MARKETING PERSPECTIVES 4493
Marketing Research & Consulting

FINAL REPORT TO:

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
U.S. PUBLIC HEALTH SERVICE - REGION VI

REGARDING:

COMMUNITY AND MIGRANT HEALTH CENTER EMERGENCY PREPAREDNESS STUDY

PREPARED BY:

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TABLE OF CONTENTS

		Page
I.	EXECUTIVE SUMMARY	1
II.	INTRODUCTION	5
III.	METHODOLOGY	7
IV.	STUDY FINDINGS	8
V.	VIABILITY OF EMERGENCY PREPAREDNESS LINKAGES	26
VI.	APPENDICES	32

Appendix A - Questionnaire
Appendix B - Potential *CHC/MHC* emergency preparedness program linkages

I. EXECUTIVE SUMMARY

To gain a greater understanding of Region VI *Community/Migrant Health Centers (CHC/MHC)* emergency preparedness, the *U.S. Department of Health & Human Services (DHHS)/U.S. Public Health Service - Region VI* commissioned Marketing Perspectives to study *CHC/MHC* ability to render emergency medical services to their communities in the event of a local disaster. Generally, the study's objectives included:

- Determining whether *CHC/MHCs* have written disaster plans describing their center's role in a community-wide disaster.
- Understanding the extent to which *CHC/MHCs* have worked with area emergency management coordinators to develop community-wide disaster plans.
- Learning the extent to which *CHC/MHCs* have assisted in actual local disaster or participated in a drill with local emergency management coordinators.
- Determining the viability of community disaster support program linkages.

After developing a telephone questionnaire designed to address the study issues, Marketing Perspectives surveyed Region VI *CHC/MHC* executive directors and administrators during October of 1992. A number of key findings emerged as a result of conducting this study.

MAJOR FINDINGS

Written Disaster Plans

Eleven out of 45 (24%), of Region VI *CHC/MHCs* reported having a written disaster plan describing their center's participation in a community-wide disaster.

Center's Role Described In Plan

About two-thirds (7 out of 11 or 64%), of the *CHC/MHCs* that had a written disaster plan said their plan addressed the center's role in a disaster relative to other area emergency response organizations.

Emergency Preparedness Officials Contact

Three-quarters (35 out of 45 or 78%), of *CHC/MHCs* said they were aware of local emergency preparedness plans, but less than two-thirds (27 out of 44 or 61%), had actual contact with *local* emergency preparedness officials. Contact with *state* emergency preparedness officials was even less (9 out of 45 or 20%).

Although the majority of the contact cited was with police and fire department on a formal basis about disaster planning, the context itself seemed to lack depth and thoroughness. Emergency management coordinators/civil defense officials were only mentioned twice. The only respondent who knew their emergency management coordinator by name learned about this person through a direct inquiry made after the questionnaire was received in the mail.

Disaster Drills and Aid To Disaster Victims

Few *CHC/MHCs* (7 out of 45 or 16%), have participated in disaster drills or rendered aid to victims during a natural or man-made disaster (9 out of 45 or 20%). However, of those *CHC/MHCs* who had rendered aid to disaster victims, two-thirds (6 out of 9 or 66%), did not have a written disaster plan compared to one-third (3 out of 9 or 33%), who did -- a difference which is not statistically significant.

Viability of Community Emergency Preparedness Linkages

About one-sixth (7 out of 45 or 16%), of the *CHC/MHCs* have linkages -- defined as the *CHC/MHC* itself and its community both having written disaster plans. The remainder (38 out of 45 or 84%) of the *CHC/MHCs* have no effectual emergency preparedness linkages. These have no linkages due to a lack of a *CHC/MHC* plan (24 out of 45 or 53%), no community plan (4 out of 45 or 9%), or the more formidable obstacle of having neither (10 out of 45 or 22%).

CONCLUSION

Of the 45 communities surveyed, most (31 out of 45 or 69%), Region VI communities have disaster plans; comparatively few (11 out of 45 or 25%), Region VI *CHC/MHCs* do. Although these *CHC/MHCs* have disaster plans, the vast majority (38 out of 45 or 84%), have not worked with local emergency management coordinators to develop an internal *CHC/MHC* disaster plan which is integrated into the community's plan. Other priorities seem to exist for these clinics. Other than *CHC/MHCs* who have recently encountered a disaster (e.g., Hurricane Andrew), little urgency for disaster preparedness was shown.

In summary, it appears that the absence of a written disaster plan has not precluded a *CHC/MHC* from actually aiding disaster victims, even though the quality and quantity of care delivered may be affected when needed medical supplies and provisions (e.g., bandages, power generator) are not stockpiled. However, impressions received from speaking with survey respondents is that formal emergency preparedness/disaster planning is not a priority for the centers. The interviews indicate disaster preparedness will not become a critical issue unless outside forces intervene, such as an actual disaster or regulatory change. In the absence of mandatory disaster plan

preparation, a step in the direction toward increasing disaster planning awareness would be to educate the *CHC/MHCs* about which communities have disaster plans waiting for *CHC/MHC* integration and the constituent elements of a sound disaster plan.

II. INTRODUCTION

A. BACKGROUND

*Community and Migrant Health Center (CHC/MHC*s) have made significant contributions to the health of medically underserved populations of Public Health Region VI. Because natural and man-made disasters frequently occur in the region, *CHC/MHC* programs need to develop and maintain an adequate level of emergency preparedness to effectively serve its user population.

To understand Region VI emergency preparedness of *CHC/MHCs*, the *U.S. Department of Health & Human Services (DHHS)/U.S. Public Health Service - Region VI* commissioned Marketing Perspectives to study *CHC/MHC* ability to render emergency medical services to their communities in the event of a local disaster and determine the extent to which actual emergency preparedness linkages exist. This research is the second of two research phases designed to study the emergency preparedness of Region VI Community and Migrant Health Centers (*CHC/MHC*).

This report summarizes the findings of Phase II's primary research, a quantitative survey among executive directors and administrators of Region VI *CHC/MHCs*. The following information is organized into sections which address the study objectives presented in the next section.

B. OBJECTIVES

The overall purposes of the proposed research were to: (1) gain an understanding of Region VI *CHC/MHC* ability to render emergency medical services to their communities in the event of a local disaster, and (2) identify the viability of the *CHC/MHCs'* community emergency preparedness program linkages. Specific objectives for this study included:

(1) Determining whether each *CHC/MHC* has a community-based emergency plan with an internal and external disaster plan component which include:

- description of the *CHC/MHC's* role in community-wide emergency preparedness plans;
- information about how *CHC/MHC* plans to implement specific procedures in response to disasters;
- provisions for management of staff, patients, space, supplies, communications and security;
- provisions for staff training in their roles during emergencies, and;
- procedures for patient transfers in the event higher levels of patient care are needed.

(2) Determining whether *CHC/MHC* community-wide emergency-based plans have been implemented in either a response to an emergency or a planned drill and evaluation of performance.

(3) Identifying *CHC/MHC* program linkages with state and local emergency preparedness organizations.

(4) Understanding the level of emergency preparedness of each *CHC/MHC* community.

III. METHODOLOGY

To accomplish the study objectives, Marketing Perspectives conducted telephone interviews with executive directors of Region VI *CHC/MHCs* during October of this year. Prior to calling the executive directors, a copy of the questionnaire was mailed to each *CHC/MHC* director along with a cover letter explaining the survey and encouraging participation.

Generally, the executive directors participated in the survey, but in many cases, referred other *CHC/MHC* administrators whom they felt were more qualified (e.g., Director of Operations, etc.) to answer the survey questions. Each interview lasted approximately ten minutes.

A total of 45 respondents out of a possible of 53 Region VI *CHC/MHCs* responded to the survey for a response rate of 85%. Seventy-three percent (33 out of 45), of the respondents interviewed were executive directors, 7% (3 out of 45), were administrator/ directors, 4% (2 out of 45), were physicians, 4% (2 out of 45), were CEOs and 2% (1 out of 45), were clinic managers.

IV. STUDY FINDINGS

A. *CHC/MHC* RESPONDENT PROFILE

- *CHC/MHC* respondent representation by state included:

State	Number Responding	Percent
Texas	25	56%
New Mexico	8	18%
Arkansas	6	13%
Oklahoma	3	7%
Louisiana	3	7%

- Almost two-thirds (28 out of 45 or 62%), of the *CHC/MHCs* responding were located in rural areas, while about one-third (17 out of 45 or 38%), were urban operations.

- Over one-half (25 out of 45 or 56%), could be classified as smaller clinics with patient loads of less than 9,000 users per year; slightly less than one-half (20 out of 45 or 44%), of the *CHC/MHCs* were large clinics with patient loads of 9,000+ users per year.

