



Introduction

Recent natural disasters prompted the increase and development of emergency preparedness planning across many sectors, including public health and health care. Successful preparation for natural disasters and emergencies requires the participation of a variety of organizations including, state health agencies (SHAs), schools, hospitals, businesses, community health centers (CHCs), as well as individuals, and families. Examples of collaborative activities between SHAs and CHCs include emergency preparedness committee involvement, training, development of operation plans, and participation in statewide exercises. Primary Care Associations (PCAs) often facilitate activities between SHAs and CHCs. This issue brief highlights the value of developing effective partnerships between SHAs and CHCs in preparedness planning.

Background

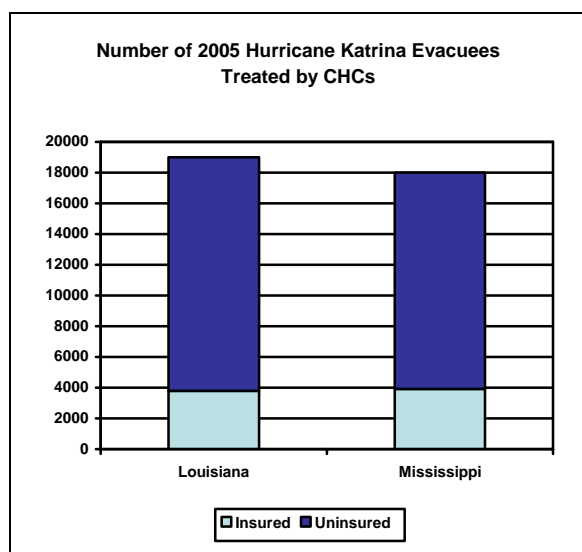
SHAs and CHCs are critical partners in state preparedness planning. In recent years, both have engaged in preparedness planning, but not always with one another. SHA emergency preparedness planning does vary from state to state but common characteristics exist, such as assessment of current emergency preparedness, education and training of personnel, and practice exercises. According to a 2004 survey of ASTHO members, most states have chosen an intrastate regional approach to emergency planning which emphasizes coordination between local health agencies and other partners. Much of the preparedness activities within states are funded by cooperative agreements from the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). In most states, these cooperative agreements are managed by the same program to enhance coordination.¹

CHCs have also engaged in preparedness planning in order to effectively provide care to patients in times of disaster or other emergencies. Common strategies include participation in assessments, drills, and staff training. As of August 2004, 70 percent of all CHCs had developed a disaster plan. In contrast to states, most CHCs do not receive any direct federal funding for preparedness planning. The number of states funding CHCs for disaster planning has been decreasing since 2004; an estimated 20 states planned to distribute disaster planning funds to their CHCs in 2006.²

Why Should State Health Agencies and CHCs Collaborate?

Natural disasters such as Hurricanes Katrina and Rita, have demonstrated the need for seamless partnerships in preparedness planning within each state. CHCs are essential partners in times of disasters, providing health care to individuals regardless of insurance status or ability to pay, and they are a vital component in the nation's healthcare safety net. CHCs serve one in eight uninsured Americans, one in every four Americans in poverty, and one in every nine Americans who live in rural areas.³ Currently, over 1,000 CHCs across the country provide care to more than 15 million individuals. The types of services offered by CHCs vary by site. Primary care, dental, mental health, substance abuse, hearing, vision, and pharmacy services are some of the services that may be available.⁴ In the communities they serve, CHCs provide a safe and consistent place for individuals to access health care.

The importance of CHCs as resources for populations was evident in 2005 after Hurricane Katrina. As shown in the following graph, without the help of CHCs, it is possible that over 35,000 individuals would have gone without needed health care services.⁵



How Do States Engage CHCs in Preparedness Planning?

The level of involvement of CHCs in preparedness planning varies among state health agencies. Below are examples of states actively engaging CHCs in preparedness planning. State primary care associations often serve as the liaison between CHCs and the agencies in emergency preparedness planning activities.

