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Pediatric Private Practice After Hurricane Katrina: Proposal for Recovery

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ABSTRACT

The health care system of the US Gulf Coast was severely damaged by Hurricane Katrina in August 2005. Physicians in the region have faced enormous financial and psychological challenges. Pediatricians have been particularly affected, because of the large number of children covered by Medicaid, with its associated low payments, and the failure of children and families to return to affected areas. Federal relief efforts to date have largely benefited nonprofit organizations, community health centers, and hospitals. Private physicians have received little to no governmental assistance, despite their vital role in the health care system. This article explores the many factors threatening the survival of pediatric private practice in the aftermath of Hurricane Katrina and offers some practical governmental solutions. The proposals outlined here aim to provide stability and recovery to health care in the region by enabling residents to obtain care from local preexisting providers on the Gulf Coast and ensuring that physicians are paid adequately for their services. These ideas have applicability beyond Hurricane Katrina and should encourage thought regarding health care delivery after future regional disasters. *Pediatrics* 2008;122:836–842

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Key Words

delivery of health care, disaster, private practice

Abbreviations

FEMA—Federal Emergency Management Agency
 FQHC—federally qualified health center
 CMS—Centers for Medicare and Medicaid Services

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HURRICANE KATRINA BROUGHT unprecedented devastation to the US Gulf Coast. Since August 29, 2005, there has been slow progress toward recovery. This recovery has involved an uneven, and often bumpy, collaboration between individuals, businesses, state governments, federal agencies, and private organizations. Despite the tremendous outpouring of assistance and resolve, many people and small businesses continue to struggle in the hardest-hit areas.^{1–3} The medical community has not escaped such pressures.

Physicians suffered enormous financial losses in the aftermath of Hurricane Katrina. Offices and equipment were damaged or destroyed by flooding and winds. The disruption in power led to the loss of thousands of doses of vaccines. Private insurance covered these losses inconsistently, and with varying time frames; some providers only recently received payment on appeals of their initial loss determinations.

For weeks to months after the storm, a lack of usable or safe office space, housing, water, power, and telephone service hindered physician efforts in reestablishing practices. Many doctors also needed time to attend to their families and their own basic physical, psychological, and financial needs. Business interruption insurance, when available, covered time away from practice to varying degrees; many practices lost thousands of dollars of unrealized revenue during this time, while facing ongoing personal and business expenses.

Although some practices had implemented electronic medical record systems, the majority of medical offices were using paper charts at the time of Hurricane Katrina. Many charts were lost, destroyed, or rendered unrecoverable because of wind and water damages. The loss of medical records created hardship not only for patients but also for physicians considering restarting or attempting to restart their practices. In the wake of these losses, many doctors left the Gulf Coast region to resettle elsewhere.⁴ Many other physicians who had evacuated returned to the Gulf Coast region over the next few weeks to months. Still others never left and began practicing as soon as the storm passed, albeit often in primitive and makeshift conditions.⁵

After Hurricane Katrina, medical care in the affected areas generally was provided by 4 groups, that is, local providers, federal Disaster Medical Assistance Teams, contracted mobile units (such as Carolinas MED-1 and National Guard expeditionary medical support), and volunteer free clinics. In the immediate first days, only local resources were available, such as hospital emergency departments. When the Disaster Medical Assistance Teams and mobile units arrived, these sites relieved local providers, brought significantly greater medical capability, and arguably became the primary sources of medical care for the region. Smaller freestanding clinics, staffed by both local providers and out-of-town volunteers, provided additional care. With time, the larger facilities gradually scaled back and eventually ceased operations, allowing the local providers and free clinics to assume more responsibility for care.

