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After the Flood: A Strategic Primary Health Care Plan for Homeless and Migrant Populations During an Environmental Disaster

[Health Care During A Disaster]

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Outline

Abstract

AN ENVIRONMENTAL CRISIS, such as a flood, can significantly affect health care delivery and services in a community.Environmental disasters can be particularly devastating to already vulnerable populations such as the homeless and migrants, who, because of social, political, and economic constraints, experience

special health care needs. In 1993, after Iowa experienced the worst flood in its history, President Clinton declared the entire state a federal disaster area. Later, the Iowa Department of Public Health received a federal grant to evaluate the health care delivered during the flood and develop a strategic plan to enhance primary health care for the homeless and migrant populations during future environmental disasters. The plan was based on data obtained during and after the flood in three critical areas - communication, health care delivery, and community. These areas were themes that emerged from a series of interviews with representatives from health care agencies and clients themselves. Each theme became the focus of specific, comprehensive recommendations and strategies to meet the daily challenges of the homeless and migrants, as well as to enhance the delivery of primary health care services in the future.

Homelessness and the Iowa Flood On April 1, 1993, after days of unrelenting rain, the Mississippi River overflowed. As it ran south, the Mississippi flood its tributaries, the Iowa and Raccoon Rivers, which overflowed in July. The Raccoon River flooded the water plant in the capital city of Des Moines, leaving more than 250,000 residents without water. Many bridges and highways across the state were impassable and closed. Most of the state was at a virtual standstill, and 6,000 residents were left homeless. The public transportation system sustained more than $5 million in damage. Total flood damage in Iowa exceeded $2.7 billion.

The flood only accentuated the problem of *homelessness, which, in Iowa, as in other areas of the United States, was growing at an alarming rate. In figures from the early 1990s, the number of homeless adults and children, representing various religious groups and ethnic backgrounds, was between 250,000 and four million nationally [1]. The Iowa Coalition for the Homeless conducts a census every two years and reports that in 1992 and 1994, the homeless population was approximately 16,000 and 19,000, respectively [2].

Included in the homeless census are migrant laborers, who, because of their transient lifestyle, lack permanent housing. The homeless and migrant populations share economic, political, and societal constraints [3]. Access to health care for both groups is hampered by economic and political forces: the expanding need for health care for the indigent, bureaucratic guidelines for service, and the continuing tendency for certain health care workers to be insensitive and stereotype individual clients.

Migrants, who often do not speak or understand English, tend to have a higher degree of social isolation. The homeless face a constant struggle for daily survival and often have histories of psychiatric disorders and substance abuse in addition to chronic health problems. The rigors of daily living and survival require tremendous coping abilities. Basic needs, such as food, shelter, and clothing, often go unmet. It is understandable, then, that health care is often a matter of low priority, despite the great risk of disease, the prevalence of mental illness, and the presence of chronic health conditions, such as

diabetes, hypertension, and heart disease.

Given the usual stresses of daily living for the homeless and migrant populations, the trauma of an environmental disaster can lead to crisis. The flood that devastated Iowa exacerbated preexisting health care problems and strained the overburdened health care system for the indigent. The waiting time for appointments increased to two to three weeks for routine concerns. Migrants who had arrived in Iowa for seasonal work found themselves without income, housing, or health care access. Wet fields and cramped living conditions increased their risk of fungal infections and tuberculosis.

The director of the Iowa Proteus Migrant Center reported that more than 4,000 migrant farm workers were in the state of Iowa during the flood. Six thousand would normally have been expected during the spring and summer, but 2,000 were diverted because of early notification of the disaster.

The Strategic Planning Process The process of strategic planning requires collaborative input, objectivity, and vision. First, an assessment of the health care community culture was done to determine where health care was and where it needed to be for the homeless and migrants. Next, data for development of the strategic plan were obtained from interviews conducted with representatives of 12 health care agencies and 27 clients. Informants were asked about their perceptions of health care problems experienced during the 1993 flood and possible solutions to such problems.

