

TESTIMONY OF

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BEFORE

THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

COMMITTEE ON ENERGY AND COMMERCE

U. S. HOUSE OF REPRESENTATIVES

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Mr. Chairman and members of the committee, I want to thank you for coming to Louisiana. We will be grateful for whatever assistance you can provide, but your willingness to visit our state is itself a gesture that we deeply appreciate.

I represent the LSU Health Care Services Division, which comprised 9 of the 11 state public hospitals and over 350 clinics that traditionally have been called the “charity hospital system” in Louisiana. I would like to begin by describing this system in brief.

Our hospitals and their clinics constitute the vast bulk of the health care safety net for the state’s uninsured and underinsured, particularly the working uninsured. Every individual in the state is eligible to receive services in any of our hospitals regardless of the parish in which they live or their ability to pay. Louisiana has one of the highest rates of uninsurance in the nation, over 20 percent of the population, and estimated to include over 900,000 individuals (and another 22 percent are on Medicaid). That was before Katrina and Rita. Blue Cross of Louisiana has recently estimated that 200,000 more individuals will join the ranks of the uninsured as businesses fail because of the storms’ destruction.

Not only is Louisiana a relatively poor state, but small employers are predominate in our economy. Many, even in the best of times, cannot offer benefits, and we often are a surrogate insurance program for business. A health care safety net is essential to both provide access to care and to support a significant portion of our economic base. The LSU Hospitals and Clinics

are the core of that safety net. The Charity campus also supported the only Level 1 Trauma Center that serves South Louisiana and much of the Gulf Coast. Since the hurricanes, many patients in need of trauma care have been transported to Shreveport and Houston. It is not unreasonable to assume that mortality rates will increase as a result of the lengthy transport time.

The LSU hospitals also have had an integral role in supporting the education programs of our medical schools and training institutions, and that includes not only LSU but also Tulane and the Ochsner Clinic Foundation. At Charity and University hospitals alone, there were around 800 Tulane and LSU medical residents in training when Katrina struck and destroyed our facility.

I know you will understand that the destruction of Charity Hospital is felt especially deeply here. “Big Charity” was the second oldest continuing hospital in the nation and has endured as one of the most significant medical institutions in the nation over the 270 years since its founding in 1736. It was destroyed once before by a hurricane, in 1779, but rebuilt just five years later. Today, it sits in ruins a short distance from here.

Your states – and almost every state – have some system that fulfills the same functions as the LSU hospitals and clinics. Outside Louisiana, however, the provider safety net for the uninsured is most often a local governmental function. You undoubtedly are familiar with county or district hospitals or comparable programs that have as their predominant mission assuring access to care regardless of ability to pay.

Having created both a **statewide** and a **public** hospital system, it is natural and appropriate that Louisiana would turn to this system in times of emergency. Under state emergency preparedness plans, our hospitals are designated as the lead facilities in each region to accept patients who have special acute needs that may become emergent in a crisis or catastrophe. We have regarded it as our hospitals' obligation to gear up for potential disasters and to continue to operate when others may not be able to. We have the capacity as a system to transfer patients to our facilities in other parts of the state, if necessary. And since Louisiana's only Level I trauma and specialty care centers – in New Orleans and Shreveport – are operated by LSU, special medical needs can be accommodated internally.

Louisiana's emergency preparedness plans, and our role in them, were fundamentally sound up to a point, but clearly that point was surpassed by the magnitude of Katrina in the New Orleans area. After incredible flooding and loss of all power, Charity and University Hospitals were unable to function as receiving facilities as disaster plans call for, and our patients and staff themselves required evacuation.

You are looking for the lessons from this disaster with an eye toward improving not only Louisiana's future emergency preparedness but also that of the nation. From our perspective, there were several general lessons and many others at the hospital operational level.

First, as this committee is aware, there proved to be inadequate ability – or insufficient

priority – to evacuate patients and staff at Charity and University Hospitals within a reasonable period of time. In the future we will not again assume that agencies that are physically and bureaucratically remote from our hospitals will come to our rescue. Instead, we will develop the means to transport patients should the need arise. Should assistance be available, we will gladly accept it, and certainly we will work cooperatively with agencies at any level to create an effective means to deal with all aspects of emergencies such as Katrina and Rita. But we will also exercise our capacity to take care of our own patients within our system.

In fact, when Rita threatened Southwest Louisiana a few short weeks after Katrina, we did evacuate threatened patients and staff from Lake Charles, Lafayette and Houma to facilities in Baton Rouge and Alexandria. We didn't wait for the established cavalry as we did after Katrina's floods. We became our own cavalry and took care of ourselves without asking or expecting help. And it worked.

One major lesson from this crisis was the need for reliable communications. Both in New Orleans and Bogalusa, where our hospital received serious wind damage, communications with our central office, the State Office of Emergency Preparedness and others were exceedingly difficult. In the case of Bogalusa, there was silence for two days. Our police radios worked in New Orleans, but only intermittently in about 45 second intervals. Ham radio was most reliable, and it is a technology we will continue to invest in – but it is slow. Interestingly, cell phone text-messaging worked in a number of cases even though cell phone conversations often did not. Satellite phones were generally useless for us. Although several different technologies failed or

were of very limited use, the communications problem undoubtedly has a technological solution. We need to determine the best way to stay in touch in emergencies, and put the appropriate equipment into the right hands.

Coordination across levels of government must be improved. There appeared to be no sense of command at the Office of Emergency Preparedness (OEP). State agencies that are accustomed to working with each other, or just respectful of one another, communicated and coordinated well. But possibly because the scale of the disaster was so massive, the various federal agencies that responded did not seem to be nearly as fluent in intra-agency communication and coordination. It is in part because of that problem that we took complete control of our fate when Rita threatened us in Southwest Louisiana.

It is not enough to have disaster plans. We must understand what they call for and be prepared to implement them unless unforeseen and overriding factors arise. To give you one concrete example, despite the designated role of our hospitals to receive evacuated patients, we received far fewer than we had capacity for. I personally worked at the state Office of Emergency Preparedness headquarters to move both the patients and the staff from Charity and University to other LSU hospitals that were prepared to accept them, but this approach – the *planned* approach – was overruled. Instead, patients from Charity and University Hospital were taken to the N.O. airport, ultimately put on military transports and scattered across the country. Only medical records, but no staff, accompanied them. To our knowledge, no record was kept of who was on what plane, where they came from or where they were taken.

Immediately after the evacuation, it was as if our patients had disappeared, and when the calls from families came asking about those in our care, we could not tell them where they were. Staff spent literally weeks calling hospitals across the country asking if any patients from Charity or University hospital had been transferred there. Despite these efforts and those of the Louisiana Hospital Association, we never did find out where all our patients were taken.

We know that improvements can and must be made in our capacity to handle hurricanes and other emergencies. It is fair to focus on the emergency preparedness system, but at the moment we have too few hospitals standing to even participate in the next catastrophe. The next bus crash or minor emergency will overwhelm current hospital capacity. Existing hospital emergency departments are taxed, but even in the best of circumstances they are no substitute for an extensive public primary and specialty clinic system. Medical education in New Orleans, which serves the needs of the entire state, could be destroyed if appropriate training sites are not re-established quickly.

LSUHCS stands ready to assist the federal government in repairing and strengthening our nation's emergency response capacity. But in Louisiana, a necessary first step is restoration of the core capacity of our public health care system. Rapid and successful restoration of that capacity will contribute to the public safety and is certain to save lives. Thank you again for your interest and for this opportunity to share LSU's insights into this critical issue.

