



## ***Ochsner Health System***

**Testimony  
of the  
Ochsner Health System  
before the  
HELP Committee  
U.S. Senate**

**July 14, 2006**

Good afternoon, Mr. Chairman. I am Patrick J. Quinlan, M.D., Chief Executive Officer, Ochsner Health System (OHS), in New Orleans, La. I appreciate the opportunity to speak to you and your colleagues about the current state of healthcare in the greater New Orleans area, and the potential for re-building and re-designing our healthcare sector.

For nearly 60 years, OHS has cared for residents in the greater New Orleans and Baton Rouge communities. Our main campus, including the 478 acute-care bed hospital and clinic, is located in Jefferson Parish, less than a mile from the Orleans Parish line and only a 15 minute drive to downtown New Orleans. In addition, we have 24 clinics throughout the New Orleans area and a sub-acute nursing facility/inpatient psychiatry/inpatient rehabilitation hospital two miles from our main campus. In Baton Rouge, we have three clinics, 70 physicians and 50 percent ownership of an acute care hospital. Recognized as a center for excellence in research, patient care and education, OHS is a not-for-profit, comprehensive, independent academic integrated health care system, and the largest non-governmental employer in Louisiana. With more than 7,400 employees – including more than 600 physicians in nearly 70 medical specialties – OHS is also one of the largest non-university-based physician-training centers in the country, annually hosting over 325 residents and fellows, 450 medical students and 400 allied health students.

When Hurricane Katrina hit the Gulf Coast, no one could have truly imagined the intense devastation it would leave in its wake. The wind and the rain wreaked havoc across Alabama, Mississippi and Louisiana. The health care system as we knew it in New Orleans was devastated. The universities responsible for 70% of the medical education in the state were closed. Knowing that the storm was headed their way, hospitals began sending home patients deemed well enough to be discharged. Those in critical condition or requiring special assistance, such as ventilator-assisted breathing, remained in the

hospital. When hospital staff emergency teams arrived for work during the weekend before the storm hit, they expected it might be only a few days before they were able to return home. However, when the levees in New Orleans broke, the situation changed dramatically. We, and our colleagues in the New Orleans metropolitan area, faced a dire situation beyond our imagination.

Throughout the onslaught of Hurricane Katrina, and during its devastating aftermath, OHS remained open, caring for patients and continuing our medical education programs. This afternoon, I would like to tell you how my hospital system prepared for the storm; what our facilities did to ensure our doors remained open to provide critical health care services to our community; what we have done subsequently to ensure continued provision of all critical health care needs to the community; how we have maintained medical education for the region; and answer any questions you and your colleagues might have about our experience.

### **Planning for Disaster**

Hospitals routinely plan and train to deal with disaster, whether it's the derailment of a train carrying hazardous substances, a multiple-vehicle accident on a nearby interstate, a plane crash, or a natural disaster such as a hurricane or earthquake. As hospitals plan for disasters and the prospect of going without public services such as electricity and water, we prepared to be on our own for at least 72 hours, in the event it takes that long for assistance to arrive from the state or federal government. Our plan, which we revise after every disaster or "near-miss" event, had been revised most recently on June 1, 2005, less than three months before Hurricane Katrina struck.

On Friday, August 27, our entire executive leadership team had assembled in New Orleans for the first day of a two-day leadership retreat. Late in the afternoon, we were notified that the storm had turned to the West and likely would strike the area. We immediately initiated the first phase of our disaster plan, which included notifying essential personnel and securing previously stockpiled supplies.

Under the most recent disaster plan, two teams of essential personnel, Teams A and B, were created to ensure continuity of care and relief for employees on duty at the time disaster strikes. Each team was to include staff members from all departments, e.g. security, housekeeping, dietary, nursing, physicians, house staff, IT, media relations, research, etc. Team members had been identified and committed by June 1.

