TESTIMONY OF KIM BOYLE

HEALTH CARE COMMITTEE CHAIRWOMAN

OF THE

LOUISIANA RECOVERY AUTHORITY

BEFORE THE

U.S. SENATE AD HOC SUBCOMMITTEE ON DISASTER RECOVERY

December 3, 2007

Good afternoon. I am Kim Boyle, a native New Orleanian who evacuated to Houston in advance of Hurricane Katrina. I am also the Chair of the Louisiana Recovery Authority's Health Care Committee. On behalf of the citizens of Louisiana and the LRA, I want to thank the members of this committee for continuing to pursue solutions to the problems that have plagued hurricane evacuees, and in this case, the cities that took them in, over the past two and a half years. I also want to thank the people and communities across America that welcomed us, the newly homeless and heartbroken, into their towns, into their schools and hospitals and into their lives.

Being forced to evacuate, I saw people struggle, not only to find a secure place to land, but also to retain their physical and mental health in the process. There is no doubt that catastrophes such as Katrina and Rita will occur again. We owe it to ourselves, the victims of this catastrophe, and the American people to ensure that our future response is different.

I was lucky. My situation and that of those closest to me was very different from that of many other people. While hundreds of thousands of Louisianans were evacuated to points unknown, many of them without kin, I was fortunate to land in Houston, a familiar place where we already had family. And I evacuated with my parents.

My elderly parents were not alone, as so many of our senior citizens were. And they left New Orleans prepared. They had a list of their medications and information about their conditions and doctors. Thanks to recommendations from family members in Houston, they were able to find good doctors. Their care was seamless. They had their prescriptions through a national drug store, so they were able to access information about their medicines electronically. While they were understandably anxious about their home and loved ones, they had the peace of mind in knowing that their medical needs were being met. For that, we were all grateful.

As the chairman of the Health Care Committee of Mayor Ray Nagin's Bring New Orleans Back Commission, which was formed right after the storms, and an active participant in health care reform panels through the LRA and other entities, I have given a great deal of thought to the manner in which we addressed human needs after the storms. Some of them we were able to employ in this catastrophe. Others occurred too late if at all. There are plenty of lessons for all of us.

I'll begin with the successes.

<u>Online Access to Pharmaceutical Records</u>
Because it was so critical that doctors and pharmacists were able to access information about the prescription drugs an evacuee took before fleeing his or her home, the Louisiana Department of Health and Hospitals (DHH) established KatrinaHealth.org, a free, secure online service for authorized medical providers.

This was beneficial to patients who were displaced, but it also helped displaced doctors or pharmacists, who were able to use KatrinaHealth.org to access their own patients' files and obtain information about prescriptions they had written or filled previously.

Emergency Prescription Drugs for Hurricane Evacuees

The Louisiana Board of Pharmacy and DHH arranged for Hurricane Katrina evacuees without financial means to fill prescriptions at any Wal-Mart, CVS, Rite Aid, Walgreen's or Kroger's pharmacy in Louisiana or throughout the country to have their prescriptions filled based on patients' emergency needs.

Recruitment of Displaced Nurses, Physicians and Health Care Providers to Fill Critical Needs

In an effort to alleviate overburdened health clinic and hospital staffs, DHH's Med Job Louisiana established a hotline for displaced medical personnel and others seeking employment. Health care organizations with staffing needs were also able to use the hotline to provide information about available practice opportunities.

Ensuring Access to Children's Medical Records, Vaccinations

DHH offered birth cards (small versions of birth certificates) at no cost to evacuees and their children through parish health units and clerk of court offices.

Additionally, the state temporarily waived the requirement for parents to present their children's immunization records to enroll them in schools. DHH used its internal LINKS system to track immunizations records and shared that information with the appropriate education officials.

Also, under approval from CDC, the LA DHH-Office of Public Health Immunization Program declared all children ages 0 through 18 years who were displaced by the hurricanes to effectively be uninsured, therefore allowing providers to immunize these children using vaccine from the Vaccine for Children program (VFC). VFC providers were able to establish the child's eligibility merely by asking the parent or guardian whether the child was displaced as a result of Hurricane Katrina. No proof of insurance was required. This allowance for the use of VFC vaccine was for all displaced children ages 0-18, regardless of whether they were staying at shelters, hotels, or with family and friends.

Implemented and Coordinated Health Care Volunteer Effort

DHH established a mechanism for accepting offers of assistance from medical professionals and for deploying volunteers.

