

**Organizational Preparedness and Community  
Readiness for a Public Health Emergency Among  
Community Service Provider Organizations in East  
Harlem, New York City**

**By**

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**A Dissertation submitted to the Graduate Faculty in Public Health in partial fulfillment of  
the requirements for the degree of Doctor of Public Health, The City University of New  
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**APPROVAL PAGE**

**This manuscript has been read and accepted for the Graduate Faculty in Public Health in satisfaction of the dissertation for the degree of Doctor of Public Health.**

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## ABSTRACT

### **Organizational Preparedness and Community Readiness for a Public Health Emergency among Community Service Provider Organizations in East Harlem, New York City**

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Community service provider organizations operating in vulnerable and minority communities are ill-prepared for a public health emergency and are largely left out of formal preparedness activities. This study had two aims: 1) to examine the association of certain organizational attributes among community service provider organizations operating with levels of organizational preparedness in East Harlem, New York City; and 2) to assess the extent to which this community is ready to engage in public health emergency preparedness activities. Organizational leaders were identified from organizational membership lists of three community groups (n=83). An online cross-sectional survey was administered to 31 organizational leaders over a 5-week period to measure organizational preparedness, individual-level preparedness, organizational confidence, and specific organizational leader and organizational characteristics. Descriptive statistics, linear, and logistic regression analyses were used to address the Aim 1 of the study. For Aim 2, six organizational leaders were randomly selected from the survey sample based on their level of organizational preparedness and participated in an in-depth interview informed by the Community Readiness Model (CRM). The CRM anchored statement rating method was used to determine the stage of overall community readiness. A qualitative analysis of the interviews was conducted using a grounded theory approach to identify themes, barriers, and opportunities for improved public health emergency preparedness. Our findings showed a 1.3 increase in organizational preparedness when associated with the level of individual preparedness and a .99 increase when associated with organizational

confidence after controlling for selected characteristics. When the outcome was treated as categorical (high versus low levels of organizational preparedness) the results were nearly identical (1.37, C.I.: 1.02-1.84 for individual preparedness; and 1.33, C.I.1.03-1.72 for organizational confidence). East Harlem is at Stage 2:Denial/Resistance within the stages of community readiness (range from 1 to 9 towards a higher stage of readiness). Four major themes, knowledge, assumptions, and community contextual factors, emerged related to public health emergency preparedness and moving towards a more prepared community. Overall, East Harlem's community service provider organizations remain ill-prepared and the community is at a critically low stage of community readiness to engage in a public health emergency preparedness activities.

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## CHAPTER I: INTRODUCTION

### a. Background

Since 2001, the federal government has invested over five billion dollars to increase the ability of our nation's cities, communities, and neighborhoods to prepare for and respond to public health emergencies, hazards, and disasters. (1, 2) Public health emergencies are broadly defined in the public health literature as situations such as a disaster, significant outbreak of an infectious disease, bioterrorist attack or other significant or catastrophic event (e.g. coastal storm) whose scale, timing, or unpredictability threatens to overwhelm routine community capabilities to respond. (3) Public health emergencies may result from types of disasters such as building collapses or explosions that place populations at risk for illness, injury, or cause mass casualties due to structural damage, a gas leak, or sabotage; as well as from utility disruptions that may power computer systems and even operating life support systems. (4, 5)

Despite this large financial investment from the government over the past decade, it is only in the last five years that public health emergency preparedness has emerged as a new field of public health practice. In the literature, public health emergency preparedness broadly refers to the capability of the public health and health care systems, communities, and individuals to prevent, protect against, quickly respond to, and recover from health emergencies, particularly those whose scale, timing, or unpredictability threatens to overwhelm routine capabilities.(2) Informed by traditional emergency preparedness practice, the field of public health emergency preparedness is concerned with having in place all pre-event preparation activities and mitigation efforts in advance of a specific disaster warning through a coordinated and continuous process of planning and implementation that relies on measuring performance and taking corrective action.(2)

Notwithstanding the novelty of the field of public health emergency preparedness, this area has inadequately engaged and invested in the emergency preparedness activities of non-public health and non-medical/health care community-based provider organizations operating in vulnerable and minority urban communities. Therefore, this disengagement has resulted in a potential public health crisis whereby these community organizations are largely ill-prepared for a public health emergency at the organizational level and are incapable to participating in a full range of prevention, mitigation, and recovery activities at the neighborhood level.(6-12)

While there are obvious lessons that can be learned from previous disasters (e.g., Hurricane Katrina and the 9/11 World Trade Center Attacks), public health emergency preparedness efforts have largely focused on two ends of the spectrum. At one end is the focus on emergency preparedness at the individual-level. At the other end is a focus on emergency planning at the city, county, state, and national level. Given the complexity of formal and informal social and resource networks and the diversity of vulnerable and minority urban communities, a new focus is needed in public health emergency preparedness. This new focus should encompass three strategies to avoid a potential public health crisis when a disaster occurs. The first strategy is to invest in emergency preparedness at the neighborhood level, which represents an important middle-ground and interface for community residents, community-based organizations, and relevant municipal systems to engage in a full range of prevention, mitigation, and recovery activities. The second strategy of this new focus is recognition of, engagement with, and investment in non-traditional community partners. This strategy is informed by two empirical sources.

One source, a community-led study [discussed in Section d on page 16] on emergency preparedness conducted in East Harlem, New York City from 2006-07, revealed two key

insights. The first insight was a lack of public health emergency preparedness activities, planning, and coordination among organizational members of two community coalitions; and the second insight was that coalition members were unable to serve as critical partners, despite having a desire to do so, because they lacked the internal capacity to be prepared and to respond beyond their usual organizational capabilities. Indeed, the coalition members were unaware which roles would be most useful during formal emergency preparedness efforts during a disaster.

The other empirical source, a recent federally sponsored review of the literature on the state of national research efforts of community organizations in emergency preparedness, found that there was limited participation of community organizations in formal preparedness efforts. This review noted that although community organizations expressed interest in collaborative emergency planning activities, many perceive individual, institutional, and organizational barriers (6) related to both participating in these activities and in building their own capacity to conduct emergency planning activities. (6) The types of individual, institutional, and organizational barriers identified include lack of organizational capacity and staff resources, lack of staff dedicated to emergency preparedness and response coordination, no community input into state/local emergency plans, emergency credentials, limited funding, lack of trust in emergency planning and response officials, language issues, and inadequate coordination, and perhaps most importantly leadership buy-in.(6, 13)

The third strategy of this new focus in the field of public health emergency preparedness is an understanding that susceptibility of vulnerable and minority communities to a disaster is determined not so much by the event itself but by social, economic, and political forces and geospatial factors that creates circumstances under which people face hazards.(14) Additionally,

susceptibility to a disaster is further deepened for racial/ethnic minority groups due to historical and systematic barriers placed against them around language and cultural differences, residential segregation, racism, and socio-economic discrimination which have caused this group to be less protected in the disaster context, and therefore, experience worse health outcomes than do other groups during and after disasters. (15-21)

To support the development of this new focus in public health emergency preparedness, this dissertation is an original research study, which takes into consideration these three strategies in its design and aims to contribute new knowledge in two ways. First, it will offer important information about organizational attributes contributing to the level of organizational preparedness among non-health and non-medical community service provider organizations and how best to build their organizational capacity to conduct and engage in public health emergency preparedness activities. Second, it will characterize the community level factors and issues relevant towards improving community's capacity to anticipate, cope with, resist, and recover from the impact of a disaster.

This study takes place in East Harlem, New York City, a historically low-income, vulnerable, and minority community. East Harlem is a good example of the type of urban community that "feels left out" by public health emergency practitioners as, noted earlier by in the community-led study. In addition, sociopolitical, cultural, economic, and community attributes of East Harlem make it a useful setting to understand vulnerability before, during, and after an emergency as something broader and more complex than just risk to disease and illness.

In this study, a community service provider organization is broadly defined as a public or private organization operating in East Harlem, is not a large public health or medical care organization [e.g. hospital or academic medical center], and provides a direct service component

utilized by vulnerable and minority residents. Hereafter, a community service provider organization is referred to as a community organization. The general types of community organizations included in this study are listed in Table 1.1 and explicitly excludes hospitals, academic medical centers, and public health organizations. These latter organizational types were excluded because they are mandated to conduct formal emergency preparedness activities and are equipped with the resources to participate in the pre-event preparation activities and mitigation efforts to protect their organization and individuals served during a disaster or emergency.(22, 23)

The type of direct services this segment of community organizations typically provide are listed in Table 1.2. These direct services are generally delivered “one on one” between the organizational representative and the individual in an organizational setting [e.g. older adults receiving lunch in a senior center as part of the organization’s nutrition program] or in a community setting depending on the nature of the direct service [e.g. a drug treatment’s community outreach condom distribution program]. Further, community organizations may be stand-alone independent organizations (e.g. Union Settlement Association - a nonprofit multi-service organization or Harlem East Life Plan, a for-profit drug treatment provider) or contain a subset of the wider group of public or private organizations such as the Boriken Neighborhood Health Center operated by the East Harlem Council for Human Services, Inc. In East Harlem, community organizations vary in terms of size and organizational structure and are usually formally incorporated, with a written constitution and or operating bylaws and a board of directors.

**Table 1.1: Examples of Eligible Types of East Harlem Community Service Provider Organizations**

- Federally Qualified Community Health Centers
- Social Service organizations (housing assistance, job placement/readiness, case management, benefits assistance, domestic violence services)
- Drug Treatment Organizations
- AIDS Service Organizations
- Human Service Organizations
- Faith Based Organizations (Churches, Temples, etc)
- Multiservice Organizations (social, human, education-based services)
- Adult and Youth Education-based organizations (e.g. Head Start, Education enrichment/Tutorial organizations)
- Youth Centers
- Older Adults/Senior Citizen Service Organizations including senior centers and assisted living facilities.
- Adult and Children Day Care Centers and Nurseries

Community organizations located in neighborhoods like East Harlem, play a critical role as the primary connectors between community members and service systems that they need. To use one East Harlem community service provider organization as an example of how to address this missed opportunity is the highly engaged home visitors of Little Sisters of the Assumption (LSA) Family Health Services Early Childhood Program. The LSA home visiting staff has the unique ability to use participatory educational methods and interventions with their Latino immigrant families, a distinct vulnerable and minority population, to put new knowledge into practice. Despite LSA's unique ability to utilize their natural engagement strategies to serve these populations, they may also use them to help these individuals to prepare for or respond to a disaster. However, this community organization is not engaged or leveraged as partners in formal emergency planning processes(7, 24) and is therefore ill-prepared and unable to respond to an emergency at the organizational level.(6)

**Table 1.2: Listing of Eligible Types of Direct Services Provided by East Harlem Community Service Provider Organizations\***

<ul style="list-style-type: none"> <li>• Education (Adult or Early Childhood)</li> <li>• Food Pantry Services; nutrition services (lunch and breakfast programs; meals on wheels)</li> <li>• Pastoral Care Services</li> <li>• Housing Placement</li> <li>• Benefits Assistance/Case Management</li> <li>• Legal Services &amp; Counseling</li> <li>• Employment/Job Readiness</li> </ul>	<ul style="list-style-type: none"> <li>• Drug Treatment</li> <li>• Domestic Violence</li> <li>• Community Health Centers</li> <li>• Education/Education enrichment services: after-school programs, tutoring, sports</li> <li>• Youth Development Services including life skills-building programs, working with runaway/homeless/street youth</li> <li>• Foster care placement</li> <li>• Community/Street Outreach</li> </ul>
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*\*Note: Community Service Provider Organization may provide one or a combination of these services*

In addition to the primary connector role these organizations assuredly carry out on a daily basis, current research suggests that *individual-level preparedness of the community service provider organizational leader* and *organizational confidence* are two organizational attributes, that may be useful explanatory factors for increased level of organizational preparedness. (25-29) However, there is a lack of specific examination of, in the context of public health emergency preparedness, how individual-level preparedness of the organizational leader and level of organizational confidence may be associated with levels of organizational preparedness among this segment of community organizations in the literature. Thus, this study aims to investigate these factors using a cross-sectional online survey administered to a representative sample of organizational leaders of community organizations providing direct services to vulnerable and minority residents in East Harlem.

Included in this study's aim, with the intention to offer specific direction to public health emergency planners, is how to focus engagement of this segment of community service providers operating in neighborhoods like East Harlem. Thus, this study examines three specific preparedness and response roles that organizations may be willing to carry out based on their

natural ability to serve as primary connectors during formal public health emergency

preparedness and response efforts. The three unique and specific roles proposed include:

1. *Being culturally and community-tailored emergency risk communicators;*
2. *Serving as coordinators and facilitators of information, resources, and services for high risk, hard-to-reach, vulnerable and minority population groups such as elderly shut-ins, undocumented immigrants, injection drug-users to shelters or public health disaster services; and;*
3. *Providing or staffing and identifying locations in the community to maximize utilization of emergency points of distribution.*

In addition to the first aim of this study, it is also necessary to determine whether a community is 'ready' and willing to engage in a process to conduct such activities. Although, the meaning of 'readiness' as it is used in emergency management is often used interchangeably with the term 'preparedness', in this study, 'readiness' has a conceptually different meaning at the community level. The concept of 'community readiness,' as used in this study, was developed in the community psychology and abuse prevention literature and reflects a community's ability to enact change towards a community-identified issue.(30-35) Based on this concept of community readiness, if East Harlem is not ready to enact change toward becoming a more prepared community, activities focused on that change are likely to be unsuccessful or short-lived.

On the basis of systematic research, the Community Readiness Model (CRM) was developed to reliably and validly assess six dimensions of community readiness that correspond to one of nine different overall stages of readiness and specifies which activities are appropriate for each stage. A key feature of the CRM is that the behavior change the community wishes to enact must be generated by the community and focused on specific community-chosen changes.(34, 35) To date, the CRM has not been applied to the field of public health emergency preparedness.(36) Informed by this model, it may more appropriate to assess the state of

community readiness among community service provider organizational leaders to engage in a process to conduct organizational preparedness activities to improve public health emergency preparedness at the community level. Thus, assessing and characterizing East Harlem's level of community readiness to engage in public health emergency preparedness activities represents the second aim of this study.

### **b. Organizational Attributes and Preparedness**

One organizational attribute not well understood in the area public health emergency preparedness and in this segment of community service provider organizations is the role that organizational leader may play in shaping the organizational culture of "preparedness" – that is in its broadest sense having in place all pre-event preparation activities and mitigation efforts in advance of a specific disaster warning. (37) Emergency preparedness aside, it is well known and studied in the leadership research literature that leaders are critical to shaping the culture of an organization.(38-40) As a leader, one is also viewed as a role model, a tone setter, a designated change agent, and even as the product of the culture of the organization. (13, 39, 40) It is the leader who is largely responsible for an organization's culture because they understand the nature of that culture, how it is created, and how it can be changed. (40)

And yet, while much of the research related to emergency management focuses on preparing broad service systems (e.g. transportation) there is an insufficient knowledge base of how the individual-level preparedness of the organizational leader may contribute to the variance in organizational preparedness among non-health and non-medical community service provider organizations operating in neighborhoods like East Harlem.(6, 41, 42) More specifically, what appears to be under investigated is the extent to which individual-level of emergency

preparedness of an organizational leader might explain the degree to which the community service provider organization is also prepared and is focused on fostering a “preparedness” culture within the organization. This idea is based on the notion that a community service provider organization’s state of emergency preparedness is role modeled by the behavior and actions of its leadership. Therefore, the first research question explores the association between individual-level preparedness of community service provider organizational leaders operating in East Harlem and the levels of organizational preparedness.

An organizational attribute that has not received adequate examination in the public health emergency preparedness context is the organization’s sense of “can do” or level of organizational confidence to deal with and overcome complex challenges including disasters and emergencies. Setting emergency preparedness aside, organizational confidence is relevant to many aspects of organizational performance. Organizational confidence is defined as the generative capacity within an organization to cope effectively with the demands, challenges, stressors, and opportunities it encounters within its environment. It exists as an aggregated judgment of an organization’s individual members about their sense of (1) collective capacities, (2) mission or purpose, and (3) resilience.(25, 26, 43) Numerous studies have tested and confirmed that self-efficacy at the individual level is a significant predictor of behavior or behavior change in various health and risk contexts. (44, 45) However, to date there is insufficient knowledge and a paucity of research efforts specifically examining the association between organizational confidence and levels of organizational preparedness. More importantly, while organizational confidence, as an organizational attribute has not been applied to public health emergency preparedness, organizational confidence is relevant to an organization’s ability to carry out daily operations and ultimately in becoming prepared. Thus, the association between

the level of organizational confidence and the level of organizational preparedness is also examined as the second research question in Aim 1 of this study. Having an understanding of an organization's "sense of can do" (26) provides a valid basis for inferring about the organization's level of confidence to serve in the three aforementioned proposed roles when afforded the opportunity to engaged in public health emergency preparedness activities.

### **c. Community Readiness to Engage in Public Health Emergency Preparedness Activities**

In addition to exploring the association between certain organizational attributes with the level of organizational preparedness, it is also necessary to determine whether East Harlem as a community is 'ready' and willing to engage in a process to conduct public health emergency preparedness activities. In the emergency management context, the use and meaning of the term 'readiness' is often used interchangeably with the term 'preparedness'. However, as noted earlier, in this study the state of community readiness reflects a community's ability to enact change towards a community-identified issue.(30-35) Therefore, if East Harlem is not ready to engage in emergency preparedness activities, then a broader set of constraints or barriers are revealed and activities focused on that change are likely to be unsuccessful or short-lived until the barriers are addressed. Thus, the second aim focuses on conducting a community readiness assessment among community organizational leaders to determine the overall stage of community readiness in East Harlem to engage in public health emergency preparedness activities using a theoretically based validated model.

*Theoretical Development of Community Readiness* The theoretical development of the concept 'community readiness' and the subsequent development of the Community Readiness Model by the Tri-Ethnic Center for Prevention Research (TEC) was shaped by the work of

Prochaska and DiClemente. Prochaska and DiClemente's work in the early 1980's on personal readiness, at the individual level, referred to as the "Trans-Theoretical Model" (TTM)(46) showed that readiness was an essential element underlying initiation of treatment and successful implementation of treatment over five specific stages.(30, 46) These five stages for personal readiness for treatment include: the pre-contemplation stage (minimal awareness of a problem and consequently no intent to invest in change), the contemplation stage (awareness but no commitment to action), a preparation stage (clear recognition of the problem and exploration of options), the action stage (implementation of proposed changes in behavior), and the final maintenance stage (both consolidation and relapse prevention). (30, 46) However, the theoretical application of individual readiness via the TTM to a community level was limited by the fact that communities are not individuals and instead they are groups. Groups have their own processes and dynamics which do not easily translate to the five stages of readiness developed by Prochaska and DiClemente.(30) Nevertheless, Prochaska and DiClemente's work demonstrated the need for and the value of a theory of readiness to accurately describe stages of readiness at the community level.

TEC researchers then looked to the work of Rogers (1983), Warren (1978), and Wandersman (1990) who developed newer models that incorporated group characteristics.(31) Rogers (1983) developed a set of stages for the innovation of decision-making process: knowledge, persuasion, decision, implementation, and confirmation. Warren's (1978) social action approach parallels these stages focusing on the group process involved. The social action approach includes five stages: stimulation of interest, initiation, legitimization, decision to act, and action. However, Rogers and Warren's work did not take into account important aspects such as leadership, community climate and knowledge, community organization and

infrastructure, and community development. Wandersman's work with community coalitions furthered developed the concept of readiness by using the term "coalition readiness"(31, 47) when examining community stress and environmental stress and how these factors inhibited community motivation. Wandersman and colleagues also distinguished the concept community climate to have three levels: individual, participant, and organizational climate; all of which served as "catalysts for action."(31, 47, 48)

The growing theoretical work on community level of readiness did not take practical shape until TEC researchers heard Mary Ann Peltz, former director of the Midwest Prevention Project, present a national meeting and state that unless a community was ready, initiation of a prevention program was unlikely, and if a program was started despite the fact that the community was not ready, initiation was likely to only lead to failure.(30) Peltz's insight stimulated the Tri-Ethnic Center for Prevention Research (TEC) to develop the community readiness theory, determine dimensions of community readiness, develop methods to measure readiness known as the Community Readiness Model, and develop suggestions for specific activities and intervention that are needed for each stage of readiness.(30)

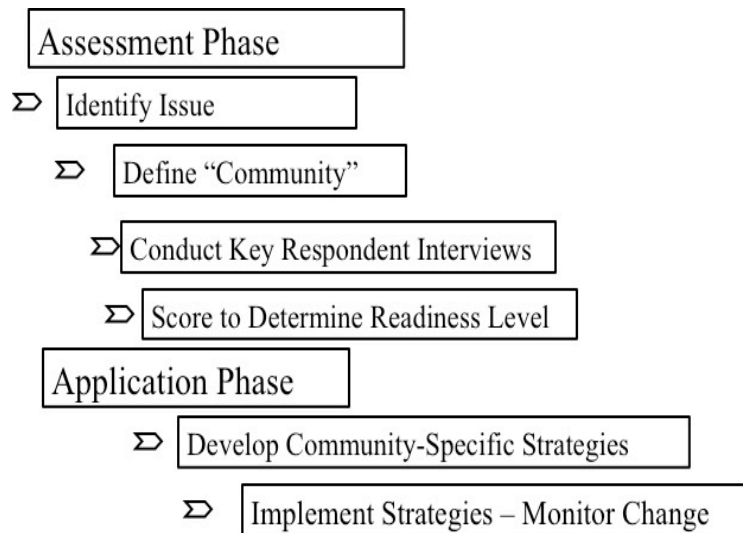
*Community Readiness Model (CRM)* Community readiness, as conceptualized in the community psychology and substance abuse prevention literature, is referred as the extent to which a community is adequately ready to implement a prevention program and is identified as a one of the first steps that need to be taken, as a diagnostic measure, to effectively create change. (30, 49)

The process of assessing community readiness provides communities with the stages of readiness for development of appropriate strategies that will be successful and cost effective.(34,

36) The community readiness assessment process, illustrated in Figure 1, is a model for community change that integrates a community’s culture, resources, and level of readiness to more effectively address an issue. The community readiness process involves an assessment and an application phase and includes the following six steps: 1) Identify your issue, 2) Define “Community,” 3) Conduct Key Respondent Interviews, 4) Score to Determine Readiness Level, 5) Develop Community-Specific Strategies, and 6) Implement Strategies-Monitor Change.(34, 36)

36) The assessment phase allows communities to define issues and strategies in their own contexts and builds cooperation among systems and individuals. More importantly, the assessment phase is highly flexible in that in can be applied in any community (geographic, issue-based, organization, etc.) and be used to address a wide range of issues and is a guide to the complex process of community change.(34, 36)

**Figure 1. Community Readiness Model Process**



The CRM is a well-tested and established theoretically based model.(30, 32-35, 50-53)

TEC researchers and others have written extensively on the methods used to develop the model

and have applied the CRM to program evaluation, community-based prevention programs, research interventions, and organizational analysis. The CRM has been effectively used with social programs such as intimate partner violence prevention,(54) needle exchange programs,(55) breast cancer disparities among Latinas, (56, 57) and community justice initiatives.(58) In addition, the CRM has been used to measure changes in readiness to implement prevention programs among Mexican, Native American, and Alaskan populations (49, 51-53, 59-62), evaluation of smoke-free policies (63), and in studying the role of the key informant in community readiness assessments conducted in a randomized group trial.(64)

Once a specific community issue and a community are identified, the community readiness assessment phase is conducted through a key respondent interview method using a 33-item open-ended interview survey tool, which is provided in Appendix A. The CRM interview tool measures “readiness” within six dimensions: *1) Community Efforts, 2) Community Knowledge of the Efforts, 3) Leadership, 4) Community Climate, 5) Community Knowledge about the Issue, and 6) Resources Related to the Issue.*(34, 36) Each interview is analyzed and scored using an anchored rating scale method developed by TEC researchers and generates a community readiness score that may fall into one of nine stages of community readiness for the specific issue identified. The nine stages of community readiness are: 1) No Awareness, 2) Denial/Resistance, 3) Vague Awareness, 4) Preplanning, 5) Preparation [*note that as a stage in this model it is conceptually different than preparation for an emergency*], 6) Initiation, 7) Stabilization, 8) Confirmation/Expansion, and 9) High Level of Community Ownership.(34) (See Appendix B for the anchored rating statements used to score each key respondent interview). For a description of each of the six dimensions and nine stages community readiness of the CRM please see Appendix C Tables 1 & 2.

To date, the Community Readiness Model has not been applied to the field of public health emergency preparedness. Thus, to address this void on public health emergency preparedness, Aim 2 of this study involves two research activities. The first activity involves CRM Steps 3 and 4 as shown in Figure 1, which includes conducting the key respondent interviews and scoring to determine the overall stage of community readiness. The second activity is an exhaustive qualitative examination of the content of the CRM interviews. Steps 5 thru 7 are beyond the scope of this dissertation study, and thus, not addressed in this study.

