

Planning the Future of New Orleans' Health Care Industry

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In many cities in the United States, the health care industry is one of the most crucial determinants of prosperity. A booming health care industry provides an economic engine and ensures a better quality of life for citizens. Perhaps the most striking example of just how important a city's health care industry is to its urban fabric is the city of New Orleans, Louisiana. Its complex system of providing health care has been fragile at best for quite some time, but it was faced with a new set of realities following Hurricane Katrina in 2005. New challenges have emerged for New Orleans' hospitals, challenges that must be addressed effectively and swiftly if the city is to be able to rebuild and realize its pre-Katrina identity.

On the morning of August 29, 2005, Hurricane Katrina made landfall at approximately 6:00 am, and by 8:00 am reached the metropolitan area of New Orleans. A wave of immense rainfall and winds with speeds greater than 100 miles per hour moved through the city over the course of the day, after which conditions calmed. However, shortly afterwards, a section of the city's concrete levee failed, ushering in the waters of Lake Pontchartrain and flooding approximately eighty percent of the city's geographical area. Some areas of the city were inundated with more than eight to ten feet of water, resulting in total damage to hundreds of buildings. It has been estimated that almost 2,000 people lost their lives in the storm, although the exact number of deaths will never be known. The storm sent the city into a downward spiral of chaos, resulting in looting of stores and homes as well as what can only be described as a nightmare

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within the Louisiana Superdome, the 70,000 seat multipurpose indoor stadium that served as the city's shelter of last resort. However, a unique plight was faced by the city's hospitals, many of which incurred major damages from the storm. Thousands of hospital workers struggled to keep patients alive and to maintain vital services while working almost day-long shifts and sleeping for only a few hours at a time. Of the more than a dozen general hospitals in the New Orleans area, only three remained open, and only one, Ochsner Medical Center, never closed its doors (Manning D6). While every hospital in the metropolitan area suffered as a result of the storm, one hospital, Memorial Medical Center in uptown New Orleans, became a shelter of pain and strife in ways unlike the others. The events that transpired there especially show, in one writer's words, how "hope turned to despair."

Memorial Medical Center was built in 1929 as Baptist Memorial Hospital and was an icon for the residents of its surrounding community. At the time of Katrina, it was owned and operated by a national health care giant, the Tenet Healthcare Corporation. After the hospital buildings had sustained considerable damage from the storm, the workers and patients inside were hanging on, under the pretense that in a matter of hours, an official evacuation would be taking place. As they waited in vain, the hospital's electrical grid, which had suffered water damage, began to fail. Its backup generators, located on the second floor, followed suit, and by 5:00 am on Tuesday morning, the hospital "had lost all power, cutting off vital life support equipment." Subsequently, doctors began responding to repeated "'code blue' emergencies, signaling that a patient was on the verge of death, and the second-floor chapel, now in use as an overflow morgue, was filling up with corpses." The loss of power also hampered the hospital's capacity for communication with the outside world. Over the next few days, patients were slowly evacuated from the hospital through limited government assistance and benevolent citizens offering a helping hand. But during this time, the death toll climbed. One patient "had a heart attack in a stairwell. Another died in his wheelchair" (Meitrodt 1). The final death toll was high, and a doctor and two nurses were later investigated for intentionally euthanizing patients in the midst of the chaos and discord. The story of this

hospital can tell us much about the state of health care in the city of New Orleans, both before and after Katrina, and about the many failures of planning and government administration. What follows is a comprehensive study of the challenges facing the city's health care industry, which will hopefully serve as a primer for taking the necessary steps to rebuild the industry from within and to help rediscover the New Orleans that once was.

An Industry in Crisis

Community and political leaders in New Orleans agree that Katrina has revealed the potential for a large-scale crisis in the city's health care industry. In July 2007, John J. Finn, president of the Metropolitan Hospital Council of New Orleans, cited plans for new hospital facilities that could greatly improve the city's health care system. But he also noted that these new facilities would not be complete until 2012 at the earliest; until then, he explained, "We have to find a way to survive to that point, to provide care, or our city will collapse." Andy Kopplin, executive director of the Louisiana Recovery Authority, argued that fixing the city's health care system "is critical both for the short and the long term...Short term, having confidence that the health care residents need will be available and accessible is vital for folks who are returning...Long term, it's important for employers—and health care is a huge business in New Orleans" (Eaton A1). Without a stable health care system, residents and visitors will not be ready to return to the city. Currently, the population of New Orleans is approximately sixty percent of what it was before Hurricane Katrina, and the rate at which this figure is increasing is slowing down.

Despite all of the circumstances surrounding healthcare in New Orleans, these same community leaders argue that all is not lost, that there is potential for the city's health care in the to become much better than it was in its broken, fragile pre-Katrina past. Dr. Patrick Quinlan, chief executive officer of Ochsner Health System, says that "the disaster presents a rare chance to create a new model of health care that could be a vast improvement on what was here before the storm" (Manning D6). The city's health care system had long existed in a very fragile balance, a balance that Katrina unabashedly stripped away. The impact of the storm has imposed heavy burdens on hospitals

in a number of their capacities, each of which merits discussion here.

No Place to Lay One's Head

Along with the damage and deterioration to their buildings as a result of Katrina, hospitals across the city have been faced with a shortage of beds for over two years. In March of 2006, seven months after Katrina, the U. S. Government Accountability Office reported that “the number of staffed beds in New Orleans and surrounding parishes had dropped by 51.4% to 1,984 in February from 4,083 before the storm.” Table 1 lists the number of staffed beds before and one year after Katrina, respectively, for acute-care hospitals open in New Orleans.

Table 1: Staffed Beds for Acute-Care Hospitals, August 2006

(U. S. Government Accountability Office,
Modern Healthcare reporting.)

