

HOSPITAL DISASTER PREPAREDNESS: PAST, PRESENT, AND FUTURE

HEARING
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS
SECOND SESSION

JANUARY 26, 2006

Serial No. 109-115

Printed for the use of the Committee on Energy and Commerce



Available via the World Wide Web: <http://www.access.gpo.gov/congress/house>

U.S. GOVERNMENT PRINTING OFFICE

30-413PDF

WASHINGTON : 2006

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2250 Mail: Stop SSOP, Washington, DC 20402-0001

COMMITTEE ON ENERGY AND COMMERCE

JOE BARTON, Texas, *Chairman*

RALPH M. HALL, Texas
MICHAEL BILIRAKIS, Florida
Vice Chairman
FRED UPTON, Michigan
CLIFF STEARNS, Florida
PAUL E. GILLMOR, Ohio
NATHAN DEAL, Georgia
ED WHITFIELD, Kentucky
CHARLIE NORWOOD, Georgia
BARBARA CUBIN, Wyoming
JOHN SHIMKUS, Illinois
HEATHER WILSON, New Mexico
JOHN B. SHADEGG, Arizona
CHARLES W. "CHIP" PICKERING, Mississippi
Vice Chairman
VITO FOSSELLA, New York
STEVE BUYER, Indiana
GEORGE RADANOVICH, California
CHARLES F. BASS, New Hampshire
JOSEPH R. PITTS, Pennsylvania
MARY BONO, California
GREG WALDEN, Oregon
LEE TERRY, Nebraska
MIKE FERGUSON, New Jersey
MIKE ROGERS, Michigan
C.L. "BUTCH" OTTER, Idaho
SUE MYRICK, North Carolina
JOHN SULLIVAN, Oklahoma
TIM MURPHY, Pennsylvania
MICHAEL C. BURGESS, Texas
MARSHA BLACKBURN, Tennessee
GRESHAM BARRETT, South Carolina

JOHN D. DINGELL, Michigan
Ranking Member
HENRY A. WAXMAN, California
EDWARD J. MARKEY, Massachusetts
RICK BOUCHER, Virginia
EDOLPHUS TOWNS, New York
FRANK PALLONE, JR., New Jersey
SHERROD BROWN, Ohio
BART GORDON, Tennessee
BOBBY L. RUSH, Illinois
ANNA G. ESHOO, California
BART STUPAK, Michigan
ELIOT L. ENGEL, New York
ALBERT R. WYNN, Maryland
GENE GREEN, Texas
TED STRICKLAND, Ohio
DIANA DEGETTE, Colorado
LOIS CAPPS, California
MIKE DOYLE, Pennsylvania
TOM ALLEN, Maine
JIM DAVIS, Florida
JAN SCHAKOWSKY, Illinois
HILDA L. SOLIS, California
CHARLES A. GONZALEZ, Texas
JAY INSLEE, Washington
TAMMY BALDWIN, Wisconsin
MIKE ROSS, Arkansas

BUD ALBRIGHT, *Staff Director*

DAVID CAVICKE, *General Counsel*

REID P. F. STUNTZ, *Minority Staff Director and Chief Counsel*

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

ED WHITFIELD, Kentucky, *Chairman*

CLIFF STEARNS, Florida
CHARLES W. "CHIP" PICKERING, Mississippi
CHARLES F. BASS, New Hampshire
GREG WALDEN, Oregon
MIKE FERGUSON, New Jersey
MICHAEL C. BURGESS, Texas
MARSHA BLACKBURN, Tennessee
JOE BARTON, Texas
(EX OFFICIO)

BART STUPAK, Michigan
Ranking Member
DIANA DEGETTE, Colorado
JAN SCHAKOWSKY, Illinois
JAY INSLEE, Washington
TAMMY BALDWIN, Wisconsin
HENRY A. WAXMAN, California
JOHN D. DINGELL, Michigan
(EX OFFICIO)

CONTENTS

	Page
Testimony of:	
Legarde, Mel, President and Chief Executive Officer, HCA Delta Division, HCA, Inc.	34
Montgomery, James T., President and Chief Executive Officer, Tulane University Hospital & Clinic, HCA, Inc.	42
Goux, Renee, Chief Executive Officer, Memorial Hospital, Tenet Healthcare Corporation	51
Smith, Robert, Senior Vice President, Regional Operations-Texas/Gulf Coast, Tenet Healthcare Corporation	56
Fontenot, Dr. Cathi, Medical Director, Medical Center of Louisiana-New Orleans	62
Smithburg, Donald R., Executive Vice President-LSU System, Chief Executive Officer, LSU Health Care Service Division	67
Sewell, Jon, Chief Executive Officer, Chalmette Medical Center, Universal Health Services, Inc.	73
Muller, Gary A., President and Chief Executive Officer, West Jefferson Medical Center	76
Agwunobi, Dr. John O., Assistant Secretary of Health, U.S. Department of Health and Human Services	122
Guidry, Dr. Jimmy, Medical Director and State Health Officer, Louisiana Department of Health and Hospitals	133
Additional material submitted for the record:	
Agwunobi, Dr. John O., Assistant Secretary of Health, U.S. Department of Health and Human Services, response for the record	155

HOSPITAL DISASTER PREPAREDNESS: PAST, PRESENT, AND FUTURE

THURSDAY, JANUARY 26, 2006

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
New Orleans, LA.

The subcommittee met, pursuant to notice, at 10:00 a.m., in the Supreme Court of the State of Louisiana, 400 Royal Street, New Orleans, Louisiana, Hon. Ed Whitfield [chairman] presiding.

Present: Representatives Burgess, Blackburn, Stupak, DeGette, Schakowsky, and Whitfield.

Also Present: Representatives Melancon and Jindal.

Staff Present: Kelli Andrews, Counsel; Mark Paoletta, Chief Counsel for Oversight and Investigations; Peter Spencer, Professional Staff Member, Kelli Andrews, Counsel; Jonathan Pettibon, Legislative Clerk; Edith Holleman, Minority Counsel; and Chris Knauer, Minority Investigator.

MR. WHITFIELD. Good morning. I want to call this hearing to order this morning. I want to welcome everyone in attendance today, and as the Chairman of the Subcommittee on Oversight and Investigations for the Energy and Commerce Committee, we are having this hearing today on Hospital Disaster Preparedness: Past, Present, and Future.

Today at this hearing we're going to examine a number of different issues. Of course, one that we want to focus on is quite evident from the title, is simply examining the hospital disaster preparedness prior to Katrina, and then, we hope to hear about lessons learned as a result of the unprecedented disaster brought by Katrina and Rita to this area.

I will tell you that yesterday, all of us on this subcommittee had the opportunity to visit for about five hours a number of hospitals in New Orleans proper, and we certainly visited many of the residential areas. As one of those who had not had the opportunity to visit New Orleans since Hurricane Katrina, I would have to say that I was really overwhelmed by the devastation that we saw, and I don't really think people out in the Nation or around the world who simply hear the news reports of what occurred here or see pictures of it, really have a true understanding of how devastating this storm was.

I would urge every Member of Congress, as a matter of fact, or every Member of the U.S. Senate to take time to come and look at New

Orleans, because none of us really had any appreciation for how bad it was.

I want to thank certainly those people with the LSU Hospital System yesterday, HCA, and others that took us on tours of their hospitals, because that was also an eye-opening experience for all of us.

I certainly want to extend a warm thanks to those of you who generally assisted our efforts in having this hearing in this courtroom this morning, in particular, Chief Justice Calogero and Justice Kimball, who graciously arranged for the use of this attractive venue for the hearing today.

Yesterday, we heard a lot of different explanations and stories of what happened, and we know that some of the plans and preparations made prior to Katrina had to be changed because of the severity of Katrina, so it did not work exactly as planned and I don't think that is unexpected.

We heard a lot of discussion about the problems that were met during the evacuation, and how, once again, these professional healthcare providers had to be quite flexible and innovative in solving some problems that came up. We heard a lot about the difficulty of communication and the impact that that had on effectively evacuating patients from the affected hospitals.

I think that we realized that there isn't--we are not here today, I might emphasize, we are not here to try to blame anybody for what went wrong, because I think more things went right than went wrong when you consider the impact of the hurricane, but we do hope to come up with some possible solutions to help not only hospitals in this area, but around the country, maybe to be better prepared in the future.

Hopefully, we can also explore what is the relationship between the Federal government, the State government, the local government, and healthcare providers as they try to implement their mission of taking care of patients who need help.

And we all have the tendency, I think, to look for someone to blame. We have heard a lot about the shortcomings at FEMA, and there were shortcomings at FEMA, but I hope that this hearing can be quite positive and really explore, to try to come up with some answers to help in the future instead of fingerpointing.

So we will have some pointed questions for our witnesses, and I will introduce each of the witnesses when we get to that period, but I just want to thank you again for giving us this opportunity to be here. We do intend to look intently at all of these issues because they are quite serious, and it is a real opportunity for us to be here. We look forward to the testimony of each one of you, because you are the experts, and we hope to learn from that testimony.

At this time, I would recognize our Ranking Minority Member, Mr. Stupak of Michigan, for his opening statement.
[The prepared statement of Ed Whitfield follows:]

PREPARED STATEMENT OF THE HON. ED WHITFIELD, CHAIRMAN, SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

Good morning and welcome to this New Orleans field hearing of the Committee on Energy and Commerce Subcommittee on Oversight and Investigations. We've called this hearing to examine hospital disaster preparedness and look especially closely at the horrific experiences – and hard lessons – of New Orleans' most critical hospital facilities, which stood square in the disaster zone created by Hurricane Katrina, thus suffering some of the worst the storm and flooding had to deliver.

At the outset, let me extend my warm thanks to those who generously assisted our efforts to organize this hearing. In particular, Justice Catherine Kimball, who sits on the Louisiana State Supreme Court, graciously assisted in the use of this attractive and convenient venue to put on the hearing.

Also, Brigadier General Hunt Downer and the Louisiana National Guard guided us on a very informative tour through some of New Orleans' hard hit areas yesterday. Without his thoughtful guidance, we would not come to this hearing with as much appreciation for the damage that Katrina wreaked.

Holding this hearing in New Orleans provides subcommittee members the important opportunity to see first hand some of the circumstances that face health providers during and following a disaster. Yesterday, as part of this effort, we toured some of the region. Given the devastation that I witnessed yesterday I can better understand the frustration and anxiety New Orleans residents feel about the future of their city.

Viewing this devastation in person gives me a greater appreciation for the difficulties people here have been confronting. After the initial reports of Katrina's destruction, particularly with respect to the health care infrastructure, we sent staff to the area in October to get an on-the-ground assessment. The extent of areas still uninhabitable today is heart-breaking. And it underscores how critically important functioning hospitals are during and after a disaster. My hope is that this hearing will shed light on how hospitals—an essential resource in a time of disaster—can better prepare for a catastrophe.

This hearing will provide members an opportunity to identify key lessons from this horrible Katrina experience so the Committee, through its jurisdiction over public health and emergency preparedness, can more ably work to ensure health provider systems here and around the nation improve disaster preparedness. It will also provide us important information about current efforts of hospitals to rebound from Katrina to meet the anticipated needs of New Orleans and its environs, actions which also have far reaching lessons for policy makers.

Today we'll hear directly from some of the hardest hit hospitals, which remain shut down five months after the storm – the Tulane and HCA hospital, Tenet's Memorial Hospital, Louisiana State University's Charity and University Hospitals and Universal Health's Chalmette Medical Center. We'll also hear from West Jefferson Medical Center, a hospital that was spared the flooding and operated through the disaster's aftermath and is now one of the essential facilities handling New Orleans current medical needs.

We'll hear about the emergency preparedness plans, and assumptions behind those plans, which these facilities deployed as Katrina approached. We should take a frank look at what went wrong, what went right, and how they managed, for this experience holds important lessons for future preparedness planning.

Perhaps the single most critical failure involved the emergency power generation at these hospitals, which in many cases simply flooded out, leaving the facilities dark and helpless for several days as they sought to evacuate patients. I'm looking forward to discussing this issue and what measures can and will be taken to ensure such life-critical power supplies when preparing for future emergencies.

We'll hear about back-up communications and the problems of simply talking to one another. I look forward to learning about the communication and coordination among hospitals in the region – what seemed to work and what didn't, and what should be done to improve this important aspect of disaster response.

Another critical topic to discuss today concerns hospital evacuations. During a disaster, the assumption should be made that hospitals will remain open. Hospitals are an essential part of the before, the during and, perhaps most importantly, the "after" parts of a disaster—helping a community to treat the acutely ill patient population and those that have been seriously injured or sickened because of disaster. The hospitals in the New Orleans region were forced to evacuate due to the prolonged flooding. We will hear first-hand about their efforts to evacuate in harrowing circumstances and, I hope, learn how patients may be evacuated in a more coordinated fashion in the future.

And we'll hear about both the current and anticipated health-care situation in New Orleans and what plans are being made as the health-care system continues to work its way back from the devastating effects of the flooding. It is my understanding that hospitals including East Jefferson, West Jefferson, Oschner, Trouro and Kenner are all open for business. Charity is also operating a makeshift medical center in the Convention center and we will hear plans for opening more facilities today.

That said, recent press reports indicate that, among the evacuees that haven't returned home to New Orleans, are many doctors, nurses and other health care professionals. According to these reports, this specialist shortage is forcing New Orleans residents to endure long waits for treatment or to turn to makeshift clinics for help.

If media accounts are accurate, this provider shortage appears to be a real challenge to public health and to rebuilding New Orleans. One account quoted a local official estimating the acute-care capacity in the four-parish area at 1,750 beds, down from 5,063 before the hurricane.

I am concerned by these reports and look forward to hearing how New Orleans hospitals are working to meet these problems.

Further, I hope that physicians, nurses and support staff of hospitals that may have moved out the region due to Katrina will hear this and come back to New Orleans.

In addition to the hospitals, we'll also hear from the U.S. Department of Health and Human Services and the Louisiana Department of Health and Hospitals. Both government agencies play an important role preparing for and responding to the urgent needs of critical care and special needs patients in time of emergency. I'm looking forward to the perspective these agencies can bring to our discussion today.

We have a limited amount of time today and a large number of witnesses, so let me again welcome the witnesses. Thank you all for taking the time to tell us your experiences and explain from your perspective what happened and what we can learn from this disaster. And let me also welcome our colleague, Congressman Bobby Jindal, who represents the Louisiana's nearby 1st Congressional District, and who has an established expertise in the matters we will examine today. Mr. Jindal, I understand you will be introducing one of our witnesses this morning.

With that, I will now turn to my good colleague, Mr. Stupak, the ranking member for his opening statement.

MR. STUPAK. Thank you, Mr. Chairman, and thank for agreeing to hold this hearing down here in New Orleans.

If I may, just a little bit of a housekeeping matter. First of all, I asked that our good friend and colleague, Charles Melancon, be allowed to sit at the dais with us today. He is a great advocate for this area and he was instrumental in getting us down here. So, I would like to have him sit with us.

MR. WHITFIELD. We are glad to have him here and he has been an effective spokesman for New Orleans in the U.S. Congress, and we welcome him here on the podium with us today.

MR. STUPAK. Mr. Chairman, I ask that my opening statement and the opening statement of all members be allowed to be presented for the record. We have spent a few days putting together our thoughts. I know I had a statement ready, but after being here and seeing firsthand what happened, that statement has changed.

It hasn't changed my commitment to work on this issue. As you know, I have been bothering you for some time to bring the hearing here. We did have a hearing in Washington, but we--Members on both sides--wanted to have the hearing down here, so I appreciate you having this hearing.

I appreciate the fact that members like Ms. DeGette and Mrs. Blackburn really had to juggle their schedules to get here. Members are really interested in what is going on and wanted to see what is going on here in the nature of healthcare, and really had to juggle their schedules to be here on somewhat short notice. Our staffs worked long and hard to prepare us for this hearing. I want to thank them.

As I said, we had a hearing in October in Washington, D.C. and we heard a lot of comments. If they say a picture is worth a thousand words, being on the ground and actually seeing New Orleans and what happened to this gulf region is worth 10,000 years. Or 10,000 words, I should say. Hopefully it won't take us 10,000 years to get it done, but at the rate it is going, it might be.

Sitting in Washington, and having an interest in healthcare and sitting on this committee for ten years, it can be a little frustrating when the Federal government moves slowly. When it comes to healthcare, if I'm frustrated, I can imagine how our witnesses must feel and the people of New Orleans.

We have spent, or at least appropriated, close to \$72 billion for the recovery effort, and after seeing things yesterday, the temporary levees, temporary healthcare, partial healthcare, and healthcare being delivered out of tents, you have to ask, where has this money gone? How is it being spent, how much is being spent for healthcare?

In the area of healthcare it looks like we are still waiting for decisions. More importantly, at least for Charity, in healthcare, they are still waiting for more money. They are over at the Convention Center in their tent hospital, if you will, and you have to applaud the medical professionals and administrators in this area for the work they are doing to deliver some semblance of healthcare, but I was struck by the fact that we have no Level 1 trauma center in a major city like New Orleans, no Level 1 trauma center in this gulf region without going a number of hours to find one. But I was struck most by the fact that at your tent hospital, if you will, which has been running, I think, since early October and will be shut down by March seven or eight, right after Mardi Gras, not one penny, not one penny has gone to Charity to help them provide the services that are being provided.

Now, with \$72 billion on the table, I would think the Federal government, FEMA, HHS, whoever is responsible, could at least spare a few pennies for the healthcare delivery being provided at the Convention Center. Charity has had to lay off 90 percent of their people to try to make ends meet to pay the salaries of those who are still working and for supplies. This is five months and they still can't get reimbursed? I am struck by that fact.

And who, really, if you take a look at the history of healthcare delivery in this area, who are Charity's patients? If I am correct, about 80 percent of the working poor make just enough money to stay off Medicaid. They are Medicaid patients and they are the uninsured. Where do these people go for healthcare if Charity is not there? Charity's tent hospital, to my understanding, sees about 3,000 patients right now a month. What happens on March 7, when they close that tent hospital?

I mean, again, if I am frustrated, I'm sure other people must really be frustrated.

You know, if you take a look at it, I was also struck by the fact that we started our tour yesterday at University Hospital, and we did a couple more and we came back across the street and we went to Tulane Hospital. That's part of the HCA healthcare system. They seem to have the resources to redo their first floor and be putting in an emergency room, and they have done a great job.

Now, is that the private sector helping out one of their hospitals? And if the private sector can get it right and make a decision, why can't the Government get it right and help Charity and the other hospitals get back up and running? Why did this one hospital--it struck me as we left the old Charity, walked across the street to the new hospital being done--Kim gave us that tour--and we just walked across the street and there you had lights. The other side of the street didn't even have a light on. It

didn't make any sense. Obviously, they are doing that right, so is that a business plan FEMA and HHS and Congress should look at, how do we get a hospital back up and running immediately?

It was just so many things struck me. After seeing the damage firsthand, these questions have only become more frustrating, if you will. The lack of answers. Or maybe the questions should be more intense? I'm not sure. I mean, if we--as a country, we all realize the need for healthcare. We can do it. I question at times the willingness to do it. Today, later on, I'm going over to Mississippi. I want to see what is happening over there. But every decision that the Federal government will make, Mr. Chairman, every decision we make is going to have a dramatic impact on the character of New Orleans and what it will be in the future. We have to get these decisions right. Every decision we make, every policy decision will affect who will be able to return and who will not be able to return. Every policy decision we make, if it is private resources or public resources, will determine who will be allowed to come back to New Orleans and rebuild.

So, every decision that will be made will greatly affect the future of this great city. I look forward to working with the Members of this delegation and with this committee and the U.S. Congress to make sure we rebuild this city and this region like it was before. I think most of us have been here when New Orleans was running, vibrant, a great time. Let's put that city back on the map and give it the healthcare it deserves and it needs.

Thank you, Mr. Chairman.

[The prepared statement of Bart Stupak follows:]

PREPARED STATEMENT OF THE HON. BART STUPAK, A REPRESENTATIVE IN CONGRESS FROM
THE STATE OF MICHIGAN

Mr. Chairman, let me begin by thanking both you and the rest of my colleagues who have convened here today to see for ourselves the challenges of health care in New Orleans post-Katrina and meet on this very important subject of hospital and disaster preparedness. You have all traveled a great distance, and several of you canceled other obligations to be here. Again, I appreciate the cooperation each of you have given and your professionalism in this endeavor.

The many crises suffered by the residents of Louisiana and Mississippi resulting from Hurricane Katrina and the breaking of the levees have been well-documented by the media, and the heroic medical personnel during and after the storm. I have specific questions to ask about existing emergency communications systems and the credentialing of medical volunteers which I intend to explore later in my questions. But for now, we must look forward at what has been lost and what should be replaced to prepare this city and its hospitals for the next disaster.

Mr. Chairman, Louisiana State University, Tulane University and the Charity Hospitals train the vast majority of medical personnel for this state. They--and some of the other hospitals testifying today--train the doctors, the nurses, the dentists, the public health specialists and the technicians. They also are one of the major economic engines

of New Orleans and the surrounding region. This training system is in shambles because of Hurricane Katrina. These institutions also provided the only Level I trauma care for the region and much of the general health care for the working poor and indigent.

Just a few days ago, a story ran in the New York Times, which I would ask that we place into the record. It describes the current condition of the New Orleans region's hospital system. In short, the article depicts a system that is overstretched, overwhelmed, and overworked. The article provides one small, but illustrative, example that is likely playing itself over and over again in the streets across this community. Let me quote from it:

Early one recent morning, doctors and nurses at East Jefferson General Hospital in Metairie, just outside of New Orleans, were already caring for five seriously ill patients in the emergency room – because the hospital had no more beds to admit them to – while still managing a full load of incoming emergency patients near the entrance. Then two trauma victims from a car accident were brought in, followed by someone showing signs of appendicitis. The staff had to ‘play musical chairs’ with the accident victims and remaining patients to find everyone a bed and care for them, said Cheryl Carter, the nurse who directs emergency care. “That’s pretty much every day, pretty much every hospital,” Ms. Carter said. “The waiting room looks like a war center or a MASH unit. We look for more and more different ways to manage emergencies.”

The article later describes another example, this time involving another major facility in New Orleans, Touro Hospital:

For patients [now living in New Orleans] a medical emergency usually means a long wait, unless it is life threatening. Ben Cohen who is 28 and lives in the Mid-city neighborhood started to have intense abdominal pain on January 15 and spent four hours in the Touro emergency room before he was admitted. While there, he watched the single doctor on duty cope with a shooting victim and two trauma cases from a car accident. “To their credit,” Mr. Cohen said, “they did the best they could have.”

Mr. Chairman, the Times article is replete with examples of how the system as a whole and how hospitals individually are still struggling to be prepared for the next major disaster; and one will surely come.

Indeed, while many are--in the words of that patient--“doing the best they can,” there are major questions that now confront this region from both a health care perspective and a preparedness point of view: Is the city now ready for Mardi Gras? Is this region now prepared for a major refinery explosion or barge accident with the multitude of trauma cases that could result? Is this region ready for a major school bus crash on the now congested freeway? What about the next hurricane season, which is now less than six months away? Finally, are they ready for day-to-day life as some families struggle to return or reclaim their lives?

The Departments of Homeland Security and Health and Human Services have written voluminous and complex preparedness plans for all kinds of catastrophes, but are they actually willing to provide the dollars that are required to implement them? I do not believe that they are. I am not sure if it is good enough or reasonable to expect a medical system to continue this way indefinitely without some additional federal assistance.

Mr. Chairman, a number of us here have followed closely the plight of the health care system and hospital preparedness issues in this region following the hurricane. As a number of major hospitals were either severely damaged or nearly destroyed by either wind or flood waters, many facilities are still struggling to either re-open, or are doing the

best they can with what they have. Most are just hoping things will improve. Nevertheless, for many residents and for many outside observers, the pace of this effort remains slow and frankly, too uncertain.

Perhaps the most tragic hospital-related problem and now a major preparedness issue facing the New Orleans region is the loss of the Medical Center of Louisiana which is comprised of two of the region's largest hospitals: Big Charity and University Hospital. Known together as "Charity," both were severely damaged by Katrina's winds and the flood waters. We visited both facilities yesterday and saw the resulting tragedy for ourselves. What was once a major institution responsible for saving so many lives is itself on life support.

Before the storm, these two hospitals provided the only Level I trauma care for Southern Louisiana and the Mississippi Gulf Coast region. Presently, there is no Level I trauma facility for this region. After the storm, there was a military unit at the Convention Center providing such care. But it is no longer there because the military needed it elsewhere. The closest facility now that provides level I care is hundreds of miles to the north in Shreveport or to the west in Houston. It is my understanding that FEMA will be setting up such a facility for some duration, but the specifics on such a center are not yet known, and it is something that I hope this committee will explore further.

To understand what a loss these two hospitals are to the greater New Orleans area, and to understand how this loss directly impinges upon the level of preparedness for other hospitals, it helps to have some background on the demographics of the region.

Before Katrina, almost 1 million residents in Louisiana lacked health insurance. Many of these uninsured were comprised of the "working poor" who earned too much to be eligible for Medicaid. They worked at jobs without health insurance benefits nor could they afford to pay co-pays or purchase private health insurance on their own. In New Orleans alone, more than 20 percent of its residents lacked coverage. Many more were dependent on Medicaid. For Charity and University hospitals, 44 percent of its total admissions in fiscal year 2005 were comprised of patients with no insurance, while another 42 percent were covered by Medicaid. Thus, more than 85 percent of these two hospital's patient base (or approximately 275,000 of the region's residents) were indigent or comprised of what is termed, "the working poor."

Considering that the entire City of New Orleans was approximately 500,000 before the storm, these statistics show what a complex patient mix was in place before Katrina. It also suggests the impact the present and potentially-returning population will have on existing hospitals. As many Louisiana residents have now lost their jobs, the increasing stress on this system is obvious.

It is my prediction that these realities will continue to have a profound affect on hospital preparedness for the region. Indeed, as we will hear today, some of the inner-city hospitals and some of the now functioning suburban hospitals are already struggling to meet the surrounding region's medical and emergency needs. Hospital preparedness cannot take place in a vacuum.

There are certainly numerous questions regarding whether Charity or University hospitals can or should be rebuilt as before. But there are also questions regarding whether other hospitals can accommodate the former patients of these hospitals if they cannot be rebuilt. These profound questions must be addressed if New Orleans is going to successfully prepare for the next disaster and they should be front and center as part of this Committee's inquiry.

Indeed, strategic planning to provide ongoing care for returning residents or even cleanup workers – particularly those with little or no insurance – appears insufficient. And while the small tent-based Charity operation currently set up in the convention center – which is seeing almost 300 patients a day – is admirable, it cannot provide sufficient coverage for even a fraction of the existing or potential patients that may seek

to return. In short, the effort at the convention center--or the efforts at the other struggling hospitals that are doing the best they can with what they have--will likely be unable to provide sufficient care should a major disaster strike. Let me quote from Mr. Smithburg's testimony who illustrates that point directly:

We know that improvements can and must be made in our capacity to handle hurricanes and other emergencies. It is fair to focus on the emergency preparedness system, but at the moment we have too few hospitals standing to even participate in the next catastrophe. The next bus crash or minor emergency will overwhelm current hospital capacity. . . .

Mr. Chairman, as the old adage goes, "it's hard to go to church when your house is on fire." In other words, it is hard to place generators above potential flood waters, or stock up on food for the next storm when the hospital may no longer exist and all its doctors and nurses have been laid off.

How long the residents of this great city should expect to receive their health care services in overtaxed emergency rooms or even in the tents that we saw yesterday is something we should explore today. I for one would like to know answers to some of the following questions:

1. What is the plan for bringing those major hospitals in this city that were destroyed by the storm back on line. Does a formal plan exist? Are there clear milestones that lay out the steps that will need to occur for this to happen? Is there existing funding. If not where will it come from?
2. What exactly is the process FEMA will follow? Is the process transparent and fair?
3. What happens if certain key hospitals cannot be rebuilt because of a lack of funding? Is there an interim plan to serve the patients they once served?
4. Is there enough space at existing facilities for current residents under normal circumstances? What about in an emergency such as another major hurricane or that bus crash?
5. If, as some press accounts and testimony suggest--that some hospitals are already over-burdened--then what happens if another 50,000 or 100,000 residents return to the city? Is FEMA taking this into account as they review damaged hospitals or help pay for a temporary level I facility?
6. Is there a "scalable plan" to accommodate any new potential surge in demand? This is a key question directly related to how and whether existing hospitals are prepared for the next major event. As thousands of residents each month are receiving their medical care presently at a tent facility in the convention center, I question how additional hospitals could effectively take up this slack in the future if they are having a difficult time doing so now.

Mr. Chairman, I again look forward to the testimony today and I again thank you for convening this important hearing. I hope we can work together to find answers to some of these very difficult questions. I am committed to working with you to that end. Many people are really hurting down here. The need for help only continues. It cannot come too soon. It is critical that we as a Congress and as national leaders play an aggressive role in finding answers and helping the people of this great region solve these daunting problems.

MR. WHITFIELD. Thank you. At this time, I recognize the gentleman from Texas, who is the only physician here today. Up here, at least.

MR. BURGESS. Thank you. I do want to thank you for doing this. I do feel that this hearing is appropriately located in the city of New Orleans. I do feel that this hearing is late, just as my colleague Mr. Stupak has mentioned. I did visit the area myself in October. Mr. Muller and the good folks of East and West Jefferson Hospital helped me to see and understand, feel, taste, and smell what they were dealing with. And just like Mr. Stupak, I do have an opening statement for the record.

I would like to take a moment and just acknowledge what I saw in October and what I saw again yesterday and just the incredible sacrifice that has been made by the healthcare community here in Louisiana and around the Gulf Coast. And I heard the stories a couple of months ago from your doctors, nurses, administrators, and biomechanical engineers, and heard the same stories again yesterday. It didn't matter what facility we were in, the people who stayed on the front lines, while their own families and homes were being savaged by storms and then its aftermath, I don't know if reaching deep down inside I would have had the courage to do what many of you have done, but you did it and you did it with class and I take my hat off to you.

I think I should also let you know, your colleagues up in my part of the world, in North Texas, Labor Day weekend, a call went out to Dallas County Medical Society, that we have got 70,000 people who have been displaced from the Superdome who were coming to the Union Arena in Dallas, Texas. Out of 3,600 members of the healthcare and medical society, on a holiday weekend, 800 showed up to run the triage centers in the parking lot.

The medical community throughout this country can really be proud of itself and how it responded during the crisis. But now it is the aftermath of this crisis that concerns me and how to protect and defend what remains of the medical safety net in New Orleans and the Gulf Coast and going forward. How do we appropriately expense and replace that safety net as this unfolds?

I think, too, it struck me in October and it struck me again yesterday, the city itself is hardly prepared for just a regular flu epidemic, let alone something as devastating as a worldwide pandemic.

But we are learning. I do want to hear--I'm particularly interested in the hospital's emergency preparedness plans. Mr. Chairman, I suggest that we may want to do another hearing at some point about how nursing homes have prepared themselves for what was coming with Katrina. I suspect the level of preparedness was somewhat less than the hospitals, though I don't know that for a fact, but I do know in my part of the

world, when Rita threatened, we lost more people because of the way we evacuated nursing homes than were actually lost in the storm itself. So I think that is something this committee, an oversight committee, does need to pay some attention to.

I will tell you, Mr. Chairman, on my prior visit here and talking with doctors and hospital administrators, who, at that point, had been about two months without any mail, no checks in the mail, no cash across the counter, no accounts receivable, that they were hurting for money. The bond holders in the great State of New York were asking questions; doctors that I talked to were spending their personal savings to keep their offices open, to keep their employees hired.

My understanding at the time was there was significant money in the so-called disproportionate share of the DSH funds that were appropriated, and we concluded the order of the first quarter of fiscal year 2006 without those funds being dispensed because there was no hospital facility to receive them. I frankly cannot understand how the bureaucracy could not manage to deliver some of that money to the places where it was needed. And I have fought that fight on Capitol Hill by myself, it seems like, for the last two months. So I do welcome this marriage and the chance to perhaps finally be able to get that right.

We know FEMA is not a first responder and I do understand that concept, but they do have a role in helping with the recovery and the aftermath. I think Mr. Stupak correctly noted his frustration with the University Hospital versus the HCA facility. Obviously, someone is doing it right. Obviously someone is falling behind. I think our role as members of this oversight committee needs to be to help the people do it right and encourage those who are doing it right.

The issues of consolidation of facilities, that is a local decision. That is not a decision for this committee or for the Federal government. But how our funding is going to affect your recovery here properly belongs within the purview of this committee, and again, Mr. Chairman, I welcome the opportunity to be able to have this discussion.

Things as simple as federally qualified health centers might make a difference to the new ones. I have an amendment in our reconciliation bill that will allow streamlining for federally qualified health centers. That amendment was pulled at the 11th hour for reasons I don't understand from the conference committee. I encourage members of this committee on both sides to help me with that legislation as we start the beginning of next year, helping not only Louisiana, but Mississippi and other areas where displaced persons from the storm and its aftermath have fled and now have no healthcare in new parts of the world.

The notification system that was available for you-all to be able to track your patients and where they went and be able to inform families,

my perception, on the other side of the state line, was that it was nonexistent. And I know my staff spent several days trying to locate the infant of a mother who had a recent C-section. I rather suspect that story was repeated over and over again as you worked your way through those first troubling weeks after the storm.

Mr. Chairman, we are late, but we're not too late, and I welcome the fact we are having this hearing and certainly look forward to hearing the testimony today.

MR. WHITFIELD. Thank you. Our clock down here is not functioning correctly right now, so I'm going to be observing the five-minute rule, if we can.

I recognize Diana DeGette of Colorado for her opening statement.

MS. DEGETTE. Thank you so much. I want to echo my colleagues' thanks for holding this hearing down in New Orleans. I also want to echo my colleagues' impressions that touring the city here, there is just no way you could know, sitting in Washington or Denver, Colorado, or anywhere else, exactly what the citizens of New Orleans continue to grapple with every day.

I think it is critical that every Member of Congress come here, and I will do my part as a missionary to make sure that happens when we go back. I also think it is critical that we learn from this tragedy because there is much that can be learned in other parts of the country in dealing with a great crisis like Hurricane Katrina.

Most Americans on a day-to-day basis are not concerned about their access to health care. Daily check-ups for the kids are done at the local pediatrician, or the local healthcare clinic will offer flu shots, and the hospital's are there, if there is a broken bone or if surgery is needed. The elderly are cared for in nursing homes with facilities capable of handling their needs, and people with mental illness are able to go see their counselors on a regular basis.

This doesn't always work, but it works for a lot of Americans, and it works for a lot of low-income Americans. But for the poor, there are fewer options. When they don't have health insurance to pay for the care I just talked about, those individuals must find a clinic that provides charity care. So, in many cases, individuals will delay treatment before finally going to the emergency room and they will delay going to a doctor because they simply don't have the money.

Yes, there is that safety net, albeit one on tenuous footing. The safety net, by and large, is manned by a lot of the great hospitals, like Charity Hospital, throughout the country, and without them, many people simply would not have care, resulting in many more deaths.

Now, Mr. Chairman, you take the tenuous footing that we were on for our poor patients around the country and in New Orleans, and then

you add on to it the collapse of the health care infrastructure in New Orleans. No one here can take their healthcare for granted anymore. So young or old, black or white, rich or poor, access to adequate healthcare is not available. And as Charity Hospital is closed, are as Methodist, Tulane, and the Lindy Boggs Medical Center, even if someone is-- someone said to me yesterday, if President Bush came here and was injured, he would have to go to the emergency room and wait 24 hours just like everybody else.

And so, it is not a matter of powerful or powerless, or rich or poor. We really have issues in this city. A lot of the discussion today will talk about the lessons learned from the hurricanes. We need to talk about preparation for emergency situations and what we can learn, but I think what we need to talk about now is how we rebuild the medical infrastructure of the region and how we do it quickly.

Three days ago, The New York Times reported that if the 65 percent of the region's pre-storm population returns by July 1st of this year, the city will need to triple the number of hospital beds available. That would require hiring 2,500 medical staff members in the next few months, finding them housing, and paying them enough to return. It also would mean a tremendous commitment to infrastructure. So, I think this is a crisis that really needs to be addressed right now.

Yesterday, when we visited Charity Hospital and the other hospitals, we learned a lot, as you always do when you go on site. When we saw Charity, it was literally, to my mind, frozen in time, although I'm sure it was a lot worse right after the hurricane. Medical files were sitting on tables. Things had just been left and they are left there to this day. There is no ongoing source of electricity in the hospital. Now, right next door across the street, Tulane is opening a medical facility next month. Charity is still waiting for money so that they can start to do the repairs, so they can start to think about opening.

We saw in the paper, and I hope our witnesses from Charity will talk about the article today, that they are hoping to open some emergency facilities by next fall, a year after the hurricane. Why is this happening?

It is happening because Charity has no money to rebuild, and when I said, "Why hasn't FEMA given you money to rebuild" they said, "Well, we had to clean out the basement and muck it out ourselves before they could give us an estimate."

Now we hear that FEMA said it would cost \$26 million to repair Charity, and that Charity thinks the cost will be in the nature of \$258 million. So, that's 10 percent.

You can see that we are still arguing about what is going to happen and it is months after the hurricane. In the meantime, as Mr. Stupak said,

there is no Level 1 trauma center within a three or four-hour drive of New Orleans.

Mr. Chairman, I'm finishing up, but I want to say, how can we expect people to return to New Orleans when there is no Level 1 trauma center?

So, Mr. Chairman, again, I want to thank you for having this hearing. There are a lot of issues. I know we will address some of them today and I hope that we will continue to address them on an ongoing basis so we can get the facilities up and going again in this city.

MR. WHITFIELD. Thank you. At this time we recognize Mrs. Blackburn for her opening statement.

MRS. BLACKBURN. Thank you, Mr. Chairman. I want to thank you for holding the hearing and I would like to thank the Supreme Court for your hospitality. Justice Kimball and I have decided we can speak "Southern" to each other.

So, we thank each of you for your hospitality. We thank all of y'all--that is plural for you-all--for being here, because all of y'all's healthcare system--and that's plural possessive--needs help. I recognize that.

I wanted to specifically recognize our representatives for HCA Corps. HCA has over 190 hospitals and 200 outpatients throughout the United States. But most importantly, they are a fine Tennessee company, of which we are very proud. For me, many of their employees and much of their activity base is centered in my district. I would also like to mention another constituent company, Life Point Hospitals. You are going to hear a little bit more about them, I understand, from one of our representatives. They are located in Brentwood, Tennessee. They have a facility that was open, up and running and helpful during Katrina, and we appreciate their participation and their good work.

Mr. Chairman, today we are going to look at how the healthcare system was affected when Katrina hit New Orleans. One of the things we have to realize is this is a regional healthcare area. I grew up in southern Mississippi. I was there a couple of days after Katrina, I was there against last week and I could not believe the activity in Laurel, Mississippi, at the little hospital there, where people were coming for care because it is not available where they used to go. They are running golf carts out in the parking lot. Who would "athunk" such a thing would happen there? But people are going where they can get the services.

Particularly, we will look at how the hospitals prepared for the disaster and the actions that took place once the city started experiencing the flooding. Some very important issues that I will be discussing with each one of you today are these: Communication disruption, your community and emergency notification systems, power availability, your

fuel, supplies, your backup systems, electronic records, the lack of or the need thereof, your supply shortages, and I'm going to look forward to your testimony. I hope that we can learn a bit more about what went wrong. You have heard the frustration from the other Members that have spoken. But when disasters occur, lessons learned should never have to be relearned. We need to remember that. One of those lessons we should be learning is that government agencies have gotten too big, too bloated, too bureaucratic and they are too slow to respond.

Last week in Mississippi, I had someone say to me, "There ought to be a government law against such and such," pertaining to some of the responses to Katrina. And you know what, ladies and gentlemen? They are right. I'm sure Mr. Melancon has heard that many times from his constituents, because the frustration exists because the Government is too big to turn on a dime and respond. And yes, there is something that we can do about it: We can change the way the system works.

We are looking forward to hearing from you. Thank you to each one of the companies that--the healthcare providers and delivery system here. We appreciate the time that you are taking to come before us and be our partner in working through this process. Thank you.

And with that, Mr. Chairman, I yield back the balance of my time.

MR. WHITFIELD. Thank you. At this time we recognize Ms. Schakowsky of Illinois and her opening statement.

MS. SCHAKOWSKY. Thank you, Mr. Chairman and Mr. Stupak, for organizing this session here in New Orleans. I also want to thank Congressman Bill Jefferson who spent the day with us yesterday, and Congressman Charlie Melancon who has been with us here today. We have been hearing a lot from both of your local representatives about what is going on in New Orleans.

Like most of my colleagues, I pretty much scrapped the opening statement I had written before because I am now so overwhelmed with what I saw yesterday. You really do have to see it to believe it.

It has just been so incredible to stand there in what were neighborhoods filled with tens of thousands of people and there is absolutely no one there.

I want to especially thank the health professionals that took us around yesterday to see what was going on. One of the main feelings I got was this incredible commitment to serve the people of New Orleans that we saw, from the tent facility in the Convention Center to the University and Charity Hospitals, where we traipsed around in our special protective garb in the basement; the feeling of pain that is felt by so many people here in New Orleans that have seen this great international city suffering as much as it is; seeing how the helipad was

created at HCA/Tulane to actually lift people out of here was an amazing experience.

I want to congratulate--I saw in the paper, I think it was today, that some women are coming to Washington to encourage other Members of Congress to come here. I want to add my voice when I get back to Washington. It is so important for people to be on the ground here and see what is going on. So I certainly wish them well.

Couple of issues I wanted to just raise due to my trip. One thing I found is that the issues are hard to separate. This is about health care today. But it is very hard to separate health care from housing, all the issues facing New Orleans from the housing problem; from schools, because people do not want to come back if the schools are not operating. No reimbursement for work, of course, is very important the lack of nurses. Everything is really intertwined, it seems to me, in the rejuvenation of New Orleans.

In terms of reimbursement issues and the money issues, I do have to say that I was struck, as others have mentioned, by what appeared to be a two-tiered system of health care, which I think we do have in many ways in our country: People who can afford it and people who can't. The dramatic difference between HCA, Tulane, the University Hospital, the Charity system, was pretty dramatic, and I think it is something that needs to be dealt with here in New Orleans where it is so dramatically disparate, and certainly around the country as well. But if the Federal government can manage to get the money in hundred-dollar brick packages that are sent to Iraq, and helping to build the hospitals and reconstruction there, it seems to me that in our own country, that we could make a priority out of New Orleans and that money ought to be flowing here.

Clearly, there are organizational issues, governance issues. When I have asked people who are in charge overall, it is very hard to get an answer if there is some center of coordination.

I am concerned about Mardi Gras coming up. That there was an issue raised, and I saw in your paper, that was 2,100 hospital beds, and now there are 400 beds between Touro and Children's Hospitals. Meeting this morning with Dr. Leonard Glade from Touro, I understand that those beds are not all open because there are not enough nurses to serve them. So, the problem is even worse than it is portrayed.

And the community, in talking about the storm itself, we have been talking since September 11 about interoperability of communication systems, and yet, so many years later we face that same problem here in New Orleans with Katrina. I think it is time we did something about it. I know that it is not that expensive or hard to do at least a make-shift system. So, I hope we will talk about many of these issues and then help

to come up with answers and be partners in the solution for New Orleans. Thank you.

MR. WHITFIELD. Thank you, Ms. Schakowsky. And before we introduce the witnesses, as you probably know, we have two Members of the Louisiana delegation in the room right now. It has already been mentioned that Congressman Jefferson has spent a big part of yesterday with us, and at this time, we are going to provide opportunities for statements by Congressman Melancon and then, Congressman Bobby Jindal. So, Congressman you are recognized for an opening statement.

MR. MELANCON. Thank you very much to you and Congressman Stupak for taking the time to meet with us and to get down to Louisiana. I wish we could put every member of Congress on the ground not only here in Louisiana, but also in Mississippi to comprehend the enormity of this disaster. It is unlike anything I have ever seen in my 58 years, and I have seen a lot of hurricanes and tornadoes. We see them on the news, but what we see here is nothing like what we thought the pictures showed. It is truly devastating and far more disastrous than anything that anybody can imagine.

Just for informational purposes, last week, along with the Mississippi delegation, the Louisiana delegation put together a letter to Speaker Hastert and Leader Pelosi. We are asking them to lead a delegation of those Members of the House of Representatives that have not put a foot in Louisiana or Mississippi. They need to see, they need to understand. When they get back, after they have seen what has happened here, if they don't think that we need help, then there is nothing more that I can do.

I think that any human being with a heart and a soul seeing what you have seen here in New Orleans, and haven't seen, I don't think, yet, in Mississippi, it would be quite difficult for you to go back and to not try and help these Americans. They are not Democrats, they are not Republicans, they are not rich, they are not poor, they weren't white or black. They were on the roofs of their houses and devastated by the storms. Any help that Congress can see fit to give--and the President included--a helping hand. We are not asking for handouts, we are asking for helping hands.

The Stafford Act is going to need some revisions. It was designed for small disasters, and it doesn't cover the enormity we have here, much less speak to the healthcare issues. We need to look at, and the President needs to look at his executive authority to start waiving some of these rules that are out there to make this thing move faster.

As Congresswoman Blackburn said, the Government truly is big and enormous. The problem is FEMA is small and slow and they just don't know how to respond. We need to make them look at the bigger picture and give them more power and authority and probably need to link back

directly to the President of the United States because they should not have to get secretarial sign-offs in order to take actions to move something.

As we said, we can mount an attack across the board, across the globe, and we have problems getting folks down into disaster areas in a meaningful period. The Medicaid reimbursement, healthcare in general has suffered as have all of the infrastructures in South Louisiana and South Mississippi.

One of the things that a lot of people don't understand, particularly in Congress, in Louisiana, through the years, there has been protection given to funding of certain programs and areas of Government that Government takes care of because of concerns by people that receive Government funding. The irony is that the two elements of the infrastructure that are left as the ones subject to the budget cuts when times get bad are healthcare and education, two of the most important elements of any community, any State, any region. That has been what has been happening. This State legislature and Government have cut approximately \$1 billion because there wasn't the ability to do bond issues to support such operations.

We are truly in a dilemma. Some people will be critical of Louisiana, but I can tell you that we are doing everything that can be done within the constitutional confines that create problems for us in each State.

If I had to recommend to people how can we help ourselves get out of this: Waive the rules, amend the Stafford Act, provide for legislation that would let Louisiana, like all interior States, share in our Outer Continental Shelf revenue sharing. The country receives approximately \$8.5 billion a year in revenue sharing from minerals, coal, oil, gas, et cetera, across this great country off of Federal land and our Outer Continental Shelf. Those that are interior States share at a rate of 50 percent. Louisiana gets zero.

We also provide \$6 billion dollars of \$8 and a half billion to the U.S. Treasury. If we can get our share like the interior States do, we can help ourselves in many ways and we would not have to continue to beg and grovel to the Congress and to have--you wouldn't have to worry about, every year, getting appropriations.

So, I appreciate the opportunity that you have allowed me to be here. I especially appreciate the fact that you are here. And people of Louisiana, believe me, they are very, very appreciative of you taking the time from your busy schedules. Thank you.

MR. WHITFIELD. Thank you very much for that statement, and we appreciate you being here and the hard work that you are doing in Congress to assist.

At this time, we recognize Congressman Jindal for his statement.

MR. JINDAL. Thank you. I want to thank you and the members of the committee for taking the time to come down here. Like my colleague, Mr. Melancon, I do believe that the more our colleagues get to see with their own eyes the devastation on the ground, the easier it will be to comprehend the amount of work that needs to be done to rebuild this great city, not only for Louisiana but the country, not just here, but there are areas across southwest and central Louisiana that were also devastated.

Mr. Chairman, I particularly welcome you back. I know it was really just months ago you were here where we had the opportunity to visit on healthcare just several months ago. For the members of the committee, I do have a special interest in healthcare. I had the privilege before I joined you in Congress as serving as Louisiana's Secretary of the Department of Health and Hospitals. I had the privilege of coming to Washington, having discussions with the Assistant Director of the bipartisan Medicaid Commission you created and then serving as Assistant Secretary with Tommy Thompson.

