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Executive Summary

Community health is complex—poverty, environmental conditions, and the health delivery system are all implicated in health outcomes and help us understand health disparities in our communities. To better understand this complex system, we are using emergency room (ER) visits from the LSU (Louisiana State University) Interim Public Hospital, in particular preventable admissions, as an indicator of the New Orleans community’s larger systemic health issues. Emergency room data show us what health crises are happening in our communities. Those crises may be heart attacks, strokes or other critical conditions, or they may be complications from chronic or common conditions, ranging from diabetes to influenza. These emergency room admissions for preventable conditions and untreated chronic conditions suggest that communities producing these conditions are underserved by the health care delivery system and living under the constant duress of various social and environmental conditions which degrade health.

The purpose of our study is to map where there are high concentrations of emergency room usage, the “hot spots,” in order to better understand the primary care needs of the community, the costs of using the ER system, and how to transform health care away from ER use and instead reinvest in these “hot spot” communities to build stronger, thriving and healthier families. The analysis shows that a handful of Zip Codes have the highest rates of ER admissions (the “hot spots”). In New Orleans, there are eleven Zip Codes that contain approximately 55% of all ER admissions to the LSU Interim Public Hospital. These eleven represent about one-quarter of New Orleans. These Zip Codes include: 70112, 70113, 70114, 70116, 70117, 70119, 70122, 70125, 70126, 70127, and 70128.

The mapping and analysis revealed that these areas are sicker, especially with preventable conditions, are poorer, and have greater concentrations of racial minorities. While African Americans make up about 60% of the New Orleans population, they make up about 75% of the population in the “hot spot” Zip Codes. The reverse is true for Whites. While Whites represent approximately 51% of the city’s population, they represent only 20% of the population in the “hot spots.” The city has a poverty rate of 20%, compared to an almost 28% poverty rate in the “hot spot” Zip Codes.

Access to insurance is a critical issue in New Orleans. ER patients in the “hot spot” Zip Codes are more likely to rely on charity care, government sponsored health insurance, or their own money to cover their medical costs. These areas also have far fewer primary care physician locations than New Orleans as a whole, a key point of intervention in the health care delivery system. For example, there are only 63 primary care physician locations, out of a city-wide total of 478, in the “hot spots.”

We also looked at two social determinants of health indicators: unemployment and vacancy rates. Mapping and analysis show that “hot spot” Zip Codes have higher rates of unemployment and vacancy than New Orleans as a whole.
Reliance on the ER for treatment of preventable conditions is not sustainable, and represents a cost to the system, in terms of ER visit costs, patient admitted costs, and costs to others who have actual emergencies. It also represents a major cost to people in terms of poorer health and shorter life expectancies. Reliance on emergency rooms clearly signals a sign of distress for our health care delivery system, and represents an ineffective use of limited health care dollars that does not serve anyone in the system well, from patients to ER doctors to the state.

We believe that it is possible to begin to address these disparities by addressing the Medicaid system that serves these communities. Due to the Affordable Care Act, Medicaid is going to expand across the country to include an additional 15 million people. Yet we see that in New Orleans, families with Medicaid are forced to use the ER as a source of primary care. In other words, having Medicaid insurance is not equating to real preventative healthcare. Additionally, efforts to expand access to preventative care through other strategies and efforts to address social determinants of health are needed to meet the health care needs of these communities.

In organizing, we look for concrete solutions to what seem like insurmountable social issues. Therefore, beginning with reorganizing the local Medicaid system to work better for the families in these eleven Zip Codes, we can begin to save lives and build stronger and healthier communities throughout New Orleans.
Introduction

Community health is complex—poverty, environmental conditions, and the health delivery system are all implicated in health outcomes and help us understand health disparities in our communities. To better understand this complex system, we are using emergency room (ER) visits, in particular preventable admissions, as an indicator of larger systemic health issues. Emergency room data show us what health crises are happening in our communities. Those crises may be heart attacks, strokes or other critical conditions, or they may be complications from chronic or common conditions, ranging from diabetes to influenza. These emergency room admissions for preventable conditions and untreated chronic conditions suggest that communities producing these conditions are underserved by the healthcare delivery system and living under the constant duress of various social and environmental conditions which degrade health. In many cases, these admissions are better handled by primary care physicians if caught early enough, but because families do not have access to these doctors, they rely instead on the Emergency Health system. This challenge produces individual health emergencies but also illustrates a community health emergency, representing a crisis in communities who do not have access to essential health care resources and freedom from detrimental social and environmental determinants of health. Such emergencies indicate those areas where the healthcare system is not serving communities adequately and also identifies areas where we spend the most resources on costly emergency care. This inefficiency in utilizing our limited health care resources represents an opportunity for identifying places where resources could be more effectively utilized for preventive care and addressing social and environmental determinants of health.