Waiving of Licensing Requirements for Out-of-State Medical Professionals

Governor Blanco issued an executive order to allow out-of-state doctors and other licensed medical professionals to provide emergency services to patients.

Established Regional Response Teams to Treat Evacuees

In an effort to address social services needs of evacuees, DHH established two response teams in each of the regions housing evacuees -- the Baton Rouge, Houma/Thibodaux, Lafayette, Lake Charles, Alexandria, Shreveport and Monroe areas. The teams, comprised of four members each, went to shelters and other areas to communicate with evacuees and first responders to assess their needs. The teams each had a social worker, psychiatric worker, addictions counselor and registered nurse. They worked 24 hours, seven days a week to refer people recovering from the aftermath of Hurricane Katrina to services in the region where they were residing so they could receive treatment. The teams also offered on-site counseling.

On the human services side, one of the biggest achievements after the storms was also home grown.

Created the Louisiana Family Recovery Corps
Governor Kathleen Babineaux Blanco created the Louisiana Family Recovery Corps shortly after the storms to address the needs of displaced families. An independent nonprofit, the LFRC has served thousands of families who otherwise could have fallen through the cracks. The irony is that it almost didn't get funded. A state application for funding was denied by FEMA, but the agency has benefited from TANF and SSBG funding. And this past year, the Louisiana Legislature approved an administrative budget for the Recovery Corps, meaning that it was able to continue critical programs for hurricane-impacted families by offering one-time assistance for household needs and providing vital recovery information to residents displaced out-of-state.

Unfortunately, what we primarily learned after the storms was that our nation was woefully ill-prepared to handle the physical and mental health crisis of a catastrophe of this scale. I will separate the issues into two sections: health care and the delivery of human services.

Ensuring Adequate Medical Care in Host Communities

As in many other areas of hurricane recovery, the problems with health care began with the law that governs FEMA’s response after a disaster: the Stafford Act.

It’s one of the reasons the LRA is calling for an all-out reform of the law.

The Stafford Act should be amended to create a “catastrophic annex” which would trigger certain immediate actions in the aftermath of a catastrophe. Such a reform would have a profound impact on the health care response in future catastrophes.

These actions should, at minimum, include:

- **Automatic 100 percent cost share for Medicaid for evacuees displaced because of a catastrophe.** After Katrina and Rita, we waited until December 2005 for an act of Congress to give the federal government the authority to waive

Louisiana's cost share. Without this waiver, Louisiana Medicaid would have been placed in dire financial circumstances.

- **The creation of an uncompensated care program with clear eligibility guidelines for providers of health care services to uninsured victims of the catastrophe.** Congress appropriated $120 million in uncompensated care dollars for this purpose in December of 2005, but the delay caused some uninsured victims to be denied access to health care services because providers could no longer act as Good Samaritans without a formal commitment that they would be reimbursed for treating these uninsured patients. Further, in the absence of clear guidelines for eligibility and reporting by providers, many providers lost out on compensation for reimbursable expenses because they were not able to meet unique eligibility requirements of the program.

- **A provision allowing for the delivery of mental health treatment services in addition to basic crisis counseling.** In a mega-disaster such as Katrina and Rita, basic mental health services should be expanded to allow for the diagnosis and treatment of mental disorders that may surface as a result of pre-existing mental conditions, or prolonged exposure to adverse circumstances. Some of these include high levels of anxiety, clinical depression, trauma-related disorders, developmentally-related childhood conditions and failure-to-thrive situations with older adults for whom the future seems bleak. .

In addition to reforms to the Stafford Act, there is a strong need for flexibility in using Disproportionate Share Hospital (DSH) funds to cover uncompensated care services outside of the hospital setting and assistance in dealing with the unique strain placed on the state's graduate medical education programs because of the destruction or displacement of its two major teaching facilities in New Orleans.

Funding for General Health Care Services

In the wake of Hurricane Katrina, Congress provided $2 billion in the December 30, 2005 Deficit Reduction Act (DRA) to support host communities nationwide in providing health care services to displaced Katrina victims. The DRA funds and the related Medicaid demonstration waiver showed a welcome recognition of the fact that the effects of natural disasters are not confined to physical destruction in a given geographic region. The resulting allocation of nearly $700 million to the Louisiana Medicaid program to pay 100% of the costs of services to displaced victims, combined with the allocation of an additional $120 million for uncompensated services delivered by private providers around Louisiana, allowed the continuation of health care services to the most vulnerable storm victims in the months following the storm.

