In August 2005, Hurricane Katrina unleashed a series of catastrophic levee breaks that resulted in widespread, devastating flooding in the greater New Orleans area. The city was under a mandatory evacuation order for thirty days, and the water inundated the infrastructure to such an extent that the health sector was completely disrupted across the continuum of care, from basic 911 services to specialty care to hospital services. Hospital and ambulatory facilities in the city were severely damaged, some beyond repair, and many remained closed for months. Three of sixteen hospitals remained in limited operation for weeks, and they were in the suburbs adjacent to New Orleans. Complicating matters, the disaster impacted a significantly disadvantaged population burdened by chronic illness, a high rate of uninsurance, and poverty. The public hospital was unable to open for fourteen months, leaving hundreds of thousands without access to their principal source of care, including both those who had successfully evacuated and those left behind. Though horrific in scope and impact, the widespread devastation of the health care infrastructure gave the New Orleans region an unprecedented opportunity to redesign a major American health sector from the ground up.
As local providers and organizations of all types responded to the acute health crises and urgent primary care needs of the city’s population, the community began to consider a policy framework that would support the vision of a more patient-centered and effective health sector than the one decimated by Katrina. Broad reform was discussed, but inevitably attention was focused on the needs of the safety net to serve the low-income population, given that more than half of the population’s health care was supported through some sort of public program. The efforts at rebuilding and redesign began early and in earnest, with stakeholders working simultaneously to restore services and to develop a policy framework that would guide and support the new vision and infrastructure. The redesigned health system that was envisioned was to be a high-quality, cost-effective system founded on a distributed network of community health sites that used health information technology to improve the safety and efficacy of care. An important point was that the newly designed health system would need to be supported by a sustainable, flexible financing model that would support community-based primary care and give even the most vulnerable better access and choice.

The community moved forward quickly and successfully. In the first five years Hurricane Katrina, the city was able to boast an innovative, modernized community health network providing neighborhood-based access to quality care for everyone, including the most vulnerable populations in the region. This chapter provides an overview of the series of deliberate policy actions and grassroots activity that worked to build access to a high-quality health care system in the New Orleans area. In addition, the chapter provides insight into the lessons learned in establishing this network—including those related to the significant local, state, and federal barriers to developing quality, sustainable primary care in the United States, particularly for low-income populations—and discusses the challenges that this innovative system faces in spite of its success and broad support.

The State of Pre-Katrina Health Care

The rationale for redesigning the health care system of the New Orleans region following Hurricane Katrina arose from the system’s long-standing poor performance and the poor health outcomes of the population. United Health Foundation consistently placed Louisiana at the very
bottom of its ranking of quality of health care by state for the decade leading up to the storm. Health system rankings by the Commonwealth Fund for overall performance with respect to quality, access, and effectiveness demonstrated recurring poor performance, irrespective of payer. The quality of care for the Medicare population in Louisiana was the lowest in the nation and the cost of care was the highest. Though specific data for the New Orleans region were scarce when planning commenced, the region represented approximately 25 percent of the state’s population at the time of Hurricane Katrina; given similarities in population and system structure, planners extrapolated state statistics to cover the region.

The root causes of the region’s poor performance and poor outcomes were thought to be related to the health system’s infrastructure, including the low density of primary care physicians per population, high density of specialty care physicians, and higher number of hospital beds per capita than the national average. Access to primary care was an issue for low-income uninsured populations in particular. The population served, which had high rates of chronic illness, a high percentage of minorities, and low socioeconomic status, was at high risk for poor health. As in most places in the United States in 2005, technology was minimally deployed and providers relied largely on paper medical records.

