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National Association of Community Health Centers  
Division of Federal, State and Public Affairs  
1400 I Street, NW, Suite 330  
Washington, DC 20005  
(202) 296-3800

For more information, please email [research@nachc.com](mailto:research@nachc.com).

Report cover and back designed by Ken Kirkland, NACHC.

## Executive Summary

In the aftermath of Hurricane Katrina, Community Health Centers answered the complex and immediate health care needs of communities torn apart by a multi-state disaster. They dispensed medications to those who fled their homes without them, gave counseling to the distraught, and addressed chronic health needs that unchecked would have led to even greater sickness and potential death. It was a defining moment: health centers provided evacuees with the primary care available nowhere else.

The lessons of the Gulf Coast make clear that health centers, and the preventive care in which they specialize, are critical to disaster response. In addition, the opportunity to rebuild an entire public health infrastructure is raising important questions about the role of health centers – a role that recent experience shows should be both greater and more central.

**After Katrina, the conventional wisdom about our public health system is being rewritten.**

### **Why Community Health Centers?**

Health centers provide health care to low-income and medically underserved Americans, and they never turn anyone away – regardless of insurance status or ability to pay. They are local, non-profit, community-owned, and have long been recognized as an effective and cost-saving means of providing health care to underserved populations. The National Association of Community Health Centers (NACHC) represents a significant part of the nation's health safety net: over 1,000 health centers, serving 15 million people at 5,000 sites located throughout all 50 states and U.S. territories.

### **Changing Our Thinking About Disaster Response**

As most of the public health system collapsed in the days after Katrina hit, health centers were uniquely positioned to meet the medical needs of their communities. They were used to provide care in difficult circumstances to precisely those most vulnerable to a natural disaster: the elderly, disabled, chronically ill, and those who lacked the resources or transportation to leave.

**The experience of Katrina makes clear that caring for chronic diseases is, perhaps surprisingly, the single greatest need following a disaster on this scale.** In fact, the Centers for Disease Control and Prevention reported that one out of every three health concerns addressed in evacuation centers in Arkansas, Louisiana, Mississippi, and Texas were related to chronic diseases – more than any other single health care need. Access to primary care is critical for those who have been forced from their homes, and no other part of the public health system provides this care as effectively as health centers.

In the days that followed Katrina's landfall in the Gulf region, health centers stepped up to provide care to those displaced by the storm. Health centers:

- Treated more than 19,300 evacuees in Louisiana, 80% of whom had no health insurance.
- Treated 17,870 evacuees in Mississippi, 77% of who were without health insurance.
- Completely lost eleven health center facilities due to Katrina while more than 80 sustained significant damage.
- Incurred more than \$65 million dollars in damages from the storm and subsequent flooding.

## **Rebuilding Health Care in New Orleans**

Health centers were created in part to bridge the health care divide between the haves and have-nots. For that reason, some experts and national leaders now see the health center model as a key fix for the bruised and battered public health infrastructure in New Orleans. An effort now underway, led by Health and Human Services Secretary Michael Leavitt and Louisiana Governor Kathleen Blanco, among others, is overhauling and redesigning public health in the city. Secretary Leavitt has described a vision in which “community health centers dot the landscape, and every citizen has a medical home where the goal is to keep people healthy, not just treat them after they get sick.”<sup>1</sup>

With a long history of delivering high-quality, cost-effective care, health centers are tailored to the devastated regions of Louisiana and Mississippi, empowering communities to create local solutions that improve access to care and the health of the patients they serve.

## **Making it Happen**

Health centers are the beneficiaries of a long-standing, albeit uncommon, consensus between the Bush Administration and bipartisan majorities on Capitol Hill. Now, however, health centers that withstood Katrina are struggling to care for their patients, and are in desperate need of help. To let these key health care deliverers continue providing vital primary care to the most vulnerable populations:

- Congress should fully fund President Bush's request for a \$181 million increase for the Health Centers program. This increase will provide for the creation or expansion of more than 300 health center sites, benefiting medically underserved communities in Louisiana, Mississippi, and across the country.
- Congress should extend Federal Tort Claims Act liability coverage for health center medical professionals who travel across state lines to provide care in disasters or emergencies. Laws limiting FTCA coverage to within state boundaries prevent health centers from sharing resources and responding rapidly.
- Health centers should be active participants in any reinvented health care infrastructure, as well as in disaster preparedness planning. Primary care should be the focus of local-level health care, and because health centers have been major disaster responders they should be involved in planning future disaster response.

## **Moving Forward**

Hurricane Katrina caused suffering for hundreds of thousands of Americans, and even a year later the damage is often incomprehensible. But among the lessons learned from the ordeal of Katrina is the new understanding that health centers played a critical role by doing what they do best: serving populations with the greatest need under the most difficult circumstances. In rebuilding the ravaged Gulf coast and preparing for future disasters, the value of health centers as a centerpiece of the public health infrastructure cannot be overemphasized – and it is encouraging that government officials and decision makers seem to recognize that is the case.

The ability of health centers to respond to the next moment of immediate need, however, depends on the actions taken by Congress and other decision makers today. Without the funds to regroup and rebuild, the most vulnerable Americans will find themselves without access to needed care should disaster strike again.

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<sup>1</sup> HHS Secretary Mike Leavitt, delivered at the New Louisiana Health Care Redesign Signing Ceremony, July 17, 2006.

## Introduction

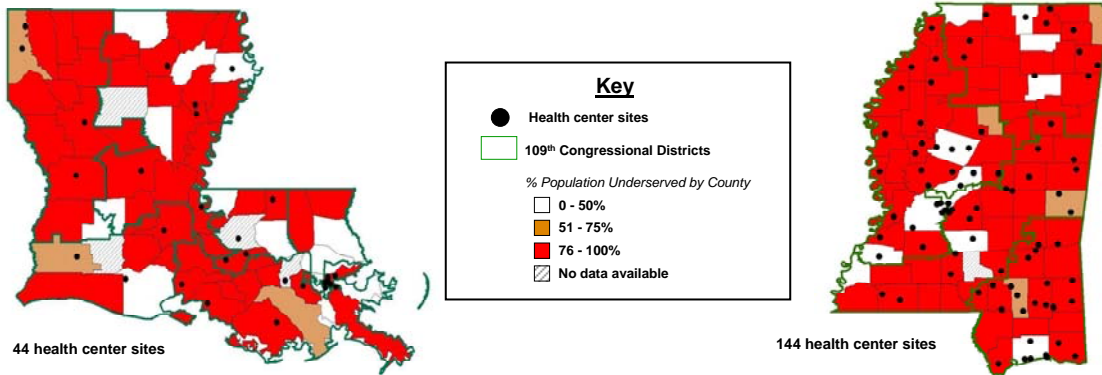
Hurricane Katrina's devastating assault on the Gulf Coast a year ago left the region in shambles. About 1,300 people lost their lives, and as many as two million people were evacuated or displaced, with thousands still dispersed throughout the United States. Approximately 350,000 homes were destroyed, as were thousands of businesses. Aside from the incalculable human suffering, there is the cost of the disaster itself. The Gulf Coast economies, once thriving hubs of tourism and natural resources, are struggling to recover. The economic impact is estimated to reach beyond \$100 billion.<sup>1</sup> Roughly 400,000 jobs were lost, and, as a result, thousands lost their health insurance. The health care infrastructure – covering primary care providers, hospitals, private physicians, and mental health facilities – was significantly damaged and continues to operate at a reduced capacity. Health care disparities affecting low income and racial/ethnic minorities plagued the region even before the hurricane struck.<sup>2</sup> Now, after the storm, health disparities will worsen unless the health care infrastructure is rebuilt to address the remaining health care needs in communities affected by the storm. Escalating health conditions among evacuees and those who remained include asthma and respiratory problems, gastrointestinal illness, skin problems, and especially mental health and substance abuse.

Beyond the dollars it will take to restore normal life to the Gulf Coast region, it is difficult to quantify in empirical terms the enormity of Katrina's catastrophic impact on public health. Few dispute the fact that the region's health care network was and remains one of the biggest casualties of the storm. But precise measurements of the immediate and long term impact are difficult to obtain for the simple fact that records were either lost or destroyed; or, more importantly, those in the position to help during and after the disaster understandably did not stop to collect data. In collecting material for this report, it became evident that the most important and compelling measures were from eye-witness accounts on the ground—not in surveys or patient medical records.

