

State Community Health Services Advisory Committee

2010-2011

**Public Health Emergency
Preparedness Work Group**

Final Report

May 20, 2011



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May 23, 2011

Ed Ehlinger, MD, MSPH
Commissioner
Minnesota Department of Health
625 Robert St. N
P.O. Box 64975
St. Paul, MN 55164-0975

Dear Commissioner Ehlinger:

I am pleased to present to you the final report of the Public Health Emergency Preparedness Work Group of the State Community Health Services Advisory Committee (SCHSAC). The SCHSAC approved this report at its meeting on May 20, 2011.

Since 2002, Minnesota has received funding from the Centers for Disease Prevention and Control (CDC) via the Public Health Emergency Preparedness (PHEP) grant. With nine years of experience with the PHEP grant, and the recent H1N1 response in which all local public health departments in Minnesota were involved, 2010 was an opportune time to reexamine elements of Minnesota's approach to public health emergency preparedness. The work group was charged with (1) reviewing progress to date in the development of statewide local capacity for responding to public health emergencies, and (2) providing input and making recommendations on issues related to the next phase of Public Health Emergency Preparedness activities including grant duties, funding formula, organizational issues, measuring progress/outcomes, regional projects, and tier classifications.

Based on recommendations from the July 2010 Preparedness Summit for state, local and tribal public health, studying improvement plans from after-action reports from H1N1 and other emergency responses, and evaluating current and potential activities, the work group developed policy statements on 15 issues that formed the basis for the work group recommendations, and that will guide MDH and local health departments in future emergency responses.

The work group also examined and analyzed a number of assessment and credentialing tools to determine a recommendation for measuring preparedness and response in Minnesota. It also examined and made recommendations focusing on regional and local preparedness structures, grant duties, and a funding formula for Minnesota's next grant cycle of preparedness work.

Together, the recommendations pave the way for strengthening emergency preparedness and response in Minnesota's public health system. On behalf the SCHSAC I request your acceptance and approval of this report.

Sincerely,

Dave Perkins, SCHSAC Chair
Olmsted County Commissioner
151 4th Street SE
Rochester, Minnesota 55904-3710

Chair Mike Podulke, Vice Chair Paul Wilson, Ken Brown, Matt Flynn, Jim Bier, Dave Perkins, Judy Ohly
County Administrator Richard Devlin, Associate Administrator Mary Callier



Protecting, maintaining and improving the health of all Minnesotans

May 26, 2011

Dave Perkins, SCHSAC Chair
Olmsted County Commissioner
151 4th Street SE
Rochester, Minnesota 55904-3710

Dear Commissioner Perkins:

Thank you for sending me the final report of the public Health Emergency Preparedness Work Group of the State Community Health Services Advisory Committee (SCHSAC). The recommendations and report thoroughly address the issues laid out in the work group charge and provide a vision and recommendations to strengthen emergency preparedness and response in Minnesota's public health system. I accept this report and its recommendations.

I applaud the work group for its thoughtful consideration and respect for the need to balance a system-wide approach to emergency preparedness while supporting the reality of local response. I believe that the recommendations in this report set the stage for strengthening the capability of Minnesota's public health system to prepared for and respond to disasters throughout Minnesota.

I look forward to working with you and the SCHSAC as we jointly implement the recommendations in this report. Again, thank you for the excellent work.

Sincerely,

A handwritten signature in black ink, appearing to read "Edmund P. Ehlinger", written in a cursive style.

Ed Ehlinger, MD, MSPH
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975

**State Community Health Services Advisory Committee
2010-2011 Public Health Emergency Preparedness
Work Group**

**Final Report
May 20, 2011**



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Executive Summary

The 2010 State Community Health Services Advisory Committee's Public Health Emergency Preparedness (PHEP) Work Group was established to review public health emergency preparedness and response programs and activities since 2002, and to make recommendations for the next phase of preparedness and response in Minnesota. After eight years of preparedness activities including at least one emergency response in every public health agency in Minnesota, it was meaningful to reflect on Minnesota's preparedness and response and to strategically prepare for the next five years of funding and ongoing preparedness and response responsibilities.

To that end, the work group was charged with

- Reviewing progress to date in the development of statewide local capacity for responding to public health emergencies
- Providing input and making recommendations on issues related to the next phase of Public Health Emergency Preparedness programs including grant duties, funding formula, organizational issues, measurement of progress/outcomes, regional projects, and tier classifications.

The work group first determined a list of priority issues by reviewing recommendations from the July 2010 Preparedness Summit for state, local and tribal public health, studying improvement plans from after-action reports from H1N1 and other emergency responses, and evaluating current and potential programming. From that beginning, the work group studied fifteen issues, ultimately making policy statement recommendations on all issues. The work group also examined and analyzed the measurement of preparedness and response by looking at a number of assessment and credentialing tools. Regional and local preparedness structures, grant duties, and funding formulas for preparedness work in Minnesota were reviewed.

Following is a summary of the work group's actions, decisions and recommendations.

Policy Statements

The work group studied policy issues relating to three categories of planning and activity: Response, Coordination, and Reaching the Public. For each of the policy statements, sub-groups looked at how to improve programs by determining a list of commonly agreed-upon planning assumptions and then drafting several statements of policy that could guide MDH and local health departments in the future. These were presented to the full work group for lively discussions and finalizations of the drafts.

The Response policy issues were:

- Balancing Consistency and Flexibility
- Decision-Making Authority
- Local Status Reports and Partner Communication
- The Use of Response Teams and Strike Teams
- Scarce Resource Management
- The Use of Emergency Declarations

The Coordination policy issues were:

- Behavioral Health Response
- Health Care Partner Coordination
- Emergency Management Coordination
- Coordination with Tribal Communities

The policy issues for Reaching the Public were:

- Voluntary Agencies & Community Groups
- Community Leaders
- Coordination with Border States and Canada
- Messaging to and for Limited English Populations
- Joint Information System & Joint Information Centers
- Coordinated Messaging

The policy assumptions and statements for all sixteen of the above issues are in Appendix A to this report.

Measurement of Preparedness and Response

In making its recommendations for measuring capacity and achievement in preparedness and response in Minnesota, the work group reviewed the following Minnesota and national tools:

- Minnesota Tiers Assessment Program, which was initiated by the 2007 SCHSAC LPH-MDH Preparedness Committee
- Voluntary National Public Health Accreditation, which is a national accreditation program for state, local, tribal, and territorial public health departments. This program which will begin in 2011, will be conducted by the Public Health Accreditation Board (PHAB); and includes a self-assessment of capacity to meet the national standards
- Project Public Health Ready (PPHR), which is an accreditation program specific to emergency preparedness, includes a self-assessment of capacity and was developed by the National Association for City and County Health Officials (NACCHO)
- Local Technical Assistance Review (LTAR), which is a detailed checklist used by state and local public health in preparing for Strategic National Stockpile responses; and
- Public Health Preparedness Capabilities List (PHPCL) released by the CDC in March, 2011 to augment the Target Capabilities List for public health emergency preparedness.

Since the different assessment or credentialing/accreditation programs had different purposes, levels of detail, or were based on different perspectives, comparisons were often difficult. However, after considerable review and discussion, the work group made the following decisions:

- The Minnesota Tiers assessment provides the best overall structure for measurement of preparedness and response in Minnesota. It is based on the life cycle of emergencies and provides milestones from planning through response and ultimately through long-term recovery.
- The LTAR and the new Public Health Preparedness Capabilities should be integrated into the structure/framework provided by the Minnesota Tiers assessment, using the Tiers system's structure and categories of activity.

- The Project Public Health Ready program was not included for integration into an assessment program at this time.

Structure, Grant Duties and Funding

The work group also considered some long-standing components of Minnesota preparedness activities. These include local and regional preparedness structures, grant duties, and the current funding formula for preparedness grant dollars.

The work group examined the variety of Community Health Board structures throughout the state, and the effect these structures have on preparedness planning and response. Conclusions from that discussion include the affirmation that preparedness planning is often most effectively accomplished by regional or multi-county coordination, but response to disasters and events is initially managed by and should be coordinated through individual counties, cities, and tribal communities, and when necessary, may also become regional.

In late April 2011, the MDH received grant guidance for the five year grant period beginning in August, 2011. This guidance provided a framework for grant duties for local public health but because the work group ended in May 2011, it was unable to provide input into the upcoming grant duties. For this and other reasons, the work group is recommending that a standing committee be named to provide ongoing review and advice on such matters to the MDH. The work group recognized that there is considerable ongoing work that needs to be done: developing grant duties, periodic provision of input into policies that affect preparedness and response at both the state, tribal, and local levels, ongoing oversight of the ever-changing needs for emergency preparedness and growing capabilities to respond effectively and efficiently. The work group believes a standing group will provide the best system for ongoing dialogue.

The work group also studied several options for changes in funding for local public health emergency preparedness and response. After the discussion, the work group supported using the 2010-11 funding approach of either base or population amount depending on the size of the county—with the funding amount being either the base figure or an amount based on the population—whichever is greater. The county or city populations will be determined as available from the Minnesota State Demographer by July 1 of each year. The awards will be granted to the Community Health Board which is then responsible for distributing the funds among its member counties.

Recommendations and Next Steps

- **Policy Issues:** The work group recommends that the issue papers containing planning assumptions and policy statements be used by MDH and local public health to review and improve planning and response to emergencies with public health impacts.
- **Measurement of Preparedness and Response:** The work group recommends continued development of a capacity assessment and measurement outcomes, which will further define capacity and achievement in public health preparedness in Minnesota. Because of new federal guidelines which emphasize the use of the Public Health Preparedness Capabilities List, the work group recommends using a combination of the Minnesota Tiers document, the local technical assistance review document from CDC, and the Public Health Preparedness Capabilities. The goal for implementation of this new approach would be January 1, 2012.

- **Local Structure:** The work group recommends that funding continue to be awarded to Community Health Boards rather than to individual counties in a multi-county structure. It is to be the responsibility of the Community Health Boards to distribute the funds effectively within their jurisdictions.
- **Regional Response:** The work group recommends that MDH and partners continue development of Multi-Agency Coordination for public health emergencies, with attention to roles and responsibilities for regional staff and the use of the Incident Management structure. The work group further recommends continued efforts toward the goal of a thriving individually based CHB system operating under a common operating framework across the state.
- **Grant Duties:** The work group recommends that the five year CDC grant guidance and planning cycle be used to determine priorities at the state and local levels as the foundation for a strategic plan to address structure, funding, and the development of grant duties and to maintain ongoing oversight of the state and local partnerships in preparedness.
- **Funding:** The work group recommends use of the current funding formula be continued, using the population of each jurisdiction as determined yearly by the State Demographer, with the funding amount being either the base figure or an amount based on the population—whichever is greater.
- **Ongoing Oversight:** The work group recommends that a state/local/tribal SCHSAC committee be named to provide continual review of public health emergency preparedness programs and issues and assure that the above recommendations can be accomplished to provide ongoing advice and guidance to the state-local preparedness partnership.

