
HEALTH CARE FORUM

BGR, January 25, 2007

Donna D. Fraiche

Board Member, Louisiana Recovery Authority

Chair, LRA Long Term Community Planning Task Force

Member, LRA Public Health and Healthcare Task Force

Member, Louisiana Health Care Redesign Collaborative

Shareholder, Baker Donelson Bearman Caldwell & Berkowitz

Health Care Policy

- Pre-Katrina
 - Post-Katrina
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**Addressing the Challenges of Recovery & Rebuilding
from Hurricanes Katrina & Rita**

Governmental Entities—Authorities—Bodies

➤ United States Government

➤ Executive Branch

- U.S. Department of Health & Human Services

- Centers for Medicare/Medicaid Services

- Homeland Security – Office of Gulf Coast Reconstruction

- Veteran's Administration

➤ Legislative Branch

- GAO

Governmental Entities—Authorities—Bodies

➤ Louisiana Government

- Department of Health and Hospitals (Medicaid and Waiver Authority)
 - LSU Health Sciences Center/Health Care Services Division
 - Academic (Schools, Research)
 - Indigent Health Care (Hospitals, Health Care)
 - Department of Insurance (D.O.I.)
 - La. Health Care Commission
 - Legislative: Task Force on Working Uninsured (plus 70 Boards/Committees)
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Governmental Entities—Authorities—Bodies

- Louisiana Recovery Authority
 - Public Health Task Force – PWC recommendations
 - LRA Health Care Committee
 - Louisiana Health Care Redesign Collaborative
 - Governor Blanco
 - U.S. Secretary Michael Leavitt
 - La. Secretary Fred Cerise, Chair
 - LRA Chair Dr. Francis
 - Members of Collaborative
 - Report to DHHS – October, 2006
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LOUISIANA RECOVERY AUTHORITY



Governor Kathleen Babineaux Blanco created the LRA to work across all levels of government to develop and oversee the implementation of a comprehensive long-term plan for a rebuilt and renewed Louisiana.

LRA ROLES IN RECOVERY

Establish priorities and strategies for redevelopment

Secure funding and other resources

Lead long-term community and regional planning efforts

Ensure transparency and accountability

Health and Wellbeing

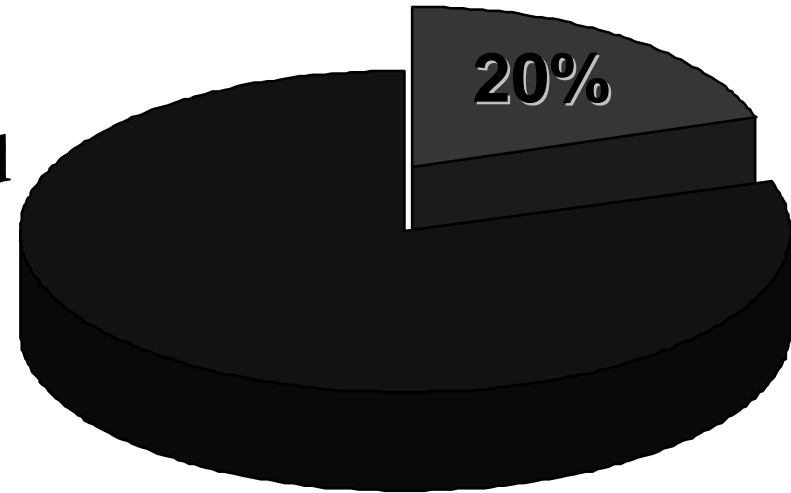
“Hurricane Katrina is a disaster from which our health care system will take years to recover.”