Katrina could not have chosen a more vulnerable health care infrastructure; prior to the storm, one out of three people in Louisiana and Mississippi did not have a regular source of primary care.<sup>3</sup> Post-Katrina, these states have dropped to the bottom of national rankings for health care infrastructure, to 49<sup>th</sup> and 50<sup>th</sup>.<sup>4</sup> There are few encouraging signs of recovery as a host of trends continue to exact a toll on an already stressed public health system. The region is struggling with a worsening shortage of safety net providers because doctors, nurses, social workers and other medical professionals have left the area. Providers willing and able to care for the growing ranks of uninsured and low income families who remained or returned after Katrina are scarce. Up to 6,000 physicians in the counties and parishes affected by Katrina were displaced, and at least 25% of them specialized in primary care. Compounding the work force shortages, is a swelling uninsured and indigent patient population in need of health care.

Community Health Centers, which form the core of the region's safety net, were also hard hit by the storm. The figures below depict where they were located within Louisiana and Mississippi prior to Katrina, and that the majority of counties and parishes have at least 76% of their residents considered medically underserved given high poverty and poor health outcomes.

Figure 1 Louisiana Health Center Sites, 2004 Figure 2 Mississippi Health Center Sites, 2004



Notes: Not all health center locations appear on this map, and some dots may overlap due to scale. This map does not include non-federally funded health centers, and the number of patients above only includes those served by federally-funded health centers. Medically underserved are those individuals who live in areas designated by the federal government as Medically Underserved Areas/Populations (MUA/MUP). These individuals have inadequate access to traditional primary health care services and rely on safety net providers.

Sources: Site information based on Bureau of Primary Health Care, HRSA, HHS 2004 Uniform Data System. Underserved estimates based on NACHC 2000 REACH data which applies 2000-2002 Census population data and HRSA MUA designations. Prepared by the George Washington University, Department of Health Policy.

In 2005, 40 federally-funded Community Health Centers in Louisiana and Mississippi served at least 408,000 patients. The National Association of Community Health Centers (NACHC) own analysis reveals that the number is severely underreported for the simple fact that many health centers impacted by the storm were unable to submit reports on patients. Indeed, Katrina destroyed 11 health center facilities and damaged at least 80 others. Nevertheless, health centers from all regions of the country – including California, New York, and Ohio – reached out to Katrina victims. Some health centers sent doctors to evacuation centers or dispatched mobile medical units to the disaster zone; others donated medicines and supplies, even shelter to displaced evacuees, or made cash donations to a fund set up by NACHC to aid health centers impacted by the storm.

Because the unprecedented devastation of Katrina overwhelmed the federal and state response efforts, those in a position to help were forced by extraordinary circumstances to act in ways beyond the conventions of policy and protocol. Health centers have a long tradition of directing help where it is most needed under the leadership of their patient-majority community boards. Because they are built from the bottom up, not the top down, health centers by design are unfettered by bureaucracies when it comes to targeting public health needs. Nevertheless, Hurricane Katrina was a transformative force, not just in terms of the scale of destruction to the communities that health centers serve; the storm also revealed and defined an evolving role for health centers as responders to the complex and immediate needs of communities in the wake of a multi-state disaster. Health centers, after all, have a pre-existing network that facilitates cooperation and the delivery of care in challenging environments. And many health centers already own mobile clinics that can be dispatched to an emergency area when needed. This nascent role as responders was recently noted in a study published by *Health Affairs* which found that health centers “may well be situated in some communities to be the first line of response to public health emergencies,” because they have the existing networks on the ground to facilitate outreach to diverse populations and cultures.

Indeed, health center patients are predominately low income and members of racial and ethnic minority groups – precisely those most vulnerable to the direct impact of a natural disaster. As Katrina’s aftermath shockingly demonstrated to the world, a majority of the people who did not evacuate were elderly, disabled, chronically ill, or lacked the resources or transportation to leave. The vulnerability of these individuals continues well into the aftermath of a disaster as health care needs remain unmet and basic infrastructures are wiped away. Health centers were created in part to bridge at least one divide between the haves and have-nots: health care. For that reason, some experts and national leaders now see the health center model as a potential fix for the bruised and battered public health infrastructure in New Orleans. An effort now underway, steered by Health and Human Services Secretary Michael Leavitt, Louisiana Governor Kathleen Blanco, and others, will overhaul public health in the city and create a model for other states to follow.

## **A Healthcare System Devastated**

The devastating and lingering effects of Hurricane Katrina set the massive storm apart from other disasters in terms of its impact on public health. Left in the storm’s wake is a decimated health care system that is swamped with patients but has too few providers to treat them. With many facilities destroyed and medical professionals displaced, recourses for effective primary, chronic, and mental health care are few. Before Katrina, low income and uninsured people relied on the hospital system in Louisiana for their health care. That system – widely viewed as fragmented and inefficient – remains irretrievably broken. Among the nine acute care hospital systems in service pre-Katrina, five remain closed and those that are open were operating at only 20% of their pre-storm bed capacity as of February 2006, according to a report by the Government Accountability Office (GAO). Charity Hospital – once one of the largest safety net hospitals in the area serving mostly uninsured and Medicaid patients and part of the Medical Center of Louisiana at New Orleans (MCLNO) – has shut its doors.<sup>5</sup> Charity’s closure, including its Level I trauma center – the only one in the area – has shifted demand to the few remaining emergency departments. At the time of the GAO’s investigation, no decision as to whether to rebuild or replace MCLNO had been made.<sup>6</sup>

The GAO also found that more than three-fourths of New Orleans area safety net clinics were closed as of February 2006. Only 19 remained open, most regularly operating at less than half capacity. The GAO also determined that specialty and diagnostic care was “extremely limited,” and that primary and emergency care were available at significantly reduced levels.<sup>7</sup> As a result, the wait time for emergency care is considerably long. Moreover, there is not a single designated inpatient psychiatric bed in Orleans parish. “Patients in need of a psychiatric state currently face a barren landscape of options,” according to Paul Whelton, Dean of Tulane University School of Medicine.<sup>8</sup> Even prior to the storm, health centers report that the number of mental health providers was too few.

Compounding the systemic hurdles for recovery is a workforce shortage. The Orleans Parish Medical Society reports that of the estimated 3,200 Society physicians who were practicing in the Orleans, Jefferson, and St. Bernard parishes prior to Katrina, only between 1,400 and 1,600 remain.<sup>9</sup> Blue Cross Blue Shield of Louisiana, in recent testimony to Congress, noted that about

three-quarters of the 4,000 some independent physicians practicing in the Jefferson, St. Bernard, and Orleans parishes have not submitted claims since the hurricane, implying that they are no longer practicing in those areas.<sup>10</sup> Indeed, the exodus of active patient care physicians from Hurricane Katrina-impacted regions (six Louisiana parishes and four Mississippi counties) may number as high as 6,000, according to University of North Carolina at Chapel Hill. The vast majority of those doctors were located in the three main evacuated New Orleans parishes. In the 10 flooded parishes and counties, 1,292 of the evacuated physicians were in primary care and another 272 were in obstetrics and gynecology. In total, around one-quarter of the dislocated physicians are primary care physicians.<sup>11</sup>

The shortage of physicians, as well as support staff, has led to a bottleneck of care in hospitals. Without nurses to discharge patients, hospital stays for patients are at least 20% longer than necessary. The scarcity of nursing homes and home health care services for discharged patients, such as the elderly and chronically ill, has also lengthened hospital stays, and exacerbated the lack of hospital beds, creating a Catch-22 problem of increased costs of care.<sup>12</sup>

### **Health Centers Sustain Severe Damage**

Throughout the region, the storm knocked out health centers' power, destroyed facilities, damaged equipment, and flooded medical records. In total, six health center sites in Louisiana and five sites in Mississippi were destroyed. The cost of the damages to health centers in the two states stands at \$65 million, though the tab is likely to swell as reconstruction begins and labor, contractors, and materials shortages drive construction costs higher. In Mississippi, Katrina destroyed several Coastal Family Health Center clinics as well as its administrative office in Biloxi and Bay St. Louis. Prior to the storm, the health center provided care to 30,454 people, 67% of whom had incomes below the poverty line. "You can't replace what we lost," said Joe Dawsey, Chief Executive Officer of Coastal Family Health Center. "In Bay St. Louis, we used to have a fully staffed clinic with several examining rooms. Everything was destroyed," said Mr. Dawsey. "Maybe it's not front page news anymore but the Gulf Coast is still hurting after Hurricane Katrina." In New Orleans, EXCELth, Inc. health center was perhaps the most severely impacted by Katrina. Four of EXCELth's six sites were destroyed, and many of the health center's 70 employees lost their homes during the storm. Another Mississippi health center, Southwest Health Agency for Rural People, Inc., suffered wind and water damage at its Columbia site and was non-operational after the storm. More than 30 miles away, Southeast Mississippi Rural Health Initiative, Inc. in Hattiesburg had their pharmacy looted and emptied.

