Locating and Reaching At-Risk Populations in an Emergency

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Introduction

In December 2006, Trust for America's Health (TFAH) released the fourth annual *Ready or Not? Protecting the Public's Health from Disease, Disasters, and Bioterrorism*, which found that five years after the September 11th and anthrax tragedies, emergency health preparedness is still inadequate in America. They also concluded that "risk communication strategies must do a better job of involving the public in planning for health emergencies."

Effective planning for emergency preparedness and response requires the capacity to reach every person in a community. To do this, a community must know what subgroups make up its population, where the people in these groups live and work, and how they best receive information. Although this may seem like a statement of the obvious, research indicates that many jurisdictions have not defined or located their at-risk populations.

At-risk populations include groups whose needs are not fully addressed by traditional service providers or those who feel they cannot comfortably or safely use the standard resources offered in disaster preparedness, relief, and recovery. They include those who are physically or mentally disabled (blind, deaf, hard-of-hearing, cognitive disorders, or with mobility limitations), people with limited English language skills, geographically or culturally isolated people, homeless people, elderly individuals, and children.

Following a widespread emergency, people may find themselves stranded, displaced, destitute, homeless, or sick; or they may experience challenges from the emergency that leave them newly vulnerable or suddenly outside of mainstream communications in ways they did not experience before the emergency. These factors can create *new* at-risk populations during an emergency.

If you follow the process outlined here, you will begin to develop a **Community Outreach Information Network (COIN)** - a grassroots network of people and trusted leaders who can help with emergency planning and serve to give information to at-risk populations in emergencies.

Trust plays a critical role in how people receive messages during an emergency. Members of your COIN should have the trust of their respective populations (for example, people who are isolated, elderly, or disabled). These populations are typically more difficult to reach during emergencies.

A COIN may also include members of the media, especially those who have closer connections to at-risk populations, such as the local ethnic media outlets. These media outlets can be a very powerful voice and provide a close connection to the populations they serve.

Building a strong network of individuals who are invested in their community's well-being, who are willing to help, and who have the ability to respond in an emergency is just the start. You must also include network members in your emergency preparedness planning, test the capacity of your COIN to disseminate information during preparedness exercises, and implement changes to preparedness plans based on the findings of evaluation reports from those exercises.

The Categories

As you start to find and reach at-risk populations, you can focus on five broad, descriptive groupings for characteristics that put people at risk:

- Economic Disadvantage
- Limited Language Proficiency
- Disability (physical, mental, cognitive, or sensory)
- Isolation (cultural, geographic, or social)
- Age

The key to this approach is that it allows you to examine the nature of the vulnerability that might put someone at higher risk in an emergency. You avoid defining an individual or group based upon their vulnerabilities or using terminology to describe people as being vulnerable - a label that no one wants to have.

Typically, individuals do not fall neatly into one category or population group, and they could fall into more than one. In some cases, an individual might not fall into one of these categories, but could have a family member who does. When this occurs, it can thwart efforts to provide services in an emergency because family members do not want to be separated.

Exploring planning efforts by using these five categories helps you develop the needed plan. For example, it is important to consider limited language proficiency when developing public health messages. To ensure that everyone can understand the information and follow public health directives, information must be culturally and linguistically appropriate and accessible to everyone.

Similarly, economic disadvantage does not necessarily impair the ability of an individual to receive information, but it can significantly affect their ability to follow a public health directive if they do not have the resources or means to do what is being asked (stockpile food, stay home from work and lose a day's pay, or evacuate and leave their home, for example). When an individual is placed at risk because of both limited language proficiency and economic disadvantage, their risk is compounded, and planning efforts should reflect that.

Working in these broad categories can be effective and manageable for emergency planning purposes.

Economic Disadvantage

Start with economic disadvantage. This is a sweeping category because many at-risk populations live at or below the federal poverty level. In the broad category of economic disadvantage, the other categories will often be found. If resources permit a community to address only one at-risk population, using poverty as a descriptor can help reach a large number of people.

Limited Language Proficiency

This category would include people who have a limited ability to read, speak, write or understand English, have low literacy skills, or who cannot read at all (in English or in their native language).

Disability (Physical, Mental, Cognitive, or Sensory)

The disability category includes people who have physical, mental, cognitive, or sensory limitations. The most evident in this category are those who are blind, deaf, and hard of hearing, as well as people who have health conditions that affect mobility or make them dependent on electricity. Mental disabilities are thought by many health and emergency planners to be the most challenging at-risk population in widespread emergencies because people who cannot understand and follow directions could jeopardize others in addition to themselves. Mental disability is a population category that will require priority attention in some emergencies.

Isolation (cultural, geographic, or social)

People can be isolated if they live in rural areas or in the middle of a densely populated urban core:

- Rural populations include ranchers, farmers, and people who live in sparsely populated mountain and hill communities. Rural areas have some special communication challenges, such as dependence on satellite television, which does not provide local channels or news. Additionally, radio stations have moved to a canned commercial feed in many communities and might not be useful for dispensing information in a local emergency. In the urban areas, people can be isolated by their language skills, lack of education, cultural practices, chronic health problems, fear, lack of transportation or access to public transit systems, unemployment, and other factors. Even if they have access to mass media, they might not have the ability or means to respond in an emergency.

- Temporary residents can be a major population for many communities, but there are enormous differences in temporary residents on a military base, a college campus, or in migrant workers' camps.

- Undocumented immigrants are foreign-born persons who reside in the United States and have not yet achieved lawful status. Therefore these individuals may consciously avoid interaction with social and public agencies.

- Single parents and caregivers face challenges because they have no one to share their responsibilities to care for those who are dependent on them. This increased responsibility can impair their ability to plan for or carry out public health directives, and it can be emotionally overwhelming.

- Religious and cultural practices can influence the likelihood of certain groups to receive emergency communications. For example, mass media communications would likely be ineffective for reaching Amish and Mennonite communities because they usually don't have televisions or radios.

Age

Although many people who are over 65 years old are competent and able to access healthcare or provide for themselves in an emergency, chronic health problems, limited mobility, blindness, deafness, social isolation, fear, and reduced income could put older adults at risk.

Infants and children under the age of 18 also can be at-risk, particularly if they are separated from their parents or guardians in an emergency. They could be at school, in daycare, hospital, or other institution; places where parents can expect them to be cared for during the crisis. There are, however, increasing numbers of young latchkey children who are home alone after school, a factor that puts them at high risk in an emergency. In addition, separation of family members can cause its own havoc in a crisis, as demonstrated during evacuations for the 2005 hurricane season when members of some families were separated during the event or sent to separate shelters, even to different states.

