

Getting People Healthy in New Orleans



Point 6: Access to Care

Adequate access to health care and related services can increase appropriate patient use of the health care system and, ultimately, improve health outcomes. Consequently, measures of access across a continuum of care are an important way to evaluate the quality of a health care system. However, major changes in the structure of the U.S. health care system, including the increasing influence of market forces, changes in payment and delivery systems, and welfare reform, have significant implications for vulnerable and at-risk populations. In light of these systems changes, Federal, state, and local public health agencies must redouble their efforts to address access barriers and reduce disparities for these populations. It is increasingly important that health care communication and services be provided in a culturally and linguistically sensitive manner.

Improving access to care is insufficient without recognizing the importance of quality. Quality monitoring systems tend to emphasize measures that focus on delivery rates for clinical preventive services because access to and use of these services are important indicators of the quality of health care providers and of delivery systems. During the 1990s and into the 21st Century, increased attention has been paid at all levels of government as well as by the private sector to improving health care quality. A few highlights from these efforts are presented below and include health plan performance, hospital overuse due to problems with primary care access, consumer feedback and participation efforts and error reduction. Examples of organizations and the quality tools they have developed are as follows:

- The National Committee for Quality Assurance (NCQA), a managed care accreditation group, led a collaborative effort to develop the Health Plan Employer Data and Information Set (HEDIS), a widely used tool for evaluating health plan performance.¹
- The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) also has developed performance measures.
- The Agency for Healthcare Research and Quality (AHRQ) has developed:
 - The Consumer Assessment of Health Plans Survey (CAHPS), an instrument to assess consumer experiences with health plans.
 - Healthcare Cost and Utilization Project (HCUP), which makes available state and nationwide estimates of hospital use. These data can be used with the HCUP Quality Indicators to provide measures of ambulatory-care sensitive conditions, which can uncover potential problems in access to primary care services.
 - The complementary *National Report on Healthcare Quality* will explore methods for integrating the data from these quality-monitoring systems with population-based data collected by the public sector.
- The Federal Advisory Commission on Consumer Protection and Quality in the Health Care Industry, established in 1997, studied changes occurring in the health care system and recommended ways to ensure consumer protection and quality health care.

- The Commission’s report² provides a foundation for the emerging issues of the next decade in monitoring and reporting on quality of health care including a “Consumer Bill of Rights and Responsibilities,”³ designed to strengthen consumer confidence in the health care system while holding participants in the system accountable for improving quality.
- The Institute of Medicine issued a report in December 1999 documenting the magnitude of medical errors in U.S. hospitals. It recommended strategies to reduce such errors, including better reporting of errors.⁴

Access to high-quality health care across each of the components in the continuum of care must be improved to realize the full potential of prevention. For example, success in reducing the burden of heart disease and narrowing the gap in heart disease outcomes between different racial groups will depend on several factors. These factors include ensuring access to clinical preventive services, such as blood pressure and cholesterol screening; effective primary care to educate people about modifiable risk factors, such as smoking, and to manage effectively chronic conditions like hypertension; high-quality emergency services to improve outcomes of acute cardiac events; and access to rehabilitative and long-term care for heart disease patients. Limitations in access to care extend beyond basic causes, such as a shortage of health care providers or a lack of facilities. Individuals also may lack a usual source of care or may face other barriers to receiving services, such as the barriers identified in Table 9.1, below.

Table 9.1: Potential Barriers to Health Care Services

Financial barriers	Lack of insurance or insufficient insurance with low disposable income for healthcare
Structural barriers	Lack of facilities or health care professionals nearby
Personal barriers	Sexual orientation, cultural differences, language differences, not knowing what to do, or environmental challenges for people with disabilities
Attitude barriers	Patients with disabilities may face additional barriers arising from facilities that are not physically accessible or from the attitudes of clinicians
Skill barriers	Those who are disabled, elderly, chronically ill, or HIV-infected, require access to health care providers who have the knowledge and skills to address their special needs. ⁵

Substantial disparities remain in health insurance coverage for certain populations. Similar disparities exist in access to a specific source of ongoing care. An average of 85% of adults identified a specific source of ongoing care in 1998, but the proportions dropped to 76% for Hispanics and 77% for those below the poverty level.⁶ Hispanics, young adults, and uninsured persons are least likely to have a usual source of care.⁶ Hispanic persons and those with less than 12 years of education are least likely to have a usual primary care provider.

