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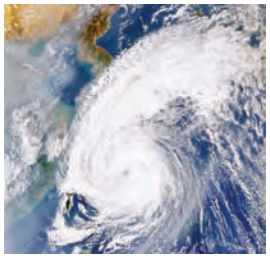

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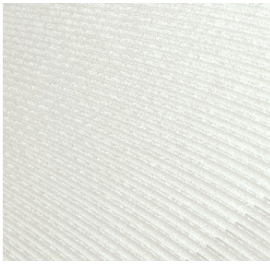
Collaborating with Community Health Centers

for Preparedness



NACCHO
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The National Connection for Local Public Health

NATIONAL ASSOCIATION OF
Community Health Centers

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Collaborating with Community Health Centers for Preparedness

Executive Summary

In recognition of the benefits of collaboration among state and local health agencies and health centers, the national organizations representing these partners sponsored the Task Force on Health Agency-Community Health Center Coordination in Preparedness made up of members from the Association of State and Territorial Health Officials (ASTHO), the National Association of Community Health Centers (NACHC), and the National Association of County and City Health Officials (NACCHO). The following report is the outgrowth of the Task Force and provides recommendations and examples of collaboration between the partners.

This report outlines the work of the Task Force, the roles and responsibilities of each partner in emergency responses, and provides recommendations for and examples of effective collaboration among the partners. The section on roles and responsibilities examines the assets and activities of each partner with regards to personnel; facilities; equipment; medication, vaccines and supplies; drills and exercises; communication strategies; and access to community members. The section on collaboration among partners defines the essential elements of successful collaboration.

The report offers examples of various models of collaboration related to discrete aspects of emergency response. Specifically, examples from California, Massachusetts, and Arkansas demonstrate effective definition of roles and inventory of resources in advance of an emergency. Examples from Maine and New Jersey offer models for planning and training to identify and correct weaknesses to ensure effective emergency response. Alabama offers an example of a potential communication strategy, and Washington, Indiana, Nebraska, Minnesota, and New York offer various models for coordinating emergency response efforts and of collaboration. Altogether the examples stress the importance of involving all members in preparedness planning, the unique contributions each partner can make in the event of an emergency, the critical role that coordinating bodies – such as the state's Primary Care Association, can play in ensuring readiness of health centers, and the benefits of collaboration.

The report also provides recommendations of additional resources and contact information for the staff at the national organizations involved in this effort.

Though collaboration among public health agencies and health centers, as demonstrated by this report, is occurring throughout the United States, many communities do not have systems in place to ensure coordination of efforts among the three entities. This report is designed to serve as a resource for those interested in strengthening their response efforts through collaboration and a motivator for those who have not yet pursued collaboration across agencies and organizations. Successful collaboration among these partners and the resulting effective use of limited resources can ensure that the needs of communities and populations are addressed to the fullest extent.

Introduction

The purpose of this report is to provide public health agency and health center staff with an overview of each entity's assets and responsibilities, examples of successful collaborations, and a suggested list of tools and resources to help organizations and agencies improve their emergency preparedness planning by including all essential partners. Local health departments are also referred to in this paper as local public health agencies and state health agencies are referred to in this paper as state public health agencies.

Task Force Background

Recognizing the importance of coordinating state and local public health agencies and primary care associations in planning during an emergency or natural disaster, the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the National Association of Community Health Centers (NACHC) formed the Task Force on Health Agency-Community Health Center Coordination in Preparedness to identify priorities and effective models for addressing public health emergencies and natural disasters. Although there are many important partners required for effective emergency planning and response, this resource's focus is the collaboration between members of the above three key players.

ASTHO's members, the chief health officials representing state and territorial public health agencies, are dedicated to formulating and influencing sound public health policy, and to assuring excellence in state-based public health practice. NACCHO's members, local health departments, are committed to working on the front lines to protect and promote the health of communities. NACHC's primary mission is to strengthen preventive and primary health care for medically underserved communities and populations through community, migrant and homeless health centers (also known as Federally Qualified Health Centers).

Several events over the past five years have demonstrated the importance of these three entities working together in responding to emergency situations, including: the 2005 hurricane season, the 2003 Southern California firestorms, and recent pandemic influenza preparedness efforts. Combining the strength of the state and local public health infrastructure with the community health center system promises to improve the health and quality of life outcomes for communities across the nation during and following a disaster.

Development

Development of the Task Force stemmed from conversations between the senior leadership of NACHC and ASTHO about the lack of coordination with and integration of health centers in the response and recovery efforts following Hurricanes Katrina and Rita. Following much dialogue between ASTHO and NACHC, NACCHO was invited to participate as a natural partner, and the idea of a task force was developed. Together, ASTHO, NACCHO, and NACHC put a call out to members for individual nominations to serve on the Task Force. Each group received an overwhelming number of nominations, further confirming the need for such a group. The Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC) provided support for the Task Force.

Members and Goals

The Task Force is composed of 17 members, including state and local health officials, primary care association (the state and regional level associations of health centers) delegates and community health center staff representing all regions across the U.S. (See the Acknowledgments page for list of members.) The goal of the Task Force is to identify priorities and effective models that address public health emergencies or natural disasters through coordination across all levels and with key partners. Specifically the Task Force hopes to:

- Encourage states to integrate health centers in planning to ensure health center readiness in the event of an emergency.

- Ensure that the needs of the medically underserved populations are included in planning for and response to disasters.*
- Enhance collaboration in states where collaboration is already occurring.
- Increase strategies to coordinate across all agency levels.
- Define roles and responsibilities of each entity.

Collaboration across state and local public health agencies and health centers in preparedness planning is critical to avoid duplicated efforts, appropriately spend awarded grant money, and achieve results that will save lives, keep businesses functioning, and allow normal life to return in an expeditious manner.

Organizational Resources & Responsibilities in an Emergency

In order to effectively respond to an emergency or natural disaster, each agency and organization must contribute resources and carry out explicit functions. Each entity has distinctive resources, such as funding, personnel, community connections, access to information technology, and manpower, to contribute during a response. To optimize all available resources, each agency and organization must work together to coordinate these assets. The purpose of this chapter is to define the roles and specific functions of state public health agencies, local health departments, health centers, and others during an emergency or natural disaster. Successful examples of collaborations between public health agencies and health centers are intertwined within this chapter. Understanding each other's unique attributes can lead to continued collaboration and a stronger response to any emergency.