The Categories Checklist

ECONOMIC DISADVANTAGE
_ Living at or under the poverty line, including those who have been in poverty for at least two generations
_ Medicaid recipients
_ Working poor with limited resources, often working multiple jobs
_ Single mothers and sole caregivers
_ Low wage workers in multiple jobs
_ Ethnic and racial minorities

LANGUAGE PROFICIENCY
_ Limited English proficient or non-English speaking groups:
• Spanish
• Asian and Pacific Island languages (Chinese, Korean, Japanese, Vietnamese, Hmong, Khmer, Lao, Thai, Tagalog, Dravidian, Polynesian and Micronesian languages)
• Other Indo-European languages (Germanic, Scandinavian, Slavic, Romance (French, Italian), Indic, Celtic, Baltic, Iranian, and Greek languages).
• All other languages (Uralic and Semitic languages as well as indigenous languages of the Americas)
_ Sign Languages/American Sign Language (ASL)
_ Limited language proficiency (read, write) in native language
_ Foreign visitors
_ Illegal/undocumented immigrants
_ Immigrants/refugees

DISABILITY (physical, mental, cognitive, or sensory)
_ Blind and visually impaired
_ Deaf and hard of hearing
_ Developmentally disabled
_ Mobility impaired

_ Electricity–dependent (life support/medical equipment)
_ Chronic disease/infirm
_ Diagnosed with HIV/AIDS
_ Immunocompromised
_ Drug and/or alcohol dependent (perhaps not in treatment)
_ Diagnosed with mental illness and substance abuse
_ Mentally ill or having brain disorders/injuries
_ Chronic pain

Non-hospitalized patients:

- _ Require renal dialysis
- _ Require supplemental oxygen
- _ Require daily medication (for example: diabetes, hypertension, pain management, oral contraceptives)
- _ Receiving chemotherapy for cancer treatment
- _ Clinically depressed individuals who may be unable to follow directions
- _ Stroke patients with limited mobility and additional care requirements

People with temporary physical challenges that they might not normally plan for:

- _ Pregnant women
- _ People recuperating at home from acute injury (for example, broken bones, recent surgery, back injury, burns)
- _ Individuals who do not identify as visually impaired, but would be impaired if they were to lose their glasses during an emergency.

ISOLATION (cultural, geographic, or social)

_ Homebound elderly
_ Homeless people
_ People living alone
_ Sole caregivers and single individuals without extended family
_ Low-income people
_ People living in remote rural areas with spotty or no reception of mass media
_ People living in shelters, for example, homeless people, runaways, or battered persons
_ Undocumented immigrants
_ People dependent on public transportation
_ Rural and urban ethnic groups
_ Religious communities (Amish, Mennonite)

Seasonal or temporary populations and those in temporary locations

- _ Commuters
- _ People displaced by a disaster
- _ Schools; students, teachers, administrators, and employees at schools, universities, and boarding schools
- _ Seasonal migrant workers
- _ Seasonal tourists, residents, and workers
- _ People isolated by recreational activity (primitive campers or backpackers, for example.)
- _ Truckers, pilots, railroad engineers, and other transportation workers
- _ Military personnel
- _ Campers and staff at residential summer camps

Locations

- _ Business centers and work sites
- _ Daycare centers (child or adult)
- _ Hospitals, emergency centers, or other healthcare settings
- _ Arts and entertainment venues
- _ Schools – public, private, and parochial
- _ Shopping centers
- _ Stadiums or arenas
- _ Transportation locations (airports, bus stations, or train stations)
- _ Assisted living facilities
- _ Group housing, (dormitories, retirement communities, hospice, hostels, YMCA, and correctional facilities, for example)
- _ Prisons
- _ Long-term care nursing facilities

_ Evacuation shelters
_ Universities, colleges, community colleges
_ Military bases
_ Theme parks and amusement parks
_ Campgrounds, national parks
_ Vacation resorts (for instance, beach and ski resorts)
_ Migrant worker farm/camp

AGE
_ Frail elderly with limited strength, but not disabled
_ Senior citizens (age 65 or older)
_ Infants in neo-natal units
_ Pregnant women
_ Mothers with newborns
_ Teens, school-age children, latchkey children
_ Juvenile offenders
_ Families with children who have healthcare needs

Creating a COIN in Your Community

Emergency preparedness planning will allow you to reach every person who lives, works, or travels through your community, regardless of the communication barriers. To set realistic goals toward attaining that vision, you must first know who is in your community at any given time, and how best to reach them with messages that will motivate action.

The steps are divided into three phases: *Define, Find*, and *Reach*. During each phase, there are specific activities which will help you create and maintain the Community Outreach Information Network.

The *Define* phase focuses on how to know the people in your community, particularly those who may have communication barriers and who are at-risk. This phase of the process discusses how to identify and engage representatives of programs, organizations, and agencies that serve these population groups in your state, region, county, or town.

Once you have gone through the steps to define the at-risk populations in your community, the *Find* phase will allow you to locate those people. You will begin to determine where these groups of people live, work, and gather. One outcome of this phase will be to learn the geographic distribution of the at-risk populations in your community. More importantly, it will lead to strengthening relationships with the local organizations that can reach and plan for the needs of people of diverse cultures and life challenges in your community.

After you have worked through the *Define* and *Find* phases for your at-risk populations, the *Reach* phase will help you reach trusted leaders of these groups and enlist their help to plan for emergencies. These leaders can also deliver messages that community members can understand and can act on in an emergency.

By following these steps, you will have laid a solid foundation for your network and you will be more prepared to reach at-risk populations during an emergency.

Phase 1: Defining At-risk Populations

Defining at-risk populations will require research to build an understanding of the unique demographics represented in your particular community. You will need to learn about the languages spoken, cultural practices, belief systems, and the physical and mental limitations of the citizens.

You can use many sources of population statistics from the national level down to local agencies. This quantitative data, previously gathered by others, will help you begin the process and build a “snapshot” of your

community. The next phase will ask people to share their opinions and knowledge that will bring the information into focus.

These first few steps will outline the process to help you initiate the dialogue and engage those representing the organizations and government agencies that can reach many people in your community. These organizations can provide a wealth of information about at-risk populations and those who represent them.

You will start building a network of collaborators and partners as you go beyond the U.S. Census Bureau data and delve into the specific demographics that distinguish your community from others. The Resource Guide includes a database template to help you manage the information you gather. Because the people and their needs can change over time, organize the data so it can be updated as needed.

STEP 1 – Collect Population Information and Data

Begin by conducting research and analyzing available data gathered by others to shed light on different population groups in your community. The U.S. Census Bureau website breaks down its information into manageable state, county, and city data to give baseline descriptors of the different populations living in a community.

Regional Councils and MPOs.

- When local governments (city or county) work cooperatively to address problems or issues for a region, they often do so as part of a Council of Governments, Metropolitan Planning Organization, or regional council.

  Regional councils have state and locally defined boundaries. They can deliver federal, state, and local programs and can function as planning organizations. They are accountable to local units of government and typically work in transportation planning, economic development, workforce development, environmental planning, services for the elderly, and providing information via clearinghouses.

  A Metropolitan Planning Organization (MPO) is an agency created by federal law to provide local input for urban transportation planning and to allocate federal transportation funds to cities with populations of greater than 50,000. According to the National Association of Regional Councils (NARC), nearly half of all MPOs operate as part of a Regional Council serving the same general geographic area.

  Many Regional Councils and Metropolitan Planning Organizations have sophisticated Geographic Information Systems (GIS) that they use to map transportation and other planning activities. This data can be extremely valuable to you for community mapping.

STEP 2 – Estimate the Number of People in At-risk Population Groups Living in Your Community

Once you have information and findings from your initial research, you can synthesize the data into a brief report to estimate the number of people within different population segments in your community. This will help you gain a greater understanding of the scope of the at-risk population outreach work that may be required.

As you collaborate with your planning partners, be sure to address the terminology you will be using as descriptors or definitions for the at-risk populations you wish to define.

STEP 3 – Identify Key Contacts at Overarching Organizations and Government Agencies

Many organizations in communities across the country have extensive knowledge about the needs of various at-risk populations. Overarching organizations that fund or partner with smaller, direct service providers are the best

place to start in engaging your community. In many areas, this would be an organization such as the United Way. These organizations provide a direct link to Community Based Organizations (CBOs) and Faith Based Organizations (FBOs) that serve many different at-risk populations. These direct service providers and government agencies have the know-how and "big picture" understanding that can be a valuable resource in planning for preparedness, response, recovery, and mitigation activities. Public libraries can also serve as excellent resources with information about community service providers, particularly in very small communities that do not have a community foundation or local United Way.