However, as important as these DRA funds were to ensuring access to care for displaced Louisiana residents, they were far too late in coming, a mistake that cannot be repeated.

We should be able to provide critical services to catastrophe victims without passing unique legislation.

For weeks, beginning shortly after the storm, officials from Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health & Human Services (HHS) declared a bold intent to pay the Medicaid and uncompensated care costs for victims of Katrina scattered to all corners of the country. The only problem was that CMS didn't have the statutory authority to make it happen.

The DRA carried the funding and authority necessary for CMS to follow through on its proposal, but by the time the bill was enacted four months after the storm, uninsured evacuees were starting to be turned away from critical care by providers whose initial Good Samaritan instincts were impacted by the realities of business and the necessity of compensation for services.

Even when the bill did pass, giving providers a sense of comfort that they would be compensated eventually, the problem was far from resolved. Only then was CMS able to initiate the program design work that laid the administrative basis for paying providers. Creating a unique program requires weeks, if not months, of regulatory processes. Certainly, the unique circumstances of every catastrophe require a program tailored to the specific situation, but this design process should be triggered in the first days following a disaster, not initiated more than four months later.

Compounding providers' concerns over administrative delays was the fact that CMS had to design the program from scratch. The ad hoc nature of the program resulted in confusion among providers about data requirements. Specifically, they were given non-traditional, patient-specific data requirements that were difficult to meet in the disaster's frenzied aftermath, eventually resulting in significant reimbursement denials that made the program far less effective than it might have been were it a standard post-disaster program.

In the absence of the DRA an even more catastrophic state decision to roll back Medicaid payments and authorized services would have taken effect. Prior to DRA passage, Louisiana expected to shoulder the full burden of Medicaid match for an expanded population of victims scattered nationwide, a burden that was growing unmanageably large before Congress acted to fully fund those Medicaid services.

Congress must act to prevent such uncertainty in access to care for future disaster victims. Providers will be more willing to provide uncompensated care if they have a clear understanding of the requirements to qualify for reimbursement, even if those eligibility requirements differ from normal reimbursement processes. Certainly, we can reasonably rely on Good Samaritans to offer services to victims in the immediate aftermath, but when the disruption to victims' lives is as prolonged as it was after Katrina and Rita and the volume of victims is as large as it was after Katrina (meaning the burden on welcoming providers is quite large), the federal government must standardize the means through which all victims can access and pay for their health care.

DSH Funding Flexibility

As important as the DRA funds were, they were time-limited and no longer provide for access to care for patients without the ability to pay. To address the access issue for uninsured patients, the state is pursuing flexibility to use its existing Disproportionate Share Hospital (DSH) funds to cover uncompensated care services outside of the hospital setting. Specifically, the state again requests that section 1902(a)(13)(A) be waived to permit the use of DSH for payments for non-hospital and physician services provided to the uninsured. This is particularly relevant to provision of specialty physician services.

The state has been informed by CMS that flexibility in the use of DSH funds will only be considered in the scope of a larger waiver request that ultimately shifts DSH funds to the purchase of insurance for uninsured individuals. Although coverage is a desirable goal, the state has done extensive analysis of this proposal and has concluded that there are insufficient funds in the DSH program to adequately cover the target population. Using the funds in a more flexible manner is a budget neutral solution that would allow the state to support physician and non-hospital (e.g., clinics) services and support the ultimate redesign of the health care system. Currently, the state is criticized for supporting a centralized, institutional-based system of care. However, federal DSH rules dictate this. The rule, which is waivable, results in more patients relying on emergency rooms for nonemergent care. DSH funds require a state match and have a cap on federal funds. This change in rule interpretation would allow us to provide greater access to care for displaced victims outside of institutional settings, with no additional federal funding that is not already available to the state today.

Financial Strains on Community Hospitals

Hospitals in the disaster parishes and surrounding host communities have reported post-disaster cost increases beyond those associated with the provision of uncompensated care. These abnormal costs include various costs of remaining open during and immediately following the disaster, increased labor costs resulting from the severely depleted labor supply in the affected parishes, and increased property and casualty insurance costs coast wide.

The United States Government Accountability Office is currently reviewing hospital financial records to discern their unique post-disaster needs. Depending on the findings of the GAO analysis, expected in early 2008, additional federal action may be necessary to stabilize the health care system in Louisiana.

