ASPR TRACIE Technical Assistance Request

Request Receipt Date (by ASPR TRACIE): 19 July 2024
Response Date: 8 August 2024; updated 28 August 2024
Type of TA Request: Complex

Request:

The requestor asked for resources and information on matching individual community health centers locally, statewide, and regionally. This relationship would be either virtual (telehealth consults) or in-person (i.e., staff would be deployed to help nearby centers during disaster, assuming they were not also affected). The requestor noted they are interested in setting up a program like this and wanted to know how other facilities have accomplished this.

Response:

ASPR TRACIE conducted an online search for relevant resources, including those in the ASPR TRACIE Ambulatory Care and Federally Qualified Health Centers (FQHC) Topic Collection. In particular, the Community Integration and Plans, Tools, and Templates: Health Centers categories will be most relevant. We also requested input from members of the ASPR TRACIE Subject Matter Expert (SME) Cadre. Section I provides comments from SMEs, and Section II includes resources containing information on collaboration between community health centers.

I. ASPR TRACIE Subject Matter Expert Comments

Please note: These are direct quotes or paraphrased comments from emails and other correspondence provided by an ASPR TRACIE SME Cadre member in response to this specific request. They do not necessarily express the views of ASPR or ASPR TRACIE.

SME Cadre Member 1:

- The efforts of connecting health centers locally, statewide, and regionally is not a new concept, however, because community health centers (both rural health centers [RHCs] and FQHCs are federal grant recipients, there are so many considerations which make such efforts very challenging.
    - Health centers cannot necessarily just pick up and go somewhere (physically or virtually) to deliver services or lend a "helping hand" to another sister program, as they are governed by the scope of work and other rules in the 330 grant from the Health Resources and Services Administration (HRSA):
        - The scope of work for a Section 330 grant is defined by the health center's project scope and includes the activities and locations that the grant funds can support. The scope of work is made up of five core elements: Sites, Services, Providers, Service area(s), and Target population(s). More information can be found here: https://bphc.hrsa.gov/compliance/scope-project/scope-project-resources

        - There are defined procedures for dealing with the scope and other issues during emergencies that have been recently consolidated and updated by HRSA. They can be viewed here: https://bphc.hrsa.gov/technical-assistance/emergency-preparedness-response-recovery-resources-health-centers/emergency-information-kit. However, the process is not very straight-forward and there is a lot of confusion among the health centers.
        - Another big concern for health centers is the Federal Tort Claims Act (FTCA) coverage both for their staff and volunteers. Again, there are some very complex rules and procedures that apply when determining what and who is covered by FTCA or not, and in my experience, health centers generally do not want to risk it when push comes to shove. More information on FTCA can be found here: https://bphc.hrsa.gov/compliance/ftca.
    - Despite all the considerations previously mentioned, I have seen some amazing collaborations and support among and by health centers during emergencies, that some may be considered for a blueprint potentially:
        - Hurricane Maria response – health centers located in Puerto Rico were a life saver for their communities and each other in general. Also, there was a successful Emergency Management Assistance Compact (EMAC) deployment of a team from Callen-Lorde FQHC to Puerto Rico. More information here: https://callen-lorde.org/puertorico/.
        - In New York City (NYC), there was an effort to establish a 911 diversion program with FQHCs evaluating patients with non-life-threatening conditions via telehealth in collaboration with NYC and the Fire Department of the City of New York (FDNY) Emergency Medical Services (EMS). Although the pilot never took shape, the concepts discussed and blue-printed may be viable for a FQHC-to-FQHC conversation.
        - I would recommend defining a process to establish a regular status update call/video call among health centers (e.g., locally, statewide, regionally) during emergencies. This call should be handled by a pre-defined party, for example a primary care association, and should include representation both from clinical and operational staff at health centers involved. This was by far the MOST useful method during COVID in New York to remain in communication with each other and understand who needs help and who can provide it. The Community Health Center Association of New York State completed an after-action report on COVID with some of this discussed in it.
        - Although no coalition is like another, the concept of coalition-level response can be applied to the request above. There is also a concept of Regional Disaster Health Response System (RDHRS) that can be tapped for best practices. Knowing where FQHCs are in the Emergency Support Functions (ESF) structure for a jurisdiction, and/or who represents them, may be a shoo-in setting up a program in question.