State Public Health Agencies

State public health agencies vary in size, location, structural organization, and function across the U.S. Most of the preparedness activities within states are funded by cooperative agreements from the U.S. Department of Health and Human Services (HHS).† In most states, these cooperative agreements are managed by the same program to enhance coordination.[1] State public health agencies are responsible for ensuring a coordinated response throughout the state. This is achieved through collaboration with local public health agencies and other partners such as health centers and Primary Care Associations (PCAs). State public health agencies are critical partners that can allocate resources and coordinate planning, response, and recovery efforts among local jurisdictions, health centers, and the private sector. State health agencies are responsible for several functions that benefit all other partners, including local health departments and health centers. For example, maintaining a standardized, accurate state lab to conduct disease surveillance for use by all local health jurisdictions is a responsibility of every state. Many states take the initiative to develop an educational curriculum for workforce development and training to assist and ensure standardization across all jurisdictions.

* Medically underserved populations include individuals who face economic, cultural, or linguistic barriers to care.

† Since 2002, all 50 states, the U.S. territories, and four directly-funded jurisdictions (Washington, DC, New York City, Chicago and Los Angeles County) have received federal funding through cooperative agreements with HHS. More than $7 billion in federal preparedness funding has been distributed through two separate, but coordinated programs. Funding for public health emergency preparedness and response is administered through the Centers for Disease Control and Prevention (CDC). Funding for hospital and other healthcare facility preparedness was administered through the Health Resources and Services Administration's (HRSA) National Bioterrorism Hospital Preparedness Program (NBHPP) until 2007. The NBHPP program was moved from HRSA to the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) in early 2007. Also in 2007, the funding for hospital and healthcare preparedness was split, with a majority of the funding going to the newly-named Hospital Preparedness Program (HPP) through the states as previously and the rest going to the newly-created Healthcare Facilities Partnership Program (HFPP). Throughout this document, when the ASPR program is mentioned, it refers to the combined NBHPP, HPP and HFPP programs.

CALIFORNIA
Defining Emergency Response Roles

Identifying appropriate roles for health centers in an emergency can be a challenge because of variations in their size and scope, inherent capabilities, and in the relationships they have with local hospitals and other response partners. To help clarify health centers' response capabilities and partners' expectations, the California Primary Care Association (CPCA) developed guidelines for health centers and facilitates collaboration between health centers and their local and regional partners.

The CPCA's Clinic Emergency Preparedness Project includes a detailed Emergency Operations Plan template for health centers. The template provides a basic plan, procedures, policies, and forms that health centers can tailor to their needs, as well as useful resources and guidance. The template's appendix, "Community Clinic Response Roles and Requirements," lists potential response roles for health centers and describes planning requirements to fulfill those roles. In addition, the template offers the following steps for defining response roles:

- Assess the pre-disaster medical care environment and the role the clinic performs in providing health services.
- Assess clinic resources including availability of staff to respond and ability of the clinic to survive intact.
- Discuss potential response roles and findings of risk assessment with Medical Health Operational Area Coordinator or local Office of Emergency Services.
- Obtain community input on the health center's emergency response plan.
- Obtain input from clinic staff especially medical and nursing directors, safety officer, and chief operating officer.
- Present recommendations to its board of directors for ratification.

In addition to the Emergency Operations Plan template, CPCA also developed the Clinic Emergency Preparedness Help Desk Library, which is a Web-based tool focused on each phase of emergency management. The 87-question Clinic Emergency Preparedness Help Desk provides information on a variety of emergency management topics, such as what a clinic incident command system is, how to conduct a hazard vulnerability assessment, and the appropriate level of personal protection equipment necessary.

At the state level, CPCA represents health centers in preparedness initiatives and advocates for health center integration into state and local response plans. The CPCA also communicates federal and state emergency preparedness grant guidance to health centers. At a regional level, 14 Regional Clinic Consortiums in California provide technical assistance to health centers. Using ASPR funds provided by the state, each consortium works with its members to conduct Hazard Vulnerability Analyses and needs assessments. These activities help define appropriate response roles based on health center location, vulnerabilities, resources (including staffing), and capabilities. Response roles include enhancing surge capacity, supporting disease surveillance, allowing the use of health center medical facilities, triaging to lower or higher levels of care, providing crisis medical and mental health services, serving as a point of dispensing site, and serving as an alternate care site.

The CPCA conducts presentations throughout the state to encourage health centers to think about how they might respond in a health or medical emergency. Once health centers have defined their roles, they are encouraged to work proactively with their local and regional partners to establish accurate expectations. Participation in drills and exercises with local partners is also encouraged to test whether health centers can actually carry out the functions they have designated for themselves.

Recently, CPCA conducted a "Clinical Readiness Survey" to assess preparedness among health centers, and in fall 2007, released a "best practices" report. CPCA has also convened a Clinic Emergency Preparedness Task Force, which meets bimonthly to discuss ongoing preparedness initiatives. Members include representatives from health centers, local public health, local emergency management, state health departments, hospital associations, the American Red Cross, and other organizations.

MASSACHUSETTS
Enhancing Surge Capacity

The Massachusetts League of Health Centers (the League), which represents all health centers in the state, has enjoyed a long-standing relationship with the Massachusetts Department of Public Health and the Boston Public Health Commission. The League has been actively engaged in emergency preparedness at the state and local levels since 2002, serving on various planning committees for all aspects of preparedness, including surge capacity. Both the state of Massachusetts and city of Boston have funded the League to work on these issues.

The League acts as an advocate for health centers in surge planning by helping state and local emergency preparedness partners increase their understanding of health centers and health centers' capabilities during an emergency. An important piece of this education is correcting the misrepresentation of health centers as mini-hospitals capable of caring for patients with acute medical needs. The League participates on a statewide surge capacity committee that includes hospitals, long-term care, home health, legal experts, academic and public health schools, and others. Recently, the committee has examined the issue of standards of care in an emergency and how these might impact operations at health centers.

In the recent past, the focus of surge capacity planning has been on pandemic influenza. In such an event, health centers in Massachusetts may serve as receiving stations for non-acutely ill patients, thus enabling hospitals to maintain available beds for those requiring acute medical care. Health centers and their staff may also help care for the "worried and concerned," including those in need of mental health support or reassurance. However, health center involvement in enhancing surge capacity extends beyond the pandemic influenza scenario to providing basic surge support in everyday mass casualty events. This may include performing basic triage or treating the "bumps and bruises" crowd.

With the support of the state and the city of Boston, health centers have explored the feasibility of performing various surge roles during tabletop and functional exercises. During these exercises, health center representatives can sit alongside hospitals and other response partner representatives and discuss their concerns and issues. Through involvement in these exercises, Boston's health centers have benefited greatly from equipment and supplies provided by the city's Emergency Medical System and obtained through Metropolitan Medical Response System and Urban Area Security Initiative grant funding.