Introduction



Charge

The 2010 SCHSAC Public Health Emergency Preparedness Work Group was charged with:

- Reviewing progress to date in the development of statewide local capacity for responding to public health emergencies
- Providing input and making recommendations on issues related to the next phase of Public Health Emergency Preparedness (PHEP) programs including grant duties, funding formula, organizational issues, measurement of progress/outcomes, regional projects, and tier classifications.



Membership

Local Health Departments

Bill Montague – Co-Chair	Polk County Community Health Board
Ted Seifert – Co-Chair	Goodhue County Community Health Board
Pam Blixt	Minneapolis Department of Health and Family Support
Sharon Braaten	Horizon (Douglas-Grant-Pope-Stevens-Traverse) Comm. Health Board
Jennifer Deschaine	Scott County Community Health Board
Robert Einweck	St. Paul-Ramsey Department of Public Health
Bonnie Engen	North Country (Beltrami-Clearwater-Hubbard-Lake of the Woods) Community Health Board
Jim Gangl	Carlton-Cook-Lake-St. Louis Community Health Board
Pete Giesen	Olmsted County Community Health Board
Lowell Johnson	Washington County Community Health Board
Mary Krebs	Dodge-Steele County Community Health Board
Kathy Krenik Minkler	Isanti-Mille Lacs Community Health Board
Cheri Lewer	LeSueur-Waseca Community Health Board
Karen Nelson	Wadena County (Morrison, Todd, Wadena) Community Health Board
Gloria Tobias	Countryside (Big Stone-Chippewa-Lac Qui Parle-Swift-Yellow Medicine) Community Health Board

Minnesota Department of Health Participants

Jane Braun	Office of Emergency Preparedness
Debra Burns	Office of Performance Improvement
Kris Ehresmann	Director, Infectious Disease, Epidemiology, Prevention and Control
Arden Fritz	Legal Unit
Aggie Leitheiser	Director, Office of Emergency Preparedness (until March, 2011) Assistant Commissioner of Health (after March, 2011)
John Stine	Assistant Commissioner of Health (until March, 2011)

Work Group Staff

Cindy Borgen	Office of Emergency Preparedness, MDH
Gail Gentling	Office of Performance Improvement, MDH
Bonnie Holz	Office of Emergency Preparedness, MDH



Background

Since 2002, Minnesota has received funding from the Centers for Disease Prevention and Control (CDC) via the Public Health Emergency Preparedness (PHEP) grant. With nine years of experience with the PHEP grant, and the recent H1N1 response, 2010 was an opportune time to reexamine elements of Minnesota's approach to public health emergency preparedness. In particular, the work group prepared for the five-year grant cycle that will begin in 2011.

In July 2010, 125 of Minnesota's local, regional, tribal and state public health staff who have responsibilities in emergency preparedness and response met at the MDH/LPHA Emergency Preparedness Policy Summit. The forum was designed to use the aspects of the H1N1 response to build directions and activities for the future. There were four areas of discussion: Public Information, Communications, Response Issues, and Roles/Structure/Responsibilities. The forum resulted in a report with almost 2,000 individual comments, organized into 75 subcategories and also provided the basis for potential policy changes that would be studied by the SCHSAC work group.

Improvement plans from after-action reports representing lessons learned from the 2009 H1N1 response experienced by every local health department in Minnesota were collected and summarized by MDH. In addition, improvement plans were available from other recent events and emergencies including responses to southeast, west central and northwest floods, tornados in several areas, the Highway 35 W bridge collapse, and even the public health responses during the Republican National Convention.

With changes in preparedness occurring on the national level and continued budgetary uncertainties in all levels of government, the group's work began at an opportune time to enact an in depth review and evaluation of current and potential preparedness programming including grant effectiveness and grant administration.

Figure: Minnesota’s Public Health Regions: The map and table below show the wide variety of sizes and configurations of Minnesota’s eight health regions.



September, 2004

Region	Population (2008 est.)	Population % of total	Community Health Boards	Local Health Departments			Area (sq miles)
				Counties	Cities	Tribes	
Central	715,467	14 %	10	14		1	12,431
Metro	2,810,414	54 %	11	7	4	1	2,942
Northeast	320,342	6 %	2	7		3	19,217
Northwest	229,320	4 %	5	13		3	16,301
South Central	287,756	5.5 %	6	11			6,244
Southeast	486,517	9 %	9	11		1	6,753
Southwest	213,043	4 %	6	16		2	11,265
West Central	185,453	3.5 %	3	8			6,796

Work Group History, Methodology, and Decisions

The Emergency Preparedness work group was convened in August 2010. The group had seven in-person meetings and four teleconference meetings.



Issue Identification

After receiving the reports from the MDH/LPHA Emergency Preparedness Policy Summit and the H1N1 After Action Improvement Plans, the work group compiled an extensive list of issues they wanted to cover during the year of study.

The work group considered policy statements and recommendations relating to these issues:

- Response
- Coordination
- Reaching the Public
- Measurement of Preparedness and Response
- Preparedness & Response Administration, including Governmental Structures, Grant Duties and Contracts, and Funding.



Assumptions and Policy Statements

Sub-groups provided initial drafts on three of the five main areas of review:

- Response
- Coordination
- Reaching the Public

Small groups prepared drafts of potential assumptions and policy statements related to sub-issues under the main categories (above). These groups were composed of at least one local public health representative and at least one staffer from MDH. After presentation of the drafts, each group integrated comments and suggestions from the entire work group into final drafts.



Measurement of Preparedness and Response

In making its recommendations for measuring capacity and achievement in preparedness and response in Minnesota, the work group reviewed the following Minnesota and national tools:

- The Minnesota Tiers Assessment Program was initiated by the 2007 SCHSAC LPH-MDH Preparedness Committee and used in every city/county health department during state-wide reviews in 2008 and repeated in 2010. This program has provided a wealth of data that can be used by MDH regional Public Health Preparedness Consultants to identify and eliminate gaps in preparedness in their regions or in individual jurisdictions. The Minnesota Tiers Assessments are a self-evaluation of perceived capacity, and do not provide an actual measure of outcomes.

- The Public Health Accreditation Board (PHAB) assessment for general public health accreditation has been endorsed by the SCHSAC Performance and Accreditation Work Group for a phased in approach with the goal of eventual state-wide use. The PHAB program does not provide detailed activity-specific guidance for emergency preparedness in public health.
- Project Public Health Ready is an assessment program for preparedness-specific accreditation, sponsored by the National Association of City and County Health officials. This program is in use in several local and state health departments nationwide including Hennepin County in Minnesota.
- The Local Technical Assistance Review (LTAR), used by state and local public health in preparing for use of the Strategic National Stockpile during a response, has been measuring very specific planning objectives relating to mass dispensing of prophylaxis. It has been used in all Minnesota health departments since 2009.
- The Public Health Preparedness Capabilities List was released by the CDC in March, 2011. This national standards program breaks down functions, tasks, and resource elements for comprehensive health emergency preparedness programs. CDC grant duties are closely tied to the Preparedness Capabilities List.

The above assessment or credentialing/accreditation programs all have different purposes and/or are based on different perspectives, so comparisons were often difficult, and always lively. The work group did an in-depth analysis of the various programs, their goals, and their relationship to the tiers assessment system currently in use in Minnesota.

Eventually, the work group decided that the Minnesota Tiers assessment, while needing updating and more detailed descriptions, provided the best overall structure because it was based on the life cycle of emergencies and provides milestones from planning through response and ultimately through long-term recovery. The work group decided to consider implementing the Project Public Health Ready program at this time, because the categories were not as consistent with the Minnesota approach and would represent a significant burden on local agencies. The work group decided to support an integration of the LTAR and the new PH Preparedness Capabilities, using the Minnesota Tier Assessment system's structure and categories of activity.

A summary of the Minnesota Tier Assessment program is in Appendix B of this report. Descriptions of the assessment and accreditation programs studied by the work group are in Appendix C of this report.



Preparedness Structure, Grant Duties, and Funding

The work group also considered some long-standing Minnesota preparedness issues. These included: local and regional preparedness structures, changes in grant duties, and the current funding formula for preparedness grant dollars.

Local Structures

The work group examined the variety of Community Health Board structures throughout the state, and the effect these structures have on preparedness planning and response. Under the leadership of some Community

Health Boards (CHBs) member counties work together in close coordination for emergency preparedness planning. Others simply divide up funding and delegate all planning responsibilities to member counties.

Conclusions from that discussion include recognition that preparedness planning can often be accomplished by regional or multi-county coordination, but response to disasters and events is initially managed by and should be coordinated through individual counties, cities, and tribal communities.

Because of the variation in structures, staffing and approach in multi-county CHBs across the state, the work group did not recommend any changes in structure or relationships. However, the work group did discuss the benefits of sharing limited resources and combining some activities across jurisdictional lines where possible and feasible.

Regional Response

The work group studied the role of regions in preparedness planning and response, and in particular addressed the question, “How well do regional Multi-Agency Coordination groups (MACs) work around the state?”

All regions have formed critical partnerships—including regional hospital preparedness coordinators, regional emergency medical services staff, volunteer groups, and interface with homeland security emergency management coordinators, and other region-specific organizations or groups. Some MACs also include local public health representatives. Many regions rely on virtual coordination during responses—using MNTrac Coordination Centers and/or conference calls for meetings. These communication tools save time by eliminating the need for travel to face-to-face meetings. Others hold face-to-face meetings whenever possible. MACs will continue to play an important role during emergencies involving more than one jurisdiction and will continue to evolve as common operating frameworks are better defined.

In addition, the work group stressed the importance of strong, effective, and efficient Community Health Boards to underpin local preparedness, especially in areas of lower population.

Grant Duties

The work group anticipated being able to review and advise the MDH after CDC guidance arrived to provide a framework for state and local workplans and for local grant duties. Because grant guidance for the upcoming five year period didn’t arrive until late April, the work group was not able to give much input on the 2011-2012 grant duties for local public health, but expressed interest in more discussion and involvement in shaping the priorities and duties for the local grants.

For this and other reasons, the work group is recommending that a standing committee be named to provide review and advice to the MDH for preparing and evaluating grant duties on an ongoing basis. The 2010-2011 Grant Awards are in Appendix D of this report.

