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Congressional Committees

Subject: *Hurricane Katrina: Status of the Health Care System in New Orleans and Difficult Decisions Related to Efforts to Rebuild It Approximately 6 Months After Hurricane Katrina*

Among the challenges facing New Orleans in the aftermath of Hurricane Katrina is the significant destruction and disruption of health care services. Hurricane Katrina, which made landfall near the Louisiana-Mississippi border on the morning of August 29, 2005, and the subsequent flooding caused by the failure of the New Orleans levee system resulted in one of the largest natural disasters to hit the U.S. Among other things, the hurricane resulted in the sudden closure of hospitals and loss of other health care providers, including one of the largest hospitals in the area, Medical Center of Louisiana at New Orleans (MCLNO), which suffered extensive damage and remains closed. MCLNO, consisting of Charity and University Hospitals, is part of the statewide Louisiana State University (LSU) system and served as the primary safety net hospital for many local residents. About half of its patients were uninsured, and about one-third were covered by Medicaid. Furthermore, MCLNO also served as a major teaching hospital and the only Level I trauma center in the area. The availability of health care services is one of the factors that can affect whether and how quickly residents return to the area.

We have undertaken work to provide a snapshot of the status of the health system in New Orleans and efforts to rebuild it approximately 6 months after Hurricane Katrina devastated the area. We are performing this work under the Comptroller General's authority to conduct evaluations on his own initiative.[1] To conduct our review, we obtained information on (1) estimates of the availability of health care services; (2) efforts by state and local officials to plan for the rebuilding of the health care system; and (3) assessments of the damage to the MCLNO facilities, cost estimates for repair or replacement, and the costs that are eligible for federal funding. The Ranking Minority Members of the House Committee on Energy and Commerce and its subcommittees on Health and on Oversight and Investigations requested a briefing on the preliminary observations of our review. We briefed the committee and other committees of jurisdiction on February 15 and 16, 2006. In addition, Comptroller General David Walker's testimony before the Senate Homeland Security and Governmental Affairs Committee on March 8, 2006, discussed the significant damage to the health care infrastructure in New Orleans. This report documents the information presented in those briefings and testimony.

[1] See 31 U.S.C. § 717(b)(1).

To obtain information on health care services, we conducted interviews in the New Orleans metropolitan area with administrative and medical staff officials at 4 hospitals and the city health department, and visited an ambulatory care center at the New Orleans Convention Center and a neighborhood that experienced severe flooding from the hurricane. We also reviewed data submitted daily by hospitals to an Internet database about their bed capacity. In addition, we conducted interviews in Baton Rouge with officials of the Louisiana State University (LSU) Health Care Services Division and the Louisiana Department of Health and Hospitals (DHH). The Comptroller General also met with LSU officials. Finally, we reviewed documents and planning reports that described the New Orleans area before and after Hurricane Katrina. Our information is limited to what officials reported to us, and we did not independently verify hospital-reported data on bed availability. Furthermore, the status of health care services has changed since our visit and continues to change as local conditions evolve. To obtain information on assessments of the damage to the MCLNO facilities and estimates for repair or replacement, as well as what costs are eligible for federal funding, we toured Charity Hospital and reviewed LSU's consultant report that included facility assessments and cost estimates. We also reviewed the Stafford Act, Federal Emergency Management Agency (FEMA) regulations and guidance, and obtained FEMA's assessments and estimates for repair. In addition, we interviewed officials with FEMA, LSU, and LSU's consultant, ADAMS. We also reviewed the LSU and FEMA assessments and estimates to identify their purpose, scope, and assumptions, and compared estimates using RS Means 2005[2] estimating guide and industry practices. We did not validate FEMA's or LSU's estimates. Our site visits were done in December 2005 and January 2006. We conducted our work from December 2005 through March 2006 in accordance with generally accepted government accounting standards.

Results in Brief

Since Hurricane Katrina hit New Orleans, the health care infrastructure was severely damaged and the availability of health services declined significantly. The area's only Level I trauma unit was closed, and the number of staffed hospital beds in the City of New Orleans was estimated to be about 80 percent less in February 2006 than before Hurricane Katrina, according to figures reported by hospitals. At the time of our visit, many safety net clinics in the city were closed, and those that were open were reported to have limited capacity. Relatively little was known about the status of physicians and other health care workers.