STEP 4 – Facilitate Discussions with Key Contacts

This step engages your community members to establish relationships and to identify potential partners and collaborators. To start, contact the overarching organizations by phone and ask who would be the appropriate representative to work with you and what would be the best approach to use (phone, mail, e-mail, personal appointment, etc.) to contact them. You may be working with the leader of the organization, the person who oversees community affairs, or a student intern. Whatever their level of authority, they can become one of your valued resources.

Phone, e-mail, or mail the key contacts at the overarching organizations and government agencies to introduce yourself and explain the critical role this person and organization will play in the process of reaching at-risk populations in your community.

Have you collected information or resources that may be useful to others? You may be able to think of ways that you can help these potential partners by offering to share information or resources. Remember to give back to the faith-based organizations (FBOs) and other agencies that you ask for help. Don't just ask them to do "one more little thing." Remember that they also have concerns about spreading resources too thin.

Arrange a time to meet with several of these key contacts at a location most convenient for the attendees. If time and travel constraints make face-to-face meetings impractical, consider alternative means of getting together, such as a conference call.

Regardless of meeting format, your role will be to facilitate the discussions and brainstorming on topics such as:

- The issue and process to define at-risk populations
- Long-term goals and objectives
- Other people who should be part of this discussion and their contact information
- A list of specific at-risk populations in your community and how partner organizations might be able to provide or contribute information

STEP 5 – Stay in Touch

Sustaining community engagement is as important as building relationships. It is important to stay in touch – not only to update your partners on your activities, but to stay updated on staff turnover and transitions in your partner organizations. It is important to stay in touch on a regular basis and build in a mechanism to maintain updated contact information. You may find it helpful at this stage to send regular brief updates on the progress of your work through e-mail, mail, or telephone calls. Later, as resources allow, you may want to develop a newsletter (in print or electronic formats) to the keep people in your network connected, informed, and responsive. Build opportunities into your communication and outreach activities for feedback from your partner organizations.

How to Use the Information

You have been collecting information that you will use throughout the process to find and reach your community's at-risk populations. You need to be able to manage the information in an accessible form that can grow as you acquire new data, contacts, characteristics, and other details.

Develop a Database

An electronic database is one of the best ways to record information so you can track multiple factors, share data with others, and keep information current. For your basic database, you will want to include the at-risk populations you are working with. Record specific demographic information such as: names, phone numbers, e-mail addresses, and postal addresses for key contacts at organizations and government agencies.

Your database does not have to be complex. You can use a simple table in a word processor or on a spreadsheet to organize the information that you collect. There is a sample database template in the tools and templates that illustrates the different headings and information categories that you can use to get started.

- If you want to plan for a more robust database and have the Information Technology (IT) staff to help you develop, build, and plan for future growth of your database, including them now in your planning activities will be helpful. If they are involved from the beginning and understand your goals, they will be better able to help you anticipate ways to organize the data so that it will be most useful as you expand your database.

As you expand your database, the following tips might be helpful:

- Many state, regional, county, or city sections of these organizations that are listed in telephone directories or online through a keyword Web search, using words such as “disability,” “blind,” “deaf,” “developmental disability,” and “mental health.”
- People may self-select into groups based on their particular disability or need:
    - University students who have mobility impairments often form organizations that provide support and advocacy.
    - People who belong to various cultural and ethnic groups may form close bonds with other individuals within the same groups.
    - People that speak a common language, share a common country of origin, or a common religion may join together in informal ways. The church, the mosque, or other house of worship is often the place where community needs, political opinions, and employment options are discussed. In some ethnic populations, community storefronts are the gathering and information centers.

These groups may not show up on an official list as they do not have national charters or oversight, and are usually informal and private, often without scheduled meetings or agendas. Leaders of these groups, whether they are the matriarch of the family, community elder, religious leader, or the club president, can provide pertinent information about the groups they represent. They also serve as valuable links in the process of building a network of collaborators and sustaining community engagement.

You may find these affinity groups by asking the representatives of the overarching organizations if they are aware of any of these types of unofficial groups in your community. Be sure to ask for names and best ways to contact the leaders. If there is a college or university in your area, you can contact the student affairs department to ask for information. Often a person belonging to the group will be the best source of information for these types of unofficial groups.

Phase 2: Locating At-Risk Populations

The best approach to find at-risk populations in your jurisdiction would be to combine Geographic Information System (GIS) technology with information acquired through community collaborations and networking. Although mapping technology is widely available in the United States and can be usefully adapted to meet the needs of public health and emergency professionals, mapping of at-risk populations appears to be sporadic. In many coastal communities, for example, mapping is used by fire departments and cities in evacuation planning. In other areas, Area Agencies on Aging or county offices of elderly affairs have mapped populations aged 65 and older. But, most communities have not specifically mapped for at-risk populations.

In small communities, mapping is often viewed as unnecessary because “everyone knows everyone else.” Yet, mapping – whether it is done by sticking colored pins on a paper map or with an electronic interpretation of data – provides an exceptionally clear picture of where hard-to-reach population groups might be found in a crisis. It is a time-saving benefit regardless of community size or diversity. Saving time is especially important when the people

responding with emergency help and support come from outside a community and may be unfamiliar with the local situation.

If you have better-than-average resources, interested technical personnel, and/or a pressing perceived need, mapping technology might be available already. In most states, resources to help update and interpret demographic data to map at-risk populations and track changing population dynamics may be available at the state level departments of public health, family services, transportation, commerce, economic development, ethnic affairs, or the education minority office, and other similar offices. In addition, every state has a GIS coordinator who is familiar with the digital mapping activities underway in their state.

Mapping is a community building process. You will collect information from sources at the local level and from those who know the community (police officers, public works crews, utility workers, tribal entities, social service providers, places of worship, barber shops, and schools). You will dig deeper into your community to learn more about neighborhoods and the people who live there, about community centers and the people who congregate there, and about the places and people that those most at risk will turn to in a time of crisis.

STEP 1 - Assess Existing Departmental Processes to Find At-risk Populations

You already know who some at-risk populations are and how to reach them because they are enrolled in programs and/or receive services from your department. State and local public health departments, for example, know women who are connected through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and generally know how to get in touch with them; or they know how to contact daycare providers who can help find parents and guardians in an emergency.

To avoid duplication of efforts, you may find it helpful to conduct an inventory of your department's current activities that include techniques and abilities to find people. Interview others in your department or agency about the successes and barriers they have experienced in finding people who use their services.

You may want to ask questions such as:

- Who are the at-risk populations served by the department?
- Where are their gathering places?
- What is the department's process for finding them? What data sources are available to use in the mapping efforts?
- How do at-risk populations receive information from the department?
- What other community and religious organizations serve these same groups?
- What other links do these at-risk population groups have to the community?
- What HIPAA or other privacy rules may impact efforts to find at-risk population groups?

This type of intra-departmental assessment can provide finding strategies as well as research data that can be used in the mapping process.

STEP 2 - Choose Digital Mapping or Alternate Methods

Research shows that about 80 percent of all information has a geographic component. A Geographic Information System (GIS) is a system that captures, stores, and analyzes data, and displays it in a map. These databases include a wide variety of information including geographic, social, political, environmental, and demographic data.