Lastly, in East Harlem, and even perhaps for other similar communities, the application of the CRM and the concept of “community readiness” to the practice of public health emergency preparedness may help to reshape how formal emergency preparedness activities are currently conducted. Specifically, the CRM as a community-driven assessment process may reveal key areas in East Harlem where certain valuable resources (e.g. time, money, and potentially lives) may need to be conserved or require further investment. More importantly, the CRM may also guide a selection of community-wide strategies critical to creating a better prepared community.(34, 36, 65)

#### **d. Preliminary Study Findings: The East Harlem Emergency Preparedness Community-Led Project**

East Harlem is a neighborhood situated in the northeastern corner of Manhattan. For the purpose of this study, the boundaries of East Harlem include 135<sup>th</sup> Street to 96<sup>th</sup> Street from North to South and 5<sup>th</sup> Avenue to East River from West to East; and also include Randall’s and Wards Islands. East Harlem is historically known as a low-income, minority and first-settlement community for several of New York City’s immigrant populations. For example in East Harlem, 1 out of 5 residents or 21% are foreign-born.(66) The neighborhood is approximately 2.4 square

miles, and most of its nearly 120,511(67) residents self-identify as Latino/Hispanic (52%) or Black/African American (36%), making East Harlem a culturally rich and diverse community.(66, 68) As a low-income community, East Harlem has one the highest concentrations of public housing at 40% than any other neighborhood in Manhattan. (66) East Harlem is situated in Community District 11 where the median household income for this district was \$25,225 in 2007, which was only 43.9% of the median income of Manhattan (\$57,477).(69) Nearly 45% of East Harlem residents or 52,237 persons received some type of income support (Medicaid, SSI, or public assistance including AFDC and home relief) in 2007.(68)

Soon after Hurricane Katrina's devastating impact on the towns and cities along the coast of the Gulf of Mexico, New York City's Office of Emergency Management (OEM) distributed to all New York City residents in June 2006 a brochure on *Hurricanes and Coastal Flooding*. The OEM brochure included a map of all five boroughs with shaded areas representing low, moderate, and high risk for damage due to coastal flooding.(5) According to the brochure, a significant portion of East Harlem's land mass was shaded as moderate damage (Zone B) due to coastal flooding.(5) This fact triggered an inquiry among two long-standing East Harlem community grassroots coalitions, the East Harlem Community Health Committee, Inc.<sup>1</sup> (EHCHC) and the Human Services Consortium of East Harlem<sup>2</sup> (HSCEH), Inc. as to how prepared were their respective organizational membership bodies to effectively protect minority and vulnerable populations in the event of a disaster. Concurrently, EHCHC and HSCEH have over 35 years working at the grassroots level with community organizations serving minority and

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<sup>1</sup> EHCHC, Inc. is a 35-year-old community health provider grassroots coalition. The mission of EHCHC is to help bring about the improved health status of East Harlem by presenting a forum for provider agencies and consumers and their representatives to cooperate, exchange ideas, build networks, and work together to strengthen health care in terms of access, quality, accountability, coordination, education, and training.

<sup>2</sup> HSCEH is a 30-year coalition primarily comprised of multiservice, social, and human service provider community based organizations whose purpose is to serve as a forum for exchange of information, resources, and conduct advocacy around social service policy and practice issues affecting the lives of East Harlem residents.

vulnerable populations. Based on this deep knowledge, the coalitions essentially hypothesized that lack of awareness about emergency preparedness, the community's complex cultural nuances, and the low socioeconomic reality experienced by residents would likely hinder the ability of both its organizational members to adequately respond and recover from a disaster.

In October 2006, the two coalitions partnered and designed a collaborative research project guided by the principals of community-based participatory research to prove this hypothesis. The coalitions designed a mixed method study to assess among its respective membership bodies how many members had emergency plans and to what extent they were ready to respond to an emergency disaster. In this pilot project, I, representing the EHCHC, co-conceived and co-directed the project with a community resident and activist who represented the HSCEH. The pilot project was called "The East Harlem Emergency Preparedness Project" and is referred to as Project hereafter. The Project's methods included collecting emergency plans from willing coalition members, content review of emergency plans by the Project team, and administration of online survey to both coalition membership bodies. The online survey examined level of knowledge and awareness of emergency plan content, knowledge of community emergency response teams (CERT), and a cursory assessment of organizational capacity to respond to an emergency.(70) The Project findings revealed a worrying lack of public health emergency disaster preparedness activities, planning, and coordination among East Harlem service provider organizations serving vulnerable and minority East Harlem residents.(7, 71)

At the time, the two coalition groups combined represented approximately 35 different community service provider organizations operating in East Harlem. For the Project, only four coalition members shared a copy of their emergency plan. These included a large private

hospital, a small community hospital, a family health center, and a multiservice provider for victims of domestic violence. The Project team reviewed each emergency plan, which informed the types of questions that would constitute the online survey. General findings from the emergency plan review revealed that the three health provider organizations were entirely focused on their internal ability to respond and protect the patients on site. Resources (such as supplies, equipment, and manpower) were only limited to an internal response. The fourth plan (the multiservice provider) appeared to have generic language about emergency response activities with no specific language as to how the agency would actually implement a response. A representative from this multiservice agency unofficially shared with the Project Team that it was common for (especially for non-public health, non-medical/health care specific) agencies to insert generic and boilerplate language about having an emergency plan in order to complete a funding proposal or application requirement of the funder.

Anecdotally, several members shared with the Project team that their agency did not have a plan, were not aware if they had one, or did not know how to access a copy of their emergency plan and were resistant in completing the Project survey for fear of attracting negative attention to their organization. Twenty of 35 coalition members responded to the online survey resulting in approximately a 57% response rate.<sup>(7)</sup> Over two-thirds of the clients served by the respondents lived in public housing and nearly 95% of the clients served lived in East Harlem. Over 77% of the respondents state that the majority of their staff lived in East Harlem.<sup>(7)</sup> Among the 18 respondents who answered the question “Does your agency/organization have an emergency plan in place?” 13 responded “Yes” to the question, 3 responded “No”, 1 responded “Don’t Know,” and 2 respondents provided other comments including “I am currently working on one” and “We have a plan for our clients and staff that mainly centers around emergency evacuation

of our buildings.”(7) When asked how often they review their emergency plans, only 14 answered the question in the following way: 8 reviewed their plan annually, 3 reported that they do not know, and 3 reported *other* which included responses such as: “*that it would be reviewed annually once complete,*” “*it has not been done since written*”, and “*on an as needed basis.*” (7) In addition to the one-time administration of the survey, the Project updates were required at all EHCHC and HSCEH general body meetings over the course of project implementation period. During these monthly updates, the Project team benefited from formal and informal discussions with the community organizations about the importance of emergency preparedness. Through these discussions the Project team gained a sense of deep concern from the community organizations about natural and man-made disasters that could possibly occur in East Harlem and the desire to use the findings to advocate around relevant policies, practices, and systems to improve the community’s ability to respond a disaster. (7)

The Project was completed in June 2007 and culminated in a community meeting which included an overview of the Project and its findings, an experts’ panel<sup>3</sup> on emergency preparedness, and a community discussion on next steps.(71) It is worth noting that prior to the Project starting, East Harlem did not have a New York City Office of Emergency Management certified Community Emergency Response Team (CERT) in place. CERTs are teams of community resident volunteers who are educated about disaster preparedness for hazards that may impact their area and trains them in basic disaster response skills, such as fire safety, light search and rescue, team organization, and disaster medical operations.(71) Within six months of the Project starting, East Harlem had in place a fully trained CERT and its captain participated as a member of the experts’ panel at the June community meeting. It was clear that the Project

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<sup>3</sup> The experts panel included the New York City of Office Emergency Management’s CERT Coordinator and the Director of Public-Private Partnerships, Principal Investigator of PROJECT VIVA, East Harlem CERT Captain, and the American Red Cross Chief Response Officer.

findings served as a “wake up call” raising several critical questions for further inquiry about the neighborhood’s state of preparedness which included: To what degree is East Harlem “ready” to prepare to conduct emergency preparedness and response activities? What are the critical organizational factors that may potentially increase organizational preparedness for East Harlem community service provider organizations? What might be the best roadmap to best interface with one another to reduce the disparate impact when a disaster strikes?(7, 71)

#### **e. Research Aims**

The research aims of this study explore the association of certain organizational attributes factors with levels of organizational preparedness and examine the state of community readiness to engage in a process to conduct public health emergency preparedness activities. This study uses both quantitative and qualitative design and analysis.

The first research aim is to describe among East Harlem community organizations, the distribution of organizational preparedness and identify characteristics of both organizational leaders and organizations that are associated with the level of organizational preparedness for a public health emergency. This first aim is grounded in three specific research questions.

1. *What is the distribution of organizational preparedness among community service providers in East Harlem?*
2. *Is there an association between the levels of individual preparedness of the community service provider organizational leader and organizational preparedness for a public health emergency in East Harlem?*
3. *Is there an association between organizational confidence and the level of organizational preparedness for a public health emergency among East Harlem community service provider organization leaders?*

The second research aim is to characterize the state of community readiness in East Harlem to engage in a process to conduct preparedness activities for a public health emergency using the Community Readiness Model. The primary research question for Aim 2 asks: *For a public*

*health emergency, how do East Harlem community service provider organizational leaders characterize community readiness across the six dimensions of readiness included in the Community Readiness Model?* In addition, four further questions are asked:

1. *What is the stage of community readiness in East Harlem to engage in public health emergency preparedness activities?*
2. *What are the key themes identified?*
3. *What are the key barriers identified and how are they described?*
4. *What are the key opportunities identified to improve the overall state of community readiness and its related dimensions and how are they described?*

The following chapters discuss the research methods (Chapter 2), the results from research Aim 1 and Aim 2 (Chapter 3), the summary and discussion (Chapter 4) and the public health implications and recommendations (Chapter 5).

## **CHAPTER II: RESEARCH DESIGN AND METHODS**

### **a. Research Design**

This study drew upon and utilized both quantitative and qualitative methods. A glossary of terms and variables referred to in this study is provided in Appendix D. Aim 1 quantitatively examined the strength of association of the levels of individual-level preparedness of the community organizational leader and organizational confidence with levels of organizational preparedness. The method for data collection for Aim 1 involved a cross-sectional online survey administered to a representative sample of organizational leaders of community organizations providing direct services to vulnerable and minority residents in East Harlem. Descriptive statistical and regression analyses were used to answer the research questions for Aim 1.

Aim 2 qualitatively characterized the state of community readiness to engage in a process to conduct preparedness activities for a public health emergency in a sub-sample of East Harlem community service provider organizational leaders. Within this aim, there were two specific research activities. The first research activity involved an in-depth community readiness assessment using the CRM in a sub-sample of the study sample of community service provider organizational leaders selected from those individuals who participated in the cross-sectional online survey in Aim 1. The second research activity involved an exhaustive qualitative analysis of the content of the CRM interviews to answer the second research question for Aim 2.

### **b. Study Setting**

This study takes place in East Harlem, New York City, a historically low-income, vulnerable, and minority community for two important reasons. First, East Harlem is a good example of the type of urban community that “feels left out” by public health emergency

practitioners as, noted earlier in the community-led study. Second, sociopolitical, cultural, economic, and community attributes of East Harlem make it a useful setting to understand vulnerability before, during, and after an emergency as something broader and more complex than just risk to disease and illness.

East Harlem is a neighborhood situated in the northeastern corner of Manhattan. For the purpose of this study, the boundaries of East Harlem include 135<sup>th</sup> Street to 96<sup>th</sup> Street from North to South and 5<sup>th</sup> Avenue to East River from West to East; and also include Randall's and Wards Islands. East Harlem is historically known as a low-income, minority and first-settlement community for several of New York City's immigrant populations. For example in East Harlem, 1 out of 5 residents or 21% are foreign-born.(66) The neighborhood is approximately 2.4 square miles, and most of its nearly 120,511(67) residents self-identify as Latino/Hispanic (52%) or Black/African American (36%), making East Harlem a culturally rich and diverse community.(66, 68) As a low-income community, East Harlem has one the highest concentrations of public housing at 40% than any other neighborhood in Manhattan. (66) East Harlem is situated in Community District 11 where the median household income for this district was \$25,225 in 2007, which was only 43.9% of the median income of Manhattan (\$57,477).(69) Nearly 45% of East Harlem residents or 52,237 persons received some type of income support (Medicaid, SSI, or public assistance including AFDC and home relief) in 2007.(68)

### **c. Disciplined Subjectivity & Project Advisory Group**

East Harlem, setting of this study, is a neighborhood, where the investigator has worked over the past twelve years. Therefore, there was a high likelihood of introducing researcher bias as a result of the investigator's personal and professional relationships with a number of the

community service provider organizations and their respective leaders that were invited to participate in this study. In order to adequately carry out the aims of this study and to ensure study validity and reliability of the findings as best as possible, the investigator self-imposed “disciplined subjectivity” which refers to the researcher's rigorous self-monitoring, continuous self-questioning and reevaluation of all phases of the research process.(72)

Disciplined subjectivity was demonstrated by establishing a Project Advisory Group (PAG). The PAG participated in all phases of the research process and served as an extended research team. The PAG was utilized to seek agreement on quantitative and qualitative data collected in this study as well as a way to “check in” informally for accuracy during the data collection phases and monitor discrepant data. For Aim 1, the PAG was utilized in the construction of a representative study sample of East Harlem community organization leaders and for pilot testing the cross-sectional survey. For Aim 2, the PAG assisted in identifying research assistants to conduct the key respondent interviews of the Community Readiness Model. All together, these actions minimized researcher bias in the data collection process for both Aims.

The PAG was comprised of four individuals who are listed by name and affiliation in Appendix E. The PAG member criteria was determined by the investigator and included being a community resident and or an organizational representative with some level of affiliation with either the East Harlem Community Health Committee, Inc. (EHCHC) or the Human Services Consortium of East Harlem (HSCEH) and having been involved in the community-led pilot project previously discussed. In-person meetings occurred when needed for tasks such as reviewing the list of organizational leaders, sharing feedback from the pilot-test of the cross-sectional survey, and to discuss preliminary results. For all other research related tasks, email

communication was utilized to provide all other relevant updates. The PAG was not compensated for their participation.

**d. Study Sample: East Harlem Community Service Provider Organizational Leaders**

East Harlem Community Service Provider Organizations The study sample of leaders of community service provider organizations was selected from all of community organizations operating in East Harlem. As described in the Chapter 1, a community service provider organization may be any one of the organizational types listed in Table 2 and is referred to as a public or private organization that operates in East Harlem and is not a large public health or medical provider organization. These organizations must also have a direct service component utilized by vulnerable and minority residents such as those listed in Table 2.1.

**Table 2.1 Examples of Eligible Types of East Harlem Community Service Provider Organizations**

<ul style="list-style-type: none"><li>• Federally Qualified Community Health Centers</li><li>• Social Service organizations (housing assistance, job placement/readiness, case management, benefits assistance, domestic violence services)</li><li>• Drug Treatment Organizations</li><li>• AIDS Service Organizations</li><li>• Human Service Organizations</li><li>• Faith Based Organizations (Churches, Temples, etc.)</li><li>• Multiservice Organizations (social, human, education-based services)</li><li>• Adult and Youth Education-based organizations (e.g. Head Start, Education enrichment/Tutorial organizations)</li><li>• Youth Centers</li><li>• Older Adults/Senior Citizen Service Organizations including senior centers and assisted living facilities.</li><li>• Adult and Children Day Care Centers and Nurseries</li></ul>
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**Table 2.2 Listing of Eligible Types of Direct Services Provided by East Harlem Community Service Provider Organizations\***

<ul style="list-style-type: none"> <li>• Education (Adult or Early Childhood)</li> <li>• Food Pantry Services; nutrition services (lunch and breakfast programs; meals on wheels)</li> <li>• Pastoral Care Services</li> <li>• Housing Placement</li> <li>• Benefits Assistance/Case Management</li> <li>• Legal Services &amp; Counseling</li> <li>• Employment/Job Readiness</li> </ul>	<ul style="list-style-type: none"> <li>• Drug Treatment</li> <li>• Domestic Violence</li> <li>• Community Health Centers</li> <li>• Education/Education enrichment services: after-school programs, tutoring, sports</li> <li>• Youth Development Services including life skills-building programs, working with runaway/homeless/street youth</li> <li>• Foster care placement</li> <li>• Community/Street Outreach</li> </ul>
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*\*Note: Community Service Provider Organization may provide one or a combination of these services*

The list of community service provider organizations was generated by obtaining and compiling the membership lists of three long-standing membership groups: the East Harlem Community Health Committee, Incorporated; the Human Services Consortium of East Harlem, Incorporated; and Manhattan’s Community Board #11. These membership groups were used to generate the total sample because they historically have had a central role in coordinating and networking community based organizations around service provision, research, advocacy and referrals.

Sampling Strategy Table 2.3 shows the source and distribution of the number of eligible community organizations. Using the lists provided by the three membership groups in East Harlem yielded a total of 276 Community Service Provider Organizations. However, there were 58 duplicates for a total sample of 214. Community organizations were excluded if they were public health organizations, large medical and health care providers such as hospitals and academic medical centers, collectives, coalitions, partnerships, elected officials, New York Police Department, if they no longer existed, and other organizations that did offer a direct service component yielding a target sample of 83 community organizations. The target sample of 83 community organizations was invited to participate on the cross-sectional online survey. Of

the 83 organizations, 35 responded and completed the survey representing a 42% response rate. However, 4 observations were excluded because of missing values on the dependent variable yielding an analytic sample of 31 participants.

**Table 2.3 Source and Estimated Distribution of Eligible East Harlem Community Service Provider Organizations: August 2012**

<b>Membership Lists</b>	<b>No. of Community Organizations</b>	<b>No. of and duplicates, excluded community organizations from all sources</b>	<b>No. of Eligible Community Service Provider Organizations</b>
EHCHC, Inc.	64	45	<b>19</b>
HSC of EH, Inc.	44	20	<b>24</b>
Community Board 11	168	128	<b>40</b>
Total	276		<b>83</b>

*Community Organizational Leaders Study Sample* The unit of analysis in this study is the community organizational leader. The organizational leader sample was generated by identifying the community service provider organizational leader from each of the organizations in the total sample (N=83). The selection of organizational leaders was based on senior level management or leadership position titles such as Executive Director, Senior Director, Center Director, Commissioner, Chief, or Program Director. This selection method was based on the emergency management and leadership research literature, whereas senior level management or leadership position titles are theoretically aligned with having a high impact leadership role in the organization and have the ability to influence the culture and operations of the community organization.(1, 13, 73-76) A primary and secondary organizational leader was identified, whenever possible, and their contact information was recorded and entered into a spreadsheet.

## e. Research Methods

### e1. Aim 1

Aim 1 was to describe the distribution of organizational preparedness and identifies characteristics of organizational leaders and organizations that are associated with the level of organizational preparedness for a public health emergency among East Harlem community organizations. Aim 1 involves two specific research questions, which ask:

- 1) *Is there an association between level of individual-level preparedness of the community service provider organizational leader and the level of organizational preparedness for a public health emergency in East Harlem?*
- 2) *Is there an association between organizational confidence as an organizational attribute and the level of organizational preparedness for a public health emergency among East Harlem community service provider organization leaders?*

Cross-Sectional Online Survey. The research questions for Aim 1 were addressed with a cross-sectional self-administered online survey. This survey measured organizational preparedness, individual-level preparedness, organizational confidence, and captured both organizational leader and organizational-level characteristics. The survey was designed using Survey Monkey, a web-based survey software program. After the online survey was developed in Survey Monkey, it was pilot tested with all members of the PAG to identify typing errors, assess readability of the language in the greeting and consent portion of the survey, and determine the estimated length of time to complete the survey.

The survey included a total of 70 questions and is provided in Appendix F. The first page of the online survey provided the necessary components required by the IRB regarding study overview, procedures, risks, benefits, confidentiality and consent. The first question of the survey was the consent question. After answering the first question,

the respondent had the option to click on “Yes, I agree to participate in this survey” and proceed with completing the remaining questions or click on “No, I choose not to take this survey” and be redirected to a “Thank you for your time” page.

Questions 2 to 69 were all close-ended items that measured organizational preparedness, individual-level preparedness, organizational confidence, and both organizational leader and organizational-level characteristics. These close-ended questions included binary (yes/no) and Likert-scale choices as responses. The last question item, Question 70, was a pre-consent question to participate in a follow in-depth interview on Community Readiness as part of the second part of this study. Respondents who were willing and interested were asked to provide their contact information.

In Survey Monkey, the e-mail addresses of all 83 organizational leaders were uploaded using the “Address Book” feature to keep the sample organized and in one place. The East Harlem Community Health Committee and the Human Services Consortium of East Harlem agreed to email their respective organizational leader members to request their support and participation in the study. An introductory email was crafted by the Chair or Co-Chairs from each coalition to express three specific pieces of information: 1) community support for this study, 2) to inform their respective member leaders that the coalition shared their mailing list with the researcher for the purpose of conducting this study, and 3) to provide advance notice to expect an email from the researcher requesting their participation in the survey. The latter piece of information also included the text of the subject line that would be used by the researcher (myself) in their email to the organizational leaders so they knew exactly what to expect. A copy of the coalition introductory email is provided in Appendix G. Three days later, the researcher

sent the dissertation survey request email via Survey Monkey. The dissertation survey request email contained the IRB approved greeting message and an embedded link for the survey website.

### *Definition and Measurement of Variables*

Dependent Variable: The dependent variable for Aim 1 is organizational preparedness and is referred to as having all pre-event preparation activities and mitigation efforts in place at an organizational level to improve the organization's ability to protect their organization and individuals served during a disaster or emergency.(6, 77, 78)

Organizational preparedness was measured by using items from the *Organizational Crisis/Disaster Preparedness Scale* (Fowler Scale) developed by Fowler and colleagues(79) and items from the *Faith-Based & Community Organization Pandemic Influenza Preparedness Checklist* (CDC Checklist) developed by the Centers for Disease Control and Prevention.(80) The *Organizational Crisis/Disaster Preparedness Scale* (Fowler Scale), shown in Appendix H was developed by Fowler and colleagues.(79) This Scale was chosen because it was developed and tested to measure perceptions of organizational preparedness among top level and middle level managers in both for-profit and non-profit organizations.(79) Originally, the Fowler Scale included 32 questions, developed based on a literature review and then tested for reliability. However, to increase the reliability of the scale, Fowler reduced the number of items through a step-by-step process of eliminating one question at a time and found that a 21-item scale had the highest reliability (Cronbach alpha=.88).(79) The Fowler Scale uses a 4-point Likert scale for each item where 1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree. The wording of some of the items in the Fowler Scale was slightly modified to remove references to the study for which it was developed.

The full *CDC Checklist* consisted of 31 items that addressed six broad themes of preparation for faith-based and community organizations to focus on to improve their ability to protect their community during a pandemic flu. Of the 31 checklist items, five specific items were selected because they were most relevant to address the types of coordinated response activities needed to carry out the three response roles of which this segment of community service provider organizations could carry out. The five items shown in Appendix I, are drawn from the following CDC Checklist: *plan for the impact of a pandemic on your organization and its mission* (1 item); *communicate with and educate your staff, members, and persons in the community that you serve* (2 items); *plan for the impact of your staff, members, and the communities that you serve* (2 items). In the cross-sectional online survey, the six items were converted to statements for which a 4-point Likert scale was applied.

Lastly, an additional item was created to capture the degree to which community organizations may carry out the three aforementioned proposed unique and specific preparedness and response roles of interest. This added item contained three subparts for each role which included: *1) culturally and community-tailored emergency risk communicators; 2) coordinators and facilitators of information, resources, and services for vulnerable and minority population groups; and 3) providing or staffing or identifying locations in the community to maximize utilization of emergency points of distribution.* The Fowler Scale, the adapted CDC Checklist, and the added role question combined measure a full picture of organizational preparedness. Therefore, the overall Organizational Preparedness segment of the online survey constituted 29 questions where each question response was recorded using a 4-point Likert scale: Strongly Agree (4), Agree (3), Disagree (2), and Strongly Disagree (1). Responses to each answer were added to generate a score. The score ranged from 29 to 116.

To assess the association between the levels of organizational preparedness with individual-level of preparedness and level of organizational confidence, organizational preparedness was specified as continuous and categorical. Organizational preparedness was categorized into a “High” and “Low” level of organizational preparedness based on the normal distribution of the data. Specifically, a 75<sup>th</sup> percentile was specified as the cut-off point such that those organizational leaders with a score at the 75<sup>th</sup> percentile or below were assigned to the “Low” level of organizational preparedness while those with a score above the 75<sup>th</sup> percentile were assigned to the “High” level of organizational preparedness.

Independent Variables The independent variables for Aim 1 are *individual-level preparedness and organizational confidence*.

*Individual-level Preparedness* Individual-level preparedness refers to the number of preparedness activities that an organizational leader has in place at a personal level in order to protect and respond to a disaster or emergency. The question items developed by Paek et al were drawn from other emergency preparedness programs and confirmed by public health officials – see Appendix J. (29). The number of emergency items was measured by asking whether or not individual community leaders possessed specific emergency supplies to respond to an emergency using choices of Yes or No. (29) The Individual-level Preparedness segment of the online survey constituted 19 questions where each question response was assigned a numerical values of “1” for questions with an answer with Yes and of “0” for those with an answer of No. Responses for each answer were added to generate a score ranging from 0 to 19.