The 12 agencies consisted of local, county, state, and private organizations, including the American Red Cross, the National Guard, and the United Way. The homeless clients interviewed were individuals living on the streets and in temporary shelters. Because migrants were inaccessible during the time the study was conducted, none were interviewed. Data about migrant workers, however, were provided by the state agency that provides services to migrant populations.

Two self-report interview tools, one for clients and one for agencies, were developed and used by the researcher. Each interview required approximately 20 minutes to complete. Data obtained from the interviews generated three major themes - the need for effective communication, the need for comprehensive health care delivery, and the need for a public presence in the community. These themes provided the foundation for a primary health care plan, specific recommendations, and strategies.

Communication Data from the interviews revealed that communication was a major concern for the agencies. During the flood, each agency acted individually, duplicated resources, and was unaware of the other agencies' roles, responsibilities, and activities.

Each agency distributed information independently without regard for duplication or consistency of information.

Homeless clients stated that they learned of available community resources by "word of mouth" from other homeless clients. They also stated that they "never got the same information or the right information." For example, it was not unusual to arrive at a soup kitchen at noon to find that service was at 11:00 AM, and information about health clinic hours and days of service was frequently inaccurate. Word-of-mouth information was not reliable, accurate, or consistent; therefore, the full range of available resources was not effectively used. Lack of communication among agencies, clients, and the general public hampered the effective and efficient use of resources.

Comprehensive Primary Health Care Delivery Primary health care requires accessibility, coordination, and organization for effective and efficient health care delivery. Health care must be delivered within the context of the client's priority of needs. Homeless clients frequently related their health problems as being inconsequential within the context of homelessness. They reported that "health was not a problem," even though multiple health problems, such as diabetes and heart problems, were found to exist.

As demonstrated by client responses, priorities of the homeless parallel the hierarchy of basic human needs: food, shelter, and clothing. The challenge for health care workers - especially during a disaster - is synergism among resources to meet basic and primary health care needs.

During the 1993 flood, basic needs were met by shelters. Shelters, in coordination with health care agencies, could provide accessible preventive and provisional health care for the homeless and migrant populations.

The Community It is the public health department that establishes a public presence within the community. Communities provide the lived experiences of health care, with the State Department of Public Health the guardian of community health. Agency representatives spoke of "frustration," "not knowing what other agencies were doing," "being repetitive in services," "too much paperwork," and "lack of primary health care direction." Homeless clients, interviewed about their health care needs and asked if they were met, would say, "ask us." This short response validates the notion that an inclusive process is required if an inclusive outcome is to follow.

It also became apparent that there is a need to develop a sense of "community" among agencies, clients, and the public health department to provide the means for clients to become self-empowered. The involvement of clients in proactive solutions to enhance

feelings of "community" should be seen as a resource in providing insightful, effective solutions to their problems.

The Strategic Plan Strategic planning is necessary for the efficient use of resources for long-term, effective primary health care. A strategic plan has been defined as "a unified, comprehensive, and integrated plan that relates the strategic advantages of the firm to challenges of the environment. It is designed to ensure that the basic objectives of the enterprise are achieved through proper execution by the organization" [4]. The planning process involves a critical analysis of what is and a vision of what could be.

The strategic primary health care plan developed in Iowa is a holistic, collaborative, and proactive approach that integrates the daily challenges of the homeless and migrant populations. It is comprehensive, functional, and capable of being revised and updated on a regular basis. Each theme - communication, health care delivery, and community - is addressed through specific recommendations and explicit strategies for action.

Communication

- General Recommendation: Establish local, state, and national communication systems for the storage of data and the dissemination of consistent, reliable health information.

- Strategies:

1. Develop, revise, and continually update a collaborative plan of action for the State Department of Public Health to enhance health care delivery to the homeless and migrant populations of Iowa.

