

A History of Safety Net Health Care in New Orleans,  
2005-2017

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## Abstract

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On August 29, 2005, Hurricane Katrina made landfall in Louisiana, leading to devastating flooding of much of the southeast of the state, including New Orleans. The flooding devastated New Orleans's safety net health care system, closing Charity Hospital, the city's major provider of uncompensated and Medicaid care, permanently. Between 2005 and 2017, major restoration of the safety net health care system has occurred through a combination of federal funding initiatives and community-based health care movements. Safety net health care in New Orleans is now delivered through a loose network of private nonprofit community-based health centers.

To understand the change from a centralized public hospital-based safety net care system to a decentralized private system, I built a history of the safety net health care system in New Orleans by systematically analyzing a variety of primary and secondary source documents about health care sites that provided care regardless of ability to pay in New Orleans over a time period of 2005 to 2017. I organized these sources by date and mapped the existing health care sites at the points of August 2005, October 2006, December 2010, and December 2017, to demonstrate the change in the number and location of such sites.

This history revealed that availability of health care sites in New Orleans, both before and after Hurricane Katrina, has been a result of funding choices at the state and federal level. It also highlights the importance of the community in building sustainable community health care for all within their own neighborhoods, and provides lessons for other areas looking to transition to community-based safety net health care. The history of safety net health care in New Orleans is incomplete, but through community commitment and dedicated funding, care for the most vulnerable in New Orleans continues to improve.

## Introduction

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In August of 2005, the devastating flooding brought on by Hurricane Katrina led to the permanent closure of Charity Hospital, which accounted for over 80% of uncompensated care in the New Orleans area. Charity Hospital had existed in some iteration since 1732, run for centuries by the Catholic Sisters of Charity before becoming a state hospital in 1970 and a part of the Louisiana State University system in 1997. For years, the emergency department at Charity Hospital was the busiest in the country, and Charity served as a medical home for many of the city's residents. At the time, one in five residents of New Orleans did not have health insurance; an additional 29% had Medicaid coverage. New Orleans residents faced rates of deaths from cancer and diabetes far above the national average.<sup>1</sup>

The Institute of Medicine defines the health care safety net as: “Those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable populations, as well as providers who by mandate or mission offer access to care regardless of a patient's ability to pay and whose patient population includes a substantial share of uninsured, Medicaid, and other vulnerable patients.”<sup>2</sup> The loss of Charity Hospital effectively left New Orleans, with half its population uninsured or on Medicaid, without a health care safety net.

By 2012, however, the safety net landscape in the New Orleans metropolitan region (defined by the New Orleans Regional Planning Commission as Jefferson, Orleans, Plaquemines, St. Bernard, St. Tammany and Tangipahoa Parishes<sup>3</sup>) looked very different. In 2012, New Orleans alone had four Federally Qualified Health Centers (FQHCs, community-based health care providers that receive funds from the federal Health Resources and Services Administration

Health Center Program to provide primary care services in underserved areas<sup>4</sup>), two FQHC lookalikes, and four community health centers that provided FQHC-like services.<sup>5</sup> In 2016, Louisiana expanded Medicaid by executive order, providing health insurance for over 50% of the previously uninsured population.<sup>6</sup> These facilities and programs have created a fairly comprehensive health care safety net based on primary and preventative care.

### **Problem statement**

While there is a body of literature on the health care system in the New Orleans area in the years immediately following Katrina, there is little literature that traces significant changes in the region's health care system beyond 2008, only three years after a natural disaster that permanently closed the city's major safety-net provider. Many of the long-term effects of the hurricane on the area and its residents have been studied through different frameworks, such as race and class-based approaches, but these studies have not focused on the health care system. The dramatic changes in safety net health care infrastructure that led to the rise of FQHCs and other community health centers in New Orleans have not yet been comprehensively documented in a history of the health care safety net since 2005.

## **Literature Review**

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How has the primary health care safety net changed in New Orleans from 2005 to 2017? Prior to answering this question, I will first consider previous literature on the safety net health care system in New Orleans and the community health center movement.

### Safety net health care in New Orleans before and after Hurricane Katrina

Many researchers have examined how health care, particularly the health care safety net, changed in New Orleans in the immediate aftermath of Hurricane Katrina. Berggren and Curiel described the health care system in April of 2006 as in a state of “chronic crisis,” with less than half the number of hospital beds across the city as before the storm, so hospitals were always operating with far fewer beds than patients.<sup>7</sup> Many authors examined the immediate effects of the closure of Charity Hospital, which greatly affected the number of hospital beds available in the city but also left most of the uninsured population and much of the Medicaid population of New Orleans without a source of care.<sup>8</sup>

Berggren noted that in the wake of the closure of Charity Hospital, some indigent patients had to go as far away as Baton Rouge, 75 miles from New Orleans, to receive care. The lack of patient beds and staff affected all areas of health care, with only 35% as many inpatient psychiatric beds as before the storm, and 20% as many primary care clinics.<sup>9</sup> Additionally, many people lost their jobs and insurance after the storm, leading to an uninsured rate of up to 50% in Orleans, St. Bernard, Jefferson, and Plaquemines parishes.<sup>9</sup>

A few articles reviewed the federal response to the hurricane’s effect of the health care system. The Emergency Health Care Relief Act of 2005 would have provided temporary Medicaid to low income individuals affected by the storm, without the regular Medicaid

categorical restrictions.<sup>10</sup> However, the Bush administration instead implemented a plan that provided temporary Medicaid to those who would have been previously eligible and had been displaced by the storm to other states; those states had to apply for this provision.<sup>9</sup> More than six months after Katrina, Louisiana received \$384 million dollars in funding from the Centers for Medicare and Medicaid Services to help support hospitals who cared for the uninsured in the wake of the storm.<sup>9</sup> Neither of these, however, constituted long-term reconstruction plans for the safety net in New Orleans.

Writing two years later, in 2007, McKenna notes that the population of the New Orleans's surrounding parishes had reached 90% of pre-storm levels, but many health care facilities remained closed, overwhelming emergency rooms. Patients routinely traveled outside of New Orleans to seek care in the surrounding parishes, further stressing those emergency rooms.<sup>11</sup> Beyond 2007, there is little peer-reviewed literature on the health care system for safety-net populations in New Orleans. Belkhir and Charlemaine examined the recovery from the storm, generally, through a lens of race, gender, and class, from 2005-2015; however, no such longer-term analysis exists more narrowly for the health care system.<sup>12</sup>

### The Community Health Center Movement

As Betten and Austin explore, isolated community health movements in the United States reach back at least as far as World War One, but early movements often faced hostility from politically conservative groups.<sup>13</sup> Federal support for community health centers began with President Johnson's War on Poverty and the creation of the Neighborhood Health Center program in 1965 as part of the Office of Economic Opportunity.<sup>14</sup> As Plaska details, the program sought to create equity in access to care through reduction in barriers, service to defined

communities, active participation and partnership with communities, multidisciplinary approaches to care, and community-oriented primary care.<sup>13</sup> Funding for these health centers increased during the 1970s, but was reduced by the Regan administration in 1981.<sup>13</sup>

In “Social Justice and Community Health Centers,” Wright explores how one doctor, Dr. H Jack Geiger, leveraged the new health center program to form the first OED-funded health centers in the United States, the Columbia Point Health Center in Boston, Massachusetts and Bolivar County, Mississippi.<sup>15</sup> The health centers focused on the determinants of health beyond the doctor’s office, repairing houses, digging wells, and setting up an agreement with a local grocery store to provide food for malnourished children. Geiger discusses in “The First Community Health Center in Mississippi” how the health center has been owned by a community improvement organization for the last forty years, increasing the investment of the community in the center.<sup>16</sup> Since federally qualified health centers must draw 51% of their board of directors from current patients, he explains, patients have a more powerful voice in FQHCs than in any other part of the U.S. health care system.<sup>15</sup>

Beyond federal programs, community groups and activists have worked to open their own health care facilities for their communities. The Black Panther Party, for example, operated free clinics in Boston in the 1970s.<sup>17</sup>

As chronicled by the National Association of Community Health Centers, the community health movement continued to grow beyond the 1960s and 70s. After its diminishment during the Reagan era, the Federally Qualified Health Center program was created under President George H.W. Bush.<sup>18</sup> In 2009, the American Reinvestment and Recovery Act, a stimulus bill under President Obama, provided new funding opportunities for health centers. The Affordable Care Act also provided additional opportunities for health centers.<sup>17</sup>



## Methods

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Research involved collecting and evaluating data in order to compile a comprehensive history of the safety net health care landscape in the greater New Orleans area since 2005. Data came from primary sources, collected through library systems and online public records. These sources include federal Medicaid data, Health Research and Services Administration data, State of Louisiana and City of New Orleans data, data collected and reported on by health care systems, city and state planning documents, health care system policy and planning documents, congressional hearing records, federal and state legislation, and contemporary news reports. This list is not exhaustive and many more types of primary sources were used, and can be explored in the Appendix.

Some data came from secondary sources. These sources use data from primary sources or synthesize data from multiple sources. These sources include scientific literature, State of Louisiana and City of New Orleans reports, federal and congressional reports, and prior histories of New Orleans, community health centers, and state and federal health policy since 2005. This list is not exhaustive and many more types of secondary sources were used, as noted in the Appendix.

For the purposes of this project, I have limited the types of health care delivery sites that I considered. First, I only researched sites within the City of New Orleans, excluding sites outside of the city in the Greater New Orleans area. The Greater New Orleans Area includes Orleans Parish, which encompasses the city of New Orleans, as well as Jefferson, Plaquemines, and St. Bernard parishes. While these surrounding parishes also faced changes in their safety net health care systems between 2005 and 2017, studying them would have made this a much longer

project. Additionally, I researched only sites in the City of New Orleans that provided or provide primary care to adults, regardless of their ability to pay. This invariably excluded many sites that exclusively provide behavioral health care, pediatric care, or specialty care. These sites are still significant to the landscape of safety net health care in New Orleans, but beyond the scope of this project.