Fred P. Cerise, M.D., M.P.H.
Secretary, Louisiana DHH

Pre-Katrina Outlook

- **Approximately 20% uninsured**
- **High poverty**
- **Shortage of health care professionals**
- **Medicaid budget of approximately \$5.3 billion**
- **In 2003-2004, about 16% of Louisiana residents had Medicaid coverage**



Pre-Katrina Outlook

- **2/3 of Medicaid enrollees living in areas affected by Katrina**
- **Orleans Parish served by 9 acute care hospitals**
- **Care to uninsured in New Orleans provided by Charity System**
 - **Charity had 83% of inpatient and 88% of outpatient uncompensated care costs in New Orleans area**
 - **Dominant provider of substance abuse, psychiatric and HIV/Aids care**
 - **Only Level 1 trauma center on the Gulf Coast**

FORCED TO CHANGE

Charity Hospital, an icon in trauma treatment and teaching, will never be the same after Katrina



CAUTION Caution tape warns people away from Charity Hospital. Damage from Hurricane Katrina has left the hospital unusable, teeming with not only mold but also potentially lethal bacteria. STAFF PHOTO BY NAIT POPE

**By Keith Darce
and John Pope**
Staff writers

The debate had raged for years over whether to revamp Charity Hospital or tear down the art deco building on Tulane Avenue and replace it with a smaller facility better attuned to economic reality in an era of increasingly market-driven medicine.

Katrina ended the debate and may even have framed a decision on the hospital's future.

For most of New Orleans' history, Charity Hospital was at the epicenter of the city's medical community, as a center for treating victims of typhoid and grave disease — especially the poor and uninsured — and as the training ground for most of Louisiana's doctors.

That tradition ended in August. Post-Katrina floods inundated the basement, wrecked wiring and plumbing and trashed medical equipment.

See **HOSPITAL**, A-7



FLOODING Floodwater surrounds Charity Hospital, just days after Hurricane Katrina inundated the city. Basement flooding wrecked wiring and plumbing and trashed medical equipment, much of which was so old that replacement parts aren't made anymore. STAFF PHOTO BY ALEX BERGSON

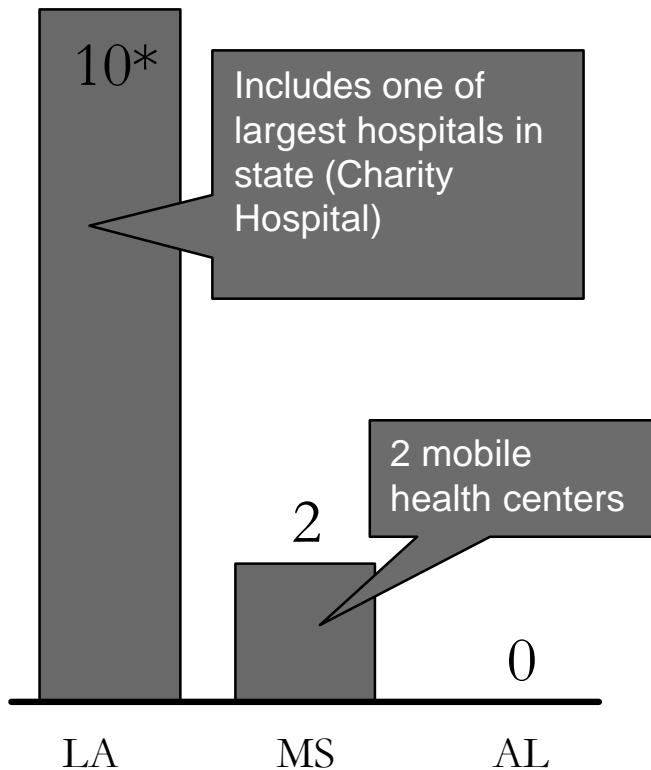
Hospital Damage



Louisiana Suffered More Than 30x The Losses To Medical Infrastructure Than Its Neighbors