So, I especially am passionate about the issue you are here to discuss, which is healthcare and in particular, hospitals. You know, I think one of the greatest needs as we try to encourage people to return and resume their normal lives is the need to restore a safety net, to restore formal critical healthcare services. I know you are also here to focus on the continued operations of hospitals and disasters in the future and make sure we ensure the safety of patients who entrust their care to these facilities.

Clearly, we need to do more in terms of the planning for evacuation, continuity of care for patients already in facilities, as well as protecting the hospitals so they can play a role in emergency medical treatment, as well as relief for those that are stranded. During Hurricane Katrina only a handful of hospitals in the greater New Orleans region were able to continue operating during the storm and its aftermath. Quite literally, these buildings were buffeted by winds. Flooding knocked out the city's entire electrical grid, cutting power to those hospitals along with everything else. In these hospitals, you had patients, you had nurses, you had doctors, you had dedicated staff who endured heat, no electricity, and limited communication. To make matters worse, not all of these hospitals in the flood zones had emergency generators. Not all of them had field supplies. Many of them did have them but they were located on lower floors or in basements, and therefore, had outages due to flooding.

As a result of the primary power failure, in many cases, you had the loss of backup power as well, yet hospital staffers were called upon to

perform life-saving efforts such as hand-bagging respiration continuously, for hours, until they could evacuate their patients, and truly, those were some of the unsung heroes of this tragedy, these dedicated workers who stayed by the bedsides of their patients, asking for additional assistance and rescue. Some of the most heartbreaking calls--we provided all the help we could, providing information to the forces on the ground in order to facilitate aid for those stranded in the hospitals, and the rescuers sometimes found themselves climbing floors to avoid the rising waters.

I will close, and I want to introduce one of the members of the panel. I'm very honored to be able just to take a little bit of your time. I know it is an exception to the normal rules of the committee and subcommittee, so I thank the Chairman for his indulgence.

And I want to echo, as my colleague said, and I very much appreciate your taking the time to come see this. Many of the Members have been here before, and we appreciate your willingness to come and see this for yourself. I want to thank the staff as well for spending their time here as well.

I want to close by introducing one of the members of your distinguished panel. One of the men in the heart of the disaster, who fought hard to keep his hospital operational and patients safe, and he's sitting here today, and that is Mr. Gary Muller. He is the President and Chief Executive Officer of West Jefferson Medical Center. That is one of the hospitals that stayed open during the storm and continued to stay open and continued to operate. Mr. Muller is the immediate past chairman of the Louisiana Hospital Association. He recently received Louisiana's Senior Level Health Healthcare Executive Regent's Award for 2004 from the American College of Healthcare Executives.

You have got his biography in front of you. I won't go through all of his particulars, but I do want to say that is a well-deserved honor, when you consider his staff's and his medical center's extraordinary performance and what they did under his leadership during the extraordinary circumstances of Hurricane Katrina and Rita.

I want to thank you in advance, and I know when we come back to Congress, it is widely anticipated that the House will concur with something the Senate majority approved, which is something your committee played a critical role in, in providing substantial relief to Louisiana's Medicaid program. I want to thank you for that because that will go a long way to mitigating some of those cuts that Charlie Melancon talked about. Nearly \$2 billion from the Gulf Coast, nearly half of that coming from the State of Louisiana. That is absolutely critical in giving the State the time it needs to reorganize its healthcare services.

Mr. Chairman and members of the committee, thank you for allowing Charlie and I to be here.

MR. WHITFIELD. Thank you very much for your statement, and we appreciate your leadership in the Congress on necessary healthcare issues.

With that, I will just dismiss the two of you, and we look forward to hearing the testimony of our panel. So, thank you all very much for being here.

At this time, it gives me great pleasure to introduce our first panel. First of all, we have Mr. Mel Lagarde, who is the President and CEO of HCA Delta Division. Second of all, we have Mr. James Montgomery, who is the President and Chief Executive Officer of Tulane University Hospital and Clinic. Third we have Mr. Rene Goux, Chief Executive of Memorial Hospital and Tenet Healthcare Corporation. Fourth, we have Mr. Robert Smith, who is Senior Vice President of Regional Operations for Texas/Gulf Coast Tenet Healthcare Corporation. We have Dr. Cathi Fontenot, who is Medical Director at the Medical Center of Louisiana, and we spent some time with her yesterday. Dr. Donald Smithburg, who is Executive Vice President of the LSU system, Chief Executive Officer of the LSU Healthcare Services Division. We spent some time with him yesterday. And then, Mr. Jon Sewell, who is the Chief Executive Officer of Chalmette Medical Center, University Health Services Corporation, and then, Bobby Jindal has already introduced Mr. Muller, but Gary Muller, who is the President and Chief Executive Officer of the West Jefferson Medical Center.

Before I proceed with you all, I do want to ask unanimous consent. We have a letter here given to us by the President of the Louisiana State University System, William Jenkins, who was also with us yesterday and we want to introduce this into the record. I think you have got a copy of this, Mr. Stupak.

Without objection, so entered.

[The information follows:]



Health Sciences Center
HEALTH CARE SERVICES DIVISION

School of Medicine in New Orleans
School of Medicine in Shreveport
School of Dentistry
School of Nursing
School of Allied Health Professions
School of Graduate Studies
Health Care Services Division

January 10, 2006

The Honorable Michael O. Leavitt
Secretary U.S. Department of
Health and Human Services
200 Independence Avenue
Washington, DC 20201

Dear Sec. Leavitt:

As you know, the Medical Center of Louisiana at New Orleans (MCLNO) suffered significant damage as a result of the destruction caused by Hurricanes Katrina and Rita. Currently, MCLNO is providing emergency and outpatient services in the Greater New Orleans area, but is not yet able to resume inpatient services. MCLNO's state hospital license remains valid and active. Frederick Cerise, M.D., Secretary of the State of Louisiana Department of Health and Hospitals has confirmed MCLNO's active status and continues to be very supportive in all efforts to re-establish health care in the New Orleans area. (See attached document) It's our understanding that, notwithstanding the interruption in inpatient services, MCLNO remains eligible to bill for the outpatient and emergency services it is providing. I am submitting this letter to request an acknowledgement of MCLNO's continued eligibility to bill for outpatient and emergency services until the inpatient services are re-established.

The following briefly describes MCLNO's current operations and long-term plans to rebuild MCLNO and re-establish inpatient services.

Current operations:

- Emergency services are being provided in hall "J" of the New Orleans Convention Center. Emergency Medical Services, along with dental care, are provided twenty-four (24) hours a day, seven days a week. Patients are triaged, evaluated, treated and released or transported via ambulance to an area hospital.
- Ambulatory/Outpatient services are being provided at the Delgado Building located at 1545 Tulane Avenue. This facility has twenty-seven (27) exam rooms and is currently the site of our primary care and HIV clinics.

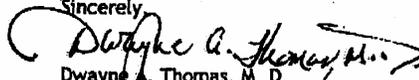
The Honorable Michael O. Leavitt
 January 10, 2006
 Page Two

Future plans include:

- Re-establishment of Level One Trauma Services (February 15, 2006): MCLNO is currently in active negotiation with Ochsner/Elmwood Medical Center, located at 1221 South Clearview Parkway, to lease the Emergency Department, a patient care/support services floor, laboratory and radiology areas.
- MCLNO and the LSU Health Science Center are in negotiations with Touro for the lease of St. Charles General Hospital. It is anticipated that this area will staff one-hundred (100) beds and utilize the facility for elective and ambulatory surgical and medical inpatient services.
- University Hospital will be repaired/renovated to accommodate a minimum of 200 hospital beds with expansion of the Emergency Department and Intensive Care Unit. It will function as a temporary interim facility until a replacement hospital has been constructed.
- Adding twenty-four (24) twenty-three (23) hour observation beds at the emergency site in the convention center
- Re-opening the HIV Clinic site located at 136 South Roman Street. This site will also be used to provide out-patient sub specialty services which include Cardiology, Hematology-Oncology and Renal Services
- Opening five (5) mobile medical clinics that will be staffed by MCLNO employees, LSU, Tulane and MCLNO physicians and Nurse practitioners. The community based clinics will deliver outpatient primary care, dental, and family services which will include WIC, Family Planning, Infant screening and immunizations.

We appreciate your attention to this important matter. Please do not hesitate to contact me if you have questions or need clarification on any of our current services or operational arrangements.

Sincerely,


 Dwayne A. Thomas, M. D.
 Chief Executive Officer

cc: Fred Cerise, M. D.
 Robert Plaisance
 Ed Burke
 Leslie Norwalk, CMS

2005-12-19 14:37

225-342-5568 DHH Off. of The Sec.

P 2/2



Kathleen Babineaux-Bianco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

December 15, 2005



Frederick P. Cerise, M.D., M.P.H.
SECRETARY

Mr. Robert Platsance, Deputy CEO
LSU Health Sciences Center
Health Care Services Division
8550 United Plaza Blvd., 4th Floor
Baton Rouge, LA 70809-2256

Dear Mr. Platsance:

RE: Medical Center of Louisiana at New Orleans (MCLNO)

This letter is written in response to your correspondence of November 30, 2005, regarding the Medical Center of Louisiana at New Orleans (MCLNO). At this time, MCLNO's state license is valid and active; no action has been taken by the Department against the hospital's license. Act 7 of the recent Special Session of the Legislature, which added La. R.S. 40:2007.1, states the Department will not take action to terminate or revoke a facility's license solely because a facility experiences an interruption in the provision of services as a result of events that are the subject of an executive order or proclamation of emergency or disaster. This is conditioned upon the facility complying with the provisions of that statute.

Regarding licensing of the outpatient off-campus facilities, as long as the provisions of La. R.S. 40:2007.1(D) are complied with, the off-campus facilities would be licensed. However, for certification and reimbursement purposes, authorization is needed from the Centers for Medicare and Medicaid Services (CMS). Lisa Deaton and Patricia Pittman of DHH Health Standards have been in contact with CMS on this issue. CMS is requesting that you send them a request in writing detailing your request for MCLNO to be able to continue to bill for outpatient and emergency services until such time as the inpatient services can be re-established. CMS can determine if this warrants action under the provisions of the Section 11358 Waiver, which would expire January 31, 2006.

As to the request to be allowed to utilize operating and recovery rooms with Ochsner, please be advised that the facility cannot simultaneously use surgical and recovery rooms with Ochsner.

If you have questions regarding this information, please do not hesitate to contact me.

Sincerely,

Frederick P. Cerise
Frederick P. Cerise, M.D., M.P.H.
Secretary

FPC/kih

cc: Charles Castille
Lisa Deaton
Kim Humbles

OFFICE OF THE SECRETARY
1201 CAPITOL ACCESS ROAD • P. O. BOX 620 • BATON ROUGE, LOUISIANA 70821-0620
PHONE #: 225/342-8508 • FAX #: 225/342-5568
"AN EQUAL OPPORTUNITY EMPLOYER"

MR. WHITFIELD. I want to remind all of you, we are holding an investigative hearing. When doing so, it is our practice to take testimony under oath. Do you have any objection to testifying under oath this morning? I would advise you that under the rules of the House, and the rules of the committee, you are entitled to be advised by legal counsel,

and I would ask: Do any of you desire to be advised by legal counsel today?

In that case, if you would all rise and raise your right hand, I would like to swear you in.

[Witnesses sworn.]

Thank you, you are now under oath, and Mr. Lagarde, we call on you to begin with your five minute opening statement.

TESTIMONY OF MEL LAGARDE, PRESIDENT AND CEO OF HCA DELTA DIVISION, HCA INC.; JAMES T. MONTGOMERY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, TULANE UNIVERSITY HOSPITAL & CLINIC, HCA, INC.; RENE GOUX, CHIEF EXECUTIVE OFFICER, MEMORIAL MEDICAL HOSPITAL, TENET HEALTHCARE CORPORATION; ROBERT SMITH, SENIOR VICE PRESIDENT, REGIONAL OPERATIONS-TEXAS/GULF COAST, TENET HEALTHCARE CORPORATION; CATHI FONTENOT, MEDICAL DIRECTOR, MEDICAL CENTER OF LOUISIANA—NEW ORLEANS; DONALD R. SMITHBURG, EXECUTIVE VICE PRESIDENT—LSU SYSTEM, CHIEF EXECUTIVE OFFICER, LSU HEALTHCARE SERVICES DIVISION; JON SEWELL, CHIEF EXECUTIVE OFFICER, CHALMETTE MEDICAL CENTER, UNIVERSAL HEALTH SERVICES, INC.; AND A. GARY MULLER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, WEST JEFFERSON MEDICAL CENTER

MR. LAGARDE. Good morning. I am President of HCA Delta Division, which encompasses Louisiana and Mississippi. Headquartered in Nashville, HCA is the largest private healthcare provider in the United States. As Delta Division President, I have taken an active part in formulating our comprehensive strategy on emergency preparedness. As a former hospital CEO, I have come to appreciate the critical importance of preparation for all types of disasters. In the wake of Hurricane Katrina, I have acquired first-hand experience in amending and modifying that strategy. We created the Disaster Readiness Manual, which serves as a comprehensive reference for our hospitals.

Ever since our inception in 1968, HCA has taken seriously our responsibility for emergency preparedness and response.

Historically, the Joint Commission on Accreditation of Healthcare Organizations has served as the national survey and standards agency for accreditation based upon quality and patient safety. JCAHO accreditation represents, in part, that accredited hospitals have designed,

implemented, and demonstrated the efficacy and compliance of the emergency preparedness plans of accredited institutions. All HCA hospitals have full JCAHO accreditation, based in part upon compliance with the organization's emergency preparedness standards. Particularly motivated by the events of September 11, HCA has scrutinized and enhanced its comprehensive strategy toward emergency preparedness. HCA is looking to enhance not only the emergency preparedness of each affiliated hospital, but also the emergency preparedness of the entire HCA network, and most importantly, the communities served by HCA affiliates. In designing our approach, working in conjunction with the CEO of each HCA facility, we began by assessing the emergency preparedness of our affiliates. HCA also conducted facility audits to ensure data quality and accuracy. We then met with the departments of health of various States, JCAHO, and the American Hospital Association to develop community-based emergency preparedness strategies.

On the Federal level, HCA met with the Department of Health and Human Services, Office of Emergency Preparedness, to discuss the role that HCA Resource Deployment could play in national emergency preparedness plans. HCA also was among the first private-sector entities to meet with officials at the Department of Homeland Security shortly after Congress had established the agency. HCA's Delta Division encompasses Louisiana and Mississippi. As Delta Division President, I have taken an active part in formulating HCA's comprehensive strategy on emergency preparedness. As a former hospital CEO, I have come to appreciate--both professionally and personally--the critical importance of preparedness for all types of disasters.

In the wake of Hurricane Katrina, I have also acquired firsthand experience in implementing and modifying that strategy. Before I delve into my experiences in preparing for and managing emergency, however, I would like to provide you with some background information on the structure of HCA. I believe that this information will help you appreciate the interconnections between the emergency preparedness plans of HCA affiliates, the communities served by HCA hospitals and the HCA network.

One. Community Based Emergency Preparedness Strategies.

Hospitals are community institutions, where people turn for care and solace in times of crisis. September 11 and the anthrax attacks underscored the need for hospitals to be cognizant of disasters within the communities they serve and the special risks that such service entails. And in an era of terrorism, hospitals no longer can afford to be isolated from each other or from governmental agencies. Rather, these parties must form a seamless web in order to formulate a coherent emergency response and to educate the community on emergency preparedness.

HCA encourages all affiliates to contribute and comply with their community-based emergency preparedness plan. HCA's participation also enables employees to serve on disaster medical assistance teams, which may be deployed anywhere in the United States to support communities overwhelmed by emergency.

HCA also encourages affiliates that currently are located outside affected areas to coordinate with local and State agencies to ensure that appropriate emergency preparedness plans are developed for their communities. Additionally, HCA affiliates serve as participants in the National Disaster Medical System, prepared to receive disaster victims in the event that a mass casualty situation arises.

HCA currently sponsors two DMATs, one based in Atlanta, Georgia, comprising 125 members, and another based in Denver, Colorado, comprising 127 members. HCA's director of emergency preparedness commands the Georgia-based team, which was deployed to New York after the September 11 attacks, and to the Gulf Coast after Hurricane Katrina. HCA staff members also lead the Colorado based DMAT. In both cases, HCA acts as a resource for the DMATs by recruiting new members, arranging training, and coordinating deployment. HCA also provides material support in the form of pharmaceuticals, communications equipment, defibrillators, protective gear, vehicle rentals for training exercises and storage space.

HCA's leadership believes that affiliates should take an active role in educating their communities on emergency preparedness. To help affiliates assume these educational responsibilities, we have provided them with materials such as posters, web casts, seminar programs, and conference programs. One example of the materials that we have distributed is entitled "General Guidelines for the Recognition, Immediate Treatment, and Precautions in the Management of Potential Victims of Radiological, Biological, or Chemical Exposure." Our internal emergency preparedness manual, entitled Disaster Readiness, Guidelines for Emergency Management Planners, is another example of the materials that we distribute. HCA has mailed copies of disaster readiness to State hospital associations, the HHS-OEP, the Centers for Disease Control, JCAHO and to education programs aimed at healthcare professionals.

I am proud to note that HCA personnel served as members of the DMAT deployed to ground zero in the immediate aftermath of the events of September 11. Additionally, HCA personnel at one of our affiliate hospitals in Florida diagnosed and treated the first anthrax victims.

Two. Enhancing the Emergency Preparedness of the HCA Network.

In addition to participating in community-based emergency planning, HCA has taken steps to enhance the emergency preparedness of the HCA

network. For example, HCA has created the Disaster Readiness Manual, which is updated annually, to serve as a comprehensive reference for our affiliated hospitals. The manual explains the hospital emergency incident command system, which we require affiliates to adopt. I will speak more about HEICS later, in which I will detail HCA's attempts to strengthen the emergency preparedness of affiliates. In addition to describing the HEICS, the Disaster Readiness Manual provides affiliates with templates of specific plans dealing with natural disasters, bioterrorism, chemical terrorism, and radiation sickness. HCA requires affiliates to implement and customize these templates as appropriate. A chief nursing officer is designated for each division and is responsible for making sure that the hospitals under their supervision comply with the manual's policies. We also train affiliate CEOs and CNOs in disaster readiness through web cast, conference calls, and facility-specific customized training.

As part of our emergency preparedness guidance, HCA provides each hospital with an algorithm to calculate the quantity of drugs, supplies, and equipment that would be needed in a crisis situation. Factors of computation include: one, size; two, medical staff support; and, three, patient census trends among others in the various markets. We utilize these calculations toward emergency preparedness against all kinds of hazards, whether natural or man made.

Although HCA expects each affiliate to maintain emergency supplies of pharmaceuticals and medical call equipment, we recognize that a catastrophic event could cause affiliates to exhaust provisions quickly without hope of restocking from older suppliers. HCA has, therefore, created the central supply warehouse system, which is devoted to storing drugs and medical supplies vital to the natural emergency response. The warehouse system requires each division to set up a central supply center containing caches of burn/trauma kits, SARS/respirator kits, and pharmaceutical kits. The Far West and the East Florida divisions are responsible for storing bio-isolation units. Additionally, HCA has developed the capacity to transport kits and bio-isolation units to any affiliate hospital within 24 hours.

HCA also recognizes that affiliates responding to catastrophic events may confront insufficient personnel to treat the number of incoming patients. We, therefore, have relied on one of our subsidiaries, All About Staffing, to augment the emergency response capabilities of our affiliates. Whenever an emergency occurs, AAS is ready to provide temporary staffing for affected facilities. AAS generally provides nursing support, although an affected facility, we had any type of staff essential to fulfilling patient needs. HCA has appreciated the Federal government's waiving of licensure requirements after declarations of

emergency. HCA believes that these waivers have enhanced our ability to draw upon staff throughout our network in response to emergencies of national dimensions.

So far, I have been speaking to you about how HCA has attempted to enhance network response to emergencies. Now I would like to speak briefly about HCA efforts to prevent catastrophic events. Throughout the HCA hospital network, we conduct syndromic surveillance of emergency room patients with laboratory testing needs. For example, HCA monitors the white blood cell volume of such patients daily. Our surveillance has been instrumental in identifying increased rates of influenza in the communities that our affiliates serve. We believe that our syndromic surveillance system may be helpful in identifying the spread of other diseases of national import. Currently, CDC is considering the role that HCA may play in national surveillance through the CDC syndromic surveillance program.

Three. Strengthening the Emergency Preparedness of HCA Affiliates.

HCA has taken steps to strengthen the emergency preparedness of our affiliates, as they inevitably are on the front lines of catastrophic events. As I mentioned previously, HCA requires affiliates to adopt the hospital emergency incident command system. There are two reasons for this requirement. First, HEICS creates a common vocabulary for use during an emergency response. HCA has also encouraged other healthcare providers to utilize HEICS, because we believe that more widely expressed use would ensure better coordination among first responders in every community. Second, HEICS creates a framework of leadership positions, and assigns specific responsibilities to those positions. The HEICS command structure establishes an “all hazards” command structure within the hospital, which links with the “community” command structure--whether that “community” comprises the neighborhoods in proximity to the hospital, our other HCA divisions, other local hospitals, or corporate offices.

HEICS therefore creates fully operational chains of command at the first sign of an emergency. Such command chains include the hospital experiencing the events, the division and market where that hospital is situated, the CSC associated with that division and HCA corporate headquarters. Although HCA sister facilities are not direct links in the command chain, they stand ready to provide support, using HEICS as a shared platform.

As I mentioned previously, HEICS has the benefits of providing a common vocabulary, role definition and organizational structure, and accountability. Accordingly, the system has the ability to supersede

corporate titles and business positions that establish the traditional lines of authority during nonemergency situations.

As part of our quality review system, every 12 to 24 months, HCA conducts routine audits and surveys of the emergency preparedness of each affiliate hospital. While HCA data collection demonstrates that affiliates steadily are improving their programs, HCA continues to use QRS to ensure that facilities comply with the disaster readiness guidelines.

Four. HCA Response to Hurricane Katrina.

HCA has been in operation since 1968 and we often must contend with hurricanes and other natural disasters. In 2004 alone, HCA affiliates in Florida were exposed to four major storms, including the devastating effects of Hurricanes Charlie, Frances, and Ivan. Needless to say, severe weather preparedness is a top priority for our HCA affiliates in the southeast. Accordingly, in November of 2004, HCA senior executives and the CEOs of our affiliate hospitals met in Orlando, Florida, to discuss "Hurricane lessons learned."

The meeting helped HCA identify three areas in our severe weather plan that needed improvement: one, communication; two, transportation of supplies; and three, sourcing for alternative energy should public utilities fail. In the following months, HCA provided our affiliates with satellite phones, hurricane shutters, and additional portable emergency generators. HCA also contracted with local businesses--like refrigeration companies, water companies, and diesel and gasoline retailers--to provide supplies quickly in the face of an emergency. In hurricane strike zones, we began to move food, medical supplies, and other gear to warehouses near hospitals.

Despite this extent of experience and preparation, Hurricane Katrina inflicted an unprecedented level of destruction on the region, which affected our HCA affiliates in Louisiana and Mississippi. Lakeview Regional Medical Center in Covington, Louisiana, sustained weather and wind damage but remained open. Garden Park Medical Center in Gulfport, Mississippi, sustained flooding and roof damage, but resumed emergency room operation shortly after Hurricane Katrina passed. Since Garden Park Medical Center was one of only two hospitals still functioning in the Gulfport-Biloxi area after Hurricane Katrina, FEMA installed tents near its parking lot to give tetanus shots and to treat the less seriously injured.

HCA was forced to evacuate two facilities. We closed Tulane-Lakeside Hospital in Metairie, Louisiana, after local officials ordered a mandatory evacuation, and we transported patients, employees, and family members to a safe location by bus convoy. Tulane University

Hospital and Clinic in New Orleans, Louisiana, which sustained the heaviest damage, mainly had to be evacuated by helicopter.

I would like to speak now of HCA's role in the TUHC evacuation and in the national emergency response to Hurricane Katrina.

On August 29, 2005, Hurricane Katrina made landfall in Louisiana as a Category Four storm. Shortly after Katrina passed, CEO Jim Montgomery reported that TUHC had suffered only minor damage and that flooding in New Orleans appeared to be limited. Our relief was short-lived, however. By the morning of August 30, we became painfully aware of the true state of devastation caused by Hurricane Katrina.

HCA senior executives already had established an HEICS command center in the board room of the company's headquarters in Nashville, the corporate Company Command Center, and they remained there for the rest of the week to coordinate HCA disaster relief efforts along the Gulf Coast.

The Corporate Command Center's top priority was to assist in the evacuation of TUHC in any way possible. On the morning of August 30, the TUHC command center reported that flooding had intensified in New Orleans and was threatening the hospital's emergency generators. At that point, TUHC housed approximately 180 patients and 1,000 staff members and their families. Eleven patients were on ventilator support, and two were attached to heart pumps. It was clear that TUHC had to be evacuated as soon as possible. Although TUHC had called Acadian Ambulance to request helicopter assistance, we did not believe that Acadian alone could complete the evacuation within a reasonable period of time. HCA therefore chartered 24 helicopters to support TUHC efforts.

On the morning of August 31, the Corporate Command Center learned that HCA-chartered helicopters had arrived at TUHC, with the HCA contractors providing flight coordination. Since the TUHC evacuation proceeded in stages, HCA headquarters arranged to load each chartered helicopters with 750 pounds of food, water and medical supplies to help TUHC staff and patients remaining in New Orleans. Rather than transporting patients from one staging area to the next, the Corporate Command Center prearranged for other HCA facilities to be awaiting their reception. Many of the evacuees initially were taken to Women's and Children's Hospital in Lafayette, Louisiana. HCA sent 50 nurses from AAS to support affiliated hospitals in the Gulf Coast receiving evacuees, and we stood ready to deploy 170 additional nurses, if needed. On the evening of August 30, TUHC lost backup power causing the communications network to fail. The following morning, headquarters helped TUHC set up a radio network by flying in three

members of the Tallahassee Amateur Radio Club, who set up a portable generator-powered HAM radio with a satellite uplink. The three radio operators used the satellite uplink to contact HCA offices in Tallahassee, Florida, for evacuation information. They then used two-way radios to relay evacuation information to TUHC staff. The three radio operators also delivered flight directions from HCA staff to the helicopter pilots.

On September 1, TUHC completed the evacuation of its patients, along with 38 patients from Charity Hospital. The Corporate Command Center was encouraged by our hospital's response to the greatest natural disaster in our nation's history.

Apart from my account of the evacuation itself, let me now give you a sense of the magnitude of HCA's response to Hurricane Katrina. In terms of supplies, HCA provided the following to aid Katrina's victims: 30,000 gallons of bottled water; 95,600 pounds of ice; 30,320 meals ready to eat; 5 truckloads of other food; 4 truckloads of linen; 1 truckload of scrubs; 7 truckloads of assorted supplies; 1 truckload of mattresses; 2,500 gallons of gasoline for vehicles and small portable generators; and 50,000 to 100,000 gallons of diesel fuel for large portable generators. In terms of pharmaceuticals, HCA provided 17,360 doses of Cipro, tetanus immunizations and insulin injections, along with other drugs.

To serve transportation needs, HCA provided 24 chartered helicopters for patient evacuation, as well as one fixed-wing plane to deliver supplies, two Boeing 727s to transport staff and families to Houston and Atlanta, 200 commercial airline tickets, five buses for evacuations, and one refrigeration truck.

In terms of communications, HCA provided cell phones and 15 satellite phones. Finally, HCA sponsored the Georgia-based DMAT response to Hurricane Katrina. We traveled 1,400 miles to set up a mobile hospital in Galveston, Texas. That DMAT team provided medical assistance to 4,000 evacuees, nearly all of whom were at least 65 years old.

HCA's efforts to help victims of Hurricane Katrina are continuing today. HCA established the HCA Hope Fund and contributed \$4 million, also offering to match employee donations dollar for dollar. HCA's hospital business partners and vendors, including the Rapides Foundation, St. David's Foundation, Health One, the Methodist Foundation and Meditech, have contributed a total of \$1.5 million. HCA affiliates throughout the Nation and our employees have donated an additional \$450,000 to the fund. Displaced HCA employees continue to be on payroll and HCA has offered to help them relocate, either temporarily or permanently, within the HCA network. Moreover, the HCA Hope Fund gave \$1.5 million in grants to help displaced employees meet immediate living expenses. We also have donated \$1 million to the

American Red Cross. Finally, HCA has shown dedication to New Orleans by reopening Tulane Lakeside Hospital, and by moving forward with the recovery process at TUHC.

V. Lessons Learned From Hurricane Katrina.

Since grappling with the effects of Hurricane Katrina last summer, HCA is continuing the process of analyzing our procedures for emergency preparation and response, continually seeking to enhance our practices and procedures. For example, in March 2006, HCA headquarters will host a lessons learned meeting, which will be attended by each of our affiliate hospitals that experienced hurricane and other natural disasters during 2005. In the meantime, HCA is working with its affiliates to assess the positions of emergency generators and to enhance their communications capabilities. In addition, our current efforts to improve upon preparedness are focusing on meetings, preparation, response, and relief for Avian flu. On balance though, I believe that the HCA response to Hurricane Katrina revealed far more strengths than weaknesses in our emergency preparedness strategy. On the community level, HCA was able to relay critical information to TUHC and Federal authorities after the hospital's communications systems failed. Garden Park Medical Center in Gulfport, Mississippi coordinated with FEMA to determine how to treat less seriously injured victims of Katrina. On the network level, HCA successfully created a command chain and drew upon the resources of all our affiliates to evacuate TUHC, to provide placement for all TUHC patients, and to provide food, water, and medical supplies as needed. On the affiliate level, TUHC followed the Disaster Readiness Manual and developed an effective emergency preparedness plan. At all levels, therefore, HCA launched an appropriate response to Hurricane Katrina.

In sum, we are justly proud of our colleagues at TUHC, as well as all 190,000 members of our staff and the communities that we serve.

Thank you, Mr. Chairman, and members of the committee, for your time and attention. I will be happy to respond to any questions.

[The prepared statement of Mel Lagarde follows:]

PREPARED STATEMENT OF MEL LAGARDE, PRESIDENT AND CEO OF HCA DELTA DIVISION,
HCA INC.

Mr. Chairman, members of the Committee and staff – good morning. My name is Mel Lagarde, and I am the Delta Division President of HCA, Inc. (“HCA”). HCA is the largest private healthcare provider in the United States. Headquartered in Nashville, Tennessee, HCA affiliates operate 180 hospitals and eighty-two outpatient surgery centers in twenty-three states, England, and Switzerland. HCA facilities currently employ approximately 190,000 people worldwide. Ever since our inception in 1968, HCA has taken seriously our responsibility for emergency preparedness and response.

Historically, the Joint Commission on Accreditation of Healthcare Organizations (“JCAHO”) has served as the national survey and standards agency for accreditation

based upon quality and patient safety. JCAHO accreditation represents, in part, that accredited hospitals have designed, implemented and demonstrated the efficacy and compliance of the emergency preparedness plans of accredited institutions. All HCA hospitals have full JCAHO accreditation, based in part upon compliance with the organization's emergency preparedness standards. Particularly motivated by the events of September 11th, HCA has scrutinized and enhanced its comprehensive strategy towards emergency preparedness. HCA is looking to enhance not only the emergency preparedness of each affiliated hospital, but also the emergency preparedness of the entire HCA network, and most importantly, the communities served by HCA affiliates.

In designing our approach, working in conjunction with the CEO of each HCA facility, we began by assessing the emergency preparedness of our affiliates. HCA also conducted facility audits to ensure data quality and accuracy. We then met with the Departments of Health of various states, JCAHO, and the American Hospital Association ("AHA") to develop community-based emergency preparedness strategies. On the federal level, HCA met with the Department of Health and Human Services, Office of Emergency Preparedness ("HHS-OEP") to discuss the role that HCA resource deployment could play in national emergency preparedness plans. HCA also was among the first private sector entities to meet with officials at the Department of Homeland Security ("DHS"), shortly after Congress had established the agency.

HCA's Delta Division encompasses Louisiana and Mississippi. As Delta Division President, I have taken an active part in formulating HCA's comprehensive strategy on emergency preparedness. As a former hospital CEO, I have come to appreciate – both professionally and personally – the critical importance of preparedness for all types of disasters. In the wake of Hurricane Katrina, I also have acquired first-hand experience in implementing and modifying that strategy. Before I delve into my experiences in preparing for and managing emergencies, however, I would like to provide you with some background information on the structure of HCA. I believe that this information will help you appreciate the interconnections between the emergency preparedness plans of HCA affiliates, the communities served by HCA hospitals, and the HCA network.

I. Community-Based Emergency Preparedness Strategies

Hospitals are community institutions, where people turn for care and solace in times of crisis. September 11th and the anthrax attacks underscored the need for hospitals to be cognizant of disasters within the communities they serve, and the special risks that such service entails. And in an era of terrorism, hospitals no longer can afford to be isolated from each other, or from governmental agencies. Rather, these parties must form a seamless web in order to formulate a coherent emergency response and to educate the community on emergency preparedness.

HCA encourages all affiliates to contribute and comply with their community-based emergency preparedness plan. HCA's participation also enables employees to serve on Disaster Medical Assistance Teams (DMATs), which may be deployed anywhere in the United States to support communities overwhelmed by emergency. HCA also encourages affiliates that currently are located outside affected areas to coordinate with local and state agencies to ensure that appropriate emergency preparedness plans are developed for their communities. Additionally, HCA affiliates serve as participants in the National Disaster Medical System ("NDMS"), prepared to receive disaster victims in the event that a mass casualty situation arises.

HCA currently sponsors two DMATs – one based in Atlanta, Georgia comprising 125 members, and another based in Denver, Colorado comprising 127 members. HCA's Director of Emergency Preparedness commands the Georgia-based team, which was deployed to New York after the September 11th attacks, and to the Gulf Coast after Hurricane Katrina. HCA staff members also lead the Colorado-based DMAT. In both cases, HCA acts as a resource for the DMATs by recruiting new members, arranging

training, and coordinating deployment. HCA also provides material support in the form of pharmaceuticals, communications equipment, defibrillators, protective gear, vehicle rentals for training exercises, and storage space.

HCA's leadership believes that affiliates should take an active role in educating their communities on emergency preparedness. To help affiliates assume these educational responsibilities, we have provided them with materials such as posters, web casts, seminar programs, and conference programs. One example of the materials that we have distributed is entitled *General Guidelines for the Recognition, Immediate Treatment, and Precautions in the Management of Potential Victims of Radiological, Biological, or Chemical Exposure*. Another example is our internal emergency preparedness manual, entitled *Disaster Readiness: Guidelines for Emergency Management Planners*. HCA has mailed copies of *Disaster Readiness* to state hospital associations, the HHS-OEP, the Centers for Disease Control ("CDC"), JCAHO, and to educational programs aimed at healthcare professionals. I am proud to note that HCA personnel served as members of the DMAT deployed to Ground Zero in the immediate aftermath of the events of September 11th. Additionally, HCA personnel at one of our affiliate hospitals in Florida diagnosed and treated the first anthrax victims.

II. Enhancing the Emergency Preparedness of the HCA Network

In addition to participating in community-based emergency planning, HCA has taken steps to enhance the emergency preparedness of the HCA network. For example, HCA has created the *Disaster Readiness* manual, which is updated annually, to serve as a comprehensive reference for our affiliated hospitals. The manual explains the Hospital Emergency Incident Command System ("HEICS"), which we require affiliates to adopt. I will speak more about HEICS later, when I detail HCA attempts to strengthen the emergency preparedness of affiliates. In addition to describing HEICS, the *Disaster Readiness* manual provides affiliates with templates of specific plans dealing with natural disasters, bioterrorism, chemical terrorism, and radiation sickness. HCA requires affiliates to implement and customize these templates as appropriate. A Chief Nursing Officer is designated for each Division and is responsible for making sure that the hospitals under their supervision comply with the manual's policies. We also train affiliate CEOs and CNOs in *Disaster Readiness* through web cast, conference calls and facility-specific customized training.

As part of our emergency preparedness guidance, HCA provides each hospital with an algorithm to calculate the quantity of drugs, supplies and equipment that would be needed in a crisis situation. Factors of computation include: (i) staff size; (ii) medical staff support; and (iii) patient census trends, among others in the various markets. We utilize these calculations to achieve emergency preparedness against all kinds of hazards – whether natural or man-made.

Although HCA expects each affiliate to maintain emergency supplies of pharmaceuticals and medical equipment, we recognize that a catastrophic event could cause affiliates to exhaust provisions quickly, without hope of restocking from ordinary suppliers. HCA has therefore created the Central Supply Warehouse system, which is devoted to storing drugs and medical supplies vital to the national emergency response. The Warehouse system requires each Division to set up a Central Supply Center ("CSC"), containing caches of burn/trauma kits, SARS/respiratory kits, and pharmaceutical kits. The Far West and the East Florida Divisions are responsible for storing bio-isolation units. Additionally, HCA has developed the capacity to transport kits and bio-isolation units to any affiliate hospital within twenty-four hours.

HCA also recognizes that affiliates responding to catastrophic events may confront insufficient personnel to treat the number of incoming patients. We therefore have relied on one of our subsidiaries, All About Staffing ("AAS"), to augment the emergency response capabilities of our affiliates. Whenever an emergency occurs, AAS is ready to

provide temporary staffing for affected facilities. AAS generally provides nursing support, although an affected facility may request any type of staff essential to fulfilling patient needs. HCA has appreciated the federal government's waiving of licensure requirements after declarations of emergency. HCA believes that these waivers have enhanced our ability to draw upon staff throughout our network in response to emergencies of national dimensions.

So far, I have been speaking to you about how HCA has attempted to enhance network response to emergencies. Now I would like to speak briefly about HCA efforts to prevent catastrophic events. Throughout the HCA hospital network, we conduct syndromic surveillance of emergency room patients with laboratory testing needs. For example, HCA monitors the white blood cell volume of such patients daily. Our surveillance has been instrumental in identifying increased rates of influenza in the communities that our affiliates serve. We believe that our syndromic surveillance system may be helpful in identifying the spread of other diseases of national import. Currently, CDC is considering the role that HCA may play in national surveillance through the CDC Syndromic Surveillance Program.

III. Strengthening the Emergency Preparedness of HCA Affiliates

HCA has taken steps to strengthen the emergency preparedness of our affiliates, as they inevitably are on the front-lines of catastrophic events. As I mentioned previously, HCA requires affiliates to adopt the HEICS approach to crisis management. There are two reasons for this requirement. First, HEICS creates a common vocabulary for use during an emergency response. HCA also has encouraged other healthcare providers to utilize HEICS, because we believe that more widespread use would ensure better coordination among first responders in every community. Second, HEICS creates a framework of leadership positions, and assigns specific responsibilities to those positions. The HEICS command structure establishes an "all hazards" command structure within the hospital, which links with the "community" command structure – whether that "community" comprises the neighborhoods in proximity to the hospital, our other HCA divisions, other local hospitals, or corporate offices.

HEICS therefore creates fully-operational chains of command at the first sign of an emergency. Such command chains include the hospital experiencing the event, the Division and Market where that hospital is situated, the CSC associated with that Division, and HCA corporate headquarters. Although HCA sister facilities are not direct links in the command chain, they stand ready to provide support, using HEICS as a shared platform. As I mentioned previously, HEICS has the benefit of providing a common vocabulary, role definition, and organizational structure and accountability. Accordingly, the system has the ability to supersede corporate titles and business positions that establish the traditional lines of authority during non-emergency situations.

As part of our Quality Review System ("QRS"), every 12-24 months HCA conducts routine audits and surveys of the emergency preparedness of each affiliate hospital. While HCA data collection demonstrates that affiliates steadily are improving their programs, HCA continues to use QRS to ensure that facilities comply with the *Disaster Readiness* guidelines.

IV. HCA Response to Hurricane Katrina

HCA has been in operation since 1968, and we often must contend with hurricanes and other natural disasters. In 2004 alone, HCA affiliates in Florida were exposed to four major storms, including the devastating effects of Hurricanes Charley, Frances and Ivan. Needless to say, severe weather preparedness is a top priority for our HCA affiliates in the Southeast. Accordingly, in November of 2004, HCA senior executives and the CEOs of our affiliate hospitals met in Orlando, FL to discuss "Hurricane Lessons Learned." The meeting helped HCA identify three areas in our severe weather plan that needed

improvement: (i) communications; (ii) transportation of supplies; and (iii) sourcing for alternative energy should public utilities fail. In the following months, HCA provided our affiliates with satellite phones, hurricane shutters, and additional portable emergency generators. HCA also contracted with local businesses – like refrigeration companies, water companies, and diesel and gasoline retailers – to provide supplies quickly in the face of an emergency. In hurricane strike zones, we began to move food, medical supplies, and other gear to warehouses near hospitals.

Despite this extent of experience and preparation, Hurricane Katrina inflicted an unprecedented level of destruction on the region, which affected four HCA affiliates in Louisiana and Mississippi. Lakeview Regional Medical Center in Covington, Louisiana sustained water and wind damage but remained open. Garden Park Medical Center in Gulfport, Mississippi sustained flooding and roof damage, but resumed emergency room operation shortly after Hurricane Katrina passed. Since Garden Park Medical Center was one of only two hospitals still functioning in the Gulfport-Biloxi area after Hurricane Katrina, FEMA installed tents near its parking lot to give tetanus shots and to treat the less seriously injured.

HCA was forced to evacuate two facilities. We closed Tulane-Lakeside Hospital in Metairie, Louisiana after local officials ordered a mandatory evacuation, and we transported patients, employees, and family members to a safe location by bus convoy. Tulane University Hospital and Clinic (“TUHC”) in New Orleans, Louisiana, which sustained the heaviest damage, mainly had to be evacuated by helicopter. I would like to speak now of HCA’s role in the TUHC evacuation and in the national emergency response to Hurricane Katrina.

On August 29, 2005, Hurricane Katrina made landfall in Louisiana as a Category 4 storm. Shortly after Katrina passed, CEO Jim Montgomery reported that TUHC had suffered only minor damage and that flooding in New Orleans appeared to be limited. Our relief was short-lived, however. By the morning of August 30th, we became painfully aware of the true state of devastation caused by Hurricane Katrina. HCA senior executives already had established a HEICS Command Center in the boardroom of the company’s headquarters in Nashville (the “Corporate Command Center”), and they remained there for the rest of the week to coordinate HCA disaster relief efforts along the Gulf Coast.

The Corporate Command Center’s top priority was to assist in the evacuation of TUHC in any way possible. On the morning of August 30th, the TUHC Command Center reported that flooding had intensified in New Orleans and was threatening the hospital’s emergency generators. At that point, TUHC housed approximately 180 patients, and one thousand staff members and their families. Eleven patients were on ventilator support, and two were attached to heart pumps. It was clear that TUHC had to be evacuated as soon as possible. Although TUHC had called Acadian Ambulance to request helicopter assistance, we did not believe that Acadian alone could complete the evacuation within a reasonable period of time. HCA therefore chartered twenty-four helicopters to support TUHC efforts.

On the morning of August 31st, the Corporate Command Center learned that HCA-chartered helicopters had arrived at TUHC, with HCA contractors providing flight coordination. Since the TUHC evacuation proceeded in stages, HCA headquarters arranged to load each chartered helicopter with 750 pounds of food, water, and medical supplies to help TUHC staff and patients remaining in New Orleans. Rather than transporting patients from one staging area to the next, the Corporate Command Center prearranged for other HCA facilities to be awaiting their reception. Many of the evacuees initially were taken to Women’s and Children’s Hospital in Lafayette, Louisiana. HCA sent fifty nurses from AAS to support affiliated hospitals in the Gulf Coast receiving evacuees, and we stood ready to deploy 170 additional nurses, if needed.

On the evening of August 30th, TUHC lost backup power, causing its communications network to fail. The following morning, headquarters helped TUHC set up a radio network by flying in three members of the Tallahassee Amateur Radio Club, who set up a portable generator-powered HAM radio with a satellite uplink. The three radio operators used the satellite uplink to contact HCA offices in Tallahassee, FL for evacuation information. They then used two-way radios to relay evacuation information to TUHC staff. The three radio operators also delivered flight directions from HCA staff to the helicopter pilots.

On September 1st, TUHC completed the evacuation of its patients, along with thirty-eight patients from Charity Hospital. The Corporate Command Center was encouraged by our hospital's response to the greatest natural disaster in our nation's history.

Apart from my account of the evacuation itself, let me now give you a sense of the magnitude of HCA's response to Hurricane Katrina. In terms of supplies, HCA provided the following to aid Katrina's victims:

- 30,000 gallons of bottled water;
- 95,600 pounds of ice;
- 40,320 meals ready to eat (MREs);
- five truckloads of other food;
- four truckloads of linen;
- one truckload of scrubs;
- seven truckloads of assorted supplies;
- one truckload of mattresses;
- 2,500 gallons of gasoline for vehicles and small portable generators; and
- 50,000 to 100,000 gallons of diesel fuel for large portable generators.

In terms of pharmaceuticals, HCA provided 17,360 doses of Cipro, tetanus immunizations, and insulin injections, along with other drugs. To serve transportation needs, HCA provided twenty-four chartered helicopters for patient evacuation, as well as one fixed-wing plane to deliver supplies, two Boeing 727's to transport staff and families to Houston and Atlanta, two hundred commercial airline tickets, fifty buses for evacuations, and one refrigeration truck. In terms of communications, HCA provided cell phones and fifteen satellite phones. Finally, HCA sponsored the Georgia-based DMAT deployed in response to Hurricane Katrina. That DMAT team traveled 1,400 miles to set up a mobile hospital in Galveston, TX and provided medical assistance to 4,000 evacuees, nearly all of whom were at least sixty-five years old.

HCA's efforts to help victims of Hurricane Katrina are continuing today. HCA established the "HCA Hope Fund" and contributed \$4 million, also offering to match employee donations dollar-for-dollar. HCA's hospital business partners and vendors – including the Rapides Foundation; St. David's Foundation; Health One; the Methodist Foundation; and Meditech – have contributed a total of \$1.5 million. HCA affiliates throughout the nation and our employees have donated an additional \$450,000 to the Fund. Displaced HCA employees continue to be on payroll, and HCA has offered to help them relocate – either temporarily or permanently – within the HCA network. Moreover, the HCA Hope Fund gave \$4.2 million in grants to help displaced employees meet immediate living expenses. We also have donated \$1 million to the American Red Cross. Finally, HCA has shown its dedication to New Orleans by reopening Tulane-Lakeside Hospital, and by moving forward with the recovery process at TUHC.

V. Lessons Learned From Hurricane Katrina

Since grappling with the effects of Hurricane Katrina last summer, HCA is continuing the process of analyzing our procedures for emergency preparation and response, continually seeking to enhance our practices and procedures. For example, in March 2006, HCA headquarters will host a "Lessons Learned" meeting, which will be attended by each of our affiliate hospitals that experienced hurricanes and other natural

disasters during 2005. In the meantime, HCA is working with its affiliates to assess the positioning of emergency generators, and to enhance their communications capabilities. In addition, our current efforts to improve upon disaster preparedness are focusing on mitigation, preparation, response and recovery for Avian Flu.

On balance though, I believe that the HCA response to Hurricane Katrina revealed far more strengths than weaknesses in our emergency preparedness strategy. On the community level, HCA was able to relay critical information to TUHC and federal authorities after the hospital's communications system failed. Garden Park Medical Center in Gulfport, MS coordinated with FEMA to determine how to treat less seriously-injured victims of Katrina. On the network level, HCA successfully created a command chain and drew upon the resources of all our affiliates to evacuate TUHC, to provide placement for all TUHC patients, and to provide food, water, and medical supplies as needed. On the affiliate level, TUHC followed the *Disaster Readiness* manual and developed an effective emergency preparedness plan. At all levels, therefore, HCA launched an appropriate response to Hurricane Katrina. In sum, we are justly proud of our colleagues at TUHC, as well as all 190,000 members of our staff, and the communities that we serve.

Thank you, Mr. Chairman and members of the Committee for your time and attention. I will be happy to respond to any questions.