In Massachusetts, defining response roles for health centers is done locally based on an identified need(s) and the capabilities of health centers in that area. Health centers are encouraged to work directly with hospitals and other partners in their community. In addition, the League is creating a task force to prepare health centers to fulfill their possible roles in a surge event. Key issues for the task force include helping health centers with their patient capacity at any one time during an incident and how logistical support will be provided to adequately staff health centers.

Local Health Departments

Similar to state public health agencies, local health departments differ in size, location, and funding streams. With the exception of the agencies in New York City, Chicago, Los Angeles County, and Washington, D.C., local health departments do not receive direct preparedness funding from the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR). Seventy-three percent of local health departments receive funding from their state health agency. Local health departments have used preparedness funding for a variety of activities, including communication equipment upgrades, development of surveillance systems, and staff training.[2] Most often, local health departments provide on-the-ground support, though with limited resources and personnel.

Health Centers & Primary Care Associations

Health centers and PCAs are also partners that play a critical role in a response to an emergency or natural disaster. Health centers have a mission to represent and serve vulnerable and medically underserved communities. They have unique knowledge about the individuals that make up their particular communities, and they offer culturally and linguistic appropriate services to ensure that patients receive high quality care. In this way, health centers often serve as more than a medical home for their patients. Health center resources can provide maximum benefit to emergency responses when integrated with local and state

efforts. Serving as triage centers or alternate care sites, caring for the walking wounded, and reaching out to hard-to-reach populations are common roles most health centers can fulfill during an emergency event. State PCAs oftentimes act as the coordinator of health centers for emergency preparedness planning and response. Through regular communication and other efforts, PCAs can identify health center needs and hopefully bring all centers to an equal level of preparedness and awareness. California and Massachusetts demonstrate effective definition of roles and responsibilities in advance of an emergency. Please see pages 5 and 6 for details.

Funding support for the resources and functions health centers and PCAs can offer during an emergency is limited. In fiscal year 2006, only $11.1 million (or 0.7 percent) of the $1.54 billion healthcare and public health emergency management funding awarded nationwide through the Center for Disease Control and Prevention (CDC) and ASPR was given to health centers or PCAs. More specifically, 58 percent of states provided funding to health centers or PCAs for emergency management activities.[3] On July 5, 2007, ASPR announced the availability of $15 million for the 2007 Healthcare Facilities Partnership Program. The purpose of this grant was to encourage hospitals, health centers, mental health centers, and other agencies to partner in order to improve surge capacity and enhance community and hospital preparedness for public health emergencies.

National Organizations

National organizations play a distinctive role in emergency management. Each organization has access to a specific constituency that represents different populations, organizations, or other subgroups across the nation. Organizations like ASTHO, NACHC, and NACCHO can provide:

- A direct link to specific members, federal agencies, and other national groups.
- Institutional knowledge and assistance with information gathering.
- Links for their members to aid from disaster relief organizations.
- Coordination among their respective members.

ARKANSAS
Resource Integration

Preparing for large-scale emergencies poses unique challenges in rural areas, especially for those without hospitals. As the largest network of health centers in Arkansas, the White River Rural Health Center (WRRHC) serves nine rural counties through its 16 clinics. Only three of these counties have hospitals. For those individuals living in communities without hospitals, WRRHC is the primary provider of health and medical services in the event of an emergency or disaster.

Accordingly, WRRHC has become actively engaged in emergency planning. Examining ways to integrate resources across all its clinics, as well as resources from local, county, and state agencies, has been a focus of WRRHC planning efforts. The first step was to identify a central location that would serve as the hub for providing emergency health services. Working with local and county officials, WRRHC chose the Woodruff County Fairground because of its size, central location, facilities, and availability for use in drills and exercises. The site would serve as a POD location to care for the "walking wounded," or as a triage or holding station for the injured until they could be transported to a hospital.

WRRHC is responsible for providing staff and basic supplies, while oversight of the Fairground lies either with the Arkansas Department of Health or the Woodruff County Office of Emergency Services, depending on the type of incident. The County's Emergency Services Coordinator or judge is responsible for activating the fairground in response to a crisis.

WRRHC has worked closely with county and state officials to establish a memorandum of understanding to ensure that adequate supplies and staff are available in an emergency. In addition, WRRHC has stockpiled supplies at its central supply depot, which can be used until additional supplies are obtained through mutual aid or via the Strategic National Stockpile. WRRHC is currently pre-identifying a list of critical supplies that it might need from the county or state under different scenarios, and developing a plan for the delivery of supplies to the Fairground.

To meet staffing requirements, WRRHC can pull personnel from all 16 of its clinics using a call-down list of key personnel – a process that has proven effective when tested in drills or during actual incidents such as tornadoes. There are agreements in place with county and city police departments to transport key personnel to the Fairground in the event that assistance is required.

Personnel

Each organization may pre-assign staff to specific roles in the event of an emergency. Every organization must also coordinate personnel to maintain continuity of operations during an emergency. This may be a challenge depending on the type and magnitude of emergency event.

All state public health agencies have a unit, program, or division dedicated solely to emergency preparedness planning and response. In addition, staff from other programs across the state agency may be pre-designated and trained to fill a specific role during times of emergency. These positions range from medical to administrative support staff. The situation is similar in larger local health departments while smaller local health departments may face greater challenges due to their limited staff. Depending on the size and type of agency, health agency staff that would play a direct role in an emergency response could include:

- Epidemiologists
- Mental and behavioral health personnel
- Environmental health specialists
- Laboratory personnel
- Medical officers
- Registered nurses
- Emergency preparedness planners
- Community Connectors: outreach workers and home visiting staff

Depending on the type of emergency, health center staff would be used for emergency response within their own organizations, often treating patients and providing mental health services to response workers and patients and triaging critical patients to more appropriate settings such as hospitals. The following health center staff can be used to staff a point of dispensing (POD) or an alternate care site:

- Physicians
- Nurse practitioners
- Registered nurses
- Support staff

ALABAMA
Emergency Communication

During a public health emergency or disaster, the Alabama Incident Management System (AIMS) allows health centers, hospitals, and other health care organizations to track staff, facility status, bed availability, and supplies in real time. AIMS is a Web-based tool that was developed originally as a bed-tracking system for hospitals. As the potential applications of AIMS for other health care organizations became evident, the system was expanded to include specific modules for Emergency Medical Services, health centers, nursing homes, and medical needs shelters.

The health center module in AIMS has been operational for approximately two years, and all health centers in the state participate. Health centers worked with the Alabama Department of Public Health and the University of South Alabama to define requirements for the module, such as the types of data health centers would report in an emergency and information they would need from other facilities. Health centers are responsible for designating which staff has access to AIMS, a system that is controlled by user login and password protection. AIMS's online interface guides data entry through drop-down menus and form fields customized for each type of health care organization.