Alabama

The Alabama Department of Public Health (ADPH), the Alabama Primary Health Care Association (APHCA), and the University of South Alabama have developed a solid relationship to coordinate emergency preparedness planning. Committee involvement, funding, and the use of technology are a few of the activities in which the organizations work together. APHCA is represented on the following ADPH-led committees: Emergency Preparedness Advisory Committee, Hospital Preparedness Committee, and Pandemic Influenza Planning Committee. Through grants from CDC and HRSA, ADPH has provided funding to APHCA for emergency preparedness since 2004. Table 1 illustrates the amount of funding and how the funds were used.

Alabama has been awarded two additional HRSA grants for emergency preparedness planning. Based on requirements of the cooperative agreements, generators and satellite dishes have been purchased for 26 of 30 sites.

Funding from APHCA has given the 114 community health centers in Alabama the ability to act as a critical partner to hospitals during a disaster by performing triage and providing non-emergent care, which provides emergency departments the opportunity to care for the most critical patients.

Table 1: Alabama Grant Distribution

Year	\$	APHCA Use of Funds
2004	\$517,690	<ul style="list-style-type: none"> Assess readiness of Federally Qualified Health Centers. Purchase of Southern Linc phones with two-way radios. Install negative pressure rooms.
2005	\$531,000	<ul style="list-style-type: none"> Purchase of personal protective equipment. Purchase of decontamination kits and shower stalls. Monthly fee for Southern Linc phones.
2006	\$200,000	<ul style="list-style-type: none"> Antibiotic purchase and storage for employees, family members, and emergency preparedness workers. Operating support for Southern Linc phones and radios.

In an effort to meet the requirements of Emergency Support Function (ESF) 8, managing both surge capacity and capability, ADPH and APHCA turned to the University of South Alabama to develop a common information sharing system for providers in Alabama. The result was the Alabama Incident Management System (AIMS), which provides real time damage assessment and a profile of available resources and capabilities. Hospitals were the first providers to participate, followed by CHCs, and most recently, nursing homes. During an emergency, AIMS allows organizations to update the number of available beds, site conditions, including damage, as well as identify providers that have the capacity to care for critical and non-critical patients. Hospitals, CHCs, nursing homes, public health clinics, medical need shelters, and Emergency Medical

Services all participate in AIMS. This system is managed by the emergency preparedness coordinator at each CHC and is overseen by the Director of APHCA. The Center for Emergency Preparedness within ADPH is responsible for operating AIMS.

Testing plans is a critical component of emergency planning. Planned testing occurs for AIMS and the Strategic National Stockpile Program several times a year. The Southern Linc phone alert system is tested weekly for CHC response. The baseline CHC response rate was 25 percent, but has increased to 60 percent in recent months. Individual CHCs and APHCA vary their emergency plan exercise schedule.

Other Activities

During Hurricanes Katrina and Rita, a Web-based prescription record system, Katrinahealth.org, was established to retain records for individuals displaced by the hurricanes. Patients who had prescriptions filled at major drug stores such as Walgreens, RiteAid, Wal-Mart, and CVS were merged into a single online record. Over 900,000 patients had records or semi-records following the hurricanes. The site was eventually taken down as the need lessened. A new initiative, by the Gulf Coast IT Task Force, is underway to create a permanent database that will maintain medication histories of patients from Alabama, Florida, Louisiana, Mississippi, and Texas. Once created, *In Case of an Emergency Prescription Database* (ICERX) will help ensure continuity of care in times of disaster or emergency. The Web site, currently under construction, is available at www.icerx.org.

The Poarch Band of Creek Indians Reservation has set an example for preparedness in Alabama. Their emergency response system is responsible for a significant portion of a major thoroughfare, Interstate Highway 65. This group also operates a federally qualified health center and regularly participates in exercises and training offered by CHCs and ADPH. In 2005, the Poarch Band of Creek Indians volunteered to serve as a demonstration site for a large, statewide preparedness exercise which were observed and evaluated by CDC as a grantee requirement. They also are a point of dispensing for the Strategic National Stockpile Program and

manage a medical needs shelter, available to any resident of Alabama otherwise meeting the admission criteria.