MR. WHITFIELD. Thank you, Mr. Lagarde. At this time, I recognize Mr. James Montgomery for his five-minute statement.

MR. MONTGOMERY. Good morning. I'm Jim Montgomery, President and CEO of Tulane University Hospital and Clinic. Tulane serves as a teaching hospital for Tulane University students and has formed a partnership between Tulane University and HCA. Our three facilities provide New Orleans with a complete range of medical services. As the committee is aware, Katrina inflicted heavy damage on Tulane's main campus. Yet we have made significant progress toward resuming our goal of bringing healthcare back to the community. We anticipate reopening with limited services by the end of February.

Long before Katrina, Tulane had developed its own emergency and crisis management plans. As President and CEO, I oversaw formulation of these plans and witnessed their implementation before, during, and after the aftermath of Katrina. On Friday, August 26, we convened the formal Command Center meeting and evaluated staffing needs. We also considered discharging patients and contacted the HCA Corporate Command Center in Nashville. The following day, Katrina had been upgraded and we began to operate the Command Center on a 24-hour basis. We asked staff to prepare for continuous 12-hour shifts and identified patients ready to be discharged. We also contacted HCA and obtained an additional portable emergency generator.

Sunday, Katrina was upgraded to Category 5 and we continued the staff briefing. In anticipation of flooding, we relocated an emergency generator to a higher floor. We also moved food, water, and other medical supplies to a more secure location. We improvised our plan by moving patients on life support to the fourth floor where we set up

gas-powered generators, should the main generators fail. At 3:00 a.m. Monday morning, Katrina made landfall. We lost power, but the generators immediately began operating. By late afternoon, the wind subsided, and based upon the immediate post-storm assessment, we moved the emergency department back to the first floor. Unfortunately, we soon learned that New Orleans was flooding.

Despite our best efforts, systemic failures caused disruption in our building's ability to maintain outside communications.

On Tuesday, when flooding disrupted our emergency generators, we decided to evacuate our patients. Around 6:00 a.m., we contacted HCA to coordinate the helicopter evacuation. By noon on Tuesday, helicopters began to evacuate our priority patients. Command Center staff identified and secured receiving facilities for our evacuees. We also designated staff to accompany patients.

Into the night we evacuated patients, briefly halting flights upon reports of gunshots. Later that afternoon we lost emergency power, but we had evacuated all ventilator patients and we immediately hooked up the heart pump patients to portable generators located on the fourth floor. Shortly afterwards, we lost telephone communication. On Wednesday, HCA-chartered helicopters arrived. HCA also provided phones, food, and water. After evacuating second and third priority patients, we stabilized the remaining patients based on helicopters and equipment that arrived.

In the afternoon, Charity Hospital requested that we evacuate four of their critical patients. By Wednesday night, Tulane had evacuated 160 patients in 36 hours and only 19 patients remained. On Thursday, we evacuated all 19 remaining patients, including nonambulatory patients and heart patients, and a six-hundred pound bariatric patient. Tulane evacuated those Charity Hospital patients who arrived that morning. At all times, patient evacuation was our priority. When arriving helicopters reached their capacity or were not configured to accommodate patients, we filled the space with staff and family members. No space was wasted.

By Thursday night, 400 Tulane employees and family members remained. Tulane police secured the premises. We slept in the parking garage. By nightfall Friday, all patients were en route to Lafayette, Louisiana.

What would I do different? First, we must address the placement of generators, and we agree on the need to focus on communication systems, making sure we are connected to colleagues and to police and fire rescue. Lastly, no hospital can perform and function when there is a breakdown in civil order.

Mr. Chairman, Hurricane Katrina wrought unprecedented devastation on our community, but that experience, one that not one of us who struggled through it would wish to repeat, demonstrated the character of those who faced life-threatening challenges to help others at Tulane University, that included thousands of the employees and medical staff who banded together. We achieved so much and will achieve much more. Thank you for your time and attention. I will be happy to respond to your questions.

[The prepared statement of James T. Montgomery follows:]

PREPARED STATEMENT OF JAMES T. MONTGOMERY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, TULANE UNIVERSITY HOSPITAL & CLINIC, HCA INC.

Summary

Tulane University Hospital and Clinic (“TUHC”) serves as the teaching hospital for Tulane University Medical School, and operates as a partnership between Tulane University Medical Group and HCA, Inc. (“HCA”). As the Committee undoubtedly is aware, Hurricane Katrina inflicted heavy damage on TUHC’s main campus, which currently is closed. Although we are several months from restoring full operations, I have great confidence in HCA’s ability to resume its presence serving healthcare needs in New Orleans, and we already have made significant progress toward that goal.

But long before Hurricane Katrina struck New Orleans, TUHC had developed its Emergency Preparedness Management Plan – a comprehensive document establishing operating procedures for emergency preparedness and crisis management (the “Plan”). Our Plan details both general emergency processes, as well as specific policies dealing with disasters, ranging from severe weather to biological and chemical terrorism. As President and Chief Executive Officer, I have overseen the formulation of that Plan. I also witnessed the Plan’s implementation – before, during, and in the aftermath of Hurricane Katrina.

Once activated due to a threatened emergency, the Plan may be divided into four distinct phases: (i) activating the chain of command; (ii) mobilizing emergency personnel; (iii) maintaining emergency equipment and supplies; and (iv) establishing communications with the appropriate authorities, both internal and outside the hospital. Being a part of the HCA network of healthcare providers, TUHC also has incorporated the Hospital Emergency Incident Command System (“HEICS”) into our emergency planning. HEICS is a model utilized nationally by numerous industries and communities to establish an “all-hazards” command structure within the hospital (or other business), and it has helped HCA to activate a clear chain of command during an emergency.

Although Hurricane Katrina wrought unprecedented devastation on the New Orleans region, few accurately predicted the full force of destruction that would be left in its wake. But hurricane response is nothing new to TUHC, and HCA-affiliate hospitals nationwide have contended with natural disasters and emergencies of innumerable kinds. By relying on our established emergency preparedness and disaster management plans, TUHC was able to execute an evacuation of nearly two hundred patients, as well as over one thousand employees and families. And while Katrina’s scale and volatility forced us to improvise at times, and to rely on the larger HCA network to a greater extent than originally anticipated, in a word – our plans worked.

Mr. Chairman, members of the Committee and staff – good morning. My name is Jim Montgomery, and I am the President and CEO of Tulane University Hospital and

Clinic (“TUHC”). TUHC serves as the teaching hospital for Tulane University Medical School, and operates as a partnership between Tulane University Medical Group and HCA, Inc. (“HCA”).

TUHC comprises three facilities in the New Orleans metropolitan area. Our main campus is a 235-bed tertiary-care facility in downtown New Orleans. Our secondary campus is the 119-bed Tulane-Lakeside Hospital in Metairie, LA (“Lakeside”). We also operate the DePaul Tulane Behavioral Health Center, a 110-bed psychiatric hospital located in uptown New Orleans (“DePaul”). Among these three campuses, TUHC aims to provide a full range of medical services, including inpatient rehabilitation.

As the Committee undoubtedly is aware, Hurricane Katrina inflicted heavy damage on TUHC’s main campus, and damage to Lakeside and DePaul sufficient to close each facility for a period of time. The main downtown building currently is closed, and we are several months from the resumption of full operations. Yet, I use the present tense to speak of HCA’s presence in the New Orleans area, because I have great confidence in our rebuilding process. In fact, we already have made significant progress toward that goal. HCA’s Lakeview Regional Medical Center, a separate HCA-operated facility located in Covington, Louisiana, never closed. Lakeside resumed full operations within weeks of the storm. At the main campus of TUHC, which suffered greatest damage, we have completed the remediation of safety and environmental hazards, and the Emergency Department has been renovated. All told, our Tulane facilities have received over 14,000 patient visits since Hurricane Katrina unleashed its destruction last summer. TUHC has achieved so much, and I have faith that we will achieve much more in the long months ahead.

As President and Chief Executive Officer, I have overseen the formulation of TUHC’s policies and procedures for emergency preparedness management. I also witnessed the Plan’s implementation – before, during, and in the aftermath of Hurricane Katrina. I appreciate the opportunity to come before you this morning to discuss my experiences, both in terms of emergency preparedness and emergency management.

I. TUHC’s Emergency Preparedness Management Plan

Long before Hurricane Katrina struck New Orleans, TUHC had developed its Emergency Preparedness Management Plan – a comprehensive document establishing operating procedures for emergency preparedness and crisis management (the “Plan”). Our Plan details both general emergency processes, as well as specific policies dealing with disasters, ranging from severe weather to biological and chemical terrorism. I would like to speak first about TUHC’s general emergency plan, which may be divided into four distinct phases: (i) activating the chain of command; (ii) mobilizing emergency personnel; (iii) maintaining emergency equipment and supplies; and (iv) establishing communications with the appropriate authorities, both internal and outside the hospital.

A. Activating the Chain of Command

When faced with a threatened emergency, I am responsible for deciding whether to implement the Emergency Preparedness Management Plan. In my absence, the Chief Operating Officer (COO), Kim Ryan, possesses the authority to make the decision. Once the Plan is executed, our next step is to establish a local Command Center, comprised of nine individuals: (i) the CEO and COO, who are responsible for overall coordination and decision-making; (ii) the Chief Medical Officer, Chief Nursing Officer, Clinic Representative, and Public Relations Officer, who are responsible for ensuring the continuity of medical operations at the main TUHC campus; and (iii) the Director of Facility Services, Hospital Safety Officer, and TUHC Police Director, who are responsible for protecting the physical integrity of TUHC buildings in downtown New Orleans. In the event of an emergency, Lakeside, DePaul and the TUHC campuses each

establish their own local Command Centers to monitor their respective preparedness and response.

B. Mobilizing Emergency Personnel

The TUHC Command Center uses a coding system to alert in-house staff to emergencies. For example, Code Orange means that either an internal or external disaster has occurred, and that TUHC immediately should implement the Emergency Preparedness Management Plan. Code CD means that TUHC may experience civil disturbance, and that TUHC staff should execute the appropriate policies. Typically, the TUHC Command Center announces these codes through the facility-wide speaker system.

Depending on the type and the severity of the emergency, the Command Center may summon off-duty staff to the hospital. To enable the Command Center to reach such staff, the Plan requires that TUHC departments maintain a list of employee home and pager numbers. Each department updates this call-in list on an annual basis. The Plan also requires essential staff to contact their supervisors and await further instructions, even if they are off-duty and have learned of an emergency through third-party sources, such as the media.

C. Maintaining Emergency Equipment and Supplies

TUHC's Emergency Preparedness Management Plan anticipates that public utilities may fail during an emergency. To ensure that critical areas and systems continue to operate, we have acquired stationary and portable emergency generators to ensure power, portable suction machines to provide vacuum, and portable cylinders to supply medical gases. We have stockpiled potable water in bottles, and we can store non-potable water in containers, sinks, and tubs. TUHC even has purchased bells for patients to call nurses in the event of a power disruption. According to the Plan, departments responsible for medical care during an emergency create checklists of necessary medical supplies, and procure any that they find lacking.

D. Communicating with Governmental Authorities and HCA

The Plan also provides for contingencies in the event that communication networks fail during an emergency. If this occurs, our Command Center communicates with governmental authorities using the Hospital Emergency Area Radio ("HEAR") network. And if HEAR fails, the Command Center may resort to use of our telecommunications system, which is connected to emergency generators in order to ensure back-up power. TUHC police communicate using two-way radios, which are configured to ensure that they will not fail in the event of an emergency.

As I mentioned before, TUHC is part of the HCA network of healthcare providers. Accordingly, like all HCA facilities, TUHC incorporated the Hospital Emergency Incident Command System ("HEICS") into our emergency planning. HEICS is a model utilized nationally by numerous industries and communities to establish an "all-hazards" command structure within the hospital (or other business), and it has helped HCA to activate a clear chain of command during an emergency. The use of HEICS as a common platform allows those engaged in a disaster to link communications with the command structure of multiple communities. Additionally, the structure's training and implementation results in multiple individuals' being prepared to assume an appropriate position within the command center.

For example, the role of commander within the command center during an emergency may be filled by the CEO or the COO, allowing both comparatively-trained individuals to serve on a rotating basis across an extended period of time. HEICS also provides a common vocabulary to use when communicating with the corporate Command Center at HCA headquarters, as well as other affiliated hospitals, and the

communities that we serve. Both the command structure and the common vocabulary proved valuable in the wake of Hurricane Katrina, when TUHC turned to HCA's Corporate Disaster Team ("CDT") and other HCA hospital and organizational staff for support in navigating the unimaginable devastation.

II. TUHC's Severe Weather Program and Total Facility Evacuation Plan

Before relating my experiences with Hurricane Katrina, I would like briefly to describe TUHC's Severe Weather Program (the "Program"), which outlines specific policies to deal with adverse weather conditions. Given our location in downtown New Orleans, hurricanes obviously have been our primary concern. With respect to hurricane preparedness, our Program is divided into six stages for disaster mitigation.

The First Stage extends from December 1st to May 31st, which falls outside the Gulf Coast's official hurricane season. During this stage, TUHC operates normally, while our Hospital Safety Officer updates the Program and educates employees on compliance with its procedures.

The Second Stage of the Program extends from June 1st to November 30th, which officially comprises hurricane season in the Gulf Coast. During this stage, all TUHC departments are required to review the Program and designate "essential" personnel. In addition, they update employee call-in lists, distributing copies to the Hospital Safety Officer and the hospital operators. All departments also are required to inventory and confirm the quality of necessary emergency supplies.

When the National Weather Service's National Hurricane Center issues a hurricane advisory, we initiate the Third Stage of our Program. During this stage, our COO announces the implementation of the Program's emergency measures. Essential staff and other off-duty personnel remain on standby, and departments are required to complete their supply inventories and arrange for additional deliveries as needed. All departments maintain close contact with the hospital operations personnel.

When the National Hurricane Center issues a hurricane watch, we initiate the Fourth Stage of our Program. During this stage, the COO establishes the local Command Center. Depending on the specific circumstances, the Medical Director may decide to summon off-duty physicians to TUHC. In addition, the Pharmacy Department and Emergency Department are required to inventory supplies of typhoid vaccine, insulin, and snakebite antidotes, and report their results to the Command Center.

When the National Hurricane Center issues a hurricane warning, we initiate the Fifth Stage of our Program. During this stage, the Command Center takes complete control of TUHC operations. To ensure that TUHC has sufficient beds should mass casualties result from the hurricane, the Command Center cancels all scheduled elective surgery and discharges appropriate patients. It also must verify that all departments have completed preparations for the arrival of the hurricane, including the procurement of supplies, and confirm that the HEAR radio is adequately staffed and operational. The Command Center is responsible for ensuring that sufficient staffing is available for at least two continuous, twelve-hour shifts, as well as establishing a pool of personnel not assigned to particular departments, who can fulfill different responsibilities if necessary.

During the Fifth Stage, nursing staff move remaining patients to interior rooms, which are less prone to wind damage. They would then close drapes and blinds throughout TUHC, and verify that flashlights and fresh batteries are available. Finally, nursing staff fill bathtubs, whirlpools, and other vessels with non-potable water.

The Sixth Stage of our Severe Weather Program takes place immediately after the hurricane. The Command Center must make sure that the communications network still is operational, and then uses the network to fulfill internal and external requests for services and supplies. Assuming that TUHC remains relatively intact, the Command Center may prepare personnel to receive mass casualties. If TUHC has suffered significant structural damage – as was the case following Hurricane Katrina – then the

Command Center implements the Total Facility Evacuation Plan. In general, TUHC prioritizes patients for evacuation in the following way: (i) patients in imminent danger from the disaster; (ii) wheelchair and ambulatory patients; (iii) bed-ridden patients; and (iv) patients receiving oxygen. Please note, Mr. Chairman, that this system of classification and priority assumes that TUHC emergency generators are in operation and powering ventilators.

Upon notification of total evacuation, triage physicians and nurses are required to screen patients, placing them in one of the above four categories, and then immediately provide a list of patient classifications to the Command Center and the Nursing Supervisor. Prior to Katrina, the Total Facility Evacuation Plan anticipated that most patients would be transported by commercially-owned buses. If bus transportation is not feasible, the Plan authorizes TUHC to transport patients using any means available, including vehicles provided by the National Guard, the City of New Orleans, or a state agency. After the Total Facility Evacuation Plan has been completed, nurses or other hospital staff search each room to ensure that no patients, visitors, or employees remain in the building.

III. TUHC's Response to Hurricane Katrina

Although Hurricane Katrina wrought unprecedented devastation on the New Orleans region, few accurately predicted the full force of destruction that would be left in its wake. But hurricane response is nothing new to TUHC, and HCA-affiliate hospitals nationwide have contended with natural disasters and emergencies of innumerable kinds. By relying on our Emergency Preparedness Management Plan, Severe Weather Program, and Total Facility Evacuation Plan, TUHC was able to execute an evacuation of nearly two hundred patients, as well as over one thousand employees and families. Although Katrina's scale and volatility forced us to improvise at times, and to rely on the larger HCA network to a greater extent than originally anticipated, in a word – our plans worked.

I would like to conclude my testimony by giving you a day-by-day account of the TUHC downtown campus response to Hurricane Katrina. I then hope to discuss both where the plan worked, and where human ingenuity had to take over.

By Friday, August 26, 2005, Hurricane Katrina had formed as a Category 1 storm moving westward towards Mobile, Alabama. At that time, the National Hurricane Center was predicting that Katrina would strengthen and likely change course, with New Orleans falling within the potential landfall forecasts. As a precautionary measure, TUHC implemented the Fourth Stage of our Severe Weather Program. Accordingly, COO Kim Ryan convened the first formal Command Center meeting, and we considered TUHC's staffing needs during the hurricane. We also discussed whether TUHC should begin discharging patients. We also contacted the Corporate Command Center at HCA headquarters in Nashville to discuss the status of Hurricane Katrina and TUHC's anticipated needs. At the end of that day, we adjourned the TUHC Command Center meeting, agreeing to meet again at noon the next day. All told, we had followed the Severe Weather Program to the letter.

On Saturday, August 27, 2005, the National Hurricane Center upgraded Hurricane Katrina to a Category 3 storm and calculated that the eye would pass over Alabama or Mississippi. Given our continued proximity to the predicted storm track when we reconvened the Command Center at noon, we initiated the Fifth Stage of the Program. At this point, we began to operate the Command Center on a 24-hour basis, and began to make provisions at the hospital for sheltering employees and families. We determined which employees would be asked to staff each of two continuous, twelve-hour shifts, and the Chief Medical Officer requested that physicians identify patients ready to be discharged. We also contacted HCA headquarters and obtained an additional portable

emergency generator. By the end of the day, we had completed about half of the duties mandated by the Fifth Stage of the Program.

On Sunday, August 28, 2005, the National Hurricane Center upgraded Hurricane Katrina to a Category 5 storm and refined its landfall prediction to the border between Louisiana and Mississippi. We continued Fifth Stage preparations. TUHC physicians and staff arrived at 6:30 a.m., according to Plan, and the Command Center conducted a staff briefing on emergency procedures prior to the start of each shift. In anticipation of possible flooding, we relocated the Emergency Department and the Central Sterile Supply unit to the 3rd floor of the building. We also moved food, water, and other medical supplies to a more secure location on the 5th floor. TUHC staff identified the number of patients on life support – at that point, we had eleven ventilator patients, none using oscillators, and two patients dependent on heart pumps (BVAD). We made our first improvisation from the Plans by moving patients on life support to the 4th floor, where we set up gas-powered portable generators. Should our main emergency generators fail, we wanted the ability to connect the patients to portable generators as rapidly as possible. We even were prepared to feed the portable generators with gasoline from our cars, if necessary.

Late on Sunday afternoon, government officials requested that we provide space for fifty-eight hurricane victims with special needs, who were housed at the Superdome. A significant number required oxygen or otherwise were medically fragile, potentially placing them at risk in the event of structural damage to the facility. Nevertheless, we agreed to house them at TUHC. These individuals also were expected to arrive accompanied by a federal Disaster Medical Assistance Team (DMAT), able to provide any necessary medical care and additional supplies. However, the DMAT encountered delays at Baton Rouge, so we immediately assembled a group of Internal Medicine physicians to assess their medical condition.

At roughly 3:00 a.m. on Monday, August 29, 2005, Hurricane Katrina made landfall in Louisiana as a Category 4 storm, with hurricane-force winds battering the hospital. We lost power at about 6:00 a.m., but the emergency generators immediately began operating. By around noon, the winds began to subside, so TUHC staff inspected the outside of the downtown building. We found only minor roof damage and a few broken windows. Better yet, it appeared that the flooding was limited. Based upon the immediate post-storm assessment, and in order to maximize the facility's patient-care resources, the Command Center decided to move the Emergency Department back to the 1st floor, and as required by the Sixth Stage of the Severe Weather Program, we prepared for the arrival of hurricane casualties.

Unfortunately, our jubilation on Monday afternoon was short-lived. By 9:30 p.m., the Director of Facility Services notified the TUHC Command Center that New Orleans was flooding at a rate of one inch every ten to fifteen minutes. By midnight, we realized that we had no idea when – or if – the flooding would stop. And despite our best planning efforts, systemic failures of the regional and national communications systems caused significant disruptions in our ability to maintain communications with outside individuals and entities. Without the means to obtain reliable current information, the Command Center decided to return the Emergency Department to the 3rd floor, along with the Central Sterile Supply, Pharmacy, and Materials Management units.

On Tuesday, August 30, 2005, the Command Center discovered that the flooding threatened our emergency generators. In fact, notwithstanding the prospect of flood damage, we had depended on the generators since Monday and projected that they would provide at best another two to three hours of emergency power. At that point, I decided that we must evacuate our most critically-ill patients. At around 3:00 a.m., we contacted HCA headquarters and Acadian Ambulance in order to coordinate a helicopter evacuation. Since the designated area at TUHC for helipad services had flooded, the Command Center decided to employ the roof of the Saratoga Parking Garage as the best

alternative helicopter landing site. Personnel from the TUHC Facilities Department prepared the roof by removing four light poles.

Once the decision was reached to initiate a total facility evacuation, the Command Center asked the Chief Medical Officer and her staff to assign evacuation priorities to all remaining patients, without distinguishing between TUHC patients and those from the Superdome. First, we evacuated the neonates and the patients in our Pediatric Intensive Care Unit on ventilator support. We then determined that patients on ventilator support would be most vulnerable should emergency generators fail. Accordingly, we deviated from the priorities established by the Total Facility Evacuation Plan, evacuating the adults on ventilator support next. The third group to be evacuated would be the remaining critical care patients, except for the two patients on heart pumps (BVAD). They were to be followed by the pediatric and adult patients needing urgent medical or surgical care. The final evacuation group was to include all remaining patients. After determining the evacuation priority, we then tried to locate ambulatory pumps and helicopters with high weight limits, since two patients were connected to heart pumps weighing over 500 pounds.

At noon on Tuesday, we began the helicopter evacuation of our first priority patients. The Command Center staff, coordinating with HCA headquarters, identified and secured receiving facilities for our evacuees. The Command Center also determined which staff members needed to accompany patients during the evacuation. All afternoon and well into the night, we continually evacuated patients, briefly halting flights only when the Command Center received reports of gunshots.

We lost emergency generator power between 5:30 and 6:00 p.m. Thankfully, by then we already had evacuated all of the ventilator patients, and we immediately hooked up the two heart pump patients to the portable generators located on the 4th floor. At around 7:00 p.m., we lost all reliable telephone communication. We then decided to split the Command Center into two functioning organizations. The Clinical Care Command Center relocated to the Deming Pavilion, which was powered by a portable generator. The Administrative Command Center relocated to the Lab Conference Room, enabling communications through incoming calls on the hospital's "brown phones" – analog telephones that are hard-wired to BellSouth, not routed through the TUHC digital switch. The two Command Centers were able to communicate with each other, and with the roof of the Saratoga Parking Garage, through two-way radios. Neither Command Center had a dependable means to make outgoing local or long-distance calls, however, so we were forced to rely on sporadic mobile phone and Blackberry service, as well as calling cards on pay phones.

On Wednesday, August 31, 2005, the HCA-chartered helicopters arrived to supplement the evacuation process. HCA headquarters also provided satellite phones, food, water, medical supplies, and bulletproof vests. After TUHC evacuated all second and third priority patients, we started taking into account the configuration of the helicopters to determine further evacuation priority. For example, if the helicopter was configured for stretchers, we would evacuate patients on stretchers. If the helicopter was configured with seats, we would evacuate ambulatory patients. At some point during the morning, the Louisiana Department of Wildlife and Fisheries arrived with boats to assist with the evacuation of ambulatory Superdome patients and their families. In the afternoon, we received a request from Charity Hospital and evacuated four of their critically-ill patients, each of whom had already been hand-ventilated for two days. By the end of the day on Wednesday, TUHC had evacuated around 160 patients in thirty-six hours. Only nineteen patients remained, including a bariatric patient weighing over six-hundred pounds, and a cardiac patient connected to a 500-pound heart pump.

On Thursday, September 1, 2005, we evacuated the nineteen remaining TUHC patients. This group included non-ambulatory patients, who our staff carried flight after flight, down darkened stairwells in oppressive heat. Two remaining evacuees posed

particular logistical challenges – a heart-pump patient, whose survival depended upon more than five hundred pounds of medical equipment, and the 600-pound bariatric patient. In addition, TUHC evacuated dozens of additional patients who were transported that morning from Charity Hospital. At all times, patient evacuation was our priority. When arriving helicopters reached their capacity for additional patients, or were not configured to accommodate patient transport, we filled any available space with hospital staff and family members. No space was wasted. Helicopters took staff to an airport staging area, where they were decontaminated and placed on buses headed for Lafayette, LA. At the end of Thursday, about four hundred TUHC employees and family members still awaited evacuation. At the suggestion of TUHC police, we all slept in the Saratoga Parking Garage, making it easier to secure the premises. By nightfall on Friday, all TUHC employees were en route to Lafayette, LA.

Thank you, Mr. Chairman and members of the Committee for your time and attention. I will be happy to respond to any questions.

MR. WHITFIELD. Thank you, Mr. Montgomery. At this time, we recognize Mr. Rene Goux, who is the Chief Executive Officer of Memorial Medical Hospital for his five minutes.

MR. GOUX. Thank you. My name is Rene Goux, I'm the CEO of Memorial Medical Center in New Orleans, Louisiana. I was at Memorial before, during, and after the hurricane ripped through the city. As a person who was commanding Memorial's operations during this tragedy, I would like to speak about Memorial's preparedness and response efforts.

I have been involved with hospital management in Louisiana for 27 years, including two at Memorial. As we know now, the scope of Katrina's devastation is unprecedented both on a broader scale and on its impact on the infrastructure of healthcare in New Orleans. Although we made it through the hurricane, the failure of the city's levees on a massive and unexpected scale overwhelmed emergency power systems. Surrounded by 10 feet of polluted oil-slick water without power or reliable communications, the staff at Memorial worked for nearly five days to treat, feed, and evacuate patients, families, and local residents who sheltered in the hospital.

The weekend before Katrina reached land on Monday, August 29, we implemented our standard emergency preparedness procedures. These included establishing an incident command center, canceling elective surgical procedures and releasing ambulatory patients, and stocking a four-day supply of food, fuel, and other provisions.

On Sunday, August 28, at 9:30 a.m., the mayor issued a citywide evacuation order, but that order did not call for the evacuation of hospitals. During the hurricane, we could feel the entire building shaking violently in the wind. Windows in the walkways that connect the medical office buildings to the hospital began breaking as debris flew through the city streets. When daylight came after the storm, we could see about a foot of water in the street and a lot of wind damage to the

surrounding area, with many trees down. The power had gone out, but we were able to convert to generators. We believed we had survived the hurricane, and things could get back to normal quickly.

Then, on Tuesday morning, the levees started breaking, and the water began rising rapidly, ten to 12 feet until our basement was completely flooded. We were able to move patients, food, and other supplies to the higher floors. As the water continued to rise, we were completely cut off. I immediately moved the Command Center to the third floor and worked with the hospital management to reassess and respond to the evolving situation. By Tuesday evening, when we were able to evacuate 18 babies from a neonatal intensive care unit aboard Coast Guard helicopters, spirits were lifted, as we saw this as evidence that rescue operations were underway.

Throughout Tuesday and into Wednesday, as we watched from the windows and roofs, the focus shifted to the thousands of residents trapped in attics and rooftops through the flood zones.

Conditions at the hospital deteriorated rapidly. The hospital's air conditioning system broke down, causing temperatures to reach higher than 105 degrees. We started losing electricity on Tuesday and we had no power for the last two days. There was no plumbing and the toilets were overflowing. The smell of sewerage was unbearable. We started breaking windows to give ventilation. Communication with Tenet headquarters was unreliable and nearly nonexistent with emergency officials.

Personal safety became a huge issue as local residents swam to the parking garage seeking a dry area. At times, the sound of gunfire rang throughout the streets. Looting broke out throughout the neighborhood. We locked down the hospital and ensured that no outsiders could get inside, and established a perimeter around the hospital. On Wednesday, officials at Tenet were informed by government officials that if they wanted their hospitals, including Memorial, evacuated, they would have to mount a private rescue effort. None of the elevators were working, so we had to carry patients up stairwells to helipads or down to boats, some as many as eight flights. When the handheld radios gave out, we stationed people on every floor in the parking garage to transmit messages in furtherance of our internal evacuation efforts. We completed our evacuation by Thursday evening. At the end, about 70 of us spent the night on the rooftop waiting for the helicopters to return in the morning.

Again, our mission is compassionate healthcare. Throughout this ordeal, our staff at Memorial and our colleagues in Dallas never forgot this. Our well-trained professionals put the safety, comfort, and well-being of our patients first. I want to take this opportunity to

recognize the staff of Memorial's resilience, courage, and dedication in the face of one of the Nation's greatest natural disasters. In the weeks and months after the hurricane, it has become clear just how long and difficult the road to recovery will be. I am pleased that in October, Tenet announced the company's commitment to remain in New Orleans, joining our remaining hospitals in a locally managed network aided by our downtown campus.

Let me reiterate: First, at Memorial we felt prepared for even a major hurricane like Katrina. What we could not be ready for is a flood caused by the failure of levees and a municipal public system that closed all the other nearby hospitals and stranded all of us inside Memorial without municipal power, water, and sanitation for four days. When that catastrophe happened, I'm proud to say we counted on the heroism of our people to get us through. Thank you for the opportunity to address the subcommittee.

[The prepared statement of Rene Goux follows:]

PREPARED STATEMENT OF RENE GOUX, CHIEF EXECUTIVE OFFICER, MEMORIAL HOSPITAL,
TENET HEALTHCARE CORPORATION

Summary

- As CEO of Tenet's Memorial Medical Center in New Orleans, Louisiana, I led Memorial's ground floor preparation and response efforts related to Hurricane Katrina.
- Despite unprecedented devastation caused by Hurricane Katrina, including the failure of the city's levees, which overwhelmed emergency response systems, staff at Memorial worked tirelessly to treat, feed and evacuate patients and others who sought shelter at the hospital.
- Before the storm hit, we set up an Incident Command Center at Memorial, ensured that we had a four-day supply of food, fuel and other provisions, canceled elective procedures and released ambulatory patients. We also followed Mayor Nagin's evacuation order, which did not call for the evacuation of hospitals and first-responders.
- During the storm, we lost power but were able to rely on our generators. Initially, we believed we had survived the hurricane and that the situation would return to normal fairly quickly.
- However, the levees failed and the situation began to deteriorate rapidly, causing serious flooding. We moved patients, food, supplies, and the Incident Command Center to higher floors. Our chief priority became the safe evacuation of our patients, and by Tuesday evening, we had safely evacuated 18 babies from our neonatal intensive-care unit aboard Coast Guard helicopters.
- By Wednesday morning, flooding had caused a total loss of electrical power. There was no plumbing; the toilets were overflowing; and the smell of sewage was nauseating. We broke windows to create ventilation for our patients. With no working elevators, we carried patients up stairwells to the helipad or down to the boats – some as many as eight flights.

- Communication with Dallas was difficult, as cell phones and a satellite phone had service only sporadically; communication with emergency officials was nearly non-existent.
- When looting and the sound of gunfire threatened our personal safety, we locked-down the hospital, established a perimeter around the hospital, and required everyone inside to wear their identification wristbands.
- Despite planning, training and preparing for a major hurricane like Katrina, we could not be ready for the catastrophic flooding caused by the failure of the levees and the municipal pumping system, which stranded us without power, water and sanitation for four days.
- Under the dire circumstances, our well-trained professionals put the safety, comfort and well-being of our patients first. Additionally, we followed established procedures and were able to safely evacuate all patients and family members by Thursday evening.

Chairman Whitfield, Congressman Stupak, Subcommittee members:

I thank you for inviting me to appear today before the Subcommittee.

I am the CEO of Memorial Medical Center in New Orleans, Louisiana. Memorial is a 347 bed tertiary care hospital located on Napoleon Avenue in the Freret neighborhood of downtown New Orleans. The hospital was opened in 1926 and is still known to many of the city's inhabitants by its original name – Southern Baptist Hospital. The hospital grounds consist of eight buildings, covering three blocks, and include the general hospital, the New Orleans Cancer Institute, the New Orleans Surgery and Heart Institute, a Diabetes Management Center and Sleep Disorders Center, and a medical office building for more than 100 physicians. In addition, Memorial provides residency training for physicians in conjunction with the Louisiana State University Health Sciences Center.

I was at Memorial before, during, and after Hurricane Katrina ripped through the city. As the person who was commanding Memorial's operations during this tragedy, I would like to speak about Memorial's preparedness and response efforts.

I am joined today by Bob Smith, the Senior Vice President of Operations for the Texas/Gulf Coast Region of Tenet Healthcare, who will speak about the impact of Katrina throughout the six Tenet hospitals located in New Orleans and Mississippi – including Lindy Boggs Medical Center in Orleans Parish; Kenner Regional Medical Center and Meadowcrest Hospital in Jefferson Parish; NorthShore Regional Medical Center in Slidell, Louisiana; and Gulf Coast Medical Center in Biloxi, Mississippi.

I have been involved in hospital management in Louisiana for 27 years, including two years at Memorial Medical Center. As we all now know, the scope of Katrina's devastation is unprecedented on a broader scale, and the same is true of its impact on the health care infrastructure of New Orleans. Although we made it through the hurricane, the failure of the city's levees on a massive and unexpected scale overwhelmed emergency response systems at the local, state and – ultimately – federal levels. Surrounded by ten feet of polluted, oil slicked water, without power or reliable communications, the staff of Memorial worked for nearly five days to treat, feed and evacuate patients, families and local residents who sought shelter at the hospital. I will never forget the valiant efforts of those people and the hundreds of others involved in the rescue.

The weekend before Katrina reached land on Monday, August 29th, we implemented our standard hurricane preparedness procedures. These procedures are outlined in Memorial's Hurricane Preparedness Plan, a copy of which has been provided to the Subcommittee. The plan was developed in coordination with local and state emergency response officials, and was available for review by state and local emergency planning organizations, as required by Louisiana hospital licensing regulations.

These procedures included: (1) establishing an Incident Command Center, which we initially set up on Memorial's first floor administrative offices; (2) canceling elective procedures and releasing any ambulatory patients; and (3) stocking a four-day supply of food, fuel and other provisions. On Sunday, August 28th at 9:30 AM, Mayor Nagin issued a city-wide evacuation order, but that order did not call for the evacuation of hospitals and first-responders. This was understandable, as many patients in acute care hospitals are too sick to move, especially on a long trip by ground or ambulance, to a facility far enough away as to be outside the broad and unpredictable path of a major storm such as Katrina. Moreover, hospitals are a critical part of the local emergency response system that is needed for post-storm rescue and recovery.

We had approximately 2,000 people at Memorial during Katrina--260 patients, 500 employees and hundreds of family members who had come to the hospital to ride out the storm. During the hurricane, we could feel the whole building shaking violently in the wind. Windows in the walkways that connect the medical office building to the hospital began breaking out as debris flew through city streets. It was quite an experience. When daylight came after the storm, we could see about a foot of water in the street and a lot of wind damage to the surrounding area, with many trees down. The power had gone out, but we were able to convert to our generators. We believed we had survived the hurricane and things would get back to normal fairly quickly. In fact, some people left the hospital to survey damage throughout the city and check their own homes.

Then, on Tuesday morning, the levees started breaking. Our hospital sits in the New Orleans "bowl." The water started rising rapidly, 10 or 12 feet, until our basement was completely flooded. It was terrifying to see it rise so quickly. We didn't know where it was going to stop. We were able to move patients, food and other supplies up to the higher floors. As the water continued to rise, we were completely cut off. I immediately moved the Incident Command Center to the third floor and worked with the hospital management leaders to reassess and respond to the evolving situation.

By Tuesday evening, we were able to evacuate 18 babies from our neonatal intensive-care unit aboard Coast Guard helicopters. Spirits were lifted, as we saw this as evidence that rescue operations were underway. But throughout Tuesday night and into Wednesday, as we watched from windows and the roof, the focus shifted to the thousands of residents trapped in attics and on rooftops throughout the flood zone.

Conditions at the hospital deteriorated rapidly. The hospital's air-conditioning system broke down, causing temperatures to reach higher than 105 degrees. We started losing electrical systems on Tuesday, and we had no municipal electrical power for the last two days. There was no plumbing; the toilets were overflowing. The smell of sewage was nauseating and it was unbearably hot. We started breaking windows to give our patients some ventilation. Communications were unreliable, although we were able to maintain sporadic contact with Tenet headquarters by cell phone and a satellite phone delivered by helicopter. Communication with emergency officials was nearly nonexistent.

Personal safety became a huge issue as local residents swam into the parking garage seeking a dry area. At times, the sound of gunfire rang out through the streets. Looting broke out throughout the neighborhood. We locked-down the hospital to ensure that no outsiders could get inside and established a perimeter around the hospital. We also required that everyone legitimately within the hospital wear their identification wristbands.

On Wednesday morning, some guys--volunteers from southern Louisiana--showed up in airboats. There was no sign of any organized rescue effort, just these kind people who came from out of nowhere. We were able to get some non-critical patients and family members out with them -- although we later learned that many of these people were only taken as far as the Superdome or other dry land, joining the thousands of others trapped in the devastated city.

On Wednesday, officials at Tenet were informed by government officials that if they wanted their hospitals – including Memorial – evacuated, they would have to mount a private rescue effort. Bob Smith will speak about that effort in more detail. At Memorial, we had a core group of nurses and about 40 physicians who were just incredible – working around the clock to treat patients and prepare them for evacuation. Many of their family members – including teenagers and young kids – stood for hour upon hour upon hour fanning our patients by hand and bathing them with bottled water to make them more comfortable.

None of the elevators were working, so we had to carry patients up stairwells to the helipad or down to the boats – some as many as eight flights. When our hand-held radios gave out, we stationed people on every floor and in the parking garage to transmit messages in furtherance of our internal evacuation efforts.

We completed our evacuation of patients and family members by Thursday evening. At the end, about 70 of us spent the night on the rooftop waiting for the helicopters to return in the morning. At some point, there was a huge explosion in the city. We could see looters in some of the buildings nearby, and continued to hear gunshots in other parts of the city.

Again, our mission is compassionate healthcare. Throughout this incredible ordeal, the staff at Memorial and our colleagues in Dallas never forgot this. Our well-trained professionals put the safety, comfort, and well-being of our patients first. I want to take this opportunity to recognize publicly their resilience, courage, and dedication, in the face of one of this nation's greatest national disasters. Their actions are even more heroic when you consider that many of these people lost their homes to Katrina and left the hospital only to themselves enter the stream of evacuees facing an uncertain future. I am pleased that Bob is here to talk to you about the extensive efforts Tenet has made to assist our displaced employees.

In the weeks and months after the hurricane, I have remained in New Orleans working with the management teams of Tenet's four other Louisiana hospitals and corporate management on the recovery. During this time, it has become clear just how long and difficult the road back will be, especially for Orleans Parish. With the loss of six major downtown hospitals, the health care infrastructure of the parish was nearly destroyed. And as many have observed, we face a classic "chicken-and-egg" problem – hospitals and other healthcare facilities can't survive without a population to support them, but people are hesitant to return to a city where health services are not readily available. I am pleased that in October, Tenet announced the company's commitment to remain in New Orleans, joining our remaining hospitals into a locally managed network anchored by a downtown campus. In doing so, we will be working with government officials, private organizations, and community representatives to ensure that residents of New Orleans will have access to the highest quality care available.

Let me reiterate a couple of points that I'm sure this committee is most interested in. First, at Memorial we felt prepared for even a major hurricane like Katrina. We planned for it and trained for it, and the hospital and staff had been through numerous storms before. What we couldn't be ready for was a flood coupled with the failure of the levees and municipal pumping system that closed all the other nearby hospitals and stranded all of us inside Memorial without municipal power, water and sanitation for four days. When that catastrophe happened, I'm proud to say that we could count on the heroism of our people to get us through.

Thank you again for the opportunity to address the Subcommittee today.

MR. WHITFIELD. Thank you, Mr. Goux. At this time, we recognize Mr. Robert Smith, also with Tenet.

MR. SMITH. Thank you, Mr. Chairman. I am Bob Smith, Senior Vice President of Operations for Tenet Gulf, which includes New Orleans, Louisiana, and Biloxi, Mississippi. My office is in Dallas, where I oversaw the relief efforts for our six hospitals in two affected areas, so mine was the prospective of an outsider trying to deal with the crisis. These efforts began as the focus on the logistics of supplies, food, medicine, water, and fuel and rapidly evolved into an evacuation that ultimately included five of our six hospitals, and those of others as well.

Our North Region Medical Center in Slidell, Louisiana, remained in operation to support the needs of the community and acted oftentimes as a field hospital, receiving patients from all over the region during that time frame. While we worked with the resources from all levels of government, we were just simply overwhelmed. Everyone tried to help, but the magnitude of the situation simply overpowered them all.

So, what have we learned? Each of you has really articulated very well this morning other comments I was going to make about the things that you have seen and what happens, so let me be brief.

We believe that the development and implementation of a command and control structure in a disaster situation is very critical to coordinate communications and the emergency response system at all levels. This is just absolutely imperative. The Government and private sector must work to ensure this is accomplished. We stand prepared, and I know my colleagues do today as well, to work on this aggressively and to get it done and make sure this type of thing doesn't happen again without the right type of communication and response.

A mechanism to track patients, as Congressman Burgess indicated, where transferred was applied in Hurricane Rita, where we have a number of hospitals in Texas. It was somewhat more effective, but it needs to get better. This will link patients to their needed care, to their family members, and to their physicians. We think this is also critical.

Lastly, supplies were critical, and someone on the outside, such as myself, in a command center working to support our facilities and their ongoing need--and again, at the time of the storm, we had six in operation, we ultimately had to evacuate five--but trying to maneuver the various agencies to receive approval to get access to the area was extremely cumbersome. We did not know where to go or who to talk to or how long it would take. We had the supplies, we had them staged and ready; we just couldn't get to them.

We are pleased to say that today, four of our six hospitals are in operation. One in Biloxi, Mississippi as well, which often really doesn't get the recognition as the hospitals in New Orleans. The same thing has happened here.

So, we believe our people were heroes. We evacuated in excess of 5,000 people from the region. We believe we have done it successfully and we learned a lot of lessons. Thank you for having us today.

[The prepared statement of Robert Smith follows:]

PREPARED STATEMENT OF ROBERT SMITH, SENIOR VICE PRESIDENT, REGIONAL OPERATIONS-TEXAS/GULF COAST, TENET HEALTHCARE CORPORATION

Summary

- As Senior VP of Operations for the Gulf Coast-Texas Region, I led Tenet's regional preparedness and response efforts to Hurricane Katrina and its immediate aftermath. In my many years dealing with emergency preparedness, I have never experienced any natural emergency that reached the gravity and magnitude of Katrina.
- Emergency preparedness has been a priority for Tenet. We have invested extensive resources to develop plans for many different situations. Each Tenet hospital had updated preparedness plans for hurricanes, electrical power interruption, floods, communications failure, and facility evacuation.
- Tenet owns 6 hospitals in the Katrina impact zone. As soon as the magnitude of the disaster became clear, we established two command centers. One command center at Tenet's NorthShore Regional Medical Center operated as a *de facto* field hospital, from which we coordinated the influx of patients and hospital personnel from other hospitals throughout the region and the evacuation of those same individuals to facilities and locations outside of the affected region.
- We also established a corporate command center in our Dallas headquarters, where we coordinated and oversaw the execution of our emergency plans both regionally and in each hospital. We organized re-supply and evacuation efforts. We quickly assembled a fleet of private helicopters, aircraft and buses. Employee and patient locator services, emergency pay, grants, temporary lodging and employment services, and volunteer management were also coordinated from our headquarters in Dallas.
- As a result of our experience during Katrina, I believe we need to reinforce a command and control structure that will provide for communication and cooperation at all levels of response. Without this structure, it was difficult to get basic information and assistance on critical issues.
- This tragedy has also reinforced the importance of communication in emergency situations. I believe that all levels of government and the private sector should work together to ensure that communications are improved. In addition, Tenet is developing and employing new communication safeguards and technologies to equip our hospitals.
- Finally, in the case of emergencies for which there is advance warning, such as hurricanes, critical supplies should be pre-staged for expeditious delivery to the affected area.

Chairman Whitfield, Congressman Stupak, Subcommittee members:

I thank you for inviting me to appear today before the Subcommittee.

My name is Bob Smith and I am Senior Vice President for Operations for the Texas/Gulf Coast Region for Tenet Healthcare. Tenet Healthcare owns 69 hospitals across the country. We own six hospitals in the Katrina impact zone. In downtown New Orleans, in addition to Memorial Medical Center, there is Lindy Boggs Medical Center, a

188-bed hospital first opened in the 1920s as Mercy Hospital, and which includes the Transplant Institute of New Orleans. In nearby Jefferson Parish, we operate Kenner Regional Medical Center, a 203-bed acute care community hospital in Kenner, and Meadowcrest Hospital, a 207-bed general medical and surgical acute care facility in Gretna. NorthShore Regional Medical Center is a 174-bed acute care hospital located on the north shore of Lake Pontchartrain in Slidell. Finally, in Biloxi, Mississippi, there is Gulf Coast Medical Center, which consists of a 189-bed medical and surgical acute care facility and a 45-bed behavioral health facility. Prior to Katrina, together these hospitals employed approximately 5000 people with an annual payroll in excess of \$230 million, worked with 2500 affiliated physicians, and paid nearly \$16 million per year in state and local taxes.

I have been asked by the Subcommittee to speak to Tenet's corporate-level response to Katrina, and to offer some recommendations on dealing with future emergency situations.

I have worked in hospital management for over 28 years. In that time, I have had many experiences planning for and handling emergencies. That said, I have never experienced any emergency that approaches the gravity and magnitude of Katrina. For our five hospitals in New Orleans, the damage inflicted by the storm itself was not significantly greater than other hurricanes weathered by Tenet hospitals in the past, but the catastrophic flooding that resulted due to failed levees completely destroyed the entire city and region. Federal, state, and local governments were overwhelmed in their efforts to evacuate tens of thousands of citizens, and the resulting sense of chaos and desperation led to lawlessness and civil unrest.

What was unique about Katrina was the scope of the disaster. More typical emergencies impact a local area, and resources can be readily brought to the facility and patients moved to other nearby hospitals. In contrast, Katrina affected every hospital in New Orleans, flooding made reaching some hospitals difficult or impossible, and multiple hospital evacuations caused competing demands for all emergency services and private assets that could be used to aid evacuations.

Emergency preparedness has been a priority for our hospitals. Over the years we have invested a great deal of resources in developing plans for many different situations and conducting emergency preparedness training in conjunction with local public safety officials. But the devastation caused by Katrina was truly unprecedented. In a (for lack of a better term) normal emergency – be it a hurricane, earthquake, tornado or other event – severe damage tends to be relatively localized and the emergency response system focuses on getting resources such as command, communication and rescue teams into the affected area. In the rare event that such damage requires the complete evacuation of a hospital, other unaffected facilities nearby move rapidly to accept evacuated patients and absorb the influx of victims seeking emergency treatment. Yet as we all know, Katrina was not a normal emergency. It involved the complete evacuation of an entire urban center, much of it reachable only by boat or air, in an area surrounded by hundreds of other communities that had also been devastated by the storm. Simply put, the situation completely overwhelmed government officials and private citizens at every level. For hospitals in New Orleans, especially those in the flood zone, that meant moving thousands of critically ill patients hundreds of miles, often with little or no assistance or guidance from emergency officials.