**"You can't replace what we lost...we used to have a fully staffed clinic with several examining rooms. Everything was destroyed."**

Health centers in the region faced irregular electricity, unreliable funding, substantial staff shortages, inaccessible medications, and lack of communication. From a treatment perspective, accessing patient health records proved hugely problematic. Patients were often referred to health centers from other regions. Without working faxes or phones, records could not be obtained. Coastal Family Health Center in Biloxi was forced to cope with the devastating flood of 50,000 paper medical records. "We lost our entire practice management system and financial

data,” said executive director Joe Dawsey. At sites with electronic medical records, such as Family Health Care Clinic in Pearl, Mississippi, the lack of electrical power meant that their patient health records could not be accessed. To get to work, employees at the Greater Meridian Health Clinic in Meridian, MS had to be helped out of their garages because they could not lift the electric doors by themselves. Others were blocked by huge trees that had fallen on their homes and their streets. Many Mississippi health center employees carpooled to work because of gas shortages. At health centers themselves, downed power and water pumping also wreaked havoc. “It was complete chaos,” said Wilbert Jones, Executive Director of the Greater Meridian Health Clinic.

## **Health Takes a Turn for the Worse**

The alarming surge in acute health problems amid a wasteland of health care options in the region is one of Katrina’s most harmful legacies. Despite a growing level of need, there remains a severe shortage of clinics and inpatient facilities, leaving the sick with a paucity of healthcare options. Katrina’s destructive force exacerbated the already high levels of asthma and respiratory problems. Burning storm debris, increased diesel exhaust, heavy metals, toxic chemicals, mold and fumes from glue and plywood in new trailers caused a spike in lung and nasal irritation. The Natural Resources Defense Council found mold levels in New Orleans to be nearly 13 times higher than the highest levels deemed acceptable by allergists.<sup>13</sup> Moreover, airborne mold levels left in New Orleans pose considerable respiratory danger to residents returning to the devastated city in the aftermath of Hurricane Katrina.<sup>14</sup> In the words of one health center clinician, “We saw allergies and sinus and asthma problems that were likely the result of mold and all the demolition. People who never had allergies would come in to the mobile medical unit with sinus infections and say, ‘I’m miserable,’” said Dr. Maria Crawley, a health center physician who served on a mobile medical unit in Biloxi, Mississippi.<sup>15</sup> Health care experts continue to warn people with serious illness and respiratory conditions to stay away from the ravaged areas.<sup>16</sup>

Public health officials and responding providers have also been forced to focus on chronic illness. Officials at the Center for Disease Control and Prevention (CDC) reported that chronic diseases were the biggest health concern to be addressed in evacuation centers in Arkansas, Louisiana, Mississippi, and Texas, accounting for 33% of the 14,531 reported clinical visits in the initial days following Hurricane Katrina.<sup>17</sup> A survey of adult Katrina evacuees in Houston shelters completed September 10-12, 2005 found that 33% of evacuees had experienced health problems or injuries as a result of the hurricane, many of which experienced multiple conditions. Nine percent had previously diagnosed heart disease; 23% had hypertension; 12% had diabetes; 12% had asthma or other lung disease; 16% had a physical disability; and 1% had cancer.<sup>18</sup> These findings are not surprising given that in 2005, Louisiana ranked 44<sup>th</sup> and Mississippi 50<sup>th</sup> in the percent of adults with high blood pressure, and 47<sup>th</sup> and 49<sup>th</sup> respectively in the percent adults with diabetes.<sup>19</sup>

Health centers reported that the disaster disrupted care for thousands of mental health patients and for others significantly increased the incidence of depression, anxiety disorders, substance abuse, family conflicts, post traumatic stress disorders, and even suicides and homicides. Individuals and families in the impacted areas are still living in challenging conditions, many

with their lives on hold. They are living in temporary lodging, FEMA trailer parks, or are doubled up with friends and family while they struggle with insurance, finding new jobs, and the rebuilding or relocating process. How children and adults will fare over the long term with the stress of displaced lives is a question experts will be asking for years to come. And there are troubling signs that the psychological wounds from Katrina are so vast and extensive that healing may be beyond the city's strapped resources. New Orleans officials estimate that the city's suicide rate has nearly tripled since before the storm.<sup>20</sup> At least 100,000 children who lived through Katrina are likely to suffer post-traumatic stress disorder (PTSD).<sup>21</sup> Officials at Louisiana State University's Health Sciences Center reported that nearly a third of the children being screened at clinics are showing signs of emotional trauma, such as nightmares, heightened anxiety and flashbacks.<sup>22</sup> More than half (60%) of the population in New Orleans suffers from depression and/or post traumatic stress disorder, according to a grant proposal submitted post-Katrina by the Greater New Orleans Medical Foundation, in collaboration with EXCELth, Inc.<sup>23</sup> The Substance Abuse and Mental Health Services Administration estimates that 500,000 people who were affected by the hurricane will probably need some form of mental health counseling – triple the number of adults with mental health needs from before the storm.<sup>24</sup> The situation is exacerbated by loss of mental health professionals after the hurricanes, as well as the high cost of prescription drugs for the uninsured.

Other Katrina-related health concerns included skin problems and gastrointestinal illness. Gastrointestinal illness was one of the most common problems identified at evacuation centers in Arkansas, Louisiana, Mississippi, and Texas, accounting for 27% of the total visits in September 2005.<sup>25</sup> Approximately, 1,000 cases of diarrhea and vomiting were reported among adults and children evacuees in Mississippi and Texas.<sup>26</sup> In addition, Katrina triggered a per capita increase in accidental injuries and stress-related morbidity.<sup>27</sup>

Health centers have provided some services for acute problems at FEMA trailer sites, shelters, and on-site at centers, and have solicited volunteers to help. For example, Coastal Family Health Center in Mississippi was successful in securing funding through the Children's Health Fund for a mobile clinic staffed by a psychologist and social worker to provide services to children in day care centers, schools, and temporary housing, but they have not found any available resources to assist with adult mental health services needs. This center reports that, of its 15,000 current patients, 25% also need/utilize mental health services. Only substance abuse counselors now remain available through the center.

### **Thousands Lose Health Insurance**

Adding to the scarcity of health care options is a pervasive lack of health insurance. As noted earlier, Louisiana and Mississippi were struggling with one of the highest rates of poor and uninsured in the nation. Louisiana ranked fourth in uninsurance and had the third highest rate of population considered low income, while Mississippi ranked ninth in uninsurance and first in low income population.<sup>28</sup> Katrina destroyed an estimated 18,750 businesses in New Orleans and Biloxi, according to the Louisiana Recovery Authority.<sup>29</sup> Last October, the Louisiana Department of Labor reported that the state's unemployment rate hit 11.3% – almost double the rate the year before and considerably higher than the national rate of 5%.<sup>30</sup> The Louisiana Department of Labor paid 200,000 storm-related Unemployment Insurance and Disaster

Unemployment Assistance claims, significantly higher than the 3,000 claims per week the Department typically processed before the storm. That figure, however, does not reflect that many more claims were actually filed.<sup>31</sup> With massive unemployment there are fewer people with health insurance coverage in the region today. In fact, the uninsurance rate – already one of the highest in the nation – likely rose between 4 and 5.5%,<sup>32</sup> and as many as 200,000 Louisiana residents alone lost their employer-based coverage.<sup>33</sup>

The growing ranks of the uninsured have made it difficult for providers to stay financially afloat, according to regional experts. The closure of Charity Hospital has forced both uninsured and Medicaid patients to turn to other hospitals – which in turn are not adequately compensated for providing these services.<sup>34</sup> The number of uninsured outpatients has risen from around 6% before Katrina to 20% at Tulane-Lakeside and 40% for Tulane University Hospital & Clinic. “The Louisiana Legislature has authorized financial support to Louisiana hospitals for care of patients without health insurance, but this assistance does not address the financial plight of the physicians who provide the care,” asserts Whelton. In other words, the funding to help hospitals is insufficient and support “is not reaching the individual healthcare providers.”<sup>35</sup> Meanwhile, many laborers helping in the rebuilding effort are arriving at hospitals without even workers’ compensation insurance.