*Organizational Confidence* Organizational confidence is defined as a generative capacity within an organization to cope effectively with the demands, challenges, stressors, and opportunities it encounters within its environment.(25, 81) More simply stated, as Bohn(25, 26,

43, 81) writes, in its most basic form, organizational confidence is a sense of “can do” and it is measured in the online survey in two ways. First, it was measured by using a subset of items from Bohn’s Organizational Efficacy Scale (43). Bohn’s Organizational Efficacy Scale is a validated scale grounded in efficacy theory and predicts high reliability for a three-factor solution to improve levels of efficacy which include: collaboration, sense of mission, and sense of resilience. In this study, only the items used to measure the factor of collaboration as a component of organizational confidence were included in the online survey – see Appendix K. These items were included because they specifically related to the “collective sense of capacities” concerning the organization’s capacity to control outcomes and the three aforementioned unique and specific response roles of interest when a public health emergency occurs. The second way involved developing one item specific which asked the organizational leader to rate the degree to which they agreed with their ability to carry out the three previously described response roles of interest to serve as:

1. Culturally and community-tailored emergency risk communicators;
2. Coordinators and facilitators of information, resources, and services for vulnerable and minority population groups; and
3. Provide staff or identify locations in the community to maximize utilization of emergency points of distribution.

The Organizational Confidence segment of the survey included 9 questions with a 6-point Likert scale with each question assigned the following numerical values: Strongly Agree (6) Agree (5), Agree Somewhat (4), Disagree Somewhat (3), Disagree (2), and Strongly Disagree (1). Responses to each answer were added to generate a score. The score ranged from 9 to 54.

Covariates A series of organizational leader and organizational-level characteristics constituted the covariates measured with 13 items in the online survey. Organizational leader characteristics included: Age, Gender, Race/Ethnicity, Marital Status, and whether he/she lives

in East Harlem. The age variable was collected with six age categories and assigned a numerical value of 1 to 6 respectively. The gender variable was collected with three categories: female, male, and transgender. The gender variable was recoded to Male (1) and Female (2). Transgender was not a chosen category by the respondents and not used in the analyses. Race and ethnicity was collected using two questions, one for ethnicity and one for race. Further, race/ethnicity was recoded into four categories in the following way: Non-Hispanic White (1), Non-Hispanic Black (2), Hispanic (3), and Other (4). Marital status variable was collected by asking, “Are you now married, widowed, divorced, separated, or never married?” Each status category was assigned a numerical value from 1 to 5 respectively. Whether he/she lives in East Harlem variable was collected by asking, “Do you live in East Harlem?” with Yes or No as the response category. Organizational-level characteristics included: Organizational Type, Years the Organization has in East Harlem, No. of Individuals Served, Number of Full-Time Employees, and Size of Organizational Budget. Organizational type variable originally include 8 response categories and was recoded into four categories and specified for analyses as Community Health, Youth & Education, Multiservice, and Other. Years the Organization variable was collected using three categories: Less than 10 years, 11 to 20 years, and More than 20 years. The number of individuals variable served was collected using four categories: Less than 1,000; 1,001 to 3,000; 3,001 to 5,000; and More than 5,000. The number of full-time employees variable was collected using four categories: Less than 50, 51 to 100, More than 100, and Don’t Know. The size of organizational budget variable was collected using four categories: Less than \$100,000, \$100,001 to \$500,000, Over than \$500,000, and Don’t Know.

## e.2. Aim 2

Aim 2 was to characterize the state of community readiness in East Harlem to engage in a process to conduct preparedness activities for a specific public health emergency. The research question of Aim 2 asks:

*For a public health emergency, how do East Harlem community organizational leaders characterize each of the six dimensions of community readiness of the Community Readiness Model which include: the state of community efforts, community knowledge of the efforts, leadership, the community climate, the level of community knowledge about a public health emergency, and the resources related to respond?*

This research question was further specified into three additional sub-questions:

1. *What are the key themes identified?*
2. *What are the key barriers identified and how are they described?*
3. *What are the key opportunities identified to improve the overall state of community readiness and its related dimensions and how are they described?*

Aim 2 used the Community Readiness Model (CRM) and refers to the *Community Readiness Model Handbook*, developed by the Tri-Ethnic Center (TEC) for Prevention Research to carry out the research activity associated with this aim.

Based on the community-led study and the research activities conducted in Aim 1, the first two steps in the assessment phase as shown in Figure 1 on page 24 (Identify Issue and Define “Community”) were achieved. As described earlier, the issue identified is *preparedness for a public health emergency* and the defined community is *East Harlem* as represented by community service provider organizational leaders. In this study, Aim 2 addressed Step 3 (Conduct Key Respondent Interviews) and Step 4 (Score to Determine Readiness Level) of the assessment phase shown earlier in Figure 1 on page 24. Specifically, Step 3 involved conducting an in-depth community readiness assessment with East Harlem organizational leaders representing key respondents in this study. Once the assessment was completed, Step 4 was conducted which involved scoring and calculating the community’s stage of readiness for each

of the six dimensions as well as the overall score using the anchored rating scale method developed by TEC as described in the CRM Handbook.

The in-depth community readiness assessment was conducted using the CRM interview tool. The CRM interview tool consisted of 33 pre-set items measuring community readiness within six dimensions which include (Appendix C): 1) Community Efforts, 2) Community Knowledge of the Efforts, 3) Leadership, 4) Community Climate, 5) Community Knowledge about the Issue, and 6) Resources Related to Identified Issues.(30, 34) These six dimensions derives the final Community Readiness Score, which is then associated with one of nine CRM stages of readiness, where 1 is the lowest stage of readiness and 9 is the highest stage of readiness maintained by a community. The nine stages of community readiness include and are described in Appendix C: 1) No Awareness, 2) Denial/Resistance, 3) Vague Awareness, 4) Preplanning, 5) Preparation [*note that as a stage in this model it is conceptually different than preparation for an emergency*], 6) Initiation, 7) Stabilization, 8) Confirmation/Expansion, and 9) High Level of Community Ownership.(34)

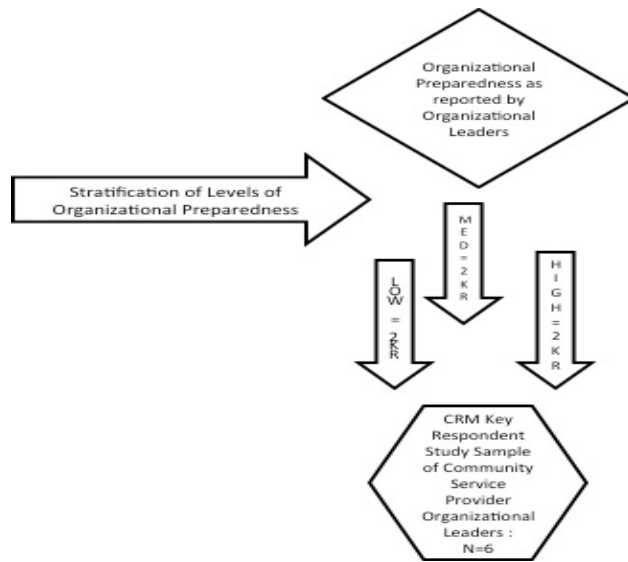
The items included in the CRM interview tool are purposively generic so that one can insert the “community identified” issue of choice into each question and make minor modifications. The interview tool was modified by inserting the term “public health emergency preparedness” for the “issue” in each question and made specific reference to the “East Harlem” community when the “community” is reference in each question.

An interview protocol was developed and is included in Appendix L. The interview protocol included instructions on how to greet, initiate, conduct, and complete the interview, how to complete the written consent form, the receipt of payment confirmation form, and the interviewer reflection form. The protocol also included the CRM interview tool and had scripted

prompts to create ease of flow throughout the interview. The inclusion of scripted prompts came highly recommended as per consultations with the TEC and with a researcher who recently used the CRM in a Native American community.(36, 65)

CRM Key Respondent Sample The participants involved in Aim 2 were drawn from the analytic sample (n=31) used in Aim 1. The process used to select the organizational leaders to serve as the sample of key respondents (KR) for the CRM in-depth interviews added rigor to the overall research study design by gaining a cross-section of perspectives based on three different levels of organizational preparedness. The Organizational Preparedness scores of all 31 respondents were divided into distribution tertiles. The first category constituted 9 respondents with scores between 63 and 71 and was labeled as “Low.” The second category constituted 13 respondents with scores between 72 and 82 and was labeled as “Medium.” The third category constituted 9 respondents with scores 83 and higher and was labeled as “High.” These tertiles were based on the score distribution. To prevent selection bias, two organizational leaders were randomly selected from each tertile to serve as Key Respondents (KR) resulting in 6 KRs (2 from “High”, 2 from “Medium”, and 2 from “Low” categories.) The sampling strategy used is illustrated in Figure 2.

**Figure 2. Key Respondent (Organizational Leaders) Sampling Method**



CRM Interviews To eliminate researcher bias, the investigator identified two research assistants to conduct the in-depth interviews. The research assistants did not live in East Harlem or have a previous working relationship with any of the organizational leaders participating in part 2 of the study. Each research assistant was trained on the CRM interview tool and provided with the interview protocol for hand-written note taking and a digital audio recorder device to audiotape the interview. Each research assistant was assigned 3 organizational leaders, one from each level of organizational preparedness.

An email by the investigator was sent to all of six organizational leaders to thank them for their participation in the first part of the study and to inform them that they would be contacted shortly by one of two research assistants to schedule a time to conduct the CRM in-depth interview. The research assistants contacted the organizational leaders via email and telephone to schedule their respective interviews. The six interviews were conducted in-person and over a three-week period. The interviews lasted from 20 minutes to just over 1 hour. Each

organizational leader was consented and offered financial compensation according to the CUNY Graduate Center IRB guidelines.

## **f. Analytic Plan**

### **f1. Aim 1**

Descriptive statistics for selected characteristics were calculated for the total study population and according to levels of organizational preparedness. In addition, measures of central tendency and dispersion were presented for continuous variables for the total population.

Organization preparedness was assessed for normality. Linear regression was used to estimate the association between the level of organizational preparedness and individual-level preparedness among organizational leaders with community service provider organizations operating in East Harlem before and after controlling for selected organizational leader characteristics including: age, gender, race/ethnicity, and living in East Harlem. Logistic regression was used to assess the strength of the association between individual-level of preparedness and level of organization preparedness as a dichotomous dependent (“High versus “Low). These analyses were repeated using the level of organizational confidence as the main independent variable.

### **f2. Aim 2**

For Aim 2, the CRM interviews were scored using an evaluative process developed by researchers at the Tri-Ethnic Center for Prevention Research and as described in the CRM Handbook. Two scorers familiar with the CRM analyzed each interview and scored using the CRM anchored rating scale method provided by the CRM Handbook.(34) Each of the six dimensions has 9 anchored rating statements respectively (shown in Appendix B), for which the scorer had been trained to use and apply. The scorer reviewed each dimension in the interview

separately and highlighted or underlined statements that referred to the anchored rating statements. If the response exceeded the first statement, they proceeded to the next statement. In order to receive a score at a certain stage, all previous statements must have been met up to and including the statement that the scorer believes best reflects what was stated in the interview. In other words, a response cannot be at stage 7 without having achieved what is reflected in the statements for stages 1 through 6.

The scorers compared the scores and re-reviewed them in the case of disagreement with the help of one of the members of the PAG who acted as a moderator. This is an accepted procedure in the CRM Handbook since the objective is to find consensus during scoring. As prescribed by the CRM Handbook, the scores for each dimension were added and an average was calculated for each dimension.<sup>(34)</sup> Averaging the six final dimensional scores derives the final Community Readiness Score, which is then associated with one of nine CRM stages of readiness. The nine stages of community readiness include and are described in Appendix C: 1) No Awareness, 2) Denial/Resistance, 3) Vague Awareness, 4) Preplanning, 5) Preparation [*note that as a stage in this model it is conceptually different than preparation for an emergency*], 6) Initiation, 7) Stabilization, 8) Confirmation/Expansion, and 9) High Level of Community Ownership.<sup>(34)</sup> This procedure was derived from the work of Oetting et al. (1995) at the Tri-Ethnic Center at Colorado State University.

The analysis of the CRM interview content was guided by grounded theory to develop an explanation supplementing the calculated overall stage of community readiness and the current reality around emergency preparedness activities for a public health emergency in East Harlem.<sup>(82)</sup> In this study the qualitative analysis is driven by specific *generative research*

*questions* to help guide the research but is not intended to be either static or confining. The specific generative research questions are:

1. *What are the key themes identified?*
2. *What are the key barriers identified and how are they described?*
3. *What are the key opportunities identified to improve the overall state of community readiness and its related dimensions and how are they described?*

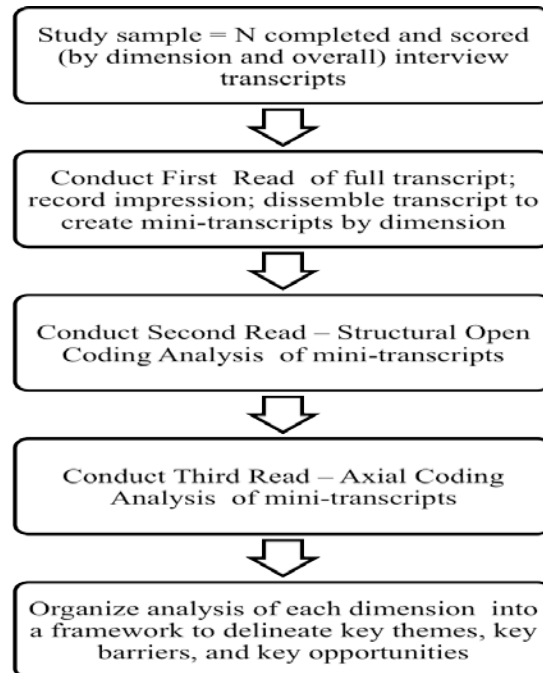
Figure 2.1 illustrates the analytic strategy for the CRM Interviews. Specifically, *coding* is used and is defined as marking the segments of data with symbols, descriptive words, or category names. Coding is a process for both categorizing qualitative data and for describing the implications and details of these categories.

A first read of the transcripts was conducted to gain initial impressions and to make notations on the transcript of words, terms, phrases that emerged while reading. During this first read, the investigator dissembled the transcript by each of the six dimensions of readiness to create “mini-transcripts” by marking a start point when the first question was asked in a specific dimension to when the last question was asked in that same dimension marking the end point.

Structural open coding was conducted during the second read. Structural open coding involved reading the transcript carefully, line by line, and dividing the data into meaningful analytical units (i.e., segmenting the data.) Once the structural open coding is complete, a third read is done to conduct axial coding of the mini-transcripts, which allows more intensive coding concerted around the single “open code” categories. Axial coding has often been characterized as the “spokes” emerging from the center, as do the spokes on a tire wheel. These emerging axis’ are related to and/or fundamental elements of the core (hub) category code (such as barriers and opportunities) but may manifest as different variants of it. (83) In other words, axial coding will allow exhaustive examination to appropriately respond to the proposed research question.

In addition, throughout the entire process of this qualitative data analysis, memoing, a critical technique in qualitative data analysis, took place. Memoing is the recording reflective notes about what the investigator learns from the data. Memos are recorded in a composition notebook when ideas and insights emerge. Memos are included as additional data to be analyzed.

**Figure 2.1 Aim 2 Analytic Plan**



## CHAPTER III: RESULTS

### a. Introduction

This study was developed to examine organizational preparedness and community readiness for public health emergency preparedness within a specific segment of community service provider organizations operating in East Harlem, New York City. In this chapter, the results are presented.

Aim 1 proposed to examine whether individual-level preparedness and level of organizational confidence was associated with level of organizational preparedness for a public health emergency in East Harlem. The first research aim described among East Harlem community organizations the distribution of organizational preparedness and identified characteristics of both organizational leaders and organizations that are associated with the level of organizational preparedness for a public health emergency.

This aim was grounded in three specific research activities that answered three specific questions. The first research question asked: *What is the distribution of organizational preparedness among community service providers in East Harlem?* For this research question, this study used descriptive statistics to characterize the study sample and the distribution of organizational preparedness and individual-level preparedness activities as well as the level of organizational confidence. The second research question asked: *Is there an association between the levels of individual preparedness of the community service provider organizational leader and organizational preparedness for a public health emergency in East Harlem?* For this research question, this study hypothesized that the higher the individual-level preparedness of the organizational leader, the higher the level of organizational preparedness is for a public health emergency in East Harlem. The third research question asked: *Is there an association between*

*organizational confidence as an organizational attribute and the level of organizational preparedness for a public health emergency among East Harlem community service provider organization leaders?* For this research question, this study hypothesized that the higher the level of organizational confidence as reported by the organizational leader, the higher the level of organizational preparedness the organization has for a public health emergency in East Harlem. The research questions for Aim 1 were addressed with a cross-sectional online survey, which measured the level of organizational preparedness, individual-level preparedness of the organizational leader, organizational confidence, and captured selected individual and organizational-level characteristics. In this chapter, the results of the cross-sectional online survey and hypotheses testing are presented.

Aim 2 characterized the state of community readiness of East Harlem to engage in a process to conduct public health emergency preparedness activities using the Community Readiness Model. The research question for Aim 2 asks: *For a public health emergency, how do East Harlem community service provider organizational leaders characterize community readiness across the six dimensions included in the Community Readiness Model?* In addition, four follow-up questions are asked with regard to the qualitative information collected through the in-depth interviews. These questions included:

1. *What is the stage of community readiness in East Harlem to engage in public health emergency preparedness activities?*
2. *What are the key themes identified?*
3. *What are the key barriers identified and how are they described?*
4. *What are the key opportunities identified to improve the overall state of community readiness and its related dimensions and how are they described?*

In this chapter, the dimensional and overall community readiness score results from the in-depth Community Readiness Model interviews are presented. In addition, findings from the qualitative analysis addressing the four follow-up questions are presented.

**b. Aim 1 Results**

*Characteristics of the Study Population:* Of the organizational leaders that participated in the cross sectional online survey (n=31), 60% are middle aged between 40 and 59 years of age, 61.3% are female, 56.7% are married, and 83.9% do not live in East Harlem. One third (35.5%) of the organizational leaders are non-Hispanic White, 35.5% are Hispanic/Latino and the remaining 29.0% self-identify as Non-Hispanic Black or Other - see Table 3.1.

As expected, the majority (65%) of the community service provider organizations are longstanding operating for greater than 20 years in East Harlem. Over forty-five percent of the sample (45.2%) identified as multiservice type organizations and 22.6% were youth development/educationally oriented type organizations - see Table 3.1. Common to most community service provider organizations, this sample of organizations is doing a lot with a little. Most organizational leaders reported serving 1000 individuals (80%), with less than 100 employees (74%) and on an organization budget of less than \$500,000 (86.7%) see Table 3.1.

**Table 3.1 Individual and Organizational Level Characteristics of Organizational Leaders Participating in Cross-Sectional Online Survey**

Characteristic	%	Total (N=31)
Age Range (years)		
21 – 29	3.2	1
30 – 39	16.1	5
40 – 49	25.8	8
50 – 59	35.5	11
60 +	19.4	6
Gender		
Female	61.3	19
Male	38.7	12
Race/Ethnicity		
Non-Hispanic White	35.5	11
Non-Hispanic Black	16.1	5
Hispanic/Latino	35.5	11
Other	12.9	4
Marital Status*		
Married	56.7	17
Divorced	13.3	4
Separated	10.0	3
Never Married	20.0	6
Live in East Harlem		
No	83.9	26
Yes	16.1	5
Organizational Type		
Community Health	12.9	4
Youth & Education	22.6	7
Multiservice	45.2	14
Other	19.4	6
Years Organization in East Harlem (years)*		
< 10	17.2	5
11 – 20	17.2	5
> 20	65.6	19
No. of Individuals Served*		
<1,000	20.1	6
1,001–3,000	37.9	11
3,0001 – 5,000	6.9	2
>=5,000	34.5	10
No. of Full-Time Employees		
< 50	41.9	13
51–100	35.5	11
>100	16.1	5
Don't Know	6.5	2
Size of Organizational Budget*		
<\$100K	3.3	1
\$100,001 – \$500K	10.0	3
>\$500K	86.7	26

\*Percent does not add up to 100 due to missing data

*Distribution of Organizational Preparedness Activities.* Organizational preparedness refers to having all pre-event preparation activities and mitigation efforts in place at an organizational level to improve the organization's ability to protect their organization and individuals served during a disaster or emergency.(6, 77, 78) The distribution of organizational preparedness activities from the cross-sectional online survey are organized into four categories which include and are shown in Table 3.2: *1) Preparedness Activities within the Organization; 2) Organizational Communication Plans for Preparedness and Response Roles; 3) Organizational Coordination; and 4) Assessment.*

*1) Preparedness Activities within the Organization.* Most respondents agreed that a series of organizational preparedness activities were in place - see Table 3.2. Almost all respondents agreed that they were familiar with their building's evacuation plan (87%), knew where the fire extinguisher was (76%), would still have a job (26%), continue to get paid (87%), and still have employment and benefit coverage (97%). There was less agreement for several key activities. Less than half (48%) were familiar with the disaster plan and only a few had an individual kit (23%).

*2) Organizational Communication Plans for Preparedness and Response Roles.* Most respondents agreed that they were prepared with having in place internal and external communication strategies - see Table 3.2. Internally, if a crisis or evacuation occurred at their organization, most of respondents agreed with being familiar with the plan on how to communicate with their employees at scattered or emergency locations, for example, through email, cell phone, or websites (73%). Externally, most of the respondents agreed that as part of their emergency plan, the individuals they serve would be able to contact them for information (74%). If a public health emergency occurred in East Harlem, the majority of respondents agreed

that their organization would know how to best share accurate information, avoid rumors, misinformation, fear, and anxiety among the individuals they serve 84%. Consequently, it is not surprising that when developing information materials, most of the respondents agreed that their organization considers the culture, language, and reading levels of their staff and the clients served in East Harlem (87%).

Further, with regard to carrying out the three proposed unique and specific preparedness and response roles, the respondents overwhelmingly agreed that if East Harlem experienced a public health emergency that they could serve as: *1) culturally and community-tailored emergency risk communicators (97%); 2) coordinators and facilitators of information, resources, and services for vulnerable and minority population groups (97%); and 3) providing or staffing or identifying locations in the community to maximize utilization of emergency points of distribution (76%).*

**Table 3.2 Distribution of Organizational Preparedness Activities of Organizational Leaders Participating in Cross-Sectional Online Survey**

Category	% Strongly Agree/ Agree	N	% Disagree/Strongly Disagree	N
<i>Preparedness Activities within the Organization</i>				
Familiar with Building Evacuation Plan	87	27	13	4
Familiar with organization's crisis/disaster plan	48	15	52	16
If my organization suffered a serious crisis...				
I might lose my job	26	8	74	23
I would still get paid until we reopen	87	27	13	5
I would still have employee benefits	97	30	3	1
Organization has provided each employee with basic emergency kit	23	7	77	24
I know where the nearest fire extinguisher is to my workstation*	76	23	24	7
I know where the nearest emergency exits are to my workstation*	100	30	-	-
<i>Organizational Communication Plans for Preparedness and Response Roles</i>				
I am familiar with the plan on how to communicate with employees at scattered or emergency locations*	73	22	27	8
As part of our emergency plan, the people we serve would know how to contact us	74	23	26	8
My organization would know how to best share accurate information, avoid rumor, fear, anxiety, and misinformation to the people we serve	84	26	16	5
When developing materials, my organization considers the culture, language, and reading levels of staff and individuals served	87	27	13	4
My organization can serve as...				
Culturally and community tailored emergency risk communicators*	97	29	3	1
Coordinators and facilitators of information, resources, and services	97	30	3	1
Providing, staffing, or identifying community locations for emergency points of distribution*	76	24	24	5
<i>Organizational Coordination</i>				
My organization offers to pay to have volunteers with trained in CPR and first aid.	35	11	65	20
My organization's emergency plan has been coordinated with local agencies (e.g. fire department)	32	10	68	21
My organization has established relationships with our most vulnerable and special needs populations so they will expect and trust our presence during a public health emergency	38	15	62	16
My organization has contingency plans in place for persons with special needs	39	12	61	19
<i>Assessment</i>				
My organization has determined the potential impact of a public health emergency on our organization's usual activities	49	15	51	16
My organization has a contingency plan in place so our clients/patients would be covered if we suffered a disaster*	60	18	40	12

\*Missing Data

3) *Organizational Coordination.* Organizational coordination and assessment had fewer activities were in place as shown in Table 3.2. Nearly two-thirds (65%) of the respondents disagreed with the statement that their organization offers to pay to have volunteer employees trained in basic life support techniques such as CPR and first aid. Nearly the same proportion of respondents (68%) also disagreed with the statement that their organization's emergency plan had been coordinated with local agencies such as fire departments, hospital, etc. Sixty two percent (62%) of the respondents disagreed with the statement that their organization has established relationships with East Harlem's most vulnerable and special needs populations in advance so that they will expect and trust their presence during a public health emergency. In addition, if East Harlem experienced a public health emergency, 61% of the respondents disagreed with the statement that their organization had contingency plans in place for persons with special needs (e.g. elderly, disabled, limited English-speaking).

4) *Assessment.* The respondents were nearly split (49% in agreement versus 51% in disagreement) as to whether their organization had determined the potential impact of a public health emergency on their organization's usual activities. Similarly, there was a slightly higher level of agreement (60%) than disagreement (40%) among the respondents as to whether their organization had a contingency plan in place so their clients would be covered if they suffered a disaster – see Table 3.2.

*Distribution of Individual-level Preparedness Activities* On the whole, the respondents were individually prepared for a public health emergency by having in their possession some of the most common emergency preparedness items - see Table 3.3. Most respondents were likely to have in their position a flashlight (90%), a battery-powered or hand-cranked radio (55%),

three days of water and non-perishable foods (71%), extra batteries (81%), and first-aid kit (58%); least likely to not have a dust mask (74%).

