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Action Steps for Access to Care

As Louisiana approaches its eleventh month since the twin disasters of hurricanes Katrina and Rita, the state is still without a roadmap for rebuilding its health system. The health infrastructure remains in shambles in the New Orleans region: more than half of hospital and nursing home beds are closed, 80 percent of “safety net” clinics are gone and 55 percent of private physician offices were closed or destroyed.

Bold and decisive action is needed at this point in Louisiana’s history. Having failed to provide adequate health services for its population for decades prior to the hurricanes, the state can ill afford to dally now that the system must be reengineered. Even so, at the end of the 2006 legislative session, there has been little discussion or debate about fundamental reform of the health care system. Moreover, the Louisiana Recovery Authority’s Task Force on Health, charged with guiding the system-wide recovery effort, still has not determined whether health care reform is under its jurisdiction.

A long-awaited study commissioned by the Louisiana Recovery Authority Foundation and performed by the consulting firm PricewaterhouseCoopers was made public in late April. The 244-page report, perhaps the most comprehensive and thoroughly documented study of Louisiana’s health care system, was met with

stunned silence from the state’s medical establishment. The report made 15 recommendations for Louisiana to reform its health system, including the following:

- Do away with its “polarized state healthcare system with two delivery systems living within it – one for the insured and one for the uninsured.”
- Close most of its charity hospitals.
- Shift much of the medical education activities to public/private partnerships.

These recommendations were too drastic for some policymakers, so the quest for a “better”—and less radical—plan continues.

PAR recommends that Louisiana commit to a new direction in health care that will be focused on the needs of patients instead of inefficient and costly institutions. This new direction will be difficult and controversial, but the state should be unrelenting in its efforts to build a system that produces excellent health outcomes while promoting cost-effectiveness and financial sustainability. No element of the current system should be immune from this effort.

The Louisiana health care system requires fundamental change, including the downsizing and closure of some charity hospitals and a substantial

This is the first report in an ongoing series of PAR health care policy briefs highlighting major issues and recommending reforms that affect health care programs and state and federal spending in Louisiana. PAR’s overview of the state’s health care system and its deficiencies, as well as the challenges and opportunities presented by hurricanes Katrina and Rita, was published in April 2006. Future briefs will focus on other specific issues, including the challenge of providing for the uninsured, long-term care for the elderly and persons with disabilities, and state Medicaid spending. Each brief will provide specific recommendations for system change and improvement.

increase in access to primary and preventive care for all citizens, particularly the indigent population. However, the charity hospital prescription is bitter medicine for a state that continues to cling to a long tradition of health care that stopped working effectively long ago. While waiting for the state's leaders to recognize this, the state should not allow the charity hospital closure issue to obscure the validity and urgent need for other meaningful reforms.

Other health care recovery and rebuilding efforts can and should move forward immediately. In this policy brief, PAR lists several recommendations for change that will be easier to embrace and simpler to implement than contentious and difficult charity hospital reforms.

PAR recommends that the primary care initiatives described in this report commence immediately after budget authority is granted. Meanwhile, the fundamental reforms involving the charity hospital system and medical education cannot be ignored. It is imperative that the Louisiana Recovery Authority (LRA), the Health Redesign Collaborative and legislative committees over the next few months rapidly develop a plan to transition the state from a difficult-to-access, hospital-centered system to a decentralized, community-based system of care that emphasizes primary and preventive health care for all citizens.

FOCUS ON ACCESS

Two hallmarks of an effective health care system are accessibility and quality. Louisiana is deficient in both, but most of the state's health care reform planning efforts so far have focused on quality to the exclusion of accessibility. For the one in five citizens in Louisiana who are uninsured and relegated to a system of care with fundamental design flaws that prevent access, this approach falls short.

Both nationally and in Louisiana, planning efforts for health care reform and recovery place priority on quality improvements. The national quality movement, started by the Institute of Medicine of the National Academy of Sciences, makes no direct reference to the problem of access to care, except to concede that quality is irrelevant without access. The Louisiana Healthcare Redesign Collaborative also focuses on

quality, obscuring the state's critical need for dramatic improvements in access to care. The 37-member collaborative is a newly created advisory body to the Louisiana Department of Health and Hospitals (DHH) charged with developing plans for the redesign of the Louisiana health care system. While the emphasis on quality is laudable, Louisiana planning efforts would benefit from a clear and direct statement of major deficiencies in the system, the most prominent being poor access to primary and preventive care.