Many local organizations are already using digital mapping techniques to display information ranging from neighborhood crime data to environmental information, such as air quality and the amount of smog. Few, however, have made the leap to using this information to find at-risk populations for public health emergencies.

If you do not have access to digital mapping resources, you may want to consult with organizations that could become project partners to help you map your at-risk populations.

These could include:

- The MPO or regional council that serves your area (in regional communities with population over 50,000)
- Your state GIS coordinator

- Your state GIS data clearinghouse
- The geography department at local colleges and universities
- Your state department of transportation
- Your state or county department of emergency management
- Your local police, fire, or public works departments

In addition, your state demographer maintains data on populations in your state and can be a resource for analyzing this data. They will often have GIS professionals on staff.

To find resources with GIS software to help you, start with MPOs and regional councils. You might also want to contact your state GIS Coordinator to request information about the data clearinghouse for your state. The National States Geographic Information Council (NSGIC) is the professional organization that will be able to direct you to the GIS coordinator or the contact for your state.

- The geography department at local colleges and universities might be able to provide names of students who might consider developing your project for course credit. You might also find knowledgeable students who are willing to serve as interns or even volunteer their time to help you. You can also contact departments of transportation or local police and fire departments to see if they use GIS software and are willing to assist. Ask to speak with someone in the GIS, research, or planning departments when seeking this information. You may ultimately find that MPOs are the most likely to have the GIS software to find at-risk populations.

  When using GIS software to find at-risk populations, you will be bringing the population data you collected to define at-risk populations into the mapping program. Some GIS mapping software comes with U.S. Census data embedded. Remember that the timeframe between updates and reliance on self-reporting for Census data will require that you re-check and update the data as necessary. Also, consider printing out the data at regular intervals so the information is accessible in emergencies if there are widespread power outages.

  For some small departments and agencies, it is possible to collaborate with partners to find at-risk populations and not map the information. However, the best planning efforts will incorporate both geographically mapping the populations with their gathering places, and also forming collaborations and partnerships to create more lasting relationships with various groups and their trusted sources.

  If you don't have access or are unable to use GIS software for your mapping, post a map of your community on a wall. Use the Census and other data you've collected in the define steps and/or information gathered from community collaborators to determine where your at-risk populations may be found. Use pushpins or markers for a visual representation of the at-risk populations in your community.

STEP 3 - Find and Map Gathering Places for the At-risk Populations You Have Identified

Find the places that special populations gather in order to find individuals and groups within these populations. Collaborate with Community Based Organizations (CBOs) and Faith Based Organizations (FBOs) to make this job much easier.

People who share important aspects of their lives gravitate socially and geographically to traditional gathering places or venues. Obvious examples are soup kitchens for homeless populations, or day-worker sites that attract undocumented persons. Commercial locations can be important gathering places. For example, people who live in remote rural areas gather at retail shopping locations on weekends. In many cases, employees at these stores will be the trusted information sources because they are part of extended families in the area, and are therefore excellent resources to find people with special needs and for sharing health or emergency information.

STEP 4 - Identify and Map Trusted Sources in the At-risk Population Communities

People are more likely to receive information and act on it when the message comes from a trusted source that they view as credible. Spokespersons in authority are not always the credible, trusted sources we hope they will be in delivering information to the general public and may even be less credible for the at-risk populations you are

trying to reach.

That is why it is so important to build your network of trusted spokespersons that your at-risk populations will identify with and trust. These people may not serve in an official capacity, nor be known to public health and emergency providers, but they can serve as a main channel of information and a cadre of leaders in emergencies. The same qualities that make them unofficial, but trusted, leaders in their communities, often make them willing to serve in a liaison capacity between health and emergency professionals and at-risk populations.

A trusted source might be the director of a multicultural community center, or a Community Health Worker (CHW).

In addition to the confidence of the people the center serves, this person might also have a good network already in place to reach community members through an e-mail listserv, telephone tree, mailing list, or simple word of mouth.

Include trusted sources in meetings and planning sessions with other community organizations and service providers. Add them to your database, capturing their contact information and how they prefer to be reached.

As you build your network of trusted sources for your network, map their locations in your community so you can begin to get a visual representation of the network you are developing. Eventually you will be able to integrate this information in such a way that you can develop digital maps showing the locations of trusted sources, spokespersons and community resources coordinated with the populations that they serve. Later on, this graphic representation of your network and the populations that they serve will help you to better identify gaps in coverage for at-risk populations in your community. For a simple way to generate maps to show the locations of your COIN members using free, online tools (Google Earth, Batch Geocode) see the Resource Guide.

Engaging community members in activities to find at-risk populations requires collaboration, contribution, and commitment. You will be asking already busy people to share their time, their energy, and their information to help you expand your capacity to reach every person with health and emergency information. You have already started building your network through your discussions and meetings with representatives of organizations. You are now taking the COIN to the next level by engaging people who are on the front lines of providing service to the wide variety of at-risk populations in your community and those who are members or trusted leaders in their population group.

You will be developing long-term relationships built on respect, credibility, and a shared concern that people in at-risk population groups are included in health and emergency planning, response, and recovery.

STEP 5 - Facilitate Discussions with Representatives from Community Organizations Connected with At-Risk Populations

Designate a contact person within each of the organizations and partners with whom you will regularly work. Their names, addresses, and phone numbers can be added to your database as you acquire them.

You can host a meeting or conference call with these representatives to discuss the issues involved as you find at-risk populations. Talking with representatives of community organizations that serve at-risk populations, including those that address human service needs as well as community needs, is essential to determine which organizations can help you the most to find at-risk populations. Not every community representative will have a role to play in the *Find* phase, but they can be valuable connections to reach groups and to disseminate health or emergency information. This dialogue will enable you to meet community collaborators who can help you learn where to find at-risk population groups.

When you talk with them, ask community collaborators to explain:

- The populations they serve
- How they distribute and receive information
- Their classification as an overarching organization or a direct service provider
- What their potential outreach could be – the number of organizations and/or individuals this collaborator or partner could reach with ordinary and crisis communications

STEP 6 - Expand Your COIN to Include Service Providers, Businesses and Others Who Work with, Represent, and Belong to At-Risk Populations

An overarching organization is the lead organization that may partner with or provide funding to many direct service providers. The service provider organizations are a more direct link to the populations they serve. You first contacted overarching organizations and government agencies in the *Define* phase. These organizations can now serve as a link to service providers, providing detailed information and saving you time and resources.

If the overarching organization is unable to provide the requested information about its member organizations, you may have to contact each service provider directly to get the information you need.

An important way to build trust is to build upon existing trusted relationships. Many CBOs and FBOs are already involved in public health initiatives to reach at-risk populations to eliminate health disparities. Reach out to these public health programs to enlist their help to reach these partners for your network.

At the local level, small faith-based organizations such as missions, ministries, or individual congregations may provide informal community outreach through programs that visit shut-ins or provide after-school mentoring or other services. By asking general questions about such programs you might find some of the at-risk populations in your community. Based on your conversations from Step 5, you may want to add some new questions or topics to the sample questionnaire template/telephone script in the Resource Guide.

After identifying those organizations most appropriate to find at-risk populations, you can begin to discuss the roles of your department and the other network members to find and reach everyone in your jurisdiction regardless of individual or community barriers.

How to Use the Information

Expand Your Database by Adding Contact Information for Community Collaborators and Program Partners

Using the database you created in the *Define* phase, add new fields across the top, such as the organization's contact person, his or her title, physical and mailing addresses, city, state, ZIP code, phone number, fax number, and e-mail address, as well as a brief description of the organization's outreach capabilities and geographic area. You can also add the places where you have been able to find at-risk populations and their gathering spaces.