At the time of Katrina, our Louisiana and Mississippi hospitals had updated preparedness plans for hurricanes, electrical power interruption, floods, communications failure, and facility evacuation. These plans were developed in close coordination with the Metropolitan Hospital Council, the Office of Community Preparedness and other public safety officials. All of the plans contemplate coordination with local public safety officials, such as fire, police, the Metropolitan Hospital Council and the Office of Community Preparedness.

In the days before Katrina made landfall, all six of our Gulf Coast hospitals implemented their emergency response plans. Ambulatory patients were discharged, elective surgeries were cancelled, and non-essential personnel were sent home and advised to comply with official evacuation orders. Generators were checked, fuel was delivered, and the hospitals stocked up on food, bottled water, medical and other supplies to support patients and staff for up to four days. Senior corporate officials and I held conference calls with the hospital management teams to check on preparations.

Things went pretty well throughout the storm on Monday. Power was lost to the facilities, but back-up generators kept critical systems running. There were sporadic communications problems. A last minute change in the storm's direction focused the heaviest winds on Biloxi, and damage to Gulf Coast Hospital, located only a few blocks from the water, resulted in a decision to evacuate that facility immediately following the hurricane.

But as daylight came on Tuesday, we were pleased to find that our five New Orleans hospitals emerged with only moderate damage. Like everyone in the city, we thought we had "dodged the bullet" and that recovery crews would soon have everything back on the road to normal. When the levees were breached on Tuesday, however, situations rapidly deteriorated across the city and at our hospitals. Our hospitals were soon inundated with people and water, or they became isolated islands surrounded by flood waters. This overwhelming force of nature also brought about a virtual collapse of the city's infrastructure, leaving hospitals without power and with temperatures in excess of 100 degrees, with virtually no water service, and with little available and efficient access to provide supplies and assistance to address critical health care issues.

As a result:

- Memorial and Lindy Boggs were facing immediate and severe flooding issues with no short-term guarantee of assistance or help available;
- Kenner and Meadowcrest had major public infrastructure issues and growing safety concerns;
- Gulf Coast, which had been hardest hit by the hurricane winds, would have to evacuate; and,
- NorthShore, which remained open, effectively became a field hospital because of the influx of patients from the surrounding area.

To address these very different situations, we assembled 2 major command centers:

- One at NorthShore to help provide immediate guidance on the ground closest to the disaster. This command center was key to ensuring that we could continue to serve the critical needs of the people during this unprecedented time. It is important to note that although NorthShore was several miles away from the lake, there were numerous water and flooding issues nearby that made conditions in Slidell treacherous and dangerous as well. Given all the issues – the flooding of New Orleans, the need for assistance, and the mass exodus – NorthShore became overwhelmed with people. The hospital CEO, Mike O'Bryan, later recounted of those days, "We started getting people in from all directions. Some walked in, some swam in. Helicopters were setting down on campus for the next 24 hours, and we had no idea what they were bringing us – trauma, gunshot wounds ... most of them were the walking wounded. At that point, we turned every building into an acute field hospital. Some folks were on stretchers in the hall. We had folks lined up everywhere. We were practicing field medicine."
- Also during this time, Tenet set up a corporate command center in Dallas. The corporate command center consisted of about 50 company reps from finance, HR, security, government relations, communications, travel, and supply logistics departments. Through this effort we oversaw the strategic plan to begin the resupply of NorthShore, coordinating airlifts of supplies and

personnel into NorthShore. We also had extensive communications with governmental authorities regarding evacuation plans. This center also evolved as the strategy center after we received a phone call on early Wednesday morning.

In my office on Wednesday morning, I received a phone call from the Office of Emergency Preparedness indicating that if we wanted our patients, staff, and family members evacuated quickly, we should attempt to do it using private assets given the extraordinary strain on that office's resources. The corporate command center became vital to ensuring that we could do that. After that call, I notified our CEO who quickly consulted with Ross Perot, Jr. to obtain an overview on undertaking a massive evacuation effort, including the necessity of procuring security personnel to protect our patients and staff at our facilities. With the command center coordinating resources, we arranged for helicopters, air ambulances and supplies for the major evacuation and resupply effort.

Through the coordinated efforts and hard work of many people, those tasks were achieved. In retrospect, we are grateful and humbled by the humanitarian efforts we witnessed.

By late Wednesday night, Tenet's friends and contractors had airplanes, helicopters, buses and ambulances headed to the New Orleans area in full force.

- Eight airplanes, five helicopters, 50 buses, 26 ambulances and 32 security personnel were used to support the private rescue and resupply effort.
- Cigna provided a jet for Tenet's use, as well as three semi-trucks of food and supplies.
- British Petroleum donated 1,000 gallons of unleaded gas and 300 gallons of diesel to help keep NorthShore's evacuation efforts functioning.
- Aviation Services in Dallas provided five helicopters that ran multiple trips, moving personnel and supplies in and out of NorthShore.
- Acadian Ambulance, one of the first private responders on the ground to assist Tenet, provided ambulances.
- Dr. Kip Schumacher, a practicing physician, provided three trucks of supplies and helped with local communications in the area.

We witnessed greatness from so many of our business partners and friends, and it was truly amazing to see how they responded in our time of greatest need.

Within our own corporation, many employees gave so much of themselves, going above and beyond, to try and help those in need as well.

At corporate headquarters, an Employee Disaster Assistance Center was created to handle the flood of calls from employees and families ranging from trying to reunite with loved ones to obtaining emergency pay checks to looking for temporary employment. We had many employees who volunteered to work after hours, in addition to their regular jobs, to help staff phone lines or to do whatever they could to help during these difficult times.

More than 1,000 employees from across the country volunteered through a corporate web site to provide assistance. Some of those employees were mobilized to fly in to relieve teams of exhausted health care providers and employees at NorthShore, many of whom worked virtually around the clock for several days without rest until relief arrived.

Through this substantial effort, by Thursday evening:

- Lindy Boggs had been evacuated with air assistance from the Fire Department and local residents using boats.
- Memorial and Meadowcrest patients had been evacuated; and
- Kenner's evacuation was complete by about 8 p.m. using both ground and air resources.

In addition, private aircraft took the last of Memorial's staff and employees out by midday Friday. Then, aircraft that we had secured to help in our evacuation efforts were sent to assist with Charity, Methodist and University hospitals.

During and after the rescue, the command center also dealt with many other issues. A critical function was locating patients evacuated from or through our hospitals. This was extremely difficult, since we didn't have any reliable information on the destinations of patients not evacuated by us, and early in the disaster no government agency provided a central locator system. We also established an employee assistance center to provide housing vouchers, emergency loans, 401(k) withdrawals, and grants to displaced employees, along with job relocation assistance.

Now I would like to share with the Subcommittee a few recommendations on how local, state and federal emergency response efforts can be improved in preparation for a future disaster such as Katrina. First, we must reinforce a command-and-control structure that will provide for communication and cooperation among all levels of response. As I have already stated, the rescue needs created by Katrina throughout the Gulf Coast completely overwhelmed emergency response officials. Clear lines of authority need to be established. Without this authority, it became very difficult to get basic information on critical issues, such as obtaining flight clearance for rescue choppers, where non-patient evacuees should be taken, and even the final location of patients evacuated by the Coast Guard and others.

Second, all levels of government and the private sector should work together to ensure that communications are improved. In response to our experience with Katrina, Tenet is developing and deploying new communication safeguards and technologies to our hospitals. But that is only part of the answer. Government officials must also invest in such technology and take the lead in improving communications so that communications throughout the entire emergency response system can be maintained in the face of a disaster.

Finally, in the case of a hurricane or other disaster for which there is advance warning, critical supplies such as fuel, spare generators, food and medical supplies should be pre-staged ready for delivery into the affected area. Doing so effectively will require the cooperation of local and state emergency response officials to ensure the security of deliveries and access to the disaster zone.

I am happy to say that progress is already being made on much of this, including procedures put into affect in Texas in advance of Hurricane Rita only three weeks after Katrina.

In the months since Katrina, three of the five evacuated hospitals, Gulf Coast Medical Center in Biloxi, Mississippi, Kenner Regional Medical Center and Meadowcrest Hospital in Gretna, Louisiana have reopened for various levels of service. North Shore Regional Medical Center in Slidell, Louisiana remained open throughout despite experiencing some hurricane damage.

Memorial Medical Center and Lindy Boggs Medical Center, in the heart of New Orleans, remained flooded weeks after Katrina struck. They remain closed and full damage assessments are still under way. We have announced the development of a new NOLA regional health network to continue to serve New Orleans and to restore service to both hospitals; it is yet unknown whether that means the existing sites need to be repaired or possibly rebuilt.

Thank you again for the opportunity to address the Subcommittee. Despite the huge cost Katrina has inflicted upon our hospitals, we remain a proud citizen of the communities in which our hospitals reside, and we remain committed to them. Returning healthcare services to the citizens of the Gulf Coast is critical to the rebuilding of the historic and economically vital region. We will continue to work with federal, state and local leaders toward that end.

Thank you.

MR. WHITFIELD. Thank you. At this time, we recognize Dr. Fontenot for her five-minute opening statement.

MS. FONTENOT. Thank you, Mr. Chairman. Thank you for the opportunity to share our Katrina experiences.

I believe that the Medical Center of Louisiana and New Orleans, as the designated regional disaster hospital provider was as prepared as we could have been for the horrible event that occurred on August 29. As the regional hospital provider, our pre-Katrina disaster plans did not include evacuation. Instead, we try to take care of disaster victims in the event of a hurricane or other natural disaster or emergency. As a routine annual exercise, the hospital perfected Code Gray drills which included identification of employees and physicians who were assigned to be present and caring in University Hospitals, which comprised the Medical Center of Louisiana, for the duration of a weather event after the code is activated.

In the past, LMCO has activated Code Gray status about twice annually. The usual Code Gray activations last about two days and are then over with, with resumption of routine activities to follow. This activation was much different in that the hospitals, both Charity and University, suffered substantial damage, including loss of electricity and water for the five days post-storm, forcing reliance on emergency generator power. It was also necessary at this time to utilize additional supplies and equipment we had ordered as part of our annual preparation for hurricanes.

At the time of the storm, University Hospital had a census of 167 patients, and at Charity, about 200. I will provide you with a synopsis of our preparation. It began the summer of 2000, when we purchased 1,000 5-gallon buckets with lids for future use as human waste containers. On June 1st every year, we purchased an additional 12,000 gallons of bottled water, 1,000 bottles of bleach, and 14 days of nonperishable food supplies above normal usage. The specific Hurricane Katrina preparations began on Thursday, August 25, when we conducted dietary and pharmacy assessment of inventory in advance of the storm. On Saturday 27, at 8:00 a.m., when Katrina crossed Florida and headed for the Gulf Coast, our CEO issued e-mails to all employees to inform them of a Code Gray watch in anticipation of evacuation.

Later that day, the administrative team met to review the Code Gray plans and the decision was made to activate the following morning. Physicians were notified to discharge all patients who could be safely discharged. Environmental assessments, movement of essential equipment, like water, body bags, and generators were accomplished that afternoon. Sunday morning, August 28, at 7:00 a.m., Code Gray

activation began. A Command Center was established at University Hospital, and prestaging of supplies and water bags was completed.

The patients were moved away from windows later in the afternoon as the wind approached tropical force. On Monday we lost electric power at both campuses with emergency generators beginning automatic operation within two to three minutes without power loss.

At that point, about 3 feet of water surrounded the University, but the area, the streets outside of the Charity campus, were still dry. Rising water later in the afternoon led us to believe there must have been a levee breach because there was no more rain. The sump pumps were still operating, but were ultimately overcome by rising water later in the day. We lost running water. Tuesday through Friday was spent treating patients, triaging patients for planned evacuation. Ultimate evacuation was accomplished on Friday, by both boats and helicopters, four days after the loss of power. The loss of patient life was minimal and limited to critically ill patients.

Lessons learned from this disaster include the absolute necessity of reliable communication devices. Hospital police radios were reliable but required frequent battery changes and recharging. Cell phones were unreliable as were satellite phones. Our HAM radio operator, who was a routine part of our hurricane preparedness, was effective in establishing contact; better coordination with governmental agencies to ensure communication between military, fire, and law enforcement personnel is required. For example, if we could have had some notice that the levee system had failed rather than just watching as the water steadily rose, we could have anticipated the need for vertical evacuation; clearly, evacuation plans need improvement in the timeliness of getting critically ill patients out of devastated facilities.

The Medical Center of Louisiana historically has been a viable partner in planning for disaster preparedness, and we look forward to our future role and are committed to improve on the past and plan for the future. Thanks for the opportunity to talk here.

[The prepared statement of Cathi Fontenot follows:]

PREPARED STATEMENT OF CATHI FONTENOT, MEDICAL DIRECTOR, MEDICAL CENTER OF
LOUISIANA—NEW ORLEANS

Mr. Chairman and members of the committee, thank you for the opportunity to share our Hurricane Katrina hospital experiences with you. I believe that the Medical Center of Louisiana at New Orleans, as the designated regional disaster hospital provider, was as prepared as we could have been for the horrible event that started on August 29.

As the regional HRSA hospital provider, our pre-Katrina disaster plans did not include evacuation. Instead, we prepared to take care of disaster victims in the event of a hurricane or other emergency.

As a routine annual exercise, the hospital conducted "Code Grey" drills which included identification of employees and physicians who are assigned to be present in

Charity and University Hospitals, which comprise the Medical Center of Louisiana, for the duration of a weather event after the code is activated.

In the past, MCLNO has activated Code Grey status approximately twice yearly. The usual Code Grey activations last about two days, and then are over with resumption of routine activities. This activation was much different in that the hospitals (Charity and University) suffered substantial damage, including loss of electricity and water for the five days post storm and forcing reliance on overwhelmed generator power. It also was necessary to utilize the additional supplies and equipment we had ordered as part of our annual preparation for hurricanes.

At the time of the storm, University Hospital had a census of 167 patients and Charity, approximately 200.

I will provide you with a synopsis of our preparation:

Summer of 2000

Purchased 1000 5 gallon buckets with lids for future use as human waste containers.

June 1st annually

Purchase 12,000 gallons of bottled water, 1,000 gallons bleach, 14 days of pharmaceutical stocks above normal usage, and 14 days of nonperishable food supplies above normal usage.

Specific Hurricane Katrina Preparations

Thursday 8/25/05

Conducted dietary and pharmacy assessment of inventories in advance of the storm.

Saturday 8/27/05

8 am: Katrina crosses Florida and heads for the Gulf Coast.

11 am: CEO of MCLNO emails all employees to inform them of a Code Grey watch and anticipated activation.

2 pm: Administrative team meets to review code grey plans and the decision to activate the following morning. Physicians are notified to discharge all patients who can be safely discharged.

4 pm: Notified department directors of Code Grey warning and plans for activation the following morning. Environmental assessments and movement of essential equipment (water, body bags, generators) from warehouse to facilities completed. Media notified of intent to raise Code Grey status to full activation

Sunday 8/28/05

7 am: code grey activation begins. Incident command center established at University campus. Prestaging of supplies, generators, plywood and water vacuums completed. Announcement made to media of closure of hospital to all but emergency services. Patients moved away from windows as winds approach tropical storm force.

Monday 8/29/05

Loss of electrical power at both campuses with emergency generators beginning automatic operation within 2-3 minutes of power loss. Three feet of water surrounded University campus.

Rising water late afternoon despite no rain. Sump pumps operating in basements. Pumps ultimately overwhelmed by rising water and hospitals dependent on portable generators. Running water lost.

Tuesday through Friday, 8/30-05 – 9/2/05, were spent treating patients and triaging for planned evacuation. The ultimate evacuation from both campuses was accomplished Friday 9/2/05 by both boats and helicopters, four days after the loss of power.

Loss of patient life was minimal and limited to critically ill patients.

The lessons learned from this disaster include the absolute necessity of improved and reliable communication devices. Our hospital police radios were reliable but required frequent battery change and recharges. Cell phones were unreliable, as were satellite phone systems. Our Ham radio operator was effective in establishing contacts.

Better coordination with governmental agencies to ensure communication between military, fire and law enforcement personnel is required. For example, if we could have had some notice that the levee system had failed, rather than just watching as the water rose, we could have better anticipated the need for vertical evacuations inside the facilities.

Clearly, evacuation plans need improvement in the timeliness of getting patients out of such a devastated facility. This will require careful planning with outside entities. Heliports should be considered at any healthcare facility for possible medical evacuations.

The Medical Center of Louisiana historically has been a vital partner in planning for disaster preparedness and we look forward to our future role. We are committed to improve upon the past and plan for the future.

Thank you for the opportunity to share our experiences.

MR. WHITFIELD. Thank you. At this point, we recognize Mr. Don Smithburg for his five-minute opening statement.

MR. SMITHBURG. Thank you. We appreciate you being on the grounds with us this week.

I represent the LSU Healthcare Services Division, which, before the storms, comprised nine of the 11 State public hospitals and over 50 clinics that traditionally have been called the Charity Hospital system in Louisiana. Our hospitals and clinics constitute the bulk of the healthcare safety unit for the State's uninsured and particularly the working uninsured. Every individual in the State is eligible to receive services in any of our hospitals regardless of their State or parish or ability to pay. Louisiana has one of the highest rates of uninsureds in the nation, 20 percent of the population, and is estimated to include over 900,000 individuals. Another 22 percent of the population on top of that is on Medicaid. And that was before Katrina and Rita. Blue Cross and Blue Shield of Louisiana has recently issued a report that calls for an estimated 200,000 more citizens to join the ranks of the uninsured as the businesses that they work for failed because of the storm's destruction.

Not only is Louisiana a relatively poor State, but small employers are predominant in our economy. Many, even in the best of times, cannot

offer benefits and we have offered our surrogate health insurance program for businesses. The healthcare safety net is essential to both provide access to care and to support a significant portion of our economy. The LSU hospitals and clinics are the core safety net where the vast majority of medically indigent patients are hard-working individuals. We are the only Level 1 trauma center to serve South Louisiana and much of the Gulf Coast.

Since the hurricanes, many patients in need of trauma care have been transported as far away as Shreveport and Houston, and other local hospitals have stepped forward to help take care of as much trauma care as they can reasonably handle. It is not unreasonable to assume, unfortunately, that mortality rates will increase as a result of the lengthy transport times to trauma centers outside of the region.

LSU Hospital also has had an integral role in supporting the educational programs of our medical schools and training institutions and that includes not only LSU, but also our partners at Tulane and the Ochsner Clinic Foundation.

At Charity and University Hospitals alone, there are over 800 Tulane and LSU medical residents in training and thousands of nurses were in place when Hurricane Katrina struck our sister facility down the street. I know you understand the destruction Charity felt here. Big Charity, as we call it, is the second oldest continually operating hospital in the United States. It has been in place since 1736, almost 270 years. It was destroyed once before by a hurricane, back in 1779, and it was replaced, prior to FEMA obviously, just five years later.

Having created a statewide Charity system, it is natural and appropriate that Louisiana would turn to this system in times of emergency. Understanding emergency preparedness, our hospitals are designated as the lead facilities in the region to accept patients with special acute needs that may become emergent in a crisis. We have regarded our hospital's obligation to gear up in potential disasters and to continue to operate when others may not be able to do so.

LSU's emergency preparedness and our role in them were fundamentally sound to a point. That point was surpassed by the cataclysmic loss by Katrina. After flooding and losing power, Charity and University were unable to function as receiving facilities. Our patients and our staff themselves needed to be evacuated. We are looking for lessons learned as you are from the subsidiaries with an eye toward improving not only Louisiana's emergency preparedness, but also that of our Nation.

From our perspective, there are many lessons. First, as this community is aware, it proved to be inadequate in ability or low priority to evacuate patients and staff at Charity and University Hospitals within

a reasonable period of time. In the future, we will not again assume that agencies that are physically and bureaucratically remote from our hospitals will come to our rescue. Instead, we will try to develop the means to transport patients should they need us, just as our colleagues do in the private sector. Should assistance be available, gladly we will accept it and we will work with hospitals at any level to create an effective means to deal with all aspects of emergencies such as Katrina and Rita, but we'll also try to take care of our patients within our system with the limited resources we have. In fact, when Rita threatened Southwest Louisiana just a few short weeks after Katrina, we did evacuate our threatened patients and staff from our hospitals in Lake Charles, Lafayette, and Houma, to our facilities in Baton Rouge and Alexandria, out of harm's way. We did not wait for the established cavalry, as we did after Katrina's floods. We became our own cavalry and took care of ourselves without asking for or accepting help and it worked.

Another lesson is the need for reliable communication. I can't emphasize it enough. Both in New Orleans and Bogalusa, where our hospital received extensive storm damage, communications with our central office in the State Emergency Command Center and others was exceedingly difficult. In the case of Bogalusa, there was silence for two days. Police radios worked in New Orleans but only intermittently. HAM radio was the most reliable and the technology will continue to be investigated, but it is slow. Text messaging on cell phones, interestingly, worked, while cell phones often did not. Satellite phones were generally useless. Although several different technologies failed or were of limited use, communications undoubtedly needs a logical solution.

Cooperation across levels of government needs to be improved, in my view. There appeared to be no sense of command at the office of emergency preparedness where I was anchored during the storm. State agencies that were accustomed to working with each other were respectful of each other, communicating and coordinating seemingly well. The United States Health Service was a godsend to the region. Because the scale of this event was so massive, there were other Federal agencies that responded, but did not seem to be nearly as fluent in intra-agency communication and coordination. It is in part because of that problem that we took complete control of our fate when Rita threatened Southwest Louisiana.

It is not enough to have disaster plans. We must understand that when we call for them, we need to be prepared to implement them.

Moving towards closing, despite the designated roles of our hospitals in New Orleans to receive evacuated patients, we received far more than we had capacity for. I personally worked at the State Command Center

headquarters to both move patients and staff from Charity and University to other hospitals across the State, but this approach, the planned approach was overruled. Instead, patients from our hospitals in New Orleans were taken to the New Orleans Airport, ultimately put on a military transport, and scattered across the country. Only the medical records that our staff taped to our patients left with the patients. But no staff, while we asked for it, no staff could accompany them, and to our knowledge, no record was kept of who was on what plane, where they came from or where they were going.

Now, we know that improvements can and must be made in our capacity to handle hurricanes and other emergencies. It is fair to focus on the emergency preparedness system, but at the moment, we have too few staff to even participate in the next catastrophe. The next bus crash, as you noted, could have happened in New Orleans, but it happened in Jacksonville, Florida. Today USA Today covered it. If that crash had occurred here, where in that case regrettably there were seven deaths, I don't think our system could handle it.

Existing hospital emergency departments are taxed, but even in the best of circumstances, there is no substitute for an extensive public primary specialty clinic network. Medical education in New Orleans that serves the needs of the entire State could be destroyed if not.

Mr. Chairman, we deeply thank you for being on the ground today with our committee and we looked forward to working with you in meeting these unprecedented challenges. Thank you.

[The prepared statement of Donald R. Smithburg follows:]

PREPARED STATEMENT OF DONALD R. SMITHBURG, EXECUTIVE VICE PRESIDENT—LSU SYSTEM, CHIEF EXECUTIVE OFFICER, LSU HEALTH CARE SERVICES DIVISION

Summary

The LSU Hospitals and Clinics are the core of Louisiana's safety net for the uninsured and the principal sites for the training programs of the LSU and Tulane medical schools. Charity Hospital in New Orleans was also the only Level 1 Trauma Center serving South Louisiana and much of the Gulf Coast. Both Charity and University Hospitals are closed due to damage from Hurricane Katrina, and both experienced significant problems associated with a flawed reaction to the emergency created by the storm.

The experience of Charity and University Hospital represents an opportunity to improve the system of emergency preparedness in Louisiana and the nation. However, the destruction of these hospitals means that there are no public facilities in the region to participate in improved processes. Our first priority is to restore the capacity of our public health care system and then to work with other agencies at all levels to improve our capability to respond cooperatively to emergency situations of all types.

The major areas in which improvement in emergency processes is needed include the ability to evacuate patients in a safe, timely and organized manner when conditions warrant; the technical ability to communicate and exchange information with those

outside the hospitals during a crisis; and the development of seamless working relationships with federal officials, as well as among state agencies, so that emergency plans can be implemented or, if appropriate, altered in a coordinated manner.

Mr. Chairman and members of the committee, I want to thank you for coming to Louisiana. We will be grateful for whatever assistance you can provide, but your willingness to visit our state is itself a gesture that we deeply appreciate.

I represent the LSU Health Care Services Division, which comprised 9 of the 11 state public hospitals and over 350 clinics that traditionally have been called the “charity hospital system” in Louisiana. I would like to begin by describing this system in brief.

Our hospitals and their clinics constitute the vast bulk of the health care safety net for the state’s uninsured and underinsured, particularly the working uninsured. Every individual in the state is eligible to receive services in any of our hospitals regardless of the parish in which they live or their ability to pay. Louisiana has one of the highest rates of uninsurance in the nation, over 20 percent of the population, and estimated to include over 900,000 individuals (and another 22 percent are on Medicaid). That was before Katrina and Rita. Blue Cross of Louisiana has recently estimated that 200,000 more individuals will join the ranks of the uninsured as businesses fail because of the storms’ destruction.

Not only is Louisiana a relatively poor state, but small employers are predominate in our economy. Many, even in the best of times, cannot offer benefits, and we often are a surrogate insurance program for business. A health care safety net is essential to both provide access to care and to support a significant portion of our economic base. The LSU Hospitals and Clinics are the core of that safety net. The Charity campus also supported the only Level 1 Trauma Center that serves South Louisiana and much of the Gulf Coast. Since the hurricanes, many patients in need of trauma care have been transported to Shreveport and Houston. It is not unreasonable to assume that mortality rates will increase as a result of the lengthy transport time.

The LSU hospitals also have had an integral role in supporting the education programs of our medical schools and training institutions, and that includes not only LSU but also Tulane and the Ochsner Clinic Foundation. At Charity and University hospitals alone, there were around 800 Tulane and LSU medical residents in training when Katrina struck and destroyed our facility.

I know you will understand that the destruction of Charity Hospital is felt especially deeply here. “Big Charity” was the second oldest continuing hospital in the nation and has endured as one of the most significant medical institutions in the nation over the 270 years since its founding in 1736. It was destroyed once before by a hurricane, in 1779, but rebuilt just five years later. Today, it sits in ruins a short distance from here.

Your states – and almost every state – have some system that fulfills the same functions as the LSU hospitals and clinics. Outside Louisiana, however, the provider safety net for the uninsured is most often a local governmental function. You undoubtedly are familiar with county or district hospitals or comparable programs that have as their predominant mission assuring access to care regardless of ability to pay.

Having created both a statewide and a public hospital system, it is natural and appropriate that Louisiana would turn to this system in times of emergency. Under state emergency preparedness plans, our hospitals are designated as the lead facilities in each region to accept patients who have special acute needs that may become emergent in a crisis or catastrophe. We have regarded it as our hospitals’ obligation to gear up for potential disasters and to continue to operate when others may not be able to. We have the capacity as a system to transfer patients to our facilities in other parts of the state, if necessary. And since Louisiana’s only Level I trauma and specialty care centers – in New Orleans and Shreveport – are operated by LSU, special medical needs can be accommodated internally.

Louisiana's emergency preparedness plans, and our role in them, were fundamentally sound up to a point, but clearly that point was surpassed by the magnitude of Katrina in the New Orleans area. After incredible flooding and loss of all power, Charity and University Hospitals were unable to function as receiving facilities as disaster plans call for, and our patients and staff themselves required evacuation. You are looking for the lessons from this disaster with an eye toward improving not only Louisiana's future emergency preparedness but also that of the nation. From our perspective, there were several general lessons and many others at the hospital operational level.

First, as this committee is aware, there proved to be inadequate ability – or insufficient priority – to evacuate patients and staff at Charity and University Hospitals within a reasonable period of time. In the future we will not again assume that agencies that are physically and bureaucratically remote from our hospitals will come to our rescue. Instead, we will develop the means to transport patients should the need arise. Should assistance be available, we will gladly accept it, and certainly we will work cooperatively with agencies at any level to create an effective means to deal with all aspects of emergencies such as Katrina and Rita. But we will also exercise our capacity to take care of our own patients within our system.

In fact, when Rita threatened Southwest Louisiana a few short weeks after Katrina, we did evacuate threatened patients and staff from Lake Charles, Lafayette and Houma to facilities in Baton Rouge and Alexandria. We didn't wait for the established cavalry as we did after Katrina's floods. We became our own cavalry and took care of ourselves without asking or expecting help. And it worked.

One major lesson from this crisis was the need for reliable communications. Both in New Orleans and Bogalusa, where our hospital received serious wind damage, communications with our central office, the State Office of Emergency Preparedness and others were exceedingly difficult. In the case of Bogalusa, there was silence for two days. Our police radios worked in New Orleans, but only intermittently in about 45 second intervals. Ham radio was most reliable, and it is a technology we will continue to invest in – but it is slow. Interestingly, cell phone text-messaging worked in a number of cases even though cell phone conversations often did not. Satellite phones were generally useless for us. Although several different technologies failed or were of very limited use, the communications problem undoubtedly has a technological solution. We need to determine the best way to stay in touch in emergencies, and put the appropriate equipment into the right hands.

Coordination across levels of government must be improved. There appeared to be no sense of command at the Office of Emergency Preparedness (OEP). State agencies that are accustomed to working with each other, or just respectful of one another, communicated and coordinated well. But possibly because the scale of the disaster was so massive, the various federal agencies that responded did not seem to be nearly as fluent in intra-agency communication and coordination. It is in part because of that problem that we took complete control of our fate when Rita threatened us in Southwest Louisiana.

It is not enough to have disaster plans. We must understand what they call for and be prepared to implement them unless unforeseen and overriding factors arise. To give you one concrete example, despite the designated role of our hospitals to receive evacuated patients, we received far fewer than we had capacity for. I personally worked at the state Office of Emergency Preparedness headquarters to move both the patients and the staff from Charity and University to other LSU hospitals that were prepared to accept them, but this approach – the planned approach – was overruled. Instead, patients from Charity and University Hospital were taken to the N.O. airport, ultimately put on military transports and scattered across the country. Only medical records, but no staff,

accompanied them. To our knowledge, no record was kept of who was on what plane, where they came from or where they were taken.

Immediately after the evacuation, it was as if our patients had disappeared, and when the calls from families came asking about those in our care, we could not tell them where they were. Staff spent literally weeks calling hospitals across the country asking if any patients from Charity or University hospital had been transferred there. Despite these efforts and those of the Louisiana Hospital Association, we never did find out where all our patients were taken.

We know that improvements can and must be made in our capacity to handle hurricanes and other emergencies. It is fair to focus on the emergency preparedness system, but at the moment we have too few hospitals standing to even participate in the next catastrophe. The next bus crash or minor emergency will overwhelm current hospital capacity. Existing hospital emergency departments are taxed, but even in the best of circumstances they are no substitute for an extensive public primary and specialty clinic system. Medical education in New Orleans, which serves the needs of the entire state, could be destroyed if appropriate training sites are not re-established quickly.

LSUHCS stands ready to assist the federal government in repairing and strengthening our nation's emergency response capacity. But in Louisiana, a necessary first step is restoration of the core capacity of our public health care system. Rapid and successful restoration of that capacity will contribute to the public safety and is certain to save lives. Thank you again for your interest and for this opportunity to share LSU's insights into this critical issue.

MR. WHITFIELD. Thank you. At this time, we recognize Mr. Sewell for his five-minute opening statement.

MR. SEWELL. Mr. Chairman, members of the committee, I want to thank you for inviting me here to testify on behalf of Chalmette Medical Center. My name is Jon Sewell, and I serve as the CEO at Chalmette Medical Center in Chalmette, Louisiana. CMC is owned and operated by a subsidiary of Universal Health Services and served the residents of St. Bernard Parish. CMC had 230 beds that provided a wide array of services, including cardiac surgery, orthopedic, hyperbarics, and a 30-bed ICU. Annual admissions were approximately 9,000 and emergency room visits approximately 25,000.

CMC, until it was destroyed by the hurricane, was the only inpatient and emergency room providing for St. Bernard Parish. Over the seven days prior to the hurricane, or Hurricane Katrina making landfall, hospital officials working with the local Emergency Preparedness Council and watched the storm closely. For most of the time, the hurricane was not considered to be a threat. As of 11:00 a.m. Friday, in fact, it was still supposed to hit the panhandle of Florida. It became of greater concern Friday at 5:00 p.m. and projections moved it farther west to Gulfport, and by Saturday morning, the projected landfall was approximately at New Orleans.

CMC decided Saturday morning to implement its disaster plan. We had cancelled elective surgeries the prior day and began to discharge patients who had any means of evacuation. Attempts to transfer patients

to other hospitals in the region were stalled because of the storm track being so wide. Any hospitals within 100 miles were potentially in harm's way and reluctant to admit patients. Plans to transport patients were scarce, as there was a lot of competition from nursing homes and special needs patients at other hospitals.

CMC then began discussions with its sister hospital, Methodist Hospital, to attempt to transport as many patients there as possible, as they had a taller structure and a more secure emergency power system. Sunday was spent moving all ICU, inpatient rehab, psych, and skilled nursing patients to Methodist. This was achieved using a combination of school buses for ambulatory patients and ambulances for more critically ill patients. We lost ambulances on Sunday afternoon and began preparations for riding out the remaining storm. We had approximately 200 staff and family members in the hospital.

Our disaster plan had also called for movement of all essential supplies to the top floor of CMC, including food, water, pharmaceuticals, and other clinical supplies. We had ordered supplemental supplies earlier in the week and our final stash was estimated to last between four and five days.

As you all know, the western eye of the storm passed over St. Bernard Parish around 8 a.m. Monday. Some roofs were peeled back and two windows blown in, but by 9:00 a.m, we had already begun to have discussions about moving patients and supplies back down to the first floor, when the flooding started. By the time it ended, we had approximately 14 feet of water around us. Our emergency generators flooded at about 10:30 that morning. Cell phones were inoperative by noon.

At that point, we had no power and no air conditioning. We had no communications with anyone outside of the hospital, with the exception of two-way radio communications to the fire department. While the fire department was very helpful and supportive, they were not located in the same building as the sheriff's department or the Parish Command Center. We were never able to make direct contact with any other parish or governmental agencies during the duration of the storm.

Shortly after the storm had subsided, approximately 200 local citizens who had not evacuated showed up at the hospital seeking medical attention and shelter. They came by boat, and in some cases were quite ill. Three patients were brought in suffering from acute distress. These patients were all stabilized and eventually transferred out of the hospital. This nearly doubled the population of the hospital and became a significant distraction and security threat. With the assistance of the local sheriff's department they were all transported by boat to a local parish shelter by Tuesday.

Also on Tuesday, parish officials arrived by boat to inform us that a MASH unit had been set up at the local jail with power and air conditioning and recommended transferring our patients there. On Wednesday morning, we began transferring by boat all patients to the ER, to the jail, with the help of the parish fire department and Good Samaritans. As we transferred patients, we also sent medical staff, supplies, and other clinical staff to support the patients during their stay at the MASH unit. All patients were transferred by Wednesday afternoon.

On Thursday, helicopters began arriving to evacuate remaining employees and family members. I was among the last members of this group to leave. We were taken to Louis Armstrong Airport and were initially placed in the MASH unit, which contained approximately 2,000 patients at that point. The unit was clearly understaffed

And our group offered to assist in providing patient care to those patients in the MASH unit. The offer was accepted by the emergency physician in charge, who was charged with oversight of the unit. Nearly all of the employees of CMC volunteered to help render medical assistance to these patients, whether they were lying on stretchers on the floor or on luggage carousels.

After an hour, we were approached by an official with FEMA who ordered us away from the patients because we were not authorized by FEMA to provide patient care. We were then placed in the general population of the airport. At around midnight, another health system, HCA--thank you very much--offered us transportation out of Lafayette on buses--or to Lafayette on buses it had secured.

Notably, during the four days following the storm, the hospital received no supplies from any Federal or state agencies and very limited supplies from the local parish. USH had immediately after the flooding secured helicopters to deliver food, water, and other supplies, and although those efforts were frustrated by difficulty in getting access to air space, eventually some of those supplies were delivered to Methodist Hospital.

UHS had also set up a command center to provide assistance to families seeking information, whether the information was on patients at those hospitals or employees. Methodist provided as best they could updated information in its most accurate form.

In closing, I would like to recognize all of the doctors and staff, family members of staff, the first responders from the parish's sheriff and fire department for providing extraordinary care during one of this Nation's greatest natural disasters. I was privileged to witness a group of people who were soon to become refugees themselves, rise up and work collectively to ensure that our patients were provided with the highest

possible care. I can honestly say that I witnessed more acts of heroism and courage during this crisis than anyone could imagine.

Thank you very much for inviting me here today.

[The prepared statement of Jon Sewell follows:]

PREPARED STATEMENT OF JON SEWELL, CHIEF EXECUTIVE OFFICER, CHALMETTE MEDICAL CENTER, UNIVERSAL HEALTH SERVICES, INC.

My name is Jon Sewell. I served as the CEO for Chalmette Medical Center (CMC) in Chalmette, Louisiana. CMC is owned and operated by a subsidiary of Universal Health Services (UHS) and served the residents of St Bernard Parish, and to a lesser extent those of Orleans Parish.

CMC had 230 beds and provided a wide array of services including cardiac surgery, orthopaedics, hyperbarics, and a 30 bed I.C.U. The hospital's annual admissions totaled approximately 9,000 and emergency room visits approximately 25,000. CMC, until it was destroyed by the hurricane, was the only Inpatient and Emergency Room provider in St Bernard Parish.

Over the seven days prior to Hurricane Katrina hitting landfall, hospital officials, the Hospital Chief of Staff, and the local Emergency Preparedness Council watched the storm closely. For most of that time, the hurricane not considered a threat because as of 11 a.m. on Friday morning, Katrina was projected to hit the Florida panhandle. It became a greater concern when a Friday 5 p.m. projection had the storm center projected to hit near Gulfport, Alabama. By Saturday morning, the projections had moved the storm landfall to somewhere near the New Orleans area.

CMC decided Saturday morning to implement its disaster plan. We had already canceled elective surgeries the prior day and began to discharge any patients who had a means of evacuation. Attempts to transfer patients to other hospitals were stalled because the storm track had been so variable that any hospitals within a hundred miles were still potentially in harms way and were reluctant to admit patients. Ambulances to transport patients were also scarce because many special needs patients, nursing home residents and other hospitals were all attempting to move patients at the same time.

CMC then began discussions with its sister hospital, Methodist Medical Center, to attempt to transport as many patients as possible because Methodist had a taller structure and a more secure emergency power system. Sunday was spent moving all ICU, Inpatient Rehab, Psychiatric and Skilled Nursing patients to Methodist. This was achieved by using a combination of school buses (for ambulatory patients) and ambulances (for more critically ill patients). We lost access to ambulances sometime Sunday afternoon and began preparations for riding out the storm with the remaining patients. At that time, our census was 47 patients, and approximately two hundred staff and family members were at CMC.

Our disaster plan called for the movement of all essential supplies to the second floor (CMC's top floor), including food, water, pharmaceuticals, and other clinical supplies. We had ordered supplemental supplies earlier in the week and our final stock was estimated to last four to five days, if required.

As you all know now, the Western eye of the storm passed over St Bernard Parish around 8 a.m. Monday. Some roof was peeled back and two windows were blown in. By 9:00 a.m., we thought the worst had passed and we were considering a plan to move patients and supplies back to their original locations, but then the flooding started. By the time the flooding ended, we had approximately 14 feet of water. Our emergency generators flooded at approximately 10:30, and cell phones were inoperative by noon. At that point, we had no power, air conditioning or communications with anyone outside of the hospital with the exception of a two-way radio link to the Fire Department. While the

Fire Department was very supportive, they were not located in the same building as the sheriff's department or the Parish command center. We never were able to make direct contact with any of the other Parish government agencies.

Shortly after the storm had subsided, 200 local citizens who had not evacuated began showing up at the hospital, seeking medical attention and shelter. They came by boat and, in some cases, were quite ill. Three patients were brought in suffering from acute distress. These patients were stabilized by hospital personnel. The number of refugees nearly doubled the population of the hospital and became a significant distraction and security threat. With the assistance of the local sheriff's department, they were all transferred by boat to the Parish shelter on Tuesday.

Also on Tuesday, Parish officials arrived at the hospital by boat to inform us that a MASH unit had been set up at the local jail with power and air conditioning. Parish officials recommended that the hospital consider transferring its patients to the MASH unit.

On Wednesday morning, we began transferring patients by boat to the shelter with the help of the Parish fire department and local good Samaritans. As we transferred patients, we also sent medical staff and supplies to support the patients during their stay at the MASH unit. The transportation of all patients was completed by Wednesday, mid afternoon.

On Thursday, a helicopter from the National Guard arrived to begin evacuating the remaining employees and their family members. I was among the members of this group. We were taken to Louis Armstrong International Airport and placed in the MASH unit there which contained nearly 2000 patients. The unit was clearly understaffed and our group offered to assist in providing patient care to the MASH unit. The offer was accepted by the emergency physician charged with oversight of the unit. Nearly all of the employees present volunteered to help render medical assistance to the patients lying on stretchers, the floor or on luggage carousels. After about an hour, we were approached by an official with FEMA who ordered CMC staff away from the patient area because we were not authorized by FEMA to provide care in the MASH unit. We were then placed in the general shelter population of the airport.

Around midnight, another health care system, HCA, offered the group from Methodist and CMC transportation to Lafayette on buses they had secured.

Notably, during the four days following the storm, the hospital received no supplies from any federal or state agencies and very limited supplies from the local Parish. UHS, our management company, had immediately after the flooding secured helicopters to deliver food, water, fuel and other supplies. Although those efforts were frustrated by difficulties in getting access to airspace eventually some of those supplies were delivered to Methodist Hospital.

UHS also set up a command center immediately after the storm to provide assistance to families seeking information regarding UHS patients and employees at CMC and Methodist who provided patient care during the storm and to keep them updated with the most current and accurate information available.

Finally, I would like to recognize all of the doctors, staff, family members of staff, local citizens and first responders from the Parish sheriff's and fire department for providing extraordinary support during one of this nation's greatest natural disasters. I was privileged to witness a group of people, soon to become refugees themselves, rise up and work collectively to ensure that our patients were provided the best care possible. I can honestly say that I witnessed more acts of heroism and courage during this crisis than anyone could imagine.

MR. WHITFIELD. Thank you, Mr. Sewell. At this point in time, we recognize Mr. Muller for his five-minute opening statement.

MR. MULLER. Mr. Chairman and members of the committee, thank you for inviting me to testify today on behalf of West Jefferson Medical Center, and a special thank you to you all for coming to our region in this great country.

West Jefferson Medical Center, located ten minutes from downtown New Orleans, is a 451-bed public hospital and health system with programs and services across the complete continuum of care. We are one of only three hospitals out of 15 that remained open after Hurricane Katrina struck. We did not lose a single patient due to the storm. Ironically, we were three months out from opening a new energy and support services facility, a model for the Nation, which would be 20 feet above sea level. West Jefferson Medical Center did not flood but did sustain over \$2 million in damages.

Personal visits after the storm from Congressman Michael Burgess--thank you, sir--Congressman Rodney Alexander, also Congressmen Jindal, Melancon, and Jefferson, visits by Senator David Vitter, Secretary Michael Leavitt, Vice Admiral Carmona, Mark McClellan, and Dr. Julie Gerberding lifted our spirits and advanced our personal mission to succeed.

FEMA's response to employ a DMAT, which we personally requested the day after the storm and discussed with Senator Vitter, was admirable. The DMAT disaster hospital that did support our emergency department was noteworthy. In future disasters of this magnitude we would, however, request that DMATs be more immediately available.

We are exploring more extensive communication systems moving forward, and to install an on-site water well at the hospital. We are exploring the cost and feasibility of elevating structures for critical services such as building our new emergency room on the second floor instead of the first. The storm exposed the deficiencies of our State healthcare system. Louisiana historically has suffered from a dearth of primary and specialty ambulatory care capacity available for low-income and other consumers. A lack of this capacity coupled with low Medicaid rates for physician care and no mechanism to reimburse clinicians for any indigent care has led to an over-dependence on emergency rooms and an inadequate ability to care for low-income patients. Charity and Medicaid DHS funds were concentrated at one delivery system and were not aimed at medical centers of Louisiana. Remaining providers are absorbing patients without any payments. Medicaid DHS money did not follow the patient.

Our operating losses since Hurricane Katrina have totaled more than \$28 million. West Jefferson worked closely with our congressional delegation to identify existing Federal legislation that could provide us financial relief. We worked to offer language to the Stafford Act that

would make our hospitals eligible for a Community Disaster Loan Program.

Parallel to this effort were discussions with CMS, providing regulatory relief to the Stark Amendment, which would allow us the opportunity to provide assistance to physicians practicing in our hospitals. We must receive the CDL this month to provide for our physicians. West Jefferson is committed to retaining a physician workforce for our region and has been in conversation with both LSU and Tulane University Schools of Medicine. We are in the process of applying for major teaching hospital status, but continued concern over reimbursement issues has hindered our efforts. The Louisiana Hospital Association, LSU and Tulane are seeking an extended waiver from CMS to allow residents to keep training in alternative locations, namely private hospitals like us. The current waiver expires on January 31. We understand that CMS has yet to issue an extension. With the departure of our DMAT hospital, we need to create a separate entity, a community health center to provide emergent care services close to our emergency.

As we rebuild the healthcare delivery system, one consistent recommendation has been the immediate expansion of community-based primary care and mental health services. Potential Federal legislation or regulatory relief should include expediting an extension of CMS waiver for residents, allowing hospitals operating in immediate disaster areas the option of cost-based reimbursement on an inpatient or outpatient basis, providing for funding to follow patients cared for by health practitioners enrolled in residency programs, and provision of special dispensation for funding federally qualified health centers in the areas affected by Hurricane Katrina.

At the local and regional level, we also should enhance communications systems whether it is HAM, satellite, or VoIP. Also, facilitating improvements such as raising most facilities above flood level, enforcing regional cooperation and cooperation among hospitals, and finally sharing our updated hurricane plans, as we are all doing with the local and State emergency operation centers.

Together, we will make a difference. Thank you all very much for your time today.

[The prepared statement of Gary Muller follows:]

PREPARED STATEMENT OF A. GARY MULLER, PRESIDENT AND CHIEF EXECUTIVE OFFICER,
WEST JEFFERSON MEDICAL CENTER

Mr. Chairman and Members of the Committee:

Thank you for inviting me to testify today on behalf of West Jefferson Medical Center.

West Jefferson Medical Center, located 10 minutes from downtown New Orleans, is a 451-bed community hospital and health system with programs and services across a complete continuum of care.

West Jefferson rediscovered itself as a leader during Hurricane Katrina through the resiliency and resourcefulness of our doctors and staff. We did not lose a single patient due to the storm.

West Jefferson stayed the course during Katrina. We are building stronger. Ironically, we were three months out from opening a new Energy and Support Services facility, a model for the nation. West Jefferson Medical Center did not flood but sustained over \$2 million in damages.

West Jefferson's story goes beyond bricks and mortar. I am proud of our doctors and staff and grateful for their actions during the disaster. They put aside their personal tragedies and fears to respond to the hospital's needs.

The post-Katrina story is complex as we embrace challenges continually. Only 1/3 of the pre-Katrina hospital bed capacity in the New Orleans area is available. Providers of all types that remained operational are experiencing significant financial losses as we struggle to retain health care workers and deliver care.

The region's labor and operating expenses have inflated dramatically without corresponding payment increases. Hospitals have also experienced a dramatic rise in indigent care.