- Almost three-fifths (26 out of 45 or 58%), of the *CHC/MHCs* responding to the survey had satellite clinics associated with their center; about two-fifths (19 out of 45 or 42%), did not maintain satellite clinics.

- About one-fourth (11 out of 45 or 24%), of the *CHC/MHCs* said they had a written disaster plan that described their center's participation in a community-wide disaster.

- The balance of the study findings presented in this section will not only report on the total percentage responding to each survey question, but will also examine any significant differences between the above groups using Chi-Square statistical testing at the .05 significance (p) level.

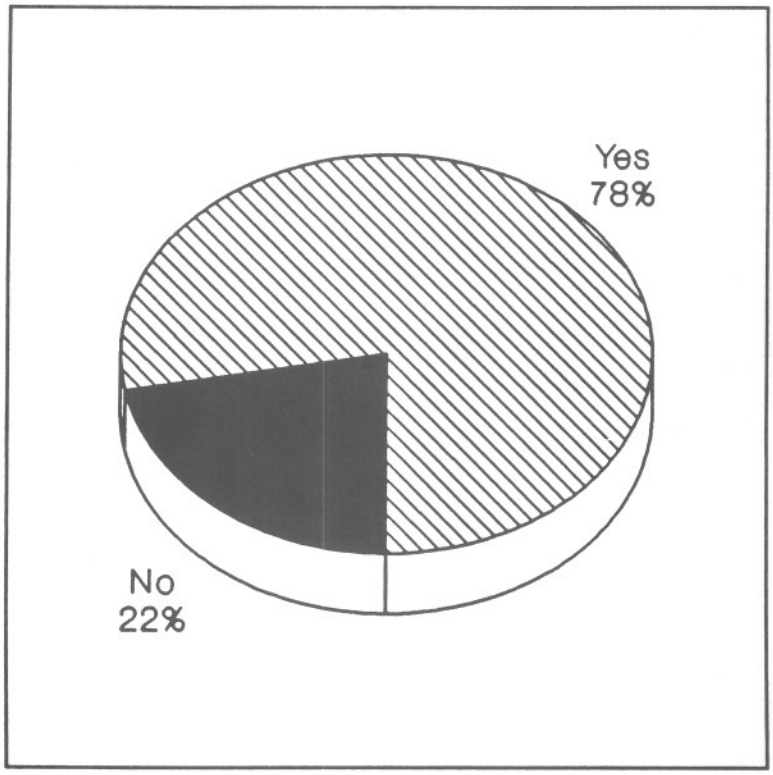
B. AWARENESS OF LOCAL EMERGENCY PREPAREDNESS PLANS

- Over three-quarters (35 out of 45 or 78%), of all respondents said they were aware of emergency preparedness plans for their local community that deal with natural and man-made disasters, as shown below in Exhibit 1.

- Significantly more (23 out of 26 or 88%), clinics with satellite operations than non-satellite operations (12 out of 19 or 63%), were aware of local emergency preparedness plans.

Exhibit 1

ARE YOU AWARE OF LOCAL EMERGENCY PREPAREDNESS PLANS?



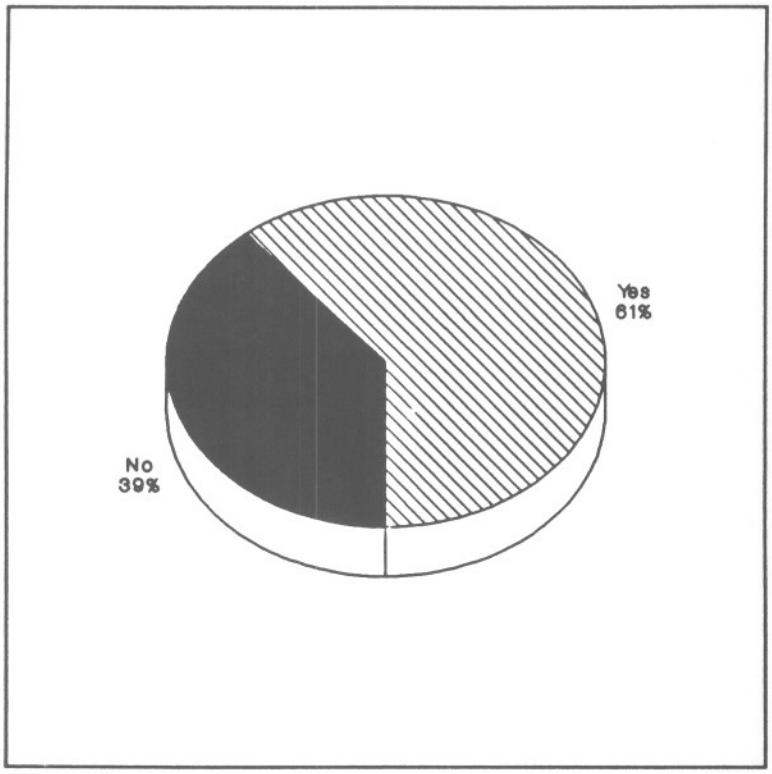
B. CONTACT WITH LOCAL EMERGENCY PREPAREDNESS OFFICIALS

- Almost two-thirds (27 out of 44 or 61%), of all respondents said they had contact with local emergency preparedness officials, as is graphically shown in Exhibit 2 below.

- Significantly more Texas (18 out of 24 or 75%), Oklahoma (3 out of 3 or 100%), and Arkansas (4 out of 4 or 67%), *CHC/MHCs* than New Mexico (1 out of 8 or 13%) *CHC/MHCs* have had contact with local emergency preparedness officials.

Exhibit 2

HAVE YOU HAD CONTACT ANY WITH LOCAL EMERGENCY PREPAREDNESS OFFICIALS?



B. CONTACT WITH LOCAL EMERGENCY PREPAREDNESS OFFICIALS (Cont.)

- Of the respondents who had contact with local emergency preparedness officials, local fire and police departments accounted for the majority of the contact (Fire - 13 out of 24 (54%); Police - 11 out of 45 (46%)), as shown in Exhibit 3 below.

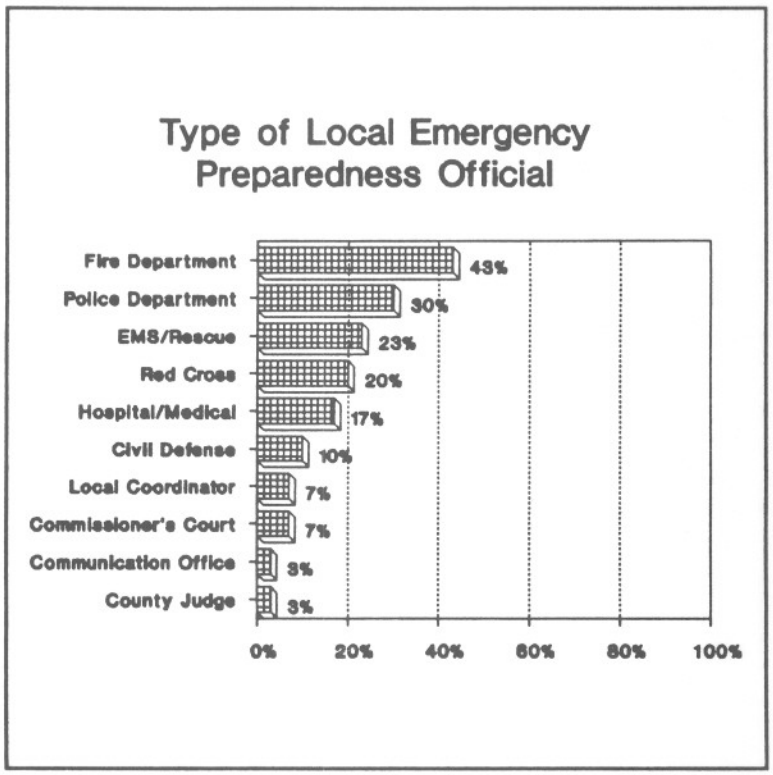
- Civil defense (3 out of 24 or 13%), and emergency management coordinators (3 out of 24 or 13%), accounted for relatively little of the local contact.

- Apparently, there is a strong reliance on the emergency organizations in the community whose main function is not mass disaster-oriented in nature.

  This suggests emergency planning on a community-wide basis is minimal, especially if the majority of the contacts are with organizations whose primary functions are non-disaster related.

