Emergency Preparedness Planning Project at Maine Federally-Qualified Health Centers (FQHCs)

Final Report

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Background

Since Sept. 11, 2001, governmental agencies and non-governmental organizations have been working to ensure maximum preparedness not only for bioterrorism but also for response to a wide range of public health emergencies such as hurricanes or pandemic influenza outbreaks. Federally qualified health centers (FQHCs)*, have been recognized as a critical participant in these emergency preparedness efforts in Maine. Located in primarily rural and medically underserved areas in Maine, the FQHCs not only have skilled providers on staff, but also can be part of ongoing statewide effort to help provide surveillance for any significant public health threat. They are important state resources for triage, surge capacity, treatment capability, specific community population profiles and support services.

From Oct. 2004 – Sept. 2006, the Maine Primary Care Association initiated a project with researchers from the USM Edmund S. Muskie School of Public Service, Institute for Public Sector Innovation to enhance selected Maine FQHCs ability to effectively respond to emergencies. Sally Farrand from Maine Primary Care Association and Diane Friese from the USM Edmund S. Muskie School of Public Service comprised the project team.

Purpose

The project was designed to meet the following two goals:

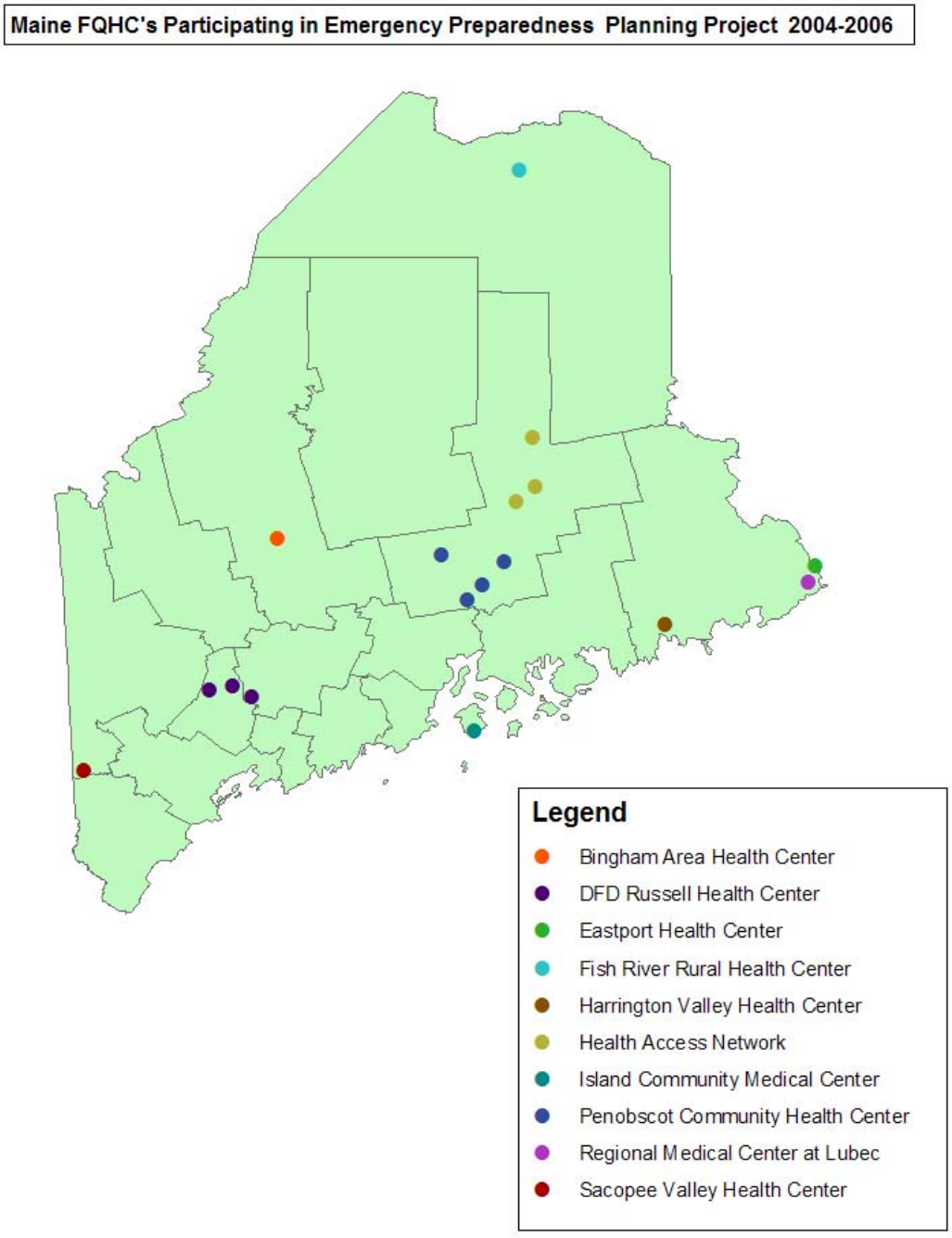
1. Build capacity of Maine FQHCs to develop an internal all hazards emergency preparedness plan for their health centers
2. Integrate the FQHCs into their community, county and state public health emergency preparedness planning efforts