On the whole the respondents conducted fewer activities within their household to personally prepare for an emergency. In this sample (n=31), 42% of the respondents reported not safely storing important documents, 56% of the respondents reported not discussing or locating utility shut-offs, and 73% of the respondents had not located a shelter they could go to. In addition, 70% of the respondents had not made a list of important contact numbers and given it to family members, 79% of the respondents had not conducted an evacuation plan or drill in their home, 52% of the respondents had not taken a first-aid or CPR class, and 68% of the respondents had not arranged a family meeting place or reconnection plan.

**Table 3.3 Distribution of Individual-Level Preparedness among Organizational Leaders Participating in Online Cross-sectional Survey**

Individual-Level of Preparedness of Organizational Leader	% Yes	N	% No	N
<i>Has anyone stocked your household with any of the following supplies to prepare for an emergency:</i>				
Flashlight	90	28	10	3
Battery-powered/hand-cranked radio	55	17	45	14
3 days of water and non-perishable foods	71	22	29	9
Extra batteries	81	25	19	6
First Aid Kit	58	18	42	13
Dust Mask	26	8	74	26
Extra Cash*	50	15	50	15
<i>Has anyone in your household performed any of the following activities to prepare for an emergency</i>				
Safely stored important documents	58	18	42	13
Set aside extra prescribed medications*	37	7	67	14
Discussed or located utility shut-offs*	44	12	56	15
Located a shelter to go to	27	8	73	22
Made a list of important contact numbers and given it to all family members*	30	9	70	21
Conducted an evacuation plan or drill in the home*	21	6	79	23
Taken a first-aid or CPR class	48	15	52	16
Arranged a family meeting place or reconnection plan*	32	9	68	19

\*Missing data

*Distribution of Level of Organizational Confidence* Across all items, the respondents demonstrated a high level of organizational confidence - see Table 3.4. As long-standing organizations in East Harlem, these organizations are likely to have weathered through various changes in the community that have presented significant, complex, and difficult challenges to overcome. Nearly all of the respondents (97%) believed their organization could take on any challenge and have a sense of purpose (94%). In their respective organizations, 90% of the respondents agreed that they coordinate their efforts to complete difficult projects and 100% of the respondents agreed that individuals in the organization can work together to accomplish a goal and can mobilize efforts to accomplish difficult and complex goals. In addition, 94% of the

respondents believe their organization had competent staff to meet the requirements and needs of the individuals served by their organization. This high level of organizational confidence aligns tightly with the high level of agreement to serve in the three unique preparedness and response roles noted the section on *Distribution of Organizational Preparedness Activities*.

**Table 3.4 Distribution of Organizational Confidence among Organizational Leaders Participating in Cross-sectional Online Survey**

<i>Level of Organizational Confidence*</i>	% Strongly Agree/Agree/Somewhat Agree	N	% Strongly Disagree/Disagree/Somewhat Disagree	N
People in this organization can take on any challenge	97	30	3	1
People here have a sense of purpose	94	29	6	2
In this organization, we can coordinate efforts to complete difficult projects	90	28	10	3
People in this organization can work together to accomplish a goal	100	31	-	-
This organization can meet customer requirements because the employees are extremely competent	94	29	6	2

\*Missing data

*Descriptive Statistics of Variable Response Scores* Response scores were calculated for the dependent variable (organizational preparedness) and the two independent variables (individual-level preparedness and organizational confidence) examined in the cross-sectional online survey. Using descriptive statistics, Table 3.5 shows that on average, organizational leaders had a relatively elevated organizational preparedness response score of 79.4 out of a maximum score of 116 and a median score of 78.0 suggesting a relatively normal distribution. The average response score for individual-level preparedness was 8.2 out of a maximum score of 19 and was slightly elevated above the median score of 7.0 suggesting a positive skew. In addition, the average and median organizational confidence response scores at 43.5 and 43 respectively out of maximum score of 54.

**Table 3.5 Descriptive Statistics of Study Variable Response Scores of Organizational Leaders in Cross-Sectional Online Survey: Organizational Preparedness (DV), Individual-Level Preparedness (IV), and Organizational Confidence (IV)**

<b>Variables</b>	<b>(n)</b>	<b>Mean</b>	<b>Std. Dev.</b>	<b>Median</b>	<b>Range</b>
Organizational Preparedness (DV)	31	79.4	11.1	78.0	29-116
Individual-level Preparedness (IV)	31	8.2	4.7	7.0	0-19
Level of Organizational Confidence (IV)	31	43.5	6.4	43.0	9-54

*Distribution of Individual and Organizational Level Characteristics of Organizational Leaders by High and Low Score Levels of Organizational Preparedness* Individual-level characteristics included age, gender, race/ethnicity, marital status, and live in East Harlem. Organizational-level characteristics included organizational type, years organization in East Harlem, number of individuals served, number of full-time employee, and the size of the organizational budget. Table 3.6 shows the distribution of individual and organizational level characteristics of organizational leaders by high and low organizational preparedness score category. Overall, 25.8% or eight respondents had organizational preparation scores that fell within the high organizational preparedness score category, which is the top 25<sup>th</sup> percentile.

Respondents between 50 to 59 years of age represented the largest proportion and oldest age group in the high organizational preparedness score category. However, in the low organizational preparedness score category, 26.1% of the respondents were 60 years of age and older. In both high and low organizational preparedness score categories, women represented a greater proportion of respondents at 75% and 56.5% respectively. In addition, respondents who did not live in East Harlem represented the largest proportion in both high and low organizational preparedness score categories at 87.5% and 82.6% respectively.

Respondents who a self-identified as Hispanic/Latino represented the majority of those with high organizational preparedness scores at 62.5%, whereas Non-Hispanic White

respondents represented the majority of those with low organizational preparedness scores at 47.8%. Multiservice type organizations were equally represented with community health type organizations in the high organizational preparedness category yet also represented the largest proportion in organizational type in the low organizational preparedness category. Further, organizations operating in East Harlem for over 20 years represented the highest proportion of organizations in both categories of organizational preparedness at 75% and 61.9% respectively.

Proportionately, organizations serving more than 5,000 individuals have a higher organizational preparedness score, while organizations serving between 1,000-3,000 individuals are about even in both high and low categories of organizational preparedness. Among the respondents with low organizational preparedness scores, as the size of the organizational budget increased so did the number of organizations in this category. However, all eight organizations with a high organizational preparedness score also had an organizational budget greater than \$500K.

**Table 3.6 Distribution of Individual and Organizational Level Characteristics of Organizational Leaders Participating in Cross-Sectional Online Survey by High and Low Score Levels of Organizational Preparedness**

Characteristic	HIGH (>75 <sup>th</sup> Percentile)		LOW <sup>a</sup> (≤ 75 <sup>th</sup> Percentile)	
		(n=8)		(n=23)
Age Range (years)				
21 – 29	0	(0)	4.4	(1)
30 – 39	12.5	(1)	17.4	(4)
40 – 49	37.5	(3)	21.7	(5)
50 – 59	50.0	(4)	30.4	(7)
60 +	0	(0)	26.1	(6)
Gender				
Female	75.0	(6)	56.5	(13)
Male	25.0	(2)	43.5	(10)
Race/Ethnicity				
Non-Hispanic White	0	(0)	47.8	(11)
Non-Hispanic Black	12.5	(1)	17.4	(4)
Hispanic/Latino	62.5	(5)	26.1	(6)
Other	25.0	(2)	8.7	(2)
Marital Status*				
Married	62.5	(5)	54.6	(12)
Divorced	25.0	(2)	9.1	(2)
Separated	12.5	(1)	9.1	(2)
Never Married	0	(0)	27.3	(6)
Live in East Harlem				
No	87.5	(7)	82.6	(19)
Yes	12.5	(1)	17.4	(4)
Organizational Type				
Community Health	37.5	(3)	4.4	(1)
Youth & Education	25.0	(2)	21.7	(5)
Multiservice	37.5	(3)	47.8	(11)
Other	0	(0)	26.1	(6)
Years Organization in East Harlem** (years)				
< 10 years	12.5	(1)	19.1	(4)
11 – 20 years	12.5	(1)	19.1	(4)
> 20 years	75.0	(6)	61.9	(13)
No. of Individuals Served**				
<1,000	12.5	(1)	23.8	(5)
1,001 – 3,000	37.5	(3)	38.1	(8)
3,0001 – 5,000	0	(0)	9.5	(2)
Over 5,000	50.0	(4)	28.6	(6)
No. of Full-Time Employees				
< 50	12.5	(1)	52.2	(12)
51–100	62.5	(5)	26.1	(6)
>100	25.0	(2)	13.0	(3)
Don't Know	0	(0)	8.7	(2)
Size of Organizational Budget*				
<\$100K	0	(0)	4.6	(1)
\$100,001 – \$500K	0	(0)	13.6	(3)
>\$500K	100	(8)	81.8	(18)

\*Missing 1 response

\*\*Missing 2 responses

<sup>a</sup>all p-values for chi square comparison are greater than .05.

*Individual-level Preparedness* For the first research question, this study hypothesized that the higher the individual-level preparedness of the organizational leader, the higher the level of organizational preparedness is for a public health emergency in East Harlem. A positive linear correlation between individual-level preparedness and level of organizational preparedness was observed using a Pearson Correlation with an r-value of .56. In an unadjusted linear regression analysis, results showed that for every unit increase in level of individual-preparedness, there was a 1.3 ( $p < .05$ ) increase in the level of organizational preparedness score - see Table 3.7. When adjusted for individual-level characteristics including age, gender, race/ethnicity, and live in East Harlem, this increase remains identical ( $\beta=1.3$ ,  $p < .05$ ) - see Table 3.7. Results from these analyses support the hypothesis: the higher the individual-level preparedness of the organizational leader, the higher the level of organizational preparedness is for a public health emergency in East Harlem.

To further support the results, a logistic regression using organizational preparedness as a continuous variable was conducted. The response scores of level of organizational preparedness (dependent) variable were dichotomized as discussed earlier in to high and low categories. The unadjusted logistic regression showed that the odds of falling within the high organizational preparedness score category increases by 35% (C.I. 1.07-1.70) with every one unit increase in the individual preparedness score – see Table 3.8. When adjusted for the same individual-level characteristics, the probability of falling within the high level of organizational preparedness increases to 37% (C.I. 1.02-1.84) – see Table 3.7. Despite the small analytic sample size of  $N=31$ , the findings from these statistical analyses remain robust and consistent with results obtained when using level of organizational preparedness as a continuous variable.

**Table 3.7 Linear Regression Results: Unadjusted and Adjusted Coefficients (for selected Individual-Level Characteristics) of Individual-Level Preparedness on Level of Organizational Preparedness among Organizational Leaders participating in Cross-Sectional Online Survey**

Variable	Unadjusted Coefficient Estimate	P-value	Adjusted Coefficient Estimate	P-value
Individual-level Preparedness	1.3 (0.37)	<0.00*	1.3 (0.45)	<0.01*
Age			-1.9 (1.68)	
Gender			5.1 (3.58)	
Race/Ethnicity			1.2 (1.94)	
Lives in East Harlem			-3.0 (4.73)	

**Table 3.8 Unadjusted and Adjusted Odds Ratio of Individual-Level Preparedness and Individual Level Characteristics with a High Level of Organizational Preparedness among Organizational Leaders participating in Cross-Sectional Online Survey.**

High Score Level of Organizational Preparedness (>75 <sup>th</sup> Percentile)		
Odds Ratio (95% C.I.)		
Variable	Unadjusted Odds Ratio	Adjusted Odds Ratio
Individual-Level Preparedness	1.35* (1.07 – 1.70)	1.37* (1.02 – 1.84)
<i>Individual Level Characteristics</i>		
Age		0.15 (0.02 – 1.11)
Gender		14.68 (0.55 – 394.17)
Race/Ethnicity		8.96 (0.91 – 88.05)
Lives in East Harlem		0.24 (0.00 – 32.03)

\*p value <0.05; Unadjusted p-value = 0.01; Adjusted p-value = 0.04

Organizational Confidence For the second research question, this study hypothesized that the higher the level of organizational confidence as reported by the organizational leader, the higher the level of organizational preparedness the organization has for a public health emergency in East Harlem. In an unadjusted linear regression analysis, results showed that for every unit increase in level of organizational confidence, there was a 0.69 (p < .05) increase in the level of organizational preparedness score - see Table 3.9. When adjusted for certain organizational-level characteristics including the number of years operating in East Harlem, number of individuals served, number of full-time employees, and size of organizational budget, there was a 0.99 (p < .05) increase in the level of organizational preparedness score for every

unit increase in level of organizational confidence - see Table 3.9. Results from these analyses support this hypothesis: the higher the level of organizational confidence as reported by the organizational leader, the higher the level of organizational preparedness the organization has for a public health emergency in East Harlem.

**Table 3.9 Linear Regression Results: Unadjusted and Adjusted Coefficients (for selected Organizational Level Characteristics) of Organizational Confidence on Level of Organizational Preparedness among Organizational Leaders participating in Cross-Sectional Online Survey**

Variable	Unadjusted Coefficient Estimate	P-value	Adjusted Coefficient Estimate	P-value
Organizational Confidence	0.69 (0.297)	0.03*	0.99 (0.405)	0.02*
<i>Organizational Level Characteristics</i>				
Years of Organization in East Harlem			1.33 (3.17)	
No. of Individuals Served			0.65 (2.17)	
No. of Full-Time Employees			4.10 (2.81)	
Organizational Budget			0.80 (4.45)	
Organizational Type			-4.17 (2.45)	

\*p value <0.05

To further support the results, a logistic regression using organizational preparedness as a continuous variable was conducted, treating the level of organizational preparedness in the same way dichotomized in high and low categories. The unadjusted logistic regression showed that the odds of falling within the high organizational preparedness score category increases by 23% (C.I. 1.02-1.49) with every one unit increase in the level of organizational confidence – see Table 3.10. When adjusted for the same organizational-level characteristics, with the exception of size of organizational budget, the probability of falling within the high level of organizational preparedness increases to 33% (C.I. 1.03-1.72) – see Table 3.10. Size of organizational budget was excluded because there was a disproportionate distribution in the response categories making it difficult to fit the model. Despite the small analytic sample size of N=31, the findings from these statistical analyses remain robust and consistent with results obtained when using level of organizational preparedness as a continuous variable.

**Table 3.10 Unadjusted and Adjusted Odds Ratio of Organizational Confidence and Organizational Level Characteristics with a High Level of Organizational Preparedness among Organizational Leaders participating in Cross-Sectional Online Survey.**

High Score Level of Organizational Preparedness (>75 <sup>th</sup> Percentile)		
Odds Ratio (95% C.I.)		
Variable	Unadjusted Odds Ratio	Adjusted Odds Ratio
Organizational Confidence	1.23* (1.02 – 1.49)	1.33* (1.03 -1.72)
<i>Organizational Level Characteristics</i>		
Years of Organization in East Harlem		3.122 (0.47 - 20.61)
No. of Individuals Served		0.831 (0.29 - 2.38)
No. of Full-Time Employees		2.056 (0.49 - 8.63)

\*p value <0.05; Unadjusted p-value = 0.03; Adjusted p-value = 0.03

**c. Aim 2 Results**

Sample Description Six organizational leaders who participated in the cross-sectional online survey were interviewed about community readiness for a public health emergency using the Community Readiness Model. The six organizational leaders represented a cross-section of levels of organizational preparedness (2 from each level: High, Medium, and Low) as described in Aim 1. Each organizational leader had a high impact leadership position in their respective organizations – ranging in leadership titles from Executive Director to Chief Operating Officer. As shown in Table 3.11, the organizational leaders came from an environmental justice organization, a federally qualified community health center, two multiservice providers, a youth services provider, and a legal aid service provider. None of the organizational leaders participating in this part of the dissertation study lived in East Harlem. All of the community service provider organizations are longstanding and were established at least twenty years ago.

**Table 3.11 Organizational Type, Leadership Title, and Level of Organizational Preparedness of Organizational Leaders participating in the CRM Interview**

Organizational Type	Leadership Title	Level of Organizational Preparedness
Environmental Justice	Executive Director	Low
Multiservice Provider	Executive Director	Low
Legal Service Provider	Attorney in Charge	Medium
Multiservice Provider	Executive Manager	Medium
Community Health Center	Chief Operating Officer	High
Youth Services Provider	Center Director	High

*Community Readiness Score Results* The Community Readiness Model measures the state of community readiness to engage in a process to conduct public health emergency preparedness activities based on six dimensions listed in Appendix C and include: *community efforts, community knowledge of the efforts, leadership, community climate, community knowledge about the issue, and resources related to the issue*. These six dimensions derives the final Community Readiness Score, which is then associated with one of nine CRM stages of readiness, where 1 is the lowest stage of readiness and 9 is the highest stage of readiness maintained by a community. The nine stages of community readiness include and are described in Appendix C: 1) No Awareness, 2) Denial/Resistance, 3) Vague Awareness, 4) Preplanning, 5) Preparation [*note that as a stage in this model it is conceptually different than preparation for an emergency*], 6) Initiation, 7) Stabilization, 8) Confirmation/Expansion, and 9) High Level of Community Ownership.(34)

The CRM interviews were audiotaped and transcribed for both scoring and coding purposes. Interviewee identifiers were removed from the transcript and audio recording to minimize bias. Each interview was labeled with an interview date, level of organizational preparedness, and interviewer name. To conduct the scoring, the scorers used the transcripts and read through each once using the anchored rating scale referred to in Appendix B. The scorers

used the CRM Scoring Worksheet provided in the CRM Handbook to record, combine, and calculate the overall stage of community readiness.

Overall and Dimensional Community Readiness Score Table 3.12 shows the dimensional specific community readiness scores by level of organizational preparedness of the organizational leader. Overall, there is no clear pattern or trend displayed in the spread of scores in each dimension and the level of organizational preparedness of the organizational leader. One pattern of note is that Dimension F Resources was the lowest scored dimension across nearly all of the organizational leaders, with exception of one leader who scored a 3 which is a higher stage of readiness.

Table 3.13 shows the dimension-specific and overall community readiness scores and stage. The overall community readiness score is 2.36, which places East Harlem in stage 2 out of 9 possible stages. According to the CRM Handbook, Stage 2 is known as *Stage 2: Denial/Resistance*. In this stage, East Harlem as a community experiences denial and/or resistance in engaging in public health emergency preparedness activities. In *Stage 2 Denial/Resistance*, East Harlem as a community recognizes public health emergency preparedness as an issue but there is no awareness of relevance to it as a local problem or that local solutions can be effective.(34)

The interpretation of each dimension falling within community readiness in Stage 2 in East Harlem is as follows. For Dimension A (Community Efforts), there is no recognition that efforts addressing public health emergency preparedness are needed in East Harlem. For Dimension B (Community Knowledge about Efforts), East Harlem has no knowledge about local efforts. In Dimension C (Leadership), leadership in East Harlem does not believe this is an issue that needs addressing locally. In Dimension D (Community Climate), the prevailing attitude in

East Harlem is “there is nothing we can do” or “it’s not happening here” with regard to public health emergency preparedness. In Dimension E (Community Knowledge about Issue), East Harlem has no knowledge about public health emergency preparedness. Lastly, for Dimension E (Resources Related to Issue) with an average score of 1.42, East Harlem would fall into Stage 1 where there is awareness for the need for resources to dealing with public health emergency preparedness.

**Table 3.12 Dimensional Community Readiness Score by Level of Organizational Preparedness of the Organizational Leader.**

Interviews	Level of Organizational Preparedness of Organizational Leader						Average
	High		Medium		Low		
	#1	#2	#3	#4	#5	#6	
Dimension A (Community Effort)	1	2.3	3.5	2.3	3	3	2.52
Dimension B (Community Knowledge)	2	1	3	2.5	3	3	2.42
Dimension C (Leadership)	3	1	3	2	3	2.5	2.42
Dimension D (Community Climate)	4	3	1.5	3	1	4	2.75
Dimension E (Community Knowledge About Issue)	3.5	2	2.8	3	2	2.6	2.65
Dimension F (Resources)	1	1.5	1	1	3	1	1.42

**Table 3.13 Overall and Dimension Specific Community Readiness Score and Stage**

Dimensions of Community Readiness	Average Score	Stage	
Dimension A:	2.52	2	<b>Overall Community Readiness Score</b>
Dimension B:	2.42	2	
Dimension C:	2.42	2	
Dimension D:	2.75	2	<b>Overall Stage:</b>
Dimension E:	2.65	2	
Dimension F:	1.42	1	

*CRM Interview Analysis Plan* Throughout the coding process, an organizing principal was utilized in which the investigator served as the temporal reference point, not the issue itself. Therefore, the findings that emerged prior to theme development were organized by what the investigator discovered first, second, third, and so on, during the course of multiple readings of each interview transcript. (84) At the point of theme development, the investigator organized the findings into relevant themes based on shared elements of specific barriers and opportunities identified.

Cleaned transcripts and interviewer reflection forms were read first for overall impressions and disassembly of interview content based on each dimension of readiness measured in the CRM interview tool. The second read of the cleaned transcripts revealed 14 open codes in which some of the codes were similarly labeled to a dimension of readiness such as RESOURCES and others were labeled based on the consistent phrases/terms/words voiced by the organizational leaders. For example PHE\_CONCERN [Public Health Emergency as a Concern] and LEADERSHIP are two of the fourteen codes. The open code PHE\_CONCERN refers to a category whereby the organizational leaders discussed the various ways of how much of a concern public health emergencies were in East Harlem and why. The open code LEADERSHIP aimed to capture all the ways in which the organizational leaders described, commented on, and critiqued the behavior of leaders with perceived authorial presence and power.

During the second read, text supporting the 14 open codes when appropriate was underlined and marked in two ways. First, the text was marked was another coding system developed by the investigator to distinguish which segments of the data signaled a barrier, opportunity, or both, to improve East Harlem's overall state of community readiness to engage in

public health emergency preparedness activities. The underlined text was either marked in the margin with a “B” to represent barrier, an “O” to represent opportunity, or a “B/O” to represent both. The “B/O” was used for pieces of data that were not explicitly described as either one but rather shared by the organizational leader in a way where the perceived problem and solution intertwined in their response. This coding method allowed the investigator to see coding patterns and comparisons that emerging across the six dimensions of community readiness in all of the interviews. Second, the text was marked with an asterisk symbol “\*” to flag possible exemplary quotes to support what would emerge as the predominant themes.

Guided by Spradley’s Universe of Semantic Relationships, (Figure 3), the “attribute” relationship emerged as a useful and meaningful way to think about how the barriers cited and the potential opportunities described represented the “X” characteristics of the overall stage of community readiness or the “Y.” This analytical framework provided meaningful criteria for which to examine the data for distinctions, shared elements, and comparisons. (85, 86)

**Figure 3: Spradley's Universe of Semantic Relationships**

Strict inclusion	X is a kind of Y
Spatial	X is a place in Y; X is a part of Y
Cause-Effect	X is a result of Y; X is a cause of Y
Rationale	X is a reason for Y
Location for Action	X is a place for doing Y
Function	X is used for Y
Means-End	X is a way to do Y
Sequence	X is a stage or step in Y
Attribution	X is a characteristic of Y

In the third read, axial coding was conducted to deepen the texture of the open codes. The transcripts and especially the marked text as described earlier was re-read to identify properties associated with the structural open codes developed in the second read. Not all of the 14 open

codes were subjected to axial coding, as some codes were deemed complete. Using the earlier example of the two open code categories, PHE\_CONCERN and LEADERSHIP, each respectively emerged with a series of sub-codes or axial codes adding to the texture of relationships around the “axis” of the category being focused upon.(83) For PHE\_CONCERN, the surrounding axial codes, represented constituent elements of the core (hub) category code which included: FREQ (frequency), UNPRED (unpredictability), IMPACT, and DEF (definition). For LEADERSHIP, the surrounding axial codes gave texture to the behavior of the community leaders and included: NO.PRI (Not a priority), REACT (reactionary) and SUM1\_ELSE. The “B” and “O” coding system was applied to the axial codes allowing for a listing of additional and varying types of barriers and opportunities which gave an in-depth picture about what was happening in East Harlem and what community readiness means to this community as perceived by the organizational leaders.

At this point in the analysis, the predominant themes that emerged came about through a process of comparing and contrasting open codes and their respective axial codes with one another to form four groups of findings resulting in four predominant themes. The first three predominant themes emerging from the data are: *1) knowledge and awareness of public health emergency preparedness, 2) assumptions about public health emergency preparedness, and 3) contextual factors of public health emergency preparedness.* These three themes were produced by identifying shared elements among codes marked as barriers such that when grouped together are then scaled up to a series of broad themes which characterize *what it means* to be in a overall community readiness stage 2 Denial/Resistance and describe *what is happening* at this stage in East Harlem. The fourth theme was produced by identifying the shared elements among codes marked as opportunities and “B/O” such that when grouped together, scale up to a

larger theme about *what it means* to be ***moving towards being a prepared community***.

Lastly, the investigator chose to re-present the findings using exemplary quotes of the organizational leaders to showcase their earnest viewpoint and voice about community readiness to engage in public health emergency preparedness activities. (84).

### ***Theme 1: Knowledge and Awareness of Public Health Emergency Preparedness***

Organizational leaders were asked to indicate how much a concern was preparedness for a public health emergency in East Harlem using a scale of 1 to 10 with 1 being “not a concern at all” and 10 being “a very great concern.” While the detailed responses overlapped with respect to the timing, frequency, and specificity of the type of public health emergency, the scores ranged from 4 to 9. The lowest score of 4 was given because of the unpredictable nature of emergencies which keeps the issue “out of sight and out of mind” on a day-to-day basis – for both the community service providers and community residents. The highest score of 9 was based on the perceived devastating impact a public health emergency could have on the day-to-day living of East Harlem residents, specifically on its most vulnerable and hard-to-reach populations.

