

## **Outreach Activities for Disaster Response Teams**

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Although originally designed to operate from a fixed location, DMATs have long since found the need to be more flexible and work, where the circumstances require, out in the disaster impacted community. Known as *Outreach*, these missions have taken a variety of forms but generally involve taking healthcare to the public when they cannot or will not come to the team's location.

Even with significant destruction to housing and living spaces, people will continue to live in buildings where their personal property remains. In many cases they may be fearful of leaving because of security concerns or because transportation is difficult. Further, many people value their privacy or prefer the familiarity of the areas where they live, and will thus not go to shelters. Despite the variety of medical problems they may be facing, some combination of these factors will result in people who will continue to live in the security of their neighborhoods; therefore, outreach becomes an important mission for the DMAT.

Since the first deployment of a DMAT when there was an unexpected need to support EMS, Outreach has developed in a variety of forms by several different teams. During the deployment to Hurricane Andrew, and shortly thereafter on the Hurricane Iniki deployment, Outreach missions played large and critical roles and became well established as a necessary part of a DMAT's capabilities. With more and more deployments of the DMAT teams, the outreach concept has melded all these types of missions to its current state. Outreach is by no means a static concept, but a dynamic one - always in a state of flux and adjusting to community healthcare needs.

The actual Outreach mission can consist of taking blood pressures, monitoring glucose levels, or following up on postpartum, post surgical and other patients recently discharged from the hospital. A frequent need (or request) may be to provide immunizations - such as tetanus boosters - in the disaster area. Outreach teams can also be very helpful in bringing back "medical intelligence" from areas of the community. When relayed back to the appropriate authorities these reports can resolve issues before they start, or help to begin to address potential healthcare problems. They can serve as a resource to the public health system, especially in the areas of educating the public on hygiene, the disposal of human waste, avoiding the spread of communicable diseases, and vector control.

As described above, Outreach can be done in various ways:

1. Most commonly, Outreach involves going door-to-door in a given neighborhood or geographic area and delivering healthcare. This approach necessitates an evaluation of needs as the team progresses through the area as well as the simultaneous delivery of healthcare.

2. Once specific needs have been identified, Outreach might include delivering medications and other supplies.
3. Checking patients recently discharged from the hospital might also constitute an Outreach mission if patients had follow-up care arranged by a hospital but the collapse of some part of the healthcare system prevents this from being accomplished.
4. Setting up clinics in shelters.

It is important that the Outreach mission be coordinated with the local authorities that can target communities or areas needing the assistance as well as identify specific types of needs and/or provide resources to help accomplish the mission. An example of this might be to take a local resident who knows the neighborhood and streets. This is especially important after disasters where the usual landmarks and street signs may be gone. Community leaders can potentially also identify specific patients at risk, especially the elderly, who may need to be checked on but refuse to leave their homes and possessions. Such advance medical intelligence may also enable the teams to become more efficient, bringing out those medications that the population may need. Specific medications that might not be part of the DMAT basic pharmaceutical load can thus be obtained and distributed.

In addition to asking the basic question, ‘What medical mission is the Outreach to accomplish?’ the DMAT must identify and anticipate outreach logistical requirements. In general these requirements will include the following:

1. Geography/maps: Where are we going and what will it take to cover the designated area?
2. Providers: How many and on how many teams – what provider mix is needed to accomplish the mission without detracting from the DMAT’s base mission (if any)?
3. Transportation and communications.
4. Provisioning the providers – food, water, etc.
5. Medical supply and resupply.
6. Protocols; not only for the medical mission but for referrals – what to do if specific needs are encountered.
7. Safety and security (discussed below).

As these issues are addressed and the Outreach mission is being assembled, training for the selected providers should be accomplished. At a minimum this training should emphasize the purpose and limitations of the mission, the protocols and referral mechanisms mentioned in item (6) above, and safety and security issues.

Of particular importance is the need to educate those providers working outside their normal environment on scene safety. Many non-EMS providers will not generally think through the need to assess a scene for hazards prior to entering or develop escape mechanisms should that need arise. Hazards such as weapons and hazardous materials may be obvious, but other hazards such as building damage or infectious processes may not. While scene safety is of primary importance on a daily basis, its gravity in a disaster-impacted community cannot be over-emphasized.

Appropriate scheduling is also an important element of the outreach mission. Many people, for many reasons, do not like shelters. They are noisy, quarters are cramped, and there is no privacy. Because of this, patients sometimes pack-up their possessions and move to city parks and establish “tent cities.” During the day the population of both tent cities and shelters can be quite small. Often people are out looking for housing, building materials, new jobs, and filling out loan applications. In the evening, however, both tend to swell as the people return from their daytime activities. Because of this, outreach may need to occur in the afternoon or even at night.

Outreach teams can travel by auto, air, or by foot to accomplish their mission. In all cases, the deployment of an outreach team with a security element (local police, National Guard, etc.) should be seriously considered. In addition to providing security that may be crucial in the affected community, they may also aid in distributing items (blankets, water, etc.) or to supply logistic support such as lighting and transportation for large items. Such bulk distribution might include MREs and building supplies that that population may need. In the absence of a security element, outreach at night or in a questionable neighborhood should not be attempted.

One concern that should be addressed in the planning phase is that the delivery of healthcare directly to individuals by outreach teams may be of more quantity and quality than what existed before. As DMATs pull out, it may be difficult for local authorities to maintain this high level of care. The public would happily expect this type of care on a routine basis, much to the chagrin of those charged with providing care after the teams depart.

And finally, some method of accurately counting and recording patient encounters should be developed well in advance of the Outreach effort. Traditional patient care forms used by healthcare organizations and DMATs generally have proven to be too extensive and unwieldy in the Outreach setting. However, the obvious need to capture some minimum data, along with a desire to maintain accurate patient encounter ‘counts’ necessitates some record keeping technique be developed.

In summary, previous deployments have demonstrated that DMATs will almost certainly be called upon to leave the standard fixed clinical environment and provide care out in the community. With adequate planning and preparation such missions can not only be accomplished safely but may allow the team to substantially increase its impact in the disaster area while adding a high degree of provider satisfaction for having done so.