Exhibit 3

CONTACT WITH LOCAL EMERGENCY PREPAREDNESS OFFICIALS



C. CONTACT WITH STATE EMERGENCY PREPAREDNESS OFFICIALS

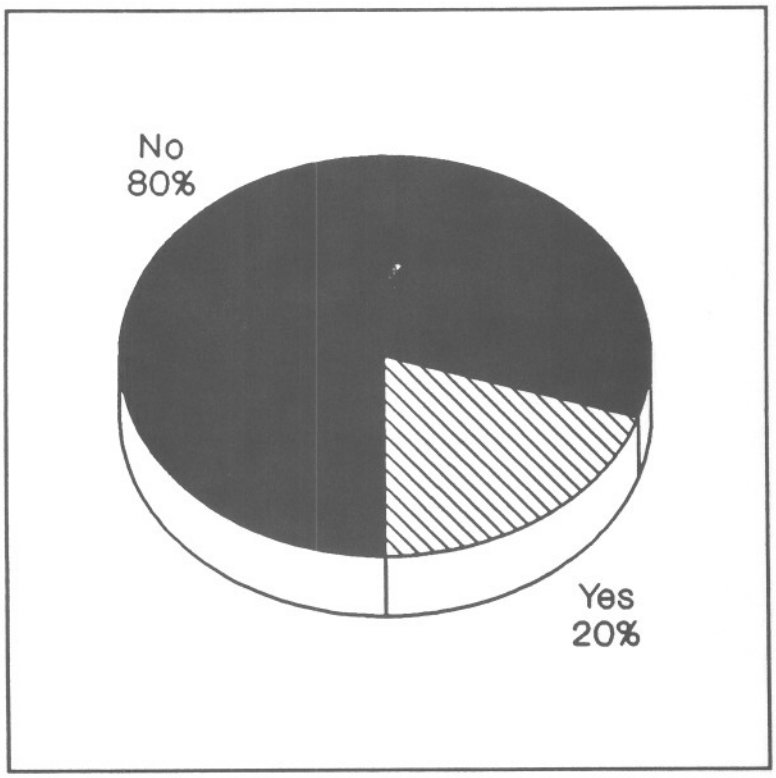
- One-fifth (9 out of 44 or 20%), of all respondents said they had contact with state emergency preparedness officials, as shown below in Exhibit 4.

- Of these respondents, only one-fifth (2 out of 9 or 20%), could *specify* the position or title of the individual with whom they reportedly had contact or the state office the individual represented -- a state EMS medical director and emergency management official.

- The relatively little contact with state emergency preparedness officials experienced by *CHC/MHCs* indicate minimal effort on the part of both *CHC/MHCs* and state officials to reach out to the communities in a concerted attempt to plan for natural disasters.

Exhibit 4

HAVE YOU HAD CONTACT WITH ANY STATE EMERGENCY PREPAREDNESS OFFICIALS?



D. AID TO DISASTER VICTIMS

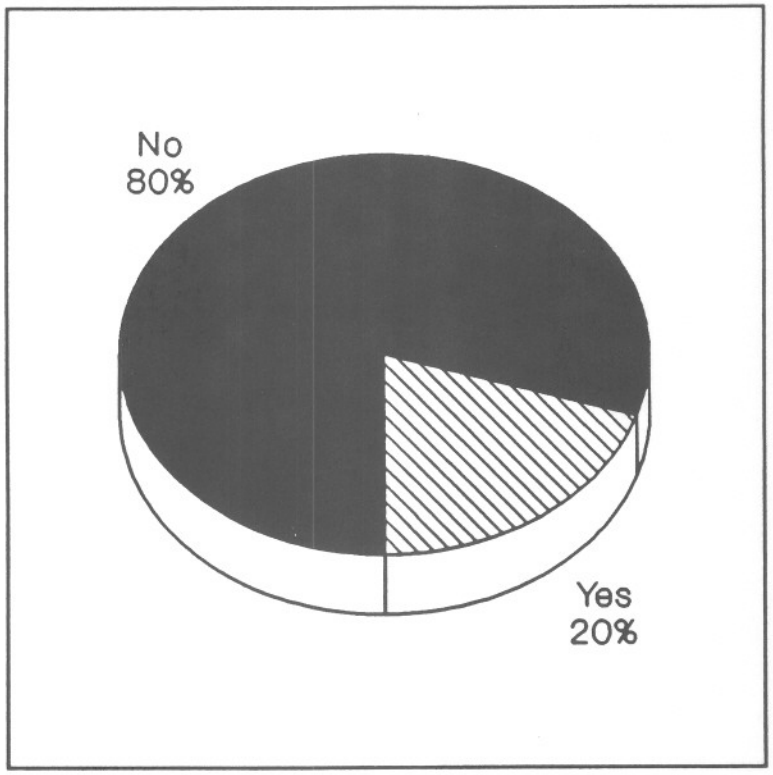
- One-fifth (9 out of 45 or 20%), of the respondents said their *CHC/MHC* had aided victims during a natural or man-made disaster in the past five years, as illustrated in Exhibit 5 below.

- Twenty-seven percent (3 out of 11 or 27%), of *CHC/MHCs* with a written disaster plan had rendered aid during natural or man-made disasters compared to *CHC/MHCs* without a written disaster plan (6 out of 34 or 18%). These differences, however, are not significant.

- This seems to indicate that not having a written disaster plan does not significantly impact *CHC/MHCs*' ability to render aid in the event of a disaster, though the absence of plan could impact quality of care issues.

Exhibit 5

HAS YOUR *CHC/MHC* RENDERED AID TO VICTIMS DURING A DISASTER IN PAST 5 YEARS?



D. AID TO DISASTER VICTIMS (Cont.)

- Of those *CHC/MHCs* which reported rendering aid to disaster victims or nine), medical support at local hospitals (4 out of 9 or 44%) and first aid/emergency medical care/triage (3 out of 9 or 33%), were the most frequently reported forms of aid rendered, as shown in Exhibit 6 below.

Exhibit 6

LEVEL OF INVOLVEMENT IN RENDERING AID DURING NATURAL OR MAN-MADE DISASTER

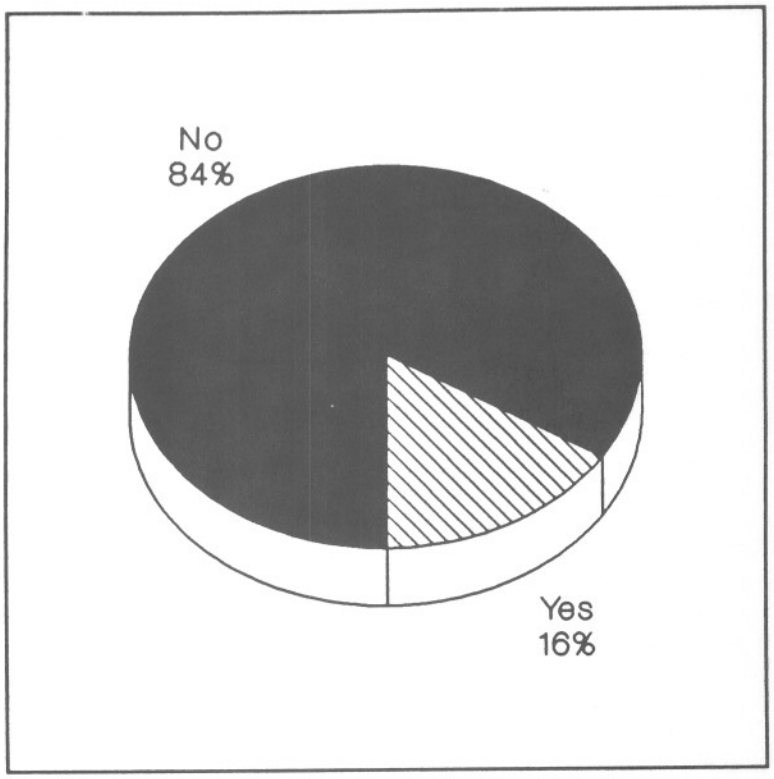
Rank	Type of Emergency Aid Rendered	Frequency (n = 9)	Response (%)
1st	Local Hospital Support	4	44
2nd	First aid/emergency medical care/triage	3	33
3rd	Prescriptions	2	22
	Food/water	2	22
	Shelter assistance	2	22
4th	Morgue assistance	1	11
	Victim relocation	1	11
	Communications	1	11
	Transportation	1	11
	Case management	1	11

E. DISASTER DRILL PARTICIPATION

- About one-seventh (7 out of 44 or 16%), of the respondents said their *CHC/MHC* had participated in a community-wide disaster drill in the past five years, as illustrated in Exhibit 7 below.

Exhibit 7

HAS YOUR *CHC/MHC* EVER PARTICIPATED IN A COMMUNITY-WIDE DISASTER DRILL IN PAST 5 YEARS?



E. DISASTER DRILL PARTICIPATION (Cont.)

- Of the respondents (eight) who said their *CHC/MHC* participated in community wide disaster drill in the past five years, mock disaster drill was the most often (5 out of 8 or 63%), mentioned type of drill in which the *CHC/MHCs* participated, as shown below in Exhibit 8.