Knowledge of and awareness about efforts to conduct public health emergency preparedness in East Harlem was virtually non-existent among the organizational leaders. This finding was likely due to the common response that they could not recall the last time there was a public health emergency in East Harlem. However, many organizational leaders cited citywide examples such as H1N1, the August 2011 Earthquake, the widespread flooding caused by Hurricane Irene (August 2011), and the utility disruptions caused by the recent snowstorm during Halloween weekend 2011. Organizational leaders noted that the period of time right before an event is expected to happen or at the time when the event happens is the moment when people become most concerned, attempt to learn as much as possible, and stay informed. Described as a

reactive approach to preparedness by many of the organizational leaders, this willingness to stay engaged in preparedness activities at a community level also appears to be short-lived as one leader states: *“Feels like an afterthought despite seeing what happen in New Orleans – we haven’t learned from Hurricane Katrina; doesn’t seem there’s a realistic plan for taking care of vulnerable populations.”* Therefore, the lack of effective planning, as one organizational leader expressed *“becomes a real concern when the public does not know what to do, then, we would get more mass hysteria; people in fear do crazy things when they lack education about what to do.”*

The infrequent nature of public health emergencies also means that preparedness is not an issue thought about on a daily basis according to the organizational leaders. As a result, some organizational leaders shared that their organizations do periodic reminders to their clients because it is part of their organizational emergency plan to conduct some educational activities. However, they have also experienced the challenge of trying to educate a community where a culture of preparedness is far-reaching. For example, one organizational leader stated:

*“...in particular I think they are not that aware of any resources or policies, and so it actually is, has become a requirement, a responsibility of the social workers to periodically – once a year – bring the topic up and make sure that their clients are aware of resources and would have a plan: in the event of this they have things on hand and emergency backup medications, they have emergency phone numbers. And I do know that it’s, with their clients at least, it’s always educating from zero. And I would think the wider community is probably more or less the same.”*

Another important reason articulated by organizational leaders as to why vague awareness about public health emergency preparedness exists in East Harlem is due to the lack of specificity in the term and what constitutes a *public health emergency*. Although the definition<sup>4</sup>

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<sup>4</sup> A public health emergency is defined as a natural or man-made disaster or crisis such as, but not limited to, a storm causing extensive flooding, a widespread and prolonged power outage, or an outbreak of a serious infectious disease

for a public health emergency was provided during the interview, nearly all of the organizational leaders felt that the term was too broad for the community to understand and that providing specific examples of types of public health emergencies would be necessary to increase knowledge and awareness. As one organizational leader eloquently expressed:

*“...community residents may know what an emergency is but that depends what is perceived as an emergency; residents probably know what is meant by ‘public health’ but all together would likely not know what is meant by the broad term or what is a public health emergency and yet would likely support preparedness efforts if better informed.”*

Despite not having detailed knowledge about public health emergency preparedness efforts, organizational leaders believed that the community does have some level of vague awareness about this issue because of what people see and learn from media coverage of catastrophic events. All of the organizational leaders credited media coverage of major natural events, often citing Hurricane Katrina, and man-made disasters (e.g. terrorists attacks) which have somehow penetrated into the community consciousness the idea that being prepared is at some level important to consider. Some organizational leaders also attributed “Hollywood” for making movies to further demonstrate the potential impact of specific types of disasters such as the movie “Contagion” that is about the rapid progress of a lethal airborne virus that kills within days.

One organizational leader expressed a different observation from the ongoing coverage of Hurricane Katrina, in particular, which was that this event showed *“the effect of not having an emergency plan...but also I think the perception that a poor community of color is more likely to suffer more from lack of effective planning.”* This sentiment was shared by nearly all of the

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that has the potential of jeopardizing the health of the public and endangering the lives of those most vulnerable.

organizational leaders in statements like “*people are aware that there’s a need for something... what and how is yet to be determined;*” and “*I don’t think we’re prepared much at all. I don’t think we are as a community.*”

Understanding the differential perception by the community of what constitutes a regular emergency versus public health emergency is another important insight revealed by the data. Consistently, organizational leaders stated that the concept of public health emergency needed to be inclusive of other types of public health issues that are threatening the community on a day-to-day basis and clearly represent imminent threats to the livelihood of East Harlem residents. For example, as one organizational leader stated passionately:

*“We had a big summit with kids and some of things that came out of it was, one of the things kids are most concerned about is dying young. To me that is a public epidemic that we have youth killing youth and now youth in the city are feeling they’re worried about dying young. And that should not be a concern most kids that age think they’re never going to die and I’m going to live forever and I’m invincible. Which they still think but just to even wrestle with death is a part of their lives but not death of an old family member dying or certain kind of thing; getting shot and killed in this community is a reality. I think we have to be careful in how we define what our – and not limit it sometimes to just weather disasters or HIV I mean even again HIV is considered an epidemic we got to control. You know, Magic Johnsons’ lived 20-something years. What medication is he taking that rest wasn’t I don’t know, but is everything available to everybody. I think that’s a question too. I’m trying to refrain. Do we all have equal access to what’s available to deal with crisis? Are some in better circumstances I mean sure more money we got yes but no matter how much money you got, if you’re trying to drive out of the city with everybody else trying to drive out you’re not getting out of there any quicker unless you have a helicopter. Do we all have equal access? The mayor we know they’re going to fly him out of the city, there’s an underground way for him to get out. Do people in East Harlem have a way? We’re trapped, we would be trapped in this community.”*

In addition to youth violence, other public health issues identified included diabetes and obesity, asthma, gang violence, interpersonal violence, teenage pregnancy, human rights violations of immigrants and their families, low access to affordable/safe/healthy housing, and East Harlem’s overall dire economic climate; all which require attention and resources. To not include these other identified “real threats” or daily living hazards as other examples of what

constitutes a public health emergency, allows for the focus on public health emergency preparedness to be sidelined. This is because within this segment of community service providers, their wherewithal to invest organizational resources in emergency preparedness activities for unpredictable and infrequent events is secondary to their primary mission to build the capacity of their clients to deal with and overcome emergent and urgent social, economic, health, and legal needs. As one organizational leader eloquently reaffirms:

*“Right now I think we do have an epidemic of diabetes, obesity, asthma. Then what do we do? We have the Bus depot open around the way. We kind of create some of these... why would a community be so devastated, teen STD’s among teens is running rampant in this community. As a whole when you look at it, this community is devastated by health conditions that are some of the worst in this city, what do we do about it? We have one of the biggest richest institutions, and I’m not saying that don’t do anything, but we still have these problems that are not conducive to other areas or not to the same extent.”*

### ***Theme 2: Assumptions about Public Health Emergency Preparedness***

Due to the lack of detailed knowledge, organizational leaders in this sample often inserted assumptions in their responses to several questions around who funds public health emergency preparedness efforts, who is supposed to be prepared for a public health emergency, the level of training and preparation of public health emergency officials, who maintains local data on public health emergencies and whether or not it is accessible, who has public health emergency plans, who would community members turn to when a public health emergency occurs, and who in the community may be working on public health emergency preparedness efforts.

Although all of the initial responses to the question of who funds public health emergency preparedness activities was “*I don’t know*” or “*I’m not sure*”, several organizational leaders followed up this initial response with who they assumed might be providing funding

which included organizations such as the Centers for Disease Control and Prevention, the New York City Office of Emergency Management, the New York City Department of Health and Mental Hygiene, Fire Department of New York, and the New York Policy Department, or a broad reference to “city government.”

In regards to who is supposed to be trained for public health emergencies and their level of training – one organizational stated: *“I hope it’s at a 10 but I don’t know.”* Many organizational leaders believed that Fire Department of New York (FDNY), the New York City Police Department (NYPD), Office of Emergency Management (OEM), the area hospitals and the New York City Department of Health and Mental Hygiene (NYCDOHMH) were responsible for being trained - but questioned whether these entities were trained in two specific ways. First, they questioned if these individuals were trained for community-wide emergency preparedness activities versus focusing at the individual level of preparedness. Second, they questioned whether these individuals were adequately trained to work with vulnerable and culturally ethnically and socioeconomically diverse neighborhoods like East Harlem. When asked about who maintains local data when public health emergencies occur in East Harlem, no organizational leader could respond with substantial knowledge or awareness. Many organizational leaders assumed that if they needed to access such data they would contact the NYCDOHMH, local hospitals, or a (an unspecified) city government official. They further stated that community residents do not know if such local data exists, or how to access it in a usable way, or how to use it to answer questions they may have.

In the responses about which entities are likely to have emergency plans in place, many organizational leaders believed that medical organizations or a city agency should have plan. Other organizational leaders referenced their own organizational emergency plan and

emphasized the need to recognize what is already in place at the agency level in East Harlem in order to examine what are the gaps and areas of unmet need to strengthen emergency preparedness activities. For example one organizational leader with a higher level of organizational preparedness stated:

*“We don’t get any funding for it. We’re required to do it and we want to do it and we do it. We set aside the time, the effort and the resources to make sure that we have an emergency plan and that we have our committee that meets on a quarterly basis and we put the time in it and our medical director is part of that MIMIC group...She goes and meets on a monthly basis and if she can’t go, I’ll go or one of us, so we’re committed to making sure we are informed.”*

Another organizational leader with a medium level of organizational preparedness admitted that while their emergency plan is available via an internal website, there are parts of it that have “cookie cutter” language that does not align with the actual capacity of the agency. However, while having organizational emergency plan in place may be a required activity for some service provider organizations, these organizations are not additionally compensated for their investment of time and resources to carry out these activities. The following excerpt illustrates this point:

*“We don’t get any money to do this. We don’t even get any recognition other than if train commission comes by or some other accrediting organization says, “We want to see your emergency plan,” or “We want to see the minutes of your quarterly meetings,” and they’re glad, but nobody’s paying for that. There’s just an expectation that it happens and, to us, it is important so we’re going to make it happen and we do what it takes, but that’s not what we’re seeing across the board with other organizations. So I don’t know. I just don’t think there’s enough of this going on. I can’t tell you. I don’t know of specific streams of money going in to emergency preparedness in this community.”*

Further, many organizational leaders find themselves in a dilemma if they would have to choose between investing in emergency preparedness activities or serving the urgent and immediate needs of the individuals they serve as represented in the following statement:

*“Do I take a case where I know I can save the person's home, or I'm pretty sure I can but something together if they are going to be able to afford the rent or do I go to a meeting to deal with emergency preparedness? And probably not just one meeting because, again, working these things out, even though it may not be a committee decision when you actually implement the plan, trying to come up with a plan and making sure everybody understands that is going to be time consuming.”*

As a primary connector to needed services, the data revealed that most organizational leaders viewed their respective organizations as the first place their clients would turn to in the event of a public health emergency in East Harlem. As one organizational stated, *“we are the agencies already providing services in the community – we are seen as most trusted...”* In addition, depending on the type of public health emergency, organizational leaders believed community residents would call 911 and 311, or go to the hospitals and the NYPD.

In the last area of who in East Harlem might be working on public health emergency preparedness, two community coalitions were cited - the East Harlem Community Health Committee, Inc. and the Human Services Consortium of East Harlem. Both of these community coalitions supported this study and co-commissioned the Pilot Project discussed in this dissertation. The acknowledgement of these community coalitions by the organizational leaders points to their ability to keep this issue on the radar among service providers. One organizational leader specifically cited the Human Services Consortium of East Harlem and the active voice of one of its co-chairs who addresses this topic a few times a year during general monthly meetings. One organizational leader cited in generality that Community Board #11 was doing something but was not aware of any additional detail. Another organizational leader shared why the East Harlem Community Health Committee monitors this issue:

*“At the East Harlem Community Health Committee, we keep emergency preparedness on our agenda. We meet on a monthly basis and it's something that we have on our radar in part because it's a concern of everyone who sits around the table and the work that Ann-Gel and Eric did brought forth the information that we needed to do more work on it.”*

### ***Theme 3: Contextual Factors affecting Public Health Emergency Preparedness***

A contextual factor revealed by the data that hampers the community's ability to engage in public health emergency preparedness efforts is the current dire economic climate in East Harlem. East Harlem, historically a low resource community, is also one that, as one organizational leader stated: *"doesn't get its fair share of city resources and we have much greater needs here."* Thus, in East Harlem, it is not uncommon for community service provider organizations, especially long-standing organizations, to "do a lot with a little and whatever it takes" to get their clients back on track. As one organizational leader described their experience:

*"We talk about it, but it's a matter of where do we go from here and, again, because so many organizations are struggling with just surviving and being able to support the huge needs of the clients that they're serving, it's almost like emergency preparedness is a luxury and something that is going to require more input or financing or something to push forward."*

Another contextual factor specific to East Harlem is the availability and type of resources (such as time, money, human power, and space) that currently exists to engage in public health emergency preparedness activities. All of the organizational leaders believed that, in theory, community residents would support and engage in public health emergency preparedness activities because they are vaguely aware of the importance to do so. The data revealed that resources in the form of time and in serving as volunteers are likely the ways in which the community would offer support but that as an underserved community, financial support is unlikely.

With regard to giving time and serving as volunteers, organizational leaders believed community capacity and infrastructure would be needed to coordinate community residents to respond to a disaster. As one organizational leader explained, it is accountability in the execution of the response that must be considered as represented in the following statement:

*“In an emergency there is certainly a place for volunteers, look, we use volunteers, lawyers and some non-lawyers to help provide legal services. Volunteers are no substitute for paid staff. You have to have paid staff to coordinate volunteers. You just can't say to people, okay, you deal with emergency preparedness and you figure out a plan. Where's the accountability, you have to have some structure. Is there a use for volunteers? Yes, in an emergency I think that you are going to depend a lot on volunteers, but to develop a plan and to implement the plan you have to have some structure in place to coordinate it so is there a place for volunteers? Yes. Is emergency preparedness primarily the responsibility of volunteers? No, I don't think so.”*

With regard to financial resources, nearly all of the organizational leaders said they currently do not receive funding to conduct emergency preparedness activities as part of their service plan. As one organizational leader stated: *“Nothing is free, emergency preparedness is not just going to happen without an investment of time and time is money. I know it sounds kind of crass to say that, but that is what it is. That is exactly what it is. We ain't got no money here.”*

Another dimension to the lack of financial resources is that for some service provider organizations participating in this sample, they do not have input into the emergency preparedness or response decisions, made by the City but are required to be responsive to City officials when designated, for example, as a cooling station for seniors during a heat wave or to open childcare care centers for clients whose parents may be emergency service workers.

To this point, the following excerpt illustrates a specific experience by one organizational leader:

*“Yes, it was the H1N1 outbreak where everybody sort of...first of all, people were really sick, but second of all there was an expectation that we as healthcare providers would have vaccines for people or would have some response and the truth is we didn't and when we did get vaccines there weren't enough. Actually, we were approached by the Department of Health as a federally qualified health center to service a site to give or offer community residents vaccines, but they were only giving us like 25 vaccines and we knew that we had, based on our patients and the demand, that if we had announced to the public, 'Oh, we have vaccines,' that they would have knocked the door down because people were desperate and scared.*

*The city was doing it's campaigning in a certain way and they were doing some information, but we don't think, from our perspective, that they were doing a good job of letting people know what the reality was of the H1N1 outbreak and how people could protect themselves and how they were affected. They were saying things on television that weren't making sense. 'Go to your doctor and get a shot.' Well, the doctor didn't have anything because we weren't given access to vaccines and the doctor really couldn't do much other than tell you, 'We think you have it.'*

*That's another thing they were saying, 'Go to your doctor and get tested.' Well, the tests were extremely expensive and you had to send them to the CDC in the beginning, so there was no way that we were going to be able to test people nor did it make sense at that point. That was as close to a public health emergency as we've gotten in the last few years here, personally, with our experience and what it showed us was that we were not prepared as an organization for the onslaught of demand, but part of that demand was pushed by the messages that were given to the public by the Public Health Department.*

*It was almost dangerous because the expectation that people had, we were absolutely swamped. We saw more patients than we've ever seen before. We had people literally standing on-line and that's never happened before and there was really nothing we could do for them except to reassure them. That's really not what the city was putting out there. The city was saying, 'Oh, go to your doctor, get tested and see if you can get a shot, blah, blah, blah,' and we didn't have the resources for that. We weren't the only ones that were experiencing that.*

*So what it showed us – a) we didn't expect what happened based on what we knew about our community and our patients and clients and b) the city, because they didn't communicate with those of us on the streets, in the trenches were setting up these false expectations and as a result the trickle-down effect was that we had an onslaught of people who we really couldn't help, but who were making it impossible for us to take care of people who were really sick.*

*There was a disconnect there that really worried us and, actually, we then decided as an organization we're not going to offer even if they tell us, 'We're going to give you a hundred doses of something.' We said to them, 'We don't want them because unless you give us the resources to set up a secure way for our clients and our residents to be able to get what they need, we just think it's dangerous because you're going to have people getting really nuts about this one and we don't have the personnel to control this and to do it safely.' We want to give what we need to if we have it there to patients and to clients and community residents, but if we can't do it safely we'd rather not."*

The lack of relevant forms of information resources about public health emergencies and public health emergency preparedness represents another debilitating contextual factor.

Organizational leaders often stated that they had not seen written materials or public messages about emergency preparedness in East Harlem and as a result did not have information or written materials available at their organizations. Conversely, they noted a high saturation of public health and community health education materials about prevention and treatment of chronic health conditions and illnesses impacting the community, such as diabetes, asthma, and HIV/AIDS.

Further, the organizational leaders were not sure where to go to find community oriented and culturally tailored materials or messengers to share with their clients or with community members. For example:

*“You can go to website and look, I guess you could make calls to people but you got to know who to call in terms of. If I had to just suggest someone I would call the community board and say what would you suggest people do in this situation. Again, I’m – they probably don’t know, I sit on the board so I couldn’t tell you either. ...How do we know? Maybe establishing a process by which that information is available for in the community. I mean is broadcasting the thing? I don’t think there is anything we can do to make sure that everybody gets all the information. But I think we need to increase our ability to be able to provide education and information.”*

The last contextual factor that obstructs community readiness for a public health emergency in East Harlem is leadership – specifically elected and appointed leaders. There was agreement across the sample that East Harlem lacked strong leadership in this area due to low interest and political will combined with the inability to actualize the devastating impact a public health emergency might have on the livelihood of its residents. As noted earlier by organizational leaders, the East Harlem leadership also behaves with a reactive nature and is seemingly responsive only to the urgency of issues, which then trigger their interest and involvement to look politically “good.”

Inside this realm of leadership is also the experience that East Harlem leaders behave as if “it is someone else’s job to do public health emergency preparedness” which sets up a dangerous set of false expectations as represented in the following statement:

*“There really is on some level a sense that someone else will take care of it. The city will take care of it, the police, the fire department and that’s it. At one point, I think people believed that the Federal Government would take care of things, but after Katrina it was clear that that wasn’t going to happen.”*

Recognition and utilization of indigenous leadership is another attribute of leadership as a contextual factor in East Harlem. All of the organizational leaders believed that informal community leaders absolutely have a place in engaging community members to conduct public health emergency preparedness activities. As one community leader stated: “...government can’t expect to do it all by themselves.” This affirmation by the organizational leaders validates East Harlem as a highly networked community, with a few long-standing community coalitions, and a rich history of community leaders committed to social justice for East Harlem’s residents. “You need the balance of the entire community both elected officials and lay people,” as one organizational leader stated. The data revealed that everyone has a role in East Harlem, as this statement represents:

*“Sometimes it’s the gardener on the corner that knows the people on that block that would be the ones we would need to go in and get out the home versus an elected official who would walk down and not see, not even see that person. I think we need a combination balance of all the people to all play a different role at a different level in supporting the community through the crisis.”*

#### ***Theme 4: Moving Towards A Prepared Community***

The opportunity to move towards improving community readiness to engage in public health emergency preparedness, may be available if specific barriers discussed by the organizational leaders are addressed which include: *aligning daily public health threats with*

*implications of public health emergencies, changing leadership behavior, and guidance and support in coordination and effective planning to support community-wide preparedness and response roles carried out by service providers and community residents.*

*Aligning Daily Public Health Threats with Implications of Public Health Emergencies*

Achieving a mindset of preparedness at the community level may mean finding a way to connect the daily living conditions experienced by East Harlem residents with the remote threat of a public health emergency as defined in this study. This unique insight revealed by the organizational leaders suggests that the message about public health emergency preparedness must be practical and relevant as this organizational leader describes:

*” ...if you could tie emergency preparedness with the importance of maintaining a working economy in the event of an emergency, you would get everybody on board and I know people in the housing projects would say, “Wait a minute. There are these big behemoth buildings and we want to make sure we know how to take care of ourselves if something goes wrong.”*

This same organizational leader further expressed their perspective of delivering a relevant message with also being mindful of what we may be asking people to do or the choices we are asking them to consider in an emergency:

*“I think you have to show people. It depends what you're asking people to do. If all you're asking people to do is listen for five minutes or things that you can do to help yourself, like have a little emergency kit at home, maybe something like that. People may say “Well, my kids want the new sneakers to wear to school and I can either get this emergency kit or I can put that money toward that pair of shoes that they want, otherwise they're going to refuse to go to school, I think those are the kind of, it just depends on what you're asking of people. But even if you are asking for time and it's to deliver a message about more bad things that can happen to you. I don't know. We have a tax clinic here and we are supposed to do tax payer education, it's a real hard sell. You have to lock people into a room and get them under false pretenses and then talk to them about tax. It's stuff that, it's information that would help them but people don't always want to listen to information that would help them because it may just be a reminder of all the crap that they don't have any control over. I may be wrong, maybe I'm sounding really cynical, but I think it's a hard sell. I think it's a really hard sell. Unless it can be somehow packaged in something like ‘Here's something that immediately helps you and by the way’ and*

*that sounds a little too cynical. I don't know how to do it exactly, but I just think it's just not, disasters on TV are exciting, emergency preparedness is not that exciting. “*

Changing Leadership Behavior In general, organizational leaders noted that elected and appointed or “official” local leadership, specifically, need to become educated about the public health relevance of this issue in order to recognize the potential impact such a disaster would have on the East Harlem community. As one organizational leader noted:

*“They also have to get a sense from their constituents and clients that this is important and I think there’s a huge gap between the knowledge of the importance of this among everybody, starting from the leadership down to all of the community residents. People don’t know how important this is and I don’t think enough resources have been put into educating and informing the public about this issue.”*

However, another organizational leader looked beyond local leadership for direction based on the premise that the community does not have control over certain resources to adequately plan for itself:

*“ there needs to be a top down approach – this is a government responsibility; community-based organizations and communities can’t lead the way necessarily because we are part of a city-wide emergency plan: Again, I don't think it's primarily the responsibility of a particular community to do it. In some ways I am saying it needs to be driven top-down because the resources need to be devoted to it and I don't see it as being, things that have day to day impact might create a ground swell where you have the pressure up, I don't think emergency preparedness is one of those. In terms of putting a plan together, there should be an opportunity for community input.*

Guidance And Support In Coordination And Effective Planning East Harlem community service provider organizations, as described by the organizational leaders, inarguably manage daily with their patients and clients urgent and emergent situations and crises such as a bed bug epidemic, youth gang and interpersonal violence, substance use, or by providing needed health and social services to uninsured individuals. This unique ability of service provider organizations revealed by the data presents an opportunity to advance East Harlem’s ability to be prepared as a

community. However, they are in need of guidance and support for formal coordination and effective planning for public health emergency preparedness that integrates this segment of community service provider organizations into formal preparedness activities. One organizational leader gives an example of feeling left out of formal emergency preparedness planning efforts and alludes to the missed opportunity of benefitting from enhanced coordination, planning, and communication:

*“...I think on some level, there’s a sense that how much can we do without engaging and being part of a conversation with the police department and the fire department and the major hospitals. I’ll give you an example. As a federally qualified health center, for years we’ve been trying to get Mount Sinai to talk to us about emergency preparedness and they won’t. We have a relationship with Mount Sinai and we have the name of the person in charge of EP at their hospital, but there isn’t any attempt to even attempt to discuss the issue because, like I said, everyone’s in their silos. The cops know what they’re doing. The fire department knows what they’re doing and there isn’t enough interaction between everybody so that they can talk about it and work on it together, especially in this community.”*

## CHAPTER IV.

### SUMMARY & DISCUSSION

#### a. **Summary and Discussion**

This study was developed to examine organizational preparedness and community readiness for public health emergency preparedness within a specific segment of community service provider organizations operating in East Harlem, New York City. Overall, the findings from this study are consistent with the findings generated from the Pilot Project that in fact, East Harlem remains broadly ill prepared. (7) Yet, in this study, the scope of unpreparedness is specifically characterized within the areas of organizational preparedness and community readiness for a public health emergency. Therefore, this study represents a modest, yet potentially important contribution to the planning processes employed by emergency management and public health officials within this segment of community organizations to foster a better prepared community.

Findings from Aim 1 showed that the participating community organizations generally not coordinated with each other or with other emergency related organizations to address and manage their clients' needs in the event of a disaster. In addition, these community organizations are not initiating or engaging in coordination emergency preparedness efforts that focus on East Harlem residents not using their services. Further, these same organizations are less likely to have determined the potential impact of a public health emergency on their organization's usual activities. As a result, this lack of coordination cultivates a silo effect with emergency planning. Yet, despite the silo effect, this finding does not suggest unwillingness on the part of the community organizations to participate in formal preparedness activities based on the qualitative findings from Aim 2.