Mental Health

Madame Chair, one of the most important services that displaced storm victims require, wherever they land after the disaster, is mental health counseling and treatment. In Louisiana, the pre-hurricane mental health infrastructure was overcommitted and inadequate to meet the needs of all those with serious mental illness. The hurricanes only

exacerbated existing problems both by destroying infrastructure, reducing the mental health workforce and creating a new population of people in desperate need of mental health services.

To date, the inpatient and outpatient mental health system is still significantly compromised, requiring major structural repairs as well as strategies for the recruitment and retention of professional and para-professional mental health care providers. It has become clear in the wake of Katrina and Rita that, once again, the Stafford Act fails to fully address an event of catastrophic magnitude, inadequately providing for mental health services for displaced victims.

The basic model in the Stafford Act of normalizing abnormal experiences for the general population is most adequate for the majority of persons who experience a natural disaster. The basic crisis counseling program (CCP) model is limited to sub acute, non-diagnostic interventions.

When a community is faced with a catastrophic event, irrespective of origin, and it results in: (1) high levels of exposure to traumatic material; (2) a recovery process involving rebuilding much of the community infrastructure, including health and mental health resources; and (3) a significantly prolonged reconciliation and recovery process, then the CCP model should have provision for the delivery of mental health treatment services as well.

The current enhancement of the CCP with "Specialized Crisis Counseling Services'" (SCCS) does allow for more organized and focused intervention, utilizing a single-session-solution focused model of intervention, but stops short of allowing for the diagnosis and treatment of mental disorders that may surface as a result of pre-existing mental conditions, or prolonged exposure to very adverse circumstance. Such conditions include high levels of anxiety, clinical depression, and trauma-related disorders, as well as a number of developmentally-related childhood conditions and failure-to-thrive situations with older adults who just want to give up because the future appears so challenging.

In short, I recommend provisions within the Stafford Act that allow for the identification of a disaster incident as catastrophic, triggering provisions for formal outpatient treatment (excluding the cost of medications) of conditions clearly related to exposure and recovery issues associated with the catastrophic event, and for a more comprehensive mental health recovery response. In this case, the length of the Regular Services CCP grant, which is now formally limited to 9 months with the possibility of extensions, automatically would be extended to a three year cycle.

In addition to Stafford Act changes, services for the severely mentally ill can be enhanced statewide if CMS grants the state a waiver of the federal Medicaid Institutions for Mental Disease (IMD) exclusion to allow a stand-alone inpatient psychiatric facility to receive federal match for Medicaid services. This would allow the state to more quickly expand beds for psychiatric services in host communities, as well as in disaster areas.

Graduate Medical Education

The sustainability of the state's health care workforce in years to come will depend on the strength of graduate medical education (GME) programs. In the wake of Hurricane Katrina, many of the state's medical students and residents were displaced from the LSU and Tulane teaching hospitals in New Orleans, landing in hospitals in Baton Rouge, Shreveport and beyond. Unfortunately, the institutions that continue to host residents are not adequately compensated under normal GME rules. Several actions are necessary to ensure sustainability of the current hosting arrangements, and further action should be taken to ensure such residency shifts after future disasters do not face similar problems. Specifically:

1. Financial relief is needed and could be achieved through an extended exemption from the "three year rolling average" for the medical schools and hospitals which stepped forth to assist residency programs post Katrina. HHS advised the state that federal legislation would be required to address the three year rolling average. Estimates from the hospitals place the cost of this at approximately $10 - $15 million over the next four years.

2. On April 7, 2006, CMS issued an Interim Final Rule that provided for continued Medicare financing of medical residents in training programs affected by natural disasters or public health emergencies. The interim final rule was applied retroactively to arrangements between home hospitals in the areas affected by Hurricanes Katrina and Rita that temporarily closed parts of their residency programs and the host hospitals that accepted the displaced residents as well as to future disasters.

   We request that the Interim final rule be extended beyond the current deadline of June 30, 2008. It is our recommendation that it be extended until such time as a new MCLNO is operational, however, it's critical that it be extended until at least June 2009.