The purpose of our study is to map where there are high concentrations of emergency room usage, the “hot spots,” in order to better understand the primary care needs of the community, the costs of using the ER system, and how to transform health care away from ER use and instead reinvest in these “hot spot” communities to build stronger, thriving and healthier families. Our research sought to understand a number of questions about the geography of ER use and health conditions in the region. Where are the geographic “hot spots” of LSU ER use in the community? What are people coming in to the ER for, and is it a preventable or chronic condition? How are people using the ER: are they insured or are they uninsured? What is the intersection of preventative health care access, race, poverty and other social determinants of health with ER use, especially in the “hot spots”? Finally, what does this tell us about the use of health care resources and do we see a relationship between areas of high ER usage and health outcomes for communities?

The remaining report is laid out as follows. Section II introduces how the ER is a useful source for data, and what using the ER data can tell us about the conditions outside of the ER in the broader community. This section also presents our mapping analysis of ER usage. Section III discusses the costs associated with the over-reliance on the ER for primary care. Section IV describes how health outcomes are inextricably linked to opportunity and place, and how the social determinants of health figure prominently in health outcomes. Section V looks at health disparities and race, and describes how race
has an independent effect on health outcomes. This section also describes in greater detail some of the health disparities evident in the region. Section VI closes with a call to action, illustrating the steps that can be taken by policy makers, community members, and the medical community to bring about the transformative change to the health care delivery system that is so clearly needed.
Emergency Room Case Study

Emergency room usage data is a key diagnostic tool for understanding access to care and the social determinants of health in the communities. In this analysis, we leverage the wealth of data that ERs generate every day to shed some light on community needs. Our intention is to use ER data to highlight where the greatest health disparities are and the preventable conditions that communities need direct preventative care for. Armed with this data, on-the-ground organizations can engage the impacted community to work together and redirect resources from ER care to a higher level of—and more effective—preventive care for the families that need it most. We hope that on-the-ground activists can transform these data into community engagement tools to address local social determinants of health.

Our approach is an extension and reorientation of prior efforts that have capitalized on the unique ability of emergency rooms to generate useful data. Prior efforts we’re aware of have been limited in one or both of the following ways by focusing on:

- the ER itself as a site of health care delivery that requires quality improvement;
- improving care for a specific patient population, such as persons with diabetes.

Corollary to these limitations, prior efforts have tended to justify themselves on the basis of cost-savings and, additionally, have tended to employ top-down solutions to care coordination. Although cost-savings is a consideration for any initiative to change health systems delivery, our primary interest is in bottom-up community engagement and transformation. We instead begin with the ER but then expand spatially outside the walls of the hospital and beyond a single patient population into the community at large.

To this end, we gather data from two separate levels: the ER level and the community level.

ER level. We obtained data from the Louisiana State University’s Health Care Services Division on ER admissions, preventable conditions, and insurance type. The data only covers ER admissions from the LSU system’s Interim Public Hospital and does not address all hospitals’ ER admissions in the New Orleans community. Although this is a shortcoming in the data set (in that it does not cover all ER admissions), this data provides a window into the dynamics of ER admission in the region.

Community level. We obtained data from multiple sources, including US Census 2010 and American Community Survey 2005-2009 data and other local data sources. The data highlight the social and environmental conditions in order to contextualize the ER admissions analysis.

These two levels constitute the data infrastructure that will be the foundation for community engagement. After gathering these data, we geocoded and mapped them using geographic information system (GIS) technology. These maps are a visualization of ER use within New Orleans at the
neighborhood level, layered with information about the social determinants of health in the individual neighborhoods themselves.