The findings from Aim 1 also confirmed initial hypotheses that an increase in the level of individual preparedness of the organizational leader and in the level of organizational confidence are associated with an increase in the level organizational preparedness for a public health emergency in East Harlem. These findings remained persistent after adjustment for certain individual and organizational level characteristics. Thus, this study suggests that the individual-level of preparedness of an organizational leader is associated with the degree to which the community service provider organization is also prepared and is focused on fostering a “preparedness” culture within the organization. As a result, an important insight offered by this study is that community service provider organization’s state of emergency preparedness may be role modeled by the behavior and actions of its leadership.

In addition to showing an association between the level of organizational confidence and the level of organizational preparedness, this study demonstrated that this segment of community organizations is overwhelmingly confident in carrying out the three proposed roles which include serving as: *1) culturally and community-tailored emergency risk communicators; 2) coordinators and facilitators of information, resources, and services for vulnerable and minority population groups; and 3) providing or staffing or identifying locations in the community to maximize utilization of emergency points of distribution.* In carrying out these three roles, East Harlem’s community organizations may maximize their role as primary connectors because they are seen as a *trusted* resource in the community due to their longstanding presence, focus on vulnerable populations, and types of services provided.

The findings from Aim 2 demonstrated how critically low the stage of community readiness is in East Harlem to engage in public health emergency preparedness activities as well as a delineation of specific barriers and opportunities for consideration by public health

emergency planners and others to enhance overall readiness in this community. Results from this study showed that East Harlem is at a Community Readiness Stage 2: Denial/Resistance. In Stage 2 Denial/Resistance, this community recognizes public health emergency preparedness as an issue but there is no awareness of relevance to it as a local problem or that local solutions can be effective.

Correlated with this stage of readiness are four themes that emerged from the qualitative findings. The first three themes focus on the complexity of the barriers related to public health emergency preparedness. These include: *knowledge and awareness of public health emergency preparedness, assumptions about public health emergency preparedness, contextual factors of public health emergency preparedness.* The fourth theme focuses on what it means to *move towards being a prepared community.* As a whole, the themes offer a deeper understanding of why the prevailing attitude in East Harlem is “there is nothing we can do” or “it’s not happening here” with regard to public health emergency preparedness and what areas may need to be addressed to improve overall community readiness.

With regard to the first two themes, the organizational leaders interviewed had little to no knowledge or awareness about activities to support public health emergency preparedness. This lack of knowledge led to a series of assumptions including but not limited to who funds public health emergency preparedness efforts, to who is supposed to be prepared for a public health emergency, to who has public health emergency plans, to who in the community may be working on public health emergency preparedness efforts. Because their responses were largely based on assumptions or what they think should or ought to be happening, this leaves a great possibility of misplaced expectations on who is in charge and who is supposed or respond when a does disaster occur.

These first two themes were linked to the third theme, which centered on the contextual factors affecting public health emergency preparedness in East Harlem. As a historically underserved and low resource neighborhood, the findings suggest that shifting the mindset of community residents from focusing on their every day challenges to preparation for a public health emergency that some day may happen is difficult to achieve. This is because emergency preparedness is deemed a “luxury” when juxtaposed to perceived daily imminent threats such as chronic unemployment, unaffordable housing, interpersonal violence, and a heavy health burden. In addition, other barriers such as the lack of robust resources (e.g. financial and technical expertise), the lack of relevant forms of community and culturally tailored information and resources about public health emergencies, and the lack of proactive and interested leadership, increases the level of difficulty and helps to sustain the community-wide attitude that “there is nothing we can do about it.”

The fourth theme suggests that the opportunity to move toward a better prepared East Harlem may be achieved if the relevance of public health emergency preparedness is connected to the reality associated with the daily public health threats noted above. Aligning the relevance of this issue with the daily reality experienced by East Harlem most vulnerable community residents may help to stimulate pro-active and interested local leadership and trigger interest among community residents and community organization to participate in developing a community-wide preparedness plan.

Overall, this study also underscores the findings discussed in a recent federally sponsored review of the literature on the state of national research efforts of community organizations in emergency preparedness. (6) Specifically, there is limited participation of community organizations in formal preparedness efforts and that these community service provider

organizations express interest in collaborative emergency planning activities, yet many perceive individual, institutional, and organizational barriers. Given the lessons learned from Hurricane Katrina, for example, this study emphasizes need to reverse the experience that community-based organizations regularly have when a disaster occurs. As the literature shows, community organizations, particularly those situated in low-resource communities, regularly experience a lack of formal collaborations with each other or with emergency preparedness officials and regularly fail to have disaster plans in place that are current and well-known internally and externally to the organization.(87-89)

Further, in vulnerable and minority communities, such as East Harlem, research and media reports have documented what happens when emergency management officials do not adequately protect these groups.(90, 91) Studies have shown that these groups are more likely to suffer adverse and unrecoverable health consequences from a public health emergency as they are disproportionately impacted and often the last to fully recover and reconstruct from such disasters –thereby making better protection of these group critical to health and safety of the public.(9, 11, 92, 93)Thus, examining organizational preparedness and community readiness for public health emergency preparedness among community service provider organizations in East Harlem, may help to position this neighborhood to be better prepared along a full range of prevention, mitigation, and recovery activities.

#### **b. Study Limitations**

Although the data from this study are illuminating, there are some limitations. First, the organizational leaders interviewed considered the term public health emergency preparedness too broad. This limitation was expected given the lack of specificity in the literature. [Nelson, 2007]

In this study, the term was refined slightly to include some specific types of emergencies as examples (see Appendix D). A second limitation is the use of a cross-sectional survey, which only establishes association and not causality. However, the mix method approach minimizes this limitation and is discussed later in *section c* of this chapter.

A third limitation is the small sample size used for Aim 1. However, the sample size did not preclude us for determining normality of the dependent variable and foremost significance results during the statistical analyses. Thus, the sample size was not an issue for the study. Fourth, out of the 83 organizational leaders invited to participate in the survey, 48 did not respond and may have affected our results. When compared to those organizational leaders that responded to the cross-sectional online survey, most of the non-respondents were organizational leaders affiliated with multiservice organizations followed by youth/education type organizations followed by community health type organizations. In addition, the non-respondent group had a nearly even gender distribution (n=25 for female and n=23 for male) while participants were more likely to be female (61.3%). While we were not able to statistically compare those who participated in the survey with those who did not, the affiliations and gender distribution of those who did not participate seem similar to participants with low organizational preparedness (Table 3.6). However, because we did not have information on the dependent and/or independent variables for the non-respondents we cannot speculate whether their inclusion would have over- or under-estimated our results.

Another limitation was that the organizational leaders interviewed with the Community Readiness Model (CRM) tool in Aim 2 were treated as key respondents because they were considered to be highly engaged well-informed individuals. However, a possible limitation of this study is that many of the organizational leaders had a great level of humility and did not

view themselves as a spokesperson for the community and at times found it impossible for them to articulate the viewpoints of a highly diverse community with one voice.

Lastly, the study was conducted in a single community, which may be viewed as an obvious limitation where the findings may not necessarily be generalizable to all neighborhoods even with similar characteristics. However, viewing generalizability of this study in three other ways may weaken this limitation. First, the findings from this study appear to be generalizable to the East Harlem community as a whole; and this was externally validated at the EHCHC community presentation made in January 2012. Second, the approach and methods used in this study may be generalizable and replicable in communities similar to East Harlem. Third, East Harlem inarguably shares particular social, economic, and health oriented characteristics that exists in other vulnerable and minority communities that could make the findings of this study relevant and useful (especially given the absence of other studies like this). For example, to date, the National Resource Center on Advancing Emergency Preparedness for Culturally Diverse Communities<sup>5</sup> lacks a study of this kind in its research and literature database and has no products or tools specifically addressing community readiness for a public health emergency in such a community. (93)

### **c. Study Strengths**

Overall, there are several notable strengths of this study. A critical strength of this study was the high level of community support from various East Harlem community leaders, the East Harlem Community Health Committee, Inc., the Human Services Consortium of East Harlem, Inc., and the Manhattan Community Board #11. Throughout the course of this study, progress

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<sup>5</sup> The National Resource Center on Advancing Emergency Preparedness for Culturally Diverse Communities is a central clearinghouse of resources and an information exchange portal to facilitate communication, networking and collaboration to improve preparedness, build resilience and eliminate disparities for culturally diverse communities across all phases of an emergency. Available at: ([www.diversitypreparedness.org](http://www.diversitypreparedness.org))

updates were provided at various community coalition meetings which raised important discussions about the lessons learned from previous disasters [e.g. Hurricane Katrina in 2006] and the impact of recent disasters on communities with vulnerable and minority populations, similar to East Harlem. Summaries from these community discussions informed Chapter 5: Public Health Implications and Recommendations.

The mixed method research design represents another important strength in this study. This research design offered a well-rounded approach to examine how individual-level preparedness and organizational confidence are associated with the level of organizational preparedness and the assessment of community readiness to engage in public health emergency preparedness activities. Specifically, Aim 1 and Aim 2 were linked with a stratified purposive sampling technique. This technique allowed for the selection of samples within samples, or in the case of this study, the selection of organizational leaders with high, medium, and low organizational preparedness scores for Aim 2 who were drawn from the analytic sample from Aim 1. (94)

In addition, the advantages associated with a mixed methods research approach fits well with the nature of inquiry that generally arises in communities which is to ask simultaneously a range of confirmatory and exploratory questions. The mixed method research design allows for both qualitative and quantitative approaches to answer such questions as well as the opportunity to provide a greater assortment of divergent views about a community identified issue. (95)

The measurement tools used in this study represent another strength. Aim 1 utilized a variety of tested and validated scales to measure the variables of interest in the online cross-

sectional survey. These scales were adapted from different bodies of literature including human resources management, leadership and organizational studies, and health communication.

For Aim 2, the Community Readiness Model (CRM) was used, a theoretically based diagnostic tool to assess community readiness developed by the Tri-Ethnic Center for Prevention Research. The CRM was useful in describing and explaining the current state of readiness to engage in public health emergency preparedness in East Harlem. The CRM was not intended nor was it designed to *predict* how East Harlem as a community would behave in the event of a public health emergency. The CRM only provides an assessment of the nature and extent of knowledge and support within the neighborhood to engage in public health emergency preparedness at one point in time. Further, predicting community behavior around emergencies and disasters is inherently difficult to do, as these events are generally unpredictable in terms of scope, timing, and impact.

In addition, the quantitative community readiness scores generated with the data collected via the CRM interviews, the data was also qualitatively analyzed using a grounded theory approach to further characterize the state of overall readiness and specify the barriers and opportunities to inform and potentially guide future action-oriented strategies in the application.

Interpreter rigor, referred to in mixed methods research as the degree to which credible interpretations are made on the basis of obtained results constituted another strength.(95) This level of rigor was present as the results from the quantitative component of the study integrated well with the results from the qualitative component of the study and reduced the possibility of missing any available data. Interpreter rigor was further validated by the positive feedback and

response when this author presented the study findings to community organizations at a recent East Harlem Community Health Committee Inc. general body membership meeting.

## **CHAPTER V.**

### **PUBLIC HEALTH IMPLICATIONS AND RECOMMENDATIONS**

This study yields empirical insights into how organizational preparedness and community readiness for public health emergency preparedness is characterized within a specific segment of community service provider organizations operating in East Harlem, New York City. This study is relevant for two important reasons: 1) it is a systematic investigation that builds upon a community-led pilot research project to examine how certain organizational factors are associated with the level of organizational preparedness; and 2) it is the first study, to this author's knowledge, that applies the concept of 'community readiness' using the Community Readiness Model to the field of emergency preparedness, specifically to public health emergency preparedness. Therefore, there is a heightened level of significance for this study considering the potential implications for the practice of public health emergency preparedness in communities similar to East Harlem.

#### **a. Implications**

As described earlier, East Harlem is a historically low-income, vulnerable, and minority community. As such, it is a neighborhood that "feels left out" by more than just public health emergency practitioners, but also by other policy makers and political leaders who have failed to allocate to East Harlem its fair share of resources. Further, the sociopolitical, cultural, economic, and community attributes of East Harlem make this community a useful setting to conjecture about vulnerability before, during, and after an emergency as something broader and more complex than just risk to disease and illness.

To potentially mitigate an inevitable public health crisis when a disaster occurs in communities like East Harlem, public health emergency preparedness practitioners must shift their resources to develop a robust local infrastructure to support preparedness at the neighborhood level. This focus at the neighborhood-level represents an important middle ground in the emergency management context – in between individual/household preparedness on one end and city/state/federal-wide systems on the other end. Without a shift to the neighborhood level, public health emergency management officials will not understand that susceptibility of vulnerable and minority communities to a disaster is determined not so much by the event itself but by social, economic, and political forces and geospatial factors that creates circumstances under which people face hazards.(14)

In 2009, Craig Fugate, Administrator of the Federal Emergency Management Agency, underscores this point with the following quote taken from his testimony before the Senate Subcommittee on Disaster Recovery, Committee on Homeland Security and Governmental Affairs:

*“In times of crisis, government plays a critical role in coordinating response and recovery efforts, especially in protecting and providing for the most vulnerable members of our population. The needs of children and other members of our communities with special access and functional needs cannot simply fall to secondary planning considerations, but must be one of the central focuses of our planning, response, and recovery.”(96)*

Despite Fugate’s statement, findings from other studies such as Saunders (2007) Honore (2008) and Davis (2010) suggest more research is needed because the literature currently does not capture the strain on health and exacerbation of health care disparities before and after a disaster in medically underserved communities. (97-99) In addition, researchers such as Andrulis et al continue to make the point that racially and ethnically diverse communities suffer a

disproportionate burden of adverse outcomes before, during and after a disaster and that research efforts are needed to prepare racially and ethnically diverse communities for public health emergencies.(9, 92, 100) While this author recognizes that the findings from this present study cannot be generalized to any population outside of East Harlem, these findings are generalizable to East Harlem. Further, this study's findings in conjunction with the findings from previously noted studies may motivate local emergency management officials, policy makers, and political leaders to formulate policies and implement programs that have protecting and providing for the most vulnerable members of New York City's population as their primary goal.

As noted earlier, this study may be the first of its kind that applies the concept of 'community readiness' to the field of emergency preparedness, specifically to public health emergency preparedness. This study showed that East Harlem is at critically low stage of community readiness. This examination was driven by the theoretical notion the state of community readiness reflects a community's ability to enact change – in the context of prevention - towards a community-identified issue.(30-35) Yet, the in the emergency preparedness context, the concept of readiness may never be well understood as it is sometimes collapsed with or considered as an attribute of the term *resiliency*.

The definition of resiliency is the ability to recover from or adjust easily to misfortune or change.(101) In the context of emergency management, this term is reactive in nature and based on the idea that an individual, group, or community has the ability to bounce back after a disaster. Whereas readiness, as a concept drawn from the substance abuse prevention literature, is proactive in nature and focuses on a community's ability to enact (prevention oriented) change towards a community-identified issue. To focus on the wherewithal of a community *after* a disaster leaves no opportunity for the community to benefit from what focusing on readiness

separately offers, which is a diagnosis of a community's ability to prepare for a disaster *before* it happens. Based on this study's intended use of the concept of readiness, specifically 'community readiness,' this author disagrees with the misguided conceptual collapse of these terms and posits that readiness and resilience should be treated as two separate concepts.

One example of the conceptual collapse of these terms is with the New York City Department of Health and Mental Hygiene Office of Emergency Preparedness and Response (OEPR, formerly known as the Bureau of Emergency Management). In August 2011, OEPR produced a report on the findings from a series of facilitated discussion groups on the topic community resiliency and recovery to establish a baseline of community resiliency with leaders from vulnerable, minority, and immigrant communities in New York City.(102) In this report, OEPR defines community resiliency as a community's capability to *prepare, withstand, and recover* from a natural or man-made disaster. Although some of the report's findings were consistent with findings from this study, when comparing the OEPR definition with the proper definition of resiliency, it is clear that OEPR is misusing this term. Specifically, OEPR's use of the term community resiliency suggests that it is being used as an all-encompassing phrase that includes what happens before, during, and after a disaster. However, the use of this term in this way is incorrect, misguided, and does not adequately focus on readiness to prepare for a disaster. Therefore, based on the findings from this study and in conjunction with the findings from other studies noted earlier, the OEPR may need to reevaluate the definition and use of the term.

## **b. Recommendations**

A specific recommendation offered by this study is to shift the focus of public health emergency preparedness towards the middle at community organizations that serve as primary

connectors to vulnerable groups. This shift in focus will involve maximizing the strengths and recognizing the limitations of community organizations.

Some of the strengths of community organizations, highlighted in this study, that could be optimized by public health emergency practitioners include having a long history with and high levels of experience providing short-term emergency services that match the services needed in the acute phase of a disaster or perceived imminent threats (such as gang violence, HIV/AIDS, substance use, high rates of unemployment.) (6) Other strengths include having a quick response time with their client base; flexibility to serve needs as they arise, such as family reunification; and a specialization in a small number of service needs to optimize resources.

In January 2012, this author presented this study's findings at a general membership meeting of the East Harlem Community Health Committee, Inc (EHCHC). After the presentation, the discussion focused on another important strength which was EHCHC's ability to form ad hoc partnerships with other community organizations to serve complementary needs (e.g., to identify efficient communication mechanisms or monitor referral pathways).

A consistent limitation of community organizations, as noted by this study and others is the lack of established relationships with the emergency response system, which leads to poor cross-sector collaboration and the inability to meet some needs (e.g. such as serving clients from a remote location or a scatter site). (6, 20, 21, 92, 93, 97, 100, 103-107) To address this limitation, this author recommends that public health emergency preparedness systems harness the power of health information and communication technologies to stay connected to "on the ground" community organizations. (96)

Further, this author recommends that emergency management and public health officials demand proactive and interested leadership, especially at the local level, to offer their political

will to close the adoption gap in communication technology, to help build and test technology infrastructure, and to support innovation in the tools and systems across sectors to communicate with at-risk and special needs groups. (96)

Recommendations for future research in public health emergency preparedness include conducting longitudinal as well as qualitative studies with vulnerable populations that can inform policy makers better as they to continue to invest federal, state, and city funding to increase the ability of our nation's cities, communities, and neighborhoods to prepare for and respond to public health emergencies, hazards, and disasters. Longitudinal studies would be better suited than cross-sectional surveys to assess economic changes and changes in living conditions over time. In addition, longitudinal studies may have a higher chance of experiencing the impact of a public health emergency, hazard, or disaster thereby offering a multiple points in time to examine readiness and resilience in action. Qualitative studies, on the other hand, could provide policy makers with valuable insights related to the daily living hazards of vulnerable populations and the strategies they believe would work best for them to prepare for and respond to public health emergencies, hazards, and disasters.

## **VI. APPENDICES**

## APPENDIX A.

### GENERIC COMMUNITY READINESS ASSESSMENT INTERVIEW QUESTIONS

1. Using a scale from 1-10, how much of a concern is this issue to your community with 1 being “not a concern at all” and 10 being “a very great concern”? Please explain. (D)  
(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)

#### **DIMENSIONS A & B. COMMUNITY EFFORTS AND KNOWLEDGE OF EFFORTS**

2. Are there efforts or programs in your community that address this issue? (A) **If YES, GO TO #2Y. IF NO, GO TO #2N.**

#### **RESPONDENT ANSWERED “YES” TO #2.**

2Y. Can you please describe these efforts? (A)

3. How long have these efforts been going on in your community? (A)

4. Who do these efforts serve? (Prompt: For example, individuals of a certain age group, ethnicity, etc.) (A)

5. Is there any additional planning for efforts/services going on in your community surrounding this issue? Please explain. (A)

6. Is there any evaluation of the current efforts? (A) **IF YES, GO TO #7. IF NO, GO TO #9.**

7. On a scale of 1 to 10, how sophisticated is the evaluation (with 1 being “not at all” and 10 being “very sophisticated?”)? (A)

**RESPONDENT ANSWERED "NO" TO #2.**

**2N. Is anyone in your community trying to get an effort started to address this issue?**

11. What are the strengths of these efforts? (B)
  
12. What are the weaknesses of these efforts? (B)
  
13. Would there be any segments of the community for which these efforts/services are or may appear inaccessible or unavailable? (Prompt: For example, individuals of a certain age group, ethnicity, income level, geographic region, etc.) (A)
  
14. Is there a need to expand these efforts/services? If not, why not? (A)
  
15. What formal or informal policies, practices and laws related to this issue are in place in your community, and for how long? (Prompt: An example of "formal" would be established policies of schools, police, or courts. An example of "informal" would be similar to the police not responding to calls from a particular part of town, etc.) (A)
  
16. Are there segments of the community for which these policies, practices and laws may not apply? (Prompt: For example, due to socioeconomic status, ethnicity, age, etc.) (A)
  
17. Is there a need to expand these policies, practices and laws? If so, are there plans to expand them? Please explain. (A)
  
18. How does the community view these policies, practices and laws? (A)

### ***DIMENSION C: LEADERSHIP***

*Optional: I'm now going to ask you some questions about how the leadership in your community perceives this issue. By leadership, we are referring to those who are perceived to represent a community and/or who lead the community in helping it achieve its goals.*

**19. Using a scale from 1 to 10, how much of a concern is this issue to the leadership in your community (with 1 being “not at all” and 10 being “of great concern”)? Please explain. (C)**  
*(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)*

**20. How is the leadership involved in efforts regarding this issue? (For example: Are they involved in a committee, task force, etc.? How often do they meet?) (C)**

**21. Would the leadership support additional prevention efforts? (C)**

*IF YES: How might they do that?*

### ***DIMENSION D: COMMUNITY CLIMATE***

**22. What is the overall feeling among community members regarding this issue, especially as it occurs in your community? (D)**

**23. Does the community support addressing this issue locally? (D)**

*IF YES: Could you please explain this, for example, how do they show this support?*

*IF NO: Could you please explain?*

***DIMENSION E: KNOWLEDGE ABOUT THE ISSUE***

24. How much do community members know about this issue in general? (e.g., signs, symptoms, consequences, effects on family and friends, etc.) (E)
25. How much do community members know about this issue as it pertains to your community? (e.g., do they know how often it occurs?) (E)
26. What type of information is available in your community about this issue (e.g. newspaper articles, brochures, posters)? (E)
27. Are there local data available on how this issue occurs in your community? (E)
- IF YES:* How do people obtain this information?

***DIMENSION F: RESOURCES FOR EFFORTS (time, money, people, space, etc.)***

28. What is the community's attitude toward supporting (prevention) efforts to address this issue, for example, local business, community foundations, citizens in general volunteering time, making financial donations, and/or providing space? (F)
29. Do efforts that address this issue have a broad base of volunteers? Please explain. (F)
30. On a scale from 1 to 10, what is the level of expertise and training among those working on this issue (with 1 being "very low" and 10 being "very high")? Please explain. (F)
- (NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)*
31. How are current efforts funded? Please explain. (F)

**32. Are you aware of any proposals or action plans that have been submitted for funding to address this issue in your community? IF YES: Please explain. (F)**

33. To whom would an individual affected by this issue turn to first for help in your community? Why?  
(F)

## **APPENDIX B.**

### **COMMUNITY READINESS MODEL ANCHORED RATING SCALE STATEMENTS**

#### **Dimension A. Existing Community Efforts**

- 1 No awareness or recognition of the need for efforts to address the issue.
- 2 No recognition of the need for local efforts to address the issue or active resistance to efforts.
- 3 A few individuals recognize the need to initiate some type of effort, but there is no immediate motivation to do anything.
- 4 Some community members have met and have begun a discussion of developing community efforts.
- 5 Efforts (programs/activities) are being planned.
- 6 Efforts (programs/activities) have been implemented.
- 7 Some efforts (at least 2 programs/activities) have been running for several years.
- 8 Several different programs, activities and policies are in place, covering different age groups and reaching a wide range of people. New efforts may be developed based on evaluation data.
- 9 Evaluation plans are routinely used to measure the effectiveness of the efforts, and the results are used to make changes and improvements.

#### **Dimension B. Community Knowledge Of The Efforts**

- 1 Community has no knowledge or recognition of the need for efforts addressing the issue.
- 2 Community has no knowledge about local efforts addressing the issue.
- 3 A few members of the community (other than those directly involved) have heard about local efforts. The extent of their knowledge is limited. (For example, they know local efforts exist and may know their names, but they have little other knowledge.)
- 4 Some members of the community have basic knowledge about local efforts. (For example, some may be able to identify specific efforts and tell you their basic purpose.)
- 5 Most members of the community have basic knowledge about local efforts. (For example, the majority may be able to identify specific efforts and tell you their basic purpose.)

6 An increasing number of community members have more than basic knowledge of local efforts. (For example, they may be able to tell you target audiences or specific aspects of the efforts.) Some in the community are working to increase the knowledge of the general community about these efforts.

7 Many in the community have specific knowledge of local efforts including target audience, specific aspects of program, contact persons, etc.

8 There is considerable community knowledge about different community efforts, as well as the level of program effectiveness.

9 Community has knowledge of program evaluation data on how well the different local efforts are working and their benefits and limitations.

### **Dimension C. Leadership (includes appointed leaders & influential community members)**

1 Leadership has no recognition of the issue.

2 Leadership believes that this is not an issue in their community.

3 At least some leaders recognize that this issue exists in their community and that there is a need to do something about it. They may not know what to do or not be involved in any planning of efforts.