Funding

The work group reviewed several options for changes in funding for local public health emergency preparedness and response. A funding formula has been in place in Minnesota since 2002 which guarantees a base level amount of preparedness funding for counties with small populations and for Minnesota’s tribal community health departments. Large counties receive an award based on a per-capita figure which can vary from year to year depending on the amount awarded by CDC to Minnesota.

After the discussion, the work group supported using the existing funding approach of either base or population amount depending on the size of the county—with the amount being either the base figure or an amount based on the population—whichever is greater. The county or city populations will be determined annually as available from the Minnesota State Demographer by July 1 of each year. The awards will be granted to Community Health Boards who will be responsible for distributing the funds among their member counties.

Ongoing Oversight

The work group recognized that there is considerable ongoing work that needs to be done: developing grant duties, periodic provision of input into policies that affect preparedness and response at both the state and local levels, ongoing oversight of the ever-changing needs for emergency preparedness and growing capabilities to respond. They recommend the appointment of a SCHSAC-sponsored standing committee of state/local/tribal representatives to provide ongoing input and review of public health preparedness efforts.

Recommendations and Next Steps



Issue Papers and Policy Statements

The work group recommends that the sixteen issue papers containing planning assumptions and policy statements be used by MDH and local public health to review and improve planning and response to emergencies with public health impacts.

The Response policy issues are:

- Balancing Consistency and Flexibility
- Decision-Making Authority
- Local Status Reports and Partner Communication
- The Use of Response Teams and Strike Teams
- Scarce Resource Management
- The Use of Emergency Declarations

The Coordination policy issues are:

- Behavioral Health Response
- Health Care Partner Coordination
- Emergency Management Coordination
- Coordination with Tribal Communities

The policy issues for Reaching the Public are:

- Voluntary Agencies & Community Groups
- Community Leaders
- Coordination with Border States and Canada
- Messaging to and for Limited English Populations
- Joint Information System & Joint Information Centers
- Coordinated Messaging

The policy assumptions and statements for all sixteen of the above issues are in Appendix A to this report.



Measurement of Preparedness and Response

The work group recommends continued development of a capacity assessment and measurement outcomes, which will further define capacity and achievement in public health preparedness in Minnesota. Because of new federal guidelines which emphasize the use of the Public Health Preparedness Capabilities List, the work group recommends using a combination of the Minnesota Tiers document, the local technical assistance review document from CDC, and the Public Health Preparedness Capabilities. The goal for implementation of this new approach would be January 1, 2012.

A summary of the Minnesota Tier Assessment program is in Appendix B of this report. Descriptions of the assessment and accreditation programs studied by the work group are in Appendix C of this report.



Structure, Grant Duties, and Funding

Local Structures

The work group recommends that funding continue to be awarded to Community Health Boards rather than to individual counties in a multi-county structure. It is the responsibility of the Community Health Board to distribute the funds effectively within their jurisdictions.

Regional Response

The work group recommends that MDH and partners continue development of Multi-Agency Coordination for public health emergencies, with attention to roles and responsibilities for regional staff and the use of the Incident Management structure. The work group further recommends continued efforts toward the goal of a thriving individually based CHB system operating under a common operating framework across the state.

Grant Duties

The work group recommends that the five year CDC grant guidance and planning cycle be used to determine priorities at the state and local levels as the foundation for a strategic plan to address structure, funding, and the development of local grant duties and to maintain ongoing oversight of the state and local partnerships in preparedness.

Funding

The work group recommends that the current funding formula be continued, using the population of each jurisdiction as determined yearly by the State Demographer.

The 2010-2011 Local and Tribal Grant Awards are in Appendix D of this report.

Ongoing Oversight

The work group recommends that a state/local/tribal SCHSAC committee be named to provide continual review of public health emergency preparedness programs and issues and assure that the above recommendations can be accomplished to provide ongoing advice and guidance to the state-local preparedness partnership.

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Appendix A: Policy Statements

Acronyms

AMEM	Association of Minnesota Emergency Managers
ASPR	Assistant Secretary for Preparedness and Response, Department of Health & Human Services
CDC	Centers for Disease Control & Prevention
DHS	Minnesota Department of Human Services
DOC	Department (MDH) Operations Center
EOC	Emergency Operations Center
H1N1	2009-2011 Influenza Outbreak
ICS	Incident Command System
IMT	Incident Management Team
HSEM	Homeland Security Emergency Management
JIC	Joint Information Center
JIS	Joint Information System
LEP	Limited English Populations
LHD	Local Health Departments
LTAR	Local Technical Assistance Review Tool
LPH	Local Public Health
MAC	Multi Agency Coordination
MDH	Minnesota Department of Health
MNICS	Minnesota Incident Command System Team (Grand Rapids MN Interagency Fire Center)
MRC	Medical Reserve Corps
PHAB	Public Health Accreditation Board
PIO	Public Information Officer
SCHSAC	State Community Health Services Advisory Committee
SEOC	State (MN) Emergency Operations Center
SNS	Strategic National Stockpile
SWEPT	South West (MN) Emergency Preparedness Team
VOADS	Volunteer Organizations Active in Disasters
VOLAG	Volunteer Groups

Introduction to the Issue Papers and Policy Statements

Background

Topics for the sixteen issue papers were selected by the work group as a follow-up to areas of concern brought up in the July 2010 Policy Summit. The issue papers are comprised of assumptions to set the context and policy statements that outline recommended parameters for future action.

Use of the Issue Papers and Policy Statements

The issue papers are designed to be used by both state and local public health. It is hoped that they will:

- provide an organization structure for important points within the topics;
- clarify points of concern;
- provide starting points for policy development;
- provide a framework for review of existing policies.

Publicizing and Promoting the Issue Papers and Policy Statements

Members of the EP work group and those of the proposed new oversight group will continue working on implementation strategies for publicizing and circulating the issue papers as a whole and for emphasizing each topic's individual policy statements. The work group recommends these possible venues for discussion and implementation of the issue papers:

- Review and discussion sessions during regional meetings
- Educational sessions during regional and state conferences
- Update sessions for staff, partners, and policy makers
- Orientation sessions for new staff
- Regular continuing education/training sessions for staff
- Written highlights of issues in newsletters and updates.

2011 SCHSAC EMERGENCY PREPAREDNESS WORK GROUP POLICY STATEMENTS

Response Issues: Balancing Consistency and Flexibility

Assumptions

The policy statements apply to an all-hazards approach to any large scale response situation (multi-jurisdiction, statewide or potentially broad population impacts).

For smaller scale response situations that are very localized or present specifically local impacts (such as a mercury spill, localized wildfire, or a meningitis outbreak in a school, for example) and where only one to a few local jurisdictions are impacted, LPH will be responsible for coordinating the public health emergency response action plan with MDH providing technical support and assistance.

MDH's Incident Command System will define large scale response situations. MDH recognizes that its role during a large scale event includes policy-setting and may include service delivery; this could create internal conflicts that need greater attention.

MDH will focus on better internal management controls and effective communication with partners. Both MDH and LPH may need to work in situations where decisions and implementation of those decisions may have to be quick and timely and sometimes based on limited information.

The greater or more severe the crisis, the less flexibility both state and local public health will have.

Policy Statements

- To the extent practical, MDH and LPH should strive for maximum consistency in public health emergency response efforts.
- MDH should develop response objectives/strategies; LPH should develop response tactics/methods that fit best in their communities.
- If there are multiple ICS organizational components (SEOC, MDH DOC, Regional MAC, local EOC, and local DOC) engaged, MDH's ICS structure will clearly communicate anticipated decisions regarding consistent objectives/strategy for public health issues.
- A process/system should be developed, planned and exercised in which State and local public health leaders jointly develop a public health action plan for the incident.
- If extenuating circumstances exist, such as situational influences or federal government direction that renders the above policy statements inadequate, MDH will clearly communicate the circumstances to local public health leadership as soon as possible.
- In dealing with large health plans serving multiple counties, agreements may be enacted that will safeguard safe, efficient, and fair distribution of resources for all local health departments.

2011 SCHSAC EMERGENCY PREPAREDNESS WORK GROUP POLICY STATEMENTS

Response Issues: Decision-Making Authority

Assumptions

The Governor of the State of Minnesota has decision making authority for state agencies. Those duties must be legally delegated to others such as the Commissioner of Health.

Local Governments have Chief Elected Officials such as County Board Chairs, Mayors, and Sheriffs that have prescribed decision making authority.

Authorities at the local level may also be delegated to other officials such as the Public Health Director.

Policy Statements

- Decision making authorities and delegations should be described within state and local Emergency Operations Plans and local All Hazard plans.
- Within an emergency response structure, the Incident Commander shall have decision making authority for response operations.
- NIMS/ICS provides details about the decision making authorities and should be understood and followed by all state and local officials.

2011 SCHSAC EMERGENCY PREPAREDNESS WORK GROUP POLICY STATEMENTS

Response Issues: Local Reporting & Partner Communications

Local Reporting Assumptions

Local Reporting refers to Local Health Department (LHD) grant accountability reports to MDH.

Emergency preparedness funding will continue. For administrative purposes, reporting from LPH to MDH will continue.

Local Reporting Policy Statements

- MDH will develop a reporting system that allows flexibility in documenting grant funded work that may include site visits as well as reporting forms and templates. The reports will collect information on grant duties, progress on improvement plans and other local and regional activities that increase LHD preparedness.
- Grant duties and report forms will identify those duties which are CDC requirements.
- MDH will provide acknowledgement/feedback on reports submitted by LPH.

Partner Communications Assumptions

Partner Communication refers to two-way communications between MDH and LPH during a response.

The size and visibility of an Incident Command structure may vary at local or state levels during any of the phases of an emergency response/recovery.

Various communication tools (MNTrac, conference calls, email, Workspace, 800 MHz, etc.) will be available for communications.

Partner Communication Policy Statements

- MDH and LPH will develop a communication system for a response that is streamlined, non-redundant and incorporates both “push” and “pull” features. Requests will be standardized and focus on critical information. MDH will share how the information will be used, and provide regional summaries back to LHDs.
- Sharing situation reports will be a key method to maintain situational awareness between MDH and LPH during a response.
- MDH and LPH will develop systems for sharing lessons learned/best practices from exercises, events, and incidents.

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Response Issues: Public Health Response Teams

Assumptions

The public health community in Minnesota has a desire to develop response teams as a resource for the state, and agencies are willing to share resources to assist each other. Agencies involved in a response can benefit from guidance from peers who have experience in responding to specific types of public health emergencies (tornado, flood, etc.). In some situations response is most effective and efficient with the use of teams.

Public health response teams are made up of experienced professionals willing to assist a Minnesota public health agency needing help responding to an event or incident.

Team members are volunteers with the knowledge, skills, and physical ability to staff a response.

