Emergency Preparedness

A compendium highlighting preparedness, response, and recovery in disasters affecting Asian American and Pacific Islander Communities

Association of Asian Pacific Community Health Organizations
AAPCHO

Acknowledgements

We wish to acknowledge Asian Health Services, Charles B. Wang Community Health Center, HOPE Clinic, International Community Health Services, Waianae Coast Comprehensive Health Center, Alameda County Public Health Department, and New York City Department of Health and Mental Hygiene for their contributions to this compendium.

We also wish to acknowledge the BRIDGE Emergency Preparedness Work Group:

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The Emergency Preparedness compendium was made possible through a grant from the Department of Health and Human Services, Health Resources and Services Administration.

Table of Contents

Introduction

Emergency preparedness training exercises at Charles B. Wang Community Health Center

As we witnessed in the aftermaths of Hurricane Katrina and the terrorist attacks on September 11, 2001, it is our country's most vulnerable populations that are disproportionately and unfairly impacted by such events. People of color, the poor, and the uninsured often unwillingly find themselves outside the boundaries of available services and benefits.

Community Health Centers (CHCs), which provide essential health care and services to these populations on a daily basis, have proven to be vital in times of crisis. Their response to disasters like Hurricane Katrina or public health threats like Severe Acute Respiratory Syndrome (SARS), have shown CHCs to be necessary links to local communities during these events, and an important component of the larger disaster response network. These organizations have not only proven able to rapidly respond to their communities in times of crisis, but also fill a critical gap in services that mainstream emergency responders leave unfilled.

Though many CHCs face extraordinary circumstances when responding to public health threats and disasters within their communities, those serving Asian American and Pacific Islander (AAPI) communities encounter unique obstacles. The challenges of providing culturally and linguistically appropriate care to meet the needs of the populations they serve are often magnified during disaster response. The purpose of this compendium is to highlight the successes of AAPI-serving CHCs during emergency preparedness, response, and recovery; to shed light on the challenges they encountered; and to share lessons that can be learned from these events.

This compendium focuses on the emergency preparedness, response, and recovery of the following CHCs:

- Asian Health Services in Oakland, California – SARS
- Charles B. Wang Community Health Center in New York City, New York – The terrorist attacks on the World Trade Center
- HOPE Clinic in Houston, Texas – Hurricanes Katrina and Rita
- International Community Health Services in Seattle, Washington – SARS
- Waianae Coast Comprehensive Health Center in Waianae, Hawaii – Hurricane Iniki

The CHCs featured in this compendium, located in areas across the United States with high AAPI populations, each had unique experiences with emergency preparedness, response, and recovery. Asian Health Services worked independently while facing SARS, their response largely reliant on a wealth of information gathered from agencies also coping with the crisis. Charles B. Wang Community Health Center dealt with the lasting effects September 11th had on the residents of New York City's Chinatown, including its mental health and financial impacts. The HOPE Clinic responded immediately to a dramatic increase in the need for linguistically and culturally appropriate health care in Houston resulting from an influx of Asian American evacuees in the city. International Community Health Services faced a barrier in serving its patients, as the fear of SARS spread throughout its community. And, Waianae Coast Comprehensive Center became an integral player in its statewide emergency disaster plan.

Through AAPCHO's Emergency Preparedness compendium, we hope to provide useful information for CHCs, Primary Care Associations, hospitals, state departments of health, and other stakeholders in the area of emergency preparedness planning, and through this document emphasize the important role of AAPI-serving CHCs in community and regional response.

Emergency Management

In the CHC setting, emergency management involves preventing and dealing with disasters that occur within the health center and the community it serves. The Federal Emergency Management Agency (FEMA), a branch of the United States Department of Homeland Security since 2003, names the four phases of emergency management as mitigation, preparedness, response, and recovery. CHCs face a variety of emergencies, which include both natural and manmade disasters. These range from everyday events, including power outages, fires, and heavy snowstorms, to infrequent occurrences like severe earthquakes and terrorist attacks.

Emergency management plans are an important part of emergency preparedness, and help to provide CHCs with a structured approach to dealing with emergencies. These plans often incorporate into larger regional response plans, although the involvement of public health departments and other organizations vary with each CHC. Emergency management plans try to anticipate responses to possible emergencies, although each disaster has its own set of challenges, which requires staff to always respond with good judgment. The goal of such a plan would be to effectively respond to the emergency while protecting the safety of patients and staff.

Many CHCs have shaped their emergency management plans to fit into the National Incident Management System (NIMS), which was developed by the Department of Homeland Security. The nationally recognized framework would allow responders from different jurisdictions and disciplines to work together, which could allow a CHC to work more effectively in a regional or statewide plan. This would correspond with FEMA's larger goal to develop a national emergency management system, in partnership with local and state governments.

Association of Asian Pacific Community Health Organizations

The Association of Asian Pacific Community Health Organizations (AAPCHO) is a national association representing community health organizations dedicated to promoting advocacy, collaboration, and leadership that improves the health status and access of Asian Americans, Native Hawaiians, and Pacific Islanders within the United States, its territories, and freely associated states, primarily through our member community health centers.

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BRIDGE Program

The Building Resources in Development, Growth, and Expansion (BRIDGE) program for Community Health Centers is aimed at providing technical assistance that strengthens the capacity of potential federally qualified health center applicants and/or existing Bureau of Primary Health Center-supported Asian American and Pacific Islander-serving organizations in the United States and Pacific jurisdictions. The goal of the BRIDGE program is to increase the number of AAPIs served at community health centers through the provision of technical assistance services to "new start" community health centers applying for Sec 330 Federally Qualified Health Center status and/or existing grantees applying for expansion grants.

Case Studies

Asian Health Services

Asian Health Services

Dr. Tammy Chen and a patient

Asian Health Services (AHS) is a comprehensive community health center that provides medical care, health education, insurance counseling, and client advocacy to the underserved Asian and Pacific Islander population in Alameda County, California. Serving the community since 1974, AHS now provides more than 80,000 medical visits to 16,773 registered patients annually. Bilingual in nine languages, AHS's 150-plus staff includes 22 providers (doctors and physician assistants) and 22 nurses. In addition, AHS is home to the Language and Cultural Access Program, a medical interpretation and translation service; and Community Voices for Immigrant Health, a health policy development program.