Hospital Name	Pre-Katrina Beds	Post-Katrina Beds
Ochsner Health System (two facilities)	505	526
East Jefferson General Hospital (Metairie)	444	443
West Jefferson Medical Center (Marrero)	317	350
Touro Infirmary	345	250
Tulane-Lakeside Hospital (Metairie)	102	116
Tulane University Hospital and Clinic	235	91
Children's Hospital	175	148
Meadowcrest Hospital (Gretna)	179	N/A*
Kenner Regional Medical Center (Kenner)	162	N/A*
Total	2,464	1,924

*Owner Tenet Healthcare Corp. declined to provide number of staffed beds.

These figures reveal a net loss of, at the very least, around two hundred beds. But they do not account for the seven other acute care facilities still closed at the time of reporting (Zigmond). In July 2007, almost two full years after the storm, only one of Orleans Parish's seven general hospitals was operating at pre-Katrina levels. Two were partially open, and four remained closed. The number of hospital beds in Orleans Parish had dropped by two-thirds, and while an additional six hospitals in adjacent Jefferson Parish were open, each experienced substantial overcrowding dating back to the storm (Eaton A1). In the second quarter of 2007, a consultant study concluded that the entire metropolitan area was "short by 1,000 beds 'at this population base and related age base'" (Thomas 1).

The Sick Get Sicker

Patient illnesses have also changed and intensified. Life in New Orleans after Katrina has imposed heavy physiological and psychological burdens on the individuals living in the city. As a result, a major concern of doctors is that "the patients they see are often far sicker than those they treated before the storm." Many suffer from chronic or longstanding illnesses but face a reduction in the amount and types of specialty care available. In June 2007, the *New York Times* reported that "doctors say this is an especially bad time to break a leg, given the shortage of orthopedists" (Eaton A1). Rates of patients with "diabetes, high blood pressure, and other chronic conditions" have substantially increased, even though the symptoms of such conditions could be ameliorated with wider and more regular access to doctors (Alpert and Moran 1). Ochsner has reported that "the number of psychiatric patients soared" (Eaton A1) as a result of the stressful conditions of life after the storm. Psychiatric complaints like "anxiety, depression, and stress" are "even harder to treat" (Morris 1). Without access to proper psychiatric care, patients with these conditions often end up in emergency rooms, where they both cannot receive the treatment they need and also compromise the delivery of emergency care for other patients.

The Dilemma for Veterans

The care of veterans of the several branches of the armed forces

has also become more difficult after Katrina. The storm left the VA hospital, built under the auspices of the Department of Veterans Affairs in 1952, in extremely poor condition, suffering from problems such as water infiltration, damage to electrical and fire safety systems, and mold. Shortly after the storm, an engineer determined that it would cost more money to rehabilitate the building than to build a new one. While plans for a new building have been developed and much funding has been secured, veterans must struggle for adequate health care during the four years that construction will take. Several flaws in the system of government aid that supports veterans' hospital trips have been exposed, and it is no small feat for veterans to obtain care reasonably. VA patients tend to be "aging and frail, some of them with limited incomes" (Moran 1 April 2007, 1). A 2006 publication by the Department of Health and Hospitals of the State of Louisiana examined the average profile of veterans seeking VA health care versus veteran non-users of VA care and the non-veterans. The findings are displayed in Table 2 below.

Table 2: VA Health Care Users Compared to VA Non-users and the General Population, 27 June 2006 (Kizer 5)

	Veteran Users of VA Care	Veteran Non-Users of VA Care	Non-Veterans / General Population
65 or older	35.6%	31.3%	17.0%
Non-Caucasian	25.4	12.5	22.8
Not married	35.7	19.4	39.0
Education < HS	26.0	15.0	24.8
Income < \$20,000	70.5	25.7	32.9
Income < \$10,000	38.5	8.7	14.6
No health insurance	59.3	14.9	32.0
Unable to work for pay /limited ADLs	79.4	40.1	7.0

Several important pieces of information should be taken from this dataset. First, veterans 65 years or older seek VA care at approximately twice the rate that the same elderly non-veteran population seeks health care elsewhere, 35.6 percent to 17 percent. Also, the percentages of veterans whose income is less than \$20,000, and less than \$10,000 are more than twice those of non-veterans. As a point of reference, the federal poverty line for an individual in 2006 was \$9,800, and the poverty line for a four-person family in 2006 was exactly \$20,000 (U.S. Department of Health and Human Services, online). These figures suggest that veterans are much more dependent on VA care than non-veterans are on other health care. The data confirms this, as the number of veterans with no other health insurance (59.3%) is significantly larger than the number of non-veterans with no health insurance at all (32.0%). Lastly, the number of veteran users of VA care who cannot work for pay or who have limited activities for daily living, or ADLs (79.4%), is over eleven times the number of similar non-veterans (7.0%).

The plight of veterans seeking VA care in New Orleans is exacerbated by a lack of VA facilities in the area. Twenty months after Katrina, the only source of VA care within New Orleans' city limits was "a 10-story building that had housed both a parking garage and a nursing home for veterans," and in December of 2005, the nursing home was converted to a clinic for veterans to receive "routine medical care, rehabilitation and counseling." Due to the scarcity of VA care, veterans are forced to travel all over the South to receive care. Some of the closest veterans hospitals to New Orleans are in Little Rock, Arkansas (7½-8 hours travel time by automobile), Alexandria, Louisiana (3½-4 hours), Biloxi, Mississippi (1½-2 hours), and several in Texas (5+ hours). Veterans needing elective surgery or laboratory work go to Memphis, Tennessee (6-6½ hours). In April 2007, one New Orleans cardiologist remarked, "It was a sad thing to see these people who clearly needed care being punted around like pawns" (Moran 1 April 2007, 1). In addition to elongating the time that veterans must wait to receive care, the requirement of travel places strain on veterans' families who assist in transportation and support, and often worsens other health conditions. There are also many special populations of veterans whose physical conditions severely impede