In order to accomplish these goals, project staff assisted FQHC's in conducting community exercises that either informed or served as the basis for developing comprehensive emergency preparedness plans.

Participating FQHCs

Maine has 18 FQHCs located across the state. The criteria used to select health centers for this project included: a willingness to participate, geographic diversity and interest in integrating their emergency planning efforts with their local community and county. The map on the next page shows the ten FQHCs who participated in this 2-year pilot project.

*****FQHCs are nonprofit, consumer-directed corporations that provide high quality of care and cost-effective treatment to the underserved and uninsured. FQHCs include Community Health Centers, Migrant Health Centers, Health Care for the Homeless programs, Public Housing Primary Care programs, and Urban Indian and Tribal Health Centers. The approximately 93 million medically underserved people in the U.S include populations that are geographically, economically and culturally challenged. There are about 722 FQHCs across the U.S. Federal health center grants, Medicaid, Medicare, private insurance payments and state/local contributions support these centers.


Maine FQHC's Participating in Emergency Preparedness Planning Project 2004-2006
Legend
Bingham Area Health Center
DFD Russell Health Center
Eastport Health Center
Fish River Rural Health Center
Harrington Valley Health Center
Health Access Network
Island Community Medical Center
Penobscot Community Health Center
Regional Medical Center at Lubec
Sacopee Valley Health Center

Methods

Initially project staff conducted individual meetings with designated safety staff and management at each FQHC. The purposes of these meetings were as follows:

a. Assess health center readiness to engage in the project
b. Identify existing emergency preparedness planning activities at each health center
c. Assess existing abilities to perform a hazard vulnerability assessment
d. Share planning tools, templates and community engagement concepts with them

After these initial meetings, each FQHC developed a timeline for developing or enhancing their all-hazard facility emergency preparedness plan and completed a hazard vulnerability assessment using a standardized electronic tool. FQHC management also developed a strategy for strengthening partnerships in their particular community and county.

In order to integrate the FQHC emergency preparedness planning with their potential community and county partners, project staff helped six of the ten participating FQHCs host a community emergency preparedness-planning meeting. The other four FQHCs involved with this project chose not to host a community meeting. Project staff provided technical assistance to all project participants for whichever planning approach they chose to adopt.

Project staff designed an individualized tabletop exercise* for each community meeting, in order to focus the planning efforts on real life scenarios. The scenario for the tabletop during year one of the project was a SARS outbreak; the scenario used for year two was pandemic influenza. Evaluation forms were distributed and collected after each community meeting in addition to a group debriefing process at the completion of each tabletop exercise.

