Community-Based Health Care for “The City that Care Forgot”

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References to New Orleans as “the city that care forgot” first appear as far back as the 19th century. Although this reference has pointed, generally, to the high levels of poverty, we submit that forgotten “care” may refer to inadequate preventative and ambulatory health care for its residents. As the most recent US census and health statistics data indicate, this epithet remained apt through the city’s mandatory evacuation in anticipation of Hurricane Katrina making landfall last month. Twenty-eight percent of residents in New Orleans lived below the poverty line (43% of children under the age of 5 years). Health statistics reported by the Centers for Disease Control and Prevention estimated that 60% of adults in Louisiana were overweight, 25% had diagnosed hypertension, 31% had diagnosed high cholesterol, 8% had diagnosed diabetes, and 85% of residents did not participate in physical activity on a regular basis. Louisiana placed 50th in overall health (i.e., the absolute least healthy state), a precarious ranking it has held for 14 of the previous 15 years.

The devastation that Hurricane Katrina and its aftermath wrought on the city of New Orleans has been described in vivid detail throughout the world’s press. We relate the salient facts here in brief. On August 29, 2005, Hurricane Katrina slammed the Gulf coast of the United States with sustained winds of 165 miles per hour. On August 30th, 2005, the levees protecting New Orleans from Lake Ponchartrain failed, resulting in widespread flooding in 80% of the city. During the days that followed, the plight of New Orleans’ poor was played out repeatedly on the international news. Evacuation plans for the poor and infirm were not well planned, executed, or communicated. In the nightmarish situation that followed the actual storms, tens of thousands were stranded on highways and at “refuge” stations waiting to be taken away from the heat and squalor. Many of these people were elderly and ill and had not been able to evacuate.

Before Hurricane Katrina, the Medical Center of Louisiana at New Orleans (also known as Charity Hospital) served as the health care safety net for many of these people. Opened in 1736, it was the oldest continually operating hospital in the United States and had remained a crucial source of healthcare in the “city that care

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forgot". It served as the only major trauma center for the region and provided inpatient care services to the level of quaternary care. It also served as the principal source of outpatient care for the urban poor through the conduct of 200,000 annual outpatient visits. Further, it was a major resource for the training and teaching programs of Louisiana State University Health Sciences Center and the Tulane University Health Sciences Center.

Historically, the staff, faculty and resident physicians at Charity Hospital have performed admirably, given the facility's limited resources and facilities that were far from ideal. Patients were required to spend hours in waiting rooms, scarce nondirect health services were available, and it was inconveniently located for many of those it intended to serve. Healthcare in New Orleans for those without insurance faced the inherent problem associated with a single center serving thousands of people, many of whom lacked transportation, who lived across a broad geographic area.

As with other essential infrastructures, Hurricane Katrina all but destroyed the health care system in New Orleans. At this writing, only three hospitals are operational in the greater New Orleans metropolitan area, none of which are in New Orleans proper. Many healthcare service facilities were likewise destroyed, resulting in the complete absence of an ambulatory care system in the city. Primary care in New Orleans is currently being delivered from tents and clinic facilities set up for first responders and those in the community who did not evacuate. For example, six health clinics have been operational at police precinct offices since the first week after the hurricane. These new clinics are comprised literally of a desk, a chair, a box of tetanus boosters, and a doctor, with some sites having blood pressure cuffs and first aid supplies.

In the aftermath of Hurricane Katrina, a unique opportunity exists to provide the long absent "care" and to improve the health of the residents of New Orleans. As the recovery effort from Hurricane Katrina began many local, state, and national leaders avowed repeatedly to improve the economy and build a "better" New Orleans. Within this context, the city, its medical personnel, and its citizens can work together to design a better model for the delivery of healthcare. Although it is crucial for urgent medical care to be available during this time period, it would be short sighted not to concurrently plan for providing better long-term preventive and ambulatory health care for New Orleans' residents. This is a once in a lifetime opportunity for a city to build its health care system completely from scratch.