Patients often sought care from free or temporary clinics instead of seeing local providers, for a variety of reasons. The outside clinics often were large, highly visible operations situated in central locations, compared with individual providers operating from more rudimentary spaces. In Waveland, Mississippi, for instance, the Carolinas MED-1 team erected a massive, white, air-conditioned tent in the parking lot of a K-Mart store, located at a major intersection into town.⁶ Similarly, the federal disaster medical assistance team (and the subsequent National Guard expeditionary medical support field hospital) was located on the grounds of the nearby community hospital, with numerous military-style tents and a substantial population of medical personnel.^{7,8} Volunteer teams from the Loudoun Medical Group in Virginia operated a clinic out of the Bay St Louis train depot, a local landmark.⁹ The Children's Health Fund Operation Assist, in conjunction with the Columbia University National Center for Disaster Preparedness, sent health care teams in mobile medical units to Biloxi, Mississippi, and other areas.¹⁰ Because communications were profoundly disrupted, patients might not have been aware of the presence, location, or availability of local providers. In addition, many patients were then unemployed and therefore uninsured; others were unsure of their insurance coverage. Patients were fearful of having to pay out-of-pocket costs for an office visit at a local provider and thus sought care from free sources. Although the longer-standing volunteer clinics did encourage patients to return to their usual sources of care, particularly when the patients had health insurance, it was noted anecdotally that even insured patients continued to use the free clinics.¹¹ As a result, local physicians found themselves competing for patients with other sources of medical care.^{9,11}

SYSTEMATIC PROBLEMS THREATEN RECOVERY OF PRIVATE PRACTICES

Even after the free clinics departed and the local providers returned in sufficient numbers to begin assuming the community's medical care, problems remained or even emerged. The area population has been increasing, but the housing shortage has created a bottleneck, prohibiting full return to prestorm numbers.¹² In particular, many families with children have delayed returning,¹³ waiting not only for affordable and appropriate housing but also for reestablishment of community services and schools and improved neighborhood conditions. Loss of major employers has left many patients without insurance, and many physicians have provided uncompensated or reduced-fee charity care at their own expense.¹⁴ Patients covered by state Medicaid programs have had to reapply for coverage when relocating to another state (since the expiration of a special Section 1115 waiver on February 1, 2006), resulting in potential temporary lack of insurance for these people as well.¹⁵ Hospitals remain closed or operate under reduced capabilities, creating a loss of inpatient revenue for private practitioners. Insurance settlements and federal Small Business Administration loans have taken months to reach physicians.¹⁶

Physicians face unique business constraints that limit their ability to recoup financial losses. Most businesses in a capitalistic society are free to raise their charges in response to scarcity, demand, or increased expenses. Physicians, however, generally contract with large health care organizations (including the federal Medicare and state Medicaid programs), which set the payments doctors receive for their services. A physician's charges are usually irrelevant to the amount the physician is paid, because payment schedules are fixed and predetermined. Out-of-network services, care for uninsured patients, and the rare contract or individual Current Procedural Terminology code paid as a percentage of charges and not otherwise capped are excluded from this generalization, but these instances typically constitute a minority of a pediatrician's revenue.

Meanwhile, other businesses operating without such artificial constraints have raised prices, compared with those before Hurricane Katrina. Higher rents, gasoline costs, fuel surcharges, and insurance premiums have increased overhead expenses and personal costs of living, in addition to the usual (not storm-related) inflation and increasing costs of vaccines.¹⁷ Therefore, physicians on the Gulf Coast face higher business and personal expenses, a decreased insured patient population, and an inability to increase reimbursement through charges.

LITTLE ASSISTANCE TO DATE

Shortly after the storm, some small measures were implemented to aid the medical community. The federal Medicare program granted 10% bonus payments to participating providers in designated health professional shortage areas. The Centers for Medicare and Medicaid Services (CMS) issued waivers of Stark violations through January 31, 2006. The federal Stark law and its subsequent rules and implementations (as published in the *Federal Register* by CMS) normally place stringent restrictions on hospital recruitment of, employment of, and assistance toward physicians, to prevent improper referral inducements.¹⁸ The post-Hurricane Katrina waivers allowed hospitals to assist temporarily or to employ already established local providers when they would otherwise have been unable to do so.¹⁹ The federal government also established a pool to reimburse hospitals and providers for uncompensated care rendered through January 31, 2006.^{14,15} In addition, state and federal medical societies, as well as other nongovernmental organizations, contributed grant money and donations of supplies.