their capability to travel. The primary examples of these populations are spinal cord injury patients, amputees, seriously mentally ill patients, substance abuse patients, post-traumatic stress disorder patients, traumatic brain injury patients, blind patients, former prisoners of war, the homeless, and Persian Gulf War veterans (Kizer 6). There is additional concern for the increasing number of veterans returning from Iraq and Afghanistan with health issues (Moran 1 April 2007, 1). Regional officials in the Department of Veterans Affairs have attempted to offset travel requirements by negotiating with at least one private hospital in New Orleans to treat VA patients until the new VA hospital is built. While such negotiations have potential for some success, that potential is also limited in scope.

Care for Those Who Cannot Pay

Beyond these issues, two overarching problems have emerged as the most significant and universal challenges facing health care institutions in New Orleans. The first of these problems is the treatment of the city's poor and uninsured citizens, who were "hit hardest" by the storm (Eaton A1). Before Katrina, the vast majority of poor and uninsured patients in New Orleans sought care at Charity Hospital, an "art deco icon that opened in 1939 and had deteriorated after decades of poor upkeep." Charity was the "safety-net hospital" that "served as a haven for generations of uninsured patients, and when it closed after Katrina, that population lost its entry point to acute medical care." Before Katrina, the share of patients who sought care at Charity with private insurance or Medicare (the government-sponsored insurance program for the elderly) was only 2.6 percent. According to data collected and distributed by the National Association of Public Hospitals in 2004, "uninsured patients outnumbered those on Medicare or other private insurance by 5 to 1" (Moran and Moller 1). As with the old VA hospital, a decision was made, in this case by Louisiana State University, the hospital's former operator, to "mothball" the building rather than repair the damage caused by flooding that, among other things, laid waste to the building's electrical and mechanical systems. To fill the void, the state of Louisiana plans to build a new hospital adjacent to the proposed VA hospital. Like veterans, the poor and uninsured must wait until this new hospital can

be completed, in the spring of 2012 at the earliest. LSU attempted to provide care for uninsured patients by operating “a makeshift hospital in a former department store for about a year after the storm.” In November 2006, fourteen months after Katrina, LSU reopened nearby University Hospital, the other hospital where uninsured patients primarily sought care before the storm. As of August 2007, this hospital had only “179 staffed beds, compared with a combined 550 beds at Charity and University before the storm.” At this time, there were an estimated 98,000 residents of Orleans, Jefferson, Plaquemines, and St. Bernard parishes without health insurance; it is estimated that there were 176,000 such residents before the storm. Without a public hospital serving uninsured patients, many take up the burden of traveling to other regional hospitals in Baton Rouge (1-1½ hours by automobile), Houma (1 hour), and Lafayette (2 hours). More often than veterans, however, many uninsured patients simply go without treatment altogether. They then crowd emergency rooms when their conditions reach the point of intolerability, and “where doctors are required by law to treat them regardless of their ability to pay” (Moran 24 August 2007, 1). The other area hospitals that have done their best to absorb uninsured patients have suffered financially, citing significant monetary losses in the months and years following Katrina.

The Doctor is Out

The second major problem facing New Orleans’ health care institutions is a shortage of workers at all levels of medical care. The health care industry was the city’s third largest employer before the storm, behind tourism and retail, and it paid much higher wages across the board than those other two industries (Eaton A1). During and immediately after the storm, the area’s hospitals were faced with the challenge of locating each of their workers who had evacuated, many leaving the state. The human resources department of Ochsner Health System, which is today the largest employer of health care professionals in Southeast Louisiana (Moran 1 October 2006, 1), needed to find approximately 8,000 employees and document if and when each would return (Manning D6). Since then, hospitals have experienced difficulty inducing medical professionals, especially doctors, to return to work in the city’s wounded health care industry. In the spring of 2006,

statistics revealed that “the area had lost 77 percent of its primary-care doctors, 70 percent of its dentists and 89 percent of its psychiatrists” (Sternberg 14). Data collected from a Blue Cross and Blue Shield of Louisiana report revealed similarly haunting results, recording that “1,502 physicians in Orleans, Jefferson, Plaquemines, and St. Bernard parishes filed claims in July [2006], down 51.4% from 3,091 a year ago. In Orleans Parish alone...the number of physician claims fell to 510, down 79%” (Zigmond). In July 2007, several studies were conducted to assess this situation, each of which generally concluded that “hundreds of doctors never returned. And some of those who did, especially specialists and young physicians, are leaving.” Dr. Ricardo Febry, president of the Orleans Parish Medical society, reported that the organization’s membership went from 650 to 400 members, a decrease of nearly 40 percent. Twenty-one months after Katrina, there were still “16,800 fewer medical jobs than before the storm, down 27 percent, in part because nurses and other workers [were] in short supply” (Eaton A1). Reconnecting with relocated doctors has proven very difficult for hospital administrators. Before Katrina, “there was no formal system for tracking the location of doctors. Post-storm Internet sites, such as www.whereismydoctor.org and www.findladocs.com, have helped displaced doctors reconnect with their patients,” but six months after the storm, “hundreds of doctors remain[ed] unaccounted for.” Officials from several other state medical boards have indicated that, in the six months after Katrina, they had “seen a jump in applications from Louisiana doctors.” In California alone, twenty-one Louisiana doctors applied for licenses during this period (Darcé 1). Many area locals, healthcare professionals and private citizens alike, hold that such trends are signals for what Dr. E. Michael O’Bryan of Ochsner Medical Center-West Bank has called “a tremendous exodus of health care professionals” (Morris May 2007, 1).