Severe Acute Respiratory Syndrome

Near the end of February 2003, AHS became aware of Severe Acute Respiratory Syndrome (SARS), a deadly illness that was affecting parts of Asia. Although news of SARS had yet to reach mainstream American media, relatives of staff and patients in China and Hong Kong provided daily reports to the clinic as panic began to build. Scrambling to gather accurate information about the illness, AHS worked to calm the fears of its staff while figuring out a protocol to deal with potential cases. Of the approximately five potential cases identified at the clinic, none were determined to be SARS.

Response and Recovery

Gathering Information

AHS administration realized it needed more information about SARS because of its potential effect on the Asian American community the clinic served. Since information was slow to filter out, clinic staff such as Sue Chan, M.D., medical director for AHS during the SARS crisis, found herself, along with two other staff, leading the clinic's pursuit of accurate information.

Dr. Chan began researching on her own, ultimately putting together a thick binder filled with the materials she gathered. Information was tracked, which came across World Health Organization emergency wires, as well as the Centers for Disease Control and Prevention. Hong Kong's Department of Health provided a wealth of SARS information in English as well as Chinese on its website, which was helpful when information was hard to come by in the beginning. It seemed as if things were developing and changing minute to minute, as cases began emerging around the world.

Since AHS had yet to receive guidelines from the county health department regarding SARS, the CHC began consulting health department responses around the country. This information was drawn from regions with large Asian American populations like neighboring San Francisco County, Washington's Seattle-King County, and New York City, all of which promptly provided helpful information for clinic staff. Some guidelines

"were unbelievably draconian," says Dr. Chan. "They said any suspected cases, you garb. The whole thing: your gown, your mask, the protective shoe covers, and everything." Although head to toe protective gear might have sounded excessive, procedures from these counties were helpful in shaping AHS's response.

Treating the Unknown

As fear spread throughout Alameda County, protective masks were hoarded. AHS wasn't able to locate any for its staff and wondered if surgical masks would provide better protection than nothing at all. After scouring the area, the clinic finally located an untapped source: an agricultural supplier in Northern California's Central Valley.

The next task was to calm the fears of AHS staff. As news spread about doctors and nurses who treated SARS patients in Asia dying, staff began to panic, and were reluctant to treat potential cases. When patients coughed in an exam room during medical visits, staff wondered how easy it would be for them to contract the illness. "It's bad enough with our active TB cases," says Dr. Chan. "Here, this is an unknown."

In-service trainings were held for each department of the clinic, to answer questions and teach safety procedures to staff dealing with potential SARS cases. All staff felt vulnerable, even the members of the finance department who rarely dealt with the public. "We had to tailor it to the level of interaction with people, but everyone wanted to have their own protocol," says Dr. Chan. "We wrote a pretty detailed protocol for almost every area of work."

A detailed protocol was especially essential to staff that would directly deal with potential SARS cases. Multi-lingual signs were posted in the clinic's elevators, instructing patients who had a cough, 104 degree temperature, and had either been traveling internationally or exposed to someone who had, to speak with the triage nurses. Three or four providers had volunteered to work with potential cases and were armed with detailed instructions on how to interact with the patients and provide counseling. Nurses still didn't want to clean rooms after possible cases were seen, which left Dr. Chan with the task of wiping down surfaces after these appointments.

Providing Information

Initially, patients had more information about SARS than AHS did. Asian media provided news coverage before American outlets did, and local Asian in-language newspapers reported about SARS while mainstream media remained silent. "I think this really speaks to the international level of this," says Joann Wong, who was clinical operations manager for AHS at the time. "Domestically, we weren't getting it. And [patients and staff] were talking to family members back home, who would hear media reports, however skewed or accurate that was, and that fueled the concerns and the fears out here."

To ensure that its patients received the most accurate information, AHS put together multi-page fact sheets about SARS. After sorting through the pages of information that were collected about the illness, the clinic pared down the facts to focus on topics important to the communities it served. General questions about the illness, its transmission, and prevention were addressed along with travel safety and the difference between SARS in the United States and the rest of the world. AHS updated this document as new information became available and provided translations in Chinese, Vietnamese, and Korean.

Positive Impacts of the SARS Crisis

Dealing with SARS gave AHS the opportunity to educate the populations it serves about the importance of good hygiene in preventing the spread of disease. Fact sheets that AHS distributed to patients emphasized the importance of hand washing and covering one's mouth when coughing, which was reinforced by conversations staff had with patients. During the SARS crisis, the clinic also posted signs in bathrooms illustrating proper hand washing techniques. "I think that was a good thing for our community to have a heads up about," says Wong. "If you practice basic, general sanitary measures, you can protect yourself from a lot of different things. It makes a difference."

The SARS scare also helped AHS become more aware of what it needed to do to prepare for an emergency and provided the clinic with an opportunity to put new systems into place. For example, clinic staff found negative pressure rooms, which prevent the spread of germs throughout a clinic facility, could be converted into isolation rooms for individuals with highly contagious airborne diseases. The clinic also began requiring all

coughing patients to put on masks during this time, although some staff felt uncomfortable asking them to do so. Signs were then created and could be simply pointed to, so patients would realize that this was part of protocol and that they were not being singled out.

The clinic's experience with SARS also gave AHS the insight it needed to better coordinate its emergency preparedness planning with organizations throughout Alameda County. AHS is in the process of updating its general emergency management plan with the help of the emergency preparedness coordinator from the Alameda Heath Consortium, the association of community-based health centers in Alameda County. The county is working on developing a coordinated emergency response plan, with representatives from hospitals, clinics, UC Berkeley, and Alameda County Public Health Department coming together for bi-monthly meetings.

Lessons Learned

- Providing in-language materials on emergency response during a crisis is critical to reaching the AAPI population. There is limited information available on emergency response in Asian languages, which could pose challenges to clinics without the time or staff to develop their own materials.

- Stronger collaborations between CHCs and public health departments are crucial to the success of any emergency response effort. It is essential for public health departments to provide information and guidelines quickly and efficiently, and important for CHCs to then work closely with their local departments to integrate this information.

