SIGN OF THE TIMES: PART I

Grit and Resilience: Louisiana Health Care Delivery Redesign
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As I reflect on SGIM’s call to take pride in General Internal Medicine (GIM) and to highlight our grit and resilience, I cannot help but think back to the whirlwind experience I have had over the last 11 years. I returned to New Orleans, Louisiana, my home town, in July 2005 after completing my GIM fellowship training. I just started my “first real job” at Tulane University School of Medicine. Shortly thereafter, on August 29, 2005, Hurricane Katrina decimated the city and health care facilities with widespread flooding. By September 2005, I was learning how to commandeer unoccupied buildings to set up makeshift clinics for first responders and local residents.1 By 2006, I was thrown head first into a barrage of health policy work all while trying to set up and manage community clinics and maintain the typical responsibilities expected in academic medicine (teaching, seeing patients, writing grants, publishing). Burnout was inevitable, but the joy of being a part of a phenomenal movement in health care redesign in Louisiana was worth it. This is the story of my journey and that of my colleagues in Louisiana.

Two-Tiered System of Care
The state of Louisiana ranks 50th in overall rankings of state population health, and is home to roughly 4.5 million people among whom 31% self identify as black (versus 12% nationally) and 23% live in poverty (versus 15% nationally).2 Most uninsured adults (12-15% of its nonelderly population) represent low-income working families. Louisiana’s racial and ethnic minorities and its impoverished populations bear a disproportionate share of the health disparities.

Historically, the delivery model in Louisiana has been a “two-tiered” system of care: Patients with insurance have always had access to a range of providers and clinical services while the poor and uninsured received most care through state-run and state-funded facilities. Having Medicaid did not open up options for clinical services since many providers (especially specialists) did not and still do not accept this insurance due to low reimbursement rates. For generations, most low-income families in New Orleans (including mine) sought all of their care through Charity Hospital or other local emergency rooms for episodic care. Typically, doing so required almost a full day off from work for medical problems that ideally should be addressed through regular primary care visits. These are the same families who largely support the service/tourist industry in New Orleans but unfortunately do not have access to insurance through their employers. The fact that Charity Hospital and University Hospital, its affiliated facility, were known as great places for health professional training because of the “great pathology” seen on inpatient teaching services was a testament to what happens to a community when access to the right care at the right time is minimal to none.

Primary Care Practice Transformation
Try to imagine the local panic that set in when Charity Hospital closed after Hurricane Katrina. The public hospital system’s services were downsized. In the aftermath of the storm, Louisiana received an unprecedented opportunity to revamp its health care delivery model for medically underserved populations to shift care from acute care settings to community-based health care providers. The Louisiana Healthcare Redesign Collaborative (led by the Department of Health and Hospitals) developed guiding principles for system redesign. These principles included affordable health care coverage, interoperable health information technology, medical home systems of care, and shared quality standards.3 New Orleans safety-net providers quickly adopted these principles to build a network of accessible, neighborhood-based clinics for the underserved populations in four southeast Louisiana parishes (aka counties). The 504HealthNet, an organization of federally qualified health centers, governmental agencies, academia, and faith-based organizations in the Greater New Orleans area, formed rapidly to galvanize local leadership into rebuilding and expanding primary care.4 They also advocated for health policy that would support this effort.

To achieve these goals, Louisiana secured $100 million in funding from the Centers for Medicare and Medicaid Services for the Primary Care Access Stabilization Grant (PCASG) to support health care delivery redesign in southeast Louisiana.5 From 2007 to 2010, 25 safety-net provider organizations participated in PCASG to increase access to primary care and mental/behavioral health services, develop organized systems of continued on page 2
care coordination, develop sustainable business models, and provide evidence-based high quality care. Payments were dispensed every six months using a formula adjusted for patient mix and service type focusing on quality rather than volume of care. PCASG also incentivized participants to achieve National Committee for Quality Assurance (NCQA) patient-centered medical home recognition. In 2009, PCASG participants were among the first health care organizations recognized by NCQA nationwide. We were doing this work out of necessity before the Affordable Care Act was passed. Providing high-quality care to the medically underserved was simply the right thing to do!

