms will be lowered, saving tax payers significantly. Health centers are an excellent public investment that generates substantial benefits for patients, communities, insurers, and governments – indeed, for all of America.

Coupled with that is the need to expand support for the National Health Service Corps, the very program that brought me to my community in need a quarter century ago. Currently 3,900 Corps clinicians, including physicians, dentists, nurse practitioners, physician assistants, nurse midwives, and behavioral health professionals, provide health care services to nearly 5 million Americans in urban and rural communities with serious shortages of health care providers. About half of all NHSC providers are at health center sites – and we need many more of them today, and will need even more tomorrow.

In closing, I would like to quote some immortal words from Dr. Martin Luther King, Jr. that are as true today as they were on the day he spoke them, nearly 40 years ago:

> *"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."*

Thank you once again for this opportunity. I would be happy to answer any questions you might have.

Louisiana's Health Centers Facts

- Louisiana's Health Centers collectively **provide over 354,000 visits to over 125,000 patients annually**.
- All Louisiana CHCs stimulate the local economy; are a proven model for quality, cost-effective care; and have excellent health outcomes.
- All Louisiana CHCs maintain intensive, state of the art quality improvement programs **focused on population-based chronic disease conditions**.
- Louisiana's communities that have CHCs have lower infant mortality rates than communities without CHCs. The CHCs provide appropriate primary care treatment, which in turn **reduce inappropriate emergency room utilization and uncompensated care**.
- Our **Medicaid patients are 22% less likely to be hospitalized for conditions that can be treated in outpatient settings**. Additionally, Medicaid patients who routinely use our CHCs **cost 30% less than other patients**.
- Louisiana CHCs are located in **28 of 64 Louisiana Parishes**.
- According to the 2005 Uniform Data System (UDS) Report, **49% of FQHC users are uninsured**, inclusive of Medicaid. Since Hurricane Katrina, the number of uninsured patients who received health care at Louisiana FQHCs has increased by an additional 15,541 uninsured evacuees.
- Total Users: 125,680
- Uninsured Users: 60,326 or 49%
- Total Encounters: 354,071
- Medical Health Service Users: 101,836 or 82%
- Mental Health Service Users: 5,222 or 4.2%
- Dental Health Service Users: 27,780 or 22%
- Average Total Cost Per Total User: $372
- Average Charge Per Self-Pay Users: $194.14 (Includes the uninsured)
- Sliding Fee Discounts : 66% of Self-Pay Users
- State Wide Weighted Average PPS Rate: ~$120
- Total Full-Time Equivalents: 644

STATE POLICY RECOMMENDATIONS

***Policy Request*: Expand Health Care Services to an Additional 544,000 Louisianans through a Multi-year phased 179 Additional FQHC Sites Expansion Initiative**

- LPCA is currently working with Capital Link, Inc., to develop a capital funding program for FQHCs that would leverage New Markets Tax Credit (NMTC) funding and the HRSA and USDA Loan Guarantee Programs to maximize funding available for FQHC infrastructure development. In the program under consideration, a state investment of $55 million in CDBG or other grant funds could leverage approximately $38 million in NMTC private sector investments and an additional $33 million in HRSA or USDA-guaranteed low-cost loans. This pool of $126 million for infrastructure investments would enable FQHCs to expand significantly to meet the primary care needs of communities across the state while leveraging the state's scarce resources to best advantage. The entire initiative will yield 179 additional health center sites, and ultimately provide health care to an additional 544,000 Louisianans.