**Weak and Centralized Delivery Model**

The greater New Orleans area, like the rest of the state, had relied on a centralized safety-net model for care of low-income, uninsured, and largely minority populations. At the center of the greater New Orleans health system for the past 275 years was the state-run public hospital, locally known as Charity Hospital. In the year before the storm, the hospital had 264,800 visits to one of its seventy downtown hospital-based clinics, but most were to the emergency department. Most of the clinics offered specialty services supporting graduate medical education for health professional programs in the region. Access to care, particularly primary care, was limited because of the hospital’s central location, and years of chronic underfunding led to the closure of clinics and a reduction in service hours. Metrics of quality were generally positive for those patients who entered the system. However, many patients reported experiencing fragmented care delivered in clinics located downtown, whose operating hours generally were more convenient for physicians and trainees than for patients.
Limited and Mismatched Financing

The means of financing care of the uninsured in Louisiana had become increasingly dependent on the federal Medicaid program called the Disproportionate Share Hospital (DSH) Program, funds for which were used as an alternative to traditional Medicaid funds to finance the public hospital system as a source of care for the uninsured. That originally was an advantageous approach because Louisiana was able to access a significant amount of DSH funding due to the high burden of uninsured residents in the state. In addition, because of the state’s low per capita income, the federal government funded the vast majority of the program after a state match. Federal rules for DSH funding require it to be used only to support hospital care, not primary care. In Louisiana, the state had preferentially applied these funds to support care in the statewide public hospital system.

Because of the reliance on DSH revenue to support the care of low-income populations, Louisiana did not develop programs to expand additional safety-net financing options, such as Medicaid. The Medicaid program in Louisiana has maintained strict eligibility criteria for adults, requiring an adult to be a parent or to be disabled and to have an income of less than $1,656 a year for a family of two (parent/caregiver and child)—criteria that mean that many working poor are uninsured. Their income is too high to meet Medicaid standards, yet most are employed by small businesses, most of which cannot afford to offer health insurance to their employees.

Shortage of Community Health Centers

Because the state relied on DSH and the public hospital system for care of uninsured and low-income people, it had failed to develop policies and programs to support primary care in community health centers, resulting in a lack of primary care infrastructure, a critical element in low-cost, high-quality health systems. Nationally, such community health centers, formally known as Federally Qualified Health Centers (FQHCs), are funded through the federal “330” grant funding program, which is administered by the Health Resources and Services Administration (HRSA). These centers receive enhanced reimbursement from public payers, a core grant to aid with supportive services, and other advantages that support them in providing health care for low-income populations. Nationally, such centers are a major source of safety-net primary
care, serving 17 million people.\textsuperscript{15} Louisiana has fewer sites per capita than other markets of similar size. Not only does that limit accessible neighborhood-based primary care, but it also means that the state is not availing itself of all available federal funding to support primary care.

**High-Risk Population**

The city’s population was disadvantaged on a number of fronts. At the time of Hurricane Katrina, 44 percent of the New Orleans population lived on an income below 200 percent of the federal poverty level, or $37,000 for a family of four.\textsuperscript{16} Rates of chronic illness such as obesity, diabetes, heart disease, and asthma were among the highest in the nation, and mortality from chronic disease also exceeded the national average. The area was also noted for its wide health disparities by race and socioeconomic status. The Louisiana was ranked by the United Health Foundation in the bottom three states in the nation each year from 1990 to 2005 in terms of the overall health of the population.

**Consensus on a Patient-Centered, Prevention-Oriented, Community-Based Health Care System**

Health policy planning for a redesigned health sector began as early as October 2005, when a broad group of stakeholders came together under the leadership of the U.S. Public Health Service. A series of other planning entities carried the concepts forward, further elucidating key elements and taking into consideration the needed changes in financing to support a redesign of the health sector. The vision and goals were based on strong evidence and focused on the need to move away from a hospital-centered safety-net model to a distributed primary care system. Communities served by systems anchored by primary care provision have better health outcomes, reduced disparities in health, better efficiency, and lower cost.\textsuperscript{17} The major recommendations from the final blue print of the Louisiana Health Care Redesign Collaborative included the following:

- Redesign health care delivery to create “medical homes” as its foundation.
- Adopt interoperable, standards-based technology to support practices aimed at reducing waste and improving safety and quality
- Create the Louisiana Health Care Quality Forum to convene payers, providers, consumers, and businesses with the goal of implementing strategies to improve health care quality.
—Ensure meaningful choice by expanding insurance coverage through increased public and private funding.