Even before Katrina, most agreed that restructuring the health system for the impoverished population in New Orleans was long overdue. The model of a single site, physician-centered care was antiquated and not meeting the needs of its clients. Inertia, politics and a lack of resources stalled the restructuring process. The storm has forced this issue, and the State of Louisiana has declared that Charity Hospital and most of its associated buildings to be condemned. Although realistic concerns exist regarding how the Charity Hospital system will be replaced, we see the current transition period as the impetus to completely overhaul the care for urban poor in New Orleans.

It is our vision that, in terms of ambulatory care, the old centralized Charity Hospital system be replaced with community-based clinics. The services we propose are not housed in "clinics" but rather in community centers, where there is exercise equipment, daycare, and resources available including internet access, educational and job training opportunities, and community activities. The health system we envision is proactive and will identify risk factors and subclinical disease, track patients' health status, and facilitate proper treatment—lifestyle modification and

pharmacological—before conditions deteriorate. These dynamic entities would focus on health rather than illness.

The new healthcare system we propose would include hospitals but would not necessarily be hospital centered. Instead, this integration of health, social, and community services into a single physical structure provides the potential to remove the stigma associated with visiting a health care facility and also will eliminate multiple trips to a single site for different services. For example, parents with young children would have access to on-site childcare and nutrition services while receiving their own healthcare. If properly designed with enticements such as televisions with sports programming, it might even entice men to visit and receive the preventive and other care they so often sorely neglect.

The community health centers we envision should provide open access and will serve as a collaborative partnership between health care professionals, community groups, local government, public schools, and area residents to improve the overall health and well-being of the community they serve. What we propose is novel, but not unprecedented, and possible within current federal regulations and funding now available. As a matter of fact, this model of care currently exists to a limited extent as comprehensive health centers and is funded under section 330 of the United States Public Health Service Act. We think a hybrid strategy that includes aspects of social planning, community organizing, community development, and policy advocacy should be implemented as part of these community health centers. The inclusion of broad community engagement is a distinguishing feature that offers the best prospect for the success of the health centers being proposed.

In structuring these community health centers, the use of electronic medical records would be essential to facilitate the sharing of medical information, preventing the provision of duplicate services such as immunization and prompting providers on the need for routine health maintenance. It would also serve as a resource for real time measurement and monitoring of the quality of care.

The current administration's call to expand the use of federally funded community health centers could help form the basis for financing this healthcare model. Not only is ongoing federal funding available for new community health centers but these centers would also qualify for a significantly increased reimbursement from Medicaid and the children's health insurance program with their designation as a federally qualified health center (FQHC). Such FQHCs also qualify for a drug discount program which provides medications to all patients at drastically reduced costs. With a base of federal funding, cost-based reimbursement from governmental programs and pharmacy discounts, a financial base would exist that would allow these centers to develop new and patient-friendly systems such as an open access approach and other innovative scheduling tools making services amenable to patients and doctors. This approach to community-based care systems exists infrequently, if at all, because the stovepipe nature of US health funding and administration.

Over the coming months, Hurricane Katrina will transform into a distant memory to those outside of New Orleans and the Gulf Coast. Although many residents of New Orleans will be busy reconstructing their lives, we must not let immediate needs erase the opportunity to create a permanent impact. Changes will be occurring rapidly, and we hope that the competing interests (e.g. healthcare administrators, state officials, community leaders, etc.) will work together to develop and implement a realistic and comprehensive plan for a healthcare system in the Greater New Orleans area. Historically, prevention and primary care, particularly for low

income individuals, has been the last funded and the first eliminated when money was tight.

The silver lining on the Katrina cloud could be we now have the opportunity to get it right for health care in New Orleans. If a network of integrated, patient-focused, community health centers is realized, we will propose New Orleans use the nickname “The city that care remembers.”

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