***Policy Request*: Provide Health Care Services to an Additional 25,754 Louisiana Residents through a State Legislative Appropriation of $5 million To Subsidize the Cost of Providing Care to the Uninsured**

- The number of uninsured Louisiana residents served by Louisiana's Health Centers has grown substantially through the years. For example, in 2003 Louisiana's Health Centers served 41,369 uninsured users. In 2004, the number of uninsured users increased by 6,468, totaling 47,837. In 2005, the number of uninsured health center users increased by 12,489, totaling 60,326 uninsured users. Louisiana's Health Centers are seeking a State Legislative Appropriation of $5 million dollars offset the cost of providing care to an additional 25,754 uninsured Louisiana residents. **An application has been submitted to Senator Mary Landrieu for the legislative appropriation.**

REQUESTS FOR FEDERAL INITIATIVES AND MANDATORY INTERVENTION

Strengths and Challenges

- Federal dollars were appropriated to the State of Louisiana for uncompensated care (UCC). Pursuant to the appropriations for reimbursement, Louisiana's CHCs submitted billable claims for UCC dollars post Hurricane Katrina prior to or by the deadline of June 30, 2006 only to be **denied UCC reimbursements by the state** whereas only a few centers received reimbursements. Furthermore, centers also **received denials for dental UCC service claims** as well.

- Pursuant to the request to serve as the point of primary care for the state of Louisiana efforts regarding its Pandemic Flu initiatives, Louisiana FQHCs accepted. Furthermore, we were asked to submit a concept paper for their grant application and responded to the request. As a result of the HRSA grant award to the state of Louisiana, Louisiana CHCs or **LPCA received no federal allocation within the grant award to the state for their collaborative efforts**.

- Louisiana's network of FQHCs has been largely endorsed by the Health Care Redesign Collaborative as the "right model" for medical home systems of care in New Orleans and other regions of the State. The *PAR Report* recommended a significant investment in developing the infrastructure of FQHCs so that greater access to primary care can become a reality for Louisiana citizens. Federal officials and other sources have fully supported and recommended this plan as the **most viable option** for a public/ private partnership in the State of Louisiana.

- In preparation for future disasters, LPCA, along with the Louisiana's Health Centers are currently developing an Emergency Preparedness Plan that conceptualizes a statewide network. While much has been accomplished over a relatively short period, LPCA is currently **limited by both operating funds and equipment to accede to the level of EP involvement that its potential represents to the overall state and regional efforts.**

The following governmental initiatives and/or requested mandates would greatly enhance the following collaborative efforts with the state of Louisiana:

- Federally mandate that the state of Louisiana set aside funding for primary care for FQHCs. Presently, federal funding is strictly dedicated to the hospitals in Louisiana.

- Expanded and specific inclusion of LPCA into all primary care federal grants (i.e. Emergency Preparedness such as Pandemic Flu and Bioterrorism; and other resources made available for the provision of/and related to primary care services) to include provisions that insure funding in primary care activities.

- Support for a broader role for non-governmental agencies in EP responses. (Primary care associations and In-Home care organizations are prime examples.)

- Assistance in securing the equipment (i.e. generators, radio and medical) necessary to fully integrate LPCA operations into supported agencies during all phases of catastrophic events.

- Assist in supporting funding for more mobile medical units.

LPCA seeks a "level playing field" and inclusion into all state primary care initiatives and processes. Assistance in acquiring the means to accomplish this is greatly appreciated.

LOUISIANA'S HEALTH CENTERS AND POST HURRICANE EFFORTS

- LPCA successfully secured seven mobile units for Louisiana CHCs after the Hurricanes Katrina and Rita to help alleviate the barrier of transportation for hurricane evacuees. As a result, Louisiana FQHCs dispatched mobile units to emergency shelters and FEMA transitional housing sites within the southern region of the state.

- LPCA secured grant funding from Direct Relief International to provide medical transportation services for hurricane evacuees in FEMA and private transitional housing areas. Medical services were made available to over 200,000 hurricane evacuees in the Greater Baton Rouge area.

- In an effort thwart the significantly spiked mental healthcare disparities encountered by providers because of the hurricanes, the Louisiana Primary Care Association partnered with Morehouse College and IBM to provide training entitled "Psychological Response to Disaster". The training educated over 160 attending healthcare providers on indicators and methodologies for treating patients suffering from PTSD and other behavioral health conditions.

