UNITED STATES SENATE
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Mr. Chairman and members of the Subcommittee: Thank you for the opportunity to speak with you today regarding the public health recovery in the city of New Orleans since Hurricane Katrina's historic landfall on August 29, 2005. It is an honor to welcome you to our city. On behalf of our students, faculty, researchers, staff and patients, I would like to express our gratitude to you for coming to see our progress and challenges first-hand.

I want to thank the Subcommittee for supporting public health recovery efforts in New Orleans. We are particularly appreciative of Secretary Leavitt's commitment to the long-term recovery of our region's healthcare system. The support from federal agencies such as the National Institutes of Health, the Centers for Disease Control and Prevention, and the Department of Veterans Affairs continues to be invaluable as we recover.

We have made significant steps forward despite almost overwhelming challenges, but still have a long way to go before health care and public health preparedness in our city and region are robust enough to serve our current population—including temporary laborers and volunteers. Together, we must ensure the presence of a sustainable public health and healthcare system that meets both the routine needs of our region as well as the needs of our population during any future disasters.

PUBLIC HEALTH AND MEDICAL CARE: THE TULANE COMMITMENT

Tulane University was founded as a public-health-oriented medical school 172 years ago in response to community needs—epidemics of yellow fever, cholera and malaria. Except for three years during the American Civil War, Tulane University, which today includes its Health Sciences Center, School of Medicine, School of Public Health and Tropical Medicine, and hospitals and clinics, has served our community without interruption, including before, during and after Hurricane Katrina. Our commitment to the success of New Orleans began long before Katrina reached our shores and our resolve

to be a vital part of the community's rebirth following the hurricane has never wavered. That commitment is sealed in our mission and in our hearts.

Prior to Hurricane Katrina, Tulane University was the largest private employer in Orleans Parish. Today we are the single largest employer in the Parish and we remain one of the fastest-growing economic engines in Southeastern Louisiana. Before Katrina, approximately 8,000 faculty, students and staff worked at the Tulane University Health Sciences Center. With more than 350 full-time faculty members, our medical group was one of the largest in the region overseeing care for approximately 1,000 inpatients and 50,000 outpatients per month. Our medical and public health training programs were amongst the most competitive in the nation. With annual research awards of approximately $140 million per year, a recent three-fold increase in awards from the National Institutes of Health, and evolving partnerships with other academic institutions in our region, Tulane supported a vibrant research and discovery community. We had an annual operating budget in excess of $650 million at the Health Sciences Center and Tulane University Hospital & Clinic, along with major additional responsibilities at the Southeast Louisiana Veterans Health Care System (Tulane provided approximately 75 percent of the physician services) and the Charity System Medical Center of Louisiana New Orleans.

Throughout and immediately after Katrina, Tulane faculty, students and staff remained to provide essential services. They performed admirably and many emerged as heroes who saved lives under extremely challenging conditions. Not a single life was lost at the Tulane University Hospital & Clinic. Our staff took whatever measures were necessary to save human lives, including hand ventilation of patients for prolonged periods when electricity was unavailable. In addition to safely evacuating all of our patients, faculty, staff, students and friends, we evacuated many of our research animals and humanely euthanatized those that could not be evacuated. Moreover, we preserved key cell lines for both clinical care and research, and vital equipment—saving U.S. taxpayers millions of dollars.

In the immediate post-Katrina environment, Tulane was the largest ambulatory care provider in Orleans Parish, with clinics that remained open seven days a week. Our medical personnel provided free care for about 400 patients per day in the absence of any formal healthcare infrastructure. The majority of those who received care were uninsured or under-insured. Our faculty provided care under awnings, in police precincts, in tents, and in parking lots. Although we are a private institution, we remained true to our mission of meeting the healthcare needs of the community. Indeed, we are still operating the Covenant House clinic in the French Quarter, one of the four free clinics that we established following Katrina. In conjunction with the Children's Health Fund we established a mobile pediatric unit, still in operation, which has allowed us to serve children in their own neighborhoods without regard to their parents' ability to pay for the services rendered. Additionally, we were able to place our clinical faculty throughout Louisiana, focusing on the sites where New Orleanians evacuated in the diaspora, such as Alexandria, Baton Rouge, Lafayette, Pineville and the New Orleans Northshore-Covington area.