Team members will serve as needed and available, and they are not formally on call or on standby.

Public health responders are aware of existing teams (EMS strike teams, IMTs, MNICS out of Grand Rapids, etc.) and resources available from a variety of jurisdictions and levels of government. MDH and LHD staff are available to assist other agencies, or in some instances, other states.

Policy Statements

- Public health agencies should build upon existing teams and resources.
- LHDs and MDH should have a structure (legal and logistical) to deploy public health response teams to assist agencies needing additional or specialized help in responding to an emergency.
- The requesting and responding agencies should clearly define expectations about the role of the responders (e.g. supplemental help, coaching, respite for an entire ICS team, etc.).
- Assistance may be in the form of assessment, planning, logistics, or operations.
- Response team members should have a standard level of training and meet a minimum standard for experience in responding to public health emergencies.
- Teams should be available to deploy on short notice to provide immediate help, as well as available for long-term response and recovery efforts.
- Public health response/strike teams should be familiar with existing teams and their capabilities, and work in conjunction with local and state systems and responders.
- Existing structures such as EMAC and MN Responds Medical Reserve Corps should be used for resource typing, rostering, and credentialing.

- Team members should be provided with liability and workers' compensation coverage for all actions taken in good faith.

Next Steps

- Establish a work group of state and local public health staff to develop a public health response team program.
- Identify existing teams and structures upon which public health response teams can be built.
- Work with MNICS, the IMT, Association of Minnesota Emergency Managers, and others to learn best practices for developing and deploying teams.
- Determine whether teams will be deployed as a group, or as a collection of individuals.
- Develop a mechanism to quickly identify the volunteers with the expertise and experience needed for a specific response.
- Determine standards for training and the necessary experience level for team members.
- Identify and resolve any liability and workers compensation issues.

2011 SCHSAC EMERGENCY PREPAREDNESS WORK GROUP POLICY STATEMENTS

Response Issues: Scarce Resources

Assumptions

There is a state-wide or national incident that means needed health care resources may not be available for several days or longer (preventive medications, medical treatments or equipment, syringes, respirators, quarantine facilities, etc.). Recommendations may vary depending on the resource type, priority, and availability.

This policy applies to resources currently under the control of MDH, CDC and/or local health departments.

Policy Statements

- Local agencies should first maximize their own capacity and deplete their own resources, or those of local or regional caches, before requesting state or federal resources.
- State and/or national resources should be allocated in the following order:
 - Limited resources should be targeted for priority groups as directed by state or national assessment of risk and efficacy.
 - Ethical principles based on the documents developed in 2009 should be applied to allocation decisions.
 - Consideration should be given for traditionally underserved populations to reduce disparity in access to health services.
- If situational awareness allows for determination of where priority groups are located, resources should be distributed to cover the need.
- If priority groups are equally distributed or if everyone is an equal priority, resources should be distributed to LHDs (or regions) using a population base (with consideration of distribution via a provider base in areas where larger providers are located). Allocation of resources in that situation is the responsibility of the LHD in collaboration with the local health care system or may be coordinated through the regional MAC unless the LHD decides to opt out of this responsibility and defer allocation to MDH. These decisions should take into account, the ethical principles guidance and consideration of traditionally underserved populations as well as factoring in minimum shipment sizes. Before distribution begins, the LHD should communicate the allocation plan to MDH.
- MDH and LHDs should assess the health resources most likely to be needed for health incidents and develop stockpiles to prevent shortages where funding allows. LHDs should not receive a larger share because they failed to plan or because they are the most vocal about their needs.
- Local government mutual aid agreements should address sharing of limited resources among jurisdictions and disciplines.
- As part of preparedness efforts, LHDs should work with the partners in their jurisdictions to maintain awareness of local resources.

2011 SCHSAC EMERGENCY PREPAREDNESS WORK GROUP POLICY STATEMENTS

Response Issues: Use of Emergency Declarations

Assumptions

Local Health Departments should not wait for or rely on state or federal declarations to begin activities that protect local resident health.

Since “all emergencies are local,” actions regarding emergencies or disasters should start at the local level.

Local declarations do not need to, nor should they, wait for a state-level declaration.

Policy Statements

- Before emergencies and/or events occur, LHDs should work with local emergency managers to identify:
 - Who can declare a local emergency based on a disaster with health implications.
 - What the local emergency declaration means for health agencies.
 - What health response actions the local emergency declaration will trigger.
- Local emergency plans should reflect the actions that locals might have to take in the absence of a state or federal declaration. For example, the use of local facilities for mass dispensing should be based on local needs, and plans should reflect that reality (and not state that the requisition of such facilities should occur only under a state- or federal-declared emergency).
- Since most local health departments feel the need for a better understanding of the use of emergency declarations:
 - Grant duties should require the citation of statute numbers in local plans, and also require full understanding of Chapter 12 and health statutes that might apply to emergency response.
 - Training on these statutes and the use of local declarations for events and disasters, as well as other legal issues (such as Isolation and Quarantine and liability coverage) should be offered to all local health departments, elected officials, emergency managers and relevant staff.
 - Legal assistance should be an integral part of MDH DOC (Department Operation Center) systems during disaster and emergency response.
- The immediate use of a local declaration may include:
 - Transportation of antivirals from a participating pharmacy to a sick patient (within or between counties).
 - Assistance with just-in-time transportation of PPE during spot shortages.
 - Assistance with transportation of other SNS assets if needed.
 - Security and traffic assistance during Mass Dispensing Clinics according to plans.
 - Access to facilities prearranged in Emergency Operations Plans (such as gymnasiums).
 - Assistance with logistics.
 - Assistance with staffing (use of MRC volunteers and/or other local government personnel).

None of these uses would be dependent on or even direct results of a state declared emergency.

The following table clarifies roles, responsibilities, and timelines.

Level of Government	Trigger Points for Emergency Decisions	Powers/Users	Other Issues/Considerations
National Public Health Emergency	[For H1N1, these were met 07/26/2009 and 10/10/2009]	90 days Grants, contracts, waivers	Public Health Service Act
National National Emergencies Act to Public Health Emergency	[For H1N1, these were met 10/23/2009]	One year Medication dispensing Waivers for health care services and payment	PREP Act 1135 waivers
National Stafford Act Emergency	Governors' requests. Usually based on impact on infrastructure.	FEMA assistance	No history of using for pandemic response.
National Stafford Act Major Disaster	Governors' requests. Usually based on impact on infrastructure.	FEMA assistance	No history of using for pandemic response.
State Temporary medical care facilities and liabilities issue	Surge in demand for care indicating system is unable to provide care in usual ways within one or more regions.	Governor issues declaration of emergency and an additional declaration authorizing altered standard of liability. Persons providing care in the affected geographic area need to follow emergency plans for providing care.	Chapter 12.31 and 12.61 Peacetime emergency requires confirmation by the Executive Committee of elected officials after 5 days and convening the legislature if the emergency extends beyond 35 days.
State Mass dispensing under the commissioner's authority	Usual medication distribution methods are inadequate to get medications to the right people quickly.	The Commissioner may determine that medication distribution is needed for pandemic influenza or other event and that usual systems are inadequate or not fast enough. Includes changes to labeling requirements	144.4198 Addresses closed PODs, head of household, postal option, unlicensed personnel or other means the commissioner deems warranted to distribute needed medications (emergency declaration not required).
Local County or city declaration of local emergency	Locals need additional staff Locals need access to facilities Locals need assistance in managing resources	Authorize powers in emergency plan such as: 1. Transportation (for SNS, Antivirals, PPE) 2. Security for Clinics 3. Communication assistance or backup 4. Access to facilities	Chapter 12.29. May be started by city Mayor or County Board chair. Needs to be confirmed by Council or Board in 5 days to continue.

Level of Government	Trigger Points for Emergency Decisions	Powers/Users	Other Issues/Considerations
State or Local	Additional staff needed to assist with vaccination clinics, antiviral dispensing	The Commissioner may authorize any person, including but not limited to licensed health care personnel, to administer vaccinations or dispense legend drugs if: 1. A local board who has declared a local emergency requests the Commissioner to do so, or 2. The Commissioner can declare for the state when there is an emergency declaration by the Governor. State-wide MRC Activation	Chapter 144.4197 Requires training and supervision of the personnel involved. Requires emergency declaration.
Tribal Government	According to tribal emergency plan	According to tribal emergency plan	According to tribal emergency plan

2011 SCHSAC EMERGENCY PREPAREDNESS WORK GROUP POLICY STATEMENTS

Coordination: Behavioral Health

Assumptions

Under the National Response Framework, Public Health is responsible for planning and coordinating Behavioral Health Services for emergencies and disasters. In the Minnesota Emergency Operations Plan, MDH is the coordinating state agency and the Department of Human Services is a supporting agency. Local Human Service agencies are the local mental health authority for services that include crisis counseling after emergencies and disasters; however, this responsibility comes without any additional funding for planning and preparation.

Throughout Minnesota, there are a myriad of local and regional structures currently coordinating local behavioral health planning and response, which leads disparities in planning and service provision.

Policy Statements

- DHS and MDH will continue to work together with Local Public Health and Human Services to clarify roles and responsibilities of behavioral health response.
- To maximize effectiveness and address complexity of behavioral health planning and response, planning and coordination should include:
 - Local Human Services
 - Local Public Health
 - Emergency Management
 - Medical Reserve Corps (MRC)
 - The Health care System (i.e. chaplains/social workers)
 - Private, public and nonprofit behavioral health organizations
- Behavioral Health response should be coordinated as part of state and local Incident Command structures to provide overall integrated response at the local, regional and state levels.
- The following components should be considered during Disaster Behavioral Health planning:
 - Reaching Limited English Populations (LEP) and other hard-to-reach populations
 - Psychological First Aid programs
 - Local and regional behavioral health volunteers as part of Minnesota Responds/MRCs
 - Planned coordination between local behavioral health authorities, VOADS and other behavioral health response agencies
 - Post-disaster recovery and long-term recovery provision through Recovery Grant Programs (when available)

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Coordination: Health care

Assumptions

Hospitals and other health care organizations are charged with providing medical care to the community, including at-risk populations, during a public health emergency and medical surge situations. Some public health emergencies, such as a pandemic, may simultaneously impact large geographic areas for prolonged periods. Needed health care resources may not be available for several days or longer. Supply chains may be disrupted during public health emergencies. Staffing challenges are expected during public health emergencies and health care and public health may be competing for limited response personnel and volunteers.

Required collaborative planning and coordination between health care and public health, in advance of a public health emergency, will facilitate and maximize an optimum community response during an actual incident or event. Coordination can be complex but is key to the delivery of essential medical services to the community during a public health emergency.