Once during each year of the project, multiple staff from each participating FQHC were invited to a daylong educational seminar. Each seminar focused on:

- Updates from state officials on Maine's emergency preparedness efforts
- Information on the National Incident Management System (NIMS),
- Presentations on mental health needs of trauma and disaster victims,
- Hands-on demonstrations of disaster equipment and
- Best practices from research

The seminar format also provided an opportunity for health centers to share their experiences with one another on their internal plans and their success or difficulty with engaging community partners into their planning processes.

* A tabletop exercise is a planned activity in which participants are presented with a simulated emergency situation(s), without time constraints. It is a facilitated informal meeting in a conference room and is designed to elicit constructive discussion among the participants. A tabletop exercise has specific goals, objectives and a scenario narrative. Emphasis is on slow-paced problem-solving rather than rapid, spontaneous decision-making.

Throughout both years of the project, project staff provided electronic, print and verbal technical assistance to each participating FQHC.

Findings

The project staff created evaluation instruments and collected qualitative data from interview notes, meeting evaluation responses and tabletop exercise group notes and FQHC administrator evaluations in order to identify key themes and effective emergency preparedness practices for community health centers. Data from these sources were compiled, sorted and then categorized by specific practices and behaviors. The recommendations on page 16 are based on these practices and behaviors associated with developing an all hazards emergency plan for a community health center.

During the second year of the project, a pre and post project evaluation form was completed by the participating FQHC administrator at each pilot site. The purpose of this tool was to determine the perceptions for progress and capacity building each administrator had for their facility and staff, from the inception of their involvement with the project until its conclusion. The chart below shows that there was an improvement in 7 of the 9 subject areas covered on the evaluation instrument.

Pre & Post Emergency Preparedness Planning and Skills Data (N=4)

		Agree	Somewhat Agree	Somewhat disagree	Disagree
1. Our health center has completed an all hazards emergency plan.	**Initial**		2	1	1
	Post project		2	1	1
2. I am familiar with the process for integrating our internal plan with other emergency plans in my community.	**Initial**	1	2		1
	Post Project	1	2	1	
3. I am knowledgeable about the availability of community resources (both equipment & personnel) to respond to a public health emergency.	**Initial**	1	2	1	
	Post Project		2	2	

		Agree	Somewhat Agree	Somewhat Disagree	Disagree
4. Our health center staff are currently engaged in emergency preparedness planning.	**Initial**	2		1	1
	Post Project	2	2		
5. Our board members understand the importance and value of all hazards emergency planning.	**Initial**	1	2		1
	Post Project	1	3		
6. Our staff has identified areas of emergency planning at our health center which need improvement.	**Initial**	3		1	
	Post Project	2	2		
7. Our health center staff understand the value of exercises such as tabletops in emergency planning.	**Initial**	1	2		1
	Post Project	1	2	1	
8. Our health center staff have participated in community public health emergency planning and/or exercises.	**Initial**			2	2
	Post Project		1	1	2
9. Our health center staff are knowledgeable about county and state emergency planning resources.	**Initial**		2	1	1
	Post Project		3	1	

The key practices which were observed the most frequently during both years of this project, which contributed to development of an all hazard's emergency plan at the community health center, are detailed below and on the following pages.

Identified Key Practices
• Organizational Commitment to Emergency Preparedness Planning • Participation of Clinical Staff • Enhanced Communication with Community Partners • Using Dynamic Preparedness Planning Exercises • Integration with County and State Plans • Use of Planning Templates

1. Organizational Commitment to Emergency Preparedness Planning

FQHC staff who were trained during or prior to this project on the interconnectivity of emergency preparedness planning to the daily provision of services to patients at their health center were observed by project staff to have an easier and more efficient emergency preparedness planning process. FQHC staff that accepted this perspective were more willing to participate in the planning process.

FQHC leadership at the community health centers understand the importance of emergency preparedness planning as shown by their commitment to actively participating on this project. The FQHC staff members who embraced the concept of developing processes and protocols prior to an emergency were more motivated to engage in their FQHCs emergency planning efforts than FQHC staff that generally did not make it a priority to develop such protocols. One source of this reluctance appeared to be staff adherence to "just in time" response protocols. While these responses are appropriate for other situations that arise at an FQHC, they are not effective for emergency preparedness response. Staffs who are not open to the shift in foci and not heavily encouraged to do so by management are less likely to participate. The FQHC leadership, who committed time and energy into having their staff participate on this project, were more successful in accomplishing their emergency planning goals.