Some federal funding was made available to pay for the hurricane-induced health care costs. Congress set aside \$2 billion for Medicaid waivers that allowed host states, among other provisions, to provide Medicaid coverage to evacuees for a five-month period until June 30, 2006. Another portion of these funds also created an uncompensated care pool to reimburse providers who cared for uninsured evacuees. Eight states received money from the uncompensated care pool: Alabama, Arkansas, Georgia, Louisiana, Mississippi, South Carolina, Tennessee, and Texas. The question remains as to whether these waivers and the uncompensated care pool adequately address the short- and long-term health needs of those affected by the storm. In addition, it is unclear whether the level of funding was enough.<sup>36</sup> Under the Medicaid waivers, coverage could not be extended to adults without children in most cases. Instead, coverage was targeted at children, pregnant women, parents, individuals with disabilities, individuals in need of long-term care, and low income Medicare beneficiaries. None of the waivers<sup>i</sup> instituted a process for individuals to permanently transition onto Medicaid.<sup>37</sup>

## **Health Centers Respond**

Health centers in Louisiana and Mississippi, including those in the hardest hit areas, rallied to provide essential health care service in their communities, even if their buildings were damaged or destroyed. But the scope of the health center response to Katrina extended across the country. Health centers in many cases responded to the escalating healthcare needs of an evacuee population with creativity and personal sacrifice. Many of these health centers already faced thin operating margins, and their response added an extra financial burden. Moreover, certain

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<sup>i</sup> In total, CMS approved 17 state Medicaid waivers, from: Alabama, Arkansas, California, District of Columbia, Florida, Georgia, Idaho, Indiana, Louisiana, Maryland, Mississippi, Nevada, Ohio, Puerto Rico, South Carolina, Tennessee, and Texas.

obstacles slowed down the ability to respond, including limited medical liability, failure in communications, and supply shortages.



Volunteers from Miami, FL outside Coastal Family Health Center's medical tent. Teams of volunteers rotated through the health center for week-long service commitments.

### Providing Care to Evacuees in Need

In the Gulf Coast communities that took a direct hit from Katrina's destruction, health centers were forced to deliver care in inventive ways, often setting up ad hoc sites in new communities. Coastal Family Health Center reopened in a tent where hurricane victims could seek

**“We needed to be where our patients were, so we packed up what we could salvage and followed our patients.”**

vaccinations, medications and treatment. EXCELth organized a relocation effort to Baton Rouge where many storm victims had fled. Staff quickly established a delivery site for evacuees cobbling together staff, supplies, volunteers and a mobile health van generously donated by Siouxland Community Health Center in Sioux City, Iowa. “When we saw what was happening in New Orleans we decided to take action,” explained Siouxland Chief Executive Officer Michelle Stephan. “It all happened so suddenly. But EXCELth needed the mobile medical unit and there was an overwhelming medical need unfolding on the ground.” EXCELth

also responded to the surge of returning evacuees from Algiers and Jefferson Parishes in the weeks and months after the storm hit. “We needed to be where our patients were,” said Chief Executive Officer Michael Andry. “So we packed up what we could salvage and followed our patients. We, too, were like our patients – homeless and struggling to find our way.”

Some 100 miles south west of New Orleans, Teche Action Clinic in Franklin, LA swung into action, despite the temporary closure of two sites in Houma and Edgard from power outages. Executive Director Dr. Gary Wilz sent medical staff to two evacuee shelters that had been set up in St. Mary's parish and opened the health center to evacuees lined up at the doors. “I have always said there should be a Statue of Liberty in front of every health center because we've always dealt with the huddled masses,” said Wiltz. “We've done it historically so we knew what to do. We were organized on the ground and had the contact network in place to provide health

care and address the immediate needs to the evacuees, many of whom were suffering from chronic diseases – diabetes or hypertension,” he said.

Teche cared for 593 evacuees and filled over 731 prescriptions, totaling over \$36,700. The clinic also provided \$89,000 in medical services to evacuee patients that included internal medicine, pediatrics, obstetrics/gynecology, emergency dental services, vaccinations, and lab work. “One of the real problems we saw is that the hurricane struck near the end of the month, before people got paid,” recalled Dr. Wilz. “Most of the people get their paychecks on the third day of the month. They had only a couple of days worth of medication left and were waiting to get paid before refilling their prescriptions bottles. Many of them had to evacuate their homes without money, and without their medications.” Teche Action also took the extra step of providing other services beyond the scope of medicine to displaced families, particularly since the Louisiana Office of Public Health was inoperable for several weeks after the disaster. Teche provided Women Infant and Children (WIC) services to 85 displaced residents, dispensing formula, diapers, and clothing for infants, breast pumps, and personal hygiene items to displaced families.

**“One of the real problems we saw is that the hurricane struck near the end of the month, before people got paid.”**

Health centers in more than 30 states treated evacuees in the weeks after Katrina, and many are still treating them almost one year later. Around 70,000 evacuees have been treated by health centers across the country, either at the centers or off site at shelters. Health centers in Louisiana treated more than 19,300 evacuees, and Mississippi health centers cared for nearly 17,900. Alabama health centers estimate they treated up to 3,000 people.

In Colorado, twelve health centers served 1,100 Katrina evacuees and approximately two-thirds of those were served by one – Denver Health. The health center set up a temporary emergency room, staffed with paramedics and attending physicians. Staff provided emergency treatment, such as vaccinations to evacuees who had been exposed to polluted standing water as a result of the flooding. Among the evacuees they treated was an elderly man who was blind, diabetic, and had an amputated foot.

In addition, Arkansas health centers treated around 1,000 evacuees, Ohio health centers cared for 1,900, 1,170 were treated by Georgia health centers, 1,500 at Tennessee health centers, and 235 in North Carolina. Even Alaska health centers saw around 50 evacuees. When some 400 evacuees arrived at the D.C. Armory at 4 a.m. one morning a week after the storm, a medical team from Unity Health Care, Inc. in Washington, D.C. met them. The medical team stayed until every one of the evacuees had been screened and treated, and continued to provide care for the entire time the evacuees remained housed at the Armory.

The lion’s share of evacuees that left their home state relocated to Texas. At least 37 of the 50 federally-funded health centers in Texas cared for 18,400 Katrina evacuees, covering 22,500 patient visits. “We are seeing patients already who have nothing but the clothes on their backs,” said one health center in Richmond, Texas. “We are waiving our usual registration process because they have no documentation, working them in if they’re sick, giving them care and

prescriptions if they have no money, and we have met with our local hospital already to collaborate on people walking in to them for routine care and medicines."

"Many of the people we treated were experiencing grief from loss of loved ones, some had lost two or three relatives," said John Sweitzer of the Pasadena Health Center in Pasadena, Texas. "Anxiety and depression were very common, as was post-traumatic stress disorder."

Southeast Missouri Health Network in New Madrid purchased a van to transport hurricane victims to clinic sites, and collected six truck loads of donated non-perishable food items. At Cabun Rural Health Services, Inc. in Arkansas, health center staff secured pharmacy donations to help chronically ill evacuees who had left their prescriptions at home. Health center staff there also threw a birthday party for a 10-year-old girl whose father was working as a police officer in New Orleans, thanks to local businesses that donated cakes and balloons.

**"When nothing else was working, when the government was saying to call this phone number and leave a message, the network of health centers was working."**

To lend a hand, Dr. Wendy Ring of Humboldt County, California, reached out to the national health center network and was immediately partnered with a health center in Texas. She drove the center's mobile clinic from California along with a mental health counselor, social worker, and AmeriCorps member (from NACHC's Community HealthCorps program) and provided care to evacuees for two weeks, at one point seeing as many as 80 patients a day. "When nothing else was working, when the government was saying to call this phone

number and leave a message, the network of health centers was working." Dr. Ring recalled.<sup>38</sup> "They were like, 'Yeah, come on down.' [Health centers] have a really good response capacity and we're used to talking to each other. That is something that works when nothing else is working."