It may be necessary for health care to receive guidance from MDH for implementing adjusted standards of care during an emergency with public health implications. Alternate care sites may be necessary during a public health emergency.

There will be an increased demand by the public and media for information from both health care and public health during a public health emergency.

Policy Statements

- Collaborative planning between public health and health care can identify gaps and potentially mitigate the impact of public health emergencies on the health care and public health systems. Barriers to coordination and response should be addressed in advance.
- MDH, in coordination with LHDs, will communicate essential hazard information to health care entities during a public health emergency.
- Continuing dialogue on roles and responsibilities between health care and public health will be essential to clarify system responses during medical surge situations, with a coordinated response as the outcome.
- Health care representatives will work within regional systems (e.g. MACs) to support coordination and sharing of resources.
- Health care and public health will coordinate public and media communication and information through a regional or statewide Joint Public Information Center established and coordinated by MDH.
- Local, regional, and state emergency response plans will include coordination between public health and health care, and will address at minimum a coordinated response for:
 - Communication

- Surge Capacity Response
 - Scarce Resource Management
 - Alternative Care Facilities
 - Sharing of Personnel and Volunteer Resources
 - Receiving and Dispensing SNS (including local and regional caches)
 - Mitigation
-
- State and local public health should identify and reach out to health care entities (i.e. Health Associations).
 - MDH will take the lead for implementing adjusted standards of care for health care during an emergency with public health implications.
 - Collaborative planning between public health and health care can identify gaps and potentially mitigate the impact of public health emergencies on the health care and public health systems. Barriers to coordination and response should be addressed in advance.

2011 SCHSAC EMERGENCY PREPAREDNESS WORK GROUP POLICY STATEMENTS

Coordination: Emergency Management

Assumptions

Varying geographical and regional boundaries for public health and emergency management as well as multiple jurisdictions in each region creates a challenge for emergency planning and response. Public health and emergency management must be coordinated at the local, regional and state levels to enable a successful and sustained response to emergencies.

Public health plans should be integrated into All-Hazard plans.

A common understanding of Incident Command Structure is essential.

Policy Statements

- MDH, HSEM, AMEM and SCHSAC will work together to develop guidance for local health department and emergency management partnerships in defining roles, goals and expectations for planning, response and recovery in emergencies to reduce duplication of effort and increase efficiency. LHD resources will be typed and a system for requesting these resources will be shared.
- Regions will develop minimum standards and outcome measures for LHD to use in collaborating with Emergency Management, including working through a regional MAC.
- MDH and HSEM will continue to provide education about the process, legal issues and roles of LHDs, local officials and Emergency Management in emergency declarations.
- To facilitate continuity with personnel changes, clear roles and responsibilities for all partners will be identified and documented in the local, regional and state-level All-Hazards plans.
- Standard terminology will be used for public health and emergency management communications.
- Public health and emergency management will coordinate planning efforts to facilitate the most efficient use of grant funds and resources.

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Coordination: Tribal Government

Assumptions

Tribal governments have varying needs and capacities for response. Some tribal governments experience frequent changes in tribal council and administration personnel which can lead to a more complicated decision-making process.

Tribes are sovereign nations, which can add another layer of consideration, as can having a large casino business.

Tribes have a wide range of health care, public health and emergency management departments and there may be challenges in identifying appropriate local and regional partners. Tribes also may work closely with LHDs to provide needed services during a response and as a partner in planning.

MDH will continue to provide funding to tribes to conduct preparedness planning. Timelines should allow for extended deadlines when appropriate.

Policy Statements

- MDH must work closely with tribes to better match grant duties with tribal needs, and to acknowledge their internal systems.
- A process is needed to clarify when tribal grant duties should be the same as local health department duties, and when the expectations should be different.
- Relationships between the tribes and MDH are important. Resources should be allocated to develop strong regional partnerships that include tribes. Tribal governments should be response partners with the state in coordination with local response efforts and resources.
- Grant duties should take into account the cultural customs of the various tribes.
- Some LHDs may consider the organized Native American communities of their counties as a special population for local planning efforts.
- Urban and rural Native Americans not affiliated with tribal reservations should be considered special populations and covered in local planning efforts.

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Coordination: Voluntary Agencies & Community Groups

Assumptions

Voluntary agencies and community groups are willing to help with emergencies in their communities.

Voluntary agencies and community groups know their local populations and can offer many services for communicating with and assisting the public in an emergency. Voluntary Organizations Active in Disasters (VOADs) are an integral part of local communities and may provide day-to-day essential services to residents that must continue in an emergency.

Community businesses may also provide services and resources for emergencies.

Policy Statements

- Local Health Departments (LHDs) and MDH should identify agencies, and groups active in their jurisdictions and solicit their interest in and capabilities for emergency response.
- LHDs and MDH should also identify businesses who have the capability, interest, and resources to provide assistance during emergency responses.
- MDH and LHDs need to work closely with voluntary agencies, businesses, and community groups to clearly define expectations, roles, and responsibilities for each entity according to the emergency.
- LHDs should engage local agencies, businesses, and organizations in regular meetings and incorporate them into public health planning routinely before emergencies occur.
- LHDs should ensure that they or local emergency managers have signed agreements with voluntary agencies and community groups in place.
- LHDs should determine a list of essential services provided by local VOADs or businesses and work with those entities on continuity of operations planning COOP (i.e.; meals on wheels, chore service, medical equipment, home care, etc.).
- MDH should work with Homeland Security and Emergency Management and representatives of statewide voluntary agencies to ensure agencies are included in planning and exercises.
- LHDs and local emergency managers should work together locally to assure proper identification, credentialing, call-up procedures and site coordination of volunteers for an emergency response.

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Reaching the Public: Outreach to Community Leaders

Assumptions

Community leaders include elected officials as well as informal leaders such as leaders in the faith and limited English proficiency (LEP) communities. They can be a valuable asset in eliciting community support for public health activities.

Community leaders want to be able to comment during a public health emergency but may not have the background or resources to do so, and may need additional support to deliver correct and timely information. Information needed by community leaders may be different from that needed by response partners.

An emergency response may be led by public health, but must be coordinated with leadership outside the public health and emergency management area. Establishing relationships with community leaders prior to a response is the best approach.

In general, LHDs/CHBs will be the point of contact with their elected official and MDH will provide resources, such as talking points. SCHSAC can serve as a resource for reaching elected officials with messages.

Policy Statements

- Local health departments need to identify, develop and maintain relationships with formal and informal leaders within their communities (e.g. elected officials, faith community and immigrant communities). These contacts and contact information should be updated annually.
- LHDs should work together to identify leadership contacts at the regional level. These should be updated annually.
- MDH should identify key contacts at the statewide level for communicating with community leaders, such as chambers of commerce, league of cities, council of churches, etc.
- MDH and LHDs should establish and maintain relationships with community leaders in advance of any particular public health emergency.
- MDH and LHDs will develop a system to coordinate between state and local leadership.
- MDH and LHDs should establish a plan for communicating with community leaders as part of their response plan.
- If a LHD needs assistance in communicating with elected officials, MDH must be willing and able to help.
- MDH and LHDs should create roles for community leaders in communicating key messages.
- During an emergency, standardize communication with community leaders.

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Reaching the Public: Coordination with Border States/Nations

Assumptions

Local public health departments (LPH) are working with MDH to maintain an active list and awareness of their respective partners in bordering jurisdictions across state and national borders. Medical and health care systems provide services across state boundaries. Media and broadcast communications outlets cross state and national borders.

MDH is working with health care systems to align cross-border emergency preparedness and response efforts with Canada and bordering states consistent with the six-tier management organization strategy, adopted by the Department of Health and Human Services (DHS) and the Great Lakes Border Health Initiative.

MDH and LPH are partnering with health care systems at the regional level through the ASPR funded grants (one example of this is the SW MN-SWEPT group).

Border States and Canada may have different emergency plans and responses from Minnesota.

People follow the path of least resistance to seek care/help.

Policy Statements

- MDH, along with local LPH that share border state borders, should annually (at a minimum) establish and maintain current contact information with border partner organizations.
- LPH will work to establish conversations on pre-event planning with border states and Canada about the potential challenges from having different planned responses.
- MDH will:
 - Proactively work with media outlets.
 - Notify the public in advance of where to seek information on potential Minnesota or local response actions to an emergency.
 - Develop a functional role within Incident Command for message coordination with Border States and Canada.
- During events that impact or have the potential to impact populations across state or national borders:
 - MDH, along with LHDs, should establish contact and communication with a goal of coordinating responses and public information/messages in order to help reduce potential public confusion.
 - MDH and LHDs should assist in directing concerns to the respective authorities for public health response and information resources in their respective jurisdictions.

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Reaching the Public: Reaching Limited English Proficiency Populations

Assumptions

Limited English Proficiency (LEP) populations are widely but not evenly distributed across the state. Recent 2010 Minnesota census data show that approximately 10% of Minnesotans speak a language other than English in their homes.

The majority of LEP are represented by approximately 11 different languages with dozens of others spoken less commonly. Interpreters and translators for these languages are not always readily available and many are not trained in health or emergency terminology and issues.

Some LEP do not historically have a written language or have the ability to read in their language, and therefore rely on spoken messages. Language access services are required by state and federal law.

Some emergency messages can be pre-scripted or even pre-recorded, but many need to be developed in response to a specific incident. Effective translation/interpretation takes time to be accurate and culturally appropriate. Some message development and most message delivery to local populations is a shared state/local responsibility. Federal agencies can be of assistance in developing materials, but often do not include all the languages needed in Minnesota. Some local public health agencies may have staff who are bilingual members of LEP populations who will be pre-identified for assignment to a response role providing translation support to local LEP populations during a health emergency.

ECHO is a resource that is supported by some local health departments and MDH. It is available for activation during an emergency which is best facilitated through prior arrangements. ATT language line is a resource to communicate with LEP individuals, and usage accounts can be set up in advance of an emergency.

Policy Statements

- Public health and emergency management will coordinate planning efforts to facilitate the most efficient use of grant funds and resources. Local health departments need to identify and develop relationships with formal and informal leaders of LEP in their communities.
- Public Health Response Plans should be developed in advance so services are delivered in the most culturally appropriate manner possible.
- Emergency messages should be available in languages that effectively reach the population at risk, potentially requiring multiple formats and delivery systems. Materials for likely Minnesota hazards should be prepared before the incident.
- Organizations that serve LEP should be engaged as partners in preparing and delivering messages before and during an emergency.