4 Leader(s) is/are trying to get something started or are interested in supporting local planning efforts.

5 Leaders are actively involved or publicly supportive in **planning** efforts, possibly as part of a committee or group that addresses this issue.

6 Leaders are actively supportive of or involved in **implementing** efforts.

7 Leaders are actively supportive of continuing current efforts and of providing or finding resources for efforts to become self-sufficient.

8 Leaders are actively participating in expanding or improving efforts

9 Leaders are continually reviewing evaluation results of the efforts and are modifying support accordingly.

### **Dimension D. Community Climate**

1 The prevailing attitude is that it's not a concern. Issue may be overlooked or ignored. "It's the way things are."

- 2 Most community members don't think that anything needs to be done locally. Overall attitude is that "It's not happening here" or "there's nothing we can do" (it is inevitable).
- 3 Overall, the community climate is neutral, disinterested, or believes that the issue does not affect the community as a whole. A few in the community are thinking more about the issue, but there is no immediate motivation to act.
- 4 There is some recognition in the community that this is a concern and something should be done about it. "We have to do something, but what?"
- 5 The general attitude in the community is "we are concerned about this," and community members are beginning to reflect modest support for efforts.
- 6 The attitude in the community is "This is our responsibility" and is now beginning to reflect modest involvement in efforts.
- 7 The majority of the community generally supports programs, activities, or policies. "We have taken responsibility."
- 8 Some community members or groups may challenge specific programs, but the community in general is strongly supportive of the need for efforts. Participation level is high. "We need to keep up on this issue and make sure what we are doing is effective."
- 9 All major segments of the community are highly supportive, and community members are actively involved in evaluating and improving efforts and demand accountability.

#### **Dimension E. Community Knowledge About The Issue**

- 1 Not viewed as an issue.
- 2 No knowledge about the issue.
- 3 Only a few in the community have some knowledge about the issue, even though general information may be available.
- 4 Some community members have general knowledge about the issue (e.g. they may recognize signs and symptoms). General information about the issue is available but local information about the issue (e.g. prevalence) is lacking.
- 5 Community members know that this issue occurs locally, and some information about the local issue is available.
- 6 A majority of community members have some knowledge about the issue and know that it occurs locally. Local data (e.g. prevalence) are available.
- 7 Community members have knowledge of, and access to, detailed information about local prevalence.

8 Community members have knowledge about prevalence, causes, risk factors, and consequences.

9 Community members have detailed information about the issue as well as information about the effectiveness of local programs.

**Dimension F. Resources Related To The Issue (people, money, time, space, etc.)**

1 There is no awareness of the need for resources to deal with this issue.

2 There are no resources available for dealing with the issue.

3 The community is not sure what it would take, (or where the resources would come from) to initiate efforts.

4 The community has individuals, organizations, and/or space available that could be used as resources.

5 Some members of the community are looking into the available resources for dealing with the issue.

6 Resources have recently been obtained and/or allocated for better addressing this issue.

7 A considerable part of support of on-going efforts is from local sources that are expected to provide continuous support. Community members and leaders are beginning to look at continuing efforts by accessing additional resources.

8 Diversified resources and funds are secured and efforts are expected to be ongoing. There is additional support for further efforts.

9 There is continuous and secure support for programs and activities, evaluation is routinely expected and completed, and there are substantial resources for trying new efforts.

## APPENDIX C.

### COMMUNITY READINESS MODEL DIMENSION AND STAGES DESCRIPTION

DIMENSIONS	PRIMARY QUESTION
1. Community Efforts	To what extent are there efforts, programs, and policies that address the issue? Programs, Activities, Policies currently in place
2. Community Knowledge of the Efforts	To what extent do community members know about local efforts and their effectiveness? <ul style="list-style-type: none"> <li>• Level and depth of knowledge and awareness about disaster preparedness</li> <li>• Communication patterns</li> </ul>
3. Leadership	To what extent are appointed leaders and influential community members supportive of the issue? <ul style="list-style-type: none"> <li>• Importance of leadership</li> <li>• Identification of formal leadership</li> <li>• Identification of informal leadership</li> <li>• Roles of formal leaders</li> <li>• Roles of informal leaders</li> </ul>
4. Community Climate	What is the prevailing attitude of the community toward the issue? (e.g., helplessness, responsibility) <ul style="list-style-type: none"> <li>• Ranking of disaster preparedness and community readiness as a community priority</li> <li>• Agenda item at community meetings</li> </ul>
5. Community Knowledge About Community Issue	To what extent do community members know about the causes of the problem, consequences, and how it impacts your community?
6. Resources Related to the Issue	To what extent are local resources (listed below) available to support efforts? <ul style="list-style-type: none"> <li>• People resources</li> <li>• Time</li> <li>• Financial resources</li> <li>• Physical resources (i.e. space)</li> </ul>

Source: Edwards, 2000

**APPENDIX C. CONTINUED**

**COMMUNITY READINESS MODEL DIMENSION AND STAGES DESCRIPTION**

<b>STAGE</b>	<b>DESCRIPTION</b>
1. No awareness/tolerance	Issue not recognized or community norms actively tolerate the behavior
2. Denial	Recognize issues, but no awareness of relevance to a local problem or that local solutions can be effective
3. Vague awareness	Recognition of the local issue but no motivation or leadership
4. Preplanning	Understanding of the problem and solutions tend to be stereotyped and leaders and committee are incapacitated in real planning
5. Preparation	Active and energetic leadership and trial programs begun
6. Initiation	Program may be starting or still on trial. Enthusiasm still exists because limitation and problems have not been experienced
7. Institutionalization/ stabilization	Established funding with administrative support, no sense of the need for change or expansion though limitations may be recognized
8. Confirmation/ expansion	Funds for new programs being sought or committed, programs viewed as valuable and authorities support expansion through new programs or outreach of current programs
9. Professionalization Collaboration/ synthesis	Highly trained staff running the programs, supportive authorities and community involvement; effective evaluation leads to detailed and sophisticated knowledge of the related issues which is used to test and modify programs.

Source: Edwards, 2000

## APPENDIX D.

### GLOSSARY

- A. **Public Health Emergency Preparedness** refers to the capability of the public health and health care systems, communities, and individuals to prevent, protect against, quickly respond to, and recover from health emergencies, particularly those whose scale, timing, or unpredictability threatens to overwhelm routine capabilities. Informed by traditional emergency management practice, public health emergency preparedness involves a coordinated and continuous process of planning and implementation that relies on measuring performance and taking corrective action.(1, 2, 77)
- B. **Public Health Emergencies**, are considered in this proposal, as broadly defined as situations such as a disaster, significant outbreak of an infectious disease, bioterrorist attack or other significant or catastrophic event (e.g. coastal storm) whose scale, timing, or unpredictability threatens to overwhelm routine community capabilities to address them. Public health emergencies may also result from types of hazards such as building collapses or explosions that place populations at risk for illness, injury, or cause mass casualties due to structural damage, a gas leak, or sabotage; as well as from utility disruptions that may power computer systems and even operating life support systems.
- C. **Community Service Provider Organization** is broadly defined as a public or private organization that operates in East Harlem, is not a large public health or medical care organization [e.g. hospital or academic medical center], and provides a direct service component utilized by vulnerable and minority residents. These direct services are generally delivered “one on one” between the organizational representative and the individual in an organizational setting [e.g. older adults receiving lunch in a senior center as part of the organization’s nutrition program] or in a community setting depending on the nature of the direct service [e.g. a drug treatment’s community outreach condom distribution program]. This segment of organizations typically play a critical role as the primary connectors between community members and service systems that they need and can serve as a critical partner to emergency management officials and others during formal public health emergency response efforts by carrying out uniquely specific roles.
- D. **Response Roles of Interest:** Community service provider organizations can effectively serve as: 1) culturally and community-tailored emergency risk communicators; 2) coordinators and facilitators of information, resources, and services for vulnerable and minority population; and 3) providing or staffing or identifying locations in the community to maximize utilization of emergency points of distribution.
- E. **Organizational leaders** are selected based senior level management or leadership position titles such as Executive Director, Senior Director, Center Director, Commissioner, Chief, or Program Director depending on the organizational structure. Based on what I have examined in the emergency management and leadership research literature, I am specifically interested in those individuals with a high impact leadership role in the organization and have the ability to influence the culture and operations of the community organization

F. **Community Readiness** reflects a community's ability to enact change towards a community-identified issue or in this case, ability to engage in a process of conducting emergency preparedness activities. Although, the meaning of 'readiness' as it is used in emergency management is often used interchangeably with the term 'preparedness', in this context, 'readiness' has a conceptually different meaning at the community level. The concept of 'community readiness,' developed in the community psychology and abuse prevention literature, reflects a community's ability to enact change towards a community-identified issue.(30-35) Indeed, if a community is not ready to enact change, activities focused on that change are likely to be unsuccessful or short-lived.

## APPENDIX E.

### PROJECT ADVISORY GROUP (PAG) MEMBERS

**Eric Canales** Community resident, Co-Chair of the Human Services Consortium of East Harlem Inc., Board Member of East Harlem Community Health Committee Inc., Co-Project Leader of the East Harlem Emergency Preparedness Project.

**Ingrid Gonzalez** Community health advocate; member of the Harlem Community & Academic Partnership.

**Sister Mary Nerney** Community resident; member of the Harlem Community & Academic Partnership; Treasurer of Human Services Consortium of East Harlem, Inc.

**Jose Martin Orduna:** Community health advocate; member of the Human Services Consortium of East Harlem; Network Director of the Manhattan HIV Care Network; member of the Harlem Community & Academic Partnership.

**APPENDIX F.**  
**CROSS-SECTIONAL ONLINE SURVEY TOOL**

# Organizational Preparedness for a Public Health Emergency

## Greetings

GREETINGS!

### Study Title

Organizational Preparedness and Community Readiness for a Public Health Emergency among Community Service Provider Organizations in East Harlem.

### Study Purpose

You are being asked to participate in a dissertation research study being conducted by Ann-Gel S. Palermo MPH, a doctorate student from the CUNY Graduate Center. This study has been approved by the Institutional Review Board of the CUNY Graduate Center. The purpose of this study is to learn how a public health emergency which is defined as any disaster or crisis such as a storm causing extensive flooding, a widespread and prolonged power outage, or an outbreak of a serious infectious disease such as the pandemic flu might affect you or your organization, how prepared you and your organization is prepared for an emergency or disaster, your level of confidence in your organization in responding to a public health emergency, as well as specific characteristics about you and your organization.

### Study Procedures

If you decide to participate in this study, you will complete an anonymous online survey that should not take more than 15 minutes to complete. It is estimated that approximately 75 East Harlem community service provider organizational leaders, like yourself, will be asked to complete this survey

### Study Risks

There is no risk to you in completing this survey.

### Study Benefits

You may or may not benefit personally from this study. Benefits may include expression of your feelings and opinions. The study will help to identify gaps in emergency preparedness among community service provider organizations in East Harlem.

### Costs

There will be no costs to you for taking part in this study.

### Confidentiality

Your name will not be recorded, used, or released in any of the survey data or results. Your participation in this survey is completely voluntary. While individual responses are anonymously obtained and recorded online data is kept in the strictest confidence. Your email addresses will be tracked using response tracking feature in SurveyMonkey for follow-up notices, but your name and email address are not associated with your survey responses. Ms. Palermo will know if you completed the survey, but will not be able to identify individual responses, therefore maintaining anonymity for the survey. The results of this study will be coded in such a way that your identity cannot be linked to your email address. Once the study is complete, all of the data will be presented using averages or generalizations about the responses as a whole. All data will be stored in a secure location in password protected files accessible only to Ms. Palermo. Upon completion of the study, all information and files will be destroyed. Final aggregate results will be made available to you upon request. The results of this study will be presented at the dissertation defense meeting at the CUNY Graduate Center and at one general monthly membership meeting of the East Harlem Community Health Committee, Inc., the Human Services Consortium of East Harlem, and Community Board 11.

### Participation & Withdrawal

Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind. You can choose not to answer any question if it makes you feel uncomfortable or embarrassed. You are free to withdraw your consent to participate and stop taking part in the survey at any time.

## Organizational Preparedness for a Public Health Emergency

At the end of this survey, you will be asked about your willingness to share your contact information to participate in Part 2 of this dissertation research project. The second part of the dissertation research project involves participating in an in-depth interview on community readiness for a public health emergency.

# Organizational Preparedness for a Public Health Emergency

## Questions about the Study

If you have questions or concerns during the time of your participation in this study, or after its completion or you would like to receive a copy of the results of this study, please contact:

Ann-Gel S. Palermo, MPH

Doctorate of Public Health Program

Tel: 646-528-3078

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## Questions about Your Rights as a Research Subject

Kay Powell

Institutional Review Board (IRB) Administrator

The Graduate Center

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For IRB Information go to: <http://web.gc.cuny.edu/orup/>

**\*1. I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. I certify that I am at least 18 years of age. By clicking on the link below, and completing and submitting this anonymous online survey, I am consenting to participate in this survey.**

YES, I AGREE TO TAKE THE SURVEY

NO, I DON'T AGREE TO TAKE THE SURVEY

# Organizational Preparedness for a Public Health Emergency

## Organizational Preparedness

This survey is about how a public health emergency, disaster or crisis might affect you and your organization and how prepared you and your organization are for an emergency.

In responding to the following items, think about major emergencies like a storm causing extensive flooding, a widespread and prolonged power outage, or an outbreak of a serious infectious disease in East Harlem or New York City wide.

To what extent do you agree with the following statements about your organization? The response categories are Strongly Disagree (1), Disagree (2), Agree (3), and Strongly Agree (4).

### **2. I am very familiar with our building's evacuation plan.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

### **3. It would be easy for a potentially threatening non-employee to gain access to my workplace.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

### **4. If my organization suffered a serious crisis, I might lose my job.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

### **5. If my organization suffered a serious crisis, I would still get paid until we could reopen.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

# Organizational Preparedness for a Public Health Emergency

**6. My organization has provided each employee with a basic emergency preparedness kit (e.g. flashlight, smoke mask, etc.).**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

**7. The security at my workplace is adequate.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

**8. If a crisis occurred at my organization, I am familiar with the plan for how family members can get information on the status (e.g. safety) of their relatives.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

**9. In the event of an emergency or disaster, I am familiar with my organization's plan to continue operations from another location.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

**10. All organization members are required to rehearse portions of our crisis plan, for example, evacuation.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

# Organizational Preparedness for a Public Health Emergency

**11. If my organization suffered a serious crisis, I would still have my job.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

**12. If my organization suffered a crisis, I would still be covered by my organization's employee benefits (e.g. health insurance, etc.).**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

**13. Security at my workplace has been significantly increased since 9/11/2001.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

**14. I know where the nearest fire extinguisher is to my desk/workstation.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

**15. If a crisis and evacuation occurred at my organization, I am familiar with our plan on how to communicate with my fellow employees from scattered or emergency locations (such as cell phone numbers, websites, or email lists).**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

# Organizational Preparedness for a Public Health Emergency

**16. Most of our employees are familiar with my organization's crisis/disaster plan.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

**17. As part of our emergency plan, the people we serve would be able to contact us for information.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

**18. If my organization suffered a crisis/disaster, I would have the data I need to do my job backed up at a remote site.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

**19. My organization offers to pay to have volunteer employees trained in basic life support techniques, such as CPR, first aid, etc.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

**20. My organization has contingency plans in place so our customers/patients/clients would be covered if we suffered a disaster.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

# Organizational Preparedness for a Public Health Emergency

## **21. I know where the nearest emergency exits are to my desk/workstation.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

## **22. My organization's emergency plan has been coordinated with local agencies, such as the fire department, hospitals, etc.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

# Organizational Preparedness for a Public Health Emergency

## Organizational Preparedness - Continued

The next set of questions are about specific activities your organization does or could do to prepare for or respond to a major public health emergency such as a storm causing extensive flooding, a widespread and prolonged power outage, or an outbreak of a serious infectious disease.

To what extent do you agree with the following statements about your organization?

The response categories are Strongly Disagree (1), Disagree (2), Agree (3), and Strongly Agree (4).

**23. My organization has determined the potential impact of a public health emergency on our organization's usual activities.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

**24. When developing information materials, my organization considers the culture, language, and reading levels of our staff and the individuals served in East Harlem?**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

**25. If East Harlem suffered from a public health emergency, my organization would know to best share accurate information, and avoid rumors, misinformation, fear and anxiety among the individuals we serve.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

## Organizational Preparedness for a Public Health Emergency

**26. My organization has contingency plans in place for persons with special needs (e.g. elderly, disabled, limited English speaking) if East Harlem suffered from a public health emergency.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

**27. My organization has established relationships with our most vulnerable and special needs populations groups in advance so they will expect and trust our presence during a public health emergency.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

**28. If East Harlem suffered from a public health emergency, my organization can serve as:**

	Strongly Disagree	Disagree	Agree	Strongly Agree
Culturally and community-tailored emergency risk communicators to the individuals we serve	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coordinators and facilitators of information, resources, and services for the individuals we serve	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Providing, staffing, or identifying locations in the community to maximize utilization of emergency points of distribution (e.g. food, clothing, shelter).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

# Organizational Preparedness for a Public Health Emergency

## Individual Preparedness

Next, we want to learn more about how prepared you are personally for a public health emergency such as a storm causing extensive flooding, a widespread and prolonged power outage, or an outbreak of a serious infectious disease.

Please respond YES or NO if anyone in your household has stocked your house with any of the following supplies to prepare for an emergency.

### 29. A flashlight, lantern, or candles?

- Yes
- No

### 30. A battery-powered or hand-crank radio?

- Yes
- No

### 31. At least 3 days of water and non-perishable food for your household?

- Yes
- No

### 32. Dust masks?

- Yes
- No

### 33. Extra batteries?

- Yes
- No

### 34. A first aid kit?

- Yes
- No

### 35. Extra Cash?

- Yes
- No

# Organizational Preparedness for a Public Health Emergency

## Individual Preparedness Continued

Please respond YES or NO or Not Applicable if anyone in your household has performed any of the following activities to prepare for an emergency.

### 36. Safely stored important documents?

- Yes
- No
- Not Applicable

### 37. Set aside extra prescription medications or copies of prescriptions?

- Yes
- No
- Not Applicable

### 38. Discussed or located utility shut-off's?

- Yes
- No
- Not Applicable

### 39. Put together an emergency kit for the car?

- Yes
- No
- Not Applicable

### 40. Located a shelter that you can go to?

- Yes
- No
- Not Applicable

### 41. Made a list of important contact phone numbers and given it to family members?

- Yes
- No
- Not Applicable

## Organizational Preparedness for a Public Health Emergency

### 42. Took a first aid or CPR classes?

- Yes
- No
- Not Applicable

### 43. Developed a home escape plan?

- Yes
- No
- Not Applicable

### 44. Conducted an evacuation plan or fire drill?

- Yes
- No
- Not Applicable

### 45. Found out designated evacuation routes from your community?

- Yes
- No
- Not Applicable

### 46. Arranged a family meeting place or reconnection plan?

- Yes
- No
- Not Applicable

### 47. Maintained at least 1/4 tank of gas in all vehicles at all times?

- Yes
- No
- Not Applicable

# Organizational Preparedness for a Public Health Emergency

## Organizational Confidence

Next, we want to learn more about your organization's "sense of can do" or "sense of confidence" to respond to and work in collaboration internally and externally when a public health emergency occurs.

In thinking about your organization, please indicate to what extent you agree with the following statements by checking the appropriate box.

The response options are Strongly Agree (1), Agree (2), Agree Somewhat (3), Disagree Somewhat (4), Disagree (5), Strongly Disagree (6).

### **48. People in this organization can take on any challenge.**

- Strongly Agree
- Agree
- Agree Somewhat
- Disagree Somewhat
- Disagree
- Strongly Disagree

### **49. This organization can beat our competition.**

- Strongly Agree
- Agree
- Agree Somewhat
- Disagree Somewhat
- Disagree
- Strongly Disagree

### **50. This organization is far more innovative than most organizations.**

- Strongly Agree
- Agree
- Agree Somewhat
- Disagree Somewhat
- Disagree
- Strongly Disagree

# Organizational Preparedness for a Public Health Emergency

**51. In this organization, we coordinate our efforts to complete difficult projects.**

- Strongly Agree
- Agree
- Agree Somewhat
- Disagree Somewhat
- Disagree
- Strongly Disagree

**52. People in this organization can work together to accomplish a goal.**

- Strongly Agree
- Agree
- Agree Somewhat
- Disagree Somewhat
- Disagree
- Strongly Disagree

**53. People in this organization can mobilize efforts to accomplish difficult and complex goals.**

- Strongly Agree
- Agree
- Agree Somewhat
- Disagree Somewhat
- Disagree
- Strongly Disagree

**54. In this organization, everyone works together very effectively.**

- Strongly Agree
- Agree
- Agree Somewhat
- Disagree Somewhat
- Disagree
- Strongly Disagree

## Organizational Preparedness for a Public Health Emergency

**55. This organization can meet customer requirements because the employees are extremely competent.**

- Strongly Agree
- Agree
- Agree Somewhat
- Disagree Somewhat
- Disagree
- Strongly Disagree

**56. People here have a sense of purpose.**

- Strongly Agree
- Agree
- Agree Somewhat
- Disagree Somewhat
- Disagree
- Strongly Disagree

# Organizational Preparedness for a Public Health Emergency

## Organizational and Organizational Leader Background Information

You are almost done! Now we want to learn more about your background and the organization you work for.

### 57. What is your gender?

- Female
- Male
- Transgender

### 58. Which category below includes your age?

- 18-20
- 21-29
- 30-39
- 40-49
- 50-59
- 60 or older

### 59. Are you now married, widowed, divorced, separated, or never married?

- Married
- Widowed
- Divorced
- Separated
- Never married

### 60. Do you currently live in East Harlem?

- Yes
- No

### 61. Not including yourself, how many other people live with you?

- None, I live alone
- 1-3
- 4-6
- More than 7

## Organizational Preparedness for a Public Health Emergency

### 62. How many children under the age 18 years of age live with you?

- None
- 1-3
- 4-6
- More than 7

### 63. Are you White, Black or African-American, American Indian or Alaskan Native, Asian, Native Hawaiian or other Pacific islander, or some other race?

- White
- Black or African-American
- American Indian or Alaskan Native
- Asian
- Native Hawaiian or other Pacific Islander
- From multiple races

Some other race (please specify)

### 64. Are you Mexican, Mexican-American, Chicano, Puerto Rican, Cuban, Cuban-American, or some other Spanish, Hispanic, or Latino group?

- I am not Spanish, Hispanic, or Latino
- Mexican
- Mexican-American
- Chicano
- Puerto Rican
- Cuban
- Cuban-American
- Some other Spanish, Hispanic, or Latino group
- From multiple Spanish, Hispanic, or Latino groups

# Organizational Preparedness for a Public Health Emergency

## 65. Which ONE category BEST describes the type of organization you work for?

- Primary Care/Community Health Clinic
- Legal Support Services
- Educationally-based (e.g. School)
- Drug Treatment
- Faith-based
- Youth Development
- Multiservice
- Housing Development/Support

Other (please specify)

## 66. How many years has your organization been providing direct services in East Harlem?

- Less than 10 years
- 11-20 years
- More than 20 years

## 67. Approximately, how many individuals does your organization serve in East Harlem on an annual basis?

- Less than 1,000
- 1,000 to 3,000
- 3,001 to 5,000
- Over 5,000

## 68. How many full-time employees work at your organization?

- Less than 50
- 51-100
- Over 100
- Don't Know

## Organizational Preparedness for a Public Health Emergency

**69. What is the estimated operational budget of the organization you work for?**

- Less than \$100,000
- \$100,001 to \$500,000
- Over \$500,000
- Don't Know

# Organizational Preparedness for a Public Health Emergency

## Willingness to Participate in Part 2 of Dissertation Research Study

I want to thank you again for taking the time to complete this survey.

As noted before starting this survey, if you are willing to participate in Part 2 of this dissertation research study, please provide your contact information below. The second part of this study involves doing in-depth interviews with organizational leaders like yourself about the general state of community readiness to engage in emergency preparedness activities for a public health emergency in East Harlem.

Your contact information will only be used for the sole purpose of possibly contacting you if you are selected to be interviewed. More information about the in-depth interview will be provided at that time, including your consent to participate if you are selected.

**70. If you are willing to participate in Part 2 of this dissertation research study, please enter your contact information below.**

**Name:**

**Organization Name:**

**Email Address:**

**Phone Number:**

**APPENDIX G.**  
**NOTIFICATION EMAIL FROM COMMUNITY COALITIONS**  
**(Sample shown here is from the Human Services Consortium of East Harlem, Inc.)**

Dear Colleagues,

On behalf of the Human Services Consortium of East Harlem, we are writing to make you aware of an important survey about Organizational Preparedness for a Public Health Emergency among Community Service Provider Organizations in East Harlem that will be sent to you in a few days via email from Ann-Gel Palermo. We allowed her access to our email mailing list based on the provision that it only be used for this purpose and at the end of the study, the email mailing list for this study will be archived.

This survey is part of the dissertation research study of Ann-Gel who is a member of our coalition. We are in support of her work because it builds upon our earlier project called the East Harlem Emergency Preparedness (2006-07) which was done in collaboration with the East Harlem Community Health Committee, Inc. It will not take more than 15 minutes to complete the survey, so we hope you are able to complete it when you receive it.

Lastly, we also want to make you aware that at the end of this survey, you will be asked about your willingness to participate in the Part 2 of this dissertation research project.

