State Health Watch

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THOMSON
AMERICAN HEALTH CONSULTANTS

Special Report:
Katrina Coverage

In This Issue

Hurricanes create major changes in the nation's health care system

In mid-September, as the Gulf Coast recovered from Hurricane Katrina and prepared for Hurricane Rita, some health care analysts started to assess the storm's broader impact on the nation's health care system. Since then, it is becoming increasingly clear these hurricanes caused disruptions and dislocations unlike anything known in many decades and may lead to radical changes in the way care is delivered and paid for.

The States React to Katrina

Consider that the hurricanes were centered on several states that are among the poorest in the country — Louisiana has a poverty rate of 22%, Mississippi 23%, and Alabama 20%. Katrina caused the evacuation of a major city in which 23% of the residents lived in poverty before the levees were breached. While many evacuees went elsewhere within their own states, an estimated 500,000 or more went to Texas, which itself had a 22% poverty rate before the influx of those forced from their homes and jobs in other states.

"Undoubtedly, Katrina has raised both the number of people in

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Though concerns about the health of children abounds, states feel time is right for progress

In spite of the significant fiscal problems they face — or, perhaps more importantly, because of those fiscal problems — officials of many states believe they are in an excellent position to take some steps that would have a positive impact on children's health.

Fiscal Fitness: How States Cope

Many of those officials say they're ready to move forward, says Health Management Associates principal **Vernon Smith**, who recently led a Commonwealth Fund-supported, daylong conversation with senior government officials involved with child health in many states.

"A time of fiscal stress is a good time to talk about issues like quality," Mr. Smith tells *State Health Watch*. "States always have limited resources and they always need to work to get the best value for the money they spend, and that means as high quality as possible."

Mr. Smith turned the results of the conversation with state officials into a Commonwealth Fund Issue Brief. He notes the health of American children has improved over recent

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State Health Watch
The Newsletter on State Health Care Reform

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Health care

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poverty and the number of uninsured living in the states hit by Katrina as well as in the states of refuge," the Kaiser Commission on Medicaid and the Uninsured said in an issue brief on Katrina's health care impact. "The only issue is the magnitude of the increase. An estimated 400,000 jobs have been lost; many of those who lost their jobs have lost not only their source of income but also the health insurance coverage that their former employers offered. Hospitals, clinics, nursing homes, pharmacies, and other facilities have been damaged or destroyed. Areas that, prior to Katrina, faced shortages of needed health care providers now have either fewer resources or none at all. Underserved populations with substantial health disparities before Katrina are now at risk for falling even further behind the rest of America."

The Kaiser report said because so many of those displaced were impoverished before Katrina, and because many more have become impoverished, it is not realistic to expect those displaced, many of whom now have no income and no health coverage, to bear the cost of needed health care services. And the ability of the states hit by the storms to finance provision of needed health care services is questionable given the damage to their economies.

Hard-hit states will lose revenues

For example, both Louisiana and Mississippi are likely to lose revenue from the temporary shutdown of many industries in the affected regions, including the oil, natural gas, refining, petrochemical, shipping and shipbuilding, agriculture, and seafood industries; the shutdown of the Port of New Orleans; the destruction of the large casinos in Mississippi and New Orleans; and the collapse of the tourism industry through which visitors spent an estimated $5.2 billion in Louisiana last year, mostly in the New Orleans area.

Consider also that in addition to the massive intrastate relocations, Katrina has caused the largest interstate migration of Americans since the 1930s Dust Bowl. As the days and weeks went by, many states reported receiving Katrina survivors and it was unclear when or even whether these displaced individuals would be able to return to their communities.

"Many of these states of refuge, like Texas, had high rates of poverty and uninsurance prior to this influx," the report said. "These states and their localities face the challenges of delivering health care to the displaced, many of whom are in poor health, while at the same time ensuring the continued delivery of health care to their own residents as well as administering their Medicaid, public health, and cash assistance programs. The economic effect of Katrina is likely to undermine the capacity of these states to meet this rapid, unexpected expansion in the numbers of impoverished people with significant health and mental health care needs."

Two major issues

The two major issues facing states and the federal government several weeks after the storm hit were the rules governing provision of Medicaid and other health care services in each state and the question of how care was to be paid for.

Within days of the hurricane's arrival, CMS said it was acting to assure that the Medicaid, Medicare, and SCHIP programs could be flexible enough to accommodate the

emergency health care needs of beneficiaries and medical providers in the states devastated by the storm.

"Many of the programs' normal operating procedures will be relaxed to speed provision of health care services to the elderly, children, and persons with disabilities who depend upon them," a CMS fact sheet said. CMS assured hospitals in neighboring states that the normal burden of documentation would be waived and a presumption of eligibility should be granted.

CMS also said it was implementing these provisions immediately:

Health care providers who furnish medical services in good faith but cannot comply with normal program requirements because of Hurricane Katrina will be paid for services provided and exempt from sanctions for noncompliance unless it is discovered that fraud or abuse occurred.

Crisis services provided to Medicare and Medicaid patients who have been transferred to facilities not certified to participate in the program will be paid.