The emphasis in this report is on improving access to basic health care services, especially primary and preventive care. Louisiana lacks the infrastructure to provide its citizens, especially the uninsured population, with basic health care services throughout the state. Major primary care expansion initiatives, therefore, should move forward even in the absence of an elaborate overarching plan for statewide health care reform.

A delivery system with ten charity hospitals located mostly in major cities makes access out of reach for people in rural areas who do not have ready transportation. That same delivery system similarly denies access to people who live just a few blocks from a charity hospital when it takes 18 months or more to get an outpatient clinic appointment. Access is also restricted in emergency departments that are overflowing with people seeking treatment for routine conditions that should be treated in an outpatient clinic.

This brief presents a list of recommendations that address some of the more pressing access to care issues in Louisiana. Because all of these recommendations deal with increasing the state's primary care capacity, they will result in significant reductions of expensive emergency room treatment and other hospital-based care. The rate of ER usage in Louisiana is 40 percent higher than the national average. ER visits for routine care incur costs that are four to six times greater than treatment in a doctor's office, clinic or after hours care facility. Creating additional primary care capacity will provide alternatives to hospital-based care and reduce unnecessary expenses.

For each ER visit that can be transferred to a doctor's office or clinic, a savings of around \$300 can be

realized. There were 2.4 million visits to emergency departments in Louisiana in 2004. According to recent estimates, 75 percent or more of these visits were for routine care and 50 percent were from persons who were either uninsured or Medicaid eligible. If just half of non-emergency ER visits can be diverted to non-hospital based primary care, a conservative estimate of potential savings would be \$135 million per year, or about \$40 million per year in state matching funds. (See Table 1.) Some savings would begin to occur immediately upon establishing less costly alternatives to ER visits, but the full impact would not be realized for three to five years. A reduction in ER visits from 2.4 million to 1.95 million would reduce Louisiana's rate of use from 548 visits per 1,000 population to 448 per 1,000 population, and the state would rank tenth in the nation instead of third.

Table 1. Potential Savings by Shifting Services from the ER

ER visits for routine care - uninsured or Medicaid (est.)	900,000
Cost per routine ER visit	\$ 500
Total cost to Medicaid program	\$ 450,000,000
Cost per clinic/MD visit (avg)*	\$ 200
Projected savings per visit	\$ 300
Estimated total savings	\$ 135,000,000

*Assumes some implementation of extended hours for clinics and physicians, and use of urgent care facilities.

The above estimate applies only to reasonable reductions in emergency room care and does not take into account savings from reduced inpatient hospitalization and specialty care. However, efforts to reduce unnecessary utilization of emergency care will require a concerted effort. Hospitals, physicians and clinics in each community will have to coordinate to establish guidelines for referring routine cases to non-emergency alternatives. An intensive patient education program will be critical to success.

Justification for similar measures also has been provided by numerous independent studies in other states and in Louisiana. According to estimates from PricewaterhouseCoopers, \$200 million in savings can be realized by reducing reliance on the use of emergency department services in Louisiana.

SIX STEPS TOWARD REFORM

Recommendation 1: *Establish an initial investment of \$50 million in state or block grant funds to assist in development of private-sector Federally-Qualified Health Centers (FQHCs), satellite FQHC sites or Rural Health Clinics (RHCs) statewide, with emphasis on the immediate needs of the New Orleans area.*

Discussion: This recommendation proposes establishment of a permanent fund to be administered by the DHH Community-based and Rural Health Program to support development of new FQHCs and sites. Over a five-year period this fund would provide resources for start-up of 75 to 100 new FQHCs, satellite sites or RHCs. According to the DHH expansion plan for FQHCs, these community health clinics have a positive economic impact on communities and provide options for subsidizing care for underserved and low-income populations:

“They positively affect local economies by creating jobs and revenue. They are also viable options for health care systems because they are eligible for enhanced reimbursement rates, federal grant monies and disproportionate share hospital payments for uncompensated care costs. Most importantly, they positively affect the health status for their service populations (underserved and uninsured) by reducing health disparities.”

