AFTER KATRINA

REBUILDING A HEALTHY NEW ORLEANS

Final Conference Report of the New Orleans
Health Disparities Initiative

May 2007

EDITORS

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INTRODUCTION AND EXECUTIVE SUMMARY

Hurricanes Katrina, Rita, and Wilma opened our eyes to vast poverty in our rich nation. The storms and the flooding from New Orleans' broken levees drew national attention to this poverty, albeit briefly and without an explanation of why so many of our poor are people of color and what it means for all of us. While New Orleans certainly has a unique history and culture, its racialized poverty and history of disinvestment in communities of color is not unique. The story of New Orleans and the Gulf Coast is also the story of cities throughout our country.

Although the storms and flooding opened our eyes to the prevalence of racialized poverty in the U.S., important questions remained to be raised. More than six months after hurricanes and flooding wrecked homes and lives on the Gulf Coast, health and health disparities issues continued to be almost absent from the national, state, and local policy discussions around rebuilding the Gulf Coast.

Because of the acuteness of racial justice issues and health impacts in the aftermath of the broken levees, New Orleans was chosen as the first site in a series of regional meetings to address health disparities across the country, creating the New Orleans Health Disparities Initiative. With support from the Health Policy Institute of the Joint Center for Political and Economic Studies, the Poverty and Race Research Action Council (PRRAC) joined with the Alliance for Healthy Homes and the Center for Social Inclusion in a six month process of outreach and planning meetings with affected organizations and communities in New Orleans, culminating in a health disparities convening on June 12, 2006.

> The storms and the flooding from New Orleans' broken levees drew national attention to this poverty, albeit briefly and without an explanation of why so many of our poor are people of color and what it means for all of us.

The June 12th meeting brought together local and national people and organizations, including New Orleans area residents, public health researchers, health care providers, community organizers, civil rights attorneys, social scientists, urban and regional planners, historians, policy advocates, environmental justice advocates, fair housing advocates, and government officials. From the day-long discussion, important insights emerged about the extent of health disparities, the role of race and class in determining health outcomes, and the harm to all New Orleans' communities in failing to address these disparities. The following key insights emerged from the day's discussions, and from the meetings that preceded and followed the June event.

Before the broken levees, poverty and lack of access to insurance made it even more difficult for New Orleans' most vulnerable populations to take care of their health. People of color were hit even harder, because they were more likely than Whites to be poor.

▶ Almost one-third (28%) of New Orleanians were poor before Hurricane Katrina hit the Gulf Coast.[1] 67% of the city was Black, and almost a third of its Black families were poor.

▶ An exceptionally high number of Louisiana residents were uninsured.

> *Almost one-third (28%) of New Orleanians were poor before Hurricane Katrina hit the Gulf Coast. 67% of the city was Black, and almost a third of its Black families were poor.*

▶ Before Katrina, over 50 percent of children living in the inner city neighborhoods of New Orleans (disproportionately neighborhoods of color) had blood lead levels above the current guideline of 10 micrograms per deciliter. Childhood lead poisoning in some of New Orleans black neighborhoods was high as 67 percent.

▶ New Orleans children had the highest asthma rates in Louisiana with over 16.4% suffering from the illness; the asthma death rate in Orleans Parish (which was disproportionately people of color – 67% black) was significantly higher than rates for the rest of Louisiana and the United States.

Inequities before Katrina made the poor and people of color even more vulnerable after Katrina.

The poor and people of color were hit the hardest and face the most health risk post-Katrina.

▶ 78% of New Orleans' extremely poor neighborhoods were flooded. In the City of New Orleans, communities of color made up nearly 80% of the population in flooded neighborhoods.[2] "Sediments of varying depths were left behind by receding Katrina floodwaters primarily in areas impacted by levee overtopping and breaches."[3]

▶ The powerful storm left behind an estimated 22 million tons of debris, more than 15 times the debris hauled away from the 9/11 attack. Half of this debris, 12 million tons, is in the majority-Black Orleans Parish.

New Orleans health care infrastructure is in crisis for all communities, especially for poor communities and communities of color.

▶ As of January 2007, half of the City's nine hospitals were still closed: excluding Children's Hospital (in Uptown/Carrollton), Touro Infirmary Hospital (Central City/Garden District), and Tulane University Hospital & Clinic (French Quarter).

▶ The location of open facilities severely disadvantages the majority-minority communities of New Orleans East, Gentilly, and New Aurora/English Turn, as well as the 91% White

Lakeview area. Citizens from these neighborhoods will have to travel for miles for emergency medical care. The location of healthcare facilities in a region impacts access to services.[4] Being close to health care facilities is especially important for those communities with the most acute need, such as the extremely poor, who often lack health insurance.

Since the levees broke, New Orleanians have been at increased risk of serious mental and emotional illness.

▶ More than a third (34%) of displaced children has one or more chronic health conditions, including anxiety.

▶ Four months after the levees breached, there was a threefold increase in New Orleans' suicide rates from 9 per 100,000 to 26 per 100,000.

▶ Up until November 2006 the Medical Center of Louisiana at New Orleans provided emergency care, including psychiatric services, at the New Orleans Centre, formerly the Lord and Taylor department store.

Four months after the levees breached, there was a threefold increase in New Orleans' suicide rates from 9 per 100,000 to 26 per 100,000.

The storms and flooding in August 2005 not only opened our eyes to vast poverty in our rich nation, they also confronted us with the costs to all of us when we choose not to invest in our most vulnerable and marginalized communities, too often communities of color. It put squarely on the table what happens when our government fails to invest in all of its people. New Orleans' health disparities and crippled health care system are symptoms of a fragile and shrinking public infrastructure. Unfortunately, New Orleans is not an isolated case.

Health disparities sound the alarm about the price to all of us when people cannot afford healthy living, nutritious food, and good doctors. Moreover, when we invest in the health of all people, every community benefits. Research shows that equality is good for the environment and for public health. States with more equality between racial groups have better environmental policies, cleaner environments, and lower premature death rates.[5] Rebuilding the New Orleans and Gulf Coast region creates an opportunity to build a new social order, a healthy society based on healthy beliefs, attitudes, values, behaviors, and economics.

To craft the right cures, though, we must first accurately diagnose the illness. Health disparities must be understood in a context, which includes but is larger than the quality of our health care infrastructure. Health is directly linked to housing, education, employment, and the environment. Good health requires safe employment, living wages, safe and affordable housing, nutritious food for the body, mind, and spirit, a positive self-image, and a clean and safe natural, built, and social environment in which to live. Access to quality and affordable healthcare – good health insurance and good doctors, equal and quality treatment, and adequate healthcare infrastructure – is also critical.

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This report summarizes the June 12, 2006 presentations and discussions, and the advocacy agenda that naturally comes out of that analysis. While the first several chapters document serious disparities in New Orleanians' health and access to quality health care, this report also shares promising solutions and new directions for rebuilding a healthy and just New Orleans for all communities. Participants consistently echoed the need for greater government accountability, meaningful inclusion of all communities in the rebuilding process, and a rebuilding plan that ensures that all New Orleans' communities have the ability to return if they choose. Some of the consistent themes coming out of the discussion included the need to:

▸ Advance a broader framework for identifying and addressing health disparities, with both a race and class lens. This framework must recognize the relationship between health, housing, jobs, and the environment.

▸ Promote increased alignment across sectors of work within the public health field (researchers, advocates, service providers, etc.), but also across other fields of knowledge such as history, law, sociology, education, communications, urban and regional planning, banking and business, etc., thereby connecting public health advocates to advocates working on housing, employment, and environmental issues.

▸ Identify the health policy implications for advocacy in the areas of housing, jobs, education, environment, and social justice, including how health issues might shift priorities or strategies for advocates working in other issue areas.

▸ Develop a long-term vision of a healthy and safe New Orleans and Gulf Coast region. Thinking outside of political constraints, identify the necessary elements for ensuring that all communities are healthy and safe.

▸ Identify policy interventions that need to occur (within and across issue areas) in the short-term to lay the foundation for achieving the long-term vision of a healthy and safe New Orleans and Gulf Coast region. Identify tools necessary to advance policy interventions and build advocates' capacity and infrastructure for moving policy proposals.

▸ Create specific indicators to assess policy impacts on health disparities and whether these policies promote the safe and just rebuilding of New Orleans for all communities.

▸ Rebuild a just healthcare infrastructure for all New Orleans communities.

▸ Implement new community development and environmental training programs for community leaders. Secure health coverage for all residents of New Orleans.

Since the 2006 Health Disparities Conference, many of the conference participants have continued to work on these issues, in different ways. Several members of the planning committee participated in the "Louisiana Health Care Redesign Collaborative," which met over six months to design a new Medicaid delivery system for the state. This report includes a chapter that gives an overview of the Collaborative's recommendations and their likely impact on lower income New Orleans residents. Other committee members organized a national environmental justice conference last October at Dillard University in New Orleans. The conference, "Race, Place, and the Environment After Katrina," examined the impacts of the disaster through an environmental justice lens with an emphasis on race and geography of vulnerability. Another group of planning committee members teamed up with the Student Hurricane Network and local poverty law and pro-bono legal providers to create the "Matchmakers for Justice" program. That program pairs law students on a one-on-one basis with displaced residents in need of legal and other forms of assistance. Finally, initial efforts have begun to establish a long-term partnership between community health providers and legal aid providers to address residents' legal needs in a medical clinical setting. These many follow up initiatives demonstrate the benefits of bringing together individuals from many disciplines and life experiences to address minority health disparities within a given region.

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ENDNOTES

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DEADLY WAITING GAME: ENVIRONMENTAL JUSTICE MATTERS IN POST-KATRINA NEW ORLEANS

Bob Bullard
August 2006

The environmental justice paradigm provides a useful framework for examining and explaining the spatial relation between the health of marginalized populations and their built and natural environment, and government response to disasters that affect calamities in African American communities. More than three decades of environmental justice research clearly documents that people of color communities have borne a disproportionate burden of pollution from incinerators, smelters, sewage treatment plants, chemical plants, industrial accidents, and a host of other man-made disasters (Bullard 2005a).

The environmental justice framework incorporates other social movements and principles that seek to prevent and eliminate harmful practices in land use, industrial planning, health care, waste disposal, and sanitation services. The environmental justice framework attempts to uncover the underlying assumptions that may contribute to and produce unequal protection. This framework brings to the surface the ethical and political questions of "who gets what, why, and how much?" (Bullard 2005a).

UNNATURAL MAN-MADE DISASTERS

Much of the death and destruction attributed to "natural" disasters is unnatural and man-made. In his book, Acts of God: The Unnatural History of Natural Disasters ill America, Case Western University history professor Ted Steinberg says humans prefer to make "Mother Nature" or "God" the villain in catastrophic losses from tsunamis, earthquakes, droughts, floods, and hurricanes rather than placing responsibility squarely on social and political forces (Steinberg 2003). In reality, "there is no such thing as a 'natural' disaster" (Smith 2005,1; Hartman and Squires 2006). What we often term "natural" disasters are in fact acts of social injustice perpetuated by government and business on the poor, minorities, and the elderly-groups least able to withstand such disasters.

Generally, "rich people tend to take the higher land leaving to the poor and working class more vulnerable flooding and environmental pestilence" (Smith 2005,1). Assigning nature or God as the primary culprit has helped to hide the fact that some Americans are better protected from the violence of nature than their counterparts lower down the socioeconomic ladder. As more Americans move

to coastal regions, future losses from "unnatural" disasters will continue to be formidable because of increased development in these high-hazard areas (Comerio 1998). Blaming nature has become a political tool and way of deflecting blame from man-made threats (Cutter 2006).

The number of people forced to flee their homes because of extreme weather events is increasing globally. In 2001, more than 170 million people were affected by disasters, 97 percent of which were climate-related. There are more "environmental refugees" (25 million) than "political refugees" (22 million). By 2050, the number of "environmental refugees is expected to top 150 million, mainly due to the effects of global warming (Simms 2005).

> Each year communities along the Atlantic and Gulf Coast states are hit with tropical storms and hurricanes forcing millions to flee to higher ground. Institutionalized racism in housing and land use planning also provides privilege for whites in securing the higher ground and environmentally safer neighborhoods. Where whites choose to live, work, play, go to school, and worship is not accidental (Lareau 2000). Many of their choices are shaped by

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Historically, the Atlantic hurricane season produces ten storms, of which about six become hurricanes and two to three become major hurricanes. However, the 2005 hurricane season produced a record 27 named storms, topping the previous record of 21 storms set in 1933, with 13 hurricanes besting the old record of 12 hurricanes set in 1969 (Tanneeru 2005). Twelve was the highest number of hurricanes in one season since record keeping began in 1851 (Cuevas 2005).

Government has a long history of discriminating against black victims of hurricanes, floods, and droughts. Clearly, race matters in terms of swiftness of response, allocation of post-disaster assistance, and reconstruction assistance. Emergency response often reflects the pre-existing social and political stratification structure with black communities receiving less priority than white communities. Race and class dynamics play out in disaster survivors' ability to rebuild, replace infrastructure, obtain loans, and locate temporary and permanent housing (Bolin and Bolton 1986; Dyson, 2006; Pastor et al. 2006).

LESSONS FROM KATRINA — AVERTING A SECOND DISASTER

On August 29, 2005, Hurricane Katrina made landfall near New Orleans leaving death and destruction across the states of Louisiana, Mississippi, and Alabama Gulf Coast. Katrina is likely the most destructive hurricane in U.S. history, costing over $70 billion in insured damage (Brinkley 2006; van Heerden 2006). Katrina was also one of the deadliest storms in decades with a death toll

of 1,325. The storm is surpassed only by the 1928 hurricane in Florida, estimates vary from 2,500 to 3,000, and the 8,000 deaths recorded in the 1900 Galveston hurricane (Kleinberg 2003).

African Americans make up twelve percent of the United States population. They also make up a significantly large share of the three Gulf Coast states hardest hit by Katrina: Louisiana, Mississippi, and Alabama. Blacks comprised 32.5 percent of the population in Louisiana, 36.3 percent in Mississippi, and 26 percent in Alabama. New Orleans was nearly 68 percent black before Katrina (U.S. Bureau of Census 2000).

Katrina's environmental devastation lies in a region that is disproportionately African American and poor. The African American population in the Coastal Mississippi counties where Katrina struck ranged from 25 percent to 87 percent black. Some 28 percent of New Orleans residents live below the poverty level and more than 80 percent of those are black. Some 50 percent of all New Orleans children live in poverty.

The poverty rate was 17.7 percent in Gulfport, MS and 21.2 percent in Mobile, AL in 2000. Nationally, 11.3 percent of Americans and 22.1 percent of African Americans live below the poverty line in 2000 (U.S. Bureau of Census 2001). Many of these same communities have for decades been adversely and disproportionately affected by environmental problems worsened by the wind and floodwaters of Katrina.

MOST VULNERABLE LEFT BEHIND

The Katrina disaster also exposed a weakness in urban mass evacuation plans (Litman 2005). New Orleans's emergency plan called for thousands of the city's most vulnerable population to be left behind in their homes, shelters, and hospitals (Schleifstein 2005). *Times-Picayune* reporter, Bruce Nolan, summed up the emergency transportation plan: "City, state and federal emergency officials are preparing to give the poorest of New Orleans' poor a historically blunt message: In the event of a major hurricane, you're on your own" (Nolan 2005).

Clearly, emergency transportation planners failed the "most vulnerable" of society—individuals without cars, non-drivers, disabled, homeless, sick persons, elderly, and children. Nearly two-thirds of the Katrina victims in Louisiana were older than age 60. This data confirms what many believe— that Katrina killed the weakest residents (Riccardi 2005, A6).

Car ownership is almost universal in the United States with 91.7 percent of American households owning at least one motor vehicle. However, two in ten households in the Louisiana, Mississippi, and Alabama disaster area had no car (Associated Press 2005). People in the hardest hit areas were twice as likely as most Americans to be poor and without a car. Over one-third of New Orleans' African Americans do not own a car. Before Katrina, nearly one quarter of New Orleans residents relied on public transportation (Katz, Fellows, and Holmes 2005). And 102,122 disabled persons lived in New Orleans at the time of the hurricane (Russell 2005).

Local, state, and federal emergency planners have known for years the risks facing New Orleans' transit-dependent residents (State of Louisiana 2000; Fischett 2001; Bourne 2004; City of New Orleans 2005). At least 100,000 New Orleans citizens do not have means of personal transportation to evacuate in case of a major storm (City of New Orleans 2005). A 2002 article entitled "Planning for the Evacuation of New Orleans" details the risks faced by hundreds of thousands of car-less and non-drivers in the New Orleans area (Wolshon 2002).

Although the various agencies had this knowledge of a large vulnerable population, there simply was no effective plan to evacuate these New Orleanians away from rising water. This problem received national attention in 1998 during Hurricane Georges when emergency evacuation plans left behind mostly residents who did not own cars (Perlstein and Thevenot 2004, AI). The city's emergency plan was modified to include the use of public buses to evacuate those without transportation. When Hurricane Ivan struck New Orleans in 2004 however, many car-less New Orleanians were left to fend for themselves, while others were evacuated to the Superdome and other "shelters of last resort" (Laska 2004).