In response, Ochsner Health System embarked on “an aggressive recruiting effort that...added at least 35 former private practice doctors to the hospital’s staff” (Darcé 1). John J. Finn and other healthcare professionals and community leaders have tried to lure doctors back “by reminding them of the things they loved about New Orleans: the food, the music, the culture.” Unfortunately, these and similar efforts

have the disadvantage that they are not sustainable for the future; at this point, former New Orleans physicians who have not yet returned are unlikely to do so. And it has not been easy to recruit new doctors to New Orleans. In October of 2007, Finn stated that “the biggest restraint we have is work force...When you don’t have a place for faculty to practice, it’s difficult to recruit...New Orleans is not the easiest place to sell right now” (Bourbon 4). In many cases, hospitals have been forced to move some of their specialty services outside of the city. Dr. Cathi Fontenot, medical director of Louisiana State University Hospital, explained that “the city did not have enough people after the storm to keep all the university’s doctor trainees occupied. Doctors and medical residents followed the patients to new population centers such as Baton Rouge” (Moran 24 August 2007, 1). While area hospitals have experienced some success in recruiting doctors to fill their shortages, they can no longer be as selective, resulting in shortages in many specialties. Joan Mollohan, senior vice president of human resources at Ochsner Health System, reported in October of 2006 that “the hospital network lost about 110 doctors out of 670 after the storm, and [had] since hired another 150. However, the 150 newly hired [did] not [necessarily] replace the specialties of the 110 lost” (Sternberg 14). By April 2006, conditions had “grown so critical that the federal government [had] declared the city a medical-shortage area—hardly a description designed to lure bright fledgling doctors” (Pope 1 July 2006, 1). As a result, citizens in need of specialty care are hard-pressed to find it. Brobson Lutz, a spokesman for the Orleans Parish Medical Society, remarked that “if he were a new doctor preparing to open a private practice, there’s no way he’d come to this area—especially if he were a specialist such as a cardiologist or surgeon, which depend on a capable hospital system to foster business. [He says that] ‘the highly specialized physicians were greatly dependent on having a hospital base population needing their services. That’s gone. When there were 1,500 hospital beds here, they were busy bees’” (Darcé 1).

New Orleans’ hospitals face a similar struggle to retain newly licensed doctors, especially those who received medical education and resident training in the region, primarily at Louisiana State University and Tulane University. Katrina “played Boggle with [the city’s]

programs for training young physicians. The storm closed Charity Hospital in New Orleans, scattered medical instructors around the country and forced the next generation of doctors into unorthodox arrangements for completing their education.” Thus, the number of in-state medical graduates who choose to pursue their medical resident training in Louisiana has been threatened. For the graduating classes of 2007, “45 percent of the 154 students graduating from the LSU School of Medicine in New Orleans will stay in the state, while 53 percent from the Shreveport campus will stay, which represents a slight decrease from pre-Katrina retention levels.” From Tulane University in 2007, “Louisiana captured 27 students from a class of 148—more than double any other state,” which marks “an in-state retention rate of 18 percent for Tulane...down from 23 percent in 2005” (Moran 16 March 2007, 1). The primary anxiety that plagues Louisiana’s graduating medical students is insufficient teaching space, a direct result of the damage to Charity and University Hospitals. Even though the plans proposed by the state and LSU to build a new teaching hospital in downtown New Orleans are making progress, that hospital will not be open before the spring of 2012. As a result, medical residents in New Orleans are spread throughout area hospitals to meet the Accreditation Council for Graduate Medical Education’s requirements for residency programs. Specifically, residents must “see a certain volume and variety of patients” and “be supervised by competent teachers at worthy hospitals.” To make up for the loss of resident training spaces, the accrediting organization arranged for residents to be trained “in other hospitals, some of which had never been involved in medical education.” Many of the doctors who left New Orleans were once heavily involved with the training of residents (Pope 1 July 2006, 1). As a result, many local medical school graduates do not consider residency training in New Orleans a viable option. One 2007 graduate, Kelley Morel, had the sense “that people are pretty frustrated and want to leave...It is partly the situation with the hospitals. It does not look like they will have a new one open within our training years.” The shortage of residents threatens the city’s future physician population, “because doctors tend to settle in the state where they complete their training” (Moran 16 March 2007, 1).

Nurses as Well

Concurrently, the city's hospitals have also struggled to fill nursing shortages. After Katrina, many nurses left the area: they "followed their spouses to new jobs outside the region, or simply decided that the emotional demands of caring for patients while rebuilding their own flooded house[s] were too much to handle." East Jefferson General Hospital, located in suburban Metairie, "alone lost 800 employees, many of them nurses." Ochsner Health System "lost about one third of its nurses after Katrina." Children's Hospital, located within the city limits, "lost about a third." The Louisiana State Board of Nursing calculated that "4,800 nurses changed the address on their license in the 10 months after Katrina, and almost half of them moved out of state." Many hospitals, including East Jefferson, were quick to fill their "depleted ranks...by hiring staff from damaged hospitals that failed to reopen after Katrina. But by snapping up nurses from other institutions, these hospitals exposed themselves to high turnover rates as employers reopened beds and called back their former employees." Conditions became difficult for nursing staffs comprised of former employees of various hospitals, resulting in "a culture clash when nurses discovered that dress codes were more stringent or operating procedures different at their new hospital. Such changes, combined with mandatory overtime, weekend shifts and other measures to cope with shortage of staff, have made work particularly stressful." Patricia Egers, the provost of Delgado Community College, related that "Hospitals are hard places to work now...It's very frustrating because you go into this business to care for people, and when you don't have time to do that, you don't feel good at the end of the day" (Moran 15 October 2006, 1). Many hospitals have resorted to encouraging older nurses to come out of retirement, says Lisa Colletti, vice president for nursing at Ochsner Medical Center-West Bank. And some hospitals have relied on traveling nurses hired through independent staffing agencies. While these traveling nurses are fully qualified to work in the city's hospitals, healthcare administrators admit that "agency nurses are not always ideal...the disadvantage has to do with continuity of care." These efforts also cannot be sustained consistently, especially when nurses still share apprehensions about working in New Orleans. In the late summer of 2006, Nancy Davis, chief nursing officer of

Ochsner Health System, attended a job fair in Houston, only to be “rebuffed by nurses who said they would be ‘nuts’ to leave Texas for post-disaster conditions in the New Orleans area.” The perception of poor quality of life looms for many who may consider a move to New Orleans.