I compared the available data on the safety net health care system in New Orleans at present (data from 2011-2017) to available data on the safety net prior to Hurricane Katrina (2005 and before), immediately after the storm (2005-2006), and the early intermediary period (2006-2010). I have chosen these time periods based on prior literature, federal and Louisiana state legislation and grant funding, and availability of data.

Table 1. Time Periods for Data Analysis and Mapping

<b>Period</b>	<b>Description</b>	<b>Rational</b>
Up until 8/2005	Baseline data	“Before” picture, capture any confounding changes
9/2005-10/2006	Storm recovery	One-year period of storm recovery
11/2006-12/2010	Early intermediary	Duration of Primary Care Access and Stabilization Grant; period of existing literature
1/2011-12/2017	Late intermediary and current landscape	Post-PCASG; Implementation of ACA

The first period, before August 2005, is designed to provide a consistent picture of safety net health care before Hurricane Katrina as well as capture any significant changes in the safety net health care system immediately before the hurricane that may impact later data. Review of the literature on the health care system in the aftermath of Hurricane Katrina demonstrates that

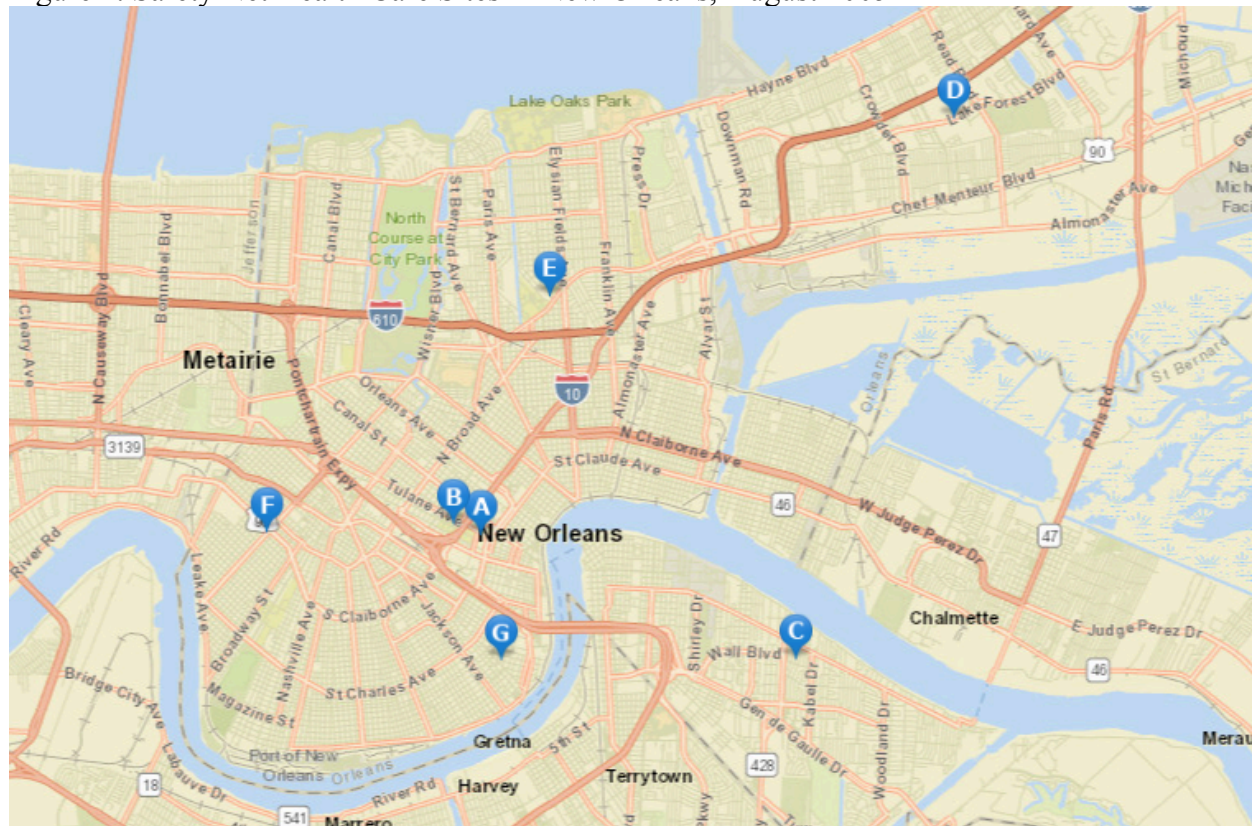
research in the subject generally ends in 2008 or, at the latest 2010, providing the cutoff for the second period. Additionally, Louisiana and the Greater New Orleans area was awarded the Primary Care Access And Stabilization grant for the period from 2007 to 2010. The final period was chosen to encompass both change from 2011-2017 and to allow for potentially incomplete recent data, supplemented with data from 2015 and 2016.

### Mapping

In order to evaluate change over time in New Orleans's safety net health care system, I create maps to compare pre-2005, immediate recovery, intermediate, and current sites of safety net health care providers. This mapping will help illustrate changes in access to care through location. Mapping was dependent on the data I was able to collect, but I believe it is comprehensive within the limitations of the project.

## History

Figure 1. Safety Net Health Care Sites in New Orleans, August 2005



All maps made using ArcGIS. [www.arcgis.com](http://www.arcgis.com)

### Key

- |                                    |  |
|------------------------------------|--|
| <b>A:</b> Charity Hospital         | <b>E:</b> EXCELth St. Bernard              |
| <b>B:</b> University Hospital      | <b>F:</b> Daughters of Charity- Carrollton |
| <b>C:</b> EXCELth Algiers          | <b>G:</b> St. Thomas Health Center         |
| <b>D:</b> EXCELth New Orleans East |  |

### Before Katrina: The State of Safety-Net Health Care in New Orleans in 2005

Just before Hurricane Katrina, in August 2005, the safety net health care system in New Orleans consisted primarily of one hospital. Charity Hospital, founded in 1736, was one of the oldest hospitals in North America, and by 2005 had transformed into the Medical Center of Louisiana at New Orleans, with over 150 primary and specialty care clinics.<sup>9</sup> In 2004, over half

of its patients were uninsured.<sup>19</sup> Beyond Charity, two federally qualified health centers, EXCELth and Daughters of Charity, operated in New Orleans. A few other clinics provided free or sliding scale health care to specific populations.

The population that these safety net providers served had a unique level of need. Before Hurricane Katrina, over forty percent of New Orleans's population was either uninsured or on Medicaid.<sup>20</sup> This reflected New Orleans's high poverty rate; in 2005, New Orleans had a poverty rate of twenty-three percent.<sup>21</sup> Poverty was not equally distributed throughout the city; African Americans, about two-thirds of the city's population, made up eighty-four percent of its residents in poverty.

Many residents struggled with chronic illness. New Orleans was among the US cities with the highest rates of obesity. Children had the highest rate of asthma in the state, at over sixteen percent.<sup>20</sup> Residents also faced environmental health hazards. Fifty percent of the children in inner city New Orleans neighborhoods had blood lead levels above 10 micrograms per deciliter, and in some neighborhoods up to sixty-seven percent of children had symptoms of lead poisoning.<sup>20</sup> More Black children faced lead poisoning, and the health of the city's African American population tended to be worse than its white population. Infant mortality among African American infants was twice the rate of white infants in 2004. As a city with such large health care needs, and so many patients without the means to pay for care, the locations and reach of safety net health care providers is crucial.

#### The Medical Center of Louisiana at New Orleans and Charity Hospital

Charity Hospital was a fixture of New Orleans for centuries. Beginning as a hospital for the poor and run by the Daughters of Charity, a Catholic order, from 1832 to 1970, Charity

served as the medical safety net for the city long before health insurance became part of our health care landscape. The Louisiana Department of Health and Human Services took over Charity in 1970, but continued its mission of servicing the poor and uninsured.<sup>19</sup>

By 2005, Louisiana State University ran the Medical Center of Louisiana at New Orleans health care system (MCLNO), which by then included Charity Hospital as well as University Hospital, located just down the street. In 2003, uninsured patients accounted for more than half of the care provided at Charity Hospital, and an additional third was to patients with Medicaid.<sup>9</sup> Patients without insurance accounted for only about four percent of the inpatient care provided at other hospitals in New Orleans.<sup>9</sup> About three quarters of Charity's patients were African American, compared to about sixty seven percent of the city's population.<sup>9</sup> Of Charity's patients, eighty five percent had an income below \$20,000.<sup>9</sup>

Charity Hospital did not serve so many people without insurance by chance. Before Hurricane Katrina, Louisiana allocated Medicaid disproportionate share hospital (DSH) funds primarily to state-run hospitals operated by the LSU system. As the only public hospitals in the city, Charity and University received DSH funds to cover their inpatient and outpatient care, while other hospitals and outpatient clinics in the city did not receive such payments.<sup>9</sup> As a result, MCLNO, and in particular Charity Hospital, delivered most of the uncompensated care in New Orleans, as well as a substantial portion of its Medicaid care. Charity provided eighty-three percent of all inpatient uncompensated care in the city, and eighty-eight percent of all uncompensated outpatient care.

Charity was also the primary provider of many essential health care services in the city. It provided most of the substance abuse and psychiatric care in New Orleans, as well as most of the

HIV/AIDS care, and was the only Level 1 trauma center for 300 miles.<sup>9</sup> In 2005, Charity had 134,406 emergency room visits and 309,290 outpatient visits.<sup>19</sup>

Charity strained to provide care to such a large population. Reported wait times for an appointment were up to twelve months. The hospital was able to provide little care management for chronic conditions. Continuation of care was difficult, with patients frequently seeing a different doctor at every visit.<sup>22</sup> Despite these shortcomings, the cultural significance of the institution loomed large over the city.

While Charity was located in Mid-City, a neighborhood with a high rate of poverty, it was located far from neighborhoods such as New Orleans East and Algiers, which also had high poverty rates and few health care options for those without health insurance.<sup>23</sup> The centralized location of the vast majority of the safety net health care in New Orleans meant that many residents had to travel significant distances to access health care, even though in many New Orleans neighborhoods, over sixty percent of households did not have access to a vehicle.<sup>24</sup> Residents in these areas would be reliant on public transportation for health care, particularly specialty care, at Charity.