The New Orleans Rapid Transit Authority (RTA) emergency plan designated 64 buses and 10 lift vans to transport residents to shelters. This plan proved woefully inadequate. About 190 RTA buses were lost to flooding. The 1,300 RTA employees are dispersed across the country and many are homeless (Eggler 2005, B1).

THE "MOTHER OF ALL TOXIC CLEANUPS"— LET THEM EAT RISKS

Hurricane Katrina has been described as the worst environmental disasters in U.S history. The powerful storm left behind an estimated 22 million tons of debris, more than 15 times the debris hauled away from the 9/11 attack (Griggs 2005). Half of this debris, 12 million tons, is in Orleans Parish. In addition to wood debris, EPA and LDEQ officials estimate that 140,000 to 160,000 homes in Louisiana may need to be demolished and disposed (Louisiana Department of Environmental Quality 2005).

A September 2005 *Business Week* commentary described the handling of the untold tons of "lethal goop" as the "mother of all toxic cleanups." However, the billion dollar question facing New Orleans is which neighborhoods will get cleaned up and which ones will be left contaminated (*Business Week* 2005). A year after Katrina, more than 99 million cubic yards of debris have been removed in Alabama, Louisiana, and Mississippi at the cost of $3.7 billion (Federal Emergency management Agency 2006). Still, nearly a third of the hurricane trash in New Orleans had not been picked up a full year after the storm.

Before Katrina, the City of New Orleans was struggling with a wide range of environmental justice issues and concerns. Its location along the Mississippi River Chemical Corridor increased its vulnerability to environmental threats (Roberts and Toffolon-Weiss 2001). There were ongoing air quality

impacts and resulting high asthma and respiratory disease rates and frequent visits to emergency rooms for treatment by both children and adults (Wright 2005). Environmental health problems and issues related to environmental exposure were hot-button issues in New Orleans long before Katrina's floodwaters emptied out the city. Some of these problems are as follows:

▶ The American Obesity Association reports that New Orleans is among the U.S. cities with the highest obesity rates. In 2000, it was ranked the city with the fifth highest obesity rate in the nation. The following year it climbed to fourth place, and in 2002 fell back to twentieth place and moved back up to seventh place in 2005. According to the New Orleans Health Department, the number one killer in the Orleans Parish is cardiovascular diseases.

▶ The 2005 Louisiana Health Insurance Survey, conducted by the LSU Public Policy Research Lab for the Department of Health and Hospitals, shows that the number of uninsured children has dropped dramatically in the past two years, while the number of uninsured adults has risen; the largest increase in adults without health care coverage since the initial survey in 2003 occurred in Orleans Parish, where more than 13,000 additional adults listed themselves as uninsured; before hurricane Katrina Louisiana had a high percentage of uninsured residents (including 23% of all non-elderly adults and 8% of all children)

▶ Over 50 percent (some studies place this figure at around 70 percent) of children living in the inner city neighborhoods of New Orleans had blood-lead levels above the current guideline of 10 micrograms per deciliter; childhood lead poisoning in some New Orleans black neighborhoods was high as 67 percent; some 83% of housing in New Orleans was built before 1978.

▶ New Orleans children have the highest asthma rates in Louisiana with over 16.4% suffering from the illness; the asthma death rate in Orleans Parish is significantly higher than rates for the rest of Louisiana and the United States; according to the Asthma and Allergy Foundation of America, childhood asthma costs in Orleans Parish are nearly $7 million per year—tops in the state.

New Orleans' humid climate and the large number of old homes, which often contain dust mites and mold create a high concentration of major asthma triggers. Add this to the piles of waste and debris from gutted home and you have the makings of a real health threat from mold. Thousands of Katrina evacuees returned to their homes in badly damages areas without the necessary protective gear (Thomas 2005). Individuals who normally do not have allergies have been coming down with "Katrina cough." It is especially worrisome for people with existing health conditions such as AIDS, asthma, and other serious respiratory illnesses, who may re-enter their homes. Mold is not just an irritant, but can trigger episodes and can develop life-threatening infections in those with

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already weakened immune systems. In late November 2005, only two of New Orleans eight pre-Katrina hospitals were reopened and fewer than fifteen percent of doctors have returned. Furthermore, many medical records are missing or destroyed (Thomas 2005).

Generally, government air quality tests focus on toxins, such as benzene, in areas where Katrina caused oil spills. There has been little testing of "biologicals" such as airborne mold that appears to be a likely cause of the problem. The government does not have regulatory standards for either indoor or outdoor levels of mold spores. Independent tests conducted by the Natural Resources Defense Council (NRDC) in mid-November found dangerous high mold counts in New Orleans air (NRDC 2005).

The spore counts outdoors in most flooded neighborhoods tested by NRDC (test areas included New Orleans East, the Lower 9th Ward, Chalmette, Uptown, Mid-City and the Garden District) showed levels as high as 77,000 spores per cubic meter at one site in Chalmette, and 81,000 spores per cubic meter at another site in Uptown (NRDC 2005). The National Allergy Bureau of the American Academy of Allergy and Immunology considers any outdoor mold spore level of greater than 50,000 spores per cubic meter to be a serious health threat. Mold spores are known triggers of asthma attacks-an illness that disproportionately affects African Americans.

The indoor test site in Uptown had a spore count of 645,000 spores per cubic meter, and the indoor site in Lakeview had 638,000 spores per cubic meter. By comparison, health experts consider outdoor mold counts of 1 to 6,499 "low," 6,500 to 12,999 "moderate," and 13,000 to 49,999 "high" (NRDC 2005).

What gets cleaned up and where the waste is disposed are longstanding equity and environmental justice issues (Bullard 1994). Dozens of toxic "time bombs" along Louisiana's Mississippi River petrochemical corridor, the 85-mile stretch from Baton Rouge to New Orleans, made the region a major environmental justice battleground. The corridor is commonly referred to as "Cancer Alley" (Wright 2005). For decades, black communities all along the petrochemical corridor have been fighting against environmental racism and demanding relocation from polluting facilities.

Two mostly black New Orleans subdivisions, Gordon Plaza and Press Park, have special significance to environmental justice and emergency response (Lyttle 2004; Wright 2005). Both subdivisions were built on a portion of land that was used as a municipal landfill for more than 50 years. The Agriculture Street Landfill, covering approximately 190 acres, was used as a city dump as early as 1910. Municipal records indicate that after 1950, the landfill was mostly used to discard large solid objects, including trees and lumber, and it was a major source for dumping debris from the very destructive 1965 Hurricane Betsy. Ultimately, that landfill was classified as a solid waste site and not a hazardous waste site.

In 1969, the federal government created a home ownership program to encourage lower income families to purchase their first home. Press Park was the first subsidized housing project on this program in New Orleans. The federal program allowed tenants to apply 30 percent of their monthly rental payments toward the purchase of a family home. In 1987, seventeen years later, the first sale was completed. In 1977, construction began on a second subdivision, Gordon Plaza. This development was planned, controlled, and constructed by the U.S. Department of Housing and Urban Development (HUD) and the Housing Authority of New Orleans (HANO). Gordon Plaza consists of approximately 67 single-family homes.

In 1983, the Orleans Parish School Board purchased a portion of the Agriculture Street Landfill site to construct an elementary school. The sites previous use as a municipal dump prompted concerns about its suitability for a school. The board contracted engineering firms to survey the site and assess it for contamination of hazardous materials. Heavy metals and organics were detected at the site.

Despite the warnings, Moton Elementary School, an $8 million "state of the art" public school opened with 421 students in 1989. In May 1986, EPA performed a site inspection (SI) in the Agriculture Street Landfill community. Although lead, zinc, mercury, cadmium, and arsenic were found at the site, based on the Hazard Ranking System (RRS) model used at that time, the score of 3 was not high enough to place them on the National Priority list.

On December 14, 1990, EPA published a revised RRS model in response to the Superfund Amendment and Reauthorization Act (SARA) of 1986. Upon the request of community leaders, in September 1993, an Expanded Site Inspection (ESI) was conducted. On December 16, 1994, the Agriculture Street Landfill community was placed on the National Priorities List (NPL) with a new score of 50.

The Agriculture Street Landfill community is home to approximately 900 African American residents. The average family income is $25,000 and the educational level is high school graduate and above. The community pushed for a buy-out of their property and to be relocated. However, this was not the resolution of choice by EPA. Instead a clean-up was ordered at a cost of $20 million, while the community buy-out would have cost only $14 million. The actual clean up began in 1998 and was completed in 2001 (Lyttle 2004).

Government officials assured the Agricultural Street community residents that their neighborhood was safe after the "clean-up" in 2001. But the Concerned Citizens of Agriculture Street Landfill disagreed and filed a class-action lawsuit against the city of New Orleans for damages and relocation costs. Unfortunately, it was Katrina that accomplished the relocation—albeit a forced one.

In January 2006, after thirteen years of litigation, Seventh District Court Judge Nadine Ramsey ruled in favor of the residents, describing them as poor minority citizens who were "promised the American dream of first-time homeownership," though the dream "turned out to be a nightmare" (Finch 2006, A1).

As of August 2006, the Concerned Citizens case was still on appeal. A year after the storm, a dozen or so FEMA trailers housed Katrina survivors in the contaminated neighborhood, where EPA announced in April 2006 it had found the carcinogen benzo(a)pyrene at levels almost 50 times the health screening level. No decision has been made by EPA to clean up the contamination found near the old Agriculture Street landfill (Brown 2006).

A year after the storm, tons of trash, hurricane debris, flooded cars, and contents from gutted homes and businesses still line some neighborhoods streets. The Army Corps of Engineers is the agency charged with one of the biggest environmental cleanups ever attempted: scraping miles of sediment laced with cancer-causing chemicals from New Orleans' hurricane-flooded neighborhoods (Loftis 2005).

A year after the storm, tons of trash, hurricane debris, flooded cars, and contents from gutted homes and businesses still line some neighborhoods streets.

Katrina floodwaters contained a "soup of pathogens" and contaminated muck (Cone 2005; Cone and Powers 2005; Dunn 200, CDC and EPA 2005). Sediments of varying depths were left behind by receding Katrina floodwaters primarily in areas of New Orleans impacted by levee overtopping and breaches (Home 2006). More than 100,000 of New Orleans 180,000 houses were flooded, and half sat for days or weeks in more than six feet of water. Government officials estimate that as many as 30,000 to 50,000 homes citywide may have to be demolished, while many others could be saved with extensive repairs (Nossiter 2005a, 2005b).

Government failure to address post-disaster needs of African Americans has lead to a "second disaster" (Bullard 2005c). Not trusting government to respond to the needs of New Orleans African American communities, in March 2006, the Deep South Center for Environmental Justice (DSCEJ) and the United Steelworkers (USW), undertook "A Safe Way Back Home" initiative—a proactive pilot neighborhood clean-up project and the first of its kind in New Orleans (Gyan 2006). The voluntary clean-up project, located in the 8100 block of Aberdeen Road in New Orleans East, removed several inches of tainted soil from the front and back yards, replacing the soil with new sod, and disposing the contaminated dirt in a safe manner. Participants included residents and Steelworkers who have received training in Hazardous Materials handling in programs funded by the NIEHS.

The broader goal of the "A Safe Way Back Home" was to provide a sustained effort over the next several months as hundreds of thousands of survivors of this disaster, many of whom are poor, disenfranchised and African American-begin the long, painful task of rebuilding their lives. Much of the work of this project focuses on the research, policy, and community outreach, assistance and education of the displaced minority population of New Orleans. The DSCEJIUSW coalition received dozens of requests and inquiries from New Orleans East homeowners associations to help clean up their neighborhoods block-by-block.

Eleven months after Hurricane Katrina struck, the federal EPA issued its final sediment report giving New Orleans and surrounding communities a clean bill of health (U.S. EPA 2006). EPA deemed New Orleans safe. Government officials concluded that Katrina did not cause any apprecia-

ble contamination that was not already there. The agency pledged to monitor "pockets of contamination" and toxic "hot spots."

Although EPA tests confirmed widespread lead in the soil—a pre-storm problem in 40 percent of New Orleans—the agency dismissed residents' call to address contamination problem as outside of its mission. Federal and state officials see no need to scrape up the three million cubic yards of mud left by Katrina. The sole EPA recommendation for soil removal include soil near the million-gallon Murphy Oil spill in St. Bernard Parish and a 6-foot by 6-foot plot in Audubon Park-where lead contamination was found near a playground that did not flood (Brown 2006). A broad coalition of scientists, health experts, environmentalists, and local residents view EPA's post-Katrina decision to simply monitor rather than clean up the contamination, as a missed opportunity.

CONCLUSION

There is a racial divide in the way the U.S. government responds to weather related disasters such as hurricanes, droughts and floods, epidemics and public health threats (natural and manmade), industrial accidents, spills, train wrecks, plant explosions, and toxic contamination from Superfund sites and abandoned waste dumps in white and African Americans communities. This racial divide is not a recent phenomenon. For decades black disaster victims have been treated as "second class" citizens, discriminated against in life and in death.

Race impacts the speed and level of cleanup of toxic waste sites in the country. Hurricane Katrina exposed this systematic weakness of the nation's emergency preparedness and response, with white communities seeing faster action and better results than communities where blacks, Hispanics and other minorities live. This unequal protection often occurs whether the community is wealthy or poor. The U.S. Environmental Protection Agency should use uniform clean-up standards to ensure equal protection of public health and environmental justice. What gets cleaned up and where the waste is disposed are key equity issues.

Dozens of toxic "time bombs" are ticking away in communities where African Americans and other people of color are fighting against environmental racism, demanding equal protection of public health, relocation from toxic "hot spots," and equal treatment before and after disasters strike. No American, black or white, rich or poor, young or old, sick or healthy should have to endure needless suffering from a disaster.

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INVESTING IN HUMAN CAPITAL AND HEALTHY REBUILDING IN THE AFTERMATH OF HURRICANE KATRINA

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INTRODUCTION

Health disparities that exist among Americans are an indicator of the inequality in health status found among the races in this country. Health Disparities refer to the disproportionate burden of disease, illness and preventable deaths bore by African Americans and other minorities in the United States. Health and Human Services (HHS) Secretary Margaret Heckler released the landmark 1985 Report on Black and Minority Health drawing national attention to this problem. Twenty years later on August 29, 2005, Hurricane Katrina struck the southeastern coastal line of the United States leaving a trail of destruction significantly affecting the region. Hardest hit were the coastal areas of Louisiana and Mississippi. While both states experienced widespread damage and destruction, the impact of this disaster was felt throughout the nation and touched the world. The portrayal of the massive destruction and its toll on human capital was played out before the nation and the world on television, radio broadcasts and through worldwide electronic and print media. The plight of human suffering could be seen on the faces of the victims who awaited rescue efforts in the days that followed the catastrophe. The city of New Orleans and state of Louisiana reigned front and center as the mounting devastation of Hurricane Katrina unfolded daily. While literally hundreds of thousands of people were affected by this storm, the poor and underserved populations were disproportionately impacted and significantly bore the brunt of loss, devastation and injustice. New Orleans, with its majority African American population and large percentage of individuals living below the federal poverty line, became the embodiment of disproportional impact.

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THE BURDEN OF INEQUALITY

Unfortunately, history reveals the ravages of disasters on disenfranchised peoples. They only serve to further the chasm between quality and inequality. Marginalized by social, economic and racial in-

justices, these individuals are often further victimized. There is general agreement among experts in the international community that the poor are disproportionately affected by the global disasters we have all witnessed in recent years. In the case of the Indian Ocean Tsunami (2004) although many countries were affected, the most vulnerable was probably Somalia. This is a very poor country (GNI per capita approx. $100) with very limited resources located in East Africa, with an ineffective governmental structure (Clay, 2004). The failure of public policy to provide for and protect its most vulnerable citizens in times of a disaster is somehow inconsistent with images of a world super power. Quigley (2006) in an article entitled "Who Was Left Behind Then and Who is Being Left Behind Now" refers to the Katrina evacuation in New Orleans as a "totally self-help operation". He suggests that those with resources, a car, money and a place to go left on their own—about 80-90 percent of the population. Quigley (2006) resoundingly concludes, "The people left behind in the evacuation of New Orleans after Katrina are the same people left behind in the rebuilding of New Orleans – the poor, the sick, the elderly, the disabled, and children, mostly African American". Unfortunately, these are the same people who are left behind in the world and in our nation; the people who seem to pay again and again. The cumulative effects of poverty, inequality, social isolation and racism on a people have a mounting effect. These social determinants are closely linked to the poor health outcomes experienced by many African Americans and other minority populations in the United States. Health disparities are the ultimate price that often results in decreases in the quality and years of healthy life for many Americans.