The following are the specific analyses we will provide:

- Where are the geographic “hot spots” of ER use in New Orleans?
- What are people coming in to the ER for, and is it a preventable condition?
- How are people using the ER: are they insured or are they uninsured?
- What is the intersection of preventative health care access, race, poverty and other social determinants of health with ER use, especially in the “hot spots”?

**Mapping Analysis**

**Map Series 1: ER Admissions and “hot spots”**

**Map 1.0** shows the total rates of ER admissions by Zip Code. This map also shows that a handful of Zip Codes have the highest rates of ER admissions (the “hot spots”). There are eleven Zip Codes that contain approximately 55% of all ER admissions. These eleven represent about one-quarter of New Orleans.

**Map 1.1** shows the total rates of ER admissions for all Zip Codes, overlaid on poverty rates. As shown in the map, areas with the highest rates of ER admissions also have higher concentrations of poverty.
Map 1.0 - Total ER Admissions Rates (New Orleans, LA)

Total rate of ER admissions by zip code

Map 1.2 focuses on the Zip with the highest rates of ER admissions, overlaid by the rate of non-White residents. As shown in the map, areas with the highest rates of ER admissions are also those that have higher percentages of non-Whites. Figure 1 provides a more detailed analysis of the racial makeup of the “hot spot” Zip Codes compared to the New Orleans as a whole. For example, while African Americans make up only about 40% of the New Orleans population, they make up about 75% of the population in the “hot spot” Zip Codes. The reverse is true for Whites. While Whites represent approximately 51% of the New Orleans population, they represent only 20% of the population in the “hot spots.”

![Racial Makeup of "hot spot" zip codes v.s. New Orleans](chart.png)

Figure 1. Comparison of racial population between Zip Codes with the highest ER admissions and New Orleans.

Map 1.3 focuses on the Zip Codes with the highest rates of ER admissions, overlaid by the poverty rate. As shown in the map, areas with the highest rates of ER admissions are also those that have higher concentrations of poverty. Figure 2 shows that the city has a poverty rate of 20%, compared to an almost 28% poverty rate in the “hot spot” Zip Codes.

Figure 2. Comparison of poverty rate between Zip Codes with the highest ER admissions and New Orleans.

Map 1.3 - ER Admissions and Poverty (New Orleans, LA)

Highest rate of ER admissions by zip code, overlaid with neighborhood poverty rates.
Map 1.4 shows the location of primary care physicians overlaid by the poverty rate, focusing on the “hot spot” Zip Codes. It is evident that there is a shortage of primary care physicians in these areas. In fact, there are only 63 locations, out of a city-wide total of 478, in the “hot spots” (Figure 3).

Figure 3. Comparison of primary care physician locations in Zip Codes with the highest ER Admissions in New Orleans, with per capita population in hot spot Zip Codes and in New Orleans. Source: ESRI Business Analyst 2010, US Census 2010.
Map 1.4 - ER Admissions and Primary Care Physicians (New Orleans, LA)

Highest rate of ER admissions by zip code with primary care physician locations, overlaid by neighborhood poverty rates

Map Series 2: Rate of ER Admissions for Preventable Conditions

Map 2.0 shows the rates of ER admissions for preventable conditions by Zip Codes, overlaid by the poverty rate. Preventable and chronic conditions\(^1\) are those that are better handled through preventative healthcare, which is largely dependent on access to primary care. Having to rely on the ER for care for these conditions likely means that by the time the patient arrives at the ER, the condition is already unnecessarily advanced. As the map shows, there are higher rates of ER admissions for preventable conditions in areas with higher rates of poverty.

\(^1\) These conditions included angina, asthma, bacterial pneumonia, cellulitis, chronic obstructive pulmonary disease, congestive heart failure, convulsions, dehydration-volume depletion, dental conditions, diabetes, gastroenteritis, grand mal and other epileptic conditions, hypertension, hypoglycemia, iron deficiency anemia, kidney/urinary infection, pelvic inflammatory disease, pulmonary tuberculosis, severe ear, nose, throat infection, and tuberculosis (non-pulmonary).
Map Series 3: Insurance coverage and ER admissions

Map Series 3 breaks ER admissions down by the type of insurance patients use. We look at:

- Medicaid (Map 3.0)
- Medicare (Map 3.1)
- Medical Assistance Program (Map 3.2)
- Private insurance (Map 3.3)
- Eligible for free care (Map 3.4)
- Uninsured (Map 3.5)

Map 3.0 and 3.1 shows the rates of ER patients paying with Medicaid and those paying with Medicare by Zip Code, overlaid by the poverty rate. As shown in the map, areas with higher rates of patients paying with Medicare and Medicaid are also those that have higher concentrations of poverty, particularly in the center of the city.