Establishing emergency communications early with the local EOC was invaluable. Personal visits and information from Congressman Michael Burgess, Congressman Rodney Alexander, Senator David Vitter, Secretary Michael Levitt, Vice Admiral Dr. Richard H. Carmona, Dr. Mark McClellan and Dr. Julie Gerberding lifted our spirits and advanced our personal and professional drive to respond not only to West Jefferson's citizens but to the region.

FEMA's response to deploy a DMAT which we personally requested through Dr. Carmona and discussed with Senator Vitter was admirable. The DMAT Disaster Hospital that supported our Emergency Department was noteworthy. Together, the DMAT staff and our teams were able to administer more than 40,000 doses of vaccine. In future disasters of this magnitude, we would request the DMAT units to arrive earlier.

In summary, we will be better prepared for the future because of what we are doing today. We are exploring a more extensive communication system and moving forward to install an on-site water well at the hospital. We are exploring the cost and feasibility of elevating structures for critical services such as building our new Emergency Room on the second floor instead of the first.

We must also arrange for a well-honed process for back-up relief teams. Personnel worked for days on end without relief. West Jefferson Medical Center plans to develop a closer relationship with the state EOC for earlier communications.

The storm exposed the deficiencies of our health care system. Louisiana (and the affected areas) historically has suffered from a dearth of primary and specialty ambulatory care capacity available for low-income and other consumers. The lack of capacity, coupled with low Medicaid rates for physician care and no mechanism to reimburse clinicians for indigent care has led to over dependence on our emergency rooms and inadequate access to care for low-income, uninsured patients.

Charity care and Medicaid DSH funds concentrated at one delivery system and not well integrated with other community care delivery points – as MCLNO has downsized, remaining providers are absorbing patients without adequate payments.

Medicaid DSH money "did not follow the patient" to other provider settings.

Financial survival has become top priority for WJMC and we have focused efforts to explore every regulatory or legislative mechanism that might assist us. Interestingly, the present situation has offered us the chance to collaborate with organizations that may

never have been viewed as partners. Our operating losses since Hurricane Katrina total more than \$28 million dollars.

West Jefferson Medical Center and East Jefferson General Hospital, both Service District Hospitals, worked closely with our Congressional Delegation to identify existing federal legislation that could provide us financial relief. We worked diligently to offer language to the Stafford Act that would make our hospitals eligible for a Community Disaster Loan Program. Parallel to this effort were discussions with CMS providing regulatory relief of the Stark Amendment which would allow us the opportunity to provide assistance to physicians practicing at our hospitals. We must receive the CDL this month to provide for our physicians as the Stark waiver will expire on January 31st.

LSU's medical school program, which trains three out of every four doctors in this state, was severely impacted by Hurricane Katrina. WJMC is committed to retaining a physician workforce for our region and has been in conversations with both LSU and Tulane University School of Medicine. We are in the process of applying for major teaching hospital status, but are concerned that GME reimbursement issues will hinder our efforts. For example, the LHA, LSU and Tulane are seeking an extended waiver on CMS caps to allow residents to keep training in alternative locations, namely private hospitals. The current waiver expires on January 31st. We understand that CMS has yet to issue an extension.

With the departure of our DMAT hospital, we made an agreement with a separate entity to provide urgent care services close to our emergency room. As we rebuild the healthcare delivery system, one consistent recommendation has been the immediate expansion of community based primary care and mental health services.

Due to Congressional budget cuts within HHS, there will be no new grant funding for FQHCs in this fiscal year, so Louisiana will have to receive special dispensation for funding (by way of an earmark appropriation) if we are to develop new, grant funded FQHCs.

Lessons learned from experiences should result in policy changes that will benefit everyone in the future. Potential legislation or regulatory relief should include:

- Allowing adjustments to the wage index calculation based on disaster related rate increases.
- Provision for adjustments to the outlier methodology and thresholds to reflect the lack of post-acute care capacity.
- Expedition and extension of CMS waiver for resident caps
- Allowing hospitals operating in immediate disaster areas the option of cost-based reimbursement on an inpatient and/or outpatient basis.
- Provision for funding to follow patients cared for by health practitioners enrolled in residency training programs
- Provision of special dispensation for funding Federally Qualified Health Centers in the areas affected by Hurricane Katrina
- Increased communications and collaboration between legislative and executive branches of government for the recovery efforts on the Gulf Coast

At the local and regional level we should:

- Enhance communications and communication systems
- Facilitate facilities improvements
- Forge regional cooperation and collaboration among hospitals
- Share our updated Hurricane Plans with local and state EOC

Together, we will make a difference. Thank you for your time today.

MR. WHITFIELD. Mr. Muller, thank you.

At this time, those of us here on the panel will each have ten minutes to ask questions, and I'm going to watch this clock rather closely, because we do have another panel, but it is such an important hearing we want to give all the Members ample opportunity to ask their questions.

Mr. Muller, let me ask you the question, you made reference to the fact that a disproportionate share of payments go to hospitals for indigent care in the State of Louisiana. I suppose because of State law, that funding goes only to the LSU Charity Hospital systems. Is that correct?

MR. MULLER. There are other hospitals that have a high proportion of uninsured or Medicaid. West Jefferson, for example, is below that. Most hospitals are. A very, very large percentage of all those funds goes to the LSU system.

MR. WHITFIELD. Well, is it a disproportionate share that goes to the LSU system or not?

MR. MULLER. In my opinion it is, because there are unmet needs in many, many, many other providers in the State of Louisiana that do not receive a dime from any of those funds.

MR. WHITFIELD. But today, because Charity is not in operation, and University is not in operation, are you being reimbursed at all for care given to indigent patients?

MR. MULLER. No, sir.

MR. WHITFIELD. Now, that is not Federal law, is it, or is this a State law that causes it to be this way?

MR. MULLER. There are two levels, to my understanding. One is the State applies to CMS and the Federal government for matching funds. That comes into the State of Louisiana and then, the State of Louisiana disburses those. So, I believe it really is mostly controlled at State level.

MR. WHITFIELD. I think that is right, because obviously, the Federal dollars match and provide a good portion of the Medicaid costs, but each State decides for itself the way a lot of that is dispensed and so forth.

Let me ask you, all of you on this panel, who has the responsibility, legal or otherwise, to evacuate patients when you have a situation like Katrina, a disaster, really, of epic proportion? Does the Federal government have any responsibility in that evacuation, making that decision? Who makes the decision to evacuate?

MS. FONTENOT. At our institution, the CEO, our commander, basically makes the decision to evacuate, of course, in conjunction with Mr. Smithburg, who is the CEO of the hospital system. But to my knowledge, that is where the decision lies.

MR. MULLER. Mr. Chairman, in Jefferson Parish's instance, the emergency operations state that's controlled by the parish president and we receive direct orders because we are a parish facility.

MR. WHITFIELD. But you don't have to obtain approval from the Federal government, or I guess any government agency to evacuate patients; that is a decision for you to make to protect your patients under the conditions that are there that day, or are present?

MR. MULLER. That is correct.

MR. WHITFIELD. Now, Congressman Stupak mentioned in his opening statement, the stark contrast between the Tulane University and Charity and University Hospitals. They are relatively close, both of them; all of them were flooded. I'm assuming that the major difference-- I mean, the Tulane hospital is going to be up and operating for limited services relatively soon, and I don't get the impression that University and the Charity Hospital are going to be in a situation to do that anytime soon now.

I'm assuming and I want you all to correct me if I am wrong, but one of the big differences here is that HCA is operating the Tulane hospital, and that is a private for-profit corporation, and so, they are putting their private dollars in, their investors' dollars in, and yet, at Charity and University, you are totally depending, I'm assuming, on the government, either local, State or Federal government, in order to get you back in operation. Is that correct? Or is that not correct?

MR. SMITHBURG. Mr. Chairman, that is generally correct. With regard to Charity and University, in fact, all of the LSU hospitals, because we are public entities and derive most of our funding from public dollars, actually most institutions do, but because we are in the public sector, we rely on public resources. As you might imagine, we were stretched thin financially to begin with. We had used reserves that we had accumulated from all of our hospitals to help deal with the tragedy, though.

MR. LAGARDE. Speaking from Tulane, our funds for reopening are property and casualty insurance as well as business interruption. So, ours is not necessarily funded by the company, but it is funded by insurance.

MR. WHITFIELD. What about Charity and University, was there insurance in place at the time?

MR. SMITHBURG. Mr. Chairman, we fall under the State's Office of Risk Management, and it is our understanding that that self-insurance policy has about \$500 million per occurrence for Rita, for Katrina. That is for the entire State infrastructure.

MR. WHITFIELD. That's self insurance?

MR. SMITHBURG. That is my understanding and I'm not an authority on that.

MR. WHITFIELD. So the State is responsible for that.

MR. SMITHBURG. And keeping in mind that the \$500 million for the Katrina episode was to cover not only the hospitals, but every piece of public infrastructure for which the State had responsibility. So, we then rely, Mr. Chairman, rely on FEMA as the public entity. We are theoretically FEMA eligible.

MR. WHITFIELD. Now, we have heard a lot today about lack of Level 1 emergency healthcare in the area, which certainly is vital. Now, it is my understanding that Charity has received approval from FEMA for FEMA to pay the entire cost to have Charity's trauma center relocated to Elmwood Hospital in New Orleans. Now, is that correct, or is that not correct?

MR. SMITHBURG. Of course, there are no answers in all of these kinds of general conclusions. What FEMA has agreed to is that our lease of Elmwood can be reimbursed by FEMA. We have not seen the funding for it. And Elmwood is a private facility, owned by Ochsner, and they have offered it to us for one year. So, FEMA has agreed that we can be reimbursed for it.

MR. WHITFIELD. So that is a temporary solution for one year?

MR. SMITHBURG. Yes, sir.

MR. WHITFIELD. And do you have any idea when you can expect to see money from FEMA for this one-year fix?

MR. SMITHBURG. Mr. Chairman, I have no idea when we will see the reimbursement from FEMA for any of our project worksheets that have been submitted.

MR. WHITFIELD. Well, I'm assuming you can't open until you receive the money. Is that right?

MR. SMITHBURG. We are going to have to figure out a way to front it, and we are working very closely with our State.

MR. WHITFIELD. I have just been told a few minutes ago that FEMA, into Louisiana, has provided either directly or indirectly, \$406 million for healthcare. Do you-all have any knowledge of that particular figure or is that a figure that is just out of the air, or does anyone have any thoughts on that?

MR. SMITHBURG. From LSU's point of view, that is the first time we have heard that number. We have about \$50 million of reimbursement requests in to FEMA.

MR. WHITFIELD. Another area I want to look at briefly--obviously, on the backup power, that is something that you-all are going to be addressing and where it is located and so forth--but when you are evacuating patients under emergency situations like this, I think for HCA and maybe even Tenet, perhaps, I don't know, but you are basically sending your patients to other entities that you own.

MR. LAGARDE. That's what we do.

MR. WHITFIELD. But it would seem to be relatively easy to keep up with the patients, and you know where these patients are. But I get the impression that in the Charity Hospital situation, that these patients were being moved to airports and transported, and no one really--FEMA or whoever was responsible--did not really keep track of who went where. Is that accurate or is that not accurate?

MR. SMITHBURG. That is accurate. We had plans to evacuate. We are not set up to evacuate out of New Orleans. We are the facility that is supposed to be the last standing as the trauma center. But we had made our own plans to evacuate our patients to other LSU hospitals out of harm's way. We don't have a fleet of helicopters or ambulances. We have to rely on public services. We submitted a plan and we were overruled.

MR. WHITFIELD. By whom?

MR. SMITHBURG. I'm not sure. It was my understanding that FEMA said they had had another evacuation and deployment plan in place.

MR. WHITFIELD. How many days did it take you to totally evacuate the Charity Hospital and University Hospital system?

MR. SMITHBURG. Well, we got out on Friday, and the storm hit Sunday.

MR. WHITFIELD. So, five to six days.

Well, my time has expired so I'm going to recognize Mr. Stupak for ten minutes.

MR. STUPAK. Thank you, Mr. Chairman. So little time and so many questions.

First of all, Mr. Chairman, I would like to introduce in the record a letter of September 6 to the Secretary of HHS Michael Leavitt; a letter of September 20 to Chairman Barton; a letter from November 4 to David Walker, comptroller of the U.S. Government Accountability Office; and again, December 15, a letter to Secretary Leavitt, Department of Health and Human Services, signed by myself, Mr. Brown and Mr. Waxman on many of these questions we have here today on preparedness and things like that. So, we would like to have that in the record. Thank you.

[The information follows:]

Congress of the United States
House of Representatives
Washington, D.C. 20515

September 6, 2005

The Honorable Michael O. Leavitt
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Leavitt:

As the disaster of Hurricane Katrina continues to reverberate, we are writing to ask that you work with us to make it possible for affected States to make greater use of the Medicaid program to meet the growing health needs of their residents. As New York's efforts after the September 11 attacks have demonstrated, Medicaid is one of the most valuable and responsive tools the State and Federal government have to help those hurt or made ill by these events and to ensure that further injury, illness, public health hazard, and loss of health care are averted.

Specifically, we would ask you to support legislation that would provide full Federal payment for Medicaid to the affected States. Their economies, already poor and struggling to recover from the recession, will be unable to support the regular matching payments needed to provide health care to the tens of thousands who will need it over the coming months. Providing a 100 percent Federal Medical Assistance Percentage (FMAP) provides direct, immediate, and pragmatic assistance to these States and to their residents.

We would also ask you to support legislation that would make all residents of these States who are at or below the Federal poverty level eligible for Medicaid, regardless of their usual categorical eligibility. Both on a humanitarian level and a practical level, it is wrong to pick and choose which poor people in this disaster can get help and which cannot.

In addition, we would ask you to take executive action to assure that States can quickly and generously use their Medicaid programs without fear that Federal second-guessing of expenses will follow. States should be encouraged to accept the applicant's personal declaration of eligibility without fear that a later accounting of error rates will be invoked to penalize them. States should not be subject to audits or penalties if they do not require people to provide documents that they no longer have.

We would also ask that you work with other States to assure that inter-State payment is easily managed. A person who is evacuated from the Superdome in Louisiana to the Astrodome in Texas should be confident that the Federal Government will facilitate and ultimately guarantee

The Honorable Michael O. Leavitt
Page 2

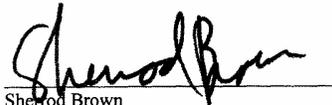
payment for its Louisiana refugees. States should receive guidance on how to deputize their sister States to determine eligibility for displaced residents. A Louisiana family, temporarily sheltered in Texas, should be able to apply for Louisiana Medicaid while housed in Texas through procedures easily accessed in Texas. Alternatively, the Louisiana family could be temporarily enrolled in the Texas program with the same streamlined rules (and 100 percent FMAP) applying.

These are just some of the important steps that should be taken to ease the considerable pain and suffering of the many victims of Hurricane Katrina. We are, of course, ready and willing to work with you to ensure that legislation can be expedited and that the Federal Government will be the best partner it can be in providing help in this disaster.

Sincerely,



John D. Dingell
Ranking Member
Committee on Energy and Commerce



Sherrod Brown
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce



Henry A. Waxman
Ranking Member
Committee on Government Reform

cc: The Honorable Joe Barton, Chairman
Committee on Energy and Commerce

The Honorable Nathan Deal, Chairman
Subcommittee on Health

4
 RALPH M. HALL, TEXAS
 MICHAEL BELMONT, FLORIDA
 VICE CHAIRMAN
 NED LYTTON, MICHIGAN
 CLIFF STARNES, FLORIDA
 PAUL E. GILLMOR, OHIO
 NATHAN DEAL, GEORGIA
 ED WHITFIELD, KENTUCKY
 CHARLIE NORWOOD, GEORGIA
 BARBARA CUBIN, WYOMING
 JOHN SHIMKUS, ILLINOIS
 HEATHER WILSON, NEW MEXICO
 JOHN B. SHADEGG, ARIZONA
 CHARLES W. "CHIP" PICKERING, MISSISSIPPI
 VICE CHAIRMAN
 VITO ROSSELLA, NEW YORK
 ROY BLUNT, MISSOURI
 STEVE BUYER, INDIANA
 GEORGE RADANOVICH, CALIFORNIA
 CHARLES F. BASS, NEW HAMPSHIRE
 JOSEPH R. FITZ, PENNSYLVANIA
 MARY BONO, CALIFORNIA
 GREG WALDEN, OREGON
 LEE TERRY, NEBRASKA
 MIKE FERGUSON, NEW JERSEY
 MIKE ROGERS, MICHIGAN
 C.L. "BUTCH" OTTER, IDAHO
 SUE MYRICK, NORTH CAROLINA
 JOHN SULLIVAN, OKLAHOMA
 TIM MURPHY, PENNSYLVANIA
 MICHAEL C. BURGESS, TEXAS
 MARSHA BLACKBURN, TENNESSEE
 BUD ALBRIGHT, STAFF DIRECTOR

ONE HUNDRED NINTH CONGRESS

U.S. House of Representatives
Committee on Energy and Commerce
 Washington, DC 20515-6115

JOE BARTON, TEXAS
 CHAIRMAN

September 20, 2005

JOHN D. DINGELL, MICHIGAN
 RANKING MEMBER
 HENRY A. WAXMANN, CALIFORNIA
 EDWARD J. MARKEY, MASSACHUSETTS
 RICK BOUCHER, VIRGINIA
 EDOLPHUS TOWNES, NEW YORK
 FRANK PALLONE, JR., NEW JERSEY
 SHERROD BROWN, OHIO
 BART GORDON, TENNESSEE
 BOBBY L. RUSH, ILLINOIS
 ANNA G. ESHOO, CALIFORNIA
 BART STUPAK, MICHIGAN
 ELIOT L. ENGEL, NEW YORK
 ALBERT R. WYNN, MARYLAND
 GENE GREEN, TEXAS
 TED STRICKLAND, OHIO
 DANAH DOBETTE, COLORADO
 LOIS CAPPS, CALIFORNIA
 MIRE DOYLE, PENNSYLVANIA
 TOM ALLEN, MAINE
 JIM DAVIS, FLORIDA
 JAM SCHAKOWSKY, ILLINOIS
 MELBA L. SOLIS, CALIFORNIA
 CHARLES A. GONZALEZ, TEXAS
 JAY INSLEE, WASHINGTON
 TAMMY BALDWIN, WISCONSIN
 MIKE ROSS, ARKANSAS

The Honorable Joe Barton
 Chairman
 Committee on Energy and Commerce
 2125 Rayburn House Office Building
 Washington, D.C. 20510

The Honorable Ed Whitfield
 Chairman
 Subcommittee on Oversight and Investigations
 2125 Rayburn House Office Building
 Washington, D.C. 20510

Dear Chairmen Barton and Whitfield:

We ask that the Subcommittee on Oversight and Investigations undertake an extensive review of the damage wrought by Hurricane Katrina, as well as cleanup and reconstruction efforts. Hurricane Katrina wrought major devastation to the Gulf region, particularly across the southern parts of Louisiana, Mississippi, and Alabama. Much of the city of New Orleans remains evacuated as do many surrounding parishes, and the Mississippi coast is almost unrecognizable as entire communities have been destroyed by wind and storm surge.

More than two weeks after Katrina came ashore, many affected regions are without basic services including safe drinking water, electricity, or effective communication. Thousands have lost homes and more than half a million jobs may also be permanently lost. As waters recede and the region's citizens begin to rebuild, vast challenges will confront all levels of government.

We ask that the Subcommittee conduct investigations and hold related hearings to keep the public apprised of the many major health, safety, and consumer issues related to reconstruction and cleanup. Assertive oversight and investigations by this Committee can improve both the quality and the rapidity of recovery while simultaneously helping to reduce waste, fraud, and abuse. Of course, other Subcommittees can and should have hearings that will often provide excellent briefings, and we are pleased that two Subcommittees are holding Katrina-related hearings this week. But the unique investigative resources available to the Subcommittee on Oversight and Investigations should give it a critical role in the overall effort by developing an independent understanding of the facts. Below are some suggested topics:

The Honorable Joe Barton

Page 2

1. Continuity of Health Care and Health Care Fraud. Many Katrina victims are presently without adequate health care, both in the short term and for the foreseeable future. How can these needs be met? What changes to the Medicaid program would expedite relief? Also, how is the Federal Government addressing anticipated efforts to defraud Medicaid and Medicare?
2. Hospitals and Nursing Homes. Health care facilities have been destroyed and heavily damaged and both hospitals and nursing homes have recently been found with significant numbers of deceased. How are the most vulnerable dealt with before an evacuation, and who is responsible for this? What will the challenges be in terms of bringing the many hospitals and public health institutions back into service and who will pay? What kinds of facilities will be available to the poor?
3. Telecommunication Issues. Immediately following the disaster, there were massive communication breakdowns. Why? Since 9/11, hundreds of millions of dollars have been provided to the States to promote interoperable communications. How has this money been spent, and why couldn't all of the first responders and other relief workers communicate with one another? What systems functioned, which systems failed, and why?
4. Environmental Health. Much of New Orleans is still inundated by flood waters containing a mix of sewage, chemicals, and petroleum products. And the issue of indoor air effects may become a major concern. Have chemical spills been reported? How are the environmental assessment activities being handled, and is the sampling adequate? What is being found, and what are the implications? How will residents be monitored, and for how long?
5. Energy Infrastructure. Much of the oil and gas infrastructure in Louisiana and more broadly the Gulf region has been damaged or adversely affected by Katrina. What is the extent of this damage and what is the potential impact on energy security for both the short and the long term?
6. Storm-related Energy Prices: Justified or Not? Damage to the Gulf oil/gas infrastructure has already resulted in a spike in energy prices, particularly gasoline prices. Moreover, we are being told that as a result of the hurricane, heating oil and natural gas prices will be increasing significantly over the next month and even into next year. Are these higher prices justified and are the increases commensurate with the production losses resulting from the hurricane?
7. Food Safety. Much of this toxic water from New Orleans is being pumped into Lake Pontchartrain. Some of this output is expected to flow into one of the most lucrative seafood beds in the country. What will be the effect on this important source of food for both the short and the long run, particularly with all the heavy metals being pumped from the numerous contaminated adjacent areas? What is the Food and Drug Administration doing to address this problem?

The Honorable Joe Barton
Page 3

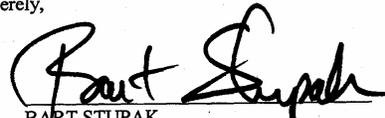
8. Internet-related Fraud. There have already been numerous reports of Internet scams popping up to defraud the victims of Katrina. This includes both identity theft as well as scams related to direct contributions. Who are these entities and where do they reside? What is the Federal Government doing to prevent this kind of activity, and is it being effective?
9. Fraud and Abuse Activities in General. All forms of contractor services from small relief groups to major environmental cleanup firms are currently in the Katrina-affected areas helping with recovery. Who are these firms and what do we know about their capabilities? Who in the Federal Government will be overseeing the quality of their efforts? Are there sufficient auditing resources to prevent overbilling and fraud?
10. Commerce and Port Operations. The port of New Orleans is still mostly closed. What is the impact on commerce and what needs to be done to reopen the port and related facilities? Also, how can local, State, and Federal authorities help rebuild commerce and tourism in the city of New Orleans?

We know that you will have many excellent ideas for oversight and investigative activities as well, and we look forward to working with you on all of these important matters.

Sincerely,



JOHN D. DINGELL
RANKING MEMBER



BART STUPAK
RANKING MEMBER
SUBCOMMITTEE ON OVERSIGHT
AND INVESTIGATIONS

RALPH M. HALL, TEXAS
 MICHAEL BLUMRICK, FLORIDA
 VICE CHAIRMAN
 FRED LIFTON, MICHIGAN
 CLIFF STEARNS, FLORIDA
 PAUL E. GILLMORE, OHIO
 NATHAN DEAL, GEORGIA
 ED WHITFIELD, KENTUCKY
 CHARLES WOODWARD, GEORGIA
 BARBARA CUBIN, WYOMING
 JOHN SHIMKUS, ILLINOIS
 HEATHER WILSON, NEW MEXICO
 JOHN B. SHADDEG, ARIZONA
 CHARLES W. "CHIP" PICKERING, MISSISSIPPI
 VICE CHAIRMAN
 VITO FOSSILLA, NEW YORK
 ROY BLUNT, MISSOURI
 STEVE BUYER, INDIANA
 GEORGE RADANOVICH, CALIFORNIA
 CHARLES F. BASS, NEW HAMPSHIRE
 JOSEPH R. PITTS, PENNSYLVANIA
 MARY BONO, CALIFORNIA
 GREG WALDEN, OREGON
 LEE TERRY, NEBRASKA
 MIKE PERGELSON, NEW JERSEY
 MIKE ROGERS, MICHIGAN
 C.J. "BUTCH" COTTER, IDAHO
 SUE MYRICK, NORTH CAROLINA
 JOHN SULLIVAN, OKLAHOMA
 TIM MURPHY, PENNSYLVANIA
 MICHAEL C. BURRESS, TEXAS
 MARSHA BLACKBURN, TENNESSEE

BUD ALBRIGHT, STAFF DIRECTOR

ONE HUNDRED NINTH CONGRESS

U.S. House of Representatives
Committee on Energy and Commerce
 Washington, DC 20515-6115

JOE BARTON, TEXAS
 CHAIRMAN

November 4, 2005

JOHN D. DINGELL, MICHIGAN
 RANKING MEMBER
 HENRY A. WAXMAN, CALIFORNIA
 EDWARD J. MARKEY, MASSACHUSETTS
 RICK BOUCHER, VIRGINIA
 EDOLPHUS TOWNS, NEW YORK
 FRANK PALLONE, JR., NEW JERSEY
 SHERROD BROWN, OHIO
 BART GOODEN, TENNESSEE
 BOBBY L. RUSH, ILLINOIS
 ANNA E. ESPO, CALIFORNIA
 BART STUPAK, MICHIGAN
 ELIOT L. ENGEL, NEW YORK
 ALBERT R. WYNN, MARYLAND
 GENE GREEN, TEXAS
 TED STRICKLAND, OHIO
 DIANA DINGETTE, COLORADO
 LOSO CAFFE, CALIFORNIA
 MIKE DOYLE, PENNSYLVANIA
 TOM ALLEN, MAINE
 JIM DAVIS, FLORIDA
 JAN SCHAKOWSKY, ILLINOIS
 NICKI L. SOLES, CALIFORNIA
 CHARLES A. GONZALEZ, TEXAS
 JAY INGLESE, WASHINGTON
 TAMMY BALDWIN, WISCONSIN
 MIKE ROSS, ARKANSAS

The Honorable David M. Walker
 Comptroller General
 U.S. Government Accountability Office
 441 G Street, N.W.
 Washington, D.C. 20548

Dear Mr. Walker:

A potentially catastrophic public health crisis is now confronting the State of Louisiana (and particularly the New Orleans region) as a result of the damage caused by Hurricanes Katrina and Rita. It includes the loss of critical healthcare services generally for the southern part of the State, the future solvency of the statewide Medicaid program, and the possible permanent loss of the only Level I trauma center in southern Louisiana. The rapid restoration of healthcare services to the greater New Orleans region will affect whether and how the city can successfully rebuild and maintain its position as a leading medical training center and tourist destination. It is also critical to any future response to any potential natural or other medical disaster, such as pandemic influenza.

One of the most serious healthcare-related problems facing the greater New Orleans region is the loss of the Medical Center of Louisiana at New Orleans (MCLNO) which is comprised of two of the region's largest hospitals, Charity and University. Known together as "Charity," both were severely damaged by Katrina's winds and the flood waters that later engulfed the basements of both facilities. Prior to the hurricanes, the two MCLNO hospitals provided the only healthcare access for many of the region's poor. Charity was also the only specialized Level I trauma center for the Southern region and was recognized and respected for its trauma care and the training it provided to emergency room physicians. The other Level I trauma center in Louisiana is in Shreveport, located in the northern part of the State. MCLNO, operated by Louisiana State University (LSU), is also the training center for many of the State's medical personnel.

Before Katrina, approximately 970,000 residents in Louisiana had no health insurance. Many of those uninsured were the "working poor" who earn too much to be eligible for Medicaid. They work at jobs without health insurance benefits or cannot afford to pay the co-pays or purchase private health insurance. These individuals still, however, pay taxes through

The Honorable David M. Walker

Page 2

their earnings and are an important part of the State's tax base. In New Orleans alone, almost 20 percent of its residents have no health insurance. For the two hospitals that comprise MCLNO, 44 percent of its total admissions in fiscal year 2005 were uninsured, with another 42 percent covered by Medicaid. Thus, more than 85 percent of Charity's patients (or approximately 275,000 of the region's residents) were indigent or the working poor. These statistics highlight the critical role of Medicaid and other public programs in ensuring that the low-to-moderate income residents of this area have access to health care. Considering that the population of the City of New Orleans was nearly 500,000 before the storm, any future recovery plans must take into account the role Charity played in providing essential healthcare services to the region.

There are certainly numerous questions regarding the future of both MCLNO hospitals. The most critical is whether these facilities can or should be repaired or rebuilt. The basements of both were submerged under contaminated floodwaters for weeks, resulting in severe damage to the electrical, mechanical, and plumbing systems of both structures. Moreover, there may be structural damage to the foundations of both hospitals.

It is also clear that significant outlays of funds will be necessary to repair or replace one or both hospitals. And at this time there appears to be no agreement among Federal, State, or local officials on a plan to rebuild or repair either facility. While the Federal Emergency Management Agency may provide some financial relief, we understand that funding will likely be inadequate to rebuild or repair either facility as a major trauma or comprehensive healthcare facility, and it is uncertain whether the funds will be received in a timely manner in order to be used for reconstruction.

Public officials need to act quickly to address these issues. If not, this situation may have a cascading effect on medical care and training throughout Louisiana and the Gulf Coast region. Tulane University and LSU depend upon these hospitals to train Louisiana's doctors, nurses, and allied health professionals. Tulane, in particular, is also a medical research center that relies on Charity's hospitals for much of their work. Tulane was the single largest private employer in the City of New Orleans. These operations and the students associated with the University represent a much-needed revenue source for New Orleans. If the hospitals are not rebuilt, these medical facilities and educational institutions will in all likelihood be forced to relocate their research and their students.

Strategic planning to provide ongoing care for returning residents or cleanup and construction workers – particularly those on Medicaid or those without any insurance – is insufficient. While admirable, the small tent-based operation near the hospital site clearly cannot provide care for even a fraction of potential patients in this region. The current contract workforce – many who lack health insurance and may remain in the region for years – may also place a heavy demand on local healthcare services. There is some hope that the Tulane hospital, which is attempting to repair its facilities, will soon reopen. But that hospital has fewer beds than Charity. It also is not a trauma care hospital, and it is unlikely that it would be able to financially afford to care for the number of poor who previously used the two MCLNO hospitals.

The Honorable David M. Walker

Page 3

Finally, because of both storms, the State of Louisiana faces a serious problem regarding its Medicaid program in general. Louisiana will have major difficulty in meeting its State match required under Medicaid, expected to be more than \$1 billion. Not only has Louisiana lost much of its tax base, but many of those displaced are living in other States, and Louisiana is now obligated to pay for their out-of-state services. This future Medicaid obligation, coupled with continuing displacement of much of the State's tax base, will pose major hurdles for recovery. There is legislation pending in Congress that could help relieve some of this burden, but as yet it has not passed, and would be a temporary remedy at best.

In staff discussions with senior Louisiana healthcare officials, there did not appear to be a clear plan for preserving the State's Medicaid coverage. Louisiana's Medicaid program has already been cut to the bone. Further cuts, combined with the match owed to other States, could completely destroy that State's healthcare system unless dramatic action is taken soon. While we remain hopeful that Congress will expeditiously enact legislation to help with Medicaid in those areas directly affected by both hurricanes, the budget reconciliation provisions that passed both the Committee on Energy and Commerce and the Senate Committee on Finance, in present form, are inadequate as they will not necessarily help those in other parts of the State or other people who are ineligible for Medicaid.

We understand that most of the Government Accountability Office's (GAO) impending hurricane recovery work is being done under "Comptroller General Authority." While we understand that this means that these audits are self-initiated (rather than being initiated by Members of Congress), we believe it is imperative that the issues discussed in this letter be examined as part of any ongoing work. We look forward to discussing with your office the following issues:

1. What is the long-term plan for meeting Louisiana's share of Medicaid costs if the State cannot generate sufficient funds to cover its obligation? Does GAO believe that sufficient State funds exist to cover Louisiana's expected Medicaid obligation without Federal assistance and without gutting funding for other essential State responsibilities like education and public safety?
2. Are plans to cover the likely Medicaid shortfall being discussed with the Department and the Centers for Medicaid and Medicare Services by the State of Louisiana, and if so, what is GAO's understanding of these plans and the status of this process?
3. Has FEMA conducted its reviews of the damaged medical facilities and whether they can be rebuilt? If so, what is your understanding of the progress of these hospitals?
4. Does GAO believe that the two hospitals can be restored and reopened or does it believe that one or both have been irreparably damaged by the storm flood waters?

The Honorable David M. Walker
Page 4

5. What is GAO's evaluation of the small M.A.S.H.-style hospital set up in the site's adjacent parking lot? Can this facility meet New Orleans's short-to-medium term healthcare needs? How long is this facility expected to be used? Is the makeshift hospital allowed to bill Medicaid for reimbursements? If so, when will it begin? If not, what steps will the hospital need to take in order to allow for billing?
6. If one or both hospitals cannot be adequately restored or entirely rebuilt, how will the many residents of the City of New Orleans and surrounding areas receive needed essential medical services? Does GAO believe that a similar level of services will ultimately need to be restored if the City of New Orleans is to recover? Also, what is the role of healthcare services in the restoration of the city?
7. Has the Administration conducted any assessments on the future quality of health care for the State and its educational system if the largest teaching facility for Louisiana is lost?

We appreciate your attention to this matter and would request that your staff contact our staff to set up a mutually-agreeable time for such briefings. If you have any questions on this matter, please have your staff contact Christopher Knauer, Minority Investigator, or Edith Holleman, Minority Counsel, with the Committee on Energy and Commerce at (202) 226-3400.

Again, we appreciate your time and effort regarding this important matter and look forward to hearing from you soon.

Sincerely,


JOHN D. DINGELL
RANKING MEMBER


SHERRROD BROWN
RANKING MEMBER
SUBCOMMITTEE ON HEALTH


BART STUPAK
RANKING MEMBER
SUBCOMMITTEE ON OVERSIGHT
AND INVESTIGATIONS

The Honorable David M. Walker
Page 5

cc: The Honorable Joe Barton, Chairman
Committee on Energy and Commerce

The Honorable Nathan Deal, Chairman
Subcommittee on Health

The Honorable Ed Whitfield, Chairman
Subcommittee on Oversight and Investigations

The Honorable Michael O. Leavitt, Secretary
Department of Health and Human Services

RALPH M. HALL, TEXAS
 MICHAEL BILIRAKIS, FLORIDA
 VICE CHAIRMAN
 FRED UPTON, MICHIGAN
 CLIFF STEARNS, FLORIDA
 PAUL E. GILLMORE, OHIO
 NATHAN DEAL, GEORGIA
 ED WHITFIELD, KENTUCKY
 CHARLIE NORWOOD, GEORGIA
 BARBARA CLIBURN, WYOMING
 JOHN SHIMKUS, ILLINOIS
 HEATHER WILSON, NEW MEXICO
 JOHN B. SHARCKO, WISCONSIN
 CHARLES W. "CHIP" PICKERING, MISSISSIPPI
 VICE CHAIRMAN
 VITO FOSSILLA, NEW YORK
 STEVE BUYER, INDIANA
 GEORGE PADANOVICH, CALIFORNIA
 CHARLES F. BASS, NEW HAMPSHIRE
 JOSEPH R. FITTS, PENNSYLVANIA
 MARY BONO, CALIFORNIA
 GREG WALDEN, OREGON
 LEE TERRY, NEBRASKA
 MIKE PERDUCCI, NEW JERSEY
 MIKE ROGERS, MICHIGAN
 CL. "BUCK" OTTER, IDAHO
 SUE MYRICK, NORTH CAROLINA
 JOHN SULLIVAN, DELAWARE
 TIM MURPHY, PENNSYLVANIA
 MICHAEL C. BURGESS, TEXAS
 MARSHA BLACKBURN, TENNESSEE
 J. GRESHAM BARRETT, SOUTH CAROLINA

BLUD ALBRIGHT, STAFF DIRECTOR

ONE HUNDRED NINTH CONGRESS

U.S. House of Representatives
 Committee on Energy and Commerce
 Washington, DC 20515-6115

JOE BARTON, TEXAS
 CHAIRMAN

JOHN D. DINGELL, MICHIGAN
 RANKING MEMBER
 HENRY A. WAXMAN, CALIFORNIA
 EDWARD J. MARKEY, MASSACHUSETTS
 RICK BOUCHER, VIRGINIA
 EDOLPHUS TOWNS, NEW YORK
 FRANK PALLONE, JR., NEW JERSEY
 SHERROD BROWN, OHIO
 BART GORDON, TENNESSEE
 BOBBY L. LUSH, ILLINOIS
 ANNA E. ESCHOO, CALIFORNIA
 BART STUPAK, MICHIGAN
 ELIOT L. ENGLISH, NEW YORK
 ALBERT R. WYNA, MARYLAND
 GENE GREEN, TEXAS
 TES STICKLAND, OHIO
 DIANA OSGETTE, COLORADO
 LOS CAPPES, CALIFORNIA
 MIKE DOYLE, PENNSYLVANIA
 TOM ALLEN, IOWA
 JIM DAVIS, FLORIDA
 JAM SCHAKOWITZ, ILLINOIS
 HILDA L. SOLIS, CALIFORNIA
 CHARLES A. GONZALEZ, TEXAS
 JAY INSLEE, WASHINGTON
 TAMMY BALDWIN, WISCONSIN
 MIKE ROSS, ARKANSAS

December 15, 2005

The Honorable Michael O. Leavitt
 Secretary
 Department of Health and Human Services
 200 Independence Avenue, S.W.
 Washington, D.C. 20201

Dear Secretary Leavitt:

On September 15, 2005 – before the water had even fully receded from the streets of New Orleans – President Bush stood in front of St. Louis Cathedral and promised that the Federal Government would provide the majority of the funding for a combined Federal, State, and local program to resurrect New Orleans. It would be “one of the largest reconstruction efforts the world has ever seen” and the Federal Government “will do what it takes, we will stay as long as it takes to help citizens rebuild their communities and their lives.” When the streets were rebuilt, “there should be many new businesses, including minority-owned businesses, along those streets.” (See, “Bush Promises a Massive Rebuilding of Gulf Coast,” *The Los Angeles Times*, Sept. 16, 2005, A1.)

It is now more than three months since Hurricane Katrina devastated most of the City of New Orleans, and much of the Southern Gulf coast. What once was a national crisis is now a national disgrace. As the *New York Times* reported this past weekend, “We are about to lose New Orleans.” (“Death of an American City,” *New York Times*, Dec. 11, 2005.) While some progress has been made in cleaning up the debris and housing evacuees, large sections in this region – particularly in the New Orleans area – still lack basic services including electricity and other utilities and functioning educational and healthcare systems. The Federal agencies, including the Department of Health and Human Services (HHS), have not followed through on the President’s promises. (See, “Wearying Wait for Federal Aid in New Orleans,” *The New York Times*, Dec. 3, 2005, A1; “New Orleans Utility Struggles to Relight a City of Darkness,” *The New York Times*, Nov. 19, 2005, A1; “Louisiana Sees Faded Urgency in Relief Effort,” *The New York Times*, Nov. 22, 2005, A1; and “New Orleans Health Another Katrina Casualty,” *The Washington Post*, Nov. 25, 2005, A3.)

The Honorable Michael O. Leavitt
Page 2

You declared a public health emergency for the Katrina-affected area on August 31, 2005. That emergency still exists, and the continuing absence of the healthcare infrastructure for much of the New Orleans region hinders the area's recovery. We are writing you to ask your personal assistance, as the Cabinet officer responsible for guaranteeing the public health of the Nation, in mobilizing the Department to carry out the President's commitments. A well-functioning healthcare system is necessary not only to serve the returning residents and workers of New Orleans, but also for the reconstruction workers, the tourists, and the students who are so critical to the city's economy. While we do not suggest that this is the only sector facing continuing challenges in the recovery process, this area in particular should receive critical attention because much of the economic recovery promised by President Bush cannot go forward without the successful restoration of the healthcare system.

The first priority in that restoration must be Charity Hospital. The medical infrastructure of Louisiana revolves around Charity Hospital, the linchpin of the area's healthcare system for the poor, the uninsured, and those suffering serious trauma. Prior to the hurricane, Charity had more than 700 beds serving more than 130,000 patients per year in its hospitals and outpatient clinics. Charity is also the State's chief medical training facility. Affiliated with Tulane University and Louisiana State University, Charity annually trained more than 600 medical and dental residents and fellows and 2,300 nurses and allied health professionals, 40 percent of whom remain in Louisiana.¹ The once growing Louisiana medical research industry was based around Tulane, LSU, and Charity Hospital. Before Hurricane Katrina, Charity was also an internationally known Level I trauma center designated by the Secret Service as the trauma center of choice for the President and visiting dignitaries. The trauma center served nine parishes. (See, "Hospitals to Share Charity's Load," *The Times-Picayune*, Oct. 29, 2005, p. 1; and "Trauma Cases Test Oschner Clinic Team," *New Orleans City Business*, Nov. 28, 2005.)

But this center of Louisiana's healthcare system, which contributed \$1 billion² to the city's economy, is not operational and, according to its chief executive, is "near its end" for lack of funds. ("Money Needed to Keep Charity Going," *The Times-Picayune*, Dec. 10, 2005.) The 3,300 university faculty, researchers, residents, and students are now scattered to other cities and States, and many may never return. New Orleans has been without a trauma center now for more than a month since a temporary military unit based at the convention center was redeployed to the Middle East. The nearest trauma center is in Shreveport, a four-hour drive by car. This would be unacceptable for any major metropolitan area in the United States, but additionally, this healthcare system serving the poor and the uninsured has been destroyed, and no replacement has been provided. And many reconstruction workers and returning residents are not only uninsured, but living and working in areas where serious traumas could result.

¹ FY2005 Fact Sheet, Medical Center of Louisiana at New Orleans.

² Louisiana Hospital Association, "Hospitals and the Louisiana Economy," May 2002

The Honorable Michael O. Leavitt
Page 3

A recent article in *The Washington Post* outlined the growing problems related to the closure of Charity Hospital, and the damage caused to many other medical facilities. The article notes that Hurricane Katrina damaged more than a dozen hospitals and uprooted thousands of private physicians.

“Now, nearly three months later, health care remains scarce. The last military medical unit in the city is gone, leaving only Touro and Children’s hospitals partially reopened. At the emergency room at Oschner Clinic Foundation in neighboring Jefferson Parish, visits are up 35 percent over this time a year ago, the number of uninsured patients has tripled and some wait as long as 10 hours for emergency care . . . [F]or most of the 25,000 clean-up workers – many of them uninsured – and an estimated 75,000 residents, health care is delivered in military tents that recently moved from a parking lot to the concrete floor of the convention center.” (*The Washington Post*, Nov. 25, 2005, A3, *supra*).

It is clear that the Louisiana healthcare system and training structure will not be rebuilt without the focus and assistance of the Federal Government. So far, that assistance appears to be lacking or caught in bureaucratic delays and indecision. This is not conducive to restoring the region’s population, its economy, or any of the goals established by the President. Many residents still struggle to find ways to access basic care, and the entire region continues to lose key healthcare staff through furloughs and eventual layoffs.

We further understand that in less than two weeks the entire staff of the Charity Hospital system in New Orleans, about 2,600 healthcare workers, will be laid off for lack of a \$15 million per month grant or loan to preserve New Orleans’s healthcare system (“A New Orleans without Public Health Care?”, WAFB, Nov. 29, 2005). While many in the region are seeking some form of assistance to keep these workers from losing their jobs, no plan – including some form of Federal assistance – appears forthcoming. The Federal Emergency Management Agency (FEMA) denied a request for a community development loan. *Id.* If these critical healthcare workers leave the State to seek employment elsewhere, it will be particularly difficult to meet the increasing healthcare needs as recovery progresses. The loss of these healthcare workers will have profound consequences for not only the New Orleans region, but the State as a whole as 40 percent of all Louisiana’s healthcare professionals train at Charity and its related institutions. It is increasingly difficult to square the President’s commitment to rebuild the region with the reality on the ground.

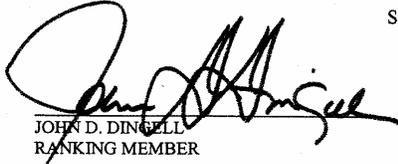
Our staffs have been in contact with senior officials from HHS regarding these matters, but the information we have received has been disappointing. While we do appreciate the efforts that are being made by HHS officials, particularly those in the field, this effort still appears *ad hoc*, uncoordinated, and without the sense of urgency and priority needed to address the region’s critical needs. Some basic steps have not been taken. For example, Charity needed a waiver from HHS before it could bill for the patients it treats in its “Spirit of Charity” tent facility, a makeshift facility which treats 150 people a day without charge. This waiver has not yet been received. HHS also needs to work with FEMA to determine what Federal funds are available for

The Honorable Michael O. Leavitt
Page 4

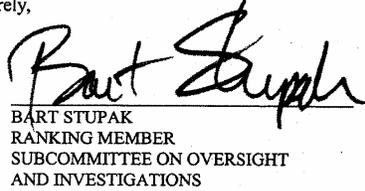
the rebuilding of these public facilities and to make the money available as soon as possible. A strategic plan is needed from your Department – a plan that details the objectives for restoring the healthcare coverage, a list of priority services that must be available, dates for meeting crucial milestones, and officials assigned to carry out those priorities. Billions of dollars will be spent in that region. HHS (and other departments) should put in place a formal written plan and create a task force to help guide these efforts and maximize the funds spent on this recovery. Given our continuing concerns, we request that you answer the questions attached to this letter and that timely staff briefings be scheduled.

We appreciate your attention to this matter and request a response by Friday, December 22, 2005. We also request that your staff contact Committee staff to set up times for briefings. If you have any questions or need additional information, please have your staff contact Christopher Knauer or Edith Holleman with the Committee on Energy and Commerce Minority staff at (202) 226-3400.

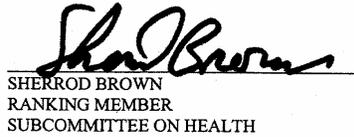
Sincerely,



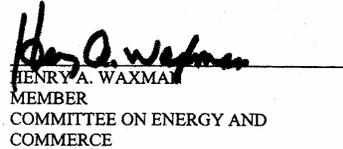
JOHN D. DINGELL
RANKING MEMBER



BART STUPAK
RANKING MEMBER
SUBCOMMITTEE ON OVERSIGHT
AND INVESTIGATIONS



SHERROD BROWN
RANKING MEMBER
SUBCOMMITTEE ON HEALTH



HENRY A. WAXMAN
MEMBER
COMMITTEE ON ENERGY AND
COMMERCE

Attachment

cc: The Honorable Joe Barton, Chairman
Committee on Energy and Commerce

The Honorable Ed Whitfield, Chairman
Subcommittee on Oversight and Investigations

The Honorable Nathan Deal, Chairman
Subcommittee on Health

The Honorable David M. Walker, Comptroller General
U.S. Government Accountability Office

**Questions for the Honorable Michael O. Leavitt
Secretary, Department of Health and Human Services**

1. A written strategic plan developed by HHS for the restoration of healthcare services in the Gulf Coast region would focus the Federal response more effectively. It should include (a) the priorities of where hurricane relief monies for healthcare restoration should be spent, the source of those funds, and detailed reasons for such expenditures; (b) a listing of the healthcare services and institutions that should be restored or rebuilt; (c) the role of various Federal agencies in funding and/or restoring such services; and (d) a schedule for restoration. Has HHS or any other agency developed such a plan? If yes, please attach a copy and include the names of HHS officials responsible for carrying out such a plan. If not, please describe any other strategic planning.
2. Has HHS established a task force to coordinate its response to the destruction of healthcare facilities and systems on the Gulf Coast resulting from Hurricanes Katrina, Rita, and Wilma? If so, please list the purpose of the task force, its members, and their respective responsibilities. If not, please describe how the Department is coordinating the response among its various offices and other government agencies and attach any relevant documentation.
3. Is there an inter-agency task force in place that has as one of its responsibilities coordination of the restoration of the healthcare systems along the Gulf Coast? If yes, please describe the task force, list the HHS representatives, and attach any relevant documentation. If the answer is no, please discuss in detail how the Federal response is being coordinated.
4. Under its Public Assistance program, FEMA is responsible for providing 75 percent of the funds to rebuild public facilities, such as hospitals and community health centers, damaged or destroyed by natural disasters. Five hospitals – three of which are public facilities – and several community healthcare centers were destroyed or severely damaged by Hurricane Katrina. At least one was damaged by Hurricane Rita. In previous disasters, FEMA has not provided funds to rebuild healthcare facilities in a timely manner. Has HHS been briefed regularly by FEMA concerning the status of the reimbursement? Has HHS taken any steps to encourage and facilitate timely payments by FEMA?
5. The current Federal cost share under the FEMA Public Assistance Grant Program is 75 percent, which can be increased in catastrophic disasters. Hurricane Katrina has been classified as an “incident of national significance,” or a catastrophic disaster. Has HHS taken any steps to evaluate whether the Federal share should be increased for these facilities? If so, please describe them. If not, please explain why not.