- Crisis situations serve as opportunities for CHCs to test and revisit their emergency response plans and existing protocols. These events may also allow staff to reinforce positive public health practices, such as encouraging good hygiene to prevent the spread of illness and disease, in the communities they serve.

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Charles B. Wang Community Health Center

Community Health Care Association of New York State

Pandemic influenza table top training session

Charles B. Wang Community Health Center (CBWCHC) provides high quality, affordable, culturally competent health care to the Asian American community in New York City. The majority of the center's clients are low-income, uninsured, or under-insured Asian immigrants with no source of basic health care. In addition to providing comprehensive primary care services, CBWCHC promotes the health of the community through innovative health education and advocacy programs, and by recruiting and training bilingual health care providers. In addition to its clinical services, the center has also nurtured a generation of health, social services, and other professionals for community service through its training and internship programs.

Terrorist Attacks on the World Trade Center

On September 11, 2001, New York City was devastated by the terrorist attacks on the World Trade Center. Chinatown residents watched as the two buildings, which could clearly be seen from points throughout the community, were destroyed. The main offices of CBWCHC, located approximately 10 blocks away from the site of the attacks, were just within the police lines, preventing the center from operating for a few days. Even months later, constant reminders of the tragedy remained in the community, through faces of missing loved ones on thousands of flyers plastered on the neighborhood walls and the odor of Ground Zero still lingering in the air.

Response and Recovery

Mental Health

In the days following the attack, mental health staff began assisting the center's staff and patients, as well as Chinatown community members. The staff consulted with its former medical director to organize its mental health emergency response and bolster outreach efforts. Several group sessions were held to help health center staff be better prepared to respond to patient and community needs. Patients coming into CBWCHC for medical reasons were also screened for anxiety and post-traumatic stress disorders. Some of the staff also worked independently with FEMA crisis counseling services, helping people work through the mourning process while searching for lost family and friends. The American Red Cross referred patients to the center because of its ability to provide cultural competent and bilingual services.

Staff soon found that just as each patient's experience on September 11th was different, so was his or her emotional response to the event. "In the process of helping others to cope with the 9/11 attack, actually I found out it was a really, really very individualized situation," says Teddy Chen, director of the Bridge Program at CBWCHC. "Different people responded to it differently." One patient who watched the tragedy unfold on his television in Shanghai was so strongly affected he could not return to work at a noodle

shop upon returning to New York City. Many patients who saw the burning buildings in person were also clearly affected by the experience. One man, Chen mentions, was working at a restaurant in Chinatown during the attacks. Every few minutes during his shift, he would run down the street to see the fiery destruction of the two buildings. He became completely emotionally disabled and was haunted by symbolic dreams of pigeons flying into buildings and exploding.

CBWCHC's Bridge Program is a nationally recognized mental health program that "bridges" the gap between primary care and mental health, with the aim of reducing the stigma attached to mental health in the Chinese American community. During the six-month period following September 11th, Bridge program staff screened some 640 individuals for post-traumatic stress disorder, anxiety disorders, and depression. Chen and members of the Bridge team published an article entitled "The Emotional Distress in a Community After the Terrorist Attacks on the World Trade Center," which appeared in the *Community Mental Health Journal*. The article was based on a study about the emotional state of patients immediately after the attacks and five months later.

Chinatown Health Partnership and the September 11th Fund

In the months following September 11th, many residents and merchants within the Chinatown district were not only coping with the psychological impact of the tragedy, they were dealing with financial hardships, as many businesses faltered. CBWCHC recognized the additional need for health care services among local workers who lost their jobs or could no longer afford health insurance, and joined with the Lutheran Family Health Centers in Brooklyn to form the Chinatown Health Partnership. The Partnership was awarded a grant by the September 11th Fund, which was created by the New York Community Trust and the United Way of New York City, and was known as the September 11th Fund's Health Care program.

Potential patients were first evaluated at screening sessions to see if they qualified for the special program. Individuals who were eligible for public health insurance programs such as Medicaid or Child Health Plus were enrolled in those programs. Those who met the September 11th Fund's Health Care program's criteria were enrolled in New York City victims' assistance program Safe Horizon and allowed to select from a list of participating clinics, including CBWCHC. "Through the September 11th Fund, we were able to provide comprehensive, free health care to residents and workers in Chinatown affected

by the tragedy," says Jane Eng, Esq., the health center's chief executive officer. "They could come in for a physical, they could see a specialist, they could go for mental health services, or they could go to women's health. They received services to help with recovery." The program's original 12-month benefit period was extended more than once, providing for some that enrolled at the start of the program with two years of health care.

Outreach and Media

Although the September 11th Fund's Health Care Program was designed to help workers who were unable to afford health care, the local community was not enrolling in the program when it was first launched. "Their problem was the Safe Horizon staff initially was not able to reach out to the Chinese community," says Art Cusack, the center's senior administrator. "So the first thing that we did was to go and market within the community and get people to just understand that these programs were there and direct them to the Safe Horizon orientation sessions."

CBWCHC launched an advertising campaign in local community language newspapers and personally brought the message to the community at fairs and other events. "We put together a really phenomenal team, of which we had four individuals who spoke Mandarin, Cantonese, Fujianese, who just went out into the community," says Cusack. "We went down to the schools, went down to the shops. We just canvassed the entire neighborhood."

Following the targeted outreach, the program received 10,000 phone calls from individuals inquiring about the program; 5,000 individuals participated in the screening and orientation programs; and 2,000 individuals selected their health care services from CBWCHC over other alternatives.

The Bridge Program also worked with the local ethnic news media to spread their message. Bridge team members started a community education campaign on mental health issues, including post-traumatic stress disorder, which continued for several years after the attacks. Clinicians and health educators conducted hotline radio program where community members can call in and ask questions. While the radio program provided a forum for the community to better understand their experiences, a few callers asked the Bridge staff to stop talking about September 11th. "We suspect some of the people that called in, asking us to stop, actually were the people who were really hurt seriously and they didn't want to be reminded of anything about 9/11," says Chen.