- Resources for rapid translation/interpretation for statewide and localized emergency messages should be identified in advance and Memorandums of Understanding developed to facilitate service delivery during an emergency.
- LEP focused materials for a statewide incident should be developed by MDH.
- LEP focused materials for a localized incident should be developed by MDH and LHD in partnership.
- The MDH Website should have translated materials that are readily accessible to LEP during an emergency.
- ECHO—a non-profit collaborative project designed to address the growing health, safety and emergency information needs of Minnesota’s rapidly expanding limited English speaking communities—is another resource for MDH and LHDs. The mission of ECHO is to leverage partnerships to deliver vital health, safety, emergency and civic engagement information to help the ever-changing, diverse population integrate and become successful in our communities. Information on ECHO resources is available at www.echominnesota.org.

Additional information and resources are available at: www.umtia.org and www.health-exchange.net.

2011 SCHSAC EMERGENCY PREPAREDNESS WORK GROUP POLICY STATEMENTS

Reaching the Public: Joint Information System (JIS) & Joint Information Centers (JICs)

Assumptions

A Joint Information System (JIS) provides the mechanism to coordinate information across multiple jurisdictions and/or disciplines. A JIS includes the plans and protocols to provide public information. Federal, State, tribal, regional, health care system or local Public Information Officers and Joint Information Centers (JICs) are critical supporting elements of the JIS.

When the State Emergency Operations Center is opened, the SEOC JIC will be activated to provide coordination of state agency information through the media. During a health related incident, the MDH Communications Office PIOs, serving in the role of Department Operations Center PIO, will play a critical role in coordination of messaging for the public health system.

MDH may also assist locals by developing or coordinating messages during a localized health incident. Although all local health departments have a designated emergency spokesperson, many LDHs do not have a full-time designated PIO. The local spokesperson may not be trained as a PIO or employed as a health official in day-to-day responsibilities.

During a statewide health incident, MDH takes the lead in developing messages for the media, providing partners with talking points, issuing news releases, developing and web-posting fact sheets and other collateral materials, and conducting media briefings.

Media markets don't match state or local boundaries, so some Minnesotans may hear different messages from other states/countries. Many greater Minnesota counties have limited media resources so must rely on the larger markets for messaging.

Policy Statements

- Minnesota should establish and maintain a JIS to guide overall public information coordination for health emergencies involving more than one jurisdiction, including the use of JICs.
- JICs should be used for incidents that involve multiple jurisdictions and/or exceed the capacity of a local agency. They may take the form of a physical location where public information activities can be coordinated, or a "virtual" JIC that can be convened using electronic communications technologies. Options include:
 - A virtual JIC using the MNTrac system coordination center. Increased statewide awareness and procedures for efficient use should be developed.
 - Routinely scheduled conference calls.
 - Local PIO representatives physically present at an Operations Center.
- Functions of a JIC should include the collection of situational awareness information, rumor control, identification of concerns and needed messages, reports on media activities at state and local level, and coordinated message development and delivery.

- MDH and LHDs should explore additional ways to engage non-metro media in MDH-led media briefings.
- MDH-led media briefings should consider the reach of metro media markets when developing messaging to ensure accuracy for both metro and non-metro Minnesotans.
- MDH should continue to maintain the HAN messaging system and secure Workspace and to provide standard talking points, media releases, and other message coordination resources. MDH should make every effort to deliver messages to LHDs before releasing to the media.
- MDH should work with bordering states and Canada to increase standardization of messaging for large incidents.

2011 SCHSAC EMERGENCY PREPAREDNESS WORK GROUP POLICY STATEMENTS

Reaching the Public: Coordinated Messaging

Assumptions

Conflicting messages create credibility and response issues with the targeted population. Consistent coordinated messaging across federal, state and local agencies enhances response and yields the most positive outcome.

The more flexibility in the response, the less coordinated messaging can be.

Incidents evolve and may change rapidly, resulting in the need for both flexibility and timeliness of coordinated messaging.

Depending on the incident, basic talking points early may be more important than waiting for a more complete package of messages. Pre-scripting messages may work for some situations, such as floods, tornadoes, winter storms, and specific infectious diseases.

MDH and local public health share responsibility for consistent messaging to the public and determination of dissemination. When applicable, the JIC will assist with determinations.

Policy Statements

- The MDH Office of Emergency Preparedness (OEP) will initiate and lead collaboration across state agencies to support consistent messaging.
- To the extent possible, OEP will ensure MDH messaging is consistent with federal messaging and provide information when there are differences.
- MDH will assign a team/person, at the state level, tasked to focus on coordinated, consistent messaging relative to websites, fact sheets, public information releases, social media sites, etc. MDH will identify a messaging contact with local public health during a response.
- MDH will develop a system to determine which messages can be pre-scripted. The system should incorporate MDH development of initial messages that would allow for local public health to “customize” to the local and/or regional level. The system should have a process to rapidly develop messaging for incidents where messages cannot be pre-scripted or when additional messages are needed.
- Social media should be incorporated for messaging as applicable per state and local policy.
- Local public health should defer to the MDH position when there is conflicting information or recommendations on the state and federal level.

Appendix B: Minnesota Tier Assessment Program

Comparison of the 2008 and 2010 Self-Reported Tier Assessments by Local Health Departments

Introduction to Tiers Assessments

The emergency preparedness tiers were developed in 2006-2008 by a SCHSAC work group--The MDH-LPH Preparedness Committee - Roles and Responsibilities subgroup. The tiers were designed to capture the varying capabilities and capacities that exist in local health departments across the state. In 2008 and again in 2010, the MDH public health preparedness consultants worked with all the local health departments in Minnesota to conduct a self-assessment of their emergency preparedness capacities and capabilities.

Responses were initially intended to connect to the grant duties, i.e., assessing the Local Health Departments' responsibilities. The tiers were developed as part of the LHD Incident Lifecycle, which details the process and progress of a response and includes an evaluation loop. The general categories in the lifecycle are:

- Planning and Preparedness,
- Detection,
- Response,
- Recovery, and
- Long-term Recovery.

Each general category is composed of a number of specific activities such as Communications, Exercises, Work Force Readiness, etc.

2008 Tier Assessments

The 2008 self-assessments showed significant differences between metro and non-metro regions, with the majority of regions reporting that half or more of the local health departments reported that their assessment level was Base. A full report of the 2008 Assessment Process, Results, and Analysis is available through the MDH Office of Emergency Preparedness.

2010 Tier Assessments

With the significant state-wide and regional response to events, incidents, and disasters that unfolded in late 2008, and in 2009 and 2010, the Office of Emergency Preparedness decided to repeat the Tier Assessment process to see if there was a corresponding significant shift in perceived capacities. These events included:

- The Republican National Convention, held in the Metro in late summer of 2008,
- Spring flooding in the West Central and Northwest regions in the springs of 2009 and 2010,
- Summer and fall flooding in the South Central and Southeast regions in 2010,
- Tornadoes in South Central, Southeast, and Central regions in 2010,
- H1N1 Pandemic Influenza statewide from spring of 2009 through winter of 2009-10.

Re-administration of the Tiers Self-Assessment program took place throughout seven of the eight health regions during the spring and summer of 2010, and in the Central region in late 2010/early 2011.

This Summary Report

This report was prepared for the State Community Health Services Advisory Committee’s Emergency Preparedness Work Group, which analyzed issues and programs related to local and state health preparedness in 2010-2011.



September, 2004

Region	Population (2008 est.)	Population % of total	Community Health Boards	Local Health Departments			Area (sq miles)
				Counties	Cities	Tribes	
Central	715,467	14 %	10	14		1	12,431
Metro	2,810,414	54 %	11	7	4	1	2,942
Northeast	320,342	6 %	2	7		3	19,217
Northwest	229,320	4 %	5	13		3	16,301
South Central	287,756	5.5 %	6	11			6,244
Southeast	486,517	9 %	9	11		1	6,753
Southwest	213,043	4 %	6	16		2	11,265
West Central	185,453	3.5 %	3	8			6,796

Tier Analysis Comparison Report Overview

This rest of the report summarizes the changes illustrated by 2008-2010 assessments. The full Tiers Analysis report consists of the tier level graphs of the general categories’ specific activities, a summary of the results, and an analysis of the data. The full report also includes a longer discussion of the limitations and other factors that may have influenced self-assessment results.

The Tiers Capacity/Capability Continuum

It’s important to remember that there is no “right” level for an activity for any health department. The Tiers project was designed to help determine an agency’s level of readiness, to provide information for analyzing gaps in preparedness programs, and to provide a state-wide snapshot of the continuum of capacities and capabilities.

activities, and in the Alert and Notification Response activities. Again the Central region showed changes along the “less-capacity” continuum in four of the six activity categories, with Southeast, South Central, and the Metro showing this “less-capacity” shift in two of the six activity categories and the Southwest showing the “less-capacity” shift in only one of the categories.

Tier Assessment Definitions

The following table provides explanations of the activities in each of the five categories.

Activity Categories	Base	Mid-level	Comprehensive
Planning & Preparedness			
Exercises	Lead or participate in at least one local exercise consistent with HSEEP; exercise notification of local staff twice a year; participate in statewide exercises as requested	Participate in multi-jurisdictional exercises; evaluate neighboring exercises	Conduct HSEEP compliant multi-county or regional exercises
Leadership	Assign local health department (LHD) staff response roles; train staff in NIMS	Assign staff three deep	Assist other LHDs with leadership response staff
Communi-cations	Maintain capacity to use Health Alert Network system and MDH Workspace; collaborate on back-up communications systems	ID and train local spokespersons	ID subject matter experts with the region; provide training to city/county leadership on risk communication
Legal Framework	Maintain list of applicable statues and requirements for response	Help with regional mutual aid development	Lead in regional mutual aid
Workforce Readiness & Training	Facilitate and track (using MN.TRAIN, Excel or Access) training for public health staff and volunteers; report to MDH as required	Facilitate, support and track training using MN.TRAIN for all public health department staff; communicate at least annually with volunteers; develop ongoing MN Responds MRC volunteer management plan	Develop and coordinate training opportunities for local and regional public health staff; other city/county department staff; and public health volunteers in local exercises, events, and trainings
Planning	Write and maintain the Health and Medical Annex of the city/county emergency operations plan; be familiar with local city/county emergency operations plan; write and maintain the local health department all hazards emergency operations plan	Participate in hazard/vulnerability and other assessments led by emergency management for local city/county	Participate in or lead regional planning for public health incidents and events; if applicable, develop operational plans for managing the Regional Distribution Node (RDN)
Detection & Surveillance			
Assessment	Identify and monitor changes in local public health hazards and vulnerabilities	Work with emergency response partners to develop strategies to address public health hazards and vulnerabilities	Collect and analyze data on local hazards monitor impact of mitigation on hazard and vulnerability assessments