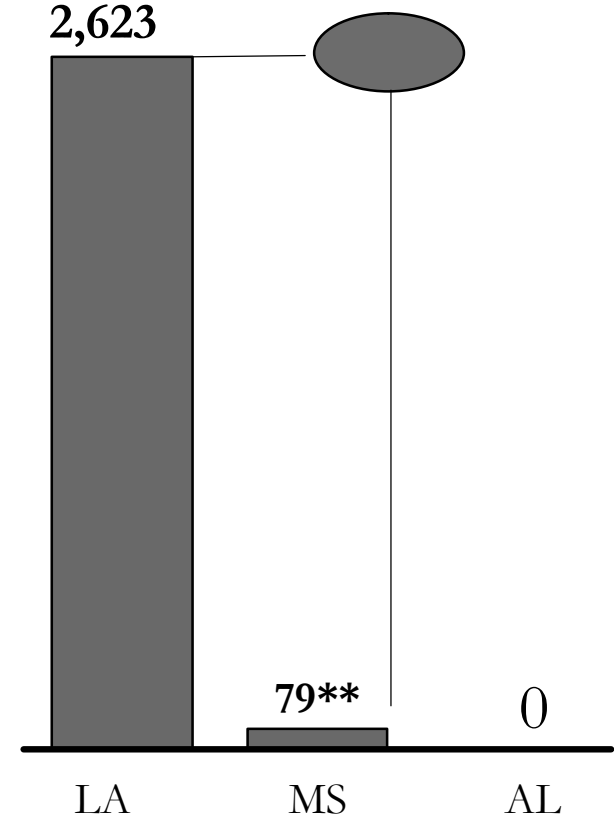
Facilities remaining closed (as of 2/28/06)

Hospitals and mobile health centers



Capacity off-line

Beds closed in affected facilities



* 3 facilities have announced they will not be re-opened; others assessing repair options

**79 of 104 beds at Hancock Hospital in Bay St. Louis; no beds associated with two mobile health centers

Source: Louisiana Hospital Association; Health Resources Services Administration; Mississippi Hospital Association

Assessment

Charity and University hospitals have been rendered “uninhabitable and unsalvageable.” The mechanical, electrical and plumbing systems “have sustained major damage . . .” and there was “very significant damage to interior/finish systems and vertical transportation systems.”

~Emergency Facilities Assessment
The Adams Group
November 2005

NORMC Hospitals, Research, Medical Education, Health Care Businesses

- Employed over 20,000, including professionals, researchers, educators, healthcare workers, nurses, graduates/residents.
 - Hospitals included:
 - MCLNO – “Charity” (Safety Net) – Level One Trauma
 - LSU-University Hospital
 - Tulane University – HCA
 - Veterans Administration Hospital
 - ALL were flooded with services destroyed, interrupted or suspended
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- The number of staffed hospital beds in New Orleans was estimated to be about 80% less in February 2006 than before Katrina.
 - Of the 9 acute care hospitals in the city prior to Katrina, only 3 had reopened at a capacity of approximately 456 staffed beds as of February 22, 2006.
 - Since Katrina, increased demand has been reported at the open emergency departments and has led to slow unloading of patients from ambulances and to patients being housed in the emergency department.
 - More than three-fourths of the safety net clinics have closed.
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- Maintaining and attracting the workforce for health care facilities is a serious issue.
 - Long-term decisions about the health care system in New Orleans are affected by uncertainties about the future.
 - The core population of New Orleans has declined by approximately 68% since the storm (484,674 to 156,900). Some project that the population in 2008 will be 247,000, about half of the pre-Katrina population due to lack of housing and other services.
 - A survey of residents in FEMA-supported housing found 44% of caregivers and 10% of children lacked insurance
 - Many indicated they lost insurance when they lost their job after the storm
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- As of June, 2006 – 3 of Orleans Parish's 9 acute care hospitals were operational
 - Bed capacity in New Orleans Metro area pre-Katrina was 4,083; Mid-July, 2006 = 1,971
 - Orleans Parish was 2,269; Mid-July, 2006 = 479
 - As of April 24, 2006, Charity's ED and trauma center now operating out of Elmwood Hospital
 - Volume at Earl K. Long Medical Center in Baton Rouge is up by 50%
 - Other hospitals are now providing a greater than usual share of uncompensated care
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Big Health Issues Post-Katrina

1. Addressing the loss of health coverage by hundreds of thousands of displaced and newly impoverished Katrina victims
2. Restoring the shattered health care infrastructure and housing in the impacted areas
3. Decreased quality of patient care due to displaced Doctors and patients
 - 6,000 physicians displaced
 - 1,300 Residents displaced