Louisiana compares poorly to other southern states in numbers of FQHC sites to provide care for the uninsured, Medicaid recipients and low-income persons. (See Table 2.) West Virginia and Mississippi have approximately three times as many sites and treat four times as many patients per population as Louisiana. To equal the rate of sites per population that Mississippi has, Louisiana would need 223 sites, an increase of 179 compared to the 2004 total of 44. This comparison is made to emphasize the disparity between the two states, rather than to set a goal to duplicate Mississippi's effort. There are approximately 55 FQHC sites currently in operation in Louisiana. The state also should approach U.S. Department of Health and Human Services (DHHS) Secretary Mike Leavitt, who has taken a special interest in

Louisiana, about assisting in this effort by providing a more flexible and expeditious federal application process for FQHCs. The possibility of expanding the annual federal grant for eligible sites and/or other potential federal funds for start-up and development or operational expenses also should be explored. In order to assure continuity of care for the patient population of these centers, requirements should be promulgated to ensure that arrangements between clinics and nearby hospitals have been negotiated and that clinic physicians have admitting privileges.

Table 2. Federally Qualified Health Centers
Comparable Southern States

State	Sites	Patients	Patients per 1,000 pop.
MS	144	310,807	109
WV	132	270,775	152
AR	56	104,889	39
LA	44	101,278	23

Source: Kaiser State Health Facts, 2004 data

FQHCs and RHCs derive revenues from several sources. The FQHC patient mix in 2004 consisted of 44 percent federal grant for uninsured, 29 percent Medicaid, 5 percent Medicare, 7 percent self-pay, 3 percent insured and 6 percent from other sources. RHC patient mix data are limited, but 48 percent of patients were Medicaid, according to DHH.

The average annual cost of operating an FQHC or RHC is approximately \$1 million. The state share of this cost would be less than one-third of Medicaid payments to the facilities, or around \$100,000 per year for each clinic.

Recommendation 2: Raise Medicaid fees to the Medicare payment rate for primary care physicians and other physicians in short supply. Medicaid fee increases could be phased in over a three-year period at \$12 million per year in state funds. A special rate should be established for physicians in Orleans, Jefferson, St. Bernard and Plaquemines parishes to assist with extraordinary expenses related to treating Medicaid patients in the post-Katrina environment.

Discussion: Numerous studies have shown that health care systems with high proportions of primary care physicians correlate strongly with high quality and

low costs. Louisiana has a relatively low proportion of primary care physicians, a major reason for the state's high costs and low quality. It is important that the state find ways to train and retain higher numbers of primary care physicians. In a recent report, the American College of Physicians warns that primary care may be on the verge of collapse and that payment policies contribute to the problem. According to the ACP study:

“Factors affecting the supply of primary care physicians, and general internists in particular, include excessive administrative hassles, high patient loads, and declining revenue coupled with the increased cost for providing care. As a result, many primary care physicians are choosing to retire early. These factors, along with increased medical school tuition rates, high levels of indebtedness, and excessive workloads, have dissuaded many medical students from pursuing careers in general internal medicine and family practice.”

Medicaid rates for primary care physicians in Louisiana are expected to increase for the 2007 fiscal year to about 75 percent of the rates paid by Medicare for similar procedures. This recommendation proposes that the state undertake a sustained commitment to increase rates paid by Louisiana Medicaid for primary care physicians to the Medicare reimbursement level within three years. Thereafter, the state should maintain parity with Medicare rates. Consideration also needs to be given to adjusting rates for physician practices that provide after hours care for routine cases to provide an alternative to excess usage of emergency rooms.

The higher rates also should apply to certain non-primary care specialties in order to maintain adequate numbers of those practitioners that are proven to be in critical need but persistent short supply.

Priority in using these funds to bring payments to the Medicare level should be given to primary care physicians and specialties in short supply in (1) Orleans, Jefferson, St. Bernard and Plaquemines parishes, and (2) other parishes statewide. Consideration should be given to establishing rates at the Medicare level immediately for the four-parish priority region.

Addressing this vital need will require a recurring annual commitment of state dollars as Medicaid matching funds. The total cost of achieving parity with Medicare rates is approximately \$120 million, including about \$36 million in state matching funds. Spreading these increases over three years will reduce the annual state match requirement to about \$12 million per year, but this does not include additional amounts to match generally modest increases of 4 percent per year in Medicare rates granted by the federal government.