Map 3.2 shows the rates of patients characterized as Medical Assistance Program (people who are in the application process for assistance) by Zip Code, overlaid by the poverty rate. As shown in the map, areas that have higher concentrations of poverty also tend to have very few people in this category.

Map 3.3 shows the rates of patients paying with private insurance by Zip Code overlaid by the poverty rate. As shown in the map, areas with higher rates of patients paying with private insurance are also those that tend to have lower concentrations of poverty.

Map 3.4 shows the ER admissions for patients paying with free care, those with Medicare but eligible free care, and those with commercial insurance but who are eligible for free care. As shown in the map, areas with higher rates of eligible recipients are also those that tend to have higher concentrations of poverty.

Map 3.5 shows the ER admissions for patients without insurance. Many of these patients are likely to be enrolled in Medicaid once health care reform takes place. Areas with higher rates of uninsured ER patients tend to have higher concentrations of poverty.
Map 3.0 - ER Admissions and Medicaid (New Orleans, LA)

Rate of ER admissions paying with medicaid by zipcode, overlaid with neighborhood poverty rates

Inset Map

Medicaid ER Admissions by Zipcode (per 1000 residents in zipcode)

- 0.68 or below
- 0.69 - 2.10
- 2.11 - 4.72
- 4.73 or greater

Poverty Rate by Census Tract
- 5% or below
- 5% - 10%
- 10% - 20%
- 20% - 40% (High)
- Above 40% (Concentrated)

Map 3.1 - ER Admissions and Medicare (New Orleans, LA)
Rate of ER admissions paying with medicare by zipcode, overlaid with neighborhood poverty rates

Inset Map

Medicare ER Admissions by Zipcode (per 1000 residents in zipcode)
- 0.3 or below
- 0.3 - 1
- 1 - 1.5
- 1.5 or greater

Poverty Rate by Census Tract
- 5% or below
- 5% - 10%
- 10% - 20%
- 20% - 40% (High)
- Above 40% (Concentrated)

Cost of High ER Usage and Inaccessible Primary Care

Reliance on the ER for treatment of preventable conditions is not sustainable, and represents a cost to the system, in terms of ER visit costs, patient admitted costs, and costs to others who have actual emergencies. It also represents a major cost to people in terms of poorer health and shorter life expectancies. Reliance on emergency rooms as a primary source of health care, clearly signals a challenge in our health care delivery system, and represents an ineffective use of limited health care dollars that does not serve anyone in the system well, from patients to ER doctors to the state.

Unfortunately, we can expect in the coming years the issue of rising health care costs to become an even more critical issue. One of the most immediate issues is the expansion in Medicaid that will result from the passage of the Patient Protection and Affordable Care Act. Although the ACA provides $434 billion for the expansion of Medicaid, this covers only a portion of the costs associated with the expansion, the rest will be left to the states to fund—states that are already struggling with large budget deficits. The impacts are already being felt in Louisiana. Medicaid reimbursement rates already fall below private insurance and Medicare. For example, in 2008, Medicaid reimbursement rates in Louisiana averaged 90% of Medicare (Zuckerman, Williams, & Stockley, 2009). But since August 2009, Louisiana has cut physician Medicaid reimbursement by at least 10% (Trapp, 2010). As a result, many primary care physicians will no longer accept Medicaid patients, leaving these patients only one option—the ER.

While Medicaid coverage is an improvement over no coverage at all, it does not mean that patients using Medicaid can expect drastically improved access to primary care. In fact, some research anticipates that this expansion of Medicaid will actually increase the use of ER care. One study estimates that these changes will generate 65 million ER visits, nationally (Holz-Eakin & Ramlet, 2010). A 2007 national survey on ER use found that Medicaid enrollees utilized ER care at twice the rate of uninsured or privately covered patients (Holz-Eakin & Ramlet, 2010).