**Community Engagement and Funding to Build Community Health Capacity**

Progress in realizing this vision of community-based infrastructure for community health care has been dramatic, and its success rests largely in the grassroots efforts that started just after Katrina in the very early days of rescue and recovery. A series of makeshift care sites cropped up across the greater New Orleans region, established by volunteers to meet the needs of those who were not evacuated, those who returned quickly, and first responders. The volunteers began with meager resources, practicing basic urgent care wherever they were needed, in tents, mobile vans, and borrowed buildings—wherever they could find space. They worked without power, potable water, or sewerage. Over time, some of the sites evolved into permanent facilities that were independently operated by a broad range of academic, government, and faith-based organizations, and some became federally qualified health centers and free clinics. This volunteer disaster response created the foundation for a new community health care network that is now an important source of care for a population that historically had relied on the public hospital and emergency rooms for primary care.

Initially, the operations of the community health care sites were largely supported by volunteers and private philanthropy. The sites received their first significant support from an emergency social service block grant to Louisiana from the U.S. Department of Health and Human Services Department of Administration for Children and Families, which contributed $21.7 million of the $220 million received by the state for providing primary care and mental health services to the greater New Orleans region. That financial infusion was enough to maintain necessary care for the population for a year while the policy efforts continued and the design of a more sustainable financing system could be completed. Immediately following issuance of the Louisiana Health Care Redesign Collaborative report, the state of Louisiana requested a waiver to allow flexibility in the use of Medicaid disproportionate share funds to support expansion of coverage as well as gap coverage for the community health network. Negotiations between the state and federal government on the proposed changes then fell apart.
When the state government’s plans for health care financing were unsuccessful, the community of providers worked collaboratively to secure other sources of funding while long-term financing could be structured. Community health providers jointly testified at a hearing of the House Oversight and Investigations Subcommittee of the Energy and Commerce Committee of Congress in March 2007. During that hearing, providers requested the allocation of $100 million to support community health care for the uninsured in the greater New Orleans area. Providers also asked for workforce development support and a partnership with the federal government to ensure responsible use of the funds and to work toward sustainability.

In May 2007, following the hearing, the U.S. Department of Health and Human Services (HHS) established a special grant program to allocate $100 million to support the community health network and allow continued expansion to meet the population’s needs. That primary care access and stabilization grant (PCASG) was awarded to the Louisiana Department of Health and Hospitals to support the development and operation of a community-based care network providing primary care.
Karen DeSalvo

and behavioral health services. The Louisiana Public Health Institute served as the local administrator and worked with the community and providers to create an innovative model of delivery supported by a new payment method that enabled the rapid development of a high-quality, affordable, patient-centered network. All providers who shared a
common mission to maintain an open door policy, offering access to services for patients regardless of their ability to pay, were eligible to participate, thus establishing an inclusive approach to the development of the primary care network.

The PCASG funding was intended to act as bridge financing until coverage expansion could be enacted in Louisiana. However, in spite of aggressive activity to achieve that goal, a program was never implemented. With funding for the network of community clinics ending, the federal and state governments acted to protect the important new infrastructure not only because it was considered an innovative model but because its capacity would be needed when coverage was expanded under the Affordable Care Act. To protect the community health infrastructure, in the fall of 2010, the state and federal governments, with significant input from local government and community leaders, negotiated a solution to allow traditional hospital financing to be redirected to support the care of the uninsured in the new community health care sites. The financing provides a bridge until 2014, when health care coverage will be increased through expansion of Medicaid or the private insurance exchange.

Concurrent with the $100 million grant for primary care, HHS also provided $35 million in funding to expand and retain the primary care and mental health workforce to support the community health care sites. The resulting organization, called the Greater New Orleans Health Services Corps, was given an additional boost by a $35 million professional workforce supply grant. This program allowed organizations to provide incentives to recruit health workers back to the area. It built on a $15 million professional workforce grant program funded in March 2006 to bolster the numbers of the health care workforce, which was reduced by the storm. These programs have successfully recruited and retained hundreds of primary care and mental health clinicians, and they have been critical to the successful development of the community health network.