See the Resource Guide for a sample database showing the entries that can be added, the types of headings, and organizations that can be included.

Update and Maintain your Database

Review the Community Organizations that Helped Find At-Risk Populations

In the *Define* phase, you began to build your network and capture contact information in a database. In the *Find* phase, you added many contacts to the database, including governmental and quasi-governmental agencies, overarching organizations and service provider organizations (CBOs and FBOs, education and English as a Second Language (ESL) organizations, hospitals, rehabilitation centers, community centers, senior centers, and independent living facilities).

As the work to find and reach at-risk populations continues over time, members of your COIN may change or their contact information may change. Keeping your database current will be extremely important as your work moves forward.

Develop Policies and Procedures for the Information You Gather. Maintain Confidentiality of Contact Information for Your COIN Members

As you begin to build your database, it is likely that information you collect will become very attractive to other partners (including federal and state agencies), and you may get requests to share contact information for your network members. Address this possibility early by developing clear policies and procedures outlining who within

your organization will have access to contact information and the ways that the information can be used.

The success of your network is built upon trust. Demonstrate your commitment to COIN members by having clear policies for how contact information will be used and by clearly defining confidentiality issues at the start of your relationship with each member.

The best approach might be to have a blanket policy that information collected will not be shared. It would be inappropriate to share contact information of a network member without their express permission, but if you decide that you will share information with partners on some limited basis, clearly outline the circumstances in which this might occur. As keeper of this important contact information, decide ahead of time if you would be willing to disseminate messages on behalf of other partners during a non-public health emergency, and include policies and procedures to do this.

These are only some of the issues that you may encounter. As you continue to build and develop the network, maintaining the trust and anticipating possible concerns of your members will ensure the future success of your COIN.

Phase 3: Reaching At-Risk Populations

In an emergency, messages must not only inform and educate, but they must also mobilize people to follow public health directives. People are reached through the languages they speak and by dissemination channels such as television, radio, newspaper, bill inserts or flyers, through word-of-mouth (often the most effective communication method), and through their social and community networks. For people to act, they must understand the message, believe the messenger is credible and trustworthy, and have the capacity to respond. (See "*First Hours"* in the Resource Guide. First Hours provides messages that can be adapted for use during a terrorist attack or suspected attack).

An important first step is determining the outreach capacities, processes, and resources that are already being utilized to reach at-risk populations within your community. In a few states, the departments of public health and emergency management are working together to implement communication plans that have elements of at-risk population outreach.

There are many organizations across the United States that have extensive knowledge about the needs of various at-risk populations. Community Based Organizations (CBOs) and Faith Based Organizations (FBOs) provide a direct, trusted link to the populations they serve. The challenge is to incorporate their skills, knowledge, and communication strategies into your plans to reach at-risk populations. This integration will provide a more inclusive response in public health emergencies.

The network you have been building can play a role in the comprehensive and integrated preparedness approach you need for at-risk population outreach. This work requires significant investment on the part of public agencies. It means sharing resources, sharing power, and sharing responsibility for outcomes.

Step 1 - Survey Agencies and Organizations to Learn About Their Successes and Failures

The best way to learn what works well is to ask people who are already in the business of reaching at-risk populations. You can conduct a simple interview or survey with people in and outside your agency who routinely communicate with members of at-risk populations. This might include professionals such as first responders (fire, police, and emergency medical services), people who are in charge of programs such as Meals on Wheels, tribal elders, instructors in English as a Second Language (ESL) classes, ethnic media representatives, and healthcare practitioners at clinics.

You will be able to use this information to start planning appropriate ways to augment your existing communication plan to include at-risk population outreach. This preliminary survey can help you identify practices that succeed – some of which you may want to incorporate in your plan – and those that failed to accomplish any measurable objective.

Step 2 - Conduct Focus Groups or Community Roundtables

An important next step is to use qualitative research techniques to reveal in-depth details on the barriers and specific communication needs of at-risk population groups in your community. Focus groups and community roundtables allow you to talk directly with members of the populations you want to reach. This research can give you a better understanding of your at-risk populations by delving into topics like:

- Barriers to receiving information based on past experiences
- Preferred methods of communication
- Key spokespersons and trusted sources of public health messages
- Media usage/habits
- Primary languages spoken
- Culturally competent messages

This information can be obtained by asking leading questions like:

- What sources do you usually use to get news and other information?
- Whom do you trust to give you information about healthcare and other health-related issues?
- When there is an emergency, how do you get information?
- If there were a public health emergency, where would you go for information?
- How do you prefer information to be communicated (e.g., in what language, verbal, or written)?
- In the past, what types of barriers have kept you from receiving important information?

Before arranging focus groups, consider the best ways to access your intended population. For example, if your target demographic is the elderly (age 65 or older), conducting a focus group may not be effective because elderly people may have transportation or mobility issues that prohibit them from attending a focus group.

A telephone interview would be a more appropriate research method, and research shows that most elderly people can receive information via the telephone. As an alternative, a written survey delivered by a trusted source, such as a Meals on Wheels provider or a family member, could be an effective way to encourage participation.

While a written survey doesn't have the qualitative capability of assessing perceptions, attitudes, and behaviors through interpersonal communication and interaction, it can provide statistical data that determines recurring themes, best communication methods and practices, most used media outlets, and most trusted information sources for the at-risk populations you are trying to reach.

When you plan focus groups for your intended population, try to schedule them at convenient times and at locations, such as multi-cultural community centers, churches, schools, or senior centers that are easily accessible. You may need to arrange for interpreter services, depending on the specific population you are inviting, and the following resources can help you find foreign language and American Sign Language (ASL) interpreting services and additional information that will be helpful:

- National Council on Interpreting in Health Care (NCIHC)
- Registry of Interpreters for the Deaf (RID)
- National, state and local on-site interpreting providers
- State and local interpreting associations
- Recommendations from local organizations that frequently use interpreting services (CBOs, clinics, hospitals, courts, law offices, etc.)
- Diversity Rx for links and resources about cultural and linguistic competence in health care

Step 3 - Analyze Data Gathered From the Surveys, Focus Groups, and Your Previous Research Efforts

As you review your research findings from the *Define* and *Find* phases of this process, along with your recent

focus groups and surveys, you may see common characteristics and needs that will enable you to create a list of key findings for each population. Look for common themes and emerging patterns as they relate to reaching at-risk populations with messages they understand and to which they can respond.

You might find, for example, that certain groups (people who might be categorized as minorities, but whose economic circumstances, language, and education are not limited) can be reached through mainstream communication methods with messages aimed at the general public. However, the research may also show that African Americans, Hispanics, Native Americans, or other cultural groups distrust official government messages and desire communication materials that are culturally relevant to their group. CBOs and FBOs can serve an important role in reinforcing and validating information for these groups who may first receive information through mainstream channels.

Step 4 - Collaborate with Community Organizations

Your research provides the basis for understanding the cultural and linguistic characteristics of your community and the communication barriers faced by at-risk populations. Such findings will serve as the basis for developing communication strategies that overcome communication barriers and convey information that is understandable and relevant to members of the diverse populations.