The unequal burden of disease and death is illustrated in substantial differences in life expectancy in the United States from 1970 – 2003. Figure 1 charts life expectancy for White non-Hispanic females at 80.5 years, African American non-Hispanic females at 76.1 years, White non-Hispanic males at 75.4 years and African American non-Hispanic males at 69.2 years. This finding suggests a

Figure 1. Life Expectancy at Birth, by Year – United State, 1970-2003
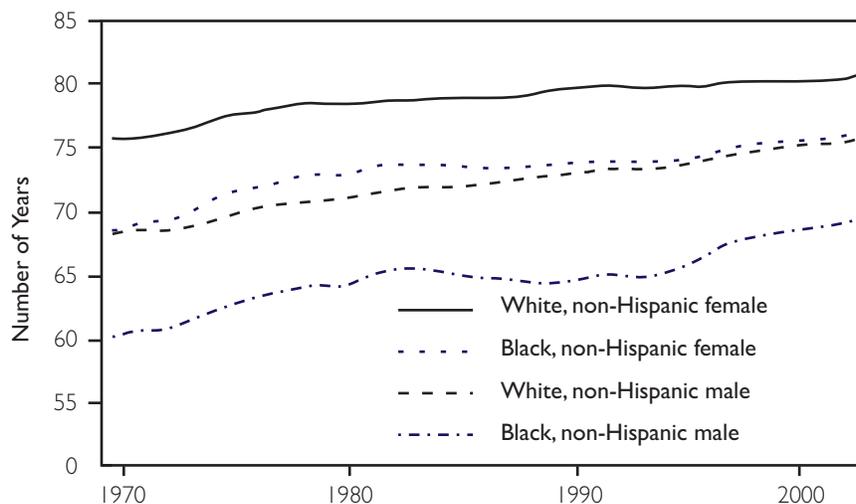
Source: QuickStats from the National Center for Health Statistics.

Figure 2. Historical Trends (1978-2002)

Key

Mortality
Breast
Female
All Ages

Louisiana
White ○

United States
White △

Louisiana
Black □

United States
Black ▽

(Y-axis: Deaths per 100,000 resident population; values 0, 20, 25, 30, 35, 40, 45. X-axis: Year of Death; values 1980, 1985, 1990, 1995, 2000)
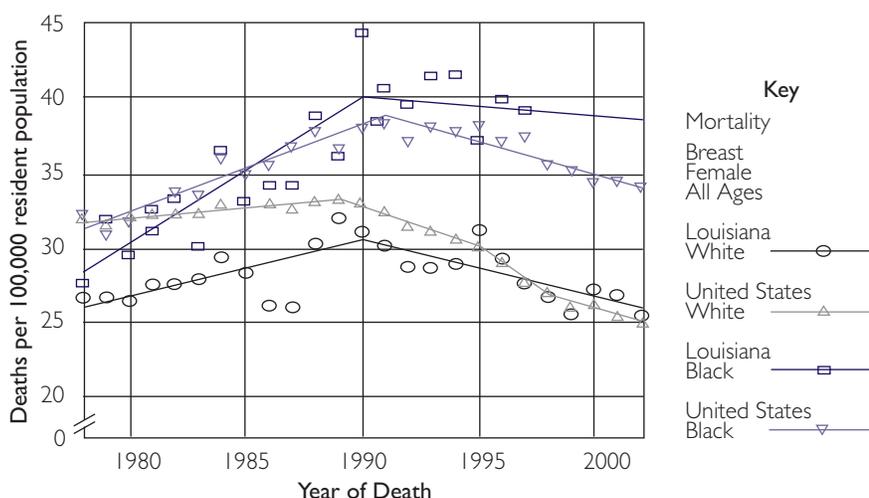
Created by statecancerprofiles.cancer.gov on 06/29/2005 3:59 pm.
Regression lines calculated using the Joinpoint Regression Program.
Source: Death data provided by the National Vital Statistics System public use data file. Death rates calculated by the
National cancer Institute using SEER*Stat. Death rates are age-adjusted to the 2000 US standard population by 5-year
age groups. Population counts for denominations are based on Census populations as modified by NCI.

range of a low - 7 months longer life expectancy for African American women when compared with White males; and a high 11 years longer in life expectancy for White females, when compared with African American males (National Center for Health Statistics 2004).

Disparities in mortality rates for Louisiana women diagnosed with breast cancer from 1978 - 2002 per 100,000 population are further illustrated in Figure 2. Louisiana breast cancer death rates for both White and African American women were slightly higher when compared with national rates for their respective racial groups. However, breast cancer mortality rates overall were significantly higher for African American women in Louisiana and in the United States. when compared with their White counterparts. Furthermore, as illustrated in Figure 2, the gap in breast cancer mortality rates between African American women and White women has been consistently wider in Louisiana compared to the national gap (National Vital Statistics).

POVERTY

The U.S. Census Report (2000), identified Louisiana as the poorest state in the nation, with the largest percentage of its residents with incomes below the Federal Poverty Level (FPL). This finding, unfortunately, reflected no change in ranking since the 1990 Census Report. In August of 2005, when hurricane Katrina hit the Gulf Region, 22 percent of Louisiana residents and 23 percent of New Orleans residents were living in poverty ($ 16,090.00 for a family of three). Almost 50 percent of Louisiana residents live at or below 200 percent of the FPL. The child poverty rate for New Orleans MSA was the highest in the nation in 2005 (Annie E Casey Foundation 2005). Consistent with this finding, single parent households were predominant with 62 percent of children living with single parents compared with 43 percent of all children living in Louisiana and 31 percent of all children living in the United States in 2004. The average family income for New Orleans residents ($36,465) was 33

percent lower than the U.S. average family income of $53,692. For families with children, the average family income was 42 percent lower ($30,112 compared to $51,187) than the national average. New Orleans unemployment rates for the same reporting period were 7 percent as compared to a 5 percent rate for the state and the U.S (U.S. Census Report 1990, 2000; Zedlewski, 2006).

The economic status of children in Louisiana and New Orleans shows limited prospects for improvement given low salaries, large numbers of single parent families and fertility rates highest among single women. Seventy percent of all births in New Orleans and 47 percent of all births in the state, compared to 29 percent of all births in the U.S., were to unmarried females. Along with high rates of poverty in New Orleans and Louisiana are high rates of uninsured individuals.

Table 1. Sociodemographic Characteristics of the Sample (0N=189)

Demographic Characteristics	Frequency	Percentage
Marital Status		
Single	49	25.9
Married	58	30.7
Divorced	41	21.7
Widowed	41	21.7
Total	189	
Income		
$5,000 – 9,000	74	39.6
$10,000 – 19,000	38	20.3
$20,000 – 29,000	38	20.3
$30,000 – 39,000	14	7.5
$40,000 – 49,000	9	4.8
$50,000 – 59,000	6	3.2
$60,000 and Above	8	4.3
Total	187	

Approximately 21 percent of the state's population (900,000) does not have health insurance. The Medicaid rate for the state is 19 percent, the third highest in the nation, providing coverage for children and pregnant women up to 200 percent of the FPL (Louisiana Department of Health and Hospitals, 2005).

High rates of poverty and single female heads of households for many women remain consistent throughout the life cycle. Webb (2004) conducted a study on the "Relationship of Selected Cultural Attributes to Knowledge, Beliefs, and Behaviors For Early Breast Cancer Detection, Among African American Women in New Orleans". In a sample population of 189 women ages 40 – 80 years Table 1 shows 69 percent of the study population reported being single, divorced or widowed. Only 31 percent of the women reported being married. Forty percent of the women's annual household incomes were below $10,000. Another 41 percent of the women reported incomes between $10,000 and $30,000 annually. Only about 20 percent of the women reported incomes over $30,000 and two individuals reported household incomes of less than $5,000 annually.

HEALTH STATUS

Louisiana ranks among the lowest of the 50 states in several health indicators: teen birth rate – 44th, infant mortality rate – 47th, and low birth weight – 49th. Louisiana has the fourth highest cardiovascular disease (CVD) death rate in the nation. CVD is the leading cause of death in Louisiana, accounting for about 40% of all deaths in the state. Louisiana has a high incidence of diabetes with approximately 7 percent of adults in the state diagnosed in 2004. Cancer incidence in the state is also higher. Louisiana's overall ranking of 49th in the nation for health status places it near the bottom with only its neighbor Mississippi ranking worse. Infant mortality rate in 2002 for the state was 10.2 and in Orleans Parish 13.0 per 1000 live births. Louisiana is ranked 6th in the nation in percent of the population lacking access to primary health care (BRFSS, 2004; Louisiana Office of Public Health, 2005).

HEALTH DISPARITIES

African Americans and other minorities in Louisiana, similar to other states in the U.S., are disproportionately affected by illness and disease. Cardiovascular disease, cancer, and diabetes are among the leading causes of death in the state. African Americans are consistently at greater risk with generally higher morbidity and mortality rates. African American women have a 40% higher chance of dying of cardiovascular disease than white women. In the case of breast cancer, African American women have lower rates of disease incidence but higher mortality rates when compared to white women in the state. African Americans have the highest prevalence of diabetes, with a 10.9 percent diagnosis rate, compared to 7.9 percent of Hispanics and 7 percent of the white population. Infant mortality rates per 1,000 live births for African American infants were 14.1 in the state and 10.4 in New Orleans, just over two times the rate for white infants. Of the persons who are living with a diagnosis of HIV/Aids in the state and parish African Americans comprise 66 and 60 percent respectively compared to a national rate of 42 percent (BRFSS, 2004; Louisiana Office of Public Health, 2005, 2006).

The burden of inequality as previously discussed in relation to poverty, health status and health disparities, begs the question, "Does place and race matter"? These health status data suggest if you lived in Louisiana you were at risk for living in poverty and having poor health outcomes. However if you lived in Louisiana and were African American you were at increased risk for living in poverty and having poor health outcomes. On the other hand if you lived in New Orleans you were more than likely African American and you were at an even greater risk of having poorer health and living in poverty.

PLACE MATTERS

On August 29, 2005 Hurricane Katrina hit the costal areas of Louisiana, Alabama and Mississippi. Louisiana and Mississippi both experienced widespread damage and destruction. However, the historic city of New Orleans withstood the greatest impact from this disaster; with major flooding resulting from a failed levy system. The shaded areas of the map in Figure 3 indicate flooding to 80 percent of the city destroying over 180,000 homes, the health care delivery system, schools, businesses jobs and a way of life for so many.

Figure 3. The Flood Zone
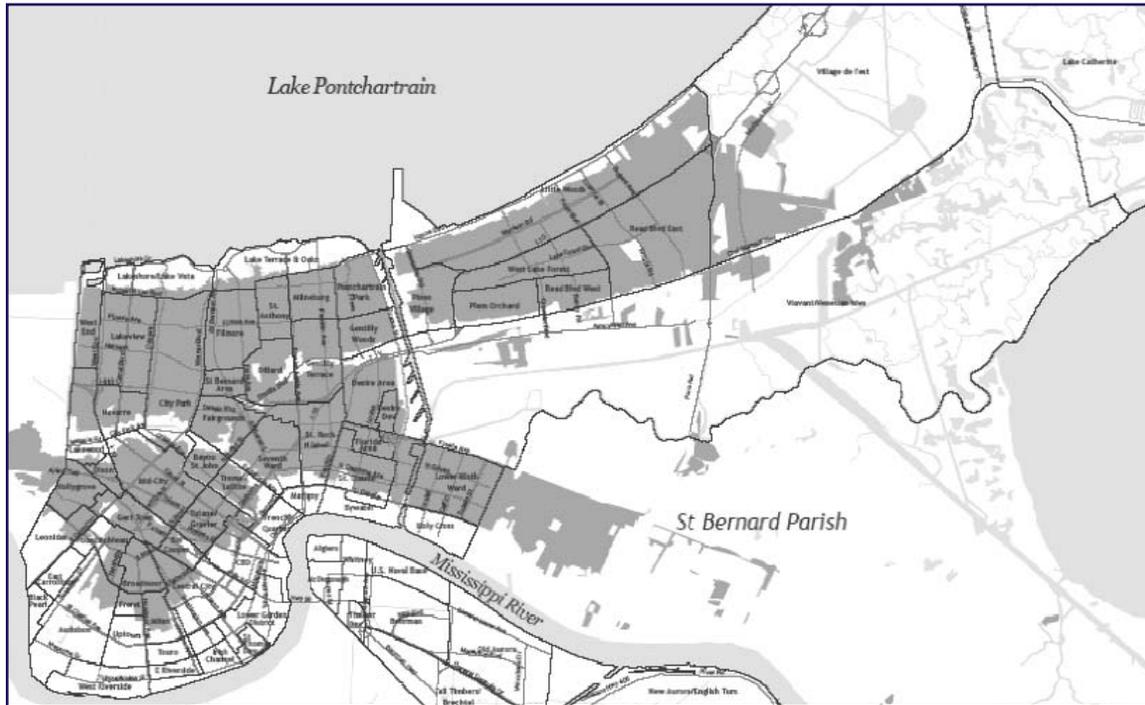
Orleans Parish September 11th flood extent with neighborhoods & major roads

African Americans in New Orleans' poorest communities, renters and the unemployed—were disproportionately impacted by Katrina's floodwaters. Quigley (2006) reported that damaged areas were populated by 46 percent African Americans compared to 26 percent African Americans in the rest of the city. Forty-six percent of the population in the most damaged areas were renters compared to 31 percent in the rest of the city, and 21 percent lived below the federal poverty level compared to 15 percent in the rest of the city. If you lived in New Orleans and were African American you were at increased risk for sustaining storm related damages and losses. Pastor et al. (2006) suggests groups of individuals lacking access to resources, power and information are usually further disenfranchised before, during, and after a disaster.

New Orleans residents evacuated to 44 different states; the poorer you were the greater the likelihood you ended up in a location not of your own choosing and the further away you landed. A significant number of evacuees, however, ended up in Baton Rouge, Louisiana, the State's capital. According to a report from the Federal Emergency Management Agency (FEMA) (2005) the total number of evacuees reporting addresses with Baton Rouge zip codes in October 2005, was 202,042. Baton Rouge is 84 miles west of New Orleans and ranks third among cities with the most evacuees. Individuals are at risk for poor health and social outcomes based on where they live. There is substantial research that suggests place matters.

Table 2 displays a demographic comparison among West and East Baton Rouge parishes and Orleans parish. The combined parishes of West and East Baton Rouge population were slightly smaller 434,453 compared to Orleans' 484,674. Baton Rouge had a slightly small elderly popula-

Table 2. Demographic Comparison

	West Baton Rouge	East Baton Rouge	New Orleans
Total Population	21,601	412,852	484,674
Age 65 years & over (%)	9.7	9.9	11.7
White race (%)	62.8	56.2	28.1
African American race (%)	35.5	40.1	67.3
Asian race (%)	0.2	2.1	2.3
Hispanic (%)	1.4	1.8	3.1
Owner Occupied Housing Units (%)	78.8	61.6	46.5
High School Graduate (%)	73.4	83.9	74.7
Bachelors Degree or higher (%)	11.1	30.8	25.8
Median Household Income (1999)	37,117	37,224	27,133
Families Below Poverty Level (%)	13.2	13.2	23.7

tion comprising 10 percent for people age 65 or older compared to 12 percent for New Orleans. Stark contrasts are noted in the White and Black racial make-up of the populations. Whites accounted for 63 and 56 percent of the population in West and East Baton Rouge compared with 28 percent for Orleans Parish. African Americans comprised 36 and 40 percent of West and East Baton Rouge Parishes compared to 67 percent for Orleans. Asians and Hispanics were less than 5 percent of the population in all three parishes. Seventy-nine and 61 percent of the housing units were owner occupied in West and East Baton Rouge compared to 47 percent for Orleans Parish. High school graduation rates for all three parishes were above 70 percent. Bachelors degrees and higher were highest at 31 percent for East Baton Rouge and lowest at 11 percent for West Baton Rouge, Orleans Parish was 26 percent. Median annual household incomes were $37,000 for Baton Rouge compared to $27,000 for New Orleans. Interestingly, the lower attainment of Bachelors degrees in West Baton Rouge had no effect on median household income. Families living below poverty in Baton Rouge comprised 13 percent of all families compared to 24 percent of families in Orleans Parish (U.S. Census Data 2000). This demographic comparison suggests if you lived in Baton Rouge instead of New Orleans you would have greater earning potential, which would decrease your risks for living in poverty and possibly increase your potential and opportunity for home ownership. These findings indicate that place does matter. As individuals attempt to rebuild their lives of major consideration is the concern for an improved and more equitable quality of life for all.

THE AFTERMATH

New Orleans was the epicenter of medical commerce in the state. In the immediate aftermath of the storm state and local governments focused all attention on emergency response activities in providing healthcare services to the hundreds of thousands of evacuees across the state. U.S. Public Health Service officials led the charge in reassembling the collapsed health care delivery system in New Orleans, St. Bernard, Jefferson and Plaquemine Parishes. Health care planning and systems redesign discussions in the aftermath of the disaster have taken on a life of their own. Health care providers, planners, consultants and government officials alike are spending inordinate amounts of time and energy in the frenzy of planning. These planning processes are constrained by efforts to include and involve the appropriate stakeholders in the face of blistering deadlines. Earlier planning activities under the Governor's "Health Reform Panel", " Louisiana Recovery Authority, Public

Health & Health Care Taskforce" and Mayor Nagin's "Bring Back New Orleans Commission", all provided leadership and a focal point for health care delivery systems revamping activities. These former activities laid the groundwork and helped frame issues for the Louisiana Healthcare Redesign Collaborative (Collaborative).