Many hospitals have responded by turning to the health care markets of foreign countries. In August of 2006, the chief operating officer of East Jefferson traveled to the Philippines, “a former U.S. territory that annually sends thousands of English-speaking nurses overseas.” The immigration process, however, is difficult for employers and their candidates alike. The Immigration and Nationality Act requires “a visa application [and a] background check.” Immigrant nurses must also “pass a credentialing exam required by the Commission on Graduates of Foreign Nursing [and] they must also have a bachelor of science degree with an English curriculum and pass the U.S. board certification exam” (Morris 26 April 2007, 1). The entire process generally takes an entire year or more, and is further complicated by the arduous process of securing work visas (Fleming). Filipino nurses have certain advantages; for instance, they have been raised in a culture that is “strongly focused on helping family members,” and many “are eager to come to the United States to send money back home to help relatives in their homeland” (Morris 26 April 2007, 1). Also, immigrant nurses are required to sign contracts that they will stay for a minimum of three years. Davis comments that “the Filipino nurses will be a good thing for the community because they will stay. They are not coming for a year or two and moving back home. They are looking to immigrate” (Moran 15 October 2006, 1). On the other hand, one disadvantage of foreign nurses is that “communication was sometimes a problem...Patients could not always understand the nurses.” Such a culture gap creates problems for the quality and continuity of patient care, which all agree should not be sacrificed. Additionally, many of the immigrant nurses have experienced difficulties associated with “being in a place where they didn’t know anyone or have any relatives” (Morris 26 April 2007, 1). All things considered, the efforts to recruit foreign nurses has shown some success, but it should be noted that foreign nurses still account for only a relatively small percentage of the nursing workforce in New Orleans.

Leaders have also created new academic programs to educate a new generation of health care workers at no cost to students. In the summer of 2007, an alliance of healthcare providers and community institutions called the St. Tammany Healthcare Alliance entered into a partnership with Delgado Community College, Louisiana's oldest and largest community college, to offer several academic programs to individuals from ten parishes in the metropolitan and surrounding rural regions. The alliance consisted of "St. Tammany [Parish] hospitals, the Slidell and West St. Tammany chambers of commerce and the Ochsner organization." Under this program, free training became available for health care careers such as "registered nurse, certified nursing assistant, nurse faculty member, nurse educator, surgical technologist, pharmacy technologist, respiratory therapist, paramedic, basic emergency medical technician, and billing/collections representative," in addition to a course "for high school students studying the health care industry" (Krieger 1). While the creation of such programs should encourage optimism, there still remain several impediments to their success, most importantly a lack of instructors. Janice Kishner, the chief operating officer at East Jefferson, said in October 2006 that there had been a "bottleneck at universities, which turn away nursing school applicants because of a perpetual shortage of instructors." This shortage of instructors is a result of increased wages for health care workers since Katrina, as hospitals have had to raise wages across the board to retain their workforces, which has "helped keep veteran nurses at hospitals when they might otherwise go into teaching" (Moran 15 October 2006, 1).

An Emergency Situation

A direct and important consequence of these problems is the consistent overcrowding of emergency rooms in area hospitals. Before Katrina, emergency care had been one of Ochsner Medical Center-New Orleans' most successful ventures: "'patients waited [an average of] just twenty minutes to be seen,' said Dr. Joseph Guarisco, chairman of emergency services at Ochsner...After the storm, the number of people coming into the emergency room jumped, on some days reaching nearly twice the pre-hurricane volume." Over this time, patient satisfaction rates, as measured by patient surveys, went from an

immaculate 99 percent to a paltry 34 percent (Eaton A1). While emergency rooms had been operating at full capacity since Katrina, the situation went from unfavorable to critical in March 2007, as it was reported that there were “no empty beds waiting for patients who require an overnight stay. Every hospital [was] full.” At one hospital, Touro Infirmary, the emergency wait times had “mushroomed to seven or eight hours — the equivalent of a road trip to Dallas or Atlanta.” At times patients were forced to “remain inside ambulances or wait in the hallways on gurneys until space opens up” (Moran 9 March 2007, 1). Many of the area’s hospitals have embarked on ambitious capital improvement projects to alleviate the stresses on their emergency rooms. However, success in this area relies not only on physical space but also on financial solvency.