Activity Categories	Base	Mid-level	Comprehensive
Surveillance	Report relevant infectious diseases to MDH; report hazards with public health impact to MDH and/or Duty Officer and local emergency management	Update MDH about impact of diseases or hazardous incidents	Conduct investigations related to incidents in coordination with MDH
Response			
Situational Awareness	Report scope and impact of incident to MDH	Continue assessment and update MDH and partners	Monitor and report effects of the incident
Alert and Notification	Alert and notify LHD staff and local officials; know when and how to ask for help; communicate with MDH	Communicate with MAC	Respond to LHD requests for help; provide support
Response Strategies	Identify response strategies and logistical needs	Coordinate response strategies and logistical resources	Lead in coordinating response strategies and logistical and workforce needs
Workforce Response	Identify public health staff and volunteers; identify training needs and facilitate just-in-time training	Assure a 3 deep staffing rotation; provide or facilitate just-in-time training	If applicable, deploy workforce regionally; participate in MAC; provide regional mutual aid
Communications	Implement public health communications annex	Provide public health updates for multi-county/regional communications	Provide public health multi-county/regional coordination
Public Education	Provide info about special populations communication needs; distribute information	Coordinate or provide communications with special populations	Coordinate multi-county or regional education materials production and distribution
Recovery			
Situational Assessment	Debrief with local responders; write after action reports (AAR) and improvement plans (IP); Identify long-term public health recovery issues	Participate in MDH sampling assessments; assign an staff person for recovery issues	Coordinate recovery for region; participate in community recovery activities to address public health issues
Education and Training	Facilitate staff training on changed services and resources	Provide or facilitate training for PH staff and partners about changes in response plans	Identify and develop public health education and training materials
Behavioral Health	Help staff and community adjust to the new normal and ongoing public health risks	Assess behavioral health needs of public health staff; facilitate training in Psychological First Aid	Conduct regional assessment of behavioral health needs; identify strategies to address behavioral health needs; coordinate behavioral health services and resources
Communications	Work with partners to compose and deliver messages about changes & respond to incorrect information /rumors	Provide public health updates to media; provide correct information in response to misperceptions & rumors	Coordinate regional public health message development & distribution

Activity Categories	Base	Mid-level	Comprehensive
Patient Care/ Treatment	Communicate with healthcare systems about services & responses; continue public health response roles as needed	Help in med-surge step down, closure of alternative care sites, and other healthcare system activity decisions	Help in planning and coordinating med-surge step down, closure of alternative care sites, and other family/friend care information services
Mass Fatality Care	Communicate with providers of mass fatality care activities	Assist in coordination of mass fatality care activities as requested & able	Provide regional assistance & coordination
Environmental Health	Communicate with environmental health staff about concerns	Coordinate delivery of emergency environmental health services (food, water, sanitation, indoor air assessment); assist with shelter & compromised utility situations; participate in mitigation discussions; determine resource gaps	Coordinate with partners on strategies for controlling exposures & secondary effects
Long-Term Recovery			
Education and Training	Inform staff & MDH of long-term effects of incident/event	Assess ongoing training needs of LHD staff; facilitate training to address needs; Identify or develop training on long-term recovery issues	Identify or develop training on long-term recovery issues
Behavioral Health	Maintain awareness of local needs & resources; make necessary referrals	Assist with needs assessment activities, provide information & referrals; facilitate Psychological First Aid training	Assess behavioral health needs for staff & communities; coordinate with providers on referrals; provide Psychological First Aid training
Communi- cations	Provide public health information to local media	Assist in identifying misinformation/rumors & response	Develop public health messages about long-term protection strategies & other public health messages
Long-term Follow-up and Research	Assist MDH in identifying needs and in reaching those affected or in need	Support preventive, remediation and mitigation strategies, research and long-term studies	Assess need for and request intervention as indicated; participate in public health-related remediation
Environmental Health	Maintain awareness of local needs and report concerns to MDH; if a delegated county, assist local regulated facilities to clean-up according to MDH recommendations	Assist with projects for data collection and communication by others	Provide information and other services for prevention of additional disease, illness, and injury; participate with agencies who are collecting data or analyzing the impact of the incident on communities and systems

Appendix C: Assessment and Accreditation Programs

Local Technical Assistance Review Tool (LTAR)

The Local Technical Assistance Review Tool (LTAR) was developed by the CDC Division of Strategic National Stockpile to provide a blueprint to measure planning and preparedness for an event involving the use of SNS assets. There are twelve planning elements to be assessed annually for evidence of overall readiness to manage, distribute and dispense medical countermeasures during a public health emergency.

Medical Countermeasures Activities

- Distribution and dispensing of vaccine
- Distribution and dispensing of antibiotics
- Distribution and dispensing of antivirals

The twelve planning elements

1. Developing an SNS plan
2. Requesting SNS assistance
3. Managing SNS operations
4. Tactical communications
5. Public information and communications
6. Security
7. Regional/Local distribution Sites
8. Controlling inventory
9. Distribution
10. Dispensing
11. Hospitals and alternate care facilities coordination
12. Training, exercising and evaluating.

OVERALL SCORE						
SECTION	FUNCTION	Points	Max Points	Section Fraction	Weight	Weighted Score
1	Developing a SNS plan		7		.03	
2	Management of SNS/Command & Control		6		.10	
3	Requesting SNS		6		.03	
4	Tactical Communications		6		.03	
5	Public Information and Communication		6		.07	
6	Security		6		.10	
7	Receipt, Store, Stage		24		.14	
8	Controlling Inventory		6		.03	
9	Repackaging		4		.02	
10	Distribution		8		.10	
11	Dispensing		9		.22	
12	Treatment Center		5		.03	
13	Training, Exercise and Evaluation		23		.10	
		Overall Score = Sum of 13 Function Scores =				

There is also a section for baseline data, which includes 9 data elements such as “Population covered by the plan” and “Estimated number of personnel needed to staff 100% of Point of Distribution functions”.

Using the LTAR Results

The LTAR scores, which are weighted according to criticality, measure verification of achievement for the range of scores assigned to each planning element. Scores can be compared year to year to show progress and achievement, and can be used to provide gap analysis for areas needing more work.

The LTAR parallels a tool for measurement of state preparedness documentation and achievement—the STAR, or State Technical Assistance Review.

In Minnesota, all local health departments (county, city, and tribal) are required to complete the paperwork required by the LTAR annually.

LTAR resource sharing tips can be found at <http://www.orau.gov/sns/>.

Public Health Accreditation Board (PHAB) National Voluntary Accreditation

PHAB is the accrediting body for national public health accreditation. The organization was created to manage and promote the national accreditation program. PHAB was incorporated in 2007, and is developing the national accreditation program for launch in 2011. There are two sets of standards and measures: one for Local Health Departments (also used by tribal health departments) and one for State and Territorial Health Agencies.

The two sets of standards and measures are very similar. Each is organized around eleven domains and has the same set of standards; however, in some cases the measures vary in order to properly reflect a local or state context. There are a total of 30 standards, and a total of 102 measures for local health departments and 111 for state and territorial health agencies.

The preparedness measures fall under three of the 30 standards. They include the development and maintenance of an All Hazards/Emergency Response Plan and the protocols and triggers for initiation of the plan.

PHAB Preparedness Standards Considerations

- They are limited in scope to issues involving preparedness plans.
- They do not encompass the range of an incident's "life-cycle"; there is limited inclusion about response, and none about recovery.
- They do not enumerate the many sub-issues regarding preparedness including volunteers, mass dispensing, behavioral health, incident management, etc.
- Minnesota will be moving toward PHAB accreditation under recommendations by the Performance Improvement and Accreditation Work Group of the State Community Health Services Advisory Committee, December 2010.

The electronic link to the PHAB Accreditation program is:

<http://www.phaboard.org/index.php/accreditation/standards/>

Project Public Health Ready (PPHR)

The Project Public Health Ready program is a national voluntary accreditation for public health emergency preparedness. Developed by NACCHO (the National Association for City and County Health Officers), PPHR was designed to build preparedness capacity and capability through a continuous quality improvement model.

It is organized under three goals and seven measures.

Goal 1: All Hazards Preparedness Planning.

Measure 1: Possession and Maintenance of a Written All-Hazards Response Plan.

Goal 2: Workforce Capacity Development

Measure 2: Training Needs Assessment

Measure 3: Workforce Development Plan

Measure 4: Staff Competency

Measure 5: NIMS Compliance

Goal 3: Quality Improvement through Exercises and Real Events

Measure 6: Learning and Improving through Responding in an Exercise or Real Event

Measure 7: Comprehensive Exercise Plan

PPHR Program Considerations

- Accreditation under PPHR is a paper-based process; the process requires documentation of the achievement of the criteria in an electronic format. This is time-consuming and labor-intensive. [In volume, the PPHR criteria cover 32 pages, as compared to 10 pages in PHAB, and 6 pages of Minnesota's Tier criteria.]
- The process includes regional coordination and also close coordination with state accreditation assessment. The process now requires a minimum of 5 agencies in a state.
- The PPHR criteria are more specific than the Tier competencies currently in use in Minnesota.
- Plans must be operational and specific to meet the PPHR criteria.
- PPHR program strengths lie in the emphasis on planning and quality improvement. The program structure does not readily equate with Minnesota's "Life Cycle" perspective of looking at preparedness through the spectrum of planning to response to recovery.

The electronic link to Project Public Health Ready is:

<http://www.naccho.org/topics/emergency/PPHR/Criteria.cfm>

Public Health Preparedness Capabilities

In March, 2011, the Centers for Disease Control and Prevention released introductory material on a new way of classifying preparedness activities for public health preparedness, and a framework that will serve as the basis for the determination of measure and outcomes that health departments can use to assess the status of their preparedness.

The CDC identified fifteen public health preparedness capabilities as the basis for state and local public health preparedness; these are organized under six domains:

- Biosurveillance
 - Public Health Laboratory Testing
 - Public Health Surveillance and Epidemiological Investigation
- Community Resilience
 - Community Preparedness
 - Community Recovery
- Countermeasures and Mitigation
 - Medical Countermeasure Dispensing
 - Medical materiel Management and Distribution
 - Non-Pharmaceutical Interventions
 - Responder Safety and Health
- Incident Management
 - Emergency Operations Coordination
- Information Management
 - Emergency Public Information and Warning
 - Information Sharing
- Surge Management
 - Fatality Management
 - Mass Care
 - Medical Surge
 - Volunteer Management

Organization of the Capabilities

- The **Capability Definition** defines the capability as it applies to state, local, tribal, and territorial public health
- The **Function** describes the critical elements that need to occur to achieve the capability
- The **Performance Measure(s)** lists the CDC-defined performance measures (if any) associated with a function.
- The **Tasks** describe the steps that need to occur to complete the functions.