Programs will reimburse facilities for providing dialysis to patients with kidney failure in alternative settings.

Medicare contractors may pay the costs of ambulance transfers of patients being evacuated from one health care facility to another.

Normal prior authorization and out-of-network requirements will be waived for those covered by Medicare, Medicaid, or SCHIP managed care plans.

Normal licensing requirements for doctors, nurses, and other health care professionals who cross state lines to provide emergency care in stricken areas will be waived as long as providers are licensed in their home states.

Certain HIPAA privacy requirements will be waived so providers can talk to family members about a patient's conditions even if the patient is unable to grant permission to the provider.

Hospitals and other facilities can be flexible in billing for beds that have been dedicated to other uses, such as if a psychiatric unit bed is used for an acute care patient admitted during the crisis.

Hospital emergency rooms will not be held liable under the EMTALA for transferring patients to other facilities for assessment if the original facility is in an area when a public health emergency has been declared.

While that initial response seemed to cover many issues for those who were enrolled in the programs before the storm hit, a larger question was how to provide health care services to those who had not been eligible before, or who were eligible but had not enrolled.

CMS enrollment template

CMS administrator **Mark McClellan** said the agency was developing a template states could use to have evacuees apply for emergency Medicaid waivers, retroactive to one week before the hurricane. Evacuees with or without documentation were able to use the template and states were given flexibility to lower copayments and beneficiary contributions.

McClellan said CMS was working with states to develop a new category of Medicaid and SCHIP eligibility for evacuees who can't prove either current eligibility or eligibility in their home state.

In a Kaiser Commission on Medicaid and the Uninsured telephone briefing, Ohio Medicaid director **Barbara Edwards** said states needed CMS to provide "simple and straightforward" answers about financial reimbursement for health services provided to hurricane victims. They needed to know, she said, how to proceed with Medicaid eligibility for Katrina victims whose Medicaid status could not immediately be verified and for individuals who now qualify for the program as a result of losses suffered.

Louisiana deputy Medicaid director **Ruth Kennedy** said the storm damage increased the demand for Medicaid-provided services. Thus, elderly people previously cared for by family members at home might now require nursing home care. And evacuees have significant health needs and must be enrolled in Medicaid coverage as quickly as possible.

One model pointed to by some experts was the Disaster Relief Medicaid program implemented in New York City in the months after Sept. 11, 2001. While that situation was much more localized and much of the health care infrastructure remained intact, it showed how to provide eight months of continuous Medicaid coverage for more than 350,000 New York City residents.

"Such a process could include a single page application form, self-attestation of residence and income information, and issuance of temporary Medicaid cards to eligible individuals at the time of initial application," Kaiser said. "To fully realize the benefits of the Disaster Relief Medicaid model, a single income eligibility standard could be applied to those displaced and impoverished by Katrina regardless of the state in which they were living at the time of application. In the absence of such a standard, each state will otherwise apply its own Medicaid income and resource standards, which vary substantially from state to state."

Because so many of those displaced by Katrina are impoverished, the Kaiser analysis suggested the federal government adopt time-limited changes to Medicaid as a vehicle for temporarily assisting those without

coverage. Because Medicaid funds "follow the person," with payments for services that are medically necessary to beneficiaries made to the providers actually serving the beneficiaries, Medicaid is seen as the most accurate mechanism for targeting federal assistance to the areas, providers, and low-income individuals who need it most, regardless of where they are living now or move to.

It has to be recognized, Kaiser said, that increasing Medicaid enrollment will place additional demands on the budgets of states taking in evacuees, because they are responsible for their share of Medicaid administrative and service costs for the displaced populations. And at the same time, the displaced individuals who qualify for Medicaid will not be able to contribute to the tax revenues of the receiving states until they find jobs.

"The resulting increased demands on state funds may lead to reductions in Medicaid eligibility, benefits, or provider payments for the entire population in the states of refuge," Kaiser cautioned.

Is congressional action needed?

The report said the federal government could consider obtaining congressional approval to pay 100% of the costs of Medicaid coverage for those impoverished or displaced by Katrina, both in the three states hit by the storm and in any state receiving evacuees.

To make Medicaid work as a source of coverage for all individuals displaced or impoverished by Katrina, limits on program eligibility would have to be changed since Medicaid generally only covers people who fall into certain defined categories — children, parents of dependent children, pregnant women, individuals with disabilities, and the elderly. Thus, adults who are not elderly, disabled, or pregnant, and who don't have dependent children, are not eligible for Medicaid regardless of their poverty status.

"It seems that many of those displaced or impoverished by Katrina are childless single adults or couples, including older adults with chronic health conditions," the report said. "To help these individuals, the federal government could make 100% federal matching funds available for the cost of furnishing Medicaid services to evacuees without regard to the categorical requirements that normally apply."

While several bills had been introduced to make Medicaid modifications and provide funding, CMS said the most efficient approach was for states to obtain expedited approval of Section 1115 waivers. Three weeks into the crisis, waivers had been approved for Texas, Mississippi, Alabama, and Florida, and CMS said it would approve waivers for other states that have large numbers of evacuees.