Exhibit 8

TYPES OF COMMUNITY-WIDE DISASTER DRILL PARTICIPATION

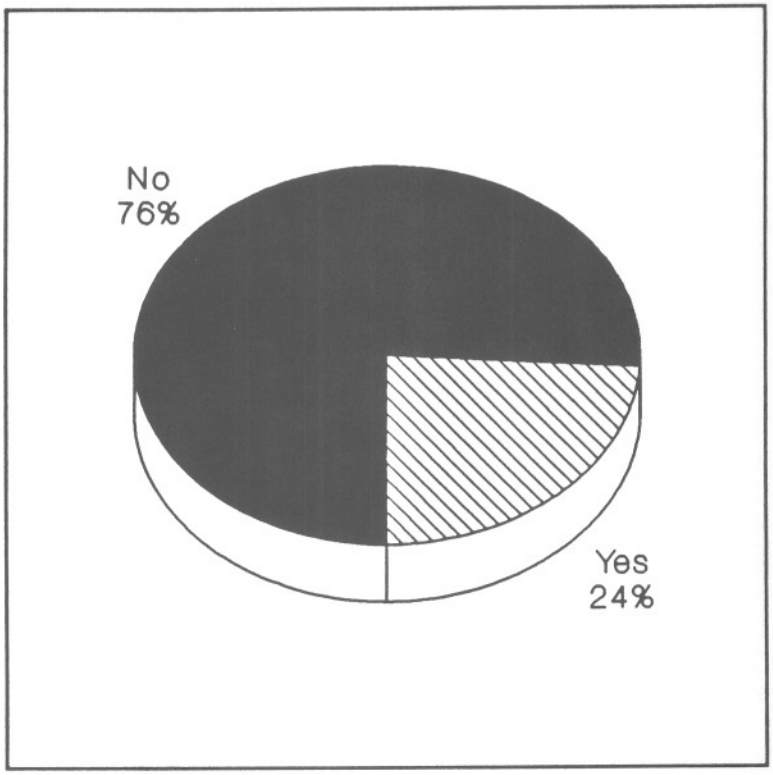
Rank	Type of Emergency Drill Participation	Frequency (n = 8)	Percent (%)
1st	Mock disaster drills	5	63
2nd	Tornado drills	2	25
	Earthquake drills	2	25
3rd	Drills for employees & patients	1	13

F. WRITTEN DISASTER PLAN

- About one-fourth (11 out of 45 or 24%), of the respondents said their *CHC/MHC* had a written disaster plan describing their center's participation in a community-wide disaster, as shown below in Exhibit 9.

Exhibit 9

DOES YOUR *CHC/MHC* HAVE A WRITTEN DISASTER PLAN DESCRIBING YOUR CENTER'S ROLE IN A COMMUNITY-WIDE DISASTER?



G. CENTER'S ROLE IN DISASTER

- About two-thirds (7 out of 11 or 64%), of *CHC/MHCs* having a written disaster plan describing their center's participation, stated the plan addressed their *CHC/MHC's* role in relation to other area emergency response organizations.

- When asked to describe these roles, respondents offered a variety of capacities distinguished by their lack of specificity and consensus, as can be seen in Exhibit 10.

- Significantly more rural (6 out of 6 or 100%), than urban (1 out of 5 or 20%), *CHC/MHC's* plans describe their roles in relation to other area emergency organizations.

Exhibit 10

CHC/MHC ROLES IN RELATION TO OTHER AREA EMERGENCY RESPONSE ORGANIZATIONS

Type of CHC/MHC Role	Frequency of Mention (n = 9)
Report and be assigned	1
Prioritized list of EMS services to call	1
Hospital will use clinic for information center	1
Housing patients	1
Stabilize and transfer patients	1
Designated roles in clinic	1
Center will come under hospital's director of physicians	1
Rendering first aid/medical services	1
Licensed personnel go to hospital	1

H. DISASTER PLAN CONSTITUENTS

- Of those *CHC/MHCs* having written disaster plans, the most frequently appearing constituent elements were management of staff (8 out of 11 or 73%), followed by staff training (7 out of 11 or 64%), as shown in Exhibit 11 on the following page.

- Significantly more urban (4 out of 5 or 80%), than rural (1 out of 6 or 17%), *CHC/MHCs* contained procedures in *response to environmental or man-made events*.

- Significantly more non-satellite clinic operations (4 out of 5 or 80%), than *CHC/MHCs* with satellites (1 out of 6 or 17%), had plans which addressed management of health center *floor space*.

- Significantly more non-satellite clinic operations (4 out of 5 or 80%), than *CHC/MHC* with satellites (1 out of 6 or 17%), addressed *communications systems*.

- Significantly more non-satellite clinic operations (4 out of 5 or 80%), than *CHC/MHC* with satellites (1 out of 6 or 17%), addressed *management of supplies*.

- Significantly more non-satellite clinic operations (3 out of 5 or 60%), than *CHC/MHC* with satellites (0 out of 6 or 0%), addressed *patient admissions*.

- Significantly more non-satellite clinic operations (3 out of 5 or 60%), than *CHC/MHC* with satellites (0 out of 6 or 0%), addressed *transfer of patients*.

- Significantly more non-satellite clinic operations (3 out of 5 or 60%), than *CHC/MHC* with satellites, (0 out of 6 or 0%), addressed *control of patient information*.

Exhibit 11

MOST FREQUENTLY MENTIONED CONSTITUENTS OF *CHC/MHC* DISASTER PLANS

Rank	Constituent Element of *CHC/MHC* Disaster Plan	Frequency (n = 11)	Response (%)
1st	Management of staff, in terms of staff assignment and distribution of functions and responsibilities in disaster response situations	8	73
2nd	Staff training in their roles during emergencies	7	64
3rd	Semi-annual implementation of the plan, either in evaluation to an emergency or a planned drill	6	55
	Evaluation of performance on implementation of plan	6	55
4th	Information about how your *CHC/MHC* intends to implement specific procedures in response to environmental or man-made events	5	45
	Management of health center floor space	5	45
	Management of supplies (e.g., stockpile of drugs, etc.)	5	45
	Communications system (e.g., radio telephone) permitting instant contact with law enforcement agencies, rescue squads or other emergency services within the community	5	45
5th	Management of security	4	40
6th	Management of patients, including procedures for:		
	- Triage/disposition of patients	4	40
	- Patient admissions	3	27
	- Transfer of patients	3	27
	- Control of patient information	3	27

I. SATELLITE CLINIC OPERATIONS

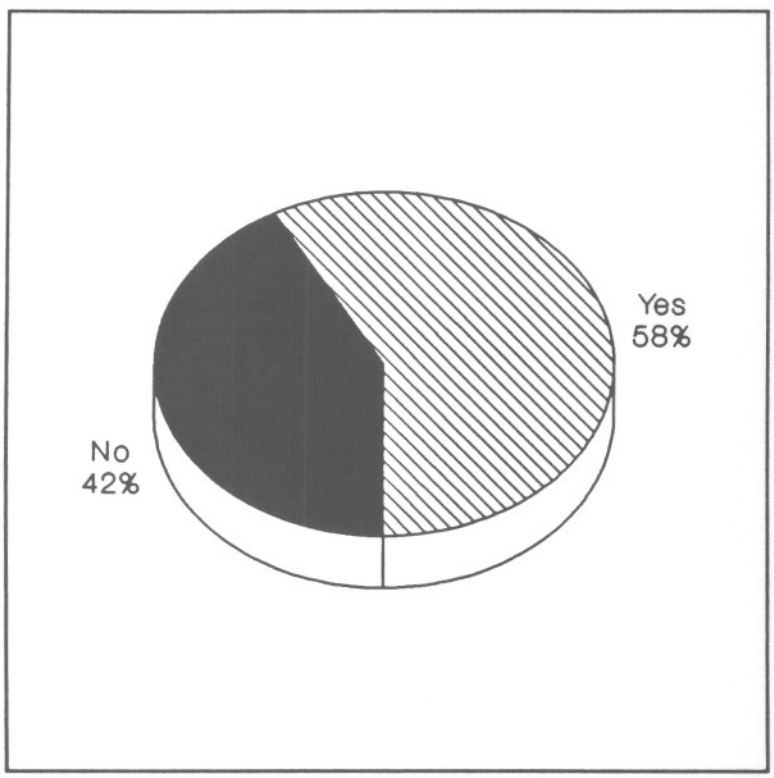
- As previously mentioned, over one-half (26 out of 45 or 58%), of the *CHC/MHCs* reported having satellite clinic operations, as shown in Exhibit 12 below.

- Approximately one-fifth (5 out of 26 or 19%), of the satellite clinics had disaster plans which integrated with their community disaster plans.

- Of these satellite clinics one-half (3 out of 6 or 50%), had plans that linked with their *CHC/MHC's* disaster plan.

Exhibit 12

DO YOU HAVE SATELLITE CLINICS ASSOCIATE WITH YOUR *CHC/MHC*?