2. Participation of Clinical Staff

The four pilot sites who had clinicians participate in their planning process created more comprehensive plans in a shorter time frame that the sites who did not have medical staff participate. The Fish River Rural Health Center was innovative in this regard by using a retired physician to draft their plan. This particular physician knew the community, county resources and had participated in drafting an emergency preparedness plan for the closest hospital in Fort Kent. The California template was used as the base document for their draft plan. The physician's clinical background was invaluable to the plan's comprehensiveness and gave a significant jumpstart in both time and content to the Fish River Rural Health Center emergency planning process.

The tabletop exercises used by the majority of the pilot sites elicited many questions that could best be answered by clinical staff. When they were absent, an information gap emerged that then needed to be addressed at a future time. This postponement often inhibited discussion of a particular protocol or process during the tabletop exercise.

Multiple skills are needed when responding to large-scale emergencies. Medical and administrative personnel within a FQHC need to collaborate and coordinate their response during a public health emergency, particularly if it extends out to multiple weeks/months as with a pandemic. This pilot project demonstrated that clinical staff participation in emergency preparedness planning is an important component for effective FQHC response to patients during a large-scale emergency.

3. Enhanced Communication with Community Partners

Most FQHCs in Maine are located in small rural communities where everyone knows most members of the community and the agencies who provide services to the community. The results of this project indicated that although FQHC leadership personally knew all potential community partners, discussions about emergency preparedness with them had not occurred prior to this project.

During this project, FQHCs were proactive in reaching out to community partners to enhance their relationships with them on this topic. Prior to this project, the FQHC leaders in several communities had not been invited to participate in community emergency preparedness exercises. Through the collaborative process of emergency preparedness planning, several FQHCs have now participated in local and county exercises. This process has strengthened the visibility and viability of these FQHCs as a resource for emergency response in their respective communities.

4. Using Dynamic Preparedness Planning Exercises

As was documented in the 2004-05 Project Report, the use of simple, community relevant tabletop exercises focusing on a realistic scenario enhanced the ability of FQHCs to develop emergency preparedness plans for their particular facilities. During the 2005-06 phase of the project, two FQHCs chose to engage in tabletop exercises specific to their health centers– Island Community Medical Services (ICMS) on Vinalhaven Island and Penobscot Community Health Center (PCHC), which is located in multiple facilities across the greater Bangor area. The other two pilot sites in year two, decided instead to participate in exercises being planned in their local communities or county. The following are summaries of the ICMS and PCHC tabletop exercises. These case studies describe how participating in tabletop exercises can improve a FQHCs capacity to conduct emergency preparedness planning.

Islands Community Medical Services

The FQHC on Vinalhaven Island has a service catchment area of 1235 year round residents and has an increase in population to approximately 5000 persons during the summer. This health center decided to do a modified community tabletop exercise facilitated by project staff. Invitees were limited to 10 people who were comprised of staff from: the Island FQHC, Vinalhaven Fire Dept., Vinalhaven Ambulance, Vinalhaven School Dept., Knox County EMA, Pen Bay Medical Center and Maine CDC. The scenario focused on a pandemic influenza outbreak across Maine.

Because Vinalhaven is an island with unique geographic related constraints, their planning involves accessing resources from the mainland and utilizing resources they already have on the island. Essentials for daily life – food, fuel and medical supplies are all dependent on daily boat delivery from the mainland, weather permitting. This tabletop planning exercise

with key partners enabled all participants to identify both their assets and vulnerabilities. The following are a few of the comments from the participant tabletop evaluation forms:

> "I am impressed with the community cohesiveness and planning already in place on Vinalhaven."
>
> "There is a need to identify other people to get involved as back up for all the key positions including ferry operators."
>
> "I have more questions about the use of the school building as a staging or feeding area during a pandemic."
>
> "There is a need to educate the community about citizen preparedness and what preparedness planning is being done by this group. The Vinalhaven community is the answer to response to a flu pandemic."

