

The Katrina and Rita Disasters' Impacts on
Population Health and the Health Sector in Louisiana:
Lessons for Disaster Recovery Policy Planning and Coordination

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I. Introduction and Overview

Hurricanes Katrina and Rita displaced more than 1.5 million people, took more than 1800 lives, destroyed more than 200,000 homes and businesses, and left a scar of devastation on Louisiana and the Gulf Coast— both physical and psychological - that is likely to persist for decades. This paper – presented by New Orleans’-based researchers - seeks to outline the major adverse impacts of Katrina and Rita both on the health of the regional population and on the health sector in Louisiana. We will summarize existing data (including our own data) pertaining to the immediate and ongoing population health impacts, as well as important aspects of health sector recovery and rebuilding. The data will reveal the disasters’ impact on access to health care; significant mental health consequences; diminished health workforce availability; and healthcare sector recovery prospects. From our own group’s community-based participatory research work, including key stakeholder interviews and discussion groups with diverse community members – policymakers, healthcare administrators and providers, patients and advocates – we will select and incorporate illustrative quotes and key findings, with emphasis on coordination of policy responses for the disaster recovery among relevant local, state, and federal agencies. We provide these perspectives with the intimate knowledge afforded to us as New Orleans community members, and with direct interest in the application of sound reason and science to the federal, state, and local policy processes intended to guide regional recovery from the 2005 disasters.

II. Impacts of the Disasters on Population Health and the Health Sector:

Access to Care, Mental Health, Workforce Challenges, and Health Sector Recovery

More than two years after Hurricane Katrina, problems persist with accessing health care in New Orleans. Flooding from the levee breaches destroyed the primary system of care for low-income people in New Orleans. Over 40 percent of the New Orleans population prior to the hurricane was either uninsured or enrolled in Medicaid and relied on the Medical Center of Louisiana, New Orleans system (MCLNO - Charity and University Hospitals), which was significantly downsized since flooding.ⁱ Nearly three-quarters of MCLNO patients were African American, and 85 percent of its patients had income below \$20,000.ⁱⁱ A large number of people in affected areas also lost their jobs and health insurance, at least temporarily.^{iii iv v vi} Clinics and public health centers were shut down by the disaster as well.^{viii} Hospital capacity was reduced by 80% initially and about 75% of the safety-net clinics closed in New Orleans.^{ix} An estimated 4,400 physicians were displaced initially and a large proportion of the health care workforce was laid off.^x Hospitals and clinics that survived have struggled to deal with the adverse impact of population displacement, substantial burdens of uncompensated care, and persistent workforce shortages. Two years later, hospitals have continued to operate at maximal capacity while experiencing ongoing financial losses, and the remaining community-based providers are significantly strained.^{xi xii xiii xiv xv xvi xvii}

Evidence from the Harvard Department of Health Policy's Hurricane Katrina Community Advisory Group (HKCAG), a study of a nationally representative sample of persons who lived in

the Katrina and Rita-impacted areas at the times of the disasters, reveals that more than 1 in 5 persons with chronic conditions had cut back on care for those conditions within six months of the hurricanes.^{xviii} Difficulty getting care was correlated with being of ages 18-64; lack of insurance; unstable housing after the disaster; and social isolation. Frequent reasons for disrupted care included problems accessing physicians (41.1%), medications (32.5%), insurance/financial means (29.3%), transportation (23.2%), or competing demands on time (10.9%).

In separate published analyses, the HKCAG study also reveals significantly elevated symptomatology for depression and post-traumatic stress disorder among Katrina and Rita survivors, with more than 1 in 3 adults from the affected areas showing symptoms of these disabling illnesses.^{xix,xx} This is more than double the national prevalence, and is significantly higher than demonstrated among survivors of prior disasters. The time course for resolution of the symptoms and personal recovery has also been prolonged compared to other traumatic disasters.^{xxi} This suggests that the extent and persistence of the physical devastation in the communities, and ongoing population displacement, may have contributed to more severe and relentless psychological consequences. From the same study, more recently published analyses demonstrate as well that appropriate care for mental illness has been especially difficult to access, with very few persons receiving evidence-based and appropriate care^{xxii}. Notably, depression ranks highly among the leading causes of disability worldwide, and can be treated. Evidence from randomized, controlled trials suggests that treatment for depression has long term and direct economic benefits for the treated individual, as well as for employers.^{xxiii,xxiv}

Participants in our own key stakeholder interviews from summer of 2006 described these access and mental health challenges with striking clarity. Access to care for mental health services was poor overall, according to one state-level planner in health care recovery, “For behavioral health...it doesn’t really matter whether you have insurance or not. The services are so scarce that it is difficult to receive care...Even with insurance you’re looking at a one- to two-month wait for an initial appointment with a psychiatrist.”

One health care administrator bluntly assessed the mental health care situation in the New Orleans area as follows: “There are no psychiatrists in town. Mental health is just a wasteland, an abysmal wasteland.... How [can we] care for folks that are dealing with ...the biggest crisis they’ll ever face in their lives?”