These supportive measures, although helpful, have failed to provide significant, systematic, long-term, financial stability to private physician practices. As of this writing, state and federal governments have not developed any programs to stabilize private practices, and it has been up to individual providers to seek alternative practice models. In many ways, however, the individual physicians, although the most affected by these problems, are the least able to bring the problems to the attention of state and federal officials. Physicians on the Gulf Coast have been exposed on a daily basis to the

physical, mental, and socioeconomic problems caused by Hurricanes Katrina and Rita, through their patients, which has created personal stress and fatigue. Doctors also have experienced the effects of the hurricanes for themselves.

Physicians have been struggling to reestablish and to grow their own practices in the midst of the devastation and challenges, in some cases moving to multiple locations over the course of the past 3 years.²⁰ In theory, physicians could reorganize as nonprofit organizations and federally qualified health centers (FQHCs) and become eligible for expanded funding and grant opportunities. In practice, it is neither fair nor reasonable to ask physicians to restructure their practices into these unique and complicated models, particularly while continuing daily practice and facing the stresses of life in the disaster area. In addition, physicians receive payment based on services provided; therefore, time spent away from direct patient care, such as participating in meetings or writing grant proposals, leads to lost revenue.

Many doctors also lack the political knowledge and connections to navigate the proper channels efficiently and to effect change to the current system. As an example, Medicaid programs are administered by state agencies, are funded by the state legislatures, and receive federal contributions through the CMS under the US Department of Health and Human Services, which in turn receives its funding and some operating guidelines from the US Congress. Pediatricians seeking increased postdisaster funding and disbursements for Medicaid would thus need to convince influential persons in ≥ 4 separate state and federal offices.

Economic stresses, limited time, and other pressures create risk for provider burnout. Depletion of financial reserves, accompanied by the lack of long-term guarantees of stability, has led physicians to consider closing their practices and leaving the area.²¹⁻²³ The health care infrastructure is no closer to recovery, and in many ways is at greater risk of collapse, than it was immediately after Hurricane Katrina.

NEW PARADIGMS FOR RECOVERY: RETURNING PATIENTS TO LOCAL MEDICAL HOMES

The post-Hurricane Katrina environment presents a unique opportunity for rethinking the institutionalized response for health care recovery and delivery. To date, the official disaster response has favored short-term care, provided by temporary or new physicians, at the expense of preexisting community providers. A fundamental goal of recovery should be expediting the return of patients to their local medical care. In the language of pediatrics, this means reestablishing the medical home, to the benefit of both patients and physicians. Until there are formal incentives and assistance to allow local physicians to remain and to practice in the area, and to encourage patients to return to their predisaster physicians, the health care system continues to have a precarious and uncertain future.^{23,24}

Original solutions have been proposed, many of which involve restructuring existing programs or rela-

tionships to connect the public and private sectors. Currently in the United States, $\sim 85\%$ of pediatric encounters occur in privately owned and operated practices.²⁵ In the aftermath of a disaster, the traditional divisions between public health and private practice may no longer apply, as even for-profit providers become physicians for the entire community. Linking public resources to private practices and encouraging a blending of public and private roles could enable equitable ready access for all patients in the community, while ensuring the maintenance of a physician presence. The ultimate goal is a return to self-sufficiency as the community recovers; therefore, all recovery measures are intended to be temporary in nature.

Proposed solutions for health care recovery include the following. The first solution is to direct federal grants to individual providers. An appeal for direct funding is not always the most politically expedient solution to a problem. Nevertheless, the federal government has established precedents for such measures. First, in January 2007, the Department of Health and Human Services announced the release of \$160 million in grants to hospitals and skilled nursing facilities.²⁶ Eligible recipient hospitals are able to use such funds for recruitment and retention of providers but are under no obligation to do so. An additional \$15 million has been allocated for recruitment of providers to the New Orleans area, but none has been earmarked for Mississippi and, more significantly, none has been directed toward retention of providers already in the region. The economic, psychological, and social factors of daily life in the region create an environment in which recruiting new doctors is far more difficult and expensive than retaining existing ones. Second, the federal government authorized the Air Transportation Safety System and Stabilization Act after the terrorist attacks on September 11, 2001.^{27,28} This legislation included \$10 billion in loans and another \$5 billion in direct compensation to the airline industry as a whole. In passing the Air Transportation Safety System and Stabilization Act, Congress recognized the country's need for a solvent air transportation system. Although health care is at least as vital as transportation and the government already has an active role in funding, providing, and ensuring health care, Congress authorized only \$2 billion for health care after Hurricanes Katrina and Rita.²⁹

