Post Katrina Recovery: Restoring Healthcare in the New Orleans Region

Statement by
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Good Morning, Chairman Towns and other distinguished members of the Committee on Oversight and Government Reform. I would like to thank you for allowing me to offer testimony in this public forum on the ongoing healthcare concerns and challenges facing the New Orleans region post-Hurricane Katrina.

My name is Michael Griffin, and I am the Chief Executive Officer of Daughters of Charity Services of New Orleans, a primary healthcare provider whose organization has its roots in New Orleans for 175 years with service to the poor and vulnerable. The Daughters of Charity Services of New Orleans, or DCSNO, is sponsored by Ascension Health. Ascension Health was formed in 1999 when the Daughters of Charity and the Sisters of St. Joseph joined their health ministries into one organization.

DCSNO's mission is to improve the health and well-being of our community, and we are dedicated to providing primary and preventive healthcare services which address the needs of the total individual – body, mind and spirit. I welcome this opportunity to inform you on how the Primary Care Access and Stabilization Grant (PCASG) program has assisted in restoring and improving the healthcare delivery system in New Orleans and what challenges are still before us.

When Hurricane Katrina struck the City of New Orleans on August 29, 2005, it severely impaired the healthcare delivery system. Medical and other support personnel were displaced and the city lost several hospitals and numerous primary care providers. DCSNO was not sheltered from the impact of Katrina. We lost our one and only healthcare center site to flooding in the aftermath of the storm. Yet as our history demonstrates, the DCSNO Board and Ascension Health would remain steadfastly committed to serving the poor and vulnerable in New Orleans. Within 45 days after the storm, we opened a new health center in the Metairie area, next door to the Department of Health. However, the diminished capacity of the overall heathcare infrastructure in New Orleans severely compromised continuity of care for low income and minority populations who were attempting to remain or return to the area.

Katrina resulted in the loss of five hospitals -- one of which served the vast majority of the medically underserved and poor. The aftermath of Hurricane Katrina was the litmus test which

challenged DCSNO to improve access to healthcare services at additional locations throughout the metropolitan area with the goal of meeting the primary care needs of the community at large. It was because of the Primary Care Access and Stabilization Grant (PCASG) grant awarded by the U.S. Department of Health and Human Services and authorized by Congress that DCSNO was able to rapidly expand from one to three primary healthcare centers. Today these health centers are currently providing primary care services to the underserved communities of Carrollton, St. Cecilia and Metairie.

As a direct result of PCASG funding, DCSNO has been able to provide affordable or free primary care to 20,034 patients, totaling 65,509 patient visits. Seventy two percent of our patients are uninsured, 15 percent are on Medicaid, 5 percent are on Medicare and 7 percent have other forms of insurance. DCSNO has experienced unanticipated growth, with a 49 percent increase in our patient population just since last year.

PCASG funding allowed us to retain and hire new doctors. We are offering free pharmacy services, have expanded access to our mental health providers to both children and adults, and have plans to provide dental care and optometry. In addition, we have leveraged PCASG funding to encourage partners like the Unity Foundation and United Way to help fund a mobile primary care unit, two mobile pre-natal Mom & Baby units, and to restore our Seton Resource Center for Adolescent and Mental Health Development that offers behavioral health and counseling services at 10 public and parochial schools.

Our medical providers focus on "primary care prevention" and integral to our delivery system is the use of electronic health records. These records enable center providers to stay abreast of our patients' needs for chronic care management. The integrated patient-centered medical home model of care provided to all of our patients reduces the amount of time our patients must wait to be seen and treated; enhancing the quality of care a patient receives from our health centers. All three of DCSNO's healthcare centers have received the National Committee for Quality Assurance's Level Three Recognition -- their highest level of recognition -- for our patient-centered, medical homes. This achievement was made possible by funding received through the PCASG grant.

Additional outcomes linked to PCASG grant funding include a significant and documented increase in the use of primary care providers and improved health status for community residents served by our centers. PCASG funding has, in fact, enhanced and fundamentally altered the way medical care is delivered in New Orleans, forever.

Let me share a brief story with you. An uninsured mother, who didn't have a regular physician, recently attended a health fair staffed by DCSNO's primary care mobile unit that was offering free testing for hypertension, cholesterol and glucose. While having her testing done, the woman expressed concerns to our medical provider that her daughter had been complaining of not feeling well, that she was constantly drinking water and going to the restroom. She wondered if we could just take a quick look at her. We gave the 9-year-old girl a glucose test and found her glucose level to be above 300, which is extremely dangerous. Our clinician recommended that the mother immediately take her child to Children's Hospital for further treatment. The child was, in fact, admitted to Children's Hospital where the emergency room doctors informed the mother that had she prolonged getting her daughter to the hospital any longer, the child would have probably died or slipped into a coma.

I tell this story because it demonstrates the type of community outreach that we are doing at DCSNO to help those who do not have insurance or a family physician to call when a child gets sick.

Daunting challenges still confront New Orleans. The largest hospital in our region, Charity Hospital, has not reopened and many of the area's poor are still lost without the care it provided. However, DCSNO and the other PCASG grantees have stepped up in a significant way to provide a more appropriate way for the uninsured to receive healthcare services in lieu of queuing up for care in Charity's ER. As a native of New Orleans, I can attest that many of our patients are now seeing the advantages of receiving care at a primary care clinic rather than waiting long hours in the ER to get treated for a sore throat or, worse, to manage a chronic condition such as diabetes, asthma or high blood pressure.

Our budget is comprised of 50 percent of the funds received through the PCASG program. Should PCASG funding disappear, who and what will fill the void? We are looking at various scenarios right now, none of them good. We would likely have to cut out most, if not all, of our community outreach activities. I worry about what will happen to the homeless population that is presently being served by our mobile health unit. Where will the new Latino worker population go to secure healthcare? Who will make the effort to bring healthcare facilities to impoverished areas and how long will it take to see that brought to fruition?

I believe that in the years to come, the foresight that Congress had in providing funding for primary care services post-Katrina will be credited with fundamentally changing the way that New Orleans residents seek access to medical care. I believe that one major reason for the success of PCASG funding was that it was made available to all nonprofit safety net providers in the community and eligibility was not limited to entities already participating in other federal primary care programs, such as the federal CHC or FQHC programs. Under current law, health centers that are owned and operated by another entity, such as the Daughters of Charity, are not eligible to participate in those federal programs.

One option that many of us in New Orleans have considered, and that GAO cited in its report, is to convert our organizations to FQHC Look Alike status or to try to qualify for Public Health Service funding through the Community Health Center program. Unfortunately, funding under the federal CHC program is extremely limited. It is my understanding that new grantees may not be able to receive funding as new access points for several years. The bulk of the $2 billion that Congress authorized in the stimulus bill went to existing CHC grantees and only $200 million was made available for new access points.

I would like to be able to say that the sustainability of DCSNO is assured and that we will be able to continue to expand along the lines that we have been able to over the past few years in partnership with the federal government. But I cannot. It is hard for me to imagine that we will be able to continue or even sustain our current patient load because of the high rate of uninsured people we serve and our inability to qualify for existing federal programs aimed at improving access to primary care to the medically underserved.

We look forward to a continued dialogue with Congress to ensure that we continue to work together to achieve Ascension Health's goal of 100% access and 100% coverage for all by 2020.

Thank you, Chairman Towns, for this opportunity to testify before Congress and thank you for your support of New Orleans.