These concerns were echoed by a primary care provider and administrator in this description of the community’s experience of stress: “Probably 90 per cent of the patients that I see now include stress as part of their history taking. ‘I’m under a lot of stress at home,’ or ‘I’m under a lot of stress with the insurance companies,’ ...Stress is mentioned...at least 90 percent of the time during a medical office visit – and I’m not a psychiatrist!”

Closures of healthcare facilities and workforce displacements have posed challenge for the region’s economic and health sector recovery as well. Health care represents one of the region’s three leading industries, along with tourism and the shipping trade through the ports of New Orleans and Louisiana. A majority of New Orleans hospitals were closed by the disaster,

several potentially for years to come, with earliest foreseeable prospects of reopening new Veterans Administration or Charity Hospital facilities, for instance, likely to occur more than 10 years after the Katrina floods. Many small businesses such as clinics, nursing homes, laboratories and supply companies were shuttered by the disasters as well. Large institutions such as Louisiana State and Tulane universities initially laid off thousands of health care employees, many of whom ultimately relocated to other parts of the country.

The impact of these closures on access to health care has been profound for those who formerly accessed services at now-closed or scaled down facilities as well as low income community members with fewer care options.^{xxv} Hospitals have seen limited financial relief in the form of federal block grant support, and regulatory changes to support hospital reimbursement. Primary care physicians and nurse practitioners have been offered state and federal incentives designed to encourage health professional retention and recruitment into the region. Primary care clinics recently received the first allotments of a regional \$100 million grant from the Department of Health and Human Services for stabilization of primary care safety net services. Unfortunately, most of these federal and state initiatives were slow to emerge, beginning up to 2 years after the disaster, after layoffs and ongoing hardship in the health sector had led to additional workforce attrition and emigration to other areas of the country, and while the people of this region continued to suffer through the absence of affordable or accessible health care. In addition, persistent wrangling among federal and state stakeholders regarding coverage for uninsured and the future of the Charity Hospital system has done little to address concretely the community's ongoing need for hospital-based or specialty diagnostic or therapeutic services.

The strong sense of uncertainty for the health sector following the disaster and the closure of Charity Hospital (as the leading source of care for the region's poor and uninsured), as well as implications for providers and the community, are suggested in this quote by a community health care provider whom we interviewed approximately one year after the disaster:

“People that had very limited access to health care pre-Katrina, they have come back [to New Orleans]. And mainly Charity [Hospital] was their access to care. And, you know, I’ve heard positive things and I’ve heard negative things about that system. But...we’re seeing nurses and teachers that were employed, and happy, the day before Katrina, and now... months later...they have no income ...and no health care. And they’re trying to put their lives together. Their families are displaced. And their homes are destroyed. And you know? It’s just too much ... I don’t know how people get through it all.”

Workforce shortages that succeeded the displacements have been significant, with particular challenges in recruiting specialty physicians, clinician researchers and educators for medical schools, mental health professionals, dentists, nurses, and non-professional staff such as medical office assistants and nursing assistants. Major barriers to recruitment into the region include persistent low-cost rental housing shortages; inflated residential real estate prices; limited availability of necessary infrastructure including schools and grocery stores in some areas; concerns about the adequacy of regional flood control and levee systems; and negative national perceptions of the state of the regional recovery. While the recent infusion of federal grant

support through the Primary Care Access and Stabilization Grant and Health Professional Shortage Area designation provide assistance to bolster recruitment efforts into the region, at least for the short term, this infusion will also support hiring at higher pay grades within the region. Anecdotal evidence suggests that this has encouraged aggressive competition for existing personnel in the region, encouraged professional workforce mobility across employers rather than an influx from the outside, and likely resulted in additional short-term hiring and re-training expenses.

In our interviews with health sector stakeholders, healthcare workforce re-entry was described as very difficult, complicated by the aforementioned closures of facilities, limitations of regional infrastructure, and housing shortages. As one hospital industry-based participant summarized the problem, “*New Orleans is [difficult] to recruit people into right now. I mean...there’s no place to live.*” Recruitment challenges were described as complicated by the threat of ongoing attrition. According to one health sector executive, “*We don’t have a lot of new workforce coming in, and we’re afraid that the workforce that’s here is going to start getting tired.*” The impact of policy steps to mitigate these challenges remains to be seen.

III. Federal-State-Local Coordination of Recovery Policies: Opportunities and Challenges

Andrew Brimmer^{xxvi} eloquently described the missed opportunities of the current Bush Administration and federal agencies to act decisively and to exert substantial leadership during immediate relief and ongoing recovery efforts along the Gulf Coast after the 2005 hurricanes. Mr. Brimmer's review of the shortcomings of the federal responses and reminder of the promise of ongoing commitment and leadership made by the President in Jackson Square in September, 2005 points to the need for renewed vitality, leadership and attention by the Administration to Louisiana and the Gulf Coast's regional recovery and rebuilding.