### Federally Qualified Health Centers

Some residents did have access to safety net health care closer to home. At the time of Hurricane Katrina, there were two federally qualified health centers (FQHCs) within New Orleans. One FQHC was a Healthcare for the Homeless site run by the City of New Orleans. EXCELth, the other FQHC, had four sites throughout the city, including in Algiers, St. Bernard, and New Orleans East.<sup>25</sup> EXCELth also operated a Daughters of Charity clinic in Uptown New Orleans.<sup>26</sup> The Algiers, New Orleans East, and Daughters of Charity clinics all operated in

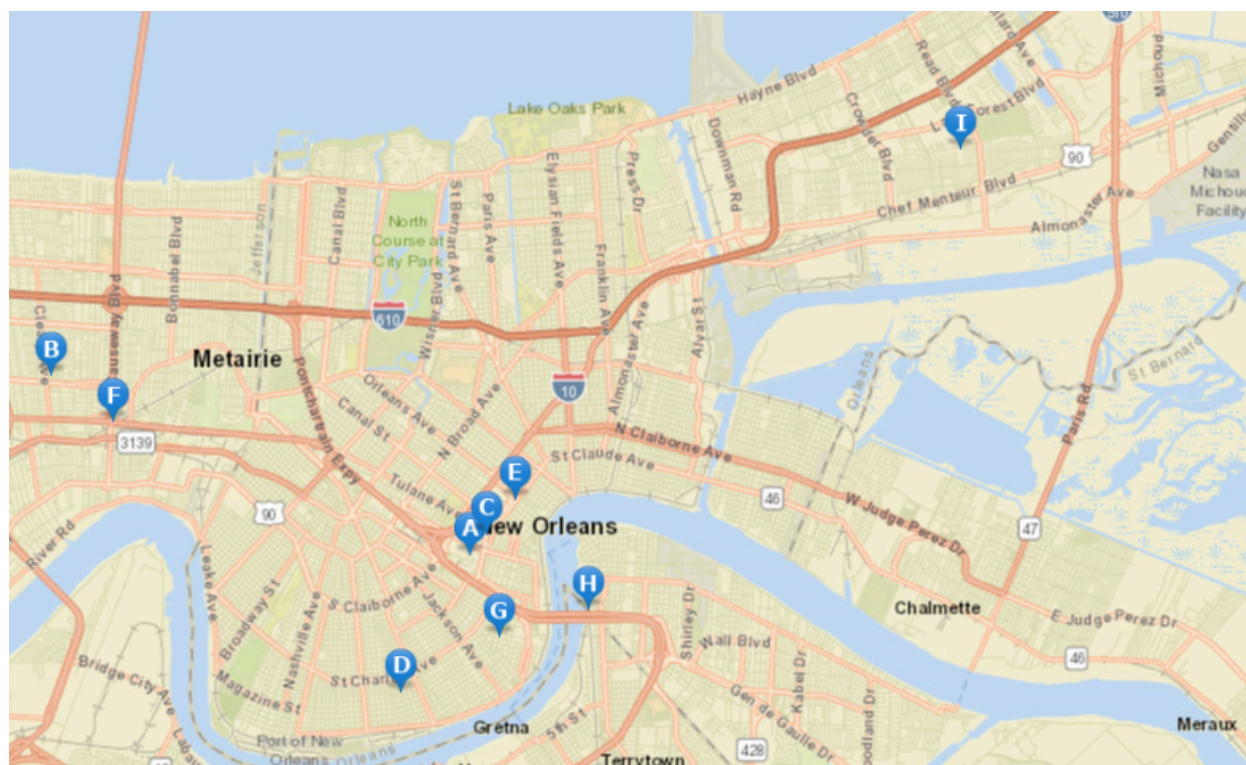
neighborhoods with high rates of poverty, with over seventy-four percent of residents living below twice the poverty line.<sup>23</sup> These sites provided care to insured and uninsured patients, including primary and family care, behavioral health care, and HIV care.<sup>23</sup> They served 17,500 people in 2004.

#### Other Clinics and Sites

New Orleans had other clinics and health care sites that served the uninsured within specific communities, including five school-based health centers. Notably, the St. Thomas Health Clinic, part of the St. Thomas housing development, provided primary care to those living in the development and in five surrounding ZIP codes.<sup>22</sup> While these clinics did not have a broad reach, they are notable for their provision of low-cost health care within their communities.



Figure 2. Safety Net Health Care Sites in New Orleans, October 2006



#### Key

**A:** Medical Center of Louisiana Temporary Site  
**B:** Elmwood Hospital (Charity's temporary replacement)  
**C:** Tulane University Hospital  
**D:** Touro Infirmary Hospital

**E:** Tulane Community Health Center at Common Ground  
**F:** Daughters of Charity—Metairie  
**G:** St. Thomas Health Center  
**H:** Common Ground Clinic  
**I:** Operation Blessing Clinic

#### One Year Later: September 2005 - October 2006

Hurricane Katrina and the resulting floods had a devastating effect on the health care infrastructure of New Orleans, and its safety net health care system in particular. With more than 80% of the city flooded, all hospitals in the cities closed during the duration of the storm, and most remained closed for months.<sup>27</sup> By November 2005, only two of New Orleans's eight pre-

Katrina hospitals had reopened, and fewer than fifteen percent of the physicians in the city had returned.<sup>20</sup> Neither Charity Hospital nor University Hospital, the two public hospitals in the city, reopened. EXCELth's network of clinics, the only federally qualified health center in the city besides the city health department's Health Care for the Homeless program, was devastated.

In October 2006, New Orleans's population was less than half pre-storm levels.<sup>28</sup> 187,525 of 484,672 people had returned, about half of the previous 4,000 hospital beds were available, and nineteen of ninety clinics of all types had reopened.<sup>29</sup> However, these beds and clinics were almost exclusively private, those that had provided so little of the safety net care before the storm. More than a year after the storm, critical care was still provided through a disconnected hodgepodge of free, temporary, and relocated clinics, many outside of the city limits. According to a Kaiser survey of New Orleans households in October 2006, ninety percent of respondents felt that there were not enough health care services, including hospitals, clinics, and other medical facilities, in the New Orleans area.<sup>29</sup>

#### Medical Center of Louisiana Temporary Site & Elmwood Hospital

Charity and University Hospitals both flooded extensively during the storm. In the aftermath of the storm, MCLNO set up a temporary site in a parking lot to continue to provide critical services.<sup>22</sup> Once flooding subsided, the site was moved first to the Ernest N. Morial convention center, which had hosted evacuees in the aftermath of the storm.<sup>30</sup> Called "The Spirit of Charity" while located at the convention center, MCLNO provided minor emergency care, from including setting fractures and stitching wounds to managing overdoses.<sup>30</sup> In December 2005, this site had more than 4,500 patient visits.<sup>30</sup>

By October 2006, the temporary clinic moved to a former Lord & Taylor department store at a closed mall in the Business District, not far from the still-shuttered Charity Hospital.<sup>20</sup> The facility continued to provide emergency care, including psychiatric care.<sup>20</sup> Meanwhile, University Hospital was being repaired, with plans to reopen. No such plans existed for Charity Hospital.

Eight months after the storm, in April 2006, Louisiana State University reopened Charity's Level 1 Trauma Center at Elmwood Hospital, owned by the private Oschner Clinic Foundation.<sup>9</sup> Elmwood was located in neighboring Metairie, outside of New Orleans city limits. While the New Orleans area now had a functioning trauma center, it still did not have an adequate public hospital. Indigent patients reported traveling seventy-five miles to the public hospital in Baton Rouge.<sup>7</sup>

### Other Hospitals

The closure of Charity Hospital and its associated clinics left uninsured patients without a source of care. The three private hospitals that had reopened by October 2006, Children's Hospital, Touro Infirmary, and Tulane Hospital, had no plan to provide care for the population previously served by Charity.<sup>29</sup> However, New Orleans's lack of a public hospital equipped to handle more than minor emergencies meant many patients, especially those in need of emergency care, had no choice but to go to private hospitals. Additionally, the storm left a still undetermined number of people who previously had private insurance uninsured, due to disaster related job loss.<sup>29</sup>

Taken together, these factors placed an unprecedented burden of uncompensated care on private hospitals, as well as straining their emergency rooms. Touro Infirmary's uncompensated

care went from approximately \$17 million per year pre-Katrina to \$41 million in 2006. Their emergency room visits rose from 20,000 to 30,000 per year in the same period.<sup>29</sup> However, because Medicaid DSH funds were still allocated to state-run hospitals, New Orleans's private hospitals did not receive funding to offset this spike in uncompensated care. Furthermore, Louisiana cut Medicaid reimbursement by ten percent to stretch Medicaid funding in the aftermath of the disaster.

In response to concerns from private hospitals that they could not sustain such a level of uncompensated care and reduced Medicaid reimbursement, both the federal and state governments provided relief funding. Congress provided \$680 million in Medicaid relief and \$134 million in uncompensated care reimbursement to Louisiana in 2006.<sup>29</sup> The state of Louisiana provided \$52 million in uncompensated care funding to hospitals in 2006, and \$28 million to increase Medicaid payments.<sup>29</sup> However, these stopgap measures did not represent a change in long-term Medicaid DSH funding strategy; without such a change, the issue of uncompensated care at private hospitals would persist.

#### Free and Temporary Clinics

In the year following Hurricane Katrina, much of the care for all patients in New Orleans and patients without insurance in particular was administered by a variety of temporary and free clinics throughout the city. The first temporary clinic, a "floating trauma center," was a Navy hospital ship docked in the Port of New Orleans in the first week of September 2005.<sup>31</sup> However, the ship saw no more than 100 patients in its two weeks, demonstrating the limited reach of its services in the aftermath of the disaster.