Community collaborators who have become a part of your network will bring their experiences in implementing communication strategies to the process. At a meeting or by telephone, ask your collaborators to share their strategies. In an emergency, public information must meet the needs of at-risk populations to be effective. Some communication tactics would include:

- Keep messages simple and concise by using short sentences and plain language to allow for easy translation of materials (consider using sixth grade reading level or lower).
- Provide translated materials in bilingual or multi-lingual form.
- Include such visual aids as pictures and maps to reinforce key messages.
- Repeat key information.
- Include directions and phone numbers.
- Use large fonts.
- Identify preferred communication methods (face-to-face, door-to-door, word-of-mouth) and develop messages accordingly.
- Identify preferred media through which messages are delivered; is it the local newspaper, ethnic radio station, or the church pastor?

As part of your ongoing efforts to strengthen your local communities' capacity to respond to a public health emergency, you can conduct workshops with representatives of at-risk populations and community leaders who are already committed to participating in your agency's outreach work.

The workshops would:

- Help sustain relationships with members of your network
- Provide an avenue for them to participate in decisions and actions that directly affect their communities and reinforce their sense of dignity
- Increase their awareness of cultural and social diversity in your jurisdiction
- Demonstrate your long-term commitment to the network.

Depending on the size of your jurisdiction, you may choose to have a series of workshops in different locations. Activities at these sessions might be to:

- View a basic "train-the-trainer" video on disaster-related communication, the leaders' roles and responses, and techniques for conveying information quickly and accurately to members of the intended populations.

- Review materials produced specifically for at-risk population groups.
- Gather input on how existing materials can be adapted or new materials developed to better meet the needs of various populations.

All-Hazard Emergency Planning

Collaborate with community organizations or bring COIN members to the planning table to address the needs of at-risk populations in your agency's all-hazards emergency preparedness plan.

Ask them for ideas about how best to reach them or address their needs in an emergency. Work together to include this information in your preparedness plans and to test the plans in your preparedness exercises. Invite them to participate in your exercises and include them in post-exercise evaluations and after-action reporting activities. Be sure to complete the process by updating your preparedness plans based on what you learn from your exercises.

Step 5 - Identify Appropriate, Trusted Messengers to Deliver the Messages

At-risk populations might respond differently to a message depending on the messenger. For ethnic minorities, the person delivering the message is often better received if he or she is from a similar racial or ethnic group, or is in a similar situation as the intended audience. Doors are more likely to open for peers who deliver healthcare messages to their neighbors than for someone from a different ethnic background who lives outside the neighborhood.

Even when members of an at-risk population have access to the mainstream media, they may be more responsive (and therefore more willing to follow directions) if someone they know delivers the message. For instance, elderly persons may watch television and listen to the radio, but may be most persuaded to take action if encouraged to do so by family or caregivers. For non-English speakers, a family member or representative of their faith community may have the most influence in delivering information.

People to consider as messengers include:

- Trusted persons within at-risk populations are essential conduits of information to and from those groups. They must be identified, invited to the process, and their needs and concerns met so they are willing to be active participants in the emergency preparedness process prior to a public health emergency. The network you have been building throughout this process contains names of the community leaders considered credible by specific at-risk populations.
- In some urban areas, religious leaders, barbers and hair stylists can be trusted sources of information about health care and the community.
- Community and neighborhood leaders who are perceived as credible are more likely to be believed during a crisis by at-risk populations than official government spokespersons.
- Reporters, editors, announcers, and news directors in media outlets that serve your community can be considered traditional messengers that will have a broad reach into most at-risk populations.
- In many populations, the matriarch of a family is the most respected and trusted source of information, while in other cultural groups, elders are the respected and trusted sources of information. As you meet with community members to build your network, it is best to ask representatives from the different groups who they consider to be the best person to disseminate messages to their community. Avoid making assumptions about who the trusted person might be based upon your interactions with other groups.

How to Use the Information

Enter New Information in Database

In your existing database, add vertical headings (such as barriers, channels, and messages) and enter the new information from your research on barriers for at-risk populations, preferred channels of communication, and the

messages ranked most effective by your focus groups. This information will be an excellent resource and help you keep focused on the goals you have set.

Enhance Your Communication Plan to Reach At-risk Populations

Using your key findings from your surveys, focus groups, research, and the information in your database, you can enhance your existing communication plan to include at-risk population groups and to designate the appropriate, trusted spokespersons for them. Be sure to include members of the at-risk populations groups in your planning sessions. Encourage them to provide input so that your communication plan is feasible and appropriate.

Your plan could be a supplement your organization's existing Crisis and Emergency Risk Communication (CERC) plan, or incorporated into the body of the CERC plan itself. If your agency or department does not yet have a formal CERC plan, please see the Resource Guide for information on CERC materials and available training resources.

Elements to address in your communication plan include:

- Identifying the roles played by state, local, and tribal officials and staff, public agencies and service providers, CBOs, and members of your COIN. This element is often overlooked in communication plans and can lead to confusion, duplication of effort, and "turf" issues.
- Defining your at-risk population groups.
- Finding these intended audiences and their gathering places.
- Developing strategies to describe your approach to achieve your goals and objectives around reaching at-risk populations.
- Developing tools and tactics that define actions to be taken or materials to be developed.

Exercise Your Network with Drills and Preparedness Exercises

Using the information in your database, plan and carry out a simple drill to test your network using an e-mail message. Before the test, alert COIN members and give instructions for their response. Plan a test message that is relevant and brief.

At the appointed time and day, send an e-mail test to the network members. A template for an email drill is in the Resource Guide. Consider including information on individual emergency preparedness in the email to COIN members to promote jointly–sponsored public education events or activities.

Include your COIN members in preparedness exercises and drills to test their capacity to disseminate information to the at-risk populations they represent.

You might even consider exercising select portions of your network to disseminate non-emergency public health messages periodically. As you get more experience and get a better understanding of your network membership, it will become easier to separate groups for different message dissemination purposes.

Revise Your At-risk Populations Outreach and Emergency Preparedness Plans

Exercise your network through drills and during preparedness exercises. Invite your members to participate in the exercises and post-exercise meetings to evaluate the effectiveness of your preparedness planning to reach your at-risk populations.

These meetings should generate after-action reports that will outline the gaps in your emergency communications and preparedness plans that were identified during the exercise. Be sure to revise and update your preparedness plans based upon the after-action report findings

When exercising the capacity of the network for information dissemination, look for gaps in message delivery. Questions that you and your COIN members should ask include:

- What elements worked as planned?
- Were community leaders of special populations reached effectively?
- Was anyone left out?

- Who needs to be added to the COIN?
- What reactions and factors did we fail to anticipate?
- Where can we improve the plan?

Continue to include your network in preparedness planning and exercises for at-risk populations and regularly repeat the cycle to:

- Exercise the capacity of your network
- Evaluate the effectiveness of your network
- Identify gaps in:
  - information dissemination
  - planning for the needs of special populations
- Identify ways to address gaps
- Identify agencies and organizations that will need to coordinate activities to address each gap
- Determine a reasonable timeframe to address each gap
- Assign responsibility to an individual in each agency or organization tasked to address each gap
- Update respective preparedness plans to reflect changes that are implemented
- Exercise revised preparedness plans for:
  - information dissemination
  - planning for the needs of at-risk population

Expand Your Scope

Once you have been able to successfully find and reach members of your initial five at-risk population groups, you can expand your initiative to include more groups using the same steps you followed in each phase of this process.

Other ways to expand your scope in this work include:

- Host meetings for your COIN members to keep them involved and connected with one another
- Provide training sessions to train COIN members on their responsibilities during an emergency.
- Develop training materials for your COIN members to help them keep up to date.
- On a limited basis, you might consider enlisting the voluntary participation of COIN members to help disseminate public health prevention messages. Your COIN will be exercising its capacity to reach its members and helping you disseminate public health information. This can only make your COIN stronger and more effective when it is needed to reach at-risk populations in an emergency and to possibly save lives.
- Include more COIN members in preparedness planning activities for the at-risk populations they represent.