The major types of data captured in AIMS are available beds (numbers and types), staff (by licensure and specialty area), supplies, and facility status (open, closed, or on generator power). The Alabama Department of Public Health collaborated with its partners in health care to develop common definitions for system inputs. Users also have access to an instant message function to send resource requests or other questions to the Alabama Department of Public Health's Emergency Operations Center (EOC). The EOC sets up a Patient Transfer Center to support AIMS when it is activated. Representatives from all organizations that participate in AIMS are part of the Patient Transfer Center, which serves as a central location for coordinating medical assets and enabling the management, transfer, and deployment of supplies, staff, and medical volunteers.

During non-emergencies, health centers have access to all AIMS training opportunities, including online tutorials, on-site trainings at individual health centers, Web casts, and the Advanced Regional Response Training Center in Mobile, Alabama. The state encourages health centers and other facilities to make AIMS part of their community drills and exercises and provides support when needed. Health centers participate in regular AIMS testing and are represented on an AIMS working group that addresses general and facility-specific issues that may arise.

Liability Issues

A major personnel concern for state and local health departments as well as their health center partners is legal issues related to liability and malpractice. Many state and local health departments do not have enough personnel to respond to large-scale emergencies and rely on volunteers to supplement these staff shortages. State health agencies are developing Emergency Systems for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) to identify, register, and pre-credential health care volunteers within the state. State and local health departments are also working with community volunteer groups such as the Medical Reserve Corps (MRC) to identify and train health care volunteers. Various state and federal laws related to liability and malpractice may apply to these volunteers, and the situation becomes even more complicated for volunteers who cross state lines. These same challenges exist for health center employees who wish to offer services outside of their actual health center location. Some states, like Missouri, have recently passed laws that allow any health care provider that is licensed, registered, or certified in any state to be deployed to provide services during a Governor-declared emergency. This bill also states volunteers are not liable for civil damages unless damages are the result of willful acts or omissions from the care that is provided.[4]

MAINE

Emergency Preparedness Training for Health Centers

Under the direction of the Maine Primary Care Association (MEPCA), health centers are actively involved in all-hazards emergency preparedness planning and training. MEPCA began this work in 2006 by conducting a needs assessment of ten federally qualified health centers to better understand what roles health centers might have in an emergency, their response capabilities, and their training requirements. The results of the assessment revealed wide variation among health centers with regards to the extent to which they were engaged in emergency preparedness planning and prompted MEPCA to develop an Emergency Operations Plan template that all health centers could adapt to meet their needs.

Beyond developing plans; however, MEPCA recognizes the importance of training and working one-on-one with health centers to provide targeted education and training in emergency preparedness. Training topics include the Incident Command System, the use of personal protective equipment (PPE), building local partnerships for preparedness and response, and health center operations during a pandemic or other infectious disease outbreak. Each year, health center staff participates in a one-day educational seminar. Examples of topics covered in this seminar include:

- Updates from state officials on Maine's emergency preparedness efforts.
- Information on the National Incident Management System.
- Presentations on mental health needs of trauma and disaster victims.
- Hands on demonstrations of disaster equipment.
- Health center networking and sharing of resources.

MEPCA also partnered with the Muskie School of Public Service at the University of Southern Maine, to provide on-site training to health centers. Topics include technical assistance in acquiring supplies and equipment and how to integrate with state and local emergency plans. Moreover, MEPCA ensures that health centers have access to personalized training services through the Harvard School of Public Health's Center for Public Health Preparedness and the Yale New Haven Center for Emergency Preparedness and Disaster Response. Health centers are also encouraged to augment their internal training with participation in community drills and exercises with their local partners.

To ensure the training provided to health centers is consistent with state guidance, MEPCA serves on a Public Health Emergency Preparedness Coordinating Committee (also known as the County/Local Leadership Team), which is responsible for implementing the state's emergency preparedness training plan. Currently, the County/Local Leadership Team is focused on pandemic influenza preparedness and meets monthly to discuss the roles and responsibilities of key county, local and state partners. Members of the team represent the two public health departments, the three regional resource centers, Maine Emergency Management Agency, and the Maine Center for Disease Control. Guidance from state health officials on emergency preparedness planning and training is passed down to all the health centers through the County/Local Leadership Team.

In August 2007, HRSA/BPHC issued a clarifying Policy Information Notice (PIN 2007-16) on Federal Tort Claims Act (FTCA) malpractice coverage for health centers in emergency situations. While the PIN does not provide the flexibility many had hoped for, it does establish some useful guidance on FTCA coverage in emergency situations and provides for more flexibility than did the earlier draft PIN on the subject. Specifically, the PIN:

- Permits impacted health centers to establish temporary locations within or adjacent to their current service areas in order to provide services to victims in an emergency. **Prior approval is not required**, but notification within 15 days is required.
- Permits health centers to establish temporary sites outside their service areas or in adjacent service areas as long as their sites are inoperable and the temporary sites are located within the center's general geographic region. **Prior approval is required.**
- Provides for coverage of non-impacted health centers and their health care professionals when they assist at temporary sites within their service area or immediate vicinity, or operate temporary sites in accordance with the provisions of this PIN.

Facilities

Depending on the type of emergency, facilities may be needed to care for injured and ill individuals or administer vaccines or antibiotics. Hospital facilities are an essential resource for the acutely injured, wounded, or sick in the event of an emergency. Already set up to care for patients 24 hours a day, seven days a week, hospitals are a primary point of contact with the health system for individuals seeking care during an emergency.

Health centers' familiarity in the community makes them an excellent place to triage non-critical patients. During an emergency, health centers can serve as treatment centers for the "walking wounded" or non-emergent visits. In addition to using their own clinic to provide services to those in need, some health

NEW YORK
Infectious Disease Control

After 9/11, the New York City Department of Health and Mental Hygiene recognized the need to involve health centers in emergency preparedness and response and reached out to the Community Health Center Association of New York State (CHCANYS) to engage health centers in its preparedness efforts. One area of preparedness that has become a focal point of collaboration between CHCANYS, New York City, and state health officials is infection control for pandemic influenza.

The state's pandemic influenza plan recognizes health centers and other non-hospital health care organizations as "critical to the successful management of a pandemic situation." Health centers are responsible for maintaining infection control practices, such as 1) developing screening and isolation protocols, 2) establishing separate triage areas, and 3) distributing educational materials. In conjunction with New York City and state health officials, CHCANYS has developed a triage protocol to help health centers promptly recognize and isolate infected people during a communicable disease outbreak.