At the urging of HHS Secretary Leavitt, the Collaborative was created by legislative authority to design a new waiver request that addresses the rebuilding of the Health Care Delivery system in the New Orleans Region, and influences health policy statewide. The mission of the Collaborative was "to develop, and oversee the implementation of, a practical blueprint for an evidence-based, quality driven health care system for Louisiana. This blueprint will serve as a guide for health care policy in Louisiana and to the rebuilding of health care in the hurricane-affected areas of the state." Significant in the charter of the Collaborative is the expectation that the waiver will go much farther than the previous Medicaid Health Insurance and Flexibility Act (HIFA) waiver application, be tailored to respond to the loss of infrastructure and population shifts, and include a Medicare demonstration as part of the design. The significance of the latter is that Medicare is 100% financed through the federal government. The blueprint was scheduled for presentation to Secretary Leavitt, the Governor, the Legislature and Louisiana Recovery Authority in late 2006.

HEALTH CARE INFRASTRUCTURE

Nearly one year after the storm, in areas sustaining the greatest devastation such as New Orleans and the lower lying parishes of St. Bernard and Plaquemine, the health care delivery system remains greatly fractured. By August of 2006 only 3 of the 12 acute care hospitals in Orleans parish had reopened their doors. Acute inpatient care is provided among the 9 hospitals operating in Orleans and Jefferson Parishes. Service capacity is static with the number of operating hospitals, while demand increases with the returning population. Many services are limited, particularly sub-specialty care. Psychiatric beds are in great demand with mental health needs a number one priority. New Orleans Adolescent Hospital opened in June 2006 with 10 pediatric psychiatric beds and 20 acute adult psychiatric beds formerly housed at the Medical Center of Louisiana at New Orleans (MCLANO). Access to care for the uninsured is a great challenge. MCLANO continues to provide emergency services for this population from the New Orleans Centre formerly the Lord and Taylor Department Store. Veterans Administration Hospital is operating ambulatory care clinics while the inpatient facility remains closed. An agreement between the Veterans Administration and LSU Health Care Services Division is in negotiations for the building of a joint facility. Nearly a year later, private hospitals report significant losses in earnings as a result of uncompensated care expenditures, increased lengths of stay resulting from the absence of continuum of care providers such as nursing homes, and low Medicare Diagnostic Reimbursement Group (DRG) payments.

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By early fall of 2006, there were 11 primary care clinics in Orleans Parish opened or reinvented. The most recent site is the EXCELth Primary Care Network, Daughters of Charity Health Center in Bywater. There were 9 mobile units serving adults and children in Orleans and Jefferson Parishes, with additional mobile units slated for roll out in the near future. Crippled by significant layoffs and damage to its infrastructure the New Orleans Health Department is operating only (3) of its clinics. Five School-based Health Centers are operating 3 in Orleans Parish and 2 in Jefferson Parish. Mental health services are available at community and school sites through primary care clinics and the Metropolitan Human Service District. Federally funded (FEMA) mental health counseling services through Louisiana Spirit is provided in storm-affected areas across the state and metropolitan New Orleans. This fledgling patchwork delivery effort, although commendable under the circumstances, constitutes about 25 percent of pre-storm capacity. It is hardly adequate to meet the current service delivery demands. Health workforce shortages also remain significant and are critical to infrastructure repair.

HEALTH WORKFORCE

According to some reports, primary care physician availability for the insured population is now less of an issue. For the uninsured population, there are shortages of primary care physicians, psychiatrists and dentists. Nursing and pharmacy shortages have increased since the storm. Nursing support staff such as Licensed Practical Nurses, Certified Nurse Aids and other support staff is also short. Academic institutions serving in the role of preparing a qualified workforce scurry to re-establish functionality.

LSU Health Science System is challenged to fulfill its dual missions of medical education and caring for the underserved. Both LSU and Tulane Medical schools are operating with stable student enrollment for incoming students. LSU Dental School remains in Baton Rouge. Dillard University will be back at its Gentilly campus and Xavier University is open and operating. The three other colleges with schools of nursing in New Orleans:—Charity Delgado, Holy Cross, and William Carey—are open. However, in order to continue operating, most academic institutions have cut programs with faculty and staff lay offs. The open doors of these institutions are encouraging indeed, in a sea of daily disappointments and discouragement. Unfortunately, the pipeline between education and practice does not afford an immediate solution to the severe shortages of today. Some health professionals fed up with the struggles of recovery choose to leave. The healthcare workforce, as a major artery of the healthcare delivery system, continues to hemorrhage.

MENTAL HEALTH

Mental health needs are at the top of the chart in the aftermath of the disaster. The immediate stress and trauma experienced by many individuals are now manifesting in the form of depression and anxiety disorders. Individuals with chronic mental illness conditions are exacerbated in the absence of stability in their lives, treatment facilities and medical providers. In a survey conducted of evacuated families still in Louisiana in February 2006, mental health problems were significant. The survey documented nearly half of the parents reporting behavior or emotional problems observed in

their children after the storm (Abramson and Garfield, 2006). Based on results from a standardized mental health-screening tool, more than half of the mothers scored at a level consistent with a psychiatric diagnosis. The deputy coroner of Orleans Parish recorded almost a threefold increase in suicide rates, from 9 per 100,000 to 26 per 100,000 in the four months after Katrina hit. A year later there have been 93 homicides in New Orleans, compared with 202 by this time last year, according to police reports. This suggests that murders are running at about the same rate as before the storm, considering the drastically reduced population. There are also reported increases in domestic violence cases. In a report from the *Journal of the American Medical Association,* only 22 percent of the 196 psychiatrists are practicing in New Orleans, with drastic reductions in inpatient beds. The poor, the uninsured, the elderly, the homeless and people of color are disproportionately impacted in the situations and circumstances they currently face in post Katrina life.

HEALTHY REBUILDING AND INVESTING IN HUMAN CAPITAL

In the healthy rebuilding of New Orleans and the entire Gulf Region, extraordinary leadership is needed from all sectors of government, the private sector, business community, nonprofits, academia, the Faith-based community, and from everyday citizens. The rebuilding of the region will require broad based participation, commitment and resources. Governmental funding and resources are essential however rebuilding efforts will be greatly stymied without additional resources and assistance from the other societal sectors. While the entire region experienced what has been termed the worst disaster of our nation's history, it is still dazed by the might of the impact. The wounds of destruction are visible and appear as gaping holes seen and felt throughout the region. The people of the region are substantially affected and need time and unprecedented support to assist in their healing and recovery. The most vulnerable received the greatest impact and are suffering disproportionately. These individuals need even more support and assistance as they attempt to piece their lives and communities back together. Investing in human capital in rebuilding lives, families and communities is sorely what is needed in the days that follow.

Another immense challenge, nearly one year post hurricane Katrina, is the redesign of a health care delivery system in the face of very extraordinary circumstances, a feat Louisiana did not accomplish under normal conditions. While the Health Care Redesign Collaborative focuses on health systems redesign, Louisiana also grapples with parallel problems of the collapsed health care system in New Orleans, serious health workforce shortages and the fiscal crisis experienced by the remaining operating hospitals within metropolitan New Orleans. There is no one solution to this myriad of very complicated problems. The approaches and solutions needed are both long and short term and will more than likely require many years to be phased in. How will Louisiana establish the future political will to carry a long range plan to fruition, when elected officials and policy makers serve four year terms? There is no shortage of studies, reports, and expert recommendations on what needs to be done to fix the broken system. However, long term commitments from federal, state and local governments that transcend four year terms of office are needed. The appropriate levels of accountability through monitoring and evaluation feedback loops with flexibility to change are also needed. Consistency in lead-

ership and accountability at all levels of development, implementation and evaluation is vital to the challenge of designing and building a system that is accessible, patient centered, efficient, quality driven and cost effective. A most obvious need is a unified approach in the form of public policy and the available mechanisms and resources to accomplish such an unprecedented task.

The rebuilding of healthy communities in New Orleans will involve re-establishing schools, businesses, housing, transportation systems, infrastructure, and faith-based institutions. The difficulties faced by all who are impacted and involved in the rebuilding effort, is to build better communities and systems in the face of such daunting challenges. A number of community level planning processes have engaged homeowners and neighborhood associations in designing and planning their future neighborhoods. It is yet to be seen as to how this input will translate into public policy decisions and the allocation of resources. Renters are less advantaged as the options for rental units are limited by the scarce availability of rental property and escalating costs. Public housing units have been closed to its previous occupants, making it nearly impossible for the return of these individuals and families to New Orleans. Policy decisions regarding the repopulation of the city should include affordable housing options for renters and homeowners, mixed use neighborhoods with ample green spaces for walking, recreation and biking. All neighborhoods should be cleaned and free of environmental contaminants and hazardous substances. Finally, sustainable employment opportunities with a living wage should be the central focus of policy decisions regarding the building of healthy communities. Addressing many of the social and economic determinants of health will go a long way in eliminating health disparities. This moment in history should be embraced as an unparalleled opportunity for change. In the resulting paradigm shift, the future New Orleans will be incompatible and incommensurate with what existed before the devastation.

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CULTURAL COMPETENCE IN MENTAL HEALTH SERVICES POST DISASTERS

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August 2006

Cultural competence as defined by Georgetown University's National Center for Cultural Competence "is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations". According to African American psychologist Dr. Wade Noble, "Culture represents the vast structure of behaviors, ideas, attitudes, values, habits, beliefs, customs, language, rituals, ceremonies and practices 'peculiar' to a particular group of people. Culture provides...(1) a general design for living and (2) patterns for interpreting reality". New Orleans had 72 distinct neighborhoods which included 20 historic ones prior to Hurricane Katrina. Many of these neighborhoods were inhabited by a large volume of families who lived in poverty, but these diverse neighborhoods constituted the numerous rich cultural traditions that were the core of New Orleans. The diaspora caused by the hurricane has New Orleanians scattered throughout the country, and throughout primarily rural Louisiana. The very fabric of neighborhoods' cultures as well as many of the racial and ethnic cultural activities practiced by families and individuals in New Orleans are decimated. Many of the people's community, neighborhood and individual support systems on which their cultures relied no longer exists, therefore, they are unable to effectively negotiate within the systems in which they currently reside to return to New Orleans.

Culture offers a protective system that is comfortable and reassuring. It defines appropriate behavior and furnishes social support, identity, and a shared vision for recovery. For example, stories, rituals, and legends that are a part of a culture's fabric help people adjust to catastrophic losses by highlighting the mastery of communal trauma and explaining the relationship of individuals to the spiritual. Culture as a source of knowledge, information, and support provides continuity and a process for healing during times of tragedy (DeVries, 1996). Survivors react to and recover from disaster within the context of their individual racial and ethnic backgrounds, cultural viewpoints, life experiences, and values. The cultural isolation of New Orleanians is a factor in some of the depression and anxiety that they are experiencing.

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Despite the strengths that culture can provide, responses to disaster also fall on a continuum. Persons from disadvantaged racial and ethnic communities may be more vulnerable to problems associated with preparing for and recovering from disaster than persons of higher socioeconomic status (Fothergill et al., 1999). Because of the strong role that culture plays in disaster response, services are most effective when survivors receive assistance that is in accord with their cultural beliefs and consistent with their needs (Hernandez and Isaacs, 1998). As service providers seek to become more culturally competent, they must recognize three (3) important social and historical influences that can affect the success of their efforts. These three (3) influences are the importance of family and community, racism and discrimination, and social and economic inequality.

THE IMPORTANCE OF COMMUNITY

Disasters affect both individuals and communities. Following a disaster, there may be individual trauma, characterized as "a blow to the psyche that breaks through one's defenses so suddenly and with such brutal force that one cannot react to it effectively" (DHHS, rev. ed. in press). Cultural and socioeconomic factors contribute to both individual and community responses to the trauma caused by disaster.

> The culture of the community provides the lens through which its members view and interpret the disaster, and the community's degree of cohesion helps determine the level of social support available to survivors. A community that is disrupted and fragmented will be able to provide less support than a cohesive community.

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A classic example of this is from sociologist Kai Erickson, who studied the impact of the devastating 1972 flood in Buffalo Creek, West Virginia (Erickson, 1976). The flood led to relocation of the entire community. Erickson describes a "loss of community", in which people lost not only their sense of connection with the locale but also the support of people and institutions. The results of this community's fragmentation included fear, anger, anxiety, and depression.

Compared with non-disaster-related suffering, which is isolating and private, the suffering of disaster survivors can be collective and public (Dynes et al., 1994). Disasters can have positive outcomes; they can bring a community closer or reorient its members to new priorities or values (Ursano, Fulleton et al., 1994). Individuals may exhibit courage, selflessness, gratitude, and hope that they may not have shown or felt before the disaster.

Community is often extremely important for racial and ethnic minorities because it affects their ability to recover from disaster. For example, a racial or ethnic minority community may provide especially strong social support functions for its members, particularly when it is surrounded by a hostile society. However, its smaller size may render it more fragile and more subject to dispersion and

destruction after a disaster. Members of some racial and ethnic minority groups, such as refugees, previously have experienced destruction of their social support systems, and the destruction of a second support system may be particularly difficult (Beiser, 1990; Van der Veer, 1995).

New Orleans had a unique tradition of generations of African American extended family members living in close proximity to one another. This living arrangement provided significant familial support. In many cases, all family members' homes were destroyed. These extended families are now scattered throughout the country, and are now without their trusted support systems.

RACISM AND DISCRIMINATION

African Americans, American Indians, Chinese and Japanese Americans have experienced racism, discrimination, or persecution for many years in this country. Both legally sanctioned and more subtle forms of discrimination and racism are an undeniable part of our nation's historical fabric. Despite improvements in recent decades, evidence exists that racial discrimination persists on many fronts. As a result of past and present experiences with racism and discrimination, racial and ethnic minority groups may distrust offers of outside assistance at any time, even following a disaster. They may not be accustomed to receiving support and assistance from persons outside of their own group in non-disaster circumstances. Therefore, they may be unfamiliar with the social and cultural mechanisms of receiving assistance and remain outside the network of aid.

Particularly during the "disillusionment phase" of the disaster, when intra-group tensions are typically high, racial and ethnic minority groups can face the brunt of anger and even blame from members of the larger culture. Such psychological assaults and experiences with racism and discrimination can result in increased stress for individuals and groups.

SOCIAL AND ECONOMIC INEQUALITY

Poverty disproportionately affects racial and ethnic minority groups. Social and economic inequality also leads to reduced access to resources, including employment, financial credit, legal rights, and education, health, and mental health services (Blaikie et al., 1994).

Poor neighborhoods also have high rates of homelessness, substance abuse, and crime (DHHS, 2001). Poverty makes people more susceptible than others to harm from a disaster and less able to access help (Bolin and Stanford, 1998).

Low-income individuals and families typically lose a much larger part of their material assets and suffer more lasting negative effects from disaster than do those with higher incomes (Wisner, 1993). Often, disadvantaged persons live in the least desirable and most hazardous areas of a community, and their homes may be older than and not as sound as those in higher income areas. For example, many low-income people live in apartment buildings that contain un-reinforced masonry, which is susceptible to damage in a disaster (Bolton et al., 1993). The Lower Ninth Ward of New Orleans was a majority low-income/working class neighborhood situated in a low-lying area that abuts to an industrial canal

whose levy was breached during Hurricane Katrina. Many homes were washed away from the force of the water, and the majority of the others were damaged beyond repair. This neighborhood had one of the highest home ownership rates in New Orleans, but due to poverty, the majority of the residents had minimal or no flood insurance, and the neighborhood is struggling to find resources to rebuild, but many people believe that it may not ever recover to become a vibrant community again.

Although disaster relief activities can help ameliorate some of the damage rendered by a disaster, some groups cannot readily access such services. Negative perceptions derived from pre-disaster experiences may serve as a barrier to seeking care.

The lack of familiarity with sources of community support and transportation are common barriers for many immigrants and the unwillingness to disclose their immigration status is a major barrier. They may find it difficult to accept assistance from mental health and social service agencies. They may fear a loss of control and find it humiliating to accept emergency assistance such as clothing, food, loans, and emotional support from disaster workers.

In some instances, people of lower socioeconomic status exhibit strong coping skills in disaster situations because they have seen difficult times before and have survived. In other instances, the loss of what little one had may leave an individual feeling completely hopeless.

DISASTER PHASES AND RESPONSES

Survivors' reactions to and recovery from a disaster are influenced by a number of factors, including:

▶ The disaster's unique characteristics, such as its size and scope, and whether it was caused by human or natural factors

▶ The affected community's unique characteristics, including its demographic and cultural make-up and the presence of pre-existing structures for social support and resources for recovery; and

▶ The individuals' personal assets and vulnerabilities that either reduce or exacerbate stress (DHHS, 2000e).