The second proposed solution is to create Medicaid incentive payments for providers in disaster areas. This proposal was first brought to the attention of state and federal authorities just days after Hurricane Katrina.³⁰ The federal Medicare program already has established such incentive payments, through the Health Resources and Services Administration health professional shortage areas; however, Medicare covers a limited segment of the population. In particular, children and families are far more likely to be covered by Medicaid than by Medicare. Pediatricians thus are largely excluded from Medicare incentives and require special attention of their own. Furthermore, Medicaid is the largest single insurer for children, covering approximately one half of all children in Louisiana and Mississippi.^{31,32} Pediatricians who

participate in the Medicaid program play a vital role in public health.

Although the individual states assume responsibility for administering their Medicaid programs, the funding is shared between the state and federal governments. Medicaid expenditures are already a significant source of strain on state budgets.³³ Furthermore, states affected by widespread disasters face significant financial problems and are hardly in a position to increase health care expenditures unilaterally. Funding for incentive payments probably would require federal assurance of assistance to cash-strapped states, but the federal government has established precedent with the assumption of 100% of affected states' portions of Medicaid from August 24, 2005, through January 31, 2006.¹⁵

The third proposed solution is to extend disproportionate share hospital adjustments to individual providers. Currently, private offices have no incentive other than simple "good will" to care for large proportions of Medicaid-covered and uninsured patients and in fact face significant financial disincentives to provide care to the indigent. Medicaid generally pays physicians less than private insurance for similar services, whereas uninsured patients often are unable to pay for their health care at all. The loss of employer-based private health insurance in the region means a proportional shift of patients to Medicaid and uninsured status, to the financial detriment of pediatricians. The CMS recognize that hospitals that provide care to large numbers of Medicaid, Medicare, or uninsured patients face financial difficulties, and the CMS attempt to compensate the hospitals with disproportionate share hospital adjustments.^{28,34} The CMS can and should create a similar supplemental system for individual physicians' practices that care for large numbers of poor and indigent patients.

The fourth proposed solution is to fast-track and to expand the National Health Service Corps loan repayment program for affected areas. The loss of stable medical care means that much of the disaster area qualifies as a health professional shortage area. Physicians need incentives to stay and/or to return, and loan forgiveness is one way to accomplish this. However, the existing process can take up to 1 year for approval of a provider and his or her site for the loan repayment program. The National Health Service Corps should fast-track all applications for disaster-area providers and should authorize priority funding to ensure the providers' commitment to staying in the affected area. Fast-track approval also guarantees physicians' presence during the first few years of recovery, encouraging longer-term stability and reestablishment.

The fifth proposed solution is to have the Federal Emergency Management Agency (FEMA) contract with private physicians to provide care for uninsured patients. As mentioned previously, the loss of major employers in the disaster area means the loss of employer-based health insurance for a large number of people. In addition, the tremendous amount of construction has brought into the area many migrant workers, who also lack health insurance. Uninsured patients seek health care from free clinics, go to the local emergency depart-

ment (the costs of which often are unreimbursed and uncollected, taxing already overextended hospitals), pay out of pocket to private physicians, or simply go without medical care. Private physicians, for the most part, would be glad to treat these patients, provided the physicians did not have to bear the burden of providing significant unreimbursed care. FEMA could bridge this gap by contracting private physicians to provide medical care for otherwise uninsured patients. The program could be administered by an existing agency, such as Medicare, Medicaid, or a private health insurance company (such as how Blue Cross and Blue Shield of Mississippi operates the State Children's Health Insurance Program). This arrangement would enable residents and recovery workers to obtain consistent health care, while helping physician practices assume primary responsibility for the community's medical needs. The recovery of the entire community would be advanced, which falls within the mandate for FEMA. Of note, the federal government has established precedent through the uncompensated care pool that was retroactive through January 31, 2006; this proposed contracting can be seen as an offshoot of that pool, with more-formal administration.

