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# Gaining in New Orleans

With help from a federal grant, wounded city builds a model primary-care system

By Jessica Zigmond

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Four years ago, an integrated primary-care system that provides access to high-quality care to New Orleans residents in their own neighborhoods was nearly unthinkable. Today, as a new report from the not-for-profit Commonwealth Fund shows, not only is that system a reality, but also it might serve as a model for the rest of the nation to follow.

In 2007, the system was made possible by a \$100 million grant from the federal government that has helped the city of New Orleans rebuild its broken healthcare system following Hurricane Katrina. But when that grant money ends later this year, health officials and providers fear that the new system—which has produced positive results—won't be able to survive.

Before the storm hit in August 2005, uninsured residents in New Orleans received care primarily at the LSU Health System's Charity Hospital, the center of the city's large safety net hospital system known as the Medical Center of Louisiana at New Orleans. Severe flooding and damage forced Charity's closure, and the city's inpatient bed capacity dropped by more than 50%, while the number of ambulatory clinics fell to 19 from 90. Meanwhile, about 4,500 physicians were dislocated temporarily, and about 35% of those were primary-care physicians, the report said.

Two years later, HHS awarded the state a \$100 million Primary Care Access and Stabilization Grant, referred to commonly as the PCASG, which ends in October. In granting the money, the federal government chose the not-for-profit Louisiana Public Health Institute to administer the grant and work with federal, state and local partners. Since then, the healthcare system literally has been transformed into an expanding network of independent, neighborhood primary-care clinics. The grant was awarded to 25 organizations, which in turn operate 93 sites (besides clinics, there are also mobile-health units). Of those sites, the Commonwealth Fund conducted interviews at 27 grant-supported sites in 2009 to evaluate their progress. As the study shows, the results are more than promising.

"When you compare national rates with what we found with the clinic patients, patients were very satisfied with the care that they received," said Michelle Doty, assistant vice president at the Commonwealth Fund and one of the lead authors of the report. "The level of patient-doctor communication was really excellent. The vast majority of people found their doctor understood them and their medical history," she said, adding that patients also had an easy time getting an appointment. "We're seeing a really high level of patient-centered care. I found that surprising, given that the majority

of these patients are really low-income and uninsured and historically this level of quality of care isn't really seen in these types of populations."

Data for the study—conducted from early February 2009 until early April 2009—came mostly from the Commonwealth Fund 2009 Survey of Clinic Patients in New Orleans, an in-person survey that analyzed a sample of 1,573 clinic patients aged 18 or older or adults accompanying a children under the age of 18. The two-part survey interviews last about 20 minutes and were conducted at 27 PCASG-supported primary-care and pediatric clinics across Orleans Parish in New Orleans. According to the results, 88% of patients reported having easy access to care; 79% said they had excellent communication with their physicians; and 86% of respondents with children rated patient-clinician communication highly. In addition to patients, physicians appear satisfied with the new system.

"It's far and away the best structure I've had to manage," said Karen DeSalvo, executive director of Tulane Community Health Centers, which has two comprehensive, primary-care sites and three mobile-care units. "The teams are happier; the patients are getting good care."

There are several reasons for the program's success, according to DeSalvo. These include medical school loan-repayment programs, which provide an incentive for new physicians to choose primary care; integrated services—including primary care and mental health—in the same location; and, perhaps most important, a payment structure that allows the money to follow the patient.

"From the devastation emerged an opportunity to restructure and reorganize primary care for low-income and vulnerable populations in New Orleans," said Melinda Abrams, assistant vice president at the Commonwealth Fund and the study's other lead author. According to Abrams, one key element of success has been the strong partnership between the sites and the Louisiana Public Health Institute, which she said has credibility with the primary-care sites; applies common reporting measures; brings the clinics together; and offers financial incentives for care delivery.

Clayton Williams had served as director of health systems development for the institute and oversaw the federal grant process that established the new system. On Jan. 19, Williams will begin his new role as the assistant secretary for the Louisiana Health and Hospitals Department.

As Williams explained, the PCASG grant had four clear goals: to increase access to care; to provide evidence-based, quality care; to establish an organized system of care; and to develop sustainable business entities. Two years after the grant was awarded, officials and providers have achieved those goals.

"We've seen the number of delivery service sites grow from 67 to 93; we've seen volume grow by over 50% over the past two years," Williams said, adding that about 175,000 individuals have been treated at the 93 sites over two years. Meanwhile, there has been what Williams calls a "dominant rise" in physician availability, and the public health institute implemented policies that required same-day visits for patients needing urgent care as well as 24-hour access to a physician by phone.

In terms of quality, there were two components, Williams said. First were the requirements the institute established regarding access to care, and the second element was \$4 million that the institute set aside as incentives for those clinics that exceeded the minimum requirements. The institute also worked with the National Committee for Quality Assurance to allow the sites to apply to become patient-centered medical homes. An indication of the system's success in quality is that the NCQA has recognized 40 of the 93 sites as patient-centered medical homes.

Establishing an organized system of care had been a goal before Katrina, Williams said, and the institute continued this effort with the new integrated system. "We've created GNOCommunity.org for patients to go and seek services," he said. "It allowed all of the clinics to have a site for referrals: clinics use it; patients use it," he added. "More important, agreements were brokered among the healthcare providers and the public hospital," he said, adding that referrals and information-sharing have allowed the neighborhood primary-care clinics to refer their patients for diagnostic testing even if the clinic isn't

affiliated with a particular hospital.

For the final goal—developing sustainable business entities—Williams said the public health institute made sure early in the process that the sites had the capacity to bill third-party insurers “so they’re not leaving any money on the table.” He acknowledged that the federal funding has been crucial to helping these providers, many of whom have uninsured patient levels as high as 50% or 60%. According to Williams, the sites cannot be sustainable without some help. “The needles are all moving in the right direction,” Williams said. “We’re still concerned about the future.”

The future is a worry for physician Don Erwin, CEO of St. Thomas Community Health Center, one of the grant recipients and also recognized as a medical home. According to Erwin, about 75% of St. Thomas patients are uninsured, and about 14% are Medicaid patients.

“It’s going to be a real game-changer if that money goes away,” Erwin said. “We have about a \$4.5 million a year budget; \$3 million comes from the PCASG grant,” he added. “If we had 40% Medicaid, we’d be OK. We may have 40% Medicaid in two years, if there is enhanced eligibility,” he said, referring to a possible result of a final healthcare reform bill from Congress. But what could happen to St. Thomas until then could be “pretty scary,” Erwin said.

“Clearly, one of our biggest concerns is that about \$30 million a year that has been flowing into these clinics will disappear,” said Tony Keck, deputy secretary at the Louisiana Health and Hospitals Department. “The clinics have attracted more Medicaid and private-pay patients,” he added. “Even with those improvements, there is still a gap in how money flows into the system.” To address this problem, the department is exploring a few alternatives, such as seeking financial assistance from the state, a possible one-time grant with remaining funds from the Louisiana Recovery Authority, or a disproportionate-share hospital waiver that would allow funds to be injected not just to the public hospital, but to the primary-care system.

Despite the concern about future financing, the primary-care system that has evolved in New Orleans since Katrina has yielded enough positive outcomes—in terms of access, quality care, and patient and physician satisfaction—to be considered a model for congressional leaders as they work toward a final health reform bill.

“As we get closer to healthcare reform and universal coverage, we need to find a way to quickly expand capacity and quality of primary care,” Williams said. “Communities are going to ask: ‘If we have more people with access to care, how will we accommodate that demand?’ ” he added. “We’ve shown how—if there is adequate investment.”

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