One of the most difficult problems in emergency medicine is the care of patients without medical insurance. At Touro, the number of visits from uninsured patients between January and June 2006 increased by a figure of 80 percent compared to the same period in 2005, the period just before Katrina (Zigmond). The requirement that hospitals treat these patients is a main reason that area hospitals have been forced to operate under serious financial deficits. In 2006, many of the hospitals in Jefferson and Orleans parishes reported serious monetary losses, “anywhere between \$900,000 to \$9 million a month —because they have to...care for uninsured people who otherwise would have gone to Charity Hospital” (Pope 5 June 2006, 1). A report to the U.S. House Subcommittee on Oversight and Investigations compared the financial returns for five local hospitals in the first five months of 2005 with returns for the same period in 2007. In 2005, the hospitals made a combined profit of \$12 million over these five months, while in 2007, they lost a combined \$60 million in the same period (Alpert and Moran, 1). A. Gary Muller, the president and chief executive officer at West Jefferson Medical Center, remarked, “We’d like to get...out of this ditch...We can’t get people in here if we can’t get paid.” These financial losses continue in the “absence of an all-encompassing health-care plan with provisions for caring for uninsured patients” (Pope 5 June 2006, 1). Hospital leaders have lobbied the Louisiana legislature for compensation, with mixed results. In May 2006, the Louisiana Department of Health and Hospitals proposed

nearly \$300 million, combining federal and state funds, to be appropriated to New Orleans' hospitals in compensation for their losses (Moran 9 May 2006, 1). However, in the same year, the state also appropriated the money from its reported surplus "elsewhere, such as for a teacher pay increase" (Pope 5 June 2006, 1). In response, Ochsner Health System's CEO Pat Quinlan said that "many don't grasp the importance of restoring New Orleans' health-care system." He continued, "Levees don't cost money when they're sitting there...Hospitals do." Warner Thomas, president and chief operating officer of Ochsner Health System, noted that the health care network's anticipated deficit for 2006 as a result of the "several million dollars of charity care per month...is not sustainable in the long term" (Moran 9 May 2006, 1).

Another financial issue for hospitals concerns their treatment of patients in government-administered insurance programs, namely Medicare and Medicaid. Under these programs, a hospital will provide treatment for a patient and give the state a report of its expenses, for which the state will reimburse the hospital. In the period between Katrina and April of 2007, around twenty months, Ochsner Health System reported that the rate of its Medicaid payments "climbed 40 percent." However, the state uses a compensation formula that does not provide a dollar-for-dollar match. In nearby Hammond, North Oaks Hospital collects "33 cents from the program for every dollar it spends treating a Medicaid patient." William C. Ward, Ochsner's vice president for facilities and real estate, argues that this "shortfall drains cash reserves that could otherwise be used for capital improvements, marketing campaigns, and employee incentives" (Thomas 1). Medicare suffers from similarly insufficient compensation rates. Dr. Mark Peters, the president and chief executive officer at East Jefferson, reported to the House Subcommittee on Oversight and Investigations in August 2007 that the "rates for Medicare...[were] based on data before the hurricane" (Alpert and Moran 1). The federal government has appropriated a great amount of money for compensation, which totaled over \$500 million in 2005 and 2006 (Manning D6). Unfortunately, the need to spread this money throughout the state is problematic for the fiscally unsound New Orleans hospitals. In one instance, the federal government appropriated an extra \$99 million for Medicare

compensation, but this money was spread out among 60 hospitals in 31 parishes (Alpert and Moran 1). East Jefferson received a paltry \$5 million, far short of its needs. Granted, the state of Louisiana has had to allocate its limited financial resources to New Orleans in ways that address all the city's needs, of which health care is only one, albeit an important one. It has also had to face criticisms that its programs for New Orleans' recovery have left the rest of the state in a condition of subordination, its cities unable to secure the assistance to meet their own needs.

A Sufficient Response?

In response to the dire situations inside their emergency rooms, area hospitals have begun using the Internet to make updated information available to all. This interface is called EMSys, and "while it is available to hospitals around the state, health care providers in the New Orleans area are the only ones using it on a daily basis to juggle patients among besieged emergency rooms." Hospitals utilize the system "to direct patients to the emergency room where they can get the most effective treatment in the shortest amount of time." The site "displays what kind of beds each hospital has open — medical-surgical, intensive care, psychiatric—and uses color-coding to show the average unloading time for ambulances at each of the local facilities." It also "has a 'section for comments, where hospitals can broadcast changes in availability of services that would not be discernible from looking at the general bed census.'" For example, Bryan Dean, clinical manager of the emergency department at Tulane University Hospital and Clinic, "said he posted a note when the CAT scanner, a type of X-ray machine that shows cross sections of body tissues and organs, was down for an hour for maintenance."

Normally, the site is not intended for ambulances dispatched to serve patients with "life-threatening conditions, such as a gunshot wound or a failing heart," but rather is used to redirect "patients with less grievous conditions who might be forced to wait several hours for treatment at a crowded facility." Still, the system has drawbacks. As it stands now, the status of beds and patient volume is updated by a hospital staff member who logs on and changes the information, "a job that sometimes gets done every two to four hours." The site does

not provide a forum for hospitals to update information on the number of patients piling up in their lobbies, which can change from minute to minute. Nevertheless, the system represents a large step forward in the way that hospitals in New Orleans prepare for a natural disaster. Hospitals elsewhere in the state will generally only use the site in a disaster situation, because they “do not all have a comfort level about sharing this kind of information because it may give another facility a competitive edge.” However, Dr. Jimmy Guidry, Louisiana’s state health officer, says that “New Orleans does not have a problem sharing because everyone there is struggling to meet demand” (Moran 23 January 2007, 1). The effective transfer of information among New Orleans’ hospitals reveals the potential for this system’s value in the event of an impending crisis anywhere in the state.

Hospitals have also responded to overcrowded emergency rooms by operating a large number of small, neighborhood clinics, to which they will transfer an increasing volume of their patients. Some of these clinics are operated as subordinate entities of larger hospitals, while others are more small-scale endeavors. One example is the St. Thomas Community Health Center in New Orleans, which serves both “insured and uninsured patients (about 30 percent and 70 percent, respectively) and is the only place in the city for uninsured women to get screening and diagnostic mammograms” (Bourbon 4). It offers “primary care normally found in hospitals, including pulmonary and kidney care, cardiology, gynecology and optometry.” Since Katrina, the clinic has undertaken several projects to expand its services, including a new wellness and counseling center for its increasing volume of psychiatric patients. Meanwhile, Ochsner Health System has acquired several independent clinics and renovated them to rehabilitate their facilities and expand their services. Many of these projects are funded partly through federal and state contributions to the health care network. The future of these clinics will undoubtedly be shaped by the involvement of the area’s large hospital systems, and the level of private funding injected into their operating budgets, of which there is no guarantee.