6. FEMA has the authority to provide emergency shelter for medical personnel on the basis that medical care is an "essential community service." HHS has reported that its Public Health Service team in New Orleans is "working on" housing for healthcare workers. However, *USA Today* recently reported that New Orleans-area hospitals were "in desperate need of staff," mainly because there was no housing for staff ("Gulf Region's Hospitals Struggling after Katrina," *USA Today*, Dec. 5, 2005). What steps is HHS taking to encourage FEMA to respond in a timely manner to these medical needs?
7. Was HHS consulted on FEMA's recent decision to deny a community development grant to Louisiana State University to assist in keeping Charity viable until new facilities could be obtained?
8. In a document presented to staff by Leslie Norwalk, Deputy Administrator of the Centers for Medicare and Medicaid Services (CMS) on November 29, 2005, it is reported that medical care for seniors, persons with disabilities, limited-income families, and children is "being addressed." Please explain what steps have been taken to address this need and if new legislative authority is needed.
9. The health care of the survivors and the existing Medicaid recipients are in jeopardy as long as Louisiana's tax base is in jeopardy. In the House reconciliation bill, there is a provision that would address this issue by providing a 100 percent federal match for all of Louisiana's Medicaid population as well as for evacuees who have been reallocated to other states. Please explain why the Administration is not supporting this bipartisan effort.
10. The Administration has said that it is using FEMA funds to help States set up uncompensated care pools. Please list the states and the amount of funds that have been committed for this purpose. If a State does not have an uncompensated care pool, how does it reimburse providers for giving medically necessary services and supplies for Katrina evacuees who have no other coverage for such services?
11. Please list all of the additional grants and other assistance provided to physicians willing to provide services in areas designated as Health Professional Shortage Areas that were also affected by Hurricanes Katrina, Rita and/or Wilma. Describe any outreach done to providers, local, and state governments to make them aware of this program.
12. Please list all of the State hospital preparedness grants issued by Health Resources and Service Administration to address needs resulting from Hurricanes Katrina, Rita and/or Wilma and the purpose of each of the grants.
13. Please list all of the Crisis Counseling Assistance and Training Program grants for outreach and crisis counseling that were issued by FEMA and being monitored by the Substance Abuse and Mental Health Services Administration to address evacuee needs resulting from Hurricanes Katrina, Rita and/or Wilma and the purpose of each of the grants.

14. Please list all of the applications from provider hospitals that the CMS has received under the Medicare Extraordinary Circumstances Exception provision resulting from Hurricanes Katrina, Rita and/or Wilma and that status of each of those applications.
15. Charity Hospital needs a waiver from CMS to bill for the services that it is providing in its tent facilities. What is the status of this waiver and any other CMS waiver of requirements that would be necessary for payment?
16. Charity Hospital is negotiating with Oschner Hospital to lease some facilities for a small Level I trauma center. Is HHS working with Charity to facilitate the accreditation of this center and its ability to bill patients and obtain Medicare and Medicaid reimbursement? Please describe the steps HHS is taking, if any.
17. Before Hurricane Katrina, Charity Hospital operated a Level I trauma center that served nine parishes in New Orleans and parts of Mississippi. What is the position of HHS and/or the Administration as to whether and when this capability should be restored? What steps is HHS taking to restore this capability? Has HHS and/or FEMA undertaken any action to establish a temporary Level I trauma facility staffed by the Public Health Service or other volunteer medical staff such as those serving as part of the National Disaster Medical System?

MR. STUPAK. To all of our witnesses today, thank you very much for appearing today and thank you for all the work you have done. It goes without saying your efforts truly are heroic and not only at the time of the hurricane and shortly thereafter, and yet you are still here today. One of the disappointments I do have is that we don't have anyone from FEMA here to testify. When we just get word--and did receive word--

that \$406 million has been spent in Louisiana, we don't know if it is for total health care or for the whole State or what it was for. That's why I wish they would have been here.

Let me go a little bit more because I again raise the contrast between HCA and Charity and how it all came about and how it strikes me as we have one entity up and running and yet others are struggling to get up and running. There is no doubt about it, that financial resources are a part of that. Mr. Montgomery, you said most of your money was probably insurance money?

MR. MONTGOMERY. That is correct.

MR. STUPAK. Did you receive any money at all from FEMA or HHS, for evacuation or--

MR. MONTGOMERY. No.

MR. STUPAK. When you evacuated your patients, they went to other HCA hospitals, correct?

MR. MONTGOMERY. That is primarily true. Children's Hospital, one in Texas and one in Little Rock.

MR. STUPAK. Mr. Muller, did you testify that your patients went from your hospital, to the airport, or was that you, Mr. Sewell?

MR. SEWELL. Our patients were transported to a MASH unit set up at the parish jail. We were not informed where their ultimate designation was going to be. In fact, I think a lot of those decisions were being made while patients were in the air.

MR. STUPAK. Who was making those decisions?

MR. SEWELL. I couldn't tell you that. I believe we were being evacuated by the National Guard. And I think they were trying to determine locations for the patients.

MR. STUPAK. The thing that struck me, one of you two gentlemen testified that you went to the airport, asked if your healthcare professionals could help out, and they did and then were told no, they could not help out. Then people were dispersed around the country and the only way their records were with them, they were taped to the person?

MR. SEWELL. There were two or three different testimonies there. I did relate the story of our staff --

MR. STUPAK. Who made that decision, that you had to move them out of the airport and your staff couldn't help out? Medical personnel who are trained, licensed, or certified and you are shorthanded, but they were not allowed to help out. Who would make a decision like that?

MR. SEWELL. I couldn't tell you. My observation was, there were a lot of different agencies at Louis Armstrong Airport, and a lot of very well-intentioned people who were trying to help, but there was little, if

any, coordination, and I think a lot of people who were trying to help were very frustrated in their inability to help.

MR. STUPAK. Was Louis Armstrong Airport ever designated, prior to Katrina, as a site where you would bring patients who needed medical attention?

MR. SEWELL. I don't know that. I believe FEMA established that site using DMAT on Tuesday night, prior to even being authorized by the Governor to do that. I think FEMA acted on their own initiative and set that up.

MR. STUPAK. Mr. Smithburg, today's Times-Picayune says "New Orleans Given a New Lease on Life. General Care Trauma Facility to Return by the Fall."

Is that true or is that a poke and a hope?

MR. SMITHBURG. I would like to quote you, Mr. Stupak. I would characterize our situation at University Hospital as one where FEMA has agreed to a work order to bring up parts of University Hospital temporarily, and the initial work order was for about \$13 million, and it is my understanding--although I can't prove it here under oath--it is my understanding that once FEMA gets into a project, they will continue it through to the end, even if the initial work order did not cover the entire expense.

I think that they way overestimated our situation. We are moving in the right direction, but let me assure you, the committee is moving heaven and earth to get to this point, when as you all so eloquently said, the needs of this community are so desperate. So, we are moving in the right direction and we are cautiously optimistic, but I won't believe it until it happens.

MR. STUPAK. Okay. And you said FEMA now has offered \$13 million to help you make that transition?

MR. SMITHBURG. Yes, sir.

MR. STUPAK. In your estimation, is that going to be enough to cover it?

MR. SMITHBURG. I don't think so. Again, it is my understanding of FEMA regulations that once they commit to a project, they will see it through. I think there will be a lot more damage that is not visible to the naked eye once destructive testing is done. In the case of Charity, we don't expect we can ever bring that back up online for healthcare purposes.

MR. STUPAK. That is the older Charity?

MR. SMITHBURG. Yes. As a temporary facility, we think we could, with baling wire and chicken wire.

MR. STUPAK. How far is University from Charity?

MR. SMITHBURG. Just a couple of blocks away.

MR. STUPAK. Why are they up and running, and you still do not even have the lights on?

MR. SMITHBURG. I can't say for sure why Tulane is up and running, but I think it is because, in part, as Mr. Montgomery noted, they do have insurance, private insurance, or business interruption insurance.

MR. STUPAK. Is it an issue of financial resources?

MR. SMITHBURG. I think it is a combination of an issue of financial resources, but also, the condition of the facilities. I can only speak for mine, and that's because of our very restrained resources over time, we have not been able to reinvest in the physical plant, so clearly our buildings are kind of starting with one arm behind their back before the storm.

MR. STUPAK. Your tent facility that I mentioned, at the Convention Center, that has been there since early October. Correct?

MR. SMITHBURG. We have been operating in tents since October, whether it was in the parking lot or in the Convention Center.

MR. STUPAK. Have you been reimbursed for any of that care since then by FEMA or HHS?

MR. SMITHBURG. No, sir. Millions of dollars really--

MR. STUPAK. Have you applied to FEMA or HHS for reimbursement?

MR. SMITHBURG. We have applied to HHS for a waiver to apply.

MR. STUPAK. Have you received that waiver?

MR. SMITHBURG. No, sir.

MR. STUPAK. How long have you been waiting for the waiver?

MR. SMITHBURG. I will have to check in the record, but I believe, Mr. Stupak, we began talking to them about that--

MR. STUPAK. Why do you need a waiver to provide this healthcare--

MR. SMITHBURG. Our understanding is that under CMS regulations, in order to be reimbursed, you provide care in what is considered standard of care facilities, such as regular hospitals or doctors' offices.

MR. STUPAK. But it is also my understanding that JAHCO has approved your hospital, right? The tents?

MR. SMITHBURG. Yes, they have.

MR. STUPAK. Is that proof, then, for HHS, or do you need more to give HHS?

MR. SMITHBURG. HHS has to do their own independent inspection.

MR. STUPAK. Is that inspection going to be sometime before March 7, before you close?

MR. SMITHBURG. I hope so, sir.

MR. STUPAK. Any date set?

MR. SMITHBURG. Not to my knowledge.

MR. STUPAK. You also pointed out several weaknesses in the disaster preparedness system, including the nonfunctional communications system, lack of a clear chain of command, particularly at the Federal level, but most importantly, you stated that the emergency response cannot exist until a core capacity of the public health system is restored. What do you see as the first step in restoring that system?

MR. SMITHBURG. Trying to identify what safety assets are available in the community and making them available for healthcare use regardless of Government structure or any of the other typical issues one deals with before a catastrophe hits--that we find a way to access those and have the resources to back up our facilities.

MR. STUPAK. And you have done that with this one hospital that you are hoping to have open--

MR. SMITHBURG. We are finishing the paperwork on it, yes, sir.

MR. STUPAK. You have identified and now we need the Federal government to give you those waivers to reimburse you for your care and to get into this new facility as soon as possible?

MR. SMITHBURG. We have reason to believe that once we occupy the Elmwood temporary trauma center, that that will be standard of care as an existing hospital.

MR. STUPAK. Any more questions on waivers, Mr. Chairman?

MR. WHITFIELD. Thank you. Dr. Burgess, you are recognized for ten minutes.

MR. BURGESS. Well, Mr. Smithburg, on the subject of waivers, when Secretary Leavitt came to Dallas and spoke at our medical facility, it was set up rather quickly, but there had been waivers granted because they understood these patients were being seen in facilities that were not standard Medicare-certified hospitals. So, that has not happened in Louisiana?

MR. SMITHBURG. It has not. And I have spoken with the Secretary and the CMS Administrator and his deputies, and certainly, in conversation they are inclined. Regretfully, it has not happened yet.

MR. BURGESS. With the--and I guess you heard my frustration earlier there, there are probably \$200 million of disproportionate share funds from September 30 to December 31 from the last quarter of the year.

MR. SMITHBURG. I can't swear to that.

MR. BURGESS. There are millions of dollars available, and again, I just can't understand why those funds couldn't be made available to you to reimburse you for the care that you are delivering. What is the obstacle there? How can we help you get past that? Because it makes no sense. These are not new dollars that have to be appropriated from somewhere else and we have to find offsets. These are dollars that are

there sitting in some account, unspent. And you have doctors leaving the area because they cannot get paid, and your own employees are just staying out of their own good graces. Is there a way we can help you access those funds--is the State part of the problem here?

MR. SMITHBURG. Dr. Burgess, I think you are right in your assertions and I think all of my colleagues share in the same sentiment that getting access to those DHS dollars is of paramount importance. Keeping in mind a comment made by Congressman Jindal, our State government, constitutionally, there are only two areas that can be cut and that is education and healthcare. The State has got its own economic disaster as well. The special session in the legislature in November, they went through a budget-cutting process. \$200 million budget cut out of New Orleans was done.

As you probably know, the DHS program, you have to put up State-matching and draw-down Federal dollars. The State is having a challenge in generating its own match. So, with some of the Medicaid legislation that has been proposed, well, Medicaid legislation and other legislation, to have a Federal match taking place at the State level for at least some period of time, as relates to DHS, that will be helpful as well.

Then, there probably does need to be some liberalizing of disproportionate share allocation once it gets to the State, so that nontraditional teaching hospitals would have access to at least temporary dollars.

MR. BURGESS. I know in our State we got a waiver that allowed for I think one hundred percent Federal dollars. There was no State match required for treating the displaced persons from the storm. So again, if we can help you get that, that you need that designation--again I'm having trouble why you have not gotten it already--we ought to be able to help you do that.

MR. SMITHBURG. Thank you.

MR. BURGESS. Mr. Sewell, I did visit your facility earlier. Mr. Muller and his group brought me there. I have to tell you my heart goes out to you. It looks exactly like the hospital I used to practice in. I can just imagine what it must have been like for you and your staff. I did hear that same story about your doctors not being allowed to participate in the care of their own patients out at the airport. I think Mr. Muller told me a similar story about the Lakefront airport. Perhaps there is a way, from a hospital or medical staff perspective, that we can help those people gain the credentials they need to get to be part of the federally certified task force, because it is under the control of the Federal government, as I understand it.

Again, I'm new at this and I have trouble understanding the bureaucracy and why it is necessary.

HCA has done great things with the DMAT teams. I had not known you had done that. I think it was a tremendous effort to be able to provide that sort of backup to the guys here on the ground.

I saw Mr. Muller in your parking lot that day in October, just doing a phenomenal job, and taking care of a great number of people in a timely fashion that otherwise would have just put additional pressure on your doctors, in the emergency room.

I will have to say as a resident of Texas and someone who watched the tropical storm Alicia that came through Houston, no levees broke, but it rained 36 inches in an hour and Houston is low, like New Orleans, and they had a lot of trouble with the medical center. And talking about lessons learned, okay, I don't know if it is a JAHCO problem or just a hospital problem, but we have got to do a better job. Again, Mr. Muller, I thank you for having the foresight to do that and get that stuff off the ground. Unfortunately, it just didn't quite get done before the disaster, but clearly it will happen again in low-lying areas.

The same stories of doctors and nurses having to carry the patients down six flights of stairs to the cardiac care unit and bagging them the whole time, that was the story out of Houston in 2001. A reasonable person might have predicted that New Orleans was also at risk for a similar sort of event. Again, I think that is something that needs to be taken care of through the industry and not the Federal government. We talked about lessons learned, and that seems to be one of them. But it does keep happening.

We saw the article in the paper this morning, Mr. Smithburg, and what--it seems like there have been more obstacles in your path to get things up and running, and I guess I'm having a hard time understanding, are those obstacles that we at the Federal level are putting in your way or the State is putting them in your way? Is it just the overall mess of your hospital that has made it more difficult to achieve the same sort of results as across the street with the rebuilding effort?

MR. SMITHBURG. The best I can do, Dr. Burgess, to respond to that is to know that in our environment, the public hospital environment which is also the profession's training program, 70 percent of the health professionals of the State swing through Charity Hospital one way or the other, so we need to find homes for residents and other trainees, either public or private, that have been devastated by the storms. So, at the same time, we are essentially an arm of the State government with its own budget problem. At the same time, trying to work through with FEMA and in particular, I learned through my colleagues at Houston and spent a lot of time with people through lessons learned. FEMA is clearly a marathon, but we are in a sprint environment right now, and so, trying to figure out how to cross that Rubicon of long-term planning under the

FEMA paradigm with today's needs is a challenge and we need your help.

MR. BURGESS. I would just say, I spoke about the safety net, and the hospitals have stayed open, they are certainly to be commended for preserving that. I have to say what I saw your guys doing and the graduate medical student education efforts are continuing, I know that is how you get doctors in your area, is because you train them here and a certain number will stay. That is a tremendous effort put forth by your emergency room doctors and in the tents there at the convention center. That is one of the most encouraging things as far as what does the future look like going forward. To me that is one of the most encouraging things I have seen down here.

Are you planning on being open by Mardi Gras?

MR. SMITHBURG. We hope so.

MR. BURGESS. This year?

MR. SMITHBURG. Yes, sir, we hope so. Right now, the inevitable paper chase has us bogged down. We know what it will take to turn it into a converted trauma center. It will take four to six weeks. We're ready to roll, it is just a matter of it happening.

MR. BURGESS. Mr. Muller, as a representative of one of the only hospitals open during the storm and the aftermath, you have heard people talk about Level 1 trauma centers. Obviously, by default, you are the trauma center right now. Is that correct?

MR. MULLER. That is correct.

MR. BURGESS. And your doctors, neurosurgeons, orthopedists, general surgeons are taking that load upon themselves at this point. Is that not correct?

MR. MULLER. That is exactly correct.

MR. BURGESS. So the stories we hear about four hours to get care, that is not always true, because your hospital has been open and able to service those patients?

MR. MULLER. Thank you for mentioning that. We do it every day and are glad to do it.

MR. BURGESS. How are you looking to get reimbursed?

MR. MULLER. Waivers to have the money follow the patient. Again, we are working through the bureaucracy, basically at the State level.

MR. BURGESS. That is an important concept. Mr. Chairman, if I may. The same thing is true with school children: The money needs to follow the students and the money needs to follow the patients. We need to take that message back.

MR. WHITFIELD. Thank you.

Ms. DeGette, you are recognized for your ten minutes.

MS. DEGETTE. Mr. Muller, you are not certified as a Level 1 trauma center, you're just doing it because you have to do it in the breach, correct?

MR. MULLER. Correct.

MS. DEGETTE. You are not pursuing Federal certification as a Level 1 trauma center, are you?

MR. MULLER. No, ma'am.

MS. DEGETTE. You do need to go get those monies from those waivers, from the DHS money and the other money to be able to sustain this in the short run, correct?

MR. MULLER. Yes, ma'am.

MS. DEGETTE. You can't, over the long run, become a Charity-type hospital, that's not your hospital's business plan or your mission, right?

MR. MULLER. Right.

MS. DEGETTE. I can assume, Mr. Lagarde and Mr. Montgomery, you are doing everything you can and you are going to be doing everything you can, but in the long run, your mission is not to be a Charity Hospital either.

MR. LAGARDE. That's correct.

MS. DEGETTE. I just want to say we are in awe of everybody here. This whole committee is. What we saw yesterday at Charity, what we saw yesterday at HCA was amazing to us. When we saw where you were talking about the heart patient and the MASH unit, and where folks were walking up and down stairs with that person, and that person lived, I mean, that was extraordinary to us. I just want to preface by saying we think everybody in the private and public sector really fulfilled their mission as healthcare professionals, and I want to thank you on behalf of the American citizens for that.

And I also want to say, the other thing that struck some of us yesterday was how much faster the private hospitals have been able to get back on their feet because they have private insurance money. And, really, Charity has been left kind of, as often happens, holding out their cup, begging for Federal and State assistance. And I really want to focus on that. Because I think everybody here would agree, we have to get the hospital back up and running. I mean, we have 1 million people who, before the hurricane in the New Orleans area, did not have health insurance. And while people can help collaboratively, and they have been, in the long run, we are going to have 65 percent of the people come back, which is what the projections are, and we have to get them some health care.

And so, I want to ask you, Mr. Smithburg, in your written testimony you said a necessary first step is restoration of the core capacity of our

public healthcare system. Can you just tell me briefly why you think that is true?

MR. SMITHBURG. Looking at the projections of the population, it is almost like nailing Jello against the wall. And it changes regularly. But what we foresee, at least at LSU, is that while the population may be smaller in New Orleans proper, there is a reasonable chance the number of uninsured, at least the whole number, is going to rise for the foreseeable future.

When you think about the renaissance of New Orleans, it is going to be built in large part on the backs of low-income workers doing dangerous work with little or no access to healthcare. The community hospitals are already taxed. As you noted, their business plan does not plan for a long-term care of the public patients as it does for us. That is our mission.

And so, in order to attract people to come back here, in addition to the work, we have to have some sort of healthcare infrastructure, a safety net, we believe, to accommodate the growing needs, healthcare needs, chronic and acute.

MS. DEGETTE. Mr. Smithburg, when you came back to Washington and talked to the Secretary and others, did they seem to agree with you that we need a strategic plan to restore health care for those folks in New Orleans?

MR. SMITHBURG. The "they" in your question requires a number of different answers. There certainly have been some who left--elected officials or appointed officials who are sympathetic, and in fact, we achieved a great deal of sympathy and we have tried to transfer that into waivers or special dispensations for funding and the like, and in many cases, that has been forthcoming.

MS. DEGETTE. Has anybody from the Federal government or State talked to you about working collaboratively for a specific plan to restore the core healthcare plan for the New Orleans area?

MR. SMITHBURG. Really, it is--

MS. DEGETTE. Or is it more ad hoc with the waivers and so on?

MR. SMITHBURG. As it relates to LSU, we clearly have a strategy that relates to trying to get waivers, trying to lease assets that may be available for the public healthcare needs. I can't say that there is a plan per se forthcoming at either the Federal or State level.

MS. DEGETTE. It is really being driven by your plan?

MR. SMITHBURG. Yes, ma'am.

MS. DEGETTE. Let me talk about the waivers for a minute. Seems like a lot of waivers have been applied for and it seems to me that these waivers are reasonable, to give an extension of time to let these graduate medical students practice at other facilities so that they stay in the area.

Get DHS waivers so that these hospitals that are taking on DHS patients can get some reimbursements in the interim period.

There are some other kinds of waivers, say, for operating your hospital at the Convention Center. There is nothing wrong with the medical care given there. What is wrong is that it doesn't qualify as the standard of care because it doesn't have hard walls, right?

MR. SMITHBURG. That is exactly right.

MS. DEGETTE. It seems to me if you had the waivers already, you would have money coming into the system. Right?

MR. SMITHBURG. I think that is right. To add a corollary, the Congress also has before it a bill that could have a Federal match to the Medicaid program that would affect all healthcare providers to help keep the doors open, and that has not been acted on at the time. As a result, our State has had to cut the Medicaid program at a time when we need it the most.

MS. DEGETTE. So, you need waivers from HHS, from the Executive Branch, but you also need Congress to act on legislation that would help with Medicaid waivers, correct?

MR. SMITHBURG. Yes.

MS. DEGETTE. We are going back into session next week, Mr. Chairman, and I think one of our top priorities for congressional action should be this. I hope we do that.

Well, if we can't get budget reconciliation, we need to put it in some other bill, a stand-alone bill.

I want to ask another question, because having toured your facilities, the old Charity Hospital and there is a University Hospital, and I think there is some consensus that the old Charity is a very dated facility and it may not just be worthwhile to use that as a medical facility, although it may be appropriate for something else.

How much of the delay you folks have had getting back up and running is due to discussions about how do you reconfigure the way that you are delivering health care to the indigent, given the strange opportunity that you know you are having to start from scratch, recognizing this is more of a marathon than a sprint?

MR. SMITHBURG. As it pertains to dealing with FEMA, the discussion has been more about logistics. With regard to our future replacement and recognizing this is more of a marathon than a sprint, we do have a plan to replace ourselves and to replace ourselves with a smaller footprint.

If FEMA were to determine that Charity Hospital and University Hospital were totaled, according to their recipe, we would theoretically be eligible for replacement dollars.

MS. DEGETTE. FEMA is going to make that determination?

MR. SMITHBURG. You know, we don't know. We have been pressing very hard for the FEMA road map and they just now have agreed that they will begin to share with us their road map.

Again, I have visited with my friends in Houston and Southern California after the earthquake, and it was five years or more before any real resolution with FEMA was reached.

MS. DEGETTE. You have got the temporary solution that you are going to open some emergency facilities through University Hospital. Is that going to be a Level 1 trauma center?

MR. SMITHBURG. It's our hope to convert it into a small Level 1 trauma center.

MS. DEGETTE. How many patients will that be able to handle?

MR. SMITHBURG. We have not gotten that far yet because we need to get deeper into the evaluation of the University, but we can tell you this: We are hoping to bring online about 200 beds. Some of these will be critical care beds, some of these will be bassinets. But we don't really have the projections yet.

MS. DEGETTE. When will you have those projections?

MR. SMITHBURG. I wish I knew the answer to that. It takes a while, working with FEMA.

MS. DEGETTE. Does FEMA have all the information from you folks they need to make these decisions? I'm just trying to figure out what the reason for this delay is.

MR. SMITHBURG. I know we have provided them with really thousands of pages of technical engineering reports and the like on the conditions of the building.

MS. DEGETTE. When did you give them that information?

MR. SMITHBURG. In November.

MS. DEGETTE. And they have given you no indication of when you are going to hear from them?

MR. SMITHBURG. We are in active, regular dialogue with them, but timeframes and roadmaps have been difficult to acquire.

MS. DEGETTE. I yield back my time.

MR. WHITFIELD. Mrs. Blackburn, you are recognized for ten minutes.

MRS. BLACKBURN. Thank you, Mr. Chairman. I appreciate that. Again, I thank all of you for your endurance this morning.

We have talked a lot about the reimbursement. Mr. Smithburg, I know you would like to catch your breath, you have been talking endlessly. There are some other things we want on the record. I am going to ask you all to endure with me because we have been making notes as quickly as we can, as you have talked.

I want to focus on the operations end and move to that for just a moment so that we have some of that information from you for the record.

One of the things we are tasked with, and the Chairman has touched on it, Mr. Stupak has touched on it, is looking at who is responsible for what, and beginning to clearly define and draw some bright white lines so that going forward, as we talk about what we have learned, we figure out who is responsible for what and where decisions are to be made, where the responsibility lies.

So, this is what I'm going to do. I'll just read through this series of questions with you, and if you all make your notes and just respond per entity, that will be great. I am going to ask you to do it as a written response, I'm not going to ask you to sit here and we will go down the line and do A, B and C. I would like to have some thoughtful responses from you, because if we come in here and we say, the system is broke, it's a mess, Government is too bureaucratic, nobody can respond to this, da-da-da, then we don't make any progress.

Our goal should be very simple: It should be to preserve access to healthcare for our constituents. Our problem is how we get there.

So, I know that a lot of our rural hospitals have disaster plans that they go through to manage catastrophes, and I see that in my district in Tennessee. Many times those are supplemented with guidelines from the AHA through a disaster readiness report. I know that HCA has a Disaster Readiness manual. Mr. Muller, I think from--I have figured out from your testimony, you-all have a very complete one and I appreciate that.

I would like to know if each of your hospitals have a similar Disaster Readiness manual, and in addition to just having the manual, do you have an implementation plan, because reading through the testimony, I think one of the things we are figuring out is that you have words on paper, but you do not have a game plan for how to best get this into practice if it really happened; and do your plans include a network of supporting hospitals to which you are going to turn? Do each of the departments in your hospital have a copy of this? Do they have team leaders, and do they have a chain of command?

And Mr. Muller, you referred to this and I appreciate that you did. Is there an operating chain of command so that they know who is in charge? How often do you go through the process with your team? As you look at attrition and bringing in new people, how often are you talking with them about how to get it done? How often do you practice these drills? Are you giving lip service to it or are you putting your forces behind this to be certain that they understand that?

Let's talk about generators, because we had a lot of this in the testimony. I was reading about all these generators and I did some digging getting ready for this hearing, and I come across a report, Hospital Security and Safety Management, December 1995, special report, "Recent Manmade and Natural Disasters, Testing the Hospitals and Their Readiness."

In here, it talks about New Orleans and it talks about New Orleans getting 19 inches of rain in eight hours. And it talks about the generators and the flooding.

Now, this was '95, so I want to know: How were your generators--when was the last time you had them tested; did you do as recommended and move them to upper floors, or were they still in the basement? Your potable water, the supply for that, was it in the basement or was it moved to an upper floor?

Your fuel supply for the generators, what were you looking at as your fuel supply for your generators? What was your storage capacity, what was the length of the expectation; and fuel supply, let me know if it is electric or if you are going to fuel, let me know what in your capacities are going to battery. I would love to know that too.

The Louisiana State evacuation plan, how familiar you are with that? The plan states that hospitals have to put their generators and their potable water on upper floors in order to obtain an operating permit. So, are your permits up for review on a periodic basis? When were your operating permits last reviewed prior to Katrina, did your hospitals comply with the upper floor requirement of the plan and did the review examine this? And if not, why not?

In order to make a decision--and the Chairman talked about this a little bit with your evacuation--I would love to know what your chain of command is for making a decision. One of you is a parish hospital and we have got public and we have got private. What is that chain of command? What is that readiness of availability of that chain of command during a time of emergency?

This is what I want to know: If we gave you the pen and if you wrote the laws, what would you, if you were to write the rules, the regulations, and the laws, I would like to know what you would abolish.

Mr. Muller went through this in his testimony and I appreciate that. That's the kind of information that is helpful to us.

Let's talk about communications. Some of you mentioned the HAM radio worked for you, some of you had mentioned the cell phones and satellite phones did not. We had a hearing on this in DC and I know VoIP was used by a couple of people. I would like for you to talk to us about your communications plan and where you are going to go with

this. How are you going to layer in these different technologies to be certain that you have a workable communications plan?

Mr. Chairman, I think that as our committee works on the communication transition, and the analog spectrum becomes available, what we are hearing today is one of the reasons that the analog spectrum needed to be made available for first responders and military, so that they have that to work from.

Couple of things on supplies, because one of the consistent things in your testimony is that you had about four days of supplies, and having four days of backup and supplies, I would like to know if you-all have changed your procedure and if you are looking at having a 7-day supply of your critical items. Are you still working from a template that says four days of supplies? I know that some of these folks last week in Mississippi were talking about they had changed that and were looking at a 7-day supply. So, I would like to know, as a policy change, if you have made that as a change.

Also, on your supplies, we had most of the hospitals closed and a few open, so, if you were to have a surge of flu patients, as we talked about having facilities that are not Level 1 trauma facilities filling that need, and we talked about New Orleans coming back around, have you changed your plan so that you have emergency supplies in order to be able to accommodate that? I think that is important.

One final question I have for with you, another article I found is a 1999 article by Dr. Andrew Milstein on "Hospital Response to Acute Onset Disasters." If you have not read it, I recommend that each of you read it. It is absolutely excellent. One thing he points out on page 37 of this article, it is talking about Hurricane Camille. I was a senior in high school when Hurricane Camille hit. I remember it very, very well. It talks about Hurricane Hugo. It talks about since Hurricane Hugo, more deaths have occurred during the post-impact period than during the impact phase.

I would think as healthcare professionals, this is something that we all need to be aware of, and that we would be hopeful that all of you are aware of.

With that, I will yield back my time, and again, I hate to give you homework, but I am so appreciative of you-all being here, of working with us, and I hope that you accept this as our desire to be a partner with you, working through this as we address the healthcare. I hope that we learn lessons from you that are applicable to each of our congressional districts, and that we spend that time together.

Mr. Chairman, I thank you.

MR. WHITFIELD. Thank you. I know you are going to be excited by answering these questions. We may have some additional questions for you as well.

At this time, I recognize Ms. Schakowsky for ten minutes.

MS. SCHAKOWSKY. Thank you. Our witness that is coming on the second panel from HHS is going to testify that HHS has, at least as I understand it, issued all the waivers that are necessary for healthcare providers to continue to get reimbursements. Seven pages of the 21-page testimony are talking about all of the different waivers that have been put in place. We talked about the 1115 waiver, 1135s. Has anybody received any of that money?

Let me ask you this: I understand on November 10, Louisiana received approval for the 1115 Medicaid waiver ensuring that certain Katrina victims will receive temporary enrollment in Medicaid through January 31, 2006. Has the State received approval to extend this deadline? All right. Obviously that is an issue that we will have to follow up on.

I wanted to ask about the potential for future problems. Obviously, you want people to come here for Mardi Gras, we understand the economic impact of that, but still, I want to ask: if the city of New Orleans is able to respond to another disaster, perhaps like another Katrina or a severe flu epidemic, or now the big Avian flu epidemic, or carnival, and so on, what is the plan? Anyone who wants to answer?

MS. FONTENOT. I will be happy to speak to that. I have been involved in that as well as with EMS providers. I can tell you that as people have stated before, we are in a healthcare crisis. On any given day there are anywhere between 10 and 40 acute beds available, and that is not just Orleans Parish, but Region 1, including Plaquemines, St. Bernard, Jefferson, and Orleans Parish. So, we are one bus crash away from a major disaster, and I think the emergency room doctors that are at the institutions up and functioning will verify that.

We have been in planning with formal representation, but clearly we have limitations. We are working together to establish a central command and control for EMS for Orleans and Jefferson Parish, and there is a website that is good at updating, and we ask them to update those more rapidly because it has been a daily, so that EMS and Central Control and Command Center can access the web site to see where beds are available. It is specific.

MS. SCHAKOWSKY. Literally, it says here, thousands of beds at various locations. Is that feasible or are any of these units available? Have you asked for them?

MS. FONTENOT. There have been--I know Dr. Guidry is on the next panel, and he may be able to give you more accurate and updated to

information. We have asked for military assets. And I'm not sure where those requests stand. I am told that with the stretch already on the military medical operations, those may not be forthcoming.

MS. SCHAKOWSKY. Is he part of your planning unit?

MS. FONTENOT. He is the State Medical Officer and he always has a representative at the meeting.

MS. SCHAKOWSKY. Now, sir, you stated that your hospital was the only inpatient and emergency provider in St. Bernard Parish. Despite the lack--there were 8,000 people back in St. Bernard and your facility remains closed. Right?

MR. SEWELL. That is correct.

MS. SCHAKOWSKY. Are you intending to reopen it?

MR. SEWELL. No decision has been made at this time. They are still trying to ascertain the total amount of damage, but if a presence is rebuilt there, it will most likely involve razing the current hospital and constructing a totally new one.

MS. SCHAKOWSKY. And in the meantime, who is supposed to provide medical care for the citizens of St. Bernard Parish? Is it spread around?

MR. SEWELL. There is a clinic operating, I believe FEMA is operating it, it is in a Wal-Mart parking lot. I believe that is the only provider of care. There are no inpatient providers.

MS. SCHAKOWSKY. You stated, and I don't recall if you said in your oral testimony, that as your medical staff, which was evacuated to the airport, along with 2,000 patients, your staff were not allowed by FEMA to provide care because they were not authorized, even though they are clearly licensed by the State of Louisiana. So, credentialing of volunteer medical staff is a major issue. What do we need to do about that?

MR. SEWELL. I'm not sure. My heart went out to the gentleman who was overseeing the MASH unit there, Dr. Ed Thornton from the Texas DMAT. He clearly was understaffed, and we had actually overheard him asking some other agency officials for some help, because they needed to move a lot of patients from one area to another and needed to change where they were staged. We overheard him asking for help and then offered him help. He said to me at the time, "I need to inform you that you are not authorized to do this, but you know the drill: We need your help and we will take what you can give us."

At that time, our staff attempted to do what we could to help them. They were tending to patients and mopping floors. It was some time after that, that some other individual noticed we didn't have the correct shirts on or the right acronyms on the back, and informed us that we were not sanctioned to do that and asked us to move away.

MS. SCHAKOWSKY. So you were asked to move away?

MR. SEWELL. Yes.

MS. SCHAKOWSKY. That seems like an obvious thing to correct.

I want to address the mental health situation. I don't know if anyone here is especially capable of answering that, but we all read about it and some of you may know of it personally, situations where people have committed suicide or are suffering from severe depression. Can anybody describe the capabilities of addressing any mental health issues?

MR. MULLER. If I could, that was a pre-Katrina problem and is a much more acute post-Katrina problem. There are several areas. It is a daily problem at every provider because we can't hold mental health patients because there are no available inpatient beds. At the same time, the outpatient treatment can be done, but it slows down everything in the ED for the patients who can come in. The good doctors get them outpatient treatment and give them meds.

MS. SCHAKOWSKY. Speaking of medication, we have heard about problems with Medicare Part D around the country and availability of medication. Is that a problem? Has it complicated the situation here?

MR. MULLER. It continues to be a problem. The elderly are very confused. We have a program at West Jeff that attempts to educate the best we can every elderly patient that comes in to the hospital. It is very, very confusing.

Now, with that being said, it is going to work eventually, probably, but it will be awhile.

MS. SCHAKOWSKY. Mr. Montgomery, we were pleased to hear yesterday that HCA will be opening by the end of February, or some services will. Do you have an emergency room here in the central city? Will your hospital be able to treat Medicaid and underinsured patients everywhere, or will they be sent elsewhere?

MR. MONTGOMERY. They will be treated here.

MS. SCHAKOWSKY. I wanted to ask some more questions about communications. Again, I feel frustrated because--we are all frustrated,--but what kind of communication system should be established to work in case of such a disaster? Can something be done rapidly as we approach the hurricane season again? Are there steps being taken to get there right now and should it be interoperable between all respondents, not just hospitals, but police, fire, sheriff, and all the emergency facilities? Are you working on that now?

MR. SMITHBURG. I will take a crack at it. To be blunt, and this will probably come across as sounding a little self-serving, but we learned in Katrina that at the end of the day, you have to take care of yourself, and take care of others if you can, but you have got to take care of those in your charge. That, in fact, I think relates to communication. While interoperability would be ideal, we have learned that HAM radio is

something we are going to have to continue to invest in and grow that network, and that will be our fallback position. That worked. Again, it is slow. The intermittency of the police radios that we relied on is not sufficient if we have a catastrophe of that level. I am sure there are lots of solutions out there, but at the end of the day, at least in the near term, we have to focus on what we have to do for ourselves. I hate to sound that way, but that is the way things are.

MS. SCHAKOWSKY. Back to the future, huh? HAM radios.

Thank you.

MR. WHITFIELD. I want to thank this panel very much. It has been truly enlightening. We recognize there are several significant problems still out there, and I guess that is always the case when you are dealing with the local government, State governments and particularly with the complexity of our healthcare system. I think we are going to leave New Orleans, thanks to this panel, with certain clear understandings of precisely what the problems are here. I think as everyone has indicated to you, we want to do everything we can to expedite the reopening of all of these facilities and continue to deliver effective healthcare in this area.

So I commend all of you and I thank you for your time and your expertise and your commitment and enthusiasm. With that, the first panel is dismissed and we will now call the second panel.

On the second panel today we have Dr. Jimmy Guidry, who is the Medical Director and State Health Officer for the Louisiana Department of Health and Hospitals, and we also have with us Dr. John Agwunobi, who is the Assistant Secretary of Health, United States Department of Health and Human Services.

I want to remind you both, we are holding an investigative hearing. When doing so, it is our practice to take testimony under oath. Do you have any objection to testifying under oath this morning?

I would advise you that under the rules of the House and the rules of the committee, you are entitled to be advised by legal counsel, and I would ask: Do either of you desire to be advised by legal counsel today?

So, if both of you would simply rise, and I would like to just swear you in at this time. Raise your right hands.

[Witnesses sworn.]

MR. WHITFIELD. You are now sworn in. Dr. Agwunobi, we will ask you to give your five-minute opening statement.

TESTIMONY OF DR. JOHN O. AGWUNOBI, ASSISTANT SECRETARY OF HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND DR. JIMMY GUIDRY, MEDICAL DIRECTOR AND STATE HEALTH OFFICER, LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

DR. AGWUNOBI. Thank you, sir.

Before I begin, I should probably state that prior to serving in this role, Assistant Secretary of Health and Human Services, I served as a State Health Officer, a counterpart of Jimmy's, in the State of Florida. And we went through a number of hurricanes, with 200 hospitals as our responsibility. I just want to say that the hospital leaders of this community are absolutely outstanding, by all of the standards that I have seen out there, as a group and as individuals. They have seen their hospitals through some extremely, extremely tough times, and my hat is off to them.

Mr. Chairman and members of the subcommittee, I'm extremely happy to be here.

The past few months have been a very challenging time for HHS and the Nation as a whole, but we are proud of our efforts to date. HHS's response to the hurricane disaster has been led from the very beginning by Secretary Leavitt. He has been extremely engaged and has been a participant at each step of the way and in the affected areas, announced that he was making available the Department's full complement of emergency response assets and resources to States, hospitals, and citizens in general. He has not held back.

On August 29, 2005, Hurricane Katrina struck the Gulf Coast just east of New Orleans, near Gulfport, Mississippi. The storm's impact was significantly increased by the failure of the levee around New Orleans on August 30. On September 23, 2005, Hurricane Rita made landfall east of Port Arthur, Texas. The storms forced the evacuation of over 4 million people, destroyed tens of thousands of businesses and over 100,000 homes, forced the long-term relocation of over 685,000 families, destroyed at least eight hospitals, and were responsible for the deaths of over 1,200.

By comparison, the four Florida hurricanes of 2004 required the long-term relocation of 20,000 people and at the time set a record for that statistic.

HHS Secretary Mike Leavitt declared a public health emergency in the affected areas and announced he was making available the Department's full complement of emergency response assets and resources to States, municipalities, hospitals, and others in need of public

health assistance for response to Hurricane Katrina. The HHS operations center, which operates 24 hours a day, increased its staff and was in constant communication with State and local emergency management operations, as well as other Federal departments.

Several of the agencies and the Department have responsibility for hurricane and disaster preparedness efforts. To respond to this unprecedented natural disaster in our Nation's history, the Health Resources and Services Administration (HRSA), U.S. Public Health Service Commissioned Corps, and the Centers for Medicare and Medicaid Services (CMS) undertook extensive efforts, which I will discuss below.

During the hurricanes of 2005, several States were able to directly and indirectly aid in the recovery and restoration of health and medical care to the most severely impacted Gulf States. As a result of funds awarded through the HRSA National Bioterrorism Hospital Preparedness Program, North Carolina and Nevada provided on site mobile medical facilities and associated medical teams, supplies, and equipment to support these facilities. Other States that received large numbers of evacuees, many with pre-existing health conditions that had gone untreated for many days and weeks, were able to exercise surge plans, assemble and credential extra medical personnel, and have adequate supplies of medications and equipment ready to receive and treat evacuees. Other States were able to donate communications equipment to the most severely impacted States to begin reestablishing communications with healthcare partners.

In the case of Katrina, HRSA's Emergency Systems for Advance Registration of Volunteer Health Provisions Program (ESAR-VHP) began working shortly after the hurricane made landfall. This program worked with 21 States to provide as-needed assistance in the registration, credential verification, and deployment of volunteer medical and healthcare professionals to the Gulf region. Based on preliminary figures, those 21 States reported sending over 8,300 pre-credentialed volunteer medical and healthcare providers to assist in the Katrina response. To accomplish this, the ESAR-VHP program developed a temporary online registration and credential verification system that was used by seven States that had not yet started developing their ESAR-VHP systems.

Secondly, the program successfully negotiated with major physician and nurse credentialing organizations for free verification of volunteer credentials for the duration of the emergency.

Finally, the program assisted States in working with their State's emergency management agency to deploy health and medical personnel through the emergency management assistance compact in compliance

with the national response plan. Per requests from Louisiana, the HHS Office of the Surgeon General provided extensive support through the Commissioned Corps. We supported a Secretary's Emergency Response Team in Baton Rouge, with responsibility for all Emergency Support Function No. 8 incident leadership, command, operations, and logistics; provided assistance for environmental health support for water, wastewater, sewer system, and food safety issues at schools, child care centers, shelters, nursing homes, restaurants, pharmacies, and other retail establishments; supported FEMA and the Strategic National Stockpile by coordinating distribution of pharmaceutical caches to response teams; staffed Special Needs Shelters across Louisiana to care for people who had been displaced from nursing homes, assisted living centers, and private homes during both Katrina and Rita. These people were almost exclusively elderly, most had ambulation problems, many were on oxygen, and quite a few required electronic device support to sustain life; staffed 3,550 beds in Federal medical shelters that were established to receive special needs patients and lower acuity hospital patients in Louisiana; supported two animal rescue shelters in Louisiana; worked with Disaster Mortuary Operations Response Teams and Family Assistance Centers in Louisiana to collect and identify the deceased and trying to match grieving families with loved ones; visited shelters throughout Louisiana to provide tetanus, influenza, and other common vaccines; and staffed the Surgeon General's Call Center, which recruited 34,000 plus civilian volunteers willing to deploy as nonpaid HHS employees. As a result, more than 800 civilians were federalized and served in Louisiana.

We formed public health teams to assess the health status of the population as well as the medical capacity of the impacted States, provided mental health services in cooperation with the State Department of Education to reach 200,000 school children that were dealing with behavioral health issues related to the storm; evaluated a large number of hazardous waste, petroleum spills, and chemical sites in the impacted States.

During this multi-State, multi-event response by over 2,500 Commissioned Corps officers and 1,400 nonpaid HHS civilians, they distinguished themselves in hundreds of ways with their exceptional work to support the citizens of Mississippi, Louisiana, Texas, and Florida. The dedicated service of Corps officers in this deployment truly made an impact on the health status of the stricken people in the Gulf States.

The Centers for Medicare and Medicaid Services has acted to assure that the Medicare, Medicaid, State Children's Health Insurance Programs and the Clinical Laboratory Improvement Amendments of 1988 have

accommodated the emergency healthcare needs of beneficiaries and medical providers in States directly affected by Hurricane Katrina this year. As part of the HHS effort to quickly aid beneficiaries and providers, Secretary Leavitt invoked time-limited statutory authority under Section 1135 (b) of the Social Security Act to permit CMS and its agents to waive or modify certain requirements or modify certain deadlines and timetables for the performance of required activities to ensure that sufficient healthcare items and services are available. The 1135 waivers have and will continue to assist States directly affected by Hurricane Katrina and States hosting evacuees.

Furthermore, the Secretary authorized several Section 1115 demonstrations, under which States may apply on a demonstration basis. These demonstrations help States to provide coverage to evacuees from the affected geographic areas of Louisiana, Mississippi, and Alabama, in which a natural disaster, consistent with the Stafford Act, has been declared.

In addition, CMS temporarily relaxed and waived many of the policy and billing requirements for hospitals and other providers to accommodate the emergency healthcare needs of beneficiaries and medical providers in the Hurricane Katrina-affected States.

Residents of the States affected by the hurricane and the providers in all States that are assisting victims have faced extraordinary circumstances, and CMS fully supports the efforts of all providers to offer assistance. Further, State agencies and their staff were an important and crucial part of the preparation and response and continue to be an intrinsic part of the recovery phases. Hurricane Katrina demonstrated the importance of our partnership with State agencies as contacts for communications, advocates, links for resources, and facilitators for the provision of healthcare for all of those in need of care.

In partnership with States, CMS has acted to speed the provision of healthcare services to the elderly, children, and persons with disabilities by relaxing normal operating procedures until providers can reasonably be expected to continue under the normal requirements. The agency has been working closely with State medical agencies to coordinate resolution of interstate payment agreements for recipients who are served outside their home States.