Among the next steps that this tabletop exercise generated for Island Community Medical Services were:

- Share this tabletop exercise with a wider group of community people to ask them what they can do/provide/assist with during a public health emergency such as a pandemic
- Bring someone to Vinalhaven to train on fit-testing N95 masks
- Identify ham radio operators available on the island or persons interested in becoming active operators
- Educate island people about pandemics and infectious disease outbreaks and what they will need to do

As the above list of next steps indicates, using a concrete scenario by means of a tabletop exercise often generates more questions than answers. The process of discussing emergency preparedness by a diverse group of people can create a realistic plan for response. This activity clearly brings people together to help solve problems, identify what they can provide for themselves and what resources they will need to ask for from county or state agencies.

Penobscot Community Health Center (PCHC)

Penobscot Community Health Center is located in the urban area of Bangor and serves 35,000 people per year with approximately 150,000 patient visits to date during 2006. Patient services are provided by 75 practitioners in nine locations. This FQHC is located in the urban area of Bangor. As part of the project, PCHC chose to have a tabletop exercise with only internal staff from their established safety committee invited to attend. Seven representatives from various parts of their multi-facility health center used this tabletop exercise as a starting point for writing their emergency plan. Similar toVinalhaven, project staff facilitated the tabletop using the pandemic influenza scenario, but adapted the exercise to the geographical and service parameters of this particular health center.

The tabletop exercise was used essentially as a group brainstorming session on how they would respond to a pandemic influenza outbreak. The synergy of the group produced some creative ideas on how to utilize existing resources and produced more questions to research. A few of these ideas follow:

- Use existing waiting room video monitors to play looping video presentations on emergency preparedness response in the home and for influenza outbreaks
- Potential use of the mobile dental clinic to reach people at their homes and keep infected patients away from the FQHC
- Use a trailer or tent with a heater in the parking lot to triage patients
- Assign wait numbers for people to be called by number as they wait in their cars before being triaged
- Designate a nurse who patients know and trust to be the first contact in the waiting room or in triage area
- Triage some people by phone using a separate phone line

The Penobscot Community Health Center Safety Committee plans on using ideas from this opening exercise to reach out to additional staff to participate in emergency planning for the FQHC. These include, clinical, pharmacy, dental and mental health staff. They plan on meeting bi-weekly until their plan, using the Maine template, is completed. PCHC Planning leadership has already connected with county emergency preparedness planning efforts and will continue to liaison and collaborate with these county-wide efforts.

Although these FQHCs used the tabletop exercise in different ways, both found that using a concrete scenario helped open the discussion to identify specific response protocols and resources which will be needed for their particular FQHC. This project demonstrated that tabletop exercises are a positive tool to engaging staff and community participation whether one is a very small FQHC or a facility that provides medical services to thousands of patients.

5. Integration with County and State Plans

Local, county and state agency representatives participated in the tabletop exercises during this project. Their participation brought both a larger perspective and planning expertise to the discussion with the FQHCs. In particular, the County Emergency Management Agency Directors (EMAs) were helpful during the tabletop exercises. York and Knox County EMA Directors provided valuable assistance respectively to Sacopee Valley Health Center and Islands Community Medical Centers. The enhanced relationship between these two FQHCs and EMA Directors has already improved the FQHCs ability to provide services to their patients, not only for emergency preparedness but also for ongoing support for medical response. In addition, these strengthened relationships have educated the EMA Directors about particular issues and situations that are unique to emergency response at each of these health centers.

FQHC project participants were encouraged to share their written plans with their County EMA Director. EMA Directors likewise have shared appropriate written plans with FQHCs.

Project staff were able to provide both general information and printed resources from state and national agencies to tabletop participants and to FQHC leadership prior to the community meetings. The positive response to this information indicates that this was useful to the FQHC planning process.