From previous experience, we realized the importance of not only adequately stocking essential supplies on-site, but also creating a back-up system to ensure additional supplies could be secured in times of an emergency. On Friday, we activated our supply chain and began to secure the additional supplies we had stockpiled off-site. Important supplies included: 400 flashlights; 100 head lamps; 2,000 batteries; 4,000 glow sticks, including 2,000 with lanyards; 600 SpectraLink wireless telephones with 1,800 batteries; 450 oscillating fans, one per patient; 250 box fans for work and sleeping areas; 20 55-gallon

drums of water on each floor for commode flushing; 3000 gallons of water for drinking (we also have a deep water well on campus with a 10,000 gallon holding tank for additional water in an emergency); 60,000 gallons of diesel fuel; 10 pallets of sandbags; eight pallets of plastic bags; 100 blue tarps; 20 dehumidifiers; five pallets of plywood; and 50 additional shop vacuums. We also increased our food supply. At this time, we inspected our power sources. Our emergency generators are all located above our facility's second floor and our transformers were located on the ground level, behind 10-foot floodwalls.

On Saturday, August 28, executive leadership met with the vice presidents, directors, and managers and agreed to order Team A on-site by Sunday afternoon. Staff then began discharging the appropriate patients and moving those that would be unable to leave the facility. The families of the remaining patients were given "boarding rules" – one family member per patient would be allowed to stay. Similarly, staff was discouraged from bringing family members to work unless they absolutely could not make other arrangements. All patient and personnel families were pre-registered and given "special" parking passes to access our parking garage. During previous storms, we experienced problems with people in the community attempting to use our garage to protect their cars and boats. Under the revised plan, we stationed armed guards at the entrances to the garage to ensure that hospital staff, patients and their families could access the garage, and that all entrances were kept clear.

On Sunday, "sleeping" assignments were made. Due to concerns about the predicted high winds, patients were removed from the highest floors of the hospital. Patients were also moved into hallways and rooms without windows to protect them in the event of flying glass. Because OHS is a research facility, we house numerous research animals, which were evacuated to facilities in northern Louisiana. After evacuations were complete, we settled in to wait and see what Hurricane Katrina would bring.

### **Weathering the Storm**

Ochsner's main campus survived the actual hurricane quite well. We sustained some roof and structural damage to our main facility, but overall the news was positive. Our generators functioned properly, the Internet was up and running, and our internal communications system was fully operable. Employees lost cellular phone and beeper capabilities due to damage to local cell towers; however, we had planned for such an event, and staff members were armed with SpectraLink wireless telephones. As a result, communication critical to patient care was uninterrupted. Our land-based telephones also remained in working order due to redundancy in our carrier network. Our medical record system is entirely electronic, and with power and the Internet operable, we did not have concerns about the availability of critical patient information. We had adequate supplies and believed we would be able to ride out the next few days.

However, as the situation in and around New Orleans rapidly deteriorated with the breach of the levees, conditions inside the hospital also took a turn for the worse. On the second day, one of our generators failed due to a mechanical problem, and we were forced to do

without air conditioning. As a result, our Internet servers were shut down to prevent them from being damaged by the heat. Unfortunately, server shutdown meant the electronic medical record system was inoperable. We attempted to send our helicopter out to secure the needed parts for the generator, but all non-governmental aircraft were temporarily grounded. We were, however, able to locate the necessary parts the next day to get the generator up and running again.

Conditions in our immediate area continued to worsen. Our main facility is located a few miles from the I-10/Causeway where large numbers of people attempting to make their way out of New Orleans after the storm congregated. Many of those gathered turned to the hospital for assistance on their way. However, we are a hospital, not a shelter. We tried to point people in the right direction to get the help they needed, and also dispatched medical personnel to the site to care for individuals in need, transferring those needing hospitalization back to our campus. Conditions in our neighborhood further destabilized as floodwaters began to rise; looting of nearby businesses began. At that point, we felt compelled to ask the National Guard to assist us in securing the safety of our patients and staff, and placed OCF on lockdown.

Operations inside the hospital similarly were beginning to show signs of strain. Although we had made extensive plans for securing and relieving essential personnel with the Team A and B designations, and had gone to great lengths to keep staff apprised of the situation – setting up a telephone tree as well a dedicated Web page with information – we had difficulty securing relief staff. Many had evacuated with their families to Baton Rouge and beyond. Fortunately, we were able to locate a good portion of staff members there and bring them in by bus convoy. As the floodwaters continued to rise, the same convoys were used to evacuate exhausted staff and their families, as well as patients who could be moved and their family members, to our facilities in Baton Rouge. These same convoys were our lifelines for supplies as well, enabling us to continue functioning.