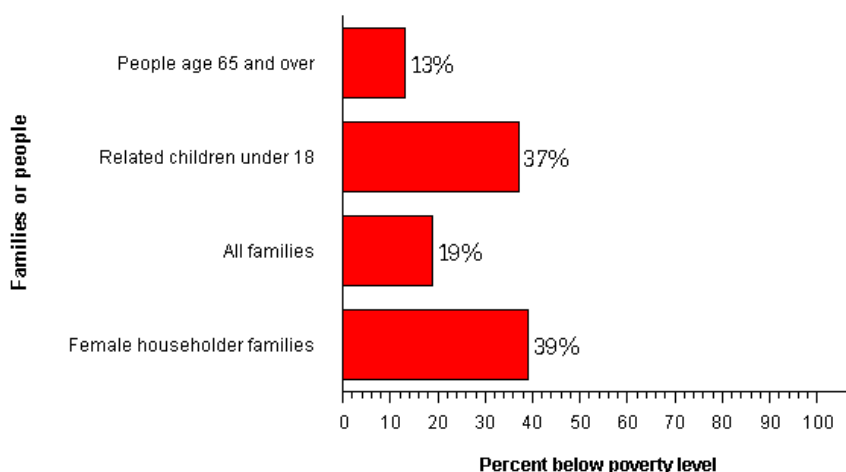


The extent to which poverty exists in, and impacts upon, the City of New Orleans is extraordinary, and must be the principal focal point for the successful implementation of a new plan for delivering primary care services to all residents in need. Poverty, poor housing, and lack of employment, along with poor academic performance, all contribute to the health care crisis. Orleans Parish’s health record is poor by national standards, and within the parish, there is great inequality between the health of affluent and poorer neighborhoods.

The highest poverty rates in Louisiana are in the eleven parishes that abut the Mississippi River in the northeast part of the state, and in Orleans Parish, where as much as three-quarters of the population is low-income.

- Median household income in Louisiana is \$34,307 compared to the national median household income of \$43,527. The median income of households in 2003 in New Orleans was \$30,703. Further, 34 of the 73 New Orleans neighborhoods have median household income less than \$25,000.⁷ The New Orleans Council for Young Children reports that every two hours a child is born into poverty in New Orleans.
- New Orleans ranked 60th out of 64 parishes for family income.⁷
- New Orleans has the third-highest poverty rate in the nation for children.
- One in four Louisiana children is abused or neglected. Many children face violence daily in homes or neighborhoods.

Figure 9.1: Poverty Rates in New Orleans, 2002⁸



With a total population of 435,000, there are:

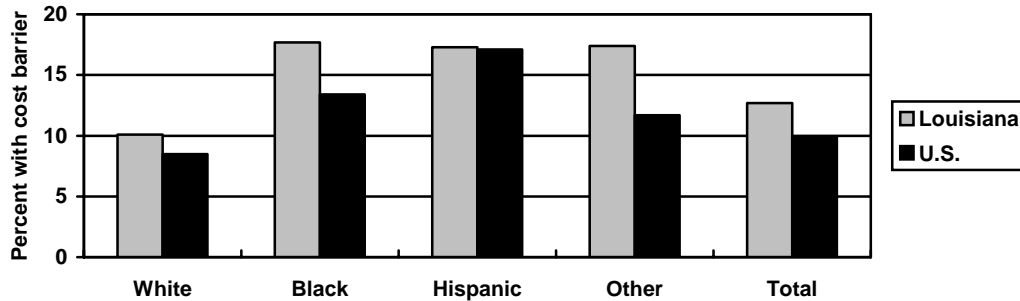
- 8,202 cumulative AIDS/HIV cases in New Orleans,
- More than 13,000 homeless people in the City,
- Nearly 60,000 people in public housing,
- 24,047 substance abusers,
- 113,161 low-income school children,
- Four in 10 pregnant women who receive inadequate prenatal care, resulting in a high incidence of premature births and low-birth-weight infants,
- Nearly one birth in every five is to an adolescent mother, (State of Louisiana statistic), and
- Less than half of "at-risk" children receive quality childcare or preschool services.