In total, about twenty permanent and temporary clinics opened or re-opened in the year following Hurricane Katrina to serve the low-income population of New Orleans.<sup>9</sup> This group included four mobile clinics, with one specifically serving the city's Latino population.<sup>9</sup> It also included many temporary clinics, such as a 7-day pop up clinic at the Audubon Zoo in February 2006.<sup>29</sup> The clinic, run by the New Orleans Health Department and staffed by volunteers, saw 5,212 patients, including some who had to be taken to hospitals for emergency care. The clinic included eyeglasses, dentures, immunizations, cancer screenings, 30-day supplies of prescriptions, and referrals for follow-up care as well as a host of other services.<sup>29</sup> The huge demand for this clinic demonstrates the significant lack of access to affordable health care in the year following Hurricane Katrina.

#### New and Re-Opened Permanent Clinics

##### The Tulane Community Health Center at Covenant House

In early September 2005, the Tulane Community Health Center at Covenant House began as a card table with first-aid supplies.<sup>29</sup> The makeshift clinic, staffed by Tulane University Hospital providers, eventually became a full-service clinic out of a former boy's dormitory at Covenant House, a youth shelter.<sup>32</sup> The clinic became, in the words of its executive director, a prototype medical home for patients.<sup>29</sup> The clinic provided free care, not just to children at Covenant House but to uninsured adults in the community.<sup>29</sup>

##### Common Ground Clinic

In Algiers, a neighborhood in eastern New Orleans, a group of medical volunteers and activists formed Common Ground Clinic in the days and weeks following the storm.<sup>33</sup> Originally

a few providers biking around the neighborhood taking blood pressure levels, the organization eventually began operating out of a mosque.<sup>33</sup> The clinic provided full-service, free care to an area of the city left without any public clinics.<sup>34</sup>

### Daughters of Charity

Although the Daughters of Charity were forced to close their clinic in New Orleans after Hurricane Katrina, they re-opened forty-five days after the storm in neighboring Metairie.<sup>22</sup> Although not within the city limits, they were still able to provide low-cost care while they began the process of re-opening a clinic within New Orleans and expanding their services.<sup>22</sup>

### St. Thomas Community Health Center

St. Thomas Community Health Center, a health center focused on providing care to its immediate surrounding community within a housing development, reopened six weeks after Katrina.<sup>29</sup> Immediately, the clinic saw patients from all over the city, including a significant number of patients without health insurance. The clinic increased its services to provide primary care, preventative care, and specialty consultations.<sup>29</sup> The clinic became the only site in the city where an uninsured woman could receive a mammogram and follow-up care.<sup>29</sup>

### Odyssey House

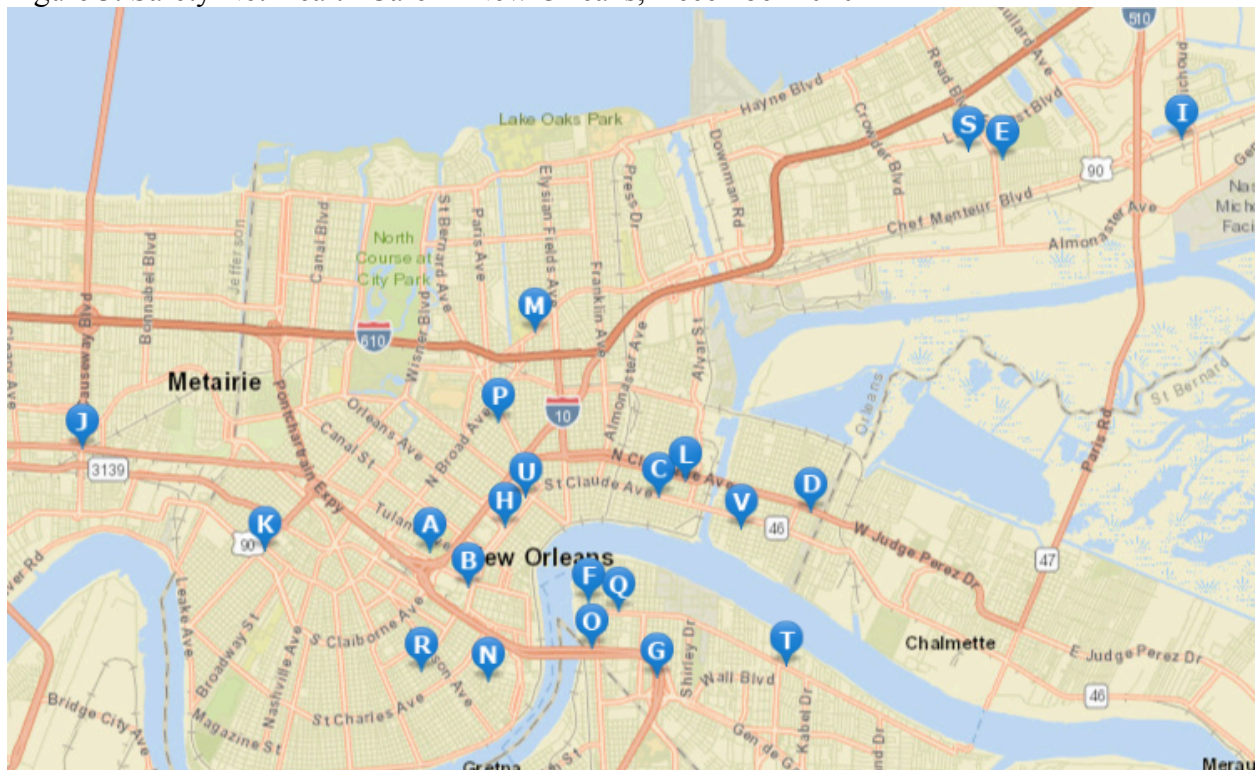
Odyssey House Louisiana, a substance abuse treatment program, began offering a full-service medical clinic in January 2006 in response to community need for health care services.<sup>35</sup> The clinic was staffed with Common Ground and LSU personnel and provided free care. The clinic quickly became part of the Katrina Aid Today consortium, a Federal Emergency

Management Agency initiative that allowed them to access significant funding. By August 2006, they had expanded their mission to include social services for people returning to New Orleans, services for people recently released from prison, and job training programs in addition to its free medical clinic and substance abuse services.<sup>35</sup>

### Operation Blessing Clinic

Operation Blessing International, a Christian nonprofit, began a full medical and dental clinic in New Orleans East April 2006.<sup>36</sup> The clinic, staffed by volunteers, saw between 75-100 patients a day, over 50% of whom had high blood pressure and 26% had diabetes.<sup>29</sup> The clinic's location had previously been served by a community health center operated by EXCELth that closed in the wake of the storm. The hospital that had served New Orleans East, Methodist Hospital, had also closed after the storm. Operation Blessing became a primary source of care for this significant portion of New Orleans.

Figure 3. Safety Net Health Care in New Orleans, December 2010



### Key

- |   |  |
|---|--|
| <b>A:</b> LSU Interim Public Hospital     | <b>L:</b> Daughters of Charity St. Cecelia         |
| <b>B:</b> LSU Clinics at Lord and Taylor  | <b>M:</b> Daughters of Charity Gentilly            |
| <b>C:</b> LSU Frederick Douglass Clinic   | <b>N:</b> St. Thomas Health Center                 |
| <b>D:</b> LSU Jackson Barracks Clinic     | <b>O:</b> Common Ground Clinic                     |
| <b>E:</b> LSU New Orleans East Clinic     | <b>P:</b> Odyssey House                            |
| <b>F:</b> LSU Martin Behrman Clinic       | <b>Q:</b> Ida Hymel Health Center                  |
| <b>G:</b> LSU Henderson Clinic            | <b>R:</b> Edna Pillsbury Health Center             |
| <b>H:</b> Tulane CHC at Covenant House    | <b>S:</b> New Orleans East Family Health Center    |
| <b>I:</b> NOLEA Clinic                    | <b>T:</b> EXCELth Algiers Clinic                   |
| <b>J:</b> Daughters of Charity Metairie   | <b>U:</b> Anna's Place Medical Mission             |
| <b>K:</b> Daughters of Charity Carrollton | <b>V:</b> Lower 9 <sup>th</sup> Ward Health Clinic |

**Building a New System: November 2006- December 2010**



Huge health disparities and gaps in access to health care persisted in New Orleans between 2006 and 2010. In 2007, 1 in 4 residents of New Orleans had no regular provider of health care other than the emergency room, including 54% of the uninsured.<sup>29</sup> 49% of residents in the Greater New Orleans area reported problems with health care access.<sup>29</sup> In 2008, 25% of the non-elderly in New Orleans was uninsured and 24% had some sort of public insurance coverage, each significantly higher than the national average.

A study of emergency room admissions data from 2009 and 2010 demonstrated a persisting correlation between race, poverty, and high rates of emergency room utilization. The New Orleans ZIP codes with the highest rates of ER admissions were both predominantly African American and had the highest concentration of poverty.<sup>37</sup> This may indicate that the populations of these zip codes had higher rates of emergency medical conditions or had less access to regular health care coverage than the city's whiter, wealthier zip codes.

Although access to safety net health care in New Orleans was still a challenge by December 2010, two federal grants provided funding that allowed for significant expansion of the health care safety net between 2006 and 2010. The first, the Primary Care Access and Stabilization Grant (PCASG), was designed to support safety net primary care and behavioral health care in the greater New Orleans area. The second, the American Reinvestment and Recovery Act of 2009 (ARRA), was an economic stimulus package that included several grant programs for Federally Qualified Health Centers. Due to these grants, safety net health care sites proliferated within the city between 2006 and 2010.