In spring 2005, CHCANYS conducted a tabletop exercise on pandemic influenza at its Clinical Leadership Forum. Following this, CHCANYS held four emergency preparedness kickoff meetings for health centers, each featuring a pandemic influenza tabletop. As interest and demand for the tabletops grew, CHCANYS partnered with the Primary Care Development Corporation (PCDC) to expand the delivery of the tabletops to over 30 health center sites. In addition to the tabletop exercises, CHCANYS began offering trainings and drills on screening and isolation, personal protective equipment, and internal notification systems. CHCANYS coordinates with New York City and state health experts on topics and content for the trainings and drills.

Health centers are also part of New York's Health Alert Network, which they can use to receive updates and guidance from state health officials on appropriate infection control measures. Health centers may also obtain ongoing education on infection control through monthly "Emergency Preparedness and Clinical Committee Learning Calls" sponsored by CHCANYS. These calls feature a wide variety of emergency preparedness topics, including infection control, pandemic influenza, and surveillance, as well as information on upcoming exercises, trainings, and drills. CHCANYS may call on experts from the state or city health department or other appropriate entities to participate on these calls when additional expertise is necessary.

WASHINGTON
Building Health Care Coalitions

In the state of Washington, health care coalitions are regional networks of health care organizations and providers that work together to build emergency response capability. The primary function of the health care coalitions is to serve as effective platforms for information sharing, cooperative planning and response, and mutual aid. While many coalitions throughout the state are in early stages of development, more advanced coalitions such as Region 6 (King County) and Region 5 (Pierce County) boast a membership that includes hospitals, public health, home health, mental health, long-term care, private medical groups, and health centers.

Prior to adopting a coalition model, emergency preparedness in Washington was based on a regional system in which hospitals were responsible for inviting other health care organizations to participate in their planning sessions. However, this system proved too hospital-centric and discouraged health care organizations from planning as a broadly representative group. The Washington Department of Health advocated for a regional coalition model, which it felt would promote a more collaborative and integrative planning process. State health officials encouraged these regional coalitions to incorporate health centers and other health care providers. The Washington Association for Community and Migrant Health Centers established a liaison to work with the state and provide technical assistance for emergency preparedness funding directed toward health center readiness.

Washington's coalition model consists of two main components: a policy-level Executive Council and topic-specific subcommittees to develop operational policies and processes.

- Representatives from each member organization may participate at the policy level, which provides governance and input on medical resource management, reviews preparedness activities, and advises local health officials on emergency policy matters. This gives health centers a seat at the table to communicate to other coalition partners concerns or issues that confront health centers in emergency preparedness.
- Each coalition's subcommittees work on issues relevant to their focus area and provide recommendations at the policy level. Coalitions in Washington State incorporate emergency management and/or regional homeland security representation as well as local health jurisdictions to ensure that the appropriate jurisdictional link takes place. In Washington State, this is done through Emergency Support Function 8 (ESF 8) of the county Comprehensive Emergency Management Plan. This emergency support function is where health and medical connects with jurisdictional and state incident management. In multi-county regions, once regional health surge policies, processes or agreements are finalized, they can then be incorporated at the jurisdictional level as appropriate.
- King County also has a Medical Resource Center, which works on coordination and resource-management issues under the ESF 8 component of the King County Comprehensive Emergency Management Plan. In an emergency, the Medical Resource Center manages all resource requests and provides situational updates to local public health departments. During non-emergencies, it inventories available resources and identifies existing capabilities. While King County is currently the only coalition with a Medical Resource Center, some planners are optimistic that other coalitions will establish Medical Resource Centers as well.

The state health agency encourages health centers to attend coalition meetings and to work with other coalition partners to determine how they can best maximize surge capacity and capability needs in a region during an emergency. A health care coalition coordinator from the Washington Department of Health works with the regions, providing technical assistance statewide to promote medical surge capacity and healthcare coalition development, and shared resources, tools and other materials to support coalition regional work.

centers have mobile vans that could be used to provide additional care at another location, such as an alternate care site, hospital, or other designated area. Communities may use other buildings or locations to treat patients. For example, Arkansas identified a county fairground to serve as the central hub to provide services during an emergency. See page 7 for further information. If necessary and feasible under state law, health centers can bring staff and minimal equipment to serve patients at a specific location.

Several state and local health departments operate primary care or other clinics that could be used in a similar manner as a community health center. Also, some agencies may have created or purchased storage facilities for specific supplies. Each state is responsible for maintaining a lab to conduct disease surveillance for all local health departments.

Equipment

Types and quantities of emergency equipment vary from state to state and agency to agency. Equipment that state and local health departments may have purchased for emergencies include personal protective equipment (PPE), mobile facilities and/or labs, information technology or communication equipment. Similarly, health centers may have purchased generators, radios, decontamination showers, or other PPE depending on funding availability. In some cases, state health departments have provided health centers and PCAs with PPE, communications equipment, generators, and decontamination tents.

NEW JERSEY
Emergency Drills and Exercises

In addition to participation in emergency preparedness exercises, New Jersey health centers also design, implement, and evaluate them. New Jersey is divided into five public health regions, each with at least one designated Medical Coordination Center (MCC). Located at a hospital in the region, the MCC assists in the coordination of overall planning, training, exercise, response, and recovery activities. The MCC includes the New Jersey Department of Health and Social Services (NJDHSS), hospitals, public health agencies, health centers, long-term care, home health, emergency medical services, state police, and other emergency preparedness partners.

Each region takes a "step approach" to its exercise program, beginning with tabletop exercises before moving to functional and then full-scale exercises. This approach is designed to allow health centers and their partners to work out problems at each stage and build partnerships and confidence working together. Health centers are represented at the exercise planning and design process and vote on exercise injects to ensure that scenarios include issues that are important to health centers. In addition, health centers are actively involved in joint after-action analyses with their MCC partners.

To enhance collaboration with the state, federally qualified health centers, hospitals, long-term care, home health, and other partners across the continuum of care have formed the New Jersey Healthcare Associations Emergency Preparedness Alliance. This volunteer workgroup brings a unified voice to emergency preparedness discussions with NJDHSS. Monthly meetings promote information sharing and coordination. Health centers participate alongside state health authorities three to seven times a year in preparedness exercises and drills.

Health centers also receive exercise support from the state in the form of supplies and props. For example, through an agreement with Burlington Community College, health centers can use NJDHSS-funded mannequins during pandemic flu exercises. The mannequins, which are owned by NJDHSS, are sophisticated enough that they can "stabilize" or mimic death depending on what decisions are made. These props provide health center staff with crucial "hands on" training to help them respond effectively in an emergency.

By actively participating in an exercise, health centers better understand their potential roles in an emergency and the expectations of their local medical and other health partners. Federally qualified health centers receive approximately $25,000 from the state to put towards emergency preparedness. Approximately $5,000 is typically spent on training, including center participation in drills and exercises.