Alabama recently passed preparedness legislation regarding medical needs shelters. House Bill 533 designates ADPH as the lead agency to coordinate with other state and local agencies in the development of disaster shelters for those individuals with medical needs and requires state agencies that regulate or contract with organizations that provide care to individuals with disabilities or limitations to include emergency and disaster provisions in their contracts. More information regarding this legislation can be found at <http://alisd.b.legislature.state.al.us/acas/ACASLogin.asp>.

Future Preparedness Planning

Alabama intends to facilitate additional cross-border collaboration in their emergency preparedness planning. The exchange of information, resources, and emergency preparedness plans has the potential to benefit a larger population in the event of an emergency.

The collaborative partnerships among ADPH, APHCA, the University of South Alabama, hospitals, CHCs, and other providers in Alabama have allowed for successful emergency preparedness planning. Alabama credits success to strong leadership from each organization, coupled with energy, time, and belief in the importance of emergency preparedness planning.

California

Due to the large number of clinics across the state, collaboration between the California Department of Health Services (CDHS) and CHCs is essential. CDHS contracts with the California Primary Care Association (CPCA) to ensure that CHCs are actively engaged in emergency preparedness planning. Using funding from HRSA and CDC, CDHS has assisted CPCA in providing technical assistance at the clinic level for emergency preparedness since 2002. Funding awarded at the local level has supported the purchase of equipment, development of a training program, and the

creation of a Web-based help desk library for clinic emergency preparedness.

Emergency preparedness funding is allotted to local jurisdictions, often a health agency, and then distributed. In order to secure funding for emergency preparedness, CHCs in California must include in their application a letter of support from a health care association, like CPCA. This requires CHCs to come to CPCA in order to complete their application. CDHS partnered with Los Angeles health agencies to combine resources for further emergency preparedness planning.

To engage CHCs in preparedness planning, the CPCA created the Clinic Emergency Preparedness Project, initially piloted in four regions across the state. This project created a comprehensive Emergency Operations Plan template, tools, and strategies for CHCs to use in preparedness planning for their own clinics and with community partners. The plan template includes job description sheets, hazard assessment tools, inventory checklists, procedure lists, after action reports, and many more helpful tools. This template is available on CD-ROM and on the CPCA Web site for replication and tailoring by any state. The California plan has been designated as a model by the Bureau of Primary Health Care for other states to emulate. Later this year, a Web-based help desk will be available for users to search topics related to emergency preparedness planning without having to call CPCA.

Participation on the Joint Advisory Committee of Public Health Emergency Preparedness is a requirement of both CDC and HRSA cooperative agreements. A representative from CPCA and the Regional Clinic Association aids in the effort to prevent duplication in planning. Another group, the Clinic Emergency Task Force includes the hospital association, the Regional Clinic Association, disaster relief organizations, and emergency preparedness organizations. This task force focuses on policy and programs to enhance clinic response and impact government processes. In October, a representative from CPCA participated in a table top exercise in Los Angeles, sponsored by Trust for America's Health. In the past, CPCA has had

representation on an ad hoc strategic planning group.

Together, the California Department of Health Services and CPCA have defined the roles required for PCAs and CHCs to be successful in both preparation and response to an emergency.

PCA Roles

- Represent CHCs at state emergency planning tables.
- Provide training and technical assistance to CHCs as they develop their emergency operations plan.
- Serve as the communication link between CHCs and government resources.

CHC Roles

- Serve as an alternative care site.
- Dispatch staff, resources, or mobile medical vans to facilities or locations in need.
- Act as points of distribution sites for pharmaceuticals, vaccines, or antivirals.
- Provide post-event mental health services.

Effective collaboration can result in improved preparedness for any emergency or natural disaster, as demonstrated in California.