Despite the differences in disasters, communities and individuals, survivors' emotional responses to disaster tend to follow a pattern of the seven (7) "disaster phases" (National Institute of Mental Health, 1983; DHHS, 2000e) listed below:

▶ Warning or threat phase;

▶ Impact phase;

▶ Recscue or heroic phase;

▶ Remedy or honeymoon phase;

▶ Inventory phase;

▶ Disillusionment phase; and

▶ Reconstruction or recovery phase.

The characteristics of the disaster, as well as those of the community and its individual residents, affect the duration and nature of the seven (7) phases. The phases do not necessarily move forward in a linear fashion; instead, they often overlap and blend together. Furthermore, individuals may experience a given phase in different ways (DHHS, 1999), and different cultural groups may respond differently during these phases:

▶ *Warning or Threat Phase:* It occurs with hurricanes, floods, etc. for which there is warning hours or days in advance. The lack of warning can make survivors feel vulnerable, unsafe, and fearful of future unpredicted tragedies. The perception that they had no control over protecting themselves or their loved ones can be deeply distressing.

Racial and ethnic groups sometimes differ in the ways in which they receive information about risks and in the credence they place on such information.

▶ *Impact Phase:* It occurs when the disaster actually strikes. Depending on the characteristics of the disaster, reactions range from confusion, disbelief, and anxiety (particularly if family members are separated) to shock or hysteria.

▶ *Rescue or Heroic Phase:* Individuals or activity levels are typically high and oriented toward rescue operations, survival, and perhaps evacuation. People generally work together to save lives and property; and pre-existing tensions between racial and ethnic or cultural groups are set aside. However, if family members are separated, anxiety may be heightened.

▶ *Remedy or Honeymoon Phase:* Optimism may reign as the community pulls together and government and volunteer assistance become available. The interactions between relief workers and survivors from different cultures can be very important and can influence people's long-term perceptions of the disaster relief effort. People's perceptions and beliefs about how healing occurs may also influence recovery. Frequently disaster workers who have had no orientation to local cultures and lack sensitivity to them are brought in to help out during this phase. Such workers may exacerbate, rather than mitigate, cultural differences.

▶ *Inventory Phase:* Survivors recognize the limits of help and begin to assess their futures. They become exhausted because of multiple demands, financial pressures, and the stress of relocation or living in a damaged home. Initial optimism may give way to discouragement and fatigue. This time is also characterized by high levels of grief and loss.

▶ *Disillusionment Phase:* It occurs when survivors recognize the reality of loss and the limits of outside relief. It is characterized by a high level of stress that may be manifested in personally destructive behavior, family discord, and community fragmentation. Obtaining assistance from relief agencies can be extremely difficult, and survivors may feel helpless and angry. Hostility between neighbors and among groups is common, and tensions may erupt among different cultural, racial, and ethnic groups.

▶ *Reconstruction or Recovery Phase:* This is the final phase and may last for years. It involves the structural rebuilding of the community as well as the integration of changes occasioned by the disaster into one's community and one's life. A common problem during this phase is a lack of housing. In such situations, housing shortages and rent increases disproportionately affect racial and ethnic minority groups (Bolin and Stanford, 1991; Peacock and Girard, 1997). It is not unusual for local political issues to create friction and fragmentation in the impacted community during the disparate reconstruction progress and buyouts between neighboring counties.

To develop cultural competence in mental health services to address racial, ethnic, and cultural minority groups you must:

▶ Assess and understand the community's and individuals' composition;

▶ Identify culture-related needs of the community and individuals;

▶ Be knowledgeable about formal and informal community institutions that can help meet diverse needs;

▶ Gather information from and establish working relationships with trusted organizations, service providers, and cultural group leaders and gatekeepers; and

▶ Anticipate and identify solutions to cultural problems that may arise in the event of a disaster.

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NEW ORLEANS AREA HEALTH DISPARITIES INITIATIVE CASE STUDY: HURRICANES KATRINA AND RITA AND THE BERNARD-WALKER FAMILY

June 2006

To help frame a discussion aimed at identifying priority issues for the healthy rebuilding of New Orleans, a case study profiling a New Orleans family displaced by Hurricane Katrina was developed. A multi-disciplinary panel from the fields of medicine, social work, mental health, law, environmental justice and health access offered commentary on the case study before participants were broken into small groups to identify priority issues. Below appears the case study and commentary offered by the panel.

CASE STUDY

After considering the following scenario, participants should work in their small groups to identify problems and develop an action plan to resolve the problems identified. Include the following contexts in your collaborative discussion and outcome: (1) status of health care delivery system and services; (2) cost dimensions of proposed solutions and real resources; (3) health policy implications that are embedded in both this situation and in proposed resolutions; (4) current transportation and housing options, in the event of eviction or another hurricane that would require mandatory evacuation. This family does not own a computer or PDA. The original house in Mossville, LA is the only permanent housing that the Bernard-Walker Family claims as family/community property.

> Prior to the hurricanes, the household supported six special needs individuals, ranging in ages from 6 months to 90 years. They did not evacuate during Hurricane Katrina as a result of insufficient time after notification, as well as a lack of available funds, transportation, or place to go.

A multigenerational African American family of immediate and extended relatives was severely impacted by the effects of Hurricanes Katrina and Rita on the New Orleans area. The family, seven adults, two teenagers and three children, previously shared a three bedroom, two bathroom residence and collective resources. Prior to the hurricanes, the household supported six special needs individuals, ranging in ages from 6 months to 90 years. They did not evacuate during Hurricane Katrina as a result of insufficient time after notification, as well as a lack of available funds, transportation, or place to go. Familial, as well as individual characteristics are provided for consideration.

Kenicia, is a 22 year old single mother of three children. In June of 2005, Kenicia was laid off without unemployment benefits as her employer did not participate in the program. She recently graduated after completing 14 months of a Licensed Practical Nurse curriculum. Her daughter, Kamanee, is four years old. Her sons, Jkwon and Jacoby, are six months and eight years old, respectively. Jkwon was prematurely born in Mossvillle, LA, a town 210 miles west of New Orleans and suffers from bronchopulmonary dysplasia necessitating continuous oxygen therapy and other therapies. Mossville is renowned for industrial pollution which contaminates the surrounding soil and air. They resided in a dilapidated, 75 year old home with space heaters.

Kenicia's mother, Cynthia, a New Orleans Regional Transit authority (RTA) bus driver who was laid off from her job, is a recently widowed 38 year old chronic hypertensive person who remained in New Orleans during Hurricane Katrina to assist in caring for other family members. Cynthia's husband and car drowned in Katrina's catastrophic flood waters. Although the family remained in a devastated zip code for two months following the hurricane, they were ineligible for FEMA and Red Cross assistance as they were in their home when they applied. Funds are not available for repairs since she could not afford homeowners insurance. Additionally, she ran out of her prescribed meds and supplies and was unable to procure more because her previous pharmacy did not maintain electronic records which could have been transmitted to other pharmacies. Unfortunately, the 30-day meds and supplies Cynthia received upon her return to New Orleans during Health Recovery Week were misplaced two weeks later and she is once again without necessary pharmaceutical support. Cynthia's resources are inadequate to sustain her household in addition to her healthcare needs.

Kenicia's grandmother and great-grandmother to her children, Connie, is 60 years old and suffering from hypertension, major depressive disorder, and arthritis. After staying in New Orleans for two months, Connie secured a ride with neighbor and moved her 80-year old great uncle and two grandchildren to Houston, Texas. Connie remained in Houston for two weeks but felt obligated to seek other arrangements as her relative could not provide for an additional four individuals. She moved to Magnolia, MS with her great uncle and two grandchildren in a FEMA trailer. Connie would like to return to New Orleans but cannot afford her current mortgage and associated living expenses for four individuals while her home is repaired on her $2,500 government and unemployment checks.

Kenicia's great uncle, Elijah, is an 80 year old retired New Orleans public school teacher with pancreatic cancer, diabetes, and dementia. He requires constant supervision and care to maintain his heath and safety. Additionally, the effect of diabetes on his kidneys is such that he must be dialyzed three times a week. Elijah is wheelchair dependent for mobility but currently is without since it could not be accommodated in the vehicle used to move to Texas. They listen intently to radio and television appeals for displaced New Orleanians to "Come back home…"

Kenicia's two sisters, Jenicia and Kejuan, 16 and 17 years old respectively, reside with Connie and Elijah. It was suggested by Janicia's previous high school that she participate in anger management

counseling since she had frequent verbal and physical altercations with student and teachers. She attended three sessions prior to being displaced by the storm. Recently, Connie had to withdraw Janicia from the public high school in Magnolia, MS for disruptive behavior after being referred to as "another New Orleans troublemaker." Kejuan missed the deadline for enrollment in a charter school and has decided not to attend school. After running away, both teenagers were discovered in New Orleans with plans to reunite with friends and live in abandoned homes or cars in eastern New Orleans near a landfill site at 16600 Chef Menteur Highway.

Connie's second request for a FEMA trailer in New Orleans was approved since her request for a public housing unit was denied by the New Orleans Housing authority, but she must absorb the costs of relocating, her third in less than a year. Cynthia's husband's remains will finally be released to her next week — his life insurance policy expired in June 2006. She lost her health and retirement benefits when RTA laid her and other city bus drivers off from work after the storm. Cynthia has exhausted her savings and was diagnosed with Type 2 diabetes by a volunteer physician in the local hospital emergency room 12 weeks after hurricane Katrina. She is more concerned about feeding her children, grandchildren and uncle and keeping them safe and together under the same roof. A friend of the family has agreed to allow the FEMA trailer to sit in their yard in Mid City as long as utilities are paid and Cynthia takes care of the friend's elderly mother during the daytime.

COMMENTARY

Overall Planning, Access and Delivery of Health Care
Michael Andry, Excelth, Inc.

As of June 2006, most of community hospitals and none of the private hospitals have reopened, leaving only 330 beds in Orleans Parish for inpatient care. Price Waterhouse Coopers' report for the Louisiana Recovery Authority notes that the shortage of inpatient beds is compounded by a lack of places for those in hospitals to be discharged to due to destroyed infrastructure. The prognosis for those requiring specialized care is even bleaker. Many in elder care lost their personal support networks when their families evacuated the region. Pediatric care suffers from not only a shortage of physicians, but resources to promote healthy youth such as day care and summer programs. Mental health services and Private and Public hospitals for indigent care are almost non-existent. Many issues related to health care access are due to lack of action in getting resources back into place, and the rebuilding of the infrastructure is being held hostage to larger political issues. We've got long-term issues but we have to start doing things right now. However, Social Services Block grant dollars are extremely limited: only $21 million is allocated for public health institutions and a mere $80 million will be going to mental health. More than 1/3 of the population is going to need mental health services. FEMA is governed by the Stafford Act and health care is not an appropriate expenditure of disaster relief funds. $90 million to LSU health sciences center. The resources that

> Many issues related to health care access are due to lack of action in getting resources back into place, and the rebuilding of the infrastructure is being held hostage to larger political issues.

are being put to work are not the resources of the federal government. In New Orleans, Katrina's aftermath can be compared to a patient suffering from a terminal disease who is in denial, so the patient fails to make decisions about treating the disease. That denial is fed by the fact that the "disease" was preventable (here, meaning stronger levees would have saved the City from catastrophic flooding). New Orelans needs an action plan that incorporates prevention and keeps the population healthy and safe.

Cultural Competency

Almarie Ford, LCSW, Louisiana Department of Hospitals, Office of Mental Health

How do mental health practitioners develop skills in dealing with patients? We should look at the family as a system operating in a larger community. However, within larger communities there are diverse needs. Mental health practitioners need to identify and understand the related needs of culture and individuals. Also, practitioners must establish working relationships with organizations trusted in communities impacted by the storm. Those trusted organizations function like gatekeepers, and they can assist practitioners as they enter into those communities. Practitioners must also learn the survival skills used by members of different racial and ethnic groups. A key survival skill involves the healing process, and that process varies between different cultures. Social behavior and cultural responses to a disaster will be defined and happen along a continuum according to three factors: 1) Importance of their communities; 2) race/discrimination and 3) social/economic inequality in the U.S. A people's loss of their community and institutions are cause for fear and anger. Reconstruction and recovery takes years to accomplish.

Mental Health, Healing

Dr. Charlotte Hutton, LA Department of Health and Hospitals,
New Orleans, Adolescent Hospital

Many patients at Adolescent Hospital lost their parents in Hurricane Katrina and, therefore, lost their decision-makers on health and other matters. A genogram of the case study family shows that most of the women gave birth early in life. The implications of premature pregnancy and the effect on wage earning and linkage to poverty is important to understand here. The lack of financial and other resources caused by poverty makes priority setting very difficult. Typically, chronic medical issues take precedence and the older folk in need of care take priority of over the younger. Resurgences of toxic exposures and post partum depression in the case study are also a concern. The adolescents in the case study family who ran away may have been attempting to regain some level of life structure. For young people especially, there is a stigma associated with being a New Orleans evacuee. Patients don't know by heart the type of medicine they take and the records kept by pharmacies were lost in the floodwaters. Shelter eligibility rules would help to render this whole family homeless.

> The lack of financial and other resources caused by poverty makes priority setting very difficult. Typically, chronic medical issues take precedence and the older folk in need of care take priority of over the younger.

Safe and Affordable Housing
Ranie Thompson, JD, New Orleans Legal Assistance Center

This case study presents many interwoven issues, involving three families struggling to rebuild. In order to move forward, these families must find safe and affordable housing. Katrina caused many New Orleans residents to become homeless, and without any housing options evacuees cannot return. Affordable housing is key to any repopulation plan, but at the present there is no such repopulation plan. Public and subsidized housing is virtually non-existent in New Orelans, and rules for eligibility for such housing place additional barriers on homeless evacuees seeking to return to the City. In New Orleans, families have lived in their houses for generations and many families did not have homeowners insurance. Homeowners without insurance present an array of legal issues involving the federal government. Without insurance, many families have to wait for federal disaster assistance in order to rebuild their homes. In the meantime, these families took up residence in FEMA trailers. FEMA had to be sued before the agency would provide families with disabled family members with handicap accessible trailers. FEMA trailers isolate evacuees in remote areas that are not serviced by public transportation, negatively impacting their ability to return. Without transportation, one cannot apply or find work; and without work, one cannot secure a permanent home in any community.

Environmental Hazards and Impact
Dr. Beverly Wright, Deep South Center for Environmental Justice

There is a non-existent system for dealing with Environmental Health and Environmental Diseases in Louisiana. The various governmental agencies responsible for our protection are at odds over how to deal with contamination caused by Hurricane Katrina (US Environmental Protection Agency vs. Louisiana Department of Environmental Quality vs. City government). The anger issues found in many of the case study's family members could be due to lead poisoning that occurred before Katrina. New Orleans lacks a plan for debris removal, and $650 million in federal disaster assistance will revert back to the federal government if no plan is submitted by June 30, 2006. No one in the government is admitting that Hurricane Katrina caused any environmental problems in New Orleans; which means there does not have to be any environmental cleanup of the City. How can that be, when 300,000 cars were abandoned after being destroyed in the storm and having sat for weeks under water, emitting pollutants into sitting water? Clean up and then the land will become worth millions. In fact, that may be the long term plan—defer cleanup until it is clear that certain people do not return. Unfortunately, the people of New Orleans are a living experiment in environmental health. Many health problems will not be known for years, when the first cancer clusters will appear.

> The anger issues found in many of the case study's family members could be due to lead poisoning that occurred before Katrina. New Orleans lacks a plan for debris removal, and $650 million in federal disaster assistance will revert back to the federal government if no plan is submitted by June 30, 2006.

Access/Delivery, Key Issues, Priorities
Monir Shalaby, M.D., Excelth, Inc, Medical Director

The sad thing is the number of families whose stories mimic that of the case study. There is nothing unique about it. Loss of insurance based on loss of jobs. Premature childbirth will be impacted by a bad environment. Access to continuous medical care is a major concern. The storm highlights the need for electronic medical record keeping. Society needs to develop evacuation plans that reach special needs patients. One cannot evacuate oneself using a wheel chair.