In 2009, The Commonwealth Fund released State scorecards on health system performances, which ranks states based on 38 indicators of access, quality, costs, and health outcomes. Louisiana ranked 49th (McCarthy, How, Schoen, Cantor, and Belloff, D. 2009). Such a ranking incurs substantial costs. For example, if Louisiana improved its performance to the level of the best-performing state for preventable hospital admissions, the state could save $131,034,483 (McCarthy et al., 2009). Likewise, if the state improved its performance on hospital readmissions to the level of the best-performing state, Louisiana could save $77,337, 238 (McCarthy et al., 2009).

Further research is needed to explore the cost ramifications for the ER “hot spots” in New Orleans, and assess how improvements in health care access can empower communities to recapture limited health care resources and redirect it into the community to improve health outcomes.
Opportunity, Place, and Health Outcomes

Health is more than health care. It not only reflects personal choices about healthy habits, or access to primary care, but is significantly impacted by where one lives. The ER case studies and maps illustrate this. First, although equitable access to quality health care remains an unrealized promise and a key determinant of health, social factors like poverty, unemployment, housing, education, and the food system collectively exert an equally important, maybe even greater, impact on health. Second, health is local—or, better yet, regional. Whites and racial minorities experience starkly different neighborhood contexts, which result in different exposures to “positive” factors, such as resources and services, as well as “negative” factors, like violence and environmental toxins. Put another way, irrespective of factors like personal motivation to be healthy or access to a primary care provider, where one lives exerts a strong, independent effect on health by determining access to opportunity structures. This is in part why we can identify ER “hot spots.”

Consider the illustration (Robert Wood Johnson Foundation, 2008) below as a simple model of the “determinants” of health:

![Figure 4. The determinants of health. Source: Robert Woods Johnson Foundation.](image)

As the figure indicates, although access to health care services and individual behavior play important roles in determining health, one’s immediate environment and access to opportunity structures are significantly more important.
Map Series 4 and 5: The Intersection of ER Use and the Social Determinants of Health

Map 4.0 shows the highest rates of ER admissions by Zip Code, overlaid by the unemployment rate. As shown in the map, areas with the highest rates of ER admissions are also those that have higher rates of unemployment. In fact, while the city of New Orleans has an unemployment rate of 8.42%, the “hot spot” Zip Codes have an unemployment rate of almost 13% (Figure 5).

![Unemployment Rate for "hot spot" zipcodes vs. New Orleans](image)

**Figure 5.** Comparison of unemployment rates between Zip Codes with the highest ER admissions and New Orleans. Source: American Community Survey 2005-2009.
Map 5.0 shows the highest rates of ER admissions by Zip Code, overlaid by the vacancy rate. As shown in the map, areas with the highest rates of ER admissions are also those that have higher rates of vacancy. In fact, while the city of New Orleans has a vacancy rate of 2.6%, the “hot spot” Zip Codes have a rate of 3.51% (Figure 6).

![Vacancy Rate for "hot spot" zip codes vs. New Orleans](image.png)

Figure 6. Comparison between vacancy rates for Zip Codes with the highest ER admissions and New Orleans. Source: American Community Survey 2005-2009.
Health Disparities and Race

The above analyses show not only how access to primary health care matters for health outcomes, but also how place is deeply implicated in these outcomes. Structures and place are indeed critical features of health access and outcomes, and the ER case study illustrates this. The ER case study also suggests that race is a significant indicator of health outcomes. As was shown, ER hot spots were poorer and majority-minority.

Despite advances in medical care, countless studies document the persistent, large racial disparities in health outcomes. An alarming pattern has emerged: people of color get sick younger, have more severe illnesses, and die sooner than Whites. Socioeconomic status (SES), which is usually measured by income, education, or occupation, is one of the most powerful predictors of health, more powerful than genetics, exposure to carcinogens, and even smoking (William, 2010). However, while class status accounts for a large part of the racial differences in health, research has found that there is an added burden of race, over and above socioeconomic status, that is linked to poor health outcomes. So while race and class are related, they are not interchangeable systems of inequality. Race has an independent effect on health; research reveals that health is affected by exposure to social and economic adversity over the life course, and that personal experiences of discrimination and institutional racism are added pathogenic factors that can affect the health of people of color in multiple ways (William, 2010).