Recommendation 3: *Restore medical care to rural parishes and other underserved areas by providing incentives for primary care physicians to practice in those areas. Incentive programs would require an initial investment of \$25 million in state or block grant funds.*

Discussion: Besides raising Medicaid rates, other incentives are needed to increase the primary care physician presence in underserved areas. An initial investment of \$25 million in state or block grant funds would enable a program of sufficient scope to re-establish a physician presence in rural communities and some inner-city areas. Underserved areas in the New Orleans region should be given special consideration in the use of these funds.

There is a well-documented need for primary care doctors in underserved areas of Louisiana. According to the DHH Bureau of Primary Care and Rural Health, 43 out of 64 of Louisiana's parishes have poor health status and 19 parishes are in very poor health. DHH further says: "The poor health status and limited primary care capacity of the state make it imperative for Louisiana to invest in and concentrate on expanding the primary care safety net in [the state's Health Professional Shortage Areas]." See Figure 1 for a map of the shortage areas.

An increased investment in the DHH Community-based and Rural Health Program would provide opportunities to assist physicians in establishing practices in underserved areas. Incentives could include assistance with malpractice insurance premiums, bonuses based on performance and/or need, loan guarantees, grants to assist with start-up costs and assistance with student loan repayments. An additional incentive could be a premium

Medicaid payment rate for physicians who practice in underserved areas. This option would require a federal waiver approved by the federal DHHS secretary.

DHH is already utilizing loan repayment programs and a Public Health Service Corps scholarship program to encourage physicians to practice in underserved areas. While these efforts have been partially successful, DHH officials believe that additional incentives would produce better results. For example, physicians in private practice cannot participate in student loan repayment programs that use federal funds. A state-funded program would provide more flexibility and expand the number of physicians recruited.

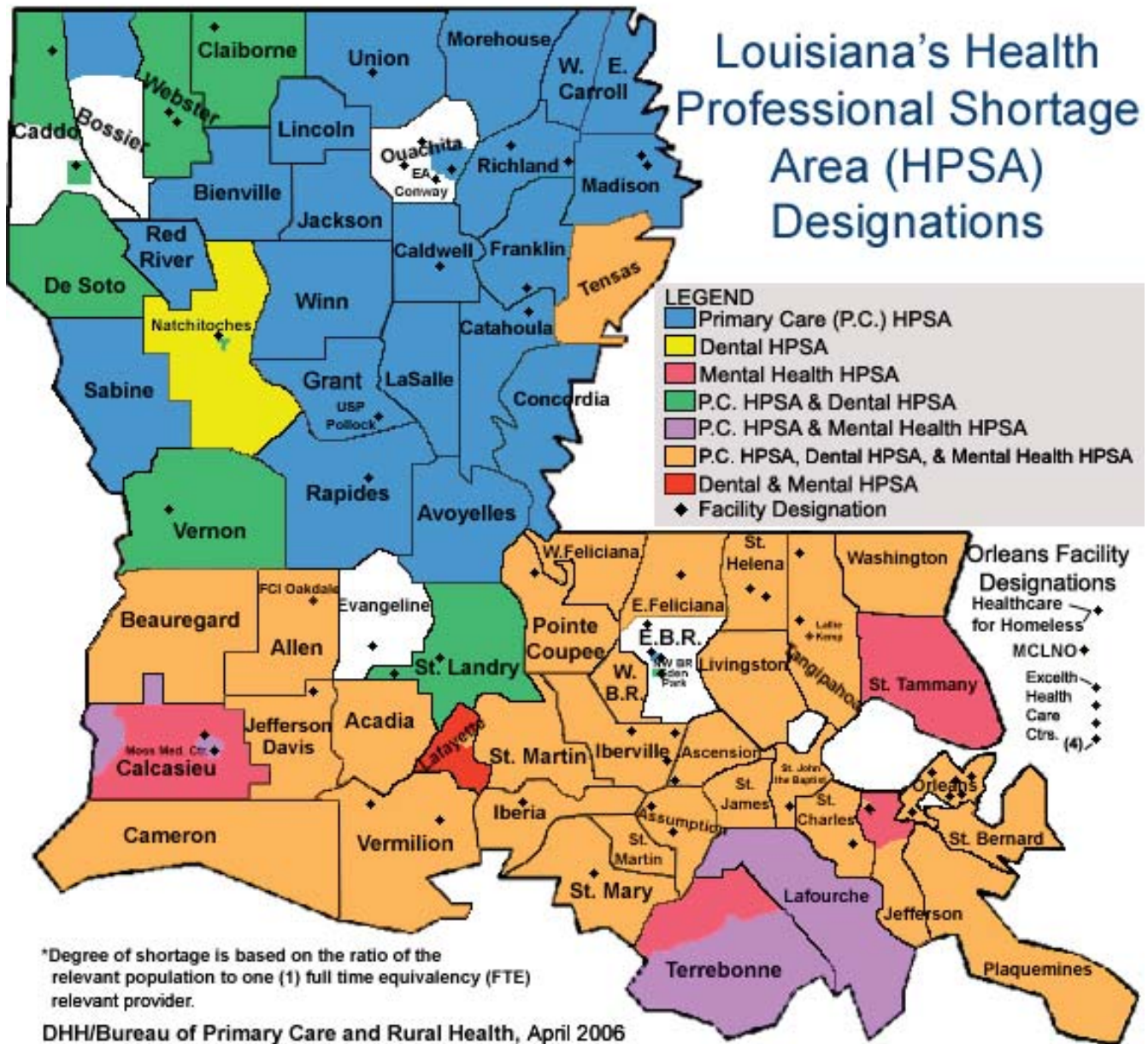
In return for incentives, participating doctors would agree to certain obligations, such as participating as a Medicaid CommunityCARE physician, agreeing to practice in an underserved area for a specified number of years and adhering to DHH guidelines for electronic medical record systems.

