New Orleans Health System Recovery Is Slow

Only half of the 3,000 physicians who practiced in the area before the storm had returned by mid-2006.

BY ALICIA AULT
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Two years after Hurricane Katrina's floodwaters submerged much of New Orleans, the city's relatively few open health care facilities and diminished corps of physicians are struggling to serve a smaller, but just as medically needy, population.

It's a picture that's changed some—but not much—since a year ago.

Emergency rooms, in particular, are bearing the brunt of the broken system, as they are one resource that is nearly always available to the uninsured and those with little access to primary care.

It is thought that about 200,000 people now reside in the city, with another 400,000 in the three surrounding parishes (Jefferson, Plaquemines, and St. Bernard). In that region, there are some 101,000 uninsured residents and 147,000 Medicaid recipients, according to the Louisiana Department of Health and Hospitals (DHH).

It's still unclear how many of the approximately 3,000 physicians who practiced in the area before the storm have returned. By mid-2006, according to claims information from Blue Cross and Blue Shield, only half of them had come back.

The Louisiana State Board of Medical Examiners said that from August 2005 to July 2006, the number of primary care physicians declined from 2,645 to 1,913.

The lack of access to care has hit hard. According to an analysis of death notices in the Times-Picayune by Dr. Kevin U. Stephens Sr., director of the city health department, and colleagues, there was a 47% increase in the mortality rate in the first 6 months of 2006—to 91/100,000, compared with 62/100,000 seen in 2002-2004 (Disaster Med. Public Health Preparedness 2007;1:15-20). The authors said that they studied death notices because of vast gaps in state and city data.

Primary Clinics to Be Medical Homes

According to Dr. Frederick P. Cerise, secretary of the Louisiana Department of Health and Hospitals, there are 26 primary health care sites in the New Orleans area, including federally qualified health centers, Tulane University and Louisiana State University outpatient clinics, and mobile and nonprofit clinics.

The sites will receive about $100 million from the federal government over the next 3 years, said Dr. Cerise in an interview, as part of a $161 million allocation aimed at improving health care around the area.

The clinics are eagerly awaiting the shot in the arm, said Dr. Karen DeSalvo, executive director of Tulane University Community Health Center at Covenant House, in an interview. The Tulane clinic is part of an 18-clinic alliance, the Partnership for Access to Healthcare (PATH).

The money is "going to give us a chance to expand upon what's been developing—multiple neighborhood clinics that are turning into medical homes," said Dr. DeSalvo, who also is chief of general internal medicine and geriatrics at the university and special assistant to its president for health policy.

All PATH clinics have agreed to uphold and advance the principles of a medical home, she said.

The concept was developed by the American Academy of Pediatrics and is being promoted on a national level by the American College of Physicians and the American Academy of Family Physicians.

Jay Westcott/Elsevier Global Medical News

A new medical center is planned on a 37-acre parcel a few blocks from Charity Hospital, said Mayor C. Ray Nagin.

Dr. DeSalvo said that while she believes the primary care picture is vastly improving in the city, noting that the 18 clinics see about 900 patients a day, too many patients still seek routine care from the emergency departments.

"We're trying to find those patients in the ER and get them into our system," she said.

Inpatient Capacity Still Down

Currently, in New Orleans proper, there are five hospitals open; five more are either abandoned or closed, according to the Louisiana Hospital Association.

Louisiana State University, Baton Rouge, is once again operating a level one trauma center in downtown New Orleans at the LSU Interim Hospital (formerly University Hospital).

The now-179-bed Interim Hospital and Tulane Hospital are all that's left of the Medical Center of Louisiana at New Orleans. Before Katrina, that campus also included Charity Hospital, a Veterans Affairs (VA) hospital, and medical office buildings. LSU was able to open Interim Hospital with $64 million in Federal Emergency Management Agency (FEMA) funds. It has recently added a 20-bed detox unit (only 5 were staffed as of press time) and is in the midst of adding 33 inpatient mental health beds elsewhere in the city, as well as a mental health unit in the emergency department.