CMS moved quickly to support efforts of the healthcare community. The agency made short-term administrative adjustments to our Medicare and Medicaid payment rules. CMS implemented a flu Medicaid template waiver that provides for immediate, temporary and Medicaid coverage and financial support for medical services that fall outside of standard Medicaid benefits, all using existing systems in affected States to put them into service quickly and effectively. In addition, CMS

quickly established multiple strategies to communicate with affected providers about the changes. For instance, CMS posted question and answer documents on the CMS website; held special “open door forums” and arranged meetings with the affected States, national and State provider associations, and individual providers.

Mr. Chairman and members of the subcommittee, Hurricane Katrina caused severe devastation. However, the network of compassion and caring demonstrated by Federal, State and local officials as well as healthcare providers and others was a profound and powerful manifestation of the greatness of this country. Providers rushed to care for those in need without even considering payments or program requirements. Providers who were personally affected by the hurricane as well as those in area shelters and evacuees have provided extensive medical service under the most challenging conditions. Our role is to support better efforts to care for seniors, people with a disability, children, and facilities with limited means and anyone else who needs care and has nowhere else to turn.

I want to assure you, Mr. Chairman and members, that HHS is actively focused on working with the affected communities. HHS will continue its efforts to work with hospitals and other facilities and ensure that they have adequate emergency plans in place should a disaster occur. And we are constantly reassessing the state of our preparedness for natural disasters as well as terrorist attacks and disease outbreaks, in order to ensure the best outcomes for our future.

I will stop there, and I will be happy to answer any questions.

[The prepared statement of Dr. John O. Agwunobi follows:]

PREPARED STATEMENT OF DR. JOHN O. AGWUNOBI, ASSISTANT SECRETARY OF HEALTH,
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to discuss the Department of Health and Human Services (HHS) emergency preparedness strategies. The past few months have been a challenging time for HHS and our nation as a whole.

On August 29, 2005, Hurricane Katrina struck the Gulf Coast just east of New Orleans, near Gulfport, MS. The storm’s impact was significantly increased by the failure of the Lake Pontchartrain levee around New Orleans on August 30th. On September 23, 2005 Hurricane Rita made landfall east of Port Arthur, Texas. The storms forced the evacuation of over 4 million people, destroyed tens of thousands of businesses, and over 100,000 homes, forced the long-term relocation of over 685,000 families, destroyed at least 8 hospitals, and were responsible for the deaths of over 1,200 people. By comparison, the four Florida hurricanes of 2004 required the long-term relocation of 20,000 people, and at the time, set a record for that statistic.

HHS Response to Hurricane Disasters

HHS Secretary Mike Leavitt declared public health emergencies in the affected areas and announced he was making available the Department’s full complement of

emergency response assets and resources to states, municipalities, hospitals and others in need of public health assistance for response to Hurricane Katrina. The HHS Operations Center, which operates 24 hours a day, increased its staff and was in constant communication with state and local emergency management operations, as well as other federal departments.

Several of the Agencies within the Department have responsibility for hurricane and disaster preparedness efforts. To respond to this unprecedented natural disaster in our nation's history, the Health Resources and Services Administration (HRSA), US Public Health Service Commissioned Corps, and the Centers for Medicare & Medicaid Services (CMS) undertook extensive efforts, which I will discuss below.

Health Resources and Services Administration Response

During the hurricanes of 2005, several states were able to directly and indirectly aid in the recovery and restoration of health and medical care to the most severely impacted Gulf States. As a result of funds awarded through the HRSA National Bioterrorism Hospital Preparedness Program, North Carolina and Nevada provided on-site mobile medical facilities and associated medical teams, supplies and equipment to support these facilities. Other states that received large numbers of evacuees, many with pre-existing health conditions that had gone untreated for many days and weeks, were able to exercise surge plans, assemble and credential extra medical personnel and have adequate supplies of medications and equipment ready to receive and treat evacuees. Other states were able to donate communications equipment to the most severely impacted states to begin re-establishing communications with healthcare partners.

In the case of Katrina, HRSA's Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program began working shortly after the hurricane made landfall. The ESAR-VHP program worked with 21 states to provide "as-needed" assistance in the registration, credential verification, and deployment of volunteer medical and healthcare professionals to the Gulf region. Based on preliminary figures, these 21 states reported sending over 8,300 pre-credentialed volunteer medical and healthcare providers to assist in the Katrina response. To accomplish this, the ESAR-VHP program developed a temporary on-line registration and credential verification system that was used by seven states that had not yet started developing their ESAR-VHP systems. Secondly, the program successfully negotiated with major physician and nurse credentialing organizations for free verification of volunteer credentials for the duration of the emergency. Finally, the program assisted States in working with their State emergency management agency to deploy health and medical personnel through the Emergency Management Assistance Compact in compliance with the National Response Plan.

US Public Health Service Commissioned Corps Response

Per requests from Louisiana, the HHS Office of the Surgeon General provided extensive support through the Commissioned Corps (CC):

- Supported a Secretary's Emergency Response Team (SERT) in Baton Rouge, with responsibility for all Emergency Support Function #8 incident leadership, command, operations, and logistics.
- Provided assistance for environmental health support for water, wastewater, sewer system, and food safety issues at schools, childcare centers, shelters, nursing homes, restaurants, pharmacies, and other retail establishments.
- Supported FEMA and the Strategic National Stockpile by coordinating the distribution of pharmaceutical caches to response teams.
- Staffed Special Needs Shelters across Louisiana to care for people who had been displaced from nursing homes, assisted living centers and private homes during both Katrina and Rita. These people were almost exclusively elderly,

most had ambulation problems, many were on oxygen, and quite a few required electronic device support to sustain life.

- Staffed 3,550 beds in Federal Medical Shelters that were established to receive special needs patients and lower acuity hospital patients in Louisiana.
- Supported two animal rescue shelters in Louisiana.
- Worked with Disaster Mortuary Operations Response Teams and Family Assistance Centers in Louisiana to collect and identify the deceased and trying to match grieving families with loved ones.
- Visited shelters throughout Louisiana to provide tetanus, influenza, and other common vaccines.
- Staffed the Surgeon General's Call Center which recruited 34,000 + civilian volunteers willing to deploy as non-paid HHS employees. As a result, more than 800 civilians were federalized and served in Louisiana.
- Formed public health teams to assess the health status of the population as well as the medical capacity of the impacted states.
- Provided mental health services in cooperation with the State Department of Education, to reach 200,000 school children that were dealing with the behavioral health issues related to the storms.
- Evaluated a large number of hazardous waste, petroleum spills, and chemical sites in the impacted states.

During this multi-state, multi-event response by over 2,500 Commissioned Corps officers, and 1,400 non-paid HHS civilians, they distinguished themselves in hundreds of ways with their exceptional work to support the citizens of Mississippi, Louisiana, Texas, and Florida. The dedicated service of Corps officers in this deployment truly made an impact on the health status of the stricken people of the Gulf States.

Centers for Medicare & Medicaid Services Hurricane Disaster Efforts

The Centers for Medicare & Medicaid Services (CMS) has acted to assure that the Medicare, Medicaid, State Children's Health Insurance Programs, and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) have accommodated the emergency health care needs of beneficiaries and medical providers in states directly affected by Hurricane Katrina this year.

As part of the HHS effort to quickly aid beneficiaries and providers, Secretary Leavitt invoked time-limited statutory authority under section 1135(b) of the Social Security Act to permit CMS (and its agents) to waive or modify certain requirements, or modify certain deadlines and timetables for the performance of required activities, to ensure that sufficient health care items and services are available. The 1135 waivers have and will continue to assist states directly affected by Hurricane Katrina and states hosting evacuees. Furthermore, the Secretary authorized several section 1115 demonstrations, under which states may apply on a demonstration basis. These demonstrations help States to provide coverage to evacuees from the affected geographic areas of Louisiana, Mississippi, and Alabama, in which a Natural Disaster, consistent with the Stafford Act, has been declared.

In addition, CMS temporarily relaxed and waived many of the policy and billing requirements for hospitals and other providers to accommodate the emergency health care needs of beneficiaries and medical providers in the Hurricane Katrina affected states.

Residents of the states affected by the hurricane, and the providers in all states that are assisting victims have faced extraordinary circumstances and CMS fully supports the efforts of all providers to offer assistance. Further, state agencies and their staff were an important and crucial part of the preparation and response and continue to be an intrinsic part of the recovery phases. Hurricane Katrina demonstrated the importance of our

partnership with state agencies as contacts for communications, advocates/links for resources, and facilitators for the provision of health care for all of those in need of care.

In partnership with states, CMS has acted to speed the provision of health care services to the elderly, children, and persons with disabilities by relaxing normal operating procedures until providers can reasonably be expected to continue under the normal requirements. The Agency has been working closely with state Medicaid agencies to coordinate resolution of interstate payment agreements for recipients who are served outside their home states.

CMS moved quickly to support efforts of the health care community. The Agency made short-term administrative adjustments to our Medicare and Medicaid payment rules. CMS implemented a new Medicaid template waiver that provides for immediate, temporary Medicaid coverage and financial support for medical services that fall outside of standard Medicaid benefits, all using existing systems in affected states to put them into service quickly and effectively. In addition, CMS quickly established multiple strategies to communicate with affected providers about the changes. For instance, CMS posted question and answer documents on the CMS website; held special "Open Door Forums;" and arranged meetings with the affected states, national and state provider associations, and individual providers.

CMS Requirements for Emergency Situations

CMS works with a number of different entities, including state government agencies, professional associations, and contractors to ensure that entities receiving Medicare and Medicaid payments comply with established requirements for their provider type. These requirements are referred to as Conditions of Participation (CoPs) and Conditions for Coverage (CfCs). Besides requiring that providers have policies and procedures in place to ensure quality of patient care, these conditions also require that providers are adequately prepared to continue treating patients if an emergency situation occurs.

These conditions, which may reference other consensus standards such as the National Fire Protection Association codes, require organizations to have emergency contingency plans in place, for which requirements vary by provider type. CMS uses state health agencies and accrediting organizations to determine whether health care providers and suppliers meet Federal standards. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called "deeming") meet or exceed Medicare standards.

Regulations and guidance for hospitals

Hospitals are required to comply with CMS conditions of participation. As such, the hospitals must develop and implement a comprehensive plan to ensure that the safety and well-being of patients are assured during emergency situations. The hospital must coordinate with Federal, State, and local emergency preparedness and health authorities to identify likely risks for their area (e.g., natural disasters; bioterrorism threats; disruption of utilities such as water, sewer, electrical communications, and fuel; nuclear accidents; industrial accidents; and other potential mass casualties) and to develop appropriate responses that will assure the safety and well-being of patients. Further, there must be emergency power and lighting in at least the operating, recovery, intensive care, and emergency rooms, and stairwells. In all other areas not serviced by the emergency supply source, battery lamps and flashlights must be available. Also, there must be facilities for emergency gas and water supply; however, there is no duration specified for the fuel supply.

In an emergency, CMS defers to State and local governments to consider issues such as the special needs of patient populations treated at the hospital (e.g., patients with psychiatric diagnosis, patients on special diets, or newborns); pharmaceuticals, food,

other supplies and equipment that may be needed during emergency/disaster situations; communication to external entities if telephones and computers are not operating or become overloaded (e.g., use of satellite (cell) phones to reach community officials or other healthcare facilities if transfer of patients is necessary); and transfer or discharge of patients to home, other health care settings, shelters, or other hospitals.

CMS Conducts Oversight of Hospital Compliance

In addition to the regulations outlining the emergency preparedness requirements for all Medicare and Medicaid providers, CMS has multiple oversight functions in place to ensure that facilities adhere to the Agency's standards of operation. CMS maintains oversight for compliance with the Medicare health and safety standards for hospitals serving Medicare and Medicaid beneficiaries, and makes available to beneficiaries, providers/suppliers, researchers and State surveyors information about these activities.

The survey (inspection) for this determination is done on behalf of CMS by the individual State Survey Agencies.

CMS Accommodated Emergency Health Care Needs After Hurricane Katrina

CMS has acted to assure that the Medicare, Medicaid and State Children's Health Insurance Programs were flexible to accommodate the emergency health care needs of beneficiaries and medical providers in the Hurricane Katrina devastated states. More specifically, many of the Medicare fee-for-service program's normal operating procedures were temporarily relaxed to speed provision of health care services to the elderly, children and persons with disabilities who depend upon them.

CMS Worked to Expand Availability of Inpatient Beds

To expand the availability of inpatient beds and ensure that patients have access to needed inpatient care, CMS waived many of Medicare's classification requirements, allowing specialized facilities and hospital units to treat patients needing inpatient care. For example,

- CMS did not count any bed use that exceeds the 25-bed or 96-hour average length of stay limits for critical access hospitals (CAHs) located in the public health emergency states if such use was related to the hurricane.
- CMS did not count admissions to inpatient rehabilitation facilities (IRFs) located in the public health emergency states toward compliance with the 75 percent rule if such admissions were related to the hurricane.
- CMS did not count patients admitted to a long-term care hospital (LTCH) located in the public health emergency states toward the calculation of the facility's average length of stay if such admissions were related to the hurricane.
- CMS allowed beds in a distinct psychiatric unit in an acute care hospital located in the public health emergency states to be available for patients needing inpatient acute care services if such use was related to the hurricane.

CMS Relaxed Medicare Billing Requirements and Accelerated Payments

To accommodate the emergency health care needs of beneficiaries, CMS temporarily relaxed Medicare billing requirements and offered accelerated payment options for providers furnishing such care. For example,

- CMS allowed hospitals to have a responsible physician at the hospital (e.g., chief of medical staff or department head) to sign an attestation when the attending physician could not be located.
- CMS allowed providers affected by the hurricane to file paper claims if necessary.

- CMS instructed its contractors to facilitate the processing of claims for services furnished by physicians to treat patients outside the normal settings (e.g., shelters).
- CMS paid the inpatient acute care rate and any cost outliers for Medicare patients that no longer needed acute level care but remained in a hospital located in the public health emergency states until the patient could be moved to an appropriate facility.
- For those teaching hospitals that were training residents that were displaced by the hurricane, CMS temporarily adjusted the hospital's full-time equivalent cap on residents, as needed, to allow the hospital to receive indirect or direct graduate medical education payments for those displaced residents. The temporary adjustment applied as long as the original program in which the displaced resident trained remained closed.
- Accelerated or advance payments were available to those providers who were still rendering some services or were taking steps to be able to furnish services again, despite having their practice or business affected or destroyed by the hurricane.
- CMS instructed its contractors to process immediately any requests for accelerated payments or increases in periodic interim payments for providers affected by the hurricane.
- The intermediaries also were instructed to increase the rate of the accelerated payment to 100 percent and extend the repayment period to 180 days on a case-by-case basis.
- CMS instructed its intermediaries to approve requests for extensions to cost report filing deadlines for providers affected by the hurricane.
- The intermediaries also were instructed to accept other data they determined are adequate to substantiate payment to the provider when a facility's records were destroyed. This determination was done on a case-by-case basis.
- CMS allowed providers who waived the coinsurance and deductible amounts for indigent patients affected by the hurricane to claim bad debt, even in cases where documentation regarding a patient's indigence was unavailable. Providers were required to note their observations or submit any documentation they could along with a brief signed statement by medical personnel regarding the patient's indigence.

CMS Assistance Available for Rebuilding Health Care Infrastructure

CMS - Medicare Extraordinary Circumstances Exception Provision

The Medicare inpatient prospective payment system includes payment for hospital inpatient capital costs, which is made on a per-discharge basis. The extraordinary circumstances exception provision provides an additional payment if a hospital incurs unanticipated capital expenditures in excess of \$5 million (net of proceeds from other funding sources, including insurance, litigation, and government funding such as FEMA aid) due to extraordinary circumstances beyond the hospital's control (e.g., a flood, fire, or earthquake).

For most hospitals, the exception payments for extraordinary circumstances are based on 85 percent of Medicare's share of allowable capital costs (100 percent for sole-community hospitals) attributed to the extraordinary circumstance. The payments are made for the annualized portion of the extraordinary circumstance costs, over the useful lifetime of the assets, not in a lump sum. A hospital must make an initial written request to its CMS Regional Office (RO) within 180 days after the occurrence of the extraordinary circumstance causing the unanticipated expenditures.

CMS Makes Available Waiver of the Physician Self-Referral Law for Limited Cases

In response to the recent hurricane, CMS has received inquiries concerning whether hospitals can provide free office space, or low interest or no interest loans, or offer certain arrangements to physicians who have been displaced by the hurricane. The Secretary has given CMS authority to waive sanctions for violations of the physician self-referral (Stark) law (which prohibits physicians from referring Medicare patients to an entity with which the physician or a member of the physician's immediate family has a financial relationship, unless the arrangement meets the criteria of one of the statutory or regulatory exceptions). The States in which the Stark waiver is available are limited to those States that have received a Section 1135 waiver due to Hurricane Katrina.

CMS is considering Stark waiver requests on a case-by-case basis and/or through guidance posted on the CMS website, and is waiving Stark violations in such circumstances as CMS determines appropriate. The focus is to ensure access to care and to assist displaced physicians in the affected areas. CMS is temporarily allowing arrangements that otherwise would not meet the specific criteria for an exception, provided that such arrangements do not lead to program or patient abuse, and that other safeguards which may be applicable to the specific arrangement under consideration exist.

The Role of Section 1115 Demonstrations

In an effort to ensure the continuity of health care services for the victims of Hurricane Katrina, CMS developed a new section 1115 demonstration initiative. Under this program, States were able to apply to be part of a unique cooperative demonstration that allows Medicaid and State Children's Health Insurance coverage of evacuees from the affected geographic areas of Louisiana, Mississippi, and Alabama. Under this demonstration, effective retroactively to August 24, 2005, evacuees who were displaced from their homes as a result of Hurricane Katrina were provided the opportunity to enroll to receive services under the Medicaid or SCHIP programs in whatever State they now reside so long as the host state applied for a Katrina demonstration. The host states are allowed to provide their state's Medicaid/SCHIP benefit package and comprehensive State Plan services to evacuees, who can receive this coverage for up to 5 months. Evacuees apply through a simplified application within the Host State through January 31, 2006. This demonstration allows for self-attestation for items such as displacement, income, residency, resources, and immigration status if the evacuee is unable to provide documentation. There is no obligation on the Host State to redetermine eligibility for evacuees at the end of this period. States are encouraged to assist individuals in applying for assistance in the State in which they are currently residing.

States that have been authorized 1115 demonstration authority include Alabama, Arkansas, California, the District of Columbia, Florida, Georgia, Idaho, Indiana, Louisiana, Maryland, Mississippi, Nevada, Ohio, South Carolina, Tennessee, Texas and Puerto Rico.

CMS reviewed and approved waivers for states housing the vast majority of evacuees, and is now providing immediate, comprehensive relief for evacuees who have left their home state, regardless of whether they had previously been determined eligible for Medicaid in their home state, or they are newly eligible for Medicaid due to loss of income and resources as a result of Hurricane Katrina.

This demonstration initiative permits Host States to offer Medicaid and SCHIP benefits to parents, pregnant women, children under age 19, individuals with disabilities, low-income Medicare recipients, and low-income individuals in need of long-term care within certain income parameters using a simplified eligibility chart or the eligibility levels from the affected States. As an evacuee, an individual is required to attest that he/she is displaced from certain geographic regions and to cooperate in demonstrating evacuee status.

Uncompensated Care Pools

CMS approved uncompensated care pools in several states. The uncompensated care pool allows States to reimburse providers that incur uncompensated care costs for medically necessary services and supplies for Katrina evacuees who do not have other coverage for such services and supplies through insurance, or other relief options available including Medicaid and SCHIP for a 5 month period effective from August 24, 2005, through January 21, 2006. The pool may also be used to provide reimbursement for benefits not covered under Medicaid and SCHIP in the states. These uncompensated care pools cannot be used to reimburse providers for uncompensated care costs beyond January 31, 2006 or for services provided to Medicaid and SCHIP eligibles in the host state.

The Role of 1135 Waivers

Section 1135 of the Social Security Act allows the Secretary of Health and Human Services to waive or modify certain Medicare, Medicaid, or SCHIP requirements to protect the public health and welfare in times of national crisis.

On August 27, 2005, President Bush made a disaster declaration in response to Hurricane Katrina. On Wednesday August 31, 2005 Secretary Leavitt notified the Congress that he was invoking his waiver authority, as a consequence of Hurricane Katrina, in order to protect the health and welfare of the public in areas impacted by this crisis. CMS is taking action consistent with this authority to ensure that the people in these areas receive all necessary health care services.

In his declaration, the Secretary specified that a public health emergency existed since August 24, 2005 in the State of Florida and since August 29, 2005 in the States of Alabama, Louisiana, and Mississippi. Declaring a public health emergency enabled the Secretary to authorize waivers to states in order to facilitate the provision of health care services. He began authorizing 1135 waivers on September 4, 2005, which became effective on September 6, 2005, but were effective retroactively to August 24, 2005 in Florida; August 29, 2005 in Alabama, Louisiana, and Mississippi; and September 2, 2005 in Texas. CMS approved waivers in other states that were directly affected by Hurricane Katrina or hosted evacuees, including Arkansas, Colorado, Georgia, North Carolina, Oklahoma, Tennessee, West Virginia, and Utah.

By issuing 1135 waivers to states affected by Hurricane Katrina, there was increased flexibility for providers and beneficiaries. The waivers flexed the normal eligibility and enrollment requirements used to apply for Federal benefits so that no one who has been a victim of the hurricane would be prevented from getting benefits. For instance, CMS recognized that many evacuees lost all identification and records, so the Agency gave states the flexibility to enroll people without requiring the usual documents such as tax returns or proof of residency. In addition, requirements were temporarily relaxed for

- certain conditions of participation, certification requirements, program participation or similar requirements, or pre-approval requirements for individual health care providers or types of health care providers, including as applicable, a hospital or other provider of services, a physician or other health care practitioner or professional, a health care facility, or a supplier of health care items or services;
- the requirement that physicians and other health care professionals hold licenses in the State in which they provide services, if they have a license from another State (and are not affirmatively barred from practice in that State or any State in the emergency area);
- sanctions under the Emergency Medical Treatment and Labor Act, or EMTALA, for the redirection of individuals to receive a medical screening examination or transfer;

- permitting Medicare Advantage enrollees to use out-of-network providers; and,
- sanctions and penalties arising from noncompliance with certain provisions of the HIPAA privacy regulations including the requirements to obtain a patient's agreement to speak with family members or friends or to honor a patient's request to opt out of the facility directory.

Through these efforts, evacuees are getting the care they need so they can get back on their feet. CMS is making sure that the health care community is reimbursed for providing that care. Further, the Agency is making sure that states hosting evacuees are covered for any substantial expenses that they incur.

Conclusion

Mr. Chairman and Members of the Subcommittee, Hurricane Katrina caused severe devastation. However, the network of compassion and caring demonstrated by federal, state, and local officials, as well as health care providers and others was a profound and powerful manifestation of the greatness of this country.

Providers rushed to care for those in need without even considering payments or program requirements. Providers, who were personally affected by the hurricane, as well as those in areas sheltering evacuees, have provided extensive medical services under the most challenging conditions. Our role is to support their best efforts to care for seniors, people with a disability, children and families with limited means, and anyone else who needs care and has nowhere else to turn.

I want to assure you, Mr. Chairman and Members, that HHS is actively focused on working with the affected communities. HHS will continue its efforts to work with hospitals and other facilities and ensure they have adequate emergency plans in place should a disaster occur. And we are constantly reassessing the state of our preparedness for natural disasters, as well as terrorist attacks and disease outbreaks, in order to ensure the best outcomes for our future.

This concludes my testimony. I will be happy to answer any questions.

MR. WHITFIELD. Thank you.

Dr. Guidry, you are recognized for five minutes for your opening statement.

DR. GUIDRY. Thank you very much, Mr. Chairman and committee members, for giving us this opportunity.

I must tell you that we certainly want to spend the time doing this so that we can move to lessons learned and certainly intend to see what we have been through.

I think the disaster is not the correct word for what occurred here, catastrophe is. Everybody has been planning and preparing for disasters, which is in the short term, but every day I hear, "We have never done this before, we have never done this before."

So I think that pretty much tells it. What I thought I would do with my five minutes is try and move very quickly through some of the things that were successful, that have not made the media, that very few people are aware of.

Pre-storm, we established a department of triage lines to help those people evacuate and help make their decisions about leaving their families and reporting to special needs shelters as a last resort or seeking

care and sheltering in area hospitals. We evacuated from this affected area some 1.3 million people, which I think is phenomenal, to move that many people from the highway and off the highway to shelters and hotels.

We accepted 150 special needs evacuees in Baton Rouge from the Superdome prior to the storm, and staff from the city of New Orleans opened a section of the Superdome for special needs evacuees. It is critical that we explain that with the hospitals' ability to take care of sick people being downsized and the number of people that are becoming elderly (inaudible) the specialty population is growing at an alarming rate.

The Department of Social Services (inaudible) we cared for some 1,200 special need evacuees pre-storm and worked with the Nursing Home Association to evacuate 19 nursing homes prior to the storm. We worked with the hospital association to assist hospitals and evacuate patients that were able to travel. We worked with CMS to try to assist with some of this (inaudible) for transportation that was overwhelmed.

Post-storm we sent a Federal DMAT team into the Superdome to help (inaudible) did special need sheltering at Nicholls State and established temporary MedEvac staging areas. This I think is a critical piece (inaudible).

We opened up an assembly center with 400 beds, initially wrapped up with 800 true emergency room beds. Never been (inaudible) through this country. Over 40,000 of those evacuees were triaged to that facility, and on the Nicholls campus, over 20,000. I think what we have a hard time understanding is that not only the damage but the volume (inaudible) not of saving lives when there is total chaos and disaster.

We worked with NOMS to create a Medicare program at the Kenner airport, where we sent 180 hospital patients out of State. Keep in mind, that system had never been used in the history of this country, so, obviously, there were some issues there as we moved people out of this affected area. We sent EMS teams to search and rescue, and had a base of operations there at the Causeway because that was above water. We worked with the Nursing Home Association and evacuated another 34 nursing homes post-storm. Hospital Association evacuated 25 hospitals, 12,000 patients and caregivers, as you heard this morning, heroic efforts by anybody's measurements. We evacuated 120 premature and newborn babies from New Orleans hospitals to Baton Rouge Women's Hospital, and provided immunization and pharmaceuticals provided to evacuees at shelters with the help of public health. We gave over 110,000 vaccinations (inaudible) and coordinated (inaudible) medical volunteers.

You heard this morning there was a credentialing issues. There are issues when you try to work with the Federal team as to whether you are

allowed to do that. We worked with DMAT to (inaudible) in Rita, which a lot of us have not talked about this morning, which was right on the heels of Katrina, we then moved all people who had been moved to the west side of the State, up north, back to the east side. So, again, special needs shelters in Lafayette were closed and those patients were moved to Shreveport and Monroe.

Special needs shelters in Baton Rouge increased their capacity to receive these evacuees. We then opened school gymnasiums so nursing homes could bring in their (inaudible) assisted nursing homes could not handle anymore. There were 19 hospitals evacuated (inaudible) medical needs (inaudible).

What I'm afraid of is this next hurricane season, as we develop our plans, we are going to rely on some assets we used in Rita that were very successful. We didn't lose people in Rita. Those assets were here because Katrina had occurred. The fear is that (inaudible) and we had a lot of assets we wouldn't normally have, so when you get this next hurricane season, people think these assets will be readily available again, and I think the planning will fall way short.

Post-Rita, we reopened special needs shelters temporarily in Lafayette and received those Katrina evacuees back into the area. We opened a temporary medical staging area at one of the hospitals in Lake Charles. We also opened a base of operations at the Convention Center in Lake Charles. We assisted with hospitals by sending (inaudible) to shelters that would take patients that were too sick (inaudible) and sent back to us. We worked with DMAT to address surge. There were some 600 needs (inaudible).

We had met several times with the Louisiana Recovery Authority and healthcare reform groups to talk about what they could do to help us and what they need to look at. I would like to go into detail with some things that we have to look at in the upcoming season and long term.

Some of the things we talked about was how to incentivize, making sure we can take care of people's healthcare needs in a State that is one of the poorest in the country, with the most healthcare needs. As you heard today, the hospitals and emergency rooms are critical because our patients (inaudible) preventing healthcare.

So, we talked to groups about how they can help us with that. Because of the shortness of time, I'm going to go directly to some of the recommendations I see as critical. HRSA grants, really since 9/11, have made a difference in hospital preparedness. They literally were islands until themselves until these grants forged the networks we had in the State which at its regional level, each State has come to the table, and how do they help those around the State? So, these grants haven't been discussed as possibly diminishing in the future. I can tell you without

those grants, I would not have saved so many lives. It would not have happened, because a lot of this manning and preparation occurs as a result of those grants.

The Stafford Act, if I heard it one more time--it is just, you know, it does not address healthcare. It does not take care of healthcare, so when FEMA comes in, it will help take care of what our needs are, but healthcare needs, as you all heard this morning, are not being met. Unless we make the Stafford Act apply to healthcare or we have the healthcare act address catastrophes, we see (inaudible) and how do we address that for the long term? Nobody's gone beyond a week or two weeks in addressing healthcare needs (inaudible).

Money for purchasing generators and special needs shelters. I opened special needs shelters (inaudible) which were all at risk of being flooded, taking care of patients that need care. I have asked for generators for ten years. I have asked the State, I have asked the Federal. They are very expensive. We are talking about anywhere from \$700,000 to \$1 million for generators. We put in switches to get the generators in, we asked the State for them. There were some in Florida. We did not get those. (Inaudible). We brought some in from Illinois. They brought the generators in, but they did not have the connections. So, these generators were not even able to be used.

Then, as you heard about the hospital generators, we have asked for mitigation funds for this. People say, well--knowing this could happen--I said yes, and no one stepped up to the plate to help us figure out to do this financially. And I said, "Now we have had the biggest disaster in the country and no one stepped up to the plate to figure out how to do a generator."

So to say that, "Did you ask for it, that's not the question. The question is, "When you do ask for it, do people think it is a critical need?" We are all getting older and we are all going to be dependent on power to (inaudible). It is a life-saving measure.

So, that's a quick summary of what I have to say. I'm sure you have a lot of questions and I really am proud to be here and that you came to see this. I think part of the issue has to be that you-all realize the magnitude.

[The prepared statement of Dr. Jimmy Guidry follows:]

PREPARED STATEMENT OF DR. JIMMY GUIDRY, MEDICAL DIRECTOR AND STATE HEALTH OFFICER, LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS

Summary of accomplishments by DHH and Partners:

Hurricane Katrina:

PRE-STORM:

- Established Triage lines to assist special needs evacuees to make decisions about leaving with their families, reporting to special needs shelters as a last resort or seeking shelter or care at hospitals.
- Accepted 150 special needs evacuees in Baton Rouge from the Superdome prior to storm.
- Assisted with equipment and staffing to City of Orleans to open section of Superdome for special needs evacuees (approximately 400 capacity).
- Opened with DSS and DHH staff and supplies 7- Special Needs Shelters
- Cared for 1200 special needs evacuees pre-storm
- Nursing Home Association assisted 19 nursing homes evacuate pre-storm
- LA Hospital Association assisted hospitals evacuate patients that were able to travel and admitted patients that were too ill to travel
- EMS assisted with the transport of hospital and special needs evacuees

Summary of accomplishments by DHH and Partners:

Hurricane Katrina:

POST-STORM:

- Federal DMAT sent to the Superdome with a DHH Advance Team to assist with medical needs
- Special Needs sheltering expanded at Nicholls State University and LSU to establish TMOSAs – Temporary Medical Operations and Staging Areas.
- LSU – TMOSA, Pete Maravich Assembly Center opened as a surge facility for emergency rooms with the capacity for 800 beds. Over 40,000 evacuees were triaged at this facility.
- Nicholls State TMOSA, Lafourche – triaged over 20,000 evacuees.
- Other Special Needs Shelters around the state expanded capacity to care for over 2000 special needs evacuees at one time.
- Worked with NDMS to create a Med-evac Program at the Kenner Airport – to send 1800 hospital patients out of state.
- Sent EMS Teams to Search and Rescue Base of Operations (SARBOO) at the Causeway to help triage thousands of evacuees.
- LA Nursing Home Association helped get resources to evacuate another 34 homes
- LA Hospital Association helped evacuate 25 hospitals – 12,000 patients and caregivers
- Evacuated 120 premature and newborn babies to Woman’s Hospital in Baton Rouge
- Immunizations and pharmaceuticals provided to evacuees in shelters with the help of OPH, NDMS, and USPHS.
- Assisted with medical professionals and supplies to support West Jefferson, East Jefferson and Oschner hospitals to remain open
- Coordinated credentialing and placement of medical volunteers
- Worked with DMORT to address the deceased

Hurricane Rita

PRE-STORM:

- The Special Needs Shelters in Lake Charles and Lafayette moved to Shreveport and Monroe respectively.
- The Special Needs Shelters in Alexandria and Baton Rouge increased their capacity to receive evacuees
- School gymnasiums opened to Nursing Homes to evacuate because the other nursing home facilities were already filled with Katrina evacuees (24 nursing homes evacuated for Rita pre-storm).

- 19 hospitals evacuated patients within the state with a few patients going out of state
- Medical needs of general shelters addressed with EMS, DMAT and USPHS teams because all shelters were already at capacity.

HURRICANE RITA

POST-STORM:

- Re-opened Special Needs Shelters and operated a TMOSA in Lafayette to serve returning Rita and Katrina evacuees
- Opened a TMOSA at St. Patrick’s Hospital, Lake Charles
- Opened a SARBOO at the Convention Center, Lake Charles
- Assisted with hospital surge by accepting hospital discharge patients to special needs shelters.
- Sent medical professionals and DMAT teams to identified hospitals so that they could address surge
- Worked with DMORT to address re-interment

Crosswalk of LRA and Healthcare Reform Projects

	Louisiana Recovery Authority	Healthcare Reform
Primary Question:	<i>How do we mitigate disaster? How do we minimize risk?</i>	<i>How do we address the changing population needs? How do we improve health outcomes?</i>
Imminent Threat:	Upcoming Hurricane Season Pandemic Flu	Increased healthcare demands Decreased resources
Pre-Katrina/Rita Plans:	Model Home Health Plan	A: Provide Care to the Uninsured
	Model Nursing Home Plan	B: Access to appropriate healthcare resources
	Dialysis Referral Network	C: Improve and restructure long-term care
	Health Resources and Services Administration (HRSA) Hospital Network	D: Health Education and Awareness
	Special Needs Sheltering Network	E: Improve administrative delivery of healthcare F: Focus on performance outcomes using evidence based principles

Crosswalk of LRA and Healthcare Reform Projects

	Louisiana Recovery Authority	Healthcare Reform
Post-Katrina/Rita Plans:	Review, Reinforce, Reformulate Model Plans to address gaps	A: Uninsured - Determine the population, demographics, and funding for the uninsured
	Integration of networks	B: Access - Address the increase in mental health and primary care needs; address health in schools
	Support for the Louisiana Emergency Response Network (Trauma/Time-sensitive illnesses network)	C: Long-Term Care - incentivize assisted living and right-sizing institutional care
	Support for development of DHH Emergency Preparedness Office	D: Health Education - Incentivize wellness to decrease demand on limited resources
	Address building codes to mitigate threat risk	E: Delivery/ Accountability - Revisit Medicaid policy to incentivize preventive care to mitigate increase in healthcare spending
		F: Performance Outcomes - Continue to encourage and incentivize best practices

	Louisiana Recovery Authority	Healthcare Reform
Primary Question:	<i>How do we mitigate disaster? How do we minimize risk?</i>	<i>How do we address the changing population needs? How do we improve health outcomes?</i>
Imminent Threat:	Upcoming Hurricane Season Pandemic Flu	Increased healthcare demands Decreased resources
Pre-Katrina/Rita Plans:	Model Home Health Plan	A: Provide Care to the Uninsured
	Model Nursing Home Plan	B: Access to appropriate healthcare resources
	Dialysis Referral Network	C: Improve and restructure long-term care
	Health Resources and Services Administration (HRSA) Hospital Network	D: Health Education and Awareness
	Special Needs Sheltering Network	E: Improve administrative delivery of healthcare F: Focus on performance outcomes using evidence based principles

	Louisiana Recovery Authority	Healthcare Reform
Post-Katrina/Rita Plans:	Review, Reinforce, Reformulate Model Plans to address gaps	A: Uninsured - Determine the population, demographics, and funding for the uninsured
	Integration of networks	B: Access - Address the increase in mental health and primary care needs; address health in schools
	Support for the Louisiana Emergency Response Network (Trauma/Time-sensitive illnesses network)	C: Long-Term Care - incentivize assisted living and right-sizing institutional care
	Support for development of DHH Emergency Preparedness Office	D: Health Education - Incentivize wellness to decrease demand on limited resources
	Address building codes to mitigate threat risk	E: Delivery/ Accountability - Revisit Medicaid policy to incentivize preventive care to mitigate increase in healthcare spending
		F: Performance Outcomes - Continue to encourage and incentivize best practices

The Future:
Health Care’s Needs to Prepare and Respond to Catastrophic Disasters

- Continue HRSA Grants, with increased level of funding
- Reform Stafford Act to include health care costs for catastrophic events and long term response
- Funding for purchase and pre-staging of generators for special needs shelters
- Mitigation funds for relocation of hospital generators

MR. WHITFIELD. Thank you, Dr. Guidry. Thank you so much.

Dr. Agwunobi, I’m going to ask you a question that I’m sure everyone on the panel wants to ask you. In your testimony, you say that CMS is making sure that the healthcare community is reimbursed for providing care. And yesterday, all of us went on a tour of the University system, the Charity system, the Tulane University system, and Convention Center where they have the temporary system for the Charity Hospital system there. They told us yesterday they were not being reimbursed for the care being provided at the temporary emergency center because the waiver had not been granted yet. From the testimony that you have given this morning, I get the impression that all waivers have been granted. So if that is the case, why are they not being reimbursed for the care being provided?

DR. AGWUNOBI. Sir, if I may, I should clarify. There are a number of waivers that have been signed that are in effect. They extend all the way back to the storm itself, and the immediate days following. No two

waivers are the same. Each waiver accomplishes a different task. The LSU waiver that I think is what we are referring to right now, is under consideration. There are many others that have already been signed. As you are well aware, there has been so much work done by CMS and by other agencies.

MR. WHITFIELD. How long has it been under consideration?

DR. AGWUNOBI. I'm actually not aware of when the request was first received, but I will get you the exact date.

MR. WHITFIELD. It seems to me that this hurricane was in August, the safety net has been removed from New Orleans, and if there were ever a case where a waiver would be appropriate, it seems to me that where you have a temporary emergency facility meeting the needs of the people in this community that needs so much right now, that that would be an incident of where a waiver should be granted.

So, what is your understanding of--is there some legal requirement that is not being met, is there some regulatory requirement that is not being met? What is the problem here?

DR. AGWUNOBI. Sir, I'm not sure there is a problem. I have no doubt that this particular waiver is being processed in an expedited fashion. I'm not exactly sure--but I have no doubt that it is being given a lot of thought and due diligence in as expedited a fashion as possible. CMS is fully aware of the need to move quickly on these issues. We are essential to the people of this community. I have no doubt they are working as fast as they can.

MR. WHITFIELD. The problem is they are going to be closing that facility relatively soon and hopefully going to Elmwood for a temporary site, but I would ask you to give a personal message to the Secretary that we find it hard to believe that this waiver has not been granted.

DR. AGWUNOBI. I will deliver that message in person, sir.

MR. WHITFIELD. Thank you.

Now, Dr. Guidry, we have heard testimony today that one of the reasons that Charity has been slow in getting back up to speed--we know that there are some issues with FEMA as well. I would like to ask you, on FEMA, how does your part of the country work with FEMA? Are you all in a lot of coordination with each other, a lot of dialogue back and forth as FEMA tries to make decisions about when to grant money? If you were speaking to the Rotary Club here in Louisiana, how would you explain this interaction?

DR. GUIDRY. Early in the process they come in and say, "How can we help you?" So you start putting in all these requests. And everything medical or health-related comes through the State (inaudible) approval, not because I want it that way, but because they want a safety net to justify the expense. So, in going through these, and in putting it forward,

there is a close relationship between the folks that work with FEMA and saying "I need these things."

There were so many things coming in that keeping a way of knowing what was being looked at and going to be delivered became an unbelievable task, so you kept putting in these requests and putting in these requests. And you never knew if they were going to say yes.

For instance, I had to deal with one of the things (inaudible) was all the deceased, and trying to identify them so we could give them to family members. It took three months to even know what they were willing to pay for. I put two scopes of work forward and they said they could take care of it, contract it and do it cheaper than I could. Two or three months later--

MR. WHITFIELD. Are you talking about FEMA?

DR. GUIDRY. DMAT. So, over and over again, I guess, the millions and millions of dollars, the amounts we are looking at, especially on healthcare, I kept getting the answer, "We have never done it before, we have to send it up."

So I started going every morning, at 7:30 a.m. in the morning, to the Joint Field Office so when they had FEMA and all the folks there and Baton Rouge were there, I entered their discussion and gave them my needs so they could take it directly to the top, also talking to people in Washington at the same time. And still, the process, you never knew to what extent it's going to be paid.

MR. WHITFIELD. Let me ask you this question. FEMA has told us that they have either obligated or spent \$406 million in healthcare in Louisiana, which we know it is going to take a lot more than that. How much has the State of Louisiana spent at this point?

DR. GUIDRY. At this point, I don't have the totals, but the State (inaudible) on the request for special needs shelters, there is a request on the hospital associations, hospitals, shelters here. It is in the hundreds of millions of dollars.

MR. WHITFIELD. Now, someone testified earlier today that under the Louisiana constitution, the only two areas in which there can be a reduction in funding is in education and healthcare, and as a result of that, I guess, particularly with Katrina and the impact of that on the State, I'm sure the State is struggling with the financial issue here, as is the country, as a matter of fact. But HCA, in their testimony, they talked about how they had provided insurance coverage for this, or partial coverage, and the State is self-insured. Is the State prohibited from having private insurance coverage on something like this, or is it just a policy that they be self-insured?

DR. GUIDRY. That is something that I'm not familiar with the details on. I am afraid to answer it in the sense that I may be giving

misinformation but I will tell you this: on all the insurance that we normally do, it's through risk management, which is self-insurance, the State is self-insured. So, on our buildings, or repair and replacement for our buildings, we work with older systems (inaudible). I'm not aware of private insurance as part of (inaudible).

MR. WHITFIELD. So the State is self-insured for the full amount, whatever it is? I mean, most companies that I'm aware of, when they are self-insured, they will pay, like, the first five or ten million, then they have catastrophic coverage above that. Is that the way the State of Louisiana operates?

DR. GUIDRY. I think we are talking about, our catastrophic insurance is through the Government.

MR. WHITFIELD. Okay. I don't think I will ask any more questions about that.

Mr. Stupak is recognized for ten minutes.

MR. STUPAK. Thank you, Mr. Chairman. Dr. Agwunobi, I have put into the record a number of letters written to the Secretary, one on September 6, 2005, another one on December 15, 2005, and we really need the Secretary to answer those letter. I hope (inaudible) on this issue, but to not even get a response or a phone call back. So I hope we can get some answers.

One of the questions I'm going to ask today is what does HHS believe to be the vision of health care after this hurricane, or two hurricanes, here in New Orleans? What does HHS envision the healthcare and delivery system to be? In talking with the Charity folks, they testified this morning, they have a vision, apparently now HHS has a vision, and it doesn't sound like either vision is working together.

DR. AGWUNOBI. Sir, the first part of your question, I can assure you that the Department is working hard to provide you with answers on those issues. The Secretary has personally become involved in his recognition that there is an opportunity in this tragedy, and an opportunity for this city to build something even better than what it had before. He has a firm belief that the Department should serve as a--not only should it (inaudible) future resources but it should also be one of the catalysts that this great city and State, local, individual players--

MR. STUPAK. That hasn't happened.

DR. GUIDRY. In actual fact, a number of things have occurred, including a meeting that occurred that the Secretary attended himself in January, during which a set of principles were discussed on how this community would be formed and how we would map forward and what its goals might be.

MR. STUPAK. So, we don't even have a committee yet?

DR. AGWUNOBI. Actually, I think it started on the premise that it begin with the Louisiana Recovery Authority, Dr. Fred Cerise, with the State Department of Health, is an active player in that. I also know that there was a follow-up call yesterday on that first meeting.

MR. STUPAK. Let me move on, because it sounds like (inaudible) HHS, sounds like you are going to be a while before you get your vision, so, let me ask you this: Do you know a Dr. Leslie Norwalk?

DR. AGWUNOBI. I do.

MR. STUPAK. Assistant General Counsel?

DR. AGWUNOBI. Deputy Director of the Centers for Medicare and Medicaid Services.

MR. STUPAK. She has promised us that there will be answers and no problems with waivers. But we are still hearing that you are waiting for waivers. Just reimbursement for the care of people who were in the tents, or emergency services provided at the Convention Center, if they were going to be paying for any of those services, when can they expect to be paid for those services?

DR. AGWUNOBI. I know they are processing and working through the issuance of that with her, very rapidly, and it is under consideration, sir.

MR. STUPAK. (Inaudible) How about the waiver that currently exists, which, to my understanding, is due to expire here for those who are the residents, the training of doctors who have been placed in hospitals. That waiver is due to expire January 31. Tulane, LSU would like to extend that waiver if it can be extended.

DR. AGWUNOBI. I don't know if we received a request for that, but I do know that if we have it, it will be placed under consideration and acted on appropriately.

MR. STUPAK. Okay.

Let me ask you about your testimony on pages 10, 11, and 12; you talk about CMS relaxing Medicaid billing requirements and accelerated payments. At the top of page 12, you indicated that CMS temporarily relaxed Medicare billing departments and offered accelerated payment options for providers furnishing such care. Do you know of any provider--in New Orleans--who has been offered accelerated payment options?

DR. AGWUNOBI. I don't.

MR. STUPAK. Well, how did you get the facts for the statement and your testimony, then, if you don't know of anyone who received them?

DR. AGWUNOBI. The impression, if I may, in New Orleans--I don't know, but I do know for a fact that this waiver was (inaudible) allowing providers to take advantage of it. What I'm not clear on is whether or not any have.

MR. STUPAK. The other members on the panel have told us they have not received any payments. You are telling us you know for a fact that it was offered, so, if they didn't receive any, and you don't--you saying that people have been offered the opportunity just doesn't jive. It just doesn't--those two statements are inconsistent.

Let me ask you this: CMS instructed its contractors to facilitate processing of claims for services furnished by physicians during the (inaudible) settings, for example, shelters outside the normal setting. This would include the tents at the Convention Center, would it not? It is outside the normal settings.

DR. AGWUNOBI. I'm not sure if the tents at the Convention Center is what this particular waiver was aimed at. Once again, I recognize that there is a particular waiver that has been requested by the University system for this particular site, and that is under consideration.

MR. STUPAK. But you don't know when the consideration will be done?

DR. AGWUNOBI. No, sir.

MR. STUPAK. How about at the bottom of page 12, you said, "Accelerated and advance payments were available to those providers who are still rendering some services or taking steps to be able to furnish services again, despite having their practice or business affected or destroyed by the hurricane." So, Charity, which is obviously providing a service, you heard today is trying to negotiate a lease, they should be receiving payments, accelerated or advance payments, right?

DR. AGWUNOBI. I'm not sure if this particular provision would apply to them. I can check for you, sir.

MR. STUPAK. If you don't know if these provisions for paying these providers apply here in New Orleans, why then would that be included in your testimony?

DR. AGWUNOBI. My point is that I don't know the specifics of any individual entity or provider as it relates to these waivers. It would be inappropriate for me to testify as to specifics.

MR. STUPAK. I wouldn't think that HHS would want a witness who couldn't testify about the situation in New Orleans (inaudible).

Let me ask you this one. There is a program called the Community Disaster Loan Program. It is a (inaudible). I know Charity has applied for one of those. Do you know what has happened to their application for a Community Disaster Loan Program loan, so that they can remain operating? Do you have any idea on that?