**Innovations in the Community Health Care Model**

The community health centers are remarkable not only for the speed with which they were developed following the catastrophe of Katrina and the intense community input in their development. They are considered innovative by national thought leaders because of their implementation of key health care delivery elements, including the patient-centered medical home model; integration of primary care and mental health services; a
balance of competition and cooperation between providers; and a flexible payment method.

The successful implementation and continuation of the model can be attributed largely to the flexible payment method. Since inception, providers have been paid a prospective, multi-month payment that was risk adjusted for patient age and gender and type of service (primary care or mental health) provided for the entire population of patients linked to the clinic. That allowed for stable budgets and allowed the providers to develop cost-effective models focused on serving their population as a whole rather than the individual patient who presented at the clinic. The limited risk-adjustment method used in the program encouraged network providers to take on those with higher risk. Also, the payment structure supported team-based care, allowing providers to include social workers and provide legal assistance and other enabling services, such as health education and support for patients referred for services outside of the primary care medical home (PCMH), to assist the population served in achieving better health outcomes.

On the basis of lessons learned from this model, the state Medicaid program is moving ahead with supplemental payments for medical home status through its traditional and newly emerging managed Medicaid programs. In addition, the major commercial player in Louisiana, Blue Cross/Blue Shield (BCBSLA), stepped forward in autumn of 2010 to recognize the network’s innovative service delivery system and began providing incentive payments to providers who achieve recognition as patient-centered medical homes, including the newly developed community health sites. All of these payment methods and incentive programs are moving away from the volume-based models to support instead the quality of care and the medical home model implemented by community health providers. The broadening of the new payment system will mean sustainability for the local community health centers.

**Evaluation and Outcomes:**

**Quality, Accessible Care for Low-Income Patients**

The newly developed community health network has been regarded as a success at both the local and national levels and by external evaluation. Early assessments—which include reviews of access to care, quality of care, patient experience, and cost-effectiveness—show promising results.
The network has met the goal of increasing access to care. Since data collection began in September 2007 until September 2010, there was a dramatic increase in community health providers’ capacity to provide care for the population, with a 25 percent increase in the number of sites available. At the peak, the network included ninety-three care sites in the four-parish area of greater New Orleans (see figure 4-1). The sites vary in the comprehensiveness of the care offered, the services available on site, and staffing and structure. Together, they represent an innovative approach to filling geographic and other gaps in care using techniques such as mobile medical units, school health centers, and faith-based programs for mental health.24

The number of patients seen at the sites also has grown steadily since the program began. According to data from the Louisiana Public Health Institute, between September 2007 and September 2010, more than 329,320 individuals have sought care at one of the sites.25 An important point is that this newly emerged community health network is serving the minority, low-income, and uninsured population most likely to lack access to care.
adequate health care and to have health problems (see table 4-1). This is a critical success for the community health clinics because they were designed to serve as a safety net to provide care for the most vulnerable and for those who received care through the public hospital system before Hurricane Katrina. The respondents to the Commonwealth Fund Evaluation survey had a higher burden of medical illness than the average

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number (percent)</th>
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<tbody>
<tr>
<td>Total population</td>
<td>329,320 (100)</td>
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<tr>
<td>Age</td>
<td></td>
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<tr>
<td>0–18 years</td>
<td>113,681 (34.5)</td>
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<tr>
<td>19–64 years</td>
<td>204,197 (62.0)</td>
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<tr>
<td>65 years and older</td>
<td>10,953 (3.3)</td>
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<tr>
<td>Gender</td>
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<tr>
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<tr>
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<td>150,294 (45.6)</td>
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<td>Race</td>
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<tr>
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<tr>
<td>Uninsured</td>
<td>149,376 (45.4)</td>
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<tr>
<td>Medicaid</td>
<td>79,778 (24.2)</td>
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<tr>
<td>Medicare</td>
<td>9,557 (2.9)</td>
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<tr>
<td>Commercial</td>
<td>49,493 (15.3)</td>
</tr>
<tr>
<td>More than one insurer</td>
<td>37,008 (11.2)</td>
</tr>
</tbody>
</table>

Source: Maria Ludwick, Louisiana Public Health Institute, internal data, on file with author. Adapted with permission.