Over time, investments targeted at increasing the number of primary care physicians practicing in the state will lead to significant savings because of improvements in several areas: reduction of unnecessary use of hospital emergency rooms and inpatient care, better management of chronic conditions, better pre-natal care and birth outcomes, and earlier diagnosis and treatment of serious illness.

Recommendation 4: *Double the enrollment in school-based health centers by implementing an aggressive development program. Establish an initial investment of \$10 million in state or block grant funds for start-up and development of school-based health centers. Unused funds should be carried forward into future fiscal years to continue this important initiative.*

Discussion: School-based health centers (SBHCs) provide preventive, diagnostic and treatment services, including direct primary and mental health care for acute and chronic illnesses, health education, case management assistance and immunizations. Over the past 10 years the number of SBHCs has grown from 23 to 56 sites pre-Katrina/Rita. Five sites were destroyed in New Orleans and one in Cameron Parish. Partial or complete restoration of services has occurred at four locations.

Figure 1. Louisiana Map of Health Professional Shortage Areas, 2006



SBHCs have proved themselves to be a very effective method of making health care accessible to children. According to the Louisiana Assembly on School-Based Health Care (LASBHC), “students can access nearly any health care service in an SBHC that they can receive in a general practitioner’s office. There is never a direct cost to families for these services and parental consent is required for students to enroll for center services.”

In Louisiana, SBHCs currently have more than 50,000 children enrolled. This recommendation is intended to at least double that number within three to five years. It is expected that the Office of Public Health in DHH would work collaboratively with the LASBHC to develop a process to determine need for centers at each proposed site. The benefits of direct and convenient access to care will improve health outcomes for young children and adolescents, groups

which typically have the least exposure to primary care. Early diagnosis and treatment, management of chronic conditions and a reduction in unnecessary care in emergency rooms will result in savings that far exceed costs.

Two additional options for SBHC expansion are currently under consideration by LASBHC. A full 12-month operational schedule, instead of the current school-year schedule, is being studied. Also, discussions are under way with Louisiana Medicaid about the possibility of enrolling SBHCs in the CommunityCARE program as primary care providers.

Recommendation 5: *Relax practice requirements for non-physician clinicians or mid-level practitioners to enable them to practice independently in some cases, particularly in those underserved areas where there is no physician presence.*

Discussion: Nurse practitioners (NPs), physician assistants (PAs) and certified nurse midwives (CNMs) are all non-physician clinicians or mid-level practitioners. Each of these professions came into existence during the 1960s, typically in response to a shortage of physicians in various geographic areas where primary care services were needed. Over the last four decades, each of these practitioner groups has grown rapidly. Today there are more than 100,000 NPs in the United States, more than 50,000 PAs and approximately 8,000 CNMs.