Next Steps

In a community, this systematic process can be used by all emergency planners to work together to find and reach at-risk populations. We hope that everyone exploring the process will work to connect with one another and to coordinate their activities.

We encourage you to make the connections to build a robust and functional Community Outreach Information Network (COIN) that will serve your community well during an emergency.

Appendices

Diversity in the United States

U.S. Census Bureau data indicate that the United States was more racially and ethnically diverse in the year 2000 than in 1990. Communities throughout the country have experienced an increase from approximately one-fourth to one-third in their diverse racial and ethnic groups and going forward this trend is expected to continue.

But, much more than race and ethnicity contribute to community diversity in the United States. Geographic location, nationality, citizenship status, acculturation, assimilation, gender, education, literacy, age, sexual orientation, political affiliation, socio-economic status, disabilities (physical, mental, cognitive, or sensory), language, religious or spiritual beliefs, cultural values and health practices are among the many factors that contribute to the diversity of a community. Sometimes these factors create communication barriers that make groups of people hard to reach.

The public sector recognizes that communicating with at-risk populations in both emergency and non-emergency situations is critical. Communicating in a crisis or about urgent health issues is different from communicating when there is not an emergency. In an emergency, the urgency of the situation doesn't leave room for exploring options for message content or delivery mechanisms. Those options must be in place before the crisis.

The usual professional channels – officials to media, media to the public – don't work in crises as well as they once did. A seismic shift has taken place: many people simply don't trust authority the way they once did, and certain immigrant and other populations do not trust government authority at all.

Effectively motivating individuals to act for their own good and the good of their families and fellow citizens during widespread health crises, especially if they occur in conjunction with prolonged periods without electrical power, requires communication through multiple channels. These channels will depend on relationships developed over time and already well-established when the crisis occurs. A Community Outreach Information Network (COIN), built from trusted communication sources and channels, can be the lifeline to carry messages across communication barriers and provide the safety net to ensure that public health messages will reach at-risk population groups.

You need a strong understanding of the socio-economic, cultural, linguistic, and disability characteristics of their communities in order to better address the communication barriers and preparedness planning challenges faced by special populations.

A Historical Perspective of Federal Regulatory Activity Related to Cultural and Linguistic Competence

Title VI of the Civil Rights Act Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, provides that no person shall "on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."[www.usdoj.gov/crt/cor/coord/titlevistat.htm]

Executive Order 13166
On August 11, 2000, the President issued Executive Order 13166 "Improving Access to Services for Persons with Limited English Proficiency (LEP)," [www.usdoj.gov/crt/cor/Pubs/eolep.htm].

Under this order, every federal agency that provides financial assistance to non-federal entities must publish guidance on how their recipients can provide meaningful access to LEP persons and thus comply with Title VI regulations forbidding funding recipients from restricting "an individual in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service, financial aid, or other benefit under the program" or from utilizing "criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respects individuals of a particular race, color, or national origin." [www.LEP.gov]

Culturally and Linguistically Appropriate Services (CLAS) Standards
In March, 2001, The Department of Health and Human Services (DHHS) and The Office of Minority Health (OMH) issued their final report, "National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care." The collective set of CLAS mandates, guidelines, and recommendations are intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services. [www.omhrc.gov/assets/pdf/checked/finalreport.pdf].

Revised DHHS Guidance for Limited English Proficiency (LEP)
The Department of Health and Human Services (HHS) published revised Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (''Revised HHS LEP Guidance''). This revised HHS LEP Guidance is issued (August 8, 2003) pursuant to Executive Order 13166 to ensure that federally assisted programs aimed at the American public do not leave some behind simply because they face challenges communicating in English. [www.usdoj.gov/crt/cor/lep/hhsrevisedlepguidance.pdf]

IV. Who Is a Limited English Proficient Individual?
Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be limited English proficient, or ''LEP,'' and may be eligible to receive language assistance with respect to a particular type of service, benefit, or encounter.

Examples of populations likely to include LEP persons who are encountered and/or served by HHS recipients and should be considered when planning language services may include such as those:

- Persons seeking Temporary Assistance for Needy Families (TANF), and other social services.
- Persons seeking health and health related services.
- Community members seeking to participate in health promotion or awareness activities.
- Persons who encounter the public health system.
- Parents and legal guardians of minors eligible for coverage concerning such programs.

Principles of Community Engagement

Principles of Community Engagement (CDC, 1997) represents the first time that the relevant theory and practical experience of community engagement has been synthesized and presented as practical principles, or guidelines, for this important work. It defines key concepts and insights from the literature that support and influence the activities of community engagement. This publication, available online at [www.cdc.gov/phppo/pce], sets the standard, and continues to be used nationally and internationally.

Principles of Community Engagement provides a science base and practical guidelines for engaging the public in community decision-making and action for health promotion, health protection, and disease prevention. These guidelines can help public health professionals and community leaders improve communication, promote common understanding, and strengthen coordination, collaboration, and partnership efforts among themselves and community members and institutions.

The principles, a set of nine fundamental guiding ideas, form the core of the document and hold true for efforts across public health disciplines regardless of the initiating organizations:

1. Be clear about the purposes or goals of the engagement effort and the populations and/or communities you want to engage.
2. Become knowledgeable about the community in terms of its economic conditions, political structures, norms and values, demographic trends, history, and experience with engagement efforts. Learn about the community's perceptions of those initiating the engagement activities.
3. Go into the community, establish relationships, build trust, work with the formal and informal leadership, and seek commitment from community organizations and leaders to create processes for mobilizing the community.

4. Remember and accept that community self-determination is the responsibility and right of all people who comprise a community. You should not assume that you can bestow on a community the power to act in its own self-interest.
5. Partnering with the community is necessary to create change and improve health.
6. You must recognize and respect community diversity. Awareness of the various cultures of a community and other factors of diversity must be paramount in designing and implementing community engagement approaches.
   (Engaging these diverse populations will require the use of multiple engagement strategies).
7. Community engagement can only be sustained by identifying and mobilizing community assets, and by developing capacities and resources for community decisions and action.
8. You must be prepared to release control of actions or interventions to the community and be flexible enough to meet the changing needs of the community.

Community collaboration requires long-term commitment by the engaging organization and its partners.

To earn public trust and the trust of your partners:

- Be clear. People want direction.
- Be concise. Too much information is a barrier to understanding.
- Be correct. Check facts. Update frequently.
- Be connected. Know the people to reach in key communities and build relationships with them.
- Be confident – but don't confuse confidence with control. People trust the confidence shown by real leaders, not the control tactics of authority figures.
- Be transparent. Make your goals, values and priorities evident.
- Be a role model. Practice these principles as a model for your partners.

Developing and Testing Messages for Cultural and Linguistic Competence

It is important to remember that your perception of the messages you develop may not be the same your audience's. While you want them to understand and respond to the information you provide, they are first listening to hear that 1) you respect them, 2) that their needs have been considered, and 3) that they are included in emergency plans.

Linguistic and cultural competence means understanding the most effective ways to convey information to members of diverse populations. Often the main form of communicating public health information is through written materials, such as brochures, newsletters, and flyers. If you are trying to reach a population or community with limited English proficiency, then materials may need to be translated into that community's native language or presented visually in a picture format. Also consider that for those who are not literate in their native language, these print materials will not be effective, and recorded audio messages may be more appropriate.

Consider the cultural relevancy of the photographs, images, and other visual features when creating messages and materials.