Efforts to rebuild the health care system were being affected by several factors, including uncertainty about how quickly the population would return and how a future health care system should be configured, particularly since some experts noted that New Orleans had an oversupply of hospital beds before Hurricane Katrina. Residents are expected to return to the area slowly, and their return will be affected by the availability of housing and other services. Uncertainty about how quickly the population would return to New Orleans, as well as who would return, was making it difficult for local officials to plan the restoration of health services. Although various

[2] RS Means provides a series of estimating and cost index guides used in the construction industry.

planning efforts were completed or underway, at the time of our visit no clear consensus had emerged.

The MCLNO facilities, which were either in poor physical condition or needed significant repairs prior to Hurricane Katrina, sustained significant damage from the hurricane. Prior to the disaster, both hospital facilities had documented deficiencies and were having difficulty meeting health care standards. Because they were affected by the disaster, the facilities are eligible for federal aid under the Public Assistance program managed by FEMA. FEMA's estimate for repairing the damage was considerably lower than an LSU estimate prepared by ADAMS, a consultant to LSU. Because the lower FEMA estimate determines federal funding, LSU is likely to receive less federal funds than it expected. The LSU repair estimate of $117.4 million for University Hospital and $257.7 million for Charity Hospital, which included correcting some pre-disaster condition deficiencies, exceeded 50 percent of the buildings' replacement value and indicated that replacement of the facilities was the best option. However, FEMA's estimate of $12.4 million for University Hospital and $23.9 million for Charity Hospital, which included only those repairs required to return the facilities to pre-disaster condition, totaled significantly less than 50 percent of each building's replacement value. Although FEMA has decided that these facilities are only eligible for reimbursement of repair costs, should LSU repair the facilities, the total reimbursement could increase as additional problems are discovered. Therefore, given the uncertainty about the ultimate amount of the federal contribution and the uncertainty of how a future health care system should be configured, LSU faces a complicated decision about whether to repair Charity and University hospitals or build a new facility.

Background

Charity and University Hospitals, together known as the MCLNO, are part of the statewide system of ten public hospitals.[3] Charity Hospital has been continuously operating since 1736 and built its current facility in 1937; the University Hospital facility was built in 1972. MCLNO served as the primary safety net hospital for many local residents. About half of its patients were uninsured, and about one-third were covered by Medicaid. In fiscal year 2004, it provided more than 25,000 inpatient admissions, over 300,000 clinic visits, and 135,000 emergency visits. MCLNO served as a major state resource through its training programs for health professionals, including medicine, nursing, allied health, dentistry, and public health. In fiscal year 2004, MCLNO trained 618 medical residents and fellows and 2,265 nursing and allied health students.

The MCLNO facilities damaged by the disaster are eligible for federal aid under the Public Assistance program managed by FEMA. This program, authorized by the Stafford Act, provides grants to pay up to 90 percent of costs for restoring a facility to pre-disaster condition. According to federal regulation, a facility is considered repairable when disaster damages do not exceed 50 percent of the cost of replacing a facility to its pre-disaster condition, and it is feasible to repair the facility so that it can perform the function for which it was being used as well as it did immediately

[3] Eight hospitals are operated by the LSU Health Care Services Division and two hospitals are operated by the LSU Health Sciences Center in Shreveport, Louisiana.

prior to the disaster.[4] Although initial grant obligations are based on FEMA's estimate of the costs of repairs to restore the facility to its pre-disaster condition, reimbursements are based on actual, documented repair costs, which could be higher than the original estimate. Alternately, if FEMA's estimated repair costs exceed 50 percent of its estimated replacement costs, FEMA is authorized to grant up to 90 percent of its estimated costs to replace a facility. There is a possibility for additional federal reimbursements under the Public Assistance program for required code upgrades that are triggered by the repairs. Code upgrades, although eligible for reimbursements, are not included in determining whether repair costs exceed 50 percent of replacement costs. In the event that FEMA's estimated repair costs do not exceed 50 percent of its estimated replacement costs, funds authorized for repair may be used to rebuild a new or improved facility, but reimbursements will be limited to 90 percent of FEMA's estimated cost to repair and restore the original facility to pre-disaster condition. In addition, projects for hazard mitigation to prevent damage in future flooding events are eligible for Public Assistance funding.