#### Primary Care Access and Stabilization Grant

In September 2007, the Centers for Medicare and Medicaid Services awarded Louisiana with the PCASG for the four parishes that comprise the Greater New Orleans area.<sup>38</sup> The grant provided for \$100 million dollars over three years to increase access to high-quality health care for all residents and to promote sustainable primary care for low income and uninsured residents.<sup>38, 22</sup> The grant, administered by the Louisiana Public Health Institute, was broken into awards for individual public and private nonprofit organizations.<sup>38,22</sup>

Payments were awarded to twenty-five organizations in the greater New Orleans area, allocated in seven payments between 2007 and 2010.<sup>38,22</sup> Payments were based on both numbers of providers and patients, weighed by patient demographic, service type, and payer mix.<sup>38</sup> The program required grantees to submit sustainability plans with their applications, and established standards for quality and access at all PSASG clinics.<sup>38,22</sup> The PCASG program also established a voluntary Quality improvement Incentive Payment Program, which offered bonus payments to clinics recognized by the National Committee on Quality Assurance as medical homes.<sup>38</sup> By December 2009, the PCASG had supported 91 primary care and behavioral health clinic sites in the greater New Orleans area, 50 in New Orleans.<sup>38,22</sup> They had collectively served 252,000 patients.<sup>22</sup> Thirty-one clinics in New Orleans had received NCQA recognition.<sup>38</sup>

#### American Reinvestment and Recovery Act

The American Reinvestment and Recovery Act provided funding for three grant awards for Federally Qualified Health Centers: New Access Point (NAP) Awards, for FQHCs expanding to new sites, Increased Demand for Services (IDS) awards, for health centers with growing numbers of patients, and Capital Improvement Project (CIP) awards, for construction or renovation projects.<sup>22</sup> Funding from ARRA supported three FQHCs in New Orleans. EXCELth

received IDS and CIP awards, City of New Orleans Health Department Health Care for the Homeless received IDS and CIP awards, and St. Thomas Community Health Center received NAP, IDS, and CIP awards. By December 2010, New Orleans FQHCs had received about \$7.4 million in ARRA funding.

### University and Methodist Hospital

While University Hospital was renovated and reopened in a limited capacity as LSU Interim Hospital in November of 2006, private hospitals in New Orleans still assumed large amounts of care for the uninsured. Tulane had provided \$6.8 million in uncompensated care in 2007.<sup>29</sup> Louisiana Medicaid DSH funds were still directed to public hospitals, but the state provided \$120 million in uncompensated care relief for hospitals in 2007.<sup>29</sup>

Methodist Hospital, in New Orleans East, remained closed. In July 2010, the city of New Orleans bought the old Methodist Hospital site with plans to renovate and re-open the hospital by 2013. At the time, New Orleans East had no hospital services.<sup>39</sup>

### Free, Temporary, and Mobile clinics

While new fixed health centers began to open across New Orleans, free, temporary, and mobile clinics still provided a significant amount of care for uninsured and low-income residents. EXCELth, Daughters of Charity, and Tulane all operated mobile clinics.<sup>40</sup> Tulane's mobile clinic, financed through a donation from the State of Qatar, provided services four days each week at different apartment complexes, churches, and schools.<sup>40</sup> After the success of their first free clinic in February 2006, Operation Blessing ran a second free clinic in February 2007, staffed by volunteers from around the country. The clinic provided prescriptions, vision and dental care, immunizations, and cancer screenings.<sup>29</sup> Another group, the National Association of

Free Clinics, operated a two-day free clinic in August 2010, which provided services limited to primary care.<sup>41</sup> St. Anna's Medical Mission, which had previously operated a free mobile clinic, became Anna's Place, a twice-weekly clinic operated out of a parked bus in the parking lot of St. Anna's Episcopal Church. The clinic provided free primary care services, health education, and referrals.<sup>42</sup>

### LSU Primary Care Clinics

Louisiana State University opened six primary care community health clinics in March of 2008, supported by the PCASG.<sup>43</sup> Three of clinics, Murray Henderson and Frederick Douglass in the West Bank and Martin Behrman in the Upper Ninth Ward, provided primary care, pediatric care, hearing and vision screenings, vaccinations, chronic disease management, sexually transmitted disease screenings and treatment, smoking cessation programs, telemedicine services, and assistance with accessing specialty care and prescriptions.<sup>43</sup> Two of the clinics, Jackson Barracks in the Lower Ninth Ward and the New Orleans East clinic in New Orleans East (the former Operation Blessing clinic), provided primary care, pediatrics, obstetrics and gynecology services, prenatal care, telemedicine, behavioral health care and prescription assistance.<sup>43</sup> LSU also opened a school-based health clinic at this time.

LSU continued to operate a variety of specialty clinics at the old Lord and Taylor department store, as well as a clinic for musicians, an HIV clinic, two dental clinics, and an ophthalmology clinic. Taken together, these clinics saw 76,370 patients in between September 2007 and September 2008 and 65,463 patients between September 2008 and September 2009.<sup>22</sup>

### City of New Orleans Health Department Clinics

The City of New Orleans Health Department opened three primary health care clinics, in addition to re-opening their Health Care for the Homeless program.<sup>44</sup> The clinics, in New Orleans East, Algiers, and Central City, served three of the poorest areas of the city and provided social services, such as WIC enrollment.

### Tulane Clinics

Between 2006 and 2010, Tulane operated eight health care sites for uninsured and low-income populations, including school based health centers and mobile clinics. They operated two fixed sites open to the broader community: Covenant House and the NOELA clinic.

The Tulane University Community Health Clinic at Covenant house continued to provide free care and serve as a medical home for patients through 2010. The clinic received PCASG funding<sup>29</sup> and was recognized by the NCQA as a Patient Centered Medical Home.<sup>29</sup>

The NOELA (New Orleans East Louisiana) Clinic began as a partnership between Tulane and the Mary Queen of Vietnam Community Development Corporation, a nonprofit dedicated to community development in the Vietnamese-American community in New Orleans East. The clinic opened in 2008 and provided care for the entire New Orleans East community.<sup>29</sup>

### Lower Ninth Ward Health Clinic

The Lower Ninth Ward Health Clinic began when two former employees of Charity Hospital, a nursing supervisor and a registered nurse, decided to open a clinic at one of their homes in the Lower 9<sup>th</sup> Ward to address health care access in the geographically isolated neighborhood.<sup>22</sup> The clinic opened in February of 2007. The clinic was intentionally designed as a medical home and initially staffed by volunteers.<sup>22</sup> The mission of the clinic was to prevent ER

visits and hospitalizations and improve quality of life in the Lower Ninth Ward. The clinic was awarded PCASG funds, which allowed it to employ staff and provide services.<sup>22</sup>

By December 2009, the clinic served over 2,200 regular patients.<sup>22</sup> The clinic had implemented chronic disease management programs, individualized patient education, and preventative care screenings.<sup>22</sup> 90% of the clinic's patients were uninsured. Unfortunately, the end of the PCASG program forced the clinic to close in December 2010.<sup>45</sup>

### EXCELth

EXCELth received PCASG funding and continued to provide mobile health care throughout the city, as well as operate two clinics, the New Orleans Family Health Center in New Orleans East and the Algiers Community Health Center in Algiers. In 2007, the Algiers Community Health Center received a \$17,000 grant from the pharmaceutical company AstraZeneca.<sup>26</sup> In 2009, the NCQA recognized the Algiers Community Health Center as a Patient-Centered Medical Home.

### St. Thomas

St. Thomas grew significantly due to PCASG funding. The PCASG allowed St. Thomas to grow its staff to 45 people and hold over 22,000 patient visits by 2009.<sup>22</sup> Seventy-two percent of St. Thomas patients were uninsured.<sup>22</sup> St. Thomas grew to provide care for much more of the city, as well as provide specialty care. While before Hurricane Katrina, St. Thomas served patients from three to five zip codes within New Orleans. By 2009, the clinic saw patients from 251 zip codes.<sup>22</sup> In addition to primary care, the clinic provided breast and cervical cancer

screening, cardiovascular care, screening for diabetic retinopathy and glaucoma, and treatment for ear, nose, and throat cancers for the uninsured.<sup>22</sup>

The clinic also became a Federally Qualified Health Center, but was still reliant on PCASG funds as the FQHC annual grant only made up 14% of their budget.<sup>22</sup> They found that FQHC Medicaid rates did not help their budgetary stability, as only 14% of St. Thomas patients had Medicaid.<sup>22</sup> However, FQHC status allowed St. Thomas to receive funding through ARRA. A New Access Point Award allowed them to plan to open a second St. Thomas Clinic.<sup>22</sup>