Currently, the Stafford Act explicitly authorizes the federal government to use private nonprofit organizations in providing essential disaster response services.³⁵ For-profit entities are not mentioned in the Stafford Act and thus are neither endorsed nor prohibited, with a favorable interpretation possible.³⁶ Alternatively, FEMA allows funding to state and local governments, which in turn could contract with for-profit businesses to provide other aspects of emergency response and recovery, such as debris removal.³⁷

The sixth proposed solution is to allow private physicians' offices to become federally designated community health centers (FQHCs). FQHCs are required to serve an otherwise underserved population and to provide service to all residents regardless of ability to pay; most physicians desiring to remain in an affected area already would be fulfilling both of those obligations. With FQHC designation, the physician would benefit from enhanced Medicare and Medicaid funding while reestablishing a presence in the community. The physician and patient could find each other while minimizing each party's concern for out-of-pocket costs. At present, FQHC applicants agree to an extensive list of rules and regulations in exchange for increased payment. One of these regulations states that pediatricians, obstetrician/gynecologists, and internists cannot become freestanding FQHCs, because these specialties cannot individually treat all patients.^{38,39} The Department of Health and Human Services could grant a waiver for this and similar requirements or could provide a special representative to help coordinate these disparate specialties into one primary care group and to assist in the process of becoming a FQHC.

The seventh proposed solution is to allow private physicians to become employees or independent contractors of local health departments. If local physicians are serving the public health through practice in a disas-

ter area, particularly by caring for the underserved, then this role can be solidified by extending employment or other contractual affiliation to the local physicians. The local health department and the providers can cooperatively assume and expand a presence and provide health care for the community. The disadvantage of this arrangement is that health departments within disaster areas have been critically short of building space and funding; therefore, this would require a special commitment from state, and most likely federal, authorities.

The eighth proposed solution is to create a fast-track health care recovery loan for physicians. The Small Business Administration has been overwhelmed with demands for posthurricane relief loans. As a result, it is taking many months for loans to be approved and funds disbursed.¹⁶ Physicians generally represent excellent credit risks and need ready access to funds to restore their practices quickly. If the existing Small Business Administration loan process cannot be expedited specifically for physicians, then a separate loan program should be created to allow medical practices to be restarted and to return to helping the community. Ideally, these loans would have low interest rates or no interest, with extended repayment periods.

The ninth proposed solution is to create tax breaks or credits specifically for providers in disaster areas. The Internal Revenue Service could allow providers to deduct unreimbursed care, either as unrealized income or as charitable contributions. Of note, the Internal Revenue Service already has created special deductions for charity care related to Hurricane Katrina, including the use of a private automobile in providing charitable services after Hurricane Katrina, as well as costs associated with housing individuals affected by Hurricane Katrina.⁴⁰

Certainly other solutions are possible, but these ideas are intended as a starting point. The medical infrastructure of the Gulf Coast needs help urgently, before conditions deteriorate further. If physicians leave the area, then it will be far more difficult to entice new doctors, and the health care of the region will fail accordingly.

The closure of private physician practices has practical consequences for both individual patients and the greater community recovery. The Louisiana Health Care Redesign Collaborative, established with the assistance of US Secretary of Health and Human Services Michael Leavitt, has been charged with rectifying New Orleans' historically "two-tiered" health system of divided private and public services.⁴¹ If and when private physicians leave the Gulf Coast, the remaining citizens will be able to receive care only from hospital-run groups or community health centers. Although the Louisiana Health Care Redesign Collaborative intends to expand choice, equality, and services for New Orleans, the greater Gulf Coast continues on a path toward losing these very qualities, which has frightening implications for long-term recovery and the attractiveness of the region for potential new residents and businesses.