LRA Board Resolution

- Adopted PWC Report Recommendations
 - Adopted La Health Care Redesign Collaborative's recommendations
 - Committee Recommending CDBG funding based on "commitments" from LSU \$74 M funding for land acquisition and design for LSU-VA
 - Condition commitment on strategic study to incorporate Health Care Redesign for additional \$226 M
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Louisiana Health Care Redesign Collaborative

Louisiana Health Care Redesign Collaborative

On July 17, 2006, Secretary Michael Leavitt, US. Department of Health and Human Services, Gov. Kathleen Babineaux Blanco, Secretary Dr. Fred Cerise, Department of Health and Hospitals and Dr. Norman Francis, Louisiana Recovery Authority, signed the Louisiana Health Care Redesign Collaborative Charter

Louisiana Health Care Redesign Collaborative -- Mission and Vision

- To develop, and oversee the implementation of, a practical blueprint for an evidence-based, quality driven health care system for Louisiana. This blueprint will serve as a guide to health care policy in Louisiana and to the rebuilding of health care in the hurricane-affected areas of the state.
 - To develop and submit to the U.S. Department of Health and Human Services a comprehensive system-wide Medicaid Waiver and Medicare Demonstration proposal for parishes of the Greater New Orleans area
 - The Collaborative orientation is both statewide and local
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Overview

- Strategies for Coverage
 - Basic Benefit Package
 - Managed Medical Homes and Integrated Systems of Care
 - HIT
 - Paying for the System of Care
 - Additional Issues
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Overview

- Short-Term priorities
 - Establish Louisiana Health Care Quality Forum
 - Provide for Families of Uninsured Children (200-300% poverty)
 - Cover Pregnant Women
 - Medicaid, SCHIP, LaCHIP, TANF (Temporary Assistance to Needy Families)
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Background

Pre-Katrina

- New Orleans' uninsured cared for in the public hospital system or in emergency rooms
 - “Big Charity”
- New Orleans Region ~ 2000 hospital beds
 - ~462 psychiatric beds in southeast Louisiana

Post-Katrina

- Charity Hospital closed
 - 50% fewer doctors practicing in Region I
 - ~ 1000 hospital beds
 - ~ 190 psychiatric beds
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History of the Collaborative

- Louisiana Recovery Authority – Public Health & Healthcare Task Force
 - PWC Report and Findings
 - HCR 127 – recommended blueprint
 - Charter
 - Workgroups – from July to October, 2006
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Vision

“Everyone will have access to, enroll in, and contribute appropriately and within their means to an affordable, dependable public or private insurance program or other mechanism to ensure regular access to a medical home, through which access to a core system of quality-driven health care will be financially secured.”

Guiding Principles from the Collaborative Charter

CMS Position:

- Single-Tiered System
 - Dollars follow the Patient
 - HIT – Electronic Medical Records
 - Improve Quality
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The Louisiana Health Care Redesign
Collaborative Unanimously Approved the
October 20, 2006 Concept Paper

[Subject to DHH/CMS negotiation and waiver submittals]