For example, we know that one of the best indicators for a healthy pregnancy outcome is a mother’s educational attainment: the higher her education, the better the outcomes. But does this hold true regardless of race? Research has in fact found that it does not, that a mother’s race does matter, independent of educational attainment. In fact, infant mortality rates for Black women with an advanced college degree or higher are almost three times higher than the infant mortality rates for White women with a college degree or higher and African American mothers with a college degree have worse birth outcomes than White mothers without a high school education (Adelman & Smith, 2008). Another study found that after controlling for major factors that account for preterm deliveries including income, education, smoking, alcohol and depression, Black women who reported experiences of racial discrimination were two times more likely to have pre-term deliveries than White women (Kreiger, 2008). The following section describes how racial disparities in health have shown up in Louisiana and New Orleans.

Health disparities in Louisiana and New Orleans

The ER case study provided a highly localized analysis of the New Orleans community’s overall broken health care system. The facts that follow illustrate the need to continue advocacy efforts beyond the “hot spot” zones as well. We also discuss the different challenges in health care access for African Americans and Hispanics in particular. Understanding these disparities and differences can translate the localized actions taken for changing the outcomes in the “hot spot” zones to a broader, regional focus.
Louisiana has some of the poorest health outcomes of any state in the US, especially in rates of heart disease, obesity, diabetes, and uninsured residents. Within Louisiana and in New Orleans in particular, the disparities between the White and Black populations in terms of health outcomes are especially pronounced. African Americans make up a disproportionate amount of the socio-economically disadvantaged in the state. The Kaiser Foundation found that while 14% of Louisiana Whites lived below the poverty line, a staggering 40% of African-Americans lived in poverty (Kaiser Family Foundation, 2011). These socioeconomic disparities translate into disparities in health outcomes. A report by the American Medical Association concluded that Louisiana’s minority populations bear a disproportionate burden of the state’s excess morbidity and drew a correlation between socio-economic status and mortality and poor health outcomes (Broussard, 2011).

Such disparities are also evident in New Orleans. In a study of New Orleans health outcomes after Hurricane Katrina, The Kaiser Foundation found that more than one third (35%) of residents in the New Orleans area can be defined as economically disadvantaged, and 30% of these were African American, a group in New Orleans with a long history of disparities in health coverage and access (Kaiser Family Foundation, 2007).

Not surprisingly, the disparities in socioeconomic status manifest themselves in health insurance disparities. According to the Louisiana Department of Health, over 32% of African-Americans and just over 30% of Hispanics in the state are uninsured, compared to just over 17% of their White counterparts (Griffin, Goidel, & Herman, 2010). And employment does not equal coverage. Even among employed low-income adults, they were far less likely to receive employer-based coverage than wealthier counterparts (35% vs. 79%), reflecting the fact that many are employed in part time or low wage jobs and cannot afford premiums. White residents in Louisiana are also 50% more likely to have employer-provided health coverage than African-Americans and 70% more likely than Hispanics to have this coverage (Kaiser Family Foundation 2007). Twice as many Hispanics and African-Americans within the state report not being able to see a doctor because of costs compared to Whites. Almost 25% of African-Americans in Louisiana and over 30% of Hispanics do not have a primary health care provider compared to only 16.5% of Whites (Kaiser Family Foundation, 2011). As a result, residents of color tend to have poorer health choices readily available.