Planning for the future of healthcare in New Orleans will most heavily involve its large health care providers, the most influential actors on the ground. In April of 2007, John J. Finn characterized

their actions by saying, “The only answer I have is that I believe these hospitals are not waiting for government to do something for them. They’re doing it themselves” (Thomas 1). Three developments are, arguably, the most important for the immediate future of the city’s health care industry. The first is Ochsner Health System’s purchase, in September 2006, of three of the metropolitan area’s hospitals from Tenet Healthcare Corporation, a national for-profit healthcare network based in Dallas. The three hospitals acquired through the deal are Memorial Medical Center in New Orleans (now Ochsner Baptist Medical Center), Meadowcrest Hospital in suburban Gretna (now Ochsner Medical Center-Westbank), and Kenner Regional Medical Center (now Ochsner Medical Center-Kenner). Ochsner paid Tenet \$56.8 million for the three facilities, an extremely low price that amounts to pennies on the dollar for the actual value of the hospitals, and suggests Tenet’s sense of urgency to abandon the New Orleans health care market. Immediately after the purchase, Ochsner assumed control of “26 percent of the market in Orleans and Jefferson Parish, but its dominance will be greater than the numbers suggest because many beds have fallen into disuse since Hurricane Katrina.” Ochsner CEO Pat Quinlan summed up his hopes for the purchase: “I hope this galvanizes the community to do the right things and to take chances to make the future happen...Most great things require moments of courage in the face of uncertainty, and really great places make their own futures” (Moran 1 October 2006, 1). Since the purchase, Ochsner has completed a great number of renovation projects at each site and has opened all three to serve a variety of patients in a variety of medical capacities. The most important of these projects involve the Baptist campus, a symbol of the uptown New Orleans community. The improvements there include a surgical hospital, two medical office buildings, and a new imaging center, as well as the capacity to offer radiation therapy for cancer patients. However, Ochsner’s plans for the campus differ greatly from Tenet’s pre-Katrina services. Before the storm, “Tenet operated more than 300 beds at the hospital, [but] Ochsner plans to cap bed capacity at about 100—about a third of the size of its nearest competitor, Touro Infirmary.” Instead, Ochsner plans to “convert the remainder of the main hospital building into a 200- to 250-unit development for seniors that will include independent

apartments, assisted living and nursing home care” (Moran 4 August 2007, 1). These plans represent a bold attempt to rebuild the community by attracting more of the city’s scattered population to return. William C. Ward sees this as a unique opportunity to show the elderly citizens who formerly resided in the area that necessary care for them can be readily available in the city (Ward). Ochsner has also undertaken the task of building a new cancer center. This ambitious six-story project is valued at \$50 million (Thomas 1). Ochsner has the largest share of the renovation and new facility projects among the city’s hospitals.

The second and third main developments that will be crucial to the future of the city’s health care industry are two new hospitals, one to be built by Louisiana State University and the other by the Department of Veterans Affairs, which are scheduled to open in 2012 and 2014, respectively. In 2007, as already noted, LSU unveiled plans to build a new teaching and research hospital to fill the many voids created by the loss of Charity and University Hospitals, to be completed at the earliest in the spring of 2012. The state of Louisiana had planned to replace Charity Hospital even before the storm, given the facility’s age and poor upkeep. The plans call for the expenditure of \$1.2 billion in state funds over the next four years. They include “a main hospital, an ambulatory care building, a physical plant, and a parking deck.” After these expenditures, the state hopes to save money on its annual operating costs by sharing emergency services and laboratory space with a new VA hospital to be built next door. New Orleans Mayor C. Ray Nagin regards the plans as extremely positive, as they would “help anchor a biomedical research corridor.” The new facilities would also provide graduates of the medical schools at LSU and Tulane an opportunity to complete their resident training. Many feel that building these two new facilities would serve as an economic driver. However, the plans for the LSU hospital have been the subject of intense debate over the past two years. Some individuals, including Pat Quinlan, have strongly opposed the enormously expensive plans, arguing that, on the whole, people do not like having to travel downtown to receive health care; rather, they would prefer to seek care at facilities in the suburbs. There is also much doubt about the earning potential of the new hospital if a certain portion of New

Orleans' pre-Katrina population does not return. If not enough people return in the next five to ten years, the facility may become "a millstone around the necks of taxpayers when it fails to generate the revenue from private insurance now being projected" (Moran and Moller 1). The new LSU hospital's fiscal success will depend on its ability to secure patients who were loyal to other hospitals, including those that have closed since the storm, and the ability of its doctors to convince patients to be admitted there as opposed to private hospitals. Similarly, the costs of the proposed hospitals will depend on the costs that the state will bear to annex and to purchase all of the land for the facility. Hopefully, the new VA hospital will be able to enjoy financial solvency and not become a burden on the Department of Veterans Affairs for increasing financial support.

Conclusions

1. *Collaboration and cooperation is key.* The hospitals in the New Orleans area are faced with the challenge of collaborating with one another while, at the same time, competing with one another for a larger share of the city's patient demand. Given the current circumstances of the health care system, there are issues of competitive imbalance to be solved. Health care in New Orleans will continue to be fragmented and its potential for success limited if cooperation does not emerge from the efforts of the leaders of the hospitals. But such cooperation also has the potential to show other cities to see how its benefits outweigh its costs, prompting them to cooperate even without the threat of imminent disaster.