A volunteer doctor and nurse care for a patient inside Coastal Family Health Center's medical tent, set up in Long Beach, MS to provide vaccinations, medications and treatment following the destruction of several health center facilities.

## The Response Takes a Financial Toll on Health Centers

Health centers' response to Katrina added an extra financial burden to their already stretched revenue sources. Many health centers also had the additional challenge of dealing with evacuees from Hurricane Rita, which closely followed Katrina. Some centers were able to get direct federal and charitable assistance. Others had to reach into their operating budgets to provide care. Although Congress provided \$2 billion in Medicaid waivers and uncompensated care funds, some states that treated evacuees outside of the Gulf Coast region did not have access to those funds. For example, more than half of the health centers in Louisiana cared for Katrina evacuees, according to a recent survey by the Louisiana Primary Care Association. Of the more than 19,300 evacuees treated, 80% were uninsured. There were more than 26,000 visits to health centers from uninsured evacuees, racking up nearly \$2.6 million in health care costs. After shouldering the financial burdens of a swelling indigent and uninsured patient population, health centers in Louisiana were unable to get needed financial support from the state; an amendment to fund Louisiana health centers with \$1.5 million failed in the state legislature. Meanwhile, in Mississippi, health centers cared for 17,870 evacuees, 77 percent of whom were uninsured.<sup>39</sup>

For health centers, a number of logistical hurdles delayed financial reimbursement for providing care. While some health centers were eventually able to receive funds from the federally-funded uncompensated care pool for uninsured evacuees, Louisiana health centers struggled with a host of denied health care claims for dental services.<sup>40</sup> The Louisiana Primary Care Association also reports that over \$1.3 million in charges to the uncompensated care pool for uninsured evacuees treated at health centers have been denied by the state. This amount equals 63% of total health center charges billed to the pool. In Mississippi, health centers were not able to use their electronic billing systems, making it impossible to bill patients and their insurers for services. As of May, Mississippi health centers had yet to be reimbursed for \$3.5 million in uncompensated care costs.<sup>41</sup>

Texas health centers also paid a heavy price for providing care. Pasadena Health Center in Pasadena, Texas estimates that it lost \$70,000 in caring for 750 Katrina and Rita evacuees, though most of the losses were a result of Katrina. The Medicaid program was paying approximately \$25 for every \$100 turned in, according to Executive Director John Sweitzer. And Lone Star Community Health Center in Conroe, Texas believes it lost \$50,000-\$60,000 in treating evacuees, even after receiving some reimbursements from the state. In Colorado, total costs reached roughly \$376,000 (or less than \$350 per evacuee). Health centers in Colorado were not eligible for any of the \$2 billion in federal Medicaid or uncompensated care assistance. Most Colorado health centers used their existing grant dollars or foundation money to pay for the cost of care; one Colorado health center received financial assistance from FEMA.<sup>42</sup>

In Arkansas, health centers received more direct state assistance for the evacuees they treated. Representatives of health centers and the Medicaid agency worked together to ensure that the health centers would receive payment for the care they provided to uninsured patients as well as those who would have qualified for Medicaid had they been Arkansas residents. Several health centers also received FEMA funds, grants, and donations from their communities to help offset the costs for serving the Katrina evacuees.

## Barriers to Providing Needed Care

The act of delivering care without delay was often done under demanding circumstances. Health centers confronted several barriers to care delivery, including the limited scope of malpractice liability, communications failures, and supply shortages.

Many additional health centers in other states wanted to send mobile units or teams of clinicians down to affected areas, but the Department of Health and Human Services said their health center malpractice coverage would not cover the health center outside their designated service areas. For example, Community and Rural Health Services, a health center in Fremont, Ohio, raised \$20,000 in funds to send medical staff in a mobile medical unit to Biloxi. But the trip was cancelled after the center learned it would lose medical liability protection once staff crossed state lines – triggering national news headlines. A similar situation unfolded in Iowa, when volunteers from Siouxland Community Health Center had to return from New Orleans after a week because they, too, could not be assured of medical liability protection.

Health centers have access to federally-funded malpractice insurance through the Federal Tort Claims Act (FTCA), and the rules on where health center clinicians can be covered remain unclear. Health centers across state borders may be the nearest source of primary care and disaster response during an emergency. Yet the limits on FTCA coverage prevent health centers from responding to a multi-state disaster or public health threat.

“You know there's too much bureaucratic red tape when it prevents humans from helping other humans,” noted an editorial in the Fremont (Ohio) *News Messenger*. “That seems to be the case with the law that has stopped dozens of federally insured medical providers – including Community Health Services in Fremont – from helping the Gulf Coast recover after Hurricane Katrina because their medical liability protection doesn't apply outside their own states.”<sup>43</sup> NACHC has repeatedly pressed HHS for a change in the policy. Legislation to remedy the problems is also pending in Congress.

Health centers were forced to work efficiently and effectively in a communications vacuum. On the ground, there was often no reliable, updated and accessible information source for first responders, FEMA, and other disaster coordinating centers on where people could turn for healthcare. One example of the poor communication played out in Meridian, Mississippi. Two 500-bed mass units were set up, but hardly any patients arrived. The local health center, Greater Meridian Health Clinic, meanwhile, had lines outside the door for people seeking treatment. Providers at the mass units did not contact the health center to coordinate care, according to Greater Meridian's Executive Director Wilbert Jones. One volunteer health center clinician told NACHC that the federal government insisted on having all the medical volunteers funneled to a single phone number and then did not contact the professionals who enrolled. With no telephone lines or electric power, the Louisiana Primary Care Association (LPCA) relied on cellular text messaging to field requests and calls for help from besieged health centers. Among their requests were prescriptions for evacuees who had fled their homes without their medications.

LPCA attempted to contact the Strategic National Stockpile (SNS) for medications without success. At one point during the first week after the disaster, the warehouse distribution site for

the SNS moved to an abandoned grocery store in Baton Rouge to make room for relief supplies and food – a likely cause of the confusion. Nevertheless, the scope of the disaster was a challenge for those charged with manning the requests for the SNS, which was designed to respond to a bioterrorism event – not a natural disaster (it was previously activated only twice before – during 9/11 and the anthrax attacks in Washington, D.C.). “We gave [health centers] what they wanted so long as they had a pharmacist to dispense the drugs, or a pharmacy nearby” said Philip McCrory, Pharmacy Director of the Louisiana Department of Health and Hospitals, Office of Public Health, who oversaw requests for medications from the stockpile during the disaster. “If they had the name of a pharmacy we’d ship it – either by courier, or an ambulance, or in some cases, through the National Guard. The problem was once anyone found out the stockpile was activated, then it was like Christmas. If evacuees went to the church, then the church thought they were entitled to the stockpile, but we couldn’t send prescriptions to a site where there was no pharmacist to dispense the medications. This was the first time that a natural disaster had to be addressed. There were a lot of decisions to be made on the fly and a lot of things just kind of came together by fate,” McCrory told NACHC. As it happened, circumstances often trumped policy. Many local pharmacy outlets such as Rite-Aid, Wal-Mart stores, and Walgreens, began filling prescriptions for free in the weeks following Katrina, dispensing over \$8 million in medications. “I learned that these drugstores came together and said they’d put pills in the empty bottles people were bringing them and give it to them free,” said McCrory. “So we [Office of Public Health and the state board of pharmacy] went to FEMA and struck a deal so that the pharmacies would be reimbursed for filling the prescriptions. That way, any one who was displaced or shelter eligible could take their prescription and get it filled for free.”

**“There were a lot of decisions to be made on the fly and a lot of things just kind of came together by fate.”**

Despite the difficulties on the ground, one common theme emerged in the response efforts: patients who were grateful for their health center care. At the Renaissance Village trailer park set up for evacuees in Baton Rouge, for instance, a number of patients shared their stories about the help they received from EXCELth, which dispatched mobile clinics to the site. “If it wasn’t for Dr. Williams [an EXCELth clinician], we would have a lot of sick people that wouldn’t know what to do with themselves,” said James Waller, a patient. Another patient, an elderly woman, remarked on how the health center staff made her feel at home. “Even though I’m in Baton Rouge, I feel like I’m in New Orleans. You know, the people are so warm, they are so glad to see me. It’s a good feeling.” Darlene Leavall, a New Orleans bus driver who evacuated through deep flood waters and ended up in Renaissance Village, said: “I needed help, and everywhere I went in Baton Rouge, I couldn’t get help – until I walked into the trailer of EXCELth. She [Dr. Sheila Webb] saw the need I had; she saw the pain that I was in.”