Under the agreement, states get immediate support for the medical care provided to Katrina evacuees, including money for uncompensated care. The waiver also supports innovative ways to provide needed care that differ from standard approaches in Medicaid, including expanded community-based health care centers, mobile units for providing basic care at convenient locations for evacuees and new referral networks, and care provided by health care professionals who don't otherwise participate in Medicaid.

Evacuees with little ability to pay for care can get coverage through Medicaid or SCHIP for up to five months, even without the usual documentation. Needed medical services will be delivered to evacuees who are children up to age 19 and their parents, pregnant women, individuals with disabilities, low-income Medicare beneficiaries, and those who need long-term care and meet certain income requirements. Evacuees will be asked to complete a simplified application form declaring their income and assets, if any. Services provided will be through states' standard benefits packages.

However, many state officials and policy experts say those Section 1115 waivers, while welcome, don't go far enough to address the needs that exist. The National Governors Association wrote to Senate and House leaders urging quick passage of legislation that would temporarily provide 100% federal financing for all the Medicaid and related healthcare needs of displaced individuals.

Kaiser Commission on Medicaid and the Uninsured staff member **David Rousseau**, who helped write the report, tells *State Health Watch* that while negotiating waivers with states was a quick approach to the problem, the waivers are with the states rather than the individual beneficiaries and don't cover people as they move from one state to another. He said legislation for federal funding was likely to help survivors more directly as they move to new locations.

Working on Grassley's bill

While several emergency health care bills had been introduced in both the House and Senate, the one that appeared to have the most traction was submitted by Senate Finance Committee chairman **Chuck Grassley**, R-IA, and that committee's ranking Democrat, **Max Baucus**, D-MT.

Under their Emergency Health Care Relief Act of 2005, Louisiana, Mississippi, and Alabama counties under a disaster declaration would receive a 100% federal match until the end of 2006. And there would be targeted, temporary Disaster

Relief Medicaid coverage to those people in or evacuees from the hardest-hit counties in Louisiana, Mississippi, and Alabama. Coverage would be for all people up to 100% of the federal poverty line or up to 200% for pregnant women, children, and the disabled. States would be reimbursed at 100% federal match for care provided through Disaster Relief Medicaid.

Assistance would be provided to help individuals who qualify for Disaster Relief Medicaid but have private health insurance so they could pay their premiums and maintain their private coverage. There also would be assistance to qualified employers in the hardest hit counties to help them maintain private health insurance coverage for their employees. Qualified employees would be those who operated in the disaster area and are 1) inoperable as a result of damage sustained from Katrina; or 2) not paying salary or benefits to employees as a result of damage.

The Disaster Relief Medicaid would be in effect for five months from the date of enactment, retroactive to the day before the hurricane made landfall, and could be extended by the president for another five months.

The bill would create a disaster relief fund to provide payments to Medicaid providers experiencing a significant increase or decrease in patient volume due to Hurricane Katrina. Direct payment also could go to providers to offset costs incurred as a result of the hurricane and to enable them to continue operations.

The letter from the National Governors Association said the governors "are very supportive of your relief package and appreciate that you have been willing to work with us in making sure the needs of our most vulnerable citizens are addressed." It said the bill would be "critical to help these individuals put their lives back together and retain some semblance of stability."

However, the White House's initial position was that the issue could be better addressed without a legislative solution. Pursuing that reasoning, McClellan said, "I don't think it's necessary or helpful or timely to set up new federal systems to deal with this problem." And even as some members of Congress questioned the wisdom of continuing with Medicaid reform efforts aimed at cutting $10 billion from the Medicaid budget over the next five years, given the magnitude of hurricane-related needs, McClellan said such reform was "even more urgent" since the hurricane, insisting that expanded use of generic medicines and stricter asset transfer rules could reduce Medicaid spending "without reducing benefits to anyone."

The Kaiser report concluded that with more than a million people, including many who are poor, elderly, and suffering from a range of chronic conditions and disabilities, displaced from their homes and relocated in other parts of their own states or other states, three health issues need an immediate response: the loss of health coverage by hundreds of thousands of impoverished Katrina victims, restoring the shattered health care infrastructure in the impacted areas, and avoiding further disruption in access to medications for dual eligibles.

"The Medicaid program provides an immediate and practical solution for addressing the health care coverage needs of low-income survivors," Kaiser said. "Medicaid's availability in every state, coverage of a range of health and long-term care services, established payment arrangements with providers, and targeting of coverage to low-income beneficiaries makes it uniquely equipped to assist the low-income individuals who need medical or mental health services quickly. Policy-makers have already recognized that normal documentation requirements will be impossible for most survivors to fulfill and are taking steps to streamline enrollment. Facilitating a quick and effective Medicaid response at the state level also requires the federal government to address two primary issues: the level of federal financing and eligibility for assistance."

In addition to resolving the Medicaid issues, Rousseau tells *SHW* it's important the government move quickly to repair the health care infrastructure in the areas ravaged by the hurricanes so people are able to obtain the physical and mental health services they need when they return.