At their height, the floodwaters rose as far as the doors on one side of the hospital, but we maintained the ability to leave and enter the building from other entrances and faced no real danger. Instead, we realized that rumor and speculation were a larger threat to the internal stabilization of the hospital than the floodwaters, and created an internal communication system to keep staff and patients informed of the conditions within the hospital and the city at large. The leadership team met twice daily to be updated and then fanned out across the facility, sharing the news they had just heard and answering questions. This open and honest communication policy went a long way toward assuaging staff and patient fears, and keeping the hospital in a calm state.

Toward the end of the crisis, we began to run low on food. However, we had an ample supply of water and were able to make do until relief shipments could be brought in. We also ran low on insulin, but because our telephones had been unaffected, we were able to secure 10,000 doses donated from sanofi-aventis pharmaceutical company.

## **Reaching Beyond Our Walls**

With the situation in OHS' main facility well in-hand, our leadership team sought to inform local officials and offer assistance to other health care facilities hit harder by the storm. Since our land-based telephone system was operable, we believed this would be easy. However, we had great difficulty trying to contact other hospitals and local agencies that were not as fortunate in the quality of their communications systems. We even found it difficult to locate the proper state and federal officials to offer our assistance.

According to our regional emergency plan, we report to the Jefferson Parish Office of Emergency Preparedness (OEP). However, the OEP system was overwhelmed and communication was impossible. When our attempts to reach the Jefferson OEP failed, we attempted to reach the Baton Rouge OEP. This was also challenging, as it appeared that the bandwidth of their system could not accommodate the high volume of incoming requests and was overloaded. We eventually successfully contacted the Orleans Parish OEP following the levee break, requesting both information, as well as assets. During this exchange, we became aware of their communications difficulties with the downtown hospitals that were in the midst of evacuating.

It was virtually impossible to coordinate air evacuation due to the various agencies involved – both military and civilian – and their lack of ability to communicate. We sent a vice president through the floodwaters downtown to the Orleans OEP with a hand radio to try and assist their coordination efforts, but were unsuccessful in reaching them. We instead found a widespread lack of coordination: police communication systems that were ineffective due to infrastructure damage and volume, and a National Guard system that was able to facilitate communications amongst guard units, but had difficulty communicating with local authorities. Of external communications, satellite systems were unreliable, and cell service, for a while, was virtually eliminated. Text messaging and Internet were the most reliable methods of communication.

Communication improved on day four when the United States Public Health Service (USPHS) arrived, and interagency daily meetings at OHS' main facility began. In addition to the USPHS, these meetings included "all" hospitals and representatives from the Jefferson and Orleans OEP health care divisions. The USPHS was able facilitate requests through the previously frustrating channels. They were particularly helpful with things like fuel and security; however, they did not have access to many of the assets we required. Prior to the USPHS's arrival, we were so frustrated in our inability to notify authorities that we were open and able to accept patients, that we used large trash bags to spell "OPEN" on our garage roof hoping to attract the attention of the armada of helicopters flying overhead.

## **Recovery**

With our Board's permission, and because of our commitment to the community, and at a great expense to Ochsner, we have kept our workforce on payroll throughout and after

the immediate crisis. We have recruited to fill both professional and non professional positions in order to be able to open approximately 100 additional beds to serve the needs of the community. We have leased one of our facilities, the Elmwood Medical Center, to the state to be used as a Level I trauma center. Even as our indigent care discharges have nearly quadrupled and our cost of operations has escalated, we have re-dedicated ourselves to be the healthcare safety net for the region. Despite operational losses of nearly \$70M, we have maintained all of our primary, tertiary and quaternary services, including state of the art cancer treatment, solid organ transplant, and cardiovascular interventions. We have received virtually no financial relief for our efforts and to offset our losses. Because we are a private not for profit institution, we have not been eligible to directly receive loans from the Community Disaster Loan program. HRSA grants, similar to what was offered to NYC institutions following the 9/11 disaster, have not been made available to us.