Emergency Preparedness

Emergency Management Plan

In addition to the clinic's success in conducting community outreach and delivering health and mental health services after September 11th, CBWCHC has gained a new perspective regarding emergency preparedness. The clinic has utilized this knowledge to develop and refine its emergency management plan. To date, a team of key staff at CBWCHC conducts quarterly reviews on the emergency management procedures for the center's three clinics.

CBWCHC's emergency management plan has been updated to include new scenarios and formatted so each situation meets FEMA standards, addressing mitigation, preparedness, response, and recovery. The plan addresses emergencies including fire, utility disasters, bomb threats, hostile acts within the health center, hostile acts outside of the health center, and emergencies during non-operating hours. Rather than reinvent the wheel, the center adopted the language, formatting and layout from a sample developed by the Community Health Care Association of New York State (CHCANYS).

A multi-disciplinary team of representatives from different departments within the clinics helps CBWCHC determine whether proposed protocols would work during a crisis. A procedure like calling patients to reschedule appointments in the event of a clinic shutdown, for example, might not seem like a difficult process now that CBWCHC has switched to electronic medical records. But while accessing these records remotely might be simple for clinicians, it was a more difficult process for other members of the staff. The team is currently working on an overall revision to the emergency management plan, and is tackling the question of when to inform staff that the clinic will be closed and to not report to work.

Collaboration

Like many agencies that find themselves within the vortex of a crisis, CBWCHC realizes that the best response to an emergency is to coordinate and collaborate with local, state, and federal agencies. The CHC works with the New York City Department of Health and

Mental Hygiene to prepare for their role in a regional plan. "In New York City, one thing that we try to do is partner community health centers with the health department, with the hospitals, sort of like a three-prong approach," says Elsie Lee, M.D., medical director for CBWCHC's Flushing, Queens site. "And surrounding that approach is going to be the first response: police, fire, EMS. It's been a very good partnership."

Prior to serving as medical director, Dr. Lee worked for the Department of Health, a role she continues in as the Outpatient Emergency Preparedness Medical Coordinator. She has worked with Federally Qualified Health Centers (FQHCs) including CBWCHC in the years after September 11, 2001 through CHCANYS and the Primary Care Development Corporation. Dr. Lee works with clinics to build infrastructure for emergency preparedness, providing materials and trainings. This has been a multi-year project, beginning with an assessment in 2003 of FQHCs in four New York City boroughs. Education and awareness materials were tailored to the programs the following year, with drills and tabletop training sessions held in the clinics in 2005. A reassessment of the FQHCs is currently being done in order to evaluate the effects of the outreach and trainings.

Working directly with the clinics has helped the Department of Health identify the gaps within its own programs. It became clear after doing a training session with a hospital about avian influenza that there was an inconsistency in infection control measures with the staff. The Donning and Removing Personal Protective Equipment Practicum was developed to address this issue. Dr. Lee also points out that during the SARS crisis, CBWCHC was in contact with the Department of Health, consulting them on the appropriate handling of patients exhibiting SARS symptoms. "I think the health department got a better sense of what it needs to do; the next step in terms of being more prepared to address community concerns," says Dr. Lee.

Although CHCs have been given a presence at regional response talks, they do not yet play an active role in planning. "Our big vision in the end is to have a whole regional response plan in New York City," says Dr. Lee. She envisions all the health centers uniting under CHCANYS, receiving information from the primary care association and reporting the situation in their area. Dr. Lee also sees the great benefit of hospitals working local CHCs into their emergency plans: CHCs could treat the hospitals' less serious patients, agreeing to provide rooms, space, and a triage area for these patients.

Lessons Learned

- AAPI-serving CHCs can play a vital role in larger response and relief efforts, providing the bicultural care and outreach that national mainstream organizations may be unable to provide.

- Culturally-appropriate outreach is important in reaching the AAPI population during a crisis. In-language approaches are often most effective, utilizing the local ethnic media as well as targeting community events and gathering places.

- Establishing stronger partnerships between CHCs and public health departments, as well participation in a regional response plan, helps to ensure that underserved AAPI communities are not overlooked.

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HOPE Clinic

Ngay Nay Newspaper (Matt Jenkins)

Outreach to Asian American hurricane evacuees at Houston's Hong Kong City Mall

The Asian American Health Coalition (AAHC) of Greater Houston Inc. is a non-profit organization dedicated to improving the health of all Asian Americans in Houston by increasing access to health care and through population-specific health promotion and health education projects. In 2002, the board and officers of the Asian American Health Coalition established the HOPE Clinic to help address the unmet health needs of medically underserved Asian Americans and other residents of Southwest Houston. The HOPE Clinic started out as an all-volunteer effort supported by the Chinese Baptist Church, which provided most of the volunteers and the Chinese Community Center, which provided the space to operate the clinic.

Hurricanes Katrina and Rita

On August 29, 2005, Hurricane Katrina made landfall in the north-central Gulf Coast. Its heavy rains overwhelmed New Orleans' levee system, causing flooding and mass devastation. Less than a month later, Hurricane Rita brought another round of destruction to the area. An estimated 15,000 Asian Americans were evacuated to the Greater Houston region of Texas. The majority of these evacuees were Vietnamese Americans, many of whom were limited English proficient. While FEMA and the American Red Cross offered services at large venues like the George R. Brown Convention Center and Reliant Stadium, many Asian Americans instead turned to community-based and faith-based organizations for aid.

Response

Outreach to Katrina/Rita Evacuees

The Hong Kong City Mall was the center of Houston's outreach efforts to the Asian American hurricane evacuees. Hundreds turned out at the large Asian shopping center, responding to announcements made over Vietnamese radio about services being offered there. "It was this sea of humanity walking through the Hong Kong City Mall, looking somewhat shell shocked and traumatized," says Beverly Gor, immediate past president of the HOPE Clinic. "And there also was this wave of compassion that was coming from the community."

The community response was a pan-Asian effort, representing the many Asian American communities in Greater Houston. Groups of South Asian volunteers donated their time to helping the evacuees, along with Vietnamese, Chinese, and Filipino groups. Catholic nuns came by, as well as families dropping off donations of clothing. The vendors at the Hong Kong City Mall also did their part, putting out *jook* (Chinese rice soup) and *char siu bao* (steamed buns with barbecued pork) every few hours, allowing the evacuees to help themselves to the food "because the need was so great," says Gor.