## **Philanthropy Comes to the Rescue**

Numerous organizations and individuals were extremely generous in assisting health centers to provide care to Katrina victims, and in rebuilding their damaged or destroyed facilities.

## **NACHC Health Center Hurricane Relief Fund**

Immediately following Hurricane Katrina, NACHC established a special Health Center Hurricane Relief Fund, which provided nearly \$1.8 million in monetary contributions to 34 health centers already serving over 400,000 patients, including three in Alabama, 14 in Louisiana, 10 in Mississippi, and seven in Texas. The Fund assisted these health centers in providing health care to evacuees, repairing facilities, and purchasing needed equipment, supplies, and pharmaceuticals. Major donors include Johnson & Johnson (\$500,000), Direct Relief International (\$350,000), the Robert Wood Johnson Foundation (\$750,000), and the Monroe Plan for Medicaid Care, Inc. (\$5,000). In addition, \$164,000 in contributions have been received from private individuals, health centers from around the country, and other organizations and businesses. **Appendix A** lists the health centers that received grants from the NACHC Hurricane Relief Fund, as well as more information on how individual contributions were used to assist the 34 health centers.

## **Other Charitable Assistance**

Numerous other foundations, corporations, and organizations responded to the needs of health centers immediately after the storm, and many continue to provide assistance. In Biloxi, Mississippi, the CAVU (“Ceiling and Visibility Unlimited”) Foundation in Massachusetts came to the rescue of Coastal Family Health Center. The CAVU Foundation has been instrumental in assisting Coastal with their rebuilding and service delivery. CAVU continues to bring in volunteer nurses to work at Coastal’s remaining and temporary locations. According to CAVU Foundation, the storm exacerbated the already existing nurse shortage in the area. Of Coastal’s 32 nurses, 17 have not been able to return. CAVU also brought in mental health providers from Massachusetts health centers to address the mental health needs of Coastal’s own staff, since they too suffered major disruptions in their own lives and are working in a high stress environment. CAVU coordinated an effort to shore up Coastal’s significant cash flow problems and enlisted volunteers to write grant applications and sought corporate donors, such as Pfizer.<sup>44</sup>

Operation USA, a disaster relief and post-disaster redevelopment organization based in California, also provided direct aid to health centers overwhelmed with evacuees. The organization distributed large volumes of medical supplies and medications to clinics in Alabama, Louisiana, Mississippi, and Texas, as well as a number of generators, portable lights, water purification devices, and sleeping bags. Operation USA was also instrumental in making a series of cash grants to 36 clinics in both rural and urban areas soon after Katrina, including many health centers. They have also made a grant to the City of New Orleans to help it begin to rebuild its damaged community health system.<sup>45</sup>

Countless other organizations and individuals provided financial support, supplies, and met workforce needs for health centers impacted by Katrina. Among them were: Project HOPE; Hands On USA and Hands On Network; Hyman, Phelps, McNamara, PC; AmeriCares; Merck & Co.; Children’s Health Fund; Sisters of Mercy; and Brigham and Women’s Hospital.<sup>ii</sup> In

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<sup>ii</sup> NACHC regrets that we cannot acknowledge all organizations and individuals for their efforts, but remains deeply grateful.

addition, Johnson & Johnson provided \$50,000 to EXCELth in recognition of the New Orleans health center's outstanding response to the storm.<sup>46</sup>

## **Looking Ahead**

A year after images of Katrina's destruction were televised across the nation, the disaster remains frighteningly real. Little has been done to meet the Gulf region's healthcare needs as evidenced by the rising incidences of asthma and mental illness, coupled with the skyrocketing numbers of uninsured. The area's health care infrastructure must be reorganized to most effectively meet the needs of those who remain, and those who plan to return. Given their ability to provide efficient and effective care to the most vulnerable, health centers should be the foundation of any newly created health care system. However, many health centers require additional assistance so that they may continue serving evacuees, and some still require capital funds to rebuild.

### **The Need to Remodel the Health Care System**

Most experts agree that the health care system in Louisiana before the disaster was heavily reliant on costly institutional care. Louisiana used more hospital-based emergency department and outpatient care than the national average, and higher use of emergency departments leads to more inpatient hospital stays. This likely explains why the number of health center visits in the state was only 40% of the national average in 2003, and why even before Katrina, the state had begun to take steps toward redirecting the Medicaid population away from hospitals to community-based settings.<sup>47</sup> Subsequent reports have noted that expanding the capacity of health centers and shifting non-urgent hospital-based care to primary care settings would generate substantial savings to the state.<sup>48</sup>

Hurricane Katrina left the Gulf Region positioned to recreate an efficient and effective health care system, one that encourages the receipt of timely, preventive and primary care, especially among the low income and medically underserved who need it the most. As HHS Secretary Leavitt recently stated about the situation after Katrina, "those circumstances have contrived to create an unprecedented opportunity, the chance to build a new, patient-centered system that will provide a continuum of care — from preventing diseases to long-term support for chronic conditions. Doing so will not only save lives and reduce suffering, it will light the way for a nation struggling to find a better way to deliver healthcare."<sup>49</sup>

So far the city, state, and federal government have each formulated plans to rebuild and redesign the health care infrastructure in the New Orleans area, and many have focused on a more primary care-based model. For example, New Orleans Mayor Ray Nagin has tasked the "Bring New Orleans Back" Commission with finding ways to shift the now skeletal health care infrastructure in the city away from the traditional hospital-based care and towards ambulatory-based preventive care, health promotion, and chronic disease prevention.<sup>50</sup>

HHS Secretary Leavitt has described a new health care system in which "community health centers dot the landscape and every citizen has a medical home where the goal is to keep people

healthy, not just treat them after they get sick.”<sup>51</sup> Leavitt’s vision has been echoed by health care experts in the region, who argue the post-Katrina system should move away from the institution-based system.<sup>52</sup> In July of 2006, Louisiana state officials announced the creation of the Louisiana Health Care Redesign Collaborative, which will propose changes to the Medicaid and Medicare programs aimed at reshaping the delivery and financing of health care in the New Orleans area, and will work in partnership with the federal Department of Health and Human Services. The goal is to create a less fragmented, more efficient health infrastructure that relies on primary and preventive care and curtails inappropriate and costly care, such as avoidable visits to the emergency room. To achieve this, the Collaborative will strive to provide all residents with a medical home for all of their primary care needs, and access to medical records electronically. Health centers will be a major source of primary care under this initiative. The plan for action will be outlined by October 20, 2006 in a “large-scale” Medicaid waiver and Medicare demonstration project, both of which require approval from HHS.<sup>53</sup>

Leavitt’s proposal for a community-based model of care is part of a long-standing, albeit uncommon, consensus between the Bush Administration and bipartisan majorities on Capitol Hill on a health care plan. Over the past six years, that consensus has resulted in more than \$750 million in new federal funding to establish new and expand existing health centers across the country, extending health care to more than 4 million previously unserved individuals. Health centers have a long history of delivering high quality, cost effective care that narrows health care disparities. They are tailored to the people in need in devastated regions of Louisiana and Mississippi. Now, just as in 1965 when they were first established, health centers are designed to empower communities to create locally-tailored solutions that improve access to care and the health of the patients they serve. Key to health centers’ accomplishments is patient involvement in service delivery through patient-majority governing boards that manage health center operations. Board members serve as community representatives and make decisions on services provided, assuring responsiveness to local needs. As a result, low income, uninsured health center patients are much more likely to have a usual source of care than the uninsured nationally. Women of low socioeconomic status seeking care at health centers experience lower rates of low birth weight infants compared to all such mothers. The Institute of Medicine and the GAO have recognized health centers as models for screening, diagnosing, and managing chronic conditions such as diabetes, cardiovascular disease, asthma, depression, cancer, and HIV. Health centers’ efforts have led to improved health outcomes for their patients, as well as lowered the cost of treating patients with chronic illness. Moreover, care received at health centers is ranked among the most cost-effective. Several studies have found that health centers save the Medicaid program around 30% in total annual spending for health center Medicaid beneficiaries due to reduced specialty care referrals and fewer hospital admissions, thereby producing significant savings in combined federal and state Medicaid expenditures.<sup>54</sup>