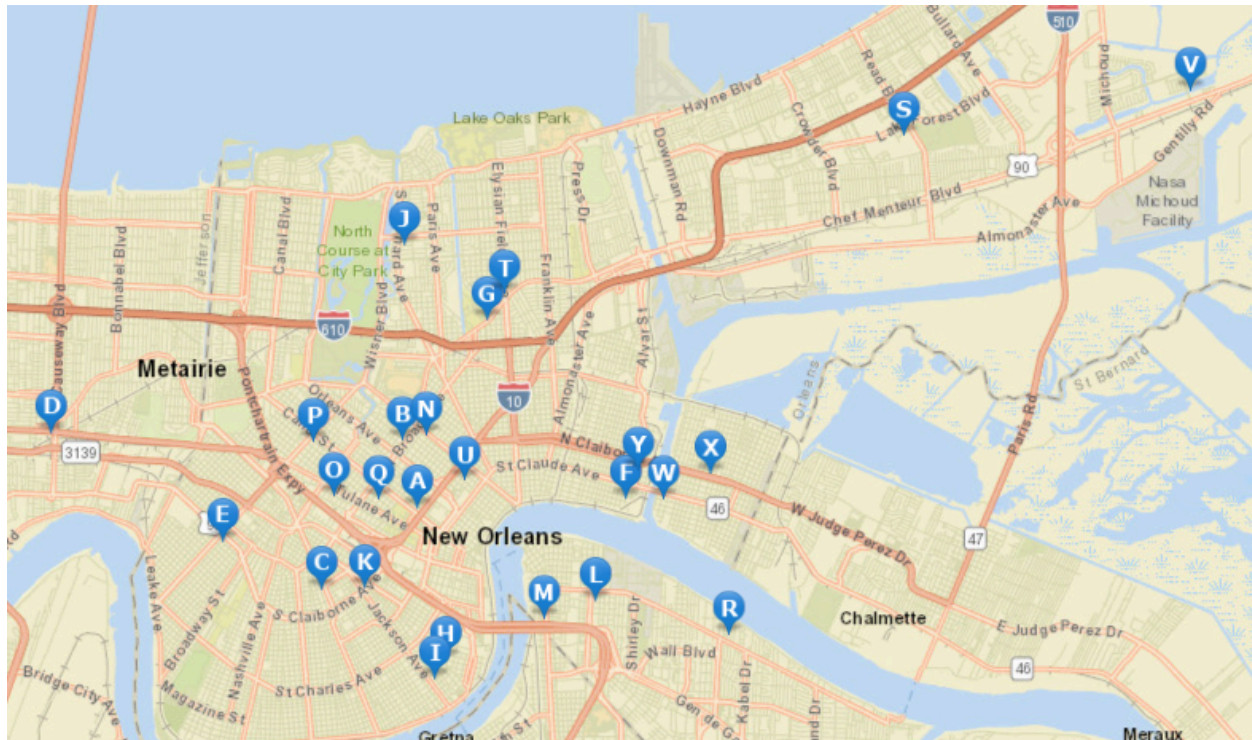
### Daughters of Charity

The Daughters of Charity received a PCASG award, which allowed them to expand from their post-Katrina site in Metairie to two new health centers, one in Carrollton and one in the Upper Ninth Ward.<sup>22</sup> Fifty percent of their budget came from PCASG funds. By December 2009, these health centers had provided 65,509 patient visits.<sup>22</sup> This includes a forty-nine percent increase in patients between 2008 and 2009. Seventy-two percent of Daughters of Charity's patients were uninsured, and fifteen percent were on Medicaid.<sup>22</sup> Daughters of Charity clinics also provided free pharmaceuticals and mental health services. All three clinics received NCQA recognition.

### Common Ground

Common Ground continued to provide community health services, with plans to expand to a larger clinic space. They received NQAC recognition in 2009 as a patient-centered medical home.<sup>46</sup> The clinic saw 4,100 patients in 2010, eighty five percent of whom were uninsured.<sup>47</sup>

Figure 4. Safety Net Health Care Sites in New Orleans, December 2017

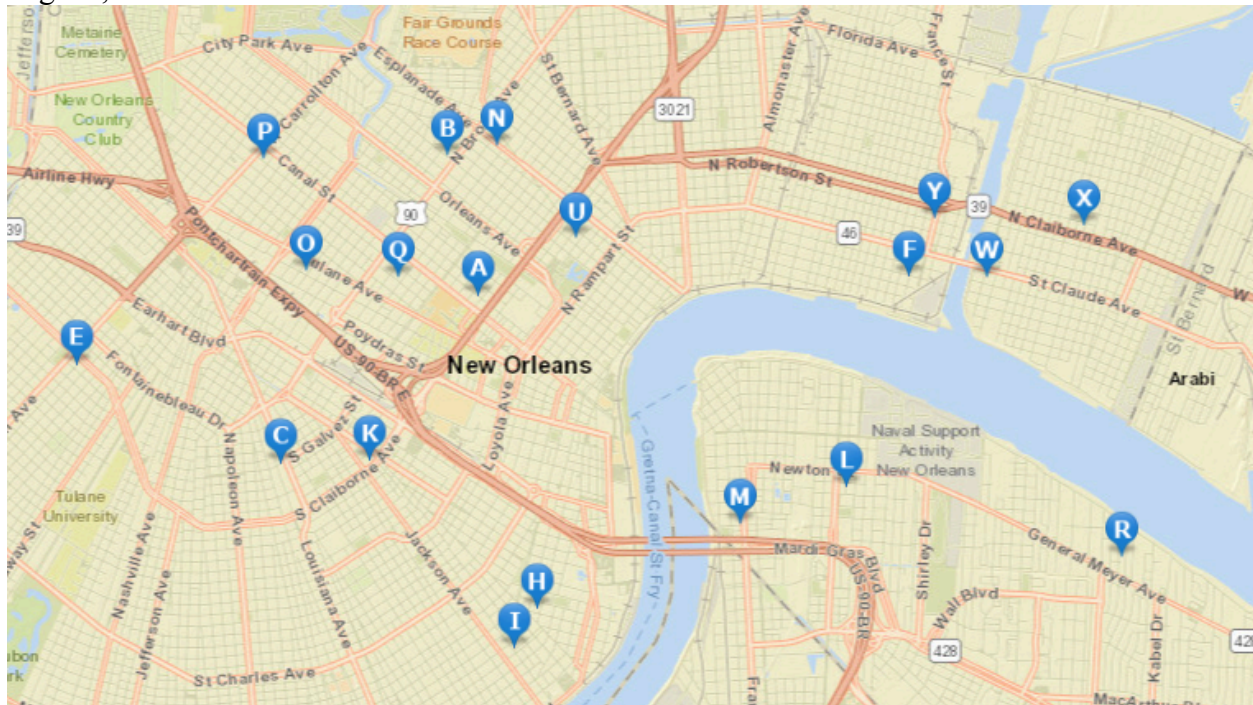


#### Key

<b>A:</b> University Medical Center	<b>N:</b> Odyssey House
<b>B:</b> Ruth E. Fertel Community Health Center	<b>O:</b> CrescentCare
<b>C:</b> South Broad Community Health Center	<b>P:</b> CrescentCare Family Services
<b>D:</b> Daughters of Charity Metairie	<b>Q:</b> CrescentCare Mid-City
<b>E:</b> Daughters of Charity Carrollton	<b>R:</b> EXCELth Algiers
<b>F:</b> Daughters of Charity St. Cecelia	<b>S:</b> EXCELth New Orleans East
<b>G:</b> Daughters of Charity Gentilly	<b>T:</b> EXCELth Gentilly
<b>H:</b> St. Thomas St. Andrews Health Center	<b>U:</b> Anna's Place Medical Mission
<b>I:</b> St. Thomas Donald T. Erwin Health Center	<b>V:</b> NOLEA Community Health Center
<b>J:</b> St. Thomas Columbia Parc Health Center	<b>W:</b> Baptist Community Health Center, Location 1
<b>K:</b> St. Thomas Mahalia Jackson Health Center	<b>X:</b> Baptist Community Health Center, Location 2
<b>L:</b> St. Thomas L. B. Landry Health Center	<b>Y:</b> Baptist Community Health Center, Location 3
<b>M:</b> Common Ground Clinic	



Figure 4. Safety Net Health Care Sites in New Orleans, December 2017: Central City, Midcity, Algiers, and New Orleans East



### Continued Development: January 2011- December 2017

Between 2011 and 2017, poverty and health disparities persisted in New Orleans. In 2011, New Orleans reported higher rates of premature deaths, children in poverty, STIs, and violent crime, and higher percentages of low birth weight babies and people without insurance, than the rest of the state. Rates of emergency room admissions at LSU Interim Public Hospital for preventable and chronic conditions were higher in areas with higher rates of poverty.<sup>37, 48</sup> Poverty persisted in neighborhoods such as Central City, Gert Town, the Seventh Ward, and the Lower Ninth Ward, and these neighborhoods also reported the lowest numbers of prenatal care recipients in 2013.<sup>48</sup>

However, the primary care safety net continued to grow significantly. By 2013, the safety net had the capacity to reach 80% of the city's low-income population.<sup>48</sup> Average reported wait

time to schedule an appointment across safety-net clinics was less than one week.<sup>48</sup> Health and Human Services secretary Kathleen Sebelius recognized New Orleans's safety net care system as a national model.<sup>48</sup>

The rapid and continued expansion of community-based, safety net primary health care in New Orleans was only possible due to a combination of federal grants, federal policies, and community organizing. Communities within New Orleans who sought local, affordable health care for their residents started many of the clinics that opened and expanded between 2011 and 2017.

#### Factors in the Increase In Community Safety-Net Primary Care

##### Greater New Orleans Community Health Connection

Several grants and programs facilitated the continued growth of safety net primary health care in New Orleans. With the end of the Primary Care Access and Stabilization Grant, the Louisiana Department of Health of Human Services submitted a proposal to CMS for a Medicaid section 1115 waiver, titled Greater New Orleans Community Health Connection (GNOCHC). The waiver proposed a demonstration that would continue funding PCASG participating organization, reduce DSH funding, and support primary care medical homes.<sup>44</sup> The demonstration provided health care coverage for residents of the Greater New Orleans area with incomes up to 200% of the federal poverty line who were not eligible for Medicaid, CHIP, or Medicare and who had been uninsured for at least six months.<sup>44</sup> Those eligible could receive care without cost sharing through GNOCHC participating sites, all of which had been PCASG participating sites.<sup>44</sup> CMS approved the waiver from October 1, 2010 through December 31, 2013 and extended the program through December 2014.<sup>44</sup>

GNOCHC coverage provided primary and behavioral health care, preventative care including immunizations, laboratory and radiology services, substance disorder treatment, and care coordination. It also provided for any specialty care provided by a GNOCHC provider or provided through a referral agreement with a GNOCHC provider. Providers received unique encounter rates, as well as quarterly incentive payments for NCQA Patient Centered Medical Home recognition.<sup>44</sup> The program also provided infrastructure improvement grants to sites for purchasing population health management or telemedicine systems, staff training, and NCQA PCMH application fees.