Short-Term Issues

- Allocate \$120M to National Health Service Corp. for workforce recruitment and retention
 - Crisis Counseling
 - Behavioral Health
 - Medicare Adjustments
 - Allocate \$30M to Uncompensated Care
 - Extend SSBG
 - Appropriate \$150 M for hospitals that remained open or opened shortly after Katrina
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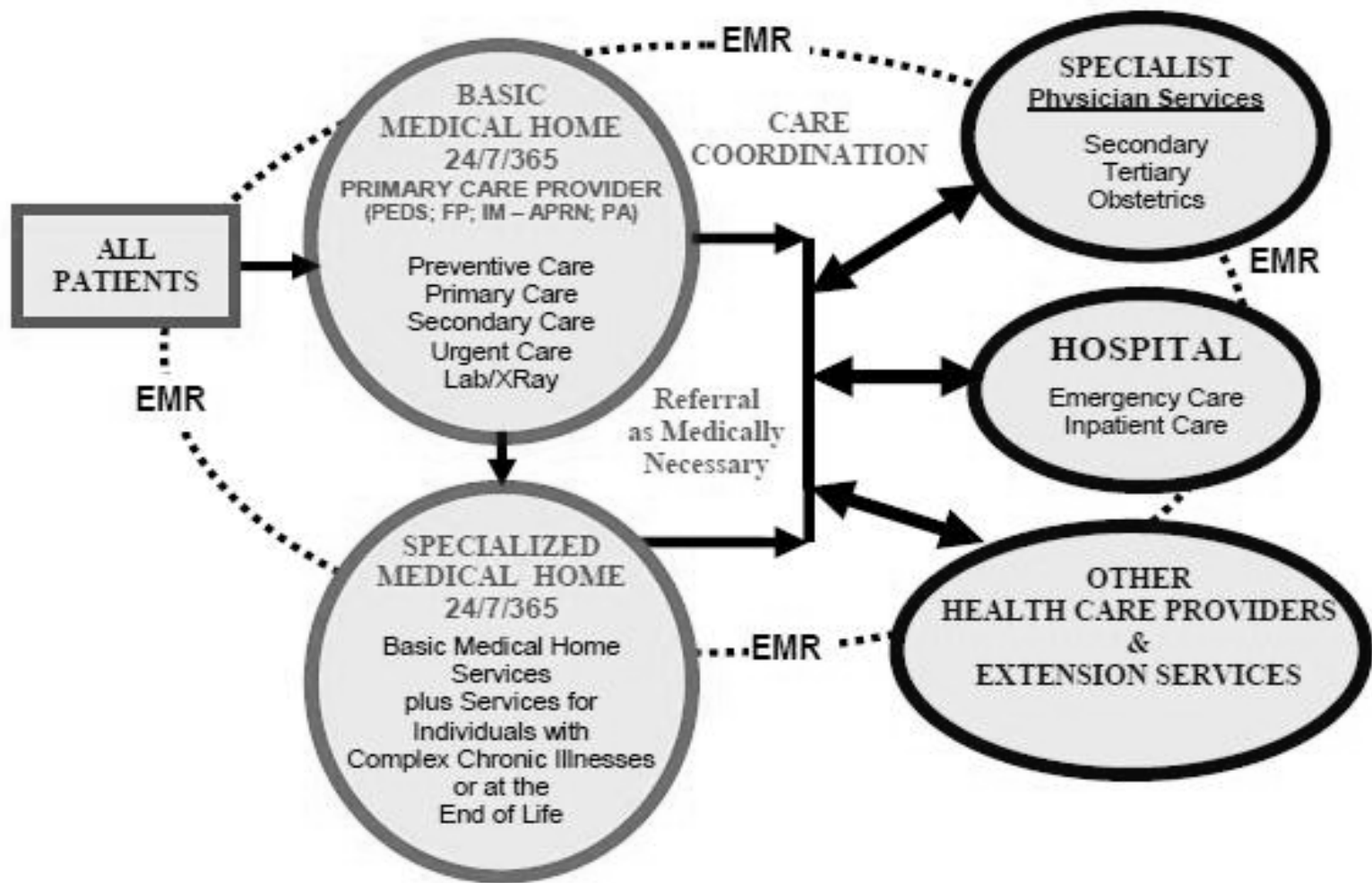
Populations

- Medicaid
 - Uninsured
 - Incentive Employer Sponsored
 - Severe Mental Illness (SMI)
 - Uninsured Parents and Childless Adults
 - 200% below FPL ? Medicaid Plan or Private Insurance
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The Medical Home System of Care

