

BEST PRACTICES

HURRICANE MARIA: A CLINIC RESPONSE TO A SURGE OF DISPLACED PUERTO RICAN PATIENTS

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Most primary care facilities operate at capacity and are therefore unable to respond effectively to a high-volume influx of patients resulting from disaster situations.¹ On September 20, 2017, Hurricane Maria created this type of scenario after it decimated the island of Puerto Rico, including its healthcare infrastructure. A mass displacement of the population began within weeks and continues today, with approximately 14% of the population of Puerto Rico expected to leave by the end of 2019.² Primary care facilities in communities greeting the displaced in the continental United States have since found themselves overwhelmed with new patients and scrambling to figure out how to help.

Fair Haven Community Health Care (FHCHC), a Federally Qualified Health Center in New Haven, Connecticut, was particularly impacted by patient influx following Maria. This was unsurprising for multiple reasons. Because of its large Puerto Rican community, Connecticut was predicted to receive the seventh largest influx of displaced individuals among receiving states, with specific numbers expected to fall between 3,676 and 11,334 in the first year.² Moreover, FHCHC serves one of the largest Puerto Rican neighborhoods in New Haven County, where recent estimates have indicated that Puerto Ricans comprise 24% of the population.³ Finally, the most recent uniform data system (UDS) data for FHCHC indicate that Hispanics make up over 70% of our patient population.

As expected, we began to see significant numbers of new patients from Puerto Rico soon after Maria. Through discussions with staff with ties to Puerto Rico, and survey data, we anticipated significant medical, social, and behavioral health needs. With strong support from senior leadership of the clinic, we formed a multi-disciplinary development team to establish a specialized

clinic for our incoming hurricane-displaced population that consisted of internal medicine and pediatric providers, social workers, a behavioral health provider, administrative staff leadership, and nursing leadership. Its task was to create a pilot based on a set of core principles:

1. **Rapid Access:** displaced individuals seen within a week.
2. **“One Stop Shopping”:** address in the same visit, the expected high prevalence of social, psychological and medical needs.
3. **Team-based care:** logistically coordinating patient visits with three different providers mandated high level teamwork: efficient communication and hand-offs, flexibility allowing real-time triage of patients’ needs, and a consistent team to allow for rapid plan, do, study, act (PDSA) cycles.
4. **Maintenance of access for existing patients:** ensure FHCHC continues to run at full capacity but maintain follow-up and urgent access for all (new and preexisting) patients.

FHCHC was well positioned to rapidly implement the clinic for the displaced Puerto Rican population based on a number of resources:

1. **Patient centered medical home:** FHCHC has robust behavioral health and social work/care management departments. This well-informed staff committed to further developing their expertise around resources specific to the hurricane-displaced population.
2. **Culturally competent care:** with our high baseline proportion of Spanish speaking Hispanic patients, we employ a high proportion of bilingual and bicultural staff with consistent access to interpreters.
3. **Unequivocal support from clinic leadership:** within a

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week of the hurricane, the profound effect on our large Puerto Rican staff and patient population was clear and our executive management team expressed full commitment to a response to support these groups within our scope. This involved IT support in a needs assessment, clinical logistical support in providing space and staffing for the clinic in short timing, and leadership advocacy at the local, state and national level to raise awareness and resources for the displaced population.

4. **Community partnerships: prior to the hurricane FHCHC participated in active partnerships with other community groups and local government officials and leadership. As these organizations and individuals developed their disaster refugee response plans, we were well positioned to work in concert with them with bidirectional referrals.**

A number of key lessons came from our initial experience and rapid PDSA cycles. Top among these was the importance of real-time communication between clinic providers to inform care decisions, help establish rapport with our patients, and prevent repetition in the patient interview. Ideally the co-location of nursing staff, a social worker, and behavioral health and medical providers facilitates warm hand-offs. However, back-up communication methods were also employed: A coordinator to relay information as the team members became available (attending physician during resident clinic, a nursing coordinator otherwise), and a clipboard which “follows” the patient through their visit, providing essential data, such as the date of arrival, insurance status, housing situation, and urgent medical needs.

The logistics of scheduling were consistently our largest challenge,

and standardized clinic workflows often needed to be adjusted or bypassed as a result. A new workflow for our scheduling/phone staff was created to triage the appropriate population. Staff had to be trained to bypass certain processes around insurance and salary verification to reduce barriers and allow rapid access. Generally behavioral health, social work, and medical providers have their own schedules with automated reminder calls to patients, which was also not practical. Finally, time with each provider varied greatly between patients, which created unusual gaps of downtime and rushes in normal scheduling. We addressed this through a combination of mixing in “regular” patient appointments, staggering medical providers’ schedules and blocking some appointments to effectively lengthen the provided appointment time.

Our experience largely matched our expectations. We noted a higher-than-average social services need frequently including food and housing instability, insurance confusion and lapses, and need for winter clothing. There was a high prevalence of mental health diagnoses, notably PTSD and depression, both pre-existing and hurricane-related. There was also acute and chronic medical complexity complicated by abrupt discontinuation of care without access to prior records. We met a great variety of medical needs including diabetic patients without medications, interrupted cancer treatment, and urgent surgical referrals, with the majority of patients seen for interruption of chronic disease management. Our nurses and behavioral health provider used validated questionnaires to screen for PTSD, anxiety, and depression and made many referrals for the evaluation and treatment of pre-existing and hurricane-related concerns. Eventually, our behavioral health provider created a weekly therapy group for those affected by the hurricane. Perhaps

most importantly, our social worker screened and connected the displaced to much needed resources within the community during this first visit to our clinic.

Regarding training, we found that inclusion of residents was not only possible, but also helpful. The new population and rapid development of the new clinic provided learning experiences that were unique. As earlier referenced, having residents see patients also allowed the attending to remain available and thus facilitate warm handoffs and address flow problems. Our residents participated voluntarily when we had the clinic as an extra night session, but it would be equally feasible to have the clinic in place of one of their standard continuity sessions. Residents see fewer patients in a half-day than our clinic attendees, which may make their regular sessions more adaptable to this clinic model.

Looking back on the influx of patients subsequent to hurricane Maria, we feel the model of care we developed was far superior to our standard model. Our standard model would have been overwhelmed by the volume and need, stressing providers and staff and meeting fewer patient needs. Virtually every patient we encountered needed multiple team-member’s services if not all three, especially in the first few months of the crisis. In the unfortunate, if inevitable, situation of a similar disaster and patient influx, we will be pleased and ready to implement it again, and are looking to adapt this model to use with a high risk subpopulation of our existing clinic population.

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