Under the Public Assistance program, FEMA is authorized to reimburse up to 100 percent of eligible costs for emergency work, including costs associated with providing emergency medical services. Currently under this provision, FEMA has funded numerous emergency medical services throughout the New Orleans area.

The Health Care Infrastructure Was Significantly Damaged

The health care infrastructure in the New Orleans area, including emergency, hospital, and clinic facilities, was severely damaged by Hurricane Katrina. The MCLNO, along with its Level I trauma unit, was forced to close.[5] Level I trauma services are available in the state in Shreveport, Louisiana. Other Level I trauma units are located outside of the state in Houston, Texas; and in Mobile and Birmingham, Alabama.[6]

Other health services in New Orleans were also severely damaged, including hospitals, emergency services, and safety net clinics.

- **Hospitals:** The number of staffed hospital beds in the City of New Orleans was about 80 percent less in February 2006 than before Hurricane Katrina, according to figures submitted daily by hospitals to an Internet database about their bed capacity.[7] Of the 9 acute care hospitals in the city prior to Katrina, only 3 had re-opened at a capacity of approximately 456 staffed beds as of February 22, 2006 (see table 1).[8]

[4] 44 C.F.R. § 206.226(f).
[5] Trauma centers are designated based on existing resources and expertise to treat differing types and severity of injury. Level I trauma units are able to treat any type of injury, no matter how severe. According to the American College of Surgeons, a Level I trauma center has a full range of specialists and equipment available 24-hours a day and admits a minimum required annual volume of severely injured patients.
[6] MCLNO announced plans to re-establish a Level I trauma unit in the New Orleans area working in conjunction with another facility.
[7] The Internet database is called "GNOEMS" and was developed by the Greater New Orleans Healthcare Taskforce with the assistance of the U.S. Public Health Service.
[8] Before Hurricane Katrina, some health care experts characterized New Orleans as having an oversupply of hospital beds.

Table 1: Number of Staffed Beds at Acute Care Facilities in the Greater New Orleans Area Before and After Hurricane Katrina

Facilities in New Orleans (Orleans Parish)[a]	Pre-Katrina staffed beds	Staffed beds as of Feb. 22, 2006[a]	Change
Touro Infirmary	345	250	(95)[b]
Children's Hospital	175	143	(32)
Tulane University Hospital and Clinic[c]	362	63	(299)
Lindy Boggs Medical Center	168	Closed	(168)
MCLNO	500	Closed	(500)
Memorial Medical Center	252	Closed	(252)
Methodist Hospital	261	Closed	(261)
New Orleans VA Medical Center	206	Closed	(206)
Total	2, 269	456	(1,813)
Facilities outside of New Orleans (Jefferson and St. Bernard parishes)			
East Jefferson General Hospital	444	444	0
West Jefferson Medical Center	317	330	13
Ochsner Clinic Foundation	472	484	12
Lakeside Hospital	102	97	(5)
Kenner Regional Medical Center	162	73	(89)
Meadowcrest Hospital	179	100	(79)
Chalmette Medical Center	138	Closed	(138)
Total	1,814	1,528	(286)
Total New Orleans and outside	**4,083**	**1,984**	**(2,099)**

Source: GAO analysis of data from the GNOEMS online Internet hospital reporting system and from the Bring New Orleans Back Health and Social Services Committee Hospital and Specialty Care Subcommittee.

[a] New Orleans and Orleans Parish have the same geographical boundaries.
[b] Parentheses indicate a decrease.
[c] At the time of our visit, Tulane University Hospital and Clinic was undergoing repairs from flooding and an official said they expected to reopen in February with 63 beds, along with emergency department services. Tulane opened its limited facility on Feb. 14, 2006.

• **Emergency Care:** Increased demand has been reported at the open emergency departments and has led to slow unloading of patients from ambulances and to patients being housed in the emergency department because hospital beds were not available. For example, according to data reported by hospitals on February 22, 2006, wait times for emergency medical services (EMS) vehicles to offload stable patients into emergency departments varied from no wait at some hospitals to as long as 2 hours reported by 2 hospitals, and hospitals reported that 38 patients had been admitted and were being housed in the emergency department.