The commitment of our healthcare professionals to helping the community has been extraordinary and universal amongst faculty, staff and students. As one of many examples, we, in conjunction with Common Ground, are running a special *Latino Health Outreach Project Clinic* on the West Bank section of the city. This clinic was the brainchild of Catherine Jones, a third-year student in Tulane's combined medical degree and master of public health degree program. Jones, a native of New Orleans, heard the distressing news—of uninsured, non-English-speaking day laborers—while an evacuee with her family in Texas. She immediately returned to Louisiana, and with the help of others provides free health care for up to 50 New Orleanians each day in an abandoned storefront in Algiers.

On February 14, Tulane University Hospital & Clinic (TUHC) became the first hospital to reopen in downtown New Orleans following the hurricane. TUHC serves as a vital resource for repopulation of the city. The opening of the hospital was critical to assuring the success of this year's Mardi Gras and was a sign that the city was ready to welcome back both tourists and the business community.

As reported by the Government Accountability Office in March 2006, 63 beds were staffed in February at the downtown TUHC. Today, that number is 93, which represents a 48 percent increase in five months, but this is still only 40 percent of our pre-Katrina 235-bed capacity. Concurrently, we have been staffing approximately 60 beds at our Tulane-Lakeside Hospital in Jefferson Parish, which we reopened in October. This represents about half of the 119-bed capacity at that hospital.

Through the summer, we have been adding outpatient clinics throughout the city and region. At our downtown campus, we have reopened emergency, urgent care, transplant and multi-specialty clinics. The Tulane Cancer Center infusion and clinical treatment clinics are in the process of reopening, with cancer radiation therapy and other clinics planned to open in August.

With much appreciated help from our colleagues in south Texas, we maintained the integrity and quality of our School of Medicine training programs. Likewise, with help from the other accredited schools of public health, we provided our public health students the opportunity to continue their studies at many of the nation's best schools. Our School of Public Health and Tropical Medicine, the oldest in the nation, restarted its educational programs in New Orleans in January. And as of last week, all of our medical students and medical residents have returned to the city. Medical students, and especially medical residents, often decide to stay and practice where they receive their medical education and training. Returning our trainees to New Orleans is a vital step in the rebuilding of the health professions workforce for our region. Also, the public health students who are enrolled at Tulane, and the many that stay after graduation, contribute to improving the community's health through public health outreach initiatives, education endeavors and research.

While learning, our medical students and residents participate in clinical rotations and training programs that add to the clinical care resources of the city. We retained 98 percent of our medical student body. I am pleased to report that we were able to fill our residency slots for the 2006-07 year with highly-qualified candidates—in most instances they were our first or second choices. Also, after receiving more than 7,000 applications for admission to our MD program (consistent with recent years' numbers), our incoming medical school class is among the largest in our history and has an academic profile congruent with prior entering classes. In addition to this, many have chosen Tulane because they want to participate in rebuilding the community's healthcare system. All combined, these promising results reflect the interest of young health professionals in providing care in a challenging environment.

Before the storm, the city's medical district was an epicenter for the training of healthcare professionals, including more than 1,400 medical residents. Tulane lost vital medical resident training positions due to the closure of the Charity System's Medical Center of Louisiana, New Orleans and the Southeast Louisiana Veterans Health Care System inpatient facilities in New Orleans. TUHC has helped by opening up nearly 50 additional temporary residency positions. Furthermore, we have placed medical residents at our Tulane-Lakeside Hospital in Jefferson Parish and several other hospitals in the community, including the Ochsner Medical Center, Touro Infirmary, West Jefferson Medical Center, East Jefferson General Hospital and Slidell Memorial Hospital. TUHC is negotiating a lease of approximately 40 beds to the VA—expected to become operational by October 1st. Not only will these beds help serve the needs of local veterans and their families who must now travel many miles for inpatient services, but they will serve as a vital part of our medical resident training program. Despite all of the above, it remains a challenge to find appropriate training environments for training of our medical residents.