While the New Jersey Primary Care Association continues to provide training to health centers, many health centers have reportedly taken "ownership" over their emergency preparedness activities. For example, during a recent flooding incident, one health center put into practice what it had learned from training to set up an incident command center and implement its emergency plan.

INDIANA
Emergency Management Program

In Indiana, health centers are urged to adopt a comprehensive emergency management approach in developing their respective emergency management programs. This approach requires health centers to address issues across the spectrum of mitigation, preparedness, response, and recovery; and it is a mainstay of practice within the emergency management community. This approach is emphasized in the guidance provided to health centers by the Indiana Primary Health Care Association (IPHCA) and reflected in all templates and tools developed for health centers by IPHCA.

A major resource that IPHCA developed for health centers is the Emergency Management Program Guide, which contains doctrine, templates, and samples of standard operating procedures and a hazard vulnerability analysis, guidelines on the Incident Command System, and job action sheets. The Guide also includes an emergency operations plan template designed to establish the framework or direction for health centers' emergency management programs. Some of the Guide's tools and templates are available on the IPHCA Web site (www.indianapca.org).

Health centers are also part of the Indiana Health Alert Network, which provides real-time alerts about infectious disease, other threats, and events to health organizations. The Indiana Health Alert Network has a component designed specifically for health centers, which the IPHCA can use to disseminate information that is applicable only to health centers.

IPHCA has two working groups that meet regularly and provide critical input and guidance on the development of emergency management programs for health centers. The Technical Advisory Committee (TAC) consists of representatives from a broad range of disciplines with roles in emergency management, as well as two health center executive directors. TAC ensures that IPHCA and health centers are progressing in accordance with current doctrine and practice in the community at-large. In contrast, the statewide health center Task Force consists primarily of health center representatives and two external subject matter experts. The Task Force ensures that guidance provided by IPHCA to health centers is feasible, realistic, and consistent with health center parameters and needs.

IPHCA maintains a close working relationship with Indiana's State Department of Health. The health department provides funding through a contract with IPHCA to support a full-time Bioterrorism and Emergency Management Program Director on IPHCA staff. IPHCA is also a member of the health department's Bioterrorism Planning Committee and Public Health Preparedness Committee. Through these forums, health department and other committee members are kept informed of health centers' missions and capabilities, and IPHCA can pass along to health centers federal or state guidance that it receives.

At a local level, integration of planning efforts is also crucial and district coordinators (the state is divided into 10 public health districts) are urged to include health centers in local planning activities, meetings, and exercises. The Marion County Health Department in Indianapolis offers an example of successful integration. The local health officer and key staff consistently include IPHCA and health centers in important planning activities, drills, and exercises. They also support health centers with emergency management funding.

MINNESOTA
Clinic Coordination

Clinic emergency preparedness and coordination in the Twin Cities metropolitan area was identified as a planning priority in 2003 with the formation of the Metro Clinic Coordination Workgroup (MCCW). MCCW is an adjunct workgroup of the Metro Hospital Compact. The Compact consists of 29 Twin Cities metropolitan area hospitals that coordinate planning efforts and participate in the Regional Hospital Resource Center (RHRC) for communicating, monitoring and reallocating resources as necessary during an emergency.

MCCW is comprised of representatives from six major health systems and seven local public health departments. It is a multi-jurisdictional workgroup and is facilitated by a coordinator from Hennepin County Public Health. The objective is to bring together stakeholders and facilitate discussions to create coordinated emergency operations plans within the healthcare community by:

- Identifying clinic roles in a coordinated response
- Participating in policy and procedure decision-making
- Developing and sharing tools
- Providing educational opportunities.

One important goal of this group is the identification of regional clinic coordination mechanisms for the long term, including a metro clinic compact and an ongoing regional coordinator role. With these additional coordination components in place, specific roles for clinic response to community-wide events can be better defined. Until such time, it is assumed that each clinic site should be preparing for its role in various events of different types and scope.

Local public health departments maintain a list of clinics in their jurisdiction, their partner hospital or health system, and the point of contact for each clinic or system. This is accomplished via surveys conducted by MCCW and/or by local communications. The number of employees at each clinic location is monitored to assure appropriate planning for prophylaxis of them as essential personnel. Clinics in each jurisdiction are a part of the Minnesota Health Alert Network for issuance of urgent notifications to clinicians via fax or email.

While MCCW focuses on the needs of the clinics that are part of a health system, the local public health counterparts coordinate emergency planning with clinics not affiliated with a hospital or health system. Each local jurisdiction determines how they will connect with the non-system clinics in their area. Hennepin County is just one example of how local public health is working to support local clinics in their preparedness efforts. The Hennepin County Human Services and Public Health Department facilitates a workgroup called the Hennepin County Public Health and Clinic Partnership (HCP^2) that brings together non-system clinics located within the county for the purpose of emergency preparedness planning.

HCP^2 was initiated in the fall of 2004 and meets bimonthly. Community clinics, pediatrics, family medicine, internal medicine and specialty clinics comprise its participants. Some topics discussed at these meetings include: writing an Emergency Operations Plan, emergency communications in the clinic setting, infection control protocols, surge capacity planning, business continuity, and hazard vulnerability assessments. Hennepin County has also purchased supplies for members of the workgroup and hosted training sessions on varying topics such as PPE Fit-Testing Train the Trainer and Psychological First Aid.

Each clinic is likely to have a different type of response to incidents that reach beyond their own site because of the various structures under which they operate. In order to improve the likelihood of a successful response, it is recommended that clinics that are physically part of a hospital complex or located in proximity to the facility should be considered in the hospital's emergency management plan. Clinics that are part of a health system that includes hospitals should mutually incorporate emergency operations planning. Independent clinics are encouraged to establish a patient referral plan with the closest hospital or their primary referral hospital. Clinics also need to designate a point of contact to the local public health department in their jurisdiction.

Medication, Vaccines, & Supplies

Many state and local public health agencies as well as health centers and hospitals have stockpiled medication, vaccines, and other basic medical supplies. Commonly stockpiled items include antibiotics such as ciprofloxacin or doxycycline, PPE such as masks, and medical supplies such as bandages. These supplies are available for use in localized incidents as well as to protect employees, first responders, and their families during an emergency. Thoughtful placement of these stockpiles in various locations across the state enables rapid response to emergencies and helps ensure that basic supplies are not immediately depleted following a mass casualty incident or large disease outbreak.