[Many background documents and the Kaiser Commission issue brief are available on-line at www.kff.org. Also find National Governors Association materials at www.nga.org. Legislation is available at thomas.loc.gov. Contact David Rousseau at (202) 654-1431.] ■

Fiscal Fitness

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generations, with infant mortality declining and vaccines developed for polio and chickenpox reducing the number of children with serious disabilities. But even with these improvements, there remains strong evidence that the quality of children's health care is inadequate, he says. Research has found that up to 75% of children don't receive recommended health care services to prevent disease, reduce disease complications, and achieve optimal health and development. Children often receive inappropriate care, such as antibiotics for the common cold and unnecessary hospital admissions. In addition, poor children and minority children are more likely to receive inferior care, and the level of care varies substantially across geographic regions in ways that appear to be unrelated to health needs.

According to Mr. Smith, the incidence of illnesses such as asthma and cancer is rising to a disturbing extent. And while it is recognized that developmental assessments are especially important for children from birth to age 3, several studies have documented that all too often young children are not assessed or diagnosed until they reach school. Even when assessments are done, a recent study found that one-third can't adequately identify early signs of disease and learning disabilities.

State resources are stretched thin

"Clearly state policy-makers must address these issues to improve the quality of health care for children," Mr. Smith wrote. "State resources, however, have been severely stretched during the recent economic downturn, forcing cutbacks in virtually every state program. From 2001 to 2004, every state initiated actions to slow the rate of growth in Medicaid spending. In this fiscal environment, states cannot afford to waste resources by paying for poor quality care or for care that is ineffective or unnecessary."

Despite their fiscal challenges, Mr. Smith and the state officials concluded, states are in key positions to affect children's health care as they bear primary responsibility for critical programs and services, especially Medicaid and SCHIP, but also mental health, public health, and education programs that significantly affect health and health care for young children.

Also, states are significant purchasers of health care due to the coverage they provide for state workers and their dependent children. Altogether, states administer health programs that serve about 100 million Americans, about half of whom are children.

"State governments... have unique opportunities to directly affect quality of care for children," Mr. Smith wrote. "As purchasers, states can also powerfully influence quality by defining expectations and incentives for improvements and by rewarding performance that meets these expectations."

While the federal government has an impact on quality through setting the rules under which states administer programs financed with federal funds, it generally is the states that administer and make key decisions about the programs.

"Without question," Mr. Smith says, "states today are in the best position, among all American entities and organizations, to influence young children's health and health care."

Because programs for children generally enjoy broad support among public policy-makers in both legislative and executive branches of state governments, it may be easier to build consensus around specific quality improvement strategies.

Potential strategies for promoting higher quality in children's health identified in Mr. Smith's conversation with state officials include:

- **Promoting** a common vision for improving quality through conferences and programs of national advocacy organizations. Such efforts can reinforce the notion that quality is a priority.
- **Encouraging** small changes in the right direction such as improving data systems, adopting reimbursement systems to reward higher quality, or incorporating measures of quality development by national standard-setting organizations into Medicaid, SCHIP, or state employee health plan contracts. Short-term goals can help states be laboratories for innovation and progress, Mr. Smith says, and demonstration projects can build expertise, develop capacity, foster new ideas, facilitate coalition and partnership relationships, demonstrate the impact of new approaches, and provide models for others.
- **Defining** indicators of quality and performance that can be measured, since this is the key to quality improvement, although states often don't have expertise in development and use of quality measures and thus may need technical assistance that can come from work being done in other states to help ensure uniform measurements.
- **Developing** reimbursement methodologies to encourage quality performance through incentive-based, pay-for-performance mechanisms that reward quality. States also can pursue partnerships with private sector organizations such as business groups that are pursuing quality improvement.
- **Making** information about quality performance available to the public since providers, consumers, and policy-makers can use readily available data when making decisions.

• **Steering** business to providers based on quality performance. Because managed care plans depend on new members to maintain enrollment levels, they are motivated to focus on quality measures that feed Medicaid enrollment including HEDIS or EPSDT measures that relate to children.

• **Educating** parents by providing good information so they can make informed choices to help improve the quality of health care for their children. Parents with good information are better prepared to ask pertinent questions and be informed advocates. States can help provide information to parents through printed materials or telephone nurse hotlines and can encourage parents to take greater personal responsibility for ensuring quality health care. Mr. Smith says such efforts can result in appropriate self-treatment of minor medical issues, fewer unnecessary visits to the doctor or hospital emergency room, and improved adherence to medical recommendations.

• **Making** the business case for quality, because its absence is seen as a significant obstacle to investment in quality improvement initiatives. A health care business case has to go beyond the strict definition of a financial return on investment (ROI) since clear, positive ROI evidence in health care is more often the exception rather than the rule. Mr. Smith says demonstrating a business case for children's health care may be even more difficult, requiring a less fragmented system of financing and delivery and a newly defined approach to providing excellent, family-centered care.

• **Involving** the community as partners for moral and ethical reasons, rather than because of a valid business case, and because there may be opportunities to develop a coordinated local referral system and financing base.