LSU is one of the main backers of a huge new medical campus within a few blocks of Charity Hospital on a 37-acre partly undeveloped parcel that the city has said it will take. According to testimony by Mayor C. Ray Nagin at a field hearing of the U.S. House Committee on Veterans' Affairs in early July, the new campus would include 30 public, private, and nonprofit organizations, including LSU, Tulane, Xavier University, Delgado Community College, the LSU and Tulane hospitals, medical offices, and biotechnology companies. The state has put aside $38 million to fund a cancer research institute at the site.

The city—along with LSU and Tulane—

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Grants Offered for Primary Care Help

The state of Louisiana and city of New Orleans are struggling to lure physicians—especially primary care doctors—dentists, mental health professionals, and nurses back to the city or at least to convince those who did come back to stay in the face of a new and bigger onslaught of uninsured patients and a patchwork system of care.

After Katrina, thousands of residents, many of them doctors and nurses, evacuated. A recent study, citing Louisiana State Board of Medical Examiners data, reported that the number of board-certified primary care physicians in New Orleans dropped from 2,645 in August 2005 to 1,913 in July 2006 (Disaster Med. Public Health Preparedness 2007;1:21-6).

In April 2006, the federal government declared the greater New Orleans area—encompassing Orleans, Jefferson, Plaquemines, and St. Bernard parishes—a health-professional shortage area.

The region became eligible for federal grants to offer incentives to retain or recruit health professionals and gave rise to the Greater New Orleans Health Service Corps.

The Louisiana Department of Health and Hospitals, which is overseeing the Corps, has received $50 million to spend on recruitment and retention. The first chunk, $15 million, was received in March 2007; 70% of the funds were earmarked for recruitment and 30% for retention.

In mid-June, the state agency received another $35 million. Realizing how difficult it is keep physicians in the city, the state received permission to adjust the split, said Gayla Strahan, a program administrator for the DHH's Bureau of Primary Care and Rural Health and manager of the Service Corps effort. Now, half goes for recruitment and half for retention.

When the state applied for federal health shortage funds—in mid-2006—there were 405 primary care physicians and 30 psychiatrists in the region, but just 76 primary care doctors and 6 psychiatrists at that time took Medicaid or uninsured patients.

The DHH determined that—based on the region's population at that time (about 700,000) and the Medicaid enrollment (about 135,000)—there was a need for 48 more primary care physicians, 38 more dentists, 10 more psychiatrists, and 33 other mental health professionals, such as psychologists, licensed clinical social workers, and marriage and family therapists.

The department also will seek to retain and recruit faculty at the area's medical, nursing and allied health schools, said Ms. Strahan.

The goal is to retain 50 primary care physicians and recruit 48 new ones by September 2009, when the grant cycle ends, she said. For mental health, the goal is 24 retentions and 43 recruits; for dentists, it is 10 and 30, and for faculty, the aim is to keep 48 current positions and bring in 46 new appointments, including 24 at the medical schools.

The Service Corps also has earmarked a little over $2 million to retain 5 specialists and bring in 15 new ones. The bar is a little higher for a specialist—the applicant has to show there is a dire need. For instance, if there's only one cardiologist who agrees to accept Medicaid patients, "that's a dire need," said Ms. Strahan.

Applicants—and there were 300 as of press time—have to accept Medicare, Medicaid, and the uninsured; must work at least 32 hours a week in clinical practice; and have to be licensed in Louisiana or at least agree to become licensed before starting work. Once accepted, participants have a 3-year obligation.

Physicians, psychiatrists, and dentists can tailor their own package of incentives up to $110,000, which is paid in one lump sum at the beginning of the 3 years. They can use it toward salary, to repay loans, for malpractice premiums, and/or to buy health information technology.

Mid-level providers are eligible up to $55,000, registered nurses and nurse faculty up to $40,000, and allied health professionals can receive $10,000 to $40,000, depending on the discipline.

So far, there have been at least 125 awards, including 62 primary care positions (including mid-level providers), 16 dentists, 42 mental health professionals, and 5 pharmacists.

For more information on the program and to download an application, visit www.pcrh.dhh.louisiana.gov.

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is trying to convince the VA to rebuild on the campus.