Relief efforts at the Hong Kong City Mall were largely driven by the Boat People SOS, a national nonprofit whose Houston office was located in the mall. The organization provided Vietnamese refugees and immigrants with mental health, family, and survivor services since 1980. During its outreach to the hurricane evacuees, staff and volunteers helped with everything from translating information, including procedures regarding relief benefits, into Vietnamese for the evacuees, to helping them fill out FEMA applications.

As Boat People SOS provided help with social service issues, the evacuees' need for linguistically and culturally appropriate health care became apparent. Staff from the HOPE Clinic called on their pool of volunteer medical staff and one part-time doctor to provide health care services in the mall. Setting up in the Boat People SOS office, they treated their first patients on Friday, September 2nd. After serving approximately 130 evacuees that weekend, the HOPE Clinic expanded its one day a week schedule at its main Chinese Community Center clinic to four days a week and continued its outreach at the mall.

Satellite Clinic at the Hong Kong City Mall

Operating a health clinic at the Hong Kong City Mall became a great collaborative effort. With their volunteer-staffed medical team working extra days at the main clinical site, the HOPE Clinic team serving at the satellite clinic worked with members of the Medical Reserve Corps who came from Kaiser Permanente and Scripps Health, a community-based health care delivery network from San Diego, California,. The HOPE Clinic provided acute, basic medical care and medical supplies, while volunteers from Boat People SOS served as case managers and interpreters.

Through the work of these volunteers, the Hong Kong City Mall clinic provided services six days a week and treated approximately 200 patients a day. Many of the evacuees were suffering from diabetes and hypertension, and a number needed follow-up appointments or refills on medications. All services, including laboratory and pharmacy, were provided at no cost.

Besides their medical needs, evacuees had mental health needs resulting from the trauma of Katrina and Rita. Many were in shock or dealing with depression. Some Vietnamese Americans were diagnosed as suffering from post-traumatic stress disorder as they

relived their refugee experiences through the hurricane ordeals. Asian American Family Services provided mental health case management and counseling to many of these individuals. The Boat People SOS also tried to provide therapeutic opportunities, including group activities and meals, the singing of songs, storytelling, and encouraging evacuees to talk about their experiences.

A report issued by Houston Asian Relief for Rita/Katrina (HARRK), found that the HOPE Clinic served approximately 2,875 individuals in the first seven weeks following Hurricane Katrina, while the Boat People SOS served 1,260 call-in and 8,400 walk-in evacuees during the same time period. The report, entitled "Thousands in the Gap," documented the outreach to AAPI hurricane evacuees conducted by these and other organizations. The report also identified the HOPE Clinic as the only Houston medical provider to offer language-appropriate services for the Asian American community.

Expanding the HOPE Clinic's outreach was an expensive undertaking, despite the generosity of its volunteers. The HARRK report documented an additional cost of $27,296 in the first seven weeks to the clinic's regular expenses, including rent for an expanded space and money for supplies, laboratory services, and additional staffing. In-kind volunteer hours were valued at $20,160. According to the report, the HOPE Clinic was ineligible for FEMA funds because medical services are not a covered service through local government. Another important source, however, helped the clinic meet its needs. "Once the City of Houston Health Department started seeing that we were seeing so many people, they actually diverted some of their supplies to us," says Gor. The health department donated so much that the clinic rented a public storage unit to store some of the supplies.

Recovery

Moving Forward

After about a month, the number of hurricane evacuees began to diminish at the Hong Kong City Mall. The clinic closed its doors at the end of October 2005, although the HOPE Clinic's main location continued to operate at four days a week. By December, the number of evacuees coming in to the clinic had dropped off significantly. "Originally, one of our goals was to then tailor the services of the HOPE Clinic to meet these Katrina

evacuee needs, but really, we don't have that many that are coming anymore," says Gor, who heard from other patients that most of the Asian American evacuees had returned to their homes in Louisiana.

The HOPE Clinic treated approximately 3,000 Katrina and Rita evacuees from September 2 to December 31, 2005. This outreach, expanded from a one day a week service into a multi-day, multi-clinic operation, was made possible mainly through volunteer efforts and not state support. "It was really heartwarming because we as a community health center, not one affiliated with a governmental body like a city health department or Harris County Hospital District, saw more Katrina evacuees at our little community health center than any other community health center in Houston," says Gor.

The HOPE Clinic relocated to a new location in March of 2007 from their original site at the Chinese Community Center. Gor says that the clinic wanted to shake the perception that they were only a Chinese American-serving clinic and that the move has helped them to reach a more multicultural community. In fact, some African-American Katrina and Rita evacuees continue to use the clinic.

Research

Although the HOPE Clinic is no longer seeing the volume of Hurricanes Katrina and Rita patients it once did, Gor continues her work with the population through her research efforts. Through a $50,000 grant, Gor is evaluating the health status of hurricane evacuees the clinic served. The grant, from Morehouse School of Medicine's Regional Coordinating Center for Hurricane Preparedness, enables Gor to examine 2,706 patient medical records. Through her work with the Center for Research on Minority Health at the University of Texas M.D. Anderson Cancer Center, she has analyzed these records to determine the health problems, place of origin, and ethnic and socio-demographic information of the patients.

Her initial findings indicate that 90 percent of the patients seen at the clinic were Asian American, of Vietnamese, Chinese, Cambodian, Filipino, Japanese, Korean, and South Asian descent. Most common diagnoses or procedures done were immunizations, upper respiratory infections, hypertension, musculoskeletal pain, and dermatological problems. Gor intends to publish her findings once a more thorough analysis of the medical records is complete.

Gor ultimately wants to share the results of her research with both the health department and community-based organizations in Louisiana. She hopes her findings will help educate local agencies, such as the Louisiana Department of Health, of the health conditions facing Asian American evacuees that have returned home, and in turn show how the HOPE clinic was able to initially address many of those issues. Gor also expects this research will give other Asian American organizations the data they need to better advocate for the health care needs of evacuees in their communities.