Break down silos

Mr. Smith tells *SHW* that one of the key things that came out of his meeting with state officials was the realization that the various areas of state government tend to operate in isolation from each other and breaking down that isolation through collaboration could yield positive results.

"I think our discussions opened their eyes to the need to work across organizational lines," he says.

Because every state's situation and dynamics are different, the strategy that is most important in each state will vary. What they may have in common, however, is the need for a champion, a public official who has improvement of health care quality for children as a significant part of his or her agenda and wants to get something accomplished.

"If that kind of champion brings the right groups together and encourages them to share a common vision, they could make a real difference," Mr. Smith asserts.

Mr. Smith's conversation also identified what he says are considerable but not insurmountable challenges in improving health care quality, including challenges:

• in the health care delivery system since the current system's culture, traditions, and practice patterns may include incentives that encourage poor quality or inappropriate care such as use of hospital emergency rooms to provide non-urgent care. Mr. Smith says state officials have "powerful tools and assets" at their disposal to change such incentives, including using different reimbursement incentives, publishing and distributing performance results on key quality measures, using performance measures in purchasing decisions, and enforcing compliance with quality performance requirements.

• in financing since it is difficult for states to invest in quality improvements, particularly expensive information technology tools, in an environment of fiscal distress and budget shortfalls. Mr. Smith notes that while some quality improvement initiatives reduce costs, available studies often don't satisfy budget officials who demand evidence of fiscal impact to justify funding decisions. Additional documentation would go a long way in assisting state decision makers, he adds.

• of "silo" organizations, programs, and funding that often prevent states from taking full advantage of their market strength. Because restructuring existing systems would be very difficult. Mr. Smith suggests states seek to improve quality within the current organizational and funding systems. One approach could be creation of a cabinet position focused on children.

• of leadership so a champion is identified who sees the value and payoff of improving health care quality for young children and is able to communicate a way to turn that vision into action.

• of a short-term state policy focus, realizing that while what needs to be done may well take longer than a current legislative session, budget year, or term of office, policy-making often focuses on what can be achieved in the immediate future.

• of inadequate data and information systems, since quality improvement requires a benchmark for performance and data to document progress.

• of inadequate measures of quality for children, with the National Quality Forum pointing to a "paucity of child-relevant measures in widespread use and concluding that performance measures applicable to children are markedly underrepresented in the universe of national voluntary consensus standards."

"There's no underestimating these challenges," Mr. Smith tells *SHW.*

He says the most important thing may be to recognize how long it will take to accomplish goals that are set and to find champions who are committed to getting something done even if it takes longer than the time they expect to be around.

"The priority should be to develop performance measures for key elements of state programs, generate the best data possible on those measures, share the results broadly, and use the data to reward good performance," Mr. Smith says. "Working with key policymakers and officials will be of central importance, to encourage these leaders to become champions of the cause. State officials are more likely to realize improvements when they work across departmental lines collaboratively, with a focus on the health of the child rather than the individual program."

Mr. Smith says the feedback received so far on the issue brief has been positive, with some state officials even indicating a desire to move forward with some steps in their states.

"In the spectrum of health care issues, none has more broad support than health care for children," he says. "There's always a great interest in what can be done to make things better. The future of all health care is quality improvement for public purchasers. States have an obligation to get the best value, and they can't get the best value without good quality. Public officials are so stretched and stressed that focusing on something like this is a luxury for them, but when they do it, something good can happen."

[The brief is available from the Commonwealth Fund's web site at www.cmwf.org. Contact Mr. Smith at (517) 482-9236 or e-mail him at VSmith@healthmanagement.com.] ■

Should hospitals be required to evacuate?

News of 44 bodies found at New Orleans' Memorial Medical Center have raised questions about whether hospitals should be required to evacuate patients in the face of potential disasters such as major hurricanes.

The Tenet Healthcare facility reportedly was dry Aug. 30 when broken levees spilled water onto the streets and quickly submerged the hospital's basement. Efforts to rescue the 256 patients weren't coordinated and suffered from glitches in communication, according to hospital officials.

For three days, the only help that came were two National Guard trucks and four private airboats. The Coast Guard reportedly continued to drop patients at the hospital's helipad even as temperatures rose inside and patients' family members fanned their sick loved ones and helped staff members carry them up dark staircases on stretchers and mattresses.

"They did not die as a lack of care," Memorial Medical Center director of support services **David Goodson** told the press. "The care of those patients was heroic. These patients were not abandoned."

Some of the bodies were found in the hospital's morgue, apparently people who had died before the storm hit, while others were hospital patients or from a long-term rehabilitation facility operated in the hospital.

"When the storm hit, there was a period when authorities could not help us and people were in there and temperatures were above 100 degrees," said Tenet spokesman **Harry Anderson**. "Some may have died because of the conditions before the evacuation. No one, no living person, was left in that hospital when we completed the evacuation by Friday [Sept. 2]."

Mr. Anderson said the company continued to check on the dead after the evacuation and pleaded with local coroners to remove the bodies.

"They weren't just left," he said. "We have known about them and have been trying to get them recovered for more than a week."

