Continuing Mobile Care for Katrina’s Children

Geographic circumstances: I responded as a volunteer to Hurricane Katrina on the Gulf Coast and subsequently returned frequently to provide on-site clinical services and administrative organizational activities.

About the author: I am a community pediatrician and since January 2006 have served as chief medical officer of Children’s Health Fund (CHF), a national not-for-profit organization based in New York that supports a national network of 24 programs that provide comprehensive health care services to medically high-risk children and families. Patients served include the homeless, those who live in rural and urban pockets of the country that lack pediatric providers, and immigrant and postdisaster populations, who face significant barriers to health care. Previously, I served for more than 11 years as medical director of the South Florida Children’s Health Project, a CHF program in Miami-Dade County. My move from south Florida to New York was directly linked to Hurricane Katrina.

Before Hurricane Katrina, most of my days were spent on a 38-ft-long mobile clinic providing a medical home to a largely immigrant and low-income population in south Florida. A dedicated team of nurses, mental health providers, and case managers addressed the medical, mental, and social complexities of our patient population. We delivered well-coordinated and integrated health care services between primary and subspecialty providers as well as related community programs, such as food pantries and domestic violence shelters. Medical students and pediatric/family practice residents worked with us, learning the importance of community pediatrics.

Then, Hurricane Katrina struck. I quickly volunteered to go to the Gulf Coast to provide care to needy children and families in crisis. In fact, 13 of 17 Children’s Health Fund (CHF) programs at the time sent staff and/or mobile clinics to the region, beginning just days after Katrina made landfall. My experience in southern Mississippi left me with these initial impressions:

- the extent and depth of the medical, mental, and social needs in the area were on a level incomparable to anything I had ever witnessed;
- many health care providers in the area before the storm had lost too much professionally and/or personally to be able to continue their practice;
- postdisaster-based health care was provided effectively from the mobile units because of their obvious ability to reach different populations in a timely fashion;
- mobile clinics, stocked with supplies and medications, were able to provide management of chronic and acute medical conditions; and
- staff from the CHF’s national network generally felt more at ease than others working on the mobile clinics; CHF staff was not only accustomed to the space limitation but also more experienced in the
delivery of care to medically underserved populations.

There is an overwhelming amount of physical and emotional stress on the providers in disaster situations. To avoid provider burnout, we set up scheduled debriefings. These frequent sessions proved invaluable in obtaining and sharing information as well as recognizing and responding to staff needs and burnout. During those conversations we noted the serious and almost total lack of communications between the well-meaning individual volunteers and organized governmental and nongovernmental agencies.

After sharing these findings, concerns, and corresponding recommendations with Dr Irwin Redlener, president and co-founder of the CHF, the opportunity arose to take on my chief medical officer role in New York City. Over the next few years, I would spend a significant amount of time in the Gulf Coast; it became my home away from home.

Among my initial responsibilities was oversight of Operation Assist, an initiative designed to support clinical, research, and advocacy efforts related to the effects of the storm. CHF capitalized on the strengths of our national network, area institutions, and agencies involved in relief efforts mainly by opening and maintaining the lines of communication by all interested parties. Critical to the success of Operation Assist was the establishment of 3 clinical programs with our partnering institutions.

The need to establish the 3 programs became clear within the first few weeks after our arrival as we realized that the health care infrastructure had been decimated and would take years, if not decades, to rebuild. Despite the mass exodus of a large segment of the population, those left behind had extensive needs. Thus, 3 mobile clinic programs were established at local institutions: the New Orleans Children’s Health Project at Tulane University School of Medicine; the Baton Rouge Children’s Health Project at Louisiana State University School of Medicine; and the Mississippi Gulf Coast Children’s Health Project at Coastal Family Health Center, a federally qualified health center.

Each of these programs included medical and mental health teams that have since worked in tandem to provide comprehensive medical, mental, and social services to children and families. Services were, and continue to be, provided through the use of mobile clinics that visit community and school sites on a regularly scheduled basis. They serve as enhanced medical homes providing integrated care. Over the years, as populations in need have shifted and grown, the programs have been able to redirect services through the use of mobile clinics and other innovative programs. Leadership at our 3 partnering institutions was and remains critical to the development and sustainability of these programs.

While the New Orleans Children’s Health Project, for example, continues to focus much of its energy on the lower 9th ward, a neighborhood notoriously impacted by the hurricane, it recently expanded services into Plaquemines Parish, a rural and underserved community not only impacted by Hurricane Katrina but also, more recently, by the Deepwater Horizon oil spill. The Baton Rouge Children’s Health Project initially began providing services to those living in Renaissance Village, the infamous trailer park intended to temporarily house children and families left homeless by the storm. However, many families stayed for a year or more and lived in deplorable, crowded, and often frightening conditions, which put children at great risk because they were often exposed to violence and commonly missed school for months because of transportation barriers. Once the park was permanently closed in 2008, the Baton Rouge Children’s Health Project shifted its focus toward East Baton Rouge and partnered with area schools to provide for children who had resided in Renaissance Village and to meet the needs of other children who lacked access to mental health and medical services.

In the Mississippi Gulf Coast Children’s Health Project, the health care team subsequently developed a tele-mental health program that complements the work of its mobile medical and mental health staff and helps the most emotionally affected children access pediatric psychiatrists on a timely basis.

As of December 2010, the 3 Gulf Coast programs had had more than 125 000 patient encounters. Among the biggest challenges in establishing these programs was the recruitment of qualified professionals who were willing and able, despite the hardships, to move to the area along with their families.

There was some initial skepticism about the use of mobile clinics for acute health care delivery, much less as medical homes. However, it soon became clear that a mobile clinic was not only a feasible option but, for many, the only option. Having worked on a mobile clinic for an underserved population for more than 11 years, I had no doubt about the value of this system of delivering care. I predicted that the need would not only continue but would likely grow over the next 5 years, and that is exactly what has transpired.

Under the oversight of Dr David Abramson, director of research at the National Center for Disaster Preparedness, and in collaboration with the CHF, the Gulf Coast Child and Family Health Study was developed. It is a longitudinal cohort study of a representative 1079 randomly sampled households in Louisiana and Mississippi that includes 427 children. The intent was...
to evaluate the impact of Hurricane Katrina on children and their families over years. From the initial set of data collected in January 2006, just 5 months after Hurricane Katrina, through the fourth wave of data collection in 2010 the results have consistently substantiated verbal reports obtained in our debriefing sessions. Children exposed to the disaster are “nearly 5 times as likely as a pre-Katrina cohort to exhibit serious emotional disturbances.”1 Clearly, much work remains to be done.

Clinical and research findings have substantiated CHF’s advocacy efforts for those communities directly affected by Hurricane Katrina, including the specific needs of local and regional institutions that are trying to provide services. We have also been able to draw national attention to how ill prepared we still are in pediatric disaster preparedness and response.

My colleagues from collaborating institutions in the Gulf Coast and I are determined to make sure that the voices of children are heard loud and clear. The message is: Hurricane Katrina came and went, but the emotional, physical, and social effects linger. We have and will testify to local, state, and federal officials. And when, not if, the next hurricane, earthquake, or other disaster comes along, natural or otherwise, we need to be better prepared to take care of our children lest we again bear witness to the most severe consequences of a major disaster falling on the shoulders of those who are most vulnerable.

REFERENCE

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