2. Coordinate the development of county health departments' disaster plans to include provisions for homeless and migrant populations.

3. Use the statewide fiber optic network system as a means to access and disseminate information among state, local, and federal agencies. The network also should be used to maintain client records and other relevant client information. All information must be readily available so that required statistical information can be provided to the federal government.

4. Develop multilingual informational brochures, booklets, and/or pamphlets that list community services with addresses and telephone numbers. Distribute these materials in schools, churches, homeless shelters, and other congregative sites.

5. Facilitate the development of a support group to create an avenue for positive

interaction among the homeless and migrants to develop alternative coping behaviors.

6. Establish a disaster communication panel composed of health care providers who will proactively agree on health information to be distributed in the event of an environmental disaster. Information must be written at an appropriate level and updated regularly.

7. Negotiate with the local long distance telephone companies for a specified donation in the form of a debit card. These cards can be made available to the homeless and migrant populations through various agencies. Corporate involvement, such as donations, provides tax benefits to the corporation while adding to community resources.

Health Care Delivery

- General Recommendation: Coordinate, organize, plan, and direct accessible health care delivery with health promotion and illness prevention to homeless and migrant populations.

- Strategies:

1. Maintain an active volunteer list for agency and personnel participation in the delivery of such services as immunizations, primary health care, and client education.

2. Develop a basic health care client information form for documentation of client data during a disaster situation. This strategy will provide uniformity and continuity in record keeping. Several benefits of the form would include: (a) standardization, (b) statistical disaster information, and (c) the ability to have sufficient copies for client, agency, and resource reference lists.

3. Provide, through multiagency collaboration and partnerships, a unification of resources that would include housing, food, clothing, and health care resources.

4. Organize all resources according to community roles, responsibilities, and provisions for service during a disaster situation.

5. Develop an interagency disaster plan to include designated responsibilities.

6. Implement health care incentives by providing transportation vouchers for increased accessibility to health care.

7. Establish a health care consortium with local schools of nursing to provide community health screenings and teaching.

Community

- General Recommendation: Provide an opportunity for active client and agency involvement.

- Strategies:

1. Create a community liaison position or incorporate this position within an already existing job description to bridge the gap between governmental bureaucracy and community action.

2. Create community inclusiveness by facilitating the development of a homeless and migrant newspaper that could be edited, staffed, and distributed by clients.

3. The State Department of Public Health can help to resocialize psychiatric clients into the community by establishing partnerships with churches and resource agencies to develop functional half-way houses. A high percentage of homeless clients have psychiatric problems, and these problems are exacerbated by the effects of homelessness. Half-way houses could serve as shelters, as well as provide appropriate mental health counseling.

4. Actively assist homeless and migrant workers in finding work within the community through a community-established coalition. Agency and client interviews revealed that health-seeking behaviors will be encouraged if self-actualized to meet basic needs.

5. Increase the Department of Public Health's visibility and commitment to health care. A weekly column, written for local newspapers, would provide a public service and improve public relations. During a disaster, this service could be extended through the use of a hotline to provide necessary community information.

6. Evaluate disaster actions according to preestablished criteria based on collaborative holistic client outcomes. The evaluation should include: (a) community accessibility, appropriateness, and effectiveness, (b) consistency of information, and (c) an active feedback mechanism for recommendations.

7. Actively explore the possibility of employing advanced practice nurses and physician assistants as an alternative to physician-provided care.

8. Actively solicit opportunities to speak as homeless and migrant advocates to political organizations, civic organizations, churches, schools, and other aggregate groups.

Preliminary Actions According to the Iowa Department of Public Health (IDPH), a statewide public health communication has been established with initial funding from the Federal Emergency Management Agency. Computers with appropriate software were introduced into public health offices in 99 counties. A software program supplied by the Centers for Disease Control and Prevention has brought about nearly instant communication between IDPH and local offices. This system, used extensively after the flood, allows for consistent and timely information, and helps avoid duplication of services and misinformation.