- The **Resource Elements** section lists the resources a jurisdiction needs to have or have access to (via an arrangement with a partner organization, memoranda of understanding, etc.) successfully perform a function and the associated tasks. CDC categorizes the Resources into three categories:
 1. **Planning:** Elements that should be included in existing operations plans, standard operating procedures and/or emergency operations plans. This may include language on suggested legal authorities and at-risk populations.
 2. **Skills and Training:** The baseline competencies and skills necessary for personnel and teams to possess to competently deliver a capability.
 3. **Equipment and Technology:** The equipment that a jurisdiction should have in their possession (or have access to), and the equipment should be in sufficient quantities to adequately achieve the capability within the jurisdiction.

CDC further defines some Resource Elements as “Priority”. Priority elements are considered to be the most critical of the Resource elements and as “minimum standards” for state and local preparedness. The remaining Resource Elements are recommended or suggested activities for consideration by jurisdictions.

Using the Public Health Preparedness Capabilities

The CDC suggests that the Capability document will be useful for strategic planning on both the state and local level. Here are the suggested steps:

- Phase 1: Assess Current State
 Step 1a: Assess organizational Roles and Responsibilities
 Step 1b: Assess resource elements
- Plans
 - Skills & Training
 - Equipment & Technology
- Phase 2: Determine Goals
 Step 2a: Review Jurisdictional Inputs
 Step 2b: Prioritize Capabilities & Functions
 Step 2c: Develop Short-term and Long-term Goals
- Phase 3: Develop Plans
 Step 3a: Plan Organizational Initiatives
 Step 3b: Plan Activities
- Capacity Building Activities
 - Sustaining Activities
 - Scaling Back Activities
- Step 3c: Plan Capability Evaluations & Demonstrations

Public Health Preparedness Capabilities List Considerations

- There is better integration of public health and health care planning, collaboration, and cooperation.
- The Capabilities List provides a better perspective of the needs of public health and health care than the 2007 Target Capabilities List.

- It is unclear at this time to what extent state and local Emergency Preparedness Grants will be based on the Capabilities List.
- It is unclear at this time to what extent state and local emergency preparedness plan updates and rewrites will be based on the capabilities.
- The Capabilities List document is very long with a high attention to details; some local health departments want such specificity, and others prefer to receive direction at the Functional level so they can provide their own detailed roadmap for accomplishment of the planning goals.

The electronic link to the PHP Capabilities is:

http://www.cdc.gov/phpr/capabilities/Capabilities_March_2011.pdf

Appendix D: 2010-2011 Local and Tribal Preparedness Awards

2010 to 2011 Local/Tribal Preparedness Awards						
4/10/2011						
Community Health Board	2008 Population estimate	2008 Population for Per Capita Counties	CHB population	2010-2011 Base Award	Per Capita Award based on .782 Per person	2010-2011 Total Award (CURRENT)
Aitkin-Itasca- Koochiching CHB			73,499			\$70,808
Aitkin	15,736			\$18,000		
Itasca	44,512	44,512			\$34,808	
Koochiching	13,251			\$18,000		
Anoka County CHB	327,090	327,090	327,090		\$255,784	\$255,784
Becker County CHB	32,000	32,000	32,000		\$25,024	\$25,024
Benton County CHB	39,878	39,878	39,878		\$31,185	\$31,185
Blue Earth County CHB	60,401	60,401	60,401		\$47,234	\$47,234
Brown-Nicollet			57,889			\$45,269
Brown	25,862	25,862			\$20,224	
Nicollet	32,027	32,027			\$25,045	
Carlton-Cook-Lake-St. Louis CHB			246,843			\$216,483
Carlton	33,933	33,933			\$26,536	
Cook	5,437			\$18,000		
Lake	10,609			\$18,000		
St. Louis	196,864	196,864			\$153,948	
Carver County CHB	90,043	90,043	90,043		\$70,414	\$70,414
Cass County CHB	28,732	28,732	28,732		\$22,468	\$22,468
Chisago County CHB	50,257	50,257	50,257		\$39,301	\$39,301
Clay-Wilkin CHB			62,053			\$61,610
Clay	55,767	55,767			\$43,610	
Wilkin	6,286			\$18,000		
Cottonwood-Jackson CHB			22,017			\$36,000

2010 to 2011 Local/Tribal Preparedness Awards

4/10/2011						
Community Health Board	2008 Population estimate	2008 Population for Per Capita Counties	CHB population	2010-2011 Base Award	Per Capita Award based on .782 Per person	2010-2011 Total Award (CURRENT)
Cottonwood	11,283			\$18,000		
Jackson	10,734			\$18,000		
Countryside CHB			45,937			\$90,000
Big Stone	5,365			\$18,000		
Chippewa	12,414			\$18,000		
Lac qui Parle	7,165			\$18,000		
Swift	11,035			\$18,000		
Yellow Medicine	9,958			\$18,000		
Crow Wing CHB	62,172	62,172	62,172		\$48,619	\$48,619
Dakota County CHB	392,755	392,755	392,755		\$307,134	\$307,134
Dodge-Steele CHB			56,297			\$46,579
Dodge	19,751			\$18,000		
Steele	36,546	36,546			\$28,579	
Faribault-Martin CHB			35,059			\$36,000
Faribault	14,624			\$18,000		
Martin	20,435			\$18,000		
Fillmore-Houston CHB			40,095			\$36,000
Fillmore	20,850			\$18,000		
Houston	19,245			\$18,000		
Freeborn County CHB	30,927	30,927	30,927		\$24,185	\$24,185
Goodhue County CHB	45,897	45,897	45,897		\$35,891	\$35,891
Hennepin County CHB	598,767	598,767	598,767		\$468,236	\$468,236
* City of Bloomington CHB	81,280	81,280	81,280		\$63,561	\$63,561
* City of Edina CHB	45,608	45,608	45,608		\$35,665	\$35,665
* City of Minneapolis CHB	382,605	382,605	382,605		\$299,197	\$299,197

2010 to 2011 Local/Tribal Preparedness Awards

4/10/2011						
Community Health Board	2008 Population estimate	2008 Population for Per Capita Counties	CHB population	2010-2011 Base Award	Per Capita Award based on .782 Per person	2010-2011 Total Award (CURRENT)
* City of Richfield CHB	32,728	32,728	32,728		\$25,593	\$25,593
Horizon CHB			66,614			\$100,354
Douglas	36,258	36,258			\$28,354	
Grant	6,005			\$18,000		
Stevens	9,661			\$18,000		
Traverse	3,660			\$18,000		
Pope	11,030			\$18,000		
Isanti-Mille Lacs CHB			65,482			\$51,207
Isanti	39,105	39,105			\$30,580	
Mille Lacs	26,377	26,377			\$20,627	
Kanabec-Pine CHB			44,388			\$40,128
Kanabec	16,091			\$18,000		
Pine	28,297	28,297			\$22,128	
Kandiyohi County CHB	40,679	40,679	40,679		\$31,811	\$31,811
Le Sueur-Waseca CHB			47,485			\$39,929
Le Sueur	28,042	28,042			\$21,929	
Waseca	19,443			\$18,000		
Meeker-McLeod Sibley CHB			75,262			\$65,161
McLeod	37,165	37,165			\$29,063	
Meeker	23,143	23,143			\$18,098	
Sibley	14,954			\$18,000		
Morrison-Todd-Wadena CHB			70,121			\$62,425
Morrison	32,893	32,893			\$25,722	
Todd	23,917	23,917			\$18,703	
Wadena	13,311			\$18,000		

2010 to 2011 Local/Tribal Preparedness Awards

4/10/2011						
Community Health Board	2008 Population estimate	2008 Population for Per Capita Counties	CHB population	2010-2011 Base Award	Per Capita Award based on .782 Per person	2010-2011 Total Award (CURRENT)
Mower County CHB	37,859	37,859	37,859		\$29,606	\$29,606
Nobles-Rock CHB			29,841			\$36,000
Nobles	20,365			\$18,000		
Rock	9,476			\$18,000		
Norman-Mahnomen CHB			11,733			\$36,000
Norman	6,605			\$18,000		
Mahnomen	5,128			\$18,000		
North Country CHB			74,879			\$88,279
Beltrami	43,835	43,835			\$34,279	
Clearwater	8,249			\$18,000		
Hubbard	18,810			\$18,000		
Lake of the Woods	3,985			\$18,000		
Olmsted County CHB	141,360	141,360	141,360		\$110,544	\$110,544
Otter Tail County CHB	56,786	56,786	56,786		\$44,407	\$44,407
Polk County CHB	30,694	30,694	30,694		\$24,003	\$24,003
Quin CHB			47,645			\$90,000
Kittson	4,462			\$18,000		
Marshall	9,502			\$18,000		
Pennington	13,747			\$18,000		
Red Lake	4,069			\$18,000		
Roseau	15,865			\$18,000		
Redwood-Renville CHB			31,354			\$36,000
Redwood	15,493			\$18,000		
Renville	15,861			\$18,000		
Rice County CHB	62,390	62,390	62,390		\$48,789	\$48,789

2010 to 2011 Local/Tribal Preparedness Awards

4/10/2011						
Community Health Board	2008 Population estimate	2008 Population for Per Capita Counties	CHB population	2010-2011 Base Award	Per Capita Award based on .782 Per person	2010-2011 Total Award (CURRENT)
Scott County CHB	128,937	128,937	128,937		\$100,829	\$100,829
Sherburne County CHB	87,660	87,660	87,660		\$68,550	\$68,550
St. Paul-Ramsey CHB	501,428	501,428	501,428		\$392,117	\$392,117
Stearns County CHB	147,076	147,076	147,076		\$115,013	\$115,013
Southwest Health and Human Services			48,465			\$73,428
Lincoln	5,837			\$18,000		
Lyon	24,844	24,844			\$19,428	
Murray	8,389			\$18,000		
Pipestone	9,395			\$18,000		
Wabasha County CHB	21,813		21,813	\$18,000		\$18,000
Washington County CHB	229,173	229,173	229,173		\$179,213	\$179,213
Watonwan County CHB	10,860		10,860	\$18,000		\$18,000
Winona County CHB	49,879	49,879	49,879		\$39,005	\$39,005
Wright County CHB	119,701	119,701	119,701		\$93,606	\$93,606
TOTALS	5,220,393	4,704,149	5,220,393	\$792,000	\$3,678,645	\$4,470,645
				LHD Amt Available		\$4,469,538
				Base county awards for 44 counties		\$792,000
				Per capita award for 47 cities/counties		\$3,677,538
				Per capita population		4,704,149
				Per capita amount		\$0.782

Tribal Governments are awarded the \$18,000 base amount



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