American Hospital Association spokesman **David Allen** tells *State Health Watch* that there are no mandatory evacuation requirements and that facilities must individually make decisions based on their own circumstances, both where they are located in relation to a storm or other disaster and how easy it is to move their patients.

"There are difficulties involved in evacuating hospitals," Mr. Allen says. "Hospitals have to look at where they are in the flood plain and whether there is a helipad available. They have to determine if it is possible to bring patients down by hand from upper floors and take them out by boat."

Evacuation is a local decision

According to Florida Hospital Association spokesman **Rich Rasmussen** evacuation decisions are made by local government officials and the management of hospitals. Hospitals can request evacuation, he said, but resources may be stretched thin as many other people try to evacuate at the same time. Also, he said, hospitals need to evaluate their patients' conditions and determine if trying to transfer them actually could be more dangerous than staying in place.

Mr. Rasmussen noted that Florida hospitals have been built to very stringent codes that generally make them better able than most

commercial buildings to withstand a hurricane's fury.

"Even in the worse hurricanes that have hit Florida," Mr. Rasmussen tells *State Health Watch*, "our hospitals have primarily suffered roof damage and not major structural damage. Also, hospital generators are usually above ground level and able to continue providing power."

Getting ready

Three weeks after the hurricane hit, East Jefferson General Hospital CEO **Mark Peters** testified on behalf of the American Hospital Association before the House of Representatives Energy and Commerce Health Subcommittee and Energy and Commerce Oversight and Investigation Subcommittee on the status of his Metairie, LA, hospital and the general situation with hospitals. Mr. Peters noted that his 450-bed tertiary care facility has been able to remain open and care for patients, one of four hospitals still open in the New Orleans area.

"Knowing that the huge storm was heading their way," Mr. Peters said, "hospitals began sending home ambulatory patients. Those in critical condition or requiring special assistance, such as ventilator-assisted breathing, remained in the hospital. When hospital staff reported to work on Monday, they knew it might be a few days before they were able to return home. When the levees in New Orleans broke, however, the situation changed dramatically."

Before the storm hit and roads were closed, East Jefferson moved its neonatal unit to Women's Hospital in Baton Rouge and many other patients were transferred to facilities both in and out of state. Mr. Peters said they did not transfer ventilator-assisted patients, fearing the risk to their health during a transfer would be too great.

He discussed the difficulties in obtaining food and in restaffing, as well as problems with communication and security. Throughout the storm, he said, the first priority always was patient safety, with staff safety second, although only by a hair.

"Obviously, other hospitals in the Gulf Coast region went much longer before relief arrived," Mr. Peters reported. "They relied on generators until fuel ran out, all the while trying to arrange the means to evacuate patients and hospital staff. In New Orleans, of course, the situation was exacerbated by the rising flood waters, as patients were carried up flights of stairs to drier floors, and authorities tried to arrange air and water evacuations."

Setting priorities

Current needs in the area at the center of the disaster, he said, include restarting cash flow to affected health care facilities, relieving staff, obtaining temporary housing, and accessing fuel.

"As we assess the damage and attempt to rebuild our facilities, it is critical that we find a way to improve our cash flow. If we have no patients, we have no income. If we have no income, we have no way to pay our workers, to obtain services such as food and water, and to continue providing health care services to areas that have already lost so much of their infrastructure.

"Every tragedy and disaster provides lessons to either avert the next one or, if that is not possible, mitigate the consequences," Mr. Peters added. "This disaster is no exception. During the last few weeks, we've learned a number of valuable lessons and gained some insights on how best to work together. We realize that response to disasters is always ad hoc at the start, when it is best to rely on good judgment rather than policies and procedures.

"We learned this time, as we did with the events of Sept. 11, 2001, that communication systems are the first thing to go. From our experience at East Jefferson, it is obvious that an alternative reliable communications service must be in place, so that public officials, first responders, and the health care community can efficiently communicate their needs, situations, and availability to assist," he concluded.

[American Hospital Association information on hospital emergency plans is available on-line at www.aha.org. Contact Mr. Rasmussen at (850) 222-9800.] ■

This issue of *State Health Watch* brings you news from these states:

HIV patients displaced by Katrina scramble for meds, care

Among the thousands displaced by Hurricane Katrina were an estimated 8,000 HIV and AIDS patients attempting to remain healthy and alive without their usual clinics, doctors, medications, and support systems.

The Health Resources and Services Agency (HRSA), the federal agency that provides health care for people afflicted with HIV, completely lost service centers in New Orleans and Biloxi, MS, and suffered major damage at other centers in Hattiesburg, MS, and Mobile, AL.

Two weeks after the hurricane, HRSA reported that displaced individuals were moving to other jurisdictions and seeking medications and medical care there. States faced several hurdles in providing needed HIV/AIDS care, HRSA said, including 1) lack of authority to provide AIDS Drug Assistance Program (ADAP) aid (pharmaceuticals) and other Ryan White Comprehensive AIDS Resources Emergency Act (RWCA) treatment and care to patients who are not residents of the jurisdiction; 2) absence of patient documentation of eligibility, medical records, or lists of medications taken; and 3) lack of capacity to provide additional care.