DR. AGWUNOBI. For Charity, I don't.

MR. STUPAK. Do you know of anything in the Stark Amendment that would allow providers to provide assistance to physicians practicing at hospitals outside the service?

DR. AGWUNOBI. No.

MR. STUPAK. You don't know that? Have any of the hospitals in this area applied for that?

DR. AGWUNOBI. You would have to ask the hospitals that.

MR. STUPAK. I understand the Stark waiver will expire on January 31. Will you take it back to the Secretary and tell him to get it done before January 31, so that these physicians--because these residents are not going to be back here by February 1st practicing medicine.

DR. AGWUNOBI. I will relay your message.

MR. STUPAK. Does the HHS have a commitment to reopen Charity Hospital as part of your vision?

DR. AGWUNOBI. I'm sorry, sir.

MR. STUPAK. Does the Administration have a formal commitment to help reopen Charity Hospital as part of their vision for healthcare here in New Orleans?

DR. AGWUNOBI. When you refer to the Administration, are you referring to the Department of Health and Human Services?

MR. STUPAK. Sure.

DR. AGWUNOBI. Sir, we believe firmly that the decisions that are made on a provider by provider, hospital by hospital basis should be made at the local level. Our job should be to support, No. 1 the--

MR. STUPAK. Then there is no need for the Administration to have a vision, it should be determined at the local level, right? (Inaudible).

DR. AGWUNOBI. That's right, and I think there has to be a vision at our level. It has to be one that sets forth (inaudible), that demands and expects cooperation.

MR. STUPAK. Some of these questions I'm asking--like about the vision--those were in letters of December 15 and September 6. I'm asking you now because we still haven't had any answers. Please have whomever is in charge of answering those letters to answer them, so we can get some answers to our questions.

DR. AGWUNOBI. I will relay your message, sir.

MR. STUPAK. Let me ask you this: we heard testimony today about patients removed from one hospital to the Louis Armstrong Airport, and the healthcare professionals from those hospitals trying to help and being told they could not help. Then patients were sent wherever. Would HHS have made the decision to do that?

DR. AGWUNOBI. I'm not sure that would have been (inaudible) that would be managed in the field and they were consistent with the events that were (inaudible) occurring during the storm.

MR. STUPAK. But HHS had people in the field during the time of the storm?

DR. AGWUNOBI. Thousands of people. That particular operation was, of course, managed by a different entity, from what I heard today.

MR. WHITFIELD. At this time, we recognize Dr. Burgess for ten minutes.

MR. BURGESS. Thank you, Mr. Chairman. Although in your absence, I gave myself some additional time. On the issue of credentialing, I have to ask either Dr. Agwunobi or Dr. Guidry, I believe you actually referenced this, I just think it will be extremely helpful to know. I have practiced for 25 years and I did not know of such a credentialing policy. Basically, I went on the Internet to find out. That is a useful tidbit of information for any of us who actually practice, that if a disaster occurs, that we would be able to be there and take care of our patients, either at a field hospital or--so I think that is an extremely important concept to develop and make known to hospitals and medical staff, that HCA, as a corporate decision, had decided to sponsor. That seems to be an extremely good idea and an example of forward thinking. And maybe others could do similarly. What was the acronym you told us?

Dr. Guidry?

DR. AGWUNOBI. It might have been when I was referring to the emergency system for a fast registration of volunteer health professionals. It existed in 13 States prior to the storms. Quickly as the storms approached, seven States were brought on. It is our intent, I think we are up to 30-something States as we speak. All States have the ability to have this expedited credentialing for volunteers.

MR. BURGESS. And I stress it is a good idea because the guys on the ground should have been making the decisions and relying on hospital staff. The poor guy with the DMAT team doesn't know that. It is his responsibility to protect the Federal government from liability, because they are going to be practicing under the Federal government's liability with the practicing facility.

DR. GUIDRY. If I could shed some clarity on that. One of the things I had to deal with during this chaos and trying to take care of patients were all of the volunteers showing up and wanting to help. Managing that becomes difficult because a lot of folks come expecting to do what they are trained to do. They are not willing to do just anything you need. Two, you have to find out if they are credentialed. The Governor had an executive order that allowed other people to come from other States and practice medicine. The Office of Public Health, we were quickly looking to see if they were licensed and could do this. So, the HRSA bill is something proposed--that HRSA has been proposing that you do, before you have this all happen. It is a monumental task and keeping track of

people's credentials and training, as you know, keeping track of your own individual one is a monumental task.

MR. BURGESS. Let me cut you short because we need to talk about waivers a little bit more. I heard the Secretary on Labor Day weekend tell the doctors at the tents in Dallas that there is a waiver, you will be paid, but I came down here in October, and I got the impression from private physicians who were conforming to all of the things they were asked to conform with that they were not being paid under these waivers, under their own clinics or institutions, or when they saw patients in the emergency rooms of their hospitals that were up and running. This is an extremely important situation, and I would add to what Mr. Stupak said. I urge you to get the Secretary or the Administrator to rule on this. It is of utmost importance to preserving what is left of the safety net here on the ground, and allowing them to build, going forward.

The concept of the money following the patient in a situation like this is that something that we can help you with? It seems like a fundamentally straightforward and common sense way to approach a disaster situation, that rather than have the patient fit into a neat category of whether it's FEMA, or HHS, CMS waiver or grant or what have you, just have the money following the patient, and let the doctor or hospital or nurse practitioner be reimbursed for the care they deliver. I mean, that's what it's all about, right?

DR. AGWUNOBI. I recognize how frustrating it must seem. I can tell you this, that even within the Department we are looking at all of our processes and learning from this storm as we did from prior storms. And I have no doubt that as that review, as that process of learning is underway, that where we find the opportunity to have you help us improve the system, that our Secretary will reach out to your services or your organizations as is appropriate.

MR. BURGESS. It makes sense if you do the same thing with schools as well, and let the money follow the student. While things--while the structure is not in place to do what we've always done, to at least allow the child to continue to receive the education and the patient continue the medical care, and the person who is doing the work for that would get paid so that they can continue to do that good work. It just makes sense to me and I don't understand why we don't do it that way.

Now, there were the community development loans that were passed and signed into law in October, I believe, or right at the end of September, and how have we done with those? Are those loans coming to the healthcare institutions that are the ones that were left up and running? Ochsner, for example, would they even be able to participate in that, since they are an entirely private entity?

DR. AGWUNOBI. I have to admit I don't know the details of how many. I do understand that that process is under way.

MR. BURGESS. Again, maybe you could look into it. I know the East and West Jefferson Parish Hospitals are governmental entities, and would be suitable for those types of loans and I would just be interested to know where we sit with that today, because, again, that legislation was passed rather hurriedly, and I think that was the end of the first week in October, and we are now well into a new year and it would be nice to know if that money is getting where it was designed to go.

DR. AGWUNOBI. I will make sure that the committee is updated on that.

MR. BURGESS. I mean if it has just been sitting there for a quarter in someone's account, I don't even know if it's drawing interest.

On the evacuation aspect, and this is something I didn't bring up to the other panel, because I don't even know if it's appropriate. I spent some time in Iraq, where they have the contingent medical facility, and they took the wounded from all over the battlefield to a central location and stabilized them, operated if necessary, took them to Germany, and then they were flown back to Walter Reed Medical Center. Sitting on the sidelines in another State and watching a system made up as we went along-- (inaudible).

I will yield back my last 15 seconds.

MR. WHITFIELD. Thank you very much. I appreciate your generosity. I would like to make one comment. There seems to be some discrepancy on the timeline for the request for waivers from HHS to reimburse the temporary emergency room care at Charity's Convention Center. So, I would like to ask Dr. Fontenot and Dr. Agwunobi if you-all would submit to the committee the time lines as you understand them, the time lines for the request for this waiver. We have one letter here that's dated like January 10, and we have one letter from the State of Louisiana dated December 15. I know that we all want to expedite this, but I think it would help us get a little bit better understanding if you-all would be willing to do that with supporting documents. Thank you.

MR. STUPAK. May I add that besides a formal application for these waivers, if Dr. Agwunobi and the others could put in there the times when they had discussions about the waivers. As the record will reflect, the letters I put in earlier, especially the one from December 15 that I wrote along with Mr. Dingell and others on this side of the aisle that actually wrote letters, question No. 15 said, to the Secretary of HHS, "Charity Hospital needs a waiver from CMS to bill for services that it is providing in its tent facilities. What is the status of the waiver and any other CMS waiver of requirements that would be necessary for payment?"

So, even back on December 15, Charity was frustrated because it could not get any kind of answers. So, we actually put in a letter thinking maybe a congressional letter could get some answers, and we still don't have any answers.

And with the admission of this document, which we admitted earlier, I have no objection to your letter of January 10.

MR. WHITFIELD. Yes, and also, LSU will be submitting their time line as well.

At this time, we recognize Ms. Schakowsky for ten minutes.

MS. SCHAKOWSKY. I think you can tell from the nature of the questions, that this panel, as well as the people who have testified before it, feel frustrated in being able to accomplish on the ground what they need to do--in some part, maybe not in large part--and then again, a catastrophe makes us all improvise in many ways and do what needs to be done, but it seems to me that the role of the Federal government to not just to sit back and say, "You need to apply for this, you need to apply for that." Or, "Well, we couldn't do anything because you didn't know about that waiver," or "It didn't come in time."

It seems to me in the midst of a catastrophe, that the Federal government can be proactive and come to the State and the hospitals and the localities and say, "We see the problem that you have. This is in our arsenal of things that we can deal with, how can we help you deal with this?" And, "We are going to help you figure out exactly how. In fact, maybe someone on staff could even help you draft something."

I mean, is that outrageous? It feels to me like there is almost a certain amount of "gotcha" here. You know, you said I'm not sure there is a problem, referring to the waiver for payments for the Convention Center tent facility. Well, if the justification for saying that is because the letter didn't arrive until January 12, I'm saying, shame on you. We had a December 15 letter that some of our Democrats on the committee sent to you.

In other words, look at the problem, how can the Federal government be a partner and then how can we help you actually do that.

We know, some of the Democrats on the committee have had the experience of not even getting a phone call that says we've received your letter, a letter that took a lot of work. This was not just written on the back of a napkin. This is a many-page document outlining our understanding of the problem--and how many questions is it--we have specific questions.

And then, you are coming hear today saying here is this thing we have with the Federal government, but we don't know if it applies to Louisiana. Quite frankly, I think it is really insulting. I think you need to come armed with exactly those things that Louisiana needs. You

knew what the questions would be. If there is a program or some sort of reimbursement plan, then you need to know how it applies to Louisiana.

I wanted to ask Dr. Guidry a question. We heard just today that there is this 400-plus million dollars of FEMA's--who, by the way, I'm sorry is not here on this panel to answer some of these questions--but have you seen the \$400 million? Do you know anything about it or how it is supposed to be spent?

DR. GUIDRY. There's been different amounts that have been told to me: \$300 million, \$400 million that's sitting there for you. And so, I have not seen that funding. All I keep doing is filling out the requests and filling out the project worksheets about what we want and what we need to be reimbursed. I have got way over that amount in requests.

So, I don't know about a specific amount of money. I know they put aside some money but we have more requested than they put aside. Most of it goes back to debating about whether it is something FEMA covers, because it is health related. I have even had the State helping me, which is a little frustrating. Public Health Services and those folks have been wonderful in helping me to fill out my requests, because I was so overwhelmed, and they did help me do that.

I even heard from FEMA that what they learned in Florida's events--and this is what was killing me--is that when Public Health asks for a request, they need to look real hard at that because the Stafford Act doesn't cover a lot of those requests. I think health requests are really delayed compared to all other requests.

We removed half the debris that has occurred in this disaster. Debris. And the people that are getting hurt removing it, we can't take care of them. So there is a huge gap here as to what is critical and what is important. Half of that debris is a tenth of what they removed in 9/11. That shows you how much debris we have. You saw some of it. Well, people get hurt removing it, and when healthcare asks for something, it gets pushed back. So if that exists, it has not been readily forthcoming.

There have been a number of requests for paying health professionals so they can keep their practices going and so they don't leave, and we can't figure out how to do that.

MS. SCHAKOWSKY. I met with one of those doctors this morning who said he is starting over; they're going into their savings. Heroic efforts for health professionals and institutions to keep it going. It seems to me the very least that the Federal government can do is help everyone figure out how to work their way through the bureaucracy. I mean, it is not right that when we have the HCA, who has private insurance, those checks, I'm assuming, have come through, they have been able to transfer their people within their own system. That's great.

But when applied to poor people, and public health dollars, it has just been a morass, a maze of trying to figure it out. I just think that issues of the credentialing, on waivers, on reimbursements. I mean, I certainly don't know all of these acronyms and letters, and I'm in Congress; and how people sitting in the midst of a catastrophes would know--so I think I'm talking about attitude here and I just wondered if you wanted to comment on that.

DR. AGWUNOBI. I urge you to forgive me if I seemed as if I was being flippant or insulting. I didn't mean to imply that. The premise was I'm not sure if there is a problem with the process. I'm not sure if we have identified a problem--

MS. SCHAKOWSKY. There is definitely--can I tell you? There is a problem with the process. Do you need to hear any more? There is clearly a problem with the process. We all need to work together to figure out how to smooth that out, but there is no way you can be in this city and say there is not a problem with the process. That is obvious.

DR. AGWUNOBI. I wasn't speaking to the general process, I was speaking to that specific waiver, since it has been applied for, whether or not during its review of that waiver request, whether or not there is a problem in that waiver. I don't know. That was my response.

In response to your letter, I concur that the letter appears as if a lot of work went into it and I would only respond by saying that the Department of Health and Human Services is putting just as much effort in drafting a response.

MS. SCHAKOWSKY. Do you have any authority to give answers to the questions that were in that letter?

DR. AGWUNOBI. I believe that that letter's response is being worked on, even as I sit here.

MS. SCHAKOWSKY. Let me just make a suggestion: It would have been a good idea over a month later that at some point somebody would have made a phone call and said "We've received your letter and we're working on it and here's when you can expect it."

That's the other thing: Time, these things are all happening in real time and people are in desperate situations right now. And we are going to be heading toward another hurricane season, there is Mardi Gras coming up, there is the flu season coming up. So, our Government has to take extraordinary means to help facilitate and smooth that out. It is not business as usual. Thank you.

MR. WHITFIELD. Thank you.

Mrs. Blackburn, you are recognized for ten minutes.

MRS. BLACKBURN. Thank you, Mr. Chairman. I want to thank both of you for being here. And Dr. Agwunobi, as you can see, we are all frustrated. The bureaucracy, as I said in my opening statement, has

become so overpowering and convoluted and so elusive. I can understand the elusive nature of many of your responses, because you are dealing with a bureaucracy that doesn't want to give concretes. I'm sure if we were to give you the pen, as I offered to the panel previously, and said, put a line through things that don't work, tell us what doesn't work, and that folks there at HHS would have some thoughts as to what they would do, because there is a lot that is getting in the way. We have got a lot of red tape that's getting in the way in getting around to providing healthcare and providing funding. And I do hope that the message that you carry back today is that it is time to look at making Government more workable and more responsive and that people are very tired of empty answers and very tired of hearing things like, "a response is being worked on as we speak."

Well, why in the world wasn't that response worked on a month ago? You knew the letter was coming. And there should have been a response in the works then.

As long as I have--and I would encourage you all on the administrative side of the table to remember this is a government of, by, and for the people. And that is very important, that that be a part of your mission statement as you move forward every day.

One question for you: every time we have a disaster, a hurricane, 9/11, Oklahoma, do we have this many problems with the disaster? Do we have this many problems in other States, or is it more difficult than it has been in other areas? Is Katrina more difficult than any other disaster we have ever had? Is it unique?

DR. AGWUNOBI. Probably given that so many disasters have occurred over hundreds of years, I'm probably not qualified to comment on a relative scale of how one ranks with the others. I can tell you that Katrina was unique in its scale and scope, and it wasn't just a fast ball, it had curves, twists, and turns. The levee breaking after the storm had passed by, those kinds of things.

MRS. BLACKBURN. There was forewarning in a report written in 1999 on the post-impact.

DR. AGWUNOBI. I concur. There are really two parts in every disaster that go to its eventual impact. One is the nature of the crisis itself, the other is the ability of the community to respond to that and to be ready for it.

MRS. BLACKBURN. To quicken the answer a bit, is this that unique? Do you have this kind of problem in other States? Are the layers of problems more unique to Louisiana than you have seen in other States? Like the Florida hurricanes and other areas? This is what I'm trying to gauge.

DR. AGWUNOBI. I worked in Florida through six hurricanes.

MRS. BLACKBURN. Did you have this many problems?

DR. AGWUNOBI. Each storm gave us a different set of problems and this was a unique storm.

MRS. BLACKBURN. Dr. Guidry, looking at your plan that you have got, the health readiness, and I appreciate your presentation on that and the readiness that is, or the preparation going through there as you look at readiness. The State Evacuation Plan, now, in developing that, does that come under your department, the State Evacuation Plan?

DR. GUIDRY. The State Evacuation Plan is under the Department of Homeland Security and Emergency Preparedness.

MRS. BLACKBURN. But you-all have your interface and component with that?

DR. GUIDRY. Yes.

MRS. BLACKBURN. The inspection of the hospitals with their permits, does that come under you?

DR. GUIDRY. It comes within our Bureau of Health Standards in our department.

MRS. BLACKBURN. So that is in a subdivision of your department?

DR. GUIDRY. Licensing.

MRS. BLACKBURN. Getting back to the operational end, which is where I have gone through this hearing, was it your department that was holding the investigations and the reviews on these hospitals, being certain that they had the supplies, that their generators were moved? I mean, were you-all giving the permits and doing these inspections?

DR. GUIDRY. There are two pieces to this. It is not a simple answer.

MRS. BLACKBURN. Give me a yes or no on this. Did you-all do those inspections? I'm seeing heads nodding yes.

DR. GUIDRY. Some, yes.

MRS. BLACKBURN. Why were you giving a permit to hospitals that still had generators in the basement?

DR. GUIDRY. The Bureau of Health Standards, I put the question to them, because it is not something I'm intimately familiar with.

MRS. BLACKBURN. Would you get an answer from them for me?

DR. GUIDRY. Their answer is they look to see if they have a plan, not to see if it is workable.

MRS. BLACKBURN. There again we have plans with words on paper, but we don't have an implementation strategy that would carry out the plan in case we ever needed the plan to go in place.

DR. GUIDRY. To that issue, yes.

MRS. BLACKBURN. All right. That answers a question I have been scratching my head over since September 1.

DR. GUIDRY. I understand. So have I.

MRS. BLACKBURN. So, we never thought we were going to have to put the plan in place, and the plan was written on paper, but nobody ever thought that in a million years we would really have flooding and that the generators would really be out of the basement, and we would really need to have batteries for the radios?

DR. GUIDRY. There is no simple answer. I knew of the generator issue. When I went around and networked with hospitals as State Health Officer, we had discussions about how do you get your generators moved, they are not in the right place. There is no one sitting at this table this morning that would tell you that they didn't know that was not a good plan.

Getting it changed or funded when it has been there for all these years, that's the issue.

MRS. BLACKBURN. Dr. Guidry, thank you for your forthrightness. I thank you so much for being here and talking with us and working with us on this, and as I said earlier to the gentlemen and the lady that were at the table, we really want to be your partner. There are some lessons here that should be lessons learned. Government is too big. It is not responding quickly enough, and I do hope that Dr. Agwunobi takes that message back. I do hope that, from you-all, that everyone understands, there has got to be a course of action. There has to be a communication plan. When we look at this analog spectrum and make that available, I hope that we address the need for our military and first responders to have an ability to interface on that so that communications are made easier. I hope there is an allowance through VoIP on some of the broadband spectrum that will allow some additional communications for you-all. And I hope that we remember when all else fails, that there has to be plan Z. When the cell phones are not working and the hard lines are down, and the electricity is gone, you have got to have a plan to move people and take care of the needs, to be able to meet the needs of those that are most at need in our communities.

Thank you very much. I want to thank the Chairman and staff and other members who worked on this. I yield back my time.

MR. WHITFIELD. Thank you. Dr. Guidry, we genuinely appreciate your testimony today, and Congressman Jefferson was with us yesterday as we toured these facilities, and he wasn't here this morning with our other guides, Congressman Jindal and Congressman Melancon. So, we'd like to give him the opportunity to make a statement for the record.

We really appreciate you being with us yesterday as we toured the hospital and we want to thank you for the great leadership you have provided to Congress on healthcare issues and being the spokesman for New Orleans and your constituents. With that, I will recognize you for your five minutes.

MR. JEFFERSON. Thank you, Mr. Chairman. I am grateful for this opportunity to address the committee today. More than that, I'm grateful for the committee's visit to our area and for the hearing you have held here. It is important, as you noted yesterday, that as many members of Congress who can come out to see what really is going on here and what people are struggling with, but also, how I think with great courage and commitment they are dealing with these issues. We saw yesterday as we toured the commitment of our healthcare professionals to bring back these institutions. We were a healthcare delivery system that had wonderful teachers and hospitals, where we had wonderful emergency treatment facilities, where we had wonderful facilities here to care for our children and pediatric facilities. We have gone from a 2,100 bed capacity to just a few hundred beds now. That is not nearly enough to build our city back up. And people don't want to be part of this great New Orleans unless we can get our levees right, get our housing right, and get our healthcare right. Unless they know that there is a chance, if they are in trouble, they have someplace to go and be attended to, there is no chance we will be able to bring our city back.

So, this is critical to us and your visit here and the message you take back will do a lot toward us building back our region. So thank you very much for what you have done.

We have had Members of Congress dealing with levee and water board and transportation questions. This is the first time we have had the healthcare issue spotlighted, and it really-- there is not a whole lot more important things. Without this aspect being taken care of, there is no chance we can build back our city. So, your work is important, your presence very, very much appreciated.

We saw yesterday at our teaching hospitals, it is not just a matter of service to our people, it is also a matter of the future of the healthcare profession and who will be in our city and our region. So, this thing has more than one dimension to it, and we are very, very keen on making sure that we bring back not only the capacity we had before, not only the facilities we had before and not only the top people we had before, but to build a future here, and we are building something very important here and centralizing a great healthcare service system which we want to help get back on track. Your presence helps us to focus on that and get our people back online to restore our healthcare facilities. So, thank you all very much for your presence.

MR. WHITFIELD. Before we conclude this hearing, we have all been moved by a number of specific issues that were raised, but we intend to follow up on those issues and we are going to be as helpful as we can be in helping you address this problem and in getting the healthcare system back in full operation. And we are going to leave the record open for ten

days for the questions to be submitted and then another 30 days to provide answers to those questions. With that --

MR. STUPAK. Before we leave, if I may, I hope we will continue this. You indicated in your statement at the end here that we will continue to monitor things, but I hope more than monitor. I hope we have more hearings, and I would like to hear from FEMA, I would like to hear from the person in charge of these waivers at HHS. And I hope to move this along. You've been generous with your time: ten days for questions and 30 days for answers. That's 40 days, and I hope we can set another hearing then in Washington for all of us to go over this together. This hearing is a small step toward that eventual goal.

MR. WHITFIELD. Thank you. Also, I do want to thank General Downer and the National Guard for their assistance yesterday. Certainly, the Chief Justice, who has just walked in the back, we thank him for letting us use this courtroom.

With that, the hearing is adjourned.

[Whereupon, the subcommittee was adjourned.]

RESPONSE FOR THE RECORD BY DR. JOHN O. AGWUNOBI, ASSISTANT SECRETARY OF
HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

**House Energy and Commerce Subcommittee on Oversight and
Investigations
Field Hearing
“Hospital Disaster Preparedness: Past, Present, and Future”
Assistant Secretary for Health John O. Agwunobi, MD, MBA, MPH
January 26, 2006**

1. During the hearing, a representative from the Federal Emergency Management Administration (FEMA) e-mailed Committee staff information regarding the agency’s ongoing projects involving public health-related projects (See attachment 1). The e-mail included two spreadsheets that identify specific healthcare-related obligations of funds for both Louisiana and Mississippi. Some of these obligations appear to be related specifically to hospital services or hospital reconstruction.

Question (a): Because the funding reflected in these spreadsheets affects healthcare delivery and public health preparedness, is the Department of Health and Human Services (HHS) coordinating the management of these funding efforts with FEMA? If not, please explain why not, especially in light of your statement that, “Several of the Agencies within the Department have responsibility for hurricane and disaster preparedness efforts.” If so, please explain how the Department coordinates the management of these funding efforts with FEMA.

Answer: HHS is not involved in the management nor coordination of the specific FEMA funds detailed in the spreadsheets you provided. It appears these funds are for hospital reconstruction efforts attributable to storm damage, which is a FEMA responsibility. However, HHS is involved in other health care and disaster preparedness activities in coordination with FEMA, DHS, and local officials. A few examples of these activities include:

- o HHS developed an “interagency playbook” for the 2006 hurricane season, which is a plan for the public health and medical response to disasters. The plan will be updated annually, and includes the approach to the operation, action steps, triggers and essential elements of information needed for public health and medical preparedness.
- o HHS developed pre-scripted FEMA mission assignments for HHS to support personnel and equipment deployments, and individual assistance to replace prescription drugs and limited durable medical equipment for evacuees.
- o To meet the unique care requirements of persons with disabilities, HHS, its Federal partners (DHS and FEMA) and the American Red Cross

developed a Clinical Interview and Shelter Assessment Tool to meet the unique care requirements of persons with disabilities affected by disasters.

- o In Louisiana, HHS has maintained a full-time presence on the Louisiana evacuation planning team. The HHS Office of Public Health Emergency Preparedness surveyed nursing homes and hospitals in the 12 coastal parishes of Louisiana for evacuation and shelter in place preparedness. The office has also participated in multiple evacuation exercises and worked with GSA and FEMA on an ambulance, air ambulance and Para-Transit bus contract.

Question (b): Assuming the Department does coordinate key health care and disaster preparedness activities with FEMA, please explain, to the extent of your understanding, how each “applicant amount” is being spent. In other words, for each “applicant amount,” please indicate the amount of money being spent on medical services and the amount being spent on hospital reconstruction.

Answer: As mentioned above, since the funds detailed in the spreadsheets are managed by FEMA, HHS cannot speculate on whether the funds have been awarded or how such funds may have been spent by the applicants.

Question (c): Does the Department receive regular briefings about the ongoing efforts by FEMA pertaining to HHS matters, such as public health and healthcare preparedness issues? If so, what is the frequency of those meetings and who represents HHS at these meetings? Also, if such briefings are held, are regular minutes prepared?

Answer: HHS has had a permanent presence at the FEMA Joint Field Office since March, 2006. The purpose of this HHS activity has been to assist FEMA in preparing Louisiana for the 2006 hurricane season. Specific activities have included the development of an Emergency Support Function #8 plan specific to the evacuation of residents, patients, and other populations from the 12 coastal parishes in Louisiana. Meetings and briefings conducted at least weekly. HHS representatives at these meetings include the Senior Health Official and/or Regional Emergency Coordinators. HHS is not familiar with any minutes FEMA may be keeping.

Question (d): If HHS is coordinating these efforts, please describe the ‘working group’ structure used to do so. Please provide the names, titles, and contact numbers of the people who are responsible for this effort?

Answer: These meetings were convened by FEMA; HHS is not coordinating these efforts.

2. During the field visit to New Orleans, Committee Members visited University Hospital, Charity Hospital, and Tulane University (currently run by Hospital Corporation of America (HCA)). According to testimony, staff interviews, and press accounts, many existing healthcare facilities appear to be nearing (or have surpassed) emergency room capacity. You testified that the Secretary of HHS has a “healthcare vision” for the greater New Orleans and Gulf Coast regions, but you were not able to provide details regarding what that vision was for much of the region.

Question (a): What is the “vision” for the hospital infrastructure in the New Orleans region for both the present and the future?

Answer: HHS is supporting the efforts of the people of Louisiana to design a health care system of the future. Early this year, Secretary Leavitt appeared before the Louisiana Legislature, urging creation of the Louisiana Health Care Redesign Collaborative. The Collaborative was created to empower a group of health care leaders from across the state with the design process. HHS is supporting the work of the Collaborative with staff, expertise and by removing roadblocks. Secretary Leavitt has pledged to support large-scale Medicare and Medicaid waivers to bring about the goals of the design effort, as long as the Collaborative adheres to agreed upon principles. The Collaborative has set a goal of presenting its blueprint for redesign in Fall 2006.

Question (b): Is this “vision” contained in a strategic document or plan that gives specifics about rebuilding the New Orleans healthcare infrastructure, particularly relating to hospitals, hospital preparedness, or healthcare preparedness? If so, please provide that document to the Subcommittee.

Answer: The Louisiana Healthcare Redesign Collaborative is preparing a plan that is expected to be submitted to HHS in Fall 2006.

Question (c): What is the Department’s understanding of the ‘surge capacity’ of existing operational facilities in the New Orleans region from a health care crisis/preparedness perspective?

Answer: Current estimates are that within the New Orleans region, hospital beds are approximately at 50% of the pre-Katrina levels. This number reflects available beds, not staffed beds. HHS can assist with temporary health care staffing needs in the wake of a crisis or other event with potential for higher medical staffing resource demands. For example, after Katrina, HHS provided temporary medical support to New Orleans to respond to heightened medical needs that could result from the increased tourist population for the city’s celebration of Mardi Gras.

Question (d): Does the Department prepare documents or reports on a regular basis that measure the Gulf Coast/New Orleans region’s preparedness capability? If so, what

process is used for those measurements? If reports are produced, please provide them to the Subcommittee.

Answer: The Department does not prepare documents that measure the Gulf Coast/New Orleans region's preparedness capability.

Question (e): Does the Secretary receive regular briefings as to the capability of the region's healthcare infrastructure to handle 1) mass casualty events such as a refinery explosion, chemical spill, traffic accidents or 2) any potential pandemic (i.e. an avian flu outbreak)? If so, who provides the briefings and what actions are being contemplated by the Department to better prepare existing hospitals?

Answer: The Secretary has received briefings on the status of hurricane preparations with regard to overall preparedness in Louisiana. Moreover, to assist the Gulf Coast or other regions during an emergency, HHS has established a department-wide incident management system and rostered, trained, and equipped teams of Public Health Service officers. The teams include a rapid deployment force of five teams of 105 officers each, deployable within 12 hours of notification; an applied public health team and mental health team, deployable within 24 hours; and incident response coordination teams. HHS has also developed 20 Federal medical stations with a 5,000 bed capacity for deployment, which can be onsite within 48 hours.

Question (f): Given the current limitations of present hospital preparedness for the greater New Orleans region, what additional measures does the Secretary believe are necessary to allow the region to successfully confront the upcoming hurricane season?

Answer: In preparation for the 2006 hurricane season, the Secretary has deployed full-time personnel to work in the Joint Field Office since March, 2006. This team has worked closely with State and local health officials to develop a plan for the evacuation of the 12 coastal parishes most likely to be affected by a hurricane. Accomplishments include:

- A medical evacuation plan;
- Conducted a survey of the capacity for nursing homes to shelter in place or evacuate;
- Conducted a hospital survey of the capacity of hospitals to evacuate or shelter in place;
- Participated in FEMA led exercises.

3. Your testimony mentioned a number of waivers that the Department was considering to assist various hospitals and healthcare facilities in the New Orleans region to provide needed care and relief:

Question (a): Please provide a list of the waivers that have been granted and a brief description of the purpose or objective of each waiver that has been approved.

Answer: On September 1, 2005, Secretary Michael Leavitt of the Department of Health and Human Services exercised his waiver authority under Section 1135 of the Social Security Act with respect to Louisiana and other states. Under this provision, the Secretary can waive or modify certain Medicare, Medicaid, or State Children's Health Insurance Program (SCHIP) requirements during certain emergencies to ensure that sufficient health care items and services are available to meet the needs of Medicare, Medicaid and SCHIP beneficiaries and that health care providers that furnish such items and services in good faith may be reimbursed for them. On Wednesday August 31, 2005 Secretary Leavitt notified the Congress that he made the determination that a public health emergency exists in Alabama, Florida, Louisiana and Mississippi as a consequence of Hurricane Katrina. This determination ensured that the section 1135 waiver is in effect in the emergency areas impacted by the crisis in order to protect the health and welfare of the public.

To ensure that Medicaid and SCHIP beneficiaries would receive necessary services, the Centers for Medicare and Medicaid Services (CMS) took action under section 1115 waiver authority to provide flexibility and make services quickly available to the residents of Louisiana. Specifically, on September 16, 2005, CMS released a State Medicaid Director's letter and a Multi-State Section 1115 Demonstration Application Template to Provide Medicaid and SCHIP for evacuees of Hurricane Katrina. Under the approved section 1115 demonstrations, eligible evacuees displaced from their homes were able to enroll to receive services under the Medicaid or SCHIP programs in the State where they are located. Eight states, including Louisiana, were allowed to set up uncompensated care pools to reimburse providers who incurred uncompensated care costs for medically necessary services and supplies for evacuees who do not have other coverage for such services and supplies through insurance or other options available, including Medicaid and SCHIP, effective August 24, 2005 through January 31, 2006. Louisiana's section 1115 waiver was approved on November 10, 2005 and the State's uncompensated care pool plan was approved on March 24, 2006.

The Deficit Reduction Act of 2005 (P.L. 109-171) (DRA) signed into law by President Bush on February 8, 2006 provided \$2 billion for payments by the HHS Secretary to eligible states for health care needs of areas affected by Hurricane Katrina. Consistent with the authority in the DRA, on March 24, 2006, Secretary Leavitt released \$1.5 billion to the 32 states with approved Katrina 1115 Demonstrations to help offset the medical costs of caring for evacuees, and, of this amount, Louisiana received \$768.9 million. The funding amount provided to each state was based on state projections of claims sent to CMS for care provided to evacuees and affected individuals. The remaining balance of the funds (\$500 million) from the DRA will be used to cover future costs for the states.

In addition to these Medicaid and SCHIP waivers, CMS acted to relax many of the Medicare fee-for-service program's normal operating procedures in the wake of Hurricane Katrina in order to speed provision of health care services to the elderly,

children and persons with disabilities. Specific examples of these actions include:

Skilled Nursing Care

- To ensure patients have access to needed skilled nursing care, CMS waived the 3-day prior hospital qualifying stay for Medicare's skilled nursing facility (SNF) benefit for
 - those who were evacuated from a nursing home in a public health emergency area,
 - those who were discharged from a hospital (in an emergency area or a receiving location) in order to provide care to more seriously ill patients, and
 - those who need SNF care as a result of the hurricane, regardless of whether they were in a hospital or nursing home prior to the hurricane.

Inpatient Hospital Care

- To expand the availability of inpatient beds and ensure that patients have access to needed inpatient care, CMS waived many of Medicare's classification requirements, allowing specialized facilities and hospital units to treat patients needing inpatient care. For example,
 - CMS will not count any bed use that exceeds the 25-bed or 96-hour average length of stay limits for critical access hospitals (CAHs) located in the public health emergency states, if such use was related to the hurricane.
 - CMS will not count admissions to inpatient rehabilitation facilities (IRFs) located in the public health emergency states toward compliance with the 75 percent rule, if such admissions were related to the hurricane.
 - CMS will not count patients admitted to a long-term care hospital (LTCH) located in the public health emergency states toward the calculation of the facility's average length of stay, if such admissions were related to the hurricane.
 - CMS will allow beds in a distinct psychiatric unit in an acute care hospital located in the public health emergency states to be available for patients needing inpatient acute care services, if such use was related to the hurricane.

Mental Health Counseling

- Beneficiaries enrolled in Part B of the Medicare program have coverage for mental health counseling by a Medicare approved provider (doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician's assistant). In certain situations partial hospitalization is also covered.

Home Health Care

- To ensure that patients have access to needed skilled care in the home, CMS clarified that a shelter, or temporary housing, is considered an individual's home for purposes of receiving home health benefits under Medicare.
- Home health agencies that are operating under the time limited statutory waiver in the affected disaster areas may complete an abbreviated patient assessment. This abbreviated assessment does not have to meet the 5-day completion date or the 7-day lock date. In addition, the OASIS transmission requirements are suspended for those

Medicare approved home health agencies serving qualified home health patients in the affected areas. Home health agencies are expected to use this policy only as needed.

Care for People with End Stage Renal Disease (ESRD)

- CMS is committed to remaining flexible to accommodate the emergency health needs of those beneficiaries who have end stage renal disease (ESRD). For example, Medicare will reimburse facilities for providing dialysis to patients with kidney failure in alternative settings.
- CMS is working with the ESRD Networks, the State of Louisiana, the Federal Emergency Management Agency (FEMA), Public Works, the American Red Cross and other Federal and state emergency response agencies in to locate those in need of dialysis and making sure that they get services quickly and efficiently.
- The ESRD Network can assist beneficiaries in locating available facilities for dialysis and necessary items such as transportation for dialysis, dialysis supplies and renal medications. In previous disaster situations, the ESRD Networks have served as a central contact for patients, facilities and state agencies to call regarding the status of facilities (e.g., open, closed, able to take additional patients) to facilitate emergency access to dialysis services.

Ambulance Services

- Existing ambulance payment policies are expected to cover medically necessary ambulance services for Medicare beneficiaries affected by Hurricane Katrina. CMS clarified how ambulance providers should bill for patients transported between hospitals or to other locations, and for transporting patients evacuated from the affected areas.
- For ambulance trips furnished to residents of skilled nursing facilities, consolidated billing rules will not apply.

Durable Medical Equipment

- Durable medical equipment will be repaired or replaced if it was damaged in the hurricane.
- Medicare will pay for the temporary use of portable oxygen when a beneficiary living at home with stationary oxygen
 - has to be transported to another location, or
 - if electrical power is lost at the beneficiary's home.

Laboratory Services

- In situations where laboratory specimens are destroyed or compromised by the hurricane, Medicare contractors have discretion to pay for another drawing fee, specimen transport, or test, if the results have not been communicated to the patient's physician.

EMTALA Requirements

- The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to provide a medical screening exam to all persons who come to the hospital seeking emergency care, regardless of ability to pay or any other non-medical factors. If an emergency condition is identified, the hospital must provide treatment to stabilize that condition, or an appropriate transfer to another facility capable of stabilizing the patient. To ensure access to emergency care during the declared public health emergency, these general requirements of EMTALA will continue to apply.
- However, CMS will not penalize hospitals within the declared public health emergency areas for redirecting or moving individuals to other locations to receive a medical screening exam pursuant to a state emergency preparedness plan, or for transferring unstabilized patients, if necessary, pursuant to the hospital's disaster protocol. This waiver does not apply to any action that discriminates among individuals based on their source of payment or their ability to pay.
- CMS clarified that EMTALA does not require a full medical screening exam for persons who come to hospital emergency departments merely to refill prescriptions that were lost during evacuation from an affected area, but only screening appropriate to the request being made. Hospitals may wish to develop protocols for streamlined screening of patients seeking only prescription refills.

Billing and Payment

- To accommodate the emergency health care needs of beneficiaries, CMS relaxed billing requirements and offered accelerated payment options for providers furnishing such care. For example,
 - CMS will allow hospitals to have a responsible physician at the hospital (e.g., chief of medical staff or department head) to sign an attestation when the attending physician cannot be located.
 - CMS will allow providers affected by the hurricane to file paper claims if necessary.
 - CMS has instructed its contractors to facilitate the processing of claims for services furnished by physicians to treat patients outside the normal settings (e.g., shelters).
 - CMS will pay the inpatient acute care rate and any cost outliers for Medicare patients that no longer need acute level care but remain in a hospital located in the public health emergency states, until the patient can be moved to an appropriate facility.

- For those teaching hospitals that are training residents that were displaced by the hurricane, CMS will temporarily adjust the hospital's full-time equivalent cap on residents, as needed, to allow the hospital to receive indirect or direct graduate medical education payments for those displaced residents. The temporary adjustment applies as long as the original program in which the displaced resident trained remains closed.
- Accelerated or advance payments are available to those providers who are still rendering some services or are taking steps to be able to furnish services again, despite having their practice or business affected or destroyed by the hurricane.
- CMS has instructed its contractors to process immediately any requests for accelerated payments or increases in periodic interim payments for providers affected by the hurricane. The intermediaries have also been instructed to increase the rate of the accelerated payment to 100 percent and extend the repayment period to 180 days on a case-by-case basis.
- CMS has instructed its intermediaries to approve requests for extensions to cost report filing deadlines for providers affected by the hurricane. The intermediaries have also been instructed to accept other data they determine is adequate to substantiate payment to the provider when a facility's records are destroyed. This determination will be done on a case-by-case basis.
- CMS will allow providers who have waived the coinsurance and deductible amounts for indigent patients affected by the hurricane to claim bad debt, even in cases where documentation regarding a patient's indigence is unavailable. Providers must note their observations or submit any documentation they can along with a brief signed statement by medical personnel regarding the patient's indigence.

Provider Enrollment

- CMS has instructed its contractors to streamline and expedite the enrollment process for physicians or providers who have set up a practice in a different physical location due to the hurricane. Rather than requiring completion of an 855 enrollment package, contractors will require providers who have an original signature on file to submit their tax ID and other identifying information to the contractor via facsimile

Question (b): Please provide a list of the waivers that are still pending and a brief description of the purpose of each pending waiver. For each pending waiver, please provide the expected approval date as well as any specific issues that are delaying the approval.

Answer: There are currently no pending waivers. January 31, 2006, was the deadline for waiver applications. This date is tied to the eligibility period in the section 1115 waiver template for when evacuees are able to apply for assistance. Specifically, the waiver template states that "Applications for eligibility for evacuee status will be accepted from August 24, 2005 through January 31, 2006, and may be retroactive to August 24, 2005." Nevertheless, Secretary Leavitt has pledged to support additional, large-scale Medicare and Medicaid waivers to bring about the goals of the Louisiana Health care Redesign Collaborative, as long as the effort adheres to agreed upon principles

Question (c): Does the Department believe that additional waivers for the Louisiana-Mississippi-New Orleans region related to health care will be necessary? If so, for what purpose?

Answer: Notwithstanding the Collaborative previously mentioned, the Deficit Reduction Act of 2005 (P.L. 109-171) (DRA) signed into law by President Bush on February 8, 2006 provided \$2 billion for payments by the HHS Secretary to eligible states for health care needs of areas affected by Hurricane Katrina. Consistent with the authority in the DRA, on March 24, 2006, Secretary Leavitt released \$1.5 billion to the 32 states, including Louisiana and Mississippi, with approved Katrina 1115 Demonstrations to help offset the medical costs of caring for evacuees. The remaining balance of the funds (\$500 million) from the DRA will be used to cover future costs for the states.

4. In the two spreadsheets provided by FEMA to the Subcommittee staff, there are specific, multiple-line items for two of the hospitals visited by Subcommittee Members. The first line item identifier, "LSU HCSD MEDICAL CTR OF LA AT NEW ORLEANS," appears to refer to the Louisiana State University (LSU) Health Care Services Division, State of Louisiana. The other line item identifier, "FACILITY PLANNING AND CONTROL, STATE OF LOUISIANA" appears to refer to Charity Hospital, as noted in the "Remarks" column of the spreadsheet.

Question: Do these line items, in fact, refer to those facilities?

Answer: It appears the line items refer to the facilities you indicate. But since these spreadsheets were prepared by FEMA, we cannot respond definitively.

5. As both of these hospitals represent major contributors to public health and emergency preparedness in the region, particularly for the poor and indigent, please address the following:

Question (a): What is the Department's understanding of the funds related to both of these hospitals? For example, for "LSU HCSD MEDICAL CTR OF LA AT NEW ORLEANS," the attached FEMA worksheet lists a total of \$13,125,000 in the "Applicant Amount" column. What is the Department's understanding of the purpose of this obligation as it relates to this facility?

Question (b): For the applicant identified as "FACILITY PLANNING AND CONTROL, STATE OF LOUISIANA" "LSU HCSD MEDICAL CTR OF LA AT NEW ORLEANS," a total of \$23,856,735 appears to be "obligated or in system" for that facility, according to the referenced spreadsheet. What is the Department's understanding of the purpose of that obligation as it relates to this facility?

Answer: Both of the above questions refer to FEMA documents and funds administered by FEMA under its authorities. Since HHS is not involved in the awarding or administration of these funds, we can not speculate on the purpose of the obligations listed for the facilities.

6. On January 26, 2006, a public notice ran in the *New Orleans Times Picayune* titled “FEMA PUBLIC NOTICE (FEMA ASSISTANCE IN FLOODPLAINS AREAS).” This notice makes reference to certain actions regarding the LSU Medical Center and notes that an initial public notice was published on September 23, 2005. The notice states:

This final notice only concerns emergency location of a temporary medical facility that will be located within Zone AE (areas with special flood hazards inundated by the 100-year flood; base flood elevations determined) in Orleans Parish. Executive Order 11988 (Floodplain Management), as implemented at 44 Code of Federal Regulations Part 9, requires FEMA to review its actions in floodplains or affecting the base floodplain elevation for practicable alternatives outside of the floodplain and to minimize future vulnerability from flooding. FEMA has determined that for this emergency repair to life-safety system components and to critical MEP equipment and for reconfiguration of those portions of the hospital scheduled for use as a short-term level 1 trauma facility located in the aforementioned parish, there are typically no practicable alternatives to siting the emergency temporary medical complex outside the floodplain. University Hospital Complex, 2021 Perdido Street, New Orleans, LA, is the primary health facility within the City of New Orleans that would be available for use as a Temporary Level 1 Trauma Facility and critical medical equipment facility. Mitigation measures to protect critical elements will be incorporated on an action by action basis, when feasible.

Question (a): What is the Department’s understanding of this public notice as it directly affects public health and hospital preparedness needs for a major urban region?

Question (b): This public notice states that the “University Hospital Complex, 2021 Perdido Street, New Orleans, LA, is the primary health facility within the City of New Orleans that would be available for use as a Temporary Level 1 Trauma Facility and critical medical equipment facility.” Is it the Department’s understanding that this will become the new temporary level 1 trauma center for the greater New Orleans region?

Answer: With regard to the two questions, above, we can not speculate on the meaning of this FEMA notice. But we note that HHS’ United States Public Health Service Commissioned Corps has continued to work with Louisiana health officials. Also, experts from across HHS, including Centers for Disease Control and Prevention and the Food and Drug Administration, were made available to augment state and local public health resources. Hundreds of thousands of doses of antibiotics and other medications, as well as medical supplies and equipment from the Strategic National Stockpile were shipped to the Gulf Coast. Moreover, the Department of Veterans Affairs (VA) deployed over 100 experts (nurses, radiology technicians, health technicians, respiratory therapists and other health care professionals) to the New Orleans area to assist with their current healthcare personnel shortage. VA health care professionals continued to support local hospitals (Tulane Medical Center, East Jefferson General Hospital, West Jefferson General Hospital and Meadowcrest Hospital) through the end of September 2006.

Question (c): Was this public notice coordinated with the Department, and if so by what sections of the Department?

Answer: The notice was not coordinated with HHS.

Question (d): It was the Subcommittee's understanding that a temporary Level 1 trauma center would be located and paid for by FEMA in Elmwood, Louisiana, which is located outside of Orleans Parish. This public notice appears to suggest otherwise. What is the Department's understanding of the status of the Elmwood facility, and does this notice change in any way the status of that facility?

Answer: The Elmwood facility is operational, has been augmented with medical and surgical staff, and has the capability of caring for trauma victims. To our knowledge, however, it has not received a trauma level designation. We can not speak to the effect of FEMA's public notice on the status of the facility.

Question (e): Is the Department providing any assistance or input to FEMA regarding the feasibility and/or advisability of efforts to restore Level I trauma capability to the greater New Orleans region? If so, please describe the assistance that the Department is providing. If not, please describe why the Department is not lending its expertise to this seemingly critical preparedness effort.

Answer: Principally, HHS has worked with FEMA on developing an evacuation plan for the healthcare system. We have also maintained a full-time presence in Louisiana, working with state and local health officials to augment local resources and assist with efforts to restore its public health infrastructure. HHS is the principal proponent of State efforts to create the Louisiana Health Care Redesign Collaborative. The Collaborative, which will initially focus on the greater New Orleans area, is committed to developing a blueprint for the redesign of the state's health care system.