Despite research inventory and facilities losses of more than $120 million, Tulane University remains the region's largest research enterprise and the area's only institution to be ranked in the top 100 for receipt of awards from the National Institutes of Health. Last year the university received more than $140 million in research awards, with more than $110 million awarded to faculty at the Health Sciences Center, the largest in our history. I expect our health sciences faculty will end the year with awards totaling between $100 million and $105 million (90 to 95 percent of last year's total). Again, this is another example of our commitment to the region's economic recovery.

Our School of Public Health and Tropical Medicine has assiduously monitored public health concerns and provided information through initiatives—from recovery issues to non-disaster health maintenance, e.g., nutrition and heart disease. Specifically, faculty from the Tulane Department of Environmental Health Sciences worked alongside federal, state and local health officials to provide real-time guidance to community residents for pressing environmental health issues—from drinking water safety and air pollution to mold remediation. The school has retained more than 80 percent of its students and already has exceeded its goals for fall enrollment, with a similar academic profile to that of previous years. An exiting development last fall was the start of our

new undergraduate program in public health, one of a few in the nation. Already, enrollment has exceeded expectations and in a few years the program will produce young, vibrant public health professionals.

PUBLIC HEALTH AND MEDICAL CARE: THE KEY CHALLENGES

Fragmented healthcare infrastructure

Currently, a safety net for the uninsured is lacking. The burden on hospital bed capacity, as well as the lack of financial support to care for this growing segment of the population, is seriously threatening the functioning and sustainability of what was already a fragile city public health and healthcare system. The loss of the Charity and VA system's inpatient capacity has exacerbated the situation. Accelerated in the aftermath of the storm and its related economic fallout, patient capacity to pay for health care has been greatly diminished. Before Katrina, the percentage of uninsured patients in New Orleans was already larger than the national average. At Tulane, the number of uninsured outpatients has risen from around 6 percent pre- Katrina to recent numbers of 20 percent for Tulane-Lakeside and 40 percent for Tulane University Hospital & Clinic. HHS funds to help 32 states shoulder increased medical costs attributable to Katrina had covered a fraction of Medicaid providers' costs at hospitals for claims of uninsured patients through Jan. 31. Also, the Louisiana Legislature has authorized financial support to Louisiana hospitals for care of patients without health insurance but this assistance does not address the financial plight of the physicians who provide the care. The bottom line is that (a) the funding directed to help hospitals is insufficient and (b) support is not reaching the individual healthcare providers and many, especially physicians, have made the decision to relocate to other regions of Louisiana or to other states. Many more are considering relocation. Compensation for care of uninsured patients is a growing crisis that could lead to further deterioration of our region's healthcare infrastructure.

In addition to the financial challenges for healthcare professionals and healthcare systems, there is an acute shortage of clinics and inpatient facilities. This is disproportionately being felt in some key areas of need. For example, there is not a single designated inpatient psychiatric bed in Orleans Parish. In addition, when patients are discharged from hospitals there are few options available for homecare or institutional care, such as nursing homes. This has resulted in a prolongation of hospital stays by approximately 20 percent—further exacerbating the shortage of inpatient beds and cost of care.

Loss of a competent healthcare provider workforce

The considerably decreased patient base and permanent relocation of hundreds of physicians continues to significantly impair our community's ability to provide quality care. Repopulation cannot occur without a commensurate investment to retain and recruit physicians, nurses and other health professionals. Retention of physicians and public health professionals is already a problem and could get worse before stabilizing.

This should be a very high priority. If we lose our network of medical professionals in New Orleans—which includes a mix of primary care physicians and specialists—it will be challenging and expensive to rebuild. Before Katrina, the Orleans Parish Medical Society estimated 3,200 physicians were practicing in Orleans, Jefferson and St. Bernard parishes. Today, they estimate the number is between 1,400 and 1,600 physicians, of which Tulane practitioners represent about one-fourth of those currently in practice.