Some of the proposed strategies are ongoing efforts of IDPH, but many have not been implemented due to jurisdictional limits, funding, or practicality. Others are still under consideration.

Barriers to Health Care Among the Homeless and Migrants

The quantity and quality of health care is less for the homeless than for other populations [5], despite their tendency to have more severe health problems of a crisis nature. The health care needs of the homeless and migrant populations are similar. Their living conditions increase the spread of such communicable diseases as hepatitis, upper respiratory infections, and tuberculosis.

The homeless and migrants have a societal barrier to health care due to their lack of housing permanency [5]. In a study by Roth and Bean [6], participants were asked to prioritize their needs. Housing was listed as the first priority, followed by employment and social support. Mental and physical health were near the bottom of the list.

A study by Hunter et al. [3] reported barriers to health care as perceived by providers. Some results were as follows: 81.7 percent of the health care professionals sampled considered cost of service to be the major problem. Perceived barriers to health care were clients' inability to follow through with care (78.8 percent), lack of funds (69 percent), and lack of a safe place for discharge (69.2 percent). The stigma related to homelessness and facilities' cost-containment policies were mentioned by only a few respondents. Thirty-eight percent of respondents believed homelessness was the result of bad luck and 41 percent believed, given half a chance, the homeless could pull themselves out of their situation. Although respondents basically stated that homeless persons should have equal access to health care services, their personal beliefs were inconsistent [3].

Killion [7] stated that health care professionals perceived the homeless to be worthy or unworthy of certain care services, depending on what they believed caused the homelessness. Quality of care was also linked to the reason for homelessness.

The homeless enter the health care system without immediate goals, active participation in health care programs, or use of available resources. Tollett and Thomas [8] stated that health care professionals view this behavior as indifference and apathy, thereby confirming the notion that these individuals are lazy and choose to be homeless.

What Can Nurses Do? The nursing profession is a visible, caring, and proactive part of society that is dedicated to the advocacy for humanitarian equity in health care. The plight of the homeless and migrant populations can be lessened by the economic, political, social, and health care lobbying of nurse activists. This plan provides a blueprint for nurses in developing a prospective approach for the inclusion of clients with unmet health care needs. As nurses move outside the hospital setting, communication, primary health care delivery, and a sense of community become necessary to establish an interdisciplinary network of resources. It also is important for professional nurses to be actively involved in influencing the philosophical direction of health care by identifying and understanding the social, economic, and political barriers to health care for homeless and migrant populations.

REFERENCES

1. Coogan, D., & Mason, T. (1992). Health screening for the homeless. Nursing Connections, 5(3), 5-8. [CINAHL Link] [Context Link]

2. Molseed, M. (1995, June). Homeless children and families in Iowa: 1994 summary. Report prepared for the state of Iowa in cooperation with Drake University, University of Dubuque, and the Iowa Department of Education. [Context Link]

3. Hunter, J., Getty, C., Kemsley, M., & Skelly, A. (1991). Barriers to providing health care to the homeless: A survey of providers' perceptions. Health Values, 15(5), 3-11. [CINAHL Link] [Context Link]

4. Jaunch, L., & Glueck, W. (1988). Business policy and strategic management (5th ed.). London: McGraw Hill, p. 11. [Context Link]

5. McDonald, D. (1986). Health care and cost containment for the homeless: Curricular implications. Journal of Nursing Education, 25(26), 261-264. [CINAHL Link] [Context Link]

6. Roth, D., & Bean, G. (1986). New perspectives on homelessness: Findings from a statewide epidemiological study. Hospital and Community Psychiatry, 37(7), 712-719. [Context Link]

7. Killion, C. (1995). Special health care needs of homeless pregnant women. Advances in Nursing Science, 18(2), 44-56. [Fulltext Link] [CINAHL Link] [Context Link]