3. The GME programs do not have the ability to readily reassign residents in the aftermath of a disaster. The state currently is developing a demonstration proposal to create a process that could be employed in any disaster situation that forces the closure or partial closure of a major teaching hospital or hospitals. This would only apply to residency slots that could not be supported educationally and financially by the impacted hospital. This model, in many ways, follows the model currently being tested in the State of Utah, but the scope of the demonstration would be considerably smaller. This project would provide both flexibility and stability to sponsoring institutions and host hospitals, ensuring accreditation of programs and the necessary financial support to allow host hospitals to open their doors to additional residents.

Portability of Medical Records in Disaster

The majority of Louisiana's 1.2 million citizens who were displaced due to Hurricane Katrina lost access to their physicians as well as their medical records. Recognizing the enormous challenge this presented, shortly after the storm, the DHHS Office of the National Coordinator (ONC) committed $3.7 million to Louisiana to develop an electronic health information exchange (HIE) to recover and recreate electronic medical records.

Through this contract between ONC and DHH, a prototype of a statewide HIE was developed. This prototype demonstrated the ability to collect critical medical information for Louisiana citizens into a database that could be accessed in the event of another disaster. In addition, it demonstrated the utility of having the ability to share electronic information in the day-to-day care of patients. Governor Blanco and the legislature subsequently committed $53 million to strengthen this aggressive health information technology agenda.

These funds will build upon the federal funding from the ONC as well as a $350,000 contract from DHHS/ONC and the Agency for Healthcare Quality and Research for work on Louisiana's Health Information Security and Privacy Collaborative to further develop the Louisiana HIT agenda. This agenda is focused on creating an interoperable health information system that allows for seamless sharing of electronic information to improve patient safety, improve health care outcomes and increase efficiency in the provision of health care.

Specific plans include:

- Developing regional health information organizations (RHIO) in 3 major regions of the state, including the New Orleans area - $3 million;
- Supporting the adoption of electronic medical records in physicians' offices - $7 million; and
- Promoting the use of electronic medical records systems in rural hospitals - $13 million.

In addition, the Louisiana Legislature appropriated $30 million for the Louisiana State University System Electronic Medical Records adoption. These funds will support the overall state's commitment to health information technology.

Providing Social and Human Services to Evacuees in Host Communities

When looking at the human and social impacts on communities hosting large number of evacuees in the aftermath of the 2005 hurricanes, two challenges stand out: evacuees' access to coordinated services in their new communities and determining who should lead and provide social and human services to these evacuees.

Access to and coordination of services

Displaced citizens have an abundance of complex social and human needs. Some citizens were reliant on such services before the 2005 hurricanes, many were not. The two primary challenges in this realm related to the lack of coordinated services and the lack of access to services. This led to a substantial demand on the infrastructure and capacity on service providers, government entities and churches in host communities.

Coordinated services should incorporate the resources of the federal and state governments in addition to those of local service providers, churches and non-profits.

Accessing appropriate services is complicated in a new locale, albeit in a shelter, trailer village, new apartment or home of a relative. A clear "lesson learned" is the need for wrap-around services to citizens in all types of FEMA housing placements, but most especially for those in FEMA villages. Many residents of FEMA villages lacked personal transportation, limiting their ability to seek out even basic services on their own. Increased public transportation was funded for a limited time in some trailer locations, but once this was discontinued, the residents were increasingly isolated from services and limited by the location of their FEMA housing. Placing individuals in isolated FEMA trailers without access to transportation or other community services is not an acceptable or effective way to serve displaced residents in host communities.

A forthcoming report by the Louisiana Family Recovery Corps (LFRC) indicates citizens in FEMA trailer communities felt less hopeful about the progress of their recovery compared to their counterparts in more permanent housing, such as apartments. Indeed, compared to residents in permanent housing solutions, more trailer residents describe their recovery as not even having begun yet. These findings underscore the need for greater social and human services for citizens in FEMA trailer communities – both to benefit the citizen and reduce the burden on host communities. According to an LSU survey of residents in FEMA trailer parks, an alarming 58 percent of residents showed signs of clinical depression, about eight times the normal rate.

In the immediate future, we need to do the following:

- Share data on clients so that services and case management can assist in transitioning to more permanent housing without a disconnection from needed services. We still lack sufficient data to be able to reach out to our citizens currently undergoing transitions out of trailer parks. We are also losing track of those no longer eligible for services or those that are now being determined ineligible by FEMA. We cannot even ascertain the scope of the problem because of a lack of coordination with FEMA and the State. **This is a problem that can and should be easily solved by mandating that FEMA partner with the State to ensure that these vulnerable citizens are connected to appropriate case management.** We also need clear, advance notice of trailer park closures. The alternative is to have them burden our system of social services in the future further down the pipeline when their situation has deteriorated further or worse

yet, they fall through the cracks entirely. This lack of information also makes it nearly impossible to identify the current and potential future number of citizens who are or will become homeless (or are at risk for homelessness).