These population groups, along with the approximately 3% (less than 7,000) of other minorities (non-Black/African American) in New Orleans, all have a high prevalence of health problems, particularly chronic disease. Medical problems creating a high need for primary health services in Orleans Parish include coronary heart disease, cancer, diabetes and births to teenage mothers.

Health care to this portion of the community is delivered from a fragmented system of clinics, emergency rooms (predominantly MCLNO's Charity and University Hospitals) and other health care providers, which do not adequately meet their continuing primary health care needs. Improving access to quality health care can have a substantial impact on both individual and community health in New Orleans.

Figure 9.2 demonstrates both the low access to care in Louisiana and the racial disparity in the ability to visit a doctor. Given this racial disparity in access, New Orleans residents are even less likely to visit a doctor than Louisiana residents.

Figure 9.2 Percentage of Louisiana citizens with cost barriers to health care.⁹



Orleans Parish ranks among the worst in the state in critical health status indicators, including those for children, in spite of increasing enrollment under expanded Medicaid coverage for children under 18 years of age), as shown in Table 9.2. Additionally, there is limited access to preventive and primary care services for low-income families throughout Orleans Parish.

Table 9.2 Health Status Indicators, City of New Orleans, 2004¹⁰

Health Status Indicators for the City of New Orleans	Orleans	LA	Healthy People 2010 Goals
Waiting Time for Public Housing	25 Months +		
Shortage of primary care physicians	HPSA/Yes		
Unemployment Rate	5.50%		
Percent of individuals \leq 200% poverty	50.00%		
Percent of uninsured individuals	26.11%		
Cancer Rate	256.7/100,000	202/100,000	161,100,000
Coronary Heart Disease Rate	222.5/100,000	216/100,000	166/100,000
Diabetes Rate	6.9/100,000		3.87/100,000
Infant Mortality	10.70	7.20	
Late Entry into Prenatal Care	24%	17%	
Low Birth Weight Rate	12.50%	7.50%	
Births to Teenage Mothers	19.0%	17.0%	
Suicide Rate	12.3/100k	7.4/100,000	
Aids/HIV Rate	40/100,000	16/100,000	
Percent of Elderly Population	13.00%	11.60%	
Percent of Minority Populations (All)	70%	24.9%	
Other: Unmarried Mothers	63.70	32.40	

In recognizing that access to quality care is important to eliminate health disparities and increase the quality and years of healthy life for all persons in the United States, the NOHD has selected the following four priority service areas to address:

- clinical preventive care,
- primary care,
- emergency services, and
- long-term and rehabilitative care.

Together with health care delivered by specialists and care received in hospital settings, these elements represent major components of the continuum of care.



CITY OF NEW ORLEANS

CITY OF NEW ORLEANS PRIMARY CARE STRATEGIC HEALTH PLAN

The City of New Orleans Health Department (NOHD) commissioned a project in late 2004: to develop a blueprint to improve access to care from a comprehensive review of planning district and neighborhood level data.

The NOHD as a public entity, cannot by itself, solve all the major health care problems that exist in the City of New Orleans. Collaborative efforts and partnerships have developed over the years, providing the opportunity for diversified stakeholder involvement. To ensure strategic planning buy-in, the stakeholder process brought key players to the table, including the two major City providers – the NOHD and the Medical Center of Louisiana at New Orleans (MCLNO). With no authority and no vested interest relative to direct primary care or other direct health care-related service provision at this time, The Partnership for Access to Healthcare (PATH) was deemed the ideal vehicle to present, debate, discuss, negotiate, and reconcile ideas and issues. This organization provided the initial vehicle for integral stakeholder involvement through meetings and later, through a strategic planning retreat held in early March 2005. **PATH, an affiliated program of the Louisiana Public Health Institute (LPHI), is an organization of leaders in the health and social service sectors of New Orleans that work together to achieve quality, equity and access to comprehensive health and social service systems for people with limited access to care in the New Orleans area.** All stakeholders are committed to working proactively towards building capacity in community health systems in New Orleans relative to the provision of integrated, quality, efficient, and effective health care services to improve the health status of all New Orleanians.