We thank you in advance for you participation. Please direct any questions about the survey to Ann-Gel Palermo at [apalermo21@gmail.com](mailto:apalermo21@gmail.com).

Sincerely,

Eric Canales

**APPENDIX H.**  
**AMALGAMATED ORGANIZATIONAL PREPAREDNESS SCALE**

**Crisis and/or Disaster Preparedness Scale (Fowler et al, 2007)**

1 = *strongly disagree*, 2 = *disagree*, 3 = *agree*, 4 = *strongly agree*

1. I am very familiar with our building's evacuation plan.
2. It would be easy for a potentially threatening nonemployee to gain access to my workplace. (R)
3. If my organization suffered a serious crisis, I might lose my job. (R)
4. If my organization suffered a serious crisis, I would still get paid until we could reopen.
5. My organization has provided each employee with a basic emergency preparedness kit (e.g., flashlight, smoke mask, etc.).
6. The security at my workplace is adequate.
7. If a crisis occurred at my organization, I am familiar with the plan for how family members can get information on the status (e.g., safety) of their relatives.
8. In the event of an emergency or disaster, I am familiar with my organization's plan to continue operations from another location.
9. All organization members are required to rehearse portions of our crisis plan, for example, evacuation.
10. If my organization suffered a serious crisis, I would still have my job.
11. If my organization suffered a crisis, I would still be covered by my organization's employee benefits (e.g., health insurance, etc.).
12. Security at my workplace has been significantly increased since 9/11/2001.
13. I know where the nearest fire extinguisher is to my desk/workstation.
14. If a crisis and evacuation occurred at my organization, I am familiar with our plan on how to communicate with my fellow employees from scattered or emergency locations (such as cell phone numbers, websites, or e-mail lists).
15. Most of our employees are familiar with my organization's crisis/disaster plan.
16. As part of our emergency plan, the people we serve would be able to contact us for information.
17. If my organization suffered a crisis/disaster, I would have the data I need to do my job backed up at a remote site.
18. My organization offers to pay to have volunteer employees trained in basic life support techniques, such as CPR, first aid, etc.
19. My organization has contingency plans in place so our customers would be covered if we suffered a disaster.
20. I know where the nearest emergency exits are to my desk/workstation.
21. My organization's emergency plan has been coordinated with local agencies, such as the fire department, hospitals, etc.

Note: (R) = Reversed scored items

## APPENDIX I.

### CENTERS FOR DISEASE CONTROL AND PREVENTION EMERGENCY PREPAREDNESS CHECKLIST FOR FAITH-BASED AND COMMUNITY ORGANIZATIONS (ABBREVIATED)

#### CDC Checklist Items Response Scale 2=Yes, 1= No, 0=In progress\*

22. Has your organization determined the potential impact of a public health emergency on your organization's usual activities?
23. Do you ensure that what you communicate is appropriate for the culture, language, and reading levels of your staff and the individuals you serve in East Harlem?
24. When communicating to the individuals you serve in East Harlem, have you considered the unique contribution your organization may have to address rumors, misinformation, fear and anxiety when a public health emergency occurs?
25. Have you identified persons with special needs (e.g. elderly, disabled, limited English speaking) and be sure to include their needs in your response and preparedness plans?
26. Have you established relationships with these vulnerable and special needs populations groups with them in advance so they will expect and trust your presence during a public health emergency?

**\*Questions were modified and adapted to a 4 point likert scale.**

## APPENDIX J.

### INDIVIDUAL LEVEL PREPAREDNESS - NUMBER OF EMERGENCY ITEMS Adapted from Paek et al. (29)

*Please tell me if anyone in your household has stocked your house with any of the following supplies to prepare for an emergency....Please answer YES (1) or NO (0):*

1. A flashlight, lantern, or candles?
2. A battery-powered or hand-crank radio?
3. At least 3 days of water and nonperishable food?
4. Dust masks
5. A store of batteries
6. A first aid kit?
7. Extra cash?

*Please tell me if anyone in your household has performed any of the following activities to prepare for an emergency...Please answer YES (1) or NO (0).*

8. Safely stored important documents?
9. Set aside extra prescription medications or copies of prescriptions?
10. Discussed or located utility shut-offs?
11. Put together an emergency kit for the car?
12. Located a shelter that you can go to ?
13. Made a list of important contact phone numbers and given it to family members?
14. Take a first aid or CPR classes?
15. Developed a home escape plan?
16. Conducted an evacuation or fire drill?
17. Found out designated evacuation routes from your community?
18. Arranged a family meeting place or reconnection plan?
19. Maintained at least ¼ tank of gas in all vehicles at all times?

## **APPENDIX K.**

### **ADAPTED ORGANIZATIONAL EFFICACY SCALE – Bohem Scale Items (43)**

#### **Items on Collaboration Factor:**

1. People in this organization can take on any challenge
2. This organization can beat our competition.
3. This organization is far more innovative than most organizations.
4. In this organization, we coordinate our efforts to complete difficult projects.
5. People in this organization can work together to accomplish a goal.
6. People in this organization can mobilize efforts to accomplish difficult and complex goals.
7. In this organization, everyone works together very effectively.
8. This organization can meet customer requirements because the employees are extremely competent.
9. People here have a sense of purpose.

**Response Scale: 6= Strongly Agree, 5=Agree, 4=Agree Somewhat, 3=Disagree Somewhat, 2=Disagree, 1=Disagree**

**APPENDIX L.  
INTERVIEW PROTOCOL  
TABLE OF CONTENTS**

Principal Investigator: Ann-Gel Palermo, MPH – DPH Program

**IRB PROTOCOL #: 11-06-161-0135**

Project Title: Organizational Preparedness and Community Readiness for a Public Health Emergency among  
Community Service Provider Organizations in East Harlem.

	<b>PAGES</b>
• <b>INTERVIEW PROTOCOL FOR COMMUNITY READINESS IN-DEPTH INTERVIEWS</b>	<b>2-3 MODEL</b>
• <b>COMMUNITY READINESS MODEL WRITTEN CONSENT (2 Copies)</b>	<b>4-9</b>
• <b>COMMUNITY READINESS MODEL INTERVIEW TOOL</b>	<b>10-17</b>
• <b>RECEIPT OF PAYMENT CONFIRMATION</b>	<b>18</b>
• <b>INTERVIEWER REFLECTION FORM</b>	<b>19</b>

*ITALIC TEXT IS WHAT IS READ TO THE INTERVIEWEE.  
TEXT BOUNDED BY [ ] ARE INTRUCTIONS TO THE INTERVIEWER*

## **PART I INTERVIEW PROTOCOL**

**INTERVIEWER:** This protocol is your guide on how to initiate, conduct, and complete the interview.

### **INITIATION OF INTERVIEW:**

#### **GREETING AND INSTRUCTIONS**

*Good morning (afternoon). My name is \_\_\_\_\_. Thank you for making time to conduct this interview. This interview involves 34 questions, most are open-ended. The purpose of this interview is to better understand the level of readiness in East Harlem to engage in a process to prepare for and respond to a public health emergency, disaster or crisis such as a storm causing extensive flooding, a widespread and prolonged power outage, or an outbreak of a serious infectious disease. There are no right or wrong or desirable or undesirable answers. I would like you to feel comfortable with saying what you really think and how you really feel.*

#### **PREAMBLE/CONSENT FORM INSTRUCTIONS**

*Before we get started, please take a few minutes to read this preamble and consent form. [Hand Respondent consent form/preamble - Part II.]*

*Please let me know if you have any questions and I will do my best to respond. [Be sure the respondent has read the document and consented accordingly.]*

### **TRANSITION TO CONDUCT INTERVIEW:**

*Great! Thank you.*

#### **AUDIO RECORDER INSTRUCTIONS**

*If it is okay with you, I will be audio-recording our conversation. The purpose of this is so that I can get all the details but at the same time be able to carry on an attentive conversation with you. I assure you that all your comments will remain confidential.*

#### **INTERVIEW INSTRUCTIONS**

*Now let's begin the interview. [Proceed with the questions as written in PART III CRM interview tool beginning on page 6 of this document.]*

### **COMPLETING THE INTERVIEW:**

#### **COMPENSATION INSTRUCTIONS**

Once the interview is complete, please provide the \$40 cash compensation to the participant and use the confirmation receipt form provided on page 14 to document signature and date.

#### **INTERVIEWER REFLECTION INSTRUCTIONS**

After you have completed the interview, please take a couple of minutes to indicate your reactions and observations about the interview. An electronic copy of this form has been provided at the end of the interview tool or on page 15. Feel free to use this hard copy for your own notes, but please submit the electronic copy for official use.

**PART II. COMMUNITY READINESS MODEL WRITTEN CONSENT FORM**  
**INTERVIEWER COPY**

\*\*\*\*\*

**Study Title:** Organizational Preparedness and Community Readiness for a Public Health Emergency among Community Service Provider Organizations in East Harlem.

**Study Purpose**

You are being asked to participate in a dissertation research study being conducted by Ann-Gel S. Palermo MPH, a doctorate student from the CUNY Graduate Center/Hunter College School of Public Health. The purpose of this interview to better understand the level of readiness in East Harlem to engage in a process to prepare for and respond to a public health emergency, disaster or crisis such as a storm causing extensive flooding, a widespread and prolonged power outage, or an outbreak of a serious infectious disease.

**Study Procedures**

Six organizational leaders will be interviewed for this study. If you decide to participate in this study, you will be interviewed and asked a series of questions about community efforts to address public health emergency preparedness, community knowledge of the efforts, leadership, community climate, community knowledge about public health emergency preparedness, and resources related to public health emergency preparedness which should not take more than 45-60 minutes to complete.

**Study Risks**

There is no anticipated risk to you in participating in this interview.

**Study Benefits**

You may or may not benefit personally from this study. Benefits may include expression of your feelings and opinions. The study will help to identify various areas to improve the level of community readiness in East Harlem to prepare for a public health emergency.

**Costs**

There will be no costs to you for taking part in this study.

**Compensation**

For your participation in the interview, you will receive \$40 cash.

**Confidentiality**

Your name will not be asked or recorded, used, or released in any of the interview data or results. You are free to take back your consent to participate and stop taking part in the survey interview at any time. If there are questions that you do not want to answer, you do not have to answer them, and you may ask me to move on to the next question. Should you wish to stop the interview before it is completed be sure to let me know. Remember that participation in this study is voluntary and confidential.

For each question that I ask you, I will record your response by hand. I will also audio record the interview to make sure I did not miss anything in your response. The information will be transcribed and reviewed by Ms. Palermo and will be used to guide future efforts in addressing emergency preparedness in East Harlem. The written interview responses and audio tapes will be kept in a locked file and will be available only to Ms. Palermo. Upon completion of the study, all information will be destroyed. Final aggregate results will be made available to you upon request. The results of this study will be presented at the dissertation defense meeting at the CUNY Graduate Center and at one general

monthly membership meeting of the East Harlem Community Health Committee, Inc., the Human Services Consortium of East Harlem, and Community Board 11.

**Written Agreement:**

I volunteer to participate in this interview. I have had a chance to ask questions and have them answered. Signing this document means that the research study, including the above information, has been described to me orally, and that I voluntarily agree to participate.

\_\_\_\_\_  
Print Name of Participant

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

**Audio Recording Consent:**

Parts of the recording of the session will be transcribed to written form, without identifying the speakers. The recording will be erased when all data from it have been reviewed and coded

**I AGREE TO HAVE THIS INTERVIEW AUDIO-RECORDED.**

**CIRCLE ONE: YES OR NO**

**Questions about the Study**

If you have questions or concerns during the time of your participation in this study, or after its completion or you would like to receive a copy of the results of this study, please contact:

Ann-Gel S. Palermo  
Doctorate of Public Health Program  
City University of New York School of  
Public Health at Hunter College  
Tel: 646-528-3078  
Email: [apalermo21@gmail.com](mailto:apalermo21@gmail.com)

Luisa Borrell, DDS, PhD  
Associate Professor  
Department of Health Sciences  
Graduate Program in Public Health Lehman  
College  
City University of New York School of Public  
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**Questions about Your Rights as a Research Subject**

Kay Powell  
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**For IRB Information go to: <http://web.gc.cuny.edu/orup/>**

**PART II. COMMUNITY READINESS MODEL WRITTEN CONSENT FORM**  
**INTERVIEWEE COPY**

\*\*\*\*\*

**Study Title:** Organizational Preparedness and Community Readiness for a Public Health Emergency among Community Service Provider Organizations in East Harlem.

**Study Purpose**

You are being asked to participate in a dissertation research study being conducted by Ann-Gel S. Palermo MPH, a doctorate student from the CUNY Graduate Center/Hunter College School of Public Health. The purpose of this interview to better understand the level of readiness in East Harlem to engage in a process to prepare for and respond to a public health emergency, disaster or crisis such as a storm causing extensive flooding, a widespread and prolonged power outage, or an outbreak of a serious infectious disease.

**Study Procedures**

Six organizational leaders will be interviewed for this study. If you decide to participate in this study, you will be interviewed and asked a series of questions about community efforts to address public health emergency preparedness, community knowledge of the efforts, leadership, community climate, community knowledge about public health emergency preparedness, and resources related to public health emergency preparedness which should not take more than 45-60 minutes to complete.

**Study Risks**

There is no anticipated risk to you in participating in this interview.

**Study Benefits**

You may or may not benefit personally from this study. Benefits may include expression of your feelings and opinions. The study will help to identify various areas to improve the level of community readiness in East Harlem to prepare for a public health emergency.

**Costs**

There will be no costs to you for taking part in this study.

**Compensation**

For your participation in the interview, you will receive \$40 cash.

**Confidentiality**

Your name will not be asked or recorded, used, or released in any of the interview data or results. You are free to take back your consent to participate and stop taking part in the survey interview at any time. If there are questions that you do not want to answer, you do not have to answer them, and you may ask me to move on to the next question. Should you wish to stop the interview before it is completed be sure to let me know. Remember that participation in this study is voluntary and confidential.

For each question that I ask you, I will record your response by hand. I will also audio record the interview to make sure I did not miss anything in your response. The information will be transcribed and reviewed by Ms. Palermo and will be used to guide future efforts in addressing emergency preparedness in East Harlem. The written interview responses and audio tapes will be kept in a locked file and will be available only to Ms. Palermo. Upon completion of the study, all information will be destroyed. Final aggregate results will be made available to you upon request. The results of this study will be presented at the dissertation defense meeting at the CUNY Graduate Center and at one general

monthly membership meeting of the East Harlem Community Health Committee, Inc., the Human Services Consortium of East Harlem, and Community Board 11.

**Written Agreement:**

I volunteer to participate in this interview. I have had a chance to ask questions and have them answered. Signing this document means that the research study, including the above information, has been described to me orally, and that I voluntarily agree to participate.

\_\_\_\_\_  
Print Name of Participant

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

**Audio Recording Consent:**

Parts of the recording of the session will be transcribed to written form, without identifying the speakers. The recording will be erased when all data from it have been reviewed and coded

**I AGREE TO HAVE THIS INTERVIEW AUDIO-RECORDED.**

**CIRCLE ONE: YES OR NO**

**Questions about the Study**

If you have questions or concerns during the time of your participation in this study, or after its completion or you would like to receive a copy of the results of this study, please contact:

Ann-Gel S. Palermo  
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## PART III. COMMUNITY READINESS MODEL INTERVIEW TOOL

**[WE ARE NOW GOING TO BEGIN THE INTERVIEW.]**

1. Using a scale from 1-10, how much of a concern is preparedness for a public health emergency in East Harlem with 1 being “not a concern at all” and 10 being “a very great concern”? Please explain why you chose that number. (D)

*(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)*

### **DIMENSIONS A & B. COMMUNITY EFFORTS AND KNOWLEDGE OF EFFORTS**

2. Are there efforts or programs in East Harlem that address preparedness for public health emergencies? (A)

**WATCH  
FOR  
SKIP**

**IF THE RESPONSE IS YES, FOLLOW ARROW TO #2Y AND PROCEED.**

**IF THE RESPONSE IS NO OR DON'T KNOW, FOLLOW ARROW TO #2N**

→ 2Y. Can you please describe these efforts? (A)

3. How long have these efforts been going on in East Harlem? (A)

4. Who do these efforts serve? (Prompt: For example, individuals of a certain age group, ethnicity, etc.) (A)

5. Is there any additional planning for efforts/services going on in your community surrounding this issue? Please explain. (A)

**WATCH FOR  
SKIP**

6. Is there any evaluation of the current efforts? (A)

**IF THE RESPONSE IS YES, PROCEED WITH Q7 THRU Q 10.**

**IF THE RESPONSE IS NO, GO TO 2N**

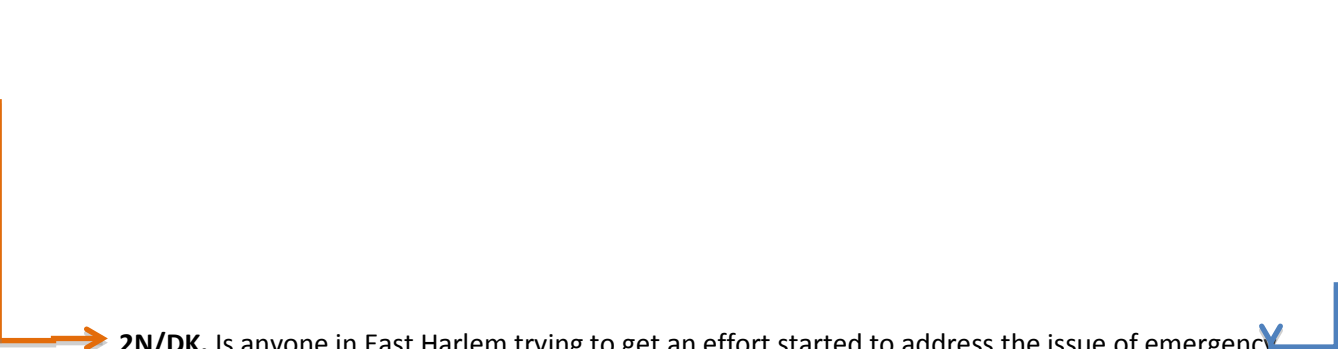
7. On a scale of 1 to 10, how rigorous is the evaluation (with 1 being “not at all” and 10 being “very sophisticated?”)? (A) (NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)

8. Are the evaluation results being used to make changes in programs, activities, or policies or to start new ones? (A)

9. Not considering those directly involved in planning or implementing efforts addressing this issue, approximately how many in the East Harlem community are aware of these efforts? Would you say none, a few, some, or most members of the community are aware of the efforts? Please explain. (B)

10. What does the community know about these efforts or activities? For example, do they know the purpose of the efforts, who they are targeted to, what they do? (B)

**CONTINUE TO 2N**



2N/DK. Is anyone in East Harlem trying to get an effort started to address the issue of emergency preparedness for a public health emergency? *IF YES: How so? (A)*

***IF RESPONSE IS YES THEN PROCEED WITH UNTIL YOU FINISH THIS DIMENSION***

***IF THE ANSWER IS NO OR DON'T KNOW, SKIP TO DIMENSION C: LEADERSHIP***

11. What are the strengths of these efforts? *(B)*
  
12. What are the weaknesses of these efforts? *(B)*
  
13. Would there be any segments of the East Harlem community for which these efforts/services are or may appear inaccessible or unavailable? (Prompt: For example, individuals of a certain age group, ethnicity, income level, geographic region, etc.) *(A)*
  
14. Is there a need to expand these efforts/services? If not, why not? *(A)*
  
15. What formal or informal policies, practices and laws related to preparedness for public health emergencies are in place in East Harlem, and for how long? (Prompt: An example of “formal” would be established policies of schools, police, or courts. An example of “informal” would be similar to the police not responding to calls from a particular part of town, etc.) *(A)*

16. Are there segments of the East Harlem community for which these policies, practices and laws may not apply? (Prompt: For example, due to socioeconomic status, ethnicity, age, etc.) (A)
17. Is there a need to expand these policies, practices and laws? If so, are there plans to expand them? Please explain. (A)
18. How does the East Harlem community view these policies, practices and laws? (A)

**DIMENSION C: LEADERSHIP**

***[I'M NOW GOING TO ASK YOU SOME QUESTIONS ABOUT HOW THE LEADERSHIP IN EAST HARLEM PERCEIVES PREPAREDNESS FOR PUBLIC HEALTH EMERGENCIES. BY LEADERSHIP, WE ARE REFERRING TO THOSE INDIVIDUALS WHO ARE PERCEIVED TO REPRESENT EAST HARLEM AND/OR WHO LEAD THE COMMUNITY IN HELPING IT TO ACHIEVE ITS GOALS.]***

19. Using a scale from 1 to 10, how much of a concern is preparedness for public health emergencies to the leadership in East Harlem (with 1 being “not at all” and 10 being “of great concern”)? Please explain. **(C) (NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)**
20. How is the leadership involved in efforts regarding preparedness for public health emergencies? (For example: Are they involved in a committee, task force, etc.? How often do they meet?) (C)
21. Would the leadership support additional prevention efforts? (C)  
*IF YES:* How might they do that?

**DIMENSION D: COMMUNITY CLIMATE**

***[NOW, I WANT TO ASK YOU A FEW QUESTIONS ABOUT WHAT YOU THINK HOW PEOPLE IN EAST HARLEM MIGHT FEEL ABOUT PUBLIC HEALTH EMERGENCIES]***

22. What is the overall feeling among East Harlem community members regarding preparedness for public health emergencies, especially as it occurs in this community? (D)

23. Does the community support addressing preparedness for public health emergencies locally? (D)

**IF RESPONSE INCLUDES "YES":** Could you please explain this, for example, how do they show this support?

**IF RESPONSE INCLUDES "NO":** Could you please explain?

#### **DIMENSION E: KNOWLEDGE ABOUT THE ISSUE**

**[NOW, I WANT TO ASK YOU A FEW QUESTIONS ABOUT WHAT YOU THINK PEOPLE IN EAST HARLEM MIGHT KNOW ABOUT PUBLIC HEALTH EMERGENCIES AND PUBLIC HEALTH EMERGENCY PREPAREDNESS]**

24. How much do East Harlem community members know about preparedness for public health emergencies in general? (e.g., types, consequences, effects on family and friends, etc.) (E)
25. How much do community members know about preparedness for public health emergencies as it pertains to the East Harlem community? (e.g., do they know how often they may occur?) (E)
26. What type of information is available in the East Harlem community about preparedness for public health emergencies? (e.g. newspaper articles, brochures, posters)? (E)
27. Are there local data available when public health emergencies occur in the East Harlem community? (E)

**IF RESPONSE INCLUDES "YES":** How do people obtain this information?

***DIMENSION F: RESOURCES FOR EFFORTS (time, money, people, space, etc.)***

***[GREAT, NOW I WANT TO ASK YOU ABOUT RESOURCES, SUCH AS TIME, MONEY, PEOPLE POWER, SPACE, ETC, RELATED TO PREPAREDNESS FOR PUBLIC HEALTH EMERGENCIES IN EAST HARLEM]***

28. What is the East Harlem community's attitude toward supporting (prevention) efforts to address preparedness for public health emergencies, for example, local business, community foundations, citizens in general volunteering time, making financial donations, and/or providing space? *(F)*
29. Do efforts that address preparedness for public health emergencies have a broad base of volunteers? Please explain. *(F)*
30. On a scale from 1 to 10, what is the level of expertise and training among those working on preparedness for public health emergencies (with 1 being "very low" and 10 being "very high")? Please explain. *(F)*

***(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)***

31. How are current efforts funded? Please explain. *(F)*
32. Are you aware of any proposals or action plans that have been submitted for funding to address preparedness for public health emergencies in the East Harlem community? *IF YES:* Please explain. *(F)*
33. To whom would an individual affected by public health emergencies turn to first for help in the East Harlem community? Why? *(F)*

**34. (ADD ON QUESTION)** In East Harlem, is there a role for informal leader type individuals such as non-elected or appointed community advocates or certain types of well-informed individuals to engage or help to prepare community residents to be ready and respond to a public health emergency? If yes, how so?

**WRAP - UP**

***[WE ARE NOW DONE WITH THE INTERVIEW. I WANT TO THANK YOU FOR BEING GENEROUS WITH YOUR TIME AND ATTENTION. ]***

**DO YOU HAVE ANY QUESTIONS OR IS THERE ANYTHING ELSE YOU WOULD LIKE TO SHARE?**

**STOP VOICE RECORDER.**

***REFER TO INTERVIEW PROTOCOL:***

- ***REMEMBER TO DISTRIBUTE \$40 COMPENSATION***
- ***OBTAIN SIGNATURE FOR RECEIPT OF PAYMENT USING THE FORM PROVIDED***

**PART IV. CONFIRMATION OF RECEIPT FOR PAYMENT:**

I \_\_\_\_\_ confirm that I have received \$40 in cash from

[print name]

\_\_\_\_\_ my participation in the interview on \_\_\_\_\_, 2011.

[interviewer name]

[insert date]

\_\_\_\_\_

[Signature of Participant]

## **PART V. INTERVIEWER REFLECTION**

### **INSTRUCTIONS:**

*When the interview is complete, please take a couple of minutes to indicate your reactions and observations about the interview. Feel free to use this hard copy for your own notes, but please submit the electronic copy for official use*

Your name (the interviewer):

Date of Interview:

Please describe the respondent's attitude toward you and the interview:

Please describe any unusual circumstances and/ or events that had any bearing on the interview such as interruptions, language difficulty, etc.:

Please describe anything else that happened during the interview that has any bearings on the study's objectives:

Additional comments:

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