In New Orleans, health care access is similarly restricted. For example, 37% of African Americans reported the emergency room as their only source for medical care, which is 10% over the average for the city and 23% over the national average. Also, 35% of African Americans made more than one trip to the ER, compared to only 20% of Whites, per year (Kaiser Family Foundation, 2007).
Perhaps most frustrating about the racial disparities in chronic diseases such as heart disease, diabetes, and other chronic illnesses, is that many of these have been shown to be treatable with the preventative medicine that comes with having consistent primary care and adequate health coverage (Missouri Foundation for Health, 2009). Tellingly, African-Americans and Hispanics fare much worse in these categories. Hispanics in Louisiana suffer chronic health problems at a rate of 16.3%, compared to rates of 9.6% and 9.9% for Whites and African-Americans respectively (Kaiser Family Foundation, 2011). Thirteen percent of African-Americans and 10.5% of Hispanics in the state have diabetes compared to only 9.4% of Whites, and while only 5.9% of Whites are diagnosed with coronary heart disease, 8.2% of Hispanics are (Kaiser Family Foundation, 2011). Stunningly, African-Americans in Louisiana die of diabetic complications at a rate of 57%, compared to 25% of Whites (Kaiser Family Foundation, 2011).
Racial disparities in cancer for Hispanics and Whites may also sadly reflect this lack of access to primary care and adequate health coverage across the state. For example, 12.1% of Hispanic men in Louisiana are diagnosed with prostate cancer compared to 5.5% of White men. These numbers correlate with the percentage of men who have had a prostate exam. While 48.8% of White men have had the preventative exam, only 38% of Hispanic men have been given the exam. Hispanic women are more likely to be diagnosed with breast cancer in the state. Seventy-one percent of Hispanic women in Louisiana have received a physical breast exam, compared to 82.6% of White women.

As outlined above, poor access to health care has a disproportional effect on several health factors, and has major implications for prenatal and child health. Ninety-two percent of White mothers receive prenatal care, compared to only 79% of African Americans and Hispanics in the state. Alarmingly, the African-American infant mortality rate in Louisiana is 14.5%, almost double the rate of 6.6% for infant mortality among White infants (Kaiser Family Foundation, 2011).
African-American babies also have twice the risk of being born underweight in the state as White babies, 15% to 8% (Kaiser Family Foundation, 2011). Additionally, 20% of African-American infants in the state are born pre-term, compared to only 12% of White infants (Kaiser Family Foundation, 2011). As these children grow, they face further health disparities. For example, African-American children in New Orleans are 12% more likely to be obese (Kaiser Family Foundation, 2007).
Lack of access can contribute to the level of screening for many conditions. In New Orleans, quality care is available; however, the capacity to serve all those in need is constrained by extremely limited resources. Public hospitals such as LSU with a mission to serve the uninsured and underinsured complete screening for preventable conditions at rates higher than state and national levels. For example, in 2011, 74.8% of male patients for whom a prostate exam was indicated received the screening from the LSU hospital in New Orleans. Improving access is a priority.

Conclusion and Call to Action

Our report shows that eleven Zip Codes in New Orleans, whose demographic make-up is largely low-income people of color who depend on both Medicare and Medicaid, or have no insurance whatsoever, experience the strongest failure of the healthcare system. These Zip Codes include: 70112, 70113, 70114, 70116, 70117, 70119, 70122, 70125, 70126, 70127, and 70128.

Race, poverty, and place—individually and taken together—exert powerful limitations to the ability of these communities to access health care opportunities that are afforded to more affluent and largely White communities. The result is that people in these 11 Zip Codes are dying sooner and suffering more catastrophic illnesses.

The emergency is regional in scope. While the most drastic impact is felt in these eleven Zip Codes, the facts on health disparities indicate that health care access, in all of its forms — including insurance, primary care access, and so on—is a major concern for the entire region. In a country that is aiming to better achieve true fairness and equality, it is unacceptable that these conditions still exist.

Note that these data are only from the public hospital which serves a disproportionate share of the uninsured and underinsured.
Micah’s Call to Action

We believe that it is possible to begin to address these disparities by addressing the Medicaid system that serves these communities. Due to the Affordable Care Act, Medicaid is going to expand across the country to include an additional 15 million people. Yet we see that in New Orleans, families with Medicaid are forced to use the ER as a source of primary care. In other words, having Medicaid insurance is not equating to real preventative healthcare.

In organizing, we look for concrete solutions to what seem like insurmountable social issues. Therefore, beginning with reorganizing the local Medicaid system to work better for the families in these eleven Zip Codes, we can begin to save lives and build stronger and healthier communities throughout New Orleans.

Our efforts will target the Medicare and Medicaid systems first because they are public systems and a significant number of people, who are in the ER even with this coverage, still experience limitations to accessing primary care. If we want to begin to change the health care system overall, this is a key point of intervention, because it’s public money and we can hold our government accountable to creating a higher standard of care for Medicare and Medicaid patients while saving money.