A COMMUNITY-BASED PARTICIPATORY ASSESSMENT OF HEALTH CARE NEEDS IN POST-KATRINA NEW ORLEANS: AN UPDATE FOR COMMUNITY MEMBERS AND ADVOCATES

Benjamin Springgate, MD, MPH[1], Catherine Jones[2], Charles Allen, MPH[3], Shaula Lovera, MPH[4], Ruth Klap, PhD[5], Diana Meyers, RN[6], Lawrence Palinkas, PhD[7], and Ken Wells MD, MPH[8]
On behalf of the REACH-Louisiana Community and Scientific Advisory Boards[9]

March 2007

The Rapid Evaluation and Action for Community Health in Louisiana (REACH-LA) Phase I was a four-month project conducted between May and August 2006 to identify the needs, existing resources, gaps, and solutions to ensuring health care in New Orleans after Hurricane Katrina. Unlike other studies of post-hurricane health issues, this project used community-based participatory methods to engage community members themselves in the design, conduct, and interpretation of the results. Various New Orleans' citizens comprised a Community Advisory Board (CAB), which secured community engagement throughout the project's duration. A Scientific Advisory Board was assembled to provide scientific oversight, methodological and conceptual support. Finally, information was collected through 30 interviews of key informants (policymakers, health sector recovery planners, healthy system administrators, health care providers, and community health leaders), four Community Discussion Groups (CDG) in diverse Greater New Orleans neighborhoods, and a Community Feedback Conference. This approach afforded insight into the depth and breadth of concerns and ideas for solutions in the aftermath of one of the largest disasters in the nation's history. This brief report describes the findings from the Community Discussion Groups, which affords the most direct insight into grassroots community perspectives on healthcare needs in response to the disaster.

GOALS

The primary goal of REACH-Louisiana Phase I is to identify and to document qualitatively the challenges in access to health care, and to identify community and policy level solutions to address those challenges in the Greater New Orleans area since Hurricane Katrina and design failures of the federal levee system destroyed much of the New Orleans area on August 29, 2005. The goal of the Community Discussion Groups featured in this report, was to provide rapid community input into identifying healthcare needs, challenges, and solutions.

BACKGROUND

More than twelve months after Hurricane Katrina, problems in accessing health care persist. The hurricane hit states with the worst health statistics in the nation.[10]

▶ Over 40 percent of the New Orleans population prior to the hurricanes was either uninsured or enrolled in Medicaid and relied on the Charity Hospital system, which was closed after the flooding.[11]

▶ Nearly three-quarters of the Charity Hospital system patients were African American, and 85 percent of its patients had income below $20,000.[12]

▶ A large number of people in affected areas have lost their jobs and health insurance.[13][14]

▶ Clinics and public health units were shut down by the Hurricane as well. Hospital capacity was reduced by 80% initially and about 75% of the safety-net clinics closed in New Orleans.[15]

▶ An estimated 4,400 physicians were displaced and a large fraction of the Louisiana State University and Tulane University health care staff was laid off.[16]

▶ Mental health and specialist care is limited and community-based providers are strained.[17][18]

▶ New Orleans lost 77 percent of its primary care physicians and 89 percent of its psychiatrists according to Louisiana estimates.[19]

▶ Recent results from an ongoing study indicate that more than 30 percent of hurricane survivors suffer from clinically significant mental health symptoms.[20]

FINDINGS

These summary findings reflect many of the leading priorities and themes through which participants in the four community discussion groups characterized the current state and future of health services and health recovery in the Greater New Orleans area. Many participants felt very strongly about the issues raised, and many conflicting opinions emerged. Our findings reflect an attempt to capture the overarching themes and priorities that emerged. This summary also attempts to highlight not only the current post-disaster challenges, but also the resources, opportunities, and priorities by which the community has responded to these significant challenges, and in which the community places some of its hopes for the future of health and recovery in the region.

COMMUNITY DISCUSSION GROUPS

Seventy-six community members who were identified through CAB members' affiliated agencies, participated in four neighborhood discussion groups to describe their own concerns and visions for health and health care recovery. The discussion groups were held in diverse neighborhoods, hosted by the following community partners:

▶ Algiers community: New Homes Ministries Church (with Common Ground Health Clinic): 18 participants

- Central City community: Israelite Baptist Church: 22 participants

- Treme community: St. Anna Episcopal Church (with Holy Cross Neighborhood Association): 16 participants

- Kenner community: Hispanic Business & Technology Center (with the Hispanic Apostolate and Catholic Charities): 20 participants

In these two-hour facilitated discussion groups, community members provided feedback on themes and priorities selected by the CAB, but were free to describe other community concerns as well. Topics included:

- Current resources contributing to health in the community

- Opportunities to improve community health and health care, including, government and policy solutions to health and health care challenges

RESOURCES CONTRIBUTING TO HEALTH IN THE COMMUNITY

Community members in the four discussion groups outlined a variety of resources that they felt have been contributing to health and healthy recovery since Katrina. In particular, participants highlighted the critical roles of the following types of resources for themselves, their families, and their communities:

1. **Faith-based and non-profit organizations:** Many individuals felt that these community-based organizations have contributed enormously to health and healthy recovery through the development of health fairs, community clinics, mobile health units, church nurse programs, or by providing spiritual guidance during the difficult post-disaster period.

2. **Traditional health care resources:** Resources such as the standing hospitals and emergency rooms were perceived to be valuable to the community, as were the subspecialty resources for the uninsured. Participants noted that since the disaster closed many safety net facilities, many valuable specialty services for the uninsured were now available only through facilities in Houma or Baton Rouge, Louisiana, approximately 75 miles from the city of New Orleans.

3. **Novel Community Strengths:** Participants described a number of new community-based assets that have contributed to health in the recovery period, including newly utilized sources of health information such as the internet, churches, neighborhood resource centers, emerging community support groups, and growing neighborhood networks. In addition, they described how individual responsibility can play a role in healthy recovery, including eating well, quitting tobacco, going to parks, and engaging in regular exercise. Participants also emphasized the benefits of community-wide collaboration, and building on common goals since the disaster, including the importance of developing a new sense of who and what community really means during the period of recovery after the disaster.

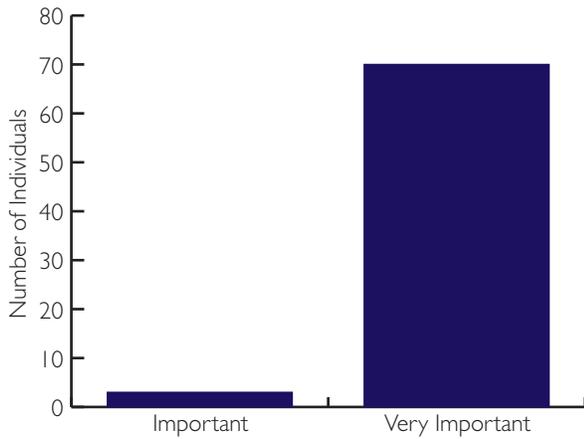## Figure 1 - Expanding Insurance Programs to Support the Uninsured

Figure 2 - Increasing Support of Public Healthcare Facilities
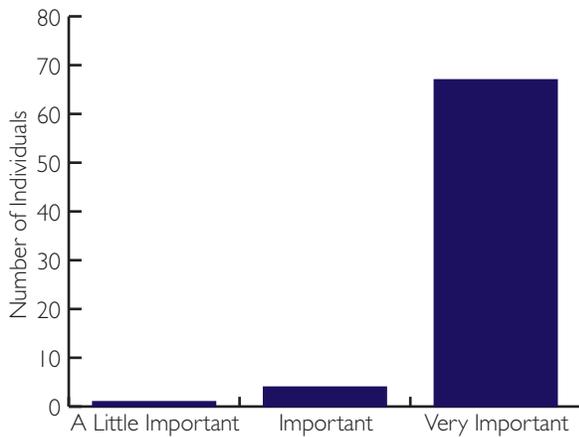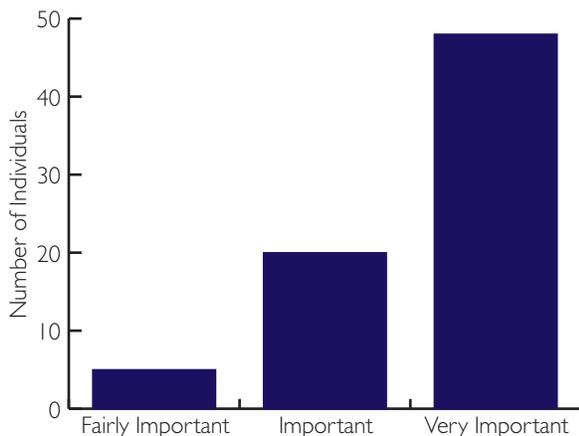

Figure 3 - Increasing Availability of Neighborhood Clinics

AVAILABLE OPPORTUNITIES TO IMPROVE HEALTH

After acknowledging the available resources, community discussants also reflected on the opportunities to improve health in the community, for their families, and for themselves since the Katrina disaster. Among the leading opportunities they described were:

1. **Improving Access to Health Care.**
   Community members recognized that breaking the cycle of poverty would be critical to improving access to health care in the current health care system. Some barriers that they cited to accessing health care were independent of the disaster, including the perception that many jobs that don't pay well or provide health insurance. They also noted the paucity of Spanish language health care services in the community, despite a dramatic rise in the population of Latino immigrants contributing to rebuilding in the community. Participants commonly expressed as well a perception that community voices are not being heard during the recovery processes, that their views are not being taken into account, and that their opinions are not valued in policy debates around health care recovery and redesign.

2. **Envisioning Model Solutions.**
   Community discussants cited a number of specific models that might be pursued to improve health and health care in the post-Katrina recovery period and beyond. They pointed to the recent model of "universal health care" implemented on the state level in Massachusetts as a promising model. Community members also emphasized the opportunities to expand Medicaid eligibility, by changing income or residency requirements. They also felt strongly about

the need to augment mental health resources to help the community recover and cope with post-Katrina stress, trauma, and depression. They emphasized hopes for development of built infrastructure like hospitals and clinics, improved epidemiology and surveillance for disease and environmental hazards, and better sources of information about health and health care resources.

3. **Changing Local, Regional, and National Priorities.** While considering opportunities for healthy recovery, community members highlighted perceived opportunities to change funding priorities at various levels of government. Some participants voiced concern that local and state priorities favored rebuilding the Superdome instead of investing in health care services for the uninsured, while others noted that national spending priorities favored investment into rebuilding Baghdad, Iraq, while Americans in New Orleans neighborhoods were struggling to survive without basic health care, or an effective public school system.

COMMUNITY DISCUSSION GROUP PRIORITIES

Community discussion groups also included a participant response system, through which 76 participants were able to score and rank a wide variety of health care health care recovery priorities on a scale from 1 (Not Important) to 5 (Very Important). The following tables demonstrate how community members rated the importance of specific health-related recovery priorities. These priority rankings reveal overall that these community members value highly potential investment in health care resources and health-related projects in the context of setting community recovery priorities following the devastation of New Orleans by Hurricane Katrina and associated levee failures. (Figures 1-6)

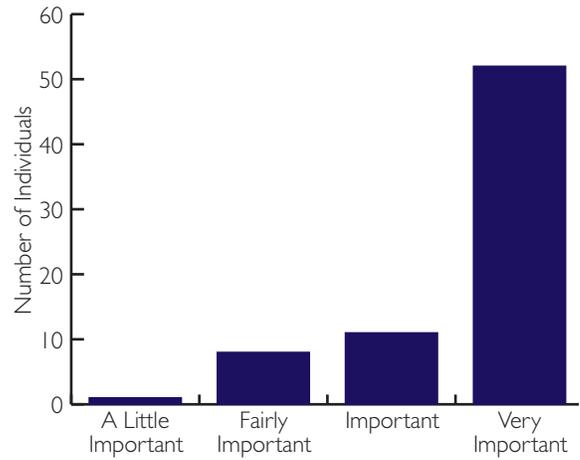### Figure 4 - Increasing Support for Mental Health Programs

Figure 5 - Increasing Availability of Emergency and Hospital Care
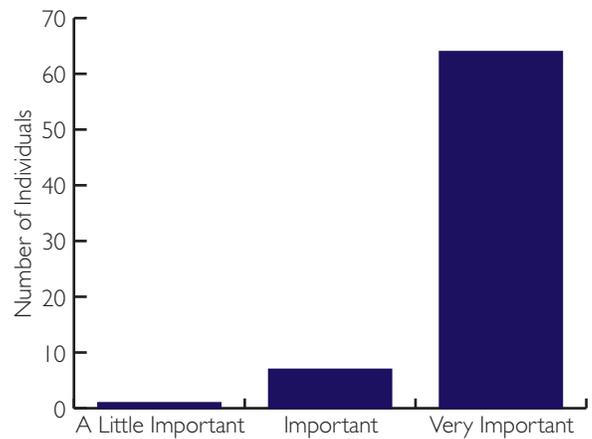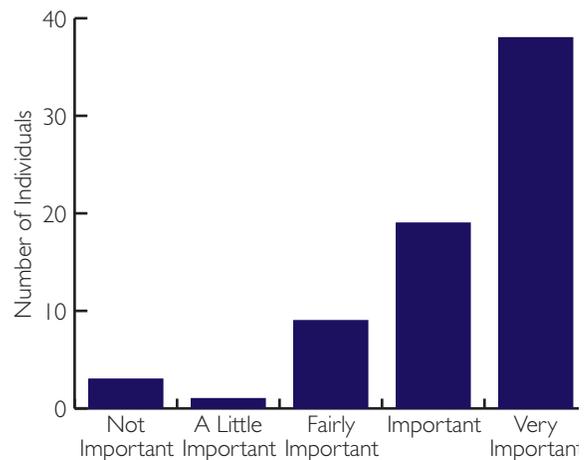

Figure 6 - Increasing Community Ownership of Health Programs

DISCUSSION

Following a major disaster, the community voice in leadership for health planning may be difficult to obtain but is important to achieve. Community priorities and views can offer insights into how recovery may proceed and which of many priorities require the most urgent attention. The discussion groups reported here were community-led, community-located, and the participants were diverse. Formal ratings of priorities revealed that a range of key health-related concerns were rated as of high importance, which may not be surprising in the aftermath of such a wide-spread disaster with physical and structural damage and widespread displacement. Ranking priorities within this context may not be as helpful as actual community member discussion in capturing what the community is most concerned about, but nevertheless can serve as a springboard for that discussion. We found that the rich discussions generated information on more focused areas of concern, such as suggestions for proceeding in recovery, including building on the strengths of faith-based programs, and descriptions of emerging community solutions.

The discussions were also useful for capturing community values and the climate of opinion. For example, the community discussants emphasized the importance of honoring values to rebuild an accessible universal system of healthcare, that should be a high priority for government resources, even in the face of other national and international crises. Other specific gaps noted by the groups included the lack of Spanish language services despite an increase in Spanish speaking populations to help with reconstruction; and the lack of attention to the community voice in current policy setting activities, which made these community discussion groups an important outlet for community members seeking to express their views and hoping to participate in their community's recovery. Despite the expression of frustration over government responses and concern over the inclusiveness of policy planning from a community perspective, the community groups were able to engage in wide-ranging discussions of important policy issues and concerns, and balance their frustration with knowledge of community strengths and hope for community solutions.

ACKNOWLEDGEMENTS

Community Advisory Board Membership for Phase One included:

▶ Charles Allen, MSPH of the Holy Cross Neighborhood Association and the Tulane/Xavier Center for Bioenvironmental Research

▶ Rev. Larry Campbell of Israelite Baptist Church

▶ Catherine Jones of the Latino Health Outreach Project and Tulane School of Medicine

▶ Shaula Lovera, MPH of the Latino Health Access Network of Catholic Charities of New Orleans

▶ Diana Meyers, RN of St. Anna Episcopal Medical Mission of New Orleans

▶ Ravi Vadlamudi, MD of the Common Ground Health Clinic and Tulane Department of Family and Community Medicine

▶ Clayton Williams, MPH of the Louisiana Public Health Institute

Scientific Advisory Board Membership for Phase One included:

▶ Claudia Campbell, PhD of Tulane University, Department of Health Systems Management

▶ Naihua Duann, PhD of the UCLA-NPI Health Services Research Center

▶ Paul Koegel, PhD of RAND Health

▶ Jeanne Lambrew, PhD of George Washington University

▶ Nicole Lurie, MD, MSc of RAND Health

▶ Larry Palinkas, PhD of the USC School of Social Work

▶ Kenneth Wells, MD, MPH of UCLA-NPI Health Services Research Center and RAND Health

Drs. Springgate and Wells were the co-principal investigators for this project. Additional consultation in community partnership and engagement for research was provided by Loretta Jones, MA (Healthy African American Families, Los Angeles, CA). Data collection and analysis support were provided by Ruth Klap, PhD and Lily Zhang (UCLA-NPI HSR Center), Chris Joplin, MD, Anjali Niyogi, MD (Tulane School of Medicine, Program in Medicine and Pediatrics), and Suhaila Khan, PhD (Tulane School of Public Health and Tropical Medicine, Department of International Health). Rachel Pearson and Abigail Lockhart of UCLA-NPI HSR Center, and Cristina Punzelan, MPH of the UCLA Robert Wood Johnson Foundation Clinical Scholars Program, provided substantial organizational and project management support.

ENDNOTES

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2   Tulane School of Medicine and Latino Health Outreach Project of Common Ground Health Clinic.