To address the ongoing shortcomings of disaster recovery policy planning, coordination and implementation, Dr. Brimmer proposes creation of an empowered federal agency – the National Commission for Reconstruction of the Gulf Coast Region (NCR-GCR) - with Cabinet equivalent authority to lead and to coordinate the federal response to the Katrina and Rita disasters in partnership with the affected states. He justly proposes that strengthened and centralized coordination among and across federal agencies and states would enhance their joint recovery agendas and the likelihood of substantial improvement of quality of life for the people of the region.

From our own experiences in post-Katrina New Orleans, the most common concern expressed by community members regarding the substance and pace of disaster recovery

following the failures of the federal flood protection system, has been the void of effective leadership at all levels of government, to jump-start and coordinate the complex and long term recovery from this unprecedented national catastrophe. Dr. Brimmer's proposal to legislate creation of State-level counterpart agencies to partner with the NCR-GCR in federal-state activities, and his sketch of the organization and development of these agencies, represents a reasonable model that would work to ensure that states are sufficiently engaged in the policy planning and implementation. We would encourage, however, in the organization of both these state and federal commissions, specific attention to ensure broad and empowered local representation in the constitution and leadership of the proposed federal and state coordinating structures.

Federal and state coordination of policy responses must involve local stakeholders in central and substantive roles. In the health sector, as described by Professor Jeanne Lambrew and former Secretary of Health and Human Services Donna Shalala in the Journal of the American Medical Association^{xxvii}, ample opportunity existed 2 years ago for enhanced federal and state coordination of specifically federal-state policy responses, such as Medicaid waivers to allow access to healthcare in the states to which affected low-income or uninsured community members were displaced in great numbers. This opportunity was largely squandered, due to insufficient federal leadership. By contrast, there has been the late promise of success in recent funding for reinvigoration of primary care safety net system in New Orleans through the aforementioned Department of Health and Human Services' \$100 million Primary Care Access and Stabilization Grant (PCASG). This grant in large part has been planned and administered by local leadership from the Louisiana Public Health Institute in partnership with DHHS and dozens

of locally run safety net clinics. While the state and federal officials have battled for 2 years since the hurricane to a stalemate of non-cooperation over the resurrection of the Charity Hospital System, local leadership among affected stakeholders worked to develop a vision to make an immediate impact on the health sector and access to quality health care. In partnership with DHHS, these local leaders and stakeholders are implementing a promising recovery program (PCASG) that will leave a legacy of enhancing access to care after the disaster, stabilizing much needed safety net clinics for uninsured, and sustained improvement of regional health care organization and quality of care.

Our experience has indicated consistently that the recovery from the 2005 hurricanes, including in the health sector, while driven in part by federal and philanthropic funds, has been fueled in equal part by brilliant examples of local civic organization, local policy advocacy, grass roots activism, volunteerism, non-profit and small businesses innovation, and by organized local and migrant workers striving to make a tangible difference here and now. These local citizen leaders, faced daily with the exigencies of the post-disaster life and persistent consequences of policy remediable conditions, have unique insights as to how disaster recovery policies play out on the ground in real time. In the absence of meaningful direction from the ranks of state and federal officialdom to date, non-elected local leaders have demonstrated time and time again that ingenuity and effort to fuel recovery on the ground has succeeded in effecting improvements in quality of life for the population, as often in spite of federal and state policy efforts as because of them.

If strengthened federal and state coordination such as rightly proposed by Dr. Brimmer is to occur with tangible impact for the ongoing recovery from the Katrina and Rita disasters (and not simply represent a footnote of what may have been achieved if things had played out differently) -and if this coordination is to mitigate some of the ongoing duress during a recovery expected to take ten to twenty years - we would propose lastly that the necessary federal-state-local coordination and supplemental planning begin now. Many prognosticators appear to rest hopes on what the next president's leadership can bring to the region's prospects or recovery. We propose that the hardworking people of this region no longer have the luxury of waiting for the federal, state, and local governments to wait for Godot. There is a great opportunity now for the proposed coordinating agencies to engage the activated and keenly interested community stakeholders in a collaborative recovery agenda, and to build on the victories achieved at the federal, state and local levels, now.

As after all disasters and perhaps as during all attempts at multi-stakeholder coordination, negotiations among community stakeholders, state officials and federal officials at times will be difficult. Commitments by involved stakeholders to patience and persistence, to full participation, and to transparency, will support their mutual goals of productivity in this challenging environment. Given the sense of abandonment and mistrust that has emerged since the disaster among local stakeholders after many dealings with federal (e.g. FEMA) and state (e.g. Governor Blanco's Road Home program) agencies, community stakeholders now rightfully expect timely, frank and open dialogue with their government officials. This dialogue must reflect mutual commitments to accountability and transparency, and include communications strategies that acknowledge both the risks and benefits of proposed policies in plain terms that

average community members can understand. With full participation and honest engagement of local, state and federal stakeholders in coordination of disaster recovery policy planning and responses, we anticipate greater gains for the immediate recovery, as well as the promise of sustainability of Dr. Brimmer's proposed model, to the benefit of domestic well-being and health security for years to come.

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