The NOHD and other Primary Care Strategic Plan stakeholders sought to improve and expand neighborhood-based preventive and primary health care access to all citizens and population groups of New Orleans and in all planning districts and neighborhoods, based on the prioritization of need. City of New Orleans health care advocates and stakeholders created an agenda that recognized roles that all interested parties - public health department, major tertiary health systems, community health centers, community agencies, and other health care and social service organizations – can assume in changing the current environment to one that fosters **100% access and no disparities.**

New Orleans' critical issues, which need substantial attention include:

- The need for a neighborhood-based delivery system design,
- The necessity of neighborhood coordination and community participation in plan development,
- A viable financing and funding methodology, and
- A functional organizational and operational structure needed for the proposed delivery system changes.

We anticipate that this Primary Care Strategic Plan will be embraced, not only by the health care advocates and stakeholders who have developed the plan thus far, but by other groups, agencies, and interested parties through collaborative efforts in order to ensure successful implementation. The process of developing, implementing and maintaining a citywide strategic plan for primary care medical services is a complex task and requires the participation of numerous community organizations and individuals.

The Primary Care Strategic Plan focuses on five major goals. Based on priority, they are as follows:

Goal 1: Building on existing assets, create a neighborhood-based preventive and primary care delivery system throughout the city, based on need prioritization.

Goal 2: Expand the provision of quality primary health, behavioral health, and oral health care services and programs in the city's neighborhoods, based on need prioritization.

Goal 3: Reduce health disparities of all populations in the city, including medically underserved, uninsured, and special population groups.

Goal 4: Promote the development, recruitment, and retention of primary health care professionals along with behavioral health, oral health providers and other health resources, ensuring that the plan’s activities are carried out.

Goal 5: Coordinate timely and relevant health information with appropriate information systems through a vehicle that supports the neighborhood-based initiative.

Specific comprehensive actions for all strategic plan objectives include but are not limited to the following:

- Convert City-operated health units to Federally Qualified Health Centers (FQHCs), FQHC “Look-Alike” health centers, and/or other ambulatory care models.
- Expand services within existing School-based Health Centers, and create School-based Health Centers for additional public schools in the New Orleans School District.
- Target specific critical Health Status Indicators, with the goal of improving them to acceptable (*Healthy People 2010*) levels.
- Increase access to mental health, substance abuse and dental health services, and provide coordinated care between and among service providers.
- Coordinate the decision-making of health care providers and organizations to better meet the needs of the city at both the planning district and neighborhood level through advisory and oversight committees.
- Establish clinical and service standards for all populations currently at need and/or underserved or uninsured.
- Strengthen links between local, state and federal agencies.
- Create a scheduling system that will guarantee appointments within 48 hours of initial contact.
- Implement improved telecommunications and information systems for efficient scheduling, reporting, and billing.
- Building on the Clinical Inquiry (CLIQ) system, create a Local Health Information Infrastructure (LHII) that would allow HIPAA-compliant access to all necessary clinical information by clinicians at the point of care, regardless of where the care is provided within the community.
- Establish a Communication and Marketing Taskforce.

Healthy People 2010 includes many objectives that are important to address in the development of a primary care system that is integrated in the larger health care delivery system. As the strategic plan continues to be developed, the resulting infrastructure should provide the framework for achieving the following objectives.

HEALTHY PEOPLE 2010 OBJECTIVES RELATED TO PRIMARY CARE:

2. Arthritis, Osteoporosis, and Chronic Back Conditions	
2-2.	Activity limitations due to arthritis
2-3.	Personal care limitations
2-6.	Racial differences in total knee replacement
2-7.	Seeing a health care provider
2-11.	Activity limitations due to chronic back conditions
3. Cancer	
3-10.	Provider counseling about cancer prevention
3-11.	Pap tests
3-12.	Colorectal cancer screening
3-13.	Mammograms
5. Diabetes	
5-1.	Diabetes education
5-4.	Diagnosis of diabetes
5-11.	Annual urinary microalbumin measurement
5-12.	Annual glycosylated hemoglobin measurement
5-13.	Annual dilated eye examinations
5-14.	Annual foot examinations
5-16.	Aspirin therapy