3   Tulane-Xavier Center for Bioenvironmental Research and Holy Cross Neighborhood Association

4   Catholic Charities of New Orleans

5   UCLA-NPI Health Services Research Center

6   St. Anna Episcopal Medical Mission

7   USC School of Social Work

8   UCLA-NPI Health Services Research Center

9   See Acknowledgements for complete listing of Community and Scientific Advisory Board Members. A portion of this update is derived in part from an unpublished report submitted to the Joint Center for Political and Economic Studies on August 29, 2006 by Dr. Springgate, Mr. Allen, Ms. Meyers, Dr. Jeanne Lambrew, Dr. Palinkas, and Dr. Wells.

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THE LOUISIANA HEALTH CARE REDESIGN COLLABORATIVE

Judith Solomon
May 2007

During its 2006 session, the Louisiana legislature formed the Louisiana Health Care Redesign Collaborative. The 40-person Collaborative included health care providers, members of the Louisiana legislature, representatives from business groups, insurance, and local government, and consumer advocates.[1] The legislature directed the group to advise the Louisiana Department of Health and Hospitals on the development of a "practical blueprint for an evidence-based, quality driven health care system for the New Orleans region."

In July of 2006, the Collaborative took on the task of developing the framework for a waiver of Medicaid and Medicare rules that would be submitted to the U.S. Department of Health and Human Services (HHS) by October 20. At the time the charter for the Collaborative was signed by its members, HHS Secretary Michael O. Leavitt stated that the Collaborative had "an opportunity to design and implement fundamental change in the financing and delivery of health care in Louisiana that could serve as a model for the nation."

It was clear from the outset that HHS intended to use federal funding as leverage to influence the blueprint developed by the Collaborative. According to Secretary Leavitt, the federal government provides three-fifths of the total funding for the health care system in the New Orleans region. Representatives of the Centers for Medicare and Medicaid Services (CMS), the agency within HHS that administers Medicare and Medicaid, were stationed in Louisiana and Secretary Leavitt visited the state on several occasions. In August, Leavitt described New Orleans as a "green-field" and proposed that the Collaborative substitute a new health care system for what he described as a two-tier system: private care for people with insurance and the Charity hospital system for people with no coverage.[2] From the outset Leavitt limited the role that the federal government would play in financing the new system by cautioning the Collaborative and state officials that the state's proposal would have to be budget-neutral to the federal government.

> In August, Leavitt described New Orleans as a "green-field" and proposed that the Collaborative substitute a new health care system for what he described as a two-tier system: private care for people with insurance and the Charity hospital system for people with no coverage.

THE ROLE OF MEDICAID IN LOUISIANA'S HEALTH CARE SYSTEM

In 2003, Medicaid provided health coverage for over one million Louisiana residents, including 638,000 children and over 184,000 people with disabilities.[3] Almost 57 percent of Louisiana Medicaid beneficiaries are African-American compared to 23 percent in the United States as a whole.[4] The federal government provides Louisiana with matching funds at a 70 percent matching rate, which means that the state gets $2.31 in federal funds for every state dollar it spends. In 2005, total Medicaid spending in Louisiana, including state and federal funds, was $5.47 billion.

Despite the broad charge to the Collaborative to overhaul the region's health care system, its primary focus was on a proposal for a Medicaid waiver that would be submitted to the federal government.[5] A Medicaid waiver could provide the state with authority to cover childless adults with federal funds, which is not possible without a waiver, and could also allow the state to change the way benefits are provided. However, Medicaid waivers do not allow the state to spend more federal dollars while the waiver is in effect than the state would have spent during the same time period under usual Medicaid rules. This requirement of "budget neutrality" requires that states agree to a cap on federal funds during the waiver period that equals the amount that the federal government would have contributed in the absence of the waiver.[6]

> While Medicaid is a critical source of health coverage for poor and low-income Louisiana residents, Louisiana has very low income eligibility levels for parents and does not provide any coverage for childless adults. As a result, a high percentage of poor, non-elderly adults in Louisiana remain uninsured.

While Medicaid is a critical source of health coverage for poor and low-income Louisiana residents, Louisiana has very low income eligibility levels for parents[7] and does not provide any coverage for childless adults. As a result, a high percentage of poor, non-elderly adults in Louisiana remain uninsured. Before Hurricane Katrina, about 17 percent of residents of Louisiana were uninsured. Almost half of those that were uninsured were African American.[8]

Medicaid also provides funding for health care services delivered to the uninsured through payments to hospitals, which are known as disproportionate share funds (DSH). In 2005, over a billion dollars in Medicaid funds, about 19 percent of total Medicaid spending in the state, went to safety net hospitals to care for the uninsured.[9] Most of this funding went to the Charity Hospital system.[10]

The lack of a promise of additional federal funds meant that the tools at the Collaborative's disposal, while substantial, were not sufficient to address the significant shortcomings of the health care system in the New Orleans region, including the disparities in health coverage and health outcomes based on poverty and race. A Medicaid waiver would not provide a way to rebuild the hospitals damaged or destroyed by Hurricane Katrina, nor would it provide the state with sufficient means to attract physicians, nurses and other health care workers to the region to address the workforce shortages, or even to provide health coverage for all uninsured residents of the region. Further, changing the way Medicaid funding is used could exacerbate the disparities that already exist.

THE COLLABORATIVE'S PROCESS AND RECOMMENDATIONS

With a very short time frame to fashion a proposal, the Collaborative broke into a number of work groups and quickly settled on the concept of a "medical home" as the organizing principle for the redesign of the region's health care system. Under this model, each individual would have a physician or other health care professional who would provide the individual with most health care services and would facilitate and coordinate the specialty care and other health care services that the individual might need. People with more complex medical needs, such as individuals with HIV or sickle cell disease, would receive care at "specialized medical homes" that could provide care suited to their specific condition. The medical homes would be linked to hospitals, behavioral health care providers, and specialists in an organized system of care.

At the end of September, as the Collaborative's recommendations took shape, representatives of HHS expressed displeasure with the direction the Collaborative was taking. According to press accounts, HHS believed that the state's plans for a system built on medical homes did not do enough to eliminate the "two-tier" system of care where uninsured people get care from the Charity hospital system and people with insurance get care from private providers.[11] The federal government wanted a plan that provided individuals with vouchers or other types of subsidies to purchase private health insurance that could be used to obtain care.[12]

In response to this pressure from HHS, the Collaborative developed what was described as a "hybrid" approach. While the medical home model remains as the system for the delivery of health care services, the plan also includes a "health insurance connector," a concept that had been originally advanced by the Louisiana State Medical Society. The Medical Society had proposed a health insurance exchange that would serve as a "market organizer" for both group and individual health insurance. State residents, including Medicaid beneficiaries, state employees and others, would be able to purchase insurance through the exchange.[13]

The Collaborative met its deadline of October 20 and sent a short concept paper to HHS along with a longer paper with more details on the recommendations.[14] The concept paper included short-term requests for additional federal funds separate from the Medicaid waiver, including adjustments in Medicare payment rates to account for increases in labor costs and longer hospital stays due to Hurricane Katrina, a request for $120 million for workforce recruitment and retention initiatives, and $30 million for uncompensated care provided by physicians and other health providers.

As a framework for the waiver proposal, the Collaborative recommended expansions in health insurance coverage that would decrease the substantial percentage of uninsured people in both the state and the region. On a statewide basis, eligibility for coverage for children would be expanded to include those with family income up to 300 percent of the poverty line ($51,510 for a family of three). Pregnant women, including those who are undocumented, would be covered for prenatal care and related services if their incomes are below 200 percent of the poverty line ($20,420 for an

individual), and individuals with serious mental illness with incomes up to 200 percent of the poverty line would also be covered. In the four parishes affected by Hurricane Katrina (Orleans, Jefferson, Plaquemines, and St. Bernard) parents and childless adults with incomes up to 200 percent of the poverty line would be eligible for Medicaid coverage as well.

The "preferred vehicle, if available" for health insurance coverage for people newly eligible for coverage would be private insurance offered through the health insurance connector rather than coverage offered through the state Medicaid program. Current Medicaid and State Children's Health Insurance Program (SCHIP) beneficiaries could also select private health plans offered through the connector.

The concept of a health insurance connector or exchange has been promoted by the Heritage Foundation as an alternative to employer-sponsored coverage and Medicaid and as a way of creating a single market for health insurance.[15] For most participants, the model would substitute individual coverage for group coverage that had been provided through employers or through public coverage. However, as currently structured in most states, the individual market does not provide coverage that is uniformly available, adequate or affordable. People with health conditions are often turned down for coverage or offered coverage that excludes treatment of their existing health conditions. Policies in the individual market provide coverage that is less comprehensive than group coverage, and coverage can be unavailable or unaffordable for older people and those with health problems.[16]

According to the concept paper, the connector would offer employer-sponsored insurance as well as individual coverage. All individuals eligible for Medicaid except for those in "high-risk" categories would get a financial credit to use for either individual insurance or employer-sponsored coverage that was available to them. The credit would be based on the individual's income and would be adjusted based on the individuals' age, gender, health risk status, and geographic location. Coverage for families below 150 percent of the poverty line would be fully subsidized. In other words their credit would be equal to the cost of the coverage. Between 150 percent and 300 percent of the poverty line, there would be a sliding scale premium contribution required from the family.

According to the concept paper, Louisiana "may continue to offer the current Medicaid program to existing beneficiaries." It appears that people with disabilities would continue to receive Medicaid coverage and would not be expected to seek private coverage through the connector.

The Collaborative's proposal included the concept of a medical home for both private and public coverage. Private insurers would be required to include medical homes in their products offered through the connector, and Medicaid providers would also be expected to come into compliance with medical home standards "over time." A new "Louisiana Health Care Quality Forum" would establish standards for medical homes. Providers participating in the medical home system would also be expected to use electronic medical records that would allow them to exchange information with other providers in the medical home network.[17]

THE BUSH ADMINISTRATION'S PROPOSAL FOR LOUISIANA

The concept paper presented only the broad outlines for a Medicaid waiver and left many questions unanswered. Negotiations between the state and the federal government took place in November and December of 2006. In January 2007, the Bush Administration announced a new initiative called "Affordable Choices."

Affordable Choices offers states the option of diverting federal funds currently being used to help support hospitals providing care to the uninsured. Under Affordable Choices, states would use their disproportionate share hospital (DSH) funds to provide subsides to uninsured individuals who could use these subsidies to help pay for "basic private coverage."[18]

Affordable Choices offers states the option of diverting federal funds currently being used to help support hospitals providing care to the uninsured.

In late January, just after the release of details on Affordable Choices, HHS provided Louisiana with a proposal and a financial model for changing its health care system. Consistent with Affordable Choices, the HHS model would provide an estimated 319,000 uninsured individuals with private insurance. Most of the funding would come from redirecting the DSH funds that have been used to support the Charity Hospital system. In addition, the HHS proposal presumed that the state would save money through better management of its existing Medicaid programs. These savings would also be used to finance subsidies for the 319,000 individuals who would get covered under the new program.

Louisiana has not agreed to the HHS proposal. The HHS proposal would provide only enough funding for about half of the state's uninsured population.[19] At the same time it would eliminate all the federal funds now used to provide care for the uninsured through DSH payments to safety net hospitals. Over 300,000 Louisiana residents would be left without health care coverage under the HHS proposal. At the same time the state would be left without federal funds to help support the health care providers that would be called upon to provide care to these individuals.

Besides leaving many state residents uninsured, HHS's assumptions on the costs of providing coverage to the uninsured are significantly below Louisiana's estimates. The difference is attributable in part to the fact that HHS failed to factor in the state's estimate that 17 percent of the childless adults who would be covered under the expansion have a chronic illness or disability.[20] HHS allotted a monthly payment of just $157 (or $1,884 on an annualized basis) for private coverage for each of these adults, an amount far below what would be needed to purchase comprehensive coverage.

A recent analysis examined the affordability of private coverage for individuals at different income levels. Because estimates of the cost of coverage in the individual market are difficult to obtain, the analysis used 2004 national data on the cost of insurance in the small group market for employers with less than ten workers. For an individual policy, the cost of coverage averaged $3,998 per year in 2004. That is more than double the $1,884 per year allocated by HHS for coverage in Louisiana in *2007*.[21]

This difference in cost estimates is particularly important, because Louisiana would bear *all* of the risk if health care costs under the plan prove higher than HHS has estimated. HHS is requiring that the final plan be budget neutral to the federal government. If the costs of providing coverage to childless adults turn out to be greater than HHS estimated or if health care costs for Medicaid beneficiaries rise more quickly than anticipated, the state would have to fill the gap entirely with state funds (or cut eligibility, benefits, or provider payments to lower costs).[22]

> **The model that HHS provided to Louisiana also suggests that coverage under Affordable Choices could be both inadequate and unaffordable for many low-income people.**

The model that HHS provided to Louisiana also suggests that coverage under Affordable Choices could be both inadequate and unaffordable for many low-income people.

Under the HHS plan for Louisiana, individuals aged 19 to 64 who have income below 200 percent of the poverty line ($34,340 for a family of three) could choose from four plans, with varying premiums and cost-sharing. The premiums are not specified, but each plan has high cost-sharing, a $500,000 cap on lifetime benefits, and a $100,000 cap on annual benefits. Before receiving any coverage, participants would have to satisfy annual deductibles ranging from $1,000 to $5,000. After satisfying the deductible, participants would still have significant costs, as all of the plans would pay only 75 percent of the cost for most health care services. Moreover, some services would not be covered at all, such as treatment of mental health problems or substance abuse, dental care, or eye exams.

The combination of premiums, a high deductible, steep cost-sharing on the services that are covered, and the exclusion of important services means many low-income people would likely continue to go without a number of necessary health care services if offered this type of plan. A large body of research shows that even relatively low premiums result in a sharp decrease in participation in health coverage by low-income individuals. In addition, cost-sharing has been shown to cause low-income people to delay or reduce their use of health care services and to result in poorer health outcomes among low-income individuals who are not in good health.[23]

In a March 2007 memo to the Collaborative, Dr. Frederick Cerise, Secretary of the Louisiana Department of Health and Hospitals, explained why the state was unable to accept the HHS proposal. He stated:

> [A]bsent an infusion of new state funds to replace federal dollars, these practices [the LSU hospitals and clinics and other community hospitals] would have no ability to serve as a safety net for the remaining uninsured. Using the most conservative estimates, the number remaining without insurance would be more than 300,000 individuals.

> The model that is on the table is in simplest terms, a trade. It involves redirecting the funds that support access points of care across the state for the uninsured population for an insurance product for less than 50% of those uninsured. Those newly insured will have fewer choices for appropriate services resulting in more deferred care and greater emergency room utilization.[24]

CONCLUSION

The outcome of the debate over health coverage and changing Louisiana's Medicaid program is still not resolved, and it will likely continue over the coming months. The Administration's Affordable Choices initiative is clearly not the answer. It would leave many state residents uninsured and at the same time hospitals and other health care providers would be deprived of support they need to provide care to uninsured patients. Moreover, the coverage that state residents would have received under the HHS proposal would be unaffordable and inadequate.

ENDNOTES

1   HCR 127, the concurrent resolution establishing the Collaborative included provisions describing the individuals and organizations that should be represented on the Collaborative.

2   John Pope, "Brand-new health care system urged," *The Times Picayune,* August 24, 2006.

3   The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services, 2006.

4   Center on Budget and Policy Priorities analysis of the Annual Social and Economic Supplements from the Census Bureau's 2004 through 2006 Current Population Surveys.

5   The Collaborative also worked on a proposal for a Medicare waiver that would allow integration of services for certain beneficiaries who receive both Medicare and Medicaid.

6   Funding caps under Medicaid waivers are usually computed on a per capita basis. Thus if enrollment goes above projections, the state would still get additional funds for new enrollees. However, if increases in health care costs are greater than expected, the state would not get additional federal funds to compensate. See, Andy Schneider, *The Medicaid Resource Book,* Kaiser Commission on Medicaid and the Uninsured, July 2002. (Chapter III)

7   Working parents are covered only if family income is below 20 percent of the poverty line ($3,320 for a family of three). For nonworking parents, the income limit is even lower at 13 percent of the poverty line ($2,158 per year). Donna Cohen Ross and Laura Cox, "In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families," Kaiser Commission on Medicaid and the Uninsured, October 2005.

8   Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements).

9   Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Centers for Medicare and Medicaid Services-64 reports, October 2006.

10   Robin Rudowitz, Diane Rowland, and Adele Shartzer, "Health Care in New Orleans Before and After Hurricane Katrina," *Health Affairs* Web Exclusive, August 2006.

11   Jan Moller, "State plan for health care faces hurdles," *The Times Picayune,* September 29, 2006.

12   Jan Moller, "Deal to revamp health care in N.O. stalls," *The Times Picayune,* October 3, 2006.

13   The Medical Society's proposal was called Health Access Louisiana, and is available at http://www.lsms.org/HAL.htm.

14   The short and long concept paper are at http://www.dhh.louisiana.gov/offices/publications.asp?ID=288&Detail=1417.

15   Robert E. Moffit, "The Rationale for a Statewide Health Insurance Exchange," The Heritage Foundation, October 5, 2006.

16   Karen Pollitz and Richard Sorian, "Ensuring Health Security: Is the Individual Market Ready for Prime Time?" *Health Affairs* Web Exclusive October 2002.