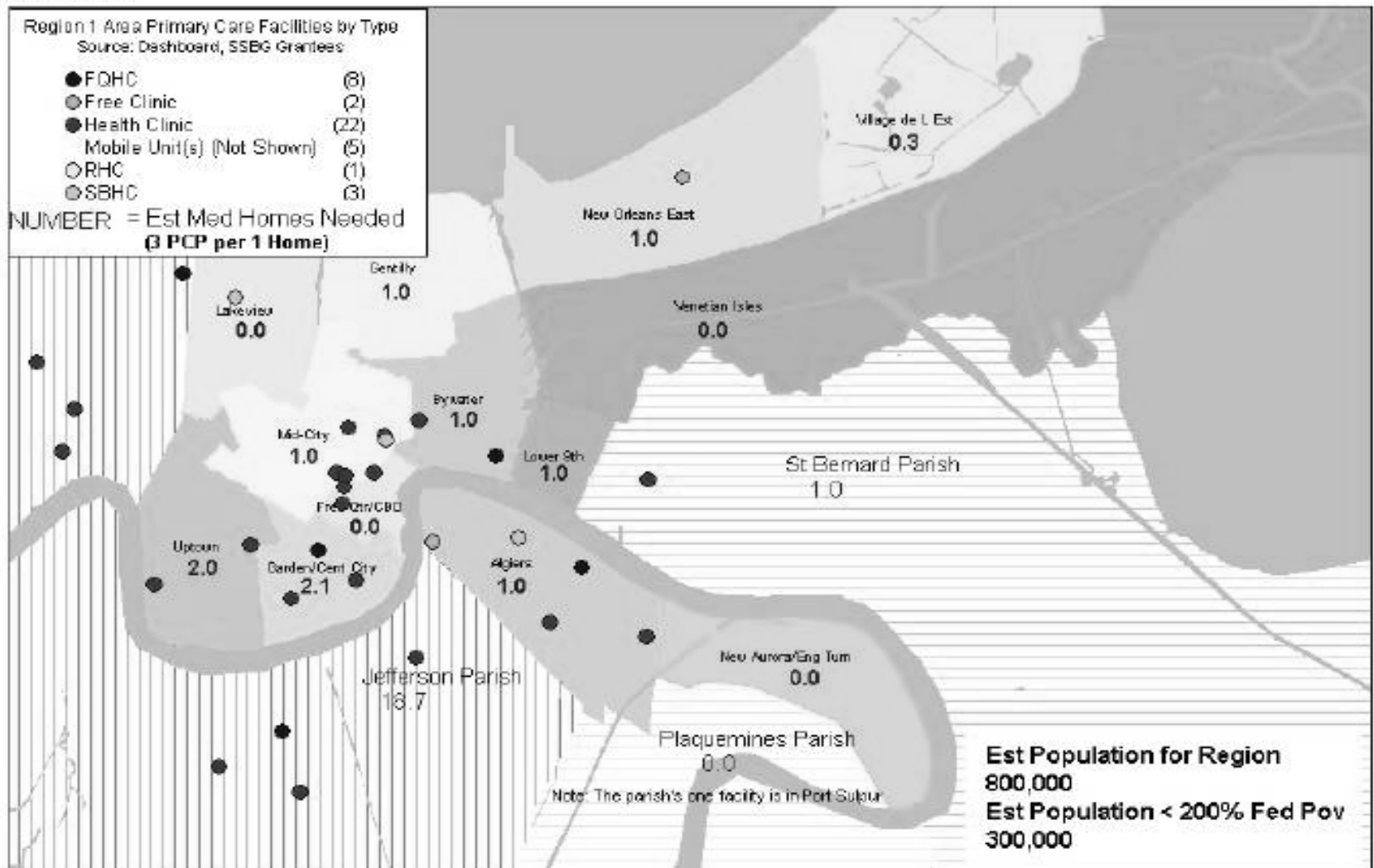
- IOM Framework for delivery
 - Accessible, integrated, community-based, ambulatory care
 - Strong preventative/primary care focus
 - Comprehensive continuum
 - Coordinated
 - Providers
 - Primary, Tertiary and LTC
 - Inpatient, Outpatient, Home & Community
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Region 1 Medical Home System of Care



**Estimated Number of Additional Medical Homes Needed for Residents Below 200% Poverty
Facilities Plotted Indicate Ongoing Primary Care Services**

REGION 1



Population estimates for residents: FEMA's housing damage and Census prestorm population
NOTE: Assuming Each Existing Service Provider Contributing 2.0 PCP FTE

Entry Point

- Health Promotion
 - Health Maintenance
 - Patient Education
 - Evidence-based
 - Accessible 24 hours
 - Interoperable EMR or EMH
 - Care Planning/Coordination
 - Extension Services for Complex & Special Populations
 - Specialized Homes
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Health Insurance Connector