6. Disability and Secondary Conditions	
6-7.	Congregate care of children and adults with disabilities
6-10.	Accessibility of health and wellness programs
7. Educational and Community-Based Programs	
7-2.	School health education
7-3.	Health-risk behavior information for college and university students
7-5.	Worksite health promotion programs
7-7.	Patient and family education
7-8.	Satisfaction with patient education
7-12.	Older adult participation in community health promotion activities
9. Family Planning	
9-1.	Intended pregnancy
9-2.	Birth spacing
9-3.	Contraceptive use
9-5.	Emergency contraception
9-6.	Male involvement in pregnancy prevention
9-10.	Pregnancy prevention and sexually transmitted disease (STD) protection
9-11.	Pregnancy prevention education
9-13.	Insurance coverage for contraceptive supplies and services
11. Health Communication	
11-2.	Health literacy
11-6.	Satisfaction with health care providers' communication skills
12. Heart Disease and Stroke	
12-1.	Coronary heart disease (CHD) deaths
12-15.	Blood cholesterol screening
13. HIV	
13-6.	Condom use
13-8.	HIV counseling and education for persons in substance abuse treatment
13-9.	HIV/AIDS, STD, and TB education in State prisons
13-10.	HIV counseling and testing in State prisons
14. Immunization and Infectious Diseases	
14-5.	Invasive pneumococcal infections
14-22.	Universally recommended vaccination of children aged 19 to 35 months
14-23.	Vaccination coverage for children in day care, kindergarten, and first grade
14-24.	Fully immunized young children and adolescents
14-25.	Providers who measure childhood vaccination coverage levels
14-26.	Children participating in population-based immunization registries
14-27.	Vaccination coverage among adolescents
14-28.	Hepatitis B vaccination among high-risk groups
14-29.	Influenza and pneumococcal vaccination of high-risk adults
15. Injury and Violence Prevention	
15-7.	Nonfatal poisonings
15-8.	Deaths from poisoning
15-10.	Emergency department surveillance systems
15-12.	Emergency department visits
15-19.	Safety belts
15-20.	Child restraints
15-21.	Motorcycle helmet use
15-23.	Bicycle helmet use
15-24.	Bicycle helmet laws
16. Maternal, Infant, and Child Health	
16-1.	Fetal and infant deaths
16-2.	Child deaths
16-3.	Adolescent and young adult deaths
16-17.	Prenatal substance exposure
16-18.	Fetal alcohol syndrome
16-20.	Newborn bloodspot screening
16-22.	Medical homes for children with special health care needs
16-23.	Service systems for children with special health care needs

17. Medical Product Safety	
17-3.	Provider review of medications taken by patients
17-5.	Receipt of oral counseling about medications from prescribers and dispensers
18. Mental Health and Mental Disorders	
18-6.	Primary care screening and assessment
18-7.	Treatment for children with mental health problems
18-8.	Juvenile justice facility screening
18-9.	Treatment for adults with mental disorders
18-10.	Treatment for co-occurring disorders
18-11.	Adult jail diversion programs
18-12.	State tracking of consumer satisfaction
18-13.	State plans addressing cultural competence
18-14.	State plans addressing elderly persons
19. Nutrition and Overweight	
19-1.	Healthy weight in adults
19-2.	Obesity in adults
19-3.	Overweight or obesity in children and adolescents
19-4.	Growth retardation in children
19-17.	Nutrition counseling for medical conditions
19-18.	Food security
21. Oral Health	
21-7.	Annual examinations for oral and pharyngeal cancers
21-10.	Use of oral health care system
21-11.	Use of oral health care system by residents in long-term care facilities
21-13.	School-based health centers with oral health component
21-14.	Health centers with oral health service components
21-15.	Referral for cleft lip or palate
21-16.	Oral and craniofacial State-based surveillance system
21-17.	Tribal, State, and local dental programs
22. Physical Activity and Fitness	
22-12.	School physical activity facilities
22-13.	Worksite physical activity and fitness
22-14.	Community walking
22-15.	Community bicycling
23. Public Health Infrastructure	
23-1.	Public health employee access to the Internet
23-2.	Public access to information and surveillance data
23-3.	Use of geo-coding in health data systems
23-8.	Competencies for public health workers
23-9.	Training in essential public health services
23-10.	Continuing education and training by public health agencies
23-12.	Health improvement plans
23-13.	Access to public health laboratory services
23-14.	Access to epidemiology services
24. Respiratory Diseases	
24-6.	Patient education
24-7.	Appropriate asthma care
24-11.	Medical evaluation and follow-up
25. Sexually Transmitted Diseases	
25-11.	Responsible adolescent sexual behavior
25-13.	Hepatitis B vaccine services in STD clinics
25-14.	Screening in youth detention facilities and jails
25-15.	Contracts to treat non-plan partners of STD patients
25-16.	Annual screening for genital chlamydia
25-17.	Screening of pregnant women
25-18.	Compliance with recognized STD treatment standards
25-19.	Provider referral services for sex partners
26. Substance Abuse	
26-18.	Treatment gap for illicit drugs
26-20.	Treatment of injection drug use
26-21.	Treatment gap for problem alcohol use