17   The concept paper also includes a proposal for a Medicare demonstration project that would improve care for beneficiaries with a diagnosis that usually leads to death within 18 to 24 months as well as changes in federal reimbursement for graduate medical education that would allow the state to receive reimbursement for training in hospitals outside of the Charity Hospital system.

18   For more information on Affordable Choices, see J. Solomon, "President's 'Affordable Choices' Initiative Provides Little Support for State Efforts to Expand Health Coverage," Center on Budget and Policy Priorities, April 3, 2007.

19   The most recent estimate of uninsured residents in Louisiana is 657,000. This estimate, based on a study by Louisiana State University's Public Policy Research Lab, has been accepted by state and federal officials. Associated Press, "Study says La. Has more than 657,000 uninsured residents, *The Times Picayune,* April 25, 2007.

20   *Ibid.*

21   Lisa Dubay, John Holahan, and Allison Cook, "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs*, web exclusive, November 30, 2006.

22   In a Section 1115 waiver, a state agrees to a cap on the federal funds it will receive during the five-year waiver period. The cap is an estimate of the amount the state would have received from the federal government in the absence of the waiver. In Louisiana, the cap proposed by HHS was based on its estimate of the amount that the state would spend on beneficiaries eligible for Medicaid under regular rules, plus most of the state's DSH allotment. The state would have to cover childless adults within this overall budget cap.

23   "Health Coverage for Low-Income Americans: An Evidence-Based Approach to Public Policy," Kaiser Commission on Medicaid and the Uninsured, November 2006.

24   Letter from Secretary Cerise to Louisiana Health Care Collaborative, March 2007.

APPENDIX A

Katrina Resources Relating To Health Care Access, Health Disparities and Environmental Justice

Environmental Justice Analyses

Bullard, Robert D. "Let Them Eat Dirt: Will the 'Mother of All Toxic Cleanups' Be Fair to All NOLA Neighborhoods, Even When Some Contamination Predates Katrina?" April 14, 2006. URL: <http://www.ejrc.cau.edu/Let_Them_Eat_Dirt.pdf>.

> Highlights environmental justice issues entrenched in New Orleans including toxic exposures before and after hurricane Katrina, discrepancies between government versus independent efforts, and high risk groups.

Pastor, Manuel, Robert D. Bullard, James K. Boyce, Alice Fothergill, Rachel Morell-Frosch, and Beverly Wright. "In the Wake of the Storm: Environment, Disaster, and Race After Katrina." A Report from the Russell Sage Foundation. 2006 Published by The Russell Sage Foundation, New York, NY.

> Discusses inequalities predating hurricane Katrina that predispose certain populations in New Orleans—the poor, disabled and minorities- to the worst impacts of the hurricane, closest proximity to environmental hazards in general, and the slowest recovery. It also describes an environmental justice framework and how its application to recovery and reconstruction efforts can impede the continuation of environmental inequalities.

The Brookings Institution, Special Analysis by the Metropolitan Policy Program. October 2005. "New Orleans after the Storm: Lessons from the Past, a Plan for the Future." URL: <http://www.brookings.edu/metro/pubs/20051012_NewOrleans.pdf>.

> Shows how the region's past development trends including racial and economic segregation, exacerbated the catastrophe, and suggests how the region might rise again on a better footing by transcending the mistakes of the past.

Health Aftermath

Brant, Mary, et al. "Mold Prevention Strategies and Possible Health Effects in the Aftermath of Hurricanes and Major Floods." *MMWR* produced by the Centers for Disease Control and Prevention June 9, 2006 55(RR08);1-27.

> Provides detailed information from the CDC about flood associated mold formation, health consequences (mainly exacerbation of asthma and allergies), and guidelines for clean up and prevention of health consequences.

Centers for Disease Control and Prevention: Recovery from Katrina & Other 2005 Hurricanes. Website: http://www.bt.cdc.gov/disasters/hurricanes/katrina_2005.asp

> This page contacts information on CDC response to hurricane Katrina, health information for workers and evacuees, and information from CDC, EPA and NIH on testing environmental exposures including air, water, mold and sediment.

Centers for Disease Control and Prevention. "Surveillance for Illness and Injury After Hurricane Katrina – New Orleans, Louisiana, September 8-25, 2005. *MMWR Weekly* Vol. 54, No. 40 Oct. (2005):1018-1021.

> Data is available on some medical conditions within a month post the hurricane, on people who visited 8 health care centers located in four parishes on New Orleans (Jefferson, Orleans, Plaquemines and St. Bernard). Health outcomes include respiratory infections, skin ailments, injuries and other conditions among evacuees.

Centers for Disease Control and Prevention. "Update on CDC's Response to Hurricane Katrina." From the CDC Director's Emergency Operations Center - P.M. Update, September 14, 2005.

> Summarizes CDC efforts as of a month post hurricane Katrina, which include: 216 workers deployed to the area, epidemiologic surveillance, and infectious disease control in evacuation centers (screening and treatment). Also provides update as of a September 2005 on mortality from injury and infectious diseases including: skin infections, West Nile virus, rash, diarrheal illness, trench foot and cholera.

Kesseler et al., Ronald C. "Mental Illness and suicidicity after hurricane Katrina." Bulletin of the World Health Organization: Type: Research Article ID: 06-033019; Article DOI: 10.2471/BLT.06.033019.

> A national survey conducted by the World Health Organization found a significantly higher prevalence of mental illness after hurricane Katrina compared to before the event. Other findings included a surprisingly lower prevalence of suicidal feelings, and that non-Hispanic whites had the highest prevalence of mental illness in the survey sample.

Solomon, Gina M., MD, MPH and Miriam Rotkin-Ellman. "Contamination in New Orleans Sediment: An Analysis of EPA Data." Natural Resource Defense Council February 2006. URL: <http://www.nrdc.org/health/effects/katrinadata/sedimentepa.pdf>.

> This report produced by the Natural Resource Defense Council after examination of sediment samples post Katrina, revealed dangerously high levels of contaminants in soil and sediment. In particular 4 compounds: arsenic, diesel fuel, benzo(a)pyrene and lead, upon physical with skin or inhalation are known to cause a number of health problems.

> The concern is that areas hardest hit by the hurricane have the highest concentrations of toxicants and house the most vulnerable populations of people—the disabled, poor and minorities. These populations are least able to recover from detrimental health outcomes associated with the hurricane.

World Health Organization
Website: http://www.who.int/en/

> Search "Hurricane Katrina" to get information on health impact of hurricane Katrina and the collaboration between WHO and the US. Their publication on mental illness is listed in the articles section below.

Health Care Access & Health Disparities

Franklin, Evangeline (Vancy). "A New Kind of Medical Disaster in the United States," (pp. 185-195) *There is No Such Thing as a Natural Disaster.* Chester Hartman and Gregory D. Squires, eds.

> Examines from a first hand perspective the state of health and health disparities prior to the hurricane, damages to health infrastructure, how the hurricane exposed weaknesses in the health care system, and the potential for recovery.

Labarthe, Darwin R., MD, MPH, PhD. "Heightened Risks of Major Chronic Disease Complications in the Hurricane Aftermath." Centers for Disease Control and Prevention October 31, 2005. URL: <http://www.cdc.gov/pcd/disasters/2005/labarthe_factsheet.htm>.

> Discusses the consequence of lack of health care access for people with chronic illness. Just a little over a month post hurricane Katrina, people lacking access to daily medications used for control of chronic conditions including hypertension, asthma and diabetes, are at high risk for developing complications such as stroke, heart attack and diabetic coma. In addition, physical and emotional distress produced by natural disasters can exacerbate chronic conditions.

Lovinger, Sarah Pressman, MD. "Community Health Centers Respond to Hurricane Katrina." *Medscape Medical News* Sept, 16 2005. URL: <http://www.medscape.com/viewarticle/513018>.

> Discusses the important role being played and the challenges faced by community health care centers in different states, particularly in Texas, in providing treatment for Katrina evacuees.

Madrid, Paula A. et al. "Challenges in Meeting Immediate Emotional Needs: Short-term Impact of a Major Disaster on Children's Mental Health: Building Resiliency in the Aftermath of Hurricane Katrina." *Pediatrics* Vol. 117, No. 5, May(2006): 448-453.

> The National Center for Disaster Preparedness (NCDP) and the Children's Health Fund have launched mental health program called Operation Assist in Louisiana and Mississippi. In establishing the program, they have set up mobile medical units in the hard-hit areas where immediate mental health needs are met as well as public health assessment for long term program development. This article provides information on the psychological impact of a traumatic event like hurricane Katrina on children including development of a number of mental disorders (e.g. depression and anxiety) as a result of separation, relocation, and uncertainty about the future. It also provides recommendations to improve child resiliency.

Tracy, Lisa, M.A. *Muddy Waters: The Legacy of Katrina and Rita Health Care Providers Remember – And Look Ahead.* 2006 Published by the American Public Health Association, Washington, DC.

> *Muddy Waters* author Lisa Tracy conducted personal interviews one year after the storm and reviewed diary and journal entries to recreate the extraordinary contributions of health care workers—including doctors, nurses and health department employees in coping with disaster-related tragedies. The commemorative edition is dedicated to health care providers who served during the hurricanes.

Zuckerman, Stephan and Teresa Coughlin. "Initial Health Policy Responses to Hurricane Katrina and Possible Next Steps." Produced February 2006 by The Urban Institute: http://www.urban.org. Article is available at: http://www.urban.org/UploadedPDF/900929_health_policy.pdf.

> Discusses health care status prior to the hurricane and issues with reconstruction of the health care system after including the role of Medicaid.

General Web Resources

ACORN Proposal for Hurricane Katrina Recovery and Rebuilding:
Website: www.acorn.org/rebuilding

Center on Budget & Policy Priorities
Website: www.cbpp.org/11-2-05hous.htm

> Provides information on costs associated with government assistance of populations affected by the hurricane, and concern for the most vulnerable populations- the poor, disabled and elderly- in rebuilding efforts. Featured article: "BRINGING KATRINA'S POOREST VICTIMS HOME: Targeted Federal Assistance Will Be Needed to Give Neediest Evacuees Option to Return to Their Hometowns". Related reports at: http://www.cbpp.org/pubs/katrina.htm.

Katrina Information Network
Website: www.katrinaaction.org

Lawyers Committee for Civil Rights Under Law
Website: www.lawyerscommittee.org

> For information on the class action lawsuit against FEMA.

PolicyLink
Website: www.policylink.org

> This site discusses the economic and social equity issues surrounding hurricane Katrina. Some of the featured articles on their websites include: "Equitable Renewal: Ten Points to Guide Rebuilding in the Gulf Coast Region"; "Policy Matters: Regional Equity in the Gulf Coast".

National Council of Churches USA (NCC) Special Commission on the Just Rebuilding of the Gulf Coast.
Website: www.nccusa.org

> On January 21, 2007 the Special Commission released a report card which reviewed response and rebuilding efforts in the city of New Orleans, the states of Louisiana, Mississippi, and the federal government in areas such as transportation, healthcare, housing, schools, insurance, and environmental justice. "Report Card: The Triumphs and Struggles in the Just Rebuilding of the Gulf Coast" is available on their website.

The Brookings Institute's Metropolitan Policy Program
Web: http://www.brookings.edu/metro/katrina.htm

> This website contains updates on current events in New Orleans including rebuilding efforts; issues and ideas involved in rebuilding including policy; and addresses environmental justice issues pertaining to New Orleans such as the history and impact of concentrated poverty in this region.

The Library of Congress Thomas
Website: www.congress.gov

> Search via Bill Text or Bill Number for the "Hurricane Katrina Recovery, Reclamation, Restoration, Reconstruction and Reunion Act of 2005" (H.R. 4197) or other Acts pertaining to Katrina.

APPENDIX B

New Orleans Area Health Disparities Initiative
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APPENDIX C

Conference Agenda:
New Orleans Area Health Disparities Initiative

June 12, 2006
8:00am -5:30 pm
Hilton New Orleans Riverside
2 Poydras Streets
New Orleans, Louisiana

8:00am -8:30am
Continental Breakfast

8:30am -9:00am
Welcome and Purpose of Meeting

Welcome and Introductions
▶   Deeohn Ferris, J.D., Sustainable Community Development Group, Inc.

Welcoming Remarks
▶   Gail Christopher, DN, Joint Center for Political and Economic Studies

▶   Phil Tegeler, J.D., Poverty and Race Research Action Council

▶   Robert Zdenek, DPA, Alliance for Healthy Homes

A Review of the Day's Activities

▶   Deeohn Ferris, J.D.

9:00am -10:00am
Panel: Promoting Health Justice: Opportunities in Healthy Rebuilding of the New Orleans Area

Perspectives on the History and Culture of the New Orleans Area
▶   Keith Weldon Medley, Author, "We as Freemen: Plessy v Ferguson"

Deadly Waiting Game: Addressing Environmental Health Disparities in Communities of Color
▶   Robert Bullard, PhD., Environmental Justice Resource Center

Investments in Human Capital and Healthy Rebuilding in the New Orleans Area

▶ Shelia Webb, PhD., Center for Empowered Decision-Making

10:00am -10:45am
Health Disparities In Context: What Are The Conditions That Led To The Creation Of Health Disparities In Greater New Orleans And Opportunities For Change?

Plenary Discussion   Moderator: Deeohn Ferris, J.D.

10:45am -11:00am
Break

11:00 am -11:30am
Presentations:

Action/Strategy Agenda for Rebuilding Healthy Communities: What Are The Immediate Priorities That Need To Be Met And Opportunities To Ensure Healthy Rebuilding For All New Orleans Communities?

Healthy Rebuilding: Strategies To Meet Community Needs

▶ Video: "A Tale of Two Cities" EXCELth, Inc.

  Long Term Needs Identified Through Community-Based Participatory Research - Rapid Evaluation and Action for Community Health in Louisiana: A Model for Assessing and Implementing Community Priorities

▶ Ben Springgate, M.D., MPH, Robert Wood Johnson Scholars Program

11:30am -Noon
Table Discussion: What Strategies Do We Need to Achieve Our Long-Term Goals? How to Reconcile Meeting Immediate Needs and Opportunities With Long-Term Planning?

▶ Important partnerships

▶ Local group needs and national group' roles

▶ Priorities for the next (three/six/nine) months

Noon -12:30pm
Tables Report-Back/Plenary Discussion

▶ Moderator: Deeohn Ferris, J.D.

12:30pm -1:30pm
Luncheon

Invocation
▶ Luncheon Speaker - Gloria Wilder Braithwaite, M.D., MPH

1:40pm -2:15pm
Panel: Analysis of a Post-Hurricane New Orleans Area Case Study: Health Disparities, Health Care and Access -Planning, Challenges And Opportunities In The Rebuilding Process

Panelists:

▶ Michael Andry, EXCELth, Inc. —Moderator

▶ AIMarie Ford, LCSW, LA Department of Health and Hospitals, Office of Mental Health

▶ Charlotte Hutton, M.D., LA Department of Health and Hospitals, New Orleans Adolescent Hospital

▶ Monir Shalaby, M.D., Medical Director, EXCELth, Inc.

▶ Ranie Thompson, J.D., New Orleans Legal Aid Society

▶ Beverly Wright, PhD., Deep South Center for Environmental Justice

2:15pm -3:30pm
Small Groups — Discussion of Case Study:

What Does The Case Study Suggest Are The Primary Issues For Rebuilding A Healthy New Orleans For All Communities? What Strategic Opportunities Exist That We Should Be Taking Advantage Of To Address These Issues And Short-And Long-Term Goals?

1) identifying a few (small number) priority issues to work on next;

2) some (also small number) demands that go with these Issues (or at least some principles to guide the work); and

3) some sort of (very basic) structure through which the work can be carried out collaboratively; and

4) identifying what external and internal (to New Orleans) resources are available to support #3.

3:30pm -3:45pm — Break
3:45pm -5:30pm
Small Groups Report Back/Plenary Discussion: Next Steps

Moderator: Deeohn Ferris, J.D.

▶ What are the commitments outside groups can make to this effort?

▶ What kind of structure can we create to continue this effort?

▶ Are there any issues we can identify as primary issues to work on?

▶ How do we develop a list of Demands around the primary issues identified

5:30pm – Adjourn

Additional Priority Issues/Needs:

▶ Health and health care delivery infrastructure

▶ Communications, social networks and institutions

▶ Community organizing, engagement

▶ Mobility, transportation

▶ Children's health and vulnerable populations (e.g., elderly, chronically ill, disabled)

▶ Worker safety and health

▶ Immigrant populations

▶ Legal, advocacy implications

▶ Schools issues

▶ Intersection of Employment/Jobs, Education, Community Development

Small Group Facilitators:

▶ Joann Hale, Church World Service

▶ AI Huang, J.D., Natural Resources Defense Council

▶ Judith May, Reach 2010: At the Heart of New Orleans

▶ Lynne Wolf, J.D., Center for Social Inclusion

▶ Bob Zdenek, DPA, Alliance for Healthy Homes