New York

Through a contract with the Community Health Center Association of New York State, the New York State Department of Health is collaborating with New York State CHCs on several emergency preparedness activities. The association is using funds to expand workforce devoted to preparedness activities to assist their members, CHCs, with emergency preparedness activities. The following activities have begun or will occur during 2006 and 2007.

The New York State Director for Health Systems Emergency Preparedness is working closely with the association's Clinical Director for Emergency Preparedness to plan and coordinate beneficial emergency preparedness activities between the organizations. Letters are being sent to emergency preparedness planners in each county where an affiliated CHC is located, to demonstrate interest in participating in planning with hospitals, local health departments, and other clinics.

The association, with input from the New York State Department of Health, offer hands-on training for CHC staff to create or improve emergency preparedness plans. The proposed training will encompass:

- Establishing emergency preparedness teams.
- Building community relationships.
- Promoting family preparedness.
- Hazard vulnerability analysis.
- Risk communication.

In addition, regional emergency preparedness training will be offered to all CHC staff. Following emergency preparedness trainings, the Community Health Center Association of New York State and the New York State Health Department plan to offer several opportunities each year to test emergency preparedness plans through drills, tabletops, and other exercises. Recently, CHCs near Albany participated in two tabletop exercises.

The association and the New York State Health Department also plan to create a database of CHC emergency resources to track and share information related to total number of staff, rooms, onsite pharmacies, and medication and stockpile supplies. Directly related to the development of a resource database is the creation of a critical assets survey for CHCs. Critical asset surveys are often used by hospitals, nursing homes, and other health care providers to inventory key items needed in an emergency. Key items inventoried by CHCs include the number of ventilators, staff, available space, and pharmaceuticals.

The use of CHC staff and facilities for alternative care or triage sites or sharing CHC resources at other sites are examples of valuable contributions that CHCs could make during an emergency. In New York, several projects are underway to create effective alternative care sites. Long Island Jewish North Shore Hospital and its affiliates plan to implement buffer model alternative care sites to decrease the load on the emergency departments of nearby hospitals and free their inpatient space to care for critical patients in an emergency. Similarly, the hospitals, local health agencies and other planning partners in three counties in the Albany

area are developing plans for the creation of alternative care sites.

In coming months, the association plans to work with New Jersey and Connecticut to develop a tri-state leadership conference. The goal of this conference is to share success stories, models, and best practices between states and encourage cross-state collaboration in emergency planning.

Recommendations

The states featured in this brief exhibit several common themes on how and why to partner with CHCs, and have offered recommendations for other states to facilitate successful collaboration:

- Develop relationships with health care providers and other state and local organizations.
- Get representatives from all organizations in the same room.
- Discuss funding requirements.
- Review mission of the state.
- Do not focus on the obstacles, plan for what you can.

Conclusion

Collaboration between state health agencies and CHCs is essential in order to provide clinical and public health services in the occurrence of a natural disaster or other emergency. The states mentioned in this brief provide concrete examples of how effective partnerships can be created between agencies and CHCs.

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¹ Association of State and Territorial Health Officials. "The Organization of Preparedness in the States: A Public Health Case Study." Available at www.astho.org/pubs/PreparednessCaseStudy-Organization.pdf. Accessed 9-28-06.

² National Association of Community Health Centers. "Legacy of a Disaster: Health Centers and Hurricane Katrina One Year Later." Available at www.nachc.com/press/files/katrinareport.pdf. Accessed on 8-7-06.

³ The Source on Women's Issues in Congress. "Health Centers Renewal Act Approved by Senate Committee." Available at www.womenspolicy.org/thesource/article.cfm?ArticleID=2149. Accessed 9-25-06.

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⁵ National Association of Community Health Centers. "Legacy of a Disaster: Health Centers and Hurricane Katrina One Year Later." Available at www.nachc.com/press/files/katrinareport.pdf. Accessed on 8-7-06.

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