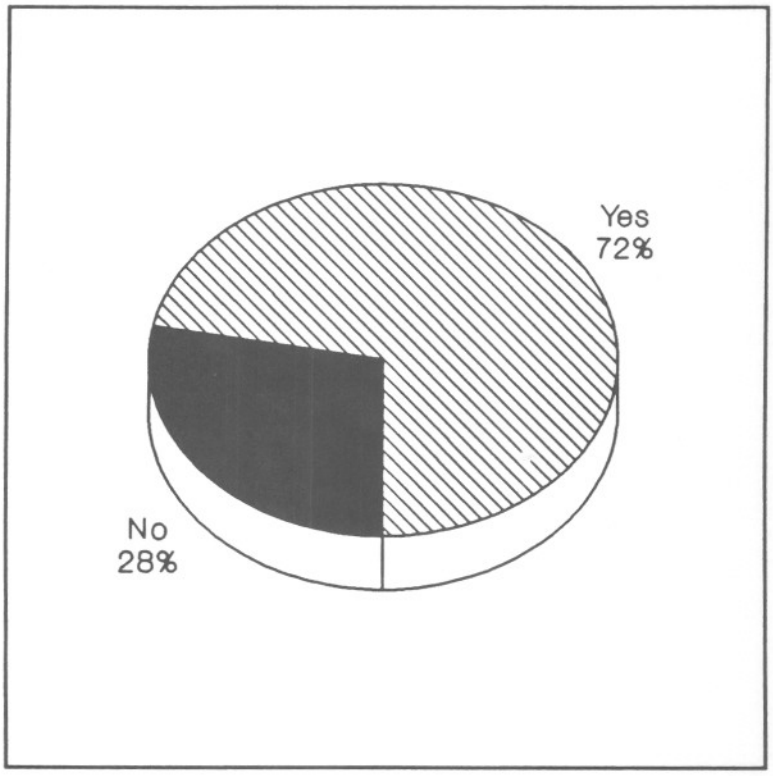
J. PLANS FOR FUTURE INVOLVEMENT IN PROVIDING DISASTER SUPPORT

- Almost three-quarters (23 out of 32 or 72%), of the *CHC/MHCs* administrators said they plan to become actively involved in providing emergency support to their community in the event of a disaster, as shown in Exhibit 14 below.

- There were no significant differences observed between any of the groups tested.

Exhibit 14

DOES YOUR *CHC/MHC* HAVE PLANS TO BECOME ACTIVELY INVOLVED IN PROVIDING DISASTER EMERGENCY SUPPORT?



K. DESCRIPTION OF PLANS FOR FUTURE DISASTER SUPPORT

- In describing what their plans were to become more actively involved in providing emergency support to their local community in the event of a disaster, most (10 out of 22 or 45%), respondents said they *had no formal plans*, but *would do whatever was mandated and would aid victims in area disasters as they arise* in a disaster.

  This attitude is the essence of the overall approach the *CHC/MHCs* are taking regarding emergency preparedness: no plans, unless led to plan by outside agencies, but will help as disasters arise.

- Brief descriptions of the various plans are provided in Exhibit 15 below.

Exhibit 15

DESCRIPTION OF PLANS TO BECOME MORE ACTIVELY INVOLVED IN PROVIDING DISASTER SUPPORT TO COMMUNITY

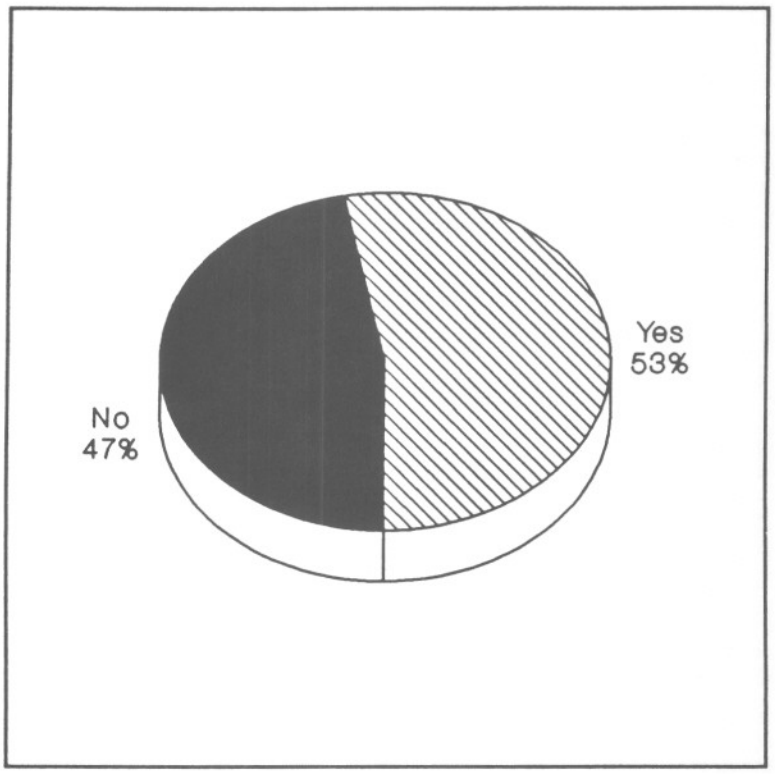
Rank	Description of Plans	Frequency (n = 22)	Response (%)
1st	No formal plans, but will do what ever is mandated and, in the event of a disaster, will do what is necessary to aid victims in the meantime	10	45
2nd	Holding discussions with different emergency management agencies	3 3	14 14
3rd	Create stronger linkage with local EMS Contact local hospital officials	2 2	9 9
4th	Contact local Red Cross Support local hospital Contact local officials Depends on local officials	1 1 1 1	5 5 5 5

L. PLANS TO DEVELOP WRITTEN DISASTER PLANS

- Of those *CHC/MHCs* which do not have written disaster plans (34 out of 45 or 76%), about one-half (17 out of 32 or 53%), said they had plans to develop written disaster plans for aiding their communities, as shown below in Exhibit 16.

Exhibit 16

DOES YOUR *CHC/MHC* HAVE PLANS TO DEVELOP WRITTEN DISASTER PLANS FOR RESPONSE TO EXTERNAL DISASTERS WITHIN THE NEXT 12 MONTHS?



M. REASONS FOR NOT PLANNING DEVELOPMENT OF DISASTER PLAN

- Of those *CHC/MHC* respondents who said they did not have plans to develop a written disaster plan, most said *other priorities* (6 out of 22 or 35%), currently needed their attention, as shown in Exhibit 17.

- The second most frequently cited reason for not developing a written disaster plan was their *ability to help locally without an internal CHC/MHC* written disaster plan (5 out of 17 or 29%), while deferring to other authorities accounted for over one-third (6 out of 17 or 35%), of their reasons.

- This, again, reflects a "no plans unless mandated" approach toward disaster planning, an attitude of many *CHC/MHCs*.

Exhibit 17

REASONS FOR NOT PLANNING TO DEVELOP WRITTEN DISASTER PLAN IN THE NEXT 12 MONTHS

Rank	Reasons Given For Not Planning To Develop Written Disaster Plan	Frequency (n = 17)	Response (%)
1st	Other priorities currently	6	35
2nd	Able to help locally without an internal *CHC/MHC* written plan	5	29
3rd	Deferring to local authorities for plan	4	24
4th	Limited staff	3	18
	Not been an issue	3	18
5th	Limited funds	2	12
6th	Depends on outside local committee/agency	1	6
7th	Deferring to federal authorities	1	6

V. VIABILITY OF EMERGENCY PREPAREDNESS LINKAGES

Region VI *CHC/MHC*-community emergency preparedness linkages appear to be relatively weak overall. About one sixth (7 out of 45 or 16%), of the *CHC/MHCs* have viable linkages -- defined as the *CHC/MHC* itself and its community both having written disaster plans. The remainder (38 out of 45 or 84%), of the *CHC/MHCs* have no effectual linkages. These have no linkages due to: (1) a lack of a *CHC/MHC* plan (24 out of 45 or 53%), (2) no community plan (4 out of 45 or 9%), or (3) the more formidable obstacle of having neither (10 out of 45 or 22%).

Exhibit 18, shown on page 28, is a matrix designed to show the viability of linkage between individual *CHC/MHCs* and their local communities. The quadrant names -- *LOCAL DISASTER MEDICAL SERVICE, PARTIAL DISASTER MEDICAL SERVICE, ISOLATED DISASTER MEDICAL SERVICE* and *NO LOCAL DISASTER PLANS* -- were coined to characterize the potential quality of care levels which might be delivered by the plan scenarios (presence/absence) depicted. These quadrants are defined as follows:

- **Local Disaster Medical Service (7 out of 45 or 16%)**

  Clinics that have disaster plans integrated with community disaster plans. These *CHC/MHCs* are characterized as fully integrated with all other area emergency organizations. *CHC/MHCs* function as primary responders in their communities.