You may need to consider the reading and comprehension level of your intended audience and use simple sentences, plain language, and avoid technical and medical terms. Most successful communications to the general public are produced at a sixth grade reading level. Studies show that even sophisticated readers are subjected to so much information in a day that they now require this level of simplicity for full comprehension, particularly in stressful emergency situations.

After you have developed sample messages and materials, you can conduct a series of focus groups with members of different at-risk populations. Ask their opinion on the content, the presentation, whether the materials are sensitive toward their needs and culture, and if the message increases their awareness, changes their opinion and/or motivates them to change.

Planning for Language Services

About Translation

In popular usage, the terms “translator” and “translation” are frequently used for conversion of either oral or written communications. Within the language professions, translation is distinguished from interpreting according to whether the message is produced orally or in writing.

> **Translation:** The conversion of a written text into a corresponding written text in a different language.
>
> **Interpreting (noun):** The process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately and objectively in another language, taking the cultural and social context into account.

Adapted from: National Council on Interpreting in Health Care (NCIHC) The Terminology of Health Care Interpreting: A Glossary of Terms. October 2001.
[www.ncihc.org/NCIHC_PDF/TheTerminologyofHealthCareInterpreting.pdf]

Translation Services

Professional translation services are the first choice when converting any important written information into another language. To ensure quality, ask if the provider uses certified and/or accredited translators, and if the provider has insurance to protect against omissions and errors.

Experienced translation providers often offer “translation memory” or “terminology management” services that reduce costs by recording recurring terms and phrases in a database and leveraging these over time, so that you do not have to pay multiple times for the same text to be translated in different documents. This can significantly decrease costs, especially when departments pool resources and decide to use the same text with slight variations through the same translation provider.

Checklist: Things to Look For in a Translation Provider

- □ Uses accredited/certified translators
- □ Employs a quality process flow that includes a separate editor and proofreader
- □ Has desktop publishing capabilities (to translate text on brochures directly in native file formats)
- □ Can provide translation of websites
- □ Offers cultural adaptation as well as linguistic adaptation of content, images, etc.
- □ Is willing to provide samples of similar work and/or testimonial
- □ Utilizes translation memory or terminology management services
- □ Has an insurance policy that covers errors and omissions
- □ Can assist with other language needs, such as multilingual voice recording, for non-written communication needs.

Community Health Workers (CHW)

Community Health Workers (CHW) can become the trusted resources to help you plan and to disseminate information to at-risk populations in an emergency.

The following bullets are excerpted from Introduction to Training Community Health Workers: Using Technology and Distance Education. April 2006 (DHHS, HRSA) [http://ruralhealth.hrsa.gov/pub/TrainingFrontier.asp]

- Community Health Workers (CHW) play a pivotal role in meeting the health care needs of rural communities.
- They may work under many labels, including Community Health Worker, Community Health Advisor (CHA), Promotora, ayudante, and other locality-specific titles.
- Community Health Workers help increase access to health services (particularly among racial and ethnic minority groups).

- They contribute to broader social and community development.
- As "in-between people," CHWs "draw on their insider status and understanding to act as culture and language brokers between their own community and systems of care."
- Although not always accepted by the medical establishment, a number of key organizations support the development of CHW programs, including The American Public Health Association (2002), the Centers for Disease Control and Prevention (2005), and the National Rural Health Association (2000).
- The Pew Health Professions Commission recommended in its 1998 report: Recreating Health Professional Practice for a New Century, that public health schools, programs and departments focus some of their resources on training lay health workers and community residents to understand the mission of public health and equip them in basic competence to achieve this mission.
- CHWs might be paid or unpaid/volunteer, and could have varying levels of job-related education and/or training.
- According to the National Rural Health Association, "the most significant commonalities of CHA programs are that:

    - they are focused on reaching hard-to-reach populations;
    - the workers usually are indigenous to the target population;
    - their expertise is in knowing their communities rather than formal education" (National Rural Health Association, 2000).
- As isolated populations increase, their dependence on these multi-tasking and frequently over-burdened healthcare workers also increases.

Dissemination Channels

Channels for disseminating and delivering the messages are varied and your selection of which ones to use will depend on availability, access, and how well they reach your different populations. Some things to consider include:

- Television, in particular, is considered the preferred medium among all populations for receiving emergency information such as weather alerts and news about disease outbreaks and prevention.
- The ethnic media community is usually underestimated. Few communication plans emphasize ethnic media, although one in four adults use ethnic media daily. Even when members of an intended audience have access to the mainstream media, they are far more responsive to messages delivered by a person from a similar cultural or ethnic group. Most organizational communication plans do not include in-depth use of ethnic media.
- Internet access is a primary source of information for most of America. Even people who are homeless have access at public libraries and regularly use the Internet for information. Many state government websites have been translated and are available languages other than English. For people who are deaf or hard of hearing, electronic messaging is an invaluable communication tool. Blogging and other types of online bulletin boards, with direct posting to an electronic network community at large, provide untapped possibilities. Also consider podcasting as an information dissemination channel for those who are visually impaired or those who prefer to listen to, rather than read, information.
- The use of cell phone/text messaging technology has exploded. Text messaging is a main access point for young people and is a resource for the people in deaf and hard of hearing communities. Newer cell phones also allow for Internet access.
- Reverse 911 is a mechanized phone system technology that can dial and deliver a pre-recorded message to homes with phones in a particular jurisdiction. Some form of it is currently used in many communities to give neighborhood announcements and crime alerts. It is not available in all areas of the country.
- Telephone calling trees are effective ways to reach remote rural populations, and oftentimes, these trees are self-initiated by residents of these areas. During blizzards, for example, rural neighbors will call or use ham radios to check on each other.
- 2-1-1 is an easy to remember telephone number that, where available, is answered by live operators and referral specialists who can connect people with important community services and volunteer opportunities. As the public becomes more and more familiar with using 2-1-1, they may think to call

this number in an emergency. Both telephone 2-1-1 and the 2-1-1 website www.211.org may be available to assist with providing public health information, tailored by location for your community. Services that are offered through 2-1-1 will vary from community to community, so contact your local 2-1-1 to see what capabilities are available in your jurisdiction.

When Mainstream Media is Not an Option

Channels for delivering the messages are varied and will depend on availability, access, and how well they reach your populations. In certain emergencies, a loss of power will severely limit options.

Delivery channels when the electricity has not been affected or limited can include:
_ Television/mass media (radio, newspaper)
_ Ethnic media
_ Podcast
_ Internet
_ Satellite Radio
_ COIN
_ NOAA Weather Radio All Hazards (NWR)
_ 2-1-1 website[www.211.org]

Delivery channels during a blackout or when electricity is not available to all areas could include:
_ Cell phone/text messaging
_ Battery-powered radio
_ Reverse 911
_ Battery-powered walkie talkies
_ COIN
_ 2-1-1 Telephone
_ Ham radio networks
_ Telephone calling trees/networks (using landline phones that do not require electricity)

Plans for message delivery should be set up in advance of a disaster so that a telephone calling tree is available when disaster strikes.

Other tactics for reaching at-risk populations include:
_ Door-to-door information distribution including door hangers and pamphlets
_ Information distribution to a pre-determined emergency information point (churches, libraries, grocery stores, post offices, schools, restaurants, markets)
_ Peer ambassadors designated to help neighbors receive information
_ Police alerts

Tools for reaching at-risk populations include:
_ Picture books
_ Braille and alternative language handouts
_ Closed-captioned videos
_ Audiotapes