* Totals may not all add up to 329,320 or 100 percent due to missing information.
American, but less than one-third of survey respondents reported that they went without needed health care because of cost. The national figure, in contrast, was 41 percent of adults.

Community surveys performed by the Kaiser Family Foundation in 2006 and 2010 did not target health center users but did ask questions about access to them. Their findings demonstrate that more people reported having a usual source of care other than the emergency room (73 percent, up from 66 percent); more people reported having a clinic in their neighborhood that offered free or reduced-price care (32 percent, up from 14 percent in 2008); and more people reported having used such a clinic (12 percent, up from 4 percent in 2008).

**Quality**

These care sites are recognized for their quality by the National Committee for Quality Assurance (NCQA), a national entity that recognizes quality primary care that employs evidence-based medicine, ensures good access to care, uses a population health approach, and coordinates care for patients. As of 2010, thirty-seven of the community health sites had been recognized. A payment program that was part of the overall PCASG program gave bonus payments to providers who achieved recognition as a PCMH dramatically facilitated the clinics’ achievement of that status. In March 2010, the PCASG participating organizations—the Louisiana Public Health Institute and the Louisiana Health Care Quality Forum—received one of the NCQA’s annual health quality awards in recognition of their work in building a high-quality primary care and behavioral health care network.

**Patient Experience**

The Commonwealth Survey of community health center users also assessed patient experience. Seventy-four percent of New Orleans community clinic respondents reported confidence in the quality of their care; in contrast, only 39 percent of adults nationwide did so. Forty percent had an “excellent” experience; 90 percent reported better access to care; and 75 percent reported excellent patient-clinician communications.

**Cost-Effectiveness**

The PCASG program has been regarded as both fiscally responsible and successful in developing a high-quality, cost-effective, and innovative health care foundation for the greater New Orleans area. Two reports...
on the program by the U.S. Government Accountability Office found that funding is responsibly used and that the program is achieving its original goals.\textsuperscript{33}

An ongoing outcome evaluation of PCASG funding being conducted by the University of California at San Francisco is to be completed in 2011. This evaluation will give better information about the cost-effectiveness of services provided across the continuum of care. However, half of the population served is uninsured, and it will be impossible to accurately track its use of the health system in the absence of a unique identifying number. Nonetheless, the per-person cost to provide care for the nearly 150,000 uninsured patients seen each year is approximately $223. Assuming that 25 percent of those individuals would have visited the emergency room once annually, at an average cost of $1,000 for an emergency room visit, the program saved $112,032,000. The return on investment was safely $12 million.

\textit{Coordination and Integration of Health Services}

The health centers also are moving toward other structural changes aimed at improving efficiency and opening up opportunities for funding besides insurance payments. The organizations have developed alliances aimed at coordinating services and reducing redundancy. Part of the impetus for that is the recognition that horizontal links—including support for patients with complex or chronic conditions and those with mental health challenges—can improve efficiency and patient care. They have established a formal consortium to improve their collective effectiveness and to work cooperatively toward sustainability. The new organization, 504HealthNet, which currently includes seventeen of the new community health safety-net providers that have emerged since Hurricane Katrina, represents the majority of care providers in the community health safety net. Individually, these medical homes provide sophisticated, high-quality care, but they need to be integrated with one another and with the larger health system to optimize outcomes.\textsuperscript{34} Integration becomes especially important as the broader New Orleans health care infrastructure is rebuilt with the investment of more than 1 billion dollars for a new public hospital, a hospital in New Orleans East, and a facility in St. Bernard Parish. The focus should remain on the care of the broader population, with efficiencies gained through shared planning, coordination of services, and quality programs. Added funding and technical infrastructure
support for programs that integrate services horizontally and vertically will continue to be needed to support this network.

**Implications for Future Policy**

The development of the new distributed primary care network as the foundation for the redesigned health care system for post-Katrina New Orleans has been swift, but the security of the network and innovations remains a challenge. Although some of the challenges are specific to the policy framework of Louisiana, others are common to other areas of the United States and to the world. Sustaining this investment and its continuing evolution will require ongoing payment policy innovations by government and private payers as well as broadening of the definition of FQHCs and workforce training to prepare skilled medical home teams.