- **Partial Disaster Medical Service (24 out of 45 or 53%)**

  Clinics without disaster plans in communities with disaster plans. These clinics are usually in touch with local EMS agencies. However, much less coordination and aid to disaster victims is realized than with **Local Disaster Medical Service**.

- **Isolated Local Disaster Medical Service (4 out of 45 or 9%)**

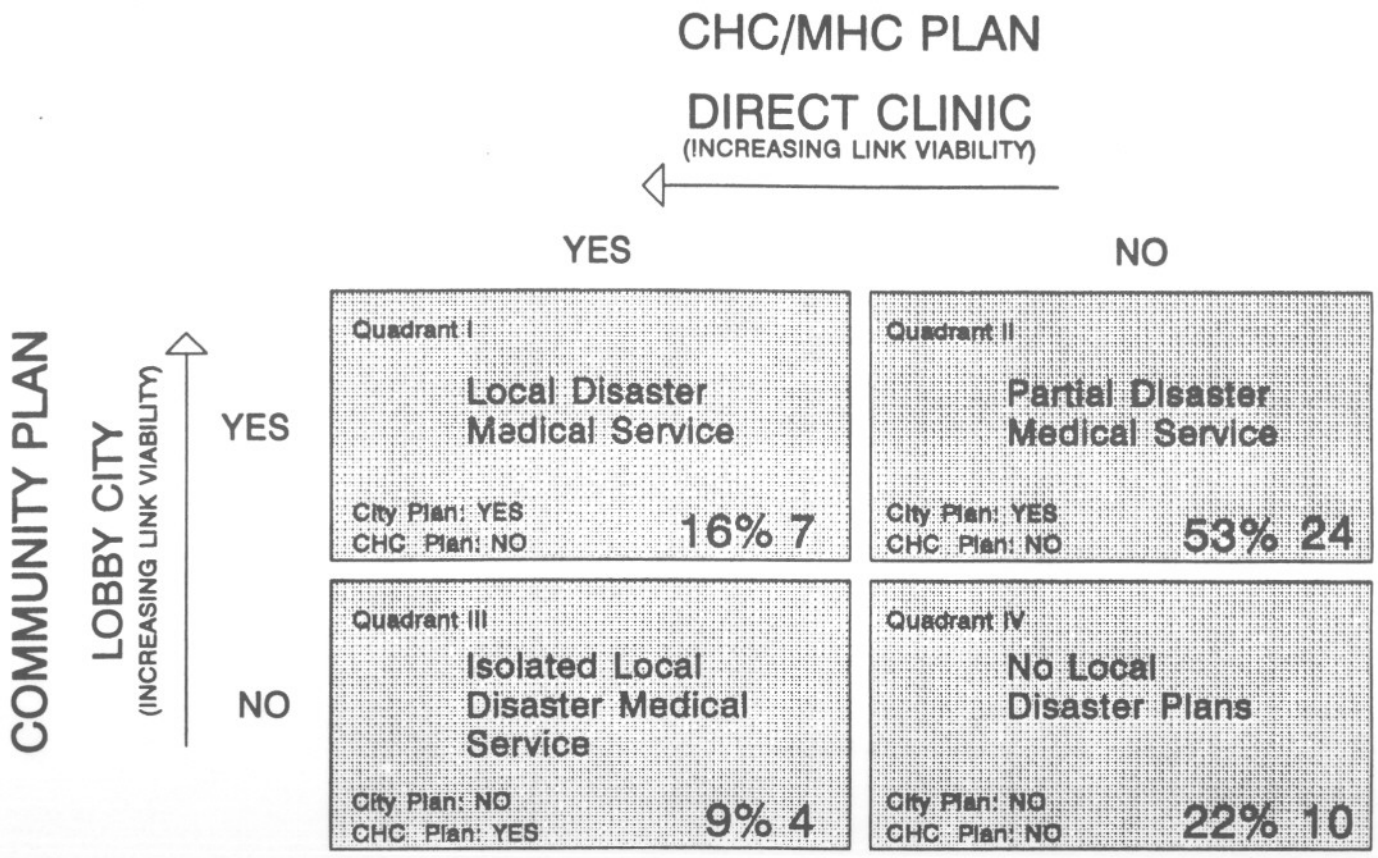
  Clinics with disaster plans in communities without disaster plans. These *CHC/MHCs* can more effectively take the initiative to aid disaster victims than **Partial Disaster Medical Service**, but not as effectively as **Local Disaster Medical Service.**

- **No Local Disaster Plans (10 out of 45 or 22%)**

  Clinics without disaster plans in communities without disaster plans. These clinics will most likely be the hardest to move into the **Local Disaster Medical Service** category.

Exhibit 18

VIABILITY OF CHC-COMMUNITY EMERGENCY PREPAREDNESS LINKAGES



Explanation of Exhibit 18

- The viability of the *CHC/MHC*-community emergency preparedness linkage is strongest when moving across the top row to the left (from Quadrant II to Quadrant I). Here, Quadrant II without disaster plans should more rapidly be able to develop a viable linkage than Quadrant III or IV because of the "red tape" required for municipalities to develop extensive, community-wide disaster plans under State requirements.

- The next most viable linkage is created by moving up the left hand column (from Quadrant III to I) for reasons previously cited.

- The least viable linkage is created by trying to move from the lower right hand quadrant to the upper left (Quadrant IV to I). To bring the clinics in this group, **No Local Disaster Plans**, into line, they should first be encouraged to develop an internal disaster plan. In doing so they would move from the lower right to left, thereby increasing the possibility for a viable link.

Another factor to be considered in analyzing the viability of emergency preparedness linkages is to understand the completeness of a given disaster plan. Exhibit 19, shown on page 31, reveals the degree of completeness of Region VI CHC/MHCs (11 out of 45 or 24%) that said they currently had a written disaster plan.

Exhibit 19 has been constructed to list essential elements of a disaster plan -- as presented in Question 7c of the survey -- and provide a visual check regarding whether the CHC/MHCs had the element contained in their overall plan. The columns are labeled with an abbreviated summary of the plan element; the names of the Region VI CHC/MHCs which reported having a written disaster plans are shown at the left of the columns.

As can be seen from this exhibit, only two out of the eleven CHC/MHCs have what could be considered a complete plan -- one that addresses all major elements of clinical operation during a disaster. Five of the eleven reported being less than 50% complete.

This *Community and Migrant Health Center (CHC/MHC) Emergency Preparedness Study* reveals a willingness on the part of *CHC/MHCs* to respond to disasters within their communities. The study also reveals that most of the *CHC/MHCs* are not woven into a communitie's disaster response plan. Although the legislative mission of the *CHC/MHCs'* program does not include any responsibility for emergency preparedness or disaster response, the *CHC/MHCs* could be a critical life saving resource in the early stages of a natural or man-made disaster. The role of *CHC/MHCs* in disaster response planning is an issue that deserves further consideration. Most notably, some twenty-four communities (of the forty-five centers responding) have a community disaster plan where *CHC/MHCs* could become a part of the response by developing a disaster plan for the center.

Exhibit 19

DISASTER PLAN COMPLETENESS

City	% of Rating	Rating	F	G	J	K	A	B	C	D	E	H
Crystal City, Texas	100%	13	1	1	1	1	1	1	1	1	1	4
El Paso, Texas	100%	13	1	1	1	1	1	1	1	1	1	4
Brownsville, Texas	62%	8	1	1	1	1		1	1	1	1	
Sioll Island, Louisiana	62%	8	1	1				1	1			4
Galveston, Texas	46%	6	1				1	1	1	1	1	
Cameron, Texas	39%	5	1	1	1	1	1					
Hampton, Arkansas	31%	4	1		1	1						1
West Memphis, Arkansas	31%	4	1	1		1	1					
Leveland, Texas	15%	2		1	1							
Tierra Amarilla, New Mexico	8%	1							1			
Portland, Arkansas	0%	0										

- A - Information about how to implement plan.
- B - Management of floor space.
- C - Management of supplies.
- D - Communication system.

E - Management of security.
F - Management of staff.
G - Staff training.
H - Management of patients.

J - Semi-annual implementation of plan.
K - Evaluation of implementation.

APPENDICES

Appendix A

QUESTIONNAIRE

OMB No. 09937-0196
Approval Expires: 9-30-93

U.S. PUBLIC HEALTH SERVICE
REGION VI

Community/Migrant Health Center Emergency Preparedness Survey

Please help us understand the degree to which Region VI Community/Migrant Health Centers (CHC/MHCs) are prepared to offer basic emergency medical care to their communities during a natural or man-made disaster. Our goal is to determine whether CHC/MHCs could serve to help strengthen a stressed emergency medical system in their communities during a catastrophic disaster.