Lessons Learned

- Culturally appropriate and in-language care essential to serving the AAPI population is even more important during a crisis. Agencies that provide these services meet these populations where they are at, both physically, by being located within their communities, and culturally, by utilizing outreach methods that are effective in reaching these groups.

- Partnering with other AAPI-serving agencies can help strengthen the overall response to this diverse community during a disaster. Combining resources strengthens outreach efforts, and enables organizations to more appropriately refer community members to agencies that will best meet their needs.

- AAPI populations often rely on community-based and faith-based organizations for health or social services, rather than government-sponsored agencies.

- Eligibility workers at CHCs and community-based organizations, who often provide assistance to patients applying for federal programs such as FEMA assistance, are critical resources during a crisis and should be an integral part of emergency response efforts.

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International Community Health Services

International Community Health Services

Dr. Alan Chun with a patient

International Community Health Services (ICHS) in Seattle, Washington specifically targets its services to the Asian/Pacific Islander communities, yet strives to serve the health needs of all individuals, in a manner sensitive to the patient's language and cultural needs. ICHS provides high quality health care with a focus on education, prevention and early intervention. ICHS also serves as an educational and advocacy resource in the larger health care community, based on its experience working with culturally diverse communities. ICHS offers interpretation in 14 languages on site, with contractual arrangements for languages less frequently requested.

Severe Acute Respiratory Syndrome

In early 2003, fearful conversations began to spread throughout the International District in Seattle. SARS had been spreading through Asia, affecting people in Hong Kong, China, and Vietnam, countries where many of the district's population continued to have strong family ties. Public Health-Seattle & King County (PH-SKC) soon released guidelines to possible case definitions of SARS. ICHS evaluated approximately three cases that fit the definition of SARS, which were hospitalized.

Response and Recovery

Fear and Rumors

With very limited information about SARS available, there was a lot of fear and apprehension in the International District, a multiethnic neighborhood that includes Seattle's Chinatown. "It was interesting because there were some superficial facts and then a whole lot of rumors that filled in the context," says Alan Chun, M.D., who was medical director at ICHS at the time. Staff told him about different rumors they heard from patients, including that the clinic had seen some actual SARS cases and that staff contracted the illness. "Some of our staff was afraid, so they were wearing masks," says Dr. Chun. "So the patients didn't know what was going on. They thought they were wearing masks because they had SARS or they were afraid that other staff had SARS." After ICHS closed down both its clinics for half-day staff trainings, word spread throughout the community that the clinics had been closed for sterilization because of SARS infections.

Fear, fueled by powerful rumors, soon kept people from visiting the CHC as well as much of the International District. At the peak of the SARS scare, people stayed away from the clinics for approximately two months. Chinese Information and Service Center, a sister agency that does advocacy and social services for the Chinese population, was very tied into the community, trying to manage rumors about the International District as a whole. Restaurants and shopping centers in the district were largely being avoided as rumors began to spread that staff was infected with SARS.

Collaboration: Public Health-Seattle & King County

Though ICHS could do little to control the rumors surrounding its clinic and SARS, it did find a strong partner that helped the clinic strengthen its response to the crisis. During the SARS scare, ICHS worked closely with PH-SKC. The public health department was very proactive, providing resources to help train staff about isolation and protective gowning. PH-SKC was also prompt to put out guidelines which helped clinicians identify possible SARS cases and deal with the unknown factors of this illness. ICHS and PH-SKC stayed in contact during the SARS incident through almost weekly conversations.

PH-SKC also helped prepare ICHS for the media attention the clinic was about to attract. News reporters were calling the clinics, asking staff, regardless of their professional expertise, about the SARS situation. ICHS didn't have a public spokesperson at the time, which is something Dr. Chun believes is common among clinics. PH-SKC was a good resource, having strong relationships with both the media and other clinics. ICHS worked closely with PH-SKC's public relations department to develop the message they wanted to convey. Dr. Chun also took part in a press conference held by PH-SKC along with the public health department's communicable disease doctor.

Emergency Preparedness

Emergency Response Plan

With its recent SARS experience in hand, ICHS began to develop an emergency response plan. ICHS's plan is consistent with the National Incident Management System, which the Bureau of Primary Health Care encourages, and allows for responders from different jurisdictions and the state and federal government to coordinate their efforts during a large-scale disaster.

ICHS's Emergency Management Committee is instrumental in establishing emergency preparedness at the CHC and shaping this newly-formed plan. Following a Hazard Vulnerability Assessment of the clinics, results are reviewed by the committee. Additional risks are then discussed while plans for preparedness are made, which includes identifying necessary trainings and exercises for ICHS staff. The committee also helps to determine the role that ICHS will play in a regional response.

Coordinating efforts with other local responders requires not only emergency preparedness planning, but good communication in a crisis situation. Meetings held with Seattle-King County officials would determine regional needs, and what ICHS could do to fill in the gaps. During such an emergency, the CHC would be strongly connected with PH-SKC, keeping the public heath department's Emergency Operations Center updated with current status reports.

Working with the Media

In addition to having a sound emergency management plan in place, Dr. Chun believes a key to managing emergency preparedness in AAPI populations is for CHCs to assume a larger role in dealing with public relations and the media. With SARS, "the mainstream media responded to it; Seattle-King County Public Health Department responded to it, saying 'these are the facts,' " he says. "But a lot of our population, who are limited English speaking, are not watching those newscasts."

Since the SARS incident, there have been more resources provided locally in the Seattle and King County areas to help clinics get their message out, through information and training opportunities. PH-SKC held trainings specifically on dealing with communications during emergencies and how to respond to a disaster in the clinic setting.

The next challenge for a CHC like ICHS is tailoring the message to reach specific populations. "Part of it is to really be prepared in terms of knowing the different ways of communication in the community, which is maybe different than the mainstream media," says Dr. Chun. "The other thing is to have a person who understands the importance of how to communicate, and to have clear guidelines about who can communicate."