**Need for Sustained Gap Funding for the Primary Care Safety Net in the United States**

The ideal long-term revenue stream will mirror those of the most robust community health networks and will be a mix of public and private funds, including gap funding for the care of uninsured individuals. Significant gap funding is needed for the community health providers in the network until 2014, when health reform legislation is expected to take effect, extending insurance coverage to an estimated 80 percent of the population. Health care centers in the safety net, like those in New Orleans, will continue to need ongoing gap funding because under the current federal framework, the Affordable Care Act, there will still be substantial numbers of uninsured and underinsured people who will rely on the centers for care.\(^{35}\) In addition, the centers will care for patients with greater medical and social needs, which require resources in addition to those provided by typical reimbursements. Enhanced funding to care for such high-risk populations will be an ongoing need for health centers, just as it is for hospitals.

A number of health care centers are moving toward recognition as federally qualified health centers, since historically that is the major tool available to the state and federal government to provide additional funding and structural support to the low-income, socioeconomically disadvantaged, and working poor population. Such health centers can
be an invaluable resource in the wake of disaster. Of the current community health centers, only a limited number have obtained the FQHC designation, reflecting the larger picture in Louisiana. Competition is intense for FQHC grants. Unfortunately, some of the major providers in the network of community health primary care providers are ineligible under current rules, and others are so new that they are not able to meet the many requirements. Both federal and state support for this transition will be needed; such support could include technical assistance and operational support through enhanced reimbursement to providers in this valuable network.

**Workforce Development**

The local policy efforts aimed at addressing the historical shortage of primary care and community health professionals have largely been successful, although shortages persist. As in much of the nation, ongoing loan repayment programs aimed at recruiting and retaining community health professions will be essential. In addition, expansion of health professional training in the community health setting may help to pique interest in community health as a career. Federal programs called for in the Affordable Care Act, such as teaching health centers, may help to improve interest and provide opportunities to expose physicians to community health practice. The collaborative nature of the network in New Orleans, particularly between academia and community organizations, means that a number of the providers in the New Orleans network may meet eligibility criteria for this program.

**Conclusion**

Even with only early results, the network has been called a model for the nation because it has demonstrated success in developing patient-centered medical home facilities, integrating primary care and mental health services, and creating new payment models to support team-based, innovative primary care services. In addition, it has integrated workforce training and research, expanding economic opportunity and innovation in real world settings. Perhaps most significant, it has demonstrated itself to be a reliable mechanism for rapidly expanding capacity to provide primary care services for uninsured populations in a cost-effective and high-quality manner—something the entire nation will need to meet the expectations of health reform.
The Rise of Community Centers

Following the flooding of New Orleans and surrounding parishes, a unique convergence of community and policy efforts resulted in an empowered and forward-thinking health sector reform movement that has lead to transformational change. What had been the most ineffective health care system in the United States has become one that can serve as a model for others. The system has expanded from one that had only a single major safety-net primary care provider to a collaborative of more than twenty-five organizations that serve the community. The care provided within the system is better than that available before Katrina; more important, patients receiving care report better care than the average American. This health network is demonstrating innovations including team-based care; successful integration of mental health and primary care services; attention to nonmedical aspects of health status, such as housing and literacy; and new ways to pay for primary care. From the devastation of Hurricane Katrina, a model of community health care has emerged for the nation.

Notes


4. Louisiana State University Public Policy Lab, “Louisiana Health Insurance Survey 2005.”


6. Katherine Baicker and Amitabh Chandra, “Medicare Spending, the Physician Workforce, and Beneficiaries’ Quality of Care,” Health Affairs 7 (2004).

9. Ibid.
13. Rudowitz and others, “Health Care in New Orleans before and after Hurricane Katrina.
16. Rudowitz and others, “Health Care in New Orleans before and after Hurricane Katrina.
24. “Greater New Orleans Community Health,” Louisiana Public Health Institute (www.gnocommunity.org)
The Rise of Community Centers

25. Maria Ludwick, Louisiana Public Health Institute, internal data, on file with author.
28. Kaiser Family Foundation, “New Orleans Three Years after the Storm.”
32. Doty, “Coming out of Crisis.”