Public reporting burden for this collection of information is estimated to average 20 minutes. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: PHS Reports Clearance Officer, Attn: PRA, Hubert H. Humphrey Bldg, Rm. 721-B, 200 Independence Avenue, S.W., Washington D.C. 20001 and to the Office of Management and Budget, Paperwork Reduction Project, 0937-0196, Washington D.C. 20503.

You do not need to fill out the questionnaire as the information will be obtained by Marketing Perspectives through a telephone interview.

COMMUNITY/MIGRANT HEALTH CENTER
Emergency Preparedness Survey

1. What is the name of your CHC/MHC?

   _____

2. What is your CHC/MHC's location:

   a. City/Town: _____

   b. County: _____

   c. State: _____

   d. Zip Code _____

3a. What is your name? _____

3b. What is your title or position? _____

3c. What is your telephone number? _____

4. Are you aware of emergency preparedness plans for your local community that deal with natural and man-made disasters?

   (1) __ Yes
   (2) __ No

5. Has your CHC/MHC ever had *contact* with any local government emergency preparedness officials or state emergency preparedness officials?

	Yes	No
a. Local Emergency Preparedness Official?	___	___

If "yes," identify specific linkage(s) (e.g., Police, Fire, Medical, Red Cross, etc.)

_____

_____

_____

_____

_____

	Yes	No
b. State Emergency Preparedness Official?	___	___

If "yes," identify specific linkage(s) (e.g., Police, Fire, Medical, etc.)

_____

_____

6. Has your CHC/MHC ever been involved in aiding victims during a natural or man-made disaster or participated in planned community-wide disaster drill in the past 5 years?

	Yes	No
a. Aided disaster victims?	___	___

If "yes," briefly indicate your level of involvement.

_____

_____

_____

_____

_____

6. (Cont.)

	Yes	No
b. Participated in community-wide disaster drills?	___	___

If "yes," please indicate the type of drill(s).

_____

_____

7a. Does your CHC/MHC have a written *disaster plan* that describes your center's role in a community-wide disaster?

(1) __ Yes
(2) __ No ***(SKIP TO QUESTION 8a)***

7b. Does the plan describe the *role* your CHC/MHC will play in relation to other area emergency response organizations (e.g., hospitals, fire departments, etc.) during a community-wide disaster?

(1) __ Yes
(2) __ No

If "yes," briefly describe your CHC/MHC's *role*.

_____

_____

7c. The following are the types of concerns that would need to be addressed to obtain Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation. If you have a written disaster plan, please answer the following questions.

IF YOU DO NOT HAVE A WRITTEN DISASTER PLAN, SKIP TO QUESTION 8a.

	Yes	No
a. *Information about how your CHC/MHC intends to implement specific procedures in response to environmental or man-made events*	___	___
b. *Management of health center floor space*	___	___
c. *Management of supplies (e.g., stockpile of drugs, bandages, etc.)*	___	___

7c. (Continued)

	Yes	No
d. *Communications system (e.g., radio telephone) permitting instant contact with law enforcement agencies, rescue squads or other emergency services within the community*	__	__
e. *Management of security*	__	__
f. *Management of staff, in terms of staff assignment and distribution of functions and responsibilities in disaster response situation*	__	__
g. *Staff training in their roles during emergencies*	__	__
h. *Management of patients, including procedures for:*		
- Patient admissions	__	__
- Transfer of patients	__	__
- Triage/disposition of patients	__	__
- Control of patient information	__	__
i. *Fire plan addressing:*		
- Use & function of fire alarm	__	__
- Detection systems	__	__
- Fire Containment	__	__
- Transfer to areas of refuge	__	__
- Evacuation	__	__
- Fire extinguishment	__	__
j. *Semiannual implementation of the plan, either in response to an emergency or a planned drill*	__	__
k. *Evaluation of performance on implementation of plan*	__	__

8a. Do you have satellite clinics associated with your CHC/MHC?

(1) __ Yes; *Specify number of satellite clinics:* ____
(2) __ No **(SKIP TO QUESTION 10a)**

8b. Do your satellites have written disaster plans that integrate the plan with their community disaster plans?

(1) __ Yes; *Specify number with plan:* ____
(2) __ No; *Specify number without plan:* ___ **(SKIP TO QUESTION 10a)**

8c. Do the satellite disaster plans link with your CHC/MHC disaster plan?

(1) __ Yes; *Specify number that link plans with your CHC/MHC:* ___
(2) __ No; *Specify number that do not link plans with your CHC/MHC:* ___

Organizations (JCAHO)?

(1) __ Yes
(2) __ No

10a. Does your CHC/MHC have plans to become more actively involved in providing emergency support to your community in the event of a disaster? *(If your CHC/MHC has a written disaster plan, disregard this question.)*

(1) __ Yes
(2) __ No

10b. If "yes," to Question 10a, please briefly describe your plans below.

_____

_____

_____

_____

11a. Does your CHC/MHC plan to develop a written disaster plan in response to external disasters within the next 12 months? *(If your CHC/MHC has a written disaster plan, disregard this question.)*

(1) __ Yes
(2) __ No

11b. If "no," to Q.11a, briefly indicate your reason(s) below.

_____

_____

_____

A representative from Marketing Perspectives will be calling you to obtain your responses by phone. If you should find it necessary to mail your responses, please mail no later than October 9, 1992, to: Mr. Jerold Beazley, Marketing Perspectives, 4303 Alpha Road, Dallas, TX 75244

Thank you for your assistance and time!

Appendix B

POTENTIAL CHC/MHC EMERGENCY PREPAREDNESS PROGRAM LINKAGES

TABLE 1
POTENTIAL CHC/MHC EMERGENCY PREPAREDNESS PROGRAM LINKAGES

STATE OF TEXAS

CHC/MHC	CITY	JURISDICTION	EMERGENCY PREPAREDNESS PLAN AVAILABLE	NAME OF EMERGENCY MGMT COORDINATOR	TELEPHONE NUMBER
061010 MLK, JR. FAMILY CTR	DALLAS	CITY OF DALLAS	YES (100%)*	BOBBY J. MARTINEZ	214/670-4275
060680 LOS BARRIOS UNIDOS COMM CLINIC	DALLAS	CITY OF DALLAS	YES (100%)	BOBBY J. MARTINEZ	214/670-4275
060670 VIDA Y SALUD - HEALTH SYSTEMS	CRYSTAL CITY	CITY OF CRYSTAL CITY	NO (10%)	ARMANDO Z. PEREZ	512/374-3477
060710 CROSS TIMBERS HEALTH CLINIC	DELEON	CITY OF DELEON	YES (100%)	CLYDE BRINSON	817/893-2600
060740 UNITED MEDICAL CENTERS	EAGLE PASS	CITY OF EAGEL PASS	YES (100%)	GUADALUPE CARDONA	512/773-1111
060750 HIDALGO COUNTY HEALTH CARE	PHARR	CITY OF PHARR	NO (50%)	JUAN RUIZ	512/787-2761
060810 GONZALES CO. HEALTH AGENCY	GONZALES	CITY OF GONZALES	NO (10%)	ANDY RODRIQUEZ	512/672-6717
060820 COMMUNITY HEALTH SVC AGENCY	GREENVILLE	CITY OF GREENVILLE	NO (65%)	DORSEY DRIGGERS	903/457-2941
060840 SU CLINICA FAMILIAR/FAMILIA	HARLINGEN	CITY OF HARLINGEN	YES (100%)	ROGER V. RIOJAS	512/427-8837
061510 BROWNSVILLE COMM. HEALTH CLINIC	BROWNSVILLE	CITY OF BROWNSVILLE	YES (100%)	VICTOR RODRIGUEZ	512/548-7051
060950 SO. PLAINS HLTH PROVIDER ORG	PLAINVIEW	CITY OF PLAINVIEW	YES (100%)	JIM JEFFERS	806/296-1185
060970 RURAL HEALTH INITIATIVE	RIO GRAND CITY	STARR COUNTY	NO (10%)	J.M. MARTINEZ**	512/487-2307

* *Denotes % of emergency preparedness documents filed with the State. Assumption made that "no plan available" if less than 50% of documents filed.*

** *Planning responsibility rests with the County Judge.*

TABLE 1
POTENTIAL CHC/MHC EMERGENCY PREPAREDNESS PROGRAM LINKAGES

STATE OF TEXAS (Cont.)