The Louisiana Health Care Redesign Collaborative

and other governmental authorities navigate uncharted waters as they attempt to rebuild the Gulf Coast health care system. The lack of concrete data regarding numbers and distribution of remaining doctors, numbers of insured and uninsured patients, medical expenditures, health care utilization, and ongoing trends hampers prioritizing, budgeting, and planning. However, this lack of data cannot imply that problems do not exist or have been exaggerated. There is emerging research and anecdotal evidence that residents face difficulty obtaining care, health care needs are not being met, and doctors continue to leave without replacements arriving.^{23,42-45}

According to a recent survey by the National Center for Disaster Preparedness, between one fourth and one third of children in the region now lack a medical home.²³ Given these reports from the field, the absence of a more comprehensive survey of the area's health care lends credence to the idea that a looming crisis remains unaddressed. The reported lack of improvement in health care despite recovery in other sectors (such as population, public utilities, housing, and business) supports state and federal intervention sooner rather than later.

CONCLUSIONS

The health of the Gulf Coast medical community, and by extension the health of the entire community, teeters on the brink. The United States has never before faced such an encompassing regional crisis in health care delivery. More than 3 years after Hurricane Katrina, state and federal authorities still lack a systematic and comprehensive remedy, particularly one that includes physicians in private practice. Practical effective solutions exist, but they cannot become reality without the resources and direction of the government. Furthermore, as devastating as Hurricane Katrina has been, no one would presume that another disaster of similar or even greater magnitude will not strike again, on the Gulf Coast or elsewhere. In taking steps to save the Gulf Coast, we can begin to develop a new paradigm for restoring health care after future events.

DENOUEMENT

The author was in solo private practice in Bay St Louis, Mississippi, from February 2004. His community suffered some of the worst devastation of Hurricane Katrina and, while he and his family evacuated to safety, he lost his home and office in the storm. He returned to practice 1 month later. From December 2005 through June 2006, he practiced from a classroom trailer without running water, in the local hospital's parking lot. Because of financial, psychological, and lifestyle factors, he closed his practice in June 2007 and is now employed with a FQHC in Naples, Florida.

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NATIONAL HEADACHE FOUNDATION REQUEST FOR PROPOSAL (RFP)

TYPE OF RESEARCH GRANT: Competitive. Each application will be reviewed comprehensively by an expert committee of the National Headache Foundation Board of Directors. Each proposal will be reviewed for determination of applicant's eligibility and the proposal's scientific merits, clinical relevance, and potential advancement of headache medicine.

AMOUNT OF FUNDING: 10 000 USD, Duration of funding: One year

ELIGIBILITY CRITERIA:

1. Behavioral or basic scientist, physician, or physician scientist with a demonstrated interest in developmental specialties
2. Either in training (Graduate student or medical resident) or less than 5 years post graduation or residency experience
3. Affiliated with a United States based program, within the 50 States
4. Committed to present results of completed research at a national or international conference

APPLICATION: Eligible applicants should submit the following documents:

1. A maximum two-page proposal for a research project. Required components of the proposal are:

- Project title of the project
- Specific aims
- Objectives
- Background on chosen subject
- Methods of data collection and data analyses
- Budget and budget justification
- Sources of additional project funding, if applicable
- NIH budget catchment, if applicable

2. A signed and dated recent curriculum vitae
3. Two letters of recommendations from senior colleagues personally familiar with the applicant's professional work experience and expertise
4. All applications and correspondence should be directed to:
 - National Headache Foundation, 820 N. Orleans, #217, Chicago, IL 60610-3132.
 - Phone: 312-274-2651, Fax: 312-640-9049, Attention: Ms Suzanne Simons

DEADLINE FOR APPLICATION: December 1, 2008

Pediatric Private Practice After Hurricane Katrina: Proposal for Recovery

Scott Needle

Pediatrics 2008;122:836-842

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Updated Information & Services	including high-resolution figures, can be found at: http://www.pediatrics.org/cgi/content/full/122/4/836
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