• **Safety Net Clinics:** More than three-fourths of the safety net clinics in the New Orleans area were closed, and many of those that were open had limited capacity, according to data gathered by officials at the DHH. For example, prior to Katrina, 90 clinics were in operation, including 70 clinics run by MCLNO, with the remainder being federally qualified health centers, mental health or addictive disorder clinics, or other specialty clinics. Post-hurricane, 19 clinics were open according to DHH figures, generally operating at less than 50 percent of pre-Katrina capacity.

At the time of our visit, primary and emergency department care was available within the city, though at reduced levels, and access to specialty and diagnostic care was very limited, local health care officials said. Two hospitals were open with reduced bed capacity, and MCLNO was operating a limited emergency care clinic called "Spirit of Charity" at the Ernest N. Morial Convention Center in downtown New Orleans. Spirit of Charity medical personnel were using donated Air Force field mobile hospital tents and portable buildings set up on the convention center floor to handle minor emergencies such as simple fractures and lacerations, conduct medical assessments, and manage overdoses and intoxication, MCLNO officials said. The clinic's medical personnel were seeing an increasing number of patients each month, with more than 4,500 visits in December 2005, officials said. At the time of our visit, MCLNO officials said Spirit of Charity would have to leave the convention center site by early March.[9]

In addition to the severe damage sustained by health facilities, maintaining and attracting the workforce for these facilities is also a serious issue for local officials. An estimated 3,200 physicians lived in the metropolitan area before Hurricane Katrina, with 2,664 of those physicians residing in New Orleans itself, according to DHH figures. We were unable to obtain an estimate of how many physicians are currently in New Orleans. Hospital officials said they faced a shortage of support staff, such as food service or janitorial workers, who were unable to return due to a lack of housing or were being offered higher wages at hotels and restaurants.

Long-Term Decisions About the Health Care System in New Orleans Are Affected by Uncertainties About the Future

As the city struggles to restore some capacity to meet the immediate needs of the population currently there, long-term decisions about how to rebuild it are affected by questions about whether the health care system should be rebuilt to its pre-Katrina configuration and uncertainties about the returning population. Some health policy researchers have noted that the efficiency of the pre-Katrina health system in New Orleans could be improved by moving away from New Orleans' hospital-centric system. Some local officials have also suggested that the health care situation prior to the hurricane was less than ideal and the city has a chance to rebuild a better system.

Uncertainty about how quickly the population will return to New Orleans, as well as who will return and where people will settle, poses difficult challenges for officials attempting to plan the restoration of health care services, such as how much capacity will be required and where to locate services. Prior to Katrina, the 2000 Census estimated the city's population at 484,674 people. The most recent estimates of the size of the population found that as of December 2005, the number of people who remained in the city each night (referred to as the "core" population) was about 156,900, a decline of approximately 68 percent, according to figures reported by DHH. The population increased by about 100,000 during the day, including former residents living outside the city and returning during the day and workers involved in reconstruction activities. The estimates showed that most of those returning were

[9]Spirit of Charity was moved to a former department store located near Charity Hospital on March 11-12. Costs associated with this move and leasing of the site were funded by FEMA under the Public Assistance program.

between the ages of 35 and 44. DHH noted that relatively few children had returned, in large part because most schools in New Orleans remain closed. One projection estimates that the population in 2008 will be 247,000, about half of the pre-Katrina population, due to a lack of housing and other services.