Dr. Michael Kaiser, acting chief medical officer of the LSU Health Care Services Division, said at the field hearing that—before Katrina—the VA bought at least $3 million in services from LSU annually. Before Katrina, 75 Tulane physicians had joint VA-Tulane appointments, and 120 Tulane residents received training at the VA, said Dr. Alan Miller, interim senior vice president for health sciences at Tulane, at the hearing.

Currently, 40 Tulane doctors provide services and training at VA outpatient clinics, which represents $2.2 million in physician compensation, he said.

The private Ochsner Health System is vying to have the new VA hospital built across the street from its campus in Jefferson Parish.

At the field hearing, Dr. Patrick J. Quinlan, Ochsner's CEO, noted that the site "is above sea level and not located in a flood plain."

Because the federal government has not agreed to fund a new campus, Gov. Kathleen Blanco signed an executive order allocating an immediate $74.5 million for land acquisition and planning. To come up with the additional $1.2 billion needed, the state will float a series of bonds.

And some stalwarts have not given up on reopening Charity. Last year, the state legislature approved a study by an independent team of investigators to see if the first three floors could be refurbished while a new medical campus is put together.

EDs Feel Ripple Effect

The lack of inpatient beds and mental health care, and the shortage of primary care sites are felt most acutely in the area's emergency departments.

Two years ago, the now-shuttered Charity Hospital received 120,000 to 200,000 ED visits a year. Granted, there are fewer people in the city now, but there are more now who come in the door sicker or in need of basic care, said Dr. Jim Aiken of the emergency medicine department at LSU.

"We do a lot of renewing prescriptions and checking blood pressures," and other primary care types of interventions, he said in an interview.

The Interim Hospital sees about 3,500 patients a month. Although things have improved in the last year, the ED is admitting more patients than before the storm, and "we struggle every day with surge capacity," said Dr. Aiken.

Diversion is not uncommon, but the hospitals in the area now at least have a new communications module that lets them track online what's happening at other facilities in the area.

The lack of adequate mental health care, combined with poststorm stress and anxiety, is having the biggest impact on the ED, said Dr. Aiken. It is not unusual for the hospital to be holding 15 psychiatric patients at its 31-bed ED, he said.

Charity also housed a crisis intervention unit where the police could take the mentally ill. With that unit gone, those with psychiatric needs have been spread out around the city.

Before Katrina, there were 578 psychiatric and detox beds in and around New Orleans; that number is now at 236, with only a small portion of them actually in downtown New Orleans, according to Dr. Cerise.

The deteriorated mental health system is "probably in my mind the most critical health care issue in this state since the storm," said Dr. Aiken.

Even the LSU system in Baton Rouge has been affected, said Dr. William "Beau" Clark, president of the Louisiana chapter of the American College of Emergency Physicians.

Emergency rooms in that city have absorbed some of New Orleans' outflow, including psychiatric patients who end up boarding in Baton Rouge, he said. ■

Only One in Four U.S. Physicians Has Adopted Electronic Medical Records

BY TIMOTHY F. KIRN
Sacramento Bureau

SEATTLE — Despite the government's push to encourage the development of the electronic medical record system, only a quarter of physicians keep medical records electronically, and only 11% of hospitals have fully implemented them, according to Dr. Karen M. Bell, director of the federal government's Office of Health IT Adoption.

In addition, of the electronic record systems in use, probably fewer than half are fully operational, that is, able to take notes, make lab and pharmacy orders, and get lab results, said Dr. Bell at the annual meeting of the American Geriatrics Society.

"The reality of it is that adoption of really good functionality is really very low," she said.

The barriers to widespread adoption continue to be the lack of good, accepted computer applications, and the time and cost, said Dr. Bell.

While it is thought that the use of electronic health records eventually would result in financial savings, start-up costs continue to be prohibitive, she said.

The cost to get every record interface—every office, laboratory, pharmacy—up to speed with appropriate software and hardware may be $5,000 for each one, and for the nation as a whole it may cost $50 billion, Dr. Bell said.

At the same time, those who are using electronic medical records are finding that they are not exactly time saving. In part, that is because there is a learning curve involved.