CHC/MHC	CITY	JURISDICTION	EMERGENCY PREPAREDNESS PLAN AVAILABLE	NAME OF EMERGENCY MGMT COORDINATOR	TELEPHONE NUMBER
061000 CHAPPARAL HEALTH CLINIC	BENAVIDES	CITY OF BENAVIDES	YES *(100%)	O.G. BARTON	5.2/256-3283JASPER-
061190 JASPER-NEWTON COMMUNITY HEALTH	NEWTON	CITY OF NEWTON	(HAS UPDATED BASIC PLAN)	WELDON R. WILKERSON	409/379-5691
061220 S. PLAINS RURAL HEALTH SERVICE	LEVELLAND	CITY OF LEVELLAND	NO *(10%)	KENNY WILLMON	806/894-0113
061230 CENTRO DE SALUD FAMILIAR LE FE	EL PASO	CITY OF EL PASO	YES *(100%)	JACK E. PARKS	915/541-4450
061260 E. TEXAS COMMUNITY HEALTH SVC.	NACOGDOCHES	CITY OF NACOGDOCHES	YES *(100%)	WILLIAM A. MILLER	409/564-3395
061610 GALVESTON COUNTY COORD. COMM.	LA MARQUE	CITY OF LA MARQUE	NO (55%)	NICHOLAS J. FINAN	409/938-7201
061750 LAREDO MH-UHI PROJECT	LAREDO	CITY OF LAREDO	YES (100%)	MIKE B. PEREZ JR.	512/722-7504
062120 SOUTH TEXAS RURAL HEALTH	COTULLA	CITY OF COTULLA	NO (10%)	JOE R. LOZANO	512/879-2367
062360 BARRIO COMP FAMILY HEALTH CTR	SAN ANTONIO	CITY OF SAN ANTONIO	YES (100%)	JOE CANDELARIO	512/299-8580
063250 CENTRO DEL BARRIO, INC.	SAN ANTONIO	CITY OF SAN ANTONIO	YES (100%)	JOE CANDELARIO	512/299-8580
063940 ELLA AUSTIN HEALTH CENTER	SAN ANTONIO	CITY OF SAN ANTONIO	YES (100%)	JOE CANDELARIO	512/299-8580

* *Denotes % of emergency preparedness documents filed with the State. Assumption made that "no plan available" if less than 50% of documents filed.*

** *Planning responsibility rests with the County Judge.*

TABLE 1
POTENTIAL CHC/MHC EMERGENCY PREPAREDNESS PROGRAM LINKAGES

STATE OF TEXAS (Cont.)

CHC/MHC	CITY	JURISDICTION	EMERGENCY PREPAREDNESS PLAN AVAILABLE	NAME OF EMERGENCY MGMT COORDINATOR	TELEPHONE NUMBER
062390 ATASCOSA HEALTH CLINIC	PLEASANTON	CITY OF PLEASANTON	NO (5%)*	VICTOR GAENZEL, JR.	512/569-3867
063520 CENTRO MEDICO DEL VALLE INC.	EL PASO	CITY OF EL PASO	YES (100%)	JACK E. PARKS	915/541-4450
063910 UVALDE COUNTY CLINIC	UVALDE	CITY OF UVALDE	NO (10%)	JAMES THURMOND	512/278-3315

* *Denotes % of emergency preparedness documents filed with the State. Assumption made that "no plan available" if less than 50% of documents filed.*

** *Planning responsibility rests with the County Judge.*

TABLE 2
POTENTIAL CHC/MHC EMERGENCY PREPAREDNESS PROGRAM LINKAGES

STATE OF ARKANSAS

CHC/MHC	CITY	JURISDICTION	EMERGENCY PREPAREDNESS PLAN AVAILABLE	NAME OF EMERGENCY MGMT COORDINATOR	TELEPHONE NUMBER
060060 LEE COUNTY COOPERATIVE CLINIC	MARIANNA	LEE COUNTY	YES (1990)*	ROBERT ANDREWS, JR.	501/295-6182
060110 JEFFERSON COMPREHENSIVE CLINIC	PINE BLUFF	JEFFERSON COUNTY	YES (1987)**	ROBERT J. PALMATEER	501/535-5649
060140 EAST ARKANSAS FAMILY HEALTH	W. MEMPHIS	CRITTENDON COUNTY	YES (1991)	WILLIAM M. FORMAN	501/739-3200
062140 MID DELTA RURAL HEALTH CTR	CLARENDON	MONROE COUNTY	YES (1990)	STEVE THOMAS	501/734-1758
062730 CABUN RURAL HEALTH SVC	HAMPTON	CALHOUN COUNTY	YES (1990)	LOREN STRICKLAND	501/798-4818
062730 MAINLINE HEALTH SYSTEM	PORTLAND	ASHLEY COUNTY	YES (1988)	NORMAN T. WATSON	501/853-8044
060940 WHITE RIVER RURAL HEALTH CTR	AUGUSTA	WOODRUFF COUNTY	YES (1991)	NOAH H. BELL	501/347-2608

* *Date of last plan update*

** *Scheduled update - 4th quarter 1991*

\- *All Counties in Arkansas have an "All-Hazard" plan in place.*

TABLE 3
POTENTIAL CHC/MHC EMERGENCY PREPAREDNESS PROGRAM LINKAGES

STATE OF LOUISIANA

CHC/MHC	CITY	JURISDICTION	EMERGENCY PREPAREDNESS PLAN AVAILABLE	NAME OF EMERGENCY MGMT COORDINATOR	TELEPHONE NUMBER
060180 TECHE ACTION CLINIC	FRANKLIN	ST. MARY PARISH CIVIL DEFENSE	YES	JAMES BERNAUER	504/385-2600
060190 NATCHITOCHES OUT PATIENT MEDICAL CENTER	NATCHITOCHES	NATCHITOCHES CITY/PARISH	YES	LEIGH PERKINS	318/352-4453
062480 MEDICAL CENTER	SICILY ISLAND	CATAHOULA CIVIL DEFENSE	YES	TRAVIS COOPER	318/744-5697
063380 BAYOU COMP MEDICAL CTR	LAKE CHARLES	CALCASIEU CIVIL DEFENSE	YES	SAMUEL H. RUSSEL	318/437-3499

- *All of these clinics use the parish wide plan.*

TABLE 4
POTENTIAL CHC/MHC EMERGENCY PREPAREDNESS PROGRAM LINKAGES

STATE OF NEW MEXICO

CHC/MHC	CITY	JURISDICTION	EMERGENCY PREPAREDNESS PLAN AVAILABLE	NAME OF EMERGENCY MGMT COORDINATOR	TELEPHONE NUMBER
060240 ALBUQUERQUE FAMILY HEALTH	ALBUQUERQUE	BERNALILLO COUNTY	YES	JESSE O. WADDLES	505/764-6322
060330 HEALTH CTRS OF NORTHERN N.M.	ESPANOLA	RIO ARRIBA COUNTY	NO*	ARCHIE MEDINA**	505/753-6249
060360 GALLUP FAMILY HEALTH CENTER	GALLUP	MCKINNELY COUNTY	YES	ROBERT GABALDON	505/722-4195
061290 LA CASA DE BUENA SALUD	PORTALES	ROOSEVELT COUNTY	YES	RALPH DAVIS	505/356-4450
062160 CENTRO RURAL DE SALUD, INC. ***(ST. FRANCIS MEDICAL CENTER/PMS)	CARLSBAD	EDDY COUNTY	NO*	STEVE MASSEY**	505/887-9511
063010 LA CLINICA DE FAMILIA	SAN MIGUEL	DONA ANA COUNTY	YES	TONY OTERO	505/527-8741
060370 BEN ARCHER HEALTH CENTER	HATCH	DONA ANA COUNTY	YES	TONY OTERO	505/527-8741
063450 PRESBYTERIAN MEDICAL SERVICES	SANTA FE	SANTA FE COUNTY	NO*	WENDY BECK**	505/986-6204
063920 LA FAMILIA MEDICAL CENTER	SANTA FE	SANTA FE COUNTY	NO*	WENDY BECK**	505/986-6204

** *Use the State-prepared plan*

** *Do not have paid coordinators*

*** *Name change was supplied by the STATE OF NEW MEXICO, DEPT. OF PUBLIC SAFETY*

TABLE 5
POTENTIAL CHC/MHC EMERGENCY PREPAREDNESS PROGRAM LINKAGES

STATE OF OKLAHOMA

CHC/MHC	CITY	JURISDICTION	EMERGENCY PREPAREDNESS PLAN AVAILABLE	NAME OF EMERGENCY MGMT COORDINATOR	TELEPHONE NUMBER
060530 COMMUNITY HEALTH CENTERS INC.	OKLAHOMA CITY	CITY OF OKLAHOMA CITY	NO*	GARY MARRS	405/297-3314
063930 MORTON COMPREHENSIVE HLTH SVC INC.	TULSA	CITY OF TULSA	YES	ALLISON KING	214/271-6472
063890 KONOWA COMMUNITY HEALTH CTR INC.	KONOWA	SEMINOLE COUNTY	YES	ROBERT DODSON	405/382-1314

* *OKLAHOMA COUNTY/OKLAHOMA CITY ARE STILL WORKING ON THEIR PLAN. THERE IS NONE IN EXISTENCE AT THIS TIME. THERE IS A STATE-WIDE DOCUMENT.*