Health Information Technology (HIT), including Electronic Medical Records (EMRs), is a tool for measuring and improving health care quality, eliminating health disparities, and potentially even reducing costs. As Katrina demonstrated, paper records are easily lost, and electronic records can be sent to new providers treating displaced evacuees. The loss of records could put a patient at risk. The post-Katrina health care infrastructure should rely on HIT as a way to maintain and improve health care quality. Unfortunately, only about 8% of health centers currently report using a full EMR, less than the rate among private, office-based physicians; another 16% of centers report

using a partially electronic medical records system. The single greatest impediment to wider EMR adoption is the lack of financial resources.<sup>55</sup>

A major challenge to rebuilding is determining how many residents will return, and when, and where they will settle. These factors determine how much capacity will be necessary and where to locate these services. Labor shortages also affect immediate rebuilding needs and increase rebuilding costs. As of December 2005, the city's population was about 68% of what it had been in 2000 (approximately 485,000). By 2008, the population may still be half the pre-Katrina estimate.<sup>56</sup> A lack of housing, schools, health care, and other services may be what is impeding the return of the city's residents, as well as affecting the health care workforce shortage. The city is caught in the middle – the lack of infrastructure dissuades people from returning, and since people cannot return, the cost of rebuilding has significantly increased.

### **The Continuing Need to Rebuild Health Center Facilities**

Health centers must be rebuilt in order to serve the communities still recovering from Katrina, and to serve as responders for the next emergency. Immediately after Hurricane Katrina, NACHC asked Secretary Leavitt for \$65 million to help rebuild and repair damaged facilities, and this amount is likely too little. So far, no FEMA money has been directed at health center rebuilding. Only one health center - Coastal Family Health Center in Mississippi – received funding through a Social Services Block Grant for construction. The success of health center efforts to draw from other funding sources has been mixed. For instance, on June 1, then U.S. Treasury Secretary John Snow announced that \$15 million in tax-credits will be directed to health centers. Then, on June 23, Mississippi Governor Haley Barbour announced a \$6.1 million direct grant for Coastal Family Health Center to restore medical, dental, pharmacy, and behavioral health services.<sup>57</sup> But with potentially more than \$65 million in construction damage inflicted by Katrina, much more assistance is needed.

### **The Need for Health Center Involvement in Disaster Preparedness**

Serious concerns remain about the Gulf region's – and the nation's – readiness for the next disaster. This is especially apparent in training and funding directed at emergency preparedness. Despite the key role of health centers in treating disaster victims, since 2004 there has actually been a decline in the number of states funding health centers for disaster preparedness and in the dollars provided. The Health Resources and Services Administration (HRSA) National Bioterrorism Hospital Preparedness Program provides every state and territory, the District of Columbia and the three largest municipalities funds to prepare for bioterrorism and other public health emergencies. These funds are given to state public health departments which then distribute the money to select entities, and may include health centers. According to NACHC's annual survey of state primary care associations, only 11 states provided \$2 million in funding to health centers and/or state primary care associations for emergency preparedness in September 2003. By the following year, there were encouraging signs that states were finally willing to invest in the health center response role; 27 states provided funds totaling \$5.8 million. But by August 2005, just before Katrina hit, only 24 states funneled a total sum of \$4.5 million to health centers for disaster planning. In 2006, 20 states are expected to provide funding to health centers and/or PCAs totaling \$3.8 million. While the vast majority of states include health centers

and/or PCAs in their disaster planning process, the level of involvement varies widely, planning does not correlate with funding, and the amount of funding is largely inadequate. Of the states most directly impacted by Hurricane Katrina, Alabama and Mississippi health centers received some funds in fiscal year 2005 (\$531,000 and \$50,000, respectively), but centers in Louisiana and Texas received nothing.

Despite the lack of funding, health centers are involved in emergency planning in almost every state. 70% of health centers reported that they have developed disaster plans, as of August 2004. Over the last few years, health centers across the country have reached out to their communities to partner on disaster preparedness efforts. Activities have included drills, training, and needs assessments. Still, it is important to note that the modest disaster preparedness funds that health centers receive stands in sharp contrast to the vast resources directed to hospitals.

Moreover, as the foundation of a remodeled New Orleans' health care system, health centers need to be appropriately reimbursed for the health care they have provided to Hurricane victims. Although health center grant funds cover the costs of health care services for the uninsured, such funding was never designed or intended to address a significant influx of patients due to an emergency such as Hurricane Katrina. Thus the grant funding available is wholly inadequate to meet the health care needs of Hurricane Katrina victims.

### **The Role of Medicaid in Emergencies**

Currently, Medicaid is the single largest health insurer of health center patients nationally, as well as health centers' single largest source of revenue. More importantly, Medicaid is the only available program that can finance the delivery of care to individuals and populations – typically low income – that are victimized by a disaster or public health emergency. In the wake of Hurricane Katrina, Congress briefly considered extending Medicaid coverage, with 100% federal financing, to all Katrina victims and evacuees; that effort fizzled, however. Although HHS Secretary Leavitt approved several Medicaid waivers providing fully federally-financed coverage, the waivers covered only individuals who meet Medicaid's complex and limited categorical eligibility rules. Left out entirely in this scheme were most single adults and childless couples, unless they were severely disabled.

More recently, new rules went into effect on July 1, 2006 that require all Americans to provide documentation and proof of citizenship when they apply for or renew their Medicaid benefits. Concerns have been raised that the new requirements will make Medicaid's already difficult enrollment process even more arduous. As noted in *The Times-Picayune*, locating records such as birth certificates will be particularly difficult for Katrina victims who lost their records in the floods. "It certainly exacerbates the problem in Louisiana for those people who did lose their documents (in the storms)," J. Ruth Kennedy, deputy director of the state's Medicaid program, told the newspaper. An estimated 30,000 to 40,000 people who apply for Medicaid benefits every month will likely be impacted because they will have to provide documentation proving their citizenship before they can qualify.<sup>58</sup>

## Recommendations

Based on the events that have happened over the last year, and the experience of health centers in responding to those events, NACHC has generated a list of recommendations for steps that could – and should – be taken in order to be better prepared for future disasters. Some of these recommendations were identified through NACHC’s interviews with health center and foundation staff who actively participated in Hurricane Katrina response efforts.

### I. Congress should:

1. Fully fund President Bush's request for a \$181 million increase for the Health Centers program. This increase will provide for the creation or expansion of more than 300 Health Center sites, extending care to as many as 1.5 million new patients in high-need communities not served by health centers today. Given the destruction left by Katrina, and the fact that Louisiana and Mississippi are among those states with the highest rates of medically underserved people, communities in these two states would likely be prime candidates for new or expanded health center funding.
2. Provide funding for base grant adjustments for existing health centers so that grant funding can address the unanticipated costs health centers have faced in the wake of these disasters.
3. Extend Federal Tort Claims Act liability coverage for health center clinicians who travel offsite to provide care at health centers affected by disasters or emergencies. NACHC has asked Congress to respond to this lapse and extend community health center liability coverage across state lines.
4. Reinstate statutory construction authority and provide funding so that affected health centers can rebuild, repair, or restore facilities that were damaged or destroyed by the hurricane and subsequent flooding. This should include expansion of the HRSA Loan Guarantee Program.
5. Enact changes to federal Medicaid law to:
  - A. Provide Emergency Medicaid coverage to all victims or evacuees of a natural disaster, regardless of categorical eligibility, with expanded income and assets eligibility thresholds, and with 100% federal funding.
  - B. Streamline Medicaid eligibility requirements in such cases, and ease documentation requirements in an effort to overcome administrative barriers.
6. Support the acquisition and maintenance of Health Information Technology (HIT), including Electronic Medical Records (EMRs), at health centers. Such support should be separate and apart from the financial support health centers receive for care provided to their uninsured patients. Electronic patient records that are housed in secure locations and able to be transferred to other providers will help displaced patients receive the most appropriate care from new providers during a public health emergency.
7. Take steps to expand the federally-supported health care workforce available to serve in health centers on the Gulf Coast, through increased funding and flexibility for the National Health Service Corps, J-1 Visa Waiver Program, United States Public Health Service Commissioned Corps and other sources.