- LPCA successfully secured grant monies from the Baton Rouge Area Foundation and Operations USA for Louisiana's FQHCs. These funds provided placement of 14 providers—psychologist and licensed clinical social workers—to respond to mental health disparities.

- LPCA, in conjunction with HRSA, worked successfully in placing over 20 temporary medical providers throughout Louisiana FQHCs in response to the displaced evacuees needs.

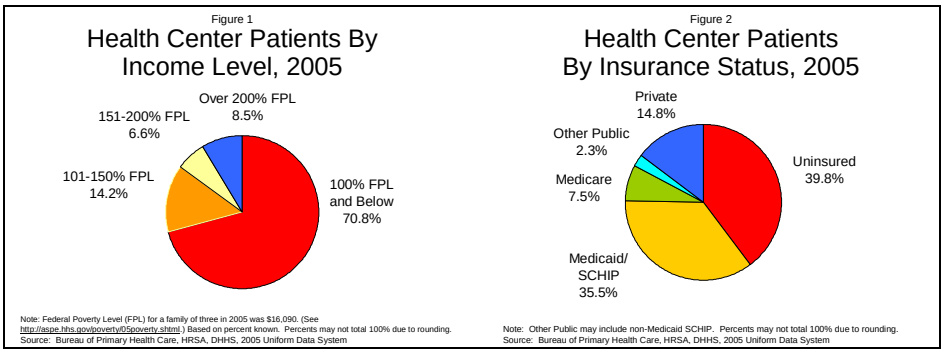
- Presently, Louisiana continues to have displaced residents post Hurricane Katrina located in transitional housing areas. Louisiana CHCs continue to provide health services to all regardless of the ability to pay.

Community Health Centers: Working for America

WHAT ARE COMMUNITY HEALTH CENTERS?

Located predominantly in inner city and rural communities where health care is needed but scarce, America's community health centers* **provide high-quality, affordable primary care and preventive services** to millions of people who typically have little or no access to care elsewhere. Today, community health centers serve as the family doctor and health care home for almost 16 million people in more than 5,000 communities across the country. As Figures 1 and 2 demonstrate, virtually all of their patients are from low-income families, and more than 80 percent are either uninsured or rely on public insurance coverage.

Community health centers bring good health to needy communities, without regard to family income, health insurance status, race, culture or health condition. Health centers have compiled a remarkable record of achievement in providing care of superior quality, with exceptional cost-effectiveness and efficiency. **Their costs of care rank among the lowest, and they reduce the need for more expensive in-patient and specialty care, saving billions for taxpayers and society**. The program has been ranked one of the 10 most effective federal programs by the Office of Management and Budget, and the top competitive grant program within HHS.



WHAT IS THE`SECRET OF COMMUNITY HEALTH CENTERS' SUCCESS?

Community health centers possess several key features that make them unique within our healthcare system:

- ✓ **Every health center is located in a high-need area**, identified by the federal government as having elevated poverty, higher than average infant mortality, and where few physicians practice;
- ✓ **Each health center is firmly grounded in its local community,** governed by patient-majority boards that ensure a focus on the community's most pressing needs – a feature unmatched anywhere else in our healthcare system;
- ✓ **They occupy the most opportune place in the health care system,** at the entry point, where quality preventive and primary health care, and committed management of chronic conditions, can yield both better care and enormous system savings, averaging 30 to 34 percent in total Medicaid spending for their patients.
- ✓ **They make their care affordable to everyone, regardless of ability to pay**, removing barriers that cause too many to delay necessary care or to use costly alternatives such as ERs. In fact, the cost of care at a health center is $250 less annually per patient than the same care provided by private physicians.
- ✓ **They are held to high standards for performance and accountability** by federal program managers, and by each other – leading the prestigious Institute of Medicine to praise them for "providing care…of better quality and lower costs," and to recommend them as models of primary health care.