        - The national peer-group, called Primary Care Association Emergency Management Advisory Coalition (PCA EMAC) - https://www.healthcenterinfo.org/emac/ - can be replicated for community health centers.
        - There is some work currently happening with Florida PCA on exact same issue.
- I think ultimately, the biggest challenge would again be to make sure that those health centers interested in helping each other, know exactly what needs to be done to protect themselves from risks to their federal grants and FTCA coverage. Once those risks are mitigated and appropriate controls are implemented, connecting them in an organized fashion would be much easier.

SME Cadre Member 2:

- Many of these centers are involved in healthcare coalitions at the local level and they should encourage those connections. The ability for them to support the centers at a regional or national level would be fantastic and should complement the local response and the clinic's ability to engage their coalition and ESF-8 local partnerships.

SME Cadre Member 3:

- Reach out to the various state health department emergency preparedness offices since some may already have ties to community health centers.

II. Select Resources

ASPR TRACIE. (2018). Medical Surge and the Role of Health Clinics.

Because of their extensive geographic coverage, strong community ties, and potential to reach medically underserved areas, health clinics play a key stakeholder role in emergency and disaster preparedness and response. ASPR TRACIE conducted this exploratory study to learn more about the scope and level of implementation of emergency management activities among health clinics, including activities that some clinics may have initiated in response to the CMS Final Rule. (Access the report summary: https://files.asprtracie.hhs.gov/documents/aspr-tracie-medical-surge-and-the-role-of-health-clinics-summary.pdf.)

Association of State and Territorial Health Officials. (2008). Collaborating with Community Health Centers for Preparedness.

This report outlines the work of the Task Force on Health Agency-Community Health Center Coordination in Preparedness, the roles and responsibilities of each task force partner in emergency responses, and provides recommendations for and examples of effective collaboration among the partners. There is a section on roles and responsibilities, and one on partnerships that defines the essential elements of successful collaboration.

Association of State and Territorial Health Officials. (2007). Developing Partnerships with Community Health Centers for Emergency Preparedness Planning.

This guidance document outlines collaborative disaster planning practices between state health agencies and community health centers to enhance operations plans, training, and exercise development.

Health Resources & Services Administration. (2019). A Guide for Rural Health Care Collaboration and Coordination. U.S. Department of Health and Human Services.

This guide provides information on the importance of rural healthcare coordination, examples and key elements of this collaboration, and two case studies which illustrate how the key elements were incorporated into rural care coordination.

Health Resources and Services Administration. (2018). Chapter 14: Collaborative Relationships | Bureau of Primary Health Care.

This chapter of the Health Center Program Compliance Manual outlines the requirements for community healthcare providers specific to creating and maintaining partnerships with other health facilities in their catchment areas. Doing so can help reduce non-urgent use of hospital emergency departments and improve patient care. The chapter also provides information on how health centers can demonstrate compliance with these requirements (e.g., document select efforts, obtain documentation that illustrates coordination).

Jones, E. and Ku, L. (2015). Sharing a Playbook: Integrated Care in Community Health Centers in the United States. American Journal of Public Health.

This research, though based on slightly older data, illustrates to what extent community healthcare organizations are collaborating with other types of healthcare providers. The authors found that while sharing information between behavioral healthcare providers and medical providers was common, joint case conferences were less so, partly due to health centers not using electronic health records and/or having fewer behavioral health workers. The authors advocate for financial incentives and technical assistance to boost support of integrated care.

Koh, H.K., Shei, A.C., Bataringaya, J., et al. (2006). Building Community-Based Surge Capacity Through A Public Health And Academic Collaboration: The Role Of Community Health Centers. Public Health Reports. 121(2):211-6.

The authors describe a collaboration among community health centers (CHCs), government agencies, and academia in the Boston area to develop community-based surge capacity. They describe the project in detail, and discuss lessons learned about how CHCs can help provide a "flexible, linked network of 'reserve' health care capacity

to supplement, support, and extend the efforts of acute care hospitals in their communities."

National Association of County and City Health Officials. Local Health Department-Community Health Center Collaboration Toolkit.

This toolkit can help local health departments and community health centers collaborate to better reach and provide preventive care and medical treatment to underserved populations. It includes three "tools:" a worksheet to assess potential partnerships, an action plan for activities that enhance partnerships, and a tool that can help partners identify strategies to address challenges identified during these processes.

Primary Care Development Corporation. (2017). Emergency Management and Community Resilience: A Capacity-Building Toolkit for Health Centers.

This toolkit was created to help increase emergency management capacity among health center staff. It can also be used to help guide staff in their planning and emergency management endeavors. **NOTE**: Sections 12-14 of this document address building community resilience and partnering with other stakeholders that may be helpful to this request.