8. Guarantee health centers needed medical supplies and other resources through the National Pharmaceutical Stockpile, FEMA and other federal programs. Health centers should be on a priority distribution list of disaster supplies.
- II. Congress and the Administration should jointly develop and fund a demonstration project based on Secretary Leavitt's recommendation that the health care infrastructure in New Orleans be rebuilt around the health center model of delivering care
- III. Health centers should be active participants in any reinvented health care infrastructure, as well as in disaster preparedness planning. Primary care should be the principal focus of a local area health care system, and because health centers have been major disaster responders, they should be part of planning for the next one.
- IV. The Bureau of Primary Health Care (BPHC), the agency that oversees the Health Centers Program, should release guidelines for health centers on how to prepare for and respond to disasters. Health centers need help identifying and addressing priority needs for disaster preparedness and response.
- V. The federal government should offer a zero interest line of credit to health centers serving in disaster zones so that they can continue serving the community. This should be in addition to drawing on federal grant dollars early.
- VI. Greater coordination of communications across the different federal agencies involved in emergency response is needed.
- VII. Clear communications from FEMA regarding the applicable procedures for obtaining federal assistance. Different deadlines and procedures for applications in each of the states created confusion and the potential for loss of access to needed resources.
- VIII. Create a policy for ensuring that residents in disaster areas have access to their medications, especially those with chronic illness and undergoing treatments.
- IX. Leadership from all federal agencies that must respond to the crisis should also visit the disaster zone. Only those who see the situation on the ground can truly understand the needs and limitations of health centers and other providers.
- X. Education surrounding the National Strategic Stockpile is needed for organizations at the local level. Greater clarity on the types of pharmaceuticals and other supplies available would be beneficial. Moreover, clear instructions on the procedures for obtaining supplies would greatly enhance the ability of health care organizations to meet the needs of the community.

## **Conclusion**

The most compelling measure of Katrina's force and destruction is the direct and long-term impact of the storm on the people who remain in the Gulf Coast. Yet Hurricane Katrina also demonstrated the unique nature of the national network of health centers, not only in meeting the needs of their respective communities in times of crisis, but also in responding to the needs of those in other communities affected by a disaster. The storm highlighted a special health center role that went largely unnoticed prior to Katrina – a national disaster response mechanism that can be rapidly mobilized and targeted toward need. Even health centers that lost supplies, records, billing collection capabilities, or facilities creatively found ways to continue serving those in their communities without wasting a moment. Yet, even with health centers' record of success during the aftermath of Hurricane Katrina, we as a nation still have a long way to go

before being completely prepared for the next public health emergency. With the imminent threat of avian flu, natural disasters, and the possibility of future acts of terrorism, much more needs to be done. NACHC's recommendations will help to better prepare both health centers and other responders for the next public health emergency, *before* it hits.

In the meantime, New Orleans – one of the hardest hit areas – now has a chance to rebuild a much more effective and efficient health care system. Many already agree that any new system should move away from costly institutional care, and instead emphasize low-cost, high-payoff preventive and early primary health care. Health centers have demonstrated their ability to be the model of care on which to rebuild the health care infrastructure in New Orleans and elsewhere. Hurricane Katrina was a reminder that no health care system can truly be complete before, during, or after a crisis without health centers.

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## Appendix A

### National Association of Community Health Centers Hurricane Relief Fund

**Table 1. Health Center Grantees**

<b>Alabama</b>	<b>City</b>	<b>Grant Amount</b>
Mostellar Medical Center	Irvington	\$122,912
Franklin Primary Health Center	Mobile	\$104,878
Mobile County Health Department	Mobile	\$48,840
	<b>Total</b>	<b>\$276,630</b>
<b>Louisiana</b>		
<b>Louisiana</b>	<b>City</b>	<b>Grant Amount</b>
Rapides Primary Health Care Center	Alexandria	\$35,035
Jefferson Community Health Care Center	Avondale	\$50,130
EXCELth Inc. Family Health Center	Baton Rouge	\$100,850
Capitol City Family Health Center	Baton Rouge	\$37,996
Primary Care Providers for a Healthy Feliciana	Clinton	\$36,716
Teche Action Board, Inc.	Franklin	\$79,988
St. Helena Community Health Center	Greensburg	\$39,936
Innis Community Health Center	Innis	\$34,441
Southwest Louisiana Health Center	Lake Charles	\$91,000
St. Charles Community Health Center	Luling	\$35,000
Primary Health Services Center	Monroe	\$38,628
Iberia Comp. Community Health Center Inc.	New Iberia	\$30,000
New Orleans Health Care for the Homeless	New Orleans	\$46,200
Southwest LA Primary Health Care Center Inc.	Opelousas	\$27,550
	<b>Total</b>	<b>\$683,470</b>
<b>Mississippi</b>		
<b>Mississippi</b>	<b>City</b>	<b>Grant Amount</b>
Coastal Family Health Center	Biloxi	\$138,956
Greene Area Medical Extenders	Biloxi	\$5,600
Southeast MS Rural Health Initiative	Hattiesburg	\$53,618
Central MS Civic Improvement Assoc	Jackson	\$48,480
Dr. Arena Mallory Comm. Health Center	Lexington	\$36,439
Amite County Medical Services	Liberty	\$18,300
Greater Meridian Health Clinic Inc.	Meridian	\$40,349
Family Health Care Clinic	Pearl	\$50,530
Claiborne Co. Family Health Center, Inc.	Port Gibson	\$34,135
SW Health Agency for Rural People Family Care Ctr	Tylertown	\$78,553
	<b>Total</b>	<b>\$504,960</b>
<b>Texas</b>		
<b>Texas</b>	<b>City</b>	<b>Grant Amount</b>
MLK Jr. Family Clinic, Inc.	Dallas	\$63,588
El Centro de Corazon	Houston	\$34,995
Good Neighbor Healthcare Center	Houston	\$10,576
S. Central Houston Community Health	Houston	\$49,128
Gulf Coast Health Center, Inc.	Port Arthur	\$52,500
Fort Bend Family Health Center, Inc.	Richmond,	\$10,540
El Centro del Barrio	San Antonio	\$42,129
	<b>Total</b>	<b>\$263,456</b>

**Table 2. Fund Contributors**

<b>Funding Source</b>	<b>Guidance</b>	<b>Amount</b>
<b>Johnson &amp; Johnson</b>	Hurricane Katrina Relief; no restrictions on use for health center relief and recovery	\$500,000
<b>Direct Relief International (DRI)</b>	Hurricane Katrina Relief, funds used for expenses related to the provision of medical services, purchasing health-related products, medical personnel, and medical outreach and health initiatives, and for the physical rehabilitation/reconstruction of damaged clinics	\$350,000
<b>Robert Wood Johnson Foundation – (RWJF)</b>	Hurricane Katrina Relief; funds used for items such as medical supplies and equipment, additional providers, support staff, minor clean up and other items deemed direct delivery of services.	\$750,000
<b>Monroe Plan for Medical Care Inc</b>	Hurricane Katrina Relief; funds for health centers in Texas	\$5,000
<b>General Donation Fund</b>	No restrictions general contributions	\$163,971
	<b>TOTAL</b>	<b>\$1,763,971</b>

Note: The funds not granted to health centers in response to Hurricane Katrina have been earmarked for future disasters as part of a general Disaster Relief Fund.

For more information on NACHC’s Hurricane Relief Fund, please contact  
 Jason Patnosh  
 Director of Partnership Development  
 National Association of Community Health Centers  
 (301) 347-0400 ext. 2068  
 jpatnosh@nachc.com

## ABOUT NACHC:

The National Association of Community Health Centers (NACHC) represents the nation's health safety net: over 1,000 Community Health Centers, serving 15 million people at 5,000 sites located throughout all 50 states and U.S. territories. Community Health Centers provide health care to low-income and medically underserved Americans, and they never turn anyone away – regardless of insurance status or ability to pay. They are local, non-profit, community-owned and federally funded.

NACHC is the leading source for information, data, research and advocacy on key issues affecting Community Health Centers. NACHC provides education, training, technical assistance and leadership development to promote excellence and cost-effectiveness in health delivery practice and community board governance. In addition, it builds partnerships that stimulate public and private-sector investment in quality health care services.

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PLEASE VISIT: [WWW.NACHC.COM](http://WWW.NACHC.COM)