It should be noted that most communities in which FQHCs reside have written emergency preparedness plans. Parts of the FQHC facility plan can be integrated into the local community plans and vice versa. For example, the Vinalhaven Fire Dept. recently drafted an updated emergency preparedness plan for their community when Islands Community Medical Services began participating in this project. The medical response section of the community plan needed further development and through collaboration with ICMS they were able to easily improve their plan. Because this Vinalhaven Community Emergency Plan is user friendly and comprehensive, ICMS only had to focus on writing particular facility protocols and procedures for their internal plan. Both entities integrated sections of their plans, saving time and avoiding duplicative planning processes.

6. Use of Planning Templates

At the beginning of the project, a template developed by the California Primary Care Association was disseminated to all pilot sites. This comprehensive template proved too unwieldy for the FQHCs. In response, project staff modified the California Plan and created a Maine template that recognizes the size, geography and staffing appropriate to FQHCs in Maine.

The FQHCs participating in year two of this project received the more user-friendly Maine template and therefore reduced the amount of time editing sections that were appropriate for their facility.

Some FQHCs chose to write their draft plans prior to their community tabletop exercises and others did the reverse process. Throughout the project there appeared to be no distinction as to a preferred order for writing. It was apparent to project staff that those FQHCs who decided to use the Maine template were better able to start the drafting process, than those who started writing from scratch.

Recommendations

The following recommendations are based on observation by the author and evaluations received by the FQHC Administrative leadership at each pilot site and evaluations from tabletop exercise participants.

1. Foster Emergency Preparedness Planning

FQHCs have finite financial resources and staff to provide services to patients in their respective catchment areas. In addition, most FQHC staff have multiple responsibilities. As a result, it is helpful to have a designated person available to act as the lead resource for emergency preparedness across all FQHCs in Maine. This point person can assist FQHC administrators in educating their staff on emergency preparedness planning. The Maine Primary Care Association's leadership in this capacity during this project was critical to the success of the planning efforts of the pilot FQHC sites for this project.

2. Engage FQHC Clinical Staff

Emergency preparedness planning at FQHCs without clinical staff participation reduces the quality and effectiveness of the planning effort. Clinical staff need to be encouraged to participate by scheduling planning meetings and convenient times and by emphasizing the value of their participation to the effectiveness of the FQHC operation.

3. Increase Outreach to Community Partners

FQHC Emergency preparedness planning can increase community visibility and impact for each FQHC in Maine. Bringing community partners together to discuss resources available and needed during a large-scale public health emergency, increases the capacity of everyone in the community to effectively respond.

4. Share Emergency Preparedness Plans

When FQHCs share their emergency preparedness plans with local, county and state leaders they better position themselves for receiving the necessary resources during an emergency. Likewise, local, county and state emergency planners will understand what infrastructure and staff are available at a particular FQHC and therefore can incorporate this important information into their plans.

5. Practice Emergency Preparedness Response

Regular drills and tabletop exercises are an effective way for FQHCs to keep staff engaged with these plans, guarantee emergency preparedness plans are regularly updated and that community partners continue to be integrated into the planning process. It is recommended that key components of a plan be exercised annually. In addition, FQHC staffs are encouraged to attend any local, county or state emergency preparedness exercises to which they are invited.

6. Use Planning Templates

FQHCs are encouraged to use any existing emergency preparedness templates as the platform to writing their plans. By using a template, the focus of time and energy can be placed on the specific content appropriate to their individual FQHC.

Conclusion

The ten FQHCs participating in this project increased their ability to respond to emergencies at their facilities and in their communities. The foundation of emergency preparedness planning is the person-to-person interaction of knowing who to call and what resulting response will be implemented. During each tabletop exercise conducted for this project, an epiphany always occurred, when one or several participants learned about a resource in their community which they were not aware of prior to this discussion. These local interactive planning efforts can enhance FQHCs capacity to become part of the grassroots link for local public health emergency medical response across Maine communities.

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