We have also become the academic safety net for the region. Shortly after the hurricane, we invited investigators from both Tulane and Louisiana State Universities to use our research laboratory facilities in order that their research could continue uninterrupted. This has allowed numerous investigators from both universities to not only maintain their NIH funded work, but also to secure additional funding.

Our teaching programs have continued uninterrupted. We had a very successful match for our residencies programs this year. Despite, our concerns of top students not wanting to continue their training in New Orleans, all of our programs filled at approximately the same or improved level from prior years. We even increased our match numbers by 5 this year, despite the state offering a \$10,000 bonus to students who matched into the competing University programs.

Since we have an extensive infrastructure for academic activities, we have offered to host additional LSU and Tulane based residents and medical students at our facilities. We are doubling the number of medical student rotations to over 900 annually. At this time, it appears we will have 50 to 75 additional residents training at our institutions. We are doing this even though it imposes a significant financial risk to us. The April ruling by CMS for temporary transfers of CAP FTEs during a disaster intends to ameliorate the financial burden. However, there are two aspects that significantly adversely affect our ability to host the residents. The ruling that the additional CAP transfer positions must be averaged over a three year period will have us not breaking even until the third year. At this time, when our cash flow is a significant issue, given our operating losses secondary to the hurricane, it is problematic that we will be able to continue to host the residents. Additionally, the three year maximum time period is significantly short of the time it will take for LSU and Tulane to restore their teaching facilities.

The training of these house staff is critical to the New Orleans region being able to maintain an adequate public health workforce. Prior to the hurricane, the Louisiana Medical Education Commission has reported that Louisiana was in a relatively steady state in regards to the training and establishing of new physician practices relative to the number of physicians leaving practice. With large numbers of physicians having left

New Orleans after the hurricane, any threat to the New Orleans region training programs will significantly affect the public health work force and the ability to care for the healthcare needs of citizens in this region. Therefore, it is extremely important that the three year rolling average be abolished and the three year maximum time limit for this emergency ruling be extended.

As you undoubtedly will learn from the LSU and Tulane presentations, the universities will be scrutinized extensively this summer by their accrediting bodies. Both the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee for Medical Education (LCME) will evaluate the respective residency training programs and medical school curricula. It is imperative that the medical schools demonstrate adequate teaching sites and supervision for both the residents and the students. If not, they will lose accreditation, faculty will leave, and students and residents will not be trained in their programs locally. The development and deployment of an appropriate public health workforce will not occur. This will result in the worsening of what already is a crisis.

One of the success factors for Ochsner during and immediately after the hurricane has been our electronic medical record. This is the only fully functioning electronic medical record in the region. This was and continues to be a life saver for our patients. No matter where they arrived after the hurricane, their health record was available to them. This type of record is of paramount importance for all of our residents, whether in the midst of a disaster or in the course of their routine care. Because we recognize this, we have been working with local and state groups in the planning of health information technology for the region. We offer the use of our electronic medical record to be used by other institutions and patients in the region. The ability to make this available will require funding to adapt it to other institutions' platforms.

### **Summary and Conclusion**

Ochsner Health System is a non-profit (501c3) independent academic integrated health care system. We have stayed open during the hurricane and expanded our ability to care for patients and maintain the academic programs in New Orleans. This has occurred at great financial impact to us. We have as of yet received no significant financial assistance to offset our losses. Our academic activities have allowed the two universities to return to New Orleans, and so far to remain in compliance with their accrediting bodies. Our electronic medical record is unique in the region and has been the lifeline for our patients.

As you help to plan and oversee the rebuilding of healthcare in this region, we ask you to consider:

- Stabilizing the public healthcare workforce by asking CMS to amend its April Emergency Ruling to void the 3 year rolling average and three year time limit on the Cap transfer positions;

- Securing the availability of necessary healthcare services by assisting us in identifying funding to offset our hurricane related operating losses;
- Ensuring the availability of patients' medical records during a disaster, as well as, for routine care by assisting the implementation of our electronic record for all providers regionally.

We look forward to working with this committee and staff to forge ahead toward a shared goal of improving the healthcare in New Orleans.