ICHS's emergency response plan now includes a public information officer to keep the CHC's message focused during a crisis. Together with their clinical manager, who is referred to as the site incident commander in this plan, the public information officer assesses needs and releases internal and public communication materials, in hopes to quiet rumors by providing accurate information. Press releases and other forms of communications with the public will also be coordinated with PH-SKC.

By working with local in-language media, ICHS can work to diminish the misinformation that often spreads through the community they serve. "Being outside of mainstream

media leads to more diverse formal and informal channels of communication, including rumors and hearsay," says Dr. Chun. "How to manage these channels or to stay ahead of them is the big challenge." While many focus on the importance of preparing multilingual emergency preparedness materials for limited English proficient populations, Dr. Chun feels doing so "is not sufficient to addressing the communications gap in a crises situation." Dispelling myths and providing correct information through a channel geared toward the target community could work to ICHS's benefit, and ultimately lead to the spreading of facts instead of fear.

Lessons Learned

- Collaborating with public health departments in a regional plan helps strengthen a CHC's ability to serve its targeted population during a crisis. These partnerships often facilitate the availability of emergency preparedness or response resources that either entity would be unable to acquire on its own.

- Local ethnic media outlets are often more effective in reaching the AAPI population than mainstream media. Emergency planning for CHCs in the area of communications would entail developing a clear response to media inquires, designating appropriate spokespeople, and collaborating with advocacy organizations with media experience and resources.

- Organizations should consider partnerships with community agencies that serve the same limited English population. Pooling knowledge and expertise from organizations that focus on advocacy and social issues can be beneficial to CHCs that lack these resources.

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Waianae Coast Comprehensive Health Center

Waianae Coast Comprehensive Health Center

Lori Kaleiopu treats a mass casualty patient with suspected avian bird flu in the Lightning Rescue 07 training exercise

Waianae Coast Comprehensive Health Center (WCCHC) serves low-income individuals and families along the Waianae Coast of Oahu, Hawaii, a population which is comprised primarily of Native Hawaiians. WCCHC offers family practice treatment as well as a range of other services, including 24-hour emergency care, specialty services (orthopedics, urology, ob-gyn, allergy, etc.), laboratory and radiology services, dental, preventive health, case management, outreach, family planning, a teen clinic, perinatal case management, Native Hawaiian healing (*lomilomi*, *laau lapaau*, *hooponopono*, and *laau kahea*) and integrated services, homeless outreach, adult day care, transportation, mental health treatment, substance abuse outreach and treatment, health career training, health professional training, and WIC services.

Hurricane Iniki

On September 11, 1992, Hurricane Iniki tore through the Hawaiian Islands. The Category 4 hurricane made landfall on the island of Kauai, destroying more than 1,400 homes and severely damaging 5,000 more. Before reaching Kauai, Iniki stormed past the island of Oahu, battering the state's most populated island. Much of the destruction was concentrated on the western (leeward) side of the island with the town of Waianae enduring considerable damage from strong winds, flooding rains, and powerful surf pounding against its shores.

Response

Community Outreach

As the Waianae Coast prepared for the approaching hurricane, WCCHC knew the region's large homeless population needed to be alerted about the approaching storm. Eva Galariada-Rosa, homeless coordinator for WCCHC at the time, gathered her crew and hopped into the CHC's vans, heading to the beaches where most of the homeless lived, often in tents or their cars. "We went to every site that we did outreach to and talked to the people, because the police had already come and plenty didn't want to move," she says. "So we went and we talked to them and offered to use our van to move them. Did whatever we needed to do to get them out of there."

Eventually, all of the families were cleared off of the beaches. Some relocated to relatives' or friends' homes, while others asked for money for gas so they could move their vehicles. Others had no place to go. Van crews helped to pack up these families and their belongings, allowing them to set up in a corner of the WCCHC parking lot. The CHC, located on a hill overlooking the town, would protect them from the high surf generated by the hurricane-force winds. The remaining individuals refusing to leave the beach were cleared by the police, with many simply crossing over the main road, Farrington Highway, and setting up shelters closer to the mountain.

Operating the Clinic

As the storm drew nearer, WCCHC quickly prepared its clinics for the unknown. Windows were taped up in anticipation of glass shattering because of flying debris. Coolers were filled with water to prepare for the possibility of the water being cut off during the storm. All patients that were scheduled for appointments were called, with staff letting them know that the clinics would only be handling emergencies. Security guards were posted at the bottom of the routes up to the clinics, only letting up staff with identification or emergency patients.

Soon after Iniki hit the leeward side of Oahu where WCCHC is located, the clinic lost power. Backup generators restored electricity to specific areas of the clinics, allowing the emergency room to continue operation and powering certain refrigerators that housed medication. This generator, however, wouldn't last much longer than 24 hours. Since WCCHC had the only emergency facility located within a 21 mile radius, the Hawaiian Electric Company worked quickly and soon restored the CHC's power.

Waianae's remote location also provided many challenges during Iniki. Downed electrical poles not only knocked out power, but when combined with flooded roads caused portions of the main highway to be completely blocked off. Closure of the four-lane road, being the only route connecting the remote Leeward Coast to the rest of the island, prevented many of the doctors, who lived in downtown Honolulu, from reaching WCCHC. Waianae-based doctors reported to the CHC to deal with emergencies, including delivering babies of mothers unable to get to the hospital because roadblocks confined them to Waianae.

Throughout the storm of Hurricane Iniki, WCCHC staff pulled together to deal with the challenges that came their way. "I think we were ready," says Galariada-Rosa. "We weren't panicking; I think we did well. We took care of everyone who needed to be taken care of." And while the CHC had a disaster plan that was enacted as the hurricane swept by, Galariada-Rosa felt the experience helped the staff learn how to better pull together during an emergency.

Emergency Preparedness

Emergency Management

Being located in a rather isolated corner of an island, WCCHC must prepare for a unique set of challenges. The CHC identified flooding, hurricane, tsunami, fire, toxic material accident, and terrorism (including potential use of weapons of mass destruction) among its top six hazards. The nearest hospital, Hawaii Medical Center West, is 12 miles away. Roadblocks on Farrington Highway could prevent Waianae residents from accessing this medical center as well as keep them essentially trapped on this remote side of the island.