26-22.	Hospital emergency department referrals
27. Tobacco Use	
27-5.	Smoking cessation by adults
27-7.	Smoking cessation by adolescents
27-8.	Insurance coverage of cessation treatment
28. Vision and Hearing	
28-1.	Dilated eye examinations
28-2.	Vision screening for children
28-10.	Vision rehabilitation services and devices
28-11.	Newborn hearing screening, evaluation, and intervention
28-13.	Rehabilitation for hearing impairment
28-14.	Hearing examination
28-15.	Evaluation and treatment referrals

HEALTHY PEOPLE 2010 ACCESS TO HEALTH CARE OBJECTIVES:

Sixteen objectives have been established related to access to health care, all of which are being considered by the New Orleans Health Department as it re-invents itself. These are listed below, and more detailed information can be found in Appendix I.

<u>Number</u>	<u>Objective Short Title</u>
Clinical Preventive Care	
1-1	Persons with health insurance
1-2	Health insurance coverage for clinical preventive services
1-3	Counseling about health behaviors
Primary Care	
1-4	Source of ongoing care
1-5	Usual primary care provider
1-6	Difficulties or delays in obtaining needed health care
1-7	Core competencies in health provider training
1-8	Racial and ethnic representation in health professions
1-9	Hospitalization for ambulatory-care-sensitive conditions
Emergency Services	
1-10	Delay or difficulty in getting emergency care
1-11	Rapid prehospital emergency care
1-12	Single toll-free number for poison control centers
1-13	Trauma care systems
1-14	Special needs of children
Long-Term Care and Rehabilitative Services	
1-15	Long-term care services
1-16	Pressure ulcers among nursing home residents

Healthy Louisiana 2010 has adopted the *Healthy People 2010* objectives shown on the next page to measure impact in this area. Louisiana current statistics and projected targets are included, where available, as well as specific strategies to achieve these objectives.

Healthy Louisiana 2010: Access to Healthcare Goals and Strategies

1-1. Increase the proportions of persons with health insurance.	
	<i>No data currently available</i>
Strategies: <ul style="list-style-type: none"> • Continue the development of the Community Care and Primary Physician coverage statewide. • Increase funding for LaCHIP to ensure health insurance coverage for the children of Louisiana. Develop a task force to identify special needs for diversity groups such as: women, elderly, black and Hispanic populations, and all American Indian tribes in the state. • By 2004, add questions to the BRFSS regarding the awareness/knowledge of the LaCHIP and Community Care Programs. • Track this data for planning purposes for future improvements. 	

1-4a Increase the proportion of persons who have a specific course of ongoing care. (Primary Care Physicians)			
	USA: 87 %	LA: <i>Not available</i>	Target: 96 %
Strategies: <ul style="list-style-type: none"> • Continue the development of the Community Care and Primary Physician coverage statewide. • By 2004, add questions to the BRFSS reporting system regarding knowledge of the Community Care Program. • Develop an education campaign for the community on the purpose and success stories of the Community Care Program. • Increase funding for the Community Care Program to promote growth, manpower and resources. 			