HRSA said RWCA grantees in Georgia, Texas, Tennessee, Alabama, Arkansas, and Florida were treating people living with HIV/AIDS from Louisiana and Mississippi. With the approval of their governors, the states and grantees were providing services, including medications, to those in need. Physicians were writing new prescriptions for those who did not have documentation of their drug regimen. For those with no medications and no list of their drugs taken, physicians were doing basic testing before writing new prescriptions.

HRSA pointed to Texas as a model for other states because its ADAPs were enrolling evacuees through a simple, one-page enrollment form to ease the transition. The state also contacted all eight companies that make ADAP drugs to ask that their pharmaceutical assistance programs reimburse the Texas ADAPs, at least for one month, through in-kind contributions of drugs the Texas ADAPs were dispensing to displaced people.

Keep good records

Because HRSA said it couldn't waive its regulations, states receiving evacuees were advised to document the services provided to them in the event reimbursement funds become available. The National Association of State and Territorial AIDS Directors (NASTAD) also contacted the eight drug companies about providing free medications for all Katrina-related evacuees. Some responded positively, while others negotiated with NASTAD over ways to provide streamlined access to ADAPs.

NASTAD assistant executive director **Murray Penner** tells *State Health Watch* that state RWCA and ADAP programs have done the best they can in serving HIV patients who come to them, given that HRSA has not been as helpful as they would have liked.

"We haven't been happy with the federal response," he says. "They aren't backing the programs up as much they need."

Penner says to be fair to HIV Bureau staffers in HRSA, it appears they are being held back by staff higher in the Department of Health and Human Services or the administration. Fortunately, he says, states have quite a bit of latitude in the RWCA program to provide services that best meet their clients' needs.

Even several weeks after the hurricane first hit, Penner says it remains "frustrating dealing with HRSA. They still can't say whether client services can be billed to the (RCWA and ADAP) grants."

According to Penner, AIDS programs in Louisiana and Mississippi are under extreme pressure to resume operations but governmental bureaucracy has been standing in the way of that happening.

"There ought to be a better, more flexible response," he says. "It shouldn't be hard to get extensions of deadlines or a waiver for a report that's due."

The NO/AIDS Task Force, the oldest HIV/AIDS service organization along the gulf, based in New Orleans, found a temporary home at the Montrose Clinic in Houston, a medical center specializing in the needs of the lesbian, gay, bisexual, and transgender community. Montrose executive director **Katy Caldwell** said evacuees arrived by the dozens and lack of funds did not affect access to care.

"We treat them first, worry about the money later," she said.

At the Houston Astrodome shelter, billboard posters and on-site medical providers advised HIV-infected people to go to the city's Thomas Street Health Center for a quick AIDS test, physical exam, and a month's supply of medication.

But experts recognized that social stigma could limit some access to care.

"People are not going to walk up to the American Red Cross and say, 'Hi, I have HIV,'" said AIDS Alliance for Children, Youth, and Families spokeswoman **Diana Bruce**. "More likely they're going to try to find an HIV provider."

Because evacuees who seek medical assistance from providers at emergency centers could end up with doctors who have no experience caring for people with HIV, Dr. **Nicholaos Bellos**, president of the Dallas-based Southwestern Infectious Disease Association, helped launch an on-line triage program to advise doctors working in emergency clinics how to care for and medicate patients with HIV. Bellos said people with HIV and AIDS typically have complex medical histories that are well documented at their clinics, but it's hard to treat them without this detailed background.

"Not many of these people had a chance to go by and pick up their medical records on the way out of town," he said. "One of our biggest problems, right off the bat, is just documenting their HIV-positive status."

What a difference 3 days make

National Association of People With AIDS (NAPWA) executive director **Terje Anderson** wrote an opinion column noting the irony in the fact that what happened to many hurricane victims suffering from HIV/AIDS came because the storm hit Aug. 29 instead of a few days later.

"Most upper- and middle-class Americans probably don't get the significance of that date," he said. "If you're not someone on welfare, on food stamps, on a disability check, or you're not someone who simply lives paycheck to paycheck, the complete horror of a disaster hitting two days before the end of the month may be lost on you."

But because Katrina hit two days before payments and food stamps are delivered to their many recipients, hundreds of thousands of poor people, working people, old people, and disabled people were not able to get out of the way of the oncoming storm.

"At the end of the pay period, at the end of the month, too many people simply don't have enough cash left to put gas in the car or shell out for a bus ticket out of town for the entire family," Mr. Anderson wrote.

He said for those people, it didn't matter if newscasts said an evacuation was mandatory. Without money for gas, bus tickets, motel rooms, and meals, for the many whose funds were running out at the end of the month, officials might as well have ordered a mandatory two-week vacation in an expensive resort someplace as a mandatory evacuation of their homes.

"If you were going to be homeless and penniless somewhere," he said, "why on earth would you do that far away instead of back home on familiar territory among people you know? So people did what poor people do everywhere: They stayed together in the communities they live in, hanging out with families and friends and hoping that they would survive whatever life threw at them. Surviving a hurricane is just one more in a long series of survival challenges: surviving poverty, surviving hunger, surviving violence, surviving disease, surviving community decay, and surviving the daily assaults on human dignity."