On rare occasions, depleted state and local health agency resources will be supplemented by the Strategic National Stockpile (SNS). Managed by the U.S. Department of Health and Human Services, SNS is a national program that houses large amounts of medicine, including antibiotics, life-support medications, chemical antidotes, and medical supplies at several sites across the country, in order to help protect all Americans in the event of a public health emergency. The request for SNS assets comes from a state's governor, usually at the recommendation of the state health agency.[5] State health agencies are also responsible for management of SNS assets following their delivery by CDC. These activities include monitoring SNS inventory, ordering additional supplies, delivering assets to local distribution sites, ensuring the safety of the SNS assets, coordinating communications with state, local and federal partners, and supporting the activities of local health departments. Local health departments are intensively involved in setting up points of dispensing (PODs) in their local communities. Their activities include determining the best POD locations, identifying personnel and volunteers to staff the PODs, communicating with the public, and dispensing SNS assets directly to the public. In some state and local preparedness plans, health centers can serve as POD sites during an emergency, creating an important link between health centers and health agencies.

NEBRASKA
Partner Liaison

As a result of the influx of emergency preparedness demands and funds, the Nebraska Department of Health and Human Services (DHHS) has contracted with the Public Health Association of Nebraska to serve as a liaison between local health departments in Nebraska and the DHHS. This contractual relationship ensures that local health departments are represented when decisions are made on programs and budgets affecting local areas. The Public Health Association of Nebraska has become the entity with which the state communicates to reach all local health departments.

The Public Health Association of Nebraska organizes monthly conference calls between local health departments and DHHS. These monthly calls, which began with a focus on emergency preparedness, have since become an opportunity for local health departments to have routine conversations with the state about all topics. The calls resulted in a strategic planning process of state and local health officials to determine the state to local shift in responsibility. In addition, quarterly face-to-face meetings are held between state and local health departments to discuss issues of public health and provide an opportunity for an exchange of ideas.

The contract between the State and the Public Health Association of Nebraska began with emergency preparedness needs, but has expanded to include training and coordination of disease investigations, management needs, grant writing and other skills necessary for state and local health department staff. The greatest benefits of this contractual agreement have been the relationships developed and the collaboration and planning between the state and the locals.

Similar contractual relationships have been initiated by the State with federally qualified health centers, hospitals and tribal reservations.

Drills & Exercises

Performing a variety of drills or exercises at the state, local, and community level is critical to identifying strengths and weaknesses of emergency plans including those related to staffing, communication, and equipment. Although each public health agency and community health center participates in drills and exercises separately, most state and local health departments coordinate at least one drill together each year to ensure both agencies are able to work together successfully. The number of states that include health centers in table top exercises and other drills continues to increase each year. This is the result of a direct health agency invitation, an established relationship, or a health center approaching their local or state health department about participating in a joint activity. Maine, New York, and New Jersey all offer examples of coordinated planning and training to ensure effective emergency response. To learn more, see pages 9, 10, and 12 respectively.

Organizational learning derives from evaluation or after action reports completed following a drill or exercise. Evaluation of the organization's performance provides each agency or clinic the opportunity to revise and update their emergency plan for improved performance at the next run through or during an emergency. Participation in drills can also identify the need for engaging another community or state partner essential for an effective emergency response.

Communication

The sophistication of communication systems varies across state and local health departments, and health centers. Some agencies and health centers have purchased satellite phones while others own two-way radios that can be used to communicate during an emergency event. At the very minimum, each agency needs to have direct telephone numbers to specific individuals at partner agencies for use in the event of an emergency.

State public health agencies serve as the hub of emergency communications using the Health Alert Network. The Health Alert Network disseminates health advisories, alerts, and updates to state and local health departments, hospitals, and community and federal partners. The Health Alert Network is also used to provide long distance bioterrorism learning or training and for routine communication uses among partners.[6] Many local health departments use the Health Alert Network to link to their state health agency. Local health departments employ on the ground communication mechanisms as well, including e-mail and pager systems, radio communication, and satellite phones. States differ in whether or not they choose to include health centers in their emergency communication system plan.

It is recommended, however, that to improve a community's ability to effectively respond and care for patients in an emergency, health centers should be linked to a statewide or local communication system, including the Health Alert Network. Alabama has developed a comprehensive communication system that connects health centers, hospitals, and other organizations. See page 8 for more information. In addition to linking to the communication systems and/or plans, specific trainings need to be developed to teach health centers the skills to monitor the system and appropriately respond if an alert is issued. Some health centers have purchased video-conferencing equipment to facilitate trainings or host meetings with other health centers or partners, including state and local public health agencies. These same clinics have identified the opportunity for the equipment's dual use, and have incorporated the video-conferencing technology into their clinic emergency plan. Video-conferencing technology is an excellent example of resources that can be used for regular clinic operations as well as during an emergency. A strong business case for purchase of such technology could be made for those clinics currently without video-conferencing. State primary care associations are great candidates to coordinate the communication aspect of emergency response among health centers.

Community Member Access

Health centers offer a unique set of assets to state and local public health agencies in regards to direct access to community members. Established to serve as a community's medical home, health centers possess specific knowledge of their patients' distinctive needs. For example, health centers offer interpretive services to patients during an emergency event. Because health centers "speak the language" of their patients, health center staff either has the personnel resources or familiarity with utilization of language lines to ensure that patients get the care that they need. Interpretive services could be a critical resource during an emergency, when services are disrupted and confusion is widespread.

Providing outreach to hard-to-reach individuals, such as undocumented persons, the homeless, migrant seasonal farm workers, or individuals with a substance abuse addiction, is another distinct resource health centers can provide during an emergency. Health centers and staff have earned the trust of these vulnerable populations, and therefore often have the greatest opportunity to make contact in the event of an emergency to ensure any needed services are obtained.

As mentioned previously, state and local health departments vary in size, resources, jurisdiction, and population across the U.S. These differences play a large role in how each state prepares for and responds in the event of an emergency. Smaller and less populated states may exhibit more collaboration among state and local health departments, health centers, and hospitals, than larger, more densely populated states. Larger states may be more able to redirect resources to affected locations.

Although not specifically examined for this report, hospitals are a key player in emergency planning and response. At a minimum, most state and local health departments serve on emergency preparedness committees to coordinate planning, which can include the assignment of partner responsibilities. Hospitals must be included in the communication strategy established by state and local agencies as they can contribute many valuable resources, including expert medical professionals, facilities, equipment, medication, and supplies, for an effective emergency response. Many states coordinate their emergency planning efforts with local hospitals.

Primary Care Associations (PCAs) are another partner essential to emergency preparedness planning and response. As seen throughout this report, PCAs work closely with their health centers and often act as a coordinator for emergency preparedness planning, activities, and response.