Anticipating Medicaid expansion under the Affordable Care Act, PCASG-funded providers transitioned to the Greater New Orleans Community Health Connection (GNOCHC; 1115 Medicaid Demonstration Waiver) program in 2010. GNOCHC provided insurance coverage for adults who lived in the southeast Louisiana parishes affected by Katrina and otherwise did not qualify for Louisiana Medicaid. By 2013, close to 134,000 patients were served by 18 participating provider organizations providing integrated primary care and mental/behavioral health services. Louisiana saw a rapid expansion of community health centers in southeast Louisiana as result of these health policy efforts, and now has 30 federally qualified health centers operating 162 sites throughout the state.

Most of the GNOCHC-funded provider organizations simultaneously participated in the $13.5 million Crescent City Beacon Community Initiative (CCBC) between 2010 and 2013 to accelerate the role of health information technology in population health management. The CCBC’s successful initiatives included implementing the Greater New Orleans Health Information Exchange with more than 170,000 unique patient records; generating automatic notifications from local emergency departments to community clinics to facilitate transitions of care; funding chronic disease care management quality improvement efforts in four hospital systems and 20 primary care practices; establishing a clinical seminar series for community providers to share best practices; and, launching a mobile health diabetes awareness program.

All of the aforementioned health care redesign efforts were under the leadership of the 504 HealthNet and the Louisiana Public Health Institute (LPHI). While the 504 HealthNet members did most of the health policy advocacy work and implemented practice transformation, LPHI administered the PCASG and CCBC initiatives. One of LPHI’s greatest assets was its ability to effectively engage community stakeholders in designing pragmatic delivery models and health care interventions. LPHI also strongly promoted population health management—a concept that was relatively new to some organizations. Perhaps it was this attribute that has kept so many health care providers engaged in this challenging yet rewarding work for the past 11 years.

Nonetheless, we have seen “casualties” along this journey. Some organizations have either downsized services or closed clinics to maintain financial stability while caring for a largely uninsured population. For those of us who kept the doors open, we continued to struggle to gain timely access to specialty services for both the uninsured and Medicaid population. While we took pride in expanding primary care services, it was professionally disappointing to advise patients that they can only receive certain specialty services in select places and that they might have to wait several months to a year to receive it.

Medicaid Funding

While most states implemented Medicaid expansion in 2014, Louisiana’s former Governor Bobby Jindal vowed not to adopt it. By 2012, the Louisiana legislature reduced Medicaid funding and applied most of these cuts to the state hospital system. Private-public partnerships were created in 2013 and 2014 through which private companies lease and operate the hospitals and their affiliated clinics. The privately run hospitals are still required to provide indigent care to uninsured individuals and participate in graduate medical education.

The newly elected Democratic Governor John Bel Edwards campaigned in 2015 on implementing Medicaid expansion. He issued an executive order by January 2016 to adopt it during his first month in office. The state used the Supplemental Nutrition Assistance Program to successfully facilitate enrollment by July 2016 when coverage took effect. To date, we have more than 350,000 Medicaid enrollees for the
first time ever in Louisiana history. The need for coverage in such a largely rural and impoverished state is obvious.

The Struggle Continues
I have shared only snapshots of our story, but there are many important lessons that can be gleaned from our experiences. First, health care providers must engage in health policy advocacy work if we truly believe in keeping patients first. Second, the practice of medicine is best achieved when we integrate public health perspectives into the design of our work. Third, galvanizing the community and other stakeholders in our mission will always help us surpass our goals beyond what we could ever achieve on our own. Finally, this work is not for the weary. It takes grit and resilience to see the light at the end of the tunnel.

Given U.S. president-elect Donald Trump’s intent to repeal or amend the Affordable Care Act, our 11-year journey to health care re-

form in Louisiana remains tenuous. Nonetheless, as a community, we remain unmoved and dedicated to ongoing health policy advocacy work on local, state, and national levels. It is our form of social justice for the historically disadvantaged. Indeed, the struggle is real. The battle is not yet won. However, this too shall pass.

References