2. *An all-encompassing plan for uncompensated care must be implemented.* As discussed, hospitals are crippled by their constant treatment of uninsured patients with largely inadequate compensation from the state and federal government. The state and federal government has made several one-time appropriations to these hospitals, but these can ease losses only briefly. Instead the state government should create some type of all-encompassing plan for compensating hospitals for treating uninsured patients that is fair, equivalent to costs, and can be sustained for multiple years.

3. *Regional planning must take on a whole new, more aggressive approach to health care.* With all of New Orleans' struggles after Katrina, it is

difficult for leaders to isolate any of them to provide answers for their related problems, as the relationships between them are complex. However, bringing back the health care industry is certainly one of the most crucial steps for the rebuilding New Orleans. Planning for the future of health care must become more aggressive and vigorous, which may involve increased professional staffing within planning and government agencies.

The conditions that afflict the post-Katrina city of New Orleans and its health care industry must be addressed and their impacts alleviated. While the situation seems grim, there is still hope and promise that the actions taking place today may, one day, improve health care beyond the city's pre-Katrina standards. More comprehensive study and increased oversight will be necessary for the administrative entities at each level of government to revitalize one of the largest and most important aspects of life in New Orleans.

Works Cited

- Alpert, Bruce and Kate Moran. "Local Hospitals Seek Help Coping with Rising Costs." *The Times-Picayune*, 1 August 2007, National, 1.
- Bourbon, Julie. "Health Industry Gets Back on its Feet." *Times-Picayune*, 11 October 2007, Money, 4.
- Darcé, Keith. "The Doctor is Out." *Times-Picayune*, 8 February 2006, National, 1.
- Deichmann, Richard E. *Code Blue: A Katrina Physician's Memoir*. Bloomington IN: Rooftop Publishing, 2007.
- Eaton, Leslie. "Shuttered Hospitals Ensure Slow Recovery in New Orleans." *New York Times*, 24 July 2007, A1.
- Fleming, Martha. Interview, 11 April 2008.
- Kizer, Kenneth W. *Extreme Makeover: A Case Study of Veterans Health Care*. Baton Rouge: Department of Health and Hospitals, State of Louisiana, 27 June 2006.
- Krieger, Kadee. "Program Aiming to Fill Health Care Worker Shortage." *Times-Picayune*, 21 June 2007, Covington Picayune, 1.
- Manning, Anita. "New Orleans' Healthcare Might Never be the Same." *USA Today*, 19 September 2005, 06D.

- Meitrodt, Jeffrey. "For Dear Life: How Hope Turned to Despair at Memorial Medical Center." *Times-Picayune*, 23 August 2006, National, 1.
- Moran, Kate. "VA Selects Three Firms to Work with on Hospital Design." *Times-Picayune*, 8 September 2007, Metro, 1.
- "Without Charity Hospital, the Poor and Uninsured Struggle to Find Health Care." *Times-Picayune*, 24 August 2007, National, 1.
- "Memorial Hospital Coming Back to Life." *Times-Picayune*, 4 August 2007, National, 1.
- "Hurricane Katrina Disabled the VA Hospital in New Orleans." *Times-Picayune*, 1 April 2007, National, 1.
- "As Fledgling Docs Get Feel for Future, so Does State." *Times-Picayune*, 16 March 2007, National, 1.
- "Hospitals Run out of Space." *Times-Picayune*, 9 March 2007, National, 1.
- "Forum Tackles Financing Health Care for the Poor." *Times-Picayune*, 26 January 2007, Metro, 1.
- "Hospitals Go Online to Coordinate Their Efforts." *Times-Picayune*, 23 January 2007, National, 1.
- "Foreigners Tapped to Fill Nursing Gap." *Times-Picayune*, 15 October 2006, Metro, 1.
- "Healthy Growth." *Times-Picayune*, 1 October 2006, National, 1.
- "Hospitals Want State to Ante Up." *Times-Picayune*, 9 May 2006, Metro, 1.
- Moran, Kate and Jan Moller. "Ochsner Chief Disputes Need for New Hospital." *Times-Picayune*, 12 August 2007, National, 1.
- Morris, Melinda. "Hospitals' Costs Create Health Crisis, CEOs Say." *Times-Picayune*, 10 May 2007, Gretna Picayune, 1.
- "Hospitals Recruiting Nurses from Near, Far." *Times-Picayune*, 26 April 2007, Gretna Picayune, 1.
- Pope, John. "New Doctors Follow Their Hearts to N.O." *Times-Picayune*, 1 July 2006, National, 1.
- "Hospitals Seek Help to Staunch Bleeding." *Times-Picayune*, 5 June 2006, National, 1.
- Sternberg, Scott. "Doctor Shortage Ails New Orleans, But Med School Grads Injecting New Life." *Times-Picayune*, 12 October 2006, Economic Outlook, 14.

- Thomas, Greg. "Long Term Care: New Orleans-Area Hospitals are Rebuilding, Expanding, and Shaping the City's Future, in Sickness and Health." *Times-Picayune*, 29 April 2007, Money, 1.
- U.S. House of Representatives. *Post Katrina Health Care: Continuing Concerns and Immediate Needs in the New Orleans Region. Hearing Before the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce*. 110th Cong, 1st Sess., 13 March 2007.
- U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation. *Prior Health and Human Services Poverty Guidelines and Federal Register References*. <<http://aspe.hhs.gov/poverty/figures-fed-reg.shtml>>
- Ward, William C. Interview, 28 December 2007.
- Zigmond, Jessica. "Still in Recovery." *Modern Healthcare*, 21 August 2006, 6-27.