Essential Ingredients for Collaboration and Effective Relationship Building

In order to become effective partners in planning for, responding to, and recovering from major emergencies or disasters, state and local health departments and health centers must engage and work collaboratively. Like any partnership, the long-term viability and success of this relationship depends on several key factors. The Task Force on Health Agency-Community Health Center Coordination in Preparedness identified eight essential factors to ensure effective working relationships between health centers and state and local public health agencies for emergency preparedness.

1. *If possible, bring partners into the process early.* This helps to build strong relationships by allowing partners to identify common goals and objectives, thus clarifying what the participants hope to achieve through the collaboration. However, it is never too late to extend an invitation to health centers or other partners to partner in planning. See page 11, 13, and 14 respectively to read about the success of Washington's health care coalitions, Indiana's comprehensive emergency management program, and Minnesota's clinic coordination group.

2. *Approach partners thinking, "How can I help them?"* Because each partner varies in size and scope, each has different capabilities to contribute during an emergency. State and local public health agencies and health centers should be proactive in educating one another about the expertise or services they can provide during response and recovery (e.g., coordination, personnel, facility space, supplies, translation services, mobile health resources).

3. *Identify gaps in level of preparedness.* Encourage communities and their partners to assess their level of preparedness and work towards a common goal.

4. *Clearly define roles among state public health agencies, local public health agencies, and health centers. Identify and use strengths of each partner.* Each partner brings a unique set of skills or expertise to the table. Through education and dialogue, these unique skills can be identified and used to clarify the role(s) of various partners in preparing for and responding to emergencies. Contracts, memoranda of understanding, or other types of written agreements may help facilitate dialogue and further collaboration between partners. See page 15 to read about a successful contractual relationship between Nebraska health agencies.

5. *Cultivate open communications.* State and local public health agencies, health centers, hospitals, and emergency management should maintain open dialogue with one another about preparedness activities, meetings, and drills. Health centers can work with their state's PCA to serve as the link to the state health agencies and to lend a unified voice to the concerns of health centers.

6. *Establish leadership support.* One important prerequisite to collaboration and relationship building is obtaining buy-in from the leaders of each agency or center. Support from the top is vital to expanding each partner's role in preparedness and pushing the process forward when obstacles are encountered. Securing buy-in requires educating health center executive directors and state health agency leaders about the benefits to their organization of preparedness (e.g., risk management, business continuity), as well as for the community.

7. *Engage in joint activities, such as training, drills, and community forums.* By participating in exercises and drills alongside its partners, each agency and organization can better understand its roles and responsibilities, while also building trust with its partners. Joint training can help shift the focus from the individual needs and wants of an organization to the collective issues confronting the community.

8. *Fund collaborative preparedness planning.* A major obstacle to health center engagement in emergency preparedness and response is the lack of funding to support these activities. Health centers can work with their state and local health departments to set aside funds to support health center emergency preparedness initiatives by demonstrating the mutual benefit derived from such collaboration.

Conclusion

The difference in size, organization, and programs across states can be vast. These differences greatly influence the type and amount of collaboration between state and local public health agencies, health centers, primary care associations, hospitals, and other partners. However, as evidenced in this report, there are a variety of collaboration models that communities can employ to ensure an effective response to emergency situations.

State and local public health agencies and health centers each have valuable resources to offer in the event of an emergency or natural disaster. As the direct link to the federal government, state public health agencies distribute and manage pertinent information, funding, educational curriculums, and at times medication, to local public health departments. Local public health agencies are at the forefront of any emergency response. It is critical that local health departments have necessary resources and a developed communication system that is coordinated with other local partners such as hospitals and clinics. Health centers possess unique access to vulnerable and underserved populations and are a trusted pillar in the communities they serve. It is the responsibility of each partner to communicate and work with one another to define specific responsibilities and determine how to best use available resources. Ongoing communication and joint activities are necessary in order to reinforce these valuable relationships.

Ideas and lessons from the state stories featured in this report can be extracted and applied in others states in order to create similar relationships to increase the likelihood of a successful response to a public health emergency. However, acknowledging that a successful collaboration is not created overnight, public health agencies and health centers need to take steps immediately to nurture relationships that could be critical in the time of an emergency.

Though this report demonstrates that effective collaboration is indeed occurring in many areas, such collaboration is not taking place in every community across the country. This report should serve both to demonstrate the benefits of collaboration in emergency response and as a practical resource for those already pursuing improved collaboration. If you have a successful collaboration story or resource to share, please send to lratner@astho.org and we will provide a link to your story via a newsletter or post on line.

Additional Resources

Templates – Health centers

California Primary Care Association - http://www.cpca.org/resources/cepp/

- Clinic Emergency Operations Plan
- Clinic Needs Assessment Tools

Indiana Primary Health Care Association - http://www.indianapca.org/htm/bioterrorism-plans-templates.php

- Emergency Management Plan
- Hazard Vulnerability Analysis
- Standard Operating Procedure

Community Health Center Association of New York - http://www.chcanys.org/index.php?src=gendocs&link=ep_forcenters&category=Main

- Emergency Management Plan
- Communications Policies and Procedures Manual Section
- Memorandum of Understanding Template and Guidance
- Patient Brochure: "What to Expect from Your Health Center in an Emergency."

Useful Web sites

Association of State and Territorial Health Officials – Public Health Preparedness http://www.astho.org/?template=preparedness.html

- Public health preparedness and response success stories and promising practices featured through the States of Preparedness Project.
- Emergency preparedness publications and links to additional resources.

California Department of Health Services - http://bepreparedcalifornia.ca.gov/epo/

- Emergency preparedness guidelines for individuals and families, schools, businesses, community organizations, and persons with disabilities.
- Emergency preparedness guidelines for partners, including local health departments, hospitals and clinics, providers, and other partners like the Centers for Disease Control and Prevention and the American Red Cross.

King County Health Care Coalition - www.metrokc.gov/health/hccoalition/

- Preparedness and Response Roles
- Governance
- Members
- Objectives
- Tiered Response
- Tools

National Association of Community Health Centers - http://www.nachc.com

- Extensive research and data page with resources to educate state and local health departments about health centers and the populations they serve.
- Emergency management resources and tools specific to health centers.

National Association of County and City Health Officials – Advanced Practice Center Site - http://www.naccho.org/topics/emergency/documents/APCProductMatrixDecember07.pdf

- Matrix of tools from NACCHO's Advanced Practice Centers that includes the focus area, brief description, and link to resource.

New York State Department of Health - http://www.health.state.ny.us/environmental/emergency/

- Family Emergency Planning brochures in English and Spanish.
- Emergency specific facts sheets with information for health care providers and the public.
  - Biological
  - Chemical
  - Radiological
  - Weather

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