By 2014, there were 42 GNOCHC participating providers in the greater New Orleans area.<sup>44</sup> The Louisiana DHH submitted a proposal for the program's renewal, which was approved with alterations: the program was thereafter limited to those below 100% of the FPL, and requirement that participants be uninsured for six months prior to enrollment was removed.<sup>44</sup>

At the end of 2014, 56,393 people were enrolled in GNOCHC, and the program continued to grow. 60,531 patients were enrolled by September 2015.<sup>44</sup> Many GNOCHC providers were dependent on the program, reporting that GNOCHC revenue accounted for, on average, forty-one percent of their total patient revenue. Twenty-one percent of providers reported that GNOCHC revenue accounted for more than seventy-five percent of their patient revenue. On average, thirty percent of patients at GNOCHC sites were GNOCHC enrollees, and twenty-eight percent were uninsured.<sup>44</sup>

In 2014, the GNOCHC program was extended through December 2016.<sup>49</sup> The GNOCHC program ended when Louisiana expanded Medicaid, which covered the GNOCHC population, effective July 1<sup>st</sup>, 2016.<sup>44</sup>

### Beacon Community Program

New Orleans received a second significant health care grant in 2010, a Beacon grant from the Department of Health and Human Services Office of the National Coordinator for Health Information Services.<sup>50</sup> The grant was designed to improve local health information technology systems, with the goals of improving population health and lowering health care costs.<sup>50</sup> The three-year, \$13.5 million grant established the Greater New Orleans Health Information Exchange to manage a city-wide health information technology structure.<sup>50</sup> The grant was divided into \$100,000 grants to twelve sites and used to implement care coordination at those sites that linked primary care to hospitals and specialty service providers.<sup>50</sup> The grant allowed many safety net clinics in New Orleans to better coordinate care and referrals for their patients. The grant allowed for better care coordination for more than a quarter of a million patients.<sup>50</sup>

### Medicaid Expansion

Louisiana expanded Medicaid in July 2016.<sup>6</sup> In the program's first year, 52,393 people in New Orleans signed up for expanded Medicaid, including many who had previously had GNOCHC coverage.<sup>6</sup> Although it is soon to tell the impact of Medicaid expansion on primary care safety net providers in New Orleans, it extended the financing many clinics relied on from GNOCHC. It also likely reduced the number of uninsured patients clinics encountered and allowed them to increase their financing from Medicaid reimbursement; across Louisiana, the total number of residents without insurance decreased from 21.7% in 2013 to 12.7% in 2017.<sup>6</sup>

### 504 HealthNet

504 HealthNet is an organization of health care providers in the Greater New Orleans area dedicated to increasing access to high quality, medical-home based care, regardless of the ability to pay.<sup>51</sup> The organization grew out of the increase in safety net clinics from the PCASG. 504 HealthNet works with health care providers that accept Medicare, Medicaid, and uninsured patients, and helps clinics coordinate between each other and improve quality of care.

504 HealthNet engages in advocacy work and outreach and provides services for member clinics. They advocated for the implementation of the GNOCHC program and for Louisiana's Medicaid expansion.<sup>52</sup> They work to connect people with services at their member clinics. They also provide training opportunities and technical support for member clinics.<sup>52</sup> The presence of 504 HealthNet helps provide the support that allows for sustainable community-based safety net care in New Orleans.

### Clinic Closures and Transfers

#### Louisiana State University Clinics

LSU's clinics were GNOCHC participants and a Crescent City Beacon Community Program member. LSU received two infrastructure improvement grants from GNOCHC for the clinics, one in 2011 and one in 2013.<sup>44</sup> In 2015, most of LSU's clinics closed, although one in Algiers was taken over by St. Thomas. The Interim LSU Public Hospital closed as well, and its operations, along with the clinics, were relocated to the new University Medical Center, designed to replace Charity Hospital and University Hospital.<sup>53</sup> The LSU clinics that had been operating in an old Lord and Taylor department store since shortly after Hurricane Katrina finally had a

permanent home, but the community-based clinics had been re-absorbed into the centralized, Charity Hospital model. Ten years after Katrina, Charity had been replaced.<sup>54</sup>

#### City of New Orleans Health Department

The City of New Orleans Health Department was a GNOCHC participating provider.<sup>44</sup> However, their three sites all transferred to private ownership in 2011.<sup>55</sup> The city government viewed private clinics as more efficient and believed they were able to provide higher quality care at lower costs, as medical homes with more efficient electronic medical records systems. Dr. Karen DeSalvo, then the New Orleans Health Commissioner, cited the PCASG's role in the growth of community health in New Orleans as the enabling factor in the transfer.<sup>55</sup>

#### Tulane

Tulane became a GNOCHC participating provider. They continued to provide mobile health services and operate the Covenant House and NOLEA Community Health Centers. In 2011, Tulane transferred operation of NOELA to Mary Queen of Vietnam Community Development Corporation, the community partner that co-founded NOELA.<sup>44</sup>

In May 2012, Tulane relocated the community health center at Covenant House to a new location and renamed it the Ruth U. Fertel/Tulane Community Health Center.<sup>56</sup> Tulane continued to provide drop-in primary and behavioral health care to children and youth at the Covenant House location.<sup>53</sup> In March 2013, Tulane transferred ownership of Ruth U. Fertel/Tulane Community Health Center to Access Health Louisiana, an organization that operates community health centers throughout Louisiana.<sup>44</sup>

## Sustained Operations

### Common Ground Health Clinic

Common Ground Health Clinic was a GNOCHC participant and received a GNOCHC infrastructure grant in 2013. The clinic became a Federally Qualified Health Center in November 2013 and now provides full adult and pediatric primary care and behavioral health care services.<sup>57</sup> They are a Crescent City Beacon Community Program member.

### Odyssey House

Odyssey House continued to provide primary care as well as behavioral health care. They were a GNOCHC participant and became a Federally Qualified Health Center.<sup>58</sup> They received a GNOCHC infrastructure grant in 2012 and another in 2013.

### Anna's Place Medical Mission

Anna's Place Medical Mission is a twice-weekly free services clinic that provides urgent care, screenings, vaccinations, and health education.<sup>42</sup> Operating out of a parked RV in the parking lot of St. Anna's Episcopal Church, the medical mission offers limited services but provides referrals to other clinics.<sup>59</sup> The RV was originally a mobile clinic that operated across the Greater New Orleans area.

## Expansion, Development, and Community Investment

### Mary Queen of Vietnam Community Development Corporation

MQVCDC assumed operation of the NOELA Community Health Center in 2011. The clinic was opened in response to the needs of a large Vietnamese community in New Orleans

East, which previously did not have a significant source of health care. The center participated in GNOCHC and received 2 GNOCHC infrastructure improvement grants in 2011, and one in 2013.<sup>44</sup> They are also a member of the Crescent City Beacon Community Program. NOELA provides primary care services for adult and pediatric populations, as well as OB/GYN services, chronic disease management, health education, and behavioral health services.<sup>60</sup> The clinic is able to provide language services for its Vietnamese patients, an underserved group in New Orleans.

#### Daughters of Charity

Since 2011, Daughters of Charity has expanded their number of clinics and services. They were a GNOCHC participant and are a Crescent City Beacon Community Program member. In March 2012, Daughters of Charity affiliated with Marillac Community Health Centers in order to achieve Federally Qualified Health Center Look-Alike status for their Carrollton, Gentilly, and Metairie locations.<sup>44</sup> In May 2012, Daughters of Charity took over the New Orleans East city clinic at the old Methodist hospital site.<sup>44</sup> In 2014, they partnered with the LSU School of Medicine's obstetrics program to offer OB/GYN services.<sup>44</sup>

#### EXCELth

Between 2011 and 2017, EXCELth grew substantially across New Orleans. They opened two health centers in 2011, one in Gentilly and one in Algiers, replacing their former Algiers site and re-opening in their pre-Katrina location.<sup>26</sup> They also took over the operations of the city's Ida Hymel Health Center and referred those patients to the new Algiers site. EXCELth also



opened their New Orleans East site in 2014. EXCELth was a GNOCHC participant and Crescent City Beacon Community Program member.<sup>44</sup>

#### St. Thomas

St. Thomas grew significantly from 2011 to 2017. Their clinics were GNOCHC partners and Crescent City Beacon Community Program members. They received GNOCHC Infrastructure grants in 2011 and 2013. In 2011, they took over the patients of the New Orleans Health Department Edna Pillsbury Health Clinic and referred patients to the nearby St. Thomas Mahalia Jackson clinic.<sup>57</sup> In 2012, they opened the Donald T. Erwin Center and relocated their primary care services to that site, re-designating the original St. Thomas site for specialty care services.<sup>44</sup> They took over the former LSU clinic in Algiers in 2015.<sup>61</sup> They also began operating a clinic in the underserved Gentilly neighborhood, and in 2017 opened a permanent clinic site.<sup>62</sup> With these five clinics, St. Thomas is able to reach a significant portion of the city's uninsured and underserved patients.

#### Access Health Louisiana

Access Health Louisiana, an organization that operates community health centers across the state, took over the Ruth U. Fertel/Tulane Community Health Center in 2013.<sup>44</sup> The clinic remained a GNOCHC partner and received a GNOCHC Infrastructure grant in 2013. Access Health Louisiana also opened the South Broad Community Health Center in 2015, a partnership with the Broadmoor Improvement Organization, a grassroots community development group.<sup>63</sup> The clinic reaches patients in the underserved Central New Orleans Broadmoor and Gert Town

neighborhoods. The clinic provides primary care, pediatric care, health education and behavioral health.<sup>64</sup>

#### CrescentCare

CrescentCare, formerly NO/AIDS Task Force, has provided HIV/AIDS services in New Orleans since 1983,<sup>65</sup> and became a full-service Federally Qualified Health Center in 2014 in response to expected funding opportunities through the Affordable Care Act.<sup>66</sup> They expanded to two new sites in 2015, with all locations in Central New Orleans. They were a GNOCHC provider and a Crescent City Beacon Community Program member. As of 2017, CrescentCare plans to expand to a new site in 2018 that will triple the volume of services the organization can provide.<sup>67</sup> The organization still provides a large volume of HIV care, with 38% of their patients HIV positive in 2016.<sup>68</sup>

#### Baptist Community Health Services

Inspired by other community health centers in the city, the New Orleans Baptist Association opened a community health clinic in the Lower 9<sup>th</sup> ward in 2014 and later opened a second and a third location, as well as a pediatric-specific clinic.<sup>69</sup> Clinics provide preventative and primary care as well as behavioral health care and health education.<sup>70</sup>

## **Findings**

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### Compensated and Uncompensated Care

The structure of safety net health care in New Orleans before Hurricane Katrina, as well as its structure now and at every point in between, was and is a result of the various funding programs available to those who sought to provide care to the uninsured and underinsured. Louisiana's allocation of Medicaid DSH funds to only state-run hospitals prevented private hospitals from financing large amounts of uncompensated care. Patients without insurance knew they could receive care at Charity Hospital, which provided over 80% of the city's uncompensated inpatient and outpatient care. The vast majority of the private clinics that provided care for the uninsured were able to do so with funding as Federally Qualified Health Centers. The ones that were able to operate without FQHC designation and funding, such as St. Thomas's, were small clinics that catered to their immediate community and had other support from public sources. St. Thomas received financial support through the St. Thomas public housing development.