Facing a grim reality

Mr. Anderson said Katrina forced us to recognize something he believes most people in America would prefer to forget — that in the richest country in the world, one only has to scratch slightly below the surface to find millions of Americans who are barely getting by, who live one paycheck away from complete destruction. This is an America, he said, that often doesn't even have the resources to flee from the path of a life-threatening storm, an America facing life and death drama daily.

"Maybe Katrina will wake America up to the vast inequities that characterize our society," Mr. Anderson concluded. "Maybe Americans will be embarrassed into action by the realization that poor people don't have health care, transportation, food, or safety all of the time, not just when the flood waters come. Maybe the in-your-face racial inequalities will finally be impossible to ignore. Maybe we'll understand that thousands of people die unnecessarily every day because of these circumstances. Maybe we'll stop ignoring the floodwaters of addiction, AIDS, homelessness, violence, poverty, poor education, incarceration, and discrimination that have been inundating these communities. And maybe this time we'll be willing to do what it takes to save people's lives without requiring them to cling to roofs and wave towels to get our attention in the first place."

Issues needing to be addressed

On behalf of the National Association of People With AIDS, Mr. Anderson also wrote to Health and Human Services secretary **Mike Leavitt** on Sept. 2, just after the storm hit, outlining immediate, midterm, and long-term issues "that will literally be life and death for people living with HIV/AIDS."

• **Treatment Interruptions**. How will the emergency response ensure that people will have immediate access to the life-saving medications they need, he asked. How will this take place in the potential absence of medication or insurance documentation? Will people who leave their home state be able to access immediate health care benefits in the state where they seek refuge? What steps is HHS taking to prevent dangerous treatment interruptions? How is the government communicating clear and consistent guidance to health care providers and funders about

how various federal funds can be used to support care and treatment for refugees from the impacted area?

• **Infectious Disease**. Mr. Anderson said those living with HIV/AIDS are more vulnerable to a variety of infections and diseases because of the damaged state of their immune systems. Thus, he said, the post-hurricane environment holds special dangers for the spread of a variety of diseases, both in the areas directly hit by the hurricane and in facilities where people congregate for housing and services. "People with impaired immune systems will be exposed to a large variety of potentially dangerous pathogens in the post-hurricane and post-flood situation. The spread of diarrheal diseases, tuberculosis, influenza, and countless other bacterial, fungal, and viral infections will skyrocket in the post-hurricane period. What steps will HHS take to protect people, especially those with immune system suppression, from the spread of infectious diseases?"

• **Continuity of Care**. How will HHS ensure that people are able to experience minimal disruption in their care and treatment? How will state eligibility for Medicaid, ADAP, and other programs be transferred to a new place of residence? How will HHS help people find appropriate and knowledgeable care and treatment providers in their new communities?

• **Support for the Care/Treatment Infrastructure in New Locations**. Clinics and organizations in communities receiving evacuees are going to have their resources quickly strained beyond the breaking point. It is essential that they receive additional and immediate support to absorb the added work they are taking on. Also, state ADAP officials will need additional financial support to bring on the additional enrollees they will pay for.

• **Rebuilding Care/Treatment Infrastructure That Has Been Damaged or Destroyed**. It will be essential that health clinics and AIDS service organizations be rebuilt as people are able to return to their home communities. How will HHS provide resources to ensure that the essential infrastructure is rebuilt in a timely manner?

• **Safe, Clean, Secure Housing**. While other agencies of the U.S. government are primarily responsible for housing issues, NAPWA expressed the hope that housing services would be well coordinated with health services. "For people living with life-threatening diseases, housing is an essential part of good health," the group said. "Living in crowded, cramped housing conditions (including large group shelters) leaves people vulnerable to a range of infections and diseases. What will HHS be doing to ensure that the health of vulnerable people is protected by rapidly finding safe, clean, and secure housing?"

• **Prevention**. NAPWA said documented experience around the world shows that large-scale displacement of populations can be a significant risk for a spreading HIV epidemic. The circumstances necessary for increased HIV transmission are present in the current situation, it says, as hundreds of thousands of evacuees are uprooted from their home communities and thrown into uncertainty and chaos. An effective public health response must address the need to prevent further infections during this challenging period.

• **Leadership**. Mr. Anderson said that part of responding effectively to the needs of people living with HIV/AIDS during this public health emergency must be through strong coordination and leadership. "Without such leadership, there is a very real risk that the needs of people living with HIV/AIDS will be lost in the enormity of the crisis," he cautioned. He asked if the Department of Health and Human Services had designated a lead for HIV/AIDS issues in the context of Katrina, saying it is necessary that a high-level designee be given that responsibility.

No response

Contacted by *State Health Watch*, Mr. Anderson said he was disappointed that several weeks after he wrote what he considered to be a "timely and thoughtful letter," the federal government still had not responded.

[More information is available from www.hrsa.gov, www.nastad.org, www.napwa.org, and www.kff.org. Contact Mr. Penner at (202) 434-8099.] ■