The records also generally require more information than what went into records previously, as part of an effort to improve and ensure quality.

The government currently has public policy advisory committees to encourage more adoption and to deal with privacy issues—significant challenges, Dr. Bell said.

In the meantime, her office is continuing to develop an exact definition of what is going to be needed in an electronic health record, she added. "There are no standard definitions for any of this stuff."

Of the EMR systems in use, probably fewer than half are fully operational, that is, able to take notes, make lab and pharmacy orders, and get lab results.

Other speakers at the meeting described the significant hardship they went through acquiring a system specifically for geriatrics.

The electronic health record industry and its products are geared to the acute care environment, and when they can be used for a facility that cares for older persons, they need to be modified significantly, the speakers said.

"As I was trying to figure out which electronic health records system we would use for geriatrics, I really ran into a lot of roadblocks," said Dr. Irene Hamrick of the division of geriatrics at East Carolina University, Greenville, N.C. "There really is nothing out there that is very good."

Her institution finally chose General Electric Company's Centricity system because it can be used in many locations, such as the home for health care visits. But, the institution found that it needed to tailor the system for specific geriatric needs, adding records of diet and activities of daily living, and changing the physical exam form to include sections for foot and mental status exams.

"Very little out-of-the-box software is user friendly for geriatrics. None is totally acceptable to my mind. If you want to use them, you have to adapt them," Dr. Hamrick said.

When the Gurwin Jewish Geriatric Center of Commack, N.Y., began to look for an electronic medical record system, the institution had no idea it would take so long to find and implement one, said Dr. Suzanne Fields, the medical director.

The center found that there are Web sites (such as www.providersedge.com/ehr_links_products_services.htm) that can help one find a system, and that the American Academy of Family Practice has a rating form that one can send to vendors to get information on their systems for comparison.

Moreover, the center found a number of products for long-term care. But, the center has both outpatient day care and clinics, and inpatient beds, and none of the products adequately accommodated both, Dr. Fields said.

They, too, found that they had to adapt a system to their needs. In the end, the center combined two products, one for long-term care and another for physician care. The system is not yet up and running.

"It has to be individualized. That's what I didn't realize," she said. ■

Pharmacists in the ED Enhance Patient Care, Doctors and Nurses Say

WASHINGTON — A 99% majority of emergency department staff said that a clinical emergency pharmacist in the ED improved the quality of patient care, based on data presented at a conference sponsored by the National Patient Safety Foundation.

Drug-related adverse events in the ED remain a significant public health problem. Reports of the success of clinical pharmacists in other hospital areas suggest that the ED-based clinical pharmacists could improve the quality of patient care; however, ED-based pharmacy programs are relatively rare, and their impact has not been well studied.

To assess the ED staff's perception of their facility's emergency clinical pharmacists, Dr. Roger J. Fairbanks and colleagues at the University of Rochester (N.Y.) surveyed a random sample of ED staff members in a tertiary care academic medical center and trauma center that included an emergency medicine residency program.

Anecdotal reports suggest that ED staff members value clinical pharmacists, but no previous studies had addressed the question, the researchers said in a poster.

They collected responses from 33 doctors and other health care providers and 42 nurses as part of a research program supported by the Agency for Healthcare Research and Quality.

A total of 96% of the respondents said that the emergency pharmacist was an integral part of the ED team. In addition, 93% of the respondents said that they regularly consulted the emergency pharmacist, and 93% reported using the pharmacist more in the ED location than in the pharmacist's previous location.

Overall, 47% of the ED staff (55% of physicians and other providers and 40% of nurses) said that immediate availability for consultation was the most valuable role of a clinical pharmacist. By contrast, slightly more nurses than doctors or other providers reported that attending medical and trauma resuscitations was the most valuable role of an emergency pharmacist (38% vs. 22%, 36% overall). Another 7% of the respondents said that the emergency pharmacist's most important role was reviewing orders, and 8% said that the emergency pharmacist's most important role was staff education.

A Web site hosted by the University of Rochester (www.emergencypharmacist.org) provides resources for doctors and hospitals that are thinking of adding an emergency pharmacist to the ED.

—Heidi Splete