Disaster preparedness

Public health and healthcare preparedness are integral to disaster readiness. Multi-faceted challenges, such as disaster recovery and preparedness, cannot be solved with monolithic solutions. While we need to look broadly and think long-term, my biggest immediate concern is for the middle phase of recovery—simplified, I'll refer to it as Year 2. We have moved beyond the rescue and rebounding phase of Year 1. Now federal emphasis is on long-term rebuilding starting in Year 3. I support the Department of Health and Human Services and Secretary Leavitt's redesign for Louisiana Region I. With federal assistance, our long-term prospects look promising. My fear is for this gap between Years 1 and 3. The next 6 to 9 months are critical, and I am hoping that this Subcommittee can help address this concern. By helping us now, you will further the understanding of this middle period of insecurity to the benefit of future disaster recoveries. The importance of a successful execution of this middle phase has been demonstrated internationally. For example, investment during this transition period after the Kobe, Japan disaster provided a critical foundation for subsequent long-term, sustainable recovery. Please keep our second post-Katrina year in mind and in motion.

PUBLIC HEALTH AND MEDICAL CARE: LOOKING FORWARD

Assuring a robust healthcare infrastructure

In my opinion, a federal policy for care of those without health insurance is much needed. This should be an immediate priority for New Orleans, because if unaddressed it promises to undermine the capacity of the healthcare provider community to survive. In New Orleans, there appear to be three groups of uninsured patients: (1) residents who did not have insurance before Katrina; (2) residents who had health insurance prior to Katrina, but no longer do so, either because they lost their job or lack the resources to continue paying for their insurance; and (3) day laborers who are temporary residents and lack any form of health insurance. We need a better understanding of the relative contribution of each group and ways in which their acquisition of health care can be encouraged and facilitated.

Strengthening the healthcare and public health workforce

Healthcare providers make choices to stay or leave a distressed community. In this context, it could be valuable to have a national registry of physicians, as well as other healthcare professionals. In addition to helping patients locate their providers, such a

registry could help providers from unaffected areas who want to assist in recovery efforts. This concept not only creates surge capacity in a seamless fashion nationwide, but also comports with the federal emphasis on regional preparedness. We also could also utilize Public Health Service personnel to rebuild the healthcare infrastructure and to fill provider gaps as needed—current examples of need include nursing, mental health and dental health. However, while volunteers might be effective in the short-term, ultimately our community needs the stability and quality that comes from the long-term commitment of local providers.

The ability to support healthcare providers is pivotal to retaining a competent clinical staff. I am grateful to the Board of Tulane and the university administration for ensuring that payroll and benefits were covered for our faculty, clinicians and medical residents, and to our clinical partners at HCA, who did an outstanding job in evacuating patients and staff and in helping to place them in jobs at other facilities. While we benefited from a temporary relaxation of the Stark law through 2005, there needs to be consideration of a national policy which extends that time frame in the aftermath of a disaster, so that hospitals and organizations with the resources can help doctors with housing and other accommodations. We, as a nation, also need to consider bridge-income strategies for healthcare providers, beyond SBA loans and Medicare patches, which would be effective in retaining the healthcare provider workforce. This is an ever-growing concern as the cost of living and the cost of doing business continues to increase as a result of the post-disaster regional economic environment.

Next, we need to enhance health professionals' knowledge of public health emergency preparedness. In maximizing Tulane's academic disaster expertise for public health and biodefense, starting this fall, our School of Public Health and Tropical Medicine will offer the nation's only concentration in disaster management for a Master of Public Health or Master of Science in Public Health degree. The degrees will be offered both on-site and on-line, to help create a readiness workforce. Tulane will work to enhance the South Central Center for Public Health Preparedness and the South Central Public Health Training Center, which we launched in 2002, to serve the public health workforce in the four-state region of Alabama, Arkansas, Louisiana, and Mississippi. In the 2004/ 05 year the South Central Center for Public Health Preparedness trained 17,550 and the South Central Public Health Training Center trained 6,965 professionals. For 2005/ 06, the respective numbers exceeded 17,000 and 8,700. Training and education provided by these centers addressed critical disaster preparedness and response components such as *Incident Command, Chemical Terrorism*, and sessions specific to the lessons learned from Hurricane Katrina. Continued federal support will help our efforts for first-time and continuous training of public health professionals and first responders: EMTs, police officers, fire fighters, nurses and doctors.