Most studies have concluded that non-physician clinicians are valuable assets to physician practices in any setting. Their value is especially noteworthy in underserved areas where physicians are few and far between. About 25 states allow nurse practitioners considerable latitude and even autonomy in their clinical practice. Not all states, however, are accepting of mid-level practitioners. A national survey by the federal Health Resources and Services Administration found that Louisiana was one of seven states with a low acceptance level for non-physician clinicians.

Considering the enormity of the problem in Louisiana, where 85 percent of parishes are Health Professional Shortage Areas (HPSAs), the state should work to ensure that health care is available where it is needed most. In those areas where efforts to attract physicians repeatedly have failed, the presence of

nurse practitioners with independent practice authority should be welcomed. An approach that is working in some other states is to develop models of integrated care where physicians and NP organizations work together as teams in a patient-centered model of care. Another proactive step in reducing unnecessary emergency room usage could be to utilize non-physician practitioners to assist in staffing for expanded office hours at physician practices.

Regardless of the approach adopted in Louisiana, the state should find ways to utilize this resource, which is not being exploited fully yet.

Recommendation 6: *Provide no-interest loans to physicians in the Greater New Orleans region to assist them in re-establishing their medical practices. Priority would be given to physicians in private practice who are also “safety-net providers.” The initial cost of this program would be \$25 million in state or block grant funds with the expectation that these loans would be repaid during a specified period.*

Discussion: There is an urgent need to maintain physician practices in the New Orleans region. The pre-Katrina estimate of practicing physicians in Orleans Parish was 2,664. Post-Katrina estimates show that number was reduced to 1,200, a 55 percent reduction. The single most pressing problem related to health care capacity post-Katrina is the lack of physician manpower and primary care facilities. Ongoing reports of overcrowding in private hospitals are largely due to the destruction of the non-hospital primary care infrastructure in the region, resulting in lack of physician offices and primary care clinics.

Failure to assist physicians and provide them with incentives to maintain their practices will allow the depletion of the physician workforce to continue. Vital primary care and specialty physician services already have experienced significant degradation that will worsen if action is not taken.

DHH should provide an expeditious review and approval for those physician practices that meet prescribed criteria for demonstrating need and documenting storm damage. DHH should be prepared to receive applications from physicians almost immediately in order to begin making loans at the

earliest possible date but no later than October 1. Guidelines for loan eligibility and spending should be available by mid-July. Priority should be given to primary care physicians and to non-primary care specialties that are determined to be in critical need but short supply in the region.

CONCLUSION

Despite the unprecedented opportunities that Louisiana has to remake its dysfunctional health care system, the state so far shows few signs of taking advantage of them. State leadership currently is contemplating future directions but seems unprepared to make choices. It is clear that the specter of tackling the most fundamental of all possible changes, downsizing and closing charity hospitals, is not an appealing prospect on the eve of an election year in 2007.

PAR considers fundamental health care system change, including changing the method of delivery of care for the uninsured, to be a necessity in light of Louisiana's expensive but low-performing health care infrastructure. PAR is therefore proposing a series of actions that allow state leaders to advance rapidly to provide citizens with better access to primary care. The lack of primary care is the most obvious deficit in the system, as well as the one that all parties can agree on.

The state should consider using federal Community Development Block Grant funding to cover the costs of implementing these reforms. Alternatively, funding

may require adjustments to the state budget to utilize available state funds or other revenues. The savings that could be realized by replacing emergency room care with primary and preventive care will far exceed these initial costs, so every effort should be made to make these investments immediately. Further benefits will be gained in the reduction of inpatient and specialty care that will accrue from early diagnosis and treatment and better health outcomes.

The current health care crisis once again exposes the elemental problem at the heart of Louisiana's dysfunctional health care system: there is no shortage of money in the system, only a shortage of political will to carry out the reforms needed to fix the problems. The system is organized to deliver costly and often inefficient institutional care at the expense of primary and preventive care. All too often, spending priorities are focused on institutions and providers, rather than patients.

Adoption of these recommendations will allow the state to move in the direction of improving access to health care statewide, with emphasis on the New Orleans area. The gridlock that developed over the future of charity hospitals should not be allowed to impede the immediate and significant steps forward on other problems that are just as crucial to solve but much less divisive. No matter what decisions ultimately are made regarding the state's charity hospital system, increased access to primary care for both the insured and uninsured populations is essential to improve the health prospects for Louisiana.

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"PAR is an independent voice, offering solutions to critical public issues in Louisiana through accurate, objective research and focusing public attention on those solutions."

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