16-6a Increase the proportion of pregnant women who begin prenatal care in the first trimester of pregnancy.			
	USA: 83 %	LA: 83 %	Target: 90 %
Strategies: <ul style="list-style-type: none"> • Develop cultural and language materials by 2004 and develop them on a fourth grade reading level in languages suitable for Louisiana. • Develop an education program for all school age children on the benefits and treatment during pregnancy with an emphasis on grades 8-12. • Develop a public information campaign stressing the benefits and importance of prenatal care. • Encourage the usage of the Medicaid and Community Care Programs. • Increase community health centers to help identify women early in their pregnancy. 			

Healthy Louisiana 2010: Mental Health Goals and Strategies

18-9b	Increase the proportion of adults with recognized depression who receive treatment.		
	USA: 25 %	LA: <i>Not available</i>	Target: 50 %
Strategies:			
<ul style="list-style-type: none"> • Provide an education program for the public to reduce the stigma of mental disorders through community education and local media campaigns. • Promote and advocate the use of community and state health resources. • Partnership with university programs to provide services and resources for depression. • Develop a media campaign defining “depression” and the resources available statewide. 			



**GETTING PEOPLE HEALTHY IN NEW ORLEANS:
STRATEGIES AND ACTIVITIES**

REORGANIZATION OF NOHD CLINICS

On-going efforts of the NOHD offer specific activities to improve access to care and medications. This division of the New Orleans Health Department (NOHD) provides a wide range of services that can positively impact the access to care challenges of our citizens.

Community and School-Based Clinics:

Providing primary and secondary health care to specific communities and schools, these comprehensive clinics can diagnose and provide treatment and follow-on recommendations for the health conditions described throughout this document, including obesity, overweight, proper nutrition and physical activity, diabetes, and cardiovascular disease.

Services are provided through the Maternal and Child Health clinics and programs. In addition to community-based clinics, school-based clinics address the health needs of school-aged children, including those in need of maternity care and childcare. These clinics provide a comprehensive array of health services. Services provided through these clinics address the need for education for women who are pregnant or may become pregnant, appropriate obstetrical care, addressing issues related to prenatal substance exposure, and prenatal and newborn screening for specific treatable diseases, among others.

Specific goals for the coming year related to these clinics include:

- Gain and maintain Federally Qualified Health Clinic status for each clinic, which will increase the resources available to provide comprehensive health care services at each site.
- Increase participation rates in health care programs that support receipt of services (i.e., LaCHIP, WIC)
- Provide services in a well-organized, high-quality manner in each clinic.

General activities required to achieve these goals, many of which are already in place, will include upgrades in physical plant, information management infrastructure and service activities. These activities are outlined in more detail in Section III of this plan.

Please refer to the *Healthy People 2010* Template in Appendix I, which has details on each of the *Healthy People 2010* Objectives.

¹ NCQA. *Health Plan Employer Data and Information Set (HEDIS 3.0)*. Washington, DC: NCQA, 1997.

² President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. *Quality First: Better Health Care for All Americans: Final Report to the President of the United States*. Washington, DC: U.S. Government Printing Office, 1998.

³ President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. *Consumer Bill of Rights and Responsibilities—Report to the President*. Washington, DC: the Commission, 1997.

⁴ Kohn, L.; Corrigan, J.; and Donaldson, M., eds. Committee on Quality of Health Care in America. *To Err Is Human: Building a Safer Health System*. Washington, DC: IOM, 1999.

⁵ Bierman, A.S.; Magari, E.S.; Splaine, M.; et al. *Journal of Ambulatory Care Management* 21(3):17-26, 1998.

⁶ National Center for Health Statistics (NCHS). *National Health Interview Survey*. Hyattsville, MD: NCHS, unpublished data.

⁷ U.S. Census Bureau Data, 2000.

⁸ American Community Survey, 2002.

⁹ BRFSS, 2000. "Was there a time during the last 12 months when you needed to see a doctor, but could not because of the cost?"

¹⁰ Health Resources and Services Administration, U.S. Public Health Service section 330 (e) grant application submitted by the City of New Orleans Health Department (December 1, 2004)