To achieve these changes, Micah proposes the following actions:

1. Primary care providers responsible for the hot spot Zip Codes will form “high utilizer” teams to focus on the patients who are most frequently using the ER, and provide a higher quality of direct care for them—which include home visits for check-ups and to monitor medications, as well as connecting patient to the appropriate social supports. In this way, the patients who need the most care can be better monitored, and it would be possible to save Medicaid dollars for reinvestment in the primary care network for “hot spots.”

2. Micah will partner with Daughters of Charity, and others, to lead a place- based community engagement and direct service strategy in the hot spots. Micah leaders and DOC community health workers will canvass the hot spot Zip Codes, both through congregations and door-to-door, to listen to community priorities for the primary care system. Community health workers will give direct service to patients to ensure they are receiving proper primary care, and Micah will mobilize the community to work with primary care providers on improving the local healthcare system for families.

Together, Micah and our partners will determine how much Medicaid money is being saved through these practices and find the mechanism either locally or through the state necessary to capture a portion of Medicaid savings which can be reinvested into the primary care system in line with the communities’ health priorities.

In the end, we know that reliance on the ER for treatment of preventable conditions is not sustainable, and represents a cost to the system (in terms of ER visit costs, patient admitted costs, cost to others
who have actual emergencies) but also a cost to people (in terms of poorer health and shorter life expectancy). We also know that there are people ready and willing to work for the kind of change needed; transformation is necessary not only for fairness, but also for effectiveness. The analyses we have undertaken and shared in this report are an important first step towards this transformative change, but our work is only just beginning.
Appendix A: Organizational Information

The Micah Project and the Kirwan Institute for the Study of Race and Ethnicity at the Ohio State University have embarked on a collaboration to analyze health opportunity in the New Orleans region, with particular attention to marginalized communities of color. We come together with the intention to build a common understanding of the conditions necessary for health in order to bring transformative change to the public health delivery system that is not only sustainable, but that promotes better health outcomes for all. Key to this understanding is an awareness of the causes and consequences of health inequities and their relationship to racial and ethnic disparities and hierarchies.

The Micah Project’s core mission is to bring people of all faiths together to build relationships, develop strong leaders, and improve the quality of life in Orleans and Jefferson Parishes. In very broad terms, Micah trains volunteers from area congregations and equips them in the areas of leadership and advocacy required to effect social change needed to improve the quality of life in their communities.

Micah’s community organizing methodology is simple. Working alongside member congregations, Micah trains volunteers to:

- Reach out to their neighbors
- Identify common concerns
- Research possible solutions
- Collaborate with key decision-makers to implement solutions

Micah’s path to building a more just world involves teaching people of faith how to build and exercise their own power to address the root causes of the problems they face. In Micah, this struggle for justice is rooted in our faith.

At the center of Micah’s model of faith-based community organizing is a belief in the potential for transformation – of people, institutions, and our larger culture. This belief stems directly from Micah’s rootedness in faith communities, and radiates throughout the organization, influencing the way Micah relates to public officials, to community members, and to one another.

Through faith-based community organizing, congregations practice public story telling. Both telling and hearing one another’s stories, within their congregations and in the public arena, will be the basic culture of the congregation—connecting wherever possible our stories with the Biblical story. Finally, along with serving as vehicle to address pressing quality of life concerns, the faith-based community organizing process helps develop new leaders who can take on responsibilities to strengthen the vitality of their congregations.
The Kirwan Institute is a multi-disciplinary research organization at The Ohio State University in Columbus, Ohio. The Kirwan Institute partners with people, communities, and institutions worldwide to think about, talk about, and engage issues of race and ethnicity in ways that create and expand opportunity for all. Through interdisciplinary research and other working partnerships, the Institute aims to deepen the understanding of the causes and consequences of racial and ethnic disparities, in order to stimulate change to bring about a society that is fair and just for all people. We believe that all communities of people are interconnected and that society benefits when all human capabilities are developed and maximized to serve the greater good.

The Institute’s Opportunity Communities Program conducts applied research to support civic engagement, community development, fair housing and sustainable development. The program collaborates with partners to build community capacity and identify solutions to create pathways to opportunity in housing, community and regional development, employment, health, and civic engagement for marginalized communities.

Appendix B: Works Cited