For two of the more region-specific disasters, there are warnings that precede the events. As Incident Commander, Milo Huempfner, Compliance and Clinical Operations Director for WCCHC, tracks hurricanes as they make their way into the western and central Pacific. As a tropical storm or hurricane heads closer, he sends frequent updates to staff about its location and when it's expected to pass within the range of the Hawaiian Islands. The plan was activated recently when Hurricane Flossie entered Hawaiian waters in early August 2007, with a projected path over the southern tip of the Big Island and five day projections that included the Leeward Coast of Oahu experiencing the effects of the storm. While hurricanes might have a few days notice before striking, tsunamis have a much briefer warning period. An earthquake on the Big Island could generate a tidal wave that might reach the island of Oahu in 20 to 30 minutes. This would leave little time for the Hawaii State Civil Defense, the governmental agency responsible for all-hazard mitigation and emergency response, to clear the beaches or the CHC to prepare an adequate response for the disaster.

The CHC's emergency preparedness was also recently tested when the clinic dealt with a near disaster of its own. In May 2007, a large brushfire threatened the CHC's administrative building as well as a number of nearby homes before it was contained. The approaching fire gave the clinics an opportunity to practice evacuation procedures, from keeping staff informed to identifying key evacuation meeting points. This emergency did, however, point out a flaw in their plan. WCCHC had set up a phone line that would connect them directly with the telephone operator and be answered as a priority call. During the brushfire, such a large number of staff members called the number that it overwhelmed the phone system. The protocol was since changed to specify that one designated staff person would make the emergency call.

WCCHC's Disaster Preparedness committee meets bimonthly to review emergency responses like this one. Past emergencies as well as disaster exercises the CHC participated in are analyzed, to discover the clinics' strengths and weaknesses. Huempfner and Edward Ho, the current emergency room operations manager and emergency preparedness coordinator, also meet with different departments throughout the CHC to discuss each department's role in the event of a disaster. A detailed protocol is also listed in WCCHC's Emergency Operations Plan, which outlines response within the clinic and its role in a statewide emergency response plan.

Collaboration: Statewide Response

Having the only 24-hour emergency room on Oahu's Leeward Coast, WCCHC is part of the State of Hawaii's Emergency Medical Services System as a designated trauma support clinic. The clinic would not only be called to respond to disasters on the Leeward Coast, but could also treat patients flown out by Military Assistance to Safety and Traffic (MAST) helicopters, an air medical evacuation system. Taking part in a statewide plan has also required WCCHC to make major revisions to its emergency management plan to meet National Incident Management Systems standards, making its plan compatible with other participating emergency responders.

As a designated trauma support clinic, WCCHC receives equipment from the Healthcare Association of Hawaii, which coordinates statewide responses to handle a range of emergencies. Walkie-talkies help connect departments during power outages when phones and computers are down. Portable decontamination showers were also donated to the CHC, as were respirators and protective suits which were provided to deal with patients exposed to toxic chemical leaks or spills. A number of staff is also trained to respond to radiological emergencies, because of nuclear powered ships and submarines that are stationed at Naval Station Pearl Harbor. The CHC also anticipates receiving a Geiger counter to detect radiation levels when needed.

WCCHC has also taken part in large-scale trainings with other organizations as well as the government. As an affiliate member of the Healthcare Association of Hawaii, the CHC took part in the Lightning Rescue 07, an exercise in responding to a pandemic influenza outbreak. Ho and the assistant emergency room operations manager ran the field hospital in this exercise, which involved federal, state, and city and county government as well as the Department of Defense. The CHC also participates in annual statewide hurricane

exercises. These exercises help participating agencies identify other organizations' needs, as well as resources that will prove useful during an actual disaster.

The State of Hawaii is also working on ways to aid hospitals and health centers during crises. The Hawaii Department of Health is developing a Medical Reserve Corps, which is open to health professionals willing to volunteer during emergencies or disasters. Huempfner mentions that this opportunity is ideal for individuals who aren't bound by organizational commitments; who work on-call or are retired. The state is also working on creating state-issued identification cards for licensed health professionals. Scanning an individual's card would call up his or her credentials and qualifications to assist in an emergency response effort.

Lessons Learned

- Updating emergency management plans to make them consistent with National Incident Management System standards allows CHCs to take part in regional emergency response as well as training exercises.

- Working as a part of a regional or statewide plan can allow the CHC to use its resources to aid in a larger effort while helping to maintain operational stability for the CHC during a crisis.

- CHCs with emergency rooms can play a vital role in larger regional plans during a disaster. These clinics could extend services to treat members of their community as well as patients transported in from throughout the region via transport vehicles, such as ambulance and air medical evacuation systems.

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Conclusion

Chinese Daily News (Matt Jenkins)

Outreach to Asian American hurricane evacuees led by the Boat People S.O.S. in Houston

CHCs play a vital role in serving AAPI populations during a crisis situation. The challenges of providing the linguistically and culturally appropriate care necessary to meet the needs of these populations are often magnified during an emergency. CHCs that serve AAPI communities must not only respond to an emergency quickly and skillfully, but also keep the populations they serve informed about the facts of the disaster or public health threat, for the sake of their health and safety.

Many CHCs, as we've seen in this document, have done just that, and have illustrated how in times of crisis, they are at the frontline providing services to a population of people who otherwise wouldn't receive them. And they have done so successfully through strong collaborations with partners ranging from public health departments to social service agencies, and through communications work involving in-language community newspaper and radio outlets. All of this has been done in the face of numerous obstacles, ranging from a lack of appropriate funds, staff, and translated health education materials, to an absence of coordination with relevant state and federal agencies.

The importance of AAPI-serving CHCs in reaching this population during emergency efforts is clear. Regional emergency management plans often anticipate that their population will depend primarily on hospitals during an emergency. This isn't necessarily true, especially among the AAPI community. "Most of the community people will go to a place they trust, not the ER," says Dr. Elsie Lee of CBWCHC and the New York City Department of Health and Mental Hygiene. "They're going to the community health centers. Because we know that during a really big emergency, if you are a non-English speaking person, you're going to a clinic that you know will have other people that speak your language, understand your culture, and aren't going to disrespect you."

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