Over the long term, rebuilding the health care system will be vital to attract people back to New Orleans and ensure its recovery. State, local, and federal governments all have important roles to play in the recovery process. At the state and local levels, commissions to plan for the future health care system have been established, and one has completed its work. The Mayor of New Orleans' Bring New Orleans Back Commission issued recommendations to shift the focus, to the degree possible, toward ambulatory care, wellness and preventive medicine, health promotion, and chronic disease prevention and away from institutional care; maintain a university teaching hospital in New Orleans; and build capacity for electronic medical records. The commission also noted the difficulty of doing effective planning without reliable information on the population and what segments of the population will return. The Louisiana Recovery Authority, established by the Governor, included one task force dedicated to health care issues. At the federal level, the Department of Health and Human Services has a support role under the National Response Plan for long-term community recovery and mitigation to enable community recovery from the long-term consequences of a large-scale incident.[10]

Despite the multiple planning efforts that had been completed or were still underway, a clear consensus on how to rebuild had not yet emerged at the time of our visit. Several hospital officials we interviewed said they were looking for strong local leadership to emerge. LSU officials were not waiting for the results of the planning efforts and were proceeding with their own plans. LSU officials said they intended to fulfill their statutory mission of care for the uninsured and also did not want to abandon the work in trauma services and health professions' education. In particular, LSU officials were focusing on the disposition of the Charity Hospital facility. In February 2006, they signed an agreement with the Department of Veterans Affairs to explore the feasibility of jointly building a teaching hospital and Level I trauma center in downtown New Orleans.

Funds Available From FEMA to Repair MCLNO Hospitals Will be Limited to Hurricane Damage

Hurricane Katrina and the subsequent flooding caused by the failure of the New Orleans levee system have exacerbated the already deteriorating physical conditions of Charity and University Hospitals. Prior to the disaster, both hospital facilities had documented deficiencies and were having difficulties meeting health care standards. LSU Health Care Services Division had decided to support the construction of a new facility to replace both Charity Hospital and University Hospital and was in process of seeking funding for the project when the storm occurred.

[10] We will be following the Department's efforts to fulfill this role in the coming months.

FEMA's estimate for repairing the damage to the MCLNO facilities caused by the hurricane was considerably lower than an estimate prepared by ADAMS, a consultant to LSU. LSU's estimate included correction of pre-disaster deficiencies that under the Public Assistance program are ineligible for federal funding, while FEMA's estimate included only repair to what it considered damage caused by the hurricane.

Shortly after Katrina struck the New Orleans area, LSU hired ADAMS consulting to conduct a facilities assessment and develop an initial estimate for repair of the MCLNO facilities. The estimate developed for Charity Hospital was $257.7 million and for University Hospital was $117.4 million. These estimates included whole building repair, meaning that they addressed damage from Katrina and many deficiencies that had been identified before the hurricane. ADAMS also estimated replacement costs at $395.4 million for Charity Hospital and $171.7 million for University Hospital. Based on these estimates, ADAMS determined that repairs exceeded 50 percent of replacement costs for the MCLNO facilities.

As noted earlier, the LSU estimate is for a whole building repair. This estimate also includes a 66 percent cost escalation over a commonly used index of labor and material cost for New Orleans. The cost escalation was meant to anticipate material and labor shortages over the next 3-6 years as a result of the hurricane. According to the LSU assessment, the structural systems, such as columns, beams and flooring systems, are in functional condition, although destructive testing would be required to verify this condition. However, the mechanical, electrical, and plumbing systems are beyond repair and there are significant environmental safety problems. Repair cost estimates were based on visual inspections of systems.

FEMA's basis for its estimate for repair cost for the MCLNO facilities was for work to rectify the damage from flooding and wind only, since these are the only repairs eligible for federal reimbursement. The agency conducted surveys and prepared estimates based on FEMA regulations and guidance. Its estimate for repair of Charity Hospital was $23.9 million and for University Hospital $12.4 million.

Like the LSU estimate, FEMA's cost estimate was based on a visual survey. Unlike the LSU estimate, it was detailed in exact material items needed, such as number of doors and windows and costs associated with installation. FEMA also used a cost index of labor and material for New Orleans with no cost markups. A recently awarded contract for renovation work for the New Orleans Arena had three out of five bids submitted at below the government estimate. Based on this data, FEMA concluded that cost increases to its original estimate due to wage and material inflation were not justified. Table 2 compares LSU's repair and replacement estimates to FEMA's.

Table 2: LSU and FEMA Estimates for Charity and University Hospitals

Charity Hospital	LSU estimate in millions	FEMA estimate in millions
Repair estimate	$257.7	$23.9
Replace estimate	$395.4	$147.7 - $267.3
Percent of replace estimate	65%	9% - 16%
University Hospital		
Repair estimate	$117.4	$12.4
Replace estimate	$171.7	$57.4 - $103.9
Percent of replace estimate	68%	12% - 22%

Source: ADAMS 2005 Emergency Facilities Assessment and FEMA Project Worksheets.