- FEMA is good at logistics. That's what they do. They can procure and establish temporary living arrangements more efficiently than most agencies. However, they are not well suited for providing human services and our citizens are not commodities to be treated as inventory. Resources and responsibilities for the well-being and transitioning of the displaced need to be handed off earlier in the process through a coordinated effort between FEMA, HHS, State agencies and non-profit service providers. This will allow a much smoother transition to a more permanent living situation for the displaced where continuity of services can be maintained in a holistic manner to maximize the well-being of our most vulnerable who have suffered incredible disruptions to their lives.

- If FEMA is going to manage the human caseload, the agency must be accountable for ensuring that all of our citizens are appropriately served and accounted for. We need clarity on who can hold FEMA accountable.

In the longer term, we must heed the lessons learned after Katrina and Rita and enact the following changes when serving displaced citizens:

- Place the displaced in existing communities to the best extent possible.

- Where temporary group sites are required, incorporate community spaces in the design and ensure that adequate transportation and comprehensive case management services are readily available. To the extent possible, cluster evacuees with pre-existing relationships, be they family, friend or neighborhood relations, to provide a sense of continuity in community.

- Create partnerships between FEMA and governmental and non-governmental entities to coordinate services.

In addition, to eliminate the burden currently placed on communities still hosting those displaced by the 2005 hurricanes, we must assure a continual and coordinated effort to provide services and support to these citizens. Coordination has diminished to a point that causes difficulty in addressing critical recovery issues.

Delivery of case management and social services

A key question Louisiana faced in 2005 was how case management and social services should be provided and funded after a catastrophic disaster and who should lead these efforts.

Many different models for service delivery were implemented including; a) FEMA-led case management, b) case management and services funded by federal dollars via

Louisiana to the Louisiana Family Recovery Corps (LFRC), a new non-profit established for this purpose established after the storm, c) stand-alone case management provided by various non-profits independently funded, and d) case management funded via a national non-profit (UMCOR) but no funding for direct social services.

Many lessons were learned with each model – for example, federal dollars can be sent via a federal funding stream that is possibly unintentionally too stringent to meet the evolving needs of displaced citizens.

Another lesson learned is that case management services *without* service delivery dollars leads to an unfunded service burden on host communities to provide social and human services. Stand-alone operations via nonprofits likely have the greatest potential to be dynamic and immediately responsive, but many of these local groups faced challenges related to coordination of their work with government entities and funding of this new demand for their services by populations displaced in their communities.

Ultimately, Louisiana found that using federal funding streams governed by strict guidelines and lacking flexibility did not meet the evolving human service needs of citizens displaced after the catastrophe and that overburdening one entity of government with responsibilities outside of their usual expertise hindered evacuees' ability to access critical services.

Conclusion

In the future, we must implement the following changes to ensure clear leadership and proper delivery of medical care, case management and social services following a disaster:

- Amend the Stafford Act to create a "catastrophic annex" which would trigger immediate medical funding and assistance in the aftermath of a catastrophe.

- To address the access issue for uninsured patients, provide more flexibility in the use of Disproportionate Share Hospital (DSH) funds to cover uncompensated care services outside of the hospital setting.

- Grant flexibility at a state and federal level in the use of funding for human and social services and the interpretation of law and policy so that funds can reach those they were intended to serve.

- Capitalize on the strengths and expertise of entities. FEMA has strong logistical capabilities, but less expertise in providing needed human services, such as housing case management. This should be recognized in the planning process so that federal, state, and local partners can coordinate with FEMA early in disaster response to ensure targeted resources get where they are needed.

- Use intermediaries to coordinate the vast range of services from various funding streams so that the needs of displaced individuals can be address holistically.

To improve the situation in communities still hosting the displaced, we need a clear definition of roles and accountability structures put in place for case management and service provision with the goal of moving citizens from transitional housing into permanent housing solutions.

The victims of hurricanes Katrina and Rita were fortunate to have host communities who provided physical, emotional and even spiritual sustenance.

We need to ensure that, when such a catastrophe occurs again, these host communities have the resources they need to adequately address the human toll without placing undue strain on their own populations.