- Combined Premium Subsidy
 - Affordable Health Insurance Options
 - Facilitating Patient Choice
 - Up to 300% FPL
 - Transparency
 - Information Sharing
 - Employer-sponsored/Group Health Plan
 - Public/Private
-

Louisiana Benchmark Health Plan

- Managing Care Creates Savings
 - Medicare Reimbursement
 - Risk Adjustment
 - State Administration of Eligibility
 - Independent State Approved Agency with Board of Directors
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Chronic Complex Conditions/ End of Life Care

- In the 18-24 Months leading to death
 - In Louisiana, cost \$60K
 - In US, cost \$36K
 - Coordinate Care
 - Interdisciplinary team dialogue
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Financing

Combined Resources

- State Government
 - General Fund
 - Medicaid
 - Dispro
 - Federal Government
 - Flexible
 - Medicaid
 - Medicare Demo
 - DSH
 - Local Funds
 - Independent Contributions
 - Premium
 - Co-Pay
 - Employer Contribution
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Feasibility

- GME Carve Out
 - Expanded Coverage – Subsidy
 - Medical Savings
 - HIT Investment Savings
 - Major Quality Initiative
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Louisiana Quality Forum

- Framework
 - \$10M – National Quality Forum
 - Desired Health Care Outcomes
 - Infrastructure
 - Targeted Health Conditions
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Private-Public Partnership

- Collect Data
 - Monitor Population
 - Establish Quality Measures & Standards of Care
 - Public Reporting
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Strategies for Coverage

- Cover Categorically Eligible with Medicaid in the Managed Medical Home Plan
 - Cover all children up to 300% FPL with cost sharing as appropriate – Mandate Insurance for Kids
 - Premium Assistance for Childless Adults aged 19 – 64
 - Medicare/Medicaid Dual Eligible
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Strategies for Coverage

- High cost patients will be ceded to specialized health plans subsidized by Medicaid.
 - The Connector concept as developed elsewhere may become the mechanism for the coverage of the expanded populations assuming network design is consistent with Medical Home.
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Strategies for Coverage not yet discussed with the Collaborative

- Create a state wide purchasing pool that state, municipal, and small employer groups can offer as an option. This plan will include the Medical Home and Integrated System of Care concepts. It will also cede high cost patients to a plan underwritten by Medicaid and case managed.
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Basic Structure of Benefit Package

- Medical Home model that is consistent with guiding principles
 - Medical Home Systems of Care include ambulatory based clinics, with partnerships for I/P and O/P care and specialty care
 - Specialized Medical Home
 - Quaternary Care
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Medical Homes

- How many do we need?
 - The current estimate is 18-30 depending on their size.

- Do we know where they should be?
 - This work is currently being completed along with work refining the population estimates.

Health Information Technology

- “Backbone of Design”
- EMR
- Software/Hardware
 - \$13K/year or \$32K/system



Health Information Technology

- To prevent the problems faced by thousands of people in the face of recent disasters and improve the quality and efficiency of health care for all an EMR will be implemented by all providers and be connected to the HIE. The cost of this will be paid from a pool funded 90% Federally and 10% State similarly to other major MMIS projects.
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What does HIT cost?

- Cost Estimate per Practitioner¹
 - Software \$1,600
 - Implementation \$3,400 (one time)
 - Support \$1,500/year
 - Hardware \$6,600 (Replace every 3 years)

- Total – Year 1 \$13,100
- Total – 5 Years \$43,300²
- Total – 5 Years \$54,545³

¹"A Cost Benefit Analysis of Electronic Medical Records in Primary Care" Excerpta Medica, Wang et al, 2003

²Includes estimate of productivity loss for implementation

³With inflation since 2003 at POTUS budget estimate of 8%

Financing HIT in the MHSC

- Assumptions:
 - MD sees an average 28 patients/day
 - 4,000 visits per MD/year
 - 5 yr total cost of EMR = \$54,545
 - Annual cost of EMR = \$10,909
 - \$2.72visit = cost of EMR
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ONE YEAR LATER . . .

“This is the first act of a
very long play.”

Reese Fayde, CEO Living Cities, quoted in The Times-Picayune, 2/26/06

Only those who dare to
fail greatly
can ever achieve greatly

Robert Kennedy