***** The term Community Health Centers includes all community, migrant, homeless, and public housing health centers that receive funding (or are eligible to receive funding) under Section 330 of the Public Health Service Act.

HOW DO COMMUNITY HEALTH CENTERS MAKE A DIFFERENCE?

Community health centers remove common barriers to care by serving communities who otherwise confront financial, geographic, language, cultural and other barriers, making them different from most private, office-based physicians. Community ownership of health centers assures responsiveness to local needs, and helps guarantee that health centers improve the quality of life for millions of patients in the following ways:

- ✓ **Improve Access to Primary and Preventive Care**. Health centers provide preventive services to vulnerable populations that would otherwise not have access to certain services, such as immunizations, health education, mammograms, pap smears, and other screenings. *Uninsured health center patients are much more likely to have a usual source of care, less likely to have an unmet medical need, less likely to visit the emergency room or have a hospital stay, and more likely to have had a general medical visit than the uninsured nationally*.

- ✓ **Cost-Effective Care**. Care received at health centers is ranked among the most cost-effective anywhere. Several studies have found that *health centers save billions in annual Medicaid spending* for health center Medicaid beneficiaries due to reduced specialty care referrals and fewer hospital admissions, saving billions in combined federal and state Medicaid expenditures. *If avoidable visits to emergency rooms were redirected to health centers, over $18 billion in annual health care costs could be saved nationally*.

- ✓ **High Quality of Care**. Studies have found that *the quality of care provided at health centers is equal to or greater than the quality of care provided elsewhere.* Moreover, 99% of surveyed patients report that they were satisfied with the care they receive at health centers.

- ✓ **Reduction of Health Disparities**. Several studies have concluded that *disparities in health status do not exist among health center patients*, even after controlling for socio-demographic factors. The Institute of Medicine's landmark 2002 report, *Unequal Treatment*, recognized the importance of health centers in increasing access to care and in improving health outcomes for all patients, especially minorities; and a recent study in *Health Affairs* found that expanding health centers would lead to reduced disparities for minorities and the uninsured.

- ✓ **Effective Management of Chronic Illness**. Health centers meet or exceed nationally accepted practice standards for treatment of chronic conditions. In fact, the Institute of Medicine and the General Accountability Office have recognized health centers as models for screening, diagnosing, and managing chronic conditions such as diabetes, cardiovascular disease, asthma, depression, cancer, and HIV. *Health centers' efforts have led to improved health outcomes for their patients, as well as lowered the cost of treating patients with chronic illness*.

- ✓ **Improve Birth Outcomes**. *Communities served by health centers have much lower infant mortality rates* than comparable communities not served by health centers, and low-income women receiving prenatal care at health centers have lower rates of low birth weight compared to all such mothers. In fact, a recent study found that if the success of health centers in lowering rates of low birth weight were achieved nationally, there would be 17,000 fewer low birth weight black infants annually.

- ✓ **Create Jobs and Stimulate Economic Growth**. Health centers employ nearly 100,000 full-time employees most of whom are local community residents. *They bolster local business, sustain vital community services like pharmacies, and stabilize neighborhoods by stimulating community development and economic growth*.

WHY IS INVESTING IN COMMUNITY HEALTH CENTERS IMPORTANT?

An expansion of community health centers would quickly address the needs of the underserved across our nation and be a critical step in transforming our health care system. Health centers improve the health of the patients and communities they serve by providing cost-effective, regular primary and preventive care that translates into reduced hospitalizations, lower use of emergency rooms, and fewer referrals to costly specialists, reducing overall health care spending significantly and producing far better health care outcomes. As a result, pressure on local emergency rooms will be lowered, saving tax payers significantly. **Health centers are an excellent public investment that generates substantial benefits for patients, communities, insurers, and governments – indeed, for all of America.**