Health care funding for those without insurance became an immediate issue after Katrina. Hospitals that reopened after the storm struggled with the volume of uncompensated care that they were asked to provide. The increase in the number of people without insurance as a result of the storm added to this sudden burden. Eventually, the state and the federal government provided uncompensated care relief for hospitals, but did not change the policy allocating Medicaid DSH funds to public hospitals. Exterior funding, whether federal or donations, allowed many of the clinics that began after Katrina to open or continue their operations. This includes the Odyssey House Clinic, which was able to offer primary health care services through the FEMA Katrina

Aid Today Consortium, and the Operation Blessing clinic, which financed through outside donations.

The increase in numbers of community health clinics between 2006 and 2010 is largely attributable to the Primary Care Access and Stabilization Grant, awarded by CMS and administered by the Louisiana Public Health Institute. The award divided \$100 million dollars between twenty-five different nonprofit organizations across the Greater New Orleans area. Almost every community health organization operating in New Orleans between the terms of the grant, 2007 to 2010 benefited from it, whether it allowed them to open or re-open, continue their operations, or expand. Many of these organizations expressed that they were unsure they would be able to continue operating at the end of the grant term. In fact, the Lower Ninth Ward Clinic had to close because it was ineligible for any continued government support. Clinics in New Orleans also benefitted from the American Reinvestment and Recovery Act, which helped them expand their service capabilities and renovate existing sites.

The Greater New Orleans Community Health Connection program began, in part, as a means to continue support for PCASG-supported clinics. The continuation of this funding allowed for continued expansion of multiple community health center networks in New Orleans. Several of these networks, including St. Thomas and Daughters of Charity, also became Federally Qualified Health Centers, guaranteeing them an additional source of funding. The continued renewal of the GNOCHC responded to concerns from community health centers that they would not be able to continue their operations if it ended. The program also provided for a variety of infrastructure and technology improvements in the city's community health centers. While it is early to evaluate the results of Louisiana's Medicaid expansion, it is safe to assume that the funding it brought to community health centers was similar, if not even greater, than the

GNOCHC, due to the increased number of people eligible for Medicaid and the subsequent larger number of patients for whom community health centers could receive reimbursement.

#### Community-based, Community-built

The majority of the community health centers and community health center networks that were founded after Hurricane Katrina and that persist to this day were started by and are operated by those who saw a need in their communities and worked to provide the care that people could not receive elsewhere. From the initiative of Tulane students providing health care on the street in the aftermath of the storm came the Covenant House Community Health Center and eventually the Ruth U. Fertel/Tulane Community Health Center. Common Ground Health Clinic began with providers cycling around the neighborhood. Today, this clinic is a Federally Qualified Health Center. Odyssey House, an existing behavioral health provider, saw the great need for primary health care and began providing it, and still operates a community health center 12 years later. The South Broad Community Health Center and NOELA clinic were both started by community development associations that grew out of residents looking for means to improve their own communities.

These are only some examples from the range of clinics that have begun or expanded their patient services since Hurricane Katrina. Many of these sites also provide social services such as Medicaid enrollment, job training programs, and referrals to other low cost and free community resources. Because of investment in and knowledge of their communities, these clinics are better able to serve the unique needs of their patients. The expansion of community health care in New Orleans exemplifies the role of the community in creating sustainable health care sites that effectively address their needs.

### Transition from Centralized Public to Decentralized Private Nonprofit

As it became evident that Charity Hospital would not reopen, Louisiana State University and the City of New Orleans each opened primary care clinic throughout the city. In many instances, they partnered with a multitude of private nonprofit organizations. However, both LSU and the city ultimately either closed all of those public clinics or transferred them to private nonprofit operators. When the City of New Orleans privatized its clinics in 2011, it viewed privatization as a cost-saving measure that would improve efficiency. This was not novel in New Orleans; health care authorities, particularly at LSU, had been discussing a transition from the large, centralized, public provision of care for the uninsured at Charity to a decentralized model of care provided by community health centers. The dramatic shift from a centralized public system to a decentralized nonprofit system would likely not have occurred if Charity had immediately reopened, or if LSU had provided the same volume of care for the uninsured within the city.

### **Implications, Recommendations, and Areas for Further Research**

Both federal and state funding will continue to be a determining factor in the survival of community health care in New Orleans. The threat of contracting Medicaid funding or the lapse of the Federally Qualified Health Center program would devastate many, if not all of the current community health centers in the city. Medicaid expansion, however, a relatively new development in Louisiana, has the potential to bolster the safety net health care system in the city. For other areas seeking to expand access to community-based safety net health care, careful evaluation of the funding landscape is crucial for long-term sustainability. For those who

determine funding options for safety net health care providers, the importance of continuity in funding cannot be over-emphasized.

The value of community investment in community health centers, demonstrated by the development of New Orleans's centers, provides valuable lessons for both the city and other areas seeking to expand access to community health. Further investment in community health in New Orleans should focus on the needs of communities as identified by those communities and work with them to build access to health care. Other areas looking to expand access to community-based safety net health care should also adopt this model of building health care access for and with communities.

Although New Orleans does not provide a perfect model of a transition from a large, centralized provider of care to decentralized community care, it demonstrates many of the important factors in such a transition, including the two outlined above. Additional lessons can be drawn from 504 HealthNet, which assists safety net health care providers in working with each other to provide comprehensive care to their patients. This kind of collaboration can help disconnected nonprofit community health centers work as partners in one citywide system. The role of insurance coverage is also emphasized in New Orleans's story. By providing a form of insurance coverage to much of New Orleans's previously uninsured population, the GNOCHC helped support the survival of community health centers. Other communities seeking ways to sustain community health could draw lessons from the GNOCHC model, or consider Medicaid expansion.

New Orleans also carries many examples of what, precisely, not to do to encourage the development of community health and maintain health care access for those without insurance. Closing a large hospital that is the only source of care for a significant population of the city, for

example, does not encourage the development of community health as much as it simply abdicates responsibility. Safety net health care providers need to be able to count on the continued availability of the federal; inconsistency in funding availability will inevitably lead to a less stable and comprehensive safety net health care system.

Further research could consider the history of the safety net health care system in the greater New Orleans area, beyond the city itself. Due to the time constraints of this study and the increased size of the metropolitan area, this was not feasible for this project, but greater New Orleans faced many of the same factors in barriers to care, natural disasters, and funding for community health that the City of New Orleans did both before and after Hurricane Katrina. Understanding how the safety net health care landscape has shifted beyond the city limits is a natural next step. Further investigation into the rise of mobile-based health care for uninsured and low-income populations, an increasingly popular method of care delivery, may also be interesting in the context of New Orleans.

Other areas beyond the limits of this research include where community health patients live within the city and how the expansion of community health in New Orleans influenced health outcomes. Where this data was readily available, it has been incorporated into this research, although it was not the focus of the study. In-depth analyses of these questions could reveal the effectiveness of the expansion of community health in New Orleans in reaching each population of the city and providing care that impacts people's health.

Finally, community health is still developing in New Orleans. New clinics are expected to begin operations in 2018 and beyond. The effects of Medicaid expansion on the sustainability of safety net health care in the City of New Orleans remain to be seen. Further research into how



Medicaid expansion influences the continued development of community health in New Orleans would be valuable.

## **Limitations**

The scope of this history limits its generalizability. In the interest of the length of time available to complete this research project, this history focuses on primary health care facilities. Every facility listed provided primary care to adults. Pediatric facilities, behavioral health facilities, and specialty care facilities were not included. Both of these populations are worthy of their own history of care in New Orleans. When pediatric care, behavioral health, or specialty care were provided at a clinic site, it was noted, but this does not provide a full picture of the pediatric, behavioral, and specialty care landscape in New Orleans at any point. The scope is also limited as a history of the City of New Orleans; it does not extend beyond the city limits to the Greater New Orleans area, except in the cases of two sites in Metairie, when New Orleans health care sites were forced to relocate there.

This paper is also limited in that it does not capture the health outcomes results of the proliferation of safety net health care clinics in New Orleans or the neighborhoods where each clinic's patients lived, except in a few cases. As noted in the areas for further research, these would be valuable avenues to explore in further studies.

Finally, this paper is limited in that its findings may not be generalizable beyond New Orleans, or particularly Louisiana. The conditions that allowed for the landscape of safety net care in New Orleans in 2005, and the subsequent expansion of primary care safety were unique. The combination of one main safety net site, a state system that only awarded Medicaid DHS funds to public hospitals, a catastrophic natural disaster, and the decision not to reopen that

safety net site for ten years are certainly factors in the development of the primary care safety net system in New Orleans. However, the importance of consistent funding for safety net clinics and support for community-led health care initiatives could apply to locations vastly different from New Orleans, and the shift from public safety net health care to a private nonprofit system may be interesting to any area interested in such a model.

## **Conclusion**

The history of safety net health care in New Orleans between 2005 and 2017 is an incomplete story. The efforts made over the past twelve years to rebuild a health care system devastated by a combination of natural causes and human conditions are only the beginning of a movement that will surely continue for the foreseeable future. Many, many more people in New Orleans now have access to primary care within their communities that is affordable or covered by their newly available insurance, but opportunities to continue to improve access to care still exist, and community health centers across the city are working to expand their reach every day. With the sustained and passionate effort of those community members working for their health care and their neighborhoods, along with the national and local-level investment that they need, safety net health care in New Orleans can continue to improve health and quality of life in the city for years to come.

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**Appendix**

Attached are two appendices of key sources and data points used for this project. Appendix A contains data from scientific journals and reports. Appendix B contains data from congressional hearings.

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