Tulane took the lead in assuring disaster preparedness. Both the School of Public Health and Tropical Medicine and the School of Medicine have in place school-wide emergency preparedness and response plans. Parts of the plan were successfully exercised through drills this spring. Now, every faculty member, staff and student can develop a personal preparedness plan to be executed in time of disaster.

The Public Health Security and Bioterrorism Preparedness and Response Act

The Public Health Security and Bioterrorism Preparedness and Response Act is an important vehicle to solidify collaboration of public and private sector resources. Specifically, the following programs are illustrative of the synergism between academia and government to assure frontline preparedness and response:

a. CDC's public health preparedness grants for state health departments – These grants are vital mechanisms for disaster planning and response. Diminishing the commitment to this program will severely hamper Louisiana's and other states' abilities to respond to disasters.
b. Centers for Public Health Preparedness – Funded through the CDC, this program is administered by the Association of Schools of Public Health and is a proven strategy for training first responders, medical personnel, public health specialists and EMTs. Of special note is that the center, led by the Tulane University School of Public Health and Tropical Medicine, provides life-long, just-in-case and just-in-time training and education to disaster personnel in four states including Mississippi, which also shares the threats of the Gulf Coast.
c. HRSA's hospital preparedness program – Tulane participates in the regional system established by the State of Louisiana under this program. Having a primed regional hospital system will allow for critical surge capacity in times of crisis.
d. Electronic database (ESAR-VHP) – While the funds are limited, Hurricane Katrina showed the real need for a database that facilitates advanced registration of health professionals, so that they can be mobilized at a moment's notice. Tulane will participate with the State in implementing this program.
e. HRSA health professions terrorism training grant – While Louisiana was not a recipient under this grant program, the goal of the program to assure a cadre of trained public health professionals is just what we need to respond to terrorism and assure care during disasters.
f. Expansion of the national stockpile – Tulane's hospitals participate in the stockpile program. Hurricane Katrina has demonstrated the importance of having the appropriate supplies—both accessible and tailored to local needs.
g. City readiness initiative – The City of New Orleans currently does not participate in this initiative. However, the HELP Committee could consider the eligibility of cities like ours, even though the population size might not appear to substantiate the need. Having the funds provided through this initiative will make a difference in the readiness of our city.

PUBLIC HEALTH AND MEDICAL CARE: CONCLUSION

Reinventing New Orleans' healthcare systems will prove vital to rebuilding the economy in New Orleans, as the two are interdependent. This is not a theory, but a proven correlation in models of developing countries. Rebuilding New Orleans' healthcare systems is not only essential for its region's residents, it is also valuable to federal lessons for biodefense, as well as for reinventing healthcare systems across the nation.

I ask that you consider New Orleans' impending needs for

- Assuring we have a robust healthcare infrastructure, including provisions to help the uninsured.
- Strengthening our healthcare workforce, to allow for repopulation and economic recovery.
- Reauthorizing the Public Health Security and Bioterrorism Preparedness and Response Act and funding the programs, which will help for this and future disaster recoveries, as well as improved planning.

Despite enormous challenges and financial losses at the Tulane University Health Sciences Center, we remain committed to preserving the integrity and quality of our educational, clinical and research programs, which result in great economic opportunities for the region and state. As the leader in disaster preparedness and recovery, the federal government should support institutions such as ours in maintaining their missions and serving as economic engines for their communities.

The public health and medical care community in the New Orleans metropolitan area faces many serious challenges. However, with the support of the American people and through our public leaders such as those of you on this Subcommittee, we will recover. My colleagues and I at Tulane are fully committed to the rebirth of our community and to working with you toward achieving a mutual goal of excellence in health care and disaster preparedness. Thank you.