Based on its assessment and estimates, LSU believed that its facilities were damaged beyond 50 percent of their total replacement cost, meeting the Public Assistance program criteria for replacement funding. Based on FEMA's initial repair and replacement estimates, repair costs as a percentage of replacement costs ranged from 9 to 22 percent, well under the threshold for qualifying for replacement funding. Although LSU could appeal the estimate that FEMA developed, it will not be able to increase the scope of eligible repairs to correct pre-disaster deficiencies. Consequently, LSU is likely to receive federal funds that will be significantly below its original expectation.

Over time, should LSU decide to proceed with repairs to one or both facilities, FEMA's estimate and the subsequent federal reimbursement is likely to increase. For example, FEMA's current estimate does not yet include clean up or removal of environmental hazards such as asbestos or mold, does not include any elevator repairs, and does not include code upgrades that may be triggered by renovation work. Any of these costs, if found to be legitimate, may be eligible for reimbursement above and beyond the initial FEMA grant. Even including all of these factors, it is unlikely that the repair work cost totals will reach 50 percent of the replacement costs.

Should LSU decide to rebuild the hospitals, LSU is authorized under the Public Assistance program to use funds approved for repair on a replacement facility. However, the amount eligible for reimbursement will not increase past the initial FEMA grant for repair, pending any appeals of the estimate and their resolution.

Concluding Observations

Approximately 6 months after Hurricane Katrina hit New Orleans, city, state, and hospital officials we interviewed generally agreed that the local health care system had been severely compromised and that the number of operating facilities and available health care providers remained much smaller than before the hurricane. Population return is projected to be slow, and population projections suggest that New Orleans will be smaller in the future compared to its pre-Katrina status.

Apart from self-reported hospital data, it has been difficult to find firm information about the returning population and the status of the workforce. The lack of reliable information makes planning difficult and can create risks for moving forward due to uncertainties about what the future will look like. Although various planning efforts were completed or underway, at the time of our visit no clear consensus had emerged.

Because MCLNO played a major role in the pre-Katrina health care infrastructure in both New Orleans and for the State of Louisiana, LSU's decision about rebuilding these facilities could have significant implications for health care service delivery in post-Katrina New Orleans and for statewide training and Level I trauma care. Faced with uncertainty about how quickly the population will return, how a future health care system should be configured, how much LSU will receive from the Public Assistance program for repair of Charity and University hospitals, and uncertainties about availability of other funds, LSU faces a complicated decision about whether to repair Charity and University hospitals or build a new facility. Since the facilities were severely damaged and were already outdated, proceeding with federal funding for repairs may be wasting tens of millions of dollars. Further major renovations or new replacement facilities would be needed to provide facilities that meet the standards of modern health care delivery. If LSU decides to build a new facility, FEMA Public Assistance funds would likely not cover the cost.

We provided a draft copy of this report to DHS and LSU for review and comment. DHS and FEMA officials provided oral comments and LSU officials provided comments via e-mail. These were technical comments which have been incorporated as appropriate.

We are sending copies of this report to the Secretary of DHS and other interested parties. We will also make copies available to others on request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report.

If you or your staffs have any questions about this report, please contact Cynthia Bascetta at (202) 512-7101 or BascettaC@gao.gov for issues related to health services. Please contact Katherine Siggerud at (202) 512-2834 or SiggerudK@gao.gov for issues related to health facilities. Major contributors to this report were Terrell Dorn, Assistant Director; Linda Kohn, Assistant Director; Michaela Brown, George Depaoli, and Karen Doran.

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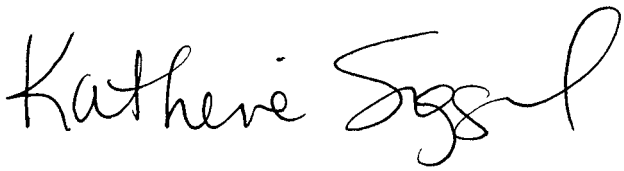

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